maryland
health services
cost review commission

635th Meeting of the Health Services Cost Review Commission

October 8, 2025

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on September 10, 2025

Specific Matters

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

Docket Status – Cases Closed

2679A Johns Hopkins Health System
2680A University of Maryland Medical Center- WITHDRAWN

2. Docket Status – Cases Open

2681A Johns Hopkins Health System
2682A Johns Hopkins Health System

Informational Subjects

3. Presentation: GBRICS - Regional Partnership Catalyst Program

Subjects of General Applicability

4. Report from the Executive Director
    a) Model Monitoring
    b. AHEAD Model Update
5. Presentation: EQIP Performance (CY 2024)
6. Presentation: Summary of Physician Cost Report

7. Draft Recommendation: Marketshift Improvements (VCF, Markets, Exclusions)
8. Draft Recommendation: Select Hospital Volume Realignment
9. Draft Recommendation: ED Best Practices Policy - RY 2028
10. Materials Only: Regional Partnership Catalyst Program - CY 2024 Activities
11. Hearing and Meeting Schedule

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MINUTES OF THE 634th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION SEPTEMBER 10, 2025

Chairman Joshua Sharfstein called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, also in attendance were Vice Chairman James Elliott, M.D., Jon Blum, M.P.P., Maulik Joshi, D.Ph., Nicki McCann, J.D., Ricardo Johnson, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Blum and seconded by Commissioner Sabi, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:15 p.m.

REPORT OF SEPTEMBER 10, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed on September 10, 2025, in the Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM JULY 30, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Vice Chairman Elliott and seconded by Commissioner Joshi, the Commission voted unanimously to approve the minutes of July 30, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2675A	Johns Hopkins Health System
2676A	Johns Hopkins Health System
2677A	Johns Hopkins Health System
2678A	Johns Hopkins Health System

ITEM III
OPEN CASES

2679A	Johns Hopkins Health System
2680A	University of Maryland Medical Center

ITEM IV
PRESENTATION: GILCHRIST EXPANDING PALLIATIVE MEDICINE SERVICES

Ms. Catherine Y. Hamel, MA, President, Gilchrist and Executive Vice President and Chief Strategy Officer, Greater Baltimore Medical Center (GBMC) HealthCare; Dr. David S. Wu, Senior Advisor Education & Outreach Gilchrist; and Dr. Lakshmi Vaidyanathan, MBA, Section Chief, Palliative Medicine Associate, Chief Medical Officer, Gilchrist, presented on a New Paradigms in Care Delivery-funded project entitled Gilchrist: Expanding Palliative Medicine Services.

Gilchrist, a wholly-owned subsidiary of GBMC, is the largest provider of hospice services in Maryland and focuses on providing comprehensive care during the last three to five years of an individual's life. The Palliative Care division offers services in four Maryland hospitals and runs a large community-based program for about 800 patients.

Dr. Vaidyanathan explained that Gilchrist's Palliative Care Service Line provides specialized medical care for individuals with chronic and serious health conditions, focusing on alleviating symptoms, supporting caregivers, and improving quality of life. She outlined a strong case for expanding these services, citing evidence that this model of care enhances the patient experience, lessens caregiver burdens, and reduces "burdensome transitions" like frequent hospital visits. This approach would lead to more timely hospice transitions and an average cost savings of $14,000 per patient.

The proposed expansion is designed to provide earlier and broader access to palliative medicine for vulnerable populations, building upon Gilchrist's current partnerships with GBMC, Johns Hopkins Howard County Medical Center, Anne Arundel Medical Center, and Doctors Community Medical Center. The multi-faceted plan includes placing a dedicated practitioner in the emergency department for early intervention, expanding service hours to 12 hours a day, seven days a week, implementing telehealth for high-risk patients after discharge, integrating crisis-level hospice care in the hospital, and launching a statewide education initiative.

To ensure accountability and measure success, Dr. Vaidyanathan confirmed that Gilchrist actively reviews and reports internal data on its impact. This information, which tracks both patient-facing outcomes and the cost of care, is available to demonstrate the value and effectiveness of their palliative care programs.

Dr. Wu's presentation centered on a statewide educational initiative that would clarify the true purpose and benefits of palliative care for all residents. The initiative will begin at the community level, anchored by Gilchrist, with a dedicated focus on educating diverse and underserved neighborhoods. The effort will then broaden to create a unified message by partnering with other healthcare institutions across the state. Finally, the plan aims for long-term sustainability

by collaborating with state agencies to embed this education into a permanent framework, ensuring the growth of both palliative care services and awareness throughout Maryland.

Presentation: Vizient/AACN Nurse Residency Program (NRP)™ & Maryland Organization of Nurse Leaders (MONL)/Maryland Nurse Residency Collaborative (MNRC)

Ms. Jennifer Zipp, Executive Director MONL/MNRC and Ms. Monica Nelson, Director of Clinical Education presented on the Vizient/AACN Nurse Residency Program (NRP)TM & Maryland Organization of Nurse Leaders/ Maryland Nurse Residency Collaborative.

Ms. Zipp's presentation detailed Maryland's highly successful nurse residency program, a statewide initiative born from the 2010 Future of Nursing report. With crucial funding from the Nurse Support Program (NSP), Maryland launched its collaborative in 2013 and, by 2018, became the first and only state where every acute care hospital has a standardized program. This mandatory 12-month curriculum is designed to bridge the gap between school and professional practice by developing a new nurse's skills in leadership and evidence-based care. A standout feature is its cohort model, where residents progress with a consistent peer group, providing vital support to help them overcome the challenges of their first year.

The program's signature achievement is its incredible impact on nurse retention. Maryland's first-year retention rate for nurse residents is a remarkable 89-91 percent, far exceeding national averages. This success translates into a significant return on investment; Ms. Zipp noted that the state's $12.3 million investment prevented an estimated $38 million in turnover costs. Furthermore, survey data shows that both Maryland's nurse residents and hospital leaders report higher satisfaction with the program than their peers nationwide in nearly every category.

Ms. Zipp stressed that the program's secret sauce is the Maryland Nurse Residency Collaborative (MNRC). This central body unites program coordinators from across the State to share best practices, resources, and innovative teaching strategies. This spirit of cooperation drives continuous improvement and is key to retaining nurses within Maryland, even if they switch hospitals. Ultimately, this state-supported collaborative has built an essential and robust system for developing and keeping a skilled nursing workforce.

Ms. Nelson's presentation focused on the holistic strategies used to retain new nurses throughout the state of Maryland, not just at a single hospital. She highlighted a crucial shift in perspective from the traditional "work-life balance" to a more modern "life-work balance," recognizing that today’s graduates prioritize personal wellness and family. To meet this need, the residency program creates a safe space for new nurses to build not only their clinical competence but, more importantly, their confidence in their judgment and interpersonal skills.

She explained that this support is delivered through a robust, multi-layered system that builds over time. A new nurse's journey begins with a Hospital Orientation to cover fundamental, task-oriented skills. This is immediately supplemented by the 12-month Nurse Residency Program, which provides consistent peer support and monthly sessions with content experts. Finally, a dedicated Mentoring program adds a crucial third layer, pairing the nurse with an experienced guide who is committed to their long-term success and retention in the profession.

Ms. Nelson stressed that this entire supportive umbrella, from initial professional development plans to long-term mentorship, is made possible by grant funding. This financial support is essential for creating the comprehensive system needed to develop and retain a confident, capable, and resilient nursing workforce for Maryland.

No action was taken on this agenda item.

ITEM V
REPORT FROM THE EXECUTIVE DIRECTOR

Dr. Jon Kromm, Executive Director, announced that the Commission is accelerating the development of next year's policy agenda. This faster timeline will allow staff to incorporate recent ideas from Commissioners and prepare for potential future agreement requirements that may arise. The goal is to be more proactive in setting the Commission's direction for the upcoming year.

The development process will begin with finalizing internal discussions among the Commissioners. A draft timeline and policy agenda will be circulated to all stakeholders for a period of feedback and public comment. The final, revised agenda will then be presented at a future Commission meeting for official approval.

Dr. Kromm assured the Commission that this accelerated planning will not delay any items already on the schedule. He specifically confirmed that the important market shift proposal is still on track to be presented in October 2025 as planned, and all related work is proceeding without interruption.

Commissioner Blum requested more detail on the process for developing the new policy agenda. Specifically, how the process will work for the Commissioners and external groups like the hospital community and other stakeholders. Dr. Kromm outlined a transparent, multi-step process for developing the policy agenda. He explained that after the Commission creates a more "fleshed out" internal draft, it will be posted publicly for a formal comment period. This step is designed to ensure that the hospital community and other key stakeholders have a clear opportunity to provide feedback and input on the proposed agenda before any final decisions are made. Following the comment period, the revised agenda will be brought back to the

Commission for discussion during a public meeting before it is finalized. Dr. Kromm added that while this procedure doesn't normally require a formal vote, this final public discussion is particularly crucial this year given the high stakes of the current healthcare landscape.

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data through May 2025 (for claims paid through July 2025). The data showed that Maryland's Medicare hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were also unfavorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is 1.48 percent above the nation through May 2025, and that Maryland Medicare hospital and non-hospital growth through May resulted in savings of $75 million.

No action was taken on these agenda items.

ITEM VI
HEARING AND MEETING SCHEDULE

October 8, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:20 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission
September 10, 2025

Chairman Sharfstein stated the reasons for Commissioners to move into administrative session, under the authority provided by the General Provisions Article §3-103, §3-104, and §3-305 for the purposes of discussing the administration of the Model, the FY25 Hospital unaudited financial performance, and conferring with legal counsel to obtain legal advice.

Upon a motion made in public session, Chairman Sharfstein called for an adjournment into closed session.

The administrative session was called to order by motion at 12:07 p.m.

In addition to Chairman Sharfstein, Commissioners Blum, Elliott, Joshi, Johnson, McCann, and Sabi.

Staff members in attendance were Jon Kromm, William Henderson, Claudine Williams, Alyson Schuster, Geoff Dougherty, Cait Cooksey, Laura Goodman, Erin Schurmann, Bob Gallion and William Hoff.

Joining by Zoom: Deb Rivkin and Christa Speicher.

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

Item I

The Commission heard from Ms. Erin Schurman, Associate Director, Strategic Initiatives, and Counsel related to a Regional Partnership.

Item II

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

Item III

Mr. Henderson also updated the Commission, and the Commission discussed the FY25 Hospital Financial Condition through June FY25.

Item IV

Dr. Jon Kromm, Executive Director updated the Commission on the status of the AHEAD model.

The Closed Session was adjourned at 12:55 p.m.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

October 8, 2025

maryland
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cost review commission

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2491
BALTIMORE, MARYLAND	*	PROCEEDING:	2681A

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on September 2, 2025, on behalf of its member hospitals (the "Hospitals"), Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, 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 cardiovascular services, spine surgery, CAR-T and certain cancer and bone marrow transplants with One Team Health, an international TPA. The System requests approval of the arrangement for a period of one year beginning October 1, 2025.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the 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 cardiovascular services, spine surgery, CAR-T and certain cancer and bone marrow transplants for a one-year period commencing October 1, 2025, 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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SYSTEM	*	FOLIO:	2492
BALTIMORE, MARYLAND	*	PROCEEDING:	2682A

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Central Maryland Regional Crisis System

Health Services Cost Review Commission

October 8, 2025

Behavioral Health System Baltimore

BEHAVIORAL HEALTH SYSTEM BALTIMORE

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that manages Baltimore City's behavioral health system—the system of care that addresses emotional health and well-being and provides services for substance use and mental health disorders.

Vision

We envision a city where people thrive in communities that promote and support behavioral health and wellness.

Mission

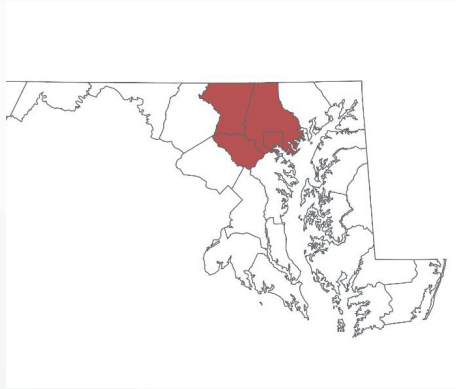
We work to develop, implement and align resources, programs and policies that support the behavioral health and wellness of individuals, families and communities.

Values

Integrity, Equity, Innovation, Collaboration, Quality.

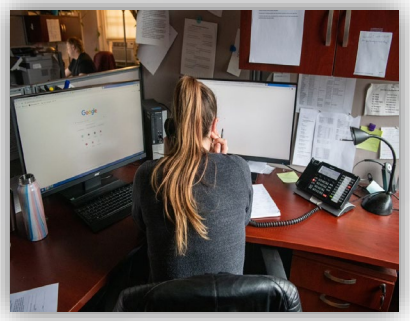
Central Maryland Regional Crisis System

- Formerly known as the Greater Baltimore Regional Integrated Crisis System (GBRICS)
- Five-year, $45 million to invest in behavioral health infrastructure and services.
- Developed in collaboration with 17 hospitals, leaders and community partners, and behavioral health authorities in Baltimore City, and Baltimore, Howard, and Carroll Counties
- BHSB serves as the Regional Administrative Manager for the project



Carroll Hospital * Grace Medical Center * Greater Baltimore Medical Center * Howard County General Hospital * Johns Hopkins Bayview Medical Center * Johns Hopkins Hospital * MedStar Franklin Square Medical Center * MedStar Good Samaritan Hospital * MedStar Harbor Hospital * MedStar Union Memorial Hospital * Mercy Medical Center * Northwest Hospital * Sinai Hospital * Ascension Saint Agnes Hospital * University of Maryland Medical Center * University of Maryland Medical Center * Midtown Campus University of Maryland * St. Joseph Medical Center

Crisis Response:
Anyone, Anywhere, Anytime



Someone to call

Someone to respond

Somewhere to go

Overall Goal:

Reduce unnecessary Emergency Department (ED) use and police interaction for people in behavioral health crisis

988 Call Center: Create a regional, integrated 988 hotline that is supported with infrastructure for real-time bed and appointment capacity and referral tracking, coordinated dispatch of mobile crisis response, and increased data.

Mobile Crisis Services: Expand capacity, set regional standards following national best practices

Open Access: Support behavioral health providers to offer same day walk-in/virtual services for people in immediate need of behavioral health care.

Community Engagement & Public Education: Support culture change to increase awareness and use of the 988 helpline as an alternative to calling 911 or using the ED.

Non-profit Multistakeholder Oversight: Drive regional activity and shared accountability.

Crisis System Infrastructure – Someone to Call

988 Helpline for immediate counseling and connection to resources
24/7. Regional. Answers 4,000+ calls a month. Makes 1,400+ follow-up/care coordination calls to 600+ people per month. 54% of incoming calls from people in Baltimore City. 91% of calls resolved on the phone.

115 counselors and 6 dispatchers answering 988 calls
Average call answer time = 23 seconds. Call answer rate = 90%. One of the highest in the country. Maryland based network for back up calls.

Community engagement and public education
Support culture change to increase awareness and use of the 988 helpline as an alternative to calling 911 or using the ED. Community shaped public education strategies.

CALL988 Campaign

Paid marketing to increase awareness and use of the 988 Helpline. Community informed campaign.

Community Ambassadors Program
Trusted people in communities spreading the word about 988

988 Helpline

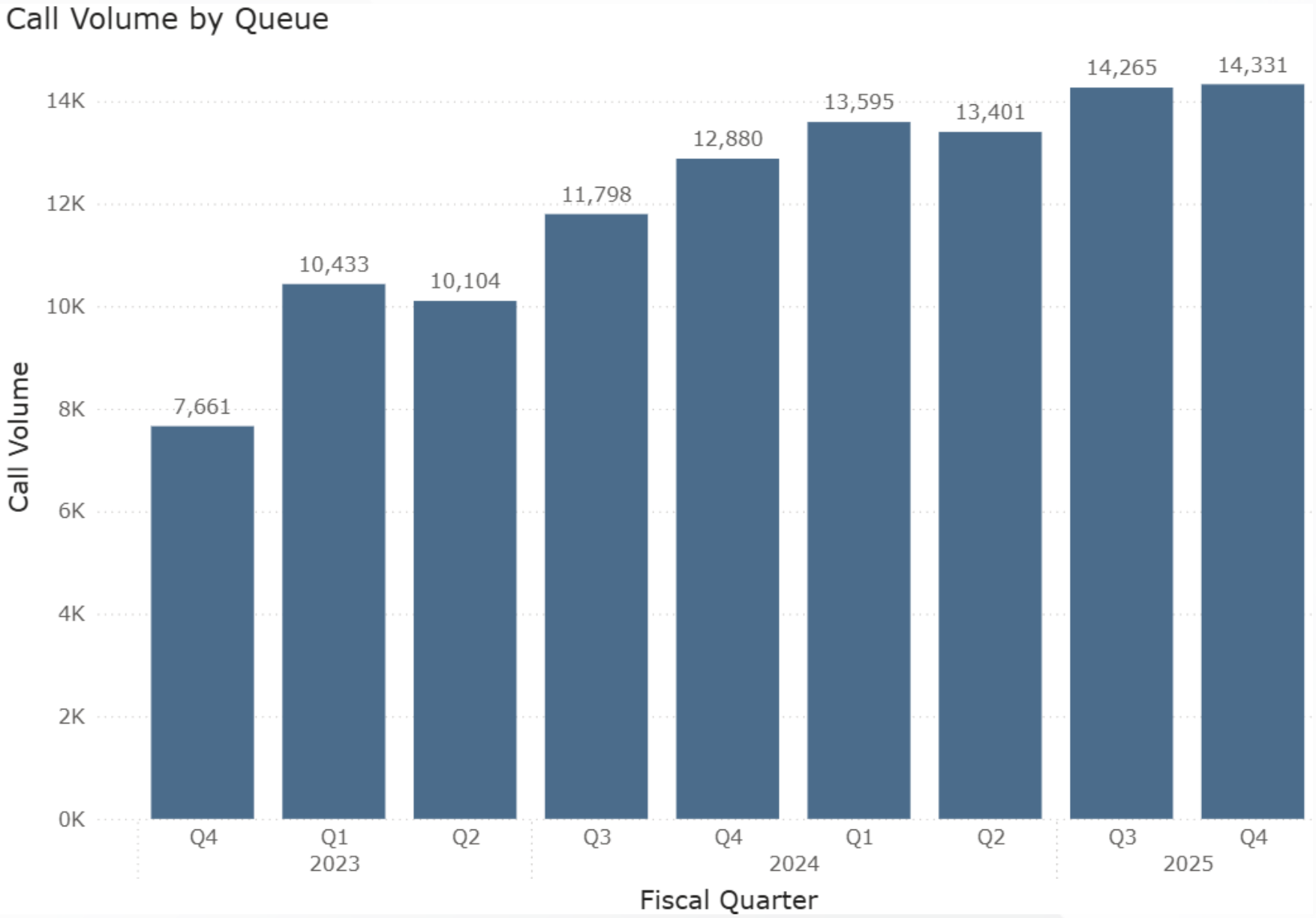
Call Volume

April 2022 – June 2025

Source = Behavioral Health Link

- Major phone carriers began georouting to 988 Sept. 2024

- 91% of calls using the 988 # resolved on the phone



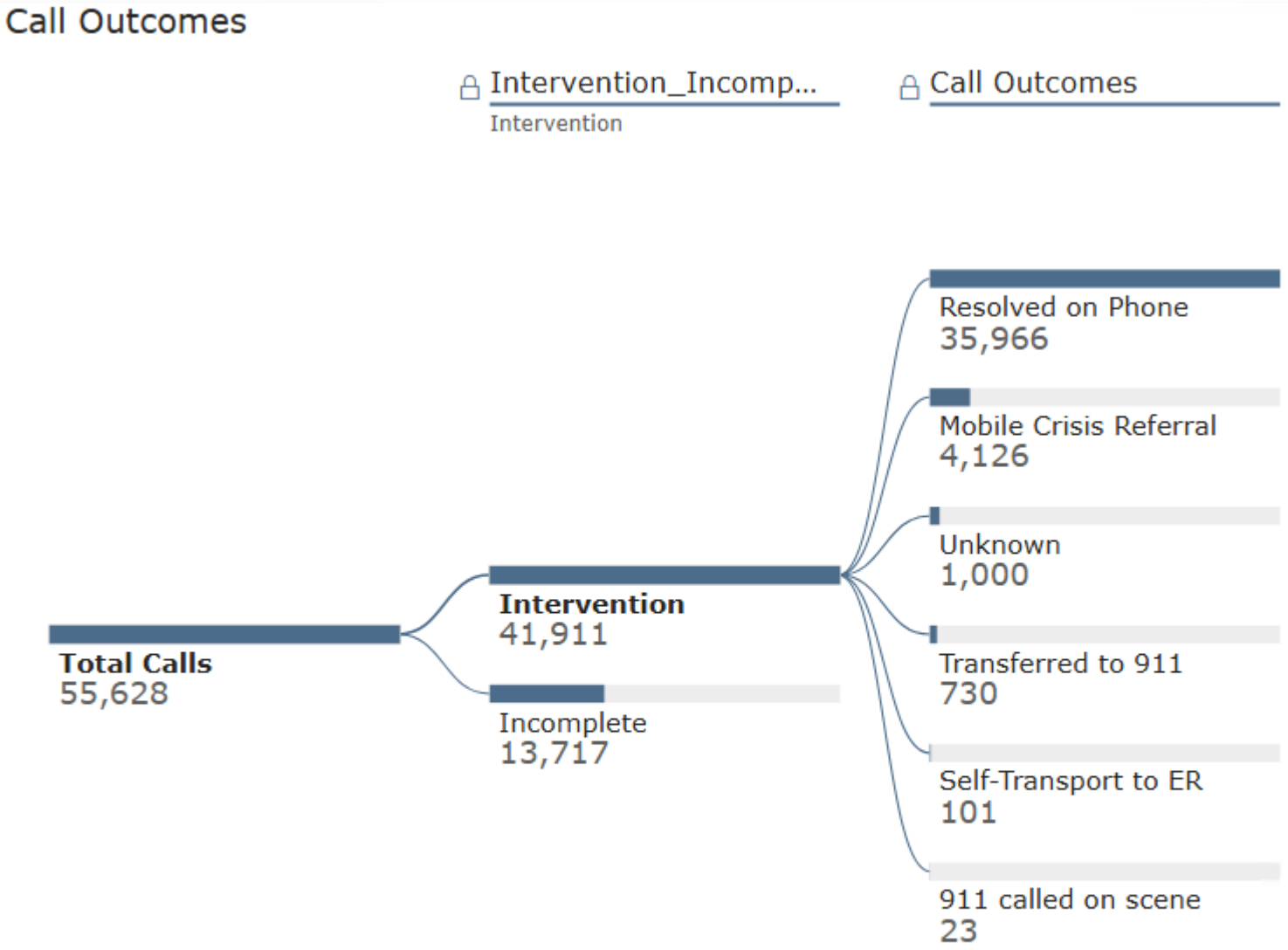
988 Helpline

Call Outcome

July 2024 – June 2025

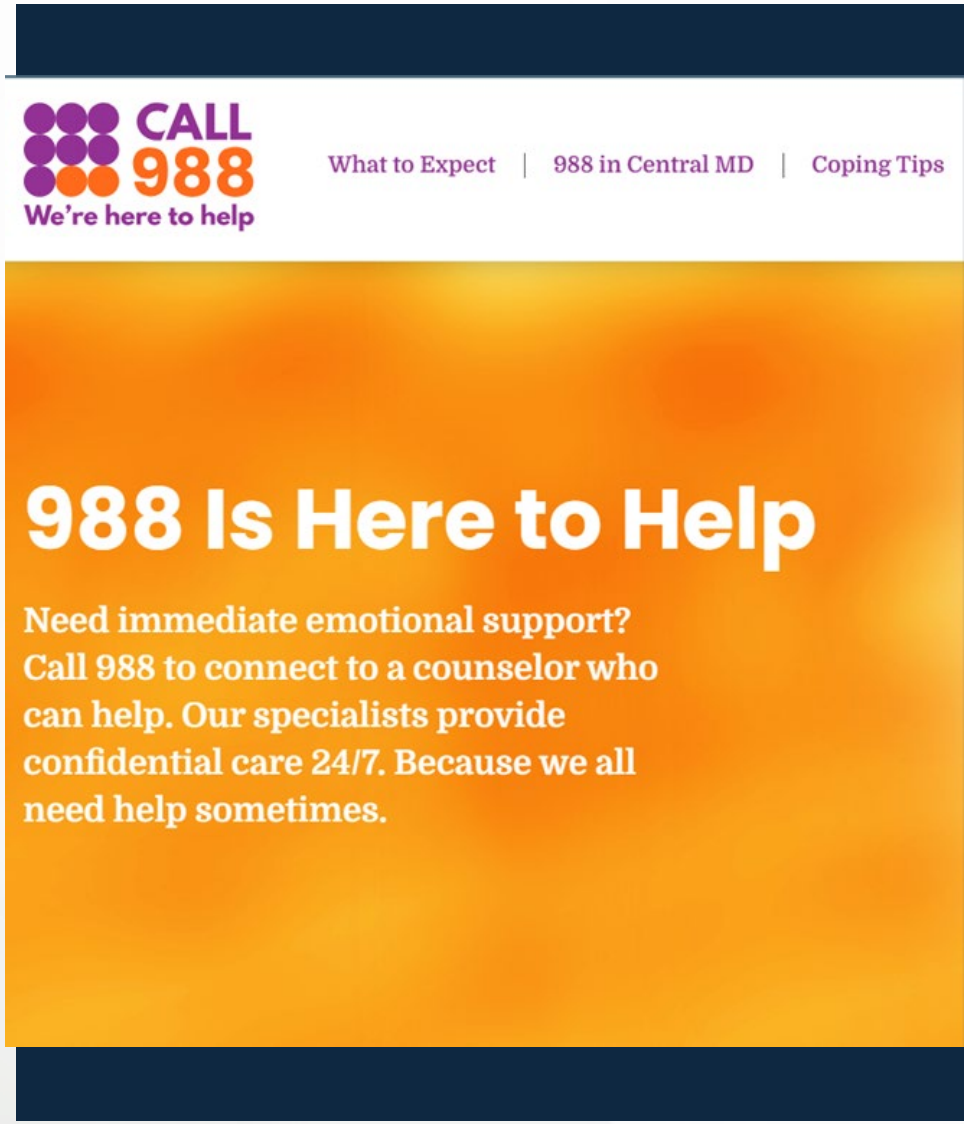
Source = Behavioral Health Link

Incomplete = hang ups, silent calls, wrong #s, prank calls



Public Education Activities

- Established Central Maryland brand: CALL988
- Launched CALL988 website: 988helpline.org
- Equipped partners with CALL988 materials
- Launched 988 Community Ambassadors Program
- Launched series of advertising campaigns
- Developing targeted material for in-patient/out-patient education with hospital partners
- Creating online store for partners to purchase CALL988 materials



Crisis Services Public Education in Hospitals

Hospital Public Education Strategies:

- Training for hospital staff and creation of short training video
- “Ask me about 988” pins for staff
- Posters in staff break rooms (for 988 referrals)
- Posters in waiting areas / patient rooms
- Tables with information and giveaways in lobbies or other high-traffic areas

Crisis System Infrastructure – Someone to Respond

Mobile crisis services for community-based, in-person assessment, counseling and connection to acute and ongoing care

24/7. Serves people across the lifespan. Licensed/credentialed clinician & peer team. 3 providers.

Specialty mobile crisis services for children and youth

Provides crisis response 10 hours/day, 5 days/week & follow up and support for up to 6 weeks. Mobile crisis teams can refer for intensive follow up.

Triage matrix to guide decision making & promote the least police response possible

Guidance for call takers to ensure consistency in what kind of team is dispatched by 988. Enhances transparency for the community on when law enforcement is requested by 988.

Mobile Crisis Services

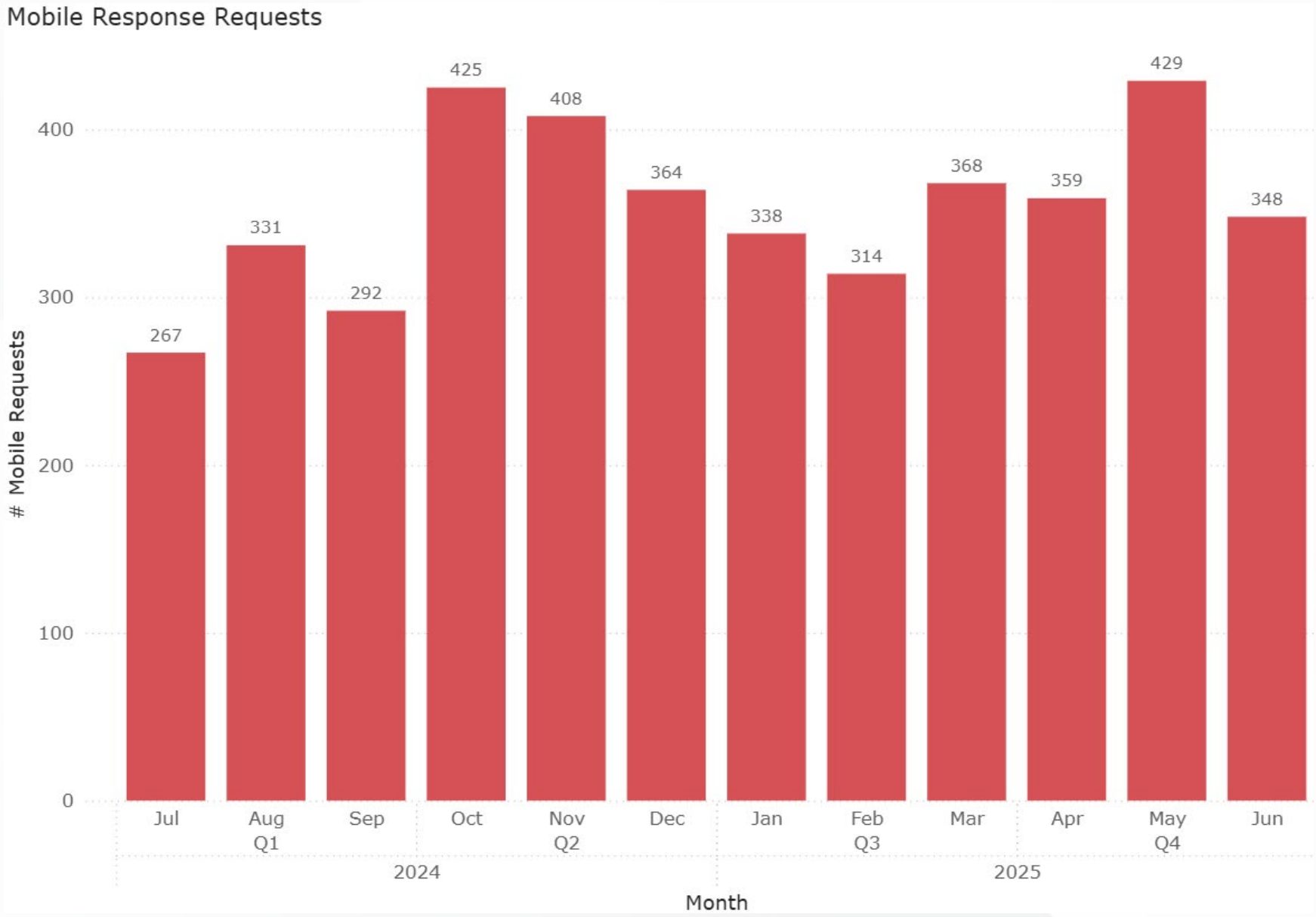
Mobile Crisis Response Volume

Central MD Region

July 2024 – June 2025

Source = Behavioral Health Link

Total requests = 4,243



Mobile Crisis Services

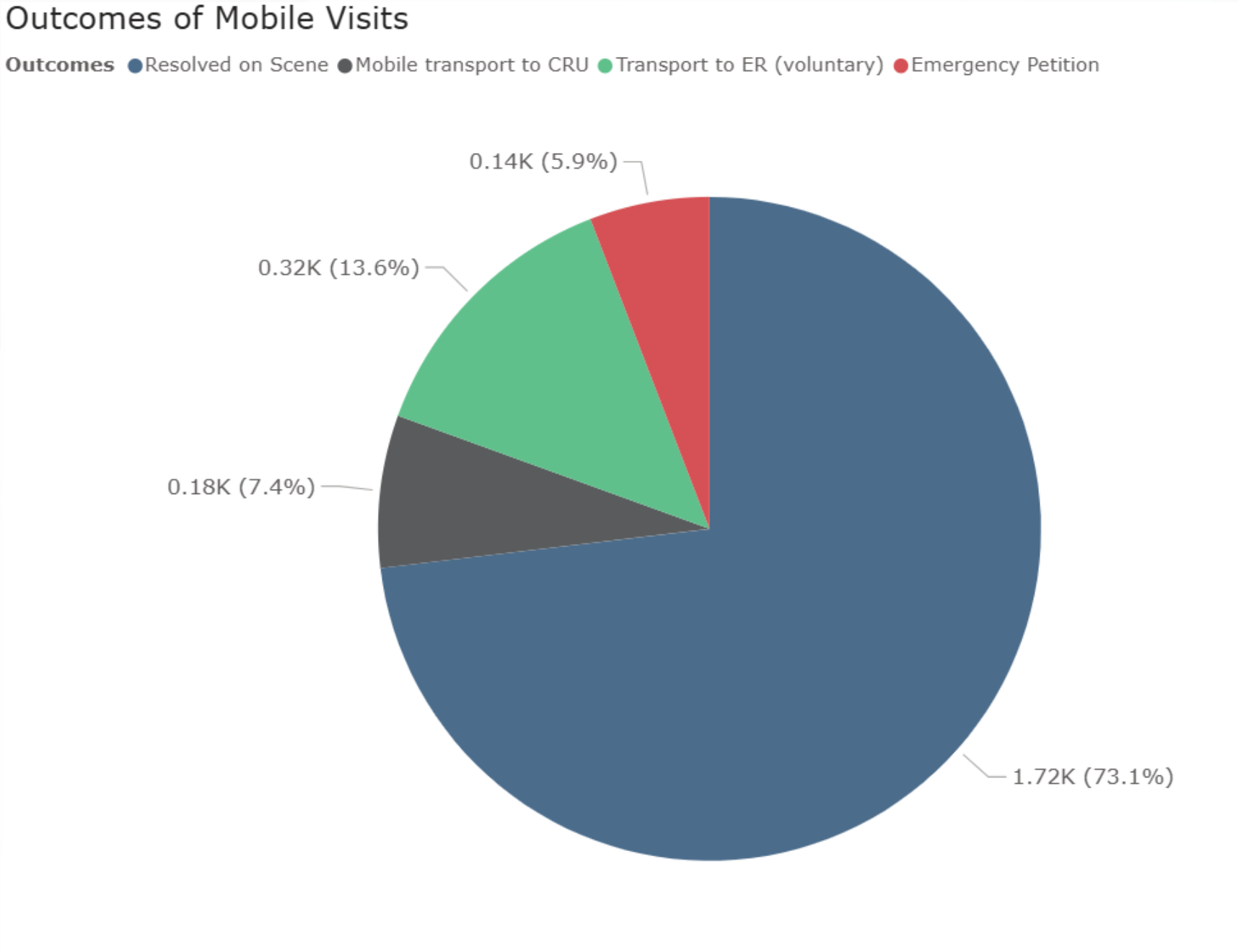
Outcome of Visits

Central MD Region

July 2024 – June 2025

Source = Behavioral Health Link

- All completed visits where services were provided by mobile crisis services dispatched through 988
- 80.5% resolved without ED visit
- Data reflect multiple teams supported through diverse funding resources



Crisis System Infrastructure – Somewhere to go

Urgent SUD services

24/7 assessment and stabilization for substance use. Connection to ongoing resources. Average length of stay = 24 hours. 1 provider = 35 beds. Serves 300+ people/mo. Access = walk-in or 988.

