maryland
health services
cost review commission

620th Meeting of the Health Services Cost Review Commission

May 8, 2024

(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 1:00pm)

CLOSED SESSION
12:00pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on April 10, 2024

Informational Subjects

2. Presentation on Queen Anne's County Mobile Integrated Community Health Program

Subjects of General Applicability

3. Innovation Competition – HSCRC & Maryland Department of Health (MDH) Partnership
4. Update: Revenue for Reform
5. Presentation by the Maryland Hospital Association: Hospitals & the Significance of Nurse Education
6. Final Recommendation: Nurse Support Program II (NSP II) Grants - FY2025
7. Report from the Executive Director
    a. Hospital Financial Conditions Report
    b. Model Monitoring
    c. Update on Hospital Reimbursement Law Implementation
8. Update: Accounting and Budget Manual Updates
9. Draft Recommendation: RVU Updates
10. Draft Recommendation: CRISP Funding - FY 2025

11. Update: ED Wait Times

    a. EDDIE

    b. Multi-Visit Patient Policy

12. Draft Recommendation: Update Factor - FY 2025

Specific Matters

13. Docket Status – Cases Closed

    2630R UM Shore Medical Center at Easton - Withdrawn

14. Docket Status – Cases Open

    2645A Johns Hopkins Health System
    2646N UM Shore Medical Center at Easton

15. Hearing and Meeting Schedule

MINUTES OF THE 619th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION April 10, 2024

Chairman Joshua Sharfstein called the public meeting to order at 12:03 p.m. In addition to Chairman Sharfstein, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Adam Kane, Ricardo Johnson, and Maulik Joshi. Commissioner Nicki McCann, J.D, attended virtually. Upon motion made by Commissioner Kane and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:09 p.m.

REPORT OF APRIL 10, 2024, CLOSED SESSION

Paul Katz, Analyst, External Affairs and Policy, summarized the items discussed at the April 10, 2024, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE MARCH 13, 2024, PUBLIC MEETING AND CLOSED SESSION

The Commission voted unanimously to approve the minutes of the March 13, 2024, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
PRESENTATION FROM THE CAMDEN COALITION

Kathleen Noonan, President, and Chief Executive Officer, Natasha Dravid, Chief Strategy Officer, and Ashley Humienny, Chief of Staff, The Camden Coalition, presented an overview of The Camden Coalition (see "The Camden Coalition- Approaches to Strengthening Ecosystems of Care" available on the HSCRC website).

The Camden Coalition ("Coalition") is a multidisciplinary, community-based nonprofit working to improve care for people with complex health and social needs in the city of Camden, across New Jersey, and around the country. They develop and test care management models and redesign systems in partnership with consumers, community members, health systems, community-based organizations, government agencies, payers, and more, with the goal of achieving person-centered, equitable care.

(

As one of New Jersey's four Regional Health Hubs, the Coalition works with regional partners, New Jersey's Medicaid office, and other state agencies to expand data-sharing and collaboration between organizations so that patients across South Jersey experience seamless, whole-person care.
The Coalition's mission is to improve the health and well-being of people with complex needs by demonstrating and advancing equitable ecosystems of care. Their vision is to transform health and social systems to ensure every individual receives person-centered care rooted in an authentic healing relationship.

By implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being, the Coalition's work is to deliver better care to those negatively affected by social determinants of health. Supported by a robust data infrastructure, cross-sector convening, and shared learning, community-based programs address the complex health and social needs of the most vulnerable individuals in Camden and South Jersey.

The Coalition's two decades of community-based work has made them a leader in the growing field of complex care. Through their National Center for Complex Health and Social Needs initiative, they share best practices and lessons learned from their work in Camden, and convene others doing similar work across the country with the goal of advancing complex care programs on a national scale.

Commissioner Johnson asked how the Coalition is funded.

Ms. Noonan stated that the program is funded through administrative dollars through the Medicaid program.

Commissioner Johnson asked if the Coalition programs are only for Medicaid patients.

Ms. Noonen stated that most of the programs are primarily for Medicaid recipients, however, there have been programs involving Horizon Blue Cross/Blue Shield (New Jersey).

ITEM III
CLOSED CASES

2644A – Johns Hopkins Health System

.

ITEM IV
OPEN CASES

2630R - University of Maryland Shore Medical Center at Easton - Full Rate Application – No action required at this time.
2645A – Johns Hopkins Health System – ARM – Accarent Health – Under review by State.

(

ITEM V
NURSE SUPPORT PROGRAM II (NSP II): PROGRAM RENEWAL DEVELOPMENT PLAN

Erin Schurmann, Chief, Provider Alignment and Special Projects, Laura Schenk, Grant Administrator and Kimberly Ford, Assistant Grant Administrator, Maryland Higher Education Commission (MHEC) presented the development plan for the HSCRC renewal of the Nurse Support Program II (NSP-2) (see "Nurse Support Program II - Program Renewal development Plan FY 2026 – FY 2030" available on the HSCRC website).

The HSCRC has funded programs to address cyclical nursing workforce shortages since 1986. In July 2001, the HSCRC implemented the hospital-based Nurse Support Program I (NSP-1) to address the nursing shortage impacting Maryland hospitals. HSCRC provides $18M in annual funding to the program. Commissioners approved the NSP-1 as a permanent program in 2022.

The HSCRC established the NSP II program on May 4, 2005, to increase Maryland's academic capacity to educate nurses. Provisions included a continuing, non-lapsing fund with a portion of the competitive and statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. The Commission approved funding of $18M in annual funding (0.1 percent of gross patient revenue). MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. NSP-II is reviewed for renewed funding by the HSCRC every 5 years. The current program cycle ends at the end of FY 2025, with the next renewal due by June 30, 2025.

The guiding principles of the NSP II are as follows.

- Fostering innovation and excellence in nursing education
- Achieving goals set forth in National Academy of Medicine's Future of Nursing.
- Promoting diversity in faculty and student bodies.
- Facilitating stability and sustainability in planning and investment.
- Aligning and collaborating with NSP I to ensure a well-prepared new nursing workforce with direct pathways to hospital employment.

Consideration with NSP-II program renewal.

- Request for permanent funding- Continue NSP II as an ongoing program with permanent funding that does not require renewal, with the requirement for NSP II to provide annual reports on funded activities and accomplishments.
- Future of nursing goals- The foundational goal for NSP II is to increase educational capacity and strengthen nurse educators for an adequate supply of well-prepared nurses for Maryland hospitals and health systems.
- Diversity- In alignment with the NSP II statute's guideline provisions, the program tracks, analyzes, and prioritizes grant initiatives that promote the recruitment and retention of underrepresented groups of nursing.

(

NSP I and II will continue to work closely together to find solutions to mutual priorities to meet the needs of schools of nursing and hospitals in Maryland. Nursing workforce needs are considered in the development of NSP II program goals and initiatives through NSP I representation in advisory groups, the competitive grant review process, and the establishment of program goals.

NSP II will regularly engage with various stakeholders to assist with completing a comprehensive program renewal and end-cycle progress report.

Program renewal process begins in FY 2024:

- April 2024: present program renewal plan to HSCRC
- November 2024: draft recommendations for program renewal
- December 2024: formal public comments solicited.
- January 2024: final recommendations and Commissioner vote

Existing funding ends: June 30, 2025.

After approval, renewed funding would begin: July 1, 2025.

ITEM VI
REPORT FROM THE EXECUTIVE DIRECTOR

Maryland Total Cost of Care Model

Jon Kromm, Executive Director, reviewed The Centers for Medicare and Medicaid Services (CMS) evaluation of the Maryland Total Cost of Care Model (Model) FY 2019 to FY 2022

Based on CMS evaluation the following is noted:

- The Model achieved a net savings of $689M for the Medicare program between 2019 and 2021.
- The Model also reduced admissions and improved related quality measures.
- The Model reduced disparities to unplanned readmissions, preventable admissions, and timely follow up by race and place.

Model Monitoring

Deon Joyce, Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 12 months ending December 2023. The data showed that Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce stated that Medicare Nonhospital spending per-capita was unfavorable when compared to the nation. Ms. Joyce noted that Medicare TCOC spending per-capita was unfavorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail position is 1.82% below the nation through December, and that Maryland Medicare hospital and non-hospital growth through December shows a savings of $206,661,000.

(

Legislative Update

Deborah Rivkin, Director, Government Affairs, presented the Staff's Legislative Update (see "Legislative Update" available on the HSCRC website).

The 446th session of the Maryland General Assembly ended on April 8 at midnight. This year, the Commission tracked and monitored 346 bills impacting access, equity, quality, consumer protection, public health, behavioral health, hospitals, providers, insurance, workforce, prescription drugs, procurement, information technology, and state employees. Staff took formal positions on 13 bills and offered amendments on numerous bills that potentially impacted HSCRC priorities.

Ms. Rivkin noted that Staff was monitoring the following bills:

- SB 694/ HB 887- Maryland Department of Health – Health Commissions and Maryland Insurance Administration - PASSED
- HB 1333- Maryland Commission on Health Equity- Membership and Statewide Health Equity - PASSED
- HB 784 SB 935 – Comprehensive Community Safety Funding Act - PASSED
- HB 1143 – Emergency Medical Services – Maryland Emergency Department Wait Time Reduction Commission - PASSED
- SB 1092 – Vehicle Registration – EMS Surcharge - PASSED
- SB 1006 – Medical Debt Collection – Sale of Patient Debt - NOT PASSED
- HB 328 – Hospitals – Financial Assistance Policies – PASSED
- SB 1103/ HB 1149- Hospitals and Related Institutions – Outpatient Facility Fees - PASSED
- SB 360/ HB 350 – Budget Bill (Fiscal Year 2025) PASSED
- SB 362 HB 352 – Budget Reconciliation and Financing Act of 2024 – PASSED.
- HB 728 SB 705 – Access to Care Act – PASSED
- HB 84 SB 332- Sepsis Protocol – PASSED

HSCRC will be participating in the following task force and studies.

1. ED Wait Time Reduction Commission
2. Outpatient Facility Fees Workgroup
3. Maryland Commission on Health Equity
4. Health Commission and MIA Study

Staff will be working on the following reports:

1. Maryland Trauma Physician Services Fund
2. Evaluation of MD Primary Care Program and Update on Outcome Based Credits
3. Recruitment and Retention of Anesthesiologists in Maryland

(

4. Reimbursement for Maternal Fetal Medicine

ITEM VII
FINAL RECOMMENDATION ON READMISSION REDUCTION INCENTIVE PROGRAM (RRIP) – RY 2026

Princess Collins, Chief, Quality Initiatives, presented Staff 's final recommendation on the Readmission Reduction Incentive Program for Rate Year 2026 (see "Final Recommendation for Readmission Reduction Incentive Program for Rate Year 2026" available website) on the HSCRC.

The quality programs operated by the Health Services Cost Review Commission, including the Readmission Reduction Incentive Program (RRIP), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.

The RRIP policy is one of several pay-for performance quality initiatives that provide incentives for hospitals to improve and maintain high quality patient care and value over time. It also provides an incentive to reduce disparities in readmissions. The RRIP policy currently holds up to 2 percent of hospital revenue at-risk for performance relative to predetermined attainment or improvement goals on readmissions occurring within 30-days of discharge, applicable to all payers and all conditions and causes. The hospitals can also earn up to a 0.5 percent reward for reductions within hospital disparities. This policy affects a hospital's overall GBR and so affects the rates paid by payers at that hospital. The HSCRC quality programs are all payer in nature and so improve quality for all patients that receive care at the hospital. Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent.

Staff's final recommendation for the Maryland Rate Year (RY) 2026 RRIP is as follows:

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Set statewide 4-year improvement target of 5 percent from 2022 base period through 2026.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. To be eligible for disparity gap reward, hospitals must not

(

have an increase in overall readmission rate and must submit details on interventions aimed at reducing disparities. Scale rewards:

- beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
- capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.

6. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits in the case-mix adjusted readmission measure or inclusion of EDAC in the RRIP program. Collaborate with stakeholders to explore the causes and consequences of greater observation stay use in Maryland compared to the Nation.

Chairman Sharfstein stated that he would appreciate if the Commission could be provided with more information on hospitals' efforts to reduce disparities.

Ms. Collins stated that Staff will collaborate with MHA and the hospitals to determine the time frame for collecting information on hospitals impact on this measure.

Commissioner Elliott asked if there is any correlation between Excess Days in Acute Care (EDAC) and timely follow-up.

Ms. Collins explained she had analyzed the correlations between readmissions and EDAC but not timely follow-up.

Commissioner Kane requested clarification on the percentage of payment for rewards.

Staff explained that a hospital can earn up to 2 percent of inpatient revenue for reducing their in-hospital admissions and an additional 0.5 percent for reducing readmission disparities for a maximum total adjustment of 2.5 percent of inpatient revenue.

Commissioners agreed that the disparity measure is a step in the right direction toward health equity and that obtaining greater insight on disparity interventions would be beneficial.

Brian Sims, Vice President, Quality & Equity, Maryland Hospital Association (MHA), stated that MHA supports the staff's recommendation. Mr. Sims noted that MHA appreciates the staff's recommendation to set a multi-year target effective through December 2026. In addition, MHA also applauds the inclusion of incentives in the RRIP for hospitals to improve within-hospital readmission disparities between patients with high social risk and those with low social risk. As we gain further insights into effective strategies across different populations with varying levels of social risk, it becomes imperative for us to evaluate how the current incentive and methodology can evolve to ensure equitable results statewide. MHA proposes examining the inclusion of an attainment target in the policy.

Commissioners voted unanimously in favor of the Staff's recommendation.

(

ITEM VIII
CONFIDENTIAL DATA REQUEST: SOLVENTUM

Curtis Wills, Commission Fellow, Health Data Management, presented Staff's final recommendation for the Solventum confidential data request (see "Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data from Solventum).

Solventum (previously known as 3M Health Information Systems), is requesting access to the HSCRC Confidential Inpatient and Outpatient Hospital Data ("the Data"), to assist with the parallel evaluation of Ambulatory Potentially Preventable Complications (AM-PPC) being performed by the HSCRC, as well as with the facilitation of questions and research surrounding outpatient and inpatient focused classification and normative statistics.

The AM-PPC grouper identifies potentially preventable complications that occur following an elective ambulatory procedure, similar to the current inpatient complications grouper used in the Maryland Hospital Acquired Conditions program. The HSCRC is currently evaluating the AM-PPC grouper to support the HSCRC's overall quality objectives for the state of Maryland.

Solventum received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on February 14, 2024, and the MDH Strategic Data Initiative (SDI) office on March 1, 2024. The Data will not be used to identify individual hospitals or patients. The Data will be retained by Solventum until project completion or by December 31, 2025. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee unanimously agreed to recommend that Solventum be given access to the Data.

Staff final recommendation is as follows:

1. HSCRC staff recommends that the request by Solventum for the Data for Calendar Year 2021 through 2023 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

Commissioner voted unanimously in favor of Staff's recommendation.

ITEM IX
ED POLICY DEVELOPMENT AND IMPLEMENTATION – EDDIE UPDATE

Damaria Smith, Commission Fellow, Quality Initiatives, and Jason Mazique, Population Health Project Manager, presented, the monthly update on the Emergency Department Dramatic Improvement

(

Performance for March (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

Ms. Smith stated that Staff received March data from all the hospitals. The results of the data show the following:

- Emergency Department (ED) Median wait times in March when compared to February shows that Inpatient median wait times are longer when compared to Outpatient median wait times. Behavioral health wait times are longer than non-behavioral health wait times.

Mr. Mazique stated that the turnaround time data shows substantial movement of hospitals across all categories for March with two hospitals improving in performance and none declining in performance.

Ms. Smith stated that the Quality Based Reimbursement (QBR) ED-1 Subgroup will meet for the final time on Friday April 12th with the ED-2 Subgroup first meeting scheduled for Friday April 26th.

Next Steps

- Continue monthly EDDIE data collection from hospitals and the Maryland Institute for Emergency Medical Services .
- QBR ED Length of Stay measure.
  - Finalize QBR ED LOS Data subgroup.
  - Convene QBR ED LOS Measure and Incentive subgroup.
- Finalize work plan for additional subgroup on Best Practices (1 percent idea)
  - Consult with experts in and outside of Maryland on types of best practices to consider.
  - Recruit participants.
  - Establish meeting agendas and dates.

ITEM X.
HEARING AND MEETING SCHEDULE

May 8, 2024,	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
June 14, 2024,	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:16 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

April 10, 2023

Chairman Sharfstein stated reasons for Commissioners to move into administrative session pursuant to 3-103, 3-104, and 3-305(b)(3) of the General Provisions Article. Regarding the TCOC Model Monitoring agenda item, Chairman Sharfstein stated that monitoring the TCOC Model and its contractual requirements is sensitive in nature and necessary for administering the Model successfully without the potential for disrupting the regular functions of the rate setting system. Total Cost of Care data is not complete until the performance year is over. Regarding the FY 2024 Hospital Unaudited Financial Performance agenda item, Chairman Sharfstein stated that information is based on unaudited data and not the official measure of hospital financial performance. Hospital financial performance is a critical factor in the Commission's ability to meet the tests of the Model. When looking at hospital financial performance from the vantage point of unaudited data, we cannot be certain that accurate conclusions can be drawn. Regarding the Commission's offices agenda item, Chairman Sharfstein stated that staff will update the Commission on the status of a potential move of HSCRC offices.

