maryland
health services
cost review commission

634th Meeting of the Health Services Cost Review Commission

September 10, 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 July 30, 2025

Specific Matters

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

Docket Status – Cases Closed

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

2. Docket Status – Cases Open

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

Informational Subjects

3. Presentation: Expanding Palliative Care Services - Greater Baltimore Medical Center

4. Presentation: RN Residency Programs - Maryland Organization of Nurse Leaders (MONL) / Maryland Nurse Residency Collaborative (MNRC)

Subjects of General Applicability

5. Report from the Executive Director

    a. Model Monitoring

6. Materials Only: Nurse Support Program I - FY 2024 Report

7. Hearing and Meeting Schedule

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MINUTES OF THE
633rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
JULY 30, 2025

Chairman Joshua Sharfstein called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, 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 Johnson and seconded by Commissioner Joshi, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:05 p.m.

ANNOUNCEMENTS

Chairman Sharfstein began the meeting by extending a warm welcome to the new Commissioner, Jon Blum. Commissioner Blum thanked the Chairman and stated it was an honor to join the Commission. He noted his professional background includes two tenures at the Centers for Medicare & Medicaid Services, where he had the privilege of collaborating with the Commission on the state's current model. He has long admired the work of the HSCRC, and he is eager to contribute to the important tasks ahead.

NEW STAFF & PROMOTIONS

Dr. Jon Kromm, Executive Director, announced the promotion and hiring of the following individuals:

Ms. Prudence Akindo has been promoted to Associate Director of Financial Methodologies. Ms. Akindo has been a valuable member of the Commission for nearly eight years, and in her new role, she will take on a larger responsibility in managing the development of new methodologies and financial policies. Ms. Akindo began her career with the Commission as an analyst and has achieved numerous successes throughout her tenure. We look forward to her continued contributions.

Ms. Laura Goodman will be joining the HSCRC as an Associate Director on the Medical Economics and Data Analytics team in early September. Ms. Goodman brings 12 years of experience from the Maryland Medicaid program. Before her work with Medicaid, she gained valuable international health experience working for a USAID-funded nonprofit and serving as a Peace Corps Volunteer in Nicaragua.

Ms. Hannah Thurner is joining the Health Data Management and Integrity team as a Data Analyst. She obtained a master's in public policy from the University of Maryland Baltimore County (UMBC) and brings strong analytical and technical skills to her role. While at UMBC, Ms.

Thurner gained valuable experience through an internship at the Hilltop Institute, where she contributed to various projects for MDH and CMS.

Ms. Sophia Okoma is also joining the Health Data Management and Integrity team as a Data Analyst. She recently earned a bachelor's degree in public health from Towson University. In addition to leading educational workshops for community groups during an internship, Ms. Okoma served as the Chief of Staff for Towson University's Student Government Association and previously gained experience as an HDMI Intern.

REPORT OF JUNE 11, 2025, CLOSED SESSION

Mr. William Hoff, Deputy Director, Audit and Integrity, summarized the items discussed on July 30, 2025, in the Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM JUNE 11, 2025, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Sabi and seconded by Commissioner Johnson, the Commission voted unanimously to approve the minutes of June 11, 2025, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2668R	Johns Hopkins Howard County Medical Center-Application Withdrawn
2681N	Luminis Health Doctors Community Medical Center
2672A	Johns Hopkins Health System
2673A	Johns Hopkins Health System
2674A	Johns Hopkins Health System

ITEM III
OPEN CASES

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

ITEM IV
PRESENTATION: REVOLUTIONIZING HEART FAILURE CARE

Chairman Sharfstein shared that he had the pleasure of visiting the Thurgood Marshall Amenity Center for a community health forum sponsored by 'Engage With Heart,' one of the recent Innovation Award recipients. The event brought together a wide range of stakeholders, including

Senator Cardin, community health workers, and clinical leaders. He stated this served as a perfect introduction to the presentation showcasing another project funded through the Innovations program and invited Dr. Mitch Schwartz, President of Luminis Health Clinical Enterprise and Chief Physician Executive, and Mr. Scott Afzal to share an update on their work.

Mr. Afzal introduced *The Day Clinic*, an independent facility that partnered with Luminis Health to offer a clinic-based alternative to hospitalization for heart failure patients experiencing fluid imbalance. He described the current standard of care as an inefficient and costly emergency room visit leading to a multi-day hospital stay for IV diuretics. The Day Clinic allows cardiologists to refer patients for same-day treatment and comprehensive follow-up care. Citing conclusive data from similar initiatives, he noted this model avoids hospitalization, dramatically reduces costs, and improves the patient experience. The primary barrier to its wider adoption has been the lack of proper financial incentives. The essential next step is developing a new payment model that values this type of comprehensive care.

Dr. Mitch Schwartz explained their confidence in the partnership, which aims to efficiently solve the long-standing problem of managing recurrent heart failure admissions by creating a more effective path of care that bypasses the burdensome emergency room process.

No action was taken on this agenda item.

ITEM V
REPORT FROM THE EXECUTIVE DIRECTOR

Summary of GME RFI Submissions

Dr. Jon Kromm reported the findings from a recent Request for Information (RFI) seeking feedback on evolving Graduate Medical Education (GME) policies to address Maryland's physician shortages. The Commission received detailed responses from eight organizations, revealing a broad consensus. Stakeholders supported a strategic focus on high-need specialties and rural areas, predictable funding mechanisms, incentive-based physician retention programs, and a data-driven approach to planning. Given the complexity of the feedback, the Staff's next step is to analyze the responses more deeply and return with concrete policy recommendations.

Stakeholder Feedback

Chairman Sharfstein introduced former Commissioner **John Colmers**, whom he and Dr. Kromm had asked to review all stakeholder feedback and provide his thoughts to help the Commission prepare for the path ahead.

Mr. Colmers laid out a framework for significant, urgent changes to Maryland's healthcare system, emphasizing that his recommendations were a starting point but were driven by a firm belief that the system requires substantial updates. Key proposals included:

- A rapid shift from unit-rate billing to a **risk-based global payment model** for hospitals.
- A **"participating payer" concept**, where commercial payers who adopt global payments and other efficiencies receive lower hospital rates.
- A thoughtful redesign of the **care delivery system**, including changing hospitals' inpatient footprints.
- A **vastly simplified quality program** focused on a few key metrics where Maryland lags, such as emergency department wait times.

He also addressed critical reforms needed in physician payment, medical education, capital policy, and post-acute care, concluding that all stakeholders must work together with urgency to build a more aligned and effective healthcare system.

Chairman Sharfstein asked how the model would solve the "leakage" problem, where a health system invests in prevention but doesn't capture savings that occur at another hospital. Mr. Colmers confirmed the model would allow a hospital to meet its savings target by either reducing its own admissions or by demonstrating comparable savings through a CTI program, thus getting credit for avoided admissions elsewhere.

Commissioner Johnson asked about the stakeholder engagement process. Mr. Colmers stated he had engaged with some hospitals, read all submitted materials, and reached out to CareFirst, affirming his willingness to continue the engagement. He explained his proposal is a hybrid model designed to create the incentives of a per-capita system within the current structure.

Commissioner Blum asked what would tangibly change in hospital leadership behavior, given that the current model has similar incentives. Mr. Colmers argued that the problem with the current model is not the lack of incentives but their lack of clarity. He contended that his proposal aims to make the link between positive actions and financial rewards clear and understandable, thereby encouraging innovation over blunt actions like closing services.

Chairman Sharfstein outlined a process for moving forward. Staff will brief commissioners individually, perform an "initial triage" of the ideas, and continue the discussion at the September meeting.

Commissioner Sabi praised the proposals but argued against a slow timeline, stating the Commission must move quickly. Chairman Sharfstein clarified that triage can be done urgently, but its purpose is to determine which proposals are truly ready for practice.

Community Benefits Report -FY 2023 Report

Dr. Kromm announced that the community benefits reports are included in the Commission’s materials.

No action was taken on these agenda items.

ITEM VI
FINAL RECOMMENDATION: CONFIDENTIAL DATA REQUEST

Mr. Curtis Wills, Analyst, Healthcare Data Management and Integrity, and Jenny Cook, Oregon Health and Science University, presented the staff's Final Recommendation: Confidential Data Request (see "Final Recommendation: Confidential Data Request" available on the HSCRC website).

Mr. Wills presented the staff's Final Recommendation to approve a confidential data request from *Oregon Health and Science University* (OHSU). OHSU is seeking access to confidential hospital data to support a research project focused on improving pediatric emergency care by identifying the components of "pediatric readiness" most linked to better survival outcomes. The request was reviewed and recommended by the Confidential Data Review Committee. Staff recommends approving OHSU's request for CY 2018 through 2022 under strict conditions, including annual reporting and the certified destruction of data upon the project's completion on April 30, 2028.

Mr. Wills presented the staff's Final Recommendation from Oregon Health and Science University as follows:

1. That the request by Oregon Health and Science University for the Data for Calendar Year 2018 through 2022 be approved, previously approved at the HSCRC Public meeting on March 8, 2023;

2. That this access will include limited confidential information for subjects meeting the criteria for the research.

Chairman Sharfstein asked Ms. Cook to briefly explain the importance of the proposed research. Ms. Cook explained that children are not simply "little adults" but require specialized care in emergency situations. Her project focuses on pediatric readiness, how prepared an emergency department is for children and specifically aims to identify the exact components of this readiness that are most strongly linked to improving both short-term and long-term survival rates. By pinpointing what works best, the study will create a clear, evidence-based roadmap for all hospitals across the nation, whether high- or low-performing, to enhance their practices and deliver more effective, life-saving care to pediatric patients.

Noting his background as a pediatrician, Chairman Sharfstein asked for a specific example of a clinical scenario that the research could illuminate and how the study could lead to concrete improvements in care for children.

Ms. Cook provided examples from both trauma and medical care to illustrate the research's focus. For a trauma case, the study could reveal whether a general emergency department provides the correct initial care before transferring an injured child to a specialized pediatric

trauma center. In a medical scenario, it might assess if a child arriving with a condition like diabetic ketoacidosis (DKA) receives the specific, appropriate treatment. She clarified that the research examines not only clinical actions but also whether facilities are properly equipped with the right-sized tools, like endotracheal tubes, and have established policies and protocols to effectively manage high-stress pediatric emergencies, ultimately linking these factors to long-term survival rates.

Chairman Sharfstein requested a motion to adopt the staff's Final Recommendation. Commissioner Johnson moved to approve the staff's Final Recommendation, seconded by Commissioner Joshi. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM VII
RECOMMENDATION: ADDITIONAL FUNDING CONSIDERATIONS FOR FY2026

Dr. Kromm provided the current picture of hospital financials to inform the discussion on the FY2026 Update Factor. He reported that the state's projected cumulative savings versus the nation has been revised downward from $795 million to $630 million, leaving approximately $50 to $55 million in available capacity for potential funding increases before risking the state's essential Medicare savings target.

Given this revised projection, he outlined the financial constraints on any additional funding. With an accepted savings floor of $525 million that is considered to be necessary during the transition to the AHEAD model, and the staff recommendation to maintain a $50 million buffer to account for data volatility, there is limited room for rate adjustments.

Commissioner McCann questioned the current cautious outlook on the savings target by highlighting the historical trend. She pointed out that in previous years, initial staff estimates for the savings target were significantly lower than the final numbers achieved by the State. Given that the State has historically underestimated and then far exceeded its savings goals, she asked what makes this year different and why the current, less optimistic projection should be considered more accurate than those of the past.

Dr. Kromm provided several reasons why this year's more cautious projection is different from previous years. He explained that current data from the first four months, while early, is directionally aligned with a downward trend that is consistent with both expected economic cycles and external projections from CMS.

He emphasized that last year was an extreme and unpredictable outlier. The national cost trend was an unprecedented 7 percent, a 10-year high that no forecasters anticipated, which resulted in Maryland's unexpectedly large savings surplus. Additionally, Maryland benefited from a specific "out-of-hospital" cost advantage last year that was not expected to be sustained and has since disappeared. Therefore, the current projection is based on a return to more predictable patterns, unlike the anomalous conditions that led to the previous year's windfall.

Commissioner Johnson questioned the staff's rationale for using the $525 million savings target as the baseline for their financial calculations. He pointed out the reality of the state's ongoing negotiations with CMMI, which he believes will likely result in a higher savings requirement under the new model. Given this probable outcome, he asked why the staff was not recommending a larger financial cushion to proactively prepare for this anticipated higher target, instead of pegging their recommendations to the current $525 million figure. Dr. Kromm agreed that determining the size of the financial cushion is a judgment call. He suggested that the existing flexibility in their calculations could potentially help accommodate a higher future savings target.

Dr. Kromm summarized stakeholder feedback on potential FY2026 funding adjustments and presented options for the Commission's consideration.

- **Surge Funding.** Most comments supported an annual policy using an updated methodology, while CareFirst opposed it.
- **Inflation Corridor.** Hospitals requested suspending it to release funding, while an alternative suggestion was to narrow it.
- **Physician Costs.** Hospitals supported adding these costs to global budgets, though staff noted that further analysis is planned for the fall and that any direct rate setting may require a change in statutory authority.
- **Risk Adjustment to the Demographic Factor.** Broadly supported by stakeholders, staff is prepared to advance this discussion through a workgroup process.
- **AHEAD Preparedness.** The Commission received proposals for population health programs, as well as a suggestion from CRISP to create a "Sustainability Fund" to support innovation and infrastructure. Staff agreed that bolstering population health infrastructure through partners like CRISP is important for success in the AHEAD model but must be balanced with available resources.

Based on this feedback, Dr. Kromm presented two areas with concrete options for the Commissioners' immediate consideration.

Respiratory Surge Funding Policy

- Continuing to develop a new methodology, or

Adopting a three-year phased transition from a patient days to an ECMAD-based approach, which would result in a rate adjustment of approximately +0.5 percent for FY 2026. As with last year, this funding would come with an expectation that hospitals will maintain or expand capacity and follow MDH guidance for respiratory disease prevention.

Inflation Corridor Policy

- No change to the current policy, or

- Reduce the corridor from 1 percent to 0.25 percent, which would release 0.27 percent in funding for hospitals in FY 2026. Decisions on risk adjustment and physician costs will follow the completion of the planned workgroup and staff analysis.

Commissioner Joshi asked for clarification on the respiratory surge policy and whether the policy applies strictly to respiratory cases or if its scope includes all patient cases. Dr. Kromm confirmed that based on precedent, the policy applies specifically to respiratory volume.

Emphasizing the importance of transparency and strict adherence to the Administrative Procedures Act (APA), Commissioner Johnson raised concerns that the current approach of considering votes on issues introduced informally through comment letters deviates from the Commission's standard process. He asked if the Commission received a formal legal opinion confirming its authority to vote on matters that have not gone through a formal rulemaking procedure. Assistant Attorney General (AAG) Stan Lustman addressed the procedural concern by stating that the legal standard for the Commission's process is one of reasonableness. In his legal opinion, the Commission has met this standard. He justified this by pointing out that the topics were discussed 45 days prior, formal comments from interested parties were submitted and have been addressed, and the Commission is even allowing further live comments during the meeting. He concluded that these combined actions certainly fall "under the umbrella of reasonable."

Vice Chairman Elliott asked for confirmation on the timeline for the risk-adjusted demographic policy. Specifically, whether it will be brought back to the Commission for comment sometime before the end of this year (2025). Mr. Pack confirmed that the timeline is correct, explaining that the staff is following the policy calendar established during the Commission's retreat. He clarified that per that calendar, three items are scheduled to be brought back for consideration before the end of the year: the risk-adjusted demographic adjustment, the variable cost factor, and the geography revisions to the Market Shift policy.

Ms. Melony Griffith, President and Chief Executive Officer of the Maryland Hospital Association (MHA), described the current situation as being at a critical juncture, with hospitals facing a convergence of significant pressures all at once. Ms. Griffith detailed these challenges as climbing costs, growing and more complex patient care needs, an increase in claim denials, and unpredictable future shifts. She argued that this strain needs to be addressed in order for hospitals to continue delivering the high-quality care that Marylanders depend on while simultaneously adapting for the future.

Ms. Griffith stated that MHA's detailed points have already been thoroughly communicated to the Commission. She referenced the numerous comment letters, testimonies, meetings, and extensive workgroup participation from MHA members as evidence of their deep engagement in the process. She stated her testimony served to underscore these previously submitted comments and reinforce the urgency of the situation facing Maryland hospitals.

Ms. Tequila Terry, Senior Vice President of Care Transformation and Finance of MHA, detailed the severe financial strain on hospitals from rising operational costs, new unsupported expenses like cybersecurity, and persistent inflation. She emphasized that this is not a new problem, but a multi-year gap of underfunding that has continued to widen. To provide immediate relief, Ms. Terry urged the Commission to amend the staff proposal for Rate Year 2026 by suspending the inflation corridors and allowing the full underfunded amount of 0.52 percent to be included in hospital rates.

She then outlined several other key requests, including making the surge funding a permanent part of hospital rates, using Rate Year 2025 volumes for the Rate Year 2026 calculation. She also reiterated the need for full funding of demographic growth to serve Maryland's aging population, specifically requesting an additional 0.65 percent. Regarding a new ECMAD-based methodology that was recently released, Ms. Terry respectfully asked for more time for hospitals to evaluate its impact.

Ms. Terry also highlighted the growing financial strain of supporting essential physician services such as hospitalists and anesthesiologists. She framed the discussion as a critical moment to provide hospitals with a stable foundation as they prepare for the AHEAD model, characterizing the MHA's recommendations as targeted, achievable actions that would help hospitals remain strong for their communities.

