maryland
health services
cost review commission

622nd Meeting of the Health Services Cost Review Commission

July 10, 2024

(The Commission will begin in public session at 11:30am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
11:30am

1. Discussion on Planning for Model Progression - Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on June 14, 2024

Informational Subjects

2. Presentation on an ARPA-H Proposal

Specific Matters

3. Docket Status – Cases Closed

   2647A Johns Hopkins Health System
   2649A Johns Hopkins Health System
   2651A Johns Hopkins Health System

4. Docket Status – Cases Open

   2646N UM Shore Medical Center at Easton
   2652A Johns Hopkins Health System
   2653A Johns Hopkins Health System
   2654A Johns Hopkins Health System
   2618A Johns Hopkins Health System - Request for Extension

Subjects of General Applicability

5. Report from the Executive Director
    a. Emergency Department Initiatives Update
    b. Report (Materials Only): Maternal and Child Health Improvement Fund - FY 2023 Activities
    c. Report (Materials Only): Regional Partnership Catalyst Program - CY 2023 Activities
    d. Report (Materials Only): Nurse Support Program I - FY 2023 Activities

6. Proposed Revisions to Community Benefit Reporting Regulations

7. Development Plan: Revenue for Reform - FY 2026

8. Hearing and Meeting Schedule

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
SHORE REGIONAL	*	DOCKET: 2024
HEALTH SYSTEM, INC	*	SUBMISSION DATE: April 18, 2024
MEDICAL CENTER AT EASTON	*	FOLIO: 2456
EASTON, MARYLAND.	*	PROCEEDING: 2646N

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STAFF RECOMMENDATION

July 10, 2024

Introduction

On January 18, 2024 UM Shore Medical Center at Easton (UM SMC at Easton or the Hospital) received an approved Certificate of Need (CON)[1] to replace the existing facility, the majority of which was built between 1955 and 1975,[2] with a 407,872 square foot hospital that will be relocated to an undeveloped 200-acre site located at 10000 Longwoods Road in Easton, Talbot County, approximately 3 miles from the existing campus. The proposed replacement hospital will include 110 acute care beds, 12 special hospital rehabilitation beds, and 25 observation beds. The Hospital will also include an emergency department (ED) with 27 treatment spaces and three behavioral health holding rooms, regulated outpatient clinics, a full-service laboratory, and space for administrative and education functions.

The estimated project cost is $539,558,871 for the relocation and replacement of UM SMC Easton, which will equate to annual depreciation and interest of $44,733,329. UM SMC Easton proposes to finance the project with approximately $39 million in cash, $50 million in philanthropy, $333 million in proceeds from debt financing, $100 million in state funding,[3] and approximately $18 million in interest income.

In concert with the approval of the CON and to ensure UM SMC Easton can update and modernize their facilities with today's standards, the Hospital is requesting gross capital funding in the amount of $18.6 million, $11.9 million as part of the Commission's capital funding policy and $6.7 million from prior system savings that was generated by converting the medical facility in Cambridge from an acute care hospital to a freestanding medical facility in 2021. UM SMC at Easton has put forward a proposal that link the $6.7 million restoration to trends in total cost of care and key metrics developed during a community planning process, as described later in this memo. This agreement will require a future executed contract with the HSCRC.

[1] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2024_decisions/con_shore_easton_2463_rpt_20240118.pdf

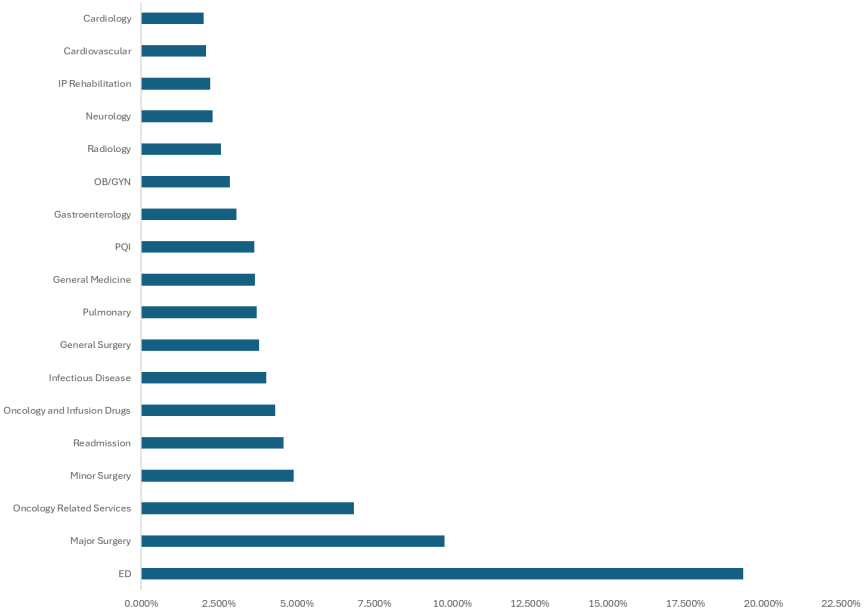
[2] See Appendix A for UM SMC at Easton Facility by Year of Construction

[3] The State has already provided $40 million and has noted in its publications that it has committed a total of $100 million to the project - https://dbm.maryland.gov/budget/Documents/operbudget/2025/proposed/FY2025MarylandStateBudgetHighlights.pdf (Page 21)

Background

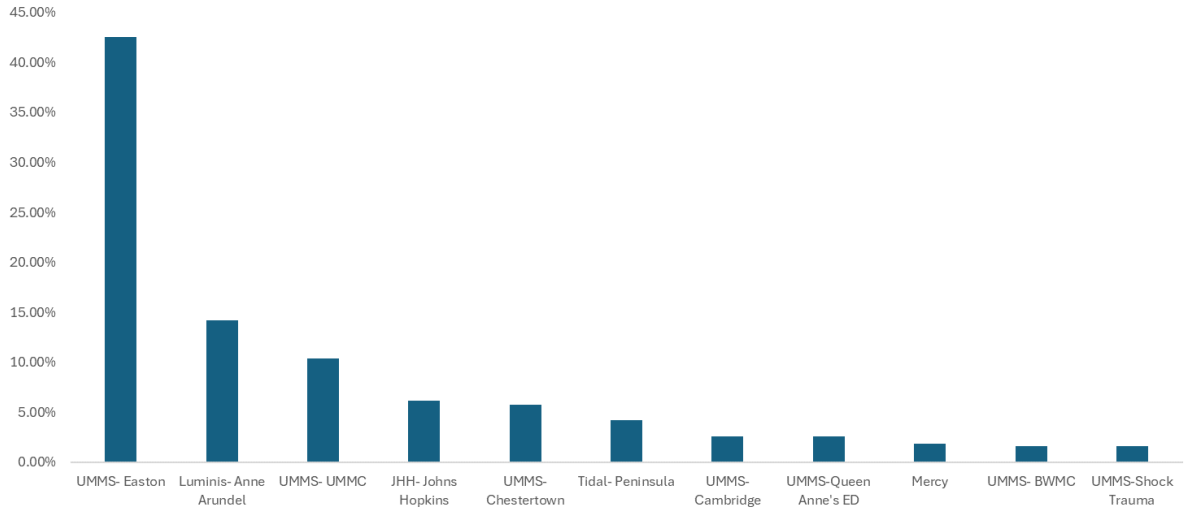
UM Shore Regional Health (UM SRH) is a regional, not-for-profit, healthcare network formed on July 1, 2013, through the consolidation of two UMMS partner entities, the Shore Health System ("UM SHS", comprised of UM SMC at Easton, its two Freestanding Medical Facilities, or "FMFs" at Cambridge and Queen Anne's), and Chester River Health. The UM SRH network is the primary provider for the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's and Talbot counties, providing 53 percent of hospital-based services to residents of the five counties in Fiscal Year 2023, of which UM SMC at Easton compromised 80 percent.[4] UM SRH includes UM SMC at Easton, the regional hub for hospital-based services, UM SMC at Chestertown, a Rural Hospital Model, two FMFs (UM Shore Emergency Center at Queenstown and UM SMC at Cambridge), as well as a number of ambulatory centers offering specialty care, primary care, behavioral health, rehabilitation, diagnostic services, and urgent care located in each of the five counties.

Table 1a. UM Shore Health System Fiscal Year 2023 Service Line Distribution in Five County Service Area
(ECMADS; excludes services comprising less than 2% of service delivery)



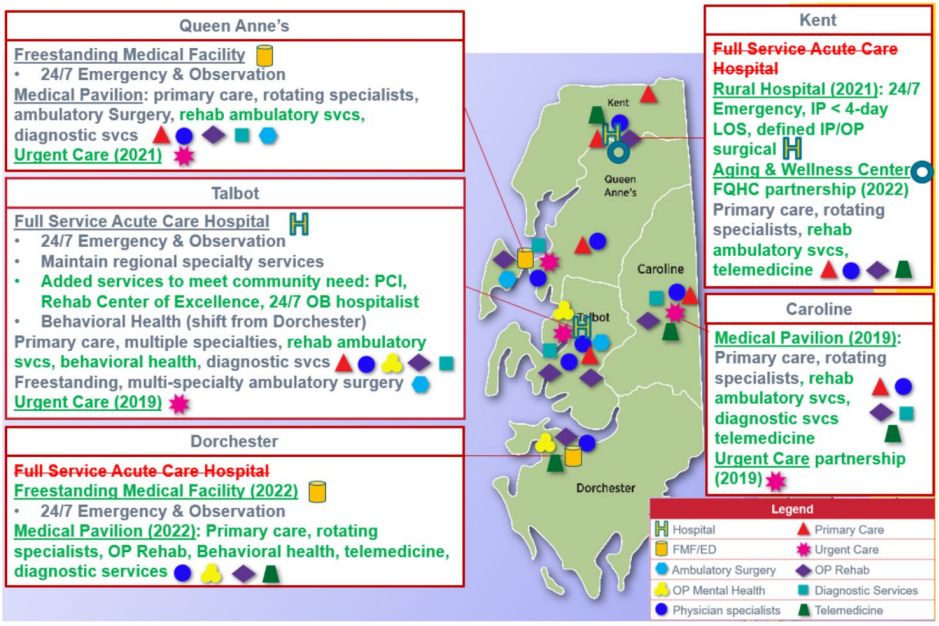
[4] Share is calculated using Commission's casemix adjusted measure of inpatient and outpatient services, equivalent casemix adjusted discharges (ECMADS). UM SHS' share of unadjusted discharges and outpatient visits in the five upper shore counties is significantly higher (71 percent in Fiscal Year 2023). The divergence between the two shares, ECMADS vs unadjusted discharges/visits, is largely driven by UM SHS' larger proportion of services that are provided to emergency room patients (37 percent of discharges/visits versus statewide average of 27 percent).

Table 1b. UM Shore Health System Fiscal Year 2023 Market Share in Five County Service Area (ECMADS; excludes hospitals comprising less than 1% of service delivery)



UM SRH's relatively large, preexisting footprint in the Mid-Shore and the incentives of the TCOC Model have allowed the system to functionally redesign the healthcare system in its five county service area, thereby eliminating excess fixed costs and improving unnecessary utilization metrics as well as a total cost of care (see table 2 for care delivery redesign)

Table 2 UM Shore Regional Health System Redesigned Care Delivery for the Mid-Shore[5]



[5] Source: UM SMC at Easton Partial Rate Application

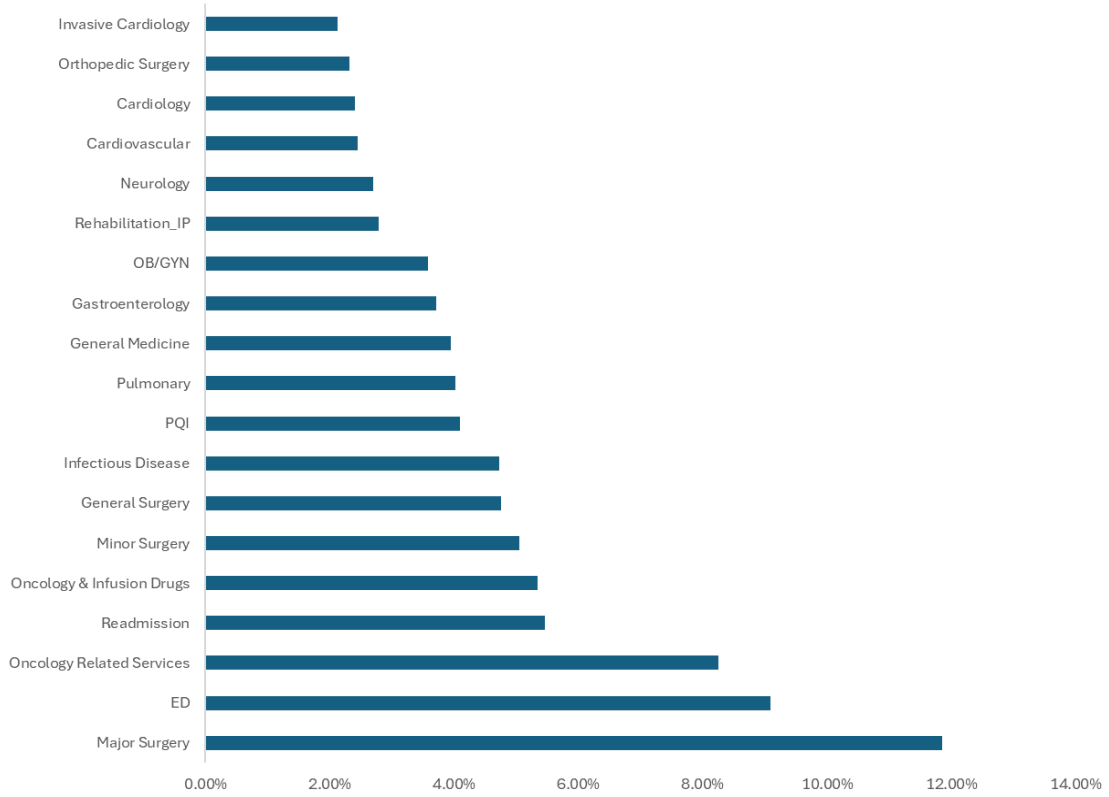
According to the Hospital, because of this redesign UM SRH has meaningfully impacted avoidable hospital utilization since Calendar Year 2016, (all numbers exclude COVID-impacted time periods of Calendar Years 2020/2021):

1) 10% less Emergency Department ("ED") utilization (FY2019 vs. FY2015)
2) 21% reduction in readmissions vs. 8% Statewide (CY2019 vs. CY2016),
3) Casemix-adjusted readmission rate that was 21% below the State average in CY2019
4) 48% fewer discharges for ambulatory-sensitive conditions (CY2019 vs. CY2015)
5) 20+% reduction in overall Medical Surgical Acute Average Daily Census (including observation) (CY2019 vs. CY2015)

In terms of total cost of care, UM SMC at Easton and UM SMC at Chestertown rank 18th and 12th respectively on the Medicare FFS Total Cost of Care attainment metric used in the most recent *Integrated Efficiency* policy and 18th and 7th respectively on Medicare FFS improvement since 2019 (UM SRH's freestanding facilities at Queenstown and Cambridge are not included in the reported measures). According to HSCRC's TCOC Benchmarking methodology from 2019 to 2021 Shore generated $7.5 million of total cost of care savings across Medicare and Commercial populations above the statewide average improvement, $5 million and $2.5 million respectively.

UM SMC at Easton, which is the UM SRH's intended medical hub for its system's acute services, is a not-for-profit 118-licensed bed hospital, serving residents of the 5 county Mid-Shore region since 1915. The Hospital provides specialty services including cancer care, stroke care, cardiovascular and pulmonary services, minimally invasive robotic assisted surgery, telemedicine, kidney transplant and vascular access clinics, general surgery, urology, OB/GYN, otolaryngology, orthopedics and joint replacement services, neurosurgery, diabetes management, wound care, rehabilitation, behavioral health, digestive health, sleep disorders, palliative care, and home health care.

Table 3. UM SMC at Easton Fiscal Year 2023 Service Line Distribution in Five County Service Area (ECMADS; excludes services comprising less than 2% of service delivery)



UM SMC at Easton's current licensed bed capacity of 118 is significantly below its current physical capacity of 165. 37 semi private rooms in the existing hospital, which the Hospital indicates do not meet current standards of care, account for some of this excess in physical capacity, as often patients cannot share a room due to a patient's isolation status, gender, or acuity level.[6] This disparity between physical beds and licensed beds creates operational and cost inefficiencies. The proposed capital project "right sizes" the facility by establishing physical capacity at 122 for inpatient services with no semi private rooms and an additional 25 beds for dedicated observation.

[6] "In the last two decades the majority of hospital physical plant modernization and expansion projects reviewed by the Commission have included the transition of semi-private to private room capacity. Often these hospitals also maintain semi-private rooms that, operationally, become single occupancy rooms" - STATE HEALTH PLAN FOR FACILITIES AND SERVICES: ACUTE CARE HOSPITAL SERVICES (page 3) https://dsd.maryland.gov/regulations/artwork/10241001.pdf

Table 4. UM SMC at Easton Bed Capacity Statistics

Beds	Physical Capacity	Current Licensed Capacity	CON Approved Physical Capacity
MSGA	*120*	*72*	*86*
Obstetric	*13*	*13*	*11*
Pediatric	*5*	*3*	*1*
Psychiatric	*12*	*10*	*12*
Subtotal Acute	***150***	***98***	***110***
Rehab	*15*	*20*	*12*
Subtotal Inpatient	***165***	***118***	***122***
Dedicated Observation	***0***	0	25
Total Inpatient and Observation Beds	***165***	***118***	***147***

The project contemplates an 11% decrease in physical Medical Surgical Acute Adult and Pediatric beds compared to the historic bed complement across SMC Easton and Dorchester (prior to transitioning to an FMF), and according to the MHCC recommendation on the CON, the proposed bed capacity aligns with current volumes plus population estimates put forward by UM SRH, which project that the mid-shore will grow by 0.9 percent to 1.0 percent annually for Fiscal Year 2023 through Fiscal Year 2032. HSCRC staff were at first concerned that this projection was potentially aggressive since total population growth from 2010 to 2020 was 1.66 percent. However, after accounting for the aging of the population using the age weights from the Commission's Demographic Adjustment policy, which recognizes expected hospital use rates due to the aging of the population, staff calculated a compound annual growth rate of 1.59 percent, suggesting the projections are reasonable.[7] The Hospital does not expect that the proposed physical capacity, relative to current licensed capacity, will yield any changes in the hospital's market share, as the growth is in line with anticipated demographic changes. However, UM SMC at Easton does anticipate in 2029, when the replacement hospital opens, that the market share for adult psychiatric patients will increase by 6.9 percent, leading to 83.5 percent market share, because the Hospital will be able to admit patients previously referred to Delaware.[8]

Additionally, volumes in the Fiscal Year 2023 Experience Report already justify the contemplated 87 MSGA/Pediatric beds and 25 observation beds, meaning UM SMC at Easton will have to offset anticipated population growth with reductions in avoidable utilization and/or length of stay.

[7] See Appendix B for age adjusted population modeling.

[8] "The capacity constraints and staffing limitations UM SMC Easton experienced in FY 2022 resulted in 121 patients being referred to hospitals in Delaware" - https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2024_decisions/con_shore_easton_2463_rpt_20240118.pdf (Page 119)

Table 5. UM SMC at Easton MSGA Patient Days and Observation Days in Fiscal Year 2023

	FY2023 Days	Proposed Beds
Med/Surg ICU	2,333	
Med/Surg	21,797	
MSGA Days	24,130	
MSGA ADC	66	
Occupancy	80%	
Needed MSGA Beds	**83**	**87**
Pediatric Days	99	
Pediatric ADC (Days/365)	0.3	
Occupancy	80%	
Needed Pediatric Beds	**0.3**	**1**
Observation hours	223,395	
Observation Days (Hours/24)	9,308	
Observation ADC (Days/365)	**26**	**25**

Source: HSCRC FY2023 Experience Reports

Hospital Capital Methodology Request

The HSCRC staff reviewed the hospital's capital request under partial rate application standards. In October 2003, the Commission adopted the staff's recommendation permitting rate increases for major projects approved through a CON under an alternative partial rate application process. The partial rate application process builds on the Inter-Hospital Cost Comparison (ICC) standard methodology, but with adjustments. HSCRC staff updated its approach to capital requests to include evaluations of total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity, in addition to the historical analyses of capital cost efficiency and cost per case efficiency. This updated methodology was approved at the December 11, 2019 Commission meeting, and thus far has been successfully used to adjudicate capital requests from Suburban Hospital, Adventist Shady Grove Medical Center, and Greater Baltimore Medical Center.

The Hospital's partial rate application requests that the HSCRC grant a revenue increase to fund projected incremental capital costs associated with the regulated portion of the project. The CON includes projected average annual interest cost of $16,772,329 and first year depreciation cost of $27,961,000 for a total of $44,733,329 in annual capital cost.

The Hospital is requesting approximately 42 percent of the $44.7 million ($11.9 million as part of the Commission's capital funding policy and $6.7 million from prior system savings that were generated by converting the medical facility in Cambridge from an acute care hospital to a freestanding medical facility in 2021), which, if approved, will be added to rates at the time of the opening of the new facility and will effectively increase the rate structure of UM SMC at

Easton by ~6 percent. The request for significantly less than 100 percent depreciation and 70 percent interest, which is the maximum available in the capital policy, reflects UM SMC at Easton's acknowledgement of the scaling in the capital financing methodology.

Under the HSCRC's historical capital methodology, UM SMC at Easton's request would have been capped at the 50/50 blend of a hospital's capital cost share (inclusive of the new request's first year estimated depreciation and interest costs) and the peer group average capital cost share, and that value would be scaled for cost per case efficiency. Using the HSCRC capital methodology adopted in December 2019, the capital request from UM SMC at Easton will continue to be capped at the 50/50 blend of the hospital's capital cost share (inclusive of the new request's annualized estimate for depreciation and interest) and the peer group average, and that value will be scaled for cost per case efficiency, total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity.

Table 6. Capital Methodology Steps

Steps	Additional Commentary
Step 1: Determine Capital Cost of New Project	Requires final determination from MHCC on allowed capital project size and verified useful life and interest rate values
Step 2: Determine Eligible Capital Cost	Calculated by averaging hospital's capital costs, inclusive of the new project, and statewide peer group
Step 3: Efficiency Adjustment	Scales capital projects from 0-100% based on ranked efficiency in hospital cost per case and TCOC (each ranking worth ~2%)
Step 4: PAU Adjustment Credit	Provides additional funding to hospital if they demonstrate low levels of avoidable utilization and thus have more limited room for improvement in profitability
Step 5: Excess Capacity Adjustment	Reduces available funding if hospital has had significant volume declines since 2014 because the hospital should be able to contribute to capital by reducing fixed costs,
Step 6: Check against Maximum Depr & Interest	Policy caps available funding at 100% depreciation, 70% interest to require hospitals to fund a portion of project out of capital reserves or philanthropy
Step 7: Provide Markup	Revenue is marked up for uncompensated care and governmental discounts

Step 1: The first step of the capital methodology determines the allowed, regulated portion of UM SMC at Easton's capital project, per MHCC, which is $539,558,871. Additionally, staff confirms that the project has an annualized depreciation figure of $27,961,00[9] and an annualized interest figure of $16,772,329 on a 30-year loan with a 5.00 percent interest rate.[10]

Combined, the depreciation and interest bring the Hospital's current capital cost share of 8.43 percent to 26.62 percent, an increase of 18.19 percentage points (or $15,206,457 to $59,939,786).

[9] See Appendix C for an itemization of the useful life of each capital

[10] See rate assumption as per page 42 of the Capital Rate Application, which is consistent with that used in the CON application dated January 6, 2023.

Staff are concerned about the relatively large share of total costs being devoted to capital costs that this project contemplates, i.e., 26.62 percent versus a statewide average of 7.64 percent. However, there are several additional factors that should be considered when determining the reasonableness of the project size:

1) The projected use rates and bed capacity that were approved by MHCC align with current volumes and reasonable projections of population growth, as discussed in the *Background* section, and MHCC has confirmed that the project's cost per square foot for the replacement hospital is $46.87 per square foot less than the Marshall Valuation Service ("MVS") benchmark for Class A, good quality construction, which is the industry standard for capital cost benchmarking.
2) A component of the large capital share is due to UM SRH's purposeful consolidation of facilities in the Eastern Shore. Specifically, inpatient services have been centralized at UM SMC at Easton while:
    a) The hospital in Cambridge was converted to a freestanding medical facility in 2021, thus eliminating its delivery of inpatient services, and
    b) Chestertown was reengineered to provide services under a critical access hospital model, which necessitates maintaining average daily census less than 96 hours and has effectively reduced Chestertown's licensed bed capacity from 41 at the start of the All-Payer Model to 5 in Fiscal Year 2024.

    Given this consolidation, staff, purely for analytical purposes, have assessed the depreciation and interest as a percent of total UM SRH costs to recognize the regional consolidation the system has embarked upon. This analysis, inclusive of the allowed consideration for unique cost multipliers that will be discussed below, indicates that while still high (21.1 percent), the costs associated with capital as a percentage of total hospital costs are more reasonably related to statewide values once these considerations are accounted for.

3) As outlined in the MHCC recommendation and HSCRC analyses of cost inflation, approximately $76.3 million in the $540 million capital project are fairly unique to UM SMC at Easton's capital project (as compared to the prevailing experience in the State), and thus are not reflected in the statewide average capital cost share that is utilized in Step 2 of the capital methodology.
    a) First, building in a rural environment brings both land development and labor workforce issues that are different from building in a more heavily populated geography. This is evident given that the last major rural capital project in Maryland, Western Maryland Hospital Center which opened on November 21, 2009 had first year depreciation and interest of 19.49 percent versus a statewide average of 8.36 percent. Additionally, of the last five major hospital capital projects approved through the CON process, only one of them did MHCC identify

as having building and site multipliers, and this particular facility (University of Maryland Capital Regional Medical Center) was almost funded entirely by State and county revenue transfers, not a rate enhancement through HSCRC capital methodologies. As noted in Table 7 below, due to the rural nature of UM SMC at Easton, it had cost multipliers that were equivalent to 7.7 percent of its project versus 4 percent for University of Maryland Capital Regional Medical Center and 0 percent for all other recently evaluated hospitals.

Table 7. Site Preparation & Building Costs Premiums in Recent Major Capital Projects MHCC-Approved CONs[11]

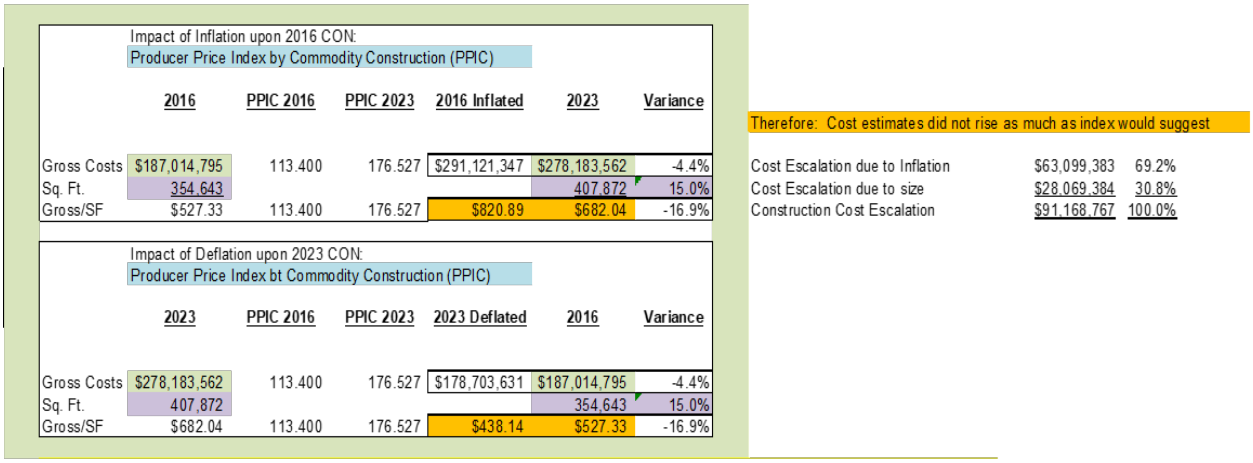
		Recent Major Capital Replacements				
	Easton	Shady Grove	GBMC	Suburban	WOMC	UM Capital Region
Site Multipliers						
Premium due to abnormal labor shortages/remote areas	2,664,598	-	-	-	-	-
Premium for minority business enterprise	1,090,430	-	-	-	-	1,798,368
Premium for prevailing wage	2,664,598	-	-	-	-	724,871
Total Site Multipliers	6,419,626	-	-	-	-	2,523,239
Building Multipliers						
Premium due to abnormal labor shortages/remote areas	12,998,316	-	-	-	-	-
Premium for prevailing wage	12,998,316	-	-	-	-	19,232,575
Premium for minority business enterprise	8,570,914	-	-	-	-	9,115,520
Total Building Multipliers	34,567,546	-	-	-	-	28,348,095
Total Site Prep and Building Premiums	**$40,987,172**	-	-	-	-	**$30,871,334**
Percent of Total Project Costs	7.7%	0.0%	0.0%	0.0%	0.0%	4.0%

b) Second, supply chain and inflationary issues have inherently increased the magnitude of cost required to undertake such a project. HSCRC's analysis of cost increases, which utilized the St. Louis Federal Reserve capital inflation indices,[12] indicates that of the $91.2 million escalation in construction costs between UM SMC at Easton's 2023 CON and UM SMC at Easton's 2016 CON application, $63.1 million of that escalation is related to inflation (with $28M of the escalation related to relocating 29 total beds – 17 MSGA and 12 Psych – from UM SMC at Dorchester as it transitioned to an FMF).