Residential SUD withdrawal management (ASAM level 3.7)

24/7 medically managed high-intensity service for people who need monitoring, counseling and support in a residential, community-based setting. Average length of stay = 7days. 3 providers. Access = call provider directly.

Mental health crisis beds

24/7 medically managed high intensity service for people who need monitoring, counseling and support in a residential, community-based setting. Average length of stay = 7 – 9 days. 1 provider. Serves 650+ adults/yr. Access = 988

Open Access Clinic

Same/next day outpatient appointments. Access = 988 or call provider directly

Open Access

Intake & diagnostic evaluation for behavioral health services available on the same day or next day that someone calls for an appointment.

Purpose: Provide seed funding to outpatient behavioral health clinics to expand or begin to offer same day intake appointments (virtual or in person) for immediate-need behavioral health services.

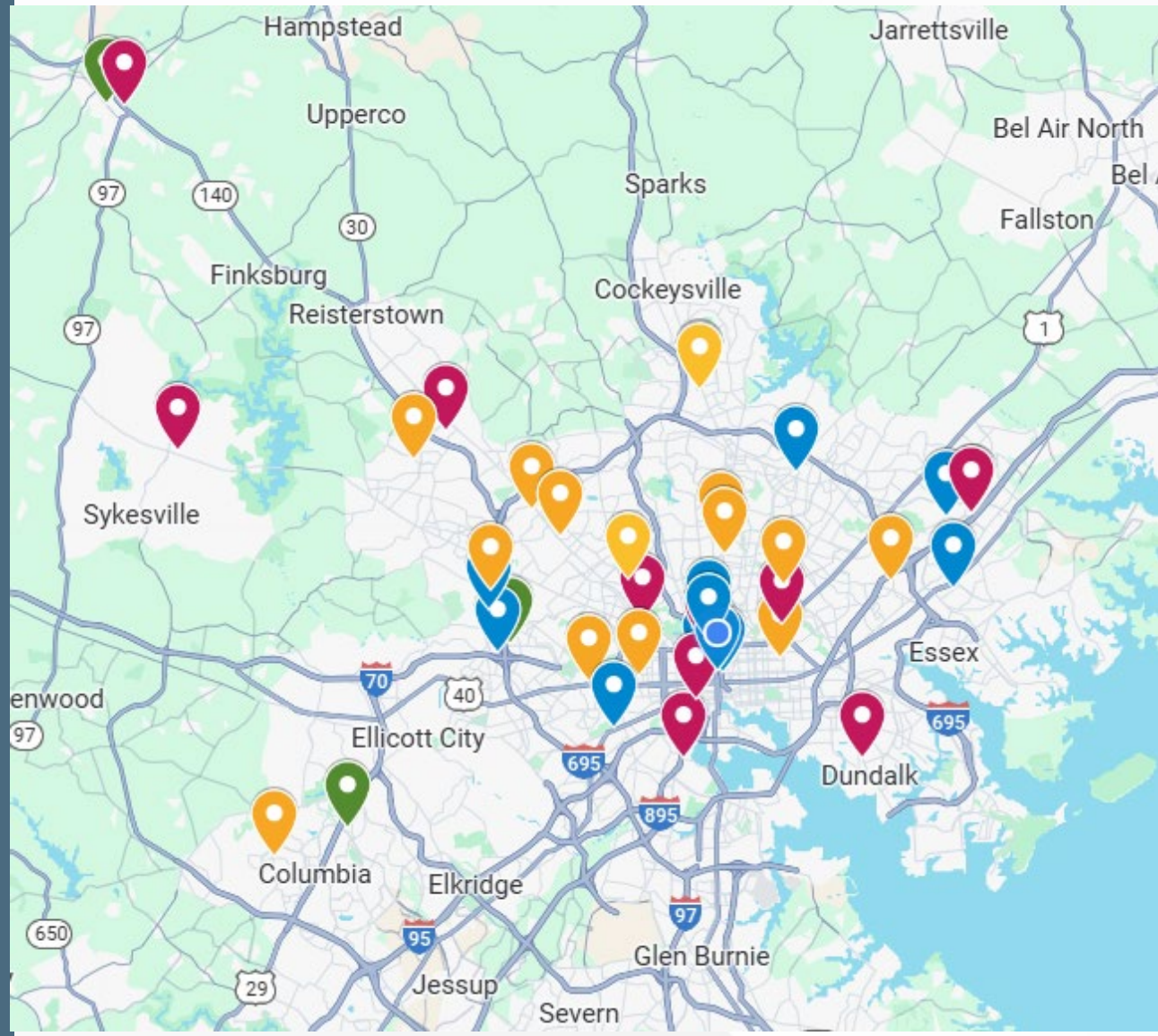
Goal: Give people more control and convenience over their behavioral health services while increasing system capacity to address urgent behavioral health needs in a community setting.

Consultant: CMAG & Associates

Provide technical assistance, collect baseline data, develop workplans tailored to needs of each site, convene a learning community, and more.

Open Access

- 41 clinics to continue the Open Access model after seed funding ends.
- Clinics receive referrals from 988 as well as calls directly to their clinics
- University of Maryland is evaluating the Open Access model and will produce a report Dec 2025.



Green = Cohort 1; Red = Cohort 2; Orange = Cohort 3; Blue = Expansion

Crisis System Infrastructure – Accountability

Regional accountability structure

BHSB works with state to oversee regional services & system accountability. Grant funds services. Regularly convenes providers and other LBHAs. Partners with community to receive feedback & raise awareness of 988.

Crisis response standards and regulations

Agreed upon principles & practices developed in 2021 through community engaged process. Used to guide service development & promote consistency & accountability across the system. State regulations for mobile response services effective 1/1/2025.

Continuous quality improvement

Monthly review of crisis response data with providers & other LBHAs. Monthly case review with 1st responders.

Crisis System Infrastructure – Sustainability

Advocacy for Dedicated State Funding for 988

Maryland established a $0.25 telecom fee that will generate $23.9M statewide in FY26 for the 988 Trust Fund. The Central Maryland Regional Call Center received funding from the 988 Trust Fund in FY26.

Mobile Crisis Fee for Service System

Mobile Crisis providers began billing the fee for service program in January 2025. Based on preliminary analysis of Medicaid claims data from January-March 2025, we estimate there will be a gap in funding for mobile crisis services after the HSCRC funding ends.

Open Access Sustainability

The Open Access model has been sustained by clinics after the seed funding ended. The University of Maryland Evaluation (to be completed in December 2025) will provide more information on sustainability.

Community Engagement and Public Education

Strong partnerships with community groups and leaders will allow the community engagement to continue. Baltimore City is investing funding to continue 988 ambassadors and public education in the city.

Crista Taylor

President & CEO

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Update on Medicare FFS Data & Analysis

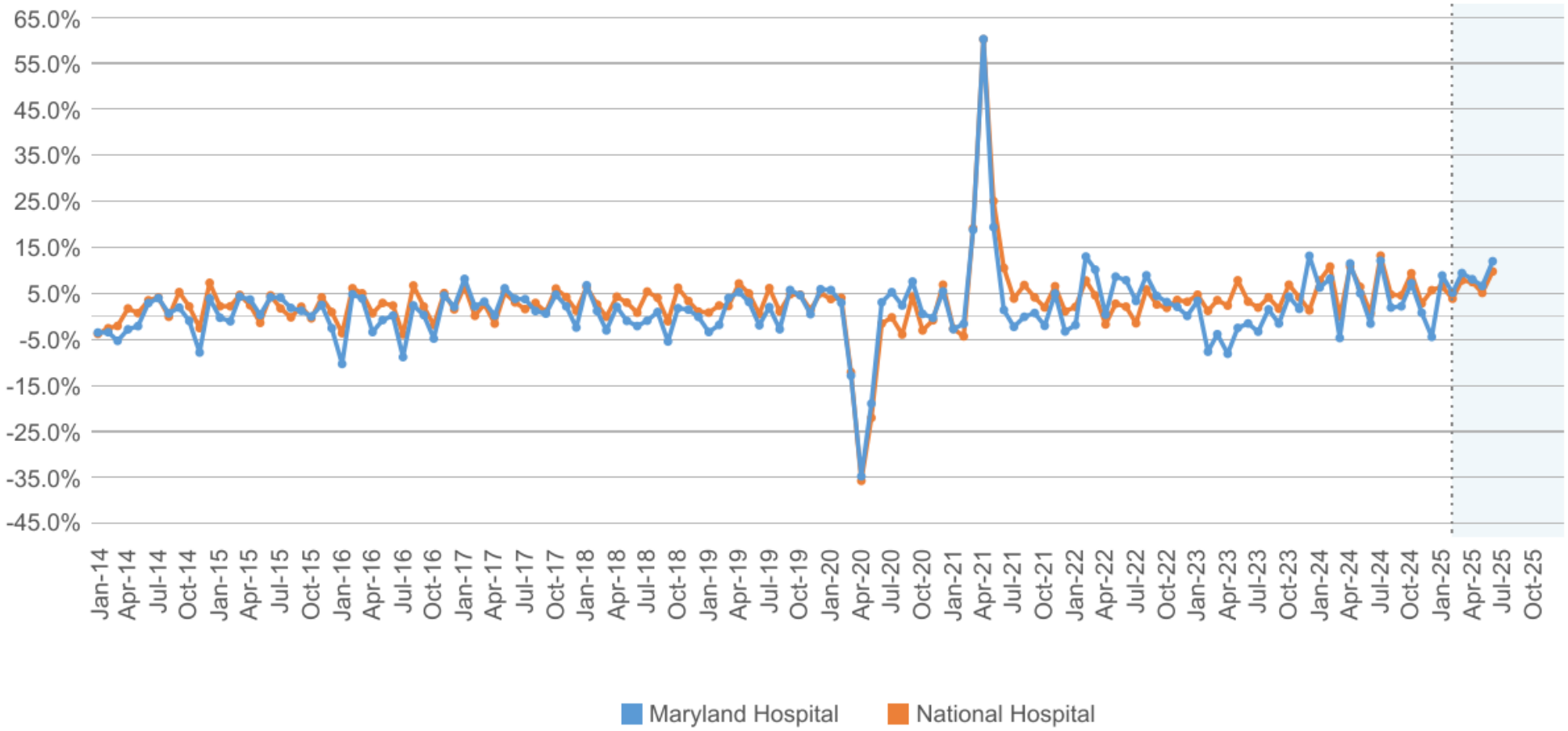
October 2025 Update

Data through June 2025, Claims paid through August 2025

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

Medicare Hospital Spending per Capita

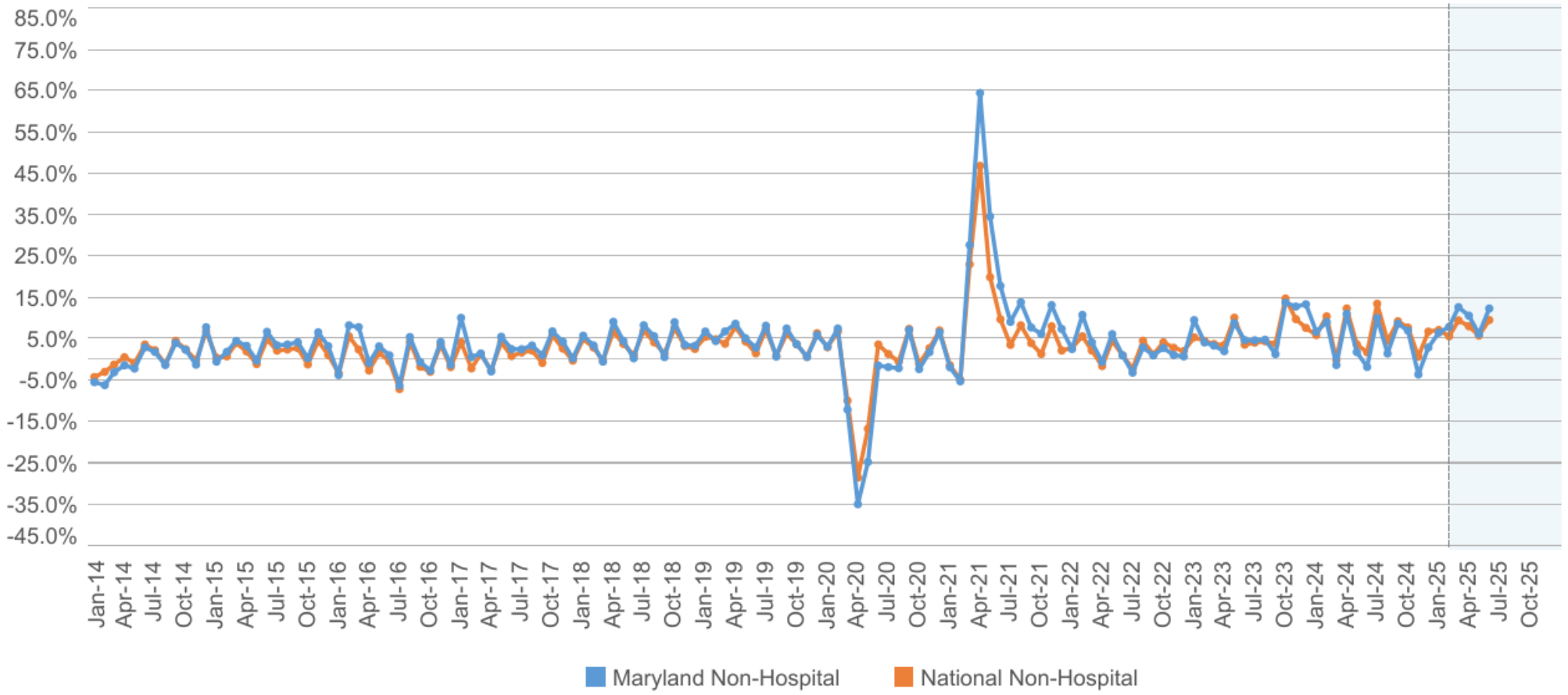
Actual Growth Trend (CY month vs. Prior CY month)



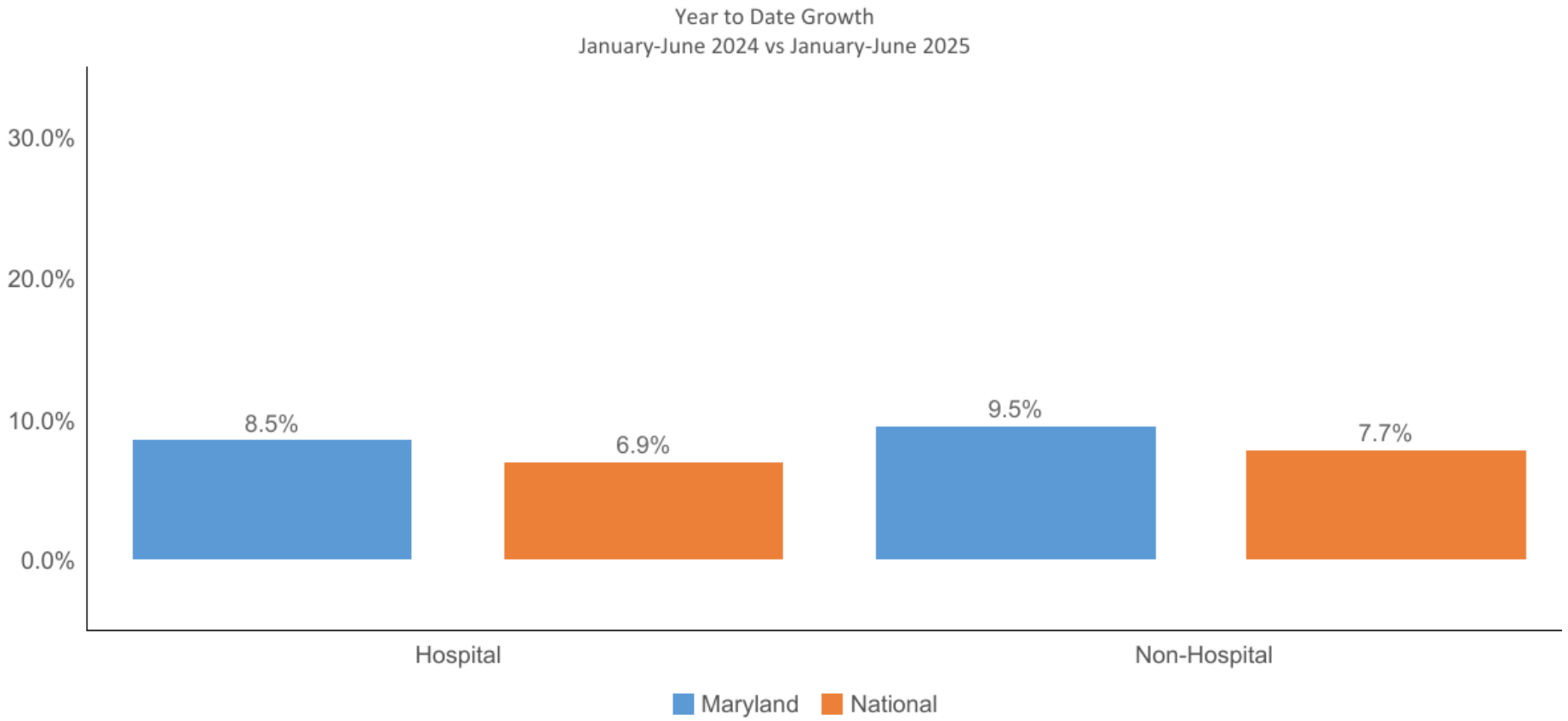
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

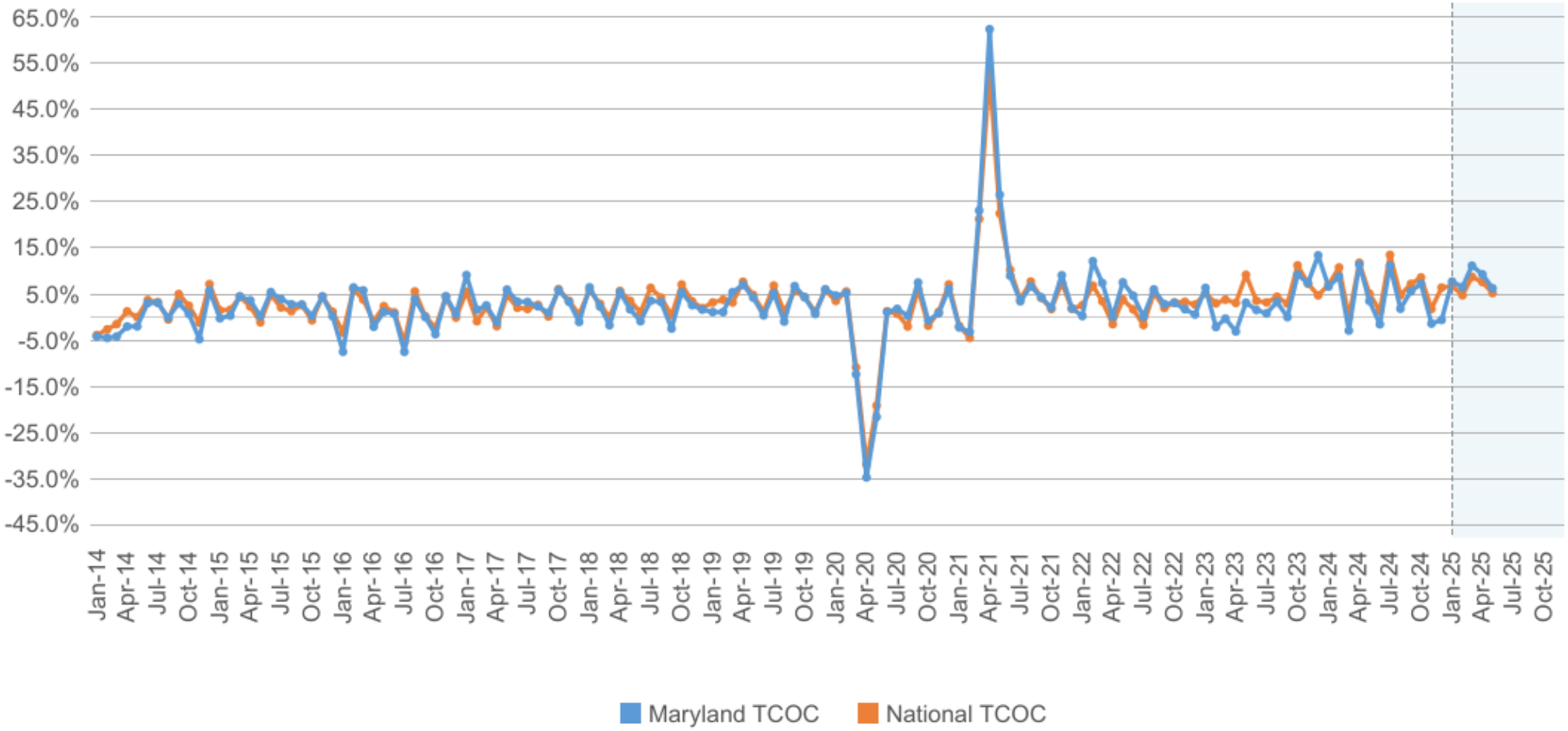


Medicare Hospital and Non-Hospital Payments per Capita



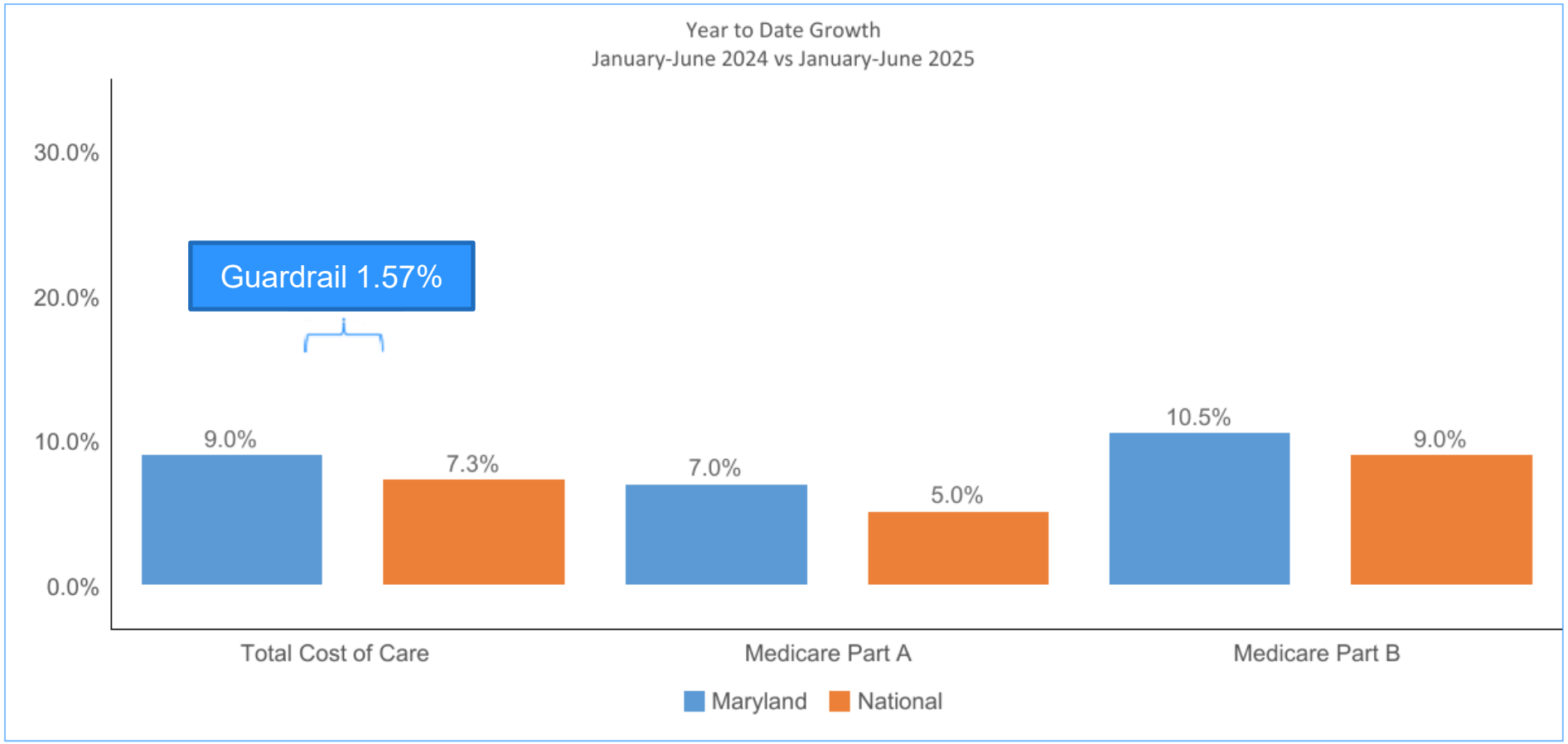
Medicare Total Cost of Care Spending per Capita

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



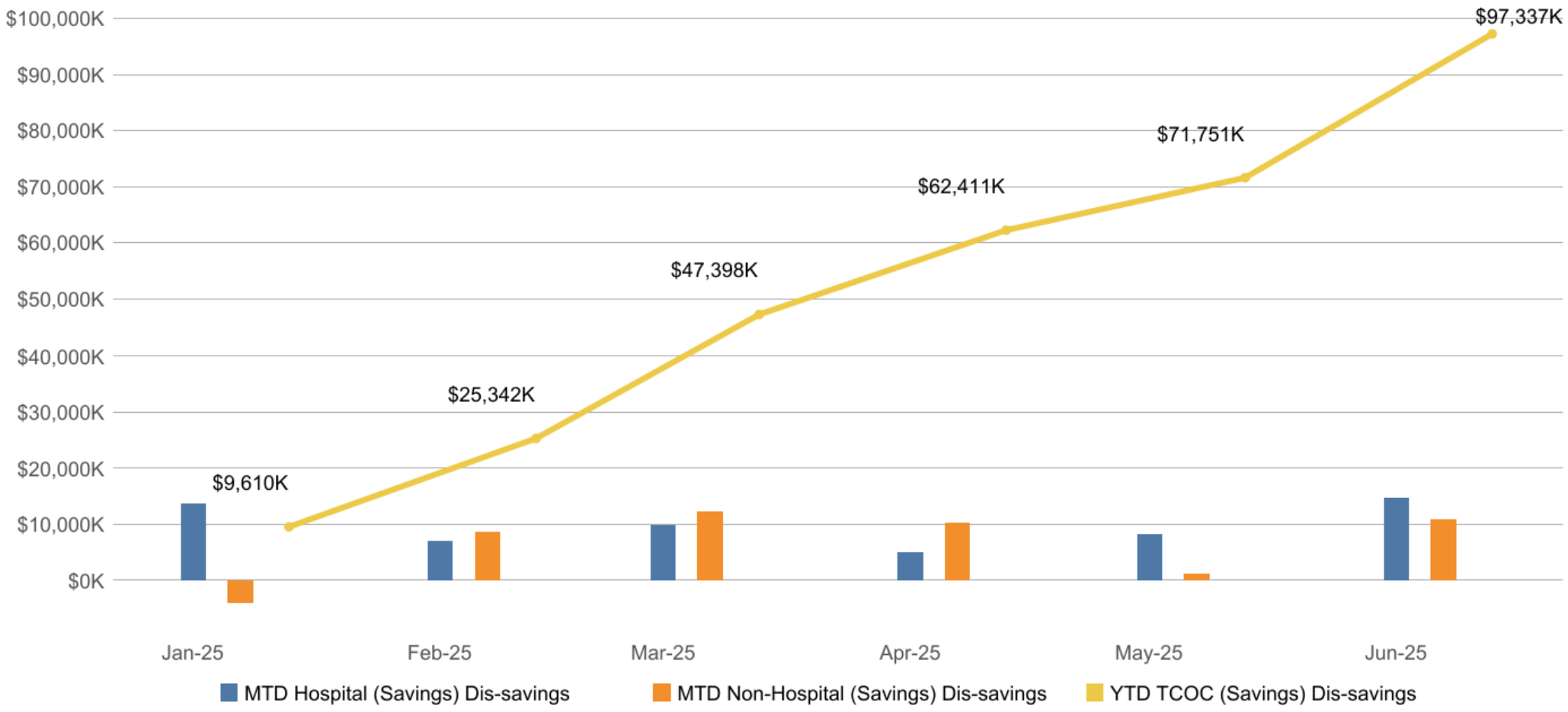
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through June 2025



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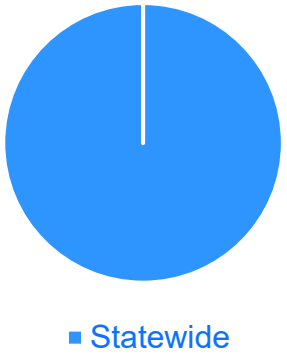
Update on Demographic Adjustment

October 8, 2025

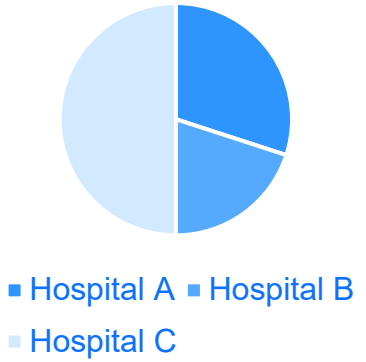
Background

Statewide population growth determines the **amount of funding** to be provided via the Demographic Adjustment, while age-adjusted population growth determines the **distribution of the funding** at the hospital level.

Statewide DA Funding



Distribution of DA Funding



Statewide population growth determines the "size of the pie."

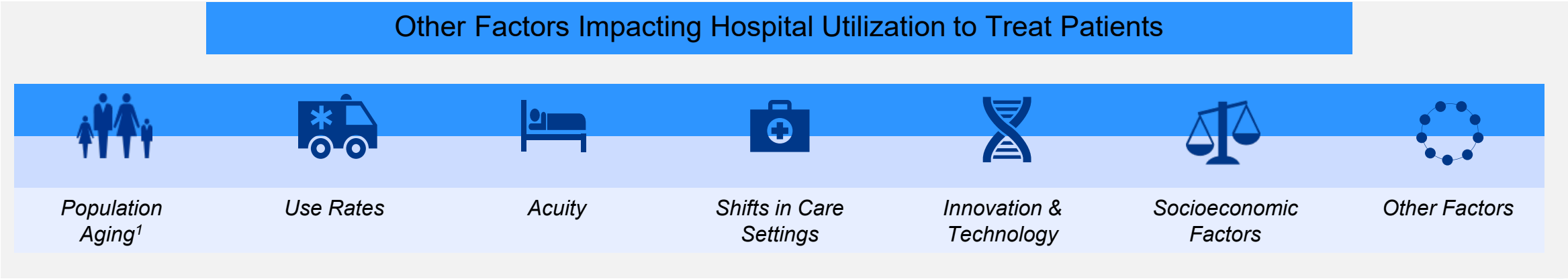
Example: Maryland population grew by 2% YoY so statewide Demographic Adjustment funding is capped at 2% of in-state revenue.

The distribution of funding at the hospital level is based on the **share of age-adjusted population growth**.

Example: Hospital C above experienced 50% of the total age-adjusted population growth statewide, and therefore receives 50% of total DA funding.

Many factors impact hospital utilization

The statewide population growth doesn't account for all factors impacting hospital utilization. With the shift to AHEAD, the Commission is exploring alternative approaches.



The workgroup engagement on October 29th will discuss a more nuanced governor that can account for the key factors that impact hospital utilization. This will necessitate using national data because Maryland utilization patterns reflect TCOC Model impacts. Our plan is to bring a proposal to the November meeting.

Note (1): Population aging is used to determine the distribution of Demographic Adjustment funding. Other factors listed above are not directly considered in the Demographic Adjustment Methodology.

