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

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

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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.

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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.

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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.

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

FY 2016 – FY 2021

July 2021

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maryland health services cost review commission

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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.

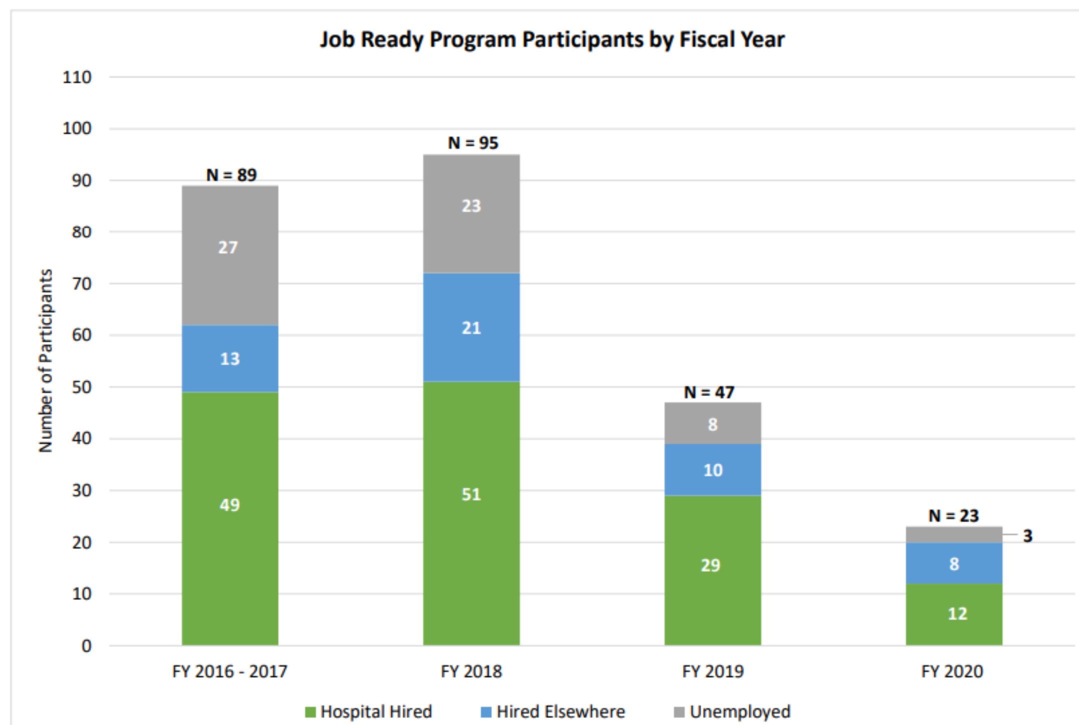
Employment Rate[3]

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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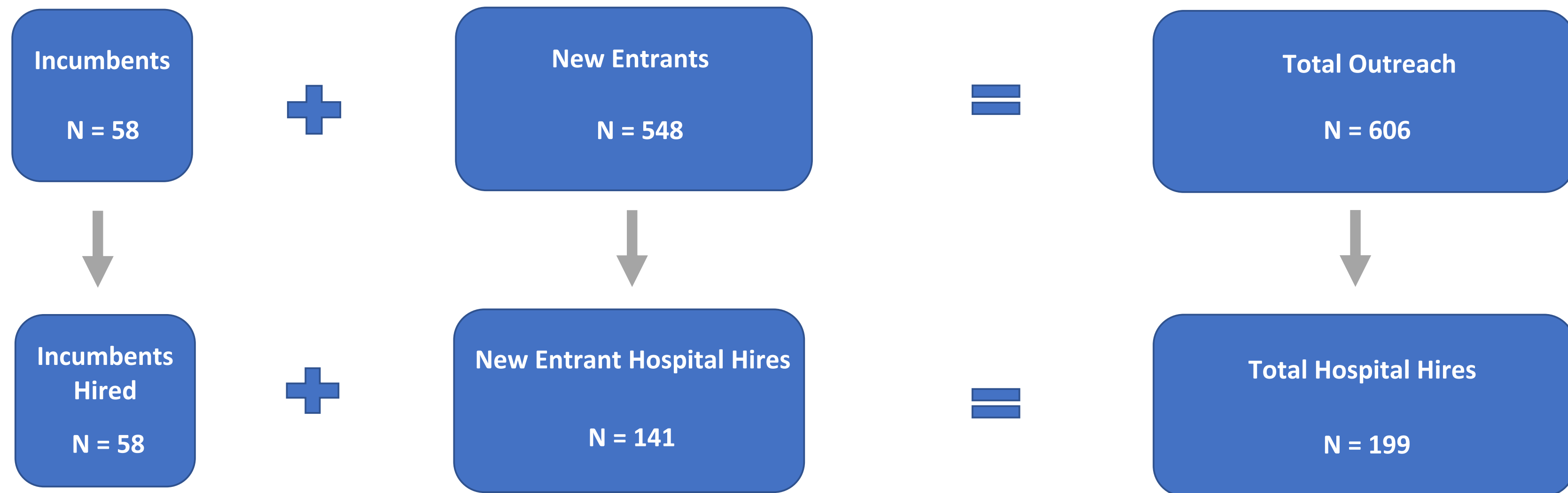
Population Health Workforce Support for Disadvantaged Areas Program

