DRAFT FOR STAKEHOLDER INPUT

Progression Strategy Summary

September 14, 2016

HSCRC
Health Services Cost Review Commission

Background

- The All-Payer Model requires Maryland to submit a plan to CMS by December 31, 2016. The plan must address:
  - The All Payer Model's requirement to expand its focus to limit the growth in Medicare total cost of care (TCOC); and
  - The State's focus on limiting the growth in the Medicaid costs for dually eligible beneficiaries.
- Some strategies will require CMS approval and waivers before implementation and CMS could require changes
- The Advisory Council is charged with making recommendations on this strategic progression plan
- This document provides a **high level overview of potential progression plans based on initial stakeholder comments and for additional stakeholder review and comment**
- Content on Dual Eligible Model will be added in next version

Presentation Overview and Purpose

- This presentation suggests a potential outline and initial content for the Strategic Plan to be submitted by December 31, 2016

- Strategic Plan Outline:
  - Background: Current All-Payer Model and Amendment
  - Scope and Strategic Considerations
  - Draft Strategy Recommendations
  - Potential Timeline

- Background Materials in Appendix

Key Discussion Questions

- Content:
  - Are we focused on the right opportunities?
  - Are these the right strategies?
  - Are there other strategies?
  - How do these strategies align with current provider and health plan initiatives?
- Timeline:
  - How should the strategies and models be prioritized? What is the best phased approach? What is the timeline?
- Process:
  - How should we go about developing the plan and the models?

Background: Current All-Payer Model and Amendment

All-Payer Model Status

- All Payer hospital revenue growth contained, even as Medicaid expanded and marketplace enrollees grew under ACA
- Medicare hospital savings on track/non-hospital costs rising
- Quality measures on track
- Stakeholder participation contributing to success
- Delivery systems organizing and transforming
  - All hospitals on global budgets
  - Medical homes for many privately insured
  - Accountable care organizations for ~ 200k Medicare enrollees
  - Clinically integrated networks and regional partnerships forming
  - New Medicare Advantage plans forming
- Well developed hospital regulatory infrastructure
- Sophisticated health information exchange
- Generally positive feedback from CMS

Challenges and Areas to Address

- Need to address the remaining 44% of Medicare services not under global budgets
  - ~56% of Medicare costs under hospital global budgets
- Further progress for Medicare is dependent on advancing care redesign, alignment, and supporting infrastructure
- State lacks strong alignment tools to overcome largely fee-for-service model for non-hospital providers
- Ongoing delays in getting data and alignment tools from CMS
- Gaps in care supports for complex and chronically ill (including those in custodial care) Medicare fee-for-service (FFS) beneficiaries
- Variation among systems in implementation and performance

Care Redesign Amendment Coming Soon

- Providers called for alignment strategies
- Care Redesign Amendment developed and currently in CMS review to allow hospitals to participate in Care Redesign:
  - Access Medicare data
  - Implement Complex and Chronic Care Improvement Program and Hospital Care Improvement Program
  - Amendment allows flexibility for additional care redesign programs
  - Allows hospitals to share resources and pay incentives (if they choose to) based on savings within TCOC benchmarks
  - State working to align Amendment with MACRA requirements

Scope and Strategic Considerations

Progression Plan: Scope of Expenditures

Approximate CY 2015 Figures (for 6 million Marylanders)	
All Payer Hospital Revenues (Maryland Residents in Maryland hospitals)	$14.8 billion
Medicare Non-Hospital Spend (Maryland Beneficiaries anywhere)	$3.9 billion
Medicare Hospital Spend Non-Regulated	$0.5 billion
Medicaid Costs for Dual Eligible Patients	$1.7 billion
Total Costs to be Addressed in the Strategic Plan	**$19.9 billion**

Notes:

1. Hospital revenues incorporate ~$4.8 billion of Medicare spend.
2. Medicare savings requirements incorporates spend for Maryland beneficiaries in Maryland and other locales.
3. Medicare spend includes only payments by Medicare.
4. Medicare non-regulated hospital spend is primarily out-of-state hospital spend. Also includes in-state specialty hospital spend.
5. Medicaid figures are estimated and may be updated. They reflect non-I/DD full duals, but do not remove MA enrollees or ACO members.

Advisory Council Summary and Recommendations for Progression (July 2016)

- Maintain focus
- Retain and strengthen the All-Payer Model
- Set targets and allow flexibility to meet them
- Acquire needed data and use data in hand
- Promote accountability
- Foster alignment
- Modernize governance and regulatory oversight
- Ensure person-centered care

MACRA Provides New Opportunities for Aligning Providers

- Federal legislation referred to as MACRA dramatically alters physician reimbursement for Medicare
- Removes flawed across the board payment reductions for "excess" volume
- Introduces two value-based incentive approaches, both of which encourage the participation in Alternative Payment Models (APMs)
  1. MIPS (Merit-Based Incentive Payment System) provides incentives that could range from +/- 9% over time, and rewards participation in APMs
  2. With participation in Advanced Alternative Payment Models, physicians can opt out of MIPS and receive 5% lump sum bonuses and higher fee schedule updates
- MACRA provides an opportunity to engage physicians in the goals of the All-Payer Model (which is an APM) of better care, better health and lower costs
- Maryland will adapt its approaches to optimize opportunities under MACRA and the All-Payer Model to create Advanced APMs that can harmonize performance goals.
  - Final MACRA regulations are due in November

Aging of the Population Will Have A Profound Effect on Utilization in Maryland

- 18% of Maryland's population >65 years old by 2025
  - 28% increase in proportion age >65 between 2015 and 2025
  - 41% increase in proportion age >65 between 2015 and 2030

- Profound impact on federal and state budgets and delivery systems
  - E.g. the 28% potential increase in utilization/spend by 2025 in Medicare/Medicaid for dually eligible
  - Need to make significant changes in delivery system and community services to address service needs
  - Reduce medically unnecessary care and improve chronic care management in community settings

Draft Strategy Recommendations

Focus on Key Opportunities

- Incorporate/Expand tailored person-centered approach
  - Use data/information to tailor approach, focus on high needs persons
  - Engage consumers, families, community
  - Patient Designated Provider (PCP or other) in community for care coordination/chronic care management

- Approximately 3/4 of Medicare TCOC related to a hospitalization. Key opportunities:
  - Reduce unnecessary and preventable utilization in high cost settings
  - Ensure high quality efficient episodes with optimal outcomes;
  - Utilize expertise and resources of post-acute, long-term care, and home based providers in more flexible and effective ways to meet the growing needs of an aging population

- For dually-eligibles, just under 1/2 of Medicaid costs consist of custodial care in long-term care facilities, approximately 40% in home and community based services. Key opportunities:
  - Reduce the need for preventable high level custodial care
  - Ensuring high quality, well coordinated services

4 Key Strategies Maryland is Considering to Address Total Cost of Care and System-wide Outcomes

I. Incorporate Medicare patients into a Primary Care Home Model to support engaged patients in person-centered care with supporting care teams, data-driven care coordination, focus on high needs persons, and a supporting payment model

II. Incorporate Medicare TCOC targets and common system-wide outcome goals into all providers' incentive structures

III. Develop a focused portfolio of payment and delivery system transformations to support key goals

IV. Develop/support models that include upside and downside risk or increased levels of incentive tied to performance targets

1. Develop Primary Care Home Model (see separate presentation)

- Create a broadly applied model of person-centered care with supporting care teams, data-driven care coordination, and a supporting payment model.
  - Strive to have a Patient Designated Provider (usually PCP) who takes responsibility for coordinating services from all providers; this "quarterback" should be paid adequately for performing coordination role.
  - Replace CMS' FFS chronic care management fee with a risk adjusted care management payment per beneficiary, consistent performance metrics with incentive payments, and an option for upfront visit payments to facilitate alternative care delivery, similar to CMS CPC+ model
  - Focus on high needs patients and chronic care improvement with hospitals, ACOs, PCMH, payers, and other models.
  - Align with All Payer Model--Adjust MACRA bonus based on overarching provider performance measures including Medicare TCOC
  - Improve access to community-based, behavioral health services and supports

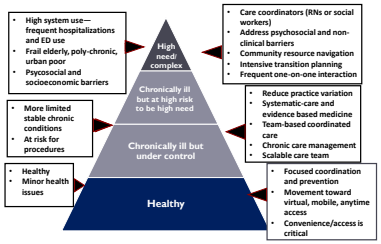
Example: Hospital Global Model Relationship with Primary Care Home Model

Hospital Global Model

Hospitals and care partners focused on population of patients within a geographic area (and their patients)

Common Approaches and Aligned Measures

Person-centered care tailored to needs



Risk stratification (esp for high needs persons)
Care coordination
Chronic care management
Reduction of avoidable utilization
All provider incentives aligned with total cost of care and outcomes goals

Primary Care Home Model

Patient Designated Providers (PDPs) are focused on their panel of patients

Patients

2. All Provider Incentives Aligned with Total Cost of Care and Outcome Goals

Goal: Create a pathway for all providers to align with key goals of All Payer Model and create opportunities for MACRA qualification for bonuses (subject to CMS approval)

Incentive Alignment Concept: Incorporate incentives for all providers based on Medicare TCOC, population health and care outcomes

- A portion of each providers payments would be based on a common set of measures
- Hospitals:
  - Beginning CY 2017/FY 2018, incorporate incentives into global budgets (similar to other quality programs) based on Medicare TCOC. Add population health and other care outcomes measures in 2019.
    - Begin with modest incentive program to allow for learning
- Physicians: (requires CMS approvals and Advanced APM qualification)
  - MACRA bonuses could be scaled up or down based on care outcomes, population health, and Medicare TCOC in a geographic area for those Advanced APMs that are created in Maryland (e.g. Care Redesign Amendment, Primary Care Home Model, Geographic Model, etc.)
- Other non-hospital providers (e.g. SNFs, etc.)
  - TBD- Need to be developed

3. Portfolio of Payment and Delivery System Transformations

- Payment and Delivery Transformation to be accomplished via:
  - Primary care/complex care/chronic care transformation
    - Care Redesign **Amendment** (Complex and Chronic Care Improvement Program) (2017)
    - **Primary Care Home Model** (develop 2016, implement 2018)
    - **Post-Acute** and **Long-Term Care** initiatives (TBD)
    - Other MACRA-eligible programs (TBD)
  - Episode-of-care focus
    - Care Redesign **Amendment** (Hospital Care Improvement Program) (2017)
    - **Post-Acute Care** initiatives (TBD)
    - Other MACRA-eligible programs (TBD)

3a. Optimize the Use of Post-Acute and Long-Term Care Services

- Post-acute and long-term facilities have significant expertise in caring for aging population
- Request that CMS grant Maryland flexibility in utilizing and optimizing these services
  - Request that Maryland be granted authority to relax the 3 day rule, where partnerships of providers agree to take on responsibility of cost and outcomes for acute and post-acute care, with no net negative impact on Medicaid
    - E.g. may be a geographic area or acute/post-acute episodes
  - Provide additional primary care and medical services in long-term care settings that will reduce preventable and unnecessary hospitalizations
- Establish a work group and set a timeline to develop specific models and timelines

4. Models to Incorporate Upside/Downside Incentives or Risk

- **Geographic Model**
  - Elements already included in Care Redesign Amendment through Hospital geographic area guardrail for physician incentive payments
  - State strategy to add +/- incentive payment based on TCOC to GBR—a MACRA qualification strategy that CMS must approve
  - Geographic Model could evolve to include larger upside/downside incentive payments over time, or develop a shared savings model with upside/downside risk similar to ACOs
- **Dual Eligibles** developing ACO/PCHH strategies also transitioning to upside/downside risk over time
- State policy strategies encourage ACO, PCMH, and Clinically Integrated Network use, including capabilities to take on upside/downside risk over time

Overview of Straw Model to Support Progression

Medicare FFS TCOC and Outcomes Focus

		ACOs	Medical Home or other Aligned Models	Duals Model (TBD)	Geographic Model
#benes in models with upside / downside incentives	2017	~50k?/200k*?	0?/35k*?	0?	830k?
	Future	250k?	150k?	80k?	400k?

Supporting Payment/Delivery Approaches with All Payer Applicability

Global Hospital Budgets
All Provider Incentive Alignment
Amendment--Complex/Chronic Care, Hospital Care/Episodes
Primary Care Home--Chronic care,Visit budget flexibility
Post-acute and Long-term Care Initiatives
Other MACRA-eligible programs

**Higher figures include all beneficiaries, including those with no downside incentives or revenue at risk*

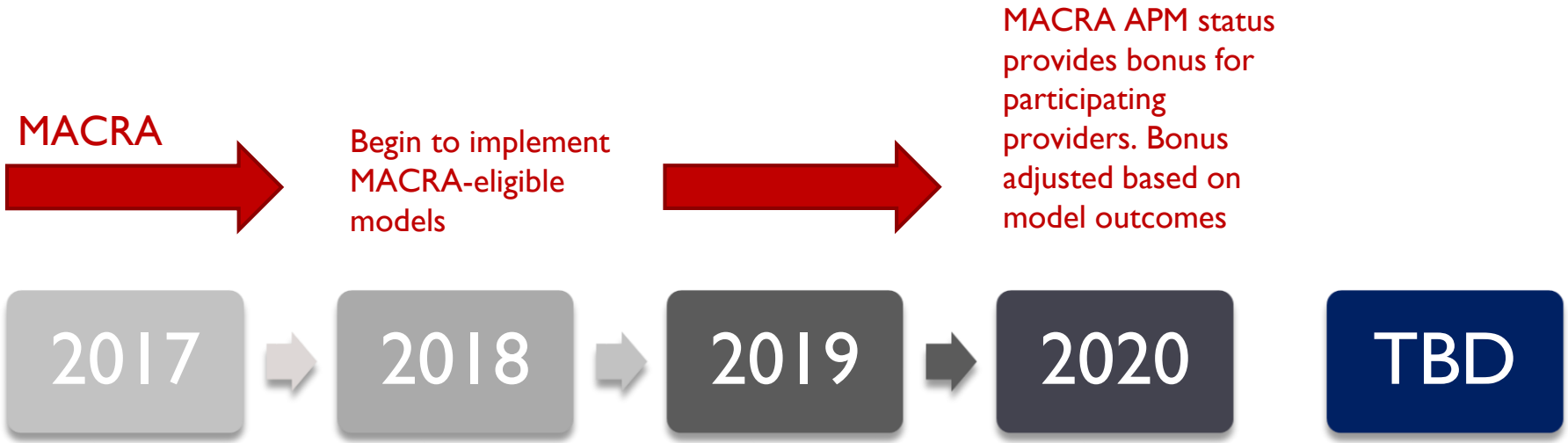
Other Needs to Address

- Develop supporting infrastructure
  - CRISP
  - Administrative/governance infrastructure
  - Transformation resources
- Linkage to public health
  - State Health Improvement Plan
  - Resources
- Consumer and community engagement
  - Patient designated provider
  - Consumer advisory
  - Breath of Fresh Care and other consumer campaigns
- Consider other strategy areas
  - Stakeholder idea, incorporate retail pharmacy savings but not risk
- Continuing refinements to global hospital model
- Integrating and harmonizing administrative, clinical, and financial aspects of care models

Potential Timeline-2016

- Develop progression plan for All Payer Model due to CMS by Dec 31, 2016
  - Develop Primary Care Model for Maryland to file with CMS by Dec 31, 2016 for possible implementation in Jan 2018
  - Develop Dual Eligibles Model for implementation in 2019
  - Progress on Population Health Plan due mid-2017
- Prepare to implement Care Redesign Amendment (no shared savings/gainsharing in 2017)
- Develop incentive approach for Medicare TCOC for implementation in 2017/2018
- Align with MACRA requirements

Potential Timeline



Note: * Indicates anticipated MACRA-eligible models (Advanced Alternative Payment Models).

