628th Meeting of the Health Services Cost Review Commission

February 12, 2025

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on January 8, 2025

Specific Matters

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

Docket Status – Cases Closed

2. Docket Status – Cases Open

Informational Subjects

3. Presentation: Advancing Innovation in Maryland (AIM) Winners

Subjects of General Applicability

4. Report from the Executive Director
    a. Staff Retirement Announcement
    b. Model Monitoring
    c. New Paradigms in Care Delivery Update
    d. High Value Care Plans

5. Final Recommendation: Nurse Support Program II - Program Renewal

6. Draft Recommendation: Readmission Reduction Incentive Program (RRIP) for RY 2027

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7. Presentation: System Financial Results for FY 2024

8. Presentation: Episode Quality Improvement Program (EQIP) and Care Transformation Initiatives (CTI) Results

9. Legislative Update

10. Public Discussion: AHEAD and HSCRC Volume Policies

11. Hearing and Meeting Schedule

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Nurse Support Program II

Competitive Institutional Grants Program

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

February 12, 2025

This document contains the final staff recommendations for the Nurse Support Program II.

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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 I (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 Nurse Support Program II (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). In 2021, 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 recipients.

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.

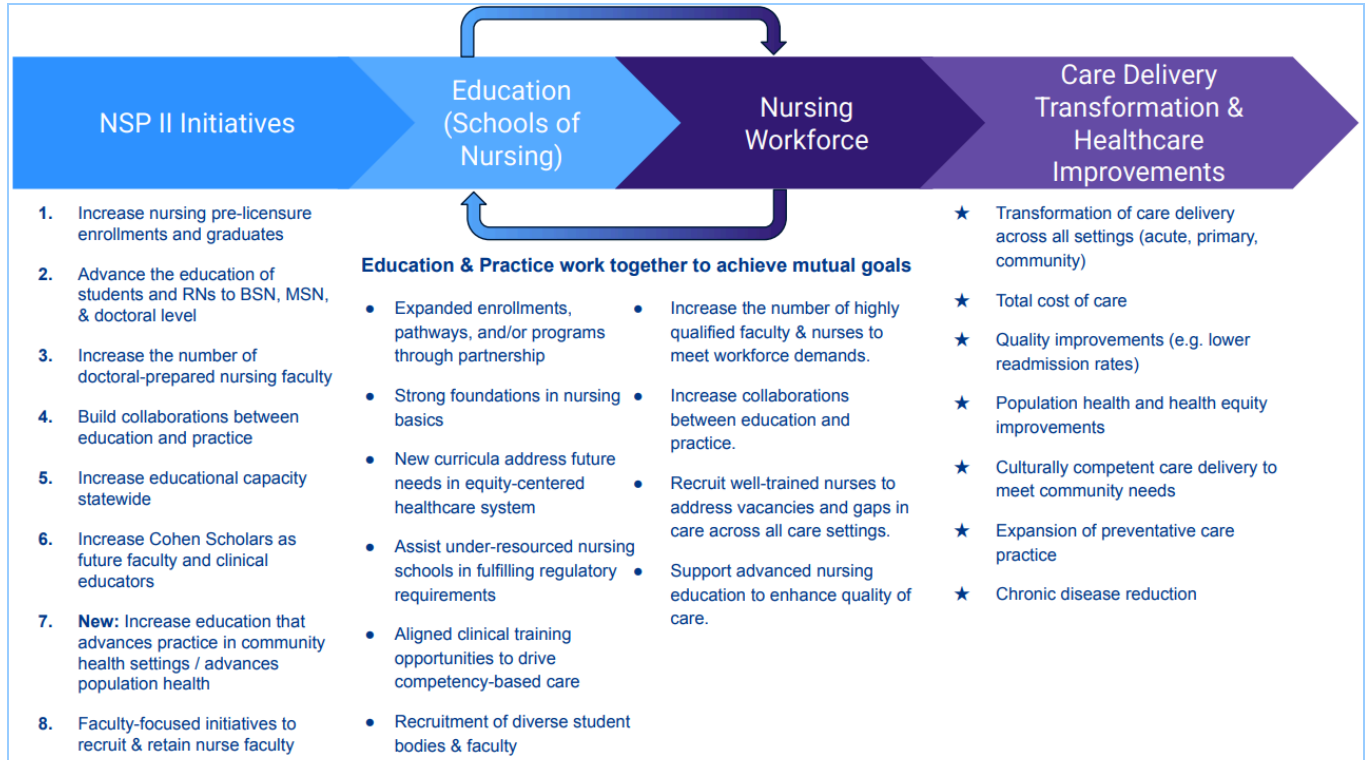


Figure 1. Conceptual Framework for Nurse Support Program II

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. Increase 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 Maryland’s first-time pass rates for the NCLEX-RN licensure exam by 6 percent since FY 2018.
- The number of candidates taking the NCLEX-RN licensure exam in Maryland increased by 22 percent 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 at higher education institutions in Maryland.
- 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 in Maryland 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

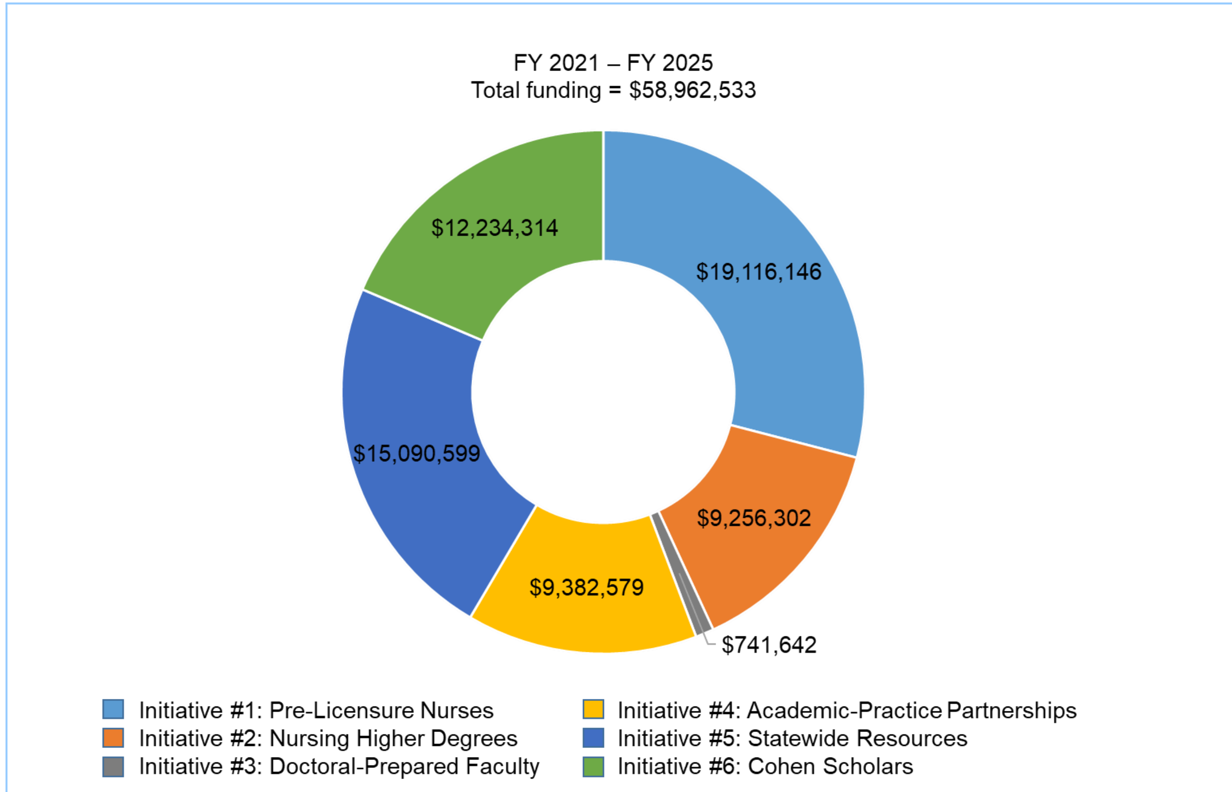
Competitive institutional grants were awarded for projects addressing the following initiatives:

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
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:

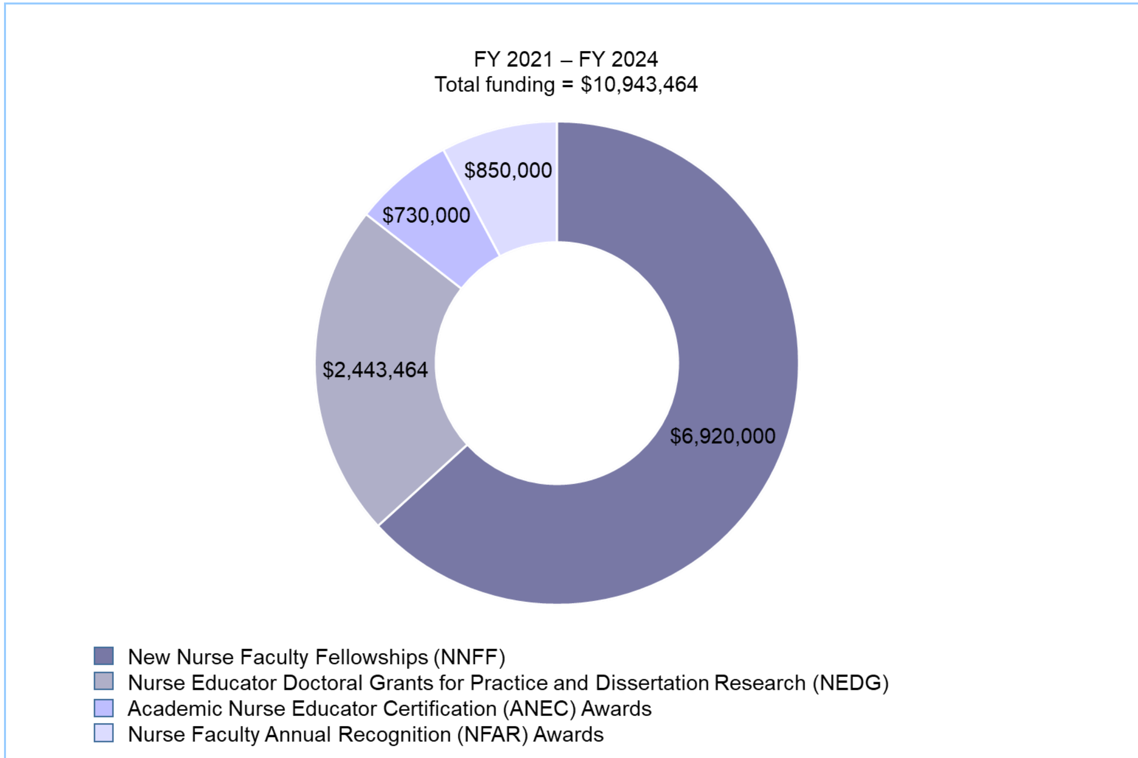
1. New Nurse Faculty Fellowships (NNFF), for new nurse faculty hired by Maryland institutions to expand enrollments in their nursing programs;
2. Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG) for existing faculty to expedite doctoral degree completions;
3. Academic Nurse 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 include support for professional development activities and 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 the 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

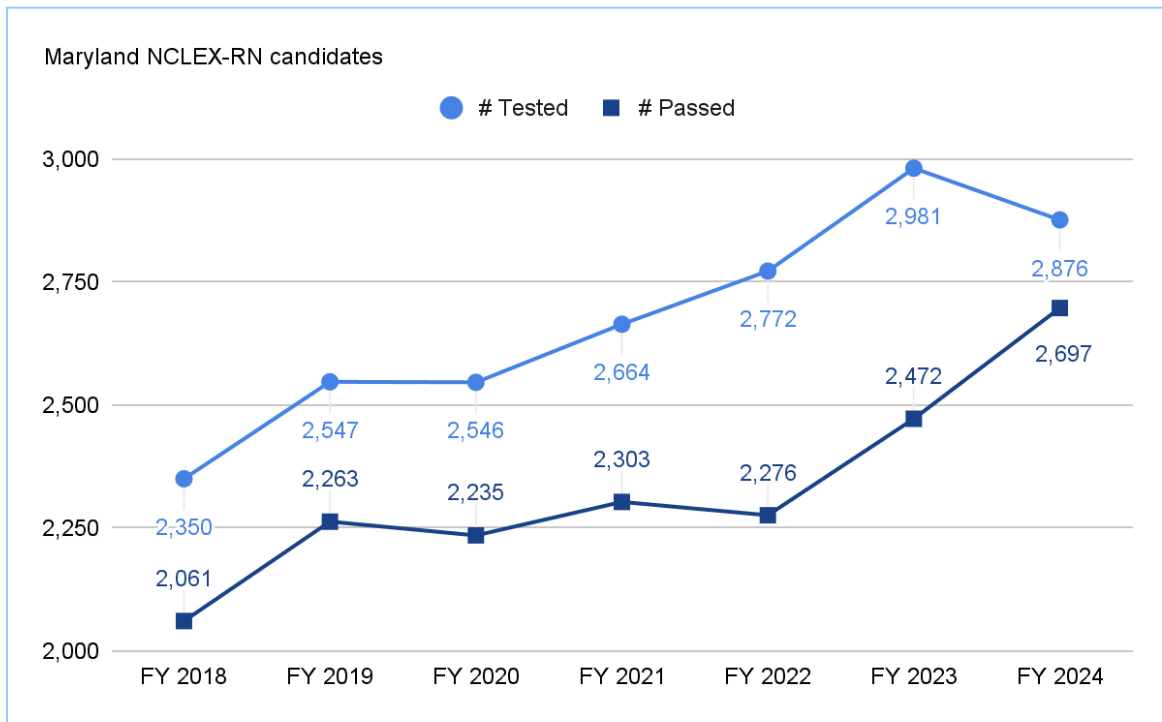
This section highlights the challenges and opportunities within nursing education, including the impact of faculty shortages on program capacity and the success of new graduates in achieving licensure. Key data is explored regarding entry-to-practice in Maryland, focusing on NCLEX-RN pass rates and trends 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 estimates that approximately 50 percent of faculty are doctorally-prepared (AACN). National data shows that only 17.3 percent of registered nurses hold a graduate degree and 2.9 percent of nurses 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; and
- 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 34 percent of newly hired nurses

left their positions within one year, representing a 66 percent national retention rate (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

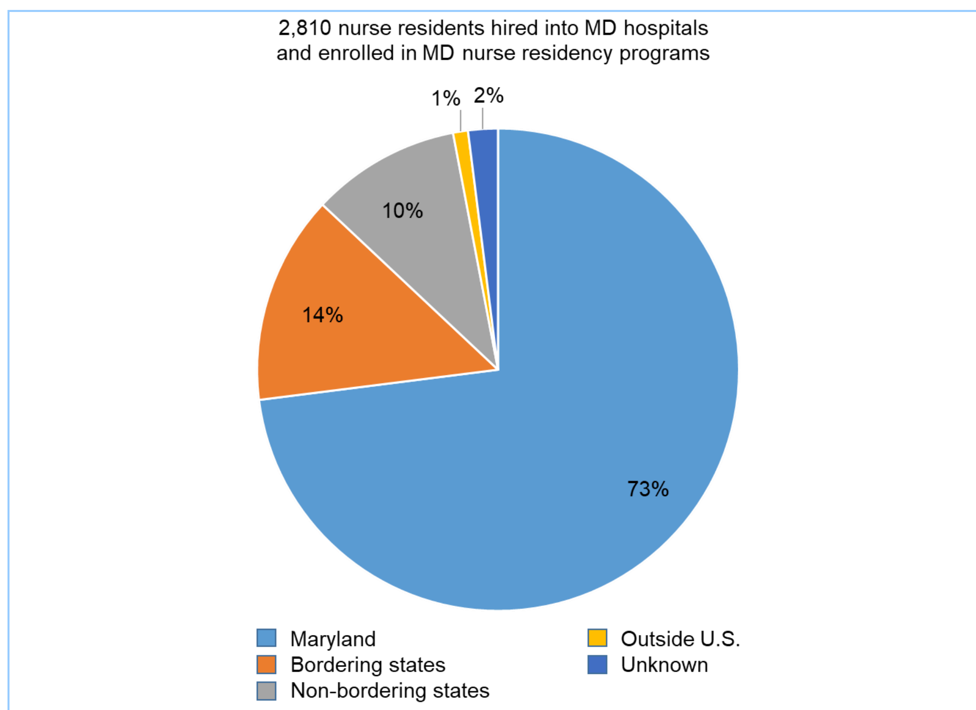
Examining the employment of new nursing graduates is critical when assessing the state of the nursing workforce in Maryland, as it directly reflects the ability of the healthcare system to absorb and retain newly licensed professionals. The transition from education to practice is a pivotal phase in 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 in Maryland 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 Nursing Workforce Center:** The Maryland Nursing 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
- Maryland Nursing Workforce Center Symposium
- University of Maryland School of Nursing Institute for Educators Spring 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;

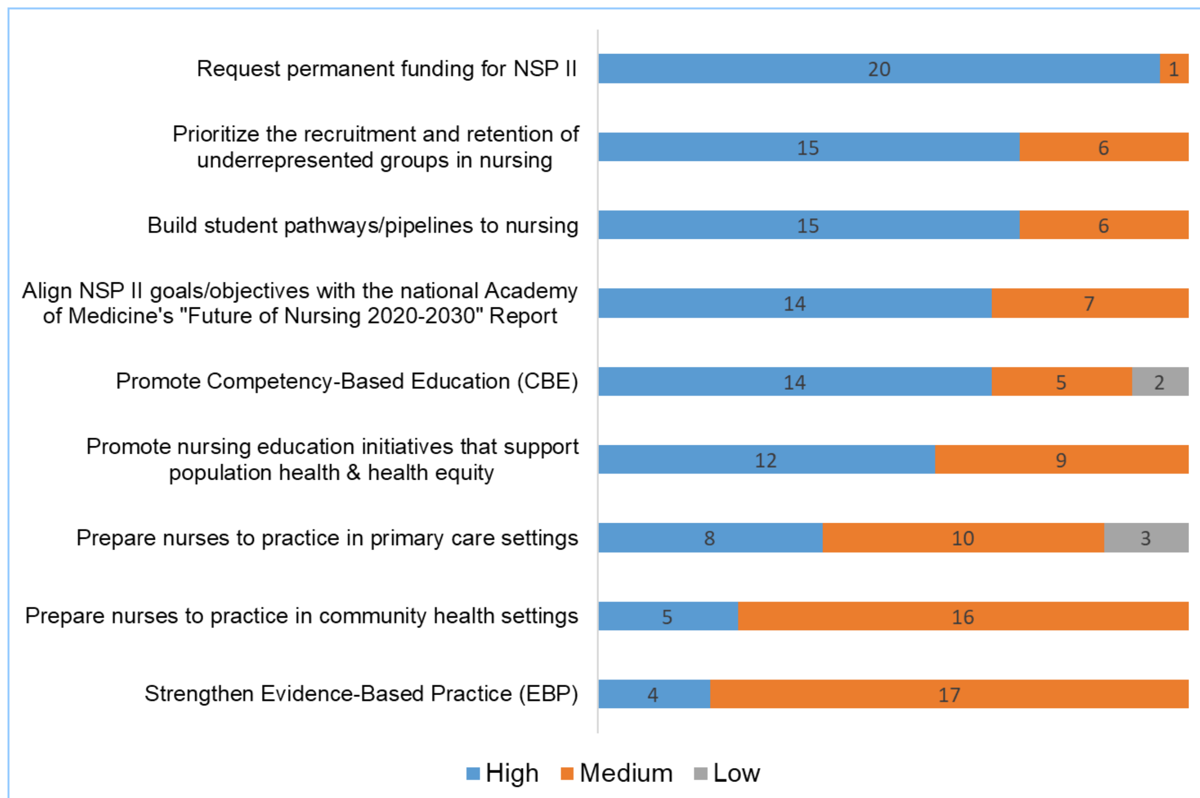
5. Development of advanced nursing roles;
6. Support for critical workforce needs; and
7. Support for diversity and underrepresented groups in nursing.

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.

Public Comment Letters

Comments from the public were solicited and a summary of this feedback is provided with this final report with recommendations. The call for public comments was initiated with the draft report with recommendations that was presented to the Commission on December 11, 2024. A total of eleven letters were received by January 21, 2025, which included feedback from the following organizations/individuals:

1. Bowie State University;
2. Johns Hopkins School of Nursing;
3. Morgan State University;
4. University of Maryland School of Nursing;
5. University System of Maryland;
6. Maryland Hospital Association;
7. National League for Nursing;
8. Maryland Action Coalition;
9. Dr. Mary Etta Mills, Professor Emerita, University of Maryland School of Nursing;
10. Dr. Rita F. D'Aoust, Associate Professor, Johns Hopkins School of Nursing; and
11. Dr. Diane M. Billings, Chancellor's Professor Emeritus, Indiana University School of Nursing.

All of the letters conveyed strong support for continued funding of NSP II, highlighting its crucial role in addressing Maryland's nursing shortage and improving healthcare delivery. Some of the common themes from the public comments received included:

- **Faculty Development:** NSP II funding supports essential faculty development programs (such as the CNE® course), enhancing teaching quality and preparing nursing educators to address evolving challenges.
- **Innovative Projects and Collaborations:** Projects like the Maryland NextGen Test Bank and community-based initiatives have been instrumental in improving nursing education and expanding access to care.
- **Workforce Diversity and Health Equity:** There is a consistent emphasis on increasing diversity within the nursing workforce to better serve Maryland's diverse populations, with a strong focus on addressing health disparities and promoting equity.
- **Community and Population Health:** Many letters stress the need to prepare nurses for community health and primary care roles, helping alleviate pressures on hospitals and improving overall public health outcomes.
- **Outcomes and Results:** NSP II has led to positive outcomes, including improved NCLEX pass rates, increased nursing school enrollments, and stronger faculty expertise, demonstrating its effectiveness.

- **Long-term Sustainability:** Many letters express support for making NSP II a permanent program, with ongoing funding and annual reporting to ensure continued success and efficient use of resources.

These themes collectively underscore the importance of NSP II in strengthening nursing education, improving health equity, and addressing Maryland's healthcare workforce needs.

The Maryland Hospital Association's (MHA) public comment letter emphasized the need to retain NSP II's focus on preparing nurses for bedside roles in acute care, as hospitals report a continued high demand for nurses, particularly in medical-surgical units. Based on this feedback from MHA, which represents Maryland's acute care hospitals, the staff recommendations were revised to demonstrate NSP II's continued commitment to supporting nursing education initiatives that address workforce needs in acute care settings.

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:

    - Increase 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 while still prioritizing support to address nurse vacancies in acute care areas; 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 acute care, 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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January 21, 2025

Erin Schurmann, MPA, PMP
Associate Director, Strategic Initiatives
Medical Economics and Data Analytics
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Ms. Schurmann,

As the Chair of the Department of Nursing at Bowie State University, the oldest Historically Black College/University (HBCU) in the state of Maryland, I support the Nursing Support Program II (NSP II). In January 2020, I moved from a state that did not have the resources that Maryland has for Nursing education, so was amazed over the many financial benefits the Nursing Support Program II offered. I immediately began informing my faculty of these opportunities.

As a result of the New Nurse Faculty Support (NNFF) program, seven faculty were hired and retained; the Certified Nurse Educator workshop resulted in going from zero Certified Nurse Educators (CNE) to 12; eight CNE's received the Academic Nurse Educator Certification (ANEC) award; four faculty became recipients of the Nursing Faculty Annual Recognition (NFAR) award; eight were awarded funds and three faculty were able to benefit from the Nurse Education Doctoral Grants (NEDG). These types of incentives not only assisted in the retention of faculty (88%), but they also contributed to increasing the NCLEX-RN pass rate. Within the past 5 years the scores increased from 56% to 85.71%. Therefore, it is without hesitation that I highly recommend the continuation of the NSP II program.

Sincerely,

Jacqueline J. Hill

Jacqueline J. Hill, PhD, RN, CNE
Chair & Professor
Department of Nursing
Bowie State University

January 15, 2025

To: The Maryland Health Services Cost Review Commission (HSCRC)

From: Sarah Szanton, Dean, Johns Hopkins School of Nursing;
Natalia Barolin, Sr. Health Policy Adviser, Johns Hopkins School of Nursing

Re: New NSPII conceptual framework & staff recommendations

Dear Colleagues,

We are writing to commend the HSCRC and support the staff recommendations for updates to the NSPII program. The changes that prioritize education that advances practice in community health settings and population health will strengthen Maryland's nurse workforce to meet the goals in the AHEAD model and improve the future of Maryland's health while also working more efficiently in the face of budget challenges.

Specifically, we would like to support the following recommendations:

- Educating and retaining nurses in primary care and community health
- Promoting competency-based learning

At the Johns Hopkins School of Nursing (JHSON) we are implementing programs in alignment with these new recommendations. These changes in NSPII funding will help us expand opportunities for student nurses and nurses already in the workforce. We also anticipate that these changes will help catalyze and support similar changes at schools of nursing across Maryland. Below are some current and emerging programs at the JHSON that align with the recommended changes:

Educating and retaining nurses in primary care and community health

As the pressures and demands on acute care settings increase and spiral out of control, more care is moving to the community. Consequently, we need a nurse workforce prepared to meet these challenges and changes to how care is delivered through a renewed focus on primary care, community-based care and population health. The challenges of an aging population, more need for primary care access, behavioral health, high maternal mortality and morbidity, and growing health inequities require that we train nurses to function in the community at high levels of competency.

At Johns Hopkins we allow our nursing students to apply to a cohort for which all of their clinical training is out in the community. This is not public health alone. It is also in cancer infusion, center-based hospice, palliative care and dialysis. They receive 1:1 preceptorship with

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preceptors who understand the competencies they are working towards. These students not only gain quality clinical training in a variety of outpatient and community-based settings but are exposed to employment opportunities beyond the inpatient hospital setting. Many hospitals, like our own at Hopkins, are health systems with health care delivery in a variety of settings facing workforce challenges beyond the inpatient setting.

In addition to outpatient and community based clinical training, the JHSON is developing and staffing community-based models of care to create more job opportunities for nurses interested in addressing health care challenges in the community. These programs also help alleviate pressures on our acute care and hospital-based systems and workforce by bringing preventive care, improved chronic disease management, behavioral health and social needs care to people in the community where they live, love, work, learn, worship and play.

For example, the schools of nursing at Morgan State, Coppin State and Johns Hopkins have joined together to staff nurses in Baltimore city schools and to design and implement a Neighborhood Nursing program across Maryland. Through **Neighborhood Nursing,** Maryland residents will have access to a nurse and community health workers to address health and social needs of individuals, households, and communities block-to-block and family-to-family. The nurse and community health worker will help Marylanders establish goals for their health, and then achieve them while preventing illness, building social connections and improving overall health. The goal is to reduce total cost of care through primary, secondary and tertiary prevention while engaging all people in ways meaningful to them to better manage their health and overall well-being.

Promoting competency-based learning

Competency-based education (CBE) will allow learners to progress by mastering competencies rather than adhering to rigid timelines and testing. This isn't just a shift in methodology; it's a revolution in efficiency and stewardship of resources. Time, once a rigid opponent, becomes a flexible ally, adapting to the pace of each learner. The economic implications are equally profound. Costs shrink, yet our capacity to educate nurses expands. But the most significant outcome is that nursing school graduates complete their programs with both a degree and the necessary readiness to practice in the evolving health care environment that will demand our workforce to address complex needs across health and social factors in new settings outside of the hospital. To meet these changes and evolving demands, the JHSON is currently designing a new CBE curriculum to be launched in 2027.

Taken together, the competency-based education, emphasis on community-based care and population, the changes to the NSPII will help usher in the nursing workforce of the future. This workforce will be equipped to support the health of all Marylanders across all stages of life and across the whole health spectrum from population to acute, chronic and restorative.

We look forward to ongoing collaboration.

Sincerely,

Sarah L. Szanton, PhD, ANP, FAAN
Dean
Patricia M. Davidson Health Equity and Social Justice Endowed Professor

Natalia Barolín, BA, BSN, RN
Sr. Health Policy Adviser

Office of the Dean
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410-955-7548
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15 January 2025

Joshua Sharfstein, MD
Chairman
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Letter of Support for Continued NSP II Funding

Greetings,

I am writing to express my strong support for continued funding of Nurse Support Program II (NSP II) initiatives. The transformative impact of NSP II funding on the Morgan State University Nursing Program underscores its critical role in advancing nursing education and addressing workforce needs.

Before my arrival as Program Director in 2015, the pre-licensure program faced significant challenges. Limited resources hampered our ability to ensure adequate outcomes for graduates, leading to suboptimal NCLEX-RN® pass rates, constrained employment opportunities post-graduation, and the program's failure to achieve initial accreditation in 2013.

Upon assuming leadership, I utilized the limited NSP II funds available to begin turning the program around. These funds enabled us to build a dedicated team of faculty and support staff, which led to remarkable improvements within the first year. Inspired by our mantra, *Semper Ad Meliora* ("Always Towards Better Things"), we leveraged additional NSP II funding—notably the SAM II initiative—to drive further progress. Over the years, this support has facilitated:

1. **Reaccreditation of the Master of Science in Nursing program** in 2016 for the maximum ten-year period.
2. **Preparation for the initial accreditation site visit** for the pre-licensure program in 2017.
3. **Comprehensive professional development** for faculty, fostering enhanced student outcomes.
4. **A statewide mentoring initiative**, enriching the professional growth of nursing educators and students.

1700 E. Cold Spring Lane, Baltimore, MD 21251
Tel: 443.885.4144
Fax: 443.885.8319

The outcomes speak volumes:

- In 2017, the pre-licensure program achieved initial accreditation, and in 2023, it was reaccredited for another ten years.
- Our first-time NCLEX-RN® pass rate soared to 100% in FY 2018, a benchmark of excellence. While the challenges of COVID-19 caused a temporary dip, the strategies funded by NSP II enabled recovery, with our FY 2024 first-time pass rate reaching 90.6%.

Building on this success, we are now expanding both our graduate programs and the capacity of our pre-licensure program. These achievements would not have been possible without NSP II funding.

Morgan State University's Nursing Program is a testament to the transformative power of NSP II support. We enthusiastically endorse continued investment in this vital program, which has not only improved our outcomes but also strengthened the nursing workforce to meet the healthcare challenges of today and tomorrow.

Thank you for your unwavering commitment to advancing nursing education.

Semper Ad Meliora,

Maija R. Anderson

Maija Anderson, DNP, APRN, FNE-A/P
Chair
Department of Nursing

Cc: K. Ford, L. Schenk, K. Sydnor

1700 E. Cold Spring Lane, Baltimore, MD 21251
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UNIVERSITY of MARYLAND
SCHOOL OF NURSING

Susan L. Bindon, DNP, RN, NPD-BC, CNE, ANEF, FAAN
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Associate Dean for Faculty Development
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Erin Schurmann, MPA, PMP
Associate Director, Strategic Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

January 11, 2025

Dear Ms. Schurmann,

As a faculty leader and project director on multiple NSP II grants, I am writing to provide support for the December 2024 *NSP II Outcomes Evaluation and Draft Recommendations for Future Funding* report. Thank you for the opportunity to review and comment.

I read the report in its entirety and want to offer my full support for the identified trends and future priorities for the NSP II program. The impact of NSP II grants over past funding cycles, and particularly in the past five years, has put Maryland in the forefront of nursing education across the country in terms of workforce data, nurse faculty certification, creative academic/practice partnerships, and faculty development. Each time my colleagues and I share our NSP II project outcomes, peers from around the country are impressed by (and sometimes even envious of) the tremendous opportunities and results this resource provides us.

I appreciate the program's current and future focus on mentoring and supporting underserved populations. The program has always prioritized diversity and inclusion and I am happy to see this continue. The program also provides faculty with the opportunity to learn grantsmanship and stewardship while implementing much needed projects in Maryland's nursing programs. I commend the grant administrator team of Dr. Schenk and Ms. Ford for their tireless efforts to support nursing education and the project teams across the state as they do their work.

Thank you again for this invaluable resource, I hope to see NSP II continue far into the future. I am proud to be an NSP II grant recipient and program champion. Please let me know how I can support this effort going forward.

Sincerely,

Susan L. Bindon

CC: Laura Schenk, DNP, RN, CNE, Grant Administrator NSP II
Kimberly Ford, BS, Assistant Grant Administrator NSP II

University System of Maryland
3300 METZEROTT ROAD // ADELPHI, MD 20783
WWW.USMD.EDU // 301.445.1901

January 15, 2025

Nurse Support Program II
Maryland Higher Education Commission
6 N Liberty Street, 10th Floor
Baltimore, MD 21201

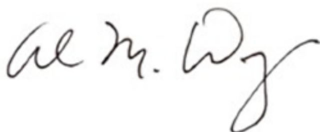
Dear Members of the Nurse Support Program II Review Committee,

Thank you for the opportunity to write a letter of support for the Nurse Support Program II (NSP II). The University System of Maryland (USM) fully supports the continued funding of the NSP II. USM recognizes the critical importance of fostering a highly skilled and diverse nursing workforce to meet the growing healthcare needs of our state and the System fully aligns with the NSP II's mission to increase the number of nursing faculty and enhance diversity within the nursing profession.

The NSP II initiatives are essential to addressing the ongoing nursing shortage in Maryland. By providing funding for faculty development and educational programs, the NSP II enables nursing schools across the state to foster the next generation of nurses and nursing educators. Funding for the NSP II not only supports current healthcare needs, but helps ensure a pipeline of qualified, diverse professionals that will improve nursing and healthcare across the state into the future.

We encourage the continued investment in the NSP II program to strengthen the nursing profession in Maryland. Thank you for your consideration of our support for this crucial program.

Sincerely,



Alison M. Wrynn, Ph.D.
Senior Vice Chancellor for Academic and Student Affairs
University System of Maryland

Maryland
Hospital Association

January 21, 2025

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 draft recommendation for Nurse Support Program II: Competitive Institutional Grants Program. We appreciate HSCRC's request for the hospital field's feedback on this program and for ensuring the field's inclusion in the Nurse Support Program II Advisory Group to help shape the draft recommendation.

Maryland hospitals proudly support the Nurse Support Program II. As outlined in the staff's conceptual framework, aligning the goals of the hospital field with our academic partners is essential to grow the nursing workforce pipeline.

We support the following staff recommendations:

1. Request for NSP II permanent funding with annual reports on program performance
    - Providing permanent funding will align this program with NSP I and provide stability for the program
2. Focus on retaining graduates in Maryland through alignment with NSP I goals, by building student pathways to nursing that address vacancies in understaffed specialties and care settings in Maryland, including primary care and community health
3. Identify new opportunities to prioritize funding to underrepresented groups in nursing through both competitive institutional grants and faculty-focused programs
4. Promote curriculum updates to strengthen Evidence-Based Practice (EBP) and promote Competency-Based Education (CBE) to reduce learning gaps and promote retention of new graduates
5. Enhance data collection infrastructure and analysis to promote greater accountability in reporting statewide data and support responsiveness of NSP II to Maryland nursing education and workforce trends
    - We support collecting data on new graduate employment in Maryland
6. Based on data results, prioritize funding initiatives that best support the needs of Maryland's health care system

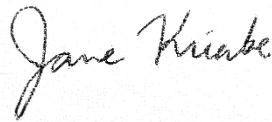
We offer suggestions on the following staff recommendations:

- Add new and updated NSP II funding initiatives, prioritizing education that prepares nurses to address health equity and practice in community/population health settings to align with AHEAD Model goals
    - While it is important to focus on community health nursing and care delivered outside the hospital walls, we encourage HSCRC to maintain NSP II's emphasis on preparing nurses to practice at the bedside in acute care settings
    - Our hospital members continue to identify bedside nurses as being in high demand, especially those working in medical-surgical units

Maryland hospitals fully support the Nurse Support Program II's goals and the staff recommendations. We appreciate HSCRC and the Maryland Higher Education Commission for providing us with the opportunity to engage in work group discussions on NSP II.

Should you have any questions or wish to discuss our recommendation further, please do not hesitate to contact me.

Respectfully,



Jane Krienke
Director, Government Affairs & Policy
Maryland Hospital Association

January 13,2025

Erin Schurmann
Health Services Cost Review Commission
Baltimore, Maryland
erin.schurmann@maryland.gov

Dear Erin Schurmann,

Over the last four years, the National League for Nursing (NLN) has experienced the pleasure of collaborating with the Maryland Higher Education Commission Nurse Support Program II (NSP II). The outstanding individuals working within the NSP II and the Maryland Higher Education Commission are to be commended for the dedication and the excellent work that has supported this program.

The collaboration that the NLN has established has been related to activities by the NSP II to support nurse educator faculty in the progression of careers and attaining the certifications offered by the NLN, including the Certified Nurse Educator (CNE®) and the Certified Clinical Nurse Educator (CNE®cl) certifications, which indicate a level of excellence in the roles of nurse educators. Working with the NSP II, the NLN has provided preparatory review courses, which enhance the faculty understanding of the competencies and task statements related to each of the roles. The program sponsored by the NSP II has been very successful and now Maryland has become #6 state in the nation for numbers of certified nurse educator faculty.

The NLN has also collaborated with the NSP II for the establishment of a database that is aimed at tracking the outcomes of faculty receiving financial support for achieving higher levels of academic education in nursing education. In 2024, 108 faculty receiving this financial support used the database to document their achievements and outcomes being achieved that are supported by the program.

The NLN Certification Program had established a Certification Star Award. This award is given periodically to faculty and programs that are identified as providing excellence in the support of nurse faculty wishing to achieve nurse educator certification. Twice since inception of this award, the staff at the NSP II program have been recognized for dedication and excellence in providing this type of support. The first ever Star Award was given to Peg E. Daw. In her honor, the Star Award was renamed as the Peg E. Daw Certification Star Award. In 2024, the Award was presented to Kimberly Ford of the NSP II program.

The NLN provides this letter of support for the NSP II program and the excellence it demonstrates in performance for the State of Maryland. We are looking forward to our future collaboration encouraging the further education and certification achievements of nurse educator faculty in the State of Maryland.

Best regards,

Beverly L. Malone, PhD RN FAAN
President & CEO
National League for Nursing

January 15, 2025

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

Dear Dr. Kromm,

On behalf of the Maryland Action Coalition (MDAC), we are writing in our capacity as the Co-Chairs of the Coalition, to express strong support for the report and draft recommendations regarding the renewal of the authorization for the Nurse Support II Program, as presented by the Maryland Higher Education Commission at the HSCRC meeting on December 11, 2024.

The Maryland Action Coalition was formed in 2010, following the release of the Institute of Medicine's report on *The Future of Nursing: Leading Change, Advancing Health.* The seminal report detailed the challenges facing the nursing profession in preparing the nursing workforce to provide care to an increasingly diverse and aging population in the context of the growing complexity of the health care system. Following the release of that report, The Robert Wood Johnson Foundation, and the AARP, launched a national initiative – the *Future of Nursing: Campaign for Action* – to implement the IOM recommendations through coalitions in each of the 50 states and the District of Columbia. The Maryland Action Coalition has been an active participant in this nationwide effort since its inception.

The NSP II programs of the Maryland Higher Commission have been instrumental to the State of Maryland's successful response to the challenges of the initial IOM report and its ongoing work to meet the recommendation of the successor report from the National Academies of Medicine, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity.* Through the guidance, support, and funding provided by the NSP II program, Maryland has been able to successfully meet critical goals, including:

- Expanding the number of nursing school graduates;
- Increasing the number of baccalaureate-educated nurses to 80%;
- Increasing the number of doctorally-prepared nurses and Advanced Practice Registered Nurses able to provide vital care, particularly in underserved areas;
- Increasing the diversity of the nursing profession to better meet the needs of our highly diverse communities; and
- Addressing the need for better workforce data through the establishment of the Maryland Nursing Workforce Center.

Through support for nurse faculty, the NSP II program has made it possible to increase nursing school enrollments, as sufficient, well-prepared faculty is a critical element. The NSP II program has also provided competitive institutional grants that have fostered new and innovative efforts to develop new curriculum, initiate community-based projects and increase academic and clinical practice partnerships. It is through partnerships such as these that we are addressing critical needs such as the coordination of patient care from the hospital setting to the community. And, developing new approaches to addressing the social determinants of health and health disparities in our communities.

Each year, the Maryland Action Coalition holds an Annual Summit, which draws participation from 200-400 members of Maryland nursing profession, including nurse faculty, clinical practitioners, and nurse leaders from institutions throughout the State. We have utilized these meetings to share the results of projects and activities funded by the NSP II program, thereby ensuring significant dissemination of information and findings from NSP II funded initiatives and fostering replication of promising approaches throughout the State. This annual event is representative of the important ongoing strategic relationship between the NSP II program and Maryland's nursing profession as we jointly seek to address critical issues facing healthcare delivery in Maryland and nationally.

We strongly support the recommendation contained in the draft report to continue NSP II as an ongoing program with permanent funding and a requirement for annual reports in lieu of the current five-year program renewal cycle. As indicated, this would align the NSP I and NSP II programs and improve grant planning and efficient use of resources, as well as support competitive institutional grant planning, and ensure continuity with respect to strategic initiatives.

We also strongly support the proposed prioritization of initiatives to prepare nurses to address health equity and increase practice in community/population health settings; this is in keeping with the national needs articulated the Academy of Medicine's *Future of Nursing: 2020-2030: Charting a Path to Achieve Health Equity.* In addition, the MHEC proposal to revise existing initiatives in accord with this latest report will be of tremendous benefit in focusing attention and effort on meeting the challenges of the future. Finally, the proposed focus on strengthening Evidence-Based Practice and promoting Competency-Based Education is very appropriately aligned with national objectives and reflects changes being made in the content and approach to nursing education nationwide and with it, the preparation for licensure for nursing practice.

Given the proven track record of success for the NSP II program and its demonstrated experience and expertise in executing vital projects, the Maryland Action Coalition urges the HSCRC to continue its funding support of NSP II as we collectively address the ongoing and pressing need to prepare our nursing workforce. Nurse colleagues and leaders throughout the U.S. regularly express their envy with respect to Maryland's NSP II program. The Health Services Cost Review Commission and the Maryland Higher Education Commission can be justifiably proud of the unique contributions that this program makes to strengthening the nursing workforce in our State.

We appreciate the opportunity to comment on the draft recommendations. We commend the Maryland Higher Education Commission for its steadfast and ongoing support of the nursing profession in Maryland and we appreciate the commitment of the Health Services Cost Review Commission to ensuring that Maryland has a nursing workforce that is well-equipped to meet the needs of the diverse communities within our State.

Thank you for your thoughtful consideration of the draft report and recommendations.

Sincerely,

The Co-Chairs of the Maryland Action Coalition

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cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
William Henderson
Erin Schurmann, HSRC Associate Director of Strategic Initiatives

4513 Weitzel Ave.
Baltimore, MD 21214

January 6, 2025

Erin Schurmann
Health Services Cost Review Commission

This letter is in response to the opportunity for public comment regarding continuation of the Nurse Support Program II now being reviewed by the Health Services Cost Review Commission. I have been associated with the Nurse Support Program II since 2001. In addition to receiving grant funding through the NSP II program, I have been involved in several five year evaluation periods whereby outcomes of the program were reviewed and funding continued by HSCRC. I have also had the privilege of working with the NSP II leadership as program initiatives have evolved over time to address statewide nursing needs through the development of successful, innovative and creative actions.

Funding from NSP II grants across the State of Maryland has significantly benefited the development of exceptionally well prepared nurses able to address the needs of hospitals to provide healthcare across diverse locations and populations of patients. Furthermore, the NSP II program has become a national model for the generation of new programs to achieve statewide advancements in nursing education, academic-practice partnerships to develop outstanding nurse clinicians and faculty, and successful approaches to retain nurses in both education and clinical practice settings. As a result of the NSP II program, the State of Maryland has seen an increase in the enrollment and graduation of new nurses, advanced education of nurses, collaboration between education and practice, and development of outstanding nurse faculty.

Importantly, the NSP II has served as the critical ingredient to bring together nurse educators, clinicians and leaders from Maryland schools of nursing and hospitals to address, develop and support programs designed to increase the number and quality of nurses in the State of Maryland. This in itself is a major achievement that deserves to be recognized and supported.

Looking to the future, I fully endorse the proposed recommendations for program renewal to continue NSP II as an ongoing program with permanent funding, thereby replacing the five-year program renewal cycle. Furthermore, as proposed, future NSP II initiatives should prioritize educational preparation of nurses to address health equity and practice in community and population health settings as well as continuing to prioritize areas where improvements are needed. As proposed in the evaluation document, the alignment of NSP I and NSP II goals could

further advance the objectives and goals of both programs through collaboration with HSCRC and stakeholders.

In summary, the NSP II program is critical to continuing the development and advancement of a qualified nursing workforce in the State of Maryland. I strongly endorse continuation of the program and the staff recommendations included in the evaluation report.

Sincerely:

Mary Etta Mills, ScD, RN, NEA-BC, FAAN
Professor Emerita
University of Maryland School of Nursing

Rita F. D’Aoust
9565 Morning Mews
Columbia, MD 21046

January 6, 2025

To: Erin Schurmann, MPA, PMP
Associate Director, Strategic Initiatives

I have carefully reviewed the proposal (pp 162-212) and offer a couple of thoughts:

- I love the proposed framework, especially how academic-practice collaboration has been conceptualized.
- The move to community-based care and competency of nurses is crucial given our new state model for total cost. The lack of access contributes to poor health and avoidable hospital based or specialty care.
- The move to community-based care offers an opportunity for faculty practice and ability to have first-hand clinical experience for population health and community-based care. This offers faculty the full spectrum of practice and not only acute care and machinery skills.
- Population health initiatives should be measurable, even if it’s a process measure until impact measures are obtained. This should be aligned with competency-based education.
- The growth in faculty support programs (NNF) should be balanced with actual need and performance return on investment measures.
- I support the NSP II move to quality, not just quantity, and retention.
- The recognition for advanced practice nurse education (APRNs) is well supported, especially given the shortage to primary care providers in our state. In Maryland, Nurse Practitioners have full scope of practice and meet crucial access needs for our population.

Thank you for the opportunity to review and provide public comment.

Sincerely,

Rita D'Aoust

Diane M. Billings

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Brownsburg, IN 46112
317.626.5751
dbillin@iu.edu

January 13, 2025

Erin Schurmann, MPA, PMP
Associate Director, Strategic Initiatives
Medical Economics and Data Analytics
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Schurmann,

I am writing to offer the strongest support possible for the renewal of the Nurse Support Program II (NSPII). For over more than 15 years, I have served on grant review panels; provided consultation for programing for NSPII grants; served as faculty for the Certified Nurse Educator (CNE) Review Course that Maryland Higher Education Commission collaborates with the National League for Nursing to offer two or three times a year; and was a co-project director for the grant that funded the development of the NextGen NCLEX Test Bank, a repository of test questions that faculty and students in Maryland and worldwide can use at no cost to prepare students to pass the licensing exam. Because of my involvement in these programs, I know firsthand the impact of the NSPII funding has meant for nursing and nursing education in Maryland.

In my opinion, one of the most impactful projects supported by NSPII funding was the Maryland NextGen Test Bank which was developed in response to a request from the Maryland Council of Deans and Directors to provide training and resources for faculty who were preparing to write new and very complex forms of test questions (NextGen questions) that would be used on the upcoming new nursing licensing exam. The goal for this project was to develop test questions that could be used by faculty to prepare their students to pass the licensing exam. Because the Testbank was designed as an open-source resource, the Testbank ultimately served faculty and students worldwide. The outcomes from this project included 1) teaching faculty to write test questions in the new style; 2) developing a peer review process that established validity of the test questions; 3) developing resources to assist faculty integrate the test questions into their teaching and evaluation processes; and 4) most importantly, achieving a high first time pass rate for the students who ultimately took the licensing exam.

My current involvement in NSPII funded programs is to offer the CNE Review Course. The course is now offered virtually, and thus able to reach faculty throughout the state. Each offering of the course fills to capacity with active participation by those attending. While passing the certification exam is the goal, the course also prepares attendees to integrate best practices in nursing education into their own courses, a dual outcome that improves teaching capacity for all nursing schools in Maryland.

Maryland is the only state that provides resources for nursing and nursing education and as a result of this investment, the state has benefited from increased nursing faculty expertise in teaching and learning; improved student pass rates on the licensing exam; and is the state with the highest percentage of Certified Nurse Educators! Because of the engagement of the students and faculty in Maryland and the demonstrable outcomes of the NSPII funding, I urge the commission to renew the funding.

Sincerely,

Diane M. Billings, Ed.D, RN, FAAN, ANEF
Chancellor's Professor Emeritus
Indiana University School of Nursing
Indianapolis, Indiana

maryland
health services
cost review commission

Draft Recommendation for the Readmission Reduction Incentive Program for Rate Year 2027

February 12, 2025

This document contains staff draft recommendations for the RY 2027 Readmission Reduction Incentive Program. Comment letters are due by COB Wednesday, March 12, 2025 and may be submitted to hscrc.quality@maryland.gov.

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health services
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List of Abbreviations

ADI	Area Deprivation Index
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-for-service
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

Key Methodology Concepts and Definitions

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar in clinical characteristics and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

Observed/Expected Ratio: Readmission rates are calculated by dividing the observed number of readmissions by the expected number of readmissions. Expected readmissions are determined through case-mix adjustment.

Case-Mix Adjustment: Statewide rate for readmissions (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These statewide norms are applied to each hospital's case-mix to determine the expected number of readmissions, a process known as indirect standardization.

Prevention Quality Indicator (PQI): a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Area Deprivation Index (ADI): A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

Patient Adversity Index (PAI): HSCRC-developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

Excess Days in Acute Care (EDAC): Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

maryland health services cost review commission

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 Readmission Reduction Incentive Program (RRIP), are intended to drive improvements in patient outcomes and to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care on an all-payer basis. 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 RRIP policy is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.	The RRIP policy currently holds up to 2 percent of hospital revenue at-risk for performance relative to predetermined attainment or improvement goals on readmissions occurring within 30-days of discharge, applicable to all payers and all conditions and causes.	This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent.

Recommendations

These are the draft recommendation for the Maryland Rate Year (RY) 2026 Readmission Reduction Incentives Program (RRIP):

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023
3. Retroactively apply a blended base period of CY 2022 and CY 2023 to the RY 2026 policy
4. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
5. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
6. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
    a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
    b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
7. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in the RRIP program.
8. Update the RRIP policy in future years to align with statewide AHEAD model goals for readmissions.

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 in 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 Readmissions Reduction Incentive Program (RRIP) is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time that targets unplanned readmissions. While some hospital readmissions are unavoidable, other hospital readmissions within 30 days result from ineffective initial treatment, poor discharge planning, or inadequate post-acute care and result in poor patient outcomes and financially strained healthcare institutions.[1] The RRIP currently holds up to 2 percent of hospital revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates. In addition, the disparity gap component of the RRIP policy rewards hospitals up to 0.5% of their IP revenue for reducing disparities in readmissions

[1] Rammohan R, Joy M, Magam S, et al. (May 15, 2023) The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes. Cureus 15(5): e39022. doi:10.7759/cureus.39022

based on race (Black vs Non-Black), ADI (high area deprivation vs low deprivation), and Medicaid status (Medicaid beneficiary vs Non-Medicaid beneficiary).

For RRIP, as well as the other State hospital quality programs, updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2027 RRIP Draft Policy, staff vetted the updated proposed recommendations with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Additionally, with the onset of the Total Cost of Care Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the RRIP policy, the overhaul was completed during 2019, which entailed an extensive stakeholder engagement effort. The major accomplishments of the RRIP redesign were modifications to the inclusion and exclusion criteria for the readmission measure, development of a 5-year (2018-2023) improvement target, adjustment of the attainment target, and the addition of an incentive to reduce within hospital disparities in readmissions.

This draft policy recommends extending the four-year improvement target but with an updated base period, discusses the issue of revisits to the emergency department/observation following an inpatient admission, and continues the incentive for reductions in within-hospital disparities. The draft policy does not recommend any changes to the current case-mix adjustment readmission measure, and recommends no updates to the disparity gap measurement. In future years, the RRIP policy will be updated to align with the new AHEAD model and any statewide readmission improvement targets.

Background

Brief History of RRIP program

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland historically performed poorly compared to the nation on readmissions; it ranked 50th

among all states in a study examining Medicare data from 2003-2004.[2] In order to meet the All-Payer Model requirements, the Commission approved the inaugural RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions beyond the incentives already inherent in the global budget system. Under the TCOC model, CMMI requires the State's readmission measure to be all-payer. Using this all-payer readmission measure, the State's goal was to improve readmissions by 7.5 percent in 2023 compared to 2018. Additional discussion on current Maryland performance is included below in the assessment section.

As recommended by the Performance Measurement Work Group (PMWG), the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause, all-condition measure that includes all eligible discharges regardless of payer.[3] Furthermore, it assesses both improvement and attainment and provides an incentive to focus on disparities.

RRIP Methodology

Figure 1 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (e.g., pediatric oncology, patients who leave against medical advice, rare diagnosis groups) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment.[4] The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

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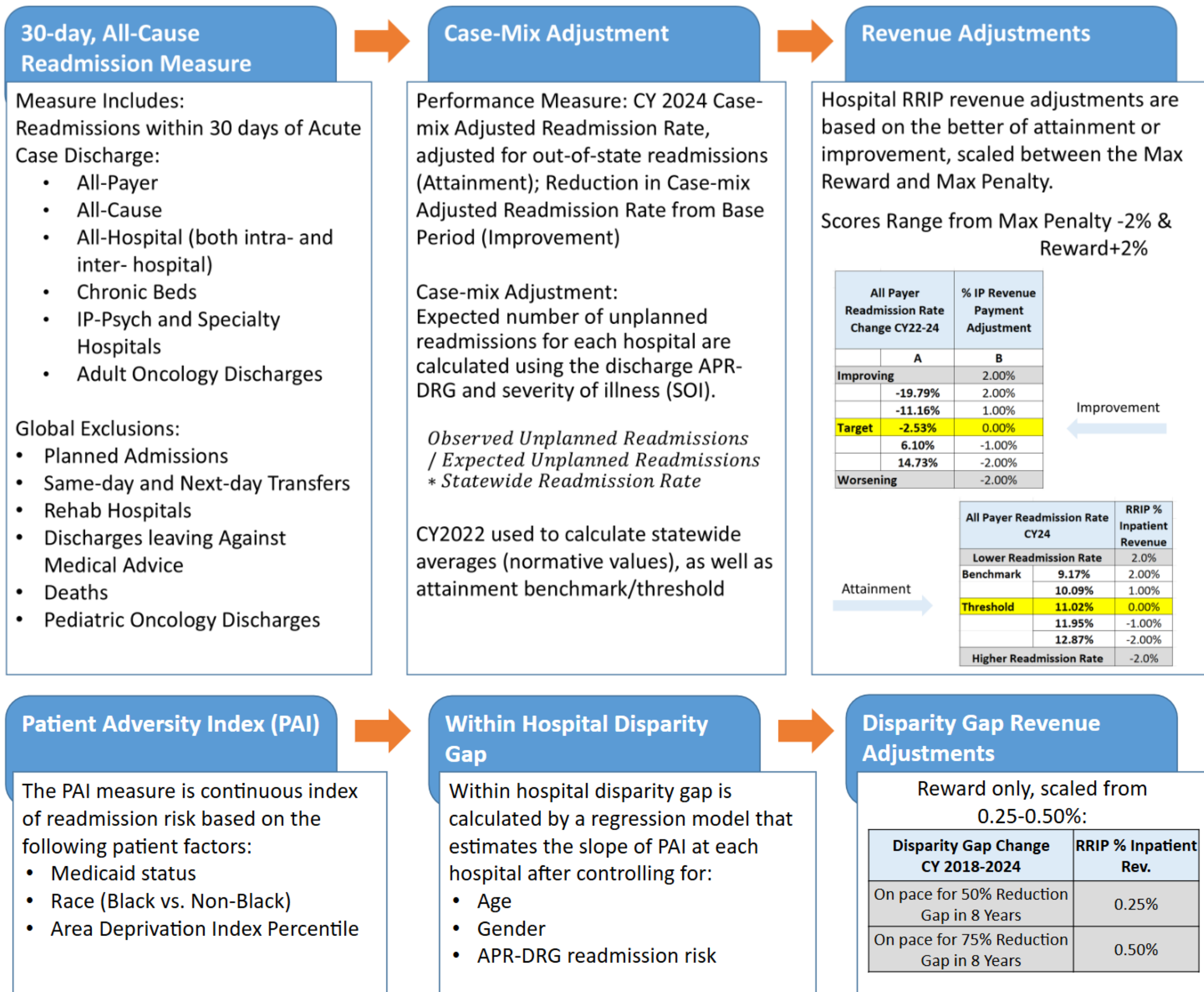
[2] Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.
[3] For more information on the HRRP, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program
[4] See Appendix I for details on the current RRIP methodology.

Figure 1. RRIP Methodology RY26



Assessment

For RY 2027, the main policy decision is to determine the base period from which to assess improvement for CY 2025 readmission rates. In order to assess the most appropriate base year for improvement, this section assesses readmissions performance and provides improvement scenarios for consideration. While there are no proposed changes to the readmission measure, staff is recommending that additional analytics continue to be conducted over the coming year to assess hospital revisits to the emergency department and/or observation, which staff believes will

complement some of the other workstreams the Commission currently is engaging in to improve emergency room length of stay and address concerns raised by CMMI about higher use of observation status in Maryland. Finally, staff provides performance on the disparity gap measure and recommends to continue this targeted focus on high adversity patients.

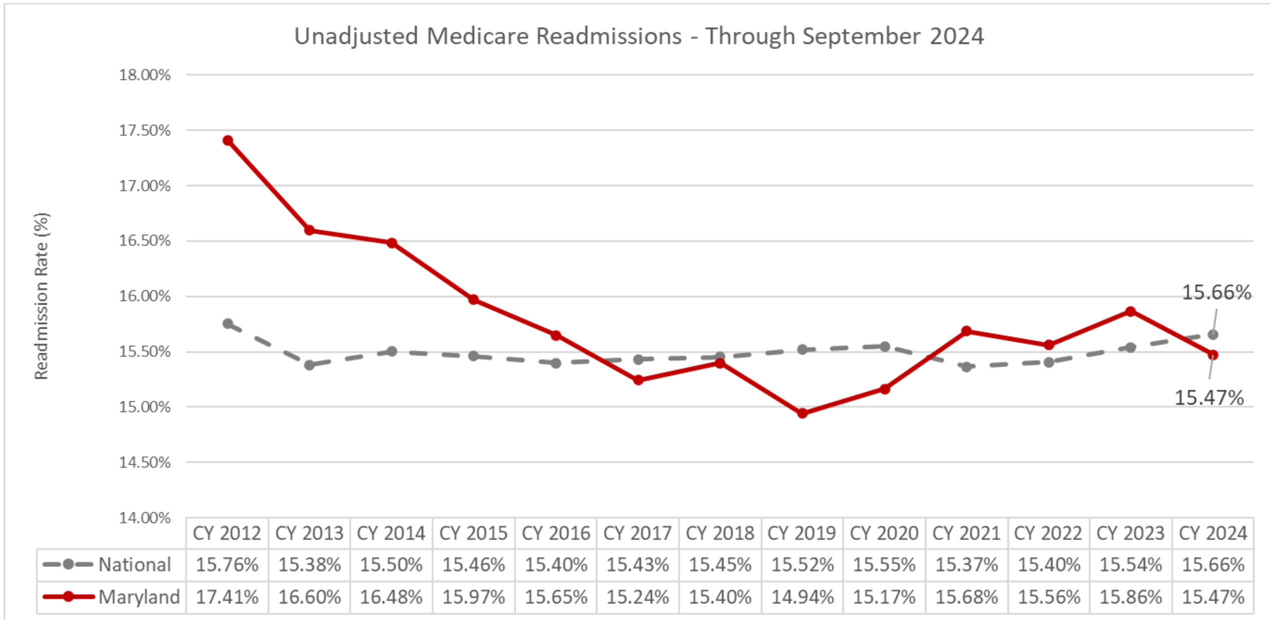
Current Statewide Year To Date Performance

Readmission performance is assessed in several ways. First, we present data on the unadjusted, all-cause Medicare Readmission Rate (the original "Waiver Test"), which shows that Maryland currently has a slightly lower unadjusted readmission rate than the nation. Next, Maryland and the Nation's performance within the Hospital-Wide Readmission measure is presented (the new "Waiver Test"). Last, we present the all-payer, case mix adjusted readmission results used for the RRIP.

Medicare FFS Performance

At the end of 2018, Maryland had an unadjusted FFS Medicare readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This is the measure that CMMI used to assess Maryland's successful performance on readmissions under the All-payer Model. Under the TCOC model, Maryland is required to maintain a Medicare FFS readmission rate that is below the nation. The most recent readmission data, which is presented in Figure 2, shows Maryland's readmission rate at 15.47 percent which is slightly lower than the Nation's performance at 15.66 percent.

