



**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 and December 19, 2024

**Specific Matters**

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

Docket Status – Cases Closed

2. Docket Status – Cases Open

2668R Johns Hopkins Howard County Medical Center

**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 and High Value Care Plans

5. Final Recommendation: Nurse Support Program II - Program Renewal
6. Draft Recommendation: Readmission Reduction Incentive Program (RRIP) for RY 2027
7. Presentation: Episode Quality Improvement Program (EQIP) and Care Transformation Initiatives (CTI) Results
8. Legislative Update
9. Medicare Advantage Discussion
10. Hearing and Meeting Schedule

**MINUTES OF THE**  
**627th MEETING OF THE**  
**HEALTH SERVICES COST REVIEW COMMISSION**  
**January 8, 2025**

Chairman Joshua Sharfstein called the public meeting to order at 12:12p.m. In addition to Chairman Sharfstein, in attendance were Commissioners James Elliott, M.D., Ricardo Johnson, Maulik Joshi, DrPH., Adam Kane, J.D., Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Joshi and seconded by Commissioner Johnson, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:18 p.m.

**REPORT OF DECEMBER 19, 2024, COMMISSION RETREAT AND**  
**JANUARY 8, 2025, CLOSED SESSION**

Mr. William Hoff, Chief of Audit and Integrity, provided summaries of the discussions from the Commission retreat held on December 19, 2024, and the Closed Session held on January 8, 2025.

**ITEM I**  
**REVIEW OF THE MINUTES FROM DECEMBER 11, 2024, PUBLIC**  
**MEETING AND COMMISSION RETREAT DECEMBER 19, 2024**

Chairman Sharfstein proposed consideration of two distinct motions: one for the approval of the minutes of December 11th, and a second for the approval of the minutes of December 19th. Upon motion made by Commissioner Sabi and seconded by Commissioner McCann, the Commission voted unanimously to approve the minutes of December 11, 2024, for the Public Meeting and Closed Session and to unseal the Closed Session minutes. A second motion was made by Commissioner Sabi and seconded by Commissioner McCann, and voted upon unanimously by the Commission to approve the minutes of December 19, 2025, from the Commission retreat.

**ITEM II**  
**PRESENTATION BY JOHNS HOPKINS ON IMPLEMENTATION OF A COMPREHENSIVE**  
**HOSPITAL-BASED ADDITION PROGRAM**

Dr. Michael Fingerhood, M.D., Director, Division of Addiction Medicine and Dr. Peter Hill, M.D., Senior Vice President of Medical Affairs and Chief Medical Officer for Johns Hopkins Health System, presented an update on the implementation of a Comprehensive Hospital-Based Addition Program. (see “Presentation by Johns Hopkins on Implementation of a Comprehensive Hospital-Based Addition Program”).

**Joshua Sharfstein, MD**  
Chairman

**James N. Elliott, MD**  
Vice-Chairman

**Ricardo R. Johnson**

**Maulik Joshi, DrPH**

**Adam Kane, Esq**

**Nicki McCann, JD**

**Farzaneh Sabi, MD**

**Jonathan Kromm, PhD**  
Executive Director

**William Henderson**  
Director  
Medical Economics & Data Analytics

**Allan Pack**  
Director  
Population-Based Methodologies

**Gerard J. Schmith**  
Director  
Revenue & Regulation Compliance

**Claudine Williams**  
Director  
Healthcare Data Management & Integrity

Dr. Fingerhood presented the multi-faceted approach to the Johns Hopkins Health System (JHH) hospital-based addiction program which encompasses a wide range of strategies including multimodal pain management reduce opioid reliance; community outreach; providing expert care for patients with an addiction medicine consult service; facilitating access to buprenorphine and methadone; streamlining Naloxone distribution; standardizing treatment protocols for alcohol withdrawal management; establishing transitional care post-discharge; and partnering with SNFs to provide comprehensive substance abuse care. The key to success has been the focus on patient centered care and peer recovery coaches who provide invaluable support throughout the treatment journey. The program aims to be a model for other hospitals, demonstrating that effective opioid stewardship can be achieved with a comprehensive and coordinated approach.

**No action is necessary on this agenda item.**

**ITEM III**  
**CLOSED CASES**

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

**ITEM IV**  
**OPEN CASES**

2667A	University of Maryland Medical Center
2668R	Johns Hopkins Howard County Medical Center

**ITEM V**  
**REPORT FROM THE EXECUTIVE DIRECTOR**

**Advancing Innovation Maryland (AIM) Update**

Ms. Christa Speicher, Deputy Director, Payment Reform provided an update on the Advancing Innovation Maryland (AIM) contest, a public-private partnership between the Maryland Department of Health, the Health Services Cost Review Commission (HSCRC), and local foundations. The contest solicited innovative ideas to enhance Maryland's healthcare model, focusing on improved patient care and health outcomes, greater equity, and increased affordability. The competition was structured around three categories: Innovative Interventions, Innovative Collaborations, and Innovative Payment Approaches. Forty-one (41) applications were received and following a rigorous review process by a diverse judging



panel, 10 winning ideas were selected. A formal public announcement of the winners will be made later this month and an in-person event to be held in February, providing opportunities for engagement with key stakeholders. The winning proposals will be presented at an upcoming Commission meeting in 2025 to facilitate discussion and explore potential implementation strategies.

**No action was necessary on this agenda item.**

### **AHEAD Model Update**

Dr. Jon Kromm, Executive Director provided an update on the upcoming policy work related to the Maryland Model. The current economic climate and the impending AHEAD model implementation presents an opportune moment to assess hospital needs and broaden community requirements. The goal is to gather stakeholder input on key policy development areas to inform the Commission's work.

Stakeholders are asked to provide their input on several key questions focused on high-value care, with specific emphasis on the volume-related policies:

- **Affordable Care Models and Improved Health Outcomes:** How effective are the current models in bringing affordable care to the state and improving the health of Marylanders? How can additional opportunities be identified for better management of chronic illnesses and preventative care?
- **Common Utilities for High-Value Acute Care:** Can the HSCRC identify further opportunities to create common utilities (such as CRISP or GBRICS) to support the delivery of high-value acute care services?
- **Reducing Low-Value Care:** Given the demonstrated existence of low-value care within fee-for-service systems, how can the HSCRC collaborate with hospitals, physicians, and other partners to improve clinical decision-making and reduce such care?
- **Incentives for Reducing Avoidable Utilization:** Should additional incentives be implemented to reduce potentially avoidable utilization, as defined by readmissions and PQIs? Should the HSCRC consider alternative or complementary approaches to this definition?
- **Hospital Planning Needs:** What are the planning needs of hospitals as they seek to optimize high-value care and reduce low-value care within their facilities?

Interested parties have three weeks to submit their comments. During the February meeting, stakeholders will have additional opportunities to provide in-person feedback and Commissioner engagement. The Commission will utilize the input received to inform future policy development.

Chairman Sharfstein asked how will staff keep track of the feedback and how should recipients reference specific questions when replying. Dr. Kromm clarified that respondents should reference the corresponding question number when submitting their feedback.

Commissioner Kane asked if staff would analyze whether the existing financing structure appropriately supports the Commission's goals. Dr. Kromm agreed with the suggestion to analyze the existing

financing structures and proposes presenting an analysis at the next Commission meeting that maps out the current incentives and financing mechanisms already in place. Instead of immediately focusing on creating new structures or incentives, staff will use this analysis as the baseline to understand and document what already exists. This "level setting" will provide context for future discussions and decisions.

Commissioner McCann asked how the HSCRC can engage community stakeholders who may not be aware of or understand Maryland's unique reimbursement system. Her proposal for proactively disseminating information about the model and actively seeking feedback involves two key components: 1) finding ways to explain the complex reimbursement system in a more accessible way for the public, and 2) establishing platforms or opportunities where the HSCRC can actively push out information and solicit feedback, particularly from the physician community. Chairman Sharfstein agreed that getting community input is important, however, staff can leverage existing engagement channels, particularly those led by the MDH and the Health Equity Commission, to reach the wider community. He expressed confidence in the existing channels for engaging physicians.

Dr. Kromm reviewed several areas related to access to care that the Commission is requesting input, including:

- **Comprehensive Measurement:** The Commission is seeking ideas for a more holistic approach to measuring access to care that moves beyond individual metrics.
- **ER Wait Times:** Should the Commission consider payment policy adjustments to mitigate volume declines in health systems related to this issue?
- **Market Shift Policy:** What changes are appropriate to support access to needed care without abandoning population-based payment?
- **Hospital Global Budget Adjustments:** How should annual adjustments to hospital global budgets (for statewide population growth) be modified or focused?
- **Hospital Effectiveness:** What are the key domains and metrics (avoiding efficiency metrics) to assess hospital effectiveness in providing expected care, potentially using national comparisons for metrics like length of stay and per capita utilization?

Dr. Kromm outlined other cross-cutting policy areas that the Commission is requesting public comment on.

- **Facility Conversions:** Exploring facility conversions, particularly in relation to the flexibility offered by the AHEAD model regarding the percentage of revenue under global budgets.
- **Physician Costs:** Understanding the cost pressures facing Maryland hospitals related to physicians, even though these costs are outside the HSCRC's direct regulatory authority.
- **Other Major Policy Changes:** Soliciting input on other significant policy changes the HSCRC should consider.

Dr. Kromm outlined the next steps to the feedback process, starting with refinement and numbering of the questions, then beginning in February, engaging Commissioners in productive discussions.

Commissioner McCann asked whether the Commission itself should define "high-value care" or if they should solicit input from stakeholders to arrive at a definition. Dr. Kromm agrees the Commission should both consider existing definitions and solicit input to develop potentially new ones. He advocates a pragmatic approach, implementing short-term improvements, while working towards a more robust long-term definition. This parallels the discussion of access, where a similar short-term/long-term strategy is appropriate.

Chairman Sharfstein framed the upcoming feedback process as a crucial opportunity to shape Maryland's healthcare future under the AHEAD model, urging participants to consider the needs of the entire community and work towards shared goals.

**No action was necessary on this agenda item.**

### **Model Monitoring**

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through September 2024 (for claims paid through November 2024). The data showed that Maryland's Medicare hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is -1.77 percent below the nation through September, and that Maryland Medicare hospital and non-hospital growth through August resulted in savings of \$129 million.

**No action was necessary on this agenda item.**

## **ITEM VI**

### **FINAL RECOMMENDATION: HIGH-COST DRUG FUNDING APPROACH**

Mr. William Henderson, Principal Deputy Director, Medical Economic and Data Analytics presented the Staff's Final Recommendation for the High-Cost Drug Funding Approach (see "Final Recommendation for the High-Cost Drug Funding Approach" available on the HSCRC website).

Mr. Henderson reviewed the comments received from MHA, TidalHealth, UMMS, JHHS, and MedStar. Although commentors were largely supportive of the policy change to 100 percent reimbursement, Mr. Henderson highlighted key stakeholder concerns and the staff's response.

He noted that staff have amended the policy as follows based on the feedback:

- **Clarification of Penalties:** The potential penalty of up to 20 percent applies to the relevant CDS-A drug costs, not total drug costs. Staff will develop a detailed proposal for implementing penalties with stakeholder input and present the proposal to the Commission for approval at a later time.

- **Additional Adjustment on March 1st:** Hospitals can voluntarily submit a projection of their current fiscal year drug costs. If the increase is above a certain threshold, a rate adjustment can be made to accelerate revenue recognition on March 1st. This is in addition to the existing January and July adjustments.
- **Overhead Application:** Staff acknowledged the need for a more comprehensive review of how overhead is applied to drugs and is committed to conducting an analysis and sharing it with the industry in the spring.
- **National Drug Code (NDC) Data:** Will work through existing policy for adding this field to case mix data.

Mr. Henderson reviewed the staff's revised final recommendations as follows:

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by staff in consultation with industry stakeholders.
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated
3. Change volume funding to 100 percent of the measured cost change per the annual audit, effective January 1<sup>st</sup> of each year.
4. Implement two provisional adjustments for each year, one on March 1<sup>st</sup> and one on July 1<sup>st</sup>, to smooth the impact of the increased adjustment size:
  - a) The March 1<sup>st</sup> adjustment will be voluntary and based on a projection of current year spending prepared by the hospital. To be eligible for this funding adjustment, the projection must show a cost increase above a minimum threshold established by staff and be subject to staff review and approval.
  - b) The July 1<sup>st</sup> adjustment will be automatic and based on the first 6 months of data from the prior fiscal year, minus any adjustment made on March 1st. The adjustment will be directly calculated by staff using case mix data, excluding drugs with outlier dosage counts. No manual adjustments will be made to this adjustment. The impact of any adjustment made in the prior March 1<sup>st</sup> adjustment will be deducted.
  - c) Provisional adjustments will be temporary only, final adjustments derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.
  - d) Set the drug component of inflation in the update factor to only reflect any price inflation not captured during the volume adjustment; inflation on drugs will primarily be provided through the volume adjustment
  - e) Implement a new annual report, produced by a consultant, to identify hospital effectiveness in managing CDS-A drugs and assess penalties of 20 percent of relevant CDS-A drug costs, to hospitals that are not meeting target goals. Prior to the implementation of any penalties a revised version of this policy will be developed, with stakeholder input, that specifies in greater detail the approach for any penalties assessed.
  - f) Hospitals will continue to be expected to "tier" charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with disproportionate overhead, resulting in unfair costs to consumers.



- g) Continue to audit data reported in Case Mix to validate amounts reported and gather appropriate ASP and 340B price data.

Staff recommend implementing the revised policy retrospectively for FY 2024, effective January 1, 2025. As volume adjustments under this policy were always implemented retrospectively, HSCRC Staff believe it is appropriate to implement these changes in FY 2025.

Chairman Sharfstein asked if Staff would have the necessary information to effectively oversee the implementation and impact of the new drug reimbursement policy. Mr. Henderson assured Dr. Sharfstein that the staff will have the necessary data on specific drug usage, in part, because of the planned collection of NDC coding. He further indicated that preliminary data and analysis will be shared with the Commission.

Chairman Sharfstein noted that while the Commission won't dictate drug choices, the data collected through the new reimbursement system creates a valuable opportunity to identify areas for improvement in patient care and cost-effectiveness. He sees academic detailing and collaboration with experts as potential mechanisms for translating this data into positive change.

Commissioner Kane asked what's the justification for doing a separate off-time rate order for high high-cost drugs. Mr. Henderson noted that the standard rate-setting process, with its scheduled adjustments, is not responsive enough to handle the volatile nature of high-cost drug expenditures. The off-cycle rate orders are necessary to provide timely adjustments and prevent hospitals from being significantly underfunded due to unforeseen drug cost increases. He stated that waiting for the next regular rate adjustment could create a substantial financial burden on hospitals in the interim.

Commissioner Kane asked if there will be a standard or criteria to determine when an off-cycle adjustment is warranted. Mr. Henderson indicated that a percentage-based threshold will be used to determine when an off-cycle rate adjustment is necessary. He also stated that the impact of this policy will likely be limited to a subset of hospitals with significant oncology programs, thus mitigating the potential for excessive administrative burden on staff.

Commissioner Johnson noted that there should be a closer and more timely examination of how hospitals are tiered and how they manage overhead costs for high-cost drugs, especially given the implications for self-insured accounts. He suggests that a more standardized approach to tiering might be beneficial. Mr. Henderson assured the Commission that the concerns about hospital tiering are being taken seriously and will be addressed proactively. Staff is pursuing this issue on a separate track, and have already begun initial analysis, and plan to engage with the MHA and the broader industry to discuss their findings and potential next steps.

Chairman Sharfstein requested a motion to vote on the staff's final recommendation. Commissioner Johnson moved to approve the staff recommendation, and it was seconded by Commissioner Joshi. **The motion passed unanimously in favor of the staff's recommendation.**

**ITEM VII**  
**DRAFT RECOMMENDATION: ED BEST PRACTICES INCENTIVE POLICY & ED WAIT TIME ACTIVITIES**

Ms. Tina Simmons, Associate Director for Quality Methodologies, presented the staff's draft recommendation on the Emergency Department (ED) Best Practice Incentive Policy and updated the Commission on ED Wait Time Activities (see "Draft Recommendation: Emergency Department (ED) Best Practice Incentive Policy & ED Wait Time Activities" available on the HSCRC website).

Ms. Simmons reviewed the quality improvement program that encourages hospitals to implement selected best practices focused on ED throughput, communication, and collaboration. The program will be implemented in phases, starting with infrastructure development and data collection in Year 1, with the potential for future financial incentives based on performance in subsequent years.

The staff's draft recommendations for Rate Year (RY) 2027 are as follows:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
  - a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
  - a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer inpatient revenue to be assessed in January 2026.
3. Staff proposes that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

Hospitals will select two of the following six best practices for implementation: interdisciplinary rounds; bed capacity alert process; standard daily shift huddles; expedited care processes; patient flow and throughput optimization; and establishment of clinical pathways. These best practices are designed to enhance communication and collaboration with patients and among clinicians across different medical disciplines. Ms. Simmons presented examples of proposed measures; however, specific performance measures, tiers, and targets are currently under development and are expected to be finalized in January.

As next steps, staff will continue to develop and refine measure definitions, performance tiers, and targets. The public comment for this policy is due by January 17, 2025. Staff will return to the Commission at the February meeting with the final policy that will incorporate the feedback received and ongoing development.

Dr. Saba's reiterated her concerns regarding the program's focus on superficial compliance rather than genuine improvement. She worries hospitals will simply check the box by selecting existing practices,



rather than critically assessing their effectiveness and seeking meaningful change. This is especially concerning given that the metrics are considered "Basic Hospital Operations 101." Ms. Simmons concurred with Dr. Saba's concerns about hospitals doing the minimum to comply with the policy requirements. She emphasized the importance of shared discovery and critical self-assessment; and draws a parallel to the implementation of core measures, noting that initial perceptions of already meeting standards often gave way to the realization of gaps in implementation and infrastructure upon closer examination and measurement. Ms. Simmons used the example of interdisciplinary rounds to illustrate how a practice is reported to be in place but not consistently applied across a hospital system, highlighting the potential for optimization. While acknowledging that throughput was the initial driver, she reiterated that the goal is to improve patient care.

Commissioner McCann commended staff on the collaborative engagement they have had with hospitals, and she has received positive feedback from her hospital colleagues about the process. She agreed with the measured approach to first collect and analyze the data before applying financial penalties and rewards.

Commissioner Joshi praised the staff's effort to develop the detailed specifications for the program, acknowledging the difficulty of this process. He stressed the importance of ensuring that the best practices are implemented with fidelity and reliability, recognizing that measuring this can be challenging but is crucial. He suggested adding milestones for evaluating hospital progress will be very informative in understanding how the program is performing, what has been learned, and how the results compare to previous time periods. This information will be valuable for planning the next year's activities.

Commissioner Johnson argued against providing additional financial incentives for implementing best practices, suggesting that these practices should be considered a baseline expectation. He proposed focusing instead on penalties for non-compliance, given the existing incentives already in place. Ms. Simmons agreed that a penalty-only approach could be implemented in Year 2. However, as a starting point, the incentives are meant to be a tool to drive investment in proven, high-impact solutions identified through data analysis. This approach aims to encourage innovation and maximize the program's effectiveness.

Commissioner Kane asked how staff will handle a situation where a hospital implements the required best practices, but their ED length of stay outcomes do not improve. Ms. Simmons acknowledged there is potential for the program to not achieve its primary goal of reducing length of stay through best practice implementation alone. There is potential to adapt the program by shifting to outcome-based incentives, while also highlighting the ancillary benefits of optimizing these practices for overall patient care and hospital throughput.

Vice Chairman Elliott recommended that we consider best practices that address the entire patient flow process, encompassing both the ED and the inpatient phase. He pointed to the examples given that focus primarily on inpatient length of stay. A more holistic approach should also include best practices that address ED length of stay. Ms. Simmons explained that while the selected best practices address both ED and inpatient flow by focusing on ED boarding, they also include elements like expedited care that

directly address ED processes. Furthermore, she indicated staff is considering incorporating strategies related to multi-visit patients to further enhance the program's impact.

Vice Chairman Elliott proposed simplifying the performance tiers for the best practices by using a single, inclusive measure. He suggested that the highest tier could encompass all the elements of the lower tiers, effectively becoming the sole measure. Ms. Simmons noted that the multiple tiers were originally intended to provide a graduated incentive structure and encourage initial adoption. However, with the introduction of the monitoring year, it may be possible to simplify the measure.

Chairman Sharfstein asked based on the current understanding of hospitals' practices, is there an expectation that implementing these best practices will lead to tangible improvements in patient care. Ms. Simmons stated that the program's focus on communication, collaboration, and expedited care will have a tangible positive impact on patient care, confirming the program's potential value.

Chairman Sharfstein questioned whether hospitals would have a process to provide a rationale for the best practices chosen and how will staff evaluate the rationale to ensure they align with the hospital's specific challenges. Ms. Simmons stated that while the initial approach is to give hospitals autonomy in choosing the best practices, staff is considering a future requirement for hospitals to cycle through all six best practices, ensuring broader optimization. This potential change will be discussed with stakeholders. Chairman Sharfstein also recommended collecting some information from hospitals about their rationale to help inform future policy decisions.

**No action was necessary on this agenda item.**

**ITEM VIII**  
**HEARING AND MEETING SCHEDULE**

February 12, 2025,	Time to be determined
	4160 Patterson Ave.
	HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:15 p.m.

**Closed Session Minutes  
of the  
Health Services Cost Review Commission**

**January 8, 2025**

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session under the Authority provided by the General Provisions Article §3-103 and §3-104 for the purpose of discussing the administration of the Model.

Upon motion made in public session, Chairman Sharfstein called for adjournment into closed session:

The Administrative Session was called to order by motion at 12:12 pm.

In addition to Chairman Sharfstein, Commissioners Elliott, Kane, Johnson, Joshi, McCann and Sabi were in attendance.

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Geoff Dougherty, Claudine Williams, Alyson Schuster, Cait Cooksey, Christa Speicher, Megan Renfrew, Erin Schurmann, and William Hoff.

Also attending was Assistant Attorney General Ari Elbaum, Commission Counsel.

Assistant Attorney General Stan Lustman joined by Zoom.

**Item One**

Dr. Jon Kromm, Executive Director, updated the Commission, and the Commission discussed the internal and personnel processes of the Commission.

**Item Two**

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the TCOC model monitoring.

**Item Three**

Mr. Henderson updated the Commission, and the Commission discussed the FY24/25 Hospital Unaudited Financial Performance and the FY24 Audited System Financial Results.

The Closed Session was adjourned at 1:18 pm.

**Closed Session Minutes  
of the  
Health Services Cost Review Commission Retreat  
December 19, 2024**

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session under the authority provided by the General Provisions Article §3-103, §3-104 and §3-305 for the purposes of discussing the administration of the Model and internal personnel processes.

Upon motion made in public session, Chairman Sharfstein called for adjournment into closed session:

The Administrative Session was called to order by motion at 9:02 am.

In addition to Chairman Sharfstein, Commissioners Elliott, Johnson, Joshi, McCann and Sabi were in attendance.

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Claudine Williams, Geoff Dougherty, Allen Pack, Alyson Schuster, Cait Cooksey, Erin Schurmann, Christa Speicher, Deborah Rivkin and Tina Simmons.

Also attending were Assistant Attorneys General Stan Lustman and Ari Elbaum, Commission Counsel.

**Item One**

Chairman Sharfstein facilitated and the Commission and staff discussed internal and personnel processes of the Commission.

The Closed Session was adjourned at 10:24am



TidalHealth  
Population Health

# SWIFT: An innovative mobile integrated health program

HSCRC Presentation

Kat Rodgers, MPH, Director of Community Health  
Initiatives

February 12, 2025

# Salisbury-Wicomico First Care Team (SWIFT)

## Salisbury Fire Department:

- Program Coordinator/Paramedic: David Phippin
- Paramedic: Miranda Webster



## TidalHealth:

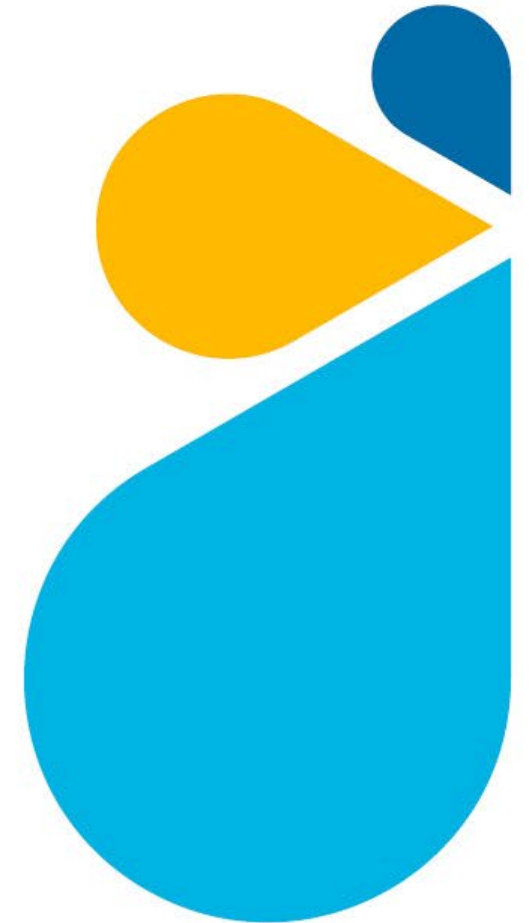
- Clinical leader/Nurse Practitioner: Tammy Walbert
- Nurse Practitioners: Aaron Sebach, Jessica Stoner
- Community Health Nurses: Katie Sabater, Jenny Adkins
- Community Health Workers: Jaquelin Ixtecoc Reyes, Terrie Shatney, Gloriyah Walker
- Social Worker: Bonnie Willey
- \*As needed – pharmacist, physical therapist, respiratory therapist



# SWIFT Explained

## SWIFT 1.0:

- Service area: All jurisdictions – Wicomico County
- Eligibility:
  - Referral from EMS
  - Individuals who call 911 five or more times in a six-month period for non-life-threatening medical reasons
  - Identified as a frequent utilizers or multi-visit patients of Emergency Department
  - High risk for readmission



## SWIFT 2.0/Minor Definitive Care Now

- Paramedic + NP respond to low acuity 911 calls in Salisbury
- Treat patients on scene, enabling ambulance to return to service and be available for higher acuity calls
- MIEMSS protocol – the only operational program in the state of Maryland
- Services provided:
  - E-prescribe medications
  - Starter packs of medications
  - Wound care
  - Point of care testing
  - Referrals to specialty providers and community support programs including SWIFT 1.0

