

Final Report of Health Services Cost Review Commission Regarding Population Health Work Force Support for Disadvantaged Areas

As Approved by the Commission on December 9, 2015

Introduction

At the Commission's September 9, 2015 public meeting, a panel of several hospital representatives and the Maryland Hospital Association proposed that the HSCRC provide up to \$40 million through hospital rates to establish about 1,000 entry level health care jobs in areas of extreme poverty and unemployment. At the November 18, 2015 public meeting, staff presented a preliminary report on the Health Job Opportunity Program Proposal ("Proposal"), and a number of public comments were received. Input was also received from the Payment Models Workgroup comments received highlight the need for a concerted effort by all participants who are serious about improving the unfavorable conditions that exist in economically deprived areas within Maryland.

At the December 9, 2015 public meeting, the Commission determined that the approach suggested by the Proposal was not within its framework. However, the Commission adopted an alternative approach building on the staff policy analysis and within the framework of the HSCRC that focuses on supporting the implementation of the All Payer Model.

This final report focuses on synthesizing input provided through the staff policy analysis for consideration by the Commission and the Commission's final determination in approving efforts that can support the important objectives of the initiative within the framework of the HSCRC.

Background

The Proposal came about as a result of the unrest in Baltimore City and the strong belief that employment is an important element needed to change the current situation. Hospitals are among the largest employers in Baltimore City as well as in other areas of the State that have pockets of extreme poverty and unemployment. The Proposal seeks to create community-based jobs that can contribute to improved community health as well as hospital jobs that create employment opportunities in economically challenged areas.

All parties have acknowledged the importance of jobs in reducing economic disparities. However, there are critical differences in thinking about how creating job opportunities should be addressed and who should provide the funding for job creation.

The Proposal submitted was very broad in nature, extending beyond the areas of focus and expertise of the Health Services Cost Review Commission. Additionally, as initially proposed, the jobs program would have Medicare, Medicaid, insurers, businesses, and patients represent the sole source of funding through hospital rate increases, with no funding identified from the considerable resources of hospitals or from their charitable community benefits funds. On December 1, 2015, letters from Ronald R. Peterson of Johns Hopkins Medicine and Robert A. Chrencik of the University of Maryland Medical System offered an alternative proposal that called for a 20% hospital match for any amount funded in rates. Public comments and letters received from a number of the parties who would constitute the primary funding sources indicate that they were not on board with the proposal before it was submitted to the HSCRC. Further work is required by the proposers to gain stakeholder agreement.

The Department of Mental Health and Hygiene and the Health Services Cost Review Commission have been implementing extensive changes in health care delivery and financing that focus on improving population health, especially in areas of the State with extreme poverty and unemployment. These efforts are expected to result in population health initiatives that increase the need for “community-based” employment by hospitals and other organizations.

Analysis

Summary of Input Received--

Payment Models Work Group

The Payment Models Workgroup held a meeting to discuss this and other topics on October 5, 2015. Program description materials and a series of questions were sent out in advance of the meeting and posted to the website. Comments were also accepted from other individuals attending the meeting.

The work group members and other commenters expressed their appreciation for the leadership in bringing forward this proposal. All parties acknowledged the importance of jobs in reducing disparities.

Following is a general summary of work group comments, as presented in the Executive Director’s report at the October 14, 2015 Commission meeting:

- Several commenters expressed the view that if the Commission were to take on a program of this nature, that it would be very important to define success. Success would

need to be framed not only in creating jobs, but also in the context of the New All Payer Model and Triple Aim of improving care, improving health, and lowering costs.

- A program that could not meet those requirements might be better implemented outside of the rate system.
- Proposers of the Program indicated that evaluative criteria should be developed and that if the Program was not meeting those criteria, that it should be discontinued.
- Because the jobs are entry level and for untrained workers, there was an indication that it might take some time to evaluate the impact on health and costs. Whether the jobs could be filled and the workers maintained could be determined much sooner.
- Several commenters felt that it would be important to focus on jobs outside of hospitals, such as Community Health Workers. The concern was expressed that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were referred to in the Proposal.
 - One of the Academic Medical Centers felt that its utilization would not decrease with potentially avoidable utilization, but would backfill as out of state volumes increased or other referrals could be served.
 - One commenter expressed concern about the need for training of Community Health Workers, making sure they were prepared to be in the community working with frail and severely ill patients. (Note that there was a work group that recently produced a set of recommendations regarding Community Health Workers.) More design and structure would need to be in place.
- Several commenters felt that infrastructure adjustments already provided to hospitals, or the additional amount that is slated for award in January 2016, were already focused on similar activities and that this effort would be duplicative.
 - Proposers expressed that the infrastructure funds were already committed in their budgets for other purposes, and that a new source of funding is needed for rapid deployment of additional jobs.
 - Commenters indicated that a Return on Investment should be expected, similar to the recent infrastructure increases approved by the Commission.
- It was also suggested that other funding sources be considered for Program implementation.
 - The proposers indicated that this might slow the process down, or detract from the level of possible implementation and impact.
- Several commenters indicated that if the Proposal were to move forward, much more detailed design work needs to take place.