Figure 2. Maryland and National Medicare FFS Unadjusted Readmission Rates



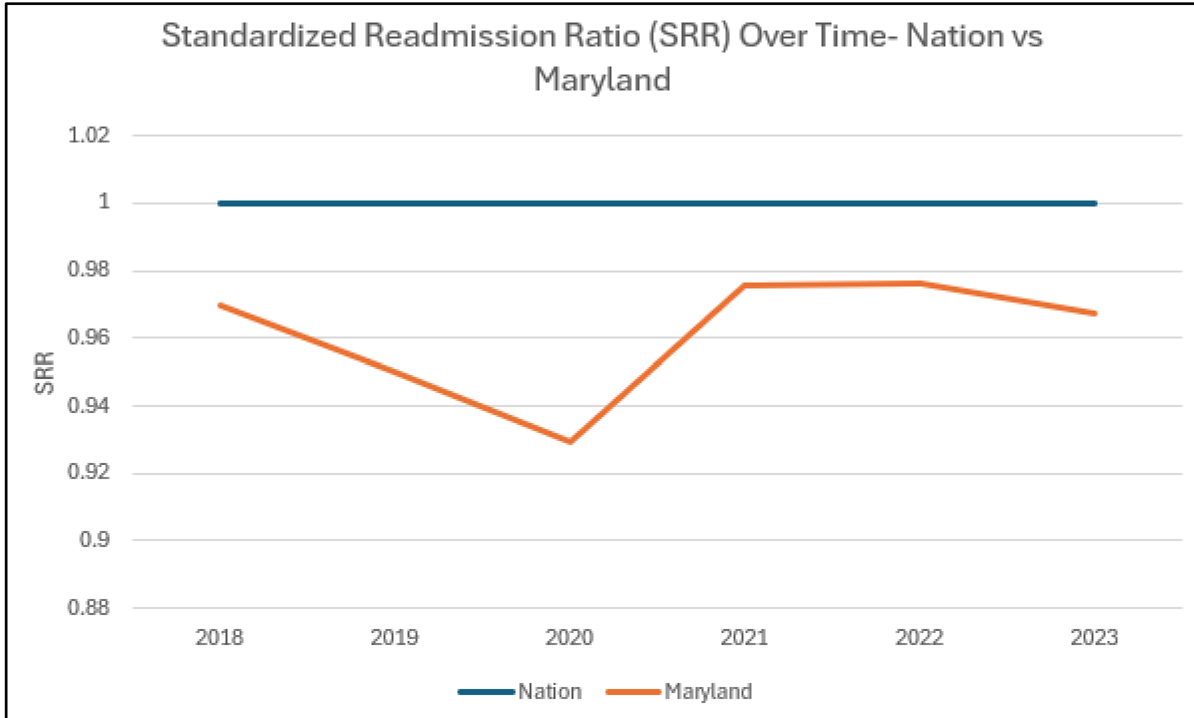
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.54%	15.66%
Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.86%	15.47%

Hospital Wide Readmission Measure Performance

Below in Figure 3, Maryland and the Nation's performance within the HWR measure is presented. The presented statistic is the Standardized Risk Ratio which indicates how observed readmission rates compare to the expected rates; a ratio less than 1 indicates lower than expected readmission rates. Since Maryland's SRR and confidence intervals for all years[5] are below 1, the State performed better than the Nation within this measure in CYs 2018-2023.

[5] When this analysis was provided to Staff, Lewin was in the process of calculating 2018 confidence intervals, but the 2018 SRR was 0.9700, which is also better than the Nation's.

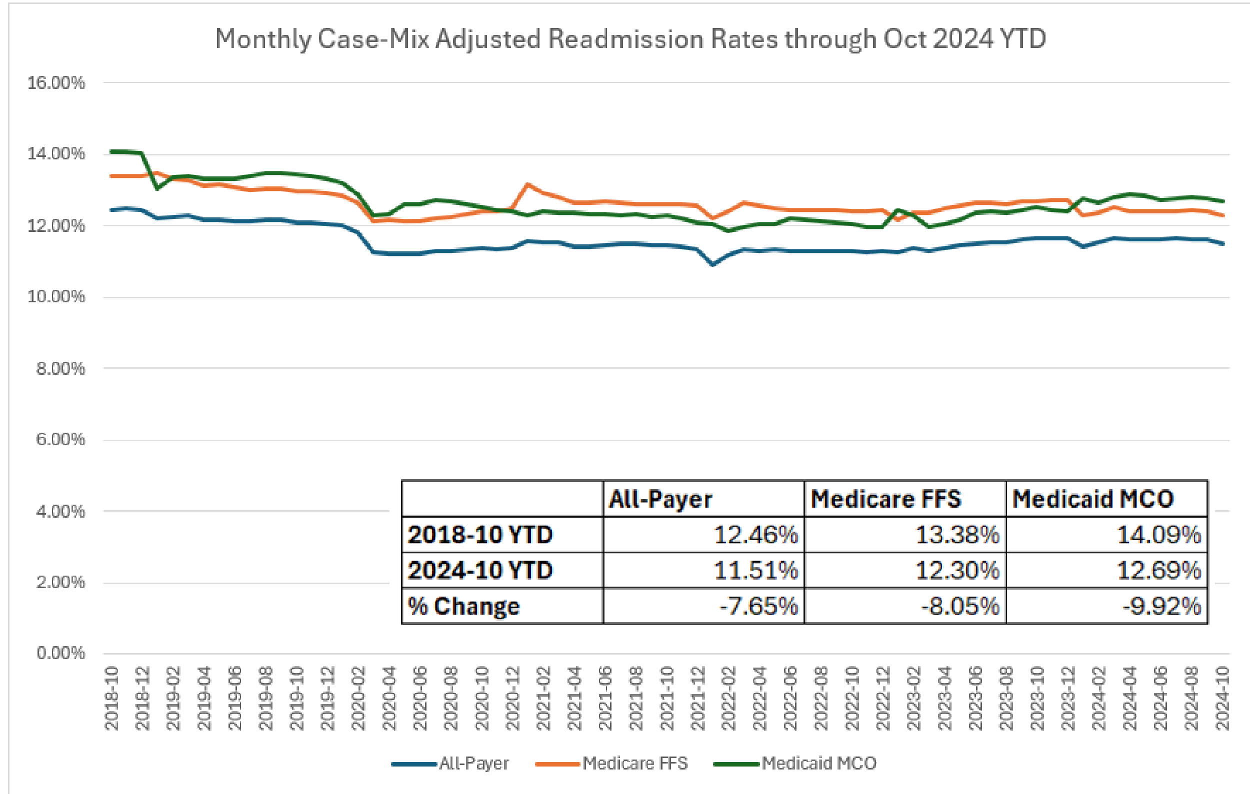
Figure 3. Maryland and National Medicare FFS Hospital-Wide Readmission Measure Performance



All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 4, with All-payer, Medicare FFS, and Medicaid MCO readmission reductions of 7.65 percent, 8.05 percent and and 9.92 percent from October 2018 YTD respectively.

Figure 4. Statewide Improvement in Case-Mix Adjusted Readmission Rates by Payer, October 2018 YTD through October 2024 YTD



	All-Payer	Medicare FFS	Medicaid MCO
2018-10 YTD	12.46%	13.38%	14.09%
2024-10 YTD	11.51%	12.30%	12.69%
% Change	-7.65%	-8.05%	-9.92%

The RY 2026 RRIP program assesses improvement from CY 2022 to CY 2024, and attainment performance in CY 2024 based on historical standards. As illustrated in Figure 5 below, 13 hospitals are on target to reach the improvement goal of 2.53 percent, and as shown in Figure 6, 7 hospitals are on target to have a readmission rate below the threshold of 11.02 percent. Hospitals performing well on both improvement and attainment will receive a revenue adjustment equal to the better of these evaluations, in line with the policy aim of simultaneously incentivizing excellent performance and constant improvement. Overall there are 14 unique hospitals on track to receive a scaled reward for CY 2024 performance, which concerns staff given that the State performs better than the Nation on an unadjusted basis and that the overall improved performance relative to the Nation is not driven by improvement of a few large facilities (i.e., some of the largest facilities have higher/worse readmission rates in 2024 than they did in CY 2022

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despite the State performing better than the Nation over the same time period). CY 2024 YTD performance indicates that most hospitals are experiencing an increase in readmissions from CY 2022 (N=26/43), as illustrated in Figure 5 below. To address this concern, staff, with input from the PMWG, is recommending changing the base period which is discussed further in the next section.

Figure 5. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2022-YTD 2024

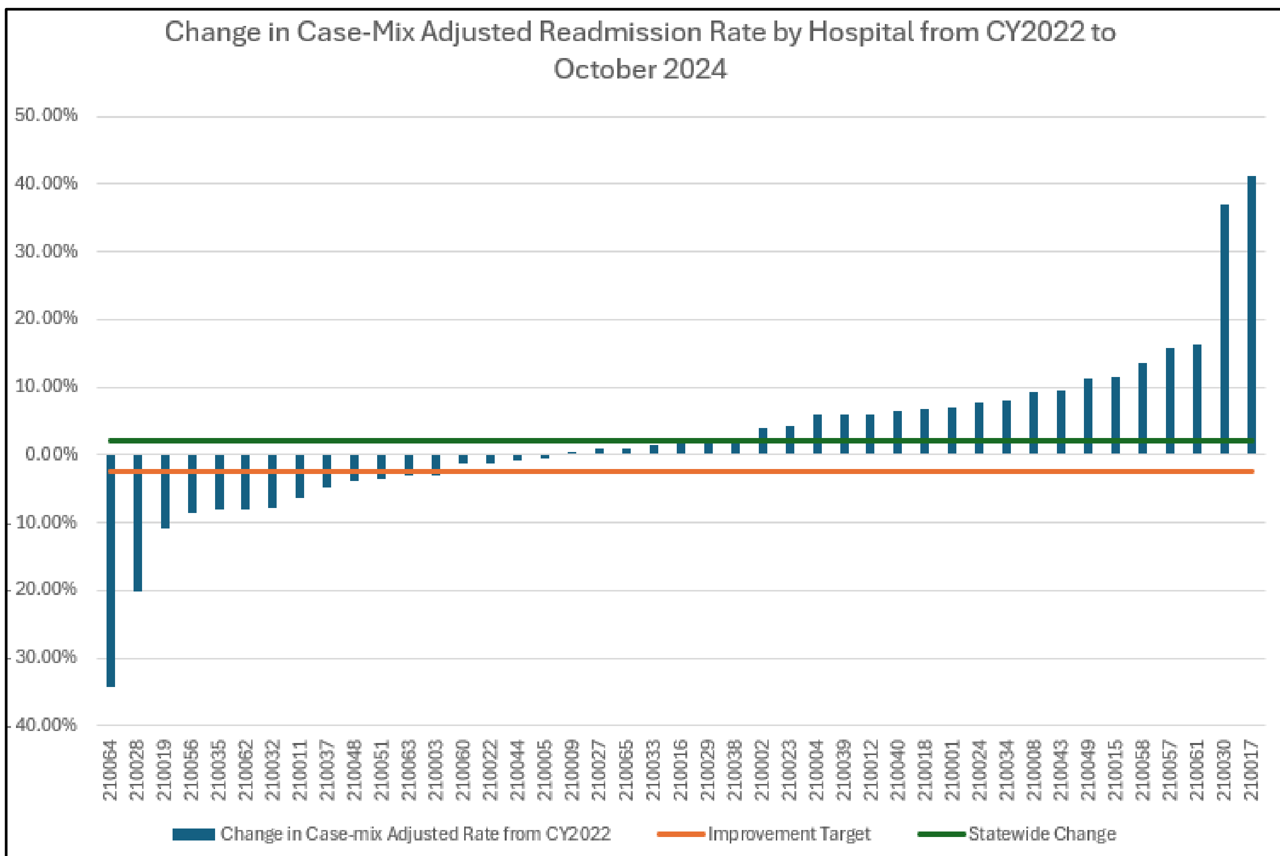
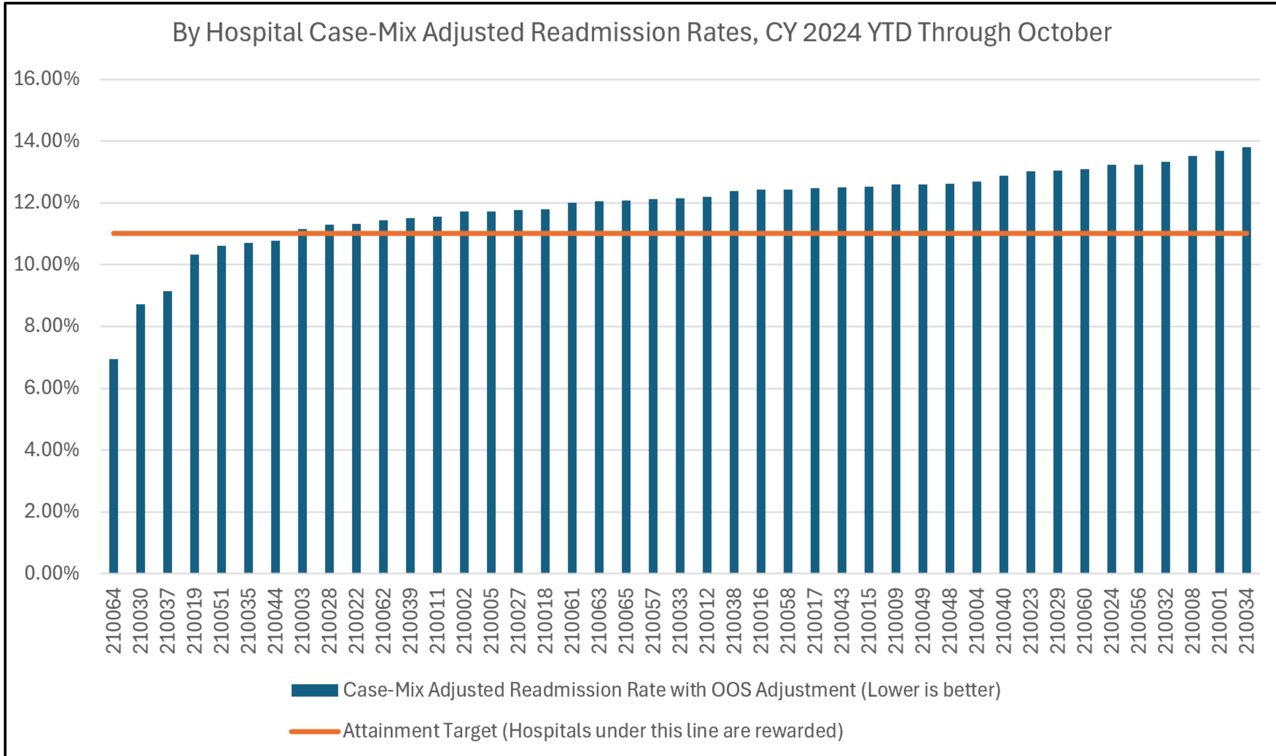


Figure 6. By-Hospital Case Mix Adjusted Readmission Rates, YTD 2024



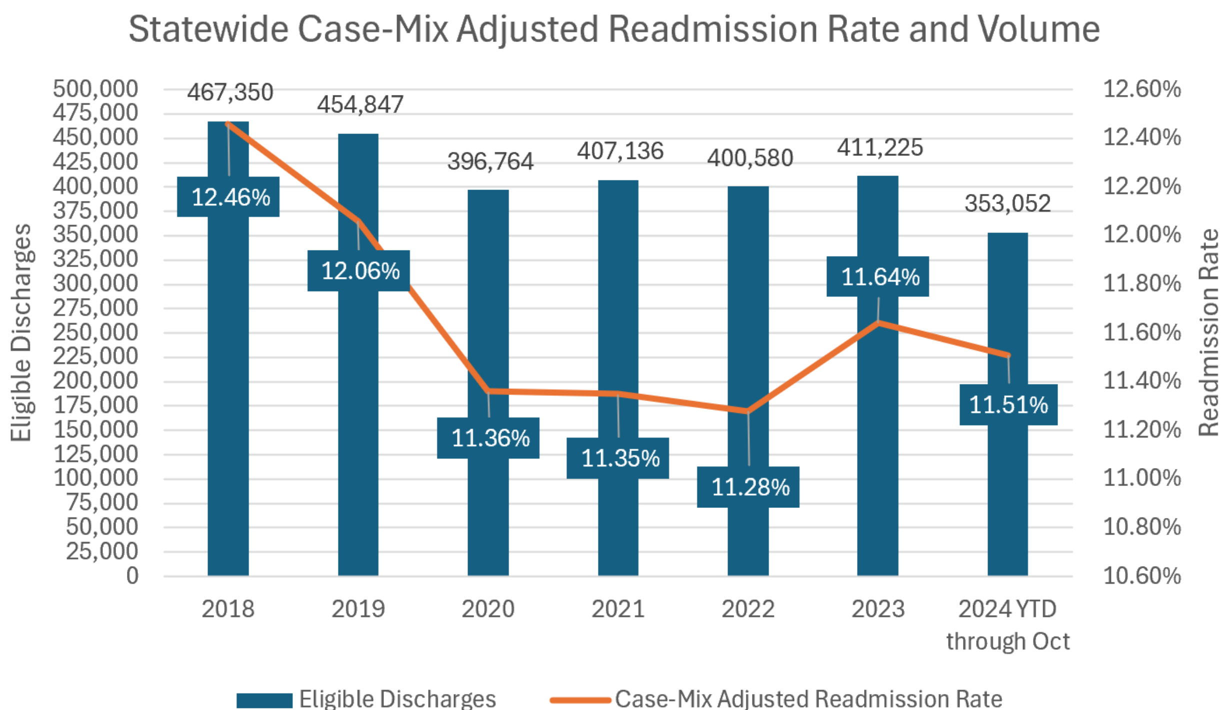
Base Period Concerns

Historically, readmission improvement has been measured over multiple years with a fixed base (e.g., 2013-2018 in the All-Payer Model, 2018-2023 in the TCOC Model). This was used to address concerns that hospitals may not be able to make incremental annual improvements and so that large improvements in one year that are maintained receive credit under the policy. In the RY 2026 policy, a 5 percent improvement target over 4 years from 2022 to 2026 was approved.

Under the RY 2026 policy, hospitals have worse performance in the RRIP than has been seen in previous years and hospitals have raised whether using a static year to assess improvement (unlike other quality programs) is appropriate in general and whether CY 2022 is a representative year to use in particular. Members of PMWG expressed concern with the use of CY 2022 as the base period due to its historically low volumes and low readmission rate, which is illustrated in

Figure 7 below.[6] Staff agrees with the concerns expressed by the stakeholder workgroup and is recommending a blended base period of CY 2022 and CY 2023 for the RY 2027 policy and to apply this base period retroactively to the RY 2026 policy, which also uses CY 2022 as the base period. This recommendation is the only deviation from last year's approved policy. Future iterations of the policy, which will have to consider rebasing due to a new statewide improvement goal, may consider rebasing beyond CY 2022 and CY 2023

Figure 7. Statewide Case-Mix Adjusted Readmission Rate, CY 2018-2024 YTD

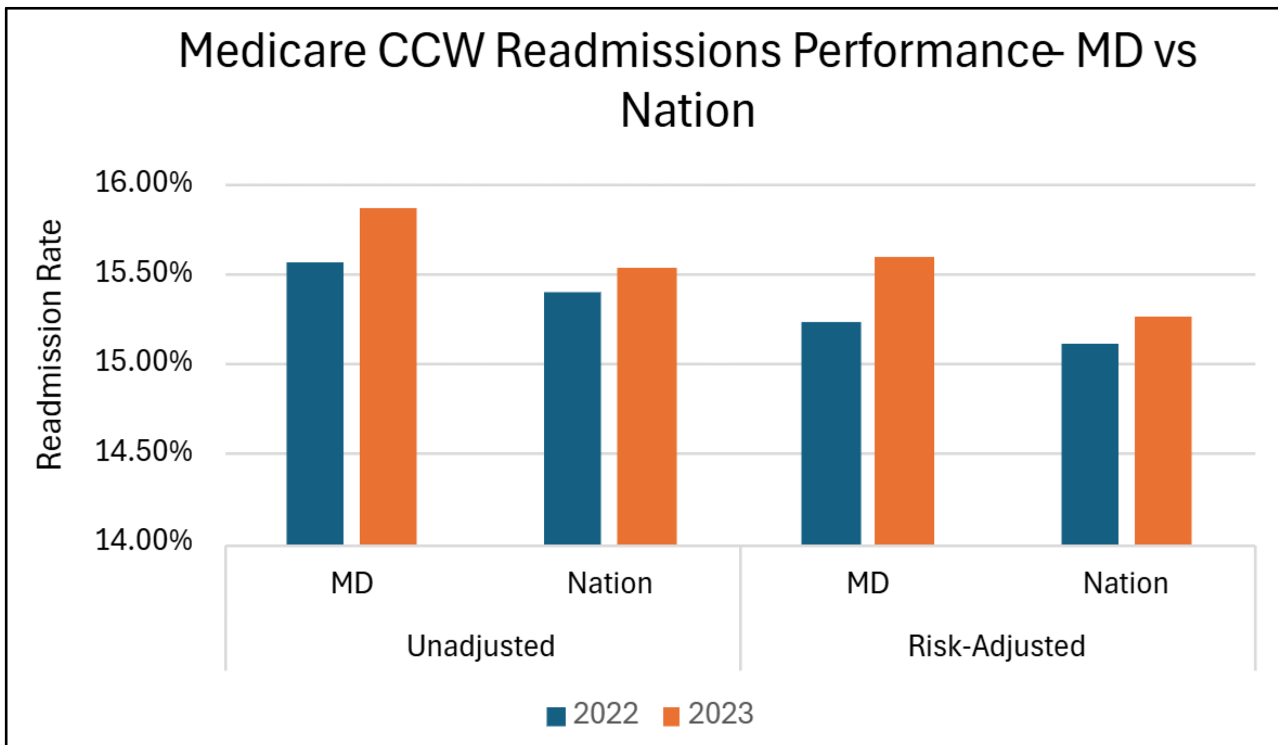


As shown below in Figure 8, both Maryland and the Nation experienced a degradation in readmission rates in CY 2023 on both an unadjusted and risk-adjusted basis. While both the Nation and the State saw a degradation in readmission rates from CY 2022 to CY 2023, the State saw a greater degradation while simultaneously performing worse than the Nation in both years, which led staff to reject the idea of moving the base period to CY 2023. Staff believes that blending CY 2022 and CY 2023 takes into account the secular degradation in readmission rates

[6] Due to the COVID-19 PHE, CY 2020 readmission performance has not been evaluated in RRIP policies and therefore should not be considered as a potential base period.

that occurred in CY 2023 without excusing the worsening rates and poor performance compared to the Nation. Further, blending CY 2022 and CY 2023 for the base period provides more stable norms by using a longer time period to establish them; this approach was approved in the RY 2021 MHAC policy to address an identical concern of unstable rates.[7] Modelled revenue adjustments with base period of CY 2022 only and a blended two year base period for RY 2026 YTD and estimated RY 2027 are presented in Appendix II.

Figure 8. Maryland and National Readmissions Performance, Unadjusted and Risk-Adjusted[8]



Revisits to Emergency Department and Observation Stays

Improvement in readmission rates under the model should result in better patient experience. However, the current readmission measure only counts a readmission if the patient returns to the hospital and is admitted into an inpatient bed. Thus, revisits to the emergency department or for

[7] RY 2021 MHAC Policy, two year base period decision is detailed on pages 20-21.

[8] The unadjusted readmission rates are provided monthly by CMMI. The risk-adjusted rates presented here are HSCRC calculated based on CCW data for all ages captured and risk-adjusted for 38 Elixhauser comorbidity flags (ICD-10 Version) and not the newer CMMI risk adjusted measure as we do not have 2024 readmission rates under this methodology.

an observation stay after an initial inpatient admission are not considered; revisits that occur after an initial or index ED visit or an observation stay are also not considered. This potentially has an impact on hospital throughput and ED boarding as ED hospital staff have anecdotally indicated that they are doing more testing and diagnostics in the ED that previously may have been done during the inpatient admission to determine whether an admission is really necessary. While this might be appropriate clinically, if these revisits represent quality of care or care coordination concerns, these are not being identified for payment incentives at this time (only exception is PAU, which includes observation stays >=24 hours as inpatient stays). When staff looked at this previously for just observation stays, we found that while readmission rates increased when observation stays were included, the correlation between the readmission rates with and without observation stays was 0.986 in 2018. More recently, staff have been working with MPR to explore observation revisits on a risk-adjusted basis and continue to discuss with stakeholders and experts the clinical rationale for observation use. Also, it should be noted that at this time the national program does not include observation stays in their readmission measures. Thus for RY 2027, staff recommends that the RRIP readmission measure remain an inpatient only measure. However, staff is continuing to assess this issue to ensure that hospitals are not being rewarded for “gaming” through use of observation, discuss clinical and operational factors impacting patient status during revisits, and will continue to collaborate with CMMI to better understand observation use in Maryland. As discussed below in the AHEAD section, the inclusion of observation is recommended by CMMI so staff will need to address this concern in the coming year. .

Excess Days in Acute Care (EDAC)

As discussed above, stakeholders remain concerned about emergency department and observation revisits, especially given the global budget incentives to avoid admissions. Another approach for addressing this issue would be to adopt the Excess Days in Acute Care measure into payment. The EDAC measure captures the number of days that a patient spends in the hospital within 30 days of discharge, and includes emergency department and observation stays by assigning ED visits a half-day length of stay and assigning observation hours rounded up to

half-day units.[9] Staff have worked with our methodological contractor to adapt the Medicare Excess Days in Acute Care (EDAC) condition-specific measures to an all-cause, all-payer measure for potential program adoption in future years. This work was completed and monitoring reports for this measure are posted on the CRISP portal on a monthly basis for hospital monitoring and input. However, the EDAC measure has been criticized by some PMWG members because of the time element associated with the readmission. Specifically, the concern is that readmissions with a longer length of stay (which would represent worse performance) may indicate a less preventable readmission. While staff will consider this concern, it could also be countered that a longer readmission represents a more serious quality of care issue from the initial admission. As staff continue to assess observation revisits, EDAC should be monitored.

Digital Measures/Electronic Clinical Quality Measure (eCQM)

Under the Inpatient Quality Reporting program, CMS transitioned from the claims-based 30-day Hospital Wide Readmission (HWR) measure to the digital Hybrid HWR measure. Initially, the July, 1 2023-June 30, 2024 reporting of the hybrid measure for Medicare patients for Federal Fiscal Year 2026 payment year was mandatory; however, CMS shifted the requirement to be voluntary reporting, with mandatory reporting postponed to the July 2024 to June 2025 reporting period. The HWR 30-day readmission hybrid measure merges electronic health record data elements with a set of 13 Core Clinical Data Elements (CCDE) consisting of six vital signs and seven laboratory test results; hospitals must map these 13 CCDE to the patient electronic health record (EHR). The claims and CCDE data are then submitted and used to calculate measure results. For the initial year beginning July 1, 2023, HSCRC required hospitals to submit the hybrid HWR measure data to the State for Medicare patients. Beginning with July 1, 2024 discharges, Maryland expanded the measure submission to include all-payers and patients aged 18 and above. To prepare for this update, CRISP and Medisolv (CRISP's digital measure subcontractor) have updated the data collection infrastructure and are ready to receive data on the expanded measure with the first submission scheduled to begin in January 2025. However, some hospitals and stakeholders have previously signaled that some hospitals' EHRs may not be ready to submit data on the expanded measure. HSCRC staff will continue to monitor the issues voiced by

[9] Additional information on the EDAC measures and methodology can be found here: https://www.qualitynet.org/inpatient/measures/edac/methodology

hospitals and identify strategies as needed to progress on expansion of the Hybrid measure, and will also consider options for augmenting the RRIP all-payer measure with EHR data elements in the future.

Reducing Disparities in Readmissions

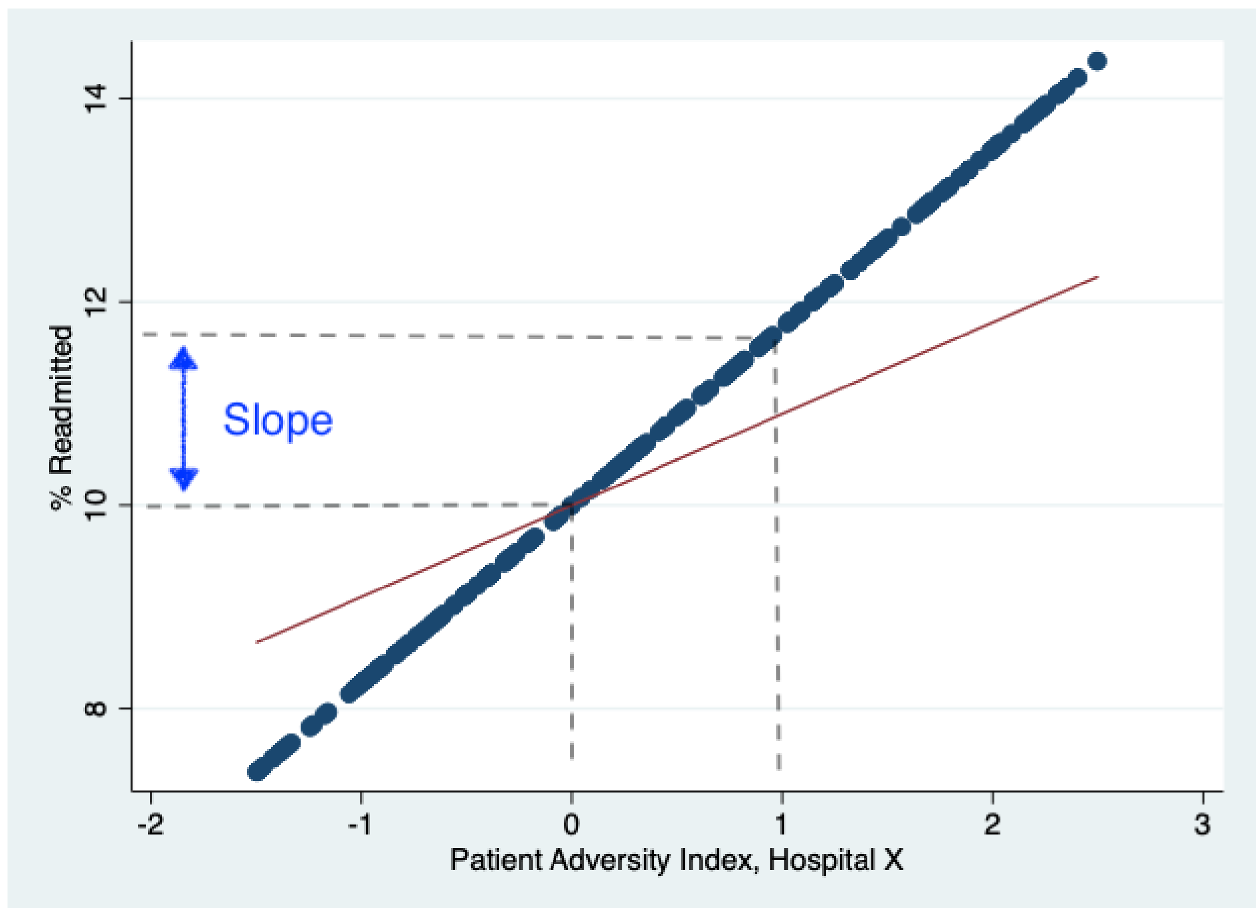
Racial and socioeconomic differences in readmission rates are well documented[10,11] and have been a source of significant concern among healthcare providers and regulators for years. In Maryland, the 2018 readmission rate for Blacks was 2.6 percentage points higher than for whites, and the rate for Medicaid enrollees was 3.4 points higher than for other patients. A 2019 Annals of Internal Medicine paper co-authored by HSCRC staff[12] reported a 1.6 percent higher readmission rate for patients living in neighborhoods with increased deprivation. Maryland hospitals, as well as CMS and the Maryland Hospital Association, identify reduction in disparities as a key priority over the near term. Thus, staff developed and the Commission approved adding a within-hospital disparity gap improvement goal to the RRIP in RY2021.

Specifically, the RRIP within hospital disparity methodology assesses patient-level socioeconomic exposure using the Patient Adversity Index (PAI), a continuous measure that reflects exposure to poverty, structural racism, and neighborhood deprivation. As shown in Figure 9, the relationship between PAI and readmissions is then assessed for each hospital for the base and performance period, and improvements in the slope of the line or in the difference in readmission rates at two points on the line (e.g., PAI = 1 vs PAI = 0) are compared for the base and performance period to calculate improvement. Hospitals that improve on the within hospital disparity gap and improve on overall readmissions, are eligible for a scaled reward up to 0.50 percent of inpatient revenue. Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.[13]

[10] Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. *Ann Surg*. 2014;259(6):1086–1090. doi:10.1097/SLA.0000000000000326;
[11] Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.
[12] Jencks, Stephen F., et al. "Safety-Net hospitals, neighborhood disadvantage, and readmissions under Maryland's all-payer program: an observational study." Annals of internal medicine 171.2 (2019): 91-98.

[13] RY 2021 RRIP Policy

Figure 9. Hypothetical Example of Relationship between PAI and Readmission Rates



The RRIP disparity gap improvement goal was set through the end of the TCOC model (CY2026) and aligns with one of the goals in the Statewide Integrated Improvement Strategy. The SIHIS goal is to have half of eligible hospitals achieve a 50 percent reduction in readmission disparities. CY 2023 data shows that 22 hospitals saw a reduction in their within-hospital disparities in readmissions, ranging from a 0.55% reduction to a 34.87% reduction, compared to CY 2018. Through the RY2025 RRIP-Disparity Gap Program (CY 2023 performance), scaled rewards were provided to two of these hospitals for reducing their disparities in readmissions by the required

minimum of 29.29 percent while simultaneously reducing their overall readmission rate; the range of revenue adjustments was 0.27 percent to 0.32 percent for a statewide total of about $1.8 million in rewards.

The State remains committed to ensuring hospitals are advancing health equity by continuing to financially incentivize reductions in disparities through the Readmissions Reduction Incentive Program (RRIP) policy and other policies. The ability to set hospital payment incentives specifically for advancing health equity is an important hallmark of the TCOC Model and exemptions from national quality programs. In the RY 2026 Quality Based Reimbursement program, this disparity gap methodology was adapted to the Timely Follow-Up post hospitalization measure and the Commission approved financial incentives for reductions in disparities in follow up for Medicare patients.

For RY 2027, the RRIP disparity gap draft recommendation uses the previously calculated improvement targets pushed forward to CY 2025 performance.

AHEAD Model Considerations

The AHEAD model will begin on January 1st, 2026. As part of the AHEAD model, the state must set Statewide Quality and Equity targets for five mandatory domains and one optional domain. As shown in Table 1 below, CMMI has provided recommended measures for each of the domains. Within the Utilization and Quality Domain, CMMI has recommended readmissions as the measure and at this time the HSCRC and MDH are not proposing a different area of focus for this domain (i.e., State is in agreement to focus on readmissions). However, CMMI has specifically recommended that the National Committee for Quality Assurance's Plan All-Cause Readmission (NCQA PCR) measure be used by AHEAD states to assess statewide performance over the 9-year model. Currently, HSCRC staff are working with Maryland Department of Health, Maryland Commission on Health Equity's Data Advisory Committee, and contractors to review the NCQA PCR measure specifications in comparison to the RRIP, CMS HWR measure, and the current CMMI developed readmission measure for MD. Based on this assessment, the state will need to pick a readmission measure and develop biannual statewide targets for improvement. The NCQA readmission measure differs from the RRIP and HWR measure in that it includes observation

stays as eligible for a readmission and as a readmission from inpatient. Other differences include differences in inclusion/exclusion criteria and risk adjustment approach. In addition, the data source (claims from payers, HSCRC case-mix) for calculating the readmission measure needs to be determined. Currently staff plan to assess whether it is feasible to use the NCQA specifications with the HSCRC case-mix data and if modifications would need to be made. Staff are also working to compare Medicare results using claims versus HSCRC case mix data. The advantage of using HSCRC case mix data is that it is more timely than claims and is thus used for RRIP so that hospitals can monitor progress during the performance year. However, CMMI will need to approve any measure adaptations to the NCQA readmission measure, including changes to the type of data used to calculate the measure, or approve the use of an alternative measure for this domain through the process outlined in the CMMI contract with Maryland. Ultimately, the staff believes that the RRIP measure and goals should be aligned with the statewide targets as much as possible, while recognizing there may be reasons to have a more aggressive hospital target (e.g., front loading of improvement, need to ensure statewide target is met). Thus, in future years, staff recommends that the RRIP policy be updated to provide as much alignment as possible, set goals for hospitals to try and ensure that the statewide improvement goal is met, while maintaining the ability to provide hospitals with performance results during the performance period.

Table 1.

	Domain	Measure
1	Population Health	● CDC HRQOL- 4 Health Days Core Module
2	Prevention and Wellness *Choose at least 1 measure*	● Colorectal Cancer Screening (CCS-AD) ● Breast Cancer Screening: Mammography (BCS-AD)
3	Chronic Conditions *Choose at least 1 measure*	● Controlling High Blood Pressure (CBP-AD) ● Hemoglobin A1c Control for Patients with Diabetes (HBDAD)
4	Behavioral Health	● Use of Pharmocotheraphy for Opioid

	Choose at least 1 measure	Use Disorder ● Antidepressant Medication Management (AMMAD) ● Follow-Up After Hospitalization for Mental Illness (FUHAD) ● Follow-Up After ED Visit for Substance Use
5	Health Care Quality and Utilization	● Plan All-Cause Unplanned Readmission (PCRAD)
Must choose at least 1 focus area		
6	Focus Area 1- Maternal Health Outcomes *Choose at least 1 measure*	● Live Births Weighing Less Than 2500 Grams (LBWCH) ● Prenatal and Postpartum Care: Postpartum care (PPC-AD)
	Focus Area 2- Prevention Measures *Choose at least 1 measure*	● Adult Immunization Status ● Prevalence of Obesity ● Medical Assistance with Smoking and Tobacco Use Cessation (MSC) ● ED Visits for Alcohol and Substance Use Disorders
	Focus Area 3- Social Drivers of Health *Choose at least 1 measure*	● Food Insecurity ● Housing Quality

Recommendations

These are the draft recommendation for the Maryland Rate Year (RY) 2026 Readmission Reduction Incentives Program (RRIP):

1. Maintain the all-payer, 30-day, all-cause readmission measure.
2. Improvement Target - Maintain the statewide 4-year improvement target of -5.0 percent through 2026 with a blended base period of CY 2022 and CY 2023
3. Retroactively apply a blended base period of CY 2022 and CY 2023 to the RY 2026 policy

4. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
5. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
6. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
    a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
    b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
7. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in the RRIP program.
8. Update the RRIP policy in future years to align with statewide AHEAD model goals for readmissions.

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Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology

Introduction: RRIP Redesign Subgroup

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
    - Case-mix adjustment acknowledges increased severity of illness over time
    - Standard Deviation analysis of Eligible Discharges suggests that further reduction in
    - readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
    - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
    - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
    - Include Oncology Discharges with more nuanced exclusion logic
    - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
    - 7.5 percent Improvement over 5 years (2018-2023)
    - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
    - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
    - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
    - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
    - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

Methodology Steps

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.[14] Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.[15] Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.[16]
- Exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.[17]
- Exclude patients with a discharge disposition of Left Against Medical Advice (PAT_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.

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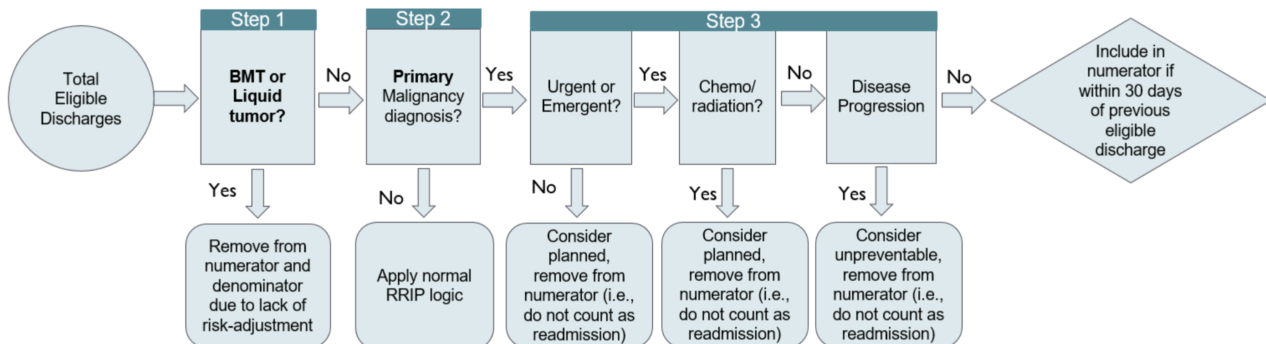
[14] Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].
[15] **Rehab** DRGs: 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs**: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[16] **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.
[17] **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.
      HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

Step 1: Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure which risk-adjusts for bone marrow transplant and liquid tumors. HSCRC staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

Step 2: Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff think we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

Step 3: Flag planned admissions using additional criteria beyond the CMS planned admission logic:

a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:
To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2023 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. CY 2022 data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

SOFTWARE: APR-DRG Version 42 for CY 2018-CY 2025.

Calculation:

Case-Mix Adjusted Readmission Rate = (Observed Readmissions) / (Expected Readmissions) * Statewide Base Year Readmission Rate

Numerator: Number of observed hospital-specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

Calculate the Statewide Readmission Rate without Planned Readmissions.

- Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals,

given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of eligible discharges
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital’s DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

Expected Value Computation Example – Individual APR-DRG

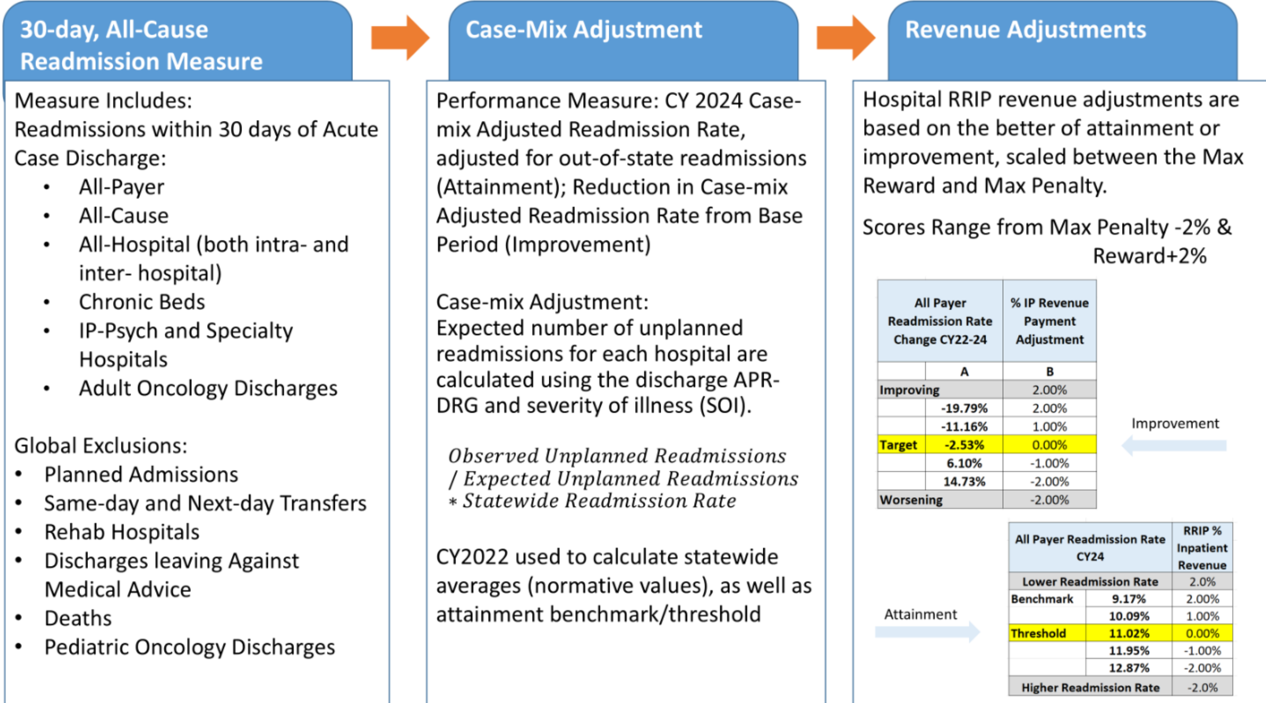
A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
Total	**500**	**45**	**.09**		**56.5**

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E) The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

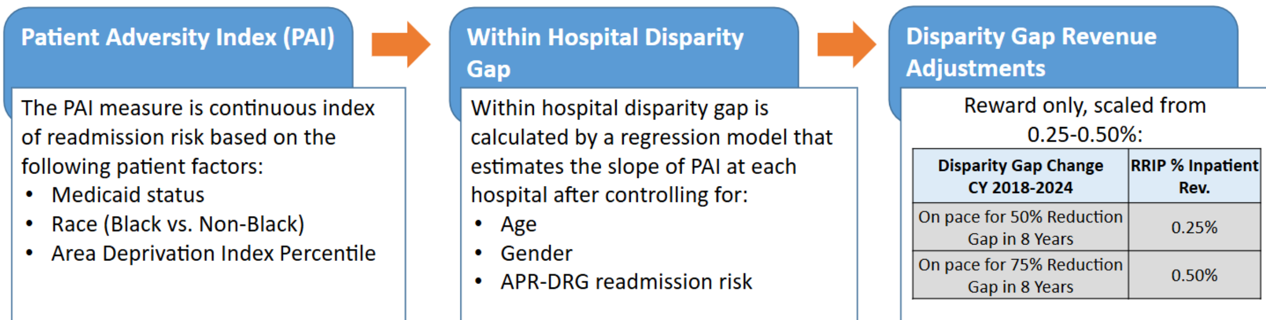
4) Revenue Adjustment Methodology

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 2 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2026 RRIP methodology for reference.



	All Payer Readmission Rate Change CY22-24	% IP Revenue Payment Adjustment
	A	B
Improving		2.00%
	-19.79%	2.00%
	-11.16%	1.00%
Target	-2.53%	0.00%
	6.10%	-1.00%
	14.73%	-2.00%
Worsening		-2.00%

All Payer Readmission Rate CY24		RRIP % Inpatient Revenue
Lower Readmission Rate		2.0%
Benchmark	9.17%	2.00%
	10.09%	1.00%
Threshold	11.02%	0.00%
	11.95%	-1.00%
	12.87%	-2.00%
Higher Readmission Rate		-2.0%



Disparity Gap Change CY 2018-2024	RRIP % Inpatient Rev.
On pace for 50% Reduction Gap in 8 Years	0.25%
On pace for 75% Reduction Gap in 8 Years	0.50%

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Appendix II. Modelled RY 2026 and RY 2027 Revenue Adjustments

RY 2026 YTD Modelled Revenue Adjustments, CY 2022 Base Period vs CY 2022 & 2023 Base Period

			CY 2022 Base			CY22/23 Blended Base		
			Modelled Adjustment			Modelled Adjustment		
HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	$ Better of Attainment or Improvement	RY 25 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	$251,995,786	-$2,696,355	-1.07%	Imp	-$2,393,960	-0.95%	Imp
210002	UMMS-UMMC	$1,473,072,120	-$13,846,878	-0.94%	Att	-$5,450,367	-0.37%	Att
210003	UMMS-Capital Region	$309,492,831	-$680,884	-0.22%	Imp	$464,239	0.15%	Att
210004	Trinity - Holy Cross	$413,940,590	-$4,346,376	-1.05%	Imp	-$3,684,071	-0.89%	Imp
210005	Frederick	$254,562,530	-$381,844	-0.15%	Imp	-$1,603,744	-0.63%	Att
210008	Mercy	$220,664,524	-$3,199,636	-1.45%	Imp	-$2,030,114	-0.92%	Imp
210009	JHH- Johns Hopkins	$1,818,903,395	-$5,274,820	-0.29%	Imp	-$3,637,807	-0.20%	Imp
210011	St. Agnes	$254,764,484	$1,120,964	0.44%	Imp	-$101,906	-0.04%	Imp
210012	Lifebridge-Sinai	$519,012,883	-$4,982,524	-0.96%	Imp	-$4,515,412	-0.87%	Imp
210015	MedStar-Franklin Square	$371,862,302	-$6,544,777	-1.76%	Imp	-$4,536,720	-1.22%	Att
210016	Adventist-White Oak	$242,890,872	-$922,985	-0.38%	Imp	-$48,578	-0.02%	Imp
210017	Garrett	$28,988,189	-$579,764	-2.00%	Att	-$579,764	-2.00%	Att
210018	MedStar-Montgomery	$96,052,028	-$1,258,282	-1.31%	Att	-$1,181,440	-1.23%	Att
210019	Tidal-Peninsula	$350,375,491	$4,169,468	1.19%	Imp	$4,134,431	1.18%	Imp
210022	JHH-Suburban	$249,484,035	-$99,794	-0.04%	Imp	$948,039	0.38%	Imp
210023	Luminis-Anne Arundel	$367,930,454	-$2,943,444	-0.80%	Imp	-$3,164,202	-0.86%	Imp
210024	MedStar-Union Mem	$267,917,283	-$3,188,216	-1.19%	Imp	-$1,366,378	-0.51%	Imp
210027	Western Maryland	$183,379,829	-$696,843	-0.38%	Imp	-$825,209	-0.45%	Imp
210028	MedStar- St. Mary's	$100,479,485	$1,969,398	1.96%	Imp	$1,406,713	1.40%	Imp
210029	JHH- Bayview	$471,786,218	-$2,736,360	-0.58%	Imp	-$3,208,146	-0.68%	Imp
210030	UMMS-Chestertown	$7,562,394	$151,248	2.00%	Att	$151,248	2.00%	Att
210032	ChristianaCare, Union	$84,802,922	$678,423	0.80%	Imp	$474,896	0.56%	Imp
210033	Lifebridge-Carroll	$162,844,959	-$602,526	-0.37%	Imp	-$65,138	-0.04%	Imp
210034	MedStar-Harbor	$128,234,465	-$1,782,459	-1.39%	Imp	-$1,141,287	-0.89%	Imp
210035	UMMS-Charles	$97,586,229	$800,207	0.82%	Imp	$985,621	1.01%	Imp
210037	UMMS-Easton	$123,617,439	$2,472,349	2.00%	Att	$2,027,326	1.64%	Att
210038	UMMS-Midtown	$140,418,656	-$688,051	-0.49%	Imp	$224,670	0.16%	Imp
210039	Calvert	$80,925,064	-$517,920	-0.64%	Att	-$388,440	-0.48%	Att
210040	Lifebridge-Northwest	$160,861,387	-$1,672,958	-1.04%	Imp	-$1,045,599	-0.65%	Imp
210043	UMMS-BWMC	$325,584,009	-$4,558,176	-1.40%	Imp	-$3,190,723	-0.98%	Imp
210044	GBMC	$263,774,655	$105,510	0.04%	Att	$184,642	0.07%	Att
210048	JHH- Howard County	$220,287,562	$704,920	0.32%	Imp	$594,776	0.27%	Imp
210049	UMMS-Upper Chesapeake	$236,862,562	-$3,766,115	-1.59%	Imp	-$2,108,077	-0.89%	Att
210051	Luminis-Doctors	$187,232,106	$1,142,116	0.61%	Att	$1,479,134	0.79%	Att
210056	MedStar-Good Sam	$186,628,391	$1,772,970	0.95%	Imp	$1,343,724	0.72%	Imp
210057	Adventist-Shady Grove	$333,973,100	-$4,341,650	-1.30%	Att	-$2,104,031	-0.63%	Att
210058	UMROI	$80,968,088	-$59,512	-0.07%	Att	-$1,295,489	-1.60%	Att
210060	Adventist-Ft. Washington	$37,782,970	-$226,698	-0.60%	Imp	-$298,485	-0.79%	Imp
210061	Atlantic General	$47,434,007	-$588,182	-1.24%	Att	-$493,314	-1.04%	Att
210062	MedStar-Southern MD	$210,921,411	$1,708,463	0.81%	Imp	$1,919,385	0.91%	Imp
210063	UMMS- St. Joe	$292,568,045	-$672,907	-0.23%	Imp	-$1,960,206	-0.67%	Imp
210064	Lifebridge-Levindale	$68,147,842	$1,362,957	2.00%	Att	$1,362,957	2.00%	Att
210065	Trinity - Holy Cross Germantown	$94,710,748	-$331,488	-0.35%	Imp	-$227,306	-0.24%	Imp
STATEWIDE		**$11,821,284,339**	**-$56,029,431**			**-$34,944,112**		
Penalty			-$74,188,424			-$52,645,913		
Reward			$18,158,993			$17,701,801		

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RY 2027 Modelled Revenue Adjustments, CY 2022 Base Period vs CY 2022 & 2023 Base Period

			CY 2022 Base			CY 2022/23 Blended Base		
			Final Adjustment			Final Adjustment		
HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	$ Better of Attainment or Improvement	RY 25 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	Meritus	$251,995,786	-$3,049,149	-1.21%	Imp	-$2,746,754	-1.09%	Imp
210002	UMMS- UMMC	$1,473,072,120	-$16,351,101	-1.11%	Att	-$7,365,361	-0.50%	Att
210003	UMMS- Capital Region	$309,492,831	-$1,145,123	-0.37%	Imp	$123,797	0.04%	Att
210004	Trinity - Holy Cross	$413,940,590	-$4,925,893	-1.19%	Imp	-$4,304,982	-1.04%	Imp
210005	Frederick	$254,562,530	-$763,688	-0.30%	Imp	-$1,934,675	-0.76%	Att
210008	Mercy	$220,664,524	-$3,530,632	-1.60%	Imp	-$2,339,044	-1.06%	Imp
210009	JHH- Johns Hopkins	$1,818,903,395	-$8,003,175	-0.44%	Imp	-$6,184,272	-0.34%	Imp
210011	St. Agnes	$254,764,484	$764,293	0.30%	Imp	-$458,576	-0.18%	Imp
210012	Lifebridge- Sinai	$519,012,883	-$5,761,043	-1.11%	Imp	-$5,242,030	-1.01%	Att
210015	MedStar- Franklin Square	$371,862,302	-$7,065,384	-1.90%	Imp	-$5,020,141	-1.35%	Att
210016	Adventist- White Oak	$242,890,872	-$1,287,322	-0.53%	Imp	-$412,914	-0.17%	Imp
210017	Garrett	$28,988,189	-$579,764	-2.00%	Att	-$579,764	-2.00%	Att
210018	MedStar- Montgomery	$96,052,028	-$1,431,175	-1.49%	Att	-$1,315,913	-1.37%	Att
210019	Tidal- Peninsula	$350,375,491	$3,678,943	1.05%	Imp	$3,643,905	1.04%	Imp
210022	JHH- Suburban	$249,484,035	-$449,071	-0.18%	Imp	$573,813	0.23%	Imp
210023	Luminis- Anne Arundel	$367,930,454	-$3,458,546	-0.94%	Imp	-$3,679,305	-1.00%	Imp
210024	MedStar- Union Mem	$267,917,283	-$3,590,092	-1.34%	Imp	-$1,768,254	-0.66%	Imp
210027	Western Maryland	$183,379,829	-$971,913	-0.53%	Imp	-$1,081,941	-0.59%	Imp
210028	MedStar- St. Mary's	$100,479,485	$1,828,727	1.82%	Imp	$1,255,994	1.25%	Imp
210029	JHH- Bayview	$471,786,218	-$3,396,861	-0.72%	Imp	-$3,915,826	-0.83%	Imp
210030	UMMS- Chestertown	$7,562,394	$151,248	2.00%	Att	$151,248	2.00%	Att
210032	ChristianaCare, Union	$84,802,922	$559,699	0.66%	Imp	$347,692	0.41%	Imp
210033	Lifebridge- Carroll	$162,844,959	-$846,794	-0.52%	Imp	-$309,405	-0.19%	Imp
210034	MedStar- Harbor	$128,234,465	-$1,961,987	-1.53%	Imp	-$1,333,638	-1.04%	Imp
210035	UMMS- Charles	$97,586,229	$663,586	0.68%	Imp	$849,000	0.87%	Imp
210037	UMMS-	$123,617,439	$2,336,370	1.89%	Att	$1,903,709	1.54%	Att
210038	UMMS- Midtown	$140,418,656	-$884,638	-0.63%	Imp	$14,042	0.01%	Imp
210039	Calvert	$80,925,064	-$647,401	-0.80%	Att	-$485,550	-0.60%	Att
210040	Lifebridge- Northwest	$160,861,387	-$1,898,164	-1.18%	Imp	-$1,270,805	-0.79%	Imp
210043	UMMS- BWMC	$325,584,009	-$5,013,994	-1.54%	Imp	-$3,679,099	-1.13%	Imp
210044	GBMC	$263,774,655	-$316,530	-0.12%	Att	-$131,887	-0.05%	Att
210048	JHH- Howard County	$220,287,562	$374,489	0.17%	Imp	$286,374	0.13%	Imp
210049	UMMS-Upper Chesapeake	$236,862,562	-$4,121,409	-1.74%	Imp	-$2,415,998	-1.02%	Att
210051	Luminis- Doctors	$187,232,106	$879,991	0.47%	Att	$1,273,178	0.68%	Att
210056	MedStar- Good Sam	$186,628,391	$1,493,027	0.80%	Imp	$1,063,782	0.57%	Imp
210057	Adventist- Shady Grove	$333,973,100	-$4,909,405	-1.47%	Att	-$2,504,798	-0.75%	Att
210058	UMROI	$80,968,088	-$78,944	-0.10%	Att	-$1,400,748	-1.73%	Att
210060	Adventist-Ft. Washington	$37,782,970	-$279,594	-0.74%	Imp	-$355,160	-0.94%	Imp
210061	Atlantic General	$47,434,007	-$673,563	-1.42%	Att	-$554,978	-1.17%	Att
210062	MedStar- Southern MD	$210,921,411	$1,392,081	0.66%	Imp	$1,624,095	0.77%	Imp
210063	UMMS- St.	$292,568,045	-$1,082,502	-0.37%	Imp	-$2,369,801	-0.81%	Imp
210064	Lifebridge- Levindale	$68,147,842	$1,362,957	2.00%	Att	$1,362,957	2.00%	Att
210065	Trinity - Holy Cross Germantown	$94,710,748	-$473,554	-0.50%	Imp	-$369,372	-0.39%	Imp
STATEWIDE		**$11,821,284,339**	**-$73,463,000**			**-$51,057,405**		
Penalty			-$88,948,411			-$65,530,991		
Reward			$15,485,411			$14,473,586		

February 3, 2025

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

Dear Mr. Kromm

Adventist HealthCare ("AHC") appreciates the opportunity to provide comment on HSCRC policies that support the goals of the AHEAD Model and other related priorities.

Optimizing Maryland HSCRC Policies to Ensure Access to Medically Necessary Care

While volume, quality, and other HSCRC policies could benefit from refinement, 90% of Hospital Global Budget Revenues ("GBR") remain tied to three primary drivers:

1. Base Hospital GBR revenues set at the inception of the Maryland Model in 2014
2. Annual Inflation and Demographic Adjustments
3. Market Shift Adjustments

Numerous other annual HSCRC policy adjustments exist, but they have an immaterial impact to the big picture, influencing ~10% or less of GBR. Our comments focus on fundamental gaps in Maryland's HSCRC policy framework related to these core components that currently prevent funding for medically necessary care. Prioritizing these changes will have the greatest impact on strengthening the Maryland model in preparation for AHEAD.

1. Fund Medically Necessary Acute Care

Current HSCRC policies incentivize reducing all hospital volumes, including medically necessary care. When volume decreases, hospitals retain ~50% of the reimbursement for those cases. However, when volume grows due to population increases or the chronic needs of the community, hospitals receive far less financial support. As a result, there is no policy incentive to provide medically necessary care beyond an established GBR, as the current framework does not fully cover these costs.

In theory, the Demographic policy should fund the growth of medically necessary care, but it reimburses only a fraction of that growth. For example:

- In FY25, only 0.25% of the statewide 4.25% age-adjusted demographic growth was funded. This equates to ~$40M in annual gross revenues for Adventist HealthCare, more than 2x its CY24 operating margin.
- Since FY2015, only 4.22% of the 11.63% statewide age-adjusted demographic growth was funded leaving a -7.41% gap in funding for hospitals since FY2015. This equates to ~$75M in annual gross revenues for Adventist HealthCare, more than 4x its CY24 operating margin.

The combination of financial incentives to reduce volume and an insufficient Demographic adjustment makes it impossible in areas of the state with high growth to ensure access to medically necessary care. This forces hospitals to ration care—even when that care is medically necessary—to maintain financial solvency within GBR limits.

Proposed Policy Solutions

- **Tie incremental demographic funding to population metrics** such as per capita use rates.
  - As long as per capita use rates remain low, funding should have limited constraints to ensure access and prevent harm.
- **Introduce a demographic adjustment booster** for hospitals in extreme percentiles of utilization.
  - **Collectively, the following metrics indicate limited access to medically necessary care despite overall low utilization.**
    - Montgomery County (population: 1 million) has a Medicare admission rate per capita comparable to Chautauqua, Kansas (population: 3,500), placing it in the lowest 17% of U.S. counties.
    - Montgomery County Medicare emergency department (ED) utilization rate ranks in the lowest 7% of US counties, comparable to Kodiak, Alaska (population: 13,000).
    - Maryland ranks 47th in the Nation with lowest hospital beds per capita.
    - White Oak Medical Center has the 8th longest ED wait time in the United States
  - Additional funding would expand access without jeopardizing financial targets, leveraging excess savings from strong Medicare Total Cost of Care (TCOC) performance.

2. Fund Medically Necessary "Potentially Avoidable" Acute Care

HSCRC defines "avoidable utilization" (PAU) narrowly and does not reimburse hospitals for any incremental growth in these cases, as they are stripped from the Market Shift, Demographic, and Efficiency policies. While a strong PAU policy is necessary for a population-based reimbursement system, these cases are only "potentially" avoidable.

By the time a 50-year-old patient arrives at the emergency room with severe hypertension and a stroke, the care is medically necessary. Yet, under HSCRC's current framework, the hospital receives zero reimbursement for treating a new PAU patient and bears 100% financial risk.

By contrast, under Medicare IPPS, hospitals are at risk for up to 3% of reimbursement for readmissions. The disparity is clear:

- **Medicare IPPS risk is too low** to incentivize meaningful change.
- **HSCRC's PAU policies are too extreme**, jeopardizing access to medically necessary care.