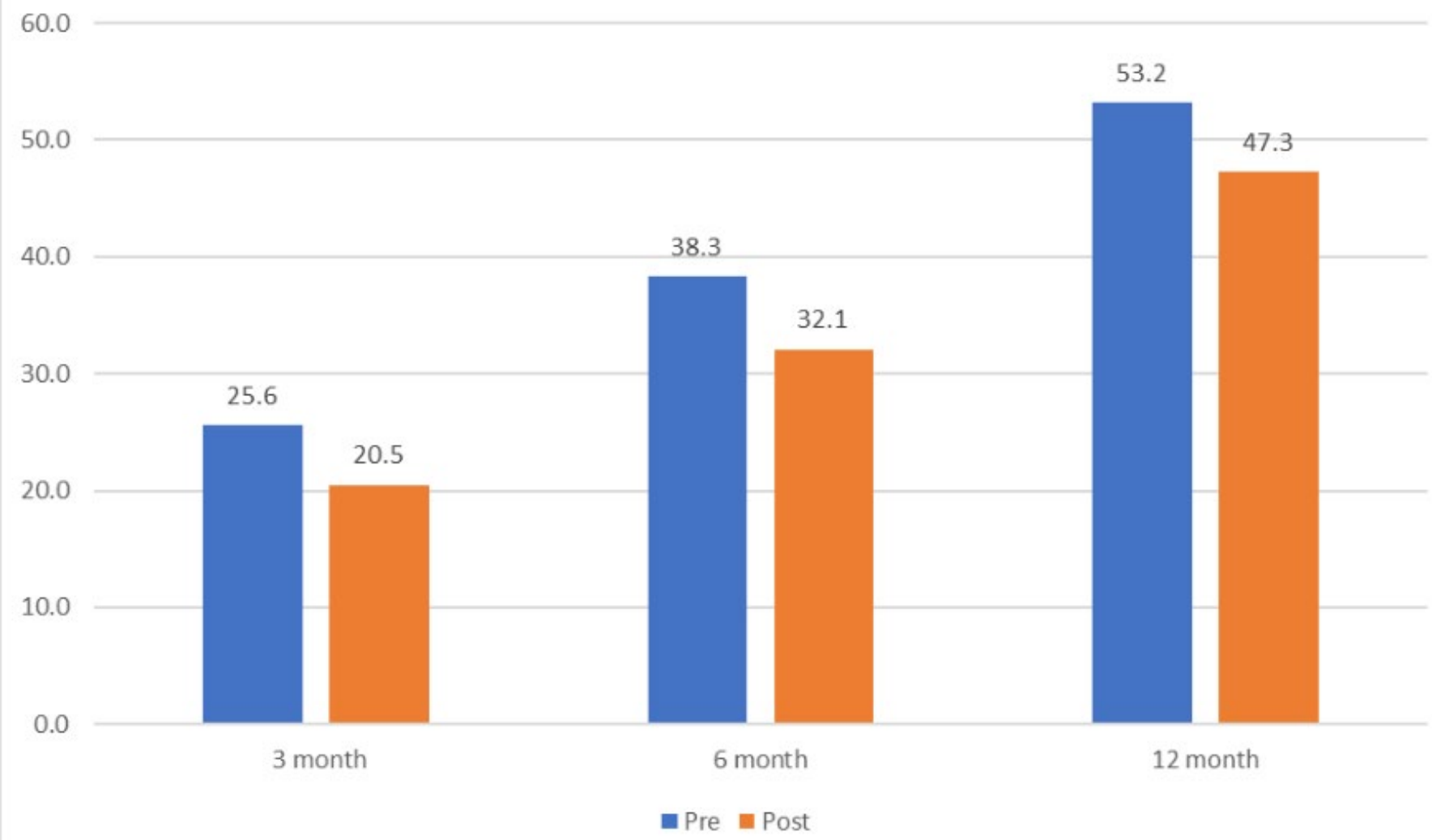


# SWIFT Outcomes



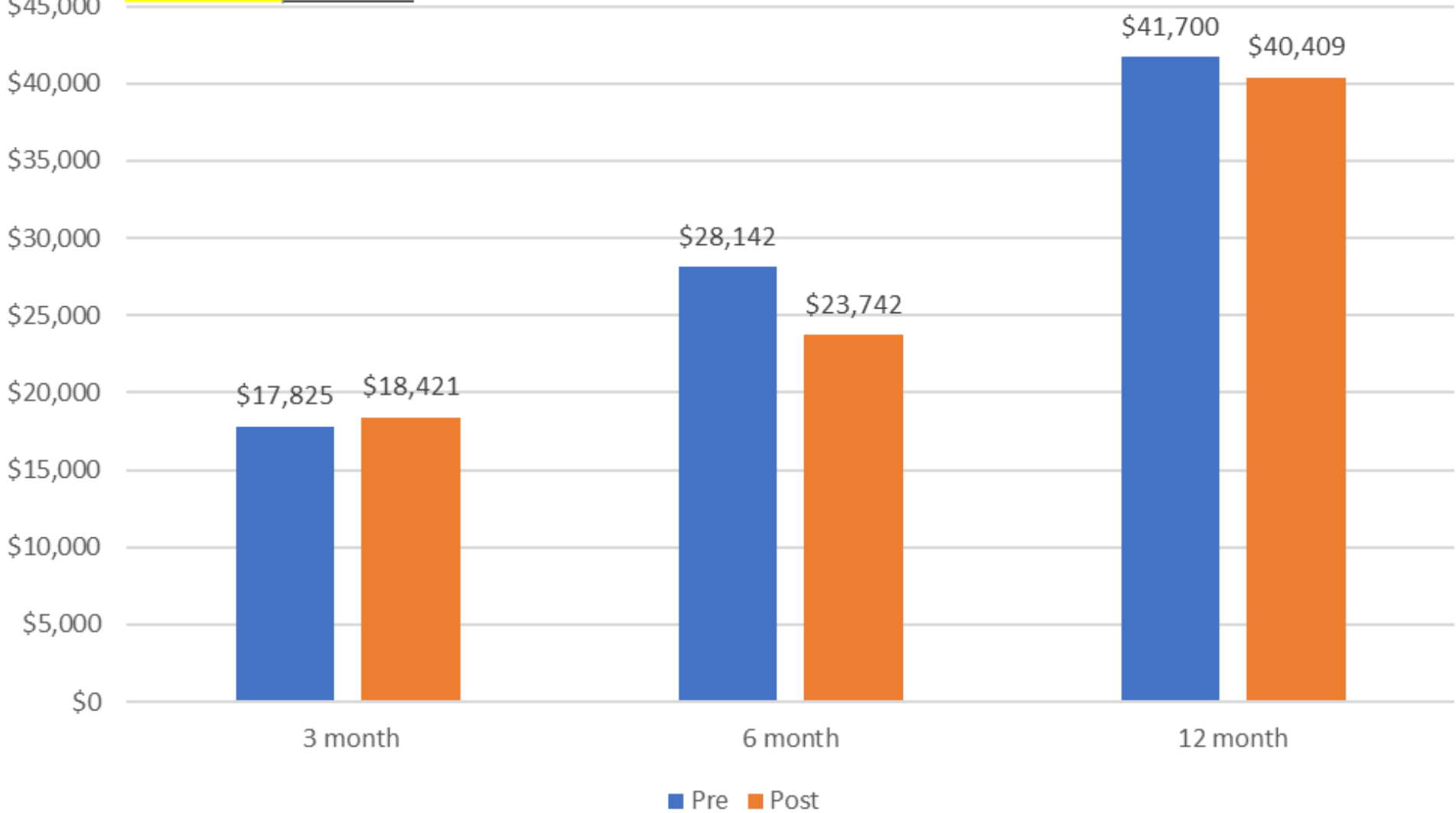
**10/17/2024** Run Date  
**8/31/2024** Claims Thru  
**Apr23-Mar24** Panel Dates

### SWIFT ED Visits/10 Patients Served



**10/17/2024** Run Date  
**8/31/2024** Claims Thru  
**Apr23-Mar24** Panel Dates

### SWIFT Charges per Patient



# SWIFT 2.0/MDCN Outcomes FY24

Total 911 calls: 607

Total appropriate for MDCN: 416

Total consenting to MDCN: 166

Conversion rate: 87% (Benchmark 35%)

SWIFT 1.0 Patients seen: 126

SWIFT 1.0 Patients Enrolled: 15

Medication starter packs: 78

PCP Referrals: 102

Specialty Referrals: 36

Dollars saved per hour: \$230.20

**Estimated ED Visit Reduction Cost Savings: \$335,748**





# Implications for Maryland



Expand access to primary care



Advance health equity



Prevent and reduce utilization of emergency resources



Reduce cost of care

**Thank you**



# POP-IN

## Postpartum Outpatient Pediatrician Interventional Network

Ananya Dewan

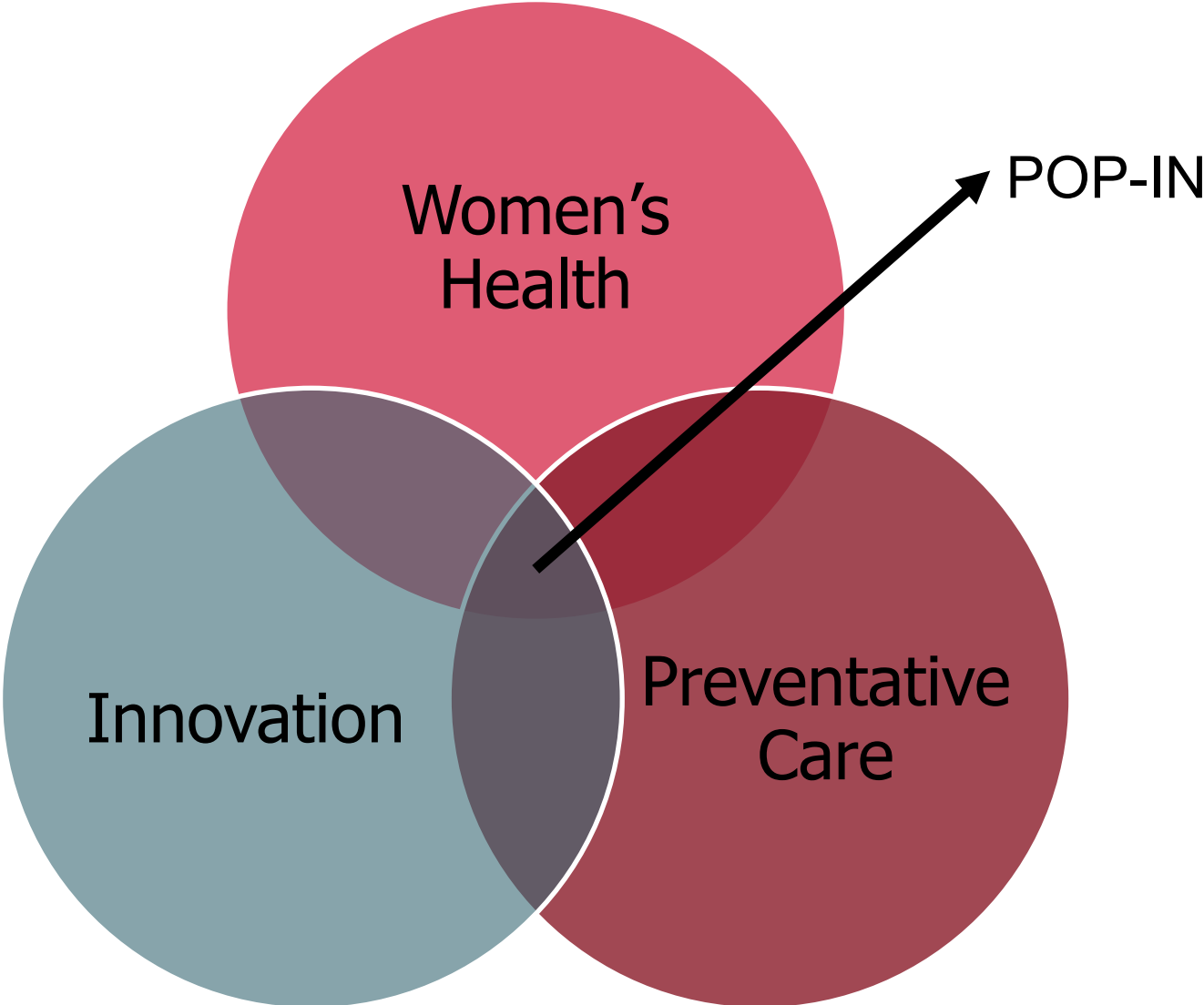


# About Me

POP-IN



My passions:



VAGELOS LSM  
Life Sciences and Management  
Arts & Sciences · Wharton  
UNIVERSITY of PENNSYLVANIA

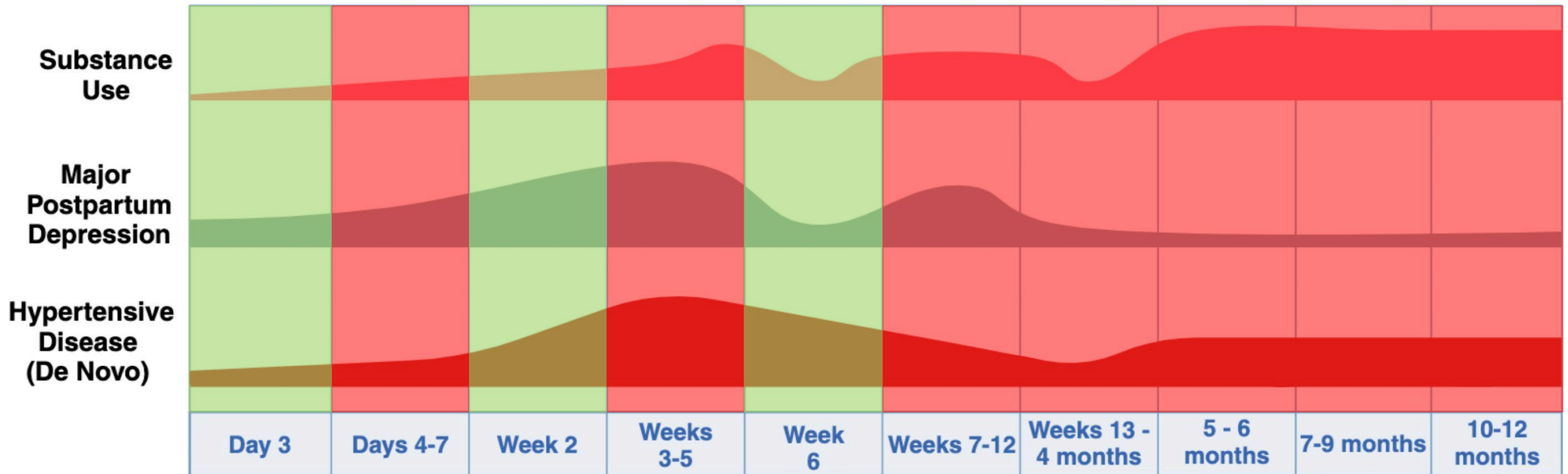



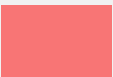
JOHNS HOPKINS  
MEDICINE

# Postpartum care is patchy and has low adherence

POP-IN

## Relative Incidence of Postpartum Morbidity in the First Year Postpartum

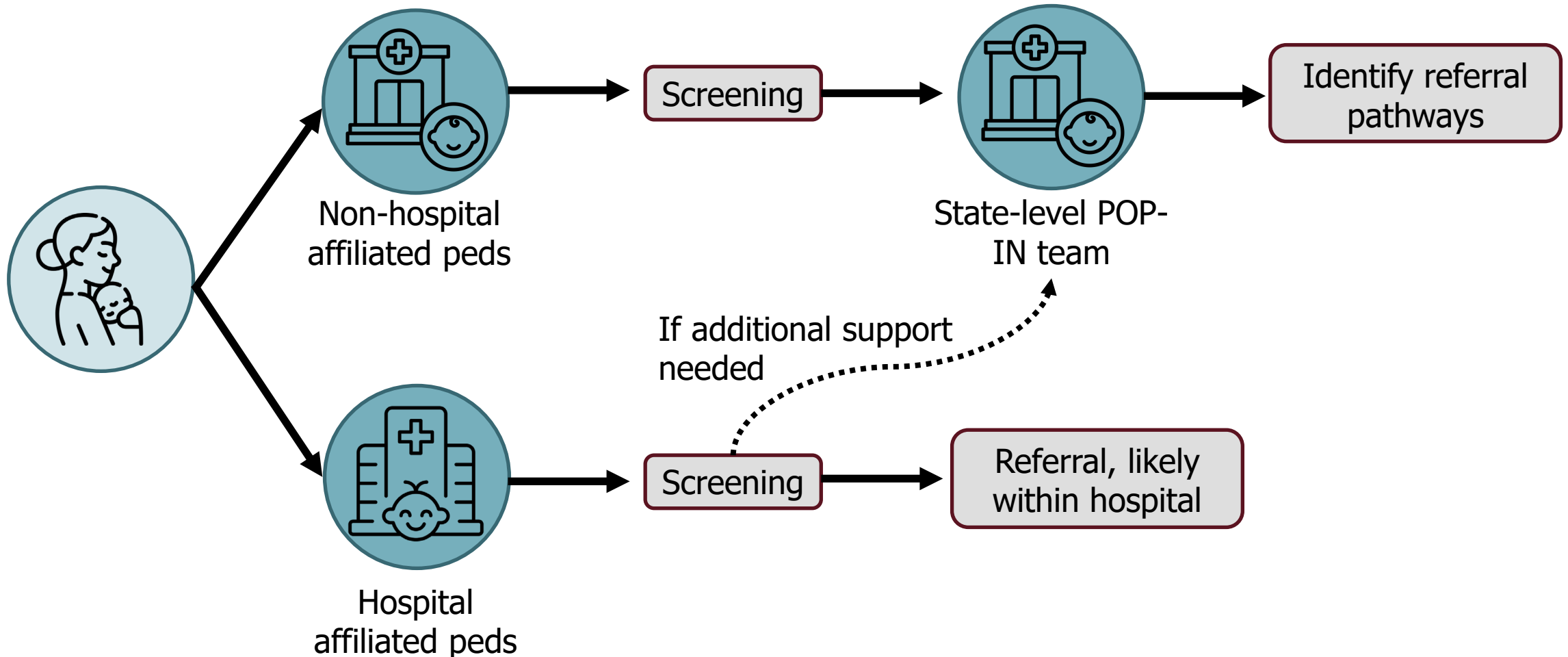


 = Postpartum Appointments  
 = No Postpartum Appointment

# Leveraging newborn appointments as care touchpoints

POP-IN

**Longitudinal:** 7 pediatrics visit in first year (vs. 3 postpartum)  
**Extensive reach:** ~80-85% adherence to peds visits (vs. ~65% postpartum)





# Screening pilots demonstrate feasibility and impact

POP-IN

## Hypertensive Diseases



**167%<sup>1</sup> additional** cases identified

## Postpartum Depression



**5.4% less** PPD with screening and subsequent support

## Substance Use

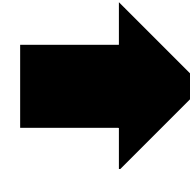
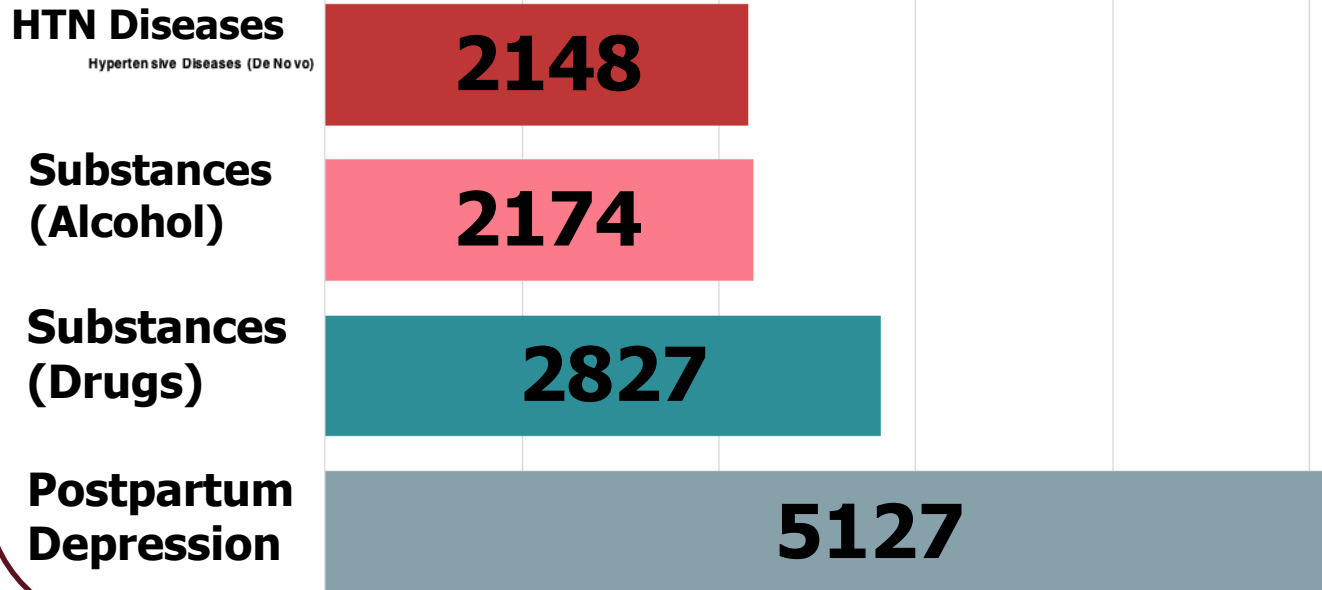


**Caregiver acceptance** of universal substance use screening

# POP-IN generates positive health and economic effects

POP-IN

## Projected # of Cases Identified or Identified Earlier by POP-IN in a Year of Maryland Deliveries (n=68,782)



Direct costs savings of benefit  
\$11.2M (\$163/person)



SIHIS, Total Population Health

RRIP

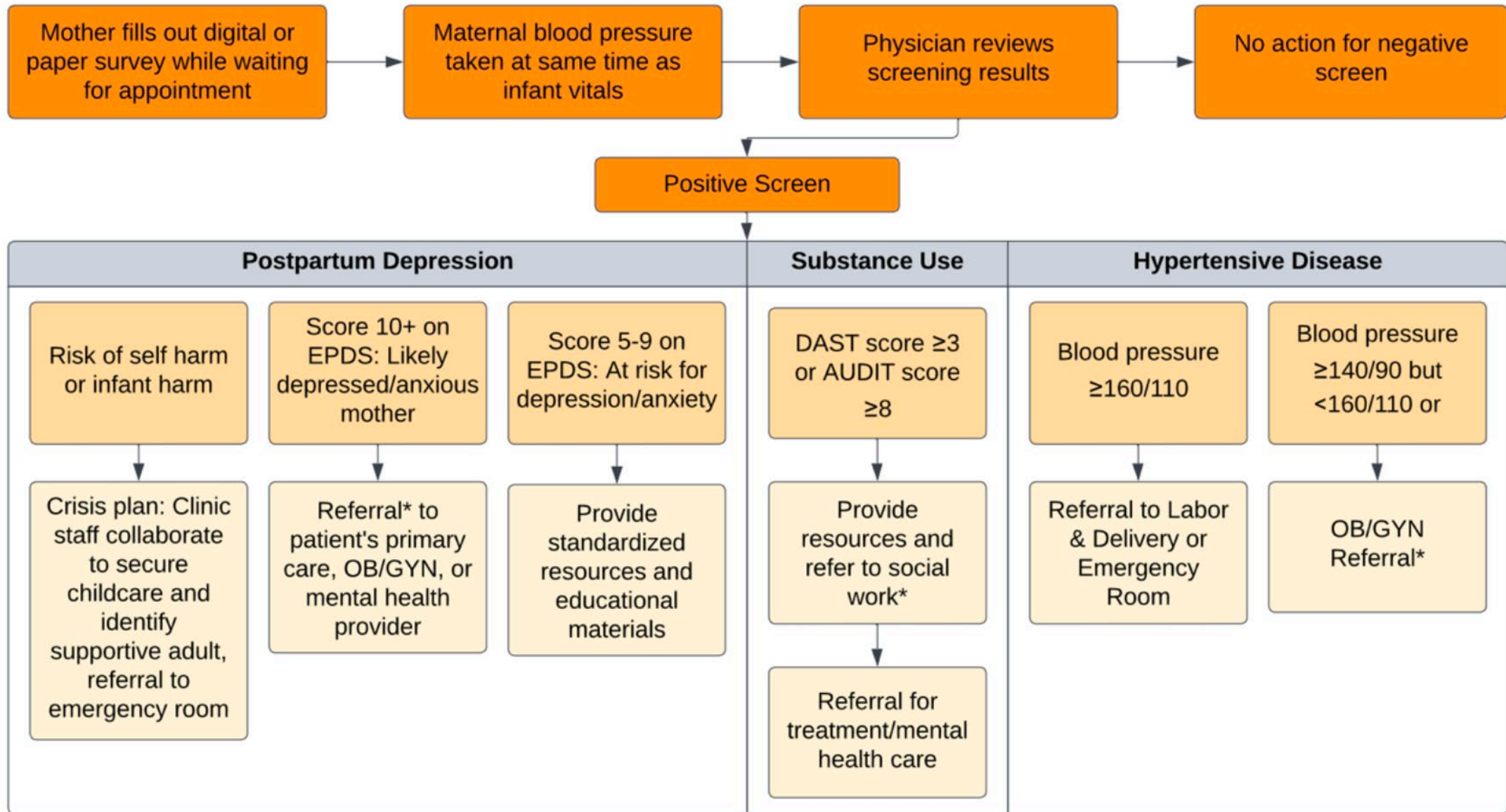
# Thank You!

Questions?  
adewan3@jh.edu

# Appendix

# Clinical Workflow

POP-IN

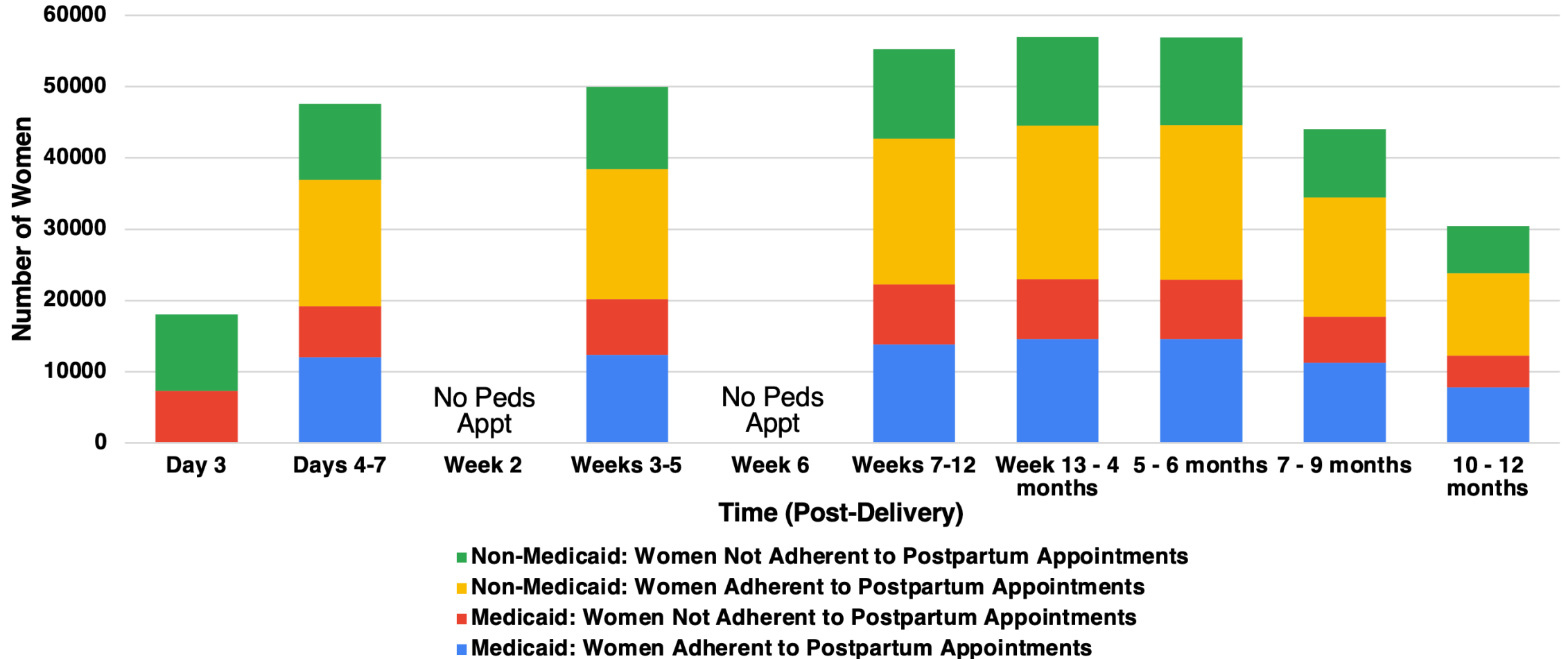


\*Clinics will leverage POP-IN's dedicated coordinators and social workers to handle referral burden, case capacity, and follow-up

# Addressable Population

POP-IN

**Figure 1: Number of Maryland Postpartum Women with Care Gaps Addressable at Pediatric Visits in the First Year Post-Delivery**



# Model

**Figure 1A**

Key Assumptions	
Women Delivering in Maryland/Year	68782
Medicaid coverage of Births in Maryland	0.403
<b>Total Medicaid Patients in Maryland Delivering per Year</b>	<b>27719</b>
% of Maternal Attendance to Peds Visits	0.95

	Day 3	Days 4-7	Week 2	Weeks 3-5	Week 6	Weeks 7-12	Week 13 - 4 months	5 - 6 months	7 - 9 months	10 - 12 months
<b>Standard Appointment Schedules</b>										
Postpartum Visit	Yes	No	Yes	No	Yes	No	No	No	No	No
Pediatric Visit	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes
<b>Adherence Rates</b>										
Maternal Adherence to Postpartum Visits	70%	70%	67%	67%	64%	64%	64%	64%	64%	64%
Peds Visit Adherence (Ambulatory center)	92%	91%	0%	90%	0%	89%	89%	88%	68%	47%
<b>% of Peds Visits with Mother Present</b>	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
<b>% of Women Receiving Supplemental Postpartum Follow-Ups Between Appointments due to Higher Risk</b>	0%	20%	0%	15%	0%	5%	2%	1%	1%	1%

Addressable Patient Population										
<b>Gaps in Postpartum Appointment Coverage</b>										
Adherent Women In Between Regularly Scheduled Postpartum Appointments	0	48147	0	46084	0	44020	44020	44020	44020	44020
Supplemental Postpartum Follow-Ups Between Scheduled Appointments	0	-13756	0	-10317	0	-3439	-1376	-688	-688	-688
Total Adherent Women with Care Gaps	0	34391	0	35767	0	40581	42645	43333	43333	43333
Total Non-Adherent Women	20635	20635	22698	22698	24762	24762	24762	24762	24762	24762
Total Patients with Postpartum Care Gaps	20635	55026	22698	58465	24762	65343	67406	68094	68094	68094
<b>Medicaid Patients</b>										
Total Adherent Women on Medicaid with Care Gaps	0	13860	0	14414	0	16354	17186	17463	17463	17463
Total Non-Adherent Women on Medicaid	8316	8316	9147	9147	9979	9979	9979	9979	9979	9979
Total Medicaid Patients with Postpartum Care Gaps	8316	22175	9147	23561	9979	26333	27165	27442	27442	27442
<b>Physically Attend Pediatric Visits</b>										
Postpartum-Adherent Women with Care Gaps who Physically Attend Pediatric Visits (*0's are due to no pediatric visit occurring at that time)										
Medicaid	0	11982	0	12324	0	13828	14531	14599	11281	7797
Non-Medicaid	0	17749	0	18257	0	20484	21526	21627	16712	11551
Postpartum-Nonadherent Women who Physically Attend Pediatric Visits										
Medicaid	7268	7189	0	7821	0	8437	8437	8342	6446	4456
Non-Medicaid	10767	10650	0	11586	0	12499	12499	12358	9550	6600
<b>Total Women with Postpartum Care Gaps Seen at Pediatric Clinic ("Addressable Patients")</b>	<b>18035</b>	<b>47570</b>	<b>0</b>	<b>49988</b>	<b>0</b>	<b>55248</b>	<b>56993</b>	<b>56926</b>	<b>43989</b>	<b>30404</b>



# Model

POP-IN

## Postpartum Morbidity Addressable by POP-IN

	Day 3	Days 4-7	Week 2	Weeks 3-5	Week 6	Weeks 7-12	Week 13 - 4 months	5 - 6 months	7 - 9 months	10 - 12 months
--	-------	----------	--------	-----------	--------	------------	--------------------	--------------	--------------	----------------

### Incidence Rate Per Time Period

#### Substance Use

Incidence Rate (Drug use - opioids, sedatives, cocaine, stimulants, etc.)