Commissioner Blum asked staff to clarify if the $150 million being discussed is the Medicare-only portion or the total amount across all payers. Dr. Kromm responded it was the total amount across all payers. Commissioner Blum followed up by asking if the proposed change to the inflation corridor policy a temporary suspension or a permanent elimination would be. Ms. Terry noted that although MHA supported the temporary suspension of the inflation corridors as an appropriate action for today, she reiterated MHA's long-standing position that the policy should be permanently eliminated.

Mr. Gene Ransom, CEO of MedChi, The Maryland State Medical Society, began his presentation by invoking the 60th anniversary of Medicare and Medicaid, framing the discussion around compassion and patient care rather than solely on costs. He argued that the Commission's primary goal should be to meet the negotiated federal savings target under the Total Cost of Care agreement, not to exceed it. He contended there is no benefit for beating the target, and any funds saved beyond that negotiated amount are funds that are not being invested in patient care. Citing data from previous years where actual savings far outpaced projections, he concluded that the Commission has the ability to increase funding to hospitals to support patients and that he is generally supportive of the hospitals' requests.

Mr. Ransom also made the case for immediate investment in Maryland's Health Information Exchange, CRISP, which he praised as the best in the country. Significant investment is needed now to prepare for the future demands of the AHEAD model and new value-based care programs. He specifically pointed to the need to upgrade tools like the one for Medicaid eligibility to meet new federal requirements (such as for HR1 (One Big Beautiful Bill Act)). This

would be a critical and worthwhile investment to ensure the state's healthcare infrastructure is ready for the significant changes ahead.

If an immediate investment in CRISP could not be approved today, Mr. Ransom requested that the Commission direct the Staff to return before the end of the year with a detailed plan on how to make that investment. He concluded by urging the Commissioners to consider patients as they are the ones ultimately impacted by funding decisions.

After acknowledging that the Commission does not have the authority to regulate physician rates, Commissioner Sabi asked Mr. Ransom if the state's physicians, through their society, could provide the Commission with 1) deeper insight into the specific cost and operational pressures they are facing, and 2) recommendations for potential solutions that the Commission could then consider. Mr. Ransom agreed to the request, confirming that the Maryland Medical Society would be happy to come back with insights and recommendations on the physician cost issue.

Mr. Arin Foreman, Vice President and Deputy Chief of Staff for CareFirst BlueCross BlueShield, voiced a strong procedural concern, stating that the Commission is straying from its established norms of inclusive and transparent policymaking. He contrasted the Commission's long history of using a thorough process, including stakeholder work groups, detailed staff analysis, and formal public comment periods with the current discussion, which he described as a review of comments that lacks a formal staff recommendation and was not vetted by a work group. Arguing that these decisions directly impact on a vulnerable public, he urged the Commission to refrain from taking any action until staff can develop a written recommendation that follows the proper, established stakeholder process.

Ms. Megan Priolo, Executive Director of CRISP, began by thanking the Commission for their long-standing partnership and highlighting CRISP's central, collaborative role within Maryland's unique healthcare environment. She described CRISP's cobbled together funding structure, which is intertwined with the Maryland Model and faces potential sustainability risks in a time of change. She encouraged future models to incorporate stable funding to maintain the state's vital data infrastructure, specifically suggesting a mechanism that would allow CRISP to establish reserves and be on stronger footing.

Commissioner McCann asked how long CRISP could sustain its operations if its funding were to be suspended. Ms. Priolo stated that CRISP's operational runway is in the range of months, aided in the short-term by a line of credit. She explained this is a direct result of their business model, which is time and materials with multiple-braided funding sources. This is intended to keep revenues and costs closely aligned as a cost-effective partner. As such, they don't build large reserves by design, and suspension of a funding source would force immediate and difficult conversations about which core services would need to be cut.

Dr. Sarah Szanton, PhD, MSN, Dean of the Johns Hopkins School of Nursing (JHSON), began her presentation by offering a different perspective on how system-wide savings should

be used. She argued that when a dollar is saved, it doesn't necessarily need to go back into acute care, as proactive and preventive care in neighborhoods and homes is also a 24/7 operation. Citing the U.S. healthcare system's overly reactive nature, she stated her intent to present two innovative ideas that would shift resources and creativity toward prevention.

Her first proposal addresses both food waste and food insecurity through a model already piloted in Delaware. Using an analogy to Priceline.com, the program would offer deep discounts to SNAP-eligible individuals on grocery store food that is approaching its expiration date. Dr. Szanton explained that this modest-cost program would prevent food from spoiling while providing nutritious food to those in need, which in turn helps address the many chronic conditions linked to poor nutrition.

Dr. Szanton's second idea involves leveraging the state's data system, CRISP, to proactively manage cardiovascular disease. She proposed a tiered intervention model that would stratify individuals by risk, providing escalating levels of support ranging from a digital app for low-risk individuals to in-person care from a nurse and community health worker team for high-risk individuals. This could be combined with a community-level approach, using CRISP to assign care teams to high-risk neighborhoods, building on the success of the HSCRC's Neighborhood Nursing program to ultimately reduce ER visits, strokes, and heart attacks.

Chairman Sharfstein indicated that the Commission had been exploring the concept of making common investments in prevention that could generate savings across the entire system, thereby reducing the savings targets for individual hospitals. He asked whether her two proposals would be good candidates for such a shared, system-wide investment. Dean Szanton agreed that her proposals are a perfect fit for the common investment model. Focusing on her idea of assigning a nurse and community health worker team to a neighborhood zone, she argued it should be a common investment because the benefits of preventing acute care are shared across many different insurers and hospital systems. To solve this problem of the common good, she endorsed the idea of a common fund to support this role, likening it to a school nurse for the neighborhood, which would allow all stakeholders to share in the savings generated by prevention.

Chairman Sharfstein suggested the Commission discuss each topic individually, vote on it, and then move to the next.

Respiratory Surge Funding Policy

Commissioner Johnson reiterated his concern about the process of the vote and questioned the rationale for using patient days as the metric for the respiratory surge policy, instead of the ECMADs methodology, he asked whether there was a clinical benefit to using patient days. Dr. Kromm explained that patient days were used as the metric because they were a direct way to reflect the high volume during the historical surge period. Although an ECMADs-based methodology is valid, he reiterated that the use of days was simply a tool to recognize and account for the historical trend.

Commissioner Sabi urged for a more holistic and cautious financial approach, urging that the current spending path is not sustainable and there's a ceiling on available funds. She argued for spending every dollar more thoughtfully, with a focus on investing in preventing and shortening hospitalizations rather than just accumulating new costs. She stated her belief that many hospitalizations and long lengths of stay are avoidable if the system properly invests in pre-hospitalization care and safe discharge options. Commissioner Sabi noted there have been three rate increases in the past year—to address underfunding, inflation, demographic changes, and uncompensated care. Given these substantial investments, she strongly advocated that the Commission should pause and allow those funds to flow through the system to assess their impact before making new spending decisions.

Commissioner Blum asked for a technical clarification on the mechanics of the proposed rate increases. He sought to understand if the adjustments are intended to be a one-time increase that does not affect future calculations, or if they would be permanently incorporated into the hospitals' base rates. Chairman Sharfstein clarified that the respiratory surge policy is intended to be an ongoing policy for future years, not just a one-time adjustment. He explained it would become part of the regular annual update, functioning as a formula-based calculation that would depend on the severity of that year's respiratory season. He emphasized that while the calculation might be potentially automatic, the Commission would still retain its authority and vote on the final rate update package each year.

Commissioner McCann argued that the respiratory surge funding is a necessary, retroactive payment to cover the costs of care that hospitals have already delivered but was underfunded in both 2024 and 2025. While she urged moving the policy forward to address these immediate needs, she noted it must be done with an eye toward the larger, long-term goal of addressing all volume policies.

Commissioner McCann also strongly agreed with Commissioner Johnson's call for more clinical input. Commissioner McCann endorsed the idea of bringing together stakeholders and clinical experts in the future to determine the most appropriate permanent methodology (e.g., ECMADs versus patient days) and to answer clinical questions, such as what defines an appropriate length of stay. She balanced her position by supporting a vote to approve the funding today while also committing to a more thorough, expert-driven process to find the right long-term solution.

Commissioner Joshi offered a specific recommendation regarding the policy being phased-in over three years. He suggested that instead of committing to a long-term plan now, the Commission should use the proposed "blended" methodology for the current year to address the immediate need. Then convene a formal policy group to be tasked with developing the permanent methodology for all subsequent years. Commissioner Joshi agreed on the critical need to invest in preventive care; however, a "bridge" is required to adequately fund hospitals to handle the reality of everything that's happening today. Citing Mr. Colmers, he noted that there must be equitable payment for the care currently being delivered, even if that care is happening in a less-than-ideal setting.

Chairman Sharfstein proposed a two-step approach as a compromise. He suggested that the Commission could vote today to authorize the total recommended funding amount, while simultaneously directing staff to convene a work group to study the methodology issue (ECMADs versus patient days) and make a formal recommendation. The final distribution of the approved funds to hospitals could then be adjusted later in the year based on the workgroup's findings.

Chairman Sharfstein called for a motion to approve $100.5 million for the respiratory surge funding as set forth by the staff, with the condition that the specific methodology for distributing these funds to hospitals would be determined by a workgroup and then brought back to the Commission for final approval. Commissioner Joshi moved to adopt the motion, which was seconded by Vice Chairman Elliott. **The motion passed, with five votes in favor (Vice Chairman Elliott, Commissioners Blum, Joshi, McCann, Sabi) and one vote in opposition (Commissioners Johnson).**

Inflation Corridor Policy

Commissioner Johnson opened the discussion by asking a question about the inflation metric the Commission uses. He pointed out the difference between the 3.35 percent figure used in rates versus the standard Consumer Price Index (CPI) of 2.9 percent and asked if staff had determined whether the inflation index used is a more accurate predictor of actual hospital costs. As the Commission considers removing the inflation corridor which helps protect against volatility, this is an opportune moment to validate and ensure confidence in the underlying inflation target. Mr. Pack responded that while staff has previously confirmed the internal weights of their inflation model are very similar to national standards, they have not recently compared the different indices. He noted that the use of the Global Insights index is based on long-standing precedent as the appropriate measure for hospital costs. However, he agreed with Commissioner Johnson's suggestion and confirmed that the staff could perform a more in-depth analysis, potentially looking at other measures like the Medicare Economic Index (MEI).

Vice Chairman Elliott stated his support for reconsidering the inflation corridor, arguing that circumstances and funding uncertainties have changed since the Commission's original vote. He asserted that underfunded inflation has real consequences for hospital finances and patient services, and therefore, rates should follow actual inflation as closely as possible. He stressed

that the policy must be fair and "bi-directional," accounting for overestimations as well. He agreed with MHA's position that if the state successfully meets its overall federal savings target, the Commission should not enforce individual hospital claw backs.

Commissioner Blum framed the discussion as finding the right balance. He noted that reducing or eliminating the inflation corridor would inherently increase financial volatility for hospitals, and he stated that accepting this increased risk would be a conscious policy choice for the Commission.

Chairman Sharfstein positioned the staff's recommendation as a compromise. He described it as a middle ground between the two extremes of keeping the current policy and eliminating it completely. It was designed to keep spending within a range the staff considers fiscally prudent.

Commissioner Johnson disagreed with the idea that hospitals require more protection now. He stated that since the Commission last voted on the 1 percent corridor, the most significant change is that hospital margins have actually improved. Therefore, he argued, it was not logical to suggest that hospitals are facing increased risk compared to when the policy was first enacted. Commissioner McCann countered, arguing that circumstances have changed in ways that create even more uncertainty for hospitals now than when the 1 percent corridor was first approved. She disagreed that improved margins were the only significant change, pointing instead to several new or increased risks. Specifically, she cited tariffs and higher costs, upcoming changes to Medicaid, and the general uncertainty surrounding the AHEAD model's future.

Chairman Sharfstein called for a motion, and Commissioner McCann made a motion to suspend the inflation corridor and to distribute the full 0.52 percent of underfunded inflation to hospitals. It was seconded by Commissioner Joshi. **The motion subsequently failed with three votes in favor (Vice Chairman Elliott, Commissioners Joshi, McCann,) and four votes in opposition (Commissioners Blum, Johnson, Sabi and Chairman Sharfstein).**

Chairman Sharfstein asked for a motion to approve the staff's second option for the Inflation Corridor Policy. This option would amend the corridor threshold to 0.25 percent and would not apply to the corridor if inflation is overfunded and all saving tests are met. Commissioner Joshi moved to adopt the motion and was seconded by Commissioner Blum. **The motion passed with four votes in favor (Vice Chairman Elliott, Commissioners Blum, Sabi, Joshi) and two votes in opposition (Commissioners Johnson and McCann).**

Commissioner McCann requested that staff report back to the Commission with an anticipated timeline for when the workgroup is expected to address the demographic adjustment policy issue. She also recommended proactively bringing stakeholders (like payers and hospitals) together in a workgroup before the public meetings to forge compromises on complex issues.

ITEM VIII
RECOMMENDATION: UPDATES TO THE CONSUMER FINANCAIL ASSISTANCE AND MEDICAL DEBT REGULATIONS

Ms. Hannah Friedman-Bell, Chief, Medical Economics and Data Analysis, presented the staff's Draft Recommendation for Updates to the Consumer Financial Assistance and Medical Debt Regulations (see "Updates to the Consumer Financial Assistance and Medical Debt Regulations" available on the HSCRC website).

Ms. Friedman-Bell reviewed that staff's recommendation for the Commission to approve forwarding the draft Hospital Payment and Collection regulations to the Administrative, Executive, and Legislative Review (AELR) committee to begin the mandatory 30-day public comment period. She stressed the urgency of this action, as the regulations have not been updated since 2021 despite numerous statutory changes. The goal is to finalize the new regulations before the pre-session freeze in November, warning that any subsequent substantive changes would restart the entire process and delay the update for another year.

Ms. Friedman-Bell explained that the current draft is the result of a thorough workgroup process conducted this year, which incorporated statutory changes from six different bills passed between 2022 and 2025. This effort builds upon a similar process from 2023 that was ultimately derailed by unanticipated technical and procedural delays, which is why the regulations have remained outdated. The process involved multiple iterations of the draft regulations and several opportunities for stakeholder comment and review.

Ms. Friedman-Bell highlighted three key areas that are being revised to achieve the overall goal of a standardized and streamlined payment process.

- **Defining Income:** Aligning the definition of income to household income (from individual income) for both income-based payment plans and financial assistance applications.
- **Documentation of Income:** Aligning the types of documentation required from consumers across both the payment plan and financial assistance processes.
- **Use of Asset Tests:** Providing a clear, single definition and application for the use of asset tests in financial assistance, resolving previously varying interpretations of the statute.

Chairman Sharfstein called a motion for the staff's Recommendation to forward the draft regulations to the AELR committee. Commissioner Johnson moved the motion, and it was seconded by Commissioner McCann. **The motion passed unanimously to approve the staff's Recommendation.**

ITEM IX
HEARING AND MEETING SCHEDULE

September 10, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:35 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

July 30, 2025

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

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 12:05 p.m.

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

Staff members in attendance were Jon Kromm, Jerry Schmith, William Henderson, Allen Pack, Claudine Williams, Cait Cooksey, Christa Speicher, Erin Schurmann, and William Hoff.

Joining by Zoom: Deb Rivkin and Geoff Dougherty.

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

Item I

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

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 May FY25.

The Closed Session was adjourned at 12:40 p.m.

maryland
health services
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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

September 10, 2025

maryland
health services
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:	2489
BALTIMORE, MARYLAND	*	PROCEEDING:	2679A

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on July 31, 2025, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Johns Hopkins Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for solid organ and bone marrow transplants and ventricular assist device procedures (VAD) with Optum Health, a division of United HealthCare Services, Inc. The System requests approval of the arrangement for a period of one year beginning September 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 unfavorable. Prior to this past year, the contract has shown a consistently favorable history. The Hospitals have adjusted the prices in their current arrangement to eliminate the losses. Staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for solid organ and bone marrow transplants and VAD procedures for a one-year period commencing September 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.

Gilchrist: Expanding Palliative Medicine Services

September 10, 2025

Live Every Moment

Presenters

Catherine Y. Hamel, MA
President, Gilchrist & Executive Vice-President and Chief Strategy Officer, GBMC HealthCare

Cathy has over 30 years of executive experience in healthcare management. She joined Gilchrist in 2008 and became president in 2015. In addition, she was appointed to the position of the Executive Vice President of Strategy, for GBMC HealthCare, responsible for the development, oversight and management of the enterprise-wide strategic planning development and execution. Cathy oversees the organization's redesign work aimed at making care more coordinated from the eyes of the patient

David S. Wu, MD
Senior Advisor Education & Outreach
Gilchrist

Dr. Wu brings a distinguished background in hospice and palliative medicine with leadership roles spanning clinical care, research and education. As Senior Advisor of Education and Outreach, Dr. Wu is leading the development of statewide palliative care education for healthcare providers, patients and families.

Lakshmi Vaidyanathan, MD, MBA
Section Chief, Palliative Medicine
Associate Chief Medical Officer
Gilchrist

Dr. Vaidyanathan has over 25 years of experience including work in hospital medicine, palliative medicine and population health. She joined Gilchrist in 2024 where she is currently responsible for the strategic planning and operational oversight for the growth of the Gilchrist palliative care program

Gilchrist

Our Mission

To provide counseling, support and care to anyone with serious illness, so they may live life to the fullest.