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Episode Quality Improvement Program – PY3 Results

HSCRC Commission Mtg

10/08/2025

Partnership HSCRC, CRISP, & MedChi

MedChi's Role in EQIP

EQIP Subgroup

- Hosts bi-monthly EQIP Subgroup meetings.
- Gene Ransom, CEO of MedChi, serves as Chair of the EQIP Subgroup Committee.

New Episode Development

- Supported development of new episodes for EQIP.
- Requested feedback from 10 national specialty societies for PY5 episode development.

EQIP Curriculum

- Partnered with CRISP to create the EQIP Curriculum.
- The **EQIP Curriculum** consists of 7 learning modules with:
  - Brief informational videos
  - Slide decks
  - Downloadable guides

MedChi's Role in EQIP Enrollment

Specialty Webinar Series

- Overview of PY5 Episodes
- PY5 Ophthalmology Episodes
- PY5 Orthopedics & Musculoskeletal (MSK) Episodes
- PY5 Gastroenterology Episodes
- PY5 Cardiology/Vascular Episodes

Targeted EQIP Webinars

- EQIP Webinar with Maryland Orthopedic Association
- EQIP Webinar - MedChi & Maryland ACS
- Additional presentations were also conducted with individual organizations upon request.

PY5 Enrollment:

- MedChi was directly involved with enrollment of 42 Entities consisting of a total of 1,168 practitioners.
  - MedChi Entities
  - Independent Entities with MedChi as Administrative Proxy

MedChi EQIP Entities

MedChi created EQIP Entities to increase participation in value-based care for growing practices. MedChi provides its EQIP Entities with resources including administrative assistance, educational materials, and performance data reports.

PY3 (CY2024):	PY4(CY2025):	PY5(CY2026)*:
8 EQIP Entities consisting of	8 EQIP Entities consisting of	9 EQIP entities consisting of
57 Organizations and	66 organizations and	73 organizations and
114 practitioners	150 Practitioners	171 practitioners

**PY5 numbers are preliminary and subject to change pending final CMS vetting, auditing, and contracting processes.*

MedChi Administrative Work

In addition to managing the MedChi Entities, MedChi also offers administrative support to EQIP practices regardless of their size or affiliation. MedChi serves as an Administrative Proxy to EQIP Entities upon request.

PY3 (CY2024):	PY4 (CY2025):	PY5 (CY2026)*:
1 EQIP Entity consisting of	5 EQIP entities consisting of	33 EQIP entities consisting of
42 practitioners	136 practitioners	997 practitioners

**PY5 numbers are preliminary and subject to change pending final CMS vetting, auditing, and contracting processes.*

How CRISP Supports EQIP Participants

Program Administration & Oversight
Manage applications, enrollment, compliance, and program operations

Episode Reporting & Performance Insights
Determine eligible episodes, deliver reporting, and explain performance drivers

Participant Support & Education
Provide webinars, office hours, toolkits, and one-on-one technical assistance

Stakeholder Engagement & Advocacy
Bridge communication between participants, HSCRC, CMS, and vendors

Continuous Improvement
Collect participant feedback and evolve processes, tools, and resources

PY3 (CY 2024) Results

EQIP PY3 Program Growth Highlights

- **New Episodes Added:**
  - **6 new episodes** in PY3
  - **1 new clinical episode category:** Pulmonology
- **Entity Participation:**
  - **71 new entities** in PY3, bringing total participation to **117 entities**
  - **46 entities** carried over from PY2
- **Episode Volume:**
  - PY3: **144,260 episodes** (+83.4% vs. PY2's 78,644 episodes)

EQIP PY2 vs. PY3 Performance Highlights

- **Positive Savings Generated:**
  - PY3: **$62.6M** (+70.6% vs. PY2's $36.7M)
- **Entities Achieving Shared Savings:**
  - PY3: **67 of 117 entities (57%)** met performance thresholds
  - PY2: **31 of 64 entities (48%)** met performance thresholds
- **Net Distribution to Entities:**
  - PY3: **$29.1M**
  - PY2: **$19.5M**
- **Program Guardrail:**
  - A **3% minimum savings rate** is required to ensure statistically significant savings before payouts occur.

*Numbers are considered preliminary

Overview of EQIP Results – PY2 vs. PY3

Clinical Episode Category	Number of EQIP Clinical Categories		Average Entity Size by Number of CPs		Average Episode Volume		Number Exceeding Target Price		Percent Exceeding Target Price	
	PY2	PY3	PY2	PY3	PY2	PY3	PY2	PY3	PY2	PY3
Allergy	21	35	133	67	59	137	12	14	57%	40%
Cardiology	38	38	117	40	87	75	12	11	23%	29%
Dermatology	3	1	362	21	40	55	3	0	100%	0%
Emergency Department	110	127	173	61	269	264	72	76	65%	60%
Gastroenterology	46	40	108	29	549	610	18	11	39%	28%
Ophthalmology	6	10	335	15	680	1840	0	0	0%	0%
Orthopedics	120	184	83	36	123	309	34	66	28%	36%
Urology	5	4	42	40	67	56	4	2	80%	50%
Pulmonology	-	24	-	68	-	134	-	8	-	33%

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

Overall Assessment & Next Steps

- PY4 - Transition from Prometheus to PACES
  - EQIP initially used the national Prometheus grouper to define and measure episodes of care. Beginning in PY4, EQIP transitioned to PACES, Maryland's customized grouper, to better align with the state's Total Cost of Care model and provide more flexibility and clinical relevance.
- PY5 – EQIP has added 70 new episodes
- Support for practices
  - The EQIP Practice Transformation Grant (PTG) Program is designed to support smaller, independent, and under-resourced practices that have not yet achieved savings under the EQIP model
  - By reinvesting Year 1 savings, the program provides targeted intervention resources to help these practices succeed in EQIP and improve efficiency, patient management, and cost savings.
- Quality Metric Evaluation
  - PY5 quality measure framework will stay the same as in PY1-4.

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Annual Filing Modernization

Clinician Cost Schedule Update to Commissioners

October 8, 2025

Agenda

- Purpose of CCS Reporting
- Metrics Reported
- Performance of CCS Tool
- Clinician Cost Financial Results (FY 2024 pilot)
- Most Significant Results By Specialty
- Possible Improvements for 2025 and Beyond

Purpose of the CCS Data Reporting

UNDERSTAND…

The overall nature of net unreimbursed costs of clinician services borne by hospitals:

Who?

What?

Where?

Why?

01 Volume & Specialties

- Capture the volume of clinicians working for hospitals
- Create specialty reporting list

02 Arrangement Types

- Define types of arrangements being used to employ and contract physicians and APPs (“clinicians”)

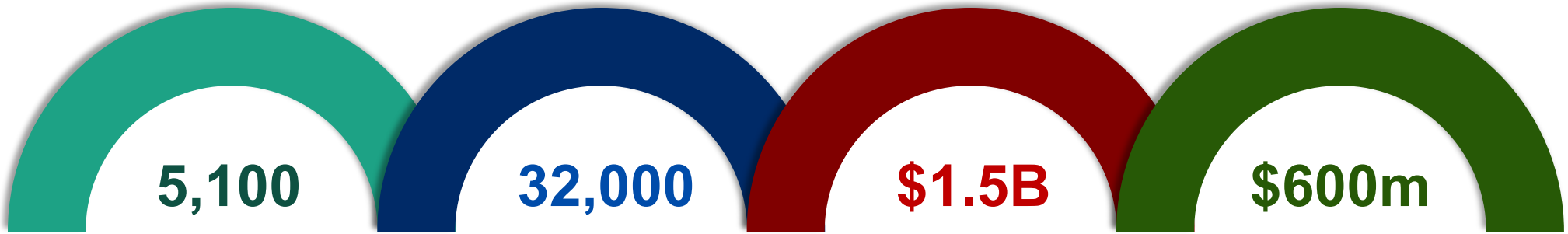
03 Net Costs

- Define net cost of employing and contracting clinicians to support regulated and unregulated services

04 Offsetting Revenues

- Capture offsetting professional revenues earned
- Payor mix to understand explainable variances in net cost

Overall Metrics Reported



Number of Clinician FTEs

On-Call Hours per week

Compensation Cost

Offsetting Revenues

Key Points:

1 All 45 acute care hospitals submitted responses

2 Submitted results for regulated and unregulated Clinician services from 38 of 45 hospitals were deemed acceptable for evaluating the tool and Clinician cost results. Amounts in this presentation based on the 38 hospitals included in the data set, excluding Clinician Support Costs.

Performance of the CCS Tool – Version 2 (2024)

01 Volume of Incomplete Data

Mismatch between FTEs and Remuneration

Employed Clinicians benefit costs not reported

Missing Specialty Assignments

Offsetting pro fee revenues and payor mix by specialty

- Payor mix was not provided

02 Data Definition Interpretation Varied

Additional data definitions are needed to clarify meaning behind requested information

- Included reported APPs in Clinician Support
- Included other types of revenue as Offsetting Revenue
- Definition and reporting of Clinician Support Costs

03 Analytics Impeded by Tool Design

Categories were combined and limited breakout of specific data sets:

- APP vs. Physician FTEs
- APP vs. Physician Cost
- Separate Identification of pure On-Call compensation

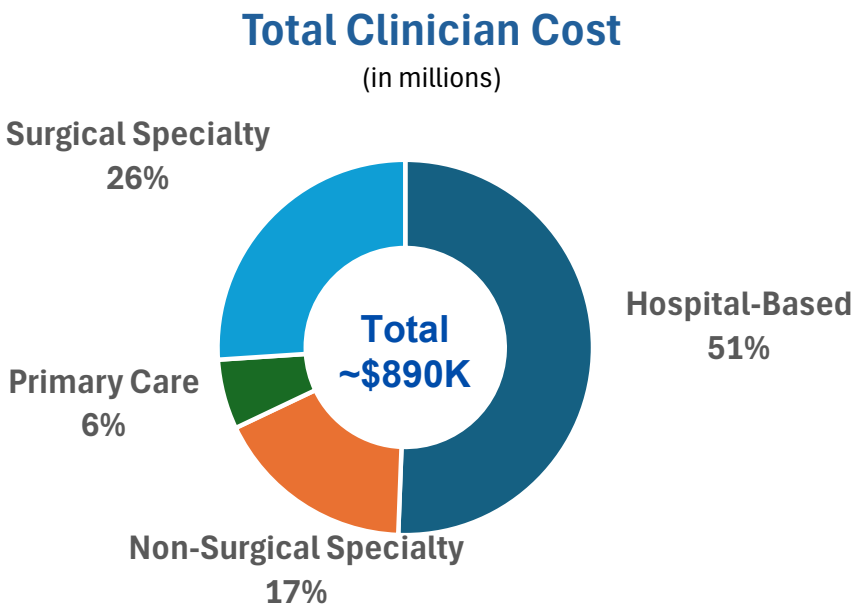
Overall Financial Results*

- Wages, Benefits & Subsidies
- Offsetting Revenues

	Total Clinician Costs & Offsetting Revenues (in millions)	Average per Hospital (in millions)	% of Regulated Revenue
Employed Clinician Wages & Benefits	$400.0	$10.5	
Contracted Fees & Subsidies	$270.0	$7.1	
Related Entity Fees & Subsidies	$820.0	$21.6	
TOTAL Direct Cost of Clinician Services	**$1,490.0**	**$39.2**	**12.5%**
Offsetting Revenues	($600.0)	($15.8)	**-5.0%**
NET Direct Cost of Clinician Services	**$890.0**	**$23.4**	**7.5%**

* Amounts based on the 38 hospitals included in final database (excludes Clinician Support costs)

Top 10 Specialties by Net Direct Cost of Clinician Services by Type*



(in millions)

Grouping / Specialty	Net Direct Clinician Cost	% of Total Clinician Cost
Hospital-Based	**$452,682**	**50.6%**
Anesthesiology	$130,619	14.6%
Hospitalist: Internal Medicine	$108,293	12.1%
Emergency Medicine	$62,752	7.0%
Critical Care: Intensivist	$50,795	5.7%
Radiology: Diagnostic	$46,625	5.2%
Pediatrics: Hospitalist-Int Med & Gen	$21,839	2.4%
Pathology: Anatomic and Clinical	$8,082	0.9%
Hospitalist: OB/GYN	$7,208	0.8%
Radiology: Interventional	$6,874	0.8%
Hospitalist: Family Medicine	$6,837	0.8%
All Other HB (4 specialties)	$2,758	0.3%
Primary Care	**$53,826**	**6.0%**
Internal Medicine: General	$21,839	2.4%
Obstetrics/Gynecology: General	$15,634	1.7%
Hospice/Palliative Care	$8,202	0.9%
Family Medicine (without OB)	$6,988	0.8%
OB/GYN: Gynecology (Only)	$5,410	0.6%
Pediatrics: Adolescent Medicine	$3,601	0.4%
Geriatrics	$3,323	0.4%
Family Medicine: Sports Medicine	$2,740	0.3%
Family Medicine: Amb Only (No IP)	$2,282	0.3%
PHY Coordinated Care Center	$2,198	0.2%
All Other PC (4 types)	$1,920	0.2%

(in millions)

Grouping / Specialty	Net Direct Clinician Cost	% of Total Clinician Cost
Non-Surgical Specialty	**$155,187**	**17.3%**
Psychiatry: General	$32,095	3.6%
Cardiology: Noninvasive	$20,538	2.3%
Gastroenterology	$16,971	1.9%
OB/GYN: Urogynecology	$13,413	1.5%
Neurology	$12,666	1.4%
Pediatric-Nonsurgical Specialist	$12,046	1.3%
OB/GYN: Maternal & Fetal Med	$11,038	1.2%
Cardiology: Invasive	$8,612	1.0%
Pediatrics: Neonatal Medicine	$8,462	0.9%
Nephrology	$6,332	0.7%
All Other NS (38 specialties)	$13,014	2.2%
Surgical Specialty	**$232,968**	**26.0%**
Surgery: General	$52,708	5.9%
Surgery: Neurological	$23,400	2.6%
Surgery: Cardiovascular	$16,157	1.8%
Orthopedic Surgery: General	$14,598	1.6%
Surgery: Trauma	$12,887	1.4%
Orthopedic Surgery: Trauma	$12,557	1.4%
Orthopedic Surgery: Spine	$8,476	0.9%
Surgery: Colon and Rectal	$7,914	0.9%
Urology	$7,647	0.9%
Surgery: Thoracic (Primary)	$7,550	0.8%
All Other SS (32 specialties)	$69,074	7.7%

* Amounts based on the 38 hospitals included in final database

Improvements being considered for 2025 & the Future

Key Areas of Focus

01 Incorporate Hospital-Based Specialty Type

02 Add Validity Checks

03 Refine Offsetting Revenue Reporting

04 Refine Clinician Support Definition

05 Regulated vs. Unregulated

Comments

- Move from 3 to 4 Types of Specialties by re-assigning Specialties to a new Hospital-Based Type
- Add basic validity checks between FTEs vs. Cost by specialty
- Exclude non-Pro Fee revenues (e.g. Drugs and Infusions)
- Exclude APP costs reported as Clinicians on Sched.1A, B & C
- Segregate APP Costs and FTEs from Physicians in reporting
- Attribute Clinician Support Cost more accurately to specialties
- Create ability to clearly define costs that are aligned with regulated services

Future

As quality and consistency of reporting increases, the scope of Clinician Cost reporting may narrow to aggregate selected specialties and thereby reduce the burden of reporting.

Next Steps

Actions planned to occur over the next 12 months

RELEASE AGGREGATED FY24 DATA

In October 2025 share meaningful aggregated data to hospitals and stakeholders

COLLECT FY25 DATA

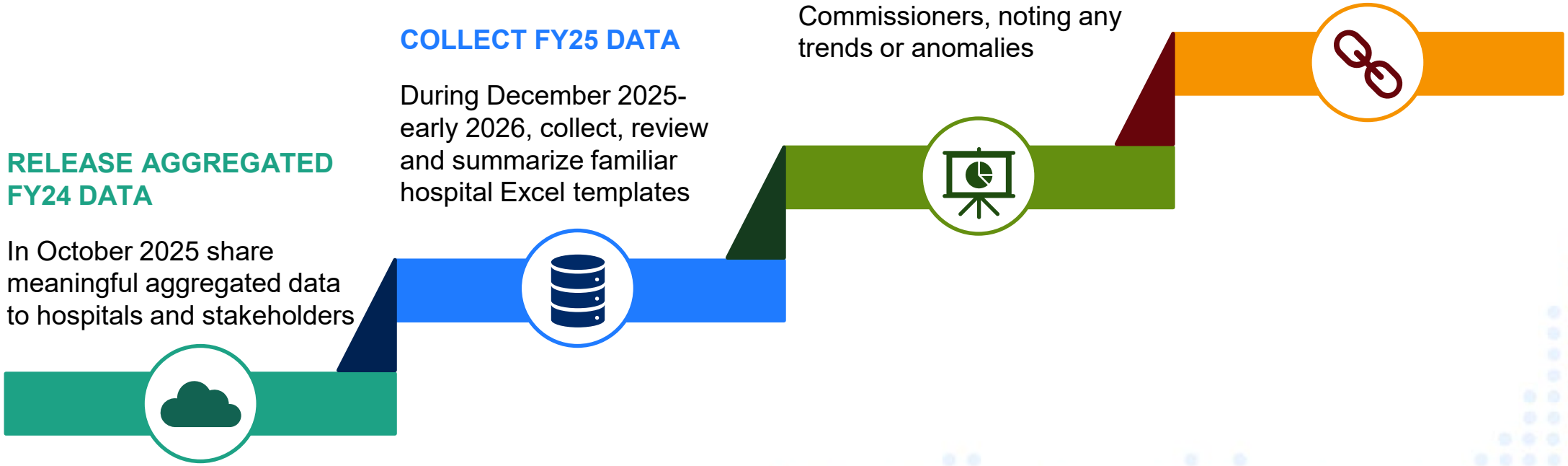
During December 2025-early 2026, collect, review and summarize familiar hospital Excel templates

PRESENT FY25 DATA

Present data to hospitals and Commissioners, noting any trends or anomalies

INCORPORATE INTO eF2

Incorporate CCS data collection into eF2 online submission process



Questions, Comments & Other Suggestions?

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Draft Recommendation for Market Shift Refinement

October 8, 2025

Market Shift Adjustment (MSA)

Purpose

- To provide **criteria for increasing or decreasing the approved regulated revenue** of hospitals under GBR agreements.
- Designed to **foster a competitive market environment** where revenue follows the patient
- Disincentivizes volume growth beyond population growth, thus making it **a more sustainable health financing method** compared to others that implement revenue caps without addressing underlying cost management.

How it Works

- Reallocates hospital revenue when patient volume shifts between hospitals independent of general volume increases in the market.
- Standardized comparison groups use zip codes/counties to define populations and service lines to define services.

Methodology

- The MSA algorithm compares volume between hospitals with utilization increases and hospitals with utilization decreases
- GBR adjustments are capped at the lesser of the growth for volume gains or the decline for volume losses (i.e., capped at what can be identified as market shift rather than other factors like a change in demographics)

Key Industry Concerns with Market Shift Policy

Variable Cost Factor

Stakeholders have voiced concern that the Market Shift Policy sometimes does not provide **consistent and adequate funding**, especially with respect to the 50% variable cost factor. Hospitals with significant volume growth might not receive sufficient funding to cover service costs, while those with volume declines may retain more revenue than necessary, leading to inefficiencies.

Definitions of Markets

Stakeholders believe that the granular market shift calculations that evaluate small geographic regions or small service lines may result in **statistical instability** and **random variations**. These small market assessments might not accurately reflect true utilization patterns, causing unrepresentative shifts in funding.

Service Line Exclusions

Stakeholders have noted that when there are significant system realignments, e.g., payer initiated shifts, there should be more precise and real time methods of evaluation.

Variable Cost Factors

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Overview

- Variable costs, i.e., the degree to which costs vary with incremental changes in volume, are fundamental to recognizing necessary changes in cost structures
- With revised evaluations, regulated hospital operating costs were found to be approximately **59% variable with volumes**, which is slightly higher than the 50% VCF historically used in the Market Shift Policy. Revisions to calculation* included:
  - Using costs directly from Annual Filing
  - **Key Innovation:** Estimating variability with linear regressions
- Analysis indicates that **costs in surgical service lines are more variable** with volumes on average than costs in medical service lines.
  - Surgical Service Line VCF was found to be between 63-66%.
  - Medical Service Line VCF was found to be between 54-57%.
- These results were found to be directionally consistent when replicated across multiple years of data.

	Historical VCF	Revised VCF
Overall Statewide VCF	**50%**	**59%**
Overall IP VCF	**50%**	**60%**
Medical VCF (IP)	50%	57%
Surgical VCF (IP)	50%	66%
Overall OP VCF	**50%**	**56%**
Medical VCF (OP)	50%	54%
Surgical VCF (OP)	50%	63%

** See Appendix 1 for detail on Hybrid VCF Calculation*

Note (1): Categorical Exclusions and Innovation Flag cases are removed and CDS is excluded for Oncology Infusion Drugs (OP service line)

Marketshift Stability

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Use Simulation Methods to Evaluate Small Zip Reliability Solutions

Analytic Purpose

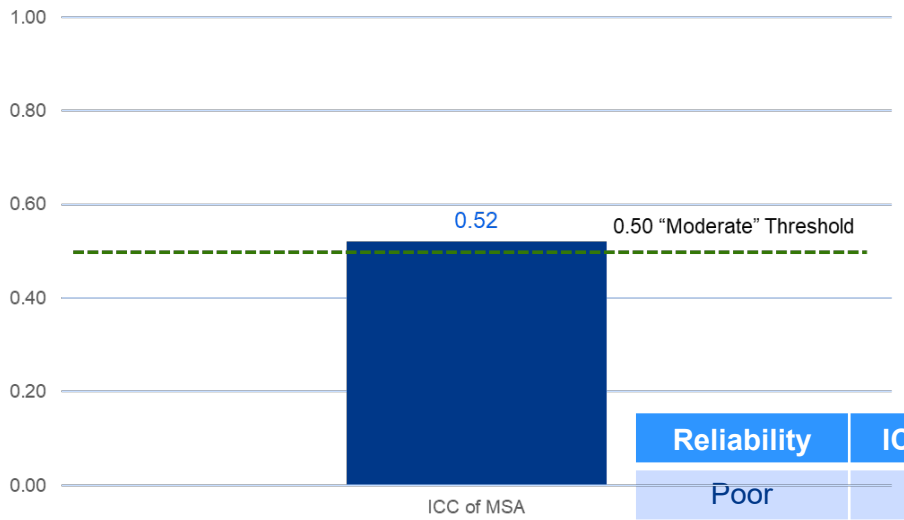
- The **Market Shift Adjustment (MSA)** adjusts a hospital's Global Budget Revenue for **supply or market preference changes** at the local level, currently a combination of both zip codes and counties.
- However, changes among **geographies with small volume** may not effectively distinguish between these structural changes and random noise.
- This analysis serves two purposes:
  - Test the **statistical reliability** of the MSA calculation using bootstrapping* and the Intraclass Correlation Coefficient (ICC)**.
  - Evaluate the degree that reliability can be improved by **aggregating/carving out small markets**.

Analytic Approach

- **Simulate** discharge volume to test various “what if” scenarios in a statistically sound manner.
- **Calculate** and **Evaluate** MSA reliability under several aggregation scenarios.
  - For surgery service lines, aggregate zip codes to Maryland Health Care Commission (MHCC) regions or statewide level.
  - Investigate consolidating service lines by clinical overlap.
  - Consider excluding low-volume inpatient service lines.

** See Appendix 2 for detail on Bootstrapping Method*
*** See Appendix 3 for detail on Intraclass Correlation Coefficient*

Baseline Reliability (ICC)



Reliability	ICC Range
Poor	< 0.50
Moderate	0.50 – 0.75
Good	0.75 – 0.90
Excellent	≥ 0.90

Source: Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. Journal of Chiropractic Medicine, 15(2), 155-163.

Outpatient service lines tend to have much stronger results

- ICC for outpatient service lines were higher than inpatient service lines.
- ICC for outpatient service lines ranged from 0.70 for Cardiovascular to 0.97 for ED service line.
- Service lines that are present in a greater number of Hospital Markets tend to have higher ICC.

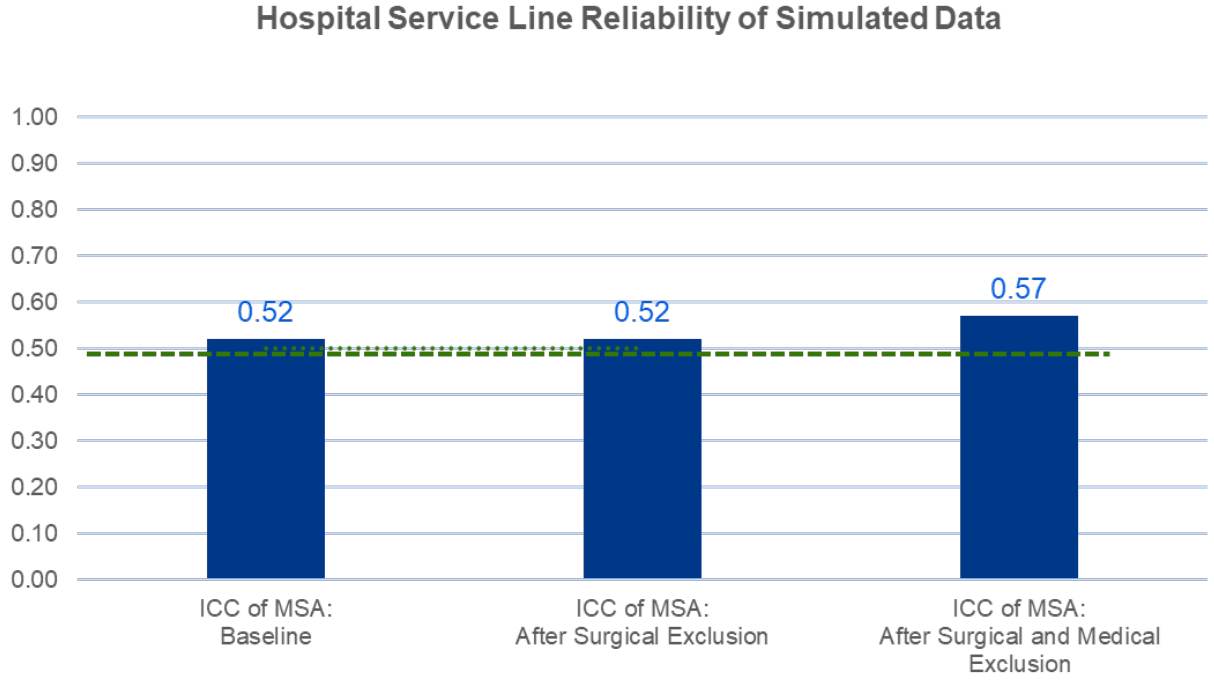
Inpatient service lines vary significantly:

- ICC for inpatient service lines ranged from 0.003 for Ophthalmologic Surgery to 0.68 for OB/GYN service line.
- Lower ICC is largely driven by greater service line disaggregation (32 service lines versus 13 in outpatient)

Lower reliability statewide basis was expected due to two main factors:

- the inherent trade-off in reliability when moving away from a fee-for-service model, which, while highly reliable, perpetuates a "sick care" system that incentivizes acute care over preventative services; and
- the significant disaggregation of inpatient service lines, resulting in low-volume assessments, especially for high dollar services, that inherently lead to lower reliability scores.

Excluding Low-Volume Inpatient Service Lines Could Improve Baseline Reliability



- There are six inpatient surgery service lines and one inpatient medical service line that tend to have the lowest reliability scores, represent limited dollars statewide, and are not ideally suited for population-based methodologies.
  1. Endocrinology Surgery
  2. ENT Surgery
  3. Gynecological Surgery
  4. Ophthalmologic Surgery
  5. Thoracic Surgery
  6. Urological Surgery
  7. Ventilator Support (Medical)
- After excluding the inpatient surgical service lines from the analysis, baseline ICC does not improve.
- After excluding both the inpatient surgical service lines and ventilator support, baseline ICC improves to **0.57.**

A panel of clinicians also concluded that there are six inpatient service lines that could be consolidated into three service lines based on clinical overlap.

1. Spinal Surgery with Neurological Surgery
2. Thoracic Surgery with Cardiothoracic Surgery
3. Ventilator Support with Pulmonary

After consolidating these service lines from the analysis, baseline ICC increases to **0.54**.

Service Line Exclusions

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Overview of the Problem

- Due to methodology limitations, there are certain instances where service lines should be excluded from the MSA. Key categories of exclusion are as follows:
  - Ongoing Carveouts
  - Facility Conversion
  - Intersystem Shifts
  - Payer Driven Volume Shifts
  - Material Volume Shifts
  - CON Approved Service Expansions
- Common reasons for exclusions are:
  - Providing more immediate funding given the lag in MSAs
  - Differential variable costs
  - Not all volumes are precisely adjusted for in market shift policy (e.g., OOS)
- The current process for handling service line exclusion is not standardized; each review is tailored to fit the hospital's specific request.
  - A hospital will contact the HSCRC, explaining the service line situation and the reason for the need to be excluded from the MSA. This typically includes a supporting analysis.
  - The HSCRC then performs an analysis to validate or refute the hospital's findings.
  - Further discussions occur after the HSCRC's analysis to decide if there will be an adjustment.

Flowchart for Existing Service Line Exclusion Adjudication

Types of Adjudicated Exclusions

	Facility Conversions	Intersystem Shifts	Payer Driven Volume Shifts	Materiality Exclusions	CON Approved Service Expansions
Step 1: Hospital identifies future volume shift or change in service line					
What kind of shift or event is a hospital expecting in the future?	Services shifting due to an asset acquisition, facility closure, or a facility conversion	Shifting services in a system for consolidation or efficiency purposes (e.g., moving all rehab services to one facility)	Payer driven realignment of volume from one facility to another that is greater than 1% of global budget revenue	Material provider-driven shifts (i.e., greater than 1% of service line revenue) between facilities that require immediate funding	New program is implemented post CON approval
Step 2: Hospital submits an analysis to the HSCRC 6 months prior to the shift or event					
What data is required for the supporting analysis?	• Casemix data • Hospital Internal data	• Casemix data • Hospital Internal data	• Casemix data • Hospital Internal data • Payer submitted data • Materiality Evaluation	• Casemix data • Hospital Internal data • Materiality evaluation	• CON Approval Casemix data • Hospital Internal data • TCOC Impact

Step 3: Staff performs an analysis to confirm triggering event

What will the HSCRC analyze?

- Order of magnitude and reliability of data to perform assessments, e.g., Kaiser payer variables for payer-initiated shifts.
- Consolidated Market Shifts, e.g., 2 hospitals assessed as 1, OR Isolated Volume Assessments that cap evaluated volume to baseline value to ensure it is a realignment and not a statewide net change (unless new growth is allowed under CON)
- Methodology for supporting analysis and interactions with existing methodologies, e.g., high cost OP drugs may not need to be carved out because of CDS-A
- Potential impact on statewide revenue and savings tests

Step 4: If a service line exclusion is warranted, the service line will be excluded from the MSA for 2 years or agreed upon timeframe. Staff will also notify all affected parties

Step 5: Build service line exclusion back into Market Shift based on the most recently available 12-month period

Draft Recommendations

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Draft Recommendations

1. Effective immediately, adopt for all volume policies the newly calculated variable cost factors for inpatient medical (57 percent) and surgical (66 percent) and outpatient medical (54 percent) and surgical (63 percent) in lieu of the historical standard of 50 percent.
2. For CY 2026 performance assessments, remove from the Market Shift the following service lines: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support, and consolidate Spinal Surgery and Neurological Surgery.

   Any volume changes for services removed from the Market Shift as a result of this recommendation shall be adjudicated similar to the Out-of-State Volume policy, i.e., a revenue adjustment will only occur when the volume change is material, i.e., 1 percent of service line revenue when volume increases, 3 percent of service line revenue when volume decreases.

1. Officially establish the process described herein by which Service Line Exclusions from the Market Shift policy can be triggered and adjudicated provided one of the following criteria is met:
   a. Facility Conversions
   b. Intersystem Shifts
   c. Payer Driven Volume Shifts
   d. Material Provider Initiated Shifts
   e. CON Approved Service Line Expansions

Comments on this draft are due to the Commission by Wednesday October 15, 2025, via email to allani.pack@maryland.gov

Appendix

Appendix 1: Hybrid Variable Cost Factor Calculation

	HSCRC	MHA	Hybrid
Service Setting for calculation	Calculated separately for IP and OP	Calculated separately for IP and OP	**IP & OP are combined since costs are combined in Annual Filings**
Direct Cost Calculation	Applies Direct cost to charge ratio to case-mix charges	Uses Direct cost from M-schedule from cost report	**Uses direct cost from M-schedule from cost report**
Charge Bucket	HSCRC classifies rate centers into different charge buckets for calculation	Directly uses rate centers	**Uses more granular charge buckets to balance low volumes with unique properties of certain services**
Direct Variable Cost Percent	Direct cost % * Direct cost variability by charge buckets	Assumed 100% of the direct costs as variable	**Direct cost variability (Calculated at the charge bucket level by way of a linear regression model using volumes and inflation adjusted costs from the Annual Filing cost reports) * Direct costs**
Indirect Variable Cost Percent	(1 – Statewide direct costs as % of Adj charges) * 10%	Not considered	**Indirect cost % * 10%**
Variable Cost Factor	Indirect variable cost percent + Direct variable cost as a % of adj charges	Op1 – Direct expense/Level IV Exp Op2 – (Direct exp + Pat care OD – plant) / Level IV Exp Op3 – Level I Exp/ Level IV Exp	**Indirect variable cost percent + Direct variable cost** **The final VCF is a weighted average of VCFs calculated across charge buckets**

Appendix 2a: Bootstrapping Example

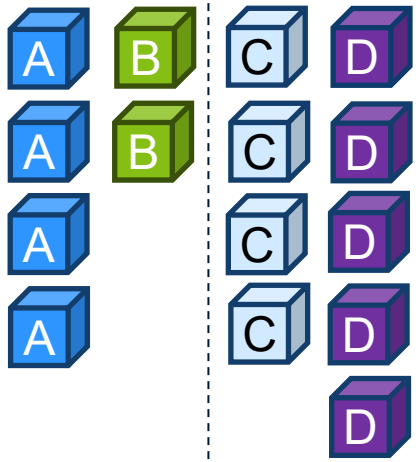
- Statistical reliability is the extent that repeated measurements of the same group produce consistent results.
- In Marketshift, to evaluate repeated measurements requires simulation or “bootstrapping”
- Each simulation iteration generates records mirroring observed data, allowing for real life variability.
- By increasing the number of simulations, we reduce the influence of unlikely combinations on the overall outcome
- Hospital strata maintain each hospital’s total discharge volume but vary allocations across markets, ensuring the resamples are representative of the original data.