Additionally, PAU funding was built into hospital budgets based on 2013 volumes and has not been adjusted since, despite significant shifts in population, demographics, and patient preferences. The current policy framework lacks safeguards to ensure PAU patients receive medically necessary care.

Proposed Policy Solutions

- **Implement a short-term fix by releasing demographic adjustments** to provide immediate funding for medically necessary care.
- **Modify PAU policies for a long-term solution**, adjusting the at-risk amount to 50% for incremental PAU cases.
    - This would continue to hold hospitals accountable for avoidable care while ensuring funding for truly necessary cases.

3. Fix Base Hospital Rate Inequities to Ensure Regional Access

Base hospital rates were inequitably set at the Maryland Model's inception, favoring regions with more infrastructure and higher initial GBR contracts. While Maryland operates an all-payer system, ensuring that all patients pay the same rate for a specific procedure at a specific hospital, the price of the same procedure varies significantly across Maryland hospitals.

For example, White Oak Medical center's base rates are on average -13% below the statewide average which equates to ~$24M in annual GBR. This is just one example of baked in inequities that have compounded over time, limiting infrastructure growth in underserved areas like Fort Washington, Prince Georges and White Oak, Montgomery.

Proposed Policy Solutions

- Use incremental funding from excess savings or targeted update factors to rebalance resources without reducing funding for hospitals with higher rates.
- Implement a targeted booster for hospitals in underserved areas to ensure equitable funding and expand access to medically necessary care. GBR per capita could be used to measure equitable investment.

4. Implement Regional Planning and Align MHCC & HSCRC Policies

HSCRC policies rely heavily on statewide averages, which mask geographic disparities in access and funding. A regional planning approach would better address these gaps by analyzing per capita GBR and redirecting resources to underserved areas.

Additionally, there is a critical misalignment between MHCC (which licenses hospital beds) and HSCRC (which funds them). Currently, MHCC's dynamic licensing process increases bed licensure based on prior-year census, while HSCRC does not adjust funding accordingly. As a result, White Oak Medical Center is licensed for more beds than it physically has, operating at full capacity since its opening in 2019 without a proportional increase in funding to open access to meet the demand.

Proposed Policy Solutions

- **Align MHCC bed licensing with HSCRC funding**, ensuring that financial resources match patient demand and support hospitals where they are most needed.
- **Convert all HSCRC policies to a regional view** to better direct resources and ensure equitable access to care.

Conclusion

By addressing these core policy areas—funding medically necessary care, correcting base rate inequities, and implementing regional planning—the Maryland HSCRC model can be significantly strengthened. These targeted changes are essential to ensuring access to medically necessary care and preparing for the AHEAD Model.

Just as in Maslow's hierarchy of needs, broader population health goals cannot be achieved from hospitals until medically necessary acute care is adequately funded.

Adventist appreciates the opportunity to provide comment. Direct answers to the specific itemized questions are included below and reinforce our recommended prioritized changes.

Katie Eckert, CPA

Senior Vice President, Strategic Operations

Adventist HealthCare

cc: Joshua Sharfstein, MD
Farzaneh Sabi, MD
James N. Elliott, MD
Ricardo R. Johnson
Maulik Joshi, DrPH
Adam Kane, Esq
Nicki McCann, JD

1. **Ensuring High Value Care**. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

    a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. *To further drive this work, how can the payment system better recognize effective efforts?*

    Just as in Maslow's hierarchy of needs, broader population health goals cannot be achieved from hospitals until medically necessary acute care is adequately funded.

    b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

    Align MHCC bed licensing with HSCRC funding, ensuring that financial resources match patient demand and support hospitals where they are most needed.

    Convert all HSCRC policies to a regional view to better direct resources and ensure equitable access to care.

    c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. *How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?*

    Ensure that medically necessary care is funded before further incentivizing new ways to reduce volumes which could further exacerbate areas of the state without access to medically necessary care.

    d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. *Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?*

    Yes, because the current policy framework lacks safeguards to ensure PAU patients receive medically necessary care. See comments in letter for policy recommendations.

    e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?

    A first step to help hospitals would be to implement coordinated regional planning for MHCC and HSCRC. A key area of concern is the critical misalignment between MHCC (which licenses hospital beds) and HSCRC (which funds them). Currently, MHCC's dynamic licensing process increases bed licensure based on prior-year census, while HSCRC does not adjust funding accordingly.

2. **Improving Access to Care.** Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

    a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

    HSCRC should look at all volumes on a per capita basis to identify gaps in the throughput continuum. Admissions, observation cases and outpatient-in-a-bed all reflect bedded care. Notably, admissions per capita are not listed in 2a metrics. Overly focusing on "avoidable" care to the detriment of "medically necessary care" has led to gaps in access. Additionally, all metrics should be reviewed on a regional basis so that the state average does not mask regional inequities.

    b. Reducing ER wait times is a state priority. *Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?*

    Yes. The State must ensure access to medically necessary care. Underfunding this access is one of the key drivers of long ER wait times in the State.

    c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. *What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?*

    Currently, the Market Shift policy pays up to a 50% variable cost factor for volume (VCF) growth/decline however not all service lines operate at a 50% VCF. Modifying the policy to use a service line specific VCF will results in more accurate funding shifts for volumes. Additionally, moving to a county or regional analysis would more closely algin with a regional planning approach to healthcare access. Finally, PAU volumes under the current Market Shift policy are removed and not reimbursed. By providing $0 reimbursement for PAU cases, this sets up a barrier to access to care.

    c. Hospital global budgets are adjusted every year for statewide population growth. *How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?*

    Since FY2015, only 4.22% of the 11.63% statewide age-adjusted demographic growth was funded leaving a -7.41% gap in funding for hospitals. This must be corrected to fund medically necessary care. See comment letter for recommendations.

d. *Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?*

Yes, but this cannot be done in isolation. For example, hospital excess ER wait times are in direct correlation to low acute care capacity. Individual metrics cannot be used in isolation to measure the performance of a healthcare or hospital system. Hospital performance expectations should be adjusted accordingly for gaps in the State's infrastructure.

3. **Other topics**. There are several cross-cutting policy areas that could also be addressed in 2025. a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC.
   a. *With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?*

   Traditional mechanisms to cover physician market costs include expanding services to increase volumes and negotiating higher rates with commercial payers. These tools do not exist for Maryland hospitals. In the absence of these tools its appropriate to fund a portion of the cost to retain hospital-based providers in GBR in order to ensure access to care. Like IME/GME residency funding, HSCRC could provide a component in GBR for hospital based.

   b. Facility conversions. *Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?* Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?

   Yes. A model like Dynamis' Healthy Villages could be used to advance ambulatory and community care. See Kaufman Hall's article "A Different Way of Thinking About Hospital Closures".

   c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. *What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?*

   The HSCRC could consider paying volumes on a fee-for-service real-time basis for hospitals in services areas with low use rate per capita. Under a certain threshold, the risk of restricting access is greater than the risk of growing volumes.

4. *What other major changes to policies under the Maryland Model of population-based payment should be considered?* Please be as specific as possible.

Funding medically necessary care, correcting base rate inequities, and implementing regional planning are essential to ensuring access to medically necessary care and preparing for the AHEAD Model.

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Aledade

Good evening,

Below you will find Aledade's answers to the questions contained in the request for comment on the AHEAD model recently announced by HSCRC.

1. Ensuring High Value Care. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

a. *Over the past decade, hospitals have used the flexibility of global budgets to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?*

Hospital management is largely focused on treatment over prevention, overlooking the actors best positioned to make substantive impacts on highlighted criteria: primary care. Primary care is not only more cost-effective but also leads to better health outcomes. Emphasizing hospital based treatment incentivizes intervention after the point at which the cost of care expands significantly. Instead, HSCRC should work to further integrate primary care into the existing TCOC model and the forthcoming AHEAD model by ensuring interoperability with programs such as MSSP and MDPCP. Interoperability would ensure primary care's ability to participate in HSCRC's processes as efficiently and effectively as possible. Parallel to this, mandated investment by commercial providers would change the economics of primary care and allow for the stabilization of current capacity and set the foundation for future expansion. Despite being the foundation of our health care system, primary care currently receives only 7¢ of every health care dollar. As a result primary care suffers from severe underinvestment resulting in reducing capacity and causing increased hospital utilization across the board. This recommended one-two punch would effectively reduce the exposure of hospitals to the expansion of utilization of their expensive care while simultaneously supporting the long-term viability of the most cost effective form of care ensuring that all boats rise across the health care ecosystem.

Aledade, Inc.
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b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?

Nationwide studies have shown that the best programs for reducing cost of care focus on integrating multiple systems together to deliver valuable, high quality care over fee for service. The future successful operation of HSCRCs models is incumbent on identifying the areas where interoperability eases the process of care and ensuring that all levels of health care are working effectively to reduce instances of chronic illness and disease. Identifying opportunities to integrate fragmented care into holistic systems emphasizing value base care would go a long way toward ensuring the long term success of Commission's goals. Additionally exploring opportunities to emphasize programmatic interoperability and the long term survival of primary care would form a foundation for future investments to intervene in the most severe cases of inefficiency.

c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?

The root cause of low-value, fee-for-service care is the economic incentives structure that keeps it viable; to reduce its instance, rewarding value is key. Through the forthcoming AHEAD model HSCRC should prioritize payments focused on results over services delivered. MSSP has demonstrated in primary care that coordinated care with an emphasis on value reduces instances of chronic disease, increases positive outcomes, and reduces cost. Across Maryland primary care physicians already have a track record of success leveraging well integrated programmatic support, through MSSP and MDPCP, to achieve the transition to value based care. By opening pathways to financial stability that emphasise outcomes over services, HSCRC would influence the clinical decision making present at every level of care. Furthermore, by ensuring that primary care is included in this process and emphasising programmatic interoperability, HSCRC would move the critical point of intervention back to the space where it is most easily and effectively managed on a cost basis.

Aledade

d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?

It is readily apparent that adequate primary care capacity represents the best path forward for reducing overall utilization. The emphasis on using hospitals as the mechanism to reduce rates of hospitalization is addressing the problem after it has already arisen. To reduce overall rates of utilization an adequate network of primary care must be in place. Primary care is best positioned to manage the long term care of patients to prevent the development of chronic illnesses and control the spread of diseases that result in hospital admissions. Ensuring its long term success is, therefore, critical to the successful reduction of utilization rates across the board. Currently the economic environment for primary care is extremely difficult. Low reimbursement rates from commercial providers, reduced reimbursements from the federal government, and poor interoperability between support programs force primary care providers to make difficult choices. Reducing the economic barriers to practice operations through mandated commercial investment, expanded interoperability of support programs, and closer integration with the existing TCOC infrastructure would ensure long term viability. Programs such as MSSP and MDPCP have already demonstrated the value of primary care in reducing utilization. Further integration with the state's programs and agreements with CMS would allow for better upstream intervention in developing health issues and reduced instances of hospitalization.

We appreciate the opportunity to submit our comments and look forward to the opportunity to testify on the 12th. In the meantime please let me know if there is anything else that I can do to help.

Sincerely,

Will London

Senior Policy Analyst

wlondon@aledade.com

Ascension Saint Agnes

February 3, 2025

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

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes, I am writing today to respond to the request for comments from the Health Services Cost Review Commission (HSCRC) regarding potential changes to policies as the State of Maryland prepares to begin the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

In addition to the answers to the specific questions posed by the HSCRC, Ascension Saint Agnes would like to encourage the HSCRC to focus on the following policy and funding priorities:

- **Demographic policy**. The current demographic policy does not adequately account for the aging of the population, underfunding hospitals based on the expected increases in utilization.
- **Market shift policy**. The current policy does not appropriately account for and fund shifts in patient movement nor does it appropriately differentiate the variable costs across service lines. Ascension Saint Agnes is also concerned that the current policy does not account for events outside of the hospital's control such as the cyberattack that occurred in 2024.
- **Physician investments**. While Ascension Saint Agnes understands the potential statutory limits of the HSCRC to fund physicians directly, current policies do not account for the increasing expenses being required to adequately staff the physician enterprise, both to operate the hospital and a robust ambulatory network to support population health efforts.

Below are answers to the specific questions raised by the HSCRC:

- **Over the past decade, hospitals have used the flexibility of global budgets to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?**

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For each of the payment programs established by the HSCRC, there needs to be a clear connection between hospital action and reward or penalty. Some of the existing programs such as the Medicare Performance Adjustment (MPA) do not have a clear line to accountability between actions in the span of control of the hospitals and the corresponding financial impact. This leads to lack of engagement from the hospitals and highly variable results amongst them year over year.

- **Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?**

  Ascension Saint Agnes continues to be supportive of the investments that have been made in the state's Health Information Exchange (HIE), CRISP, as having one data utility to route clinical information amongst hospitals and provide program performance data has been critical. Ascension Saint Agnes would encourage the HSCRC to review any investments in additional data tools on a statewide basis through this lens, providing equitable access for all users, rather than each individual system or hospital separately investing in disparate tools.

- **Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?**

  The HSCRC could take the following concrete steps to partner with hospitals and physicians to address low-value care:
    - Convene a stakeholder group to review the data, by hospital, for low value care to determine the areas of greatest opportunity. This group would be tasked with identifying best practices to reduce this type of care and make recommendations to the HSCRC regarding financial incentives that could be used to drive positive change.
    - Partner with the hospitals to reform the medical malpractice climate in Maryland. Defensive medicine is a reality in the state and is a factor in the ordering of potentially unnecessary or duplicative tests, etc.

- **The HSCRC policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?**

  The readmissions program is an example of one where there are specific interventions that hospitals can pursue to make positive improvement with clear financial rewards or penalties. It is also all payer, allowing broad based interventions for all patients. The HSCRC should

endeavor to reform or eliminate existing policies that cannot clearly tie hospital behavioral change to an impact on metrics.

Hospitals are currently penalized for moving care to lower cost, more appropriate settings which is just as meaningful as managing potentially avoidable utilization. The deregulation incentives should be revisited to ensure care is provided in the most appropriate setting without risk of excessive reductions to regulated revenue.

- **Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?**

  Given the significant excess savings currently being generated by the Model, there is an opportunity to provide start-up funding for hospital programs that demonstrate an opportunity to significantly improve quality or reduce total cost of care. These funds could also be used to target specific performance improvement activities such as length of stay and Emergency Department (ED) throughput.

  One of the challenges with previous funding of these types of initiatives is that the funding is temporary, even if the intervention has proven successful. The HSCRC should consider funding these initiatives permanently if they are achieving the results outlined in the initial proposal.

- **Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?**
  The Model has successfully reduced hospital utilization, but these reductions have not been consistent across hospitals and have not drawn an effective distinction between positive reductions (Potentially Avoidable Utilization) vs negative reductions (restricting access to the community). The HSCRC should consider a more refined approach to utilization reductions, rewarding hospitals for reducing unnecessary care while adequately funding (at least covering the cost) medically necessary care.

- **Reducing ER wait times is a state priority. Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?**

  Stabilizing the financial performance of hospitals is one straightforward way to ensure EDs are staffed appropriately for the demand.

- **As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning**

population-based payment and creating an excessive financial incentive for hospital-based treatment?

The current market shift methodology doesn't recognize the varying degrees of variable cost across different service lines. This is one adjustment that could be incorporated to ensure the cost of shifting volume is covered. It's important to note that this does not provide a strong incentive to grow volume to grow margin like the rest of the country, only to ensure that hospitals do not incur financial losses by providing medically necessary care due to patient choice.

- **Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?**

  The current demographic adjustment does not adequately account for the aging of the population, thereby underfunding hospitals for expected increases in acute care utilization. This aspect of the current policy needs to change to provide appropriate funding to hospitals, without which hospitals will be unable financially to commit significant resources to population health initiatives.

- **Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?**
  The current Integrated Efficiency Policy is not an accurate measure of the efficiency of hospitals. Two of the measures utilized, comprising 50% of the total ranking, are measuring the total cost of care for Medicare and Commercial members. As discussed earlier, these measures are difficult to impact for a single hospital, particularly year over year.

  In addition, the policy does not drive behavioral change. Once in the bottom quartile, the hospital has limited options to improve performance, including increasing volume, which is counter to the goals of the HSCRC. A new policy is needed which accurately measures the efficiency and effectiveness of hospitals,

- **Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?**

  Physician costs are a necessary and required expense to run an acute care hospital, however the regulatory system has not kept pace with changing physician coverage models, with community physicians no longer rounding on patients in hospitals to the extent they once did. Although lacking clear statutory authority, the HSCRC has already recognized that rate regulated revenue can be used to pay physicians as the Revenue for Reform policy

specifically calls out physician expenses as an approved use. The HSCRC needs to develop a methodology that acknowledges the costs needed for physician coverage in hospital rates.

- **Facility conversions. Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers? Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?**

  Freestanding Medical Facilities (FMFs) are an effective care delivery solution for rationalizing excess acute services yet ensuring emergency and other needed ancillary services are available to communities. The HSCRC should revisit its incentives for how hospitals evaluate transitioning acute facilities to FMFs, particularly for those hospitals that are part of larger, Maryland-based health systems.

- **Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?**

  Obstetrics and newborn services are not service lines that hospitals should be expected to manage under a population-based payment model, as the model is meant to reduce unnecessary utilization which doesn't apply to these services. These services should be carved out and handled on a fee-for-service basis.

Thank you again for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

Beau Higginbotham
President & CEO

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi

Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

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CareFirst

February 3, 2025

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 in response to the Health Services Cost Review Commission's (HSCRC) call for comments related to policy changes and investments to maximize Maryland's success.

Marylanders would benefit from a healthy Medicare Advantage market

Medicare Advantage (MA) has become a primary source of health insurance coverage for the elderly nationally. It provides robust benefits and is resourced to actively manage care for beneficiaries, unlike the Medicare Fee for Service program. HSCRC has discussed the interplay between the model and the federal MA program, which inadvertently distorts payment and holds back the market from its potential. If high value care and access are HSCRC priorities entering the AHEAD model, Medicare Advantage should be viewed as an asset and helpful tool in achieving better outcomes across those domains. HSCRC can correct the model's impact on the MA market and, as a result, put population health interventions into the market driving down low value care. CareFirst would happily work with HSCRC on a solution.

Global budgets should not exist without service and access standards

The state should develop a data-driven perspective on the service needs within communities. This would help guide investment decisions and put patients at the center of the conversation. There has been a lot of angst in the industry caused by the movement of patients throughout the system, hospitals' differing responses to the incentives of the model, and whether the appropriate amount of revenue was transferred between hospitals. HSCRC should develop standards that accompany global budgets (i.e. hospital must maintain X staffed beds), just like any other contract, and those standards should be informed by service needs in community.

The state's standards on access should cut across the delivery system and not stop at hospital services. They should leverage data to determine where investments are most needed to provide access to communities and conversely where investments would be duplicative and unproductive. This would require considering nuances and defining what adequate access looks like – for example, does a physician's office offer evening or weekend access? Do they accept Medicaid patients? Do they offer online scheduling? How far out is the next available appointment? This level of sophistication acknowledges that setting up physical space is not enough to constitute patient-friendly access.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Value-based care remains an underutilized opportunity

Many of HSCRC's questions focused on high and low value care, which can be addressed through more robust value-based care arrangements than the ones in market today. HSCRC should push for value-based arrangements between payers and various provider types while continuing to promote multi-payer alignment. For example, we believe there is an opportunity to leverage the flexibility afforded to Maryland through the model to test an expanded version of global budgets that allows some hospitals to voluntarily take accountability for the total cost of care of all patients in their community.

HSCRC should also push for health systems to create innovative value-based partnerships with other provider types to address some of the length of stay issues contributing to long emergency department wait times. Value-based care can help with fiscal stewardship in optimizing current bed capacity.

HSCRC does not regulate physician costs

While we understand hospitals have made tremendous investments in unregulated physicians, some of which are necessary to sustain core hospital operations, we do not believe it is within the HSCRC's statutory mandate to fund these costs. As long as health systems are billing separately for physician services, and comprehensive physician investment data is not collected and critically analyzed, there is no place for HSCRC to consider policy changes that address these costs.

We appreciate the opportunity to comment on these questions that demonstrate staff is putting a great deal of effort into their policy calendar at this inflection point in the model. CareFirst looks forward to engaging with staff and industry stakeholders to shape appropriate policies that center patients and drive improvements in access, affordability, outcomes, and equity.

Sincerely,

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

February 3, 2025

Jonathan Kromm, PhD, MHS
Executive Director
Health Services Cost Review Commission
Submitted via email to hscrc.care-transformation@maryland.gov

RE: *HSCRC Opportunity for Comment* on the AHEAD Model

Dear Executive Director Kromm:

The Chesapeake Regional Information System for our Patients ("CRISP"), the state designated health information exchange ("HIE") and health data utility ("HDU") for Maryland, appreciates the opportunity to comment on HSCRC's questions related to the implementation of the AHEAD model. While CRISP does not have written comments to offer on questions related to policy design or payment methodology, we do want to take this opportunity to express our continued support and partnership as the state moves toward the AHEAD model.

As it relates to the creation and investment in common utilities to enhance care and health outcomes, CRISP is honored to serve as both the state-designated HIE and HDU for Maryland. CRISP's vision is to advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration. To that end, CRISP is able to build on existing technology infrastructure and reporting tools that have developed collaboratively over the past decade and serve as a common utility to provide reports or other technology-based tools to help enhance care and health outcomes.

As it relates to the development of useful access measures that also prioritize funding requirements and the best use of existing initiatives, CRISP is prepared to leverage its expertise in data collection, normalization, and reporting. We are happy to leverage and enhance existing reporting tools to support the state in its ability to analyze data trends across a broad array of health care providers and places of service.

CRISP leads the nation with innovation in reuseable data exchange with robust governance. CRISP has significant experience connecting unique data sets from multiple sources to create usable tools for clinicians, public health agencies and care coordinators across multiple settings. Our tools are leveraged throughout Maryland including use at the point of care, care coordination, population health reporting, program administration, and public health. Our CRISP Reporting Services (CRS) offers a robust suite of reports where users can access claims data to evaluate population health trends and performance. Our CRS and Program

Administration teams have partnered with HSCRC for years to provide technical assistance in addition to reports to all Maryland hospitals. We also partner with other state agencies such as MDPCP and Medicaid to provide comprehensive reporting for primary care providers and Managed Care Organizations. Both teams work closely with their state counterparts to regularly enhance and perfect the tools provided to make sure we are continually meeting market needs.

CRISP is eager to support HSCRC in data, reporting and technology tool needs that may arise as a result of this request for comments. CRISP highly values its relationship with the HSCRC and the Maryland healthcare community. As we engage throughout the country, there is no doubt Maryland is leading the way in innovation with advanced cost and quality initiatives in health care. We look forward to continuing to support Maryland in its leadership role, and we look forward to working together to implement these ground-breaking initiatives. CRISP stands ready to support the HSCRC and the Maryland healthcare community with the AHEAD model.

Sincerely,

Megan Priolo

Megan Priolo, DrPH, MHS
Vice President & Executive Director, CRISP Maryland

GBMC HealthCare System

Greater Baltimore Health Alliance
Greater Baltimore Medical Center
Gilchrist Hospice Care

John B. Chessare, M.D., MPH, FACHE
President & CEO

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January 31, 2025

Maryland Health Services Cost Review Commission

Dear Commissioners:

Please accept these three ideas in response to your call for comments on policy changes and investments that would help with the implementation of the AHEAD model.

Funding Provider Organizations to Drive Improved Health Outcomes and Patient Experience while Reducing Cost and Improving the Joy of Care

The definition of maximum value in healthcare is the best health outcome and care experience at the lowest cost. In Maryland and especially within the City of Baltimore, there is a huge opportunity to improve the health outcome and care experience and reduce the cost of those with chronic disease. The population is ageing and therefore the burden of chronic disease is growing rapidly, unfortunately, the system is not structured to drive maximum value.

Acute care hospitals are constructed to safely deliver babies, to do high end surgery, and to rescue those with acute illness and then return them to the community. Hospitals are not structured to manage the health of a population of chronically ill people and keep them from requiring acute rescue. The Affordable Care Act brought us the notion of "accountability" and the concept of the Accountable Care Organization. CMS and the Innovation Center now have good evidence that these physician-led organizations can and do drive greater value. In the absence of a clinical team that is accountable along with the patient for driving the best outcome and reducing non-value care, patients, especially those from historically underserved communities, are left to fend for themselves, with nowhere to turn until they get to a point of acute need where they present to an emergency department and often get admitted to the hospital because the ED clinicians are reluctant to discharge them without a clinician who will assume the accountability for their care.

The Maryland Primary Care Model is an excellent first step in building an accountable system. Now that it will include Medicaid as a payor, more accountable relationships will be built with chronically ill and marginalized individuals. To make faster progress, however, more resources must be applied to the creation of accountable care organizations or their

equivalents in multi-specialty group practices that are incentivized to drive value and move into underserved neighborhoods. This will only happen if funding is moved to capitation per individual served, with financial incentives for value performance.

Adding more revenue to the system does not improve the value equation, however. The good news is that especially in the City of Baltimore, we have excess hospital capacity. While the state of Maryland average of 2.0 beds per thousand residents is below the national average of 2.35 beds per thousand residents, in the City of Baltimore we have 6.1 beds per thousand residents.

We know that some patients come from all over the world to get care in Baltimore's outstanding academic medical centers, so Baltimore should have more than the statewide average of beds. However, we believe that we could close some of the beds and use some of the savings to incentivize the creation of accountable physician-led clinical groups. This will require new authority within the HSCRC or the creation of a new entity, to close hospital capacity and effectively move the funds to the accountable clinician groups. Organizations that saw a reduction in beds could be given a "right of first refusal" to create accountable provider organizations that would move into underserved communities in the city.

An innovative move of this nature will require strong leadership for change. In the absence of a redesign of this nature, the HSCRC should explore other means to move resources to those ready to be held accountable to better manage those with chronic disease and drive better health outcomes, better care experience at lower cost with more joy for those providing the care, the so-called quadruple aim of U.S. healthcare.

Creating Standard Work to Reduce Waste in the Transition from Inpatient to Post-Acute Care

A second suggestion to create more value in Maryland's healthcare system is to standardize the mechanics of transition from inpatient units to extended care facilities. Today, no two post-acute facilities have the same procedure for accepting admission. As an example, some facilities use the term "accepted" to mean they are ready to take the patient, and others use the term "accepted" to mean that the patient will be welcome sometime in the future when a bed becomes available. GBMC is now working with several post-acute providers to design a transition process that will move patients when they are ready and a bed is available, without the over-processing and rework loops that are now prevalent. This design could be extended to all post-acute facilities in the State.

Increasing Access to Palliative Care to Reduce Non-value Added Admissions at End of Life

A third suggestion is to create robust palliative medicine services at Maryland hospitals to give patients symptom relief and better options as they approach the end of life. Creating a proposal for this initiative is underway between GBMC/Gilchrist and Commission staff.

Thank you for your time and consideration.

Sincerely,

John B. Chessare MD, MPH

HOLY CROSS HEALTH
A Member of Trinity Health

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February 3, 2025

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

Dear Dr. Kromm,

On behalf of Holy Cross Health, I am writing to provide comments to the Health Services Cost Review Commission (HSCRC) regarding policy priorities to prepare for participation in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

Holy Cross Health believes the following policy and funding priorities are most critical to address as the HSCRC reviews feedback from the industry:

- **Demographic policy -** The current policy does not appropriately fund hospitals because it does not adequately adjust for the aging of the population. This limits the funding hospitals need to address the increases in acute care utilization that will occur as the population ages.

- **Physician losses -** The dynamics of the physician workforce within the hospital have changed dramatically since the HSCRC was created, yet the statutory authority and policies have not been updated to reflect these changes. Hospitals do not have sufficient funding to absorb the increasing financial losses resulting from maintaining adequate physician coverage within the hospital and also invest in ambulatory practices to meet the goals of the Model.

- **Market shift policy -** The current policy underfunds hospitals and is not consistent with other policies whereby funding follows the patient/person. Incentives can be maintained that do not reward volume growth while ensuring that hospitals receive the necessary revenue to care for patients.

Below are Holy Cross Health's comments to specific questions raised by the HSCRC:

<u>Ensuring High-Value Care</u>

- **Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?**

  The HSCRC should give hospitals funding to support innovative population health pilot

programs and provide ongoing funding for successful ones. Hospital rates can be used to fund hospital-community partnerships that can reduce total cost of care (TCOC) beyond hospital savings. Two examples of successful programs include:

- The Wellness and Independence for Seniors at Home (WISH) program was one of the first programs developed by Montgomery County's Nexus Montgomery Regional Partnership. It was very successful in reducing TCOC for vulnerable seniors, but the savings could not be attributed to specific hospitals, so hospitals were not able to continue the program when the HSCRC funding ended.

- The Skilled Nursing Facility (SNF)-Real Time partnership generated benefits that were system-wide but couldn't be tied to specific hospital readmission savings.

In addition, the Medicare Performance Adjustment (MPA) should be adjusted to be program-specific vs. broad-based so that hospitals can influence the results and be held accountable for performance. The MPA as it stands today does not create or incent hospital-specific action.

- **Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?**

  The HSCRC can encourage and fund pilot programs to test common utilities and then deploy those that work systemwide. The Hospital-SNF partnership that tested the Real Time data monitoring system in 10 SNF's was a good example of this that led to Medicaid offering it to all SNFs.

  The HSCRC could work with CRISP (Chesapeake Regional Information System for our Patients) to expand its functionality to better incentivize physician utilization. CRISP's role could also be expanded to provide hospitals with more data and analytics regarding performance improvement opportunities.

- **Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?**

  Financial support for development of hospital/system-owned physician practices may help to shift provider incentives from a fee-for-service (FFS) mindset to a TCOC management perspective because the upside (and downside) opportunities are substantially higher than the FFS opportunity of a standalone practice. Aligning the incentives between physicians and hospitals can promote greater collaboration and focus on reducing certain types of low value care as identified in the study.

- **The HSCRC policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?**

  The HSCRC should consider demonstration projects between hospitals and SNFs to reduce readmissions and other avoidable utilization. This may require seeking Centers for Medicare and Medicaid Services (CMS) waivers or other authority to pay SNFs differently and better align them with the Model.

  The HSCRC should also evaluate the list of PQIs to determine whether hospitals can truly influence and be held accountable for preventing them, e.g. diabetic amputations are often a result of the life-time effect of health behaviors and socioeconomic conditions and cannot be solved by hospital interventions alone.

- **Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?**

  Support for capital investments is needed to ensure that hospitals can care for patients, both inside and outside of the hospital. Many hospitals have had to defer needed capital improvements or expansions due to limited resources.

<u>**Improving Access to Care:**</u>

- **Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?**

  The HSCRC should convene a multi-stakeholder workgroup to set high level goals and measures that align different provider types across the continuum. These policies need to be flexible to drive performance.

  Aligning providers across the continuum will likely necessitate payment changes, data reporting, regulatory mandates or other requirements on non-hospital providers such as primary care, urgent care, and post-acute. Using post-acute as an example, the current regulatory construct allows them to utilize insurance denials or other tactics to reject patient discharges, negatively impacting hospital length of stay and contributing to ED wait times.

- **As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?**

The HSCRC should modify the market shift calculation to recognize a greater share of variable costs by evaluating costs on a service line basis and simplifying the geographic definitions. The current zip code methodology does not sufficiently capture shifts in volume between hospitals.

- **Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?**

  The demographic adjustment should be revised to ensure that a hospital's age-adjusted growth is fully funded so hospitals have sufficient resources to cover the higher cost of caring for an aging and generally sicker population. Holy Cross Health recommends, as part of the annual payment update for Rate Year 2026, that the limit on age-adjusted growth be removed and a long-term plan be developed to review the demographic characteristics of the population and risk adjust for more complicated populations such as hospitals with high catchment areas/referrals from LTAC, SNF, and Rehab facilities.

  Consideration should also be given for hospitals with higher uninsured patient populations as access to outpatient care for preventative and post-hospitalization care is markedly limited. Similarly, care for patients with a high level of social needs and/or limited English proficiency also takes longer and impacts ED and inpatient length of stay, which isn't currently accounted for in payment policies.

Other Topics:

- **Physician costs - Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?**

  Physician salaries are rising out of proportion to insurance reimbursements. The cost to compensate physicians for taking call is steadily rising because they can make more money outside of the acute care setting. In addition, the availability of physicians in Maryland is decreasing secondary to competition from nearby markets (DC, VA, PA, DE) where they are compensated higher. In markets, like Holy Cross Health's, with a significant number of uninsured patients, physicians are unable to recoup professional fees for their services which requires hospitals to provide a stipend/bridge the gap for the care they provide in the hospital. The state needs to allocate more funds for uninsured patients for emergent care.

  Payers need to fairly compensate physicians for the care they provide. The low payer reimbursement in Maryland is a significant driver of the financial losses that hospitals are sustaining to maintain the physician enterprise.

  The HSCRC should pursue two potential avenues for addressing this issue:

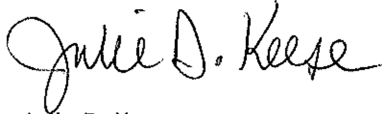
  - Include hospital-based physician costs that are not otherwise offset by

revenue as a regulated, essential hospital cost and fund through hospital rates.

- Pursue legislation to mandate a floor for commercial payer reimbursement to ensure that physicians can remain financially stable in Maryland and to limit the subsidies that hospitals are providing.

Thank you for the opportunity to provide comments on these important policy matters.

Sincerely,



Julie D. Keese
Vice President and Chief Financial Officer
Holy Cross Health, Inc.

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, HSCRC Chairman
Dr. James Elliott, HSCRC Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Andre (Dre) Boyd Sr., Regional President & CEO, Trinity Health MidAtlantic and Holy Cross Health

Luminis Health

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Annapolis, Md. 21401
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February 3, 2025

Jonathan Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(transmitted via email)

Dear Dr. Kromm,

On behalf of Luminis Health, we appreciate the opportunity to provide comments on Maryland's transition to the Advancing All-Payor Health Equity Approaches and Development (AHEAD) Model. While we support the AHEAD goals, ten years into global budgets and five years into the Total Cost of Care (TCOC) model, there are unintended consequences now threatening hospital financial viability. To sustain high-quality care and meet AHEAD's goals, key policies and practices must be revised and addressed, including:

- **Market Shift and Volume Recognition**. Luminis Health experienced $12.2M in volume growth from CY23Q1Q2 to CY24Q1Q2 but will receive only $1.1M in market shift funding—just 9% of actual growth. We support the recommendation articulated by the Maryland Hospital Association (MHA) to review the Variable Cost Factor (VCF) at the service line level and to shift away from ZIP code-based calculations to more accurately reflect real volume changes.

- **Age-Adjusted Demographic Growth Funding**. Maryland has experienced a 40% increase in the 65+ population in the past decade. The demographic adjustment fails to account for Maryland's aging population, leading to a cumulative statewide underfunding of $7.4B since FY16. This must be corrected to ensure hospitals can sustain access and invest in population health programs.

- **Integrated Efficiency Accuracy**. The current policy continuously awards the hospitals in the top quartile while reducing revenue for those in the bottom quartile, with limited ability for hospitals to positively impact their ranking.

- **Recognition of Hospital-Based Physician Expenses**. Luminis Health's hospital-based physician costs have risen 68% since FY20, straining resources. These expenses are directly linked to the quality and delivery of 24/7 hospital care and therefore should be considered under GBR.

- **Payor Accountability**. Rising payor denials are straining operations, with Luminis Health's denial write-offs increasing from 1.5% to 4.6% of gross revenue ($49.6M) since FY19, while revenue cycle and appeal costs have surged 152%.

The cumulative impact of these policy shortfalls has left growing hospitals in financial peril. Emergency Department (ED) overcrowding has negative impacts on ED wait time, bed capacity, patient safety, and patient experience when not appropriately addressed in a hospital's global budget. Hospitals maintaining access and experiencing increases in medically necessary care are impacted by these challenges disproportionately compared to hospitals that are treating less patients. Luminis Health has incurred an $8.8M operating loss through December 2024 on a consolidated basis – our fourth consecutive year of negative operating margins. Several HSCRC policies restrict our ability to maintain financial sustainability, particularly the items noted above as well as the lack of Global Budget Revenue (GBR) support for new graduate medical education (GME) programs, and much needed behavioral health services.

The Medicare FFS cumulative *excess savings* (i.e. above established targets) under the TCOC model from 2019-2024 exceed $1B. This number is substantially higher on an all-payor basis. These dollars could have been invested in hospitals that maintain community access, meet patient demand, and fund broader population health initiatives. While there has been some reduction in utilization statewide, most of the savings have been the result of rate suppression (across all payors) and payor denials (commercial, Medicare Advantage and Medicaid MCOs). Rate suppression and denials do not improve population health or reduce disparities in care and outcomes.

Ensuring High-Value Care

Hospitals need financial flexibility to invest in innovative population health solutions. Over the past decade, Luminis Health has aligned with the goals of the Model, the Statewide Integrated Health Improvement Strategy (SIHIS), and the Governor's healthcare vision by investing in programs such as:

- Maternal Health - Centering Pregnancy Program; new access points in Prince George's County
- Behavioral Health (BH) - Luminis Integrated Teen Experience; increased adult psychiatric bed capacity and BH urgent care and walk-in clinics
- Luminis Health-Gilchrist Life Care Institute (hospice and palliative care joint venture)
- Post-acute/Skilled Nursing Facility (SNF) partnerships
- Colo-rectal, prostate and breast cancer screening and early intervention
- Diabetes Prevention Program
- Advanced Medicine and Transitional Care Clinics (opening access to hospital and ED discharged patients)
- Mobile Integrated Community Health
- Remote patient home monitoring for chronically ill patients

Many of these initiatives (and others) were recently enumerated in our response to the HSCRC's call to inventory population health programs. Continued support for these and future investments — such as Hospital at Home, ambulatory palliative care, hospice, and home care —require sustainable funding. The AHEAD model's success hinges on population health initiatives – but these cannot be supported while health systems operate at a financial loss or have insufficient margins to reinvest in the organization.

Improving Access to Care

The HSCRC should prioritize funding programs that align with the Maryland Health Improvement Plan, especially in behavioral health and women's health. Rising medical malpractice insurance costs, particularly in OB, deter needed service expansion. For example, Luminis Health's associated premiums and reinsurance expenses have increased 157% since FY20, far exceeding inflationary adjustments. In 2023, Luminis Health Doctors Community Medical Center (LHDCMC) opened an inpatient behavioral health unit aligned with state priorities yet was denied GBR funding. Given the lack of margin produced by these two service lines, it is not a coincidence that BH and OB are among the most frequently closed clinical programs nationally. Policies must evolve to ensure equitable funding for essential services.

Current policies on Potentially Avoidable Utilization (PAU) funding are overly restrictive and limit hospitals' ability to improve access to care. The three major volume policies – market shift, demographic, and integrated efficiency – all exclude this volume, failing to account for medically necessary care provided by hospitals, often to patients presenting to the emergency departments.

Addressing Emergency Department Overcrowding

ED overcrowding is exacerbated by inadequate primary care reimbursement, incentivizing payors to route patients to hospital EDs where payments are capped under GBR. Meanwhile, Luminis Health has made substantial strides in reducing diversion hours and improving Emergency Medical Services (EMS) transfer times. Being efficient at managing an overcrowded ED has resulted in increased EMS arrivals, further exasperating the ED volume challenges. Payor accountability is critical to resolving this crisis.

Recognizing Hospital-Based Physician Costs & GME

Hospital-based physician costs are essential to acute care hospital operations. Gone are the days of private practice physicians making daily rounds and being on-call around the clock. Commercial payor professional fees have been studied exhaustively and place Maryland in the lowest decile nationally. Hospitals need rate support for these services.

Maryland must align with national standards by establishing a dedicated funding mechanism for GME programs. To date, Luminis Health has invested $103M in GME with no GBR support, despite its critical role in addressing physician shortages and maintaining access to care.

Reforming Integrated Efficiency

The Integrated Efficiency policy fails to recognize chronic underfunding in Maryland hospitals. With 19 hospitals operating at a loss and more than $1B in excess Medicare savings generated largely through rate suppression, the methodology requires recalibration to prioritize hospital solvency.

Payor Accountability & Their Role in the Model

Under the waiver, Maryland hospitals have lost leverage with insurance companies that benefit from favorable "all payor" rates set by the HSCRC. Hospitals face numerous, burdensome payment policies that can be unilaterally modified by insurers. While some insurers are provider-owned, others are large national corporations focused on profits. The HSCRC must ensure hospitals receive value in exchange for these rates, possibly by establishing consistent payment policies across all payors or reducing the number of participating payors. Additionally, Managed Medicaid Plans should be monitored and reassessed regularly. The HSCRC and policymakers need to redefine the role of payors in Maryland's system to ensure they add value rather than creating inefficiency and higher costs, which is critical for the success of AHEAD.

Conclusion

Rising costs, growing demand, and limited funding have driven many Maryland hospitals into financial turmoil, threatening access to care. The AHEAD model needs to strike a balance between fiscal sustainability and its goals of access, quality, and equity. The excess savings generated under the model provide the HSCRC with the opportunity to take immediate action on the issues outlined in this letter. For issues outside the scope of HSCRC, we urge legislative collaboration and support.

We look forward to the opportunity to testify at the February 12th public meeting and future collaboration with the HSCRC to strengthen Maryland's healthcare landscape. As always, we are available for any questions you may have.

Sincerely,

Victoria W. Bayless
Chief Executive Officer

Stephanie K. Schnittger
Chief Financial Officer

cc:
Laura Herrera-Scott, MD, Secretary, Maryland Department of Health
Joshua Sharfstein, MD, Chairman
James N. Elliott, MD, Vice Chair
Adam Kane, JD
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February 3, 2025

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, MD 21215

Subject: Comments on HSCRC policies and Their Impact on Patient Access to life-saving procedures and Innovation

Dear Members of the Health Services Cost Review Commission,

I appreciate the opportunity to provide comments regarding the HSCRC policies and their impact on patient access to care, innovation, and life-saving procedural volume restrictions.

As a physician who recently relocated from New York to practice in Maryland, I have witnessed firsthand how the limitations imposed by the GBR model significantly affect access to life-saving cardiovascular procedures.

I have reviewed the HSCRC letter with great interest, particularly the figure summarizing the AHEAD vision. A central word in the figure—inside a red arrow spanning all AHEAD columns—is accountability. I could not agree more; accountability is the cornerstone of any healthcare policy. However, despite this emphasis, I have yet to find a single study evaluating GBR's accountability. The few available studies on GBR's effects on cost saving are retrospective and suffer from significant methodological flaws. Furthermore, the HSCRC letter does not mention any funding or funding opportunities to rigorously assess the GBR's value or its impact on healthcare in Maryland.

Maryland has a unique opportunity to guide the nation in determining the most effective payment model. While fee-for-service is not the answer, we also cannot claim that GBR is the optimal solution, as we lack the necessary data to support its foundational objectives.

As an interventional cardiologist specializing in valve disease, I can attest that the current model deprives Maryland residents of life-saving and medically necessary valve procedures.

Aortic stenosis, one of the most common and deadly valve diseases, has treatment options ranging from open-heart surgery to minimally invasive transcatheter procedures—both of which are proven to be life-saving interventions.

In 2023**, 48% of patients nationwide** with symptomatic severe aortic stenosis were referred to a specialist for treatment. In contrast, during the same time frame, **only 31% of patients in Montgomery County** received such referrals. This stark disparity should prompt us to critically evaluate whether the Maryland model truly serves the best interests of its residents.

While the GBR model has successfully controlled healthcare costs and promoted preventive care initiatives, it has also introduced unintended consequences that hinder access to innovative and life-saving treatments. The cap on procedural volumes creates a restrictive environment where hospitals face financial penalties for exceeding their allocated budgets, even when providing essential, life-saving procedures such **as Transcatheter Aortic Valve Replacement (TAVR) and Transcatheter Edge-to-Edge Repair (TEER). This is unfortunately not sustainable.**

In my clinical experience, the constraints of GBR have directly resulted in delays and denials of care for patients requiring advanced cardiovascular procedures. Hospitals in Maryland, particularly those with high procedural demand, often lack the infrastructure to support growing medical needs of their communities. This results in an alarming trend—patients being referred to neighboring states where procedural caps are not imposed. Consequently, Maryland residents must travel long distances to access the care they need, which contradicts the GBR's intended goal of improving patient-centered healthcare delivery.

Additionally, the GBR model stifles medical innovation. As new, evidence-based interventions become available, hospitals struggle to adopt these advancements due to budgetary restrictions. Unlike fee-for-service models that incentivize the adoption of cutting-edge procedures, Maryland's payment system discourages hospitals from expanding their service offerings. This places Maryland at a disadvantage compared to other states, where patients have access to a broader range of emerging technologies and treatment options.

Furthermore, while the GBR system has been in place for over a decade, there remains a significant lack of data demonstrating its effectiveness in improving patient access to specialized care. While cost containment is a key priority, it should not come at the expense of timely and equitable access to essential medical treatments. Future policy refinements should consider mechanisms that allow hospitals to provide medically necessary

procedures without financial penalties and foster an environment where innovation can thrive.

I urge the HSCRC to evaluate these concerns seriously and consider reforms that will balance cost control with improved patient access and innovation. As Maryland embarks on the AHEAD Model, it is crucial to ensure that financial structures do not create barriers to care or drive patients out of state for treatment. Thank you for your time and consideration of these pressing issues.

Moving forward, the HSCRC should consider reforms that:

1. **Support greater procedural flexibility**—hospitals should not be penalized for providing proven life-saving interventions. A Hybrid model between GBR and fee-for-service may be warranted for life saving highly innovative procedures that otherwise will not be offered under the current model. Alternatively, exclusions from the cap requirements of certain rapidly growing life-saving procedures should be considered.

2. **Incorporate mechanisms for innovation**—new life saving treatments should be incentivized, not restricted. Incentives for new service liens providing life-saving procedures.

3. **Fund independent research**—a comprehensive evaluation of GBR's impact on access to specialized care is essential. Specifically for marginalized populations.

Sincerely,

Homam Ibrahim, MD, FACC, FSCAI

Director, Structural Heart Disease

Director, Cardiovascular Research

Adventist Healthcare

February 3, 2025

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

Dear Dr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input as the State prepares to move into the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Over the past five years, JHHS has engaged in extensive collaboration and policy discussion with the Health Services Cost Review Commission (HSCRC), and has previously responded to many of the questions posed for this comment period, particularly within the whitepapers JHHS has shared with HSCRC and Maryland Department of Health (MDH) leadership. These whitepapers are included here along with previously shared comment letters for additional consideration. As highlighted in these comment letters and whitepapers, JHHS believes the below priority issues must be resolved before the State is prepared to move into the AHEAD model, and proposes the following potential solutions.

1. **Adequate funding for quaternary and tertiary care delivery and growth.**

   Trending of financial information since the inception of global budget revenue (GBR) indicates that Maryland hospitals are falling behind national hospitals in terms of recapitalization, adoption of new technologies, and the expansion of complex tertiary and quaternary care service lines. According to Vizient 10-year projections, virtually all inpatient growth—both in the state of Maryland and nationally—is projected to be in high-CMI and tertiary and quaternary care, an area exclusive to academic medical centers (AMCs) and advanced community hospitals.

   Despite this trend and these projections, the percent growth in total staffed acute beds at JHH grew 5% from 2015-2022, vs. the National AMC total growth of 10%. Maryland's AMCs are not keeping pace nationally with quaternary and tertiary volume growth.

   The model must preserve Marylanders' access to critical lifesaving care and curative therapies that can only be safely and effectively delivered by AMCs. GBR and current volume policies

create significant pressures to limit access to these key services based on a rationing of fiscal reserves to cover less intensive levels of care. Given the population-based payment flexibilities granted under the State's AHEAD agreement, JHHS urges the Commission to develop a policy that excludes these critical services from GBR and adequately funds AMC-level care.

2. **Adequate funding for medically necessary care.**

   During the last 10 years of GBR, the state saved $1B over stated targets, which can be considered underfunding of the industry. While the goal of the Model is to reduce avoidable or unnecessary utilization, this statement is optimistic and based on data provided, unattainable due to clinical necessity. As in any capped system, fixed payments provide strong incentives to reduce all utilization, not just avoidable utilization. Data shows that to be the case in Maryland, therefore, strong oversight (market or regulatory) is necessary to guarantee that hospitals continue to provide necessary services for the patients in their service area, and that these necessary services are appropriately funded. As some hospitals respond to the incentives of the system by reducing capacity and in turn, utilization, other hospitals then absorb this volume and deliver this necessary care; these hospitals should not be penalized for providing needed care. Under the current HSCRC policies and methodologies, an empty bed is more financially valuable than a staffed bed with a patient in it – this dynamic must change.

   JHHS recommends that the HSCRC appropriately fund this medically necessary care by ensuring core volume policies provide sufficient funding to cover the cost of doing that work. This means that the demographic adjustment appropriately accounts for expected changes due to aging of the population (and that those funds are directed to the hospitals that are taking on the burden of doing that work), and that the market shift adjustment yields a variable cost factor that is appropriate to the care being provided. This can differ dramatically by service line, for patients moving from one hospital to a different hospital. There are some high-cost service lines such as neurology and cardiac surgery that likely demand a higher variable cost factor so that the hospital gaining market shift receives more revenue to support a higher cost service.

   The HSCRC must ensure there are guidelines to identify concerning trends as some hospitals respond to the incentives of the model as they exist today. This includes shifting volumes to out of state providers, deregulating care without disclosure to the HSCRC, lower acuity care being provided in hospitals designed to handle the highest acuity and therefore lowering access for patients with significantly complicated care needs, and redesigning major clinical offerings that greatly reduce or expand access that result in patient displacement in the marketplace or transfer limitations.

3. **Addressing excess capacity and related retained revenues to support community and population health.**

   The success of the Demonstration Model in reducing acute care volumes resulted in some hospitals operating at a lower census and sub-optimal efficiency in Baltimore City, both on operating and clinical quality levels. In any other state, these hospitals would close, effectively right-sizing capacity in the area. However, the model has protected these hospitals from closures, and as a result, significant funding is retained in facilities with limited value, efficiency, and quality of care.

Simultaneously, increasing funding for population health resources is critical to the model, however, to assume that these programs will be funded through PAU volume savings dramatically underestimates the level of funding and time horizon required for significant improvements in population health status. It is also important to note that population health initiatives must involve collaboration and support across hospital systems, non-hospital providers, and state and local governments. The data demonstrates that the biggest impact to population health can be achieved within Baltimore City, but cannot be driven by just one hospital. This work requires partnerships.

JHHS recommends that the State establish a process to evaluate capacity in a semi-regular basis, make recommendations on reductions or increases in capacity, and develop incentives for implementation; through this process, the State can redirect funding currently retained in low capacity facilities towards needed capacity expansion, population and community health initiatives. In collaboration with the Maryland Health Care Commission in their role as the authority over Certificate of Need, this extensive public process should examine the utilization and cost of hospital services, the financial health of the facilities themselves, and the long-term bed need by region and across the state based on future demographic projections. This process would allow for long-term planning to take place in an open, transparent, and thoughtful manner, rather than relying solely on ad hoc policies to drive the necessary changes.

The whitepapers that follow outline the above model distortions and proposed solutions in more detail. Additionally, JHHS offers the following feedback on the HSCRC's proposed questions:

1. **C/D: How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care? Given answers to the questions above, should the HSCRC consider alternative or complementary approaches to PAU policies?**

   Currently, the approach to PAUs does not encourage collaboration to improve the health of a population in order to reduce PAU. For example, if Hospital A eliminates a program and those patients are then seen at Hospital B, Hospital B is penalized for any PAUs associated with this new volume. However, the responsibility for health improvement for this set of patients should lie with Hospital A, who is not getting penalized for this PAU, and instead rewarded with retained revenue for shedding this volume. A revised approach would create accountability for PAU and incent hospitals to work more collaboratively to care for a geographic population.

   JHHS encourages the HSCRC to develop a stakeholder process to develop a more focused and effective approach to current PAU policies. In coordination with staff, this group would be tasked with establishing an accountability mechanism through specific measures in a select number of categories. Subsequently, the HSCRC should consider developing policies to incentivize the activities and initiatives that impact those select measures.

2. **B: Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ED wait times?**

   The concern remains that the emphasis on volume reduction is leading to reduced access to care, not simply the elimination of avoidable or unnecessary utilization. Over the course of GBR, and during this period of volume decline, statewide ED yellow diversion hours increased by

27.2% per year, suggesting a loss of access to care since the inception of GBR. With the exception of a decrease in yellow alerts in CY2017, there has been an increasing trend since 2013. Of note, the year after the inception of GBR, yellow alerts more than doubled in 2014 (8,208 hours).

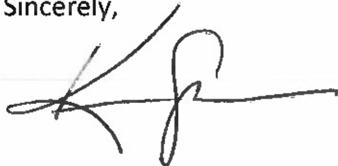
Instead of payment policy to slow the rate of volume decline for specific services related to ED wait times the HSCRC should develop policies that adequately fund medically necessary care. Adequately funding medically necessary care would allow hospitals to invest in staffing beds as needed.

2. **E. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?**

   JHHS believes that the HSCRC should engage the industry in developing a data-driven, commonly accepted definition of "effective" hospitals in the context of broader value-based goals of the AHEAD Model (high-value care, fairness in access to care, and equitable outcomes) and that efficiency metrics should hold hospitals directly accountable to that definition. As it stands, the current efficiency metric does not accomplish this goal. A process to define "effective" that engages the industry as partners in that definition, and a comprehensive re-thinking of the efficiency metric on those terms is needed.

JHHS appreciates the Commission's attention to the important feedback of the industry, and looks forward to resolution of the above model distortions and key issues prior to entering into the AHEAD model.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

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

The following documents are included here, and reflect JHHS's concerns and recommendations related to the questions posed for comment.

Whitepaper	Date
Reforming Maryland's Model	04/2023
Volume Distortion Analysis	08/2024

Comment Letter	Date
Revenue for Reform Comment Letter #1	12/2021
Revenue for Reform Comment Letter #2	05/2022
Revenue for Reform Comment Letter #3	06/2022
Summary of Kevin Sowers HSCRC Testimony	10/2022
Potential Corrective Action Comment Letter #1	10/2022
Potential Corrective Action Comment Letter #2	11/2022
Total Cost of Care Model Progression - Physician Engagement & Alignment Workgroup Comments	04/2023
Total Cost of Care Model Progression - Cost-containment and Financial Targets Comment Letter	05/2023
FY24 Update Factor Comments	05/2023
Efficiency Policy Comment Letter	06/2023
Emergency Department Dramatic Improvement Effort Comment Letter	07/2023
MPA & CTI Comments	10/2023
MPA Comments	12/2023
JHHS AHEAD Comments	12/2023
Emergency Department Potentially Avoidable Utilization (ED PAU) Policy Comments	01/2024
FY25 Update Factor Comments	05/2024
AHEAD Priorities Comment Letter	06/2024
MPA & CTI Comments	06/2024
Financial Hardship Request Process Comments	09/2024
Emergency Department Best Practices Policy Comments	09/2024
Quality Based Reimbursement Emergency Department Length of Stay Policy Comments	09/2024
Excess Savings Comments	10/2024
Deregulation, Repatriation and Out of State Volume Policy Comments	10/2024
AHEAD Preparation Funding Comments	12/2024
Outpatient High-Cost Drug Funding Comments	12/2024

Global Budgets and Total Cost of Care: Reforming Maryland's Model

Whitepaper

April 2023

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Introduction

Since the introduction of the Maryland Demonstration model and Global Budget Revenue (GBR) in 2014, the payment system and regulatory structure for Maryland's hospitals has fundamentally evolved, moving from a pure fee-for-service system to one that attempts to align payment policies with the goals of driving value, improving health, and reducing cost. Although significant strides have been made to reduce unnecessary utilization, improve readmissions and hospital-acquired conditions, and move care to more cost efficient and clinically appropriate non-hospital settings, the system must evolve over time to adapt to changes in the healthcare environment and capitalize on key lessons learned.

After eight years of fixed hospital revenues under GBR, a number of critical distortions have arisen that jeopardize the long-term success and viability of the Model. Some of these are unintended consequences of policy decisions while others reflect a fundamental misalignment between the stated goals of policy makers and the operational realities experienced by the hospital field. These issues impact the hospital field broadly and, in some instances, the Academic Medical Centers (AMC) in particular.

The purpose of this paper, offered jointly by the Johns Hopkins Health System (JHHS) and the University of Maryland Medical System (UMMS), is to explore some of the challenges with the current Model while providing thoughtful, actionable recommendations for future improvements. The recommendations will likely require changes to the agreement with the Center for Medicare and Medicaid Innovation (CMMI), policy changes at the Maryland Department of Health (MDH), including the Health Services Cost Review Commission (HSCRC) and Maryland Health Care Commission (MHCC), and include other policy and funding levers that State and local government could utilize to best support the overarching goals of the Model.

JHHS and UMMS recognize that many of these issues are complex in nature and that any policy changes need to be thoroughly vetted and nuanced to meet the needs of all stakeholders – policy makers, hospitals, payers, clinical leaders, and community providers. Furthermore, we recognize that many of these challenges are exacerbated by the impact of the pandemic, ongoing staffing shortages, and struggling hospital performance across the country. We believe, however, that certain fundamental changes to the current Model need to be considered to promote its long-term success.

Guiding Principles

When the Maryland General Assembly (MGA) established the HSCRC in the 1970s, it articulated four key rate setting principles:

- Efficiency
- Access for all
- Equity among payers
- Solvency for all efficient and effective hospitals

JHHS and UMMS have consistently advocated for these principles over the years, both through policy and legislation. We believe that these core principles remain relevant in a healthcare environment that has fundamentally changed since the inception of the Maryland Model:

- Hospitals have moved away from traditional fee-for-service in favor of fixed revenue GBRs

- Managed Care Organizations (MCO) are now responsible for the large majority of Medicaid beneficiaries
- Commercial health plans have expanded in size and scope, with benefit design concepts, such as high deductible and value-based plans, that change the ways in which patients access care
- State and local governments, specifically local health departments, have stepped back from their traditional roles as safety net providers, depending upon hospitals and other private providers to step into the gap
- The public mental health system, particularly for inpatient care, has largely disappeared over the past 20 years, with the expansion of community-based services not keeping up with demand
- The pandemic has exacerbated the country's mental health crisis, placing even greater demands on hospitals
- CMMI, created as part of the Affordable Care Act in 2011, continues to push greater accountability for cost and quality onto providers, including increasing expectations for providers to address the social determinants of health

Building upon the foundational rate setting principles, and incorporating these changes in the healthcare landscape, JHHS and UMMS established the following guiding principles to inform its findings and recommendations:

- A key strength of the Model is its all-payer nature, reflecting a focus on equitable access and care for all patients, regardless of payer or ability to pay
- Hospitals have an obligation to meet the needs of the communities that they serve, including providing access to medically necessary care
- The financial incentives of the Model should reward cost-efficient providers that provide high-quality care to patients
- Regulatory programs need to have distinct criteria and rules that are objectively developed and uniformly enforced, with exceptions only being granted to address emergent and unforeseen events
- Regulatory constructs should contemplate and account for unique hospital circumstances, rather than strict application of across-the-board methodologies. Rural providers, providers with safety net functions, and AMCs have fundamental differences that must be reflected in policies and methodologies.
- State and local governments, including their budgeted priorities, initiatives, and policy objectives, should be leveraged to support the overarching goals of the Model

Issues with the Current Model

JHHS and UMMS remain committed to providing care of the highest quality and safety standards to all patients and have shown our commitment to the Maryland TCOC Model, integrating the goals and incentives of the model to transform the way our member organizations interact with the many communities they serve:

- Building a patient support and population health management infrastructure through significant investments in case management, care coordination, social work, navigators, and community outreach
- Building an integrated delivery model that improves access to care while reducing reliance on hospital-based services with investments in mental health, mobile integrated health, high-risk clinics, post-acute care, urgent care, primary care, and home care.

- Engaging communities in evidence-based care management to deliver value in terms of outcomes and community needs.
- Expanding partnerships with community organizations and investing in community-based initiatives to address identified community needs: community outreach, workforce development, place-based investments, and social determinants of health.
- Impacting health disparities and prioritizing equity.

While we remain committed to the overarching goals of the Model, the challenges outlined below represent a necessary evolution of the model's financial and care delivery incentives to position the Model for sustained, long-term success. The challenges with the current Model have arisen in part due to decisions made during the development and early implementation of GBR and in part because of policy decisions that have been made over the course of the Model. This is understandable as the purpose of CMMI Demonstration Models is to test new payment types, learn what works and what needs improvement, and course correct along the way. Maryland needs to similarly recognize that although there have been many benefits of the current model, like all models it needs to evolve over time to address unintended consequences, negative incentives, and other issues that present themselves.

These challenges with the current model can be placed into two categories – those that impact all of Maryland's hospitals due to the uniform payment model and those that uniquely affect the AMCs.

Systemic Issues Impacting Hospitals

Retained Revenue

The policy intention of the Maryland Demonstration Model, first the All-Payer Model (2014-2018) and now the TCOC Model (2019-present), is to transition away from volume-based payment methodologies toward implementing financial incentives for hospitals to continually invest in community health and care transformation (moving from "volume" to "value"). For the first eight years of the Demonstration Model, the primary financial incentive has been the fixed revenue GBR. Under GBR, hospitals are provided a fixed annual revenue amount (initially based on 2013 volumes), with limited adjustments for both utilization increases and decreases. As utilization decreases, hospitals are allowed to "retain" this revenue, thereby generating savings to drive continuous investment in care transformation. Policies to date have focused on preserving hospitals' ability to retain revenue related to volume declines, providing a maximum incentive to reduce hospital-based utilization. The magnitude of the retained revenue that resulted from the GBR policy construct has been one of the most significant distortions in the Model prior to the pandemic (2014-2019), and factors such as the COVID-19 crisis, ongoing labor shortages, and eroding hospital financial performance have added complexity to this issue today.