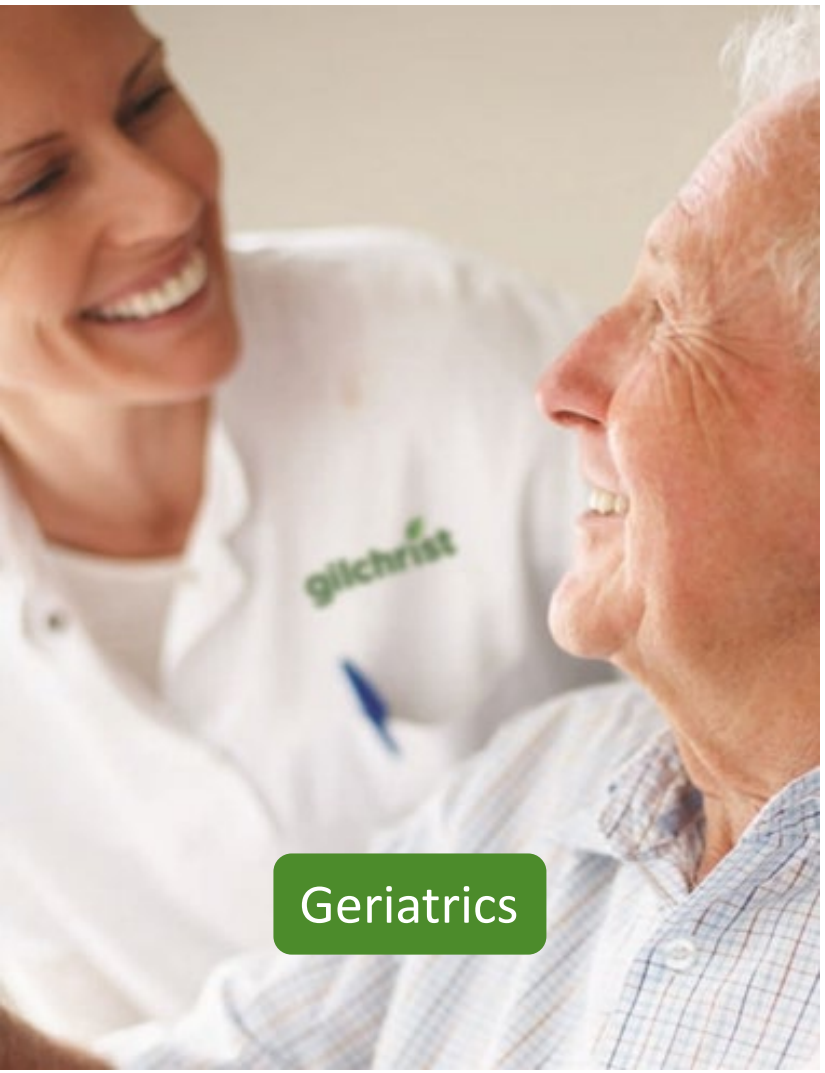
Our Vision

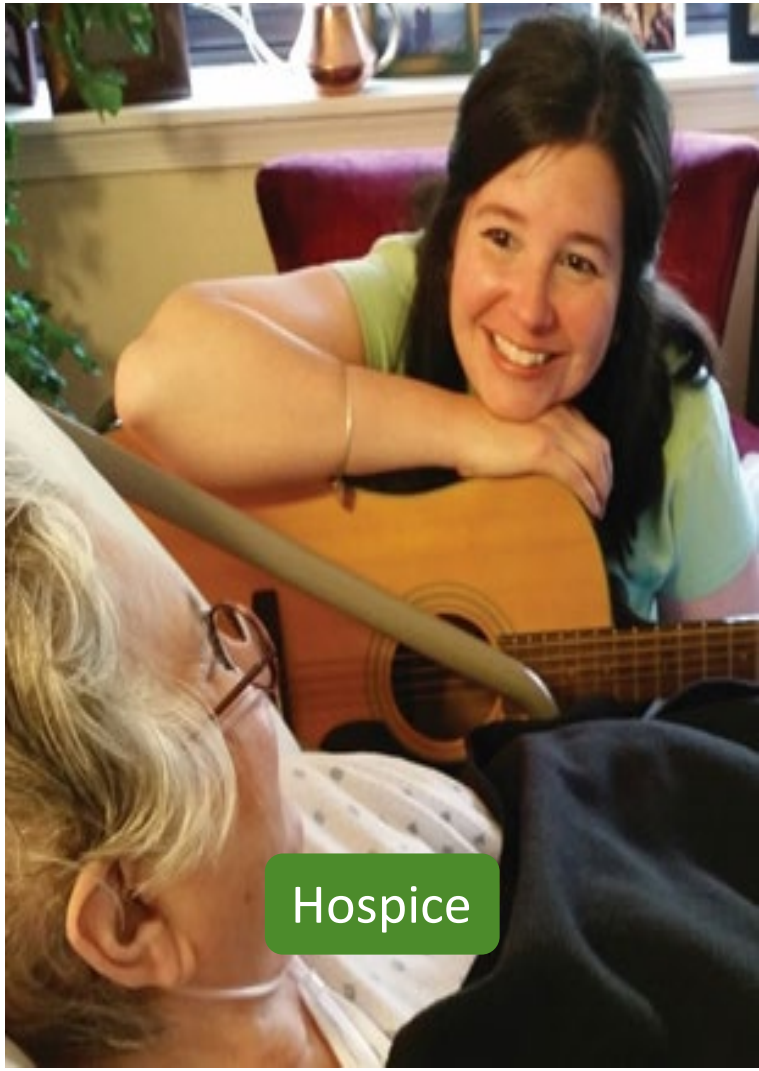
We are deeply committed to giving people the clear information and loving support they need to make informed choices about their care.

Our North Star

Be the undisputed leading provider of serious illness and end of life care in the mid-Atlantic region. We offer our community a wide range of patient and family centered services regardless of their ability to pay.

Horizontal Integration of Care for Seriously Ill Patients





Gilchrist Palliative Care

Focused on relieving symptoms like pain, nausea, and stress associated with serious illnesses, our program helps patients and families understand treatment options, make informed decisions, and improve quality of life

Gilchrist Hospital Palliative Medicine Sites of Service

Anne Arundel Medical Center

JOHNS HOPKINS
MEDICINE
Howard County Medical Center

Why Palliative Care?

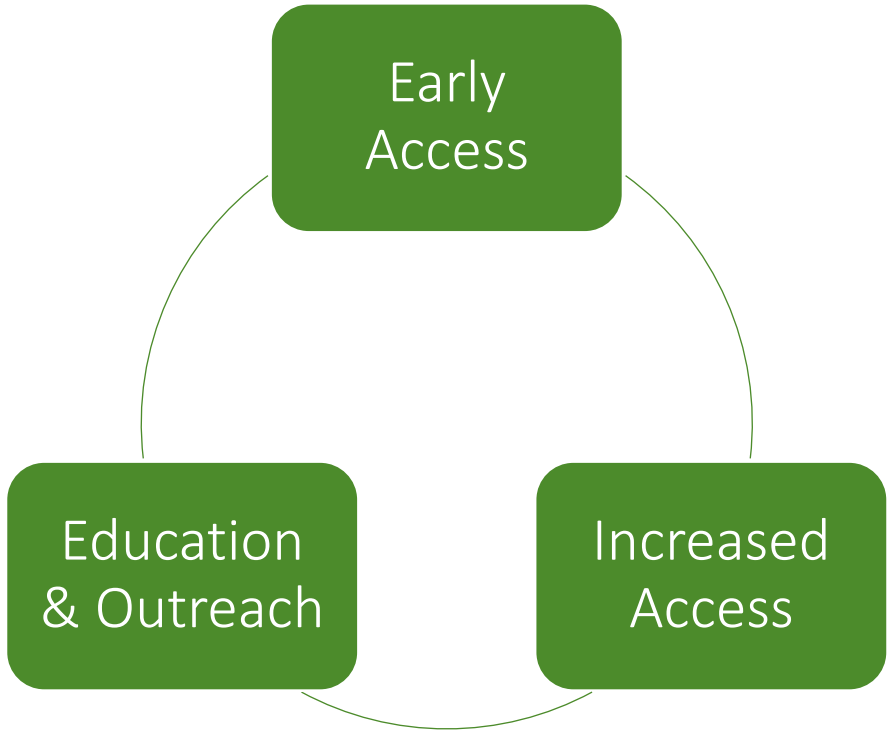
★★★ Better quality of life and care aligned with patient values

 Maryland's current hospice utilization ranks 35th in the country

 Internal pre vs. post cost savings: $14,000 per patient

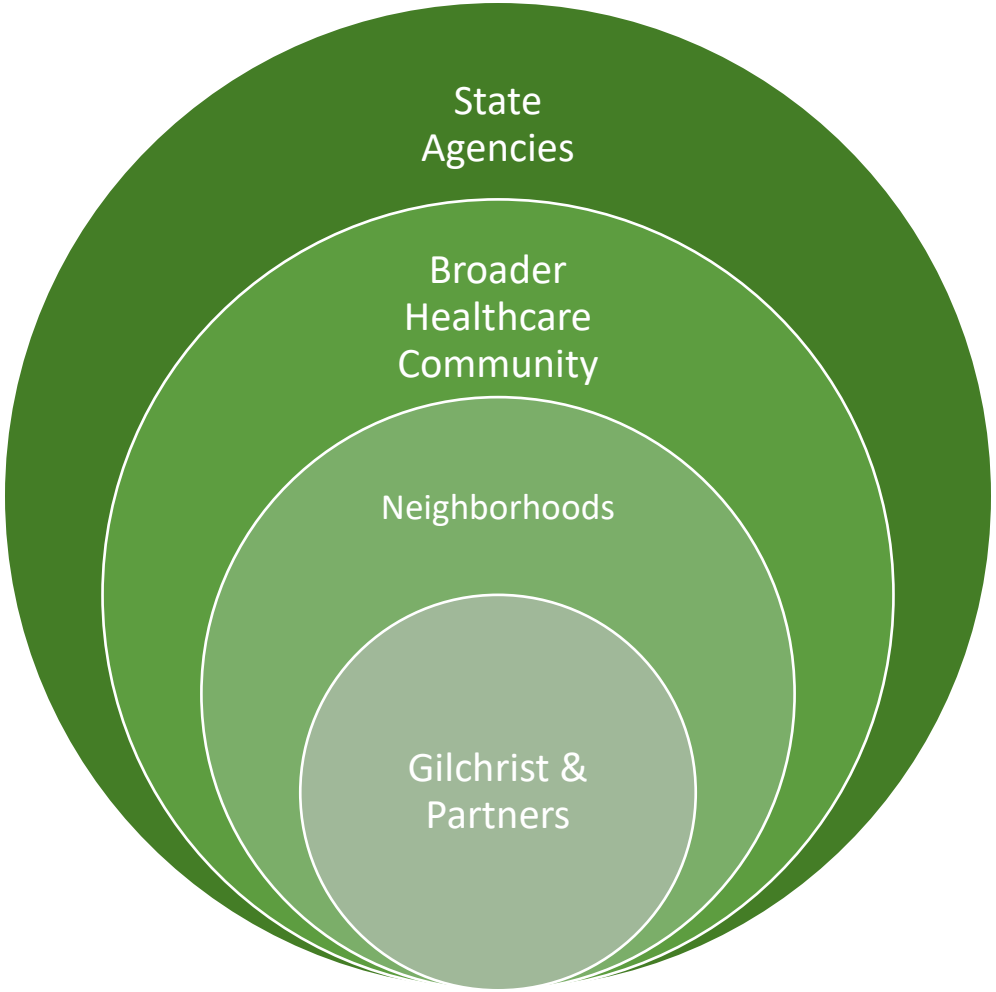
~30% of total Medicare spending is for last year of life

New Paradigms in Care Delivery: Palliative Care Expansion



- **Double the patients served**
- **Increase touchpoints**
- **Improve outcomes & experience**
- **Lower burdens & cost of care**

Statewide Palliative Care Education



gilchrist

Questions?

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Thank you

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MARYLAND ORGANIZATION
MONL
OF NURSE LEADERS

Vizient/AACN NRP™ & MONL Inc./ MNRC

September 10, 2025

History

2010 — **FUTURE OF NURSING REPORT**

2011 — **MARYLAND ACTION COALITION SUMMIT**

2013 — **MARYLAND ORGANIZATION OF NURSE LEADERS, INC.**

2013 — **VIZIENT/ AACN NRP™**

2017 — **WHO WILL CARE GRANT**

2018 — **ALL ACUTE CARE HOSPITALS IN MARYLAND**

Conceptual Framework

MARYLAND ORGANIZATION
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MNRC
Maryland Nurse
Residency Collaborative
Maryland Organization of Nurse Leaders, Inc. Special Committee

A transition to competency and professionalism

- Transition from advanced beginner to competent nurse
- Develop effective decision-making skills
- Provide clinical nursing leadership at the point of care
- Incorporate research-based evidence into practice
- Strengthen professional commitment to nursing
- Formulate an individual development plan

The year-long journey

High expectations

At 6 months

At 12 months competent practitioner

Longitudinal study of length of nurse residency program:

Goode, C., Lynn, M., McElroy, D., Bednash, G., & Murray, B. (2013). Lessons learned from 10 years of research on a post-baccalaureate nurse residency program. *Journal of Nursing Administration, 43*(2), 73-79. doi:10.1097/NNA.0b013e31827f205c

Source: 1) https://www.pinterest.com/pin/132011832806434969, 2) https://blog.employersolutions.com/keeping-medical-professionals-drug-free/ 3) https://www.goconqr.com/p/5289707-jobs-descriptions-flashcards---flash_card_decks

Structure

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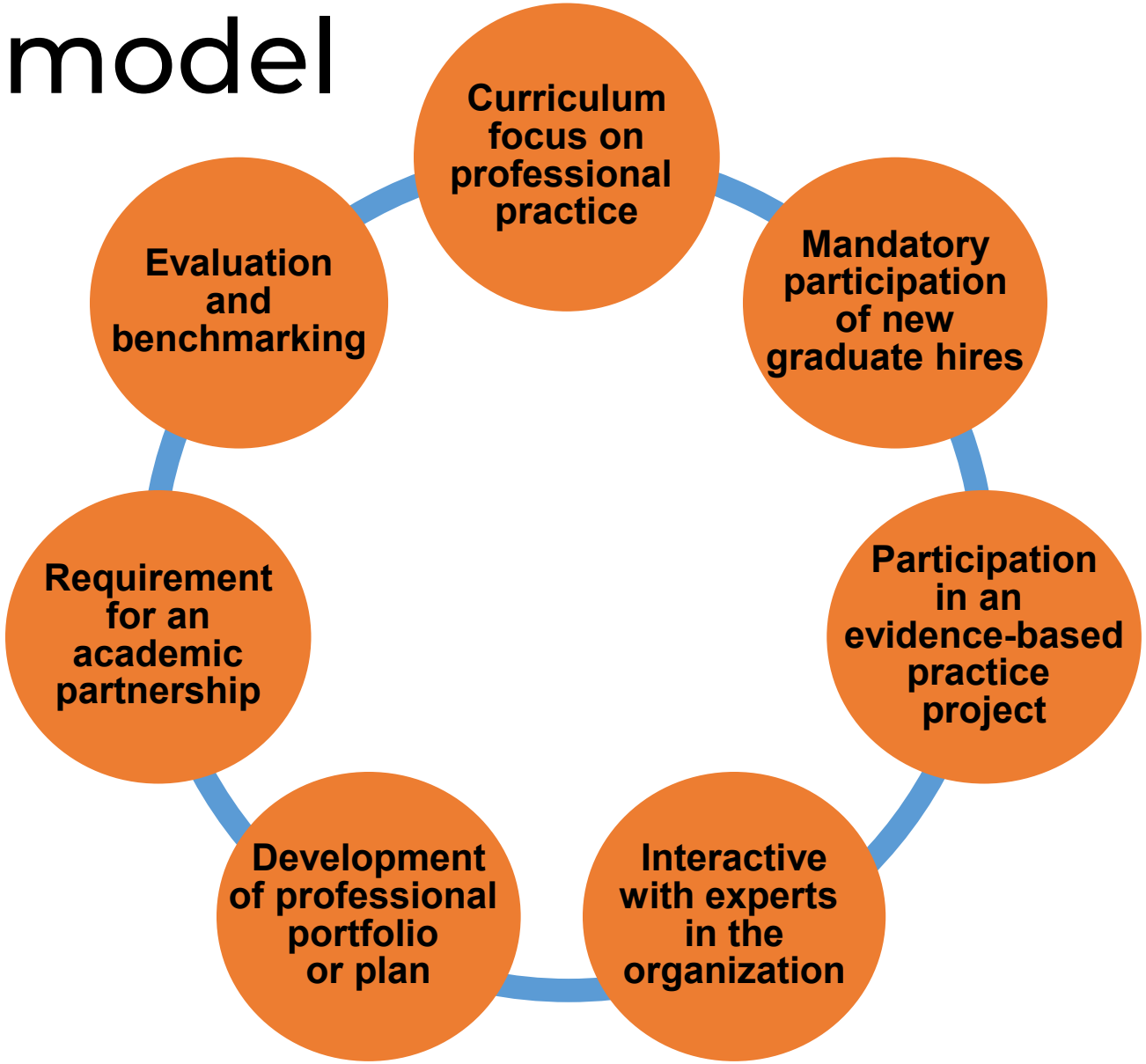
MNRC
Maryland Nurse
Residency Collaborative
Maryland Organization of Nurse Leaders, Inc. Special Committee