0.019%	0.077%	0.135%	0.406%	0.135%	0.813%	0.542%	1.083%	1.625%	1.625%
--------	--------	--------	--------	--------	--------	--------	--------	--------	--------

Incidence Rate (Alcohol, over 7 drinks a week)

0.015%	0.060%	0.104%	0.313%	0.104%	0.625%	0.417%	0.833%	1.250%	1.250%
--------	--------	--------	--------	--------	--------	--------	--------	--------	--------

#### Postpartum Depression (PPD) - Unipolar Major

Incidence Rate

0.251%	0.752%	1.755%	3.943%	0.433%	2.600%	1.733%	0.195%	0.293%	0.293%
--------	--------	--------	--------	--------	--------	--------	--------	--------	--------

#### Hypertensive Diseases (De Novo Postpartum)

Incidence Rate

0.070%	0.281%	0.491%	1.474%	0.491%	0.382%	0.267%	0.535%	0.802%	0.802%
--------	--------	--------	--------	--------	--------	--------	--------	--------	--------

### Number of Addressable Patients Affected

#### Substance Use

Morbidity Incidence (Drug Use)

3	37	0	203	0	449	309	617	715	494	<b>2827</b>
---	----	---	-----	---	-----	-----	-----	-----	-----	-------------

Morbidity Incidence (Alcohol)

3	28	0	156	0	345	237	474	550	380	<b>2174</b>
---	----	---	-----	---	-----	-----	-----	-----	-----	-------------

#### Postpartum Depression (PPD) - Unipolar Major

Morbidity Incidence

45	358	0	1971	0	1436	988	111	129	89	<b>5127</b>
----	-----	---	------	---	------	-----	-----	-----	----	-------------

#### Hypertensive Diseases (De Novo Postpartum)

Morbidity Incidence

13	134	0	737	0	211	152	304	353	244	<b>2148</b>
----	-----	---	-----	---	-----	-----	-----	-----	-----	-------------

# Model

POP-IN

## POP-IN Per Case Costs and Savings (Reported in 2024 Dollars)

### Per Case Basis:

#### Savings (Direct Medical and Societal Costs)

Postpartum Depression	
Indirect - e.g. Productivity Loss, Suboptimal breastfeeding	\$ 27,105
Substance Use - Drug Use	
Indirect Savings - e.g. Productivity Loss, Criminal Justice	\$ 27,828
Direct - Associated Medical Costs with Ongoing Drug Use (Inpatient, Outpatient, Outpatient drugs)	\$ 15,640
Substance Use - Alcohol	
Direct - Healthcare Costs	\$ 328
Justice	\$ 532
Hypertensive Diseases	
Indirect	\$ 392
Direct Savings - Preventable Hospital Readmission	\$ 5,492

#### Costs

Pediatrician Reimbursement	
Cost/Survey	\$ 15
Coordinating Care	
Cost per Administrator Hired	\$ 46,200
Cost per Social Worker Hired	\$ 74,000
Depression/Substance Use Case)	\$ 70
Treatments	
Postpartum Depression	\$ 1,212
Substance Use - Drug Use	\$ 6,000
Substance Use - Alcohol	\$ 525
Hypertensive Diseases	\$ 1,355

# Model

POP-IN

**POP-IN Aggregate Costs and Savings (Reported in 2024 Dollars)**

	Day 3	Days 4-7	Week 2	Weeks 3-5	Week 6	Weeks 7-12	Week 13 - 4 months	5 - 6 months	7 - 9 months	10-12 months		
<b>Aggregate Basis:</b>												
<b>Total Savings (Direct Medical and Indirect Costs) in \$100k's</b>												
Postpartum Depression												
Indirect	\$ 12.26	\$ 96.98	\$ -	\$ 534.29	\$ -	\$ 389.35	\$ 267.76	\$ 30.09	\$ 34.88	\$ 24.10		
Substance Use - Drugs												
Indirect	\$ 0.97	\$ 10.24	\$ -	\$ 56.51	\$ -	\$ 124.92	\$ 85.91	\$ 171.61	\$ 198.92	\$ 137.49		
Direct	\$ 0.55	\$ 5.76	\$ -	\$ 31.76	\$ -	\$ 70.21	\$ 48.28	\$ 96.45	\$ 111.80	\$ 77.27		
Substance Use - Alcohol												
Indirect	\$ 0.00	\$ 0.03	\$ -	\$ 0.19	\$ -	\$ 0.41	\$ 0.28	\$ 0.57	\$ 0.66	\$ 0.45		
Direct	\$ 0.01	\$ 0.12	\$ -	\$ 0.65	\$ -	\$ 1.43	\$ 0.98	\$ 1.96	\$ 2.27	\$ 1.57		
Hypertensive Diseases												
Indirect	\$ 0.05	\$ 0.53	\$ -	\$ 2.89	\$ -	\$ 0.83	\$ 0.60	\$ 1.19	\$ 1.38	\$ 0.96		
Direct	\$ 0.04	\$ 0.38	\$ -	\$ 2.06	\$ -	\$ 0.59	\$ 0.43	\$ 0.85	\$ 0.99	\$ 0.68		
Direct Savings (\$100k's)	\$ 0.59	\$ 6.25	\$ -	\$ 34.47	\$ -	\$ 72.22	\$ 49.69	\$ 99.26	\$ 115.06	\$ 79.53	\$ 45,707,251.88	
Total Savings (\$100k's)	\$ 13.87	\$ 114.03	\$ -	\$ 628.35	\$ -	\$ 587.73	\$ 404.24	\$ 302.72	\$ 350.89	\$ 242.53	\$ 264,437,126.09	

<b>Total Costs in in \$100k's</b>												
Pediatrician Reimbursement												
Surveys	\$ 2.71	\$ 7.14	\$ -	\$ 7.50	\$ -	\$ 8.29	\$ 8.55	\$ 8.54	\$ 6.60	\$ 4.56		
Coordinating Care												
Hiring 10 POP-IN Case Administrators (Fixed - One Time Cost)	\$ 4.62	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
Hiring 10 POP-IN Social Workers (Fixed - One Time Cost)	\$ 7.40	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
Social Work Reimbursement	\$ 0.04	\$ 0.30	\$ -	\$ 1.63	\$ -	\$ 1.56	\$ 1.07	\$ 0.84	\$ 0.98	\$ 0.67		
Treatments												
Postpartum Depression	\$ 0.55	\$ 4.34	\$ -	\$ 23.89	\$ -	\$ 17.41	\$ 11.97	\$ 1.35	\$ 1.56	\$ 1.08		
Substance Use - Drug Use	\$ 0.21	\$ 2.21	\$ -	\$ 12.18	\$ -	\$ 26.93	\$ 18.52	\$ 37.00	\$ 42.89	\$ 29.64		
Substance Use - Alcohol	\$ 0.01	\$ 0.15	\$ -	\$ 0.82	\$ -	\$ 1.81	\$ 1.25	\$ 2.49	\$ 2.89	\$ 2.00		
Hypertensive Diseases	\$ 0.18	\$ 1.82	\$ -	\$ 9.99	\$ -	\$ 2.86	\$ 2.06	\$ 4.12	\$ 4.78	\$ 3.31		
Total Costs (\$100k's)	\$ 15.71	\$ 15.94	\$ -	\$ 56.01	\$ -	\$ 58.86	\$ 43.42	\$ 54.34	\$ 59.69	\$ 41.26	\$ 34,523,750.09	

Direct Financial Benefit (Direct Savings - Total Cost) (\$'s)	\$ 11,183,501.78
Total Financial Benefit (Direct+Indirect Savings - Total Costs) (\$'s)	\$ 229,913,375.99
Direct Cost Savings per Person	\$ 162.59



maryland  
**health services**  
cost review commission

---

## Report from the Executive Director





maryland  
**health services**  
cost review commission

---

# Update on Medicare FFS Data & Analysis

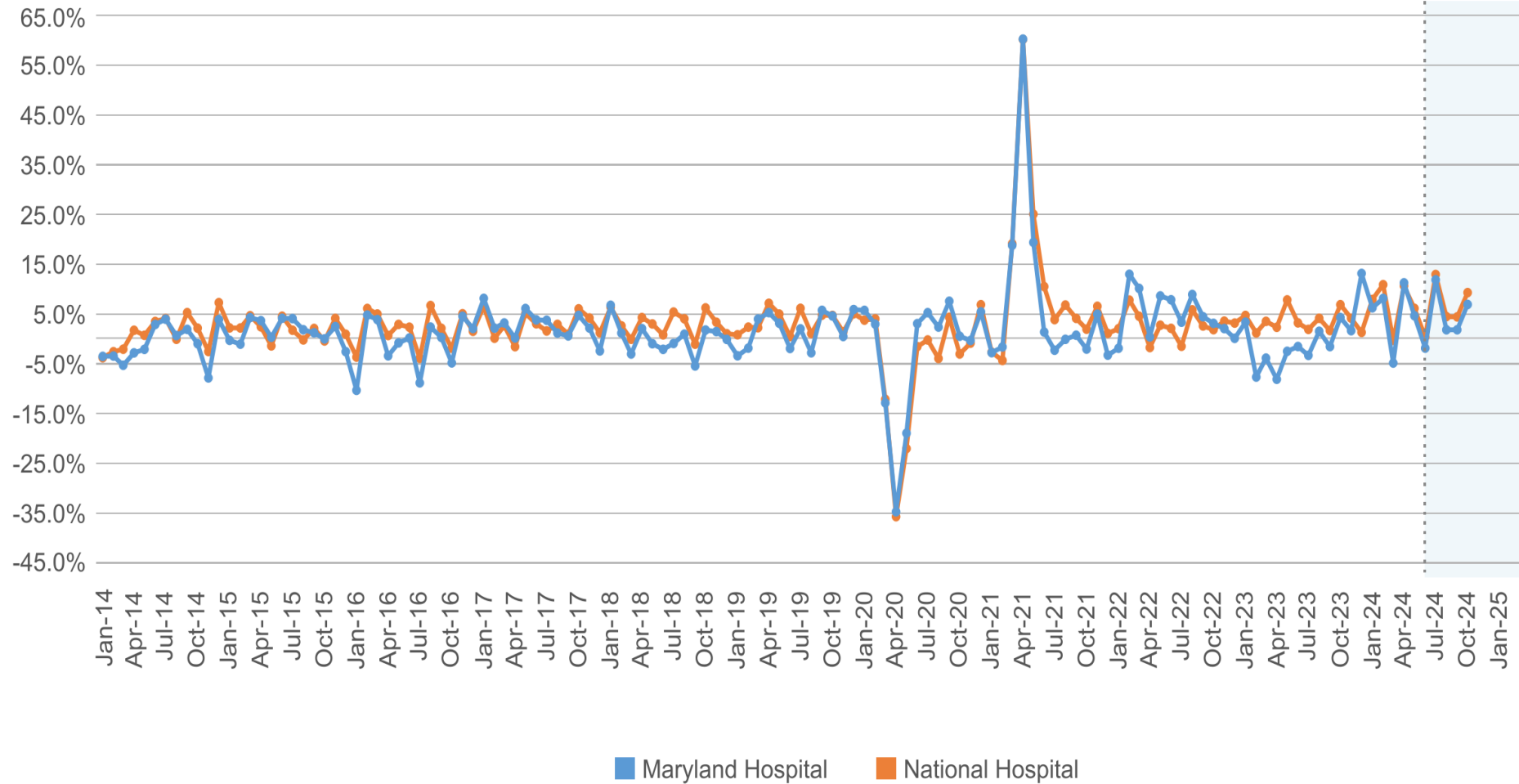
## February 2025 Update

Data through October 2024, Claims paid through December 2024

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

# Medicare Hospital Spending per Capita

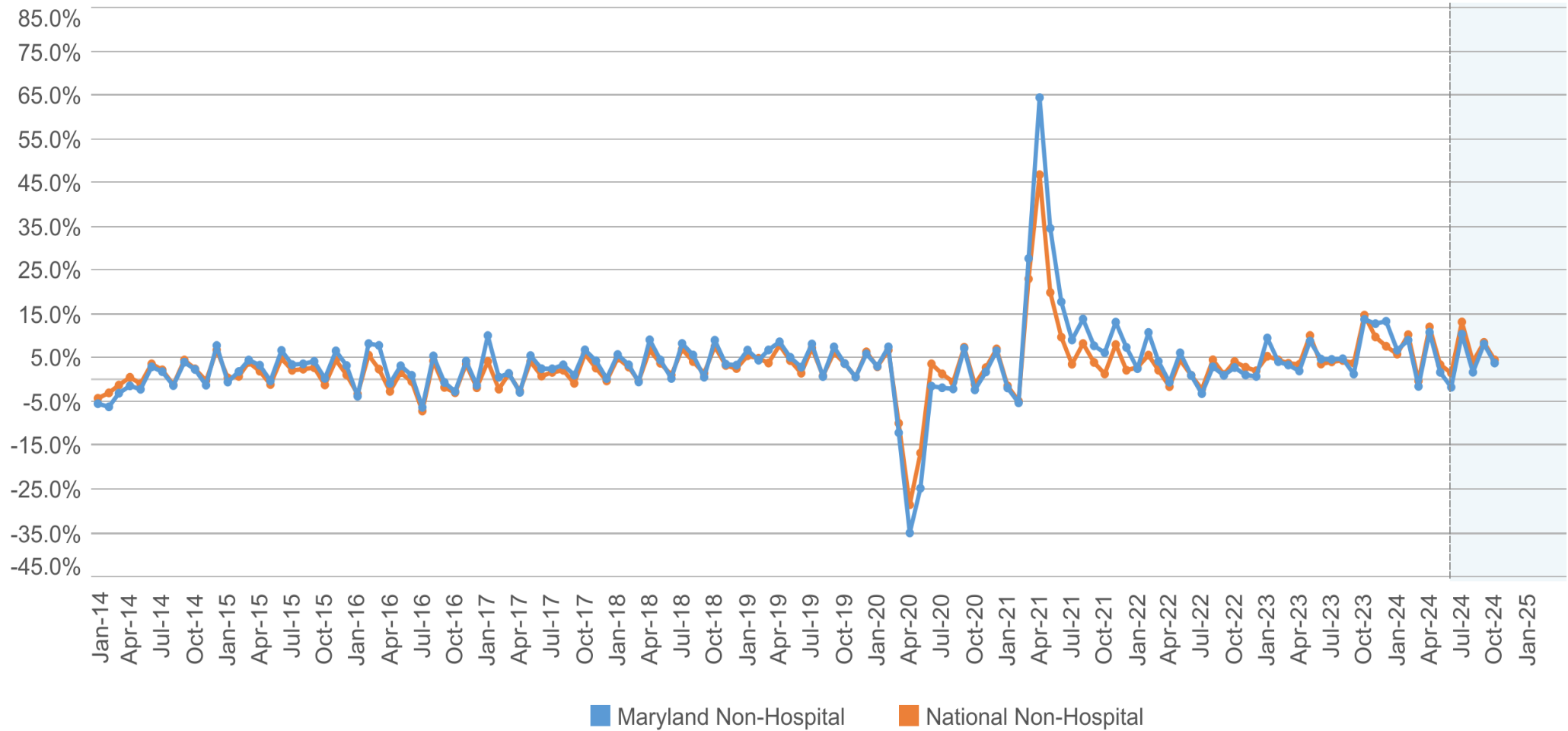
## Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge.

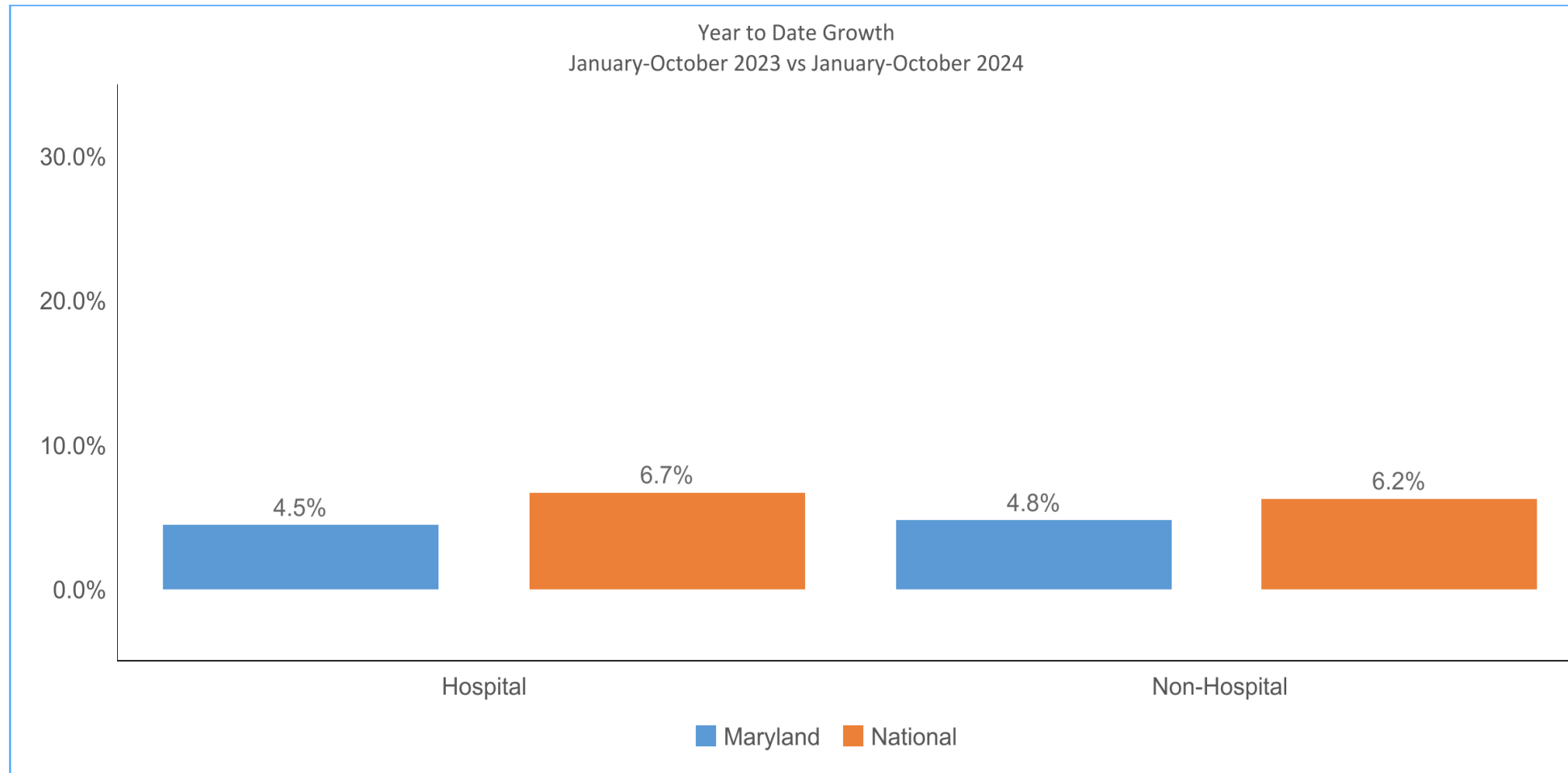
# Medicare Non-Hospital Spending per Capita

## Actual Growth Trend (CY month vs. Prior CY month)



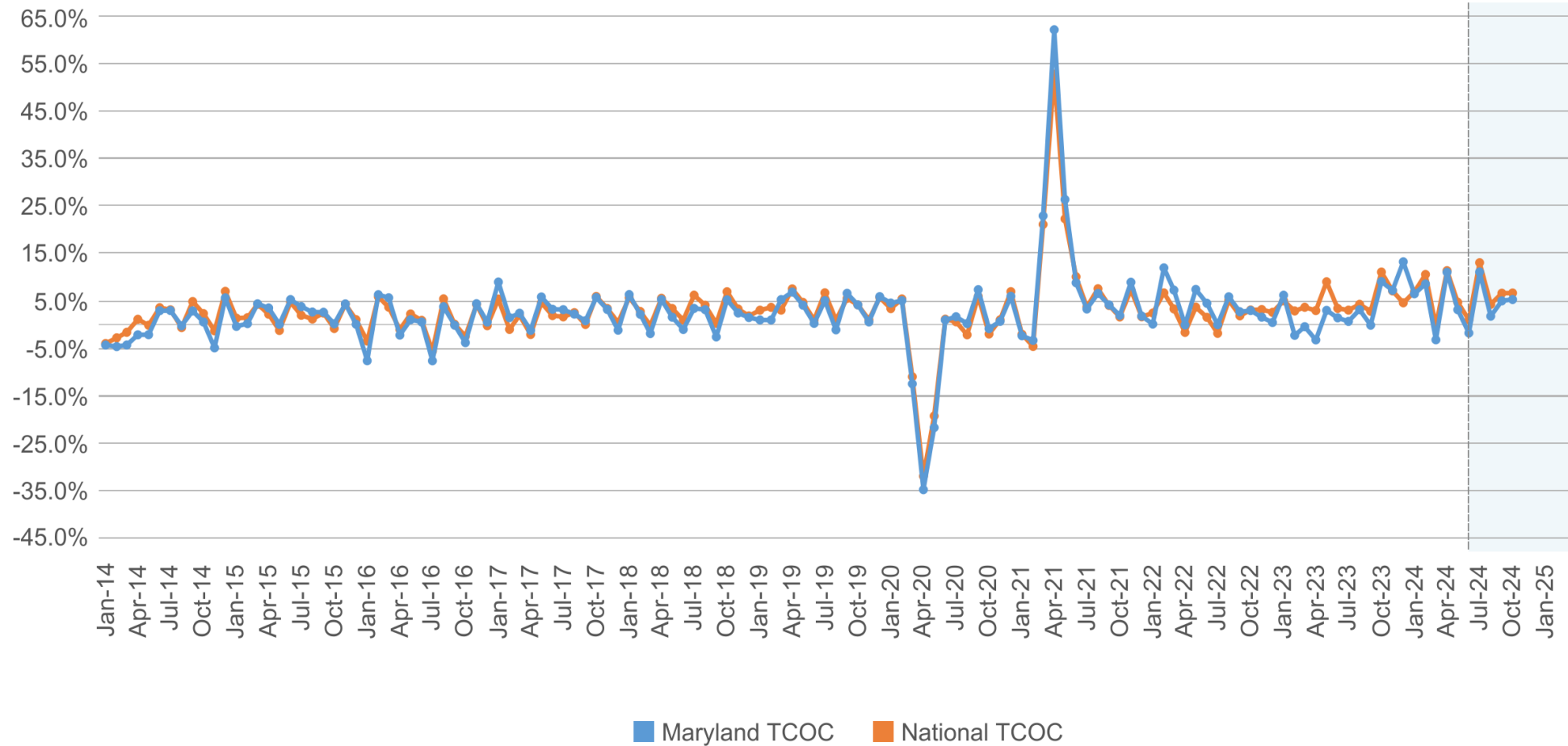


# Medicare Hospital and Non-Hospital Payments per Capita



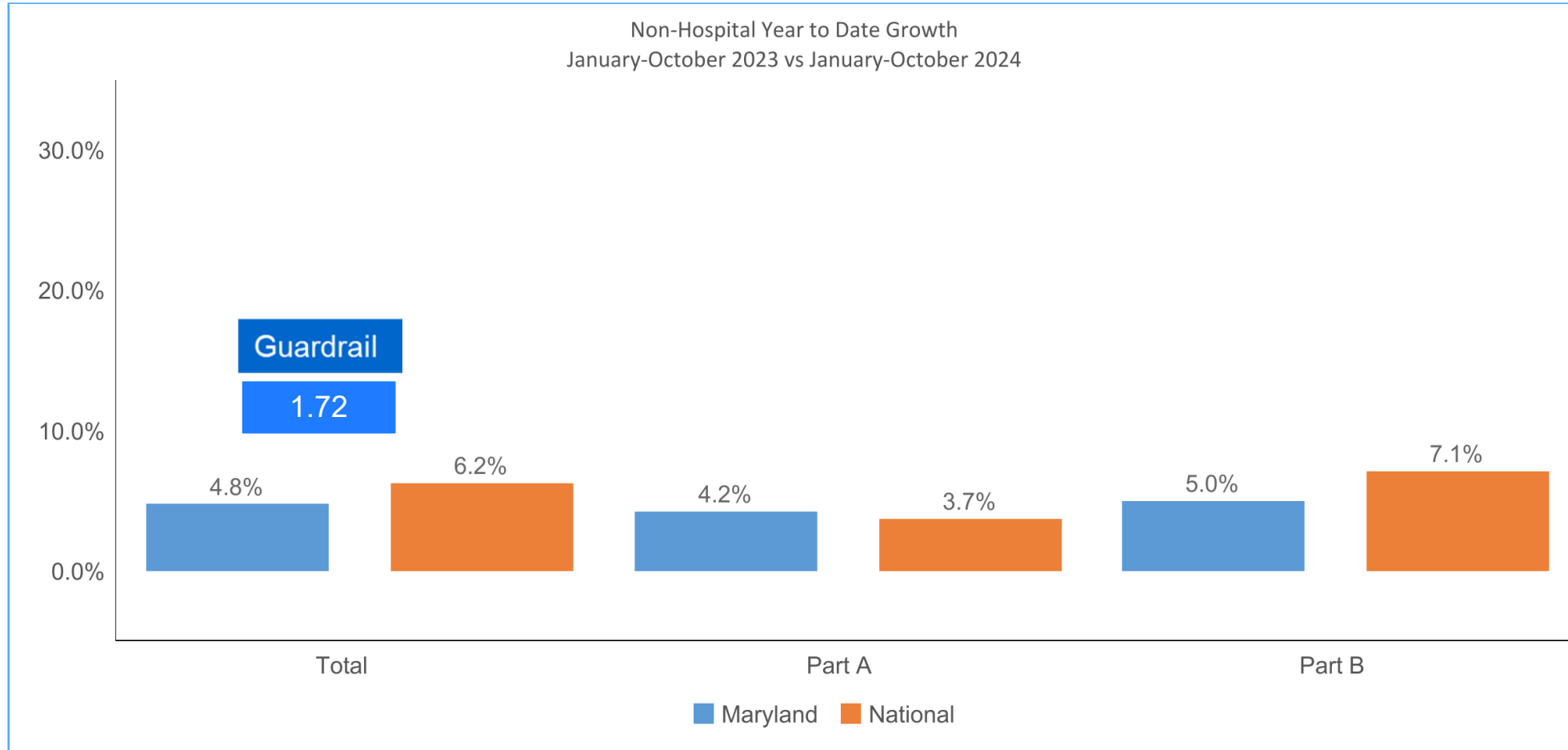
# Medicare Total Cost of Care Spending per Capita