Observed Data

Observed Hospital Market Data
(N=4 markets)

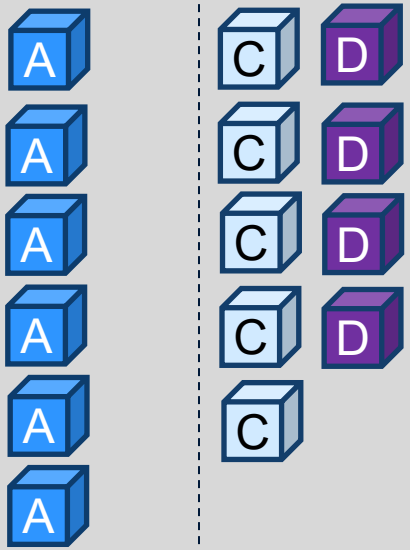
Hospital	Market	Discharge Volume
1	A	4
	B	2
2	C	4
	D	5

Expanded Data
(N=15 Discharges)



Simulated Iteration

Expanded Data
(N=15 Discharges)



Simulated Hospital Market Data
(N=4, including
zero-volume markets)

Hospital	Market	Discharge Volume
1	A	6
	B	0
2	C	5
	D	4

Hospital Stratum	$Hospital_1$ (N=6)	$Hospital_2$ (N=9)	$Hospital_1$ (N=6)	$Hospital_2$ (N=9)

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Appendix 2a: MSA Simulation Approach with Bootstrapping Method

01

Import

- CY2022 / CY2023 discharge volume
- ECMAD = Equivalent casemix adjusted discharge volume
- COUNT = Unadjusted discharge volume
- Exclude CR service lines, OP service line for Onc & Inf Drugs, and IP service lines for Categorical Exclusions, Innovation, PDI, PQI, and Readmission

02

Calculate Casemix

- For each Hospital Market (Hospital + Service Line + Zip Code), calculate casemix for CY2023:

$$casemix_{23} = \frac{ECMAD_{23}}{COUNT_{23}}$$

03

Calculate Growth

- Hospital-level growth rate
- Compare CY2022 to CY2023

$$growth_{23} = \frac{ECMAD_{23} - ECMAD_{22}}{ECMAD_{22}}$$

04

Simulate

- Sample CY2023 COUNT with replacement (iterations = 1000); stratify by hospital
- Create Simulated ECMAD for each Hospital Market:

$$Simulated\ ECMAD = Sampled\ COUNT \times casemix_{23} \times (1+growth_{23})$$

- Compare Simulated ECMAD to CY2023 ECMAD to calculate Hospital Shift and MSA

Appendix 3: Intraclass Correlation Coefficient (ICC) Overview

- Intraclass Correlation Coefficient (ICC) is a measure of reliability, where ICC = 0 indicates no reliability and ICC = 1 perfect reliability, i.e., all measures in a group are identical.

$$\text{ICC} = \frac{variance\ between\ groups\ (V_b)}{variance\ between\ groups\ (V_b) + variance\ within\ groups (V_w)}$$

- Each MSA in the simulation is used in the above formula such that:

V_b: The variation between group means, measured around the overall (grand) mean.

V_w: The variation among MSAs within the same group, measured around each group's mean.

- Group means are the average MSA across 1000 simulations for each hospital service line
- Grand Mean is the average of all the MSAs across all the hospital service lines.

Signal: Variation between hospital service line MSAs for a given simulation.

Noise: Variation of hospital service line MSAs across simulations.

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Draft Recommendation for Market Shift Refinement

October 8, 2025

Health Services Cost Review Commission

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This document contains the draft staff recommendations for updating the Market Shift methodology. Please submit comments on this draft to the Commission by Wednesday October 15, 2025, via email to allani.pack@maryland.gov

Key Methodology Concepts, Definitions, and Abbreviations

1. Variable Cost Factor – The percentage of charges required to reimburse a hospital for the variable costs (supplies, drugs, etc.) associated with increases in volume. The historical standard by which the industry and the Commission evaluates volume funding adequacy is 50 percent, as prior analyses indicated that 50 percent of all service charges on average covers fixed costs and 50 percent covers variable costs. This value is not uniform by service line.

2. Service Lines – Groupings of services into higher level categories that reflect similar clinical delivery. Service lines are utilized to determine market shifts in the Market Shift methodology

3. Equivalent Case Mix Adjusted Discharges (ECMADS) – Often referred to as casemix, ECMADS are a volume statistic that account for acuity, as not all services require the same level of care and resources.

4. AHEAD - Achieving Healthcare Efficiency through Accountable Design

5. CMS - Centers for Medicare & Medicaid Services

6. CY - Calendar year

7. FFS - Fee-for-service

8. FY - Fiscal Year, typically refers to a State fiscal year from July 1 through the following June 30

9. FFY - Federal fiscal year refers to the period of October 1 through September 30

10. GBR - Global Budget Revenue

11. HSCRC - Health Services Cost Review Commission

12. RY - Rate year, which is July 1 through June 30 of each year

13. TCOC - Total Cost of Care

Table of Contents

Executive Overview

This draft policy update reflects a mature evolution of Maryland's Total Cost of Care model, addressing real-world data challenges, aligning incentives, and enhancing responsiveness to system change. The revised Market Shift methodology ensures the program remains financially sound, statistically valid, and adaptable—in line with both the original intent of the GBR model and the forward-looking goals of the upcoming AHEAD Model.

Introduction

As part of the All-Payer Model (2014) and the Total Cost of Care Model (2019), Maryland transformed its healthcare system to a population-based model, moving from volume-based payments to focusing on total hospital spending per capita and outcomes: readmissions, in-hospital complications, potentially avoidable utilization, and total cost of care, among others. The State exceeded all contractual targets through 2024.[1]

A key component was the Global Budget Revenue (GBR) methodology, which provided hospitals with annual prospective budgets. To address population-related utilization changes and market shifts, the HSCRC developed at the start of the All-Payer Model the Demographic Adjustment and Market Shift Adjustment methodologies. The Demographic Adjustment accounts for age-adjusted growth/decline.

The Market Shift Adjustment evaluates patient movement between hospitals, transferring funds at a 50 percent variable cost factor. This aimed to ensure a competitive market while controlling statewide volume growth. In 2019, the HSCRC modified the Market Shift policy in keeping with the long standing Commission tradition to constantly review and evolve policies.[2] However, concerns have emerged regarding the accuracy of the 50 percent variable cost factor and the overall reliability of the market shift. Stakeholders argue that:

a) The 50 percent variable cost factor provides inadequate funding for growing hospitals and may retain excess revenue for declining ones, leading to inefficiencies.

b) Granular market shift calculations for small regions or service lines can be statistically unstable and inaccurate.

c) During major system realignments, the policy is too imprecise and delayed to account for events like facility closures or intersystem shifts.

To address these, staff have engaged technical experts from the field in a Volume Workgroup since July 2025 and discussed three potential changes:

- **Variable Cost Factor:** Re-evaluating the calculation to determine its accuracy and to differentiate between inpatient/outpatient and surgical/medical services.

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[1] Limiting all-payer hospital spending per capita in line with the growth of the economy, saving Medicare a total of at least $795 million by keeping Maryland's Medicare per beneficiary growth below the national growth rate (currently the State has cumulatively saved $3.6 billion), reducing Medicare readmissions to the national average (currently 2.7% lower than national average; 4.7% on a risk adjusted basis), reducing hospital acquired complications by 30 percentage (currently the State has reduced from 2018 to 2024 by 41 percent), moving virtually all hospital payment methodologies to approved population based approaches, and effectively incentivizing hospitals to engage in site neutral activities that improve the affordability of the system.

[2] In 2019, the Commission voted to consolidate defined markets in the Market Shift methodology by reducing service lines with clinical overlap and assessing inpatient surgery and other highly specialized services at a county level. This effectively reduced the defined markets in the Market Shift methodology from potentially being in excess of 20,000 to approximately 5,000, and markets with less than 10 discharges (an indicator of a potentially unstable cell size) went from approximately 7,000 to 1,000 - Final Recommendation Market Shift Consolidation

- **Market Definitions and Reliability:** Aggregating service lines where clinical overlap exists and potentially excluding from Market Shift unreliable low-volume services.
- **Service Line Exclusions:** Considering temporary exclusions from the Market Shift policy for material system realignments, similar to the proposed AHEAD Model Specifications.[3]

The policy recommendation herein will describe the work of the Volume Workgroup and the methods by which staff and stakeholders concluded that modifications to the Market Shift policy are warranted.

Background

The Market Shift, initially implemented in RY 2015 based on CY 2014 calculations, is an algorithm designed to reallocate funding when patients transfer from one hospital to another. It does not account for overall volume changes; increases or decreases in volume not quantified as shifts are addressed through the Demographic Adjustment, Full Rate Applications, or retained (without revenue adjustments) by hospitals as an incentive to reduce avoidable utilization.[4] Avoidable utilization is defined by Commission policy as readmissions and avoidable admissions, but also includes areas identified by hospital operators, such as services that can be more efficiently delivered in other settings such as sleep labs in hospital facilities, when Commission policies are less prescriptive.

The Market Shift algorithm, chosen by staff in collaboration with industry and payer stakeholders, was selected because it avoids creating incentives for volume growth beyond population growth. This makes it a more sustainable health financing method compared to others that implement revenue caps without addressing underlying cost management, such as the Medicare Physician Sustainable Growth Rate System.[5]

Due to its reciprocal nature—a hospital receiving additional volume funding only if another hospital experiences a corresponding decline in the same service and geography—the net statewide adjustment typically fluctuates around $0. Between CY14 and CY24, the average statewide market shift was ~$2.2 million, typically realigning ~$50 million among all hospitals.

Overview of Market Shift Calculation

The Market Shift Adjustment (MSA) methodology is an algorithm to calculate MSAs for a specific service line (e.g., orthopedic surgery) and a defined geographic location (e.g., ZIP code) using the case-mix adjusted volume measurement of equivalent case-mix adjusted discharges (ECMADS) for regulated inpatient and outpatient services. In total, there are 45 service lines, 32 inpatient and 13 outpatient, that are determined by 3M's aggregation of inpatient All Patients Refined Diagnostic Related Groupings (APR-DRG's), and HSCRC's aggregation of 3M's outpatient Enhanced Ambulatory Patient Groupings (EAPG's). The outpatient groupings are based on hospital rate center analyses to indicate the general services received at the hospital (e.g., emergency room services), while the inpatient service line aggregation is based on the diagnosis and/or procedure a patient receives (e.g., cardiothoracic surgery). There are also over 264 geographies in the Market Shift, as there are zip code level analyses for dense

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[3] https://www.cms.gov/files/document/ahead-tech-specs-v30.pdf - page 41

[4] Various failsafes exist in the Model to ensure that hospitals do not retain too much revenue for averted volume, including GBR Corridors, which necessitate that a hospital has to provide 95 percent of its budgeted volumes in order to recoup its entire global budget, and efficiency policies that withhold annual inflation updates if a hospital's charge per case and total cost of care performance deviates too drastically from statewide norms.

[5] The [Sustainable Growth Rate System] first set of problems relates to its design as a strict budgetary tool, with no mechanism for influencing provider performance toward improved care and prudent use of resources. In comparing total spending with a calculated target, the SGR formula aggregates spending across all physicians furnishing services to Medicare beneficiaries and, therefore, does not provide incentives for individual physician practices to control health care spending or improve care quality. Moreover, the SGR system does little to counter the volume incentives that are inherent in fee-for-service payments." - (page 4) - https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun11_Ch01.pdf

parts of the State and 15 county level analyses for less dense parts of the State. After arraying volume in various service lines and geographies, the market shift algorithm compares the growth in volumes at hospitals with utilization increases to the decline in volumes at hospitals with utilization decreases.

It is important to note that not all revenue is included in the MSA. For instance, potentially avoidable utilization (PAU), which consists of 30 day readmissions and Prevention Quality Indicators,[6] is excluded because the Commission does not want to reward hospitals for growth in PAU, nor does it want to disincentivize hospitals from reducing PAU. The scope of volume evaluated in the MSA is as follows:

Table 1: Scope of Volume Addressed in Market Shift Calculation

Included (~75%)	Excluded (~25%)
-In-state Inpatient Discharges	-Out-of-state Units and Cases
-In-state Outpatient Visits	-High Cost Outpatient Drug Codes
	-Quaternary Cases
	-PAU Cases
Policy Adjustments	
-Market Shift Adjustments	-Out-of-state Policy
-Demographic Adjustment	-CDS-A
-Other Volume Adjustments	-Complexity and Innovation
-Full Rate Application	

Table 2 provides an illustration of the market shift calculation for ZIP code 21000 and the General Surgery service line. Within this ZIP code, the total volume increase is 654 equivalent case-mix adjusted discharges (ECMADs), and the decline is 129 ECMADs. Applying the "lesser of the two" rule, i.e., the Market Shift algorithm, the allowed market shift is limited to 129 ECMADs, which is allocated to other hospitals with volume increases proportional to this hospital's volume increase in total utilization. In the end, the net impact of market shift volumes in each ZIP code and service line combination equals zero - dollar values deviate slightly from $0 due to different price structures for each hospital.

[6] Readmissions are admissions to a hospital (defined as inpatient admission or observation stay greater than 23 hours) within a specified time period after a discharge from the same or another hospital. In the PAU measure, readmissions are specified as 30-day, all-payer, all-cause readmissions at the receiving hospital with exclusions for planned admissions. Hospitalizations for ambulatory sensitive conditions are measured by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs). In the PAU measure, PQIs are measured on inpatient admissions and observation stays greater than 23 hours for ambulatory care sensitive conditions

Table 2: Example Calculation of Market Shift Algorithm

ZIP Code 21000 General Surgery	Volume CY13	Volume CY14	Volume Growth	Hospital's Proportion of Total Increase/Decline	Market Shift
	A	B	C=B-A	D=C/Subtotal C	E=D*Allowed Market Shift
Hospital A	1,000	1,500	500	76%	99
Hospital B	500	600	100	15%	20
Hospital C	50	100	50	8%	10
Hospital D	-	4	4	1%	1
Utilization Increase	1,550	2,204	654	100%	129
Hospital E	500	400	(100)	78%	(100)
Hospital F	50	25	(25)	19%	(25)
Hospital G	4	-	(4)	3%	(4)
Utilization Decline	554	425	(129)	100%	(129)
ZIP Code Total	**2,104**	**2,629**	**525**	-	0
Allowed Market Shift			**129**		

Summary:

1. **Array all APR-DRG's and EAPG's into service lines and geographies** for each hospital based on 3M inpatient service line specifications, HSCRC outpatient service line specifications based on rate center analyses, and geographies based on the patient's residency – zip code level for denser parts of the State and county level for the 15 rural jurisdictions in the State.
2. **Remove from consideration all excluded market shift revenue**, including potentially avoidable utilization, out-of-state volume, categorical exclusions, oncology drugs, and chronic cases from the MSA algorithm
3. **Run the Market Shift algorithm to determine growth**, both increases and decreases in volume for each service line and geography
4. **Calculate final market shift adjustment** by multiplying the volumes that have been deemed market shifts by a hospital's unique service line average charge per equivalent case mix adjusted discharge, inclusive of a standard variable cost factor. The average charge includes all charges and therefore includes outlier charges built into the base of each hospitals GBR

Methodology Assessment

In this section staff will analyze current concerns and/or potential advancements to the Market Shift methodology (Variable Cost Factor, Market Definitions and Stability, and Service Line Exclusions) and identify methods by which to evaluate these issues. Staff will further outline modifications to the Market Shift that will create greater reliability/precision in the results.

Variable Cost Factor

Prior staff assessments of the variable cost factor utilized in the Market Shift policy concluded it was 50 percent. However, due to the thoughtful work of various industry stakeholders and the Maryland Hospital Association (MHA), it was determined that the Commission evaluation could be improved if it used direct costs from the annual filings submitted to the HSCRC, e.g., nursing staff expenditures, in lieu of the

cruder approach of utilizing a generalized cost to charge ratio to approximate total costs from hospital charges. Staff agreed with this proposed improvement but also noted that the MHA proposal had a few other areas that could be improved as well, namely estimating variability of costs through linear regressions[7] versus assuming all direct costs are 100 percent variable and estimating that indirect costs, e.g., financial accounting, had limited variability of 10 percent versus assuming there was no variability in indirect costs. By using the original Commission evaluation plus the various improvements described above, the Volume workgroup coalesced on a hybrid approach that increased the statewide variable cost factor from 50 percent to 59 percent.[8]

Table 3a: Hybrid Approach to Variable Cost Factor Calculation

	HSCRC	MHA	Hybrid
Service Setting for calculation	Calculated separately for IP and OP	Calculated separately for IP and OP	**IP & OP are combined since costs are combined in Annual Filings**
Direct Cost Calculation	Applies Direct cost to charge ratio to case-mix charges	Uses Direct cost from M-schedule from cost report	**Uses direct cost from M-schedule from cost report**
Charge Bucket	HSCRC classifies rate centers into different charge buckets for calculation	Directly uses rate centers	**Uses more granular charge buckets to balance low volumes with unique properties of certain services**
Direct Variable Cost Percent	Direct cost % * Direct cost variability by charge buckets	Assumed 100% of the direct costs as variable	**Direct cost variability (Calculated at the charge bucket level by way of a linear regression model using volumes and inflation adjusted costs from the Annual Filing cost reports) * Direct costs**
Indirect Variable Cost Percent	(1 – Statewide direct costs as % of Adj charges) * 10%	Not considered	**Indirect cost % * 10%**
Variable Cost Factor	Indirect variable cost percent + Direct variable cost as a % of adj charges	Op1 – Direct expense/Level IV Exp Op2 – (Direct exp + Pat care OD – plant) / Level IV Exp Op3 – Level I Exp/ Level IV Exp	**Indirect variable cost percent + Direct variable cost** **The final VCF is a weighted average of VCFs calculated across charge buckets**

[7] Regressions are single year assessments in keeping with the intention of year over year market shift assessments. Over time, staff would anticipate higher variability. See Appendix 1a for Detailed Variable Cost Factor Calculation; see appendix 1b for results of Variability Statistics Using Linear Regressions

[8] Evaluation was tested across multiple years of data to confirm its reliability

Table 3b: Results of Hybrid Approach to Variable Cost Factor Calculation

Calculation Component		Emerg	Observation	Lab & Tests	MSS & CDS	OR	Other	R&B	Clinic	Therapy	Total
Total Cost (M-Sched Level 3)	A	$ 1,131,998,574	$ 422,338,075	$ 2,454,722,481	$ 4,205,740,888	$ 2,259,425,315	$ 287,983,334	$ 5,659,016,420	$ 570,969,148	$ 554,735,133	**$ 17,546,930,368**
Direct Costs:											
Direct Costs (D_Direct)	B	$ 648,775,164	$ 236,194,068	$ 1,317,868,952	$ 3,218,830,565	$ 1,113,049,368	$ 137,139,572	$ 2,980,604,780	$ 276,303,996	$ 350,281,156	**$ 10,279,047,622**
Direct Cost %	C=B/A	57%	56%	54%	77%	49%	48%	53%	48%	63%	**59%**
Direct Cost Variability	D	100%	88%	65%	100%	96%	100%	100%	100%	62%	**94%**
Direct Variable Cost	E=D*B	$ 648,775,164	$ 207,850,780	$ 856,614,819	$ 3,218,830,565	$ 1,068,527,394	$ 137,139,572	$ 2,980,604,780	$ 276,303,996	$ 217,174,317	**$ 9,611,821,386**
Direct Variable Cost %	F=E/A	57%	49%	35%	77%	47%	48%	53%	48%	39%	**55%**
Indirect Costs:											
Indirect Costs	G=A-B	$ 483,224,411	$ 186,144,007	$ 1,136,853,529	$ 986,910,323	$ 1,146,375,946	$ 150,843,763	$ 2,678,411,640	$ 294,665,152	$ 204,453,976	**$ 7,267,882,746**
Indirect Cost %	H=G/A	43%	44%	46%	23%	51%	52%	47%	52%	37%	**41%**
Indirect Cost Variability	I	10%	10%	10%	10%	10%	10%	10%	10%	10%	**10%**
Indirect Variable Cost	J=G*I	$ 48,322,441	$ 18,614,401	$ 113,685,353	$ 98,691,032	$ 114,637,595	$ 15,084,376	$ 267,841,164	$ 29,466,515	$ 20,445,398	**$ 726,788,275**
Indirect Variable Cost %	K=J/A	4%	4%	5%	2%	5%	5%	5%	5%	4%	**4%**
Variable Cost Percent	L=K+F	**62%**	**54%**	**40%**	**79%**	**52%**	**53%**	**57%**	**54%**	**43%**	**59%**
Fixed Cost Percent	M=1-L	38%	46%	60%	21%	48%	47%	43%	46%	57%	**41%**

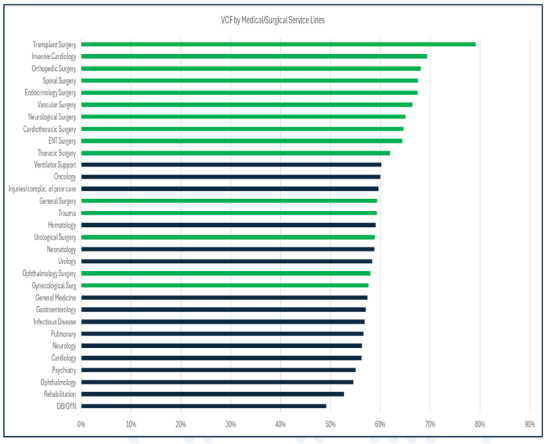
Staff also, per workgroup request, calculated the variable cost factor for each service line in the Market Shift policy, using the same method. The reason for this request was that stakeholders previously have noted that the 50 percent variable cost factor (or 59 percent under the new calculation) is a statewide average that may not be indicative of service lines with inherently higher variable costs, e.g., surgical service lines that have unique device costs for each procedure. As expected, this analysis did indicate there was significant cost variation in surgical versus medical service lines and between inpatient and outpatient services:

Table 4: Service Line Results of Hybrid Approach to Variable Cost Factor Calculation

Inpatient Service Lines

Medical SL Average: **57%**

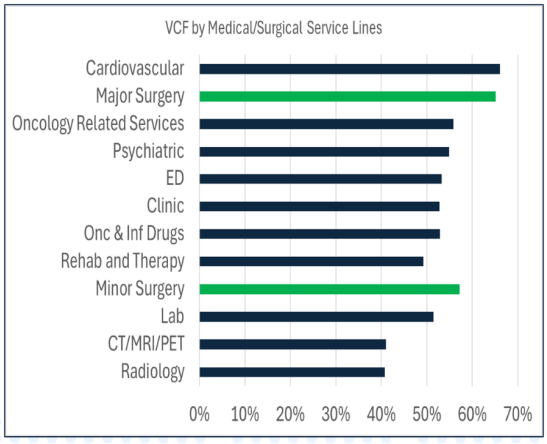
Surgical SL Average: **66%**



Outpatient Service Lines

Medical SL Average: **54%**

Surgical SL Average: **63%**



Further discussion amongst the Volume workgroup members was whether the Commission should use the statewide calculated variable cost factor, the service line specific variable factor, or the medical and surgical variable cost factor groupings. **While there were no strong opinions expressed, in light of these findings staff recommend, effective immediately, that for all volume policies the Commission adopt the newly calculated variable cost factors for inpatient medical and surgical and outpatient medical and surgical in lieu of the statewide average variable cost factor or the service line specific variable cost factors.** The reason for this recommendation is as follows:

1) The new assessment of determining variable costs uses far more precise methods, which when replicated across multiple years yielded very similar results.
2) There is limited variance amongst surgical and medical groupings, once inpatient and outpatient demarcation is established; the lone outlier is transplant surgery but the volumes for this service line are primarily handled through a standalone policy (*Complexity and Innovation*[9]) that independently recognizes the higher variable costs for quaternary services.
3) The use of four variable cost factors versus 45 will reduce administrative complexity, especially as this finding is extended to all volume policies, e.g., deregulation, repatriation.
4) The linear regressions to determine variability in direct costs are an improvement to prior methods of calculating variable costs, but caution should be taken when using them to precisely determine the variable costs of each service line in the State, as single-variate regressions can incorrectly attribute the effects of an unincluded variable to the variable that is included, otherwise known as omitted variable bias.

Market Shift Statistical Stability

Stakeholders noted that numerous small markets lead to statistical instability, especially in year-over-year growth comparisons. To assess Market Shift stability, staff used bootstrapping simulations and the Intraclass Correlation Coefficient (ICC). This method allowed for modeling hypothetical Market Shift configurations, helping the Volume Workgroup evaluate hypothetical proposals for improved reliability.

Reliability means consistent results from repeated measurements. For example, if there are two different tests for assessing blood pressure, the reading has strong reliability if the two tests yield similar results, stronger still if there are similar readings across additional testing approaches, i.e., 3 or more. For marketshift assessments, staff could not apply different tests, but instead ran many simulations through the bootstrapping[10] method to see if the market shift adjustments for hospitals were fairly similar when there is a replacement of discharge data for a given hospital's services in a given market.

After simulations, the ICC (0-1) assesses between group variability versus variability across simulations; higher values mean more reliable assessments. A score closer to 1 indicates consistent Market Shift assessments, suggesting detected variation is due to patient selection (e.g., better service offerings) rather than random simulation-induced variation.[11]

Staff analysis shows statewide Market Shift reliability is moderate (ICC=0.52), strong for outpatient service lines (Weighted Average ICC[12] = 0.87), and moderate for some inpatient service lines but generally poor overall due to several low-volume medical and surgical service lines (Average ICC = 0.39)

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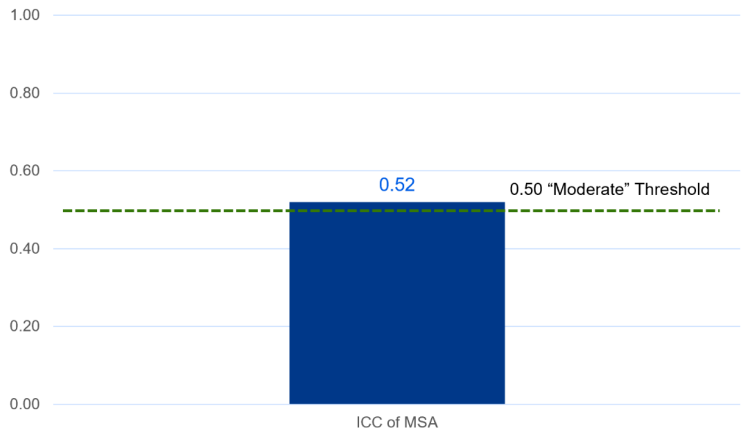
[9] Complexity & Innovation

[10] For more information on bootstrapping, please see Appendix 2

[11] For more information on Interclass Correlation Coefficient, please see Appendix 3

[12] To weight each service line ICC staff used charges as a percentage of total inpatient or outpatient revenue.

Table 5 : Hospital Service Line Reliability of Simulated Data without Aggregation



Reliability	ICC Range
Poor	< 0.50
Moderate	0.50 – 0.75
Good	0.75 – 0.90
Excellent	≥ 0.90

Source: Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. Journal of Chiropractic Medicine, 15(2), 155-163.

Less than excellent reliability on a statewide basis was expected due to two main factors: a) the inherent trade-off in reliability when moving away from a fee-for-service model, which, while highly reliable, perpetuates a "sick care" system that incentivizes acute care over preventative services; and b) the significant disaggregation of inpatient service lines, resulting in low-volume assessments, especially for high dollar services, that inherently lead to lower reliability scores.

Staff modelled four hypothetical reconfigurations of the Market Shift for the Volume Workgroup, but only two of them showed promise in improving the baseline statewide reliability score of 0.52:

- Assessing all inpatient surgical service lines in line with the Maryland Health Care Commission’s four regions for Certificate of Need evaluations (Statewide ICC = 0.51)
- Assessing all inpatient surgical service lines on a statewide basis (Statewide ICC = 0.51)
- Consolidating, based on clinical review, Spinal Surgery with Neurological Surgery, Thoracic Surgery with Cardiothoracic Surgery, and Ventilator Support with Pulmonary service lines (Statewide ICC = 0.54)
- Excluding from Marketshift assessments Endocrinology Surgery, ENT Surgery, Gynecological Surgery, Ophthalmologic Surgery, Thoracic Surgery, Urological Surgery, and Ventilator Support (Statewide ICC = 0.57)

The final configuration was seemingly the most attractive to the Volume Workgroup because of its significant impact on reliability and due to the fact that these services are not ideally suited for population based methodologies/interventions as they are high cost, low volume service lines that are often not preventable and/or occur much later in the disease cycle, e.g., hysterectomies

In light of these findings, staff recommend for CY 2026 performance assessments removing from the Market Shift the following service lines: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support - equivalent to 2.5 percent of in-state revenue; and consolidating Spinal Surgery and Neurological Surgery. Staff additionally recommend that any services removed from Market Shift be handled similar to the Out-of-State volume policy, namely still part of global budgets but volume variable and only adjusted for when volume change is material, i.e., 1 percent of service line revenue when volume increases, 3 percent of service line revenue when volume decreases.

Staff are recommending a CY 2026 implementation because it provides the hospital field with an opportunity to adapt to new methods for calculating volume changes. This approach also can be more readily absorbed by the AHEAD contract provision, effective January 1, 2026, which permits an additional 5 percent of in-state services to fall outside of population-based methodologies.

Staff did not recommend consolidation of Thoracic Surgery with Cardiothoracic Surgery, and Ventilator Support with Pulmonary, because instead the former, in both cases, are to be removed from Market Shift and handled through this alternative methodology. Increasing the magnitude of those carveouts further by consolidating with other service lines would jeopardize the State's ability to maintain 90 percent of in-state revenues within population based methodologies as required by the AHEAD model contract

Service Line Exclusions

Under normal circumstances, the Market Shift policy addresses changes in hospital selection across all-payer in-state services. However, over the past decade, the Commission has occasionally departed from this methodology when there are significant system realignments, e.g., payer initiated shifts, that require more precise and real time methods of evaluation. This is consistent with the Commission's authority, as detailed in the Global Budget Agreements between the HSCRC and individual hospitals, to modify global budgets for "…service discontinuations, shifts of services from the Hospital to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share and other relevant factors that are pertinent to the effective operation of the GBR model…"[13]

To effectuate departures from the Market Shift policy, staff have either altered (on a temporary basis) the Market Shift assessment, e.g., combining hospitals when a facility conversion occurs, or removed data from the Market Shift and and assessed volume change independent of the Market Shift algorithm, e.g., payer initiated shifts that move entire populations from one hospital to another.

The benefit of this approach is that it avoids the imprecision of the market shift methodology that naturally occurs when there is a purposeful, material realignment in the market. For example, if a hospital realigns services within its health system, while other hospitals experience utilization growth due to natural population changes, a portion of the realignment will be partially attributed to other facilities outside of the system that are experiencing use rate growth due to secular demographic changes (see example below).

