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Regional Partnership Transformation Funding Program

2020 Annual Summary

May 2021

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Overview

The Maryland Health Services Cost Review Commission ("HSCRC," or "Commission") staff has prepared the following draft summary to report on the progress of the Regional Partnership Transformation Grant Program. Funding for the program expired on June 30, 2020. Regional Partnerships provided their final report on FY 2020 activities in September 2020.

Background

The Commission authorized the Regional Partnership Transformation Grant program in June 2015. This four-year competitive grant-based program was designed to create and fund hospital-led multidisciplinary teams that work across statewide geographic regions to develop interventions for high-risk and high-utilizing Medicare beneficiaries, who often present at hospitals with multiple complex and chronic conditions. As part of the program, hospitals partnered with neighboring hospitals and/or diverse community organizations including local health departments, provider organizations, community health workers, and behavioral health resources to develop interventions that were intended to result in more efficient care delivery under the metrics of the All-Payer Model.

There were 14 hospital-led partnerships created and funded through the grant program that included 41 of Maryland's acute care hospitals (Appendix A) and served both rural and urban areas across the State. The most common interventions performed by Regional Partnerships include behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies and focused primarily on reducing potentially avoidable utilization for high-need and high-risk Medicare patients.

The funding model for the Regional Partnership Transformation Grant program was approved by the Commission in June 2015 and authorized up to 0.25 percent of FY 2016 total statewide all-payer hospital revenue to be distributed to grant applicants under a competitive bidding process. Based on this, the HSCRC released a "Request for Proposals" (RFP) and subsequently awarded hospitals $37 million in FY 2017 to implement the regional programs. Awards were reduced annually in an effort to prepare hospitals to develop financial alternatives for sustaining programs. An annual ten percent hospital cost sharing requirement was established each year through the final year of funding (FY2020).

- FY 2017 = $37.0M
- FY 2018 = $33.3M (10% Cost Share)
- FY 2019 = $29.6M (20% Cost Share)
- FY 2020 = $25.9M (30% Cost Share)

The grants limited the maximum award to 0.50 percent of a hospital's FY 2016 global budget for each approved application. Funding was issued via HSCRC-approved rate increases for hospitals who participated in Regional Partnerships. The grants expired on June 30, 2020.

Regional Partnership Transformation Funding Program

The competitive transformation implementation awards were intended to support and leverage a culmination of investments and activities related to partnerships, strategies, progress, and vision for care coordination and provider alignment in the State. The intent of these partnerships and strategies were to reduce potentially avoidable utilization at Maryland hospitals through better care coordination and provider alignment, which resulted in improvement on the metrics required under the new All-Payer Model. Those metrics included:

- Keeping the all-payer total hospital per capita revenue growth rate for Maryland residents below 3.58%;
- Achieving Medicare savings for Maryland beneficiaries in the amount of $330 million over 5 years compared to Medicare trend;
- Bringing the Maryland Medicare readmission rate to below the national average;
- Reducing Maryland Hospital Acquired Conditions in the State by 30% over 5 years; and
- Keeping Maryland Medicare per beneficiary growth over any two-year period at or below the national growth.

Transformation Program Activity

Hospitals that were granted funding were required to use these additional funds to work in collaboration with other hospitals, physicians, post-acute providers and other community-based providers. The collective goal of these activities was to support delivery system change with a focus on:

- Supportive services for persons living with chronic disease.
- Long-term care and post-acute care integration and coordination.
- Integration and coordination of physical and behavioral health services.
- Support of primary care, particularly so that care plans and most medical services are well coordinated.
- Identification, case management, and other supports for high needs and complex patients
- Episode improvements, including quality and efficiency improvements.
- Patient-centered clinical consolidation and modernization to improve quality and efficiency.
- Consumer and community engagement strategies aimed at improving patient and family-centered care and communication.
- Integration of community resources relative to social determinants of health and activities of daily living.