[11] Source: UM SMC at Easton Partial Rate Application

[12] https://fred.stlouisfed.org/tags/series?t=capital%3Bgoods%3Binflation

Table 8. Analysis of Construction Cost Escalation
2016 vs. 2023 CON



Impact of Inflation upon 2016 CON:
Producer Price Index by Commodity Construction (PPIC)

	2016	PPIC 2016	PPIC 2023	2016 Inflated	2023	Variance
Gross Costs	$187,014,795	113.400	176.527	$291,121,347	$278,183,562	-4.4%
Sq. Ft.	354,643				407,872	15.0%
Gross/SF	$527.33	113.400	176.527	$820.89	$682.04	-16.9%

Therefore: Cost estimates did not rise as much as index would suggest

Cost Escalation due to Inflation	$63,099,383	69.2%
Cost Escalation due to size	$28,069,384	30.8%
Construction Cost Escalation	$91,168,767	100.0%

Impact of Deflation upon 2023 CON:
Producer Price Index bt Commodity Construction (PPIC)

	2023	PPIC 2016	PPIC 2023	2023 Deflated	2016	Variance
Gross Costs	$278,183,562	113.400	176.527	$178,703,631	$187,014,795	-4.4%
Sq. Ft.	407,872				354,643	15.0%
Gross/SF	$682.04	113.400	176.527	$438.14	$527.33	-16.9%

UM SMC at Easton has requested that $40.1 million in unique cost multipliers outlined in Table 7 and $35.3 million of the $63.1 million HSCRC has determined is attributable to recent inflationary trends in Table 8 (for a total of $76.3 million) should be passed through the 50/50 blend in the Step 2 of the capital methodology without qualification, similar to how the Commission adjusts for other costs beyond a hospital's control, e.g., labor market in efficiency policies or graduate medical education in TCOC assessments.

Staff agrees with these requests because MHCC has approved the entire $540 million capital project and has not directed the HSCRC to exclude any cost multipliers and/or exemptions from capital rate support calculations. Moreover, the capital policy never contemplated unique rural cost multipliers that would not be accounted for in statewide average capital cost share statistics nor did the policy anticipate that hospitals, recapitalizing in a post-pandemic time period, would have differentially higher capital costs because of labor premiums and supply chain disruption. Moving forward, staff recommend that all exclusions and multipliers that are approved as part of the total capital project through the CON process be passed through the capital policy without qualification and that staff assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

Step 2: Averaging the requested capital share of 26.62 percent to the peer group average of 7.64 percent, per Step 2 of the capital methodology, yields an allowed capital cost share of 17.13 percent, which equates to a 8.70 percentage point increase in capital costs, or $19,154,648.

However, given staff's recommendation to pass through without qualification $76.3 million of the capital project due to unique cost drivers, staff ran two capital models that will then be combined in the final step:

1. the first model (the "pass through model") calculates depreciation of $3,952,679 and interest of $2,371,003 on a project size of $ 76,274,200, which when inflated to the 2029 (the year of the facility opening) and marked up for uncompensated care and government discounts, equals $8,522,602; this proposed funding is carried to the final step without further adjustment as Staff is recommending special treatment for this funding.
2. the second model, which is $463,284,671 and, unlike the pass through model, will run through all of the additional steps of the capital methodology, yields depreciation of $ 24,008,321, interest of $14,401,325, and a requested capital cost share of 24.50 percent.

Averaging the requested capital cost share of model two of 24.50 percent to the peer group average of 7.64 percent, per Step 2 of the capital methodology, yields an allowed capital cost share of 16.07 percent, which equates to a 7.64 percentage point increase in capital costs, or $16,776,520.

Step 3: After a figure is derived in Step 2 for model 2 described above, the capital methodology then scales the result in Step 3 by the *Integrated Efficiency* of hospital cost per case and total cost of care, which is a relative ranking of hospitals that provides approximately 2 percent for each additional increase in ranking. In the case of UM SMC at Easton, which is the 3rd best hospital in the fifth quintile of performance, the hospital is entitled to 18 percent of the allowed capital cost share, or $2.9 million.

Step 4: The capital methodology provides a credit to hospitals that have lower levels of PAU, as defined by 30-day readmissions and avoidable admissions for PQIs. UM SMC at Easton's performance is in the middle of the second quintile of performance and better than the state average performance (15.6 percent compared to the statewide average of 16.15 percent), thus earning a credit of $58,109 and bringing total funding to $3,040,602.

Step 5 The capital methodology removes costs associated with excess capacity, as defined by reductions in bed days from 2010 to 2023. UM SMC at Easton did not experience a reduction in bed days since 2010; thus, there is no adjustment for excess capacity and no change to total funding.

Step 6 In Step 6, staff review the project to determine if eligible funding exceeds 100 depreciation and 70 percent interest, which is equivalent to $34,089,249. Because eligible funding does not exceed that value, there is no change to total funding.

Step 7 The Hospital's markup in Fiscal Year 2024 was 1.1076; therefore, the capital allotment for UM SMC at Easton is eligible for under model 2 is $3,367,771. Combined with the value calculated under the pass through model ($8,522,602), the total capital allotment for the Hospital is $11,890,372. See table 9 below for an itemized schedule of the capital methodology.

Table 9. Capital Methodology Schedule

Algebra	Step	Model 1 (Pass Through Model)	Model 2	Total
	Capital Project Size	$76,274,200	$463,284,671	$539,558,871
A	Depreciation	$3,952,679	$24,008,321	$27,961,000
B	Interest	$2,371,003	$14,401,325	$539,558,871
C=A + B	Step 1: Determine Capital Cost of New Project	$6,323,682	$38,409,646	$44,733,329
	Step 2: Determine Eligible Capital Cost			
D	Current Hospital Capital Ratio	NA	8.43%	
E	Hospital Proforma Capital Ratio	NA	24.50%	
F	Peer Group Capital Ratio	NA	7.64%	
G=Avg(E,F)	Average of the Hospital and Peer Group	NA	16.07%	
H=G-D	Addditional Capital Funding %	NA	7.64%	
I	Addditional Capital Funding $	$7,694,657	$16,776,520	$24,471,177
	Step 3: Efficiency Adjustment			
J	Scaling due to Integrated Efficiency Peformance	NA	18%	
K=I x J	Qualifying Capital Cost After Efficiency Adjustment	$7,694,657	$2,982,492	$10,677,149
	Step 4: PAU Adjustment Credit			
L	Credit due to PAU Performace	NA	58,109	
M=K + L	Qualifying Capital Cost After PAU Adjustment	$7,694,657	$3,040,602	$10,735,258
	Step 5: Excess Capacity Adjustment			
N	Adjustment due to Bed Day Reduction	NA	0	
O=M + N	Qualifying Capital Cost After Excess Capacity Adjustment	$7,694,657	$3,040,602	$10,735,258
	Step 6: Check against Maximum Depr & Interest	NA	NA	
	Step 7: Provide Markup			
P	Estimated Markup	1.1076	1.1076	1.1076
Q=O x P	Additional Capital Funding	$8,522,602	$3,367,771	$11,890,372

Hospital Restoration of Funding Request

In 2020, UM SRH discussed with HSCRC staff the concept of transitioning UM SMC Dorchester from a full-service hospital to an FMF and prioritizing redirecting the resulting GBR savings to contribute to the UM SMC at Easton capital project, rather than generating system savings. HSCRC staff expressed a willingness to consider such an arrangement, subject to Commissioner approval. However, when UM SMC at Dorchester transitioned from an acute care facility to an FMF in November 2021, HSCRC staff removed $6.7 million in system savings, citing the lack of an active, docketed CON project.

As UM SMC at Easton's replacement and relocation capital project is now underway, UM SRH is resubmitting its request to use the GBR capacity generated from the UM SMC at Dorchester FMF transition to contribute to covering capital costs of the UM SMC at Easton replacement and relocation project, rather than system savings. Without this accommodation, the effective financing for this project from the capital policy alone would be 26 percent versus the 42 percent the Hospital is requesting.

Because UM SMC at Easton understands that this request is outside of the capital policy, it has put forward the following proposal to make the $6.7 million restoration, which will be used to fund 16 percent of the new facility's depreciation and interest, at risk for geographic TCOC improvement, as measured by the Care Transformation Initiative (CTI) policy framework:

1) Potential evaluation
    a) Two-sided risk structure
        i) Range of potential funding outcomes: $0 - $6.70M
    b) Geographic/community-based care CTI thematic area
    c) Risk structure tied to policies that are in effect upon activation of the funding (i.e., 2029)
        i) Ex: CTI for TCOC risk, Revenue for Reform for the buyout provision
2) Expected outcome
    a) Geographic TCOC improvement vs. agreed upon base period for 5-county Mid-Shore
        i) At least dollar for dollar savings, i.e., $6.7 million, to be achieved within a reasonable time frame, e.g., 7 years of the start of the new hospital, and relative to a reasonable established target
        ii) In year 1, total cost of care for Medicare recipients in the 5-county region is at least $1 million better than agreed upon benchmark, which grows to $6.7 million per year better than the target in year 7.
        iii) If target savings are not achieved, then rates are lowered to recoup the difference. For example, if only $500K saved in year 1, reduction in $500K in rates in year 2. An additional $2 million will still be expected in year 2.
        iv) After year 10, risk structure sunsets and three year average TCOC savings run rate is permanently reflected in UM SMC in Easton's rate structure (not to exceed $6.7 million).
3) Risk reduction provision
    a) UM SRH will have an opportunity to reduce of half of the TCOC risk if two conditions are met
        i) Investments in enhanced access are made (UMMS is indicating that at least $3.5 million will be spent annually), and
        ii) Progress on key community health improvement indicators are met
    b) The details of which investments to make and what the key improvement indicators are should be worked out through a community planning process, and reviewed and found to be appropriate by the Commission staff
    c) Examples of potential investments in enhanced access:
        i) Rural primary care residency program
        ii) Mobile Integrated Health/Community Health Workers
        iii) Community-based mental health services
        iv) Primary care community physicians
        v) Community physicians oriented to community needs
        vi) Chronic condition medical specialties – Cardiology, Pulmonary, Diabetes
    d) Examples of key performance indicators (KPI's):

i) Lives touched/encounters in non-hospital setting
ii) Number connected to services addressing social needs
iii) Number connected to outreach programs
iv) Emergency department admissions per capita
v) Avoidable admissions per capita
vi) Readmissions performance at SRH hospitals

Below is an outline of the potential risk arrangement which will be subject to further negotiation should Commissioners approve staff's recommendation to advance a contract negotiation with UM SRH:

Table 10. Potential TCOC At-Risk Schedule

Cumulative Evaluation ***Poor Performance*** *($ Millions)*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Final Reconciliation (Year 11)	Total	Permanent Funding (Average of Last 3 Years)
Capital Installment	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7		$67	
Required Savings Relative to Baseline	$1	$2	$3	$4	$5	$6	$7	$7	$7	$7		$49	
Actual Savings	$1	$3	$2	$2	$5	$4	$0	$0	$0	$0		$17	$0
Annual Reconciliation				$0	($2)	$0	($2)	($7)	($7)	($7)	($7)	($32)	
Cumulative Reconciliation	$0	$0	$0	$0	($2)	($2)	($4)	($11)	($18)	($25)	($32)		

Cumulative Evaluation ***Excellent Performance*** *($ Millions)*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Final Reconciliation (Year 11)	Total	Permanent Funding (Average of Last 3 Years)
Capital Installment	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7		$67	
Required Savings Relative to Baseline	$1	$2	$3	$4	$5	$6	$7	$7	$7	$7		$49	
Actual Savings	$1	$1	$2	$2	$5	$4	$5	$8	$9	$10		$47	$6.70
Annual Reconciliation				($2)	($2)	$0	($2)	($2)	$1	$2	$3	($2)	
Cumulative Reconciliation	$0	$0	$0	($2)	($4)	($4)	($6)	($8)	($7)	($5)	($2)		

Placing at risk a funding source for a major capital project's depreciation and interest is an unprecedented request, as the new facility is not an asset that can be easily liquidated if the Hospital fails to maintain enhanced access and/or performs poorly on expected TCOC improvement.

Staff recognize the concern that missed performance metrics may cause margin erosion and liquidity deterioration. However, given the UM SRH's demonstrated ability to rationalize its acute care service delivery and improve upon avoidable utilization metrics and total cost of care, staff recommend that the Commission approve the restoration of the $6.7 million in system savings, contingent on an executed contract between UM SRH and the HSCRC that codifies expected deliverables and associated KPI's/expected outcomes. UMMS financial reserves would serve as the backstop for the project. The final contract will be subject to Commission approval.

Stakeholder Comments

4 comment letters were submitted from the following institutions: University of Maryland Medical System (UMMS); Maryland Hospital Association (MHA); TidalHealth (Tidal); and MedChi. Comments focused on three principal areas: proposed modifications to Capital Policy; the need for more extensive review of the Capital Policy; and the potential utility of the Full Rate Application in lieu of a revision to the Capital Policy. Excerpts from the comment letters can be found below:

Table 11. Excerpts from Comment Letters

	UMMS	MHA	Tidal	MedChi	Commissioners
Proposed Modifications to Capital Policy	"The proposed adjustments represent an improvement to the policy that is consistent with the handling of unique costs in other methodologies."	As Maryland hospitals represent broad and diverse geographies, each with its own unique challenges for successfully funding and executing capital projects, acknowledging the specific circumstances for each of them and adjusting accordingly is an important evolution of the current policy.	"We disagree with using the Capital Policy as the mechanism to request support for funding the $18.6 million… The Capital Policy was intended to be a formulaic approach and we believe it should be kept as such, which would limit the funding to $3.8 million." "The HSCRC has the Full Rate Application process that considers other cost unique factors relative to the Hospital. We believe that is the appropriate mechanism to request the additional $14.8 million where there is precedent for such decisions outside of the formulaic approach."	"We would recommend support for this application…"	Expressed concern that staff were driving to a negotiated answer that is being done outside of typical policy development. Others communicated that Commission should be nimble enough to make adjustments to policies
Need for More Extensive Review of Capital Policy	"We believe that the Capital Funding Policy should be viewed through the lens of providing sufficient funding to enable necessary recapitalizations of aging facilities…, We look forward to continued policy progression toward that goal.	"MHA would also encourage the HSCRC, however, to conduct a broader review of the current capital policy to ensure hospitals can adequately fund recapitalization of aging facilities or replace them entirely…. the current policy largely excludes inefficient hospitals from capital funding as measured by the Integrated Efficiency Policy due to the perception that they have retained revenue that can be used to reinvest, yet those same inefficient hospitals are also subject to Revenue for Reform which compels them to spend those excess funds or be potentially penalized.		"...and continuing to move forward on a rehaul of the capital policy as discussed in June meeting."	Concerned about the complexity of the capital policy and expressed a desire to reevaluate the capital policy.

Generally, stakeholders were supportive of the proposed modifications to the capital policy with the notable exception of TidalHealth that suggested the Commission should use the formulaic nature of the capital policy and if necessary the full rate application for additional funding.

Staff Response: ***Staff believe that the best way to amend policy is through the typical policy making process (i.e., 6-9 months of workgroup engagement and 2-3 months of Commission deliberation); however, it is important to remember that various financial methodologies (partial rate applications, full rate applications) are only employed when a hospital submits an application and it is virtually impossible for methodologies to account for every nuance of a particular request, especially when the environment/economics of the request have changed (e.g., capital requests in a post-inflationary period). Moreover, it has been a hallmark of the Commission to allow for adjustments to policies if the hospital, which has the burden of proof,***

provides sufficient evidence as to why a modification should be made, one, with Commission affirmation, creates precedent moving forward.

Staff generally agree with Commissioner Joshi's assertion that the Commission should be nimble enough to make minor adjustments to a policy during the year, even if the policy is not up for review based on the annual policy calendar. This is especially important in a modern context when the Commission has far more policies and methodologies. For all these reasons, staff do not recommend using the full rate application policy to adjudicate the Easton capital request and instead propose moving forward with the 2 modifications to the capital policy.

All stakeholders were supportive of moving forward with a review of the existing capital policy. Particular concerns of the capital policy are its complexity and whether or not it addresses hospitals' ability to recapitalize in a fixed revenue system, especially when it largely precludes inefficient hospitals, as determined by the Integrated Efficiency policy, from gaining additional rate support.

Staff Response: ***Staff welcome the direction from Commissioners to review the capital policy, but would like to stress that there are several policies/methodologies that are currently under development, including, but not limited to, deregulation of volumes, repatriation of volumes, quantification of retained revenue, and access to care evaluations. Given the relatively small size of Commission staff and the large number of policies that need to be maintained, refined, or developed, any direction from Commissioners should consider rate limiting factors, such as staff bandwidth, data limitations, and available contractor support, among others.***

Staff notes that the capital policy is intentionally not simple or unyielding, as Commissioners and stakeholders directed staff to account for several influencing cost items in its development. These include, in particular, TCOC performance, excess capacity/retained revenue that could be used to recapitalize, and the relative inelasticity of global budgets, as measured by potentially avoidable utilization. Moreover, this absence of simplicity allows for adjustments that may be designed to achieve fairness.

Lastly, staff notes that the capital policy purposefully restricts funding from inefficient hospitals because these hospitals typically have more retained revenue (or cost opportunities to generate more retained revenue), and thus should be expected to provide more funding from cash reserves and/or improvements to operational efficiency. The assertion that inefficient hospitals have limited reserves for recapitalization due to Revenue for Reform is likely incorrect, as the Integrated Efficiency only scales a portion of inflation, and these policies do not retrospectively claw back several years of improved operating margins/balance sheets.

Staff Recommendation

Based on the analysis described in the prior sections of this document, staff recommend the following:

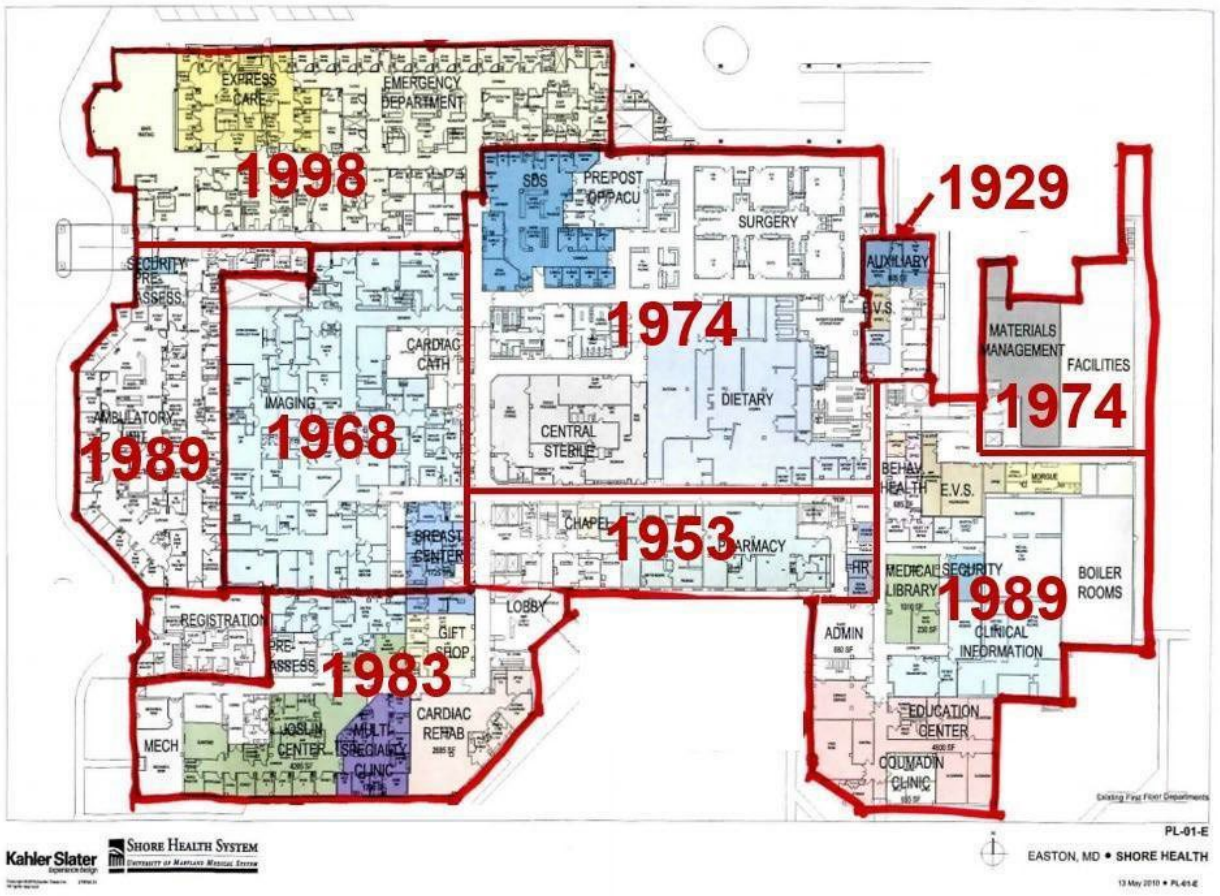
1) All exclusions and multipliers that are approved as part of the total capital project through the CON process should be passed through the capital policy without qualification and staff should assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

2) A permanent adjustment of $11,890,372, per the capital methodology, to be provided to UM SMC at Easton when the capital project is completed and the new site is available for use. The opening date of this project is anticipated to become effective on July 1, 2029.

3) A permanent adjustment of $6,700,000, which will restore funding related to the facility conversion of UM SMC at Dorchester, to be provided to UM SMC at Easton when the capital project is completed and the new site is available for use. The funding will be contingent on UM SRH executing a contract with the HSCRC that that links the funding, as indicated above, to total cost of care, investments in care transformation, and key performance indicators. The final contract will be subject to Commission approval.

Appendices

Appendix A, Current UM SMC at Easton Facility by Year of Construction:



Appendix B, Age Adjusted Population Modelling

"	A	B	C	D=B*C	E
Cohort	2020 Census	Age Cost Weights from Demographic Adjustment Policy	2010-2020 year Growth Rate	Age Adjusted 10 year Growth Rate	Age Adjusted Population Growth
0 to 4	10,735	0.6416	-10.47%	-6.72%	(721)
5 to 14	25,040	0.1395	-7.09%	-0.99%	(248)
15 to 44	71,774	0.6026	-3.36%	-2.03%	(1,454)
45 to 54	26,728	0.9082	-20.16%	-18.31%	(4,894)
55 to 64	32,753	1.4633	17.72%	25.93%	8,492
65 to 74	25,118	2.0882	36.90%	77.05%	19,354
75 to 84	13,487	2.8283	34.49%	97.56%	13,157
85+	4,688	2.8550	17.35%	49.52%	2,322
Total	210,323			17.12%	36,008
CAGR				1.59%	

Appendix C, UM SMC at Easton CON Project Depreciation Detail by Use of Funds ($'s in thousands)

	Uses of Funds	Useful Life (Years)	Annual Depreciation
Design	27,213	40.0	680
Land	2,465	-	-
Land improvement	41,409	30.0	1,380
Building construction & infrastructure	308,607	40.0	7,715
Information technology	30,711	5.5	5,584
Equipment / furnishings	54,350	5.5	9,882
Contingency	13,725	32.0	429
Subtotal	**$ 478,480**	**18.6**	**$ 25,670**
CON prep / consultants	8,100	32.0	253
Capitalized interest & borrowing fees	52,978	26.0	2,038
Total uses of funds	**$ 539,558**	**19.3**	**$ 27,961**

TidalHealth™

Executive

100 E. Carroll St.
Salisbury, MD 21801

O 410-543-7111
F 410-543-7102

June 21, 2024

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

Dear Dr. Kromm,

TidalHealth is providing comment's related to the Healthcare Services Cost Review Commission (HSCRC) Draft Recommendation for University of Maryland Shore Medical Centers at Easton's Capital Request.

We agree that rural facilities have unique challenges that need and should be addressed. We also understand, agree, and appreciate the need for a replacement facility for Easton. The facility is outdated and care for the community is compromised. However, we disagree with using the Capital Policy as the mechanism to request support for funding the $18.6 million. The 2019 approved Capital Policy would provide an additional $3.8 million in funding to Easton. The Capital Policy was intended to be a formulaic approach and we believe it should be kept as such, which would limit the funding to $3.8 million. It is worth noting that Easton will not be the only hospital needing recapitalization, and creating deviations from approved policy will create equity challenges in future applications.

The HSCRC has the Full Rate Application process that considers other cost unique factors relative to the Hospital. We believe that is the appropriate mechanism to request the additional $14.8 million where there is precedent for such decisions outside of the formulaic approach. We should note however, Easton is considered "high cost" under the Inter-Hospital Cost Comparison (ICC) and like most "high cost" hospitals have not taken appropriate rate reductions. This can be seen in Appendix C from the July 2023 HSCRC Commission Meeting where Easton is ranked 39 of 43 hospitals on the ICC (19.5% negative variance). The "low cost" hospitals, such as ours, continue to invest in our communities, but have little opportunity to move from "low cost" to a reasonable funding level to support evolving needs unless funds within the Maryland model are freed up by addressing high-cost outliers.

Finally, we value the discussion raised by commissioners about the inter-relationship between complex policies. Questions such as "how should retained revenue be used" and the relationship between the ICC and eventual capitalization are important and worth additional clarity. While the capital policy is needed, it is worth noting that the combination of appropriate operating margins, adequate balance sheets, and access to debt is the normal process to fund large capital investments in unregulated markets/outside of Maryland. In the meantime, we request that the HSCRC considers equity and fairness when there is a deviation from policy and utilizes the ICC as the measure.

Thank you for allowing Hospitals to provide comments as equitable distribution of funding is critical in maintaining access for all Marylanders regardless of where they live.

Sincerely,

Steven Leonard, PhD, MBA, FACHE
President and Chief Executive Officer

cc: Dr. Joshua Sharfstein, Chair, HSCRC
Dr. Joseph Antos, Vice Chair, HSCRC
Dr. James Elliott, Commissioner, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Dr. Maulik Joshi, Commissioner, HSCRC
Adam Kane, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC

Maryland
Hospital Association

June 21, 2024

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member organizations, I am writing today to provide feedback on the proposed revisions to the Health Services Cost Review Commission's (HSCRC) capital funding policy.

The HSCRC has specifically requested that MHA and its members comment on the staff recommendation, in the context of the capital funding request from University of Maryland Medical System Shore Regional Health, that "[a]ll exclusions and multipliers that are approved as part of the total capital project through the CON process should be passed through the capital policy without qualification and staff should assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate."

On the specific request for comment, MHA agrees with the staff recommendation as it allows unique costs to be recognized in the capital funding policy. As Maryland hospitals represent broad and diverse geographies, each with its own unique challenges for successfully funding and executing capital projects, acknowledging the specific circumstances for each of them and adjusting accordingly is an important evolution of the current policy.

MHA would also encourage the HSCRC, however, to conduct a broader review of the current capital policy to ensure hospitals can adequately fund recapitalization of aging facilities or replace them entirely. This speaks to the larger issue of how Maryland's hospitals are expected to fund capital projects under a fixed revenue model without the same levers that their peers nationally utilize. For example, the current policy largely excludes inefficient hospitals from capital funding as measured by the Integrated Efficiency Policy due to the perception that they have retained revenue that can be used to reinvest, yet those same inefficient hospitals are also subject to Revenue for Reform which compels them to spend those excess funds or be potentially penalized. The capital policy needs to provide sufficient levels of funding for hospital projects that have been approved under the state's Certificate of Need process, ensuring that Maryland's residents have access to care in high-quality, state of the art clinical settings.