## Actual Growth Trend (CY month vs. Prior CY month)



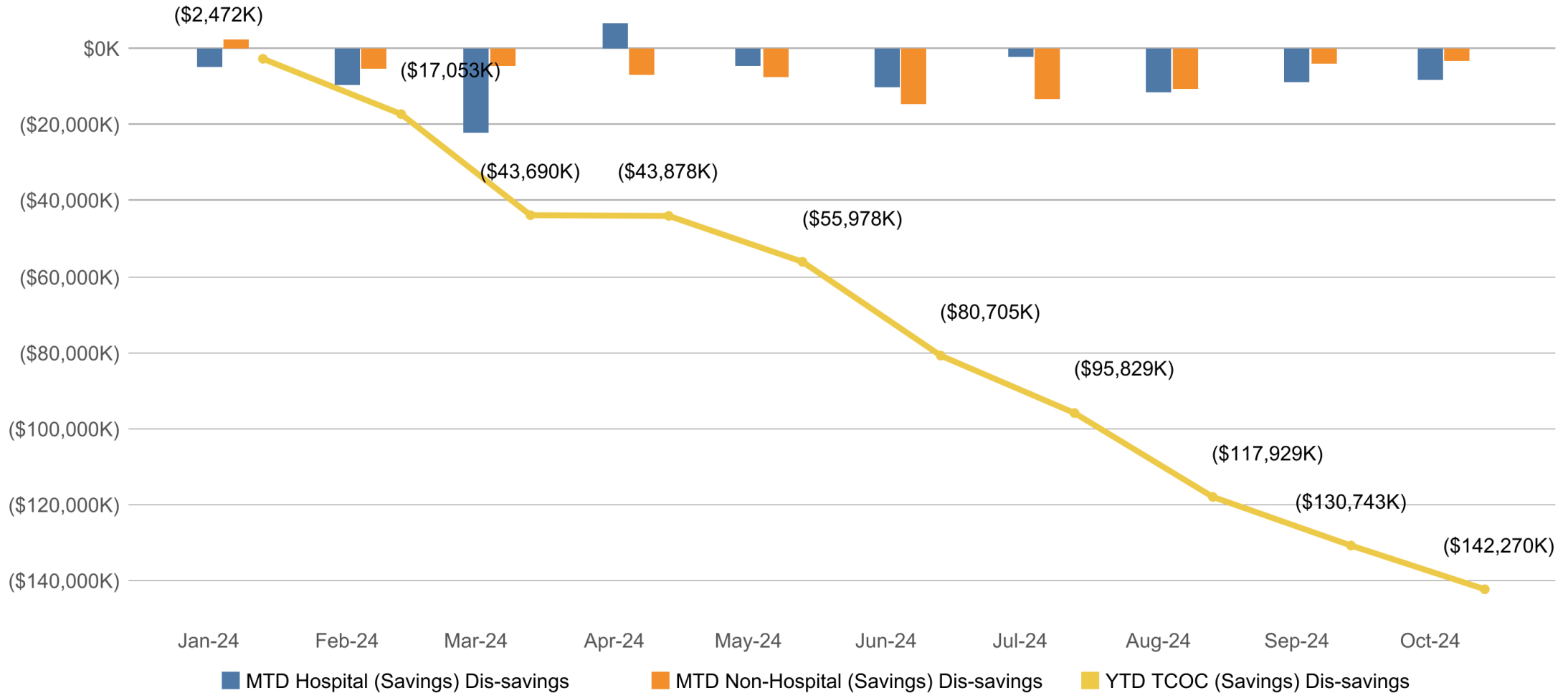
CY16 has been adjusted for the undercharge

# Medicare Total Cost of Care Payments per Capita



# Maryland Medicare Hospital & Non-Hospital Growth

## CYTD through October 2024



# New Paradigms & High Value Care Plans

# New Paradigms in Care Delivery (NPCD) Program

- HSCRC approved \$20M for investment in innovative clinical solutions via a Transformation Fund included in the RY 2025 Update Factor.
- Goal: Provide funding to hospitals and other entities to test and implement innovative solutions that prevent the need for traditional hospitalization.
- Eligibility: MD hospitals that have global budgets established under the rate-setting authority of the HSCRC
- Timeline:
  - RFI Announcement: February 4, 2025
  - Q&A Opportunity: February 26 TCOC workgroup meeting
  - Application Deadline: March 31, 2025
  - Award Notification: June 2025
  - Provision of funding: July 2025 (input into rates)



# High Value Care Plans (HVCP)

- The FY 2025 Update Factor recommendation included a requirement for hospitals to submit population health management plans as part of an efforts to reduce statewide potentially avoidable utilization (PAU).
- Hospital plans must describe new and existing strategies and programs specific to addressing the priority area of focus identified by the VBCI tool or an alternate tool. Hospitals must also include improvement targets and outcomes for the identified area of focus.
- Hospitals that do not submit plans or submit plans that do not meet passing criteria will be subject to a 0.19% clawback in their July rate orders.
- Timeline:
  - HVCP Template Sent Out: February 6, 2025
  - Q&A Opportunity: February 26 TCOC workgroup meeting
  - CRISP Session: February 18, 2025 from 11-12pm
  - Submission Deadline: March 28, 2025





maryland  
**health services**  
cost review commission

---

## Nurse Support Program II

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

February 12, 2025

Erin Schurmann, HSCRC

Laura Schenk, MHEC

Kimberly Ford, MHEC

# Stakeholder Feedback: Public Comments (1 of 2)

- Received a total of 11 public comment letters:
  - Bowie State University
  - Johns Hopkins School of Nursing
  - Morgan State University
  - University of Maryland School of Nursing
  - University System of Maryland (USM)
  - Maryland Hospital Association (MHA)
  - National League for Nursing (NLN)
  - Maryland Action Coalition (MDAC)
  - 3 individuals
- All of the letters received conveyed strong support for continued funding of NSP II and the staff recommendations for program renewal

# Stakeholder Feedback: Public Comments (2 of 2)

- Common themes:
  - Faculty development
  - Innovative Projects and Collaborations
  - Workforce Diversity and Health Equity
  - Community and Population Health
  - Outcomes and Results
  - Long-term Sustainability
- Feedback on staff recommendations:
  - Maryland Hospital Association: Retain focus on preparing nurses for bedside roles in acute care, as hospitals report a continued high demand for nurses, particularly in medical-surgical units.

# Final Staff Recommendations

- Request for NSP II permanent funding with annual reports on program performance.
- **REVISED:** 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.
- Revise existing initiatives related to the National Academy of Medicine's *Future of Nursing 2020-2030* report to reflect progress toward state/national goals for advancing the future of nursing.
- **REVISED:** 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 acute care, primary care and community health.
- Identify new opportunities to prioritize funding to underrepresented groups in nursing through both competitive institutional grants and faculty-focused programs.
- 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.
- Enhance data collection infrastructure and analysis to promote greater accountability in reporting of statewide data and support responsiveness of NSP II to Maryland nursing education and workforce trends.



# **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.

# Table of Contents

<b>Introduction</b>	<b>1</b>
<b>Background</b>	<b>1</b>
Conceptual Framework	2
NSP II Initiatives	3
<b>Major NSP II Achievements</b>	<b>6</b>
Competitive Institutional Grants Program	6
Statewide Initiatives Program	16
<b>State of Nursing and Future Issues</b>	<b>24</b>
Nursing Workforce Trends: Maryland vs Nation	25
Nursing Education Trends	26
Nursing Practice Trends	29
Stakeholder Engagement	34
<b>Staff Recommendations for Program Renewal</b>	<b>38</b>
<b>References</b>	<b>41</b>

## 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:

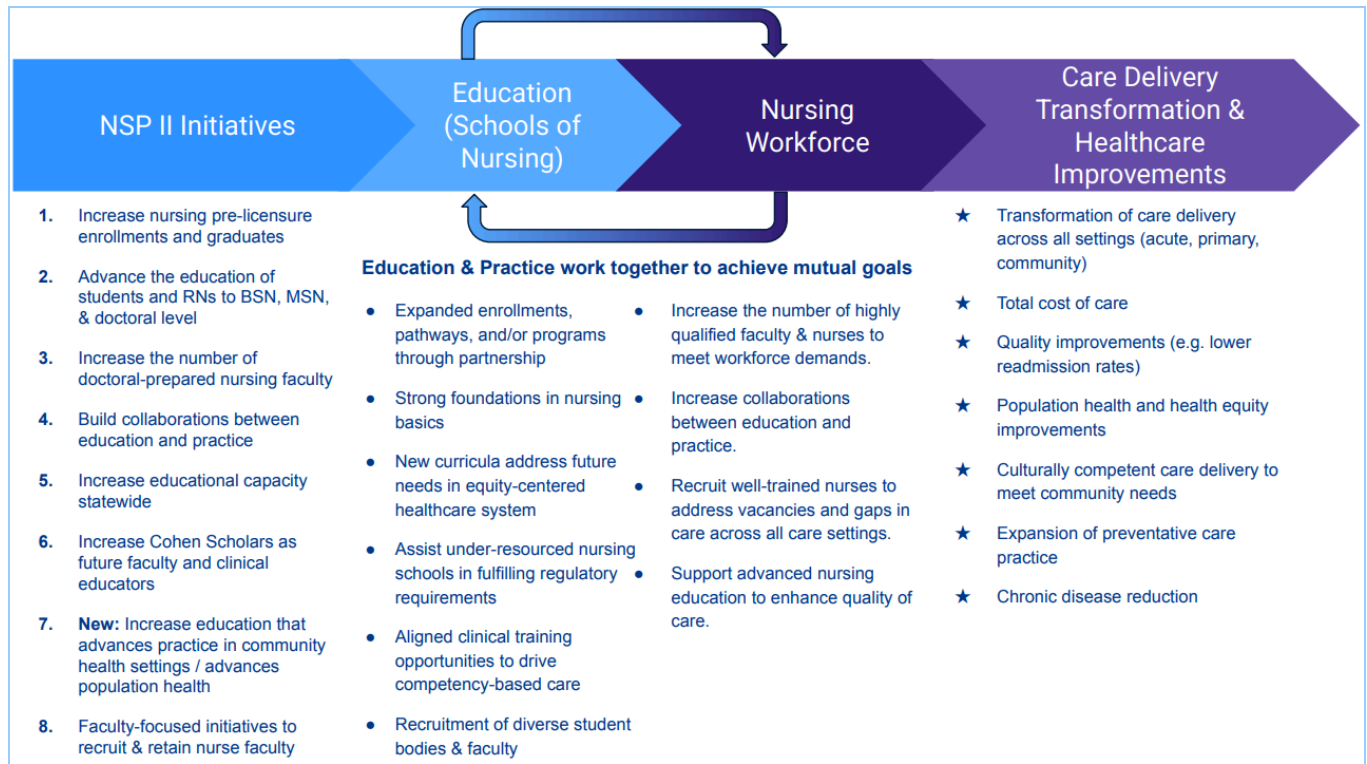


- The Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund [2006, chs. 221, 222] was amended in 2016 to delete “bedside” to ensure the best nursing skills mix for the workforce was not limited to just bedside nurses.
- In 2012, the NSP II program was modified to 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  <i>(Examples: clinical education models, dedicated education units, pipelines to nursing, community-based health partnerships)</i>	Collaborative results are specific to grant initiative  <i>(Examples: # of additional clinical education spots, # of additional partnerships)</i>	Specific to grant initiative
5. Increase capacity statewide  <i>(Examples: faculty professional development, statewide simulation resources, nursing workforce center, nurse resiliency program)</i>	Statewide results are specific to grant initiative  <i>(Examples: # of additional resources, workshops, activities or modules)</i>	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)
<i>New:</i> 7. Increase education that advances practice in community health settings / advances population health	Community / Population health results are specific to grant initiative  <i>(Examples: # of additional providers, community services provided, patient encounters)</i>	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
<b>TOTAL</b>	<b>87</b>	<b>26</b>	<b>\$58,962,533</b>

*Note.* Regions defined by Maryland Office of Tourism ([visitmaryland.org](http://visitmaryland.org)) and categorized by physical address.

## Progress by Initiative

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

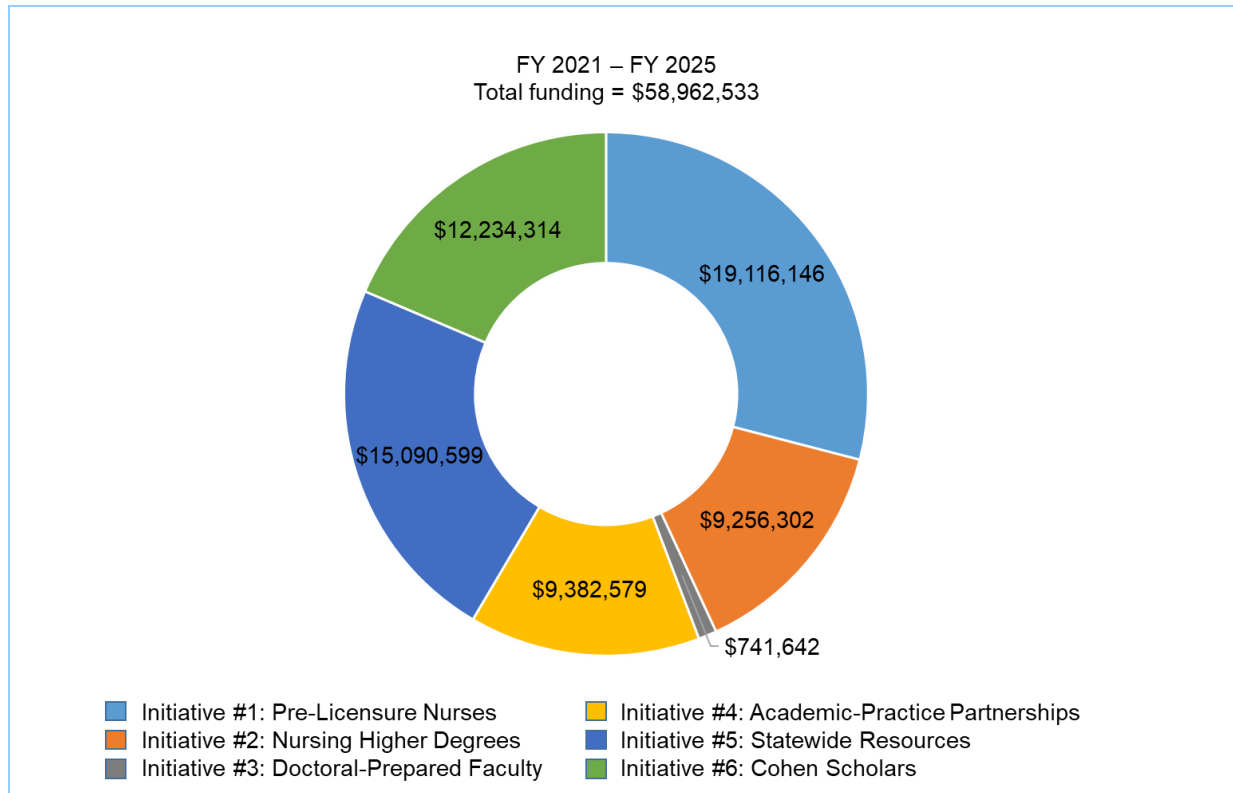
1. Increasing nursing pre-licensure enrollments and graduates;
2. Advancing the education of students and nurses to BSN, MSN & doctoral level;
3. Increasing the number of doctoral-prepared nursing faculty;
4. Building collaborations between nursing education and practice,
5. Increasing educational capacity 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
<b>Total</b>	<b>1,545</b>	<b>568</b>	<b>37%</b>

*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
<b>Total</b>	<b>845</b>	<b>566</b>	<b>67%</b>

*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
<b>Total Completed</b>	<b>30</b>	<b>33</b>	<b>110% - Exceeded Goal</b>

*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	<a href="http://www.LeadNursingForward.org">www.LeadNursingForward.org</a> 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	<a href="#">MNWC Website</a> & 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:

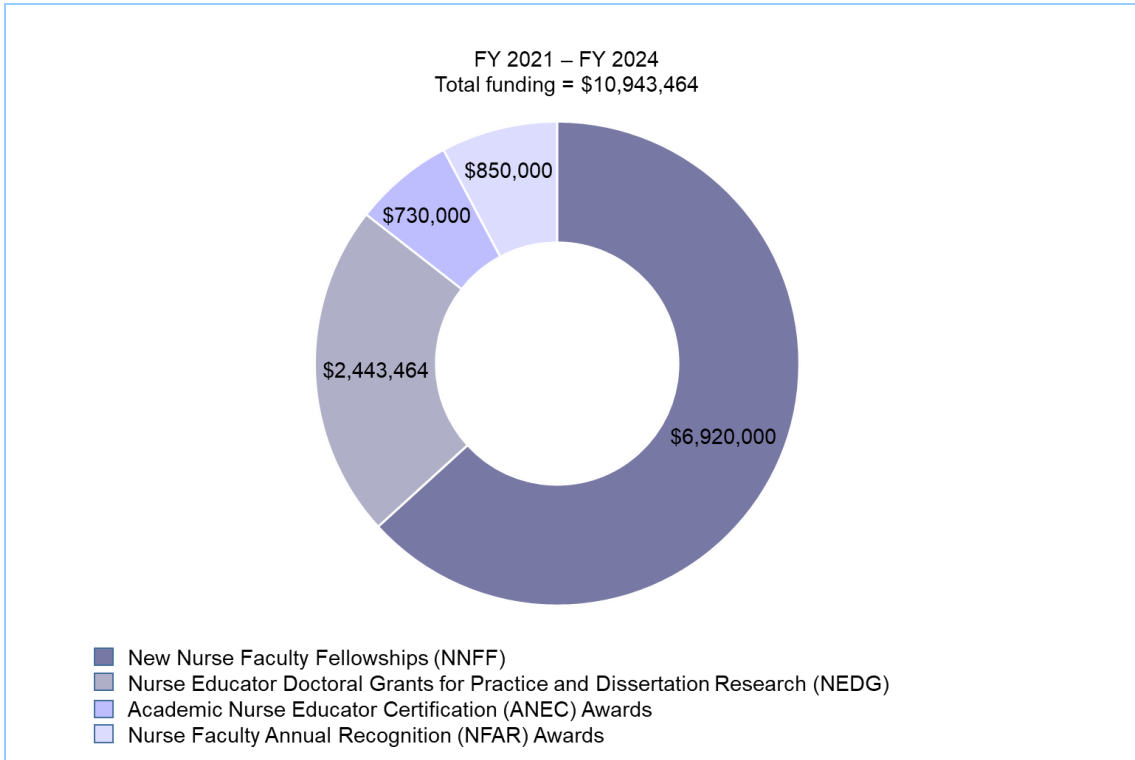
1. New Nurse Faculty Fellowships (NNFF), for new nurse faculty hired by Maryland institutions to expand enrollments in their nursing programs;
2. Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG) for existing faculty to expedite doctoral degree completions;
3. Academic Nurse 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
<b>TOTAL</b>	<b>482</b>	<b>27</b>	<b>\$10,943,464</b>

Note. Regions defined by Maryland Office of Tourism ([visitmaryland.org](http://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
<b>Maryland</b>	0.89	49,770	\$92,090
<b>West Virginia</b>	1.45	20,860	\$75,990
<b>Delaware</b>	1.20	11,810	\$94,670
<b>Pennsylvania</b>	1.16	144,100	\$87,530
<b>New Jersey</b>	0.94	82,950	\$101,960
<b>Virginia</b>	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

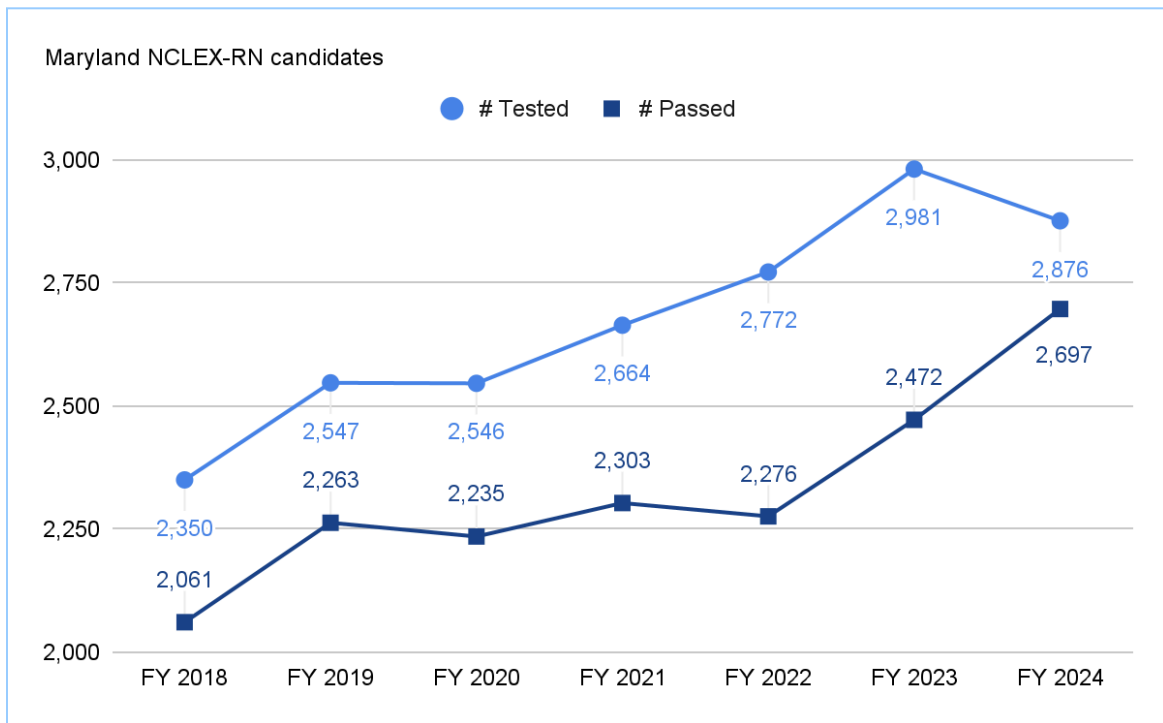
This section highlights the challenges and opportunities within nursing education, including the impact of faculty shortages on program capacity and the success of new graduates in achieving licensure. Key data is explored regarding entry-to-practice in Maryland, focusing on NCLEX-RN pass rates and trends 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 1<sup>st</sup> 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 1<sup>st</sup> 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 <sup>1</sup>
<b>Number of Residents Hired</b>	1,573	1,513	1,846	1,995	2,417	2,603	3,422
<b>Turnover Rate<sup>2</sup></b>	8%	12%	11%	17%	9%	11%	9%
<b>Retention Rate</b>	92%	88%	89%	83%	91%	89%	91%

Source: Vizient/ AACN NRP Data for MONL, Inc. /MNRC, April 16, 2024.

<sup>1</sup>2023 turnover and retention data is preliminary; data is finalized after 12 months of employment.

<sup>2</sup>Turnover rate includes voluntary and involuntary termination of employment.

## New Nursing Graduate Employment

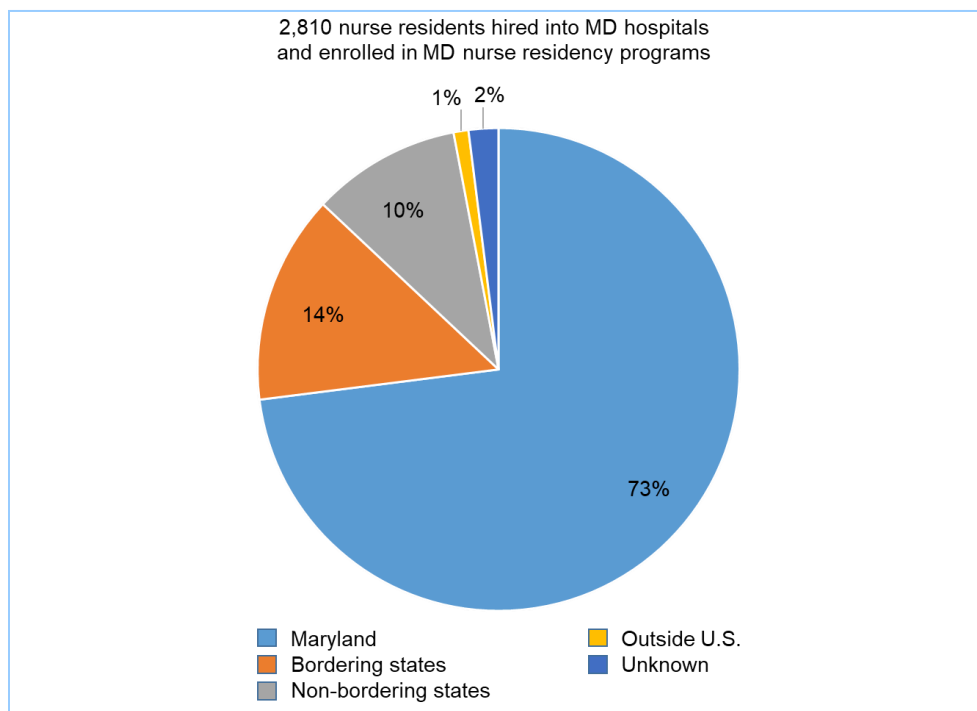
Examining the employment of new nursing graduates is critical when assessing the state of the nursing workforce in Maryland, as it directly reflects the ability of the healthcare system to absorb and retain newly licensed professionals. The transition from education to practice is a pivotal phase in 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;

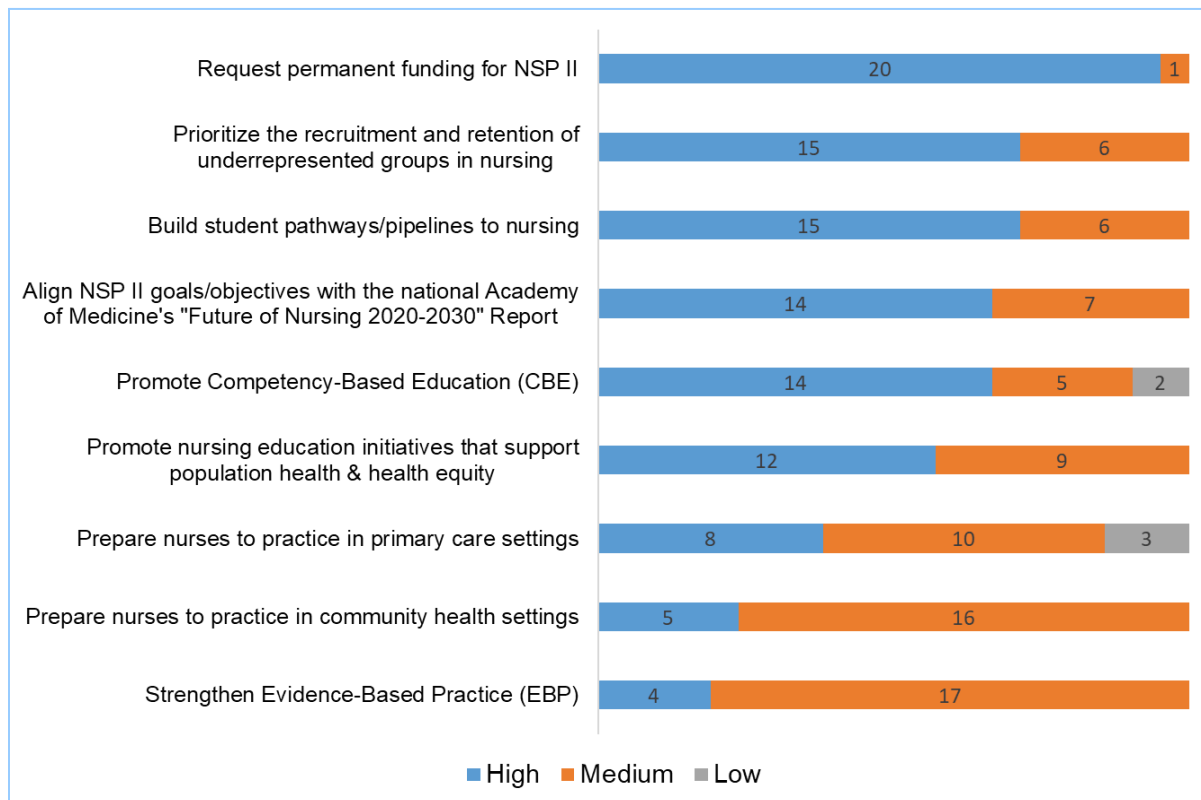
5. Development of advanced nursing roles;
6. Support for critical workforce needs; and
7. Support for diversity and underrepresented groups in nursing.

