maryland
health services
cost review commission

586th Meeting of the Health Services Cost Review Commission
July 14, 2021

(The Commission will begin public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

EXECUTIVE SESSION
11:30 am

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on June 9, 2021

2. Docket Status – Cases Closed

   2557A - Johns Hopkins Health System

3. Docket Status – Cases Open

   2555N - UM Shore Medical Center at Easton
   2558N – Adventist HealthCare Rehabilitation - Rockville Campus
   2559N – Adventist HealthCare Rehabilitation – White Oak Campus
   2560N – Johns Hopkins Bayview Medical Center
   2561N – Sheppard and Enoch Pratt Hospital
   2562R – Sheppard and Enoch Pratt Hospital

4. Population Health Workforce Support for Disadvantaged Areas (PWSDA) Presentation

5. Policy Update and Discussion
   a. CMMI Evaluation of Total Cost of Care Model
   b. Open Discussion of Tools to Strengthen the Maryland Model
      i. Promoting Care Transformation Activities
      ii. Improving Health Equity and Population Health

iii. Expanding the Scope of Quality Programs
iv. Identifying Population Health Investments
v. Addressing Capacity and Efficiency
vi. Evaluating Out-Year Savings Goals and Medicare Financial Tests

6. Legal Update

7. Hearing and Meeting Schedule

Closed Session Minutes
of the
Health Services Cost Review Commission

June 9, 2021

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 11:31 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance via conference call in addition to Chairman Kane were Commissioners Antos, Bayless, Cohen, Colmers, and, Elliott.

In attendance via conference call representing Staff were Katie Wunderlich, Allan Pack, William Henderson, Jerry Schmith, Tequila Terry, Geoff Daugherty, Will Daniel, Alyson Schuster, Claudine Williams, Megan Renfrew, Xavier Colo, Amanda Vaughn, Bob Gallion, and Dennis Phelps.

Also attending via conference call were Eric Lindemann, Commission Consultant, and Stan Lustman and Tom Werthman, Commission Counsel.

Chairman Kane observed that this public meeting will end Commissioner Colmers' tenure with the Commission. Chairman Kane thanked Commissioner Colmers for his long and exceptional service to the HSCRC and to the citizens of Maryland.

Katie Wunderlich, Executive Director, announced that CMS had officially notified the Commission that Maryland had met the requirements of the second year of the TCOC Model agreement.

Item One

Ms. Wunderlich updated the Commission and the Commission discussed the recent meeting with Dr Liz Fowler and the CMMI leadership team. Topics covered were the recent TCOC Model results, priorities to strengthen the TCOC Model in the future, and CMMI's vision for the future.

Item Two

Tequila Terry, Director-Payment Reform & Provider Alignment, updated the Commission on the status of the Strategic Planning process.

The Closed Session was adjourned at 12:34 p.m.

MINUTES OF THE
585th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
June 9, 2021

Chairman Adam Kane called the public meeting to order at 11:31 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, John Colmers, and James Elliott, M.D. were also in attendance. Upon motion made by Commissioner Colmers and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:07 p.m.

JOHN COLMERS

Chairman Kane announced that at the end of the month Commissioner Colmers' term will expire, and that he will be leaving the Commission.

Chairman Kane, Executive Director Katie Wunderlich, and the Commissioners thanked Mr. Colmers for his major contributions to the Commission, and for his devoted service to the citizens of Maryland.

REPORT OF JUNE 9, 2021 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the June 9, 2021 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE MAY 12, 2021 CLOSED SESSION AND PUBLIC MEETINGS

The Commissioners voted unanimously to approve the minutes of the May 12, 2021 Public Meeting and Closed Session.

ITEM II
CASES CLOSED

2553A- Johns Hopkins Health System
2554A- Johns Hopkins Health System
2556A- John Hopkins Health System

ITEM III
OPEN CASES

2555N- University of Maryland Shore Medical Center at Easton
2557N- Johns Hopkins Health System
2558N- Adventist HealthCare Rehabilitation- Rockville Campus
2559N- Adventist HealthCare Rehabilitation- White Oak Campus
2560N- Johns Hopkins Bayview Medical Center
2561N- Sheppard and Enoch Pratt Hospital

ITEM IV
FINAL RECOMMENDATION ON THE UPDATE FACTOR 2022

Mr. Jerry Schmith, Principal Deputy Director, Revenue and Regulation Compliance, presented staff's Final Recommendation for the Update Factors for FY 2022 (See "Final Recommendation for the Update Factors for FY 2022" available on the HSCRC website).

Staff updates hospitals' rates and approved revenues on July 1st for inflation and other factors, as well as settling all adjustments from the prior year. Calculation of the update factors for RY 2022 generally follows approaches established in prior years. Staff is considering the extraordinary circumstances of the COVID-19 response in the development of the update factor. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis.

In considering the system wide update for RY 2022, staff sought to achieve balance among the following conditions:

1. Meeting the requirements of the TCOC Model:
    a) Savings Test: Maryland must reach $300M in annual savings to Medicare by 2023.
    b) Guardrail Test: Maryland TCOC growth may not exceed that of the nation by more than 1.00 percent in any year.
2. Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes.
3. Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the TCOC Model.
4. Incorporating quality performance programs.
5. Ensuring that healthcare remains affordable for all Maryland residents.

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2022 update. HSCRC staff received and reviewed comments from Maryland Hospital Association (MHA), Johns Hopkins Health Systems (JHHS), University of Maryland Medical System (UMMS,) LifeBridge Health, Luminis Health, MedStar Health, and CareFirst. Stakeholders expressed concern over the following aspects of the Final Recommendation:

Comment: Increase Inflation to Supplement Increased Labor and Cost Pressures

MHA: Requested that core inflation be raised by 50 basis points.

JHHS: Stated that they believe other components also need to be considered this year, in light of the current economy. JHHS has seen dramatic increases in the cost of agency labor in recent months and believe that these increased costs will continue for the foreseeable future.

UMMS: UMMS requested that HSCRC consider the MHA proposal to increase the FY 2022 inflation by 0.50%.

LifeBridge Health and Luminis Health: reported that they have experienced abnormally high personnel, contracted labor, and supply and drug costs over the past year.

Staff Response: Staff acknowledges the difficulties hospitals have faced during the COVID-19 pandemic. It is our goal, when developing the update, to ensure the increase is fair and reasonable for the consumers in the State while maintaining the goals of the Model. Staff appreciates the work that has been done around the State to meet Model tests for 2020. In light of indications from hospitals that they have faced added clinical wage pressure as they emerge from the COVID crisis, staff is recommending an increase in the inflation update of 0.20 percent in recognition of the special circumstances. Staff has previously committed to reviewing 2021 expenses and providing additional funding for COVID-driven cost outliers, if the Commission elects to provide this additional inflation that will be considered an offset to any additional one-time funding that might otherwise have been provided for 2021.

For this reason, we recommend adding 0.20 percent to inflation which results in a gross inflation amount of 2.57 percent. The recommended update for RY 2022 increases as a result of these changes to 2.44 percent. The guardrail position for CY21 is estimated to be equal to the Nation which staff believes is consistent with Model tests.

Comment: Increase the Demographic Adjustment

MHA: Requested inclusion of 15 basis points for age-weighted population growth, allowing a basic demographic adjustment. Adding 15 basis points is one fourth of the 0.59% age-weighted growth; this is equal to the prior year's allowance.

UMMS: Expressed concern about the continued diminishment of the annual demographic adjustment and the significant variances that exist between the MD Department of Planning and Claritas population estimates each year. UMMS supports MHA's recommendation to fully evaluate the demographic adjustment methodology and sources as new census population data become available over the next year.

Luminis Health: Suggested using an age-weighted demographic adjustment to reflect the higher costs of an aging population.

Staff Response: The goal of the Demographic Adjustment is to provide all-payer funding for anticipated growth in line with the growth in the total Maryland population. While staff does provide age adjusted growth to individual hospitals in order to differentiate hospitals that serve an older population and thus expect higher utilization rates, the HSCRC has always scaled the statewide Demographic Adjustment back to total population growth because a) the Medicare TCOC test is a per capita test, not an age adjusted per-capita test and b) the funding thus far from the Demographic Adjustment and the Market Shift methodology has provided nearly all hospitals at least a 50% variable cost factor for changes in utilization.

Given the success of the HSCRC volume methodologies, staff does not recommend departing from the current methodology of pegging the Demographic Adjustment to the Maryland Department of Planning statewide projections, especially as unnecessary, additional funding for age adjusted growth will likely result in price increases that will jeopardize the Commission's ability to adhere to the TCOC guardrail tests. However, staff recommends redistributing the 0.15 percent to the set-aside for unforeseen adjustments, increasing the set-aside to 0.25 percent.

Comment: Eliminate Productivity Adjustment for Non-GBR Hospitals

MHA: Expressed support of HSCRC staff's proposal to suspend the productivity adjustment for psychiatric and specialty hospitals.

Staff Response: In addition to suspending the productivity adjustment for psychiatric hospitals and Mt. Washington Pediatrics, staff also recommends increasing core inflation by 0.20 percent to help alleviate the labor and cost pressures that hospitals across the State are facing. This change increases the inflation for hospitals not on global budgets to 2.57 percent.

Comment: Reconsideration of CARES Act PRF Reconciliation MedStar:

MedStar Health continues to be extremely concerned with the HSCRC's proposed "reconciliation" of CARES Act Provider Relief Fund support. Specifically, MedStar makes 3 major points:

- "The HSCRC's proposal is contrary to the federal CARES Act and in excess of the HSCRC's proper authority."
- "The HSCRC's proposal is contrary to sound healthcare policy."
- "The HSCRC relies on a flawed methodology in calculating the impact of the corridor relief granted to Maryland hospitals."

Staff Response: Only MedStar raised concerns on this issue. Staff's responses are as follows:

- "The HSCRC's proposal is contrary to the federal CARES Act and in excess of the HSCRC's proper authority."

  Staff does not agree with this comment. The HSCRC is simply taking into account available federal funding in setting its Maryland rates, which is consistent with the Commission's statutory

mandate, and which is consistent with the Commission's multiple notifications to hospitals that it would do so in providing the extraordinary relief of a GBR "guarantee" even before any federal funding was given. Staff is not dictating how hospitals use that funding. The HSCRC's proposed approach places Maryland hospitals in a position analogous to that of fee-for-service hospitals in all other states and then evaluates federal funding in this context when determining Maryland funding. Staff believes this approach is consistent with federal policy and also fair to Maryland's rate payers who should not be asked to shoulder more of the burden than payers in other states simply because of Maryland's unique system that assures hospitals of its ability to meet all their reasonable financial requirements.

- MedStar position: The HSCRC's proposal is contrary to sound healthcare policy.

  The proposed staff approach is not 100% volume based; thus, it is not sound policy.

  Staff notes: (1) that Maryland hospitals have operated in, and benefitted from, a fixed revenue system since 2013;, (2) that federal CARES funding uses a similar approach whereby total potential funding is based on attaining pre-COVID revenue and, therefore, hospitals that lost less volume (i.e., less lost revenue) are entitled to retain less funding, all else being equal; and (3) that under the draft recommendation, after considering allocated federal funds, MedStar is in the top 3 systems in the State both in total funding as a percentage of GBR, and dollars of funding received above the GBR. While Staff commends MedStar for their efforts during the pandemic, staff believes that the proposed recommendation reasonably compensates them for those efforts.

- "The HSCRC relies on a flawed methodology in calculating the impact of the corridor relief granted to Maryland hospitals"

  MedStar objected to staff's approach to calculating COVID Relief specific to the Drug and Supply Cost Centers.

  Staff agrees that the methodology used to determine COVID Relief for Drugs and Supplies was a change from the HSCRC's typical approach to these centers. However, as the circumstances during the period were clearly not typical, staff believes that the methodology applied in determining the amount of COVID Relief in Drugs and Supplies was reasonable and justified. Staff also notes that it was consistent with the Global Budget Agreements signed by all hospitals. Most importantly, staff believes it was reasonable to protect consumers from excessive rate increases during the pandemic, in contrast to rate increases that would be permissible under MedStar's preferred approach. Furthermore, no other hospital has raised concerns with the methodology, even though it was applied precisely the same way across all hospitals under a GBR arrangement.

Based on the currently available data and the staff's analyses to date, the staff provides the following Final Recommendations for the RY 2022 update factors.

For Global Revenues Hospitals:

1. Provide an overall increase of 2.44 percent for revenue (including a net increase to uncompensated care) and 2.43 percent per capita for hospitals under Global Budgets. In addition, the staff is proposing to split the approved revenue into two targets, a midyear target, and a year-end target. This recognizes an additional 0.20 percent for salary and malpractice cost pressures. Staff does not believe this should be the normal policy. However, as hospitals continue to grapple with the effects of the pandemic, staff feels the request is not unrealistic.

   Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

   Additionally, staff recommends that the adjustment to consider the reconciliation of CARES Provider Relief Funds and HSCRC support for RY 2020 be included in the midyear target.

2. Provide all hospitals a base inflation increase of 2.34 percent and allocate 0.23 percent of the total inflation allowance based on each hospital's proportion of drug cost to the total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high-cost drugs.

3. Reduce the Demographic and Population adjustment from 0.16 percent, which was included in the Final Recommendation, to 0.01 percent based on the Maryland Department of Planning estimate.

4. Increase the set aside to 0.25 percent by redistributing the decrease of 0.15 percent from the Demographic and Population reduction to the set aside for unforeseen adjustments.

   Adjust rates effective July 1, 2021, over a 6 month window, to implement the reconciliation of CARES Provider Relief Funds (PRF) and HSCRC support for Rate Year 2020 as described in this recommendation. The general impact of this proposal is that:

   - For hospitals where the sum of actual charges and PRF Funding is less than their fiscal year 2020 approved Global Budget Revenue, the adjustment would add the shortfall, net of any preliminary amount already provided in the January 1st, 2021 rate order, to their July 1, 2021 rate order.
   - For hospitals where the sum of actual charges and PRF Funding is greater than their fiscal year 2020 approved Global Budget Revenue, the adjustment would subtract from the lessor of the excess or the COVID corridor relief provided by the Commission (as defined in the body of this recommendation) from their July 1, 2021 rate order.

5. Staff recommends that the Commission guarantee RY 2021 Global Budget Revenues for hospitals and implement a similar reconciliation policy as outlined above to maintain financial stability for hospitals, given the COVID pandemic.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

1) Provide an overall update of 2.57 percent for inflation, which includes an additional 0.20 percent to gross inflation to help alleviate labor and cost pressures experienced by hospitals.
2) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing due to the COVID-19 pandemic.

Commissioner Antos questioned MedStar's dispute of the CARES Act Reconciliation Methodology. Commissioner Antos asked whether MedStar's charging practices for drugs and supplies were consistent across all MedStar hospitals. Commissioner Antos also asked what the administrative remedy was if there is a rate dispute with a hospital.

Mr. Stan Lustman, Assistant Attorney General, HSCRC, stated that if a hospital disputes the Update Factor, a full rate review option could be initiated by the hospital or the HSCRC.

Commissioner Colmers asked how much MedStar hospitals were overcharging for drugs and supplies.

Mr. William Henderson, Principal Deputy Director, Medical Economics & Data Analytics, stated that staff calculates that MedStar overcharged by approximately $60M in FY 2020 Q4, a period when volumes were down by nearly 40%. Most other hospitals in the State generated an undercharge during this period.

Mr. Schmith added that staff believed that the overcharges occurred at all MedStar facilities.

Commissioner Antos moved to initiate a full rate review to assess the reasonableness of rates at all MedStar hospitals. The motion passed, and staff will begin the full rate review process.

Commissioners Bayless and Colmers inquired about the use of the annual set-aside for Unknown Adjustments.

Mr. Schmith also stated that any unused portion of the annual set-aside reduces rates to the public.

Commissioner Bayless requested an amendment to the staff recommendation to require staff to reconcile the use of the annual set-aside. The motion passed, and the staff's Final Recommendation will be amended.

Commissioner Cohen questioned the 0.20 percent additional inflation allowance to the Update Factor. As recommended, this allowance would result in permanent funding. Commissioner Cohen suggested instead providing it as a one-time adjustment.

Mr. Schmith responded that staff had considered this possibility but believed that increased inflation expectations and raising the minimum wage justify the funding being made permanent.

Commissioner Bayless requested that staff closely monitor inflation in labor costs throughout the year if necessary, consider making an additional mid-year adjustment to support these costs.

The Commissioner voted unanimously in favor of the amended staff recommendation.

ITEM V
FINAL RECOMMENDATION ON THE MARYLAND PATIENT SAFETY CENTER FOR FY 2022

Ms. Wunderlich and Dr. Blair Eig, President and CEO, the Maryland Patient Safety Center (MPSC) presented Staff's Final Recommendation on the funding of the Maryland Patient Safety Center for FY 2022 (see "Final Recommendation on Continued Financial Support for The Maryland Patient Center for FY 2022" on the HSCRC Website)

In 2004, the HSCRC adopted recommendations to provide seed funding for the MPSC through hospital rates, with the initial recommendations funding 50 percent of the budgeted costs of the MPSC. In FY 2021, HSCRC funds accounted for 13 percent of MPSC's total budget. FY 2022 represents the last year of unrestricted funding for MPSC, as it will transition to a self-sustaining resource moving forward.

Key current MPSC hospital and non-hospital projects that particularly align with the TCOC model goals include:

- HRSA Maryland Maternal Health Innovation Grant (known as MDMOM)
  MPSC has recruited all 32 birthing hospitals in the State into their program, which provides implicit bias trainings to care providers at these hospitals. This training program is critical to improving maternal mortality and morbidity and reducing health disparities. This work directly aligns with the SIHIS goal of reducing disparities in severe maternal morbidity (SMM).

- Clean Collaborative Phase III for Long Term Care
  Last year, due to the devastation nursing homes faced during the COVID PHE, the Commission voted to provide restricted funding to MPSC to initiate an 18-month collaborative for ten LTCs across the state. Among the goals were to reduce Emergency Department visits and hospital readmissions. Following recruitment and ramp-up, data collection began in October 2020. Early results are provided later in this report, but trends are demonstrating a reduction in infection related ED visits and hospital admissions, and therefore the total cost of care.

- Clean Collaborative Phase IV: HSCRC Hospital Partnership Grants with Long Term Care—
  Recognizing the value of Phases I and II of the MPSC Clean Collaborative, three hospital systems have partnered with MPSC and are currently working with fourteen LTC partners under the HSCRC Partnership Grants. While it is very early in the data collection process which began in December 2020, early results look promising in reducing infection related ED visits and hospital admissions as well as impacting the reduction of COVID -19 positivity rates in residents and staff at the participating LTC facilities.

The HSCRC collaborates with MPSC on projects as appropriate and reviews an annual briefing on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year.

In addition to the $123,028, MPSC is proposing that the Commission consider two options: the first is a request for restricted funding to complete the Clean Collaborative Phase III with LTC that HSCRC funded in FY 2021, in the amount of $125K; the second is funding to convene an additional LTC Clean Collaborative with a new cohort of ten LTC facilities in the amount of $275K. The restricted funding request for FY 2022 ranges from $125K-$400K from the HSCRC and is detailed in the Budget sub-section under the Assessment section. Currently, Staff is not recommending funding for the Phase V LTC Clean Collaborative. Instead, MPSC should pursue direct funding with hospitals and LTC facilities to disseminate best practices around infection control that can lead to better health outcomes and lower ED utilization.