Bay Area Transformational Partnership

The Bay Area Transformation Partnership (BATP) was a partnership with Anne Arundel Medical Center (AAMC) and the University of Maryland Baltimore Washington Medical Center (UMBWMC). BATP implemented successful interventions such as Pharmacy Medication Therapy Management, and Integrated Behavioral Health in Primary Care. The BATP designed their programs to reduce the Total Cost of Care, reduce potentially avoidable utilization and show yearly positive return on investment. BATP was able to improve patient care and reduce PAU and associated costs. These outcomes were successful through improved care coordination with direct communication, providing relevant, actionable data at the point of care for each team member, with a 'no walls' approach across the continuum of care. BATP provided over 8,800 interventions in FY 2020 with over 40 program partnerships.

Community Health Partnership of Baltimore

Community Health Partnership of Baltimore (CHPB) focused on their Community Care Team's (CCTs) expansion upon existing services of primary care providers to coordinate care for high-risk Medicare patients. A typical team consisted of a minimum of one Nurse/Social Worker Care Manager, two Community Health Workers, and one Health Behavior Specialist. The teams assessed social influencers of health, medical, and behavioral health needs of patients. The

teams connected patients to primary care, resources to abate social barriers, and other medical and behavioral health resources.

Greater Baltimore Medical Center

Greater Baltimore Medical Center's Gilchrist Services, in partnership with MedStar's Total Elder Care (TEC) program focused efforts on their Elder Medical Care (formerly Support Our Elders) expansion. Medicare patients who were unable to make frequent visits to their primary care physician were supported at home by a rounding interdisciplinary team including physicians, nurse practitioners, social workers, and administrative coordinators who could care for complex chronic conditions within the patient's home. Gilchrist Services also increased the palliative care program in partnership with area nursing homes from two nursing homes to five nursing homes over FY 2019. GBMC also incorporated, in partnership with Sheppard Pratt, mental health professionals into practices through their Behavioral Health Enhanced Patient-Centered Medical Home

Howard Health Partnership

The Howard Health Partnership continued to leverage and promote infrastructure expansion through dedicating community care team staff to practices for care management and wrap around interventions/services. Howard Health Partnership launched a new Assisted Living Facility Collaborate to improve patient health outcomes for Howard County General Hospital (HCGH) patients that were transferred to assisted living facilities.

Calvert Memorial-It Takes a Village

Calvert Memorial (It Takes a Village) continued to provide a diverse range of health services to program participants in the three Calvert County Senior Centers. This program referred participants to available services that included evidence-based self-management programs, as well as hospital-based programs tailored to the needs and readiness to learn of patients.

LifeBridge

LifeBridge utilized funding toward their 'Transition Partnership Care Coordination' services. LifeBridge focused on the development and expansion of LifeBridge system-wide care management programs while maintaining community relationships. The care coordination teams dedicated to their project, focused on improving the medical, behavioral, and social health of identified participants. LifeBridge created multi-disciplinary teams to engage patients at various points across the healthcare continuum and throughout the community.

MedStar House Call Program

MedStar's House Call Program (MHCP) focused on providing home-based primary care to qualified frail elderly patients. This program used the CRISP Health Information Exchange to upload weekly patient panels and real-time alerts when hospital utilization events within the region occurred. To promote relationship and participation in high-risk inpatient rounding, MHCP co-housed its administrative offices on MedStar Good Samaritan Hospital's campus and adjusted staffing to deploy more mid-level providers to ensure the success of the program. The program also expanded to incorporate telehealth to accommodate social distance requirements due to COVID-19.

