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626th Meeting of the Health Services Cost Review Commission

December 11, 2024

(The Commission will begin in public session at 11:00 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 12:30pm)

CLOSED SESSION
11:00 am

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

PUBLIC MEETING
12:30 pm

1. Review of Minutes from the Public and Closed Meetings on November 13, 2024

Informational Subjects

2. Presentation by Gilchrist Health on Hospice and Palliative Care in Maryland

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2660A Johns Hopkins Health System
2661A Johns Hopkins Health System

3. Docket Status – Cases Open

2662A Johns Hopkins Health System
2663A Johns Hopkins Health System
2664A Johns Hopkins Health System
2665A Johns Hopkins Health System
2666A University of Maryland Medical Center
2634A University of Maryland ARM with Cigna - Extension Request

Subjects of General Applicability

4. Report from the Executive Director

a. Introduction of New Staff
b. Model Monitoring

5. Final Recommendation: Quality-Based Reimbursement (QBR) Policy
6. Draft Recommendation: Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment)
7. Draft Recommendation: Nurse Support Program II Program Renewal and Progress Report
8. Final Recommendation: 2025 Funding for AHEAD Preparation
9. Final Recommendation: Out-of-State, Deregulation, and Repatriation Volume Policies
10. Hearing and Meeting Schedule

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

December 11, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2472
BALTIMORE, MARYLAND	*	PROCEEDING:	2662A

I. INTRODUCTION

On October 30, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center and Suburban Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC ("JHHC") to add additional CAR-T services to the global rate arrangement, Proceeding 2654A, with BridgeHealth Medical, Inc. approved at the Health Services Cost Review Commission's ("HSCRC or the Commission") July 10, 2024 public meeting. The effective date of the approval for additional procedures is December 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in

payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found the experience under this arrangement has been favorable and believes that the Hospitals can continue to achieve favorable experience under this revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add additional CAR-T services to the currently approved arrangement, Proceeding 2654A, with an effective date for the additional services of December 1, 2024. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

December 11, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2473
BALTIMORE, MARYLAND	*	PROCEEDING:	2663A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on October 30, 2024, on behalf of its member hospital Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to create a new global price arrangement for reproductive health procedures for self-pay patients. The System requests approval of the arrangement for a period of one year beginning December 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the new global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

This contract is being offered to self-pay patients. All patients agreeing to the contract terms understand these procedures are not covered under their health plan or they are opting out from accessing benefits under their health plan. Patients will agree to the contract terms and make payments before any procedure is performed.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for participation in an alternative method of rate determination for reproductive health services for a one-year period commencing December 1, 2024, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

December 11, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2474
BALTIMORE, MARYLAND	*	PROCEEDING:	2664A

I. INTRODUCTION

On October 30, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County Medical Center and Suburban Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Employer Direct Healthcare for cardiovascular services, bariatric surgery, orthopedic services (shoulder, hip, knee, and spine), gallbladder, thyroid/parathyroid, oncology diagnosis and prostate services. The Hospitals request that the Commission approve the arrangement for one year beginning December 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement

among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination with Employer Direct Healthcare for cardiovascular services, bariatric surgery, orthopedic services (shoulder, hip, knee, and spine), gallbladder, thyroid/parathyroid, oncology diagnosis and prostate services for the period beginning December 1, 2024. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

December 11, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2475
BALTIMORE, MARYLAND	*	PROCEEDING:	2665A

I. INTRODUCTION

On November 20, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Carrum Health, Inc. for joint replacement and joint replacement consult services, hip and knee replacement, cardiovascular, CAR-T and spine surgery. The Hospitals request that the Commission approve the arrangement for one year beginning January 1, 2025.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in

payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination with Carrum Health, Inc. for joint replacement and joint replacement consult services, hip and knee replacement, cardiovascular, CAR-T and spine surgery for a one-year beginning January 1, 2025. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

December 11, 2024

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND MEDICAL	*	DOCKET:	2024
CENTER	*	FOLIO:	2476
BALTIMORE, MARYLAND	*	PROCEEDING:	2666A

I. INTRODUCTION

On November 22, 2024, University of Maryland Medical Center ("Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ transplant and blood and bone marrow transplants. The Hospital requests that the Commission approve the arrangement for one year beginning January 1, 2025.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement among FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. FPI maintains it has been active in similar types of fixed fee contracts for several years, and that FPI is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital application for an alternative method of rate determination with Aetna Health, Inc. for solid organ transplant and blood and bone marrow transplants. for one-year beginning January 1, 2025. The Hospital must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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Request For Extension of Approval

University of Maryland Medical Center

December 11, 2024

Background

On August 14, 2024, in accordance with the authority granted by the Commission, staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the University of Maryland Medical Center (UMMC) and Cigna Health Corporation (Cigna), Proceeding 2634A. The extension expires on December 31, 2024. However, UMMC and Cigna have not completed negotiations to extend the arrangement.

Request

UMMC requests that the Commission extend its approval for an additional three months, to March 31, 2025, to complete negotiations.

Findings

Staff found that the experience under the current arrangement has been favorable.

Staff Recommendation

Staff recommends that the Commission grant UMMC's request for a three-month extension of its approval, with the condition that if the negotiations are not completed before the expiration of this extension, that the arrangement end and that no further services be provided under the arrangement until a new application is approved.

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Final Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2027

December 11, 2024

This document contains the staff final recommendations for updating the Quality-Based Reimbursement Program for RY 2027.

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Table of Contents

List of Abbreviations

AHEAD	State's Advancing All-Payer Health Equity Approaches and Development Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CCDE	Core Clinical Data Elements (for digital hybrid measures)
CDIF	Clostridium Difficile Infection
CLABSI	Central Line-Associated Bloodstream Infection
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission for ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
HWR/HWM	Hospital Wide Readmission/Hospital Wide Mortality
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
TFU	Timely Follow Up after Acute Exacerbation of a Chronic Condition
THA/TKA	Total Hip and Knee Arthroplasty Risk Standardized Complication Rate
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Quality-Based Reimbursement (QBR) program, are intended to promote quality improvement and ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The QBR program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework.	The QBR policy currently holds 2 percent of hospital inpatient revenue at-risk for Person and Community Engagement, Safety, and Clinical Care outcomes.	This policy ensures that the quality of care provided to consumers is reflected in the rate structure of a hospital's overall global budget. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	HSCRC Quality programs (QBR and Readmission Reduction Incentive Program)) give hospitals two scores, one for achievement and one for improvement; the final score is the higher of the two scores. Including improvement allows all hospitals the potential to earn rewards regardless of the types of patients served. In advance of the approval of the RY 2026 policy, staff worked with the Health Equity Workgroup (HEW) and found disparities in the Medicare Timely Follow-Up (TFU) measure by race, dual-status, and Area Deprivation, and thus adopted a within hospital disparity gap improvement metric for TFU. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

FINAL RECOMMENDATIONS

This document puts forth the RY 2027 Quality-Based Reimbursement (QBR) final policy recommendations for consideration. The policy has few changes compared to the RY 2026 approved recommendations. Staff has vetted these recommendations with the Performance Measurement Workgroup (PMWG) and also greatly benefits from feedback provided by Commissioners and other stakeholders on draft recommendations and longer-term priorities that should be considered as Maryland transitions to the AHEAD model.

Final Recommendations for RY 2027 QBR Program:

1. Maintain Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent, Safety (NHSN measures) - 30 percent , Clinical Care - 10 percent.
    a. Within the PCE domain, weight the measures as follows:
        i. HCAHPS Top Box: 33.33 Percent
        ii. HCAHPS Consistency: 16.67 percent
        iii. HCAHPS Linear: 16.67 percent

iv. Timely Follow-Up for Medicare: 5.56 percent
v. Timely Follow-Up for Medicaid: 5.56 percent
vi. Disparities in Timely Follow-Up for Medicare: 5.56 percent
vii. Emergency Department Length of Stay: 16.67 percent

b. Within the Safety domain, weight each of the measures equally (i.e., 30 percent divided by number of measures).
c. Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally.

2. With regard to monitoring reports to track hospital performance:
    a. Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.
    b. Disseminate Sepsis Dashboard.
    c. Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
3. Implement an HCAHPS learning collaborative with hospitals.
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
5. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

INTRODUCTION

Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Quality-Based Reimbursement (QBR) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for performance by hospitals on patient experience, clinical care, and safety. In RY 2024, the net revenue adjustments statewide for QBR were -$63,871,949. HSCRC staff has evaluated the reward/penalty scale for the performance period and determined that an adjustment is needed; staff is recommending to lower the cut point from 41% to 32% based on National performance. For purposes of finalizing the RY 2027 QBR Policy recommendations, staff vetted the policy recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Under the TCOC Model, Maryland must request a waiver each year from CMS hospital pay-for-performance programs, e.g., the Value Based Purchasing (VBP) program for which QBR is the State analog. CMS assesses and grants these waivers based on a report showing that Maryland's results continue to meet or surpass those of the Nation. Currently, CMMI is reviewing the RY 2025 waiver request and any feedback will be included in the final policy. However, based on the FY 2024 VBP waiver request, and as discussed further in the assessment section of this policy, CMS continues to note Maryland's lagging performance on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and also noted Maryland's relatively high rate of Hysterectomy Surgical Site Infections, and Maryland's need to focus on areas such as the Medicaid population, ED throughput, and non-hospital settings of care.

Additionally, with the onset of the TCOC Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the QBR policy, the overhaul was completed during 2021, which entailed an extensive stakeholder engagement effort to address CMS and other stakeholders' concerns.[1] Additional changes were also approved in the RY 2026 policy, such as reintroduction of an emergency department length of stay measure. This year's final policy updates include changes to the HCAHPS measures consistent with changes to the National VBP program, and updates to the ED LOS performance standards. Figure 1 provides the RY 2027 QBR domain and measure updates, and related updates for future program years.

Figure 1. QBR Updates

Domain/ Measure	RY 2027	Future program years
Person and Community Engagement domain		
HCAHPS	• Continue to weight HCAHPS top box scores more heavily than the CMS VBP program; evaluate efficacy of including HCAHPS linear scores • Continue to use HCAHPS patient level data from the Maryland Health Care Commission (MHCC) for additional analytics, including on disparities, and hospital improvement • Collaborate with hospitals, MHA and other stakeholders on learning collaborative to share best practices with evidence that implementation improves HCAHPS scores • Modify scoring of HCAHPS Survey consistent with the CMS VBP program; beginning in CY 2025, CMS will not score the Responsive of Staff or Care Transition sub-measures.[2] • Focus linear HCAHPS weight on the three communication domains (doctor, nurse, and medication)	• Continue to use HCAHPS patient-level data from the MHCC for additional analytics, including on disparities, and hospital improvement. • Continue, through designated staff support, to work with stakeholders to facilitate sharing of best practices • Consider adoption of additional question(s) linked with best practices with evidence of improving HCAHPS performance in the payment program after CY 2024. • Modify scoring on the HCAHPS Survey measure for the RY 2028 through RY 2029 program years to only score on the six unchanged dimensions of the survey while updates to the survey are adopted and publicly reported in the Hospital IQR Program.

[1] See the RY 2024 QBR policy for additional information on the findings from the QBR Redesign.

[2] The HCAHPS Survey will be updated by adding three new sub-measures—"Care Coordination," "Restfulness of Hospital Environment," and "Information about Symptoms"—which will be publicly reported starting October 2026, with the intent to adopt the measures in the VBP Program in 2030. The updates also include removing the "Care Transition" sub-measure from Hospital Compare in January 2026 and revising the "Responsiveness of Hospital Staff" sub-measure by removing "Call Button" questions and adding a new "Get Help" question beginning January 2025.

Domain/ Measure	RY 2027	Future program years
Emergency department (ED) wait times	• Collect ED length of stay measures through HSCRC case-mix submissions • Collaborate with the new ED Wait Time Reduction Commission to develop a statewide improvement goal • Develop performance standards for RY 2027 that support statewide improvement goal • Develop risk-adjusted attainment for ED LOS for monitoring or payment • Develop separate policy on ED-Hospital Best Practices to incentivize structural and process measures to support improved hospital throughput	• Continue to evaluate ED length of stay measures, and use of the QBR program to incentivize improvement • Adopt risk-adjusted ED LOS measure for attainment into QBR • Provide staff support to the State's ED Wait Time Reduction Commission • Implement and continue to evaluate ED-Hospital Best Practice measures for monitoring and/or payment
Timely Follow-up measure	• Continue to include the TFU measure for Medicaid (added in the RY 2025) and the TFU within-hospital disparity measure beginning with Medicare (added in RY 2026) to reduce disparities and support achievement of the SIHIS goal for Timely Follow-up. Update to latest clinical logic • Explore behavioral health data sources and ways to monitor follow up following a hospitalization for behavioral health	• Evaluate the ongoing TFU rates for Medicare and Medicaid as well as the within-hospital disparity gap measure, to ensure SIHIS goal is met • Consider feasibility, based on data availability, of adding a measure that includes behavioral health patients
Safety domain		
SEP-1: Severe Sepsis and Septic Shock: Management Bundle	• Monitor hospital performance on the Sepsis Bundle measure and implement a hospital-level "Sepsis Dashboard" that includes inpatient and 30-day mortality, 30-day readmissions, and the Sepsis PPC and PSI measures	• Continue monitoring hospital performance on the Sepsis Dashboard measures and consider adjustments to payment measures if performance declines
CDC National Health Safety Network	• In light of the work group's findings that demonstrate that Maryland is on par with national performance, continue the 30% domain weight to better align with the National VBP Program; focus on improvement on current measures	• Continue to analyze Maryland trends compared to National performance. • Explore working with CDC to add more innovative and less burdensome "digital" measures.
Clinical Care domain		
Mortality	• Maintain IP and 30-day all-cause, all-payer mortality measures weighted equally in the domain • Begin implementation of data collection on an all-payer 30-day digital Hybrid Hospital Wide Mortality measure using the digital measures infrastructure	• Monitor the Medicare and all-payer digital Hybrid Hospital Wide Mortality measures using the digital measures infrastructure in advance of planning for implementation of an all-payer hybrid measure.
Total hip arthroplasty/total knee arthroplasty (THA/TKA)	• Monitor THA/TKA measure performance removed from QBR in RY2026 • Continue to explore options for expanding measurement of THA/TKA complications to all-payers and outpatient cases	• Continue to develop outpatient quality of care strategy using THA/TKA as exemplar • Explore opportunities for Patient Reported Outcome Measures (PROMs)

BACKGROUND

Overview of the QBR Program

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to 2 percent of inpatient revenue. The program assesses hospital performance against National standards for measures included in the CMS VBP program and Maryland-specific standards for other measures unique to our all-payer system. Figure 2 presents RY 2026 and proposed RY 2027 QBR measures and domain weights compared to those used in the VBP Program.

Figure 2. RY 2026 and Proposed RY 2027 QBR measures and Domain Weights Compared to the CMS VBP Program

Domain	Maryland RY 2026 and Proposed RY 2027 QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	**10 percent** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**60 percent** ● Eight HCAHPS categories (RY 2026) Six HCAHPS categories (RY 2027), top box score and consistency, 4 categories for linear scores ; ● TFU (Medicare, Medicaid, disparities improvement); ● ED LOS	**25 percent** Six HCAHPS measures top box score and consistency
Safety	**30 percent** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Six measures: Five CDC NHSN HAI measure categories; Sep 1 Bundle measure
Efficiency	n.a.	**25 percent** One measure: Medicare spending per beneficiary

The QBR Program assesses hospital performance by comparing each measure to National or State performance standards. For all measures, except the ED LOS measure[3], the performance standards range from the 50th percentile of hospital performance (threshold) to the mean of the top decile (benchmark). Each measure is assigned a score of zero to ten points, then the points are summed and divided by the total number of available points, and weighted by the domain weight. A total score of 0 percent means that performance on all measures is below the performance threshold and has not

[3] The ED LOS performance standards are 0-10 percent and 0-5 percent for those above and below the statewide average, respectively.

improved, whereas a total score of 100 percent means performance on all measures is at or better than the mean of the top decile (about the 95th percentile). This scoring method is the same as that used for the national VBP Program. But unlike the VBP Program, which ranks all hospitals relative to one another and assesses rewards and penalties to hospitals in a revenue neutral manner retrospectively based on the distribution of final scores, the QBR Program uses a preset scale to determine each hospital's revenue adjustment and is not necessarily revenue neutral. This gives Maryland hospitals predictability and an incentive to work together to achieve high quality of care, instead of competing with one another for better rank.

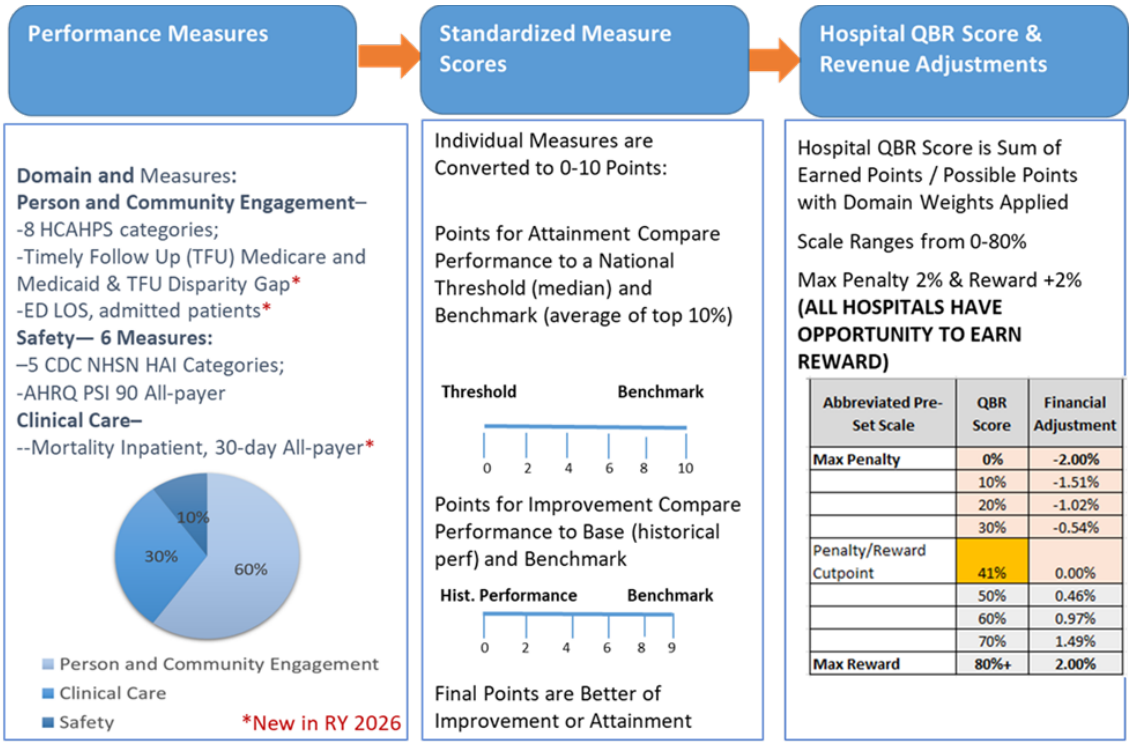
Historically, Maryland hospitals have low scores on the QBR program in part due to HCAHPS performance. In order to ensure Maryland hospitals are not rewarded for subpar performance, the preset revenue adjustment scale for the entire QBR program ranges from 0 to 80 percent, regardless of the score of the highest-performing hospital in the state (i.e., the scale is not relative to Maryland performance so that poor performance compared to the Nation is not rewarded). The cut-point at which a hospital earns rewards or receives a penalty has been based on an analysis of the national VBP Program scores. For RY 2024 and RY 2025, federal fiscal years 2016–2021 were used to calculate the average national score using Maryland QBR domain weights (without the Efficiency domain). This resulted in a cut-point around 41 percent (range of scores was from 38.5 to 42.7). However, due to the COVID Public Health Emergency (PHE) the RY 2024 through RY 2026 policies indicated that the cut point would be reassessed retrospectively with more recent National data. While this is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties due to changes in performance post-COVID compared to national hospitals. The RY 2026 approved policy lowered the RY24 QBR cut point to 32 percent based on more analyses on the impact of pre-COVID performance standards on National hospital performance. The RY 2027 policy also provides recommendations for the RY 2025 final cut point based on more recent analyses. Given performance standards are now post-COVID, staff believes scores may be higher beginning in RY 2026 than in RYs 2024 or RY 2025.

As a recap, the method for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves:

1. Assessing performance on each measure in the domain.
2. Standardizing measure scores relative to performance standards.
3. Calculating the total points a hospital earned divided by the total possible points for each domain.
4. Finalizing the total hospital QBR score (0 to 100 percent) by weighting the domains, based on the overall percentage or importance the HSCRC placed on each domain.
5. Converting the total hospital QBR scores into revenue adjustments using the preset revenue adjustment scale (range of 0 to 80 percent).

This method is shown in Figure 3.

Figure 3. RY 2026 QBR Policy Methodology Overview



Appendix A contains more background and technical details about the QBR Program. Appendix B contains the by-hospital QBR results for RY 2025 with the 41 percent cut point and a proposed revised cut point of 32 percent. With the 41 percent cut point, 36 hospitals would receive penalties totalling ~-$66M and 5 hospitals would receive rewards totalling ~$1.6M yielding a State net total of ~-$64.4M. These statewide results are similar to those awarded prior to COVID. With the proposed revised 32 percent cut point, 24 hospitals would receive penalties totalling ~$33M and 17 hospitals would receive rewards totalling ~$11M yielding a State new total of ~$22M.

Assessment

The purpose of this section is to present an assessment, using the most current data available, of Maryland's performance on measures used in the QBR program, compared to the Nation when national data is available. Finally, this final policy provides recommended measure and domain weights, as well as modeling of QBR scores with the recommended changes.

Person and Community Engagement Domain

The Person and Community Engagement domain currently measures performance using the HCAHPS patient survey, three measures of timely follow-up (TFU) after discharge for an acute exacerbation of a chronic condition (one measure for Medicare fee-for-service (FFS), one measure for Medicaid beneficiaries, and one measure on within-hospital disparity gap reduction for Medicare FFS beneficiaries). In addition, an ED LOS measure for patients admitted to the hospital (non-psychiatric) was added to the program in RY 2026. This domain currently accounts for 60 percent of the overall QBR score.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The HCAHPS survey is a standardized, publicly reported survey that measures patient's perceptions of their hospital experience. In keeping with the national VBP Program, the QBR Program scores hospitals using top box scores (e.g., the percent of respondents who indicate the highest performance category) to calculate improvement and attainment points (0-10), and counts the points for whichever is highest, across the following HCAHPS domains beginning in CY 2025 (RY 2027 policy performance period): (1) communication with nurses, (2) communication with doctors, (3) communication about medicine, (4) hospital cleanliness and quietness, (5) discharge information, and (6) overall hospital rating. Staff notes that the two HCAHPS sub measures that include the composite care transition measure and responsiveness of hospital staff measure are being updated by CMS beginning in CY 2025 and therefore cannot be included in the HCAHPS scoring for CYs 2025 through 2027 (VBP FFY 2027 through FFY 2029).[4]

The QBR Program also scores hospitals separately on HCAHPS consistency[5]; the lowest performing HCAHPS domain score is compared to the floor (worst performer in the Nation in the base) and the achievement threshold performance level. If the worst domain score is above the achievement threshold then all domains are above, and the full 20 points are earned. If the lowest domain score is above the floor but less than threshold, partial points of 1-19 are earned. If the lowest scoring domain score is less than or equal to the floor, zero consistency points are awarded.

In RY 2024, HCAHPS linear scores were added as 20% of the PCE domain (i.e., 10 percent of overall QBR score) for the following domains: the nurse communication, doctor communication, responsiveness

[4]Beginning in CY 2025, the HCAHPS Survey will be updated by adding three new sub-measures—"Care Coordination," "Restfulness of Hospital Environment," and "Information about Symptoms"—which will be publicly reported starting October 2026. The updates also include removing the "Care Transition" sub-measure from Hospital Compare in January 2026 and revising the "Responsiveness of Hospital Staff" sub-measure by removing "Call Button" questions and adding a new "Get Help" question beginning January 2025.Because of these changes to the survey, VBP scoring on the HCAHPS Survey measure FY 2027 through FY 2029 program years will be modified to only score on the six unchanged dimensions of the survey while updates to the survey are adopted and publicly reported in the Hospital IQR Program.

[5] For more information on the national VBP Program's performance standards, please see https://qualitynet.cms.gov/inpatient/hvbp/performance.

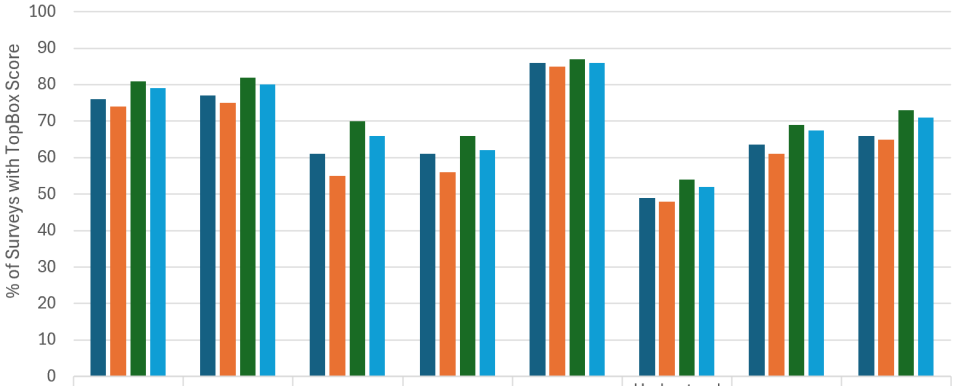
of staff, and care transition. The addition of the linear measures was designed to further incent focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top box scores. Based on stakeholder feedback from last year, HSCRC staff recommends continuing the linear measures for RY 2027 at the current weight. However, with the modifications to the HCAHPS survey beginning in CY 2025 that exclude the scores for Staff Responsiveness and Care Transition sub-measures, staff proposes to add Communication about Medicine and have only three linear measures starting in RY 2027 weighted at 10 percent of the QBR program (thus three measures weighted at same percent as previous rate years). The modeling included in this policy, reflects this proposal to focus the linear measures on the three communication domains. As staff noted in previous years' QBR policies, we will assess if adding the linear measures helps improve top-box scores over the next few years. If top box scores do not improve, staff will recommend reducing the weight or removing the linear measures in future rate years.

CMS Care Compare data on HCAHPS top box and linear performance through 6/30/23 reveal the following, as illustrated in Figures 4 and 5 below:

- Both the Nation and Maryland declined slightly from the base to the performance periods on top box and linear scores for all of the HCAHPS categories.
- For both top box and linear scores, Maryland lags behind the Nation in the base and the performance periods.
- For "Discharge Information Provided", Maryland and the Nation performed most similarly on top box scores.

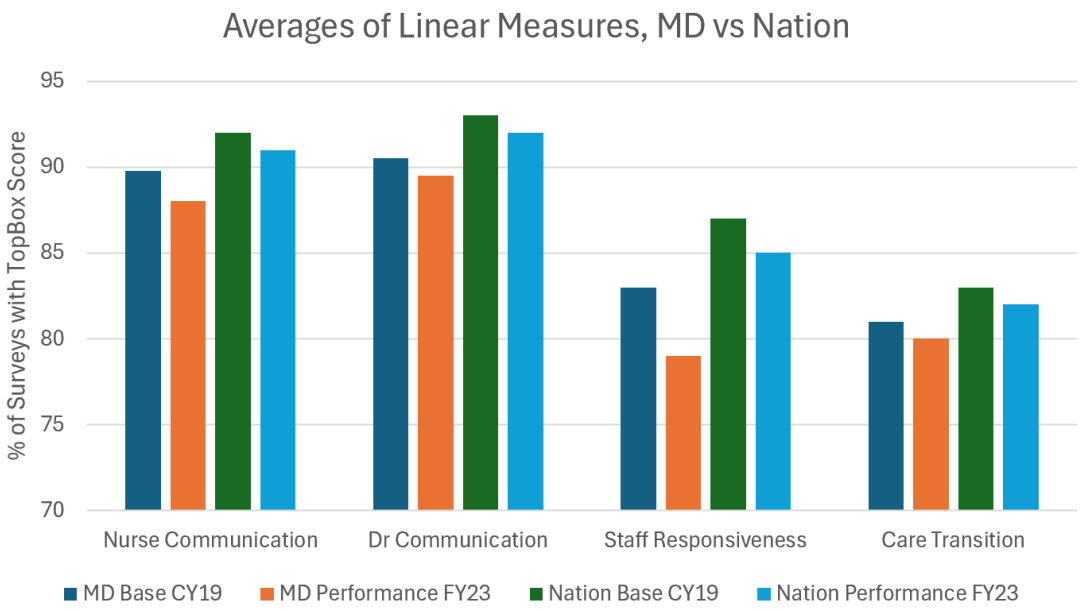
Figure 4. Top Box HCAHPS Results: Maryland Compared to the Nation , CY 2019 vs 7/1/22-6/30/23

HCAHPS Top-Box Measure Results: Maryland compared to Nation



	Nurse Communication	Dr Communication	Staff Responsiveness	Medication Explained	Discharge Info Provided	Understood Post-Discharge Info	Clean/Quiet	9/10 Overall Ranking
MD Base CY19	76	77	61	61	86	49	63.5	66
MD Performance FY23	74	75	55	56	85	48	61	65
Nation Base CY19	81	82	70	66	87	54	69	73
Nation Performance FY23	79	80	66	62	86	52	67.5	71

Figure 5. Linear Measure, Maryland Compared to the Nation, CY 2019 vs 7/1/22-6/30/23



Starting in CY 2022, MHCC began collecting patient level HCAHPS data from Maryland hospitals. This patient level data is critical for identifying opportunities within hospitals at a more granular level, including identification of disparities. See Appendix C for more information on the data collection and results indicating there are disparities by race in completion of the survey, with the black hospital population underrepresented and the white hospital population overrepresented compared to their proportion of the total population, and the black population indicating an overall lower rating of care, particularly in the Maternity service line.

HCAHPS Improvement Framework

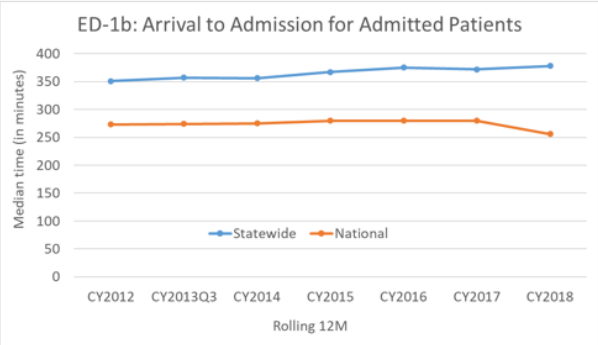
One important area CMS has identified in feedback to the Commission is the need for targeting improvement in HCAHPS in the Person and Community Engagement domain. CMS has recommended that the State consider implementing a Statewide HCAHPS performance improvement initiative that leverages input from providers, industry experts, and other stakeholders to develop future improvement goals. Further, CMS noted they are looking for the State to further develop these strategies and commit to creating a framework for setting HCAHPS performance improvement goals for future performance years. To improve HCAHPS performance as a state, the HSCRC is co-leading a Patient Experience Learning Collaborative with the Maryland Hospital Association (MHA). As outlined in Appendix D the goal of the learning collaborative is to compile best practices to help Maryland hospitals improve patient experience and attain higher HCAHPS scores. The learning collaborative will accomplish this task by analyzing patient-level HCAHPS data, learning best practices from national organizations that consult hospital providers on improving patient experience, and through quality improvement initiatives using Plan, Do,

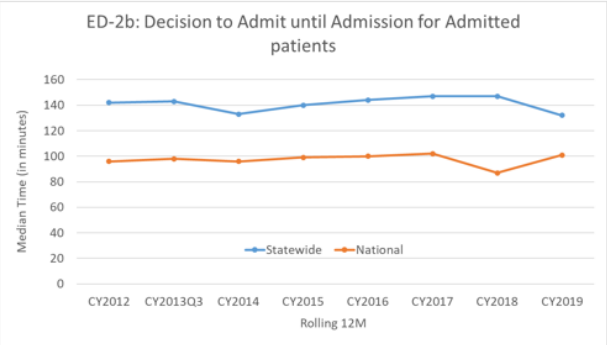
Act Study (PDSA) cycles. HSCRC has brought on an HCAHPS expert with hospital executive leadership experience as Chief Patient Experience Officer to lead the HCAHPS improvement framework implementation. Based on Maryland's overall lagged HCAHPS performance and MHCC's analysis, it is of great import to focus on disparities in HCAHPS results; staff will examine disparities, for example, in the response rates and the maternity service line responses for HCAHPS, as well as other related process and outcome measures.

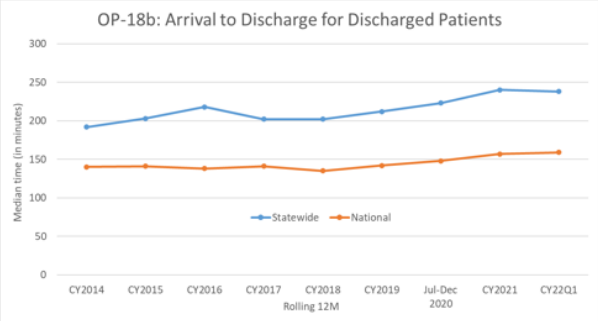
Emergency Department Length of Stay

ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[6] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission approved the addition of an ED wait time or length of stay (LOS) measure in the RY 2026 QBR program. Previously published and available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 6.

Figure 6. Emergency Department Performance on CMS ED Wait Time Measures







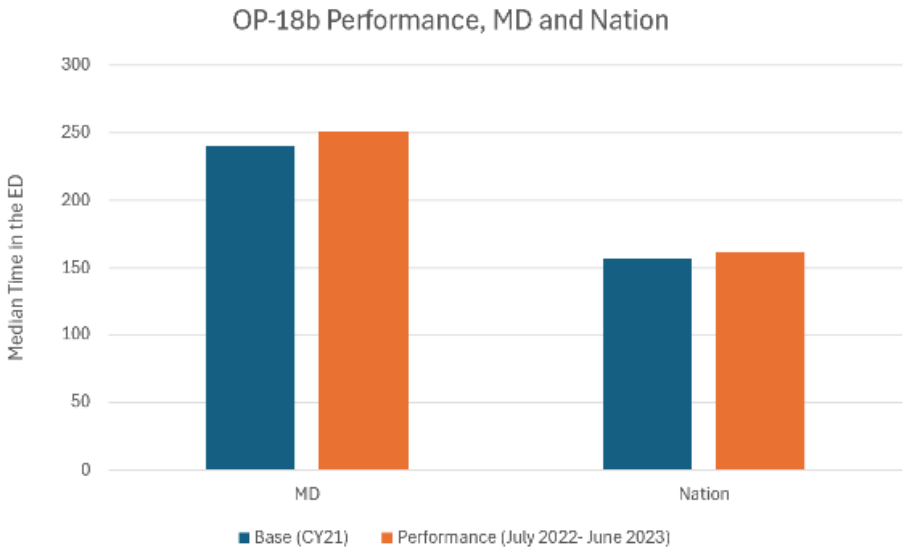
Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

As illustrated in Figure 7 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the

[6] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

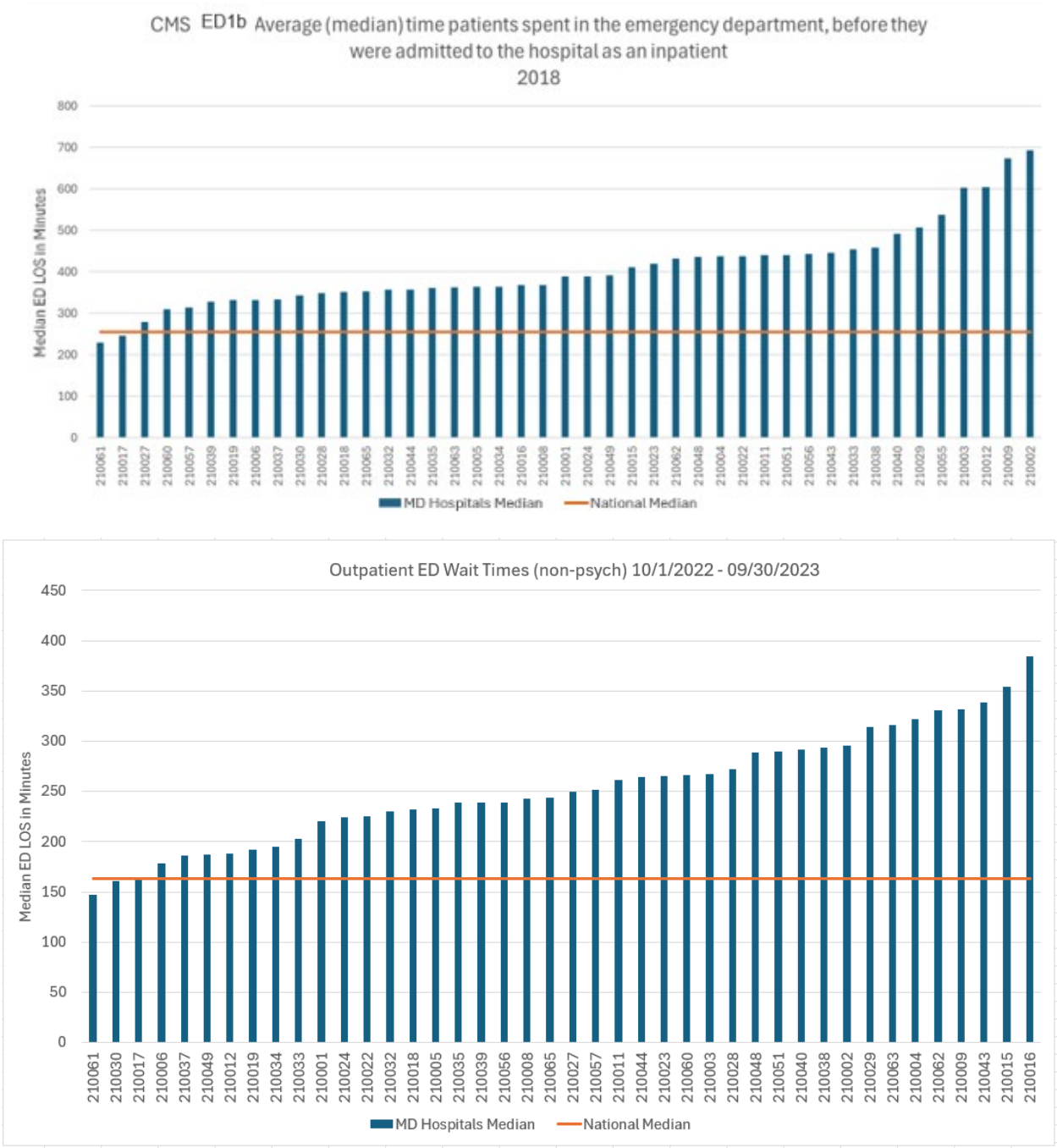
performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

Figure 7. Maryland and National Performance on ED Wait Times for Discharged Patients



Furthermore, all but a couple of hospitals in Maryland perform worse than the national average. Figure 8, shows the ED length of stay for non-psychiatric patients who are admitted (ED1b) for 2018 (last year this was reported) and for those who are discharged home (OP-18b) using the most recently available data.

Figure 8. Maryland by Hospital and National Performance on ED Wait Times



Based on these results, staff believes all hospitals in Maryland have an opportunity to improve. Furthermore, there has been increased public scrutiny on Maryland's poor performance in ED Wait times, as evidenced by the several initiatives that have been underway over the last couple years to promote understanding Maryland's ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new ED Wait Time Reduction Commission was established. The ED Commission is co-chaired by the HSCRC Executive Director and staffed by the

HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a State goal for improvement in ED wait times. The QBR ED LOS measure is one of the HSCRC levers to assist with this effort and will build off of the goals set by the Commission. Appendix E provides additional information on ED initiatives and the ED Commission.

For RY 2026, the QBR ED measure and performance standards were under development during the performance year through a stakeholder subgroup process. Recently, the hospitals have expressed concern that the ED LOS measure should have been monitored and not in payment for the CY 2024 performance period, since the exact measure and performance standards were unknown. Despite not knowing the exact measure or performance standards, hospitals were aware of the need to improve ED LOS since prior to the start of CY 2024. However, in recognition of the hospital's concerns, staff plans to recommend performance standards that give credit to hospitals for maintaining or improving the ED length of stay during CY 2024. This will be discussed as part of the ED update at the October Commission meeting, with the expectation that the decision on performance standards will be determined by the end of the month. Appendix F provides details on the development of the ED LOS measure and modeling estimates of the RY 2025 results with the ED LOS measure included, using the latest proposal on performance standards and estimates of hospital performance. Of note, the hospitals have just completed submitting the first round of historical data at a patient level for the calculation of the ED LOS based on data submission requirements that were provided to the industry in May 2024.

In terms of the RY 2027 measure and performance standards, the staff propose the following:

- Maintain the ED1b measure in the QBR PCE domain and weight at 10 percent of the QBR program (same as RY 2026)
- Continue to assess hospital on improvement on ED1b
- Develop risk-adjusted ED LOS measure for attainment
- Monitor attainment and consider retrospectively adopting attainment in the policy
- Set improvement standards based on State improvement goal established by the ED Commission
- Including observation stays (23 hrs+) as inpatient admissions in the ED1b measure

While the staff are deferring the CY 2025 performance standards, hospitals should be aware that an improvement in ED LOS is expected during CY 2025. The performance standards for RY 2027/CY 2025 performance will be determined in conjunction with the ED Wait Time Reduction Commission by March/April 2025 and be reported to the HSCRC Commission.

Timely Follow-Up After Discharge

The HSCRC introduced this National Quality Forum-endorsed measure for Medicare beneficiaries into the RY 2023 QBR Program within the PCE domain, expanded the measure to Medicaid in RY 2025, and added a within-hospital disparity gap measure in RY 2026. The measure for RY 2026 assesses the

percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice.[7] Staff recommends continuing these measures in the RY2027 QBR program using the measure that was updated in the spring of 2024 by the Partnership for Quality Measurement.[8] Specifically,"qualifying" follow up visits that contribute to the numerator are those for which follow-up care was received after the discharge date within the timeframe recommended by clinical practice guidelines, as detailed below:

- Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
- Asthma: Follow up within 14 days of the date of discharge
- Heart Failure: Follow up within 14 days of the date of discharge
- Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients (defined by ICD 10 codes)
- Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
- Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

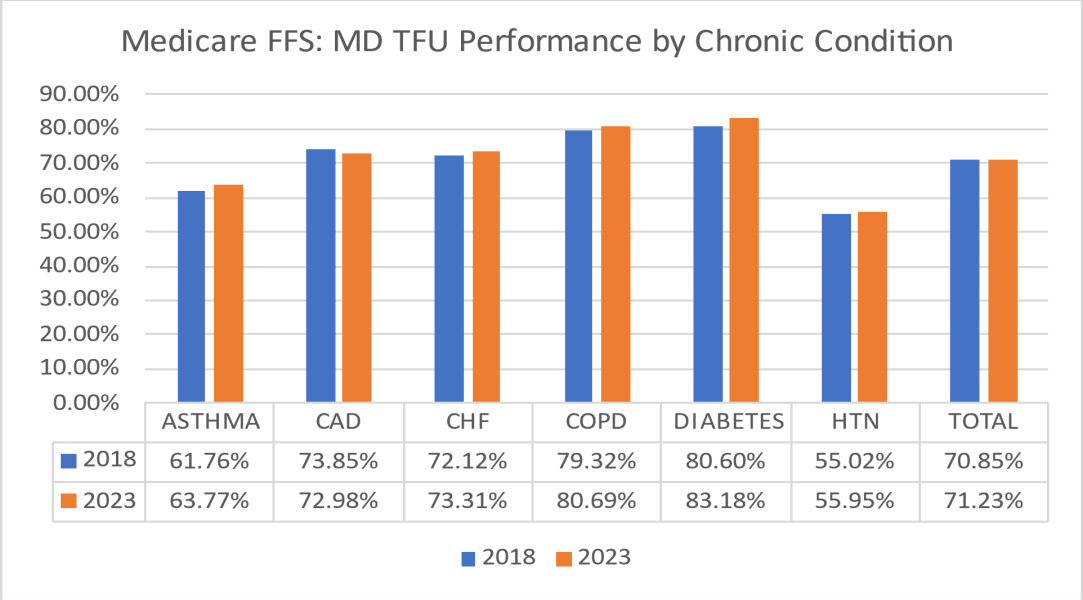
The Medicare TFU measure is also included in the Care Transition SIHIS domain with the goal of achieving a 75 percent follow-up rate by the end of 2026.[9] Figure 9 shows Maryland's performance over time for each chronic condition and all conditions combined within the Medicare population. For all conditions, there was a slight increase in Medicare rates from in 2018 to 2023 (70.85% to 71.23%) across all conditions; for asthma, CHF, COPD, diabetes, and hypertension there were increases in the rates of timely follow-up; however, for CAD there was a slight decrease in follow-up (-0.87%).

[7] The measure currently assesses the percentage of ED visits, observation stays, and inpatient admissions for one of six conditions in which a follow-up was received within the time frame recommended by clinical practice: Hypertension (follow-up within seven days), Asthma (follow-up within 14 days), Heart failure (follow-up within 14 days), Coronary artery disease (follow-up within 14 days), Chronic obstructive pulmonary disease (follow-up within 30 days), Diabetes (follow-up within 30 days).

[8] In the spring of 2024, the measure was reviewed and re-endorsed through Battelle's Partnership for Quality Measurement (PQM). As a designated Centers for Medicare & Medicaid Services (CMS) certified consensus-based entity, Battelle's PQM uses a consensus-based process involving a variety of experts - clinicians, patients, measure experts, and health information technology specialists - to ensure informed and thoughtful endorsement reviews of qualified measures. See the Battelle PQM website for more information about the measure. The HSCRC staff will update the TFU measure with the latest clinical logic for RY 2027 although the results presented here are still under the old logic.

[9] The SIHIS goal is to achieve a 75 percent TFU rate for Medicare FFS beneficiaries across the six specified conditions and respective time frames.

Figure 9. Medicare FFS: Maryland Timely Follow-Up by Condition[10]



	ASTHMA	CAD	CHF	COPD	DIABETES	HTN	TOTAL
2018	61.76%	73.85%	72.12%	79.32%	80.60%	55.02%	70.85%
2023	63.77%	72.98%	73.31%	80.69%	83.18%	55.95%	71.23%

While some stakeholders have raised concerns around the follow-up times by condition, it is important to note that Maryland and the Nation are being measured on the same timeframes and the expectation is not 100 percent follow-up. Furthermore, as discussed above, the HSCRC staff will update the TFU measure to account for the change in clinical timeframes. Figure 10 shows the annual performance on the total TFU measure for Maryland and the Nation (national data is based on the Chronic Condition Warehouse 5 percent sample). Comparing 2018 to 2023, the Nation has seen a 2.29 percent increase and Maryland has seen a 0.54 percent increase in timely follow-up rates; however, Maryland still performed about 4 percent better than the Nation in 2023.

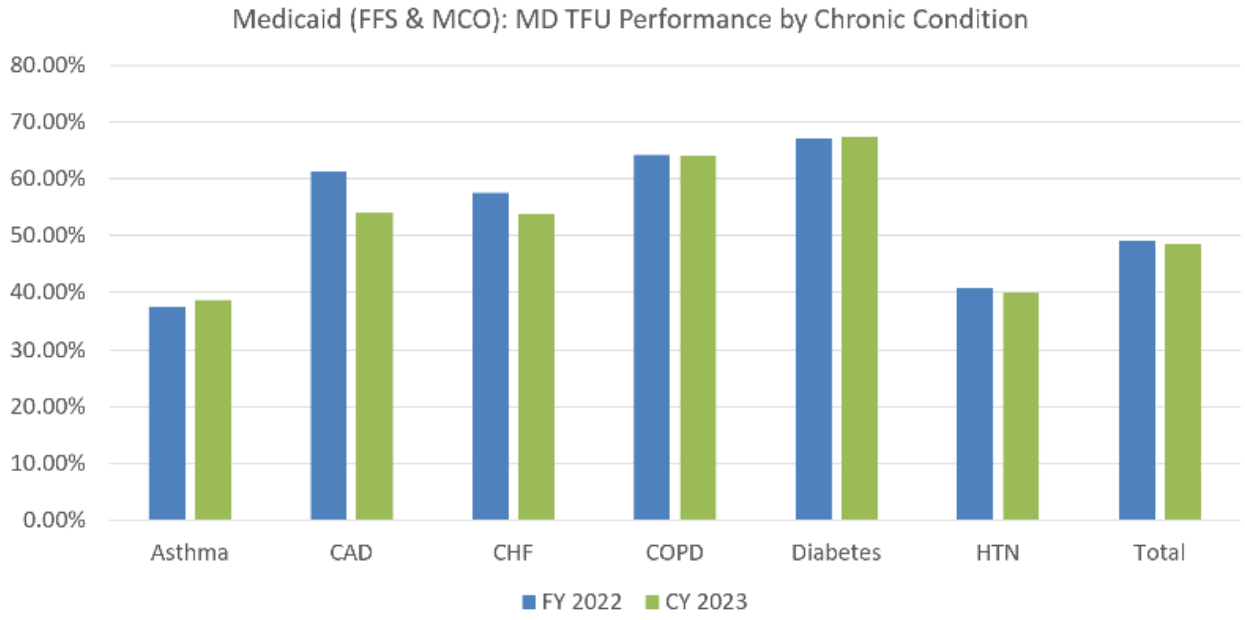
Figure 10. Medicare-only: Timely Follow-Up across All Conditions

TFU Rates	CY2018	CY2019	CY2020	CY2021	CY2022	CY2023
Maryland	70.85%	71.45%	67.90%	70.07%	70.59%	71.23%
US	66.82%	69.00%	64.75%	67.68%	67.26%	68.35%

[10] Maryland numbers are claims-based and built on the Claim and Claim Line Feed with a four-month runout. CAD = coronary artery disease, CCW = Chronic Conditions Data Warehouse; CHF = coronary heart failure; COPD = chronic obstructive pulmonary disease; HTN = hypertension.

As part of the 2021 SIHIS proposal, staff said they would explore expanding the TFU rates for chronic conditions to other payers and adding follow-up after a hospitalization for behavioral health. In CY 2022, staff worked with CRISP and Maryland Medicaid to provide hospitals monthly Medicaid Timely Follow-Up reports on the CRS portal. In RY 2025, the HSCRC introduced the Medicaid TFU measure and recommends continuing it in the RY2027 QBR program weighted the same as the Medicare measure but assessed separately due to large differences in the rates. Figure 11 shows Maryland's performance over time for each chronic condition and all conditions combined for Medicaid patients.

Figure 11. Maryland Medicaid Timely Follow-Up by Condition



Staff is continuing to work to understand the Medicare and Medicaid behavioral health data to create a Timely Follow-Up monitoring report for Behavioral Health.

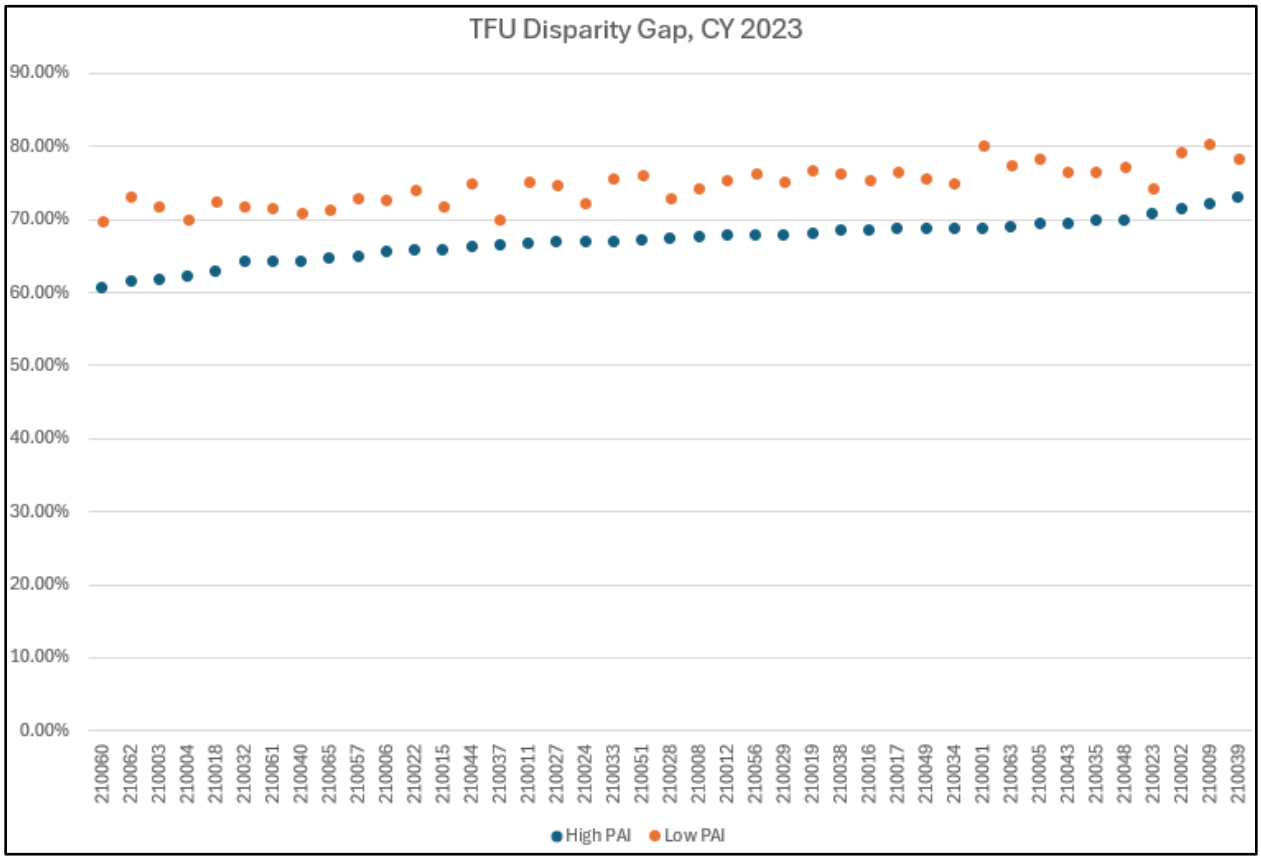
Disparities in Timely Follow-Up

In the Summer of CY 2022, staff convened a Health Equity Workgroup to review Maryland's quality measures stratified by social demographic factors to glean disparities. For the QBR program, staff stratified the Timely Follow-Up measure by race, dual-eligibility status, and Area Deprivation Index (ADI). Results of this stratification analysis found marked disparities on all three factors. Given that the State did not meet the 2021 Year 3 Milestone SIHIS Target and the overwhelming evidence of disparities in this measure, HSCRC staff developed a timely-follow up disparity gap metric similar to the readmissions disparity gap measure that was added to the PCE domain in RY 2026. The timely follow-up disparity gap metric takes the patient-level social exposures of race, dual eligibility status, and ADI and estimates the

association between these social exposures and the likelihood of receiving a follow-up in the recommended timeframe. Based on this analysis, a TFU Patient Adversity Index score (TFU PAI) is assigned to each patient and hospitals are then assessed on the TFU rate for low and high PAI patients (i.e., the within-hospital disparity gap is the difference between these rates). The performance metric for RY 2027 would be the change in the TFU disparity gap from 2018 to 2025. Staff modeled the TFU disparity gap improvement using CY 2018 to CY 2023 and proposes to use this data to set the standards for improvement in the disparity gap for RY 2027.

Figure 12 shows the TFU disparity gaps by hospital in CY 2023. The median gap between low and high PAI patients is 7.74 percent, with a range of 3.54-11.60 percent indicating all hospitals have a gap and there is variation across hospitals.

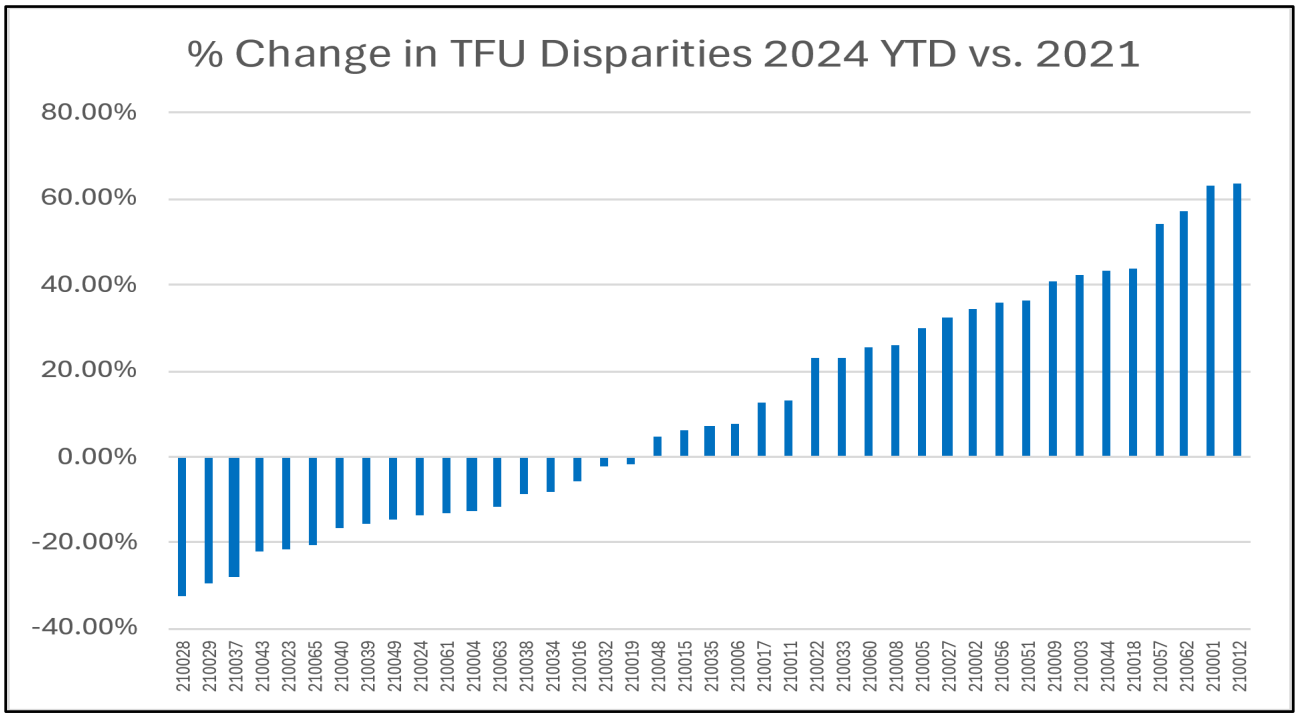
Figure 12. By Hospital TFU Disparity Gap, CY 2023



As illustrated in Figure 13 below, 18 hospitals have seen progress in the reduction of disparities in timely follow-up thus far in 2024 compared to 2021. However, 23 hospitals saw increases in their disparities with two hospitals seeing almost 60 percent increases. To continue incentivizing hospitals to improve on the

disparities experienced by their patients, staff proposes to continue use of this measure in the QBR program in the PCE domain. Because the overall goal is improvement and the performance metric is the percent change over time, this measure is assessed using the attainment methodology (i.e., we do not measure whether there was improvement on the change in the disparity gap, instead we measure whether or not the improvement made meets and/or exceeds the set performance standards). However, as stated above, staff proposes to use the change in the TFU disparity gap from 2018 to 2023, to prospectively set the attainment standards. The threshold and benchmark are to be calculated as the median percent and average for the top 10th percentile of performers respectively, on the change in disparities from CY 2018 to CY 2025 (consistent with how VBP calculates other performance standards).

Figure 13. By Hospital Improvements in TFU Disparity Gap, 2024 YTD vs 2021



Safety Domain

The QBR Safety domain contains five measures from six CDC NHSN HAI categories and the AHRQ Patient Safety Index Composite (PSI-90).[11] This domain is weighted at 30 percent of the total QBR score. In the FY 2026 VBP program, CMS added the Sepsis and Septic Shock Management Bundle

[11] For use in the QBR Program, as well as the VBP program, the SSI Hysterectomy and SSI Colon measures are combined.

(SEP-1), a measure that has been publicly reported on Care Compare since July 2018. However, staff proposed not adopting this measure in the QBR program based on stakeholder input, inclusion of sepsis mortality in QBR, and Maryland performance on sepsis. Instead, the staff proposed and has been working to finalize a Sepsis Dashboard that would allow the State and hospitals to monitor performance on a comprehensive set of measures for sepsis patients (see below for more details). Another difference between the VBP and QBR safety domain is that QBR has maintained the use of the AHRQ PSI measure rather than moving this measure to a standalone complications program, i.e., the MHAC program. While the Safety Domain will remain in the QBR program for RY 2027, consolidation of the Safety domain with the MHAC program may be considered for future years.