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.

## References

1. Auerbach, D. I., Buerhaus, P. I., Donelan, K., & Staiger, D. O. (2024). Projecting the Future Registered Nurse Workforce After the COVID-19 Pandemic. *JAMA Health Forum*, 5(2), 1-10. doi:[10.1001/jamahealthforum.2023.5389](https://doi.org/10.1001/jamahealthforum.2023.5389)
2. Auerbach, D. I., Chattopadhyay, A., Zangoro, G., Staiger, D. O. & Buerhaus, P. I. (2017). Improving nursing workforce forecasts: Comparative analysis of the cohort supply model and the health workforce simulation model. *Nursing Economics*, 35(6), 283-326.
3. American Association of Colleges of Nursing (AACN), Fact Sheets, <https://www.aacnnursing.org/news-data/fact-sheets>;  
<https://www.aacnnursing.org/students/nursing-education-pathways/phd-education>
4. American Organization for Nursing Leadership (AONL) Guiding Principles for the Aging Workforce, Accessed April 5, 2022, at <https://www.aonl.org/system/files/media/file/2020/12/for-the-aging-workforce.pdf>
5. Brassard, A. (2023). Maps Illustrate a Decade of Progress in Nursing Education. *RWJF Campaign for Action*, <https://campaignforaction.org/maps-illustrate-decade-progress-nursing-education/>
6. Health Resources & Services Administration (HRSA), National Sample Survey of Registered Nurses (NSSRN), <https://bhwh.hrsa.gov/data-research/access-data-tools/national-sample-survey-registered-nurses>;  
<https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nssrn-education-training-report.pdf>
7. Maryland Board of Nursing, NCLEX-RN First Time Candidate Performance, <https://mbon.maryland.gov/Pages/education-nclex-stats.aspx>
8. Maryland Department of Health. (2023). SB 440 Ch. 708 (2022) – 2023 Final Report – *Commission to Study the Health Workforce and Workforce Development Needs*. Maryland Department of Health. [https://health.maryland.gov/docs/SB%20440%20Ch.%20708%20\(2022\)%20%E2%80%93%202023%20Final%20Report%20%E2%80%93%20Commission%20to%20Study%20the%20Health%20Workforce%20and%20Workforce%20Development%20Needs.pdf](https://health.maryland.gov/docs/SB%20440%20Ch.%20708%20(2022)%20%E2%80%93%202023%20Final%20Report%20%E2%80%93%20Commission%20to%20Study%20the%20Health%20Workforce%20and%20Workforce%20Development%20Needs.pdf)
9. Maryland Educator Career Portal, [www.leadnursingforward.org](http://www.leadnursingforward.org)
10. Maryland Nursing Workforce Center, Next Gen NCLEX Workshops, <https://www.nursing.umaryland.edu/mnwc/mnwc-initiatives/nextgen-nclex/nextgen-nclex-workshops/>



11. Maryland Nursing Workforce Center, Analysis of COVID-19 Impact on Maryland Nursing Workforce (December, 2021), Accessed at <https://nursesupport.org/nurse-support-program-ii/grants/statewide-initiatives/-maryland-nursing-workforce-center-mnwc/>
12. Maryland Cost of Living Compared to Other States and National Costs, <https://www.insure.com/cost-of-living-by-state.html>
13. National Council State Board of Nursing, Next Generation NCLEX (NGN), <https://www.ncsbn.org/11447.htm>
14. National Council State Board of Nursing, NCSBN Research Projects Significant Nursing Workforce Shortages and Crisis (April, 2023). Accessed at <https://www.ncsbn.org/news/ncsbn-research-projects-significant-nursing-workforce-shortages-and-crisis#:~:text=The%20data%20reveals%20that%20100%2C000.if%20solutions%20are%20not%20enacted.>
15. National League for Nursing, Certified Nurse Educator, CNE®, Certification Portal, <https://www.nln.org/awards-recognition/certification-for-nurse-educators-overview>
16. National Academy of Medicine, Future of Nursing 2020-2030 and Future of Nursing (2010), accessed at <https://nam.edu/publications/the-future-of-nursing-2020-2030/>
17. Nurse Support Program, [www.nursesupport.org](http://www.nursesupport.org)
18. NSP I Annual Report on FY 2022 Activities, July 2023; <https://nursesupport.org/assets/files/1/files/nspi-nsp-i-annual-report-on-fy-22-final.pdf>
19. NSP II Data Tables in 2019-2024, Fall 2024, P. Daw, K. Ford, L. Schenk
20. NSI Nursing Solutions Inc. 2023 NSI National Health Care Retention & RN Staffing Report; [https://www.nsinursingsolutions.com/Documents/Library/NSI\\_National\\_Health\\_Care\\_Retention\\_Report.pdf](https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf).
21. NSI Nursing Solutions Inc. 2024 NSI National Health Care Retention & RN Staffing Report; [https://www.nsinursingsolutions.com/documents/library/nsi\\_national\\_health\\_care\\_retention\\_report.pdf](https://www.nsinursingsolutions.com/documents/library/nsi_national_health_care_retention_report.pdf).
22. Porat-Dahlerbruch, J., Aiken, L.H., Lasater, K.B., Sloane, D.M., & McHugh, M.D. (2022). Variations in nursing baccalaureate education and 30-day inpatient surgical mortality, *Nursing Outlook*, 70 (2), 300-308, <https://doi.org/10.1016/j.outlook.2021.09.009>.

23. U.S. Bureau of Labor Statistics, May 2023, Maryland State Level Data and U.S. Comparisons, [https://www.bls.gov/oes/current/oes\\_md.htm](https://www.bls.gov/oes/current/oes_md.htm); <https://www.bls.gov/oes/current/oes291141.htm>; and <https://www.bls.gov/oes/2023/may/oes251072.htm>.



DEPARTMENT OF NURSING

Center for Natural Sciences, Mathematics and Nursing, Suite 2101  
14000 Jericho Park Rd, Bowie, MD 20715

P 301-860-3201

F 301-860-3221

[bowiestate.edu](http://bowiestate.edu)

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



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,

A handwritten signature in cursive script, appearing to read "Sarah L. Szanton".

Sarah L. Szanton, PhD, ANP, FAAN

Dean

Patricia M. Davidson Health Equity and Social Justice Endowed Professor

A handwritten signature in cursive script, appearing to read "Natalia Barolín".

Natalia Barolín, BA, BSN, RN

Sr. Health Policy Adviser



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.





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,

A handwritten signature in black ink that reads "Maija R. Anderson". The signature is written in a cursive style with a large, prominent initial "M".

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

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

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

January 15, 2025

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

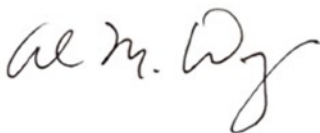
Dear Members of the Nurse Support Program II Review Committee,

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

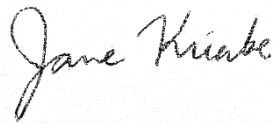
We offer suggestions on the following staff recommendations:

- 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](mailto: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*

Yolanda Ogbolu, PhD, NNP, FNAP, FAAN  
The Bill and Joanne Conway, Dean and Professor  
University of Maryland School of Nursing  
655 W. Lombard Street – Suite 505  
Baltimore, MD 21201  
[ogbolu@umaryland.edu](mailto:ogbolu@umaryland.edu)

Patricia Travis, PhD, RN, CCRP  
Senior Associate Director for Clinical Research  
Johns Hopkins University School of Medicine  
733 N. Broadway – Suite 117  
Baltimore, MD 21205  
[Ptravis2@jhmi.edu](mailto:Ptravis2@jhmi.edu)

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:

A handwritten signature in blue ink that reads "Mary Mills". The signature is written in a cursive style.

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**

---

10843 East County Road 750 North  
Brownsburg, IN 46112  
317.626.5751  
[dbillin@iu.edu](mailto: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,

A handwritten signature in cursive script that reads "Diane M. Billings".

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 RY 2027 Readmission Reduction Incentive Program Policy

HSCRC Quality Team

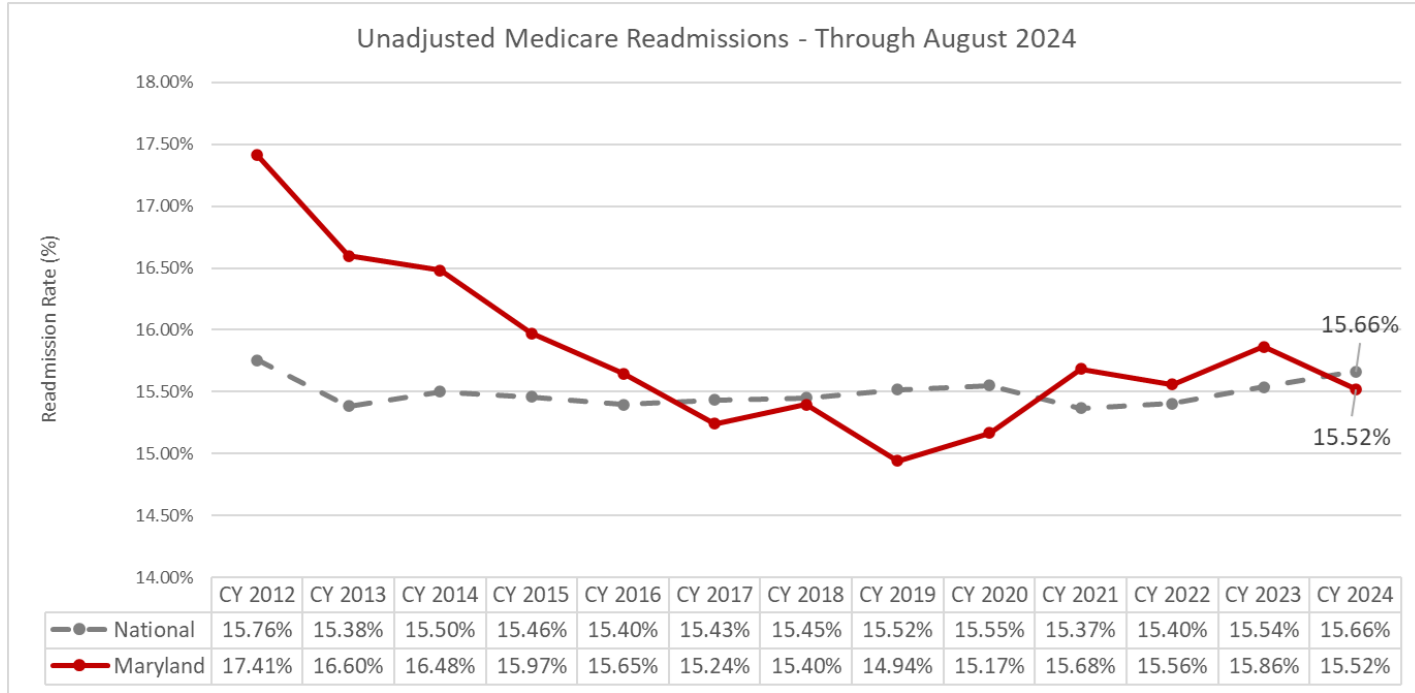
# RRIP RY 2026 Policy Intent and Considerations

The RRIP program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and guard against unintended consequences of a global budget system.

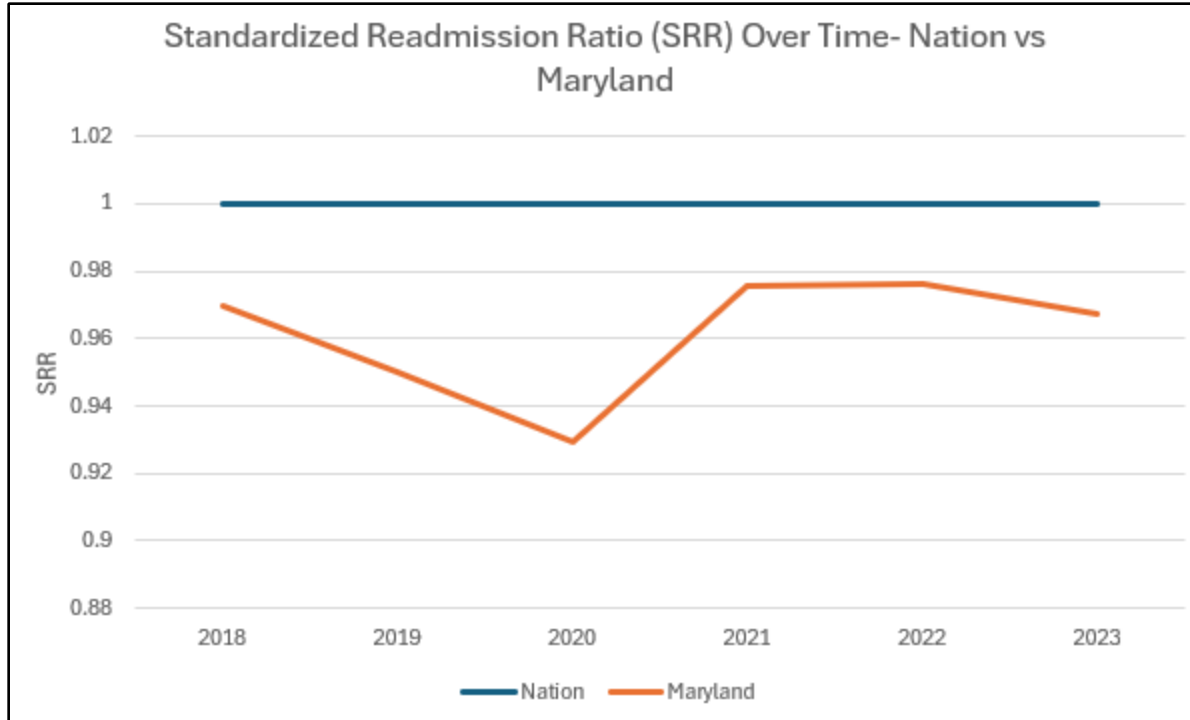
Today's Presentation:

- Evaluation of performance to date
- RY 2027 Policy Considerations:
  - Updating base period from CY 2022 to a blended two-year base period of CY 2022/2023
  - Retroactively applying the blended two-year base period of CY 2022/2023 to RY 2026
- Draft Recommendations

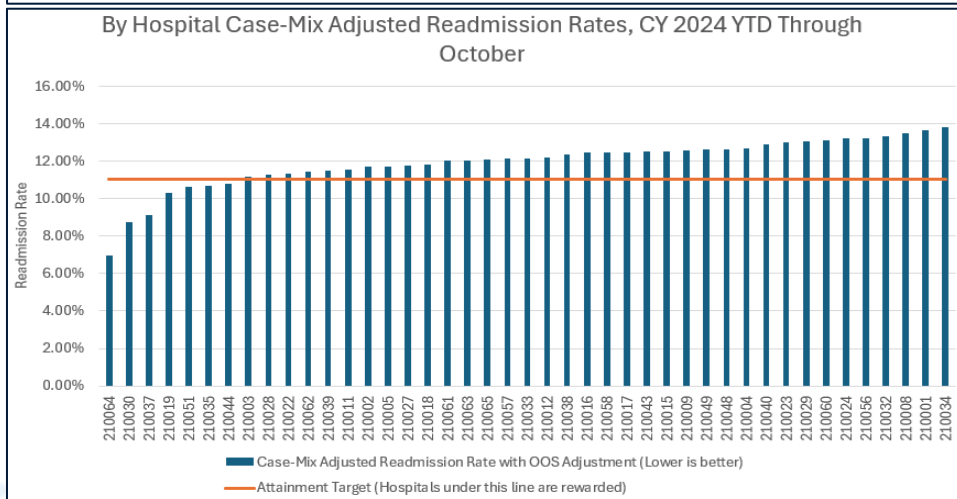
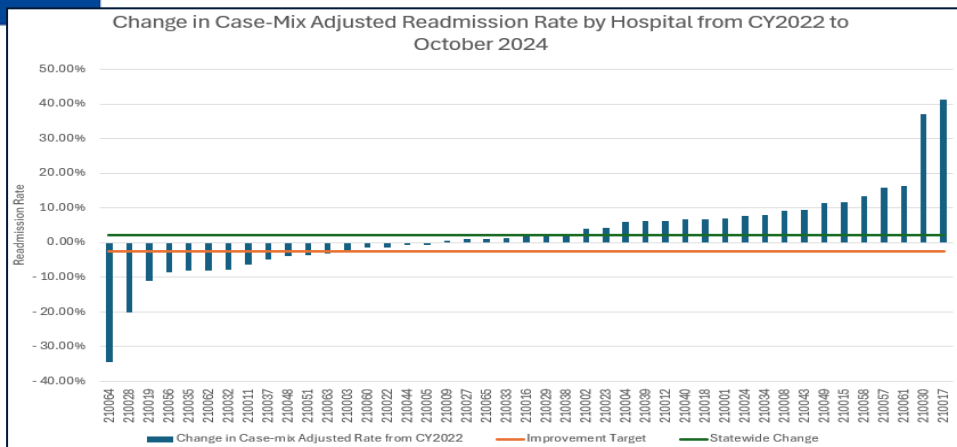
# Original Test: Unadjusted Readmission Rates, MD vs Nation



# New Test: Medicare Risk-Adjusted Hospital-Wide Readmission Measure



# RY2026 YTD By Hospital Case-Mix Adjusted Readmission Rates



- 13 hospitals are on target to reach improvement goal
- 7 hospitals are on target to reach attainment goal
- 14 unique hospitals are on target to receive a reward under the RY 2026 policy

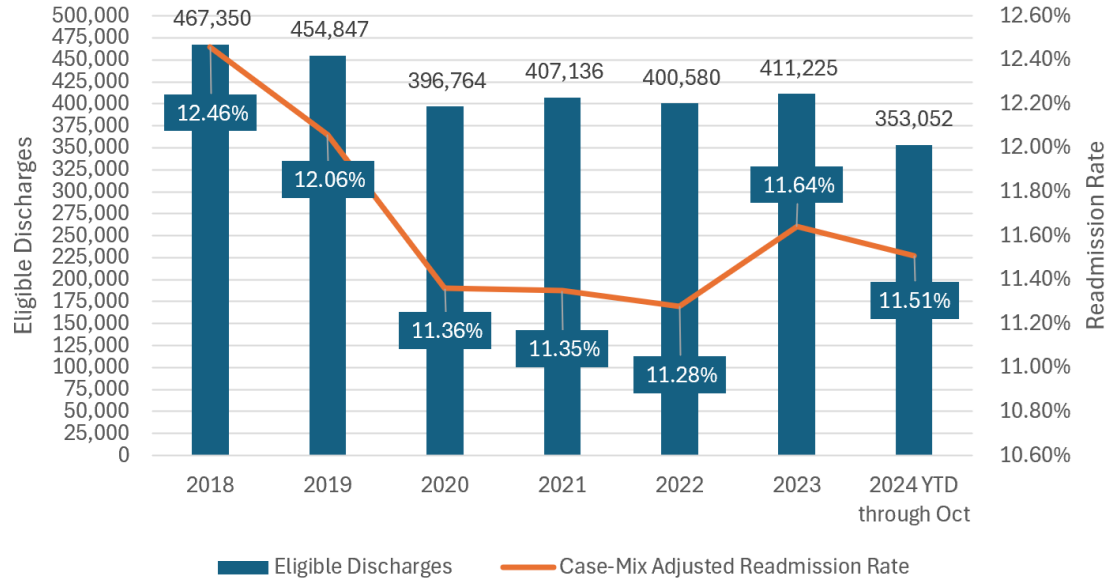
# Updates to Base Period



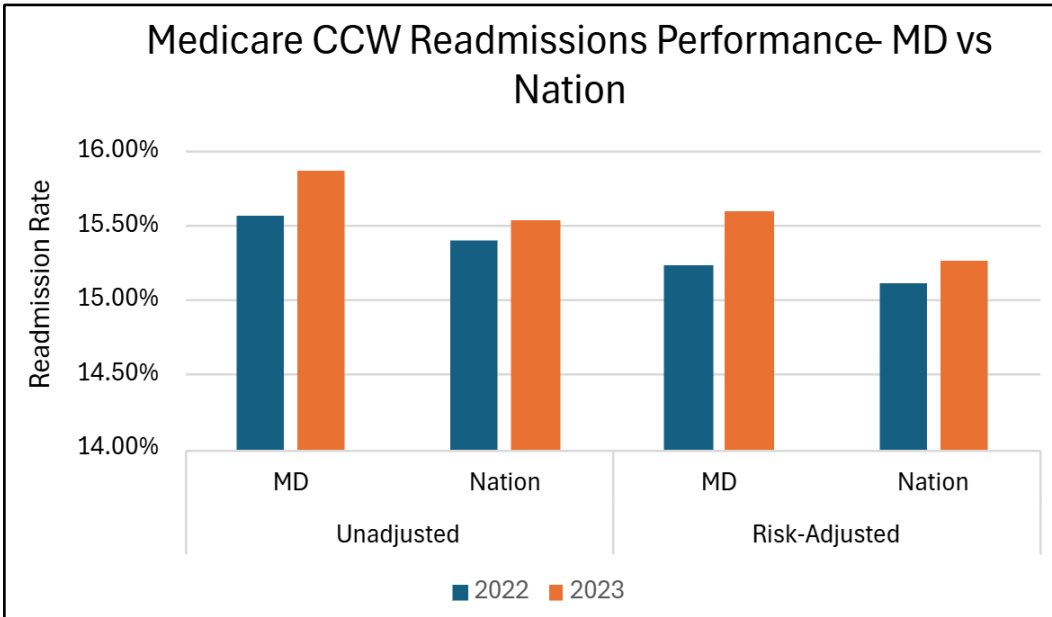
# Making the case

- Under the RY 2026 RRIP policy, hospitals are performing worse than has been seen in previous years
- Stakeholders expressed concerns with using CY 2022 as a base period due to its historically low volume and readmission rate

Statewide Case-Mix Adjusted Readmission Rate and Volume



## Staff's solution



- Staff is recommending a blended base period of CY 2022 and CY 2023 which:
  1. Provides more stable norms than a one year base period
  2. Doesn't excuse the greater degradation and worse performance compared to the Nation
- And to retroactively apply the blended base period to RY 2026

# Draft Recommendations

# RY2027 Draft RRIP Recommendations

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.

# Appendix

# RY 2026 YTD Revenue Adjustments

RY 2026 YTD Revenue Adjustments	<u>CY 2022 Base Period</u> Attainment Target: 11.02% Improvement Target: -2.53%	<u>CY2022/2023 Blended Base Period</u> Attainment Target: 11.31% Improvement Target: -2.53%
Statewide Net Adjustments (\$), (%)	~ -\$56M, -0.47%	~ -\$34M, -0.30%
Statewide Penalties (\$), (%)	~ -74M, -0.63%	~ -\$53M, -0.45%
Statewide Rewards (\$), (%)	~ \$18M, 0.15%	~ 18M, 0.15%

# RY 2027 Estimated Revenue Adjustments

RY 2027 Estimated Revenue Adjustments	CY 2022 Base Period Attainment Target: 10.88% Improvement Target: -3.78%	CY2022/2023 Blended Base Period Attainment Target: 11.31% Improvement Target: -3.78%
Statewide Net Adjustments (\$), (%)	~ -\$66M, -0.56%	~ -\$49M, -0.41%
Statewide Penalties (\$), (%)	~ -\$82M, -0.70%	~ -\$64M, -0.54%
Statewide Rewards (\$), (%)	~ 16M, 0.14%	~ \$15M, 0.12%





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](mailto:hscrc.quality@maryland.gov).

