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

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MINUTES OF THE 621st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION June 14, 2024

Chairman Joshua Sharfstein called the public meeting to order at 11:05 a.m. In addition to Chairman Sharfstein, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Ricardo Johnson, Maulik Joshi, Adam Kane, and. Nicki McCann, J.D. Upon motion made by Commissioner Joshi and seconded by Commissioner Johnson, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 12:05 p.m.

DR. VAN COOTS

Commissioner Joshi announced the passing away of Dr. Van Coots, a renowned healthcare and military leader who served as President and CEO of Holy Cross Health. The Chairman asked for a moment of silence in his memory and honor of his service.

JOSEPH ANTOS

Chairman Sharfstein announced that Vice Chairman Joseph Antos will be leaving the Commission upon the expiration of the term June 30. Chairman Sharfstein expressed his gratitude for the work that the Vice Chairman has performed for the citizens of Maryland over sixteen years of service as a commissioner.

Commissioner Antos acknowledged the recognition and expressed his gratitude and appreciation for the work performed by the Commission Staff.

REPORT OF JUNE 14, 2024, CLOSED SESSION

William Hoff, Chief of Audit and Integrity summarized the items discussed at the June 14, 2024, Closed Session.

STAFF UPDATE

Chairman Sharfstein announced the retirement of Mr. Dennis Phelps, Deputy Director, Audit and Integrity after 47 years of service with the Healthcare Services Cost Review Commission.

Dr. Jon Kromm, Executive Director, announced the onboarding of the following staff.

Tina Simmons joins the Center for Population-Based Methodologies as the new Associate Director for Quality Methodologies at HSCRC. Tina joins the HSCRC after serving as the Director of Population Health at Atlantic General Hospital.

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New Interns – Health Data Management & Integrity

Diamila Dialo is an undergraduate student studying public health at Towson University.
Sophie Okoma is a graduate student at Morgan State working towards a master's in public health.
Sujay Deevala is a graduate student at UMBC working towards a master's in data management.

New Intern – External Affairs

Zachary Starr is a graduate student at UMBC working towards a master's in public policy

ITEM I
REVIEW OF THE MINUTES FROM THE MAY 8, 2024, PUBLIC MEETING AND CLOSED SESSION

The Commission voted unanimously to approve the minutes of the May 8, 2024, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
PRESENTATION OVERDOSE IN MARYLAND

Dr. Olivia K. Sugarman, PhD, MPH, Postdoctoral Fellow, Johns Hopkins Bloomberg School of Public Health, presented and updated the Commission's on the Overdose in Maryland and opportunities for health systems to intervene. (see "Overdose in Maryland Opportunities for Health Systems" available on the HSCRC website).

Dr. Sugarman stated that there were 2,476 overdose deaths in Maryland in 2023, more than doubled since 2014 and increased of 129%. Fentanyl was present in 81% of the overdoses in 2023. Between 2016 and 2020, overdose deaths among non-Hispanic Black Marylanders rose by 57.3 percent as compared to deaths in the non-Hispanic white community, which increased by 43.9 percent. Overdoes mortality is the highest in Baltimore City, Cecil County and Dorchester County per the (Maryland Vital Statistics, 2023).

Maryland's Hospital Emergency Room (ER) visits increased 13.1% for non-fatal opioid overdoes. The data shows 9,741 cases in 2023 versus 8,589 cases in 2022. This is an undercount for drug-related ER visits. As communities handle a growing drug crisis, hospitals in Maryland and other places are treating more and more patients with opioid-related problems.

Dr. Sugarman noted that medications for opioid use disorder are the gold standard treatment for opioid use disorder. The FDA approved the following medications: buprenorphine, methadone and naltrexone. Study shows the medication for opioid use disorder cut fatal opioid overdose risk by 82%. However, 42% of people receive medication for overdose disorder.

Dr. Sugarman stated that medical professionals and Health Systems in Maryland need to start treatment with methadone or buprenorphine in the ER and provide naloxone, a lifesaving opioid reversal agent to

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prevent overdose increase. In addition, she noted that medical professionals refer people to harm reduction programs.

The benefits of receiving and staying on buprenorphine after an overdose lowered your odds of adverse outcomes and reduces the odds of the second non-fatal overdose by 4.7%, reduces ED visits by 5.3% and reduces hospitalization by 3.9%.

Few people in Maryland received the gold standard treatment. Health systems have major potential to combat overdoes by initiating medications for opioid use disorder, establishing referrals and treatment programs for retention.

Dr. Eric Weintraub, M.D., Professor of Psychiatry, Director, Division of Addiction Research & Treatment, University of Maryland School of Medicine, presented and updated on Hospital-Opioid Overdose and Opioid-Related Emergency Medical Conditions Treatment Act HB115 – SB1071.

Dr. Weintraub summarized House Bill 1155/ State Bill 1071 Hospitals Opioid Overdose and Opioid Related Emergency Medical Condition Treatment Act as follows:

Each hospital must have the protocols and capacity to treat a patient who is present in a hospital ER for care and treatment of an opioid-related overdose or opioid related emergency medical condition with a medication for opioid use disorder (OUD) if the treatment occurs as recommended by the treating health care practitioner and is voluntarily agreed to by the patient.

A hospital must possess at least one formulation of each U.S. Food and Drug Administration-approved full and partial opioid agonist used for the treatment of OUD (methadone, buprenorphine).

Before discharging a patient who is diagnosed with an OUD or administered or prescribed medication for OUD, a hospital must (1) make a referral of the patient to an appropriate provider or facility for a timely appointment, when possible, to voluntarily continue treatment in the community and (2) work with peer support professionals, as available, or other resources to assist the patient in accessing the identified treatment services.

Dr. Weintraub stated that effective 1/25/25 hospitals must establish a protocol that must include any Maryland Department of Health requirement regarding prescribing opioid treatment.

In addition, hospitals must develop uniform practices for the following:

1. screening and diagnosing specified individuals who present with an OUD based on the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;

2. offering and administering opioid agonist medication to treat an opioid-related overdose or OUD;
3. To identify community-based treatment services that are appropriate for;
   (i) treating opioid use disorder
   (ii) assisting patients to voluntarily access ongoing community-based treatment at discharge

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Chairman Sharfstein asked whether the standard is only for people who overdosed.

Dr. Weintraub stated the standard is for everyone who is presented in the ED to be screened for overdose abuse disorder just like you are screened for diabetes and high blood pressure.

Chairman Sharfstein asked Dr. Shugarman if more people were treated and better connected with care, whether we can expect fewer ED visits?

Dr. Shugarman agreed.

Dr. Weintraub also stated there should be uniform guidelines across all hospitals and the Commission can be helpful assisting under resource Hospitals that require help.

ITEM III
OPEN CASES

2646N- UM SHORE MEDICAL CENTER at EASTON

Mr. Kenneth Kozel, President and Chief Executive Officer of University of Maryland Shore Regional Health and Dr. Roderick King, Senior Vice President and Chief Diversity, Equity and Inclusion Officer presented and updated the Commissioners on UM Shore Medical Center at Easton Request for Capital Funding.

Mr. Kozel started his presentation by acknowledging and thanking the Commission staff, Dr. Kromm, and Mr. Pack for closely working with the Hospital to develop the recommendation that is being presented. The hospital is requesting capital funding to support the long overdue replacement of the Shore Medical Center at Easton. Additionally, the presentation focuses on the impact the hospital has on rural communities.

1. An understanding of the hospital approach to community health in rural underserved populations.
2. How to use the unique tools in the Maryland model to meet the needs of the community.
3. The importance of the Regional Medical Center Project and equity on Maryland's Eastern Shore.

The new Shore Regional Medical Center is greatly needed to be an essential part of the Health System service delivery plan that is foundational to meet the unique needs of the Mid-shore Community. This facility is being built with the desire to support the current and future evolution of the Maryland model. It is smaller and reflects the emphasis on community-based care, reducing physical capacity by approximately 15%. It also supports advancement in equity by improving access for acute care and regional services.

The hospital supports the staff recommendation, recognizing they still have considerable work to do to make this project financially viable and sustainable for decades to come. While expanding access to

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primary care, ambulatory services and investment in population health services across the region. The expectation is to reduce the total cost of care as an anchor institution in rural community.

Dr. King stated they are studying the interplay between rural health disparities and the racial ethnic disparities. This is important for them to differentiate because the county is watching to see their results. They have made some progress, and the Health System has established a health equity plan that is being finalized to specifically look at the interplay around unplanned readmissions. The hospital is on its way to demonstrating for the rest of the country and for the State of Maryland how they are addressing both inequalities, but also reducing cost and improving quality at the same time.

Mr. Allen Pack, Principal Deputy Director, Quality and Population-Based Methodologies presented and updated UM Shore Medical Center at Easton Capital Funding Request (see "Staff Recommendation Shore Regional Health System, Inc Medical Center at Easton" available on the HSCRC website).

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, 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 links 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.

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. UM SRH includes UM SMC at Easton, the regional hub for

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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 several ambulatory centers offering specialty care, primary care, behavioral health, rehabilitation, diagnostic services, and urgent care located in each of the five counties

Based on Staff's analysis, 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.

    - Given the implications this will have on the capital policy moving forward, staff ask for public comment on this proposal by June 21, 2024, and that Commissioners use this commentary when considering this alteration to the capital policy in a subsequent Commission meeting.

2. A permanent adjustment of $11,890,372, per the capital methodology, is 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 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.

Commissioner Kane asked Mr. Pack why the hospital would agree to $35M and not the $63M as a pass through in capital methodology. Mr. Pack deferred to the hospital.

Ms. Alicia Cunningham, Senior Vice President, Corporate Finance and Revenue Advisory Services, University of Maryland Health System stated their request was a negotiation and they wanted to be fair and reasonable requesting the $35M and not the full $63M.

As this is a draft recommendation no Commission action is necessary.

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ITEM IV
REPORT FROM THE EXECUTIVE DIRECTOR

Dr. Kromm informed the hospitals that The HSCRC is requiring that all hospitals submit patient-level Sexual Orientation and Gender Identity (SOGI) data beginning October 1, 2025. To ensure that this data is collected in a culturally appropriate manner, the HSCRC is providing training to hospital staff.

This data collection is crucial for ensuring that we provide equitable and inclusive care to all Marylanders. Fortunately, there is one synchronous training session left which will be held on June 18th from 1pm-5pm. The registration link for this session is on the HSCRC website under the "Stakeholder Engagement and Workgroups" page.

Once the sessions are completed, a SOGI training sessions will become available and accessed via the HSCRC website; however, Staff highly recommend that participants attend the synchronous sessions as they are interactive and allow for discussion, feedback, and questions. If hospitals have any questions, please contact the HSCRC Quality Team.

Emergency Department Dramatic Improvement Effort (EDDIE) Update

Dr. Kromm also stated there was no new finding in the EDDIE data. A new workgroup is convening to develop EDDIE incentives for quality. The State passed an ED Wait Time Commission which will be co-chaired by Dr. Kromm and the Secretary of Health. They will be advancing some of the work on Hospital ED best practices and the Statewide Best practices implementation.

Dr. Kromm noted that work continues concerning the policy for the multi-visit patient. Staff will provide an update next month and continue to do EDDIE data collection.

UPDATE: COMMUNITY BENEFIT REPORTING INSTRUCTIONS

Ms. Megan Renfrew, Deputy Director, Policy and Consumer Protection presented and updated on the Hospital Community Benefit Report Instructions workgroup. (see “Hospital Community Benefit Reporting Instruction Workgroup- Update” available on the HSCRC website).

FACILITY FEE WORKGROUP

Ms. Renfrew presented and updated on the 2024-2025 Facility Fee Workgroup Charter (see “2024-2025 Facility Fee Workgroup Charter” available on the HSCRC website).

Workgroup Responsibilities

Maryland law requires the Health Services Cost Review Commission (HSCRC) to consult with multiple State Agencies and other stakeholders on a study on facility fees. HSCRC is convening this workgroup to provide advice to the HSCRC on the study and any related recommendations to the legislature.

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The Workgroup's discussions shall help inform Staff's development on two reports to the legislature, due December 1, 2024, and December 1, 2025. These reports are as follow:

- HSCRC Facility Fee Study and Reports
- Guiding Principles

All Workgroup meetings are open to the public. Reasonable notice for each meeting shall be given to members through email and to the public on the HSCRC website.

ITEM V
FINAL RECOMMENDATION: RELATIVE VALUE UNITS UPDATES

Mr. William Hoff, Chief Audit & Compliance, presented Staff's final recommendation on changes to the Relative Value Units (RVUs) for Speech Therapy (STH) and Audiology (AUD) (see "Changes to the Relative Value Units for Speech & Audiology Effective July 1, 2024, Final Staff Recommendation" available on the HSCRC website).

The proposed changes were sent out to all hospitals for comments. The comment period closed on May 15, 2024, with one comment received from St. Agnes Hospital.

> "The hospital recommended the Speech-Language Evaluation, and the Speech-Language Treatment relative values units be similar or have equal values."

Staff responded that the workgroup used the Medicare Physician Fee Schedule weights to determine the RVUs values of each procedure, and the methodology was consistent with all conversions.

Hospitals were required to calculate a conversion factor to assure no change in the hospital revenues because of this RVU conversion. Hospitals will begin using these revised RVUs effective July 1, 2024.

Staff's draft recommendation is as follows:

1. That the Commission approves the revisions to the RVU scale for the STH & AUD Rate Centers. The revisions are specific to the Chart of Accounts and Appendix D of the Budget Manual. These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff.
2. That the RVU scale be updated to reflect linkages of RVUs to the CPT codes to incorporate the changes in STH & AUD practices. The RVU scale was also updated to link charging guidelines for STH & AUD services to the national definition, consistent with the HSCRC's plan to adopt MPFS RVUs where possible.
3. That the new and updated RVUs be effective July 1, 2024, and that the conversion of the STH & AUD RVUs be revenue neutral to the overall Hospital Global Budget Revenues; and
4. That revisions to Appendix-D and the Chart of Accounts for Medical Supplies Sold be effective July 1, 2024.

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Commissioner unanimously approved Staff's recommendation.

ITEM VI
FINAL RECOMMENDATION: CRISP FUNDING – FY 2025

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented the final recommendations for FY 2025 funding to support Health Information Exchange (HIE) Operations and CRISP (See "Maryland's Statewide Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients: FY 2025 Funding" on the HSCRC website).

The final recommendation is the same as the draft recommendation as Staff did not receive any comments letters.

Staff's final recommendation is as follows: In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,1 this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2025 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under MES Federal Programs for HIE operations and infrastructure ($3,080,000)
- Direct funding and MES matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($6,340,000). Staff propose using $1,000,000 of accumulated reserves to reduce the revenue generated through rates for FY2025 to $5,340,000 for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $8,420,000 for FY 2025. As a result, the HSCRC will be funding approximately 20 percent of CRISP's Maryland funding, compared to budgeted 15 percent in FY 2024. The increase in funding from $4,800,000 to $8,420,000 is related to a change in the requirements to obtain Federal matching funds as described below and a reduction in the amount drawn from accumulated reserves from $1,700,000 to $1,000,000 as those reserves are spent down. The increase in the share of CRISP funding being paid through hospital rates also relates to the Federal funding change. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health.

Commissioner unanimously approved Staff's recommendation.

ITEM VIII
FINAL RECOMMENDATION UPDATE FACTOR- FY 2025

Mr. Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations, Mr. William Henderson, Principal Deputy Director, Medical Economics & Data Analytics, and Mr. Allan Pack, Principal Deputy Director, Quality and Population Based Methodologies, and Caitlin Cooksey, Deputy Director, Hospital Rate Regulation presented staff's recommendation for the Update Factors for FY 2025 (See "Final Recommendation for the Update Factors for FY 2025" available on the HSCRC website).

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The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year in the development of the update factor, the HSCRC is considering the impact recent inflationary trends have had on the healthcare industry. As in all the HSCRC policies, this draft recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, Staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement, including achieving $336 million in annual Medicare savings by the end of CY 2024;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to developing the RY 2025 annual update is outlined in this report, as well as Staff's estimates on calendar year Model tests.

Hospital revenue is divided into two categories:

- Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per-capita growth rates, rather than unit rate changes.

- Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

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Staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2025 update. Comments generally focused on 7 areas: fund current inflation, catch up methodology, revised PAU policy, clarification of set-aside, outpatient oncology & infusion drugs, retained revenue and support inflation for Specialty Hospitals. MHA submitted a proposal outlining the increase for its member hospitals, while CareFirst submitted a letter suggesting that an increased portion of the Update Factor should be directed to population health improvement efforts. In addition to MHA and CareFirst's letter, the following hospitals submitted comments: University of Maryland Medical System, John Hopkins Health system, Holy Cross Health, MedStar Health, Tidal Health, Adventist HealthCare, Sheppard Pratt, Mount Washington Pediatric Hospital, LifeBridge Health, Atlantic General, and Ascension St. Agnes. The request and comments outlined by MHA, CareFirst, and echoed by member hospitals are outlined below with staff's response.

Fund Current Inflation:

All hospitals requested that the commission fund current inflation to 3.24% reflecting data from Global Insight's First Quarter 2024 book.

Staff agree to update current inflation to Global Insight's First Quarter 2024 book to reflect 3.24%. This new value will be reflected in the Final Recommendation. The update will influence TCOC savings and the magnitude of any catch-up inflation value.

Inflation Catch-Up Methodology:

CareFirst suggests that:

1. There should be no additional funding provided in RY 2025 because the catch-up methodology doesn't account for prior overfunding. Hospitals have been "cumulatively overfunded by more than $1 billion above actual inflation"
2. If any catch up inflation is provided in RY 2025, CareFirst suggests targeting additional funding to invest in reducing statewide maternal mortality rate by 50% over 5 years. In addition, CareFirst suggests providing 0.1% funding in rates paid via an assessment to MHA to create a Maternal Quality Care Collaborative. If improvements are not made over 5 years, the additional funding provided for this effort should be removed from the rates.

Staff agree that the catch-up methodology should account for prior overfunding and thus are amending the staff recommendation to utilize a 2014 baseline. Staff, however, do not agree with CareFirst's assessment of cumulative overfunding, as it considers cash reserves and fails the typical regulatory standard of adjusting in a prospective manner. Moreover, this same approach was not considered when resolving the census forecasting error in the Demographic Adjustment, which would have shown significant, negative impacts to cash reserves.

Lastly, staff appreciate CareFirst's novel proposal to address maternal mortality. This type of coordinated policy action could be supported by the proposed population health provision, which will be further vetted with a technical workgroup and other key stakeholders, most notably the Department of Health.

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All Hospitals are in support of a catch-up methodology to address the underfunding of inflation that has occurred in RY 2022 and RY 2023. MHA and its member hospitals request that half of the 2.34% totaling 1.17% be funded in RY 2025 and the remainder be funded in RY 2026. The 2.34% is based on a 5-year cumulative growth calculation which considers RY 2020- RY2024. In addition, any correction for overfunded inflation be limited to 0.5% per year and not be applied if savings exceed the Medicare target. If adjustments exceed 0.5%, they should be spread over multiple years to ensure financial stability and predictability.

Tidal Health request for additional funding to address underfunded inflation in FY25. They propose targeting this funding to efficient hospitals and scaling a portion to limit growth for "Low-Efficiency Outliers".

Staff believe there needs to be a catch-up methodology that can be used moving forward but disagree with the approach proposed by the MHA and its member hospitals.

1. Calculation of over/(under)funding should go back to 2014 and calculate cumulative funding through 2023. Staff do not agree that 2024 should be included in the calculation of funding since that period is not considered 'final'.
2. There must be two-sided risk and overfunding should have the same corridor as underfunding. The impact on consumers, as well as hospitals, must be considered in this methodology.
3. Any catch-up inflation will be applied to all hospitals equitably
4. Additional inflation values still need to be considered against required savings.

PAU:

Various Commissioners expressed concern that under the new methodology, select hospitals will receive a reward, i.e., a net increase to their revenue base, and it is unclear if the hospitals have done anything to warrant such a reward.

Almost all hospitals are in support of adjusting the PAU savings methodology to better reflect hospitals' ability to influence their rates while funding full inflation. They also support maintaining incentives for care transformation and seek clarification on certain aspects of the staff recommendation.

Medstar agrees with Staff's draft recommendation that an analysis be funded out of hospital rates and activities of current interventions to reduce PAU, an establishment of a single point of executive accountability for the PAU reduction strategy, and an agreement to engage in future PAU performance analyses. They further emphasize the need for additional analyses to acknowledge that not all PAU volume is avoidable.

Staff ran several analyses to see if there was a relationship between the rewards in the new PAU methodology and improvement in PAU performance over the course of the Model. While there were occurrences where hospitals have clearly demonstrated improvement and are able to get a reward (e.g., Garrett Regional Medical Center, MedStar St. Mary's, Chestertown Hospital), there was not a statistically

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significant relationship across the entire industry. Similarly, hospitals attainment performance at the start of the Model was not correlated with the current reward structure, suggesting that the proposed methodology captures both hospitals that had excellent performance at the start of the Model but have not necessarily decreased PAU (e.g., Holy Cross) and hospitals that have improved under the Model. Considering this finding, staff recommend amending the PAU Shared Savings policy to cap rewards for hospitals to 0%. In addition to a single point of accountability, hospitals would need to submit a plan for Commission approval to reduce PAU or maintain low rates of PAU.

Staff appreciate the hospital's support in amending the PAU policy and reviewing PAU performance over the course of the Model. If approved by the Commission, staff will utilize a portion of the set aside ($500k-$1M) to contract a vendor to support efforts to better understand and reduce PAU in Maryland.

Set Aside Funding:

Several hospitals express concerns about the estimate of set-aside funding, emphasizing the need for transparency and clear criteria for distribution.

- Support the commission's proposal but stress the importance of developing fair criteria for accessing these funds (UMMS & LifeBridge). One hospital specifically cited concerns over using cash-on-hand to determine financial hardship, stating it can be misleading when establishing need. (LifeBridge)
- Suggestion to prioritize funding for "High-Efficiency Outliers" before other requests. (Tidal Health)
- Opposed increasing set aside funding, citing concerns about creating incentives and impacting inflation funding for all hospitals. (MedStar)

Given the relatively strong support to establish criteria for distributing set aside funding, and yet no proposals for what the criteria should be (other than removal of a cash consideration), Staff is putting forward the proposal from the draft recommendation with one amendment. Staff also share MedStar's concerns that increasing the set aside could crowd out potential inflation for all hospitals and could increase the likelihood of a woodwork effect, i.e., hospitals request funding purely because there is available revenue. For these reasons, staff do not believe that the funding for the set aside should be larger and again note the need for sufficient gatekeeper tests to access funding for financial hardship, like what is utilized in the Integrated Efficiency policy.

1. The below criteria must be met to provide funding to hospitals with a clear financial hardship:

    - Below State Average Operating Margin, and Regulated Operating Margin decline of more than 3 percent, and Total Operating Margin decline of more than 1 percent.
    - Or 125 days cash on hand.
    - Or two consecutive years of negative Cash Flow from Operations (on the regulated entity).

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2. The Commission will create a process where the set aside is distributed through a competitive process
    - Twice per year (depending on funding availability) hospitals submit applications citing either relative efficiency performance or financial hardship and the details of their revenue request
    - Staff provide recommendations in subsequent meeting
    - Commissioners vote on requests
    - Hospital must submit a corrective action plan approved by their Board

Outpatient Oncology and Infusion Drugs:

Hospitals have seen a significant rise in pharmaceutical costs that exceed core inflation. There is concern about the differing treatment for Academic Medical Centers. Hospitals are requesting that there should be no distinction in inflation rates and that any substantial changes in inflation or cost increases should be thoroughly evaluated before being implemented long-term. The impact of this funding on non-academic hospital rates means that fewer hospitals can provide care to the community. Hospitals suggest that high-cost drug cases should be funded outside of the GBR and operated on a fee-for-service basis.

The distinction in inflation rates between Academic Medical Centers and other hospitals was based on a thorough evaluation of the data. Academic medical centers have experienced higher cost growth over recent years and the proposed differential inflation rates reflect that. It is also consistent with the guidelines established in prior years when Staff noted that differential inflation rates could be used if trends diverged between hospitals. Prior to this year the data had not indicated this adjustment. Staff agrees that a review of the policies related to high-cost drugs would be appropriate and plans to initiate a review during FY 2025.

Retained Revenue:

During the presentation of the Draft Recommendation of the Update Factor, Commissioners raised concerns regarding the funding of inflation on retained revenue. It was suggested that inflation should only be funded on the portion of revenue not related to retained revenue or scaled to accommodate retained revenue at the hospital.

Staff disagree with this idea. The GBR rewards hospitals by allowing them to retain revenue as volumes decline (at 50% VCF). This incentive is fundamental to the Model to ensure that there is funding available in hospitals to invest in population health, physicians and other opportunities that will improve the total cost of care in their service areas. The side effect of too much retained revenue is that a hospital may operate inefficiently, which is why the Integrated Efficiency Policy was created and approved by the Commission in April of 2021. This policy is the mechanism by which retained revenue should be addressed and have that revenue removed from the system. Removing retained revenue from all hospitals rather than just outliers, as currently outlined in the policy may disincentivize hospitals to manage total cost of care and invest in their service area.

Non-GBR Hospitals:

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Non-GBR hospitals should receive full inflation and an additional adjustment for underfunded inflation in FY 2025, equivalent to GBR hospitals. As downstream providers with low volumes still below CY 2019 levels, they struggle to maintain positive margins and required staffing.

HSCRC Staff agree to include the catch-up inflation value of 1.00 percent in the Final Recommendation. Volumes remain low compared to 2019 at the specialty hospitals, but demand remains high. Specialty hospitals experience the same inflationary pressures as acute hospitals. The cost pressures, specifically specialized staffing needs, make it difficult for these hospitals to fill vacancies and as a result are these hospitals utilizing agency staffing at higher levels. These hospitals represent an important component of the overall delivery system in Maryland and ensuring continued access to these services is crucial.