[13] Global Budget Agreement

Table 6 : Example of Purposeful System Realignment Interacting with Marketshift Policy

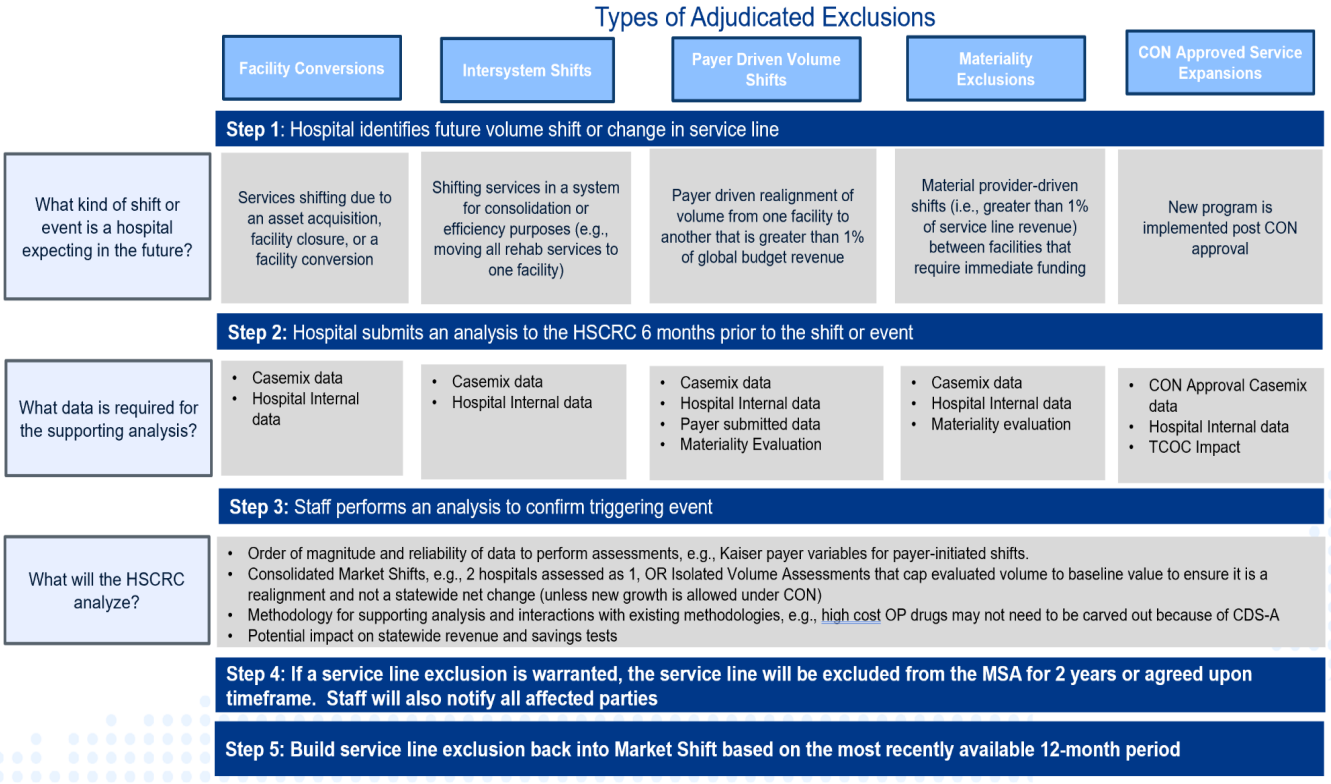
			Hospital A (System 1)	Hospital B (System 2)	Hospital C (System 2)	Total	Comments
Normal Marketshift Assessment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C	Market Driven Volume Changes	5	-2	-3	0	
	D = B+C	Total Volume Change	15	-2	-3	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		5			
	F=D/Total Growth or Decline* E	Awarded Marketshift	5	-2	-3	0	Must equal 0 to ensure only shifts are quantified
	G=A+B+F	New Baseline Volume	115	98	97	310	*5 units of volume are shifted from Hospital B & C to Hospital A*
			Hospital A (System 1)	**Hospital B (System 2)**	**Hospital C (System 2)**	**Total**	**Comments**
Normal Marketshift Assessment interacting with Purposeful System Realignment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C1	Market Driven Volume Changes	5	-2	-3		
	C2	System Realignment	0	-8	8		*System 2 elects to shift 8 units of volume between its hospitals (e.g., consolidation of rehab program)*
	D = B+C	Total Volume Change	15	-10	5	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		10			
	F=D/Total Growth or Decline* E	Awarded Marketshift	7.5	(10.0)	2.5	0	Must equal 0
	G=A+B+F	New Baseline Volume	117.5	90.0	102.5	310	*An additional 2 units of volume are shifted from Hospital B to Hospital A because the system realingment is scored as a marketshift*

Net Effect	***An additional 2.5 volume units are awarded due to population growth, which is misattributed as a marketshift***	***All Volume Decline is Correctly Scored***	***2.5 volume units related to system realingment are NOT awarded due to interaction with marketshift***

In light of these historical practices, and to better align with the proposed AHEAD Financial Specifications that similarly intend to account for these activities through a "Service Line Adjustment,"[14] **staff propose that the following triggers and processes be employed to exclude service lines from Market Shift for a temporary period of time:**

[14]"Service Line Adjustments (SLA) adjust prospective HGBs to account for anticipated revenue changes from pre-planned service line changes, including additions, eliminations, expansions, or contractions of service lines within a given market area." https://www.cms.gov/files/document/ahead-tech-specs-v30.pdf (Page 41)

Table 8 : Triggering Events and Processes for Service Line Exclusions



While there were no concerns raised by the Volume Workgroup over what staff put forward as a service line exclusion and the process therein, one member did question whether the Payer Driven Volume Shift category, as currently defined, could be utilized to address one additional phenomenon in the market, namely when an insurer deems a hospital to be out of network. Staff do not know if this is a workable solution because unlike a typical Payer Driven Volume Shift, the volume realignment will not be localized between two hospitals, and it is unclear where the transition (if any) will land. Plus, there is no actor in this occurrence that has an incentive to assist staff with precisely realigning volume among the various regulated entities.

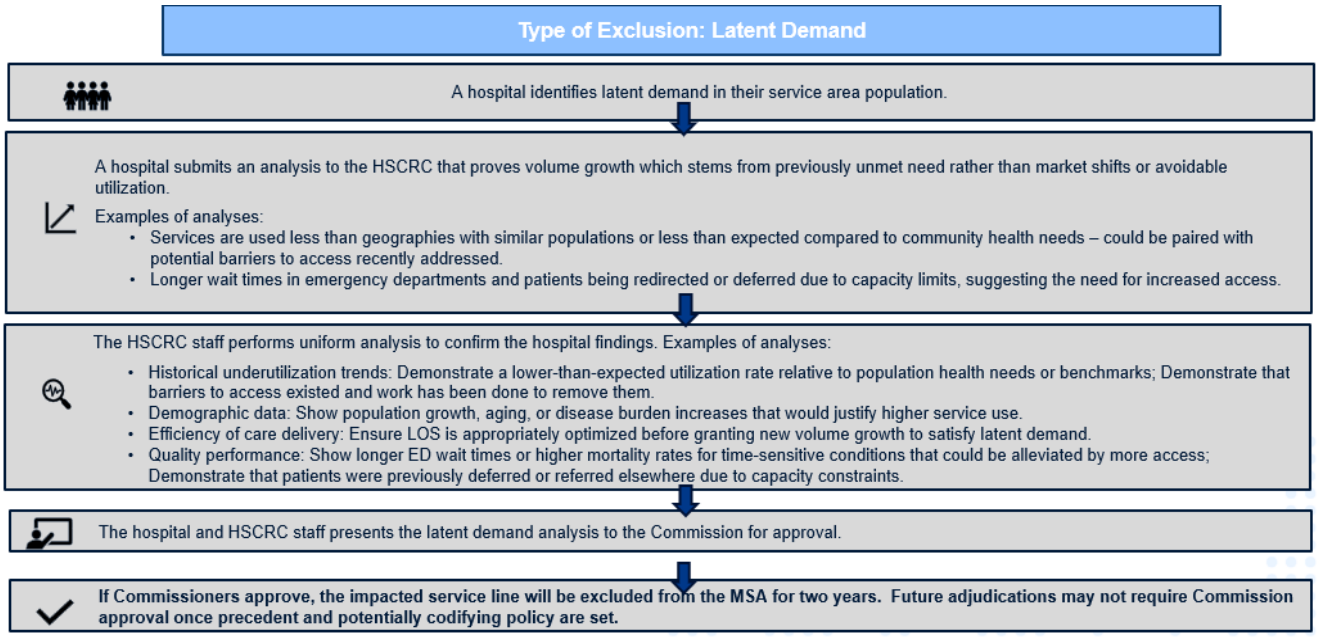
Normally, HSCRC policy would account for volume shifts of this kind through a combination of Market Shift and Deregulation, but given the unique nature of this activity, staff are bringing it forward for Commissioner consideration.

Additional Considerations for Future Policies

Staff wishes to explore an additional service line exclusion of "Latent Demand" for future policy development. This term may be defined as a potential need for a healthcare service that is not currently being realized in the market. A potential future policy consideration could be developed to create a semi-automatic approval process where hospitals can submit volume increase requests related to latent demand that are not large enough for a CON application but should be addressed independent of the Market Shift and Demographic Adjustment policies.

For a potential process for Latent Demand, please see exhibit below:

Table 9 : Process for Potential Latent Demand Service Line Exclusions



Recommendations

Staff recommends the following updates to the current Commission Methodologies:

1. Effective immediately, adopt for all volume policies the newly calculated variable cost factors for inpatient medical (57 percent) and surgical (66 percent) and outpatient medical (54 percent) and surgical (63 percent) in lieu of the historical standard of 50 percent.

2. For CY 2026 performance assessments, remove from the Market Shift the following service lines: Endocrinology Surgery; ENT Surgery; Gynecological Surgery; Ophthalmologic Surgery; Thoracic Surgery; Urological Surgery; and Ventilator Support, and consolidate Spinal Surgery and Neurological Surgery.

   Any volume changes for services removed from the Market Shift as a result of this recommendation shall be adjudicated similar to the Out-of-State Volume policy, i.e., a revenue adjustment will only occur when the volume change is material, i.e., 1 percent of service line revenue when volume increases, 3 percent of service line revenue when volume decreases

3. Officially establish the process, described herein, by which Service Line Exclusions from the Market Shift policy can be triggered and adjudicated provided one of the following criteria is met:
   a. Facility Conversions
   b. Intersystem Shifts
   c. Payer Driven Volume Shifts
   d. Material Provider Initiated Shifts
   e. CON Approved Service Line Expansions

Appendix 1. Variable Cost Factor Calculation

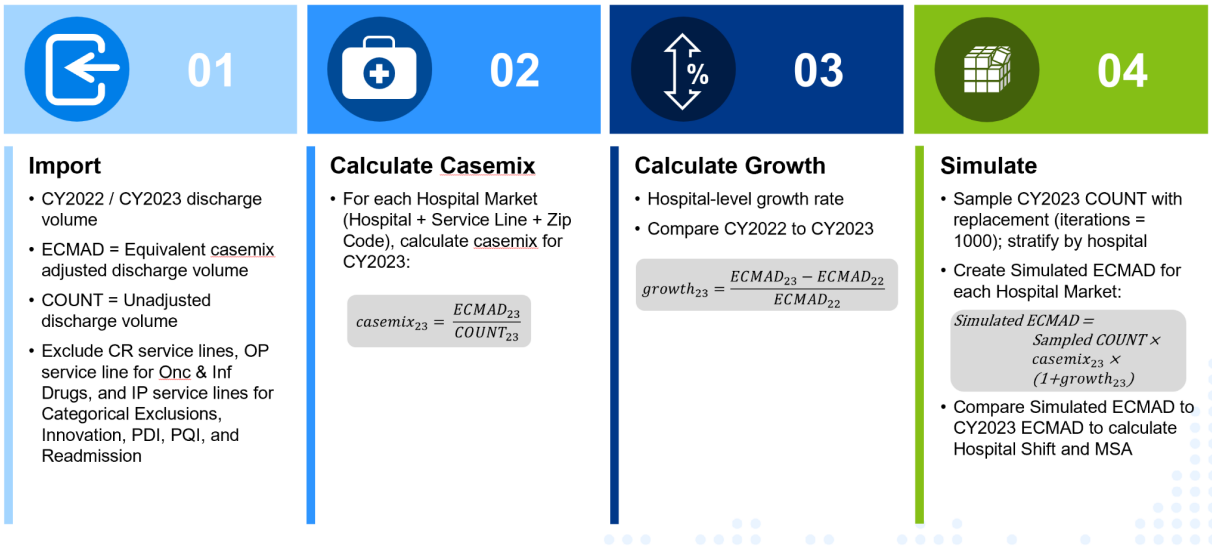
1. Level 3 costs are obtained from M schedule of annual filing cost report for the entire state by charge bucket
2. Direct costs are obtained from M schedule of annual filing cost report (D_Direct)
3. Direct Cost % = Direct Cost from step 2 / Level 3 costs
4. Apply direct cost variability to direct costs to calculate direct variable costs
5. **Direct variable cost % =** Direct variable cost / Level 3 costs
6. Indirect Costs % = (Level 3 Costs – Direct Variable Costs from step 2) / Level 3 costs
7. Apply indirect cost variability (10%) to indirect costs to obtain indirect variable cost
8. **Indirect variable cost % =** Indirect variable Costs / Level 3 costs
9. **Absolute Variable cost % =** Direct variable cost % + Indirect variable cost % (Calculated by charge bucket)
10. **Variable cost % =** Weighted average of absolute variable cost % based on total costs by charge bucket

Appendix 1b. Direct Cost Variability By Charge Bucket Using Linear Regressions

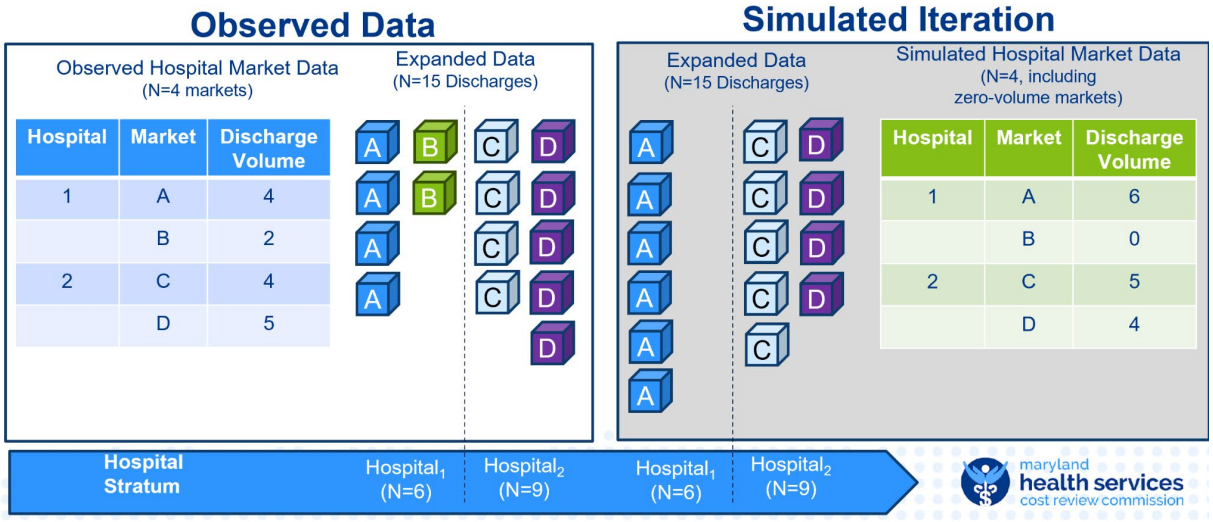
Charge Buckets	Calculated Direct Cost Variability					
	FY24	FY23	FY22	FY19	FY18	FY17
R&B	100%	100%	100%	100%	100%	100%
OR	66%	70%	70%	66%	66%	68%
Lab & Tests	64%	68%	67%	58%	75%	61%
MSS & CDS(1)	100%	100%	100%	100%	100%	100%
Therapy	57%	65%	61%	65%	62%	63%
Emerg	100%	100%	100%	100%	100%	100%
Observation	97%	98%	93%	77%	79%	83%
Clinic	100%	100%	100%	100%	100%	100%
Other(1)	100%	100%	100%	100%	100%	100%

Note (1): MSS/CDS and Other are assumed to be 100% variable with volumes. Analysis was not performed to validate this assumption.

Appendix 2a. Detail on Bootstrapping Method in Markets Shift Simulations



Appendix 2b. Detailed Example of Bootstrapping Method



Appendix 3. Detail on Interclass Correlation Coefficient

- Intraclass Correlation Coefficient (ICC) is a measure of reliability, where ICC = 0 indicates no reliability and ICC = 1 perfect reliability, i.e., all measures in a group are identical.

$$\text{ICC} = \frac{variance\ between\ groups\ (V_b)}{variance\ between\ groups\ (V_b) + variance\ within\ groups(V_w)}$$

- Each MSA in the simulation is used in the above formula such that:

V_b: The variation between group means, measured around the overall (grand) mean.

V_w: The variation among MSAs within the same group, measured around each group's mean.

- Group means are the average MSA across 1000 simulations for each hospital service line
- Grand Mean is the average of all the MSAs across all the hospital service lines.

Signal: Variation between hospital service line MSAs for a given simulation.

Noise: Variation of hospital service line MSAs across simulations.

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Draft Recommendation for Select Hospital Volume Realignment

October 8, 2025

Executive Summary

Kaiser Permanente background

- Kaiser Permanente (KP) is the largest Medicare Advantage and second largest Commercial insurance carrier in Maryland. While Kaiser does not operate its own hospital facilities in Maryland, it partners with a network of hospitals (KP Core Hospitals).
- Permanente Physicians and Kaiser Foundation Health Plan staff are embedded in these hospitals to provide direct care to Kaiser Permanente members and coordinate their care within their integrated delivery system.
- Kaiser Permanente is strategically consolidating its Maryland member hospital utilization to Core Hospitals within its integrated delivery system, which will impact many hospitals across the State. This process is underway and should be finalized sometime in early calendar year 2026.

Volume adjustments for Kaiser Permanente patients

- Kaiser Permanente patient volumes and reimbursements in Maryland follow population-based methodologies, including adjustments for demographic changes (annually) and market shifts (every six months), consistent with policies applied to all payers.
- There have been instances where volume realignment outside of the normal market shift adjustment for Kaiser Permanente patients is necessary. These prospective adjustments required complex negotiations and reconciliations and typically only addressed a shift between two hospitals.

Purposeful System Realignment Interacting with Marketshift Policy

Payer-specific volume alignment

- The Commission has occasionally deviated from standard market shift methods to assess shifts specific to unique payers rather than broad payer-initiated shifts.
- Payer-specific adjustments avoid the imprecision of standard market shift methods during intentional realignments, where utilization changes might otherwise be misattributed to unrelated demographic trends at other hospitals.
  - For example, if a hospital system realigns services within its health system, while other hospitals experience utilization growth due to natural population changes, a portion of the realignment will be partially attributed to other facilities outside of the system that are experiencing use rate growth due to secular demographic changes (see illustration to the right).

MSA with purposeful system realignment

Illustrative Example:	Hospital A (System 1)	Hospital B (System 2)	Hospital C (System 2)
A = Baseline Volume	100	100	100
Volume adjustments: B1 = Population related change	+10	-	-
Volume adjustments: B2 = Market driven change	+5	-2	-3
Volume adjustments: B3 = System realignment	0	-8	+8
B = Total Vol change (B1+B2 + B3)	+15	-10	+5
Growth or decline?	Growth	Decline	Growth
C = Absolute value of lesser of total statewide growth/decline	10	10	10
D = Ratio of lesser to total growth/decline	0.75	1	0.25
E = MS Awarded = C * D	7.5	-10	2.5
F = New Volume = A+B1+E	117.5	90	102.5
Net Effect	Additional 2.5 units awarded	Volume decline scored accurately	2.5 volume units related to system realignment not awarded

B3. In system realignment, System 2 has decided to shift 8 units from one hospital to another within the system due to consolidation of their rehab program

This adjustment does not occur in the usual market shift calculation methodology

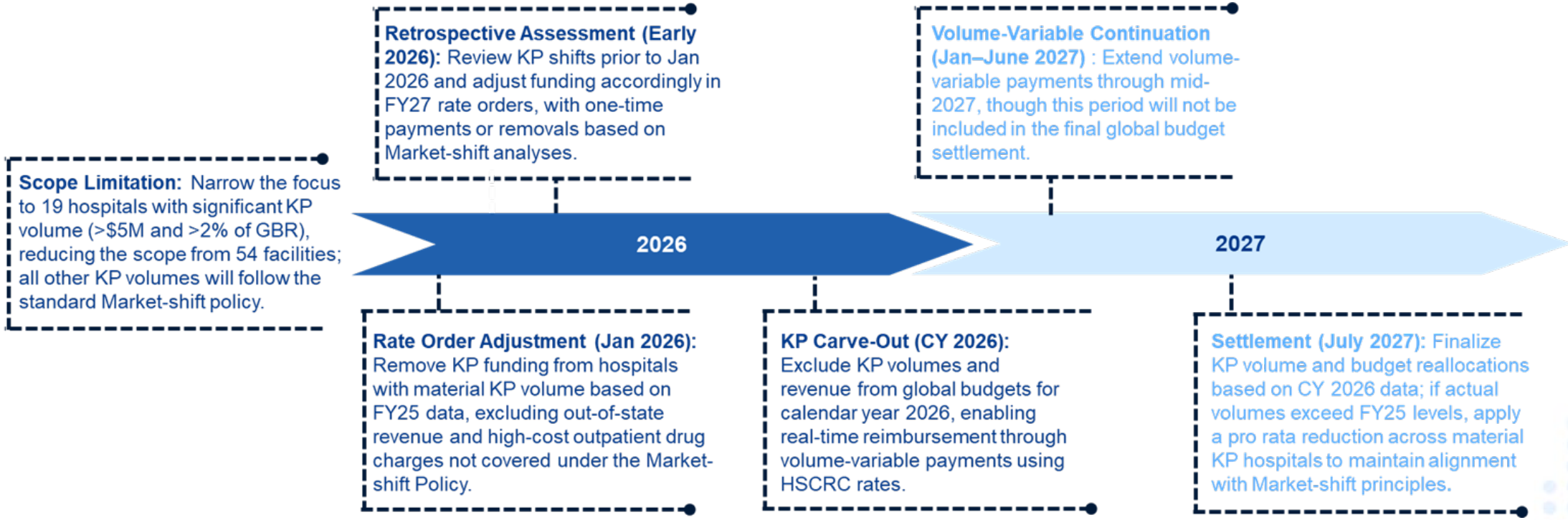
B. Total Growth = 20

Total Decline = -10

C. Market shift eligible volume considers the lowest absolute value amongst the volume changes in step B

Proposal and Relevant Considerations

Past Prospective KP adjustments required complex negotiations and reconciliations, prompting staff to propose **a streamlined alternative approach:**



The proposed approach complies with the TCOC requirement that 95% of in-state volume be population-based, as retrospective assessments and pro rata adjustments will ensure volumes stay within FY25 levels. Staff will also implement a supplemental reporting schedule to monitor monthly and year-end GBR compliance, ensuring hospitals are not penalized for carved-out KP volumes.

Draft Recommendations

1. **KP Volume and Revenue Removal (Jan 2026–June 2027):** Exclude KP volumes and revenues from global budgets for select hospitals under the Market-shift policy.
2. **Real-Time Reimbursement**: Reimburse excluded KP volumes and revenues in real time using volume-variable methodology at HSCRC rates.
3. **Budget Rebuild (July 2027)**: Restore KP volumes and revenues to global budgets based on actual volume-variable reimbursements from Jan-Dec 2026.

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Draft Recommendation for Select Hospital Volume Realignment

Please submit all comments to allani.pack@maryland.gov by COB October 29, 2025.

Table of Contents

List of Abbreviations

AHEAD	Achieving Healthcare Efficiency through Accountable Design
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care

Executive Summary

The approach outlined in this draft recommendation aims to simplify the process for handling Kaiser Permanente's (KP) material market shift in hospital utilization, reduce the scope of affected facilities, and provide more accurate, real-time reimbursements. It also ensures that volume-based adjustments are consistent with Maryland's established methodologies while accommodating KP's ongoing efforts to realign its healthcare delivery model.

Section I: Facts

Kaiser Permanente is an integrated healthcare delivery system that provides health plan coverage and coordinated medical services for its members. KP has over 750,000 members in the Mid-Atlantic States Region, which includes Maryland. KP is the largest Medicare Advantage and second largest Commercial insurance carrier in Maryland . While KP does not operate its own hospital facilities in Maryland, it partners with a network of hospitals (KP Core Hospitals). Permanente Physicians and Kaiser Foundation Health Plan staff are embedded in these hospitals to provide direct care to KP members and coordinate their care within their integrated delivery system. Although KP members can access emergency services at any hospital and utilize non-emergent services when clinically appropriate in out of network locations, the majority of hospital utilization for KP members occurs at KP Core Hospitals.

The volumes and reimbursements associated with KP patients operate under the same population based methodologies that all payers are subject to in Maryland. Specifically, KP patient volumes at regulated hospitals are adjusted for anticipated use rates in line with population growth through the annual Demographic Adjustment policy and every six months are also adjusted for changes in market selection/patient choice through the Market-shift policy.

Kaiser Permanente is currently in the process of realigning its members amongst its Core Hospitals and is actively pursuing a strategy of consolidating its members to these facilities. This process is underway and should be finalized sometime in early calendar year 2026.

Section II: Issue

Under normal circumstances, the Market-shift policy, which evaluates all payers and all in-state services,[1] addresses changes in hospital selection. However, over the past decade, the Commission has occasionally departed from this methodology during significant payer-initiated shifts and instead has assessed shifts isolated to unique payers. This is consistent with the Commission's authority, as detailed in the Global Budget Agreements between the HSCRC and individual hospitals, to modify global budgets for "…service discontinuations, shifts of services from the Hospital to other related or non-related hospitals or non-hospital providers, changes in the Hospital's market share and other relevant factors that are pertinent to the effective operation of the GBR model…"[2]

The benefit of this approach is that it avoids the imprecision of the market shift methodology that naturally occurs when there is a purposeful, material realignment in the market. For example, if a hospital system realigns services within its health system, while other hospitals experience utilization growth due to natural population changes, a portion of the realignment will be partially attributed to other facilities outside of the system that are experiencing use rate growth due to secular demographic changes (see example below).

Table 1: Example of Purposeful System Realignment Interacting with Marketshift Policy

			Hospital A (System 1)	Hospital B (System 2)	Hospital C (System 2)	Total	Comments
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Normal Marketshift Assessment interacting with Purposeful System Realignment	A	Baseline Volume	100	100	100	300	
	B	Population Related Volume Change	10	0	0	10	
	C1	Market Driven Volume Changes	5	-2	-3		
	C2	System Realignment	0	-8	8		*System 2 elects to shift 8 units of volume between its hospitals (e.g., consolidation of rehab program)*
	D = B+C	Total Volume Change	15	-10	5	10	
	E = Lesser of D Total Growth or Decline (Absolute Value)	Marketshift Eligible Volume		10			
	F=D/Total Growth or Decline* E	Awarded Marketshift	7.5	(10.0)	2.5	0	Must equal 0
	G=A+B+F	New Baseline Volume	117.5	90.0	102.5	310	*An additional 2 units of volume are shifted from Hospital B to Hospital A because the system realingment is scored as a marketshift*

Net Effect	***An additional 2.5 volume units are awarded due to population growth, which is misattributed as a marketshift***	***All Volume Decline is Correctly Scored***	***2.5 volume units related to system realingment are NOT awarded due to interaction with marketshift***

[1] Limited exceptions to this are high cost outpatient drugs that are handled through a unique volume variable methodology known as the CDS-A policy (insert CDS-A link) and unique quaternary cases performed at the State's two academic medical centers, which are addressed through the Complexity and Innovation policy (https://hscrc.maryland.gov/Documents/global-budgets/2023%20Website%20Update%20Files/Final%20Innovation%20Policy%20v3%20%28002%29.pdf)

[2] https://hscrc.maryland.gov/Pages/gbr-tpr.aspx

This is the inherent tradeoff caused by using population-based methodologies. While these approaches effectively incentivize a shift away from the traditional "sick care" model, which often rewards providers for acute care services over preventative one, they also introduce a degree of imprecision in revenue allocation. This imprecision can be particularly noticeable when significant market changes occur.

Section III: Proposal and Relevant Considerations

The Commission has previously used a prospective adjustment and then a zero-sum evaluation, similar to the Market-shift Policy, to address KP-initiated shifts in hospital global budgets due to their growth and dissipation. This method allowed for real-time funding adjustments, which was crucial given the scale of these market shifts. Following these prospective adjustments, staff utilized Market-shift datasets and KP-submitted data to finalize the settlement of KP volumes and revenues among affected hospitals.

While past prospective adjustments were generally accurate, they often involved extensive negotiations with hospitals, retrospective data submissions from KP, and reconciliations of the initial adjustments.

Considering the numerous steps in this adjudication process and the broader impact of the proposed KP shift across several hospitals, staff are now proposing an alternative approach. Specifically:

1) Scope Limitation: Limit the scope of affected hospitals to facilities with material KP volume, defined as greater than $5 million in annual charges and greater than 2 percent of global budget revenue. This effectively reduces the scope from 54 facilities to 19 facilities.[3] All other KP volume will be handled through the normal Market-shift policy.

2) Rate Order Adjustment (January 2026): In January 2026 rate orders, remove KP funding across hospitals that had material KP volumes, based on Fiscal Year 2025 KP submitted data. KP out-of-state revenue and revenue associated with the high-cost outpatient drugs evaluated in the Commission's CDS-A policy will not be removed, as they are not part of the Market-shift Policy.

3) KP Carve-Out from Global Budgets (January 1, 2026 - December 31, 2026): Carve out KP volumes and revenue from global budgets from January 1, 2026, through December 31, 2026. This will allow them to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates.

4) Settlement of Reallocated Volumes/Budgets (July 2027): Settle in July 2027 the reallocated KP volumes/global budgets based on actual experience from January 1, 2026, through December 31, 2026. This will necessitate an assessment across the designated material KP hospitals to ensure that volume does not deviate from Fiscal Year 2025 volumes, thereby ensuring this is a methodology analogous to

[3] For a complete list of affected hospitals, please see Appendix 1. These hospitals may change slightly once RY 2025 data is available.

Market-shift. If volumes do deviate from the prior KP cap, staff will implement a pro rata reduction to material KP facilities.[4]

5) Continuation of Volume Variable Methodology (January 1, 2027 - June 30, 2027): Continue the volume-variable methodology for January 1, 2027, through June 30, 2027. This period will not be used for the final settlement of global budgets.

6) Retrospective Assessment of Prior KP Shifts (Early 2026): Retrospectively assess in early 2026, in line with Commission Market-shift analyses, any KP shifts that occurred prior to January 1, 2026 (both increases and decreases). This one-time funding (or removal of funding) will be provided on July 1, 2026, rate orders (FY 27) or in January rate orders if the adjudication process lags.

A key consideration in this approach is the TCOC contract provision that 95 percent of in-state volume is assessed under a population-based methodology, while the AHEAD Model allows 90 percent. Because staff will conduct a retrospective assessment and potential pro rata reduction to ensure that volumes do not exceed the Fiscal Year 2025 volume base, staff believe this proposed method aligns with the tenets of a population-based methodology and does not count against the 95 percent requirement.

To effectuate this proposal, staff also need to consider GBR compliance. For the hospitals affected by this recommendation, staff will create a supplemental schedule to submit along with the monthly experience data. The schedule will provide volume and revenue data by rate center (experience data) for patients where KP is the primary payer. Staff will use this data to monitor monthly compliance with GBR. For year-end compliance, staff will take the hospital-reported KP revenue for the year and deduct it from the hospital's total actual revenue in the "GBR1" tab of the rate model, so hospitals are not penalized for patient volume carved out of their GBR. Finally, staff will reconcile the hospital's submitted experience data schedule for KP with the case-mix data to ensure that the submission is accurate.

Section IV: Draft Recommendations

1) From January 1, 2026 through June 30, 2027, remove, for select hospitals, KP volumes and revenues evaluated in the Market-shift policy from global budget revenues.
2) Allow removed KP volumes and revenues to be reimbursed in real time through a volume-variable evaluation, using HSCRC rates.
3) On July 1, 2027, build back into global budgets removed KP volumes and revenues based on volumes reimbursed through a volume variable evaluation from January 1, 2026 through December 31, 2026.

[4] Staff will allow for minimal deviation to account for population growth and if hospitals and Kaiser can prove insurance conversion.

Appendix I: Material Kaiser Permanente Hospitals

	CY 2024 Total Charges	KP % of Hospital KP Data
Adventist Healthcare Shady Grove Medical Center	$ 543,605,124	3.7%
Adventist Healthcare White Oak Medical Center	$ 380,039,915	3.4%
Suburban Hospital	$ 441,639,383	11.7%
Northwest Hospital Center	$ 313,385,400	3.0%
Anne Arundel Medical Center	$ 758,821,697	4.6%
Doctor's Community Hospital	$ 309,125,401	9.7%
MedStar Frankin Square Hospital Center	$ 699,845,763	2.3%
MedStar Harbor Hospital Center	$ 227,871,902	2.5%
MedStar Montgomery Medical Center	$ 228,808,222	2.9%
MedStar Southern Maryland Hospital Center	$ 347,892,688	6.9%
Ascension St. Agnes Hospital	$ 518,077,452	3.9%
Holy Cross Hospital	$ 614,339,914	36.1%
Holy Cross -Germantown	$ 171,802,036	14.0%
University of Maryland, Baltimore Washington Medical Cent	$ 544,485,893	9.2%
University of Maryland, Capital Region Medical Center	$ 450,109,777	11.7%
University of Maryland, Charles Regional Medical Center	$ 194,127,129	3.3%
University of Maryland, St. Jbseph Medical Center	$ 500,504,604	10.2%
University of Maryland Medical Center	$ 1,938,006,414	2.5%
University of Maryland -MIEMSS	$ 318,461,530	4.5%
	$ 9,500,950,244	7.4%

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ED-Hospital Best Practice Policy-Draft Recommendations

October 8, 2025

Draft Recommendations for RY 2028

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in CY 2026 after CY 2025 data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2028.
    - Failure to implement and report data to the Commission by December 31st 2026 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027.
3. We intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY2026 Best Practice program impact is assessed.

Rationale

- Data for CY 2025 will be submitted in December. A continuation of monitoring will ensure adequate time to analyze the data and understand the impact of each best practice at individual hospitals and across the state.
- Continued monitoring with reporting accountability rather than a transition to pay for performance will provide time to consider how this program will be integrated into and align with the AHEAD model transition.
- HSCRC believes that with the AHEAD transition in progress, hospitals should continue to hardwire existing practices to ensure consistency and improvement in RY 2028.
- Preliminary results indicate that implementation of these best practices have yielded improvements in throughput

Example of ED Hospital Throughput Best Practice Successes

Bayview Hospital Best Practice: Patient Flow/Throughput PI Council

Focus is building capacity and enhancing patient throughput throughout the entire hospital

Application: Bayview created a Hospital Capacity Steering Committee focused on building on capacity and enhancing patient throughput across the entire hospital.

Current Focus #1: Reduced ED Boarding Times

Median ED Boarding Data:

There was a cultural shift enabled by the Hospital Capacity Steering Committee, but it took time to build the foundation, identify root causes, and launch targeted projects.

Where we used to be: Jul–Sep 2024: 12:07 hours median boarding per patient

Where we are currently: Jul–Sep 2025 (mature projects): 8:00 hours median boarding per patient

33% improvement

Current Focus #2: Lower Walkout Rate (combined LWBS, LBT, SAL) as this is an outcome measure that closely correlates with ED boarding and ED wait times.