# Table of Contents

<b>List of Abbreviations</b>	<b>2</b>
<b>Key Methodology Concepts and Definitions</b>	<b>3</b>
<b>Policy Overview</b>	<b>4</b>
<b>Recommendations</b>	<b>5</b>
<b>Introduction</b>	<b>6</b>
<b>Background</b>	<b>7</b>
Brief History of RRIP program	7
RRIP Methodology	8
<b>Assessment</b>	<b>9</b>
Current Statewide Year To Date Performance	10
Medicare FFS Performance	10
Hospital Wide Readmission Measure Performance	11
All-Payer Readmission Performance	12
Base Period Concerns	15
Revisits to Emergency Department and Observation Stays	17
Excess Days in Acute Care (EDAC)	18
Digital Measures/Electronic Clinical Quality Measure (eCQM)	19
Reducing Disparities in Readmissions	20
AHEAD Model Considerations	22
<b>Recommendations</b>	<b>24</b>
<b>Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology</b>	<b>1</b>
<b>Appendix II. Modelled RY 2026 and RY 2027 Revenue Adjustments</b>	<b>9</b>

## 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).

## Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
<p>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.</p>	<p>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.</p>	<p>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.</p>	<p>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.</p>	<p>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.</p>

## 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.<sup>1</sup> 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

---

<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

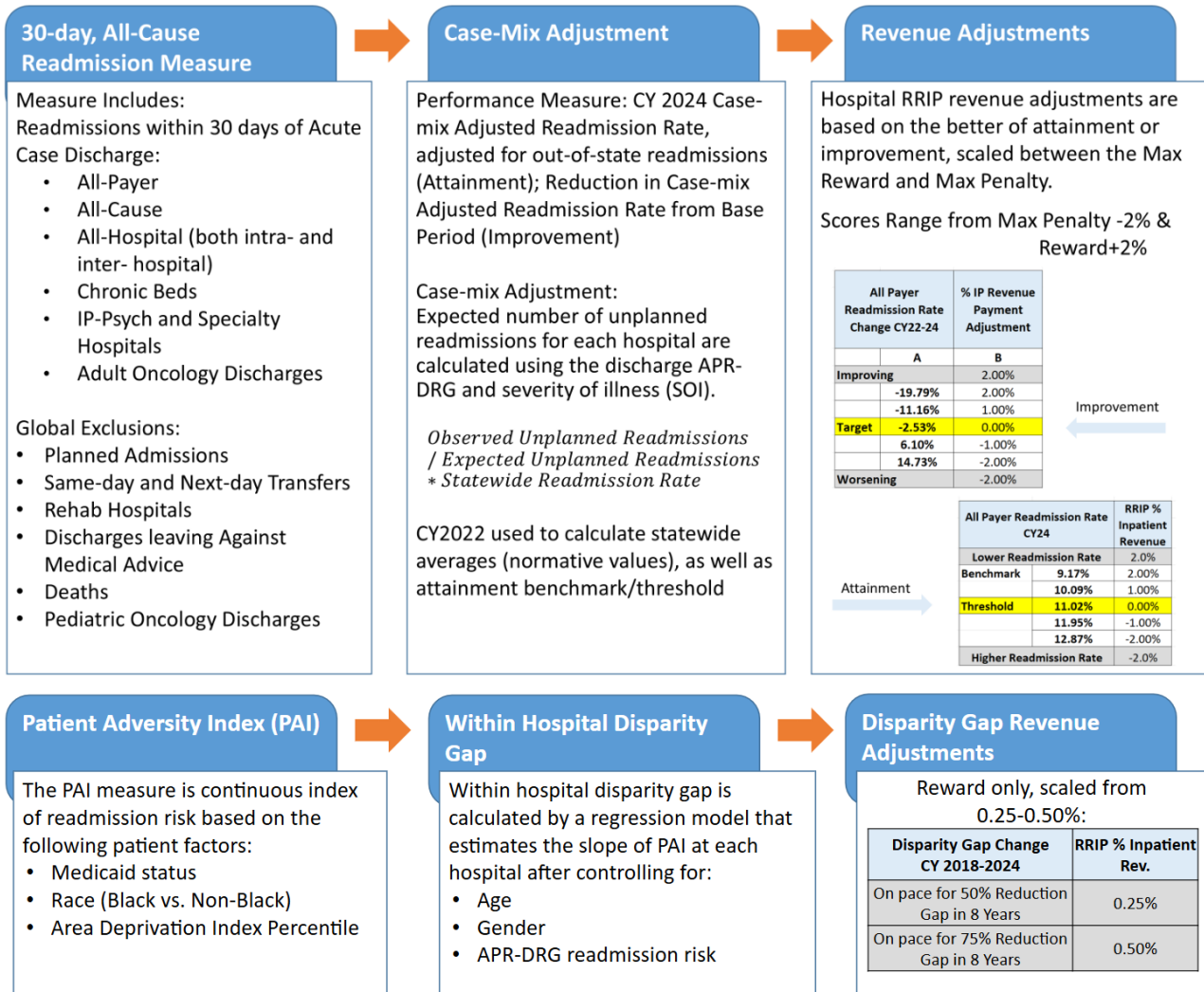
---

<sup>2</sup> 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.

<sup>3</sup> For more information on the HRRP, please see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program>

<sup>4</sup> 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.

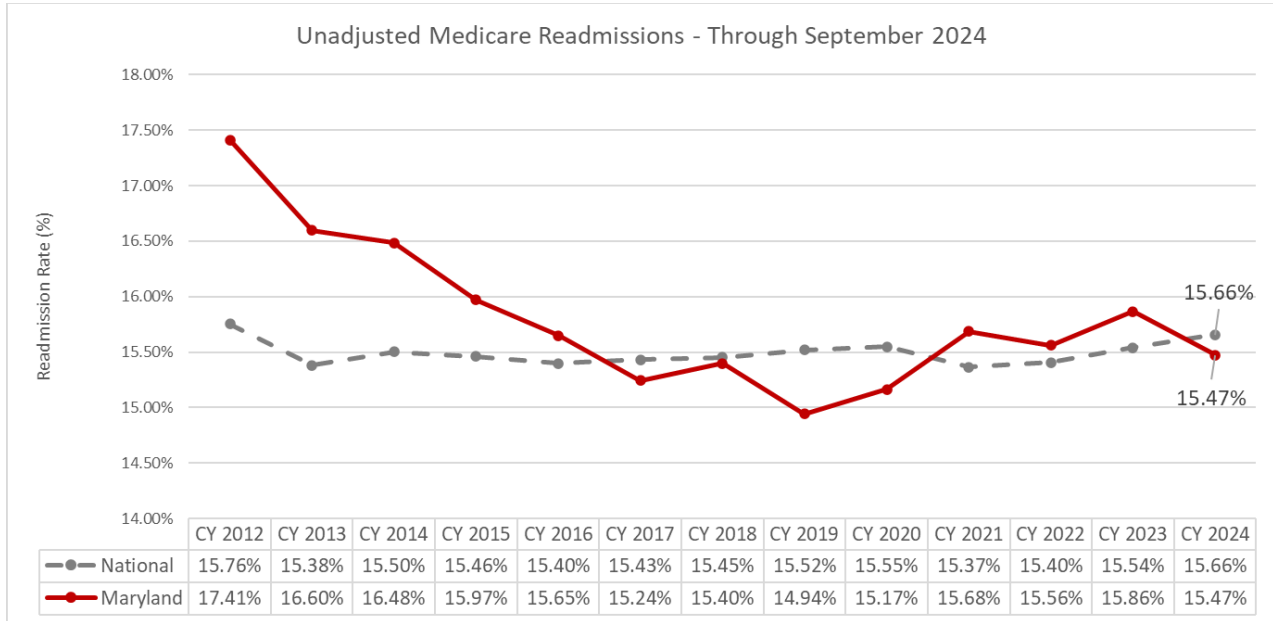
## **Current Statewide Year To Date Performance**

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

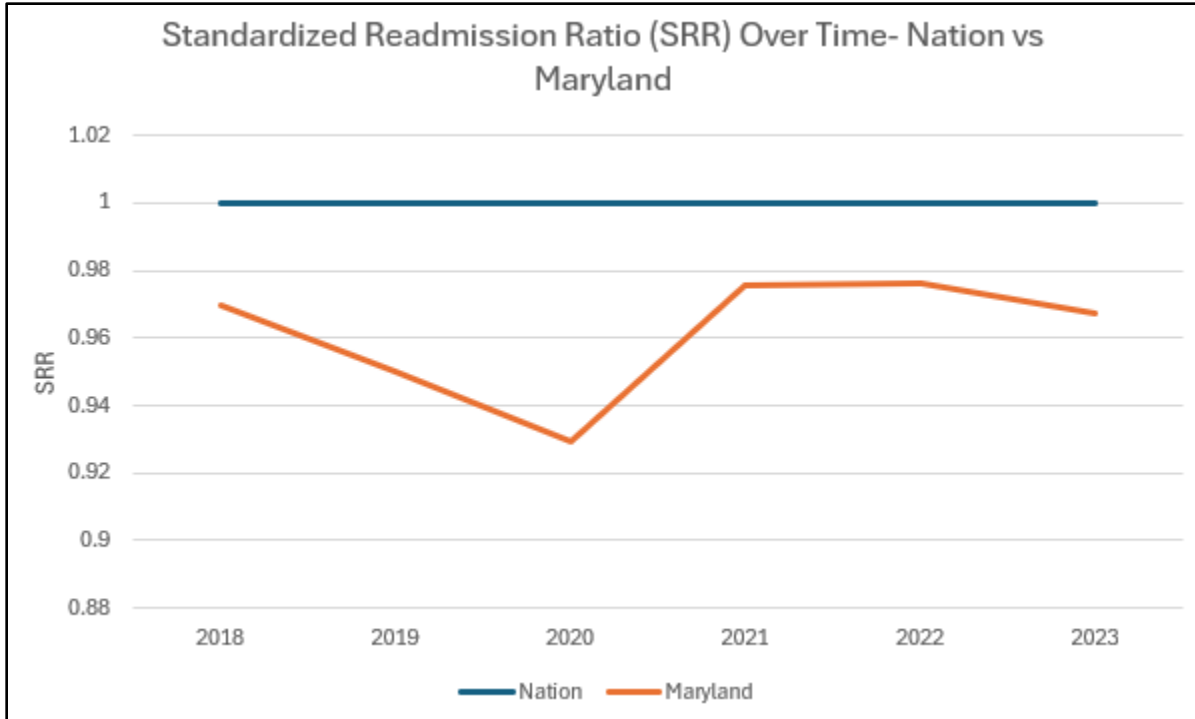


### Hospital Wide Readmission Measure Performance

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<sup>5</sup> are below 1, the State performed better than the Nation within this measure in CYs 2018-2023.

<sup>5</sup> 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.

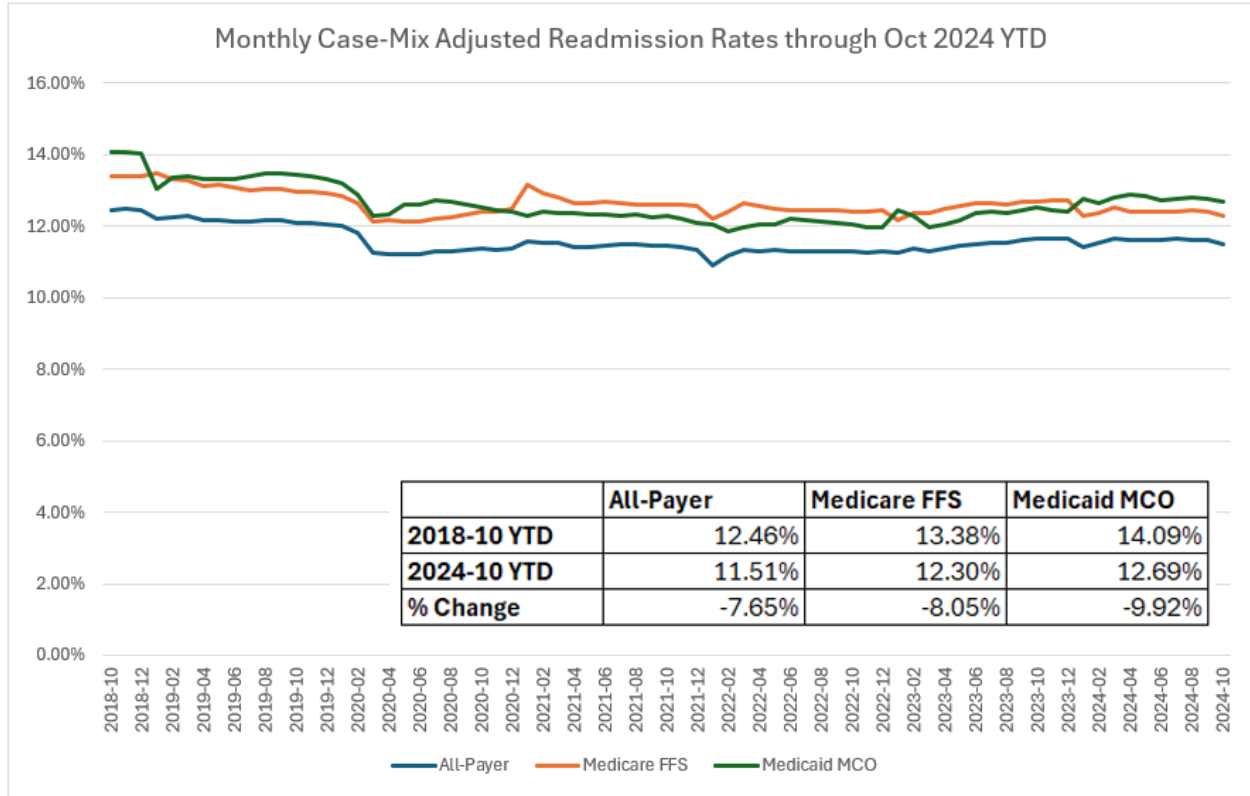
Figure 3. Maryland and National Medicare FFS Hospital-Wide Readmission Measure Performance



### 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 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



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



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

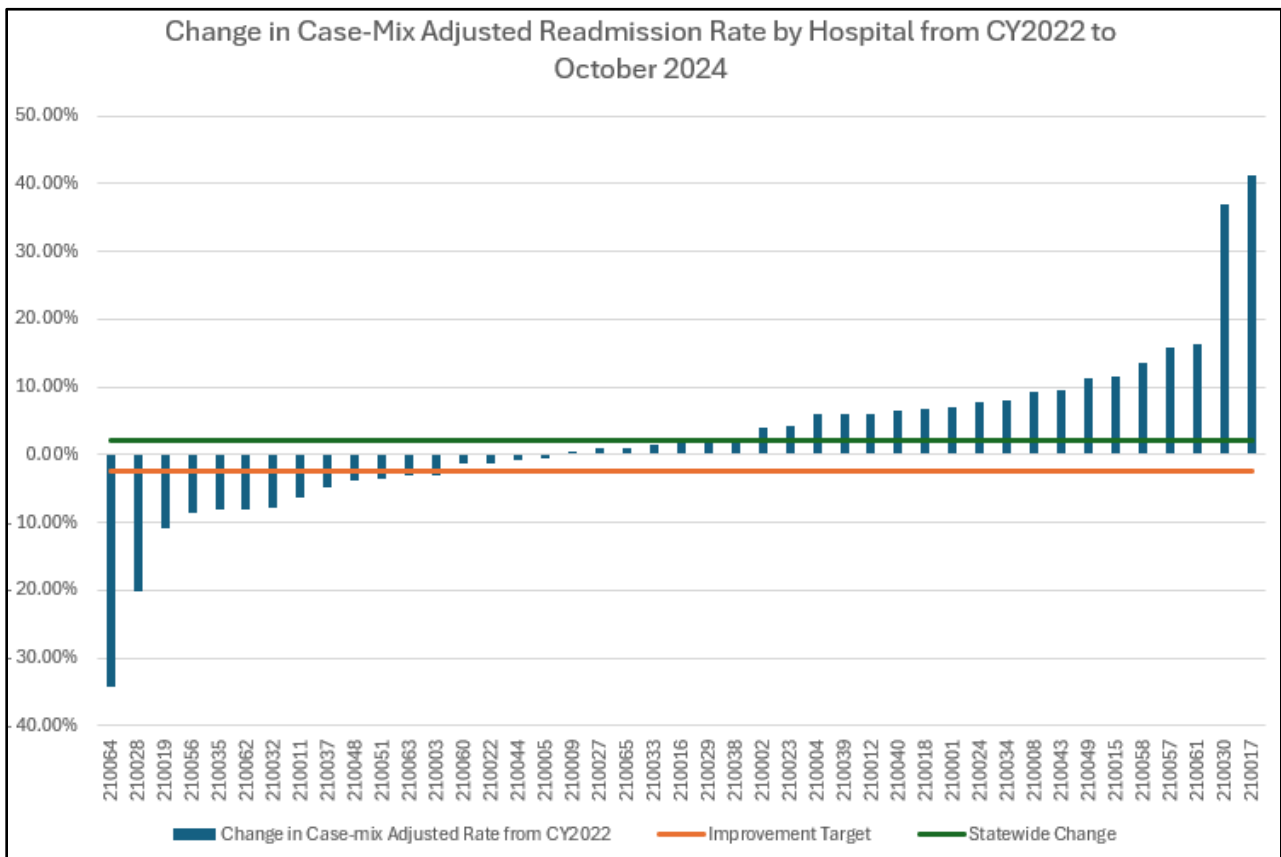
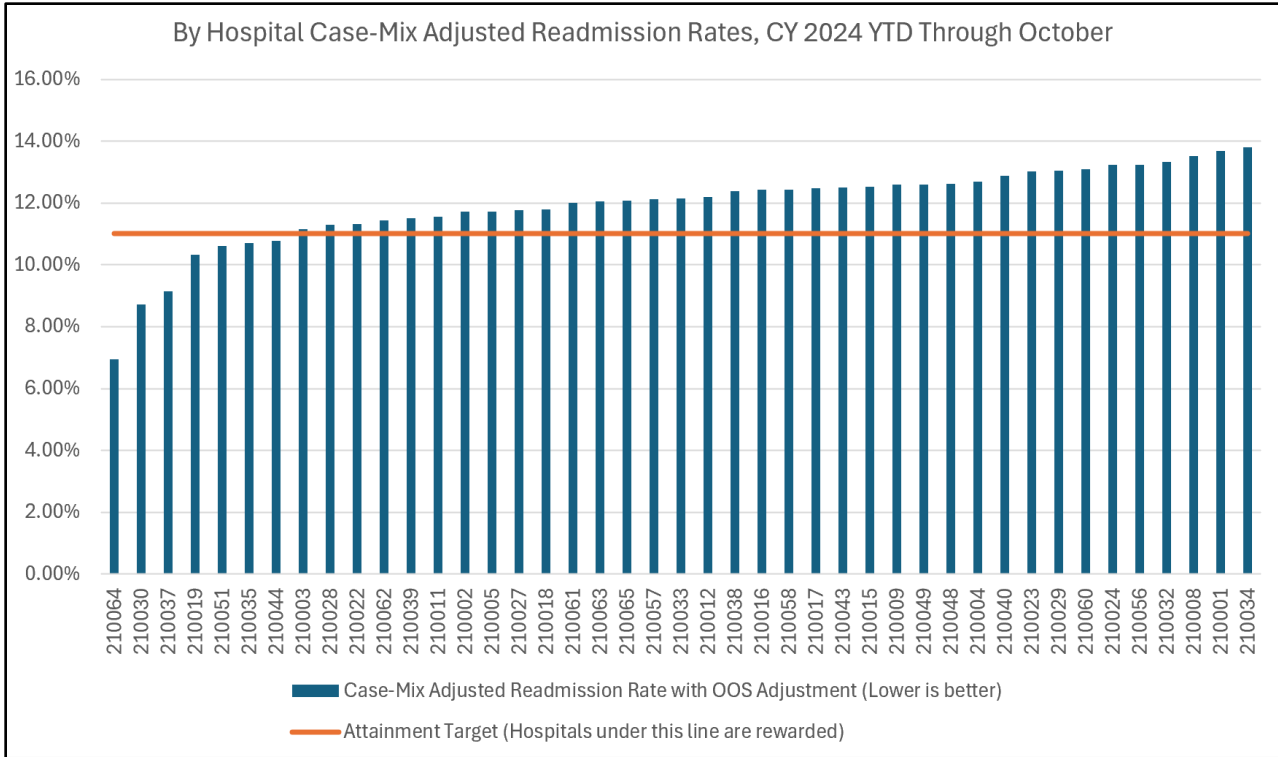


Figure 6. By-Hospital Case Mix Adjusted Readmission Rates, YTD 2024



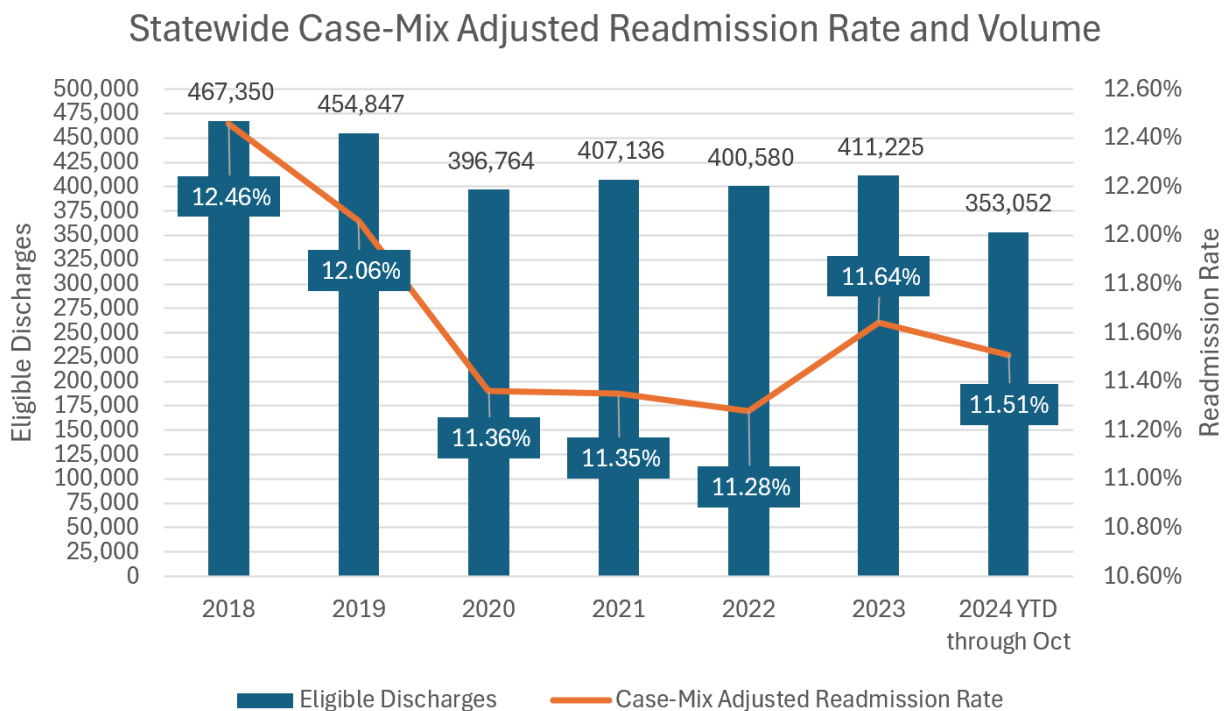
## Base Period Concerns

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.<sup>6</sup> 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

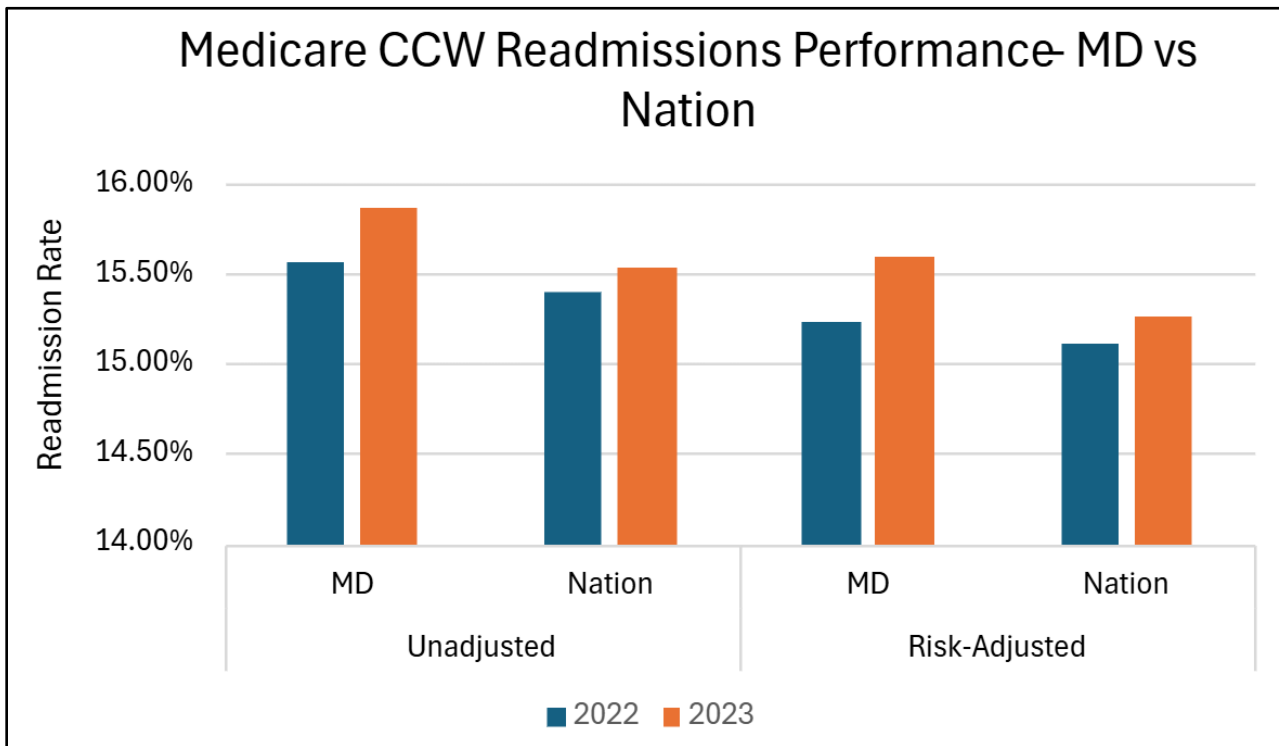


As shown below in Figure 8, both Maryland and the Nation experienced a degradation in readmission rates in CY 2023 on both an unadjusted and risk-adjusted basis. While both the Nation and the State saw a degradation in readmission rates from CY 2022 to CY 2023, the State saw a greater degradation while 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

<sup>6</sup> 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.<sup>7</sup> 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<sup>8</sup>



## 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

<sup>7</sup> [RY 2021 MHAC Policy](#), two year base period decision is detailed on pages 20-21.

<sup>8</sup> 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  $\geq 24$  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.<sup>9</sup> 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

---

<sup>9</sup> 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<sup>10,11</sup> 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<sup>12</sup> 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.<sup>13</sup>

---

<sup>10</sup> 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;

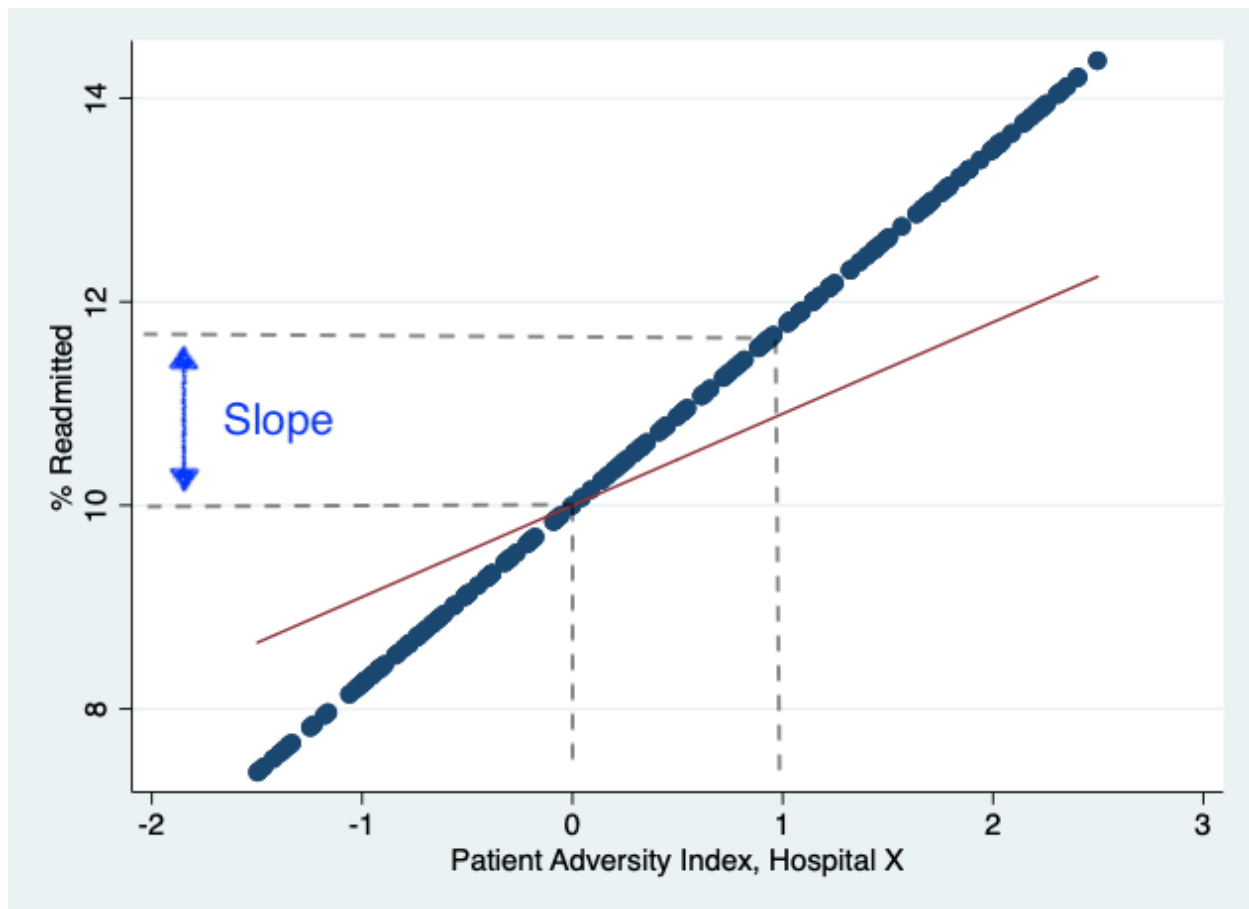
<sup>11</sup> Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.