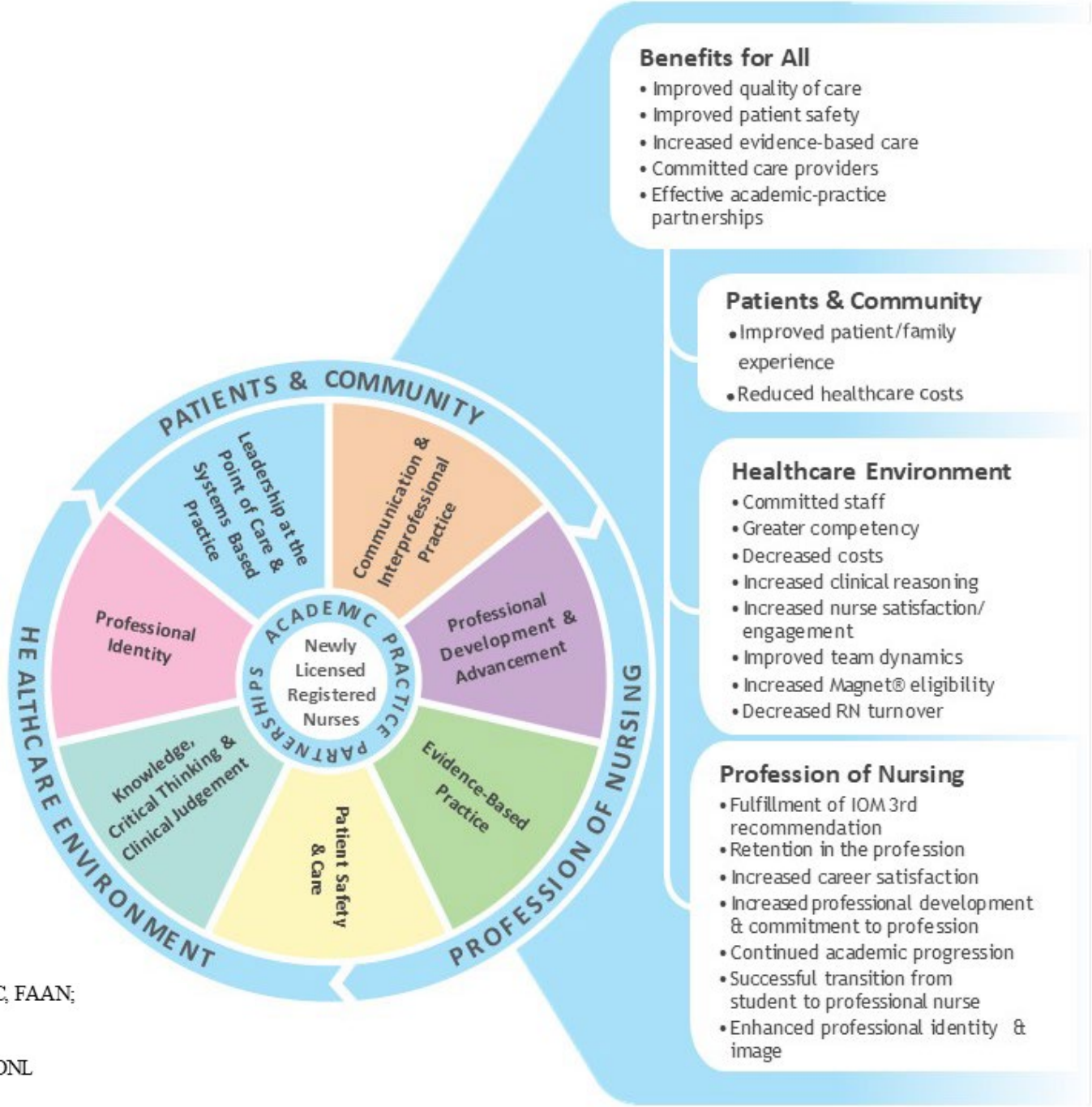
Structure of the Nurse Residency Program

- Builds upon the foundational knowledge from nursing school and focuses on leadership, patient outcomes and professional role
- Layered on top of orientation and skills training
- Monthly seminars for 12 months with same peer group
- Collaborative approach with nursing leadership, preceptors, coordinators, and facilitators to support the resident in a successful transition into practice
- Supports the new to practice nurse in their growth and development into a professional nurse and increases their confidence and their dedication to the nursing profession

Program model



Conceptual Framework for Evaluation and Benefits of the Vizient/AACN Nurse Residency Program™



Note: Developed by Developed by Erica Axilrod, MS, BA, RN; Joan I. Warren, PhD, RN-BC, NEA-BC, FAAN; Hussein M. Tahan, PhD, RN, FAAN, FCM; Jennifer S. Zipp, DNP, MS, RN

Outcomes & Return on Investment

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Maryland Organization of Nurse Leaders, Inc. Special Committee

Retention is a signature outcome of the Vizient/AACN Nurse Residency Program™

YEAR	RETENTION RATE		
	MNRC*	Vizient Nationally	NSI*
2020	90%	90%	78%
2021	91%	86%	68%
2022	89%	88%	67%
2023	91%	89%	66%
2024	89%	89%	78%

Return on Investment

	# Turnover (Residents)	Cost*
Vizient/ Maryland Retention (89%)	=379	33.5M
National Retention (78%)	~812	71.4M
Difference	~433	38.1M

- x 88,000 –(Jones, 2008)
- NSP spent 12.3M in FY’24

Resident Data

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Demographics

- 3460 Residents (54% BSN, 38% ADN)
- ADNs more likely to leave within the year
- Primarily into M/S, ED & Critical Care
- 16.3% UMSON, 7.7% CCBC, 7.6% Howard CC, 6.8% Towson

Compared to National

- Outperform/ Meeting benchmark on
  - 3/4 Casey Fink Domains- Higher at baseline stress
  - 6/6 Progression Domains (including Competence)
  - All domains of the Program Evaluation
- Rank Lack of Confidence as troublesome at baseline
- Rank Workload as troublesome at 12 months
  - Improved work environment would make them feel supported
- Most Satisfying-Peer Support
- Least Satisfying- Nursing Specific Dimensions (Unrealistic Ratios, tough schedule, futile care)

State-wide Leadership Data

MARYLAND ORGANIZATION
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Stakeholders

Supervisory
- nurse manager
- supervisor
- director
- lead
- CNO

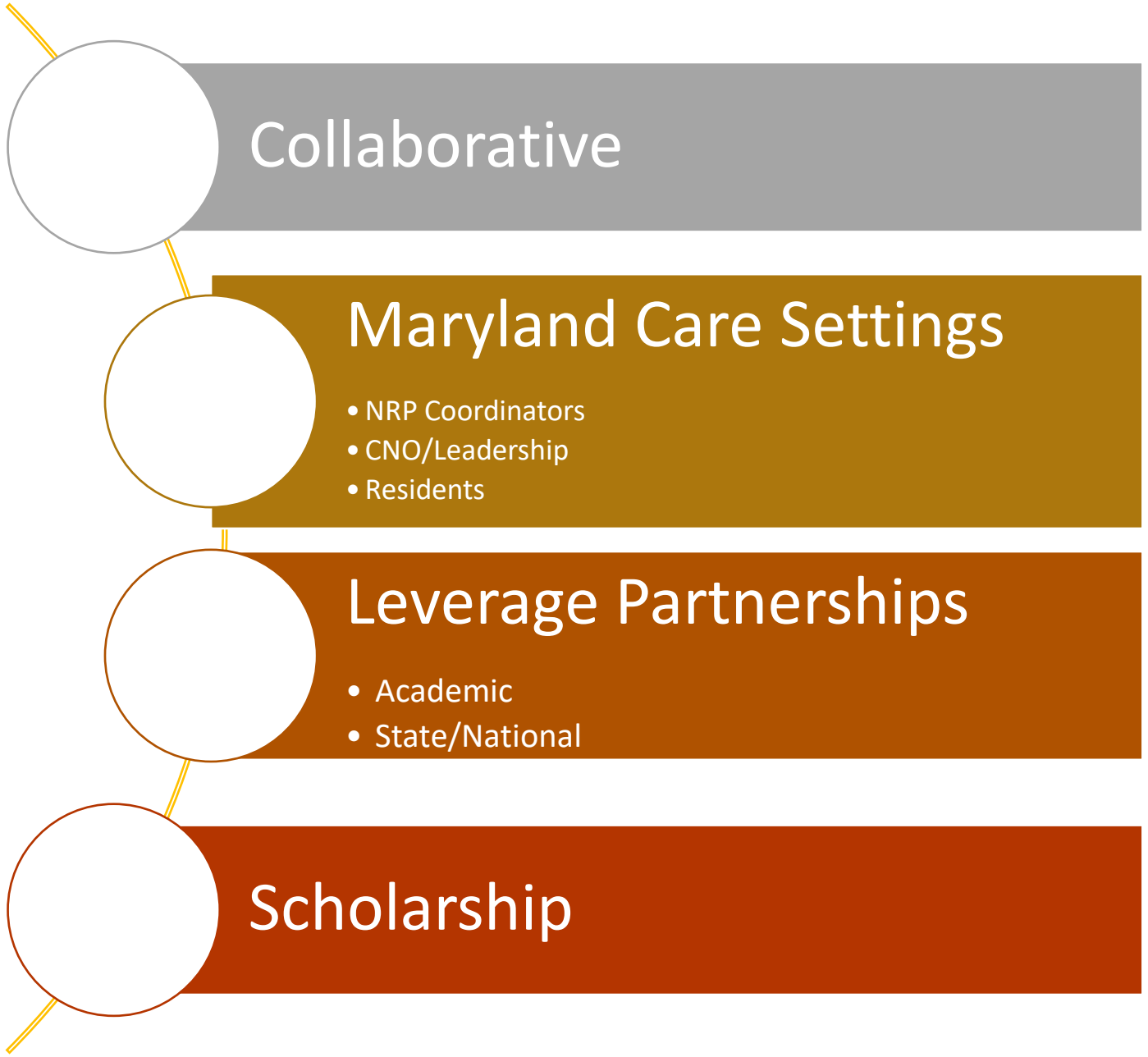
Educational
- staff nurse
- RN
- clinician
- CNS
- instructor
- educator
- facilitator
- preceptor

- N=772 (59% Supervisory, 41% Educational)
- Performed above benchmark in all domains:
  - Impact on Unit/ Insititution
  - Impact on Resident
  - Contribution of EBP Project
  - Leadership of NRP Graduates
  - View of the Program
- Supervisory more favorably than Educational

View of the Program

Question	Supervisory (MNRC/Nation)	Educational (MNRC/Nation)
Residents speak positively about the NRP	↑ 3.31/3.17	↑ 3.19/3.02
The NRP is considered an essential part of what we do here	↑ 3.55/3.39	↑ 3.41/3.32
The feedback I get from residents is that they appreciate the NRP	↑ 3.26/3.14	↑ 3.17/3.02
The NRP is a recruitment tool	↑ 3.40*/3.28	↑ 3.25/3.16

MNRC Support



Resources

MNRC

- About Us
- The Nurse Residency Program
- Hospital Members
- Coordinator Directory
- NRP New Coordinator Overview
- NRP Coordinator Resources
- MNRC Resources & Links
- Toolkits
- MNRC Conference 2024
- The MNRC Connection Podcast
- Universal Onboarding
- Contact MNRC

State-wide MNRC Advisory Board

Presentation Workshops

Networking & Partnerships

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MONL

Maryland Nurse Residency Collaborative
NRP Coordinator

2023 Meeting Schedule
Networking & Sign-in: 0800-0830
Meeting: 0830-1200

Friday, February 24, 2023: Adventist Healthcare White Oak Medical Center

Friday, April 28, 2023: Luminis Health Anne Arundel Medical Center _
*Larger Academic Partnership Meeting

Friday, June 23, 2023: TidalHealth Peninsula Regional

Friday, August 25, 2023: University of Maryland St. Joseph Medical Center

Friday, October 27, 2023: Mercy Medical Center
*Larger Academic Partnership Meeting

Friday, December 08, 2023: The Johns Hopkins Hospital OR Johns Hopkins Bayview Medical Center (TBD)

RESILIENT NURSES INITIATIVE
• MARYLAND •

Faculty & Research | Research | Centers | R3 Initiative

R³ - R³ Tools

The Johns Hopkins Nursing Evidence-Based Practice Model

JHEBP Online Course

This 5-module course is an engaging online experience, containing interactive elements, self-checks, instructional videos, and demonstrations. Learn how to put the JHEBP model and tools to use on your own schedule, where ever you are.

APPENDIX

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Seminars

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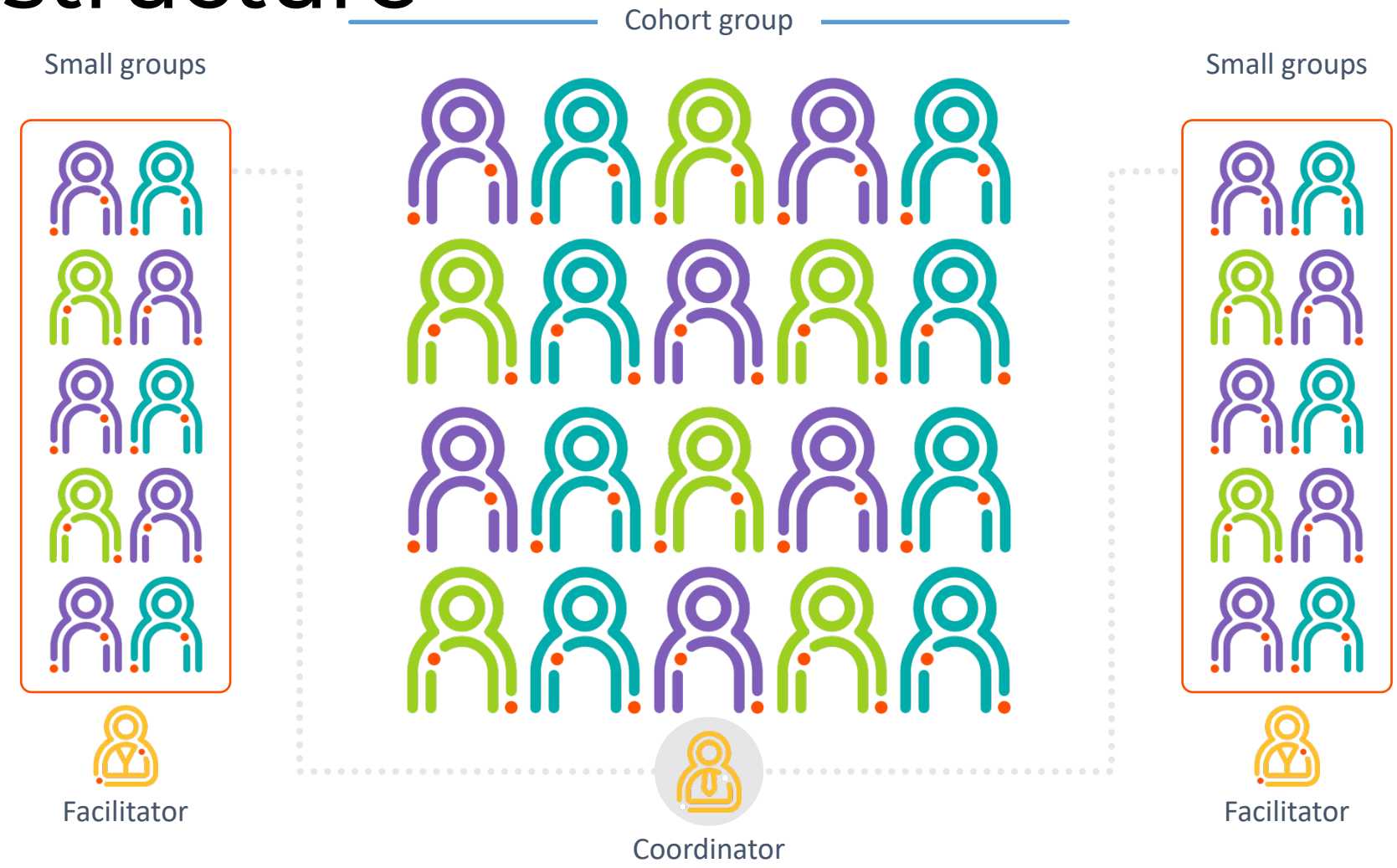
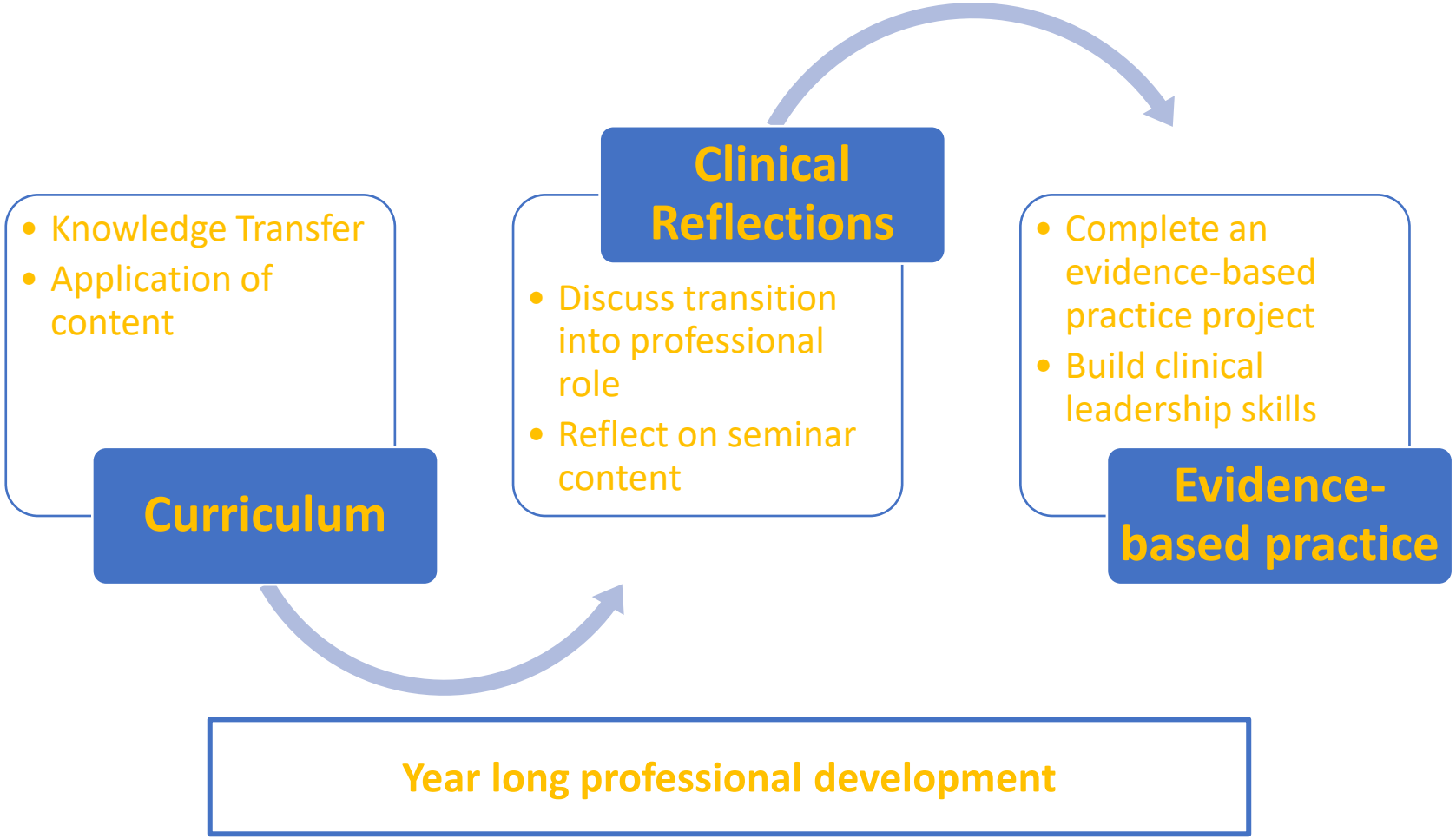
Residency Collaborative
Maryland Organization of Nurse Leaders, Inc. Special Committee