HSCRC staff provides the following Final Recommendations for the MPSC funding policy for FY 2022:

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of unrestricted funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.

2. To receive funding from the hospital rate setting system, the MPSC should continue to report annually at a minimum on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.

3. MPSC requests additional funding from HSCRC that will be restricted for targeted projects that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.

    a) For FY 2022, staff recommends that the HSCRC fund an additional $125,000 for the 18-month Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.

4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted funding from the HSCRC.

Commissioner Colmers noted that funding a training program may result in permanent funding.

Commissioners Bayless and Colmers questioned whether the MPSC can generate sufficient revenue outside of HSCRC funding and whether a governmental body other than the HSCRC would be better suited to fund the MPSC in the future.

Ms. Wunderlich explained that the MPSC generates revenue from member dues, conferences, programs, and by partnering with hospitals on federal grant opportunities.

Delegate Sheree Sample-Hughes, Maryland House of Delegates District 37A, participating by telephone, stated that she would discuss the ongoing funding of the MPSC with the Appropriations Committee.

The Commissioners voted unanimously in favor of staff's recommendation.

ITEM VI
FINAL RECOMMENDATION ON INTEGRATED EFFICIENCY POLICY

Mr. Allan Pack, Principal Deputy Director, Population- Based Methodologies, presented staff's Final Recommendation on the Integrated Efficiency Policy (see " Final Recommendation on Integrated Efficiency Policy for RY2022: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue Enhancements" on the HSCRC website).

The Integrated Efficiency Policy is established by the HSCRC to simultaneously evaluate whether hospitals are "technically efficient" on a cost-per-case basis and are effective in controlling total cost per capita. Those hospitals identified as particularly high in both these categories are considered presumptively inefficient, while those that are low in both these categories are presumptively efficient. Presumptively inefficient hospitals are not granted access to a portion of inflation as part of the annual update factor. They are free to file a rate application if they so desire. Presumptively efficient and effective hospitals are granted the opportunity to request slightly higher revenue through an expedited adjustment to their GBR agreement.

Since 2018, staff has been working with Commissioners and stakeholders to develop a formulaic and transparent methodology that identifies and addresses relative efficiency performance in order to bring hospitals closer to peer average standards over time. The purpose of the policy is to update the HSCRC's efficiency measures to be in line with the incentives of Maryland's Total Cost of Care (TCOC) Model, so that objective standards are in place when the Commission adjusts hospitals' permanent rate structures, and also to address and correct maldistribution of global revenues.

In July 2019 and October 2020, a staff draft recommendation was brought before the Commission. During the course of review following the publication of the both draft recommendation, a number of comment letters were sent to the HSCRC from Maryland Hospital Association and hospitals. Public comments are as follows:

Following the first draft recommendation, staff received comment letters from Maryland Hospital Association, Luminis Health, Johns Hopkins Health System, CareFirst, and University of Maryland Medical System.

Following the second draft recommendation, staff received comment letters from the Maryland Hospital Association, Luminis Health, Johns Hopkins Health System, Greater Baltimore Medical Center,

University of Maryland Medical System, Ascension Saint Agnes Hospital, LifeBridge Health System, Mercy Medical Center, MedStar Health Inc., Tidal Health Peninsula Regional, Western Maryland Medical Center, and Meritus Health.

Staff addressed each comment:

Modify Poor Share Variable in DSH Adjustment

WMHC- The current measure [of poor share] is based on the percent of hospital revenue from Medicaid for inpatient and outpatient services for Maryland residents where Medicaid is either the primary or secondary payer. We ask that this measure be expanded to include out-of-state residents as well, given that the population served is still poor with the same general health characteristics as their Maryland counterparts. We would also ask that the measure include patients with Medicare as a primary payer but charity as a secondary payer, reflecting the low income status of these elderly patients who do not currently qualify for Medicaid.

Staff agrees with the first suggested technical adjustment of adding Medicaid out-of-state to the poor share variable that is being proposed as a means to calculate the direct risk adjustment of serving a lower socioeconomic population (in lieu of peer groups). This represents a similar population to the one staff aims to address through the DSH adjustment, which should be agnostic to a patient's home residence.

Staff does not concur with request to include Medicare as primary payer and charity as secondary payer, because this population does not necessarily represent a lower socioeconomic population, as reduced cost care can be provided to patients up to 500% of FPL. Moreover, staff's poor share variable is meant to serve as a proxy for indigent care. It will not capture all populations that are more expensive, hence the regression based approach. Finally, staff would note that CMS has not extended its stratifications/risk adjustments to include Medicare individuals outside of the dual eligible population.

Peer Groups

MHA- The analysis focused on the cost factors peer groups were originally intended to address, including indigence of the patient population, urbanicity, and hospital teaching status. Although many cost factors and their associated variables were tested, additional elements have been posited to influence ICC performance. The Commission should further evaluate the efficacy of the alternative and peer group approaches by testing factors including, but not limited to, geography, technology, and case mix index.

JHHS- HSCRC Staff should continue to work with hospitals to better understand these factors and delay the implementation of the peer groups until such analysis can be found.

UMMS- Propose that a decision to move to a statewide peer group be delayed to allow time to explore alternative peer group options and adjustments.

Luminis- HSCRC should take a prudent approach to make the necessary, straightforward changes to the peer groups now (such as moving urban hospitals into the urban group and moving hospitals with newly

established teaching programs into the teaching group, and dedicating more time to determining its handling of new teaching programs and vetting the proposed socioeconomic adjustor.

LifeBridge- It is important that a direct disproportionate share adjustment appropriately reflects the associated costs with providing care. Therefore, it would be prudent for the HSCRC to continue to explore alternatives before adopting no statewide peer groups.

WMHC and Tidal- While we understand the rationale for the potential elimination of peer groups, any shift away from this historic policy needs to adequately account for socioeconomic factors inherent in measuring the relative efficiency of hospitals. These issues are particularly prevalent in more rural areas of the state that do not have the infrastructure and resources of more urbanized areas.

St. Agnes- Eliminating peer groups entirely requires full confidence that direct adjustments to capture such issues as socioeconomic disparity are fully and precisely captured.

Mercy- Concern that the new regression does not adequately account for the direct and indirect cost of providing services in Baltimore.

Meritus- Echoed the comments of the MHA that further evaluation of additional cost factors and their influence on ICC performance is needed.

Staff agreed with the concern expressed in many of the comment letters that a movement away from peer groups should evaluate cost elements that may influence ICC performance. Staff would note though that the peer groups should chiefly adjust for their stated purpose: indigent care and teaching status. While peer groups accomplish these goals, staff's alternative approach is more effective.

Additional analysis of other cost factors have shown no material, statistically significant relationship between ICC Performance and factors for which hospitals should be held harmless. Moreover, in nearly all cases, the influence cost factors have on ICC performance was reduced by the introduction of the alternative approach of abandoning peer groups and directly risk adjusting for indigent care. For these reasons, staff recommends adopting the direct risk adjustment approach for indigent care.

Labor Market Adjustment

WHMC and Tidal- Without adjusting for the wage index, Maryland hospitals with patients in counties compared to low wage markets face a standard where Medicare prices may be as much as 35% below the national average while high wage markets may be 91% more.

Normalization Adjustments

WHMC and Tidal- The [demographic] normalization involves an adjustment from a regression model based on two measures: a measure of deep poverty level and the county's median income. The regression model explains only 13% of the variation in TCOC per Medicare fee-for-service beneficiary in the 650

counties used in the benchmark process (based on the model's adjusted R-Squared), but is nonetheless used for the normalization.
The second adjustment, however, for median income also increases the comparison benchmark, which results in a more favorable comparison for the hospital. Hence, the staff's proposed policy is to provide a more generous assessment of a hospital's relative efficiency because its patients are in high income areas. The result is a real redistribution of resources away from hospitals serving poor patients to those in affluent communities.

Staff noted that Regional Price Parity, a measure of prices was used in selecting benchmark areas, and the Medicare Wage Indexes have been criticized by Maryland hospitals due to their dependence on reporting, which Maryland hospitals are not focused on.

Staff disagreed with notion that an adjustment for deep poverty and median income necessarily redistributes resources away from hospitals serving poor communities, as an adjustment for deep poverty purposefully attempts to account for the higher than anticipated costs in a lower socioeconomic area. Staff would also note that the likely reason the R^2 for deep poverty is low (but still statistically significant) is because staff first selected peer geographies and then ran a regression to normalize for residual cost variation. If no peer selection was performed, the R^2 would theoretically be much higher.

The adjustment for Median Income, at least to some degree, does what a wage index adjustment would do in favoring areas with higher wages and therefore incomes. Also, there is extensive evidence that higher income areas do experience higher utilization and prices, particularly in the commercial population, and, therefore, higher benchmarks would be expected.

Finally, a thorough review of the TCOC results does demonstrate that various low income parts of the State (e.g., Easton) are not adversely affected by the benchmarking methodology, but staff will continue to refine the methodology with stakeholders to ensure that it yields fair and reasonable results.

Implementation Timeline

LifeBridge- The volume data used to calculate the ICC comparison is from fiscal year 2019. Understanding the inability to utilize data from fiscal year 2020 given the COVID pandemic, we believe facilities may be experiencing different levels of current volume activity when compared to fiscal year 2019 data, and that the changes in volume may be permanent moving forward as activities return to normal. Waiting for more current data will ultimately produce a more accurate result for any ICC methodology adopted. In the interim, the HSCRC maintains the ability to implement relative efficiency controls through control of volume-based corridors and associated restrictions to revenue

MedStar- We recognize these recommendations include several material changes in historical methodology, such as removing peer groups, reducing IME credit for non- academic medical centers and introducing a Medicare/Commercial TCOC benchmark. These methodological changes have created a significant change in hospital performance against the efficiency metric and may impact performance under other methodologies as well. As HSCRC and the hospitals continue to review and offer

improvements to methodology, consideration should be given to phasing-in methodology changes to allow for monitoring and adjustment.

CareFirst- CareFirst urged that an efficiency methodology be implemented as soon as possible to ensure that individual hospital costs do not become unreasonable relative to their competitors.

Staff acknowledges that the proposed Integrated Efficiency policy for RY 2022 does incorporate several new modifications to the underlying methodologies and appreciates all the work the industry has done to improve the policy while also heroically responding to the public health emergency. However, staff would note that with the exception of TCOC benchmarks, an alternative to ICC peer groups, special adjustments for Chestertown Hospital, and the alternative scaling approach, which was unanimously supported by stakeholders, these modifications, e.g., an updated indirect medical education risk adjustment, have been reviewed for more than one year and reflected in prior iterations of this policy. Also, all modifications brought forward in the last year have gone through extensive workgroup processes.

Staff would also note that while LifeBridge's comment that relative efficiency has been maintained through control of volume-based corridors is correct, these corridors have, in recent years, been more limited in incentivizing reductions in avoidable utilization because corridors are topping off. Furthermore, without implementing an efficiency policy that withholds inflation, thereby driving less variation in efficiency outcomes, staff would not support rebasing volumes in RY 2022 rate orders to CY 2019 volumes, as requested by numerous stakeholders in their comment letters.

Finally, staff would point out that while COVID will undoubtedly affect volumes for years to come and may yield a "new normal" that is different by hospital, there has not been an efficiency policy that scales inflation in the GBR era, and there has been rather strong correlation in year over year ICC results (RY19-RY20 - R=.9072) suggesting that relative efficiency has been fairly stable as the Commission has not yet addressed divergences in efficiency in our Model(s).

50/50 Weighting of ICC & TCOC

WMHC and Tidal- Hospitals on average in Maryland contribute about half of the TCOC for Medicare beneficiaries. The remainder is out of the direct control of the hospital. While the model provides incentives to coordinate across the healthcare spectrum of services other providers are still largely paid on a fee-for-service basis. Hence, the use of 50% of the TCOC benchmarks for determining relative efficiency seems excessive. Hospital revenue is being placed at risk beyond the ability for the hospital to control the performance in the market.

Mercy- At 50%, the policy significantly over weights the share of TCOC relative to individual efficiency, far beyond national programs and commercial payers.

MedStar- The Medicare and Commercial Total Cost of Care Benchmarking is a significant new measure that will most likely require adjustment over time as the HSCRC and hospitals continue to review and understand the results. Historically, when new measures of significance were introduced, the

Commission often implemented a phased-in approach. We recommend increasing the weighting of this measure in stages over the next several years (i.e., 25% in FY22, 50% in FY23) given both the newness of the measure and to ensure that it aligns with the model and other policies.

50/50 Weighting of Med/CO TCOC

JHHS- Not considering the significant payer mix differences in Maryland's hospitals could have an unintended consequence of disadvantaging a hospital based on payer mix.

Luminis- Expressed concerned that the policy assumes a 50/50 attainment measurement mix between Medicare and Commercial payers, not taking into account the significant payer mix differences in Maryland's hospitals.

Staff acknowledges various hospitals' concerns that weighting TCOC as 50% of the Integrated Efficiency policy is significant since hospitals are accountable for TCOC but not directly responsible for it. Staff would note though that emphasizing cost-per-case efficiency in a TCOC Model could lead to perverse outcomes that undermine the central incentive of the Model to improve the health of the population and reduce potentially avoidable utilization. Staff would also note that hospitals have far greater influence on Medicare TCOC when associated professional claims are considered (~70 percent vs the frequently cited 55 percent) Additionally, readjusting the weighting as outlined by MedStar in a phased-in approach, i.e., 25 percent TCOC in RY 2022, would have limited effect on the Integrated Efficiency results: Correlation (R) between Efficiency Matrix with 50/50 weighting & 75 percent ICC / 25 percent TCOC = .918; and all but one hospital (WMHC) would remain in the penalty zone.

Finally, staff would be concerned moving beyond 75 percent ICC weighting given the incentives of the TCOC Model. Therefore, staff recommends maintaining the 50/50 weighting of the ICC and TCOC.

Rebasing Global Budget Volumes

MHA- MHA requested that HSCRC set annual unit rates using volumes from the most recent 12-month period preceding the rate order, citing the complexity of measuring monthly rate compliance and adjusting unit rates, as well as the reduced need for maintaining 2013 volumes once the efficiency policy is implemented.

JHHS- JHHS believes that staff should set annual unit rates using volumes from the most recent 12-month period preceding the rate order.

UMMS- UMMS fully supports the Commission's proposal to rebase rate order volumes using FY19 data. GBR rate orders were first established in 2014 volume levels, and those volumes have since only been adjusted for targeted policies and only by modest amounts.

Meritus- Meritus agrees with MHA's position.

Staff is supportive of rebasing global budget volumes should an efficiency policy be implemented.

If inflation is withheld in RY 2022 Update Factor based on relative efficiency policy, volumes should be updated for RY 2022 rate orders to reflect CY 2019 volumes with 5 percent corridors. This limit may be extended to 10 percent at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year.

Staff, however, does not support rebasing each year based on the most recent 12 month period, as requested by MHA and JHHS for the following reasons:

- The permanent effects of COVID have not yet been settled and the Commission should consider accruing savings to payers if utilization remains far below historical norms, which an annual rebasing policy will not allow.
- The Integrated Efficiency policy only makes negative adjustments to hospitals in the fourth quartile, i.e., it is not a broad-based scaling policy, and so rebasing all hospitals' volumes each year seems inconsistent with the proposed reach of the efficiency policy.
- Corridors are the Commission's best analytic to determine deregulation of services, which the Commission must defund in the GBR in order to avoid "double billing," and rebasing each year will make it difficult for staff to use this analytical tool.

Delay provides benefits to policy development including: revised scaling approach; future removal of unreliable RY 2020 volume; and additional work on peer group and allowed medical residents in ICC methodology.

Staff final recommendation for the Integrated Efficiency Policy for RY 2022 is as follows:

1. Formally adopt policies to:
    - Determine hospitals that are relatively inefficient
    - Evaluate Global Budget Revenue enhancement requests using the criteria identified below.
2. Use the Inter-Hospital Cost Comparison, including its supporting methodologies, to compare relative cost-per-case for the above evaluations.
    - Abandon ICC peer groups, adopt a direct regression-based risk adjustment for indigent care cost variation applied to all efficiency policies.
3. Use Total Cost of Care measures with a geographic attribution to evaluate per-capita cost performance for the above evaluations.
4. Withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals based on the criteria described herein.
5. Use the set-aside outlined in the Annual Update Factor and funding secured from withholding from outlier hospitals to fund potential Global Budget Revenue enhancement requests.

6. If the HSCRC withholds inflation based on relative efficiency policy, they will update volumes for all RY 2022 Rate Orders to reflect CY 2019 volumes with 5 percent corridors. The HSCRC may extend this limit to 10 percent at the discretion of the HSCRC staff. This extension will occur if the hospital presents satisfactory evidence that it would not otherwise achieve its approved total revenue for the Rate Year.

Commissioner Bayless noted that while the policy creates an automatic adjustment to penalize inefficient hospitals, the policy does not automatically reward the most efficient hospitals.

Mr. Pack explained that it is easier to remove revenue than it is to distribute additional income formulaically. Under a formulaic approach, the inclusion of a large hospital would result in that hospital absorbing most of the revenue available for redistribution. Mr. Pack added that the staff would like to understand how the hospital intends to deploy the additional revenue.

Commissioner Bayless also questioned how many cycles the policy would require for appropriate revenue distribution to be reached.

Mr. Pack replied that Staff's intention is not to continually take money away from the lowest quartile and distribute it to the highest quartile. Instead, Staff intends to develop a methodology to determine the appropriate variation and suspend the policy upon achievement.

The Commissioners voted unanimously in favor of Staff's recommendation

ITEM VII
FINAL RECOMMENDATION ON ONGOING SUPPORT OF CRISP FOR RY 2022

Mr. Henderson presented the Final Recommendations for FY 2022 funding to support Health Information Exchange (HIE) Operations and Chesapeake Regional Information System for our Patients (CRISP) (See "Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2022 Funding to Support HIE Operations and CRISP Reporting Services" available on the HSCRC website).

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates.

In December 2013, the Commission authorized staff to provide continued funding support for CRISP for FY 2015 through 2019 without further Commission approval if the amount did not exceed $2.5 million in any year. Since FY 2020, when Maryland Health Insurance Plan (MHIP) funding terminated, requests have exceeded that amount and require Commission approval.

The Commission approved a total of $5.17 million in funding through hospital rates in FY 2021 to support the HIE and Implementation Advanced Planning Document (IAPD), Integrated Care Network (ICN) projects, and Medicaid Management Information System initiative activities for the Commission.

This funding represents approximately 24 percent of CRISP's Maryland funding. The remainder of CRISP's Maryland funding is from user fees, Federal matching funds, and the Maryland Department of Health (MDH).

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest, this Final Recommendation identifies the following amounts of State-supported funding for FY 2022 to CRISP:

Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($2,500,000)

Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($6,740,000)

Staff recommends that HSCRC provide funding to CRISP totaling $9,240.000, an increase of $4,070,000 (79 percent) from FY 2021. This amount represents approximately 31 percent of CRISP's Maryland funding, compared to 24 percent in FY 2021. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH). The significant increase in the funding level is driven by 3 factors:

- the roll-out of new programs under the Total Cost of Care Model,
- the switch from a 10 percent State match to earn Federal funds to a 25 percent State match, as funding moves from the HITECH IAPD to MES, and most significantly,
- a change in Federal matching rules that allocates Federal responsibility based on the number of beneficiaries rather than the number of providers participating in Medicaid programs.