<sup>12</sup> 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.

<sup>13</sup> [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	<ul style="list-style-type: none"> <li>• CDC HRQOL- 4 Health Days Core Module</li> </ul>
2	Prevention and Wellness <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> <li>• Colorectal Cancer Screening (CCS-AD)</li> <li>• Breast Cancer Screening: Mammography (BCS-AD)</li> </ul>
3	Chronic Conditions <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> <li>• Controlling High Blood Pressure (CBP-AD)</li> <li>• Hemoglobin A1c Control for Patients with Diabetes (HBDAD)</li> </ul>
4	Behavioral Health	<ul style="list-style-type: none"> <li>• Use of Pharmacotherapy for Opioid</li> </ul>

	<i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> <li>Use Disorder</li> <li>Antidepressant Medication Management (AMMAD)</li> <li>Follow-Up After Hospitalization for Mental Illness (FUHAD)</li> <li>Follow-Up After ED Visit for Substance Use</li> </ul>
5	Health Care Quality and Utilization	<ul style="list-style-type: none"> <li>Plan All-Cause Unplanned Readmission (PCRAD)</li> </ul>
<i>Must choose at least 1 focus area</i>		
6	Focus Area 1- Maternal Health Outcomes <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> <li>Live Births Weighing Less Than 2500 Grams (LBWCH)</li> <li>Prenatal and Postpartum Care: Postpartum care (PPC-AD)</li> </ul>
	Focus Area 2- Prevention Measures <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> <li>Adult Immunization Status</li> <li>Prevalence of Obesity</li> <li>Medical Assistance with Smoking and Tobacco Use Cessation (MSC)</li> <li>ED Visits for Alcohol and Substance Use Disorders</li> </ul>
	Focus Area 3- Social Drivers of Health <i>Choose at least 1 measure</i>	<ul style="list-style-type: none"> <li>Food Insecurity</li> <li>Housing Quality</li> </ul>

## 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.

# 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.<sup>14</sup> 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.<sup>15</sup> Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.<sup>16</sup>
- 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.<sup>17</sup>
- 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.

---

<sup>14</sup> Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].

<sup>15</sup> **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.

<sup>16</sup> **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.

<sup>17</sup> **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.

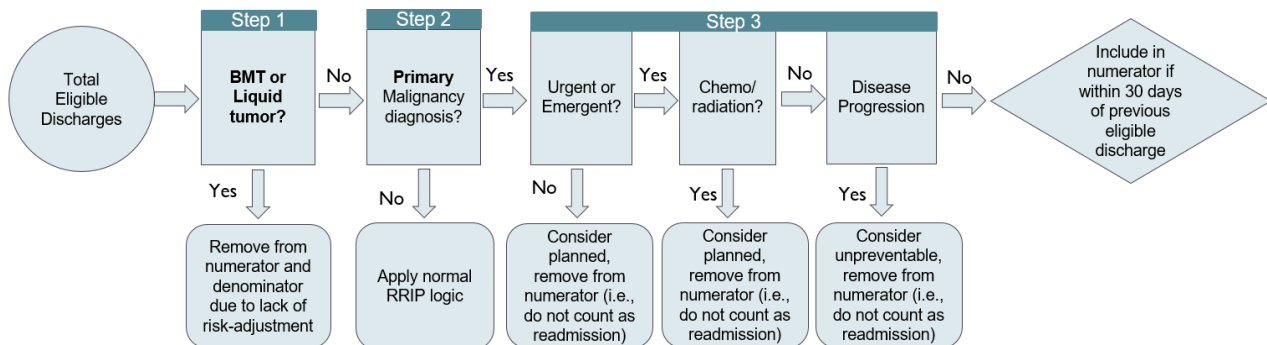


- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is not eligible for a subsequent readmission.
- 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:**

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions) Readmission Rate}}{\text{(Expected Readmissions) Readmission Rate}} \quad * \text{ Statewide Base Year}$$

**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.

- o 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

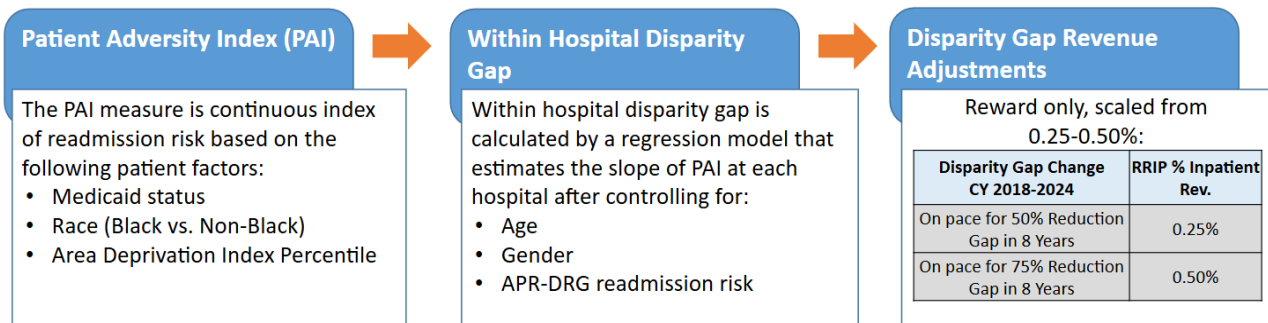
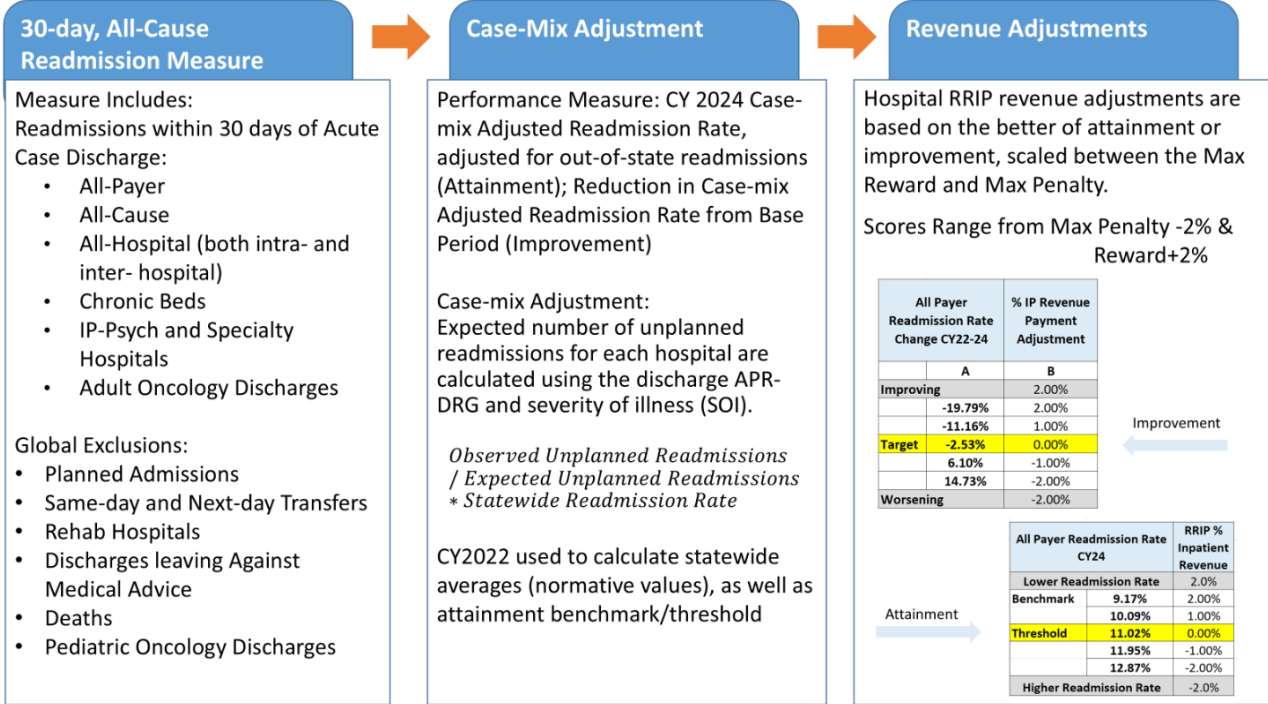
A Severity of Illness Level	B Eligible Discharges	C Discharges with Readmission	D Readmissions per Discharge (C/B)	E Normative Readmissions per Discharge	F Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
<b>Total</b>	<b>500</b>	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

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.



# 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

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	CY 2022 Base			CY22/23 Blended Base		
			Modelled Adjustment			Modelled Adjustment		
			\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment	\$ Better of Attainment or Improvement	RY 26 Prelim % Revenue Adjustment	Revenue Adjustment Based on Improvement or Attainment
210001	UMMS	\$251,995,786	-\$2,696,355	-1.07%	Imp	-\$2,393,960	-0.95%	Imp
210002	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	Lumis-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-Middtown	\$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-BYMMC	\$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	Lumis-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
<b>STATEWIDE</b>		<b>\$11,821,284,339</b>	<b>-\$56,029,431</b>			<b>-\$34,944,112</b>		
Penalty			-\$74,188,424			-\$52,645,913		
Reward			\$18,158,993			\$17,701,801		

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

HOSPITAL ID	HOSPITAL NAME	FY 24 Estimated Permanent Inpatient Revenue**	CY 2022 Base			CY 2022/23 Blended Base		
			Final Adjustment			Final Adjustment		
			\$ 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 Luminis- Anne Arundel	\$249,484,035	-\$449,071	-0.18%	Imp	\$573,813	0.23%	Imp
210023	MedStar- Union Mem	\$367,930,454	-\$3,458,546	-0.94%	Imp	-\$3,679,305	-1.00%	Imp
210024	Western Maryland	\$267,917,283	-\$3,590,092	-1.34%	Imp	-\$1,768,254	-0.66%	Imp
210027	MedStar- St. Mary's	\$183,379,829	-\$971,913	-0.53%	Imp	-\$1,081,941	-0.59%	Imp
210028	UMMS- JHH- Bayview	\$100,479,485	\$1,828,727	1.82%	Imp	\$1,255,994	1.25%	Imp
210029	UMMS- Chestertown	\$471,786,218	-\$3,396,861	-0.72%	Imp	-\$3,915,826	-0.83%	Imp
210030	ChristianaCare Union	\$7,562,394	\$151,248	2.00%	Att	\$151,248	2.00%	Att
210032	Lifebridge- Carroll	\$84,802,922	\$559,699	0.66%	Imp	\$347,692	0.41%	Imp
210033	MedStar- Harbor	\$162,844,959	-\$846,794	-0.52%	Imp	-\$309,405	-0.19%	Imp
210034	UMMS- Charles	\$128,234,465	-\$1,961,987	-1.53%	Imp	-\$1,333,638	-1.04%	Imp
210035	UMMS- UMMS- Shady Grove	\$97,586,229	\$663,586	0.68%	Imp	\$849,000	0.87%	Imp
210037	UMMS- UMMS- Calvert	\$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	Lifebridge- Northwest	\$80,925,064	-\$647,401	-0.80%	Att	-\$485,550	-0.60%	Att
210040	UMMS- BWMC	\$160,861,387	-\$1,898,164	-1.18%	Imp	-\$1,270,805	-0.79%	Imp
210043	UMMS- GBMC	\$325,684,009	-\$5,013,994	-1.54%	Imp	-\$3,679,099	-1.13%	Imp
210044	JHH- Howard County	\$263,774,655	-\$316,530	-0.12%	Att	-\$131,887	-0.05%	Att
210048	UMMS- Upper Chesapeake	\$220,287,562	\$374,489	0.17%	Imp	\$286,374	0.13%	Imp
210049	Luminis- Doctors	\$236,862,562	-\$4,121,409	-1.74%	Imp	-\$2,415,998	-1.02%	Att
210051	MedStar- Good Sam	\$187,232,106	\$879,991	0.47%	Att	\$1,273,178	0.68%	Att
210056	Adventist- Shady Grove	\$186,628,391	\$1,493,027	0.80%	Imp	\$1,063,782	0.57%	Imp
210057	UMROI	\$333,973,100	-\$4,909,405	-1.47%	Att	-\$2,504,798	-0.75%	Att
210058	Adventist- Ft. Washington	\$80,968,088	-\$78,944	-0.10%	Att	-\$1,400,748	-1.73%	Att
210060	Atlantic General	\$37,782,970	-\$279,594	-0.74%	Imp	-\$355,160	-0.94%	Imp
210061	MedStar- Southern MD	\$47,434,007	-\$673,563	-1.42%	Att	-\$554,978	-1.17%	Att
210062	UMMS- St. Levindale	\$210,921,411	\$1,392,081	0.66%	Imp	\$1,624,095	0.77%	Imp
210063	UMMS- St. Levindale	\$292,568,045	-\$1,082,502	-0.37%	Imp	-\$2,369,801	-0.81%	Imp
210064	Trinity - Holy Cross	\$68,147,842	\$1,362,957	2.00%	Att	\$1,362,957	2.00%	Att
210065	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		





maryland  
**health services**  
cost review commission

---

# Care Redesign Programs – PY2 Results

HSCRC Commission Mtg

02/12/2025



# Care Transformation Initiatives

---



# PY2 (FY 2023) Results

---

## PY2 Savings – Key Takeaways

- All hospitals participated in the CTI program and nearly 39.14% of the State's Medicare population was attributed to a hospital's clinical care transformation program in CY2023.
- During PY2, CTI's generated ~\$195M in savings. This represents a 51% increase from PY1.
- In PY1 there were 260K episodes and 305K in PY2, representing a 17% increase.

# Overview of CTI Results – PY1

Thematic Area	Number of CTI	Avg. Episodes Initiated	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	55	498	36	65%	28	51%	1.6%
Palliative Care	5	173	3	60%	3	60%	2.9%
Primary Care	23	7,946	14	61%	11	48%	2.2%
Geographic	10	3,095	5	50%	5	50%	3.2%
ED	14	1,287	8	57%	7	50%	1.0%
Total	107	2,430	66	62%	54	50%	1.9%



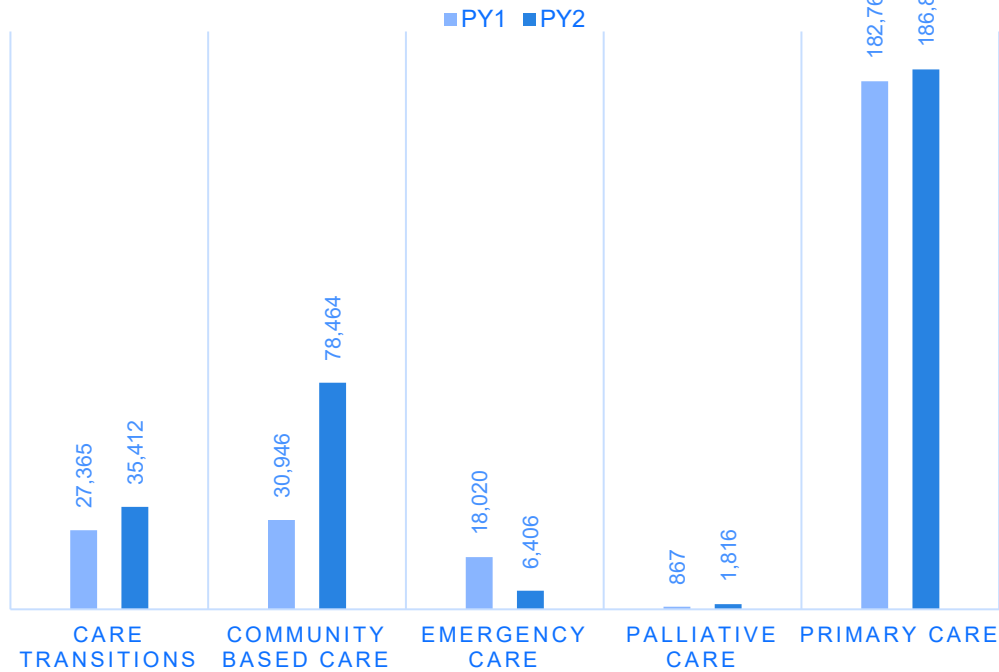
# Overview of CTI Results- PY2

Thematic Area	Number of CTI	Avg. Episodes Initiated	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	48	660	33	69%	26	54%	3.6%
Palliative Care	6	303	3	50%	3	50%	-3.8%
Primary Care	27	6,921	15	56%	11	41%	2.0%
Geographic	10	7,846	6	60%	5	50%	5.3%
ED	8	801	5	63%	5	63%	5.1%
Total	99	3,083	62	63%	50	51%	3.0%

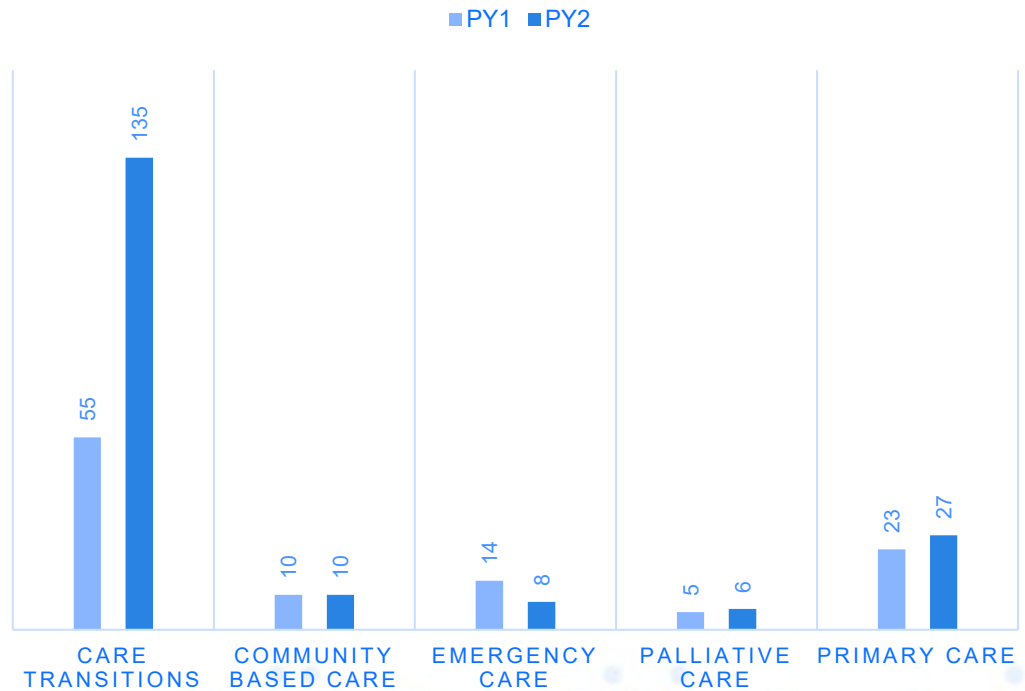
# PY2 Volume Changes

- Growth in number of CTIs occurred primarily within the Care Transitions thematic area
- Geographic thematic area had a YoY increase in volume of 154% and Palliative care had a YoY of 109%.
- The only category to see a **decrease** during PY2 was Emergency Care with -64%.

## EPISODE VOLUME



## # OF CTI



# Episode Quality Improvement Program (EQIP)



# Partnership HSCRC, CRISP, & MedChi

# EQIP – A Partnership HSCRC, CRISP, & MedChi

The HSCRC and CRISP are the program administrators for the Episode Quality Improvement Program (EQIP). They are responsible for:

- Facilitating EQIP Entity and Care Partner enrollment
- Overseeing reporting and learning systems
- Calculating EQIP episodes
- Monitoring EQIP Entity performance
- Determining incentive payments due to EQIP Entities

MedChi has partnered closely with the HSCRC and CRISP to help develop and support the EQIP initiative. MedChi assists with:

- Outreach, Education and enrollment
- Advocacy for EQIP and its participants
- EQIP Entity administrative support

The EQIP Subcommittee is chaired by Gene Ransom, CEO of MedChi. MedChi hosts the EQIP Subgroup on the third Friday of every other month.

# Developing and Expanding the program

The program is more than just a bundled payment program.

MedChi, CRISP and the HSCRC have been working together to expand EQIP and add new opportunities and further align practitioners.

We have been outreaching, meeting and working key stakeholders regarding new EQIP episode requests for Performance Year 5 (CY2026).

- Current EQIP participants
- National and local specialty societies

## Focus on the Patient EQIP Quality Metrics

- Each EQIP Entity, is subject to a Quality Score adjustment, as required as a part of EQIP's Advanced APM status.
  - For each attributed episode, the HSCRC will assess whether the three quality measures were performed, by any practitioner, within the year preceding the end of the episode.
  - The quality measures were selected with a patient focused population health mindset.
  - The Patient receives additional services if their doctor is in EQIP.

**Advance Care Plan:**

*NQF #326*

**Documentation of  
Current Medications in  
the Medical Record:**

*NQF #419*

**Body Mass Index (BMI)  
Screening and Follow-  
Up Plan:**

*MIPS #128*

# Advance Care Plan – Base Y1 vs PY1 / Base Y2 vs PY2

Episode Category	Episode Name	Base Y1 Episode Volume	Base Y1 Advance Care Numerator	Base Y1 Advance Care Denominator	Base Y1 Advance Care Performance Rate	PY1 Episode Volume	PY1 Advance Care Numerator	PY1 Advance Care Denominator	PY1 Advance Care Performance Rate
Procedural	Colonoscopy	12,906	1,300	12,906	10.07%	15,851	4,696	15,851	29.63%
Procedural	Knee Arthroscopy	895	76	895	8.49%	691	275	691	39.80%
Acute	Hip/Pelvic Fracture	1,043	493	1,043	47.27%	675	455	675	67.41%

Episode Category	Episode Name	Base Y2 Episode Volume	Base Y2 Advance Care Numerator	Base Y2 Advance Care Denominator	Base Y2 Advance Care Performance Rate	PY2 Episode Volume	PY2 Advance Care Numerator	PY2 Advance Care Denominator	PY2 Advance Care Performance Rate
Procedural	Colonoscopy	12,420	845	12,419	6.80%	16,384	5,282	16,384	32.24%
Procedural	Knee Arthroscopy	914	53	914	5.80%	686	481	686	70.12%
Acute	Hip/Pelvic Fracture	1,178	268	1,177	22.77%	828	535	828	64.61%

Episode Category	Episode Name	Base Y2 Episode Volume	Base Y2 Advance Care Numerator	Base Y2 Advance Care Denominator	Base Y2 Advance Care Performance Rate	PY2 Episode Volume	PY2 Advance Care Numerator	PY2 Advance Care Denominator	PY2 Advance Care Performance Rate
Chronic	Glaucoma	2,279	132	2,279	5.79%	880	670	880	76.14%
Procedural	Cataract Surgery	2,718	216	2,718	7.95%	3,199	2,715	3,199	84.87%



# Current Medication – Base Y1 vs PY1 / Base Y2 vs PY2

Episode Category	Episode Name	Base Y1 Episode Volume	Base Y1 Current Medication Numerator	Base Y1 Current Medication Denominator	Base Y1 Current Medication Performance Rate	PY1 Episode Volume	PY1 Current Medication Numerator	PY1 Current Medication Denominator	PY1 Current Medication Performance Rate
Procedural	Colonoscopy	12,906	3,208	12,906	24.86%	15,851	5,553	15,851	35.03%
Procedural	Knee Arthroscopy	895	302	895	33.74%	691	320	691	46.31%
Acute	Hip/Pelvic Fracture	1,043	401	1,043	38.45%	675	410	675	60.74%

Episode Category	Episode Name	Base Y2 Episode Volume	Base Y2 Current Medication Numerator	Base Y2 Current Medication Denominator	Base Y2 Current Medication Performance Rate	PY2 Episode Volume	PY2 Current Medication Numerator	PY2 Current Medication Denominator	PY2 Current Medication Performance Rate
Procedural	Colonoscopy	12,420	3,161	12,403	25.49%	16,384	6,149	16,371	37.56%
Procedural	Knee Arthroscopy	914	276	911	30.30%	686	464	674	68.84%
Acute	Hip/Pelvic Fracture	1,178	416	1,174	35.43%	828	535	827	64.69%

Episode Category	Episode Name	Base Y2 Episode Volume	Base Y2 Current Medication Numerator	Base Y2 Current Medication Denominator	Base Y2 Current Medication Performance Rate	PY2 Episode Volume	PY2 Current Medication Numerator	PY2 Current Medication Denominator	PY2 Current Medication Performance Rate
Chronic	Glaucoma	2,279	282	2,275	12.40%	880	632	878	71.98%
Procedural	Cataract Surgery	2,718	493	2,714	18.17%	3,199	2,722	3,196	85.17%

# BMI – Base Y1 vs PY1 / Base Y2 vs PY2

Episode Category	Episode Name	Base Y1 Episode Volume	Base Y1 BMI Numerator	Base Y1 BMI Denominator	Base Y1 BMI Performance Rate	PY1 Episode Volume	PY1 BMI Numerator	PY1 BMI Denominator	PY1 BMI Performance Rate
Procedural	Colonoscopy	12,906	1,441	12,715	11.33%	15,851	2,711	15,824	17.13%
Procedural	Knee Arthroscopy	895	165	869	18.99%	691	219	688	31.83%
Acute	Hip/Pelvic Fracture	1,043	149	1,035	14.40%	675	153	671	22.80%

Episode Category	Episode Name	Base Y2 Episode Volume	Base Y2 BMI Numerator	Base Y2 BMI Denominator	Base Y2 BMI Performance Rate	PY2 Episode Volume	PY2 BMI Numerator	PY2 BMI Denominator	PY2 BMI Performance Rate
Procedural	Colonoscopy	12,420	1,413	12,414	11.38%	16,384	3,803	16,352	23.26%
Procedural	Knee Arthroscopy	914	167	912	18.31%	686	430	684	62.87%
Acute	Hip/Pelvic Fracture	1,178	162	1,178	13.75%	828	275	820	33.54%

Episode Category	Episode Name	Base Y2 Episode Volume	Base Y2 BMI Numerator	Base Y2 BMI Denominator	Base Y2 BMI Performance Rate	PY2 Episode Volume	PY2 BMI Numerator	PY2 BMI Denominator	PY2 BMI Performance Rate
Chronic	Glaucoma	2,279	159	2,279	6.98%	880	324	878	36.90%
Procedural	Cataract Surgery	2,718	217	2,713	8.00%	3,199	1,373	3,192	43.01%



# Support for Practices - MedChi

Starting in PY3 (CY2024), MedChi has provided direct administrative support to EQIP Entities. This includes program education, support for quality metrics, and data performance summaries.

We also provide guidance to other practices and hospitals on the program where appropriate.

MedChi created EQIP entities to give smaller non-hospital groups the opportunity to participate in value-based care. MedChi also offers support to any organization regardless of their size or affiliation.

## In Performance Year 3 (CY2024) MedChi

### supported:

- **9** EQIP entities consisting of;
- **59** organizations and;
- **156** practitioners.

## In Performance Year 4 (CY2025) MedChi

### supports:

- **13** EQIP entities consisting of;
- **71** organizations and;
- **286** practitioners.



# PY2 (CY 2023) Results

---

# PY1 vs PY2 Participation

- 25 New Episodes
- 5 new clinical episode categories in PY2
  - Allergy
  - Dermatology
  - Emergency Department
  - Ophthalmology
  - Urology
- 18 new entities in PY2, with a total of 64 entities participating
  - 46 of 50 entities from PY1 participating in PY2
- PY2 EQIP episode volume totaled 78,644 episodes, an 108% increase from 37,758 episodes in PY1.
  - 46k of total episodes are from entities participating in PY1, 27% higher than their combined volume during PY1.
  - 32k of episode volume growth is from new entities.