For the six years prior to the onset of the pandemic (2014-2019), Maryland was able to achieve significant utilization declines, but both the drivers and value to the Model of those declines and the resulting retained revenue remains unclear. The HSCRC's current policies do not differentiate between health management and simply discontinuing services, and there is no data at this time to indicate that the bulk of hospital utilization declines prior to the pandemic were achieved through care transformation or investment in addressing community needs. Instead, all volume reductions are

rewarded as a positive outcome and there is limited accountability for continuously investing retained revenues in care transformation or improving health outcomes.

While this broad incentive to reduce all utilization and keep the revenue served as a critical mechanism to radically and fundamentally change hospital behavior in a short period of time over the early years of the Demonstration Model, allowing hospitals to retain all of the GBR savings in perpetuity regardless of utilization declines is counter to the ongoing goals of the Model and the stated policy positions of former CMMI and MDH leaders involved in the original design. After eight years of locking these revenues into increasingly price-inefficient facilities that are no longer providing the same level of care to the community, the State must grapple with the unintended consequences of doing so:

- Patients receiving care at low-volume hospitals receive inappropriately high bills.
- Revenue that could otherwise be used to invest in care transformation or to support the State's contractual obligation to achieve Medicare savings is instead unavailable as it covers the fixed costs of volumes that are no longer there.
- It limits the ability to invest in hospital services at the providers who are caring for the patients by providing inadequate annual rate updates that are spread across all hospitals, regardless of need, level of service, or investments in the community.
- Restricting access to this revenue only to the hospital that experienced the utilization declines limits the ability to make direct investments in communities with the highest priority needs, including Social Determinants of Health.

Since March 2020, the severe volume and cost disruption of the COVID-19 crisis as well as the ongoing staffing shortages and cost inflation issues serve as complicating factors for assessing retained revenue. While the general issue remains (hospitals are retaining revenues due to significant volume declines) and the same thoughts regarding retained revenues should apply eventually, we recognize that there is not yet a sufficient 12-month period to assess retained revenue issues from 2020 to today.

Excess Capacity

JHHS and UMMS recognize that rationalizing the hospital footprint by reducing excess hospital bed capacity to align with a redesigned care delivery model is an essential component of long-term success under a fixed revenue model. To its credit, UMMS serves as a leader in this area, redesigning care delivery by initiating plans to transition three acute hospitals to Freestanding Medical Facilities (FMF) where appropriate and implementing a rural hospital model on the mid-shore. While UMMS has made these efforts as part of its commitment to transform care delivery for the communities it serves, there are not direct mechanisms in place to ensure that this transformation occurs where needed.

For instance, the population of Baltimore City declined by more than 7% from 2013 (the base period for hospitals' GBR) and 2021. Not surprisingly, hospital-based volumes have decreased significantly, generating significant retained revenue among hospitals in Baltimore City. Baltimore City is over-bedded beyond the need for staffed hospital beds; however, the retained revenue keeps low-volume hospitals open that would have closed in the open market. There is a need to both periodically realign GBRs with current volumes and implement a process to facilitate right sizing hospital capacity over time. Otherwise, revenue that could be invested in continuous transformation is inefficiently covering the fixed costs of volume levels that no longer exist. While it is not the HSCRC's responsibility to close hospitals, it is its responsibility to appropriately align regulated payments with organizations that are serving patients in our communities.

By right-sizing capacity, we can create available funds that can be thoughtfully distributed to address (1) allowed retained revenue at hospitals (2) investments in care transformation and community health, and (3) contributions to savings requirements. A more equitable and logical way to meet community needs may be a policy that, if properly executed, provides for right-sizing capacity within the system, pooling a defined amount of those retained revenues, and using them to re-invest in care transformation. The HSCRC already executes the policy premise of realigning GBRs with the reduced services provided in its conversion of acute care hospitals to FMFs. When approving these new types of facilities, the HSCRC removed funding from the historic global budgets because the FMFs are providing less services than had previously been provided by their acute care hospital predecessors. The same should hold true for acute care hospitals that are providing less care than they once did.

Inadequate Focus on Population Health and Health Disparities

To date, the major incentives of the All-Payer and TCOC Models have been to (1) reduce hospital-based utilization with the intention of generating retained revenues available for reinvestment, and (2) establish broad accountability for TCOC per capita and change over time (often linked to TCOC for a specified geographic area). These incentives have changed hospitals' behavior in-terms of hospital-based utilization, created a source of funds for reinvestment, and introduced financial metrics linked to TCOC to ensure financial targets are achieved. However, policies to date do not adequately establish accountability for health outcomes or create adequate pathways for direct, differential investment of available funds into areas of highest need. Both the current agreement with CMMI and the State Integrated Health Improvement Strategy (SIHIS) establish a need for increased accountability to outcomes. Furthermore, CMMI's 10-year strategy refresh (October 2021) prioritizes accountable care models and advancing health equity among its strategic objectives. The CMMI 10-year strategy refresh also highlighted several "lessons learned" from various models that should inform our own considerations of Model Progression:

- **Ensure health equity is embedded in every Model** – this is not just a requirement to measure whether inequity exists. Maryland's model design should consider this as a mandate to identify inequities and make direct investments in eliminating them.
- **Streamline and reduce complexity to help scale what works –** Current HSCRC methodologies meant to incent TCOC improvement and care transformation tend to be both too many in number and have incentive pathways that are overly complex or carry a significant administrative burden to measure. The CMMI strategy refresh rightly points out that complexity of model design can be an impediment to care transformation. As the Maryland Model continues to progress, it should identify specific, easily measurable, and impactful outcomes, design clear incentives for hospitals to affect those outcomes, and make direct investments in improving outcomes where the most inequity exists.
- **Complexity of financial benchmarks that undermine model effectiveness –** HSCRC should evaluate the effectiveness of its broad TCOC metrics in achieving desired behavior changes and set benchmarks that maximize hospital participation while also sustainably generating savings.
- **Implement models that encourage lasting care transformation** – This means prioritizing health equity, outcomes, care transformation, and multi-stakeholder participation/collaboration in Model design.

It is essential that our State Model demonstrates the ability to make the differential investments required to impact health status in the communities with the most severe historical/structural disadvantages in the State. This is the definition of health equity. The strength of our demonstration model is that we have the ability to address this in a way that is unachievable under payment models in other States. We believe that current HSCRC policies do not adequately incent hospitals to invest significantly and collaboratively in community health programs. Although hospitals have invested in innovative programs to varying degrees, including those targeting social determinants of health, these have been difficult to scale and sustain over time. Considering the lack of regulatory or contractual requirements around the use of retained revenues, we are also concerned that overall investment in care transformation and community health initiatives both represents a small portion of overall retained revenue and is not adequately targeted toward the highest priority health inequities. Current policies, including the proposed Revenue for Reform policy, preserve an inequity of access to funding for investment at hospitals with the most retained revenues. There are likely more efficient, equitable, and targeted ways to ensure appropriate levels of investment for the highest priority health disparities in the State. Care transformation should be contemplated in terms of regional strategies that identify the highest priority community needs, and HSCRC policies should emphasize direct investment in addressing those needs as well as real accountability for improvement.

In addition, the lack of requirements regarding how GBR savings are to be spent, at least in part in the community, has led to some hospitals investing in services for more commercially insured and affluent populations outside of their primary service area. This is an unfortunate occurrence as these funds could have been better utilized to invest in community-based services in communities that most need them.

Lack of direct accountability for low intensity hospital-based care

As was discussed previously, the GBR model provides a broad incentive to reduce utilization and retain revenue, which has served as a critical mechanism to change hospital behavior around utilization management. However, policies to date have de-emphasized hospital-level accountability for utilization management in favor of broad incentives. As we are now in Year 10 of the Model, there are multiple areas where implementing more direct, hospital-level accountability will be required to drive continuous utilization improvement while also improving patient care and experience.

Price per case mix adjusted case

Price distortions are an inevitable outcome of the retained revenues under the GBR model described earlier. Without proper accountability for how retained revenue is utilized, the value of growing price per volume distortions at lower-volume hospitals is unclear. This has direct impact on patients who require hospital-level care, as patients at low volume hospitals will receive higher bills. These higher bills result in ever greater amounts of patient cost share, particularly for patients with high-deductible health plans.

Length of Stay (LOS)

A recent analysis by the Maryland Hospital Association (MHA) illustrates that LOS in Maryland is increasing compared to the nation. While the underlying causes may be difficult to discern, it is

true that the fixed revenue GBR has less clearly defined accountability for managing LOS at a case or DRG level than at a national level, which we are being benchmarked against.

Potentially Avoidable Utilization (PAU)

Since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volumes under GBR, not just avoidable volumes. There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease by disproportionately impacting PAU.

Low Intensity Volume

In this context, "low intensity volume" can be defined as care that could be provided in a different setting or as care that could be avoided altogether. For purposes of this discussion, we have identified four different types of low intensity volume:

1. The first category includes urgent care and primary care-sensitive outpatient emergency department (ED) visits. This can be thought of as patients using the ED as a setting for primary care or disease management. The most important solution here is to connect residents of the local community to resources to actively manage their health.
2. The second category consists of ED admissions that do not require an academic setting, as these cases are less complex and do not require the highly specialized care that AMCs are uniquely positioned to deliver. These patients "vote with their feet" for necessary hospital care and present at AMC EDs, but a lower cost care setting should be available to these patients.
3. The third category includes patients using regulated outpatient services such as clinics, imaging, lab, screenings, endoscopies, and other lower intensity outpatient procedures.
4. The fourth category, which JHH has moved aggressively on since the opening of its Greenspring Station Ambulatory Surgery Center (ASC) in 2019, includes a mostly commercial, non-Baltimore City population that has traditionally travelled to JHH for elective outpatient procedures that could be served in an ASC.

For both JHHS and UMMS, even as low intensity volume is a lower percentage of total volume than most hospitals, there exists a certain amount of low intensity volume as a result of both our teaching mission and our role serving communities that have significant disparities. However, addressing low intensity volume to maximize our roles as hubs of clinical innovation and as tertiary/quaternary resources to the State and region is a high priority. We are committed to exploring the following potential solutions to address low intensity volume at Johns Hopkins Hospital (JHH) and the University of Maryland Medical Center (UMMC) over the coming months. JHH and UMMC aim to partner with the HSCRC to work through the various financial and regulatory barriers that may limit the viability of these approaches and strategies:

1. **Urgent Care Strategy for Baltimore City**: To effectively reduce low intensity volume in Baltimore City, there is a need for an urgent care strategy. Given the current Medicaid reimbursement rates, urgent care facilities in Baltimore City have not been financially viable. Therefore, there is no alternative venue for Medicaid patients in Baltimore City, and many

of these patients are then seen in EDs. In collaboration with other health systems and industry stakeholders, JHHS and UMMS would like to explore the development of a Baltimore City urgent care strategy focused on creating additional access to care for Medicaid patients in lower-cost settings. Considerations for this discussion should include patient copay and financial responsibility, triage strategies, funding mechanisms, payor contracting, education, social issues, and community need.

2. **Investigate alternative hospital-based sites for lower intensity clinical care:** Since FY2018, the UMMC undertook a conscious alignment of programs that includes the strategic transfer to the UMMC Midtown Campus (MTC) of acute inpatient, post-acute, and certain outpatient surgical and clinic services from UMMC. This alignment allows for growth of programs to meet community identified needs at Midtown and, at the same time, it also enhances timely access to UMMC for the vital tertiary/quaternary resources relied upon by the entire state and region. UMMC will continue to explore opportunities to leverage its alignment with MTC in this way. At JHH, there may some opportunity to move services currently provided at JHH to Johns Hopkins Bayview Medical Center (JHBMC). For various services, including obstetrics, prostate cancer, and thoracic surgery, volumes could be transferred to JHBMC if appropriate updates are made to facilities to support this shift of volume. JHH will examine this opportunity further along with the necessary financial and operational issues that must be resolved for the viability of this strategy.

3. **Expand Movement of Services to the Ambulatory Setting:** Both JHHS and UMMS aim to continue efforts to move services to ASCs where possible given the current staffing and reimbursement landscape. Similar to urgent care, Medicaid payment rates are a barrier to establishing ASCs in Baltimore City due to the payer mix.

4. **Hospital at Home**: JHHS has launched planning for implementation of an innovative care model developed at Johns Hopkins Medicine (JHM), referred to nationally as Hospital at Home. This care model aims to offer home-based acute care services to adult patients as a lower cost and often preferable alternative to traditional hospital services. Patients would be selected and triaged from the ED and admitted to a Hospital at Home bed or transferred from an inpatient facility-based setting to continue their hospital stay at home. This care setting would provide an alternative for hospital admission that does not require an academic setting. Hospital at Home also provides tremendous promise to reduce the total cost of care through decreased utilization of post-acute services when appropriate. While Hospital at Home is frequently misunderstood as home-based primary care or home care services, it is critical to note that Hospital at Home is an acute model serving patients who need an inpatient level of care.

   Hospital at Home would allow Maryland hospitals to provide acute care in a more cost-effective setting, but the currently proposed payment model for the program prevents Hospital at Home from being a financially feasible program for hospitals. JHHS would welcome the opportunity to work with the HSCRC to revise the proposed payment model for Hospital at Home in order to allow Maryland hospitals the opportunity to launch and scale these programs.

5. **Expanded Post-Acute Care Strategies**

AMC-Specific Challenges

AMCs are leading clinical and teaching institutions that are deeply embedded in their communities, providing tertiary and quaternary healthcare services for citizens across the region, specializing in the most complex and difficult diagnoses and treatments, educating the next generation of health professionals, and often serving as safety-net providers for their local communities. AMC research provides important new knowledge leading to advances in understanding and treatment of diseases, including conducting innovative clinical trials to quickly and safely make new treatments available. AMCs also stand on the country's frontline of defense in response to public health outbreaks, natural disasters, local crises, and responding to potential terrorist attacks. In the absence of high-end clinical services that are only available at the State's AMCs, Maryland residents would either not have access to these services or would be required to travel out-of-state to access them.

AMCs operate 71% of accredited level-one trauma centers and 98% of the nation's 41 comprehensive cancer center nationally. Research suggests that patients treated at AMCs have up to 20% higher odds of survival, compared to those treated at nonteaching hospitals, and the nation's medical schools conduct 55% of the extramural medical research supported by the National Institutes of Health (NIH).

In 2019, Johns Hopkins Technology Ventures' Technology Transfer group processed 443 reports of invention, secured 147 new U.S. patents and executed 116 new agreements. The office also consulted with dozens of inventors to analyze the market for, plan the development of, and secure funding for early-stage technologies. During Fiscal Year (FY) 2019, externally-funded spending at Johns Hopkins on research and related programs totaled nearly $3.4 billion. Johns Hopkins University led all U.S. institutions in total NIH funding in FY 2021. Although these grants are important to further the research objectives of AMCs, it is important to note that these dollars do not cover the total cost of the research enterprise.

In addition to their key role as leaders of clinical care and hubs for medical and scientific research and innovation, AMCs serve as a foundation and catalyst for economic development to the region and state. They employ thousands of professionals and staff, while often producing original products and technologies that benefit millions of people worldwide. In FY 2019, Johns Hopkins and its affiliates directly and indirectly accounted for more than 102,400 jobs in Maryland, including 54,623 people employed directly by Johns Hopkins at its various Maryland locations with a payroll of nearly $4.4 billion. In FY 2019, Johns Hopkins spent more than $1.3 billion on purchases of goods and services (including construction) from companies in Maryland, directly supporting 7,700 jobs in Maryland.

Due to the unique role and highly specialized services of AMCs, they have struggled in a few major areas under the broad-based GBR policies. Of particular, consistent concern is (1) the underfunding of high intensity, AMC-oriented clinical programs and (2) the limited ability for broad-based GBR volume reduction incentives to provide a pathway to contribute to investment in both the AMC mission (teaching, research, innovation) and in care transformation for typically high needs local populations. This experience under GBR represents a significant concern for both JHHS and UMMS in terms of the

ongoing sustainability of the Model. The below issues represent the most impactful and pressing concerns driving AMC performance in the Model.

Consolidation of highly tertiary, specialized clinical programs at AMCs and growth in those volumes as new therapies and treatments occur

Highly tertiary, specialty programs (such as Transplants, Hematology/Oncology, Neurosciences, Cardiovascular Services, and other specialty surgeries) are at the core of the research and innovation that occurs at AMCs and have grown differentially at AMCs over time. At AMCs, these programs are growing, while more community-oriented programs are declining in alignment with Model incentives. At other hospitals, even other teaching hospitals, these same services are behaving similarly to, not differentially from, other service lines.

The broad incentives and volume funding mechanisms under the GBR intentionally underfund costs associated with volume growth as a disincentive for hospitals to grow. Unfortunately, at the level of cost and growth that occurs differentially at AMCs in these AMC-oriented service lines, underfunding of cost growth is not a sustainable option to support these AMC-oriented programs.

Limited ability to generate sufficient contribution to continuous investment in research and innovation

In its effort to replace volume-based payment mechanisms with value-based mechanisms, the All-Payer Model and subsequent TCOC Model took the ambitious step of implementing fixed revenue GBRs and intentionally making it financially unfavorable to grow hospital-based volume while making it beneficial to reduce volumes. This kind of policy targets the lower value hospital-based volumes described above. Due to the program mix at AMCs, the major incentives of the GBR are less impactful. AMCs nationally are contributing to significant, continuous reinvestment in research and clinical innovation by making a margin on that same AMC-oriented volume. This reality, juxtaposed against the limited ability of the Maryland AMCs to maximize the incentives of the Demonstration Model due to program mix, places Maryland's AMCs at a disadvantage compared to their national peers.

While we support the goal of the Maryland Demonstration Model to move away from volume-based incentives, we also recognize the need to drive continual reinvestment in the academic mission. However, the GBR Model eliminated the traditional route to investment without implementing a pathway to generate contribution at the magnitude required to make necessary investments in supporting the academic mission. This in turn limits Maryland's AMCs' ability to maintain their position compared to peers.

Proliferation of Graduate Medical Education

The funding of Graduate Medical Education (GME) in the United States has evolved over several decades. Originally established to ensure an adequate supply of physicians with the expansion of health insurance due to the creation of Medicare in the mid-1960s, it has changed over time from a statutory and operational perspective. Unfortunately, policy and funding changes have not kept pace with the needs of the population, resulting in thousands of medical graduates each year unable to find a residency slot.

In Maryland, due in part to the unique hospital rate setting authority of the HSCRC, Maryland's hospitals have been funded differently in some ways and similarly in others compared to their national peers. Although funding categories for Direct Medical Education (DME) and Indirect Medical Education (IME) exist in both systems, the all-payer nature of Maryland's hospital payment system ensures that all payers are equitably contributing to the social benefits derived from GME.

The challenge remains, however, that the HSCRC has not articulated an updated policy to govern GME funding since 2002. During that time, Maryland's hospitals have all transitioned to the GBR model, community hospitals have been allowed to add residency programs without a clearly articulated policy to guide them, and new medical schools have been envisioned in the State. It is incumbent upon the HSCRC to revisit the issue of GME funding in Maryland and assess whether the existing GME infrastructure can or should accommodate newly established schools of medicine. The HSCRC should evaluate these circumstances with an eye toward creating a policy that appropriately funds physician training in Maryland, ensures specialty and geographic diversity, and promotes the tenets of the TCOC Agreement with CMS.

Recommendations

The following recommendations are being offered to generate additional dialogue and discussion with CMMI and State leadership on ways to improve the current model:

Statewide Policy Issues

1. **Retained revenue accumulated prior to the pandemic (from the inception of GBR in 2014 through 2019) must be addressed (1) to ensure that hospital revenue bases reflect changes in patient choice, movement and clinical delivery and (2) to ensure revenues related to volume declines over time are available for direct investment in health disparities as well as generating system savings.**
    a. While recent efforts to develop the Revenue for Reform policy would add certain requirements for hospitals to spend a portion of retained revenues, this remains a passive mechanism that still leaves significant revenues covering fixed costs for volumes that no longer exist at a hospital and limits the ability to make direct, differential investments into areas of highest need. We believe a more direct adjustment and redeployment of funds is a better approach to ensuring that retained revenue provides accretive value to the Model.

b. We recommend utilizing a consistent methodology for calculating retained revenues. The current retained revenue calculation socialized by the HSCRC is calculated at the unit rate level. This is inconsistent with the Equivalent Case Mix Adjusted Discharges (ECMAD) volume methodology used in the market shift policy and other HSCRC policies. HSCRC should maintain consistency across policies whenever possible.
c. Such a policy must include specific considerations, such as allowing hospitals to permanently retain a portion of revenue (and potentially retain a larger portion of PAU declines), requiring a certain amount of system savings, and defining how hospitals may access funds to invest in care transformation.
d. Adjustments would likely need to be implemented over a multi-year period to allow hospitals a runway to absorb reductions.

2. **Monitor current hospital performance with a goal of establishing an appropriate period to revisit retained revenues accumulated since 2020.**
    a. Hospitals find themselves in a unique financial circumstance due to (1) the extreme disruption of the COVID crisis that began in March 2020 and extended through the Omicron surge in the Winter and Spring of 2022 and (2) the ongoing, extended impact of inflationary pressure, escalation of labor costs, and labor shortages.
    b. We recognize that assessing retained revenue during this period is significantly complicated by these factors and are wary of making permanent adjustments related to this period at this time.
    c. Eventually, retained revenue should be evaluated along the principles outlined in Recommendation 1 above once an evaluation period is established.

3. **Redesign volume methodologies going forward**
    a. While current policies have achieved a significant change in hospital mindset in a short period of time, 100% retention of revenue related to volume declines in perpetuity is not a viable policy.
    b. Current incentives to reduce utilization (market shift policy) go too far, incenting hospitals to reduce or eliminate access
        i. For PAU-related retained revenues: Any retained revenues associated with a reduction in PAUs should be protected at 100%, as this is consistent with the intent of the new model and also with other HSCRC methodologies. To ensure incentives are appropriately aligned with other HSCRC policies, these revenues should be fully protected.
        ii. Adjust the market shift policy to better account for volume changes by including differential variable cost factors depending on the service. The market shift policy is currently focused on patient movement from hospital to hospital, but this is only a small part of the full picture of volume shift. The policy therefore misses significant portions of patient choice and movement and is not as timely as needed.

4. **Establish a periodic rebalancing mechanism to adjust hospital GBRs to reflect changes in patient movement and clinical delivery. This could be done in different ways:**

a. Sync unit rates with GBR on a regular basis, effectively lowering rates at hospitals with retained revenue over time. This could be a phased approach to reduce a hospital's GBR where appropriate.
b. Implement limitations on rate corridors for hospitals who have not reached GBR for two consecutive years, and potentially remove half of the difference from the following year's GBR. This would allow retained revenues to be intentionally removed from the system through an appropriate, phased, and measurable process that continues to provide the incentive to lower total cost of care.

5. **Establish a process to evaluate capacity on a semi-regular basis, make recommendations on reductions in capacity, and develop incentives for implementation.**

    a. MDH should undertake an extensive public process to examine the utilization and cost of hospital services, the financial health of the facilities themselves, and the long-term bed need by region and across the state based on future demographic projections. This process would allow for long-term planning to take place in an open, transparent, and thoughtful manner, rather than relying solely on ad hoc policies to drive the necessary changes.

6. **Implement policies that make hospitals directly accountable for low intensity care**

    a. Create a regional approach to PAUs in order to further the focus on population health-driven strategies**.** Currently, the approach to PAUs does not encourage collaboration to improve the health of a population in order to reduce PAU. For example, if Hospital A eliminates a program and those patients are then seen at Hospital B, Hospital B is penalized for any PAUs associated with this new volume. However, the responsibility for health improvement for this set of patients should lie with Hospital A, who is not getting penalized for this PAU, and instead rewarded with retained revenue for shedding this volume. This approach would create accountability for PAU and incent hospitals to work more collaboratively to care for a geographic population.

    b. HSCRC should implement stronger incentives to reduce excess utilization due to LOS. Accountability for length of stay management is currently limited to the broad incentive to reduce utilization under the fixed revenue GBR. We do not have direct reward/penalty incentives around length of stay built into our model. Implementing strong, direct accountability for length of stay aligns with the goals of the model.

    c. Increase Medicaid rates for non-hospital services such as urgent care and ambulatory surgery centers to divert inpatient utilization and still generate substantial savings to Medicaid**.** By increasing Medicaid reimbursement and making the urgent care and ASC settings financially viable for providers, low intensity patients would have an alternative to the ED that currently does not exist. We are open to exploring options to make this proposal cost-neutral to Medicaid.

7. **Leverage the unique capability of the Maryland model to develop distinct funding mechanisms for investment in care transformation and community health, particularly in areas of highest need.**
    a. As funding sources are "stuck" at hospitals with volume declines, there remains inequitable or unavailable funding for direct investment to address the most pressing health disparities.
    b. There must be mechanisms that enable direct, differential investment in providers and programs that serve the State's most disadvantaged populations.
    c. For example, Baltimore City needs a more impactful and scalable high-utilizer strategy, utilizing lessons learned from successful national programs. We would like to develop an innovative approach that focuses on the systemic and root causes of health disparities. We propose a phased, multi-stakeholder approach that addresses SDOH, including affordable housing.

8. **Evaluate Model incentives and how they apply to areas where a "one-size-fits-all" approach may not sufficiently support long-term success.**
    a. Distinct policy considerations may be required in areas where standard incentives have either limited impact or do not adequately account for specific needs.
    b. Acknowledging the different mission and program mix of the academic medicine model.
    c. Accounting for rural communities where low population density may mean traditional approaches to volume and efficiency are insufficient to support necessary programs and care delivery models.
    d. Supporting safety net programs and ensuring differential investment in areas of highest need.

9. **Evaluate the current quality and patient safety program to ensure the metrics are actionable, impactful, and promote the overall success of the Model.**
    a. While there is a need to align with CMS requirements regarding the quality and patient safety program, Maryland should be innovative in how it approaches the type, number, and incentives/penalties of the metrics utilized to the extent possible.
    b. Any metrics selected should be appropriate for the hospital to impact, be easily measurable in near real-time to gauge performance, and have clear lines of accountability.
    c. Maryland should also explore aligning quality metrics across providers and health plans, each impacting its own specific part of the care continuum that when broadly constructed will have the greatest impact on the chronic condition or other measurable goal.

AMC-specific Issues

1. **The drug funding mechanics in the current Complexity and Innovation policy should apply to high-cost outpatient drugs (100% VCF funding of change – up and down – in cost plus markup).**

   a. For AMCs, where high-cost outpatient drugs represent more than 40% of total drug spend, 50% funding of change in cost plus markup via the Cost of Drugs Sold Adjustment (CDS-A) is not a viable methodology.
   b. This is an issue of rapidly increasing importance due to the proliferation of innovative drugs and therapies since FY2021. While high-cost outpatient drug cost plus markup at JHH and UMMC grew by $4M annually in FY 2018 to FY 2020, the two AMCs have collectively experienced $18M+ growth in each of FY 2021 and FY 2022 and expect growth in the coming years to expand beyond $20M annually.
   c. Funding only 50% of cost growth at this magnitude has a potentially devastating effect at AMCs, particularly as the HSCRC reduces the differential inflation funding it provides for high-cost drugs. Excluding outpatient drugs from the Complexity and Innovation policy and subjecting them to the current CDS-A mechanism guarantees a shortfall of funding for the great majority of new and innovative drugs and therapies and puts the Maryland AMCs at a significant disadvantage nationally.
   d. While the underfunding of costs is an issue that the HSCRC may consider addressing Statewide, its disproportionate impact at AMCs makes an AMC-solution a minimum requirement. Applying the volume funding mechanism defined in the Complexity and Innovation Policy to these high-cost drugs would resolve the issue.

2. **A cost coverage volume model, such as the funding mechanism defined in the Complexity and Innovation Policy should be applied to the high-acuity, AMC-oriented clinical programs that serve as the foundation of research and clinical innovation.**
   a. Transplants, Hematology, Oncology, Cardiovascular Services, Neurosciences, Neonatology, Extracorporeal Membrane Oxygenation (ECMO), certain surgical specialties (such as Ear, Nose, and Throat (ENT), Thoracic Surgery, and Vascular Surgery) represent an AMC's core clinical programs in terms of research and innovation.
   b. While the current Complexity and Innovation Policy utilizes a cost coverage volume funding mechanism, it identifies a limited number of specific inpatient procedures (it excludes all inpatient cases with Case Mix Index (CMI) <1.5, does not recognize any drugs and therapies that are not associated with a procedure, and excludes outpatient entirely) that represent only about 10% of an AMC's volume.
   c. The HSCRC should apply exclusion criteria for participation in this cost coverage mechanism. However, if the AMC exclusion criteria are met, the cost coverage volume funding mechanism should apply to entire clinical programs both inpatient and outpatient, rather than attempting to identify specific inpatient volumes within those programs. It is the entire program that supports the research, innovation, and teaching cost structure within it, not the limited set of inpatient procedures that are unique to AMCs.

3. **Beyond applying a cost coverage model to AMC-oriented volumes (including innovative drugs and therapies), AMCs require an additional or alternate, value-based pathway to invest in both their academic mission and care transformation.**
   a. The major incentives of the GBR are less impactful at AMCs because the community-oriented, lower intensity volumes that are targeted by GBR policies and have been a

significant driver of improved financial performance at community hospitals represent a much smaller proportion of an AMC's business.

b. While we have proposed cost coverage volume funding models on AMC-oriented clinical programs above, AMCs nationally are contributing to significant, continuous reinvestment in research and clinical innovation by making a margin on that same AMC-oriented volume. This reality, juxtaposed against the limited ability of the Maryland AMCs to maximize the incentives of the Demonstration Model due to program mix, represents a differential advantage that AMCs have nationally.
c. While we support the goal of the Maryland Demonstration Model to move away from volume-based incentives, we recognize the need to drive continual reinvestment in the academic mission. For this reason, we would propose a development of a value-based mechanism that replaces the national volume-based mechanism but provides access to a similar level of contribution.

4. There is an increasing need for thoughtful policies around the proliferation of GME programs.

a. HSCRC should review residency slots across the State periodically and provide funding in rates for existing residency slots. HSCRC should remove the cap on residents in place since 2011, evaluate current funding levels, and provide funding equivalent to the current resident levels.
b. HSCRC should review the adequacy of the current funding levels for DME for existing programs prior to funding new programs.
a. HSCRC GME funding policy should evaluate need for newly established programs. We are concerned that the growth in medical schools within the state will create a scenario that will restrict the clinical placements of existing schools of medicine. New residency programs should be complementary to, not compete with, existing residency programs, and newly established residency programs should not be automatically funded without a demonstration of need.
b. HSCRC/MHCC should periodically assess physician supply/population projections/need.
c. HSCRC should explore options to reduce the rate variation caused by having large teaching programs.
d. HSCRC/MHCC should advocate for programs to attract and retain physicians, particularly in underserved areas (such as loan forgiveness).

August 16th, 2024

The Need for Maryland Model Policy Refinement

Executive Summary

Maryland continues to be a leader nationally in the development and implementation of Alternative Payment Models (APM) for hospital global budgets, including the All-Payer and Total Cost of Care (TCOC) Models with the Center for Medicare and Medicaid Innovation (CMMI) over the past decade. Like all CMMI Demonstration Models, Maryland's Model was based on a series of policy assumptions that would either be proven or disproven over time. Policy changes, based on data and experience, would allow the Model to build upon its successes while addressing unintended consequences.

Unfortunately, these necessary and anticipated course corrections have not kept pace with the demonstrated, objective outcomes of the Maryland Model to date. Unintended consequences have negatively impacted patient access and quality of care and need to be addressed.

Policy Assumption	**Unintended Consequence**
The structure of the hospital global budgets will provide financial incentives for hospitals to reduce *potentially avoidable utilization (PAU).*	The Model provides incentives to reduce *all hospital utilization*, including medically necessary care. Since 2014, non-PAU spending decreased by 4.5% while PAU spending increased by 3.8%, demonstrating that Maryland's hospitals have disproportionately reduced necessary care.
Reimbursing hospitals for a fraction of the cost of providing additional care will reduce the incentive to provide unnecessary care to patients.	The fractional reimbursement doesn't cover the cost of providing medically necessary care, disincentivizing maintained or increased access. For example, $120 million growth in tertiary/quaternary care at Academic Medical Centers, 2014–2023 received less than $50M funding through market shift policy.
The Academic Medical Centers (AMCs) have the same opportunity as community hospitals to reduce unnecessary utilization and should therefore be under hospital global budgets.	Much of the care provided by AMCs is highly specialized, innovative, higher cost, and is not available at community hospitals. Reducing access to these types of services as envisioned by global budgets results in restrictions to patient access. For example, inpatient growth in the most complex cancer cases is projected to be 20%+

	over the next 10 years. Within Maryland, inpatient cancer care admissions for Maryland residents declined -16% for Maryland hospitals from CY19-CY23, while surrounding states saw growth in cancer admissions.
Hospitals will achieve reduced utilization through meaningful investments in population and community health, generating financial margin for the hospital to allow for additional reinvestment.	Hospitals implemented population health programs to varying degrees, but most of the reductions in utilization and subsequent hospital savings have been generated by reducing inpatient bed and Emergency Department (ED) capacity, regardless of patient need. This has resulted in Maryland having the longest ED wait times in the country. Several Baltimore City hospitals have seen a 20+% reduction in ED volumes since 2014 even as ED wait times have increased. The greatest reductions have been in areas with historic health disparities. Statewide there have been limited investments in population health. Instead, some hospitals have invested in Medicare Advantage plans and access points, including urgent care centers, in more affluent areas outside of their immediate communities. These investments are inconsistent with, and at times contrary to, the goals of the Model.
Health systems will naturally rationalize their hospital and service delivery footprint, reducing excess capacity and producing savings for the Model.	None of the health systems in the state has completely closed a hospital and there are several examples of system hospitals significantly reducing inpatient volumes to a point that would be financially unsustainable in the rest of the country. Several Baltimore City hospitals have 20+% less licensed beds than they did in 2014, yet their global budgets have remained largely intact, eliminating the incentive to repurpose these facilities into other health care delivery models, including freestanding medical facilities.

The Model as it exists today focuses primarily on utilization reduction and cost savings, reflecting the priorities of previous state and federal administrations. Moving forward, adding a focus on health equity, improved community health and advancing innovation – all priorities championed by the current state

and federal administrations – will greatly enhance the Model's positive impact on the health of Marylanders.

Understanding and adjusting the Model over time becomes even more important as Maryland moves into the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. This moment presents an opportunity to set financial and clinical goals for the state and Maryland's hospitals to achieve over the next decade. In addition to negotiating key contractual provisions with CMMI as part of Maryland's participation in AHEAD, it is critical that the Health Services Cost Review Commission (HSCRC) revise current policies to ensure that incentives are in place to promote improved patient access and quality, provide appropriate funding for the provision of medically necessary care, and fundamentally transform the delivery system.

To achieve the above goals, the following recommendations should be implemented by the HSCRC, either through contractual changes with CMMI or policy changes at the state level:

- **Enable AMCs to provide complex, specialized care that Marylanders need and deserve by removing tertiary and quaternary care from global budget restraints.** The HSCRC should seek to strike a balance between creating financial incentives for AMCs to reduce unnecessary utilization and improve the health of the local communities they serve, while simultaneously ensuring that the Model is not limiting access to highly specialized clinical treatments that have the ability to improve and save the lives of Maryland's residents.

- **Ensure adequate reimbursement for medically necessary care by allowing funds to "follow the patient."** The HSCRC should revise current policies to shift funding amongst hospitals based on patient choice, eliminating the financial penalty for hospitals treating patients that choose to receive treatment at their facility.

- **Develop policies and financial incentives that differentiate between unnecessary hospital utilization and medically necessary care.** Policies need to be enhanced to provide a more nuanced approach to differentiate between types of volume. This differentiation can provide clearer incentives for reducing PAU while eliminating incentives to reduce access to medically necessary care.

- **Develop a monitoring framework that prevents restrictions in access to care or identifies them for regulatory action**. The HSCRC should develop an oversight model whereby hospitals are encouraged to shift services based on patient choice, are provided financial incentives to provide treatment in the most cost and clinically effective settings, and are penalized for unreasonably restricting patient access.

- **Develop a process to address excess hospital capacity to ensure resources are allocated to best meet community needs.** Maryland needs a process to identify hospitals with excess capacity and to develop a plan to repurpose those captive funds. This process could result in funding being removed from under-utilized hospitals to invest in health resources for the local

communities, shifting funds to hospitals to reflect patient movement, or generating savings to the health care system, including savings to the Maryland Medicaid program to support priority areas in the state budget. The process should ensure that the local community is still adequately served, even if inpatient capacity and funding is reduced. Any impact to hospital staff could also be mitigated by repurposing existing funds for other health care services, either in the community or at other local hospitals, providing for additional employment opportunities.

Maryland has a unique opportunity, based on over a decade of experience, to make changes to the Model that will positively impact Maryland's residents. By using data and experience to improve the Model over time, Maryland can ensure that patients have access to leading clinical innovations, timely and quality care, and be a leader nationally.

Overview of the Maryland Demonstration Model

Maryland's All-Payer Model was designed to change the economic incentives for hospitals in their delivery of patient care, shifting from an emphasis on the volume of services provided under fee-for-service (FFS) payments to fixed payments for the care of the population in the hospital's service area. The volume based FFS incentives in the state were in part responsible for relatively high utilization of hospital services in the state.

To meet the requirements of the All-Payer Model, the state directly addressed the volume-based incentives that remained under the state's rate-setting model. The state had experimented with population-based payments for ten rural hospitals to stabilize volatile revenue prior to the All-Payer Model and chose to use this tool to implement the waiver model. This approach was expanded to include the rest of the hospitals in the state, shifting most of the state's hospital revenue to the Global Budget Revenue (GBR) system.[1]

The policies under the All-Payer Model and its successor, the Total Cost of Care (TCOC) model, are intended to:

- Provide a fixed annual budget to cover the expected cost of services for the patients receiving hospital services, known as GBR.
- Fund 50% of the incremental cost of changes in volume associated with demographic change, market shift, and approved changes in services – incremental funding should cover the added cost of patient care without providing added margin for the hospital to avoid incentives to capture volume.
- Encourage the elimination of potentially avoidable utilization (PAU) by allowing hospitals to keep revenue associated with reductions in readmissions and patient quality indicators (PQI) that are ambulatory sensitive conditions that may be avoided with better use of primary care.
- Generate sufficient margins to fund replacement capital and new technology to update hospital services over time.
- Fund population health activities that ultimately improve patient health and reduce the demand for hospital services, particularly through revenue retained from the reduction of PAUs (although this last item was not stated explicitly as a goal of the Model initially).

While the intentions of the Model are outlined above, distortions in practice exist such as:

1. In most examples, the market shift adjustment funds less than 50% variable cost factor when hospitals gain market share of non-PAU volumes, and conversely, leave more than 50% variable cost factor in GBR of hospitals that lose volume, thus creating distortions for both hospitals.
2. While the goal of the Model is to reduce avoidable or unnecessary utilization, this statement is optimistic and at times unattainable due to clinical necessity. ***As in any capped system, fixed***

[1] While hospitals were not required to participate in the GBR payment methodology, nonparticipation would have resulted in low inflationary updates for hospitals continuing under FFS payments. Given positive incentives to assist with the conversion and the restricted revenue for nonparticipation, all Maryland hospitals chose to accept hospital global budgets under GBR.

payments provide strong incentives to reduce all utilization, not just avoidable utilization. Strong oversight (market or regulatory) is necessary to guarantee that hospitals continue to provide necessary services for the patients in their service area.

3. Trending of financial information since the inception of GBR indicates that Maryland hospitals are falling behind national hospitals in terms of recapitalization, adoption of new technologies, and the expansion of complex tertiary care service lines.

4. Increasing funding of population health resources is critical to the model, however, to assume that these programs will be funded through PAU volume savings dramatically underestimates the level of funding and time horizon required for significant improvements in population health status. It is also important to note that population health initiatives must involve collaboration across hospital systems, non-hospital providers, and state and local governments.

The GBR Framework

Hospital budgets were originally established under the All-Payer Model using Fiscal Year (FY) 2013 as the base year, the last year before the implementation of the GBR. Revenue was established in line with the hospital's unit rates, the usual basis for rate setting under all payer rate regulations. Some hospitals negotiated adjustments to their revenue based on their individual circumstances, but statewide, this new base was the starting point for evaluating Model performance beginning in FY2014.

Moving forward, hospitals charge patients based on actual utilization. If volumes rise, hospitals lower their prices per unit rate charged because their revenue for the year is fixed – there is no additional revenue available due to rising volumes. As volumes decline, hospitals raise their unit rates to be able to hit their revenue target. Essentially, the state maintains a FFS billing system for services with a revenue cap imposed on its charging ability.

The Health Services Cost Review Commission (HSCRC) has established limits to this charging flexibility. Hospitals are allowed to modify prices within a 5% corridor unilaterally, but the HSCRC will allow hospitals to change prices up to 10% with approval. This approach serves as an implicit limit to the reduction in volume – if volumes drop too far, hospitals will not be able to fully charge their assigned budget. ***Of note, the HSCRC readjusted the volume base of some hospitals in 2018, negating the intent and value of the 5-10% corridor.***

Annual Adjustments to the GBR

For the GBR methodology to be sustainable, there must be a process to update the budget for changes in market conditions. A hospital's GBR may be modified annually due to certain volume adjustments that account for changes in PAU, demographics, patients choosing different hospitals for services, and hospitals expanding into new service lines or contracting existing service lines. Specifically, these adjustments fall into four categories: **PAU Adjustment, Demographic Adjustment, Market Shift Adjustment, and New Services or Service Closure Adjustment**.

PAU Adjustment: While the expectation is not that all PAU can be eliminated, generally the HSCRC expects hospitals to adopt clinical practices that provide higher quality and improve coordination across the clinical spectrum to avoid readmissions to acute care or to prevent unnecessary hospitalizations. The HSCRC staff defined PAU as 30-day unplanned hospital readmissions and PQIs, conditions that are potentially avoidable with appropriate use of primary care and chronic disease management. To the degree that hospitals can work with their partners to improve care coordination and reduce PAU cases, the hospital is able to keep its global budget associated with this volume, providing a strong economic incentive to avoid these cases.[2] ***Within the current demonstration model, HSCRC policies penalize hospitals in multiple ways for PAU volumes. While the industry focuses on reducing PAU volumes, a subset of these patients require care that is unavoidable and costs significant resources. Consider a diabetic patient with significant co-morbidities presenting in the emergency room with significant foot ulcers that ultimately require amputation of the foot. Hospitals must care for these patients while continuing to focus on strategies that reduce long-term complex comorbidities that increase utilization.***

Demographic Adjustment**:** The demographic adjustment accounts for changes in the demand for services associated with changes in the size and characteristics of the population served by hospitals within their primary service area. As implemented by the HSCRC staff, the demographic adjustment is age-adjusted for individual hospitals, but the results are scaled across hospitals so that the state population growth is accounted for without an age adjustment for the state. The demographic funding is allocated across all hospitals within the given service area in proportion to the existing distribution of existing market share. ***While the demographic adjustment is the HSCRC's proxy for population change which defines volume growth within a market, this adjustment is made to hospitals whether the hospital's GBR volumes have increased or decreased, resulting in additional revenue for patient care that does not exist.***

Market Shift Adjustment**:** The market shift adjustment is designed to reallocate revenue from one hospital to another within the system as patients move across hospitals for care. This feature is designed to replicate the function of a market, but in a way that will not incentivize hospitals to seek additional volume to enhance their financial performance. The market shift is designed to identify changes in the volume of specific services within hospitals in each market and to reallocate revenue to cover the incremental cost of those services. The hospital that loses the volume will have its budget reduced to reflect the lower volume it is treating while retaining part of the revenue to recognize the fixed costs facing the facility. The HSCRC has set the incremental, or variable, cost factor (VCF) at 50 percent of the hospital's approved revenue for the case. The losing hospital keeps 50 percent of the revenue while the acquiring hospital receives 50 percent. ***While 50% of the approved revenue for the case is the intent of the policy, the VCF is often variable, often less than 50% or more than 50%. The retention of revenue is designed to recognize the fixed cost of hospital care in the short run, but HSCRC policy does not specify any time frame for ending this revenue retention, even though costs are fully variable in the long run. As stated previously, the result of the market shift and demographic adjustments is often***

[2] The HSCRC has included annual reductions in the annual update factor to capture some of the savings (whether they materialized or not).

retained revenues in hospitals with low volumes and marginal clinical quality which would be subject to closure in the rest of the country.

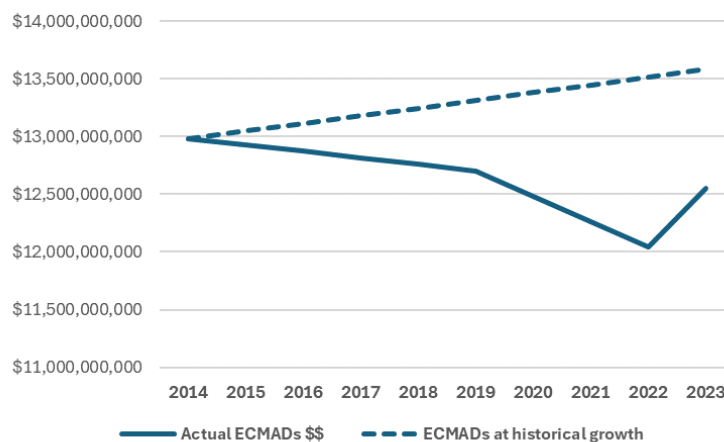
New Service or Service Closure Adjustment: The HSCRC addresses services changes through GBR adjustments on an *ad hoc* basis. Generally, if a hospital offers new services, the HSCRC staff has approved GBR adjustments to recognize the incremental cost of those services, generally funding them at 50 percent of the anticipated volume. For service closures, the HSCRC staff has allowed partial revenue to be retained and requires that hospitals inform the HSCR when services are closed or deregulated for budgets to be adjusted, although enforcement of deregulatory announcements is difficult and often occurs with a substantial lag. ***Policies governing service line additions or closures need review. Funding for service line additions does not incorporate the upfront fixed costs. Removal of funding for service line closures is challenging and occurs with a substantial lag.***

Issue #1: Misaligned Incentives on Funding of Volume Shifts over Time

Policies associated with the Model cause concern with how hospitals view fluctuations in volume. Hospitals may avoid all volume growth, rather than focusing on reductions in PAU, or on more efficient care delivery in lower acuity settings. The polices that allow hospitals to shed any volume and retain revenue indefinitely traps funds for patient care that no longer exists and simultaneously penalizes other hospitals that continue to provide clinical care by underfunding this clinically appropriate volume.

The combination of reducing PAU volume and restricting non-PAU volume reduced volume growth (in $$) in the state from 2014-2023. Prior to the introduction of GBR methodology in 2014, volume growth averaged 0.5 – 1.0% per year. Since 2014, volume has grown -0.4% per year through 2019. From 2019 to 2022 volumes declined -1.8%, assisted by COVID. Volumes increased post-pandemic 4.2% from 2022 – 2023.

Table 2: Total Maryland Volume (in dollars)
2014- 2023



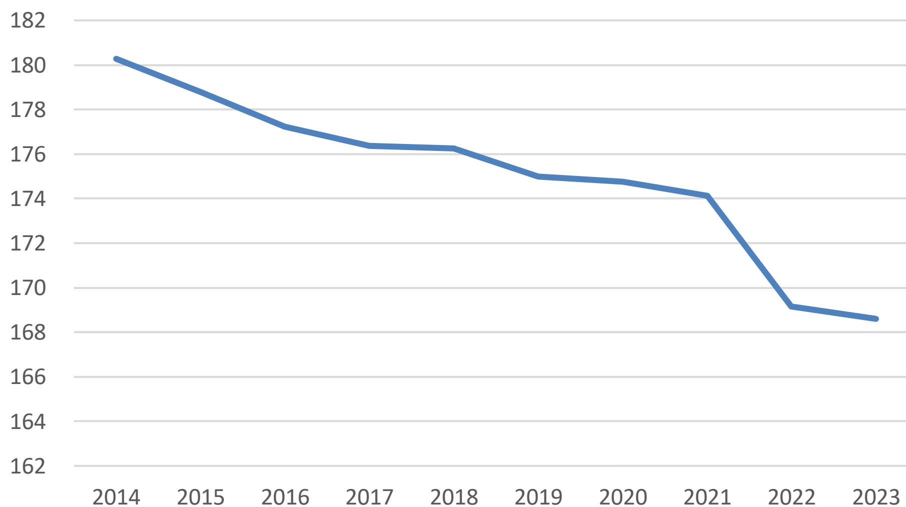
Source: HSCRC Inpatient and Outpatient Abstract Data. Trends in total volume dollars calendar years 2014, 2019, 2022 and 2023; in-state volume only

The change in growth rates from 2014 to 2023 generated a cumulative savings to Medicare of more than $433MM. While this trend has appeared to reduce volume growth in the Maryland market, additional analytics are necessary to rule out patients seeking care in other states and the potential closure of needed clinical service lines within Maryland.

The HSCRC uses Equivalent Case-Mix Adjusted Discharges ("ECMADs") as a measure of volume for Maryland hospitals. ECMADs include case mix adjusted discharges, equivalent outpatient case-mix adjusted visits, and inpatient weights that reflect resource demands and relative complexity. The higher the intensity of the case, the higher the level of ECMADs associated with it.

The increase in cumulative savings between 2014 to 2023 corresponds to a decrease in acute care ECMAD volumes during the same time period.

Table 3: Statewide ECMAD Volume/1,000 Population
2014- 2023

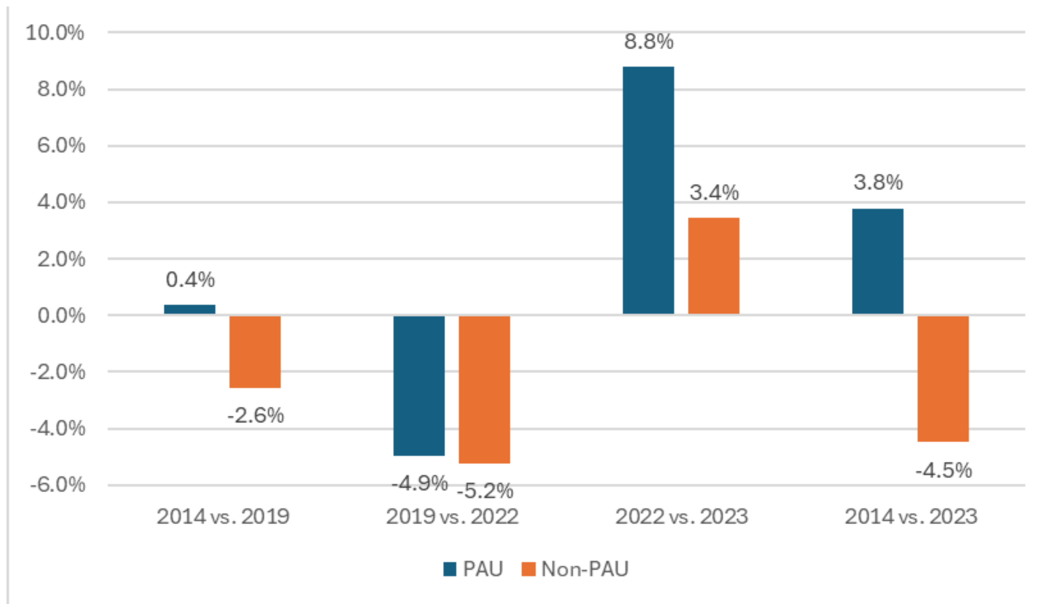


Source: HSCRC Inpatient and Outpatient Abstract Data, Claritas; excludes Oncology

When compared to statewide population growth, ECMAD growth declined faster than population growth from 2014 to 2023.

Changes in ECMAD volumes between 2014 to 2023 vary when looking at PAU vs. non-PAU volumes. Overall, non-PAU volume in dollars declined by -4.5% while PAU volume in dollars increased by 3.8% from 2014 to 2023. Prior to COVID, both PAU and non-PAU volumes declined. PAU volume grew post COVID between 2022 and 2023 due to patients receiving less care for chronic conditions during COVID leading to increased acuity and acute care needs. The overall volume change in dollars over that period was -3.3%.

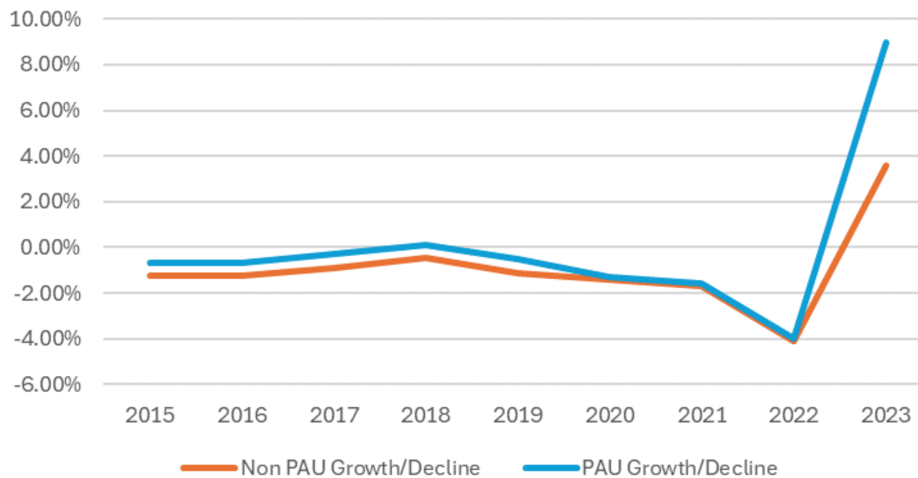
Table 4: Statewide ECMAD Volume Change: PAU vs. Non-PAU 2014-2023



Source: HSCRC Inpatient and Outpatient Abstract Data, Instate Only, Excludes Chronic, Specialty Hospitals, OP Oncology Drugs and Related Services, Categorical and Innovation

From 2014 to 2023, PAU volumes increased while non-PAU volumes declined.

Table 5: Statewide Change in ECMAD PAU vs. Non-PAU per 1,000 Population 2015-2023

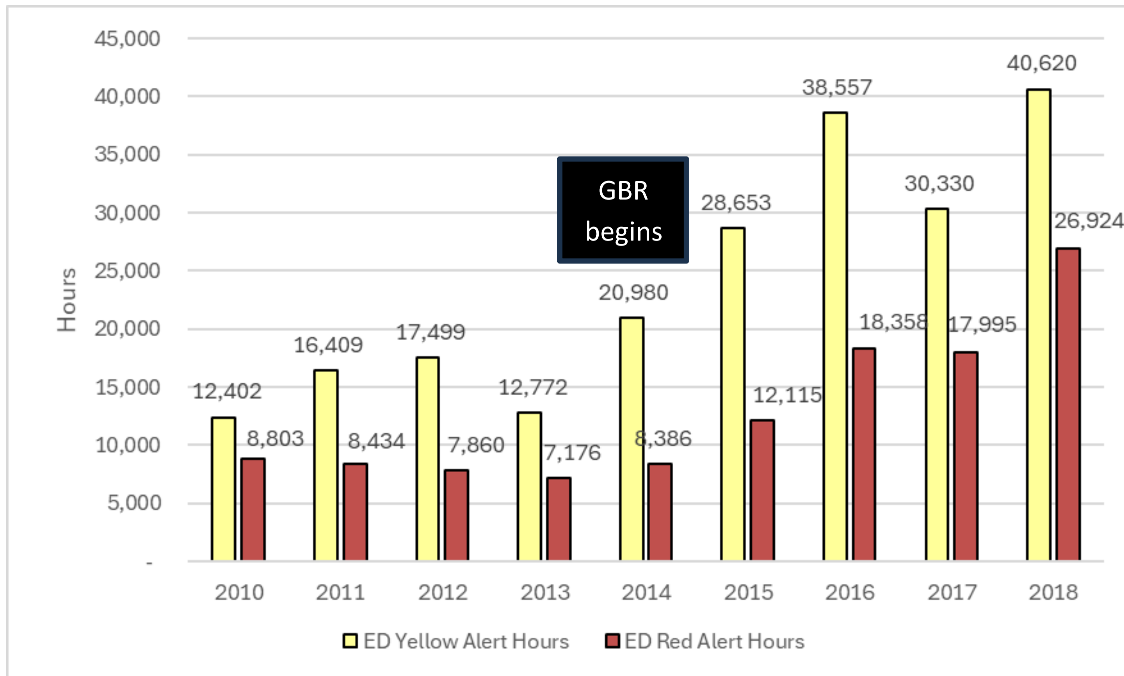


Source: HSCRC Inpatient and Outpatient Abstract Data, Claritas; excludes Oncology

Both PAU and non-PAU ECMAD growth per capita declined or remained flat from 2015-2022. PAU and non-PAU ECMAD volumes experienced post-pandemic growth from 2022-2023.

The concern remains that the emphasis on volume reduction is leading to reduced access to care, not simply the elimination of avoidable or unnecessary utilization. Over the course of GBR, and during this period of volume decline, statewide emergency department (ED) yellow diversion hours increased by 27.2% per year, suggesting a loss of access to care since the inception of GBR. With the exception of a decrease in yellow alerts in Calendar Year (CY) 2017, there has been an increasing trend since 2013. Of note, the year after the inception of GBR, yellow alerts more than doubled in 2014 (8,208 hours).

Table 6: Statewide Emergency Department Yellow Alert Diversion Hours 2010-2018, 2023



	ED Yellow Alert Hours	yoy % Change
2013	12,772	
2014	20,980	64.3%
2015	28,653	36.6%
2016	38,557	34.6%
2017	30,330	-21.3%
2018	40,626	33.9%
2023	175,920	

Source: MIEMSS database

Over the course of GBR, and during this period of volume decline, statewide emergency department yellow diversion hours increased by 27.2% per year, suggesting a loss of access to care since the inception of GBR.

Since the inception of GBR in 2014, volumes declined for EDs and inpatient services in Baltimore County and Baltimore City, particularly at community hospitals. Baltimore area hospitals experienced the largest ED volume reductions, compared to the state-wide average reduction of -19%.

Table 7: Baltimore City and Baltimore County ED Volume % Change CY14-CY23

Hospital	State Rank: % Decline	CY14 – CY23 % Volume Change	CY23 % of IP Via ED
JHBMC	42	-8%	64%
JHH	38	-11%	44%
UM – St. Joseph	30	-17%	53%
Sinai	24	-22%	59%
St. Agnes	23	-23%	65%
MS – Union Memorial	15	-27%	72%
Northwest	15	-28%	83%
MS - Harbor	13	-29%	64%
MS- Good Samaritan	11	-33%	80%
UMMC	8	-34%	47%
MS – Franklin Square	7	-37%	62%
Mercy	5	-39%	24%
Grace	4	-39%	0%
UM - Midtown	2	-47%	64%

Source: HSCRC Hospital Data

The Hospital Throughput Workgroup report found that limited hospital capacity was a key driver of extended ED wait times. Within Maryland, most community hospitals have significantly reduced staffed beds, leaving the Academic Medical Centers (AMC) to provide all levels of needed care for area patients and beyond.

Table 8: Emergency Department Average Wait Times

State	ED Avg Wait Time (min)	Min Over National Avg	Rank
Virginia	170	8	36th
Pennsylvania	182	20	41st
Maryland	247	85	50th
Nation	**162**	**-**	

Source: CMS (Data.CMS.gov)

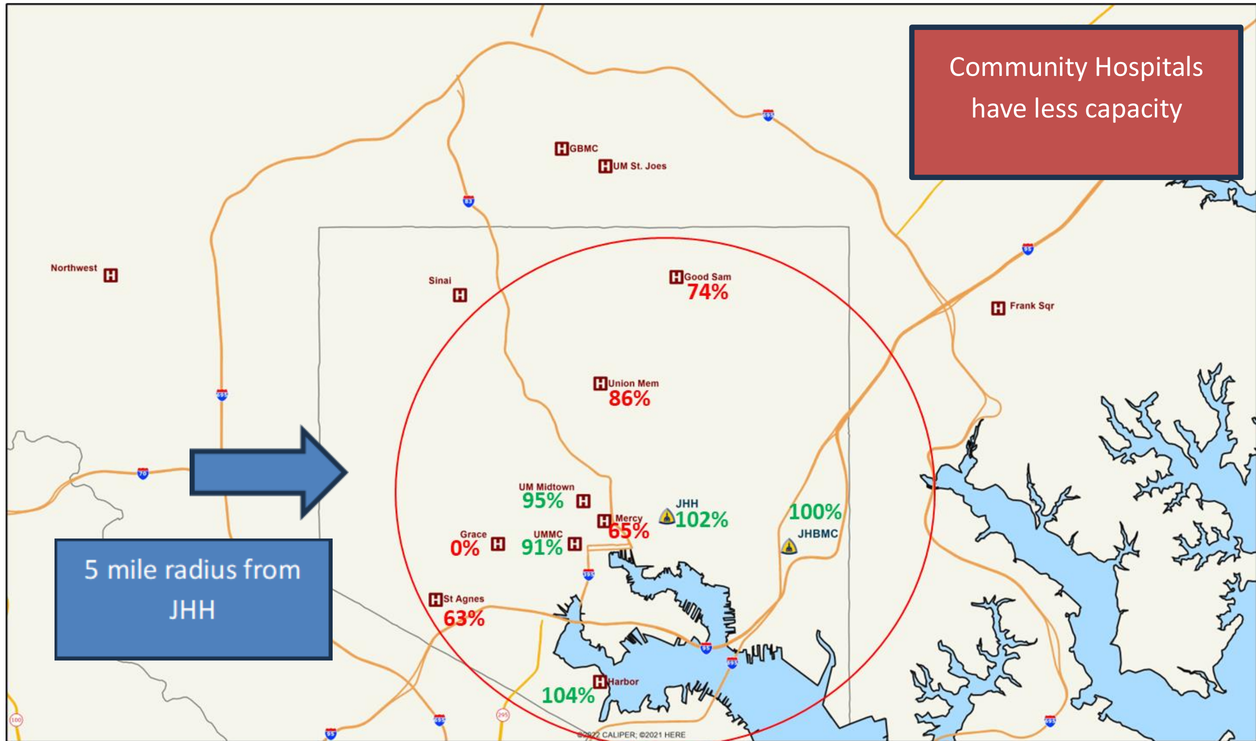
Despite an increase in ED yellow diversion hours, Maryland hospitals continue to have the longest ED wait times in the nation, 85 min greater than the national average.