In addition to the 7 general comment areas, concerns were raised pertaining to Population Health Considerations. Commissioners expressed concerns that reducing the system-wide inflation reduction for PAU would reduce the incentive for hospitals to improve or sustain efforts to reduce PAU. CareFirst also indicated that an increased portion of the Update Factor should be directed to population health improvement efforts. As such, staff are considering a withhold of 0.19% of the Update Factor (equivalent to half of the proposed modification to the PAU reduction), which would be released to each hospital in the January rate orders once the following conditions are met:

1. A plan, subject to Commission approval, for population health improvement aligned with statewide priorities.
2. The withhold will be evaluated in future years if there is not demonstrated improvement in the proposed initiative.

Based on the Stakeholder comments above the following factors that are part of the Update Factor will be adjusted as follows

Adjustment for Inflation (3.24%): The inflation factor uses the gross blended statistic of 3.24 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2024 market basket growth of 3.30 percent with 8.80 percent of the capital growth index change of 2.60 percent. The adjustment for inflation includes 4.00 percent for wage and compensation.

Additional Inflations Support (1.00%) Staff recommend providing an additional 1.00 percent to account for historical underfunding of inflation. Staff are utilizing the RY 2014 to RY 2023 time for this review. The RY 2024 period has not been included in this review, as it still requires 4 more quarters of data to be deemed complete. Cumulative underfunding from RY 2014 through RY 2023 is 1.17 percent. Utilizing a 2019 baseline, the cumulative underfunding is 2.16 percent, which is largely driven by underfunding of 2.12 percent in RY 2022 and -0.98 percent in RY 2023. By way of comparison, the largest year for overfunding of inflation was RY 2016 when the Commission overfunded by 0.73 percent. Given the significant underfunding that has occurred in the last two fiscal years and because staff is advancing a methodology that in future years would formulaically reconcile inflation if there were a material difference between actual inflation and funded inflation, Staff propose providing 1.00 percent

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additional for catch up inflation in the RY 2025 recommendation. Staff note, however, that it is imperative that any additional inflation value be considered against required savings, both the Medicare TCOC savings test and the all-payer per capita growth test.

PAU Redistribution (0.02%): For RY 2025, Staff is proposing to continue utilizing the PAU Shared Savings program, as the policy 1) has successfully generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and 2) has recognized that hospitals in a fixed revenue model do not have the same opportunity to improve profitability by reducing avoidable utilization, i.e., the range in hospital revenue attributable to readmissions and avoidable admissions is large. However, Staff are concerned that the current construct of the program, which reduces inflation and population funding for readmissions and avoidable admissions in perpetuity to generate Model savings, is potentially problematic, because it may cause access issues for hospitals with low levels of potentially avoidable utilization. Thus, Staff are proposing to discontinue the inflation and population reduction through the PAU Shared Saving Program. The PAU value for RY 2025 is -0.38 percent. The proposed refinement to this methodology would be revenue-neutral to the State, and for this reason the value represented is -0.02 percent.

Staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

1. Provide all hospitals with gross inflation increase of 3.24 percent, with an additional 1.00 percent for additional revenue support based on historic underfunding of inflation.

2. Provide an overall increase of 4.80 percent for revenue (including a net increase to uncompensated care) and 4.53 percent per capita for hospitals under Global Budgets. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff are aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

3. Adoption of a catch-up inflation methodology to use in RY 26 and beyond. This methodology, outlined in this report, would include two-sided risk to ensure hospitals and consumers are equally considered, a 1.00 percent risk corridor to ensure that inflation reconciliations are only performed when there are material variances, and recognition that all additional inflation values will be considered against required savings.

4. Establishment of criteria for distribution of set-aside funding. Staff propose the following criteria must be met to provide funding to hospitals with a clear financial hardship: Below State Average Annual Operating Margin, Annual Regulated Operating Margin decline of more than 3 percent, and Annual Total Operating Margin decline of more than 1 percent; or 125 days cash on hand (actual or projected); or Two Consecutive Years of negative Cash Flow from Operations (on the regulated entity). The Commission will create a process where the set aside will be distributed

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through a competitive exercise and require a corrective action plan for improved financial operations.

5. Amend the PAU Shared Savings policy so that statewide impact is equal to -0.02 percent and then cap rewards for hospitals to 0.0 percent. To ensure there is no backsliding in statewide performance, an analysis will be funded out of hospital rates to assess current interventions to reduce PAU, each hospital will have to establish a single point of executive accountability for their PAU reduction strategy, and all hospitals must agree to engage in future PAU performance analyses.

6. To ensure continued focus on population health within the State and ensure Hospitals are fully engaged in population health efforts, Hospitals will be required to submit a population health improvement plan. The plan should, at a minimum, (1) identify at least 3 conditions driving avoidable utilization, readmissions, and/or cost within their hospital, (2) describe programs, initiatives, and interventions intended to addressing the conditions identified; (3) specify participation in statewide efforts to address core population health goals, such as reducing maternal mortality and overdose; (4) provide performance improvement indicators and outcomes for the identified conditions and programs, including, as appropriate, measures related to equity. Staff will convene a workgroup to refine this approach. Failure to submit a population health plan that successfully addresses the conditions outlined above and discussed in the workgroup, will result in a takeback of 0.19 percent of inflation removed in the January rate updates.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

1. Provide an overall update of 3.24 percent for inflation, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014.
2. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

Mr. Arin Foreman, Vice President, Deputy Chief of Staff CareFirst BlueCross BlueShield, stated CareFirst appreciated the engagement with HSCRC staff throughout this process. He supports the staff's methodology on the catch-up inflation is reasonable and fair. However, he disagreed with the current incremental funding level and recommended .17% for FY25.

Ms. Melony G. Griffith, President & CEO of the Maryland Hospital Association, commented that MHA is sincerely appreciative of the thoughtful approach the HSCRC staff took to develop the recommendation for the annual update factor and MHA support the staff recommendation. However, she asked there be a modest adjustment to the underfunding of inflation post COVID.

Ms. Hanna Jacobs, VP/CFO, Frederick Memorial Hospital, commented that the hospital credit rating was downgraded by Fitch Rating due to the underfunding of infliction from -A to a BBB+.

Commissioner Johnson asked Ms. Jacobs, how should the Commissioners think about the over and under funding of hospitals operations?

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Ms. Jacobs responded that the hospital has scaled back their capital spending to make sure they have a strong balance sheet. They have decreased their capital spending that resulted in less update on their facilities.

Commissioner Johnson expressed concern with the change in starting the catch-up methodology in 2026 with a 1% corridor and not in 2025 that was originally proposed. He stated consistency of this policy would dedicate to start in 2025.

Mr. Pack responded that when there are data problems it should be corrected before starting a new methodology. He stated by starting in 2026, the hospital will be aware of the catch-up methodology policy.

Commissioner McCann stated hospitals that have been successful in reducing PAU have reduced over all volumes. She requested that the analysis should review both the overall volume reduction and the PAU reduction.

Chairman Sharfstein noted that in the context of the population health strategy is to prevent avoidable utilization, however, different hospitals have different opportunity.

Commissioner Kane asked what the intent of the set was aside at $33M regarding the high inflation cost.

Dr. Kromm noted hospitals that have financial hardship need some capacity to manage. However, the $33M is based on the historical trend.

Commissioner Kane expressed his concerns about the specialty hospitals volumes not being returned and the hospitals are stating there is a need for behavior health services.

Mr. Schmith responded that Staff have had conversations with one of the psych hospitals and was told one of the reasons they were having hardship was due to the high cost to add on additional staff that is why their volumes are down low than they were prior to the pandemic. That is why staff are recommending no offset for productivity.

Chairman Sharfstein noted that the low volumes are a question of supply and what is being discussed is having the ability to charge more to be able to hire more staff to generate the revenue to increase the supply of services. He stated this is a topic that needs to be discussed and the hospital should explain their issues and challenges.

Commissioner Johnson proposed an amendment to start the catch-up methodology in FY25 versus FY26. He made a motion and was seconded by Vice Chairman Antos to reduce the additional amount of the update factor from 1% to .17%. The motion failed to pass.

Vice Chairman Antos made a motion to accept the Staff recommendation and it was seconded by Commissioner Joshi. The motion passed with one no vote from Commissioner Johnson.

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ITEM VII.
HEARING AND MEETING SCHEDULE

July 10, 2024	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
August 14, 2024	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:45p.m.

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Closed Session Minutes
of the
Health Services Cost Review Commission
June 14, 2024

Chairman Sharfstein stated reasons for Commissioners to move into administrative session pursuant to 3-103, 3-104 and 3-305(b)(7) of the Authority General Provisions Articles for the purposes of discussing the administration of the Model, the TCOC Model Monitoring, the FY2024 Hospital unaudited Financial Performance and the Hospital Complaint Update. Upon motion made in public session, Chairman Sharfstein called for adjournment into closed session:

The Administrative Session was called to order by motion at **11: 05a.m**.

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

In attendance representing Staff were Jon Kromm, Jerry Schmith, Allan Pack, William Henderson, Geoff Dougherty, Alyson Schuster, Cait Cooksey, Claudine Williams, Bob Gallion, Erin Schurmann, Christa Speicher, Megan Renfrew and William Hoff.

Also attending was Assistant Attorney General Stan Lustman.

Item One

Alyson Schuster, Deputy Director, Quality Methodologies, updated the Commission and the Commission discussed the CY23 Update on Quality Performance of Hospital wide Medicare Readmission and Observation status of Maryland vs the Nation.

Item Two

Mr. Henderson updated the Commission, and the Commission discussed the TCOC Model monitoring and the on FY24 Hospital Unaudited Financial Performance

Item Three

Dr. Kromm, Executive Director, updated the Commission and the Commission discussed the staff investigation into a complaint made regarding a hospital's practices.

The Closed Session was adjourned at **12:45 p.m.**

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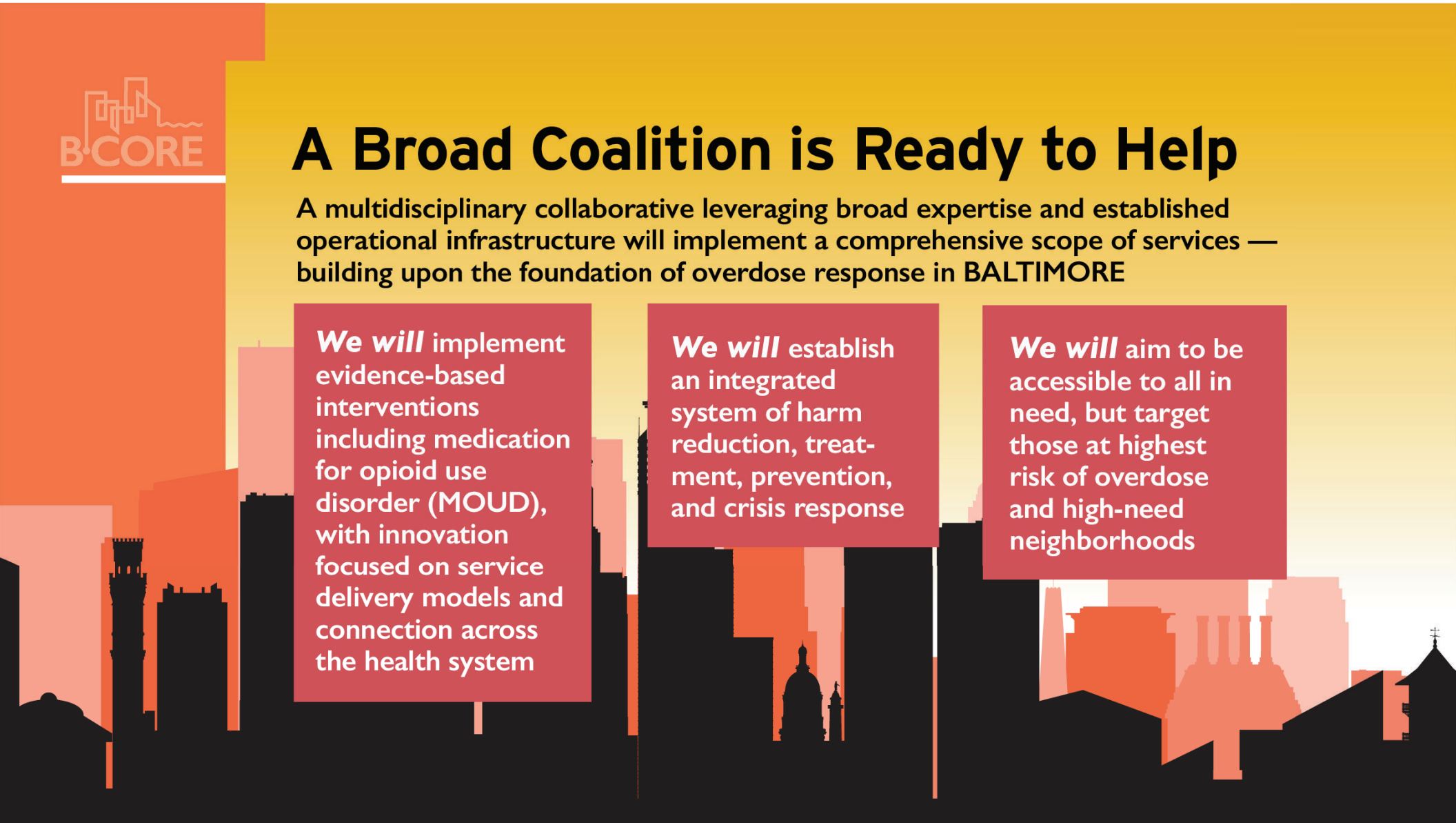
B!CORE
Baltimore
Comprehensive
Overdose
Response to
End the Epidemic

How HEROES Creates Incentives

Pick Targets	Identify Outcomes Buyers	Raise Funding	Help People	Get Rewarded
				
Health Accelerator selects an outcome and target geographic area.	**Health Accelerator secures promise of *future* payment for successful health outcomes from ARPA-H and Outcome Buyers (e.g., employers, health plans).**	**Health Accelerator raises money to be used in prevention-oriented care to fund new technologies and operations.**	**Health Accelerator deploys innovative, evidence-based technologies at scale to improve health outcomes in the specified geographic area.**	**If outcome achieved, ARPA-H and Outcome Buyers reward Health Accelerator.**
Population Benefit Over Three Years: At least $60M of value	**Possible Incentive:** Outcome buyers contribute $45M ($15M ARPA-H plus 2:1 match)	**Build Capacity:** Create tech and a community that is engaged in preventive care	**Public Health Win:** Outcomes, like heart attack risk or opioid overdoses, improve	**Fiscal Win-Win:** Outcome buyers create $60M value for $45M


B·CORE
A Broad Coalition is Ready to Help
A multidisciplinary collaborative leveraging broad expertise and established operational infrastructure will implement a comprehensive scope of services — building upon the foundation of overdose response in BALTIMORE
We will implement evidence-based interventions including medication for opioid use disorder (MOUD), with innovation focused on service delivery models and connection across the health system
We will establish an integrated system of harm reduction, treat-ment, prevention, and crisis response
We will aim to be accessible to all in need, but target those at highest risk of overdose and high-need neighborhoods

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KEY CONTRIBUTORS

University of Maryland, Baltimore

University of Maryland, Baltimore County

Johns Hopkins University

University of Maryland Medical System

Baltimore City Fire Department

Maryland Institute for Emergency Medical Services Systems

Mosaic Community Services

City of Refuge

Charm City Care Connection

Maryland Office of Overdose Response

Behavioral Health System Baltimore

Baltimore City Health Department

Baltimore VA Medical Center

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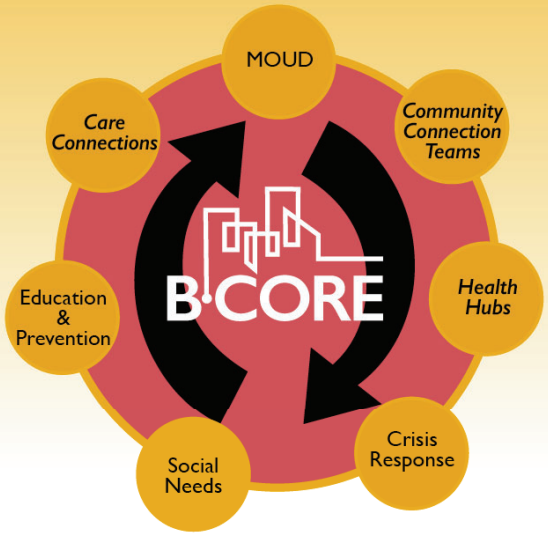
University of Maryland, Baltimore County

Adopt a Comprehensive Strategy



Expand access to integrated MOUD treatment

Develop multidisciplinary *Community Connection Teams*

Establish integrated *Health Hubs* in areas of high need

Tailor crisis response

Bolster support for programs addressing health related social needs

Create a unified community health-enabling software solution to enhance *Care Connections*

What is Needed for BCORE to Succeed

- [x] **Broad coalition**
- [x] **Great plan**
- [ ] **Up front funding**
- [ ] **Sustainable funding if successful through outcome buyers**

More About Outcome Buyers

If successful at **reducing EMS calls for opioid overdose by 10%** over three years, ARPA-H will provide up to $15 million

Other outcome buyers are needed to pay for success for sustainability, ***goal of 2:1 match***

Securing outcome buyer arrangements will be key to getting selected

Looking for systems that stand to benefit financially from this work who are willing to **work with us** to define outcome buying arrangement for our application

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Overdose
Response to
End the Epidemic

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Easton Capital Recommendation

July 10, 2024

Executive Overview

1. Funding Request
2. Consideration of Capital policy modifications
3. Stakeholder Comments
4. Linkage of funding request tied to
    a. TCOC accountability and
    b. Population health investments

Background

- As part of University of Maryland Shore Regional Health's (UM SRH) effort to rationalize acute care delivery on the Eastern Shore, they have requested $18.6 million for a $539 million capital replacement project at Easton Hospital
  - Will offset 42% of the estimated depreciation and interest costs
  - Additional support is derived from $39M in cash, $50 million in philanthropy, $100 million in state funding, and approximately $18 million in interest income.
- While this project is relatively expensive, it does represent a wholesale replacement of a facility that
  - Was largely constructed over 50 plus years ago (between 1955 and 1975)
  - Has cost premiums associated with "ruralness" and post COVID inflation
  - Right sizes the physical capacity of Easton Hospital, the final remaining general acute care facility in the mid-shore

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***

Breakdown of Request

- The capital funding request of $18.6M consists of 3 components:

Item	Incremental Funding ($Millions)	Cumulative Funding ($Millions)	Notes
Capital Policy Output	$3.8	$3.8	Represents the value that UM SRH at Easton is entitled to under the existing capital policy
Capital Policy Output with New Methodology Considerations	$8.1	$11.9	UM SRH at Easton has requested that cost premiums related to the "ruralness" of the project (e.g., installation of utilities on farmland) and quantifiable inflation related to COVID be passed through the capital policy without qualification
Additional Funding Request	$6.7	$18.6	Represents an amount equivalent to the restoration of savings that was derived from converting UM SRH at Dorchester from an acute care facility to a Free Standing Medical Center

New Methodology Consideration: Ruralness

- UM SRH noted in its application that 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:
  - Last major rural capital project in Maryland, Western Maryland Hospital Center, had first year depreciation and interest of 19.49 percent versus a statewide average of 8.36 percent.
  - Last five major hospital capital projects approved through the CON process, only one of them did MHCC identify as having building and site multipliers
- In light of this cost premium, UM SRH requests that the that $40.1 million in unique cost multipliers be passed through the 50/50 blend in the Step 2 of the capital methodology without qualification

Site Preparation & Building Costs Premiums in Recent Major Capital Projects MHCC-Approved CONs

		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%

New Methodology Consideration: Inflation

- UM SRH also noted in its application that supply chain and inflationary issues have increased the magnitude of cost required to undertake this capital project
  - Total project size increased by $190M (54%) from 2016 to 2023
- Inflationary cost increases are evident given staff's analysis of Easton's 2016 and 2023 CON
  - New construction costs increased by $91M (49%); $63M (69%) of the cost increase was attributable to inflation
  - Producer Price Index by Commodity Construction (PPIC) indicates that over 7 years the price per square foot increased by 6.53% per year (56% total); actual CON increased by 3.74% per year (29% total) - well above inflation for capital in Update Factor
- In light of this cost premium, UM SRH requested that $35.3 million of the $63.1 million HSCRC has determined is attributable to recent inflationary be passed through the 50/50 blend in the Step 2 of the capital methodology without qualification

Stakeholder Comments

- 4 comment letters were submitted
  - University of Maryland Medical System (UMMS)
  - Maryland Hospital Association (MHA)
  - TidalHealth (Tidal)
  - MedChi
- Comments focused on three principal areas
  - Proposed Modifications to Capital Policy
  - Need for More Extensive Review of Capital Policy
  - Full Rate Application in lieu of a Revision to the Capital Policy

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.

HSCRC Staff Responses to Comment Letters

- 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 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 poli

HSCRC Responses to Comment Letters cont.

- 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 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.

Recommendation on New Methodology Considerations

- 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.
- The capital policy never contemplated:
  - Unique rural cost multipliers that would not be accounted for in statewide average capital cost share statistics and/or
  - 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
  - Staff assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

Additional 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 redirecting the resulting GBR savings to the UM SMC at Easton capital project
- 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 16% of the capital costs of the UM SMC at Easton replacement and relocation project

Details of Additional Funding Request

- Potential evaluation
  - Two-sided risk structure; Range of potential funding outcomes: $0 - $6.70M
  - Geographic/community-based care CTI thematic area
- Expected outcome
  - Geographic TCOC improvement vs. agreed upon base period for 5-county Mid-Shore
  - 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
  - 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.
  - 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.
  - 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).

Details of Additional Funding Request cont.

- Risk reduction provision
  - UM SRH will have an opportunity to reduce half of the TCOC risk if two conditions are met:
    - Investments in enhanced access (UMMS is indicating that at least $3.5 million will be spent annually)
    - Progress on key community health improvement indicators are met
      - Examples:
        1. Lives touched/encounters in non-hospital setting
        2. Number connected to services addressing social needs
        3. Number connected to outreach programs
        4. Emergency department admissions per capita
        5. Avoidable admissions per capita
        6. Readmissions performance at SRH hospitals
- Staff recommend that the Commission approve the additional $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.

Final Recommendations

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.
    a. 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 provide funding equivalent 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.
    a. 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.
    b. The final contract will be subject to Commission approval.