Walkout Rate Data:

Where we used to be: Feb 2023 – Jan 2024: 26.4% total elopement/walkout rate

Where we are currently: Feb 2024 – Sep 2025: 19.7% total elopement/walkout rate

25% improvement, reflecting more patients staying to complete care rather than leaving due to long waits

These data points tie directly back to the Hospital Capacity Steering Committee and demonstrate how this best practice has helped improve key metrics, especially as we allow time for the projects to mature and for the culture to change around the importance of hospital capacity.

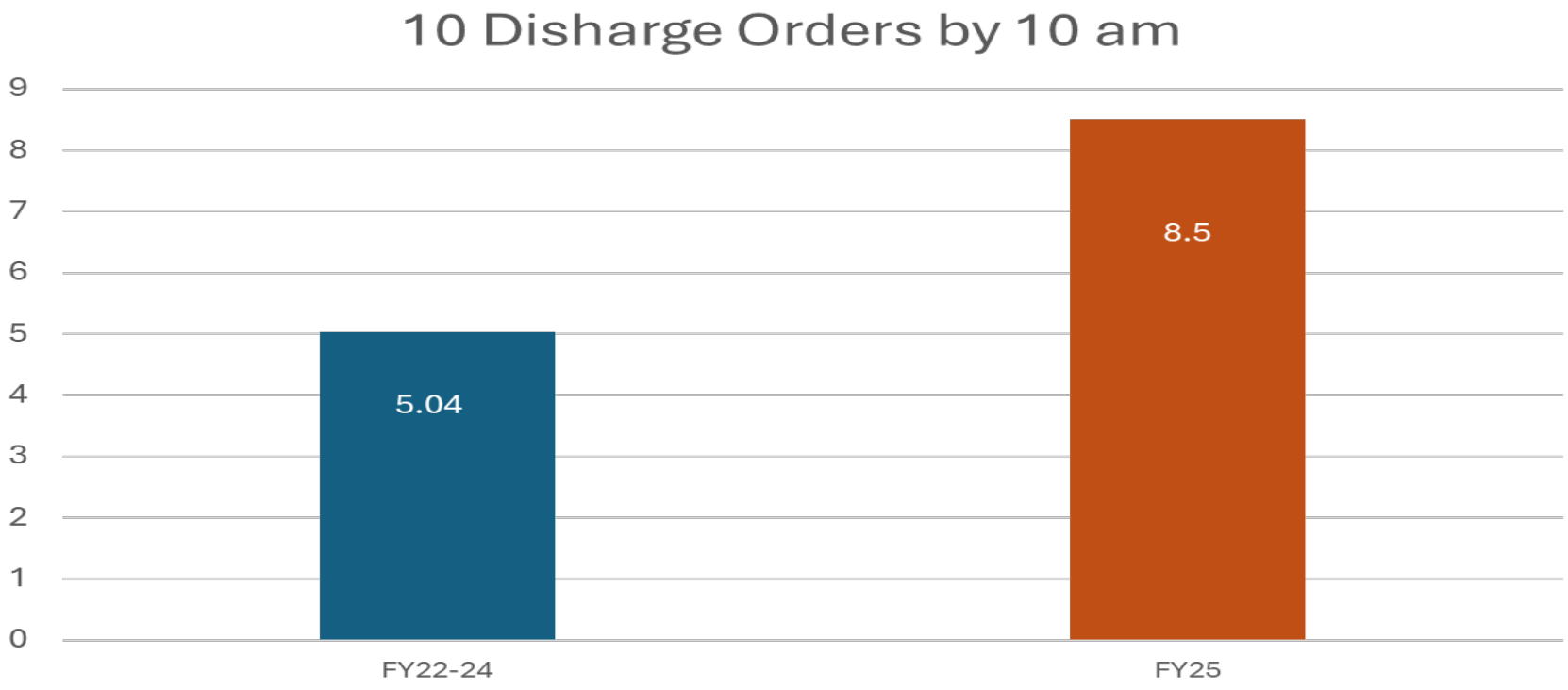
ED Hospital Throughput Best Practice Successes

Suburban Hospital Two Best Practice Submissions: Daily Huddles and Bed Capacity Alert System – impact on Throughput

Application: Suburban has created a Daily Huddle Process focused on a collaborative approach to patient throughput and safety.

- All key stakeholders are on this daily huddle, including our Hospital President, VPMS, CNO, COO, Nursing leadership, ED Leadership, Hospitalist team, and every service line.
- Focus on initiatives such as increasing early inpatient discharges (goal of 10 discharge orders by 10am) that positively impact patient flow.
- During this huddle, review bed capacity and ED volume so we can respond with appropriate actions.
- This approach builds situational awareness, capacity, and collaboration, while focusing on patient care and safety.

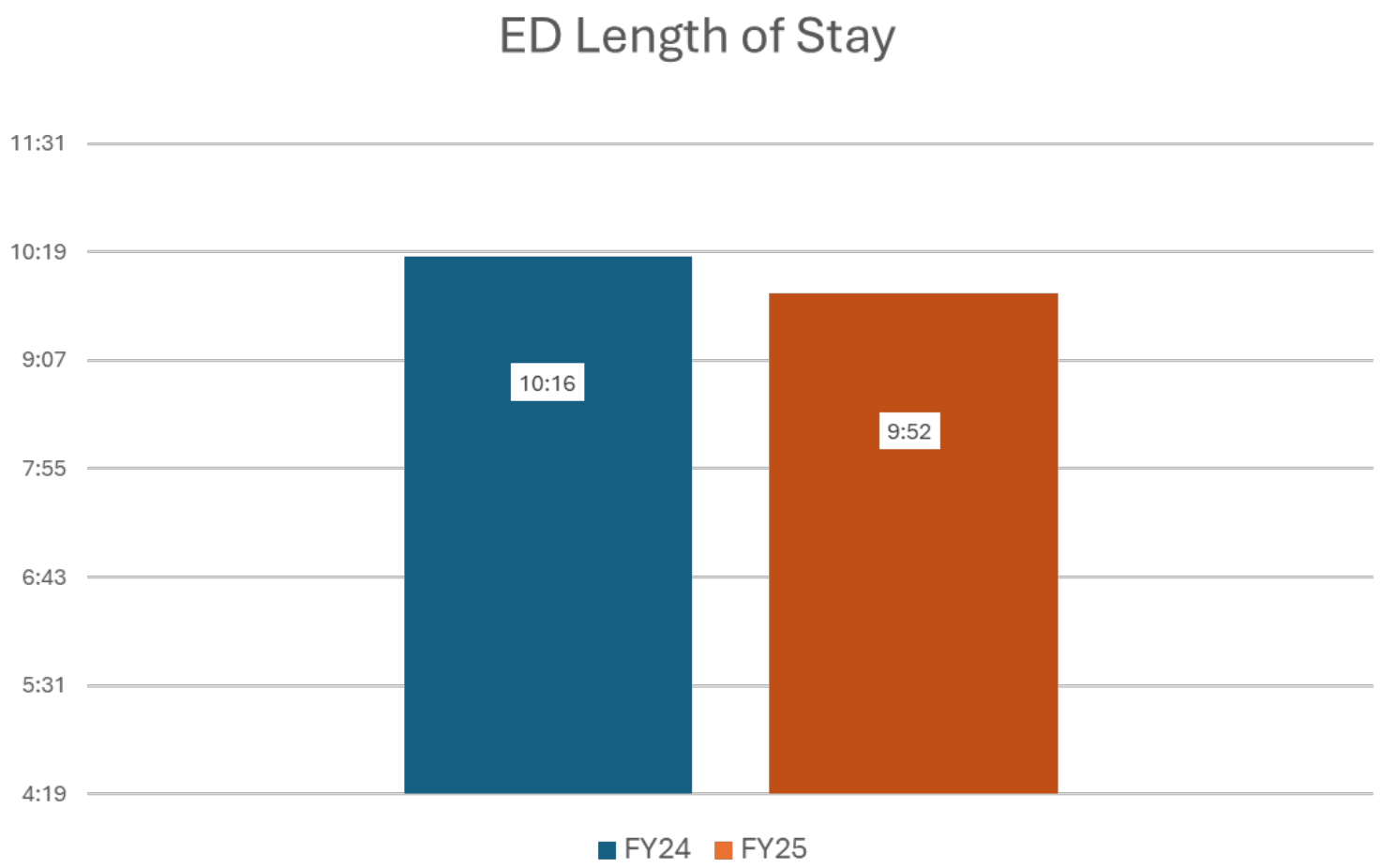
ED Hospital Throughput Best Practice Successes



Goal of entering 10 discharge Orders by 10am

- This opens bed capacity on the medical units earlier in the day
- Which allows us to move patients out of a busy ED and decreases boarding
- The slide illustrates marked improvement in FY25

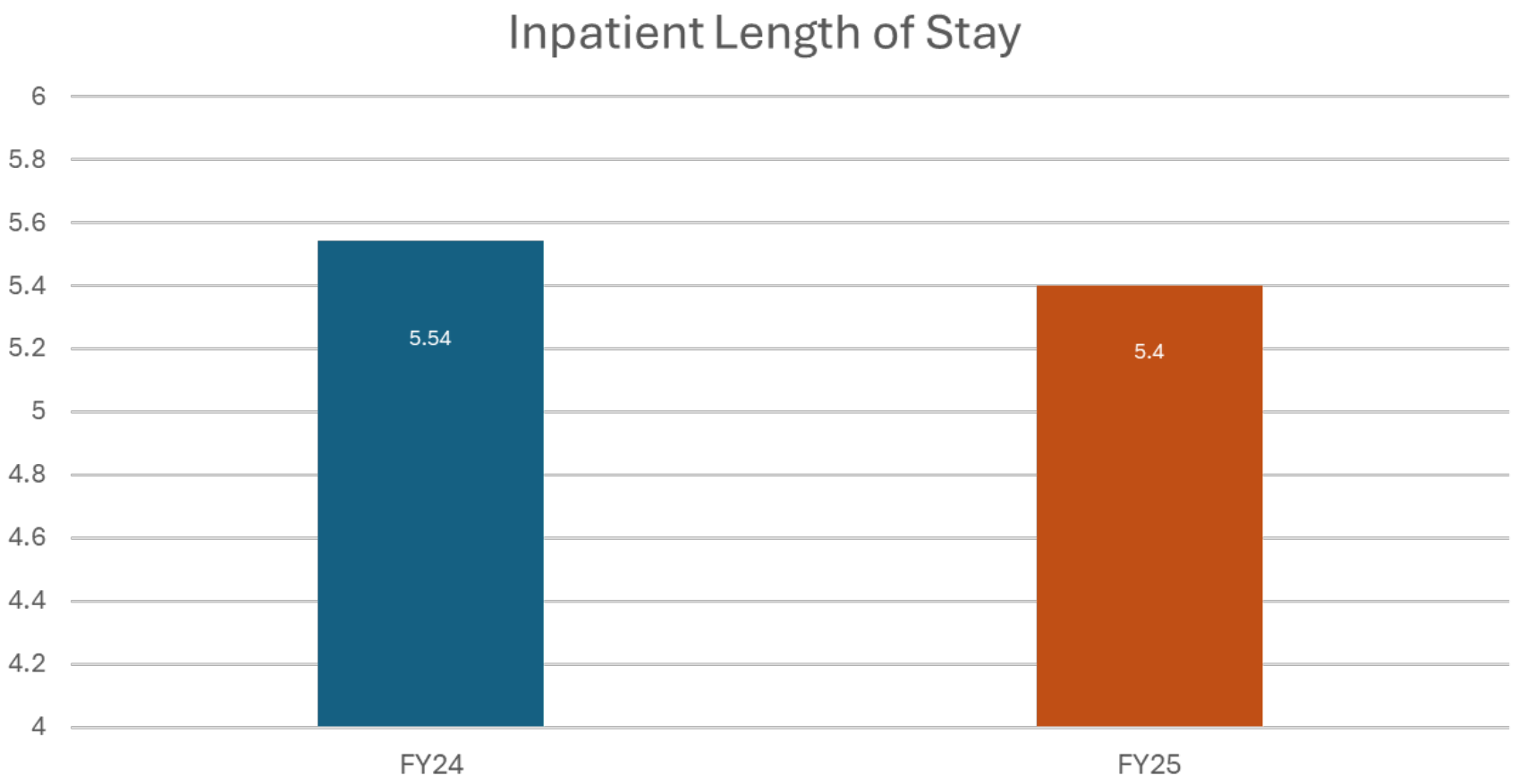
ED Hospital Throughput Best Practice Successes



Goal of decreasing our average Emergency Department length of stay

- This allows us to see more patients in a faster and safer manner
- This improves patient experience and medical care
- The slide illustrates significant improvement in FY25

ED Hospital Throughput Best Practice Successes



Goal of decreasing our average inpatient length of stay

- This increases bed availability for new patients that need admission
- Which decreases the time a patient boards in the ED
- The slide illustrates small improvement in FY25

Example of ED Hospital Throughput Best Practice Successes

- Emergency Department wait times continue to be a focus for the University of Maryland Medical System and all of its Member Organizations.
- A tremendous amount of work has gone into addressing ED wait times and the best practices instituted have begun to demonstrate positive results.
- UMMS Member Organizations have implemented and shared best practices including:
  - Daily Huddles
  - Interdisciplinary Rounds
  - Patient Flow Councils
  - Expedited Care
- The Expedited Care efforts in particular have demonstrated significant success as evidenced by:
  - Member Organizations have reduced the number of patients leaving without being seen by 26%
  - ED Arrival to Discharge times (OP-18) have improved by 6% CY to date (August) 2025 compared to CY 2024.
  - Much of this success can be attributed to Rapid Medical Evaluation/Rapid Assessment Zone programs that have emergency medicine physicians and APPs evaluating patients upon arrival.
  - The goal is to assess, initiate care, and potentially discharge patients earlier in their stay, thus saving invaluable bed capacity in the Main ED for those patients that require a bed

Draft Recommendations for RY 2028

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in CY 2026 after CY 2025 data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2028.
    - Failure to implement and report data to the Commission by December 31st 2026 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027.
3. We intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY2026 Best Practice program impact is assessed.

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Draft Recommendations for Extension of the Hospital Best Practice Policy for Rate Year 2028

October 8, 2025

This document contains the staff draft recommendations for extending the Hospital Best Practice Policy for RY 2028. Comments are due by COB Thursday, 10/16/2025 and may be submitted to hscrc.quality@maryland.gov.

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Introduction

The Hospital Best Practice Policy is a new program that was approved by the HSCRC in March 2025 and implemented by Maryland hospitals in April 2025. Unlike other quality policies that primarily focus on outcomes of care, the Best Practice policy is designed to focus on the structure and process of care delivery in Maryland hospitals. During the initial year (CY2025), the policy focused on processes that drive emergency department (ED) and hospital throughput to address the long ED length of stay (ED LOS) experienced by patients in Maryland. Specifically, the HSCRC approved a set of six best practices for RY 2027 and required hospitals to select and report data on two best practices by the end of CY 2025 (Submission before 12/31/2025). If data is not submitted by hospitals in Year 1, an accountability penalty of 0.1 % all-payer inpatient revenue will be assessed. The HSCRC staff along with the Best Practice subgroup will review the data submitted in December 2025, analyze and summarize the performance, impact, and lessons learned to share across all Maryland hospitals. Staff plan to present these results in the Spring of 2026 to the Commissioners. Staff propose for RY 2028 (CY 2026 performance) that continued monitoring will provide a valuable opportunity to continue to share lessons learned and implement best practices across hospitals and to hard-wire processes that are yielding improvements in ED and hospital throughput.

For RY 2028 staff are recommending to maintain the requirements of the RY 2027 Best Practice policy that was approved in March 2025. As discussed below, the staff continue to engage with hospitals on these Best Practices and support the Commission's extension of the policy for RY 2028.

Assessment

Since approval of the RY 2027 policy, hospital stakeholders have met on a regular basis to select the two best practices for their hospitals and develop the tiers needed to assess the robustness of each best practice. Through this policy, hospitals have engaged in working together to share lessons learned and evaluate the fidelity and consistency of these Best Practices within their institutions. Hospitals will need to submit the reporting template for the Best Practices to HSCRC no later than December 31, 2025 to avoid an accountability penalty of 0.1% all-payer inpatient revenue. The report will include performance metrics, rationale for implementation/expansion of the particular best practices selected by each hospital, and any lessons learned or suggested improvements to the process. This data will be reviewed, analyzed and summarized to share with the HSCRC Commission, ED Wait Time Reduction Commission, and Maryland hospital partners.

The HSCRC staff recommend that we continue the monitoring phase of the Best Practice measures to ensure adequate time to understand the impact of each best practice at individual hospitals and across the state, as well as determine how this program will be integrated into and align with the AHEAD model transition. In addition, HSCRC believes that with the AHEAD transition in progress, hospitals should continue to hardwire existing practices to ensure consistency and improvement in RY 2028. Hospitals will provide written notice with justification, if they intend to adopt a different approved best practice in RY 2028. The Appendix includes the RY2028 final policy with additional details on the Best Practices.

Recommendations

The draft recommendations for RY 2028:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in CY 2026 after CY 2025 data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2028.
    a. Failure to implement and report data to the Commission by December 31st 2026 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2027.
3. We intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the CY 2025 and CY2026 Best Practice program impact is assessed.

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Appendix: RY 2027 Final Policy

Final Recommendations on Hospital Best Practice Policy for Rate Year 2027

March 12, 2025

This document contains the staff final recommendations for RY 2027.

Table of Contents

List of Abbreviations

AHEAD	State's Advancing All-Payer Health Equity Approaches and Development Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission for ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Best Practices policy, are intended to promote quality improvement and ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model and subsequent AHEAD model (Maryland Model), do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Maryland Model while guarding against unintended consequences and penalizing poor performance. The objective of implementing a Hospital Best Practice Policy is to track and incentivize hospitals to implement and strengthen operational structures and processes, which are designed to provide high quality, evidence-based care to all patients, at all times.	The Best Practice policy is a newly proposed pay-for-performance quality initiative that provides incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework. For Year 1, RY 2027, we propose to focus on best practices related to hospital throughput, that should ultimately reduce ED LOS. Specifically, during Year 1, HSCRC staff will collaborate with hospitals to finalize the best practices and tiers, develop infrastructure for data collection, and disseminate statewide monitoring reports to track performance. Hospitals will be expected to participate in the implementation of best practices and submission of data for tracking by an agreed upon deadline to avoid an "accountability" penalty of 0.1 percent of all-payer, Inpatient revenue. This penalty will be applicable to any hospital that does not implement and report on the selected best practices. This approach will allow sufficient time to establish workflows, report development, and validate data collection mechanisms. This Best Practice policy will initially focus on ED-Hospital Throughput Best Practices but is written with the intention of developing and standardizing best practices for various clinical processes and operations as appropriate.	For program Year 1, RY 27, hospitals will be required to implement or strengthen best practices designed to improve patient care and throughput and report data to the HSCRC to track intensity and fidelity to the best practices. For Year 1, there is no revenue at risk associated with performance. There will be an accountability penalty that will be assessed for not reporting on best practice measures. This penalty will be 0.1% of all-payer, inpatient revenue, to be assessed in the January 2026 rate update. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.). For program Year 2, RY 28, we recommend +/-0.25% inpatient revenue at risk associated with performance on designated best practice measures. This will be reassessed at the end of Year 1 after evaluating the impact of the best practices.	This policy ensures that the quality of care provided to consumers is evidence-based and patient-centered. by incentivizing specific types of best practices to address areas of concern. Hospitals that do not participate in implementation and data tracking of best practices will be penalized 0.1% of all-payer inpatient revenue through their Global budget. This penalty will only be assessed if a hospital does not report on their selected best practices. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	There is currently not a health equity measure in the Best Practice policy, but in future years, we can potentially stratify data collected to evaluate health disparities. Health equity incentives could be integrated in a subsequent rate year. Standardization of Best Practices across all patients should better ensure that all patients receive the same evidence-based interventions. By focusing on structures and processes, this program will allow all hospitals the potential to earn rewards regardless of the types of patients served or other barriers that impact outcomes such as ED LOS. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

FINAL RECOMMENDATIONS

This document puts forth for consideration the RY 2027 (CY 2025 performance period) final policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in Year 2 (RY 2028) after Year 1 (RY 2027) data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.
3. We propose that subsequent rate years will have +/-0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

INTRODUCTION

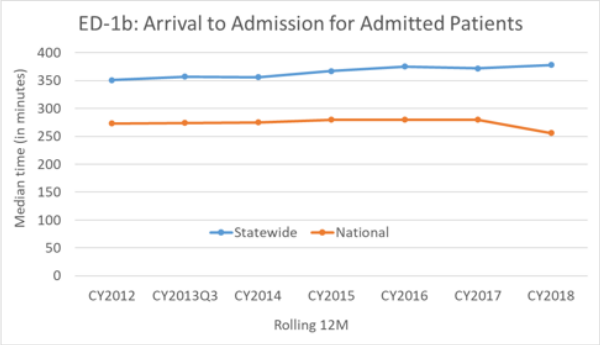
Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019 and will transition to the AHEAD Model in 2026. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, improved emergency department length of stay, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

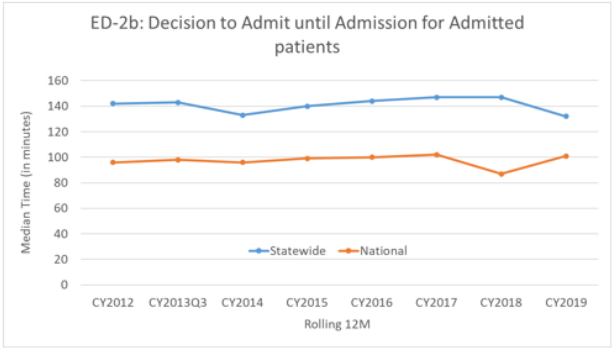
The Hospital Best Practice Policy is a new program that is being proposed for Commissioner consideration. The Best Practice Policy would be one of several quality pay-for-performance initiatives that provide +/- revenue at risk for hospitals to improve and maintain high-quality patient care and value over time. However, unlike other quality policies that primarily focus on outcomes of care, the Best Practice policy would specifically provide +/- revenue at risk tied to the structure and process of care delivery in Maryland hospitals. During this initial year, the policy will focus on processes that drive ED and hospital throughput to address the long ED LOS experienced by patients in Maryland. Specifically, the commission will refine a set of up to six best practices for RY 2027 and require hospitals to select and report data on two best practices by the latter part of CY 2025. If data is not submitted by hospitals in Year 1, an accountability penalty will be implemented. After the initial year focused on development, implementation and reporting, the program will have a designated percentage of inpatient hospital revenue at-risk based on performance on best practice measures. In addition to this Best Practice policy, the RY 2027 Quality-Based Reimbursement Policy, which was approved at the December 2024 Commission meeting, has a financial incentive tied ED LOS. The ED-Hospital Throughput best practice measures are process and structural measures aligned to support the outcome measure, ED LOS, in the QBR program.

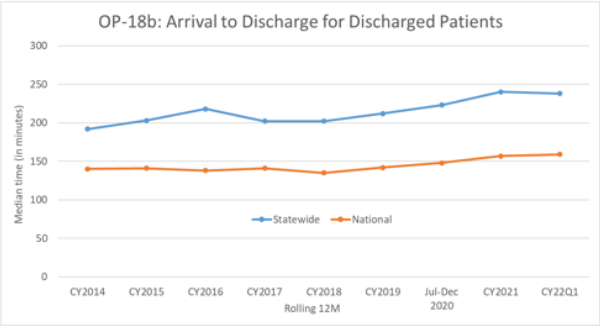
BACKGROUND

ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[1] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission approved the addition of an ED wait time or length of stay (LOS) measure in the RY 2026 QBR program and voted to continue its inclusion in RY 2027. Previously published and available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 1.

Figure 1. Emergency Department Performance on CMS ED Wait Time Measures





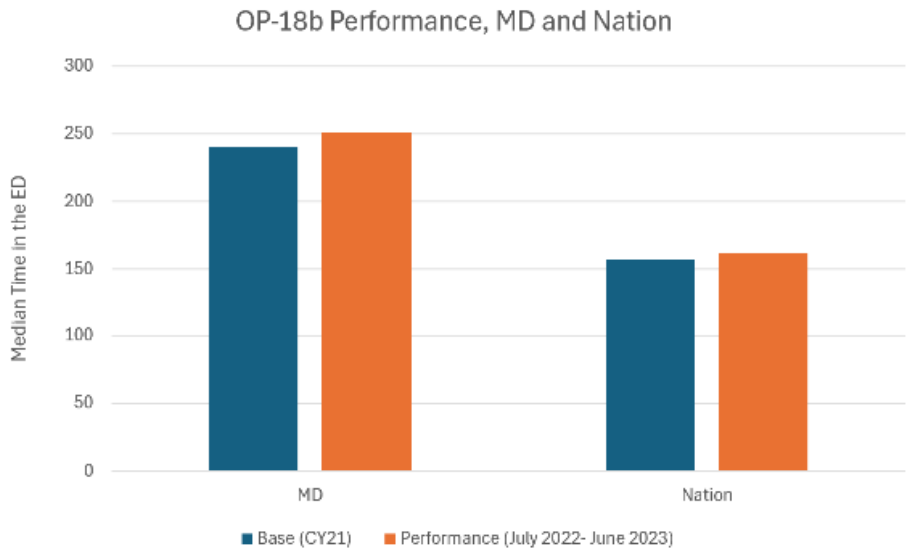


Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

As illustrated in Figure 2 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

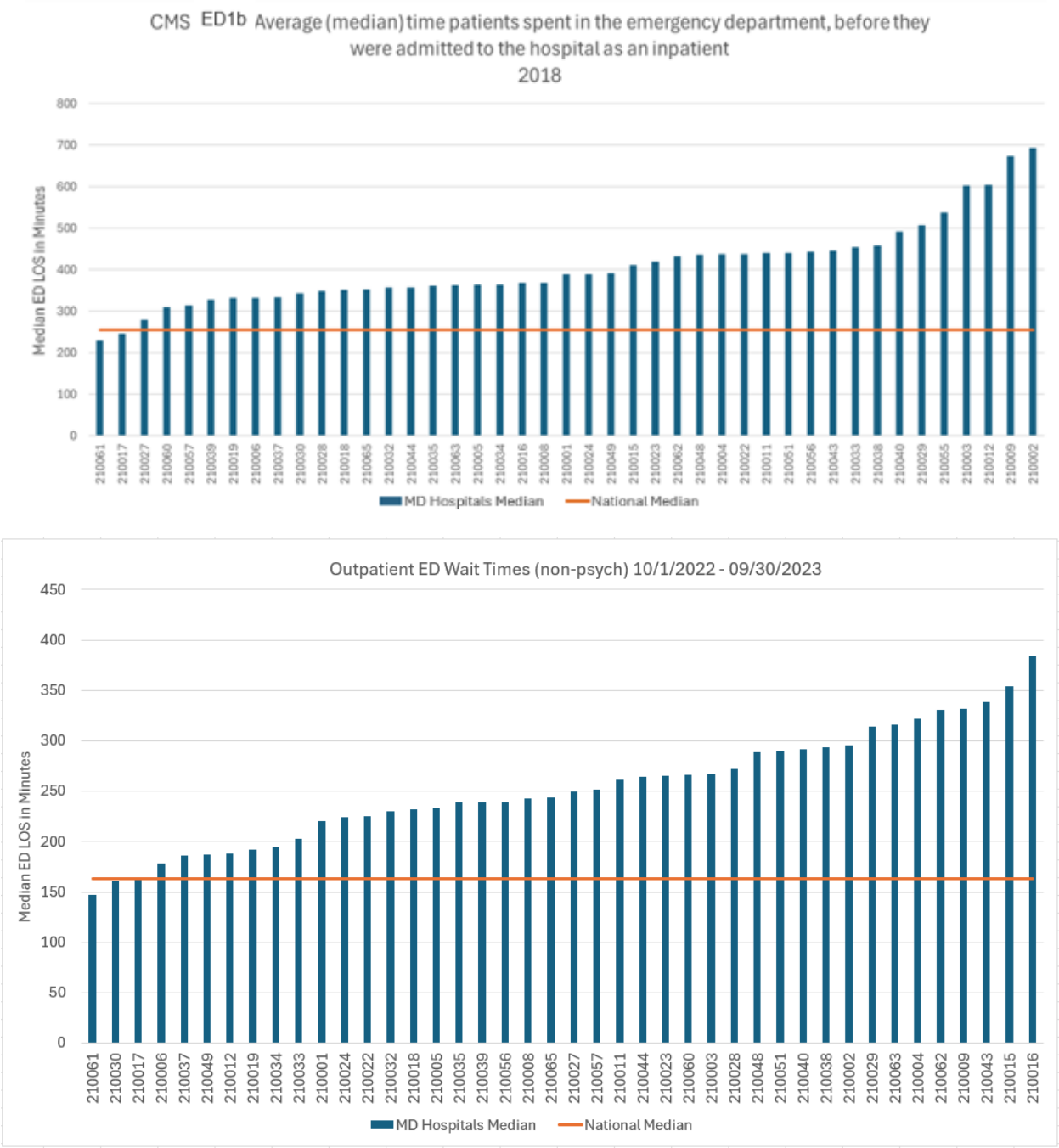
[1] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

Figure 2. Maryland and National Performance on ED Wait Times for Discharged Patients



Furthermore, all but a couple of hospitals in Maryland perform worse than the national average. Figure 3 shows the ED length of stay for non-psychiatric patients who are admitted (ED1b) for 2018 (last year this was reported) and for those who are discharged home (OP-18b) using the most recently available data.

Figure 3. Maryland by Hospital and National Performance on ED Wait Times



Based on these results, staff believe all hospitals in Maryland have an opportunity to improve ED LOS. Furthermore, there has been increased public scrutiny on Maryland's ED Wait times, which has been consistently higher than all other states for the past decade. Several initiatives have been underway over the last two years to analyze Maryland's ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new ED Wait Time Reduction Commission was established. The

ED Commission is co-chaired by the HSCRC Executive Director and staffed by the HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a state goal for improvement in ED wait times. The development of Best Practices focused on ED-Hospital Throughput is one of the specific goals outlined by the ED Wait Time Reduction Commission. Appendix A provides additional background on initiatives that the HSCRC and hospitals have undertaken to address this issue.

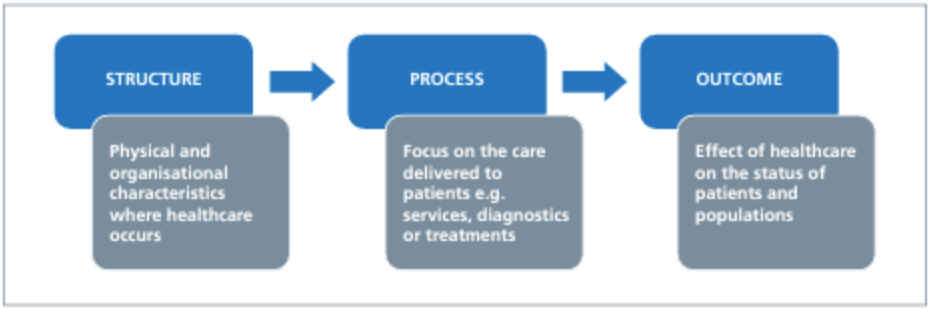
POLICY DEVELOPMENT AND IMPLEMENTATION

In this section, staff provide an overview of work done during CY 2024 to develop this Best Practice Policy. This includes discussion on why the Commission should develop incentives related to structure and process measures, description of stakeholder engagement, as well as an outline of the six best practices that have been selected and examples of tiers for assessing the intensity and fidelity to the best practices. The section concludes with next steps and recommendations for input.

Policy Origins

The Donabedian model of quality of care assesses three components as shown in Figure 4. While most current pay for performance incentives are focused on outcomes (i.e., mortality, complications, readmissions), structure and process measures are important to understand how changes in quality actually occur and are still required for some areas by CMS (e.g., attestation measures for health equity). There are several additional reasons why incentivizing structure and process measures should be considered in the case of ED LOS improvement. First, given that the ED LOS data collection and measure development is still underway, staff are hesitant to put additional revenue at risk on the outcome measure at this time. Second, the changes that can occur within a hospital to impact ED LOS may not be sufficient to improve the State's rankings nationally by themselves. This is because ED and hospital throughput is impacted by access to outpatient primary care, specialty care, behavioral health, and post-acute care. Third, there may be ways to reduce ED LOS to earn an incentive that would not result in better care for patients and these unintended consequences could be avoided by providing incentives to focus hospitals on better care delivery through optimization of known best practices. Hospitals in the State have demonstrated significant collaboration and engagement in this work. There will be an accountability measure in RY 2027 requiring data submission. Thus, staff feel that the current revenue at-risk on the outcome through QBR is sufficient at this time, but ensuring best practices such as the ones identified below will drive improvements in throughput as well as patient outcomes. By developing tiers and measures to assess the intensity and fidelity to these best practices, the State has a unique opportunity to improve more than just ED LOS. Thus, staff believe a mix of incentives on structure, process, and outcomes is appropriate and could be more impactful than simply adding more revenue to outcomes alone.