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

Sincerely,

Patrick D. Carlson
Vice President, Health Care Payment

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829
www.umms.org

CORPORATE OFFICE

June 21, 2024

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

RE: UMMS Comment Letter on Staff Recommendation for Adjustments to the Capital Funding Policy

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, I am submitting comments in support of the Health Services Cost Review Commission's (HSCRC) proposed alterations to the Capital Funding Policy, put forward in its recommendation for UM Shore Medical Center at Easton's (UM SMC at Easton) partial rate application for capital. Specifically, HSCRC staff has proposed revising its capital funding calculation in two ways:

1. To allow exclusions and multipliers recognized as allowed unique costs in in the Certificate of Need ("CON") process to pass through the Capital Funding Policy without qualification.
2. To allow HSCRC staff to assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

We brought these considerations forward in UM SMC at Easton's capital application after evaluating the Capital Funding Policy through the lens of maintaining a stringent standard for overall efficiency while also acknowledging the unique cost realities of the project. HSCRC efficiency methodologies have always excluded or passed through unique costs when evaluating Hospitals against a Statewide average, and we believe the HSCRC's proposed adjustments represent appropriate refinements in that context. The capital funding calculation as currently constructed does not contemplate either the allowed unique costs identified in the CON process or the impact of the current extreme inflationary environment (which is also now acknowledged in the CON process as an allowed cost).

Unless these allowed unique costs are excluded from the methodology as pass through costs, the capital funding calculation will hold these costs against the Hospital as "excess costs" that do not exist in the Statewide comparison group rather than "allowed unique costs", with eligible funding for those costs significantly restricted through the methodology. Because these costs already have an evaluation mechanism (they would be excluded from eligible funding by the Maryland Health Care Commission ("MHCC") if they were deemed unreasonable), UMMS believes that these unique costs should be accounted for and passed through the capital funding calculation due to the fact that they do not exist as part of the Statewide average and are unique to each individual project. HSCRC staff has appropriately identified two cost areas where unique consideration is warranted:

Unique costs identified as exclusions or multipliers in the CON cost evaluation

In the MHCC's assessment of the reasonableness of a project's cost, the Marshall Valuation Service ("MVS"), these unique costs are acknowledged as exemptions or allowed multipliers applied to cost benchmarks. The MVS recognizes the potential for premiums related to abnormal circumstances, labor shortages, and the costs of transporting equipment and construction materials. This means that the cost evaluation of the project acknowledges that these costs are above and beyond the "standard" experience.

Costs of building in the current inflationary environment

The recent supply chain disruptions and extreme inflation have significantly impacted the cost of building in today's environment. Recent CON-approved projects (UM SMC at Easton, Adventist Shady Grove Medical Center, UMMC Center Center) have estimated that costs are 25% to 40% higher due to extreme inflation. Because only one major recapitalization has occurred in this environment, the Statewide averages in the capital calculation do not reflect the current extreme inflationary environment.

We appreciate the time spent by Commission Staff to refine the Capital Funding Policy. The proposed adjustments represent an improvement to the policy that is consistent with the handling of unique costs in other methodologies. In general, we believe that the Capital Funding Policy should be viewed through the lens of providing sufficient funding to enable necessary recapitalizations of aging facilities, as the fixed revenue GBR model significantly narrows other pathways to contribute to incremental capital costs . We look forward to continued policy progression toward that goal. Please contact me if you have any questions.

Sincerely,

Alicia Cunningham
SVP Corporate Finance & Revenue Advisory Services
University of Maryland Medical System

cc: Dr. Joshua Sharfstein, Chairman
Joseph Antos, PhD, Vice Chairman
James Elliott, MD
Nicki McCann, JD
Maulik Joshi, DrPH
Ricardo R. Johnson
Adam Kane
Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, UMMS, President and CEO
Joe Hoffman, UMMS, Interim CFO

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

June 24, 2024

The Honorable Josh Sharfstein, MD, and Members
Health Services Cost Review Commission (HSCRC)
4160 Patterson Avenue
Baltimore, MD 21215

Re: University of Maryland Shore Regional Health's (UM SRH) rate application

Dear Chairman Sharfstein and Members of the Health Services Cost Review Commission,

I am writing on behalf of MedChi, The Maryland State Medical Society, regarding the recent postponement of the decision on the University of Maryland Shore Regional Health's (UM SRH) rate application. While we understand the need for thorough consideration, we urge the HSCRC to act swiftly and favorably on this matter during the upcoming July meeting.

At the last meeting, the Commission expressed general support for the project but highlighted the necessity for a more comprehensive process for evaluating capital projects. While MedChi agrees on the need for process improvement and we typically do not engage or take positions in these types of applications, the unique circumstances surrounding this case compel us to advocate against any further delays. In this situation, striving for perfection should not impede the progress of a project that already promises significant improvements to healthcare in a rural community. We would recommend support for this application and continuing to move forward on a rehaul of the capital policy as discussed at the June meeting.

UM SRH has been actively implementing a strategic plan to leverage the Model incentives, aimed at enhancing healthcare outcomes in rural areas since 2017. Their efforts include substantial investments in expanding access points and community-based initiatives, with a focus on women's health, primary care, behavioral health, and the preventative management of chronic conditions like congestive heart failure, diabetes, and oncology. Specifically, their plan targets every county with:

- Mental health partnerships
- Primary care and women's health services
- Urgent care, telehealth, and mobile integrated health services
- Medical specialties focused on chronic conditions

Notably, 75% of UM Shore Medical Group's (SMG) community physician relative value units (RVUs) are dedicated to preventative health and chronic condition management, including:

- 31% for primary care and women's health
- 43% for behavioral health and chronic condition management (covering Cardiology, Pulmonary, Endocrinology, Nephrology, Digestive Health, Oncology, Rehab, and Mental Health)

Despite some ongoing challenges, such as emergency room wait times, not moving forward with this facility's improvements will only exacerbate these issues. MedChi would also like to see a reinvestment in community physicians and alignment which could help outcomes. None the less The UM SRH's initiative has begun to show positive results:

- Per capita Potentially Avoidable Utilization (PAU) has been halved since 2014, moving from 55% above the state average in 2014 to 4% below in 2023.
- Emergency department admissions per capita have decreased by 26% since 2014, shifting from 17% above the state average in 2014 to 3% below in 2023.
- Readmissions have reduced by 30% since 2016, compared to an 8% reduction statewide, placing their readmission rates among the best in the state.
- Admissions for ambulatory-sensitive conditions (PQIs) have decreased by 50% since 2015.
- UM SRH has demonstrated strong performance on Total Cost of Care metrics.

A modernized regional medical center is crucial for the region. Easton, the only full-service hospital in a five-county area as large as Delaware, is operating with semi-private rooms in facilities that are 50 to 60 years old. Serving a rural population presents unique challenges that the new facility is designed to address.

The project's size and cost are well-calibrated to meet the community's needs, despite seeming reductions in treatment spaces and beds compared to Easton and Dorchester. The facility's bed complement aligns favorably with state averages, justified by FY2023 volume levels at Easton.

Regarding costs, the building's price is reasonable, given the transition to private rooms and the additional costs associated with rural construction and inflation. The Maryland Health Care Commission (MHCC) has evaluated and deemed the project costs as reasonable. The retained revenues from volume declines, leading to a 10% premium on hospital-based services, have supported the community health model, reducing the Total Cost of Care and improving outcomes.

However, the path to project feasibility under the fixed revenue model remains challenging. The HSCRC's capital funding proposal, which provides 25% funding due to Easton's perceived inefficiency, places a significant financial burden on UM SRH. Nevertheless, the proposal allows for the use of savings from the Dorchester transition, potentially increasing funding to near 40%, though a considerable financial gap still exists.

Timing is critical. The state has already committed $100 million in support, and the project's feasibility relies on adequate funding levels in rates. If road construction, necessary for the project, does not commence this summer and is completed before winter, a six-month delay will incur a $12 million cost.

Given these factors, we strongly urge the HSCRC to approve UM Shore Regional Health's application promptly. The benefits of this project to the community are substantial, and further delays would be detrimental to the region's healthcare infrastructure and outcomes.

Thank you for your consideration.

Sincerely,

Gene Ransom

CEO MedChi, The Maryland State Medical Society

Cc: Roopa Gupta, MD President Talbot County Medical Society

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 10, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2462
BALTIMORE, MARYLAND	*	PROCEEDING:	2652A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 30, 2024, on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to create a new global price arrangement for facial feminization consult and procedures for self-pay patients. The System requests approval of the arrangement for a period of one year beginning July 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

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

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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 10, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2463
BALTIMORE, MARYLAND	*	PROCEEDING:	2653A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 30, 2024, on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for bariatric surgery, oncology surgery procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacements, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy with Assured Partners. The System requests approval of the arrangement for a period of one year beginning July 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bariatric surgery, oncology surgery procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacements, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy for a one-year period commencing July 1, 2024, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 10, 2024

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2464
BALTIMORE, MARYLAND	*	PROCEEDING:	2654A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 30, 2024, on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for bariatric surgery, joint replacement, oncology surgical procedures and neurosurgery with BridgeHealth Medical Inc. The System requests approval of the arrangement for a period of one year beginning July 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bariatric surgery, joint replacement, oncology surgical procedures and neurosurgery for a one-year period commencing July 1, 2024, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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Request For Extension of Approval

Johns Hopkins Health System

July 10, 2024

Background

On February 9, 2024, in accordance with the authority granted by the Commission, staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Cigna Health Corporation (Cigna), Proceeding 2618A. The extension expires on June 30, 2024. However, JHHS and Cigna have not completed negotiations to extend the arrangement.

Request

JHHS requests that the Commission extend its approval for an additional two months, to August 31, 2024, to complete negotiations.

Findings

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

Staff Recommendation

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

Maternal and Child Health Population Health Improvement Fund

Program Year Two – FY 2023

Annual Report

November 2023

Table of Contents

Background

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of healthcare quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. In December 2020, the State submitted its proposal for a Statewide Integrated Health Improvement Strategy (SIHIS), which aligns statewide efforts across three domains: hospital quality, care transformation across the system, and total population health. Under the third domain, total population health, the State identified three key health priority areas for improvement: diabetes, opioid use, and maternal and child health. CMMI approved the State's proposal on March 17, 2021.

While the State identified diabetes and opioid use as key population health priority areas in the first year of the TCOC Model, the third priority area—maternal and child health (MCH)—was not selected until fall 2020. Consistent with the State's guiding principle to select goals, measures, and targets that are all- payer in nature, maternal and child health was deliberately considered as a priority area even though it is not primarily Medicare-focused. The selection of maternal and child health as a priority area reflects its importance in the State and acknowledges both the longstanding history of disparities, as well as potential for improvement.

The U.S. faces higher maternal and infant mortality rates[1] compared to other industrialized countries, with large racial/ethnic disparities for each outcome. In the U.S. in 2018, Black non-Hispanic women had a maternal mortality ratio (MMR) 2.5 times greater than White non-Hispanic women, a disparity that has persisted since the 1940s. In Maryland, while the 2014-2018 Black non-Hispanic MMR was 4.0 times the White non-Hispanic MMR.

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a significant impact on parental productivity. In Maryland, approximately 9.7 percent of children have asthma.

As part of the SIHIS proposal, the State identified two areas to improve maternal and child health, as measured by both overall reduction as well as stratified by race and ethnicity:

- Severe maternal morbidity rate; and
- Asthma-related emergency department (ED) visit rates for ages 2-17.

[1] A maternal death is defined by the WHO as "the death of a female from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy." Source: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622

Table 1. Race/ Ethnicity Disparities in Maryland SMM Tate 2018 Baseline and SIHIS Targets

Race	2018[2],[3]	2023 Year 5 Target	2026 Year 8 Target
NH White	181.4	7.5% decrease	15% decrease
NH Black	334.2	10% decrease	20% decrease
Hispanic	242.0	10% decrease	20% decrease
NH Asian	249.0	10% decrease	20% decrease
Other	205.2	10% decrease	20% decrease
Total	243.1	9.6% decrease	18.7% decrease

Table 2. Childhood Asthma-ED Visit Rates per 1,000, disaggregated by race and ethnicity

Race	Baseline 2018[2,3]	2023	2026	Absolute change	Relative Percentage Change
NH White	4.1	3.5	3.0	1.1	26% decrease
NH Black	19.1	14.36	9.6	9.6	50% decrease
Hispanic	5.4	4.7	4.0	1.4	25% decrease
NH Asian	2.7	2.6	2.5	0.2	9% decrease
Other	10.6	7.3	5.5	5.1	48% decrease
Total	9.2	7.2	5.3	3.9	42% decrease

In 2021, the Health Services Cost Review Commission (HSCRC) approved cumulative funding of $40 million across four years (FY 2022 – FY 2025) to support MCH investments led by Medicaid and the Prevention and Public Health Administration (PHPA) under the Maryland Department of Health (MDH), in conjunction with the Medicaid HealthChoice managed care organizations (MCOs). This funding has supported the scaling of existing statewide evidence-based programs and promising practices, as well as the expansion of new services for mothers and children. Additionally, using the funding in this manner

[2] There is a slight variation from what was presented in 2021, because the SMM analysis was analyzed by CRISP with an updated CASE mix file and with code/analysis that is updated by AIM/HRSA and the CDC.

[3] Chesapeake Regional Information System for our Patients Inc. (CRISP) analysis of Health Services Cost Review Commission (HSCRC) data, including blood transfusions. Accessed 3 November 2023.

creates an opportunity for the State to receive federal match funding to nearly double the investment, specifically for the Medicaid programs.

Funds are added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment. Hospitals transfer funds to the Maternal and Child Health Population Health Improvement Fund (Fund). The Fund, created through the 2021 Budget Reconciliation and Financing Act (BRFA), will receive funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners. The Fund sunsets in 2025.

The Fund committed $8 million in annual funding from fiscal year (FY) 2022 through FY 2025 to support Medicaid initiatives to address severe maternal morbidity, in alignment with the inclusion of MCH as a population health priority area under SIHIS. As noted earlier, these monies are eligible for federal matching dollars, bringing the combined total to $16 million annually. An additional $2 million in annual funding is directed to PHPA to support childhood asthma initiatives and additional interventions to address severe maternal morbidity.

Funding supports the following MCH initiatives within Maryland Medicaid:

- Home Visiting Services pilot expansion;
- Reimbursement for doula services;
- CenteringPregnancy, a clinic-based group prenatal care model;
- HealthySteps, a clinic-based intensive prenatal and postpartum case management framework; and
- MOM Program (formerly the Maternal Opioid Misuse (MOM) Model) expansion/intensive case management for high-risk pregnancies.

Funding to PHPA supports the expansion and/or implementation of mutually reinforcing programs:

- Asthma home visiting program (Medicaid partnership);
- Community-based asthma home visiting initiatives (all-payer); and
- Community-based home-visiting services and CenteringPregnancy implementation (all-payer).

The Memorandum of Agreement (MOA) between the HSCRC and MDH that governs the Fund requires MDH to submit an annual report that will outline progress toward the Fund's goals.

This document serves as the annual report for the second year of funding and details the progress of the five Medicaid programs and the initiatives under Public Health Services; further outcome measures will be incorporated into future reports as data become available. The report culminates with a report on FY 2023 expenditures and spending plans for upcoming years.

Medicaid Programs

This section presents an overview and implementation update for each of the Medicaid programs

supported by the Fund, followed by a synopsis of preliminary data from calendar year (CY) 2022, due to claims run-out.

Home Visiting Services Expansion

Program Overview

In 2017, MDH established a Medicaid Home Visiting Services (HVS) Pilot under the authority of the §1115 HealthChoice demonstration to test a service expansion initiative in Maryland aimed to improve both maternal and child health. This pilot included reimbursement for two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Both models employ specific developmental and health screenings, and have an established track record of improving the health and well-being of both the birthing parent and the child. Sites requesting coverage for this service must maintain certification of accreditation or fidelity by the national HFA or NFP organization. Effective January 13, 2022, Maryland promulgated regulations that provided coverage for both models as a new statewide benefit for Medicaid beneficiaries.

Implementation Update-PY2

As of September 2023, there are 12 sites enrolled as Medicaid providers for home visiting services, covering 14 of 24 Maryland counties. MDH continues to serve as a resource for home visiting programs as they enroll as Medicaid providers and implement Medicaid billing mechanisms. Following the benefit's launch in February 2022, 89 Medicaid participants utilized HVS services in CY 2022, for a total of 717 home visits and an average of 8.1 visits per participant.

Doula Reimbursement

Program Overview

Effective February 21, 2022, MDH began Medicaid coverage for doula/birth worker services to Medicaid participants. A doula, or birth worker, is a trained professional who provides continuous physical, emotional and informational support to birthing parents before, during and after birth. Certified doulas serving Medicaid participants provide person-centered, culturally-competent care that supports the racial, ethnic and cultural diversity of members while adhering to evidence-based best practices.

Under Maryland Medicaid's reimbursement model, doulas provide three kinds of services: prenatal visits, attendance at labor and delivery, and postpartum visits. Medicaid provides coverage for up to eight perinatal (*i.e.,* prenatal and postpartum) visits, as well as attendance at labor and delivery, known as the 8:1 model. The 8:1 model allows for any combination of prenatal and postpartum visits that equals eight or fewer visits per birthing parent. Doulas can enroll as individual providers or be affiliated with a doula practice that bills for provided services on their behalf. To recruit more doula providers and in line with other states' rates, Maryland Medicaid increased the reimbursement rate for attendance at labor and delivery in July 2023. All doulas must be trained by one of nine Medicaid-approved doula certifying organizations. MDH is in the process of expanding this list to increase the number of enrolled doulas, as detailed below.

Doula Implementation - PY2 Update

Following the benefit's launch in February 2022, MDH did see individuals utilizing doula services under Medicaid; however, the results do not meet the threshold for CMS cell suppression guidelines. This section details MDH's efforts to increase its Medicaid-enrolled doula provider network as well as facilitate access to services for Medicaid participants.

As of September 2023, there are nine doulas enrolled as Medicaid providers. During the year, MDH monitored doula provider enrollment, and implemented several measures to build out the network. First, MDH permitted MCOs to use single case agreements with doulas until network adequacy requirements are reached. Second, MDH updated its regulations, estimated as effective February 2024, to: 1) facilitate quicker expansion of the number of approved doula certification organizations; and 2) make the doula benefit self-referral until 2025. These two measures, in combination with the request for nominations process to add additional certification programs that started in October 2023, will increase the number of doulas who are eligible to become Medicaid providers. Third, as noted earlier, MDH increased the rate for attendance at labor and delivery from $350 to $800 on July 1, 2023.

Lastly, the Medicaid program worked with colleagues at MDH's Maternal and Child Health Bureau on a Doula Hub request for applications (RFA), released September 2023. The Doula Hub will identify a contractor, who will administer grant money for scholarships and technical assistance for doulas who want to become Medicaid approved.

CenteringPregnancy and HealthySteps

Program Overview

Starting in 2022, MDH utilized the Fund to expand access to innovative approaches to prenatal care and early childhood well-being through CenteringPregnancy and HealthySteps, respectively. Because prenatal care and child health visits are already covered services, the Fund provides an enhanced payment to support practices that have undertaken these programs. MDH combined implementation efforts for these two programs, which included developing infrastructure for Medicaid reimbursement, technical assistance for the MCOs and ongoing communication with the CenteringPregnancy and HealthySteps national organizations and their respective providers in the State.

MDH updated the Maryland Provider Services Manual to reflect the new CenteringPregnancy and HealthySteps benefits and define the reimbursement guidelines for the enhanced payment of these services. The Provider Services Manual is incorporated by reference into the Code of Maryland Regulations (COMAR). Effective January 1, 2023, MDH reimburses CenteringPregnancy and HealthySteps providers an enhanced payment for services consistent with the models of care provided at an accredited site or a site pending accreditation by their respective parent organizations.

CenteringPregnancy

CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. The model focuses on three core components: health assessment, interactive learning and community building. Facilitators support a cohort of eight to ten individuals of similar gestational age through a

curriculum of ten 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions. Discussion topics include medical and non-medical aspects of pregnancy, such as nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care. Studies[1] have shown that CenteringPregnancy improves health outcomes, such as decreased risk of preterm birth, as well as improves patient satisfaction.

CenteringPregnancy Implementation - PY2 Update
Following an MCO infrastructure support program in CY 2022, effective January 1, 2023, MDH began paying an enhanced rate to CenteringPregnancy providers. The enhanced payment supports the overall operations of CenteringPregnancy practices and may be billed alongside the typical group prenatal care procedure code for up to 10 perinatal care visits per pregnancy (*i.e.,* the period from conception to 60 days postpartum).

There are seven active CenteringPregnancy practices in Maryland as of September 30, 2023 and 17 Medicaid-enrolled CenteringPregnancy providers. Medicaid anticipates additional providers will work towards the CenteringPregnancy model implementation due to the partnership and grants from MDH's Maternal and Child Health Bureau (additional detail under 'Public Health Programs,' below).

HealthySteps
HealthySteps, a program of the national accrediting body ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention at accredited, or pending accreditation HealthySteps sites. The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide referrals to external services and follow-up to the whole family.

HealthySteps Implementation - PY2 Update
Similar to CenteringPregnancy, MDH began providing an enhanced payment for evaluation and management services provided by providers at an accredited or pending accreditation HealthySteps site on January 1, 2023, following an MCO infrastructure support program. Like CenteringPregnancy, the enhanced payment supports the overall operations of HealthySteps practices, including the salary of the HealthySteps Specialist.

There are two eligible providers in Maryland (University of Maryland Pediatrics Associates) and three in DC (MedStar Georgetown - MedStar Medical Group at Fort Lincoln, Children's National - Children's Health Center at THEARC and Anacostia locations). In addition, Kaiser Permanente is transforming its practices in South Baltimore and Woodlawn into HealthySteps sites, to comply with the new Medicaid requirement. As of August 2023, there were 66 Medicaid-enrolled HealthySteps providers. Maryland's implementation of the HealthySteps program, including the enhanced Medicaid payment, was recently recognized by the Prenatal-to-3 Policy Impact Center at Vanderbilt University.[4]

[4] Prental-to-3 Policy Impact Center. 2023 Maryland Roadmap Summary. https://pn3policy.org/pn-3-state-policy-roadmap-2023/md/

MCO Incentive Program

To support MDH's MCOs in building the infrastructure and successfully implementing CenteringPregnancy and HealthySteps, the Fund established a voluntary milestone-based incentive program for MCOs in 2022. MCOs had the opportunity to earn a total of $50,000 for each program for meeting three milestone categories: work plan, contracting and service implementation.

Eight of the nine Medicaid MCOs participated in the incentive program. Regulations are being promulgated that will require MCOs to contract with at least one HealthySteps provider and one CenteringPregnancy provider and to pay the enhanced rate for rendered services.

MOM Case Management Services (MOM Program)

Program Overview

The MOM program addresses fragmentation in the care of pregnant and postpartum Medicaid participants with opioid use disorder (OUD) through enhanced case management services, with an emphasis on increasing health service utilization, as well as screening and referral for social determinants of health.

Initially funded as part of a CMMI demonstration, the MOM program has supported efforts in increasing provider capacity to treat the maternal OUD population; in addition, in FY 2022, the demonstration funded a per member, per month (PMPM) payment to MCOs for the enhanced case management services. Starting July 1, 2022, the payments transitioned to the Fund, with federal matching dollars authorized under the §1115 HealthChoice demonstration. As of January 1, 2023, Maryland has ceased its participation in the federal CMMI demonstration; implementation of MOM case management services continued seamlessly.

MOM Program Implementation - PY2 Update

MOM program services started on July 1, 2021 as a pilot in St. Mary's County, continuing for one year before expanding to select counties starting FY 2023. Starting January 1, 2023, the MOM program became available statewide, open to all eligible HealthChoice members. Starting FY 2023, the PMPM payments have been built into MCO capitation rates. As of the end of September 2023, there have been 44 participants in the MOM program. Program participants to date have demonstrated an interest in engaging in treatment for their OUD, as well as efforts to change life circumstances, including enrolling in educational courses, learning to drive and securing stable housing. The program experienced a sharp increase in enrollment following the statewide expansion.

With CMMI funds, and subsequently with support from the Fund, the MOM program has partnered with outside organizations, the Maryland Addiction Consultation Service (MACS) and Bowie State University, to augment the model's impact. Through the partnership, MACS launched the MACS for MOMs program to build provider capacity to better treat the maternal OUD population. The program includes teleECHO clinics, a warmline for phone consultations, and a variety of trainings, including those for receiving a DATA 2000 Waiver which allows providers to prescribe buprenorphine. To strengthen the MOM program

by making it more attractive to communities of color, MDH partnered with Historically Black Colleges and Universities (HBCUs), led by Bowie State, to tailor the program to be more culturally responsive to Maryland's Black population.

PY2 Performance

To assess the outcomes of the Maryland Medicaid MCH Initiatives, the Hilltop Institute from the University of Maryland, Baltimore County analyzed the claims data from the program participants, comparing them with several relevant HEDIS measures. For the purposes of the analysis, all program participants were identified based on FFS claims and MCO encounters that include the program-specific procedure codes, provider types, and/or ICD10 diagnosis codes designated by MDH.

To meet the inclusion criteria for the evaluation, HVS, HealthySteps, doula, and CenteringPregnancy participants were required to have at least three visits, and MOM program participants had to be enrolled in the program for at least three months. All enrollees who met the inclusion criteria and were enrolled after their respective programs' start dates were flagged as evaluation-eligible.

All records were deduplicated so that each enrollee had one record that contained their enrollment start date, the number of program visits or number of months enrolled, and the evaluation eligibility flag. Each enrollee was then sorted into a cohort by calendar year according to the enrollment start date. Thereafter, the demographic variables birth data, sex, and region were obtained and merged from Hilltop Medicaid data sets. The 1184 newborn data set was used to merge infants to their mothers and mothers to their infants where possible, keeping the infants' birth weight, sex, and date of birth.

Separately, Hilltop used the diagnoses and the revenue and procedure codes provided by MDH to identify claims and encounters for cesarean section deliveries, severe maternal morbidity, and birth complications. August 31, 2023, was selected as a cutoff date for 2023 claims and encounters; 2023 data is preliminary due to claims lag. Identified claims and encounters were then collapsed so that there was only one record per enrollee with flags indicating if they experienced the above medical conditions. HEDIS software was used to provide the flags indicating whether enrollees had postpartum care, prenatal visits, and well care visits for CY 2021 and CY 2022. Medical and procedure flags were then merged with the cohort data sets to create a data set of mother and infant pairs with enrollee demographics and evaluation and measure flags.

Aggregate Measures

To be able to share as much of the data as possible, MDH has elected to show measures as aggregate results from participants in HVS, doula services, CenteringPregnancy, the MOM program, and HealthySteps, rather than reporting them at a program level. When combined, the sample is sufficient for the data to be reported, something not possible for the programs with lower enrollment. The tables (Appendix A – H) present the results for enrollees who had at least one qualifying visit as well as enrollees who met the minimum evaluation inclusion criteria.[5] Due to the evaluation inclusion criteria, the aggregate sample size is small for certain measures. Therefore, care should be used when interpreting some of the results.

[5] HVS, CenteringPregnancy, Doula services: At least 3 visits. MOM Program: 3 months of enrollment

Although the number of participants in the MCH programs was relatively low during the evaluation period, the data did show some positive trends. Several maternal health outcomes were extremely positive; during the evaluation period, none of the participants had cesarean deliveries nor did any of the participants experience severe maternal morbidity during their pregnancies.

The data showed improvements in other outcomes as well, with a marked decrease in birth complications between CY 2022 and CY 2023; with the latter year not having a single birth complication. The data also showed a clear improvement in infant birth weight when comparing participants with those who met evaluation inclusion criteria in both CY 2022 and CY 2023.

The data identified two areas that would benefit from continued monitoring by MDH: the timely initiation of prenatal care and the completion of a postpartum visit. It should be noted that CY 2023 data is not yet available for these measures; other outcomes showed clear improvements between CY 2022 and CY 2023. It may be premature to draw firm conclusions about either of these measures.

An overview of the results is listed below. Additional information can be found in Appendices A – H.

- Zero pregnancies with cesarean deliveries during the evaluation period
- Zero pregnancies with severe maternal morbidity
- Zero deliveries with birth complications by participants who met evaluation inclusion criteria
- Zero deliveries with birth complications in CY 2023
- A reduction in low birth weight infants between CY 2022 and CY 2023
- A lower rate of low birth weight infants born to pregnant participants who met evaluation inclusion criteria than those who had any participation
- 33.3 percent of deliveries where to a participant who initiated timely prenatal care
- 20.2 percent of deliveries were to a participant who had a postpartum care visit

Public Health Programs

The Public Health Services/Prevention and Health Promotion Administration administers funds to improve maternal and child health. Specifically, for the Fund, the Maternal and Child Health Bureau (MCHB) implements the maternal health initiatives, and the Environmental Health Bureau (EHB) implements initiatives related to asthma.