The $4,070,000 increase in HSCRC funding correlates to only a 7-percentage point increase in the HSCRC's share of funding (from 24 to 31 percent) because, simultaneously, CRISP has experienced a significant expansion in its MDH-funded public health related work. To minimize the funding required, CRISP has reduced the proposed FY 2022 budget by approximately 18 percent from projected FY 2021 levels.

Staff's Final Recommendation is for the Commission to approve a total of $9,240,000 in funding through hospital rates in FY 2022 to support the HIE and continue the investments made in the Total Cost of Care Model initiatives through both direct funding and obtaining Federal MES matching funds. Recommended funding is as follows.

Health Information Exchange Assessment	$2,500.000
Reporting and Program Administration	6,740,000
Total	9,240,000

The Commissioners voted unanimously in favor of Staff's recommendation.

ITEM VIII
FINAL RECOMMENDATION FOR THE COMMUNITY BENEFIT REPORTING

Mr. Willem Daniel, Deputy Director, Payment Reform & Provider Alignment, presented staff's Final Recommendation on Community Benefits Reporting Guidelines (see "Final Recommendation for the Community Benefit Reporting" available on the HSCRC website).

Hospitals are required to analyze their community's health needs. This assessment must include members of the community. Staff believes that hospitals generally engage in an extensive process with community members when writing their Community Health Needs Assessment (CHNA). However, the extensiveness of those efforts may vary by hospital. Additionally, hospitals are not required to report the portion of community benefit spending directed to CHNA initiatives. Currently, Community Benefit Reporting requirements mandate that hospitals report the spending in high-level categories, such as "Mission-Driven Health Services" or "Charity Care." These categories are not detailed enough to allow the HSCRC, other policymakers, or the public to identify spending directed to community health needs.

Staff Final Recommendation is as follows:

Chapter 437 of 2020 (SB 774 and HB 1169) directed the HSCRC to include additional information in hospitals' reporting of community health needs. Accordingly, staff recommends updating the Community Benefit Reporting Guidelines to require hospitals to report:

1. Which members of the community helped the hospital to develop its Community Health Needs Assessment; and
2. Initiatives the hospital performed addressing unmet needs of their community and the costs of those initiatives

   Staff further recommended that these guidelines be optional for FY 2021and mandatory beginning in FY 2022.

Commissioner Cohen asked whether there needs to be a national standard for the reporting of community benefits.

Mr. Daniel responded that staff had reviewed reports from several states. He believes that the recommended changes will ensure that Maryland's reporting aligns with national best practices.

Commissioner Colmers suggested that if hospitals choose to report the optional information for FY 2021, the HSCRC should not make the optional portions of the reports publicly available.

Commissioner Colmers explained that publicly available data would likely discourage hospitals from reporting it for FY 2021.

Mr. Daniel replied that staff would work with the HSCRC's attorneys to confirm the legality of not publicly sharing the optional information.

The Commissioners voted unanimously in favor of staff's recommendation.

ITEM IX
POLICY UPDATE

CY 2020 CMS Certification of Waiver Test Results

Ms. Wunderlich provided an update on the CMS Certification of Waiver Test Results:

CMS informed the HSCRC that Maryland met all TCOC Model requirements in CY 2020:

- Medicare Savings Test: Maryland has generated $390.6M in Medicare TCOC savings, versus a CY 2020 target of $156M
- Guardrail Test: Maryland's TCOC per-beneficiary growth was about 0.5 percent below that of the nation in CY 2020.
- Per Capita Limit: Maryland limited the per-capita all-payer growth rate of hospital costs to 0.21 percent, below the cap of 3.58 percent
- Quality Improvements: Maryland reduced preventable conditions in CY 2020 and had a readmission rate of 15.18 percent, which was lower than the national rate of 15.55 percent.
- Revenue Under GBR: Maryland had 97.9 percent of regulated revenue under GBR in CY 2020, above the 95 percent requirement.

Community Vaccination Program Update

Ms. Erin Schurmann, Chief, Provider Alignment & Special Projects, provided an update on the Community Vaccination Program.

In March 2021, the HSCRC initiated the COVID-19 Community Vaccination Funding Program. The Commission offered $12M through a competitive grant process to expand hospitals' existing mobile and community-based vaccination programs. The program specifically incentivized efforts to vaccinate underserved and vulnerable populations throughout the State. The $12M in funding represented the remaining unused portion of the FY 2021 Annual Set-Aside for Unknown Adjustments. The HSCRC awarded $12M to 12 hospitals and hospital systems in the State through the competitive grant process. As of June 2021, hospitals estimate that initiatives supported by the COVID-19 Community Vaccination Funding Program will result in the administration of 300,000 additional doses of COVID-19 vaccines.

ITEM X
HEARING AND MEETING SCHEDULE

July 14, 2021 Times to be determined, 4160 Patterson Avenue
HSCRC Conference Room

August 11, 2021 Times to be determined, 4160 Patterson Avenue
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:02 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF JULY 6, 2021

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2555N	University of Maryland Shore Medical Center at Easton	4/27/2021	5/27/2021	9/14/2021	I/P PSYCH SERVICES	WH	OPEN
2558N	Adventist HealthCare Rehabilitation-Rockville Campus	5/27/2021	6/26/2021	10/24/2021	RDL	WH	OPEN
2559N	Adventist HealthCare Rehabilitation-White Oak Campus	5/27/2021	6/26/2021	10/24/2021	RDL	WH	OPEN
2560N	Johns Hopkins Bayview Medical Center	5/28/2021	6/27/2021	10/25/2021	CHRONIC & REHAB.	WH	OPEN
2561N	Sheppard and Enoch Pratt Hospital	6/1/2021	6/30/2021	10/28/2021	CAT	WH	OPEN
2562R	Sheppard and Enoch Pratt Hospital	6/28/2021	7/28/2021	11/25/2021	FULL	JS	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

Proceeding 2558N – Adventist Health Care Rehabilitation Rockville

- On May 27, 2021, Adventist HealthCare Rehabilitation – Rockville Campus ("Rehab Rockville") submitted a partial rate application to establish a new Hemodialysis (RDL) rate.
- Rehab Rockville is exempt from rate setting because 66 2/3 or more of its annual gross patient revenue is attributed to governmental payers, Medicare and Medicaid, who are not required to pay Commission approved rates under the Medicare waiver (COMAR 10.37.03.10).
- Under the regulation, a hospital granted an exemption is required to file a quarterly report, in a manner to be prescribed by the Commission, in order to verify that the conditions that justified the exemptions still apply.
- The purpose of this rate application is to establish the RDL rate center so that it may accurately report the monthly revenue and volume usage.

Recommendation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Rehab Rockville requested a rate of $499.23 per RDL treatment, while the statewide median rate for RDL service is $999.42 per treatment.

Recommendation

After reviewing the Rehab Rockville application, the staff recommends:

1. That the RDL rate of $499.23 per treatment be approved effective August 1, 2021
2. That the RDL rate center not be rate realigned due to its unregulated status; and
3. That Rehab Rockville continue to file all other required reports in conformity with the Commission's Accounting and Budget Manual.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
ADVENTIST HEALTHCARE	*	**DOCKET:**	**2021**
REHABILITATION ROCKVILLE	*	**FOLIO:**	**2368**
ROCKVILLE, MARYLAND	*	**PROCEEDING:**	**2558N**

Staff Recommendation
July 14, 2021

Introduction

On May 27, 2021, Adventist HealthCare Rehabilitation – Rockville Campus ("Rehab Rockville") submitted a partial rate application to establish a new Hemodialysis (RDL) rate. Rehab Rockville is exempt from rate setting because 66 2/3 or more of its annual gross patient revenue is attributed to governmental payers, Medicare and Medicaid, who are not required to pay Commission approved rates under the Medicare waiver (COMAR 10.37.03.10).

Under the regulation, a hospital granted an exemption is required to file a quarterly report, in a manner to be prescribed by the Commission, in order to verify that the conditions that justified the exemptions still apply.

The purpose of this rate application is to establish the RDL rate center so that it may accurately report the monthly revenue and volume usage.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Rehab Rockville requested a rate of $499.23 per RDL treatment, while the statewide median rate for RDL service is $999.42 per treatment.

Recommendation

After reviewing the Rehab Rockville application, the staff recommends:

1. That the RDL rate of $499.23 per treatment be approved effective August 1, 2021;

2. That the RDL rate center not be rate realigned due to its unregulated status; and

3. That Rehab Rockville continue to file all other required reports in conformity with the Commission's Accounting and Budget Manual.

Proceeding 2559N-Adventist Health Care Rehabilitation White Oak

- On May 27, 2021, Adventist HealthCare Rehabilitation – White Oak Campus (“Rehab White Oak”) submitted a partial rate application to establish a new Hemodialysis (RDL) rate. Rehab White Oak is exempt from rate setting because 66 2/3 or more of its annual gross patient revenue is attributed to governmental payers, Medicare and Medicaid, who are not required to pay Commission approved rates under the Medicare waiver (COMAR 10.37.03.10).

- Under the regulation, a hospital granted an exemption is required to file a quarterly report, in a manner to be prescribed by the Commission, in order to verify that the conditions that justified the exemptions still apply.

- The purpose of this rate application is to establish the RDL rate center so that it may accurately report the monthly revenue and volume usage.

Recommendation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Rehab White Oak requested a rate of $499.23 per RDL treatment, while the statewide median rate for RDL service is $999.42 per treatment.

Recommendation

After reviewing the Rehab White Oak application, the staff recommends:

1. That the RDL rate of $499.23 per treatment be approved effective August 1, 2021;
2. That the RDL rate center not be rate realigned due to its unregulated status; and
3. That Rehab White Oak continue to file all other required reports in conformity with the Commission's Accounting and Budget Manual.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
ADVENTIST HEALTHCARE	*	**DOCKET:**	**2021**
REHABILITATION WHITE OAK	*	**FOLIO:**	**2369**
SILVER SPRING, MARYLAND	*	**PROCEEDING:**	**2559N**

Staff Recommendation
July 14, 2021

Introduction

On May 27, 2021, Adventist HealthCare Rehabilitation – White Oak Campus ("Rehab White Oak") submitted a partial rate application to establish a new Hemodialysis (RDL) rate. Rehab White Oak is exempt from rate setting because 66 2/3 or more of its annual gross patient revenue is attributed to governmental payers, Medicare and Medicaid, who are not required to pay Commission approved rates under the Medicare waiver (COMAR 10.37.03.10).

Under the regulation, a hospital granted an exemption is required to file a quarterly report, in a manner to be prescribed by the Commission, in order to verify that the conditions that justified the exemptions still apply.

The purpose of this rate application is to establish the RDL rate center so that it may accurately report the monthly revenue and volume usage.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Rehab White Oak requested a rate of $499.23 per RDL treatment, while the statewide median rate for RDL service is $999.42 per treatment.

Recommendation

After reviewing the Rehab White Oak application, the staff recommends:

1. That the RDL rate of $499.23 per treatment be approved effective August 1, 2021;

2. That the RDL rate center not be rate realigned due to its unregulated status; and

3. That Rehab White Oak continue to file all other required reports in conformity with the Commission's Accounting and Budget Manual.

Proceeding 2560N-Johns Hopkins Bayview Medical Center

- On May 28, 2021, Johns Hopkins Bayview Medical Center (“the Hospital”) submitted a partial rate application to establish a new Rehabilitation (RHB) rate.
- The Hospital’s Department of Physical Medicine and Rehabilitation (PM&R), was in partnership with the MedStar Health System, providing RHB services at Good Samaritan Hospital, one of the hospitals in the MedStar System.
- However, this contractual arrangement ended, and PR&M began utilizing licensed beds on the Hospital Campus for their Rehabilitation patients.
- The Hospital has been billing these patients utilizing its approved rate for Chronic Care.
- The Hospital is requesting approval to separate the two patient care centers to bring them in alignment with like centers across the Johns Hopkins Health System.
- The Hospital requests the rate for RHB to be effective August 1, 2021.

Recommendation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. The Hospital provided projected costs associated with the RHB services and requested a rate of $1,271.55 per day, while the statewide median rate for RHB is $1,279.99 per day.

Recommendation

After reviewing the Hospital's application, the staff recommends:

1. That the RHB rate of $1,271.55 per day be approved effective August 1, 2021;
2. That the RHB rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital's Global Budget Revenue for the RHB services.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
JOHNS HOPKINS BAYVIEW	*	**DOCKET:**	**2021**
MEDICAL CENTER	*	**FOLIO:**	**2371**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2560N**

Staff Recommendation
July 14, 2021

Introduction

On May 28, 2021, Johns Hopkins Bayview Medical Center ("the Hospital") submitted a partial rate application to establish a new Rehabilitation (RHB) rate. The Hospital's Department of Physical Medicine and Rehabilitation (PM&R), was in partnership with the MedStar Health System, providing RHB services at Good Samaritan Hospital, one of the hospitals in the MedStar System. However, this contractual arrangement ended, and PR&M began utilizing licensed beds on the Hospital Campus for their Rehabilitation patients. The Hospital has been billing these patients utilizing its approved rate for Chronic Care. The Hospital is requesting approval to separate the two patient care centers to bring them in alignment with like centers across the Johns Hopkins Health System. The Hospital requests the rate for RHB to be effective August 1, 2021.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. The Hospital provided projected costs associated with the RHB services and requested a rate of $1,271.55 per day, while the statewide median rate for RHB is $1,279.99 per day.

Recommendation

After reviewing the Hospital's application, the staff recommends:

1. That the RHB rate of $1,271.55 per day be approved effective August 1, 2021;

2. That the RHB rate center not be rate realigned until a full year of cost data has been reported to the Commission; and

3. That no change be made to the Hospital's Global Budget Revenue for the RHB services.

Proceeding 2561N-Sheppard & Enoch Pratt Hospital

- On June 1, 2021, Sheppard and Enoch Pratt Hospital (“the Hospital”) submitted a partial rate application to establish a new Rebundled Computerized Tomography (CT) rate.
- The Hospital is the nation’s largest private, nonprofit provider of mental health, substance use, special education, developmental disability, and social services.
- The Hospital does not have a CT Scanner; thus, the rebundled rate will enable the Hospital to bill for CT services provided to its patients.
- The Hospital requests a unit rate for CT services to be effective September 1, 2021.

Recommendation

Under COMAR 10.37.03.09, an approved rebundled rate must be equal to or less than the statewide median. The Hospital provided projected costs associated with the new CT services and requested a rate of $4.46 per RVU, while the statewide median rate for CT services is $4.36.

Recommendation

After reviewing the Hospital's application, the staff recommends:

1. That the CT rate of $4.36 per RVU, the statewide median, be approved effective September 1, 2021;
2. That the CT rate as rebundled services not be rate realigned; and
3. That the CT rate services be subject to the application of the Approved Revenue and Unit Rate Policies.

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
SHEPPARD AND ENOCH	*	**DOCKET:**	**2021**
PRATT HOSPITAL	*	**FOLIO:**	**2371**
TOWSON, MARYLAND	*	**PROCEEDING:**	**2561N**

Staff Recommendation
July 14, 2021

Introduction

On June 1, 2021, Sheppard and Enoch Pratt Hospital ("the Hospital") submitted a partial rate application to establish a new Rebundled Computerized Tomography (CT) rate. The Hospital is the nation's largest private, nonprofit provider of mental health, substance use, special education, developmental disability, and social services. The Hospital does not have a CT Scanner; thus, the rebundled rate will enable the Hospital to bill for CT services provided to its patients. The Hospital requests a unit rate for CT services to be effective September 1, 2021.

Staff Evaluation

Under COMAR 10.37.03.09, an approved rebundled rate must be equal to or less than the statewide median. The Hospital provided projected costs associated with the new CT services and requested a rate of $4.46 per RVU, while the statewide median rate for CT services is $4.36.

Recommendation

After reviewing the Hospital's application, the staff recommends:

1. That the CT rate of $4.36 per RVU, the statewide median, be approved effective September 1, 2021;

2. That the CT rate as rebundled services not be rate realigned; and

3. That the CT rate services be subject to the application of the Approved Revenue and Unit Rate Policies.

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Population Health Workforce Support for Disadvantaged Areas (PWSDA) Program

Report on FY 2016 – FY 2020 Activities

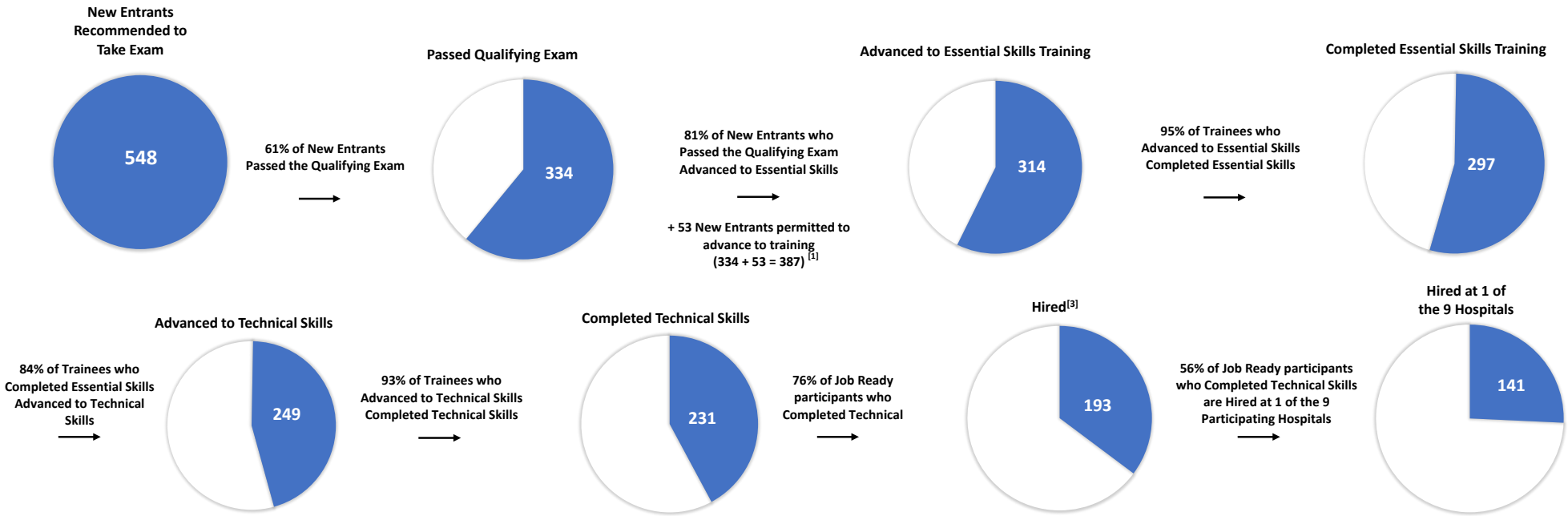
Program Overview

- In December 2015, the Commission authorized $10 million in rate increases for hospitals to train and hire workers from areas of high economic disparities and unemployment.
- Hospitals must train, hire, and assist workers to fill new positions to support care coordination, population health, and consumer engagement.
- The overall objective is to address the social determinants of health and assist hospitals in bolstering population health and meeting the goals of the Total Cost of Care (TCOC) Model.