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

The Administrative Session was called to order by motion at 12:03 p.m.

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

In attendance representing Staff were Jon Kromm, Jerry Schmith, William Henderson, Claudine Williams, Alyson Schuster, Deb Rivkin, Cait Cooksey, Megan Renfrew, Erin Schurmann, Christa Speicher, Bob Gallion, and Paul Katz.

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

Item One

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

Mr. Henderson briefly updated the Commission on the hospitals' unaudited financial performance through January 2024.

Item Three

Executive Director Jon Kromm updated the Commission on a potential move of the Commission's offices, pursuant to 3-305(b)(3) of the General Provisions Article.

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

Queen Anne's County

Queen Anne's County

Mobile Integrated Community Health

Pioneering Solutions for Enhanced Care

Jared Smith MA, BS, NRP

May 8, 2024

Queen Anne's County Health Department - Community Health

Queen Anne's County

01. The Problem MICH Addresses
02. How the Program Works
03. Aligning with the Maryland Healthcare Model
04. Program Data
05. Lessons Learned

MOBILE INTEGRATED COMMUNITY HEALTH

Queen Anne's County

Improving Health Outcomes for Vulnerable Populations

Targeting high-risk patients who often have complex medical issues and social determinants of health that make them more vulnerable to poor health outcomes.

1. Chronically ill Patients
2. Patients with Complex Medical Needs
3. Homebound or Frail Elderly Patients
4. Patients with Mental Health or Substance Abuse Disorders
5. Patients Experiencing Frequent Emergency Room Visits or Hospitalizations

MOBILE INTEGRATED COMMUNITY HEALTH

Queen Anne's County

Team Roles

Office Clerk

- Schedules patient visits
- Prediabetes risk screening
- Telephonic follow-up

Hospital-Based Pharmacist

- Medication reconciliation
- Medication education
- Affordability assessment

Paramedic

- Physical examination and assessments
- Home safety assessments
- Install safety devices

Peer Recovery Specialist

- Assist with building recovery goals
- Assistance with behavioral health system navigation
- Serving as a mentor and advocate

Community Health Nurse

- Health education and promotion
- Care coordination and case management
- Social determinants of health assessments

Substance Abuse Counselor

- Establish a therapeutic relationship
- Schedule individual and group therapy sessions
- Make appropriate intervention-based referrals

Queen Anne's County

Health and Home Safety

1. The Hendrich II Fall Risk Model
2. Physical Environment Assessment Tool (PEAT)
3. Alcohol Use Disorder Identification Test (AUDIT)
4. EQ-5D-5L (EUROQOL)

JEMS -Journal of Emergency Medical Services

Queen Anne's County

Telehealth

After collecting all the medications in the home, a list is created and sent to the PharmD for review before the telehealth visit. The focus of the PharmD telehealth visit is on the following components:

Medication History

- Review medical record
- Medication adherence assessment
- Medication organization

Affordability Assessment

- Therapeutic substitutions
- Compliance assessment
- Prior auths and refill auths

Self Management Techniques

- Blood glucose testing
- Blood pressure monitor
- Inhaler/nebulizer use

Patient Education

- Drug interactions
- Adverse effects
- Health literacy
- Identify barriers

Queen Anne's County

How is MICH Facilitated by the Maryland Healthcare Model?

Promoting Partnerships and Collaborations Between Different Entities

Leveraging the expertise and resources of diverse healthcare providers and community organizations to reach high-risk and underserved populations more effectively.

Emphasis on Data-Driven Approaches and Evidenced-Based Practices

Utilizing data and analytics to identify high-risk patients, track outcomes, and evaluate the effectiveness of interventions.

The Encouragement of Innovation and Flexibility in Healthcare Delivery

MICH is designed to be adaptable and responsive to the unique challenges and opportunities in healthcare, allowing for the development of creative solutions to improve access, coordination, and quality of care.

Prioritizing More Personalized and Accessible Care for Patients

Providing care in the patients' homes and tailored to their individual needs enhances the patient experience and increases healthcare efficiency.

Queen Anne's County

Program Data

10

Average Number of Medications per Patient

71

Median Age of Patients

75%

Percentage of Patients Over the Age of 65

6

Average Number of Comorbidities per Patient

1,098

Number of Patient Contacts

42%

Percentage of Patients Living Alone

Queen Anne's County

Reduced Hospital Utilization

Time Period	Avg. Percent Change ED Visits	Avg. Percent Change Inpatient Visits
1 Month	-58.2%	-66.8%
3 Months	-32.4%	-54.7%
6 Months	-27.9%	-41.5%
12 Months	-21.2%	-26.6%

Time Period	Avg. Percent Change ED Cost	Avg. Percent Change Inpatient Cost
1 Month	-64.6%	-66.6%
3 Months	-41.5%	-40.7%
6 Months	-25.2%	-30.1%
12 Months	-10.7%	-7.8%

MOBILE INTEGRATED COMMUNITY HEALTH

Chesapeake Regional Information System for our Patients (CRISP)

Lessons Learned

- Conducting home visits is a crucial but often excluded aspect of true comprehensive care. Assessing the patient's living conditions, observing daily routines, and identifying barriers to care provide invaluable insight into the patient's true needs.
- Involve partnerships and stakeholders early on in the program planning process. Building trust and rapport among other healthcare providers and entities is just as important as it is with patients.
- Setting up programs that allow for innovation and flexibility creates an environment that fosters creative solutions, ultimately improving access, coordination, and quality of care.
- Establishing a quality assurance and quality improvement aspect of the program is crucial for identifying program blindspots and driving continuous improvement.


Queen Anne's County
Questions?
MOBILE INTEGRATED COMMUNITY HEALTH

Queen Anne's County

Thank You!

Jared Smith
Email: jasmith@qac.org

maryland health services cost review commission

Maryland DEPARTMENT OF HEALTH

Promoting Innovation in Care Delivery

May 8, 2024

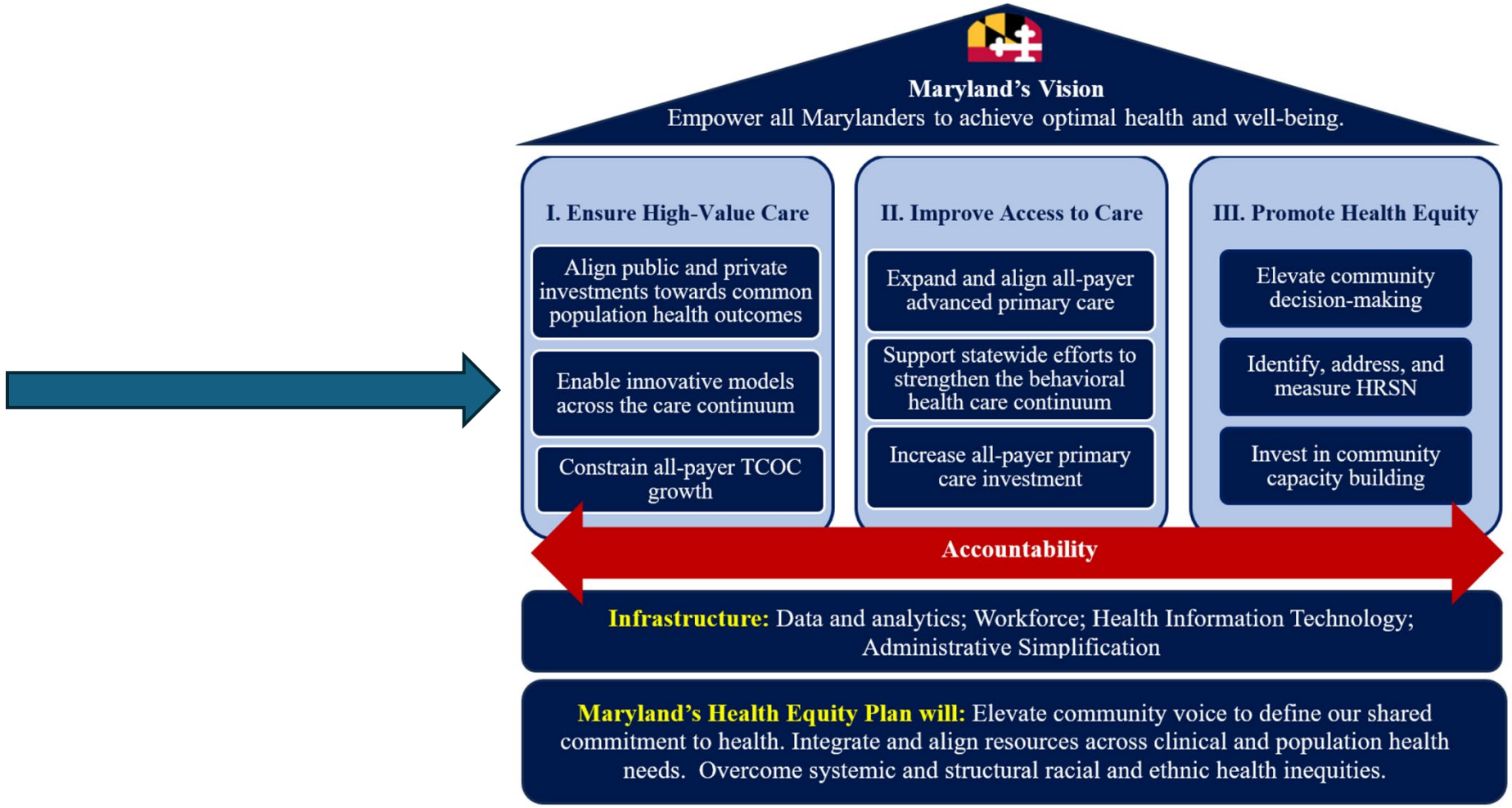
Dr. Laura Herrera, Secretary of Health

Dr. Jon Kromm, Executive Director, HSCRC

Overview

- Innovation in the AHEAD Model
- Areas for Innovation
- An Innovation Ideas Contest

Innovation in the AHEAD Model



Innovation in the AHEAD Model

- The goals of AHEAD include improved health outcomes, higher quality care, better patient experience, and advances in health equity.
- To accomplish these goals, Maryland will need to enable new approaches to care delivery. Otherwise, if we keep providing care in ways that do not produce the outcomes we want, we will not be able to expect to see different results.
- Because of its health care model's unique structure and incentives, Maryland should be the nation's best environment for innovations in care design and delivery that are effective, affordable, and equitable.
- Maryland has tremendous intellectual capital for innovation across our health systems, health care providers, universities, and community organizations.

Areas for Innovation

- Examples of Innovations in Care
  - New services to provide care more effectively and economically
  - New collaborations with community organizations to support effective care
  - New technologies that enable better outcomes at an affordable cost
- Examples of Innovations in Collaboration
  - Shared services and systems (e.g. CRISP)
  - Collaborative models of care across the care continuum
  - Creative consolidation of services across institutions to enhance quality
- Examples of Innovations in Payment
  - Greater responsibility for total cost of care for specific patient groups
  - Bundles that cross levels of care – such as hospitalization and post-acute care

An Innovation Ideas Contest

- Goal: To surface ideas from across Maryland for innovation in care, coordination, and payment.
- Winning ideas to be presented to the MDH and HSCRC leadership for discussion and consideration.
- Ideas may or may not prove feasible and appropriate for implementation. An idea that is not possible now may be worth pursuing later in the model.
- We start by tapping into the intellectual capital of our state and asking what might be possible.

An Innovation Ideas Contest

- Step 1: A public call for judges. The goal will be a diverse set of judges from multiple perspectives.

- Step 2: Development of rules for the contest. MDH and HSCRC will set the rules for 3 categories: innovation in care, innovation in coordination, and innovation in payment. To support specific problem solving, HSCRC will make information available for specific care and payment challenges, such as pediatric asthma, sickle cell disease, emergency department utilization, and post-acute care.

- Step 3: Administration of the contest

- Step 4: Cash prizes, expected to be funded by the Abell Foundation and Horizon Foundation

Conclusion

- AHEAD challenges Maryland to lead through Innovation.
- To start, let’s raise awareness of this goal and generate great ideas for consideration.
- MDH, the HSCRC, Maryland’s hospitals, and many other partners can join together in this important effort.

maryland
health services
cost review commission

Revenue for Reform Update

Year 2 Revisions & Next Steps

May 8, 2024

Erin Schurmann

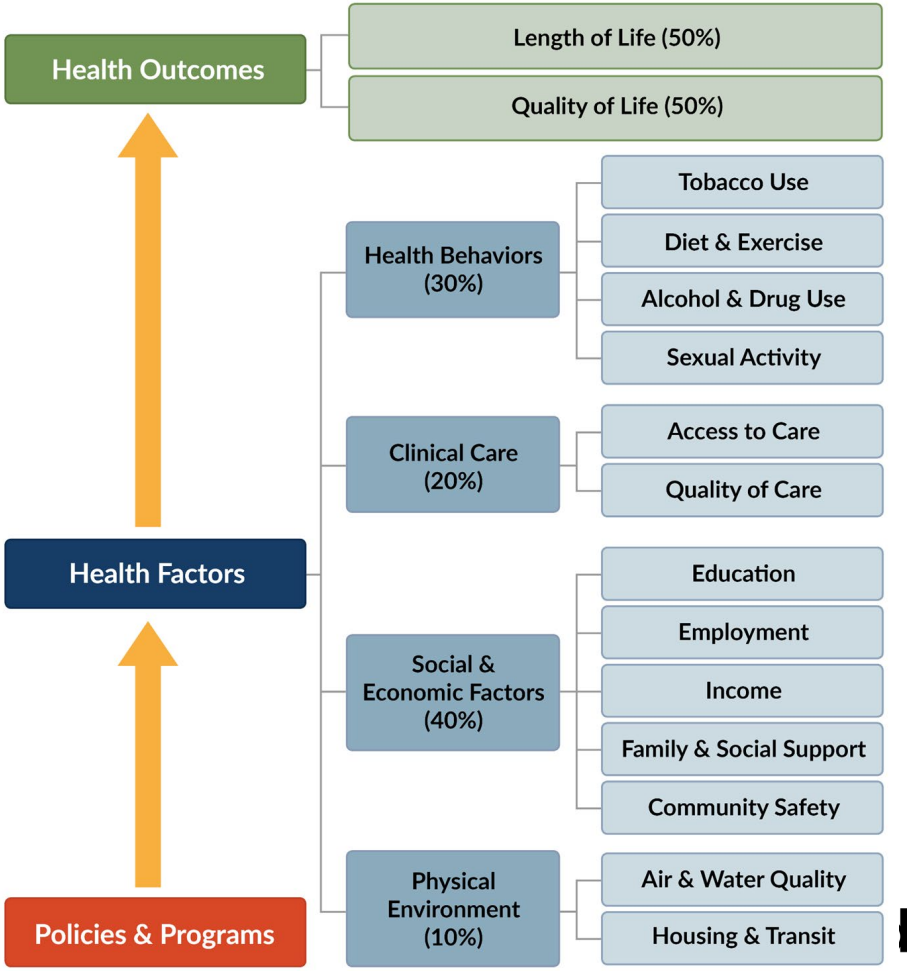
Chief, Provider Alignment & Special Projects

Model of Health

Used for County Health Rankings and Roadmaps

County Health Rankings and Roadmaps provides data, evidence, guidance and examples to build awareness of the multiple factors that influence health and support leaders in growing community power to improve health equity

Robert Wood Johnson Foundation/ University of Wisconsin Population Health Institute



Overview of Revenue for Reform

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

Year 1 Implementation

- Year 1 featured two tracks:
  - **Community Health:** Spending on unmet community health need identified in the hospital's Community Health Needs Assessment (CHNA); or implementing one of the CDC's 2030 Healthy People Interventions.
  - **Physician Spending:** Spending on primary care, mental health providers, and dental providers in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA).
- Staff issued an application template to eligible hospitals in October and hospitals submitted applications in December.
- HSCRC and MDH Staff reviewed applications and either approved, requested revisions, or rejected applications.
- Hospitals whose applications were rejected could resubmit different interventions.

Year 1 Strengths

- $26 million has been directed to community health and expanding/maintaining access to physicians in Baltimore City, the Eastern Shore, and the DC Metro region.
- Valuable dialogues about population health spending between health systems, HSCRC, and MDH.
- Examples of approved interventions goals approved are shown below.