Maternal Health Initiatives

Home Visiting Expansion

Program Overview

Home visiting programs can impact maternal morbidity in different ways, including: 1) creating human-to-human relationships that enable home visitors to provide tailored support based on the specific needs

of each family; 2) reducing pregnancy induced hypertensive disorders, preterm birth and maternal depression; 3) creating connections between mothers and health practitioners in the community, breaking down barriers to care and strengthening the link between healthcare resources and the families who need them; 4) providing screening in maternal depression both prenatal and postpartum and connecting mothers in need with the appropriate community-based behavioral health care; 5) providing referrals for mothers when certain risk factors, including trauma or domestic violence, are present in the home; and 6) targeting social determinants of health (SDOH) affecting families, such as social support, parental stress, access to health care, income and poverty status and environmental conditions.[62]

The Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) funds 10 jurisdictions and 15 programs that meet federal evidence-based criteria across Maryland. As part of MDH's efforts to improve maternal and population health MDH plans to award a total of $2.26 million over three years (August 15, 2022 through June 30, 2025) to four sites through the Fund.

Implementation Update

In 2021, through a competitive bid process that was developed in partnership with the Maryland Office of Minority Health and Health Disparities (MHHD) and the MIECHV Program to ensure there was alignment with existing home visiting programs as well as to ensure the grantees would reach out to the population in need. In fall 2022, four sites were selected through the competitive procurement process and MDH announced more than $865,000 in grant funding for FY 2023 to the following organizations: Montgomery County Health Department, Washington County Health Department, Baltimore Healthy Start and The Family Tree.

> **Montgomery County Health Department** utilizes funding to expand its Babies Born Healthy (BBH) program, a prenatal care coordination initiative that connects its participants to home visiting services and offers the March of Dimes Becoming Mom (BAM) curriculum for all BBH participants who wish to participate through group classes or individual sessions. This program enhances maternal understanding through a collaborative community-based model of care, offering prenatal education and ensuring access to quality prenatal care. The program focuses on providing services to the following high-risk zip codes in Montgomery County: 20903, 20904, 20906 and 20912. At baseline, the Montgomery County BBH program enrolls approximately 125 families, with the expansion of the program 31 additional families successfully enrolled with support from the Fund. Throughout FY 2023, the program struggled with staff recruitment challenges and internal delays in the release of funding further heightened the program's operational difficulties. However, despite these hurdles, the program initiated the expansion of its home visiting services with the existing staff.
>
> **Washington County Health Department** began the expansion of their existing home visiting

[6] American Academy of Pediatrics. Home visiting to Reduce Maternal Mortality and Morbidity Act. https://www.socialworkers.org/LinkClick.aspx?fileticket=7mhUWCPtNL4%3D&portalid=0

services via the local program affiliate of Healthy Families America (HFA), which is currently funded by MIECHV. The program enrolled a total of 26 new families from both streams of funding (Fund & MIECHV), with 15% (4) of those families being attributed to the home visiting expansion. The program successfully organized and conducted three virtual family groups, with an average monthly attendance of 18 families. The virtual family groups have proven invaluable, facilitating meaningful connections among families, providing essential parenting insights, and creating a platform for the sharing of experiences. Throughout FY 2023, the county encountered obstacles in recruiting staff and with their referral processes. The Prevention and Health Promotion Administration/MCHB met with the program to gain a comprehensive understanding of the challenges with enrollment and requested a strategic plan outlining their initiatives to improve enrollment rates and will collaborate with Washington County to facilitate peer learning video calls. The Washington County Health Department is a Medicaid-enrolled HVS provider, meaning that the expansion will further benefit the Fund's Medicaid investments as well.

Baltimore Healthy Start (BHS) collaborated with Chase Brexton Glen Burnie Health Center and with the Administrative Care Coordination Unit (ACCU) of the Anne Arundel County Department of Health to expand home visiting services to postpartum women in the following zip codes: 20724, 21060, 21061, 21225 and 21226. This initiative utilizes the Great Kids curriculum, designed for home visits to commence from prenatal to when a child reaches 36 months of age. In addition to the home visits, families who are in need of the services are offered the standard BHS case management and care coordination services through the Chase Brexton-based Medication Assisted Treatment for Substance Use Disorder Program. Enrollment of families into the home visiting program commenced in the fourth quarter of FY 2023, successfully enrolling a total of 17 families with support from the Fund.

The Family Tree facilitated the expansion of home visiting services in Baltimore City through the Parents as Teachers (PAT) model. Home visitors conduct regular visits, supporting families from pregnancy through their child's kindergarten year. The PAT curriculum addresses critical areas including mental health, nutrition, maternal depression, substance use and domestic violence. In FY 2023, the program received certification to operate as a PAT-affiliated site from the Parents as Teachers National Center, successfully recruited and onboarded staff to empower the growth of the PAT home visiting initiative. The program's collaborative efforts extended to partnerships with the following organizations: Health Care Access Maryland (HCAM), Urban Strategies and The Parent Helpline. During FY 2023, the program successfully enrolled 26 families into the PAT program for home visiting, marking a significant accomplishment.

Collectively in FY 2023, Fund-supported Home Visiting Expansion Initiatives enrolled over 75 families to home visiting programs in priority jurisdictions. Table 3 indicates the number of those enrolled by race and ethnicity and Table 4. indicates the number of enrolled by insurance provider. As stated above the home visiting sites experienced challenges with recruitment of staff for the expansion of their programs. MDH will continue to provide technical support to its Fund grantees in FY 2024 to enhance the enrollment of all home visiting sites to improve SMM rates in the state.

Table 3: Number of Enrolled in Fund-Supported Home Visiting Expansion by Race/Ethnicity

Race/Ethnicity	Number Enrolled
non-Hispanic White	*
non-Hispanic Black	57
Hispanic	13
Asian	*
Native American/ Alaska Native	*
Multiracial NOT Hispanic	*
Multiracial and Hispanic	*

Table 4: Number of Enrolled in Fund-Supported Home Visiting Expansion by Insurance

Insurance Type	Enrolled
Enrolled in Medicaid	66
Enrolled Private	*
Enrolled Uninsured	*
Enrolled Other	*

Coordination and Collaboration

To enhance alignment among the Fund-supported home visiting sites and birthing hospital representatives, the Maryland Hospital Association (MHA) and the home visiting sites organized an introductory in-person meeting. The primary goal was to boost referrals and cultivate stronger partnerships and collaboration among stakeholders. Subsequently, MDH developed a one-pager to facilitate the exchange of information regarding the expansion of home visiting programs in a hospital setting. Collaboration with MHA will continue in FY 2024, and MDH is actively exploring methods to promote peer learning among sites and enhance connections.

Increasing Access to CenteringPregnancy Sites

Program Overview

The effectiveness of CenteringPregnancy is shown most dramatically among Black birthing persons in

Maryland, who disproportionately experience adverse maternal outcomes. In response to the disproportionate (SMM) severe maternal morbidity rates affecting Black birthing persons in Maryland, MDH has reserved a total of $429,197 for a period of three years (from FY 2022 to FY 2025) to fund the implementation of CenteringPregnancy in seven additional sites across Maryland. In alignment, participating practices may be eligible for Medicaid's CenteringPregnancy enhanced reimbursement benefit, outlined above.

Implementation Update

During FY 2022 to FY 2025, funding was allocated to expand CenteringPregnancy in eight new sites across Maryland. This expansion aimed to enhance maternal healthcare, particularly for at-risk populations.

Mercy Health Foundation received funding in late State FY 2022 and in 2024, launching CenteringPregnancy at one of their OB/GYN practices in downtown Metropolitan Baltimore. In FY 2023, 15 cohorts and 78 centering classes were conducted, benefitting women at risk of severe maternal morbidity. In June 2022, MDH partnered with the **Centering Healthcare Institute (CHI)**, resulting in a successful recruitment drive and provision of start-up funds for implementing the CenteringPregnancy model in four prenatal clinics, strategically located in Baltimore County, Montgomery County, and Prince George's County. The names of the four clinics are:

- Kaiser Gaithersburg in Montgomery County
- Mary's Center Silver Spring in Montgomery County
- University of Maryland St. Joseph's Women's Health Associates in Towson Baltimore County
- Luminis Health Greenbelt in Prince George's County

All four of the sites are in their Centering Implementation Plan (CIP), which incorporates processes and tools to help sites identify and address barriers. The CIP aims to position the site to successfully complete the accreditation process. Over four to six months, CHI collaborates with each site on the following areas:

1. Creating the Steering Committee
2. Engaging Leadership
3. Building a Shared Vision
4. Goal Setting and Evaluation
5. Creating a Centering Schedule
6. Creating your Centering Space
7. Patient Enrollment
8. Provider Productivity
9. Financing and Budgeting
10. Billing and Reimbursement

For FY 2024, PHPA/MCHB braided additional public health funding from the Babies Born Healthy Program that is aimed to decrease infant mortality and disparities to provide funds for an additional three sites for a total of seven sites. In October 2023, CHI will convene a second *Centering Consortium of Maryland* to increase awareness to health organizations about the opportunity of the three public health grants

available to implement CenteringPregnancy model group for prenatal care. Once accredited or pending accreditation, Maryland Medicaid provides enhanced reimbursement to CenteringPregnancy-certified providers and MCOs that are enrolled in the CenteringPregnancy Model, thus allowing for sustainability.

Improving Childhood Asthma Initiatives

Program Overview

Environmental home visiting programs have been shown to improve asthma outcomes, including adolescent asthma, by addressing asthma triggers in the home and other related environments. Below is a description of the efforts of MDH to improve childhood asthma outcomes.

Implementation Update

MDH has utilized funds from Maryland Medicaid's CHIP Health Services Initiative (HSI) to support the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program operating in eleven jurisdictions: Anne Arundel, Baltimore, Charles, Dorchester, Frederick, Harford, Montgomery, Prince George's, St. Mary's and Wicomico Counties, as well as Baltimore City. The Asthma Home Visiting Program benefits children suffering from moderate to severe asthma. Through up to six home visits, facilitated by a Local Health Department (LHD) community health worker (CHW) and/or supervising case manager, critical objectives are reached.

These visits include an evaluation of environmental triggers, parent education and provision of supplies shown to reduce asthma severity, including a high efficiency particulate air (HEPA) vacuum cleaner and other interventions demonstrated to improve outcomes for children with moderate to severe asthma. The program also ensures care coordination amongst providers who interact with the child through the use of asthma action plans. In FY 2023, 680 children with asthma received services through this program. In support of the SIHIS and MDH goal of addressing health disparities, 80.3 percent of the children with asthma served in the program were Black or African American.

Improving Referrals to Local Health Department Asthma Home Visiting Programs

One of the most significant challenges to the Asthma Home Visiting Program has been recruiting families into the program. MDH developed several strategies to improve the referral process, including:

- Care alerts to health care providers through the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP)
- Direct electronic referrals to LHDs of children recently discharged from emergency departments or inpatient admissions for asthma exacerbations through CRISP
- Direct referrals from hospitals and managed care organizations to LHD home visiting programs

Taken together, these strategies have significantly increased referrals to LHD home visiting programs and improved the recruitment of families into the program. In particular, on September 8, 2022, the first direct electronic referrals of children with recent emergency department visits or hospitalizations

due to asthma were from CRISP to LHDs, and have continued at the rate of 10 children per LHD per week.

Community-Based and Other Programs Focused on Asthma

In addition to the $1 million from the Fund used to strengthen the LHD-operated Asthma Home Visiting Program, MDH released a $250,000 competitive request for applications for community-based programs to address pediatric asthma. The Green and Healthy Homes Initiative, Inc. (GHHI) received funding for two programs, one in Baltimore City, the other in Prince George's County, two jurisdictions with high numbers of children with more severe asthma. With these funds, GHHI is addressing asthma through both educational interventions and home-based interventions and will also expand the number of children and families in the state who may be eligible for services.

The GHHI program is using a tiered intervention approach to conduct interventions to reduce exposures to home-based environmental asthma triggers such as dust-borne antigens, mold and other asthma triggers. All properties approved to participate in the program receive a resident education, an environmental assessment and an asthma trigger reduction prevention supplies kit (cleaning supplies to control dust and other triggers). Based on the home environment and the severity of the child's asthma, additional supplies and services may also be provided, including air purifiers, dehumidifiers, or air conditioners, mold remediation, or as well (as well as Tier I Plus services by GHHI Environmental Health Educators, Environmental Assessors and Hazard Reduction Workers. Those receiving Tier II services will receive Tier I Plus services as well.

Tier I Asthma Trigger Reduction Interventions include:

- HEPA Vacuum
- Simple Green
- Buckets (2)
- Gloves
- Sponges
- Mop
- Mop Refill
- Pillowcases (2)
- Mattress cover
- Smoke Detector
- Carbon Monoxide Detector
- Basic IPM—Integrated Pest Management

Tier II Higher Level Asthma Trigger Reduction Interventions include:

- Air purifying machine installation
- Dehumidifier installation

- Air conditioner installation
- Intermediate to Severe IPM--Integrated Pest Management
- Mold remediation
- Plumbing repair
- CO/smoke detector installation
- Door replacement
- Gutter replacement
- Stabilization of baseboards
- Air filter replacement
- Caulk building corners
- R-9 Fiberglass
- Dryer vent install
- Drain cleaning

The most recent GHHI interim report for Prince George's County summarizes the performance measures and progress to date.

> Objectives: 210 children in total will be enrolled in the Program over 42 months (3.5 years). In the initial six months, GHHI planned to enroll and serve 30 asthma diagnosed children and their households. After the conclusion of the initial six months, GHHI would enroll and provide services to 60 clients annually thereafter for the next 36 months. In total, 210 children would receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and Tier I Plus and Tier II asthma trigger reduction housing interventions.
>
> Interim Report Update: GHHI received 2,300 referrals of Prince George's County children ages 2-17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. GHHI has commenced the scheduling of asthma resident educations and environmental assessments with client referrals from a large managed care organization, and other referrals from GHHI marketing and outreach and healthcare and other partner referrals. GHHI conducted marketing events and Partner Learning Collaborative Trainings with stakeholders in the healthcare, education, and social services area as well as community-based events with parents and stakeholders to increase asthma awareness and decrease hospitalizations and ED visit rates for children ages 2-17 during the grant period. GHHI fully expects to complete all services for 90 asthma resident educations and environmental assessments for asthma triggers as well as asthma trigger reduction housing interventions for higher level intervention (where applicable) client units by June 30, 2023, in meeting the performance measures for the first 18 months of the Program.

In Baltimore City, GHHI has also had some challenges in receiving referrals from its primary source (a large managed care organization).

Objectives: 280 children in total will be enrolled in the Program over 42 months. In the initial six months, GHHI planned to enroll and serve 40 asthma diagnosed children and their households. After the conclusion of the initial six months, GHHI would enroll and provide services to 80 clients annually thereafter for the next 36 months. In total, 280 children would receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and asthma trigger reduction housing interventions.

Interim Report Update: GHHI received 1,900 referrals of Baltimore City children ages 2-17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. GHHI has commenced the scheduling of asthma resident educations and environmental assessments with the Wellpoint client referrals and other referrals from GHHI marketing and outreach and healthcare and other partner referrals. GHHI expects to complete all services for 120 asthma resident educations and environmental assessments for asthma triggers as well as asthma trigger reduction housing interventions for higher level intervention (where applicable) client units by June 30, 2023 in meeting the performance measures for the first 18 months of the Program.

Asthma Community of Practice (CoP) and Provider Education

The Asthma Community of Practice (CoP) was created by EHB with the vision that all people and families living with asthma in Maryland receive the best possible care so that asthma does not affect their quality of life, and with the mission of improving practice through information and resource sharing. The purpose of the Asthma CoP is to:

1. Serve as a forum to exchange best practices and information regarding asthma treatment, management and prevention;
2. Improve collaboration among stakeholders involved in asthma care; and
3. Ensure that Marylanders with asthma get the best possible care and access to prevention services.

In FY 2023 the EHB successfully held two Asthma CoP meetings in which attendees included LHDs and asthma stakeholders across the state, representing GHHI, Johns Hopkins School of Medicine Department of Pediatrics, local community organizations and insurers.

The first meeting was held virtually via Google Meets on March 31, 2022. Amber Grabowski, Clinical Manager from Margaret Brent Middle School and Spring Ridge Middle School School-Based Health Centers), presented the services they provide to the St. Mary's community and their efforts to improve the care of children living with asthma. The Asthma CoP met again on August 18, 2023. Emmanuel Asenso, DO, MPH, delivered an overview of the proposed physician detailing project for Baltimore City. The project focuses on providers and those who serve patients with the highest burden of asthma in Baltimore City, and: 1) promotes initiatives to close the gap (*e.g.,* usage of primary care at the forefront, improving treatment plans, and removing environmental triggers); 2) increases knowledge and utilization of the latest asthma guidelines; and 3) promotes community asthma programs and other asthma

resources to educate clients on how to implement action steps to improve asthma. In addition, EHB provided the findings of the Evaluation of Asthma Home Visiting Program, which examines the impact of the program on improving asthma control and reducing asthma severity for the program participants since 2018. The EHB held the final Asthma CoP meeting on November 16, 2023.

Public Health Program Performance

MDH staff closely monitor performance on the SMM and childhood asthma goals as part of their ongoing implementation responsibilities under SIHIS and the Fund. COVID-19 has had an undeniable impact on SMM and childhood asthma goals.

Pandemic lockdowns led to a notable decrease in emergency department (ED) visits for asthma exacerbation. This decline can be attributed to reduced exposure to viral infections, environmental allergens, limited access to primary physicians, and families being hesitant to seek ED Care. At the onset of the pandemic, the CDC categorizes individuals with moderate to severe asthma as a high-risk group vulnerable to severe COVID-19 outcomes.[7] Consequently they advocated for strategies to mitigate asthma exacerbation risks, including avoiding triggers, adhering to prescribed medications, following personalized asthma action plans.

MDH remains committed to closely monitoring childhood asthma rates across pre- pandemic, pandemic, post pandemic periods to ensure optimal improvement in asthma management and child health, while improving overall well-being and reducing asthma related issues.

Severe Maternal Morbidity Performance

Statewide Performance

The State's SMM rate has increased since 2018 and is currently above the State's 2018 baseline. In FY 2023, an SMM literature review was conducted to better understand the continued rise in SMM cases. The literature review suggested that transfusions alone may inflate the prevalence of SMM and in 2021 Federal partners (Health Resources and Services Administration) updated the SMM indicators to exclude blood transfusions alone, due to lack of specificity.[8] Other significant contributors of elevated SMM rates revealed in the literature review included: COVID-19, comorbidities, hypertension, mental health, racial disparities, clinical level and patient factors.

COVID-19

Based on conversations with stakeholders such as medical professionals, clinic providers and hospital

[7] Moore WC, Ledford DK, Carstens DD, Ambrose CS. Impact of the COVID-19 Pandemic on Incidence of Asthma Exacerbations and Hospitalizations in US Subspecialist-Treated Patients with Severe Asthma: Results from the CHRONICLE Study. J Asthma Allergy. 2022 Aug 31;15:1195-1203. doi: 10.2147/JAA.S363217. PMID: 36068863; PMCID: PMC9441176.

[8] Federally Available Data (FAD) Resource Document

administrators, and the literature available we believe that the effects of COVID-19 and other respiratory viral illnesses have contributed to the SMM rate increase. According to an article published by the *Journal of the American Medical Association* (JAMA), researchers found that pregnant patients with COVID-19 infection at delivery were more likely to develop SMM compared with those without.[9] The study examined a population of 2,578,095 hospital deliveries across 2,691 centers between April and December 2020.[10] Among the individual morbidity indicators, COVID-19 infection was associated with the following outcomes: increased risk of tracheostomy, respiratory distress syndrome, ventilation, acute myocardial infarction, sepsis, shock, cardiac arrest, and coagulopathy. Additionally, the COVID-19 pandemic has brought on a long-lasting impact that disrupted health care services, increased maternal stress, potential delay in prenatal care and social determinants of health.

Comorbidities, Hypertension, Mental Health and Racial Disparities

The findings of the literature review indicated that the existence of pre-existing medical conditions was strongly associated with the risk for SMM. One study reported that 75 percent of those in their study that experienced SMM had significant medical history, which included conditions such as obesity, asthma, a mental health disorder and hypertension.[11] There are known racial disparities in SMM and maternal mortality rates between different race and ethnicity groups. Six out of the 14 studies demonstrated a higher rate of SMM in non-Hispanic Black women compared with non-Hispanic White women. Two studies reported an increased risk for Hispanic women, and two studies indicated an increased risk of SMM for Native American women. One article discussed the differences in underlying health conditions that may contribute to different rates of SMM. They demonstrated that Black women had more medical comorbidities than any other racial or ethnic group. The higher prevalence of medical comorbidities may be one reason why Black women experience higher rates of SMM.[12]

Clinical Level and Patient Factors

In conclusion, when examining the factors contributing to SMM, it becomes evident that many SMM events are preventable. According to a recent article published in the *Journal of the American Medical Association* (JAMA), a hospital review committee in Maryland determined that nearly one-third (n= 61,

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[9] Matsuo K, Green JM, Herrman SA, Mandelbaum RS, Ouzounian JG. Severe Maternal Morbidity and Mortality of Pregnant Patients With COVID-19 Infection During the Early Pandemic Period in the US. JAMA Network Open. 2023;6(4):e237149. doi:10.1001/jamanetworkopen.2023.7149

[10] Matsuo K, Green JM, Herrman SA, Mandelbaum RS, Ouzounian JG. Severe Maternal Morbidity and Mortality of Pregnant Patients With COVID-19 Infection During the Early Pandemic Period in the US. JAMA Network Open. 2023;6(4):e237149. doi:10.1001/jamanetworkopen.2023.7149

[11] Wolfson C, Qian J, Chin P, Downey C, Mattingly KJ, Jones-Beatty K, Olaku J, Qureshi S, Rhule J, Silldorff D, Atlas R, Banfield A, Johnson CT, Neale D, Sheffield JS, Silverman D, McLaughlin K, Koru G, Creanga AA. Findings From Severe Maternal Morbidity Surveillance and Review in Maryland. JAMA Network Open. 2022 Nov 1;5(11):e2244077. doi: 10.1001/jamanetworkopen.2022.44077. PMID: 36445707; PMCID: PMC9709651.

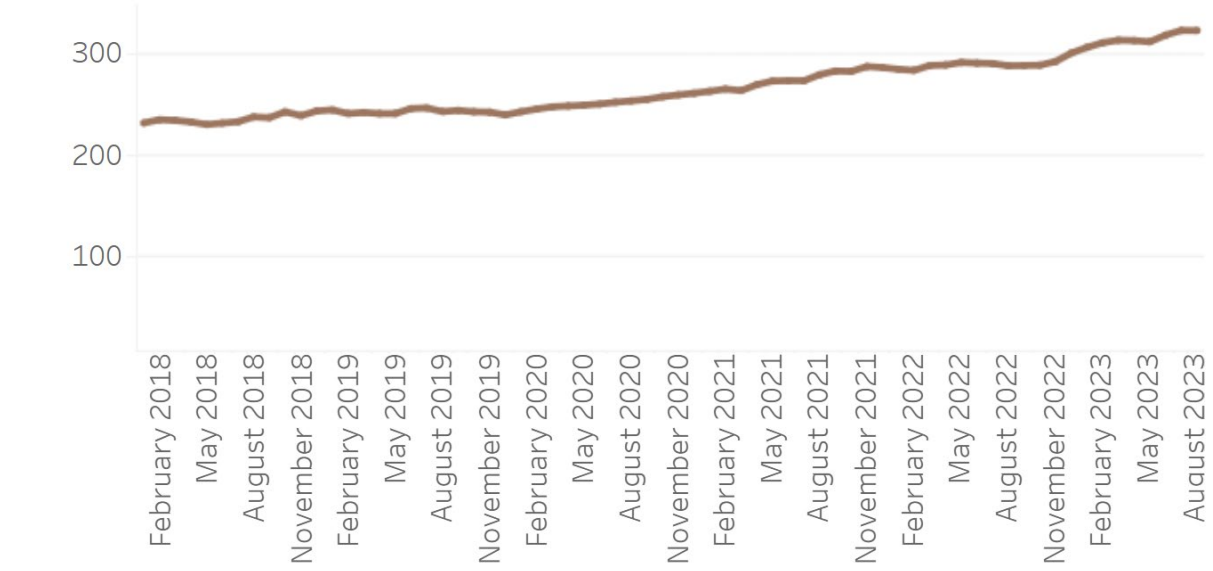
[12] Brown CC, Adams CE, George KE, Moore JE. Associations Between Comorbidities and Severe Maternal Morbidity. Obstet Gynecol. 2020 Nov;136(5):892-901. doi: 10.1097/AOG.0000000000004057. PMID: 33030867; PMCID: PMC8006182.

31.8%) of SMM events were preventable with changes to clinician, system, and/or patient factors (without COVID-19 cases, the preventability rate was similar at 32.8%). The authors stated that, "clinical level factors had the potential to alter the outcome in 60 of the 61 SMM events deemed preventable (31.3% of overall events), system-level factors in 19 events (9.9% overall), and patient-level factors in 24 events (12.5% overall)."[13] Understanding these factors and their interactions is essential in MDH's efforts to reduce SMM rates and improve maternal health outcomes. Fostering collaborations among health care professionals, implementing evidence-based protocols and raising awareness of the different level factors can further enhance preventive measures that would reduce SMM events.

MDH carefully chose to expand Home Visiting and CenteringPregnancy because these initiatives address the significant contributing factors of elevated SMM rates. The initiatives reduce pregnancy induced hypertension disorders, provide screening in maternal depression both prenatal and postpartum and connect mothers to the appropriate resources. MDH is working diligently to expand and implement the funded interventions to improve maternal health and reduce SMM in Maryland. Moving forward, MDH will partner with CRISP to update the SIHIS Dashboard to show SMM Rates with blood transfusion and without blood transfusions. MDH will also collaborate with HSCRC in regard to the likely missed 2023 milestones and will develop a mitigation plan to submit to HSCRC in Spring 2024.

Based on data through June 2023, Maryland had 317.9 SMM-related hospitalizations per 10,000 delivery discharges over the prior 12 months. This rate is 98.6 hospitalizations per 10,000 higher than the 2023 target (219.3) and 75 hospitalizations per 10,000 higher than the 2018 baseline (243.1).

Figure 5. SMM Hospitalizations for Rolling 12- Months, 2018 - August 2023



[13] Wolfson C, Qian J, Chin P, Downey C, Mattingly KJ, Jones-Beatty K, Olaku J, Qureshi S, Rhule J, Silldorff D, Atlas R, Banfield A, Johnson CT, Neale D, Sheffield JS, Silverman D, McLaughlin K, Koru G, Creanga AA. Findings From Severe Maternal Morbidity Surveillance and Review in Maryland. JAMA Network Open. 2022 Nov 1;5(11):e2244077. doi: 10.1001/jamanetworkopen.2022.44077. PMID: 36445707; PMCID: PMC9709651.

Table 6. SMM Hospitalizations Compared to 2023 Target, 2018 - August 2023

	2018 Baseline	Most Recent 12 Months	2023 Target	Difference- Most Recent 12 Months to Target
Rate per 10K	243.1	322.8	219.8	103.0
SMM Events	1,585	1,978		
Eligible Deliverables	65,199	61,279		

Health disparities are also increasing due to challenges discussed earlier in this report, further illustrating the critical need to invest in evidence-based interventions dedicated to addressing maternal health.