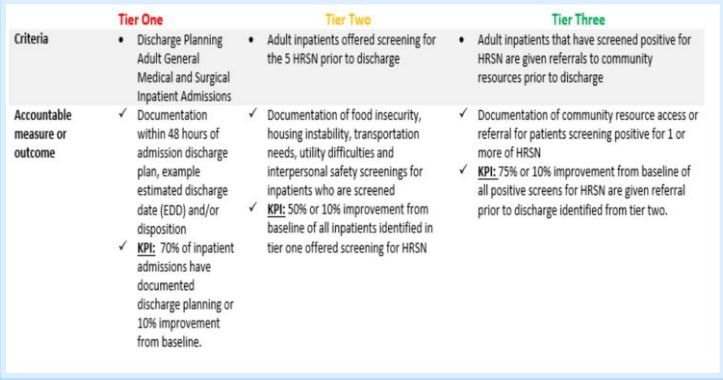
Figure 4. The Donabedian model for quality of care

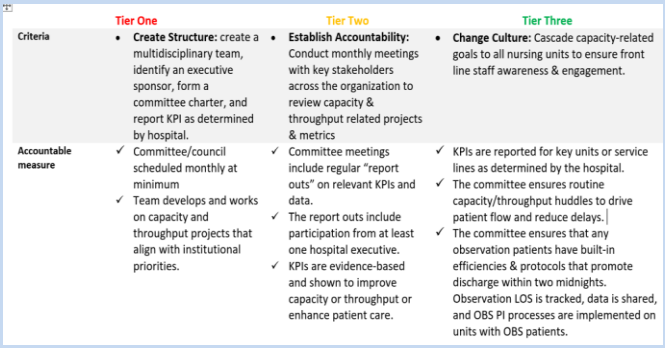


Stakeholder Process and Selected Best Practices

Staff formed an ED Subgroup in February 2024 to develop the ED LOS measure and incentive methodology for the RY 2026 QBR policy. By the fall of 2024, staff transitioned this subgroup to work on the development of ED and Hospital Best Practices to improve throughput and reduce ED LOS. This was also aligned, as mentioned above, with the ED Wait Time Reduction Commission's legislative mandate to focus on the sharing of best practices. Since September 2024, there have been eleven large subgroup meetings and multiple smaller workgroups focused on individual best practices. Specifically, the subgroup vetted over thirty best practice suggestions and narrowed down the list to six and proposed that hospitals be expected to implement or improve upon two best practices during CY 2025. While there were several discussions on whether to select two best practices that all hospitals must uniformly implement, hospitals felt strongly that options were needed since certain types of best practices may be more or less effective in different settings; additionally, since hospitals were engaged in the selection of the best practice options, measures and tiers for each of the options, the staff felt that providing choices would best maintain collaboration and address the variation in hospital settings. However, the selection of the number of best practice options, requirements for implementation, and focus of the best practices can change over time as this policy evolves. Figure 1 provides an overview of the six best practices for ED-Hospital Throughput. In addition, examples of how the best practices could be measured and tiered (i.e., assessed on intensity and fidelity) are provided. The idea would be that in future years hospitals would earn points based on the measures and could earn more points for higher intensity or fidelity to the best practice, as opposed to an all or nothing incentive.

Figure 1. ED-Hospital Throughput Best Practices

Best Practice	Measures	Points (0-10 scale)
Interdisciplinary Rounds & Early Discharge Planning		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Bed Capacity Alert System	**Tier 1**: Organization establishes one or more capacity metrics, examples could include: total number of patients in hospital, % hospital beds occupied, % of ED border c/w overall ED beds, NEDOC score, other hospital defined metrics. **Tier 2**: Organization establishes a bed capacity alert process (aka surge plan) driven by capacity metrics that triggers defined actions to achieve expedited throughput. Actions could include: Enhanced inpatient huddles to expedite discharges, rapid admission order turnarounds, hospitalist care in the ED, executive escalation, opening surge units, etc. **Tier 3**: Organization quantitatively demonstrates consistent activation of surge plans in response to bed capacity triggers. Internal metrics to be hospital defined and specific to hospital surge protocol. Examples could include: #/% of protocol activations, % discharges by specific time- maybe 1 p.m. and/or 3 p.m., etc.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Standardized Daily/Shift Huddles	The AHRQ defines a huddle as a short, standing meeting that is typically used in clinical settings to quickly share important information and touch base with a team, typically held at the beginning of each workday or shift. **Tier 1:** Implementation of, at minimum, daily huddles utilizing a multidisciplinary team approach with a focus on throughput and discharges. KPI: Multidisciplinary daily huddles are being completed at X frequency as defined by each organization. **Tier 2:** Tier 1 requirements with the addition of a standardized infrastructure (standard scripting, documentation, and/or use of huddle boards). Tier 2 would also include an escalation process for addressing clinical and/or non-clinical barriers to discharge or throughput. **Tier 3:** Tier 1 and Tier 2 requirements, with the addition of monitoring and reporting of key performance indicators (KPIs) as drivers of process improvement r/t throughput. Example KPIs could include but are not limited to, percent of discharge orders written by noon, or percent patients leaving the facility by a designated time as determined by each facility.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

Best Practice	Measures	Points (0-10 scale)
Expedited Care Intervention (Expediting team, expedited care unit)	**Many best practices are proven to reduce Hospital Length of Stay and Boarding. Select one or more of the expediting practices listed below:** • Nurse Expediter • Discharge Lounge • Observation Unit (ED or Hospital based) • Provider Screening in Triage / Early Provider Screening Process • Dedicated CM and/or SW Resources in the ED **Tier 1:** Implement/Expand one (1) expedited care practice from the list above and report KPI as determined by the hospital. For example, LWBS, Inpatient LOS, Door to Provider Time, etc. **Tier 2:** Implement/Expand two (2) expedited care practices from the list above and report KPI for each practice as determined by the hospital. **Tier 3:** Implement/Expand three (3) expedited care practices from the list above and report KPI as determined by the hospital.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Patient Flow Throughput Performance Council		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Clinical Pathways & Observation Management	**Tier 1: Design and Implement Intervention** Hospitals will select and implement a clinical pathway tailored to a specific patient population. This clinical pathway should be based on the facility's unique patient needs and can incorporate existing pathways if already in place. **Tier 2: Develop Data Infrastructure** Hospitals will establish robust data collection and analysis systems to monitor and evaluate outcomes. These systems should emphasize comparing the effectiveness of inpatient and ambulatory management strategies for the selected patient population, enabling data-driven decision-making and continuous improvement. **Tier 3: Demonstrate Improvement** Hospitals will demonstrate a measurable decrease in unwarranted clinical variation and/or measurable improvement in outcomes specific to their chosen intervention.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

The initial proposal under consideration for the Best Practice policy was additional revenue at risk for performance on best practices for CY 2025. However, the work needed to refine the tiers and develop data collection is substantial. Furthermore, given concerns about the time it took to develop the ED LOS measure and incentive

concurrent to its use, staff believe additional time is needed to do this well. Finally, stakeholder engagement has been exceptional during this process and should be commended by providing this additional time for hospitals to develop the data collection needed to measure the tiers. Staff recommend that RY 2027 be focused on refinement and implementation of best practice measures, workflow redesign, and report development and validation. Therefore, RY 2027 efforts will be focused on development of the Best Practice tiers and data collection, and no revenue be tied to performance on the best practice measures for RY2027. There will be a 0.1 percent all-payer, IP revenue, accountability penalty tied to best practice implementation and data submission, meaning a penalty would be assessed if a hospital did not report data by October 2025 for its two selected best practices. Staff intend to continue the refinement of the best practices measures and tiers throughout RY 2027.

Stakeholder Feedback

The Best Practice subgroup has representation from all hospitals/health systems, as well as MHA and several other agencies and organizations. The subgroup members have been very engaged and actively involved in the development of the best practice recommendations. Overall, stakeholders have expressed support for the Best Practice Policy. The following has been called out in comment letters:

- Consideration of the effort required for data collection and reporting, allowing flexibility across health systems for alignment of measures with specific organizational opportunities
- Encourage flexible reporting timelines
- Request to shift data reporting deadline from October 2025 to December 2025
- Request for consideration of justifiable reporting delays in hospitals that are making a good faith effort in implementing best practices that may fall outside of the extraordinary circumstances exception policy. Noted above: We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).
- Hospitals have been investing significant resources to implement initiatives directed at optimizing throughput and decreasing both IP and ED LOS. They ask that we also support and lead efforts to address external factors driving throughput and boarding issues related to an increased need for behavioral health and substance use disorder care, primary care, chronic condition management and complex post-acute care, as well as prior authorization delays and payer denials.
- Suggestions to also consider concurrent evaluation of other measures in the context of ED Wait Times, throughput and patient outcomes including: post-acute facility capacity, ambulatory and telemedicine care access related to ED wait times and hospital throughput, Left without being seen (LWBS), length of stay (stratified by discharge location and other factors), readmissions, 30-day mortality and patient experience
- Stakeholders also note external drivers of throughput issues including workforce challenges, supply delays, and capacity constraints across the continuum of care. Stakeholders support and in many instances volunteer to assist with efforts to address these external challenges, including engagement with legislators to facilitate meaningful actions.
- Request consideration of the +/- 0.25% revenue at risk in future years. Note: Policy indicates we will evaluate year 1 results before determining revenue at risk for subsequent years

HSCRC Response to Stakeholder Feedback

- The HSCRC staff support flexibility of measure reporting across health systems to allow for targeted efforts at each hospital. This flexibility is reflected in the measures in the final draft recommendation.

- HSCRC supports flexible reporting timelines and would support a data reporting timeline that would request preliminary data reporting as data is available in CY2025 with a requirement to have a data submission in December 2025.
- As reflected in the policy, regarding justifiable reporting delays, HSCRC will follow our extraordinary exception policy to address any unforeseen events. HSCRC will consider each request for delayed reporting outside of this policy on a case-by-case basis.
- HSCRC staff supports the requested focus on external drivers of ED LOS and ED Wait Times, and are working with the ED Wait Time Reduction Commission and designated subgroups to address external factors driving: throughput and boarding issues related to an increased need for behavioral health and substance use disorder care, primary care, chronic condition management and complex post-acute care, as well as prior authorization delays and payer denials.
- External drivers related to capacity across the continuum of care, supplies, external throughput challenges, and workforce issues will be evaluated by the HSCRC staff in partnership with the ED Wait Time Reduction Commission and designated representatives from hospital and other health care organizations on the Capacity, Operations and Staffing Subgroup of the ED WTR Commission.
- HSCRC staff agree with the suggestion to concurrently evaluate other measures in the context of ED Wait Times, throughput and patient outcomes, including: post-acute facility capacity, ambulatory and telemedicine care access related to ED wait times and hospital throughput, Left without being seen (LWBS), length of stay (stratified by discharge location and other factors), readmissions, 30-day mortality and patient experience.
    - HSCRC staff and the ED WTR Data Subgroup have begun analyses focused on capacity and LOS and are in agreement with analysis of the other measures noted above in the comments.
    - Regarding the post-acute facility capacity and care transitions, legislative partners have volunteered to help facilitate collaboration between HSCRC, ED WTR Commission and hospitals and post-acute partners and support data analysis. We anticipate moving forward with this collaboration during this legislative session.
- HSCRC staff believes the request for consideration of the +/- 0.25 % revenue at risk for subsequent years has been addressed, as the policy notes that we will evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

FINAL RECOMMENDATIONS

This document puts forth for consideration the RY 2027 (CY 2025 performance period) draft policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of six Hospital Best Practices that are designed to improve the emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, three weighted tiers were developed with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).

3. We propose that subsequent rate years will have a +/- 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

APPENDIX A: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

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

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

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

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

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

Ultimately, the Commission approved inclusion of ED 1-like measure in the RY 2026 QBR program to be finalized during CY 2024 and that would not require additional Commission approval. In working with ED Subgroup stakeholders in early 2024, staff selected a measure that mirrors the CMS ED1 measure, with specifications aligned with those of The Joint Commission as much as possible; the initial measure collection and submission is through an ad hoc electronic data pull for all patients that will be submitted on an ongoing basis eventually

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

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

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

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

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

Additional Initiatives: ED Potentially Avoidable Utilization

In CY 2021, Commissioners asked staff to evaluate expansion of potentially avoidable utilization (PAU) to emergency department utilization. Staff recommendations initially focused on high volume and low acuity chief complaint encounters (e.g., ear pain, dental problems) based on analysis of 2.4M ED observations with triage ratings. With workgroup/stakeholder vetting, this project was re-focused on multi-visit patients in the ED with >3

ED visits (statewide) in a 12-month period. A hospital monitoring program with reporting through CRISP has been established in CY 2023, with plans to consider a payment policy for CY 2025. A draft ED PAU policy will be presented at the November 2024 commission meeting.

Additional Initiatives: Legislative Workgroup

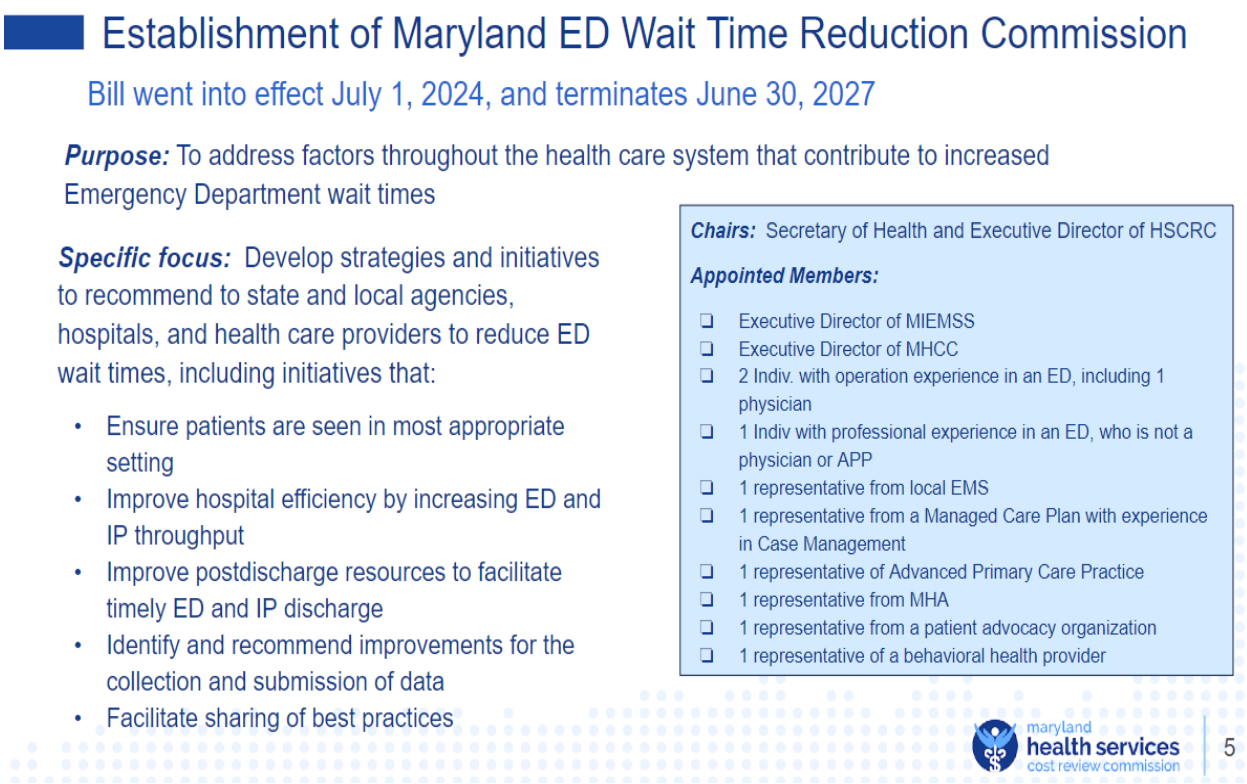
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the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

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

New Commission: Maryland Emergency Department Wait Time Reduction Commission

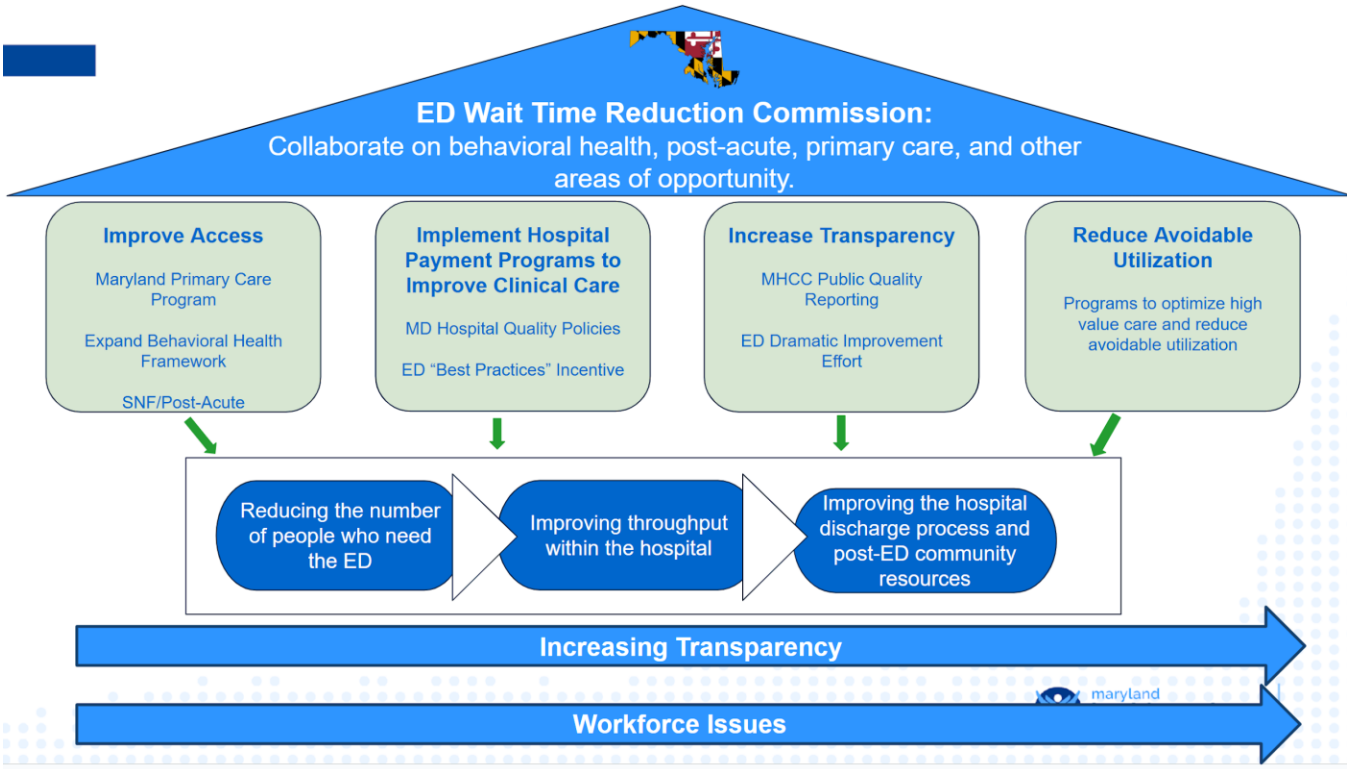
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and member representation on the ED Commission.

Figure E1. ED Wait Time Commission Description



The ED Commission's work aligns with many of the current HSCRC policies and those under development. These policies, shown in Figure E2, are designed to address ED and hospital throughput by reducing the number of people who need ED services, improving ED and hospital throughput, and improving the hospital discharge process and community resources. The ED Commission will address state-level opportunities related to access to hospital and community-based services that impact ED wait times, such as access to behavioral health care, post-acute/SNF beds, and primary care. The ED Commission will also support hospital best practices to address ED wait times and throughput across Maryland hospitals. The ED Commission members have been appointed, and the first meeting occurred in October 2024. Four subgroups have been established and are reporting up through the ED Wait Time Reduction Commission, including the ED Hospital Throughput Best Practices subgroup, which also reports up through the HSCRC Commission as it relates to hospital policy.

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



ED Wait Time Reduction Commission Subcommittees

Access to Non-Hospital Care

- Integrate and optimize best practices and data analytics for advanced primary care, specialty care, home health, post-acute care, and ancillary services in an effort to reduce avoidable ED and hospital utilization and improve care transition workflows throughout the continuum of care.
- Meetings every six to eight weeks.

Data Subcommittee

- Identify different data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data. Will support the strategic data-driven priorities of the ED Wait Time Reduction Commission
- Meetings every six to eight weeks

ED Hospital Throughput Best Practices

- Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay, advise on revenue at-risk and scaled financial incentives, and provide input on data collection and auditing.
- Meetings every four weeks.

Hospital Capacity, Operations & Staffing

- Subgroup will convene in April 2025.
- Planned focus of the subgroup is to assess access and capacity across the State, collaborate with commercial payers, Medicare, and Medicaid, and optimize workforce development opportunities.
- Meetings every four to six weeks.

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Regional Partnership Catalyst Program

Calendar Year 2024 Activities – Final Report

September 2025

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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 has funded 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 the following:

- 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 (prior to the conclusion of diabetes funding)
- 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
- 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 selecting community-based partners to reflect the culture, language, and demographics of target populations to customize marketing materials and outreach strategies to engage patients. These strategies remain critical to addressing long-standing health disparities in the State.

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. The HSCRC made a difficult decision to discontinue diabetes funding effective June 2024 due to concerns about the long-term sustainability of the program and the ability of hospitals to sustain the programs after HSCRC funding ended. As a result, final funding across all eight Regional Partnerships totals $136.9 million. Diabetes funding to Regional Partnerships ended on June 30, 2024; however, Partnerships were given until the end

of calendar year (CY) 2024 to wind down their programs or transition to sustainable models to continue diabetes prevention and management activities in CY 2025 and beyond. Behavioral Health Crisis Services programs will continue through the full program cycle, ending December 2025. This report summarizes activities for all Regional Partnerships in 2024.

As described in the report below, Regional Partnerships receiving behavioral health funding reported continued progress in expanding service delivery in CY 2024, implementing programs across a broad network of partners and healthcare delivery systems. Regional Partnerships that had received diabetes funding reported on efforts to transition and restructure their diabetes prevention and management programs for integration into hospital operations. These Partnerships cited an ongoing commitment to building effective, integrated teams and addressing the healthcare needs of their communities. Importantly, Regional Partnerships will continue to promote community engagement, improve provider awareness, and explore sustainable approaches to care for diabetic and pre-diabetic patients, despite the decision to discontinue diabetes funding early.

Overview

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 SIHIS in a more focused manner. The Catalyst Program awarded 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 Control and Prevention (CDC)-recommended Diabetes Prevention Program (DPP). DPP has shown long-term success in helping prevent the onset of diabetes and promote weight loss for those with pre-diabetes.[1] 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 and diabetes management curriculum to patients to better control their Type II diabetes. Regional Partnerships under the Catalyst Program were required to either 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

[1] CDC National Diabetes Prevention Program. https://www.cdc.gov/diabetes-prevention/programs/index.html

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 funding can potentially be sustained through 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.

Behavioral Health Crisis Programs

The TCOC Model incentivizes reductions in unnecessary 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 service 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"[2] action plan developed by the National Action Alliance for Suicide Prevention. Regional Partnerships implement one or more of the following:

- **Air Traffic Control (ATC) Capabilities with Crisis Line Expertise.**[3] 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.

[2] National Action Alliance for Suicide Prevention. Crisis Now: Transforming Services is Within Our Reach. https://theactionalliance.org/resource/crisis-now-transforming-services-within-our-reach

[3] ATC is also referred to as "Care Traffic Control" by one Regional Partnership.

- **Community-Based Mobile Crisis Teams**.[4] 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 mitigate 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
	Nexus Montgomery[5]	• Montgomery	$4,121,123	• Holy Cross Germantown • Holy Cross Hospital • Shady Grove Medical Center • White Oak Medical Center

[4] Mobile Crisis Teams (MCT) are also referred to as Mobile Response Teams (MRT).

[5] 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.

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
	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[6]	• 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

[6] FCW is funded for DSMT activities only.

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
	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 Four Diabetes Prevention and Management Activities

Early Award Termination

The 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. As reported in the CY 2024 annual report, the HSCRC was concerned about the long-term viability of the program based on low claims volumes for DPP and DSMT in CY 2023. 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; however, Regional Partnerships had 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. While the HSCRC asked hospitals to indicate whether they would continue offering DSMT or DPP, hospitals/Regional Partnerships had the flexibility to restructure, scale, or discontinue their programs to align with hospital strategic goals and ongoing operations. Based on final reports, Regional Partnership hospitals have maintained their commitment to addressing pre-diabetes and diabetes in their communities. All hospitals have identified alternative structures and financing to offer services in a sustainable manner for their individual hospitals or partnership.

Program Transitions and Integration into Health System Operations

All Regional Partnerships are continuing some form of diabetes programming and are leveraging the infrastructure and partnerships developed since Regional Partnership funding began in 2021. Most hospitals and their partners have restructured their program offerings—some are now offering only DSMT, while others have reduced the number of DPP cohorts due to staffing constraints. Some have designed their own diabetes education programs and offer them at no cost to qualifying patients. One Regional

Partnership is maintaining its original strategy to launch an umbrella hub to support community providers providing DPP. While early funding termination impacted the scale and structure of hospital programs, diabetes remains a community health priority and focus area that hospitals are continuing to address in a manner that is organizationally and financially sustainable.

Hospitals reported multiple financing strategies to integrate diabetes prevention and management programming into hospital operations. Hospitals reported leveraging a blended financing approach for most programming that includes billing for reimbursable services including Medicare, Medicaid, and commercial payers; drawing from hospital operating revenue; and leveraging grants and philanthropic contributions to offer programs to uninsured individuals and support provision of wraparound services.

DPP Activities

Most hospitals that intend to continue offering DPP reported reducing the number of cohorts offered—in some cases by significant amounts. Hospitals that reported that they will continue to provide DPP will offer both in-person and virtual options. In response to participant attrition challenges related to the year-long duration of DPP, one hospital redesigned its program to condense the curriculum into a three-month model to improve completion rates while still maintaining the integrity of the educational content.

Three hospitals determined they did not have a sustainable pathway to continue offering DPP and discontinued direct provision of the DPP. Instead, two established navigation services and referral pathways for pre-diabetic patients to existing programs in the region. Another hospital reported offering free health coaching services and nutrition counseling for pre-diabetic patients and is exploring offering alternative pre-diabetes educational programs in the future.

One Regional Partnership that prioritizes support for community-based DPP providers continues to operate as a CDC-recognized umbrella hub organization (UHO) and expanded this work in 2024. The UHO supports six DPP suppliers with administrative and operational services, including payer contracting and billing; reporting and data collection; and additional support with marketing, provider recruitment, and supplies. Partner hospitals continue to refer patients to DPP through the UHO. This UHO has continued to prioritize billing Medicaid and targeting their programs for Medicaid participants. Other hospitals reported achieving and maintaining CDC Full Plus Recognition for their DPPs, indicating they exceed national standards for program eligibility, outcomes, and participant retention.

Hospitals reported continuing to market and engage community partners to reach eligible patient populations and expanding outreach efforts through new marketing materials and engaging respected community social clubs at community effects. Hospitals continued to work with community partners to provide wraparound services and address health-related social needs with food access. While some hospitals maintained all partnerships made over the course of the program, some hospitals reduced the number of community partners to a core set focused on specific wraparound services.

DSMT/ES Activities

All hospitals report continuing to offer DSMT programs and integrating the programs into hospital operations, as well as offering wraparound services to participating patients. Hospitals plan to sustain the program through billing payers for services. Hospitals report offering DSMT programs both in-person and online, as well as through individual and group-based classes. Hospitals have approached integrating DSMT into their health systems in multiple ways. Some hospitals report that DSMT will be provided as part of a larger suite of services through dedicated diabetes resource centers; other hospitals have focused on providing DSMT and MNT through physician group practice settings to reach more patients and foster a familiar environment for in-person programs. One hospital also reported scheduling appointments to co-occur with routine medical care to reduce scheduling conflicts and address transportation barriers. Hospitals also reported integrating dedicated dieticians into practice settings, as well as certified diabetes care and education specialists (CDCES) to increase accessibility of services.

A strategy across multiple hospitals has been to expand or establish free diabetes education classes to reach patients who may face financial barriers to receiving DSMT, which traditionally has associated insurance co-pays, facility fees, or long-term time commitments. Some hospitals built these programs as part of their overall Regional Partnership program and are continuing to offer these services. Other hospitals are newly offering these as part of their post-Regional Partnership diabetes programming.

As with DPP, wraparound services, including nutrition support through healthy food programs, remain an integral part of these efforts. While some hospitals noted a reduction in the number and scale of community partners supporting these services, others are maintaining and growing their partnerships for ongoing programs.

Wraparound Services (DPP & DSMT/ES)

As hospitals restructured their programs, they continued to prioritize the provision of wraparound services to support participants in DPP, DSMT, and other diabetes education initiatives. All participating hospital programs sustained key wraparound supports—particularly those addressing nutrition—such as food delivery services, Food as Medicine initiatives, and healthy food voucher programs. Some Regional Partnerships sought additional funding through grants, philanthropy, or internal sources to sustain these services.

Addressing SDOH remained central to diabetes programming strategies. Hospitals 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 2024, Regional Partnerships offered the wraparound services shown in Table 3 to DPP and DSMT participants. Services supported by vendors and collaborators allowed for participants' needs to be met and helped remove barriers related to SDOH.

Table 3. CY 2024 Wraparound Services (DPP & DSMT)

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

Source: Regional Partnership Annual Reporting, CY 2024

Hospitals described multiple efforts to address food access that were identified through social determinants screening initiatives. Regional Partnerships conduct interviews with program enrollees (and often potential enrollees) 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. Hospitals are also partnering with community- and faith-based organizations to provide cooking classes and demonstrations.

Hospitals addressed transportation through the provision of Lyft rides and connecting participants to existing non-emergency transportation providers. To promote exercise, some hospitals offered participants gym memberships through the YMCA, free or discounted fitness programs, and at-home fitness equipment (resistance bands, fitness apps, etc.).

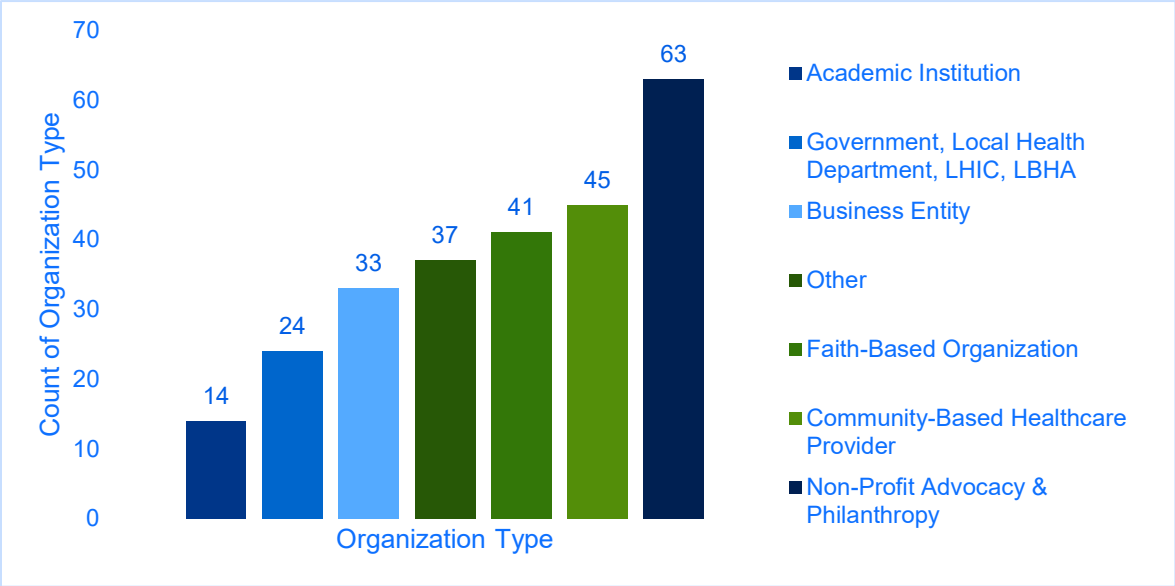
Diabetes Community Partner Collaboration (DPP & DSMT/ES)

Overall, Regional Partnerships reported that community partners are still important to reaching patient populations and helping address health-related social needs of patients. Some hospitals reported reducing the number of community partners involved with providing wraparound services and choosing to work with a limited number of partners to meet patient needs.

Core goals of the Catalyst Program are development of partnerships for long-term improvements in population health, and engagement/integration of community resources in the healthcare system. During

CY 2024, Regional Partnerships continued to convene and attend 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 2024, Regional Partnerships also worked with community partners to provide ongoing education about diabetes prevention and management, as well as 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 257 community partner organizations across Regional Partnerships. The two most common types of organizations are community-based healthcare providers and non-profit advocacy and philanthropy organizations.

Figure 1. CY 2024 Diabetes Program Community Partners



Source: Regional Partnership Annual Reporting, CY 2024

Year Four 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 Four. Activities focused on continuing to build community partnerships and expand site infrastructure to support an increased volume of patients through multiple care paths.

TRIBE – Crisis Centers

TRIBE operates two crisis centers on the Lower Eastern Shore that opened in 2022. The primary site, located in Salisbury, is operated by TidalHealth. The secondary site, originally operated by Atlantic General Hospital (AGH), is in Berlin. Both sites accepted referrals from walk-in patients in Year 4. The primary site in Salisbury is open seven days a week from 8am to 8pm. In Year Four, TidalHealth collaborated with the adult and child inpatient units to increase quality and access to comprehensive discharge planning. If patients are unable to be seen by their primary care providers within seven days of discharge, they are scheduled to see a provider at the Crisis Center. 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 crisis center service to Chesapeake Healthcare (CHC), a federally qualified health center (FQHC), as of June 2023. This change increased access to care by leveraging CHC's higher number of licensed practitioners. CHC is open Monday through Friday, and patients are referred to the primary site in Salisbury when the center is closed.

TRIBE has reported monthly patient volumes since opening both sites in 2022. There has been a 139% growth in patient volumes between 2022 and 2024, with 2,980 patients served across both sites in CY 2024.