- One suggestion was to ask the hospitals to organize an effort with other stakeholders and experts to further develop potential design criteria.
- Another commenter indicated that the Commission staff might take this on and organize a work group to develop the program.
- One commenter expressed concerns about accountability to payers, including the need for a return on investment.

Letters and Public Comment

There were a number of letters of support received. Those include letters from public officials and other interested parties. These letters outline the need for jobs and support for the Proposal.

Letters were also received from DHMH-Medicaid, CareFirst, 1199 SEIU United Healthcare Workers East, Baltimoreans United in Leadership Development (BUILD), The League of Life and Health Insurers of Maryland, Maryland Hospital Association, and Mercy Hospital.

While appreciating the effort to identify potential ways to address the daunting issue of poverty and unemployment in Baltimore and other areas of the State, especially as it relates to disadvantaged youth, letters from DHMH-Medicaid, CareFirst, and the League of Life and Health Insurers of Maryland expressed disagreement about the specifics of the Proposal. There are concerns regarding the source of funding, the lack of funding from hospitals or sources other than purchasers, businesses, and patients, and the overlap with funding already provided for hospital operations and infrastructure through existing rates or through the upcoming competitive transformation implementation grants. There is also the concern that using the rate setting authority of HSCRC to cover the costs of an employment program goes beyond the purpose of the rate setting system. Each of these parties made public comments for Commission consideration at the November 18, 2015 meeting.

1199 SEIU provided both a comment letter and public comments at the November Commission meeting. SEIU expressed concerns that the systematic poverty which hospitals seek to address through the jobs proposal will not be solved by merely creating new jobs. Jobs should also provide a meaningful pathway for workers to the middle class. SEIU also notes that while hospitals have long been Baltimore City's largest employers, they are not traditionally viewed as experts in workforce development for the people targeted by the Proposal. If the HSCRC were to move forward with a job program proposal, SEIU recommended increased transparency along with collection of extensive information about the program participants, credentials of individuals entering the program, retention details, etc. Should the HSCRC determine that further review or proposal development is needed, SEIU offered to be a resource to the process.

Mercy Hospital submitted a letter in support of the Proposal and in opposition to using funds earmarked for transformation for this purpose.

Maryland Hospital Association (MHA) submitted a letter after the November Commission meeting. The letter supports Option 3 outlined in the Staff's preliminary report, which focused on the need to continue to further evaluate and develop the proposal. MHA indicated that it supported this option but without the dollar limit the staff had indicated for the option, which was \$5 million. Option 3 provided for the following: "Defer funding and have Proposers continue to develop Program design, implementation, and evaluation parameters by March 2016, together with AHECs and other job training resources, with a potential for future funding of some educational resources or seed funding in July 2016. Funding could potentially include program development, training, coaching, funding of trainers and coaches, etc. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, hospital resources such as return on investment, and other grant, philanthropy, and foundation support." MHA is not supportive of diverting funds from transformation implementation, which is important to the goals of improving health, reducing disparities in population health, and maintaining the All Payer Model.

The Commission heard from representatives of a community group, Baltimoreans United in Leadership Development (BUILD), at the October 14, 2015 and at the November 18, 2015 Commission meetings. At the October meeting, BUILD stressed the importance of jobs in improving the situation in Baltimore. The representatives described existing programs that are making progress in employing individuals in economically deprived areas and the process they have used to ensure that the individuals employed through these programs are successful. At the November meeting, BUILD reiterated the importance of jobs and indicated that they were not supportive of staff options because the resources provided were not adequate and they were not confident of funding from other sources. The staff and Commission were very appreciative of their presentations and advice.

Commissioners expressed serious concerns about the problems and the complexity of economic disparities, and the necessary limitations of HSCRC as a hospital rate setting agency in addressing the broad public policy issues that are raised, which include job development, housing, food, transportation, and education, as well as other issues such as safety and security for community residents. There was also a discussion regarding the need for employment outside of hospitals, in primary care settings, health insurance counselors, and non-health jobs. There is a need for increased and continuing conversation among the participants.