When the focus shifts from statewide to the Baltimore region, there have been significant volume shifts between hospitals, ultimately resulting in a decline in licensed and staffed beds. Baltimore hospitals have shed over 400 inpatient medical/surgical/gynecological/addictions (MSGA) beds since GBR began, with most of the beds located at community hospitals. From 2013 to 2024, psychiatric bed capacity expanded, while MSGA, Obstetrics, and Pediatric licensed beds declined. Johns Hopkins Hospital (JHH) has more licensed beds than 2013, suggesting volume growth, and more licensed beds than physical capacity.

Table 9: Baltimore City and County Hospitals Licensed Beds
FY23 Licensed Beds vs FY14 Licensed Beds

Hospital	2013 Total Licensed Beds	Change FY13 to FY24 MSGA	Obstetric	Pediatric	Psychiatric	2024 Total Licensed Beds	% Change 2013 to 2024
The Johns Hopkins Hospital	1,000	105	-	-	-	1,105	10.5%
University of Maryland Medical Center	800	(77)	-	1	(14)	710	-11.3%
MedStar Franklin Square Hospital	355	(5)	-	(9)	16	357	0.6%
Bayview Medical Center	355	8	5	(5)	-	363	2.3%
Greater Baltimore Medical Center	270	(42)	-	-	-	228	-15.6%
St. Joseph Medical Center	247	(25)	-	-	(1)	221	-10.5%
St. Agnes Hospital	287	70	2	17	48	424	47.7%
Northwest Hospital Center	225	(62)	-	-	35	198	-12.0%
MedStar Star Harbor Hospital	160	(48)	(10)	(5)	28	125	-21.9%
Sinai Hospital of Baltimore	426	(19)	2	(9)	24	424	-0.5%
MedStar Union Memorial Hospital	236	(20)	-	(1)	(26)	189	-19.9%
Mercy Medical Center	233	(103)	-	(1)	-	129	-44.6%
Medical Center Midtown Campus	155	(28)	(20)	-	9	116	-25.2%
Grace Medical Center	115	(83)	-	-	(32)	-	-100.0%
MedStar Good Samaritan Hospital	224	(73)	-	-	-	151	-32.6%
Total	**5,088**	**(402)**	**(21)**	**(12)**	**87**	**4,740**	**-6.8%**

Source: MHCC Licensed Acute Care Beds



Baltimore hospitals have shed over 400 MSGA beds since GBR began, with most of the beds located at community hospitals.

The change in licensed beds is driven by annual changes in acute inpatient volumes. The shift in volumes between 2014 and 2023 away from community hospitals in Baltimore City hospitals led JHH to be the largest recipient of volume shifts during this time.

Table 10: ECMAD Volume Shift: Baltimore City vs. Rest of State 2014-2023

ECMAD Volume Shift City Hospitals v. Rest of State	2014 - 2019	2019 -2022	2022 - 2023	Cumulative Shift 2014 - 2023
The Johns Hopkins Hospital	3,880	977	474	5,331
Mercy Medical Center	2,364	1,368	620	4,352
University of Maryland Medical Center	3,353	(1,716)	423	2,060
Johns Hopkins Bayview Medical Center	2,079	(174)	(149)	1,756
Rest of State	1,816	(1,326)	560	1,049
Lifebridge Levindale Hebrew Geriatric Center & Hospital	35	-	-	35
UM Rehabilitation & Orthopaedic Institute	(157)	(50)	(42)	(249)
MedStar Union Memorial Hospital	(1,471)	748	(605)	(1,327)
MedStar Harbor Hospital	(1,598)	130	(119)	(1,588)
St. Agnes Hospital	(2,533)	520	71	(1,942)
MedStar Good Samaritan Hospital	(2,938)	491	(251)	(2,699)
Grace Medical Center	(1,445)	(1,301)	(18)	(2,765)
Lifebridge Sinai Hospital	(3,384)	334	(965)	(4,015)

Source: HSCRC Market Shift files using non-confidential 'in-state' abstract data

JHH is the largest recipient of volume shifts between 2014 and 2023 in Baltimore City.

Issue #2: Misaligned incentives that allow hospitals that reduce services to keep financial resources, without appropriate accountability for the use of the retained revenue

These shifting volumes between hospitals under the GBR methodologies have not resulted in proportional shifts in revenue, given the HSCRC's methodologies that allow hospitals with declining volumes to retain 50 percent of revenue to cover fixed cost. The interaction of these methodologies has resulted in overfunding for hospitals dropping volume and underfunding for those showing growth as a general rule. Regulatory incentives designed to reward hospitals for avoiding unnecessary care through improved care management and improved population health management instead appear to reward hospitals reducing access to needed care and underfunding the hospitals treating those patients denied care elsewhere.

The following table shows the overfunding and underfunding status for hospitals in the Baltimore region. JHH appears to be penalized.

Table 11: In-State Only Retained Revenue
FY2014-CY2023

In State Volume Change and Funding through Policy
(Market Shift + Demographic + PAU Savings + Deregulation Adjustments)
FY2014 to CY2023

	Volume Change						Funding			
	2014-2019		2020-2023		Total 2014-2023		Expected 50% Funding	Actual Funding	Retained (Unfunded)	
	$$	%	$$	%	$$	%	$$	$$	$$	Percent of GBR
MedStar Harbor Hospital	($56.2 M)	-24%	($0.1 M)	0%	($56.3 M)	-24%	($28.2 M)	($18.8 M)	$9.4 M	4%
MedStar Good Samaritan Hospital	(83.7 M)	-23%	4.4 M	1%	(79.3 M)	-22%	(39.7 M)	(29.7 M)	10.0 M	3%
Sinai Hospital of Baltimore	(97.6 M)	-10%	(53.4 M)	-6%	(151.0 M)	-16%	(75.5 M)	(41.3 M)	34.2 M	4%
Ascension Saint Agnes Hospital	(62.4 M)	-12%	4.1 M	1%	(58.3 M)	-11%	(29.2 M)	(10.0 M)	19.2 M	4%
MedStar Union Memorial Hospital	(50.2 M)	-10%	(1.9 M)	0%	(52.1 M)	-10%	(26.1 M)	(10.4 M)	15.7 M	3%
UMMC Midtown Campus	(0.5 M)	0%	(9.7 M)	-4%	(10.2 M)	-4%	(5.1 M)	1.3 M	6.4 M	2%
University of Maryland Medical Center	65.1 M	4%	(68.7 M)	-4%	(3.6 M)	0%	(1.8 M)	9.8 M	11.6 M	1%
Johns Hopkins Bayview Medical Center, Inc.	38.8 M	5%	(28.5 M)	-4%	10.3 M	1%	5.2 M	15.8 M	10.7 M	1%
Mercy Medical Center	0.2 M	0%	16.9 M	3%	17.1 M	3%	8.6 M	31.0 M	22.5 M	3%
The Johns Hopkins Hospital	77.3 M	3%	35.5 M	1%	112.8 M	4%	56.4 M	30.7 M	(25.7 M)	-1%
Baltimore City Hospitals	**(169.2 M)**	**-2%**	**(101.4 M)**	**-1%**	**(270.6 M)**	**-3%**	**(135.3 M)**	**(21.6 M)**	**113.7 M**	**1%**
All other	(46.1 M)	0%	(72.7 M)	-1%	(118.8 M)	-1%	(59.4 M)	124.6 M	196.1 M	2%
Statewide	**($215.3 M)**	**-1%**	**($174.1 M)**	**-1%**	**($389.4 M)**	**-2%**	**($194.7 M)**	**$103.0 M**	**$309.8 M**	**2%**

Excludes out of state and outpatient high cost drugs.
Funding through volume policies only, special adjustments excluded.

Source: HSCRC abstract data

JHH has been underfunded by nearly $25.7 million over the FY2014-CY2023 model periods for in-state patient services.

Changes in volume for specific service lines demonstrate the shifts in service lines across hospitals. Orthopedic surgery, for example, shows declines in volume from Lifebridge Sinai Hospital & University of Maryland Medical Center (UMMC) with increases at JHH over the period of GBR.

Table 12: Baltimore City and Baltimore County Orthopedic ECMAD Volume FY2014-CY2023

Baltimore City + Baltimore County Orthopedic Surgery Volume	2014 Base ECMADs	Raw ECMAD Growth (Decline) 2014 - 2023
The Johns Hopkins Hospital	1,389	325
University of Maryland Medical Center	1,582	(139)
Lifebridge Sinai Hospital	2,954	(787)
MedStar Union Memorial Hospital	2,557	477
MedStar Harbor Hospital	698	(591)
MedStar Good Samaritan Hospital	1,235	(969)

Source: HSCRC abstract data

JHH is the recipient of Orthopedic volume growth in Baltimore City and Baltimore County between 2014 and 2023.

When comparing all service lines, JHH is the leader in raw ECMAD in Baltimore City and Baltimore County between FY2014 and CY2023, while other hospitals experienced volume declines.

Table 13: Baltimore City and Baltimore Service Line Sample ECMAD Volume Change FY2014-CY2023

Baltimore City + Baltimore County	All Service Lines		Medical (High Intensity)		Medical (Other)		Surgical (Other)	
	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023
The Johns Hopkins Hospital	46,715	1,453	1,893	151	3,100	428	3,125	635
University of Maryland Medical Center	30,541	(549)	1,243	16	2,072	(120)	2,755	548
Lifebridge Sinai Hospital	34,292	(6,376)	1,673	(249)	2,816	(157)	2,671	(177)
MedStar Union Memorial Hospital	23,154	(4,670)	565	27	1,832	21	1,017	(276)
MedStar Harbor Hospital	4,935	(1,560)	155	30	493	(122)	330	(125)
MedStar Good Samaritan Hospital	19,719	(4,470)	711	(58)	2,439	(312)	1,211	374
	356,344	**(35,914)**	**13,366**	**(298)**	**32,701**	**(2,258)**	**24,599**	**1,939**

Source: HSCRC abstract data

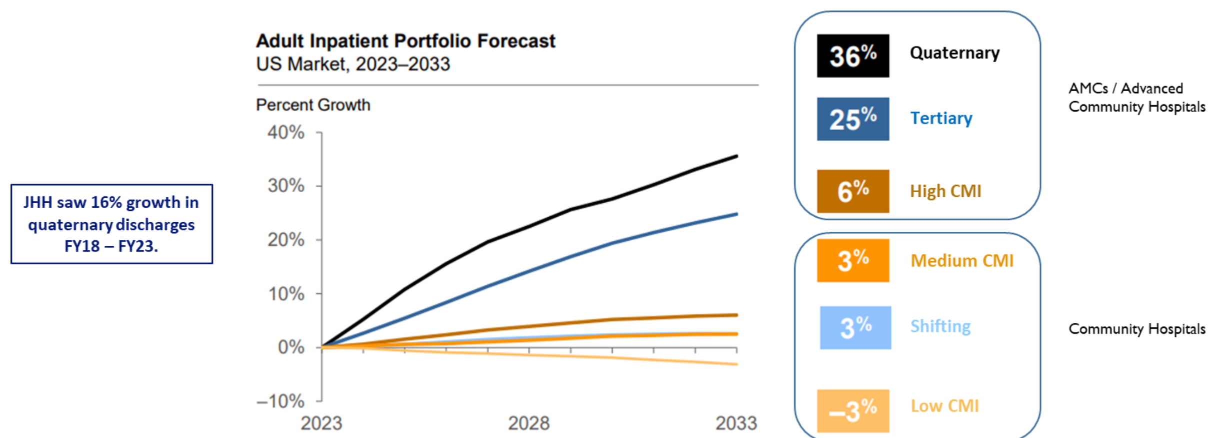
In all service lines, JHH was the only hospital gaining ECMADs, while all other hospitals serving the area experienced declines, led by Lifebridge Sinai Hospital with a drop of nearly 6,400 ECMADs.

JHH saw increases in high intensity medical volume with Medstar Good Samaritan Hospital and particularly Lifebridge Sinai Hospital losing ECMADs. JHH and UMMC experienced increases in ECMADs in surgical cases, while the other hospitals in the market declined, led by MedStar Union Memorial Hospital and followed by Lifebridge Sinai Hospital. JHH gained ECMADs in other medical volume, while most hospitals serving Baltimore City and Baltimore County lost ECMADs, with Medstar Good Samaritan Hospital dropping about twice the ECMADs of the other hospitals.

Issue #3: Care is Shifting from Community Hospitals to AMCs

According to Vizient 10-year projections, virtually all inpatient growth, both in the state of Maryland and nationally, is projected to be in high-Case Mix Index (CMI) and tertiary and quaternary care, an area exclusive to AMCs and advanced community hospitals. Community hospitals are operating at a fraction of their fixed capacity and are projected to see fewer inpatients over time. Their long-term role in the care continuum is changing with a primary focus on outpatient care. AMCs are at full capacity and experiencing unique market demands, not experienced by community hospitals locally and nationally.

Table 14: Vizient 10-Year Projections by Inpatient Care Type
CY23 vs. CY33



Source: Vizient, Sg2, JHH CaseMix Data

According to Vizient 10-year projections, virtually all inpatient growth, both in the state of Maryland and nationally, is projected to be in high-CMI and tertiary care, an area exclusive to AMCs and advanced community hospitals.

JHH quaternary and tertiary volumes are growing below the national rate. While quaternary and tertiary volumes are rising nationally, the percent growth in total staffed acute beds at JHH grew 5% from 2015-2022, vs. the National AMC total growth of 10%. Of note, total staffed acute beds at UMMC declined 1% from 2015-2022. Maryland's AMCs are not keeping pace nationally with quaternary and tertiary volume growth.

Table 15: Total Staffed Acute Beds
CY15 vs. CY22

Hospital	2015 Staffed Beds	2022 Staffed Bed	% Growth
Hospital of The University of Pennsylvania	789	1,058	34.1%
Brigham and Women's Hospital	741	880	18.8%
UC San Francisco	740	861	16.4%
University of Chicago Medical Center	624	477	-23.6%
Duke University Hospital	905	1,024	13.1%
Yale New Haven Hospital	1,391	1,481	6.5%
New York Presbyterian Hospital	2,381	2,474	3.9%
Massachusetts General Hospital	1,016	1,038	2.2%
JHH	977	1,023	4.7%
UMMC	630	622	-1.3%
National AMC Total	82,899	91,200	10.0%
National non-AMC Total	792,748	771,739	-2.7%

Source: AHA Survey

Maryland's AMCs are not keeping pace nationally with quaternary and tertiary volume growth.

This reduction in beds at community hospitals provides less access points of care for Baltimore City and Baltimore County. Limited hospital capacity results in limited access for the acutely ill patients.

Table 16: JHH Hopkins Access Line Diversions
CY23

Clinical Service	# of Diversions
Internal Medicine	383
Neurosciences (non-Brain Tumor)	342
Pulmonary	232
Pediatrics	212
Gastroenterology	207
Brain Tumor	144
Oncology (Medical)	137
Cardiovascular	92
All Other	313
Total	**2,062**

Source: JHH HAL Database

The JHH Hopkins Access Line (HAL) diverted over 2,000 inpatient transfers in 2023 due to a lack of inpatient capacity. Most cases required complex specialty care.

As JHH accepts more of the Baltimore City/Baltimore County ED volumes and the growth in staffed beds continues to be below the national average, volumes from Maryland are leaving less availability for out of state quaternary and tertiary volumes. From CY14 to CY24 annualized, total out-of-state inpatients declined -43%.

Table 17: Trend of Non-Maryland Inpatients at JHH
CY14-CY24 Annualized

Discharges	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024 A	% Change
Domestic OOS	9,045	8,779	8,034	7,804	7,606	6,794	6,171	5,726	5,519	5,660	5,450	-40%
International OOS	919	1,077	990	702	611	489	537	252	250	264	229	-75%
Total OOS	**9,964**	**9,856**	**9,024**	**8,506**	**8,217**	**7,283**	**6,708**	**5,978**	**5,769**	**5,924**	**5,679**	-43%

Source: JHHS_HSCRC_ENC

Since GBR, JHH has less capacity for destination patients as it remains full of local patients.

As a result, JHH's AMC national peers are capturing this important rare and complex patient volume. The impact of this lost volume has detrimental financial implications for JHH and for Maryland. Minimum volume thresholds are imperative to guarantee a minimum level of quality of care. Without threshold volumes, quality outcomes will deteriorate. In addition, according to the JH Office of Government, Community and Economic Partnerships: Economic Impact Report, out of state patients have a meaningful impact on the regional and state-wide economy. In 2022, JHHS out of state visitors generated $62.3M.

Another consequence of shifting low intensity volumes to JHH is the underfunding of volume. Underfunding of volume manifests itself in the erosion of financial margin and the inability to reinvest in innovation and capital. Nationally, AMCs are making significant investments to provide advanced clinical technology and expand capacity for the growing number of complex patients. Beds are primarily growing in tertiary and specialty care, most notably in oncology, cardiovascular services, neurosciences, and pediatrics. If these issues are not addressed, there will be less specialized care in Maryland to meet the needs of the aging population and Maryland residents needing this level of care will likely have to travel out of state.

Table 18: Examples of Inpatient Expansion Nationally

Hospital	Project	Description
CHOP	New IP Tower / OP Tower	140 incremental beds $1.9B
Cincinnati Children's *	New IP Tower	225 incremental beds NA
Dana Farber *	New Cancer Hospital	300 incremental beds $1.7B
Massachusetts General *	New IP Tower (Cancer and CV)	94 incremental beds $1.9B
Mayo Clinic *	New IP Towers	148 incremental beds $5.5B
NYU Langone *	New Medical Center	140 incremental beds NA
UCSF	New IP Tower	180 incremental beds $2B+
Univ. of Chicago *	New Cancer Hospital	80 incremental beds $820M
Univ. of Kentucky *	New IP Tower / OP Tower	300 incremental beds $1B+

Note: Examples above are institutions in regional markets with similar long-term growth projections. *Denotes hospitals in states with CON regulations.
Source: Health system press releases and regional news outlets.

Maryland AMCs are falling behind regional and national competitors in complex care capacity.

The impact of higher low intensity volumes and the inability to expand beds at JHH is most notably seen in Pediatrics and Oncology.

Pediatrics

Locally and nationally, community hospitals are exiting the pediatric market as they see it as inefficient and a financial burden. Nationally, economics are driving the consolidation of inpatient beds as pediatrics inpatient volume requires high cost, specialized equipment and providers. Between 2008 and 2018, nationally, 19% of all pediatric inpatient units closed.[3] Maryland is not immune to this trend. In fact, this trend is accelerated in Maryland due to misaligned incentives.

[3] *Health Affairs* 2002 June 15: An Unexpected Shortage: Beds for Children, *Pediatrics*, 2021 July: Availability of Pediatric Inpatient Services in the US

Table 19: Licensed Pediatric Beds by Region
FY14, FY20, FY24

Jurisdiction/Region	FY14	FY20	FY24	% Change F14 to FY20	% Change F14 to FY24
Western Maryland	20	11	8	-45.0%	-60.0%
Montgomery County	59	21	19	-64.4%	-67.8%
Southern Maryland	23	19	17	-17.4%	-26.1%
Eastern Shore	20	15	13	-25.0%	-35.0%
All Areas Outside Central Maryland	122	66	57	-45.9%	-53.3%
Central Maryland	316	277	275	-12.3%	-13.0%
Maryland Total	**438**	**343**	**332**	***-21.7%***	***-24.2%***

Source: MHCC

Pediatric beds in Maryland declined -24.2% between FY14 and FY24.

Between FY12 and FY24, Maryland community hospitals steadily reduced pediatric inpatient capacity, shifting the volume to Maryland AMCs or out of the state. Licensed pediatric inpatient beds declined -21.7% (95 beds) between FY14 and F20, after the inception of GBR. Montgomery County experienced a -64.4% reduction in licensed pediatric beds compared to a -12.3% decline in the Central Maryland region from FY14 to FY20. Of note, Central Maryland contains the state's AMCs. From FY20-FY24 Maryland's licensed pediatric beds continued to decline, but at a slower rate, -3.2%. Since 2019, Calvert Health Medical Center, MedStar Harbor Hospital, MedStar Franklin Square Hospital, and University of Maryland Shore Regional Health at Chestertown closed inpatient pediatric units. Hospitals that reduced the inpatient pediatric program to a single bed include MedStar Union Memorial Hospital, University of Maryland Capital Region Medical Center, Meritus Medical Center, and Western Maryland Regional Medical Center. Today, only nine hospitals in the state have more than 5 pediatric beds.

Table 20: Inpatient Pediatric Admissions (non-ED): Maryland Residents 2019-2023

Hospital State	# Change in Inpatient Pediatric Admissions (non-ED) of Maryland Residents	% Change in IP Pediatric Admissions (non-ED) of Maryland Residents
MD	-933	-2%
DC	+101	+2%
PA	+44	+14%
VA	+320	+91%

Source: HSCRC, DCHA, VHI, and PA inpatient datasets

As licensed pediatric inpatient beds decline in Maryland, patient care for this population is migrating out to surrounding states.

The top conditions for which patients leave Maryland include Neonatal Intensive Care Unit (NICU), Pulmonary Medicine, Oncology, and Bariatric Surgery.

Table 21: Pediatric Inpatient Days at Maryland Hospitals FY2023

Hospitals	NICU		Behavioral Health		All Other	
	#	%	#	%	#	%
JHH and UMMC	35,451	29%	8,297	36%	48,417	72%
All Other Maryland Hospitals	85,516	71%	15,007	64%	19,088	28%
Hospital Total	**120,967**	**100%**	**23,304**	**100%**	**67,505**	**100%**

Note: Pediatric defined as 0-19
Source: HSCRC Inpatient Dataset FY23

For those pediatric inpatients that seek care in Maryland, in FY23 JHH and UMMC served ~72% of all pediatric non-NICU/Psychiatry patient days.

Cancer Care

Inpatient growth in the most complex cancer cases is projected to be 20%+ over the next 10 years. Within Maryland, inpatient cancer care admissions for Maryland residents declined -16% for Maryland hospitals from CY19-CY23, while surrounding states saw growth in cancer admissions.

Table 22: Inpatient Cancer Admissions (non-ED): Maryland Residents 2019-2023

Hospital State	# Change in Inpatient Cancer Admissions (non-ED) of Maryland Residents	% Change in IP Cancer Admissions (non-ED) of Maryland Residents
MD	-2,176	-16%
DC	-80	-4%
PA	+5	+4%
VA	+80	+50%

Source: HSCRC, DCHA, VHI, and PA inpatient datasets

Inpatient cancer care in Maryland is declining as patients seek treatment out of the state.

The top tumor types for which adult patients leave Maryland for care are bone marrow transplantation and hematologic malignancies.

Locally and nationally, community hospitals are exiting the inpatient cancer market as routine cancer treatment shifts to the outpatient setting and complex cases aggregate at National Cancer Institute (NCI) designated centers. Primary reasons for the consolidation include an increase in the complexity of cases and the associated high-cost, specialized equipment and providers needed to provide appropriate care. Examples of this care include cell and gene therapy and high intensity outpatient treatments.

Consolidation at cancer care centers is appropriate, but these centers require full reimbursement for operating costs and essential investments in technology and capacity. JHH's inpatient medical oncology beds have operated at 90%+ occupancy for the past several years, and FY24 year to date (YTD) March inpatient occupancy is 93.5%. An occupancy of 93.5% presents significant challenges such as regular bed shortages and staffing challenges. During this same period, Maryland community hospitals are reducing inpatient oncology volume, which allows them to keep retained revenue and avoid high-cost investments in inpatient treatments. Currently, Maryland AMCs care for 80% of inpatient chemotherapy patients, 68% inpatient head and neck malignancies, and 57% of hematologic malignancies.

Table 23: Cancer Inpatient Discharges at Maryland Hospitals
FY23

Hospitals	Chemotherapy		Head & Neck Surgery		Hematologic Malignancies	
	#	%	#	%	#	%
JHH and UMMC	712	80%	395	68%	825	57%
All Other Maryland Hospitals	180	20%	186	32%	610	43%
Hospital Total	**892**	**100%**	**581**	**100%**	**1,435**	**100%**

Source: HSCRC Inpatient Dataset,

Maryland AMCs care for most chemotherapy, head and neck surgery, and hematologic malignancy as Maryland community hospital volumes decline in these areas.

The funding for the movement of oncology cases from community hospitals to JHH does not allow for inpatient cancer care growth to compete nationally. Nationally, NCI comprehensive cancer centers are adding significant inpatient and hospital-based outpatient capacity. Major cancer care center expansion projects nationally include the Barnes-Jewish Siteman Cancer Center, Dana Farber, Memorial Sloan Kettering, Moffit Cancer Center, Ohio State- James Cancer Center, and the University of Chicago. In comparison, the JHH Sidney Kimmel Comprehensive Care Center Weinberg facility is over 20 years old.

Implications

This analysis demonstrates that the GBR system results in substantial shifts in volumes across the state, with reductions in volume within the hospital. The declines have not been uniform, and shifts in patient care have occurred among hospitals. Many hospitals with revenue reductions have kept a substantial share of their revenue base while treating fewer patients – a deliberate incentive built into the current GBR structure to provide incentives to move patient care from the hospital to lower acuity settings or to prevent the need for hospital services through improved care management and population health efforts.

The GBR policy is a blunt tool to achieve these refined goals. While the HSCRC has attempted to structure policies to encourage reductions in avoidable and unnecessary hospital utilization, the financial incentives tend to reward hospitals that reduce patient services – not just low value, avoidable, or unnecessary care. Some hospitals have aggressively reduced services by forgoing the renewal of physician contracts or removing service lines that require substantial ongoing investments. Some have moved services out of state or outside the hospital to nonregulated space to serve commercial patients primarily. While HSCRC policies reduce hospital GBRs for volumes that shift to other hospitals, hospitals that engage in these reductions retain revenue to cover their fixed costs, and other hospitals in their market pick up their patients at a fraction of the cost of providing the care.

Recommendations

As the Maryland Demonstration Model evolves under the AHEAD program, a series of refinements to the HSCRC GBR policies are necessary to address the distortions discussed in this paper. Specifically, the following adjustments are required to reduce perverse incentives and better align the foundation of the model with improved access, high quality care, hospital resource equity, and impact to Maryland's population health.

1. **Better alignment of revenues with patient choice of hospital – "Revenue follows the patient."**
    a. The HSCRC Market Shift adjustment must yield a net 50% variable cost factor, or whatever the proper fixed cost percentage is determined to be, for patients moving from one hospital to a different hospital.
        i. Hospitals should not be penalized for providing needed care.
        ii. All volumes should not be treated by the HSCRC as avoidable. Reducing PAU should continue to be the primary goal for utilization reduction.
        iii. The HSCRC must improve the monitoring of corporate integrity efforts to identify where hospitals are reacting to the incentives of the model in ways that harm access, efficiency, or quality. This includes shifting volumes to out of state providers, deregulating care without disclosure to the HSCRC, redesigning major clinical offerings that greatly reduce or expand access that result in patient dumping or transfer limitations.

2. **Exclusion of key tertiary and quaternary care from the constraints of the GBR.**
    a. Both JHH and UMMC must be allowed to offer critical lifesaving and curative therapies to citizens of Maryland. The GBR creates significant pressures to limit access to these key services based on a rationing of fiscal reserves to cover less intensive levels of care. Tremendous advances in therapeutic drugs and devices occur weekly. Many of these new biologic drugs offer curative solutions to advanced disability and life-limiting diseases.
    b. JHH and UMMC must be able compete nationally with other AMCs.
        i. Attract and retain top clinical and research talent.
        ii. Invest in new capital and innovative technologies.
        iii. Increase tertiary and quaternary volumes to improve clinical quality.
        iv. Sustain financial margins that support the tripartite goals of teaching hospitals.

3. **Address excess bed capacity in Maryland by geography.**
    a. The success of the Demonstration Model in reducing acute care volumes resulted in some hospitals operating at a lower census and sub-optimal efficiency in Baltimore City, both on operating and clinical quality levels.
    b. Timing is important in the context of the healthcare employment environment as providers are fervently searching to find clinical personnel. The patients displaced by hospital closures in Baltimore City would be absorbed by other providers. Associated job displacements would be redirected to other local hospitals in critical need of clinical resources.

c. The fixed cost savings from these hospital closures would likely fuel required system savings targets for many years.

Other Demonstration Model refinements are likely required; however, these categories address many of the current distortions in the model and ensure that the citizens of Maryland will have access to high quality advanced clinical care when needed. The HSCRC, MDH and CMMI must develop criteria to assess the health of Marylanders over the period of the model. We need meaningful measures to assure that the success of reduced costs reflect improvement in health and not rationing of care. Nothing less than appropriate refinement in these areas ought to be acceptable to the state regulators at the HSCRC.

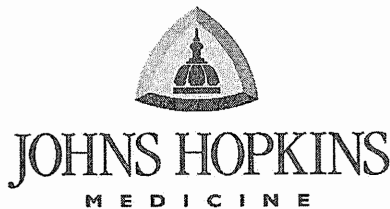
GLOSSARY

- **Academic Medical Center (AMC):** A hospital affiliated with a medical school that provides advanced clinical care, conducts research, and educates healthcare professionals. AMCs often serve as referral centers for complex cases and play a key role in healthcare innovation and specialized care delivery, as well as serving as economic engines for the state. The HSCRC defines an AMC as a facility with 500 beds or more, affiliated with a school and has a higher Case Mix Index than 1.5. In Maryland only two hospitals meet this standard, The Johns Hopkins Hospital and University of Maryland Medical Center.
- **Alternative Payment Models (APM):** Payment approaches that move away from traditional fee-for-service structures, incentivizing providers to focus on the quality and effectiveness of care rather than the volume of services. APMs include models like global budgets, bundled payments, and shared savings programs, which encourage providers to reduce costs and improve patient outcomes.
- **Case Mix Index (CMI):** A measure representing the complexity and resource needs of a hospital's patient population. Higher CMI values indicate a higher proportion of complex, resource-intensive cases, impacting hospital reimbursement rates and budget allocations in models like the Maryland Model.
- **Center for Medicare and Medicaid Innovation (CMS Innovation Center):** Federal agency, established by the Affordable Care Act, under the Centers for Medicare and Medicaid Services (CMS) that supports the development and testing of innovative healthcare payment and service delivery models that aim to achieve better care for patients, better health for communities, and lower costs through improvement for the health care system. Maryland's All Payer Model, Total Cost of Care Model, and the States Advancing All Payer Health Equity Approaches and Development Models are administered by the CMS Innovation Center.
- **Demographic adjustment:** The demographic adjustment accounts for changes in the demand for services associated with changes in the size and characteristics of the population served by hospitals within their primary service area. As currently implemented in Maryland, the demographic adjustment is distributed to hospitals based on an expected age-adjusted growth rate within their given service area, but the results are scaled across hospitals so that state revenue growth is limited to population growth without an age adjustment. The demographic funding is allocated according to market share, meaning it expects all hospitals in a service area to experience demographic changes equally.
- **Equivalent Case-Mix Adjusted Discharges (ECMADs):** A standardized measure of both inpatient and outpatient hospital utilization adjusted for case mix, or the complexity of cases. ECMADs allow for consistent comparisons of hospital volume and performance by accounting for variations in the types of patients treated, supporting accurate budgeting and performance assessments.
- **Fee-for-service (FFS) payments:** A traditional payment model where providers are paid separately for each service they perform, such as exams, procedures, or tests.

- **Global Budget Revenue (GBR):** Payment methodology established by the Health Services Cost Review Commission as part of the agreement with the CMS Innovation Center that establishes a fixed global budget for hospital services, rather than traditional fee for service. Under this fixed revenue model, there are minimal revenue adjustments as volumes increase or decline.
- **Health Services Cost Review Commission (HSCRC):** State agency that oversees hospital rates for all patient care services at acute care hospitals in Maryland.
- **Inter-Hospital Cost Comparison (ICC):** A comparison of hospital charge per ECMAD, exclusive of hospitals' unique costs and allowed funding for social goods. Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for social goods and costs beyond a hospital's control that are not included in the peer group standard.
- **Market Shift Adjustment:** The market shift adjustment is designed to reallocate revenue from one hospital to another within the state as patients move across hospitals for care. This feature is designed to replicate the function of a market, but in a way that will not incentivize hospitals to seek additional patient volume to enhance their financial performance. The market shift is intended to identify changes in the volume of specific services within hospitals in each market and to reallocate revenue to cover the incremental cost of those services. The market shift does not adjust for growth in volume, only the migration of patients from one hospital to another, if the migration can be tracked through the HSCRC's policies.
- **Maryland's Medicare Waiver**: Affects all patients, regardless of age or Medicare eligibility, treated in Maryland hospitals. Under the waiver's rules, every payor – whether an individual, Medicare, Medicaid, or a private insurer – pays the same charge for the same care at the same hospital, as set by the HSCRC.
- **Medical/Surgical/Gynecological/Addictions (MSGA) Beds**: Hospital beds designated for general medical, surgical, gynecological, and addiction-related care, excluding intensive or highly specialized care. MSGA beds support a broad range of inpatient services and are essential for accommodating routine hospitalizations. Effective use of MSGA beds is critical for managing capacity and controlling costs within the Maryland Model.
- **Patient Quality Indicators (PQIs)**: Measures that assess the quality of care management beyond the hospital walls by identifying potentially avoidable hospitalizations. PQIs highlight areas where improved primary or preventive care could reduce hospital admissions, making them an important tool in tracking hospital performance and identifying opportunities for care improvement.
- **Potentially Avoidable Utilization (PAU):** Readmissions and conditions where robust disease management in the "outside the walls of the hospital" setting can avoid future hospitalizations (such as diabetes, hypertension, heart failure).
- **Tertiary/Quaternary Care:** Advanced levels of medical care typically provided by specialized hospitals or academic medical centers. Tertiary care includes specialized consultative services, while quaternary care encompasses highly specialized, complex treatments (such as organ transplants or experimental therapies). Hospitals offering tertiary and quaternary care often act

as referral centers, providing complex care that goes beyond the capabilities of community hospitals.

- **Total Cost of Care (TCOC) Model:** Second phase of the Medicare waiver. As part of this Model, Maryland commits to saving $300 million in annual, total Medicare spending by the end of 2023, while also meeting hospital-based quality targets. The TCOC Model holds hospitals financially accountable for growth in all Medicare cost of care, including care outside the hospital. The TCOC Model will be replaced by the AHEAD Model.



December 15, 2021

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for Revenue for Reform, which would classify certain non-hospital costs as allowed population health investments, creating safe harbors for retained revenues. The draft recommendation intends to provide hospitals with credit for investments that hospitals make in population health initiatives, and JHHS supports this intent. The implementation of Revenue for Reform would have been appropriate if implemented in 2014 with the launch of Global Budget Revenue Agreement. However, it is not clear why any hospital or health system has not to date robustly invested retained revenue in population health initiatives in the surrounding community since the HSCRC specifically states "GBR methodology is an extension of TPR methodology, which encourages hospitals to focus on population-based health management by prospectively establishing a fixed annual revenue cap for each GBR hospital." Any hospital or health system who has retained revenue that has not been invested in population health has simply been violating the goals and requirements of the Maryland Model. .Additionally, JHHS has specific concerns with the current proposed policy, as detailed below:

Methodology concerns

If the methodology is only applied to the lowest quartile hospitals, JHHS believes that this policy should not cause hospitals that are not in the lowest quartile to fall into the lowest quartile. Additionally, if the methodology is applied to all hospitals, there should be a standardized report for hospitals to provide the information used to adjust the efficiency results in an equitable manner.

Impact on consumers and hospitals

Revenue for Reform does not address some of the fundamental challenges with GBR, specifically its impact on consumers – patients who need hospital level of care. If excess revenue remains in the system, and volumes continue to decline, unit rates will continue to increase. Patients receiving care at

low volume hospitals will receive inappropriately high bills. This has an unfair impact on consumers, particularly as insurers continue to increase co-pays and deductibles.

Industry-wide savings targets under the Maryland Model will be increasingly hard to reach if all retained revenue is allowed to stay within the system. Any efficiency metric needs to address excess retained revenue and Revenue for Reform simply avoids difficult actions that must be taken to ensure the integrity of the Maryland Model.

Revenue for Reform, at this time, potentially rewards hospitals who may have reduced overall volumes under GBR, not just avoidable volumes. Data indicates that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services. The Revenue for Reform policy may be rewarding those hospitals for inappropriate reduction of services. The HSCRC should develop a Revenue for Reform policy that only recognizes volume reductions associated with PAU or due to population health related programs (not all volume).

Unintended consequences

Revenue for Reform could also have the unintended consequence of disadvantaging some communities over others. As noted above, not all hospitals have retained revenue. Hospitals with retained revenue will be allowed to keep that revenue if they invest in population health initiatives in their communities. With the current draft recommendation, it remains unclear how the HSCRC will ensure that disadvantaged communities that surround hospitals without retained revenue are also supported with population health investments.

An additional unintended consequence of this policy relates to increasing concern about disproportionate population health initiatives being included in HSCRC rates, and the impact that this has on rate levels for value-based agreements. Revenue for Reform runs the risk of disproportionately disadvantaging hospitals with a larger population health footprint paid through rates. Given that some payor programs compare a specific payor to market rather than to themselves, the growth of HSCRC rates due to programs that do not relate to the value-based program does not promote progress in value-based work.

Proposed changes & additional considerations

To address the concerns noted above, JHHS proposes that the HSCRC considers revising the policy to reset hospital GBRs before implementing Revenue for Reform. A portion of the savings generated through a reset should be dedicated to a statewide fund that would be available on a need-based approach to serve communities most in need of population health investments. This equity-focused approach would ensure that these funds are made available to all communities, not just those communities located near hospitals with retained revenues. Under the current policy, communities like East Baltimore would not receive the level of investment that other communities receive, as the Johns Hopkins Hospital does not have retained revenues. By resetting GBRs before implementation of the policy, these communities would receive more equitable levels of investment to further our statewide population health goals.

While JHHS agrees with the intent of the Revenue for Reform policy, JHHS does not believe this policy can move forward in its current form without compromising consumers and equity for the reasons detailed above. JHHS appreciates the HSCRC's thoughtful consideration of the above concerns and comments related to the draft recommendation for Revenue for Reform, and thanks the HSCRC for their continued collaboration to improve population health.

Sincerely,

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

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
Katie Wunderlich
Maulik Joshi, DrPH
James Elliott, MD
Sam Maholtra

May 6, 2022

Willem Daniel
Deputy Director, Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Daniel,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the Health Services Cost Review Commission's (HSCRC) revised proposed Revenue for Reform policy. Revenue for Reform would require hospitals to demonstrate their investment in community-based efforts that address social determinants of health. As we stated in our December 15 comment letter, JHHS is supportive of the basic intention of the policy to require that some portion of retained revenues should be invested back into the community, in alignment with the goals of the Maryland Model.

Since the implementation of the Total Cost of Care (TCOC) Agreement, JHHS has developed several key population health initiatives that were highlighted as a community need through the Community Health Needs Assessment (CHNA). These initiatives include:

- Collaborating with Chase Brexton, a Federally Qualified Health Center (FQHC), to provide support for patients presenting to the Emergency Department with acute dental needs.
- Johns Hopkins Medicine partnered with Baltimore Medical System (BMS) to transition East Baltimore Medical Center to a FQHC with the goal of improving care for our local community and enhancing our ability to address key social determinants by expanding access and increasing behavioral health and other key wraparound services.
- Collaborating with the Helping Up Mission to provide housing, jobs, and supportive services for individuals in recovery for substance use disorder.
- Leading a coalition of hospitals to fund supportive housing services for high-utilizer patients in Baltimore City who are experiencing homelessness.
- Leading a coalition of hospitals to establish the Greater Baltimore Regional Integrated Crisis System.
- Implementing Journey to Better Health in Howard County, a faith health initiative, to address chronic disease in the community, especially in segments of the population that see disproportionate rates of diabetes, hypertension and obesity.

JHHS has consistently understood that the when the All-Payer Model transitioned to the TCOC Model, there was a greater expectation for the development of community and population-based health

improvement initiatives. The HSCRC, the Maryland Department of Health and the HSCRC invested significant time to develop the Maryland Population Health Improvement Plan. The Maryland Population Health Improvement plan, submitted to the Center for Medicare and Medicaid Innovation (CMMI) in December 2016, specifically notes, *"As the Maryland health care system increasingly migrates toward adopting public health approaches in order to meet the performance goals of the All-Payer Model, it requires that population health improvement beyond the clinical space to address all factors that determine health; the social determinants of health and health equity."*

Considering the effort and focus on transitioning the All-Payer Model to a population health model, it is unclear how any stakeholder in the Maryland Model could reasonably believe that all savings generated through utilization reduction would be retained on an ongoing basis rather than invested in population health strategies.

While supportive of the overall concept of Revenue for Reform, the concerns outlined in our original comment letter remain, specifically regarding consumer impact, retained revenue, excess capacity and unequitable distribution of resources. JHHS is providing additional feedback on various areas of the proposed recommendation as well as broader policy concerns.

Specific Policy Concerns

Buyout Methodology

JHHS agrees that the first two-year buyout methodology is a reasonable approach for hospitals facing efficiency penalties, as it essentially offers to redirect some portion of their retained revenue to appropriate investment in population health spending rather than losing the revenue. Some amount of retained revenues should be invested back into the community, as this has been the intent of the new model since its inception. This approach allows hospitals to choose to redirect retained revenues they would otherwise lose while ensuring these important investments are made in the health of our communities.

Retained Revenue Methodology

The December 15, 2021 JHHS comment letter addressed concerns that the Revenue for Reform policy was not aggressive enough in addressing retained revenue that has persisted and grown since the implementation of the Global Budget Revenue (GBR) model. HSCRC staff addressing this concern, stated that the goal of *"GBR is intended to incentivize reductions in utilization (not just Potentially Avoidable Utilization [PAU]). Rebasing hospitals that followed the incentives of the model would be a bait and switch."* The HSCRC position treats all utilization equally and fails to recognize the important distinction between providing medically necessary care versus making financial decisions to reduce services. It is crucial to note that volume reductions alone do not translate to more effective utilization of services. In reality, decreased volume alone may threaten patient access to quality care. The HSCRC currently has no benchmarks to determine if reduced volume is due to improved care, efficient care or just "rationing" of services. The Revenue for Reform policy may be rewarding those hospitals for inappropriate reduction of services.

JHHS advises that retained revenues be separated into two groups –PAU-related retained revenues and non-PAU-related retained revenues:

- **PAU-related retained revenues**: Any retained revenues associated with a reduction in PAUs should be protected at 100%, as this is consistent with the intent of the new model and also with other HSCRC methodologies. To ensure incentives are appropriately aligned with other HSCRC policies, these revenues should be fully protected and should not be subject to the requirements of Revenue for Reform.
- **Non-PAU related retained revenues**: As noted above, some hospitals may have generated volume reductions by shrinking or eliminating programs, in turn limiting patient access and causing subsequent volume increases at other hospitals. This does not align with the intent of the Maryland Model. To the extent hospitals have done this over the first 8 years of the model and have not invested those revenues in population health initiatives already, hospitals should not be able to retain this revenue.

Additionally, there must be a consistent methodology for calculating retained revenues. Currently, retained revenues are calculated at the unit rate level. This is inconsistent with the Equivalent Case Mix Adjusted Discharges (ECMAD) volume methodology used in the market shift policy and other HSCRC policies. To ensure better alignment with existing HSCRC methodologies, we urge staff to consider using a consistent methodology to calculate retained revenues.

JHHS recognizes the balance the HSCRC is trying to achieve in maintaining the incentives of the GBR and ensuring appropriate investments in population health. However, it is also important to note that the magnitude of retained revenue is inappropriate and should not be sustained. It locks revenue in increasingly inefficient and expensive facilities on a price per case basis, exposing patients to increasingly high bills that are only exacerbated by the shift of insurers of patients into high deductible health plans. Previous analysis has indicated approximately $600 million in retained revenue statewide. This significant amount of funding could annually support:

- 12 new elementary schools at $50 million for each school
- The purchase of 3,500 homes in Baltimore City at a median price of $167,000
- The elimination of the approximately 6,000 homeless[1] individuals in Maryland by providing them annual support of $100,000.

JHHS is not advocating against the goal of Revenue for Reform, or for the elimination of all retained revenue; however, an appropriate balance must be achieved.

Expected Population Health Spend

Different communities have different needs, as indicated by the various CHNAs. In addition, different types of hospitals have varying abilities to impact these different community needs. JHHS urges staff to move away from a one-size-fits-all approach to calculating the Expected Population Health Spend. Sole community/safety net hospitals, suburban hospitals, and academic medical centers (AMCs) are able to impact communities with different approaches and to varying degrees.

It is crucial to note that forcing all hospitals to spend 1% of their total revenue base as Expected Population Health Spend is a flawed concept. This approach assumes that all volumes can be managed under population health. It also assumes that all hospitals have an equal opportunity to do so. In this

[1] https://www.usich.gov/homelessness-statistics/md/

case, a one-size-fits-all approach could unduly penalize a hospital that is spending monies in other areas of need because they have no retained revenues.

If this methodology is adopted, it should only be applied to a portion of the revenues attributable to the populations the hospital serves. Given that certain volumes are carved out of the market shift methodology, staff should also consider carving these types of volumes out of the expected population health calculation. This would include the innovation adjustment, out-of-state volumes, PAUs, etc.

Qualifying Population Health Investments

JHHS generally supports the criteria outlined by the HSCRC as qualifying population health investments. An industry-wide focus on addressing issues identified in the CHNA creates an opportunity to address and improve social determinants of health strategies. There are many programmatic hospital-based investments, such as violence intervention, services for immigrant populations, and workforce development that JHHS believes should be included in the population health investment "safe harbor." We will continue to work with HSCRC staff to develop specific criteria that would categorize an investment as a population health initiative.

Broad Policy Concerns

How to incorporate an increasing expectation for spending on community-based programs in a constrained system

The increasing expectation for spending on community-based activities is a necessary and expected development within our TCOC policy. JHHS is concerned that the proposed policy favors hospitals with the most retained revenues while also creating a requirement to spend within their existing revenue structure at hospitals with limited retained revenue. As we consider the long-term viability of our Model JHHS believes that the growing distortions in the GBR, such as retained revenues and excess capacity, must be addressed to ensure rational and equitable access to available funds to invest in community health. JHHS is concerned that Revenue for Reform as currently constructed avoids difficult actions that must be taken to ensure the integrity of the Maryland Model.

Resetting Hospital GBRs

While generally supportive of the intention of the proposed Revenue for Reform policy to increase accountability for investing retained revenues in community-based activities, JHHS believes the concerns noted above and articulated by staff would be more adequately addressed by revising the policy to reset hospital GBRs before implementing Revenue for Reform. As we contemplate both increasing savings requirements and new expectations for investments of this type, we must consider the levers that we have to address the growing distortions in the GBR, including rebasing and addressing excess capacity in the system. Mechanisms such as these can create available funds that can be thoughtfully distributed to address (1) allowed retained revenue at hospitals (2) investing in care transformation, and (3) contributing to savings requirements. A more equitable and logical way to meet the community needs that are the stated goals of Revenue for Reform may be a policy that, if properly executed, provides for rebasing and addressing the excess capacity within the system, pooling a defined amount of those retained revenues, and using them to re-invest in care transformation. JHHS believes a thoughtful approach can strike a balance between preserving the volume incentives that drive TCOC savings in our system and meeting the increasing expectation to continually invest in care transformation.

Process to Identify Projected Bed Need Across the State

The State of Maryland would benefit from an open and robust discussion regarding the long-term bed need and sustainability of Maryland's hospitals. If the Maryland Model is ultimately successful and alternative models of care are scaled across the state, it will likely mean a reduction in the need for hospital-based inpatient services in the future.

Other states are taking similar approaches, initiating extensive public process to examine the utilization and cost of hospital services, the financial health of the facilities themselves, and the long-term bed need by region and across the state based on future demographic projections. A similar process in Maryland would allow for long-term planning to take place in an open, transparent, and thoughtful manner, rather than relying solely on the incentives in Revenue for Reform and other policies to drive the necessary changes.

JHHS recognizes the value of the intent of the proposed Revenue for Reform policy and appreciates staff's thoughtful consideration of the above comments. Though we agree that some retained revenues should be invested back into the community, we urge staff to ensure the methodology is appropriately adjusted to reflect alignment with the HSCRC's existing policies and with the intent of the Maryland Model. We look forward to continuing this important dialogue.

Sincerely,

Ed Beranek

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

June 23, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide further input on the Health Services Cost Review Commission's (HSCRC) proposed Revenue for Reform policy. In its current form, the draft recommendation would require hospitals to demonstrate their investment in specific community-based initiatives, or potentially risk losing retained revenues. As we stated in our attached December 15 and May 6 comment letters, JHHS is supportive of the primary aim of the policy; it is necessary that that some amount of retained revenues are invested back into the community, in alignment with the goals of the Maryland Model. As the policy has evolved, the JHHS position remains consistent with our past comment letters. Specifically, JHHS notes:

- Policies must address retained revenue with a distinction between appropriate and inappropriate volume declines
- Hospitals without retained revenue cannot be held to a standard investment, particularly when these hospitals likely absorbed volume from other hospitals that simply shed volume
- Investing in community and population health initiatives is consistent with the goals of the Maryland Model.

JHHS understands the goal of the proposed Revenue for Reform policy, and agrees that some retained revenues must be addressed and reinvested back into the community. We urge the HSCRC to thoughtfully consider this policy's impact on and alignment with the HSCRC's existing policies and the intent of the Maryland Model.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management & Reimbursement

Johns Hopkins Health System

Summary of Kevin Sowers Testimony on HSCRC Corrective Action Plan
HSCRC Commission Meeting
October 12, 2022

- JHHS supports the MHA position. The MHA position is a very balanced approach which looks to all stakeholders to contribute to achieving success of the Maryland Model.
    - Agree that COVID and its aftershock should be considered an exogenous factor because we would not be failing the targets if not for the pandemic.
    - Agree that some portion of the corrective action should be achieved through reductions to hospital Medicare rates.
        - The hospital industry has appropriately debated the nature of the rate reduction and has generally agreed to 75% of the rate reduction achieved through the efficiency policy and 25% achieved through rate reduction across all hospitals.
        - This process will require all hospitals to contribute to the solution
    - The HSCRC and hospital industry both are recognizing the need for a balanced approach towards corrective action - any drastic or aggressive actions should be avoided for now, until we have greater insight into the data and long-term Medicare growth.
    - However, taking incremental proactive action will signal to CMS how committed the state and hospital industry are to the success of the Maryland Model
- While JHHS supports the MHA position, we also urge the HSCRC to view the threat of corrective action as an opportunity evaluate the direction of the Maryland Model and numerous policies under the Model
    - JHHS has been very direct in voicing our concerns around retained revenue and excess capacity, particularly in Baltimore City
    - Allowing revenue to be retained within a hospital or health system indefinitely creates distortions within the overall system
        - Retained revenue creates artificially high charges at hospitals with low volume. These charges then become the burden of patients
        - Retained revenue makes long-term savings targets harder to achieve
        - Retained revenue creates perverse incentives for hospitals to arbitrarily reduce volumes and retain savings. Without clear and concrete guidance from the HSCRC on the nature of volume that *should* be reduced, some hospitals will succeed simply by eliminating services. When a hospital eliminates services, those patients either seek care at another hospital or they don't get the care they need. This is not behavior that should be financially rewarded
        - Retained revenue shields Maryland hospitals from actions and activity that is occurring in the hospital industry across the nation. As a health system with a national presence, JHHS is constantly evaluating market trends (the following is Vizient and Sg2 data that looks at market trends pre-COVID – 2015-2020)
            - Nationally staffed beds are declining at community hospitals while staffed beds at AMCs are growing
                - In Maryland staffed beds at community hospitals declined by 17% vs 3% decline nationally

            - Nationally AMC beds are growing by 9%, in Maryland AMC staffed beds remain stagnant
            - Nationally AMCs operate at 83% capacity and in Maryland JHH operates at over 90% capacity
        - Nationally, community hospitals are shrinking and the revenue from those hospitals is being shifted to the other hospitals providing medically necessary care for those patients. Yet in Maryland, this shrinkage is accelerated and most of the revenue remains with the hospitals who are closing beds
        - The Maryland Model should be used to support hospitals that either deliver medically necessary care or serve as a vital resource to a community – like in more rural areas – but the Maryland Model should not protect and insulate hospitals from bed declines that are either deliberate, or are not the result of health care transformation
- There is a need for stronger population health strategies to serve disparate communities.
    - The conversion of Bon Secours to Grace Medical serves as a strong example of how a hospital facility can be right sized to meet the needs of the community, while also allowing for strategic investments in the community
    - There are currently 10 acute care hospitals serving Baltimore City, which has a declining population. Baltimore City is over-bedded with significant retained revenue at hospitals with low occupancy rates.
    - A strong policy that reduces excess capacity or at least repurposes some retained revenue to support a coordinated population health approach could dramatically improve the overall health of high needs regions across the state.
    - Baltimore City -
        - Has a significantly higher rate of:
            - People living below the poverty line
            - Unemployment
            - Food insecurity
            - 43% of Baltimore City residents receive Medicaid vs. 23% statewide
        - There is a commonly referred to statistic in health care – 40% of an individual's health care costs are associated with the conditions they live in
        - If we are truly committed to recognizing the Maryland Model as a population health model then we need strong policies and collaborative approaches to addressing social determinants of health in areas like Baltimore City, where the need is much greater
        - No one hospital can achieve this transformation. It must be a collective effort and retained revenue represents an opportunity to both achieve savings and reinvest in our communities.
- JHHS believes there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. We urge the HSCRC to consider intentional policies and strategies that address retained revenue, volume reduction and population health.

October 7, 2022

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the potential corrective actions that may be required if the State does not meet the savings targets required by the Waiver.

JHHS supports the Maryland Hospital Association (MHA) position regarding the potential corrective action steps, specifically the approach of consideration of exogenous factors, increasing the public payer differential, Medicaid deficit assessment relief and a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This is a balanced approach that requires contributions from all stakeholders that benefit from the Maryland Model, including hospitals, commercial payers and the state of Maryland. This approach also reflects a thoughtful compromise across the hospital industry.

While JHHS is supportive of the MHA position, it is important to highlight that this approach towards corrective action does not solve the systemic problems within the Maryland Model and the Global Budget Revenue (GBR). Failing to meet the Medicare savings target presents Maryland with the opportunity to pursue a thoughtful evaluation of the policies within the Total Cost of Care Model that are improving patient care and those that are not.

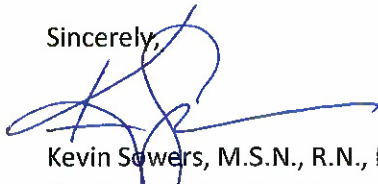
JHHS has repeatedly raised the issue of retained revenue and the need for a rational population-based and clinical needs approach to bed capacity. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services. In order to achieve the goals of the model and deliver ongoing savings, the HSCRC must develop policies that –

instead of recognizing all volume reduction – only recognize volume reductions associated with PAU or due to population health related programs. Some HSCRC staff have publicly indicated that the Maryland Model and the GBR are designed to reward any volume reduction. This is a reckless policy perspective that offers to incent rationing of health care services. Additionally, given that Maryland is benchmarked against the national Medicare spend, with a requirement to ensure Medicare fee-for-service total cost of care grows less than the nation, the current approach to retained revenue is counter-productive. While in other states, hospitals with declining overall volumes may otherwise close, in Maryland they remain open, adding to the state's total cost of care and hindering progress on the benchmark.

JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions and improved health. There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system – however some portion of retained revenue should be redirected to targeted investments in population health that focus on social determinants of health in Maryland's most disadvantaged communities.

While JHHS believes that the exogenous factor of the pandemic is a reason for the miss of the savings target, we also believe there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS appreciates the opportunity to comment on the potential corrective actions and longer-term policy corrections that may be required of the State and the industry.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra

November 28, 2022

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for adjusting for excessive Total Cost of Care (TCOC) growth in CY2022. JHHS appreciates the balanced approach that the Health Services Cost Review Commission (HSCRC) has taken with the draft recommendation. The approach leverages support for adjustments across all stakeholders that benefit from the Maryland Model, including hospitals, commercial payors and the state of Maryland. While JHHS is generally supportive of the HSCRC's draft recommendation, specific comments and concerns are noted below.

Staff recommends an all-payer rate reduction of 0.40% that will be taken from the January rate orders across the board

JHHS, and the majority of the hospital industry, supports a targeted approach to rate reductions, rather than across the board. The hospital industry developed a consensus position, recommending a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This approach was proposed by Maryland Hospital Association (MHA) at the October meeting, and most of the Maryland hospitals supported this approach. Reducing rates based on the efficiency policy accounts for the fact that some hospitals are better positioned to sustain rate reductions than others. Less efficient hospitals have retained revenue and the industry recognizes that 75% of the rate reduction should come from inefficient hospitals and 25% from the remainder. JHHS would encourage the HSCRC to reconsider this aspect of the recommendation and instead honor the industry consensus to achieve the reductions in a targeted way, utilizing the HSCRC approved efficiency policy. We strongly encourage staff to adhere to existing policies. To change policy stances in response to a correction period causes us to pause in trying to understand the purpose of a policy that has been used in the past, but is now not considered by staff to be "accurate" or "relevant" to help address the issues before us. Constant policy changes that are not properly vetted with the industry undermines the stability of the Maryland Model.

We would also encourage the HSCRC to alter the all-payer rate reduction when the state is failing the Medicare targets – there is only a need reduce Medicare costs in Maryland in order to achieve compliance. The hospital industry is facing unprecedented labor and supply costs, with operating margins deteriorating significantly. Implementing an all-payer rate reduction will worsen hospital financial conditions, resulting in difficult decisions about staffing and services for some hospitals, while providing minimal targeted savings to address the Medicare issue directly. There is no need to reduce rates to all payers, particularly when commercial payers already receive the benefit of reduced hospital costs.

Staff recommends requesting an increase to the Public Payer Differential of 1% for the remainder of FY 2023 and the duration of FY 2024, contingent upon approval of the Center for Medicare and Medicaid Innovation (CMMI)

JHHS strongly supports using the differential as a temporary tool to reduce Medicare costs in Maryland. Insurers are the biggest benefactor of Maryland's all-payer system, resulting in hospitals costs to commercial payers that are on average 25% less than the nation. Expecting all stakeholders to contribute to corrective actions sends a strong message to state and federal policy makers, recognizing that success and failure of the Maryland model requires support, commitment, and sacrifice from all parties. Additionally, as more charity care and bad debt is associated with insured patients being enrolled in high-deductible health plans, revisiting and revising the differential may be sound public policy.

Staff recommends implementation of the Medicare Performance Adjustment Savings Component of $50 million

JHHS strongly supports using the Medicare Performance Adjustment Savings Component (MPA-SC) as a policy to bring Maryland cost growth in line with the nation. As noted earlier, JHHS believes that any reduction to hospital rates should be Medicare-only, and implemented based on the integrated efficiency policy, not across the board. The MPA-SC was developed and approved as a methodology to achieve the Medicare savings target if needed. The policy should be implemented now and used to mitigate across the board and all-payer reductions.

Additionally, given that there are various factors still in flux that will impact final model performance, JHHS believes the HSCRC should be cautious not to overcorrect with the adjustments under consideration. Of note, the actions inherent in the July 1, 2022 rate adjustments are not yet included in the data, and will have an impact on the state's final performance.

Staff recommends that the Commission send a formal request to the State to reduce the Medicaid Deficit Assessment by $50 million, contingent upon approval by the State Legislature

JHHS also supports this recommendation. Similar to the differential position, reducing the Medicaid Deficit Assessment demonstrates a multi-stakeholder commitment to protecting and preserving the Maryland Model, where all parties benefit. The staff recommendation notes that any

reduction to the Deficit Assessment is contingent upon approval by the State Legislature. However, a reduction to the remittance portion of the Deficit Assessment likely does not require any action by the Legislature. The laws governing the Medicaid Deficit Assessment were last revised by Chapter 16 of the Acts of 2019. The language currently states, "for fiscal year 2021 and each fiscal year thereafter, the budgeted Medicaid Deficit Assessment shall be $294,825,000." There is no reference in current law to a remittance portion, which is currently $56 million. In fact, any requirement for a remittance portion of the Medicaid Deficit Assessment was removed from law after 2016. In reviewing the law as it is currently written, the HSCRC and the Maryland Department of Health have the authority to abandon the remittance portion of the Medicaid Deficit Assessment so long as the total assessment remains as $294,825,000.

We appreciate concerns from the Maryland Medicaid program around long-term implications of this policy. However, the recommendation is a one-time only action, and is certainly justifiable when hospitals are experiencing unprecedented financial struggles and the Maryland Medicaid program is experiencing unprecedented financial surplus due to funds through the public health emergency.

Taking Corrective Actions Without Addressing Underlying Issues with the Model is Problematic

In addition to pursuing corrective action and as JHHS noted in our previous comment letter on potential corrective action, we also encourage the HSCRC and the industry to pursue a thoughtful evaluation of the policies within the TCOC Model that are improving patient care and those that are not. We must address the systemic problems within the Maryland Model and the Global Budget Revenue (GBR).