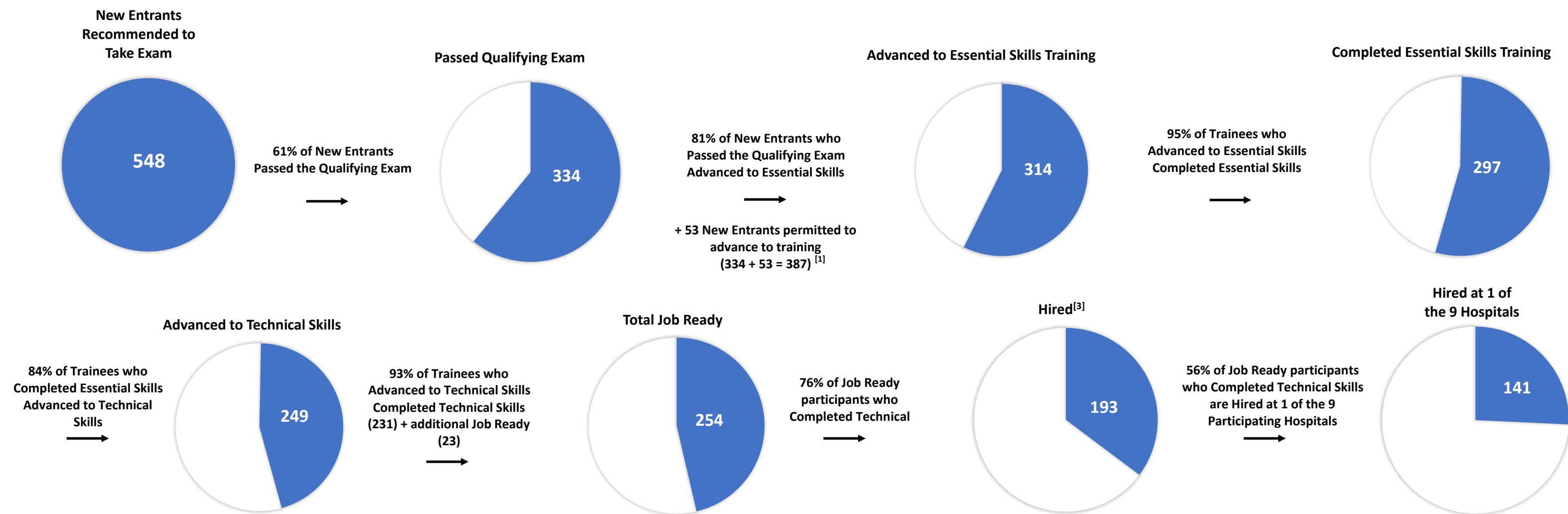
Performance Dashboard – FY 2016 – FY 2020

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.