Figure 7. SMM Hospitalizations for Rolling 12-Months by Race/Ethnicity, 2018-August 2023

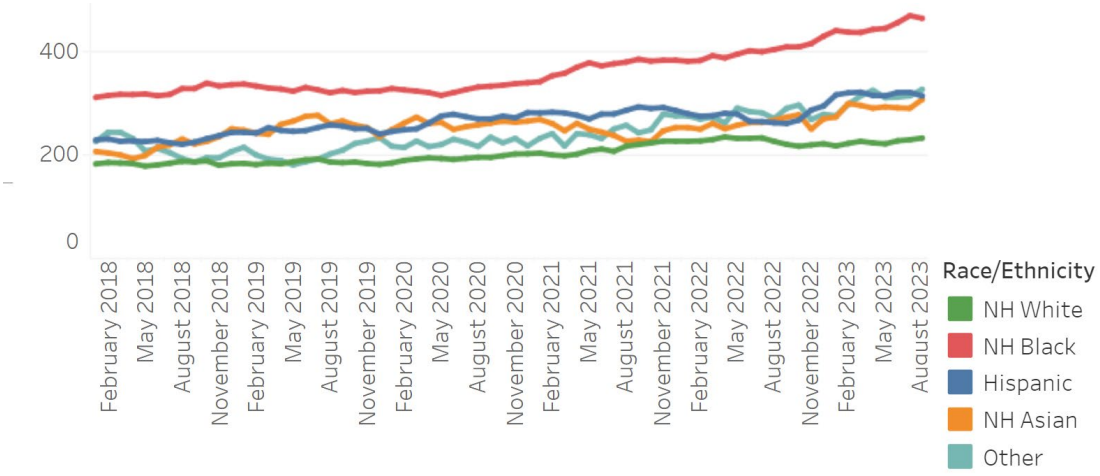


Table 8. SMM Hospitalizations Rates by Race/Ethnicity, 2018-August 2023

Race/Ethnicity	2018 Baseline	Months Recent 12 Months	2023 Target	Difference– Most Recent 12 Months to Target	Disparity Index
NH White	181.4	231.2	167.8	63.4	1.0
NH Black	334.2	462.2	300.8	161.4	2.0
Hispanic	242.0	312.2	217.8	94.4	1.4
NH Asian	249.0	305.3	224.1	81.7	1.3
Other	205.2	325.3	184.7	140.6	1.4
Statewide Total	243.1	322.8	219.8	103.0	1.4

Performance by Payer

Staff is also monitoring SMM performance by payer. Both Medicaid and commercial payers are trending upward, in line with Statewide performance. However, while Medicaid performance has been higher than other payers since 2018, it has grown at a slower pace than commercial (11 percent versus 26 percent). The graph and table below show performance between the 2018 SIHIS baseline and data through September 2022.

Figure 9. SMM Rate by Payer, 2018- September 2022

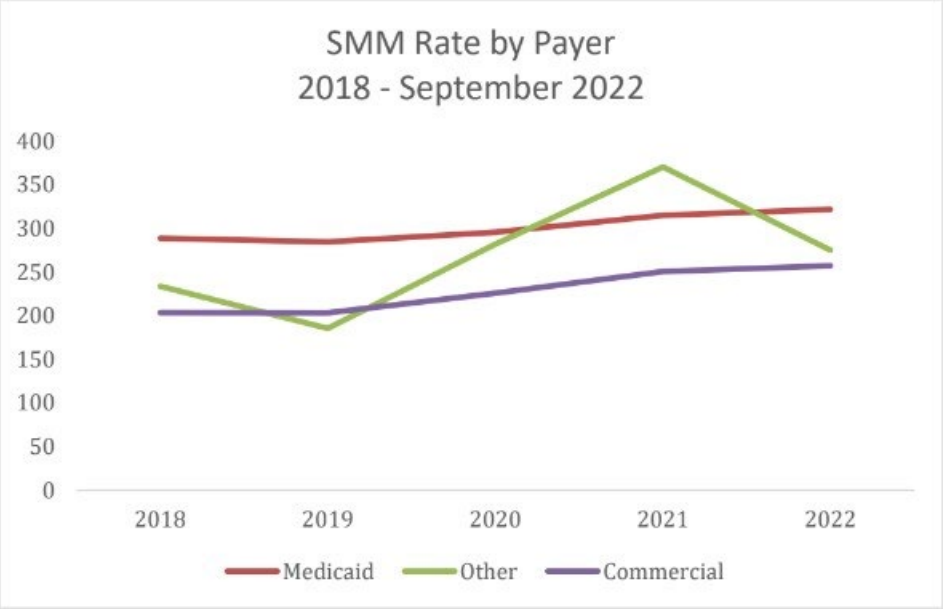


Table 10. SMM Rate by Payer, 2019 – September 2022

Payer	2018	2019	2020	2021	2022 YTD	% Change Since 2018
Medicaid	289	285	296	315	322	11%
Medicare	687	634	842	954	764	11%
Other	234	185	282	370	275	18%
Commercial	203	203	226	251	257	26%

Childhood Asthma Emergency Department (ED) Visit Rate

As is true for hospitals nationally, Maryland hospitals saw sharp declines in ED volumes in 2020 and early 2021 due to COVID-19. Understandably, Maryland's asthma-related ED visit rate for ages 2-17 declined during this period. While 2022 volumes are trending back to 2018 baselines, they are still artificially low. Despite lower ED volumes, staff believes that the underlying dynamics of childhood asthma in Maryland did not change and is working in earnest to implement interventions that will reduce childhood asthma and health disparities.

Statewide Performance

Based on data through August 2022, Maryland had 6.2 asthma-related emergency department visits per 1,000 children over the prior 12 months. This rate is 1.0 visits per 1,000 children lower than the 2023 target.

Figure 11. Childhood Asthma-Related ED Visits for Rolling 12-Months

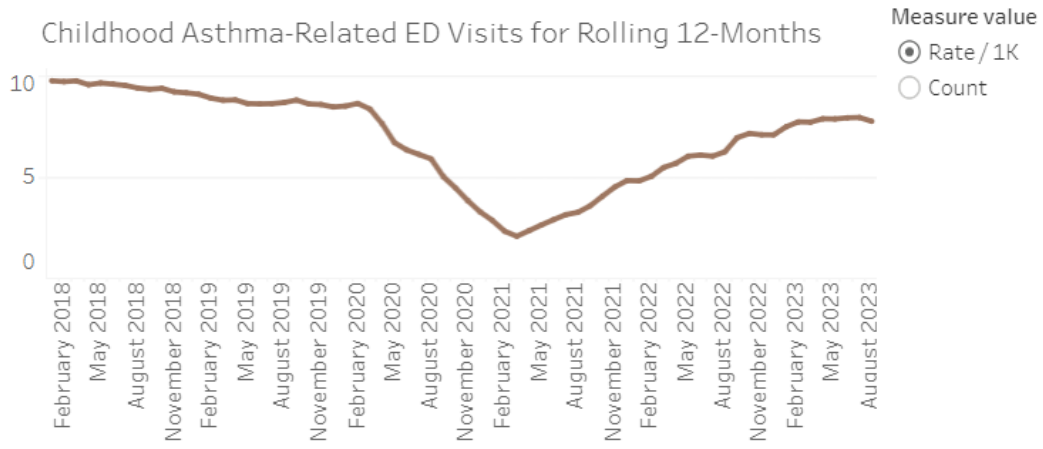


Table 12. Childhood Asthma-Related ED Visits Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Different - Most Recent 12 months to Target
Rates per 1K	9.2	7.8	7.2	0.6
Total Count	10,974	9,258		

As with the SMM rate, the impacts of COVID-19 have had a deleterious impact on health disparities, most notably with the non-Hispanic Black population. Continued investment in initiatives and programs to address childhood asthma is critical to eliminating these disparities and putting Maryland back on a path to reach the improvement goals set under SIHIS.

Figure 13. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

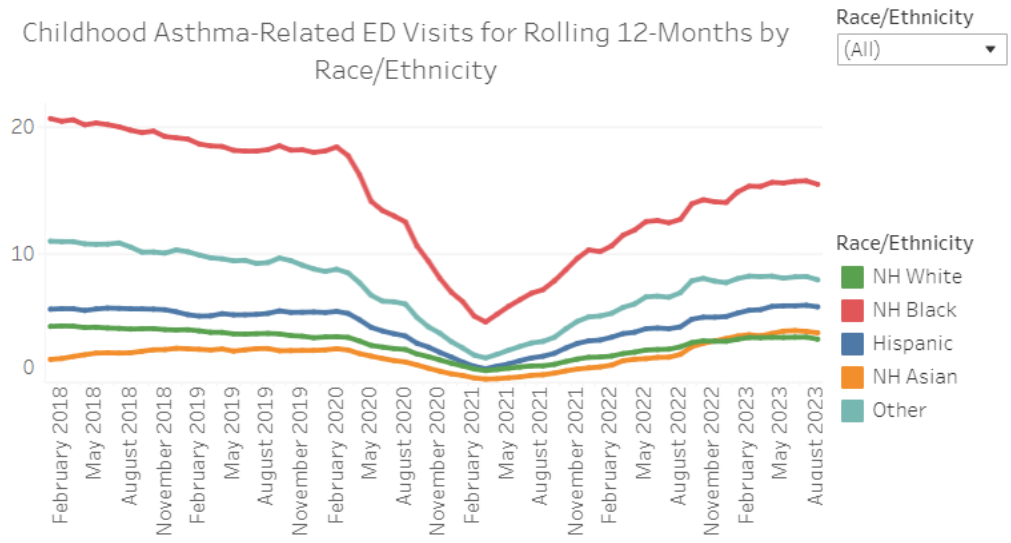


Table 14. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

Race	2018	2023 Year 5 Target	2026 Year 8 Target	Absolute Change	Relative Percentage Change
Total	9.2	7.2	5.3	3.9	42%
NH White	4.1	3.5	3.0	1.1	26%
NH Black	19.1	14.36	9.6	9.6	50%
Hispanic	5.4	4.7	4.0	1.4	25%

NH Asian	2.7	2.6	2.5	0.2	9%
Other	10.6	7.30	5.5	5.1	48%

Performance by Payer

The State is also monitoring performance by payer. As stated earlier in the report, the State believes these declines in the asthma-related ED visit rate in Maryland mirror both State and national reductions in overall ED visits due to COVID-19. Continued and expanded interventions to address childhood asthma are critical to preventing further growth in health disparities resulting from patients potentially not seeking care during the pandemic.

Figure 15. Childhood Asthma-Related ED Visit Rate per 1K, 2018-September 2022

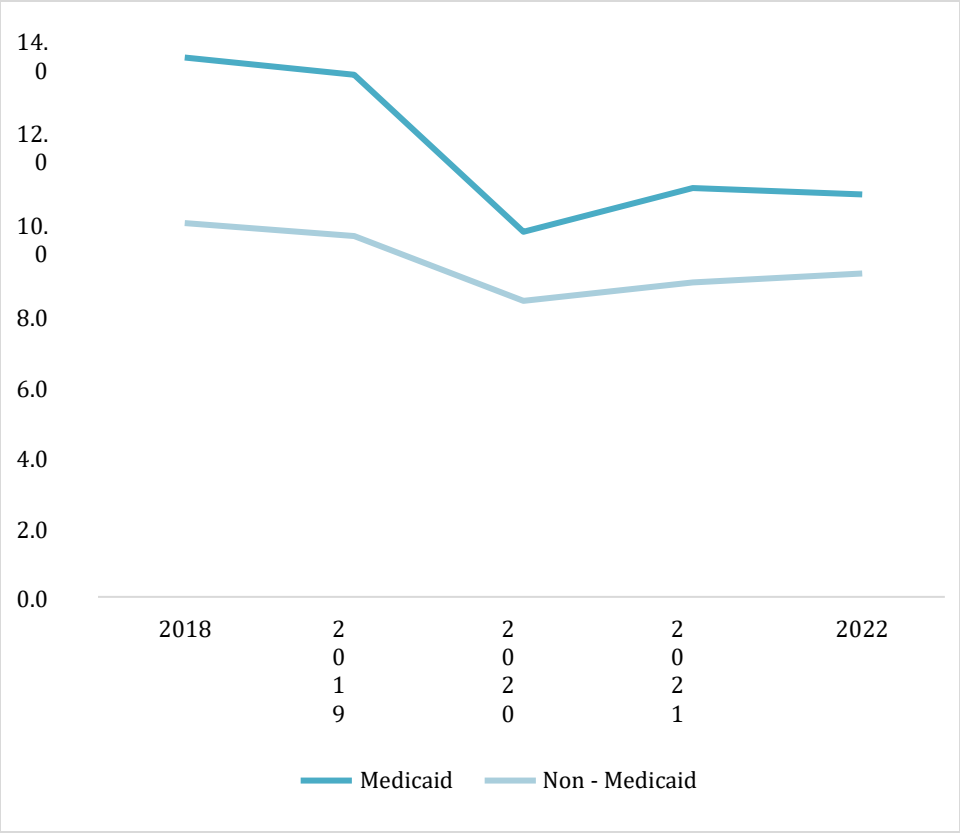


Table 16. Childhood Asthma-Related ED Visit Rate per 1K by Payer, 2018-September 2022

Payer	2018	2019	2020	2021	2022	% Change since 2018
Medicaid	13.3	12.5	5.0	7.1	6.8	-49%
Non - Medicaid	5.4	4.8	1.7	2.6	3.0	-44%

Year Two Spending

The Medicaid program devoted its efforts in FY 2023 to continuing to establish new enhanced benefits in addition to expanding those previously launched with the support of the Fund. As detailed above, implementation efforts spanned benefit design, systems changes for both payment and provider enrollment and development and approval of regulations (state authority) and Medicaid State Plan Amendments (federal authority), in addition to provider enrollment and education. The Medicaid program intends to continue to maximize the Fund's contribution by pulling down federal matching funds, which relies on service implementation.

The Medicaid program is building the full $16 million into its budget for CY 2024 and expects service delivery to increase as provider networks continue to grow and additional participants become aware of the new benefits. Medicaid is considering additional program enhancements that may increase service uptake and spending in FY2024 which may include:

- Standing up a doula training scholarship program, in coordination with MCHB;
- Outreaching providers and relevant stakeholders about the importance of the Maryland Prenatal Risk Assessment (MPRA) in an effort to increase completion of the form; and
- Supporting the conversion of MPRA - a major referral source for MCH programs - from paper to electronic.

PHPA dedicated FY 2023 to providing technical support to grantees beginning implementation of the asthma and maternal health initiatives.

Table 17. PHPA Grant Funds Expenditures - FY 2023

Initiative	FY 2023 Spending
Asthma Home Visiting Program[14]	$640,633.00
Community-Based Asthma Programs	$100,035.00
Maternal Home Visiting	$419,305.57
CenteringPregnancy	$157,114.81
Program Total	$897,782.81

Due to staffing challenges that the home visiting sites experienced and programmatic challenges most sites were unable to spend their full award. However, because the funds can be rolled over, MDH awarded the carryover funds to sites in following years. The rollover of funds have already been incorporated into the budget planning for the home visiting expansion and CenteringPregnancy FY 2024 grant funds.

Conclusion

In FY 2024, the MDH remains committed to strategically invest in the outlined projects, with a specific focus on extended services to underserved populations and those at elevated risk of SMM, as well as moderate to severe asthma. A pivotal aspect of this commitment involves an ongoing dedication to data-driven approaches and programmatic oversight to optimize care. Preliminary data shows positive outcomes for several key measures, in addition to identifying some measures in need of further observation; MDH will actively utilize data to fine-tune interventions and tailor strategies effectively, ensuring that resources reach those who need them most. Additionally, MDH will facilitate seamless coordination and collaboration among various stakeholders. This will involve fostering peer-to-peer learning calls to offer guidance and support to home visiting sites and community-based asthma programs. Moreover, the MDH will encourage collaboration opportunities between home visiting sites, LHDs, and community-based health organizations, focused on maternal and child health, ultimately leading to improved outcomes and better care.

[14] This is an estimate. Final spending will be available in early 2024.

Appendix A: Cesarean Deliveries

Percentage of Cesarean Deliveries among MCH Program Participants, January 2021 – August 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
MCH Programs	*	0%	0%	*	0%	0%

Appendix B: Severe Maternal Morbidity

Percentage of Pregnancies Associated with Severe Maternal Morbidity among MCH Participants, January 2021 – August 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
MCH Programs	*	0%	0%	*	0%	0%

Appendix C: Birth Complications

Percentage of Deliveries that had Birth Complications among MCH Participants, January 2021 – August 2023

	At Least One Qualifying Visit			Meets Eval. Inclusion Criteria		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
MCH Programs	*	4.2%	0%	*	0%	0%

Appendix D: Newborn Birth Weight

Percentage of Newborns who are Normal, Low, or Very Low Birth Weight for all Pregnant Participants Enrolled before Delivery, January 2021 – August 2023

	CY 2021			CY 2022			CY 2023		
	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight
MCH Programs	*	*	*	0%	16.7%	83.3%	1.8%	3.6%	94.5%

Percentage of Newborns who are Normal, Low, or Very Low Birth Weight for all Pregnant Participants Enrolled before Delivery and who Meet the Inclusion Criteria, January 2021 – August 2023

	CY 2021			CY 2022			CY 2023		
	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight	Very Low Birth Weight	Low Birth Weight	Normal Birth Weight
MCH Programs	*	*	*	0.0%	8.3%	91.7%	0.0%	2.8%	97.2%

Appendix E: Timeliness of Prenatal Care

Percentage of Deliveries where the Participant had a Prenatal Visit in the First Trimester, on or before the Enrollment Start Date or within 42 Days of Enrollment in the organization, CY 2021 – CY 2022

	At Least One Qualifying Visit		Meets Eval. Inclusion Criteria	
	CY 2021	CY 2022	CY 2021	CY 2022
MCH Programs	*	33.3%	*	16.7%

Appendix F: Postpartum Care

Percentage of deliveries where a participant had a Postpartum Care Visit on or between 7 and 84 days After Delivery

	At Least One Qualifying Visit		Meets Eval. Inclusion Criteria	
	CY 2021	CY 2022	CY 2021	CY 2022
MCH Programs	*	20.8%	*	0.0%

Appendix G: Procedure Codes

Program Start Dates and Procedure Codes to Identify Maternal and Child Health Programs

Program	Procedure Code	Program Start Date
HVS	99600	January 13, 2022
HealthySteps	H0025	January 1, 2023
Doula Services	W3700, W3701, W3702, T1032, T1033,	February 21, 2022
CenteringPregnancy	99078	January 1, 2023
MOM Program	*Medicaid ID supplied by MDH*	July 1, 2021

Appendix H: Program Utilization

Program Utilization among Maternal & Child Health Program Participants, CY 2021-CY 2023

Programs	CY 2021			CY 2022			CY 2023**		
	Unique Number of Participants	Total Number of Visit	Average Visits per Participant	Unique Number of Participants	Total Number of Visit	Average Visits per Participant	Unique Number of Participants	Total Number of Visit	Average Visits per Participant
HVS	-	-	-	119	764	6.4	130	1064	8.2
Doulas	-	-	-	14	46	3.3	14	37	2.6
CenteringPregnancy	-	-	-	-	-	-	43	167	3.9
HealthySteps	-	-	-	-	-	-	773	1298	1.7
MOM*	*	*	7.5	*	*	4.2	-	-	-

*For MOM, months enrolled

**Year to date, data may be incomplete due to data lag. MCOs have six months to bill and FFS claims have 12 months to bill.

Program Utilization among Maternal & Child Health Program Participants who met Evaluation Inclusion Criteria, CY 2021-CY 2023

Programs	CY 2021			CY 2022			CY 2023		
	Unique Number of Participants	Total Number of Visit	Average Visits per Participant	Unique Number of Participants	Total Number of Visit	Average Visits per Participant	Unique Number of Participants	Total Number of Visit	Average Visits per Participant
HVS	-	-	-	89	717	8.1	101	1025	10.1
Doulas	-	-	-	*	*	4.2	*	*	3.9
CenteringPregnancy	-	-	-	-	-	-	25	146	5.8
HealthySteps	-	-	-	-	-	-	132	465	3.5
MOM*	*	*	7.5	*	*	5.5	-	-	-

*For MOM, months enrolled

**Year to date, data may be incomplete due to data lag. MCOs have six months to bill and FFS claims have 12 months to bill.

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Regional Partnership Catalyst Program

Calendar Year 2023 Activities – Final Report

July 2024

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

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Introduction

The Health Services Cost Review Commission (HSCRC) created the Regional Partnership Catalyst Program (Catalyst Program) to advance the population health and health equity goals of the Total Cost of Care (TCOC) Model and to encourage and support public-private partnerships that can create sustainable initiatives to improve the health of Marylanders. The Catalyst Program funds hospital-led teams to advance two population health priority areas that are part of the Statewide Integrated Health Improvement Strategy (SIHIS): (1) diabetes prevention and management and (2) behavioral health crisis services. Teams include neighboring hospitals and community organizations such as local health departments (LHDs), local behavioral health authorities (LBHAs), non-profit and social service organizations, and provider groups to develop and implement interventions. Goals of the Catalyst Program include:

- Partnerships and strategies that result in long-term improvement in the population health metrics of the TCOC Model;
- Increased number of prevention and management services for persons at risk for or living with diabetes;
- Reduced use of hospital emergency departments (EDs) for behavioral health and improved approaches for managing acute behavioral health needs;
- Integration and coordination of physical and behavioral health services to improve quality of care; and
- Engagement and integration of community resources into the transforming healthcare system.

The Catalyst Programs are also an important tool to advance goals of health equity for Marylanders. Provision of wraparound services to address social determinants of health (SDOH) is core to Regional Partnership programming. Regional Partnerships deploy community health workers (CHWs), patient navigators, care managers, and others to screen participants for SDOH needs and connect participants to resources. Regional Partnerships recognize that addressing SDOH and treating the whole patient is crucial to preventing diabetes or helping diabetic patients manage their disease. Additionally, Regional Partnerships are intentional in the selection of community-based partners to reflect the culture, language, and demographics of target populations to customize marketing materials and outreach strategies to engage patients. These activities are critical to address long-standing health disparities in the State and have been highlighted and promoted by the Regional Partnership programs.

For the period January 2021 through December 2025, the HSCRC originally awarded $165.4 million in cumulative funding through nine awards to eight Regional Partnerships. The five-year cycle was intended to allow time to build partnerships and infrastructure prior to implementing interventions. HSCRC made a difficult decision to discontinue diabetes funding in CY 2024, so final funding under the program to all eight Regional Partnerships will amount to $136.9 million. The Behavioral Health Crisis Services programs will

continue through the original program cycle which ends December 2025. This report summarizes the activities for all Regional Partnerships in CY 2023.

As described in the enclosed report, Regional Partnerships reported progress in expanding some areas of service delivery in CY 2023, implementing programs across a large set of partners and different healthcare delivery systems. Regional Partnerships cited an ongoing commitment to build effective, integrated teams and scale critical infrastructure. Importantly, Regional Partnerships will continue to promote community partnerships, improve provider awareness and build relationships with commercial insurers and Medicaid MCOs.

Challenges persisted in CY 2023 to recruit and maintain staff, navigate changing federal and state requirements, successfully implement billing and service reimbursement, manage construction delays, and respond to the intensifying behavioral health needs of Marylanders. Continued enrollment challenges within the diabetes prevention and management programs led to the decision to discontinue diabetes funding early.

Overview

The Catalyst Program builds on the HSCRC's Regional Partnership Transformation Grant Program, launched in 2015 to reduce potentially avoidable utilization and per capita costs and demonstrate a positive return on investment through increased Medicare savings. The Regional Partnership Transformation Grant Program funded fourteen hospital-led partnerships, involving 41 of Maryland's acute care hospitals. Interventions were diverse, spanning behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies focused on high-need and high-risk Medicare patients.

Subsequent to the Regional Partnership Transformation Grant Program's expiration in June 2020, the HSCRC established the Catalyst Program to enable hospital-led partnerships to continue to build infrastructure in support of the population health goals of the TCOC Model and Statewide Integrated Health Improvement Strategy (SIHIS) in a more focused manner. The Catalyst Program made awards under two funding streams: (1) diabetes prevention and management and (2) behavioral health crisis services. The Catalyst Program is based on the HSCRC philosophy of fostering collaboration among hospitals and community partners while creating infrastructure to disseminate sustainable evidence-based interventions.

Diabetes Prevention and Management Programs

The diabetes prevention and management funding stream supported Regional Partnerships implementing the Centers for Disease Prevention & Control (CDC) recommended Diabetes Prevention Program (DPP). DPP has shown long-term success in helping to prevent the onset of diabetes and promote weight-loss for those with pre-diabetes. This funding stream also supported implementation of Diabetes Self-Management

Training (DSMT) and Diabetes Self-Management Education and Support (DSMES). DSMT/ES provides lifestyle change help and diabetes management curriculum to patients to help better control their Type II diabetes. Regional Partnerships under the Catalyst Program were required to achieve American Diabetes Association (ADA) or American Association of Diabetes Education (AADE) accreditation for their respective DSMT and DSMES programs, or partner with an accredited program.

Funding was available for wraparound services to bolster the impact of DPP and DSMT/ES. For example, Medical Nutrition Therapy (MNT) could be provided as a wraparound service for patients participating in DSMT/ES. It is provided by registered dietitians as an intensive, focused, and comprehensive nutrition therapy service. MNT delivered concurrently with DSMT/ES has been shown to increase the ability of patients to manage their diabetes. Additional wraparound services to support patient success in DPP and DSMT/ES include healthy food access, exercise programs, and transportation services to in-person classes.

DPP and DSMT/ES offer a pathway to sustainability via Medicare, Medicaid and/or commercial payer reimbursement. However, Medicare billing requires suppliers to make substantial investments in certification, training, and administration. Catalyst Program funding was intended to help build this infrastructure by supporting start-up costs, including recruitment, training, and certification.

Regional Partnerships were expected to meet different milestones over the five years of the program, with the final goal of having sustainable programs that would continue after the HSCRC funding ended. HSCRC staff found that CY 2023 performance fell short of program expectations which caused concerns about long-term program viability, leading staff to make the difficult decision to end diabetes funding early. Regional Partnership diabetes funding ended June 30, 2024, although Regional Partnerships may work through the end of CY 2024 to wind down their programs or shift towards more sustainable models. All Regional Partnerships have reported that they will continue to offer some form of diabetes programming without HSCRC funds.

Behavioral Health Crisis Programs

The TCOC Model incentivizes reductions in unnecessary emergency department (ED) and hospital utilization. Across Maryland, hospitals cite opioid and fentanyl use disorders, combined with inadequate access to acute mental health services as contributors to ED overcrowding. Maryland continues to lack sufficient infrastructure needed to divert behavioral health crisis needs from EDs and inpatient settings to more appropriate community-based care. Community-based organizations often do not receive reimbursement for crisis management services and struggle to provide the capacity needed in Maryland.

The behavioral health crisis services funding stream supports development and implementation of infrastructure and interventions consistent with the “Crisis Now: Transforming Services is Within Our Reach”

action plan developed by the National Action Alliance for Suicide Prevention. Regional Partnerships are implementing one or more of the following:

- **Air Traffic Control (ATC) Capabilities with Crisis Line Expertise.**[1] The ATC model is based on always knowing the location of an individual in crisis and verifying hand-offs to the next provider. The model creates a hub for deployment of mobile crisis services and access to other services such as crisis stabilization. The model's essential components include qualified crisis call centers and 24/7 clinical coverage with a single point of contact for a defined region.
- **Community-Based Mobile Crisis Teams**.[2] Mobile crisis services deploy real-time professional and peer intervention to the location of a person in crisis. They are intended to avoid unnecessary ED use and hospitalization.
- **Stabilization Centers**. Crisis stabilization services provide observation and supervision at a sub-acute level to prevent or ameliorate behavioral health crises and/or address acute symptoms of mental illness. Settings are small and home-like relative to institutional care.

Summary of Awards

The HSCRC awarded a cumulative $136.9 million through nine awards to eight Regional Partnerships. Five of the nine awards fall under the diabetes prevention and management funding stream. These awards total $57.8 million and involve 24 hospitals with funding through June 2024. They span Western, Central, and Southern Maryland as well as the Capital Region. Three of the nine awards fall under the behavioral health crisis services funding stream. These three awards total $79.1 million and involve 24 hospitals with funding through December 2025. They span Central Maryland, portions of the Capital Region, and the Lower Eastern Shore. A summary of awards is shown in Table 1 and 2 below.

Table 1. Summary of Diabetes Regional Partnership Catalyst Program Awards, CY 2021 – CY 2024

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	● Baltimore City	$32,730,418	● JH Bayview Medical Center ● Howard County General Hospital ● Johns Hopkins Hospital ● Suburban Hospital ● UMMC ● UMMS Midtown
	Western Regional Partnership	● Allegany ● Frederick ● Washington	$10,996,156	● Frederick Health ● Meritus Medical Center ● UPMC Western Maryland

[1] ATC is also referred to as "Care Traffic Control" by one Regional Partnership.
[2] Mobile Crisis Teams (MCT) are also referred to as Mobile Response Teams (MRT).