Nurse Residency Program structure



Seminar content



Curriculum and program emphasis

Quality outcomes

Leadership

Professional role

Evidence-based practice project

The curriculum’s content and competencies align with:

- **QSEN** (Quality and Safety Education for Nurses)
- **IPEC** (Interprofessional Education Collaborative)
- **CCNE** (Commission on Collegiate Nursing Education)
- **ANCC** (American Nurses Credentialing Center)
- **AACN** (American Association of Colleges of Nursing)

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Update on Medicare FFS Data & Analysis

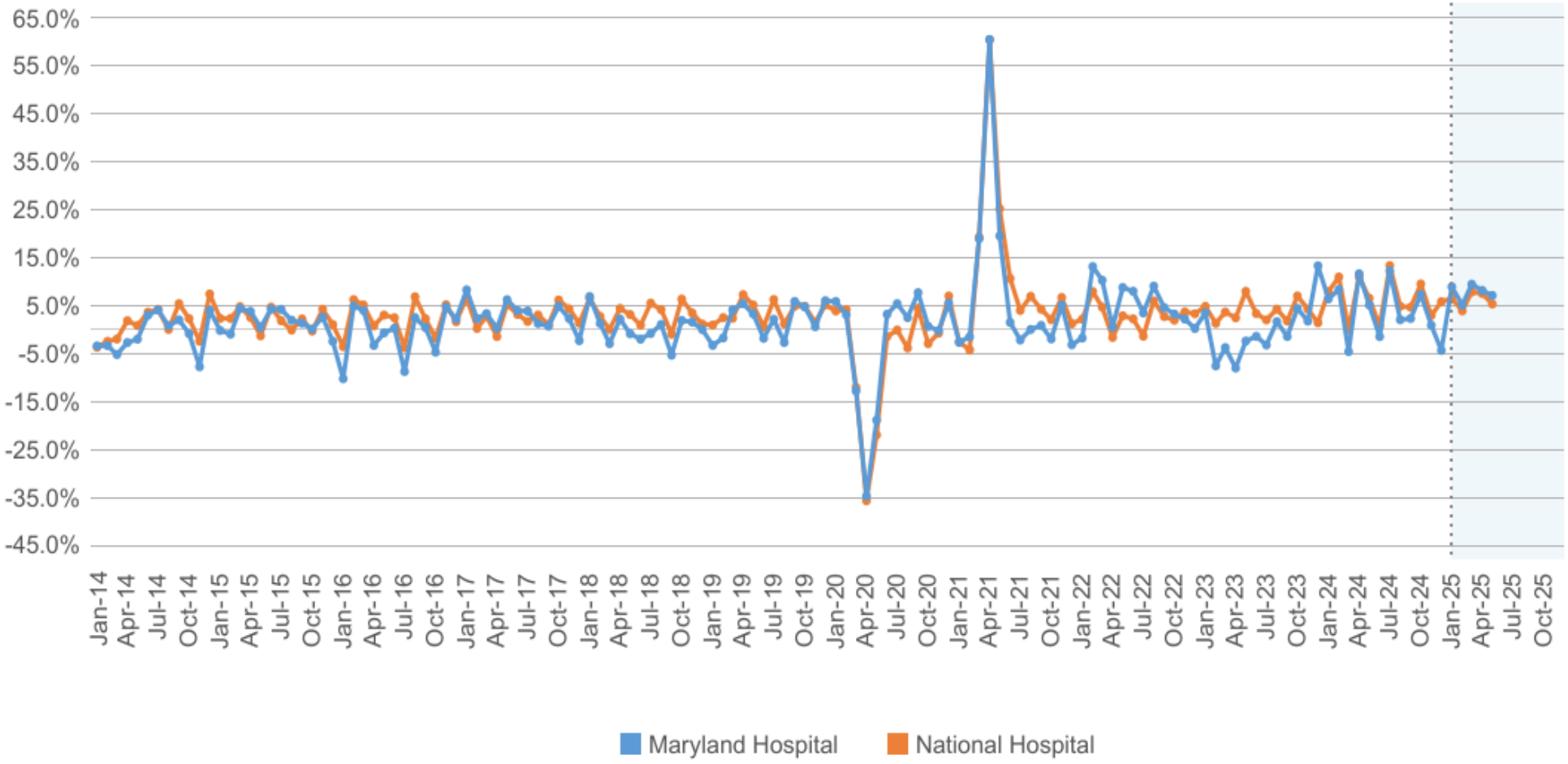
September 2025 Update

Data through May 2025, Claims paid through July 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

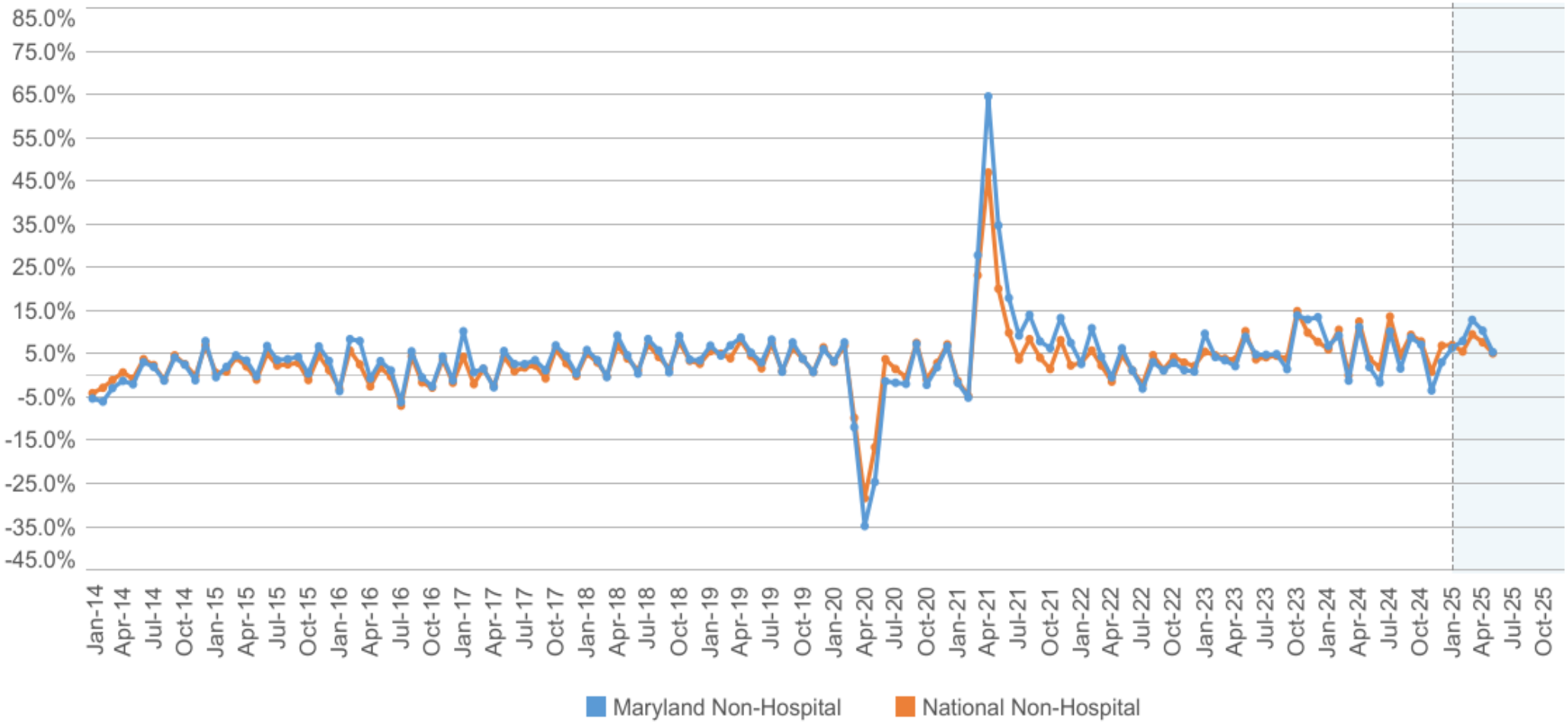
Actual Growth Trend (CY month vs. Prior CY month)



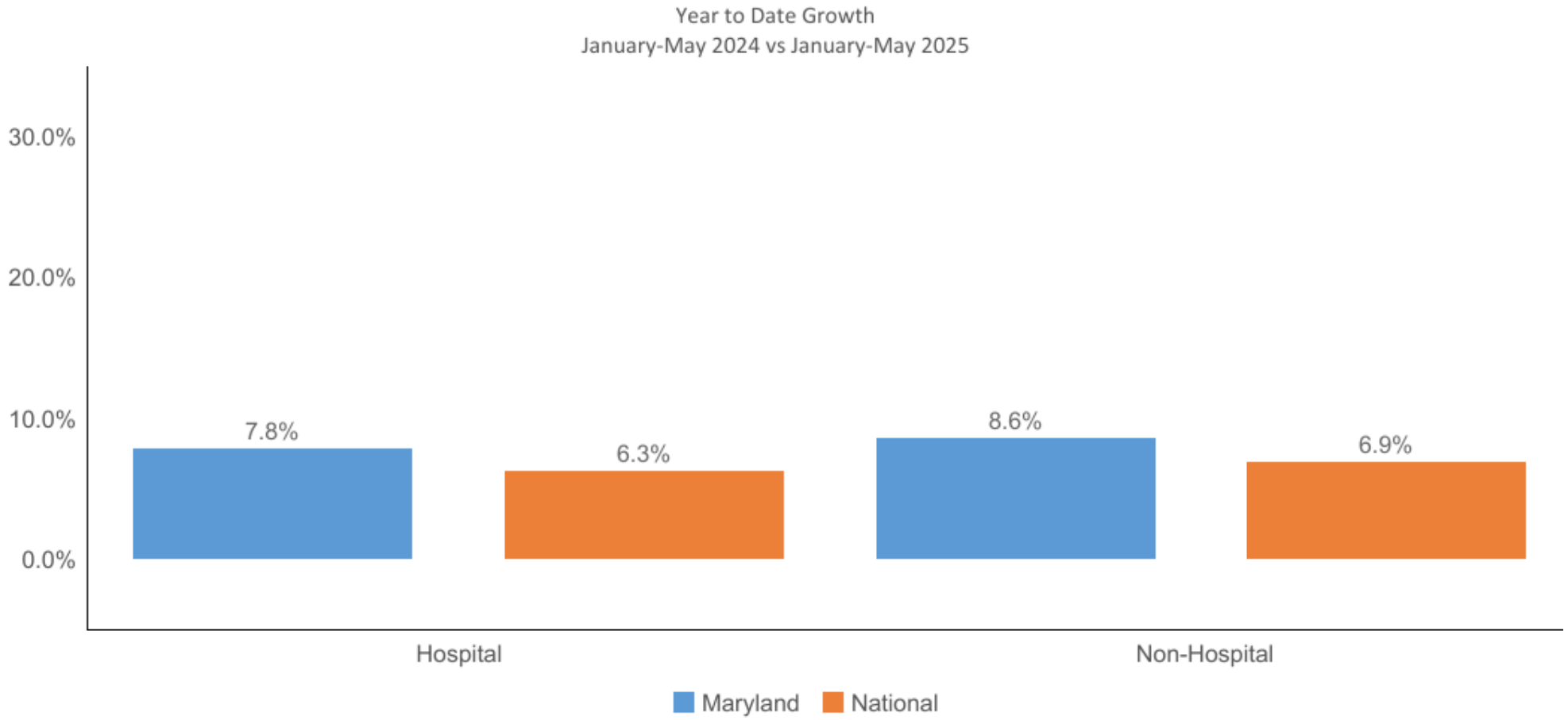
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