CDC NHSN HAI Measures

The CDCs National Healthcare Safety Network (NHSN) tracks healthcare-associated infections such as central-line associated bloodstream infections and catheter-associated urinary tract infections. Both Maryland and the Nation have seen increases in HAIs during CY 2020 and CY 2021 largely related to the COVID 19 pandemic, as was discussed in previous policies, and supported by peer reviewed research.[12]

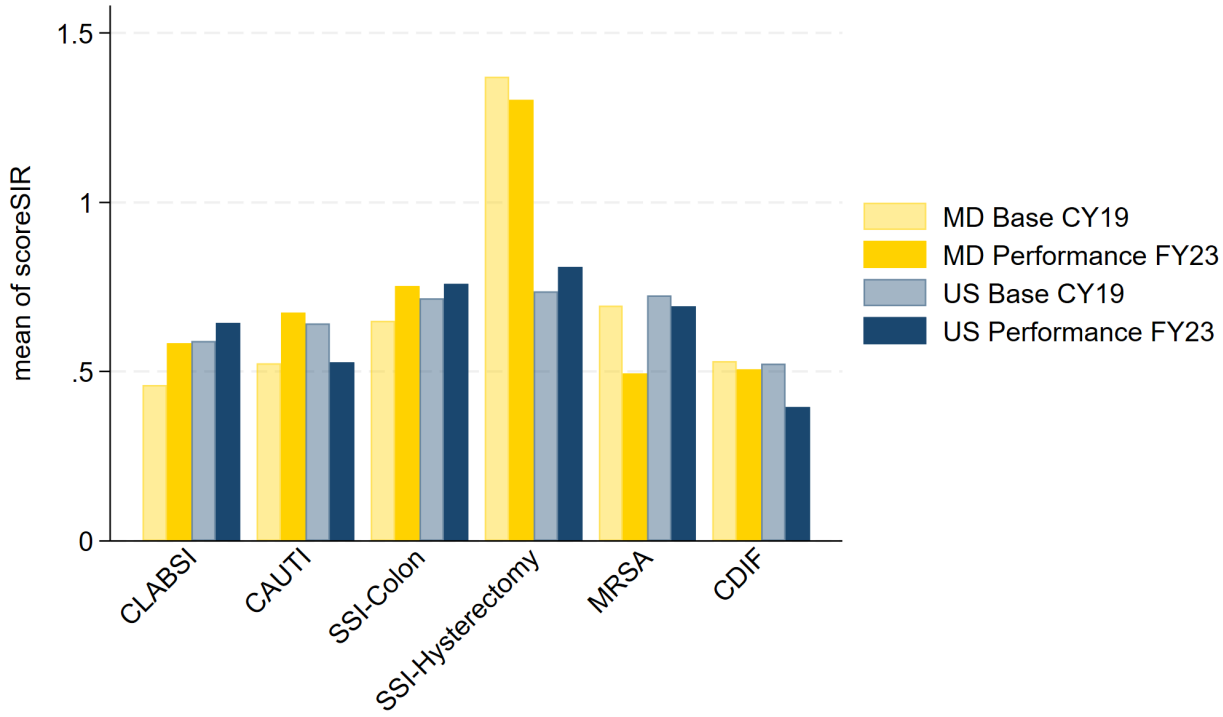
CMS Care Compare has updated the Healthcare Associated Infection Standardized Infection Ratio (SIR) data tables for the Nation and by state through June 2023. Figure 14 below shows how Maryland performs relative to the Nation, and how performance has changed over time for both Maryland and the Nation. For the most recent time period, Maryland's performance is similar to that of the Nation on SSI-Colon, worse (higher SIRs) on CAUTI, SSI-Hysterectomy, and C.Diff, and slightly better on CLABSI and MRSA. Nationally the SIRs got worse from the base period for CLABSI, SSI-Colon, and SSI-Hysterectomy, remained similar for MRSA, and improved for CAUTI and C.Diff. In Maryland, the SIRs got worse from the base period for CLABSI, CAUTI, SSI-Colon, remained similar for C.Diff, and improved for SSI-hysterectomy, MRSA. As noted previously, CMS has raised concern regarding Maryland's relatively high rate of Hysterectomy Surgical Site Infections; upon looking further into the data, staff notes State rates are impacted by relatively low numbers of events occurring at a small subset of hospitals that varied over time. For example, one hospital accounted for 30% of the SSI Hyst cases between 2018 and 2020.In reviewing the hospital's cases, they served a complex, high risk population including a large proportion of oncology patients that were not accounted for in the NHSN measure. Hospital interventions in partnership with the Maryland Dept of Health began in 2018 resulting in sustained low SIRs since 2021. Interventions included:

- Targeting Staff competency and education on vaginal and skin prep
- Pre-operative antiseptic cleansing by patient the night before and morning of surgery
- Updated antibiotic prophylaxis grid with follow up to providers for any fallouts
- Enhanced patient education regarding surgical site infection prevention
- Observations in the ER

[12] Lastinger, L., Alvarez, C., Kofman, A., Konnor, R., Kuhar, D., Nkwata, A., . . . Dudeck, M. (2022). Continued increases in the incidence of healthcare-associated infection (HAI) during the second year of the coronavirus disease 2019 (COVID-19) pandemic. *Infection Control & Hospital Epidemiology,* 1-5. doi:10.1017/ice.2022.116

- Hand hygiene observations in procedure areas
- ATP testing in the OR to ensure environmental cleanliness

Figure 14. NHSN SIR Values for CY19 compared to Q3 CY2022-Q2 CY2023, Maryland versus the Nation.



The CDC publishes an annual report that includes state specific performance on HAI measures that includes comparison of performance to the previous year as well as the statistical significance of the change;[13] Figure 15 below illustrates Maryland's change from CY 2021 to CY 2022 (the most current annual report published by CDC). The data reveal that Maryland's performance had statistically significant improvement (decrease) or unchanged performance on all HAI measure SIRs included in the QBR program.

[13]2022 National and State Healthcare-Associated Infections Progress Report found at: https://www.cdc.gov/healthcare-associated-infections/php/data/progress-report.html?CDC_AAref_Val=https://www.cdc.gov/hai/data/portal/progress-report.html, last accessed 8/15/2024

Figure 15. CDC Healthcare-Associated Infections Progress Report, Maryland SIRs, CY 2022 Compared to CY 2021

Maryland Changes in Statewide Stantardized Infection Ratios (SIRs) Between 2021 and 2022 for NHSN Acute Care Hospitals.					
	2021 SIR	2022 SIR	Percent Change	Direction of Change Based on Statistical Significance*	p-value
CLABSI	1.023	0.946	-8%	No change	0.2369
CAUTI	0.920	0.753	-18%	Decrease	0.0041
MRSA	0.941	0.767	-18%	No change	0.0566
CDI	0.645	0.57	-12%	Decrease	0.0056
SSI Hyst	1.368	1.185	-13%	No change	0.5265
SSI Colon	0.760	0.879	16%	No change	0.2512
*Percent SIR changes from 2021 to 2022 decreased for 5 of 6 categorie; the differences were statistically significant for 2 of the categories.					

The RY 2026 QBR policy finalized a slight reduction in the weight of the Safety domain from 35 percent to 30 percent compared to the VBP Safety domain weighted at 25 percent; staff is recommending maintaining the 30 percent domain weight in the RY 2027 policy. While the NHSN measures are used in the National VBP program, there are some concerns that have been raised about surveillance bias of these measures. Furthermore, the CDC is currently developing and piloting digital measures that, when broadly implemented, will help to address the concerns related to surveillance bias and also constitute less burden than current manual chart abstracted data collection efforts. See RY2023 QBR policy for additional discussion of NHSN surveillance bias concerns and assessment of Maryland performance.

Patient Safety Indicator Composite (PSI-90)

The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators were developed[14] and released in 2003 to help assess the quality and safety of care for adults in the hospital. PSI-90 focuses on a subset of ten AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PMWG noted previously that CMS removed the PSI-90 measure from the VBP program in FFY 2024 but retained the measure in the Hospital Acquired Conditions Reduction Program. Since Maryland does not have PSI-90 in the MHAC program, staff has recommended retaining the measure in the QBR program.

Maryland's statewide performance compared to the Nation on the PSI 90 Composite measure and the

[14] AHRQ contracted with the University of California, San Francisco, Stanford University Evidence-based Practice Center, and the University of California Davis for development. For additional Information: https://www.qualityindicators.ahrq.gov/Modules/psi_resources.aspx

individual measures within the Composite for FY 2022 and CY 2023 are summarized below and illustrated in Figures 16, 17 and 18.:

- On the overall PSI 90 composite measure, the State has improved.
- The State has improved with lower rates in CY 2023 compared to FY 2022 on the following PSIs:
    - PSI 08- In Hospital Fall and Fracture
    - PSI 06- Iatrogenic Pneumothorax
    - PSI 03- Pressure Ulcer
    - PSI 09- Perioperative Hemorrhage or Hematoma
    - PSI 13- Postoperative Sepsis
    - PSI 12- Perioperative Pulmonary Embolism or Deep Vein Thrombosis
    - PSI 11- Postoperative Respiratory Failure
- The State has worsened with higher rates on the following PSIs:
    - PSI 10- Postoperative Acute Kidney Injury with Dialysis (slight increase)
    - PSI 14- Postoperative Wound Dehiscence (slight increase)
    - PSI 15- Abdominopelvic Accidental Puncture or Laceration Rate

Figure 16. Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators, CY 2023 Compared to FY 2022 (July 2021-June 2022)

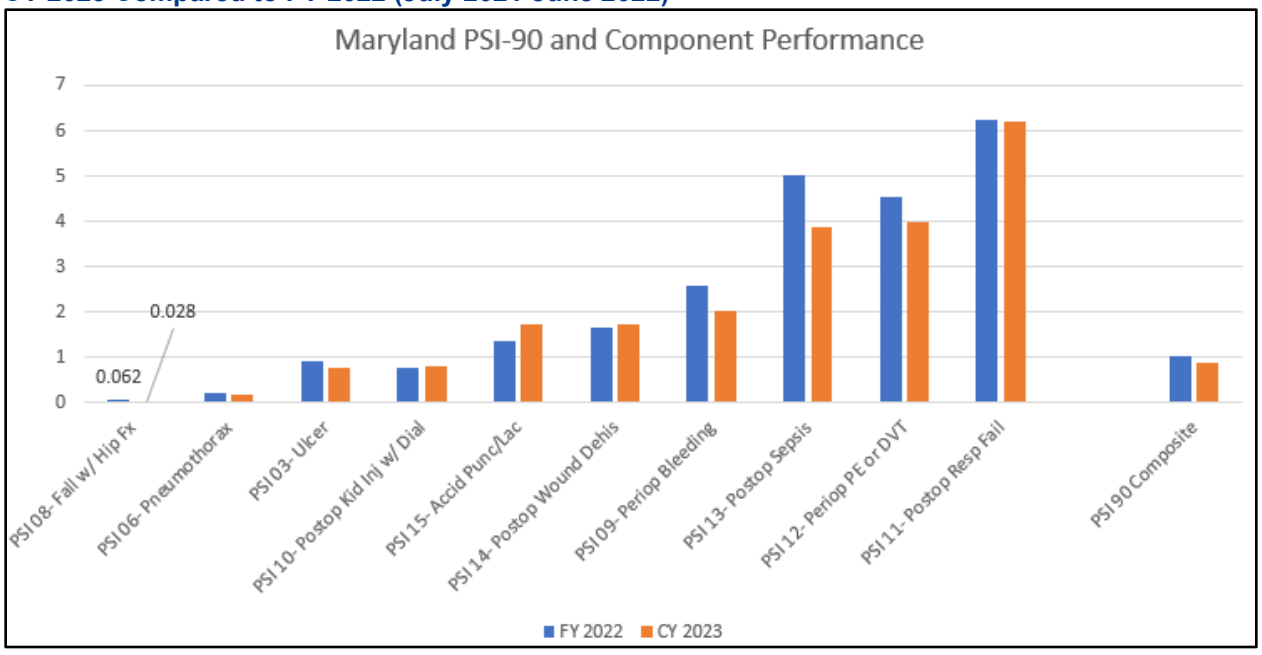
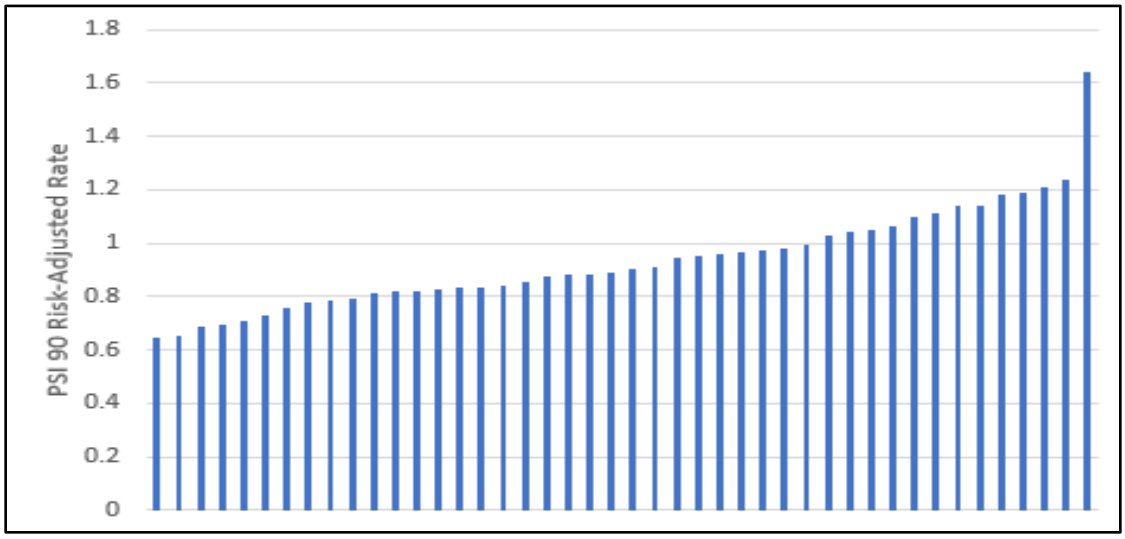


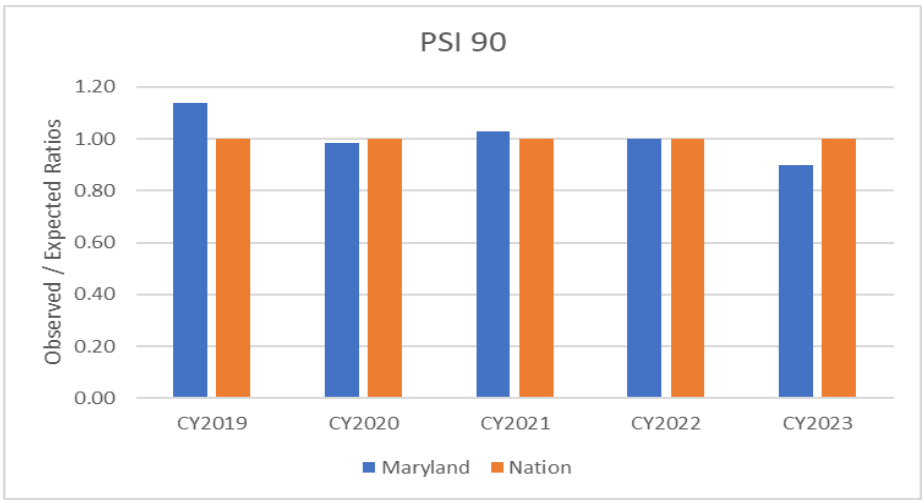
Figure 17 below illustrates the hospital-level performance on the all-payer PSI-90 composite measure for CY 2023; consistent with last year, the variation in performance by hospital suggests there may be opportunity for improvement on this measure.

Figure 17. PSI-90 Hospital-Level Performance, CY 2023[15]



The Agency for Research and Quality publishes all-payer risk-adjusted PSI 90 data by state and for the Nation using the hospital Healthcare Cost and Utilization Project (HCUP) data. Figure 18 below, indicates that Maryland has improved over time and performs better than the Nation based on the most currently available CY 2023 data.

Figure 18. Maryland vs. National Performance on PSI 90 Composite Measure, CY 19-CY 23[16]



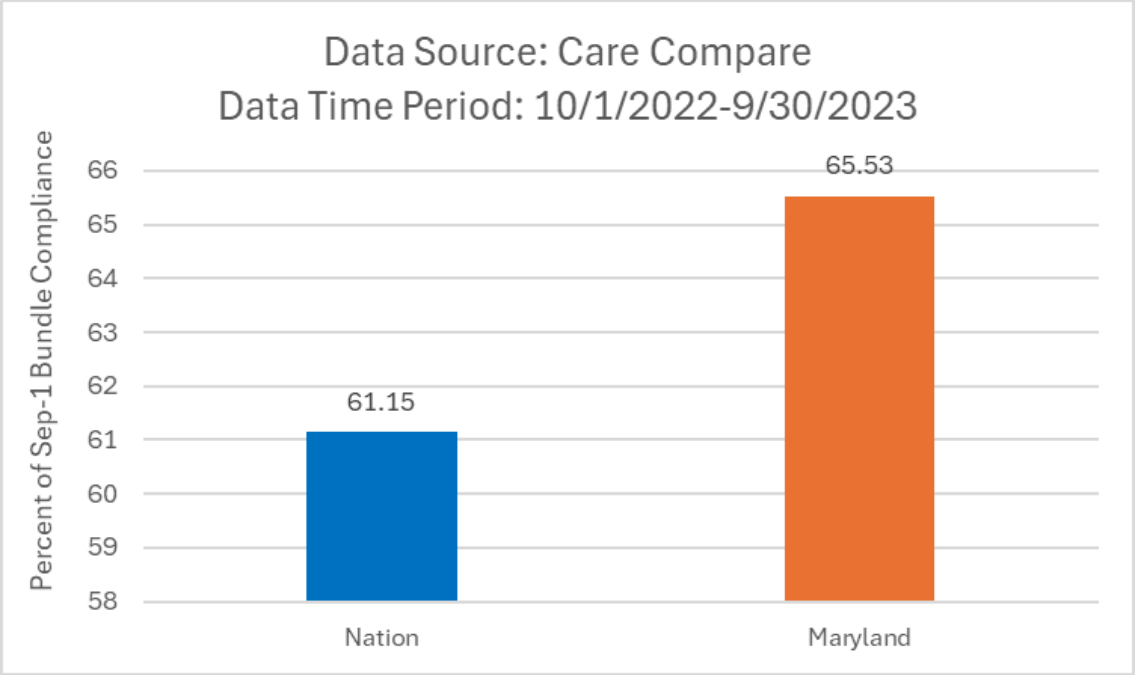
[15] Levindale Hospital performs the worst on the PSI-90 measure; their results are driven by poor performance on pressure ulcers. Given they have a longer length of stay than most acute care hospitals, they need to focus on quality improvement for pressure ulcers.

[16] Data provided by MHCC used for the Maryland Hospital Performance Guide published on the MHCC website.

Sepsis Early Management Bundle (Sep-1)

Medicare adopted the Sep-1 measure into the VBP program in FY 2026. However, in the RY 2026 QBR policy, the Commission approved the staff and stakeholder recommendation to *not* adopt the Sep-1 measure. Specifically, there were opposing views on the SEP-1 measure adoption for payment and given Maryland performed well on the measure, and includes the sepsis PSI, PPC, and sepsis mortality in the Maryland in its quality programs, the determination was made that instead of adopting the measure the HSCRC staff would develop and disseminate a hospital Sepsis Dashboard (discussed below). Given Maryland continues to perform well compared to the Nation on Sep-1 and Sepsis PSI, as illustrated in Figure 19 and Figure 20 below, the HSCRC staff still do not recommend adopting this measure.[17]

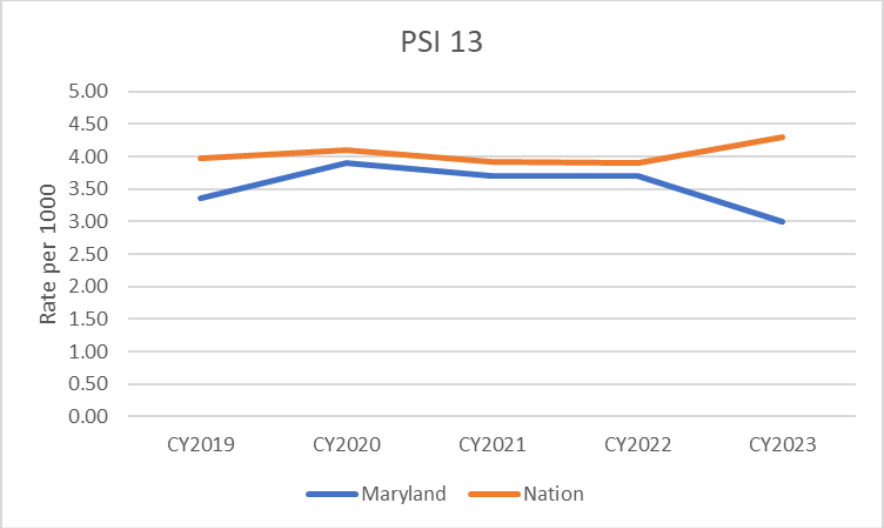
Figure 19. Maryland vs. the Nation, Sep-1 Early Management Bundle Measure



On PSI 13, Maryland has improved from FY 2021 to CY 2022 as noted in the PSI 90 section above; as shown in Figure 21 below, Maryland has performed consistently favorably compared to the Nation from CY 2019-2022.

Figure 20. PSI 13 Postoperative Sepsis, Maryland vs. the Nation 2019-2023

[17] See the RY 2026 QBR policy for additional information on the concerns with the Sep-1 measure.



Maryland Hospital-Level Sepsis Dashboard

Staff supports the continued monitoring of performance compared to the Nation along with other existing outcome measures that include PSI 13 postoperative sepsis complications, PPC 35 Sepsis acquired in the hospital, inpatient and 30-day mortality, and 30-day readmissions in a Sepsis Dashboard currently under development that will be disseminated through CRS portal by the end of the year. If performance deteriorates or concerns with the sepsis bundle measure are addressed, staff will reconsider its inclusion in QBR for future years. Finally it should be noted that in July 2024, the FDA announced that there is a shortage of blood culture vials from one of the main suppliers, and CMS has stated this may impact sepsis care, which this monitoring report may help us to identify.

Clinical Care Domain

This domain, weighted at 10 percent of the QBR score, currently includes:

- Inpatient, all-payer, all-condition mortality measure
- 30-Day all-payer, all-condition mortality measure

Of note, Maryland's QBR mortality measure currently differs from the CMS VBP Program that uses four condition-specific, 30-day mortality measures for Medicare beneficiaries. Medicare also monitors two additional 30-day mortality measures for Coronary Artery Bypass Graft (CABG) and Stroke (STK). In addition, the RY 2026 QBR policy removed the Inpatient Medicare Total Hip Arthroplasty-Total Knee Arthroplasty (THA/TKA) Complications measure with a proposal to monitor performance on the measure and consider alternative measures in the future such as the newly required THA-TKA patient reported

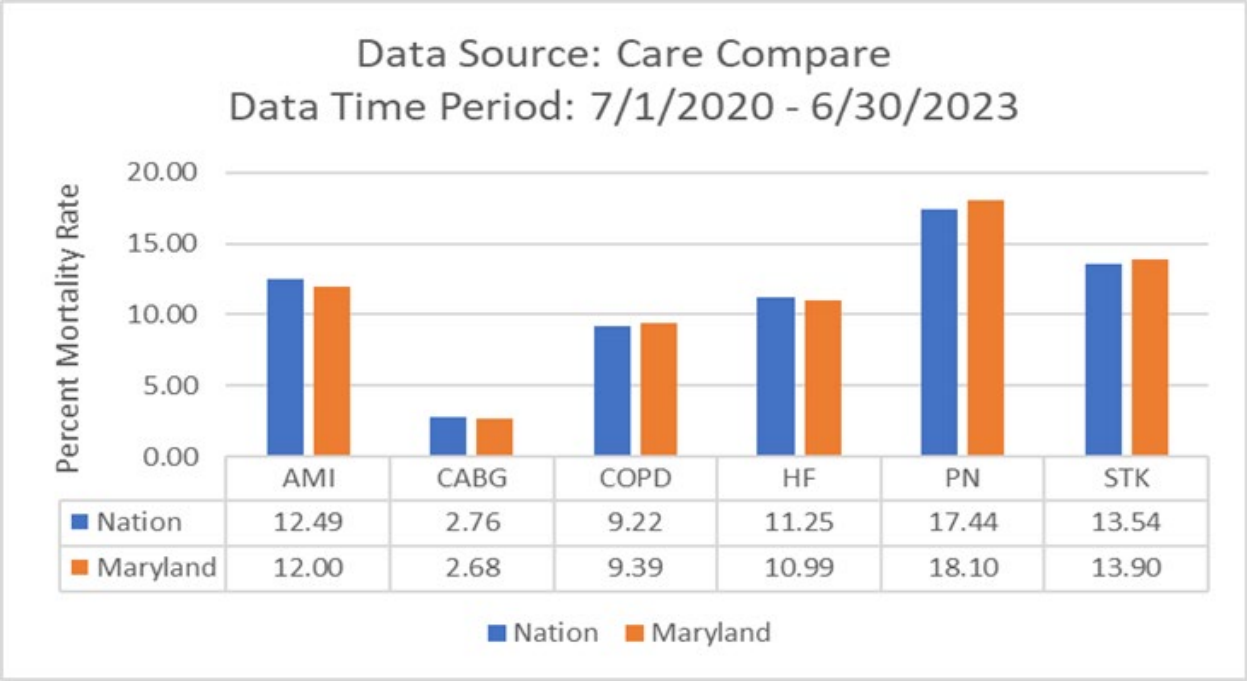
outcome measure. The data through March 2023, shows Maryland hospital performance is on par with the Nation for the THA/TKA measure.

Mortality

CMS 30-Day Condition-Specific Mortality Measures

On the CMS 30-day condition-specific mortality measures used in the VBP program, based on the most recently available data through June of 2023, Maryland performs essentially on par with the Nation (Figure 21). Specifically, Maryland performs slightly better on 30-day mortality for AMI, CABG, and HF, and slightly worse on COPD, PN, and Stroke.

Figure 21. Maryland vs. National Hospital Performance on CMS Condition-Specific Mortality Measures

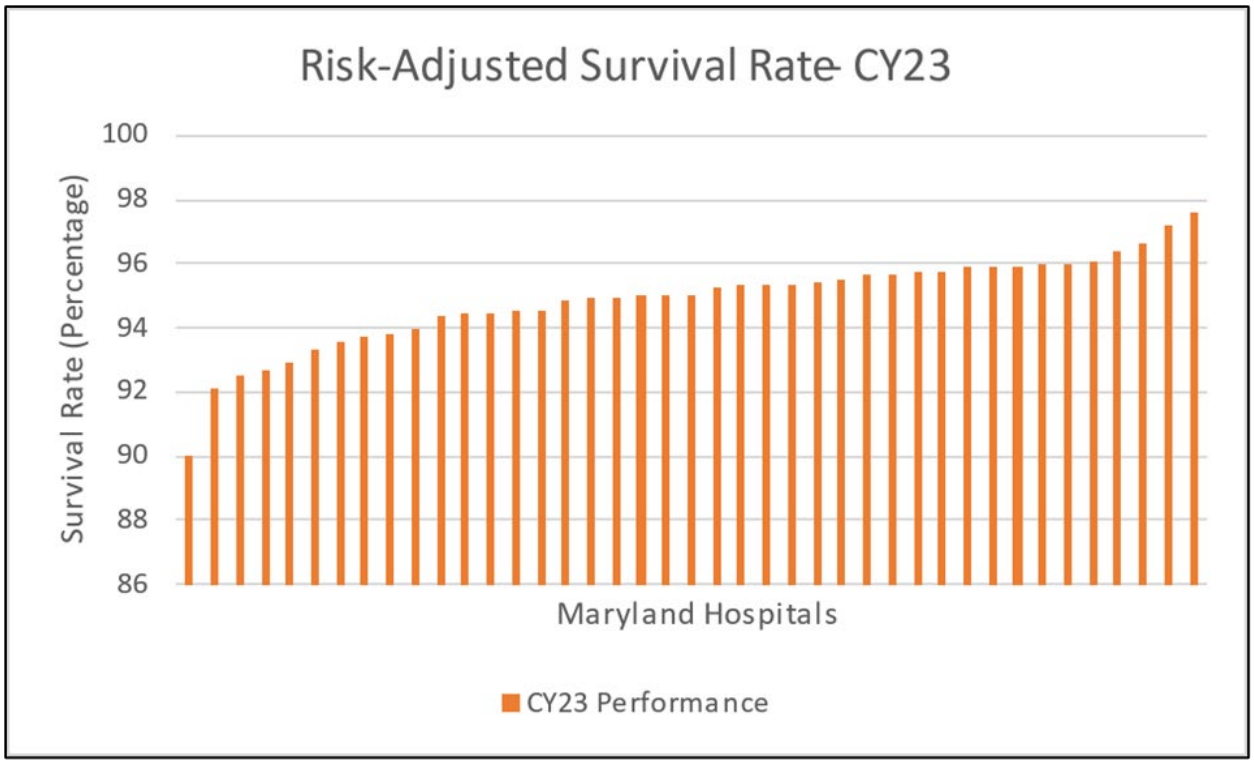


QBR Inpatient, All-payer, All-condition Mortality measure

For the QBR all-payer inpatient mortality measure, which assesses hospital services where 80 percent of the mortalities occur (80% DRG exclusion), the statewide survival rate decreased during the COVID PHE from 94.86 percent in CY 2019 to 93.55 percent in the CY 2022 performance period. In CY 2023, the statewide survival rate increased to 94.92 percent, on par with the pre-COVID PHE statewide survival rate in 2019. These mortality results were derived with a modified risk-adjustment model where COVID status during admission and percent of patients at the hospital with COVID were added to the regression model to better account for COVIDs impact on mortality. As illustrated in Figure 22 below, CY2023, all

hospitals perform above 90 percent.[18]

Figure 22. Maryland Hospital Performance, CY 2023 QBR Inpatient All Condition, All Payer Mortality Measure



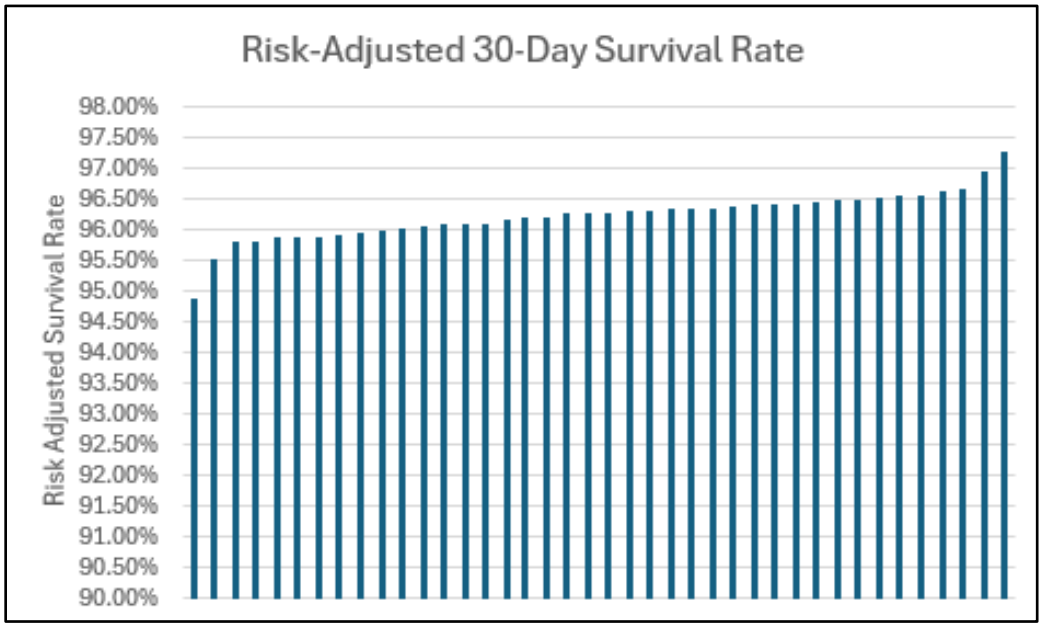
30-Day Inpatient, All-payer, All-condition Mortality Measure

HSCRC began reporting the 30-day, all-payer, all-condition, all-cause mortality measure to hospitals through the CRISP portal in CY 2023 and the measure was adopted into the RY 2026 program. For the CY 2023 performance period, as shown in Figure 23 below, survival rates range from 95 percent to 97 percent. Staff continues to support inclusion of the 30-day measure along with the inpatient measure to better capture the quality of care delivered by hospitals, and notes that these measures are not strongly correlated with one another. Staff also supports continuing to split the domain weight of 10 percent equally between the all-payer, all-cause, inpatient and 30-day mortality measures. In future years staff will further examine the correlation between inpatient and 30-day mortality and decide whether to fully move to the 30-day measure or maintain both measures if the inpatient measure is capturing different patients based on the 80 percent DRG selection. In the future staff may want to explore whether there is sufficient weight on mortality overall, given the significance of this outcome and because it is how we are assessing sepsis performance (as opposed to adding Sepsis bundle measure).

Figure 23. Maryland Hospital Performance, CY 2023 30-Day, All Cause All Condition, All Payer

[18] The lowest performing hospital is Ft. Washington followed by Atlantic General.

Mortality Measure



Last, as part of the digital measures initiative, staff plans to consider transitioning from the fully claims-based mortality measure to the hybrid 30-day mortality measure (claims plus Core Clinical Data Elements) in the future. In order to do this on an all-payer basis, electronic health record (EHR) vendors will need to be able to adapt measures specifically for Maryland's all-payer measurement environment, a difficult undertaking according to hospitals and EHR vendors providing feedback to staff.

Digital Measures Near-Term Reporting Requirements

In CY 2021 Maryland implemented statewide infrastructure and required all acute hospitals to report to HSCRC electronic Clinical Quality Measures (eCQM) measures beginning in CY 2022, with planned expansion to other digital measures going forward. The reporting requirements are more aggressive than the National CMS requirements in terms of measures, and the expectation for data submission after six months of performance and then quarterly two quarters of the performance year; by contrast, CMS requires annual data submission within one quarter following the performance year..

The State believes that more current digital data submission/availability strengthens hospitals' and the State's ability to use the data for quality tracking and improvement that is actionable. Further, the early adoption and migration to digital data and measures in general will ultimately constitute less burden for hospitals and the State. However, it is also important to note that some hospital stakeholders and Electronic Health Record (EHR) vendors have raised concerns regarding the State's expedited data submission timelines related to the timing of EHR vendor system measure updates and hospitals' implementation of the updates, and hospitals have in CYs 2023 and 2024 submitted Exceptional

Circumstances Exemption (ECE) requests for timeline extensions which have been granted on a case by case basis by the Commission. Staff has, therefore, updated its final recommendation to provide a positive incentive aligned with hospitals' estimated additional costs to meet Maryland's expedited timeline for data submission beginning in CY 2025; however, staff will also allow data submission in accordance with the CMS annual submission deadlines provided that hospitals notify the Commission in a timely manner (See Stakeholder Input and Staff Response section below). Figure 24 below illustrates the Maryland and CMS CY 2025 digital measure reporting requirements.

Staff notes that, in alignment with the State's goals to improve on maternal health and the SIHIS goal to reduce Severe Maternal Morbidity, the HSCRC required submission of the Severe Obstetric Complications measure beginning in CY 2022, a year ahead of CMS' requirement for hospitals to submit this eCQM; of note, beginning this year, staff has begun working with Medisolv and CRISP to develop risk adjustment for this measure so it may be used to compare hospital performance in the future. Also, through data/information sharing, staff will continue to collaborate with Maryland's Department of Health on this important population health improvement priority.

Figure 24. CMS-Maryland 2024- 2026 Digital Measures Reporting Requirements

Reporting Periods	CMS Measures	Maryland Measures
2024-2026	CYs 2024 and 2025 Three self-selected eCQMs; Three required eCMQs -Safe Use of Opioids -Cesarean Birth -Severe Obstetric Complications July 25-June 26 Core Clinical Data Elements for two hybrid measures for Medicare -30-day mortality -30-day readmissions	CYs 2024 and 2025 Two self-selected eCQMs Required eCQMs- -Safe Opioids -hypoglycemia -hyperglycemia -Cesarean Birth -Severe Obstetric complications July 2025-June 2026 Core Clinical data elements for two hybrid measure for all-payers July-June -30-day mortality -30-day readmissions

In addition to the eCQM reporting requirements, Maryland is also utilizing the established infrastructure to collect 30-day Hospital Wide Readmission (HWR) and Hospital Wide Mortality (HWM) hybrid measures required as of July 1, 2023. The State notes that subsequent transition to and adoption of an all-payer hybrid HWM measure will allow for its use in the QBR program.

Domain and Measure Weighting

Staff proposes to maintain the domain and measure weights adopted for RY 2026 to support the saliency of more recently added measures, e.g., ED Wait Times, Disparities in Timely Followup for the second performance year, as illustrated in figure 25 below. However, as noted previously, the HCAHPS top box measures will now only include 6 domains instead of 8 domains, and staff do not propose adjusting the weight overall. Furthermore, the linear measure weight will now be applied to only three domains (doctor, nurse, and medication communication).

Figure 25. RY 2026 and Proposed RY 2027 Domain and Measure Weights

RY2026 QBR Weighting (2% total at-risk)	Domain Weight	QBR Program Weight	IP Revenue at Risk (%)
PCE Domain		60%	1.20%
HCAHPS TopBox (8)	33.33%	20.00%	0.40%
HCAHPS Consistency	16.67%	10.00%	0.20%
HCAHPS Linear (4)	16.67%	10.00%	0.20%
ED Wait Times	16.67%	10.00%	0.20%
TFU Medicare	5.56%	3.34%	0.07%
TFU Medicare Disparity Gap	5.56%	3.34%	0.07%
TFU Medicaid	5.56%	3.34%	0.07%
Clinical Care Domain		10%	0.20%
IP Mortality	50.00%	5.00%	0.10%
30-Day Mortality	50.00%	5.00%	0.10%
Safety Domain		30%	0.60%
CAUTI	16.67%	5.00%	0.10%
C. Diff	16.67%	5.00%	0.10%
SSI (2)	16.67%	5.00%	0.10%
CLABSI	16.67%	5.00%	0.10%
MRSA	16.67%	5.00%	0.10%
PSI 90 (10)	16.67%	5.00%	0.10%

Revenue Adjustment Methodology

The revenue adjustments for QBR are calculated using a preset scale so that hospitals can prospectively and concurrently track financial performance in quality programs. In addition to determining the range of the scale, the cut point for penalties and rewards needs to be set such that it does not reward the highest performing Maryland hospitals for performance that is subpar compared to the nation. However, establishing this cut point prospectively has become more difficult to do over the course of the COVID-19 PHE. As mentioned previously, quality of care declined over the COVID-PHE in Maryland and nationally. Thus, the RY 2024 through RY 2026 policies indicated that the cut point would be reassessed retrospectively with more recent national data. For RY 2025, as discussed below, staff are proposing that the cut point be revised from 41 percent to 32 percent based on a simulation of how hospitals outside of Maryland would have performed under QBR. While a retrospective revision is inconsistent with the guiding principle to provide hospitals with a way to monitor revenue adjustments during the performance year, it protects Maryland hospitals from excessive penalties due to changes in performance post-COVID compared to national hospitals. Below is a discussion of the more recent analyses and a proposed new cut point for RY 2025, as well as updates and recommendations for RY 2026 through RY 2027.

RY2025 Update

As with RY 2024, staff reassessed the current preset scale for RY 2025 as was indicated in the policy. Based on an analysis that estimates how national hospitals would perform in the QBR program, staff are recommending to reduce the cutpoint to 32% from 41%. Staff estimated national hospitals' performance in the QBR program by applying QBR weighting to CMS/Care Compare measures and by using the average of MD hospitals' performance for MD-only measures. As noted previously, Appendix B documents how each hospital performs with the cut point of 41% and 32%. Statewide, revising the 41% cut point to 32% reduces penalties by about $33M and increases rewards by about $9M. While staff are recommending a reduction in the cut point to 32%, the definite cut point will not be determined until the final policy is passed by Commissioners.

RY2026 Update

As with RY 2024-2025, staff will reassess the current preset scale for RY 2026 as was indicated in the policy. Similar considerations will be examined as was done for RY 2024 and RY 2025; however, it should be noted that the performance standards for RY 2026 are post-COVID and thus the base periods are reflective of worse patient experience and quality of care. This could increase improvement points for performance that returns to pre-pandemic levels and lower attainment standards. Providing rewards or lower penalties for returning to pre-pandemic performance may be questionable. Thus, further discussion is needed amongst stakeholders once data is available to determine the best way to adjust the RY 2026 scaling. Furthermore, as discussed in the Stakeholder Feedback section, staff will work to provide a cut

point assessment with six months of national data (i.e., earlier in the year provide an estimate of change in cut point for hospitals).

RY2027 Revenue Adjustment Scale

For this policy, staff believe it is still important to have a preset method for taking scores and converting those scores to revenue adjustments on a prospective basis despite the concerns discussed above. Thus, for RY 2027, staff proposes to maintain the 0-80 percent scale where rewards start for those who score greater than 41 percent. As was done for RY 2024 and RY 2025 and will be done for RY 2026, staff will retrospectively assess the cut point with more recent data. However, unlike earlier RYs, the staff believes QBR scores may be on the rise since the performance standards are now set during the post-COVID time period. Thus, the cut point could decrease or increase with this retrospective assessment. As with RY 2026, staff will not use a single year of data to determine the cut point. Thus, staff proposes to maintain the current scale, but determine if the cut point needs to be amended once we have more recent complete data. If staff determines the cut point needs to be amended, we will report this to the Commission.

RY 2027 Modeling

Beginning in CY 2025, the VBP program is removing the domains Staff Responsiveness and Understood Post-Discharge Care from HCAHPS pending updates to these measures for future years. To understand how the removal of these domains impact MD hospitals' performance, staff have modeled RY 2027 scores using the most recent available data. In Figure 26 below, statewide descriptive statistics are provided using the 41 percent and 32 percent cut point. This modeling removes the HCAHPS domains Staff Responsiveness and Understood Post-Discharge care from TopBox, Linear, and Consistency measures and adds Communication about Medicines to the linear measures. The modeling also uses the RY2026 ED performance standards, which will be updated when final performance standards are established. Thus these are estimates based on historical data but indicate that the changes in the HCAHPS measures do not significantly change the overall QBR scores. Finally, these estimates do not include the proposed incentive of $150,000 per hospital for hospitals that comply with the State's expedited digital quality measures reporting submission timeline, totalling a potential maximum of $6M statewide (see Stakeholder Input and Staff Responses section below).

Figure 26. Estimated QBR Scores

Statewide Descriptive Statistics		
	RY27 Proposed Cutpoint: 41%	**Revised RY25 Cutpoint: 32%**
Mean Score	31.77%	31.77%
Median Score	30.33%	30.33%
Interquartile Range	12.81%	12.81%
Lowest Score; Revenue Adjustment ($)	17.67%	17.67%
Highest Score; Revenue Adjustment ($)	69.31%	69.31%
Statewide Net Estimated Revenue Adjustment ($); (%)	-$61,019,392; -0.55%	-$20,894,743; -0.19%
Statewide Net Estimated Penalties ($); (%)	-$62,627,302; -0.56%	-$32,234,567; -0.29%
Statewide Net Estimated Rewards ($); (%)	$1,607,910; 0.01%	$11,339,834; 0.10%

Stakeholder Input and Staff Responses

Staff have vetted this policy with the Performance Measurement workgroup. In addition, one comment letter was received from the Maryland Hospital Association (MHA) on the Draft RY 2027 QBR Policy on digital quality measures data submission requirements, and the QBR reward/penalty cut point. Additionally, Commissioner Joshi suggested analyzing the status of the reward/penalty cut point earlier in the year to signal whether an adjustment may be warranted.

Digital Quality Data Including Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE)

MHA strongly urged staff to reconsider the timeline to collect data for the development of electronic quality measure infrastructure, noting that hospitals have significant concerns about additional hospital staff burden and cost created by misaligned submission timelines between HSCRC requirements and the Centers for Medicare and Medicaid Services (CMS) requirements.

> **Staff Response:** Staff appreciates the input regarding the expedited reporting timeline. Staff continues to support the position that more current digital data submission/availability strengthens hospitals' and the State's abilities to use the data for quality tracking and improvement that is more timely and actionable. Further, the early adoption of and migration to digital quality measures reporting in general will ultimately constitute less burden for hospitals and the State. Staff notes that CMS incentivizes fully compliant reporting under the Inpatient Quality Reporting program (which encompasses the measures in the pay-for-performance programs as well as measures that are monitored). Staff reached out to hospitals and systems for input on estimated

additional incremental costs to meet Maryland's expedited reporting timeline and all-payer hybrid measure reporting requirements (including 1.Staff FTEs and salaries, 2. initial average up front costs that may be incurred after the initial years, 3.vendors, 4.IT-Related costs, and, 5.Other, e.g.,training/education, etc.). The estimated additional costs ranged between $100K and $200K per year. Based on this input, staff has updated its final recommendation for consideration by the Commission to provide a positive incentive that is aligned with hospitals' estimated additional costs of $150,000 per hospital to meet Maryland's expedited timeline for data submission, including Electronic Clinical Quality Measures and the Core Clinical Data Elements of the 30-Day all-payer Hospital Wide Readmission/Hospital Wide Mortality measures beginning in 2025 (see figure 27 below); however, staff will also allow data submission in accordance with the CMS annual submission deadlines provided that hospitals notify the Commission in a timely manner. Staff notes that the incentive for reporting should be sunsetted when the measures are adopted into pay-for-performance policies.

Figure 26. Digital Measures Expedited Data Submission Timeline

eCQM CY 2025 Performance Period		
Q1 2025 data	Open: 7/15/2025	Close: 9/30/2025
Q2 2025 data	Open: 7/15/2025	Close: 9/30/2025
Q3 2025 data	Open: 10/15/2025	Close: 12/30/2025
Q4 2025 data	Open:1/15/2026	Close: 3/31/2026
Hybrid Measures 30-Day All-payer HWR/HWM CCDE-July 2025 -June 2026 Performance Period		
Q3 2025 data	Open: 1/15/2026	Close: 3/31/2026
Q4 2025 data	Open: 1/15/2026	Close: 3/31/2026
Q1 2026 data	Open: 4/15/2026	Close: 6/30/2026
Q2 2026 data	Open: 7/15/2026	Close: 9/30/2026

RY 2025 QBR Reward/ Penalty "Cut-Point"

In MHA's letter, they noted their appreciation for HSCRC staff's plans to retrospectively adjust the RY 2025 QBR reward/penalty threshold ("cut-point") to 32%, in line with national performance which has significantly declined since the original cut-point (41%) was created using national averages. In addition, MHA and Commissioner Joshi have asked to have staff project national performance earlier in the year to track Maryland performance in a more timely manner. Further, if recent national performance trends continue, they would recommend permanently revising the cut-point going forward.

Staff Response: Staff appreciates the comments regarding the RY 2025 cut point and, going forward will retrospectively analyze national vs Maryland performance under the QBR program domain weights earlier in the performance period using six months of performance data, and will continue to analyze whether changes are needed in the future.

FINAL RECOMMENDATIONS FOR RY 2027 QBR PROGRAM

Final Recommendations for RY 2027 QBR Program:

1. Maintain Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent, Safety (NHSN measures) - 30 percent , Clinical Care - 10 percent.
    a. Within the PCE domain, weight the measures as follows:
        i. HCAHPS Top Box: 33.33 Percent
        ii. HCAHPS Consistency: 16.67 percent
        iii. HCAHPS Linear: 16.67 percent
        iv. Timely Follow-Up for Medicare: 5.56 percent
        v. Timely Follow-Up for Medicaid: 5.56 percent
        vi. Disparities in Timely Follow-Up for Medicare: 5.56 percent
        vii. Emergency Department Length of Stay: 16.67 percent
    b. Within the Safety domain, weight each of the six measures equally (i.e., 30 percent divided by number of measures).
    c. Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally(i.e., 10 percent divided by two measures).
2. With regard to monitoring reports to track hospital performance:
    a. Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.
    b. Disseminate Sepsis Dashboard.
    c. Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
3. Implement an HCAHPS learning collaborative with hospitals.
4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures; add a bonus incentive of $150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.
5. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    a. Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
    b. Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32% to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

APPENDIX A: QBR PROGRAM BACKGROUND

Maryland's QBR Program, in place since July 2009, uses measures that are similar to those in the federal Medicare VBP Program, under which all other states have operated since October 2012. Similar to the VBP Program, the QBR Program currently measures performance in Clinical Care, Safety, and Person and Community Engagement domains, which comprise 15 percent, 35 percent, and 50 percent of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85 percent), performance standards are the same as those established in the national VBP Program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR Program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the Nation by using national VBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR Program to correspond to the federal VBP Program, the HSCRC has increasingly emphasized performance relative to the Nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR Program began using national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which was measured by the national HCAHPS survey instrument to 50 percent. The weighting was increased to raise incentives for HCAHPS improvement, as Maryland has consistently lagged behind the Nation on these measures. In RY 2020, ED-1b and ED-2b wait time measures for admitted patients were added to this domain, with the domain weight remaining at 50 percent. In RY 2021, the domain weight remained constant, but the ED-1b measure was removed from the program. For RY 2022, ED-2b was removed from QBR because CMS no longer required submission of the measure for the Inpatient Quality Reporting Program.

The QBR domains and weights have remained constant from RY2023 to RY2025; modifications are proposed for RY 2026. Although the QBR Program has many similarities to the federal Medicare VBP Program, it does differ because Maryland's unique model agreements and autonomous position allow the state to be innovative and progressive. Figure A.1. below illustrates the QBR RY2025 measurement domains and weights compared with what is proposed for RY 2026 and the National VBP program.

Figure A.1. RY 2025 and Proposed RY 2026 QBR measures and domain weights compared with those used in the VBP Program

Domain	Maryland Proposed RY 2026 QBR domain weights and measures	Maryland Proposed RY 2027 QBR domain weights and measures	CMS VBP domain weights and measures
Clinical Care	**10 percent (-5% from RY 2025)** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	**10 percent** Two measures: all-cause, all-condition inpatient mortality; all-cause, all-condition 30-day mortality,	**25 percent** Five measures: Four condition-specific mortality measures; THA/TKA complications
Person and Community Engagement	**60 percent (+10% from RY 2025)** 10 measures: • Eight HCAHPS categories top box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0	**60 percent** 8 measures: • Six HCAHPS categories top box score and consistency, and four categories linear score; • TFU Medicare, Medicaid, disparities improvement; • ED LOS0	**25 percent** Eight HCAHPS measures top box score.
Safety	**30 percent (-5% from RY 2025)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**30 percent (-5% from RY 2025)** Six measures: Five CDC NHSN hospital-acquired infection (HAI) measure categories; all-payer PSI 90	**25 percent** Five measures: CDC NHSN HAI measures
Efficiency	n.a.	n.a.	**25 percent** One measure: Medicare spending per beneficiary

Note: Details of CMS VBP measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019. It involves (1) assessing performance on each measure in the domain; (2) standardizing measure scores relative to performance standards; (3) calculating the total points a hospital earned divided by the total possible points for each domain; (4) finalizing the total hospital QBR score (0–100 percent) by weighting the domains based on the overall percentage or importance the HSCRC has placed on each domain; and (5) converting the total hospital QBR scores into revenue adjustments, using a preset scale ranging from 0 to 80 percent.

QBR program revenue at risk

The HSCRC sets aside a percentage of hospital inpatient revenue to be held “at risk” based on each hospital’s QBR Program performance. Hospital performance scores are translated into rewards and

penalties in a process called scaling.[19] Rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The HSCRC previously approved scaling a maximum reward of 2 percent and a penalty of 2 percent of the total approved base revenue for inpatients across all hospitals.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP Program, where feasible,[20] enabling the HSCRC to use data submitted directly to CMS. Maryland implemented an efficiency measure outside of the QBR Program, based on potentially avoidable utilization (PAU). The PAU savings adjustment to hospital rates is based on the costs of potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality's Prevention Quality Indicators and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to develop updates to efficiency measure that incorporate population-based cost outcomes.

QBR score calculation

QBR scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as to the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period) and the benchmark (which is the mean of the top decile, or roughly the 95th percentile, during the baseline period).

Attainment points: During the performance period, attainment points are awarded by comparing a hospital's rates with the threshold and the benchmark. With the exception of the Maryland mortality measure and ED wait time measures, the benchmarks and thresholds are the same as those used by CMS for the VBP Program measures.[21] For each measure, a hospital that has a rate at or above the benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1–9 attainment points.

Improvement points: Improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below the

[19] Scaling refers to the differential allocation of a predetermined portion of base-regulated hospital inpatient revenue based on an assessment of hospital performance.

[20] VBP measure specifications can be found at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

[21] One exception is the ED wait time measures. For these measures, attainment points are not calculated; instead, the full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0–9 improvement points.

Consistency points: Consistency points are awarded only in the HCAHPS measure in the Experience of Care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain denominator adjustments: In certain instances, QBR measures will be excluded from the QBR Program for individual hospitals. Hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than one predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator is reduced from 50 to 40 possible points. If it is exempt from two measures, the Safety domain score denominator would be 30 possible points. Hospitals must have at least two of five Safety measures to be included in the Safety domain.

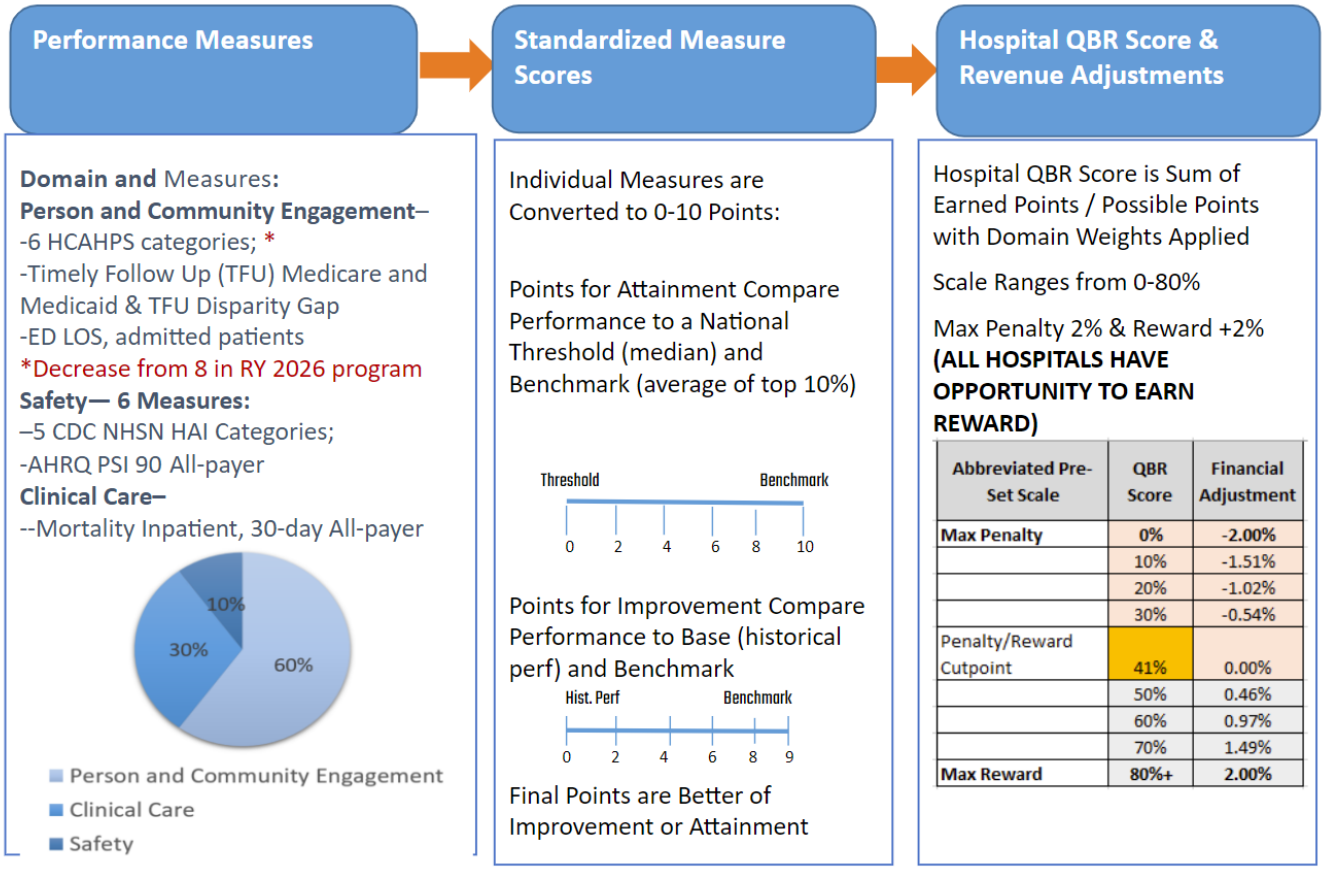
Domain scores: The better of the attainment score and improvement score for each measure is used to determine the measure points for each measure. The measure points are then summed and divided by the total possible points in each domain and multiplied by 100.

Total performance score*:* The total performance score is computed by multiplying the domain scores by their specified weights and then adding those totals together. The total performance score is then translated into a reward or penalty that is applied to hospital revenue.

RY 2023-RY 2027 Updates to the QBR Program

Since RY 2023, the HSCRC has not made fundamental changes to the QBR Program's methodology but implemented the addition of the Follow-Up After Acute Exacerbation of Chronic Conditions measure and PSI-90 composite measures. In RY 2025, Timely Follow Up (TFU) for Medicaid was added. In RY 2026, a measure of within-hospital TFU disparities reduction as well as the ED1-like measure was added and the domain weights were adjusted as follows: Patient and Community Engagement weight was updated to 60%, Safety weight updated to 30% and Clinical Care updated to 10%. Figure A.2. shows the steps for converting measure scores to standardized scores for each measure, and then to rewards and penalties based on total scores earned, reflecting the updates through RY 2026 (added the ED1 measure), and proposed for RY 2027 (no changes to domain weights from those of RY 2026, and decreasing number of HCAHPS sub-measures to six)..

Figure A.2. Proposed RY 2027 Process for Calculating QBR Scores



Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

Figure A.3. below details the baseline and performance timelines for the measures in the QBR program for RY 2027.

PSI 90 measure (adopted beginning RY 2023)

Newly adopted in RY 2023, the Patient Safety Indicator composite measure was developed by the Agency for Healthcare Research and Quality in 2003.[22] CMS first adopted the composite measure in the VBP program in FFY 2015 and removed the measure in FY 2019-FY 2022 due to operational constraints from the International Classification of Diseases, Tenth Revision (ICD-10) transition. The HSCRC had used the ICD-9 version of this measure in the QBR program but applied it to Maryland's all-payer population. CMS adopted the updated NQF endorsed ICD-10 version of the measure (Medicare only) that is used beginning with the FY 2023 Hospital VBP program[23] **,** and also adopted by the QBR program (all-payer version) in RY 2023.

AHRQ's specified PSI uses include:

- Assess, monitor, track, and improve the safety of inpatient care
- Comparative public reporting, trending, and pay-for-performance initiatives
- Identify potentially avoidable complications that result from a patient's exposure to the health care system
- Detect potential safety problems that occur during a patient's hospital stay

The discharge weighted average of the observed-to-expected ratios for the following subset of AHRQ's PSIs comprise the PSI-90 composite measure:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSII 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

[22] Source: https://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V2020/TechSpecs/PSI%2090%20Patient%20Safety%20and%20Adverse%20Events%20Composite.pdf.

[23] For more information on the measure removal and adoption, reference the FY 2018 IPPS/LTCH PPS final rule (82 FR 38242-38244) and (82 FR 38251-38256).

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected Patient Safety Indicators. The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each harm (for example, the outcome severity or the least-preferred states from the patient perspective).

The PSI 90 measure scores are converted to program scores, as described in the QBR Score Calculation section of this appendix.

Follow-Up After Acute Exacerbation for Chronic Conditions (adopted for RY 2023)

Newly proposed for RY 2023, this measure was developed by IMPAQ on behalf of CMS.[24] Technical details for calculating measure scores are provided below.

Measure full title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Measure steward: IMPAQ International

Description of measure: The percentage of issuer-product-level acute events requiring an ED visit or hospitalization for one of the following six chronic conditions: hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes mellitus (Type I or Type II), where follow-up was received within the time frame recommended by clinical practice guidelines in a non-emergency outpatient setting.

Unit of analysis: Issuer-by-product

Numerator statement: The numerator is the sum of the issuer-product-level denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for acute exacerbation of the following six conditions in which follow-up was received within the time frame recommended by clinical practice guidelines:

1. Hypertension: Within 7 days of the date of discharge
2. Asthma: Within 14 days of the date of discharge
3. HF: Within 14 days of the date of discharge

[24] Source: https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions

4. Coronary artery disease: Within 14 days of the date of discharge
5. Chronic obstructive pulmonary disease: Within 30 days of the date of discharge
6. Diabetes: Within 30 days of the date of discharge

Numerator details: This measure is defined at the issuer-by-product level, meaning that results are aggregated for each qualified insurance issuer and for each product. A product is defined as a discrete package of health insurance coverage benefits that issuers offer in the context of a particular network type, such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity. Issuers are broadly defined as health insurance providers who participate in the Federally Facilitated Marketplaces and health insurance contracts offered in the Medicare Advantage market.

Timely follow-up is defined as a claim for the same patient after the discharge date for the acute event that (1) is a non-emergency outpatient visit and (2) has a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be an office or telehealth visit and takes place in certain chronic care or transitional care management settings. The visit must occur within the condition-specific time frame to be considered timely and for the conditions specified in the numerator. For a list of individual codes, please see the data dictionary.[25]

The time frames for a follow-up visit for each of the six chronic conditions are based on evidence-based clinical practice guidelines, as laid out in the evidence form.

Denominator statement: The denominator is the sum of the acute events—that is, the issuer-product-level acute exacerbations that require an ED visit, observation stay, or inpatient stay—for any of the six conditions listed above (hypertension, asthma, heart failure, coronary artery disease, chronic obstructive pulmonary disease, or diabetes).

Denominator details: Acute events are defined as either an ED visit, observation stay, or inpatient stay. If a patient is discharged and another claim begins for the same condition on the same day or the following day, the claims are considered to be part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. The final claim of the acute event must be a discharge to community.

An acute event is assigned to [condition] if:

1. The primary diagnosis is a sufficient code for [condition].

[25] Please see https://impaqint.com/measure-information-timely-follow-after-acute-exacerbations-chronic-conditions.

OR

2. The primary diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].
    - If the event has two or more conditions with a related code as the primary diagnosis and a sufficient code in additional diagnosis positions, **assign the event to the condition with a sufficient code appearing in the "highest" (closest to the primary) diagnosis position**.