To this end, JHHS must reiterate our concerns around the issue of retained revenue and the need for a rational population-based and clinical needs approach to right-sizing bed capacity, especially in Baltimore City where the population has experienced a decline. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services:

- Recent Vizient and Sg2 data show that nationally, staffed beds at community hospitals declined by 3%, while Maryland has experienced a 17% decline in staffed beds at community hospitals. Simultaneously, AMC beds have grown 9% nationally, while in Maryland, AMC staffed beds remain stagnant.
- Nationally, community hospitals are shrinking; the revenue from these hospitals is being shifted to the hospitals that provide medically necessary care for those patients. However, in Maryland, this shrinkage is accelerated, while most of the revenue remains with the hospitals closing beds.
- Additionally, the population of Baltimore City is shrinking; the Baltimore City population was 576,498 in 2021, a 7.2% decrease from the population of 620,942 in 2010. As community hospitals are operating at a fraction of their fixed capacity and are projected

to see fewer inpatients over time, it is clear that their long-term role in the care continuum is changing.

- The Maryland Model should support hospitals that either deliver medically necessary care or serve as a vital resource to a community – like in more rural areas. The model should not protect and insulate hospitals from bed declines that are either deliberate or the result of population shifts.
- The HSCRC should investigate and explore potential regulatory opportunities regarding length of stay (LOS). The current regulatory environment in Maryland has resulted in challenges related to getting patients admitted into long-term care facilities, which in turn increases LOS, particularly for complex patients.
- The HSCRC should also explore regulatory opportunities related to skilled nursing facilities (SNFs). Due to low Medicare Advantage penetration in Maryland, there is very little utilization management, resulting in more SNF bed days in Maryland compared to the nation. This becomes a crucial consideration as we evaluate total cost of care performance compared to the nation.

In order to achieve the goals of the model and deliver ongoing savings, the HSCRC must develop policies that – instead of recognizing all volume reduction – only recognize volume reductions associated with PAU or due to population health related programs. Some HSCRC staff have publicly indicated that the Maryland Model and the GBR are designed to reward any volume reduction. This is a reckless policy perspective that offers to incent rationing of health care services. Additionally, given that Maryland is benchmarked against the national Medicare spend, with a requirement to ensure Medicare fee-for-service total cost of care grows less than the nation, the current approach to retained revenue is counter-productive. While in other states, hospitals with declining overall volumes may otherwise close, in Maryland they remain open, adding to the state's total cost of care, hindering progress on the benchmark, and limiting investments at hospitals still providing needed care to the community.

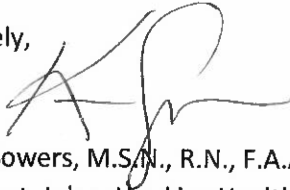
JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions, improved health, and addressing the underlying social determinants of health (SDOH). There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system. Locking retained revenue in facilities that no longer provide clinical care will also greatly limit the state's ability to invest in the types of transformative strategies that CMMI is expecting, namely housing and SDOH-focused interventions.

JHHS believes that corrective action needs to be pursued in order support the long-term viability of the Maryland Model. However, we also believe there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS would

encourage the HSCRC to begin work in January to realign the existing incentives within the Model, with the goal of implementing a comprehensive approach that addresses the underlying challenges of the current Model and places Maryland on a stronger path to success.

JHHS appreciates the opportunity to comment on the draft recommendation and longer-term policy corrections that may be required of the State and the industry.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra

April 12, 2023

James Elliott, M.D.
Commissioner; Chairman of Physician Engagement and Alignment Workgroup
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Elliott,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide input on the draft Total Cost of Care Model Progression recommendations proposed by the Physician Alignment and Engagement workgroup. As outlined in the workgroup's draft recommendation letter, the discussions have centered on modifications to the Episode Quality Improvement Program (EQIP), the Maryland Primary Care Program (MDPCP), and new programs to engage specialty providers, such as behavioral health, emergency physicians, and hospital-based physicians.

JHHS has strong participation in EQIP, with providers currently enrolled in 15 episodes. While the program has potential, the performance data to date has been limited. The program began in January 2022; providers began to see the first quarter of performance data in late fall of CY22, and the data for half of the first performance year, CY22, remains incomplete and has not yet been released. Given the incomplete data, JHHS believes further assessment of the program is needed before the program can be relied upon as a cornerstone for the next phase of the model. For both EQIP and MDPCP, JHHS urges the Health Services Cost Review Commission (HSCRC) to exercise caution as they consider aggressively expanding programs for which outcomes and impact are not yet fully understood.

The Physician Alignment and Engagement workgroup has also discussed the concept of a Global Budget Revenue (GBR) model for emergency physicians in Maryland. This is a new concept that has not yet been fully internally vetted; however, the current GBR model creates many distortions in care delivery. For the six years prior to the onset of the pandemic (2014-2019), Maryland was able to achieve significant utilization declines, but both the drivers and value to the Model of those declines and the resulting retained revenue remains unclear. The HSCRC's current policies do not differentiate between health management and simply discontinuing services, and there is no data at this time to indicate that the bulk of hospital utilization declines prior to the pandemic were achieved through care transformation or investment in addressing community needs. Instead, **all** volume reductions are rewarded as a positive outcome and there is limited accountability for continuously investing retained revenues in care transformation or improving health outcomes. JHHS believes the distortions in the current GBR model must be addressed before the HSCRC can consider expanding the model to the Emergency Department or other areas.

JHHS appreciates the efforts of the workgroup to generate policy recommendations to promote physician alignment and engagement for the next phase of the Model. As the Total Cost of Care Progression discussions continue, JHHS looks forward to the opportunity to collaborate with the HSCRC and workgroups to further the goals of the Maryland Model.

Sincerely,

Nicki McCann, J.D.
Vice President, Provider/Payor Transformation
Johns Hopkins Health System

May 9, 2023

Will Daniel
Deputy Director, Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Daniel,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide input on the draft Total Cost of Care Model Progression recommendations related to cost-containment and financial targets as discussed in the Total Cost of Care Workgroup.

Global Budget Revenue (GBR) 2.0

JHHS is supportive of the development of variations of GBR for different types of hospitals or different geographies of hospitals. GBR 2.0 is an example of this type of variation of GBR; JHHS is supportive of this recommendation if participation is purely voluntary and if participation is a fit for the hospital providing these services. Additionally, hospitals who elect not to participate should not be penalized through this policy or other related policies. JHHS also encourages the HSCRC to ensure effective safeguards are in place so GBR 2.0 does not create additional distortions in the model.

Supplemental Benefits

While using a portion of Medicare savings to provide supplemental benefits to Medicare beneficiaries is a worthy aspiration, this recommendation would use rate setting dollars to create an infrastructure that already exists through Medicare Advantage. If the goal is to create greater access to vision and dental benefits for Medicare beneficiaries, the state would be better served using these funds to supplement Medicare Advantage in Maryland. The concept of using savings under retained revenue for a dedicated purpose has merit and should be explored further. However, creating an infrastructure that is duplicative of Medicare Advantage is not the best use of resources.

The HSCRC should also consider the implications of linking additional benefits to savings; in the case where savings targets are potentially not met, these supplemental benefits would then be at risk, creating disruptions in care for patients and providers. Further, there is a level of complexity required to implement such a recommendation that is beyond the authority of the HSCRC. For these reasons, JHHS is not supportive of advancing this recommendation.

Reducing Cost Sharing

JHHS is not supportive of the concept of reduced Medicare cost sharing. JHHS agrees that the GBR effect and the increased burden for Medicare beneficiaries are distortions of the model; however, to address these distortions, JHHS believes the HSCRC should address retained revenue and excess capacity issues. This approach would more directly impact Medicare beneficiaries, and would be more effective for the model's long-term success. Additionally, significant contributors to price variability are the mid-year GBR targets and mid-year adjustments; this is within the scope of the HSCRC, and not the hospital industry.

JHHS appreciates the efforts of the workgroup to generate policy recommendations regarding cost-containment & financial targets for the next phase of the Model. As the Total Cost of Care Progression discussions continue, JHHS looks forward to the opportunity to collaborate with the HSCRC and workgroups to further the goals of the Maryland Model.

Sincerely,

Nicki McCann

Nicki McCann, J.D.
Vice President, Provider/Payer Transformation
Johns Hopkins Health System

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

May 24, 2023

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation on the FY24 payment update. JHHS appreciates the challenges the Health Services Cost Review Commission (HSCRC) faces in balancing the financial strains of hospitals with ensuring the model savings targets are met.

JHHS's comments and recommendations are outlined below.

Demographic adjustment

JHHS is in agreement with the staff's recommendation regarding the demographic adjustment. We believe that it is important, in a population health-based system/model to ensure that demographic changes are appropriately funded. JHHS thanks the HSCRC for their commitment to resolve any additional funding the Commission should provide to account for the ten-year forecasting error that occurred in the preceding decade and making sure hospitals are fully funded for demographic changes moving forward. We look forward to participating in those discussions and methodology development.

Lack of alignment with the purpose of the update factor

JHHS is concerned with the proposed recommendation, as it is not consistent with the purpose of the update factor as stated by the HSCRC, nor the goals of the Maryland Model. According to the draft recommendation, the purpose of the update factor is to "provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable within the State of Maryland[1]." The recommendation as currently proposed is inconsistent with the purpose of the update factor.

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[1] Health Services Cost Review Commission. (May 10, 2023). *Draft Recommendation for the Update Factors for RY 2024.*

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Generally, the update factor is applied evenly across all hospitals regardless of volume and capacity. Hospitals with low volume or retained revenue receive inflation beyond their operational needs. These hospitals receive inflation and funding for volumes, patients, and costs that do not currently exist.

Some stakeholders and staff believe inflation should be distributed evenly because retained revenues should be dedicated to population health investments. However, there are no data or outcomes to support that these investments have been made with retained revenues. Certain Baltimore City hospitals have the highest representation of retained revenue, yet represent some of the greatest health disparities in the state. Analysis of Baltimore City multi-visit patients indicates that 33,895 high utilizers[2] in Baltimore City represented 21% of unique patients from the city, and represented 57% of total hospital charges; this population generated $1.2B of the $2.2B of total hospital charges, with the most common chronic conditions being hypertension, chronic kidney disease, and mental health diagnoses, among others. Zip code analyses of Baltimore City demonstrate that the highest concentration of high utilizers and multi-visit patients can be found in zip codes that surround hospitals with retained revenues. There is no evidence that hospitals with retained revenue are engaged in meaningful population and community health strategies and investments.

This issue has compounded over time, and must be resolved over a number of years in order to stabilize the model. Fully inflating retained revenue for the period of 2014 through 2019 has contributed over $140M in excess cost to the Maryland Model, however applying a 50% variable cost factor would reduce the excess amount to $70M.

Impact on affordability for patients

Furthermore, the overfunding of inflation at hospitals with low volumes and retained revenues impacts affordability for patients who seek care at those hospitals; patient bills are inflated to ensure the hospital can then meet its global budget revenue (GBR). JHHS urges the HSCRC to continue to prioritize affordability for patients, and to consider the impact of this recommendation as proposed.

Funding of inflation

While historically this process may have worked well for the industry, hospitals are currently operating in extraordinary circumstances with unprecedented nursing and staffing costs due to COVID-19 and its ongoing impact. It is critical for hospitals providing medically necessary care to be appropriately funded for the previous two years. JHHS urges the HSCRC to provide further support to hospitals in these extraordinary circumstances. The HSCRC has expressed legitimate concerns that there must be a conservative approach to the update factor due to the need to achieve our model savings targets. However, there is sufficient capacity to provide a reasonable update factor that fully funds inflation for hospitals that are providing medically necessary care if strategies are pursued to address retained revenue.

Lack of alignment with the goals of the Maryland Model

[2] Defined as 3+ inpatient/emergency department/observation visits within the year; based on FY21 analysis

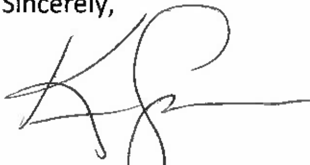
As proposed, the recommendation reflects the fundamental concerns that JHHS has repeatedly expressed regarding the direction and goals of the Maryland Model. As designed by CMMI, the model is intended to be a population health model in which targeted population health investments lead to improved health outcomes and reduced hospital utilization in certain diseases or communities, while controlling for cost and quality. However, as JHHS has previously noted, the model currently rewards any and all volume reduction, regardless of how this reduction was achieved. Hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and the repeated application of inflation to retained revenues only serves to further the distortions that currently exist in the model.

Recommendations

Given the economic climate and the challenges currently faced by the healthcare industry, JHHS believes a more nuanced and balanced approach to the update factor is required. For the reasons outlined above, hospitals should not receive inflation on retained revenue, as this is funding volumes that do not exist. Additionally, because the hospital industry remains unstable and uncertain in the aftermath of the COVID-19 pandemic, retained revenue should be assessed for pre-COVID model performance years (2014-2019). JHHS believes that these recommendations will allow the HSCRC, the State, and the healthcare industry at large to further align with the total cost of care goals.

Thank you for the opportunity to share comments and concerns both written and at the Commission meeting. JHHS greatly appreciates the HSCRC's transparent process in the development and approval of the payment update, and looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich
Maulik Joshi, Dr.P.H.
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Ed Beranek
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June 21, 2023

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of the Johns Hopkins Health System (JHHS), representing our 4 Maryland hospitals, we appreciate the opportunity to comment on the commission's Draft Recommendation on Modifications to Efficiency Policies: Full Rate Application, Integrated Efficiency Methodology, and Capital Financing. First, we would like to thank staff for continuing to consider feedback from the industry in the revisions to HSCRC policies. One of the hallmarks of the rate setting system has always been its evolutionary nature that allows the methodologies to continue to be refined as new information becomes available and the development of this policy has shown the staff's commitment to continuing that process.

JHHS supports the proposal to adjust hospital revenues for efficiency. We also believe that it is appropriate to have both a Price Efficiency metric as well as a Total Cost of Care (TCOC) metric included as part of the methodology. Measuring efficiency in a fixed revenue environment is challenging, and we appreciate the HSCRC staff's approach to balance price efficiency with hospital specific, per capita TCOC performance.

Policy Goals and Objectives, and Methodology Application

Historically, HSCRC efficiency policies have been used to identify outliers in the system and provide a way for those outliers to be brought back towards the statewide average via rate actions. JHHS believes that the current proposal of utilizing the quartile ranking continues to support this concept, which we believe is appropriate.

JHHS also believes that the efficiency policy should be revenue neutral on a statewide basis. If high-cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld. We appreciate the HSCRC staff's consideration that allows low-cost outliers to apply for increases and other proposed uses of savings.

Application of Efficiency Adjustment on a One-Time Basis

JHHS agrees with staff's concern regarding volume volatility using the COVID data period. Using this data period in methodologies that make permanent changes to hospital GBRs could be problematic. Applying the results on a one-time basis helps to lessen the potential permanent impact of using that data period. We would not want a policy in place that artificially reward or penalizes hospitals for a very disruptive data period.

Application of a Productivity Offset

JHHS understands the historical reasons for applying a productivity offset prior to the CY 2014 implementation of the Global Budget Revenue (GBR) methodology, however, it is not clear if such an adjustment is still valid under a fixed revenue model. When the productivity adjustment was suspended in the full rate application methodology, it was noted that the purpose of the suspension was to incorporate adjustments to regulated profits for both physician and population health expenditures. Since there have not been any adjustments made for these components, we believe that the productivity adjustment should continue to be suspended until those other adjustments can be made.

Inclusion of both attainment and improvement for both Full Rate Applications and Integrated Efficiency Policy

JHHS supports the staff's proposal to move to a TCOC measure that considers both attainment and improvement. In the Integrated Efficiency Policy, it is important to assure that funds are not taken from hospitals who have a high TCOC but have driven it down over time as they are moving in the right direction to achieve the goals of the TCOC system. We do have concerns in the Full Rate Application Methodology, that hospitals that have some of the lowest TCOC in the state still must reduce their TCOC faster than the statewide average improvement. We believe that staff should consider a modification to that methodology to allow for some lower threshold for hospitals with the lowest TCOC in the state.

Revenue for Reform Credit

JHHS supports the staff recommendation to allow for an offset to any inflation withhold for qualifying population health investments. We believe that a core principle of the TCOC system was for hospitals to reinvest GBR saving back into population health programs. However, we do believe that there should be some limit to how much of the dollars identified through the Efficiency Policy can be offset. Additionally, the policy as drafted does not address retained revenue that has accumulated since the inception of GBR. The Regional Entity Safe Harbor should be explored as an opportunity to redirect retained revenue that should but have not been invested in population health programs. Accumulated retained revenue within a geographical region could support the launch and operations of a Regional Entity that addresses the social and medical needs of multi-visit patients within a region.

Finally, we believe that this and all methodologies need to be reviewed and revisited on a regular basis to assure that the underlying methodologies are keeping in sync with the goals of the new model and to provide refinements where needed.

Thank you again for your consideration and thanks to the HSCRC staff for all of their efforts in crafting a policy on this very complex matter. If you have any questions, please feel free to contact me.

Sincerely,

Ed Beranek

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

July 6, 2023

Allan Pack, PhD
Principal Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Pack,

On behalf of the Johns Hopkins Health System (JHHS), thank you for allowing input on the Emergency Department Dramatic Improvement Effort (EDDIE) proposal. Given that Emergency Department wait times across Maryland are among the highest in the nation, JHHS agrees that the root causes of these wait times must be understood and addressed. JHHS appreciates the opportunity to continue partnering with the HSCRC on issues that meaningfully improve the health and outcomes of Marylanders.

As proposed, the EDDIE initiative involves collecting data from each hospital on the following metrics:

- ED1 Median Time (in minutes) from ED Arrival to ED Departure for Admitted ED Patients
- OP-18 Median Time (in minutes) from ED Arrival to ED Departure for Discharged ED Patients
- EMS turnaround time – collected by MIEMSS

JHHS's comments and feedback are detailed below:

EMS turnaround time

We agree with the measure specification of the EMS turnaround time. Assuring timely transfer of care of emergently ill patients is essential to good clinical outcomes. Using the benchmark of 30 minutes to transfer 90% of patients was felt to be reasonable by our clinical experts. This measure also ensures that outlier events are not overweighted by using 90% of all cases as the threshold.

Behavioral Health
We agree with stratifying the ED-1 and OP-18 measure by behavioral health versus non-behavioral health patients. There are significant differences in availability of medical and behavioral health resources and it is important to understand the pressure points of each separately.

Metrics
JHHS suggests the incorporation of additional meaningful metrics that provide insight into the root causes of ED wait times. While the selected ED-related measures serve as a proxy for system throughput and capacity, these measures do not provide the complete picture. Consider other indicators of capacity to target for improvement such as inpatient length of stay (separated into patients discharged to home and post-acute care), length of time to admit a patient to a skilled nursing facility/nursing home, length of time to transfer patients to tertiary and quaternary care, length of time to place behavioral patients into a psychiatric inpatient bed, ICU or PACU boarding times, *et al.*

Implementation time
While we appreciate the urgency to understand this issue, 4-6 weeks may not be an adequate timeframe for hospitals to shift resources and re-invigorate EMR algorithms to report these measures. We encourage the HSCRC to solicit hospital feedback on a more reasonable timeframe.

Understanding root causes
JHHS shares the HSCRC's position that Maryland ED wait times must be addressed, and looks forward to collaborating on further understanding the drivers of ED wait times by using complementary measures. JHHS asks for help from the HSCRC in understanding the root cause of these wait times and not just improving our measurement of the symptoms. More specifically, we would like to ask the HSCRC to help evaluate:

- the correlation between ED wait times and inpatient bed availability
- the correlation between geographic area and ED wait time (suggesting there may be a greater need for regional resource investment outside of the ED). Our JHHS data suggests there is considerable variability in ED utilization in Baltimore City compared to outside the city.
- the correlation between ED wait time and regional population density
- the correlation between ED wait time and specific social determinants of health
- the correlation of Maryland ED wait times by region compared to national based on population per licensed inpatient beds.

Alignment of nomenclature
JHHS suggests that the HSCRC consider the framing and nomenclature related to ED wait time initiatives as this work continues. Framing our short-term efforts as the "ED Dramatic Improvement Effort" suggests that lengthy wait times are related to ED operations or structure when they are instead a proxy measure to upstream demand and capacity factors. JHHS suggests the name of this effort be revised to "Hospital Capacity & Occupancy Enhancement Throughput Initiative," or a similar name. We believe this better reflects where improvement is required to successfully impact wait times associated with ED visits or patient transfers among hospitals.

Long ED wait times cause patient harm, distress, dissatisfaction, and safety issues, stresses an already burdened clinical team, and impacts hospital performance. However, ED wait times are a composite endpoint of many healthcare and public health factors that cannot be solved by hospitals alone. It is imperative that there be a coordinated approach to improve ED utilization that addresses availability of behavioral health and substance abuse resources, availability of post-acute resources, housing and food insecurity resources, medication cost reform, length of stay issues, primary care and alternate provider sites that are available evenings and weekends, medical inpatient beds, as well as coordinated radiology and lab services so that patients can have a comprehensive timely evaluation. While reporting of wait measures may be a starting point for evaluation, focusing on emergency department measures alone will not solve many of the underlying issues. As discussions regarding wait time and capacity measurement continue, the input of the industry and clinical experts will be critical. We look forward to partnering with the HSCRC and other public health agencies to improve timely access and improved outcomes for Marylanders.

Sincerely,

Peter Hill, MD
Senior Vice President Medical Affairs
Johns Hopkins Health System

cc: Adam Kane, Esq., Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Joshua Sharfstein, MD

October 24, 2023

William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Henderson,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Medicare Performance Adjustment (MPA) and Care Transformation Initiatives (CTIs). JHHS's comments are outlined below.

1. Given the challenge of timeliness of data due to claims run out, JHHS agrees that it is difficult for hospitals to predict or adjust performance based on data. JHHS supports the recommendation to limit downside risk. A maximum liability threshold will support the longer-term stability of the program.
2. Under the current policy, hospitals with sizable Medicare revenues must generate significant numbers of episodes in their CTIs in order to hit the minimum savings rate and, therefore, perform well in the program. Further, any CTI savings are offset by a statewide MPA cut, which is also calculated based on a hospital's share of statewide Medicare revenue. The linkage of these policies to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital.
3. JHHS encourages the HSCRC to apply learnings from evaluation of the first year of the program, and consider narrowing the thematic areas of the program and/or revise selection criteria to assist hospitals with program planning and guidance on future investments in population health.
4. Given the overlap with other policies, JHHS recommends that the HSCRC conduct an analysis to determine if payments are duplicated by the CTI process with other pay for performance programs.
5. A hospital's ability to influence the MPA remains unseen at this time. Therefore, JHHS believes the MPA risk should not be increased until there is further data and clarity on this issue.

JHHS appreciates the HSCRC's consideration of the above comments related to the MPA and CTIs, and looks forward to continued participation and collaboration on these programs.

Sincerely,

Ed Beranek

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

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

December 1, 2023

William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Henderson,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Medicare Performance Adjustment (MPA) CY2024 draft recommendation. JHHS's comments are outlined below.

Increasing revenue at risk to 2%

JHHS recognizes that this proposal to increase revenue at risk is moving forward at the request of the Centers for Medicare and Medicaid Innovation (CMMI). While the revenue at risk through the MPA may increase to 2%, the levers to meaningfully influence performance under the policy are not yet well understood by the industry, and the increased risk will not necessarily improve performance. JHHS encourages further communication with CMMI to ensure clarity that hospitals' ability to influence the MPA is currently limited. While the MPA aims to implement hospital accountability, the methodology and data challenges prevent the MPA from being a mechanism that truly impacts total cost of care.

Add population health measure

While JHHS appreciates the HSCRC's increased focus on meaningful population health interventions, the current proposal for an inpatient diabetes screening measure should be further considered and requires greater engagement and input from the clinical community. The inpatient screening measure proposal is significantly improved from the proposal to screen in the emergency department; however, many providers continue to express concern about the validity and efficacy of the measure. The inpatient screening measure offers tremendous promise to improve population health through identification of undiagnosed diabetes, yet there are legitimate concerns that without appropriate community resources to address diabetes, the screening measure will fall short of reaching full potential. If the opportunity to connect with community resources remains limited, the policy may also lead to overtesting and adding cost to the system without ensuring the value of testing for patients. JHHS recommends continued engagement with clinical experts to gain support and develop criteria around patients to be excluded from the measure as clinically appropriate, and understand any unintended consequences of putting

this proposal into operation may have on our systems. Efforts should continue to be invested to advance tools within CRISP to both monitor patients who have been tested and offer community resources available to help patients address their diabetes.

CTI Program Revision: Cap downside risk at 2.5%

JHHS is supportive of limiting the downside risk in the CTI program. JHHS appreciates staff's recognition that it is difficult for hospitals to predict or adjust performance given the challenge of timeliness of data due to claims run out. A maximum liability threshold will support the longer-term stability of the program.

CTI Program Revision: Reintroduce CTI buyout

JHHS agrees with staff's proposal to reintroduce the Care Transformation Initiatives (CTI) buyout. Given that hospitals implement targeted interventions for specified populations, JHHS appreciates that the buyout policy recognizes a hospital's greater ability to impact CTI populations.

Further, due to the complexity of the CTI methodology, JHHS encourages greater education on CTIs generally to allow for a deeper understanding of the policy within the industry.

Additional comments

Additionally, under the current CTI policy, hospitals with sizable Medicare revenues must generate significant numbers of episodes in their CTIs in order to hit the minimum savings rate and, therefore, perform well in the program. Further, any CTI savings are offset by a statewide MPA cut, which is also calculated based on a hospital's share of statewide Medicare revenue. The linkage of these policies to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state and country due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital.

JHHS appreciates the HSCRC's consideration of the above comments related to the CY2024 draft MPA recommendation, and looks forward to continued collaboration on these programs.

Sincerely,

Ed Beranek

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

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

December 1, 2023

Joshua Sharfstein, MD
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dr. Sharfstein,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide comments as Maryland considers participation in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. In alignment with the goals of the Maryland Model, the AHEAD Model seeks to improve the total health of a state population and lower costs across all payers. The AHEAD Model contains many components that build upon the tenets and structure of the Maryland Model, and offers the opportunity to translate learnings from Maryland to other states across the nation.

As the Center for Medicare and Medicaid Innovation (CMMI) plans to implement the AHEAD Model, and as Maryland considers the next phase of the Total Cost of Care Model, JHHS offers the attached whitepaper that comments on the current distortions that exist within the Maryland Model. In order for the AHEAD Model to successfully build upon the learnings from the Maryland Model, JHHS believes these distortions must be addressed, and offers recommendations in the attached.

JHHS looks forward to the evolving discussions about the future of healthcare delivery in Maryland, and further collaboration with the Health Services Cost Review Commission, the Maryland Department of Health, and stakeholders across the industry.

Sincerely,

Ed Beranek

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

cc: Adam Kane, Esq.
Joseph Antos, PhD
Nicki McCann, JD
Maulik Joshi, DrPH
James Elliott, MD
Ricardo Johnson, JD

*Reforming Maryland's Model Whitepaper was submitted along with this letter; see Whitepaper #1 from April 2023 in this document.

January 5, 2024

Geoff Dougherty
Deputy Director, Population Health
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Dougherty,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Emergency Department Potentially Avoidable Utilization (ED PAU) policy. JHHS supports the concept of developing strategies and accountability for multi-visit patients (MVPs), and encourages the development of policies that align with the intent of the Maryland Model. JHHS's comments and concerns regarding the ED PAU recommendation are detailed below.

JHHS agrees that hospitals should be actively engaged in addressing the needs of multi-visit patients. However, JHHS is also concerned that the current recommendation is singularly focused on hospitals without any effort or intention to engage state and local government as well as Medicaid fee-for-service and Managed Care Organizations and insurers, who are paid to manage the care of the members they serve. Commercial insurers remain the biggest benefactors of the Maryland Model, and their contribution to issues such as ED PAU should be required and measured. Collaboration and accountability for MVPs should extend beyond hospitals alone to generate meaningful change and improvement for Marylanders. As noted by the HSCRC and Maryland Department of Health in the 2016 Population Health paper submitted to CMMI, socio-economic factors such as housing, employment and education account for 40% of health care cost and utilization. Hospitals alone cannot address the lack of focus and investment in these socio-economic factors.

Though the current recommendation is reward-only, it is also crucial to note that the policy as written may have unintended consequences that are similar to other distortions that exist under the Maryland Model. As JHHS has previously noted, the model currently rewards any and all volume reduction, and views all ED volume as addressable. However, there is and will continue to be some ED MVP utilization that is appropriate and medically necessary. Within the current model, hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and could be further exacerbated by the ED PAU policy, as the proposed policy could potentially reward hospitals that limit access to care. Further, the policy does not recognize

patient preference and experience. JHHS's analyses reflect that some MVPs travel farther to seek care at specific hospitals, while others do not have the option to seek care elsewhere. JHHS urges staff to account for these additional distortions and considerations when revising the current ED PAU recommendation.

JHHS recommends that staff initiate an ED PAU policy that is limited and more intentionally focused on a single disease that truly represents avoidable care. This policy should require collaboration across multiple stakeholders, including hospitals, state and local government, commercial insurers, and MCOs. Additionally, hospitals should report on their strategies to address MVP utilization to ensure hospitals who may perform well under the policy are not achieving positive results by limiting access in order to decrease volumes. If the policy is more intentionally focused on addressable ED MVP volume, the HSCRC and the industry can then use lessons learned from the initial policy to address additional diseases or conditions in future years. While behavioral health represents the greatest opportunity to improve care for MVPs, it is important to note that the MCOs and hospitals have limited opportunity to improve care for this population under Maryland's existing Medicaid financing for behavioral health. Behavioral health is carved out of MCOs and generally "unmanaged" for the Medicaid population, which accounts for 40% of ED MVPs. Strategies to improve behavioral health care for MVPs should include a fully integrated Medicaid program.

JHHS appreciates the efforts and partnership of the HSCRC staff as the Commission and industry seek to develop intentional strategies to support the needs of multi-visit patients. While supportive of the intent of the policy, JHHS encourages a thoughtful approach to ensure new policy methodologies align with the goals of the Maryland Model, and looks forward to further discussion and collaboration on this policy.

Sincerely,

Peter Hill, MD
Senior Vice President - Medical Affairs
Johns Hopkins Health System

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

May 15, 2024

Joshua Sharfstein, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sharfstein,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation for the Fiscal Year (FY) 2025 payment update. JHHS appreciates the challenges the Health Services Cost Review Commission (HSCRC) faces in balancing the financial strains of hospitals with ensuring the model savings targets are met.

JHHS's comments and recommendations are outlined below.

Inflation Update

JHHS is appreciative of the inclusion of the 3.15% inflation increase in FY 2025 but believe the number should be updated to reflect the current inflation of 3.24% found in the recently released Global Insight's First Quarter 2024 book. This is consistent with prior years update factor. We are also appreciative of the recommendation by the staff to include an additional .65% in recognition of past years' underfunding of inflation. JHHS would encourage the HSCRC, however, to provide additional funding beyond the staff recommendation.

Based on the latest estimates shared at the May Commission meeting, the state is currently achieving savings in excess of $173m beyond the $300m Calendar Year (CY) 2023 target. These savings are accruing to the benefit of the payers without any accountability for how this financial windfall benefits consumers. These are funds that could alternatively be used to recapitalize aging facilities, invest in population health programs, or address significant labor pressures in the hospitals. Although the staff is naturally conservative in their savings estimates, each of the scenarios shared except one demonstrated significant savings for CY 2024 beyond the contractual target.

JHHS would propose three specific changes to the staff recommendation:

1. **Provide an additional 1.17% for inflation**. The cumulative underfunding of inflation over the past several years is 2.34%. Although JHHS believes that this funding should be fully restored,

we recognize the need to balance providing additional funding to hospitals while meeting the Medicare savings target. Half of underfunded inflation should be included in the FY 2025 update with a commitment to include the other half in FY 2026.

2. **Eliminate a pre-defined and limited set-aside.** The set-aside in the draft recommendation is an arbitrary estimate that doesn't reflect the needs of the hospitals or the significant savings that the state is currently generating. Rather than a specific set-aside that artificially limits the funding available to hospitals, any savings in excess of the target should be viewed as potentially available to address appropriate hospital funding requests.
3. **Eliminate inflation on retained revenues.** Consistent with past positions of JHHS, we continue to encourage the HSCRC to eliminate inflation on retained revenues. The update factor should be used to provide inflation on actual expenses incurred by the hospital to care for patients, not to inflate expenses that no longer exist because patient volumes aren't present. The current methodology continues to lock revenue into increasingly price inefficient facilities for care that no longer exists, rather than providing funding to recognize changes in patient movement.

Potentially Avoidable Utilization (PAU) Shared Savings

JHHS supports the staff recommendation on changes to the PAU Shared Savings policy given the significant savings that the policy has generated since the inception of Global Budget Revenue (GBR).

Transformation Funding

JHHS supports the creation of a $20m pool of funds to be used for innovative initiatives. For years, JHHS has engaged the HSCRC in an attempt to fund a hospital-at-home program, consistent with trends nationally. The hospital at home program has the potential to reduce low-intensity care currently provided within JHHS and provide a better patient experience. JHHS encourages the HSCRC to include hospital at home as the type of program that could be funded out of the new Transformation Funding pool.

High-Cost Drugs

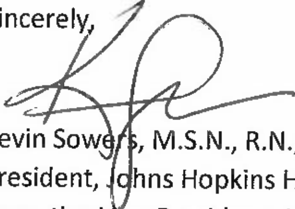
JHHS supports the staff recommendation to differentially fund high-cost drugs that are utilized at the Academic Medical Centers (AMC). JHHS would encourage the staff to continue working with the AMCs to ensure that high-cost drugs are being adequately funded and not continue a system whereby the AMCs are faced with the choice of either providing life-saving care at a significant financial loss or reducing access.

Recommendations

Given the economic climate and the challenges currently faced by the healthcare industry, JHHS believes a more nuanced and balanced approach to the update factor is required. For the reasons outlined above, hospitals should not receive inflation on retained revenue, as this is funding volumes that do not exist. Additionally, given the significant savings that the state is generating in excess of the contractual target, there are ample funds available to restore half of the unfunded inflation from the past several years.

Thank you for the opportunity to share comments and feedback. JHHS greatly appreciates the HSCRC's transparent process in the development and approval of the payment update and looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Vice Chairman

Dr. James Elliott

Ricardo Johnson

Dr. Maulik Joshi

Adam Kane

Nicki McCann

Jon Kromm

June 5, 2024

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

Dear Dr. Kromm,

As the State of Maryland works with the Center for Medicare and Medicaid Innovation (CMMI) to negotiate Maryland's participation in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, Johns Hopkins Health System (JHHS) would like to outline specific critical issues which must be addressed for the future success of the Model. These are informed by our experience in the current model, discussions with key stakeholders within Maryland and around the country, and the requirements for the long-term sustainability of the healthcare delivery system for the citizens of Maryland.

For your reference, I have included a white paper JHHS previously submitted outlining specific issues with the current Model and making recommendations for improvement. Although JHHS believes each of these issues needs to be addressed, I am writing today to encourage the Health Services Cost Review Commission (HSCRC) to actively engage with JHHS and the broader hospital industry to improve the Model in three key areas prior to finalizing the new agreement with CMMI:

- Establishing a pathway for Maryland's Academic Medical Centers (AMC) that provide tertiary/quaternary care to operate sustainably and thrive under the Model
- Reforming the current volume policies of the HSCRC to support the provision of medically necessary care, and eliminate incentives that reward reductions in access to care
- Rebalancing captive revenue and eliminating excess capacity to promote a more financially sustainable system that better supports the needs of patients

Establishing a Pathway for Maryland's AMCs

Under the current Total Cost of Care (TCOC) Model, 95% of Medicare spending is required to be under a population-based payment model which historically has been met under the Global Budget Revenue (GBR) model. This requirement has placed unnecessary constraints on the growth of highly specialized clinical programs, providing a bifurcated choice for the AMCs to either limit access to care or incur significant financial losses to provide, develop, or expand it.

At their core, GBRs are designed to provide financial incentives to reduce unnecessary utilization. However, many of the services provided by AMCs – namely, highly specialized and complex procedures and treatments – however, cannot be reduced and in fact will need to be expanded with the aging of the population and the development of cutting-edge pediatric treatments. Restricting funding

for these services in Maryland will have the unintended consequence of denying local access for Maryland residents, forcing them to travel out of state for care or forgo it.

Recent data from Vizient demonstrated a 36% and 25% increase in need for inpatient quaternary and tertiary care, respectively, over the next decade, with a 3% decline in low case mix index cases. This aligns with significant growth in staffed beds at AMCs nationally since 2015, with AMC beds increasing 10%, most notably in cancer, cardiovascular services, neurosciences, and pediatrics. This same type of growth to meet patient need and demand is constrained and financially penalized under Maryland's current GBR model.

AHEAD provides a unique opportunity for the HSCRC to reset this requirement with CMMI, given that the financial methodology for AHEAD excludes specific services that are currently included in GBR. This should become the baseline for a new approach, even as JHHS would encourage the HSCRC to push for greater flexibility to carve out from GBR the tertiary and quaternary services provided only by AMCs.

Reforming Current Volume Policies

Over the past decade, the HSCRC has developed a series of policies meant to reward hospitals for reducing utilization and penalizing hospitals for growing it. Like all demonstration models, these policies should be refined over time to ensure that the outcomes being achieved are in line with the intent of the policies. Unfortunately, the current policies have caused a misalignment between patient movement and the resources required to care for them, providing financial incentives to restrict access to care rather than maintain or expand required clinical services. The American Hospital Association reports that post-COVID, 3% of community hospital beds have closed across the nation. In MD, it is reported that we have seen a 17% decrease in these beds, thus creating access issues and requiring patients to leave the State for services.

Some challenges with the current volume policies include:

- **Market shift does not cover the variable cost of services.** Although the policy asserts that variable cost will be funded at 50%, in practice it is significantly less once other adjustments are factored in. Even if the market shift were funded at 50%, in many cases it is unlikely that it would cover the total cost of delivering the care. While the initial intent was to reward organizations for decreasing utilization, over time it has led to the closure of beds and appropriate clinical services required in our communities. Organizations have been financially rewarded for limiting clinical services.
- **Deregulation has not been uniformly enforced.** The deregulation policy is meant to ensure that revenue follows the patient as services shift into the community and to protect payers from paying twice for the same service. This has not been enforced consistently, allowing hospitals to retain revenue for services they no longer provide in the hospital and receive payment again for providing the same service in the community. For example, movement of colonoscopies that used to be performed in a hospital but are now performed in a hospital-owned ambulatory surgery center off campus, without informing the HSCRC of the shift in site of service.
- **All volumes are the same.** As a policy objective, GBR is meant to focus on reducing unnecessary utilization, not all utilization. In practice, GBR and other HSCRC policies have rewarded hospitals that reduce access by allowing them to retain revenue while underfunding hospitals that have seen increased volumes due to patient movement and choice.

- **The financial incentive is to reduce access by closing beds.** Under a capped revenue system that does not allow for margin growth by increasing volumes, hospitals are provided significant financial incentives to reduce overall capacity by reducing staffed beds. This is counter to meeting the needs of patients, particularly in already underserved areas.

The HSCRC and hospital industry need to collaborate to ensure that the incentives of the Model produce the desired outcomes, that there is a clear line between action and result, and that patient access for appropriate required clinical care is maintained.

Rebalancing Captive Revenue and Reducing Excess Capacity

GBRs have remained largely static over the course of the Model, with annual adjustments to reflect inflation, market shift, and other volume and quality related changes over time. Despite Maryland being in the Model for over 10 years, including several years of the COVID-19 pandemic, there has not been a concerted effort to examine each of the hospital GBRs to determine if the revenue provided is still appropriate for the mix of services and patients.

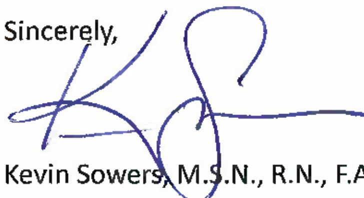
The static nature of the GBRs runs counter to the tenets of patient choice as stipulated in other Centers for Medicare and Medicaid Services' programs (Money Follows the Person) and rewards hospitals in perpetuity for limiting access. By concentrating historic revenue permanently in facilities that provide a fraction of the care from pre-GBR, the policy is effectively limiting needed investments in patient care and maintaining hospitals that would otherwise have been forced to reimagine themselves as freestanding medical facilities or, in other states, closed. It is recognized that Baltimore City has the largest excess bed capacity and also the most retained revenue. In a time when significant investments are needed, not just in hospital-based clinical services but in the broader community to support the population health goals of the Model, the current policy restricts access to hundreds of millions of dollars that could be put to better use.

Conclusion

Although JHHS appreciates the significant work required by the HSCRC to negotiate and execute the AHEAD agreement by November, it is critically important to develop a parallel process to resolve these issues if we are going to be successful in the future Model. JHHS believes it is nearly impossible for it or any system to support the State's financial commitments without an understanding of if and how these issues will be addressed. It is in the interest of the State and Maryland's hospitals to work together to promote a system with clear incentives and outcomes that appropriately invests in clinical care, preserves access, and right-sizes the system over time.

JHHS welcomes the opportunity to collaborate with the HSCRC in the coming months on these important topics and looks forward to working with you on them.

Sincerely,



Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

*Reforming Maryland's Model Whitepaper was submitted along with this letter; see Whitepaper #1 from April 2023 in this document.

June 2024

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

Dear Dr. Kromm,

I am writing on behalf of Johns Hopkins Health System (JHHS) to share our perspective on the Care Transformation Initiatives (CTI) program operated by the Health Services Cost Review Commission (HSCRC) and to offer recommendations for improvements to the program. JHHS appreciates the openness of you and your staff to review input from the hospital industry as you continue to refine existing programs and develop new ones.

As with other Center for Medicare and Medicaid Innovation (CMMI) Demonstration Models, Maryland's Total Cost of Care (TCOC) Model should learn from what has worked well, correct for unintended consequences, and continue to improve and promote programs that improve patient outcomes and reduce cost. As originally envisioned, the CTI program would allow hospitals to identify a specific cohort of patients based on a series of criteria that aligned with a clinical program, providing, at least in theory, a more direct tool to measure TCOC performance rather than solely relying on the Medicare Performance Adjustment (MPA). The financial risk to the hospitals was unclear at the outset given the level of unpredictability regarding the number of hospitals that would participate, the number of CTIs per hospital, and the performance of each of the CTIs.

Reforms to the CTI program are all the more important given the recent changes and performance of the MPA. For Calendar Year (CY) 2024, the amount of risk under the MPA doubled to 2%, with indications that CMMI may be interested in additional increases in the future. This is concerning given the volatility and uncertainty within the MPA, including the disconnect between the savings being generated under the Model and the penalties being applied to the hospitals. For CY 2023, the state generated almost $200 million in TCOC savings beyond the contractual target while the hospitals were penalized ~$24 million for TCOC performance. In addition to changes to the CTI program, the MPA must be examined to ensure that the reward and penalties are aligned with performance.

Maryland now has two years' worth of CTI performance data, allowing for enough experience to determine if certain changes need to be made to the program. Based on this experience, JHHS would like to offer the following recommendations to improve the CTI program:

1. **Institute a coding intensity adjustment cap from the baseline to the performance period.** In the current CTI program, coding changes are not capped from the baseline to the performance period. In Fiscal Year (FY) 2023, certain CTIs had a 20+% increase in

the risk score between the two periods, greatly increasing the TCOC savings that were generated. This lack of a cap is contrary to other TCOC value-based models, including the Medicare Shared Savings Program (MSSP) and commercial payer Accountable Care Organizations (ACO). Instituting a cap would ensure that any savings generated were largely the result of utilization or cost declines rather than coding adjustments.

2. **Utilize a panel-based measurement approach rather than intent to treat.** Rather than measuring a hospital's performance based on the patients enrolled in a clinical program and receiving an intervention, the current CTI program measures the TCOC performance on all patients that meet the CTI criteria, regardless if the patient was enrolled in the clinical intervention. This does not consider the significant number of patients that refuse intervention. A panel-based measurement approach would directly identify patients enrolled in programs and allow for a more robust assessment of their effectiveness. Hospitals would still be incented to enroll as many patients as possible under a panel-based measurement approach to drive TCOC savings and maximize CTI performance.

3. **Reduce the amount of Medicare fee for service (FFS) revenue subject to the CTI savings pool.** CTIs are largely focused on interventions – such as primary care, care transitions, and palliative care – that reduce unnecessary utilization. However, the current CTI program distributes the amount that each hospital is required to contribute to the CTI savings pool based on the total amount of Medicare FFS revenue at that hospital, regardless of the mix of services being provided. The Academic Medical Centers (AMC) have large amounts of revenue that is related to tertiary and quaternary care (including transfers from other hospitals), greatly increasing their financial risk under the CTI program and limiting their ability to offset this risk by improving CTI performance by reducing unnecessary utilization. Similar to the HSCRC's policy that treats innovative care provided by the AMCs differently under the Model, the amount of Medicare FFS revenue measured for purposes of the CTI savings pool should be reduced for AMCs to reflect their unique and specialized role in the system.

Given that FY 2024 has not yet been finalized, and that even early results are still very preliminary due to episode lengths and claims runout, JHHS encourages the HSCRC to consider these programmatic changes for the current performance period.

Thank you for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

Aneena Patel, MHA
Director, Provider/Payor Transformation & Affiliations
Johns Hopkins Health System

September 16, 2024

Tina Simmons, MBA, BA, BSN, RN, LSSBBH, CPHQ
Associate Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Simmons,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Health Services Cost Review Commission's (HSCRC) developing Emergency Department (ED) Best Practices policy. While JHHS agrees with the intent of the policy as it seeks to promote the adoption and expansion of processes aimed at reducing ED length of stay (LOS), JHHS notes the following comments and concerns.

Revenue at Risk

As currently drafted, the plan for this policy is to tie the best practice measures to 1% of inpatient hospital revenue. JHHS urges HSCRC staff to reconsider this percentage. While hospitals do maintain some degree of control over ED LOS and can engage in additional initiatives to improve performance and patient experience, there are a number of factors entirely out of hospitals' control that may impact performance on these measures. Hospitals should not be penalized over measures where control is limited.

The timeline for policy development is tight, and while gathering feedback from the industry in this expedited timeline is critical, this is a significant amount of revenue at risk for a measure developed in such a short time frame. It is necessary to craft these best practices and interventions while considering how to mitigate any harmful unintended consequences before implementing and potentially penalizing hospitals.

Potential Measures

JHHS proposes three categories of measures that could have the impact of improving ED utilization and throughput.

Capacity

1. *Length of Stay:* JHHS recommends a hospital LOS measure that is focused on a patient population for which hospitals have a degree of control over the outcome. This measure could apply to patients who are discharged to home, or patients under certain disease processes. We would suggest a metric tied to Observed over Expected (O/E LOS) for an agreed upon hospitalized patient population. Improvement and attainment targets can be set.
2. *Consistent Monitoring by HSCRC Staff of Staffed and Licensed Beds*: MHCC annual reporting of licensed beds is a good proxy for staffed beds on yearly basis, however some hospitals may reduce and flex up staff throughout the year. Greater transparency and monitoring of licensed, staffed and occupied beds are needed. Additionally global budgets should have greater alignment with licensed beds. Staff could consider a staffed beds measure as a best practice; This measure could include med/surg beds, intensive care unit beds, and potentially pediatric beds if applicable.
3. Related to 1 and 2, a measure which monitors ED boarding hours would be the important leading indicator of improved hospital capacity. Reducing boarding is demonstrated in the ED literature to directly correlate with improved ED LOS and improved ED efficiency.
4. Some measure that shows difficulty in discharge of inpatients such as number of denials to post-acute facilities (or perhaps certain categories of those denials).
5. Some additional best practice and related measures could include:
    - A fully staffed 24/7 observation unit
    - A staffed discharge lounge
    - Deployment (and associated cost) of tools to increase provider efficiency (e.g., scribes, AI notes, voice dictation)
    - Utilization of ED discharge planners
    - Utilization of Inpatient discharge planners + a measure of how many inpatient discharges were identified in the discharge planning portion of Epic for discharge 3 days in advance.
    - Best practices related to Discharge By Noon efforts (e.g., daily discharge labs starting at 5am, reporting DBN rates by unit)
    - In 2019, JHHS created a health system Best Practice Council, where ED leaders convene to develop system-wide policies and programs that optimize care delivery.

Appropriate Utilization

ED throughput can be modestly improved through the use of evidence based best practice guidelines. In 2017, Johns Hopkins Hospital embarked on an initiative to embed ED evidence-based care guidelines in the electronic medical record. To date they implemented 250 guidelines at the point of care, many system-wide. Designed by an interdisciplinary team, the guidelines direct best practice in accordance with current evidence, inform providers about appropriate use of tests, treatments and hospital admissions and include specific operational information to increase efficiency.

Appropriate Social Supports in the ED

Frequent utilization of the ED by individuals in need of social services in common. While these multi-visit patients have an impact on overall utilization, their contribution to ED wait times is minimal. With appropriate social supports in the ED, the multi-visit patients can be screened and discharged rapidly, however it is important to note that the social supports are addressing an unmet need in the community

and may indeed make the ED a more attractive destination for individuals who cannot access community-based resources. While the right thing to do by patient care, these resources may increase ED utilization. Examples include social work in the ED, peer recovery specialists, and other potential best practices where duration and amount would be established through HSCRC process and stakeholder engagement.

The above potential measures would require further consideration and input from industry stakeholders to ensure the policy approach is thoughtful and truly measures outcomes over which hospitals have a degree of control.

Additional Considerations

As JHHS has previously noted in multiple forums and comment letters, an evaluation of inpatient bed capacity should be considered as a key metric in improving ED LOS. ED wait times are generally a reflection of capacity constraints, not ED efficiency. The ability to improve ED LOS will be limited absent transparent evaluation and discussion of bed capacity and its distribution throughout the state and various policies that reward capacity reduction among hospitals.

Thank you for the opportunity to share feedback. JHHS appreciates the HSCRC's collaborative process in the development of these policies, and encourages staff to be thoughtful when determining these measures to ensure patients and providers do not face harmful unintended consequences. The misplaced focus on ED processes and measures as a means to address ED wait times has been distracting at best and dangerous at worst. Maryland is in the bottom of beds per capita in the nation. Under current HSCRC policies, an empty bed is more financially sustainable than a staffed bed. If the state and the HSCRC are truly committed to addressing ED wait times, JHHS strongly encourages swift and comprehensive changes to the current volume policies. Without these changes some hospitals will continue to adjust their staffed beds to meet budget targets, while hospitals who have maintained their commitment to patient care will have no opportunity to address ED length of staff. Continuation of the status quo will exasperate access to care challenges for Maryland citizens. JHHS looks forward to continued collaboration with the HSCRC in pursuit of improved quality, access, and patient experience for Marylanders.

Sincerely,

Peter M. Hill, MD, MS, FACEP
Senior Vice President of Medical Affairs
Johns Hopkins Health System
Associate Professor Emergency Medicine
Johns Hopkins School of Medicine

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane

Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

September 10, 2024

Tina Simmons, MBA, BA, BSN, RN, LSSBBH, CPHQ.
Associate Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Simmons,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Quality Based Reimbursement (QBR) Program's developing Emergency Department Length of Stay (ED LOS) policy.

The approved final recommendation for the QBR Program for RY2026 included an ED-1 EDDIE-like measure in the Patient and Community Engagement domain weighted at 10%; staff noted they would convene a technical workgroup in the first 6 months of the year and then retroactively apply this to the entire calendar year (CY2024). JHHS appreciates the HSCRC's efforts to work with hospital and industry stakeholders throughout the measurement development process; however, given that we are currently over 9 months into the calendar year, this retrospective application is no longer feasible. Hospitals have been in the measurement period for the majority of the calendar year while the policy is not yet finalized, meaning hospitals' ability to impact the measure has been limited.

JHHS proposes that staff consider creating a moderated LOS measure for the current calendar year while planning for the implementation of the full ED LOS measure and financial accountability metrics for C2025 or CY2026. For example, if a hospital performs 5% unfavorably on throughput, the loss would be capped at some amount, if around 0%, no penalty or reward, and if 5% favorable performance, a capped reward. This approach allows for some implementation of an accountability measure without unduly penalizing or rewarding hospitals for performance on a measure that remained unknown throughout the majority of the performance period.

Thank you for the opportunity to share feedback. JHHS appreciates the HSCRC's collaborative process in the development of the ED LOS measure, and looks forward to continued collaboration in pursuit of improved quality, access, and patient experience for Marylanders. JHHS continues to advocate for evaluation of bed capacity as a key metric in improving ED LOS. ED wait times are generally a reflection of capacity constraints, not ED efficiency. The ability to improve ED LOS will be limited absent transparent evaluation and discussion of bed capacity throughout the state and various policies that reward capacity reduction.

Sincerely,

Peter M Hill, MD, MS, FACEP
Senior Vice President of Medical Affairs
Johns Hopkins Health System
Associate Professor Emergency Medicine
Johns Hopkins School of Medicine

cc: Dr. Joshua Sharfstein, Chairman

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September 26, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
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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 process for hospitals that are experiencing financial hardship to apply for additional funding.

As we stated in our financial hardship request for JH Suburban Hospital, JHHS believes that significant, prolonged financial hardship is a justifiable reason to consider additional funding. In general, we agree with the HSCRC's intention to evaluate the driving issues for potential funding, particularly in an environment where we are generating savings well exceeding requirements. To the extent that hardship is linked to the volume pressure of maintaining access or meeting need, we must ensure that hospitals are adequately positioned to meet those needs and that we are not prioritizing excess savings over maintaining access to necessary care. We believe that some of these financial hardships are driven by HSCRC policies that are not operating as intended at an individual hospital level. If these policy issues are not addressed at the State level (prior to the movement into the AHEAD model) we will continue to have hospitals experiencing financial distress.

Policies should ensure that there is adequate reimbursement for medically necessary care by allowing funds to "follow the patient". They should differentiate between unnecessary hospital utilization and medically necessary care. The HSCRC should develop a monitoring framework that prevents restrictions in access to care or identifies them for regulatory action. They should also develop a process to address excess hospital capacity to ensure resources are allocated to best meet community needs. We would be happy to work with the industry and the HSCRC on the development of these policies.

As you consider how to address the many financial hardship requests, we believe that the available funding pool is defined by the room we have within our model targets to address

justified needs, and that we should **not** limit ourselves to temporary funding or arbitrary caps. Instead, financial hardship should be evaluated in the context of qualification (has the hospital shown it is experiencing financial hardship?) and merit (would we consider the driving issues as deserving of relief or funding?).

For the specific requests for comment, JHHS respectfully submits the following:

1. **What constitutes a minimally viable technical proposal?**
   a. **If hospitals reach the standard (i.e., they make it to step 3 of our process which evaluates need and oversight), should they automatically qualify for a portion of the set aside or should there be a minimum threshold in scoring?**

   In general, we view efforts to mathematically score financial hardship requests and predetermined algorithms for distributing hard-and-fast funding amounts as flawed approaches to reviewing financial hardship. If the HSCRC judges a hospital to have adequately demonstrated their financial hardship, either by utilizing the HSCRC's base criteria or by reasonably demonstrating its need, the stated drivers of that hardship should be evaluated on merit, with the goal of providing funding to address justified issues. Considering the significant excess savings currently being generated, the HSCRC has the flexibility to ensure an adequately funded hospital system. This includes addressing drivers of financial hardship that meet both qualification and merit thresholds.

2. **Should some criteria be weighted more favorably in the overall evaluation? For example, should hospital regulated margin be given more weight than total margin?**

   While total operating margin is considered the true metric of the financial health of the organization, it is important to consider the relationship between regulated margin and total margin. The GBR amounts are meant to cover the regulated operations of a hospital and if the GBR is failing to cover those operations, that certainly needs to be considered, especially if the hospital operates other operations not regulated by the HSCRC to help offset some of that shortfall. Likewise, if a hospitals operations are supported by their GBR as evidenced by a positive regulated margin, but other operations are consuming that profit and causing the total profit to be lower, the HSCRC should understand whether those other operations are a cost of doing business or a poor business decision. In our mind, any definition of financial hardship should include an evaluation of both regulated and total margin, both are important in assessing a hospital's financial hardship. Financial hardship associated with providing medically necessary care should be prioritized.

3. **Are there any suggestions for how to allocate the funding? For example, should funds be allocated based on evaluation score, margin and/or days cash on hand, total GBR, or a combination thereof?**

   We want to re-emphasize here that financial hardship requests should be evaluated based on qualification (has the hospital shown it is experiencing financial hardship?) and merit

(would we consider the driving issues as deserving of relief or funding?). We do view financial hardship as a justifiable reason to consider additional funding. However, we view setting arbitrary funding caps and mathematical approaches to distributing limited funds as a flawed approach. If a request has been deemed to meet qualification and merit thresholds, the HSCRC's guiding questions on funding should be (1) how much does the hospital need to address the issue? and (2) do we have the ability to provide that level of funding based on our current understanding of Waiver metrics? This approach is consistent with other evaluation pathways such as full rate applications and GBR enhancements. Given the current magnitude of Waiver savings, the HSCRC should prioritize addressing justified drivers of financial hardship and should not view itself as limited to $31 million of temporary funding.

4. **Should hospitals withhold executive bonuses as a prerequisite for set aside funding?**

   The HSCRC should prioritize evaluating financial hardship requests based on qualification and merit. If additional funding is deemed to meet those thresholds, it should be provided. Executive compensation is controlled by individual hospital boards, and we do not believe it can be handled from a legal perspective through a regulatory manner as it relates to this policy. It is likely that any such action would be met with legal challenges.

5. **Should hospital management be required to outline sustainable reductions in cost to offset funding priorities as a prerequisite for set aside funding?**

   HSCRC staff should evaluate the driving issues and logically assess whether permanent funds are justified or, alternatively, if only temporary funds will be provided with the expectation that the hospital generate sufficient operational efficiency to offset the loss of temporary funds over time. Most hospitals that would qualify for financial hardship are likely actively engaged in aggressive performance improvement initiatives to improve financial performance. A dollar-for-dollar cost reduction commitment should not be required to receive funding that is justified based on merit.

6. **Should hospitals need to make a pledge to not ask for funding for a specific period of time following fund allocations?**

   Once again, we do view financial hardship as a justifiable reason to consider additional funding. As with any funding tool, if a hospital receives sufficient funding to address the request, it is reasonable to set some limits on when the hospital can request further funding for that specific need or funding pathway. Otherwise, a hospital must have recourse if it disagrees with the HSCRC's recommendations.

Thank you again for the opportunity to provide comments on the set-aside process.

Sincerely,

Ed Beranek

Ed Beranek

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
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October 25, 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 suggestions for revenue enhancements in rate year 2025 due to savings over administrative target.

Maryland's hospitals and health systems continue to struggle with rising expenses that have significantly increased since the beginning of the pandemic. The operating environment for hospitals and health systems has been difficult. Rising staffing, supply, and drug costs, combined with challenges in recruitment and retention along with many other issues have made this downturn more difficult than previous ones. Hospitals also continue to confront challenges due to rising costs of essential physician coverage and increases in medically necessary volumes at certain facilities.

As we stated in our previous comment letter, JHHS believes that significant, prolonged financial hardship is a justifiable reason to consider additional funding. In general, we agree with the HSCRC's intention to evaluate the driving issues for potential funding, particularly in an environment where we are generating savings well exceeding requirements. To the extent that hardship is linked to the volume pressure of maintaining access or meeting need, we must ensure that hospitals are adequately positioned to meet those needs and that we are not prioritizing excess savings over maintaining access to necessary care. As you consider how to address revenue enhancements in rate year 2025 due to savings over administrative target, we believe that the available funding pool should be defined by the room we have within our model targets to address justified needs, and that we should **not** limit ourselves to temporary funding or arbitrary caps. Instead, financial hardship should be evaluated in the context of qualification (has the hospital shown it is experiencing financial hardship?) and merit (would we consider the driving issues as deserving of relief or funding?).

For the specific requests for comment, JHHS respectfully submits the following:

Should any revenue enhancements due to savings over our administrative target be:

1. **Targeted to an increase in the Set Aside?**

   As mentioned in our previous letter, financial hardship requests should be evaluated based on qualification and merit. We do view financial hardship as a justifiable reason to consider additional funding. However, we view setting arbitrary funding caps and mathematical approaches to distributing limited funds as a flawed approach. If a request has been deemed to meet qualification and merit thresholds, the HSCRC's guiding questions on funding should be (1) how much does the hospital need to address the issue? and (2) do we have the ability to provide that level of funding based on our current understanding of Waiver metrics? This approach is consistent with other evaluation pathways such as full rate applications and GBR enhancements. Given the current magnitude of Waiver savings, the HSCRC should prioritize addressing justified drivers of financial hardship and should not view itself as limited to $31 million of temporary funding.

2. **Applied in a broad-based manner for costs drivers that are not currently funded in rates?**

   While we believe that all hospitals are experiencing cost pressures, we also recognize that not all are experiencing these pressures at the same level or for the same reason and therefore would be opposed to an across-the-board funding for all hospitals. We believe that any funding should be specifically directed to hospitals based on specific need. One potential methodology to do this would be based on an age specific demographic adjustment. The current demographic adjustment insufficiently accounts for age-adjusted growth by lowering the adjustment to align with unadjusted state projections for annual population change. The consequence is a reduction in growth from 4.25% to 0.25% in the current rate year. A rate increase could be applied to address the underfunding of age-adjusted demographic growth, a critical need for hospitals as Maryland's population ages. This would impact all hospitals but in a differential manner and could be done in an expeditious manner.

3. **Applied in a broad base manner for new costs that would be accretive to the goals of the TCOC Model?**

   JHHS believes that only after considering the current financial needs of hospitals should other costs be considered that do not currently exist within the system. It is important to deal with the industry's current financial issues before considering other funding. Only after those issues are addressed should additional programs be considered.