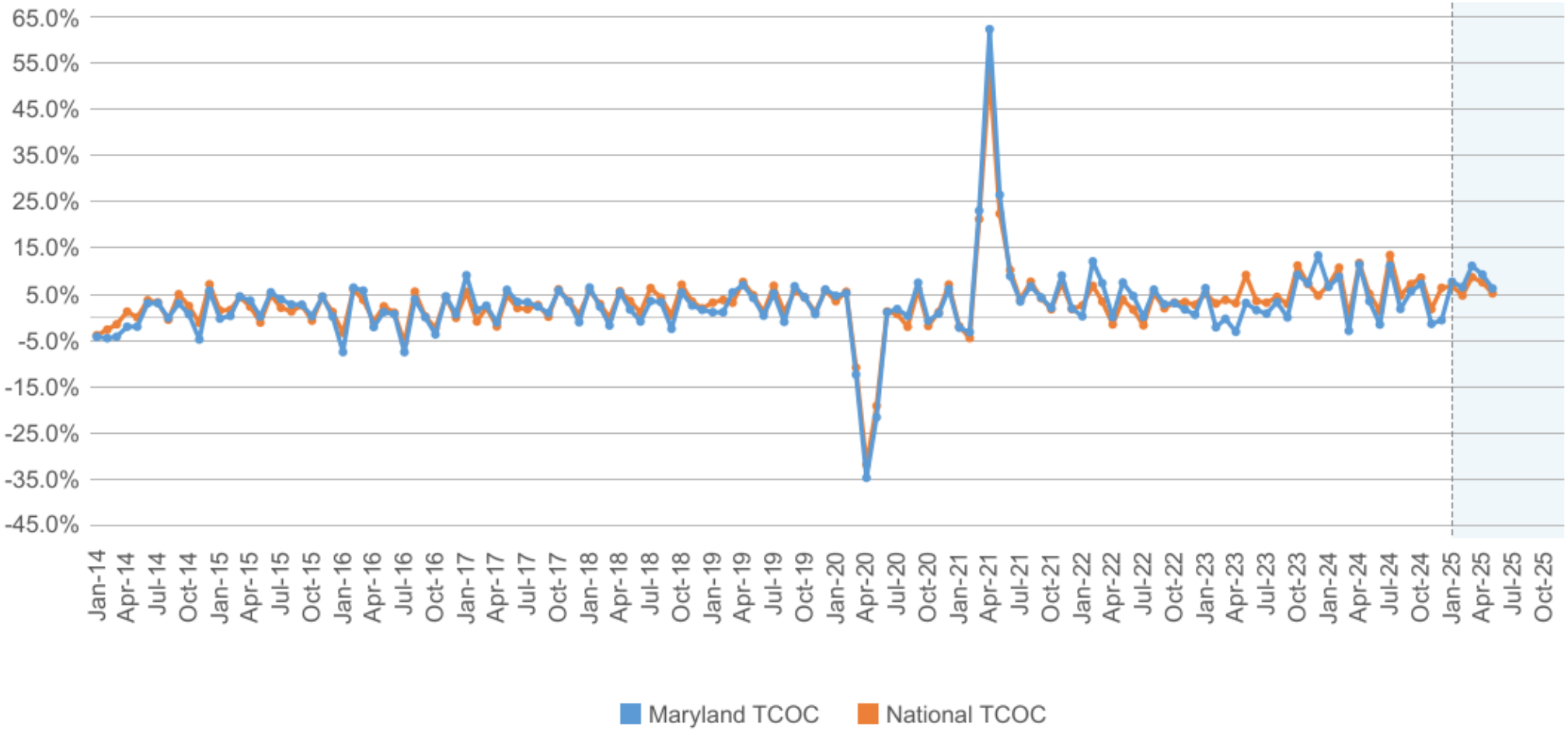


Medicare Hospital and Non-Hospital Payments per Capita



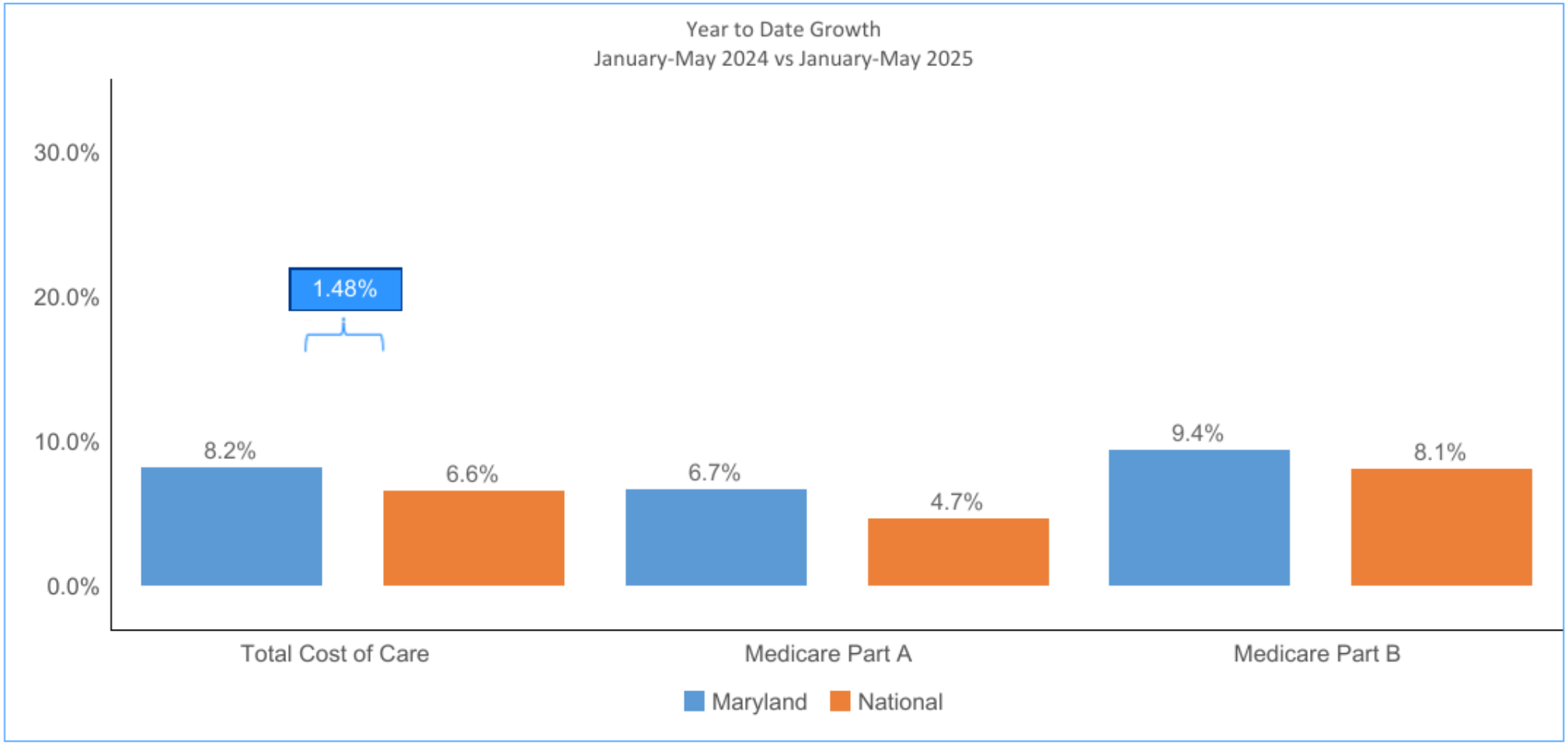
Medicare Total Cost of Care Spending per Capita

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



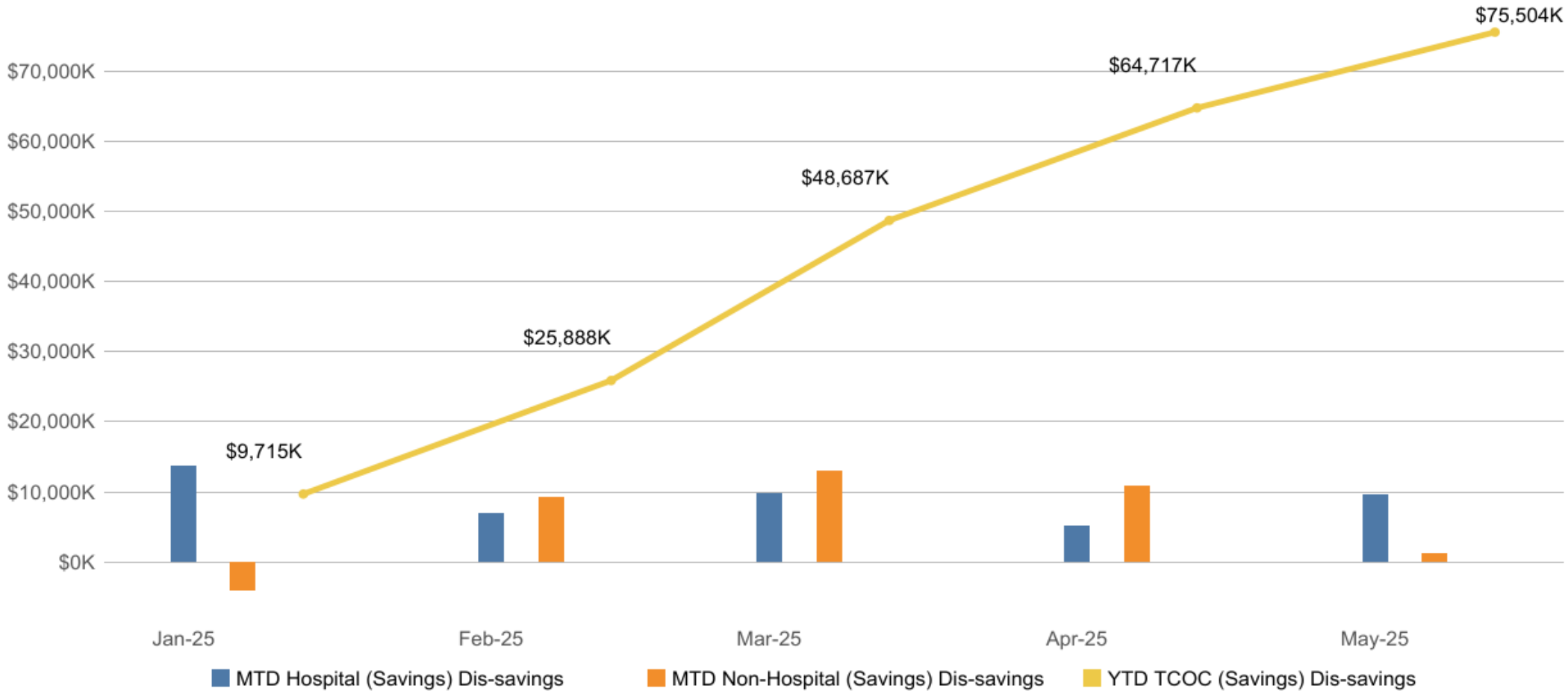
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through May 2025



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Nurse Support Program I

Annual Report on FY 2024 Activities

September 2025

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

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Table of Contents

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Introduction

Maryland's unique Nurse Support Program I (NSP I) was designed to address the short and long-term issues of recruiting and retaining nurses in acute care hospitals. Nearly $290 million in funds have been provided to hospitals in rates to support the NSP I initiatives since the program was implemented in June 2001. In May 2022, HSCRC Commissioners voted to approve NSP I as a permanent program requiring HSCRC to provide annual reports on funded activities and accomplishments. This report summarizes NSP I activities and performance against program metrics during Fiscal Year (FY) 2024.

Background

Launched in 2001, the Nurse Support Program I (NSP I) was created by the HSCRC to strengthen the hospital nursing workforce through targeted recruitment and retention initiatives. Each year, hospitals can access up to 0.1 percent of their gross patient revenue, added to hospital rates, to fund approved NSP I projects. These investments support activities aligned with the program's goals and have enabled hospitals to make substantial progress in expanding and sustaining Maryland's hospital-based RN workforce over the past two decades.

In 2010, the Institute of Medicine (IOM) published the *Future of Nursing* report, which laid out various recommendations to address the increasing demand for high-quality and effective healthcare services and provided an action-oriented blueprint for the future of nursing. The HSCRC incorporated four of the recommendations into the scope of the NSP I program in 2012:

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

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

1. **Education and Career Advancement.** This area includes initiatives that increase the number of advanced degree nurses, prepare them as future leaders, recruit and retain newly licensed nurses through nursing residency programs, and support nursing students and experienced RNs re-entering the workforce after extended leave.
2. **Patient Quality and Satisfaction**. This area includes lifelong learning initiatives such as certification and continuing education, which are linked to improved nursing competency and better patient outcomes.

3. **Advancing the Practice of Nursing.** The activities in this area focus on preparing nurses to advance healthcare delivery, for example, through nurse-driven evidence-based research, innovative organizational structures for clinical nurses to have a voice in determining nursing practice, standards, and quality of care, and the American Nurses Credentialing Center's (ANCC) Magnet® and Pathway to Excellence programs, which demonstrate nursing excellence.

With input from the NSP I Advisory Committee, staff developed nursing and organizational metrics to assess hospitals' progress in achieving these program aims. Performance against those metrics is provided later in this report. NSP I staff also work closely with the Maryland Higher Education Commission (MHEC) to administer the Nurse Support Program II (NSP II), which aims to increase Maryland's academic capacity to educate nurses and increase faculty at Maryland institutions.

FY 2024 Programs & Activities

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

1. **Continuing Education (Internal & External):** Funding supports education on various subjects, including evidence-based practices, patient safety, disaster preparedness, quality indicators, patient experience, and workplace violence. These education opportunities may be offered internally within the hospital or externally through statewide and/or national conferences hosted by leading organizations in the nursing field. Continuing education hours are increasingly provided online and are self-paced for participants, which allows practicing nurses to more easily stay current with best practices to provide optimal patient care.
2. **Leadership, Preceptorship, Mentorship Programs**: Funding supports regular training (e.g., workshops and quarterly education sessions) for nurses to develop essential leadership skills for building positive workplaces. These programs also coach nurses to become preceptors and mentors, which is critical to new nurses and the nurse residency program. Additionally, funding may support preceptor and mentor positions. Funded mentor and preceptor roles provide an avenue for hospitals to retain the expertise of retiring nurses as new staff are trained and grow in their roles.
3. **Nurse Residency Program for Newly Licensed Registered Nurses (RNs)**: The Nurse Residency Program is a one-year program that supports acquiring knowledge, skills, and attitudes necessary to successfully transition nursing students into clinical settings and develop core competencies in the field of nursing. Nurse residents attend lectures from clinical experts, participate in one-to-one clinical preceptorship, and conduct a one-year evidence-based research project to advance nursing. The NRP is a critical program that uses evidence-based techniques to

guide the acquisition of new competencies necessary to promote safe practice and individual growth and development of new nurses.

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

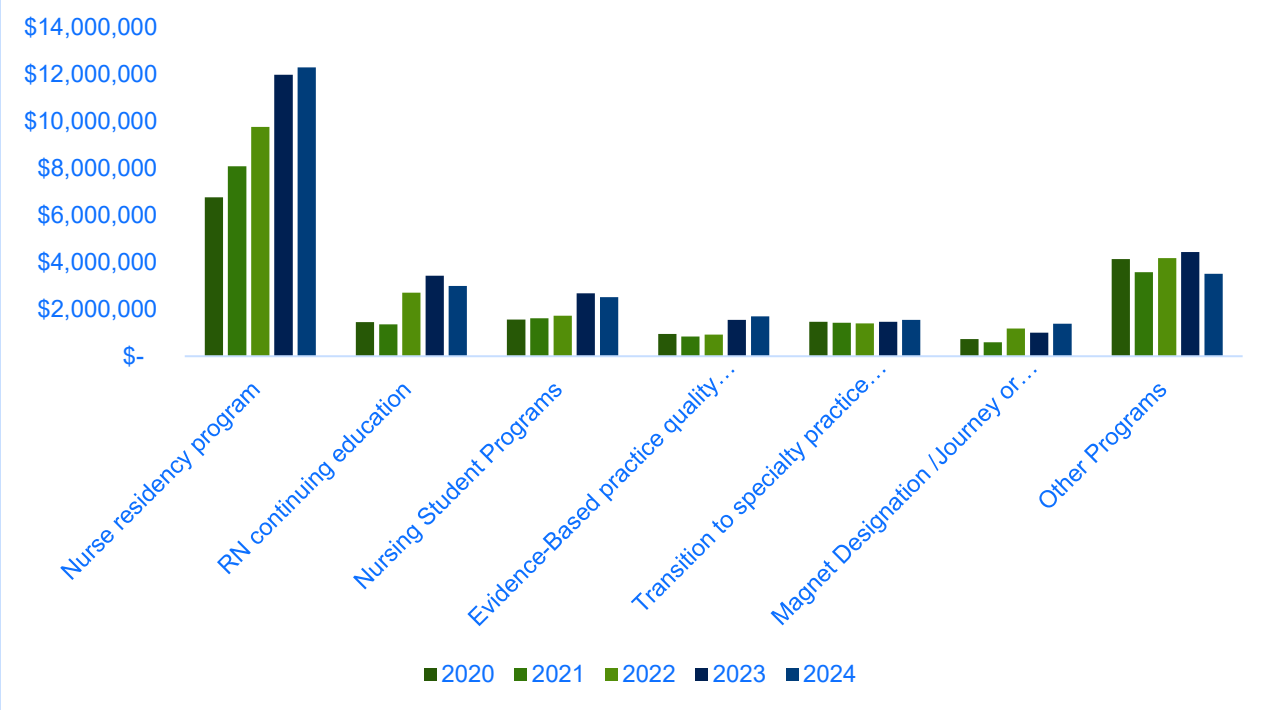
continually." Programs include Magnet® and Pathway to Excellence®. NSP I supports nursing education about nursing excellence programs and innovative projects to achieve Magnet or Pathway to Excellence.

In FY 2024, all hospitals prioritized supporting new entrants to the nursing workforce by implementing a nurse residency program for newly licensed RNs. Additionally, many hospitals provide leadership, preceptorship, and mentorship programs, as well as nursing student programs. Professional advancement was another key focus, as many hospitals funded continuing education and advanced degree programs for current staff. A collective focus on education and career advancement is expected, given nursing workforce shortages and the urgent need to attract new nurses and retain experienced staff.

Expenditures

In FY 2024, HSCRC issued $19.9 million in total funding to acute care hospitals. The top-funded programs in FY 2024 included 1) nurse residency programs, 2) RN continuing education, 3) nursing student programs, 4) evidence-based practice quality improvement, 5) transition to specialty practice programs, and 6) Magnet® designation/journey and Pathway to Excellence. Figure 1 and Table 1 show FY 2020 through FY 2024 program expenditures.