If the visits that make up an acute event are assigned different conditions, the event is assigned the condition that occurs last in the sequence. Following this methodology, only one condition is recorded in the denominator per acute event.

Denominator exclusions: The measure excludes events with:

1. Subsequent acute events that occur two days after the prior discharge but still during the follow-up interval of the prior event for the same reason; to prevent double-counting, the denominator will include only the first acute event
2. Acute events after which the patient does not have continuous enrollment for 30 days in the same product
3. Acute events in which the discharge status of the last claim is not "to community" ("left against medical advice" is not a discharge to community)
4. Acute events for which the calendar year ends before the follow-up window ends (for example, acute asthma events ending less than 14 days before December 31)
5. Acute events in which the patient enters a skilled nursing facility, non-acute care, or hospice care during the follow-up interval

Measure scoring:

1. Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (that is, codes identifying an acute exacerbation of one of the six included chronic conditions).
2. Exclusions are applied to the population from Step 1 to produce the eligible patient population (that is, the count of all qualifying events) for the measure.
3. For each qualifying event, the claims are examined to determine whether they include a subsequent code that satisfies the follow-up requirement for that event (for example, whether a diabetes event received follow-up within the appropriate time frame for diabetes, from an appropriate provider). Each event for which the follow-up requirement was satisfied is counted as

one in the numerator. Each event for which the follow-up requirement was not satisfied is counted as zero in the numerator.

4. The percentage score is calculated as the numerator divided by the denominator.

Measure-scoring logic: Following the National Quality Forum's guideline, we use **opportunity-based weighting** to calculate the follow-up measure. This means each condition is weighted by the sum of acute exacerbations that require either an ED visit or an observation or inpatient stay for all of the six conditions that occur, as reflected in the logic below.

[NUM(ASM) + NUM(CAD) + NUM(HF) + NUM (COPD) + NUM(DIAB) + NUM(HTN)] / [DENOM(ASM) + DENOM(CAD) + DENOM(HF) + DENOM (COPD) + DENOM(DIAB) + DENOM(HTN)]

Although the development team designed the measure to aggregate each condition score in the manner described above into a single overall score, programs may choose to also calculate individual scores for each chronic condition when implementing the measure. Individual measure scores would be calculated by dividing the condition-specific numerator by the condition-specific denominator, as in the example for heart failure: NUM(HF) / DENOM(HF).

The follow-up measure scores are converted to QBR scores, as described in the QBR Score Calculation section above.

Updated TFU Measurement Specifications CY 22025

Staff notes that the TFU measure specifications were updated in 2024 and were approved by the CMS-designated Partnership for Quality Measurement. The updated specifications will be adopted for the RY 2027 QBR program and include modifications in the follow up times for some conditions as illustrated below.

1. Hypertension: Follow up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
2. Asthma: Follow up within 14 days of the date of discharge
3. Heart Failure: Follow up within 14 days of the date of discharge
4. Coronary Artery Disease: Follow up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
5. Chronic Obstructive Pulmonary Disease: Follow up within 30 days of the date of discharge
6. Diabetes: Follow up within 14 days of the date of discharge for high-acuity patients

Digital Quality Measures Infrastructure: CMS Roadmap

Maryland is an early adopter of digital measure reporting and has established beginning in CY 2022 statewide infrastructure and reporting requirements, initially for monitoring; Maryland envisions transitioning to the use of digital measures in the QBR program as well as other quality-based payment programs when digital measurement has had sufficient development and implementation is feasible.

Over the past decade, CMS has led efforts to advance the use of data from electronic health records (EHRs) to enhance and expand quality measurement. However, accessing clinical patient data from EHRs for the purpose of quality reporting remains relatively burdensome. Additionally, CMS's current approach to quality measurement does not easily incorporate emerging digital data sources such as patient-reported outcomes (PROs) and patient-generated health data (PGHD). There is a need to streamline the approach to data standardization, collection, exchange, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, quality improvement, and learning.

Advancements in the interoperability of healthcare data from EHRs create an opportunity to dramatically improve quality measurement systems and realize creation of a learning health system. In 2020, the Department of Health and Human Services (HHS) finalized interoperability requirements in CMS's Interoperability and Patient Access final rule and in the Office of the National Coordinator for Health Information and Technology's (ONC's) 21st Century Cures Act final rule. Driven by the Cures Act's goal of "complete access, exchange, and use of all electronically accessible health information," these changes will greatly expand the availability of standardized, readily accessible data for measurement. Most important, CMS's and ONC's interoperability rules and policies require specified healthcare providers and health plans to make a defined set of patient information available to authorized users (patients, other providers, other plans) with no special effort using Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs). The scope of required patient data and standards that support them will evolve over time, starting with data specified in the United States Core Data for Interoperability (USCDI) Version 1, structured according to the Health Level Seven International (HL7®) FHIR US Core Implementation Guide (US Core IG).

Maryland, like CMS, believes that In the future, interoperability of EHR and other digital health data can fuel a revolution in healthcare delivery and advance Measure Calculation Tools to leverage data beyond just EHRs and across settings and providers. CMS has outlined a roadmap to transition from the current environment to a learning health system powered by advanced analytics applied to all digital health data to optimize patient safety, outcomes, and experience.[26]

[26] Please see full details on CMS Digital Quality Measurement Strategic Roadmap: https://ecqi.healthit.gov/sites/default/files/CMSdQMStrategicRoadmap_032822.pdf, last accessed 8/9/2022.

Figure A.3.QBR RY 2027 timeline: base and performance periods; financial impact

<table>
<tr><td>Rate Year (Maryland Fiscal Year)</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td><td>Q3-27</td><td>Q4-27</td></tr>
<tr><td>Calendar Year</td><td>Q1-22</td><td>Q2-22</td><td>Q3-22</td><td>Q4-22</td><td>Q1-23</td><td>Q2-23</td><td>Q3-23</td><td>Q4-23</td><td>Q1-24</td><td>Q2-24</td><td>Q3-24</td><td>Q4-24</td><td>Q1-25</td><td>Q2-25</td><td>Q3-25</td><td>Q4-25</td><td>Q1-26</td><td>Q2-26</td><td>Q3-26</td><td>Q4-26</td><td>Q1-27</td><td>Q2-27</td></tr>
<tr><td rowspan="3">Quality Based Reimbursement Program (QBR)</td><td colspan="8">Base Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td colspan="6">Performance Period: Hospital Compare (HCAHPS measures, All NHSN Measures)</td><td colspan="6" rowspan="3">Rate Year Impacted by QBR Results</td></tr>
<tr><td colspan="6"></td><td colspan="6">Base Period: QBR IP and 30-day Mortality, PSI-90, Timely Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td><td colspan="6">Performance Peirod: QBR IP and 30-day Mortality, PSI-90, Follow-up Chronic Conditions (Medicare, Medicaid and w/in Hospital Disparity Reduction)</td></tr>
<tr><td colspan="8"></td><td colspan="6">Base Period: Emergency Department Length of Stay (Admitted Patients)</td><td colspan="6">Performance Period: Emergency Department Length of Stay (Admitted Patients)</td></tr>
</table>

APPENDIX B: RY 2025 QBR PERFORMANCE BY HOSPITAL

Cut Point = 41%

HOSPID	HOSPITAL NAME	FY24 Estimated Permanent Inpatient Revenue	RY 2025 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 251,995,786	33.06%	-0.39%	-$982,784
210002	UMMS- UMMC	$ 1,473,072,120	24.60%	-0.80%	-$11,784,577
210003	UMMS- Capital Region	$ 309,492,831	29.79%	-0.55%	-$1,702,211
210004	Trinity - Holy Cross	$ 413,940,590	19.17%	-1.06%	-$4,387,770
210005	Frederick	$ 254,562,530	25.42%	-0.76%	-$1,934,675
210006	UMMS- Harford	$ 18,810,727	36.69%	-0.21%	-$39,503
210008	Mercy	$ 220,664,524	31.02%	-0.49%	-$1,081,256
210009	JHH- Johns Hopkins	$ 1,818,903,395	38.29%	-0.13%	-$2,364,574
210011	St. Agnes	$ 254,764,484	30.17%	-0.53%	-$1,350,252
210012	Lifebridge- Sinai	$ 519,012,883	11.75%	-1.43%	-$7,421,884
210015	MedStar- Franklin Square	$ 371,862,302	27.25%	-0.67%	-$2,491,477
210016	Adventist- White Oak	$ 242,890,872	27.85%	-0.64%	-$1,554,502
210017	Garrett	$ 28,988,189	65.15%	1.24%	$359,454
210018	MedStar- Montgomery	$ 96,052,028	37.60%	-0.17%	-$163,288
210019	Tidal- Peninsula	$ 350,375,491	27.67%	-0.65%	-$2,277,441
210022	JHH- Suburban	$ 249,484,035	17.46%	-1.15%	-$2,869,066
210023	Luminis- Anne Arundel	$ 367,930,454	25.83%	-0.74%	-$2,722,685
210024	MedStar- Union Mem	$ 267,917,283	38.60%	-0.12%	-$321,501
210027	Western Maryland	$ 183,379,829	38.88%	-0.10%	-$183,380
210028	MedStar- St. Mary's	$ 100,479,485	44.38%	0.17%	$170,815
210029	JHH- Bayview	$ 471,786,218	23.77%	-0.84%	-$3,963,004
210032	ChristianaCare, Union	$ 84,802,922	28.50%	-0.61%	-$517,298
210033	Lifebridge- Carroll	$ 162,844,959	35.42%	-0.27%	-$439,681
210034	MedStar- Harbor	$ 128,234,465	46.90%	0.30%	$384,703
210035	UMMS- Charles	$ 97,586,229	41.31%	0.02%	$19,517
210037	UMMS- Easton	$ 123,617,439	30.42%	-0.52%	-$642,811
210038	UMMS- Midtown	$ 140,418,656	33.15%	-0.38%	-$533,591
210039	Calvert	$ 80,925,064	56.94%	0.82%	$663,586
210040	Lifebridge- Northwest	$ 160,861,387	26.75%	-0.70%	-$1,126,030
210043	UMMS- BWMC	$ 325,584,009	32.15%	-0.43%	-$1,400,011
210044	GBMC	$ 263,774,655	28.25%	-0.62%	-$1,635,403
210048	JHH- Howard County	$ 220,287,562	27.50%	-0.66%	-$1,453,898
210049	UMMS-Upper Chesapeake	$ 236,862,562	29.75%	-0.55%	-$1,302,744
210051	Luminis- Doctors	$ 187,232,106	31.02%	-0.49%	-$917,437
210056	MedStar- Good Sam	$ 186,628,391	36.42%	-0.22%	-$410,582
210057	Adventist- Shady Grove	$ 333,973,100	26.08%	-0.73%	-$2,438,004
210060	Adventist-Ft. Washington	$ 37,782,970	18.39%	-1.10%	-$415,613
210061	Atlantic General	$ 47,434,007	39.33%	-0.08%	-$37,947
210062	MedStar- Southern MD	$ 210,921,411	25.58%	-0.75%	-$1,581,911
210063	UMMS- St. Joe	$ 292,568,045	37.42%	-0.17%	-$497,366
210065	Trinity - Holy Cross Germantown	$ 94,710,748	18.50%	-1.10%	-$1,041,818
	Statewide Total	**$11,683,416,741**			**-$64,389,900**

Cut Point = 32%

HOSPID	HOSPITAL NAME	FY24 Estimated Permanent Inpatient Revenue	RY 2025 FINAL Score	% Revenue Impact	$ Revenue Impact
210001	Meritus	$ 251,995,786	33.06%	0.04%	$100,798
210002	UMMS- UMMC	$ 1,473,072,120	24.60%	-0.46%	-$6,776,132
210003	UMMS- Capital Region	$ 309,492,831	29.79%	-0.14%	-$433,290
210004	Trinity - Holy Cross	$ 413,940,590	19.17%	-0.80%	-$3,311,525
210005	Frederick	$ 254,562,530	25.42%	-0.41%	-$1,043,706
210006	UMMS- Harford	$ 18,810,727	36.69%	0.20%	$37,621
210008	Mercy	$ 220,664,524	31.02%	-0.06%	-$132,399
210009	JHH- Johns Hopkins	$ 1,818,903,395	38.29%	0.26%	$4,729,149
210011	St. Agnes	$ 254,764,484	30.17%	-0.11%	-$280,241
210012	Lifebridge- Sinai	$ 519,012,883	11.75%	-1.27%	-$6,591,464
210015	MedStar- Franklin Square	$ 371,862,302	27.25%	-0.30%	-$1,115,587
210016	Adventist- White Oak	$ 242,890,872	27.85%	-0.26%	-$631,516
210017	Garrett	$ 28,988,189	65.15%	1.38%	$400,037
210018	MedStar- Montgomery	$ 96,052,028	37.60%	0.23%	$220,920
210019	Tidal- Peninsula	$ 350,375,491	27.67%	-0.27%	-$946,014
210022	JHH- Suburban	$ 249,484,035	17.46%	-0.91%	-$2,270,305
210023	Luminis- Anne Arundel	$ 367,930,454	25.83%	-0.39%	-$1,434,929
210024	MedStar- Union Mem	$ 267,917,283	38.60%	0.28%	$750,168
210027	Western Maryland	$ 183,379,829	38.88%	0.29%	$531,802
210028	MedStar- St. Mary's	$ 100,479,485	44.38%	0.52%	$522,493
210029	JHH- Bayview	$ 471,786,218	23.77%	-0.51%	-$2,406,110
210032	ChristianaCare, Union	$ 84,802,922	28.50%	-0.22%	-$186,566
210033	Lifebridge- Carroll	$ 162,844,959	35.42%	0.14%	$227,983
210034	MedStar- Harbor	$ 128,234,465	46.90%	0.62%	$795,054
210035	UMMS- Charles	$ 97,586,229	41.31%	0.39%	$380,586
210037	UMMS- Easton	$ 123,617,439	30.42%	-0.10%	-$123,617
210038	UMMS- Midtown	$ 140,418,656	33.15%	0.05%	$70,209
210039	Calvert	$ 80,925,064	56.94%	1.04%	$841,621
210040	Lifebridge- Northwest	$ 160,861,387	26.75%	-0.33%	-$530,843
210043	UMMS- BWMC	$ 325,584,009	32.15%	0.01%	$32,558
210044	GBMC	$ 263,774,655	28.25%	-0.23%	-$606,682
210048	JHH- Howard County	$ 220,287,562	27.50%	-0.28%	-$616,805
210049	UMMS-Upper Chesapeake	$ 236,862,562	29.75%	-0.14%	-$331,608
210051	Luminis- Doctors	$ 187,232,106	31.02%	-0.06%	-$112,339
210056	MedStar- Good Sam	$ 186,628,391	36.42%	0.18%	$335,931
210057	Adventist- Shady Grove	$ 333,973,100	26.08%	-0.37%	-$1,235,700
210060	Adventist-Ft. Washington	$ 37,782,970	18.39%	-0.85%	-$321,155
210061	Atlantic General	$ 47,434,007	39.33%	0.31%	$147,045
210062	MedStar- Southern MD	$ 210,921,411	25.58%	-0.40%	-$843,686
210063	UMMS- St. Joe	$ 292,568,045	37.42%	0.23%	$672,907
210065	Trinity - Holy Cross Germantown	$ 94,710,748	18.50%	-0.84%	-$795,570
	Statewide Total	**$11,683,416,741**			**-$22,280,907**

APPENDIX C: HCAHPS PATIENT LEVEL DISPARITY ANALYSIS

Maryland Health Care Commission Updated Patient-Level HCAHPS Analysis

Starting in CY 2022, MHCC requires that Maryland hospitals submit patient level HCAHPS data to them directly. This data collection investment was implemented by the State to address the ongoing HCAHPS performance concerns, with a focus that includes identifying disparities on HCAHPS ratings by patient demographics and service lines. MHCC analyzed the initial year of data and updated their analysis of surveys collected between July 2022 and June 2023. Findings were similar across both years. Highlights of the updated analysis are shown below.

- 30,653 surveys were included in the data set.
- White respondents are more highly represented than Black or other respondent categories relative to their proportion in Maryland's population from the 2020 Census.[27]
    - White-Comprised 74% of all responses and 49% of the population
    - Black- Comprised 21% of all responses and 26% of the population
    - Other- Comprised 6% of all responses and 22% of the population
- When collapsing "would recommend" categories into two, "No" = Definitely No/Probably No - 2,073 (7%), and "Yes" = Definitely Yes/Probably Yes – 28,580 (93%):
    - Maryland responses are similar to those of the Nation of 6% and 9 respectively..
    - More Black respondents than expected indicated the "No" category.
- When collapsing overall ratings into three categories: (1). 6 or lower, (2).7 or 8, and (3). 9 or 10:
    - Maryland responses are lower in the 9 or 10 category than the Nation.
    - There are relatively fewer White respondents and more Black respondents in the 6 or lower category.
- For the responses by service line in Maryland, there were 2,676 surveys within the Maternitycomprising 9% of the total, 17,217 surveys within Medical comprising 57% of the total, and 10,225 surveys within Surgical comprising 34%):
    - There are significant differences between Black and non-Black respondents for the Maternity service line:
        - For "would recommend", there were significantly more "No" reported by Black patients than expected.
        - For the Overall Rating, there were significantly more "6 or lower" reported by Black patients than expected

[27] Percents by race rounded up to full digit values.

For additional details on the MHCC analysis see below.

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Figure C.1. HCAHPS by Race Response Results, 2022 Q3 to 2023 Q2

Across Service Lines-Would Recommend			Maternity Service Line-Would Recommend		
	Yes	No		Yes	No
Black	92%	8%	Black	92%	8%
White	94%	6%	White	96%	4%
Other	93%	7%	Other	96%	4%

Maternity Service Line-Overall Rating			
	6 or lower	7 or 8	9 or 10
Black (n=417)	9%	26%	65%
White (n=1,873)	5%	24%	70%
Other (n=386)	6%	26%	69%

Maryland HCAHPS Exploratory Data

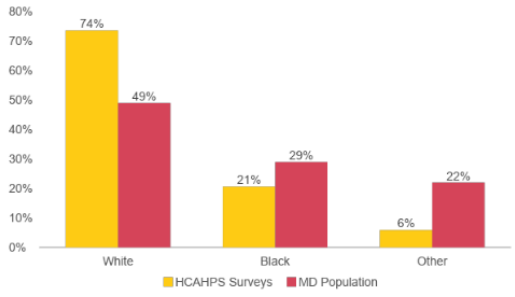
TITLE OF MEETING

NOVEMBER 2023

Background

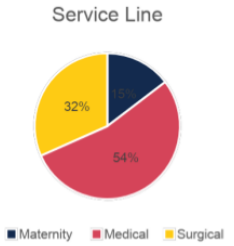
- MHCC began requiring detailed level HCAHPS data starting January 2022 (Q3 2021 discharges)
  - Joint memo with HSCRC
- Allows for more detailed analysis into race, ethnicity, service line, etc.
  - More timely
- More targeted approaches for quality improvement (e.g., patient populations, domains, etc.)

- Q3 2022 – Q2 2023 (30,653 surveys)
- MD population data from 2020 Census



Service Lines

- Denominator – 32,520
  - Maternity – 4,760 (15%)
  - Medical – 17,475 (54%)
  - Surgical – 10,285 (32%)

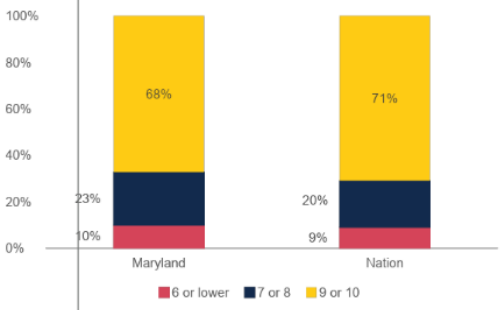


- Black & Other is higher in the maternity service line than medical and surgical

	Maternity (15%)	Medical (54%)	Surgical (32%)
White	56%	69%	75%
Black	31%	25%	20%
Other	14%	5%	5%

Overall Rating

- Collapsed Ratings 1-10
- Denominator – 30,653
  - 6 or lower – 2,963 (10%)
  - 7 or 8 – 6,966 (23%)
  - 9 or 10 – 20,724 (68%)



National data: Q2 2021-Q1 2022

- Chi-square test shows marginal differences in Overall Rating between races
  - Fewer white respondents, more black respondents in the 6 or lower category
    - White respondents: 2,108 versus 2,180 expected
    - Black respondents: 687 versus 610 expected

Overall Rating	Black 6,309	White 22,549	Other 1,795
6 or lower	687 11%	2,108 9%	168 9%
7 or 8	1,402 22%	5,144 23%	420 23%
9 or 10	4,220 67%	15,297 68%	1,207 67%

Maternity Service Line – Black Women

- Time period: Q3 2022 – Q2 2023 (30,653 surveys)
- Total Maternity Service Line Denominator – 2,676
  - Black – 417 (16%)
  - White – 1,873 (70%)
  - Other – 386 (14%)

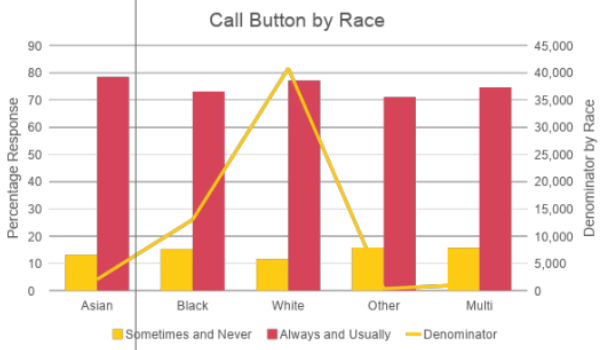
Would Recommend	Black 417	White 1,873	Other 386
No	34 8%	66 4%	16 4%
Yes	383 92%	1,807 96%	370 96%

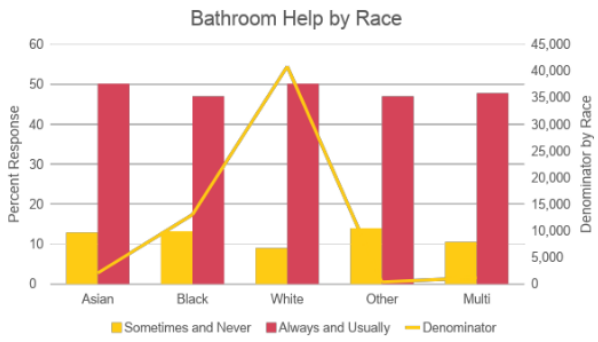
- Significant differences between black and othe races
  - Would Recommend – Significantly more "No" reported by black women than expected
  - Overall Rating – More "6 or lower" reported by black women than expected

Overall Rating	Black 417	White 1,873	Other 386
6 or lower	37 9%	94 5%	22 6%
7 or 8	108 26%	455 24%	99 26%
9 or 10	272 65%	1,324 70%	265 69%

Areas to Explore

- Areas related to communication are found to be sensitive to disparities (cite)
- Within the data set, the largest differences between Black and White respondents relate to Call Button Response and Bathroom Help, with a 4.01% and 3.17% difference between races, respectively





APPENDIX D: HCAHPS LEARNING COLLABORATIVE

Overview

The HSCRC Patient Experience HCAHPS Consultant will co-lead a Patient Experience/HCAHPS Learning Collaborative with the MHA.

This learning collaborative will include hospital leaders responsible for HCAHPS performance and reporting, operations leads, members of the HSCRC Quality leadership team, and representatives from the national survey administrators. The Collaborative will meet on a monthly basis and will be supported by staff from the HSCRC, with assistance from MHA and MHA members as appropriate.

The goal of the learning collaborative is to compile best practices to help Maryland hospitals improve patient experience and attain higher HCAHPS scores. The learning collaborative will accomplish this task by analyzing HCAHPS data, learning best practices from national organizations that consult hospital providers on improving patient experience, and through quality improvement initiatives using PDSA cycles.

The learning collaborative meetings will include level-setting knowledge of HCAHPS and how the survey is evaluated, learning best practices from survey vendors and MHA member hospitals, and presenting the results of a state-wide data analysis by the HSCRC team.

As a final work document, the learning collaborative will report findings to the HSCRC.

Work Plan and Timeline

July/August 2024 - Draft work plan presented and discussed with HSCRC leadership

September 2024 - Begin data analysis, have initial meetings with MHA leadership, and identify a co-chair from hospital leadership for the learning collaborative. The co-chair should be a champion who can both command and engage teams across all hospitals and have proficiency in quality improvement. This person should have specific qualifications and experience in conducting large scale quality improvement and an enthusiasm for the importance of patient experience.

September 2024 - Present to a HSCRC Commission meeting on the value and nuances of patient experience and the HCAHPS survey. Introduce the learning collaborative and larger effort to improve Maryland's performance.

October 2024 - Agree upon a work plan for the learning collaborative with the MHA.

November 2024 - Convene learning collaborative for the first time. Define goals and objectives.

December 2024 - Convene learning collaborative for data review with national survey vendors.

January 2025 - Convene learning collaborative for data review from the HSCRC/MHCC.

February 2025 - Convene learning collaborative to share best practices.

March 2025 - Convene learning collaborative to begin process improvement initiatives.

April - September 2025 - Facilitative sessions with the learning collaborative to share findings on improvement initiatives and develop final report.

August/September 2025 – Share findings with HSCRC and work with Performance Measurement Workgroup to assess QBR incentives to support best practices.

Schedule updates at Commission meetings throughout this process and at the conclusion of the report.

APPENDIX E: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994, including the Maryland General Assembly Hospital Throughput Work Group Final Report in March 2024.

Historically, the HSCRC has taken several steps to address emergency department length of stay concerns. However, in the past few years, the COVID public health emergency and its effects on inflation and labor have had particularly significant negative impacts on hospitals and other care settings that patients may use after receiving hospital care (e.g., nursing homes), further exacerbating pressures on emergency departments.

Previously, the HSCRC included ED LOS measures in the QBR program for two years. In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two CMS inpatient ED wait time measures (chart abstracted measures: ED-1 and ED-2) as part of the QBR Person and Community Engagement (PCE) domain because of the high correlation between ED wait times and HCAHPS performance (also in the PCE domain and on which the state also performs poorly). CMS retired ED-1 after CY 2018 and ED-2 after CY 2019 necessitating both measures' removal from the QBR program after only two years. Overall, ED LOS improved (i.e., ED LOS time went down) for more than half the hospitals when the measures were in QBR, although some of the improvements were minimal. With the retirement of the chart-abstracted ED LOS measures, the HSCRC continued to work to find a way to collect the data and include the results in QBR.

More recently, staff collaborated with CRISP and their contractor to collect the electronic Clinical Quality Measure (eCQM) ED-2 (Order of admission to admit time) for CYs 2022-2023. However, analyses of the ED-2 eCQM found that there are a significant number of hospitalizations (>50,000 statewide) that are dropped from the ED measure due to an exclusion for stays where the patient spends more than one hour in observation care. Furthermore, CMS discontinued this eCQM measure in CY 2024, rendering it not feasible for hospitals to continue to report the eCQM at this time for use in the QBR program.

To determine the direction for inclusion of an ED throughput measure in the RY 2026 QBR policy that would begin with CY2024 performance, the Commission considered several measurement options proposed by staff as well as other initiatives underway to address this issue going forward.

Ultimately, the Commission approved inclusion of ED 1-like measure in the RY 2026 QBR program to be finalized during CY 2024 and that would not require additional Commission approval. In working with ED Subgroup stakeholders in early 2024, staff selected a measure that mirrors the CMS ED1 measure, with

specifications aligned with those of The Joint Commission as much as possible; the initial measure collection and submission is through an ad hoc electronic data pull for all patients that will be submitted on an ongoing basis eventually through the existing HSCRC case mix data submission process; the initial ad hoc electronic data pull and submission includes data from CY 2023 to serve as the performance baseline period, and from January through March 2024. Hospitals will also provide an ad hoc submission in December that will correct any previously submitted data and provide data from April through September 2024; beginning with data from October 2024 going forward, the ED measure data elements will be included as part of the standard case mix submission process. The ED1 LOS measure captures the time of emergency department arrival to the time of physical departure from the emergency department for patients admitted to the facility. The population is all ED patients (pediatrics and adults) admitted to an inpatient (IP) bed and discharged from the hospital during the reporting period.

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

In June of 2023, Commissioner Joshi convened HSCRC, MIEMSS, MHA, and MDH to propose the EDDIE project with the goal of reducing the time patients spent in the emergency department, and pushed the HSCRC staff and MHA to begin this project immediately (i.e., not wait until next policy year) given the importance of this issue. The EDDIE project focuses on short-term, rapid-cycle improvement in ED patient experience by collecting and publicly reporting on ED performance data, and fostering a quality improvement process to address those metrics.

Specifically, starting in July 2023, hospitals are submitting data on measures that mirror the CMS ED 1 and OP 18 CMS measures on a monthly basis in accordance with an excel reporting template along with a memo provided by HSCRC staff that contains reporting instructions and high level specifications. The HSCRC has requested that the measures submitted be stratified by behavioral health based on initial ICD codes. Additionally, the HSCRC has developed a reporting process by which MIEMSS provides monthly reporting on EMS turnaround times by hospital. This will provide hospital accountability for improving efficiency in handoffs by EMS personnel, which will in turn improve EMS unit availability and decrease response times.

The HSCRC and MIEMSS are supporting this work by collecting and publicly reporting hospital ED wait times at monthly Commission meetings. The intent is to provide a mechanism for Commission monitoring of timely ED performance data that brings on-going attention to this issue through public reporting, provides an opportunity for the Commission to recognize and learn from high performers, and to track the hospitals performance improvement efforts relative to their aim statements. Once hospitals have submitted CY 2023 and CY 2024 patient level data, the staff will ask the Commissioners whether EDDIE data submissions are still needed.

Additional Initiatives: ED Potentially Avoidable Utilization

In CY 2021, Commissioners asked staff to evaluate expansion of potentially avoidable utilization (PAU) to emergency department utilization. Staff recommendations initially focused on high volume and low acuity chief complaint encounters (e.g., ear pain, dental problems) based on analysis of 2.4M ED observations with triage ratings. With workgroup/stakeholder vetting, this project was re-focused on multi-visit patients in the ED with >3 ED visits (statewide) in a 12-month period. A hospital monitoring program with reporting through CRISP has been established in CY 2023, with plans to consider a payment policy for CY 2025. A draft ED PAU policy will be presented at the November 2024 commission meeting.

Additional Initiatives: Legislative Workgroup

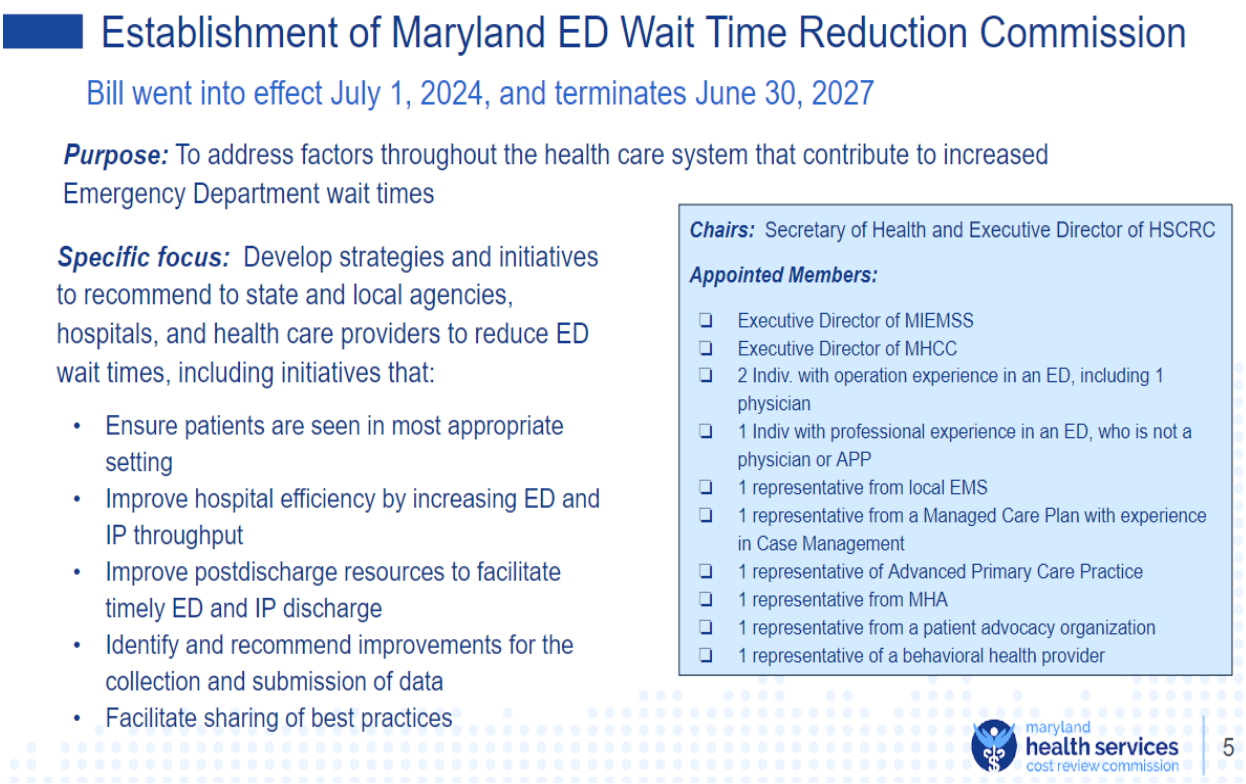
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2024. In response, MHA, with co-chair Dr. Ted Ted Delbridge, executive director of Maryland Institute for Emergency Medical Services Systems (MIEMSS), led a multi-stakeholder work group, the Hospital Throughput Work Group, aimed at making recommendations to improve the patient journey in Maryland.

Members included hospital representatives, legislators, the HSCRC, the MHCC, the state Department of Health, patient advocates and emergency department and behavioral health providers. The Task Force was charged with making legislative, regulatory and/or policy recommendations in a report. The Maryland General Assembly Hospital Throughput Work Group Final Report was submitted in March 2024. The HSCRC staff were an active participant in the Task Force and believe that inclusion of an ED length of stay measure in QBR will be consistent with any policy recommendations designed to improve ED length of stay and hospital throughput (i.e., a payment incentive should bolster performance improvement and not hinder other policy recommendations).

New Commission: Maryland Emergency Department Wait Time Reduction Commission

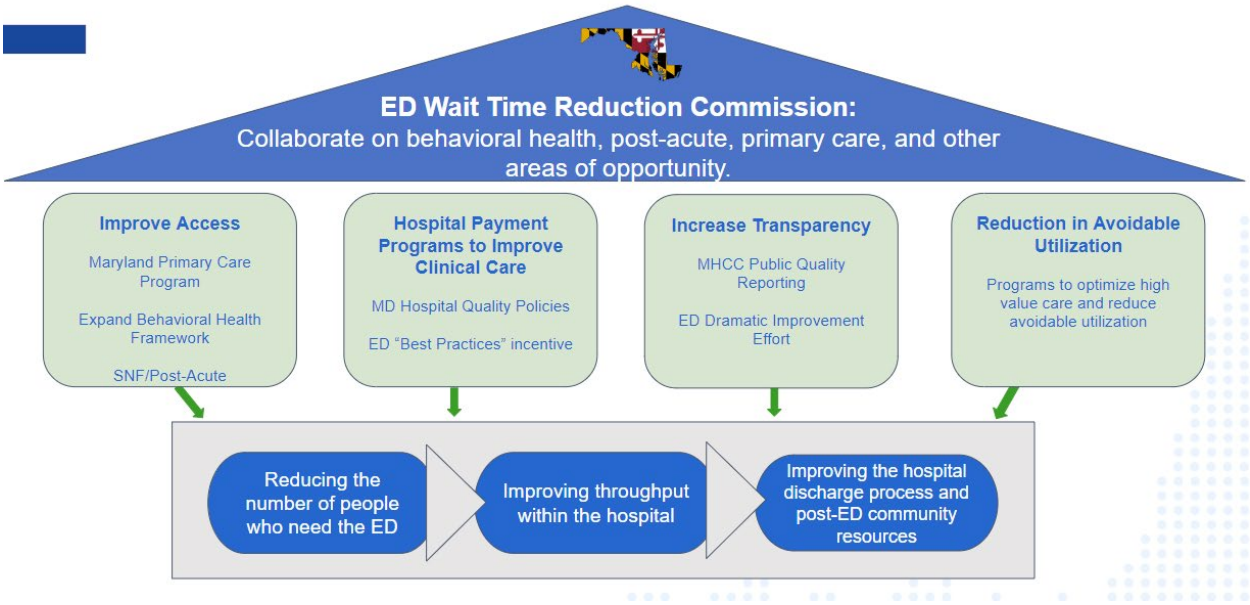
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and what types of members will be on the ED Commission.

Figure E1. ED Wait Time Commission Description



The ED Commission's work aligns with many of the current HSCRC policies and those under development. These policies, shown in Figure E2, are designed to address ED and hospital throughput by reducing the number of people who need ED services, improving ED and hospital throughput, and improving the hospital discharge process and community resources. The ED Commission will address state-level opportunities related to access and community-based services that impact ED wait times, such as access to behavioral health, post-acute/SNF beds, and primary care. The ED Commission will also support hospital best practices to address ED wait times and throughput across Maryland hospitals. The ED Commission members have been appointed and the first meeting is scheduled for the end of October.

Figure E2. ED Wait Time Commission and Other Initiatives to Reduce ED Wait Times



APPENDIX F: ED LOS MEASURE DEVELOPMENT AND MODELING

The slides below outline the development of the ED LOS measure

QBR Policy Approval and ED LOS Measurement Development Timeline

- 11/8/2023 QBR Draft Policy: Proposed options for inclusion of ED LOS measure
- 12/13/2023 QBR Final Policy: Approved inclusion of ED LOS measure at 10 percent weight
- Commission discussion:
  - QBR ED LOS Measure Development plan was proposed on January 10,2024
  - QBR ED LOS Measure Development Plan was reviewed on February 14, 2024
  - Commission meeting materials: Commission-Meetings (maryland.gov)
- Subgroup Meetings:
  - ED Subgroup 1 (Data): February 2nd, 2024, March 1st, 2024, April 12th,2024
    - ED LOS Data Submission Memo was sent via email to hospitals on May 20, 2024
    - ED LOS Data Submission Dates: Extended to September 13, 2024 (CY2023 and Jan-Mar 2024 data), December 16, 2024 (Apr-Sept data), March 2025 (Oct-Dec data)
  - ED Subgroup 2 (Incentive): April 26th, 2024, May 17th, 2024, June 21st, 2024, September 10, 2024
  - Meeting recordings and slides: Subgroup ED LOS Measure (maryland.gov)

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QBR ED LOS Incentive CY 2024

- Incentive measures improvement from CY 2023 to CY 2024
- **Measure:** Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital
- **Population:** All non-psychiatric ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
- **Scoring:** Use attainment calculation for percent change to convert improvement into a 0 to 10 point score (see next slide)
- **Data:** Ad hoc data submissions of time stamps to merge in with case-mix data
- **Statewide Goal:** TBD by ED Wait Time Reduction Commission

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Data Submission and Reporting Timeline

Tasks	Key Dates
Finalize ED-1 Measure specifications and algorithm	May/June 2024
1st Ad hoc submission window opens: Submit CY23 & Jan-Mar 2024 (15 months data)	July 2024
Release summary level statewide report on ED-1 median length of stay	September/October 2024
2nd Ad hoc submission window opens: Submit Apr-Sept 2024 (6 months data)	December 2024
Starting in Jan 2025 regular case-mix submissions will include ED-1 variables	January 2025
Final data submission (Oct-Dec 24) will use regular case-mix DSR that includes ED-1 variables	March 2025
Release summary level statewide report on ED-1 median length of stay	April/May 2025
Final RY26 QBR Revenue Adjustments	January 2026 (preliminary July 2025)

Should HSCRC try to collect CY2022 data?

Between 1st and 2nd ad hoc submissions, check data quality:

1. Data error checks
2. Match ad hoc data with Case-Mix data; provide match rate.
3. Revise DSR, if needed
4. Request statewide or hospital specific resubmissions

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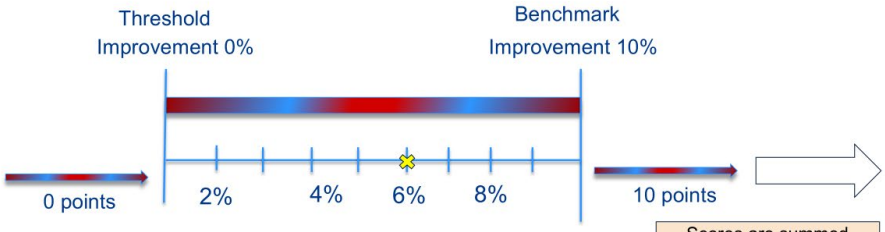
Ad-Hoc Data Submission Requirements (DSR)

Data Elements	Description	Rationale
Medicare Provider Number	Hospital Medicare ID	Required for matching
Medical Record Number	Patient's medical record number assigned by hospital	
Patient Account Number	Patient admission number	
From Date of Service	First day of patient encounter or visit	
Thru Date of Service	Date of patient discharge	
ED Arrival Date	Date patient arrived at ED (i.e., sign-in, pre-registration)	New Variables for ED-1
ED Arrival Time	Time patient arrived at ED (HHMM in military time)	
ED Departure Date	Date patient departed ED (i.e., physically left the ED)	
ED Departure Time	Time patient departed ED (HHMM in military time)	
Optional Variables		
Observation Status Date	EHR timestamp for when patient enters observation status; could be in or outside of the ED	To be able to examine impact of observation status on ED length of stay/boarding
Observation Status Time	EHR timestamp for when patient enters observation status; could be in or outside of the ED	
IP Unit Arrival Date	Date patient arrived at IP unit (HHMM in military time)	To be able to ensure we have data on total wait time if needed
IP Unit Arrival Time	Time patient arrived IP unit ED (i.e., physical arrive at unit)	

The next set of slides provide score modeling with the current proposal for performance standards.

QBR Scoring Example



Hospital Improvement = 6.0%
Calculates to a score of 6 out of 10

Scores are summed across QBR measures and weighted to get total hospital score

QBR Revenue Adjustment Scale

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

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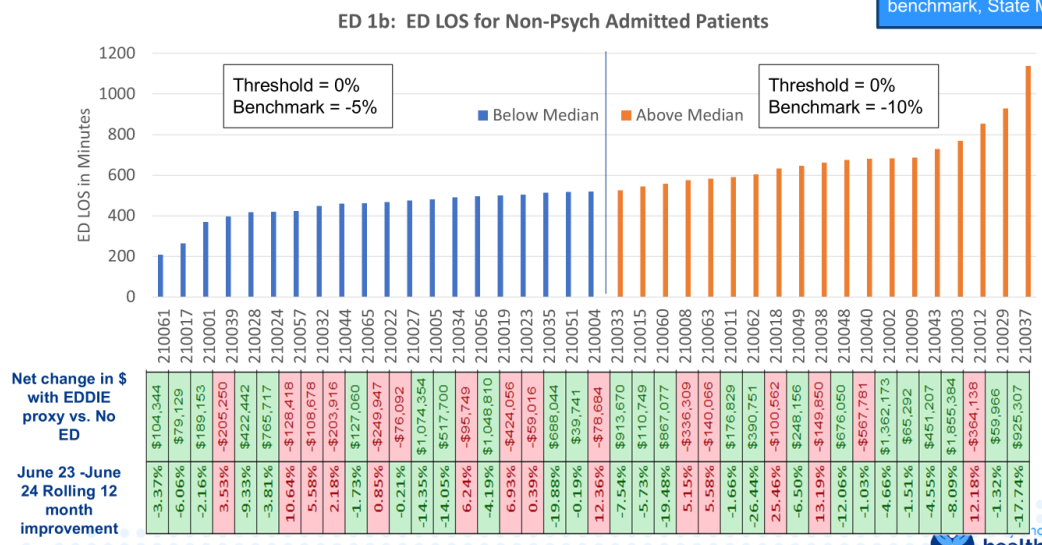
Current Proposal

Base State Median: 523

If all hospitals improve to benchmark, State Median: 491



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Medicare Performance Adjustment Calendar Year 2025

Draft Recommendation

December 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by December 23, 2024, to william.henderson@maryland.gov

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This document contains the staff draft recommendations for the Medicare Performance Adjustment for Calendar Year 2025.

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2025 and makes incremental improvements to the current policy and to the related MPA Framework.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.	This policy does not affect the rates paid by payers other than Medicare Fee-for-service. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

Recommendations For CY 2025 MPA Policy

This recommendation includes the following revisions to the Medicare Performance Adjustment (MPA) policy for calendar year 2025 (CY2025) to align with State and federal policy directives as well as feedback from the industry and other stakeholders:

1. Include non-claims-based-payments in the MPA savings target on a go-forward basis beginning in calendar year 2025 (CY 2025).
2. Revise the Care Transformation Initiative (CTI) offset distribution to reflect varying levels of opportunity for total cost of care reductions throughout the State. Make the revision effective for all hospitals effective July 1, 2025, but given the State's favorable savings position make the revision retrospectively for CTIs effective July 1, 2022, 2023, 2024 only for hospitals where the change would have a positive impact on total payments.

Otherwise, the relevant policies will remain unchanged from the prior year. Staff are recommending the limited changes described above to keep the MPA aligned with other State and federal policymaking. The following discussion provides rationale and detail on each of these recommendations.

However, in alignment with the new States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model Staff is proposing to undertake a more comprehensive review of the various MPA policies in 2025 for implementation in 2026 in conjunction with the start of the AHEAD model.

Introduction to MPA Policies

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components": (a) a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, (b) a Reconciliation Component, which rewards hospitals for the care redesign interventions and (c) a Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2025 (also known as MPA Year 7). The Efficiency and Savings Component are governed via the MPA Framework adopted by the Commission in October

2019[1] (as amended in the MPA Year 6 recommendation adopted last year). This MPA Year 7 recommendation includes an additional change to the MPA Framework. This policy does not relate to the Savings Component. These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount or inflator to the amount that Medicare pays on each claim submitted by the hospital.

Recommendations Related to the MPA Traditional Component

Recap of Current Program

The following recaps the traditional MPA as it was implemented for Calendar Year 2024, it is included as a reference. The approaches described were adopted incrementally in the Calendar Year 2021, 2022, 2023 and 2024 MPA policies, and those policies remain in effect except where changes are specifically denoted in the next section.

The first step in the process is to attribute beneficiaries to hospitals. The current attribution is as follows:

1. Hospitals, except Academic Medical Centers (AMCs) are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. AMCs are assigned all zip codes for Baltimore City for their geographic attribution. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.
2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
4. A second layer is added for AMCs. AMCs are also attributed where beneficiaries with a case-mix index (CMI) greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as to the hospital under the standard attribution. The AMC outcome becomes a blend of this approach and the standard geographic approach.

The MPA then penalizes, or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scaled the growth rate target for hospitals based on how expensive that hospital's service area is during the

[1] Available, starting on page 10, here: MPA Framework

baseline period relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below. This example covers 2019 to 2021, for each additional year another year of trend similar to item C in Table 2 is added. Each additional year is also adjusted for the Growth Adjustment Factor (item D in Table 2).

Table 2: Calculation of the MPA Targets

Variable	Source
A = 2019 TCOC	Calculation from attributed beneficiaries
B = 2020 National TCOC Growth	Input from national data
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)
E = MPA TCOC Target	A x (1 + B) x (1 + C - D) = E

Example Calculation of MPA Targets					
Hospital	**Quintile**	**Target Growth Rate**	**2019 TCOC**	**2020 MPA Target**	**2021 MPA Target**
Hospital A	1	3% - 0.00% = 3.00%	$11,650	$12,000	$12,359
Hospital B	2	3% - 0.25% = 2.75%	$11,193	$11,529	$11,846
Hospital C	3	3% - 0.50% = 2.50%	$11,169	$11,504	$11,792
Hospital D	4	3% - 0.75% = 2.25%	$11,204	$11,540	$11,800
Hospital E	5	3% - 1.00% = 2.00%	$10,750	$11,073	$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. Starting last year, as described below, the rewards and penalties were scaled such that the maximum reward or penalty was 2%, which will be achieved at a 6% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	(E - F) / E
H = MPA Reward or Penalty	(G / 3%) x 1%
I = Revenue at Risk Cap	Greater / lesser of H and + / - 2%

Example MPA Performance Calculations				
Hospital	**MPA Target**	**MPA Performance**	**% Difference**	**Reward (Penalty)**
Hospital A	$12,359	$12,235	-1.00%	0.33%
Hospital B	$11,846	$11,941	0.80%	-0.27%

Hospital C	$11,792	$11,556	-2.00%	0.67%
Hospital D	$11,800	$11,033	-6.50%	2.00%
Hospital E	$11,294	$11,859	5.00%	-1.67%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes, this is in addition to the revenue-at-risk for Total Cost of Care. These quality adjustments are derived from those in the Commission's all-payor Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program.

In the MPA Year 6 final recommendation, the Commission approved two changes to MPA policy beginning in 2024. MPA policy was revised to include an increase in the maximum revenue-at-risk as well as the addition of a population health measure to the quality adjustment included in the Traditional MPA. The amount of revenue-at-risk for Total Cost of Care performance under the Traditional MPA increased from 1% to ±2%. Increasing the revenue at risk under the MPA had been a stated goal of the Center for Medicare and Medicaid Services (CMS) for several years. The translation between actual results and the revenue-at-risk would not be changed from the current 3:1 ratio. Therefore, the revenue-at-risk would be reached at ±6%.

In addition to increasing the revenue-at-risk, MPA policy was revised to add a population health metric to the quality adjustment included in the Traditional MPA and include it in the Calendar Year 2024 and future MPA adjustments according to the formula below (adjusted for 2% revenue-at-risk):

TCOC results x 1/3 (capped at 2% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + Population Health Quality Measure) where the Population Health Quality Measure is scaled to generate a result of ±4%.

This formula will result in total revenue-at-risk of ±2.32% of Medicare payments.

Recommended Revisions to the Traditional MPA - Include Non-Claims-Based Payments

On November 13, 2024, the Commission approved a retroactive adjustment to correct the MPA savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments (NCBPs) resulting in a one-time increase to hospital rewards estimated at approximately $22.0 M from Medicare only, through Calendar Year 2023.

Staff recommend replicating this adjustment in the MPA savings target on a go-forward basis beginning in calendar year 2025 (CY 2025) consistent with the approach the Commission already adopted for prior years.

Primary care programs such as the Maryland Primary Care Program (MDPCP) have always been included in MPA scoring with data available monthly that can be attributed at the beneficiary level. However, other value-based programs have not been included in the MPA scoring, to date. The lack of NCBP data for other programs penalizes Maryland results as these programs are more significant outside Maryland. Previously these programs have not been factored into the MPA savings calculation as the data was not uniformly available, is only reported quarterly, and is not at a beneficiary specific level. However, Staff now believe the data is sufficiently complete to incorporate these programs into the MPA target.

Recommendations Related to the MPA Framework Reconciliation Component

Recap of Current Program

In the MPA Framework recommendation Staff noted that under GBRs hospitals do not capture utilization savings that occur outside their GBR and therefore any successes they achieve help the State meet the TCOC Model savings target but do not help the hospitals. The Commission adopted the MPA Framework recommendation and implemented the CTI program as a response to this disconnect. The recommendation noted the following principles to strengthen hospital incentives:

- Hospitals should keep the savings from their CTIs up to 100% to the extent feasible.
- Incentives should be structured to reward participation in CTIs and penalize non-participation.
- New and Existing CTIs that transform care across the entire delivery system should be supported.

The Framework also included the use of the MPA-RC to pay incentives earned under CTIs and to offset those incentives by reducing Medicare Fee-for-service payments to all hospitals to create a net zero adjustment (the Offset). This approach was adopted as per the Staff's October 2019 Final MPA Framework Recommendation, "First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being penalized for their non-participation. Additionally, the Offset incents participation in care redesign by encouraging participation through limited downside risk and minimizing administrative barriers. In December of 2023 (MPA Year 6 recommendation), the Framework was amended to include a cap on the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

Recommended Revisions to the MPA Framework Reconciliation Component

"Improvement Only" Aspects of CTIs

Under CTIs, all scored savings that are paid out are offset by reducing payments to hospitals by an equal amount on a pro rata basis based on Medicare FFS spending at each hospital. Dissavings after the initial offset are limited to 2.5% of Medicare FFS payments with all eliminated savings shared back across all facilities in proportion to Medicare FFS payments (the initial redistribution and stop loss application and further redistribution are collectively known as the CTI Offset). The CTI Offset was intended to (1) provide value for hospitals generating care transformation savings while maintaining savings to CMS, (2) prevent a free rider syndrome by "taxing" hospitals that choose not to participate in care redesign or are ineffective, and (3) incent participation in care redesign by encouraging participation through limited downside risk and minimizing administrative barriers. In addition to CTI payments, hospitals benefit from CTI initiatives that reduce hospital utilization via their GBR, although some of this accrues to hospitals other than the CTI owner.

Stakeholders have raised a concern that the CTIs and the CTI Offset is "improvement only" and disproportionally "taxes" hospitals with lower total cost of care management opportunity and that the Commission should revisit the "improvement only" nature of CTIs in the offset to better recognize regional differences. Two aspects of the design make CTIs an "improvement only" program:

(1) CTI rewards improvement against a hospital's own baseline, therefore hospitals in lower cost areas have less opportunity.
(2) The CTI Offset is allocated in proportion to total Medicare spend and therefore does not recognize the varying opportunity. For example, if region A and region B are the same size and region A has 3% opportunity and region B has 6% then Region A has 33% of the upside but bears close to 50% of the risk under the offset redistribution.

Under the Traditional MPA the Commission has already recognized the varying levels of opportunity through the tiered targets described above and this design was adopted to create a policy that blends improvement and attainment aspects.

Proposed Change

Staff do not wish to remove all incentives for all hospitals statewide to improve care delivery but also want to recognize that all areas of the State do not have equal opportunity. It is not technically feasible to fairly

change the first "improvement only" aspect of the program – measuring success against a hospital's own baseline - therefore Staff focused on changes to the CTI Offset. Working with stakeholders Staff developed a number of potential approaches to incorporate an attainment aspect into the CTI Offset. Staff sought to balance fairness, complexity and effectiveness in evaluating these approaches. Staff also believe a relatively mild change is justified in this revision to allow evaluation of the impact across more periods, Staff would be open to revisiting this and other CTI Offset aspects in conjunction with the full review of MPA policies next year.

Based on these considerations Staff is recommending the stop loss applied during the offset be tiered in a way that mirrors the Traditional MPA Scaled Growth Adjustment. This will provide greater protection for hospitals with less opportunity without eliminating the incentive for all hospitals to drive savings. Table 4 shows the proposed tiers (currently all hospitals are subject to a 2.5% stop loss).

Table 4: Scaled Stop Loss Tiers

Hospital Performance vs. Benchmark	Proposed Stop Loss
1st Quintile (-15% to + 1% Relative to Benchmark)	1.250%
2nd Quintile (+1% to +10% Relative to Benchmark)	1.875%
3rd Quintile (+10% to +15% Relative to Benchmark)	2.500%
4th Quintile (+15% to +21% Relative to Benchmark)	3.125%
5th Quintile (+21% to +28% Relative to Benchmark)	3.750%

Modeling using Year 2 CTI adjustments showed this change would have had the impact of shifting approximately $5 million from the highest cost quintiles to the lowest cost quintiles. Although as the portfolio of CTIs implemented changes each year the actual future impact could be less or more. However, consistent with stakeholder feedback that changes should not be applied to periods that have already been implemented Staff recommend implementing this change for CTIs starting July 1, 2025.

Staff believe that tiering the offset as described above is appropriate policy but does not wish to retrospectively change the rules applied resulting in the recommendation above being limited to CTIs initiated in the future.

As documented in the November 2024 Recommendation to the Commission regarding NCBPs, the State is currently generating significant savings beyond target as a result of the efforts of all stakeholders to drive performance under the model. Staff believe that allowing some amount of these savings to be returned to hospitals is appropriate, where a policy basis exists. Therefore, Staff is also recommending that the change above be applied to CTIs initiated in July 2022, 2023, and 2024 (CTI Years 2 through 4) retrospectively but only to hospitals where the change will result in a higher payment to the hospital. This

will take advantage of the extras savings for hospitals who had more limited TCOC opportunity, without penalizing hospitals who acted in good faith based on the prior policy. Using the Year 2 results as a proxy this will be worth approximately $15 million on a one-time basis. This change will be implemented for each year at the time the impact can be calculated.

Discussions of Comments Received

Background

As with all recommendations, this draft recommendation was developed with substantial community input including ideas and commitments resulting from prior recommendations, a series of specific workgroups and ongoing dialog with stakeholders. However, a formal comment period and Staff discussion of those responses is usually held for the final recommendation. Staff departed from this practice for this draft recommendation because this recommendation will be the basis for requesting approval from CMS for the MPA Policy, as required under the TCOC Model Agreement. Should CMS not approve the approach outline herein those changes will be addressed in the Final Recommendation.

In addition to discussion during the workgroups, Staff held two more formal comment submission periods during the workgroup process, one prior to the October 23 and 30, 2024, Total Cost of Care Workgroups and a second prior to the submission of the November 20, 2024, workgroup meeting. The next sections recap these comments along with Staff response. Across the two rounds letters were received from the Maryland Hospital Association (MHA), the University of Maryland Medical System, Adventist HealthCare, Medstar Health, and LifeBridge Health.

Staff also received substantial input on various technical aspects related to scoring savings under CTIs. In response to these comments Staff made limited technical changes to the CTI scoring methodology.

Recap of Comments

Areas of focus addressed by multiple stakeholders include:

Support for incorporating non-claims-based payments into savings calculations: Industry stakeholders strongly supported adding NCBP retroactively and on a go-forward basis.
Concerns about attainment provision in CTIs: Some stakeholders raised concern about this and do not support the change while others support the change while asking for specific methodological analysis to assess fairness. Staff believe the proposed policy is a reasonable compromise between these positions.

Strongly suggest limiting CTI policy changes to future periods: Stakeholders want to limit changes to policy during active and enrolled performance years and are supportive of changes on a prospective basis. Staff adopted this approach.

Support for the revision of MPA attribution: Stakeholders proposed revising the attribution methodology to better align. Staff deferred this until 2026 to align with AHEAD-based changes.

Concerns about MPA results and total cost of care results: Stakeholders raised concern that the misalignment of MPA and total cost of care results remains a challenge. Staff notes that the model savings test and MPA savings measurement are designed differently although the addition of NCBP to the MPA savings will partially address this concern.

Future Areas of Focus

In 2024, HSCRC received comments across a wide range of MPA-related policy areas as noted above. In the context of the new AHEAD model HSCRC is proposing a more comprehensive revisit of the MPA in 2025 in preparation for the start of the model in 2026. The areas of priority include:

- Revisit the attribution method for Traditional MPA to consider associations between hospitals and beneficiaries other than geography.
- Revisit the scaled growth rate adjustment to validate hospital groupings and targets, this will be done in conjunction with Staffs revisit of the HSCRC's benchmarking approach.
- Consider indexing the CTI offset to the State's savings position such that the offset would be reduced allowing hospitals to retain more savings if the State is performing well on the model savings test.

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Nurse Support Program II
Competitive Institutional Grants Program

Outcomes Evaluation FY 2021 - FY 2025 and Draft Recommendations for Future Funding

December 11, 2024

This is a draft recommendation. No Commission action is required at this time. Public comment should be sent to Erin Schurmann at erin.schurmann@maryland.gov by **January 15, 2024**

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

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Introduction

This report presents an update on program outcomes for the Nurse Support Program II (NSP II), an update on the current state of the nursing workforce, and recommendations for future funding. Program updates will include an analysis of activities that occurred during FY 2021 through FY 2025. This report and its recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission).

Background

The HSCRC initiated nurse education support funding (formerly titled the Nurse Education Support Program or NESP) in 1986 through the collaborative efforts of hospitals, payers, and nursing representatives. In 2000, HSCRC implemented the Nurse Support Program (NSP I) to address the issues of recruiting and retaining nurses in Maryland hospitals. In 2005, seventy-nine percent (79 percent) of the RN programs reported that they had met or exceeded their enrollment capacity. The shortage of qualified nursing faculty was identified as the fundamental obstacle to expanding the enrollments in nursing programs, thereby exacerbating the nursing shortage. The HSCRC proactively created NSP II to address the barriers to nursing education through statute with the Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund. The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses.

NSP II is distinct from, and in addition to, the NSP I hospital-specific program but shares a mutual goal to increase the number of nurses in Maryland hospitals. NSP II focuses on expanding the capacity to educate more nurses through increasing faculty and strengthening nursing education programs at Maryland higher education institutions. Provisions included a continuing, non-lapsing fund with a portion of the competitive and statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. The Commission approved funding of up to 0.10 percent of regulated gross patient revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused statewide initiatives. MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. After the conclusion of the first ten years of funding, the HSCRC continued to renew the NSP II funding, through June 30, 2025.

NSP II works closely with NSP I and stakeholders in hospitals and schools of nursing in Maryland to ensure that grant funding is addressing current needs of the state's nursing workforce. Since its inception, the NSP II program has gone through several revisions, including:

- The Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund [2006, chs. 221, 222] was amended in 2016 to delete "bedside" to ensure the best nursing skills mix for the workforce was not limited to just bedside nurses.

- In 2012, the NSP II program was modified to include support for development of new and existing nursing faculty through doctoral education grants. Revisions to the Graduate Nurse Faculty Scholarship (GNF) included renaming the nurse educator scholarship in honor of Dr. Hal Cohen and his wife Jo, and sunsetting the living expense grant component.