Table 4. TRIBE Crisis Centers (Salisbury & Berlin), Monthly Patient Volumes, 2022 through 2024

Month	2022	2023	2024
January	0	211	225
February	58	189	240
March	55	268	294
April	70	173	235
May	65	192	317
June	79	163	233
July	97	150	199
August	119	149	287
September	158	223	232
October	166	324	296
November	170	274	226
December	212	244	196
TOTAL - Annual	**1249**	**1267**	**2980**

In CY 2024, TRIBE expanded its measurement and tracking efforts to assess the effectiveness of its crisis centers. Both the primary and secondary sites successfully accepted and triaged 100% of walk-in patients, identifying their needs and making referrals to the appropriate level of care. TidalHealth achieved a 3% reduction in inpatient admissions from 2023 to 2024. Both crisis centers consistently provide care coordination, including a plan of care for all patients served. Standardized processes ensure that all providers enter Care Alerts, supporting accurate statistics in the CRISP dashboard and facilitating review of medications from external prescribers. Through its robust screening and referral processes, both sites maintained a 100% rate of directing patients to the appropriate level of care.

In addition, TidalHealth reported a collaboration with SWIFT (Salisbury-Wicomico Integrated First Care Team) to leverage their nurse-led mobile health team. This team includes a paramedic, nurse-practitioner, registered nurse (RN), and CHW that respond to non-emergency 911 calls that can be addressed more effectively outside the ED. Patients are brought directly to the Crisis Center or are scheduled for a follow-up appointment. TRIBE also reported collaborating with EMS to identify cases appropriate for diversion from emergency rooms to Crisis Centers. The organization is actively working with emergency services to achieve compliance with state regulations required for responder drop-offs.

GBRICS – Open Access Pilot

The Greater Baltimore Regional Integrated Crisis System (GBRICS) has continued to expand access to immediate-need behavioral health services through their Open Access Pilot. The Open Access Pilot provides consulting support and seed funding to behavioral health clinics and practitioners (in-person and virtual) that provide same-day or next-day intakes for patients in crisis. The pilot project is organized into two stages. In the initial six months, participating sites focus on conducting assessments, creating workplans, training staff, and determining the most appropriate number of days and hours to dedicate to Open Access appointments. During the following six months, sites put Open Access into practice, evaluate how it functions in daily operations, and design a sustainability plan.

GBRICS launched the Open Access Pilot in CY 2022 through two initial cohorts. In CY 2024, 17 outpatient behavioral health clinics participated in Cohort 3. As of July 2024, the cohort clinics began accepting Open Access referrals from the 988 Helpline (described on the following page) and other referral sources. Additionally, 13 other clinic sites from Cohorts 1 and 2 that were already offering same-day or next-day appointments also started accepting referrals from 988 in July 2024. In total, there are currently 43 clinic sites implementing Open Access in the Central Maryland region, with 30 active open access sites receiving funding from the HSCRC. Open Access clinics are located in Baltimore City, Baltimore County, Howard County and Carroll County. Monthly patient volumes increased when sites began accepting 988 referrals, ranging from approximately 40 to 170 patient visits per month between July 2024 and February 2025. As

988 call volumes increase through improved marketing and general community awareness, these same-day and next-day patient visit volumes should continue to increase.

Care Traffic Control Activities and Progress

GBRICS

During 2022, a partnership of three organizations—Baltimore Crisis Response (BCRI), the Affiliated Sante Group, and Grassroots—was selected to jointly operate a Regional 988 Helpline for GBRICS. The 988 Helpline 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 52,293 between January and December 2024. Over 90% of the average 4,000 calls per month are resolved on the phone, and many callers are referred to supports other than hospitals, such as open access appointments and case managers. The 988 system is utilized by other Regional Partnerships as a basis for referrals.

In the fall of 2024, the Federal Communications Commission directed cell phone providers to geo-route 988 calls based on the closest cell tower instead of by area code. GBRICS expects the Central Maryland 988 Helpline to see an increase in call volume by 15% in 2025 and is monitoring staffing capacity in order to keep their 87% answer rate.

Regional Partnerships continue to ensure vulnerable consumers are connected to ongoing behavioral health care. Behavioral Health System Baltimore (BHSB)—which serves as the program administrator for GBRICS—and 988 providers are implementing new ways to connect callers. As of December 2024, callers are connected to Medicaid targeted case managers through care traffic control software. Furthermore, 988 has implemented a protocol to support warm handoffs for CareFirst members, ensuring direct connection to CareFirst behavioral health case managers for ongoing care coordination. BHSB intends to initiate outreach to additional insurance carriers in the coming months to assess opportunities for establishing similar collaborative partnerships.

Totally Linking Care (TLC)

Prince George's County made continued progress in strengthening its Response System by expanding technology integration and data capabilities. During CY 2022, TLC implemented system integration between the 988 Call Center and the mobile response team dispatch module. Building on this, in CY 2024, TLC deployed the Call Center Module to better monitor incoming calls, track caller frequency, and capture episodes of care across the service continuum. These enhancements provide more granular data sets, support additional data fields, and centralize all call information within a single system, strengthening both operational oversight and data-driven decision-making. Prince George's County plans to bring on the 988 Call Center platform to the BHL platform with calls answered by the 988 Diversion Team. TLC has provided

a transition plan and is collaborating with the county to provide trainings and joint meetings to develop a workflow. Full integration of the Call Center Module with the BHL Mobile Response Module enables streamlined data sharing to efficiently identify when dispatch is necessary, facilitating seamless transfers of residents in crisis. TLC reported a volume of 2,866 cases for Year Four.

Mobile Response Team Activities and Progress

Totally Linking Care

Use of the Mobile Response Team (MRT) response team continued to develop in CY 2024 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 added two new MRTs, raising the overall team count to eight. The Mobile Crisis Response Teams (MCRT) in Prince George's County is currently operated by iMind and includes eight teams throughout the county. Two-person teams include a peer or technician paired with a mental health care professional. In CY 2024, MRT decreased overtime by aggressively recruiting and managing staff efficiently. TLC 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 works with iMind and other entities in the area to create customized data collection, create workflows, improve communications, and ensure that the most efficient crisis services are being delivered in Prince George's County. During 2024, TLC prioritized increasing MRT utilization to support long-term sustainability, working with iMind on approaches to reimbursement. TLC is working to have iMind dispatch MRT teams out of Laurel and Seat Pleasant police departments in order to improve response times by locating teams in the area with higher utilization and cutting down on transporting times. 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 1,844 team dispatches in CY 2024. 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.

TLC also tracked goals and milestones during 2024 to track the progress and impact of regional partnership activities. TLC tracked the number of dispatch cases by different levels, deciphering whether 988 mobile responses were routine calls, were resolved by the call center module, needed dispatch, and so on. They were also able to determine which 4-hour shift has the highest call volume from January to December 2024. The 12PM to 4PM shifts received the highest call volume on average, with an average of 65 calls each month. TLC also provides a geo-map of MRT calls to help Prince George's County identify the high-volume areas and help in the selection of the two-satellite offices for deployment. TLC reported a dispatch completion rate of 55.25. Completion rates are influenced by several factors, including situations where patients cannot be located at the dispatch site or when teams are unavailable due to staffing shortages or

being assigned to other calls. Although no national standard or best-practice benchmark exists for completion rates, MRTs work to steadily improve their monthly rates and reduce cancellations caused by team unavailability.

Table 5. TLC MRT Volumes, CY 2024 - Feb 2025

Metric	Jan 24 – Feb 25 Total
Dispatch Case Count	1844
Number of Initial Crisis Responses	1718
Number of Follow-Up Responses	4620
Number of Referrals to Higher Levels of Care (Emergency Room)	336
Completion Rate	55.25

GBRICS

In CY 2024, GBRICS broadened mobile crisis services in Central Maryland. The Affiliated Sante Group offered 24/7 regional coverage, and BCRI extended its services with two daily shifts in Baltimore City and Baltimore County, supplementing its existing Baltimore City–based teams. Additionally, BHSB has partnered with a new provider of child-specific mobile services, Advanced Behavioral Health, to develop their programming and promote services among stakeholders. In 2024, mobile crisis teams funded by Howard and Carroll Counties were dispatched through the Central Maryland 988 care traffic control software to improve regional service coordination.

GBRICS/BHSB strengthened its ability to analyze volume and response time data, and the system completes over 250 non-law enforcement crisis visits monthly in the region. GBRICS reported a dispatch completion rate of 67.40. As stated above, while there is no national or best-practice threshold for an ideal completion rate, MRTs aim to increase completion rates every month and minimize the number of incomplete dispatches due to the MRT unavailability. Completion rates can be impacted by a number of factors, such as an inability to find a patient once they reach the dispatch site, patients cancelling the dispatch, or no teams being available because they are on other dispatches or staffing shortages.

Table 6. GBRICS MRT Volumes, CY 2024 - February 2025

Metric	Jan 24 - Feb 25
Dispatch Case Count	1988
Number of Initial Crisis Responses	1960
Number of Follow-Up Responses	3948
Number of Referrals to Higher Levels of Care (Emergency Room)	231
Completion Rate	67.40

Regional providers are expected to begin billing in 2025 to support sustainability.

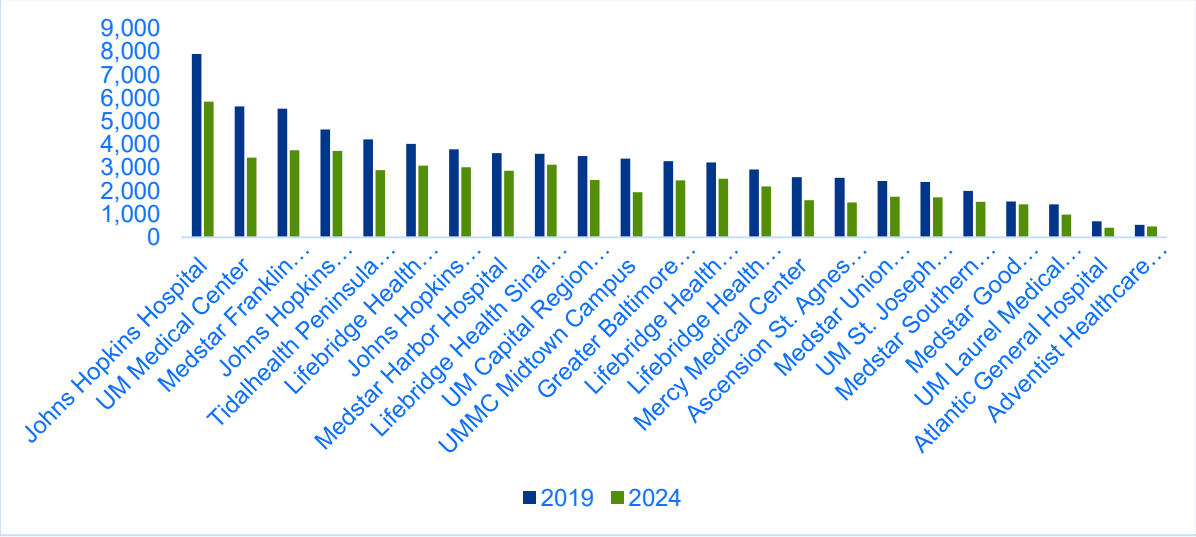
Impact Measures

In addition to the program-specific process measures each Regional Partnership provides on their individual interventions, the HSCRC also monitors ED utilization and volume data for participating hospitals. The HSCRC tracks both overall behavioral health ED volumes and well as the rate of repeat behavioral health ED visits, tracking patients with three or more visits in a calendar year across partnership hospitals.

Behavioral Health ED Visits

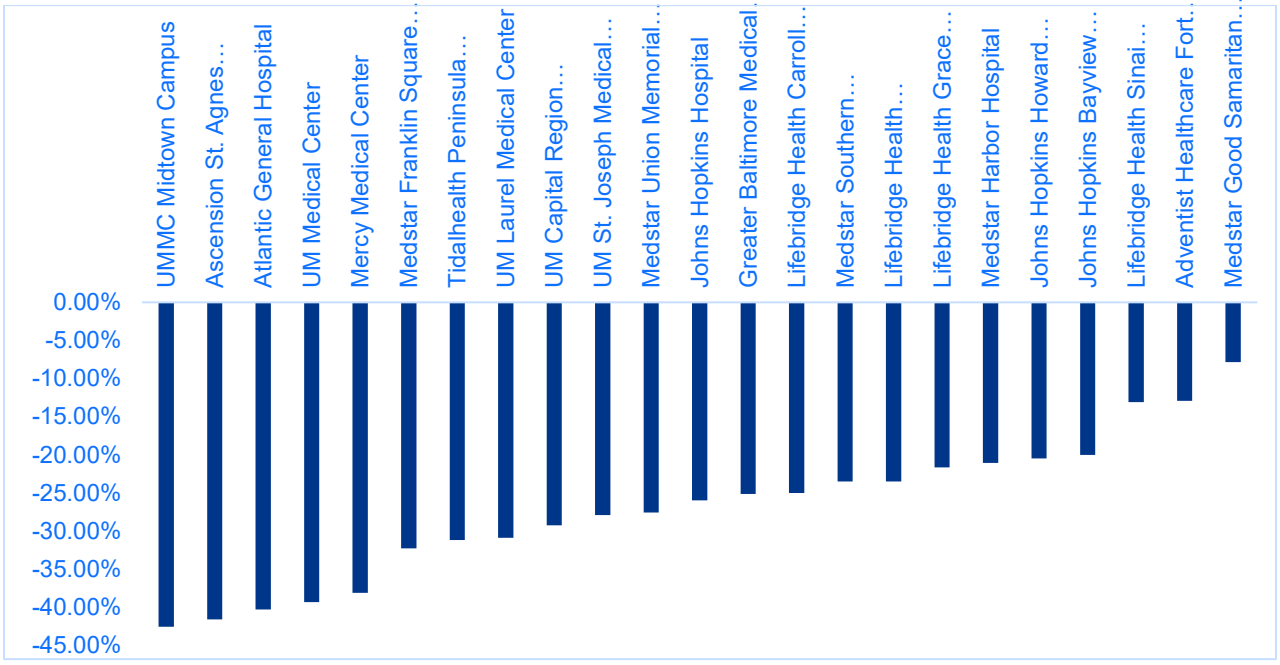
Figures 2 and 3 illustrate that total behavioral health ED volumes across participating hospitals declined between the 2019 baseline and 2024, with reductions ranging from 8% to 43%. The 2019 baseline was established during the 2020 design of the Regional Partnership program to inform appropriate evaluation metrics.

Figure 2. Behavioral Health ED Volume Declines, CY 2019 vs. CY 2024



Source: HSCRC Casemix Data

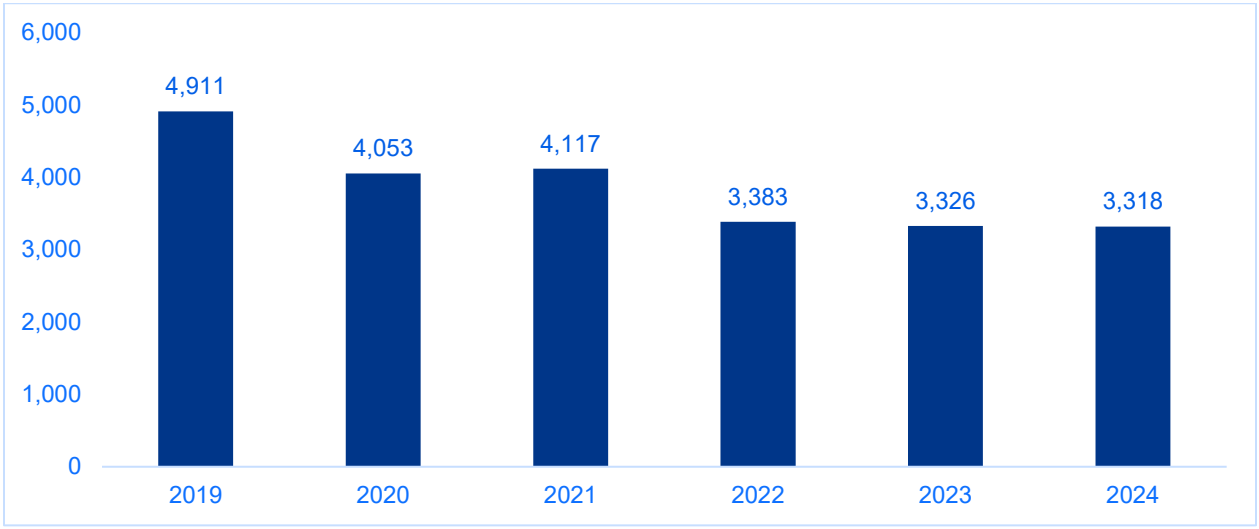
Figure 3. Percent Change between CY 2019 and CY 2024 Behavioral Health ED Volumes



Source: HSCRC Casemix Data

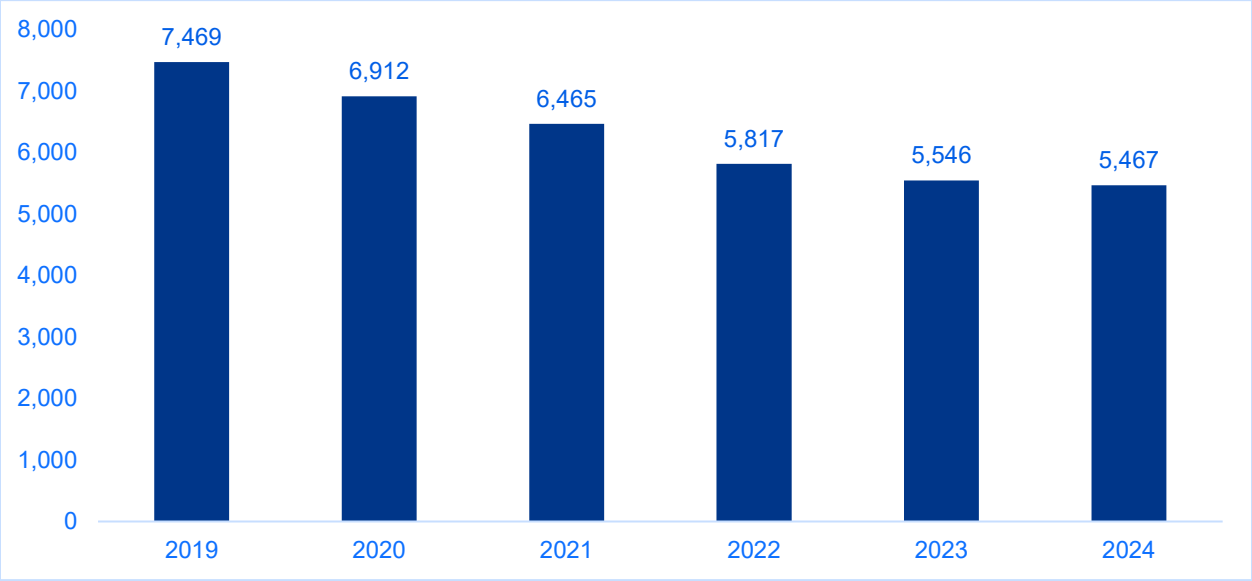
Despite substantial declines relative to the 2019 baseline in many cases, behavioral health ED volumes have remained relatively stable over the past three years. While volumes have not returned to pre-pandemic levels, no significant decreases have been observed since 2022. For clarity, Figures 4, 5, and 6 on the following pages aggregate volumes across hospitals by partnership to illustrate this trend.

Figure 4. Behavioral Health ED Volumes, TRIBE Hospitals, CY 2019–CY 2024



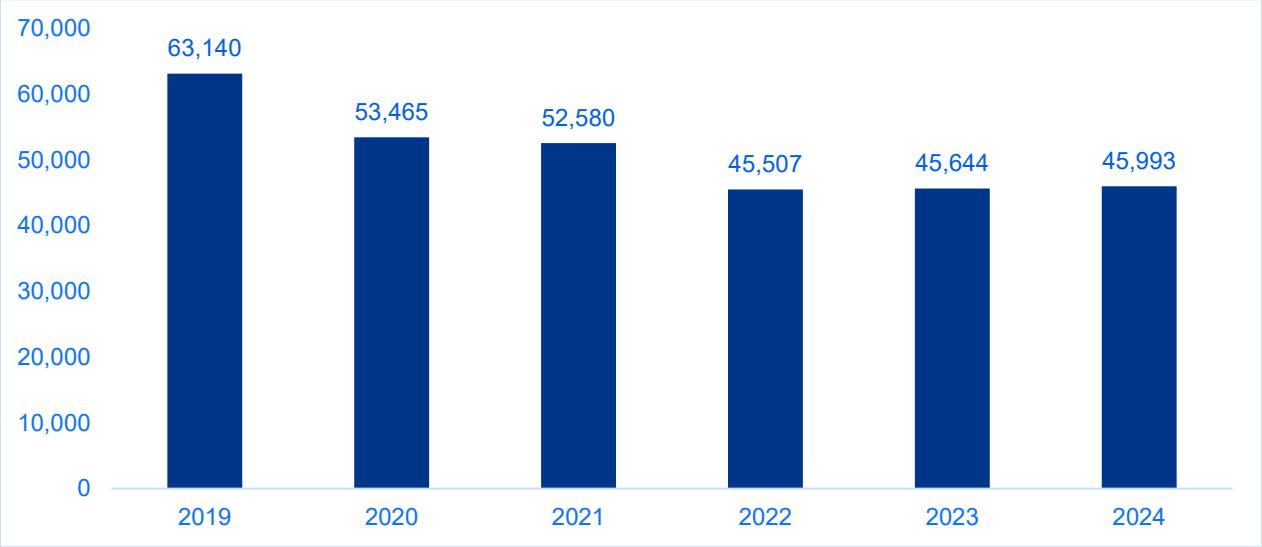
Source: HSCRC Casemix Data

Figure 5. Behavioral Health ED Volumes, TLC Hospitals, CY 2019–CY 2024



Source: HSCRC Casemix Data

Figure 6. Behavioral Health ED Volumes, GBRICS Hospitals, CY 2019–CY 2024



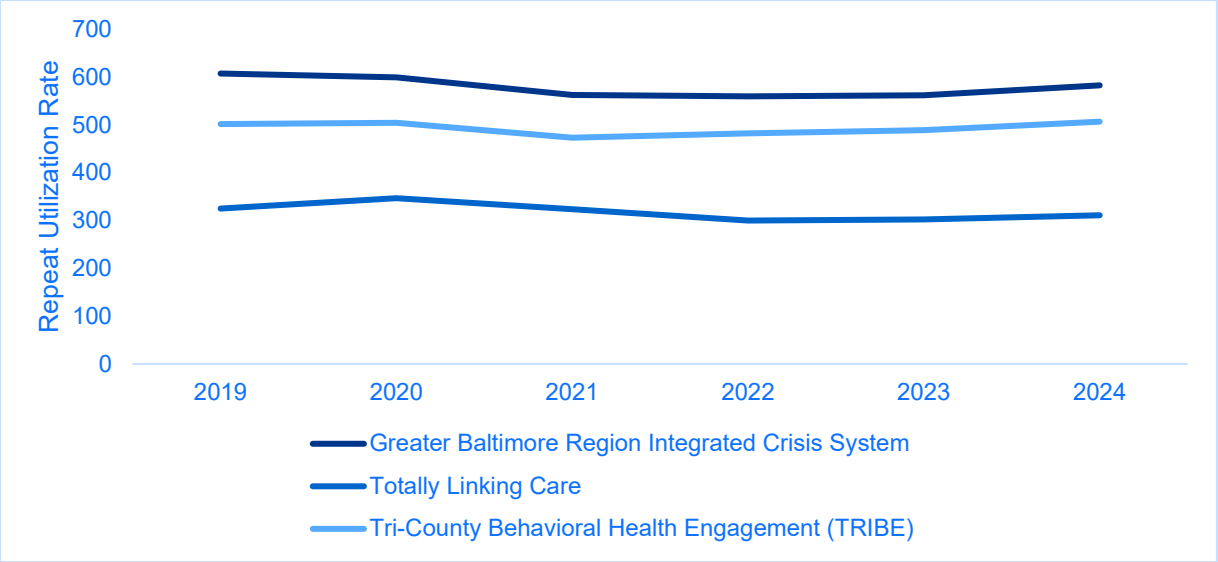
Source: HSCRC Casemix Data

Repeat Behavioral Health ED Utilization

In addition to total behavioral health ED volumes, the HSCRC monitors ED Behavioral Repeat Utilization performance for all Regional Partnerships. Performance measures the number of repeat behavioral health ED visits within regional partnership hospitals against the total number of behavioral health ED visits.

Repeat utilization is counted as three or more visits in a specific calendar year. As shown in Figure 7, staff are seeing a limited impact on repeat behavioral health utilization rates from a 2019 baseline. Since CY 2019, GBRICS has seen a decrease in 4.1% of visits, TLC has seen a decrease in 4.3% of visits, and TRIBE has seen an increase of 1.04% of visits. While Tidal reported an increase in ED utilization in 2024, this could potentially be attributed to improved mental health screening at hospitals through the use of Columbia Suicide Safety Risk Screening tool. They cited a 3% reduction of behavioral health inpatient admissions in CY 2024.

Figure 7. Repeat ED Behavioral Health Utilization Rate, CY 2019–CY 2024



Source: HSCRC Casemix Data

Behavioral Health Sustainability

Regional Partnerships continued to work toward the sustainability of 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 legislative sessions to lay the groundwork for sustainable funding. In May 2024, Governor Moore signed legislation that established a permanent funding source for Maryland’s 988 helpline.

Final Medicaid regulations for coverage of mobile crisis services and behavioral health crisis stabilization centers were posted in May 2024, providing a new source of sustainable funding to support crisis services for Marylanders. All Regional Partnerships cited that reimbursement levels for services are still not sufficient to cover the total costs of services provided for mobile response teams and crisis services, making

supplemental grants and hospital investment essential to ongoing sustainability. All Regional Partnerships report actively exploring diversified funding strategies in addition to revenue generated through billable services. Challenges with State and local budgets and decreased available funding through the impacts of House Resolution 1 have posed concerns for Regional Partnerships on future availability of state and local government grants and Medicaid reimbursement for services. Beyond financial considerations, workforce shortages and challenges with hiring and retaining workers post a significant barrier to sustaining these services.

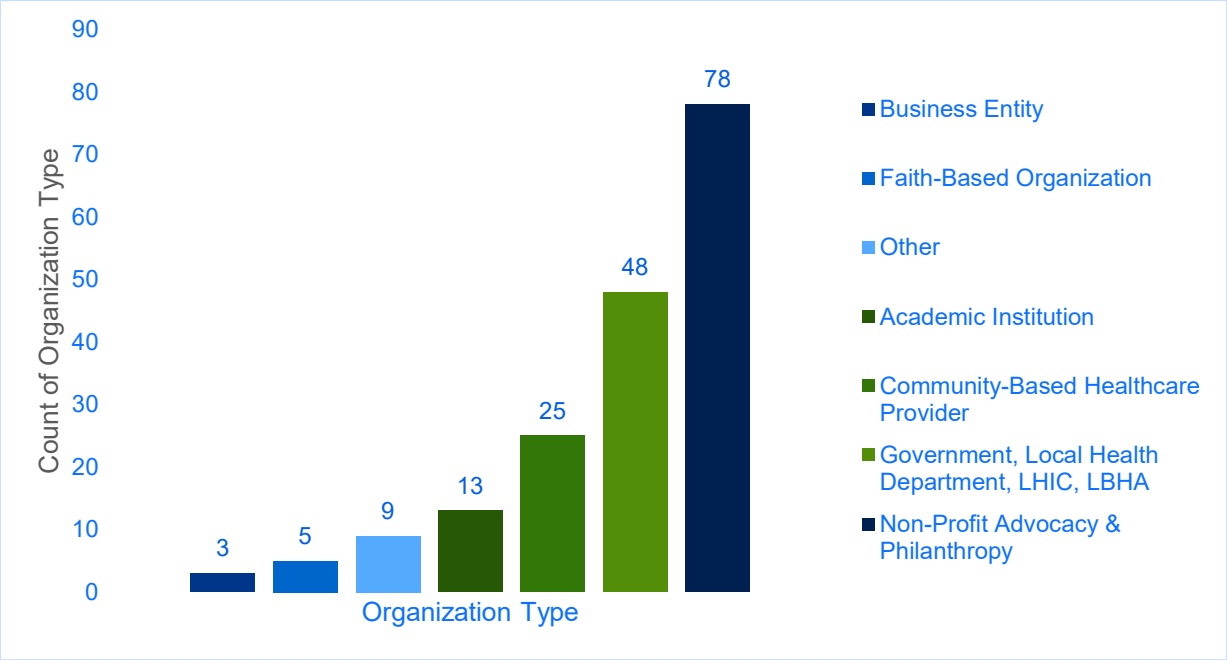
Behavioral Health Community Partner Engagement

Regional Partnerships continue to recognize the value of conducting meaningful, multi-sector input and are building on the prior year's 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 that 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. For example, collaborations helped achieve continuity of care with warm handoffs for patients in crisis, collaboration on individualized patient treatment plans, support in development of crisis stabilization center policies and procedures, and planning for longer term sustainability of services.

Figure 8 below shows the breadth of community partners for Regional Partnerships receiving behavioral health funding. There were 181 community partners. The most prevalent category was non-profit advocacy or philanthropy organizations, followed by local public entities and community-based healthcare providers.

Figure 8. CY 2024 Behavioral Health Community Partners



Source: Regional Partnership Annual Reporting, CY 2024

Catalyst Program Budget and Expenditures Summary

Regional Partnership expenditures for CY 2024 are shown in Table 7. Total expenditures across all Regional Partnerships were approximately $31.3 million. The largest category was workforce, with approximately $17.4 million in expenditures. Approximately $5.3 million was spent on other implementation activities, operations, and indirect costs; approximately $1 million was spent on IT/technology, and approximately $5.1 million was spent on wraparound services.

Table 7. Regional Partnership CY 2024 Expenditures

	Regional Partnership	Expenditures by Category	Total Expenditures
Diabetes Prevention and Management	**Baltimore Metropolitan Diabetes Regional Partnership**	• Workforce expenditures: **$5,083,931.61** • IT services: **$35,463.52** • Wraparound services: **$1,358,741.81** • Other implementation activities: **$529,672.95** • Other indirect costs: **$389,216.91**	**$7,397,026.80**
	Western Regional Partnership	• Workforce expenditures: **$2,201,142.52** • IT services: **$35,482.32** • Wraparound services: **$528,150.49** • Other implementation activities: **$80,263.01** • Other indirect costs: **$23,294.78**	**$2,868,333.12**
	Totally Linking Care	• Workforce expenditures: **$563,925.41** • IT services: **$313,959.51** • Wraparound services: **$0**	**$1,373,189.45**

	Regional Partnership	Expenditures by Category	Total Expenditures
		• Other implementation activities: **$267,121.32** • Other indirect costs: **$228,183.21**	
	Saint Agnes and LifeBridge	• Workforce expenditures: **$586,119.42** • IT services: **$0** • Wraparound services: **$568,100.09** • Other implementation activities: **$6,721.88** • Other indirect costs: **$34,477.55**	**$1,195,418.94**
	Full Circle Wellness	• Workforce expenditures: **$132,380.00** • IT services: **$0** • Wraparound services: **$69,051.89** • Other implementation activities: **$8,477.08** • Other indirect costs: **$66,568.35**	**$276,477.32**
Behavioral Health Crisis Services	**Greater Baltimore Region Integrated Crisis System**	• Workforce expenditures: **$6,209,042.52** • IT services: **$396,286.50** • Wraparound services: **$2,197,025.06** • Other implementation activities: **$970,955.08** • Other indirect costs: **$671,169.27**	**$10,444,478.43**
	Totally Linking Care	• Workforce expenditures: **$489,674.74** • IT services: **$112,000.00** • Wraparound services: **$344,865.00** • Other implementation activities: **$3,419,979.75** • Other indirect costs: **$173,699.20**	**$4,540,218.69**
	Tri-County Behavioral Health Engagement (TRIBE)	• Workforce expenditures: **$2,129,357.61** • IT services: **$135,257.11** • Wraparound services: **$0** • Other implementation activities: **$0** • Other indirect costs: **$961,490.00**	**$3,226,104.72**
		Total Expenditures	**$31,321,247.47**

Source: Regional Partnership Annual Reporting, CY 2024

HSCRC staff are 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. 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 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 CHWs 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. They 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

Although Regional Partnerships worked to build strong diabetes prevention and management programs, HSCRC staff determined in 2023 that these programs were not on a path to financial self-sustainability and that the level of funding issued through the program was not commensurate with the number of patients served. Low enrollment, as reflected in DPP and DSMT claims, led to the decision to discontinue program funding earlier than planned. Diabetes funding to Regional Partnerships ended June 30, 2024; however, Regional Partnerships had through the end of CY 2024 to either wind down their programs or restructure. All Regional Partnerships reported restructuring their diabetes programming into their health system offerings, often using adapted or scaled-back models designed to better meet patient needs, improve attendance and retention, and enhance financial sustainability. Partnerships also noted that they continue to leverage the resources and collaborations developed through Regional Partnership funding.

During CY 2024, the Regional Partnerships receiving behavioral health funding focused on fully implementing and refining operations for their funded activities. GBRICS continued to grow its Open Access Pilot by increasing the number of 988 referrals to pilot sites. TRIBE continued to operate both primary and

secondary sites, with a focus on expanding their efforts to partner with mobile response teams and EMS. Both GBRICS and TLC continued to support and enhance mobile response teams, with a focus on improving response times and completion rates for patient dispatches. Staffing and workforce shortages and reimbursement limitations remain challenges. The 988 Helpline and integration with Behavioral Health Link software continue to serve as vital tools for supporting patients in crisis. The ability to connect individuals to appropriate levels of care through mobile response teams, EMS, crisis centers, or same-day appointments remains a critical and valuable resource for Marylanders. The HSCRC is continuing to meet and discuss activities with Regional Partnerships as the final year of funding concludes. The final report on Regional Partnership behavioral health activities will be released in mid-2026.

maryland
health services
cost review commission

TO:

FROM: HSCRC Commissioners

DATE: HSCRC Staff

RE: October 8, 2025

Hearing and Meeting Schedule

November 8, 2025 In person at HSCRC office and Zoom webinar

December 10, 2025 In person at HSCRC office and Zoom webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.