Figure 1. NSP I Program Expenditures, FY 2020 - 2024



Source: Hospital NSP I Annual Reports

Table 1. NSP I Program Expenditures, FY 2020 - 2024

Programs	2020	2021	2022	2023	2024
Nurse residency program	$6,764,270	$8,095,171	$9,775,301	$11,992,219	$12,301,920
RN continuing education	$1,450,660	$1,362,360	$2,711,942	$3,425,472	$2,988,935
Nursing Student Programs	$1,562,583	$1,620,120	$1,728,939	$2,674,706	$2,521,530
Evidence-Based practice quality improvement	$954,756	$839,378	$921,317	$1,543,065	$1,700,723
Transition to specialty practice Programs	$1,460,928	$1,420,664	$1,402,766	$1,465,457	$1,550,097
Magnet Designation /Journey or Pathway to Excellence	$737,416	$596,476	$1,183,548	$1,000,840	$1,380,706
Other Programs	$4,138,211	$3,581,232	$4,173,955	$4,439,854	$3,512,888
TOTAL	**$17,068,824**	**$17,515,401**	**$21,897,768**	**$26,541,613**	**$25,956,799**

Source: Hospital NSP I Annual Reports

Performance Results

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

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

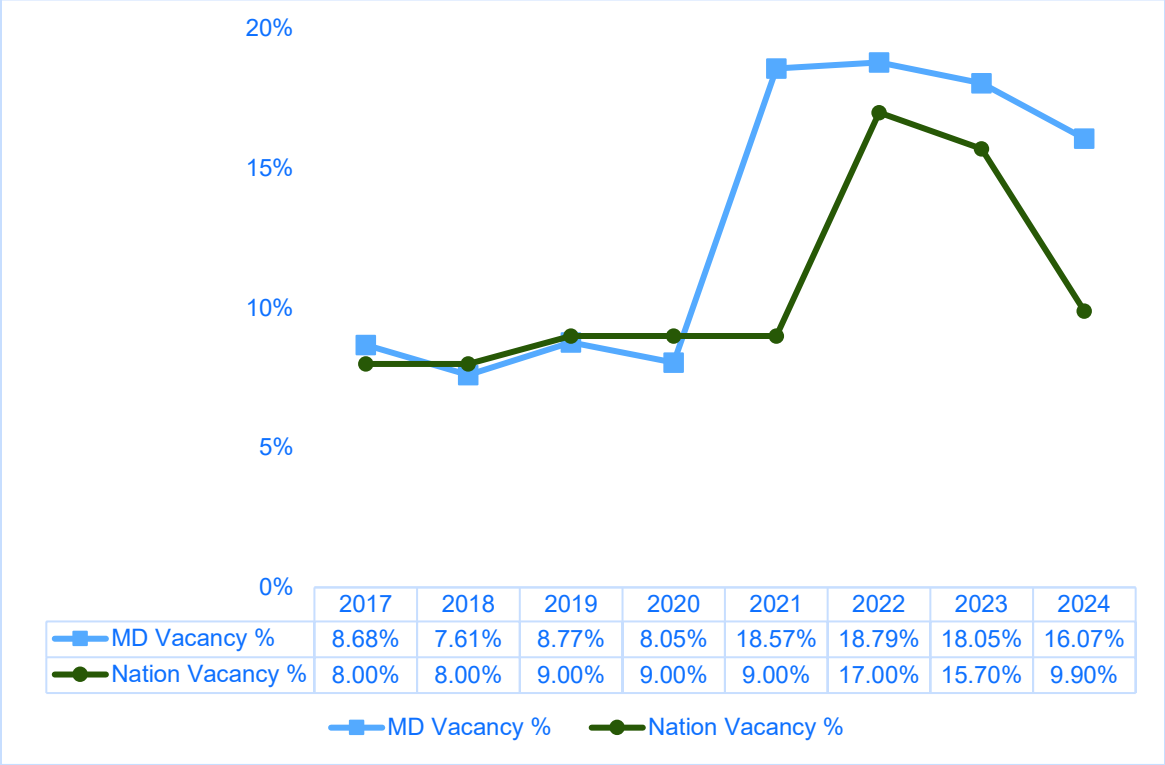
Vacancy, Turnover, & Retention Rates[1]

Maryland's FY 2024 hospital RN vacancy rate (16 percent) declined from 18 percent in FY 2023; however, it remains above the nation's vacancy rate (9.9 percent), which experienced a greater decline from 2023

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

(Figure 2). While Maryland's hospital vacancy rate exceeds the national average, more than forty percent (41.4 percent) of hospitals nationally reported a vacancy rate greater than ten percent.[2]

Figure 2. Registered Nurse Vacancy Rate in Hospitals, MD vs. Nation, 2017 - 2024



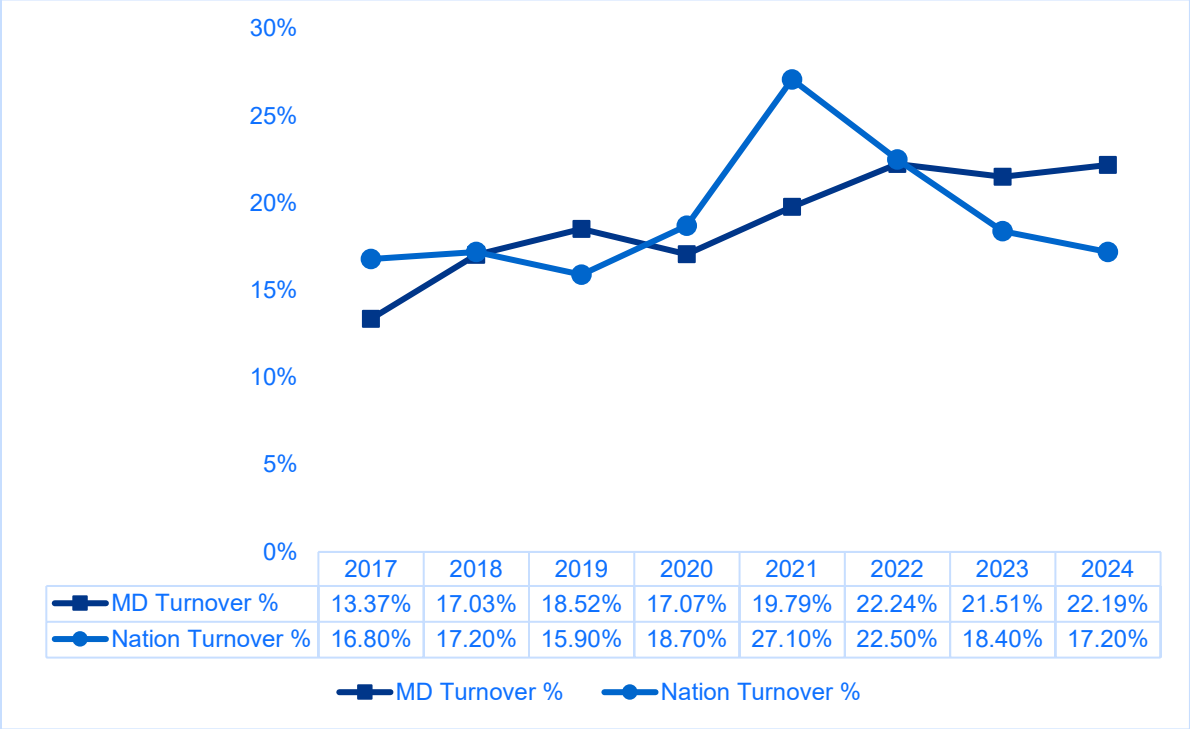
	2017	2018	2019	2020	2021	2022	2023	2024
MD Vacancy %	8.68%	7.61%	8.77%	8.05%	18.57%	18.79%	18.05%	16.07%
Nation Vacancy %	8.00%	8.00%	9.00%	9.00%	9.00%	17.00%	15.70%	9.90%

Source: Hospital NSP I Annual Reports, NSI Nursing Solutions

The Maryland RN turnover rate increased slightly between FY 2023 (21.51 percent) and FY 2024 (22.19 percent) but has been relatively stable over the last three years. While the average staff RN turnover rate for the nation is 16.4 percent, NSI reports that turnover rates can range between 5.2 percent and 36.4 percent across the country.

[2] Nursing Solutions Inc. (2025) *2025 NSI National Healthcare Retention and RN Staffing Report.* https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed July 12, 2025.

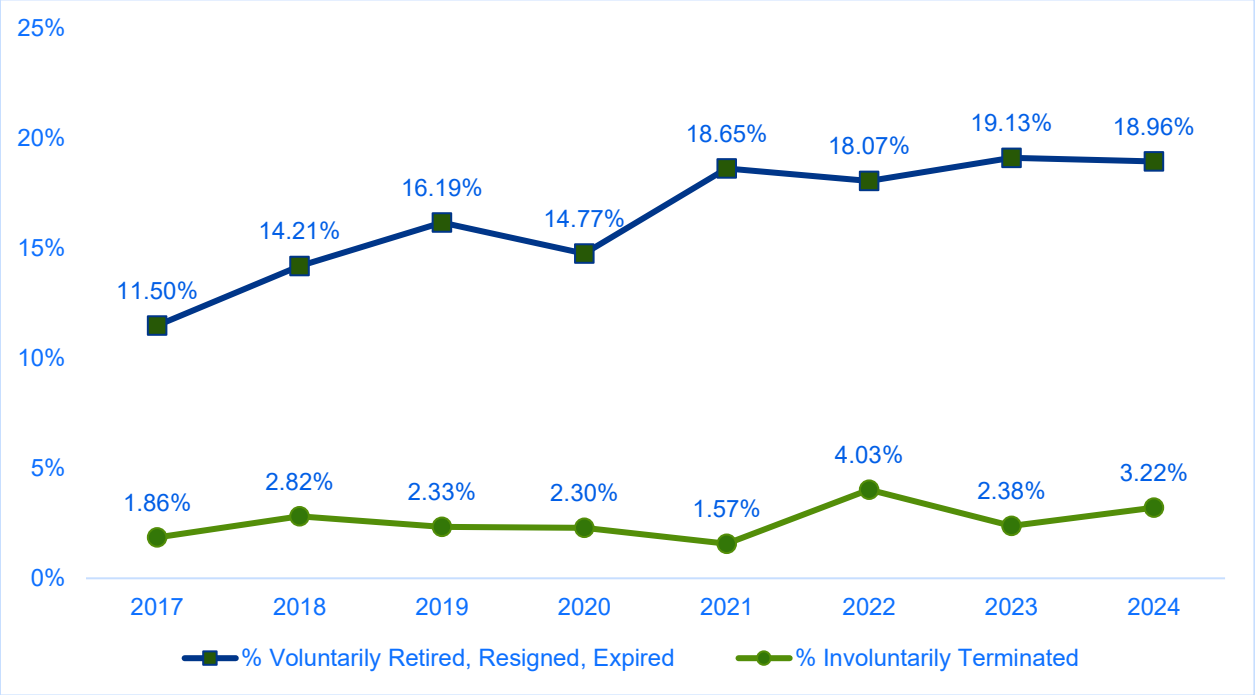
Figure 3. Hospital RN Turnover Rate, MD vs. Nation, FY 2020-2024



Source: Hospital NSP I Annual Reports, NSI

Figure 4 shows that voluntary departures have remained relatively stable since 2021. Involuntary terminations increased over the prior year but remain below FY 2022 performance; roughly 300 more RNs left nursing roles in FY 2024 compared to FY 2023. While more nurses left hospitals in FY 2024 than in FY 2023, the total number of RN FTEs grew by nearly 1,000.

Figure 4. RN Turnover Rate, Voluntary & Involuntary, FY 2020 - FY 2024

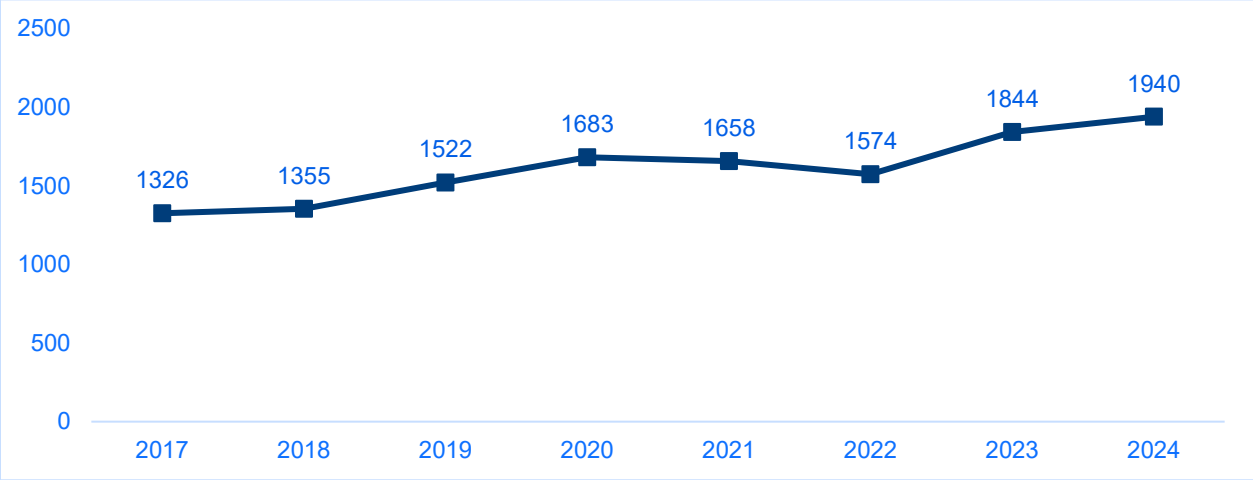


Source: Hospital NSP I Annual Reports

Nurse Residency Programs

A key strategy to support new-to-practice nurse retention is nurse residency programs. All NSP I hospitals implement the Vizient/AACN NRP™ and report that this program is essential in training and retaining new nurses at hospitals. In FY 2024, hospitals reported hiring and graduating more new-to-practice nurses through a nurse residency program (1,940 nurses) than at any point over the last eight years, a growth of 46 percent over FY 2017 nurse residents (1,326) (Figure 5). In FY 2024, NRP funding reached $12.3 million (47 percent of total reported spending), more than double the $5.6 million (30 percent) reported in 2017.

Figure 5. New Nurses Participating in RN Residency Program, FY 2017-2024



Source: NSP I Reports

NRP completion rates in Maryland continue to show strong performance. Since 2020, national retention rates for first-year nurses with or without an NRP have ranged from 66 percent to 78 percent. In contrast, national data from Vizient/AACN NRP™ shows retention rates of 89-90 percent for nurses participating in the Vizient/ AACN NRPs. Maryland has consistently performed at or above the national average, with some years exceeding national outcomes. Data from the Maryland Organization of Nurse Leaders Inc./Maryland Nurse Residency Collaborative (MONL Inc./MNRC), measured by calendar year, show an 89 percent completion rate in FY 2024. Since 2020, Maryland's completion rate has never fallen below 89 percent. Both MNRC and Vizient measure completion as the successful conclusion of the first year of the NRP.

Table 2. Nurse Residency Program Completion Rates, CY 2020-2024

YEAR	Maryland NRP	National NRP	Nation, No NRP
2020	90%	90%	78%
2021	91%	86%	68%
2022	89%	88%	67%
2023	91%	89%	66%
2024	89%	89%	78%

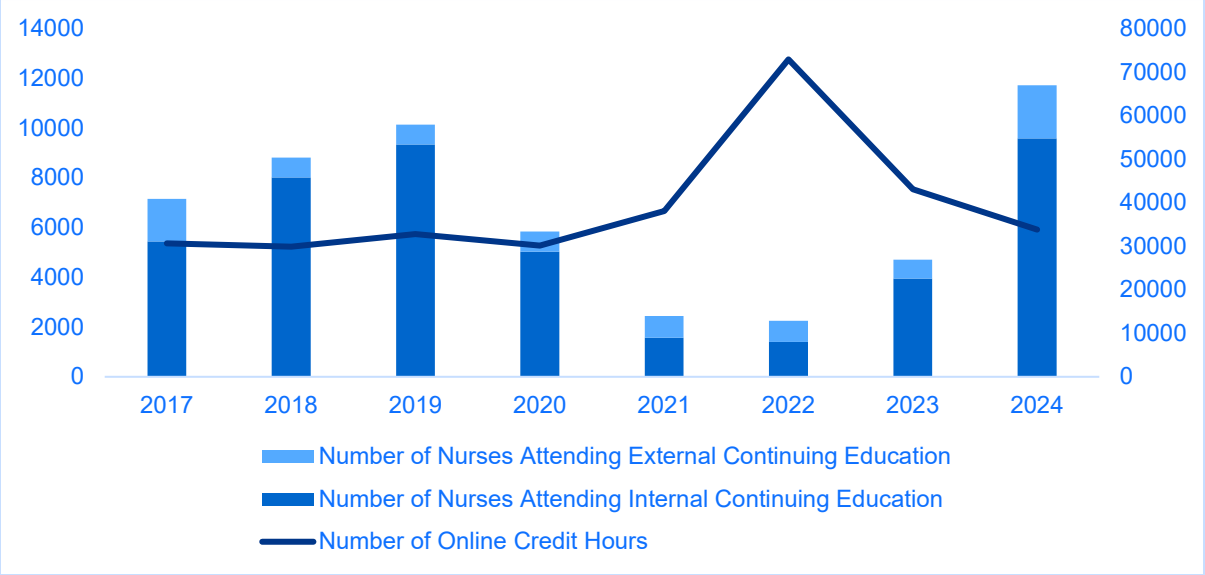
Source: MONL Inc./MNRC, Vizient/AACN NRP™, Nursing Solutions Inc. (NSI)

Because data reported to the HSCRC is captured by fiscal year and NRPs are measured by Vizient™ on a calendar year, the MNRC and Vizient data are the most reliable source of retention data on nurse residencies.

Continuing Education

Support for continuing education remains a priority for hospitals. Funding for these initiatives more than doubled between FY 2020 and FY 2024, despite a decline from FY 2023 (Table 1). While the number of online credit hours declined in FY 2024 (Figure 7), the number of nurses participating in continuing education more than doubled compared with the previous year. The surge in online credit hours between 2020 and 2022 reflected hospitals' increased reliance on in-house, remote learning during the pandemic, when external and in-person opportunities were limited. By FY 2024, both the distribution of online credit hours and attendance at external and internal continuing education events has returned mainly to pre-pandemic patterns.