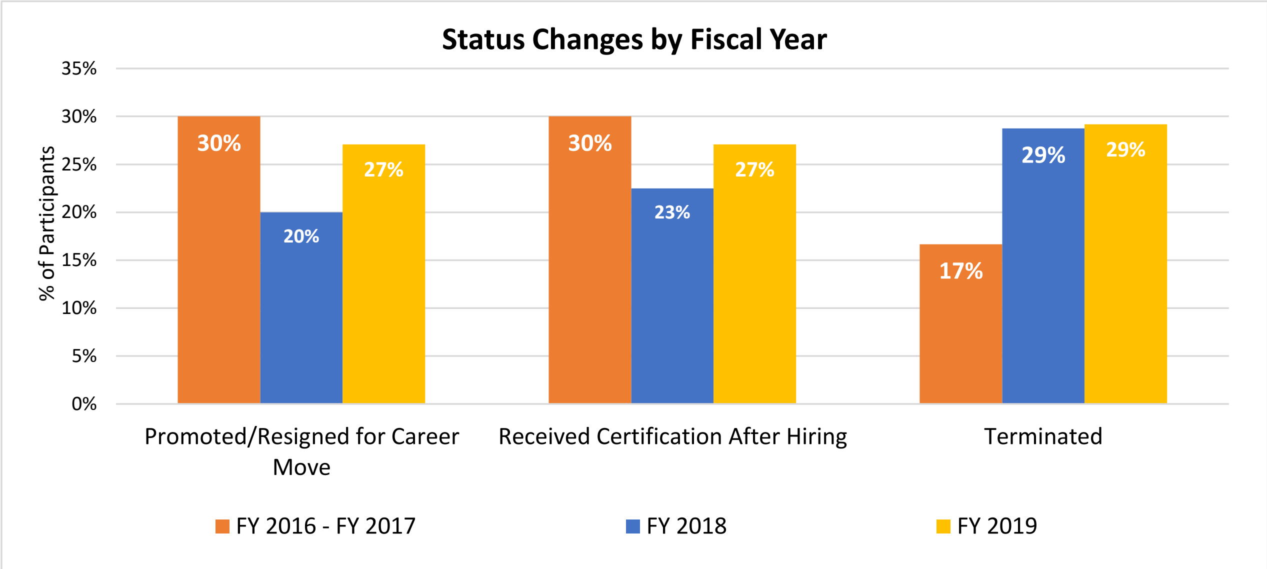
Hospital	CHWs	PRSs	FY 2019 Unduplicated Patients Served
Johns Hopkins Hospital	24	6	8,525
Johns Hopkins Bayview	12	4	3,426
MedStar Franklin Square*	6*	0*	228*
MedStar Union Memorial	8	2	2,039
MedStar Good Samaritan	7	4	1,259
MedStar Harbor Hospital	6	3	561
University of Maryland – Midtown Campus*	13*	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.



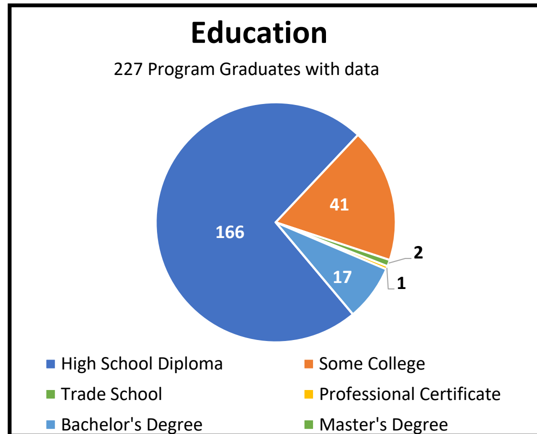
Status Changes by Fiscal Year[1]				
	FY 2016 - 2017	**FY 2018**	**FY 2019**	**Total**
Hospital Hires	**30**	**80**	**48**	**158**
Hires with Status Change	**23**	**57**	**40**	**120**
Promoted/Resigned for Career Move	9	16	13	38
% Promoted/Resigned for Career Move	**30%**	**20%**	**27%**	**24%**
Received 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%**

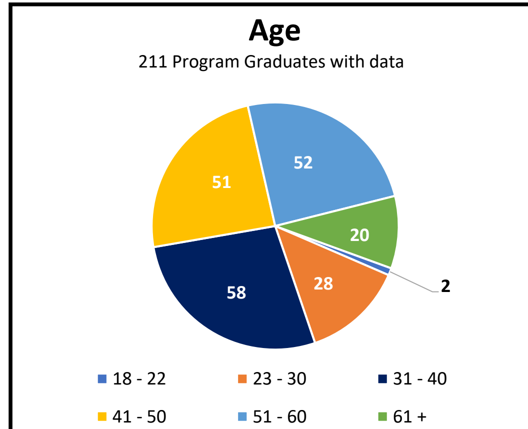
Note:
[1] Fiscal year is based on date hired at 1 of the 9 hospitals.