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

* * * * * * * * * * * * *

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

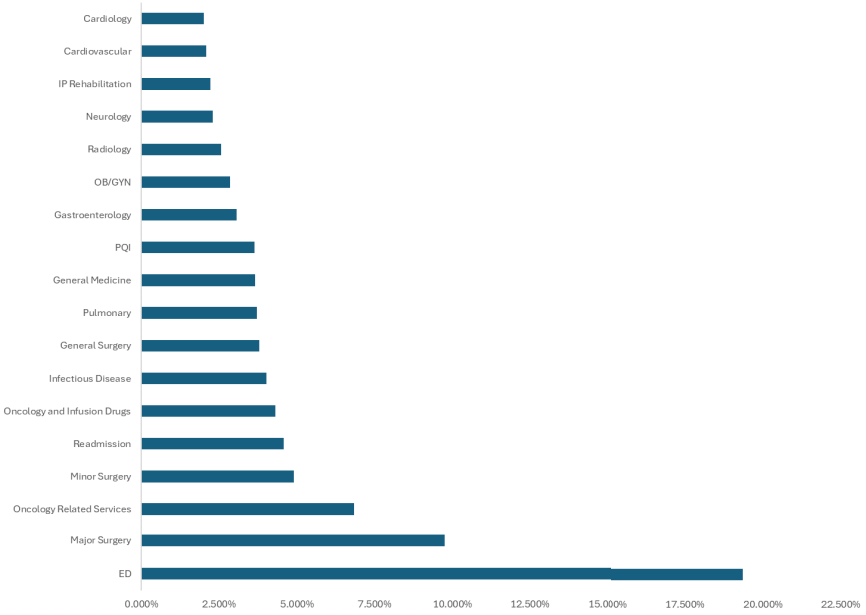
[2] See Appendix A for UM SMC at Easton Facility by Year of Construction

[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

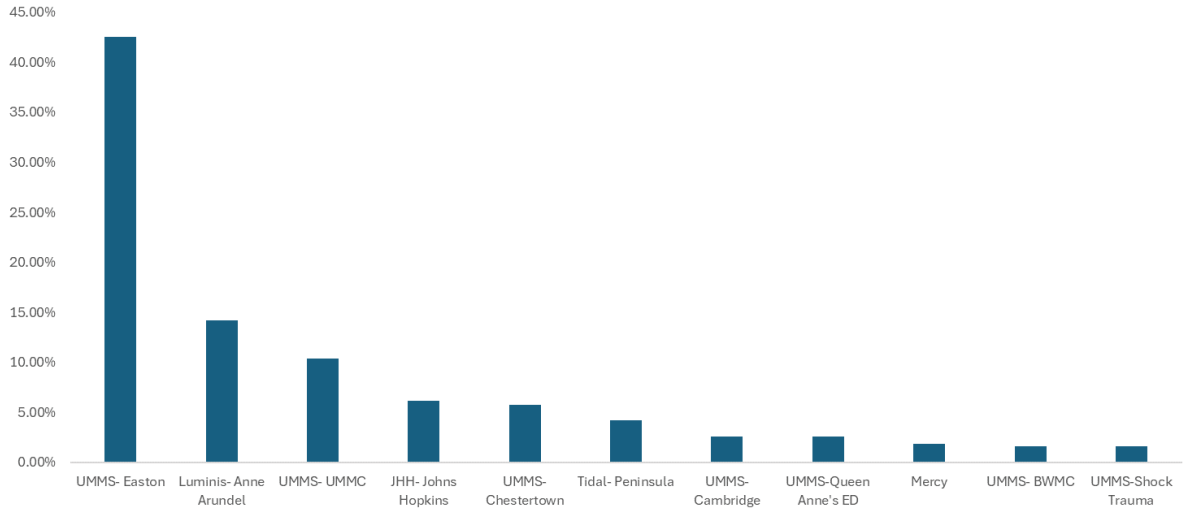
UM Shore Regional Health (UM SRH) is a regional, not-for-profit, healthcare network formed on July 1, 2013, through the consolidation of two UMMS partner entities, the Shore Health System ("UM SHS", comprised of UM SMC at Easton, its two Freestanding Medical Facilities, or "FMFs" at Cambridge and Queen 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)



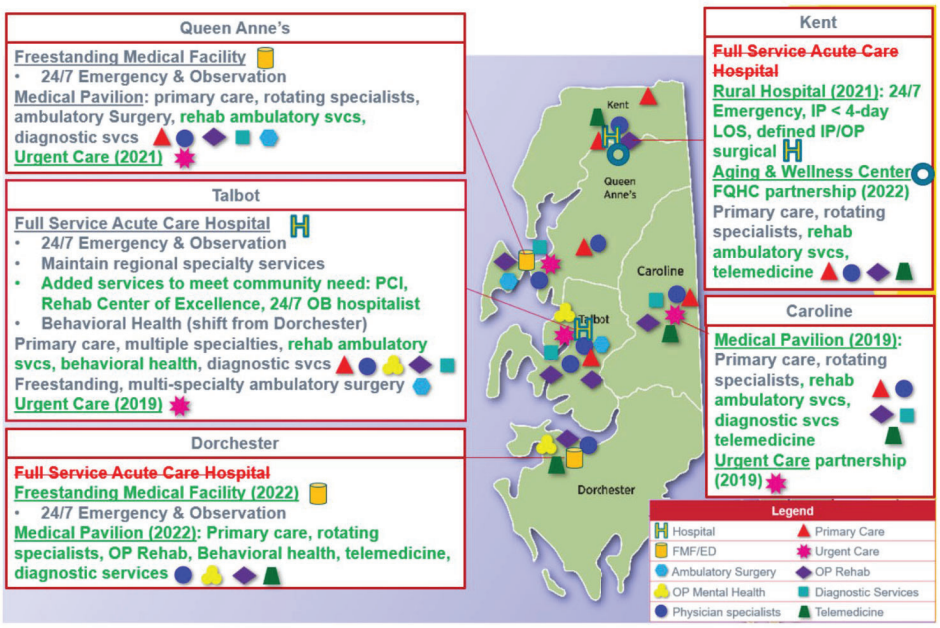
[4] Share is calculated using Commission's casemix adjusted measure of inpatient and outpatient services, equivalent casemix adjusted discharges (ECMADS). UM SHS' share of unadjusted discharges and outpatient visits in the five upper shore counties is significantly higher (71 percent in Fiscal Year 2023). 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

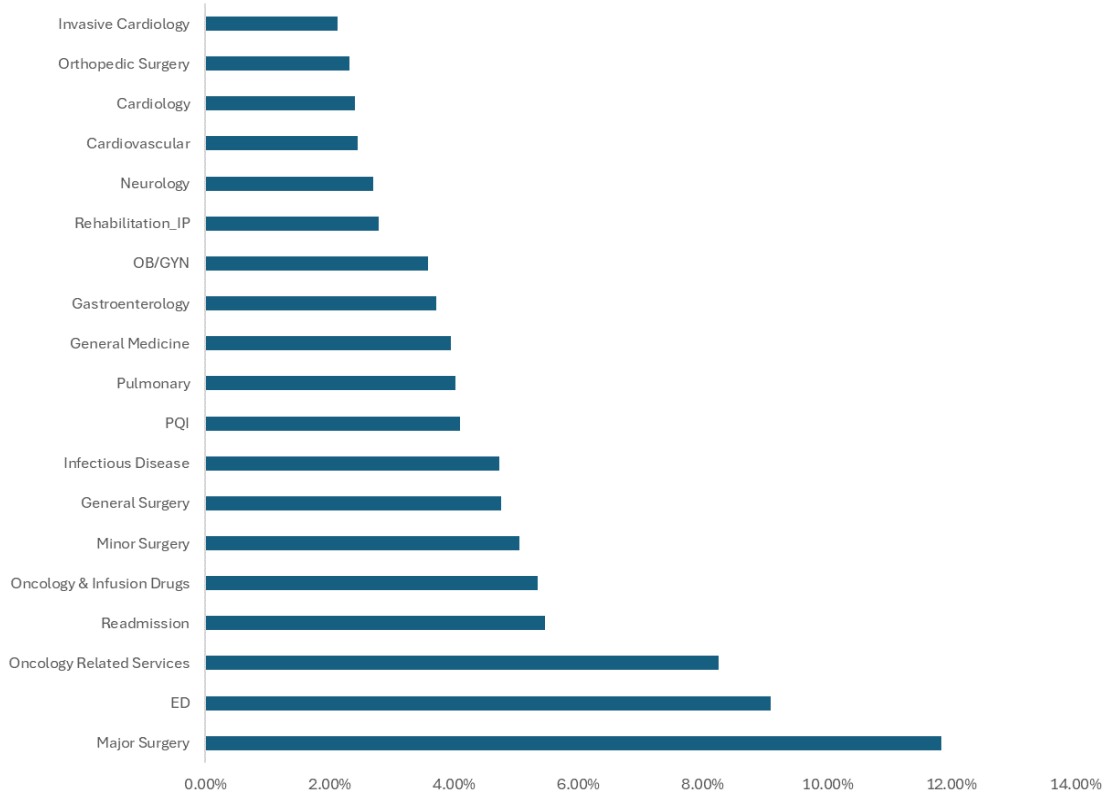
According to the Hospital, because of this redesign UM SRH has meaningfully impacted avoidable hospital utilization since Calendar Year 2016, (all numbers exclude COVID-impacted time periods of Calendar Years 2020/2021):

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%

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%

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%

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:

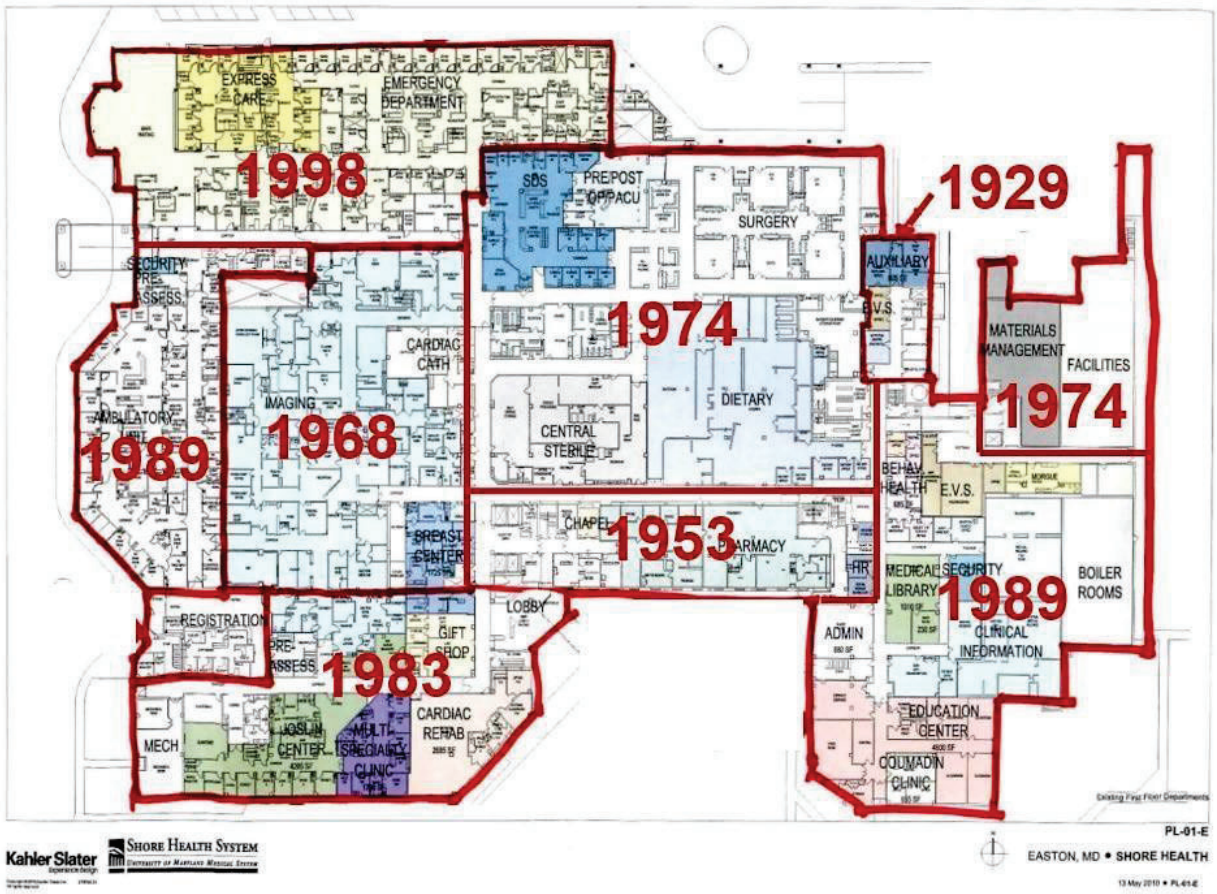
1) All exclusions and multipliers that are approved as part of the total capital project through the CON process should be passed through the capital policy without qualification and staff should assess the applicability of statewide average depreciation and interest statistics to specific requests and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

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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

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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

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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:	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.

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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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Alternative Method of Rate Determination

Johns Hopkins Health System

Request for Extension

July 10, 2024

Johns Hopkins Health System- Request for Extension

- On February 9, 2024 staff approved a 3-month extension of the alternative rate arrangement between Johns Hopkins Health System (JHHS) and Cigna Health Corporation (Cigna), Proceeding 2618A.
- On June 12, 2024 JHHS requested the Commission extend the rate arrangement an additional two months to complete contract negotiations with Cigna.
- Staff's review of historical data has shown rate agreement has been favorable.
- Staff recommends the 2-month extension be granted contingent upon completion of negotiations by August 31, 2024. If negotiations are not completed by this date, staff recommends that no more services be provided under arrangement until a new application is submitted.

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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.

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Emergency Department Initiatives Update

July Commission Meeting

Today's Presentation

- Emergency Department Wait Time Reduction Commission
- EDDIE Updates
- QBR ED-1 Subgroup Incentive Development
- HSCRC staff priorities and next steps

Establishment of Maryland ED Wait Time Reduction Commission

Bill went into effect July 1, 2024, and terminates June 30, 2027

Purpose: To address factors throughout the health care system that contribute to increased Emergency Department wait times

Chairs: Secretary of Health and Executive Director of HSCRC

Appointed Members:

- ❑ Executive Director of MIEMSS
- ❑ Executive Director of MHCC
- ❑ 2 Indiv. with operation experience in an emergency department, including 1 physician
- ❑ 1 Indiv with professional experience in an ED, who is not a physician or APP
- ❑ 1 representative from local EMS
- ❑ 1 representative from a Managed Care Plan with experience in Case Management
- ❑ 1 representative of Advanced Primary Care Practice
- ❑ 1 representative from MHA
- ❑ 1 representative from a patient advocacy organization
- ❑ 1 representative of a behavioral health provider

ED Wait Time Reduction Commission

***Purpose*:** To address factors throughout the health care system that contribute to increased emergency department wait times

Specific focus:

DEVELOP STRATEGIES AND INITIATIVES TO RECOMMEND TO STATE AND LOCAL AGENCIES, HOSPITALS, AND HEALTH CARE PROVIDERS TO REDUCE EMERGENCY DEPARTMENT WAIT TIMES, INCLUDING INITIATIVES THAT:

- *ENSURE THAT PATIENTS ARE SEEN IN THE MOST APPROPRIATE SETTING TO REDUCE UNNECESSARY USE OF EMERGENCY DEPARTMENTS*
- *IMPROVE HOSPITAL EFFICIENCY BY INCREASING EMERGENCY DEPARTMENT AND INPATIENT THROUGHPUT*
- *IMPROVE POSTDISCHARGE RESOURCES TO FACILITATE TIMELY EMERGENCY DEPARTMENT AND INPATIENT DISCHARGES*
- *IDENTIFY AND RECOMMEND IMPROVEMENTS FOR THE COLLECTION AND SUBMISSION OF DATA THAT IS NECESSARY TO MONITOR AND REDUCE ED WAIT TIMES*
- *FACILITATE THE SHARING OF BEST PRACTICES FOR REDUCING EMERGENCY DEPARTMENT WAIT TIMES*

Annual Legislative Reports Due

11/1/2025
11/1/2026

ED Wait Time Reduction Commission Application

Statewide and Hospital Interventions to Impact ED LOS

State-Driven

ED Wait Time Reduction Commission: Collaborate on behavioral health, post-acute, and primary care.

Maryland Primary Care Program

Maryland Episode Quality Improvement Program

QBR Payment Policy: ED Length of Stay

EDDIE Public Reporting & Quality Improvement

ED "Best Practices" incentive

ED Potentially Avoidable Utilization

IP PAU and other programs to optimize high value care

Hospital-Driven

Pre-hospital	Intrahospital	Post-hospital
Reducing the number of people who need the ED	Improving throughput within the hospital	Improving the hospital discharge process and post-ED community resources

maryland health services cost review commission

Draft staffing plan, subject to change

Maryland ED Wait Time Reduction Commission

Co-Chairs
Laura Herrera Scott, MDH Secretary
Jon Kromm, HSCRC Executive Director

Deb Rivkin
Megan Renfrew
Legislative Liaisons and Management

Tina Simmons
Project Manager

Lynne Diven
Project Coordinator

Geoff Dougherty
State Best Practices Implementation and Analytics Lead

Ose Emasealu
Analyst

Alyson Schuster
Hospital Best Practices Incentive and Reporting Lead

Damaria Smith
Analyst

Shared Analytics and Reporting

State Best Practices Implementation

Objective: Assess MHA taskforce recommendations and develop an accountability plan to implement the most promising recommendations.

Process:
- Conduct expert interviews
- Convene advisory group to advise on measures, data collection, and incentive structure
- Develop policy as needed for legislative and HSCRC consideration

Hospital Best Practices Incentive

Objective: Develop a hospital pay-for-performance program (1% inpatient revenue at-risk) with 3-5 process, structural, and/or outcome measures that address systematically longer ED length of stay in Maryland.

Process:
- Conduct expert interviews
- Convene advisory group to advise on measures, data collection, and incentive structure
- Develop policy for HSCRC Commission vote for CY 2025 (draft October/final December)

EDDIE Update

June Data 2024 Reporting

Monthly, public reporting of three measures:

- ED1-like measure: ED arrival to inpatient admission time for all admitted patients
- OP18-like measure: ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS): Time from arrival at ED to transfer of patient care from EMS to the hospital

Data received for 43 out of 44 hospitals

- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change

Graphs:

- Starting with February data, CRISP automated several new types of graphs/charts to illustrate EDDIE data using Tableau.
- Rolling median (June 2023-Latest Month) and change from June 2023/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

ED Length of Stay and EMS Turnaround Data

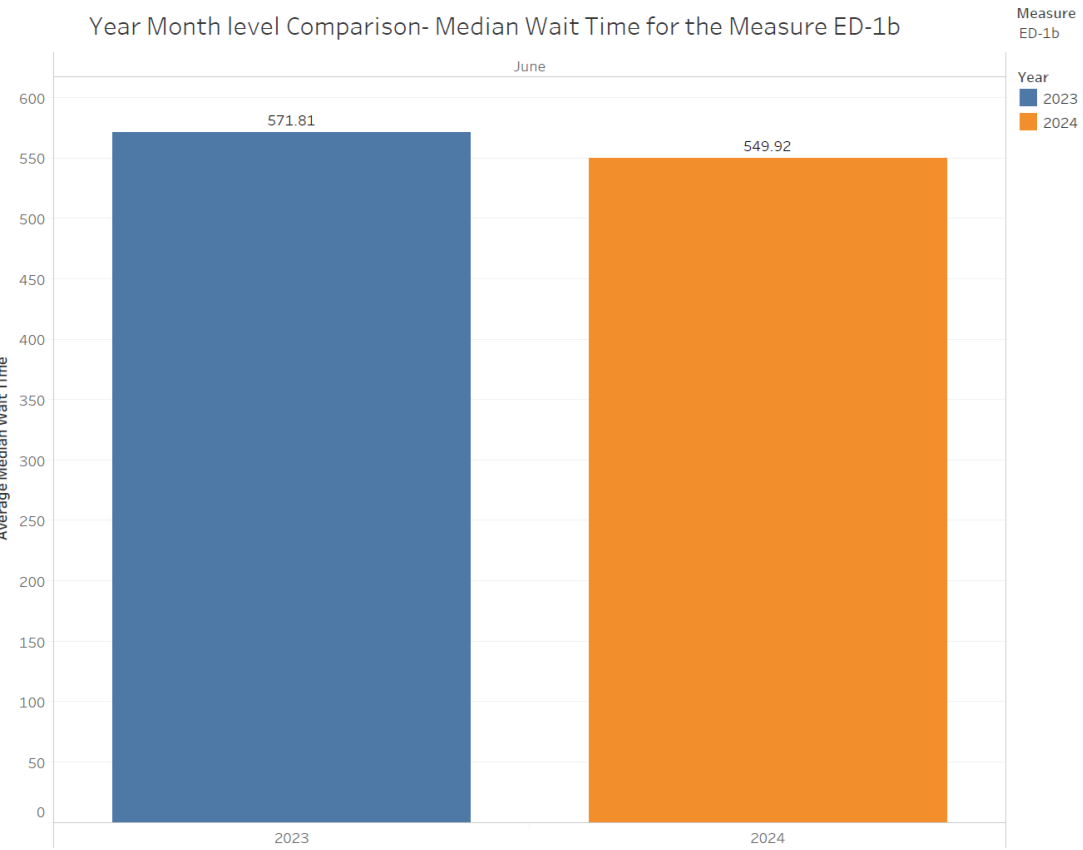
- Monthly, unaudited data on ED length of stay for June 2024 was received from 43 out of 44 hospitals (IP and OP data).
- There was a decrease for ED1a, ED1b, and ED1c in Median Wait Times in June compared to May.
    - June Average Median Wait Time:

ED1a: 539.2 minutes **ED1b: 549.9 minutes minutes** **ED1c: 764.1**

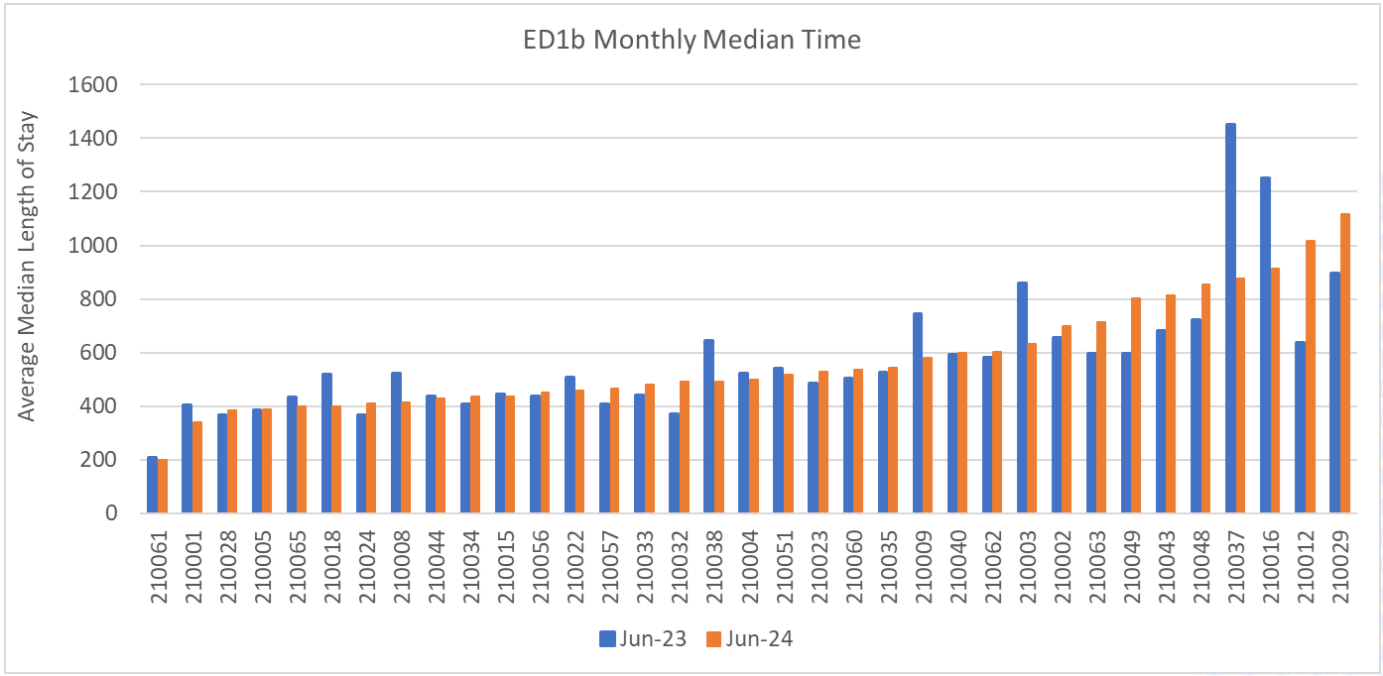
    - These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month) and the data have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital.
- EMS turnaround time data shows minimal net movement of hospitals across categories for June 2024, with four hospitals improving in performance and five hospitals declining in performance

See Appendix for graphs and data for all measures

June 2023 vs. June 2024



21 out of 40 hospitals showed a decrease June 2024 compared to June 2023



EDDIE Data Driven Performance Improvement Actions

- ❑ Preliminary Data Reviewed; Hospitals with the highest ED LOS consistently were identified.
- ❑ Those hospitals received an email requesting submission of high-level performance improvement plans for internal process improvement enhancements focused on ED LOS and throughput initiatives.
- ❑ These performance improvement plans focus specifically on improvement opportunities within the hospital's span of control, and not barriers outside of their control (e.g., behavioral health provider availability).
- ❑ Performance Improvement plans were received from all 7 hospitals
- ❑ Next steps include collaborative review of the data and performance improvement plans with these hospitals, as well as collaboration with all hospitals as the ED Best Practices Advisory Subgroup is established.

ED LOS Performance Improvement Plan Responses

- ❑ Several innovative initiatives presented that could potentially be integrated into the ED Best Practices Advisory Subgroup
- ❑ As expected, most initiatives are focused on intrahospital processes and workflow improvements
- ❑ The majority of intrahospital initiatives focus on improving hospital throughput (discharge process, handoff tools, rounding process and time, discharge lounges, case management workflow, etc.)
- ❑ Several pre and post hospital initiatives focused on primary care and SDOH wrap around services were highlighted
- ❑ Understanding specifically how these initiatives directly impact ED LOS and ED Utilization would be valuable in the next level of review

QBR ED-1 Incentive Development

Subgroup Update

QBR ED LOS Development

Subgroup 1: Data Collection

- Workgroup concluded in May
- Memo with Data Submission Requirements sent to Hospitals June 5th.
- CY2023 and CY2024 data submission window 7/16-8/1.
- Staff have been meeting with hospitals who have questions or concerns; based on meetings, at least one system is asking for an extension until late August.

Subgroup 2: Measure and Incentive Methodology

- Two meetings have been held with Subgroup 2.
- Purpose of today's presentation is to update Commissioner's and get on input on:
  - Measure
  - Improvement targets and timeframe
  - Risk-adjustment

ED LOS Measure Decision Points

Decision	HSCRC Suggestion for QBR Measure
Inpatient vs. Outpatient ED LOS	Focus on ED LOS for **Admitted** patients, monitor ED LOS for discharged patients
Measure definition	ED arrival to the time that patient **physically** leaves the ED
Measure Stata (i.e., all, non-psych, psych)	Initially focus on Non-Psychiatric patients, monitor ED LOS for psychiatric patients
Inclusion of Observation	Include ED observation and exclude Hospital observation
Other Measure Exclusions	Pediatrics? Deaths? Left AMA? IP LOS > 120 days? *These decisions can be made after collection of data for all patients. Criteria for these decisions might include populations that are statistically significantly different or clinical/policy reasons.*

Statewide Improvement Target

- Calculate gap between MD and Nation in CY 2018 for ED1b
- Calculate difference between Maryland and Nation on most recent outpatient ED LOS (OP18b)
- Calculate difference between most recent OP-18b data and 2019 (pre-pandemic) to understand Statewide change in performance
- Calculate new statewide rate if all Maryland hospitals performed at the current statewide average/median. (EDDIE data)
  - Additional scenarios tested such as all hospitals having small improvement and capping improvement for hospitals that are much higher than statewide average
- Translate EDDIE Improvement targets to Statewide goal
- Reference improvements cited in literature

Improvement Scenario Results

#	Scenario	Percent Improvement
1	Using ED1b from 2018 CMS Care Compare, calculate the difference between MD and the nation.	-32%
2	Using most recent OP18b data, calculate difference between MD and the nation.	-55%
3	Using OP18b, calculate difference between latest data and 2019 (pre-pandemic)	-23%
4	All Hospitals Above Statewide Average Improve to Statewide Average, all other hospitals have no change	-13%
5	All Hospitals Above Statewide Median Improve to Statewide Median, all other hospitals have no change	-16%
6	All Hospitals worse than Statewide Median Improve to Statewide Median (minimum improvement 5%, max improvement capped at 30%), and all Hospitals Below Statewide Median Improve by 5 percent.	-15%

HSCRC staff recommend statewide goal of 30% for ED LOS for admitted patients.