Health Behaviors	Social and Economic	Clinical Care (non-hospital based)	Physical Environment
• Reduce substance use disorder and overdose deaths • Increase patient-self management of chronic diseases • Reduce diabetes incidence through community exercise and nutrition education	• Increase job opportunities through career training and continuing education • Expand supportive services for victims of intimate partner violence • Reduce health disparities in LGBTQIA+ population • Increase SDOH screening and community referral partners	• Increase the number of primary care providers and patients served in HPSAs/MUAs • Expand telehealth access • Expand access to post-acute care for uninsured and underinsured patient populations • Reduce childhood asthma ED visits through mobile health	• Expand permanent supportive housing services (Medicaid ACIS pilot) • Expand temporary housing for high-needs patients with housing instability / no housing

Leverages County Health Rankings Model

Year 1 Challenges

- While $26 million across nine hospitals was approved for investment, this was out of a potential $43 million, meaning *$17 million was **not** invested into population health interventions.*
- Community Health
  - It was unclear how hospital applications connected to broader population health strategies.
  - Measuring impact will be difficult because there were not consistent impact measures used across programs.
  - Level of cost reporting was insufficient to understand full use of funding.
  - There is potentially duplicative funding for programs also supported by MDH.
  - Some long-standing interventions have not shown outcomes to date.
- Physician Spending
  - It was unclear how hospital applications connected to broader access strategies.
  - Substantial variability in amount of funding proposed per practitioner and patients served.
  - Level of cost reporting was insufficient to understand full use of funding.
- MDH and HSCRC should provide more effective guidance on specific projects that would be high-value investments.
- The application itself would benefit from more guidance on the level of detail required, evaluation criteria, cost reporting, and required data analyses.

Proposed Adaptations for Year 2

- HSCRC will offer three tracks to hospitals.
- Track 1 - Community Health interventions that:
  - Address the top drivers of avoidable utilization, readmissions, and/or total cost of care, and also align with the hospital CHNA or CDC Healthy People 2030.
  - Fit clearly into an overall population health strategy by the hospital.
  - Have clearly defined populations and outcome measures, with the HSCRC & MDH recommended common measures as appropriate.
  - Involve trusted community partners as appropriate for the project.
  - Have a viable plan for assessing results.
  - HSCRC and MDH will request a broader view of financial needs of programs.
  - HSCRC and MDH will review and approve/reject applications.
- Track 2 – Physician Spending
  - Support primary care, mental health, and dental providers in HPSAs and MUAs.
  - Fit clearly into an overall provider access strategy by the hospital.
  - HSCRC and MDH will request a broader view of financial needs of practices.
  - Additional review will be applied to funding per practitioner and/or patient panel to assure that expenses are reasonable.
  - HSCRC and MDH will review and approve/reject applications.
- Track 3 - Pre-approved community partnerships selected by a committee of HSCRC & MDH, based on proven experience implementing effective population health interventions.
- If there are insufficient Track 1 and 2 investments, hospitals will be directed to invest in Track 3.

Moving Forward

- Revenue for Reform should be a driver of strategic and transformative population health investments and innovation in communities.
- Based on Year 1 experience, immediate adaptations are needed for improvement in Year 2.
- Staff will return in July with a policy development plan for FY 2026.

Appendix

Revenue for Reform Hospitals – Application Summaries

Hospital	Summary of Intervention
Adventist HealthCare White Oak Medical Center	Supports primary care physician practices in the hospital's primary service area to enhance access to care and engage patients in various wellness initiatives. These practices will operate and support underserved areas that have been federally designated as HPSAs.
University of Maryland Capital Region Health	Aims to increase the supply of primary care providers in medically underserved areas of Prince George's County by attracting and retaining high-quality healthcare providers, draw in residents who currently seek care outside the County, and foster trust among providers and insurance companies that currently refer residents elsewhere.
University of Maryland Shore Regional Health	Aims to address top drivers of avoidable utilization and readmissions through expanding access to care and chronic disease management for medically underserved and vulnerable groups of all ages. Aims to increase primary care provider care capacity and enhance care coordination and connectivity through integrated patient care services.
UMMC -Midtown & UM Rehabilitation and Orthopaedic Institute	Supports the West Baltimore Health Transformation Intervention to impact top areas of health need and social determinants of health. Supports Midtown primary care expansion and pediatric community supports to reduce disease burden and improve the health and well being of adolescents.
Johns Hopkins Bayview Medical Center	Supports short term and post acute services for vulnerable patients who would not otherwise be able to access and pay for these services. Services include skilled nursing facilities (SNF), assisted living facilities (ALF), home care, dialysis, and Helping Up Mission.
Johns Hopkins Bayview Medical Center	Funds a grant to Baltimore Medical System (BMS) to support a portion of uncompensated costs incurred by BMS in providing comprehensive primary and preventative health services in pediatrics and obstetrics and gynecology at Yard 56 to medically underserved populations.
Johns Hopkins Bayview Medical Center	Supports Cardiology Heart Failure Program to optimize patients' recovery after hospitalization through education and implementation of guidelines-directed medical therapy to assist with long term stabilization of symptoms. The program aims to reduce readmissions for patients with a primary diagnosis of heart failure.
Johns Hopkins Bayview Medical Center	Supports the Multidisciplinary Empowerment for Sustainable Health (MESH) Program to provide intensive primary care and wraparound services for patients with high utilization of health care to address chronic disease management & education.

Revenue for Reform Hospitals – Application Summaries, cont.

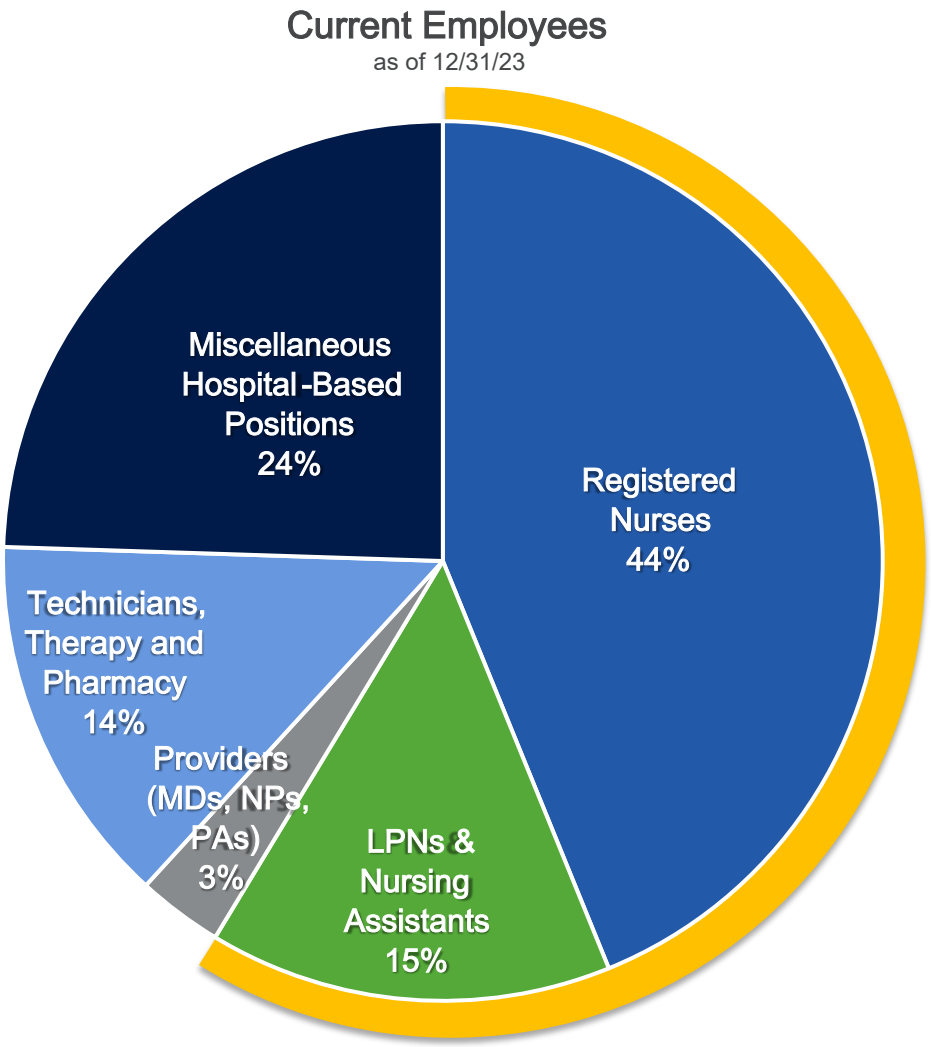
Hospital	Summary of Intervention
Johns Hopkins Bayview Medical Center	Supports The Access Partnership (TAP) of Johns Hopkins Medicine which provides access to primary and specialty care for uninsurable residents located in the East Baltimore community surrounding JHH and JHBMC with demonstrated financial need.
Johns Hopkins Bayview Medical Center	Supports the Assistance in Community Integration Services (ACIS) program which provides housing, case management, and tenancy support services to adults who are high utilizers of emergency departments or have co-occurring chronic health conditions and are experiencing housing instability or homelessness.
Sinai Hospital of Baltimore	Supports Sinai Community Care which offers preventative care services (primary, ob/gyn and pediatric) to under and uninsured patients. The clinic allows patients to connect with appropriate post-acute care with the goal of preventing or lowering return acute-care presentations.
Sinai Hospital of Baltimore	Funds the establishment of a 10-room individualized temporary housing facility to provide a viable non-acute residence option for patients with no permanent and/or established residence. Sinai would support housing for a period of up to one-year for any patient, continuing to provide maintenance primary care, including medication management services, as well as fulfilling daily dietary needs.
Union Hospital of Cecil County, Christiana Care	Supports various programs in partnership with the local health department to increase cancer screening, reduce LGBTQIA+ health disparities, and reduce substance use disorder in the community.
Union Hospital of Cecil County, Christiana Care	Supports the recruitment of new physicians to practices in the hospital's primary service areas to expand access to primary care for patients in HPSAs.
Union Hospital of Cecil County, Christiana Care	Supports case management services for targeted populations with the goal of enhanced and tailored service offerings to improve social and medical outcomes, improve self-managed health, and optimize the patient experience while improving patient satisfaction.

HOSPITALS & THE SIGNIFICANCE OF NURSE EDUCATION

May 8, 2024

Maryland
Hospital Association

MARYLAND'S HOSPITAL WORKFORCE



- Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Nursing Assistants are 59% of the hospital workforce
- Estimated 13,800 additional RNs and 9,200 additional LPNs needed by 2035
- MHA Workforce Task Force recommends
  - Expand Maryland's workforce pipeline
  - Remove barriers to health care education
  - Retain the health care workforce
  - Leverage talent with new care models

Source: MHA Workforce Survey Mar 2024
NOTE: Q4 2023 data represents a 92% Survey Response Rate; 48 of 52 hospitals.

Source: Task Force on Maryland's Future Health Workforce Report August 2022 2022 State of Maryland's Health Care Workforce Report (mhaonline.org)

ACADEMIC PRACTICE PARTNERSHIPS, COLLABOR

- Partnerships between hospitals and nursing programs are essential to build a sustainable and diverse nursing workforce pipeline
- Innovative partnerships result in:
  - Sharing staff/faculty costs to expand program capacity
  - Reducing historical barriers to education (weekend/night clinical opportunities)
  - Improving the student experience, reducing onboarding time and cost upon hire
    - Ex: UMMS Academy of Clinical Essentials (ACE)
      - ACE pairs four nursing students with an UMMS-funded bedside nurse, who also serves as their clinical instructor, to provide care throughout a 12.5-hour shift and for a full patient assignment each week. The instructor-led cohort is equal to one nurse in the unit's staffing number
  - Streamlining clinical placement process
    - MDDC Clinical Nursing Student Placements Collaborative

Source: The UMMS Academy of Clinical Essentials (ACE) | University of Maryland Medical System

INVESTMENT IN EDUCATION

- Advanced training supports practice at the top of license and impacts nursing-sensitive indicators (CLABSIs, CAUTIs, falls, etc.)
- Hospitals use programs funded through the Nurse Support Program to recruit and develop future leaders/succession planning
- BSN-prepared nurses are critical to hospitals
  - Many require a BSN for leadership positions
  - 100% of nurse managers must hold a BSN or MSN to qualify for Magnet status
  - BSN-prepared nurses often serve as charge nurses and lead quality and/or process improvement initiatives at the nursing unit level

Source: Magnet Recognition Program® Eligibility Criteria | ANA (nursingworld.org)

EXAMPLES OF NSP II FUNDED INITIATIVES

- Programming impacts current and future nursing workforce
  - R3- The Renewal, Resilience and Retention of Maryland Nurses Initiative
  - FAMI-MD- Faculty Academy and Mentorship Initiative of Maryland
  - LeadNursingForward.org
  - Maryland Nursing Workforce Center

RESILIENT NURSES INITIATIVE
• MARYLAND •

FACULTY ACADEMY & MENTORSHIP INITIATIVE
Educating Clinical Nursing Faculty in Maryland

LEAD NURSING FORWARD

UNIVERSITY of MARYLAND SCHOOL OF NURSING
MARYLAND NURSING WORKFORCE CENTER

CONTACT INFORMATION

Jane Krienke
Senior Analyst, Government Affairs
jkrienke@mhaonline.org

maryland
health services
cost review commission

Nurse Support Program II

Competitive Institutional Grants Program

Final Recommendations for FY 2025

Erin Schurmann, HSCRC
Laura Schenk, MHEC
Kimberly Ford, MHEC

Nurse Support Programs I & II

Nurse Support Program I (NSP I)

- A non-competitive hospital grant to fund projects that address the individual needs of the hospitals as they relate to nurse recruitment and retention.
- Initiated in 2000 and focused on sustaining the number of bedside RNs through educational opportunities, improved working environments, and retention initiatives.

Nurse Support Program II (NSP II)

- A program aimed at increasing the number of nurses in Maryland by focusing on expanding the capacity to educate nurses through increasing faculty and strengthening nursing education programs at Maryland institutions.
- Initiated in 2006 to increase the nursing and nursing faculty workforce with an emphasis on diversity

Both Programs are funded by the Health Services Cost Review Commission (HSCRC)

NSP I is not competitive and is administered by the HSCRC

NSP II is competitive and is administered by the Maryland Higher Education Commission (MHEC).

NSP II Initiatives

- Increase the supply of nurses by supporting schools of nursing to:
  - Increase the number of nursing lecture and clinical faculty,
  - Expand academic capacity and curriculum, and
  - Enhance enrollments and graduation
- Founded on the National Academy of Medicine's *Future of Nursing* report
- Established in collaboration with statewide nursing stakeholders
- Competitive institutional grants must address one of the six established initiatives
- Prioritize grant initiatives that promote the recruitment and retention of underrepresented groups of nursing

Pathway for NSP II Initiatives to Achieve State & National Goals

NSP II Initiative		Related NSP II Grant Outcome	Related Statewide & National metrics
1	Increase nursing pre-licensure enrollments & graduates	# of additional nursing pre-licensure graduates	• Location Quotient, RN employment & wages (U.S. Bureau of Labor Statistics) • NCLEX-RN pass rates (MBON; NCSBN) • Turnover & retention rates (MONL/MNRC; NSI)
2	Advance the education of students & RNs to BSNs, MSN, & Doctoral level	# of additional nursing higher degrees completed	• National Nursing Workforce Survey (NCSBN)
3	Increase the number of Doctoral-prepared faculty	# of additional nursing faculty at Doctoral level	• Proportion of nurses & nurse faculty with Doctoral degree (AACN; HRSA)
4	Build collaborations between education & practice[1]	Collaborative are specific to grant initiative	• Specific to grant initiative
5	Increase capacity statewide[2]	Statewide results are specific to grant initiative	• Specific to grant initiative
6	Increase Cohen Scholars as future faculty & clinical educators	# of additional Cohen Scholars	• Nurse faculty vacancy rates (NSP II Mandatory Data Tables; AACN)

[1]**Examples of collaborative initiatives:** clinical education models, dedicated education units, pipelines to nursing, community-based health partnerships.
[2]**Examples of statewide initiatives:** faculty professional development, statewide simulation resources, nursing workforce center, nurse resiliency program.

Review Panel Recommendations

- Staff recommends funding 27 proposals, totaling $13,085,063.