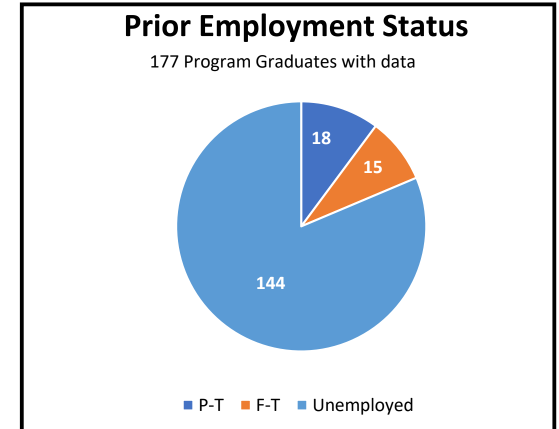
Profiles of Program Graduates

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*

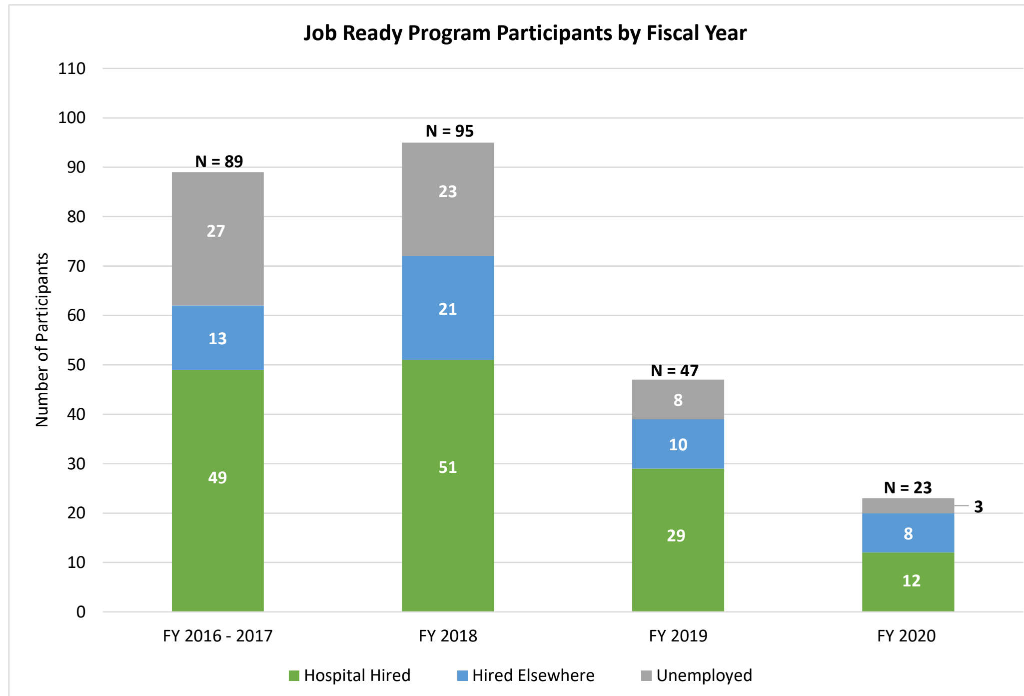
[1] Program Graduates = Program participants that completed technical skills training. N = 234 (231 New Entrants + 3 Incumbents)
[2] Transitional housing is defined as any setting that is not rented or owned.

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%.