For hospital payment policy, need to translate statewide improvement target to improvement range.

Attainment & Risk-Adjustment

- Staff concur that risk-adjustment for factors outside of hospitals control would be appropriate for attainment.
  - Staff propose adding attainment in future years as better data on occupancy.
- Staff believe for improvement, risk-adjustment would only be needed if there was significant change from 2023 to performance year, and that risk-adjustment for factors highly correlated with ED LOS may reduce improvements. The impact is currently being evaluated.
  - Stakeholders remain concerned that for improvement, risk-adjustment is important.
- Stakeholder suggestions for factors to risk-adjust include:
  - Average case-mix of hospitals
  - Percent discharged to SNF
  - Occupancy
  - Hospital Length of Stay

Multi-Year Incentive Policy for Input

	RY26/CY24	RY27/CY25	RY28/CY26 (AHEAD) and beyond
Measure	ED LOS non-psych admitted patients	ED LOS for non-psych admitted patients, Monitor ED LOS discharged patients	ED LOS for admitted patients (all?), Consider adding payment incentive for ED LOS for discharged patients
P4P Incentive	Improvement Only	Improvement Only, Develop and monitor Attainment with risk-adjustment	Better of Improvement and Attainment
Risk-Adjustment	No?	No?	Potentially
QBR Weight	10 percent	TBD	TBD
Improvement Goal range from 2023	5-10 percent	10-20 percent *Consider tiered or differential improvement goal by performance*	20-30 percent
Attainment Goal	NA	NA	TBD

Commissioners can vote to adjust/tier hospital improvement targets in Y2 & Y3 as appropriate based on updated benchmarking or progress on statewide initiatives.

HSCRC Commissioners vote on QBR policy each year in the late Fall.

HSCRC Staff Priorities/Next Steps

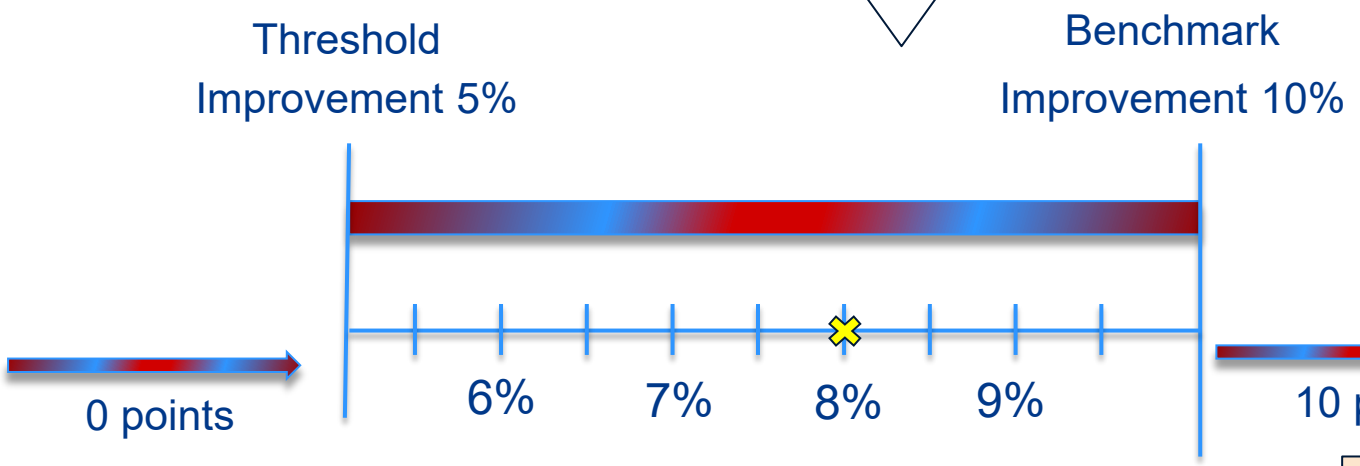
- ❑ Assist hospitals with Data Submission Requirements for ED LOS data elements
- ❑ Finalize QBR measure incentive development for CY 2024 (i.e., improvement target, risk-adjustment)
- ❑ Continue recruitment for ED Wait Time Reduction Commission members
- ❑ Finalize workplan and recruit members for Hospital Best Practices subgroup
- ❑ Continue with monthly EDDIE data collection and public reporting
- ❑ Review performance improvement initiatives with hospital that have highest and lowest ED LOS

Appendix

Example: QBR Payment Policy

Convert to 1st Year Hospital Improvement Goal of 5 to 10%

Statewide Goal 30 percent reduction in 3 years



Hospital Improvement = 8.0%

Calculates to a score of 6 out of 10

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

QBR Revenue Adjustment Scale

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

EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

Commission Reporting

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for June 2024 was received from 43 out of 44 hospitals (IP and OP data).
- There was a decrease in Median Wait Times in June compared to May.
    - June Average Median Wait Time:

ED1a: 539.2 minutes **ED1b: 549.9 minutes minutes** **ED1c: 764.1**

    - These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month) and the data have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital.
- EM turnaround time data shows minimal movement of hospitals across categories for June 2024, with four hospital improving in performance and three

See Appendix for graphs and data for all measures

June Data 2024 Reporting

Monthly, public reporting of three measures:

- ED1-like measure: ED arrival to inpatient admission time for all admitted patients
- OP18-like measure: ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS): Time from arrival at ED to transfer of patient care from EMS to the hospital

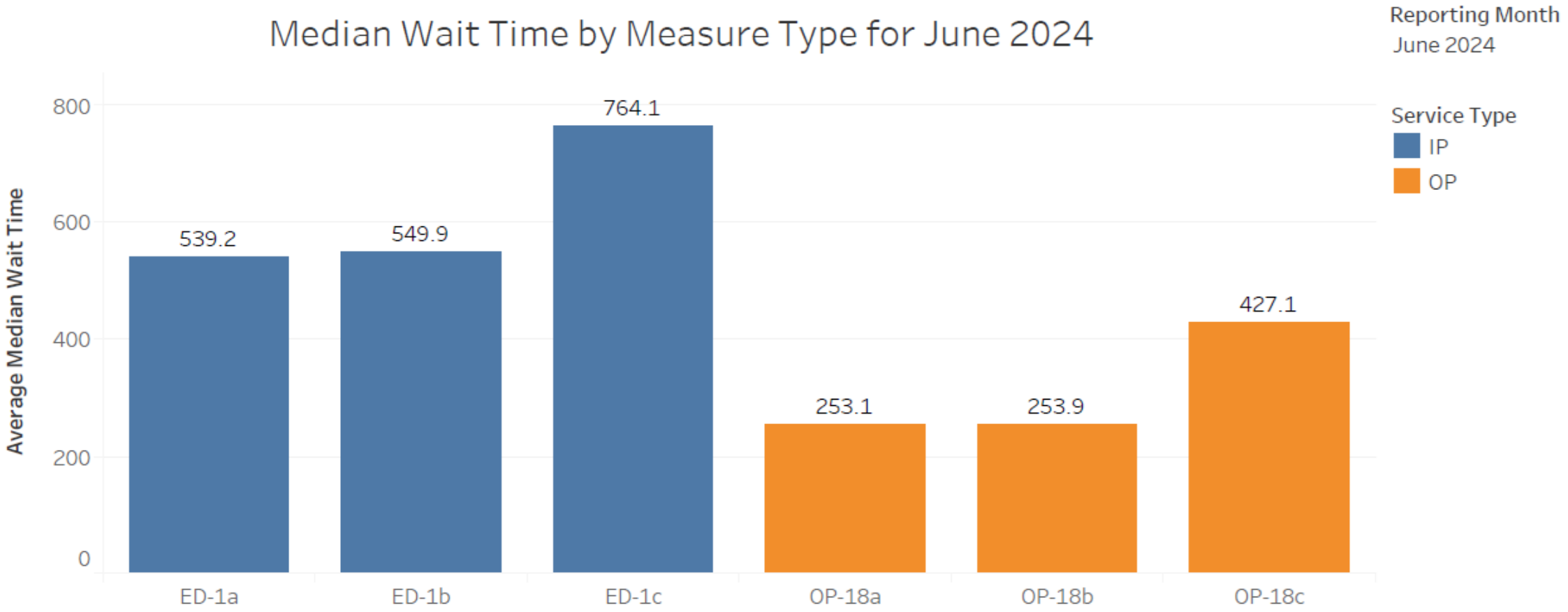
June data received for 43 out of 44 hospitals

- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change

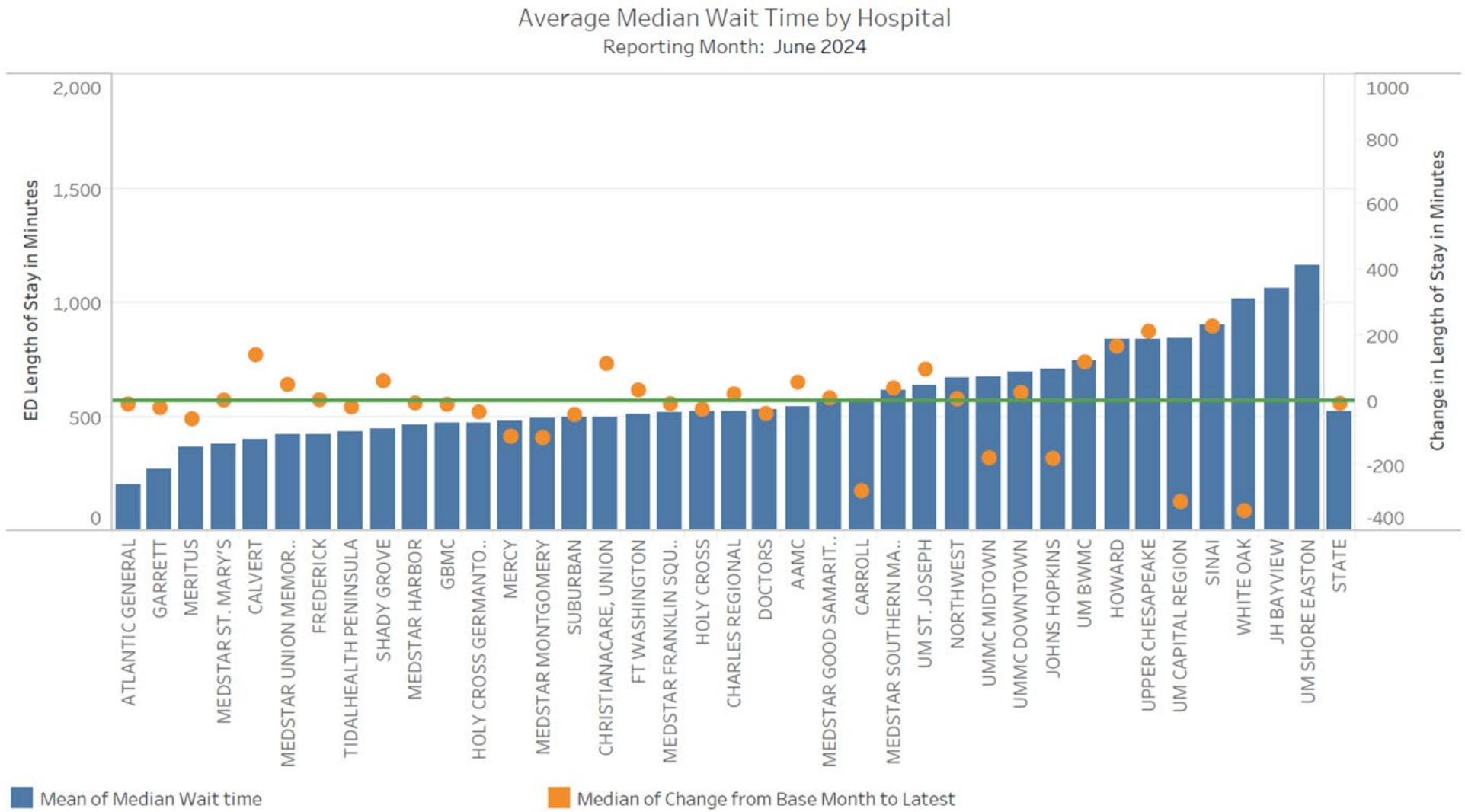
Graphs:

- Starting with February data, CRISP automated several new types of graphs/charts to illustrate EDDIE data using Tableau.
- Rolling median (June-Latest Month) and change from June/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

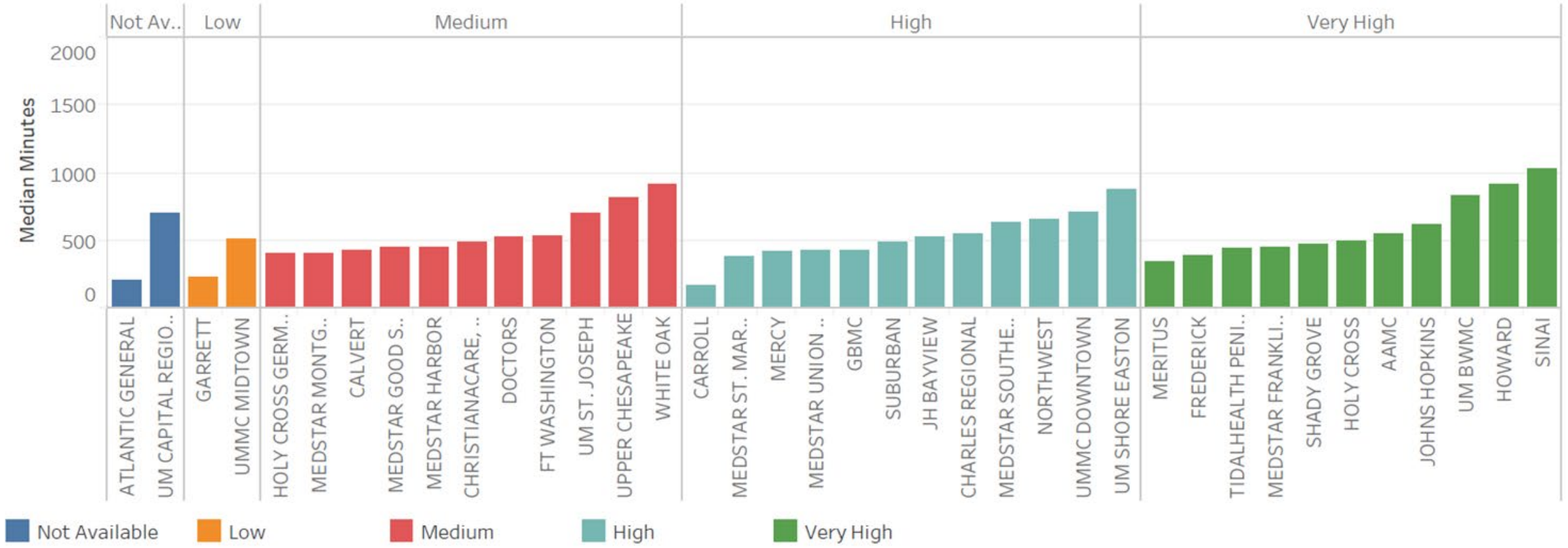
ED Median Wait Time



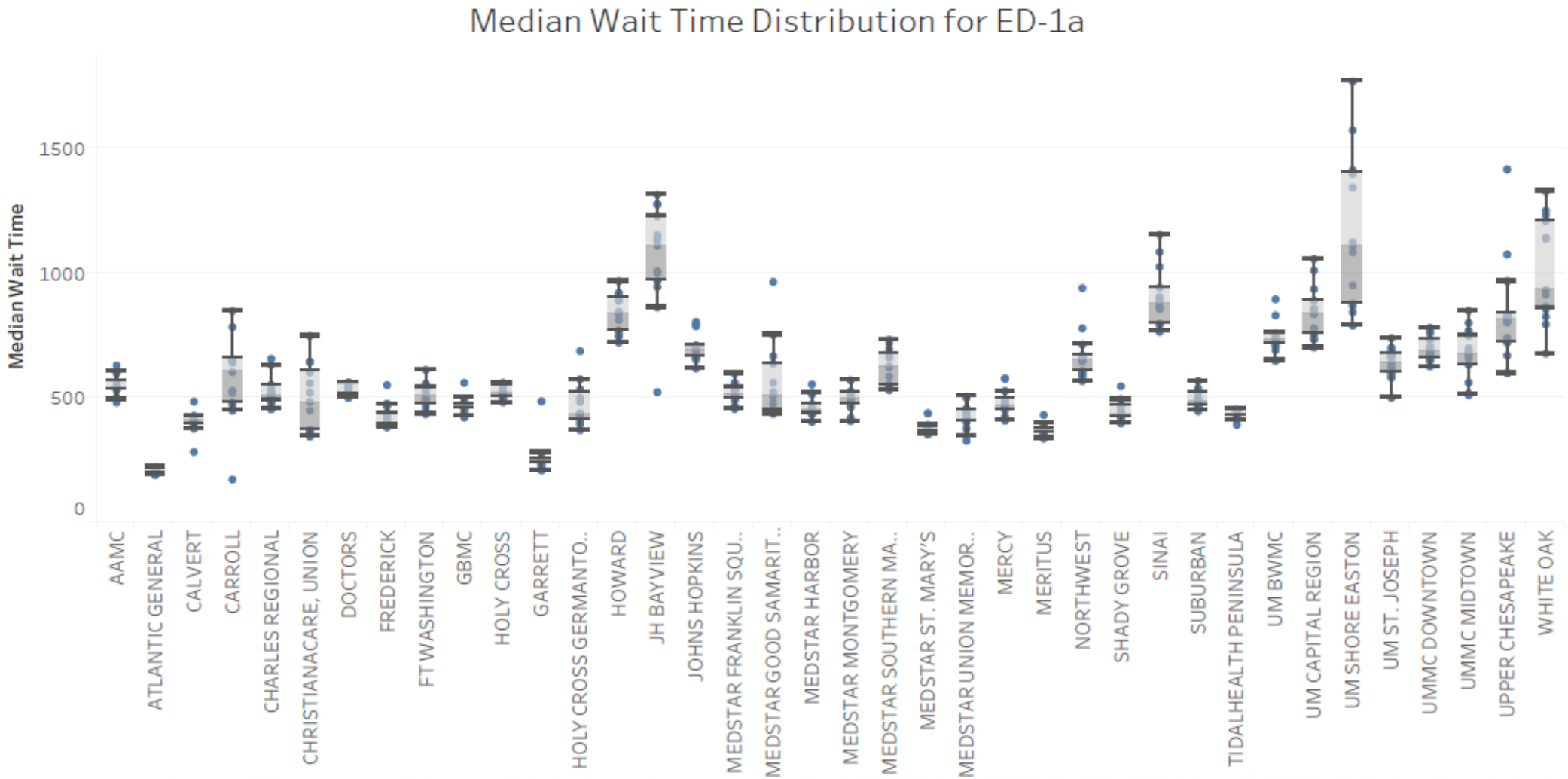
ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission Time
Latest Month Median By Volume--Latest Month



ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission

Heat Graph:
Colors are relative to June/first month reported.

Red = higher wait time
Green = lower wait time

Average Median Wait Time All Hospitals for ED-1a

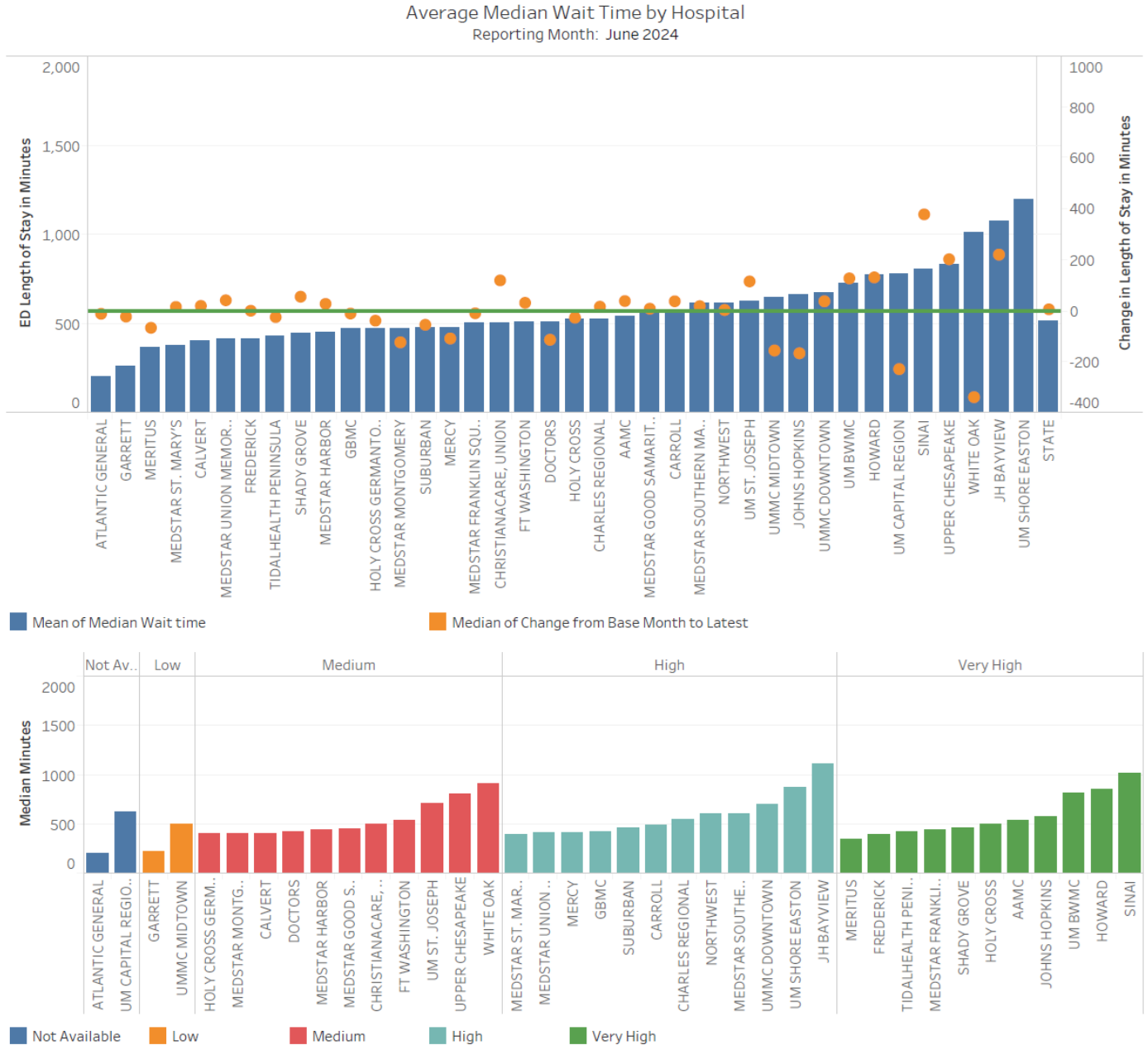
Measure
ED-1a

Change from Base
-610 819

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
AAMC	493	532	540	534	563	601	629	597	530	544	501	480	550
ASCENSION SAINT AGNES	601	564	545	574	641	576	755	772	684	694	742		
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191	199	199	200
CALVERT	282	383	411	425	405	409	484	426	408	402	375	389	423
CARROLL	447	527	481	640	602	470	654	848	656	649	783	519	171
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551	475	514	548
CHRISTIANACARE, UNION	369	351	370	343	360	448	641	601	645	557	748	520	483
DOCTORS	561	514	537	503	559	529	555	559	513	512	500	500	522
FREDERICK	392	388	382	395	416	432	464	550	476	381	386	402	395
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556	524	435	536
GARRETT			244		246	244	277	254	231	237	207	485	223
GBMC	439	467	456	475	482	420	476	559	497	474	454	457	428
HOLY CROSS	524	481	540	513	547	518	546	559	496	524		496	498
HOLY CROSS GERMANTO..	435	393	428	369	483	414	573	687	499	437		533	401
HOWARD	748	770	765	834	968	921	902	889	721	845	811	747	915
JH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001	1,110	862	522
JOHNS HOPKINS	794	680	652	697	704	708	661	804	786	710	663	666	617
MEDSTAR FRANKLIN SQUA..	463	467	493	492	532	509	560	596	539	512	537	532	454
MEDSTAR GOOD SAMARIT..	441	479	522	456	559	506	667	965	752	637	442	434	450
MEDSTAR HARBOR	458	553	474	518	513	402	441	457	436	437	432	434	451
MEDSTAR MONTGOMERY	518	461	486	495	525	497	505	569	518	480	471	419	405
MEDSTAR SOUTHERN MA..	585	544	539	530	542	554	660	733	695	673	719	622	624
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372	390	367	382
MEDSTAR UNION MEMORI..	375	456	412	326	407	400	504	500	439	410	446	347	425
MERCY	526	577	575	407	450	423	466	492	461	476	463	470	417
MERITUS	393	370	354	386	379	345	368	430	370	354	354	335	338
NORTHWEST	645	778	669	566	602	608	661	940	713	593	668	584	651
SHADY GROVE	408	427	446	435	545	494	428	437	403	470	396	419	469
SINAI	796	796	877	861	764	856	791	1,155	1,085	942	904	887	1,025
SUBURBAN	527	462	467	480	537	469	499	521	497	445	475	567	485
TIDALHEALTH PENINSULA		453	448	447	432	430	445	450	438	406	424	390	434
UM BWMC	711	740	691	708	717	647	756	895	758	731	725	743	830
UM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838	736	778	701
UM SHORE EASTON	1,399	951	1,344	1,414	1,109	789	1,574	1,770	1,084	1,124	843	868	877
UM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585	672	663	701
UMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758	731	780	705
UMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669	631	516	510
UPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392	368	539	
UPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741	834	822	811
WHITE OAK	1,251	865	1,143	855	1,328	1,210	794	825	677	1,233	1,138	932	914