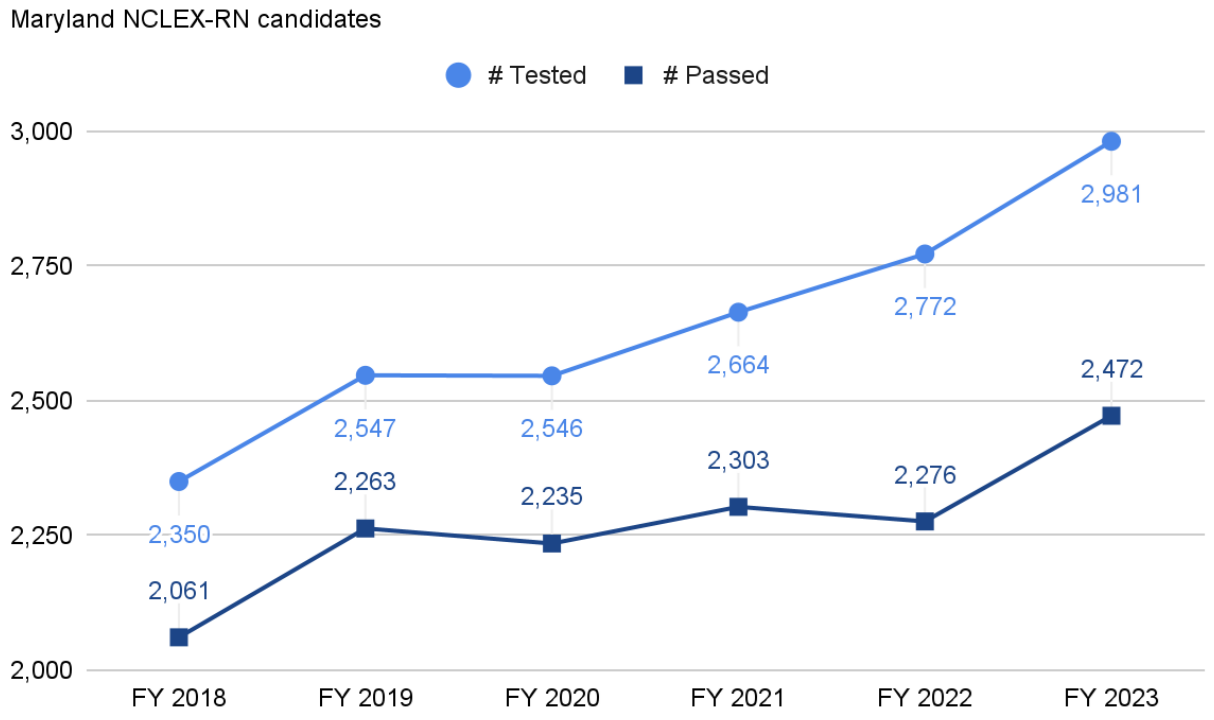
Proposal	School	Title	Duration	Total Funding Request
NSP II-25-101	Allegany College of MD	Hybrid Weekend Nursing Program Expansion	4 years	$913,019
NSP II 25-104	Frostburg State University	LPN to BSN Capacity Building	4 years	$2,150,127
NSP II 25-105	Hagerstown Community College	Evening Weekend Nursing Program	4 years	$1,656,426
NSP II 25-106	Johns Hopkins University	Graduate Academic Nurse Educator Implementation	2 years	$443,693
NSP II 25-109	Notre Dame of MD University	Cultivating Assessment Expertise	1 year	$15,256
NSP II 25-111	Salisbury University	RN-MSN: Accelerated Path	2 years	$142,764
NSP II 25-112	University of Maryland, Baltimore	Igniting Faculty Capacity	3 years	$480,907
NSP II 25-113	University of Maryland, Baltimore	Implementation of a Nurse Managed Health Center	4 years	$1,173,229
NSP II 25-115	University of Maryland, Baltimore	Planning a Part-time Program for the BSN	1 year	$75,764
NSP II 25-201	Anne Arundel Community College	Professional Development Resource Grant	1 year	$50,000
NSP II 25-202	Allegany College of MD	Professional Development Resource Grant	1 year	$34,560
NSP II 25-203	Carroll Community College	Professional Development Resource Grant	1 year	$49,975
NSP II 25-204	Chesapeake College	Professional Development Resource Grant	1 year	$7,460
NSP II 25-205	Coppin State University	NCLEX Resource Grant	1 year	$64,260

Proposal	School	Title	Duration	Total Funding Request
NSP II 25-206	Frostburg State University	Professional Development Resource Grant	1 year	$44,417
NSP II 25-207	Harford Community College	Professional Development Resource Grant	1 year	$48,995
NSP II 25-208	McDaniel College	Professional Development Resource Grant	1 year	$18,186
NSP II 25-209	Montgomery College	MCSRC Statewide Resource Grant	1 year	$1,566,000
NSP II 25-210	Montgomery College	Professional Development Resource Grant	1 year	$48,762
NSP II 25-211	Notre Dame of MD University	Professional Development Resource Grant	1 year	$49,827
NSP II 25-213	Prince George's Community College	Professional Development Resource Grant	1 year	$50,000
NSP II 25-214	Salisbury University	Professional Development Resource Grant	1 year	$50,000
NSP II 25-215	Towson University	Professional Development Resource Grant	1 year	$50,000
NSP II 25-216	Johns Hopkins University	R3 - Renewal, Resilience and Retention of MD Nurses Continuation Grant	2 years	$813,518
NSP II 25-217	University of Maryland, Baltimore	Dedicated Education Unit Continuation Grant	3 years	$484,805
NSP II 25-218	University of Maryland, Baltimore	Head Start Partnership to Expand Clinical Opportunities Continuation Grant	4 years	$756,346
NSP II 25-219	University of Maryland, Baltimore	Maryland Nursing Workforce Center Continuation Grant	4 years	$1,846,767
TOTAL				**$13,085,063**

Appendix - Nursing Workforce Trends

Nursing Workforce Trends

- Entry-to-Practice: NCLEX-RN
  - The number of nursing graduates taking and passing the licensure exam has steadily increased in recent years
- Nurse faculty vacancy rates
  - National average increased from 8% in 2021 to 8.8% in 2022
  - MD average has remained stable: 9.2% in AY 2019-2021 to 9% in 2022
- 80% BSN by 2025
  - Proportion of nurses with BSN or higher degree in MD in 2022 was 75% compared to 71.7% in U.S. *(National Nursing Workforce Survey)*



Importance of Advanced Degrees in Nursing

- BSN degree promotes greater quality and safety in patient care
- Most MD hospitals require BSN within a specified timeframe
- According to MD Nurse Residency data, new graduates with a BSN degree have a lower turnover rate (17%) than those prepared in any other way (19%)
- Summary of feedback from MD Chief Nursing Officers:
  - The BSN is perceived as the minimum standard of education for nurses;
  - The proportion of BSNs is a criteria that is assessed when hospitals are looking to demonstrate excellence through the Magnet Recognition Program®; and
  - Nurses with a BSN or higher are more skilled in leadership, quality improvement, critical thinking, evidence-based practice, professionalism, case management, and teamwork/collaboration.

maryland health services cost review commission

Nurse Support Program II
Competitive Institutional Grants Program

Review Panel Recommendations for FY 2025

May 2024

This is a final recommendation for Commission consideration at the May 8, 2024 Public Commission Meeting.

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

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

Introduction

This report presents recommendations from the Nurse Support Program II (NSP II) Competitive Institutional Grant Review Panel for Fiscal Year (FY) 2025. This report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission). The FY 2025 NSP II recommendations align with the overarching goals of NSP I and II to support excellence in nursing practice and education.

Background

The HSCRC initiated nurse education support funding (formerly titled the Nurse Education Support Program or NESP) in 1986 through the collaborative efforts of hospitals, payers, and nursing representatives. In 2000, HSCRC implemented the Nurse Support Program (NSP I) to address the issues of recruiting and retaining nurses in Maryland hospitals. In 2005, seventy-nine percent (79 percent) of the RN programs reported that they had met or exceeded their enrollment capacity. The shortage of qualified nursing faculty was identified as the fundamental obstacle to expanding the enrollments in nursing programs, thereby exacerbating the nursing shortage. The HSCRC proactively created NSP II to address the barriers to nursing education through statute with the Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund. The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses.

NSP II is distinct from, and in addition to, the NSP I hospital-specific program but shares a mutual goal to increase the number of nurses in Maryland hospitals. NSP II focuses on expanding the capacity to educate more nurses through increasing faculty and strengthening nursing education programs at Maryland institutions. Provisions included a continuing, non-lapsing fund with a portion of the competitive and statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. The Commission approved funding of up to 0.10 percent of regulated gross patient revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused statewide initiatives. MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. After the conclusion of the first ten years of funding, the HSCRC continued to renew the NSP II funding, through June 30, 2025.

NSP II works closely with NSP I and stakeholders in hospitals and schools of nursing in Maryland to ensure that grant funding is addressing current needs of the state's nursing workforce. Since its inception, the NSP II program has gone through several revisions, including:

- The Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund [2006, chs. 221, 222] was amended in 2016 to delete "bedside" to ensure the best nursing skills mix for the workforce was not limited to just bedside nurses.

- In 2012, the NSP II program was modified to include support for development of new and existing nursing faculty through doctoral education grants. Revisions to the Graduate Nurse Faculty Scholarship (GNF) included renaming the nurse educator scholarship in honor of Dr. Hal Cohen and his wife Jo, and sunsetting the living expense grant component.

- In 2012, the NSP I and NSP II initiatives were aligned with the National Academy of Medicine (NAM), formerly the Institute of Medicine, *Future of Nursing* report recommendations (2010). Recently, the NAM released the *Future of Nursing 2020-2030* to chart the path over the next decade. The NSP I and NSP II Advisory Group met to consider how the new recommendations should be incorporated into the NSP programs and agreed that nurse retention should be the critical takeaway item to focus the joint efforts.

- In Spring 2020, the GNF was renamed the Cohen Scholars (CS) program. Additionally, the evaluation responsibility for this program was transitioned from the MHEC Office of Student Financial Assistance to the NSP II staff for future oversight. During the transition, NSP II staff clarified the NSP II eligible service facilities and standardized the teaching obligation for all GNF/Cohen Scholars.

NSP II Initiatives

NSP II employs a three-prong strategy for increasing the number of nurses through strengthening nursing faculty and nursing educational capacity in the state with the ultimate goal of increasing the quality of care and reducing hospital costs. These goals are achieved by (1) increasing the number of nursing lecture and clinical faculty, (2) supporting schools and departments of nursing in expanding academic capacity and curriculum, and (3) providing support to enhance nursing enrollments and graduation for an adequate supply of nurses to meet the demands of Maryland's hospitals and health systems.

Competitive institutional grants must address one of six initiatives which are intended to impact related outcomes in additional nursing pre-licensure graduates, additional nursing higher degrees completed, additional nursing faculty at the doctoral level, or collaborative/statewide results. NSP II initiatives are founded on the recommendations outlined in the National Academy of Medicine's *Future of Nursing* report in collaboration with statewide nursing stakeholders. In alignment with the NSP II statute's guideline provisions, the program tracks, analyzes, and prioritizes grant initiatives that promote the recruitment and retention of underrepresented groups of nursing. NSP II funded initiatives provide a pathway to grow a diverse nursing workforce in the state and achieve progress toward national goals (Table 1).

Table 1. Pathway for NSP II Initiatives to Achieve State & National Goals

NSP II Initiative	Related NSP II Grant	Related Statewide & National

	Outcome	metrics (data source)
1. Increase nursing pre-licensure enrollments and graduates	# Additional nursing pre-licensure graduates	Location Quotient, RN employment & wages (U.S. Bureau of Labor Statistics)
		NCLEX-RN pass rates (MBON; NCSBN)
		Nurse residency turnover & retention rates (MONL/MNRC; NSI)
2. Advance the education of students and RNs to BSNs, MSN and Doctoral level	# Additional nursing higher degrees completed	National Nursing Workforce Survey (NCSBN)
3. Increase the number of Doctoral-prepared nurse faculty	# Additional nursing faculty at Doctoral level	Proportion of nurses & nurse faculty with Doctoral degree (AACN; HRSA)
4. Build collaborations between education and practice (*Examples:* clinical education models, dedicated education units, pipelines to nursing, community-based health partnerships)	Collaborative results are specific to grant initiative (*Examples:* # of additional clinical education spots, # of additional partnerships)	Specific to grant initiative
5. Increase capacity statewide (*Examples:* faculty professional development, statewide simulation resources, nursing workforce center, nurse resiliency program)	Statewide results are specific to grant initiative (*Examples:* # of additional resources, workshops, activities or modules)	Specific to grant initiative
6. Increase Cohen Scholars as future faculty and clinical educators	# Additional Cohen Scholars	Nurse faculty vacancy rates (NSP II Mandatory Data Tables; AACN)

Source: Nurse Support Program II Request for Applications for Competitive Institutional Grants, FY 2025.

Nursing Workforce Trends: Maryland vs Nation

The registered nurse (RN) is the single largest group of health professionals, with more than three million employed nationally and 49,770 RNs employed in Maryland (US Bureau of Labor Statistics, 2023). The demand for RNs is expected to be significant in the coming years, with a projected 193,100 open positions annually until 2032 due to nurses retiring or leaving the profession (US Bureau of Labor Statistics, 2023). If current workforce trends persist, the nation can anticipate a shortage of 337,970 full-time equivalent RNs by the year 2036 which represents a 9 percent shortage (HRSA). The projected shortage of RNs varies

geographically and by state, with non-metropolitan areas expected to experience the greatest shortages (HRSA). To better understand Maryland's supply of RNs, researchers use a Location Quotient (LQ) to quantify how concentrated the nursing industry is in this region as compared to the nation. A LQ greater than one (1) indicates the occupation has a higher share of employment than average. Maryland's share of nurses in 2023 (LQ= 0.89) was less than the national average and most neighboring states, which represents a 2 percent decline from 2022 (Table 2). The annual mean wage for registered nurses in Maryland in 2023 was higher than the average for neighboring states (Table 2).

Table 2. RN Employment and Wages for Maryland and Neighboring States

	Location Quotient (LQ)	RN Employment	Annual Mean Wage
Maryland	0.89	49,770	$92,090
West Virginia	1.45	20,860	$75,990
Delaware	1.20	11,810	$94,670
Pennsylvania	1.16	144,100	$87,530
New Jersey	0.94	82,950	$101,960
Virginia	0.85	70,650	$88,350

Source: U.S. Bureau of Labor Statistics, May 2023.

The nursing workforce is becoming younger and more diverse. The average age of nurses in the US in 2022 was 47.9 years compared to 48.7 years in 2018. In 2022, more than 65 percent of nurses were less than 55 years old and the largest age group was 35-44. The proportion of nurses less than age 55 in 2018 was 62 percent and nurses aged 55-64 represented the largest age group. Data regarding the race/ethnicity of nurses shows that the proportion of RNs that identified as non-hispanic Black increased by 3 percent and the proportion of RNs that identified as non-Hispanic Asian increased by 4 percent. Additionally, male nurses represent 12 percent of the nursing workforce, compared to 10 percent in 2018. There were similar increases to the age and diversity of nurses in Maryland from 2018 to 2022. Maryland's nursing workforce is even younger and more diverse. The average age of nurses in Maryland in 2022 was 46.2 and 69 percent were less than 55 years old. The data from 2022 also shows that 33 percent of RNs in Maryland identify as non-Hispanic Black and 11 percent identify as non-Hispanic Asian. (HRSA, Nursing Workforce Dashboard)

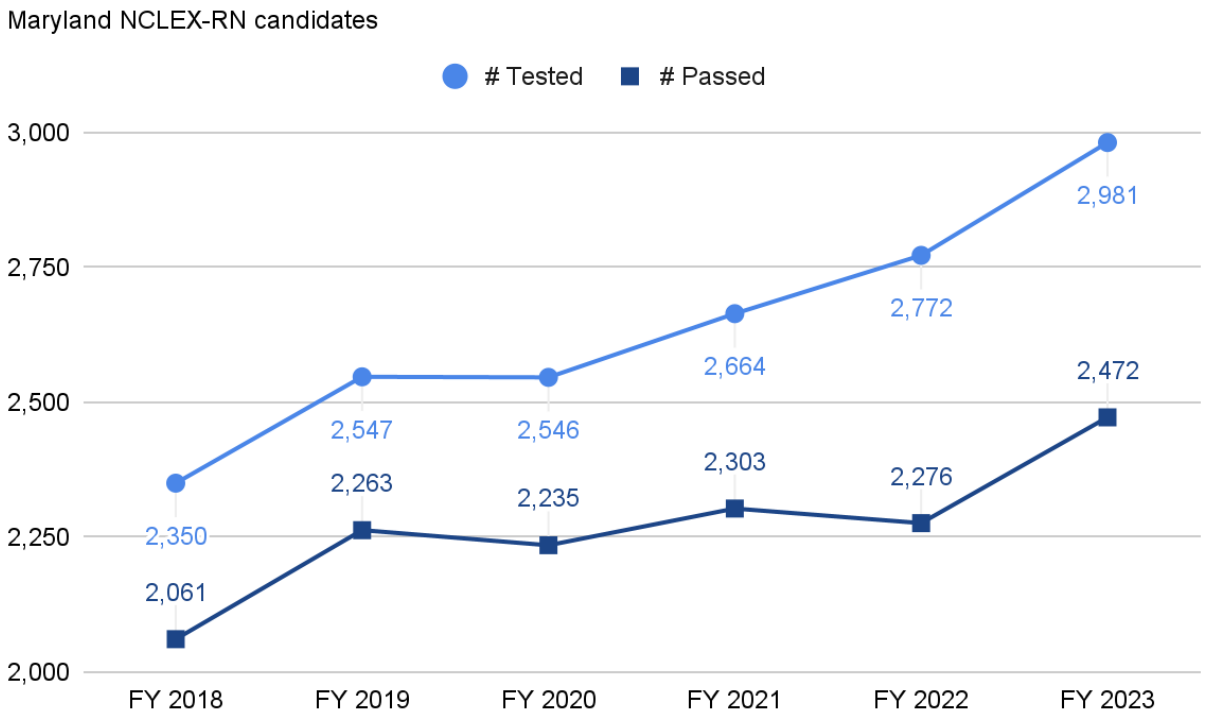
Nursing Workforce Trends: Entry-to-Practice in Maryland

According to researchers, caution should be used when the basis of policy modeling and decision making is employment trends, as nursing shortages are highly sensitive to multiple variables and complex to pinpoint beyond regional trends. A better reflection of the state of Maryland's workforce may be trends in RN entry-to-practice, as it is the most important factor affecting projections of the nursing workforce supply (Auerbach, et al., 2017, pg. 294). In Maryland, the best indicator of entry-to practice is first-time passing

rates for the National Council Licensure Examination – Registered Nurse (NCLEX-RN), available through the Maryland Board of Nursing (MBON). The number of graduates who pass the licensing exam can be a good indication of how many additional nurses are entering the workforce, since it is the last step to become a RN.