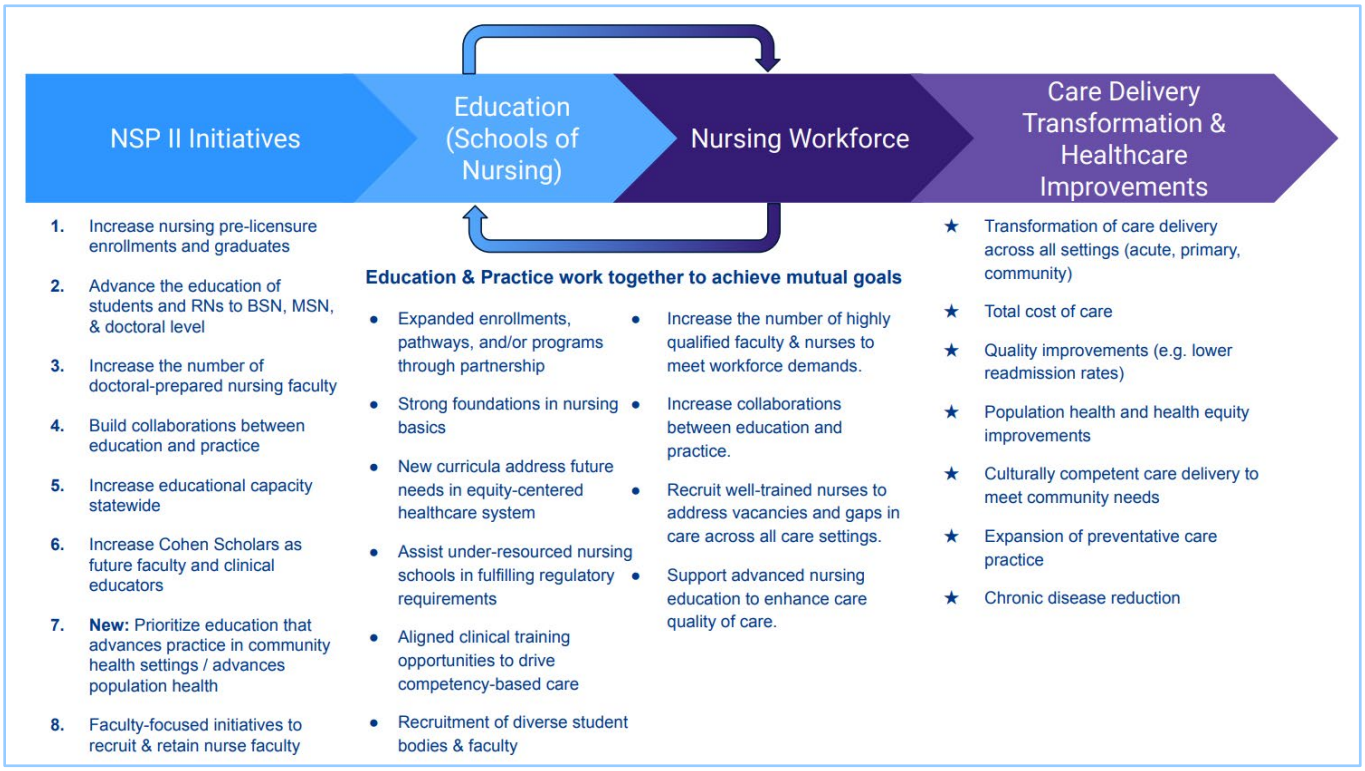
- In 2012, the NSP I and NSP II initiatives were aligned with the National Academy of Medicine (NAM), formerly the Institute of Medicine, *Future of Nursing* report recommendations (2010). Recently, the NAM released the *Future of Nursing 2020-2030* to chart the path over the next decade. The NSP I and NSP II Advisory Group met to consider how the new recommendations should be incorporated into the NSP programs and agreed that nurse retention should be the critical takeaway item to focus the joint efforts.

- In Spring 2020, the GNF was renamed the Cohen Scholars (CS) program. Additionally, the evaluation responsibility for this program was transitioned from the MHEC Office of Student Financial Assistance (OSFA) to the NSP II staff for future oversight. During the transition, NSP II staff clarified the NSP II eligible service facilities and standardized the teaching obligation for all GNF/CS.

Conceptual Framework

NSP II funding is to be used to support nursing education initiatives at all of the schools of nursing in Maryland with the goal of increasing educational capacity to meet the needs of the Maryland nursing workforce and improve the delivery and quality of care in all settings (Figure 1). Through NSP II funded initiatives, leaders in nursing education and nursing practice work together to increase the capacity to educate more nurses to grow the nursing workforce in Maryland. The collaboration between nursing schools and hospitals is a vital and interdependent one, where each supports the other's mission. Hospitals rely on nursing schools to supply them with skilled nurses, while nursing schools rely on hospitals to provide practical, clinical training to their students. NSP II initiatives are focused on supporting the essential educational components that underpin nursing practice, including the development of clinical skills, the integration of evidence-based practices, and the cultivation of leadership abilities, all of which are critical to bridging the gap between classroom learning and real-world healthcare environments. The result of a strong relationship between education and practice is a highly trained, qualified and diverse nursing workforce that is prepared to transform the quality of care in all settings.

Figure 1. Conceptual Framework for Nurse Support Program II



NSP II Initiatives

NSP II employs a three-prong strategy for increasing the number of nurses through strengthening nursing faculty and nursing educational capacity in the state with the ultimate goal of increasing the quality of care and reducing hospital costs. These goals are achieved by (1) increasing the number of nursing lecture and clinical faculty, (2) supporting schools and departments of nursing in expanding academic capacity and curriculum, and (3) providing support to enhance nursing enrollments and graduation for an adequate supply of nurses to meet the demands of Maryland's hospitals and health systems.

In 2012, the Nurse Support Program I and II initiatives were aligned with the Institute of Medicine (IOM) recommendations in its *Future of Nursing* report and included the following aims:

1. Ensuring nursing educational capacity for Nursing Pre-Licensure Enrollments and Graduates, including Associate Degree in Nursing (ADN), Bachelor of Science in Nursing (BSN), Master of Science Entry and Second Degree BSN Entry preparation for licensure by the National Council Licensure Examination for Registered Nurses (NCLEX-RN) to determine safety of new graduate nurses to enter practice.
2. Advancing academic preparation of entry-level nurses and experienced nurses to meet the needs of hospitals and health systems for a higher proportion of registered nurses with a Baccalaureate (BSN) or higher degree in Nursing.

3. Increasing the number of nurses and nurse faculty with graduate education and doctoral degrees to prepare them as leaders, researchers, and educators in academic and clinical settings, and advanced practice nurses.
4. Building collaborations between nursing education and practice for improved nursing competency through seamless academic progression and lifelong learning to improve patient outcomes and satisfaction.
5. Developing statewide resources and models for clinical simulation, leadership, interprofessional education, alternative clinical practice sites, and clinical faculty preparation.
6. Ensuring a cadre of qualified faculty and clinical nursing instructors with efforts to provide graduate educational support, recruit new faculty, retain experienced educators, and increase the number of certified nurse faculty in the specialty practice of nursing education.
7. Advancing the practice of nursing in provision of primary services as nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists.
8. Providing for the nursing workforce data infrastructure for future workforce analysis.

In addition, with Maryland's current Total Cost of Care (TCOC) Model and the implementation of the new States Advancing All-Payer Health Equity and Development (AHEAD) Model, it is essential to prioritize initiatives that advance population health goals and prepare nurses to practice in community health settings. In accordance with the NSP II statute, the program must also track, analyze, and prioritize initiatives that support the recruitment and retention of underrepresented nursing groups. Through investments in NSP II-funded initiatives, Maryland has established itself as a leader in developing a sustainable, successful model for growing a diverse nursing workforce, while advancing progress toward national goals (Table 1). This report will update the Commission on the current state of nursing, highlight the progress of the NSP II program, and provide key recommendations for its future direction.

Table 1. Pathway for NSP II Initiatives to Achieve State & National Goals

NSP II Initiative	Related NSP II Grant Outcome	Related Statewide & National metrics (data source)
1. Increase nursing pre-licensure enrollments and graduates	# Additional nursing pre-licensure graduates	Location Quotient, RN employment & wages (U.S. Bureau of Labor Statistics)
		NCLEX-RN pass rates (MBON; NCSBN)
		Nurse residency turnover & retention rates (MONL/MNRC; NSI)
2. Advance the education of students and RNs to BSNs, MSN and Doctoral level	# Additional nursing higher degrees completed	National Nursing Workforce Survey (NCSBN)
3. Increase the number of Doctoral-prepared nurse faculty	# Additional nursing faculty at Doctoral level	Proportion of nurses & nurse faculty with Doctoral degree (AACN; HRSA)
4. Build collaborations between education and practice (*Examples:* clinical education models, dedicated education units, pipelines to nursing, community-based health partnerships)	Collaborative results are specific to grant initiative (*Examples:* # of additional clinical education spots, # of additional partnerships)	Specific to grant initiative
5. Increase capacity statewide (*Examples:* faculty professional development, statewide simulation resources, nursing workforce center, nurse resiliency program)	Statewide results are specific to grant initiative (*Examples:* # of additional resources, workshops, activities or modules)	Specific to grant initiative
6. Increase Cohen Scholars as future faculty and clinical educators	# Additional Cohen Scholars	Nurse faculty vacancy rates (NSP II Mandatory Data Tables; AACN)
New: **7. Prioritize education that advances practice in community health settings / advances population health**	Community / Population health results are specific to grant initiative *(Examples:* # of additional providers, community services provided, patient encounters)	Mortality rates, chronic disease prevalence, health behaviors, access to care (County Health Rankings & Roadmaps)
		Hospital readmission rates (HSCRC Casemix Data)
8. Faculty-focused initiatives to recruit & retain nurse faculty	# Nurse faculty recruited & retained, # Certified nurse educators	Nurse faculty vacancy rates (NSP II Mandatory Data Tables; AACN); CNE® data (NLN's CNE® portal)

RN = Registered Nurse; MBON = Maryland Board of Nursing; NCSBN = National Council of State Boards of Nursing; MONL = Maryland Organization of Nurse Leaders; MNRC = Maryland Nurse Residency Collaborative; NSI = Nursing Solutions Inc.; BSN = Bachelor of Science in Nursing; MSN = Master of Science in Nursing; AACN = American Association of Colleges of Nursing; HRSA = Health Resources and Services Administration; AHRQ = Agency for Healthcare Research and Quality; CNE® = Certified Nurse Educator; NLN = National League for Nursing.

Major NSP II Achievements

The funding designated for the Nurse Support Program II (NSP II) is used for competitive grants and statewide initiatives aimed at increasing the capacity for schools of Nursing in Maryland to produce additional qualified nurses to practice in Maryland. This report contains the analysis of program outcome data to assess progress in achieving the aims of NSP II during the last five year program cycle. Major program achievements are highlighted below and in the following sections of this report.

- Participation in the Competitive Institutional Grants program from 89 percent of all schools of nursing in Maryland.
- Participation in the Faculty-Focused Statewide Initiatives program from 96 percent of all schools of nursing in Maryland.
- Increased first-time pass rates for the NCLEX-RN licensure exam by 7 percent since FY 2018.
- The number of Registered Nurses that passed the NCLEX-RN licensure exam increased by 22% since FY 2018.
- Increased the ability for schools of nursing to graduate an additional 1,545 nurses.
- Recruited 193 new nurse faculty into full-time positions.
- As of October 2024, Maryland had 299 CNE®-credentialed nurse educators, ranking sixth in the nation for total CNE®-credentialed faculty and tied for the lead in the proportion of nursing instructors with the credential.
- Established Cohen Scholars Programs at six universities in Maryland that provided graduate tuition and mentorship to approximately 250 future and existing nurse educators.
- Produced 186 Cohen Scholars graduates prepared to teach in Maryland as nurse faculty and hospital educators.
- Provided tuition support and course release time for 58 full-time nurse faculty to complete the terminal doctoral degree.

Competitive Institutional Grants Program

The Competitive Institutional Grants Program builds educational capacity and increases the number of nurse educators to adequately supply hospitals and health systems with well-prepared nurses. These grants are designed to increase the structural capacity of Maryland nursing schools through shared resources; innovative educational designs; and streamlined processes to produce more nurse faculty, and undergraduate and graduate nurses. Activities may include the establishment of new degree programs, curriculum enhancement and redesign, simulation and other productivity-enhancing instructional technologies. These grants also contribute to the creation of a more diverse nursing faculty and workforce as well as preparing graduate-level nurses to serve as lecturers and/or clinical faculty at Maryland's higher education institutions. All grant recipient project directors are required to disseminate their work through

publications in peer-reviewed journals or presentations to fellow nurses at professional nursing conferences in Maryland and nationally. Grant proposals are scored with a consistent rubric by an expert review panel. Strong consideration is given to the feasibility of the proposal's budget, the sustainability of the initiative, and the potential return on investment. A total of 120 proposals were reviewed over the five-year period. A total of $58.9 million was awarded through a competitive review process for 87 multi-year projects. Twenty-eight of the grant projects awarded between FY 2021 and FY 2025 have completed and 59 of the grant projects remain in progress.

Progress by Geographic Location, Amount and Project Type

Five rounds of competitive institutional grants have been conducted since July 2020. All current institutions with schools of nursing in Maryland were encouraged to submit proposals for competitive institutional grant funding during the FY 2021 - FY 2025 program cycle. Grant proposals were scored with a consistent rubric by an expert review panel. Strong consideration was given to the feasibility of the proposal's budget, the sustainability of the initiative, and the potential return on investment. A total of 131 proposals were reviewed over the five-year period and 87 multi-year projects were awarded a total of $58.9 million through a competitive review process.

The types of NSP II Competitive Grants fall under one of four categories:

1. **Planning grants** are available to develop detailed proposals for initiatives that will increase the enrollment and graduation of nurses who will then practice in Maryland and/or increase the supply of qualified nursing faculty required to expand the capacity of Maryland's nursing programs. Planning projects are limited to one (1) to two (2) years of funding.
2. **Implementation grants** are available for projects that will (1) increase the enrollment and graduation of nurses who will then practice in Maryland hospitals and/or (2) increase the supply of qualified nursing faculty required to expand the capacity of Maryland's nursing programs.
3. **Resource grant awards** are available for small projects that align with the goals of the NSP II but would not qualify as planning or implementation grants and cannot be reallocated within an existing open grant. The funding request must have no other option for funding within the program and this must be supported with details on why the NSP II resource grant is being requested.
4. **Continuation grants** are by invitation only and available for projects with proven outcomes and high potential to impact state level needs. Consideration for continuation grants will include a review of project impact, progress towards stated goals and objectives, financial management of funds, and compliance with reporting requirements.

The majority (44 percent) of funding ($42.4 million) was awarded to 38 implementation grants aimed at producing measurable outcomes over a period of one to up to four years. Eleven planning grants were awarded a total of $1.4 million to assess feasibility and prepare for future project implementation.

Resources that lacked alternative sources of funding were supported through a total of 29 one-year grants totaling $2.7 million. Nine successful initiatives, each yielding significant statewide impact, were chosen to submit continuation grant applications totaling $12.3 million.

The distribution of awards was geographically diverse (Table 2). Thirteen community colleges and thirteen universities received this funding, which represents a total participation rate of 89 percent from all eligible schools of nursing in Maryland (26/29). Grant recipients included schools or departments of nursing at public universities, including the State's historically black institutions, independent colleges, universities and community colleges. The majority of the institutions that received funding were located in the central region of the State and Baltimore City. No proposals were received from Southern Maryland.

Table 2. Geographical Distribution of Competitive Institutional Grants from FY 2021 - FY 2025

Geographical region	# of grants awarded	# of Institutions awarded	$ of funding awarded
Capital Region MD	9	6	$4,155,026
Central MD	57	13	$40,343,557
Eastern Shore MD	11	4	$6,628,117
Western MD	10	3	$7,835,833
TOTAL	**87**	**26**	**$58,962,533**

Note. Regions defined by Maryland Office of Tourism (visitmaryland.org) and categorized by physical address.

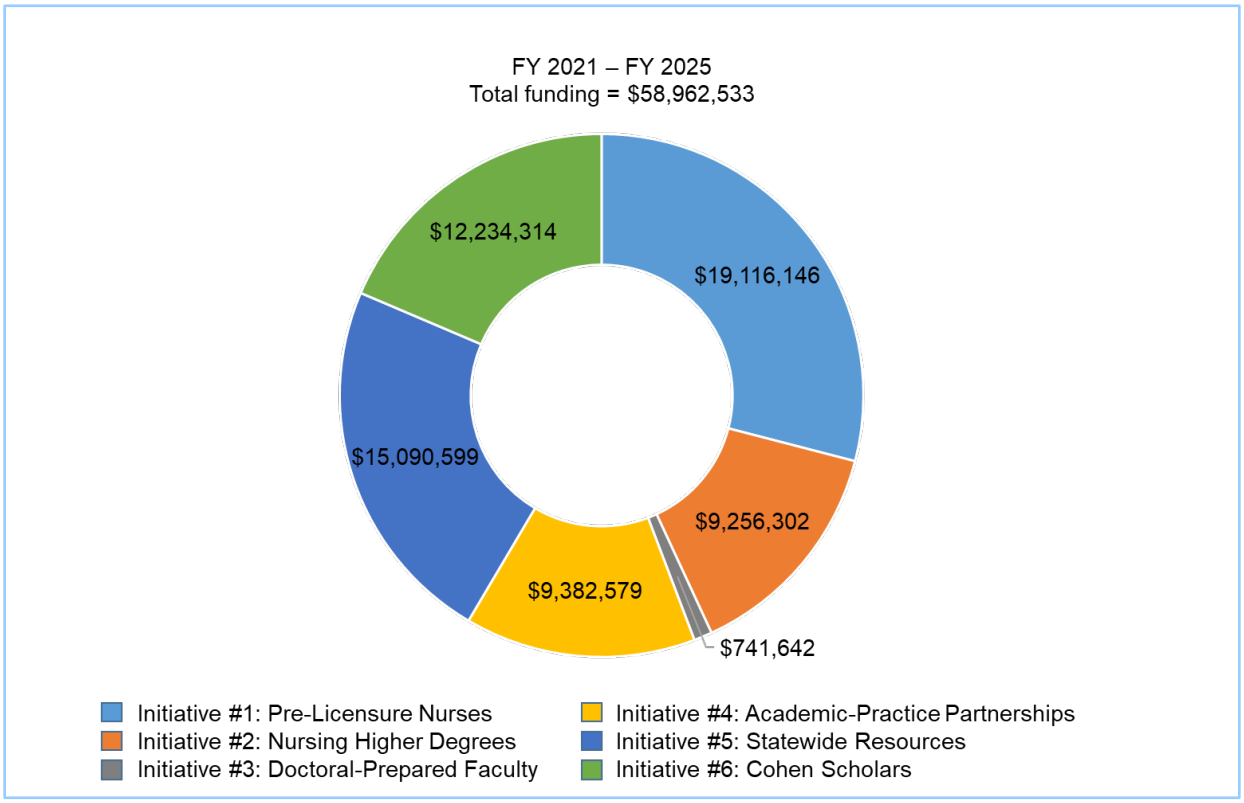
Progress by Initiative

Competitive institutional grants were awarded for projects addressing the following initiatives:

1. Increasing nursing pre-licensure enrollments and graduates;
2. Advancing the education of students and nurses to BSN, MSN & doctoral level;
3. Increasing the number of doctoral-prepared nursing faculty;
4. Building collaborations between nursing education and practice,
5. Increasing educational capacity statewide; and
6. Increasing Cohen Scholars as future nurse faculty and clinical educators.

The distribution of competitive institutional grant award funding by initiative is presented in Figure 2. The majority of funding was awarded to increase the capacity for nursing pre-licensure enrollments and graduates, followed by the development of statewide resources. In FY 2021, $12.2 million was awarded to six schools of nursing for the Cohen Scholars program, which has currently produced 186 graduates as future nurse educators. Progress on each initiative is presented in the paragraphs below.

Figure 2. NSP II Competitive Institutional Grants Awarded by Initiatives: FY 2021 - FY 2025



Note. Grants may address more than one initiative.

Initiative # 1: Increase Nursing Pre-Licensure Enrollments and Graduates

The U.S. Bureau of Labor Statistics estimates that by 2031, there will be a need for over 200,000 additional registered nurses annually to meet the healthcare needs of an expanding and aging population. Yet, many nursing schools report turning away qualified applicants due to capacity limitations. Increasing enrollments would directly address this gap, helping to meet the demand for healthcare services while ensuring that nursing students are adequately trained and prepared. The primary goal of this NSP II initiative is an increased number of nursing graduates across all pre-licensure nursing programs to successfully pass the NCLEX-RN nursing licensure examination and enter the Maryland nursing workforce. Maryland higher education institutions, consortia of institutions and/or hospitals implement sustainable strategies to combine and integrate their resources to allow for immediate expansion of nursing enrollments and graduates. This is an opportunity for expanding current cohorts, adding cohorts, and engaging in alternate delivery methods.

From FY 2021 to FY 2025, a total of 32 competitive institutional grants were aimed at addressing initiative #1 to increase nursing pre-licensure enrollments and graduates with the ultimate goal to produce 1,545 additional pre-licensure nursing graduates eligible to take the NCLEX-RN licensure exam. A total of 568 additional nurse graduates have been produced to date. An analysis of the completed grants addressing

this initiative reveals that the NSP II cost to produce each additional graduate was about $4,266.19 ($1,040,950 in grant funding / 244 graduates produced from eight grants that ended in 2023 & 2024). This demonstrates a cost-effective investment in expanding the nursing workforce. Current progress on this initiative is represented in Table 3.

Table 3. Progress toward Initiative #1: Increase Nursing Pre-Licensure Enrollments & Graduates

Year Ending	Projected # Additional Pre-Licensure Nurses	Actual # Additional Pre-Licensure Nurses	% to Goal
2023 (Completed)	32	86	269% - Exceeded Goal
2024 (Completed)	96	158	165% - Exceeded Goal
2025 (In Progress) Final Data in Sept. 2025	298	201	67%
2026 (In Progress) Final Data in Sept. 2026	456	60	13%
2027 (In Progress) Final Data in Sept. 2027	264	63	24%
2028 (In Progress) Final Data in Sept. 2028	399	no data	no data
Total	**1,545**	**568**	**37%**

Note. Grants ending in 2028 began in FY 2025 and have not yet reported annual data.

Initiative #2: Advance the Education of Students and RNs to BSN, MSN & Doctoral Level

Ongoing research findings confirm a hospital's proportion of BSN nurses, regardless of educational pathway, are associated with lower odds of 30-day inpatient surgical mortality (Porat-Dahlerbruch, et al., 2022). A summary of feedback shared with NSP II staff from Chief Nursing Officers (CNOs) in Maryland support the continued importance of the bachelor's degree in nursing (BSN):

- The BSN is perceived as the minimum standard of education for nurses;
- The proportion of BSNs is a criteria that is assessed when hospitals are looking to demonstrate excellence through the Magnet Recognition Program®; and
- Nurses with a BSN or higher are more skilled in leadership, quality improvement, critical thinking, evidence-based practice, professionalism, case management, and teamwork/collaboration.

While all Maryland hospitals hire new graduate nurses with an Associate Degree in Nursing (ADN), almost all require that they obtain a BSN degree within a certain timeframe. According to data from Maryland nurse residency programs, new graduates with a BSN degree have a lower turnover rate (17 percent) than those prepared in any other way (19 percent). As patient acuity levels rise and patients require more complex care, it is imperative to support advanced degrees in nursing.

Data from NCSBN's National Nursing Workforce Survey showed that the proportion of BSN or higher prepared nurses in the US increased to 71.7 percent in 2022 and 51.5 percent of nurses entered the profession with a BSN or higher degree (AACN). In Maryland, 75 percent of nurses responding to the National Nursing Workforce Survey had a BSN or higher degree in 2022, exceeding the national rate. (Source: MNWC). Data from the Robert Wood Johnson Foundation's Campaign for Action showed that the percentage of nurses in Maryland with a BSN or higher degree increased from 55 percent in 2010 to 69 percent in 2020, which was 10 percent higher than the 2020 national average of 59 percent (Brassard, 2023). This demonstrates that steady progress is being made towards achieving the 80 percent goal of nurses holding a BSN by 2025.

Advancing the education of students and registered nurses (RNs) to the BSN, MSN, and doctoral levels is essential for improving the quality of care, expanding leadership capabilities, and enhancing the overall effectiveness of the nursing workforce. Higher education levels in nursing contribute to a deeper understanding of clinical practices, evidence-based care, and health systems management. By advancing nursing education, the profession will be better equipped to address the increasing complexity of patient care needs, adapt to healthcare innovations, and take on leadership roles in both clinical and policy settings. Moreover, it will help to meet the growing demand for advanced practice nurses, such as nurse practitioners and nurse educators, ensuring that the healthcare system is supported by highly skilled and diverse professionals prepared to tackle future challenges.

From FY 2021 to FY 2025, a total of 16 competitive institutional grants were aimed at addressing initiative #2 to advance the education of students and nurses with the ultimate goal for an additional 795 higher nursing degrees to be completed. A total of 566 additional higher degrees have been completed to date. Current progress on this initiative is represented in Table 4.

Table 4. Progress toward Initiative #2: Advance the Education of Students and RNs to BSN, MSN & Doctoral Level

Year Ending	Projected # Additional Nursing Higher Degrees	Actual # Additional Nursing Higher Degrees	% to Goal
2024 (Completed)	32	65	203% - Exceeded Goal
2025 (In Progress) Final Data in Sept. 2025	435	386	89%
2026 (In Progress) Final Data in Sept. 2026	350	115	33%
2028 (In Progress) Final Data in Sept. 2028	28	no data	no data
Total	**845**	**566**	**67%**

Note. There were no grant projects for initiative #2 ending in 2023 or 2027. Grants ending in 2028 began in FY 2025 and have not yet reported annual data.

Initiative #3: Increase the Number of Doctoral-Prepared Nursing Faculty

The demand for nurses is growing, yet a shortage of doctoral-prepared nursing faculty limits the ability to educate the next generation of nurses and expand enrollment to meet healthcare needs. Increasing the number of doctoral-prepared faculty is crucial for training a skilled nursing workforce, as these faculty members are essential for conducting research that drives evidence-based practices, improves patient outcomes, and shapes healthcare policies. They also serve as mentors, preparing students to become practitioners, researchers, and leaders. Doctoral-prepared faculty play a key role in developing innovative curricula that reflect the latest advances in nursing practice, technology, and healthcare delivery, ensuring that nursing programs remain relevant and of high quality. Additionally, they support the professional development of practicing nurses through continuing education and mentorship, strengthening the nursing profession overall. By expanding the pool of doctoral-prepared faculty, nursing schools ensure the highest clinical and academic standards, directly impacting patient care and outcomes. Accrediting bodies emphasize the importance of faculty qualifications to maintain program quality and accreditation. Furthermore, doctoral-prepared faculty address health disparities by focusing on health equity, cultural competence, and social determinants of health, ensuring nursing students are equipped to provide equitable care in diverse healthcare settings.

Between FY 2021 and FY 2025, a total of $741,642 was awarded to initiative #3, funding two grants aimed at producing an additional 30 doctoral-prepared faculty, along with one planning grant focused on developing a PhD in nursing program at an HBCU by 2025. A total of 33 additional doctoral-prepared faculty have been produced to date, already exceeding the target goal of 30 additional doctoral-prepared faculty by 2026. Current progress on this initiative is represented in Table 5.

Table 5. Progress toward Initiative #3: Increase the Number of Doctoral-Prepared Nursing Faculty

Year Ending	Projected # Additional Doctoral-Prepared Faculty	Actual # Additional Doctoral-Prepared Faculty	% to Goal
2024 (Completed)	10	33	330% - Exceeded Goal
2026 (In Progress)	20	no data	no data
Total Completed	**30**	**33**	**110% - Exceeded Goal**

Note. There were no grant projects for initiative #3 ending in 2023, 2025, 2027 or 2028. Grant ending in 2026 began in FY 2025 and has not yet reported annual data.

Initiative #4: Build Collaborations Between Education and Practice

Building collaborations between nursing education and practice is essential for developing skilled, competent, and adaptable nursing professionals. These partnerships provide students with real-world experience, enhancing clinical skills and helping them apply theoretical knowledge in practical settings. Working alongside experienced professionals fosters critical thinking and problem-solving, which are crucial for quality patient care. Additionally, collaborations ensure nursing curricula remain relevant by incorporating feedback from healthcare organizations, addressing current challenges in patient care, technology, and delivery. Students engaged in dynamic learning experiences like clinical rotations, internships, and mentorship gain a clearer understanding of their role in healthcare, boosting motivation and engagement. These partnerships also integrate evidence-based practices (EBPs) into both education and clinical settings, ensuring students learn the latest research while practicing nurses refine their skills. Furthermore, such collaborations bridge the gap between theory and practice, preparing students to navigate complex patient scenarios. Educational-practice collaborations promote smoother transitions into the workforce, enhance nurse retention, and provide ongoing professional development. Ultimately, they improve patient outcomes by preparing nurses with the skills, knowledge, and leadership to deliver high-quality, evidence-based care.

A total of $9.3 million was awarded between FY 2021 and FY 2025 to support initiative #4 to foster academic-practice partnerships. Grant projects implemented under this academic-practice partnership initiative were designed to address the needs of nursing schools and nursing students, as well as practicing nurses and the communities they serve. The outcomes of these initiatives offer essential resources and assets to support a competent, highly skilled nursing workforce, prepared to deliver evidence-based care across all settings. Key examples are outlined in Table 6.

Table 6. Initiative #4: Examples of Grant Projects to Build Collaborations Between Education & Practice

Title	Description	Outcomes
Supporting Nursing Advanced Practice Transitions (SNAPT)	Nurse Practitioner Fellowship program that seamlessly transitions students into the workforce to increase primary care providers	24 Nurse Practitioner Fellows in Maryland

Title	Description	Outcomes
R3-Renewal, Resilience and Retention for Maryland Nurses	Statewide initiative to strengthen resiliency curriculum for academic faculty, nursing students, Nurse Residency educators, and novice nurses	Over 1500 participants; 38 online modules created; Online repository of tools/resources; Annual Statewide Conference
An Academic-Practice Partnership to Create a Home Healthcare Transition-to-Practice Model	Build the infrastructure for a statewide program to support new nurse graduates as they transition into home healthcare practice	Established a consortium of academic & practice stakeholders; Developed a Home Healthcare Residency toolkit with modules
Care Coordination Educational-to-Practice Scale-Up	Promote competency in care coordination and patient-centered care across Maryland hospitals while expanding the CC/HIT focus within schools of nursing	70 RN-BSN graduates with CC/HIT expertise; 91 nurses completed care coordination modules; Exposure to care coordination at 6 hospitals
Head Start Partnership to Expand Pediatric Clinical Opportunities	Build the capacity to provide additional pediatric clinical experiences for entry-level & DNP/APRN students through an innovative partnership with Maryland Family Network and Early Head Start of Maryland	37 clinical sites received services; 3,029 children received services; 505 DNP/APRN & 1,141 entry-level student encounters; 2,086 student clinical hours
The Nurse Leadership Institute	Through a year-long leadership program with mentorship, reflective exercises, and a leadership project, nurse faculty & clinicians develop the skills to lead change and advance health	204 new nurse leaders; 193 mentors trained; 32 academic-practice collaborative projects
Academic Practice: Pilot DEU Model	Use an innovative approach to clinical education for pre-licensure students with the Dedicated Education Unit (DEU) pilot, where staff nurses serve as clinical instructors	Implemented DEU model on two medical-surgical units; Two clinical groups established
Enhancing Clinical Education Through Partnerships	Increase the number of employee nurses serving as clinical instructors and provide professional development and graduate education to instructors	25 clinical instructors hired from hospital partners; 59 graduates hired by partners (247% increase)

CC/HIT = Care Coordination supported by Health Information Technology; DNP = Doctor of Nursing Practice; APRN = Advanced Practice Registered Nurse.

Initiative #5: Increase Capacity Statewide

Increasing nursing education capacity statewide is crucial for meeting the growing healthcare demand, improving patient care, and addressing public health challenges. Initiative #5 aims to provide resources to support nurses across both academic and practice settings. This initiative focuses on preparing future nurse educators, promoting lifelong learning through statewide professional development models, and empowering nurses to lead change and advance health in advanced practice roles. Additionally, it works to build an infrastructure for the collection and analysis of nursing workforce data by establishing the Maryland Nursing Workforce Center. Between FY 2021 and FY 2025, $15.1 million was awarded to develop

statewide resources that enhance the state's capacity to educate and graduate more nurses. Table 7 highlights the key resources made available to all Maryland nurses through this funding.

Table 7. Initiative #5: Examples of Grant Projects to Increase Capacity Statewide

Title	Description	Outcomes
Maryland Clinical Simulation Resources Consortium (MCSRC)	Strengthens the quality and quantity of simulation used in nursing education statewide through faculty and hospital educator preparation	390 simulation education leaders; 11 simulation educator certifications; 17 simulation videos created
The Faculty Academy and Mentorship Initiative of Maryland (FAMI-MD)	Introductory and Advanced Academies that prepare expert clinicians as clinical educators across the state	370 newly prepared faculty; 45.68% participation from underrepresented groups in nursing; 77% of participants accepted teaching positions at 28 SON; 43 nurse educator certifications; 6 statewide CNE® preparatory workshops
Preparing Clinical Nursing Faculty Across Maryland	Increase the number of competent clinical nursing faculty across the state through faculty workshops, ongoing professional development, and national certification exam support	277 clinical faculty prepared; 41% engagement in ongoing professional development; 20 clinical nurse educator certifications
Lead Nursing Forward	Establish a comprehensive web resource with easy-to-access information about becoming a registered nurse and nurse educator in Maryland	www.LeadNursingForward.org created; 43,398 unique visitors and 176,016 total page views since launch in 2019; 874 registered users, 148 contributors, and 75 organizations
Nurse Managed Wellness Center	Implement the nurse managed health center model and build capacity for nurse education with clinical training opportunities designed for nurses and primary care NPs	80 additional pre-licensure graduates; 20 additional DNP Primary Care APRN graduates
Igniting Faculty Capacity	Enhance Maryland's nursing workforce readiness through the increased integration of competency-based education (CBE) best practices in the state's nursing programs	100 kickoff event attendees; 200 regional CBE workshop participants from MD nursing programs; 100 CBE Networking Summit attendees; 60 faculty engage in follow-up activities
Maryland Nursing Workforce Center (MNWC)	Work with partners across the state on current nursing workforce issues with a focus on data collection, analysis and dissemination	MNWC Website & Data Dashboards; Universal Onboarding Project; NextGen-NCLEX statewide Summit & faculty workshops, Faculty case studies, NextGen-NCLEX Test bank

SON = School of Nursing; CNE® = Certified Nurse Educator; NP = Nurse Practitioner; DNP = Doctor of Nursing Practice; APRN = Advanced Practice Registered Nurse; NCLEX= National Council Licensure Examination.

Initiative #6: Increase Cohen Scholars as Future Faculty and Clinical Educators

Increasing the number of future faculty and clinical educators is essential to sustaining high-quality education in nursing and clinical training. This can be achieved by establishing a pipeline of qualified educators while ensuring their preparation to teach, mentor, and guide the next generation of students.

Promoting advanced degrees in education, such as Doctoral or Master's programs, equips nurses with essential teaching skills, while specialized programs focused on pedagogy, student supervision, feedback, and assessment design can enhance teaching effectiveness, ultimately improving nursing student outcomes.

The Cohen Scholars (CS) program plays a vital role in this effort by providing tuition support for graduate education and offering mentoring from experienced faculty members to nurses aspiring to assume a teaching role. This program supports registered nurses in completion of their Master's and Doctoral degrees, post-graduate teaching certificate, and coursework to become nurse faculty. Funding for Cohen Scholars is selective and supports tuition and fees for Maryland residents to attend a Maryland program, with a service obligation to teach in an in-state nursing program or hospital education department upon graduation. As part of the program's 1:1 service obligation requirement, graduates must work as nurse faculty at nursing schools in Maryland or as hospital educators at NSP-participating Maryland hospitals/affiliates for a duration equal to the amount of tuition support received. Recipients who are unable to meet the service obligation must repay the graduate tuition support received through a repayment plan.

Between FY 2021 and FY 2025, a total of $12.2 million was awarded to initiative #6 to fund the establishment of the Cohen Scholars program at six schools of nursing in the state. A total of 186 Cohen Scholars have graduated to date, representing significant progress toward the goal to produce an additional 216 nurse educators prepared to teach in Maryland. Cohen Scholar tuition support has been provided to approximately 250 Cohen Scholars and an analysis of service obligation status data shows that 79 percent are on track to fulfill the teaching service obligation.

Statewide Initiatives Program

The Statewide Initiatives Program supports national and state NSP II goals that are focused on faculty initiatives that increase the quality of nursing education in the state to meet the needs of the future nursing workforce. The statewide initiatives are faculty focused with multiple opportunities for all schools of nursing in Maryland to:

- Recruit, retain and recognize a diverse nursing faculty,
- Increase the number of doctoral-prepared nursing faculty,
- Increase research competence and completion of terminal degrees for existing faculty, and
- Strengthen the professional development and expertise of nurse faculty.

Current faculty-focused statewide initiative programs include:

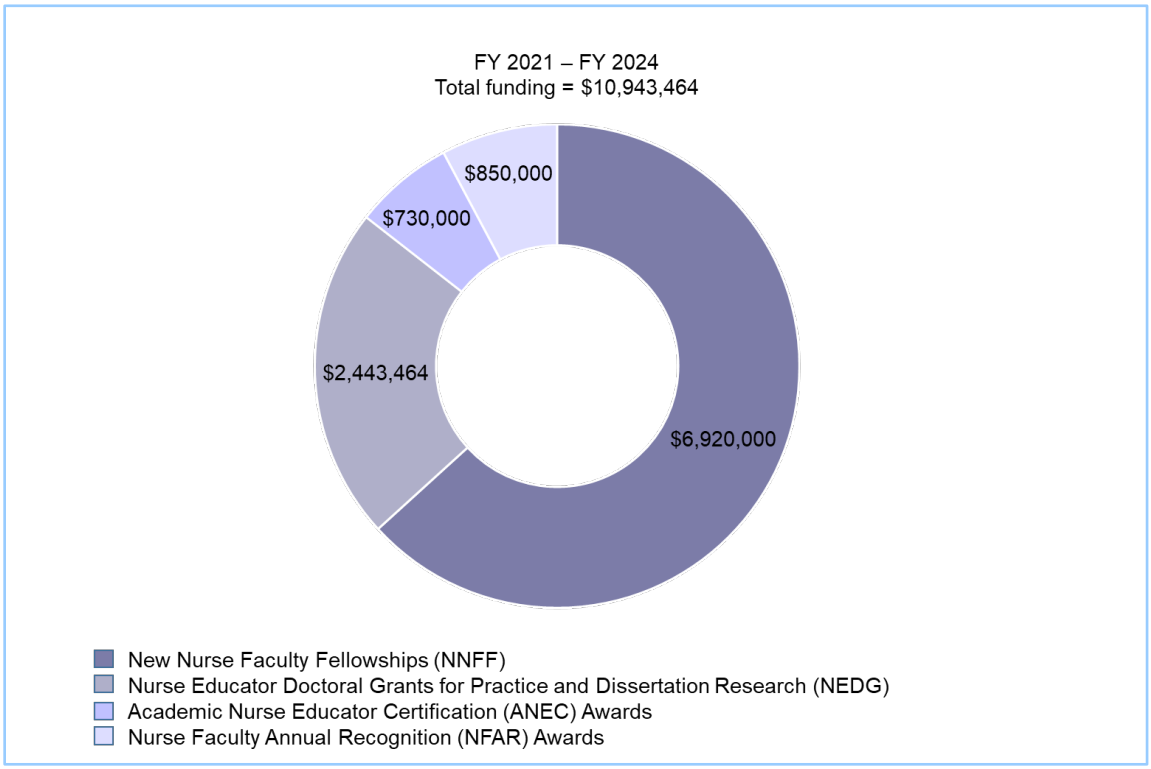
1. New Nurse Faculty Fellowships (NNFF), for new nurse faculty hired by Maryland institutions to expand enrollments in their nursing programs;
2. Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG) for existing faculty to expedite doctoral degree completions;
3. Academic Nurse Educator Certification (ANEC) Awards, for nurses who demonstrate excellence as an academic nurse educator through achieving and maintaining the National League for Nursing's Certified Nurse Educator (CNE®) credential; and
4. Nurse Faculty Annual Recognition (NFAR) Awards to recognize faculty demonstrating excellence in education in one of five areas of expertise.

As a requirement of the programs, recipients commit to advancing their careers through earning doctoral degrees; joining an institution as a new faculty member; or demonstrating expertise in the specialty practice of nursing education through national certification. Deans and Directors of nursing schools in Maryland are responsible for reviewing the eligibility criteria and nominating faculty for statewide faculty-focused award programs. Each nomination is carefully evaluated by a review panel, which uses consistent scoring and eligibility criteria to ensure a fair and objective selection process. This structured approach helps highlight the contributions of outstanding nursing faculty across the state.

Progress by Geographic Location and Amount and Program Type

From FY 2021 to FY 2024, a total of $10.9 million was awarded to nurse faculty in Maryland through the statewide faculty-focused awards program. A total of 560 nominations were received and 482 faculty-focused awards were made. The distribution of funding for the faculty-focused Statewide Initiatives by program is presented in Figure 3. The majority of funding was awarded to New Nursing Faculty Fellowships (NNFF) to recruit and retain 274 new full-time faculty to fill vacancies in 22 schools of nursing in Maryland. Progress on each initiative is presented in the paragraphs below.

Figure 3. NSP II Statewide Initiatives Program by Faculty-Focused Awards: FY 2021 - FY 2024



Note. FY 2025 funding is not included because the awarding cycle for FY 2025 is not complete.

The distribution of faculty-focused awards was geographically diverse (Table 8). Fifteen community colleges and twelve universities received this funding, which represents a total participation rate of 96 percent from all eligible schools of nursing in Maryland (27/28).

Table 8. Geographical Distribution of Faculty-Focused Awards from FY 2021 - FY 2024

Geographical region	# of faculty awards	# of Institutions awarded	$ of funding awarded
Capital MD	93	6	$2,172,350
Central MD	288	13	$6,666,114
Eastern Shore MD	50	4	$915,000
Western MD	36	3	$960,000
Southern MD	15	1	$230,000
TOTAL	**482**	**27**	**$10,943,464**

Note. Regions defined by Maryland Office of Tourism (visitmaryland.org) and categorized by physical address.

New Nursing Faculty Fellowships (NNFF)

The Nurse Support Program II provides funding for New Nursing Faculty Fellowships (NNFF) to faculty newly hired to expand Maryland's nursing programs. Maryland institutions with nursing degree programs may nominate newly hired full-time, tenured, tenure-track or non-tenured faculty members for fellowships. Individuals who are offered a full-time, long-term contract to serve as clinical-track nursing faculty also may be eligible. Funding is distributed to awardees over a five-year period contingent on continuous employment as full-time faculty in good standing at the nominating institution.

Fellowships for new nursing faculty that include support for professional development activities, provide an effective way to promote mentorship and retention in the profession by easing the transition into the faculty role. These fellowships offer new faculty the opportunity to engage in ongoing learning, skill-building, and peer collaboration, ensuring they feel well-prepared and supported as they take on teaching, research, and leadership responsibilities. By fostering strong mentorship relationships and offering targeted development resources, these programs help faculty build confidence, improve job satisfaction, and enhance their teaching and research capabilities. This support not only increases retention by reducing burnout and feelings of isolation but also strengthens the overall quality of nursing education, ensuring that new faculty are equipped to contribute meaningfully to their students' success and the advancement of nursing practice. These fellowships assist Maryland nursing programs in recruiting and retaining new nursing faculty to produce the additional nursing graduates required by Maryland's hospitals and health systems.

Between FY 2021 and FY 2024, a total of $6.9 million in funding was awarded to support the recruitment and retention of 274 full-time nurse faculty in Maryland. Of this total, $1.9 million was allocated for new awards, while $5 million was provided to support faculty who remained employed. During this period, 249 nominations for new fellowships were reviewed, and 193 faculty members were awarded fellowships to assist in their transition to the nurse faculty role. An analysis of data from FY 2019 to FY 2021 shows that, on average, 88 percent of awardees remained employed in their faculty positions after one year, and 64 percent remained employed after five years.

The inclusion of recent data from FY 2025 shows promising trends for the NNFF award. A total of 24 out of 29 nursing schools (83 percent) participated in the NNFF awards program between FY 2021 and FY 2025, including a newly established pre-licensure baccalaureate nursing program located in a rural county in Maryland. Notably, the FY 2025 awards reveal a trend of recruiting faculty from outside regional states, with 14 percent of recipients coming from non-regional areas. There have also been improvements in diversity, with the proportion of awardees from racial/ethnic minorities rising from 37 percent in FY 2021 to 49 percent in FY 2025, and those aged over 60 or under 30 increasing from 6 percent in FY 2024 to 12 percent in FY 2025.

Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG)

The Nurse Support Program II provides funding for Nurse Educator Doctoral Grant for Practice and Dissertation Research (NEDG) to full-time nurse faculty at Maryland's nursing programs who are currently enrolled in or who have recently completed a doctoral degree. Maryland institutions with nursing degree programs may nominate existing faculty pursuing doctoral degrees within the final two years of a program of study.

The growing demand for nurses is hindered by a shortage of doctoral-prepared nursing faculty, limiting the ability to expand enrollment and meet healthcare needs. Increasing the number of doctoral-prepared faculty members is vital for advancing research, developing evidence-based practices, and training the next generation of nurses, researchers, and leaders. Doctoral-prepared faculty also play a critical role in shaping curricula, promoting health equity, and supporting professional development, all of which ensure high-quality nursing education and improved patient outcomes. The DNP (Doctor of Nursing Practice) focuses on clinical practice and leadership in healthcare, preparing nurse faculty to translate research into practice and improve patient outcomes; the EdD (Doctor of Education) emphasizes educational leadership and teaching, equipping nurse faculty to design curricula and lead nursing education programs; while the PhD (Doctor of Philosophy) is research-oriented, training nurse faculty to conduct original studies that advance nursing science and inform policy.

A total of 74 nominations were received between FY 2021 and FY 2024 from 20 schools of nursing in Maryland, with 24 percent coming from Historically Black Colleges and Universities (HBCUs). The institution with the highest number of nominations and awardees was an HBCU located in Baltimore City. A total of $2.4 million was awarded to 18 schools of nursing in Maryland to support the expedited completion of 20 DNP, 28 PhD, and 10 EdD degrees for 58 full-time nursing faculty. Of these awards, 52 percent (30 out of 58) went to faculty members who identified as racial or ethnic minorities. The scholarly work produced by NEDG recipients included 23 education-focused and 35 practice-focused projects, with the majority addressing issues affecting minority and underrepresented groups in nursing (Table 9). Other significant topics focused on community and population health, particularly promoting healthy behaviors to support chronic disease prevention.

Table 9. Scholarly Work Produced by NEDG Awardees: FY 2021 - FY 2024

NEDG awardees FY 2021 - FY 2024 Doctoral dissertation topics	# scholarly works produced
Underrepresented groups/ racial/ethnic minorities	13
Community/ population health/ chronic disease prevention	12
Vulnerable populations (maternal/child, adolescents, women, older adult)	12
Organizational behaviors/ staff well-being and performance	9
Student success	9
Simulation/ educational technology	7
Transition to nursing practice/ faculty role	5
Mental health	3
Genetics & genomics	2
Academic integrity	2
Graduate education	2
Evidence-based practice	1

Note. Scholarly work may address multiple dissertation topics.

Academic Nurse Educator Certification (ANEC) Award

The National League for Nursing's Certified Nurse Educator (CNE®) credential is a mark of excellence for nurse educators. CNE® certification distinguishes nursing education as a specialty area of practice and demonstrates competency as a nurse educator.

The advanced credentialing of nurse educators plays a crucial role in enhancing the quality of nursing education. By earning the CNE® credential, nurse educators demonstrate their expertise and commitment to best practices in teaching, ensuring that they are highly skilled in delivering effective, evidence-based instruction. This level of certification signifies a mastery of both the science of nursing and the art of education, which allows nurse educators to develop curricula that are aligned with the latest healthcare standards and advances. As a result, students receive a higher quality education that is rooted in current research and best practices, equipping them with the critical thinking and clinical skills needed to provide superior patient care. Ultimately, by fostering well-prepared, competent nursing professionals, advanced credentialing in nursing education directly contributes to improved patient outcomes and the overall quality of healthcare delivery.

The Academic Nurse Educator Certification (ANEC) award is for faculty who demonstrate excellence as an academic nurse educator through achieving and maintaining the CNE® credential. For academic nurse

educators, this certification establishes nursing education as a specialty area of practice and creates a means for faculty to demonstrate their expertise in this role. It communicates to students, peers and the academic and health care communities that the highest standards of excellence are being met. By becoming credentialed as a certified nurse educator, you serve as a leader and a role model.

Between FY 2021 and FY 2024, a total of $730,000 was awarded to 146 full-time nurse faculty in Maryland who achieved or maintained the NLN CNE® credential. A total of 150 nominations were received from 25 schools of nursing in Maryland, which represents 89 percent participation from 28 eligible nominating institutions. Funding from the ANEC award program supported 107 initial certifications and 39 renewals. Program data indicates improvements in the achievement of the NLN CNE® credential from underrepresented groups in nursing. The percentage of awards given to faculty who identified as a racial/ethnic minority group almost doubled from 21 percent in FY 2021 to 41 percent in FY 2025.

Data from June 2024 reveals that 181 of the 277 nurse educators in Maryland holding the CNE® credential were ANEC award recipients (NLN). According to the NSP II Data (Daw, Ford, & Schenk), the number of faculty holding CNE® credentials increased by more than 50 percent since 2018, exceeding the goal to double the number of faculty in Maryland holding the CNE credential by 2025. This includes first-time credentialed and existing credentialed nurse educators completing the required continuing education and advancement to maintain the CNE® credential, renewed every 5 years. Recent data from October 2024 indicates that the number of CNE®-credentialed nurse educators in Maryland has risen to 299, positioning the state as sixth in the nation for the highest number of CNE®-credentialed nurse educators (NLN). When considering the proportion of nursing instructors with the CNE® credential in the state, Maryland is tied for the lead, surpassing all other states (NLN; U.S. Bureau of Labor Statistics).

Nurse Faculty Annual Recognition (NFAR) Award

Deans and Directors of all nursing programs may nominate one nurse faculty for each recognition area each year (five in total) who demonstrates excellence, innovation and leadership in their nursing programs for this annual award. The nominated nurse faculty members demonstrate excellence in teaching, engage in the life of the nursing program and college or university, and contribute to the profession as a nurse educator. There are five categories for recognition: 1. Excellence in Teaching, 2. Impact on Students, 3. Engagement in the Nursing Program and Employing Institution, 4. Innovation in Education & Technology, and 5. Contributions to Nursing Education.

This annual award program offers valuable recognition for nurse faculty and highlights the diverse and significant contributions that nurse educators make to the profession and to their academic institutions. The diversity in recognition areas ensures that faculty members who excel in various aspects of their role are recognized for their dedication to student success, program development, and the advancement of nursing education. This recognition not only celebrates individual achievements but also fosters a culture of

excellence and continuous improvement across nursing programs, inspiring faculty to continue innovating and engaging in meaningful ways with their students, institutions, and the broader nursing community.

From FY 2021 to FY 2024, a total of $850,000 was awarded to 85 full-time faculty to recognize their demonstrated commitment to excellence in teaching. A total of 87 nominations for the NFAR award were received. Faculty who received this recognition award had an average of 16.5 years of teaching experience as nurse educators. This data demonstrates that the recognition award program actively supports diversity, with an average of 29% of the faculty who received the award identifying with a racial or ethnic minority group. The greatest area of recognition was for engagement in the nursing program and employing institution (36 percent), followed by excellence in teaching (22 percent) and contributions to nursing education (15 percent). The NFAR award program was expanded in FY 2024 to allow faculty to be nominated in other categories throughout their careers as nurse educators. This expansion aims to support the retention of experienced nurse faculty, who play a crucial role in the success of nursing programs across the state.

Diversity of the Maryland Nursing Workforce

The diversity of the Maryland nursing workforce has evolved significantly over time, reflecting broader societal changes and ongoing efforts to address disparities in healthcare. Maryland's nursing workforce includes a mix of racial, ethnic, gender, and age groups, and these factors influence healthcare delivery, patient outcomes, and nursing practice across the state.

The diversity of the nursing workforce has a direct impact on healthcare delivery. A more diverse nursing staff can improve patient care by:

- **Better cultural competence**: Nurses from diverse backgrounds can offer more culturally sensitive care, improving patient satisfaction and outcomes.
- **Increased access to care**: Nurses who share the same cultural or linguistic backgrounds as patients can help bridge communication gaps, leading to better understanding and trust.
- **Addressing health disparities**: A diverse nursing workforce is better equipped to identify and address health disparities in underserved and minority communities.

The nursing workforce is becoming younger and more diverse. The average age of nurses in the US in 2022 was 47.9 years compared to 48.7 years in 2018. In 2022, more than 65 percent of nurses were less than 55 years old and the largest age group was 35-44. The proportion of nurses less than age 55 in 2018 was 62 percent and nurses aged 55-64 represented the largest age group. Data regarding the race/ethnicity of nurses shows that the proportion of RNs that identified as non-hispanic Black increased by 3 percent and the proportion of RNs that identified as non-Hispanic Asian increased by 4 percent. Additionally, male

nurses represent 12 percent of the nursing workforce, compared to 10 percent in 2018. There were similar increases to the age and diversity of nurses in Maryland from 2018 to 2022. Maryland's nursing workforce is even younger and more diverse. The average age of nurses in Maryland in 2022 was 46.2 and 69 percent were less than 55 years old. The data from 2022 also shows that 33 percent of RNs in Maryland identify as non-Hispanic Black and 11 percent identify as non-Hispanic Asian. (HRSA, Nursing Workforce Dashboard).

The diversity of nursing students and faculty should align to ensure nursing education reflects the broader population. When faculty mirror students' racial, ethnic, and gender backgrounds, it fosters inclusion, motivation, and a richer learning environment. Diverse faculty offer varied perspectives, helping students connect with the diverse patient populations they will serve. Additionally, diverse faculty serve as role models, encouraging underrepresented students to pursue and advance in nursing, ultimately contributing to a workforce that can better address health disparities. Data from 21 reporting Maryland institutions (75% response rate) shows promising progress toward a more diverse nursing workforce (Table 10). Notably, the diversity of nurse faculty in the capital region aligns closely with that of the student population. However, further growth is needed in other regions and among male nursing students. Collecting diversity metrics from all nursing schools in Maryland would help NSP II better support efforts to build a more diverse nursing workforce.

Table 10. A Comparison of Nursing Faculty & Nursing Student Diversity in Maryland: 2023

Region	Average % Students: Non-White	Average % Faculty: Non-white	Average % Students: Male	Average % Faculty: Male
Capital MD	90%	90%	12%	7%
Central MD	53%	32%	19%	9%
Eastern Shore MD	26%	9%	15%	1%
Western MD	27%	10%	12%	5%

Note. Data is from 21 reporting institutions in Maryland. Data was not available for Southern MD.

State of Nursing and Future Issues

This section of the report will provide an overview of current trends in the nursing workforce, highlighting key data on the challenges and opportunities within nursing education and practice. It examines the evolving landscape of nursing, including workforce shortages, educational capacity, and the growing demand for skilled nursing professionals. This section also addresses the critical factors shaping the future of nursing, including emerging health care needs and advancements in clinical practice.

Nursing Workforce Trends: Maryland vs Nation

The registered nurse (RN) is the single largest group of health professionals, with more than three million employed nationally and 49,770 RNs employed in Maryland (US Bureau of Labor Statistics, 2023). The demand for RNs is expected to be significant in the coming years, with a projected 193,100 open positions annually until 2032 due to nurses retiring or leaving the profession (US Bureau of Labor Statistics, 2023). If current workforce trends persist, the nation can anticipate a shortage of 337,970 full-time equivalent RNs by the year 2036 which represents a 9 percent shortage (HRSA).

The projected shortage of RNs varies geographically and by state, with non-metropolitan areas expected to experience the greatest shortages (HRSA). To better understand Maryland's supply of RNs, researchers use a Location Quotient (LQ) to quantify how concentrated the nursing industry is in this region as compared to the nation. A LQ greater than one (1) indicates the occupation has a higher share of employment than average. Maryland's share of nurses in 2023 (LQ= 0.89) was less than the national average and most neighboring states, which represents a 2 percent decline from 2022 (Table 11). The annual mean wage for registered nurses in Maryland in 2023 was higher than the average for neighboring states (Table 10).

Table 11. RN Employment and Wages for Maryland and Neighboring States

	Location Quotient (LQ)	RN Employment	Annual Mean Wage
Maryland	0.89	49,770	$92,090
West Virginia	1.45	20,860	$75,990
Delaware	1.20	11,810	$94,670
Pennsylvania	1.16	144,100	$87,530
New Jersey	0.94	82,950	$101,960
Virginia	0.85	70,650	$88,350

Source: U.S. Bureau of Labor Statistics, May 2023.

The Commission to Study the Health Care Workforce Crisis ("Workforce Commission"), established by the Maryland General Assembly during the 2022 session, recently released a final report detailing its findings. Of note, Maryland is not recovering to pre-pandemic workforce levels at the same rate and lags the region. That Maryland is not recovering at a similar pace to the region aligns with current vacancy and turnover rates, wherein the State is improving but at a slower pace than the nation (Maryland Department of Health, 2023).

Nursing Education Trends

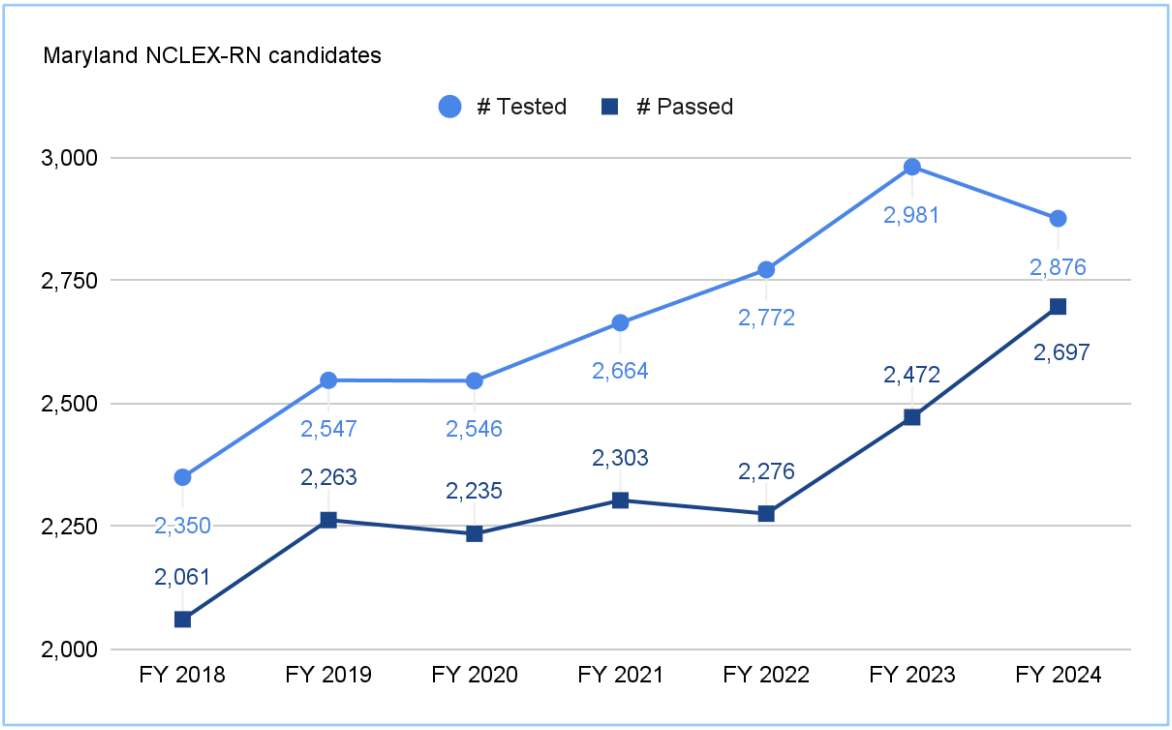
This section highlights the challenges and opportunities within nursing education, including the impact of faculty shortages on program capacity and the success of new graduates in achieving licensure. Key data is explored regarding entry-to-practice in Maryland, focusing on NCLEX-RN pass rates and trends in nurse faculty rates. It provides a snapshot of the current state of nursing education and the factors influencing its future.

Entry-to-Practice in Maryland

According to researchers, caution should be used when the basis of policy modeling and decision making is employment trends, as nursing shortages are highly sensitive to multiple variables and complex to pinpoint beyond regional trends. A better reflection of the state of Maryland's workforce may be trends in RN entry-to-practice, as it is the most important factor affecting projections of the nursing workforce supply (Auerbach, et al., 2017, pg. 294). In Maryland, the best indicator of entry-to practice is first-time passing rates for the National Council Licensure Examination – Registered Nurse (NCLEX-RN), available through the Maryland Board of Nursing (MBON). The number of graduates who pass the licensing exam can be a good indication of how many additional nurses are entering the workforce, since it is the last step to become a RN.

The number of nursing graduates taking the NCLEX-RN licensure exam has steadily increased in recent years (Figure 4). The number of nursing graduates tested in FY 2024 (2,876) was 22 percent higher than in FY 2018 (2,350). This provides evidence that the capacity to educate more nurses has increased. The number of nursing graduates who passed and became licensed RNs in FY 2024 (2,697) was 30 percent higher than FY 2018 (2,061). This equates to the addition of 636 RNs licensed to work in the state. Maryland is well positioned to continue this upward trend due, in part, to NSP II funding of the expansion of existing nursing programs and the development of new programs that provide a pathway to produce additional nursing graduates eligible to take the NCLEX-RN licensure exam.