Figure 7. Continuing Education Participants and Online Credit Hours, FY 2017 - 2024



Number of Nurses with BSN and Advanced Degrees

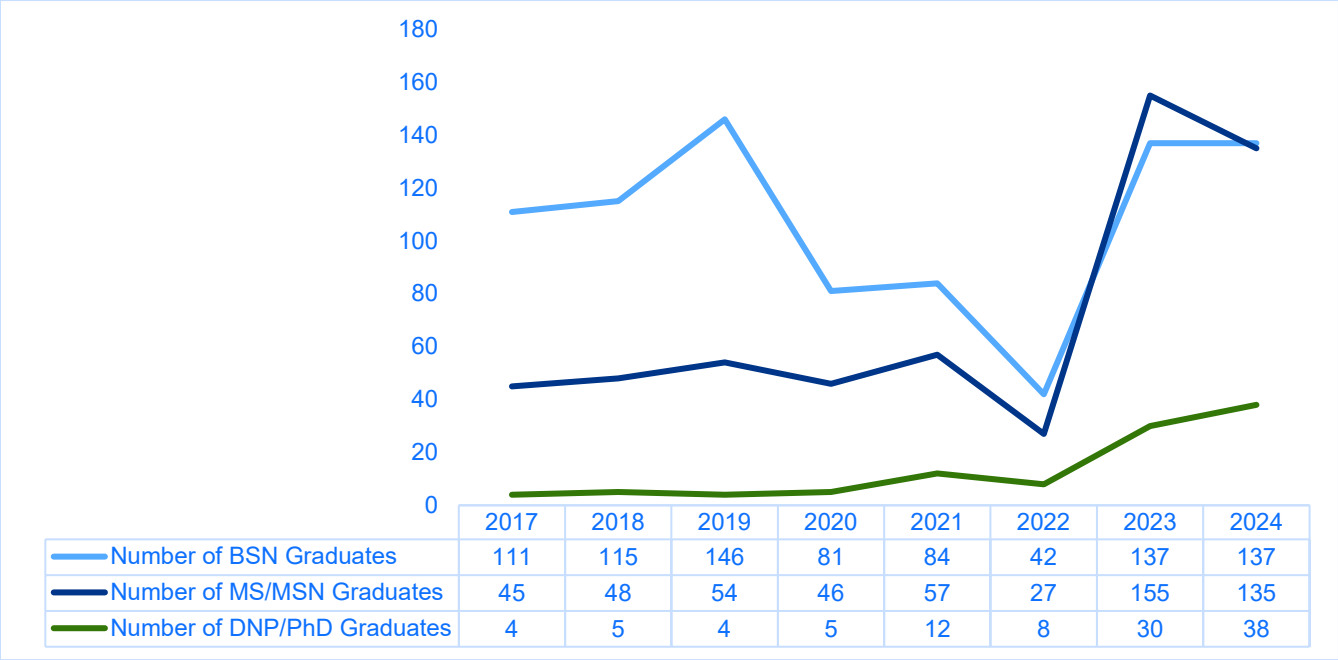
Another key goal of the *Future of Nursing* recommendations was to increase the number of nurses with advanced degrees. Strong research evidence has linked lower mortality rates, fewer medication errors, and positive outcomes to nurses prepared at the baccalaureate and graduate degree levels.[3] Quality patient care hinges on a well-educated, highly functioning, motivated nursing workforce. Figure 8 shows the

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

number of BSN, MS/MSN, and DNP/PhD degrees funded by NSP I between FY 2017 and FY 2024. While the number of BSNs supported by NSP I shows a return to pre-pandemic numbers, MSNs and DNP/PhD degrees show continued growth that far exceeds levels before 2020, indicating that hospitals are increasingly prioritizing advanced nursing degrees.

In the NSP II Outcomes Evaluation and Program Renewal Recommendation,[4] staff highlighted feedback from Maryland's Chief Nursing Officers (CNOs), who emphasized the importance of the BSN as the minimum education standard. They further emphasized that the proportion of BSN-prepared nurses is a key factor in achieving Magnet Recognition Program® designation. They also emphasized that nurses with a BSN or higher degree bring enhanced skills in leadership, quality improvement, critical thinking, evidence-based practice, professionalism, case management, and collaboration.

Figure 8. NSP I Funded Degree Type, FY 2017 - 2024



	2017	2018	2019	2020	2021	2022	2023	2024
Number of BSN Graduates	111	115	146	81	84	42	137	137
Number of MS/MSN Graduates	45	48	54	46	57	27	155	135
Number of DNP/PhD Graduates	4	5	4	5	12	8	30	38

In FY 2023, there was a dramatic increase in advanced degrees, which was sustained in FY 2024; this confirms the report from hospitals in FY 2022 that they had several nurses pursuing advanced degrees. Maryland continues progressing steadily toward the "80 Percent BSN by 2025" goals through the NSP II Program. In Maryland, 78.2 percent of nurses responding to the National Nursing Workforce Survey had a BSN or higher degree in 2024, compared to the nation at 51.5 percent (2022 data).

[4] HSCRC and MHEC staff are working to implement these recommendations as part of the FY 2027 cycle for competitive institutional grants and faculty-focused awards.

Enhanced Diversity in the Nursing Workforce

A diverse nursing workforce directly strengthens healthcare delivery. Nurses from different cultural and linguistic backgrounds provide more culturally sensitive care, improve communication and trust with patients, and are better able to identify and address health disparities, particularly in underserved communities. A key recommendation of IOM is to develop initiatives to address health disparities by increasing the number of minorities and men in all nursing roles. Specifically, NSP I programs can implement initiatives to:

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

The gender composition of Maryland hospital registered nurses closely reflects that of the state's overall nursing workforce. HRSA data from 2022[5] indicate that approximately 9 percent of Maryland nurses are male. Across all reporting years, hospitals have generally reported similar gender representation at all nursing levels, except for nurse executives in 2021, suggesting consistent alignment between hospital staffing and the broader workforce.

Table 3. Percent of Nursing Role by Gender, FY 2020 - 2024

	Gender	2020	2021	2022	2023	2024
Clinical Nurses	Male	9.62%	9.54%	9.62%	9.92%	10.70%
	Female	90.38%	90.46%	90.38%	90.08%	89.30%
Nurse Managers	Male	7.71%	8.94%	9.61%	9.21%	9.68%
	Female	92.29%	91.06%	90.39%	90.79%	90.32%
Nurse Executives	Male	10.44%	7.76%	9.21%	10.62%	9.12%
	Female	89.56%	92.24%	90.79%	89.38%	90.88%

Source: Hospital NSP I Reports

There has been limited growth in racial and ethnic diversity within nursing roles in Maryland hospitals, as shown in Tables 4–6. Additionally, the race and ethnicity composition of hospital-based RNs does not fully reflect the diversity of Maryland's overall nursing workforce. For example, while 33 percent of Maryland's

[5] U.S. Department of Health and Human Services, Health Resources and Services Administration, Nursing Workforce Dashboard, National Center for Health Workforce Analysis, accessed August 19, 2025, https://data.hrsa.gov/topics/health-workforce/nchwa/nursing-workforce-dashboard

nursing workforce identifies as non-Hispanic Black,[6] representation is notably lower across most nursing roles in hospitals. Clinical nurses have the highest share at 22.05 percent, still well below the statewide level. Similarly, although 6 percent of Maryland's nursing workforce identifies as Hispanic,[7] hospitals report that only 3 percent of clinical RNs are Hispanic, with even lower representation at the nurse manager and executive levels.

Table 4. Percent of Clinical Nurses by Race/Ethnicity, FY 2020 - 2024

	2020	2021	2022	2023	2024
NH Black	21.06%	20.53%	19.50%	21.57%	22.05%
NH White	62.01%	61.51%	60.45%	57.58%	53.87%
Hispanic	2.94%	2.98%	2.80%	3.50%	3.26%
Native American	0.37%	0.25%	0.23%	0.33%	0.31%
Pacific Islander	0.38%	0.26%	0.53%	0.21%	0.29%
Asian	11.16%	11.65%	11.43%	13.40%	12.84%
Prefer not to answer	2.08%	2.80%	5.06%	3.41%	7.38%

Source: Hospital NSP I Reports

Table 5. Percent of Nurse Managers by Race/Ethnicity, FY 2020 - 2024

	2020	2021	2022	2023	2024
NH Black	18.74%	17.33%	18.62%	20.60%	20.86%
NH White	73.81%	74.06%	68.49%	65.86%	63.55%
Hispanic	0.90%	1.18%	1.28%	2.13%	1.66%
Native American	0.13%	0.24%	0.13%	0.29%	0.10%
Pacific Islander	0.26%	0.59%	0.13%	0.19%	0.19%
Asian	5.26%	5.54%	7.53%	7.83%	9.06%
Prefer not to answer	0.90%	1.06%	3.83%	3.09%	4.58%

Source: Hospital NSP I Reports

[6] HRSA, Nursing Workforce Dashboard.
[7] HRSA, Nursing Workforce Dashboard.

Table 6. Nurse Executives by Race/Ethnicity, FY 2020 - 2024

	2020	2021	2022	2023	2024
NH Black	13.51%	15.09%	12.88%	13.21%	15.47%
NH White	83.33%	80.60%	77.68%	81.51%	77.70%
Hispanic	0.45%	1.29%	1.29%	0.75%	1.44%
Native American	0.45%	0.00%	0.86%	0.38%	0.36%
Pacific Islander	0.00%	0.00%	0.00%	0.00%	0.00%
Asian	2.25%	1.72%	1.72%	3.40%	2.88%
Prefer not to answer	0.00%	1.29%	5.58%	0.75%	2.16%

Source: Hospital NSP I Reports

A challenge that hospitals have cited with increasing the number of males and racial and ethnic minorities in nursing roles is that recruitment efforts are dependent on the pool of recent nursing graduates. Ideally, individuals should be encouraged to pursue nursing education within their local community, and then return to serve in the same community after graduation to build a sustainable and diverse nursing workforce that reflects the population it serves. Hospitals have reported working closely with local community colleges and universities to drive community-based efforts to encourage people to enter the nursing profession. Other hospitals have instituted programs with NSP I assistance, such as student nurse programs, to send certified nursing assistants and licensed practical nurses back to school to become registered nurses. Consequently, prioritizing diversity in nursing student recruitment and creating educational opportunities that are accessible to all student types, particularly non-traditional students, is crucial to building a diverse nursing workforce. Additionally, creating direct pipelines from schools to hospital nursing careers can help hospitals build a workforce that more closely reflects the racial and ethnic diversity of Maryland's nursing workforce.

To address these challenges, as part of the NSP II renewal, the HSCRC and the Maryland Higher Education Commission (MHEC) developed recommendations to prioritize diversifying educational opportunities for prospective nursing students to strengthen a diverse nursing pipeline. In February 2025, HSCRC Commissioners approved the following recommendations to support this priority:

- Identify intentional opportunities to prioritize funding to underrepresented groups in nursing:
- Revise the scoring criteria for NSP II grant proposals to promote projects that are focused on improving student and faculty diversity;
- Develop a category of resource grants to support underrepresented nursing student success;

- Expand and create statewide resources to promote ongoing mentorship of underrepresented faculty; and
- Create a new category of the Nurse Faculty Annual Recognition (NFAR) award that recognizes faculty who demonstrate excellence in mentoring underrepresented students, fostering a diverse and inclusive educational environment, or conducting research on diversity and healthcare equity.

HSCRC and MHEC staff are working to implement these recommendations as part of the FY 2027 cycle for competitive institutional grants and faculty-focused awards.

Ongoing Challenges

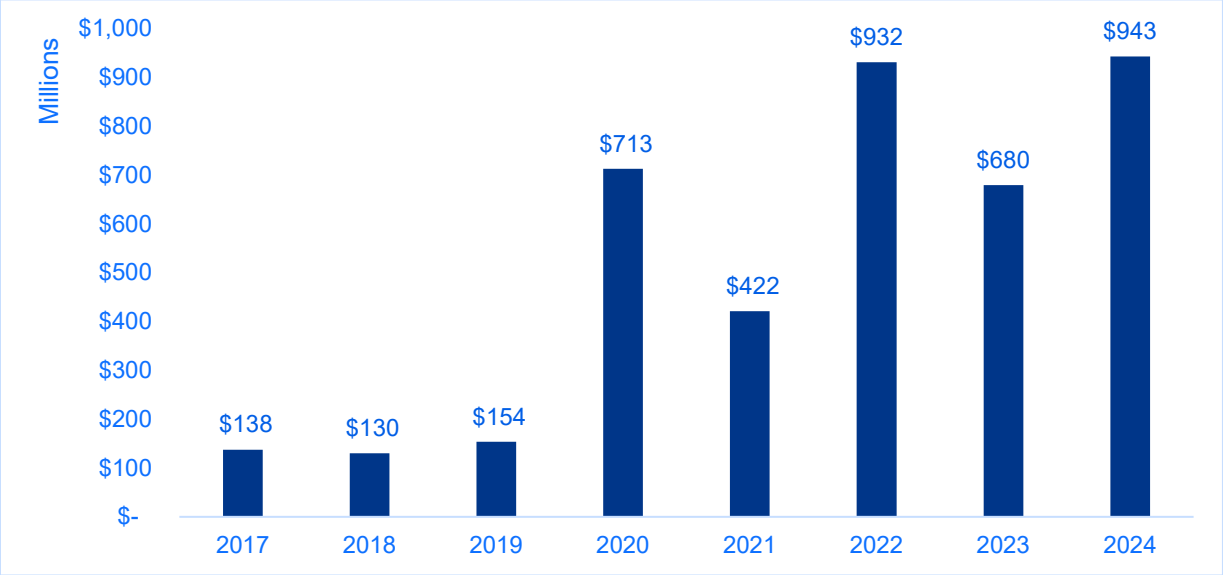
Increased Reliance on Agency Nurses

Nurses have reported leaving their positions for competing hospitals offering sign-on bonuses or for agency work that provides higher pay, more flexible hours, and reduced stress. The growing reliance on agency nurses, however, has contributed to high turnover and placed additional strain on staff nurses, who must repeatedly orient new colleagues. In discussions across nursing roles, a common concern was the pay disparity between agency and staff nurses, coupled with the fact that agency nurses are not held responsible for regulatory reporting and other administrative requirements that fall to staff.

As more nurses leave hospitals for agencies, a costly feedback loop is created as hospitals rely more on agencies to backfill the reduction in the workforce. In FY 2024, nursing agency costs to hospitals peaked at $943 million, 32 percent higher than the initial surge in agency costs during the pandemic. Nationally, despite a desire to reduce costs associated with travel/agency staff, most hospitals still rely on agencies as a solution for RN shortages, perpetuating agency nursing costs.[8]

[8] Nursing Solutions Inc. (2025) 2025 NSI National Healthcare Retention and RN Staffing Report. https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed August 16, 2025.

Figure 11. Nursing Agency Cost to Hospitals, FY 2017 - FY 2024



Source: Hospital NSP I Reports

Although agency costs declined in FY 2021, suggesting a possible return to pre-pandemic spending levels, hospitals reported a sharp increase in FY 2022, reaching $931 million as nursing workforce shortages persisted. To help offset these costs, some hospitals created hospital- or system-owned travel agencies. However, despite a notable decline in agency spending in FY 2023, as shown in the graph above, hospitals did not realize any sustained savings from these efforts in FY 2024.

Nursing Burnout

The National Council of State Boards of Nursing (NCSBN) regularly conducts a National Nursing Workforce Study,[9] surveying nearly 800,000 nurses to assess the state of the profession. The 2024 study indicates that while COVID-19-related stressors have declined since 2022, stress and burnout remain widespread, posing ongoing challenges to the nursing workforce. Notably, 39.9 percent of nurses nationally report plans to leave the workforce or retire within the next five years, citing stress, burnout, and increasing workloads, highlighting a persistent and long-term workforce concern.

Approximately 800 Maryland RNs participated in the survey, providing insights into workload, stress, fatigue, burnout, and emotional exhaustion. The NCSBN Survey found that 43 percent of nurses reported increased workloads over the past two years. Emotional strain was widespread: 57 percent felt emotionally drained at least weekly or more, 48 percent experienced burnout at least weekly or more, and 60 percent

[9] National Council of State Boards of Nursing. (2025, April 17). NCSBN research highlights small steps toward nursing workforce recovery; burnout and staffing challenges persist. https://www.ncsbn.org/news/ncsbn-research-highlights-small-steps-toward-nursing-workforce-recovery-burnout-and-staffing-challenges-persist

reported feeling “used up” at the end of the workday, underscoring significant ongoing workforce challenges. Although nursing burnout drew considerable attention during the COVID-19 pandemic, it remains a persistent challenge both nationally and in Maryland. Addressing this issue will require Maryland healthcare leaders to collaborate on comprehensive, multi-faceted strategies that reduce burnout and strengthen long-term nurse retention.

Conclusion

The NSP I Program continues to be a vital resource for hospitals, supporting efforts to retain nursing staff, develop leadership potential, expand educational opportunities, and advance nursing practice, which are critical as the State works to restore workforce levels to pre-pandemic levels. FY 2024 data show improvement in vacancies and turnover compared with the prior year; however, Maryland’s recovery continues to lag behind national performance, underscoring the need for further analysis to understand the drivers of these trends better.

At the same time, Maryland continues to lead nationally in the implementation of nurse residency programs, with hospitals retaining nearly 90 percent of new nurses after their first year of employment. Sustaining this success and ensuring long-term staffing stability will require continued investment in the new nursing workforce. Expanding and diversifying the number of nursing graduates is essential to building a workforce that is both clinically prepared and culturally responsive to the needs of Maryland’s communities. To support this goal, HSCRC and MHEC staff are advancing the approved recommendations for the NSP II program renewal, which focus on expanding educational opportunities and strengthening a diverse pipeline of future nurses. In parallel, HSCRC will continue to oversee NSP I through ongoing reporting, hospital engagement, and data monitoring to track progress and inform future strategies.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: September 10, 2025

RE: Hearing and Meeting Schedule

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

November 12, 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.