HSCRC Staff Commentary

The Commission and staff are very concerned about health disparities and have focused extensive policy development around ensuring that resources are available for enhanced hospital care in areas of disparities. This includes financial policies such as disproportionate share adjustments that provide additional revenues to hospitals in areas of the State where there is a higher estimated level of poverty. These adjustments are derived from claims data and indirect medical education allowances that provide revenues to hospitals, many of which are located in areas of the State with economic disparities. These policies have been applied in developing hospital rates for many decades. The HSCRC staff has also been attentive in developing value based performance measures to consider the impact of the social determinants of health. In fact, the HSCRC staff has been working on an Area Deprivation Index to enhance measurement of socioeconomic disparities and evaluating incorporating the index into its policies.

More needs to be done, however. In spite of significant amounts of additional funding provided to hospitals and a significantly higher amount of overall health care dollars being spent in areas of high socioeconomic disparities, serious disparities in health outcomes exist in Baltimore City as well as in other parts of the State. These disparities have been measured and documented in the State Health Improvement Plan. Hospitals have also recognized these disparities in their Community Health Needs Assessments.

The new All Payer Model recognizes that a new approach is needed to address population health and disparities in outcomes. The Commission has approved numerous policies aimed at redirecting resources to this important objective including:

- Working with hospitals to move payment to global budgets so that when care and health are improved and utilization reduced, hospitals will be able to reinvest retained savings in interventions that are focused on improving health and outcomes. Hospitals have been accorded a great deal of flexibility in spending these resources. Hospitals with historically higher levels of potentially avoidable utilization, such as readmissions, complications, and ambulatory sensitive conditions, have greater opportunities to achieve savings to invest in successful strategies, including training and employment.
- The Commission approved the funding of eight regional partnership grants focused on planning of patient-centered care coordination initiatives involving hospitals and community providers and partners. Out of \$2.5 million of funding, 40% was provided to Baltimore City and Prince George's County partnerships, counties where there are high levels of health disparities.
- By July 1, 2015, the Commission had placed more than \$200 million of funding in rates earmarked for providing infrastructure and support for interventions to improve health

and outcomes and reduce avoidable utilization. Hospitals have completed reports on historic expenditures, and strategic plans are due in December.

- In December of 2015, HSCRC will review grant applications for up to \$40 million of care coordination initiatives that would be funded through hospital rates.

Others have devoted resources as well:

- The State of Maryland has also invested in programs focused on addressing health disparities in economically deprived areas such as the expansion of Medicaid and investments in Health Enterprise Zones.
- Hospitals, government agencies, and other grantors have also dedicated resources to individuals with disparities, including free clinics, transportation, some housing, as well as other interventions.
- Public health resources in Maryland are focused on similar needs.
- The significant Medicaid expansion which took place effective January 1, 2014, provided coverage for numerous individuals in areas of high deprivation, providing a source of health coverage that has improved the access to health care services, including preventive care.
- The federal government has provided grant awards, focused in part on workforce training. Several of the hospital awardees include hospitals located in Baltimore City.

With the new focus on chronic conditions and high needs patients, situations more prevalent in populations with health and economic disparities, HSCRC and hospitals will be directing funding toward reducing health disparities, which will include creation of new positions focused on care coordination and population health improvement.

Relative to the Proposal, HSCRC staff expressed several concerns in the preliminary report.

- Staff is concerned about including traditional jobs inside of hospitals in a grant program. These should be funded through hospital budgets.
- Staff supports expanding hospital resources deployed for positions that support the transitions anticipated in the All Payer Model-- care coordination, population health, health information exchange, health information technology, alignment, and consumer engagement. However, staff is concerned about the funding sources and the potential for overlap with the additional resources that are being provided through rates as noted above. Furthermore, there are hospital community benefit dollars that could potentially be deployed in this effort. Grants are another potential source of funding.
- In order to implement programs such as those described above, significant amounts of training and coaching would be required. The programs require significant design and

dedication of resources. HSCRC staff believes that considerable development needs to take place to plan, develop, and execute these programs successfully, similar to the planning and development that have gone into nursing education programs in the past.

The HSCRC staff acknowledges the importance of jobs creation in areas of high economic deprivation, and both HSCRC and DHMH have taken proactive roles in promoting transformation that should expand opportunities. Staff is concerned about HSCRC's role in addressing the Proposal outside the context of the extensive transformation activities already underway.

Final HSCRC Staff Commentary for Commission Consideration

At the November 18, 2015 meeting, HSCRC staff offered several options for discussion with the Commission and for further public input. Staff has reviewed the letters of comment received and has listened attentively to the public comments provided. The public input process clarified that the Proposal had not been developed in concert with the parties who were identified as the sole or primary funding sources.