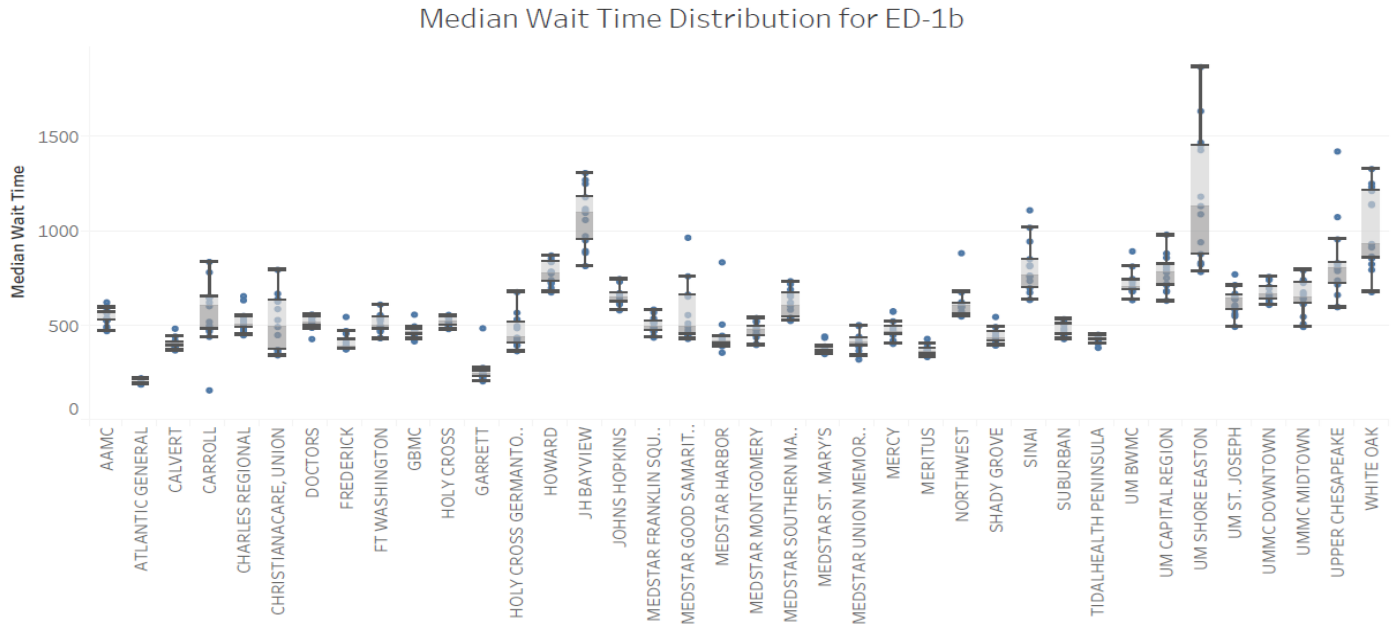
Western Maryland did submit data but not in time for inclusion

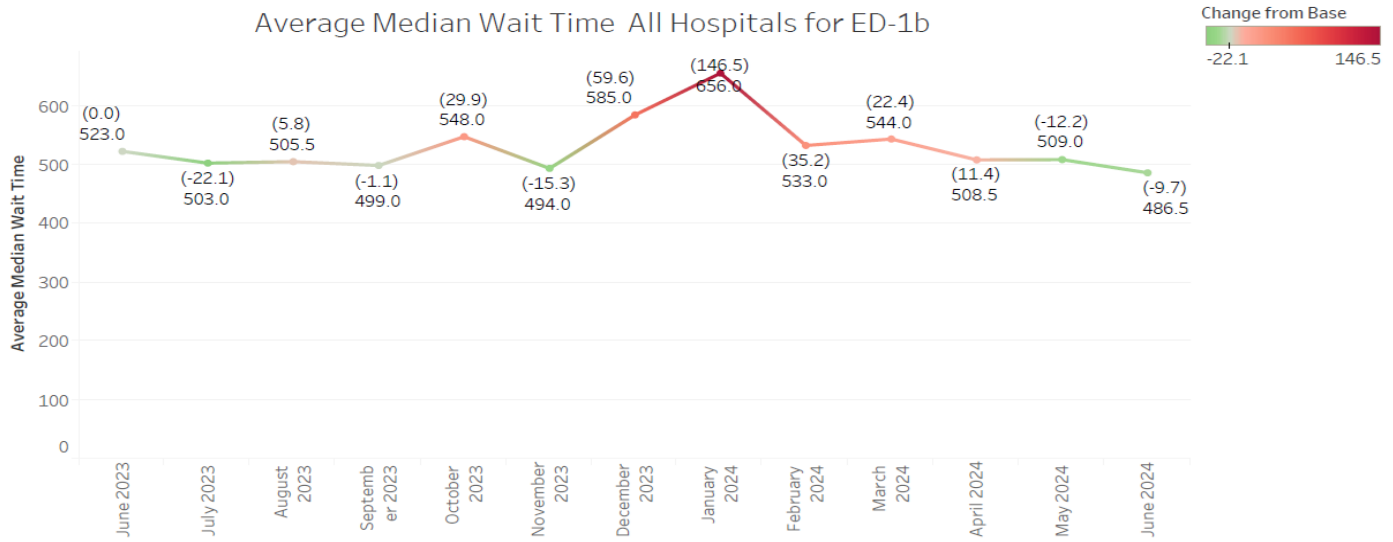
ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



maryland health services cost review commission

ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric





ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

Average Median Wait Time All Hospitals for ED-1b

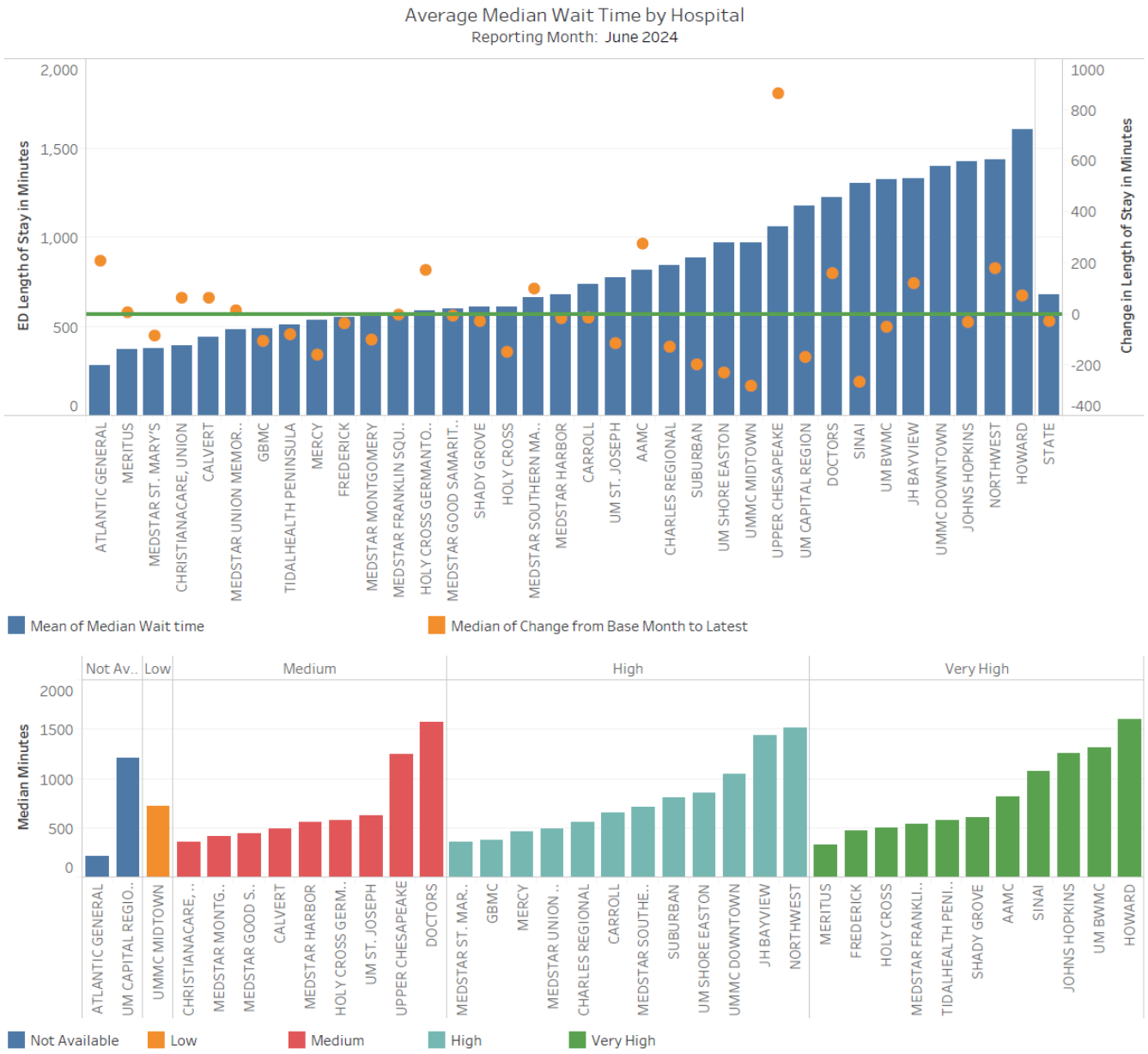
Measure
ED-1b

Change from Base
-668 822

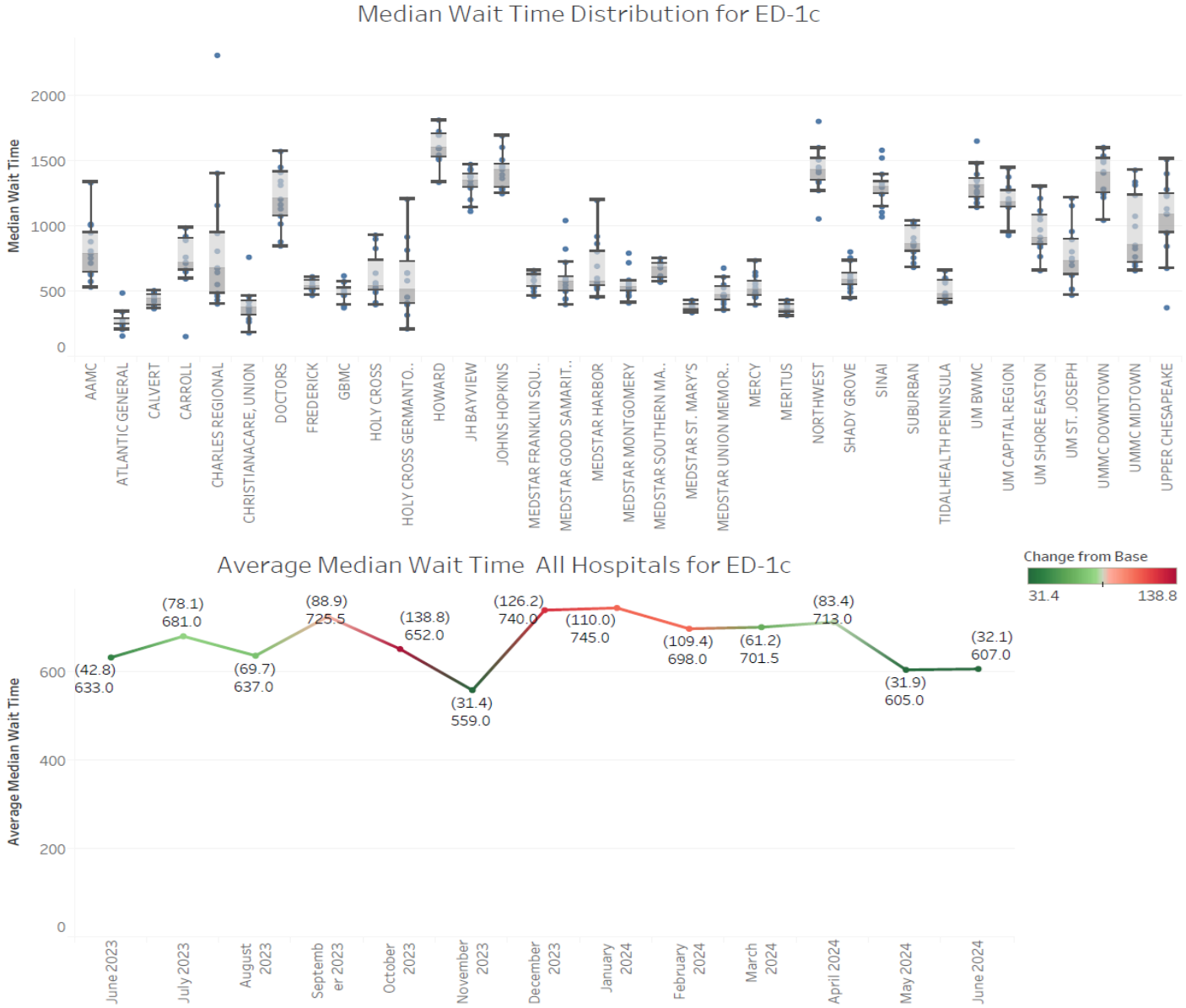
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
AAMC	488	527	536	529	565	597	623	591	528	539	495	471	528
ASCENSION SAINT AGNES	599	563	541	573	641	576	755	772	683	694	741		
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199	199	199
CALVERT		386	403	420	390	408	484	443	404	395	369	391	407
CARROLL	441	520	470	623	603	158	653	837	648	648	782	500	480
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474	516	544
CHRISTIANACARE, UNION	372	351	370	343	356	450	640	627	669	588	795	530	493
DOCTORS	541	503	525	499	559	523	547	543	510	509	489	491	429
FREDERICK	388	376	378	391	410	427	458	546	472	375	379	397	390
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556	524	435	536
GARRETT			244		246	244	277	255	227	236	206	486	223
GBMC	438	467	455	475	481	417	476	558	496	475	454	455	429
HOLY CROSS	524	482	540	513	544	518	546	557	495	524		496	499
HOLY CROSS GERMANTO..	435	396	427	365	487	414	568	677	498	436		533	398
HOWARD	722	734	729	776	871	839	836	785	676	785	741	699	855
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059	815	1,117
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623	626	581
MEDSTAR FRANKLIN SQUA..	445	471	492	484	516	471	570	585	538	492	522	512	437
MEDSTAR GOOD SAMARIT..	440	474	512	449	556	494	654	965	761	664	442	430	450
MEDSTAR HARBOR	407	506	424	835	391	357	399	447	416	432	415	406	436
MEDSTAR MONTGOMERY	520	459	478	477	525	438	490	540	495	454	448	404	398
MEDSTAR SOUTHERN MA..	584	542	536	525	540	533	654	735	691	668	720	622	604
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390	369	385
MEDSTAR UNION MEMORI..	367	442	397	321	398	389	498	503	434	413	425	342	410
MERCY	523	576	574	404	450	421	464	490	461	476	462	469	416
MERITUS	404	371	357	386	377	341	368	430	364	352	347	334	339
NORTHWEST	595	676	613	558	575	561	600	883	624	549	609	551	600
SHADY GROVE	408	424	446	434	546	493	427	437	397	468	395	419	465
SINAI	638	636	759	699	675	765	737	1,110	945	852	814	819	1,018
SUBURBAN	510	441	445	457	516	455	485	506	474	429	456	534	457
TIDALHEALTH PENINSULA		452	446	447	429	430	447	448	437	405	423	383	429
UM BWMC	684	704	681	683	699	635	740	893	747	721	698	734	813
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679	721	632
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132	823	832	878
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550	669	650	715
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742	707	758	697
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640	617	509	493
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394	360	585	
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739	826	809	803
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233	1,138	932	914

Western Maryland did submit data but not in time for inclusion

ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

Average Median Wait Time All Hospitals for ED-1c

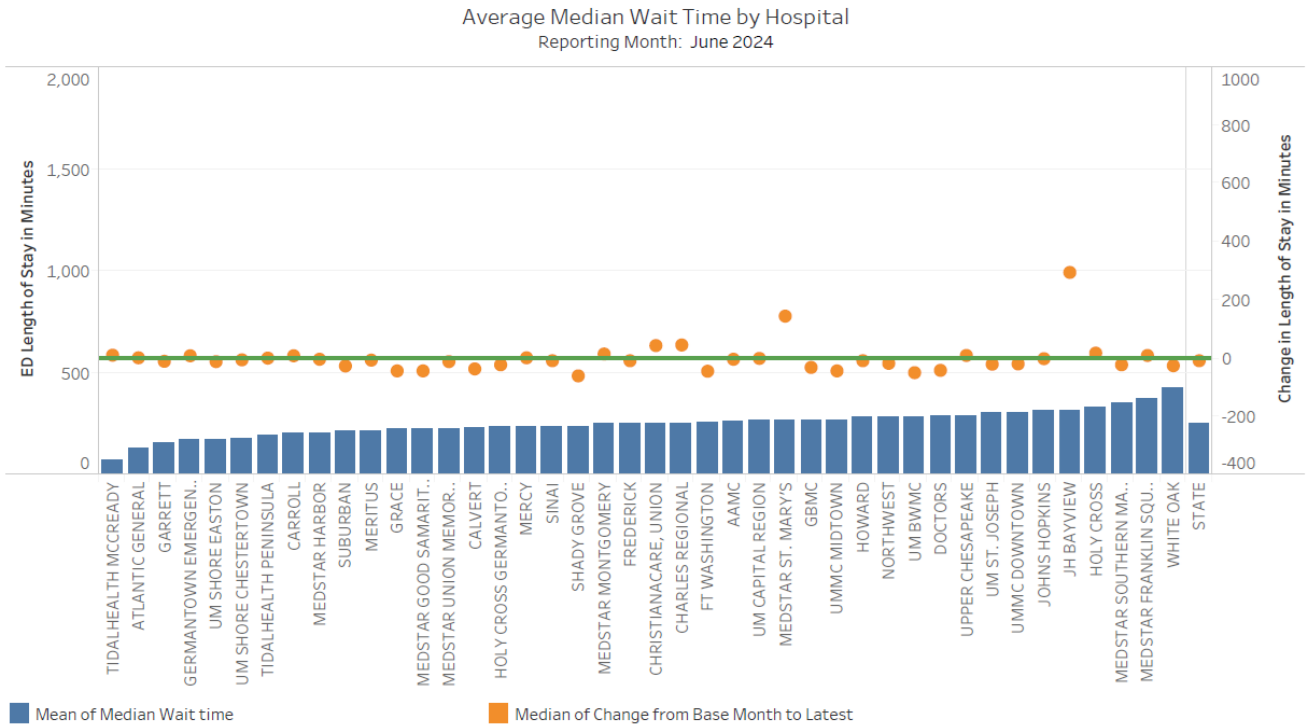
Measure
ED-1c

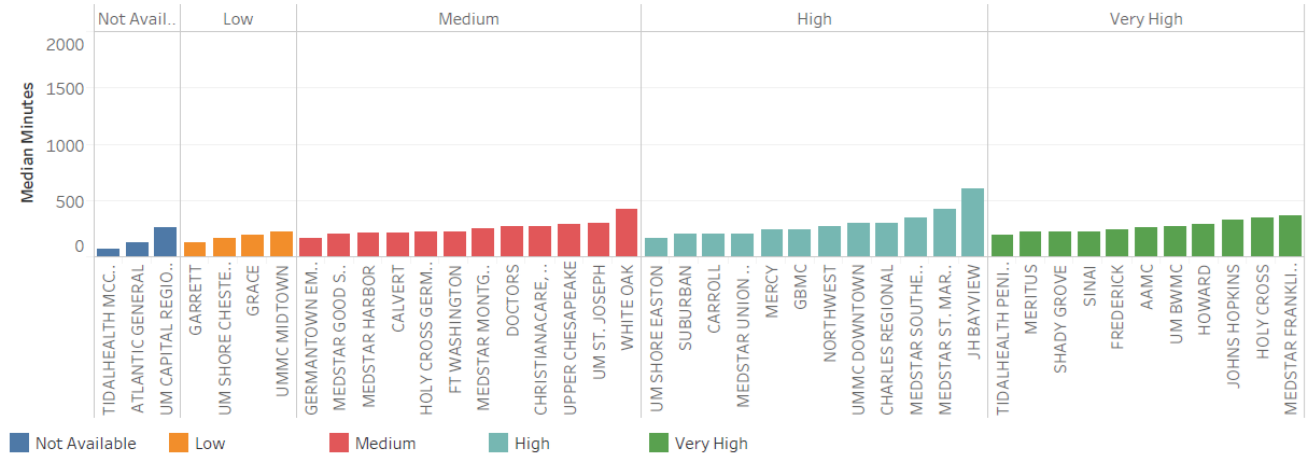
Change from Base
-564 2,701

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629	578	812
ASCENSION SAINT AGNES	755	939	631	691	652	531	682	745	698	574	839		
ATLANTIC GENERAL		345	160	262	286	490	255			254		242	210
CALVERT	425	379	457	471	508	427	501	369	449	458	393	389	490
CARROLL	665	667	764	893	598	156	724	988	989	717	924	906	652
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946	436	555
CHRISTIANACARE, UNION	290	184	268		424	422	764	431	463	388	331	375	355
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079	881	1,575
FREDERICK	506	517	540	514	613	534	586	609	613	557	514	586	471
GARRETT							470	717	428	786	131	691	
GBMC	480	387	479	476	508	526	498	621	578	471	398	573	376
HOLY CROSS	642	416	518	568	903	559	532	933	831	400		526	495
HOLY CROSS GERMANTO..	410	320	643	400	412	458	1,208	919	643	818		215	584
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519	1,603	1,547	1,598
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147	1,294	1,115	1,431
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396	1,368	1,436	1,251
MEDSTAR FRANKLIN SQUA..	532	465	500	532	627	662	469	642	542	583	589	627	531
MEDSTAR GOOD SAMARIT..	446	502	590	549	608	522	827	1,045	725	577	401	588	441
MEDSTAR HARBOR	577	868	923	1,199	806	520	695	531	603	458	540	572	562
MEDSTAR MONTGOMERY	512	472	498	532	531	722	550	795	588	568	579	465	413
MEDSTAR SOUTHERN MA..	609	575	586	573	601	714	683	717	754	722	713	622	710
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396	353	351
MEDSTAR UNION MEMORI..	464	681	473	358	475	431	612	470	530	407	553	371	480
MERCY	622	648	738	490	458	531	518	556	398	456	577	492	464
MERITUS	329	344	317	385	423	395	363	434	397	362	413	340	337
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343	1,604	1,413	1,518
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	589	552	607
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309	1,525	1,308	1,073
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040	1,025	804
TIDALHEALTH PENINSULA		659	490	441	473	415	415	567	440	596	465	605	581
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183	1,360	1,483	1,310
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959	950	1,212
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215	1,052	857
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806	702	626
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253	1,286	1,605	1,047
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855	661	721
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428	539	
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953	1,404	1,231	1,243
WHITE OAK			2,701										

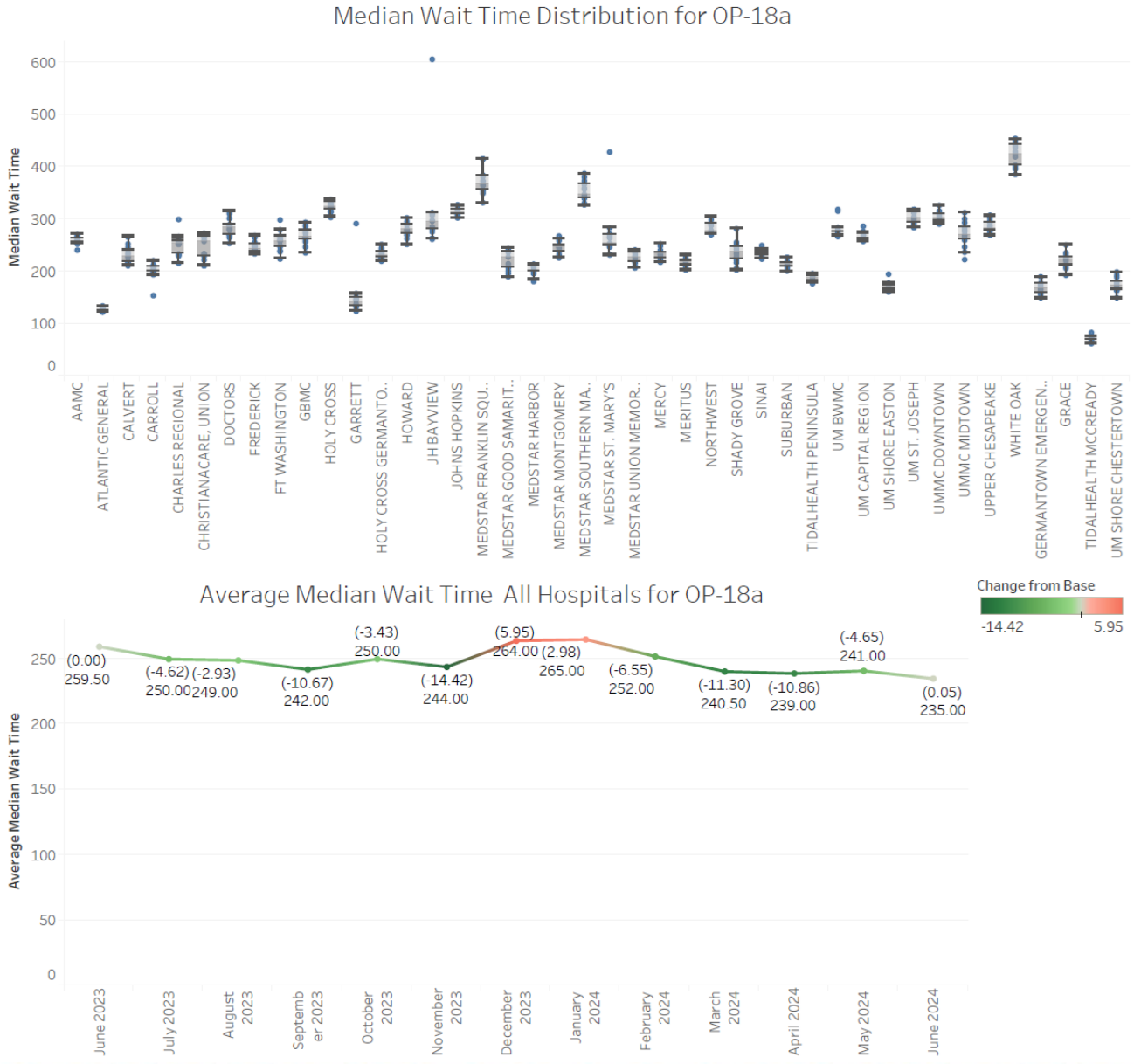
Western Maryland did submit data but not in time for inclusion