The number of nursing graduates taking the NCLEX-RN licensure exam has steadily increased in recent years (Graph 1). The number of nursing graduates tested in FY 2023 (2,981) was 7 percent higher than last year (2,772) and 26 percent higher than in FY 2018 (2,350). This provides evidence that the capacity to educate more nurses has increased. The number of nursing graduates who passed and became licensed RNs in FY 2023 (2,472) was 19 percent higher than FY 2018 (2,061). This equates to the addition of 411 RNs licensed to work in the state. Maryland is well positioned to continue this upward trend due, in part, to NSP II funding of the expansion of existing nursing programs and the development of new programs that provide a pathway to produce additional nursing graduates eligible to take the NCLEX-RN licensure exam.

Graph 1. Maryland's First Time NCLEX-RN Rates, FY 2018 – 2023



Source: Maryland Board of Nursing. National Council State Boards of Nursing, and Pearson Vue. All Maryland RN 1st time candidates who graduated from a Maryland nursing program and tested in any US jurisdiction.

Since FY 2018, NCLEX-RN passing rates in Maryland have been comparable to the overall passing rates in the U.S. and exceeded the nation in FY 2021 and FY 2022 (Table 3). Starting on April 1, 2023, entry-to-practice nursing graduates began testing with the Next Generation NCLEX (NGN) model for registered nursing licensure. This format focuses on clinical judgment and includes a variety of question types with related case studies that go beyond the usual multiple-choice options. Through the Maryland Nurse Workforce Center $1.9 million grant, NSP II funded the creation of a statewide NGN test bank in addition to over 11 free workshops utilizing in-state faculty with expertise to meet the demand for additional resources to prepare faculty and students for this change. A variety of on-demand resources are also made available to Maryland schools of nursing at no cost on the Maryland Nursing Workforce Center website (MNWC). Maryland's NCLEX-RN pass rates from FY 2023 include three months of data from graduates who tested with the NGN model for the NCLEX-RN exam (April 1, 2023 - June 30, 2023). The FY 2024 NCLEX-RN pass rates for Maryland nursing graduates, who will have been tested exclusively with the NGN model, will be available after June 30, 2024.

Table 3. Maryland's First Time NCLEX-RN Rates, FY 2018 – 2023

Fiscal Year	Maryland BSN Programs		Maryland ADN Programs		Maryland MS Entry Programs		Total For All Maryland Programs		Passing Rates	
	No. Tested	No. Passed	No. Tested	No. Passed	No. Tested	No. Passed	No. Tested	No. Passed	MD	US
2018	773	676	1,316	1,145	261	240	2,350	2,061	87.70%	87.81%
2019	867	743	1,375	1,245	305	275	2,547	2,263	88.85%	88.36%
2020	775	650	1,467	1,299	304	286	2,546	2,235	87.78%	87.93%
2021	926	755	1,376	1,218	362	330	2,664	2,303	86.45%	84.48%
2022	965	747	1,433	1,205	374	324	2,772	2,276	82.11%	80.83%
2023	1,027	796	1,542	1,324	412	352	2,981	2,472	82.93%	83.21%

Source: Maryland Board of Nursing. National Council State Boards of Nursing, and Pearson Vue. All Maryland RN 1st time candidates who graduated from a Maryland nursing program and tested in any US jurisdiction.

Nursing Workforce Trends: Maryland New Graduate Retention

The recruitment and retention of nurses is a critical issue at national and state levels. From 2020 to 2022, Maryland hospitals saw a 5 percent and 10 percent increase in RN turnover and vacancy rates, respectively (NSP I, 2023). According to the "2024 NSI National Health Care Retention & RN Staffing Report," the national RN turnover rate in 2023 was 18.4 percent, which represents a 4.1 percent decrease from 2022 (NSI, 2024). The report shows a national RN vacancy rate of 9.9 percent in 2023, which was 5.8 percent

lower than 2022. While this demonstrates some improvement nationally, it is important to recognize the impact that turnover and vacancy rates have on hospital systems. According to the NSI report, the average cost to replace one RN is $56,300 and reflects labor expenses including overtime, increases to salary, critical staffing pay and travel/agency fees. On average, hospitals lost $4.82 million in 2023 due to turnover. Compounding the problem of nurse turnover/vacancies is the time that it takes to recruit a replacement. According to NSI's data, it can take up to three months for a hospital to recruit a qualified nurse, with medical-surgical positions being the most difficult to fill. In the northeast region, which includes Maryland, it takes an average of 106 days to recruit a new nurse, which is 20 days longer than the national average. This data demonstrates how crucial it is to focus on retention efforts. The retention of nurses can result in significant cost savings to hospitals. Each percentage improvement in turnover rates could save a hospital $262,500 annually (NSI, 2024).

As a nationally recognized leader in nurse residency programs, Maryland became the first state in the US to have all acute care hospitals fund and offer nurse residency programs (NRPs) for new nurse graduates in 2018. The purpose of the residency program is to build upon nursing school's foundational knowledge to smoothly transition new nurses into professionals and retain them in the workforce. The Maryland Organization for Nurse Leaders (MONL) tracks data for the Maryland Nurse Residency Collaborative (MNRC) regarding outcomes of nurse residency programs in Maryland. Between 2013 and 2016, retention rates for Maryland hospitals offering an NRP ranged between 91 and 93 percent. Prior to the coronavirus pandemic, Maryland hospitals overall retained more than 88 percent of their new to practice nurses annually (Table 4) compared to an average of 76 percent nationally (NSI, 2021). Moreover, hospital leaders and nurse residents reported that they are more confident and competent after completing their 12-month nurse residency program, resulting in better-prepared nurses and significant hospital cost savings.

Not unexpectedly, the retention rate declined in 2020 due to the coronavirus pandemic. Additionally, staff shortages and safety requirements forced more than half the hospitals to stop their residency programs in April 2020. Maryland hospitals reinvigorated their programs in 2022 and the retention rate of Maryland new nurse graduates increased to 89 percent. The current 2023 retention rate is 91 percent, which demonstrates further improvement. However, persistent staff shortages continue to impact these programs for nurse residents. National trends show that the nursing profession is becoming younger with fewer average years of experience, which supports the continued need for mentoring through nurse residency programs. With an increasingly novice workforce, hospitals cannot rely solely on nurse preceptors on the unit to mentor new graduates to the nursing profession.

Table 4. MNRC Data on Retention of New Nurse Graduates

	2017	2018	2019	2020	2021	2022	2023[1]
Number of Residents Hired	1,573	1,513	1,846	1,995	2,417	2,603	3,422

Turnover Rate[2]	8%	12%	11%	17%	9%	11%	9%
Retention Rate	92%	88%	89%	83%	91%	89%	91%

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

[1]2023 turnover and retention data is preliminary; data is finalized after 12 months of employment.

[2]Turnover rate includes voluntary and involuntary termination of employment.

Nursing Workforce Trends: Burnout & Impact of COVID

Recent surveys have demonstrated, both nationally and in Maryland, that nurse well-being and their intent to remain in the profession were being negatively affected by pandemic-related stress, staffing levels, working conditions, increased violence in the workplace, and day-to-day uncertainties with changing patient acuity. In a three-part longitudinal study, the American Organization for Nursing Leadership (AONL) documented continually worsening job satisfaction, burnout, and intent to leave the profession by nursing leaders. A 2021 Washington Post-Kaiser Family Foundation survey found that 30 percent of healthcare workers were considering leaving their profession altogether. Exacerbating the losses is the imminent retirement of all baby boomers that will reach the traditional retirement age of 65 by 2030, leaving a gap in accumulated skills, knowledge, and experience. Unfortunately, this loss in the RN workforce coincides with the increased healthcare needs of our aging population who have more acute and chronic conditions.

The National Council of State Boards of Nursing recently examined the impact of the COVID-19 pandemic on the nursing workforce in the U.S. and found that 100,000 nurses left during the pandemic and one-fifth intend to leave by 2027 due to stress, burnout, and retirement (NCSBN, 2023). In 2021, the Maryland Nursing Workforce Center surveyed nearly 2,000 nursing staff about the impact of the COVID-19 pandemic and the results are alarming. Many nurse respondents reported that they were physically exhausted:

- 48 percent had experienced sleep disturbances,
- 40 percent experienced moderate to severe stress,
- 48 percent felt anxious,
- 43 percent were unable to control worrying, felt hopeless, and had little pleasure in usual things, and
- 49 percent had symptoms of burnout.

Additionally, about 62 percent of nurses felt their physical health and safety were compromised without their consent, and more than 60 percent indicated an intent to leave their current nursing job. When asked what would make them more willing to remain in the Maryland nursing workforce, 83 percent said that financial incentives with salary increases, annual bonuses, hazard pay, and/or increased retirement contributions, while 74 percent indicated improved staffing and nurse to patient ratios, the ability to self-schedule and flexibility in shift work would make a difference. Other motivators were acknowledgements, wellness resources, and personal protection during large-scale emergencies.

A recent study conducted by Auerbach et al. (2024) showed that nursing workforce projections have rebounded to pre-pandemic levels despite a decrease of more than 100,000 RNs during the COVID-19 pandemic. Additionally, the study found a shift in nurse employment to non-hospital settings, which represented almost all of the growth in workforce from 2018 to 2023 (Auerbach et al., 2024). For this reason, hospitals may still be experiencing nurse shortages despite growths overall. Nurse burnout and intent to leave the profession also persists and adds to the challenges of a looming nursing shortage.

NSP II Program Updates

Progress on "80 Percent BSN by 2025" Goal

Ongoing research findings confirm a hospital's proportion of BSN nurses, regardless of educational pathway, are associated with lower odds of 30-day inpatient surgical mortality (Porat-Dahlerbruch, et al., 2022). A summary of feedback shared with NSP II staff from Chief Nursing Officers (CNOs) in Maryland support the continued importance of the bachelor's degree in nursing (BSN):

- The BSN is perceived as the minimum standard of education for nurses;
- The proportion of BSNs is a criteria that is assessed when hospitals are looking to demonstrate excellence through the Magnet Recognition Program®; and
- Nurses with a BSN or higher are more skilled in leadership, quality improvement, critical thinking, evidence-based practice, professionalism, case management, and teamwork/collaboration.

While all Maryland hospitals hire new graduate nurses with an Associate degree in nursing, almost all require that they obtain a BSN degree within a certain timeframe. According to data from Maryland nurse residency programs, new graduates with a BSN degree have a lower turnover rate (17 percent) than those prepared in any other way (19 percent). As patient acuity levels rise and patients require more complex care, it is imperative to support advanced degrees in nursing.

Data from NCSBN's National Nursing Workforce Survey showed that the proportion of BSN or higher prepared nurses in the US increased to 71.7 percent in 2022 and 51.5 percent of nurses entered the profession with a BSN or higher degree (AACN). In Maryland, 75 percent of nurses responding to the National Nursing Workforce Survey had a BSN or higher degree in 2022 (Source: MNWC). Data from the Robert Wood Johnson Foundation's Campaign for Action showed that the percentage of nurses in Maryland with a BSN or higher degree increased from 55 percent in 2010 to 69 percent in 2020, which was 10 percent higher than the 2020 national average of 59 percent (Brassard, 2023). This demonstrates that steady progress is being made towards achieving the 80 percent goal of nurses holding a BSN by 2025.

Different educational pathways to the BSN are noted to increase accessibility and promote greater RN diversity. To reach this goal, NSP II funded Associate to Bachelor's (ATB) programs to streamline entry-

level education options for nursing students, combining pre-licensure completion at the community college and dual enrollment and curriculum alignments at the university. This program has significant benefits to students by saving both money and the time to complete the Bachelor of Science in Nursing (BSN) degree. In addition, RN-BSN programs expanded online and hybrid delivery options. Finally, second-degree students who successfully completed a BS degree in a different career path were offered an accelerated individualized program to complete their BSN in 12 to 15 months and enter nursing.

Nurse Faculty Workforce

An adequate supply of new graduate nurses is dependent upon enrollment and graduation rates at schools of nursing. The shortage of qualified nursing faculty has long been cited by nursing programs as a primary reason that prevents the admission of additional nursing students.

Overall, the outlook for Maryland faculty is comparable to the nation and has remained stable. According to data collected for the NSP II program, Maryland's nurse faculty vacancy rates increased slightly from an average of 8.1 percent between the 2015-2017 academic years (AY), to an average of 9.2 percent between the AY 2019-2021. However, the average reported full-time faculty vacancy rate for schools of nursing in Maryland remained stable at 9 percent in 2022. Nationally, the average overall vacancy rate for full-time faculty increased from 8 percent in 2021 to 8.8 percent in 2022 (AACN). NSP II program data between AY 2017- AY 2021 demonstrated an increase of 111 full-time faculty at both community colleges and universities (for a total of 629), which tracks along with the MBON figures from a decade ago.

The number of nurses with a doctoral degree has a direct impact on faculty vacancy rates. National data indicated in AY 2022-2023 that 85 percent of U.S. schools of nursing had faculty vacancies that required or preferred a doctoral degree (AACN). Insufficient funds to hire new faculty were reported as the top barrier by 63.3 percent of schools of nursing in AY 2022-2023 (AACN). In Maryland nursing programs, the majority (61.5 percent) of faculty were doctoral prepared, compared to national data where only 19 percent of faculty holds a graduate degree, and fewer than 2 percent hold a terminal doctoral degree (HRSA).

Aging of the nursing workforce continues to be a state and national concern. The number of FT faculty aged 60+ increased in Maryland nursing programs. The AONL Guiding Principles for the Aging Workforce outlines how employers can invest in the productivity of the older RNs including:

- Adapting work environments: providing environmental modifications for injury prevention; reducing the physical demands with bedside computers, automated beds, and non-professional staff assistance,
- Re-designing jobs: developing new and emerging roles; promoting a culture that supports older nurses and post-retirement options to avoid leaving gaps in advanced skill levels and years of expertise at the bedside.

- Other incentives: generational motivators in health benefits, and flexible schedules

Older RNs are needed to guide new nurses and maintain patient safety and quality of care.

Increased Certification of Nurse Faculty

The National League for Nursing's Certified Nurse Educator (CNE®) credential is a mark of excellence for nurse educators. CNE® certification distinguishes nursing education as a specialty area of practice and demonstrates competency as a nurse educator.

Maryland currently has 273 CNE credentialed nurse educators (NLN). According to the NSP II Data (Daw, Ford, & Schenk), the number of faculty holding CNE credentials increased by more than 50 percent since 2018, exceeding the goal to double the number of faculty in Maryland holding the CNE credential by 2025. This includes first-time credentialed and existing CNEs completing the required continuing education and advancement as an educator to maintain the credential, renewed every 5 years. There is already a NSP II FY 2022 funded project to promote the CNE-Clinical with professional development. Faculty recruitment efforts should include these previously untapped CNE credentialed nurses, who with their proven expertise, would be an excellent resource to institutions, and encourage early career educators to move into full-time roles.

New NSP II-Funded Initiatives

Expanded Pathways to Nursing

- A nursing program in Western Maryland is supporting the advancement of licensed practical nurses (LPNs) education with the creation of an online LPN to BSN program.
- A nursing program on the Eastern Shore in Maryland is accelerating degree completion for second degree nursing students with a fast-track BSN option.

Clinical Education Models

- The dedicated education unit (DEU) model provides clinical education on a designated hospital unit and harnesses the expertise of clinical nurses to provide targeted preceptorships.
- The Academy of Clinical Essentials (ACE) model pairs groups of nursing students with a hospital clinical instructor. The Practicum to Practice (P3) model offers nursing students an opportunity to select a 1:1 senior practicum placement where they intend to work. NSP II funding is being used to expand these existing clinical education models.

Community Health Partnerships

- A nursing program in Baltimore has partnered with local Head Start and Early Head Start programs to produce the dual benefits of providing care to children in the community and increasing pediatric clinical opportunities for nursing students.