Extension and Program Administration

- In 2018, staff presented a report on the initial PWSDA activities and recommended extending the program through FY 2022 for the Baltimore Population Health Workforce Collaborative.
- HSCRC Commissioners requested that staff return prior to the conclusion of the program to discuss future opportunities for the program.
- In 2019, HSCRC staff contracted with Berkeley Research Group (BRG) to serve as program monitor for the PWSDA program from FY 2019 through FY 2022.
- BRG collects, reviews, and summarizes semi-annual reports and has compiled the below summary on behalf of HSCRC staff.
- HSCRC staff conducts audits of hospital spending to validate submissions.

FY 2016 – FY 2020 PWSDA Program, New Entrants Process and Outcomes Measures

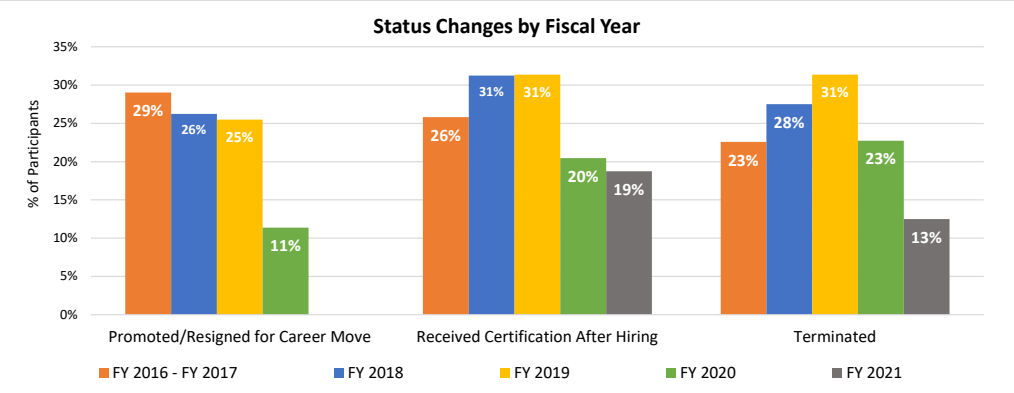


Program Evolution & Recommendations from Program Leaders

Advancement

- Evidence of employees advancing / transitioning to these positions
  - Development of Level II / Level III positions

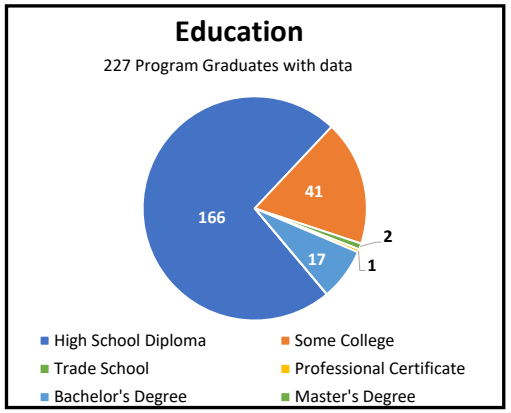
Status changes

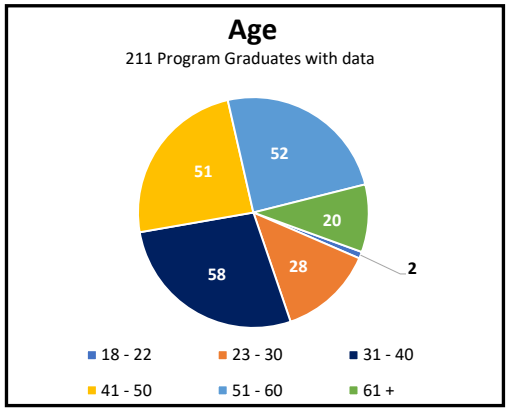


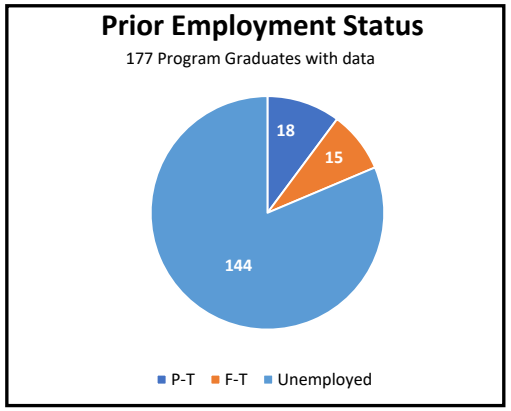
Status Changes by Fiscal Year[1]						
	FY 2016 - 2017	FY 2018	FY 2019	FY 2020	FY 2021	Total
Hospital Hires	**31**	**80**	**51**	**44**	**16**	**222**
Hires with Status Change	**24**	**68**	**45**	**24**	**6**	**167**
Promoted/Resigned for Career Move	9	21	13	5	0	**48**
% Promoted/Resigned for Career Move	**29%**	**26%**	**25%**	**11%**	**0%**	**22%**
Received Certification After Hiring	8	25	16	9	3	**61**
% Received Certification After Hiring	**26%**	**31%**	**31%**	**20%**	**19%**	**27%**
Terminated	7	22	16	10	2	**57**
% Terminated	**23%**	**28%**	**31%**	**23%**	**13%**	**26%**
Deceased	0	0	0	0	1	**1**

Note:
[1] Fiscal year is based on date hired at 1 of the 9 hospitals.
[2] Data are documented for FY 2016 - FY 2020 cohorts only. Data does not include advancement of FY 2021 cohorts (1st year of employment).

Profiles of Program Graduates FY 2016 – FY 2020





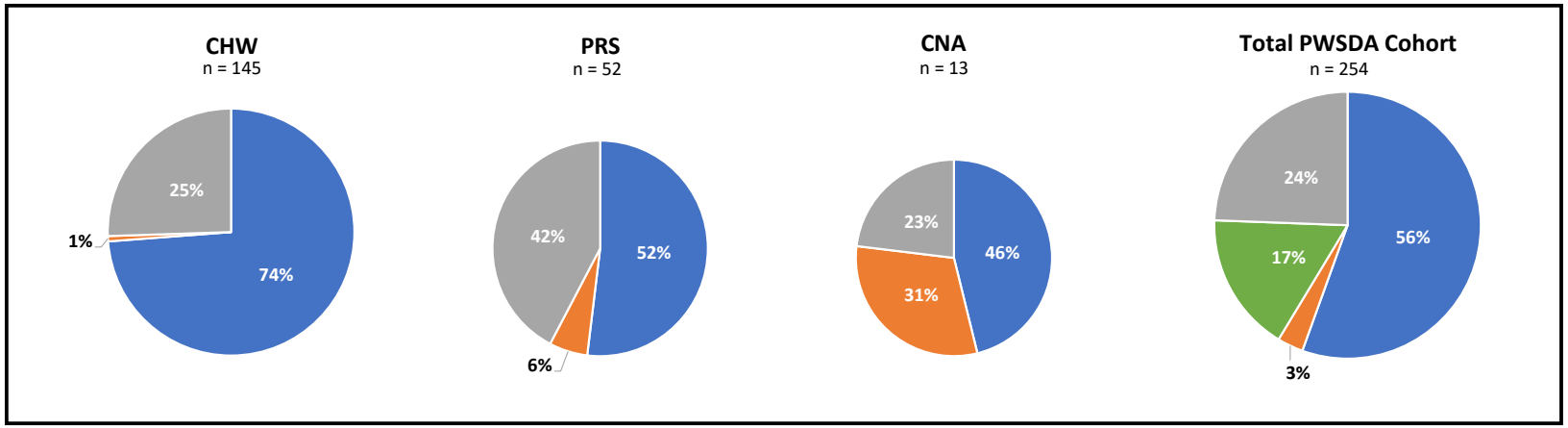


Key Indicators	Reported Yes
Criminal Record	33
Substance Abuse	32
Single Parent	14
Transitional Housing	15

← *67% were employed after training*

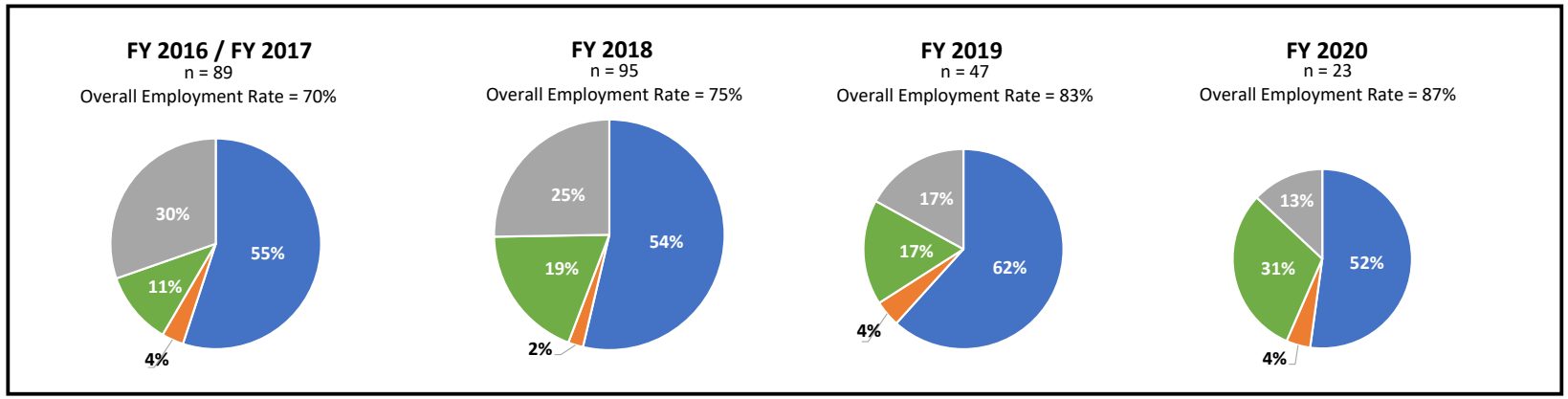
[1] Program Graduates = Program participants that completed technical skills training. N = 234 (231 New Entrants + 3 Incumbents)
[2] Transitional housing is defined as any setting that is not rented or owned.

Employment Outcomes for Program Graduates New Entrants Only



Note: There is 1 participant that is employed at 1 of the 9 Hospitals, but does not have a traditional role as a CHW, PRS, CNA/GNA.

% of Participants Hired by Fiscal Year
Employed at 1 of the 9 Hospitals or Elsewhere



Roles of CHWs and PRSs

Pivoting" to telephone communications: Report by supervisors

- CHWs/PRSs quickly adapted to working with clients / maintaining communications by telephone
  - This included leading support groups through telephone / Zoom
- CHWs/PRSs adapted quickly and effectively, building trusting relationships and providing steady support and service by telephone. Each health system commented on how noteworthy this was

High demand services / supports

- Linking clients to food supports and transportation service
- Providing second language/interpreter services
- ER-based services
  - While clinic volume and inpatient volume declined during this period, CHWs and PRSs continued to provide steady support in the ER.
  - Screening and linkage to food, housing, substance use services, and social services
- Home drop-offs
  - Laptops, food, personal items

Reassignments / Redeployment

- Many CHWs were reassigned/redeployed to provide
  - Administrative support for COVID test scheduling/operations
  - Preparation of COVID-related kits for communities, and
  - Community education/patient education
- As noted, significant time was devoted to responding to the need for food support and transportation services

Community-based outreach and services

- Education tied to COVID

Measurable Impact: Number of Patients Served in the Hospital

- One measure of impact on patient care is the number of patients served, often referred to as the number of patients "touched." Hospitals were asked to document the number of unduplicated patients served in each setting. Figures from 7 selected hospitals are presented below.
- Worth noting is the sheer number of patients impacted: The 9 hospitals documented more than 28,000 individual hospital patients served by CHWs and PRSs.
  - Important to note: Not included here are the substantial number of patients served through community-based testing and counseling programs, as well as community-based health programs.

Number of Unduplicated Hospital Patients Served by CHWs/PRSs: Hospital-Based, only FY 2019 FTEs and Patients

Hospital	# CHW / PRS Reported Data Hospital-Based only	# Unduplicated Patients Served
Johns Hopkins Hospital	30	8,525
Johns Hopkins Bayview	16	3,426
MedStar Franklin Square*	6*	228*
MedStar Union Memorial	10	2,039
MedStar Good Samaritan	11	1,259
MedStar Harbor Hospital	9	561
Univ of MD Medical Center	12	6,348
Univ of MD Midtown*	13*	4,218*
LBH Sinai Hospital	8	1,867
Total, 9 Hospitals	**115**	**28,471 patients**

*Data available only for CHWs; figures do not include PRS volume

Program Impact - Evaluation Highlights

Optimal Solutions Group was subcontracted to conduct an evaluation to provide insights on the program and identify quantifiable impacts of the program.

- Effect on Patient Experience
  - Optimal Solutions designed a difference-in-differences evaluation approach to explore the program's impact on patient experience/HCAHPS scores
  - When compared to a control group of 90 hospitals, results suggested improvements for care transition, discharge information, and decreases in readmissions
  - These positive outcomes may be the result of dedicated BPHWC efforts to promote culturally competent care, care coordination, and patient education
- Enrollment, Hiring, and Retention Practices
  - The overall PWSDA program hospital employment retention rate, 80.1 percent, was comparable to the retention rate for all hospital hires, 83.1 percent.
  - The program enrolled and graduated an increased proportion of disadvantaged individuals (52.6 percent and 92.5 percent, respectively)
- Attrition Costs
  - Optimal Solutions reviewed budget reports from FY 2016 – FY 2019 to examine staff training and onboarding costs lost to due staff attrition.
  - Staff attrition resulted in a total loss of $1,134,933, of which $167,587 was in training costs and $967,346 in onboarding costs.

Program Expenditures

- Between FY2017-2021 YTD (December 2020), total program spending by participating hospitals amounted to $19.2 million.

Fiscal Year	Expenditures
FY 2017	$746,789
FY 2018	$4,148,834
FY 2019	$5,333,875
FY 2020	$5,835,160
FY 2021 YTD (Dec 2020)	$3,137,374

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Report on Population Workforce Support for Disadvantaged Areas Program (PWSDA) Activities

FY 2016 – FY 2021

July 2021

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Introduction

In 2018, Health Services Cost Review Commission (HSCRC or Commission) staff presented a report on the initial activities of the Population Health Workforce Support for Disadvantaged Areas (PWSDA) program and recommended extending the program through FY 2022 for the Baltimore Population Health Workforce Collaborative (Baltimore Collaborative or Collaborative) a group of 9 hospitals working together in the Baltimore City area. HSCRC Commissioners requested that staff return prior to the conclusion of the program to discuss future opportunities for the program. In 2019, HSCRC staff contracted Berkley Research Group (BRG) to serve as program monitor for the PWSDA program from FY 2019 through FY 2022. BRG collects, reviews, and summarizes semi-annual reports and has compiled the below summary on behalf of HSCRC staff. This report provides an overview of program activities, as well as high-level findings from a program assessment conducted by BRG and their subcontractor, Optimal Solutions Group (Optimal Solutions).

Background

In December 2015, the Commission authorized up to $10 million in hospital rates for hospitals that committed to train and hire workers from geographic areas of high economic disparities and unemployment to fill new positions to support care coordination, population health, consumer engagement, and related positions. The PWSDA was developed in an effort to support job opportunities for individuals who reside in neighborhoods with a high area deprivation index (ADI), and thus enable communities to improve their socioeconomic status while working to improve population health. The overall objective is to address the social determinants of health and assist hospitals in bolstering population health and meeting the goals of the Total Cost of Care (TCOC) Model.

The HSCRC funded this program in two stages. The initial program awarded funding to two recipients: the Baltimore Collaborative and Garrett Regional Medical Center (GRMC). At that time, the HSCRC approved $6.67 million to the Baltimore Collaborative to train 444 individuals and hire 208 individuals by Year 3. However, the program was not effectively mobilized across hospitals until January 2017. In 2018, the HSCRC extended program funding to the Baltimore Collaborative through FY 2022. Performance targets were revised to reflect the delayed start . Commissioners approved the following recommendations as part of the program extension.

- Removed unspent funds from earlier years
- Provided an additional $5.87 million in rates for FY 2020 – FY 2022
- Required participating hospitals to match of at least 50 percent of rate funding going forward
- Re-set performance targets to reflect the program delay. The new target established the goal to retain 185 PWSDA employees by FY2022

The Baltimore Collaborative includes 9 hospitals in Maryland and targets worker recruitment efforts in neighborhoods with high poverty and unemployment rates.[1]. The four health systems represented by these hospitals designated program managers committed to the success and advancement of PWSDA employees who are hired as Community Health Workers (CHWs), Peer Recovery Specialists (PRSs) or Certified Nursing Assistants (CNAs). Participating hospitals are:

- University of Maryland Medical System
  - University of Maryland Medical Center
  - University of Maryland Midtown Campus
- Johns Hopkins Health System
  - Johns Hopkins Hospital
  - Johns Hopkins Bayview Medical Center
- MedStar Health
  - Union Memorial Hospital
  - Franklin Square Medical Center
  - Good Samaritan Hospital
  - Harbor Hospital Center
- LifeBridge Health
  - Sinai Hospital

The Baltimore Collaborative operates with partner organizations; these are well-established agencies with successful track records that provide outreach, training, and support services to Program participants. Currently, the partner organizations are:

- Turnaround Tuesday (TAT) –TAT is dedicated to readying the unemployed to enter/reenter the workforce. TAT provides community-based outreach/recruitment and conducts a 2-4 week "Essential Skills Training" program for job readiness, professional skills development, and interviewing skills. TAT conducts a needs assessment with each participant and provides support services/wraparound services to make the training and hiring period a successful one. TAT continues to provide wraparound services post-training and post-hiring.
- Baltimore Alliance for Careers in Healthcare (BACH) - BACH is dedicated to creating opportunities for wage-earning careers and partners with healthcare organizations to provide a pipeline of trained employees. BACH provides technical training, employment readiness, direct / personal linkage to Maryland hospitals, and ongoing coaching to PWSDA hospital employees. BACH also serves as headquarters for ongoing data submission by members of the Baltimore Collaborative.

Reporting Requirements

BACH, Turnaround Tuesday and the participating health systems submit performance reports every 6 months to document (a) Overall training and hiring activity; (b) Hiring, retention and advancement of PWSDA employees at each of the 9 participating hospitals, (c) Roles and activities of PWSDA employees

[1] Targeted neighborhood ZIP Codes: 21201, 21202, 21205, 21206, 21207, 21211, 21213, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21231 and 21239

at the 9 hospitals, and (d) Program spending.[2] Berkeley Research Group (BRG) integrates data from all members of the Collaborative to examine program performance relative to original program targets and to identify key variables impacting program performance. BRG has also created a longitudinal database to track employment outcomes. Based on report submissions, BRG reviews:

- Process measures: Outreach, completion of training program, employment rates, "yield" to the 9 hospitals (i.e. hospital hires as a percentage of total hires)
- Hiring and retention: Hospital-specific performance against targets
    - Number of new hires
    - Number of cumulative retained positions
- Impact on population health initiatives: Key indicators
    - Service settings where employees are deployed; specific services provided; number of patients served; evidence that social determinants of health are being addressed
- Advancement: Evidence from 9 participating hospitals on "outcomes" over time as defined by promotions, certifications, and terminations
- Policy considerations: BRG identifies policy/funding considerations based on program evolution here in Maryland and based on industry activity across the country.

Training and Hiring: Key Findings and Observations

This report highlights the key findings and observations from the FY2016-2020 PWSDA Program Review prepared by Berkeley Research Group (BRG). The data and observations documented below largely reflects activity during the FY2016-2020 period before the pandemic's full effect on program operations.