OP18a: ED Arrival to Discharge Time by Month





OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month

Average Median Wait Time All Hospitals for OP-18a

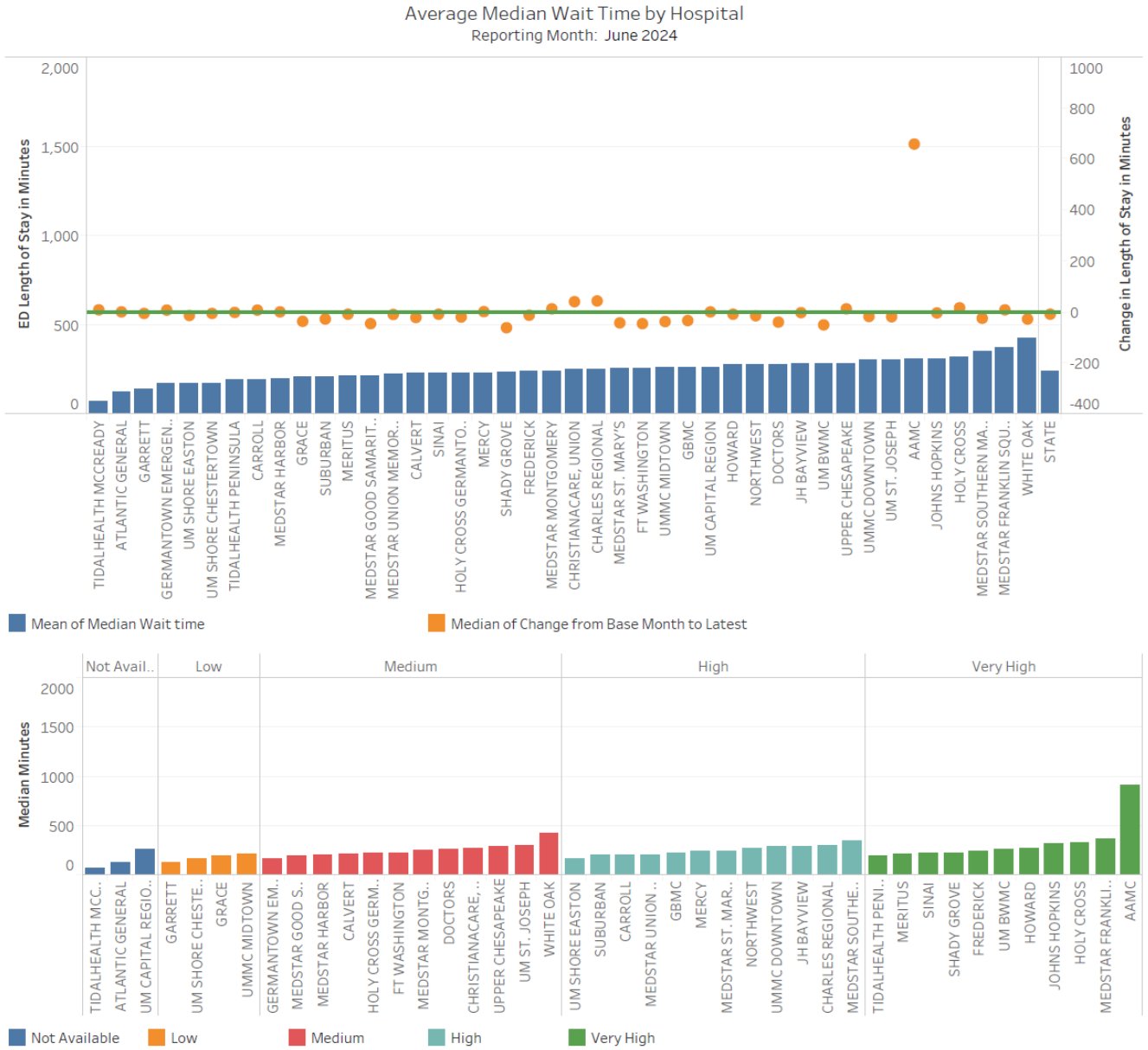
Measure
OP-18a

Change from Base
-79.0 295.0

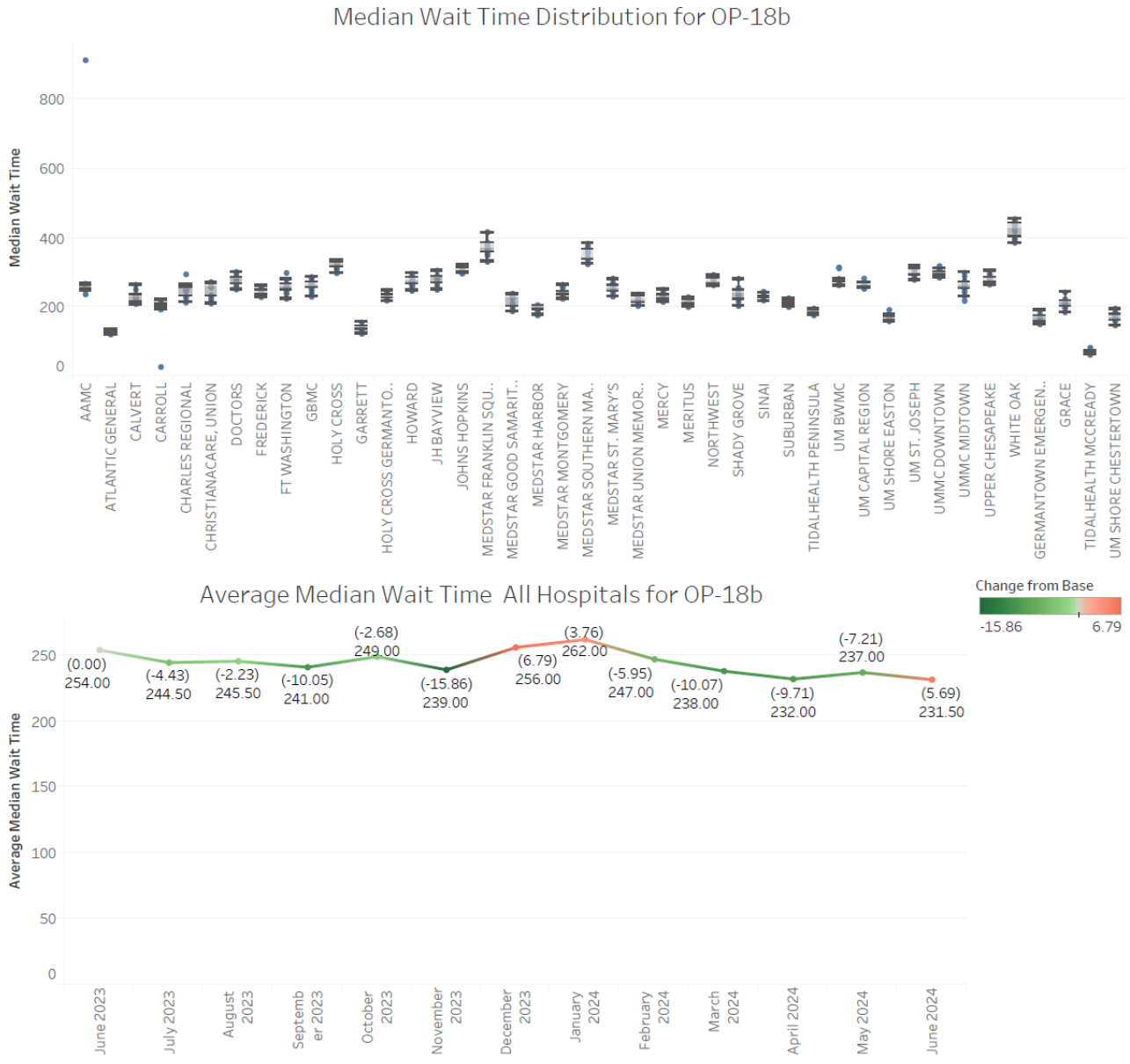
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
AAMC	258.0	255.0	260.0	254.0	266.0	263.0	271.0	268.0	256.0	258.0	253.0	241.0	255.0
ASCENSION SAINT AGNES	261.0	238.0	236.0	243.0	220.0	226.0	239.0	238.0	232.0	227.0	233.0		
ATLANTIC GENERAL	124.0	127.0	131.0	133.0	128.0	123.0	134.0		125.0	122.0	128.0	132.0	126.0
CALVERT	247.0	229.0	240.0	233.0	253.0	235.0	266.0	218.0	215.0	216.0	220.0	227.0	211.0
CARROLL	194.0	203.0	201.0	201.0	221.0	154.0	212.0	209.0	211.0	209.0	210.0	203.0	203.0
CHARLES REGIONAL	254.0	253.0	232.0	216.0	230.0	234.0	258.0	261.0	252.0	258.0	253.0	267.0	300.0
CHRISTIANACARE, UNION	229.0	234.0	222.0	211.0	211.0	234.0	271.0	265.0	272.0	258.0	260.0	266.0	273.0
DOCTORS	311.0	288.0	280.0	265.0	281.0	285.0	315.0	302.0	290.0	254.0	270.0	288.0	270.0
FREDERICK		249.0	248.0	236.0	240.0	244.0	265.0	269.0	256.0	234.0	240.0	237.0	241.0
FT WASHINGTON	268.0	238.0	262.0	247.0	260.0	259.0	299.0	280.0	266.0	259.0	250.0	240.0	224.0
GARRETT			145.0		150.0	147.0	158.0	134.0	132.0	138.0	124.0	292.0	135.0
GBMC	267.0	257.0	261.0	273.0	279.0	266.0	287.0	276.0	294.0	294.0	266.0	247.0	236.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0
GRACE	236.0	251.0	226.0	221.0	228.0	206.0	233.0	227.0	209.0	215.0	212.0	222.0	193.0
HOLY CROSS	320.0	304.0	335.0	333.0	327.0	314.0	329.0	337.0	324.0	315.0		322.0	338.0
HOLY CROSS GERMANTO..	242.0	227.0	252.0	233.0	235.0	228.0	245.0	234.0	226.0	227.0		222.0	220.0
HOWARD	290.0	290.0	303.0	252.0	275.0	263.0	296.0	280.0	271.0	269.0	280.0	278.0	282.0
JH BAYVIEW	312.0	312.0	308.0	281.0	283.0	262.0	264.0	298.0	276.0	297.0	313.0	286.0	607.0
JOHNS HOPKINS	328.0	319.0	318.0	309.0	312.0	303.0	305.0	313.0	311.0	309.0	319.0	315.0	327.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	382.0	365.0	374.0	385.0	416.0	416.0	332.0	350.0	355.0	365.0	367.0
MEDSTAR GOOD SAMARIT..	239.0	237.0	244.0	228.0	239.0	207.0	239.0	241.0	215.0	210.0	201.0	190.0	196.0
MEDSTAR HARBOR	213.0	213.0	211.0	202.0	214.0	181.0	196.0	200.0	184.0	202.0	203.0	210.0	210.0
MEDSTAR MONTGOMERY	232.0	226.0	247.0	238.0	259.0	246.0	262.0	268.0	249.0	244.0	229.0	249.0	247.0
MEDSTAR SOUTHERN MA..	367.0	344.0	331.0	328.0	340.0	329.0	388.0	381.0	358.0	360.0	374.0	348.0	345.0
MEDSTAR ST. MARY'S	284.0	269.0	272.0	251.0	254.0	249.0	265.0	265.0	252.0	233.0	247.0	232.0	429.0
MEDSTAR UNION MEMORI..	218.0	227.0	230.0	221.0	241.0	219.0	241.0	235.0	229.0	217.0	236.0	210.0	207.0
MERCY	232.0	241.0	231.0	219.0	218.0	222.0	233.0	249.0	236.0	237.0	225.0	253.0	234.0
MERITUS	225.0	207.0	207.0	221.0	211.0	203.0	225.0	231.0	221.0	218.0	221.0	219.0	219.0
NORTHWEST	288.0	291.0	304.0	279.0	291.0	290.0	299.0	272.0	271.0	273.0	277.0	272.0	271.0
SHADY GROVE	282.0	256.0	252.0	242.0	247.0	246.0	238.0	217.0	203.0	206.0	228.0	234.0	222.0
SINAI	232.0	240.0	250.0	232.0	233.0	233.0	243.0	236.0	229.0	232.0	227.0	231.0	224.0
SUBURBAN	227.0	216.0	227.0	217.0	219.0	210.0	209.0	214.0	213.0	206.0	208.0	217.0	201.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	67.0	75.0	68.0	74.0	70.0	69.0	74.0	73.0
TIDALHEALTH PENINSULA		184.0	190.0	196.0	195.0	191.0	192.0	184.0	190.0	182.0	182.0	177.0	185.0
UM BWMC	316.0	319.0	285.0	282.0	277.0	280.0	278.0	272.0	269.0	276.0	278.0	280.0	267.0
UM CAPITAL REGION	265.0	277.0	271.0	265.0	269.0	260.0	287.0	274.0	262.0	259.0	258.0	269.0	265.0
UM SHORE CHESTERTOWN	169.0	175.0	164.0	180.0	193.0	150.0	189.0	199.0	180.0	164.0	168.0	174.0	164.0
UM SHORE EASTON	178.0	165.0	172.0	174.0	163.0	161.0	178.0	195.0	164.0	173.0	164.0	174.0	167.0
UM ST. JOSEPH	313.0	305.0	313.0	319.0	319.0	291.0	318.0	302.0	295.0	287.0	284.0	296.0	293.0
UMMC DOWNTOWN	310.0	312.0	306.0	299.0	292.0	293.0	304.0	316.0	327.0	298.0	303.0	296.0	291.0
UMMC MIDTOWN	266.0	294.0	277.0	279.0	270.0	237.0	301.0	313.0	284.0	270.0	247.0	260.0	223.0
UPMC WESTERN MD	233.0	236.0	248.0	250.0	272.0	260.0	259.0	256.0	256.0	250.0	238.0	240.0	
UPPER CHESAPEAKE	278.0	280.0	278.0	270.0	280.0	282.0	308.0	303.0	294.0	277.0	287.0	297.0	288.0
WHITE OAK	455.0	404.0	420.0	397.0	452.0	402.0	426.0	445.0	439.0	397.0	386.0	444.0	430.0

Western Maryland did submit data but not in time for inclusion

OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric

Average Median Wait Time All Hospitals for OP-18b

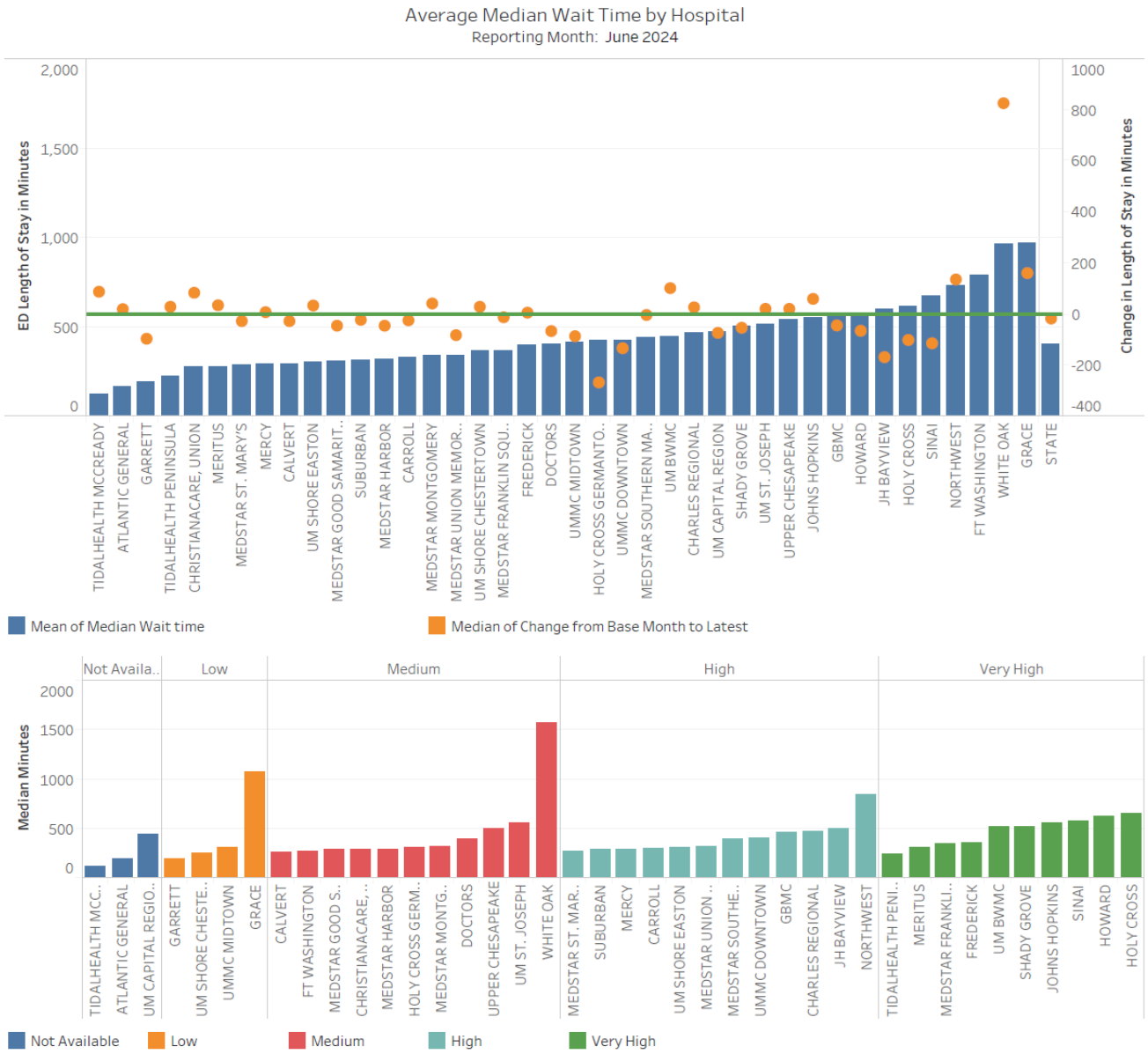
Measure
OP-18b

Change from Base
-166.0 660.0

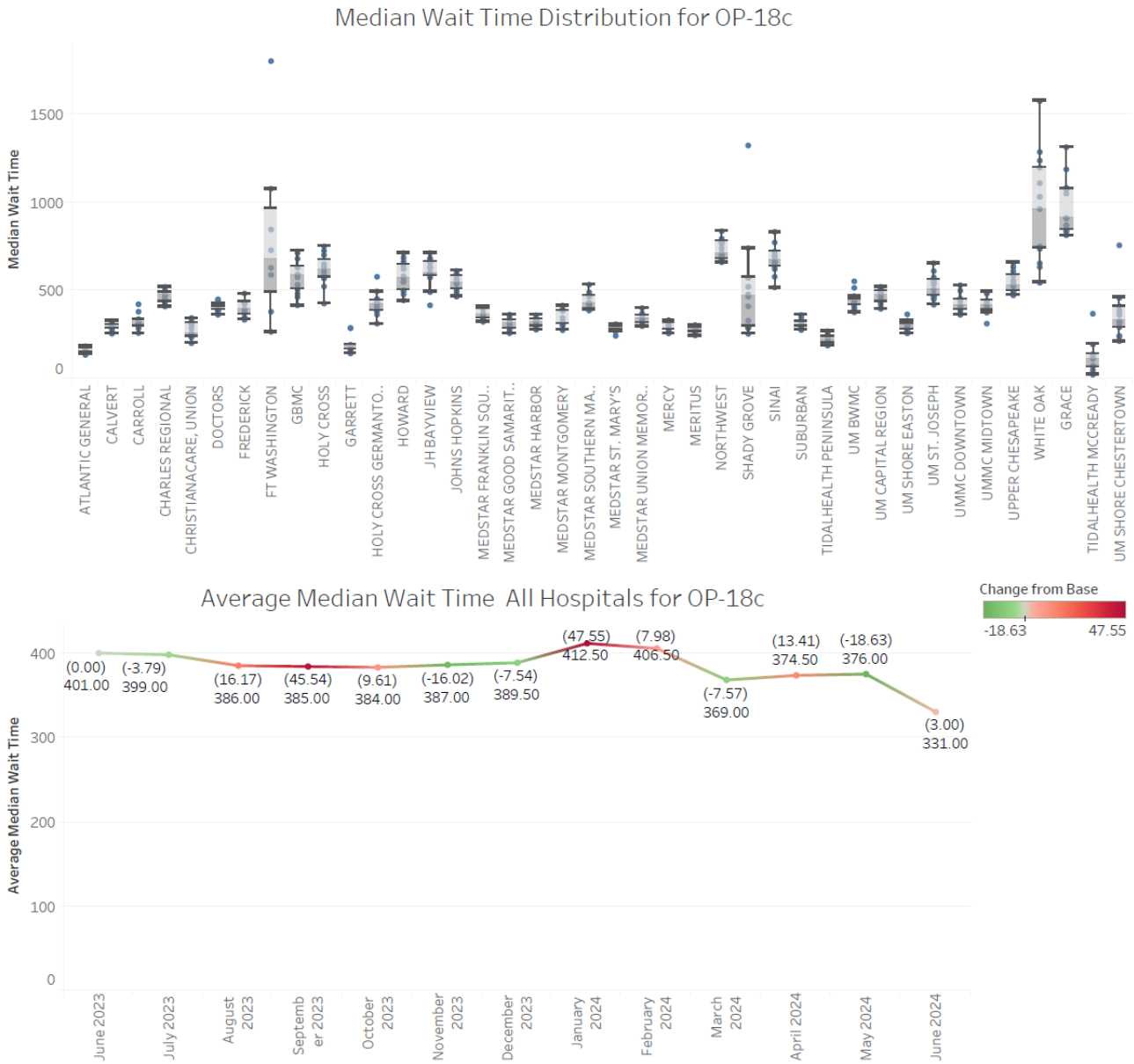
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0	251.0	237.0	914.0
ASCENSION SAINT AGNES	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0	230.0		
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0	132.0	125.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0	224.0	209.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0	209.0	202.0	202.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0	250.0	264.0	295.0
CHRISTIANACARE, UNION	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0	260.0	265.0	272.0
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0	263.0	280.0	264.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	234.0	233.0	235.0
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0	250.0	240.0	224.0
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0	134.0	134.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0	257.0	240.0	230.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0	197.0	210.0	185.0
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0		320.0	333.0
HOLY CROSS GERMANTO..	237.0	224.0	248.0	232.0	232.0	225.0	242.0	230.0	223.0	226.0		220.0	219.0
HOWARD	284.0	287.0	297.0	247.0	268.0	259.0	289.0	275.0	264.0	265.0	275.0	273.0	277.0
JH BAYVIEW	290.0	290.0	288.0	268.0	272.0	252.0	250.0	285.0	259.0	286.0	306.0	281.0	289.0
JOHNS HOPKINS	320.0	312.0	308.0	299.0	304.0	297.0	298.0	302.0	304.0	302.0	313.0	305.0	318.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	384.0	369.0	376.0	387.0	417.0	416.0	331.0	349.0	354.0	363.0	367.0
MEDSTAR GOOD SAMARIT..	234.0	231.0	239.0	225.0	234.0	202.0	237.0	238.0	210.0	208.0	198.0	188.0	190.0
MEDSTAR HARBOR	204.0	204.0	201.0	190.0	203.0	176.0	189.0	193.0	178.0	193.0	198.0	201.0	206.0
MEDSTAR MONTGOMERY	230.0	224.0	245.0	233.0	256.0	243.0	258.0	265.0	246.0	240.0	228.0	246.0	244.0
MEDSTAR SOUTHERN MA..	366.0	342.0	328.0	324.0	335.0	325.0	384.0	377.0	356.0	359.0	372.0	343.0	343.0
MEDSTAR ST. MARY'S	283.0	268.0	271.0	250.0	251.0	247.0	263.0	263.0	250.0	231.0	245.0	231.0	242.0
MEDSTAR UNION MEMORI..	211.0	221.0	226.0	218.0	235.0	215.0	237.0	232.0	225.0	212.0	230.0	205.0	203.0
MERCY	230.0	238.0	229.0	217.0	215.0	219.0	233.0	247.0	233.0	236.0	222.0	251.0	233.0
MERITUS	223.0	205.0	205.0	219.0	209.0	200.0	224.0	229.0	220.0	216.0	219.0	215.0	216.0
NORTHWEST	280.0	282.0	293.0	270.0	284.0	283.0	293.0	266.0	263.0	266.0	270.0	266.0	267.0
SHADY GROVE	282.0	256.0	252.0	241.0	247.0	245.0	238.0	217.0	203.0	206.0	227.0	234.0	222.0
SINAI	226.0	236.0	245.0	226.0	228.0	230.0	240.0	232.0	225.0	228.0	223.0	226.0	219.0
SUBURBAN	226.0	214.0	224.0	214.0	217.0	207.0	207.0	211.0	211.0	204.0	205.0	215.0	200.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0	68.0	74.0	72.0
TIDALHEALTH PENINSULA		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0	182.0	176.0	184.0
UM BWMC	312.0	315.0	282.0	279.0	271.0	277.0	274.0	269.0	264.0	273.0	274.0	277.0	263.0
UM CAPITAL REGION	261.0	273.0	267.0	260.0	264.0	256.0	283.0	270.0	259.0	253.0	254.0	267.0	263.0
UM SHORE CHESTERTOWN	166.0	171.0	160.0	176.0	184.0	147.0	185.0	196.0	177.0	161.0	167.0	167.0	162.0
UM SHORE EASTON	176.0	162.0	169.0	171.0	161.0	159.0	175.0	192.0	161.0	169.0	162.0	169.0	164.0
UM ST. JOSEPH	308.0	296.0	309.0	314.0	313.0	289.0	317.0	298.0	290.0	281.0	279.0	293.0	291.0
UMMC DOWNTOWN	301.0	306.0	298.0	293.0	289.0	290.0	299.0	311.0	319.0	294.0	297.0	292.0	285.0
UMMC MIDTOWN	254.0	276.0	267.0	265.0	262.0	231.0	289.0	300.0	271.0	263.0	243.0	251.0	218.0
UPMC WESTERN MD	229.0	232.0	246.0	244.0	268.0	249.0	251.0	249.0	247.0	244.0	227.0	234.0	
UPPER CHESAPEAKE	269.0	275.0	272.0	265.0	275.0	276.0	304.0	296.0	285.0	269.0	279.0	290.0	283.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0	386.0	443.0	429.0