- The development of a Nurse Managed Wellness Center (NMWC) in Baltimore that provides patient services to the community and clinical opportunities for RN and NP students.

Staff Recommendations for the Competitive Institutional Grants Program

The Competitive Institutional Grants Program builds educational capacity and increases the number of nurse educators to adequately supply hospitals and health systems with well-prepared nurses. The NSP II Competitive Grants Review Panel members are selected based upon their expertise relative to the grant program. The FY 2025 NSP II Review Panel was composed of eight members with backgrounds in healthcare, regulation, nursing education, and hospital administration, and included former NSP II project directors, NSP I and NSP II staff members.

Each grant proposal is compared to and evaluated against the criteria outlined in the Request for Applications (RFA) using a consistent scoring rubric. The scoring rubric assigns a maximum number of points to each section of the grant proposal, including: Abstract (5 pts), Overview (15 pts), Project Goals & Objectives (15 pts), Scope of Proposed Initiative (15 pts), Management Plan (15 pts), Evaluation Plan (15 pts) and Budget & Cost-Effectiveness (20 pts), for a total maximum of 100 possible points. The scoring rubric with guiding questions and a summary score sheet are distributed to the review panelists with a copy of each proposal. Every reviewer on the panel uses the same scoring rubric and guidelines when evaluating proposals and completed forms are submitted to NSP II staff. Every reviewer is asked to provide constructive comments on the strengths, weaknesses and suggested improvements for the proposal in a manner that can be shared with the applicant. When scoring each proposal, reviewers provide one of the following initial funding recommendations: highly recommend, recommend, recommend with revision or not recommend.

After the independent review panelist recommendations have been received, NSP II staff compile and verify the recommendations. Application scores, budgets and any budget revisions are recomputed to ensure mathematical accuracy. The review process concludes with a reviewer debriefing meeting where the strengths, weaknesses and opportunities, and the logic behind each reviewer's score are discussed in order to reach a consensus. Through the review panel debriefing process, final recommendations are formulated for each proposal. Reviewer comments are combined and appropriately paraphrased as needed for each proposal. These comments are shared with the applicants whose proposal was not recommended to help

them to better prepare future grant proposals. Reviewer identity is kept confidential at all times. A total of 35 proposals were received for the FY 2025 NSP II RFA from nursing programs at nine community colleges and eight universities. All 35 proposals were scored and reviewed by the NSP II Review Panel.

Based on the outcome of this review, HSCRC and MHEC staff recommend the following 27 proposals presented in Table 5 for the FY 2025 NSP II Competitive Institutional Grants Program, totaling $13,085,063. This final recommendation describes the panel's recommendations for Commission approval.

Table 5. FY 2025 Recommendations for Funded Proposals

Proposal	School	Title	Duration	Total Funding Request
NSP II-25-101	Allegany College of MD	Hybrid Weekend Nursing Program Expansion	4 years	$913,019
NSP II 25-104	Frostburg State University	LPN to BSN Capacity Building	4 years	$2,150,127
NSP II 25-105	Hagerstown Community College	Evening Weekend Nursing Program	4 years	$1,656,426
NSP II 25-106	Johns Hopkins University	Graduate Academic Nurse Educator Implementation	2 years	$443,693
NSP II 25-109	Notre Dame of MD University	Cultivating Assessment Expertise	1 year	$15,256
NSP II 25-111	Salisbury University	RN-MSN: Accelerated Path	2 years	$142,764
NSP II 25-112	University of Maryland, Baltimore	Igniting Faculty Capacity	3 years	$480,907
NSP II 25-113	University of Maryland, Baltimore	Implementation of a Nurse Managed Health Center	4 years	$1,173,229
NSP II 25-115	University of Maryland, Baltimore	Planning a Part-time Program for the BSN	1 year	$75,764
NSP II 25-201	Anne Arundel Community College	Professional Development Resource Grant	1 year	$50,000
NSP II 25-202	Allegany College of MD	Professional Development Resource Grant	1 year	$34,560
NSP II 25-203	Carroll Community College	Professional Development Resource Grant	1 year	$49,975
NSP II 25-204	Chesapeake College	Professional Development Resource Grant	1 year	$7,460
NSP II 25-205	Coppin State University	NCLEX Resource Grant	1 year	$64,260

NSP II 25-206	Frostburg State University	Professional Development Resource Grant	1 year	$44,417
NSP II 25-207	Harford Community College	Professional Development Resource Grant	1 year	$48,995
NSP II 25-208	McDaniel College	Professional Development Resource Grant	1 year	$18,186
NSP II 25-209	Montgomery College	MCSRC Statewide Resource Grant	1 year	$1,566,000
NSP II 25-210	Montgomery College	Professional Development Resource Grant	1 year	$48,762
NSP II 25-211	Notre Dame of MD University	Professional Development Resource Grant	1 year	$49,827
NSP II 25-213	Prince George's Community College	Professional Development Resource Grant	1 year	$50,000
NSP II 25-214	Salisbury University	Professional Development Resource Grant	1 year	$50,000
NSP II 25-215	Towson University	Professional Development Resource Grant	1 year	$50,000
NSP II 25-216	Johns Hopkins University	R3 - Renewal, Resilience and Retention of MD Nurses Continuation Grant	2 years	$813,518
NSP II 25-217	University of Maryland, Baltimore	Dedicated Education Unit Continuation Grant	3 years	$484,805
NSP II 25-218	University of Maryland, Baltimore	Head Start Partnership to Expand Clinical Opportunities Continuation Grant	4 years	$756,346
NSP II 25-219	University of Maryland, Baltimore	Maryland Nursing Workforce Center Continuation Grant	4 years	$1,846,767
TOTAL				**$13,085,063**

These highly recommended proposals address the following NSP II initiatives:

- NSP II Initiative #1 to increase nursing pre-licensure enrollments and graduates:
    - Part-time entry into practice BSN will be developed to increase diversity in nursing students and the nursing workforce; increase student success; and timely entry into the nursing workforce.
    - Hybrid weekend program at the only Western Maryland Associate Degree nursing program.
    - Adding an evening-weekend nursing cohort program to address critical nursing shortages in Washington County, MD.

- Additional capacity in a new LPN to BSN program with the new, five-semester online LPN to BSN in the first and only fully online program within Maryland. This provides a part-time pathway for working LPNs to continue their education to the BSN degree level by potentially graduating 200 additional students.
- Planning grant to facilitate a reassessment of policies and strategies to prepare students for the National Council on Licensing Examination for registered nurses (NCLEX-RN). This will support building assessment capacity, as well as develop expertise in multi-dimensional assessment including student progress consisting of persistence and retention; teaching quality; and program accountability to stakeholders and licensing and regulatory bodies.
- Resource grant that focuses on providing targeted resources to HBCU students that address factors that contributed to poor academic and NCLEX-RN exam performance. Targeted resources include mentoring, counseling, and workshops that emphasize mental wellness, and life management skills, including financial literacy and emotional intelligence.

- NSP Initiative #2 to advance the education of students and RNs to the BSN, MSN, and Doctoral level: Pathways to nursing and employment that address NSP II initiative :
  - Planning grant will redesign a RN-MSN accelerated program to update the curriculum to meet student and workforce demands. Curriculum will provide a focus for leadership and nurse educator roles with fast-track completion that meets current standards.
- NSP II Initiative #4 to build collaborations between education and practice:
  - Continuation grant that expands on the prior accomplishments of the Dedicated Education Unit (DEU) pilot. The DEU pilot showed medical/surgical students completed more skills and had increased satisfaction with clinical experiences when compared to the traditional model. The program creates pathways to employment for students and builds a well prepared cadre of staff nurses who are ready to mentor students and new graduates. The model will focus on expanding the model to all Maryland regions.
  - A continuation grant will support expanding collaboration between education and practice to build capacity to educate nurses. The grant will augment partnerships with Maryland Family Network, Early Head Start, and Head Start programs to provide family-centered service at Family Support Centers. Building on past success, the model integrates entry-level, RN-to-BSN, and Doctor of Nursing Practice/APRN students in community-based clinical placements.

- A nurse-managed health center model that addresses capacity for clinical sites, faculty practice and competency-based education while providing care to vulnerable populations in Maryland. The model will address health, equity, access and learning.

- NSP II Initiative #5 to increase capacity statewide:
  - Enhance Maryland's nursing workforce readiness through increased integration of competency-based education (CBE) best practices in the state's nursing programs. Statewide nursing faculty will be prepared by incorporating key CBE principles in their teaching approach. Four on-site regional faculty workshops for approximately 200 nursing faculty members with ongoing faculty development.
  - Statewide resource grant for clinical simulation equipment and materials that have a direct effect on student learning through increased fidelity during simulation experiences. The Maryland Clinical Simulation Resource Consortium will support all 29 Maryland pre-licensure nursing schools through this supplemental grant by providing simulation equipment and materials to be utilized in their simulation centers.
  - Continuation grant that strengthens the resilience curriculum before and after graduation. Statewide communities of practice share best practices to optimize the impact of more than 1,500 faculty, students, NRP educators, novice and practicing nurses with skills and strategies that address workload, work-life balance, reduce burnout, improve resilience, well being, job sustainability, and that forge healthy, ethical workplaces.
  - The continuation grant of the Maryland Nurse Workforce Center will work with partners in Maryland on issues relevant to the Maryland nursing workforce. The focus will be expanded to include advocacy, recruiting and pipeline, retention, and nurse education, while maintaining the primary focus on data collection, analysis and dissemination. The MNWC will expand to align with workforce centers nationally and leverage the resources and support of the National Forum for State Nursing Workforce Centers.
  - Professional Development Resource Grants for a total of 12 Schools of Nursing to support lifelong learning and quality education through faculty participation in national and statewide nursing conferences in areas of simulation, instruction, and clinical evaluation.
  - Revise nurse educator courses and provide statewide resources that prepare nurses to assume academic and clinical faculty roles by developing efficiencies for dual preparation of doctoral education and nurse educator certification.

References

1. Auerbach, D. I., Buerhaus, P. I., Donelan, K., & Staiger, D. O. (2024). Projecting the Future Registered Nurse Workforce After the COVID-19 Pandemic. *JAMA Health Forum*, 5(2), 1-10. doi:10.1001/jamahealthforum.2023.5389
2. Auerbach, D. I., Chattopadhyay, A., Zangoro, G., Staiger, D. O. & Buerhaus, P. I. (2017). Improving nursing workforce forecasts: Comparative analysis of the cohort supply model and the health workforce simulation model. *Nursing Economics*, 35(6), 283-326.
3. American Association of Colleges of Nursing (AACN), Fact Sheets, https://www.aacnnursing.org/news-data/fact-sheets
4. American Organization for Nursing Leadership (AONL) Guiding Principles for the Aging Workforce, Accessed April 5, 2022, at https://www.aonl.org/system/files/media/file/2020/12/for-the-aging-workforce.pdf
5. Brassard, A. (2023). Maps Illustrate a Decade of Progress in Nursing Education. *RWJF Campaign for Action*, https://campaignforaction.org/maps-illustrate-decade-progress-nursing-education/
6. Health Resources & Services Administration (HRSA), National Sample Survey of Registered Nurses (NSSRN), https://bhw.hrsa.gov/data-research/access-data-tools/national-sample-survey-registered-nurses
7. Maryland Board of Nursing, NCLEX-RN First Time Candidate Performance, https://mbon.maryland.gov/Pages/education-nclex-stats.aspx
8. Maryland Educator Career Portal, www.leadnursingforward.org

9. Maryland Nursing Workforce Center, Next Gen NCLEX Workshops, https://www.nursing.umaryland.edu/mnwc/mnwc-initiatives/nextgen-nclex/nextgen-nclex-workshops/

10. Maryland Nursing Workforce Center, Analysis of COVID-19 Impact on Maryland Nursing Workforce (December, 2021), Accessed at https://nursesupport.org/nurse-support-program-ii/grants/statewide-initiatives/-maryland-nursing-workforce-center-mnwc-/

11. Maryland Cost of Living Compared to Other States and National Costs, https://www.insure.com/cost-of-living-by-state.html

12. National Council State Board of Nursing, Next Generation NCLEX (NGN), https://www.ncsbn.org/11447.htm

13. National Council State Board of Nursing, NCSBN Research Projects Significant Nursing Workforce Shortages and Crisis (April, 2023). Accessed at https://www.ncsbn.org/news/ncsbn-research-projects-significant-nursing-workforce-shortages-and-crisis#:~:text=The%20data%20reveals%20that%20100%2C000,if%20solutions%20are%20not%20enacted.

14. National League for Nursing, Certified Nurse Educator, CNE®, Certification Portal, https://www.nln.org/awards-recognition/certification-for-nurse-educators-overview

15. National Academy of Medicine, Future of Nursing 2020-2030 and Future of Nursing (2010), accessed at https://nam.edu/publications/the-future-of-nursing-2020-2030/

16. Nurse Support Program, www.nursesupport.org

17. NSP I Annual Report on FY 2022 Activities, July 2023; https://nursesupport.org/assets/files/1/files/nspi/nsp-i-annual-report-on-fy-22-final.pdf

18. NSP II Data Tables in 2019-2023, Spring 2023, P. Daw, K. Ford, L. Schenk

19. NSI Nursing Solutions Inc. 2023 NSI National Health Care Retention & RN Staffing Report; https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf.

20. Porat-Dahlerbruch, J., Aiken, L.H., Lasater, K.B., Sloane, D.M., & McHugh, M.D. (2022). Variations in nursing baccalaureate education and 30-day inpatient surgical mortality*, Nursing Outlook,*70 (2), 300-308, https://doi.org/10.1016/j.outlook.2021.09.009.

21. U.S. Bureau of Labor Statistics, May 2023, Maryland State Level Data and U.S. Comparisons, https://www.bls.gov/oes/current/oes_md.htm and https://www.bls.gov/oes/current/oes291141.htm