	Nexus Montgomery[3]	• Montgomery	$4,121,123	• Holy Cross Germantown • Holy Cross Hospital • Shady Grove Medical Center • White Oak Medical Center
	Totally Linking Care (TLC)	• Charles • Prince George's • St. Mary's	$4,463,519	• Adventist -Fort Washington Medical Center • Luminis Doctors Community Hospital • MedStar St. Mary's • MedStar Southern Maryland • UM Capital Region Health • UM Laurel Regional Medical Center
	Saint Agnes and Lifebridge	• Baltimore City • Baltimore County	$4,081,555	• Ascension St. Agnes • Sinai Hospital • Grace Medical Center
	Full Circle Wellness[4]	• Charles	$1,425,078	• UM Charles Regional Medical Center
		Total Awards	**$57,817,849**	

Table 2. Summary of Behavioral Health Regional Partnership Catalyst Program Awards, CY 2021 – CY 2025

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System (GBRICS)**	• Baltimore City • Baltimore County • Carroll • Howard	$44,862,000	• Bayview Medical Center • Carroll Hospital • Grace Medical Center • Greater Baltimore Medical Center • Howard County General • Johns Hopkins Hospital • Ascension St. Agnes • Sinai • MedStar Franklin Square • MedStar Good Samaritan • MedStar Harbor • MedStar Union Memorial • Mercy • Northwest • University Maryland Medical Center • UM Midtown • UM St. Joseph Medical Center
	Totally Linking Care (TLC)	• Prince George's	$22,889,722	• Adventist Fort Washington Medical Center • MedStar Southern Maryland • UM Laurel Medical Center • UM Capital Region Health

[3] Revised award amounts are shown in Table 1. Nexus Montgomery participation ended in 2022 and all Diabetes Prevention and Management Regional Partnerships end June 30, 2024 with an additional 6- month winddown period to rollover unspent funds

[4] FCW is funded for DSMT activities only.

	Tri-County Behavioral Health Engagement (TRIBE)	● Lower Eastern Shore	$11,316,332	● Atlantic General Hospital ● TidalHealth - Peninsula Regional Medical Center
		Total Awards	**$79,068,054**	

Year Three Diabetes Prevention and Management Activities

Early Award Termination

The Regional Partnership Catalyst Program was created to fund the development of sustainable programs that support the State's population health goal to address diabetes burden. A key requirement for Regional Partnerships was to generate revenue through billing Medicare and Medicaid to create a sustainable funding source beyond HSCRC funding. Based on low claims volumes for DPP and DSMT in CY 2023, HSCRC was concerned about the long-term viability of the program. While there was growth in billable claims for Medicaid and Medicare, those volumes fell significantly below performance expectations established at the beginning of the Catalyst Program. Based on CY 2023 performance and the amount of funding issued, HSCRC staff determined that these programs were not on a path to sustainability and that the level of funding issued through the program was not commensurate with the number of patients served. Diabetes funding to Regional Partnerships ended June 30, 2024, although Regional Partnerships have through the end of CY 2024 to either wind down their programs or restructure to sustainable models to continue diabetes prevention and management activities in CY 2025 and beyond. All Regional Partnerships reported in early CY 2024 that they would continue some form of diabetes programming after HSCRC funding ended. Regional Partnerships will still be able to leverage the infrastructure and partnerships developed since 2021 when the program began.

DPP Referral, Enrollment, and Retention Strategies

During CY 2023, Regional Partnerships took a range of actions to promote DPP referral, enrollment, and retention. Strategies to support expansion of DPP capacity for underserved populations continued, with a focus on bi-lingual direct-to-consumer websites, access to translation services, building a more diverse staff workforce, access to multiple learning platforms and modalities (including both group and one-on-one offered in-person and virtually), extending hours to accommodate diverse schedules, and targeted programs to assess and address financial barriers. Continued hiring of coaches, CHWs, and administrative support staff was a strategy reported by multiple Regional Partnerships. While post-COVID returns to in-person activities were offered and were well received among some groups, distance learning and support options continued to be popular and addressed transportation and access barriers among other groups.

Regional Partnerships relied on offering both in-person and virtual options to encourage enrollment by meeting the varied needs of their diverse populations.

Health care provider multipronged referral efforts also continued and were reported as a key strategy to improve challenging enrollment trends. Regional Partnerships continued to enhance electronic health records (EHRs) to facilitate DPP referral and enrollment from within the hospital, for example with DPP referrals in after visit summaries and automated patient messages and provider prompts. In addition, Regional Partnerships worked with community providers, and community-based organizations to identify participants and address barriers to care. This included implementing technology solutions to reach community partners outside of the health system EHR. Outreach at community events and direct to consumer public marketing campaigns—including flyers, direct mail, media advertisements, and QR codes— were also effective referral sources. Despite these efforts, Regional Partnerships reported that some health care providers remained reluctant to make referrals. Financial constraints were identified as one barrier to enrollment. Regional Partnerships reported that co-insurance, deductibles, and requirements for pre-authorization contributed to enrollment challenges. Some Medicaid MCOs decline coverage DSMES/DSMT services and/or require a 'tedious' prior authorization process. One Regional Partnership introduced a 'no-cost' education option for referred patients as a way to mitigate some financial barriers to enrollment. Another Regional Partnership reported billing workflow improvements that led to better use of grant funds that reduced/eliminated patient out of pocket costs. To improve enrollment retention, Regional Partnerships regularly assessed social needs and other potential barriers to participation. During enrollment processes, Regional Partnerships continued to use supportive contact from coaches to engage participants in different formats depending on the preferences of the participant (employing individual, group, in-person, and virtual methods). Virtual methods of engagement were used by Regional Partnerships as a retention strategy. Partnerships report that the increase in convenience and ability to reach a wider range of current and potential enrollees resulted in higher retention rates relative to in-person counterparts. Regional Partnerships also continued to deploy multiple touchpoints and different approaches to support patients with different needs and preferences, for example shifting from phone calls to text messaging and purchasing smartphones for coaches to facilitate text communication. Individuals continue to be reluctant to answer phone calls from unrecognized numbers.

Regional Partnerships also leveraged community partnerships to offer wrap around supportive services that are provided based on patient eligibility and need. These wrap around services included: transportation (Lyft rides), food access and healthy meal enrollment support (including Moveable Feast, Meals on Wheels, Hungry Harvest, organized grocery store tours, grocery store gift cards), cooking classes and other healthy lifestyle support (YMCA Family Memberships, supportive meetings), and medication management and financial assistance support. Regional Partnerships also reported collaborations with faith communities as a mechanism to publicize program resources. Despite these efforts, below-target enrollment and retention

was reported as a continued challenge by Regional Partnerships. Partnerships did note, however, that enrollment and retention have improved and/or compare favorably to national trends.

Regional Partnerships supported 224 total cohorts in 2023 that were either run by the hospital or partner community organizations. 122 cohorts began in 2023, while 102 cohorts that began in 2022 concluded. Cohort sizes can vary in size based on delivery format (i.e., in-person or virtual), location, and available staffing. In general, smaller cohort sizes allow for more personalized contact between lifestyle coaches and participants which supports program retention and maximizes patient success in the program.

DSMT/ES Expansion Strategies

Regional Partnerships continued to focus on referral and enrollment efforts. Referral strategies included creating, maintaining and strengthening relationships with referring providers. Regional Partnerships continued to stress the presence of DSMT/ES educators in primary care and endocrinology practices to facilitate cross-referral and engage participants in familiar settings. Another strategy embedded DSMT staff in health care system population health teams to capture referral and enrollment opportunities found within the integration between inpatient and ambulatory services. Regional Partnerships noted that leveraging EHRs and existing care management workflows was an important method of targeting potential participants. In addition to encouraging provider referrals and EHR identification, Regional Partnerships continued to promote DSMT/ES through community-based marketing and recruitment.

Despite these various strategies, actual enrollment and engagement of participants in DSMT/ES continued to be challenging. All Regional Partnerships experienced enrollment rates well below targets. Financial barriers (such as cost sharing) were cited as a persistent barrier to participation. For Medicare FFS beneficiaries, there is a cost share requirement which can become cost-prohibitive for patients, particularly if DSMT is performed in a regulated setting.[5] [6] Medicaid MCOs may also decline coverage and/or require a burdensome pre-authorization process. Patient financial responsibility depends on the location of where DSMT/ES is provided and any supplemental benefits the beneficiary may have in addition to Medicare coverage. One Regional Partnership noted that eligible patients, despite appropriate referrals, simply choose not to enroll.

Regional Partnerships continued to expand the number and nature of DSMT/ES classes, with more sites and larger spaces, in-person and virtual, one-on-one and group, and hybrid offerings. The expansion of classes utilized a range of modalities, with a common goal for participants to receive education earlier in

[5] The deductible and coinsurance of 20 percent of the Medicare-allowed amount applies to DSMT.

[6] Centers for Medicare and Medicaid Services. *Medicare Learning Network Fact Sheet - Medicare Diabetes Self-Management Training.* May 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DSMT-Fact-Sheet-909381.pdf

their diagnoses. Some Regional Partnerships noted that they expanded class offerings in response to growing wait times for new participants.

Physician & Provider Engagement (DPP & DSMT/ES)

Regional Partnerships continued to conduct a range of physician and provider engagement activities for both DPP and DSMT/ES. Outreach methods differed for hospital-affiliated versus community-based providers. For hospital-affiliated providers, engagement activities centered on EHR tools, regular outreach meetings, and messages from leadership. Regional Partnerships also engaged community-based providers with educational visits to offices, information about the CRISP referral tool, EHR optimization offerings, and the availability of a range of referral process methods. In addition, Regional Partnerships offered educational road shows and CME modules for both categories of providers.

Impact Measures

DPP Referrals

HSCRC set a goal for Regional Partnerships to refer ten percent of their prediabetic patient population to DPP in 2023. Referrals are measured in targeted ZIP codes that were self-selected by Regional Partnerships in their 2020 proposals. There is a significant number of referrals being generated outside of targeted ZIP codes that HSCRC does not give credit for in reporting since measurement is ZIP code-based. Statewide numbers therefore show a lower-bound of referrals and actual performance exceeds the reported amounts.

In 2023, Regional Partnerships referred a total of 11,459 patients to DPP in designated ZIP codes. Referrals to DPP are inclusive of all-payers (Medicare, Medicaid, commercial, self-pay, uninsured) and were self-reported by Regional Partnerships monthly. Despite large referral numbers, however, a much smaller percentage enroll in DPP. Enrollment is a preferable measure of financial sustainability and program participation since it captures not only actual patients served, but services that generated revenue through billing.

HSCRC began using DPP enrollment data using Medicare and Medicaid claims as an official performance metric in 2023. Regional Partnerships were expected to begin billing for DPP in 2023 which would be reflected in claims data. HSCRC set a goal for Regional Partnerships to enroll 2,244 Medicare and Medicaid beneficiaries into DPP statewide. Only 312 patients, 13.91 percent of the statewide goal, were identified through DPP claims data. Some Regional Partnerships were slow to stand up DPP billing operations which would therefore not capture any Medicare or Medicaid patients served in claims data.

Low participation in Medicare DPP has been a challenge nationally as well, so this experience is not unique to Maryland.[7]

Table 3. Regional Partnership All-Payer Referrals & DPP Enrollment, CY2023

Metric	Target	Actual Statewide Performance	% of CY 23 Target Achieved
All-Payer Referral	3,943	11,459	102%
DPP Enrollment (Medicare & Medicaid)	2,244	312	13.91%

Source: CRISP Regional Partnership Monitoring Dashboard, Hospital Self-Reported Data (through March 2024)

Regional Partnerships also reported serving non-Medicare and non-Medicaid patients, but not billing for those services provided. On an all-payer basis, statewide cumulative enrollment in DPP has steadily increased since the Catalyst Program began in 2021 and is currently outpacing the nation (Table 4). This data is based on CDC programmatic data that is provided to the State on a quarterly basis and is inclusive of all DPP in the State, not solely RP-attributed DPP. Based on data through January 2024, Maryland has experienced a 261 percent increase in DPP enrollments per 100k since 2018. This rate of change is faster than the nation overall, which experienced a 109.5 percent increase over the same period.

Table 4. Cumulative DPRP Enrollment Rate per 100K Compared to National Average, 2018 - January 2024

	2018 Baseline	Most Recent Rolling 12 Months	Percent Change	National Comparison Change
Rates per 100K (MD)	269.9	974.2	261%	109.5%

Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

Despite this growth, DPRP enrollment as shown here does not reflect whether payers were billed for DPP services, which was a key implementation requirement for Regional Partnerships and informed the decision to terminate diabetes funding early, as discussed earlier in this report. Based on the low Medicare and Medicaid enrollment numbers shown in Table 3 and weighed against the $14.7 million issued in CY 2023, HSCRC staff determined that these programs were not on a path to sustainability and that the level of funding issued through the program was not commensurate with the number of patients served.

DSMT/ES Participation

The HSCRC monitored Medicare DSMT claims in CY 2023 and found that utilization remained below initial expectations when the program launched. Many Regional Partnerships had not fully established billing

[7] Centers for Medicare and Medicaid Services. MDPP Expanded Model Evaluation Report 2: Findings at a Glance. November 2022. https://www.cms.gov/priorities/innovation/data-and-reports/2022/mdpp-2ndannevalrpt-fg Accessed June 28, 2024.

operations for expanded DSMT programs in 2022 and were continuing to rebuild programs after DSMT volumes declined during the pandemic. Additionally, a great deal of DSMT/ES is reimbursed by commercial payers, but HSCRC does not currently measure commercial DSMT/ES claims and Medicaid does not provide coverage for DSMT/ES.[8] Regional Partnerships were expected to aggressively grow their DSMT claims in CY 2023 as billing processes were put into place and the volume of billable services continued to rebound from 2020 lows due to the pandemic. Additionally, the Medicare cost-sharing requirement for patients continued to be a barrier to participation. HSCRC set performance goals for initiating and retaining patients in DSMT. DSMT initiation reflects the count of Medicare[9] beneficiaries with at least one claim for DSMT services. DSMT retention is the count of Medicare beneficiaries with at least 10 units (approximately 30-minute sessions) billed for DSMT services. Multiple units can be included in a single DSMT claim.

Table 5. Regional Partnership Initiation and Retention of DSMT, CY2023

Metric	Cumulative Target	2023 Performance	% of Target
Initiation of DSMT	6,034	2,287	15.03%
Retention in DSMT	3,620	615	6.74%

Source: Medicare CCLF Data

The State also receives annual reports from the CDC on DSMES patient volumes based on data reported by the ADA and Association of Diabetes Care and Education Specialists (ADCES), as shown in Table 6. This data is inclusive of billed and non-billed DSMES. In 2022, Maryland saw a 44 percent decrease in DSMES participants from 2021, compared to a 7 percent decrease nationally. 2023 data is not yet available.

Table 6. DSMES Participation Growth, Maryland vs. Nation, 2019-2022

State	2019 Encounters	2020 Encounters	2021 Encounters	2022 Encounters	Percent Growth (since 2021)
Maryland	11,403	11,705	19,270	10,999	-44%
Nation	975,417	928,895	1,042,253	981,545	-7%

Source: American Diabetes Association (ADA) and Association of Diabetes Care and Education Specialists (ADCES)

As with DPP, DSMT performance fell short of program expectations as well. When considering the ongoing value of the diabetes funding stream, HSCRC considered the total patient volumes for both DPP and DSMT reported against the considerable size of the CY 2023 funding ($14.7 million).

[8] Some MCO reimburse for DSMT with prior authorization.
[9] Medicare Part A and B

Wraparound Services (DPP & DSMT/ES)

Provision of wraparound services to address social drivers of health (SDOH) has been important to Regional Partnership programming. Regional Partnerships deployed CHWs, patient navigators, care managers, and others to screen participants for SDOH needs and connected participants to appropriate resources as a way to encourage enrollment, program retention and improved clinical outcomes.

During CY 2023, Regional Partnerships offered the following wraparound services shown in Table 7 to DPP and DSMT participants. Services supported by vendors and collaborators allowed for participants' needs to be met and helped remove barriers related to social determinants of health.

Table 7. CY 2023 Wraparound Services (DPP & DSMT)

Wraparound Service	Count of Regional Partnerships
Food Access	5
Transportation	5
Exercise	4
Medical Nutritional Therapy	2
Remote Patient Monitoring	3
Mobile Integrated Health	1
Medication Management	2
Financial Assistance	2

Source: Regional Partnership Annual Reporting, CY 2023

Regional Partnerships described multiple efforts to address food access, identified through social determinants screening initiatives. Regional Partnerships routinely enrollees (and often potential enrollees) questions regarding their access to food types, where and how they obtain their food, and what they understand about the connection between their diabetes and nutrition.

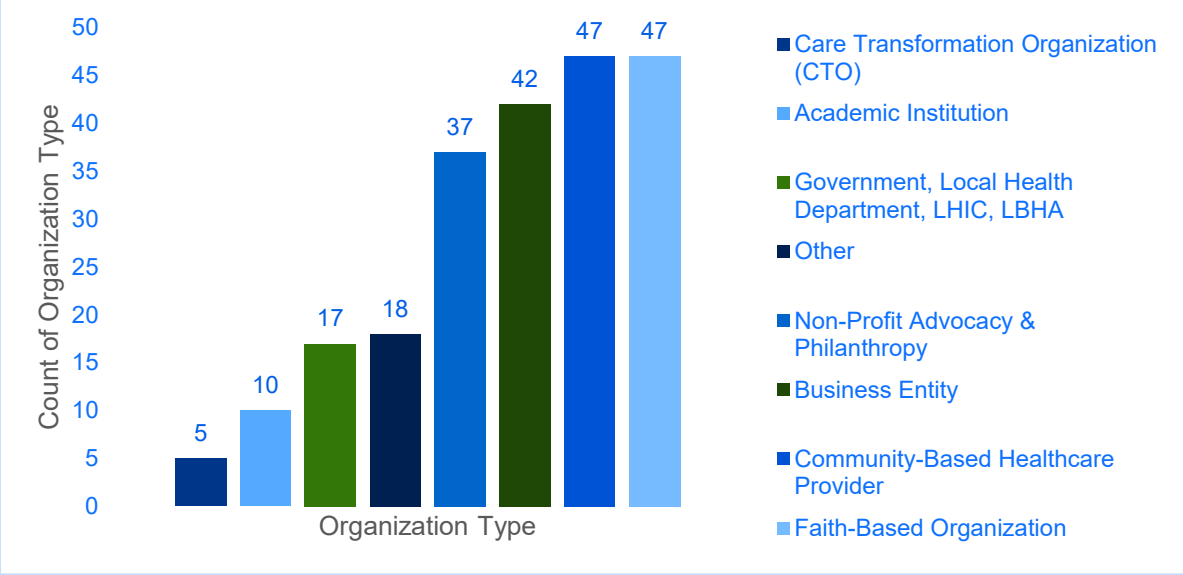
Solutions to provide healthy food included food delivery to participants' homes, virtual supermarket tours and descriptions, and partnering with supermarkets and others on healthy food access programs. Regional Partnerships are also partnering with community- and faith-based organizations to provide cooking classes and demonstrations.

Regional Partnerships addressed transportation through the provision of Lyft rides and connecting participants to existing non-emergency transportation providers. To promote exercise, Regional Partnerships offered participants gym memberships through the YMCA or County parks and recreation facilities, fitness instruction (including virtual), and/or by providing Fitbit activity trackers.

Diabetes Community Partner Collaboration (DPP & DSMT/ES)

The development of partnerships for long-term improvements in population health, and engagement and integration of community resources in the healthcare system are core goals of the Catalyst Program. During CY 2023, Regional Partnerships convened and attended community events with partners to reach potential participants outside of the healthcare setting who may be missed in other marketing efforts. The community events also enabled Regional Partnerships to build relationships with faith, cultural and other community groups that could extend message outreach by a variety of trusted community organizations. In CY 2023, Regional Partnerships also worked with community partners to provide ongoing education about diabetes prevention and management, and to establish in-person classes. Examples included programming and informational outreach conducted through faith-based organizations, apartment complexes, and senior settings. Regional Partnerships also worked closely with community partners to meet participants' SDOH needs; the most common was access to healthy food options. Figure 1 shows the breadth of Regional Partnerships' community partners for diabetes prevention and management. There are a total of 223 community partner organizations across Regional Partnerships. The two most common types of organizations are community-based healthcare providers and faith-based organizations.

Figure 1. CY 2023 Diabetes Program Community Partners



Source: Regional Partnership Annual Reporting, CY 2023

Year Three Behavioral Health Crisis Services Activities

Open Access and Crisis Center Activities and Progress

Regional Partnerships continued to make progress on crisis center activities in Year Three. Activities were focused on continuing to build community partnerships and expand site infrastructure to support an increased volume of patients through multiple care paths.

For the Maryland eastern shore, crisis protocols have been developed for both of TRIBE's sites (Tidal Health and Atlantic General Hospital/Chesapeake Health Care) which will support future growth. Both sites accepted referrals from walk-in patients in Year 3. TRIBE's TidalHealth center was open 7 days a week from 7am to 7pm. The TRIBE Regional Partnership reported a combined volume of 2,560 visits for CY 2023. TidalHealth created an EPIC dashboard to track relevant quality measures and completed SDOH screening for all patients during initial visits (and as needed during subsequent encounters). AGH transitioned its Behavioral Health service line to Chesapeake Healthcare (CHC), a Federally Qualified Health Center (FQHC), as of June 2023. This change will increase access to care by leveraging CHC's higher volume of licensed practitioners. AGH/CHC integrated its SDOH screening process into their EHR in year 3.

The Greater Baltimore Regional Integrated Crisis System (GBRICS) has continued to expand access to immediate-need behavioral health services. GBRICS also reported progress on the Open Access Project (formerly known as Same Day Access). Open Access has launched 50 percent of the clinical sites, with 17 of the planned 24 operational at the end of 2023. Open Access has been launched using phased cohorts, funding for Cohorts 1 and 2 ended as of 2023, though all but one site are still offering services after the end of these contracts. Cohort 3 (with 17 sites) will begin to receive funding in 2024, and plan to offer open access services by July 2024. Open Access clinics are located in Baltimore City, Baltimore County, Howard County and Carroll County.

Totally Linking Care has made steady progress towards opening a new crisis stabilization center, the Dyer Care Center, in Prince George's County. The Dyer Care Center will be the first-ever facility in Prince George's County to provide short-term personalized emergency crisis services to adults experiencing a mental health and/or substance use crisis. The Dyer Crisis Center will operate 24/7/365 and will accept not only walk-in patients but can accept patients directed by EMS and law enforcement. This approach ensures immediate, appropriate care to reduce the burden of public safety resources and the emergency department. Totally Linking care has led on-going workgroup meetings, and individual meetings with iMind and RI International to strengthen communications between 911, 988, mobile response teams, law enforcement, EMS, and the crisis stabilization center teams. The Dyer Center will open in August 2024.

Care Traffic Control Activities and Progress

During 2022, a partnership of three organizations – Baltimore Crisis Response, the Affiliated Sante Group and Grassroots – was selected to jointly operate a Regional 988 Helpline. The 988 operates as a cloud-based call center and utilizes the Behavioral Health Link (BHL) Care Traffic Control software. Implementation of the 988 Helpline occurred in April 2023, providing access to 100 counselors and 5 dispatchers. GBRICS reports a 988 Helpline call volume of 28,364 between May and December 2023. The 988 system is utilized by other Regional Partnerships as a basis for referrals.

The 988 Regional Call Center for Central Maryland went live in April 2023, establishing a regional Care Traffic Control system by implementing a single hotline for substance use and mental health crisis calls. Call volume was immediately high, averaging more than 100 calls per day. Moving forward, BHL will be used to track the source of call volume to 988 from other crisis lines. The 988 Helpline not only takes calls directly, but also serves as a referral from other existing systems (for example, the 211-1, the former crisis line operated by the State of Maryland and calls diverted from the 911 emergency system). This will help GBRICS understand the impact of its 988 marketing efforts. During 2023, GBRICS conducted final training of staff and continued to make system and report customization changes for Care Traffic Control. Other Regional Partnerships reported working to improve coordination, workflow processes and transfer of calls from the 911 and other systems to the newer 988 system. All Regional Partnerships reported receiving referrals from 988.

Continued progress was made on enhancing the Prince George's County Response System via technology. During CY 2022, TLC implemented system integration between the 988 Call Center with the mobile response team dispatch module. Calls from prior systems are still accepted and are routed to the new 988 call center. TLC reported a volume of 2,273 cases for Year 3. TLC-MD, Prince George's County Health Department, and the LBHA finalized standard operating procedures and workflows to make sure that the 988 system and the eight standalone Mobile Response Teams achieve seamless transfers of residents in crisis.

The TRIBE Regional Partnership reported working with the EMS services to identify and divert appropriate cases from emergency rooms to Crisis Centers.

Mobile Crisis Team Activities and Progress

Use of Mobile Crisis Team (MRT) response team continued to develop in CY 2023 as a strategy to divert patients from the ED who do not require a high-level intervention.
Based on continued needs assessments, Prince George's County increased its number of MRTs by two, for a new total of eight. Two person teams include a peer or technician paired with a mental health care professional. Overtime was necessary to staff the MRTs, as workforce shortages continued to be an ongoing challenge. TLC-MD funds four of these eight MRTs, in addition to supporting the development of

videos, marketing materials such as MRT informational cards, and first responder business card identifying the differences between the 988 and MRT services. TLC completed the full integration of the Behavioral Health Link (BHL) mobile response team into IMind (the MRT vendor) as of December 2023. TLC worked with IMind to create customized data collection. The mobile response teams' dispatchers continue to receive calls from community residents via outdated phone numbers, which will require ongoing efforts to improve referral modules. Utilizing the full integration of the BHL Mobile Response unit with the Prince George's County Behavioral Health Dashboard, TLC reported a total volume of 2,273 cases in CY 2023. These cases were referred from a wide range of sources including the 988 system, direct calls from social services, direct calls from the police/fire/EMS, schools, providers and participants. The majority of referrals came from either direct calls from Prince George's County residents or from unidentified referrals.

On the eastern shore of Maryland, TidalHealth reported a collaboration with the SWIFT (Salisbury-Wicomico Integrated First Care Team) to leverage their nurse-led mobile health team. This team utilizes a paramedic, nurse-practitioner, RN and CHW that respond to non-emergency 911 calls that can be addressed more effectively outside the emergency room.

In Central Maryland, several mobile crisis teams went live in May 2023, with more launching in summer 2023 as staff are hired. During CY 2022 GBRICS issued two awards to fund mobile crisis teams. This adds five teams: two shifts seven days per week plus a part-time shift for Baltimore City and Baltimore County coverage; and two shifts seven days per week plus a part-time shift for Howard and Carroll Counties plus additional coverage for Baltimore County. Challenges were reported in hiring staff for these programs. To support these expansions, a non-profit consultant (Dignity Best Practices or DBP) was hired to help resolve operational issues with MRT dispatch. DPT worked to develop common protocols for 988 Helpline to triage and dispatch MRTs. The protocols were reviewed and tested in 2023. Training of staff on final protocols is expected by the spring of 2024.

Behavioral Health Sustainability

Regional Partnerships continued to work toward the sustainability of Catalyst Program behavioral health initiatives. Beginning in CY 2021, Regional Partnerships coordinated with the broad-based effort to establish a statewide mechanism to fund 988 in Maryland. The "Fund Maryland 988 Campaign" brings together more than 70 partner organizations to establish a Maryland 988 Trust Fund. The campaign advocated for legislation during the 2022, 2023 and 2024 General Assembly sessions to lay the groundwork for sustainable funding. In May 2024, Governor Moore signed legislation that established a permanent funding source for the state's 988 helpline.

Regional Partnerships are taking action to ensure the programs they implement are aligned with sources of funding for long term sustainability. GBRICS has formed a Council to guide overall strategy, including plans for sustainability. The GBRICS Council, with 21 members, is internally structured to include key community

partners to guide and support sustainability planning. GBRICS also reports that, with all components of their project launched, their focus has turned to sustainability. In addition, final Medicaid regulations for coverage of mobile crisis services and Behavioral Health Crisis Stabilization Centers were posted in May 2024, providing a critical source of sustainable funding to support crisis services for Marylanders.