As a general matter staff reiterates that a principal aim of the All Payer Model, which is being implemented to improve population health. In focusing on better chronic care and socioeconomic determinants of health, it is expected that hospitals and community partnerships will propose approaches that include development of community based care coordination resources. Staff also notes that several other states are using savings from hospital cost reductions to invest in community based resources, such as housing, food, transportation, and community based workers. As the All Payer Model develops, it is expected that there should be fewer hospitalizations, particularly in areas with very high hospital use rates such as Baltimore City and, therefore, resources will become available under hospital global budgets to help support better community based care and more dedicated resources devoted to the socioeconomic determinants of health.

Given the totality of the input received, the staff recommends as follows:

Addressing disparities and deprivation is important to Marylanders and to the All Payer Model. The Proposal set out an approach for addressing the problem through a jobs creation program in hospitals. However, the stakeholder input process conducted by the HSCRC made clear that many of the proposed funders were not in agreement with key aspects of the Proposal. Proposers will need to continue the dialogue with community organizations, payers, providers, employers, and other stakeholders in identifying approaches to address these important issues.

Discussions with stakeholders should include a focus on how the existing community benefits programs could be repurposed in a transformed health system, as this may be an important

funding source for addressing socioeconomic determinants of health in a post insurance expansion environment.

The HSCRC should maintain its focus on implementation of the All Payer Model with its aim of better care, better health, and lower costs. HSCRC already has efforts underway in conjunction with DHMH. Hospitals will be filing strategic plans for transformation in December. DHMH and HSCRC will work together to evaluate these plans.

The scope of HSCRC participation in these efforts should be maintained within its areas of focus and expertise. In order to address workforce needs in a transformed Maryland health system, there may be an appropriate role for HSCRC to play. HSCRC staff recommends earmarking up to \$5 million of the fiscal year 2017 update factor for this purpose, with matching funds by hospitals that apply to participate in the development and implementation efforts. For example, the HSCRC could provide opportunities for funding of some transitional educational resources in the form of seed funding. This could potentially include program development, training, coaching, funding of trainers and coaches, etc., particularly in areas with high economic disparities and unemployment. These efforts should be targeted to assist the State and the Commission in meeting the goals of the All Payer Model. Hospitals should be expected to fund positions from existing rates, community benefits funds, resources derived from reductions in hospitalizations, and other grant, philanthropy, and foundation support. The federal government has provided workforce development grants in the past, and this avenue could be explored as a possible source of some funding.

HSCRC staff should continue to work together with DHMH diligently and expeditiously on the implementation of the All Payer Model. Implementing the Model will mean more comprehensive and permanent solutions to help improve health, improve care, and reduce costs, with an increased emphasis on addressing socioeconomic determinants of health, workforce transformation, and enhancing the workforce in Baltimore City and other economically challenged areas of the State.

Final Commission Considerations and Approval

The Commission built on the principles outlined in the staff recommendation, and expanded the program and scope from \$5 million to \$10 million in hospital rates, to create a final recommendation, which was approved by the Commission.

The recommendation approved by the Commission provides up to \$10 million in hospital rates on a competitive basis by July 1, 2016 for hospitals committing to train and hire workers from geographic areas of high economic disparities and unemployment to fill new care coordination, population health, health information exchange, alignment, consumer engagement, and related

positions. Hospitals should provide matching funds of at least 50% of the amount included in rates to increase the resources that could be deployed. Thus, if \$10 million is provided in rates, the hospital match would be at least \$5 million.

Hospitals receiving funding under this program shall report to the Commission by May 1, 2017, and each year thereafter on:

- the number of workers employed under the program;
- how many of those workers have been retained;
- the types of jobs that have been established under the program;
- how many patients or potential patients have been assisted through these positions;
- and
- an estimate of the impact that these positions have had in reducing potentially avoidable utilization or in meeting other objectives of the All-Payer Model.

The program will run through June 30, 2018 on a hospital-specific basis assuming on-going compliance by a hospital with the requirements, and could be renewed as of July 1, 2018 for an additional period if it is found to be effective.

The HSCRC will utilize consulting resources to assist in developing and monitoring the program who have expertise in similar work force development activities. The HSCRC will also utilize external resources in collecting and evaluating proposals, reporting on the results of implementing the program, and assisting in evaluating its effectiveness.

Hospitals will be required to submit proposals to obtain funding through rates and hospitals will be required to demonstrate how their plans would address the multiple needs of providing population health improvement related jobs to individuals in disadvantaged areas and meeting the objectives of the All-Payer Model.

Awardees would be required to report periodically to the Commission on their program, including annually beginning May 1, 2107. The Commission will evaluate the effectiveness of the program prior to July 1, 2018 to determine if the program should be continued in general, or for individual hospitals.