maryland
health services
cost review commission

Update on Medicare FFS Data & Analysis

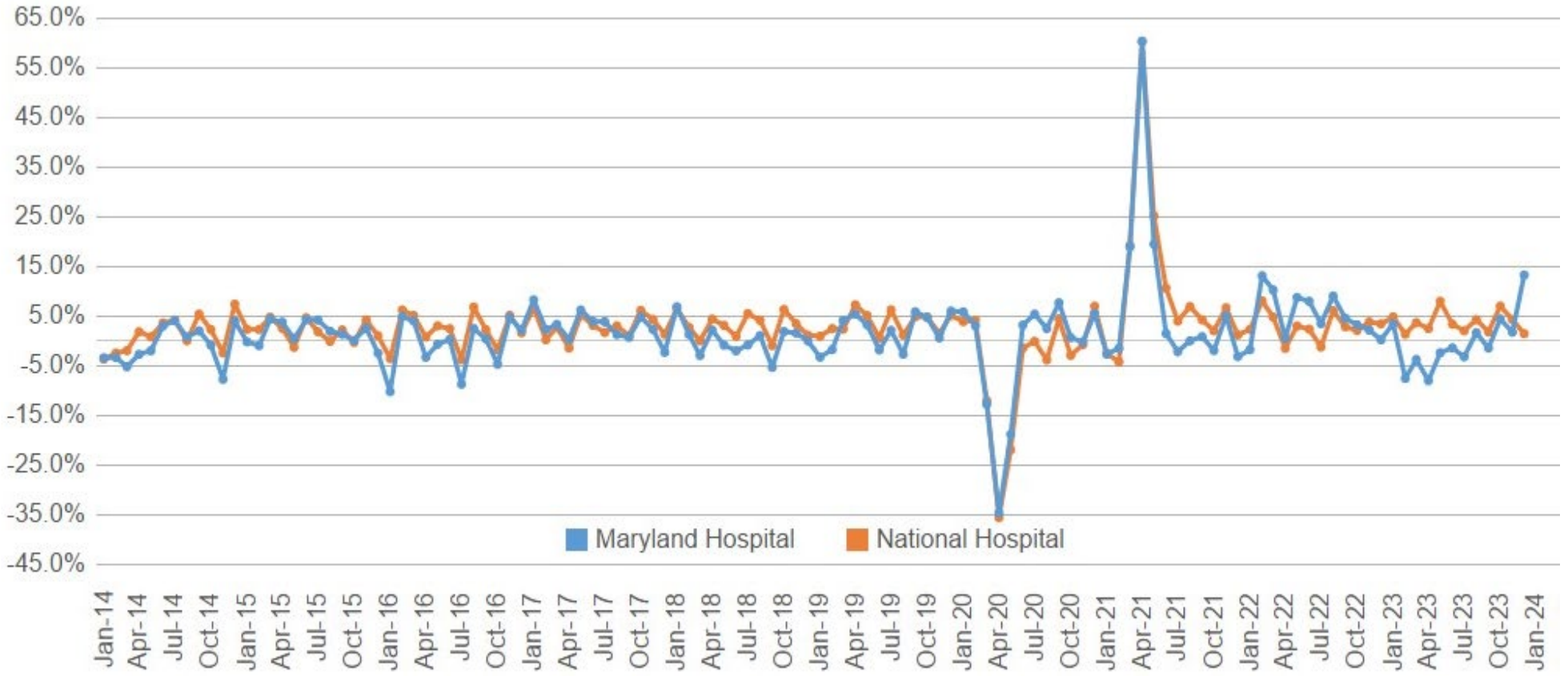
May 2024 Update – FINAL DATA

Data through December 2023, Claims paid through March 2024

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

Medicare Hospital Spending per Capita

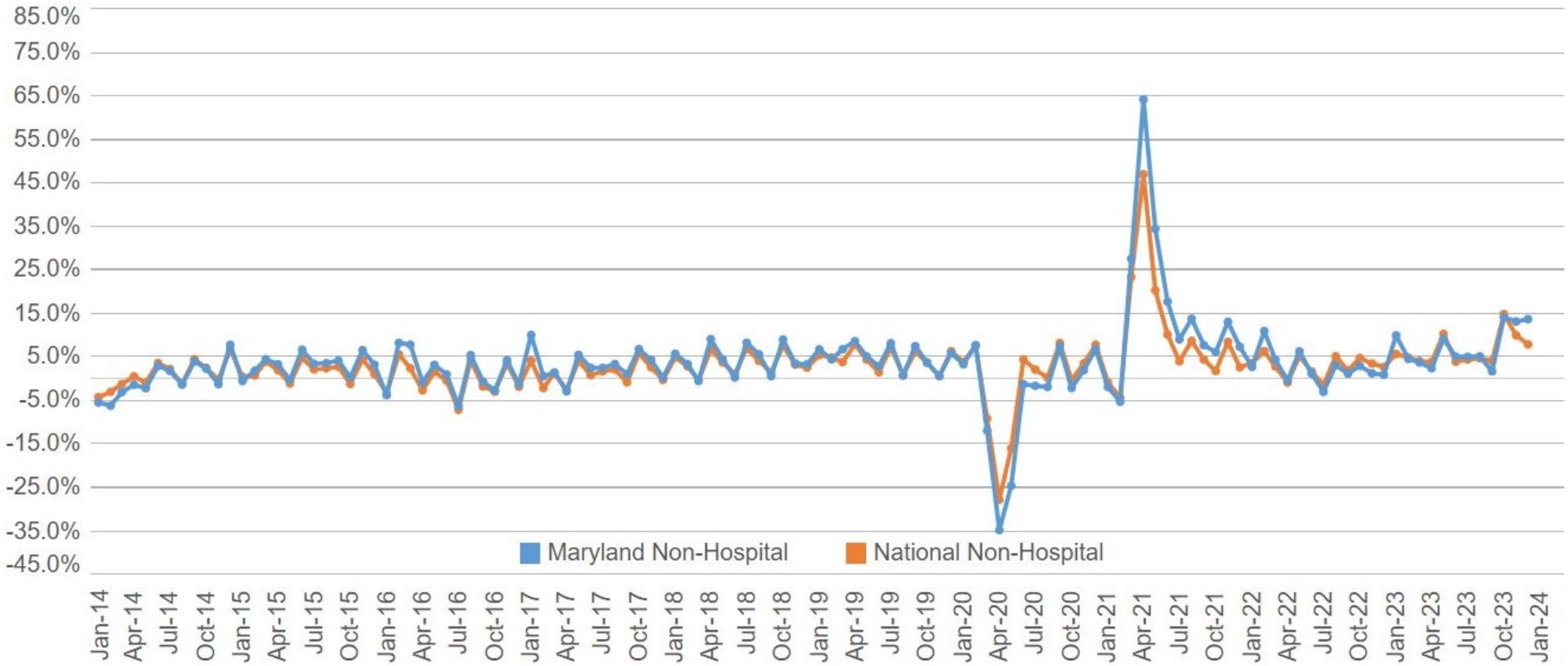
Actual Growth Trend (CY month vs. Prior CY month)



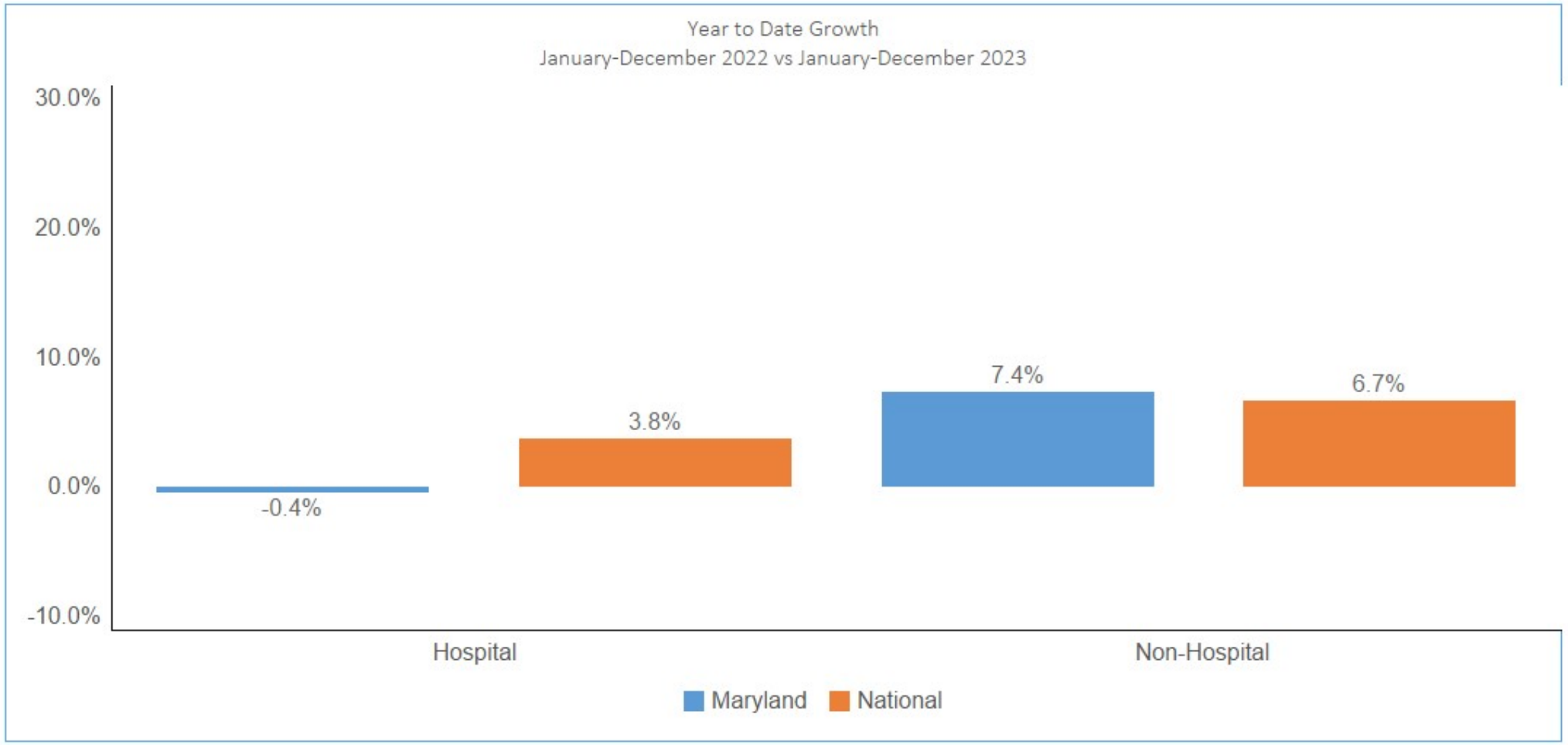
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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



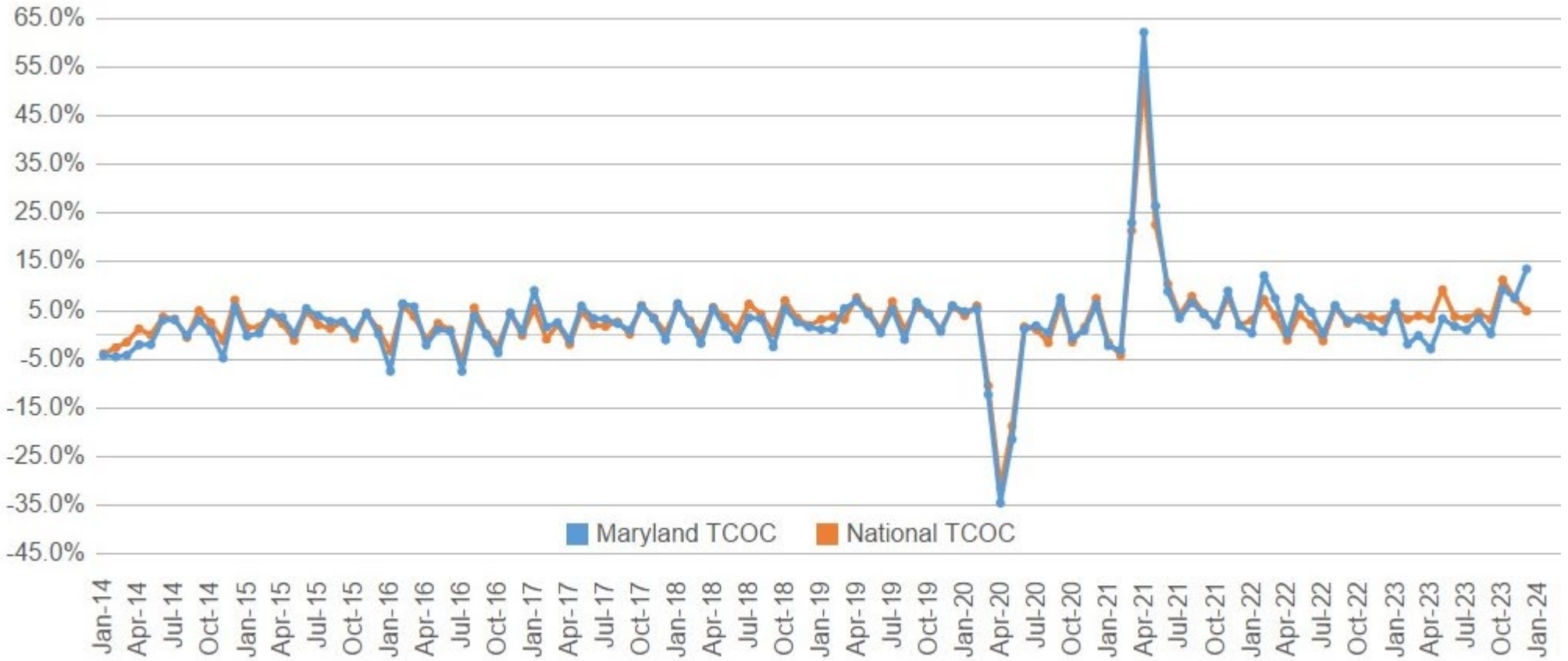
Medicare Hospital and Non-Hospital Payments per Capita



maryland health services cost review commission

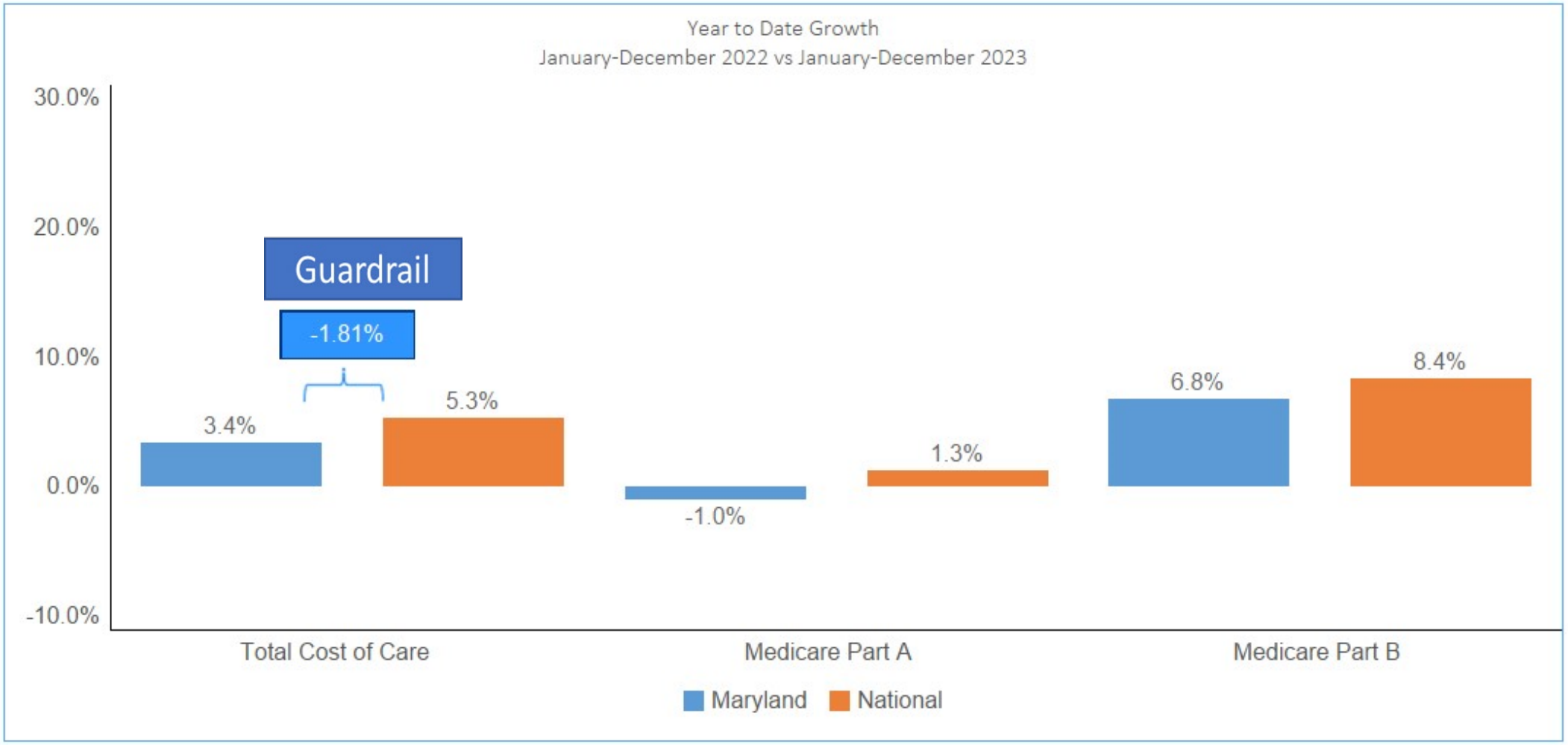
Medicare Total Cost of Care Spending per Capita

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



CY16 has been adjusted for the undercharge

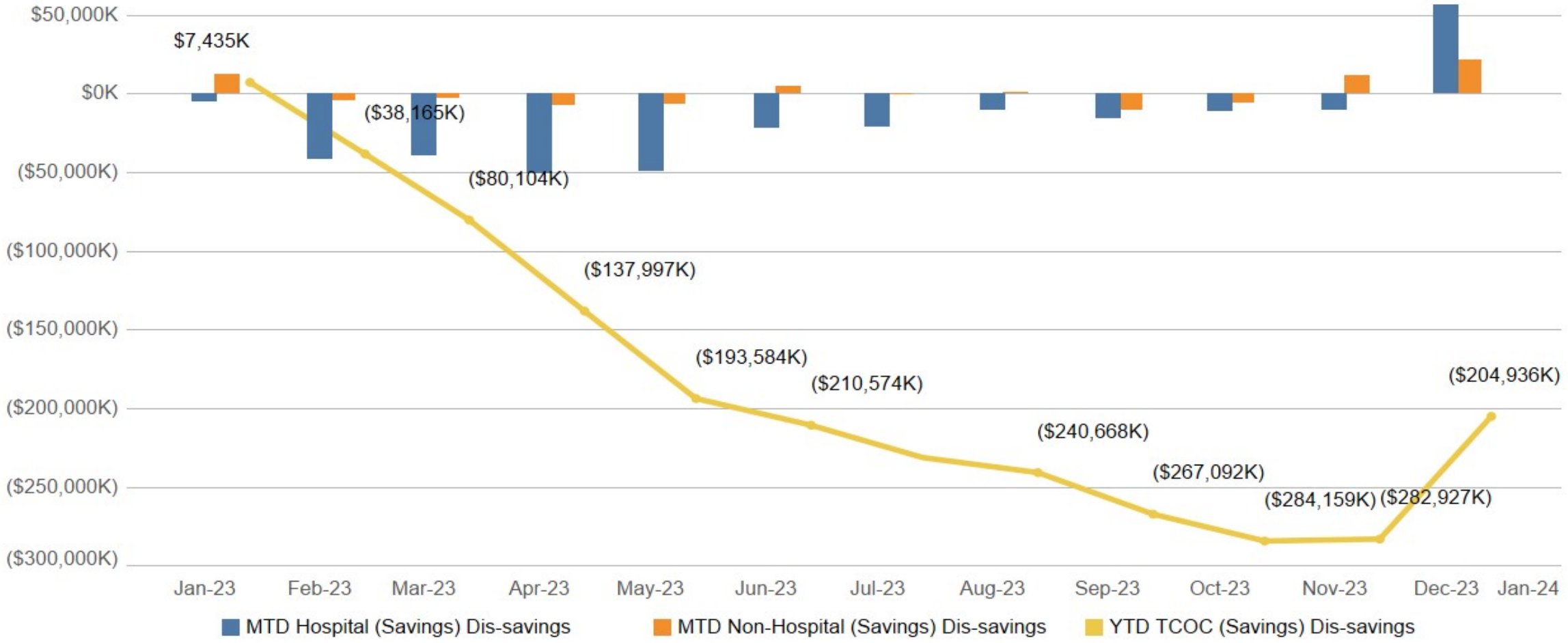
Medicare Total Cost of Care Payments per Capita



maryland health services cost review commission

Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2023



A positive number represents dissavings/excess growth

maryland health services cost review commission

maryland
health services
cost review commission

Hospital Free Care Reimbursement Law Implementation

Update

Megan Renfrew, Deputy Director

May 8, 2024

Overview of Law

HSCRC must coordinate with MDH, DHS, the Office of the Comptroller, HEAU, MSDE, and the Maryland Hospital Association (MHA) to develop a process that:

1. **Identifies** hospital **patients** who paid more than $25 for hospitals services provided in 2017-2021 who qualified for free care, using data from hospitals, the Comptroller, SNAP, Maryland's energy assistance program, and WIC;
2. **Provides reimbursement** from the hospital to the identified patients;
3. **Uses a "safe address"** to contact the patient if available; and
4. Ensure the state agencies **share and disclose** relevant information to the hospitals in compliance with state and federal law and **to the minimum extent necessary** to carry out the required process.