   Thank you again for the opportunity to provide comments on suggestions for revenue enhancements in rate year 2025 due to savings over administrative target. We are

committed to working with HSCRC staff on a sensible solution that addresses the current needs of the hospital industry.

Sincerely,

Ed Beranek

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

cc: Dr. Joshua Sharfstein, Chairman
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October 30, 2024

Dr. Jon Kromm
Executive Director
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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
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Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

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
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December 9, 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 Proposed Revisions to the Outpatient High-Cost Drug Funding Policy.

JHHS appreciates the HSCRC's willingness to continue to review and better align polices under the current model as the industry evolves and innovates. We are generally very supportive of the staff recommendation, specifically:

- We support 100% funding for high-cost drugs, especially as the cost of many of these drugs continues to increase. It is important that hospitals receive adequate funding for these lifesaving drugs.

- We support a provisional adjustment period but believe funding should flow into hospital rates in the year that the increase in expense is occurring. Many high-cost drugs are increasingly used to treat various conditions, and some are now curative for patients who previously would have suffered from chronic conditions, in turn significantly increasing the expense of delivering these treatments. Given this expense increase, we strongly believe that it is important for the revenues to match expenses in the same fiscal period.

- We are also supportive of implementing this change with the 1/1/25 rate order as this is consistent with the way the policy is currently applied.

The recommendation also lays out new reporting requirements and possible associated penalties. We believe that more information is required to ensure hospitals fully understand these new requirements and assure that they are reasonably aligned with good patient care as well as the

intent of the model. We are also concerned about the intent of the penalties being considered since we are talking about only covering the actual cost of the drug.

JHHS appreciates the opportunity to comment on the Outpatient High-Cost Drug Funding Policy. We look forward to working with staff to continue to review polices to better align them under the current system.

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
William Henderson

February 3, 2025

To: The Total Cost of Care Workgroup, Maryland Health Services Cost Review Commission (HSCRC)

From: Sarah Szanton, Dean, Johns Hopkins School of Nursing; Natalia Barolín, Sr. Health Policy Adviser, Johns Hopkins School of Nursing

Re: Comments on AHEAD Policy

Dear Colleagues,

Thank you for the opportunity to inform the policies for AHEAD implementation. We have provided a response to questions 1b and 2a below.

1. **Ensuring High Value Care**. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

Maryland communities, academic institutions and health systems have developed promising solutions; but they have not fulfilled their cost saving and equity potential due to policy gaps that undermine adoption across the state. The Advancing Innovation in Maryland (AIM) award is a good first step in identifying promising approaches for meeting the vision and goals under AHEAD. Community based interventions like Neighborhood Nursing and CAPABLE (both AIM Awardees) should be considered for HSCRC investment as a common utility to empower all Marylanders to achieve optimal health and well-being.

Maryland's TCOC Model has saved Medicare billions of dollars and set the stage for the design of the AHEAD model to be implemented in Maryland and other states. Despite this success, Maryland's per capita health care spending increased by 40% over the past decade. And while racial and ethnic health disparities have improved in Maryland, large disparities remain for key health indicators, including infant mortality and preventable health care utilization. Under AHEAD, Maryland has the opportunity to adopt promising interventions that offer value and improved health outcomes but do not fit into traditional fee for service and the fragmented payor and policy environment. For example, HSCRC could consider using savings under AHEAD to cover Neighborhood Nursing for populations attributable to hospitals and health systems across Maryland. CAPABLE can be combined with Neighborhood Nursing for the appropriate populations. The JHSON is currently designing a program to integrate CAPABLE into

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Neighborhood Nursing to address the functional needs of Neighborhood Nursing clients. We have outlined both programs below:

- **CAPABLE (Community Aging in Place—Advancing Better Living for Elders)** is a person-directed, home-based falls prevention and rehabilitative health intervention that serves older adults who wish to remain in their homes as they age but face physical and functional challenges. It improves physical function, mental health and overall well-being while decreasing hospitalization, length of stay, readmission rates, and nursing home admissions. More than 15 years of clinical trials and implementation show that CAPABLE saves money and significantly reduces unnecessary hospitalization and nursing home admissions by alleviating disability, depression, and pain. Yet, current payment structures within Medicare and Medicaid in Maryland do not effectively address functional disability. Medicare focuses on acute and chronic illnesses, while Medicaid primarily supports custodial care for those with disabilities. CAPABLE enables older adults with disability to care for themselves rather than the custodial care of Medicaid. Other states are starting to cover CAPABLE through Medicaid waivers and New York is offering it through their Aging Master Plan funds.
- **Neighborhood Nursing** links every resident in a geographic area with a registered nurse (RN) and community health worker (CHW) who offer community and home-based services, disease and chronic illness management, and social care, reducing acute care utilization and improving engagement with marginalized, low-income Marylanders. The Neighborhood Nursing model is positioned to decrease spending, improve outcomes, and eliminate disparities. Current fee-for-service based payment structures and limited multipayer alignment for services outside of the hospital pose significant challenges to Neighborhood Nursing. Shared savings and/or pooled funds across payers can be used to support a program like Neighborhood Nursing that provides a common utility to deliver the right care in the right location at the right time across Maryland.

2. Improving Access to Care. Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

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In order to understand whether Marylanders are receiving the right care at the right location at the right time, Maryland must also measure indicators of whole person health and well-being as well as what matters to individuals, families, and communities. There is an increasing body of knowledge on person-centered measures that capture whole person health and well-being. For example, the journal Medical Care recently released a special edition on Measuring What Matters Most: Considering the Well-Being of the Whole Person in Health Care. HSCRC should conduct an analysis to determine the best measures to support community based whole person care and that support models that deliver this kind of care. And then support the use and implementation of the measures via the other policies defined in AHEAD.

Maryland is well positioned to lead with cutting-edge models that can reduce total cost of care, strengthen the health care system, and support meeting the SIHIS Domain goals. Hospitals, individual providers, provider practices, and payors are already struggling to figure out how to meet the requirements under AHEAD. HSCRC has the opportunity to identify and support innovative common utility programs that can relieve pressures off hospitals and help the state and all AHEAD participants meet the requirements of the model and improve the health and well-being for all Marylanders. The HSCRC should consider using shared savings and/or developing a pooled funding stream to support programs that can be utilized across AHEAD participants to maximize reach in Maryland. These funds could be used to support bundled payments for innovative interventions like CAPABLE or to support the implementation and spread of a model like Neighborhood Nursing across the state, agnostic of payor or provider.

We look forward to ongoing collaboration.

Sincerely,

Sarah L. Szanton, PhD, ANP, FAAN
Dean
Patricia M. Davidson Health Equity and Social Justice Endowed Professor

Natalia Barolín, BA, BSN, RN
Sr. Health Policy Adviser

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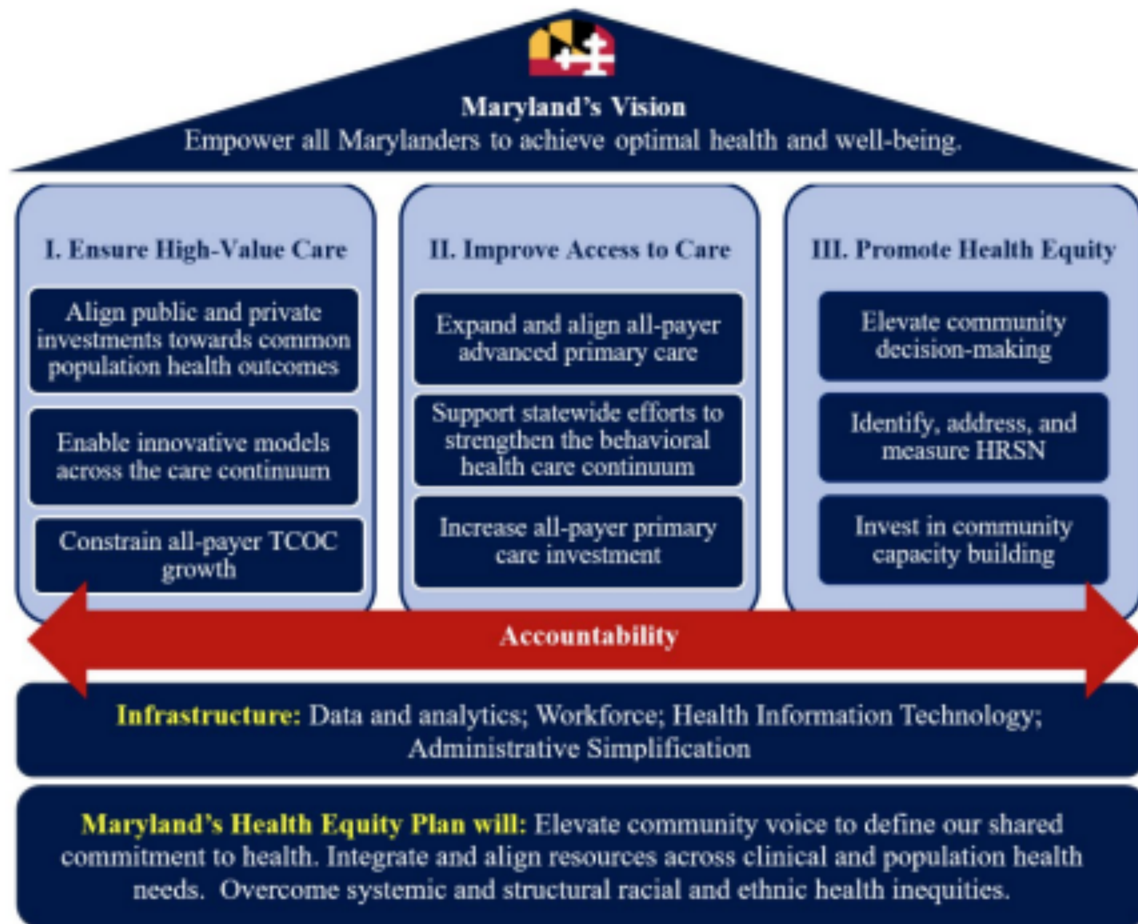
maryland
health services
cost review commission

HSCRC Opportunity for Comment

Written comments should be submitted to hscrc.care-transformation@maryland.gov by Monday, February 3, 2025. Stakeholders who submit written comments by this date will have the opportunity to provide verbal testimony at the HSCRC Public Meeting. on Wednesday, February 12, 2025

AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well being by ensuring high-value care, improving access to care, and promoting health equity (Figure). With the model due to start on January 1, 2026, this is an opportune moment for the Health Services Cost Review Commission to consider policy changes and investments to maximize Maryland's success.



In order to spur a productive conversation and prioritize our work, the Health Services Cost Review Commission is interested in comments on the following draft questions we developed internally, interested as well as health equity considerations and ideas for data analysis to inform the answers to our

questions.

Submission from the Maryland Academy of Family Physicians

Ensuring High Value Care. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. *To further drive this work, how can the payment system better recognize effective efforts?*

The payment system should incentivize quality primary care rather than number of visits. However, complicated patients cannot always be quantified by risk scoring. Longer complicated visits for complicated issues should be compensated properly. Flat fee visit payments or full capitation would disincentivize quality chronic disease management. Payments to primary care physicians should include both prospective payments based on risk scoring but also proper reimbursement for care of complicated patients via E&M payments.

Additional programs that support food and activity would be helpful, such as those from Lifestyle Medicine. These programs need health coaches and nutritionist to support patients. Currently most programs only support dieticians for patients with hyperlipidemia and diabetes. Obesity is the major contributor to both of these diseases. We need ways to educate and support a whole-food plant-based diet.

- Personalized Plans: Tailor interventions to the individual's needs, preferences, and goals.
- Collaboration with Healthcare Providers: Work with doctors, dietitians, and fitness experts to ensure holistic care.
- Behavioral Changes: Use motivational interviewing, goal setting, and small achievable steps to foster long-term habits.

b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

Maryland should invest in programs that are already working well. For instance, the MDPCP program has a very good track record and has good support among its participants, particularly its use of coaches. This should be strengthened. Though there are health and access inequities in certain parts of the state, ALL parts of the state have a significant primary care shortage. Primary care needs to be strengthened in all parts of the state.

A statewide program for initiatives around food and activity would be well received and impactful. A program like Food is Medicine.

- Key Studies:
  - The Diabetes Prevention Program:
    - Showed that lifestyle changes (diet and exercise) can reduce the risk of Type 2 diabetes by 58% in high-risk individuals.
  - The Framingham Heart Study:
    - Found that physical inactivity, smoking, and poor diet significantly increase the risk of heart disease, while regular exercise and healthy eating reduce it by 30-50%.
  - The PURE Study:
    - Investigated the impact of diet and physical activity in different countries, showing how lifestyle choices influence global health. It found that improving diet and increasing physical activity reduced cardiovascular disease mortality by 40%.

c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average:

https://lownhospitalsindex.org/unnecessary-back-surgery/. *How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?*

If physicians are incentivized to be able to educate and discuss options with patients, rather than forced to do 15 minute appointments, they will have the time to actually perform evidence based medicine per clinical guidelines. Currently physicians do not have the time to properly follow clinical guidelines due to their pay structure. The pay structure for primary care physicians should move away from RVUs and toward high quality care.

Engage Primary Care Physicians earlier in the plan when specialists are involved. Finding ways to make sure that the specialist and the primary care physician are collaborating on the patients care.

d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. *Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?*

Yes, physicians should be incentivized to follow clinical guidelines (and not punished). Any alternative or complementary approaches should be covered by insurance. Physicians and patients cannot avoid excess utilization when alternative and less expensive approaches are not available or covered by insurance.

Consider measuring Transition of Care Management visits. This would encourage standard practices for patients to see their primary care physicians after a hospitalization or ER visit.

e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?

Planning needs are important and often restricted due to financial constraints. To encourage and support this work provided grants and additional reimbursement for new services would be beneficial. New alternative forms of reimbursement for health coaches and paying form group visits would be a good start. Identifying statewide resources for social determinants of health would also help. It is difficult to screen people for these issues when you do not have solutions to help them solve their problems.

Improving Access to Care. Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

Focusing on access in the ambulatory care setting would be helpful. Measuring primary care offices on how long it takes to get an acute and TCM appointments can help ensure that patients get seen in the correct setting when needed. Having extended hours and weekend access is also very important and could be encouraged. Encouraging home visits for certain populations would also improve our current system. We need to make these types of visits accessible, and the state should help with funding to allow this type of work.

b. Reducing ER wait times is a state priority. *Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?*

c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. *What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?*

Coming up with a blended attribution would be helpful. Often patients are seen in one system, but their primary care provider is employed in another. Encouraging partnerships between organizations can create win-wins for both systems.

d. Hospital global budgets are adjusted every year for statewide population growth. *How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?*

Systems receiving money (increased rates) for providing care in the city or other higher paying regions, should be held accountable for spending/investing this money in their geographic regions. Have we looked to see if the increase that one system gets over another shows proportionate investment in their communities?

Hospital global budgets should be adjusted by amount of administrative costs vs actual costs of medical care. Hospitals should be incentivized to partner with community primary care physicians and urgent care centers to improve access to care, cost control, and population health.

e. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?

See d. Access measures could be put into place (like TCM visits). We should first focus on the state/regional comparisons, and they later be compared to national results. Administrative costs should be the primary metric. Yes, national comparisons, as well as comparisons to other similar Mid-Atlantic states should be considered.

Other topics. There are several cross-cutting policy areas that could also be addressed in 2025.

a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. *With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?*

Hospital based physicians: Non-hospital based physicians are lower cost and their payments should be increased. Most of the "facility" pricing is likely going to administrative costs rather than compensation to physicians. HSCRC should institute policies on how much of the facility fee is actually going to administrative costs rather than staffing costs.

Academic health systems are vitally needed, primarily for primary care graduate medical education. Increased state funding should be given to primary care graduate medical education, particularly Family Medicine.

There should be a study done on physician reimbursement and how they correlate to inflation and insurance reimbursement. Maryland is consistently in the 49th or 50th position (last) and this is not sustainable to support the medical needs of the state. It is driving out some of the best talent to other states. One insurer is holding over 60% of the market and this needs to be looked at and reimbursement improved.

In addition, investment in Loan Assistance Repayment Program for Physicians (Physician LARP) is a powerful tool at the State's disposal to incentivize physicians to enter primary care and ensure patient access to physicians in every part of Maryland. Making sure there is a regular source of funding for this program will be a great value add to ensure a sufficient primary care workforce.

b. Facility conversions. *Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?* Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the

restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?

Yes, this should be looked at. The number of people living in the city has decreased, yet we still have several hospital systems operating there. We also have hospitals in the county and city in very close proximity that are offering similar services. It seems there is an opportunity to decrease duplicative services.

c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. *What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?*

4. *What other major changes to policies under the Maryland Model of population-based payment should be considered?* Please be as specific as possible.

Ensuring that payments are being shared with physicians should be considered. Many hospital systems are keeping the population health payments that they receive and not passing them on to the physician.

Any institution receiving Population based payments must be required to have a part of that payment go directly to primary care physicians. Maryland has the lowest compensation for physicians in the nation and Primary care physicians are among the lowest compensated physicians. In order to improve the primary care shortage in MD, we need to improve compensation for these advanced primary care services. The population based payment must also go to actual staffing rather than administrative costs. This requirement should also not be adding to administrative burden.

When population based payments are instituted. Primary care visits should still be well compensated and there should be no flat fee or capitation that would de-incentivize physicians from seeing complicated visits.

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February 3, 2025

Sent via email to hscrc.care-transformation@maryland.gov
Maryland Health Services Review Commission
Joshua Sharfstein, M.D., Chair
4160 Patterson Avenue
Baltimore, MD 21215

RE: Response to HSCRC's Request for Stakeholder Feedback

Dear Dr. Sharfstein & HSCRC Commissioners:

On behalf of our more than 1,600 physicians practicing in and/or residing in Montgomery County, Montgomery County Medical Society is pleased to respond to HSCRC's request for stakeholder feedback. Our members include physicians of all specialties, practice modes, and practice locations in the County, and we are committed to providing quality, accessible, equitable, and affordable healthcare for more than a million patients. We share our perspectives on behalf of our patients — the most important stakeholders — in mind.

We have worked collaboratively with MedChi, the Maryland State Medical Society, of which we are a chartered component, to share individual and collective physician concerns about the Total Cost of Care Model and now about AHEAD (States Advancing All-Payer Health Equity Approaches and Development) Model. **As part of our feedback (and attached to this communication) are MedChi's positions on Healthcare Transformation, Population Health & Primary Care Investment. We support these positions and encourage the HSCRC to give serious consideration to the recommendations contained in these documents.** These recommendations represent valuable insights into the challenges of providing patient care both in the hospital and outside the hospital and include proposed solutions.

There are several areas on which we want to provide additional feedback. These issues relate to significant concerns about the current Total Cost of Care (TCOC) Model. We want to ensure these issues are addressed and resolved and not repeated in the new AHEAD model.

At the foundation of our members' concern is that the focus on cost containment has adversely affected quality and access to care under the TCOC Model, and, if not addressed, will continue and be exacerbated in the new AHEAD model.

Moreover, the statement *"AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well-being by ensuring high-value care, improving access to care, and promoting health equity"* assumes that there is a system of and infrastructure for care to be provided, and the health care workforce necessary for Marylanders to "achieve optimal health and well-being." While we agree that we need to strive toward this vision, we feel strongly that Maryland lacks a coordinated and collaborative effort to address the foundational needs and building blocks to achieve this stated vision.

Below we have categorized our feedback according to HSCRC's formal request. We recognize that some of the issues raised may not be the purview of the HSCRC; however, they directly or indirectly impact the success of the TCOC and AHEAD models and must be addressed by appropriate legislative and regulatory bodies. Given the complexity of the funding mechanisms of the TCOC, it is often difficult to determine the appropriate process through which to raise quality and access concerns and to explore solutions.

Ensuring High Value Care.

The HSCRC's focus is on ensuring "high value care." Containment of costs is important; however, not to the detriment of access to and/or quality of care. The methodology used by HSCRC and/or hospitals to measure quality of care is likely different from how physicians who admit or consult at Maryland hospitals and/or inpatients measure quality of care.

Metrics used by hospitals to measure quality of care are often patient satisfaction scores post-discharge, mortality rate, readmission rate, length of stay, compliance with clinical guidelines, infection rates, patient safety incidents, average cost per patient, bed occupancy rate, and healthcare effectiveness data and information set (HEDIS) scores. While important factors, quality of care is also impacted by:

- Inability of surgeons to schedule patients for procedures due to operating room suite closures attributed to staffing challenges or arbitrarily to diminish utilization and cost. Lack of access to surgical care negatively impacts patient care and the viability of surgical practice;
- Elimination of inpatient service lines which push patients to other hospitals in Maryland that provide the service, or into a community setting that isn't the most appropriate setting for that illness or disease treatment. The viability of such community providers is subject to market forces and reimbursement policy. Closure of outpatient services, such as dialysis, requires patients to drive long distances to receive care. In most physicians' opinions, these chronic diseases would best be treated in a community hospital for the best outcomes;
- Lack of call pay funding transparency. If used exclusively for hospital employed or contracted physicians to control costly admissions, access to cost effective, quality care provided to patients by outside specialists is undermined;
- Lack of adequate and adequately trained inpatient clinical staffing;[1]
- Unwillingness of hospitals to allow new and innovative treatments and surgical procedures because these treatments and procedures, while potentially financially profitable, could penalize hospitals under global budget models therefore denying access to such treatments or surgeries in Maryland; and
- Lack of adequate emergency room physician or hospitalist coverage to see patients resulting in additional patient care expenses from care provided by advanced practice providers and potentially greater liability;[2]

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[1] Global Data for the Maryland Hospital Association, Maryland Nurse Workforce Projections: 2021-2035. June, 2022.
[2] Zarefsky, Mark. What's the cost of scope creep? Start counting in the millions. October 5, 2023, American Medical Association News Wire.
Bernard, M.D., Rebekah. The missing variable: The effect of physician replacements on healthcare spending. Medical Economics, August 3, 2021.

- Inability of patients and physicians to share their concerns about quality of and access to care because there is no third-party, nonbiased system for collecting and reviewing such data, and having findings addressed and factored into annual budget review.

These concerns, shared with us by our members out of concern for their patients, impact quality and cost and are unfortunately the symptoms of global budget cost constraints. We expect that many of these factors are not captured and are not a part of the HSCRC funding methodology as they are more qualitative than quantitative.

Furthermore, we have learned that many physicians and surgeons are admitting their patients to hospitals in DC and Northern Virginia to expedite patient care and diagnostic and surgical procedures. Our physician members have indicated that the care provided in those out-of-state hospitals is not affected by the cost-cutting decisions which are prevalent in Montgomery County and most of Maryland's community hospitals, including lack of access to OR suites, lack of innovative equipment and medications, and inadequate nursing and physician staffing. Contrary to HSCRC's effort to enhance health equity, patients in Maryland with Medicaid coverage are precluded from receiving care outside of the state and unable to access cutting edge technology which is offered outside of Maryland.

These issues are worsened by the increasing volume of patients in Montgomery County at approximately 20% greater than pre-COVID rates (as reported by Suburban Hospital to the HSCRC), and without adequate adjustment of rates to Montgomery County hospitals to compensate for increased patient utilization. We encourage the HSCRC to look at the current volume methodology and make appropriate changes to ensure Montgomery County hospitals are appropriately compensated for increases in utilization.

Recommendations:

1)Modify the volume formula to reflect increased population utilization and fund hospitals accordingly using the "money should follow the patient" strategy. Community hospitals cannot be expected to provide care to more Maryland residents without additional resources. Free standing medical facilities and other lower acuity providers cannot provide the same services of full-service inpatient hospitals at a time of increasing population growth.

2)Evaluate the current funding methodology which has resulted in perverse incentives which ration patient care.

3)Incentivize hospitals financially to improve their offering of innovative procedures and surgeries which improve health outcomes, including requiring hospitals to pay call coverage to independent specialists.

4)Develop an independent complaint reporting system which will encourage patients and clinicians to share their feedback and concerns about inpatient care, and create a multi-disciplinary, non-biased committee to assess trends and address these complaints with specific hospitals and/or initiate improvements in hospital funding for those facilities which address complaints effectively.

5)Evaluate the disproportionate funding to hospitals within Maryland and reallocate funding to community hospitals where there is increasing demand and the need for community-based primary care which will help to achieve the goals of AHEAD. While it is understandable that funding is needed in our tertiary care facilities and trauma centers, population health strategies and improved outcomes will result from greater funding to community hospitals and community-based physicians and other outpatient services.

6)Improve the transparency of HSCRC funding strategies. It is complex and not easily understood. The general public is unaware of hospital funding methodology in Maryland or the impact it may have on their medical care.

7)Develop a publicly available and consistently applied transparent rating system for hospital quality and efficiency accessible to patients, physicians and other providers to inform consumers of quality health care.

8)Incentivize quality primary care rather than the number of visits. Physicians who care for patients with complicated health conditions should be compensated properly for the time and resources required to treat a patient effectively.

9)Medicare has established a rating system for hospitals, nursing homes, physicians and many other facilities called Medicare Compare. According to the medicare.gov website, "Medicare Compare uses a methodology that primarily relies on standardized quality measures, including process measures (what a provider does), outcome measures (results of care), patient experience measures, and sometimes structural measures (characteristics of the provider or facility), all gathered from patient medical records, claims data, and standardized surveys to generate a comparative rating for healthcare providers, allowing patients to compare quality across different facilities and doctors on the Medicare website; this often takes the form of a star rating system, where higher stars indicate better quality." Maryland's rating system could be based on similar measures but also on emergency room efficiency, acquisition of innovative equipment, staffing, etc. This rating system needs to be publicized. Hospitals should strive to achieve the highest level of quality and efficiency.

10)Consider "medical loss ratio" type reporting for hospitals. Medical loss ratios are a significant aspect of the Affordable Care Act.[3] They have been implemented in Maryland to hold health insurance companies accountable for the amount spent on medical care of every premium dollar and expose the amount spent on non-medical care expenses. The "medical loss ratio" concept applied to hospitals could limit the amount spent on administrative salaries, marketing, and non-medical projects including the building of non-patient care facilities. Hospital global budgets should be adjusted by the amount of administrative costs vs. actual costs of medical care. Hospitals should be incentivized to partner with community primary care physicians and urgent care centers to improve access to care, cost control and population health. By reporting both the resources spent on administration and health care to the HSCRC, hospitals will be held accountable for the medical care they are providing and be incentivized to meet certain targets of care. National and regional comparisons of administrative costs should be considered.

11)The payment structure for primary care physicians should move away from RVUs and toward high-quality care to compensate for time and resources needed to effectively use clinical guidelines and patient education to improve patient care and outcomes.

Improving Access to Care.

"AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well being by ensuring high-value care, improving access to care, and promoting health equity."

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[3] Hall, Mark A. and McCue, Michael J. How the ACA's Medical Loss Ratio Rule Protects Consumers and Insurers Against Ongoing Uncertainty. Commonwealth Fund Issue Briefs. July 2, 2019.

The Total Cost of Care model and the new AHEAD model will require an adequate physician workforce, in both primary and specialty care, which currently does not exist, to manage and optimize outpatient care. While MCMS recognizes that the existence of an adequate physician workforce is not the domain of the HSCRC, in its absence we will continue to witness the inability of Marylanders to "receive the right care in the right location at the right time" which is a fundamental and necessary aspect for the AHEAD model success. Longstanding and well-known physician and nursing workforce shortages in Maryland continue to challenge health care delivery, and have been studied by the State legislature, but few concrete steps have been taken to address the deficiencies.[4]

This lack of access to primary and behavioral health care is an element in Maryland's current ranking of 50th with the longest Emergency Department waiting time in the nation, a dubious distinction which Marylanders have shouldered for the past number of years. [5]

Increasing use of observation status is recognized as a strategy to avoid compromising inpatient budget allocations of the TCOC model; however, observation status can contribute to clogged emergency rooms further exacerbating emergency wait times.

While MDPCP and other alternative payment models have demonstrated success in reducing cost and increasing value, there are still too many patients who have no access to primary care who may seek care in emergency rooms or urgent care centers or receive no treatment at all for chronic or acute conditions which result in costly hospital admissions. The Primary Care Model for patients with Medicaid will also make a difference; however, both rely on an adequate number of physician and advanced practice providers to participate in these care coordination programs. Effective strategies to ensure successful transitions of care from hospital to outpatient settings, continuity of care and "medical home models" have demonstrated considerable progress toward reducing hospital admissions.

A primary driver of diminishing supply of primary (and specialty) care physicians is the inability to sustain practices in Montgomery County and Maryland due to the unique private payor environment, with one dominant insurer, CareFirst, controlling the majority of non-Medicare individuals. Over 3.5 million patients are covered in the commercial insurance market by CareFirst, allowing the insurer to set lower prices, limit its provider panels, create its own network of practices (including the largest primary care practice in Montgomery County which has practice locations in D.C. and northern Virginia as well), and create cost-containing efforts that limit physician and patient access to care that would be considered routine.

By creating barriers to standard care, by requiring additional approvals called 'prior authorizations', physicians' time is used on needless red tape, when it could instead be used for patient care. By causing unnecessary delays,

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[4] Commission to Study the Health Care Workforce Crisis: Final Report 2022/23.

[5] Twenter, Paige. Maryland confronts nation's longest ED wait times. Beckers Hospital Review. January 22, 2025.

Olaniran, Christian and Baylor, Kaicey. Maryland has the longest emergency room wait times in the country. New legislation aims to change that. CBS News. January 22, 2025.

Health Management Associates. Maryland General Assembly Hospital Throughput Workgroup Report. March, 2024

which are not based on science, patients are forced to either forego medications (some of which they have been used successfully for years) or pay for them outside of insurance.

As a result, physicians are leaving Maryland and moving out of state to practice elsewhere where the payor environment is less hostile to benefit from more insurance competition and higher payment rates, closing their practices and/or merging into larger groups, transitioning to concierge or direct membership practices, seeking employment in other medical environments such as NIH and FDA, and/or simply retiring early. A direct result of continual frustration with the status quo is a high rate of burnout.

When payors report network adequacy measures, the numbers do not reflect the reality of the situation. To understand the extent of the access problem, all one needs to do is to call a medical practice and see how long it takes to get a new patient appointment.

MCMS is so concerned about this issue that we launched our own workforce survey in the fall of 2024. The findings are:

- 32 surveys received so far since survey was launched in late September which represents 164 clinicians including physicians and mid-levels and almost 38,000 patients under their direct care.
- 42% of primary care respondents report it takes 1-4 months to set up an appointment for an established patient for routine care. 44% of specialists report it takes 1-4 months for them to see an established patient.
- 67% of specialists note it takes 1-4 months to see a new patient. 1/3 of Primary care physicians report that it takes 1-4 months for a new patient.
- For a referral, 42% of primary care physicians note it takes 3 to more than 6 months to get a specialist appointment for their patients.
- 42% of primary care physicians who answered our survey plan to retire in the next 5 years. 39% of specialists will retire in the next 5 years. This means almost 10,000 primary care patients will have to find a new physician and almost 8,000 patients of retiring specialists will as well.

With all of these factors, Maryland has been ranked in one survey as the worst in which to practice Medicine and ranks 49th of 50 states in terms of physician payments by insurers.[6] Maryland is one of the few states where commercial insurance payments are **lower** than Medicare payments.

The answer is to make Maryland a more economically favorable environment where physicians choose to practice. The answer is not to expand scope of practice for advanced practice professionals which have been shown to increase cost and liability concerns.[7] Marylanders deserve to be treated by well-trained physicians. Physicians are most able to provide cost-effective quality care in the outpatient setting. Providing additional financial incentives to physicians to establish practices in Maryland, instead of hospitals, is what’s needed to achieve “right care in the

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[6] DeSilva, Hayley. Lowest paying states for physicians. May 25, 2023.

Reynolds, Keith A. Best States to Practice. Physicians Practice. September 24, 2024. Slide 2.

[7] Zarefsky, Mark. What’s the cost of scope creep? Start counting in the millions. American Medical Association News Wire. October 5, 2023.
Bernard, M.D., Rebekah. The missing variable: The effect of physician replacements on healthcare spending. Medical Economics, August 3, 2021.

right location at the right time" as physicians are familiar with their patients' healthcare needs and can more effectively coordinate their care to avoid unnecessary hospitalizations.

According to our workforce survey 71.4% of primary care physicians note that they have considerable trouble or it's almost impossible to recruit a new physician to join their practice, while 55.5% of specialists note the same concern. Inability to match competing compensation offers is the number one reason that it is difficult to recruit physicians to Montgomery County. According to several practices in Montgomery County, the only physicians who want to live in Maryland are those who have family connections, and it's our observation that these physicians often open practices in two or three jurisdictions – Maryland, Virginia and/or D.C. – once they recognize the economics of practice in Maryland are not sustainable given the high cost of practice and low commercial insurance payments.

Recommendations:

1)Expand facility fee payment policy to include additional medical care settings. By leveling the playing field, more cost-effective, high-quality care can be performed in the outpatient setting, including independent surgery centers and medical practices increasing patient access. HSCRC should institute policies to ensure the fees are supporting patient care.

2)Enhance access to and payment for remote patient monitoring for patients enrolled in MDPCP or Medicaid Primary Care Program. Remote patient monitoring has demonstrated success in management of the care for patients with long-term chronic conditions.

3)Create an environment which encourages, facilitates and rewards cooperation, not competition, among providers of care in the outpatient setting. Finding successful ways for hospitals and all physicians to align and work together to improve patient outcomes is critical. Acquisition of medical practices by hospitals often increases costs. Investing in independent primary care to improve outcomes through programs like MDPCP and the new Medicaid Primary Care Program are helpful to manage care at the local level, yet many physicians find that the administrative burdens of such programs limit their optimal success.

4)Create legislation that no payor operating in Maryland can pay less than Medicare to primary care and behavioral health physicians working exclusively in Maryland.

5)Expand Medicaid coverage and payments to be equivalent to Medicare for the Top 25 CPT codes in the outpatient setting. If the proposed budget for Maryland is approved, Medicaid E&M codes would once again be equivalent to Medicare. Unfortunately, patients have little or no access to medical or surgical care for chronic conditions.

6) Eliminate prior authorizations for all practices participating in MDPCP and the new Medicaid Primary care program. This would immediately increase interest in participation if administrative burdens could be reduced.

7)Eliminate duplicative credentialing requirements for participation in Medicare and Medicaid managed care plans (like Medicare Advantage) if clinicians are already credentialed by traditional Medicare and Medicaid. This will improve access and expedite care.

8)Enhance outreach services to and service for underserved communities by encouraging Medicaid to match the 10% incentive in payment to physicians who practice in Health Care Professional Shortage (HPSA) areas as designated by Medicare.

9)Encourage hospitals to collaborate with and support financially nonprofit clinics and organizations which provide medical care in the community to enhance outreach to underserved populations (e.g. Mobile Medical Care, Mercy Clinic, etc.)

10)Population-based payment methodology must include payments for care provided by community-based primary care physicians to ensure appropriate care for chronically ill patients to reduce hospital admissions.

Planning is underway to replicate the Maryland model to other states through the AHEAD Model. CMS's goal in the AHEAD Model is to "collaborate with states to curb health care cost growth, improve population health; and advance health equity." According to HSCRC, "The AHEAD Model is the multi-state CMMI model that builds upon the successes of the Maryland TCOC in reducing health care cost growth and improving statewide health care quality."

Physicians across the State have been raising concerns through our medical societies, and urgent action is needed. Access to care has been a longstanding goal for physicians, patients, elected officials, and other stakeholders. Access to high quality care provided by physicians is the mission of our state and local medical societies. Patient advocacy groups share our deep concern for the future of high-quality medical care in the state.

Montgomery County Medical Society and our members are available to participate with HSCRC to create solutions to the challenges faced by our physicians and patients.

Thank you again for the opportunity to provide feedback on behalf of our physician members and their patients.

Sincerely,

Brent Berger, M.D.	Aruna Nathan, M.D.	Angela Marshall, M.D.
President	President-Elect	Immediate Past President

MedStar Health

10980 Grantchester Way
Columbia, MD 21044

MedStarHealth.org

February 3, 2025

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 Inc. (MedStar) and our seven Maryland acute care hospitals, we want to thank the Health Services Cost Review Commission (HSCRC) for the opportunity to provide comments on aspects of the Maryland Demonstration Model and how MedStar believes it could be improved as we transition to its next phase under the new AHEAD model. In addition to our direct responses to the questions posed by HSCRC staff below, we emphasize hospitals must be financially healthy and sufficiently resourced to support success under the AHEAD model. Currently, as MHA outlines in detail in their comments, hospitals in Maryland are not adequately funded to meet the baseline acute care needs of Maryland residents, invest in care transformation and population health, and make needed capital investments. To prepare for the AHEAD model, Maryland hospitals need policies to support the financial health of hospitals and access to care, address increasing payor denials (which have tripled since fiscal year 2013 and now represent $1.4B), and recognize the increasing costs of essential physicians necessary to operate a hospital and care for our communities.

1. **Ensuring High Value Care**
    a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?

    Response:
    The current model can be improved in several areas for incentivizing innovative care models:

    Achievability and Timeliness. Operational decisions to invest in new programs are funded today and over several years before potential for incentive dollars is a possibility. This approach, combined with hospitals' financial pressures and thin margins, stifle innovation. An improved model would defray upfront risk and cost of innovation for hospitals and ensure incentive success is achievable, measurable, and timely. The

model must make short-term success achievable to stimulate innovation, then "on-ramp" risk and reward as programs scale. This is like recent developments in the MSSP ACO program to provide glidepaths and more opportunities for advanced payments.

Geographic attribution. Hospitals are limited in their ability to impact health by the individuals they touch. While hospitals have a clear role in the community and supporting the health of the communities they serve, the intended impact of these are broad and long term, so unlikely to yield direct returns through TCOC. In areas where there may be one hospital for a community, this may be more feasible, but in Baltimore City or other areas with multiple hospitals, it is not possible to geographically bound activities or the community served by initiatives – either those based in the hospital or community. Hospitals are uniquely positioned however to respond to patients with 1) high levels of acute care utilization, 2) that are from marginalized areas and may rely on the ED for primary care services (e.g. unhoused, SUD, undocumented), and 3) that may have been previously lost to longitudinal care (leading to their present exacerbation of an underlying chronic condition). We should design the system to specifically incentivize hospitals to capitalize on these strengths and attributes. Programs based on population attribution (e.g. MPA and PAU savings policy) should focus on patients that explicitly touch a facility or system. Other mechanisms exist for more global attribution through providers or organizations with clearer and longitudinal patient relationships – such as through primary care and MDPCP.

We would recommend a joint task force of staff and stakeholders with experience in policy incentive design meet to develop a policy structure that better recognizes effective efforts.

b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?

Response:
Given recent cutbacks in federal funding for social programming, especially for programs to support high risk populations, there will be substantial need among community-based organizations for new funding streams to support current programming. Creating a grants program for health-related programming could help fill this gap – or potentially transferring funding to established grant structures (e.g. MCHRC) to expand their pool of funding to support these programs without requiring development and execution of a new grant program. MedStar would encourage these grant programs and/or funding support to be implemented without adding to the financial burden of hospitals.

c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?

Response:
Targeting low-value care is not a good strategy for model success under the current model incentives. Low value care metrics tend to have a narrow clinical definition sensitive to coding specificity, such that while clinical value is improved by avoiding low-value activities, the cost avoided is relatively negligible as a share of the total cost of care.

If it is a state priority to focus on clinically low value care, it should create specific, measurable incentives to promote focus on this. However, it is worth noting that given limited available bandwidth to focus on model objectives, it is unlikely that this is the highest yield focus for hospitals in achieving the model's statewide targets. Perhaps there is a lower-structure way to include this intent in the model, such as naming an annual low-value care goal and asking for qualitative reporting on best practices, in the current manner of the ED best practices policy being instituted currently.

d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?

Response:
The current policy for PAU is of limited impact as it combines all PQIs and readmissions into a single number, then compares that number to the statewide average. A more meaningful policy would take PQIs related to a specific disease state, such as diabetes, and then provide a direct connection between year-over-year diabetes PQI volume and programming aimed at reducing the same. This could potentially take a CTI-like structure, except that the measure of interest would be PQI cost versus a calculated expected PQI cost for that population (rather than total cost in current CTI).

2. Improving Access to Care

c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating excessive financial incentive for hospital-based treatment?

Response:
MedStar is supportive of revisions to the market shift methodology to improve funding accuracy and more closely reflect the actual care seeking dynamics of patients in the healthcare market. To achieve this, MedStar would support a revision to the market shift methodology to use service line specific variable cost factors when calculating GBR shifts between hospitals instead of the flat 50% variable cost factor historically applied. Further, MedStar believes market shift calculations applied at the zip code level potentially excludes true volume shifts between facilities and would therefore support a further consolidation of geographic definitions when determining if shifts in the market have happened between hospitals.

d. Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?

Response:

In addition to funding year over year inflation, updating hospital global budgets for changes in population is a core tenant of Maryland's fixed hospital revenue system. However, the current HSCRC methodology used to adjust hospital global budgets for demographic changes falls short of meeting this tenant and has left Maryland's hospitals underfunded since fiscal year 2014. Through fiscal year 2025, age-adjusted population growth statewide has been 11.63% vs 4.22% of funding provided in hospital global budgets – a hospital funding shortfall worth approximately $1.6 billion. The underfunding of population growth/aging and the associated hospital utilization increase is driven by three factors:

- Use of age-adjusted population change to distribute funding amongst hospitals but capping funding at the Maryland Department of Planning population growth projection
- Adjustment to leave PAU volume growth caused by population growth unfunded in demographic methodology
- Use of a scaling factor for expected efficiencies to bring overall demographic funding to within the levels provided under the Model contract for population growth

MedStar encourages the HSCRC to revisit the methodology used to calculate global budget revenue adjustments for demographic changes to determine if it is still appropriate to cap age-adjusted population growth funding at the MDP population growth projection, lower funding to account for PAU volumes, and scale funding for expected efficiencies. As Maryland is exceeding its annual Medicare savings requirements, hospitals have been left significantly underfunded – in large part due to underfunding of population change. As we move into AHEAD, developing a more sustainable mechanism for funding population change needs to be a top priority of the HSCRC, however Medstar recognizes this policy revision will take considerable time to develop. Therefore, MedStar encourages the HSCRC to develop both a short-term solution to this underfunding challenge that helps alleviate the current financial challenges Maryland hospitals face, as well as a long-term solution for the AHEAD model.

e. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita, and administrative costs?

Response:
MedStar is supportive of staff's efforts to study and determine the effectiveness of hospitals as it relates to access to care through the development of metrics and relevant benchmarking tools. Given the importance of such an evaluation and the potential financial implications as it relates to healthcare payment policy in Maryland, MedStar strongly recommends that the HSCRC develop a workgroup that includes stakeholders from across the industry to develop and refine key metrics to be used in this evaluation.

3. **Other Topics**
    a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?

    Response:
    MedStar appreciates the HSCRC's recognition of the challenges Maryland hospitals are facing regarding increasing physician costs. To help alleviate the financial pressures hospitals are facing related to rising physician costs, one approach the HSCRC could consider would be the inclusion of costs associated with the physicians needed to operate a hospital in the inter-hospital cost comparison methodology – which is used to determine the appropriateness of a hospital's global budget revenue. Including some set of allowable physician costs in the ICC calculation would provide hospitals with 'credit' for the physicians needed to operate a hospital and potentially unlock additional GBR for qualifying hospitals.
    Additionally, MedStar believes that to truly solve the challenge of rising physician costs, action must be taken to address the acute physician shortage in Maryland, as well as nationally. For Maryland, MedStar would propose that the HSCRC engage in a collaborative effort to determine the root cause of physician retention issues and what actions can be taken to improve retention post-residency. This retention issue plays a key role in physician shortages and therefore, rising physician costs. Nationally, an overall physician shortage is projected to occur over the next decade of an estimated 150,000 doctors. This will require a substantial investment in training the next generation of physicians and Maryland must be a leader in this space. To this end, MedStar would suggest the HSCRC study the feasibility of expanding the amount of graduate medical education available in the state – at all training institutions.

    c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?

    Response:
    Excluding any growing service from GBR will inherently create greater challenges in meeting total cost of care targets under the new Model. Despite those challenges, MedStar is supportive of the evaluation of certain exclusions and strongly encourages the HSCRC to form a workgroup, dedicated solely to this topic, to accomplish this.

Again, we want to thank you for the opportunity to provide comments on the Maryland demonstration model and any policy changes that should be considered as the state transitions to the new AHEAD model beginning in 2026. Although the AHEAD model doesn't officially begin until 2026, MedStar believes that success under the model starts now. MedStar supports the HSCRC's efforts to prepare for what lies ahead. As the Maryland Hospital Association's comment letter states, the financial condition of Maryland Hospitals, the rising cost of physicians, and the increasing rate of denials are all

issues that need our collective attention in order to establish a solid starting point for the new model. As the HSCRC processes responses to these questions, MedStar would ask the HSCRC to maintain a transparent and evolving conversation with industry stakeholders through regular updates, workgroup creation and participation, and actively seeking stakeholder feedback on major policy changes and decisions.

If you have any questions or wish to discuss any of the above further, please do not hesitate to reach out.

Sincerely,

Susan Nelson
Executive Vice President & Chief Financial Officer
MedStar Health

Stephen Evans, MD
Executive Vice President, Medical Affairs & Chief Medical Officer
Medstar Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Allan Pack

February 3, 2025

Sent via email to hscrc.care-transformation@maryland.gov
John Kromm, PhD
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Comments on Policies and Investments to Further the AHEAD Model

Dear Executive Director Kromm:

MedChi, The Maryland State Medical Society (MedChi), appreciates the opportunity to comment on possible Health Services Cost Review Commission policy changes and investments that would further the goals of the AHEAD Model. We want to first thank HSCRC for its ongoing work on physician alignment programs, including the Maryland Primary Care Program and the Episode Quality Improvement Program (EQIP). These initiatives have demonstrated significant potential to strengthen physician engagement and improve patient outcomes. We also look forward to collaborating closely with you as Maryland develops the Medicaid Advanced Primary Care Program and other programs to further the goals of the AHEAD Model.

MedChi remains steadfast in advocating for the critical issues outlined in the three attached one-page documents. We would also like to highlight the importance of moving expeditiously on the following three issues:

1. **Patient Protections with a Focus on Equity**

   HSCRC should develop and enhance policies and investments prioritizing health equity, quality, and care for every patient in Maryland while also striving to avoid unintended consequences of incentive structures that may run counter to patient safety.

2. **Adjustment of Volume Policies**

   The current volume policies reward restricting access to care and fail to cover the costs of providing care to additional patients. Limitations within the global budget create disincentives for hospitals to invest in new and innovative technologies, such as robotic surgeries or other advanced procedures, because there is no additional funding to support these investments. These challenges have not only made Maryland's hospitals less competitive on a national level but have also aggravated Maryland's physician workforce shortage and have resulted in further inequalities in access to care for Maryland patients.

3. **Physician Payment**

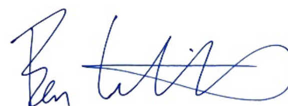
   Maryland's commercial insurers benefit from the all-payer model because annual rate increases for hospitals are capped. Despite this favorable regulatory climate, Maryland's commercial insurers offer some of the lowest physician payment rates in the country, as evidenced

by a Maryland Health Care Commission (MHCC) study. These low payment rates are driving market inefficiencies and the viability of medical practices, which has resulted in an unsustainable health care environment.

We believe that meaningful solutions will require continued dialogue and partnership between stakeholders, including HSCRC, physicians, hospitals, and health care institutions. MedChi is committed to working in a collaborative and comprehensive manner to address these issues and work toward goals we all share: to improve health equity, quality, and care for all Marylanders.

We appreciate your consideration of these critical concerns and would also respectfully request to provide oral comments during the HSCRC meeting on February 12, 2025.

Sincerely,



Benjamin Lowentritt, M.D.

Immediate Past President
MedChi, The Maryland State Medical Society

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Joshua Sharfstein, Chair, HSCRC
Dr. James Elliott, Vice Chair, HSCRC
Richardo Johnson, Commissioner, HSCRC
Dr. Maulik Joshi, Commissioner, HSCRC
Adam Kane, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC
Dr. Farzaneh Sabi, Commissioner, HSCRC
Erin McMullen, R.N., Chief of Staff, Maryland Department of Health
Dr. Padmini Ranasinghe, President, MedChi, The Maryland State Medical Society
Gene Ransom, III, CEO, MedChi, The Maryland State Medical Society
Ashton DeLong, General Counsel, MedChi, The Maryland State Medical Society

Enclosures

MedChi
The Maryland State Medical Society

The AHEAD Model: HEALTHCARE TRANSFORMATION

The Goal

As Maryland's unique Total Cost of Care (TCOC) Model is expanded and improved upon with the new Advancing All-Payer Equity Approaches and Development (AHEAD) Model, it is necessary to ensure that incentive structures do not continue to create unintended impacts such as long ER wait times, health inequities, and lack of access to mental health and addiction treatment services.

Under the AHEAD Model, MedChi Believes That We Can Transform Healthcare By:

Savings Targets – The Money Should Follow the Patient

- The AHEAD Model should attribute savings to the Maryland patient and reward practitioners with those savings regardless of healthcare setting.
- The AHEAD Model should have a savings target that ensures regulated entities are funded appropriately for innovation and modernizing patient care and reduces funding for those regulated entities that do not invest in innovation and modernization of patient care.

Access to Specialty Care in Regulated Entities

For comprehensive and expeditious care, particularly in ERs, Maryland should set standards requiring regulated entities to have specialty physicians available to treat patients and reward regulated entities that meet such standards.

Increased Oversight

The AHEAD Model should redesign oversight of all regulated entities to protect patients and participating practitioners and entities against unintended consequences of the Model by:

- Creating a transparent appeal and grievance process for patients, physicians, and others who are adversely affected by activity incentivized by the Model.
- Requiring reporting from regulated entities demonstrate how specific interventions are designed to impact social determinants of health and the outcomes of those interventions.
- Designing a regulatory structure that provides regulators with the authority to make financial adjustments and take appropriate action against regulated entities who do not meet the goals of the Model or engage directly or indirectly in activities that limit access to quality healthcare. This regulatory structure should provide regulators with the flexibility to make real-time adjustments to meet the desired goals of the Model.
- Improving transparency on capital projects to avoid subsidizing projects that do not directly impact modernization of or increased access to patient care.

Transparency in Value-Based Programs

Further the goals of the AHEAD Model, all practitioners participating in value-based programs should have full transparency and access to all financial information and terms of the program including the Episode Quality Improvement Program, Care Transformation Initiatives Program, and Maryland Primary Care Program.

Payment Differentials Policy

Maryland should ensure that there is a clear policy around the use of payment differentials to ensure fair and timely payments to practitioners and regulated entities.

Payment Floors

To further increase access to healthcare and build Maryland's healthcare workforce, the AHEAD Model should provide the State with the authority to set transparent payment floors, adjusted annually, that require all payers participating in the AHEAD Model to pay physicians, healthcare practitioners, and regulated entities for care provided at or above the set payment floor.

MedChi
The Maryland State Medical Society

The AHEAD MODEL: POPULATION HEALTH

Improving Healthcare Under the AHEAD Model

Public Health Goals

The AHEAD Model should create quality measures that apply to all areas of care with a particular focus on health equity and that clearly align with the Statewide Integrated Health Improvement Strategy.

Preventative Health

The AHEAD Model should have additional measures and incentives for all practitioners to increase screening and prevention for various healthcare conditions with a targeted focus on promoting health equity.

Improve Care Innovation

- The AHEAD Model should continue to expand the Episode Quality Improvement Program (EQIP) and EQIP Primary Care Access Program to accelerate care resign to aid physician in further improving patient care, access to health care, and care management activities.
- The AHEAD Model should provide Maryland with the flexibility to explore and implement other value-based programs to increase quality and access to patient care such as physician-led Accountable Care Organizations or similar programs.

Improve the Healthcare Workforce

Maryland needs to expand its healthcare workforce, particularly in primary care. Maryland should use funds under the AHEAD Model to reward primary care physicians choosing to work Maryland. To further aid in meeting the AHEAD Model's goals, Maryland should also consider reducing barriers to licensure for physicians to practice in Maryland.

Loan Repayment

MedChi believes that the State should request that the AHEAD Model allow for the use of funds for loan repayment to attract physicians to come and stay in Maryland.

Graduate Medical Education Reform

MedChi believes that Maryland's graduate educate needs to be protected and promoted by augmenting the current funding mechanisms and adding a rural residency program to increase investment in residency and Maryland's future physicians.

Exogenous Factors

Maryland’s current Total Cost of Care Agreement has a strong exogenous factor clause that includes a clause around defensive medicine, payment, and other important issues. This clause needs to be kept in any agreement concerning the AHEAD Model.

Transparency in Reporting

- The AHEAD Model should require increased reporting and transparency on the use of government funds for community benefit programs to ensure funds are being used to further the AHEAD Model’s goals of health equity across the State.
- The AHEAD Model should require further reporting and transparency on the use of additional funds requested by regulated entities for physician payments to ensure that funds are used for their intended purpose.

Price Transparency

Maryland should request that the AHEAD Model provide for more transparency for patients regarding the pricing of services and products provided by regulated entities and collect the data on pricing in one readily accessible and user-friendly location.

Increased Access to CRISP and Other Databases

The AHEAD Model should provide physicians and other healthcare practitioners and entities with increased access to the State’s health information exchange, Chesapeake Regional Information System for Our Patients (CRISP), Maryland's All Payer Claims Database, and other available data sources. By providing these Model participants with increased access, healthcare practitioners will be encouraged to be involved in the Model and be able to more actively further health equity. Maryland should also request funds to modernize these various data sources to increase user efficiency.

mdafp MARYLAND ACADEMY OF FAMILY PHYSICIANS

MedChi *The Maryland State Medical Society*

THE AHEAD MODEL: PRIMARY CARE

About the AHEAD Model

The Centers for Medicare & Medicaid Services (CMS) has selected Maryland to implement the new States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. With this selection, Maryland will move away from its current Total Cost of Care (TCOC) Model and continue to build on its state-wide efforts to improve health equity, quality, and access, and to control healthcare costs through the new AHEAD Model.

AHEAD Model Goals

The AHEAD Model Aims to:

- Improve the total health of a state population
- Expand health equity among all payers including Medicare, Medicaid, and private coverages
- Drive state and regional healthcare transformation and multi-payer alignment
- Increase resources available to participating states
- Support primary care and transform healthcare in communities

Prior to the AHEAD model, the State is Encouraged to:

Support and Prioritize the Maryland Primary Care Program (MDPCP) by:

- Improving and increasing enrollment opportunities, including a Medicaid program.
- Maintaining Care Transformation Organizations (CTOs), especially for small and mid-size practices.
- Using the Episode Quality Improvement Program (EQIP) as a wrap-around tool coordinating with MDPCP to target underserved areas.

Keep On-Ramp Track

MDPCP should keep an on-ramp track, so new practice sites may be added without risk.

Augment EQIP with Primary Care Bundles

MedChi and MDAFP strongly believe that we need to add several bundles targeted at primary care.

Expand MDPCP

To further advance the total health of all Marylanders and lower healthcare costs across all payers, MDPCP should be expanded to include Medicaid and private payers in the AHEAD Model.

Incorporate Transformation and MDPCP Gap Services

MDPCP will most likely not have open enrollment opportunities for 2025. MedChi and MDAFP strongly encourage incorporating a transformation role for EQIP primary care to get new practices into MDPCP once we have clarity on the future of the Maryland Model.

Develop an Accessible, Critical Primary Care Program

Using EQIP, a global budget program could be developed to provide accessible primary care for rural and urban settings with shortages. The cost could be covered by Medicaid and the HSCRC to improve outcomes, access, and population health. The program would target creating new pediatric and adult primary care services through a public-private partnership.

Maryland
Hospital Association

February 3, 2025

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 writing in response to the Health Services Cost Review Commission's (HSCRC) call for public comment on needed policy changes and investments to maximize Maryland's success as the state transitions to the AHEAD Model. We appreciate HSCRC's recognition that this is an opportune time to examine existing policies and implement changes to strengthen the Maryland Model.

The transition from the Total Cost of Care (TCOC) Model to the AHEAD Model brings us to an important moment in our ongoing effort to improve the health and wellbeing of Marylanders. Since the inception of the Maryland Model, Maryland hospitals have led the way in driving innovation through health care payment reform. Over the course of the All-Payer Model and the TCOC Model, hospitals generated $4.6 billion in Medicare savings through high-quality, efficient care delivery. Our hospitals reduced disparities in unplanned readmissions, preventable admissions, and timely follow-up both by race and for areas with challenging socio-economic conditions.

The AHEAD Model aims to build on this legacy with an even greater focus on population health and health equity and provides new opportunities to improve the health of all Marylanders. Hospitals will play a critical role in leading local interventions that focus on identifying populations that are most at risk for poor outcomes and developing targeted interventions that improve health. Our hospitals will also lead in the effort to improve health equity with each creating health equity plans that will demonstrate how equity is actively incorporated in hospital operations, strategies, and services. AHEAD includes important opportunities for hospitals to partner with other care providers across the care spectrum and, rightly, includes a focus on expanding access to primary care.

MHA Priorities

To be successful under AHEAD, hospitals must be financially healthy and sufficiently resourced to meet the baseline acute care needs of patients, invest in care transformation and population health, and make needed capital investments. ***The hospital field identified three top concerns***

that need to be addressed to support our mission of advancing health care and the health of all Marylanders: (1) policies to support the financial health of hospitals and access to care, (2) rising costs for essential physician coverage, and (3) payer denials and accountability.

Policies to Support the Financial Health of Hospitals and Access to Care

As we have highlighted over the past few months, Maryland hospitals and health systems have experienced challenging financial conditions since January 2020 as expenses have risen significantly. Maryland hospital system operating margins have been under pressure. In most quarters in the last three years, half or more of the systems have reported negative operating margins. Margins remain low with an average of just 0.3% in the third quarter of 2024, and margins lag when compared with other systems in the nation. Market experts estimate that nonprofit systems generally need a margin of 3% to sustain their missions. Since 2023, Maryland hospital systems have only reached this level once, and the average of the last 11 years was substantially lower at 1.6%.

Our hospital systems lag on other important financial performance measures as well. Due to operational uncertainty, hospitals deferred needed capital investments. In 2023, the average age-of-plant for Maryland hospitals was 13.2 years vs. 12.3 years nationally. Maryland hospital systems are below national benchmarks when comparing cash reserves to debt. Maryland also lags its peers in days cash on hand, an important liquidity measure. Labor and other cost pressures have been a challenge. From 2019 to 2023, labor costs grew by nearly 19%, outpacing the 14.2% increase in net regulated patient revenue. Staffing costs have increased to over 50% of total expenses, and the substantial labor cost increases are now a structurally high operating expense. Hospitals have seen an increase in financial losses due to costs to employ or contract with physicians. Low reimbursements do not cover the costs of these essential medical staff, and these losses have grown by 55% for all specialties in recent years.

When evaluating the financial health of hospital systems, one must look at the full spectrum of financial indicators. Credit ratings are just one measure of financial stability. Operating margins are a central metric, and when considering margins, the focus must be at a system level. The Maryland Model is a total-cost-of care model. When appropriate, hospitals are supposed to shift services to lower cost unregulated and non-hospital settings and enhance integration of care across the care continuum, including through investments outside of the hospital walls to enhance primary care, post-acute care, community care, and population health. Because our focus is on improving care in settings across the continuum of care, our financial measures must focus on hospital system level performance that includes margins on hospital and non-hospital services. An exclusive focus on regulated margins fails to account for these important aims. And there are hospital costs, like essential physician services, that are not covered under rates. Without considering total hospital system financial performance, one misses large cost drivers and loss leaders for hospitals. HSCRC must embrace a broader focus on a wholistic set of financial metrics to obtain a complete and honest picture of hospital sustainability.

The financial challenges of our hospitals have occurred when hospitals have been generating Medicare TCOC savings substantially more than what is required under the Total Cost of Care Model. For 2024, Maryland is on track to achieve more than $600 million in savings for

Medicare—well above the contractual target of $336 million. The estimated savings are well above the baseline for the start of AHEAD and the first-year target under the new model agreement where we must generate an estimated additional $16 million in savings above the baseline. Over the course of the TCOC Model, Maryland has generated more $1.1 billion in excess Medicare TCOC savings. The Maryland Model and HSCRC policies must achieve a balance of hospital sustainability, health access, and health equity with cost savings for payers and affordability for patients. The generation of substantial excess savings at time when hospitals have struggled is a sign of a Model that is out of balance. HSCRC policies and actions are not keeping up with the costs hospitals incur for providing care in their communities. This is leaving hospitals resource constrained at a time when hospitals need to be strengthened to perform successfully under the AHEAD Model beginning in 2026.

HSCRC policies and actions must enable hospitals to be financially sustainable and provide greater access to care in their communities. Changes to key policies must be made this year to better fund volume growth and shifts, inflationary and other cost pressures, and capital needs.

Needed Improvements to Volume Policies

It is imperative that volume policies ensure that hospitals receive adequate funding services. Changes are needed to the market shift policy and demographic adjustment so that they more precisely account for and sufficiently fund volume changes.

Market Shift

The existing policy governing market shifts funds volume changes at a 50% variable cost factor (VCF). MHA urges adoption of a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis. MHA recommends an approach that would use the annual filing to calculate VCF percentages by rate center, apply the calculated rate center-specific VCFs to service line/rate center charges, and then calculate service line-specific VCFs to apply statewide. An optimal approach would capture as variable costs direct expenses and direct patient care overhead costs, resulting in an appropriately higher calculated average VCF. An exception could be considered for outpatient psychiatric services, a service line with relatively high fixed costs—a higher VCF could support growth and greater access to these services.