Nexus Montgomery

Nexus Montgomery implemented several successful interventions that supported a range of patient demographics. The Wellness and Independence for Seniors at Home (WISH) helped eligible seniors to optimize their health, remain independent at home, and reduce avoidable hospital use by connecting them to the services they before their health declined. The Hospital Care Transition (HCT) program was used to support patients transitioning from the hospital to another care setting. Nexus was able to expand existing HCT programs to serve more patients at high risk for rehospitalization. Through their program, they were able to establish a learning collaborative to coordinate data share as well as identify additional areas of collaboration. The Severely Mentally Ill (SMI) program increased the availability of residential crisis beds, added their Assertive Community Treatment team, which provided ongoing care and support for up to 100

patients at risk for hospitalization, and hired an Integration Manager to facilitate interagency coordination in efforts to reduce hospital use by patients with severe mental illness.

Peninsula Regional

Peninsula Regional implemented their Wagner Wellness Van that provided in-home and telephonic care coordination, clinical assessment and treatment for high utilizers of the 911 system and Emergency Departments. Peninsula also implemented their Smith Island Telemedicine program to provide telehealth services to community members of Smith Island who would normally have no direct access to health care. Finally, Peninsula Regional was able to deploy and embed care managers in Primary Care Practices, the ED and Transitional Care to provide management services for evolving and high-risk Medicare beneficiaries through their Care Management and Disease Management Program for Chronic Conditions.

Totally Linking Care-Southern Maryland

Totally Linking Care directed their funding toward RN-based care management which focused on enrolling high utilizers admitted to partnered hospitals into the Totally Linking Care program. The care management program integrated Community Health Workers and hospital-based case managers to determine post-discharge support to better bridge the gap from hospital care to home care.

Trivergent Health Alliance

Trivergent Health Alliance implemented therapeutic services to patients in multiple outpatient physician practices needing behavioral health case management. Patients who were discharged from emergency departments with specialized behavioral case management needs were bridged to appropriate outpatient services. Trivergent also implemented their Integrated Behavioral Health Professional in Primary Care program where standardized depression screening was used to screen all adults within the Regional Partnership employed practices. Trivergent was also able to incorporate Community Health Workers in their care management infrastructure to provide high touch care to increase patient engagement.

University of Maryland St. Joseph

University of Maryland St. Joseph was able to expand mental health services within their bridge clinic to Medicare and Medicaid patients. This effort was to slow the growth of emergency department visits for behavioral health crisis events. St. Joseph also integrated intensive relapse prevention and comprehensive case management into their project to prevent the need for re-hospitalization or repeating emergency room visits.

UMUCH-UHCC

The University of Maryland Upper Chesapeake Health (UMUCH) partnership directed their grant funds toward care coordination for their 'Post Discharge Clinics' where staff monitored the immediate needs of patients after discharge from the emergency department or inpatient units. UMUCH also implemented a Community Based Care Management Program which served as a bridge between post-discharge clinics, primary care physicians and community providers.

West Baltimore Collaborative

The West Baltimore Collaborative (WBC) utilized grant funding to implement its home and community-based care coordination program. WBC focused on patient transitions from discharge to primary or specialty care medical facilities with sufficient behavioral health and other support to address social determinants and barriers to health. In addition, WBC incorporated wrap around services for food insecurity and transportation limitations to ensure the success of the participants enrolled in the program.

Program Budget

Awards were reduced annually in an effort to prepare hospitals to develop financial alternatives for sustaining programs. An annual ten percent hospital cost sharing requirement was established each year through the final year of funding (FY2020).

- FY 2017 = Baseline
- FY 2018 = 10% Cost Share
- FY 2019 = 20% Cost Share

· FY 2020 = 30% Cost Share

Grantee spending was audited by HSCRC staff each year and any unspent funding was removed from their rates.