Behavioral Health Community Partner Engagement

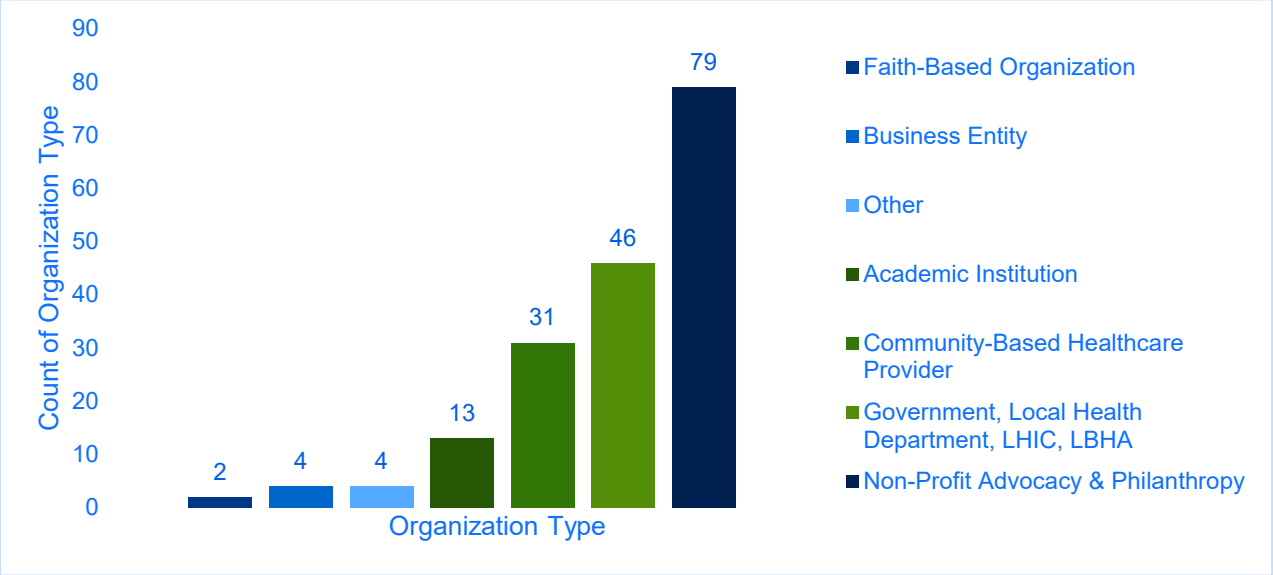
Regional Partnerships continue to recognize the value of conducting meaningful, multi-sector input, and are building on prior year progress. These relationships are vital to communicating the availability of new Catalyst Program services to the public. Regional Partnerships involve local government entities to ensure Catalyst Program efforts complement existing initiatives to develop behavioral health crisis service infrastructure. Key public entities included local government, public safety agencies, faith-based organizations, other health care providers and LBHAs.

Regional Partnerships have formal governance entities intentionally structured to engage a diverse group of stakeholders in guiding the overall strategy, implementation, and sustainability of initiatives. Collaborations helped for example to achieve continuity of care with warm handoffs for patients in crisis, collaboration on individualized patient treatment plans, support in develop of crisis stabilization center policies and procedures, and planning for longer term sustainability of services.

During CY 2023, Regional Partnerships reported the development and execution of MOUs with a range of community partners. MOUs function to ensure workflow, coordination of vendors and multiple partners, and clear accountability through detailed partnership agreements. One particular focus has been a focus on standardization of processes and procedures to ensure warm transfers and support callers in navigating to the most appropriate and timely level of care available under often new (and therefore unfamiliar) systems.

Figure 2 below shows the breadth of community partners for Regional Partnerships receiving behavioral health funding. There were 179 community partners. The most prevalent category was non-profit advocacy or philanthropy organizations, followed by local public entities, and community-based healthcare providers.

Figure 2. CY 2023 Behavioral Health Community Partners



Source: Regional Partnership Annual Reporting, CY 2023

Catalyst Program Budget and Expenditures Summary

Regional Partnership expenditures for CY 2023 are shown in Table 8. Total expenditures across all Regional Partnerships were approximately $31.7 million. The largest category was workforce, with approximately $18.3 million in expenditures. Approximately $9.3 million was spent on other implementation activities, operations, and indirect costs; approximately $1.9 million was spent on IT/technology, and approximately $2.3 million was spent on wraparound services.

Table 8. Regional Partnership CY 2023 Expenditures

	Regional Partnership	Expenditures by Category	Total Expenditures
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	• Workforce expenditures: **$6,250,720.65** • IT services: **$755,774.07** • Wraparound services: **$229,976.21** • Other implementation activities, operations, and indirect costs: **$2,309,867.06**	**$9,546,337.99**
	Western Regional Partnership	• Workforce expenditures: **$2,942,747.71** • IT services: **$128,965.32** • Wraparound services: **$179,273.71** • Other implementation activities and indirect costs: **$265,284.26**	**$3,516,271**
	Totally Linking Care	• Workforce expenditures: **$182,647.35** • IT services: **$191,150** • Wraparound services: **$0** • Other implementation activities and indirect costs: **$444,324.65**	**$818,122**
	Saint Agnes and Lifebridge	• Workforce expenditures: **$747,786.19** • IT services: **$0** • Wraparound services: **$209,248.90**	**$967,060.75**

		• Other implementation activities and indirect costs: **$10,025.66**	
	Full Circle Wellness	• Workforce expenditures: **$273,230.25** • IT services: **$0** • Wraparound services: **$45,091.12** • Other implementation activities and indirect costs: **$78,208.33**	**$396,529.70**
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System**	• Workforce expenditures: **$5,467,373.55** • IT services: **$300,700** • Wraparound services: **$1,243,184.10** • Other implementation activities and indirect costs: **$1,701,016.53**	**$8,712,274.18**
	Totally Linking Care	• Workforce expenditures: **$328,567.51** • IT services: **$334,625** • Wraparound services: **$343,620** • Other implementation activities and indirect costs: **$3,754,685.69**	**$4,761,498.20**
	Tri-County Behavioral Health Engagement (TRIBE)	• Workforce expenditures: **$2,082,742.02** • IT services: **$187,886.44** • Wraparound services: **$0** • Other implementation activities and indirect costs: **$736,144.53**	**$3,006,772.99**
		Total Expenditures	**$31,724,866.81**

Source: Regional Partnership Annual Reporting, CY 2023

HSCRC staff is conducting financial audits of all Regional Partnership spending to verify expenditures. As with all other special funding programs, any unspent funds are removed from hospital rates.

Catalyst Program Health Equity Efforts

Both the diabetes and behavioral health Regional Partnerships continue to intentionally keep health equity at the forefront of activities. Regional Partnerships are purposeful in the selection of community-based partners to reflect the culture, language, and demographics of target populations and gain insight on how to best customize materials and activities for different cultures. Regional Partnerships reported leveraging the community engagement activities and partners to provide feedback and offer recommendations for improvements that support health equity.

Screening for SDOH remains is a core element of the Regional Partnerships. Regional Partnerships report that both MRT and 988 vendors provide language lines to assist callers who require another language or hearing-impaired services. As a routine part of 988 contact, as well as in intake and throughout program activities, participants are assessed for a variety of SDOH and connected to available resources via teams including nurses, social workers, CHWs, and peer recovery specialists. The TLC Regional Partnership reported that they routinely provide marketing and educational materials in Spanish.

Regional Partnerships weave equity considerations into staffing and procurement considerations, for example to recruit diverse and bilingual staff. Regional Partnerships continue to provide interpreter services and services for individuals with hearing impairment. Staffing strategies included hiring more community

health workers reflective of communities served, pursuing grant funding to hired behavioral health peer support specialist, and developing mobile crisis leadership and service providers who are diverse with respect to gender, race, ethnicity, and sexual orientation given that culture matching can mitigate stigma mitigation and help build rapport in crisis situations.

Regional Partnerships also described their continued efforts to promote diversity through procurement, for example prioritizing organizations with strong connections to their local communities that incorporate feedback from the people they serve into their quality improvement efforts, value the roles of people with lived experience, and include small and grassroots efforts. Selecting locally owned minority businesses was another strategy reported.

Regional Partnerships conduct analyses and are beginning to collect some data to identify the specific areas and communities experiencing health disparities. Regional Partnerships have developed strategies to target historically excluded and marginalized communities for marketing and outreach. Regional Partnerships designed their tracking systems to stratify populations by a variety of parameters to facilitate understanding of how services are reaching different populations.

Conclusion

For the Diabetes Prevention and Management Programs, while Regional Partnerships' best efforts resulted in growing referrals, they did not translate into sufficient patient volumes that could help build financially self-sustaining programs. The low patient volumes shown through DPP and DSMT claims led to the difficult decision to discontinue diabetes program funding early. Regional Partnerships can continue to leverage the infrastructure and groundwork laid over the last three years to continue offering these programs to pre-diabetic and diabetic patients, even though HSCRC funding ended June 30, 2024.

During CY 2023 the Regional Partnerships receiving behavioral health funding made significant progress in developing infrastructure and refining strategies and workflow with the collective goal of expanding service delivery. As programs have moved from planning to implementation, Regional Partnerships have shifted the efforts from design toward identifying and addressing challenges identified as programs are launched. Recruiting and staffing persist as sites seek to implement new programs. Regional Partnerships are also investing more in development and refinements to workflows and partner communications to support efficient and effective operations of their initiatives. Looking ahead, the program will focus on Regional Partnerships' Behavioral Health Crisis Service programs, all of which are providing growing services to an expanding population.

maryland
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cost review commission

Nurse Support Program I

Annual Report on FY 2023 Activities

July 2024

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

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Introduction

Maryland's unique Nurse Support Program I (NSP I) was designed to address the short and long-term issues of recruiting and retaining nurses in acute care hospitals. More than $270 million in funds have been provided to hospitals in rates to support the NSP I initiatives since the program was implemented in June 2001. In May 2022, HSCRC Commissioners voted to approve NSP I as a permanent program requiring HSCRC to provide annual reports on funded activities and accomplishments. This report summarizes NSP I activities and performance against program metrics during Fiscal Year (FY) 2023.

Background

In 2010, the Institute of Medicine (IOM) published a groundbreaking report which laid out eight recommendations to address the increasing demand for high-quality and effective healthcare services and provided an action-oriented blueprint for the future of nursing. The HSCRC incorporated four of the recommendations into the scope of the NSP I program:

- IOM Recommendation 3: Implement nurse residency programs.
- IOM Recommendation 4: Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020.
- IOM Recommendation 6: Ensure that nurses engage in lifelong learning.
- IOM Recommendation 7: Prepare and enable nurses to lead change to advance health.

Incorporating the four recommendations from the IOM, the NSP I program focuses on three main areas to provide support and training for Maryland nurses:

1. **Education and Career Advancement.** This area includes initiatives that increase the number of advanced degree nurses, prepare them as future leaders, recruit and retain newly licensed nurses through nursing residency programs, and support nursing students and experienced RNs re-entering the workforce after an extended leave.
2. **Patient Quality and Satisfaction**. This area includes lifelong learning initiatives such as certification and continuing education, which are linked to improved nursing competency and patient outcomes.
3. **Advancing the Practice of Nursing.** These activities in this area advance nursing practice, for example, through nurse-driven evidence-based research, innovative organizational structures for clinical nurses to have a voice in determining nursing practice, standards, and quality of care, and the American Nurses Credentialing Center's (ANCC) Magnet® and Pathway to Excellence programs, which demonstrate nursing excellence.

With input from the NSP I Advisory Committee, staff developed nursing and organizational metrics to assess hospitals' progress in achieving these program aims. Performance against those metrics is provided later in this report.

FY 2023 Programs & Activities

NSP I funds a core set of programs within all acute care hospitals that support the IOM recommendations outlined above. Hospitals select program priorities and implement one to several programs below to grow and advance their nursing workforce. Funded programs include:

1. **Continuing Education (Internal & External):** Funding supports education on various subjects, including evidence-based practices, patient safety, disaster preparedness, quality indicators, patient experience, and workplace violence. These education opportunities may be offered internally within the hospital or externally through conferences hosted by leading organizations in the nursing field. Continuing education hours are increasingly provided online and are self-paced for participants.
2. **Leadership, Preceptorship, Mentorship Programs**: Funding supports regular training (e.g., workshops and quarterly education sessions) for nurses to develop essential leadership skills for building positive workplaces. These programs also coach nurses to become preceptors and mentors, which is critical to new nurses and the nurse residency program. Additionally, funding may support preceptor and mentor positions. Funded mentor and preceptor roles may be precious to hospitals with retiring nurses, but they want to retain their expertise as new staff are trained and grow in their roles.
3. **Nurse Residency Program for Newly Licensed Registered Nurses (RNs)**: The Nurse Residency Program is a one-year program that supports acquiring knowledge, skills, and attitudes necessary to successfully transition nursing students into clinical settings and develop core competencies in nursing. Nurse residents attend lectures from clinical experts, participate in one-to-one clinical preceptorship, and conduct a one-year evidence-based research project to advance nursing. NRP is a critical program that guides the acquisition of new competencies necessary to promote safe practice and individual growth and development of new nurses.
4. **Nursing Student Programs**: Funding may support tuition assistance for hospital employees pursuing nursing degrees toward RN licensure. It may also support externship programs and short-term employment of nursing students.
5. **Professional Advancement Programs**: Funding can support developing or implementing professional advancement programs.

6. **Professional Certification**: Funding supports tuition for certification preparatory courses, including specialty-specific certification programs. In addition to education programs, funding may reimburse certification exam fees.
7. **Projects to Build Nursing Science:** Funding supports research projects and assistance with evidence-based projects. This can include purchasing access to academic journals on nursing and the procurement of simulation equipment and training. Additionally, funding can support research coordinator positions to collaborate with nurse residents on building research skills, designing evidence-based projects, and other research-based learning endeavors. Funding may also be used to obtain expertise in external subject matter. Hospitals often set goals to publish research findings in peer-reviewed journals.
8. **RN Advanced Nursing Degree Programs**: Funding provides tuition assistance for nurses pursuing advanced degrees, particularly BSNs and MSNs. In addition to tuition assistance, funding may support one-on-one counseling, help with the application process, and other academic support for RNs pursuing advanced degrees.
9. **Shared Governance**: Funding supports nursing shared governance, which is shared decision-making between the bedside nurses and nurse leaders. Shared governance includes resource decisions, nursing research/evidence-based practice projects, new equipment purchases, and staffing. This type of shared process allows for active engagement throughout the healthcare team, which promotes positive patient outcomes while creating a culture of positivity and inclusion that leads to greater job satisfaction.
10. **Transition to New Nursing Leadership Roles**: Funding supports formal leadership programs and boot camps to build leadership competency for nurses new to leadership roles in the hospital.
11. **Transition to Specialty Practice Programs for Newly Licensed and Experienced RNs**: Funding supports learning programs and orientation transition programs for newly licensed or experienced RNs entering into specialty units and departments, including the emergency department (ED), intensive care unit (ICU), oncology (ONC), and operating room (OR).
12. **Nursing Excellence Programs**: Designation as a nursing center of excellence indicates the organization has created a “positive work environment allowing nurses to advance and flourish continually.” Programs include Magnet® and Pathway to Excellence®. NSP I supports nursing education about nursing excellence programs and innovative projects to achieve Magnet or Pathway to Excellence.

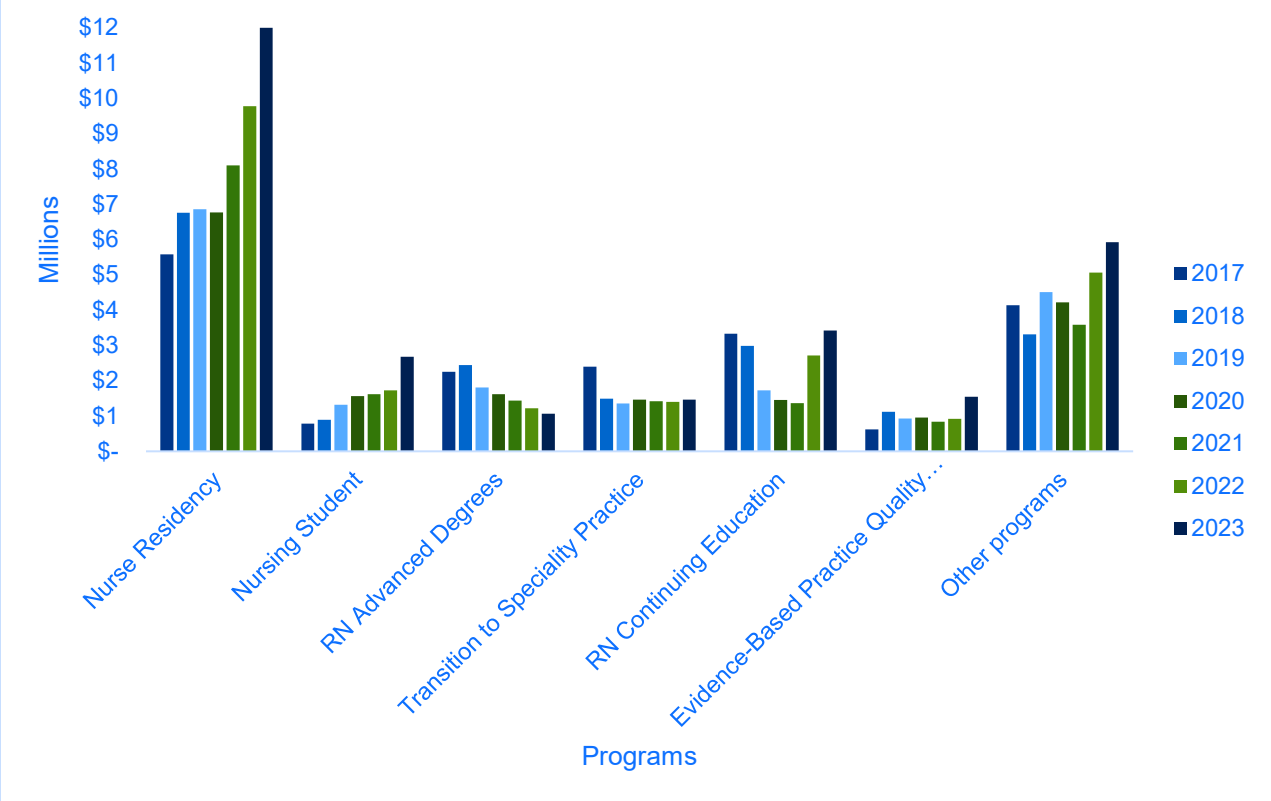
In FY 2023, all hospitals prioritized supporting new entrants to the nursing workforce by implementing a nurse residency program for newly licensed RNs. Additionally, many hospitals provided leadership, preceptorship, mentorship programs, and nursing student programs. Professional advancement was another key focus, as many hospitals funded continuing education and advanced degree programs for

current staff. The collective focus on education and career advancement is expected, given nursing workforce shortages and the urgent need to attract and retain new, experienced staff.

Expenditures

In FY 2023, HSCRC issued $21.7 million in total funding to acute care hospitals. The top funded programs in FY 2023 included 1) nurse residency programs, 2) RN continuing education, 3) nursing student programs, 4) transition to specialty practice programs, 5) evidence-based practice quality improvement, 6) RN advanced degree programs, and 7) leadership, preceptorship, and mentorship programs. Figure 1 and Table 1 show FY 2017 through FY 2023 program expenditures.

Figure 1. NSP I Program Expenditures, FY 2017 - 2023



Source: Hospital NSP I Annual Reports

Table 1. NSP I Program Expenditures, FY 2017 - 2022

NSP I Programs	2017	2018	2019	2020	2021	2022
Nurse residency program	$5,574,572	$6,754,291	$6,860,202	$6,764,270	$8,095,171	$9,775,301
RN continuing education	$3,332,324	$2,990,325	$1,727,520	$1,450,660	$1,362,360	$2,711,942
Nursing Student Programs	$786,956	$889,039	$1,316,756	$1,562,583	$1,620,120	$1,728,939
Transition to specialty practice Programs	$2,397,140	$1,494,908	$1,354,607	$1,460,928	$1,420,664	$1,402,766
RN Advanced Degree Programs	$2,255,675	$2,441,827	$1,812,569	$1,615,189	$1,433,681	$1,219,601
Magnet Designation /Journey or Pathway to Excellence	$533,210	$498,696	$1,002,797	$737,416	$596,476	$1,183,548
Leadership, Preceptorship, Mentorship Programs			$1,133,456	$1,021,250	$809,386	$1,051,685
Other Programs	$3,607,854	$2,815,687	$2,373,633	$2,456,528	$2,177,543	$2,823,986
Total Spending	**$18,487,731**	**$17,884,773**	**$17,581,540**	**$17,068,824**	**$17,515,401**	**$21,897,768**

Source: Hospital NSP I Annual Reports

Performance Results

All participating hospitals submit data on a series of key metrics, which include, but are not limited to:

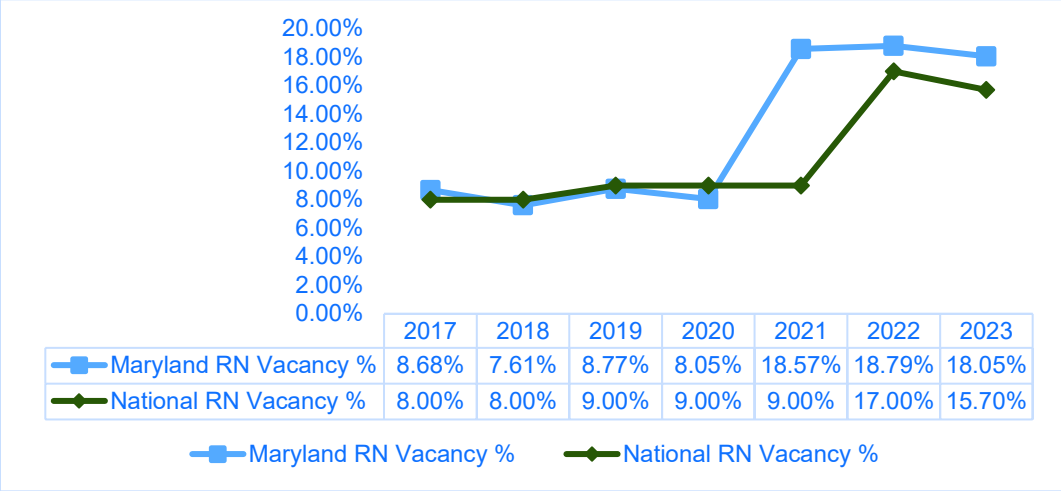
- Vacancy and Retention Rates
- Number of Nurses with BN and Advanced Degrees
- Enhanced Diversity

Vacancy, Turnover, & Retention Rates[1]

Maryland's FY 2023 hospital RN vacancy rate (18 percent) declined from 19 percent in FY 2022; however, it remains above the nation's vacancy rate (16 percent), which also experienced a greater decline from 2022 (Figure 2). The decrease in the national vacancy rate versus the stagnant vacancy rate in Maryland over the last two years may be attributed to difficulty in recruiting and broader healthcare workforce shortage trends in Maryland and the region. The RN Recruitment Difficulty Index (RDI-RN) measures the average number of days hospitals take to recruit and hire an RN. According to the National HealthCare Retention and RN Staff Report by Nursing Solutions Inc. (NSI), the North-East Region has the most significant recruitment difficulty in the nation, taking 107 days on average to recruit and fill a position, whereas the national RDI-RN is 95 days.[2]

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[3] detailing its findings, discussed briefly later in this report. 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 the vacancy and turnover rates shown in Figures 2 and 3 below, wherein the State is improving but at a slower pace than the nation.

Figure 2. Registered Nurse Vacancy Rate in Hospitals, MD vs. Nation, 2017 - 2023



	2017	2018	2019	2020	2021	2022	2023
Maryland RN Vacancy %	8.68%	7.61%	8.77%	8.05%	18.57%	18.79%	18.05%
National RN Vacancy %	8.00%	8.00%	9.00%	9.00%	9.00%	17.00%	15.70%

[1] All national statistics cited for vacancies and retention data are derived from the National HealthCare Retention and RN Staffing Report, which is an annual national survey of approximately 192 facilities from 32 states.

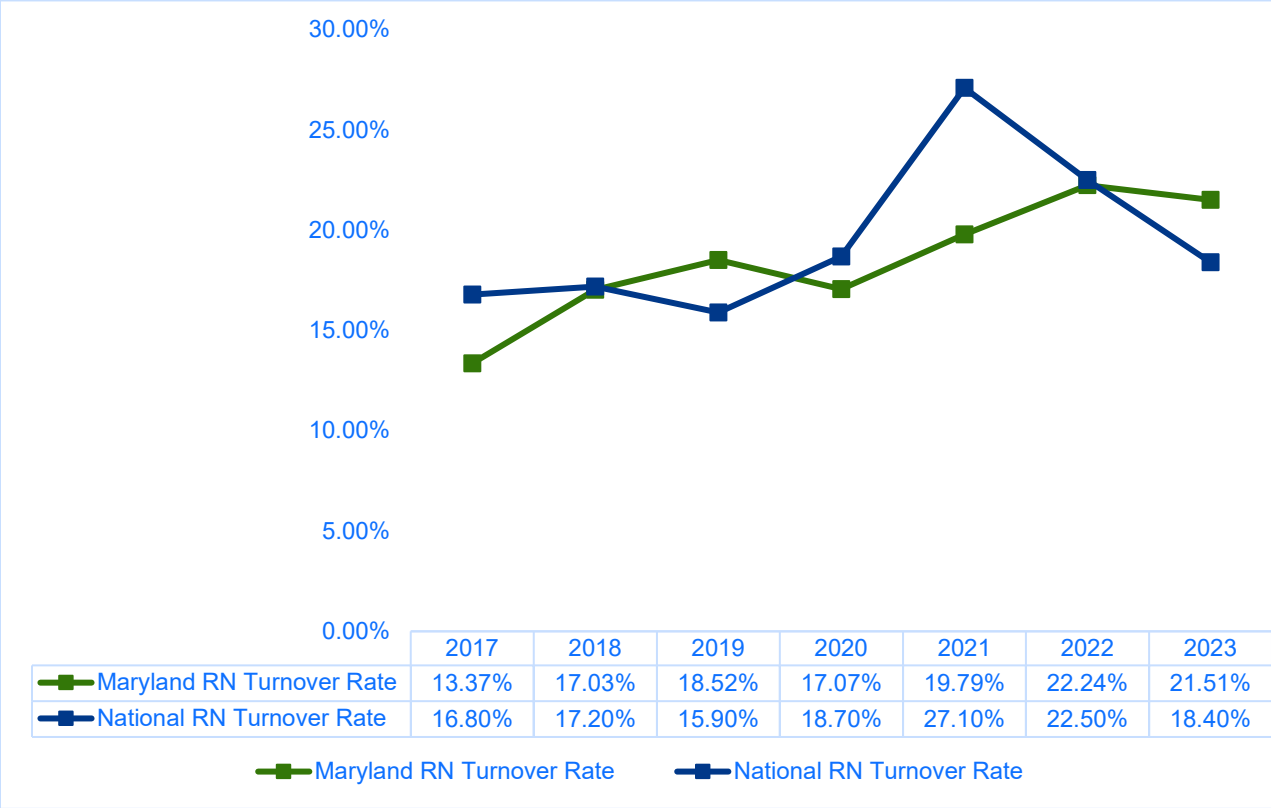
[2] Nursing Solutions Inc. (2024) *2024 NSI National Healthcare Retention and RN Staffing Report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed May 16, 2024.

[3] Commission to Study the Health Care Workforce Crisis. Final Report 2022/2023. 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%20Heal.pdf Accessed June 11, 2024.

Source: Hospital NSP I Annual Reports, NSI Nursing Solutions

The Maryland RN turnover rate declined slightly between FY 2023 (21.51 percent) and FY 2022 (22.24 percent) but is above the national average (18.4 percent). As shown in Figure 3, this is the first time MD has exceeded the national average in the past three years.

Figure 3. Hospital RN Turnover Rate, MD vs. Nation, FY 2017-FY 2023

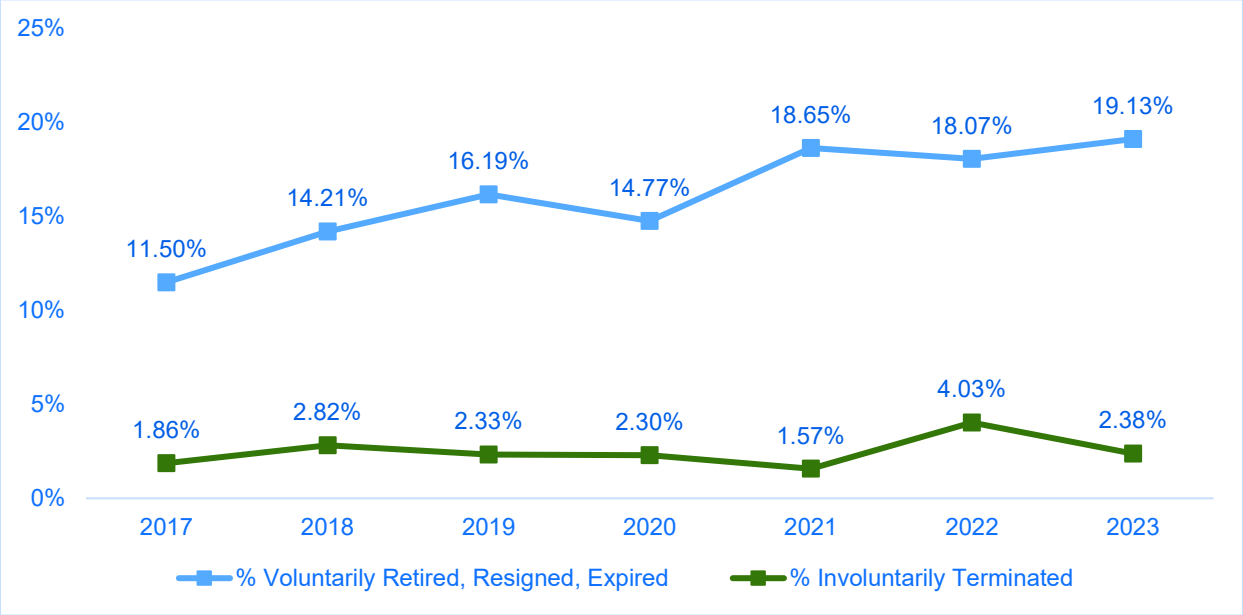


	2017	2018	2019	2020	2021	2022	2023
Maryland RN Turnover Rate	13.37%	17.03%	18.52%	17.07%	19.79%	22.24%	21.51%
National RN Turnover Rate	16.80%	17.20%	15.90%	18.70%	27.10%	22.50%	18.40%

Source: Hospital NSP I Annual Reports, NSI

Figure 4 shows that voluntary departures in FY 2023 decreased from the prior year but have increased significantly since FY 2020. Involuntary terminations have also decreased; 700 fewer RNs left the career field in FY 23 compared to FY 22. The most significant factor keeping the percentage the same from FY 22 to FY 23 is that fewer nurses were employed in FY 23.