Figure 4. Maryland's First Time NCLEX-RN Rates, FY 2018 – 2024



Source: Maryland Board of Nursing. National Council State Boards of Nursing, and Pearson Vue. All Maryland RN 1st time candidates who graduated from a Maryland nursing program and tested in any US jurisdiction.

Since FY 2018, NCLEX-RN passing rates in Maryland have been comparable to the overall passing rates in the U.S. and exceeded the nation in FY 2021, FY 2022 and FY 2024 (Table 12). Starting on April 1, 2023, entry-to-practice nursing graduates began testing with the Next Generation NCLEX (NGN) model for registered nursing licensure. This format focuses on clinical judgment and includes a variety of question types with related case studies that go beyond the usual multiple-choice options. Through the Maryland Nurse Workforce Center $1.9 million grant, NSP II funded the creation of a statewide NGN test bank in addition to over eleven free workshops utilizing in-state faculty with expertise to meet the demand for additional resources to prepare faculty and students for this change. A variety of on-demand resources are also made available to Maryland schools of nursing at no cost on the Maryland Nursing Workforce Center website (MNWC). Maryland's NCLEX-RN pass rates from FY 2023 include three months of data from graduates who tested with the NGN model for the NCLEX-RN exam (April 1, 2023 - June 30, 2023). The FY 2024 NCLEX-RN pass rate for Maryland, which reflects the performance of nursing graduates assessed solely with the NGN model, demonstrates the state's exceptional results, surpassing the national average with a 93.78 percent pass rate for first-time test takers.

Table 12. Maryland's First Time NCLEX-RN Rates, FY 2018 – 2024

Fiscal Year	Maryland BSN Programs		Maryland ADN Programs		Maryland MS Entry Programs		Total For All Maryland Programs		Passing Rates	
	No. Tested	No. Passed	No. Tested	No. Passed	No. Tested	No. Passed	No. Tested	No. Passed	MD	US
2018	773	676	1,316	1,145	261	240	2,350	2,061	87.70%	87.81%
2019	867	743	1,375	1,245	305	275	2,547	2,263	88.85%	88.36%
2020	775	650	1,467	1,299	304	286	2,546	2,235	87.78%	87.93%
2021	926	755	1,376	1,218	362	330	2,664	2,303	86.45%	84.48%
2022	965	747	1,433	1,205	374	324	2,772	2,276	82.11%	80.83%
2023	1,027	796	1,542	1,324	412	352	2,981	2,472	82.93%	83.21%
2024	1,007	912	1,472	1,407	397	378	2,876	2,697	93.78%	92.18%

Source: Maryland Board of Nursing. National Council State Boards of Nursing, and Pearson Vue. All Maryland RN 1st time candidates who graduated from a Maryland nursing program and tested in any US jurisdiction.

Nurse Faculty Vacancy Rates

An adequate supply of new graduate nurses is dependent upon enrollment and graduation rates at schools of nursing. The shortage of qualified nursing faculty has long been cited by nursing programs as a primary reason that prevents the admission of additional nursing students. Due to a multitude of factors, including anticipated faculty retirements, faculty vacancies will remain an ongoing issue and should continue to be a priority for Nurse Support Program II (NSP II).

Over recent years, the outlook for Maryland faculty has been comparable to the nation and remained stable. According to data collected for the NSP II program, the average full-time nurse faculty vacancy rate was 9 percent in 2021, which was slightly higher than the national average of 8 percent (AACN; NSP II Data Tables). The Maryland full-time nurse faculty vacancy rate remained steady at 9 percent in 2023 (NSP II Data Tables). Nationally, the average full-time faculty vacancy rate decreased slightly to 7.8 percent in 2023 (AACN). The most common contributing factors reported by schools of nursing in Maryland with faculty vacancies were a lack of qualified candidates (lack of experience in the right specialty area, competition, or unavailable in geographic area), followed by retirements/resignations and non-competitive faculty salaries. This matches national trends regarding the most common issues schools reported related to faculty recruitment (AACN). This data supports the need for Maryland to continue its efforts to grow the nurse faculty pipeline and support the recruitment and retention of qualified educators.

The number of nurses with a doctoral degree has a direct impact on faculty vacancy rates. National data indicated in AY 2022-2023 that 85 percent of U.S. schools of nursing had faculty vacancies that required or

preferred a doctoral degree (AACN). Insufficient funds to hire new faculty were reported as the top barrier by 63.3 percent of schools of nursing in AY 2022-2023 (AACN). In Maryland nursing programs, the majority (61.5 percent) of faculty were doctoral prepared, compared to national data where only 19 percent of faculty holds a graduate degree, and fewer than 2 percent hold a terminal doctoral degree (HRSA).

Aging of the nursing workforce continues to be a state and national concern. The number of FT faculty aged 60+ increased in Maryland nursing programs. The AONL Guiding Principles for the Aging Workforce outlines how employers can invest in the productivity of the older RNs including:

- Adapting work environments: providing environmental modifications for injury prevention; reducing the physical demands with bedside computers, automated beds, and non-professional staff assistance,
- Re-designing jobs: developing new and emerging roles; promoting a culture that supports older nurses and post-retirement options to avoid leaving gaps in advanced skill levels and years of expertise at the bedside.
- Other incentives: generational motivators in health benefits, and flexible schedules

Older RNs are needed to guide new nurses and maintain patient safety and quality of care.

Nursing Practice Trends

Nursing practice in Maryland is evolving to meet the needs of a diverse and growing population, responding to advances in healthcare technology, and addressing changes in healthcare policy. Maryland has made significant advancements in nursing practice, particularly with regard to Advanced Practice Registered Nurses (APRNs). In 2018, the state passed legislation allowing Nurse Practitioners (NPs) to practice independently, including prescribing medications and managing patients without physician supervision. This expansion of APRN roles addresses the growing demand for primary care and helps mitigate workforce shortages.

Telehealth has also seen a rapid rise in Maryland, especially during the COVID-19 pandemic, with nurses increasingly providing virtual consultations, remote care, and chronic disease management.

In addition, Maryland nurses are assuming leadership roles in healthcare organizations, driving innovation in patient care. There is also a growing focus on cultural competence to address the diverse population, including training nurses to work sensitively with different cultural groups. Other key trends include integrating mental health services, promoting community-based nursing, supporting continuous education, and advocating for health policies that improve healthcare access and reduce disparities.

New Nursing Graduate Retention

The recruitment and retention of nurses is a critical issue at national and state levels. From 2020 to 2022, Maryland hospitals saw a 5 percent and 10 percent increase in RN turnover and vacancy rates, respectively (NSP I, 2023). According to the "2024 NSI National Health Care Retention & RN Staffing Report," the national RN turnover rate in 2023 was 18.4 percent, which represents a 4.1 percent decrease from 2022 (NSI, 2024). The report shows a national RN vacancy rate of 9.9 percent in 2023, which was 5.8 percent lower than 2022. While this demonstrates some improvement nationally, it is important to recognize the impact that turnover and vacancy rates have on hospital systems. According to the NSI report, the average cost to replace one RN is $56,300 and reflects labor expenses including overtime, increases to salary, critical staffing pay and travel/agency fees. On average, hospitals lost $4.82 million in 2023 due to turnover. Compounding the problem of nurse turnover/vacancies is the time that it takes to recruit a replacement. According to NSI's data, it can take up to three months for a hospital to recruit a qualified nurse, with medical-surgical positions being the most difficult to fill. In the northeast region, which includes Maryland, it takes an average of 106 days to recruit a new nurse, which is 20 days longer than the national average. This data demonstrates how crucial it is to focus on retention efforts. The retention of nurses can result in significant cost savings to hospitals. Each percentage improvement in turnover rates could save a hospital $262,500 annually (NSI, 2024).

As a nationally recognized leader in nurse residency programs, Maryland became the first state in the US to have all acute care hospitals fund and offer nurse residency programs (NRPs) for new nurse graduates in 2018. The purpose of the residency program is to build upon nursing school's foundational knowledge to smoothly transition new nurses into professionals and retain them in the workforce. The Maryland Organization for Nurse Leaders (MONL) tracks data for the Maryland Nurse Residency Collaborative (MNRC) regarding outcomes of nurse residency programs in Maryland. Between 2013 and 2016, retention rates for Maryland hospitals offering an NRP ranged between 91 and 93 percent. Prior to the coronavirus pandemic, Maryland hospitals overall retained more than 88 percent of their new to practice nurses annually (Table 13) compared to an average of 76 percent nationally (NSI, 2021). Moreover, hospital leaders and nurse residents reported that they are more confident and competent after completing their 12-month nurse residency program, resulting in better-prepared nurses and significant hospital cost savings.

Not unexpectedly, the retention rate declined in 2020 due to the coronavirus pandemic. Additionally, staff shortages and safety requirements forced more than half the hospitals to stop their residency programs in April 2020. Maryland hospitals reinvigorated their programs in 2022 and the retention rate of Maryland new nurse graduates increased to 89 percent. The retention rate for Maryland nurse residents in 2023 was 91 percent, significantly higher than the national average, which shows that 66 percent of newly hired nurses left their positions within one year (NSI, 2024). However, persistent staff shortages continue to impact these programs for nurse residents. National trends show that the nursing profession is becoming younger with

fewer average years of experience, which supports the continued need for mentoring through nurse residency programs. With an increasingly novice workforce, hospitals cannot rely solely on nurse preceptors on the unit to mentor new graduates to the nursing profession.

Table 13. MNRC Data on Retention of New Nurse Graduates

	2017	2018	2019	2020	2021	2022	2023[1]
Number of Residents Hired	1,573	1,513	1,846	1,995	2,417	2,603	3,422
Turnover Rate[2]	8%	12%	11%	17%	9%	11%	9%
Retention Rate	92%	88%	89%	83%	91%	89%	91%

Source: Vizient/ AACN NRP Data for MONL, Inc. /MNRC, April 16, 2024.
[1]2023 turnover and retention data is preliminary; data is finalized after 12 months of employment.
[2]Turnover rate includes voluntary and involuntary termination of employment.

New Nursing Graduate Employment

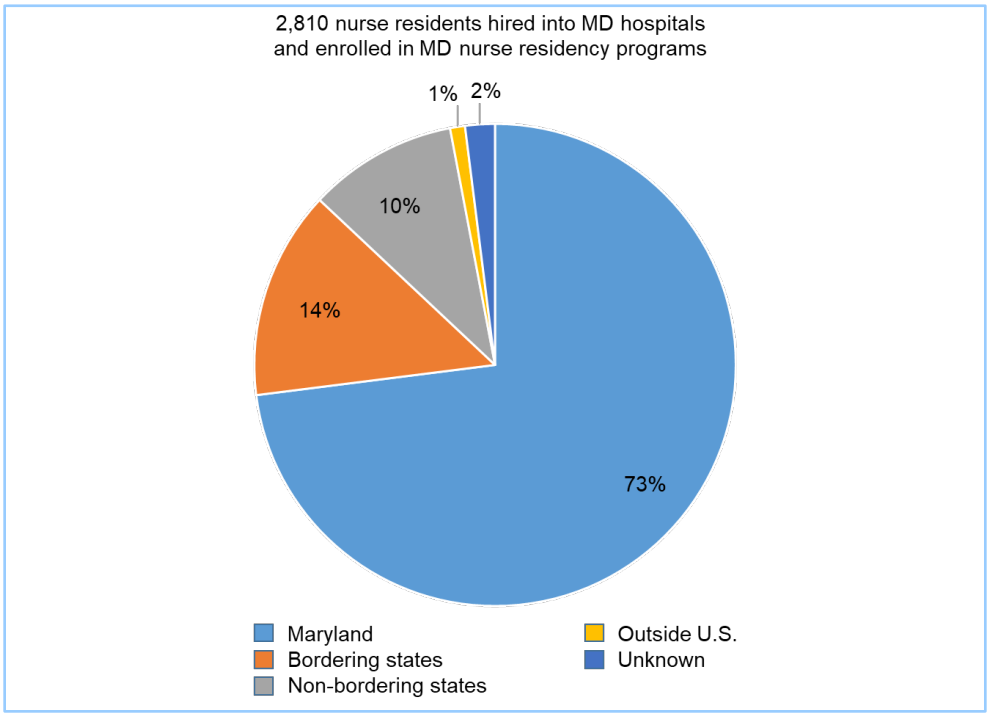
Examining the employment of new nursing graduates is critical when assessing the state of the nursing workforce in Maryland, as it directly reflects the ability of the healthcare system to absorb and retain newly licensed professionals. The transition from education to practice is a pivotal phase in a nurse's career, and the availability of jobs for new graduates is influenced by factors such as workforce demand, job market saturation, and the quality of workplace environments. Analyzing employment trends among new graduates provides valuable insights into potential gaps in staffing, identifies areas where the healthcare system may be struggling to meet demand, and helps to forecast future workforce needs. Understanding these patterns is essential for shaping workforce development strategies and ensuring that nursing programs align with the evolving needs of the healthcare sector.

A key goal of the Nursing Support Program II (NSP II) is to ensure that nurses trained in Maryland remain in the state to practice upon graduation. By encouraging in-state employment, the program aims to address the growing demand for qualified nurses within Maryland's healthcare system, particularly in underserved regions and specialty areas. Collecting and analyzing data on the in-state employment of new nursing graduates is essential for evaluating the success of this initiative. This data will help measure whether Maryland's nursing workforce is effectively retaining its newly trained professionals and highlight areas where additional support or policy changes may be needed to increase in-state employment rates, ultimately contributing to a stronger, more sustainable nursing workforce in the state.

In 2023, a total of 2,810 nurse residents were hired into Maryland hospitals and enrolled in Maryland Nurse Residency Programs (NRPs). The majority of these residents, 73 percent, came from Maryland nursing schools (Figure 5). Among the residents who graduated from Maryland nursing schools, the majority came from schools in the central region (72%), followed by the capital region (13%), the eastern shore (8%), southern Maryland (4%), and western Maryland (3%). Additionally, 14% of the residents came from

bordering states, 10% from other states, and 1% from non-US nursing schools, which accounted for 21 individuals. A small portion of the data, 2 percent, were invalid entries. Pennsylvania and Virginia were the largest contributors outside of Maryland. In terms of educational background, 43 percent of the residents held an Associate Degree in Nursing (ADN), 49 percent held a Bachelor's degree, 7 percent held a Master's degree, and 1 percent had unknown or diploma-level education. Demographically, 44.28 percent of the residents identified as a racial or ethnic minority, and 10.57 percent were male. The median age of the residents was 26 years.

Figure 5. Educational Preparation of Maryland Nurse Residents Hired in 2023



Source: Vizient/ AACN NRP Data for MONL, Inc. /MNRC, October 11, 2024.

Nurse Burnout & Impact of COVID-19 Pandemic

Recent surveys have demonstrated, both nationally and in Maryland, that nurse well-being and their intent to remain in the profession were being negatively affected by pandemic-related stress, staffing levels, working conditions, increased violence in the workplace, and day-to-day uncertainties with changing patient acuity. In a three-part longitudinal study, the American Organization for Nursing Leadership (AONL) documented continually worsening job satisfaction, burnout, and intent to leave the profession by nursing leaders. A 2021 Washington Post-Kaiser Family Foundation survey found that 30 percent of healthcare workers were considering leaving their profession altogether. Exacerbating the losses is the imminent retirement of all baby boomers that will reach the traditional retirement age of 65 by 2030, leaving a gap in

accumulated skills, knowledge, and experience. Unfortunately, this loss in the RN workforce coincides with the increased healthcare needs of our aging population who have more acute and chronic conditions.

The National Council of State Boards of Nursing recently examined the impact of the COVID-19 pandemic on the nursing workforce in the U.S. and found that 100,000 nurses left during the pandemic and one-fifth intend to leave by 2027 due to stress, burnout, and retirement (NCSBN, 2023). In 2021, the Maryland Nursing Workforce Center surveyed nearly 2,000 nursing staff about the impact of the COVID-19 pandemic and the results are alarming. Many nurse respondents reported that they were physically exhausted:

- 48 percent had experienced sleep disturbances,
- 40 percent experienced moderate to severe stress,
- 48 percent felt anxious,
- 43 percent were unable to control worrying, felt hopeless, and had little pleasure in usual things, and
- 49 percent had symptoms of burnout.

Additionally, about 62 percent of nurses felt their physical health and safety were compromised without their consent, and more than 60 percent indicated an intent to leave their current nursing job. When asked what would make them more willing to remain in the Maryland nursing workforce, 83 percent said that financial incentives with salary increases, annual bonuses, hazard pay, and/or increased retirement contributions, while 74 percent indicated improved staffing and nurse to patient ratios, the ability to self-schedule and flexibility in shift work would make a difference. Other motivators were acknowledgements, wellness resources, and personal protection during large-scale emergencies.

A recent study conducted by Auerbach et al. (2024) showed that nursing workforce projections have rebounded to pre-pandemic levels despite a decrease of more than 100,000 RNs during the COVID-19 pandemic. Additionally, the study found a shift in nurse employment to non-hospital settings, which represented almost all of the growth in workforce from 2018 to 2023 (Auerbach et al., 2024). For this reason, hospitals may still be experiencing nurse shortages despite growths overall. Nurse burnout and intent to leave the profession also persists and adds to the challenges of a looming nursing shortage.

The state faces significant nursing workforce shortages, exacerbated by burnout and an aging workforce. Maryland is addressing this by investing in nursing education and improving workplace environments to retain nurses.

Stakeholder Engagement

Nursing workforce stakeholder engagement refers to the collaborative efforts of various groups (such as nurses, healthcare leaders, policymakers, educators, and patients) to address issues affecting the nursing workforce. The goal is to identify challenges, propose solutions, and create policies that support the

recruitment, retention, and development of nurses. This process ensures that the voices and perspectives of all relevant parties are considered in decision-making. Effective stakeholder engagement leads to improved policies that enhance the nursing workforce, ensure better care delivery, and help address nursing shortages and job satisfaction.

In April 2024, MHEC and HSCRC staff initiated a comprehensive program review to guide the program renewal process. Throughout this process, staff regularly engaged with key stakeholders to assist with completing a comprehensive program renewal and end-cycle progress report. Examples of stakeholder engagement activities included:

1. **NSP I/II Advisory Group:** This pre-established group meets tri-annually to discuss current issues affecting the nursing workforce. The meeting dates, times, and agendas are public and posted to the NSP website. Membership includes select leadership from the following organizations:
    - Maryland Hospital Association,
    - Maryland Action Coalition,
    - Maryland Organization of Nurse Leaders,
    - Maryland Nurse Residency Collaborative,
    - Maryland Nurses Association,
    - Maryland Council of Deans and Directors of Nursing Programs,
    - Maryland Nursing Workforce Center,
    - Maryland Board of Nursing, and
    - HSCRC NSP I Advisory Board
2. **NSP II Program Renewal Committee:** This new committee was established in 2024 and primarily tasked with coordinating a plan and analyzing program data for the combined program renewal and end-cycle progress report. A total of five strategic planning sessions were conducted leading up to the program renewal. Membership included leadership from schools of nursing in Maryland, and representation from the Maryland Hospital Association, Maryland Nurse Residency Collaborative, Maryland Nursing Workforce Center, and HSCRC.
3. **MD Deans/Directors:** The Maryland Deans and Directors group meet every other month to discuss issues affecting Schools of Nursing and membership includes leadership from all schools of nursing in the state. NSP II is invited to attend all meetings and has the ability to engage in group discussions.
4. **MD Nurse Workforce Center:** The Maryland Nurse Workforce Center Advisory Committee meets quarterly to discuss the goals/initiatives of this NSP II-funded statewide initiative. NSP II is a member of the Advisory committee and regularly collaborates with this group to conduct data analysis relevant to program renewal.

Outside of the activities mentioned above, NSP II program staff regularly attended and/or presented at relevant national and statewide meetings and conferences to gather input about key problems affecting the nursing workforce. This included attendance at the following events during the past two years:

- National League for Nursing's Annual Nursing Education Summit
- National League for Nursing's Nursing Education Research Conference
- Organization for Associate Degree Nursing Annual Conference
- Maryland Nurses Association Annual Conference
- Maryland Action Coalition Annual Summit
- National Council for State Boards of Nursing NCLEX Conference
- Maryland Nurse Residency Collaborative Inaugural Conference

To further increase participation from stakeholders in Maryland and solicit feedback to guide the NSP II program renewal and recommendations, HSCRC and MHEC staff conducted an online survey that was sent electronically to leaders in nursing education, nursing practice, and healthcare organizations in the state, including all Maryland Deans & Directors, NSP II Program Renewal Committee members, NSP I/II Advisory Group members, the Project Directors of current statewide NSP II grant projects, Nurse Support Program I Coordinators, and all Chief Nursing Officers at Maryland hospitals. The survey was conducted via Google Forms and accepted responses over a three-week period. A total of 21 leaders responded to the survey, including 15 education partners and 6 practice partners. The majority of respondents (90 percent) answered "very well" or "well" when asked how effectively NSP II has met its overarching goal of increasing the number of nurses in Maryland by strengthening nursing faculty and educational capacity, ultimately improving the quality of care and reducing hospital costs. Additionally, 95 percent of respondents felt that NSP II aligned with their organization's or community's goals. When asked what observable impacts or benefits the program has provided to the nursing workforce and their organization or community, common positive themes from respondents emerged, including (in order of prevalence):

1. Faculty development and retention;
2. Leadership and professional development;
3. Expansion of nursing programs and enrollment;
4. Collaboration and academic-practice partnerships;
5. Development of advanced nursing roles;
6. Support for critical workforce needs; and
7. Support for diversity and underrepresented groups in nursing.

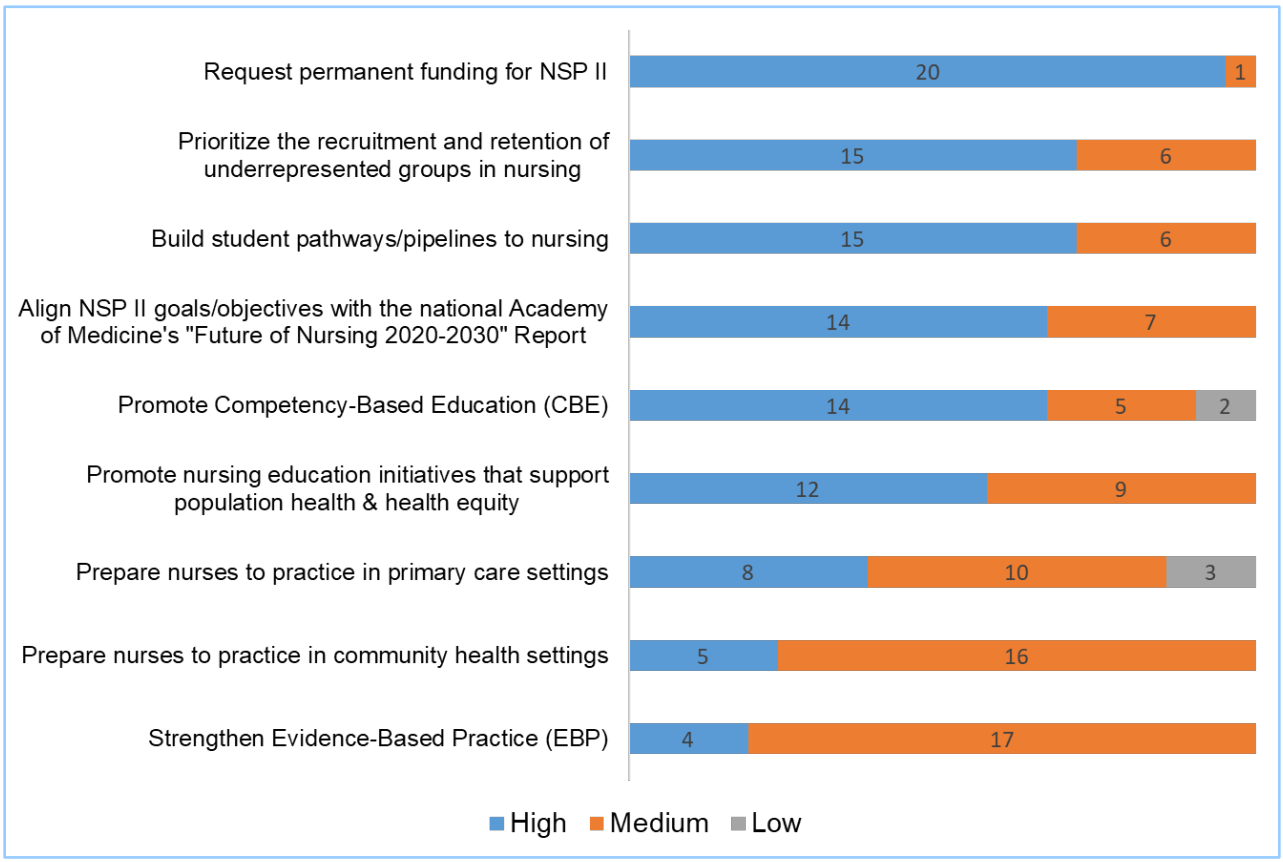
When asked what the most pressing needs and challenges of their organization were, common responses included:

- The recruitment and retention of nurse faculty;

- The need for more diverse and innovative clinical training opportunities;
- The ongoing need for resources, including funding, simulation equipment, and classroom/lab space, to expand nursing programs; and
- The desire to develop academic-practice partnerships to prepare nursing graduates to practice in community and population health settings.

Survey respondents were asked to provide feedback on the recommendations for future program funding. A summary of the feedback received from survey respondents regarding potential areas for expansion of the program is provided in Figure 7.

Figure 7. NSP II Stakeholder Engagement Survey: Summary of Feedback re: Program Renewal



Note. Total respondents = 21.

Comments from the public will be solicited and a summary of this feedback will be provided with the final report with recommendations in February 2025.

Staff Recommendations for Program Renewal

The current cycle for NSP II program funding concludes at the end of FY 2025. Based on the available data presented in this report, there is a demonstrated need to continue funding for the NSP II program. HSCRC

and MHEC staff present the following targeted strategies to strengthen the support for hospitals and schools of nursing in Maryland with the NSP II program renewal, including:

- Request to continue NSP II as an ongoing program with permanent funding with the requirement of annual reports on funded activities and accomplishments, replacing the five-year program renewal cycle.
    - In 2022, the Commissioners approved NSP I as an ongoing program with an annual reporting requirement, replacing the previous five-year program renewal cycle. This recommendation aims to align both programs under a similar funding and reporting structure, while also supporting goals and activities that foster clinical training and employment pipelines between NSP I and II. Aligning the two programs will improve grant planning by preventing duplication of efforts, ensuring more efficient use of resources, and maximizing outcomes across the state.
    - Approving NSP II as an ongoing program with annual reporting would support competitive institutional grant planning. Permanent funding ensures grant projects are fully planned and executed with the right scope and timelines, eliminates funding gaps, and allows for efficient resource allocation. It also encourages innovation, supports more expansive projects, retains talent, and attracts diverse proposals. Permanent funding for NSP II promotes high-quality, evidence-based programs, enhances impact and sustainability, and fosters long-term partnerships.
- Update the following NSP II Initiatives:
    - Prioritize educational initiatives that aim to prepare nurses to address health equity and practice in community/ population health settings in support of ongoing care delivery transformation and the goals of the Maryland Model; and
    - Revise existing initiatives related to the goals in the National Academy of Medicine's *Future of Nursing 2020-2030* report based on state/national progress, adjusting the weight of proposal scoring criteria to prioritize areas where greater improvements are needed. This will ensure that resources and efforts are focused on the most critical areas for advancing the *Future of Nursing* objectives.
- Identify intentional opportunities to prioritize funding to underrepresented groups in nursing:
    - Revise the scoring criteria for grant proposals to promote projects that are focused on improving student and faculty diversity;
    - Develop a category of resource grants to support underrepresented nursing student success;
    - Expand and create statewide resources to promote ongoing mentorship of underrepresented faculty; and

    - Create a new category of the Nurse Faculty Annual Recognition (NFAR) award that recognizes faculty who demonstrate excellence in mentoring underrepresented students, fostering a diverse and inclusive educational environment, or conducting research on diversity and healthcare equity.
- Collaborate with HSCRC and stakeholders to align NSP I and NSP II goals:
    - Build student pathways/pipelines to nursing with consideration for filling nursing vacancies in understaffed specialty units and care settings, to include primary care and community health;
    - Strengthen the evidence-based practice (EBP) of new graduate nurses; and
    - Promote competency-based education (CBE).
- Enhancements to the infrastructure for the collection and analysis of program data to promote greater accountability in the reporting of statewide data, including:
    - Electronic submission of data from potential grant recipients as a requirement for funding consideration with the goal to receive data from all schools of nursing to allow a more robust statewide analysis of key metrics (faculty/student demographics, graduation rates, employment, faculty vacancy, advanced credentials of faculty, academic progression of students, etc.);
    - Collaborate with NSP I and the Maryland Nurse Residency Collaborative (MNRC) to collect data regarding new graduate employment in Maryland; and
    - Improve the collection and analysis of data related to underrepresented groups in nursing to demonstrate the impact NSP II initiatives have on promoting diversity in nursing education and practice.

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maryland
health services
cost review commission

2025 Savings Over Target Funding

Final Recommendation

December 11th, 2024

P: 410.764.2605 | 4160 Patterson Avenue | Baltimore, MD 21215 | hscrc.maryland.gov

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List of Abbreviations

AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
GBR	Global Budget Revenue
MPA	Medicare Performance Adjustment
NCBP	Non-Claim-Based Payment
TCOC	Total Cost of Care
TCOC Model	Total Cost of Care Model

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To prepare for successful implementation of the AHEAD model.	$50 million will be added to hospital rates to support staffing and workforce costs. Additionally, a one-time adjustment to rates will be used to provide $25 million to the Population Health Trust. This temporary rate increase will be contingent on the creation of the fund.	Each Maryland hospital would gain directly from the additional workforce funding and indirectly from strengthening of the Maryland model for AHEAD.	The rate increase will add to the costs for payers and consumers however payers and consumers will also benefit from the impact as the held funds are allocated to population health improvement efforts. The workforce funding will also support access to acute care services.	As one of the fundamental goals of AHEAD is increasing health equity, preparing for successful implementation will advance this goal.

Summary of the Recommendation

Staff recommend the Commission increase rates as of January 1, 2025 by $50 million annually, on an all payer basis. The increased revenue is intended to support hospital staffing needs particularly through increases to regulated margins to offset unusual pressure in physician support costs experienced over the past few years. This investment in the hospital workforce will bolster access to acute care services across the state, improve hospital throughput, and support hospital efforts to reduce emergency department length of stay. The permanent nature of the rate increase recognizes that the costs associated with these efforts are continuous in nature. By July, the Commission will also request that hospitals provide a description of the strategies they are using to recruit and retain hospital staff and manage staffing costs to inform future policy development related to these and other funding efforts. The Commission will also initiate a policy process involving payers and physicians to discuss approaches to addressing these challenges.

Additionally, $25 million will be held and directed to the Population Health Trust the State agreed to establish under the AHEAD agreement. This one-time funding will be

contingent on the establishment of the Population Health Trust by the Maryland General Assembly. The rate increase is only for calendar year 2025 and will sunset at the end of the year if the Commission takes no further action.

There is sufficient room under the Total Cost of Care Model (TCOC Model) savings target to fund these efforts.

Background

AHEAD

The States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD) is an 11-year multi-state total cost of care (TCOC) model administered by the Centers for Medicare and Medicaid Services (CMS). The Model seeks to drive state and regional healthcare transformation and multi-payer alignment to curb healthcare cost growth, improve population health, and advance health equity by reducing disparities in health outcomes across all payers including Medicare, Medicaid, and private coverage.

Maryland will begin its AHEAD implementation period on January 1, 2026. To ensure successful implementation, significant investment is necessary to accelerate healthcare transformation, bolster access to necessary services, and develop and launch an equity-centered population health strategy.

Population Health Trust

Under the AHEAD agreement the State committed to establishing a Population Health Trust composed of public and private sources to support statewide population health improvement initiatives in alignment with the Statewide Health Equity Plan (HEP) and State Health Improvement Plan (SHIP). The Statewide HEP will be developed by the State and Maryland Commission on Health Equity (MCHE) and will serve as the foundation for all actions and investments under AHEAD. The plan is set to be finalized by July 2025 and will include quality and equity measures, along with performance targets for the state under the Model. It will address key areas such as chronic disease, behavioral health, healthcare access and utilization, population health, and the promotion

of prevention and wellness. Maryland's SHIP has already established priorities, strategies, and targets aimed at improving health, based on needs identified in the State Health Assessment (SHA), which provides a comprehensive overview of the state's current health status.

The state is strongly supportive of the Population Health Trust as a mechanism to advance an aligned, statewide strategy for population health improvement and believes that funding this year will maximize its opportunity to leverage philanthropic and other support for population health efforts. The funding will be used for a strategy that involves community health and healthcare delivery with opportunities for all stakeholders to participate.

Availability of Funds - Model Savings Position

For Calendar Year 2023 (CY23) CMS certified Maryland saving under the TCOC Model of $509 Million versus a target of $300 Million. During the Update Factor Staff estimated savings remaining approximately flat into 2024. However, through July 2024[1] (YTD CY24) Maryland's savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally. This variance is driven primarily by accelerations in national hospital spending and a slowing in Maryland non-hospital spending in comparison to the nation. Specifically:

- An increase in the national hospital per beneficiary growth to 6.7% in YTD CY24 compared to 3.7% for the same period in CY23 and average annual growth from 2013 to 2023 of 2.5%
- A reduction in Maryland non-hospital per beneficiary growth to 4.3% in YTD CY24 compared to 5.3% for the same period in CY23. For the same time period national non-hospital growth has gone up from 5.1% to 5.9%.

[1] All CY24 amounts are through July 2024 and include 2 months run out and completion. All prior periods include 3 months run out. This approach is consistent with ongoing TCOC reporting methods.

The $100 M extra savings accumulated year-to-date is split approximately 50:50 between hospital and non-hospital drivers. As long as national trends remain high and Maryland non-hospital trends remain low, Staff expect the positive savings to continue into 2025.

While Staff believes Maryland will end Calendar Year 2025 well above the TCOC Model target of $372 million and therefore some actions to utilize savings above target are appropriate, Staff also note there are a number of contextual factors to consider and these informed the recommendation of a $50 Million increase:

- The $509 million savings in 2023 will become the baseline for AHEAD starting in 2026 and should savings go below that level in the intervening years they will have to be recovered to achieve 2026 targets.
- Savings are driven by high national hospital spending and low Maryland non-hospital spending. Both factors lie largely beyond the control of the Commission.
- As noted in the bullet above YTD CY24 national hospital growth is very high compared to historical averages and data reflects only 7 months of experience
- YTD CY24 Maryland hospital growth of 4.3% is in line with projections made during the Update Factor and reflects significant catch-up inflation adjustments made during that process and significant demographic catch up adjustments made during the prior Update Factor.
- CY23 savings of $509 million were a considerable acceleration from 2022 levels of $269 million but when compared to pre-pandemic 2019 savings of $364 million are generally in line with the rate of savings accumulation ($60 M per year 2014 to 2019 versus $51 M per year 2014 to 2023). Therefore, 2023 savings levels when compared to 2022 should not be considered unusual within the longer-term view of the model but rather a correction from disruption triggered by the pandemic and continued savings into 2025 would still be within the longer-term model trajectory.

- The performance on the TCOC Model savings test described above reflects only Medicare Fee-for-Service performance, to justify an all-payer rate increase the Commission must assume other payers are seeing a similar benefit. Staff analysis has previously shown that TCOC Model has resulted in hospital cost growth below Gross State Product so the correlation of Medicare performance with all-payer performance has a historical basis but due to data lags Staff can not demonstrate the same is true of the current savings over target.

Medicare physician fee schedule increases have not kept up with inflation, particularly in recent years.[2] As Medicare fee schedules are also the basis for other fee schedules this phenomenon likely translates into other payer spaces as well. As a result, the pressure to maintain physician reimbursement is increasingly transferred to hospitals, who are asked to subsidize the fee-for-service payments in order to maintain hospital coverage and compete for physicians in national labor markets. This growing demand for subsidies requires Maryland hospitals to maintain their regulated margins versus pre-COVID periods and increase their regulated margins versus pre-GBR periods. This circumstance might be further exaggerated in Maryland because global budgets encourage shifting services to less expensive settings (while traditional Medicare Fee-for-Service often incents the opposite) resulting in a greater share of Maryland's physician reimbursement flowing through the limited Medicare professional fee schedules. These cost pressures may also have broader implications for the healthcare workforce in Maryland.

Stakeholder Comments

In the November 13 Commission meeting, Staff recommended the Commission increase rates as of January 1, 2025 for Calendar Year 2025 by 1.6 percent, on an all payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission. Twenty percent of the funds held will

[2] See for example here, here and here on Medicare payment trends through 2023. More recent increases have also been limited, see discussion here.

be directed to the Population Health Trust the State agreed to establish under the AHEAD agreement and the remaining eighty percent will be used for newly established programs as described in the prior section. The Commission was to provide specific directions for the use of funds after the creation of the necessary funding vehicles.

To avoid increasing the cost to Medicaid under this proposal, Staff recommended an increase to the deficit assessment paid to Medicaid to offset the cost of this rate increase to the Maryland Medicaid program. Hospitals would pay this assessment out of a portion of the funds they are holding under this rate increase.

The Commission received multiple perspectives in the comments to the proposed approach. In general, the payers commenting (including United HealthCare, Carefirst, and the League of Life and Health Insurers) did not support the recommendation to increase rates off cycle suggesting the increase would adversely impact members. Additionally, they believe that any costs funded should be determined prior to fund distribution. Finally, they expressed concern over the fairness for consumers and the impact the increased rates would have on the affordability of coverage.

The Local Health Departments and Community Health Representatives (including St. Mary's, Cecil, and Community Behavioral Health Assoc.) are enthusiastic about the opportunity to continue investments in the community through the Population Health Trust and believe this is an opportunity to advance the AHEAD Model. They cited critical funding needs to improve the health of their communities.

Hospitals (Including the Maryland Hospital Association, UMMS, JHHS, LifeBridge, and TidalHealth) had a range of responses to the recommendation. Most hospitals supported the direct funding of hospitals. Commenters suggested that hospitals are underfunded for various cost drivers. In particular, commenters indicated that funding should be directed to ease the financial strain caused by workforce and capital needs. LifeBridge requested that some of the funding be directed towards Medicare Advantage plans. TidalHealth urged the Commission to not direct the hospital to retain funding until newly established programs were available for reinvestment. The Commission also

received comments from hospitals that permanent rate increases are most helpful for mitigating permanent cost drivers such as the staffing of hospitals.

Finally, Maryland Department of Health and Maryland Department of Budget and Management urged consideration for the State's budgetary crisis. They suggested that the proposed increase in rates could have a significant impact on the State's budget for Medicaid and State employee benefits. They expressed support for the funding of the Population Health Trust and the opportunity to initiate investment in a comprehensive, statewide health equity and population health plan. Staff recommend $25 million in one-time funding to support this effort and accelerate efforts on population health under AHEAD; additional funding for this Population Health Trust should be considered based on the development of the trust.

Informed by the feedback from stakeholders, Staff have modified the initial approach as described in the November recommendation. First, given the concerns expressed for the impact on rate payers and consumers as well as on the State's budget, Staff concur with the suggestions that new, unspecified initiatives require more development before rates are increased or funding is provided. Therefore, the final recommendation does not include rate increases to be held and directed to such a fund. However, Staff will continue to work with hospitals and other stakeholders to further develop solutions to critical challenges facing the Maryland healthcare system.

HSCRC will be able to consider additional spending on efforts that are fully developed to prepare for AHEAD. Drawing from stakeholder feedback and discussion with Commissioners, areas of focus for future policy development (in addition to physician and broader workforce costs) would include the following:

- Innovative delivery reform efforts, such as total cost of care arrangements with hospitals and common platforms to improve costs and health outcomes.

- Funding for graduate medical education programs in the context of a review of GME funding to meet the health needs of Maryland.

- Support for health care transformation in the national capital region, an area that has received disproportionately fewer resources and has high health needs.

- A statewide program to support and align Medicare Advantage plans with hospitals in achieving goals of the Model such as reductions in low-value or avoidable hospital services. Developing this effort will require collaboration between the plans, hospitals, the MIA, and the HSCRC. Key principles include risk sharing, clear metrics, a commitment to expanding services for patients, and collaboration across the health care system.

Staff Recommendation

Staff recommend the Commission increase rates as of January 1, 2025 by $50 million annually, on a permanent all payer basis. The increased revenue is intended to support hospital staffing needs particularly through increases to regulated margins to offset unusual pressure in physician support costs experienced over the past few years. This investment in the hospital workforce will bolster access to acute care services across the state, improve hospital throughput, and support hospital efforts to reduce emergency department length of stay.

Workforce needs were among the most pressing cost drivers mentioned by commenters, and the permanence of the proposed rate increase recognizes that the costs associated with these efforts are continuous in nature. By July, the Commission will also request that hospitals provide a description of the strategies they are using to recruit and retain hospital staff and manage staffing costs. This information will be used to inform policy development, involving payers and clinicians, to support hospital workforce and access to acute care services in Maryland related to these and other funding efforts.

Additionally, $25 million in one-time rate increases will be held and directed to the Population Health Trust the State agreed to establish under the AHEAD agreement. The Commission will provide specific directions for the funding contingent on the establishment of necessary funding vehicle by the Maryland General Assembly. The rate

increase is only for calendar year 2025 and will sunset at the end of the year if the Commission takes no further action.

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December 2, 2024

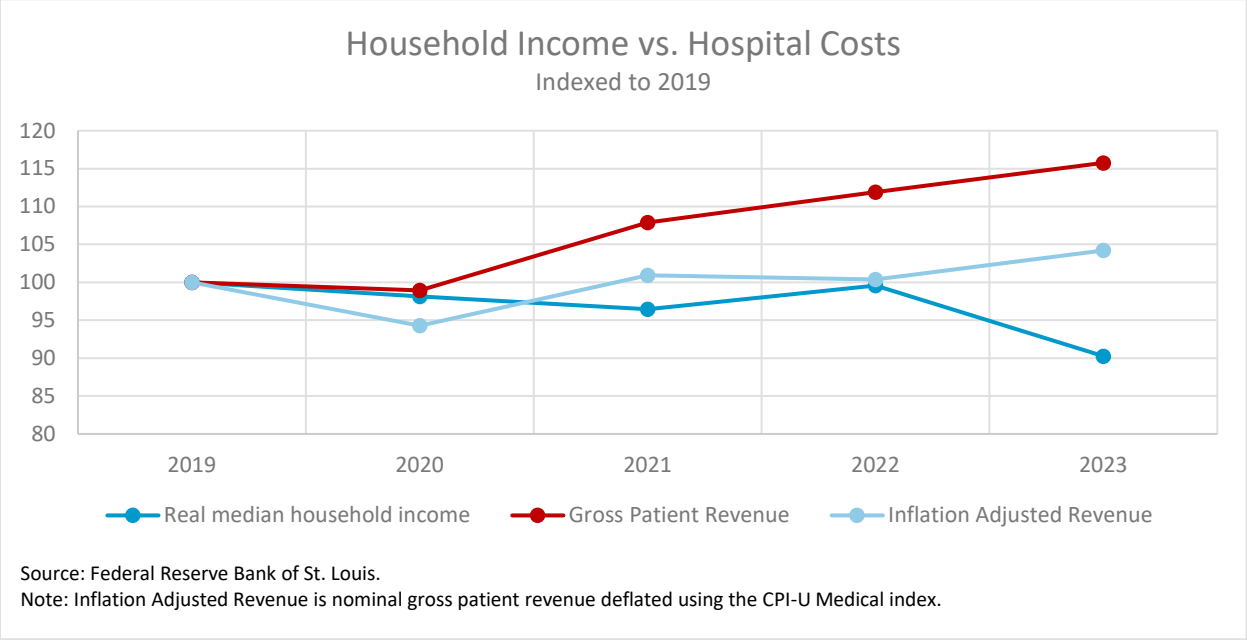
Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield ("CareFirst") appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation on AHEAD Model Preparations. We support investments in population health and have consistently urged the HSCRC to focus on access, affordability, equity, and quality. Therefore, we are supportive of the HSCRC identifying priorities and directing and monitoring funding. However, we do not support placing an added burden on consumers through a 1.6% rate increase.

The original premise of the All-Payer Model and Global Budgeted Revenue (GBR) dating back to 2014 was that hospitals would focus on reducing avoidable utilization, retain the revenue when volumes declined, and in turn use those retained revenues to support population health interventions. The HSCRC staff recently calculated that hospitals have more than $650 million in retained revenue funded and inflated year after year by consumers. As such, funding for population health investments does not require a wholesale rate increase. It would be unfair to force consumers to pay twice for these interventions, particularly when the HSCRC has been unable to validate that the $650 million has been appropriately invested in concert with population needs and model objectives.

HSCRC staff continues to assume consumers can afford rate increases because of Maryland's favorable performance on the Medicare savings test, which is a flawed assumption. Since 2019, median household income in Maryland has increased at an average annual rate of 1.3% while hospital budgets have grown at an average rate of 3.0%. HSCRC has heard consistent testimony from hospitals about inflationary pressures on their budgets, but those same pressures are faced by consumers. Median household income after accounting for inflation has *fallen* by 9.7% since 2019.



Source: Federal Reserve Bank of St. Louis.
Note: Inflation Adjusted Revenue is nominal gross patient revenue deflated using the CPI-U Medical index.

We recognize that addressing the uses of retained revenues raises challenging political and policy issues, such as the excess capacity in some hospitals, hospital cost structure efficiency relative to national peers, and preserving service access. With the model concluding its tenth year, it is past time to confront these issues, particularly as we embark on the upcoming AHEAD model journey. Without resolution, consumers are repeatedly and unfairly paying the price.

Given the premise of GBR, population health funding already paid for in the system by consumers, and growing affordability concerns, the HSCRC should not raise rates as proposed. Thank you again for the opportunity to comment on HSCRC's recommendation for AHEAD Model Preparations.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224

CECIL COUNTY HEALTH DEPARTMENT
JOHN M. BYERS HEALTH CENTER • 401 BOW STREET • ELKTON, MD 21921
LAUREN LEVY, JD, MPH, HEALTH OFFICER
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Comment on the Maryland Health Services Cost Review Commission
2025 Funding for AHEAD Preparation: Draft Recommendation

I am writing in strong support of the recommendations put forward by the Maryland Health Services Cost Review Commission related to the recently signed AHEAD Model agreement between CMS and the State of Maryland.

As a public health professional, I welcome the opportunities that the AHEAD model presents to center and elevate community voice in efforts to advance health equity and help each member of our community achieve their optimal health. This is work that local health departments (LHDs) have been doing for many years and we are eager to support and advance the efforts of the AHEAD model.

Local health departments are extraordinarily well positioned to develop, in collaboration with hospital partners and community providers, innovative models that best meet the needs of community members. Indeed, LHDs have been hubs for innovation for many years. In Cecil County, for example, we have developed unique approaches to meet the healthcare needs of our community, including individuals at risk for or diagnosed with substance use disorders (SUD).

We currently support an innovative, private-partnership model that ensures access to an onsite peer recovery specialist in the hospital 7 days per week, from 8am to 1am and telephone access to a live peer recovery specialist 7 days per week, 24 hours a day. This program is implemented by the Cecil County Health Department, Voices of Hope, Inc., a leading recovery community organization serving Cecil and Harford Counties, and the ChristianaCare Union Hospital. In addition to the peer model, over the past several months, we have rapidly developed a formal system of care for individuals with SUD who are experiencing severe wounds related to the presence of xylazine in the drug supply, strengthening linkages between community, primary, and hospital levels of care. We have heard directly from community members with SUD-related wounds that they are having more positive care experiences.

These are just two brief examples of local health department efforts that serve key aspects of Maryland's vision for the AHEAD model, namely ensuring high-value care through innovative models that align public and private investments as well as improving access to care by strengthening the behavioral health care continuum. These efforts, as with so many local health department services and programs, were developed as a direct result of community input and are built on a foundation of strong community partnerships.

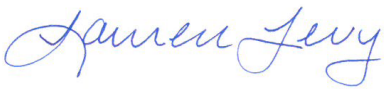
The 20 percent of funds to be directed to the Population Health Trust established under the AHEAD agreement would provide critical support to facilitate expansion of similar efforts throughout Maryland. For the remaining 80 percent, local health departments can contribute

valuable insight regarding community needs as the HSCRC works to identify priorities for funding allocations.

Our large healthcare systems provide critically important services. However, they are not as well equipped to develop and implement programming that centers community voice to ensure that services meet needs in the most equitable, effective, and appropriate manner. LHDs and community-based organizations working at the local level are trusted partners skilled at elevating community voice and developing innovative solutions to addressing health-related social needs.

The AHEAD model provides a tremendous opportunity to expand and strengthen collaborations between the people of Maryland, local public health, community-based organizations, hospitals, payers, and the Maryland Department of Health. I look forward to working with these stakeholders to empower all Marylanders to achieve optimal health and well-being.

Sincerely,



Lauren Levy
Health Officer
Cecil County

MARYLAND COMMISSION ON PUBLIC HEALTH

Comment on the Maryland Health Services Cost Review Commission
"2025 Funding for AHEAD Preparation: Draft Recommendation"

The Commission on Public Health (Commission) regards the referenced Health Services Cost Review Commission (HSCRC) draft recommendation as an extraordinary step. The proposal aims to leverage the State's public and private resources to successfully achieve the AHEAD targets, to align with existing public health efforts and capacity, and most importantly, the proposal promises to measurably improve the health of all Marylanders.

The Commission on Public Health supports the HSCRC staff recommendation for the reasons noted below and encourages its adoption and full implementation. The Commission also recommends as described below that the HSCRC AHEAD implementation reflects, supports, and leverages the public health capabilities of health departments across the state.

1. **Aligned action.** HSCRC's AHEAD implementation recommendations will synchronize and accelerate multi-pronged action on the goals of the just-released State Health Improvement Plan and the forthcoming Health Equity Plan. The State Health Improvement Plan reflects some of the common health priorities of local health improvement plans for each Maryland jurisdiction.

2. **Curing disease is not enough to achieve health equity.** The AHEAD implementation recommendations establish that hospitals alone cannot attain Statewide Quality and Equity Targets, particularly given the AHEAD model's important new all-payer approach which includes the Medicaid population. Public health agencies have extensive expertise and on-the-ground partnerships relevant to the Target domains: Population Health, Prevention and Wellness, Chronic Conditions, Behavioral Health, Maternal Health, Prevention and Social Drivers of Health. The AHEAD framework should leverage the role of local health officers as the chief health strategist in their jurisdiction, and the multisector partnerships convened by local health departments to advance public health and health equity.

3. **Statewide and local geographic coordination.** Likewise, achievement of the Statewide Population Health Targets, to be determined by July 2025, will require collective action by a broad array of partners with geographic state and local coordination. The importance of significant guiding contributions by state and local public health assets to the work of achieving Population Health Targets cannot be overstated.

4. **Establishes infrastructure, the Population Health Trust, to administer and monitor public and private investment.** The success of the AHEAD model will require action

beyond hospitals. The Population Health Trust creates an important mechanism for public and private resources to support spirited health improvement engagement by effective and accountable public health agencies, primary care, social service providers and others. The HSCRC proposal describes an affordable means to launch AHEAD implementation by funding (1) new programs to address the cost and delivery of health care services and (2) a Population Health Trust to support statewide population health improvement initiatives of which public health is an essential component.

The creation of an independent fund to manage and monitor public and private investments in upstream, community-level prevention promises truly transformative outcomes. Per the State's agreement with the Centers for Medicare & Medicaid Services, the Trust would support activities such as reducing rates of preventable conditions, increasing healthy habits, addressing health-related social needs, reducing or eliminating health disparities and building evidence of effective prevention programs. The Trust provides an exceptional opportunity to leverage Maryland's unique health assets, including proven, evidence-based public health initiatives, to drive aligned, accountable and effective collective action toward a healthier Maryland.

5. **Affordable and adaptable funding mechanism.** The AHEAD model's lengthy timeline of 11 years allows the opportunity to demonstrate the effectiveness of longer-term community level prevention interventions. While the specific funding mechanism as described in the proposal may not be fully achievable in certain rate years, a collaborative public/private, state/local infrastructure would be in place. Other funding sources could be tapped to support ongoing efforts.

6. **Workforce investment**. The proposal includes seven areas of potential investment under new programs to address health cost and delivery challenges. One area "Workforce investments, including but not limited to updates to the GME program" addresses a major barrier to health equity, particularly in rural Maryland. The shortage and maldistribution of primary care residencies could be attenuated with adequate investment into new primary care training programs and practices in underserved and rural communities, resulting in significantly improved access and reduced health disparities for underserved Marylanders.

The Commission on Public Health appreciates the commitment of Governor Wes Moore and the Maryland Legislature toward advancing the health of all Marylanders. The Commission commends HSCRC's progressive policies which reflect the importance of community-based prevention, primary care and social support along with acute care. The Commission looks forward to continuing engagement with HSCRC and the Commission on Health Equity as details of AHEAD implementation are constructed.

December 2, 2024

Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the draft recommendation for 2025 funding for AHEAD preparation. Staff recommends implementing a rate increase of 1.6% for 2025 hospital rates and redirecting these funds to further the goals of the AHEAD model; while encouraging to see that the HSCRC is taking steps to acknowledge that exceeding the savings target in any given year is not appropriate, JHHS believes the recommendation as drafted presents several challenges.

JHHS's concerns and comments are detailed further below.

Redirection of Funding

Excess savings represent a clear underfunding of Maryland hospitals, as also demonstrated by the deteriorating financial performance of Maryland hospitals. Therefore, the most productive use of these funds is to address this underresourcing by redirecting funds back to hospitals.

The draft recommendation also indicates that legislative action is required to capture and direct this funding. However, in light of the State's current fiscal challenges, there is considerable risk that any action to increase hospital rates for a dedicated purpose will be redirected to support shortfalls in the State's General Fund.

Further, according to the AHEAD agreement, the Population Health Trust is intended to be funded by a mix of both public and private sources. It is critical that the State also demonstrate its support for the AHEAD model by contributing to this fund. Without this financial commitment from both the State and the industry, a concerning precedent may be set for this fund to be solely supported through hospital rates.

New Programs to Address Health Cost and Delivery Challenges

While all areas of potential areas of investment noted in the draft recommendation are worth exploring, given the concerning fiscal situation of many Maryland hospitals, focus should be on addressing

challenges with current policies that underfund medically necessary care and overfund bed closures or capacity restriction. Any additional funding should be directed at hospitals that are providing medically necessary care. Statewide, over half of Maryland hospitals have recently reported negative operating margins in most quarters. This is an unsustainable position for Maryland hospitals, and must be addressed to adequately preserve access and care delivery in Maryland.

Comments on each area of potential investment are below.

1. *An all-payer value-based program, similar to the current Medicare Care Transformation Initiatives (CTI) program, to support clinical innovation and transformation to achieve better and more equitable health outcomes while maintaining affordability.*

   An all-payer value-based program would require significant long-term planning and evaluation. If this all-payer program is intended to be modeled after the current Medicare CTI program, there must be further evaluation of the current CTI program; until there are greater insights into how CTIs are driving performance or improving care, this program should not be expanded.

2. *Common platforms and efforts for the hospital system to improve efficiency and effectiveness of care.*

   The State and industry have already made significant investments in the State HIE, CRISP. Before moving forward with other common platforms and efforts, JHHS encourages staff and the industry to clearly identify and prioritize the currently unmet needs, and the likelihood that these potential common platforms and solutions will meet those prioritized needs. Further, this information and prioritization should be gathered through a process involving feedback from the industry and stakeholders to identify the most critical needs, and to clarify where further resources or efforts would most effectively meet those needs.

3. *Access expansions to meet latent demand for high-value clinical services across the healthcare system.*

   JHHS agrees that certain clinical care is undoubtedly underfunded in Maryland. However, this issue would be best addressed by adjustments to the state's existing volume policies. One-time funding will be insufficient to address various policies and methodologies that underfund medically necessary hospital-based services. Access challenges under the global budget construct should be addressed through a comprehensive review and evaluation of the existing volume policies.

4. *Global payment arrangements with hospitals that are working to improve health and lower costs in their geographic areas.*

   As JHHS has previously noted, there are many shortfalls that within the current global payment arrangements. These shortfalls are producing access to care challenges that are evident after a decade of global budgets and misaligned incentives. These challenges must first be addressed before these global payment arrangements could be further expanded. Any expansion of global

payment arrangements under the current methodologies will further erode access to healthcare throughout Maryland.

5. *Workforce investments, including but not limited to updates to the GME program.*

   The GME policy has not been revisited since before the implementation of global budgets, and likely requires some changes; however, these changes must be considered in a comprehensive and thoughtful manner, rather than addressed with one-time funding. A number of current workforce challenges would be best addressed through long-term policy solutions.

6. *Greater understanding of patient financial burdens with seed funding for new approaches to assistance.*

   The Maryland General Assembly has made significant changes to hospital financial assistance policies that mitigate the impact of medical costs on individual patients. If there are concerns that global budgets are having a disproportionate impact on certain patient populations, addressing these distortions directly through policy adjustments would be more impactful than a short-term funding solution that aims to mitigate the impact of GBR on these patient populations.

7. *Additional pay-for-performance programs with transformation or access impact*

   As noted throughout this comment letter, challenges and shortcomings of existing volume policies create transformation and access issues in Maryland. These issues would best be addressed through a comprehensive review of existing policies along with stakeholder engagement to improve the policies.

JHHS thanks the Commission and staff for the opportunity to provide comments and feedback on this recommendation. While JHHS agrees with the principle that excess savings are not appropriate and must be reinvested in the health of Marylanders, it is critical that this 2025 funding supports gaps in our current policies, particularly where medically necessary care is underfunded. Further, JHHS believes that because these issues are long-standing, the impact of a one-time investment will be limited. Meaningful solutions to these issues will require thoughtful, long-term solutions. JHHS looks forward to further collaboration with the HSCRC on further AHEAD planning that improves health and access for all Marylanders.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman

Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

ST. MARY'S COUNTY HEALTH DEPARTMENT

Meenakshi G. Brewster, MD, MPH - Health Officer

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November 27, 2024

Health Services Cost Review Commission

Re: Comment on the Maryland Health Services Cost Review Commission "2025 Funding for AHEAD Preparation: Draft Recommendation"

Dear HSCRC Commissioners,

Thank you for the opportunity to provide public comment on the Maryland Health Services Cost Review Commission (HSCRC) "2025 Funding for AHEAD Preparation: Draft Recommendation". The recommendation is overall a good one that would align multiple efforts and resources in the state towards the common goal of improving health of all Marylanders. The details of implementation will significantly impact the intended outcomes. My comment in response to the draft recommendation emphasizes two particular areas:

1) The importance of leveraging existing public health infrastructure, roles, and capacity in aligning efforts towards the common goal of health equity for all Marylanders. As the chief health strategists for their jurisdictions, local health departments (LHDs) have a variety of established interventions, staffing resources, and community connections to complement the work of healthcare system delivery partners. In rural areas in particular, LHDs provide a variety of critical primary care/acute care health care services, care coordination support, and leverage community health workers/trusted relationships with their community members. LHDs also have a natural core mission of health equity, and natural core role of convening multi-sector partnerships. It may be most efficient and least-costly to leverage and fund this existing infrastructure and natural mission, rather than creating any new elements to regional infrastructure.
2) Workforce investment.
    a. The Recommendation includes seven areas of potential investment under new programs to address health cost and delivery challenges. One noted is “Workforce investments, including but not limited to updates to the GME program.” The implementation of this should emphasize GME changes to support primary care, particularly those GME programs such as family medicine where graduates tend to locate in the proximity of their training program and stay in primary care. Additionally, GME programs in primary care should be supported across the state such that they address the shortages of primary care clinicians in more rural regions such as in Southern Maryland, Western Maryland, and the Eastern Shore. Of note, there are significant gaps in Maryland to address. One of its two current medical schools lacks a department/residency of family medicine. There is also only one rural family medicine residency program in the entire state (in Washington County/Western Maryland). GME funding should be prioritized to

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advance family medicine residency programs on the Eastern Shore and in Southern Maryland.

b. HSCRC and the legislature should also consider the role of Area Health Education Centers (AHECs) in advancing the pipeline from rural and underserved communities into health careers. AHECs can be leveraged in better engaging future healthcare workforce during the middle and high school years of education. Recruiting students from underserved and rural areas may be more likely to generate the future healthcare workforce in these areas. There should be a central commitment towards establishing and advancing AHEC capacity throughout the rural regions of the state – including a *dedicated* AHEC for at least Western Maryland, Eastern Shore, and Southern Maryland (Right now there is not a dedicated Southern Maryland AHEC). These AHECs should have specific workforce initiatives informed by their region's workforce data, strong engagement with their local primary and secondary educational systems (such as through healthcare magnet programs), and robust technology to support student engagement and long-term follow-up. Workforce outcomes should be tracked to ensure effectiveness of intervention in addressing workforce shortages in their region.

The combination of robust recruitment from Maryland's rural communities into health careers as well as locating primary care GME training programs in rural regions should significantly address the geographic disparities seen in access to care.

Thank you for considering the above comments as HSCRC moves forward with AHEAD implementation.

Respectfully,

Meenakshi G. Brewster, MD, MPH
Health Officer
St. Mary's County, Maryland

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

December 2, 2024

hscrc.payment@maryland.gov

RE: Comments on 2025 Funding for AHEAD Preparation

To Whom It May Concern:

On behalf of the Community Behavioral Health Association of Maryland (CBH), thank you for the opportunity to provide comments on the Maryland Health Services Cost Review Commission (HSCRC) "2025 Funding for AHEAD Preparation" draft recommendations. CBH is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

We are grateful to HSCRC for developing these recommendations to reinvest the one-time TCOC Model savings. CBH strongly endorses the creation of the fund to support successful implementation of the AHEAD model. Below, we offer several considerations for the HSCRC for modification of the fund's seven target areas, as well as several specific suggestions for future fund expenditures.