MHA also recommends modifying the geographic definitions used under the market shift methodology. The current methodology, which generally tracks shifts by ZIP code with exceptions for certain service lines that are under a county level approach, does not sufficiently capture shifts, and broader geographic definitions would improve the methodology. The change to a county or regional approach would be simpler than the existing methodology, result in a higher effective VCF, and potentially benefit hospitals experiencing unfunded volume growth. The county-level approach is used under the national AHEAD methodology, and the potential benefit to volume-growing hospitals may support efforts to address access challenges.

Demographic Adjustment

Maryland’s population is aging and becoming more complex. By 2030, nearly 20% of our population is projected to be 65 or older—this is up from just 12% in 2010 and 16% in 2020. Our state is also confronting an increased burden of chronic disease. The number of individuals with three or more chronic conditions is projected to increase. The percentage of our population with prediabetes is projected to reach nearly 30%, and the percentage of our population with diabetes will reach more than 15%. Projected figures are even higher for seniors, with 51% having prediabetes and 26% with diabetes. Our aging population with more chronic conditions will have a higher need for health care services, and the demographic adjustment must be responsive to this need.

The current demographic adjustment methodology insufficiently accounts for age-adjusted population growth by lowering the adjustment so that it aligns with unadjusted state projections for annual population change. The methodology, which discounts potentially avoidable utilization (PAU) and age-adjusted growth by a per capita scaling factor, underfunds use-rate growth to achieve the contractual all-payer revenue limit. This approach acts as an additional constraint on growth beyond the PAU adjustment, unduly limits hospital resources, and exacerbates access challenges. For Rate Year (RY) 2025, the scaling factor reduced the adjustment from 4.25% to 0.25%. The cumulative impact of the underfunded growth has been substantial. From RY 2016 through RY 2025, the methodology has resulted in a cumulative underfunding of demographic growth by $7.4 billion.

MHA urges changing the methodology to discontinue the scaling factor so hospitals can receive more funding for use-rate growth. This change needs to be implemented in time to support growth in rate year 2025. MHA can support a two-pronged effort to (1) implement a more straightforward, implementable, modification to the age-adjusted approach for funding demographic growth in the near term, and (2) develop a more refined risk adjustment approach in the long term. The status quo is not sustainable, and imminent HSCRC action is needed.

Inflationary and Other Cost Pressures

In the post-COVID years, hospitals have been contending with inflationary cost pressures, and HSCRC policies have not provided sufficient funding to address these challenges. As noted above, staffing costs have been a significant cost driver and are now a structurally high operating expense. A reasonable annual payment update for Rate Year 2026 is essential to address the challenges and support hospital financial stability and access to care with the beginning of AHEAD.

Preliminary estimates have core inflation for Rate Year 2025 ending higher than projected (3.42% vs. 3.24%). The annual payment update for RY 2025 included an additional 1% for historic underfunding of inflation, an action that provided important support for our hospitals. But under HSCRC's methodology for calculating cumulative inflation over- or underfunding, hospitals are currently underfunded by a percentage that would fall within the inflation tolerance corridor of ±1%. The current methodology would yield no additional inflationary support allocated for RY 2026.

MHA urges changing the methodology so that annual update funding for Rate Year 2026 keeps pace with core inflationary pressures and includes additional support to address underfunded inflation. This could include narrowing inflation tolerance corridors that would yield an inflation catch up for the upcoming rate year.

Deferred Routine Capital Needs

As we highlighted in December, 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 replacement, upgrade, 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. HSCRC must revise policies so that hospitals have additional resources to address deferred capital needs. Hospitals need to address these needs to meet patients' baseline acute care needs. Facility renovation, routine equipment replacement, and investment in new technology play an important role in enhancing patient experience. Improvement in HCAHPs and quality scores depends on the ability of hospitals to make these needed investments.

Rising Costs for Essential Physician Coverage

Hospitals have seen an increase in financial losses due to costs to employ or contract with physicians. Hospitals require sufficient medical staff to perform the basic functions of providing care to patients, and the losses attributable to physician employment or contractual arrangements—termed physician subsidies—are largely unavoidable.

Low physician reimbursement from payers and an increase in private equity acquisitions of physician practices are driving up contractual costs to provide adequate coverage for the hospital. In 2017, the average private physician payment rate was 104% of Medicare, one of the lowest in the nation, and physician subsidies are on the rise. A growing number of hospitals are citing increased physician subsidies, specifically in the hospital- based specialties of anesthesia and radiology, when requesting rate increases. The entry of private equity into the physician market is a challenge. When private equity enters the market, physician costs increase, particularly in instances when a single firm controls more than 30% of the market.

A survey of MHA member hospitals found that in the last seven to 10 years, expenses and net losses for physician services have grown, particularly for certain specialties.[1] For all specialties,

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[1] Survey base years differ due to respondent data availability.

losses have grown by 55% over the period. Increases were significant for a variety of specialties, including anesthesiology, hospitalists, and emergency medicine.

The current global budget and rate structure does not enable hospitals to cover the costs for these physician services that are essential to run a hospital. HSCRC must adopt a funding mechanism that enables hospitals to recover in rates expenditures for physician services that are not fully reimbursed by payers.

Payer Denials and Accountability

Maryland hospitals are confronting a significant challenge with payer denials. Denied cases have grown substantially since 2013, and this growth has accelerated in recent years. In particular, denied cases are increasing steeply in the emergency department and outpatient settings. Artificial intelligence (AI) claims analyzer technology has been contributing significantly to the increase.

From fiscal 2013 through 2024, the total dollar value of denials has more than tripled to $1.39 billion. In the last three years, denials by commercial payers have spiked, and denials for emergency department services, in particular, have risen 116%, and the dollar amount of denials up 117%. In fiscal year 2014, 13.2% of inpatient cases were denied—the highest level in six years. From fiscal 2019 through 2024, denied cases as a percentage of total outpatient services increased from 10.2% to 11.4%. Commercial payers were responsible for the largest percentage increase in outpatient denials with the percentage increasing from 8.5% to 12.5% of the total. And for commercial payers, denied cases for emergency department services increased from 6.1% to 15.2%. There has been a noteworthy increase in medically necessary denials for Medicare Advantage (232.5%) and commercial plans (79.1%). The overall denial rate for Medicaid managed care organizations has also been high over the last six years.

Denials can cause delays for patients receiving necessary care, and higher out-of-pocket costs resulting from claim denials can cause patients to defer care. Denied and delayed payment of claims is contributing to financial pressures on hospitals and operational uncertainty. Valuable staff and clinical resources are diverted to fight inappropriate claim denials.

We need a system for reviewing payer denials that refines data disclosures and ensures data integrity, enhances payer denial transparency, and reduces denial rates while examining factors that contribute to excessive denial rates, such as the use of AI in claims review and prior-authorization requirements. HSCRC can play an important role in supporting the collection and analysis of information on claim denials. MHA urges HSCRC to pursue policy development and levers that may address wrongful denials.

HSCRC Call for Input Categories

Regarding the specific areas of inquiry on which HSCRC has requested public input—high-value care, access to care, and other cross-cutting policies—MHA offers the following comments.

High Value Care

Ensuring that patients receive the right care at the right time and in the right setting is an important objective. MHA encourages language that reflects a focus on medical necessity, rather than terminology like "high value care" that may inadvertently suggest certain services lack value. A more precise framework for evaluating care appropriateness that centers on medical necessity will help hospitals provide high-quality, patient-centered care that best meets the needs of our communities.

MHA and our members recognize the importance of delivering high-quality, patient-centered care and offer the following considerations to ensure a framework that effectively supports hospitals in meeting these objectives:

- **Benchmarking Population Health Performance**: To measure progress toward high-quality, patient-centered care, there must be robust benchmarking of Maryland's population health performance. This should include an evaluation of how the state's policies under the TCOC Model have contributed to improved patient outcomes and care delivery. Establishing clear benchmarks in advance of the AHEAD Model will allow hospitals to track improvements and identify areas for further enhancement.

- **Program Funding Flexibility**: Sustainable, flexible funding mechanisms are essential to enable hospitals to launch, sustain, and scale chronic care management and population health initiatives. Providing financial support that can be adapted to evolving needs will help ensure that Maryland hospitals can continue their efforts to improve health outcomes while managing costs effectively.

- **CRISP Enhancements**: Real-time data analytics and reporting improvements through CRISP are necessary to align hospital efforts with statewide population health objectives. Investing in enhancements to data availability and usability will strengthen decision-making and allow for proactive interventions that improve patient care.

- **Increased Collaboration:** A stronger partnership among hospitals, physicians, and HSCRC is needed to refine policies and ensure alignment with the goals of the TCOC Model. Encouraging a collaborative approach to policy development and implementation will enhance the effectiveness of high-quality, patient-centered care strategies across the state.

- **Workforce Stability**: Maryland's physician workforce is essential to delivering high-quality, patient-centered care. Efforts to strengthen physician recruitment, retention, and reimbursement alignment with TCOC objectives must be prioritized to ensure stable and sustainable care delivery, particularly in underserved communities.

- **Person-Centered Care for Chronic Disease Management and Reduction of Inappropriate ED Use**: High-quality, patient-centered care should be rooted in person-centered strategies that prioritize patient engagement, self-management support, and

coordination of care. Focusing on person-centered approaches could improve chronic disease management and lead to better long-term health outcomes. Policies changes should be considered to influence patient behavior and lower inappropriate emergency department use.

Improving Access to Care

A framework for improving access to care should ensure that all Marylanders receive timely and necessary health care services. Establishing a clear, comprehensive framework for evaluating and supporting access to care is essential to ensure that Maryland hospitals can continue to meet the needs of the communities they serve. Central to any strategy to improve access to care is to embrace a focus on MHA's priorities shared above. This includes implementing policies to support the financial health of hospitals to ensure that our hospitals are resourced to meet patients' baseline acute care needs. It also includes improving volume policies to sufficiently fund demographic growth and market shifts. As HSCRC develops measures and policies to promote equitable, high-quality access to care statewide, we appreciate the opportunity to share additional key considerations from the hospital field:

Key Considerations for an Access-to-Care Framework:

1. **Establishing High-Level Measures:**
   To effectively support improved access, HSCRC should implement standardized, broadly applicable metrics that provide a comprehensive view of health care availability and utilization. These measures should account for differences such as geographic variations, workforce capacity, and patient acuity to ensure meaningful statewide assessment and prioritization of funding.

2. **Hospital Effectiveness in Access to Care:**
   A robust access framework should consider multiple factors that impact a hospital's ability to meet patient needs. Specifically, evaluations should include:

- The complexity and volume of patients served, including growing populations of older adults and patients with chronic conditions requiring specialized care.
- The availability of non-hospital health care resources, such as behavioral health services, post-acute care options, and primary care providers, which directly influence hospital capacity and patient throughput.
- The rising costs associated with recruiting and retaining both contracted and employed providers, particularly in regions with health care workforce shortages.

3. **Addressing Policy Barriers to Access through PAU Funding:**
   Current policies related to Potentially Avoidable Utilization (PAU) funding may be overly restrictive and could inadvertently limit hospitals' ability to improve access to care. For example, the market shift policy does not account for PAU. MHA encourages HSCRC to reevaluate these policies to ensure they promote, rather than hinder, access to high-quality care.

While long-term strategies are necessary to create sustainable access-to-care solutions, immediate interventions are also critical to addressing the urgent challenges hospitals face. In particular, refinements to the demographic adjustment and volume policies must be prioritized, as these directly impact hospitals' ability to respond to changes in patient populations and care demand. Hospitals must be equipped with policies that reflect real-time shifts in demographics and service utilization, allowing them to adapt and maintain high-quality care for their communities. Without these key adjustments, hospitals may struggle to manage increasing patient complexity and volume, undermining broader access-to-care goals.

Cross-Cutting Policies

We appreciate HSCRC's proactive approach in soliciting feedback on cross-cutting policy areas for 2025. We welcome the opportunity to share the field's perspectives on hospital-based physician costs, facility conversions, and consideration of services that should be excluded under the state's global budget framework:

Policy Changes to Address Costs for Hospital-Based Physicians

Hospitals depend on a stable and well-supported physician workforce to provide high-quality patient care 24/7/365. However, increasing physician costs present a challenge within the current reimbursement framework. As we discussed above, MHA urges HSCRC to recognize physician costs as an essential acute care hospital expense and to provide a means for hospitals to cover these in payment policies. HSCRC action should be part of a broader effort to evaluate Maryland's physician reimbursement levels compared to other states and address existing disparities that may affect physician recruitment and retention.

Conversion of Facilities to Freestanding Medical Facilities or Other Lower Acuity Providers

The question of facility conversion is complex and requires careful consideration of health care access, community needs, and financial sustainability. MHA members have a range of perspectives on HSCRC's role in these discussions but emphasize the following principles:

- Any policy approach should be guided by a data-driven process to assess the appropriate inpatient bed capacity needed across jurisdictions in the intermediate and long term.
- The hospital field supports preserving hospital and health system autonomy in making facility conversion decisions to ensure transitions align with community health care needs and financial sustainability.
- Future discussions should explore incentives that encourage hospitals to convert more freestanding medical facilities to increase capacity and access.

Percentage of Revenue Under Global Budgets

Members provided diverse feedback on which services should be excluded from the Global Budget Revenue model. Among the services mentioned, obstetric care, hospital-at-home, and

advanced diagnostic imaging (e.g., MRI) were highlighted as areas that may benefit from a more flexible reimbursement model.

Conclusion

The MHA vision for today and for the future is to have healthy hospitals and healthy communities. This is an important moment for the Maryland Model as we transition to the AHEAD Model. Our hospitals will be central in the effort to improve health quality, health equity, and population health. They must be empowered and resourced to meet the challenge of caring for Marylanders who are aging and have increasingly complex health needs. HSCRC must act swiftly to adopt and implement policies that will support hospital sustainability and enable our hospitals to meet baseline patient needs, invest in care transformation and population health, and make needed capital investments.

Thank you again for the opportunity to comment on these important matters. 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

January 28, 2025

Re: Written Comment AHEAD

Dear Commission on HSCRC,

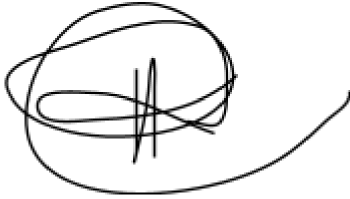
My name is Hakan Koymen and I am a pediatric dentist in the State of Maryland. I am writing during this period of "open comments" to discuss where pediatric dentistry will fit in the AHEAD Model. As a pediatric dentist, we see many young children with severe medical conditions, children with autism spectrum disorders, special needs, and/or generalized anxiety/ADHD that cannot be treated in the traditional dental setting or an Ambulatory Surgery Center (ASC). These children need to be seen under general anesthesia in a hospital setting to safely restore teeth with significant decay and extract those that are abscessed. In Maryland, there has been limited access to operating rooms for these cases because hospitals have been hesitant to provide valuable OR resources because the current payment model does not consider these dental cases.

With the AHEAD Model beginning in 2026, I feel that we have an opportunity to expand access to operating rooms for pediatric dental cases. My thought is that if you place pediatric dentistry in the "carve out" for AHEAD you would increase the number of hospitals that would be interested in seeing these children and we would create a situation where children of all socioeconomic strata, especially our most vulnerable children, would have equal opportunity for oral health. This would also significantly cut down costs for unnecessary ED visits for dental pain and abscesses which is where many of these children end up.

It also makes sense to put pediatric dentistry in the carve out, because our profession is not directly linked to the hospital. As dentists, we are not admitting children or providing comprehensive medical care to these children. They are being seen on an outpatient basis, and pediatric dentists are using the hospital to treat these children safely and once they are completed to continue their care outside of the hospital system.
Maryland has a history of bad outcomes due to dental neglect or the inability to have treatment performed in a timely manner. We only have to look as far as Deamonte Driver, who died of a dental abscess that went untreated because he couldn't be seen by a provider. With the current difficulties of limited access to operating rooms to treat these children with severe dental disease and dental pain/abscesses, we are setting up for another preventable tragedy to effect one of the children in our State.

I believe that the introduction of AHEAD allows us a window of opportunity to treat our most vulnerable population in an equitable fashion as we open the door for more hospitals to see these children and get the care they desperately need, while at the same time reducing ED visits. I urge the Commission to strongly consider including pediatric dentistry in the AHEAD carve-out to ensure equitable access to critical oral healthcare for all Maryland children.

Sincerely,



Hakan Koymen, DDS, MS
Diplomate, American Board of Pediatric Dentistry
Dental Director, Maryland Healthy Smiles–SKYGEN

1 **To:** **Jon Kromm, Executive Director**

2 **From:** **Dale Schumacher, MD, Mike Tennor, Alex Schumacher**

3 **Re:** **HSCRC Request for Comments Regarding Transformation and AHEAD –**
4 **Exploratory Analyses**

5 **Date:** **February 3, 2025**

6

7 Thank you for the opportunity to respond to the Commission's January 2025 request
8 relating to ensuring high value care, improving access to care and cross cutting policy
9 areas. We also appreciate the Commissioners' request to "engage more community input."

10 We suggest two sources of comparative organizational performance information:
11 workforce metrics as found in the National Academy for State Health Policy (NASHP)
12 database and the CMS metric, Medicare Spending Per Beneficiary (MSPB) (page 7).

13 Mathematica explored the NASHP Medicare Cost Report (MCR) database and reported
14 resource use trends related to workforce.[1] We are exploring NASHP data as part of a
15 university senior student project and we share early analyses, trend lines, and a portion of
16 a correlation matrix.

17 **Table 1. Derived From Mathematica – Change 2019 to 2022 of FTE Per 1,000 Discharges**
18 **and Direct Patient Care Hourly Rates for Massachusetts, Maryland, and Pennsylvania**
19 **Using NASHP Data**

State/Nation	Count of Hospitals Providing Data for This Variable	Change in Direct Patient Care FTE per 1000 Adjusted Discharges (%)	Change in Direct Patient Care Hourly Rate (%)
MA	59	9.0	17.1
MD	44	**20.7**	**29.5**
PA	154	6.0	23.4
Nation		5.8	25.0

20

[1] National Trends of Hospital Revenue, Profit, and Labor Costs: 2011-2022, May 2024

21 **EXPLORATORY PROJECT**

22 **Using updated December 20, 2024 NASHP data, we explore Maryland,**
23 **Massachusetts, and Pennsylvania reports.[2] The majority of MCRs were**
24 **2023 submissions.**

25 The updated tranche of NASHP 2023 data became available in December 2024. We explore
26 care labor costs and include Massachusetts and Pennsylvania hospitals for comparisons
27 with Maryland hospitals. The # listed in each table below is the Data Element from the
28 NASHP Data Dictionary.

29

30 **Table 2. #72.** Direct Patient Care FTE per 1000 Adjusted Discharges. "Count" is the count of
31 responses (the number of hospitals providing data for this particular variable).

State	Count of Direct Patient Care FTE per 1,000 Adjusted Discharges	Sum of Direct Patient Care FTE per 1,000 Adjusted Discharges	Average of Direct Patient Care FTE per 1,000 Adjusted Discharges	Median Direct Patient Care FTE per 1,000 Adjusted Discharges
MA	54	1,997	37	31
MD	44	2,582	**59**	**49**
PA	131	4,858	37	33

32

33

34 **Table 3. #75.** Direct Patient Care Hospital Labor Hourly Rate Employees.

State	Count of Direct Patient Care Hospital Labor Hourly Rate	Sum of Direct Patient Care Hospital Labor FTE	Average of Direct Patient Care Hospital Labor Hourly Rate	Median Direct Patient Care Hospital Labor HR
MA	55	$73,539.78	$59.68	$59.71
MD	44	$45,637.30	**$54.52**	**$52.02**
PA	134	$124,096.97	$49.87	$50.21

35

[2] https://nashp.org/nashp-hospital-cost-tool-4-0-launch/

36

37 **TABLE 4. #76.** Direct Patient Care Hospital Labor FTE

State	Count of Direct Patient Care Hospital Labor FTE	Sum of Direct Patient Care Hospital Labor FTE	Average of Direct Patient Care Hospital Labor FTE	Median of Direct Patient Care Hospital Labor FTE
MA	55	73539.78	1337.09	761.24
MD	44	45637.30	**1037.21**	**851.99**
PA	134	124096.97	926.10	525.74

38

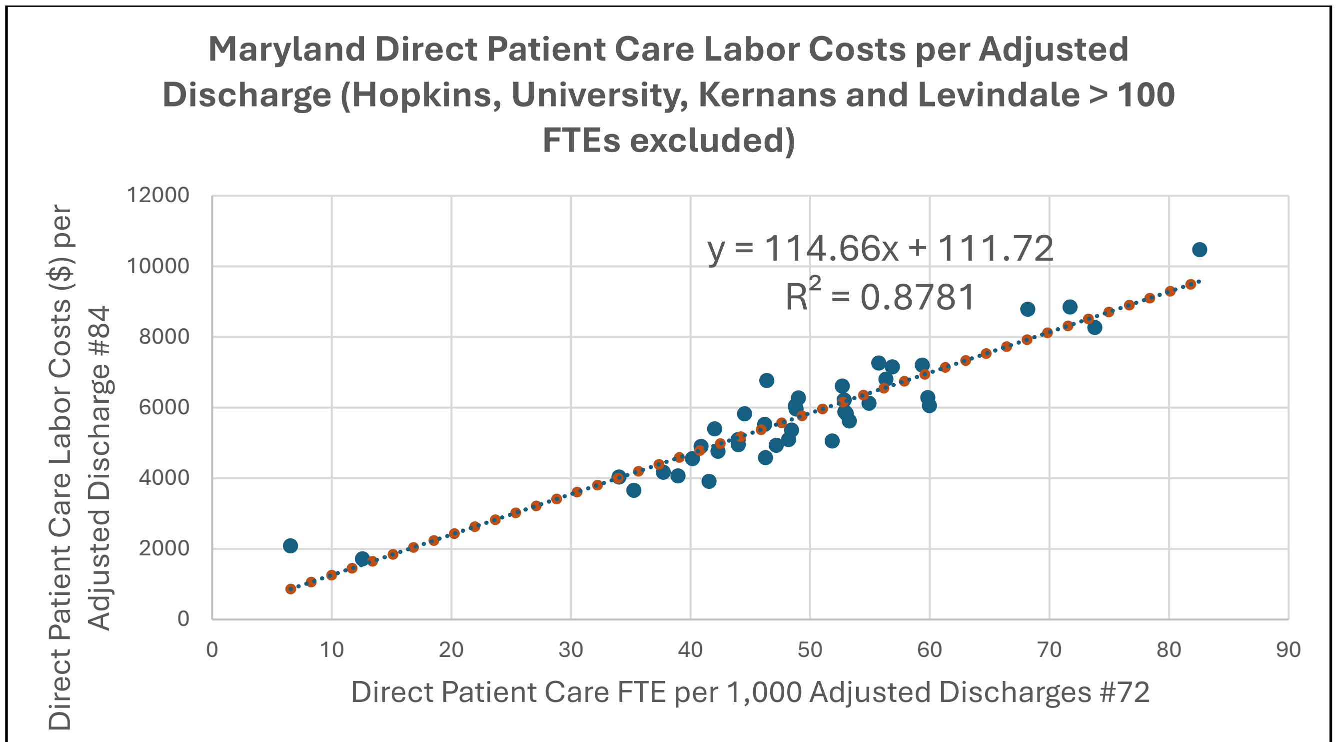
39

40 **Table 5. #84.** Direct Patient Care Labor Costs per Adjusted Discharge

State	Count of Direct Patient Care Labor Costs per Adjusted Discharge	Sum of Direct Patient Care Labor Costs per Adjusted Discharge	Average of Direct Patient Care Labor Costs per Adjusted Discharge	Median of Direct Patient Care Labor Costs per Adjusted Discharge
MA	54	$261,019	$4,834	$4,092
MD	44	$296,771	**$6,745**	**$5,854**
PA	131	$525,913	$4,015	$3,676

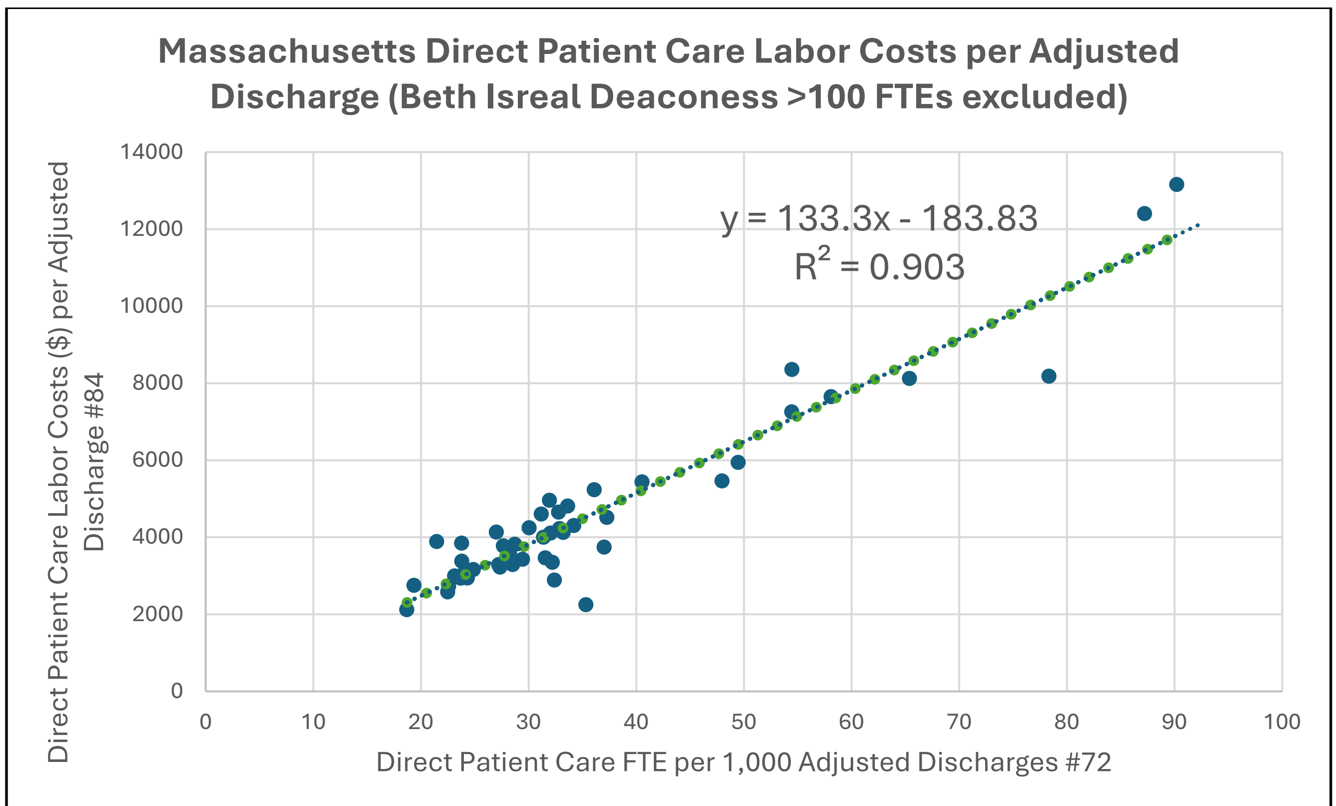
41

42 **Figure 1.**



43

44 **Figure 2.**



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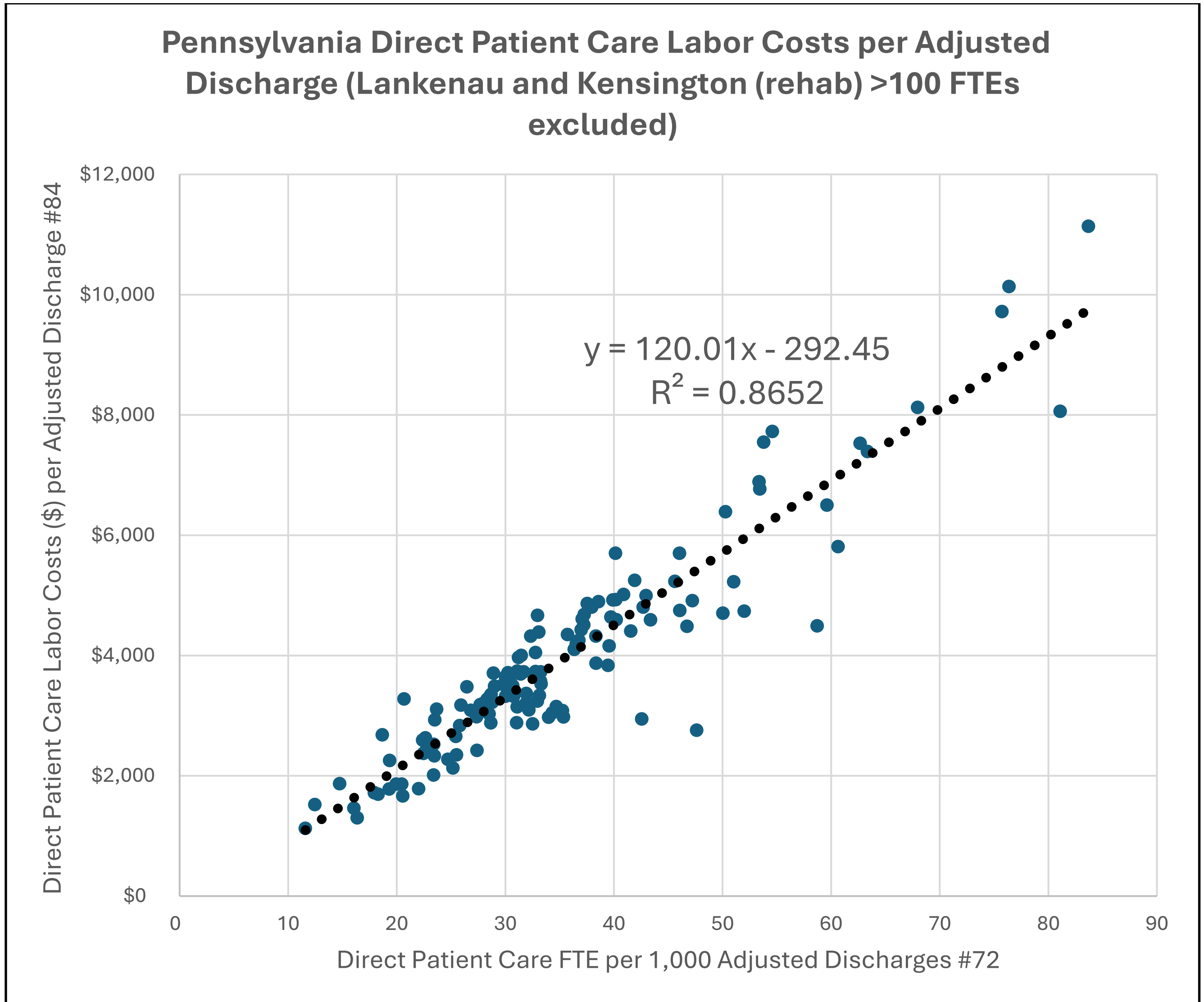
46 **Figure 3.**



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50 # EXPLORATORY PROJECT – CORRELATION MATRIX

51

52 **Table 6.** Correlation Matrix, Maryland, NASHP Data Elements, Selected Cells – Discussion
53 Draft

Data Element Definitions	Direct Patient Care FTE per 1,000 Adjusted Discharges	Direct Patient Care Hospital Labor Cost	Direct Patient Care Hospital Labor Hours	Direct Patient Care Hospital Labor Hourly Rate
Direct Patient Care Labor Costs per Adjusted Discharge	0.98	0.28	0.29	-0.19
Hospital Operating Labor Cost	0.19	1.00	0.99	0.04
Direct Patient Care Labor Cost as % of Hospital Operating Labor Cost	-0.16	0.33	0.30	0.20
Direct Patient Care Contracted Labor Cost as % of Direct Patient Care Labor Cost	0.33	0.09	0.09	-0.23
Direct Patient Care Contracted Labor FTE as % of Direct Patient Care FTE	0.46	0.21	0.18	0.05
Direct Patient Care Labor Cost per FTE	-0.26	0.07	-0.05	0.98
Management and Administrative Labor Cost per FTE	-0.15	0.23	0.17	0.48

54

55 ## Findings

56 Maryland, Massachusetts, and Pennsylvania have differing labor use and cost
57 patterns for 2023 as shown in MCRs as provided in the NASHP database. As
58 illustrated in the above tables and figures. For example, Maryland reports
59 higher FTEs per patient than Massachusetts or Pennsylvania. The Maryland-CMS
60 AHEAD agreement is not explicit regarding workforce vis-a-vis cost and quality. The
61 AHEAD project should consider and take into account these variations and
62 whether there is an impact on access.

63

64 ## Medicare Spending Per Beneficiary

65 The Commissioners asked, how can the payment system better recognize effective efforts
66 and identify objective criteria of utilization decline. The Medicare Spending Per Beneficiary
67 (MSPB) metric meets these needs. MSPB is developed from index admissions and includes
68 claims data three days prior to admission and 30 days post discharge. Figure 4 is one of
69 several reports provided by CMS.[3] CMS also considers MSPB to be a Population-Based
70 Cost Measures[4] This measure can be implemented to provide service line performance, a
71 measure more understandable to physicians vs population total cost of care measures.
72 MSPB excludes a defined list of services that are unlikely to be influenced by the clinician's
73 care decisions and are, thus, considered unrelated to the hospital admission.

74 **Figure 4.** Excerpt from Example MSPB Report[5]

Table 5: Detailed Hospital VBP Program MSPB Hospital Spending Breakdowns by Claim Type

HOSPITAL NAME

Hospital Discharge Period: January 1, 2023 through December 1, 2023

Claim Type	Hospital Spending Per Episode [d]	Hospital Percent of Spending [e]	State Percent of Spending [f]	U.S. National Percent of Spending [g]
Total 3 Days Prior to Index Admission [a]	**$886**	**4.4%**	**3.1%**	**3.7%**
Home Health Agency	$6	0.0%	0.0%	0.1%
Hospice	$0	0.0%	0.0%	0.0%
Inpatient	$0	0.0%	0.0%	0.0%
Outpatient	$91	0.5%	0.5%	0.7%
Skilled Nursing Facility	$1	0.0%	0.0%	0.0%
Durable Medical Equipment	$10	0.0%	0.0%	0.0%
Carrier	$778	3.9%	2.5%	2.8%
Total During Index Admission [a] [b]	**$11,620**	**57.9%**	**53.4%**	**53.8%**
Home Health Agency	$0	0.0%	0.0%	0.0%
Hospice	$0	0.0%	0.0%	0.0%
Inpatient	$10,296	51.3%	47.0%	47.6%
Outpatient	$0	0.0%	0.0%	0.0%
Skilled Nursing Facility	$0	0.0%	0.0%	0.0%
Durable Medical Equipment	$29	0.1%	0.1%	0.1%
Carrier	$1,295	6.5%	6.3%	6.1%
Total 30 Days After Hospital Discharge [a] [b] [c]	**$7,563**	**37.7%**	**43.5%**	**42.5%**
Home Health Agency	$566	2.8%	2.6%	2.9%
Hospice	$289	1.4%	0.3%	0.8%
Inpatient	$2,033	10.1%	10.7%	14.5%

75

[3] CMS Reviewing Your FY 2025 Hospital VBP Program, Medicare spending Per Beneficiary Hospital Specific Report, June 5, 2024

[4] 2024 Summary of Cost Measures, CMS Quality Payment Program, 2024

[5] https://data.cms.gov/provider-data/topics/hospitals/payment-value-care

76 Implementation of MSPB would be straightforward. All states other than Maryland
77 participate in the Value Based MSPB reporting. The MSPB program was initially
78 implemented in CY 2014. Because of Maryland's unique non-DRG rate setting MSPB
79 reporting was not required. That policy was changed in 2018 to include Maryland (80 FR
80 71297). The AHEAD program requires submission of Medicare claims sufficient for MSPB
81 measurement.

82 In summary, MSPB provides national and local comparisons. Utilization can be linked to
83 quality measures at the beneficiary level. These comparisons are accepted and
84 understood by the physician community.[6] MSPB can complement EQIP. CMS routinely
85 produces multiple MSPB reports so production costs are minimal and CMS or its
86 contractors provide training for data interpretation. The HSCRC is encouraged to consider
87 adoption of MSPB as a provider performance metric for systems, providers, and
88 practitioners.

[6] Following comprehensive re-evaluation, the measure was re-endorsed in June 2021 by the consensus-based entity under contract with CMS. Following the re-endorsement, the re-evaluated measure was included in CMS's "List of Measures Under Consideration for December 1, 2021" (MUC2021-131) and then underwent review by a CBE-convened multistakeholder group then called the Measure Applications Partnership during the 2021-2022 cycle, where the measure received support for rulemaking.

January 31, 2025

RE: HSCRC statement

Access to care

To Whom it May Concern:

I am not a subject matter expert, but I can offer an example of our inability to access a particular procedure in our community and state. My husband and I have lived in Montgomery County since 1986. We have always experienced excellent and accessible health care, that is until recently. In 2018, my husband Mike was diagnosed with minimal cognitive impairment, in 2020, Alzheimer's Disease and in 2021 Parkinsonism. He has a pacemaker. Over time, these diseases have progressed, particularly his right tremor, which impacts his quality of life. Our neurologist made us aware of a particular routine procedure, Focused Ultrasound, that has been very successful in eliminating tremor. With my husband's complex diagnosis, our neurosurgeon was unable to schedule this procedure in the State of Maryland due to the lack of access to specialized equipment. Ultimately, we have scheduled the procedure out of state, with a different neurosurgeon. The lack of access to treatment for this procedure, with a Maryland neurosurgeon, in the state of Maryland, was disappointing. It has created a significant delay in treatment for my husband and will require us to spend time, travel, and have an additional financial burden to access a treatment that could have been offered in Maryland. In the future, what is your plan for handling situations like ours? Please do not hesitate to reach out to me if you have additional questions about our experience.

Beth Matcham Shepherd

Michael Shepherd

301-648-9424

bmshepherd@yahoo.com

TidalHealth™

Executive

100 E. Carroll St.
Salisbury, MD 21801

O 410-543-7111
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February 3, 2025

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

Dear Dr. Kromm:

TidalHealth, Inc. ("TH") is responding to your request for comments related to Health Service Cost Review Commission ("HSCRC") policies that support goals of the AHEAD Model. We appreciate the opportunity, and we know that critical changes are needed so that the citizens of Maryland, regardless of where they live, have the needed access to healthcare services.

There are foundational issues that exist in the current Total Cost of Care Model that need to be fixed to ensure that we can meet what is required in the AHEAD Model, but most importantly, for us to be able to provide medically necessary care to our patients. These issues continue to be raised by us and others and without correcting the foundation will create major roadblocks for further improvement and meeting the goals of the AHEAD Model.

These foundational issues are around adequacy of the global budget revenue by recognizing full inflation and appropriate volume growth, while addressing inefficient Hospitals.

(1) Adequacy of the update factors given the rising cost pressures and increase in payor denial

The cost pressures referenced in the Maryland Hospital Association's letter related to growth in physician hospital-based subsidies. deferring capital needs, and increased payor denials is something we are experiencing, as well as other cost pressures. COVID funding masked the true financial picture and in FY26, we will need adequate funding for us to maintain a small operating profit. It is also necessary to proactively fund our GME program, as requested for several years, through a Rural GME Policy so we can plan and provide stabilization to our financial outlook.

Additionally, the HSCRC should move forward with the financial feasibility study that was supposed to be performed given the continued declines in hospital margins. The Industry has completed a financial feasibility study that shows unacceptable erosion in hospital financial performance.

(2) Fully recognizing demographic growth in methodologies

In FY 25, only .25% of the actual 4.25% of age adjusted population growth was funded statewide with TidalHealth Peninsula Regional Hospital("THPR") being funded only .38% of their actual 6.85% of age adjusted population growth. This is only a recent year example, but the cumulative impact is material.

This gap in funding significantly contributed to excess total cost of care savings. This has harmed the State as a whole, but certain areas of the State, like the Eastern Shore of Maryland, have been impacted more given their demographics. Current excess savings should be used to fund this differential, and policies should be revised to adequately fund for these changes going forward.

(3) Rebalancing the funding between efficient/non-efficient hospitals.

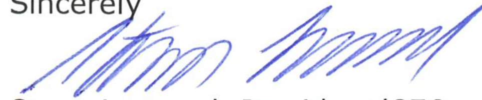
There is a wide disparity in base rates between hospitals. The cumulative funding difference between TidalHealth and other non-efficient Hospitals has created community inequities that should be corrected. Several recommendations would be:

(a) Create a standard base rate for all hospitals before add-ons, such as Graduate Medical Education, Labor Market differences, etc.
(b) Reduce excess Hospitals/Services in areas of the State by enforcing current policies and creating new policies that provide an equitable funding structure to free up funding to be redistributed; and
(c) Align HSCRC and Maryland Health Care Commission work around healthcare system needs to address adequacy of services in different counties and regions in the State.

We hope that the HSCRC will develop solutions to these on-going issues and not build on the current foundation to ensure that Marylanders regardless of where they live have access to their care needs and that Hospitals and providers caring for them receive equitable and appropriate funding levels. Attached is additional input to your specific questions.

Thank you again for providing us an opportunity to comment. We hope you take into consideration our on-going concerns.

Sincerely



Steve Leonard, President/CEO
TidalHealth Inc.

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

Attachment:

1. Ensuring High Value Care. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts? Medically necessary care needs to be adequately funded. Without adequate funds delay and rationing of care exists.

e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them? Our community needs assessment identifies our priorities and funding needs/models. Because of the prior work, TidalHealth Peninsula Regional has invested in a rural GME Program as a way to address physician shortages, access to care barriers, and the ability for patients to be cared for closer to home. These programs have attracted practicing Physicians to communities, as well as created a pipeline for the future. The HSCRC can support this by finalizing a Rural GME Policy.

2. Improving Access to Care. Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

d. Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health? This was addressed in our letter, and we believe age adjusted population growth should be funded.

3. Other topics. There are several cross-cutting policy areas that could also be addressed in 2025.

a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education? HSCRC should fund GME in rural facilities and adopt the draft policy we shared to create needed stability as we build these Programs. HSCRC could provide a set funding level in the GBR based on provider specialty for hospital-based physicians and adjusted for payor-mix to adjust for lower payments by certain payors.

b. Facility conversions. Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to

free-standing medical facilities or other lower acuity providers? Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process? We agree that HSCRC should address Hospitals that have excess capacity and high costs. We believe that a majority of the Hospitals that have excess capacity are located in Baltimore City/County and as opposed to conversion, we believe that selective closing should be considered. We believe the current Integrated Efficiency Policy can be used to guide this process with rate reductions for high-cost hospitals.

c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home? HSCRC should consider additional funding mechanisms for rural facilities given their large geographic coverage area to provide mobile/stationary clinics and home-based services not covered by Home Health, such as primary care, behavioral health, routine screenings, etc. The HSCRC could consider funding new technologies like the Center for Medicare and Medicaid Services.

250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829

CORPORATE OFFICE

February 3, 2025

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

RE: Priority issues as Maryland prepares to enter the States Advancing All-Payer Health Equity Approaches and Development ("AHEAD") Model

Dear Dr. Kromm:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, I appreciate the opportunity to provide input on policy priorities as we prepare for the AHEAD Model. This truly is a critical period in terms of setting the foundational framework for the next ten years of our Model.

UMMS is committed to driving the AHEAD Model's goals of high-value care, fairness in access to care, and equitable outcomes in the communities we serve. Throughout our time on the Total Cost of Care Model, we have committed to being a leader in implementing valid, data-driven efforts to identify where disparities exist and work in partnership within our communities to design interventions to address them, directing differential effort toward our most underserved communities. We have built a robust data infrastructure and analytic process that target supports system-wide action plans that are developed and implemented at the hospital level, targeting leading health indicators such as severe maternal morbidity, unplanned readmissions, and diabetes.

The AHEAD Model's ambitious goals, combined with the Maryland Model's unique payment tools, represent a major opportunity to establish Maryland as a national leader in transformative care. UMMS has demonstrated its commitment to those goals through its efforts to date, but we cannot go further without the financial stability and policy foundation to do so. To truly work toward these goals, our Model must address the considerable financial pressures that continue to plague Maryland's hospitals. We have absorbed years of depressed operating performance, unable to invest in critical facility needs, program improvements, innovative technology, and population health strategies. The prolonged inability to make these investments absolutely puts us behind in AHEAD preparedness and produces unnecessary risk for Maryland citizens in terms of access to high quality hospital services. Considering the significant excess savings being generated by the Model, we certainly have the resources to address that risk.

Our hope is that the Commission's opportunity for comment kickstarts a process that delivers both the investment in resources and the policy evolution necessary to establish a solid foundation for long-term viability of AHEAD. Once again, the strength of our Model is we can address our problems in a way that is unachievable under payment models in other States.

UMMS is committed to being an active, engaged participant in this important work. While our complete responses to your questions are included with this letter, I consider the following to be the highest priorities for change. Addressing each of these issues is essential to putting the Model on a sustainable path to long-term success under AHEAD:

1. **Our payment model must evolve to better addresses the needs of Academic Medical Centers ("AMCs").** AMCs are leading clinical and teaching institutions that are deeply embedded in their communities, specializing in the most complex and difficult diagnoses and treatments, educating the next generation of health professionals, and advancing healthcare. AMC research provides important new knowledge leading to advances in understanding and treatment of diseases, including conducting innovative clinical trials to make new treatments available quickly and safely. Our Model must better support this vital role by carving tertiary and quaternary care out of GBR constraints and providing more funding pathways to drive continual reinvestment in the academic mission.

2. **Stabilize hospitals' current financial outlook and create mechanisms to better allow hospitals to share in the success of the Model.** Model savings, appropriately generated, represent the success of our collective efforts. We cannot continue to allow 100% of savings beyond Model targets to accrue to payer savings. Effective value-based models engage their provider partners in continuous transformation by allowing them to share in the successes, serving as a necessary source of financial stability and re-investment in model goals. I cannot emphasize enough that resource-starved hospitals will not achieve the transformation envisioned by AHEAD. Tools like the Medicare Performance Adjustment should be linked directly to Model performance and designed to allow hospitals to share both the benefits of Model success and accountability for poor performance, similar to an ACO shared savings structure nationally.

3. **We must address the issues with volume policy through the lens of access to care.** While we understand the Model's intentional linking of financial incentives to volume reduction and recognize that this has been a critical tool in terms of fundamentally changing the way hospitals think about volume, we also believe that providing appropriate resources for medically necessary care is essential to ensuring access to needed services. Our Model should always strive to generate savings through care transformation and population health improvement, rather than through underfunding of medically necessary care. There are several areas where volume policy refinement would significantly improve the Model's ability to achieve that goal. Specifically, a comprehensive review of the demographic and market shift policies is needed.

4. **We must define the driving characteristics of an effective hospital in the context of the AHEAD Model, and rethink the integrated efficiency policy, among others, on those terms.** The goals of high-value care, fairness in access to care, and equitable outcomes require significant, differential investment in our highest need communities. Hospitals in urban and rural communities must differentially invest in equitable access, quality care, and outcomes. This need for differential investment funds cannot be labelled as inefficiency. We absolutely need to engage in a process to define an "effective" hospital in the context of AHEAD goals and hold hospitals directly accountable to that definition. As it stands, with a bottom quartile overwhelmingly populated by urban and rural hospitals in high need communities, the current efficiency metric as designed acts as a barrier to investment in our communities of highest need and compounds with increased reporting/regulatory burden to these critical hospitals and communities.

5. **We must rethink the policy approach to population health accountability.** In our experience, implementing hospital-level accountability for transformation across a broad range of hospitals hinges on some important themes: data-driven accountability, maximizing engagement, translating broad-based goals into actionable performance, a root-cause analytic approach, and rewarding success. Too often the State's TCOC tools focus on identifying macro/population-level measures without translating these broad-based metrics to more specific measures that hospitals and providers understand how to engage in and contribute to progress. This lack of engagement stunts transformation and innovation but the HSCRC is designing policies still able to guarantee that savings goals are met. We strongly believe that change in the way we collectively approach policy making and tools available to support hospitals in this space is necessary for success. UMMS would fully engage in a multi-stakeholder evaluation of existing TCOC policies through this lens.

Because we serve so many communities in Maryland in so many ways, UMMS is deeply invested in the success of the Maryland Model, and I believe strongly that we must act to stabilize hospitals, evolve our policies, and position ourselves for a better future under AHEAD. As I said at the outset, this truly is a critical period in terms of setting the foundational framework for the next ten years of our Model. I am certain that if we do not take on these priorities, we will not achieve our goals. UMMS looks forward to collaborating with our State partners over the coming months on this important work.

Sincerely,

Mohan Suntha, MD, MBA
President and Chief Executive Officer
University of Maryland Medical System

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

ATTACHMENT: UMMS Responses to HSCRC Call for Input

UMMS appreciates the HSCRC's request for input on policy evolution and investments needed to position Maryland for success under the AHEAD Model and strongly aligns with the industry's position outlined through MHA. We recognize that many of these questions pertain to broad questions of "how should we define?", "how can the system best support/engage?", and "what is the appropriate accountability tool?". When considering these questions, we believe that the key in many cases is to establish a data-driven, multi-stakeholder approach for established priorities whose intent is to define key indicators, partners, their roles in success, and agreed upon performance metrics. Along those lines, UMMS can offer the following input on the HSCRC's policy approach that apply broadly across the set of questions:

- **Identify and address the driving areas where under resourcing contributes to financial barriers to success.** UMMS absolutely agrees with the Maryland Hospital Association ("MHA") top concern that hospitals must come from a position of financial stability to maximally engage in the transformative goals of the AHEAD Model. Providing appropriate resources to ensure equitable access to medically necessary services, to address workforce shortage and inflationary pressures, and to address capital needs are core enabling factors for engaging in the more transformative goals of the Model. Policies such as the annual update factor, demographic adjustment, and capital funding policy should focus on providing sufficient resources to address needs.

- **Establish a data-driven, multi-stakeholder approach to policy building.** Many of the priorities contemplated by the questions would benefit considerably from convening stakeholders, including clinical and industry expertise, to engage in a data-driven process to identify specific drivers or indicators associated with the desired policy goal, defining the role of hospitals and providers in impacting those indicators, and designing performance measures that directly incent hospitals on those terms. To be successful, policies must engage providers in identifying goals, translate those broad goals into discreet, actionable performance metrics that hospitals and providers can engage in, and provide direct rewards for achievement. Once the policies are deployed, there should be an iterative learning system and support network at the State level to ensure hospitals do not need to duplicate policy resources internally and can focus on operationalizing the work. This process should be applied to many priority areas, including:
    - What signifies an effective hospital and designing efficiency metrics on those terms
    - Definitions and accountability for Potentially Avoidable Utilization ("PAU") and low-value care
    - Total cost of care and population health accountability tools, including AHEAD population health and equity measures
    - Ensuring volume policies promote equitable access to care

- **Avoid layering multiple policy incentives into single policies.** Instead, directly incent what you want through defined performance metrics, engaging stakeholders in the process of translating broad-based goals into specific performance expectations. It is better to have many directly incented things than

many things layered into one incentive. This disrupts the stakeholder's ability to engage in the incentive and translate into distinct actions.

Beyond those broadly applicable areas of input, UMMS offers the following responses to the HSCRC's questions around ensuring high-value care, improving access to care, and other topics.

Ensuring High Value Care: *A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.*

a. *How can the payment system better recognize effective efforts to improve health?*
b. *How can the HSCRC best identify opportunities and support the development of such efforts?*
c. *How might the HSCRC work with hospitals, physicians, and other partners to reduce low-value care?*
d. *Should the HSCRC consider alternative or complementary approaches to PAU?*
e. *How might the HSCRC support planning needs to drive innovative and affordable care models?*

UMMS offers the following input on where the HSCRC's policy approach can evolve with the goal of creating a regulatory environment that fosters innovative and affordable care models to improve health:

- **Rethink the policy approach to population health accountability.** The State's TCOC tools tend to identify population-based measures without translating these broad-based metrics to discreet, actionable performance measures. In our experience, implementing hospital-level accountability for transformation across a broad range of hospitals hinges on some important themes: data-driven accountability, maximizing engagement, translating broad-based goals into actionable performance, a root-cause analytic approach, and rewarding success.

- **Think overtly about accountability and governance for non-hospital investments.** As goals expand outside the hospital regulatory system, accountability and governance must also be bolstered in these settings in a way that supports and integrates the hospital model with other pieces of the care continuum. Maryland hospitals have supported statewide investments in regional partnerships, MDPCP, Medicaid etc. and accountability for outcomes should be prioritized to ensure a collective and fair system of change.

- **Create tools to allow hospitals to share in the success of the Model as a source of continuous investment in transformation.** Excess savings beyond what the Model requires represent the success of our collective efforts. Effective value-based models engage their provider partners in continuous transformation by allowing them to share in the successes, serving as a necessary source of financial stability and re-investment in model goals. Specifically, the Medicare Performance Adjustment should be linked directly to Model performance and designed to allow hospitals to share both the benefits of Model success and accountability for poor performance and the CTI policy should consider payment of savings beyond a statewide neutral offset if the model performance is positive

- **Create tools to directly invest in efforts to achieve desired outcomes.** Leverage the unique payment mechanisms available to make direct investments in identified priorities. Hospitals need the ability to approach this work similarly to capital or grant planning, the permanent funding sources available to support five-to-ten-year plans to impact health outcomes.

- **Rethink the policy approach to Potentially Avoidable Utilization ("PAU").** In general, UMMS believes the HSCRC should de-emphasize "PAU in all policies" in favor of penalty/rewards directly linked to desired outcomes**.** The HSCRC should convene a multi-stakeholder group to identify specific volume types that the hospitals commit to positively impacting, define actionable performance measures, and assign performance accountability for hospitals on those terms. PAU and other methods of calculating 'waste' should also have robust clinical stakeholder input and leave room for specification and refinement to a Maryland context.

Improving Access to Care: *Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.*

a. *How can the HSCRC develop more useful measures of needed access?*
b. *Should the HSCRC consider policy to slow the rate of volume declines related to ER wait times?*
c. *What, if any, changes are appropriate to HSCRC's volume policies to support access to needed care?*
d. *How should the adjustment for statewide population growth be changed?*
e. *Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals?*

UMMS offers the following input on the HSCRC's policy approach to volume and access to care:

- **Use the 10% carve out to protect access for complex care (high-cost drugs, tertiary care, quaternary care), particularly at the Academic Medical Centers ("AMCs").** Our Model must support the vital role of AMC by carving tertiary and quaternary care out of GBR constraints and providing more funding pathways to drive continual reinvestment in the academic mission.

- **Volume policies should cover the cost of doing medically necessary work.** The financial impact each additional amount of work has on a hospital has a direct impact on access. If "doing more" of a necessary thing has a negative financial impact (instead of a neutral impact), the consequence is that the hospital is incented to restrict, not meet, access. Volume policies should fund the cost of doing medically necessary work, as long as it is within the expectation of year-over-year change. Covering the cost of doing medically necessary work supports access without abandoning population-based payment or creating an excessive financial incentive. Conversely, policies that intentionally underfund the cost of medically necessary care risk creating an adverse incentive to restrict access. UMMS believes the HSCRC should evaluate market shift and demographic policies through this lens

- **Define the driving characteristics of an effective hospital in the context of the AHEAD Model, and rethink hospital efficiency policies on those terms.** The goals of high-value care, fairness in access to care, and equitable outcomes require significant, differential investment in our highest need communities. Hospitals in urban and rural communities must differentially invest in access and outcomes, and yet, having higher GBRs makes them perform worse on the existing efficiency metric. UMMS agrees that we need to define an "effective" hospital in the context of AHEAD goals and hold hospitals directly accountable to that definition. As it stands, the current efficiency metric is not that solution and risks acting as a barrier to investment in our communities of highest need.

- **Do not layer other goals onto volume funding as gatekeepers to appropriate volume funding.** While issues such as ED wait times, low value care, and hospital effectiveness are appropriate priorities, they should be defined and incented directly based on valid performance measures.

Other topics: *There are several cross-cutting policy areas that could also be addressed in 2025.*

a. *What, if any, special considerations should be made for physician costs?*
b. *Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?*
c. *What additional volumes should the Commission consider carving out of GBR?*
d. *What other major changes to policies under the Maryland Model of population-based payment should be considered? Please be as specific as possible.*

Issues such as how to address the growing burden of physician costs, payer denials, facility conversions, and graduate medical education are important to the long-term success of our model and would benefit considerably from convening stakeholders to define the desired policy goals, evaluate policy options, and define how hospitals and providers would interact with them. UMMS encourages the HSCRC to engage stakeholders in discussions of these issues.

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Date January 31, 2025

RE: HSCRC Opportunity for Comment

To Whom It May Concern at Health Service Cost Review Commision:

The way these questions are posed distracts from what many providers see as problematic. As a neurosurgeon, my concerns differ from those of primary care. My practice depends on a robust inpatient system for high-quality treatment of complex diseases and injuries in Montgomery, Frederick, Howard, and Prince George's Counties. The global budgeting system is failing Maryland's patients. They should receive care close to home, not have to travel long distances. This system restricts hospital growth and the addition of vital technology, setting procedure limits based on cost rather than quality.

Various hospitals are indicating the need to limit certain surgeries due to their high cost. This affects access to care for patients with chronic diseases such as epilepsy, Parkinson's Disease, and essential tremor. While these treatments are expensive, they significantly enhance quality of life and increase productivity. Due to global budgeting that focuses on cost and volume rather than outcomes, care is being restricted, resulting in doctors referring patients out of state. The financial constraints on hospitals, which affect their ability to monitor quality and invest in programs to improve patient access and care quality, may eventually compel physicians and patients to seek alternatives elsewhere.

That all being said, I will attempt to address the questions that I believe I can.

1a. I am unsure of the validity of the premise only because I am not exposed to this part hospital programming and efforts. However, if there was a methodology that money spent on after discharge planning, physical therapy, adherence to medication, and ensuring outpatient follow up, could be discounted from the budget this might decrease financial strain. This encourages preventive care and helps prevent re-admission. It is my assumption that these programs can be use not only outside the GBR but be allowed to make money (home nurse visits, PT charges, remote patient monitoring).

1b. CRISP has been a tremendous help in ensuring that imaging studies and other tests do not get repeated, and that information is available from multiple sources to the providers. Expanding on this by incentivizing all systems, hospitals, labs, etc. in the MD, VA, DC, Delaware region participate would be helpful. Not all systems participate.

1c,d,e and beyond.

HSCRC has done a very poor job communicating with physicians directly and allowing us to understand "low value care" concerns. This is communicated only to hospitals. There seems to be an assumption that the hospitals are effectively communicating this to the physicians. This may be true in an employed model. However, many physicians in the state of Maryland are not employed by hospitals or large institutions. These physicians need effective

communication to what the state perceives to be low value care. This should be done in an evidence-based manner. I am somewhat dubious of the low back surgery example presented here. There were several assumptions made in the methodology. The first assumption is that the chart reviews adequately screened the exams and histories - were radicular symptoms or other "acceptable diagnoses" missed and should have been included? The second assumption is that the surgeries "didn't work." I see no review of the outcomes - improved Oswestry disability index (ODI) scores, decreased opiate use, return to work and independence. All of these have a positive impact on the individual as well as society. These "low value" procedures need better examination; the baby should not be thrown out with the bath water. That is to say that a surgery that might be costly, may have a considerable positive impact on the patient. Again, this is a case where the HSCRC places cost over outcomes. There must be a way to look at physician outcome based on length of stay, complication and outcome measures (opiate use, ODI, return to work, diminished physician visits, QOL measures). When a surgeon or facility is better than their peers or peer institutions or has a better reputation for a particular procedure or treatment protocol for a given disease or condition, more people will seek treatment there. This increase in volume may negatively impact the budget until adjustments are made. This penalizes the facility, prevents important reinvestment and growth. This seems counterintuitive to aims of the system. The HCSCRC needs to look not only at cost and volume, but outcomes and quality.

Beyond these questions I would like to address how this system impacts my patients, the patients of my peers and our practices. The GBR penalizing residents in areas where the local facility is not given the opportunity to invest and grow to serve their community. Hospitals must stay within budget and therefore cannot invest in new capital equipment or new technology to serve their local community. By consequence, residents need to travel outside their community for care. This migration is not just in state - many patients are seeking treatment in West Virginia, Virginia and the District of Columbia. These jurisdictions are not limited by the budget constraints of the HSCRC. Physicians seeking to use up-to-date, modern, or innovative equipment are stymied by the inability for hospitals to make money for reinvestment. These physicians are migrating out of the state to seek other to treat their patients. State funded or private, well-endowed universities have deeper pockets to fund these endeavors, but they are only located in Baltimore. Even the most well-endowed institution is using D.C. to offload patients for radiation treatment as this is outside the clutches of the global budget. Other larger healthcare systems transfer patients from their Maryland facilities to their D.C. counterparts to escape this system as well. This undercuts those facilities who are solely Maryland based. The cost of transfer should be part of the budgetary calculation, and these practices need monitoring. This practice pulls patients from their community and families when proximity for emotional support is paramount and an essential part of the healing process.

The goal of containing cost is laudable, but the methodology of the HSCRC has curtailed innovation of care, and Maryland community hospitals are being left behind. Residents in these communities are seeking care elsewhere and the physicians are seeking other facilities to render this care. The experiment of global budgeting has failed. When neighboring states have better opportunities, shorter wait times and more innovative care, the system does not work. I urge

the HSCRC to abandon the idea of Global Budgeting as method of cost containment. Seeking higher quality is more important than containing costs. Would you want your family to have the highest quality of care of least costly care? Not that these are mutually exclusive, but quality is more important than cost for those we love, right?

Sincerely,

Zachary T Levine MD FAANS
President Washington Brain & Spine Institute
Director of Neurosciences, Adventist Healthcare

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: February 12, 2025

RE: Hearing and Meeting Schedule

March 12, 2025 In person at HSCRC office and Zoom webinar

April 9, 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.

The Health Services Cost Review Commission is an independent agency of the State of Maryland
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