A supplement to this report was prepared by BRG to document activity during July-December 2020 (FY2021, Qtrs 1-2). During this time, CHW and PRS technical training programs were halted; BACH did not generate new cohorts of trained CHWs/PRSs. However, BACH continued to coordinate employment opportunities. BACH arranged employment as contact tracers for those who completed the Johns Hopkins University online contact tracer training program. In addition, the Collaborative hospitals continued to hire CHW/PRS graduates from earlier cohorts of the PWSDA program. The summary data below represents an updated report on the number of new hospital hires and retained employees through December 2020.

Overall Performance Relative to Targets

By the end of FY2020, the Baltimore Collaborative had come close to achieving the targeted number of *new hires* through the PWSDA Program (206 actual new hires vs. the goal of 217 new hires); the Collaborative was only 10 percent below the target for cumulative number of retained employees, even amidst one quarter of the pandemic (127actual retained employees vs. the goal of 142 retained employees). In FY2021, hospitals continued to maintain their hiring pace, but retention rates fell significantly; the pandemic

[2] Note: Information on employment and retention at other job sites has been limited, but TAT recently hired a "Retention Specialist" who will be working to follow up with all program participants to track outcomes

period saw high turnover reflecting the combination of pandemic factors including increased family responsibilities, decisions to avoid public contact/workplaces, and/or physical illness. The number of cumulative retained positions is currently 24 percent below target.

Table 1. Annual Hiring and Employment Targets

	FY 2016-2019	FY 2020	FY 2021	FY 2022
# New Hires, Total	179	38	28	15
# New Hires, Cumulative		217	245	260
# Retained FTEs, Cumulative	151	142	169	185

Table 2. Actual Hiring and Employment Performance, FY 2016-FY 2021 (December 2020)

	FY 2016-2019	FY 2020	FY 2021	Percent to Target
# New Hires, Total	162	44	16	
# New Hires, Cumulative		206	222	-9.38%
# Retained FTEs, Cumulative	126	127	129	-23.67%

Performance has varied across health systems and the following points are worth noting:

- Sinai Hospital met its FY 2020 target for retained positions and aims to further grow the number of CHW positions to meet its FY 2022 target. Sinai Hospital has a longer track record than most hospitals in using community health workers; Sinai has operated professional teams with community health workers as core team members for the last decade.
- MedStar has demonstrated strong performance and achieved its FY2020 Health System target for retained positions. It accomplished this, in part, by having hired above the target number of employees (which allows for higher turnover rates while maintaining the target number of filled positions).
- Johns Hopkins Hospital has accelerated its hiring activity but remains significantly below the target number of retained positions. In part, this may reflect higher turnover rates among CNAs; Hopkins is the only hospital hiring CNAs through the PWSDA program.

Program Review and Analysis

Two important frameworks were adopted for this program review to provide constructive analysis. Appendix 1 contains additional detail on outreach, training, hiring, and patient services provided under the PWSDA program.

New Entrants vs. Incumbents

There have been two candidate pools hired through the PWSDA Program. These include

(a) New entrants - identified through formal outreach efforts or word-of-mouth who are hired as new employees to the Collaborative

(b) Incumbents – Existing employees who may be working part-time or on a PRN basis and seek full-time employment/benefits, job advancement or wage growth through professional skills or technical training. Incumbents may also include existing employees who are funded through grants and whose grant support is due to expire.

Nearly 30 percent of PWSDA employees were incumbents, defined as existing hospital employees who worked at one of the nine hospitals and sought full-time employment and/or growth opportunities. Therefore, nearly one third of PWSDA employees were not "new" to the health system but were employees who were provided avenues for benefits, wage growth, and/or professional advancement. The PWSDA grant also helped support a small number of CHW positions that had been funded by external grants but for whom funding was expected to expire.

The range of starting wages per hour in FY 2020 for CHWs and PRSs was $15.50 to $17.09. The average starting wage for CHWs was $16.36 per hour and the average starting wage for CNAs was $15.00 per hour.

Program Components and Stages

There are distinct program components with unique challenges that exist at each stage of the employment pipeline. Overall program success depends on success at each stage. Program components are:

1. Outreach/Recruitment: BACH must reach a sizable population to support a pipeline of trainees
2. Qualifying exam: Candidates must have a high school diploma and pass a standardized test to qualify for the training program
3. Essential Skills Training: Trainees must complete a 2-4 week course that focuses on job readiness, basic professional skills, and job expectations
4. Technical Skills training: Trainees must complete modules for CHWs, PRSs, or CNAs
5. Employment
6. Employment at one of the 9 Collaborative hospitals ("yield" to the 9 hospitals)

BRG examined the success rate at each stage to identify where opportunities exist to strengthen program success (participation rates; completion rates; hiring rates; etc.). Pages 4 and 5 of Appendix 1 present this data in greater detail.

Outreach

Community outreach/recruitment appears to be one of the most critical success factors. The PWSDA Program must draw a high volume of candidates at the "front of the pipeline" to allow for the fact that the number who qualify and who successfully complete the Program will be more limited. Between 2018-2019, BACH worked with 3-4 community organizations to conduct outreach and refer candidates. But in 2019,

BACH relied on only one organization for outreach (TAT). This change correlated with a steep decline in the number of program participants and program graduates. This decline in FY2019 was the major setback to achieving program targets.

Qualifying Exam

Admission to the PWSDA Program has required candidates to pass a qualifying exam, a standardized exam that establishes basic reading and math abilities. The qualifying exam reduces the potential pool of PWSDA program participants considerably**.** Between FY2016-2020, only 61 percent of candidates recommended to take the exam actually passed the exam. Therefore, while TAT identified 548 candidates for the Program, only 334 passed the qualifying exam for the PWSDA program. To date, hospitals have viewed this qualifying exam to be a necessary job requirement.

Technical Training

More than 90 percent of participants who began the technical training programs completed the training program. This fact reflects very positively on both candidate selection and the support services provided to students in the course of training. The large majority of PWSDA program graduates have been trained as Community Health Workers (43 percent) in response to hospital demands for CHWs across hospital departments (including, inpatient, outpatient and emergency departments) and community-based settings. CHWs have assumed an impressive array of responsibilities including screening, counseling, referral, and navigation services for hospital patients, home visits and home safety assessments, and patient education in the community. CHWs have also accompanied patients to appointments and helped secure housing, food support, and eligibility/benefits.

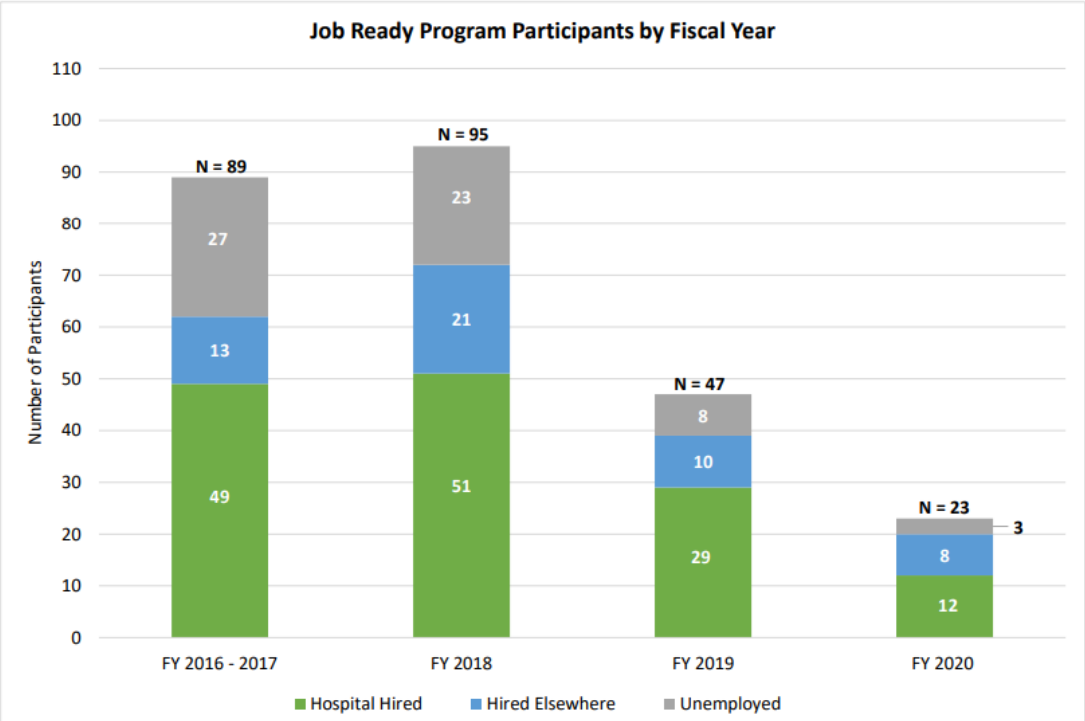
Employment Rate[3]

Seventy-six percent of program graduates were employed after program completion. This figure steadily increased across the FY2016-2020 period. In the first half of FY 2021, technical training was not provided due to the public health emergency, but BACH coordinated job placement as contact tracers and other employment sites for those who completed Essential Skills training. While total volume was small, BACH reported a 62 percent employment rate during the pandemic period.

Fifty-six percent of program graduates were hired at one of the 9 participating hospitals. While the PWSDA Program is intended to serve as a direct pipeline to the hospital workforce, the mission of the Program to expand employment/advancement opportunities is defined more broadly. Program employment success is measured by both the overall employment rate (76 percent) as well as the hiring rate at the Collaborative (56 percent).

[3] Appendix 1. Page 13.

Figure 1. Job Ready Program Participants, FY 2016 - FY 2020



Termination rate

As of December 2021, the overall termination rate was 26 percent. These terminations might be examined more closely by program managers to identify any common factors that might be addressed during training.

Profile Highlights of PWSDA Program Graduates

More than 70 percent of program graduates had only a high school diploma and more than 80 percent of program graduates had been unemployed prior to PWSDA training. The age mix was widely distributed. While 25 percent of graduates were under the age of 22 years, approximately 10 percent were over the age 60 years. Of the 234 program graduates, more than 30 individuals had either a criminal record and/or substance use condition identified in the course of the TAT needs assessment. Sixty-seven percent of the graduates with a criminal record were employed after training.

Professional Advancement

In December 2020, 25 percent of PWSDA employees were documented to have received professional certification after hiring and 24 percent had advanced through role expansion, lateral moves in the hospital, and/or job promotions. More than half of the hospitals were able to cite evidence of PWSDA employees having advanced through certification or one of these avenues for advancement. Several hospitals have created Level II positions to provide advancement as CHW supervisors.

Providing more job opportunities to disadvantaged communities

Finally, on a hospital-wide basis, it does not appear that hospitals are hiring more individuals from the targeted neighborhoods in total[4]. A high level examination documents that hospitals have historically hired a large percentage of its workforce from these zip codes and the numbers have not changed appreciably.

Program Impact: Key Findings and Observations

Patient Volumes

One measure of impact on patient care is the number of patients served, often referred to as the number of patients "touched." BRG examined data for FY2019 that documented the number of unduplicated patients. Data from FY2020 was impacted by the substantial decline in patient volume during the pandemic and therefore was not used to measure the number of patients served. The nine hospitals documented more than 28,000 individual hospital patients served by CHWs and PRSs. These figures do not include the substantial volume of patients served through community-based testing and counseling programs or at community-based health education programs, which suggests a significantly greater impact on the number of patients served.

Direct Services and Service Settings

CHWs and PRSs in this program provide a wide breadth and volume of direct services to serve the large number of patients indicated above. CHWs and PRSs are deployed across a wide array of settings: emergency departments, outpatient clinics, inpatient units, transitional care settings, and community health programs. Key services offered by CHWs and PRSs are listed below:

- Linkage/navigation to medical referrals and appointments
- Linkage/navigation to social services
- Attending appointments or companion visits
- Home visits and home safety assessments
- HCV/HIV screening and counseling
- Patient engagement during initial contact in inpatient and outpatient settings
- Outreach, education and counseling through existing community-based programs
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Overdose Survivors Outreach Program (OSOP)
- Patient engagement during initial contact in inpatient setting
- Naloxone kit distribution

[4] Targeted neighborhood ZIP codes: 21201, 21202, 21205, 21206, 21207, 21211, 21213, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21231 and 21239

- On-call availability to patients

Community Connectedness and Addressing Social Determinants of Health (SDOH)

Hospital reports indicate that PWSDA employees bring strong familiarity with local resources and knowledge on accessing these resources. For example, CHWs have supported efforts to address social determinants of health such as food supports and safe housing. PWSDA employees have also demonstrated that they build effective relationships with patients. Hospitals have validated that PRSs bring the "lived experience" to support patients with HIV and substance use. PRSs have linked patients to substance use treatment and continue to help patients "see it through."

Program Evaluation Highlights

Because of the short duration of the program, determining quantifiable cost, quality, and population health outcomes is difficult. Additionally, many workers have been incorporated into existing hospital programs which makes isolating the direct impact of PWSDA workers indiscernible. While acknowledging these challenges, HSCRC staff contracted an independent evaluator to conduct an assessment of the program to determine hospital progress towards original program goals.

Optimal Solutions Group was subcontracted to conduct an evaluation to provide insights on the program and identify quantifiable impacts of the program. Optimal Solutions focused their evaluation on three primary areas: 1) effect on patient experience, 2) program costs incurred and lost due to attrition, and 3) enrollment, hiring, and retention of disadvantaged individuals.[5]

Effect on Patient Experience

Optimal Solutions designed a difference-in-differences (DID) approach, a quasi-experimental research design to conduct an analysis to explore the potential impact on patient experience resulting from this program. An overview of the approach and high-level findings are below.

> "The evaluation used the survey of patient's experiences, Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) 2014–2019: the Centers for Medicare & Medicaid Services (CMS) data for the characteristics, quality of care, and patient health care experiences at over 4,000 Medicare-certified hospitals… The comparison group of 90 hospitals was selected using the propensity score to be similar to the BPHWC group with respect to the demographics and socioeconomic status (SES) of their communities, and the hospital characteristics.

[5] Optimal Solutions Group. *Population Health Workforce Support for Disadvantaged Areas Activities: Enrollment, Hiring, and Retention Practices and Patient Experiences.* December 2020.

> The results display the annual changes in the patients' ratings of their health care experiences, particularly highlighting changes before (2014-2016) and during (2017-2019) the program implementation periods among the BPHWC hospitals and the control group hospitals. There were some relevant descriptive results suggesting some improvements in health care experience outcomes among BPHWC hospitals as compared with a control group of hospitals. The descriptive time trends suggested slight improvements for care transition, discharge information, and the decrease in readmission rate. These patient experiences and outcomes were conceptualized as being sensitive to change resulting from the BPHWC efforts to promote the culturally competent care, continuity and transition of care, and patient education."

While these findings are positive, Optimal Solutions noted key limitations to consider while reviewing the findings.

> "The change from pre-program period to the years when the BPHWC was implemented is small in magnitude, about 1 percent change. However, given the large number of patients discharged each year by the nine hospitals (over 170,000, according to the CMS data), this small change could mean hundreds of patients with improved healthcare experiences. However, the results should be interpreted with caution due to the small scope of the program that limited inferences that could be drawn from the results regarding the program effect in promoting these outcomes. Furthermore, the use of the HCAHPS data precluded the identification of patients that were engaged by the BPHWC program. Although it's likely that some of the BPHWC patients were sampled for the HCAHPS data collection, without identifying these patients, attributing the changes over time to the BPHWC program might be problematic. Nevertheless, the trends in improvements of patients' healthcare experiences among BPHWC hospitals in reference to the comparison group of hospitals suggested the value of the DID approach and the importance in continuing to track these outcomes over time as the BPHWC program expands and matures."

Enrollment, Hiring, and Retention Practices

Optimal Solutions also reviewed the hospital enrollment, hiring, and retention practices for disadvantaged individuals and within the communities targeted by the Baltimore Collaborative (ZIP codes with high Area Deprivation Indexes (ADIs)). The overall PWSDA program hospital employment retention rate, 80.1 percent, was comparable to the retention rate for all hospital hires, 83.1 percent. However, these individual hospital retention rates varied widely across the program. Due to data limitations and variation in the number of workers employed by hospital, Optimal Solutions recommended interpreting individual hospital rates with caution.

Optimal Solutions also examined the enrollment, hiring, and retention of disadvantaged populations within the program.

> "The primary target workforce populations that were recruited, trained, and hired by the program included: 1) unemployed/underemployed, 2) with little or no work history, 3) with no more than a high school diploma or General Educational Development (GED) equivalent, 4) with a criminal record, and 5) those in long-term recovery from substance use disorders and/or mental health issues. Based on available data in the BACH database, disadvantaged individuals were identified as those belonging to at least one of the disadvantaged groups, including unemployed before the program, high school education or less, with a criminal record, or with a history of substance abuse. The results suggested that the program enrolled and graduated an increased proportion of disadvantaged individuals (52.6 percent and 92.5 percent, respectively); however, disadvantaged individuals were less likely to be employed (79.8 percent), especially by the nine hospitals (77.1 percent)... Nevertheless, the nine hospitals were able to retain a comparable proportion of disadvantaged individuals (76.4 percent)."

These numbers also varied widely by individual hospitals. However, Optimal Solution cited differences in data availability and some discrepancies between BACH and hospital data. Optimal Solutions recommended interpreting the results with these limitations in mind.

Attrition Costs

Optimal Solutions reviewed budget reports from FY 2016 – FY 2019 to examine staff training and onboarding costs lost to due staff attrition. Staff attrition resulted in a total loss of $1,134,933, of which $167,587 was in training costs and $967,346 in onboarding costs. Losses due to attrition varied by hospital and can be attributed to differences in numbers of employee trained and hired.

Program Expenditures

Between FY2017-2021 YTD (December 2020), total program spending by participating hospitals amounted to $19.2 million. HSCRC staff conducted audits of hospital spending against program budgets to validate submissions. Annual expenditures are listed below.

Table 3. Baltimore Collaborative Expenditures, FY 2017 - FY 2021 (Dec 2020)

Fiscal Year	Expenditures
FY 2017	$746,789
FY 2018	$4,148,834
FY 2019	$5,333,875
FY 2020	$5,835,160
FY 2021 YTD (Dec 2020)	$3,137,374

Impact of COVID-19

In the first half of FY2021 (July – December 2020), hospitals continued to hire PWSDA employees, although technical training was halted. PWSDA employees demonstrated a willingness to be redeployed in response to the need for more administrative support. New assignments of PWSDA employees roles included: (1) leading support groups through telephone/Zoom, (2) linking clients to food supports and transportation services, (3) home drop-offs of laptops, food, personal items, (4) preparation of COVID-related kits for distribution across communities, and (5) community education. As mentioned earlier in the report, BACH coordinated job placement as contact tracers and other employment sites for those who completed Essential Skills training. During this period, 21 of the 34 new graduates were employed and salaried by the Baltimore City Health Department positions and other employers, a 62 percent employment rate.

Conclusion

Since 2016, the PWSDA Program has provided a substantial investment in workforce training and employment to promote both hiring in disadvantaged areas and the use of CHWs and PRSs in the healthcare delivery system. Additionally, the emphasis of this program on hiring CHWs and PRSs has also aligned with other State efforts to support these new healthcare roles and professions. The Maryland Department of Health (MDH) recently developed a CHW certification program. Additionally, the Behavioral Health Administration (BHA) has provided grant support to fund PRSs in hospitals and other settings. Over the coming years, growing a culturally-competent workforce will be crucial to transforming the healthcare delivery system and achieving the goals of the TCOC Model. The PWSDA Program and work of the Baltimore Collaborative have provided a strong infrastructure towards these transformation activities and the State should consider a variety of activities to further align efforts and support this changing workforce.