Recommendation: Funds should be administered through a governance process that incorporates conflict-free decision-making, transparency, and open dialogue.

CBH recommends that the funds be administered independently from Maryland hospitals and by relying on a sound process reflecting best practices for governance. Hallmarks of good governance should include:

- Conflict-free decision-making to ensure that entities who benefit from funds do not make decisions about where to allocate funds;
- Commitment to dialogue, with no participating providers subject to non-disclosure agreements or other contractual limits on their ability to inform policy and operational discussions;
- Notice and an opportunity to comment by the public and stakeholders on material policy decisions made by the fund administrators; and
- Public availability of information about the amounts and entities to whom funds have been awarded and the result(s) achieved.

Recommendation: Investments in "common platforms and efforts" should be expanded from hospital system to include community-based behavioral health organizations.

The HSCRC's draft recommendations include using funds on "[c]ommon platforms and efforts for the hospital system to improve efficiency and effectiveness of care." CBH encourages the HSCRC to broaden this recommendation to include investments among community-based mental health and addiction treatment providers.

As the Maryland Health Care Commission (MHCC) has noted, "Challenges in securing affordable community-based care may contribute to increases in the average length of stay of acute psychiatric patients over time."[1] Through its aligned provider network, Maryland Behavioral Health Solutions (MBHS), CBH has supported its member work to connect to CRISP, reduce hospital admissions and improve timely follow-up care. CBH members who participate in the MBHS provider network – enabled with analytics to strengthen their performance on HEDIS follow-up measures – demonstrate even stronger performance in 7-day follow-up than Maryland's public behavioral health system as a whole or the average NCQA Medicaid HMO:

Follow-Up After ED Visit for Mental Illness (2022)	Within 7 days
NCQA Medicaid HMO	42%
Maryland PBHS	N/A
MBHS Provider Network	53%

Follow-Up After Hospitalization for Mental Illness (2022)	Within 7 days
NCQA Medicaid HMO	37%
Maryland PBHS Performance	49%
MBHS Provider Network	52%

Strengthening the use of CRISP across community-based behavioral health programs through a coordinated effort, like that led by MBHS, can help ensure success in the AHEAD model's behavioral health goals. For these reasons, we encourage the HSCRC to consider broadening technology investments beyond hospital systems, as well as consider targeted investments like strengthening the MBHS data warehouse work across multi-provider systems.

Recommendation: Access expansions to meet latent demand for high-value clinical services should explicitly target expansion of critical behavioral health infrastructure.

It is widely recognized that community-based mental health and addiction treatment programs are radically under-resourced. CMS has recognized that Medicare rate-setting systemically undervalues behavioral health,[2] and the MHCC has issued a series of reports in recent years itemizing the need to strengthen Maryland's community-based behavioral health services. In 2021, the MHCC noted:

[1] Maryland Health Care Commission, "State Health Plan for Facilities & Services: Acute Psychiatric Services," at p. 5 (Aug. 9, 2021).
[2] Federal Register, Vol. 88, No. 150, p. 52320 ("We continue to believe that there is a systemic undervaluation of work estimates for behavioral health services.") (Aug. 7, 2023).

> The lack of community resources and discontinuity of care leaves many individuals with mental disorders vulnerable to poor outcomes and shifts an immense burden of care to families. If funding for community health resources were increased, it should be possible to achieve more timely discharge and more efficient use of acute psychiatric beds. The General Assembly, the Governor, the Department of Health, and local government agencies should support greater investment in community-based mental health services.[3]

Similarly, in 2024, the Maryland General Assembly Hospital Throughput Work Group echoed the call for investment in sustainable funding for behavioral health programs.[4] Meanwhile, the MHCC's behavioral health workforce identified that Maryland had half the needed workforce and the existing workforce is not competitively compensated compared to surrounding jurisdictions.[5]

Given the well-documented need to strengthen Maryland's community behavioral health capacity, CBH suggests that the recommendation specifically identify this area as an intended target for the fund.

CBH further invites the HSCRC and stakeholders to prioritize capacity-building for statewide deployment of the Certified Community Behavioral Health Clinic (CCBHC) model to align with the goals of the AHEAD model. Under SB363, the Maryland Department of Health is required to apply for a Medicaid demonstration program launching by July 1, 2026, to sustain and expand Maryland's CCBHCs. The CCBHC model has demonstrated success in partnering with hospitals to better serve those with behavioral health needs, while strengthening access to hard-to-serve populations.[6]

Recommendation: Additional pay-for-performance programs should explicitly target community behavioral health initiatives.

In 2023, the Maryland General Assembly passed three bills requiring Medicaid to adopt value-based purchasing pilot programs in community behavioral health services, including a pilot program to reduce hospital utilization (SB 581**,** SB 582 / HB 1148), as well as at least one value-based purchasing contract for youth-oriented targeted case management services (SB 255 / HB 322). Unfortunately, Medicaid funding for behavioral health VBP pilot was zeroed out earlier this year.

Given the challenges facing Maryland's behavioral health services and the importance of behavioral health to the success of the AHEAD model, CBH encourages the HSCRC and fund administrators to consider pay-for-performance programs that encourage alignment of effort between hospitals and community behavioral health programs. To that end, we have appended a VBP proposal that our provider network, Maryland Behavioral Health Solutions previously offered to MDH for

[3] Maryland Health Care Commission, "State Health Plan for Facilities & Services: Acute Psychiatric Services," at p. 6 (Aug. 9, 2021).
[4] Final Report, p. 2 (March 2024).
[5] Maryland Health Care Commission, "Investing in Maryland's Behavioral Health Talent," pp. 4, 59 (October 2024).
[6] National Council for Mental Wellbeing, "2024 CCBHC Impact Report," at pp. 12-15, 35-36.

consideration. This proposal is included with this letter below in Appendix A. We believe that a VBP approach to behavioral health services is a critical component for future success in the AHEAD model.

Thank you again for the opportunity to share feedback on the draft recommendations for 2025 funding for AHEAD preparation. We welcome any questions or further discussion about CBH's feedback described here. Please do not hesitate to contact me at shannon@mdcbh.org. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director

MBHS
MARYLAND BEHAVIORAL HEALTH SOLUTIONS
410-317-6400 • WWW.MARYLANDBHS.COM

APPENDIX A: IMPROVING MARYLAND EMERGENCY DEPARTMENT CAPACITY BY ADDRESSING BEHAVIORAL HEALTH DIVERSION OPPORTUNITIES

PROPOSAL FOR VALUE-BASED PURCHASING PILOT

In 2023, three bills requiring Medicaid to adopt value-based purchasing pilot programs passed both chambers of the Maryland General Assembly and were signed by Governor Moore. The Behavioral Health Care Coordination Value-Based Purchasing Pilot Program (SB 581**)** creates a 3-year pilot program beginning with a budget appropriation in FY2025. The pilot must involve at least 500 adults who are at high risk of emergency department or inpatient utilization due to behavioral health issues. It requires a per member per month (PMPM) care management fee and establishes outcome measures that are tied to provider payment. The same requirements for a pilot program are echoed in Behavioral Health Care – Treatment and Access – Behavioral Health Model for Maryland (SB 582 / HB 1148), Senator Ferguson's omnibus bill. Finally, SB 255 / HB 322 (Public Health—Home and Community-Based Services for Children and Youth) requires MDH to fund at least one value-based purchasing contract for targeted case management services.

Maryland Behavioral Health Solutions (MBHS) is a provider network composed of 29 participating mental health and addiction treatment organizations located throughout the state. MBHS and its participating providers have the experience and shared data infrastructure to launch and effectively deliver a value-based purchasing pilots as contemplated in the legislative initiatives passed by the Maryland General Assembly.

A. ELIGIBLE PROVIDERS: AUTOMATED DATA EXCHANGE WITH CRISP

Legislation describing the value-based purchasing (VBP) pilot program requires participating providers to "have an automated data exchange with the state-designated health information exchange" (Md Code Health – General at § 13-4804(D)(4).

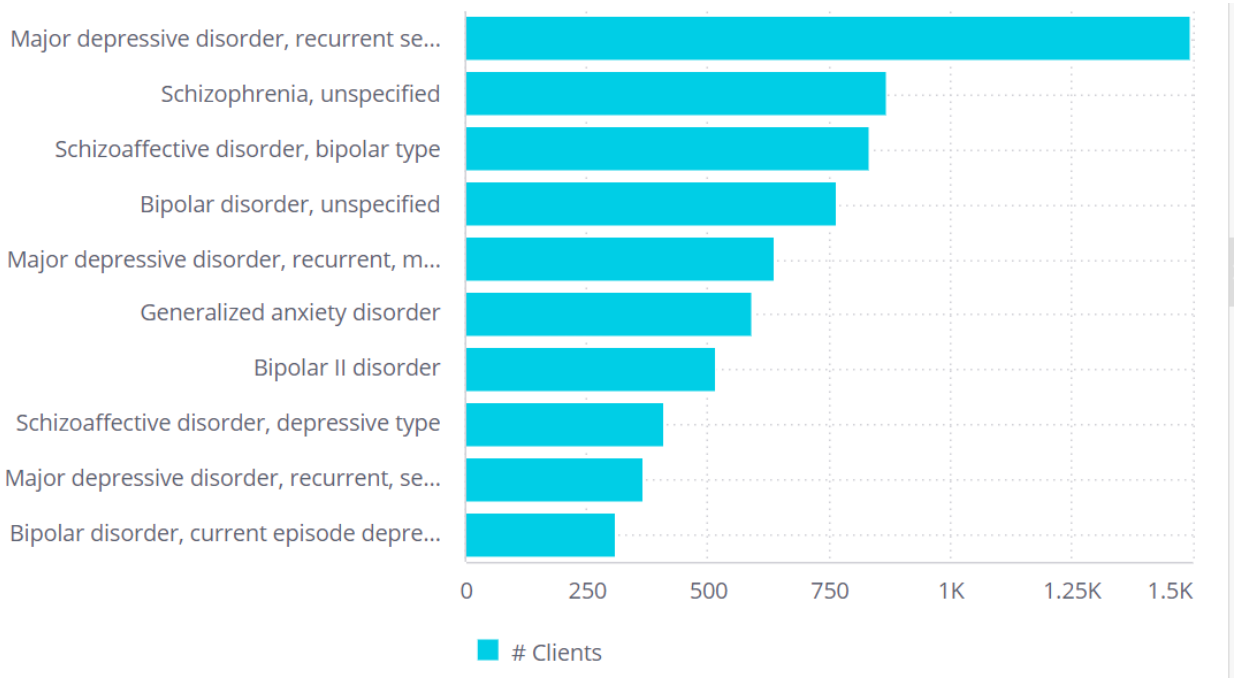
The Maryland Behavioral Health Solutions (MBHS) provider network has facilitated automated data exchange with CRISP for seven of its participating providers, and all 29 providers participating in the network are eligible to join the automated data exchange. Using the network's data warehouse as an intermediary, active patient panels and CRISP data are exchanged daily between participating providers and the state HIE. Data is delivered to providers in actionable analytics dashboards.

Currently, MBHS participating providers with automated data exchange are located in more than half of Maryland jurisdictions, including some with long ED wait times in the state:

- Arundel Lodge in Anne Arundel County
- Channel Marker in Caroline, Talbot and Dorchester Counties
- Cornerstone in Montgomery and Calvert Counties
- Lower Shore Clinic in Wicomico, Worcester and Somerset Counties
- Partnership Development Group in Baltimore City, Anne Arundel and Montgomery Counties
- Pathways in St. Mary's County

B. Eligible Patients: Active with Eligible Provider + Inpatient or ED Discharge

In CY2023, the seven organizations with automated data exchange served 10,990 clients, including 1,040 children under the age of 18. Over two-thirds of individuals served had diagnoses related to schizophrenia, major depression, or bipolar disorder.



In CY2023 there were 3,989 unique patients active with participating providers who had an ED visit or inpatient discharge. These 3,989 patients accounted for 12,125 total hospital discharges in the preceding year, of which 79% were ED visits.

MBHS proposes that the eligible patient population be identified for purposes of the VBP pilot as any patient active with one of the eligible providers at time of an inpatient admission or ED visit.

C. Proposed Outcome Measures

In order to reduce hospital utilization by patients active with community-based providers, MBHS proposes using HEDIS measures related to rapid follow-up after hospital discharge or ED visit. Using DBM's Managing for Results performance for the public behavioral health system where available, or NCQA Medicaid MCO performance, MBHS suggests negotiating a rate of improvement in HEDIS measures among participating providers with automated data exchange.

DBM Managing for Results Performance	**Baseline**
Percent of PBHS service recipients with primary MH diagnosis readmitted to inpatient hospital within 30 days of discharge	14.1% for PBHS in FY2023 Source: DBM, FY25 MFR for BHA, Obj. 1.1
Percent of PBHS mental hospital inpatient recipients with follow-up care within 7 days of discharge	50.2% for PBHS in FY2023 Source: DBM, FY25 MFR for BHA, Obj. 2.6
Percent of PBHS MH recipients with 3+ behavioral health-related ED visits	0.8% for PBHS in FY2023 Source: DBM, FY25 MFR for BHA, Obj. 4.2
HEDIS Performance	
HEDIS Measure: Follow-up within 7 days of ED visit for mental illness (FUM)	40% for Medicaid MCO in 2021 Source: NCQA
HEDIS Measure: Follow-up within 7 days of ED visit for alcohol and other drug abuse or dependence (FUA)	13.4% for Medicaid MCO in 2021 Source: NCQA

D. Alternative Measures

Relying on HEDIS measures for VBP performance may narrow the population significantly. Among the 3,989 active patients with a hospital discharge, the CRISP discharge diagnosis was left blank for 2,896 patients (73%), which would result in the exclusion of 2,896 active patients with a hospital visit from the HEDIS performance measure. The VBP legislation requires a pilot with a minimum of 500 patients, and excluding blank diagnostic fields would still yield over 1,000 patients. However, because use of the above HEDIS measures would result in an undercount of the impacted population, MBHS offers several alternative outcome measures for consideration below.

MBHS can identify high utilizers among the active patients in its connected provider network and work with MDH to incentivize providers to reduce hospital utilization. The 3,989 patients with a hospital visit in CY2023 averaged 3 visits per patient. Focused work to reduce the aggregate hospital utilization among these 3,989 patients, or a portion with multiple visits, may be one approach to the VBP pilot. Diagnostic categories and specific diagnoses on discharge data can help providers identify patients with avoidable or preventable ED utilization.

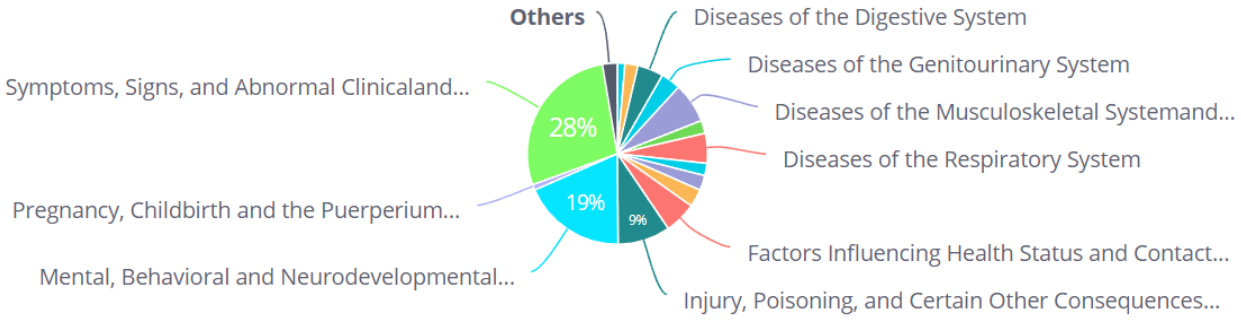
Avoidable ED Visits

In CY2023, patients in active treatment with connected providers were seen in Emergency Departments for:

- 66 visits due to homelessness
- 54 visits for prescription refills
- 12 visits due to “malingering”

Alternatively, VBP measures could incentivize connected providers to reduce hospital utilization across a defined spectrum of eligible diagnoses, including somatic diagnoses. Behavioral health-related diagnosis make up a minority of the ED visits among patients active among the MBHS connected providers, with mental health conditions contributing to 19% of hospital visits and SUD-related causes contributing another 9%. Chronic health conditions like diabetes and social determinants of health like homelessness are prevalent across the hospital discharge diagnoses. Using its data warehouse to establish current performance benchmarks, MBHS can work with MDH to define incentives for connected providers to reduce hospital utilization among defined diagnoses within the eligible patient cohort.

Figure 1 – NCHS diagnostic categories on hospital discharge encounter for MBHS CRISP-connected provider active patients, CY2023



How a VBP Pilot Could Work

Once the patient cohort and performance measures have been identified, providers will submit fee-for-service billing as normal and receive a $100 PMPM for care coordination, data analytics and more flexible, enhanced outreach for the patient cohort. MBHS can report performance to MDH monthly or quarterly. Payments will be reconciled with performance incentives annually over the course of the three-year pilot.

Tara H. Jackson
Acting County Executive

PRINCE GEORGE'S COUNTY GOVERNMENT
OFFICE OF THE COUNTY EXECUTIVE

December 6, 2024

Joshua M. Sharfstein, MD
Chairman

Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Kromm:

I consider it a responsibility, in my capacity as the Deputy Chief Administrative Officer for Health, Human Services and Education for Prince George's County, to write to you to ask for the State's commitment to the transformation of care in Prince George's County by approving a Prince George's County Access Initiative as part of the Draft Recommendation for 2025 Funding for AHEAD Preparation.

Prince George's County residents deserve access to high quality and adequate healthcare and public health resources like the rest of Maryland. Unfortunately, Prince George's County is so far behind. Frankly, in my more than 22 years of holding leadership positions in local health departments in three difference states (Tennessee, Kansas, and Maryland), I have never seen such gross underinvestment in healthcare and public health resources anywhere comparable to what is in Prince George's County. This underinvestment in health is killing our residents. Please refer to the recent study on Healthcare Resource gaps we conducted to see highlights of how critical some of these are (attached).

The current state of things calls for significant investments in advance of the AHEAD model to assure the health and wellbeing of Prince Georgians.

I want to be clear that I fully support your proposed broad approach to health and the focus on equity. Health is broad, impacted by many factors including healthcare and factors upstream of healthcare. We must intentionally approach it as such to improve health of our residents.

I highlight some points to show why it is important to approve a Prince George's County Access Initiative:

First, a recent State commissioned study quantified hospital price inequity between Baltimore area compared to Prince George's/Montgomery/Anne Arundel County as a cohort, The study found that revenue of more than $400M annually accrued to the Baltimore region simply due to price inequities.

The study quantified the difference in per-capita costs of care of Baltimore Region compared to Montgomery, Prince George's, and Anne Arundel Counties as a cohort. After adjusting for differences in risk and utilization patterns, it concludes that for employer-sponsored health insurance, the Baltimore region incremental spending is more than $135M annually because of higher hospital prices in Baltimore compared to the cohort region.

The report also quantified this for Medicare FFS IP Hospital spend and estimates more spending more than $300M excess in Baltimore. Combined, the excess spend in Baltimore for higher hospital prices, is more than $400M annually compared to our service area. This is a staggering inequity and a direct consequence of neglected price parity in the Maryland Model (attached)

Second, Prince George's County is one of the largest drivers of Medicare TCOC Savings.

The State's Medicare TCOC Spend per Beneficiary has grown approximately -1.5% below the Nation since 2014. However, Prince George's County has been disproportionately impacted growing at -2.9% below the Nation. This is nearly two times below that of the Nation! And for one of the most populous counties in Maryland, this lower growth rate generates a disproportionate amount of savings for the Maryland Model. Data per CMS 2022 Medicare Geographic Variation Files. Source: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county

Medicare TCOC Spend per Beneficiary Growth 2014-2022	
MD	**-1.5%**
MD-Garrett	9.1%
MD-Queen Anne's	4.4%
MD-Talbot	3.6%
MD-Wicomico	3.1%
MD-Somerset	2.5%
MD-Allegany	2.5%
MD-Frederick	2.4%
MD-Caroline	2.3%
MD-Baltimore City	1.8%
MD-Carroll	1.7%
MD-Anne Arundel	1.6%
MD-Baltimore	1.4%
MD-Charles	0.6%
MD-Montgomery	0.0%
MD-St. Mary's	-0.7%
MD-Calvert	-0.8%
MD-Howard	-0.9%
MD-Harford	-1.6%
MD-Prince George's	-2.9%
MD-Worcester	-3.3%
MD-Cecil	-3.9%
MD-Dorchester	-4.2%
MD-Washington	-4.6%
MD-Kent	-4.8%

	Actual per capita FFS Medicare payment for beneficiaries.												
BENE_GEO_DESC	2014	2015	2016	2017	2018	2019	2020	2021	2022	2022 Vs 2014	Above (Below) National Growth rate	FFS Bene Count 2022
National	$ 9,767	$ 9,959	$ 10,072	$ 10,332	$ 10,681	$ 11,113	$ 10,751	$ 11,659	$ 12,023	23.1%	0.0%	29,639,955
MD	$ 11,315	$ 11,583	$ 11,550	$ 11,970	$ 12,244	$ 12,584	$ 12,108	$ 13,230	$ 13,759	21.6%	-1.5%	747,584
MD-Garrett	$ 8,652	$ 9,286	$ 9,187	$ 9,594	$ 10,484	$ 10,845	$ 9,817	$ 11,106	$ 11,441	32.2%	9.1%	6,031
MD-Montgomery	$ 9,658	$ 9,958	$ 9,830	$ 10,187	$ 10,672	$ 10,966	$ 10,281	$ 11,608	$ 11,885	23.1%	0.0%	113,520
MD-Howard	$ 9,839	$ 9,717	$ 9,972	$ 10,168	$ 10,511	$ 10,767	$ 10,169	$ 11,314	$ 12,027	22.2%	-0.9%	35,628
MD-Washington	$ 10,431	$ 10,744	$ 10,942	$ 11,200	$ 11,557	$ 11,400	$ 11,564	$ 12,942	$ 12,363	18.5%	-4.6%	24,447
MD-Calvert	$ 10,262	$ 10,722	$ 10,501	$ 10,871	$ 11,362	$ 11,965	$ 11,514	$ 12,100	$ 12,553	22.3%	-0.8%	14,246
MD-Worcester	$ 10,491	$ 10,535	$ 10,349	$ 10,967	$ 10,901	$ 11,083	$ 10,703	$ 11,938	$ 12,563	19.8%	-3.3%	12,534
MD-Frederick	$ 10,187	$ 10,450	$ 10,340	$ 10,934	$ 11,317	$ 11,527	$ 10,796	$ 12,101	$ 12,780	25.5%	2.4%	34,172
MD-St. Mary's	$ 10,525	$ 10,859	$ 10,960	$ 11,466	$ 11,770	$ 11,667	$ 11,375	$ 12,414	$ 12,878	22.4%	-0.7%	15,422
MD-Anne Arundel	$ 10,372	$ 10,715	$ 10,686	$ 10,864	$ 11,133	$ 11,425	$ 10,903	$ 12,387	$ 12,935	24.7%	1.6%	73,554
MD-Charles	$ 10,472	$ 10,309	$ 11,348	$ 11,604	$ 12,258	$ 12,879	$ 11,672	$ 12,832	$ 12,953	23.7%	0.6%	19,268
MD-Queen Anne's	$ 10,192	$ 10,374	$ 9,973	$ 10,655	$ 10,659	$ 11,145	$ 10,678	$ 12,248	$ 12,991	27.5%	4.4%	9,449
MD-Carroll	$ 10,792	$ 10,935	$ 10,934	$ 11,611	$ 11,898	$ 12,243	$ 11,583	$ 12,724	$ 13,472	24.8%	1.7%	25,632
MD-Somerset	$ 10,812	$ 10,605	$ 11,357	$ 11,621	$ 12,159	$ 12,546	$ 12,570	$ 12,920	$ 13,584	25.6%	2.5%	4,306
MD-Harford	$ 11,190	$ 11,208	$ 11,034	$ 11,676	$ 11,915	$ 12,345	$ 11,855	$ 13,066	$ 13,601	21.5%	-1.6%	35,389
MD-Cecil	$ 11,470	$ 11,045	$ 11,554	$ 12,259	$ 12,391	$ 13,131	$ 12,803	$ 13,773	$ 13,677	19.2%	-3.9%	15,624
MD-Wicomico	$ 10,935	$ 11,120	$ 11,031	$ 11,876	$ 12,012	$ 12,371	$ 11,839	$ 12,597	$ 13,805	26.2%	3.1%	16,767
MD-Talbot	$ 10,972	$ 10,816	$ 11,216	$ 10,710	$ 10,849	$ 12,073	$ 10,786	$ 12,730	$ 13,905	26.7%	3.6%	10,016
MD-Prince George's	$ 11,607	$ 11,869	$ 11,954	$ 12,184	$ 12,327	$ 12,582	$ 12,179	$ 13,340	$ 13,955	20.2%	-2.9%	79,969
MD-Kent	$ 11,953	$ 12,078	$ 11,786	$ 12,038	$ 12,471	$ 12,542	$ 12,454	$ 13,131	$ 14,138	18.3%	-4.8%	4,963
MD-Allegany	$ 11,413	$ 11,712	$ 12,094	$ 12,234	$ 12,488	$ 12,765	$ 13,373	$ 13,846	$ 14,338	25.6%	2.5%	14,667
MD-Dorchester	$ 12,163	$ 12,598	$ 11,579	$ 12,455	$ 13,020	$ 12,916	$ 12,373	$ 14,025	$ 14,465	18.9%	-4.2%	6,860
MD-Caroline	$ 11,561	$ 11,358	$ 11,298	$ 12,334	$ 12,592	$ 12,938	$ 12,144	$ 13,319	$ 14,502	25.4%	2.3%	5,668
MD-Baltimore	$ 12,177	$ 12,555	$ 12,543	$ 13,063	$ 13,260	$ 13,758	$ 13,219	$ 14,319	$ 15,160	24.5%	1.4%	111,122
MD-Baltimore City	$ 15,232	$ 15,686	$ 15,615	$ 16,438	$ 16,725	$ 17,141	$ 17,339	$ 18,437	$ 19,018	24.9%	1.8%	58,329

For these reasons and more, the commitment to address long-standing issues of health equity in the second most populous County in the State is critically important.

Through a Prince George's County Initiative, the hospitals, clinicians, County Executive's Office, and health department can come together to develop a strategy to enhance health care access while emphasizing services and approaches that maximize the health and well-being of county residents.

This is why I am writing in support of the Prince George's County Access Initiative. I strongly support this initiative and ask that through this opportunity, HSCRC infuse **$100m** out of the savings to support such a strategy. This will provide an opportunity to begin to build the infrastructures necessary to promote, improve and sustain the health of our residents.

I look forward to the opportunity to discuss this further.

Sincerely,

Sanmi Areola, PhD
Deputy Chief Administrative Officer for
Health, Human Services and Education

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

November 27, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Mid-Year Rate Adjustments

Dear Executive Director Kromm:

The League of Life & Health Insurers of Maryland is the state trade association representing life and health insurance companies in the State. We appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation on AHEAD Model Preparations. The State is about to embark on another ten years of the Maryland Model, and we understand that there are many important issues to address before the start of the AHEAD Model. However, we are concerned that with this recommendation, the Commission is abandoning the principals of sound policy-making that have contributed to its success throughout the All-Payer and Total Cost of Care models over the last ten years.

The Maryland Waiver has survived for more than fifty years because the Commission has been judicious in raising rates only when there is a clear, empirical, and methodological cost finding to justify those rates; and the Commission has ensured that the underlying growth in hospital costs remains affordable for Maryland consumers. This recommendation does neither.

League members believe the HSCRC lacks a reasonable basis to justify a rate increase. The HSCRC's statutory mandate is to ensure that hospital rates are reasonably related to hospital costs. Rate increases, therefore, must have some basis in hospital costs. This recommendation does not include even a superficial level of detail – let alone a cost finding – on what this rate increase is for. There are just a few bullets on seven "potential areas of investments" to justify more than $330 million in price increases on consumers. This is tantamount to increasing rates and then figuring out some costs to justify it after the fact. It is the exact opposite of the HSCRC's statuary mandate.

Our members do not take a position on the potential areas of investment. Many of the investments may be reasonable for the State to make to prepare for the AHEAD Model. We cannot tell because the recommendation does not say. We urge the Commission to detail what will be funded and how the effectiveness of those investments will be measured before forcing a rate increase on consumers.

The assumption that Medicare savings equate to savings for consumers is unfounded. The HSCRC staff justify this rate increase by pointing to $100 million in Medicare savings that are expected to accumulate between 2023 and 2024. These savings have occurred because national hospital cost growth has been very high compared to historical averages. Whatever the cause, Maryland consumers did not benefit from the same trend. According to Bureau of Economic Analysis data, Maryland State GDP grew by 2.6 percent, through the second quarter of 2024[1], compared to Maryland hospital spending growth of 4.3 percent year to date. Thus, Maryland consumers saw dissavings over the same period.

While we understand and support the obligations that the State has to CMS, the Commission has an obligation to all Maryland residents and they deserve better than a vague assumption, unsupported by data, that what is good for the Medicare trust fund is good for them. The HSCRC should articulate a clear test for whether rate increases are affordable for consumers. And they should do so before approving more price increases on consumers. Over the past year, the commission has added an extra one percent to the annual update factor (~$200 million), an extra quarter percent to the set aside ($50 million), and now is proposing an extra 1.6 percent in rates (~$336 million). That amounts to nearly 3%, or $586 million, above and beyond regular inflation that the Commission would be forcing consumers to pay. It would be irresponsible to approve the proposed adjustment prior to knowing whether it is affordable or not.

Furthermore, League carriers all have budgeting operations that align to support the July 1st increase. When the HSCRC performs actions that are out of alignment with that cycle, and we are aware that a nimble approach must sometimes be utilized, we would appreciate that the adjustments be aligned around quality and outcomes and not just a pass-through to some entities. All the League members continue to support the State and the global approach, but shifting granularly developed incentive policy for only part of the ecosystem could have negative financial outcomes for other stakeholders including Maryland consumers.

On behalf of the health plans operating in Maryland and supporting Maryland residents, we are very grateful for your attention on this matter. If you have any questions or would like to speak with us further on this topic, please reach out to me at mcelentano@fblaw.com.

Very truly yours,

Matthew Celentano
Executive Director

[1] https://www.bea.gov/sites/default/files/2024-09/stgdppi2q24.pdf

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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CORPORATE OFFICE

December 2, 2024

Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter Regarding FY 2025 Funding for AHEAD Preparation

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, I am writing in response to the Commission's Proposed FY 2025 Funding for AHEAD Preparation. As we expressed in our letter to you on October 10th, the $650 to $700 million savings that HSCRC staff expect the Model to accumulate by the end of 2025 represents the underfunding of a Maryland hospital industry that has endured three consecutive years of statewide operating margins below 1% and continues to experience unsustainably poor financial outcomes in FY2025, with Statewide operating margins as of September at only 1.5% and more than a third of acute hospitals having negative total operating margin margins.

We must stress that the most productive use of these funds to prepare for successful performance under AHEAD is to address the underlying financial stability of Maryland's hospitals. The industry has provided the Commission with objective data vs. national benchmarks on key financial metrics, with Maryland hospitals underperforming benchmarks for operating margin, capital adequacy, and cash flow to debt ratios. Despite the HSCRC's additional update factor considerations provided on July 1, considerable financial pressures continue to plague the industry, specifically related to ongoing staffing shortages and the consequences of years of deferred routine capital. Hospitals are unable to invest in critical facility needs, program improvements, new technology and population health strategies. Prolonged inability to make these investments absolutely puts the industry behind in AHEAD preparedness and produces unnecessary risk for Maryland citizens in terms of access to high quality hospital services.

Considering the excess savings being generated, now is the time to address the persistent financial pressures that we are bearing as a hospital industry. UMMS supports the Commission's decision to take action to secure the excess savings as an investment in activities that would support the model, and we strongly believe that these funds should be utilized to directly addresses the cost pressures hospitals are encountering. Addressing these needs now puts hospitals in a better position to meet patient needs and achieve the tenants of the Maryland Model - access to care, quality outcomes, population health, health equity, and total cost of care. With these savings, we have an opportunity to invest, stabilize, and prepare for a better future under AHEAD.

In addition to that broad perspective, UMMS has the following comments regarding the specifics of the draft proposal:

Use of Population Health Trust Funds

UMMS understands the requirement in the CMS agreement to establish a Population Health Trust comprised of public and private sources to support statewide population health initiatives. We believe that the use of those funds should be a collaborative, multi-stakeholder process that includes hospitals as a key stakeholder. Because hospital dollars are redirected into the population health trust, we would also like to better understand the HSCRC's expectation for the targeted amounts for this Trust, who can access those funds for population health activities, and what accountability mechanisms will be in place to ensure that programs utilizing these funds are contributing to success under AHEAD.

Use of Remaining funds

As we have stressed in this letter, UMMS urges HSCRC Staff to prioritize addressing the underfunding of a Maryland hospital industry that has multiple years of financial pressures. UMMS broadly encourages HSCRC staff to use the flexibility provided by the excess savings rate to put permanent funding solutions in place to address the highest priority needs impacting hospital operations, such as labor costs, deferred routine capital, and meeting demand for hospital-based services.

Timing of Funding

Considering the many issues yet to be defined in this recommendation, including the stated need to work with stakeholders and the legislature on certain issues, UMMS would ask that HSCRC staff act quickly in terms of decisions for funding allocations and when these funds will be available. UMMS is concerned that the financial pressures impacting hospital operations require immediate action.

With the current excess savings, we have an opportunity to provide permanent investments in hospitals to stabilize the system's overall financial health and provide a solid foundation for success under the AHEAD model. We appreciate the opportunity to provide feedback on the Proposed FY 2025 Funding for AHEAD Preparation. Please let us know if you have any additional questions.

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Adam Kane
Nicki McCann, JD
Maulik Joshi, DrPH
Ricardo R. Johnson
Fabi Sabi, MD

Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, UMMS President and CEO
Joseph Hoffman, UMMS Chief Financial Officer

Maryland
Hospital Association

Dec. 2, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am commenting on the Health Services Cost Review Commission (HSCRC) 2025 AHEAD preparation funding draft recommendation. We appreciate HSCRC's recognition of the need and opportunity to make health care investments to support patients, hospitals, and communities, but urge faster relief that more directly addresses the cost pressures hospitals are encountering.

As we shared in November, Maryland hospitals and health systems are struggling with rising expenses that have significantly increased since January 2020. The excess savings generated beyond the contractual target under the Total Cost of Care (TCOC) Model provide an opportunity to make robust investments to strengthen acute care across Maryland's communities prior to entry into the AHEAD Model in 2026.

The proposed funding approach would increase rates as of Jan. 1, 2025 by 1.6% on an all-payer basis to lay a foundation for successful implementation of the AHEAD model. Hospitals would hold the revenues collected until directed to specific purposes by HSCRC. Twenty percent of the funds would be directed to the Population Health Trust, and the remaining 80% would go to an Access and Transformation Fund. These dollars would support investments in various health cost and delivery improvement programs to prepare the state for successful performance under AHEAD. The proposal identifies seven areas of potential investment. HSCRC staff would then collaborate with stakeholders and legislators to refine and prioritize allocations before recommending final funding allocations to HSCRC.

While the investment areas proposed under the recommendation are laudable and should be part of a comprehensive effort to strengthen the health care system in our state, MHA urges an approach that releases more funding to enhance hospital readiness and shore up acute care services. This opportunity must prioritize funding hospitals in a timely manner to address the broad-based cost drivers all hospitals are experiencing to varying degrees.

Market experts continue to observe that the operating environment for hospitals and health systems post-pandemic is the most arduous in history. Rising staffing, supply, and drug costs, combined

with challenges in recruitment and retention, increased competition from retail and private equity, insurance denials, and emerging expenses like cybersecurity, AI, and workplace violence prevention have made this downturn exceptionally challenging. Hospitals also continue to confront exorbitant, and continuously rising, costs of essential physician coverage.

Data through the first quarter of calendar year (CY) 2024 show Maryland hospitals continue to fare poorly on key financial metrics as noted here:

- **Operating margin.** The average hospital total operating margin was negative in seven of the last nine quarters, with half or more of Maryland hospitals reporting negative operating margins in most quarters. Maryland lags behind a national sample of nonprofit health care systems tracked by Bank of America.

  For the last five quarters (all quarters available), the national sample outperformed Maryland in operating margin by a cumulative 4.7%. Market experts estimate nonprofit health care providers need about a 3% margin at the health care system level to sustain their missions. Maryland's health care systems average operating margins over the last 11 years were not even half of that (1.6%), including a negative 1.1% in 2023.

- **Capital Adequacy.** On measures of capital adequacy (cash to debt, debt to capital, capital expenses as a percentage of depreciation, and average age of plant), Maryland hospitals lag behind the nation by an average of almost a full year.

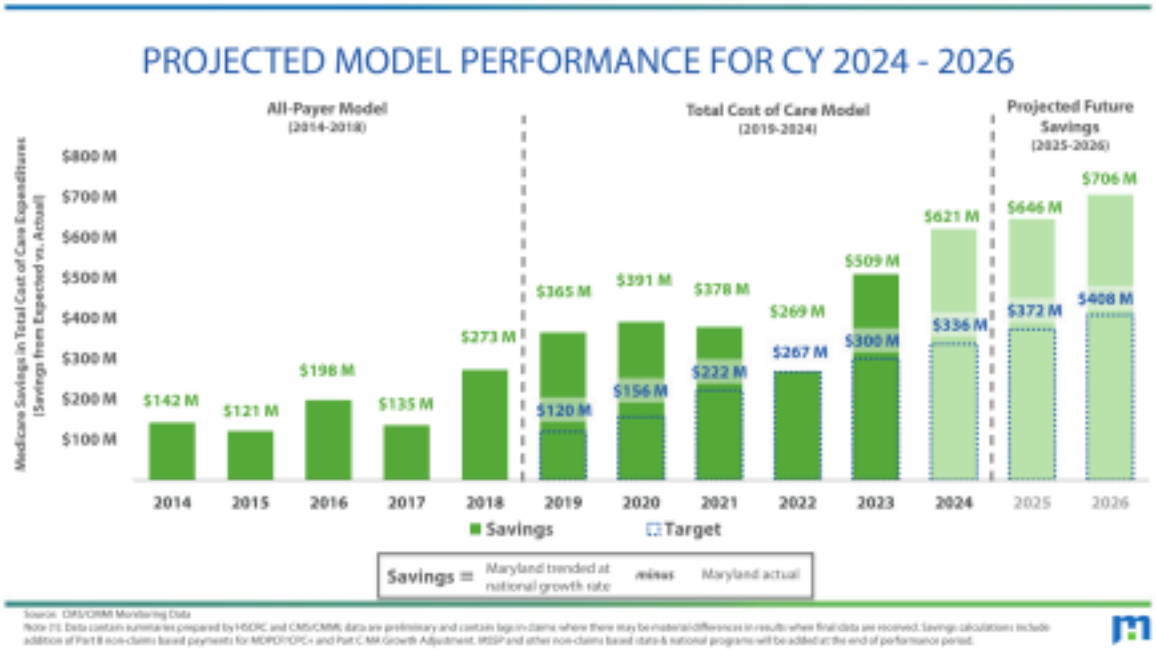
- **Cash Reserves.** Maryland health care systems' cash reserves are below benchmarks when comparing cash reserves to debt—an important credit metric. If health care systems are forced to draw down on cash reserves to cover operating losses, ratings will continue to downgrade leading to lower investment income potential setting up a losing cycle. The state's hospitals could lose access to capital at a time when capital needs are growing.

- **Rating Agency Predictions.** Credit rating agencies predict that cash flow will continue to be pressured in 2025, and operating recovery will be slow. The agencies continue to downgrade three to four times as many ratings as they upgrade nationwide. In Maryland, there were two system downgrades in the last 18 months and two systems with negative rating outlooks.

These financial concerns make hospitals unsustainable in the long term and can be addressed in the short term given the significant amount of excess savings. Hospitals that struggle financially are unable to reinvest in clinical care, recruit and retain talented staff, and invest in patient experience. Financial issues have direct implications on quality and challenge the provision of 24/7 acute care across the state.

The TCOC Model is expected to generate over $600 million in savings by the end of CY 2024—far

exceeding the savings targets of $336 million for CY 2024 and $372 million for CY 2025. This also [illegible] AHEAD Model CY 2023 baseline savings of $509 million.



Proposed Funding Relief Plan

Substantial excess savings offer the state an opportunity to invest in and strengthen acute care across every community. The savings can alleviate financial pressures stemming from underfunded costs in the TCOC Model and provide a stable baseline for success under the AHEAD Model.

There is significant room to redirect excess savings to acute care. As shown below, if HSCRC instituted a 2.7% all-payer rate increase from July 1, 2024 through June 30, 2025, it would generate $410 million in all-payer net revenue to hospitals. **This would bring an additional 2.15% in funding for RY 2025.** This rate increase should be implemented for both GBR and non-GBR hospitals to alleviate cost pressures.

IMPACT OF PROPOSED RATE INCREASE FOR HOSPITALS (7/1/24 – 6/30/25)

- $515 million in net revenue after payer discounts and adjustments for uncompensated care (UCC)
- $105 million rebated to Medicaid
- **$410 million in net revenue available for hospitals**
- Impact on Medicare TCOC savings: $171 million reduction in CY 2025

Like the HSCRC proposal, MHA suggests an approach to mitigate the potential impact an acute care funding relief plan may have on other parts of the health care system. MHA's proposal achieves a balance between acute care sustainability, health care access, and health equity with the

need to generate savings for payers and promote affordability for patients.

MHA proposes the following elements be incorporated into the funding relief plan:

- To minimize operational complexity, funding should be retroactive to July 1, 2024. Further, hospitals should be allowed to generate revenue from Dec. 1, 2024, through June 30, 2025, to spread the rate increase over the remaining seven months of the fiscal year minimizing financial implications for patients and payers.

- To recognize the challenges facing the state budget, MHA supports rebating Medicaid any portion of the funding that impacts its budget, to hold Medicaid harmless while still providing acute care relief.

Funding Allocation

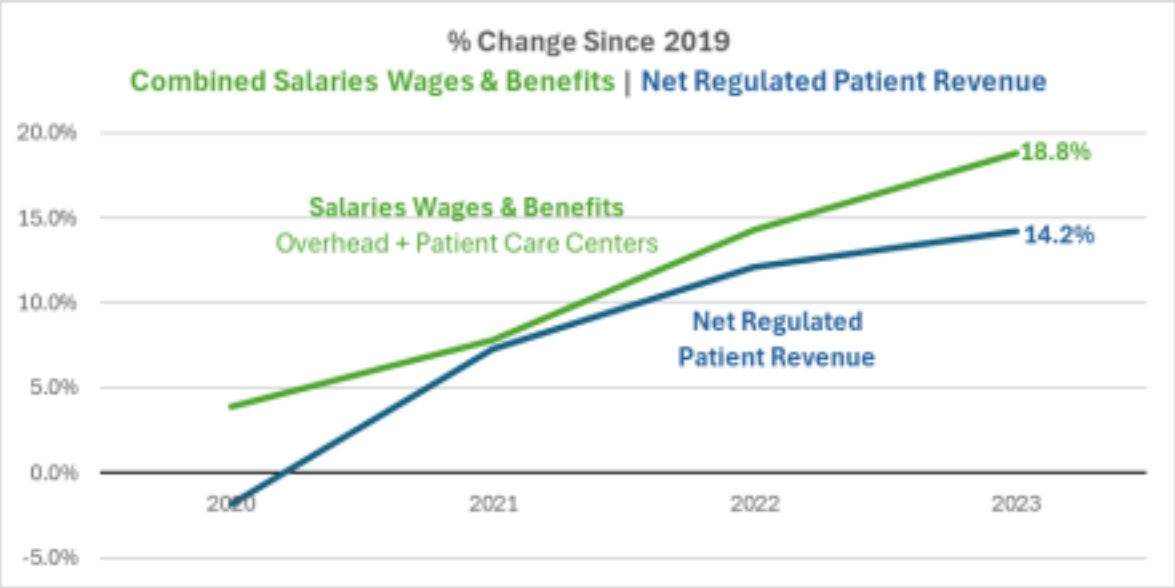
HSCRC should provide permanent funding to address broad-based cost drivers that affect acute care settings across the state to varying degrees. Funding should be allocated to address rising labor costs, routine capital investments, and age-adjusted demographic growth.

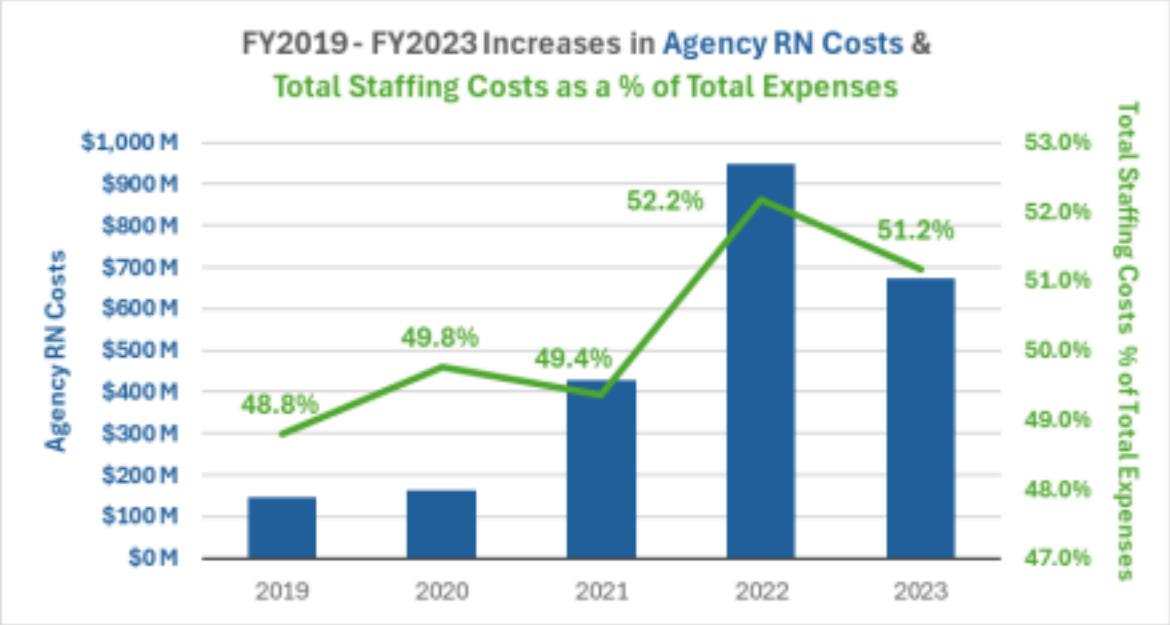
Labor Costs

Labor costs typically account for 60% of a hospital's budget. According to the American Hospital Association, hospitals' labor costs increased by more than $42.5 billion between 2021 and 2023 nationally. Data from the Bureau of Labor Statistics shows that while hourly earnings of health care and social workers are declining (from 7% in 2022 to 3.5% to 4% in 2023 and 2024), labor costs continue to grow faster than inflation. Maryland hospitals continue to contend with worker shortages and difficulty recruiting in clinical and nonclinical areas.

Since the COVID-19 pandemic began, hospitals across the state have seen sharp increases in the cost of labor and have grappled with persistent workforce shortages. There are significant financial losses due to the rising costs of physician coverage for both employed and contracted physicians.

As shown below, labor costs for regulated services have grown significantly since 2019 with the 18.8% growth in labor costs outpacing the 14.2% increase in net regulated patient revenue. Average hourly wage growth has been a substantial cost driver with increases of 5% in 2020, 3.6% in 2021, and 4.1% in 2022—growth rates that are significantly higher than the average wage growth rate of 1.6% for 2013 to 2019. While wage growth moderated in 2023 (0.9%), staffing costs have increased to over 50% of total expenses as the substantial labor cost increases are now a structurally high operational expense. With a 47% increase from 2019 to 2023, agency nurse staffing costs are a big [illegible] for hospitals.





Routine Capital

Hospitals have deferred needed routine capital investments due to financial distress over the past several years. As noted above, Maryland hospitals have an older average age of plant than other hospitals nationwide. Continued deferral of these expenses due to insufficient funding from HSCRC places Maryland hospitals further behind their peers and poses long-term risks for patients.

In a recent survey of MHA member hospitals, all respondents reported deferring routine capital purchases over the last three years to mitigate financial risk from operating income uncertainty. These deferred purchases span a wide range of areas, but include routine patient care capital [illegible]grade, and additional purchases, facility maintenance and renovations, and other

non-patient care purchases, such as for information technology, office equipment, and parking needs. Hospitals also reported having emergency capital expenditures, an indicator of having to

defer capital needs until it is unavoidable. Below are examples of Maryland hospital and health system responses from the survey.

- **Health System A** deferred $26 million of $113 million of routine capital expenditures in fiscal year 2023 and $43 million of $122 million in FY 2024.

- **Hospital B** deferred $111 million in capital spending over the last three years. During that period, the hospital spent $1.7 million on emergency capital purchases.

- **Hospital C** deferred $59.5 million in capital expenditures over the past three years due to affordability constraints and the need to prioritize other capital projects related to patient care. The hospital reported spending $11.7 million for emergency capital purchases for needs ranging from the replacement of a CT scanner to facility maintenance needs like replacement ductwork and water mains.

- Citing cash limitations, **Health System D** deferred $384.4 million in capital expenditures over the past three years and spent $116.5 million for emergency capital purchases during this period.

- **Hospital E** deferred $197.4 million in capital expenditures in the last three years, citing financial performance and capital fund limitations. During this time, the hospital spent $17.7 million for emergency capital purchases to address a variety of needs, including elopement prevention, security upgrades, ultrasounds, and renovations of inpatient units.

- **Health System F** deferred $107.3 million in capital purchases in the last three years, citing increased financial instability due to cost pressures driven by insufficient rate support, underfunding, and other factors. The system expended $17.1 million for emergency capital purchases during this period to address a variety of needs, such as medical equipment, ultrasound, and other patient care needs, parking garage and elevator repairs, IT security infrastructure, and other facility needs.

- **Hospital G** has $61 million in deferred capital purchases and $51.6 million in emergency capital purchases during the past three years. The deferred purchases included items for routine patient care as well as facility, new service, and non-patient care capital needs.

- Due to inadequate funding, **Hospital H** deferred $20 million in capital expenditures in the last three years. The hospital reported $2 million in emergency capital purchases during this period on medical equipment, building repairs, air handling units, and facilities renovation.

- **Health System G** reported $333.5 million in deferred routine capital purchases and $108.5 million in emergency capital expenditures in the past three years.

Age-Adjusted Demographic Growth

The demographic adjustment insufficiently accounts for age-adjusted growth. Lowering the adjustment to align with unadjusted state projections for annual population change creates a reduction in growth from 4.25% to 0.25%. A rate increase could address the underfunding of age

adjusted demographic growth—a critical need as Maryland's population ages.

While MHA has highlighted three broad-based cost-drivers, hospitals are also confronting other equally concerning cost pressures including growth in payer denials, cybersecurity, campus security costs, lingering supply chain issues, and other unforeseen costs that are not recoverable under rates like the cost of providing the RSV vaccine to newborns—a new requirement.

A funding solution for these broad-based cost drivers must be implemented quickly. The methodology to allocate funding for these needs should be streamlined and directed to deliver acute care funding relief to hospitals in a manner that is not administratively burdensome to hospitals or HSCRC. The current HSCRC proposal to have hospitals hold revenues collected until receiving direction from HSCRC may present administrative challenges for hospitals and result in delayed acute care funding relief, possibly until the second half of 2025.

Conclusion

The MHA acute care funding relief proposal addresses the variety of cost pressures confronting Maryland hospitals while staying within the bounds of the agreement with the federal government, protecting Medicaid programming, and minimally impacting patient bills and insurance premiums. By curbing the trajectory of savings, HSCRC can provide much-needed acute care financial relief. The funding proposal can and should prioritize hospital readiness and serve as a bridge to AHEAD.

Thank you again for the opportunity to comment on this important issue. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chair
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

LIFEBRIDGE HEALTH

November 26, 2024

Jon Kromm
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

Thank you for the opportunity to comment on the HSCRC Draft Recommendation on 2025 Funding for AHEAD Preparation. LifeBridge appreciates the staff and Commissioner discussion related to potential funding for Medicare Advantage during the most recent Commission meeting.

LifeBridge Health owns 51% of Alterwood Advantage, a Medicare Advantage Plan serving over 8,000 Medicare beneficiaries in 20 Maryland counties, including a Dual Special Needs Plan (DSNP). Our investment in Alterwood is part of our broader Medicare strategy to manage Medicare beneficiaries in a holistic approach as part of the Total Cost of Care Model (TCOC). Alterwood Advantage's membership is 79% Dual Eligible or Low-Income Subsidy beneficiaries. The Low-Income Subsidy membership historically have costs consistent with the Dual Eligible population and about twice that of the traditional Medicare fee-for-service population. A majority of Alterwood Advantage membership is minority with 56% minority members statewide and 83% in Baltimore City.

LifeBridge Health believes it is appropriate to dedicate a portion of the $350 million AHEAD Preparation Assessment towards a partnership with Medicare Advantage Plans, in light of the Commission fully funding the $81 million towards "Set Aside" for distressed hospitals and because preserving Medicare Advantage aligns with the State's AHEAD Model goals:

- TCOC: Without Medicare Advantage, many of these low-income, high acuity beneficiaries would be in the traditional fee-for-service program without benefits and integrated care coordination systems to support their needs. Medicare Advantage supplemental benefits go beyond dental, vision and hearing and include benefits specifically designed to help keep them out of the hospital like a Flex Card that allows the beneficiary to pay for utility bills.
- Future Update Factors: With the increased growth of Duals and Low-Income beneficiaries in Medicare Advantage, the shift of high-cost beneficiaries from fee for service to Medicare Advantage will allow for enhanced Update Factors in the future.

- Health Equity: Medicare Advantage Plans serve a disproportionate number of minority Medicare beneficiaries. Medicare Advantage is often the only affordable option for Medicare beneficiaries to access supplemental benefits and cost-sharing protections. Supplemental benefits also include quarterly over-the-counter drug subsidies and flexible spending cards that offset the costs of basic social determinants of health factors that affect overall outcomes. Without access to supplemental benefits and cost sharing protections, many minority beneficiaries face barriers to necessary care.

Even though Maryland has experienced recent growth in Medicare Advantage, participation significantly lags the nation. In Maryland only 17% participate in Medicare Advantage, whereas 52% of beneficiaries nationally enroll in Medicare Advantage.
According to the Kaiser Family Foundation, nationally, 9 out of 10 Medicare beneficiaries have some type of supplemental coverage and those who do not report the most affordability-related difficulties. For low-income individuals, Medicare Advantage is often the only affordable source of supplemental coverage.

Relative to the nation, Maryland's plans are disadvantaged by a technical disconnect between Medicare's payment methodology and Maryland's unique TCOC model. Further, a narrower risk pool and higher acuity membership in Maryland exacerbate the challenges for Maryland Plans. These losses disadvantage Maryland beneficiaries because it results in fewer plan choices, higher premiums and less generous benefits than their counterparts in other states.

The challenges faced by Maryland's Medicare Advantage Plans are long-standing and well-known. Over the years, plans have completely exited the market or reduced service areas and benefits. A legislatively mandated 2023 analysis conducted by the Maryland Insurance Administration found that in CY2022 the Medicare Advantage Plans experienced $233 million in underwriting losses. Losses reported to the Maryland Insurance Administration in CY2023 and Quarterly Filings from CY 2024 demonstrate similar losses ($265 million in CY23 and $256 million by the 3rd Quarter CY 2024).

The persistent, market wide scale of losses are unsustainable. AHEAD is a 10-year model and it is time for Maryland to demonstrate that Medicare Advantage can live alongside our unique model so that beneficiaries in Maryland have similar Plan choices and access to benefits as those in other states.

By allocating funds to a partnership with Medicare Advantage Plans, Maryland will expand access to needed benefits to low-income Maryland Medicare beneficiaries. This funding aligns with the goals of the state to address health equity because a disproportionate portion of Medicare Advantage members are minorities and access to supplemental benefits and cost sharing protections are important to eliminating barriers to needed care.

We support the recommendation to allocate a portion of the 1.6% assessment to a partnership with Medicare Advantage and the HSCRC has set prior precedent to administer a grant program that ensures that funds are targeted towards ensuring access to supplemental benefits for Maryland's Medicare beneficiaries.

Thank you for your consideration of a partnership with Medicare Advantage and we look forward to working with you.

Sincerely,

Neil Meltzer
President & CEO

David Krajewski
Executive Vice President & CFO

MedStar Health

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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

December 2, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

On behalf of MedStar Health System and its seven Maryland hospitals, I write to provide comments on the '2025 Funding for AHEAD Preparation' draft recommendation presented during the November 13, 2024, Health Services Cost Review Commission (HSCRC or the Commission) public session. We appreciate the opportunity to provide input on this topic and the ongoing dialogue between the Commission and industry stakeholders.

We write to express opposition to this draft recommendation, which increases hospital rates now but rather than providing needed financial support to Maryland's hospitals sets funds aside for future healthcare programs & investments that lack clarity or specifics.

This recommendation misses the opportunity to strengthen the foundation of care upon which the AHEAD Model will be built.

Even with Covid-19 behind us, Maryland's hospitals remain significantly challenged. The Maryland Hospital Association November 2024 comment letter and testimony outlines the financial status of Maryland Hospitals compared to the industry performance nationally. Hospitals are truly the only 24/7 open door for all who live in our communities, no matter their status or medical needs. We are a country that loves technology and have great hope for what it can mean for the future, but we must strengthen the foundation of care upon which those advances must be built. Maryland hospitals are a critical part of that foundation of care for our region. Irreplaceable in all respects. ***We ask you to exercise your authority at this moment of opportunity to strengthen the hospitals in the state as the foundation upon which we will build the new AHEAD model.***

This staff recommendation increases hospital rates now and sets aside these funds to be directed toward future healthcare needs without clarity or specifics about how they will be utilized.

As outlined in the Staff Recommendation, 80% of the funds generated by the proposed hospital rate increase will be set aside for programs that are not clearly defined, leaving all stakeholders including health systems and hospitals in the dark about the availability and requirements of being able to access this funding. A key benefit of the Maryland model has been the predictability and stability of hospital revenues allowing hospitals to plan strategically and adapt to the incentive structures created by the TCOC model. This approach undermines the predictability and stability of the Maryland Model

While we appreciate the actions taken by the HSCRC to increase the set-aside to fund revenue requests for financial need in FY2025, this action provides one-time financial relief and falls well short of addressing the magnitude of Maryland hospitals' financial challenges. ***As you prepare the final draft recommendation for the December Commission meeting, we express our support for and respectfully request your re-consideration of the recommended approaches proposed by the hospitals and health systems as summarized in the MHA Comment letter.*** This is our opportunity to strengthen the State's hospitals and health systems which serve as the foundation of care upon which the AHEAD Model will be built.

If you would like to discuss this matter further or have any questions, please do not hesitate to contact me.

Sincerely,

Susan K. Nelson
Executive Vice President & Chief Financial Officer
MedStar Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

TidalHealth™

Executive

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December 2, 2024

Jon Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

We are writing to submit comments on the 2025 Funding for AHEAD Preparation which was presented to the Commissioners at the November 13, 2024, meeting of the Health Services Cost Review Commission (the Commission). Staff recommended the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by 1.6 percent, on an all-payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission to prepare for successful performance under the new Advancing All-Payer Equity Approaches and Development Model (AHEAD).

While we can appreciate the need to establish programs in preparation for the evolution of this model, the industry has experienced significant financial stress and is underperforming compared to our national peers while at the same time reducing expense far beyond the model goals. The TCOC Model is expected to generate over $600 million in savings by the end of CY 2024—far exceeding the savings targets of $336 million for CY 2024 and $372 million for CY 2025. This also exceeds the AHEAD Model CY 2023 baseline savings of $509 million.

The excess savings achieved have negatively impacted the ability of Maryland Hospitals to provide access while compromising many healthcare systems in the state especially those who are on average more efficient, operating with lower cost structures, yet unable to generate a sufficient operating margin to maintain access and re-capitalize infrastructure.

Our primary request is that additional funding be authorized to address the margin gap within efficient hospitals as compared to their national peers. If there is a need to address the wider industry, we would support scaling the funding to continue efforts to address the excess variability in allowable charges across the state. The degree of variation within the state, hospital by hospital, reflects an underlying significant inequity. While we respect the difficult position of the staff when considering the influence of countless stakeholders, the current disparities that exist between hospitals and allowances given to inefficient hospitals means Marylanders in certain communities are unfairly impacted.

If the Commision insists on the AHEAD preparation funding, we would offer these comments. Per the post November 11th meeting documents, "Staff recommend the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by 1.6 percent, on an all-payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission. Twenty percent of the funds held will be directed to the Population Health Trust, which the State agreed to establish under the AHEAD agreement, while the remaining eighty percent will be used for newly established programs as described in the prior section. The Commission will provide specific directions for the use of funds after consultation with the

Maryland State Legislature and the creation of the necessary funding vehicles." Staff recommended the following as to possible uses for the additional funds.

- An all-payer value-based program, similar to the current Medicare Care Transformation Initiatives program, to support clinical innovation and transformation to achieve better and more equitable health outcomes while maintaining affordability.
- Common platforms and efforts for the hospital system to improve efficiency and effectiveness of care.
- Access expansions to meet latent demand for high-value clinical services across the healthcare system.
- Global payment arrangements with hospitals that are working to improve health and lower costs in their geographic areas.
- Workforce investments, including but not limited to updates to the GME program.
- Greater understanding of patient financial burdens with seed funding for new approaches to assistance.
- Additional pay-for-performance programs with transformation or access impact.