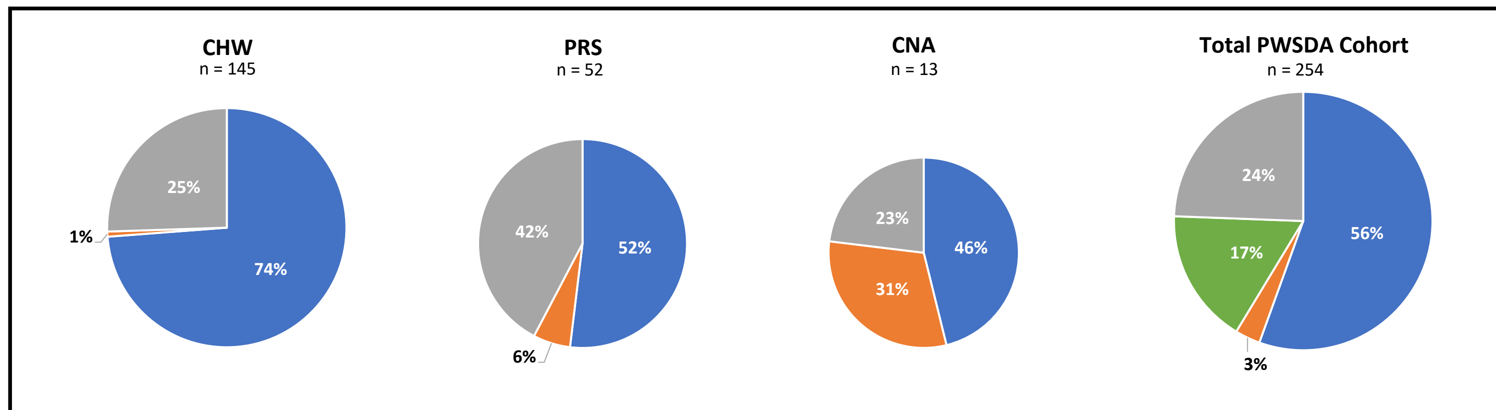


	FY 2016 - 2017	FY 2018	FY 2019	FY 2020	Total (N)
Job Ready	89	95	47	23	254
Hospital Hired	49	51	29	12	141
Hired Elsewhere	13	21	10	8	52
Unemployed	27	23	8	3	61
% Hospital Hired	**55%**	**54%**	**62%**	**52%**	**56%**
% Hired Elsewhere	**15%**	**22%**	**21%**	**35%**	**20%**
% of Total Hired	**70%**	**76%**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

Employment Outcomes for Program Graduates
New Entrants Only

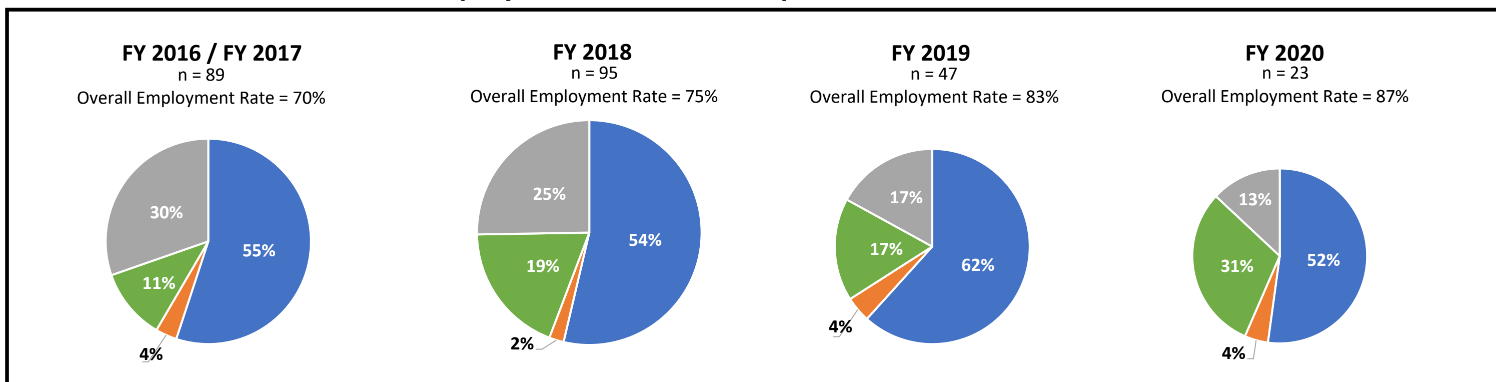
- The overall employment rate for program graduates is 76%.
- CHWs and CNAs/GNAs had the highest employment rates.
- Employment rates have increased across fiscal years.

% 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



Employed at 1 of the 9 Hospitals | Employed in PWSDA Position Elsewhere | Unemployed | Employed in Non-PWSDA Position 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

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, §§19-201, 19-211, and 19-219, Annotated Code of Maryland

.07-1 Outpatient Services – At the Hospital Determination

A. — J. (text unchanged)

K. (1) For purposes of this regulation, “telehealth services” mean health care services provided through the use of interactive audio, video, or other telecommunications or electronic technology by a health care provider at a hospital to a patient at a location other than at the hospital, which enables the patient to interact with the health care provider at the time the health care services are provided.

(a) In this subsection, “health care provider” means an individual who is licensed, certified, or otherwise authorized by law to provide health care services under Health Occupations Article, Annotated Code of Maryland.

(2) A hospital may not bill a separate hospital facility fee when a health care provider who provided telehealth services is authorized to bill independently for the professional services rendered.

(3) The delivery of telehealth services as described above constitutes outpatient services provided at the hospital.

Adam Kane, Chair

Health Services Cost Review Commission

HEALTH SERVICES COST REVIEW COMMISSION

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

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Payment Reform & Provider Alignment

Gerard J. Schmith
Director
Revenue & Regulation Compliance

William Henderson
Director
Medical Economics & Data Analytics

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.