Monitoring Maryland Performance
Medicare TCOC Data

Through June 2016

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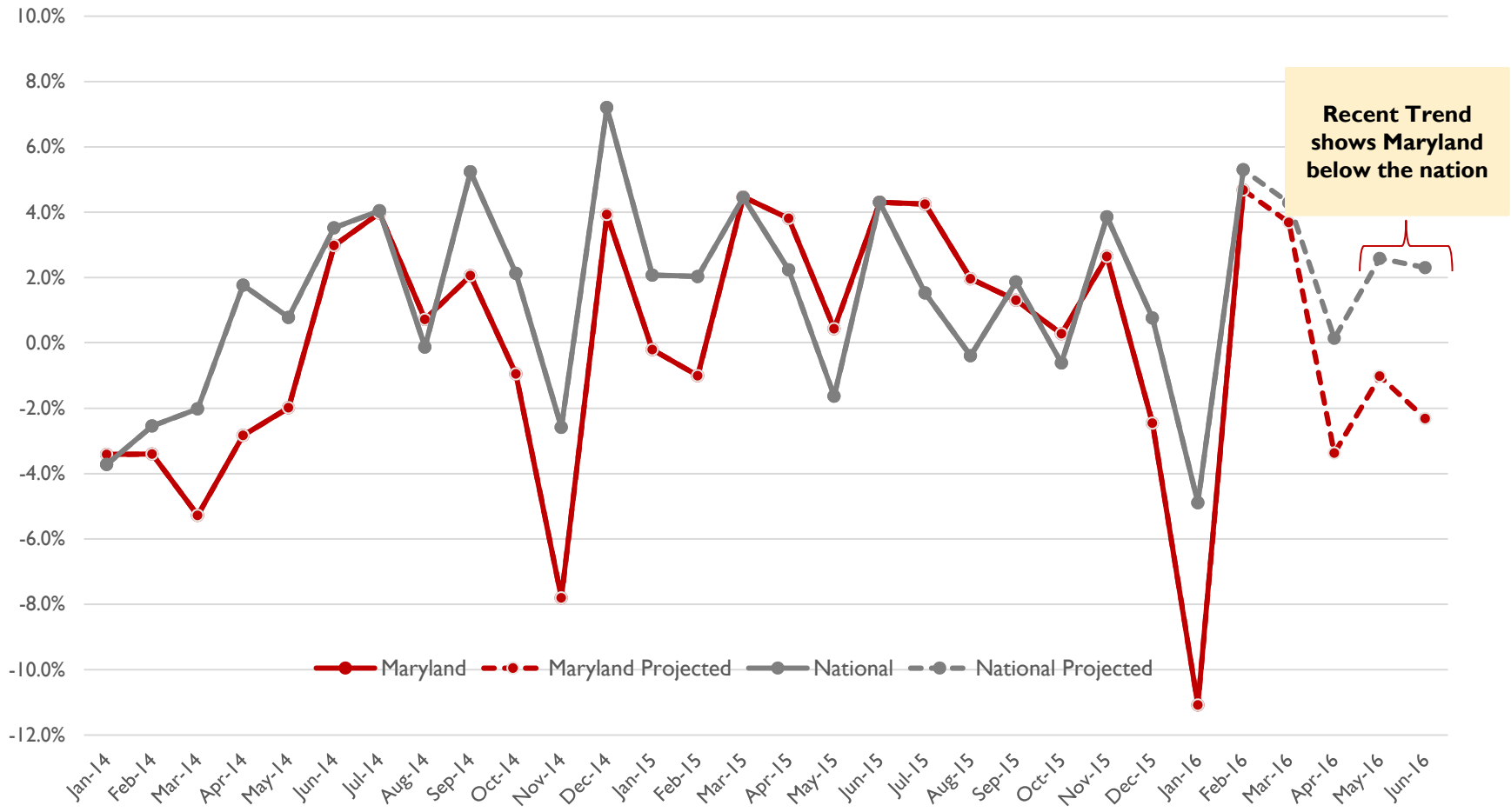
Disclaimer

Data contained in this presentation represent analyses prepared by MHA and HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



Recent Trend shows Maryland below the nation

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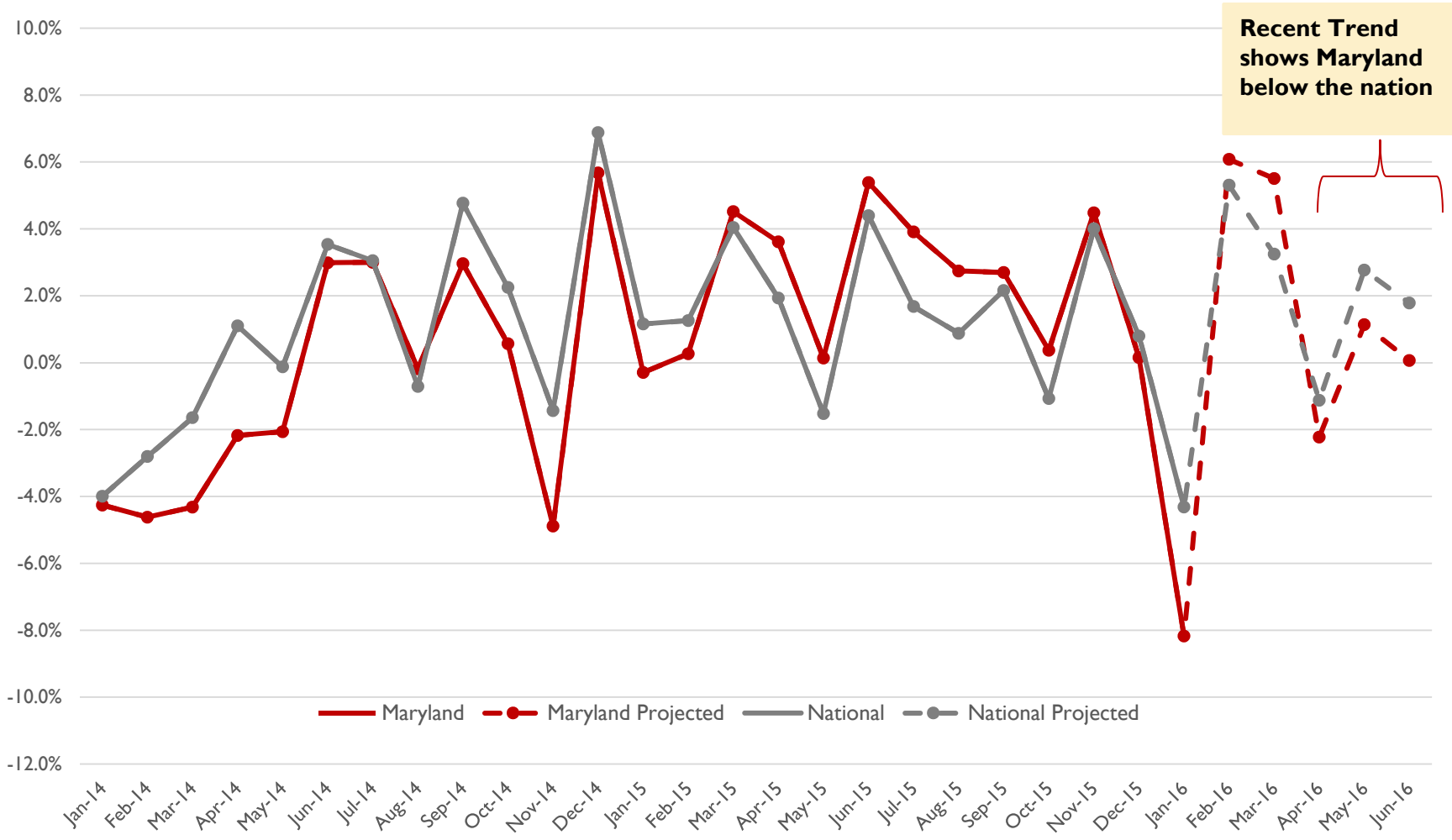
Total Cost of Care per Capita

Actual Growth Trend (CY month vs. prior CY month)