Western Maryland did submit data but not in time for inclusion

OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits

Average Median Wait Time All Hospitals for OP-18c

Measure
OP-18c

Change from Base
-462 1,072

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
AAMC	394	383	353	385	393	372	363	349	344	330	322	331	
ASCENSION SAINT AGNES	379	342	389	330	371	384	387	391	402	365	373		
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159	139	185
CALVERT		282	302	302	318	270	328	283	301	307	292	288	256
CARROLL	322	423	323	260	296	339	325	329	286	320	381	330	299
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502	488	472
CHRISTIANACARE, UNION	202	236	238	260	253	250	237	341	306	316	324	345	287
DOCTORS	451	363	389	393	380	397	404	447	411	389	397	432	386
FREDERICK		343	335	376	426	395	435	484	433	396	435	373	350
FT WASHINGTON	729	847	1,078					1,801	629	381		590	267
GARRETT			288		288	167	154	144	166	169	167	188	193
GBMC	506	681	587	631	534	714	592	586	576	723	482	417	463
GERMANTOWN EMERGEN..	87	69							246	105		18	
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814	872	1,074
HOLY CROSS	751	609	726	701	586	642	524	577	569	633		427	651
HOLY CROSS GERMANTO..	579	496	386	364	426	434	383	406	415	454		429	313
HOWARD	687	445	503	550	571	496	549	714	644	479	582	667	623
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574	583	417	492
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466	546	557
MEDSTAR FRANKLIN SQUA..	353	365	337	324	328	370	405	406	398	366	364	403	342
MEDSTAR GOOD SAMARIT..	324	333	292	314	364	285	337	351	315	273	298	259	280
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310	282	338	289
MEDSTAR MONTGOMERY	276	320	302	345	386	309	392	416	322	396	313	282	319
MEDSTAR SOUTHERN MA..	390	426	422	399	467	432	479	491	398	412	429	534	388
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275	244	276
MEDSTAR UNION MEMORI..	401	332	307	325	359	299	359	346	342	303	371	359	320
MERCY	276	302	287	274	289	275	269	324	326	258	333	319	285
MERITUS	269	251	246	262	266	301	284	293	256	283	300	291	305
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795	661	837
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288	574	255	522
SINAI	692	672	648	717	622	518	698	659	833	773	722	634	579
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346	305	279
TIDALHEALTH MCCREADY			24	52	140	369	74	133	74	37	195	121	113
TIDALHEALTH PENINSULA		202	225	254	189	270	227	208	197	226	226	237	232
UM BWMC	413	469	377	446	420	446	553	443	440	434	397	404	516
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455	425	436
UM SHORE CHESTERTOWN	214	313	411	329	382	293	363	411	459	324	239	757	244
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304	296	311
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461	508	559
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391	376	399
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376	398	313
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338	367	
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538	498	495
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109	1,286	750	1,575

Western Maryland did submit data but not in time for inclusion

EMS Turnaround Times: May Performance

- 25 hospitals reported the 90th percentile of turnaround time was <=35 minutes
  - Net decrease of 1 Hospital from last month
- 24 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
  - Net increase of 1 Hospital from last month
- 3 hospitals reported the 90th percentile of turnaround time was over 60 minutes
  - Net increase of 1 Hospital from last month
- Hospitals with improving performance
  - (Average to high performing): Anne Arundel Medical Center
  - (Low performing to average): N/A
- Hospitals with declining performance
  - (High performing to average): CalvertHealth Medical Center, Suburban
  - (Average to low performing) : St. Agnes Hospital

EMS Turnaround Times: June 2024 Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
CalvertHealth Medical Center +
Cambridge Free-Standing ED
Carroll Hospital Center +
Chestertown
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital
Grace Medical Center
Holy Cross Germantown Hospital
Holy Cross Hospital
Johns Hopkins Hospital PEDIATRIC
McCready Health Pavilion
Meritus Medical Center
Montgomery Medical Center
Peninsula Regional
Queenstown Emergency Center
R Adams Cowley Shock Trauma Center
Shady Grove Medical Center
St. Mary's Hospital
Suburban Hospital +
Union Memorial Hospital
Walter Reed National Military Medical Center
Western Maryland

>35 Minutes

Anne Arundel Medical Center -
Baltimore Washington Medical Center
Bowie Health Center
Doctors Community Medical Center
Easton
Fort Washington Medical Center
Franklin Square
Greater Baltimore Medical Center
Harbor Hospital
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
St. Agnes Hospital +
St. Joseph Medical Center
Union Hospital -
University of Maryland Medical Center
Upper Chesapeake Health Aberdeen -
Upper Chesapeake Medical Center
White Oak Medical Center

>60 Minutes

Capital Region Medical Center
Charles Regional -
Howard County Medical Center -
Southern Maryland Hospital

(+): Hospital improved by one or more categories; **(-)**: Hospital declined by one or more categories

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.
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> **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.

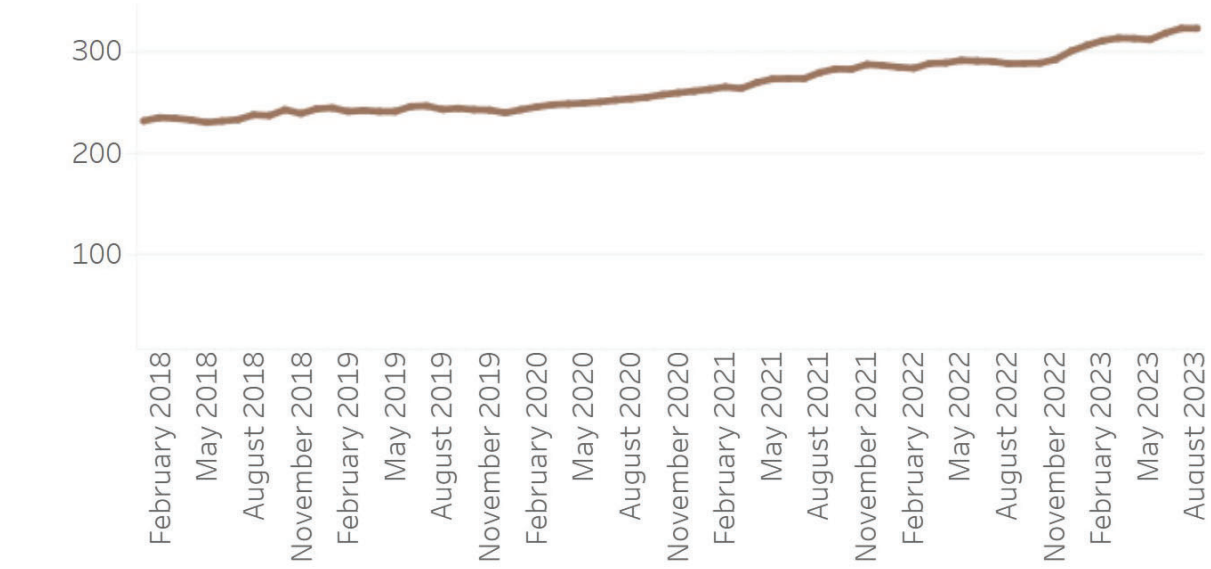
[12] Brown CC, Adams CE, George KE, Moore JE. Associations Between Comorbidities and Severe Maternal Morbidity. Obstet Gynecol. 2020 Nov;136(5):892-901. doi: 10.1097/AOG.0000000000004057. PMID: 33030867; PMCID: PMC8006182.

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

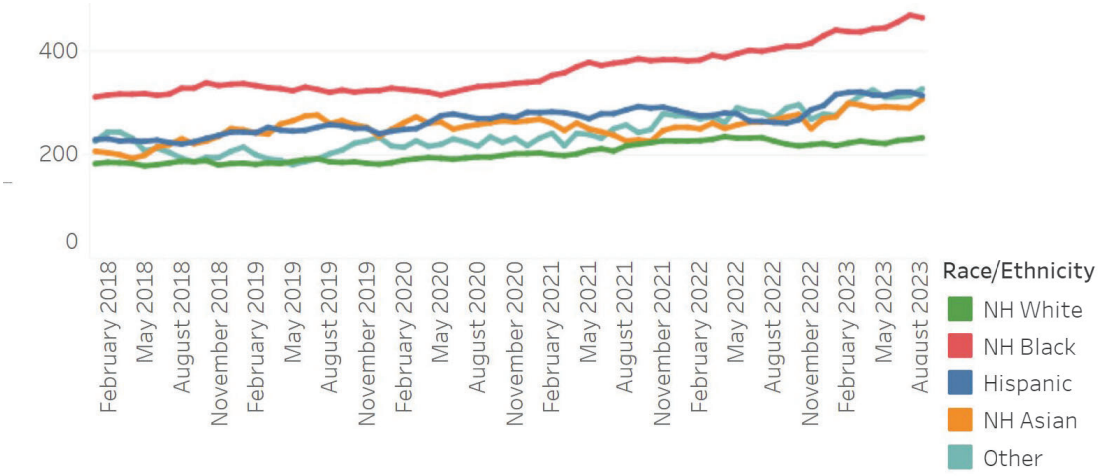


Table 8. SMM Hospitalizations Rates by Race/Ethnicity, 2018-August 2023

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

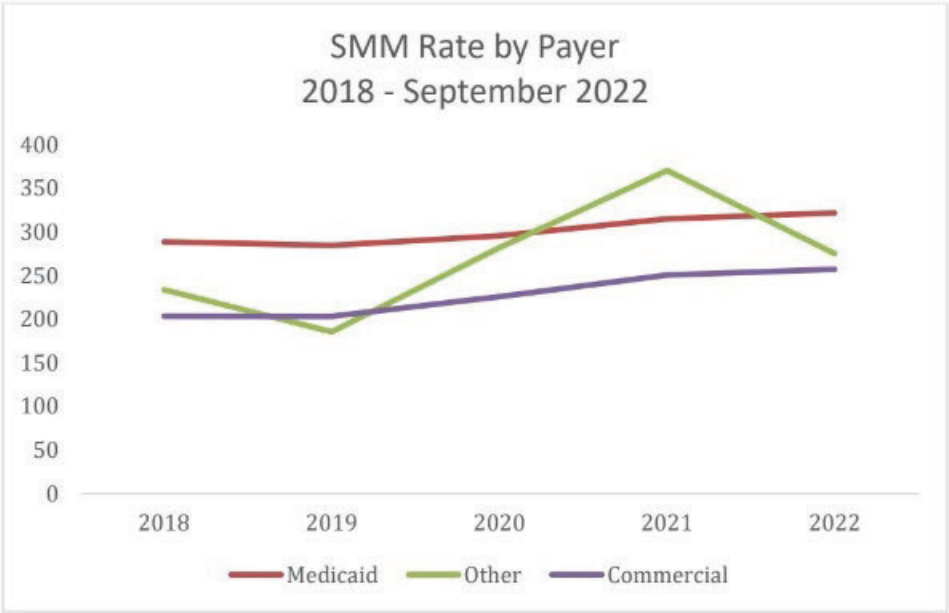


Table 10. SMM Rate by Payer, 2019 – September 2022

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

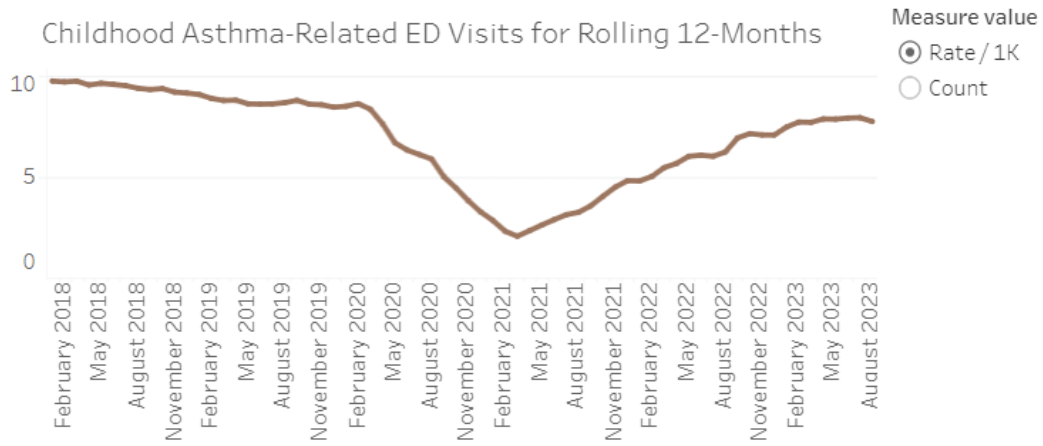


Table 12. Childhood Asthma-Related ED Visits Compared to 2023 Target

	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

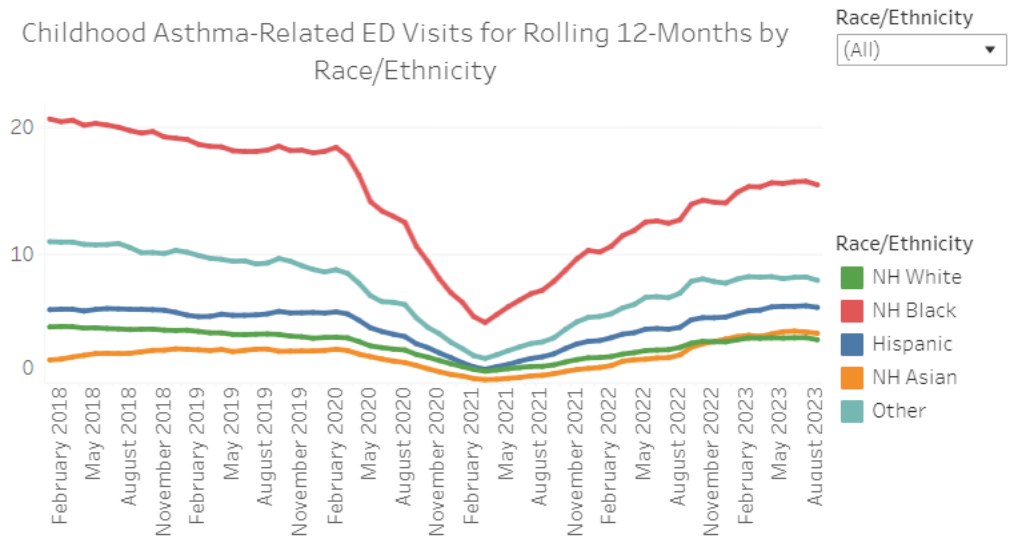


Table 14. Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2023

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

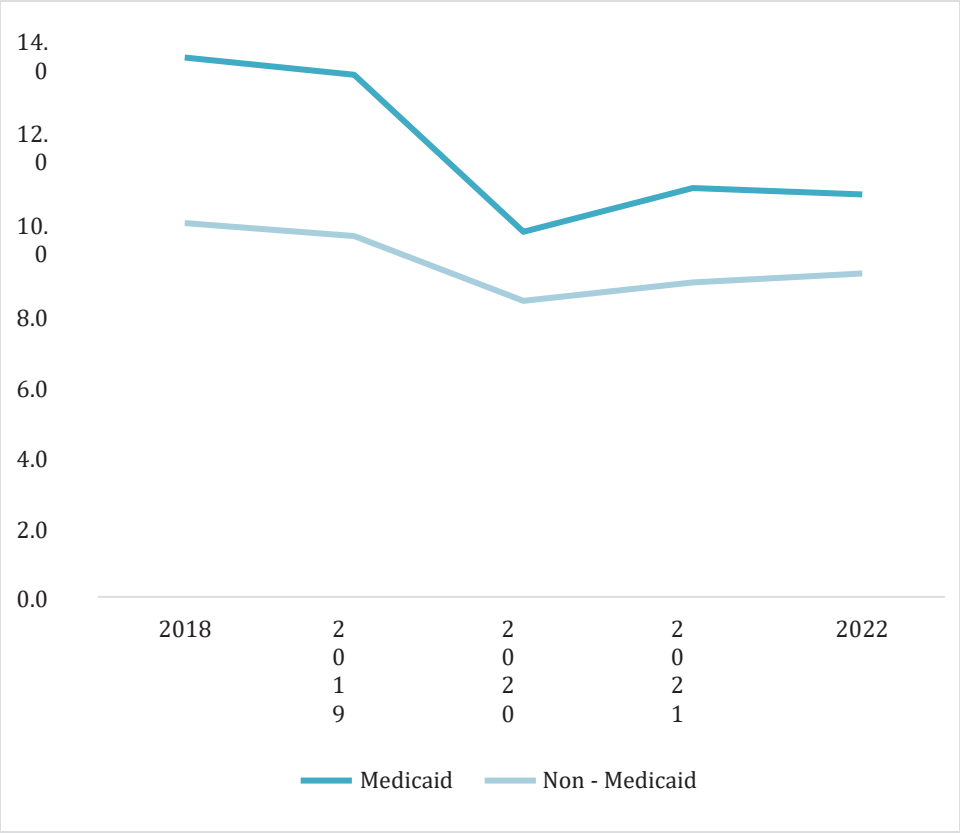


Table 16. Childhood Asthma-Related ED Visit Rate per 1K by Payer, 2018-September 2022

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

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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.

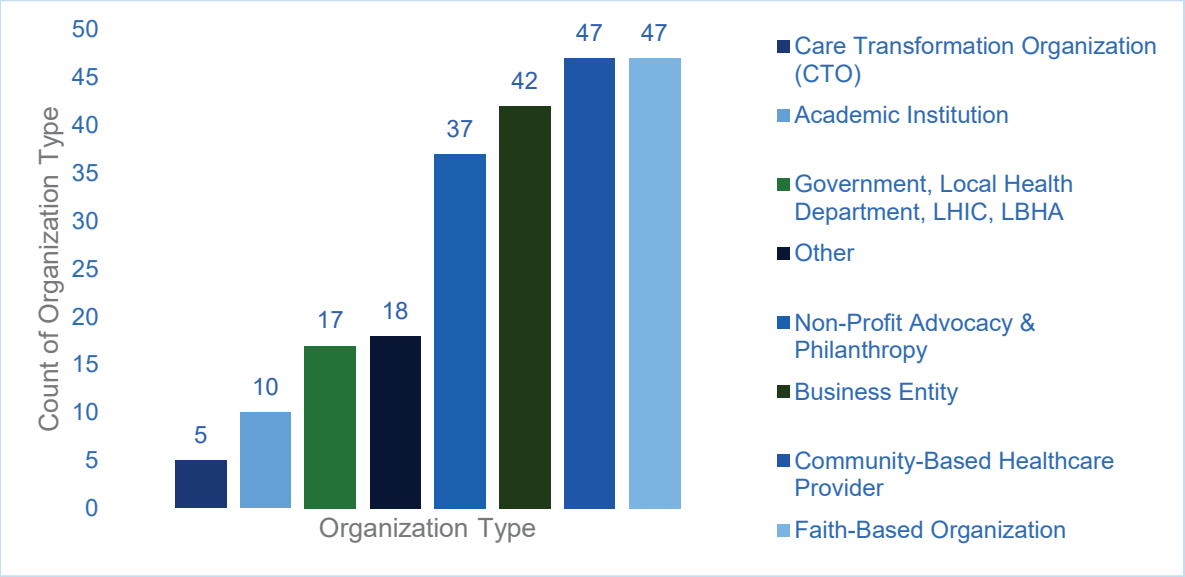
Solutions to provide healthy food included food delivery to participants' homes, virtual supermarket tours and descriptions, and partnering with supermarkets and others on healthy food access programs. Regional Partnerships are also partnering with community- and faith-based organizations to provide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

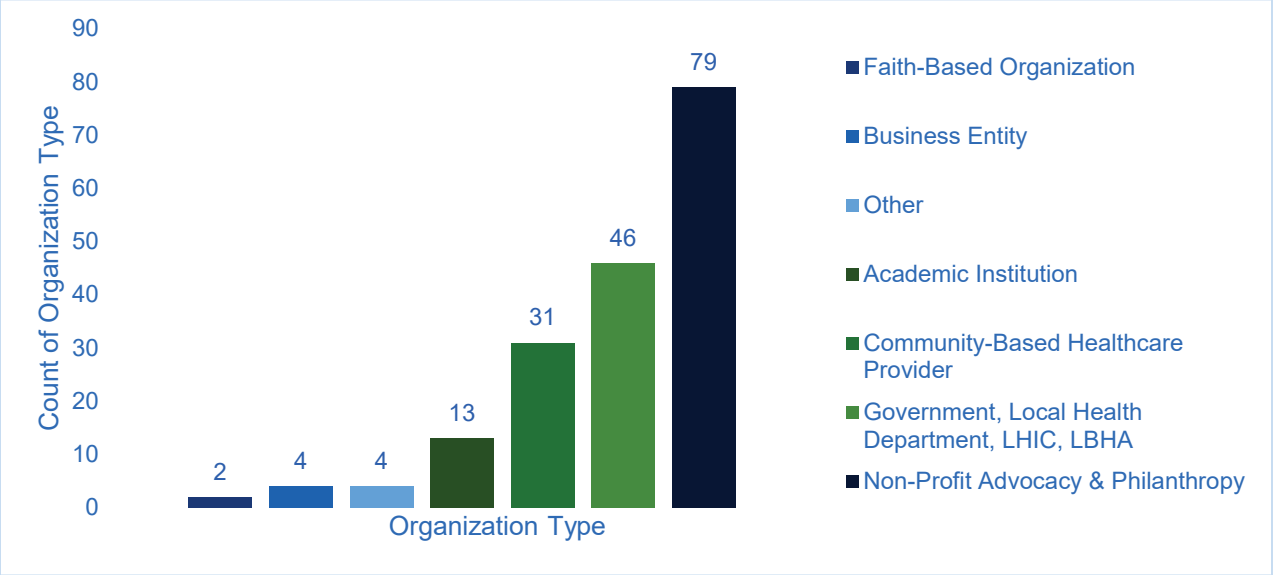
Regional Partnerships continue to recognize the value of conducting meaningful, multi-sector input, and are building on prior year progress. These relationships are vital to communicating the availability of new Catalyst Program services to the public. Regional Partnerships involve local government entities 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.

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Nurse Support Program I

Annual Report on FY 2023 Activities

July 2024

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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.