At the highest level, we have concerns about eroding model performance in a non-scientific manner without a clear understanding in advance that there will be a return on the investment or in this case "advanced payment" from model savings. It would be more conservative to facilitate an application process for additional funding of new and innovative programs prior to charge authorization, especially for hospitals who are inefficient and have retained revenue. We have reservations that a broad, across the board type of approach will yield meaningful savings in the form of better care processes and only erode model performance. This erosion will limit the ability of the Commission to address hospitals that are efficient and underfunded.

This approach also presents challenges as the additional funding would likely need to be maintained as a hospital "restricted asset" of sorts until there is clarity as to usage. The additional funding will convey an inaccurate picture of Maryland hospital financial performance with a higher operating margin that is in effect an "illusion" against some future yet to be determined expense. We are also unclear as to how the legislative session would be involved in the process. It appears like the hospitals may be placed into some sort of convenor position to fund other entities. If the industry has been depleted of important revenue and the "savings" versus target are to be re-allocated to non-hospital institutions, this is highly concerning. We believe strongly that you should consider additional industry input given the significance of the impact this will have on Hospitals that are serving their communities.

The inclusion of GME is extremely concerning as a potential use of these funds and we strongly oppose the use of this process to address GME-related needs. For the last several years, TidalHealth has been consistent in our belief that the State of Maryland should follow the Federal process to determine if a hospital is eligible to receive GME funding. There is a cap on new resident funding since 1997 and almost all hospitals in Maryland now operate under this cap. Funding should be available only for hospitals starting new GME programs and they should be given 5 years to start their programs along with the additional cap development period for each program. Regarding the specific programs, the HSCRC should respect the Accreditation Council for Graduate Medical Education determination as to each hospital's capability through the program application process. Through our engagement over the last several years we have presented clear evidence that rural GME should be an ongoing focus of commission efforts. A

rural GME policy should be developed that provides eligible hospitals with the necessary per resident funding on par with the State average. We have provided a draft policy as part of the set aside funding request and would recommend you consider this as the avenue for funding these rural GME programs. Failure to do so will result in maintenance of a health equity issue within the State (rural versus urban) as well as a significant policy/regulatory concern for TidalHealth.

We appreciate as always the opportunity to submit our comments. We do understand the staff work in a complex environment and can appreciate the desire to establish systems to reduce the total cost of care, especially in this new era of the model. However, it is more important that hospitals have a strong foundation to support improvement and excess savings achieved thus far should be redirected back to the industry.

Sincerely,

Steven E. Leonard, Ph.D., MBA, FACHE
President/CEO

Cc:
Dr. Joshua Sharfstein, Chair HSCRC
Dr. James Elliott, Commissioner
Richardo Johnson, Commissioner
Dr. Maulik Joshi, Commissioner
Adam Kane, Commissioner
Nicki McCann, Commissioner
Dr. Farzaneh Sabi, Commissioner
William Henderson

November 27, 2024

Jon Kromm, PhD.
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Submitted via email to HSCRC.Payment@Maryland.gov

Dear Director Kromm,

UnitedHealthcare provides the following comments in addition to our previous comments submitted on October 25, 2024 to the Health Services Cost Review Commission (HSCRC) regarding the draft recommendations for 2025 Funding of the AHEAD Preparation by approving an increase of 1.6% to the hospital reimbursement rates as of January 1, 2025.

UnitedHealthcare is grateful for the ongoing partnership with Maryland hospitals and the State to advance care delivery for the 880,000 Marylanders we serve. However, we have concerns about our previously approved rate filing should the recommendations be adopted as proposed.

UnitedHealthcare typically files Maryland small employer group rates in May of the previous year for a January 1st start date, and files large employer group rates in December of the previous year for July 1st start date. It has been our experience that once we file rates, the Maryland Insurance Administration (MIA) requests, and UnitedHealthcare agrees to reduce our proposed rates to assure affordability of our plans.

If the Health Services Cost Review Commission approves the 1.6% increase in hospital reimbursement rates, and does so off-cycle as proposed, UnitedHealthcare faces a business challenge as the proposed increase would have justified higher rates had we been able to consider them during the rate filing and approval process. As a result, it will likely be necessary for UnitedHealthcare to file an off-cycle rate increase request to offset the resulting increased healthcare costs.

The proposed 1.6% rate increase will also produce significant additional pressure on Medicare Advantage plans operating in Maryland. The HSCRC, MIA and Maryland Department of Health are all already aware of the structural challenges that Medicare Advantage plans face in Maryland specific to the higher than average costs for Medicare hospital services under an all-payer approach. Medicare Advantage plans will

need collaboration and partnership with hospitals to lower inpatient admissions, re-admissions and length of stay for Medicare Advantage members.

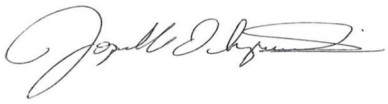
Lastly, we support efforts proposed to ensure that the Medicaid budget is not adversely impacted by the 1.6% increase to hospitals.

Should the HSCRC move forward with its proposed recommendation, however, we urge HSCRC to consider aligning any off-cycle reimbursement rate increases with quality and outcome measures that are value-based to improve care.

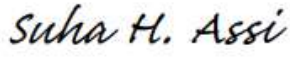
Should you have any questions or seek further information about the feedback provided, please do not hesitate to contact Kathlyn Wee by phone at (443) 896-0608 or by email at kathlyn.wee@uhc.com.

Sincerely,

Kathlyn Wee, CEO
UnitedHealthcare
Communty Plan of
Maryland



Joe Ochipinti, CEO
UnitedHealthcare Employer
& Individual, Mid Atlantic
Region



Suha Assi, CEO
UnitedHealthcare
Medicare & Retirement

maryland
health services
cost review commission

Final Recommendation for Deregulation, Repatriation, and Out-of-State Volume Policies

December 11, 2024

This document contains staff final recommendations for Deregulation, Repatriation, and Out-of-State Volume Policies.

P: 410.764.2605 4160 Patterson Avenue | Baltimore, MD 21215 hscrc.maryland.gov

Table of Contents

Recommendations

Staff recommend the following:

1. Establish a Deregulation policy based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.
2. Establish a Repatriation policy based on the methodology outlined herein that will result in positive (repatriation) and negative (expatriation) revenue adjustments to hospitals' global budgets. The terms, "repatriation" and "expatriation," refer to volumes related to Maryland residents moving into and out of state and are described in full below.
3. Establish an Out-of-State policy based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.
4. Implement Deregulation and Expatriation adjustments at the next available rate issuance on a one-time basis and negative Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
    a. The adjustment exceeds 3 percent of the hospital's GBR OR
    b. The adjustment exceeds 3 percent of the associated service line revenue
    c. All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.

   i. If deregulation methodology indicates a potential deregulation that varies from planned deregulation by more than 10 percent, staff may consider revising the deregulation adjustment
5. Implement Repatriation at the next available rate issuance on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
   a. The adjustment exceeds 1 percent of the hospital's GBR OR
   b. The adjustment exceeds 1 percent of the associated service line revenue
6. Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis one year following the initial revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding but will have the burden of proof and HSCRC staff will be the final arbiters of this decision.

Introduction

The State of Maryland has led an effort to transform health care delivery systems to a population-based system that increases the emphasis on patient-centered care, improves population health, and lowers health care costs. To achieve these goals, the State of Maryland worked closely with hospitals, payers, other providers, consumers and the Centers for Medicare & Medicaid Services to develop the Maryland All-Payer Model, which was implemented in 2014, and later the Total Cost of Care Model, which was implemented in 2019. The Models moved away from a volume-based payment system that limited the growth in inpatient charge-per-case to a system that limits the growth in total hospital spending per capita and increasingly focused on outcomes: readmissions, in-hospital complications, potentially avoidable utilization, total cost of care, and patient satisfaction, among others.

Fundamental to the Models was the Global Budget Revenue (GBR) methodology, which was piloted by ten rural hospitals in 2010 and aimed to provide stability to hospitals by establishing annual prospective budgets and allowing for charges to fluctuate in line with reasonable changes in volume.[1] However, while hospital budgets were fixed during a given fiscal year, thereby incentivizing hospitals not to grow volumes unnecessarily and providing a high level of predictability, the Commission had to develop strategies to modify budgets in future years based on changes in population, the aging of the population, changes in market selection, and new health care innovation cost drivers, the latter of which has been directly addressed by the Commission's two stand-alone volume methodologies, the CDS-A and Complexity and Innovation policies.

[1] The HSCRC allows hospitals to adjust charges for individual rate centers (e.g., room and board) to fluctuate within a 5 percent corridor. HSCRC reviews hospital requests to adjust prices beyond a 5 percent corridor.

To achieve the twin goals of funding population related utilization changes and realigning budgets for market shifts, the HSCRC developed two core volume funding methodologies: the Demographic Adjustment and Market Shift Adjustment. The Demographic Adjustment methodology provides funding for age-adjusted growth/decline at the zip code or county level in order to anticipate changes in utilization based on demographic changes.[2]

The HSCRC staff also developed a Market Shift Adjustment methodology that evaluates hospitals' growth/decline for each defined service line and geography to determine the degree to which patients moved from one hospital to another in the most recent calendar year in comparison to the prior year. The Market Shift moves money in the following year at a 50 percent variable cost factor[3] when volumes are moved up at one hospital and down at another in the same service line and geography.

Taken together, the Demographic Adjustment and Market Shift policies ensure a competitive hospital market where money follows the patient but only such that statewide volume on net does not grow for anything other than population growth and various forms of healthcare innovation. Both of these methodologies resulted in adequate volume funding statewide while maintaining the Model's status as population-based but have not addressed less common shifts in market share that occur due to deregulation, repatriation/expatriation (for Maryland residents), and changes in out-of-state service delivery. See Table 1 below for an overview of Commission policies that are either currently approved or for which staff is seeking approval by way of this recommendation; additionally, please note that staff has categorized policies as either "Stand Alone," meaning they do not require additional policies to account for volume change or not Stand Alone because they work in concert with other volume policies to appropriately address volume change.

[2] The Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the Model tests, i.e., the contractual tests are not age-adjusted.

[3] A 50 percent variable cost factor is the industry standard for determining the percent of charges necessary to cover all marginal or variable costs associated with providing one additional service and is the standard by which the Commission will evaluate its volume methodologies.

Table 1: Volume Policy Overview

Volume Adjustment	Approved Policy	Stand Alone	Purpose
Demographic Adjustment	X		Annual age adjusted population funding for in-state use rate growth
Marketshift	X		Semi-annual adjustments for regulated market shifts (zero sum)
Out-of-State		X	Annual adjustments for material changes to out-of-state volumes
Deregulation			As needed reductions for observed shifts to unregulated settings
Repatriation			As needed adjustments for cross state border hospital shifts
Complexity and Innovation	X	X	Prospective funding to Academic Medical Centers for growth in unique quaternary services
CDS-A	X	X	Funding for changes in volume for select drugs (only volume variable methodology)

While the Commission does not currently have policies that outline the methodologies for Deregulation, Repatriation, and Out-of-State volume changes, staff have made, over the course of the All-Payer and Total Cost of Care Models, adjustments to hospitals' global budgets for these changes in volume, in keeping with language in hospital's global budget contracts.

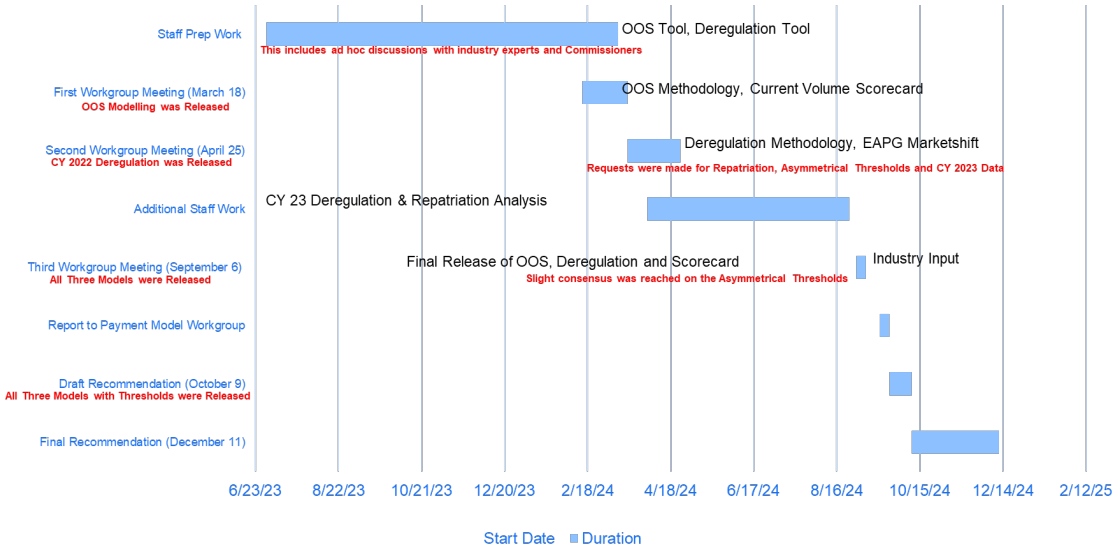
The purpose of this recommendation is to officially establish methodologies for making these volume adjustments, thereby reducing any potential arbitrary and capricious treatment that might result from not having methodologies first vetted by external stakeholders and then reviewed and approved by HSCRC Commissioners. Additionally, this recommendation will lay out for the first time a complete accounting of all volume adjustments that have occurred over the course of the All-Payer and Total Cost of Care Models, otherwise known as the "Volume Scorecard," and in so doing allow future policy makers to assess the need for potential revisions to Commission volume policies.

Background & Methodology Overview

Workgroup Engagement & Impetus for New Policies

Over the past year, staff have worked on developing new volume methodologies, which included extensive data validation, modeling, four stakeholder engagement meetings, and additional analyses in response to stakeholder feedback.[4] See Table 2 below for an overview of the Volume Workgroup Work Plan.

Table 2: Volume Workgroup Work Plan



This is first time staff have significantly reviewed volume policies since 2019 when it consolidated the geographies and service lines in the Market Shift, thereby reducing Market Shift cells (e.g., Cardiology services in Allegany County) from approximately 20,000 to 5,000, and markets with less than 10 discharges (an indicator of a potentially unstable cell size) from approximately 7,000 to 1,000. Staff additionally created new volume policies unique to the COVID -19 pandemic in 2020[5] that have since been suspended, as well as an update to the

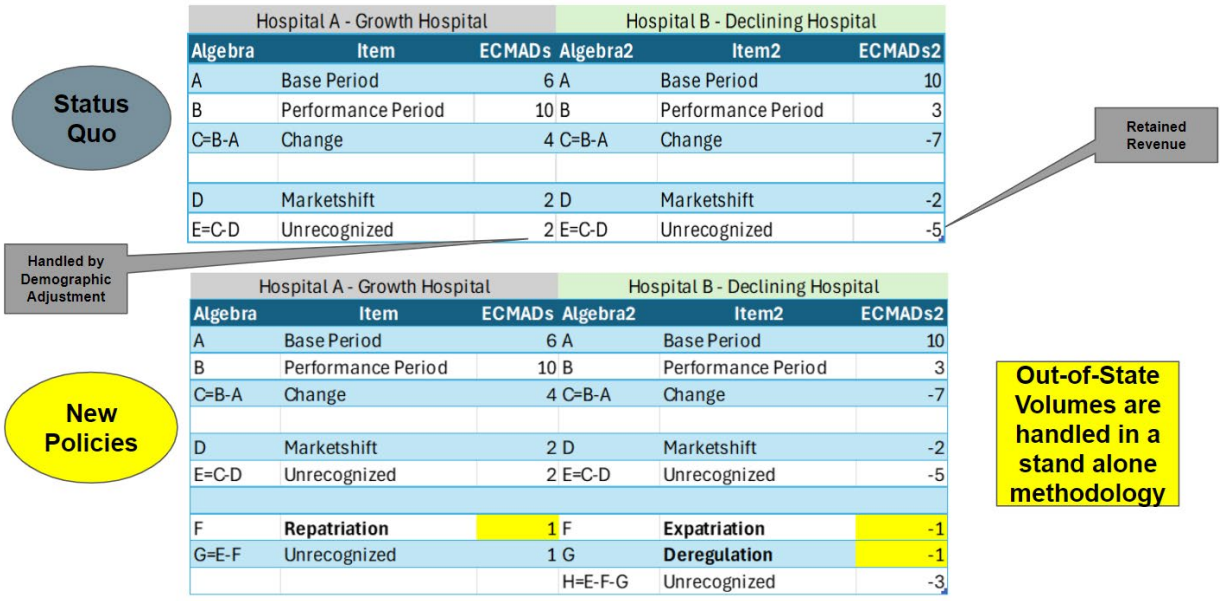
[4] Over the course of Volume Workgroup engagement, staff performed requested analyses related to the appropriateness of Commission approved variable cost factors as well as reviews of overlap with Ambulatory Surgical Center fee schedules.

[5] https://hscrc.maryland.gov/Documents/April%2030%202020%20Public%20Meeting%20Materials.pdf (Pages 6 - 15)

Demographic Adjustment policy in 2023[6] to account for the misestimate of population growth identified in the 2020 census.

Staff proposed and Commissioners agreed that in 2024 the Commission should revisit its volume policies to codify adjustments that were being made at the request of hospitals and payers. Hospitals often requested revenue enhancements due to growth in out-of-state and repatriated volumes, and payers often requested that hospitals should have revenue write-downs for volume that shifted down the continuum of care from acute care settings to unregulated sub-acute settings, e.g., ambulatory surgical centers. In effect, both sets of stakeholders were requesting that the Commission reduce the extent of use rate growth (or decline) that was not recognized in the Market Shift methodology, otherwise known as Unrecognized Equivalent Casemix Adjusted Discharges (ECMADS). See Table 3 below that outlines how Unrecognized ECMADS are classified in the absence of Deregulation and Repatriation policies, and how they can be reclassified if these volumes policies are established, thereby reducing retained revenue and extending the utility of Demographic Adjustment funding:

Table 3: New Volume Policies Overview Example



	Hospital A - Growth Hospital			Hospital B - Declining Hospital		
Algebra	Item	ECMADs	Algebra2	Item2	ECMADs2
A	Base Period	6	A	Base Period	10
B	Performance Period	10	B	Performance Period	3
C=B-A	Change	4	C=B-A	Change	-7
D	Marketshift	2	D	Marketshift	-2
E=C-D	Unrecognized	2	E=C-D	Unrecognized	-5

	Hospital A - Growth Hospital			Hospital B - Declining Hospital		
Algebra	Item	ECMADs	Algebra2	Item2	ECMADs2
A	Base Period	6	A	Base Period	10
B	Performance Period	10	B	Performance Period	3
C=B-A	Change	4	C=B-A	Change	-7
D	Marketshift	2	D	Marketshift	-2
E=C-D	Unrecognized	2	E=C-D	Unrecognized	-5
F	**Repatriation**	1	F	**Expatriation**	-1
G=E-F	Unrecognized	1	G	**Deregulation**	-1
			H=E-F-G	Unrecognized	-3

Deregulation

Deregulation is the movement of a hospital service from an HSCRC regulated space to an unregulated space (most often outpatient services but also chronic and rehab). A service is presumed to be regulated if it is provided on the campus of a hospital. Criteria outlined in

[6] https://hscrc.maryland.gov/Documents/Strong%20als%20Folder/AUUR%20-%20Unit%20Rates%20and%20GBR/FY%202024/RY24%20Amended%20Final%20UF%20Recommendation%20061420 23%20%20with%20comment%20letters%20(1).pdf (Page 11)

COMAR 10.37.10.07-1 are considered for determination of whether a service is considered regulated or unregulated.

Deregulation can be initiated by three principal actors: 1) payers/patients, 2) the hospital itself, and 3) physician practices. Examples of deregulation include:

1. Payer Initiative Example: A payer makes the decision to no longer reimburse for certain procedures or therapies to be administered in a regulated hospital setting and move them to an Ambulatory Surgery Center. Examples of this type of shift include immunoglobulin therapies and endoscopies.
2. Hospital Example: The hospital makes the decision to shift radiation therapy services to an unregulated setting. Perhaps the most straightforward example because the hospital makes the decision to move services.
3. Physician Practices Example: A community physician makes the decision to no longer perform hand surgeries at the hospital. In this instance, the physicians made the decision outside of the hospital's control. A deregulation adjustment still needs to occur because the service is no longer being provided at the hospital.

Deregulation is similar to the Commission's Market Shift policy in that there is a shift in services from one facility to another; however, because the unregulated facility that is experiencing use rate growth is outside of the HSCRC regulatory scope (and thus data availability is limited), it is difficult to quantify precisely the extent of a deregulation. The evaluation of deregulation is further complicated by the different service offerings that occur between regulated and unregulated facilities as well as the incompleteness of data, as the Commission only reliably has access to Medicare total cost of care claims data and yet all-payers are susceptible to deregulation. For these reasons, staff have created a methodology that:

1. Utilizes Medicare data to determine shifts across all settings of care
2. Utilizes 3M's Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services, in lieu of 3M's aggregated service lines to better identify at a more granular level potential deregulation (e.g., pacemaker replacement and/or echocardiography versus "Cardiovascular" service line)
3. Incorporates total trend in EAPGs to remove use rate decline across all settings, which is not indicative of deregulation
4. Extrapolates to all-payer using hospital casemix data
5. Cross references against the Market Shift methodology to ensure there are effectively no duplicative volume adjustments.
6. Removes from consideration all EAPG cases that have a dominant procedure code that maps to CMS Addendum EE -- Surgical Procedures to be Excluded from Payment in

Ambulatory Surgical Centers[7] (only applicable to the following service lines: Major Surgery, Minor Surgery, and Cardiovascular)

Greater details of the proposed methodology are summarized below:

Table 4: Actual Example and Methodology Description of Deregulation

Step	Methodology Description	Algebra	Example (AAMC; SPINE INJECTIONS AND OTHER RELATED PROCEDURES)	Comments
1	Array at an EAPG level the base year ECMAD count for regulated Medicare FFS services	A	101 ECMADS	Staff utilized 2019 base period
2	Array at an EAPG level the performance year ECMAD count for regulated Medicare FFS services	B	56 ECMADS	Staff utilized 2023 performance period in line with volume subgroup recommendation to not use 2022 due to ongoing COVID confounding
3	At an EAPG level evaluate year over year ECMAD % growth in Medicare FFS regulated services	C=B/A-1	-45%	
4	At an EAPG level evaluate year over year ECMAD % growth in Medicare FFS regulated & unregulated services (similar to Step 3)	D	-2%	
5	Subtract the regulated year over year % change from the regulated & unregulated year over year percentage change. *Exceptions: If the hospital year over year % change is greater than 0, value is listed as 0. If the total year over year % change is greater than 0, it is not subtracted from the year over year % change*	E=D-C	43%	Step ensures that general use rate decline as opposed to movement of services down the continuum of care are not scored
6	Determine potential deregulated ECMADS for Medicare FFS by multiplying the base year ECMAD volume count by the variance calculated under Step 5	F =A x E	43	If step 5 is negative (total use rate decline is greater than hospital use rate decline), there is no potential deregulation
7	Array the share of evaluated EAPG attributable to Medicare FFS from base year	G	38%	Derived from hospital casemix data
8	Determine potential deregulated ECMADS for all-payer by dividing potential deregulated ECMADS for Medicare FFS by EAPG Medicare FFS Share	H=F/G	115	
9	Array unrecognized ECMADS from EAPG marketshift*	I	94	Requires creating EAPG marketshift analysis from regular service line marketshift by prorating quantifiable shifts and unrecognized ECMADS to individual EAPGs
10	Determine all-payer ECMADS eligible for deregulation by calculating the lesser of unrecognized ECMADS & potential deregulated ECMADS for all-payer	J=Lesser of H & I	94	Ensures that deregulation does not remove more volume than actual use rate decline not recognized by Market Shift methodology
11	Array performance year average charge per ECMAD for relevant service line (base year if not available plus inflation)	K	$14,057	
12	Determine all-payer $ amount eligible for deregulation by multiplying relevant service line average charge by all-payer ECMADS eligible for deregulation and a 50% variable cost factor	L=J x K x 50%	$662,276	
13	Identify and itemize dollars associated with EAPG's under Step 12 that have a Dominant Procedure Code which cannot be performed in an Ambulatory Surgical Center (only performed for services that map to Major Surgery, Minor Surgery, and Cardiovascular Service Lines)	M	0	Per recommendation from workgroup, staff identified and removed all EAPG cases where the dominant procedure code was listed on Addendum EE -- Surgical Procedures to be Excluded from Payment in ASCs
14	Determine final potential deregulation for Hospitals	N=L-M	$662,276	

*EAPG Market Shift example can be found in Appendix 2

[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

Repatriation/Expatriation

Repatriation is the cross-border movement of Maryland residents from out-of-state hospital facilities back to Maryland regulated facilities. Unlike deregulation, the

assessment is localized to Maryland residents and does not account for any movement across the continuum of care; it only assesses patient movement from one acute care facility to another and in this case when that transpires across state lines. It is important to note that repatriation potentially improves access, patient satisfaction and clinical outcomes, because Marylanders do not have to travel out-of-state for care. Additionally, repatriation improves TCOC Model savings because funding is reduced at a 100 percent variable cost factor outside of the state, and in Maryland it is increased at a 50 percent variable cost factor, the imbalance of which may increase further if materiality thresholds that will be discussed below are included in the methodology. In effect, the Commission should consider how to more directly incentivize repatriation, as it does represent "good volumes."

Expatriation, on the other hand, is cross border movement of Maryland residents from Maryland regulated hospital facilities to out-of-state hospital facilities. When expatriation occurs, there are TCOC Model dissavings, because funding is increased at a 100 percent variable cost factor outside of the state, and in Maryland it is decreased at a 50 percent variable cost factor. However, it should be noted that there are several mechanisms currently in place to mitigate potential expatriation, including GBR corridors that limit hospital delegated pricing authority to 5 percent, the Medicare Performance Adjustment (MPA) that assesses Medicare TCOC performance that penalizes hospitals for volume loss to border states (among other things), the Integrated Efficiency Policy that scales inflation for hospitals deemed relatively inefficient (potentially due to expatriation), and the TCOC Model savings targets that ensure that any significant dissavings from activities like expatriation are accounted for in the annual Update Factor policy.

Repatriation, like deregulation, is similar to the Commission's Market Shift policy in that there is a shift in services from one facility to another; however, again it is difficult to precisely quantify the extent of the shift because non-Maryland facilities are not subject to HSCRC regulations and as such the data is incomplete. Additionally, staff were concerned that: a) assessments of volume change among hospitals not located in contiguous states (or Districts) would be indicative of random variation versus genuine, permanent changes in market selection; and b) the current Market Shift methodology that evaluates all facilities separately would be confounded by market shifts that are occurring within border states versus shifts that are occurring across state lines. For those reasons, staff have created a methodology that:

1. Utilizes Medicare data to determine shifts across state lines by determining the aggregate change for Maryland and non-Maryland facilities in a given geographic area and service line

2. Utilizes 3M's inpatient and outpatient service lines because both settings are susceptible to repatriation, and there is no need for more granular analysis since acute care facilities (in-state and out-of-state) have similar service offerings.
3. Extrapolates to all-payer using hospital casemix data
4. Cross references against the Market Shift methodology to ensure there are effectively no duplicative volume adjustments.

Greater details on the proposed methodology are outlined below in an actual example:

Table 5: Repatriation Example (Cardiology, Allegany County)

Hospital	ECMAD Change	MD Net Change	Non-Maryland Net Change	Eligible for MS	Proportion of Shift	Medicare FFS MS	Medicare FFS %	Allpayer MS	Unrecognized ECMADS	Repatriation (Expatriation)	Average Charge	Repatriation (Expatriation) Adjustment
Algebra>>>>	A=CY23 ECMADS - CY 2019 ECMADS	B=∑A(Maryland)	C=∑A(Border States)	D= Minimum of Absolute Value for B & C	E=A/(B or C)	F=KXD	G = 2019 or 2023 Med FFS % or 1	H=F/G	I = CY 2022 + CY 2023 Unrecognized ECMADS	J = Minimim of H or I if Positive, Maximum if Negative	K= 2023 or 2019 Average Charge	L=J X K X 50%
Western Maryland	49.72	42.92	-0.69	0.69	115.84%	0.80	70%	1.13	3.38	1.13	$19,015	$10,787
Meritus	3.15	42.92	-0.69	0.69	7.34%	0.05	100%	0.05	(0.32)	-	$16,096	$0
Frederick	1.13	42.92	-0.69	0.69	2.63%	0.02	100%	0.02	-	-	$17,147	$0
Calvert	0.6	42.92	-0.69	0.69	1.40%	0.01	100%	0.01	-	-	$15,554	$0
UMMS- UMMC	-0.37	42.92	-0.69	0.69	-0.86%	(0.01)	30%	(0.02)	-	-	$26,039	$0
GBMC	-0.47	42.92	-0.69	0.69	-1.10%	(0.01)	100%	(0.01)	(0.08)	(0.01)	$17,946	-$68
JHH- Howard County	-0.48	42.92	-0.69	0.69	-1.12%	(0.01)	100%	(0.01)	-	-	$13,596	$0
Lifebridge- Northwest	-0.5	42.92	-0.69	0.69	-1.16%	(0.01)	100%	(0.01)	-	-	$16,523	$0
UMMS- Charles	-0.56	42.92	-0.69	0.69	-1.30%	(0.01)	100%	(0.01)	-	-	$15,504	$0
MedStar- Southern MD	-0.76	42.92	-0.69	0.69	-1.77%	(0.01)	100%	(0.01)	(0.11)	(0.01)	$17,611	-$108
JHH- Bayview	-0.87	42.92	-0.69	0.69	-2.03%	(0.01)	100%	(0.01)	-	-	$23,417	$0
Trinity - Holy Cross Germantown	-1.35	42.92	-0.69	0.69	-3.15%	(0.02)	100%	(0.02)	-	-	$12,419	$0
Saint Agnes	-1.46	42.92	-0.69	0.69	-3.40%	(0.02)	100%	(0.02)	-	-	$24,802	$0
MedStar- Harbor	-1.51	42.92	-0.69	0.69	-3.52%	(0.02)	100%	(0.02)	-	-	$18,234	$0
Garrett	-1.53	42.92	-0.69	0.69	-3.56%	(0.02)	82%	(0.03)	-	-	$20,097	$0
JHH- Johns Hopkins	-1.82	42.92	-0.69	0.69	-4.24%	(0.03)	9%	(0.33)	(0.38)	(0.33)	$31,537	-$5,177
WV	*6.16*	*42.92*	*-0.69*	0.69	-892.75%	(6.16)	*100%*	(6.16)	-	-	-	$0
PA	*5.42*	*42.92*	*-0.69*	0.69	-785.51%	(5.42)	*100%*	(5.42)	-	-	-	$0
DE	*1.86*	*42.92*	*-0.69*	0.69	-269.57%	(1.86)	*100%*	(1.86)	-	-	-	$0
DC	*-3.72*	*42.92*	*-0.69*	0.69	539.13%	3.72	*100%*	3.72	-	-	-	$0
VA	*-10.41*	*42.92*	*-0.69*	0.69	1508.70%	10.41	*100%*	10.41	-	-	-	$0

Out-of-State

Out-of-state evaluations of volume are specific to patients that live outside of the state of Maryland, which is different from repatriation and expatriation volume assessments that are specific to Maryland residents. Per the GBR contract, the Commission can adjust a hospital's GBR "If this percentage [out-of-state volume] changes materially during the term of this Agreement…" - Section X, Global Budget Revenue Agreement.[8] To date, staff have adjudicated a few out-of-state adjustments because: a) the volume change was material; and b) the volume change represented a material share of the hospital's global budget. Due to the increasing frequency of hospital requests to adjust for out-of-state volumes, staff believe it is necessary to establish a formal policy.

Unlike typical volume methodologies, staff elected to use reported experience data in lieu of ECMADS, e.g., patient days versus weighted APR-DRGs, when previously adjudicating out-of-state volume adjustments because these evaluations were longitudinal assessments with base[9] and performance years under:

[8] Hospital GBR Agreement, section X, page 13

[9] Most hospitals have a base year of 2014 because that is when global budgets were established. A few hospitals have a more advanced base year because they were effectively rebased through a direct out-of-state adjustment or indirectly through a full rate application policy.

- Different Groupers
- Different Casemix Weighting Methodologies
- Different Diagnosis and Procedure Code Versions (e.g., ICD-9 to ICD-10)[10]

With the exception of utilizing experience data, the out-of-state methodology is pretty straight forward, as it is a volume variable methodology[11] that is only implemented when there is a material change.[12] The specifics of the methodology are as follows:

1. Out-of-state Revenue Increase = Current Hospital Rate X (Performance Year Volume - Base Year Volume) X 50 percent Variable Cost Factor
2. Excluded from this analysis are drug and supply rate centers because of the unreliable unit of cost and because a significant portion of drug costs are covered by the Commission's stand-alone CDS-A policy
3. Conversion factors are accounted for in volume assessment, e.g., clinic RVU conversion

During the volume workgroup engagement, stakeholders understood the need for utilizing experience data, especially over the course of the ICD-9 to ICD-10 conversion but were nevertheless concerned about the permanent departure from using ECMADS in a volume assessment because: a) growth in out-of-state drugs and supplies would not be accounted for; and b) multiple volume statistics would over complicate the volume ecosystem. Staff concurred and furthermore agreed to the workgroup's suggestion to lock in out-of-state assessments from Rate Year 2014 to Rate Year 2023 using experience data, and then to advance to ECMAD assessments for Rate Year 2023 to future fiscal years. Moving forward, this will require a compounding calculation on the part of HSCRC staff between the two volume statistic periods but will ensure that no future volume adjustments will be made without utilizing ECMADS, the industry standard for assessing acuity adjusted volumes.

Implementation

In this section, staff explains implementation considerations that were discussed by the Volume Workgroup and reported out to the Payment Model Workgroup.

Accuracy of Volume Evaluation and Potential for Temporal Volume Change

Three principal concerns were raised by the Volume Workgroup. First, workgroup members raised the issue of methodology accuracy, given the reliance on Medicare total cost of care data and the small and potentially temporal nature of the associated volume changes. Second,

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[10] The transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures in the United States occurred on October 1, 2015. https://www.cms.gov/medicare/coding-billing/icd-10-codes#:~:text=Pages%20in%20this%20section&text=What's%20New?,who%20bill%20Medicare%20or%20Medicaid.

[11] The Total Cost of Care contract requires that 95 percent of all in-state revenue be under a population-based methodology. Out-of-state volume is not subject to this requirement, which is why it can be evaluated through a volume variable methodology.

[12] Materiality will be discussed in the following *Implementation* section.

members noted that not all hospitals have the same efficiency and retained revenue levels, and thus there should be some consideration of varying cost structures and profitability when implementing adjustments. Third, members noted that in certain cases the reduction of services through deregulation, expatriation, and/or out-of-state movement may not be driven by a hospital and/or may happen rather suddenly, e.g., a physician practice elects to quickly sever affiliation with a hospital and moves its referrals elsewhere. In this case the hospital may still like to replace the departing practice with a new physician group over the course of the next year which would make any adjustment temporary. This last point is particularly salient for deregulation, as Commission staff noted in the workgroup engagement that it would not advance a policy incentive to Commissioners that reverses deregulation and rewards movement up the continuum of care, given the goals of the TCOC Model.

For these reasons, staff proffered the following implementation approaches:

1. Deregulation, Repatriation, and Out-of-State adjustments are to be implemented at the next available rate issuance on a one-time basis, thereby recognizing potentially temporal volume change
2. Hospitals can provide additional information to contest an HSCRC finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.
3. If one-time adjustments are made and the same finding is made the following year, the adjustment will be made permanent.
4. All adjustments will be subject to a materiality threshold.

Materiality Thresholds

Staff spent the majority of time with the workgroup debating what are appropriate materiality thresholds, which represent a tool the Commission has previously used to reduce the need for making out-of-state volume adjustments year after year, per the GBR contracts. While no consensus was reached, many members supported the idea of asymmetrical materiality thresholds, whereby hospitals would receive a negative adjustment only when a larger materiality was met - a commercial payer representative did not agree with this recommendation.

Initially staff did not support the asymmetrical proposal because symmetry is methodologically desirable and more intuitive; however, upon further reflection, staff identified that all growth in out-of-state volumes is beneficial for the Model because Maryland is effectively exporting services, which when reimbursed at a 50 percent variable cost factor, lowers hospital price per case and Maryland TCOC. Additionally, all repatriation is favorable for the Model because reimbursement at a 50 percent variable cost factor inside the state and divestment at a 100 percent variable cost factor outside the state lowers hospital price per case and Maryland TCOC. Thus, applying a higher materiality threshold to desirable actions, albeit symmetrical, may disincentive hospitals from growing “good volumes.”

In light of these considerations, staff propose the following recommendations:

Table 6: Recommendations for Materiality Threshold Implementation

Policy	Materiality Threshold	Implement one-time initially and permanently one year later (Recommendation 5)	Implement permanently upon initial adjustment
Deregulation			
Decreases GBR	Approach A	X	
Change to Rendering Location State for MD resident			
Repatriation	Approach B	X	
Expatriation	Approach A	X	
Change to Rendering Location State for Out of State residents			
Into State	Approach B		X
Out of State	Approach A		X

Materiality Approach A is:
1. The adjustment exceeds 3 percent of the hospital's GBR **OR**
2. The adjustment exceeds 3 percent of the associated service line revenue

Materiality Approach B is
1. The adjustment exceeds 1 percent of the hospital's GBR **OR**
2. The adjustment exceeds 1 percent of the associated service line revenue

Stakeholder Comments

Following the draft recommendation, staff received comment letters from seven stakeholders and several verbal comments from Commissioners.

Adventist Health (Adventist)	Maryland Hospital Association (MHA)
CareFirst Blue Cross Blue Shield (CareFirst)	MedStat Health (MedStar)

Johns Hopkins Health System (JHHS)	University of Maryland Medical System (UMMS)
Lifebridge Health (Lifebridge)	

The comments from stakeholders and Commissioners can be broadly categorized into 11 areas of concern.

Topics	Adventist	CareFirst	JHHS	LifeBridge	MHA	MedStar	UMMS	Commissioners
Efficiency	✓			✓			✓	
Implementation Process	✓				✓			
Materiality Thresholds		✓			✓			✓
Face Validity	✓						✓	
Extrapolation	✓			✓	✓	✓	✓	
Interactions					✓	✓	✓	
Exclusions					✓	✓		
Variable Cost Factor		✓	✓		✓			
Volume Scorecard	✓	✓			✓	✓		
Workgroup Process	✓			✓		✓		
General Volume Policy Concerns			✓	✓	✓		✓	✓

Staff will address each category below:

Efficiency Comments

Topic	Adventist	LifeBridge	UMMS
Efficiency	"Hospitals in the bottom quartile of IE results already receive an efficiency penalty and can submit a Revenue for Reform (R4R) application to show how their retained revenue is being used to support population health investments in the community. It is duplicative to then hit these hospitals with an additional penalty… While we respect and understand the reasoning behind using the IE results as materiality criteria in these policies, the Integrated Efficiency policy is a standalone policy that has a specific structure combined with R4R to address inefficient hospitals. It creates a cause for concern if the IE results begin to be used as a precursor in every other HSCRC policy to further penalize those hospitals."	"Ultimately, as currently adopted, the integrated efficiency policy evaluates hospitals on a price per case basis and is intended to act as a catch-all methodology to account for price drivers that cannot be accounted for through the market-shift volume and other methodologies. Layering on additional penalties results in duplicative penalties and implies the efficiency policy as currently approve no longer satisfies the staff's goals for how much and how quickly revenue should be removed from inefficient hospitals."	"We strongly believe the Integrated Efficiency policy in its current form is inherently biased against hospitals which serve the state's most difficult populations. We believe that the Integrated Efficiency policy needs to be re-thought through the lens of health equity and consideration for differential investments in challenging geographies needs to be included in the policy. Volume policies were developed to address volume funding. No other volume policy, including the main volume funding mechanisms of Market Shift and Demographic Adjustment, contemplates any factors other than volume growth or decline. It is for this reason and our concern over the Integrated Efficiency's bias that we firmly believe that volume policies should not apply results differentially based on a hospital's ranking in the Efficiency policy."

Staff concur with the concern that using the Integrated Efficiency Policy conflates volume and efficiency policies and excessively penalizes hospitals in the bottom quartile of that evaluation. **Thus, staff recommend discontinuing its use in line with the precedent established during the Complexity and Innovation policy development:**

> "While staff appreciates CareFirst's support of the Integrated Efficiency policy, which was developed to evaluate both hospital cost per case and total cost of care performance for purposes of scaling the annual update factor, staff recommends not

conflating analyses. Instead, staff recommends handling efficiency concerns through the Integrated Efficiency policy and adjusting funding for highly specialized care through the Complexity and Innovation policy" – Complexity and Innovation Policy Recommendation (page 19)

Staff disagree with the assertion that the Integrated Efficiency policy "is inherently biased against hospitals which service the state's most difficult population," as:

- The evaluation directly risk adjusts for serving a disadvantaged population
- There is no statistically significant relationship between a measure of adverse social exposure and ICC performance
- There is strong correlation between above average levels of overhead and ICC performance
- The policy allows for hospitals to reinvest in their communities versus incurring a revenue reduction through r4r

Nevertheless, staff welcome the opportunity to amend the efficiency policy evaluation and/or implementation if directed so by Commissioners, especially given concerns about ordinal ranking issues over time

Implementation Consideration Comments

Topic	Adventist	CareFirst	MHA
Materiality Thresholds		• "First, we don't believe it [the materiality threshold] is necessary. Under staff's proposal, adjustments that do not exceed a materiality threshold of either 3% of the hospital's GBR or 3% of the service line revenue would be waived. Staff has argued the materiality threshold will promote financial stability for hospitals by limiting adjustments from year to year. However, by definition, waiting for an adjustment to become "material" suggests a single large adjustment to the hospital's revenue will be more disruptive to a hospital's financial stability than incremental, immaterial adjustments. • Second, staff's proposal uses both arbitrary and asymmetrical materiality thresholds. While we do not believe the thresholds are necessary, requiring negative adjustments to reach a higher threshold for application than positive adjustments on the same issue would not defy good policy and logic"	"MHA supports the proposal to adopt a larger threshold for deregulation, expatriation, or a negative OOS adjustment. The proposed threshold—requiring a downward change of more than 3% of global budget revenue (GBR) or of the associated service line—is sound policy, recognizing that volume changes may be small or temporary while allowing greater funding predictability and financial stability for hospitals. The proposal would implement a materiality threshold for repatriation and positive OOS changes so that an adjustment would occur if it exceeds 1% of GBR or of the associated service line."
Implementation Process	"The deregulation, repatriation, and out-of-state adjustment policies should be run once a year in tandem with the final market shift policy. The results, inclusive of materiality thresholds, should be shared with hospitals at the same time market shift results are shared (approximately April-May). At the time results are shared, no overlap should remain between the policies. Positive adjustments can be included at the issuance of the next rate order; however, no negative adjustments should be included in the rate order unless hospitals have the opportunity to review and contest the results. Hospitals should have a pre-defined amount of time to review and contest the results. The HSCRC should outline specifics on the data required to contest the results within the final policy. The HSCRC should then have the same pre-defined amount of time to respond to the contested data with a final decision needing to be made by the end of that timeframe."		"In the draft, deregulation, repatriation, and OOS adjustments would be implemented at the next rate issuance, on a one-time basis with a permanent adjustment made the following year if the same change is confirmed. This is a fair approach that recognizes volume changes may be temporary. The proposal rightfully allows hospitals to provide additional information to contest an HSCRC finding in this process."

Staff concur with MHA's assertion that the asymmetrical materiality thresholds are sound policy that balance the need to:

- Recognize that volume changes may be small and/or temporary
- Provide an incentive to hospitals to bring back Marylanders back into the state for acute care services
- Provide an incentive to hospitals to attract out-of-state residents to Maryland facilities

Staff disagree with CareFirst's suggestion to abandon the asymmetrical materiality thresholds because:

- The methodology has imperfect data that requires extrapolation, albeit with a failsafe of referencing "unrecognized volume decline"
- The volume shifts are small and/or temporary
- The materiality thresholds are not arbitrary, as they:
    - Were purposefully chosen as a mid-point between 0%, the starting point for materiality, and 5%, a threshold which already triggers GBR corridors, the Commission's main deterrent to excessive volume reductions
    - Align with other methodologies that utilize a 3% statistic to determine statistical significance
- There is a misunderstanding of how the materiality thresholds will be utilized, i.e., once a threshold is triggered, the adjustment will reconcile to the threshold and not the entire variance, which negates the point that this practice will be disruptive to hospital finances

Staff disagree with MHA's suggestion to utilize a 0.5% materiality threshold for OOS growth and repatriation, because:

- This extends beyond what staff believe is a balance between recognizing small and/or temporary changes and creating an incentive to grow "good volumes"
- It is not paired with a similar reduction to the downside materiality threshold of 3%

Staff appreciate MHA's support of the implementation process that calls for a one-time adjustment with a permanent adjustment made the following year if the same change is confirmed. Staff share Adventist's concerns about delays in the data that would reduce the time period by which hospitals can contest findings, but given the data should be available in May, staff do not believe establishing a deadline is required. Staff do not agree with Adventist's suggestion that the HSCRC must provide the specifics on the data necessary to contest the results of a volume finding, as the specifics can change based on the reasoning advanced and the burden of proof rests on the hospital, per the policy recommendation. Staff do believe, however, that any data utilized to contest a finding should be: publicly available or subject to audited verification if proprietary.

Immediate Technical Consideration Comments

Topic	Adventist	LifeBridge	MHA	MedStar	UMMS
Interactions			"Hospitals may face double penalties under both policies. MHA requests excluding Equivalent Case-Mix Adjusted Discharges (ECMAD) accounted for under deregulation from the unrecognized ECMADs under the repatriation policy."	"Need to exclude Equivalent Case-Mix Adjusted Discharges (ECMADs) that are the basis of any deregulation adjustment from repatriation calculation to prevent double counting"	"These policies should be mutually exclusive and current methodology does not adjust for the results of one another, which double counts adjustments in both policies." "Results are unadjusted for any special negotiations which may be double counted in the policy."
Extrapolation	"AHC encourages additional exploration of an alternate method to estimate these volume shifts in service lines with very low Medicare volumes."	"[Extrapolation] may not be appropriate to apply to all payers when considering factors like changes in payer mix since the base period."	"We recommend removing or using alternative methods to assess repatriation for service lines with low Medicare FFS percentages." "A significant percentage (nearly half) of the procedure categories lack an appropriate Medicare FFS percentage and use a default percentage of 100%"	"Extrapolation from Medicare fee-for-service (Medicare FFS) data to calculate an all-payor adjustment may lead to distorted results that do not reflect actual experience "Use of a Medicare FFS default percentage of 100% for procedure categories that lack a Medicare FFS percentage caps repatriation funding at Medicare growth level which may not be reflective of actual experience"	"Extrapolation methodology produces unreasonable results for service lines with limited Medicare volume (ie, Obstetrics, Newborn)."
Face Validity	"We urge the HSCRC to reconsider the current volume approach. We ask the HSCRC to carefully consider the cumulative and compounding effect of all existing policies and the potential for "penalty stacking". When penalties are layered without balanced incentives, hospitals experience financial shock that disrupts long-term planning and limits the ability to sustain improvements."		\		"Deregulation policy identifies that the entire amount of use rate is taken as deregulation in over 80% of the instances across the state where the algorithm identifies the EAPG as potential deregulation. For UMMS hospitals, nearly 100% of unrecognized market shift was considered deregulation, which seems highly unlikely."

Staff agree with the concern regarding interactions, as aforementioned in the draft recommendation. The final policy results now remove volume scored in the Deregulation methodology from the unrecognized volume in the Repatriation methodology, which effectively removes approximately 689 ECMADS from expatriation ($5.3M out of a total scored expatriation of $29.9M). Additional interactions related to prior agreements with hospitals on volume funding can be adjudicated through the implementation process when hospitals can contest findings

Staff believe the concerns over extrapolation should be weighed against the following considerations:

- There is a failsafe in Deregulation and Repatriation methodologies, i.e., a reference against a hospital's unrecognized volume reductions, that ensures the Commission does not remove more volume than actual declines
- Materiality thresholds further remove the likelihood that the Commission will score deregulation or expatriation artificially due to inaccurate extrapolation
- The implementation process outlined in the recommendation purposefully allows hospitals to contest findings, which staff expect will be based on concerns over extrapolation
- Review of the Repatriation methodologies indicate that concerns related to cells where there is no available Medicare fee-for-service percentage to extrapolate is quite limited, (~400 entries out of approximately 17 thousand or ~2 percent of cells that have no extrapolation).

- As demonstrated below, the Deregulation methodology, which uses extrapolation, aligns quite well with planned deregulations hospitals have brought forward, suggesting that extrapolation has face validity

Staff do not agree with UMMS' concern that 80 percent of the use rate decline in the State is scored as deregulation, as modelling indicates that 28 percent of total declines is scored as deregulation (prior to use of materiality thresholds). Additionally, examination of several planned deregulations suggest the tool is working well:

Hospital	Planned Deregulation	Deregulation Tool
Anne Arundel	$5.8M (OP Surgery)	$5.9M (Major, Minor Surgery)
Calvert Health	$355k (OP Cardiac Testing Center)	$613k (Radiology)
Johns Hopkins	$3.6M (Green Spring Volume Shift)	$3.5M (Major, Minor Surgery)
Meritus	$1.5M (Pain and Gastro Surgery)	$1.7M (Major, Minor Surgery)
UM Midtown	$455k (OP Tower Deregulation)	$642k (Minor Surgery, Radiology)

Less Immediate Technical Consideration Comments

Topic	CareFirst	JHHS	MHA	MedStar
Exclusions			"CDS-A and innovation service lines are addressed already in their stand-alone policies and should be excluded from the repatriation analysis."	"CDS-A and innovation service lines should be excluded from the repatriation calculation as they are addressed in stand-alone HSCRC payment policies"
Variable Cost Factor	"During the review of volume policies, stakeholders questioned staff's consistent use of a 50% variable cost factor. In response, staff has provided analyses supporting their use of a 50% variable cost factor. However, regardless of the variable cost factor used, hospitals on GBR in a declining volume environment will always be funded above fee-for-service relative to volume. As such, staff's time would be better spent on policy issues that address equity, access, affordability, and quality."	"We have found that a 50% across the board VCF does not properly account for the real costs of providing care to certain types of patients. This can disadvantage a hospital that has service lines which carry a higher VCF like Oncology, Cardiac Services and Orthopedic Services. JHHS favors a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis."	"MHA favors a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis. In work group discussions, HSCRC staff offered analyses that support an overall 50% VCF. However, a preliminary service line analysis by MHA shows adoption of a higher overall VCF for inpatient and outpatient services is required, with drugs and supplies appropriately funded at a 100% VCF."	

Staff concur with the suggestion to remove CDS-A and innovation service lines from the repatriation analyses and will ensure this is accounted for moving forward. Staff's analyses of variable cost factors suggests that a 50% variable cost factor is appropriate, but we appreciate the work MHA has done to help inform this statistic. Further consideration of the appropriate variable cost factor could be included as Staff continue to revise the policies over time.

Volume Scorecard Comments

Topic	Adventist	CareFirst	MHA	MedStar
Scorecard	"AHC is concerned that the results of the scorecard have not been fully validated – most notably the special adjustment section of the scorecard. While staff has been open to addressing any remaining concerns, AHC strongly urges against any formalization of the scorecard until those concerns are fully addressed."	"We applaud staff for the extensive work that has gone into the volume scorecard. Staff have demonstrated that nearly all hospitals have received more funding than they would have if volumes were funded on a fee-for-service basis and a 50% variable cost factor. While hospital volumes have declined since the start of the model, statewide hospital costs have increased because the global budgeted revenue (GBR) model allows hospitals to retain the revenues associated with avoided utilization. Thus, generous funding relative to volume should not be surprising."	"HSCRC should consider retaining an independent third-party to validate the approach before using the scorecard to evaluate the over and underfunding of volume and whether modification is needed to methodologies for funding volume changes."	"MedStar is supportive of the volume scorecard in concept to provide the industry with a longitudinal assessment of volume funding across the state. MedStar stresses that Staff should continue to be clear that this scorecard does not provide an assessment of the appropriateness of hospital funding in totality and should not be used in HSCRC rate setting policy determinations." "The scorecard is appropriate only for use as an approximation when assessing if hospitals are appropriately funded for volume changes."

Staff appreciate CareFirst's acknowledgement of the extensive work that went into the Volume Scorecard. Staff additionally appreciate MedStar's support of the Volume Scorecard concept, i.e., as a tool that approximates appropriate funding for volume changes and not a methodology for rate setting determinations

Before determining if the scorecard needs to be independently validated, staff believe the following should be considered:

- The HSCRC is an independent regulator with no incentive to deviate from objective scorekeeping
- Multiple staff within the HSCRC have modelled volume funding and have reached the same findings
- The tool has been validated by consultants for select hospitals
- Hospitals and consultants are regularly supplied with this data and have been afforded the opportunity over the last 6 months to dispute any findings

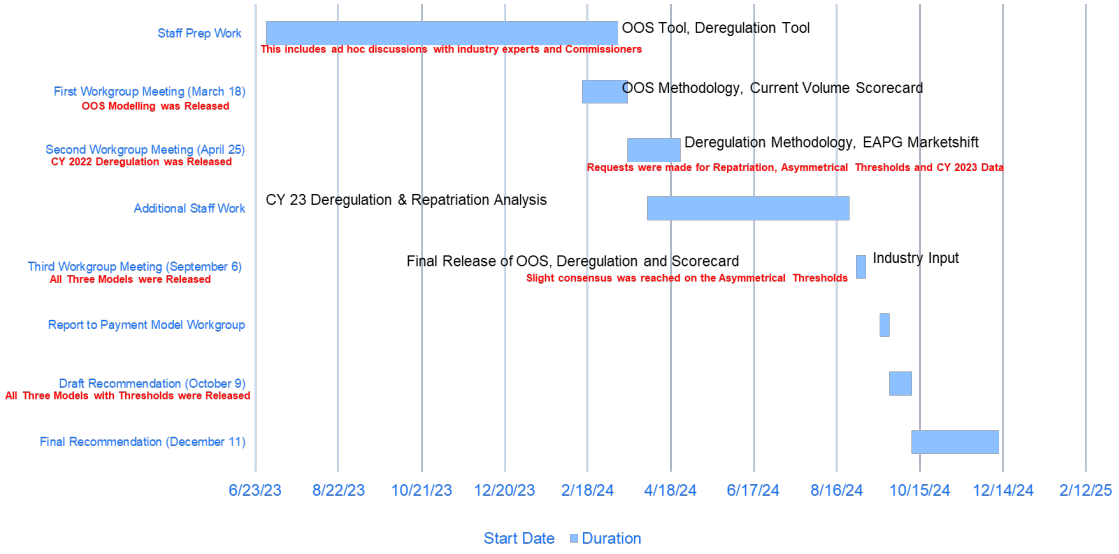
Workgroup Process Comments

Topic	Adventist	Lifebridge	MedStar
Workgroup Process	"While AHC is in full support of the development of these policies, there is an overarching concern with the timeline to finalize and execute these policies when there has been limited time for the industry to fully vet and validate the complete results. Final workbooks with the inclusion of materiality thresholds were just shared with the industry on October 9th giving hospitals only three weeks to thoroughly review each of the three distinct complex policies and provide comment."	"While there was a workgroup that discussed the need for more precise volume adjustments outside of the existing market-shift policy, in our opinion more time was spent on the principles of additive volume methodologies as opposed to the level of detail and specificity presented in the Staff's October draft recommendation."	"We want to acknowledge the tremendous amount of work that Staff did to develop these policies over the previous year as well as the collaborative nature in which Staff engaged with and was responsive to stakeholders during this process."

Staff thank MedStar for their recognition of staff's work over the past year to bring forward formulaic volume policies that adjust for shifts requested by stakeholders.

Staff do not agree with Adventist's and LifeBridge's assertion that there has been limited time to fully vet these methodologies and that discussions in the workgroup mainly focused on the principles of additive volume methodologies

As demonstrated on the next table, this engagement took over a year of work, was delayed because industry requested that staff utilize CY 2023 data in lieu CY 2022, was further delayed because Adventist requested a new methodology that was not contemplated in the original workplan (i.e., Repatriation), and results were shared well in advance of the Draft Recommendation except for the Repatriation policy.



Note: the 2024 volume workgroup was in addition to substantial work done on the demographic adjustment during the 2024 update factor workgroup in the summer of 2023 and a complete review of market shift approaches during 2019 that resulted in material redefinition of the markets.

General Volume Policy Comments

Topic	JHHS	Lifebridge	MHA	UMMS
General Policy Concerns	"Current market shift methodology, which tracks shifts by ZIP code, does not sufficiently capture shifts. The ZIP code specific methodology does not account for patient movement over a broader geographic area. Use of broader geographic definitions could improve the methodology. Additionally, the current methodology for demographic adjustments insufficiently accounts for age-adjusted growth, as mentioned in our previous letter. Lowering the adjustment to align with unadjusted state projections for annual population change has reduced the adjustment and substantially underfunded age adjusted demographic growth at a time when the state has higher utilization with an aging population. The current demographic adjustment allocates funding to hospitals whether or not they experience any actual use rate growth. This approach also needs to be reconsidered." "Broad volume policy review is needed because market shift and demographic aren't working."	"With the addition of these new policies, there will be 7 volume policies in use; none of the policies adequately adjust for the aging demographics in our communities. We believe more work and review is needed prior implementing these policies to ensure they appropriately interact with each other and comprehensively adjust for volume changes."	"The existing policy governing market shifts needs important, unaddressed updates. The methodology needs to fund variable and fixed costs more precisely." "Current market shift methodology, which tracks shifts by ZIP code, does not sufficiently capture shifts. Broader geographic definitions (e.g., county level) could improve the methodology. MHA urges HSCRC to change to the market shift methodology to allow potentially avoidable utilization (PAU) to flow through the underlying service line." "The current methodology for demographic adjustments insufficiently accounts for age-adjusted growth. Lowering the adjustment to align with unadjusted state projections for annual population change has reduced the adjustment from 4.25% to 0.25%. This substantially underfunds age-adjusted demographic growth at a time when the state has higher utilization with an aging population." "We urge you to also consider the other volume policies, including market shift and demographic adjustment, that need improvement."	"UMMS is concerned that the current approach of multiple policies overlaying volume funding is too complicated with various incentives that, at times, compete with one another. We do not believe that adding additional policies to address the limitations of existing volume funding mechanisms, including both the Market Shift and Demographic policies, is the correct approach. UMMS urges the Commission to instead, evaluate all existing volume policies to ensure they are achieving the intended policy aim. Intentional focus should be directed toward straightforward incentives that align volume policies with model goals. This review should be completed prior to year one of the AHEAD model and prior to considering additional policies in an already complex system that is challenging for hospitals to navigate."

Staff recognize that general volume policy concerns are causing consternation in the field, but would note the following considerations:

- Aging of the population does not necessarily lead to increased hospitalizations, especially when technological advances occur. For example, staff analyzed the rate of IP utilization by non-dual eligible 70-year olds represented in the Medicare's national 5 percent sample and found that utilization within this age cohort dropped by 27 percent

from 2013 to 2023. Maryland hospitals also benefit from these broad-based trends which run counter to the impact of aging

- Hospitals do lose revenue when PAU Shared Savings is considered; however, this was a purposeful incentive to compel hospitals to reduce readmissions and avoidable admissions, which some hospitals failed to do

Staff believe it is important to systematically update policies for various stakeholder considerations. For example, considerations could include: modifying variable cost factors, realigning global budget revenue based on market shifts in readmissions and avoidable admissions, and considering the impact of other broad secular trends on utilization. The next steps on volume policies will be discussed at the Commissioner retreat.

Results

This section will outline the results of the proposed methodologies,[13] both with and without the materiality thresholds and not inclusive of consideration of efficiency, which staff in the *Stakeholder Comment* section recommended discontinuing. For Deregulation and Repatriation the assessment is calendar year 2023 over 2019, per the workgroup recommendation. For out-of-state volume the assessment is rate year 2023 over rate year 2014 (except for hospitals that have been rebased since 2014).

In the draft recommendation, staff noted that there could be a scenario where deregulation adjustments and expatriation adjustments can simultaneously but independently cross reference the same service lines in the Market Shift policy, which could result in removing more volume from GBR's than actual declines that occurred - no such duplication exists for repatriation. In light of this concern, staff created an additional analysis that removes from the expatriation analysis all volumes scored as deregulation.[14] The following modeling and future iterations of these policies will account for this interaction and thus ensure that deregulation and expatriation methodologies are not duplicative.

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[13] Please note that the modeling will differ slightly from what was provided during the draft recommendation because staff amended the materiality thresholds to remove a consideration of efficiency performance.

[14] The interaction analysis is as follows: ECMADs flagged as possible deregulation in the Deregulation methodology are rolled up per service line, with no consideration for geography, and compared against the Unrecognized ECMAD counts that are used in the same service line in the Repatriation/Expatriation methodology - geography is not considered because Deregulation is assessed using the hospital's primary service area, inclusive of zip codes, and Repatriation is assessed at the county level due to data availability. Following this, ECMADs flagged as possible deregulation are removed from Unrecognized ECMAD counts, thereby yielding a lower Unrecognized ECMAD decline, which reduces the potential for scored expatriation. If the resulting Unrecognized ECMAD decline is greater than the scored expatriation (lower in terms of absolute value), a credit to the Repatriation/Expatriation methodology is applied by multiplying the average charge per case, inclusive of a 50 percent variable cost factor, by the difference between the scored expatriation prior to the interaction analysis with the scored expatriation following the interaction analysis. This analysis is limited to just those service lines assessed in both the deregulation and repatriation/expatriation policies. There is no interaction analysis for repatriation, as deregulation is downside risk only. For an example of the interaction analysis, please see Appendix 4.