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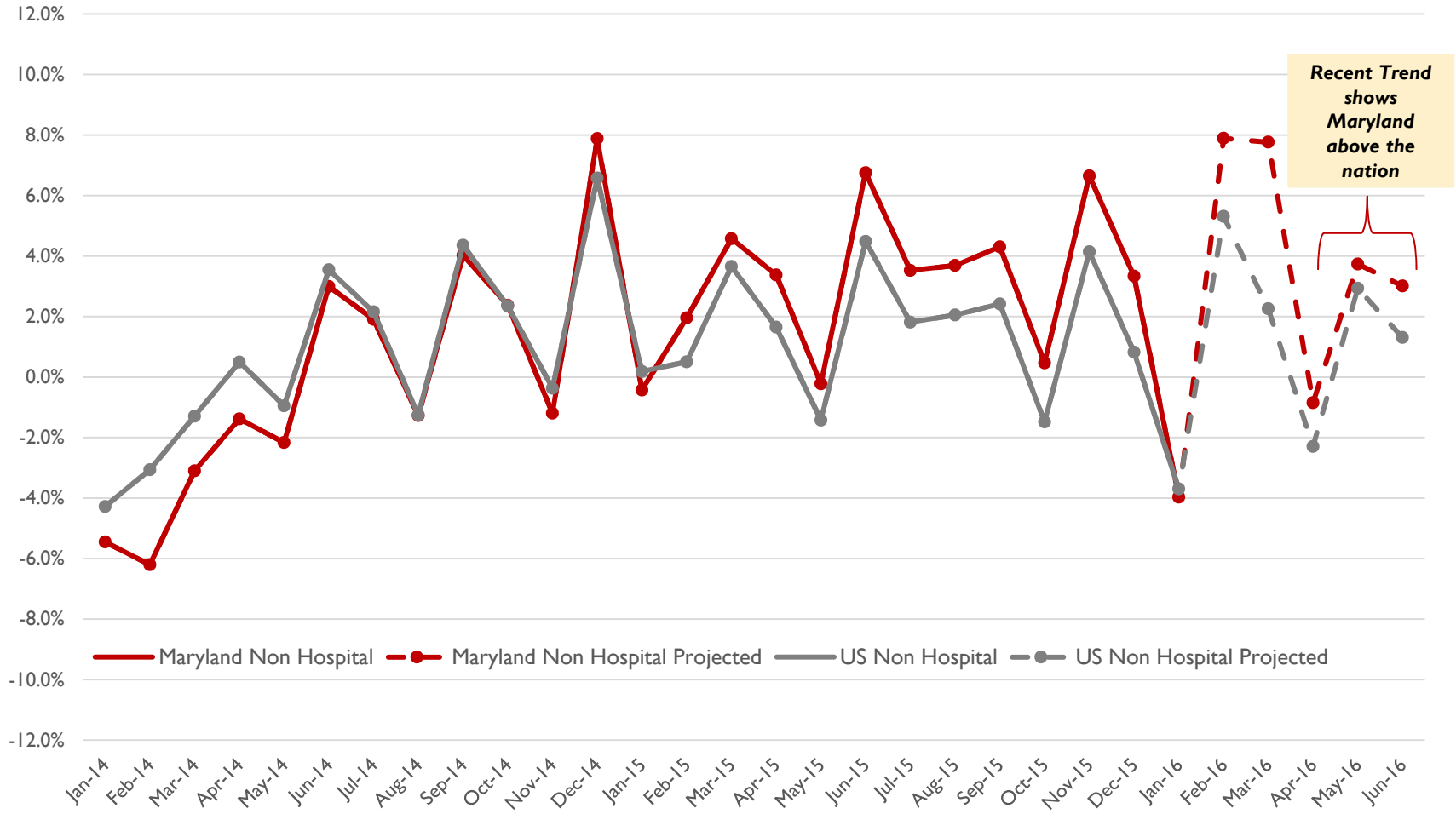
Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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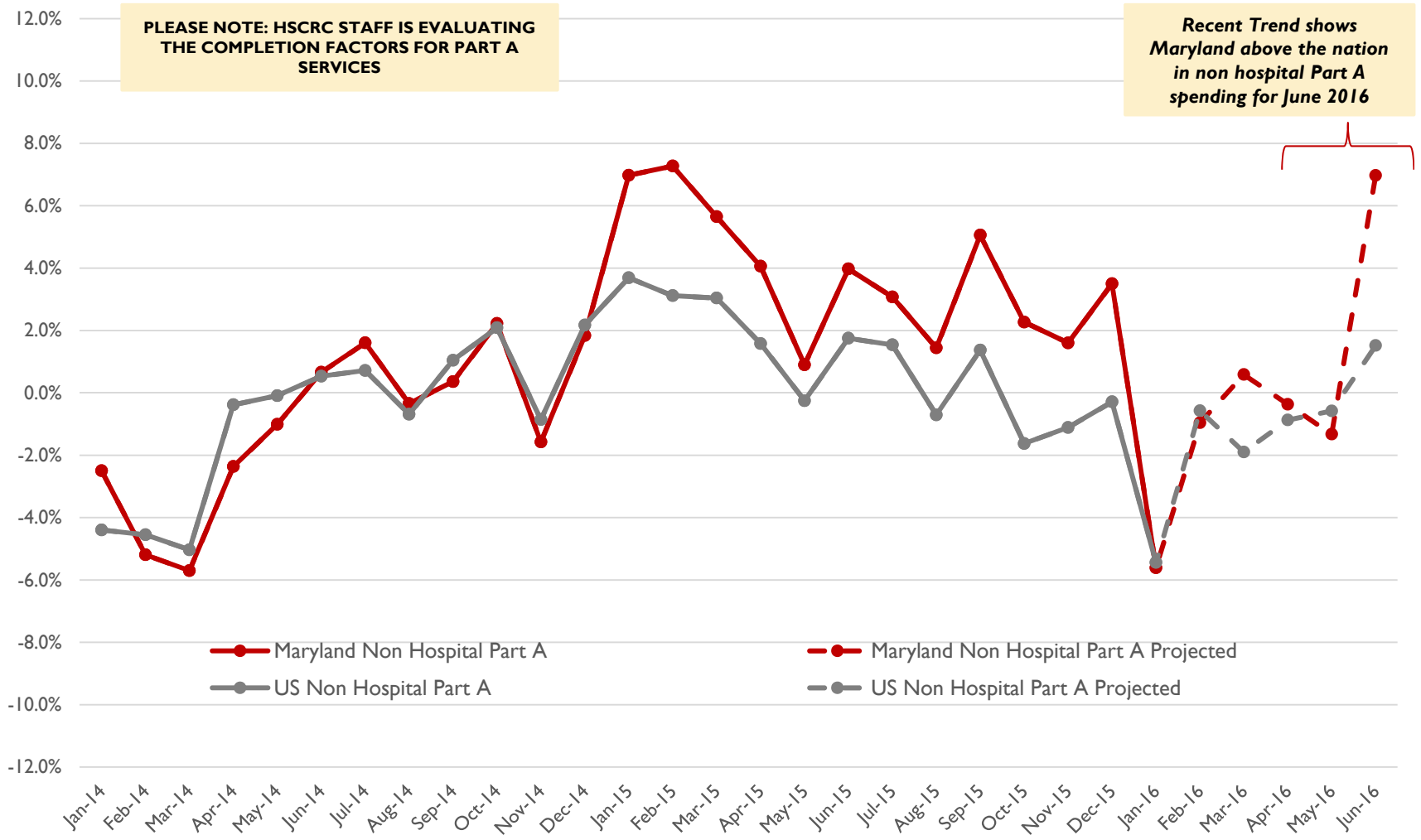
Non Hospital Part A Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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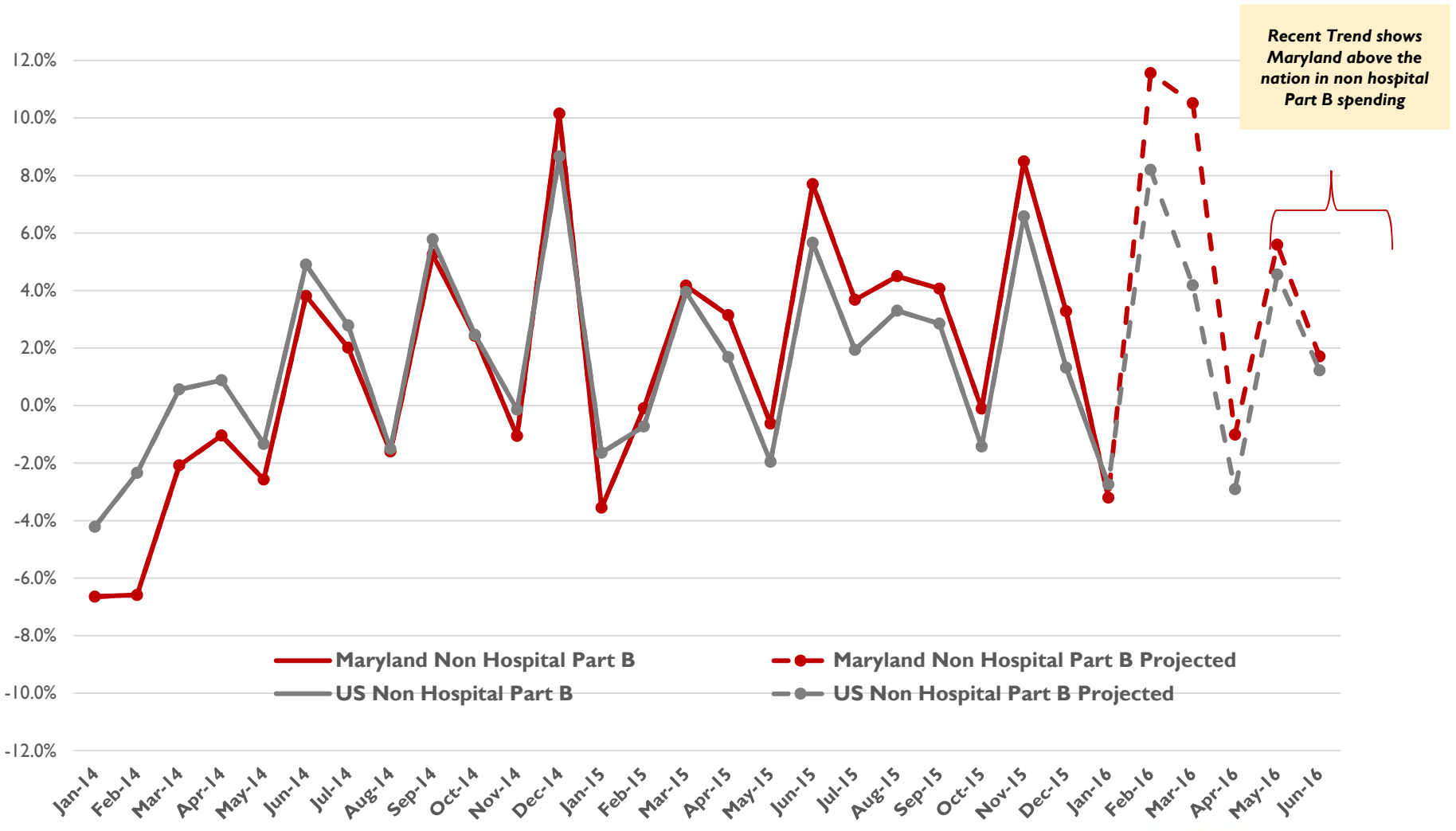
Non Hospital Part B Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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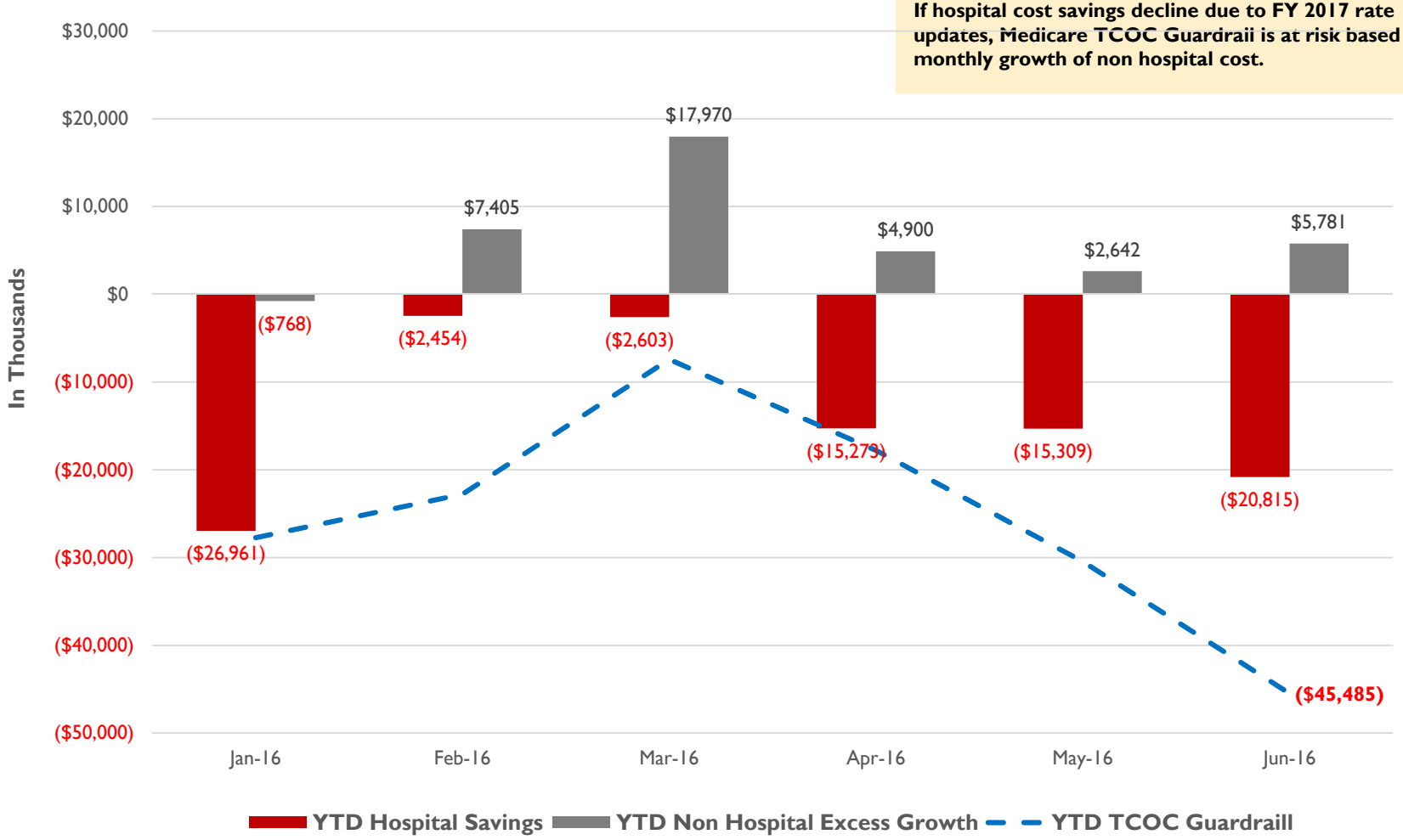
Medicare Hospital & Non Hospital Growth (with completion) CYTD through June 2016

If hospital cost savings decline due to FY 2017 rate updates, Medicare TCOC Guardrail is at risk based on monthly growth of non hospital cost.



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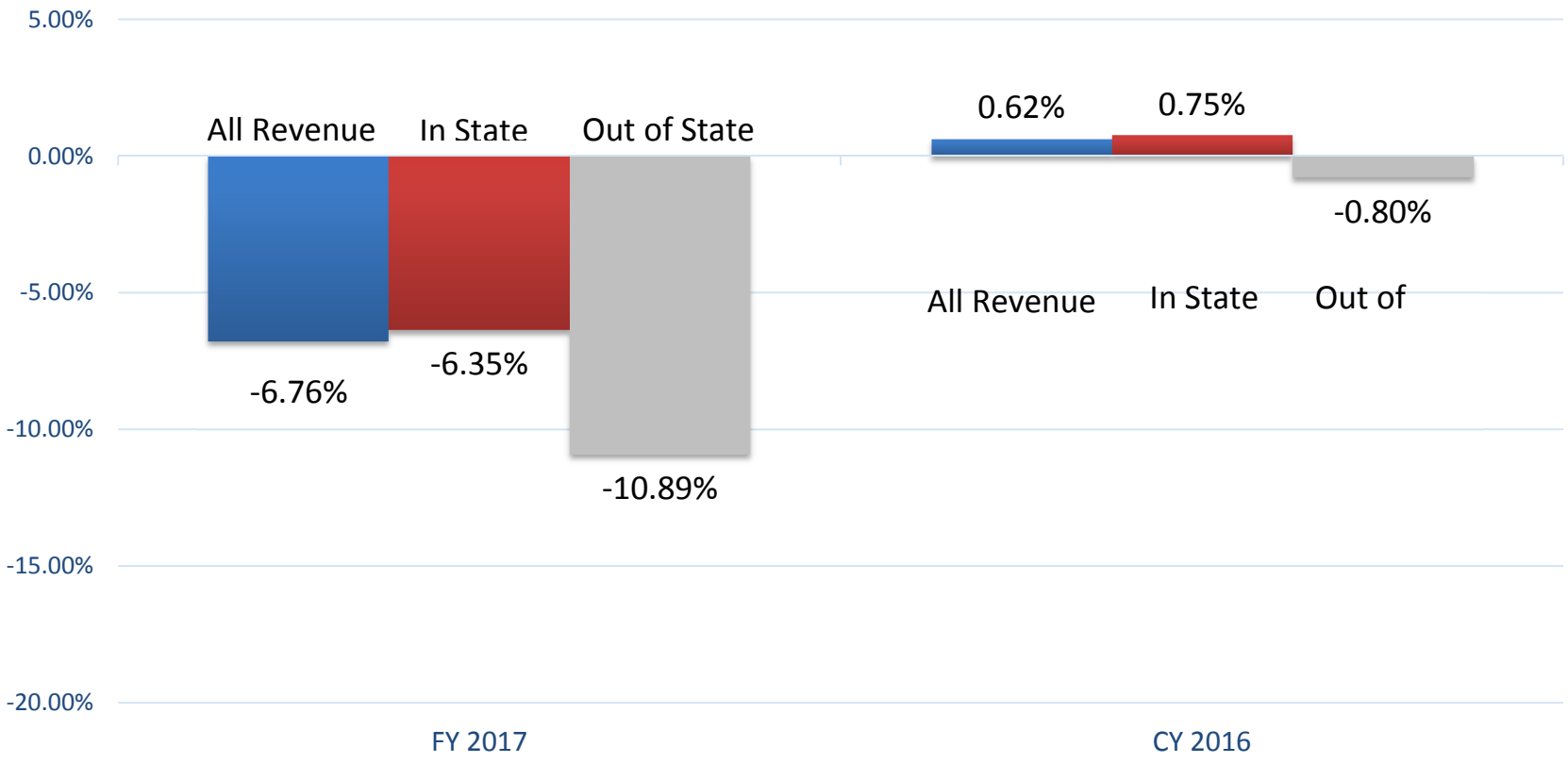
Monitoring Maryland Performance