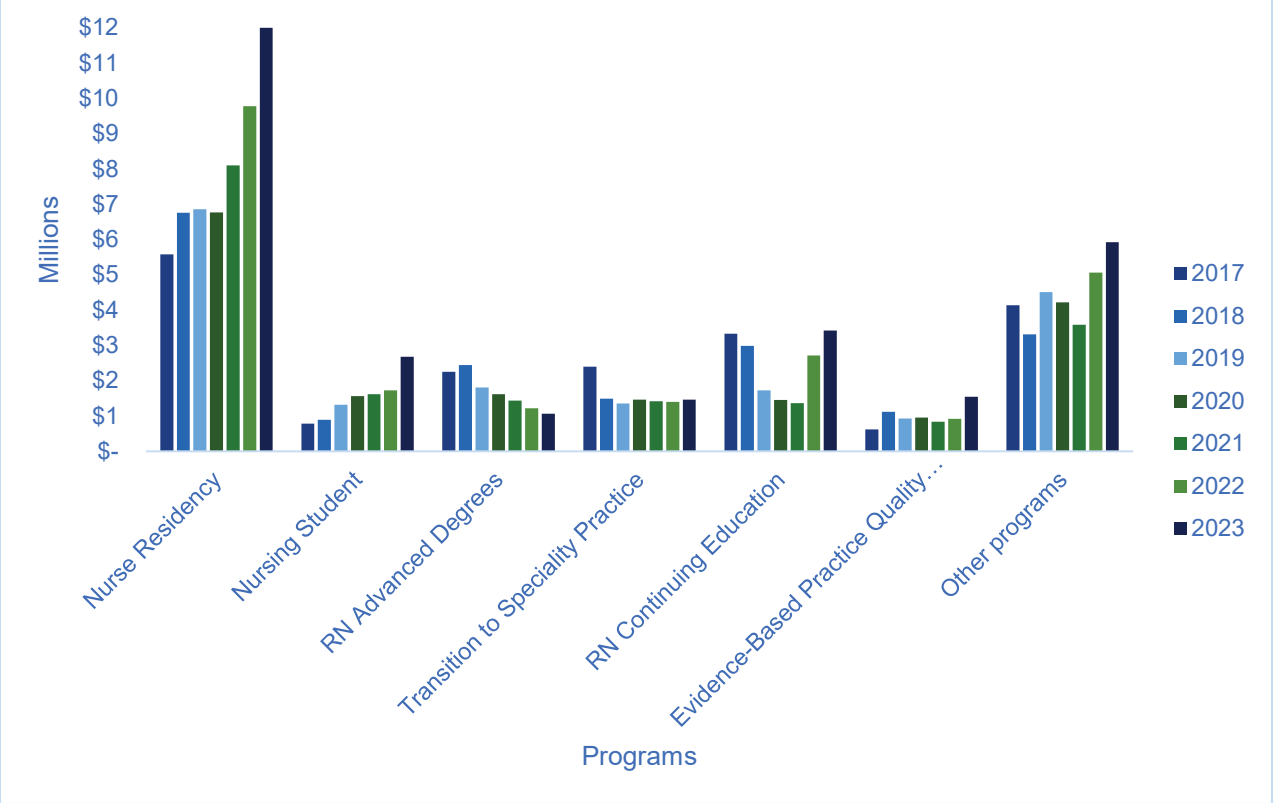
In FY 2023, all hospitals prioritized supporting new entrants to the nursing workforce by implementing a nurse residency program for newly licensed RNs. Additionally, many hospitals provided leadership, preceptorship, mentorship programs, and nursing student programs. Professional advancement was another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

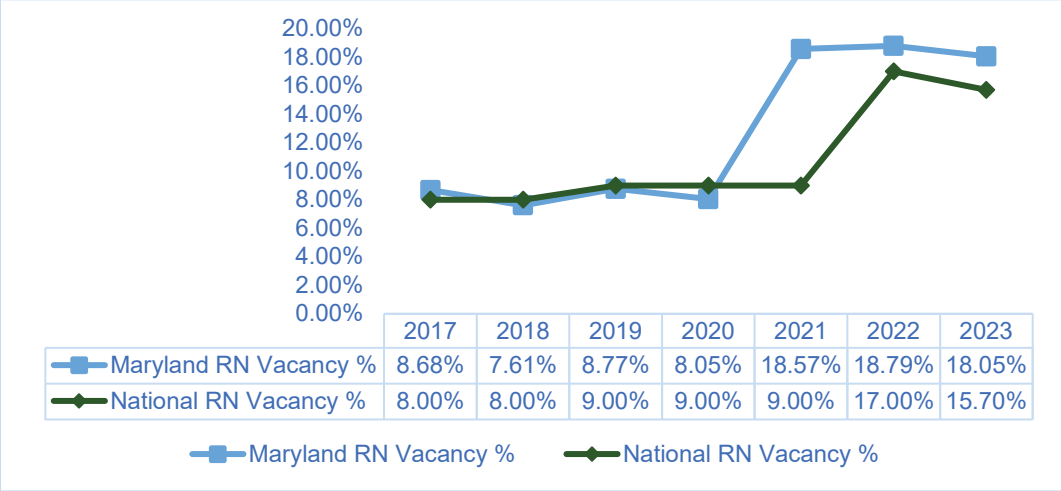
- Vacancy and Retention Rates
- Number of Nurses with BN and Advanced Degrees
- Enhanced Diversity

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.

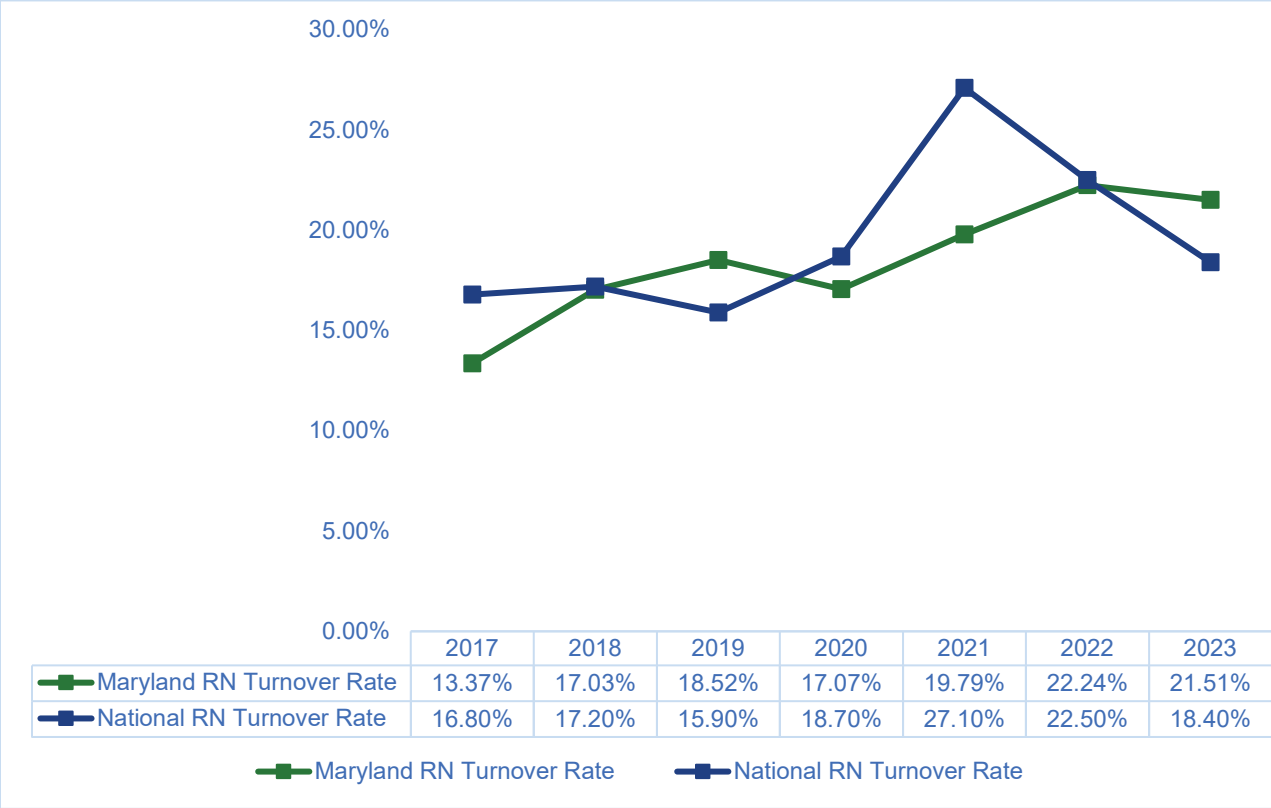
[2] Nursing Solutions Inc. (2024) *2024 NSI National Healthcare Retention and RN Staffing Report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed May 16, 2024.

[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

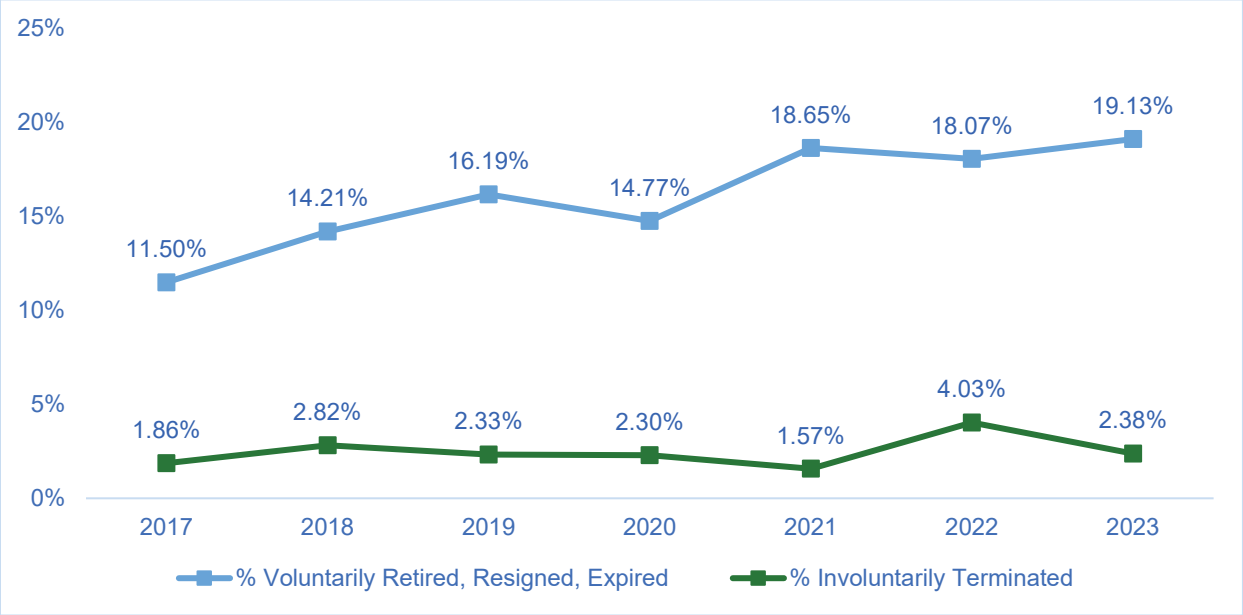


	2017	2018	2019	2020	2021	2022	2023
Maryland RN Turnover Rate	13.37%	17.03%	18.52%	17.07%	19.79%	22.24%	21.51%
National RN Turnover Rate	16.80%	17.20%	15.90%	18.70%	27.10%	22.50%	18.40%

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

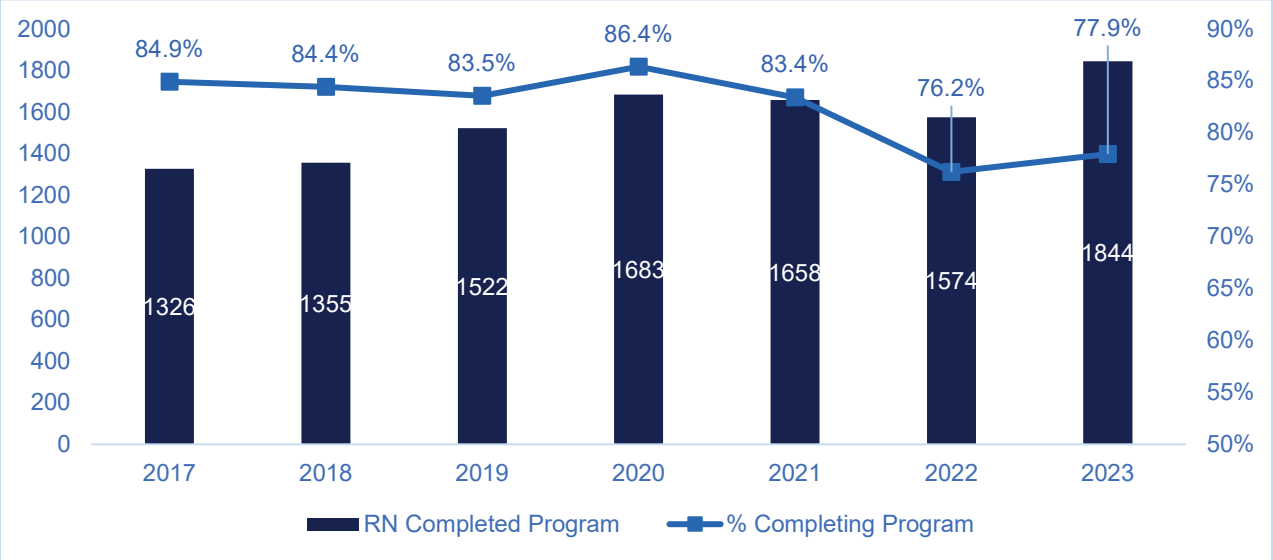


Source: Hospital NSP I Annual Reports

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.

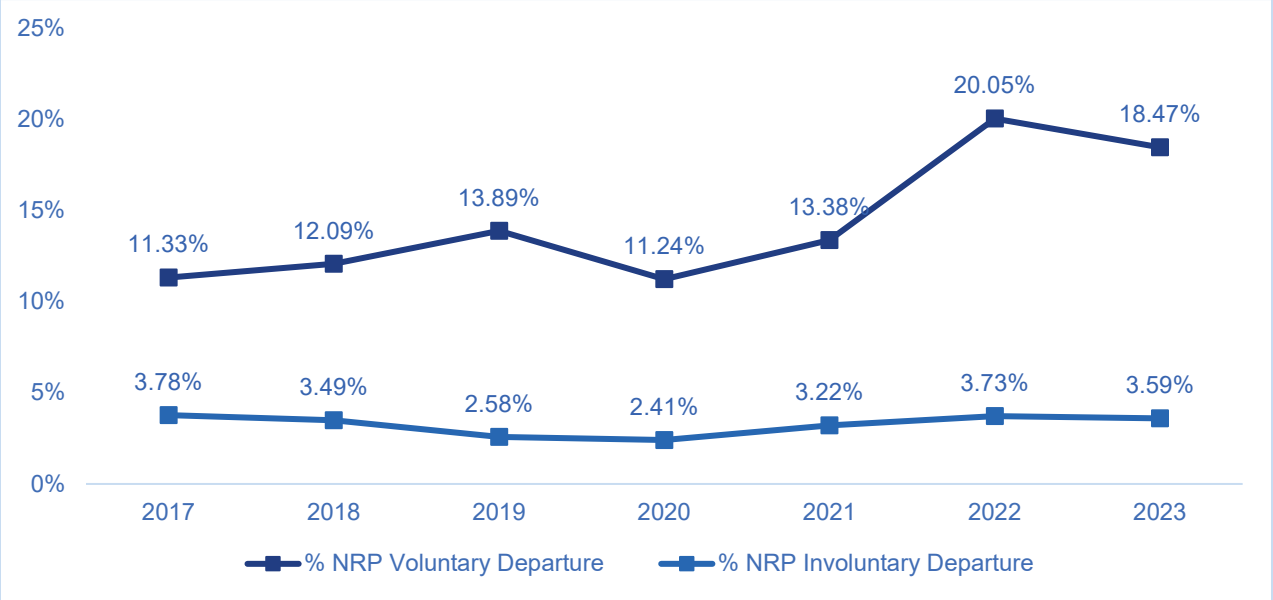
Figure 5. RNs Participating and Completing Residency Program, FY 2017 -2023



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

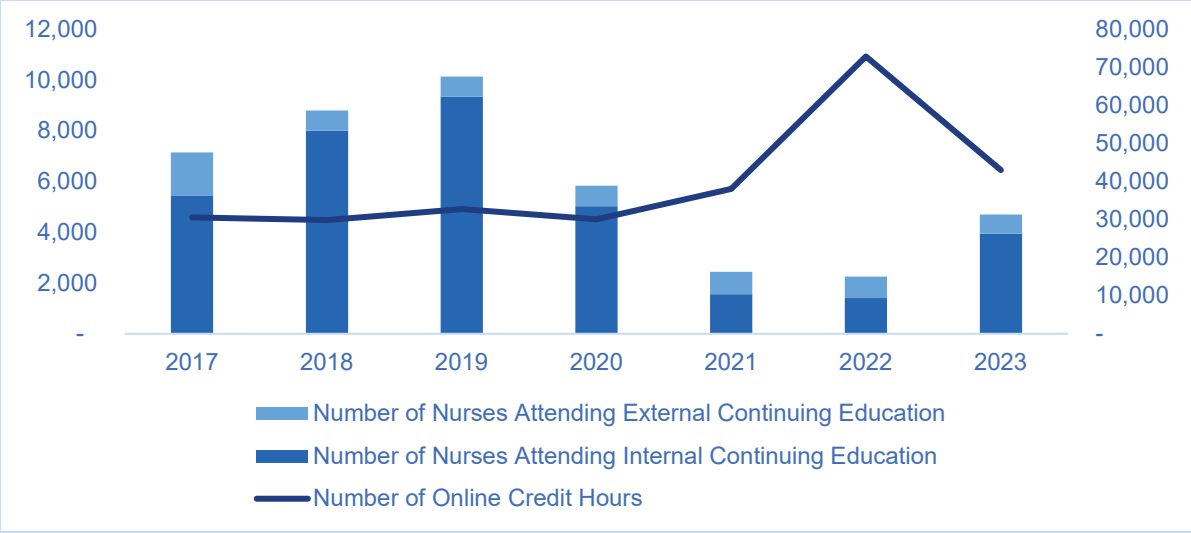


Many hospitals have cited the clinical experiences during nursing school as a critical driver of voluntary NRP departures. Safety concerns and the strain on hospital resources due to high demands on nursing staff to train new incoming nurses have caused nursing schools to find innovative ways to find 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.

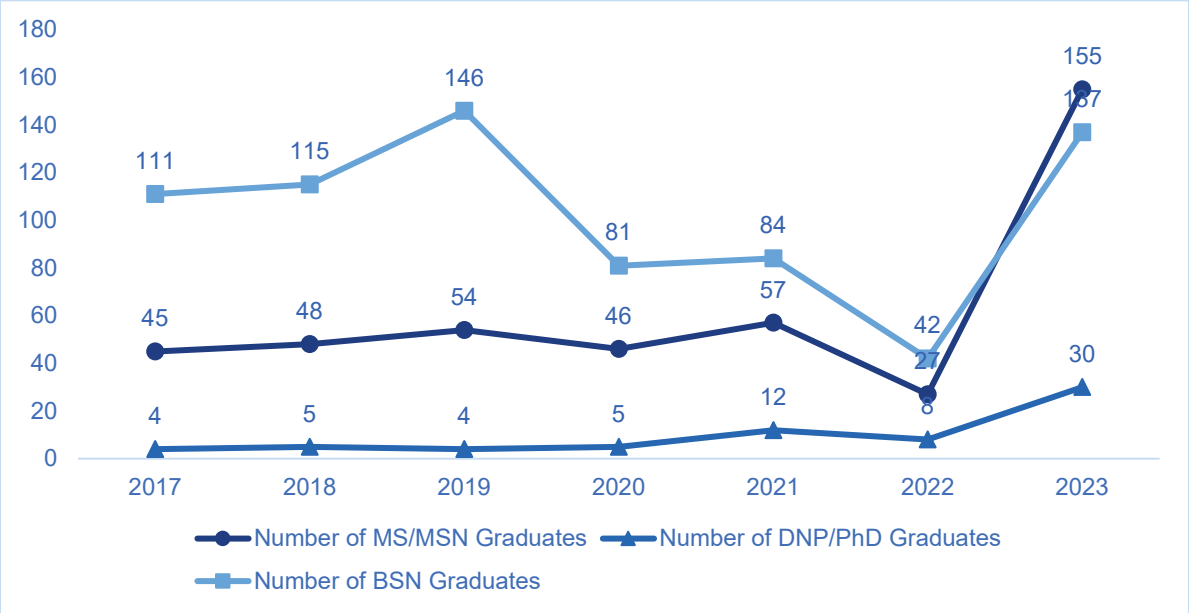
Figure 7. Continuing Education Participants and Online Credit Hours, FY 2017 - 2023



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.

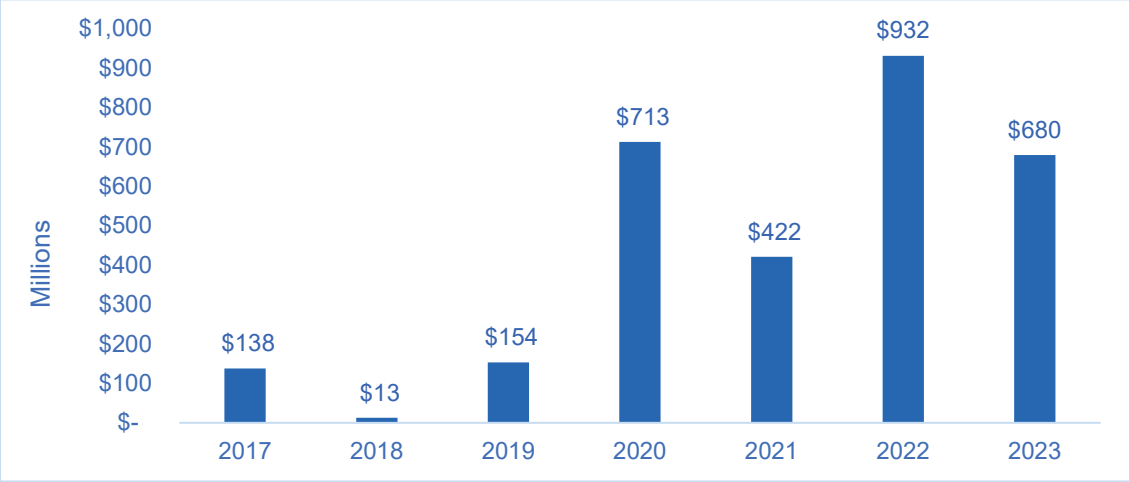
Increased Reliance on Agency Nurses

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.

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Hospital Community Benefit Reporting Proposed Changes to Regulations

July 10, 2024

Proposed Edits to COMAR 10.37.01.03

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*.

Changes were reviewed in the Community Benefits Reporting Workgroup.

Promulgating Regulations- Key Steps

- Staff engage stakeholders (workgroup)
- **Staff present proposed regulations to Commission.**
- **The Commission votes to send the proposed regulations to Maryland Register for public comment.**
- Public comment period begins when the regulations are published (30 days).
- Staff consider public comments and revise regulations if needed.
- If substantive changes are made to the regulation, staff propose updated regulations, repeating the steps above.
- **Staff present final regulations to the Commission for adoption.**
- **Commissioners vote to implement the regulations.**
- Notice of Final Action sent to Maryland Register; regulations are effective 10 days after publication.

Questions?

Megan Renfrew

Deputy Director, Policy and Consumer Protection

megan.renfrew1@maryland.gov

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.

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(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).

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Revenue for Reform

FY 2026 Policy Development Plan

Erin Schurmann

Chief, Provider Alignment & Special Projects

Background

- Revenue for Reform is a component of the Integrated Efficiency policy, which Commissioners approved in July 2023.
- The primary goals of the Revenue for Reform policy are to:
  - Direct hospital retained revenue to community-based population health investments and drive population health improvement.
  - Support projects that advance the goals of the Total Cost of Care Model to improve health equity, population health, and reduce total cost of care.
  - Create a virtuous cycle between less need for hospital services and growing hospital investments in the community.
- Revenue for Reform integrates community health spending directly into hospital global budgets, thereby creating a sustainable funding stream for community and population health investments.

Status Update on FY 2025 Applications

- In the May 2024 Commission meeting, staff put forth a list of R4R application adaptations to implement immediately for FY 2025.
  - HSCRC and MDH are finishing edits for the FY 2025 R4R application to release in late July.
  - HSCRC and MDH are working to identify worthy community health interventions for hospitals in the event hospitals do not put forth satisfactory proposals.
  - Staff anticipate that hospital submissions will be due in October.
  - HSCRC and MDH will review applications in the fall and approve them by December 2024.
- As part of the FY 2025 application, HSCRC is developing a standardized impact measurement approach.
  - Hospitals will be required to identify measures available through CRISP reporting tools, including the Public Health Dashboard, MADE, Multi-Payer Reporting Suite, Pre-Post Panels, and a Care Transformation Initiative-like option.
  - These reporting tools can provide both aggregate and patient-level data on cost savings, utilization, quality, and equity measures.
  - Hospitals must provide a relevant impact measure leveraging any of these tools, as well as a baseline and performance target(s).
  - If no CRISP tool is appropriate for a given intervention, hospitals may provide a custom measure with a baseline and performance target.

Population Health Innovations Subgroup

- Staff is forming a subgroup of Payment Models Workgroup that will advise on updates to the FY 2026 R4R policy.
- The subgroup will advise HSCRC on the development and evolution of HSCRC population health programs and initiatives, offering input on overall strategy and practical considerations impacting design and implementation.
  - Revenue for Reform - FY 2026 Revisions
  - High-Value Care / Population Health Management Plans (approved in Update Factor)
  - Innovations in Clinical Delivery Program (e.g. Hospital at Home, other innovative programs)
- Specific to R4R, the subgroup will advise on updates to the FY 2026 policy and application.
- Subgroup feedback will be incorporated into the R4R FY 2026 draft and final recommendation to Commissioners.
- The subgroup will primarily discuss:
  - Existing and new funding tracks: hospital-defined interventions, pre-approved community partnerships, State-managed population health fund
  - Multi-year strategy and implementation
  - Standardized impact measurement approach

Guiding Principles for Revenue for Reform Updates

- Aligns with Statewide and Regional Priorities
- Reflects Community and Patient Need
- Equity-Centered Strategy
- Efficient and High-Value Investments
- Standardized Approach to Measuring Impact
- Meaningful Collaboration with Community Partners
- Reflect Long-Term, Strategic Vision of Community Health Improvement
- Enables All-Payer Opportunities
- Drives Innovation in Care Delivery to Create High-Value Care

Timeline

- Call for Subgroup Members – Interested stakeholders should email hscrc.grants@maryland.gov by July 25, 2024
  - HSCRC encourages non-hospital stakeholders to participate.
- Subgroup Meetings (TENTATIVE)
  - August 20, 2024
  - September 24, 2024
- Draft Recommendation – November 2024
- Public Comment – November / December 2024
- Final Recommendation and Commissioner Vote – January 2025
- FY 2026 Application Released – March 2026

Questions for Commissioners

- How should we balance clinical community health interventions (e.g. primary care and behavioral health provider access) with non-clinical interventions (e.g. food access, healthy housing programs)?
- What should be priority agenda topics, in addition to what staff has listed?
- Are there additional guiding principles for staff to consider as part of FY R4R FY 2026 updates?
- What stakeholders should be included at the table, in addition to hospitals?

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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.