Deregulation

Table 7: Deregulation 2019-2023 ($ Thousands; with and without materiality thresholds)[15]

Hospital	Cardiovascular	CT/MRI/PET	Major Surgery	Minor Surgery	Oncology Related Services	Radiology	Total	Total with Materiality Thresholds
ANNE ARUNDEL	$68	$7	$4,558	$1,346	$698	$111	$6,788	$1,655
GBMC	$1	$51	$635	$512	$3,475	$359	$5,033	$3,390
JOHNS HOPKINS	$0	$161	$448	$3,005	$0	$41	$3,655	$33
UMMC	$94	$539	$705	$1,393	$0	$166	$2,898	$178
UM-St. Joe	$735	$60	$842	$618	$110	$516	$2,881	$962
SINAI	$56	$186	$870	$821	$479	$454	$2,865	$351
Frederick	$15	$34	$1,141	$744	$0	$161	$2,095	$788
MedStar Good Sam	$0	$0	$1	$1,924	$27	$43	$1,995	$1,373
Peninsula	$108	$144	$325	$53	$473	$638	$1,741	$577
MERITUS	$35	$0	$56	$1,628	$0	$0	$1,720	$1,073
UM-BWMC	$0	$64	$507	$850	$196	$46	$1,664	$316
Doctors	$166	$1	$459	$456	$178	$206	$1,467	$481
Western Maryland	$235	$253	$397	$313	$33	$82	$1,312	$136
ATLANTIC GENERAL	$0	$56	$58	$446	$307	$421	$1,288	$615
HOLY CROSS	$51	$195	$35	$713	$0	$172	$1,166	$347
NORTHWEST	$1	$30	$52	$146	$466	$448	$1,141	$694
Ascension Saint Agnes Hospital	$301	$0	$278	$227	$232	$77	$1,115	$64
SHADY GROVE	$70	$896	$22	$1	$0	$67	$1,054	$906
CALVERT	$56	$0	$121	$155	$0	$614	$946	$605
UM-Charles Regional	$59	$23	$73	$669	$15	$49	$888	$459
JH Bayview	$120	$80	$104	$523	$0	$37	$864	$0
MERCY	$9	$93	$82	$197	$0	$472	$853	$0
CARROLL	$21	$3	$358	$402	$0	$22	$806	$76
UMMC MIDTOWN	$1	$62	$60	$393	$9	$250	$773	$246
UM-Upper Chesapeake	$125	$218	$212	$155	$0	$41	$751	$217
MedStar Union Mem	$246	$6	$22	$35	$0	$436	$745	$315
MedStar St. Mary's	$38	$0	$177	$203	$160	$161	$738	$82
MedStar Fr Square	$0	$0	$56	$115	$459	$6	$635	$0
Adventist White Oak	$5	$270	$21	$47	$0	$249	$591	$501
UM-Easton	$6	$41	$129	$32	$0	$340	$549	$226
SUBURBAN	$13	$18	$115	$173	$0	$116	$435	$106
UM-Harford	$0	$67	$189	$54	$0	$116	$425	$98
ChristianaCare, Union	$0	$83	$124	$15	$5	$178	$405	$26
MedStar Harbor	$35	$16	$270	$11	$0	$69	$402	$30
Garrett	$7	$0	$13	$280	$0	$36	$337	$22
UM-Capital Region Medical Center	$86	$5	$19	$5	$0	$196	$310	$166
HOWARD COUNTY	$13	$2	$77	$126	$0	$28	$246	$0
Grace Medical center	$0	$128	$0	$0	$0	$108	$237	$231
MedStar Southern MD	$105	$11	$0	$10	$0	$71	$197	$48
HC-GERMANTOWN	$5	$19	$85	$28	$1	$1	$138	$10
UM-Chestertown	$0	$0	$0	$130	$0	$5	$136	$0
MedStar Montgomery	$9	$53	$29	$2	$0	$37	$129	$66
FT. WASHINGTON	$0	$0	$28	$10	$0	$59	$96	$51
Mccready	$0	$0	$0	$1	$0	$0	$1	$0
Grand Total	**$2,897**	**$3,874**	**$13,750**	**$18,966**	**$7,321**	**$7,701**	**$54,510**	**$17,522**

[15] Values are subject to change because the Rate Year 2025 Integrated Efficiency rankings have yet to be finalized due to data delays in Commercial TCOC data.

Repatriation

Table 7: Repatriation 2019-2023 ($ Thousands; with and without materiality thresholds)[16]

[16] See supra note 15

Hospital	Repatriation/ (Expatriation)	Interaction Analysis Credit	Repatriation/(Expatriation) with Interaction Credit and Materiality Thresholds
Adventist- Shady Grove	-$2,838	$892	-$1,244
Western Maryland	-$3,072	$375	-$1,187
Luminis- Doctors	-$1,355	$209	-$944
ChristianaCare, Union	-$1,294	$92	-$734
Adventist- White Oak	-$519	$406	-$618
Frederick	-$551	$158	-$428
MedStar- Harbor	-$965	$11	-$414
Lifebridge- Sinai	-$3,514	$0	-$373
Garrett	-$701	$0	-$307
Meritus	-$9	$0	-$252
UMMS- St. Joe	-$25	$233	-$160
UMMS- Easton	-$767	$194	-$99
Lifebridge- Grace	-$291	$0	-$85
Lifebridge- Carroll	-$1,340	$373	-$76
MedStar- Good Sam	-$119	$0	-$66
Atlantic General	-$187	$14	-$66
UMMS- Chestertown	-$197	$0	-$59
Lifebridge- Northwest	-$25	$86	-$43
Tidal- Peninsula	-$987	$139	-$42
MedStar- St. Mary's	-$151	$5	-$13
Tidal- McCready	-$86	$0	-$3
GBMC	-$1,585	$119	$0
UMMS- Capital Region	$217	$89	$0
UMMS- Laurel	$0	$0	$0
UMMS- Convention Cente	$0	$0	$0
UMMS- Aberdeen	$0	$0	$0
UMMS- UMROI	-$85	$0	$10
Mercy	$363	$188	$20
JHH- Bayview	$6	$0	$32
JHH- Howard County	-$399	$0	$63
Lifebridge- Levindale	-$120	$0	$74
Saint Agnes	$141	$47	$84
Trinity - Holy Cross	-$2,886	$209	$101
MedStar- Franklin Square	$391	$82	$112
UMMS- Charles	$217	$16	$121
Trinity - Holy Cross Germa	$269	$1	$122
UMMS-Upper Chesapeake	-$35	$231	$139
MedStar- Montgomery	$206	$55	$152
Adventist-Ft. Washington	$324	$38	$287
UMMS- Midtown	$629	$7	$336
UMMS- UMMC	-$2,778	$0	$384
JHH- Johns Hopkins	-$1,611	$0	$536
Calvert	$157	$253	$712
UMMS- BWMC	$978	$0	$859
Luminis- Anne Arundel	-$1,470	$625	$906
MedStar- Union Mem	$1,629	$0	$913
JHH- Suburban	$570	$149	$1,000
MedStar- Southern MD	$2,678	$0	$2,663
Total	-$21,186	$5,297	$2,413

Out-of-State

Table 9: OOS Volume Change through RY 2023 (removes potential adjustments under $500k)

Hospital	OOS Volume Change at 50% VCF	OOS Volume Change at 50% VCF with Materiality Thresholds
ChristianaCare, Union	$2,642,943	$934,768
Suburban	$2,436,391	$0
MedStar Montgomery	$1,352,522	$0
Anne Arundel	$1,204,766	$0
UM-Charles Regional	-$510,257	$0
MedStar Harbor	-$522,913	$0
Grace Medical Center	-$562,990	$0
UM-Harford	-$597,587	$0
Garrett	-$606,328	$0
UM-BWMC	-$722,384	$0
Doctors	-$882,268	$0
Holy Cross	-$923,236	$0
MedStar Union Memorial	-$1,237,563	$0
St. Agnes	-$1,402,526	$0
UM-Upper Chesapeake	-$1,488,932	$0
Shady Grove	-$1,612,735	$0
Carroll	-$1,900,591	$0
Sinai	-$2,496,323	$0
MedStar Good Sam	-$2,629,575	$0
UM-Laurel FMF	-$3,226,947	-$2,345,398
UM-St. Joe	-$3,278,295	$0
Frederick	-$3,614,904	$0
GBMC	-$3,644,367	$0
Mercy	-$5,406,642	$0
JH Bayview	-$6,222,775	$0
Adventist White Oak	-$6,669,239	$0
Western Maryland	-$8,226,074	-$616,389
UM-Capital Region	-$10,162,905	-$338,126
UMMC	-$12,358,036	$0
Johns Hopkins	-$65,682,740	-$567,814
Total	-$138,952,509	-$2,932,960

Future Considerations

Since 2014, the HSCRC has been much more than a price regulator. The Commission has direct oversight of price, volume, and revenue under GBRs. One of the goals of the Commission is to make sure that hospitals have adequate resources for the clinical services provided.

For several years, staff have determined that the combination of the Demographic Adjustment and Market Shift policy revenue adjustments exceed total in-state volume changes. However, there was no accounting for additional adjustments related to irregular volume change (deregulation, repatriation, out-of-state, and miscellaneous), negative adjustments that occurred due to the Potentially Avoidable Utilization Shared Savings policy, and Efficiency adjustments that are heavily influenced by volume change.

As such, during the Volume Workgroup engagement, staff created a "Volume Scorecard" to assess the relationship of volume to funding during the All-Payer and Total Cost of Care Models. Specifically, staff calculated an expected volume funding that would have occurred each year if all volume change was adjusted through a volume variable or fee-for-service methodology (utilizing a 50 percent variable cost factor), otherwise known as "FFS Counterfactual Funding," versus all revenue adjustments that occurred, otherwise known as "Observed Funding." Staff purposefully used a 50 percent variable cost factor because the fixed costs are already covered by the base global budgets and are adjusted each year for inflation through the Annual Update Factor.[17] The evaluation builds off previous analyses of Market Shift and Demographic Adjustment policies and purposefully demonstrates how each revenue adjustment layers on top of each other at both the state and individual hospital level.

The purpose of this scorecard is not to use it to set funding levels. It is a tool that permits a view of the impact of volume policies against the fee-for-service counterfactual to inform policymaking. Below is the Volume Scorecard for calendar year 2014 through 2023:

[17] During the Volume workgroup engagement staff did extensive analyses, per workgroup member requests, to support the use of a 50 percent variable factor. Highlights of those analyses can be found in Appendix 3.

Table 10a: Volume Scorecard (with Market Shift Adjustments)

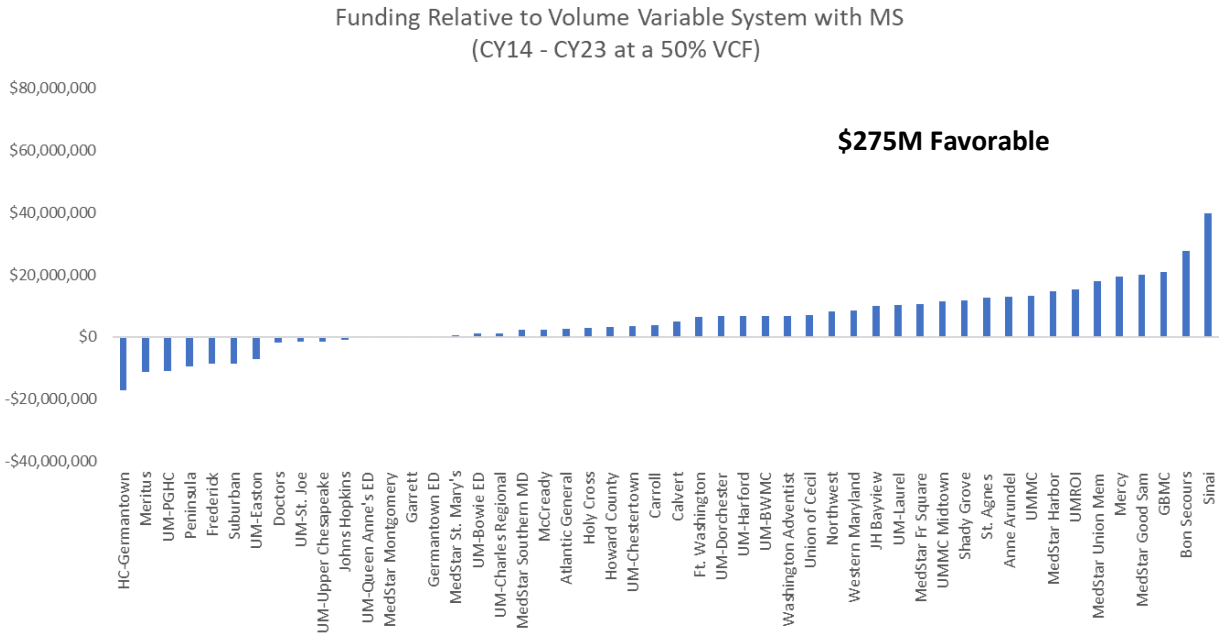


Table 10b: Volume Scorecard (with Market Shift and Demographic Adjustments)

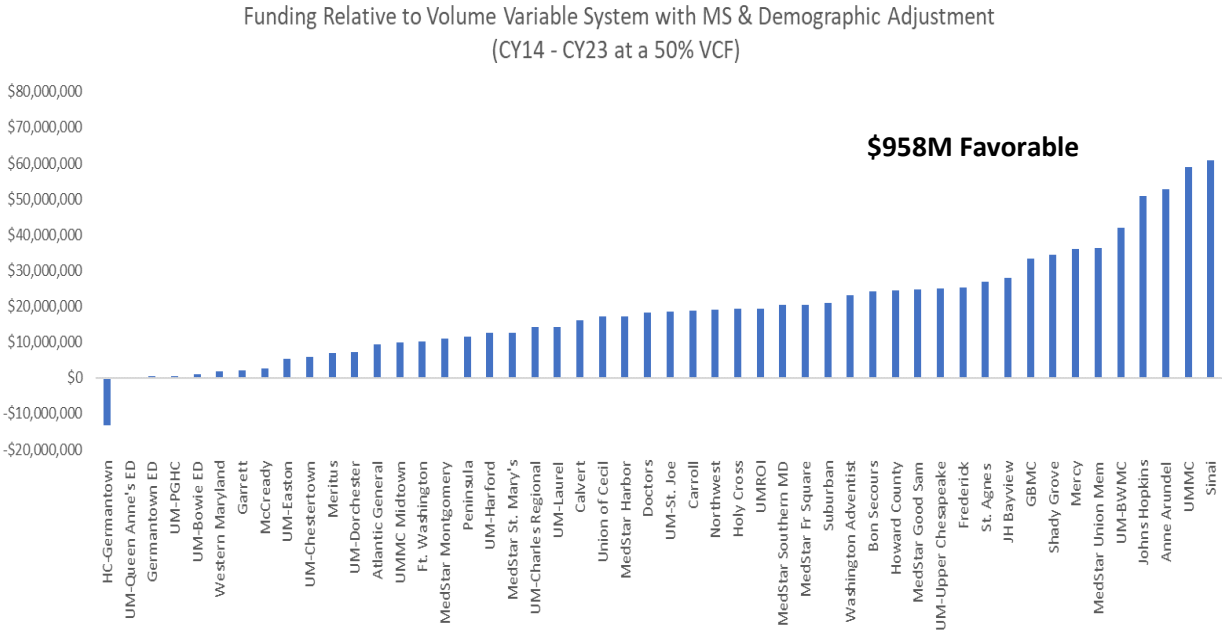


Table 10c: Volume Scorecard (with Market Shift and Demographic Adjustments & Out-of-State and Potentially Avoidable Utilization Adjustments)

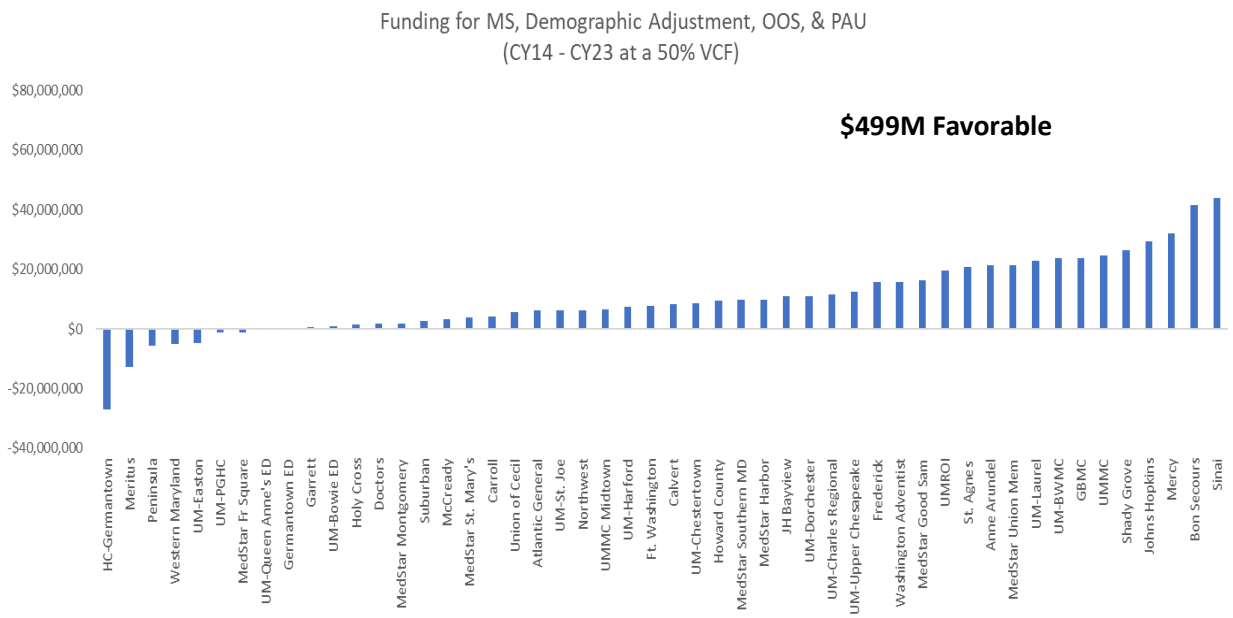
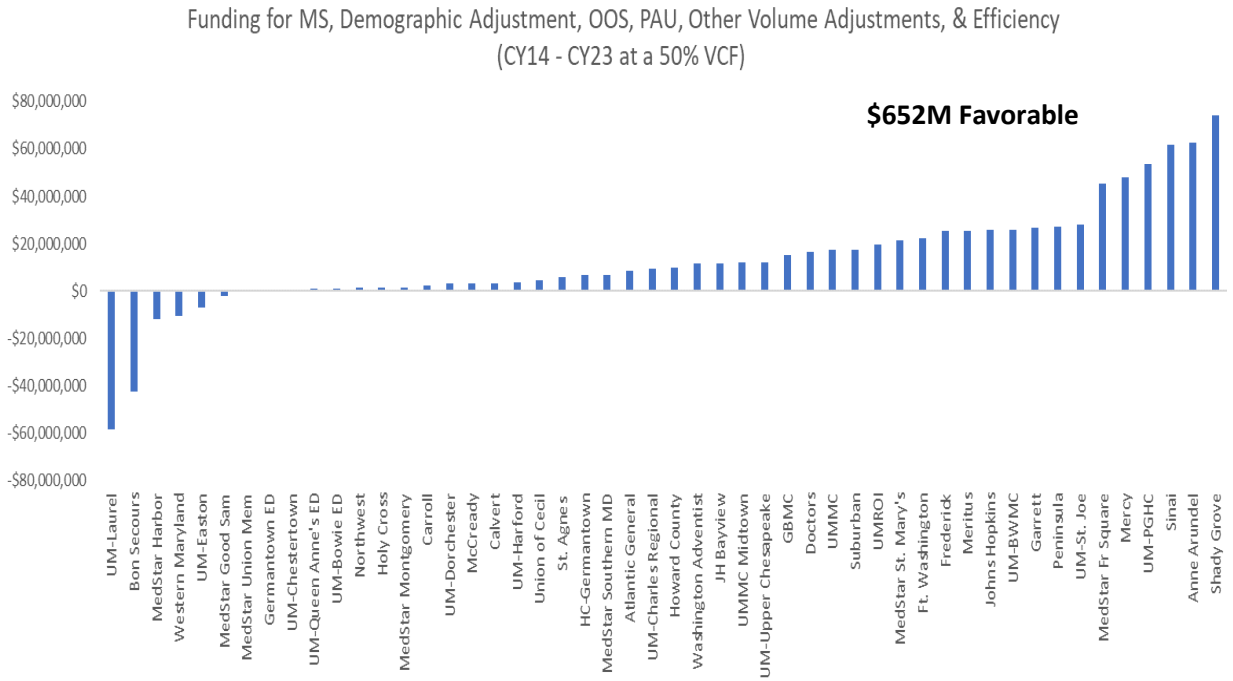


Table 10d: Volume Scorecard (with Market Shift and Demographic Adjustments, Out-of-State and Potentially Avoidable Utilization Adjustments, & Other Volume and Efficiency Adjustments)



This comparison demonstrates that when the revenue shifts are included, nearly all Maryland hospitals are receiving more funding for volume than the FFS counterfactual. This is a helpful insight but, as noted above, not dispositive in policymaking.

It is important to systematically evaluate and, if merited, update policies for various Commission goals and stakeholder requests for consideration. For example, considerations could include: modifying variable cost factors, realigning global budget revenue based on market shifts in readmissions and avoidable admissions, and considering the impact of other broad secular trends on utilization. The next steps on volume policies will be discussed at the Commission retreat.

Recommendations

1. Establish a Deregulation policy based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.
2. Establish a Repatriation policy based on the methodology outlined herein that will result in positive (repatriation) and negative (expatriation) revenue adjustments to hospitals' global budgets.
3. Establish an Out-of-State policy based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.
4. Implement Deregulation, and Expatriation, the next available rate issuance on a one-time basis, negative Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
    a. The adjustment exceeds 3 percent of the hospital's GBR OR
    b. The adjustment exceeds 3 percent of the associated service line revenue
    c. All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.
        i. If deregulation methodology indicates a potential deregulation that varies from planned deregulation by more than 10 percent, staff may consider revising the deregulation adjustment
5. Implement Repatriation at the next available rate issuance on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
    a. The adjustment exceeds 1 percent of the hospital's GBR OR
    b. The adjustment exceeds 1 percent of the associated service line revenue
6. Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis one year following the initial one-time revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.

Appendix 1. Key Methodology Concepts and Definitions

1. All-Payer Refined Diagnosis Related Groups (APR-DRG) – 3M's classification system that groups hospital inpatients according to their reason for admission, severity of illness and risk of mortality.

2. Enhanced Ambulatory Patient Groups (EAPGs) – 3M's classification system that groups outpatient medical visits and procedures based on similar clinical characteristics, resource use and costs. 3M EAPGs are designed to reflect the resources used in an ambulatory visit and to calculate expected payments for outpatient services.

3. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.

4. Markets Shift Policy (Market Shift) – Provides the criteria to reallocate funding to account for shifts in cases between regulated hospitals, with the objective of ensuring that funding follows the patient and hospitals continue to have a competitive interest in serving patients. The MSA does not currently address all volume changes, only those the Commission can quantify as shifts between hospitals and only volumes the Commission deems appropriate.

5. Demographic Adjustment Policy (Demographic Adjustment) – Provides funding for age-adjusted growth at the zip code or county level in order to anticipate changes in utilization based on demographic changes. The Demographic Adjustment is capped by Maryland Department of Planning estimates of statewide population growth to align with the per capita nature of the All-Payer/Total Cost of Care Model tests.

6. Unrecognized ECMADS – Acuity adjusted volume that grew or declined but was not shifted in the Market Shift methodology.

7. Casemix Data –Confidential patient-level hospital administrative data on all inpatient admissions and outpatient visits.

8. Experience Data – Monthly hospital unaudited revenue and volumes data by rate center used to monitor hospital charging compliance with approved rates.

9. Variable Cost Factor – The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The standard by which the industry and the Commission evaluates volume funding adequacy is 50 percent, as 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. This value is not uniform by service line.

10. Service Lines – Groupings of services into higher level categories that reflect similar clinical delivery. Service lines are utilized to determine market shifts in the Market Shift methodology and the proposed Deregulation and Repatriation Policies.

11. Volume Scorecard – A comprehensive visualization tool that accounts for all volume policies. The Volume Scorecard assesses Market Shift, Demographic Adjustment, out-of-state volumes,

deregulation, repatriation/expatriation and PAU, as well as adjustments related to efficiency policies. The scorecard will not include CDS-A and Complexity and Innovation, as those policies are standalone.

12. Chronic Condition Warehouse (CCW) Data - Medicare and Medicaid beneficiary, claims, and assessment data linked by beneficiary across the continuum of care.

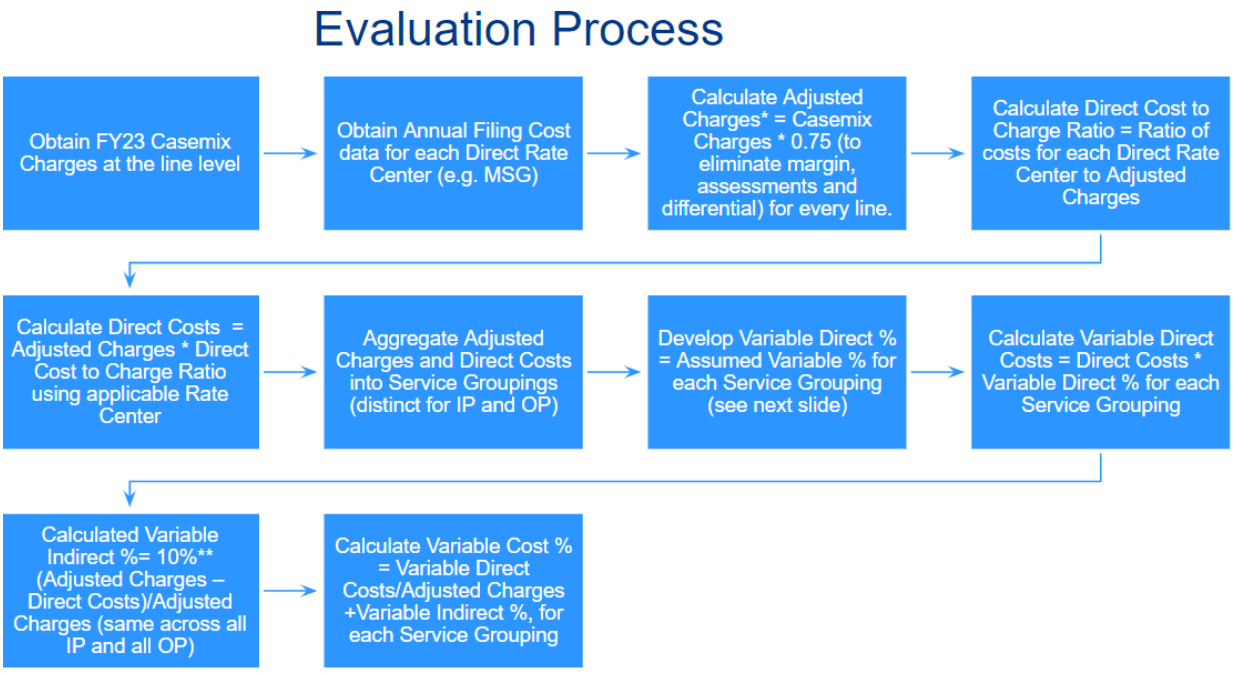
Appendix 2. EAPG Market Shift Example

Actual Unrecognized ECAMDS for Frederick Hospital, Major Surgery in Prince George's (0.953)

HOSPITALNAME	Frederick
PROD_CAT	Major Surgery
zipcode	Prince Georges

					Calculated Proof	
	A	*B*	*C=B-A*	*D*	*E=C/SUM(C:C)*	*F=CXSUM(D:D)*
Row Labels	Sum of ecmadCY1922	Sum of hospshift	Unrecog ecmads	Allocated Unrecog ecmads	Share of EAPG/Unrecognized	Normalized Unrecognized ECMADS
115:::DEEP LYMPH STRUCTURE PROCEDURES	(0.62)	(0.38)	(0.242)	(0.234)	25%	(0.234)
172:::LEVEL III KIDNEY AND URETERAL PROCEDURES	(0.94)	(0.94)	-	-	0%	-
208:::LEVEL II OTHER UTERINE AND ADNEXA GYNECOLOGICAL PROCEDURES	(0.59)	(0.29)	(0.302)	(0.292)	31%	(0.292)
26:::LEVEL I KNEE AND LOWER LEG PROCEDURES	(0.52)	(0.52)	-	-	0%	-
28:::LEVEL I SPINE PROCEDURES	(0.68)	(0.24)	(0.442)	(0.428)	45%	(0.428)
29:::LEVEL II SPINE PROCEDURES	(1.52)	(1.52)	-	-	0%	-
64:::LEVEL I LOWER AIRWAY ENDOSCOPY	0.33	0.33	-	-	0%	-
Grand Total	**(4.54)**	**(3.55)**	**(0.985)**	**(0.953)**	100%	(0.953)

Appendix 3. 50 Percent Variable Cost Factor Analyses



* Adjusted Charges is conceptually = total costs since all non-cost items have been stripped out.

** Indirect variable ratio of 10% was obtained based on a review of which indirect cost centers were likely to flex with volume in the short term. As all costs are variable in the long term this value would move towards 100% with time, this approach can be used to derive estimates of variable % over the longer time windows.

Results – Inpatient

Calculation	Service Grouping	Emerg.	Lab & Tests	MSS & CDS	OR	Other	R&B	Therapy	Total
A=Charges X .75	Adjusted Charges($M)	$698	$1,377	$1,636	$1,081	$100	$3,848	$494	$9,234
B	Direct Costs ($M)	$377	$677	$1,196	$507	$62	$2,507	$311	$5,637
C	Variable Direct %	50.0%	20.0%	100.0%	50.0%	50.0%	90.0%	80.0%	
D=B*C	Variable Direct Costs ($M)	$189	$135	$1,196	$253	$31	$2,257	$249	$4,310
E	Variable Indirect %	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
F=D/A+E	Variable Cost %	30.9%	13.7%	77.0%	27.3%	35.2%	62.5%	54.3%	**50.6%**

Results – Outpatient (see formulas on IP Table)

Service Grouping	Emerg.	Lab & Tests	MSS & CDS	OR	Other	Clinic	Rad. Therapy	Radiol.	Therapy	Total
Adjusted Charges($M)	$687	$526	$1,767	$1,255	$16	$370	$202	$714	$95	$5,632
Direct Costs ($M)	$444	$271	$1,235	$556	$6	$252	$81	$317	$51	$3,214
Variable Direct %	50.0%	20.0%	100.0%	50.0%	50.0%	50.0%	20.0%	30.0%	80.0%	
Variable Direct Costs ($M)	$222	$54	$1,235	$278	$3	$126	$16	$95	$41	$2,070
Variable Indirect %	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
Variable Cost %	36.7%	14.6%	74.2%	26.5%	23.9%	38.5%	12.4%	17.6%	47.3%	**41.1%**

Appendix 4. Interaction Analysis Example

Interaction Analysis

A = Hospital Name	*B =Hospital Service line*	*C = Sum of all Unrecognized ECMADs per hospital per service line in CY22 using CY19 as the base year (Same periods used in the RY24 marketshift)*	*D = Sum of all Unrecognized ECMADs per hospital per service line in CY23 using CY22 as the base year (Same periods used in the RY25 Marketshift)*	*E = C + D*	*F = Sum of all EAPGs tagged as possible DEREG per hospital per service line (From the Deregulation Assesment tool)*	*G = E + F*	*H = Sum of all county ECMADs tagged as possible expatriation per hospital per service line (From the Repatriation/Expatriation Assesment tool)*	*I = if absolute value of G is less than the absolute valute of H, then G. IFG is greater than declines in H, then 0. (Only scoring expatriation)*	*J = CY23 average charge per hospital per service line (from the RY25 Marketshift report)*	*K= (I-H) * J / 2*
HOSPID	SERVICE LINE	CY22 UNRECOG_ECMADS	CY23 UNRECOG_ECMADS	Net Unrecognized CY22 and CY 23	Scored Dereg	New Net Unrecognized after scoring for Dereg	Scored Repatriation / Expatriation	Allowed Repatriation / Expatriation After Interaction Review	CY 2023 Service Line Average Charge	Repatriation / Expatriation Funding After Interaction
Hosp A	Radiology	(81)	(12)	(93)	73	(20)	(90)	(20)	$ 24,487	$ 854,318
Hosp B	Cardiovascular	(16)	(5)	(20)	46	25	(18)	-	$ 20,722.05	$ 187,859

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November 4, 2024

Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield ("CareFirst") appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) volume polices. We generally support the staff's draft recommendations on the Deregulation, Repatriation, and Out-of-State volume policies.

We applaud staff for the extensive work that has gone into the volume scorecard. Staff have demonstrated that nearly all hospitals have received more funding than they would have if volumes were funded on a fee-for-service basis and a 50% variable cost factor. While hospital volumes have *declined* since the start of the model, statewide hospital costs have *increased* because the global budgeted revenue (GBR) model allows hospitals to retain the revenues associated with avoided utilization. Thus, generous funding relative to volume should not be surprising.

During the review of volume policies, stakeholders questioned staff's consistent use of a 50% variable cost factor. In response, staff has provided analyses supporting their use of a 50% variable cost factor. However, regardless of the variable cost factor used, hospitals on GBR in a declining volume environment will always be funded above fee-for-service relative to volume. As such, staff's time would be better spent on policy issues that address equity, access, affordability, and quality.

Lastly, while staff's analyses were clear, they introduced the concept of a materiality threshold that we find problematic for two reasons.

- First, we don't believe it is necessary. Under staff's proposal, adjustments that do not exceed a materiality threshold of either 3% of the hospital's GBR or 3% of the service line revenue would be waived. Staff has argued the materiality threshold will promote financial stability for hospitals by limiting adjustments from year to year. However, by definition, waiting for an adjustment to become "material" suggests a single large adjustment to the hospital's revenue will be more disruptive to a hospital's financial stability than incremental, immaterial adjustments.
- Second, staff's proposal uses both arbitrary and asymmetrical materiality thresholds. While we do not believe the thresholds are necessary, requiring negative adjustments to reach a higher threshold for application than positive adjustments on the same issue would not defy good policy and logic.

While we are generally supportive of the volume policies addressed in the draft, we urge staff to reconsider the materiality threshold.

Thank you for the opportunity to comment.

Sincerely,

Arin D. Foreman

Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
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Adventist HealthCare

October 30, 2024

Jonathan Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Adventist HealthCare ("AHC") appreciates the opportunity to provide comment on the proposed volume policies, which includes deregulation, out of state (OOS), and repatriation. AHC recognizes the thoughtful approach by HSCRC staff to create these new volume policies. For the out of state and repatriation methodologies in particular, providing a mechanism for hospitals to receive funding for the care of their out of state and repatriated patients has been an inherent weakness of the Maryland Model.

While AHC is in full support of the development of these policies, there is an overarching concern with the timeline to finalize and execute these policies when there has been limited time for the industry to fully vet and validate the complete results. Final workbooks with the inclusion of materiality thresholds were just shared with the industry on October 9th giving hospitals only three weeks to thoroughly review each of the three distinct, complex policies and provide comment. However, despite this, AHC outlines the following:

Medicare Extrapolation

AHC understands the need to use Medicare total cost of care claims as the main source of data for the volume policies as this is generally the only reliable non-acute and non-Maryland data available. However, we do have concerns with making assumptions of volume movement patterns based off only a subset of the full patient population. This is particularly a concern in the repatriation policy for some specific IP service lines that traditionally have very low Medicare volumes – most notably the OB/GYN service line. For Shady Grove Medical Center (SGMC) in particular, the Medicare ECMADs decreased from 12 to 3 between 2019 and 2023 – a decrease of only 9 ECMADs. Due to the very low Medicare percentage in this service line (approximately 0.5%), this extrapolates to an All Payer decrease of over 1,000 ECMADs. It's a concerning assumption to base the extrapolated hospital shift on only 0.5% of the patient population. Prior to applying the materiality thresholds, OB/GYN accounts for the second largest expatriation adjustment across all hospitals at approximately $(6.9M). AHC encourages additional exploration of an alternate method to estimate these volume shifts in service lines with very low Medicare volumes.

Policy Overlap

HSCRC staff has recognized that there is a potential overlap between the deregulation and repatriation policy that may double count unrecognized ECMAD volume in both policies. While there is an understanding that creating a crosswalk between these policies requires additional work, it is an important piece of the puzzle to ensure hospitals aren't being penalized twice in both policies. For example, there is a negative adjustment for SGMC in both the deregulation and repatriation policies for the CT/MRI/PET service lines that likely includes an

overlap of unrecognized ECMADs. The dollar adjustment between the two policies for the CT/MRI/PET service line is $(1.8M) but the total revenue for that service line is only $1.1M. This makes it challenging for hospitals to understand the true collective impact across these new volume policies. Our suggestion is to run the policies sequentially – deregulation policy first followed by the repatriation policy. A flag can be added to the repatriation policy for the unrecognized ECMADs already accounted for in the deregulation policy. Regardless of the process chosen, this needs to be outlined in the final policy to provide clarity to hospitals on how this will be handled.

Materiality Thresholds

Asymmetry of Thresholds

AHC appreciates the thoughtfulness behind the creation of the asymmetrical materiality thresholds (1% for positive adjustments and 3% for negative adjustments) for the out of state and repatriation policies and is in full support. As increased out of state and/or repatriated volumes are seen at the hospitals, hospitals need to have a reliable policy mechanism to fund those growing volumes that otherwise are not funded within the Maryland Model. A lower 1% threshold allows hospitals to receive funding for those volumes sooner. This supports hospitals in their efforts to improve access to care and provide services to patients closer to home. We are in favor of the higher 3% threshold for negative adjustments as it provides a critical buffer, allowing hospitals additional time and resources to address volume fluctuations before facing financial penalties. Having a longer runway when losing volumes out of state gives hospitals the opportunity to reinvest those savings in population health, which ultimately may serve as a mechanism to bring out of state and expatriated volumes back. A larger materiality threshold before penalties are applied also considers the fixed costs that hospitals must carry regardless of volume fluctuations. Fixed costs—including expenses for essential infrastructure, medical equipment, and core staffing—do not diminish even when volumes decrease. When penalties are applied too swiftly, hospitals are forced to absorb financial losses without the opportunity to balance fixed costs with necessary operational funding. By setting a higher threshold for penalties, the policy recognizes that hospitals need time to adjust and absorb changes in volume while still maintaining critical services.

Integrated Efficiency

In addition to the 3% downside materiality threshold, if hospitals were in the bottom quartile of the most recent Integrated Efficiency (IE) results, the full negative adjustment across any of the proposed volume policies will be applied to those hospitals. Hospitals in the bottom quartile of IE results already receive an efficiency penalty and can submit a Revenue for Reform (R4R) application to show how their retained revenue is being used to support population health investments in the community. It is duplicative to then hit these hospitals with an additional penalty. For the OOS policy alone, bottom quartile hospitals are receiving penalties of approximately $(37M). While we respect and understand the reasoning behind using the IE results as materiality criteria in these policies, the Integrated Efficiency policy is a standalone policy that has a specific structure combined with R4R to address inefficient hospitals. It creates a cause for concern if the IE results begin to be used as a precursor in every other HSCRC policy to further penalize those hospitals.

Service Line Thresholds

In both the deregulation and repatriation policies, CY22 is the year used for the total revenue calculation by service line. However, the proposed policies are looking at the unrecognized ECMAD changes from 2019 to 2023. There were several instances where the deregulation and/or repatriation adjustment was greater than the total

revenue for the service line. For example, the total revenue for White Oak Medical Center for the CT/MRI/PET service line in the repatriation policy was $152k, but the actual expatriated adjustment for that service line was $(178k). This brings into question the validity of the service line materiality threshold calculation; however, this likely could be addressed by using the revenue of the base year instead of CY22.

Another potential issue with the service line thresholds is the variability in total revenue amounts across service lines. Hospitals may have a multimillion-dollar adjustment, but if the adjustment is in a service line with a higher total revenue base, it may not meet the materiality threshold. This could leave a significant adjustment amount unfunded. Given the variability in base revenue between service lines, there should be a consideration to have a dollar threshold in addition to the proposed percent thresholds.

Balanced and Sustainable Policy Design

Effective policies are structured on principles of balance, fairness, and support for sustained investment, which ultimately benefit the healthcare system and patient outcomes. The most impactful policies have proven to be those that encourage high performance by offering both rewards and measured penalties, fostering a landscape of continuous improvement. In the context of the recent volume policies proposed by the HSCRC, however, there is significant asymmetry: the majority of revenue adjustments are negative (approximately $63M), resulting in financial withdrawals that could limit resources for essential operational investments. This imbalance not only risks hampering the objectives these policies aim to support but also places undue strain on hospitals striving to serve their communities effectively.

Hospital Count	**Out of State**	**Deregulation**	**Repatriation**	**Total**
Positive	3	0	23	18
Negative	11	42	23	31
Total	14	42	46	49
Revenue Total				
Positive $	1,026,394	-	9,697,401	8,029,570
Negative $	(40,726,333)	(18,025,001)	(15,092,518)	(71,149,628)
Total	**$ (39,699,940)**	**$ (18,025,001)**	**$ (5,395,117)**	**$ (63,120,058)**
FY 2023 Statewide Perm Rev	$ 19,585,655,296	$ 19,585,655,296	$ 19,585,655,296	$ 19,585,655,296
State Total Adj. As % of Rev	**(0.20%)**	**(0.09%)**	**(0.03%)**	**(0.32%)**

We urge the HSCRC to reconsider the current volume approach. We ask the HSCRC carefully consider the cumulative and compounding effect of all existing policies and the potential for "penalty stacking". When penalties are layered without balanced incentives, hospitals experience financial shock that disrupts long-term planning and limits the ability to sustain improvements. This cumulative impact places hospitals in a difficult position, diverting resources away from patient care, technology upgrades, and workforce support, and instead toward meeting ever-increasing penalty thresholds.

Implementation

The draft recommendation outlines a proposed implementation approach for the three new volume policies. Our recommendation mostly aligns with the proposal with the addition of more specific detail around

timeframes. The deregulation, repatriation, and out-of-state adjustment policies should be run once a year in tandem with the final market shift policy. The results, inclusive of materiality thresholds, should be shared with hospitals at the same time market shift results are shared (approximately April-May). At the time results are shared, no overlap should remain between the policies. Positive adjustments can be included at the issuance of the next rate order; however, no negative adjustments should be included in the rate order unless hospitals have the opportunity to review and contest the results. Hospitals should have a pre-defined amount of time to review and contest the results. The HSCRC should outline specifics on the data required to contest the results within the final policy. The HSCRC should then have the same pre-defined amount of time to respond to the contested data with a final decision needing to be made by the end of that timeframe.

Volume Scorecard

The draft policy includes a recommendation to codify a volume scorecard that provides an accounting of all volume adjustments that occurred over the course of the model. The policy encourages the use of the scorecard as an important analytical tool that can be used for future evaluations. However, AHC is concerned that the results of the scorecard have not been fully validated – most notably the special adjustment section of the scorecard. While staff has been open to addressing any remaining concerns, AHC strongly urges against any formalization of the scorecard until those concerns are fully addressed.

Conclusion

AHC is appreciative of the time HSCRC staff has dedicated to developing these new methodologies to help fill the gaps in the existing volume policy funding construct under the Model. We value the opportunity to provide feedback on these important new policies. While we are in full support of these needed enhancements to the volume funding policies, we remain concerned about the timing to push these three detailed and complex methodologies into final policy. We hope that serious consideration is given to the concerns and ideas proposed in our letter and look forward to continued partnership with staff in the final phases of development and implementation of these policies.

Sincerely,

Katie Eckert

Katie Eckert, CPA

VP, Reimbursement and Strategic Analytics
Adventist HealthCare
820 W. Diamond Ave
Gaithersburg, MD 20878

cc: Joshua Sharfstein, MD, Commission Chairman
James N. Elliott, MD, Commission Vice Chairman
Ricardo R. Johnson, Commissioner
Adam Kane, Esq, Commissioner
Maulik Joshi, DrPH, Commissioner
Nicki McCann, JD, Commissioner
Farzaneh Sabi, MD, Commissioner

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CORPORATE OFFICE

October 30, 2024

Allan Pack
Principal Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter Regarding Draft Recommendation for Deregulation, Repatriation and Out-of-State Volume Policies

Dear Allan:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, we are writing today in response to the Commission's Draft Recommendation for Deregulation, Repatriation and Out-of-State Volume Policies. We have significant concerns regarding the implementation of the volume policies as listed below:

1. UMMS does not support utilizing the Integrated Efficiency policy as a determining factor in policies.
2. There are numerous technical issues needing to be addressed.
3. All volume policies should be evaluated in a comprehensive manner rather than individually.

Use of Integrated Efficiency

As UMMS has indicated previously, we strongly believe the Integrated Efficiency policy in its current form is inherently biased against hospitals which serve the state's most difficult populations. We believe that the Integrated Efficiency policy needs to be re-thought through the lens of health equity and consideration for differential investments in challenging geographies needs to be included in the policy.

Volume policies were developed to address volume funding. No other volume policy, including the main volume funding mechanisms of Market Shift and Demographic Adjustment, contemplates any factors other than volume growth or decline. It is for this reason and our concern over the Integrated Efficiency's bias that we firmly believe that volume policies should not apply results differentially based on a hospital's ranking in the Efficiency policy.

Technical Issues

We have identified numerous technical issues within the proposed policies. The following list represents methodology concerns identified thus far, but is limited due to the short amount of time that the industry had to evaluate the models prior to the draft staff recommendation:

- **Deregulation** – policy identifies that the entire amount of use rate is taken as deregulation in over 80% of the instances across the state where the algorithm identifies the EAPG as potential deregulation. For UMMS hospitals, nearly 100% of unrecognized market shift was considered deregulation, which seems highly unlikely.
- **Deregulation** – Medicare data presented conflicts with other data sources in terms of what volumes may have shifted out of hospitals and should be evaluated prior to any implementation.
- **Deregulation** – Average charge per ECMAD used is for the current year, after volume shifts and is inconsistent with methodologies used in Market Shift policies.
- **Deregulation/Repatriation** – Extrapolation methodology produces unreasonable results for service lines with limited Medicare volume (ie, Obstetrics, Newborn).
- **Deregulation/Repatriation** – These policies should be mutually exclusive and current methodology does not adjust for the results of one another, which double counts adjustments in both policies.
- **Out of State** – Results are unadjusted for any special negotiations which may be double counted in the policy.

Comprehensive Evaluation of All Volume Polices

UMMS is concerned that the current approach of multiple policies overlaying volume funding is too complicated with various incentives that, at times, compete with one another. We do not believe that adding additional policies to address the limitations of existing volume funding mechanisms, including both the Market Shift and Demographic policies, is the correct approach. UMMS urges the Commission to instead, evaluate all existing volume policies to ensure they are achieving the intended policy aim. Intentional focus should be directed toward straightforward incentives that align volume policies with model goals. This review should be completed prior to year one of the AHEAD model and prior to considering additional policies in an already complex system that is challenging for hospitals to navigate.

We appreciate the opportunity to provide feedback on the proposed Deregulation, Repatriation and Out of State Volume policies. Please let us know if you have any additional questions.

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Adam Kane
Nicki McCann, JD
Maulik Joshi, DrPH
Ricardo R. Johnson
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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

October 30, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the Draft Recommendation for Deregulation, Repatriation and Out of State Volume Policies.

JHHS appreciates the HSCRC's willingness to continue to review polices that are out of alignment under the current system. While we understand the intent of each individual methodology laid out in the staff recommendation in a vacuum, we continue to believe that a more wholistic review of volume policy is necessary, through the lens of broader volume incentives and the behavioral economics that they create. JHHS has been consistent in its policy commentary that the existing volume policies need to better align revenue with the cost of providing medically necessary care. Without addressing volume policies in a comprehensive manner, including a review of the core market shift and demographic policies, we do not believe layering on even more policies to address shortfalls in these existing policies is the correct approach. We instead believe that volume policy should be reviewed more broadly, with a goal of simplifying the interaction between all of these methodologies and more directly aligning funding with the cost of providing medically necessary care.

The core existing market shift and demographic policies need important, unaddressed updates. The methodology needs to fund variable and fixed costs more precisely. Current methodology funds volume change at a 50% variable cost factor (VCF) across the board regardless of service mix. We have found that a 50% across the board VCF does not properly account for the real costs of providing care to certain types of patients. This can disadvantage a hospital that has service lines which carry a higher VCF like Oncology, Cardiac Services and Orthopedic Services. JHHS favors a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis.

Current market shift methodology, which tracks shifts by ZIP code, does not sufficiently capture shifts. The ZIP code specific methodology does not account for patient movement over a broader geographic area. Use of broader geographic definitions could improve the methodology.

Additionally, the current methodology for demographic adjustments insufficiently accounts for age-adjusted growth, as mentioned in our previous letter. Lowering the adjustment to align with unadjusted state projections for annual population change has reduced the adjustment and substantially underfunded age adjusted demographic growth at a time when the state has higher utilization with an aging population. The current demographic adjustment allocates funding to hospitals whether or not they experience any actual use rate growth. This approach also needs to be reconsidered.

JHHS appreciates the opportunity to comment on volume policy changes. Volume policies must do a better job accounting for and funding volume changes. While the focus of the draft recommendation is on deregulation, repatriation, and OOS adjustments, we urge you to also consider the other volume policies, including market shift and demographic adjustment, that need improvement. Broad volume policy review is needed because market shift and demographic aren't working.

Sincerely,

Ed Beranek

Ed Beranek
Vice President
Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

LIFEBRIDGE HEALTH®

CARE BRAVELY

October 30, 2024

Jon Kromm
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, MD 21215

Jon -

LifeBridge Health (LBH) appreciates the opportunity to comment on the draft recommendations for the deregulation, repatriation, and out-of-state volume policies. We are concerned about the timing of implementation of the volume policies, which are occurring at the same time HSCRC is contemplating an overall revenue increase to the State because of continued operating margin challenges and excess savings performance to the total-cost-of-care target. While there was a workgroup that discussed the need for more precise volume adjustments outside of the existing market-shift policy, in our opinion more time was spent on the principles of additive volume methodologies as opposed to the level of detail and specificity presented in the Staff's October draft recommendation. With the addition of these new policies, there will be 7 volume policies in use; none of the policies adequately adjust for the aging demographics in our communities. We believe more work and review is needed prior to implementing these policies to ensure they appropriately interact with each other and comprehensively adjust for volume changes.

Some of our concerns are outlined below, although there are likely more, once a more thorough vetting process takes place. Specifically, our concerns with the proposed draft volume methodologies are described below:

Utilizing the Integrated Efficiency Policy as a Primary Trigger

The draft recommendation suggests implementing the deregulation, expatriation, and out-of-state volume policies using materiality thresholds, or if the hospital is in the worst quartile of the most recently published integrated efficiency policy. As a result, most hospitals will not receive reductions to revenue that the methodology produces because the volume changes fall below the materiality thresholds. However, the 11 hospitals within the efficiency policy's 4th quartile are fully penalized regardless of most having identified reductions below the established materiality thresholds. As proposed in the draft recommendation, $54.5 million in total deregulation adjustments are identified. Ultimately $18 million are suggested as being enforced, with $10.4 million occurring for 4th quartile hospitals while all other hospitals, representing $44.1 million of the $54.5 million total identified reduction, receive adjustments of $7.6 million. To continue and levy revenue reductions to hospitals where volume changes are below the same materiality thresholds predicated on the efficiency policy performance is overtly punitive and not rational.

Ultimately, as currently adopted, the integrated efficiency policy evaluates hospitals on a price per case basis and is intended to act as a catch-all methodology to account for price drivers that cannot be accounted for through the market-shift volume and other methodologies. Layering on additional

penalties results in duplicative penalties, and implies the efficiency policy as currently approved no longer satisfies the staff's goals for how much and how quickly revenue should be removed from inefficient hospitals.

Continue to Vet the Results of the Draft Volume Policies

Now that staff has published to the entire field the results of its new proposed volume methodologies, we recommend the workgroup reconvene to evaluate the results and the potential for the possibility of unintended consequences. For example, the draft methodologies extrapolate Medicare fee-for-service (FFS) results to all-payer, which may not be appropriate to apply to all payers when considering factors like changes in payer mix since the base period.

In fact, the Staff acknowledge lower precision within the repatriation methodology because other states do not follow same regulations as Maryland. The work group has not discussed options to address this in the methodology.

Conclusion

While we understand the need for the HSCRC to consider modifications to its overall methods for accounting for volume changes, we strongly believe that as currently drafted the proposed methodologies have raised a number of technical concerns that deserved to be vetted further. Additionally, the volume methodologies should be independent and exclusive of the efficiency policy calculations as a mean to trigger whether reductions are, or are not, made. If the volume methodologies are endorsed as an improvement to the manner in which volumes are currently adjusted (i.e. market-shift and demographic) then they should be applied to all hospitals accordingly.

Ultimately, given the current level of excess savings, we recommend the volume methodologies simply be vetted further and applied in July 2025 as part of the Rate Year 2026 Rate Order process.

Sincerely,

Dave Krajewski
EVP & CFO, LifeBridge Health

cc: Joshua Sharfstein, M.D., HSCRC Chairman
Allan Pack, Principal Deputy Director, Quality & Population-based Methodologies, HSCRC

MedStar Health

8094 Sandpiper Circle
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Nottingham, MD 21236

MedStarHealth.org

October 30, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

On behalf of MedStar Health System (MedStar) and its seven Maryland hospitals, thank you for the opportunity to provide comments on the Health Services Cost Review Commission (HSCRC) draft Staff Recommendation for Deregulation, Repatriation, and Out-of-State Volume Policies presented on October 9, 2024. We want to acknowledge the tremendous amount of work that Staff did to develop these policies over the previous year as well as the collaborative nature in which Staff engaged with and was responsive to stakeholders during this process. MedStar is supportive of the Draft Recommendation and believes that the addition of these policies will improve volume funding for hospitals as we prepare for the start of the AHEAD Model in Maryland.

While MedStar supports the adoption of this draft recommendation overall, there continues to be room for refinement of these policies going forward and we would encourage staff to continue in dialogue with the hospital field to do so. Namely, a few issues remain with the methodologies used to calculate hospital results under the Repatriation methodology – detailed in the MHA comment letter on this draft recommendation, namely:

1. Need to exclude Equivalent Case-Mix Adjusted Discharges (ECMADs) that are the basis of any deregulation adjustment from repatriation calculation to prevent double counting
2. Extrapolation from Medicare fee-for-service (Medicare FFS) data to calculate an all-payor adjustment may lead to distorted results that do not reflect actual experience
3. Use of a Medicare FFS default percentage of 100% for procedure categories that lack a Medicare FFS percentage caps repatriation funding at Medicare growth level which may not be reflective of actual experience
4. CDS-A and innovation service lines should be excluded from the repatriation calculation as they are addressed in stand-alone HSCRC payment policies

MedStar understands that there may be some data limitations which limit commission staff's ability to address these issues, however we encourage continued analysis and collaboration to ensure these policies fund hospital patient volume as accurately as possible.

The draft recommendation includes a 'volume scorecard' that attempts to provide an accounting of all hospital volume change and volume related revenue adjustments that have occurred since the inception of hospital Global Budget Revenue. MedStar is supportive of the volume scorecard in concept to provide the industry with a longitudinal assessment of volume funding across the state. MedStar stresses that Staff should continue to be clear that this scorecard does not provide an assessment of the appropriateness of hospital funding in totality and should not be used in HSCRC rate setting policy determinations. There have been significant changes to how hospital ECMADs are calculated over the period assessed (i.e. 3M grouper changes, ICD-10 conversion, revision to outpatient service lines, etc.) making an exact calculation to determine the dollar value of hospital volume change complex and highly challenging. As such, the scorecard is appropriate only for use as an approximation when assessing if hospitals are appropriately funded for volume changes.

MedStar looks forward to the final Staff Recommendation at the December 2024 Commission meeting. If you would like to discuss this matter further or have any questions, please do not hesitate to contact me.

Sincerely,

Michael Wood

Mike Wood
Vice President, Revenue Management & Reimbursement
MedStar Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

Maryland
Hospital Association

October 30, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am providing feedback on the Health Services Cost Review Commission (HSCRC) draft recommendation for deregulation, repatriation, and out-of-state (OOS) volume policies. We appreciate the staff's review and refinement of volume policies along with the work group engagement for input from the field.

To support the Maryland Model, the ability of our hospitals to meet the health care needs of patients and community members, and the financial health of hospitals, volume policies must provide hospitals with adequate funding. HSCRC volume methodologies should more precisely account for and fund volume changes and identify and fund costs that are variable versus fixed. Though the draft recommendation on volume policies incorporates elements recommended by MHA members in work groups over the past few months, there are elements that remain unaddressed. We encourage the Commission to continue to implement needed changes.

Implementation of Adjustments

In the draft, deregulation, repatriation, and OOS adjustments would be implemented at the next rate issuance, on a one-time basis with a permanent adjustment made the following year if the same change is confirmed. This is a fair approach that recognizes volume changes may be temporary. The proposal rightfully allows hospitals to provide additional information to contest an HSCRC finding in this process.

All adjustments would be subject to a materiality threshold. MHA supports the proposal to adopt a larger threshold for deregulation, expatriation, or a negative OOS adjustment. The proposed threshold—requiring a downward change of more than 3% of global budget revenue (GBR) or of the associated service line—is sound policy, recognizing that volume changes may be small or temporary while allowing greater funding predictability and financial stability for hospitals. The proposal would implement a materiality threshold for repatriation and positive OOS changes so that an adjustment would occur if it exceeds 1% of GBR or of the associated service line.

While MHA supports this lower threshold, we encourage adopting a 0.5% threshold to more accurately capture volume shifts under the policy.

The policy would still require planned deregulation to be reported. If the deregulation methodology indicates potential deregulation that varies from what is planned by more than 10%, HSCRC may consider revising the deregulation. MHA supports this approach. Deregulation may occur due to action by payers or physicians outside of hospitals' control. The threshold and staff discretion to administer the policy recognize this dynamic and the inherent difficulty of quantifying precisely the extent of deregulation.

Repatriation

Regarding the proposed methodology for repatriation, MHA identified the following issues to be addressed:

- *Interaction with Deregulation.* Hospitals may face double penalties under both policies. MHA requests excluding Equivalent Case-Mix Adjusted Discharges (ECMAD) accounted for under deregulation from the unrecognized ECMADs under the repatriation policy.

- *Distorted Results from Extrapolation to All Payers.* Use of extrapolation from Medicare fee-for-service (FFS) data to all payers can distort results under the methodology, specifically when there is a low Medicare fee-for-service (FFS) percentage. We recommend removing or using alternative methods to assess repatriation for service lines with low Medicare FFS percentages.

- *Medicare FFS Default.* A significant percentage (nearly half) of the procedure categories lack an appropriate Medicare FFS percentage and use a default percentage of 100%. This caps repatriation growth and potential funding at the Medicare growth level. MHA recommends defaulting to a different percentage or calculating the Medicare FFS percentage at the non-county-specific service line level where a percentage may be derived.

- *Services Addressed in Other Policies.* CDS-A and innovation service lines are addressed already in their stand-alone policies and should be excluded from the repatriation analysis.

Volume Scorecard

The draft recommendation includes a request for "codification" of a volume scorecard that would provide a "complete accounting of all volume adjustments that occurred over the course of the All-Payer and [Total Cost of Care] models." The proposal would not have the scorecard serve as a methodology but would have it used to allow future policymakers to assess the need for potential revisions to HSCRC volume policies. Members have raised concerns about the results of the scorecard given that it has not been validated. MHA urges against any HSCRC "codification" or other formalization of the scorecard. . HSCRC should consider retaining an independent third-party to validate the approach before using the scorecard to evaluate the over and underfunding of volume and whether modification is needed to methodologies for funding volume changes.

Unresolved Matters

The draft recommendation addresses policies governing OOS, deregulation, and repatriation volume changes. However, improvements are needed to existing policies governing the funding of other types of volume changes.

Market Shift Methodology

The existing policy governing market shifts needs important, unaddressed updates. The methodology needs to fund variable and fixed costs more precisely. Current methodology funds volume change at a 50% variable cost factor (VCF). MHA favors a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis. In work group discussions, HSCRC staff offered analyses that support an overall 50% VCF. However, a preliminary service line analysis by MHA shows adoption of a higher overall VCF for inpatient and outpatient services is required, with drugs and supplies appropriately funded at a 100% VCF.

Current market shift methodology, which tracks shifts by ZIP code, does not sufficiently capture shifts. Broader geographic definitions (e.g., county level) could improve the methodology. MHA urges HSCRC to change to the market shift methodology to allow potentially avoidable utilization (PAU) to flow through the underlying service line. Hospitals should get funded for PAU when this is from a market shift. If a hospital provides care that could not be avoided through better planning, prevention, or care coordination efforts by that hospital, it should be fully funded for providing that care under the policy.

MHA respectfully requests that HSCRC continue to work with the field to develop and make improvements to the market shift methodology.

Demographic Adjustment

The current methodology for demographic adjustments insufficiently accounts for age-adjusted growth. Lowering the adjustment to align with unadjusted state projections for annual population change has reduced the adjustment from 4.25% to 0.25%. This substantially underfunds age-adjusted demographic growth at a time when the state has higher utilization with an aging population.

Conclusion

MHA appreciates the opportunity to comment on volume policy changes. Volume policies must do a better job accounting for and funding volume changes. Hospitals seek a balance to keep communities healthy. While the focus of the draft recommendation is on deregulation, repatriation, and OOS adjustments, we urge you to also consider the other volume policies, including market shift and demographic adjustment, that need improvement.

Sincerely,

Patrick D. Carlson
Vice President, Health Care Payment

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
December 11, 2024

RE:
Hearing and Meeting Schedule

January 8, 2025 In person at HSCRC office and Zoom webinar

February 12, 2025 In person at HSCRC office and Zoom webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday 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.