Financial Data

Year to Date thru July 2016

Gross All Payer Revenue Growth

Year to Date (thru July 2016) Compared to Same Period in Prior Year



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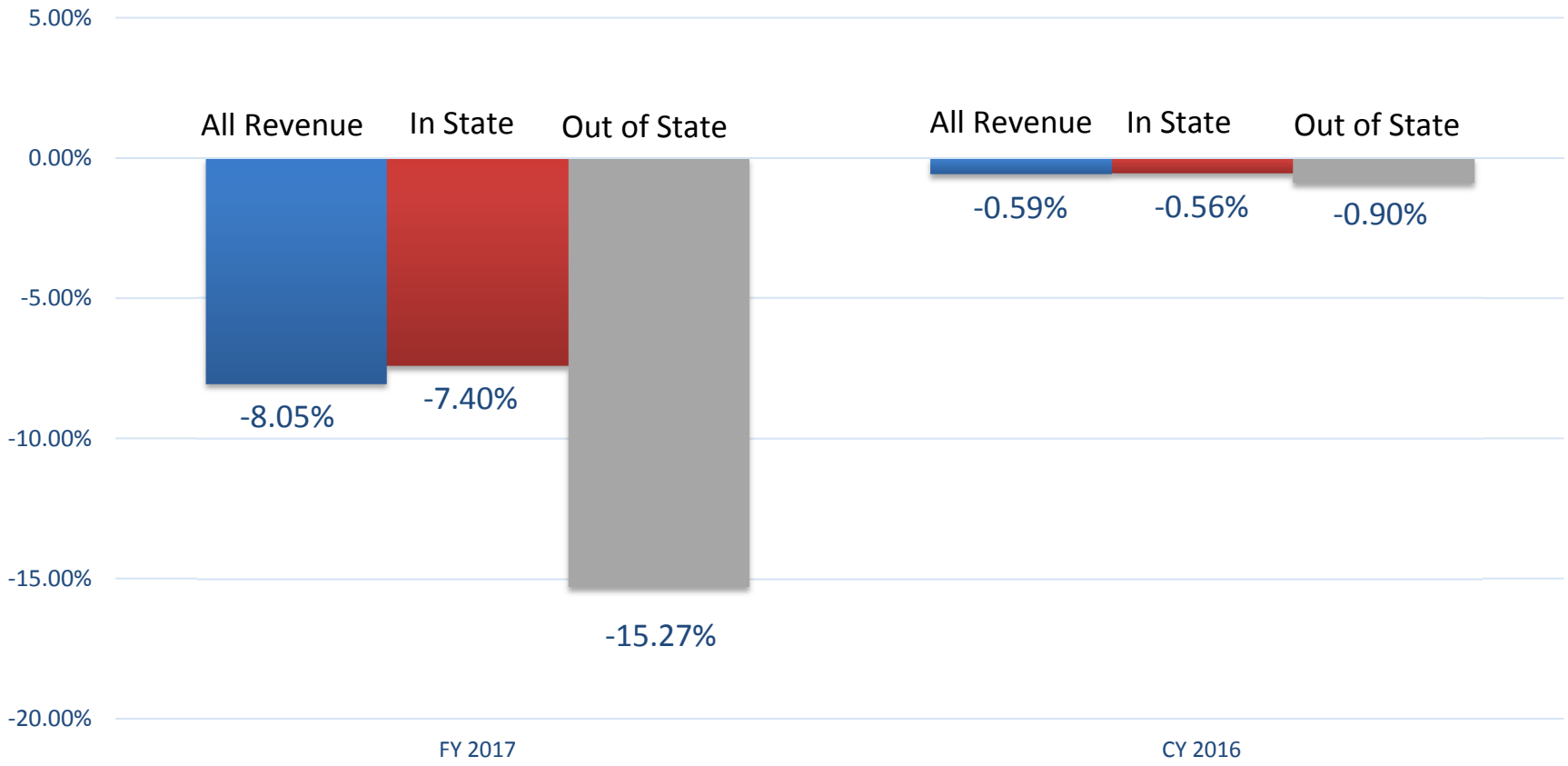
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru July 2016) Compared to Same Period in Prior Year



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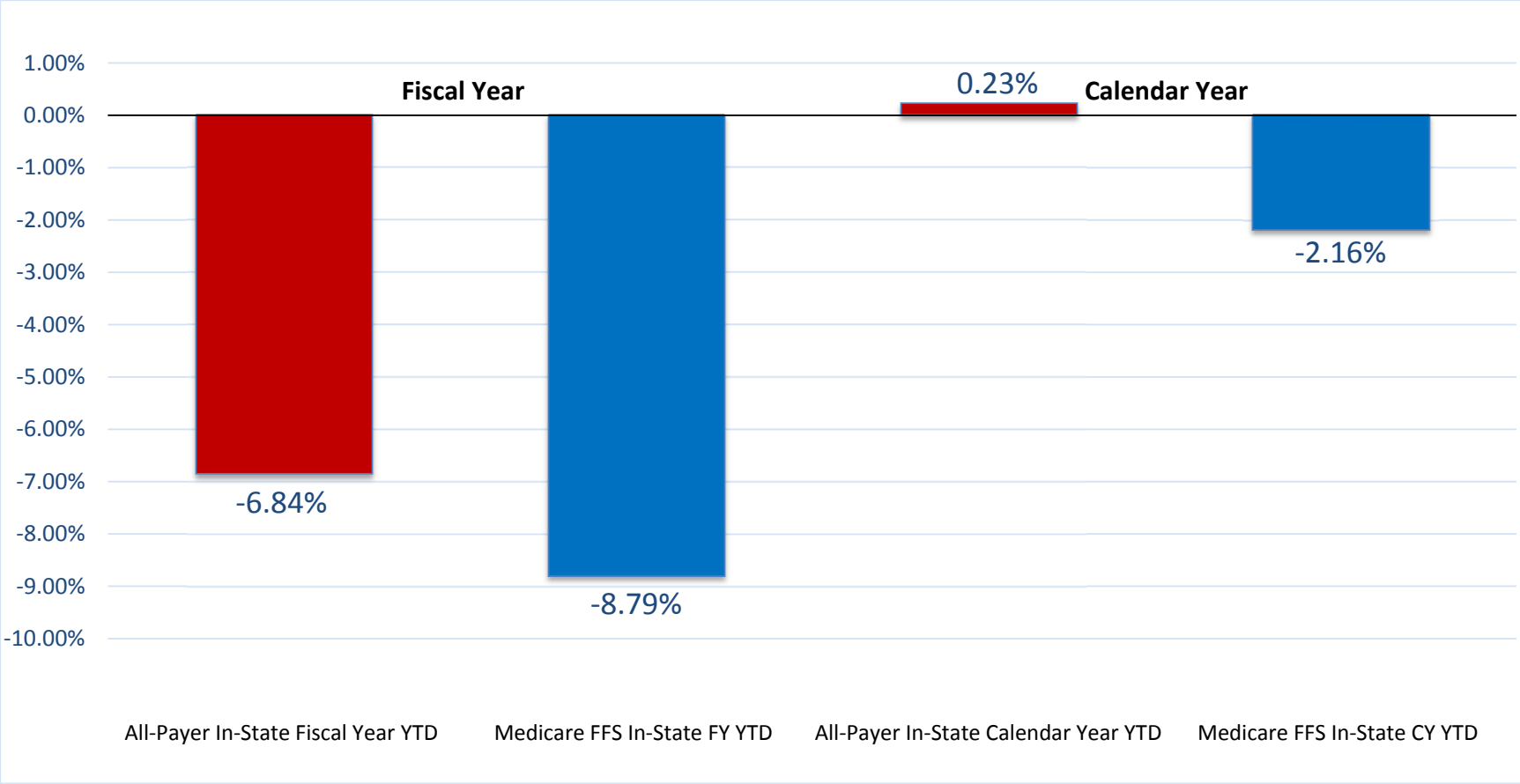
Per Capita Growth Rates

Fiscal Year 2017 (July 2016 over July 2015) and Calendar Year 2016 (Jan-Jul 2016 over Jan-Jul 2015)



- **Calendar and Fiscal Year trends through July are below All-Payer Model Guardrail of 3.58% per year for per capita growth.**

FFS = Fee-for-Service

Population Data from Estimates Prepared by Maryland Department of Planning

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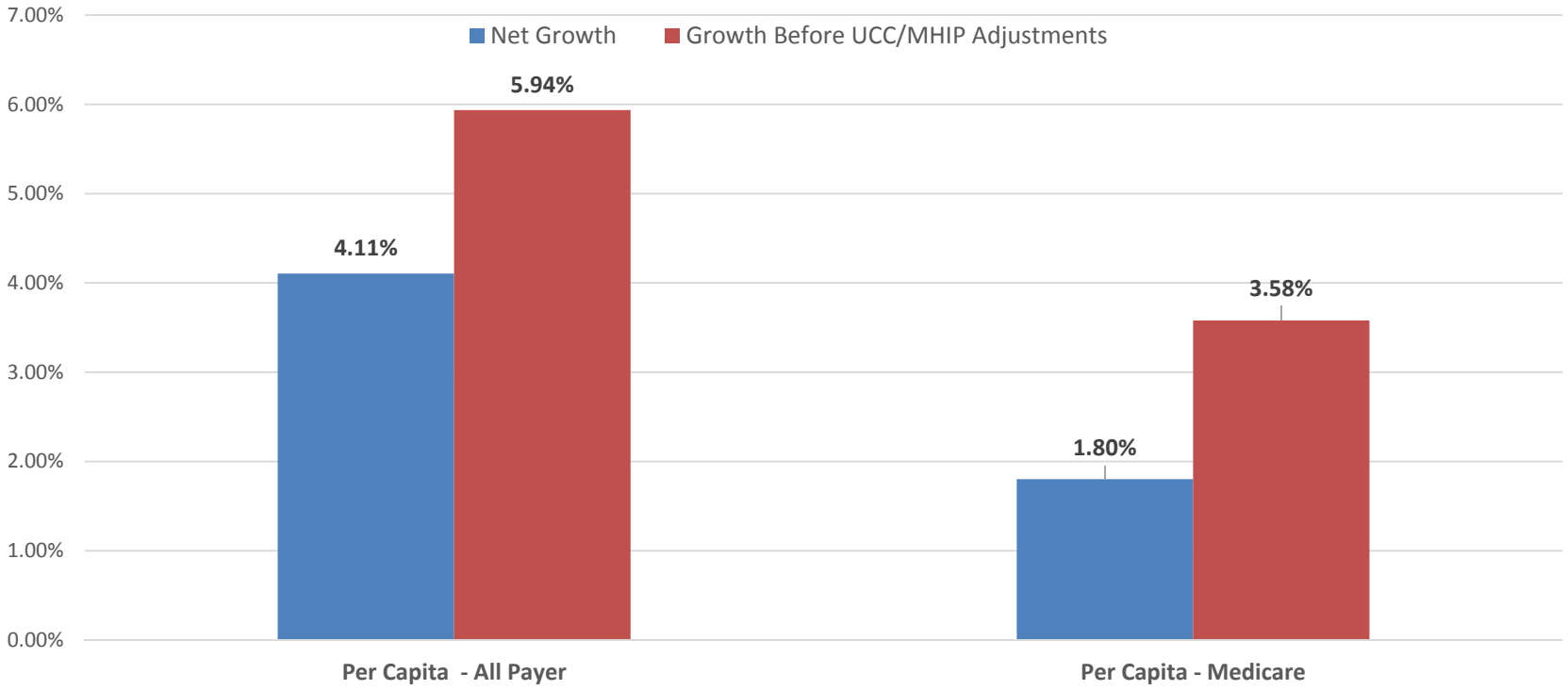
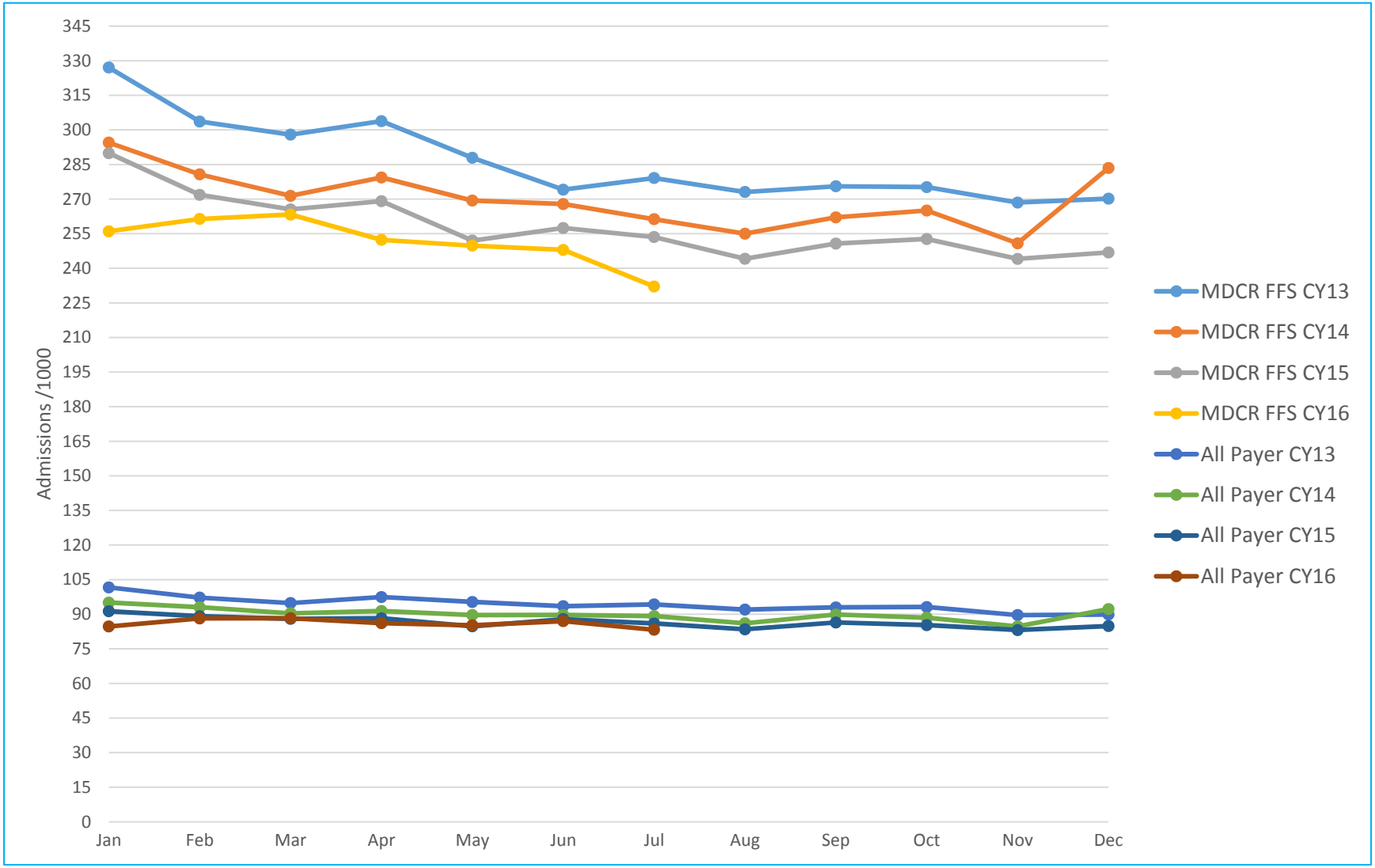
Per Capita Growth – Actual and Underlying Growth
CY 2016 Year to Date Compared to Same Period in Base Year (2013)



- Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

Annual Trends for Admissions/1000 (ADK) Annualized
Medicare FFS and All Payer



*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

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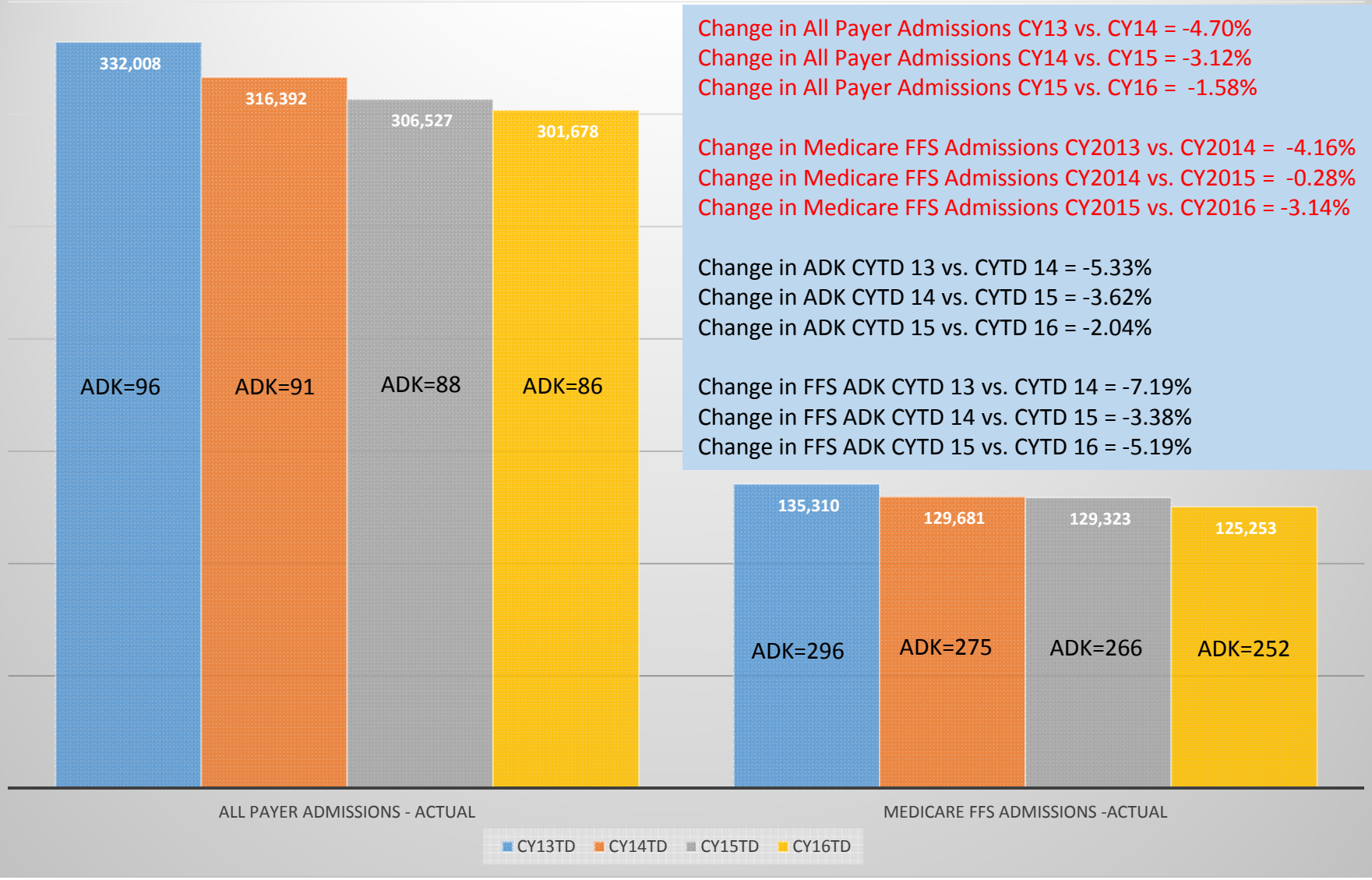
Actual Admissions by Calendar Year to Date through July



Change in All Payer Admissions CY13 vs. CY14 = -4.70%
Change in All Payer Admissions CY14 vs. CY15 = -3.12%
Change in All Payer Admissions CY15 vs. CY16 = -1.58%

Change in Medicare FFS Admissions CY2013 vs. CY2014 = -4.16%
Change in Medicare FFS Admissions CY2014 vs. CY2015 = -0.28%
Change in Medicare FFS Admissions CY2015 vs. CY2016 = -3.14%

Change in ADK CYTD 13 vs. CYTD 14 = -5.33%
Change in ADK CYTD 14 vs. CYTD 15 = -3.62%
Change in ADK CYTD 15 vs. CYTD 16 = -2.04%

Change in FFS ADK CYTD 13 vs. CYTD 14 = -7.19%
Change in FFS ADK CYTD 14 vs. CYTD 15 = -3.38%
Change in FFS ADK CYTD 15 vs. CYTD 16 = -5.19%

*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

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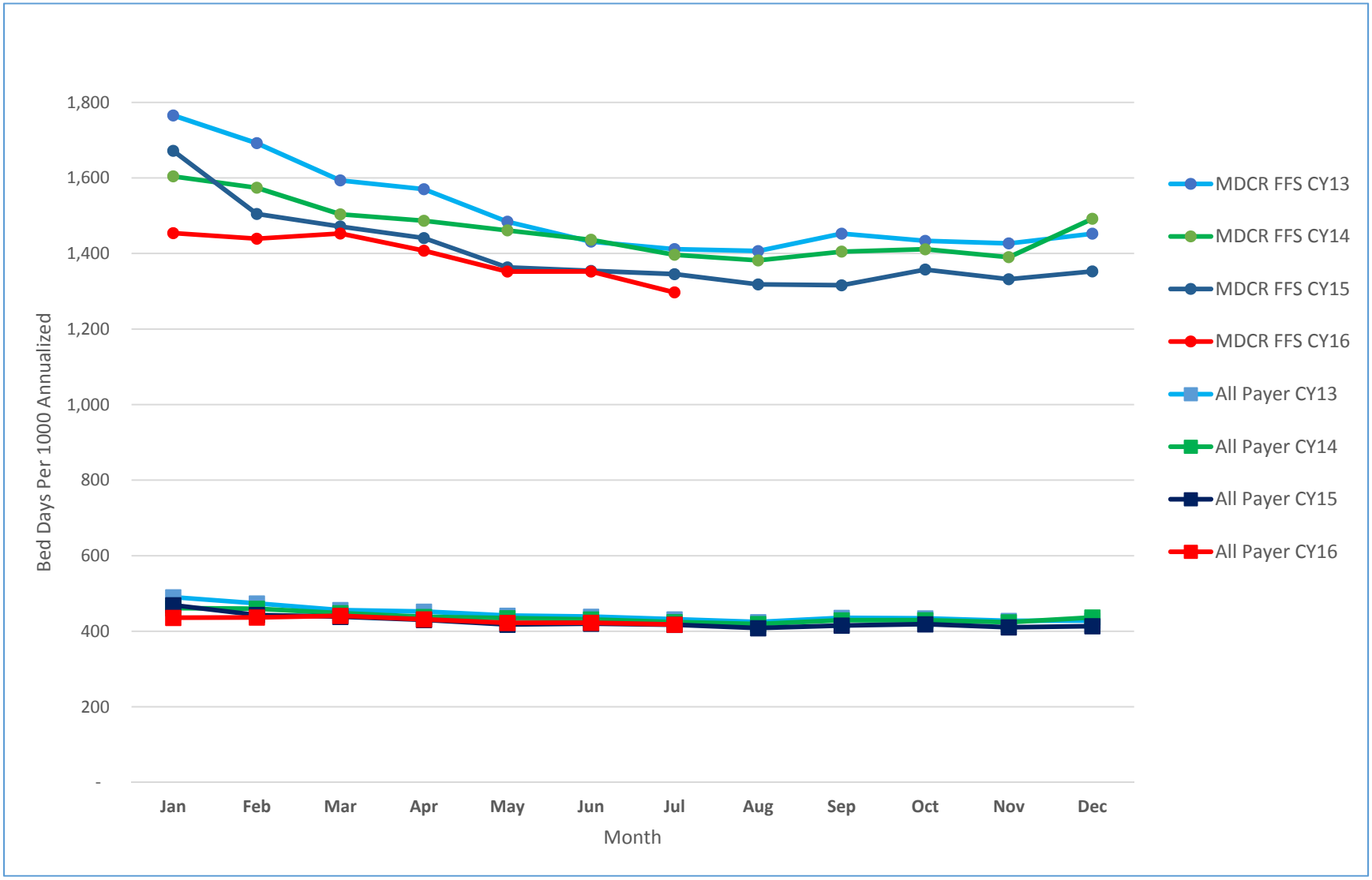
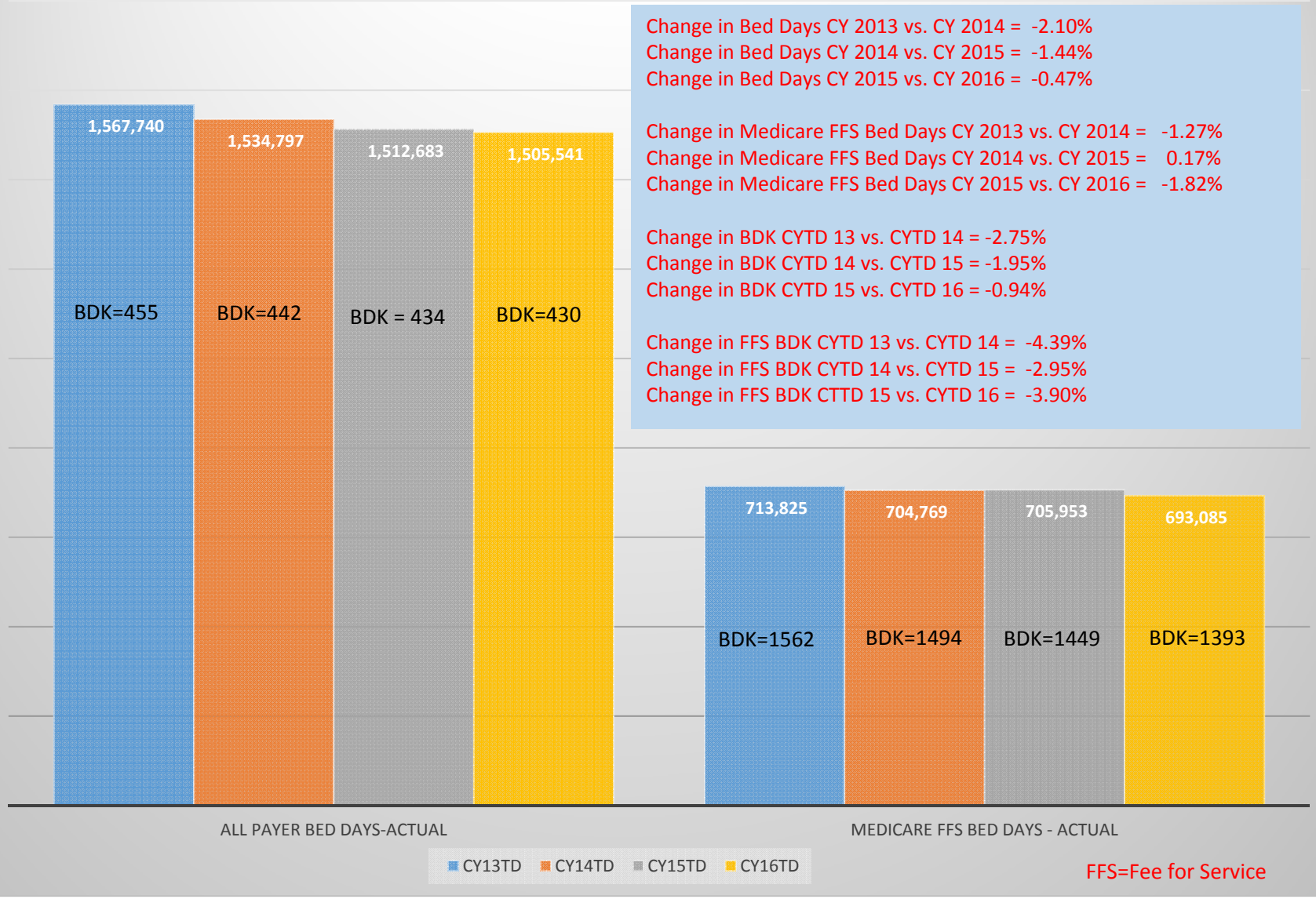
Annual Trends for Bed Days/1000 (BDK) Annualized
Medicare FFS and All Payer