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Appendix 1: Population Health Workforce Support for Disadvantaged Areas Program Performance Dashboard (FY 2016 – FY 2020)

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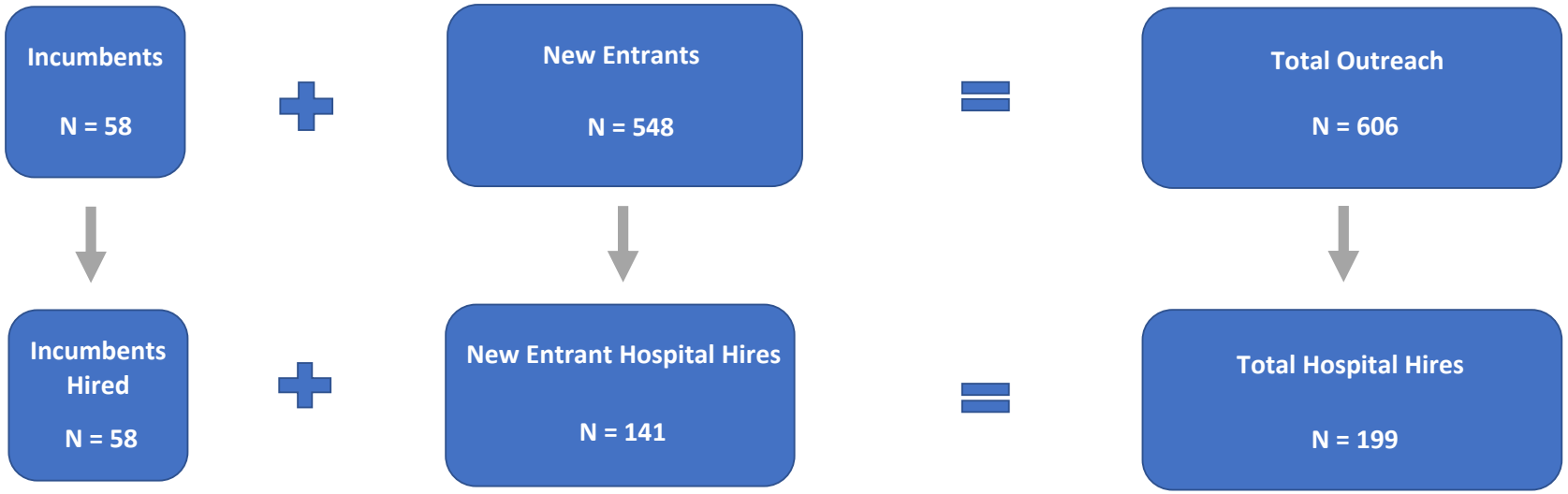
Population Health Workforce Support for Disadvantaged Areas Program

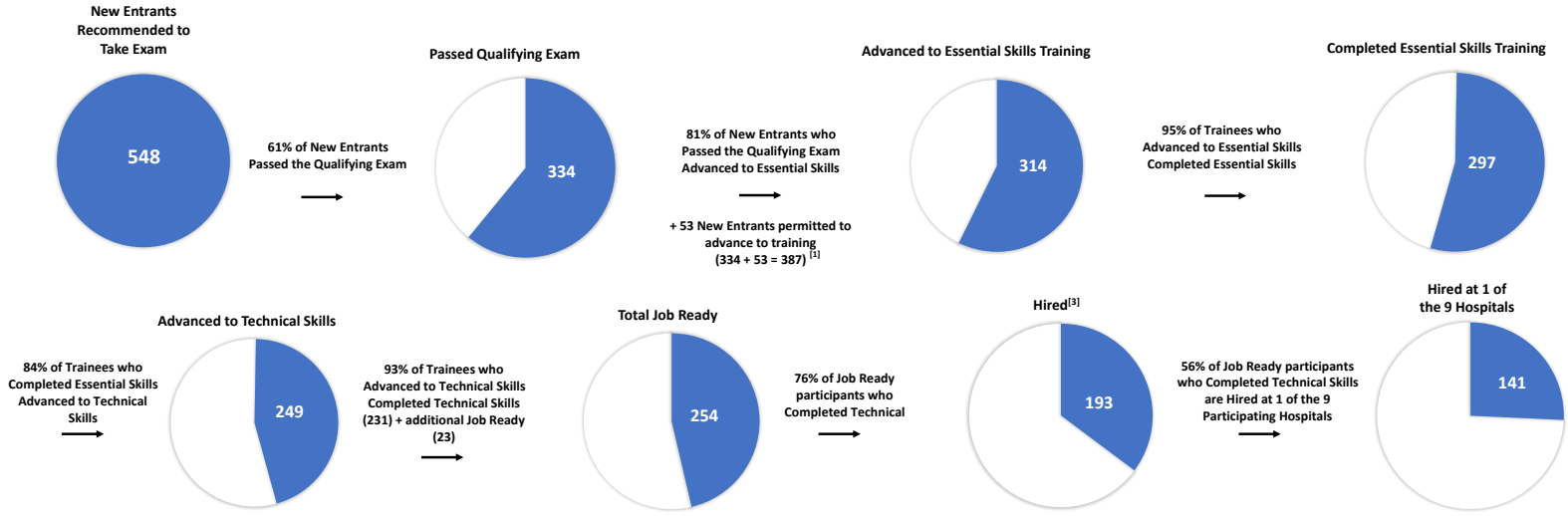
Performance Dashboard – FY 2016 – FY 2020

Program Outreach and Hospital Hires: Incumbents & New Entrants
FY 2016 - FY 2020



Program Outreach and Hospital Hires by Fiscal Year						
	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	Total
Incumbents	0	7	23	15	13	58
New Entrants	4	187	192	95	70	548
Total Outreach	4	194	215	110	83	606
Incumbents Hired at 1 of the 9 Hospitals	0	7	23	15	13	58
New Entrants Hired at 1 of the 9 Hospitals	0	49	51	29	12	141
Total Hospital Hires	0	56	74	44	25	199

Outcomes Review: Outreach to Employment
New Entrants Only
FY 2016 - FY 2020



Outcomes: New Entrants						
	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	**Total**
New Entrants Recommended to Take Exam	4	187	192	95	70	548
Passed Qualifying Exam	4	121	124	51	34	334
Qualifying Exam Waived[1]	0	11	8	17	17	53
Total Eligible for Essential Skills	4	132	132	68	51	387
Advanced to Essential Skills	4	103	107	55	45	314
Completed Essential Skills	4	100	100	52	41	297
Advanced to Technical Skills	4	93	92	46	14	249
Completed Technical Skills	**2**	**81**	**90**	**44**	**14**	**231**
Total Job Ready[2]	**2**	**87**	**95**	**47**	**23**	**254**
Total Hired	**0**	**62**	**72**	**39**	**20**	**193**
Hired at 1 of the 9 Hospitals	**0**	**49**	**51**	**29**	**12**	**141**
Total % Hired	**0%**	**71%**	**76%**	**83%**	**87%**	**76%**
Total % Hired at 1 of the 9 Hospitals	**0%**	**56%**	**54%**	**62%**	**52%**	**56%**

76% of Job Ready participants are Hired
56% of Job Ready participants are Hired at 1 of the 9 Hospitals

Outcomes: Incumbents						
	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	**Total**
Incumbents	0	7	23	15	13	58
Incumbents Hired at 1 of the 9 Hospitals	**0**	**7**	**23**	**15**	**13**	**58**

Total Hired at 1 of the 9 Hospitals	**0**	**56**	**74**	**44**	**25**	**199**

Notes:
[1] There are 53 participants who had their qualifying exam waived. An exam is considered to be waived if the participant failed the qualifying exam or has no record of taking the qualifying exam, but advanced to training program.
[2] Job Ready includes participants that did not complete technical skills, but were eligible for employment. There were 23 participants that did not complete technical skills, but were hired.
[3] The % Hired is out of Job Ready participants (N = 254).
[4] Total Hospital Hires (199) represents unduplicated employed participants. The total hospital hires on page 4 represents number of positions. Some participants have worked at more than 1 hospital. Hence, they would have 2 positions.

Hospital PWSDA Employees
Service Settings
CHWs & PRSs
FY 2016 - FY 2020

Service Setting	CHWs	PRSs	CNAs
Emergency Dept	20	34	0
Outpatient Clinics	45	6	0
Inpatient Units	33	11	0
Home Care	0	0	27
Transitional Care	20	0	0
Community Health Programs	6	2	0
Total	**125**	**53**	**27**

Note: There is one CHW that does not have a service setting listed.

Hospital PWSDA Employees
Number of Unduplicated Patients Served by CHWs/PRSs
Snapshot: FY 2019 FTEs and Patients

Note: Patients served outside the hospital are not counted in this table. Hence, the whole population of unduplicated patients is not captured here.

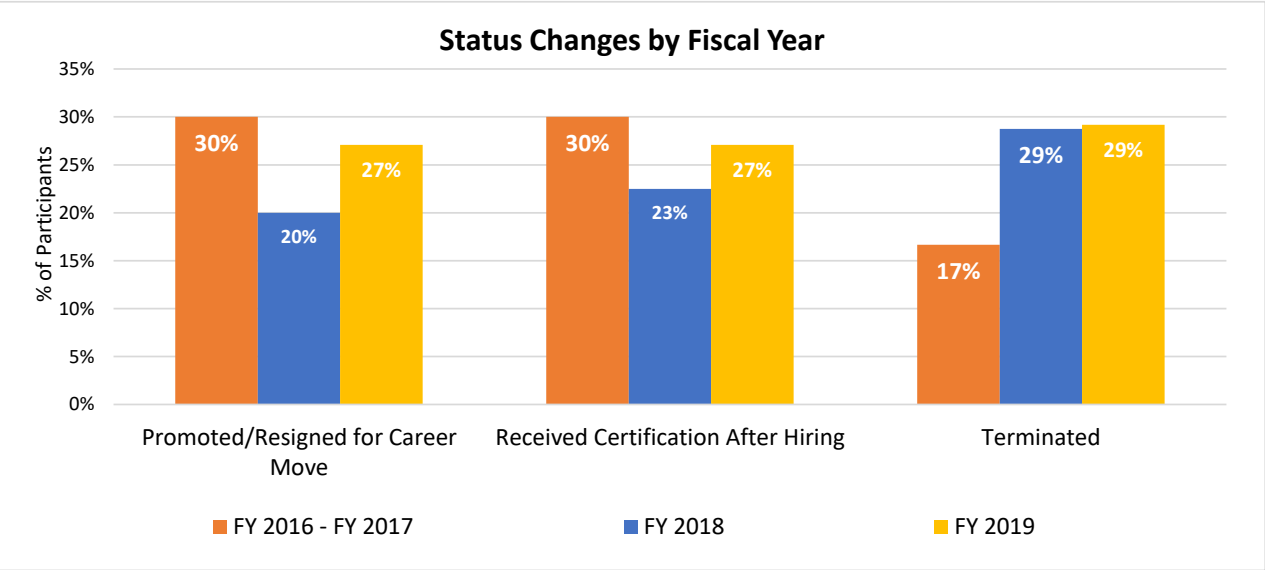
Hospital	CHWs	PRSs	FY 2019 Unduplicated Patients Served
Johns Hopkins Hospital	24	6	8,525
Johns Hopkins Bayview	12	4	3,426
MedStar Franklin Square*	6*	0*	228*
MedStar Union Memorial	8	2	2,039
MedStar Good Samaritan	7	4	1,259
MedStar Harbor Hospital	6	3	561
University of Maryland – Midtown Campus*	13*	0*	4,218*
University of Maryland Medical Center	8	4	6,348
LBH Sinai Hospital	8	0	1,867
Total	**92**	**23**	**28,471**

*Data available only for CHWs, figures do not include PRS volume.

Terminations & Promotions

New Entrants & Incumbents

The promotion rate declined and the termination rate increased from FY 2016 to FY 2019.



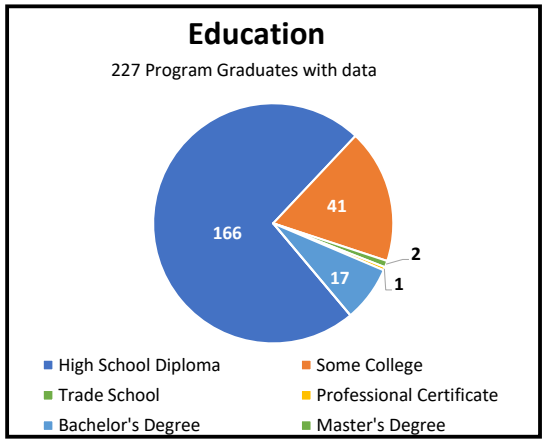
Status Changes by Fiscal Year[1]				
	FY 2016 - 2017	**FY 2018**	**FY 2019**	**Total**
Hospital Hires	**30**	**80**	**48**	**158**
Hires with Status Change	**23**	**57**	**40**	**120**
Promoted/Resigned for Career Move	9	16	13	38
% Promoted/Resigned for Career Move	**30%**	**20%**	**27%**	**24%**
Received Certification After Hiring	9	18	13	40
% Received Certification After Hiring	**30%**	**23%**	**27%**	**25%**
Terminated	5	23	14	42
% Terminated	**17%**	**29%**	**29%**	**27%**

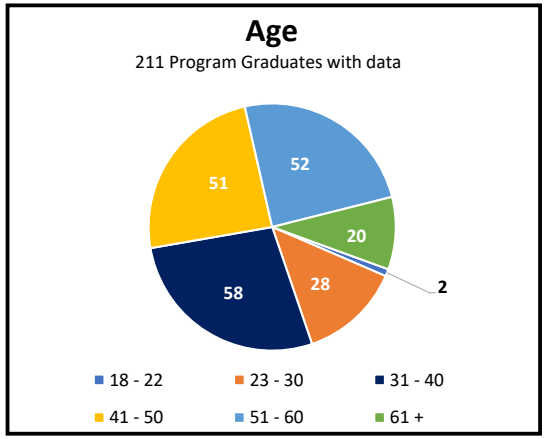
Note:
[1] Fiscal year is based on date hired at 1 of the 9 hospitals.

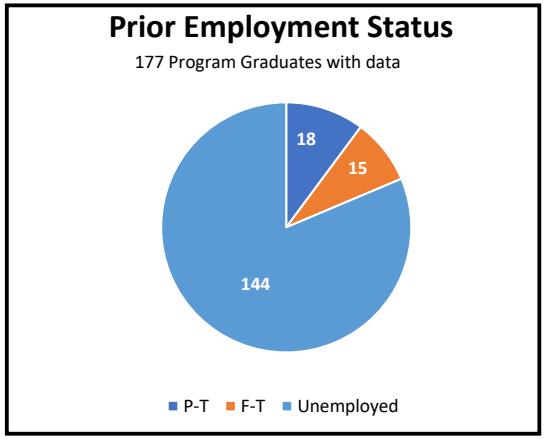
Profiles of Program Graduates

FY 2016 - FY 2020

New Entrants & Incumbents (N = 234)







Key Indicators	Reported Yes
Criminal Record	33
Substance Abuse	32
Single Parent	14
Transitional Housing	15

← *67% were employed after training*

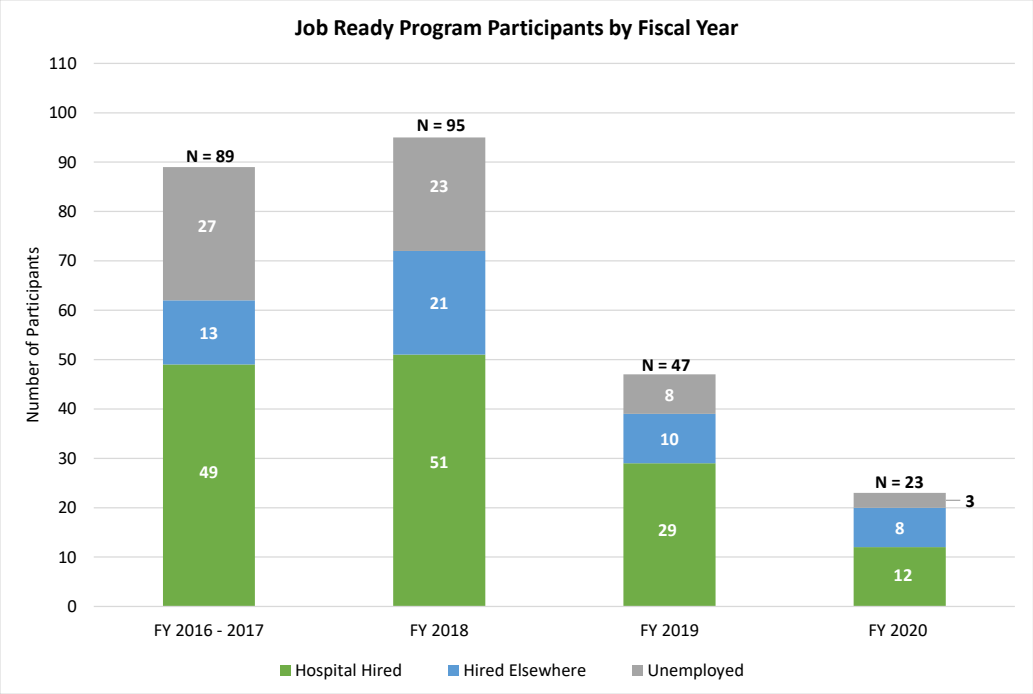
[1] Program Graduates = Program participants that completed technical skills training. N = 234 (231 New Entrants + 3 Incumbents)
[2] Transitional housing is defined as any setting that is not rented or owned.

Program Participant Employment Outcomes
New Entrants Only

The total number of program participants & trainees declined from FY 2016 - FY 2019.

The overall employment rate has increased slightly. Total percentage of job ready who are hired = 76%.

The percentage of job ready who are hired by 1 of the 9 hospitals = 56%.