Figure 4. RN Turnover Rate, Voluntary & Involuntary, FY 2017 - FY 2023

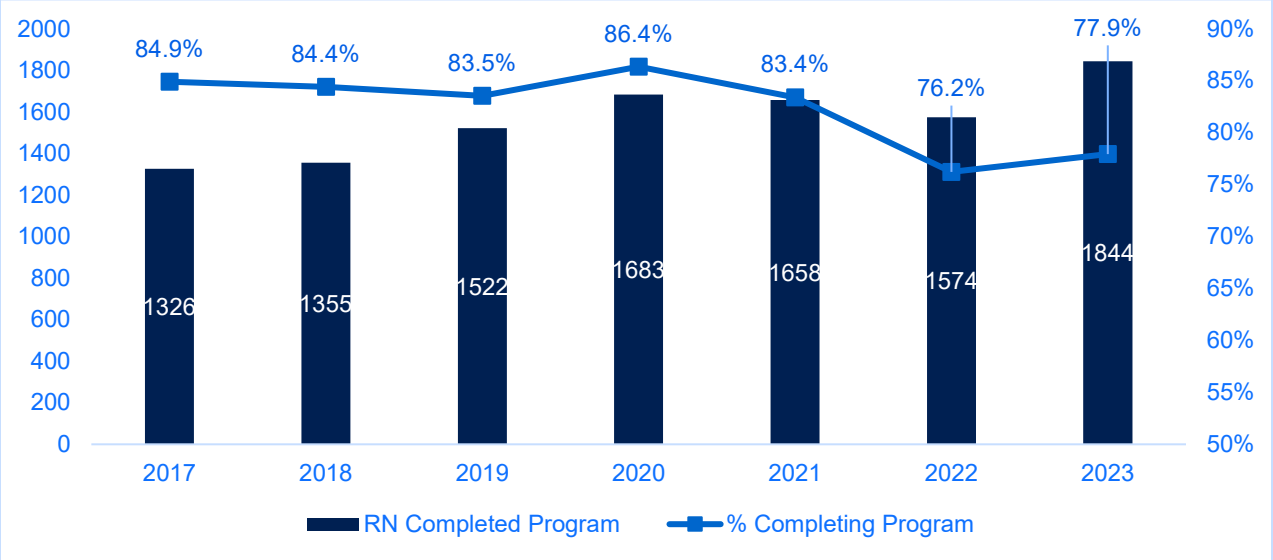


Source: Hospital NSP I Annual Reports

Involuntary termination over the prior fiscal year is improving. Educational programs and opportunities are closing the gap created by the lack of clinical hours during the COVID-19 pandemic. Many hospitals have created unique training platforms for new nurses to help ensure their success.

A key strategy to support new nurse retention is nurse residency programs. All NSP I hospitals implement nurse residency programs and report that they are essential in training and retaining new nurses at hospitals. As shown in Figure 5, the completion rates for RNs completing residency programs declined by seven percentage points to 76 percent in FY 2022 since the prior fiscal year. There has been an improvement in FY 2023, with a 78 percent completion rate; the national retention rate for first-year nurses with no NRP is at 66 percent. The data being reported by the HSCRC is captured by fiscal year. The Maryland Nurse Residency Collaborative data, captured by calendar year, shows a completion rate of 91 percent, and Vizient reports a national average of 89 percent. The Maryland Nurse Residency Collaborative Data and Vizient measure completion of the first year of the NRP. Hospitals report two-year NRP completion to HSCRC without a national comparison point.

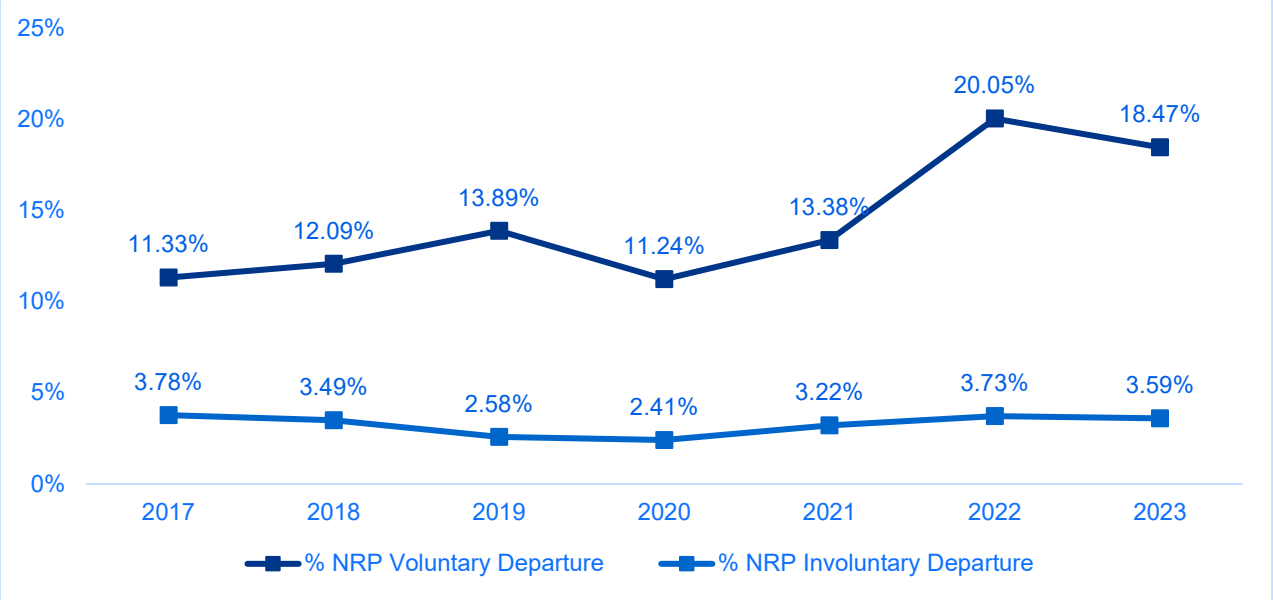
Figure 5. RNs Participating and Completing Residency Program, FY 2017 -2023



Source: NSP I Reports

The decline in completion rates since 2020 is primarily due to the growth of voluntary departures (Figure 6). Voluntary departures grew from 14 percent in FY 2019 to 20 percent in FY 2022, then declined to 18 percent in FY 2023. New nurses may be leaving for various reasons, including but not limited to 1) opting to shift to travel jobs with higher pay, 2) shifting to positions in less stressful clinical settings, and 3) ongoing residual impacts of insufficient clinical training.

Figure 6. Percent Voluntary and Involuntary NRP Departures, FY 2017-2023

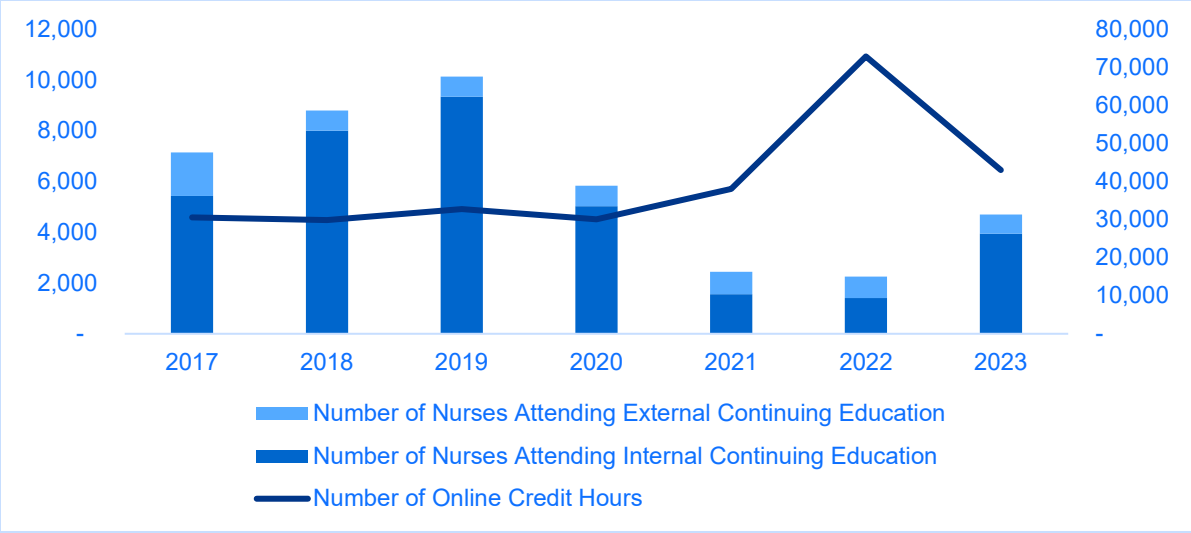


Many hospitals have cited the clinical experiences during nursing school as a critical driver of voluntary NRP departures. Safety concerns and the strain on hospital resources due to high demands on nursing staff to train new incoming nurses have caused nursing schools to find innovative ways to find clinical instructors for student nurses. To help address the impact of limited clinical training, Maryland hospitals and academics formed a committee to build a curriculum for a Transition to Nurse Residency Program (TNRP). The goal of TNRP is to restore the skills and competencies of new-to-practice nurses. The TNRP does not duplicate nor replace NRP; instead, it is a precursor to the NRP offered at onboarding and before new-to-practice nurses assume patient assignments. More than half of Maryland hospitals have implemented the program, and most use NSP I funding to support it. The TRNP program was first used post-pandemic. However, it is still used to fill out the identified GAPS of the new graduate nurses.

Continuing Education

Hospitals have reported a significant increase in credit hours associated with continuing education. As shown in Table 1, funding for continuing education declined between FY 2017 ($3.3 million) and FY 2021 ($1.36 million) but increased to $3.4 million in FY 2023. Online credit hours in FY 2023 decreased over the prior year, which peaked in FY 2022 (Figure 7). However, the number of nurses participating in continuing education in FY 2023 doubled over the preceding year. The growth in online credit hours since 2020 can be attributed to an increased focus on in-house education, as external opportunities were limited during the pandemic. While many external conferences that hospital nursing staff frequented before the pandemic have resumed, hospitals have reported increasing online education efforts to reach more staff.

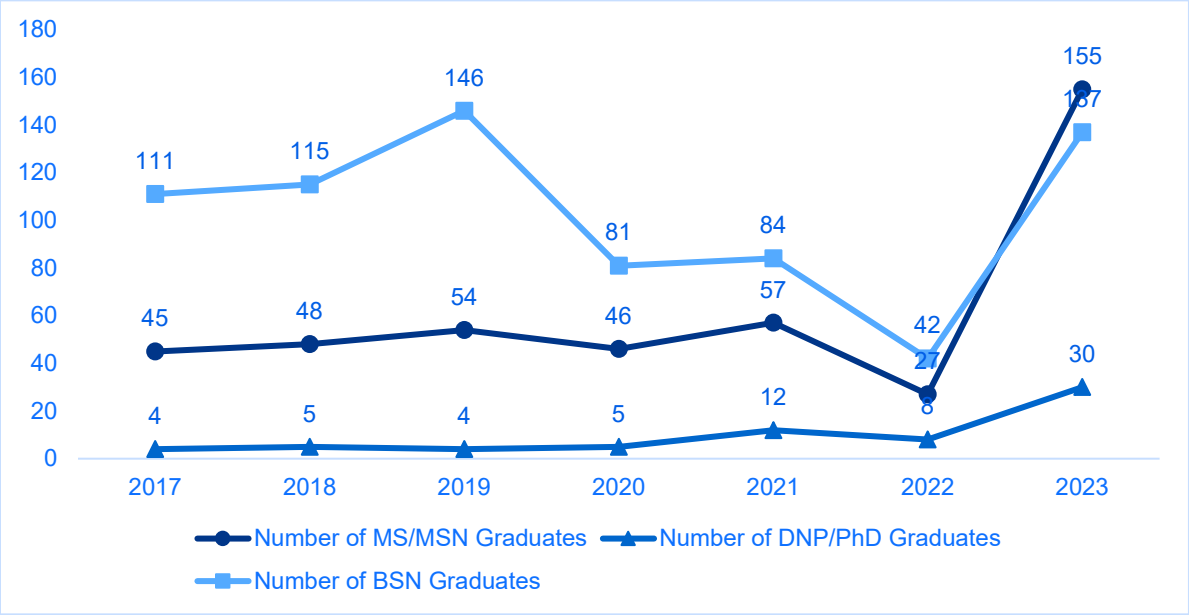
Figure 7. Continuing Education Participants and Online Credit Hours, FY 2017 - 2023



Number of Nurses with BN and Advanced Degrees

Another key goal of the *Future of Nursing* recommendations was to increase the number of nurses with advanced degrees. Strong research evidence has linked lower mortality rates, fewer medication errors, and positive outcomes to nurses prepared at the baccalaureate and graduate degree levels.[4] Quality patient care hinges on a well-educated, highly functioning, motivated nursing workforce. Figure 8 shows the number of BSN, MS/MSN, and DNP/PhD degrees funded by NSP I between FY 2017 and FY 2023.

Figure 8. NSP I Funded Degree Type, FY 2017 - 2023



Between 2017 and 2019, there was a 22 percent increase in hospital-based nurses holding NSP I-funded BSN and Advanced degrees. However, the decline in advanced degrees that began in 2020 during the pandemic continued through FY 2022. As shown in Table 1, funding for advanced degrees has declined since FY 2017 as hospitals have prioritized attracting and retaining new staff through nurse residency and nursing student programs, as well as continuing education investments to retain existing staff. In FY 2023, there has been a dramatic increase in advanced degrees; this confirms the report from hospitals in FY 2022 that they had several nurses pursuing advanced degrees. Maryland continues progressing steadily to the "80 Percent BSN by 2025" goals through the NSP II Program. In Maryland, 75 percent of nurses responding to the National Nursing Workforce Survey had a BSN or higher degree in 2022.[5]

[4] Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health.* Washington (DC): National Academies Press (US); 2011. 4, Transforming Education. Available from: https://www.ncbi.nlm.nih.gov/books/NBK209885/

[5] Health Services Cost Review Commission. (2023). Nurse Support Program II Competitive Institutional Grants Program Recommendations for FY 2024.

Enhanced Diversity in the Nursing Workforce

A key recommendation of IOM is to develop initiatives to address health disparities by increasing the number of minorities and men in all nursing roles. Specifically, NSP I programs can implement initiatives to:

- Increase the number of minority and male mentors and preceptors.
- Increase the number of minority and male nurses in leadership positions.
- Develop recruitment strategies to target racial/ethnic minorities, particularly in areas with high minority populations.

Based on reports submitted by hospitals, significant progress remains to increase the number of minorities and males in all nursing roles. As shown in Table 2, the percentage of males in clinical and nurse executive roles has remained relatively stagnant. The percentage of male nurse managers has grown since FY 2020.

Table 2. Percent of Nursing Role by Gender, FY 2020 - 2023

	Gender	2020	2021	2022	2023
Clinical Nurses	Male	9.62%	9.54%	9.62%	9.92%
	Female	90.38%	90.46%	90.38%	90.08%
Nurse Managers	Male	7.71%	8.94%	9.61%	9.21%
	Female	92.29%	91.06%	90.39%	90.79%
Nurse Executives	Male	10.44%	7.76%	9.21%	10.62%
	Female	89.56%	92.24%	90.79%	89.38%

Source: Hospital NSP I Reports

There have also not been significant changes in the race and ethnicity composition of nursing roles in Maryland hospitals, as shown in Tables 3-5.

Table 3. Percent of Clinical Nurses by Race/Ethnicity, FY 2020 - 2023

	2020	2021	2022	2023
NH Black	21.06%	20.53%	19.50%	21.57%
NH White	62.01%	61.51%	60.45%	57.58%
Hispanic	2.94%	2.98%	2.80%	3.50%
Native American	0.37%	0.25%	0.23%	0.33%
Pacific Islander	0.38%	0.26%	0.53%	0.21%
Asian	11.16%	11.65%	11.43%	13.40%
Prefer not to answer	2.08%	2.80%	5.06%	3.41%

Source: Hospital NSP I Reports

Table 4. Percent of Nurse Managers by Race/Ethnicity, FY 2020 - 2023

	2020	2021	2022	2023
NH Black	18.74%	17.33%	18.62%	20.60%
NH White	73.81%	74.06%	68.49%	65.86%
Hispanic	0.90%	1.18%	1.28%	2.13%
Native American	0.13%	0.24%	0.13%	0.29%
Pacific Islander	0.26%	0.59%	0.13%	0.19%
Asian	5.26%	5.54%	7.53%	7.83%
Prefer not to answer	0.90%	1.06%	3.83%	3.09%

Source: Hospital NSP I Reports

Table 5. Nurse Executives by Race/Ethnicity, FY 2020 - 2023

	2020	2021	2022	2023
NH Black	13.51%	15.09%	12.88%	13.21%
NH White	83.33%	80.60%	77.68%	81.51%
Hispanic	0.45%	1.29%	1.29%	0.75%
Native American	0.45%	0.00%	0.86%	0.38%
Pacific Islander	0.00%	0.00%	0.00%	0.00%
Asian	2.25%	1.72%	1.72%	3.40%
Prefer not to answer	0.00%	1.29%	5.58%	0.75%

Source: Hospital NSP I Reports

As hospitals have struggled with nurse vacancies and retention, stagnant performance in increasing diversity in the nursing force in Maryland hospitals is not wholly unexpected. Based on FY 2023 reporting, HSCRC staff has not seen robust efforts to increase male nursing staff and recruit racial/ethnic minorities, particularly in areas with high minority populations. HSCRC staff has encouraged hospitals to prioritize diversity in recruitment efforts to create a culturally congruent workforce and best reflect the needs and composition of their communities.

A challenge that hospitals have cited with increasing the number of males and racial and ethnic minorities in nursing roles is that recruitment efforts are dependent on the pool of recent nursing graduates. Hospitals have reported working closely with local community colleges and universities to encourage community people to enter nursing. Other hospitals have instituted programs with NSP I assistance, such as student

nurse programs, to send certified nursing assistants and licensed practical nurses back to school to become registered nurses. Consequently, prioritizing diversity in nursing student recruitment, and creating educational opportunities that are accessible to all student types, particularly non-traditional students, is crucial to building a diverse nursing workforce. As HSCRC staff works with the Maryland Higher Education Commission (MHEC) on the program renewal for the Nurse Support Program II (NSP II), staff and stakeholders will prioritize the significance of diversifying educational opportunities for prospective nursing students to create a diverse nursing pipeline.

Ongoing Challenges

Maryland Healthcare Workforce Levels Growing Slower than Region

As discussed earlier in this report, in 2022 the Maryland General Assembly formed the Commission on the Health Care Workforce Crisis ("Workforce Commission") to explore critical shortages in Maryland's healthcare workforce.[6] A key finding of the Workforce Commission report is that Maryland is faring worse in growing its healthcare workforce when compared to other states. Based on data from the Bureau of Labor Statistics, the Workforce Commission identified that Maryland's workforce is growing at a slower rate (4.6 percent) than other Mid-Atlantic states (5.8 percent) and the nation (11.5 percent). Maryland is also not reaching pre-pandemic workforce levels at the same pace as other states.

> "While most states in the mid-Atlantic region have not fully returned to their 2019 level of employment in the healthcare sector, Maryland is tied with Pennsylvania as having the second-worst recovery rate post-pandemic at 4.3%. This is also lower compared to the rest of the region and the nation, with a recovery rate of -2.2 % and -0.1%, respectively. Virginia is the only state in the mid-Atlantic that has reached, and exceeded, its 2019 level of employment, at 14% growth."[7]

The data on Maryland and national hospital RN vacancy and turnover rates as shown in this report align with the Workforce Commission report findings. Healthcare workforce shortages and the slow recovery to pre-pandemic levels are not isolated solely to hospitals and nursing but are prevalent across multiple healthcare settings and provider types. The challenges facing hospitals with nursing workforce shortages are driven by more complicated and systemic dynamics that the State is working to identify and address by increasing the collection and reliability of workforce data, and supporting workforce training and recruitment efforts.

[6] Commission to Study the Health Care Workforce Crisis. Final Report 2022/2023. 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%20Heal.pdf Accessed June 11, 2024.

[7] Ibid, pg 10.

Nursing Burnout

As illustrated in Figures 2-4 above, vacancy rates and retention continue to suffer in the wake of the COVID-19 pandemic. In a 2021 survey of 2,000 nursing staff, the Maryland Nursing Workforce Center (MNWC) found that over 40 percent of respondents experienced moderate to severe stress, could not control worrying, felt hopeless, and had little pleasure in usual things. Close to 50 percent of respondents indicated that they had symptoms of burnout, felt anxious, and had experienced sleep disturbances. Furthermore, 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.[8] These findings are echoed across the nation.[9] Ongoing workforce shortages continue to exacerbate these challenges.

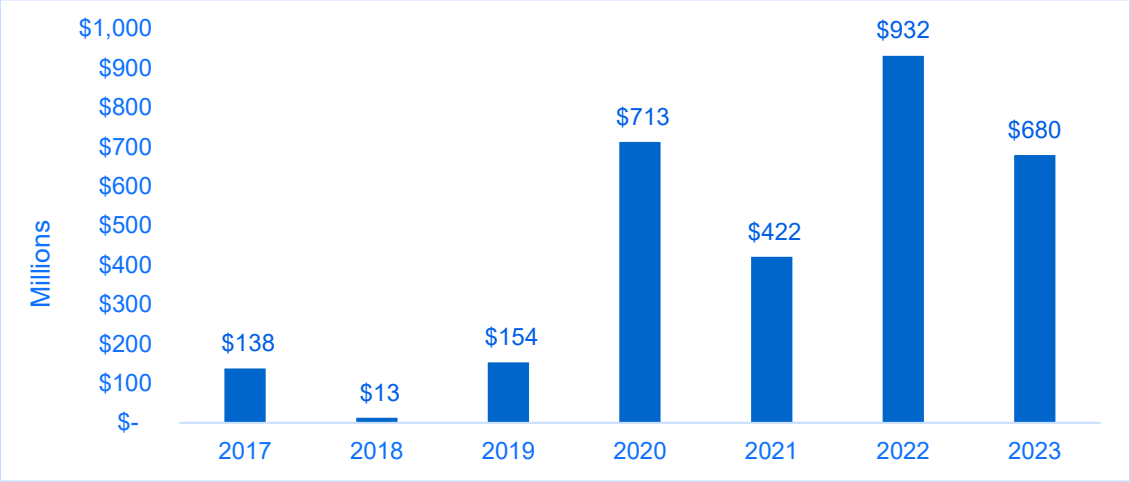
Increased Reliance on Agency Nurses

Anecdotally, nurses were leaving their positions to go to competing hospitals to sign bonuses or to agencies for better pay, better hours, and less stress.[10] The increase in agency nurses and the resulting high turnover burdens staff nurses as they must constantly orient new people. In discussions with nurses from various roles, the main complaint regarding agency nurses is that they are paid significantly more than staff nurses but are not responsible for regulatory reporting and other burdens placed on them.

As more nurses leave hospitals for agencies, a costly feedback loop is created as hospitals rely more on agencies to backfill the reduction in the workforce. The pandemic exacerbated costs to $713 million (Figure 8) in Maryland, as reported to the HSCRC in the FY 2020 NSP Annual Reports. Nationally, most hospitals are not anticipating reducing their reliance on agency nurses while costs continue to increase.[11]

[8] University of Maryland School of Nursing – Maryland Nursing Workforce Center. (December 2021). Analysis of COVID-19's Impact on Maryland Nursing Workforce. https://www.nursing.umaryland.edu/media/son/mnwc/MD-survey-of-post-COVID-workforce.pdf
[9] Hansen, A. and Tuttas, C. (2021). Professional Choice 2020-2021: Travel Nursing Turns the Tide. [Article] www.nurseleader.com.
[10] Vesoulis, Abby and Abrams, Abigail. Contract Nurse Agencies Are Making Big Money in the Age of COVID-19. Are They 'Exploiting' the Pandemic? Time.com, February 23, 2022. [Article]. https://time.com/6149467/congress-travel-nurse-pay/ Accessed May 1, 2022.
[11] Nursing Solutions Inc. (2023) 2023 NSI National Healthcare Retention and RN Staffing Report. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed May 16, 2023.

Figure 11. Nursing Agency Cost to Hospitals, FY 2017 - FY 2023



Source: Hospital NSP I Reports

While there was a drop in agency costs in FY 2021, suggesting a potential return to pre-pandemic spending levels, hospitals reported a significant increase in FY 2022 to $931 million as ongoing struggles with nursing workforce shortages continue. In FY 2023, there has been a substantial drop to $679 million, which is not at the pre-pandemic level yet, but it is trending downward, with hospitals stating that the cost will be even lower in FY 2024. To continue to bring this number down in FY 2024, hospitals have reported creating hospital or system-owned travel agencies, mitigating some of the high costs associated with travel agencies. As shown in the graph above, the cost decreased in FY 2023.

Conclusion

The NSP I Program remains an essential resource to acute care hospitals as they seek to retain nursing staff and grow leadership potential, expand educational opportunities, and advance nursing practice, particularly as the State struggles to reach pre-pandemic workforce levels. This report demonstrates that FY 2023 vacancies and turnover rates have improved over the last year; however, the state is performing worse than the nation and slowly recovering to pre-pandemic levels. Additional insight is needed to identify and understand these drivers, particularly given that the underperformance is not isolated solely to hospital nursing. MDH is leading efforts to improve workforce data collection and reliability to better understand the depth and drivers of healthcare workforce shortages in the State. There has also been no demonstrated growth in the number of males and racial/ethnic minorities serving in hospital nursing roles. Growing and diversifying the number of new nursing graduates will be vital to achieving IOM diversity goals and building a workforce of qualified nurses equipped clinically and culturally to serve their communities. HSCRC staff, the Maryland Higher Education Commission (MHEC), and the NSP I/II Advisory Committee will discuss NSP I/II alignment opportunities as part of the NSP II program renewal recommendation in fall 2024.

HSCRC staff will continue to monitor NSP I activities through ongoing reporting, meetings with individual hospitals on program progress, and data monitoring.

Purpose: These proposed amendments to existing regulations will provide the Commission with the flexibility for determining the appropriate due dates for hospitals to submit their annual reports on community benefit activities and will simplify access to the submission instructions for these reports.

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207, 19-215, and 19-303, Annotated Code of Maryland

Notice of Proposed Action

.03 Reporting Requirements; Hospitals.

A – L. (text unchanged).

M. Annual Nonprofit Hospital Community Benefit Report.

(1) Beginning on December 15, 2009, each nonprofit hospital shall submit the Annual Nonprofit Hospital Community Benefit Report to the Commission by **[**December 15 of every calendar year**]** *the date prescribed by the Commission* in the format prescribed by the Commission.

(2) Hospitals shall complete the report on the basis of actual data covering the reporting period of the previous July 1 through June 30 *or other time period as specified by the Commission*.

(3) The Commission shall provide instructions for completing the report **[**in its "Accounting and Budget Manual for Fiscal and Operating Management"**]** *on its public website*.

N – U. (text unchanged).

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
July 10, 2024

RE:
Hearing and Meeting Schedule

August 14, 2024 Cancelled

September 11, 2024 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.