*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

Actual Bed Days by Calendar Year to Date Through July



Change in Bed Days CY 2013 vs. CY 2014 = -2.10%
Change in Bed Days CY 2014 vs. CY 2015 = -1.44%
Change in Bed Days CY 2015 vs. CY 2016 = -0.47%

Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -1.27%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = 0.17%
Change in Medicare FFS Bed Days CY 2015 vs. CY 2016 = -1.82%

Change in BDK CYTD 13 vs. CYTD 14 = -2.75%
Change in BDK CYTD 14 vs. CYTD 15 = -1.95%
Change in BDK CYTD 15 vs. CYTD 16 = -0.94%

Change in FFS BDK CYTD 13 vs. CYTD 14 = -4.39%
Change in FFS BDK CYTD 14 vs. CYTD 15 = -2.95%
Change in FFS BDK CTTD 15 vs. CYTD 16 = -3.90%

FFS=Fee for Service

*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

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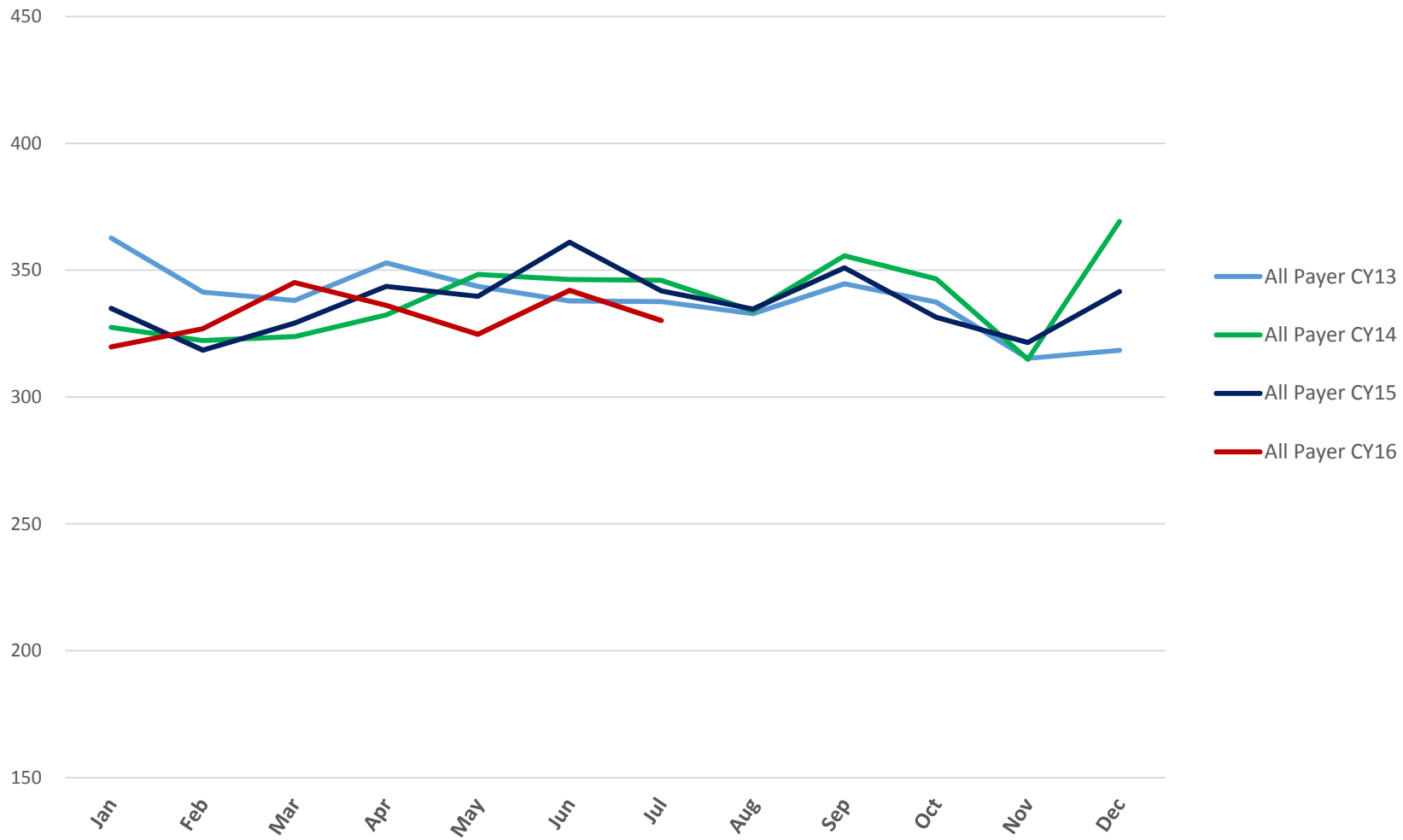
Annual Trends for ED Visits /1000 (EDK) Annualized All Payer



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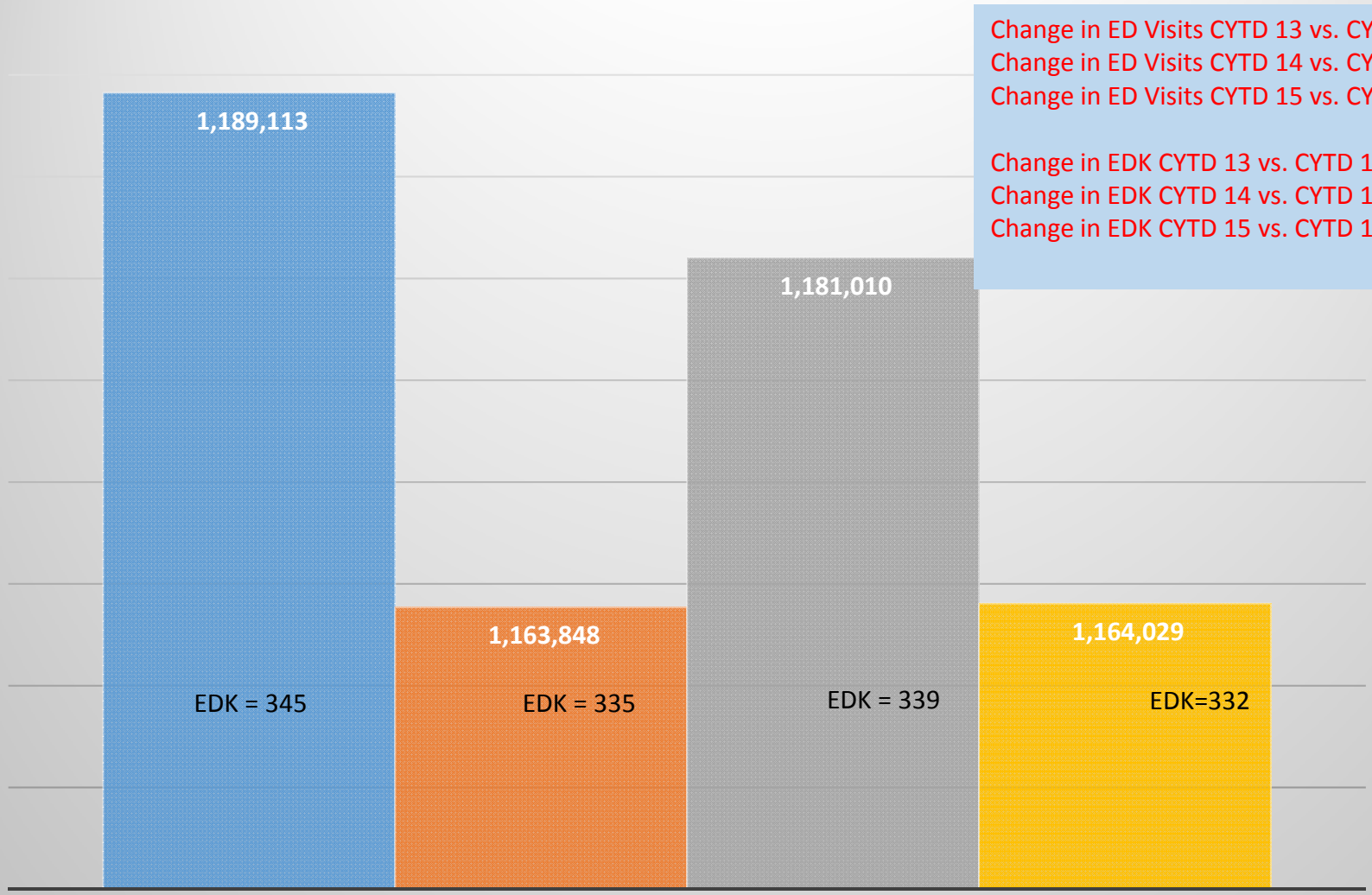
Actual ED Visits by Calendar YTD through July



Change in ED Visits CYTD 13 vs. CYTD 14 = -2.12%
Change in ED Visits CYTD 14 vs. CYTD 15 = 1.47%
Change in ED Visits CYTD 15 vs. CYTD 16 = -1.44%

Change in EDK CYTD 13 vs. CYTD 14 = -2.77%
Change in EDK CYTD 14 vs. CYTD 15 = 0.95%
Change in EDK CYTD 15 vs. CYTD 16 = -1.90%

*Note - The ED visits do not include out of state migration or specialty psych and rehab hospitals.

Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .52% for FY 16 and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

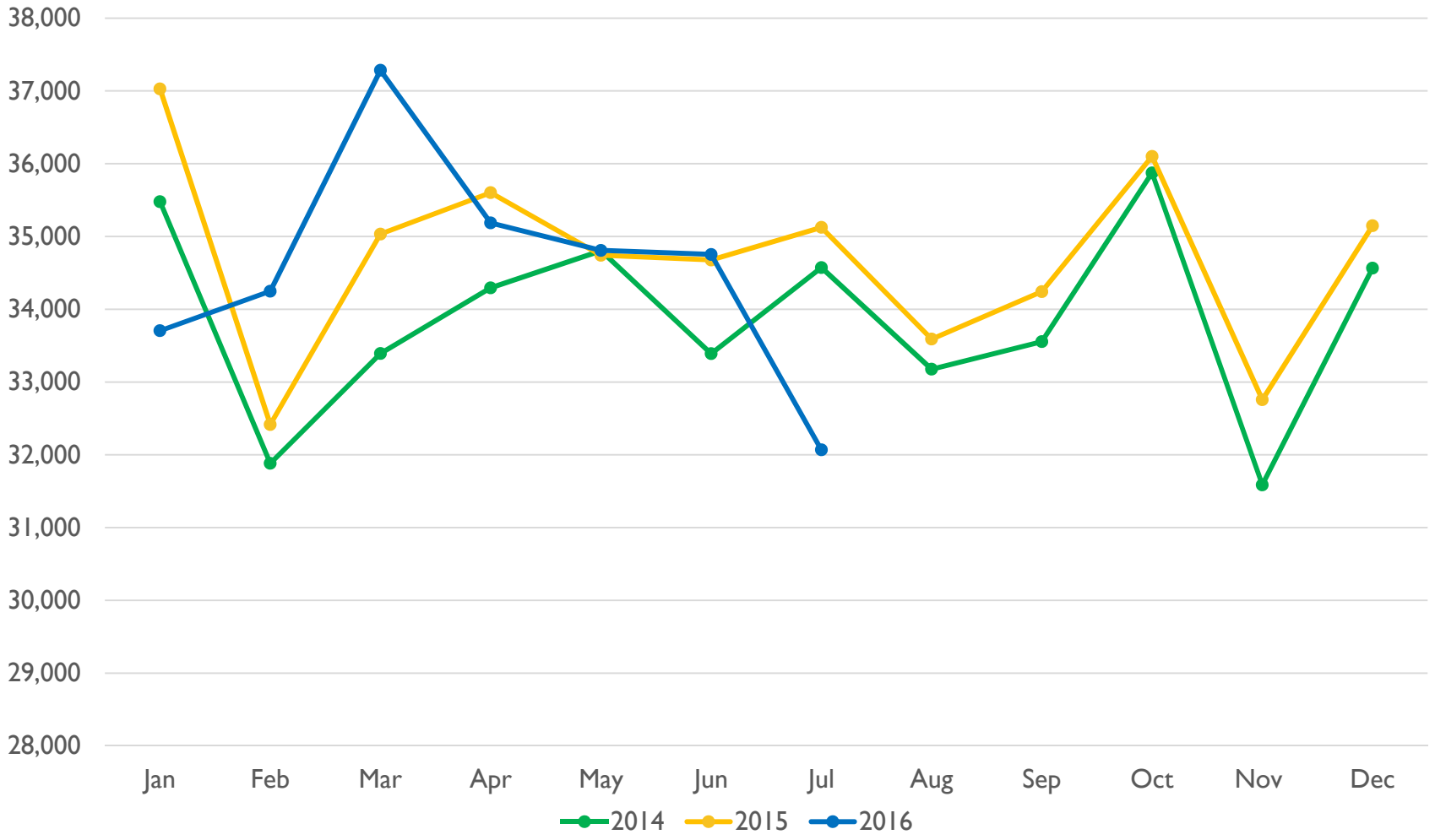
Data Caveats cont.

- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

Monitoring Maryland Performance
Preliminary Utilization Trends

2016 vs 2015
(January to July)

Medicare MD Resident ECMAD Growth by Month

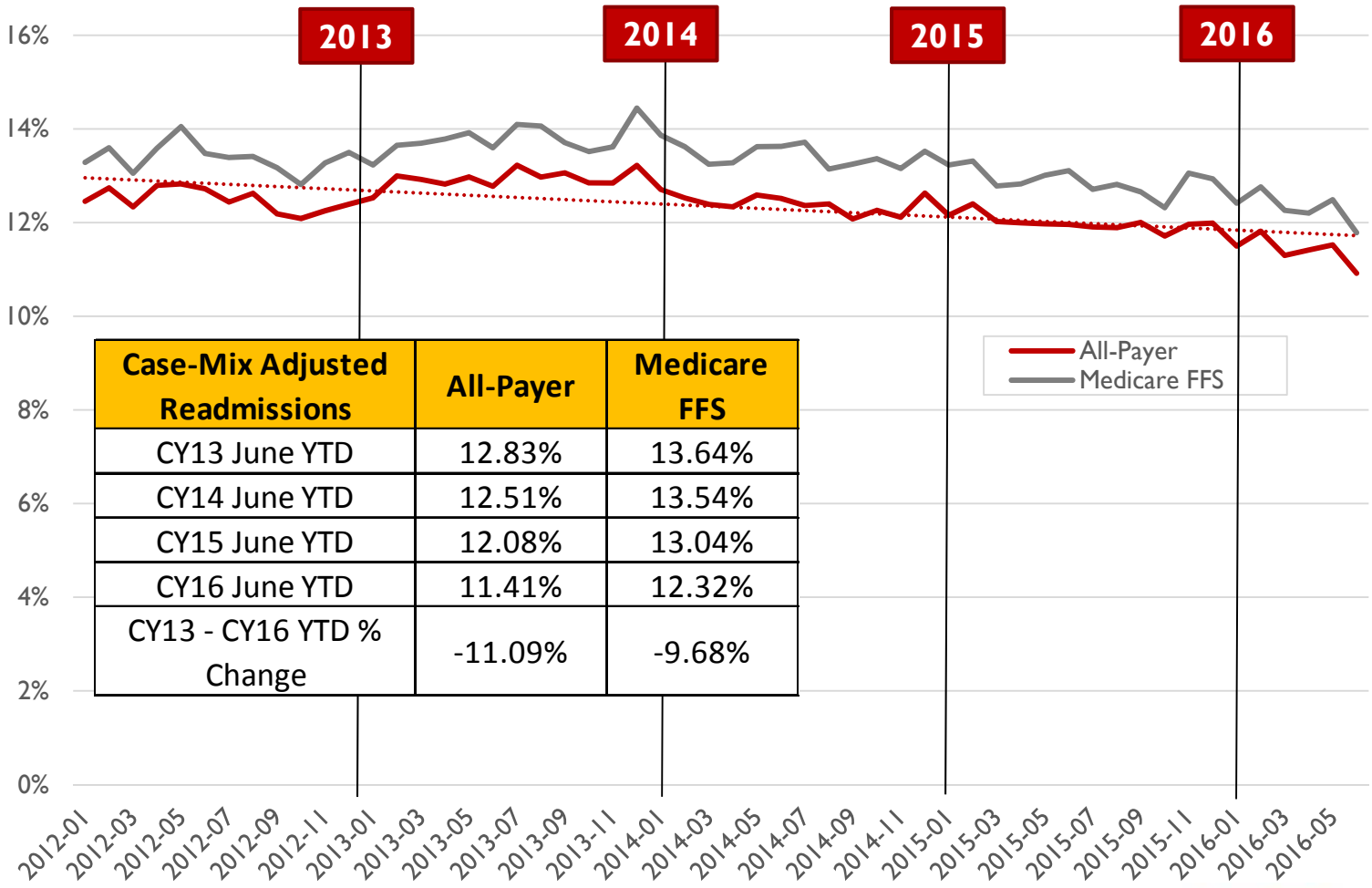


HSCRC
Health Services Cost Review Commission

Monitoring Maryland Performance
Quality Data

September 2016 Commission Meeting Update

Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY13 June YTD	12.83%	13.64%
CY14 June YTD	12.51%	13.54%
CY15 June YTD	12.08%	13.04%
CY16 June YTD	11.41%	12.32%
CY13 - CY16 YTD % Change	-11.09%	-9.68%

Note: Based on final data for January 2012 – March 2016, and preliminary data through July 2016.

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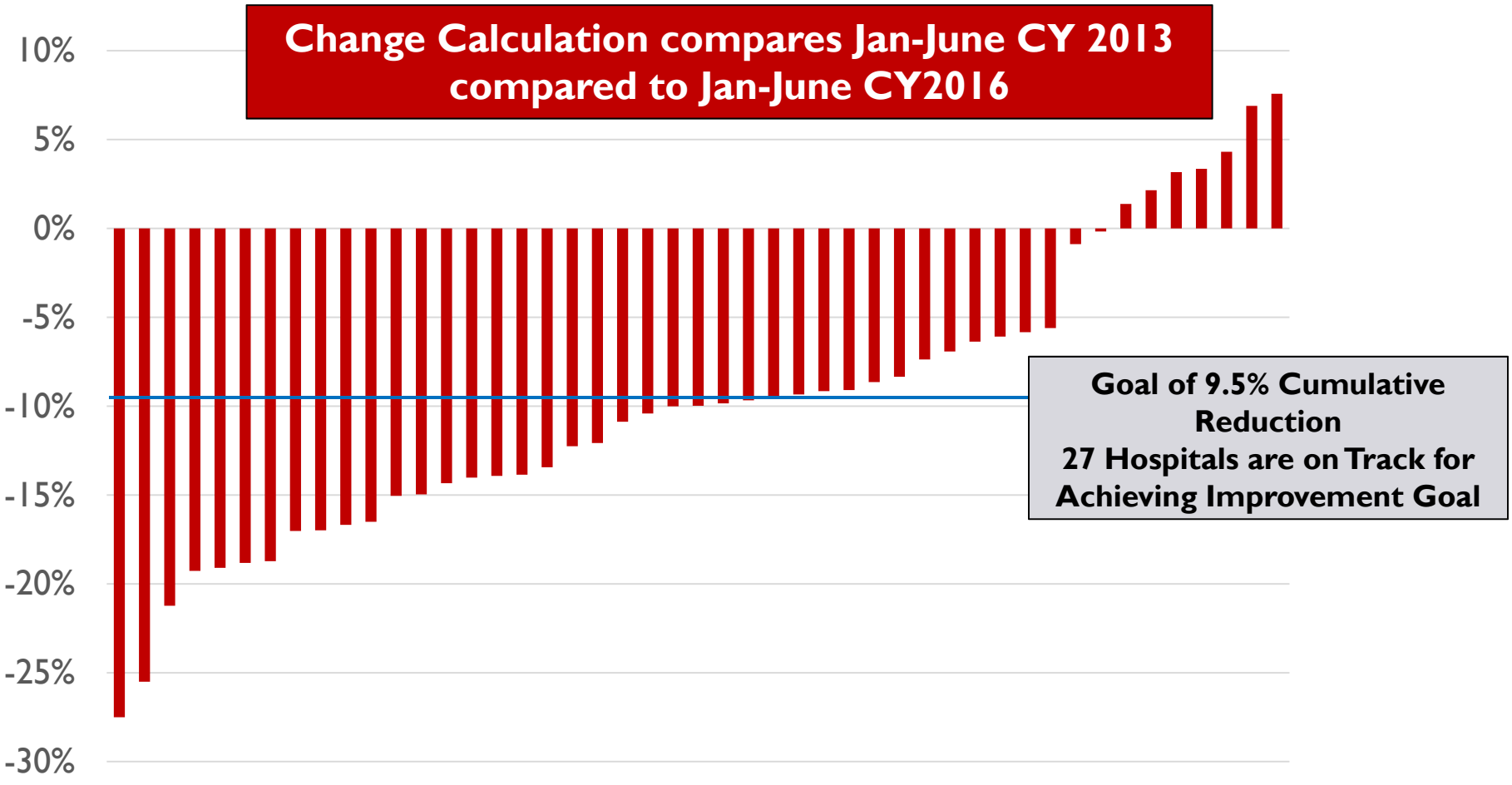
Health Services Cost Review Commission

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital



Note: Based on final data for January 2012 – March 2016, and preliminary data through July 2016.

HSCRC
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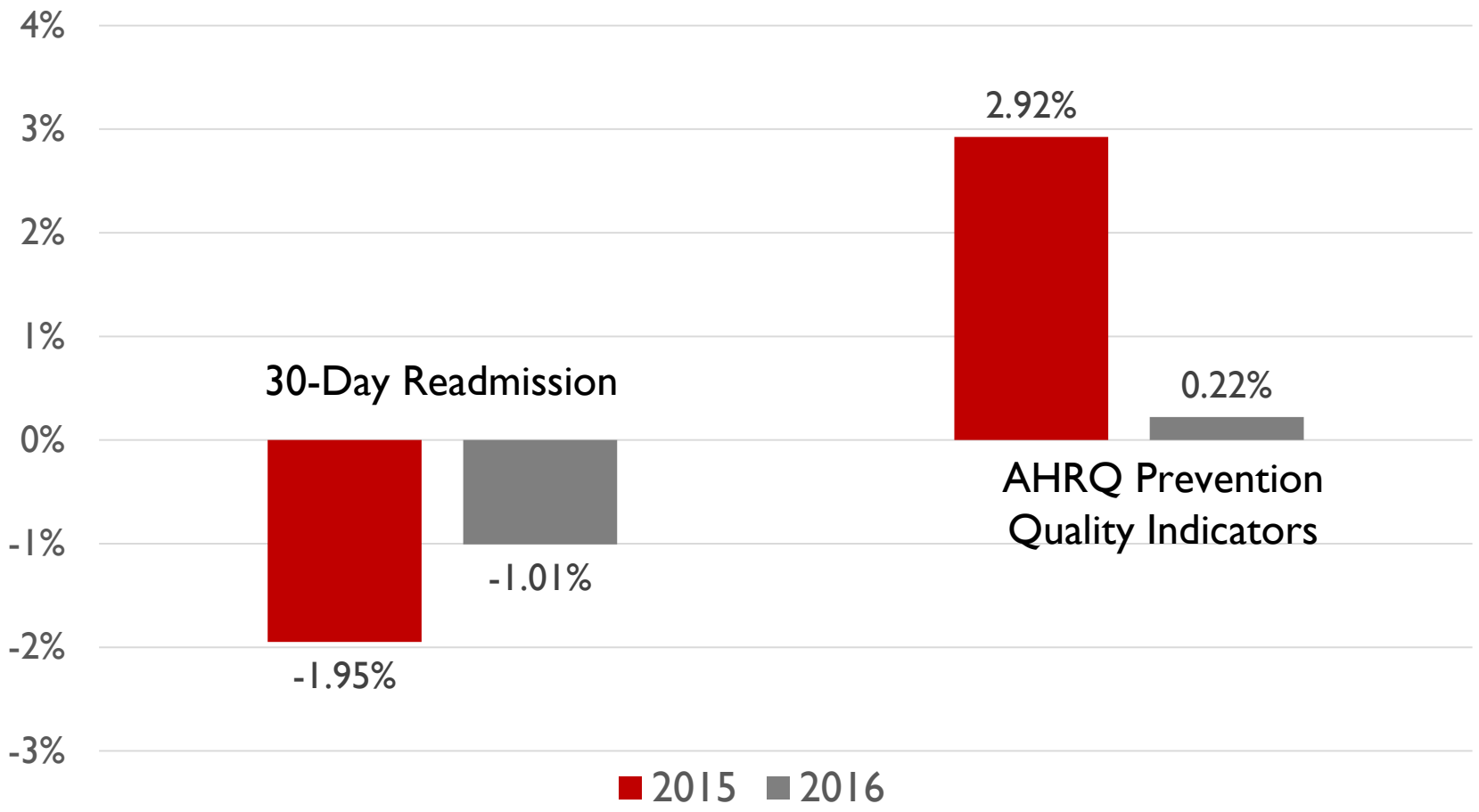
Potentially Avoidable Utilization Update