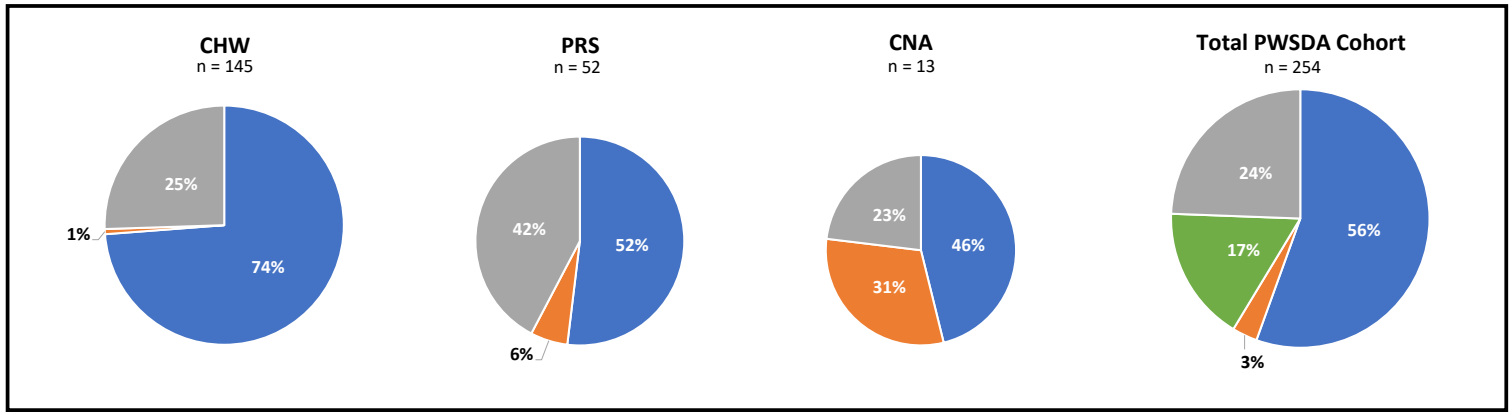


	FY 2016 - 2017	FY 2018	FY 2019	FY 2020	Total (N)
Job Ready	89	95	47	23	254
Hospital Hired	49	51	29	12	141
Hired Elsewhere	13	21	10	8	52
Unemployed	27	23	8	3	61
% Hospital Hired	**55%**	**54%**	**62%**	**52%**	**56%**
% Hired Elsewhere	**15%**	**22%**	**21%**	**35%**	**20%**
% of Total Hired	**70%**	**76%**	**83%**	**87%**	**76%**

Employment Outcomes for Program Graduates
New Entrants Only

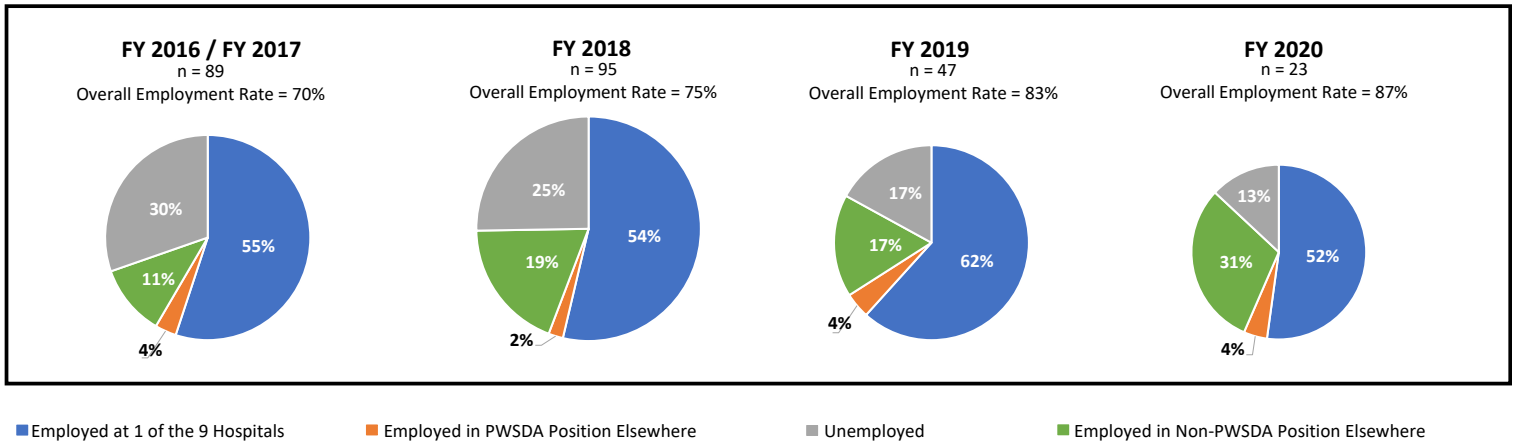
- The overall employment rate for program graduates is 76%.
- CHWs and CNAs/GNAs had the highest employment rates.
- Employment rates have increased across fiscal years.

% of Participants Hired by Professional Track
Employed at 1 of the 9 Hospitals or Elsewhere
FY 2016 - 2020



Note: There is 1 participant that is employed at 1 of the 9 Hospitals, but does not have a traditional role as a CHW, PRS, CNA/GNA.

% of Participants Hired by Fiscal Year
Employed at 1 of the 9 Hospitals or Elsewhere



Roles/Functions: Service Setting Assignments

- **Community health workers** are deployed broadly across settings; they are working in the ED, hospital outpatient clinics, inpatient units and home care setting
- **Peer support counselors** are largely based in the ED where the opportunity exists for testing, counseling and direction to treatment
- **CNAs** hired through this program all work in home care
- In FY 2020, hospitals reported assignments to the following service settings:

Service Settings Where CHWs and PRSs Work
FY 2016 – FY 2020

	# CHWs	# PRSs
Emergency Dept	20	34
Outpatient Clinics	45	6
Inpatient Units	33	11
Transitional Care	20	0
Community Health Programs	6	2
Total	**125**	**53**

Note: There is one CHW that does not have a service setting listed.

Measurable Impact: Number of Patients Served in the Hospital

- One measure of impact on patient care is the number of patients served, often referred to as the number of patients "touched." Hospitals were asked to document the number of unduplicated patients served in each setting. Figures from 7 selected hospitals are presented below.
- Worth noting is the sheer number of patients impacted: The 9 hospitals documented more than 28,000 individual hospital patients served by CHWs and PRSs.
  - Important to note: Not included here are the substantial number of patients served through community-based testing and counseling programs, as well as community-based health programs.

Number of Unduplicated Hospital Patients Served by CHWs/PRSs: Hospital-Based, only FY 2019 FTEs and Patients

Hospital	# CHW / PRS Reported Data Hospital-Based only	# Unduplicated Patients Served
Johns Hopkins Hospital	30	8,525
Johns Hopkins Bayview	16	3,426
MedStar Franklin Square*	6*	228*
MedStar Union Memorial	10	2,039
MedStar Good Samaritan	11	1,259
MedStar Harbor Hospital	9	561
Univ of MD Medical Center	12	6,348
Univ of MD Midtown*	13*	4,218*
LBH Sinai Hospital	8	1,867
Total, 9 Hospitals	**115**	**28,471 patients**

*Data available only for CHWs; figures do not include PRS volume

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Maryland Model

Tools to Strengthen the Model

July 14, 2021

Vision of HSCRC and Healthcare Reform In Maryland

- As a leader in health care reform in Maryland, HSCRC seeks to improve health and quality of life for Marylanders through the development of innovative care delivery models, care transformation and sustainable spending.
  - The HSCRC, in collaboration with CMS, will establish the State's TCOC demonstration project as a permanent, sustainable, and stable Model. We will accomplish this vision by using the flexibility of population-based budgets to engage hospitals, payers, statewide partners, practitioners, businesses, and consumers to be proactive in payment and delivery reform and addressing underlying health and social needs. Maryland will be the first state in the nation to drive cost containment across all payers, cap Medicare costs, and drive improvements to quality and cost through the broad-based use of population-based budgets.
- This vision statement should be used to:
  - Guide our work in the future
  - Focus our efforts on work that will produce results that support vision
  - Hold us accountable to identified goals
- Key element of vision is permanency of the Maryland Model
- Vision should also support and strengthen the Model, on an all-payer basis for all Marylanders

TCOC Model State Agreement

- The Maryland Total Cost of Care Model State Agreement indicates:
  - "Under this Model, CMS and the State will test whether statewide healthcare delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care."
- Performance Periods – The agreement includes 8 performance periods
  - Model Year 1 - 2019
  - Model Year 2 – 2020
  - **Model Year 3 – 2021 – First Evaluation is published and CMS will decide on measures for the Evaluation**
  - Model Year 4 – 2022 - State submits proposal for Compounded Savings Target
  - **Model Year 5 – 2023 – CMS will clear the Compounded Savings Target & Second Evaluation is published**
  - **Model Year 6 – 2024 – CMS will decide whether to expand the Model**
  - Model Year 7 - 2025
  - Model Year 8 - 2026
- Transition Period – The agreement includes a 2-year transition period
  - Model Year 9 – 2027
  - Model Year 10 – 2028

Mathematica Evaluation Highlights

- TCOC Model Evaluation performed by Mathematica uses data from 2019 and 2020 to assess 3 key pathways to reduced costs, improved quality, and transformed care:
  1. The Hospital and Care Partner pathway
  2. The Primary Care and Care Transformation Organization pathway
  3. The State Accountability pathway
- Findings and Opportunities for Improvement
  - Total Medicare spending was higher in Maryland than other states, driven largely by higher hospital spend; Maryland needs to continue to drive down Medicare total cost of care
  - Hospital global budgets are the strongest financial incentive in the Model and provide financial stability
  - Opportunities exist to expand reach of care partners and care transformation initiatives; Maryland can demonstrate broad spectrum of innovation across the State
  - Engage with State partners and providers to address health disparities and population health

Tools to Strengthen the Model

- Promoting Care Transformation Activities
- Improving Health Equity and Population Health
- Advancing Quality Programs
- Identifying Population Health Investments
- Addressing Capacity and Efficiency
- Evaluating Out-Year Savings and Medicare financial tests

Promoting Care Transformation Activities

The Episode Quality Improvement Program – EQIP

- The HSCRC plans to start a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance	Upside-only risk with dissavings accountability	Alignment with CareFirst's episode payment program	AAPM/value-based payment participation opportunities for MD physicians

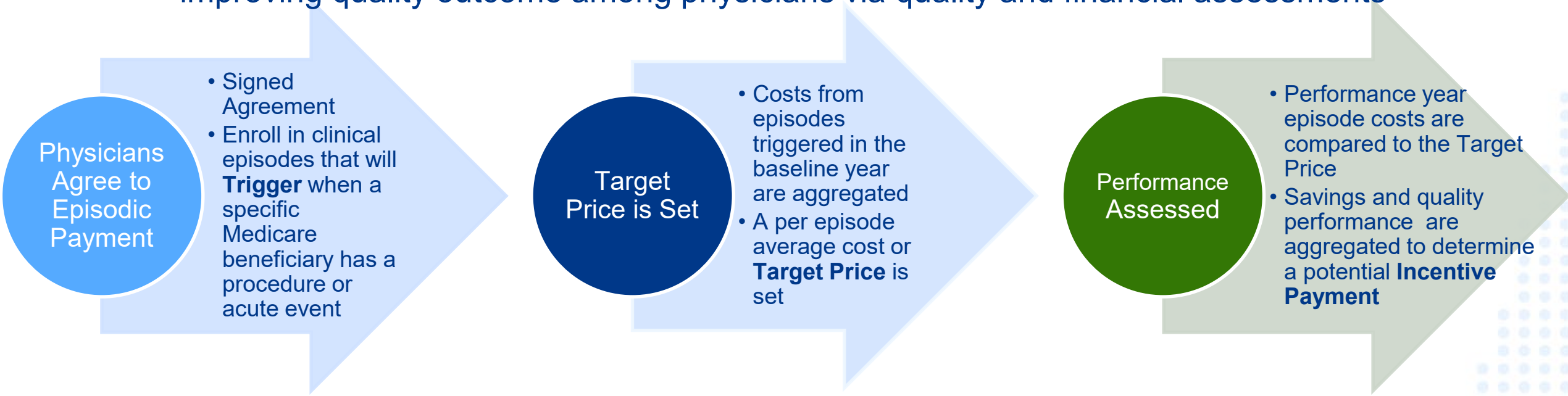
- EQIP will utilize the Prometheus Episode Grouper's relevant cost approach
- The first performance year will include episodes in the following specialty areas:
  - Gastroenterology and General Surgery
  - Orthopedics and Neurosurgery
  - Cardiology

EQIP ENROLLMENT IS NOW OPEN FOR CY2022 PARTICIPATION

Interested participants should reach out to eqip@crisphealth.org to set up access to CRISP's EQIP Entity Portal (EEP)

Physician-Focused Episodic Value-Based Payment

- Bundled-payment programs, in-particular, are effective at controlling episodic care and improving quality outcome among physicians via quality and financial assessments



- Analyses of CMS bundled-payment programs have shown 4-6 percent reductions in gross Medicare spending

Source: https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf

The University of Maryland Medical Center has Partnered with the HSCRC to Administer EQIP

- The State has partnered with UMMC to enable EQIP as an Advanced Alternative Payment Model with CMS
- Any qualifying physician in Maryland will be allowed to participate in EQIP, regardless of previous contracting, relationship and/or privileges at UMMC
- UMMC's main roles will be:
  1. Signing an individual Care Partner Arrangement with each participating physician, and,
  2. Printing checks for earned Incentive Payments.
- The HSCRC and CRISP will facilitate interactions between UMMC and Care Partners/EQIP Entities
  - Policy decisions and operations support will remain transparent and set at the State level
  - Any changes to the policy will be made at the CRP Committee and EQIP stakeholder level

EQIP Timeline

July 9th, 2021	• EEP opened for enrollment • Technical Policy and Portal User Guides available • Baseline Episode experience available in EEP
Sept. 1st, 2021	• Deadline to submit National Provider Identification (NPI) and other enrollment initiation information into EEP • Providers submitted to CMS for vetting
Dec. 1, 2021	• Care Partner Arrangements and Payment Operations Finalized • CMS Vetting Status Available, Enrollment Finalized
Jan. 1, 2022 **PY1 Start**	• Care Partner participation opportunity will be annual • Preliminary Target Prices available in EEP
Mar. 1, 2022	• Performance analytics available, updated
July 1, 2022	• PY2 (2023) Enrollment Opens
July 1, 2023	• Incentive Payments distributed

The Benefits of EQIP

- Value-based payment opportunity tailored to Maryland physicians
- No downside risk collection
- System alignment, regardless of care setting
- Alignment option with CareFirst's Episodes of Care Program
- Episodes tailored to provider practice patterns and scope of impact
- Opportunity to improve patient outcomes and contribute to health system improvement

Please reach out if you would like to schedule a meeting about EQIP with your organization or connect with the EQIP stakeholder group.

Enrollment Inquiries:
EQIP@crisphealth.org

Website:
https://hscrc.maryland.gov/Pages/Episode-Quality-Improvement-Program.aspx

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Appendix: Optional Episodes for PY1 Participation

Cardiology	Gastroenterology and General Surgery	Orthopedics and Neurosurgery
Pacemaker / Defibrillator – Procedure, 30	Colonoscopy – Procedure, 14	Hip Replacement & Hip Revision – Procedure, 90
Acute Myocardial Infarction – Acute, 30	Colorectal Resection – Procedure, 90	Hip/Pelvic Fracture – Acute, 30
CABG &/or Valve Procedures – Procedure, 90	Gall Bladder Surgery – Procedure, 90	Knee Arthroscopy – Procedure, 90
Coronary Angioplasty – Procedure, 90	Upper GI Endoscopy – Procedure, 14	Knee Replacement & Knee Revision – Procedure, 90
		Lumbar Laminectomy – Procedure, 90
		Lumbar Spine Fusion – Procedure, 180
		Shoulder Replacement – Procedure, 90

Care Transformation Initiatives (CTIs)

Purpose: Hospitals are engaged in a number of efforts to reduce avoidable utilization and reduce costs. CMMI has emphasized the importance of quantifying the impact of specific Care Transformation under the TCOC Model. The State committed to include at least 12.5% of Medicare payments under a CTI in 2021.

What are CTIs?: Any initiative undertaken by a hospital, group of hospitals, or collaborative partnering with a hospital to reduce the total cost of care (TCOC) of a defined population

CTI Thematic Areas: The Care Transformation Steering Committee has approved CTIs that focus on Care Transitions, Palliative Care, Primary Care, Community-Based Care, and Emergency Care Models

The CTI Program went live on July 1, 2021. Initial participation is as follows:

- There are 59 Care Transitions initiatives.
- There are 6 Palliative Care initiatives.
- There are 22 Primary Care initiatives.
- There are 11 Community Based initiatives.
- There are 13 Emergency Care initiatives.

Improving Health Equity and Population Health

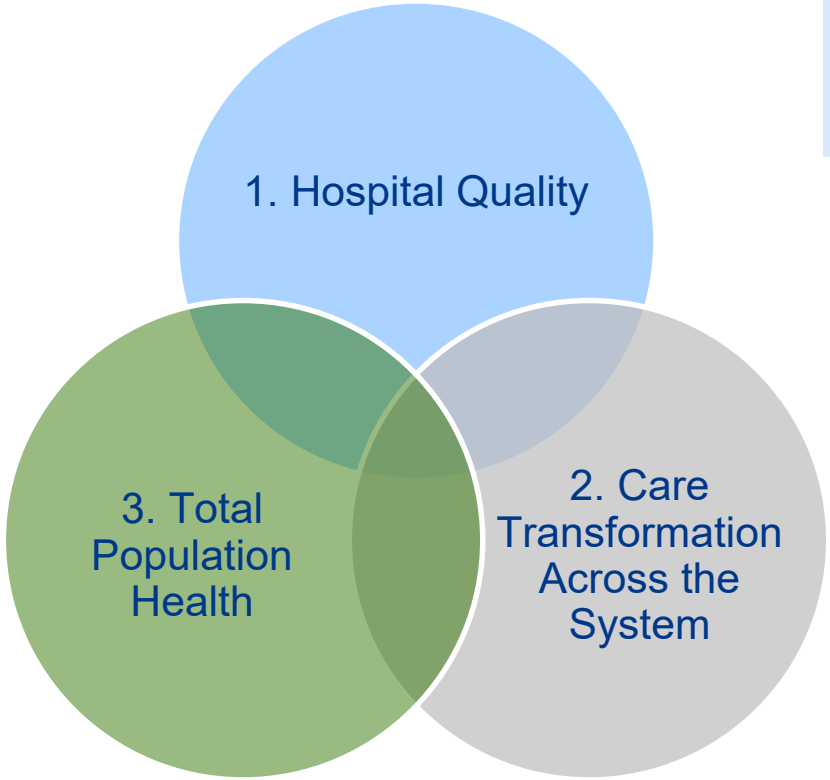
HSCRC Health Equity Initiatives

The HSCRC is working to establish policies, collect data, train staff, and collaborate with other State agencies to ensure Maryland eliminates longstanding health disparities and achieves a more equitable healthcare system.

- Statewide Integrated Health Improvement Strategy
- Hospital All-Payer Model and Quality
- Special Funding Programs
- Data and Hospital Reporting
- State Agency Collaboration
- Internal Diversity & Inclusion Task Force

SIHIS Goals Target Disparities

“Goals, measures, and targets should capture statewide improvements, including improved health equity”



Hospital Quality

- Reduce avoidable admissions
- Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation Goals

- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- Improve care coordination for patients with chronic conditions

Total Population Health Goals

- Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
- Priority Area 2 (Opioids): Improve overdose mortality
- Priority Area 3 (Maternal and Child Health):
  - Reduce severe maternal morbidity rate
  - Decrease asthma-related emergency department visit rates for ages 2-17

*Value-based models including the Care Redesign Program, Care Transformation Initiatives, and qualifying successor models.

Hospital All-Payer Model and Quality

Uncompensated Care Policy (UCC)

- The burden of uncompensated care is shared equitably by all payers and all hospitals regardless of payer mix, therefore providing more stability to hospitals especially those in low-income areas

Readmissions Disparities Program

- Commission approved the addition of a disparities component to the Readmission Reduction Incentive Program (RRIP) in March 2020
- The program incentivizes hospital improvement over time in readmission disparities
- Hospitals qualify for rewards by reducing readmissions for the patients with higher "Patient Adversity Score" relative to the rest of its population
- Maryland is the first state in the country to provide hospitals with financial incentives to reduce socioeconomic disparities in quality of care
- Currently evaluating pilot results and possible application of this methodology to other quality outcomes

Special Program Funding

- The Commission provides additional financing to hospitals through the all-payer rate setting system to support community needs, statewide priorities, and infrastructure development.