## EQIP Year 2 Results

- EQIP generated \$36.7 million in PY2 positive savings, an increase of 81.6% from \$20.2 million in positive savings in PY1
- 31 EQIP entities earned savings out of a total of 64. However, most of the smallest 25% of practices by volume saw no savings.
- Net distribution was \$19.5 million in PY2 compared to \$12.5 million in PY1
  - A 3% minimum savings rate is required, which was created to ensure that savings and payouts from EQIP would be statistically significant.
  - A lower shared savings percentage was a result of PY1 dissavings offset

*\*Numbers are considered preliminary*

# Overview of EQIP Results – PY1 vs. PY2

Clinical Episode Category	Number of EQIP Clinical Categories		Average Entity Size by Number of CPs		Average Episode Volume		Number Exceeding Target Price		Percent Exceeding Target Price	
	PY1	PY2	PY1	PY2	PY1	PY2	PY1	PY2	PY1	PY2
Orthopedics	75	120	92	83	122	123	26	34	35%	28%
Gastroenterology	39	46	115	108	642	549	27	18	69%	39%
Cardiology	38	38	118	117	94	87	19	12	50%	32%
Emergency Department	-	110	-	173	-	269	-	72	-	65%
Allergy	-	21	-	133	-	59	-	12	-	57%
Ophthalmology	-	6	-	335	-	680	-	0	-	0%
Urology	-	5	-	42	-	67	-	4	-	80%
Dermatology	-	3	-	362	-	40	-	3	-	100%

Notes: CPs = Care Partners. EQIP episodes exceeding target price are episodes where total cost exceeded the aggregate target price in that performance year. Averages reported across participating entities in each category.



# Overall Assessment & Next Steps

- CRISP Learning Collaborative commissioned a formal evaluation study for PY1 available on the [Learning System](#)
- Years 4 underwent an episode grouper change, enabling substantial opportunity to expand the program
  - HSCRC is utilizing Patient-Centered Episodes of Care System (PACES) for EQIP, starting in PY4.
  - PACES episodes offers much more complete coverage than previous grouper and paves the way for easier, more seamless program expansion in future years.
- Support for practices
  - The EQIP Practice Transformation Grant (PTG) Program is designed to support smaller, independent, and under-resourced practices that have not yet achieved savings under the EQIP model
  - By reinvesting Year 1 savings, the program provides targeted intervention resources to help these practices succeed in EQIP and improve efficiency, patient management, and cost savings.
- Quality Metric Evaluation
  - Assess current quality measure framework to determine what changes need to be made, if any, for implementation in PY5 (CY26).



maryland  
**health services**  
cost review commission

---

## Legislative Update

HSCRC February 2025 Commission Meeting

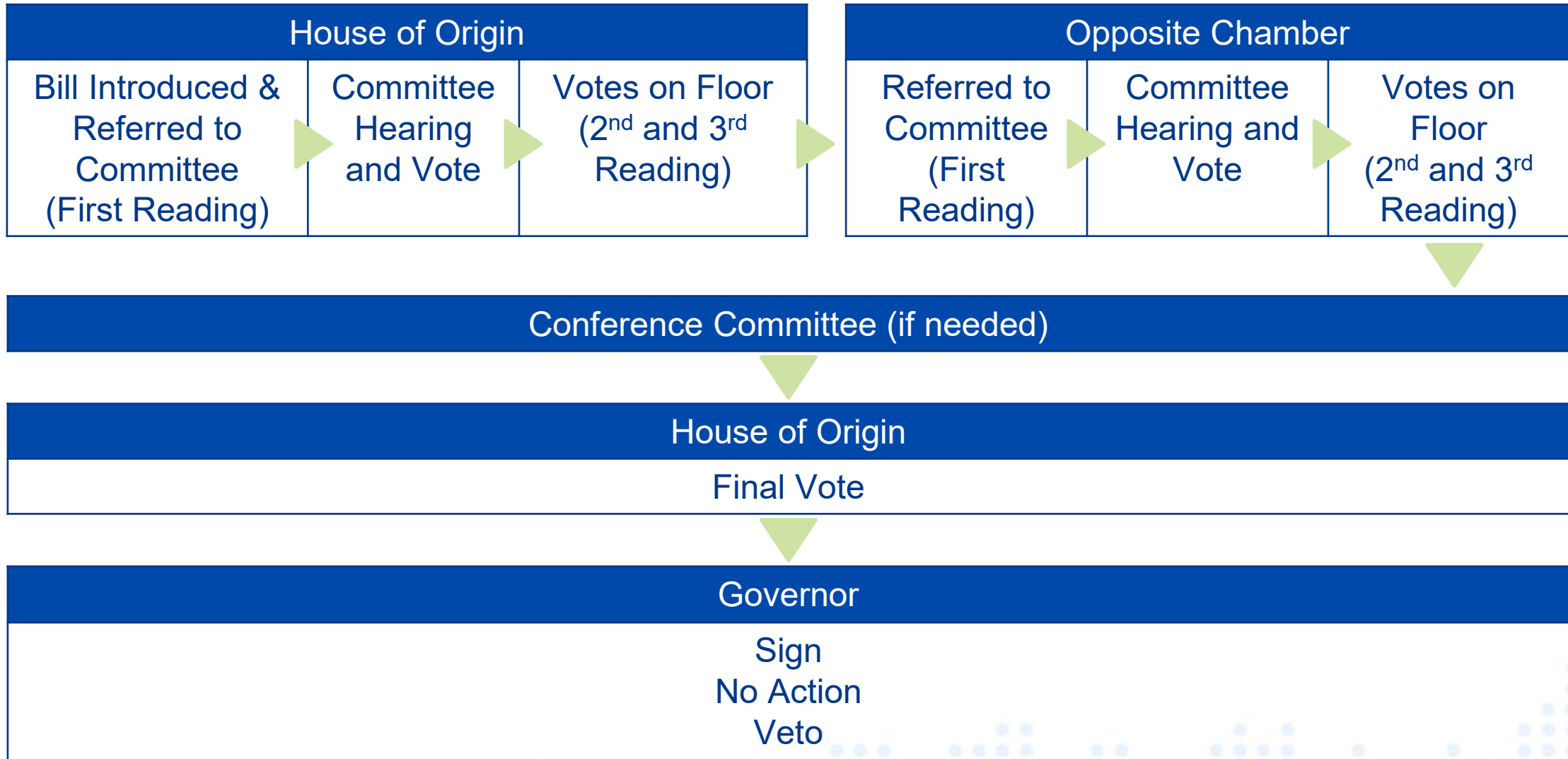
February 12, 2025



# Overview

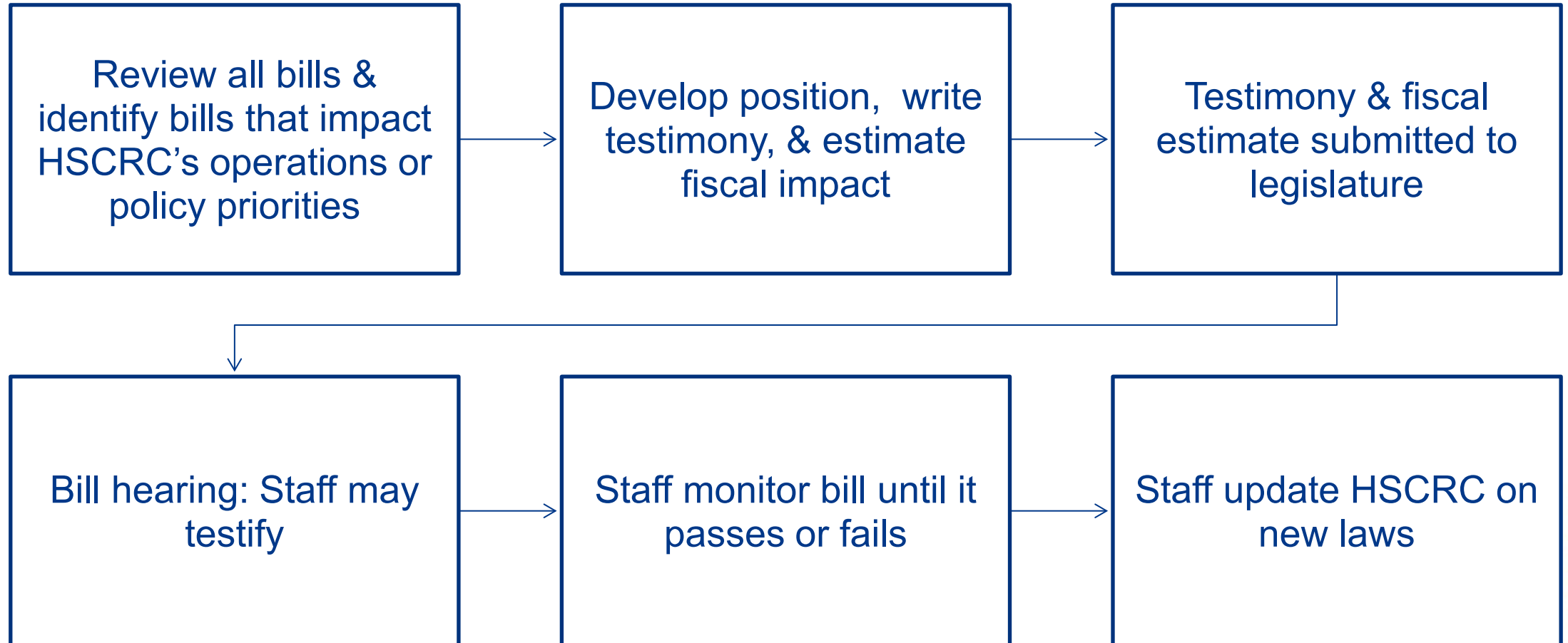
- Legislative Process and Timeline
- Staff Role
- Review of Key Bills
  - Fees, Budgets, and Funds
  - AHEAD Model and MCHE
  - Financial Assistance and Medical Debt
  - Miscellaneous
- Appendix

# Maryland Legislative Session – Process



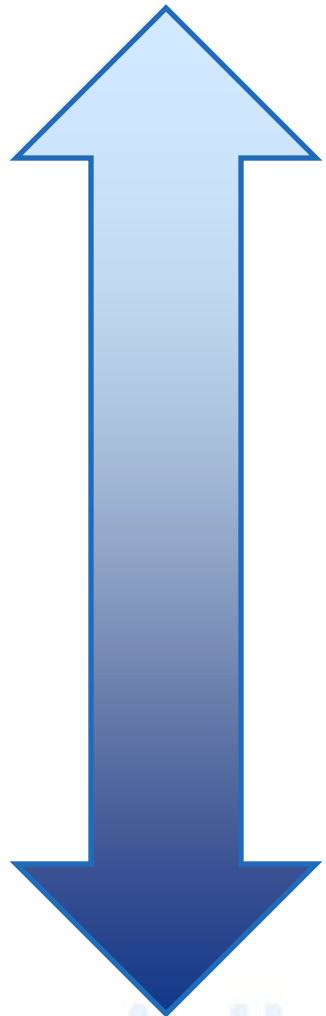
	January	February	March	April
Key Dates	<ul style="list-style-type: none"> <li>• Session Starts: January 8</li> <li>• Budget Bill Introduced by Governor</li> </ul>	<ul style="list-style-type: none"> <li>• Senate Introduction Deadline: February 3</li> <li>• House Introduction Deadline: February 7</li> </ul>	<ul style="list-style-type: none"> <li>• Crossover Date: March 17<sup>th</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Last Day of Session (Sine Die): April 7</li> </ul>
What to Expect	<ul style="list-style-type: none"> <li>• Briefings to Legislative Committees on Key Topics</li> <li>• Bill Hearings in House of Origin</li> </ul>	<ul style="list-style-type: none"> <li>• Bill Hearings</li> <li>• Amendments to Bills</li> <li>• Votes on Bills in the House of Origin</li> <li>• Agency / Department Budget Hearings</li> </ul>	<ul style="list-style-type: none"> <li>• Amendments to Bills</li> <li>• Votes on Bills in the House of Origin</li> <li>• Bill Hearings in Opposite Chamber</li> <li>• Votes on Bills in Opposite Chamber</li> </ul>	<ul style="list-style-type: none"> <li>• Votes on Bills in Opposite Chamber</li> <li>• Conference Committees</li> <li>• Final Votes on Bills in Original Chamber</li> </ul>

# Staff Role



Staff update Commissioners twice a month

# Testimony: Types of Positions



Letter of Support

Letter of Support with Amendment(s)

Letter of Information

Letter of Information with Amendment(s)

Letter of Concern



Letter of Opposition

# Bills: Fees, Budgets, and Funds

User Fee  
Assessment Cap

- **Support:** Removes the sunset date on the formula that sets the cap that HSCRC can charge hospitals to fund the agency's operating budget.

Budget Bill

- **No Position:** Contains HSCRC's operating budget.

Budget  
Reconciliation and  
Financing Act

- **No Position**
- Establishes a Medicaid Primary Care Fund, using funds from the previously approved \$31M savings in the MPA.
- Increases the Medicaid Deficit Assessment by \$50 million in FY 25 and \$100 M in FY 26.

Maternal and Child  
Health Fund

- **Support:** Allows MDH to spend existing funds on maternal and child health programs over two more years



# Bills: AHEAD Model and Maryland Commission on Health Equity

AHEAD Model  
Implementation

- **Support**
- Allows exchange of data to support AHEAD implementation
- Establishes the Population Health Fund & allows HSCRC to assess hospitals to invest in the Fund.

Maryland  
Commission on  
Health Equity

- **HB 474 / SB 129** creates a health equity advisory committee to the MCHE and requires the committee to determine the “10 widest disparities” in health care quality and outcomes. HSCRC and MDH submitted a joint letter of information.
- **SB 560** Adds five members to the MCHE and requires the Commission to examine access to transportation and health care providers
- **HB 1100 / SB 684** required MDH, in consultation w/ the MCHE to establish a health disparity data dashboard. HSCRC is not taking a position on this bill.



# Bills: Hospital Financial Assistance and Medical Debt

- Financial Assistance and Debt Collection
  - **Support:** This bill changes Maryland's hospital assistance and medical debt collection statute to protect consumers from medical debt and improve consistency in the law.
- Free Care Reimbursement
  - This bill streamlines an existing law that requires hospitals to reimburse patients who received care between 2017 and 2021 and paid a bill for that care but should have received free care.
- Sale of Medical Debt
  - Three bills that would allow the sale of hospital medical debt to government entities or nonprofits, to allow for the forgiveness of the debt.
- Credit Reporting
  - Prohibits health care facilities and providers from reporting medical debt to consumer reporting bureaus

# Bills: Miscellaneous

Study of Health Commissions & Maryland Insurance Administration

- Expands the scope of an independent study of HSCRC, MHCC, MCHRC, and MIA to require study of the current provision of health care services in the State and recommendations to ensure high quality health care for all Marylanders

Workgroup on Denials

- Establishes a workgroup to study the rise in adverse decisions in the health care system.
- HSCRC is a workgroup member and is jointly responsible, with the Maryland Insurance Association, for staffing the workgroup.

Community Benefits and Community Health Worker Partnerships

- Bill makes a community health worker workforce program an allowable community benefit program for State reporting.
- Bill allows a nonprofit hospital and a community-based organization to establish a partnership, through a MOU, for a community health worker workforce program and establishes requirements for those partnerships.

# Questions?

Megan Renfrew

Deputy Director, Policy & Consumer Protection

[Megan.renfrew1@maryland.gov](mailto:Megan.renfrew1@maryland.gov)



# Appendix: Bill Details

---

# Health Services Cost Review Commission

<p>HB 54 SB 229</p>	<p><b>Health Services Cost Review Commission – User Fee Assessment – Repeal of Sunset</b></p>	<p>Position: Support</p>
<p>Bill removes the sunset on the formula that sets the cap that HSCRC can charge hospitals to fund the agency’s operating budget.</p> <p>If the sunset is removed, the cap will continue to be set at 0.1% of the hospitals’ budgeted revenue, which is adequate to fund HSCRC.</p> <p>If the bill sunset is not removed, the cap will change to a flat dollar amount (approximately \$20M), which is less than HSCRC’s budgeted expenditures for the current fiscal year (FY 2025) and the next fiscal year.</p> <p>100% of the user fee assessment is built into rates.</p>		<p>1/15 Senate and House Hearings Complete</p> <p>HGO Subcommittee Voted Favorable</p>



# Budget

HB 350 SB 319	<b>Budget Bill (Fiscal Year 2026)</b>	No Position
<p>This bill contains HSCRC's operating budget.</p> <p>HSCRC's budget hearings:</p> <ul style="list-style-type: none"><li>• 2/27 – Health and Social Services Subcommittees of the Senate Budget and Taxation Committee</li><li>• 3/3 – Health and Social Services Subcommittee of the House Appropriations Committee</li></ul>		

# Budget

HB 352 SB 321	<b>Budget Reconciliation and Financing Act of 2025</b>	No Position
<p>Establishes a Medicaid Primary Care Fund. Fund consists of money appropriated in the state, hospital payments administered by HSCRC, and other sources.</p> <p>Increases the Medicaid Deficit Assessment by \$50 million in FY 25 and \$100 M in FY 26. The Commission will need to determine what percent of these funds are built into rates (historically approx. 80% of the Medicaid Deficit Assessment is built into rates).</p>		Hearings:  2/25 House Appropriations  2/26 Senate Budget and Taxation



# Maternal and Child Health

<p>HB 170 SB 213</p>	<p><b>Health – Maternal and Child Health Population Health Improvement Fund – Use</b></p>	<p>Position: Support</p>
<p>Bill provides two more years for MDH (Prevention and Health Promotion Administration &amp; Medicaid) to spend funding that is already in the Maternal and Child Health Fund.</p> <p>Funds may only be spent on maternal and child health improvement programs or expenses which were previously approved by the Commission.</p>		<p>Status:</p> <p>HB 170 passed the House</p> <p>SB 213 passed the Senate with no amendments.</p>

# AHEAD

HB 1104	<b>Maryland Department of Health – AHEAD Model Implementation – Electronic Health Care Transactions and Population Health Improvement Fund</b>	Position Support
<p>Allows electronic health care transactions information to be used to support the State’s participation in the AHEAD Model.</p> <p>Establishes the Population Health Improvement Fund to invest in population health improvements that support the statewide population health targets under the AHEAD Model.</p> <p>HSCRC may assess a “uniform, broad-based, and reasonable amount in hospital rates to be credited to the Fund.”</p>		Status:  2/5 House HGO  Appropriations First Reading

# Maryland Commission Health Equity

SB 560	<b>Public Health – Maryland Commission on Health Equity – Membership and Purposes</b>	Position TBD
<p>Adds five members of the MCHE.</p> <p>Adds a requirement that the MCHE examine access to transportation and proximity to health care providers.</p>		2/13 Finance Hearing
HB 1100 SB 684	<b>Public Health – Health Equity Dashboard</b>	Position: Monitor
<p>Bill requires MDH, in collaboration with MCHE, to develop a graphic data dashboard including age-adjusted health disparity data disaggregated by race, ethnicity, and gender that is updated at least every 30 days.</p>		<p>Status:</p> <p>2/18 Finance Hearing</p>

# Maryland Commission Health Equity

<p>HB 474 SB 129</p>	<p><b>Public Health – Maryland Commission on Health Equity – Advisory Committee and Hospital Reporting</b></p>	<p>Testimony: Letter of Information</p>
<p>Bill requires MCHE to establish a health equity measures advisory committee to determine the 10 widest disparities in health care quality access, or outcomes for vulnerable populations.</p> <p>Bill also requires the advisory committee to review the health equity reports submitted annually from hospitals to the Department.</p> <p>HSCRC and MDH submitted a joint letter providing information about current law and the AHEAD Model.</p>		<p>1/30 Finance Hearing</p> <p>House Bill Hearing Canceled</p>

# Financial Assistance and Debt Collection

HB 268 SB 981	<b>Hospitals - Financial Assistance and Collection of Debts – Policies</b>	Position: Support
<p>This bill changes Maryland’s hospital assistance and medical debt collection statute to protect consumers from medical debt and improve consistency in the law.</p> <p>For example, the bill creates a minimum percentage for the discounts that hospitals provide patients who qualify for reduced-cost care and clarifies the definition of “medical debt” that is used to determine eligibility for reduced cost care.</p>		1/29 HGO Hearing  2/18 Finance Hearing

# Free Care Reimbursement

HB 1336	<b>Hospitals - Financial Assistance – Medical Bill Reimbursement</b>	Testimony: TBD
<p>This bill changes a law that requires hospitals to reimburse patients who received care between 2017 and 2021 and paid a bill for that care but should have received free care.</p> <p>Hospital data will be matched with data from the Department of Human Services to identify patients who may be eligible for refunds.</p> <p>Hospitals will be required to do a marketing campaign about the refunds.</p>		HGO Hearing TBD



# Sale of Medical Debt & Debt Forgiveness

HB 405	<b>Prince George's County – Hospitals – Sale of Patient Debt PG 402-25</b>	2/5 HGO Hearing
HB 765	<b>Hospitals - Medical Debt Collection - Sale of Patient Debt (to government units and their contractors)</b>	2/26 HGO Hearing
HB 1324	<b>Hospitals - Medical Debt Collection - Sale of Patient Debt to Nonprofit Organizations</b>	Hearing Date TBD
<p>These bills allow a hospital to sell medical debt to the entities named in the bill. The entities are then obligated to forgive the debt in full.</p> <p>HSCRC's letters on these bills describe existing law and policy related to the sale of hospital medical debt. In addition, the letters recommend that the bills all contain similar consumer protections.</p>		Testimony: Letter of Information



# Medical Debt & Credit Reports

HB 1020 SB 614	<b>Consumer Protection – Credit Reporting – Medical Debt (Fair Medical Debt Reporting Act)</b>	Testimony: Letter of Information
<p>Bill prohibits a consumer reporting agency from including adverse information about medical debt information on a credit report.</p> <p>A person may not use medical debt information in a credit report when determining creditworthiness.</p> <p>Health care facilities (including hospitals) and health care practitioners may not report medical debt to a consumer reporting agency.</p> <p>Letter will provide information about current State law and federal policy on the medical debt in credit reports.</p>		Status:  2/18 House Hearing  2/20 Senate Hearing

# Health Care Services Study

HB 1376	<b>MDH – Provision of Health Care Services – Study</b>	Position TBD
<p>MDH is, under currently law, required to contract for an independent study of the responsibilities of the three regulatory commissions (HSCRC, MHCC, and MCHRC) and the Maryland Insurance Administration.</p> <p>This bill expands the scope to require study of the current provision of health care services in the State.</p> <p>The contractor should make recommendations for strategies that the State should consider to ensure high quality health care for all Marylanders.</p>		Status:  HGO Hearing TBD

# Workgroup: Insurer Denials of Health Care Charges

<p>HB 995 SB 776</p>	<p><b>Workgroup to Study the Rise in Adverse Decisions in the State Health Care System – Establishment</b></p>	<p>Position Support</p>
<p>Bill establishes workgroup to study the rise in adverse decisions (denials) in the health care system.</p> <p>The workgroup will make recommendations to improve reporting on adverse decisions.</p> <p>HSCRC is a workgroup member and is jointly responsible, with the Maryland Insurance Association, for staffing the workgroup.</p> <p>The workgroup will report findings to Maryland General Assembly by December 1, 2025.</p>		<p>Status:</p> <p>2/13 HGO Hearing</p> <p>2/28 Finance Hearing</p>

# Health Services Cost Review Commission

HB 871	<b>Health Services Cost Review Commission – Community Benefits – Community Health Worker Workforce Program</b>	Testimony: Letter of Information
<p>Bill adds a community health worker workforce program as an allowable community benefit for State community benefit reporting.</p> <p>Bill allows a nonprofit hospital and a community-based organization to establish a partnership, through a MOU, for a community health worker workforce program.</p> <p>The bill sets requirements for the partnership, including a requirement that the partnership provide health insurance to the community health workers.</p>		2/26 HGO Hearing



maryland  
**health services**  
cost review commission

---

# Proposal for Medicare Advantage Alignment within the Maryland Model

August 22, 2024



# Opportunity to Align Incentives with Global Budgets

- Under the AHEAD Model, Maryland has opportunity to align payers with the overall goals of the model as part of a path to long-term success and population health improvement.
- Unlike other states the Maryland model, through global budgets, already provides strong incentives to hospitals to manage Medicare Fee-for-service costs.
- Over time the system can reward hospitals and MA plans who work together to deliver high-quality, cost-effective care for Maryland beneficiaries
  - Members benefit from richer benefit package and the redirection of resources away from ineffective/inefficient care and towards primary care, coordinated care and prevention.
  - Hospitals benefit by retaining higher than average unit costs in return for contributing to managing costs.
  - MA plans and hospitals benefit from lower utilization in the short term and lower overall cost trends in the long term.

# Medicare Advantage Penetration has Lagged in Maryland

- MA accounts for more than 51% of Medicare beneficiaries nationally. Yet, the MA market in Maryland remains underdeveloped relative to other states.
- This lag has consequences for the Marylanders:
  - Less opportunity to access the additional benefits that can be offered under MA
  - To the extent that MA plans are able to improve health and reduce utilization, less opportunity for this benefit in Maryland.



# The MA Alignment Program: Draft Approach

- To participate, MA plans must:
  - Provide the State a plan to reduce hospital utilization via targeted interventions (e.g., chronic disease management, SDOH initiatives).
  - The plan\* must:
    - Outline population health/care management strategies for achieving projected reductions in utilization and provide evidence that these strategies will be successful;
    - Plan submissions should not include broad-based prior authorization strategies as part of the programmatic approach;
    - The MA plans proposal must be actuarially sound and approved by the HSCRC; and
    - Identify a date by which the Plan expects to achieve the utilization targets (likely 2 years or less) and interim targets that will be met.
  - To continue participation the Plan must achieve interim and final targets ensuring that cost savings, utilization trends, and health outcomes justify the continued discount.

\* The State anticipates the plan having the freedom to set the target based on their proposed strategies, however some cap to avoid overly speculative approaches might be appropriate.

# The MA Alignment Program: Draft Approach

- Potential MPA offset:
  - Subject to CMMI approval, hospitals could receive Medicare Performance Adjustment (MPA) increases equal to the MA discount, ensuring financial neutrality and allow them to invest and partner with MA plans should they choose.
  - This maintains hospital incentives for population health improvement while fostering payer/hospital collaboration.
- Program termination:
  - To ensure CMMI's and the State's commitment to value-based care, HSCRC will terminate MA discounts for plans that fail to demonstrate meaningful population health impact and meet the interim or final targets by year three of implementation.

# The MA Alignment Program: Benefits

- To the State and CMMI:
  - MA plans and hospitals both working to improve cost management and improve population health outcomes
  - Expansion of MA will assist with managing high-cost populations and increase supplemental benefits available to Maryland residents
  - Creates an evidence-based framework for integrating MA into total cost of care models
- To MA Plans
  - Upfront investment and opportunity for shared savings for their targeted initiatives
  - The shared savings is achieved through discounts to improve MA plan sustainability
- To Hospitals
  - Support from MA plans in population health initiatives
  - Potential for upside return on their investment in MA Plan initiatives
  - Potential offset for discounts through MPA adjustment

# The Maryland MA Alignment Program: Other Considerations

- Approach will require formal approval by CMS and the HSCRC
- HSCRC Staff are reviewing whether the HSCRC currently has the authority to require the proposed discounts from hospitals or if a legislative change is needed
- Specific elements of the plan will need to be refined, particularly whether savings can be measured effectively and how the discount is maintained over time



**TO:** HSCRC Commissioners  
**FROM:** HSCRC Staff  
**DATE:** February 12, 2025  
**RE:** Hearing and Meeting Schedule

**Joshua Sharfstein, MD**  
 Chairman

**James N. Elliott, MD**  
 Vice-Chairman

**James N. Elliott, MD**

**Ricardo R. Johnson**

**Maulik Joshi, DrPH**

**Adam Kane, Esq**

**Nicki McCann, JD**

**Farzaneh Sabi, MD**

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.

**Jonathan Kromm, PhD**  
 Executive Director

**William Henderson**  
 Director  
 Medical Economics & Data Analytics

**Allan Pack**  
 Director  
 Population-Based Methodologies

**Gerard J. Schmith**  
 Director  
 Revenue & Regulation Compliance

**Claudine Williams**  
 Director  
 Healthcare Data Management & Integrity