HSCRC
Health Services Cost Review Commission

All Payer Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD June



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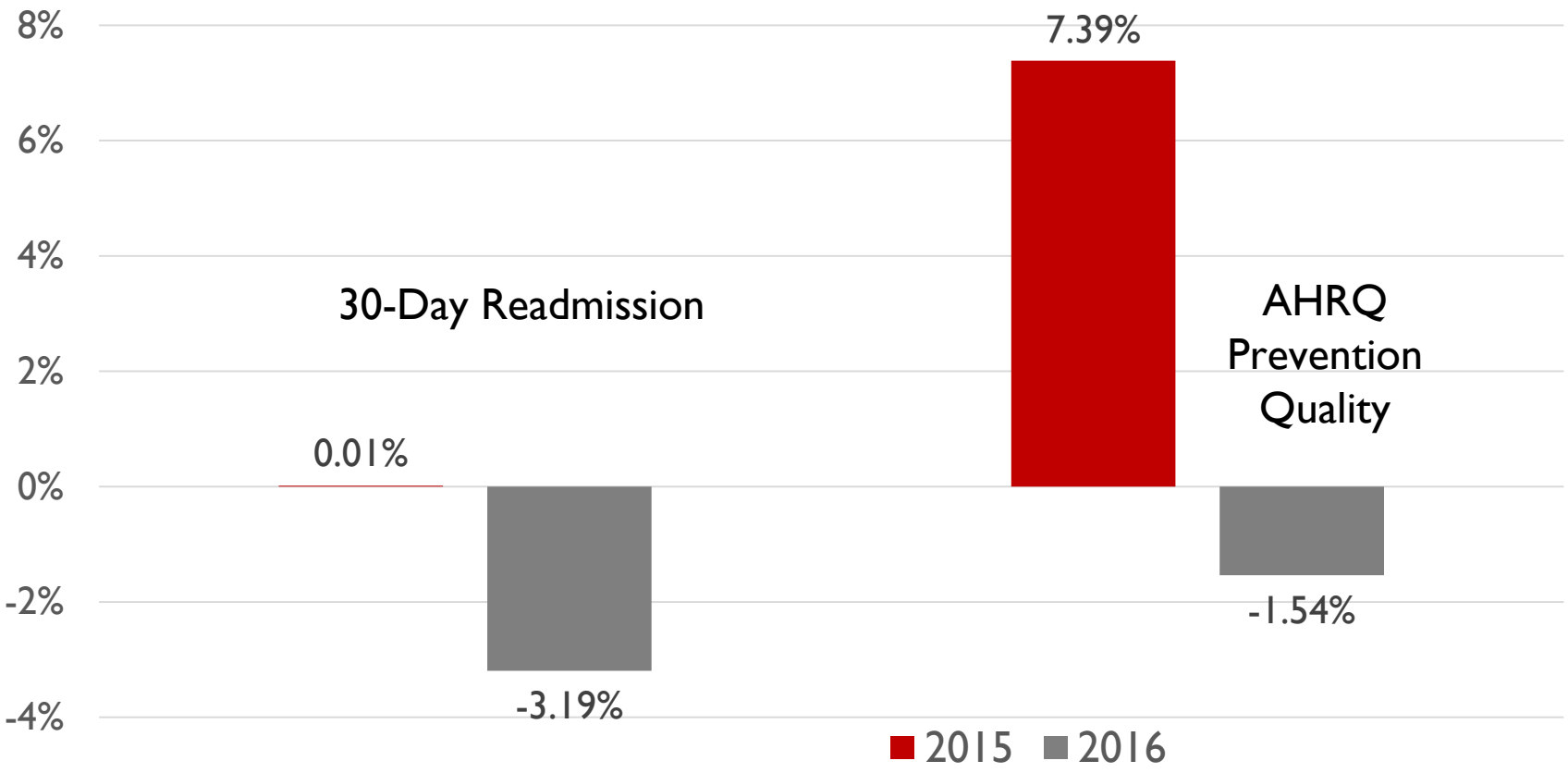
Medicare FFS Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD June



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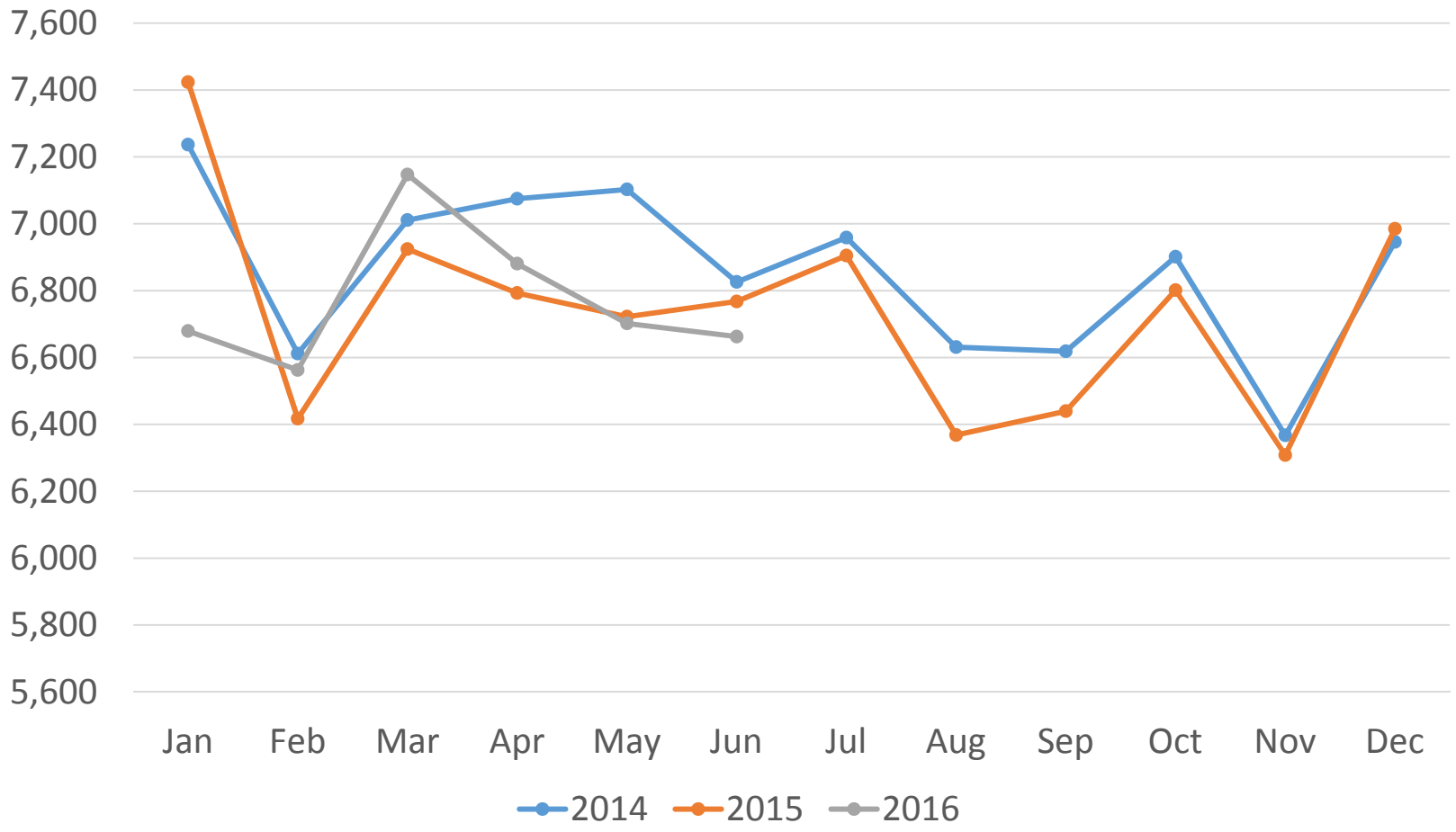
All-Payer Readmission ECMAD Growth by Month



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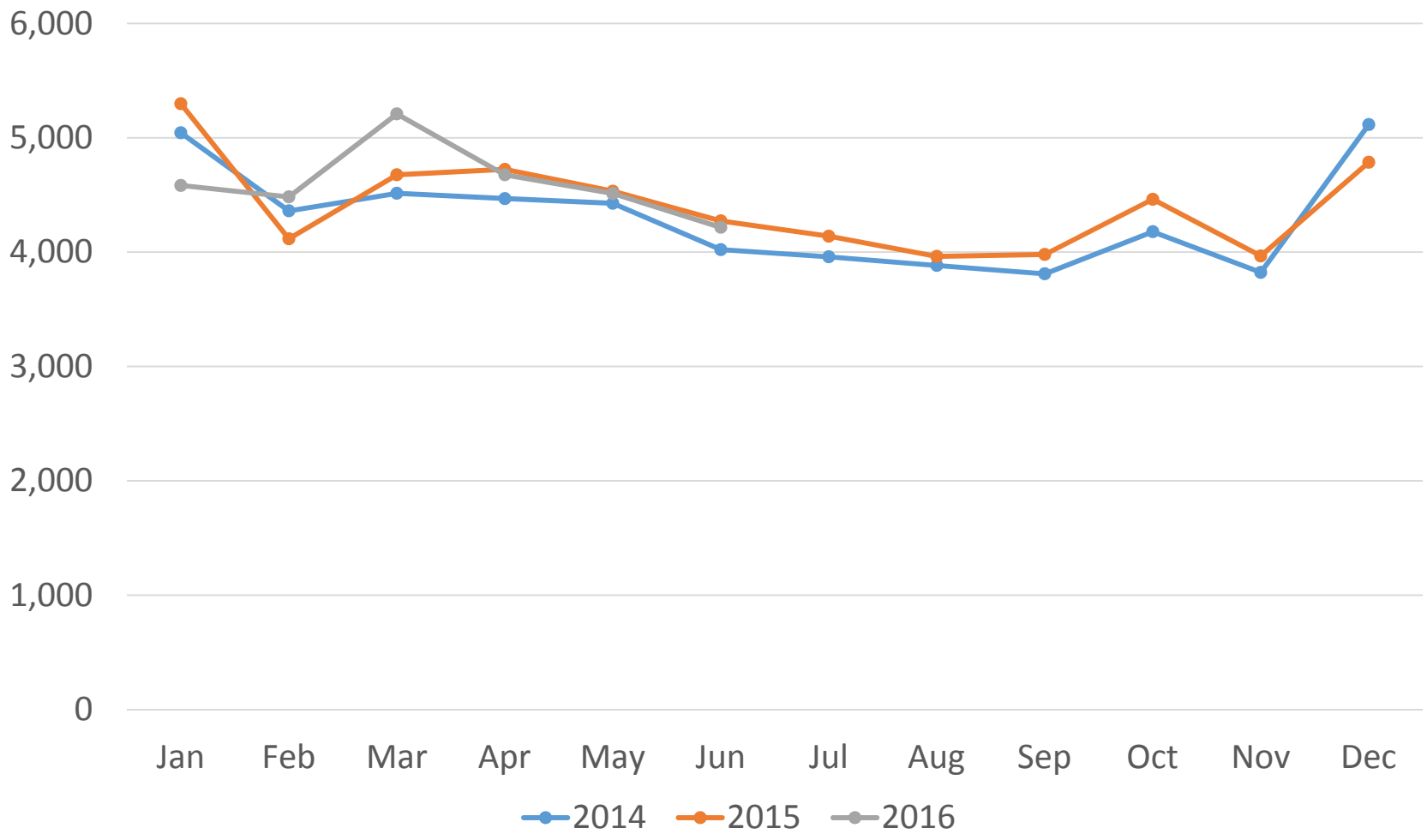
All-Payer PQI ECMAD Growth by Month



HSCRC
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CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

CRISP Medicare Data Update

HSCRC Commissioners Meeting

September 14, 2016

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

Data Supports the Waiver Amendment

Maryland has proposed an Amendment to the All-Payer Model that will provide access to the following **tools**:

- **Detailed, person-centered Medicare data (beyond hospital data across care continuum) for care coordination and care redesign**
- **Medicare Total Cost of Care data for planning and monitoring**
- Approvals for sharing resources for care coordination and care improvement
- Approvals for hospitals to share savings with non-hospital providers

Data Supports the Waiver Amendment

Current initiatives:

- HSCRC case mix-driven PaTH and High Utilizer reporting
- GBR PSA level TCOC reports (KPMG) – available this month
- Patient-level (but not identifiable) episodes analysis (hMetrix) – available by mid-October
- CMS CCLF Data (patient identifiable) available to hospitals and CRISP as of 1/1/17

Proposed Vendor Requirements

Medicare Data System

- Land Medicare data in a secure repository where it is accessible for desired downstream uses
- Transform data to create consistent, standard elements according to industry standards and best practices
- Consume data in a variety of potential methods
- Integrate to enable appropriate flow of data across the entire system

Analytics Engine

- Provide/develop/apply an analytics engine(s) to generate a suite of reports to primarily health care provider

Conceptual Model and Analytics Sets

Analytics Set #1: Hospital Information Delivery Product: refinements and ongoing support to the hospital information delivery product; allow for certain data extracts as permissible by CMS

Analytics Set #2: Data for HSCRC Administrative and Monitoring Functions: analytics for program monitoring and administration by hospitals and the HSCRC and other program administration entities; HSCRC and CRISP will determine data specifications early in the Phase of effort

Analytics Set #3: Information Delivery Product for Other Providers: provide/develop and deliver reports to support care coordination use cases with ambulatory practices and other non-hospital providers

Analytics Set #4: Information for CRISP Functions: provide analytics for CRISP administration/ monitoring of the solution through metadata; conceptualize integration strategies with other CRISP data and services

RFP Process On Schedule

Event	Approximate Dates	Notes
CRISP Issues RFP	June 22, 2016	Any proposal updates will be issues on the CRISP website
Bidders Conference	June 29, 2016	1pm ET
Intent to Respond	July 8, 2016	Email to Laura Mandel Laura.Mandel@crisphealth.org
Clarifications and Q&A	July 15, 2016	Ongoing then finalized on CRISP website
Vendor RFP Responses Due to CRISP	August 10, 2016	Email proposals by 5pm ET to Laura Mandel Laura.Mandel@crisphealth.org
Prescreen Responses	August 16, 2016	Bill, Craig, Mary, Laura Select 6 – 8 vendors
Selection Committee Meets	August 26, 2016	Select 3 – 4 vendors
Vendor Interviews and Demonstrations, Reference Review	September 12-16, 2016	CRISP will contact selected bidders to schedule interviews
CRISP Issues Final Specifications	September 23, 2016	Final specifications emailed to selected bidders
Vendors Submit Final Response and Financial Bid/BAFO	September 30, 2016	Responses submitted to Laura Mandel Laura.Mandel@crisphealth.org
Vendor Selection and Contracting	October 9, 2016	
Prepared to Land Data	January 1, 2017	Estimated delivery date from CMMI

RFP Process Update

- Vendor selection committee selected 5 vendors for in-person interviews/product demonstrations
  - CRISP Staff and CRISP Workgroup Members, (Hospital representatives, HSCRC, MHA)
- Holding in-person interviews and product demonstrations this week, reference calls on going
  - Includes selection committee, plus any additional members of the RAC and Technology Committee
- CRISP Board briefed
- HSCRC Commissioners briefed