Regional Partnership Catalyst Program

Supports hospital-led community partnerships that address statewide population health goals

Population Health Workforce Support for Disadvantaged Areas (PWSDA) Program

Funds hospital investment in community-based jobs that help advance patient health

COVID-19 Community Vaccination Funding Program

Supports community-based vaccine dissemination strategies in underserved, vulnerable, and/or hard-to-reach areas.

Data & Hospital Reporting

- HSCRC **collects and audits data** from hospitals, producing one of the **most robust hospital data sources in the country** in terms of both scope and accuracy.

Case-mix Data: Race, Ethnicity and Language ("REaL")

HSCRC and MHA have analyzed hospital discharge data to understand the quality of the race data and feel confident that the race data is accurate enough to report publicly for the purpose of improving statewide health disparities.

Race data have been incorporated into several public reporting dashboards such as:

- Hospital Readmission Reports
- COVID reporting
- Public Health Dashboard

Financial Assistance Reporting

HB 1420 (2020) requires HSCRC to submit an annual financial assistance report to the Finance and HGO Committees. The report will include:

- The total number of patients who received financial assistance by race or ethnicity, and gender.
- The total number of patients who were denied financial assistance by race or ethnicity, and gender.

Agency Collaboration

- MDH, Office of Minority Health & Health Disparities (OMHHD)
  - **COVID-19 Community Vaccination Program** - HSCRC collaborated with OMHHD on policy and funding to ensure inclusion of health equity and community perspectives.
  - **HB 309/SB 565 Public Health - Data - Race and Ethnicity Information -** This legislation requires (OMHHD) in coordination with the Maryland Health Care Commission (MHCC) to submit to the General Assembly a plan to improve the collection of health data that includes race and ethnicity information and regularly posting that data on OMHHD's website. HSCRC is providing input to on the programs that can be implemented to address the needs of vulnerable populations
- MDH, Behavioral Health Administration (BHA)
  - **"Inter-Agency Opioid Coordinating Council's Racial Disparities in Overdose Task Force"** - The purpose of the task force is to propose recommended solutions to eliminate racial disparities related to overdose fatalities. HSCRC is a member of the task force to provide input on how the Total Cost of Care Model, All-Payer Rate Setting, and other HSCRC-led initiatives can contribute to solutions.
- Maryland Commission on Health Equity
  - **SB 52/HB 78: Public Health – Maryland Commission on Health Equity (The Shirley Nathan–Pulliam Health Equity Act of 2021)** – This legislation requires the formation of the Maryland Commission on Health Equity, consisting of 26 members from Departments and agencies across the state, to determine ways for state and local government to work together collaboratively and implement policies and laws to reduce health disparities and increase health equity across the state. HSCRC will participate in an advisory committee that will provide input on issues related to the formation of the Commission and data collection, reporting, and evaluation

HSCRC Internal Diversity & Inclusion Task Force

- HSCRC staff have formed an internal staff-led Diversity and Inclusion Task Force (DITF)

Mission
• Foster a collaborative, engaged, diverse, and inclusive environment that supports interpersonal relationships, improves professional growth and development, and promotes equitable policy making to address healthcare disparities.
• Promote a culture of equality, inclusion, and diversity among staff, stakeholders and Commissioners.
• Develop equitable policies that enfranchise all HSCRC staff and ultimately improve the larger healthcare system for all Marylanders.

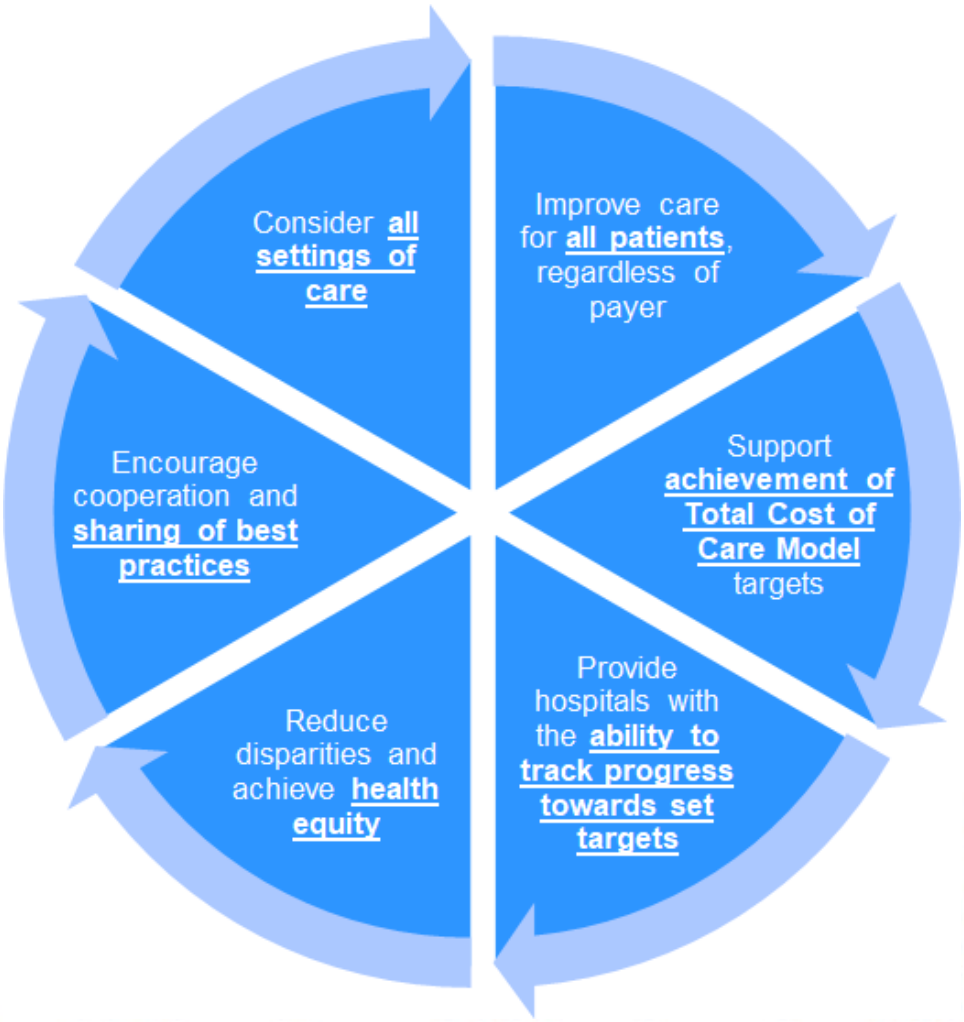
Goals
• Short term: Create and implement diversity and inclusion best practices.
• Long term: Increase the percentage of minorities in leadership roles.

DITF Activities Underway
• Promoting increased diversity through recruitment and hiring
• Facilitating staff conversations on healthcare inequality and structural racism to increase cultural competence and understanding
• Promoting inclusion of health disparities analysis in relevant HSCRC policies (e.g. quality policies)

Advancing Quality Programs

HSCRC Quality Program Guiding Principles

The overall mission of the HSCRC Quality Program is to create all-payer incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.



Quality and Population Health Strategic Plan

1. What is our guiding aspiration?

- To incent appropriate, equitable, high-quality care that maximizes the health of all Marylanders

2. Where should we work?

- Incentivize quality in hospitals' inpatient (i.e., address underperforming metrics) and outpatient departments (new) and eventually other care settings in which hospitals have accountability through partnerships (PRPA and/or expanded regulatory authority)
- Broaden quality to include access to and appropriate utilization of hospitals' services

3. How should we work?

- Focus on developing program policies and methods to create accountability that appropriately recognizes an entity's scope of responsibility
- Create capacity by outsourcing technical or technology-based activities

4. What capabilities must be in place?

- An understanding of hospitals' outpatient operations, data, and stakeholders that is as deep as the team's current understanding of inpatient operations, data, and stakeholders
- Develop clinical data capabilities (eCQM, EHR risk-adjustment)

5. What management systems do we need?

- Leaders explicitly support the team's aspirations and create capacity for expanded focus
- HSCRC teams collaborate from a stance of assertive inquiry, articulating their views and being open to alternatives that may be missing.

Advancing the Quality Programs to Support the TCOC Model

1. Expand scope of quality programs
   - Under the TCOC Model, care may move down the continuum where HSCRC has limited oversight of quality outcomes or incentives for quality improvement
   - Evolve quality programs, as pay-for-performance programs are presently **focused on IP quality**
     i. PAU expansion to avoidable **emergency department (ED) visits**
     ii. Outpatient complications for procedures like total hip/knee replacements
     iii. Measures of **access to care** (e.g. ED wait times)
     iv. Population Health performance/**SIHIS** alignment

1. Address underperforming quality metrics
   - QBR Redesign
     i. Patient experience (HCAHPS survey)
     ii. ED wait times
   - Health Disparities
     i. Currently monitoring within-hospital readmission disparities
     ii. Opportunity and intention to monitor and address other areas of health disparities

1. Advance quality measurement capabilities alongside field of quality measurement
   - Clinical/EHR data (eCQMs, hybrid risk-adjustment)
   - Patient-Reported Outcome Measures
   - OP Commercial and Medicaid quality measures and data

Identifying Population Health Investments

Update on Population Health Cost Reporting

- Historical HSCRC cost reporting has focused on traditional hospital services
- In FY20 an additional prototype report on population health health related activities was required from hospitals
  - Non-physician population health spending in regulated, unregulated and non-regulated settings (system)
  - Physician spending across the same entities, split between Hospital coverage, CHNA-driven, Primary Care and All Other
- Next steps:
  - Refine definition of population health
  - Modify to support revenue for reform
  - Consider how to view physician costs, as not all physician costs are population health focused

FY20 Statewide Spending
(June year end hospitals, all entities, net of related non-GBR revenue and including indirect loads)

Non-Physician: $200 M, ~1.5% of regulated revenue

All Physician: $900 M, ~6.5% of regulated revenue

Addressing Capacity and Efficiency

Addressing Capacity and Efficiency through HSCRC policies

- Reconstituting Hospital Capacity Footprint
  - Freestanding Medical Facility Conversions
  - Hospital Consolidations, especially in saturated markets
  - Capital Financing Methodology that accounts for excess capacity

- Development of Revenue for Reform
  - Revenue associated with growing excess capacity can/should be redeployed in community

Retained Revenue 'Problem'

Under the GBRs, hospitals have retained significant revenue as volume declines.

- This results in higher charges for consumers.
- **But also**, retained revenues are necessary to allow hospitals to invest in population health and other delivery system transformation.

The Integrated Efficiency Policy addresses excessively high costs/charges by withholding inflation from hospitals whose costs are excessive relative to their peers.

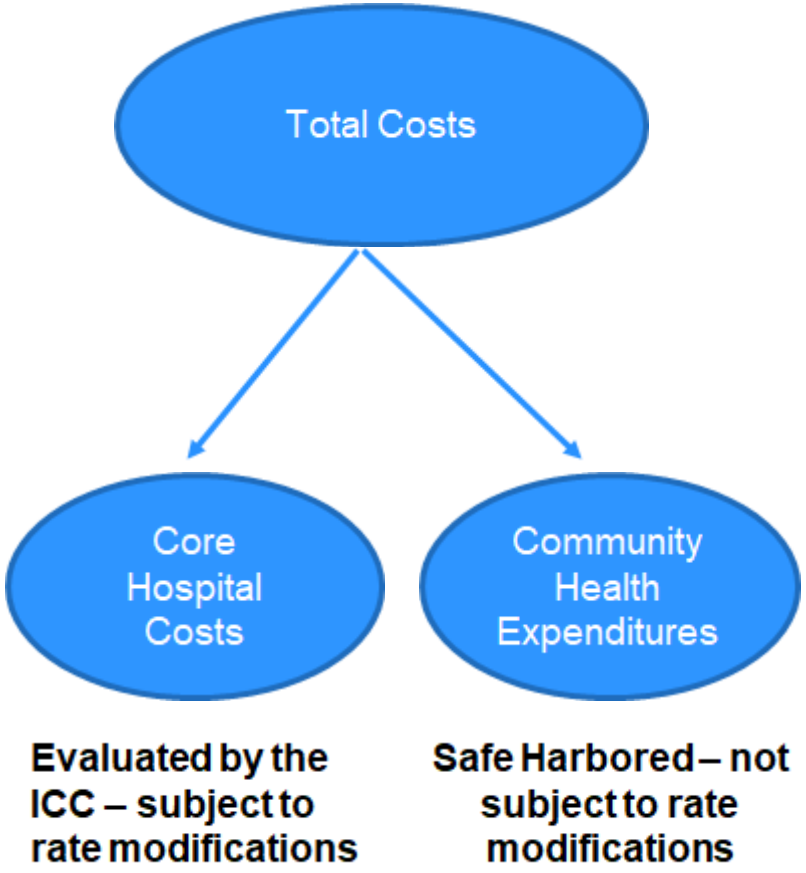
- But currently, only traditional hospital costs are included in the ICC.
- This potentially penalizes hospitals that have reinvested their retained revenues in population health management.

The Revenue for Reform policy is intended to safe harbor community health investments from the Integrated Efficiency Policy.

Objectives of the Revenue for Reform Policy

The Revenue for Reform policy will separate hospital expenditures into 'core hospital expenditures' and 'community health expenditures.'

- Core hospital expenditures will be subject to the ICC.
- Community health expenditures that meet various criteria will be safe harbored



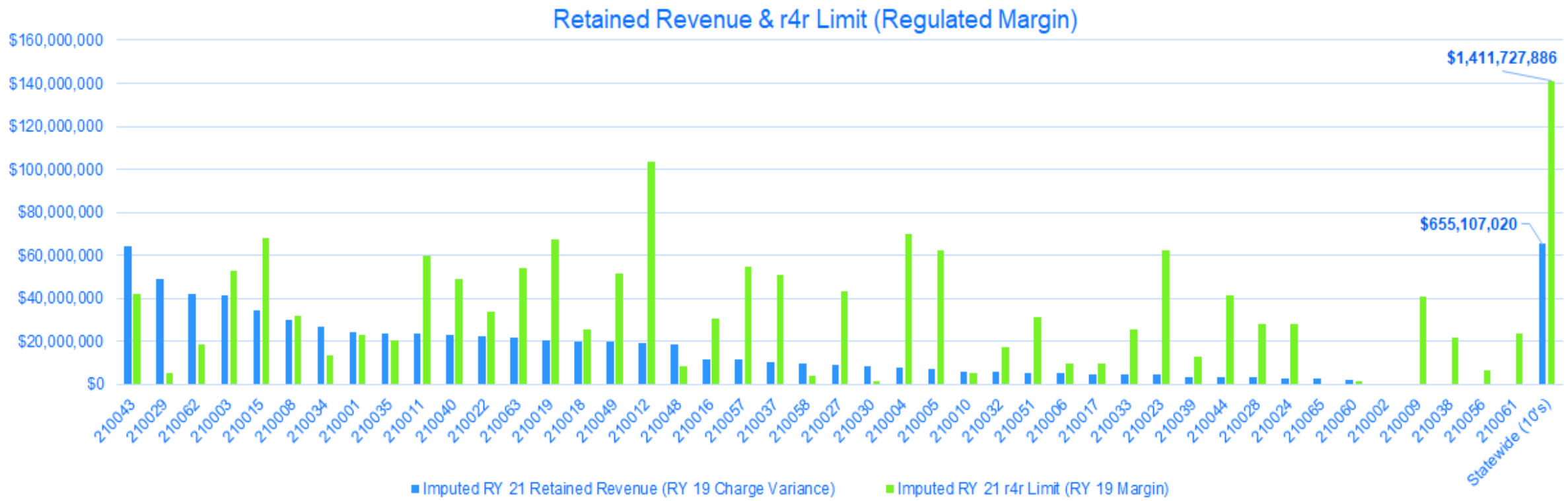
For this purpose, core hospital expenditures are costs incurred inside the hospital; and community health expenditures are spent outside the hospital

Proposed Eligibility Criteria for Inclusion in the Safe Harbor

The hospital must itemize their cost by intervention. Interventions may be included in the safe harbor if:

- Option 1: The intervention was in response to an unmet community health need as documented in the hospital's most recent Community Health Needs Assessment.
- Option 2: The intervention must be an evidence intervention identified by the CDC's Healthy People 2020 Project.
- Option 3: The intervention must support primary care, mental health, or dental providers in a medically underserved area.
- Option 4: The intervention must be for a defined population or community and have a measure to assess ROI (catch-all).

Retained Revenue & R4R Opportunity



- Method: multiply RY 19 charge variance by RY 21 permanent revenue to quantify retained revenue (negatives excluded); multiply RY 19 regulated margin to impute R4R limit (negatives excluded)
- If the opportunity for R4R was limited to retained revenue it would still be quite substantial ($655 million). To maximize the incentive, staff proposes extending the opportunity to regulated margin ($1.4 billion).
  - Staff contends that safe harbors beyond regulated margin would misappropriate revenue related to actual hospital costs

Evaluating Out-Year Savings Goals and Medicare Financial Tests

Annual Savings & Compounded Savings Targets

- The annual savings target for Maryland Medicare TCOC per Beneficiary is specified in the agreement through Model Year 5
- In Model Year 5, the State and CMS must agree to a methodology for calculating an annual savings target for the compounded growth in Maryland Medicare TCOC per Beneficiary
- The Compounded Savings Targets will be applied in Model Year 6 (2024) though Model Year 8 (2026)

Model Year	Annual Savings Target
Model Year 1 (2019)	$120 Million
Model Year 2 (2020)	$156 Million
Model Year 3 (2021)	$222 Million
Model Year 4 (2022)	$267 Million
Model Year 5 (2023)	$300 Million
Model Year 6 (2024)	Compounded Savings Target
Model Year 7 (2025)	Compounded Savings Target
Model Year 8 (2026)	Compounded Savings Target

Compounded Savings Targets

- The Compounded Savings Target must ensure that the growth rate in Maryland Medicare TCOC per Beneficiary does not exceed the growth rate in the National Medicare TCOC per Beneficiary over period of time agreed upon by CMS and the State

- By July 1 of each Model Year from Model Year 5 (2023) through Model Year 7 (2025), **CMS will calculate** the Compounded Savings Target for the following Model Year

- A contract amendment will be needed to memorialize the agreed upon Compounded Savings Target methodology and updated methodology for calculating the Annual Medicare Savings

Building the Compounded Savings Target

- HSCRC benchmarking to similar national regions was concluded in 2020 for use in various methodologies
  - Continuing to revise based on industry feedback
  - Update for more recent periods
  - Supported an ~$800 M Medicare gap between Maryland and the Nation after normalizing for risk, wealth etc.
- Working with industry to develop a model to support future targets
- CMS and CMS evaluation contractor will develop their own models

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, Annotated Code of Maryland

.03 Regular Rate Applications

A. (text unchanged)

(1)(text unchanged)

(2) The subject hospital has not obtained rates through the issuance of a Commission rate order within the previous [90] *365* days.

B. — C. (text unchanged)

Adam Kane, Chair

Health Services Cost Review Commission

HEALTH SERVICES COST REVIEW COMMISSION

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: July 14, 2021

RE: Hearing and Meeting Schedule

September 9, 2021 To be determined - GoTo Webinar
****Please note this meeting is on a THURSDAY****

October 13, 2021 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.