Partnerships of the Regional Partnership Transformation Grant Program were approved for the following amounts to implement their health outcome interventions:

Regional Partnership	Total Award Amount
Bay Area Transformational Partnership	$13,025,886
Community Health Partners of Baltimore	$20,306,052
Greater Baltimore Medical Center	$7,191,446
Howard Health Partnership	$4,992,077
Calvert Memorial-It Takes a Village	$1,225,442
LifeBridge	$9,931,268
MedStar House Call Program	$6,401,758
Nexus Montgomery	$26,056,523

Peninsula Regional	$5,339,920
Totally Linking Care-Southern Maryland	$3,982,289
Trivergent Health Alliance	$10,540,000
University of Maryland St. Joseph	$3,899,800
University of Maryland Upper Chesapeake Health	$9,154,416
West Baltimore Collaborative	$6,733,890

Transformational Impact

Although the Regional Partnership Program did not have a return-on-investment requirement, hospital partners were able to describe how funding through the Regional Partnership Transformation Program significantly impacted decreases in patient charges and emergency department visits. These impacts help to support the Maryland All-Payer Model in keeping hospital revenue per capita growth rate below 3.58%.

The program transformed care delivery among participating Maryland hospitals and among those hospitals, there were varying degrees of impact that significantly improved health outcomes, reduced costs, and reduced emergency department utilization. This was in part due to the funding opportunity through this program and alignment to the Total Cost of Care model.

Some highlights of successful interventions include:

- Howard Health Partnership saw $1,842 in TCOC savings for patients enrolled in their program.
- Peninsula Regional's Atlantic General Hospital reduced Emergency Department visits by 25.5%, decreased Potentially Avoidable Utilization by 4.1% and lowered readmissions by 7.5%.
- Totally Linking Care of Southern Maryland was able to reduce hospital admission charges by 48% and reduce hospital admissions by 31%.

Conclusion

The HSCRC's Regional Partnership Transformation Grant Program supported 14 hospital-led initiatives to execute a variety of health outcome interventions that have shown significant impact to their communities. The Regional Partners that participated in the grant program demonstrated concerted efforts in integrating coordination of physical and behavioral health services which led to promising health outcomes for beneficiaries enrolled in the 14 regional programs. This iteration of Regional Partnership grants hallmarks how meaningful collaboration within the healthcare systems across the state can address statewide health goals and positively impact population health outcomes.

Appendix A: Regional Partnership Transformation Grantees

Regional Partnership	**Member Hospital(s)**
Bay Area Transformation Partnership	1. Anne Arundel Medical Center 2. UM-Baltimore Washington Medical Center
Calvert Memorial - It Takes a Village	1. Calvert Memorial Hospital

Community Health Partnership of Baltimore	1. Johns Hopkins Hospital 2. Johns Hopkins - Bayview Medical Center 3. MedStar - Franklin Square 4. MedStar - Harbor Hospital 5. Mercy Medical Center 6. Sinai Hospital
GBMC	1. GBMC
Howard Health Partnership	1. Howard County Regional Hospital
LifeBridge	1. Carroll Hospital Center 2. Northwest Hospital 3. Sinai Hospital
MedStar House Call Program	1. MedStar - Good Samaritan 2. MedStar - Union Memorial
Nexus Montgomery	1. Holy Cross Hospital 2. Holy Cross - Germantown 3. MedStar - Montgomery General

	4. Shady Grove Adventist Hospital 5. Suburban Hospital 6. Washington Adventist Hospital
Peninsula Regional	1. Atlantic General Hospital 2. McCready Hospital 3. Peninsula Regional Medical Center
Totally Linking Care - Southern MD	1. Calvert Memorial Hospital 2. Doctor's Community Hospital 3. Fort Washington Medical Center 4. UM - Laurel Regional Medical Center 5. MedStar - Southern MD 6. MedStar - St. Mary's Hospital 7. UM - Prince George's Hospital
Trivergent Health Alliance	1. Frederick Memorial Hospital 2. Meritus Medical Center 3. Western Maryland Medical Center
UM-St Joseph	1. UM - St. Joseph

UMUCH-UHCC	1. UM - Harford Memorial Hospital 2. Union Hospital of Cecil County 3. UM - Upper Chesapeake Hospital
West Baltimore Collaborative	1. Bon Secours Hospital 2. St. Agnes Hospital 3. University of Maryland Medical Center 4. UM-Midtown