Health General § 19-214.4, as amended by Chapter 310 (2023)

Key Events

December

Released draft MOU, Data Sharing Agreement, and Scope of Work to stakeholders for comment.

January

Commission Meeting Presentation: Overview & Stakeholder Engagement Approach.

February

Received public comments.

HSCRC identified major operational challenges w/ the data sharing process.

Staff began meeting with legislators and stakeholders to develop a new approach.

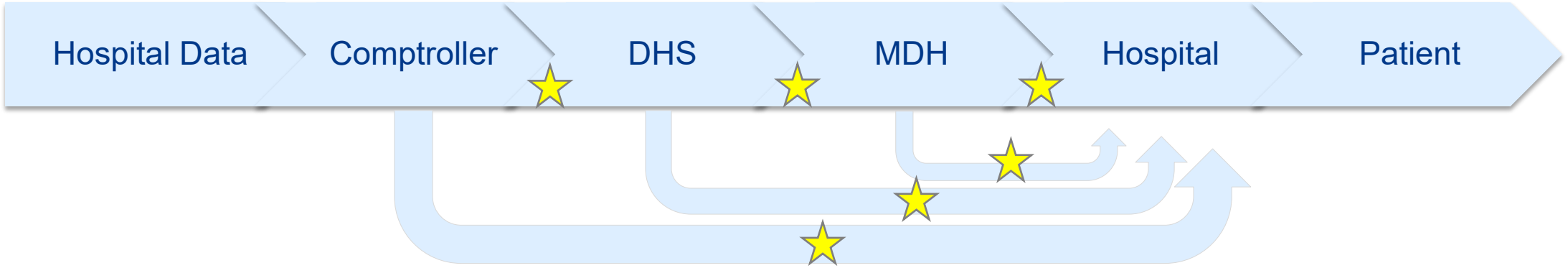
March

Developed an outline of a new process with input from stakeholders and legislators.

April

Began vetting the process through the original stakeholder engagement approach.

Challenge with 2023 Process



1. Law does not allow State data to be shared with third parties.
   - State Agencies and hospitals rely on contractors for routine business processes
   - EHRs are designed to allow interoperability (i.e., data access).
2. Tax information is subject to security requirements which are different than the security requirements for medical records.

Hospitals and State Agencies would need to significantly change business processes, which would likely result in small teams manually processing data, printing letters, and conducting other operational activities. This is a risk to the accuracy and fairness of the process.

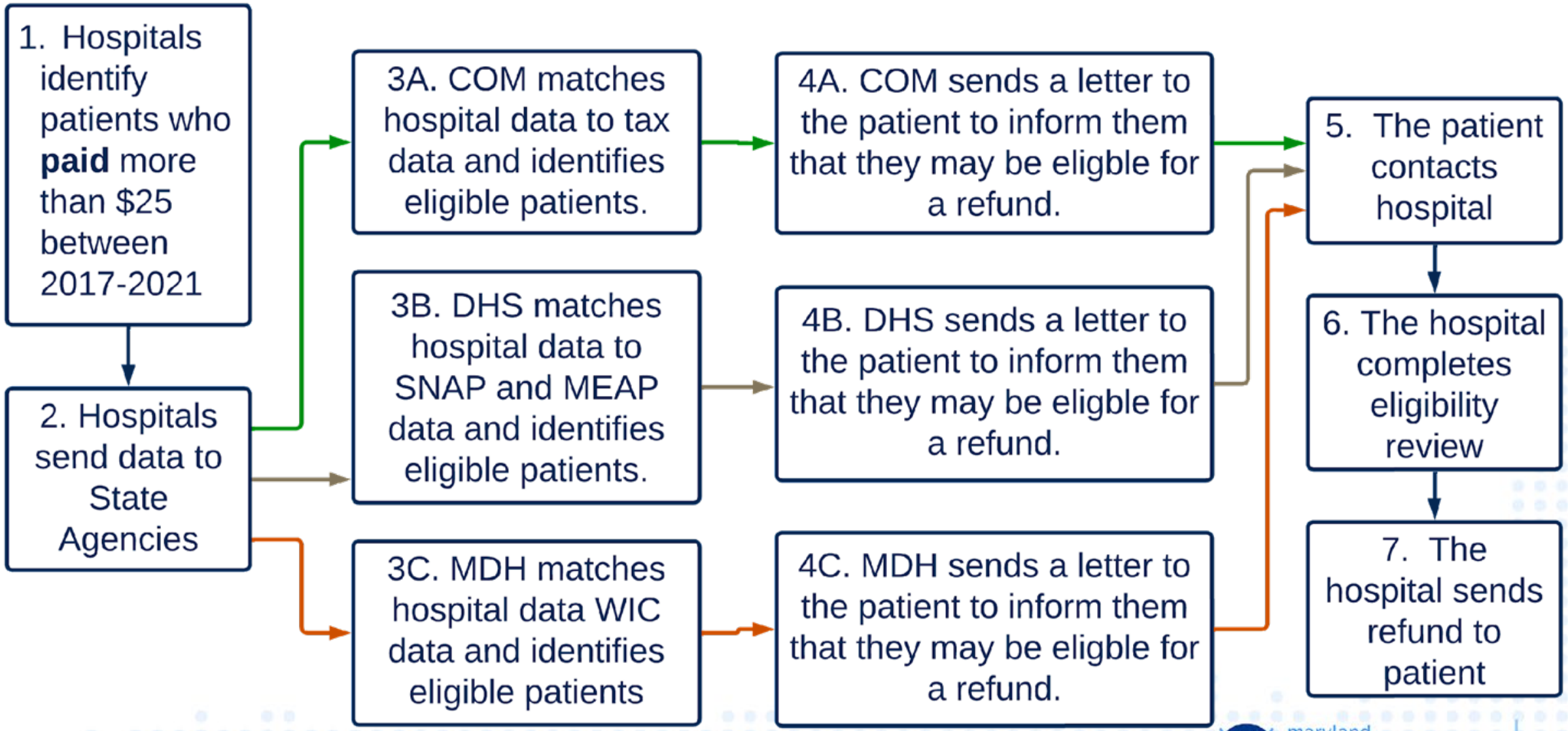
Changing the Process

Legal authority: "The Commission may modify the process …. as necessary," Health General 19-214.4(d)(1).

Goals:

- Accomplish goal of law, to provide refunds to patients.
- Eliminate sharing of PII between state agencies.
- Eliminate sharing of State data w/ hospitals.

New Data Flow



Revised Timeline

Task	Start Date	End Date
Stakeholder Workgroups	Ongoing	6/1/25
Develop, Revise, and Finalize Legal, Policy, and Operational Documents	Ongoing	12/31/24
Collect Signatures on Legal Documents	9/1/24	12/31/24
Implement Outreach Campaign	9/1/24	6/15/25
Data Exchange and Send Letters to Patients	9/15/24	March 2025
Hospital Distribution of Refunds	10/1/24	6/30/25
Sunset Date of Law	N/A	6/30/25
Hospitals Reimburse State Agencies for Resources	TBD	10/1/25

Thank you!

- Megan Renfrew, Deputy Director of Policy and Consumer Protection
  - Megan.Renfrew1@Maryland.gov

- Webpage: Free Care Refunds Implementation Updates:
  - https://hscrc.maryland.gov/Pages/Free-Care-Refunds-Implementation-Updates.aspx

maryland
health services
cost review commission

Updates to the Accounting and Budget Manual

May 08, 2024

Agenda

- Annual Filing Modernization Project
- Task 5 / Subgroup 3
- List of Updates

AFM Project Background

In August 2023, the HSCRC engaged I3 Healthcare Consulting to assist with an Annual Filing Modernization (AFM) initiative. The overall goal of this project is to obtain additional information about the operational costs at regulated hospitals to better improve HSCRC oversight, as well as streamline the documentation and collection of this information. The AFM project consist of the following workstreams:

1) Physician Cost Allocation
2) Cost Center Alignment
3) Overhead Reallocation
4) Annual Filing Submission Revisions
5) Accounting and Budget Manual Revisions

Task 5 / Subgroup 3 and List of Updates

The current version of the Accounting and Budget Manual was created in the late 1970s. Since that time, there have been revisions but not a complete overhaul. The objective of Task 5 is to modernize the manual by first removing information which is no longer relevant; adding new content learned while completing Tasks 1-4; and improving the way readers of the manual view and query its content.

At this time, HSCRC has removed outdated content and revised other portions of the manual (Phase I). A summary of these changes are as follows:

- Removed general accounting principles;
- Removed instructions for establishing an accounting system;
- Updated and added Cost Center information;

List of Updates (continued)

- Updated mailbox addresses;
- Removed reports no longer relevant;
- Updated instructions;
- Updated checklists;
- Added and updated hospital names, financial and Medicare identification numbers;

maryland
health services
cost review commission

Updates to the Accounting and Budget Manual

May 8, 2024

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

Background

In August 2023, the HSCRC engaged I3 Healthcare Consulting to assist with a Annual Filing Modernization (AFM) initiative. The overall goal of this project is to obtain additional information about the operational costs at regulated hospitals to better improve HSCRC oversight, as well as streamline the documentation and collection of this information. The AFM project consist of the following workstreams:

1) Physician Cost Allocation
2) Cost Center Alignment
3) Overhead Reallocation
4) Annual Filing Submission Revisions
5) Accounting and Budget Manual Revisions

This document focuses on Task 5, Accounting and Budget Manual Revisions.

Task 5 / Subgroup 3

The current version of the Accounting and Budget Manual was created in the late 1970s. Since that time, there have been revisions but not a complete overhaul. The objective of Task 5 is to modernize the manual by first removing information which is no longer relevant; adding new content learned while completing Tasks 1-4; and improving the way readers of the manual view and query its content. At this time, HSCRC has removed outdated content and revised other portions of the manual (Phase I). A summary of these changes are as follows:

Section 100 (Accounting Principles and Concepts)

- Removed general accounting principles;

Section 200 (Chart of Accounts)

- Removed instructions for establishing an accounting system; updated cost center information;

Section 300

- No change. This section will remain blank until the final version of the manual is finalized.

Section 400 (Reporting Requirements)

- Updated mailbox addresses; removed reports no longer relevant;

Section 500 (Reporting Instructions)

- Updated instructions; removed reports no longer relevant;

Section 600 (Reporting Schedule Checklist)

- Updated checklist; removed attestation form;

Section 700 / Appendix D (Standard Units of Measure)

- No changes;

Appendix A (Glossary of Terms)

- Removed List of Accounting Terms section;

Appendix B (Hospital List)

- Added and Updated hospital names, financial and Medicare identification numbers;

Appendix C (Center Codes)

- Added additional center codes;

Alternative Method of Rate Determination (ARM) Manual

- Removed language no longer relevant and added current policy.

SECTION 200
CHART OF ACCOUNTS

7580 AUDIOLOGY

Function

The Audiology cost center provides and coordinates services to person's age newborns through geriatrics. Audiology evaluates individuals with auditory and vestibular complaints or symptoms (including, but not limited to, impaired hearing, tinnitus, dizziness, imbalance, sound intolerance, delayed speech and language, auditory processing problems, poor educational performance, or failed hearing and/or balance screening results), and aid in the diagnosis of vestibular disease/falls risk leading to vestibular rehabilitation. Audiology diagnoses hearing loss, identifies auditory disorders, and determines the possible etiology of auditory disorders.

Conducted evaluations include, case history (including previous assessments and diagnoses, diagnostic impressions, and management planning); physical examination of the ears and cranial nerve function, gait, and posture; qualitative and/or quantitative classification of communication abilities; assessment and impact of tinnitus and/or decreased sound tolerance; behavioral (psychometric or psychophysical), physical, and electrophysiological tests of hearing, auditory function, balance and vestibular function, and auditory processing that result in the formation of a diagnosis and subsequent management and treatment planning.

Audiologists collaborate with other healthcare providers, patients and their caregivers to integrate information, test results, and treatment recommendations to develop a comprehensive needs assessment for medical, educational, psychosocial, vocational, or other services. They also design and implement programs to prevent the onset or progression of hearing loss and identify individuals exposed to potentially adverse conditions.

Description

This cost center contains the direct expenses incurred in maintaining an Audiology program. The expense related to the sale of hearing aids and disposable medical supplies must not be included here but accounted for in the Medical Supplies Sold cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Audiology Relative Value Units (RVU) as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted services or procedures should be estimated based on other comparable modalities or procedures.

Data Source

The **number** of RVU shall be obtained from an actual count maintained by the Audiology Cost Center.

Reporting Schedule

Schedule D - Line D43

7110 MEDICAL SUPPLIES SOLD
7111 Medical Supplies-Billable
7112 Medical Supplies-Non-Billable

Description

The Medical Supplies Sold cost center is used for the accumulation of the invoice cost of all disposable medical and surgical supplies and equipment used in daily hospital service centers, ambulatory service centers and certain ancillary service centers (Labor and Delivery and Delivery Services, Account 7010, Operating Room, Account 7040, Ambulatory Surgery, Account 7050, Speech-Language Pathology, Account 7550, and Audiology, Account 7580, Interventional Radiology/Cardiovascular, Account 7310, Occupational Therapy, Account 7530, and Physical Therapy, Account 7510). The invoice/inventory cost of non-chargeable disposable supplies and equipment issued by the Central Services and Supplies cost center (Account 8460) to patient care cost centers shall be maintained in this cost center. If such items are purchased by the patient care cost center, the invoice cost of preparing and issuing medical and surgical supplies and equipment must be accumulated in the Central Services and Supplies cost center (Account 8460). The cost of reusable (non-disposable) medical and surgical supplies must be accounted for in the Central Services and Supplies cost center (Account 8460). The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (excl. nursery)
Gross Inpatient Revenue

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the General Ledger. Inpatient Admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule D - Line D26

7550 SPEECH-LANGUAGE PATHOLOGY

Function

The Speech-Language Pathology cost center provides evaluation and treatment to persons with impaired speech, language, cognitive-communication, or swallowing function. Speech-Language Pathology includes evaluation, treatment, and establishing plans of care to address areas of need. Specific Speech-Language Pathology services, which shall be implemented or supervised by a licensed speech-language pathologist, include but are not limited to diagnostic assessment and evaluation, treatment, and continued evaluation/periodic re-evaluation.

Diagnostic assessment and evaluation includes clinical appraisal of speech (articulation, voice, fluency, motor speech disorders), deglutition (clinical bedside dysphagia exams and instrumental dysphagia assessments, such as flexible endoscopic examination of swallowing or modified barium swallow studies), language competencies (expressive and receptive language domains), and underlying processes (speech perception, visual perception, motor skills, cognitive skills, memory, attention, etc.) through standardized and informal tests, and hearing screening. Treatment includes planning and conducting treatment programs on an individual or group basis, to develop, restore, improve or augment functional skills of persons disabled in the processes of speech, deglutition, language and/or underlying processes. Continued evaluation/periodic re-evaluation includes both standardized and informal procedures to monitor progress and verify current status.

Additional activities may include but are not limited to preparation of written diagnostic evaluative and special reports; provisions of extensive counseling and guidance individuals and their families; and maintaining specialized equipment utilized in evaluation and treatment such as assistive communication devices and speech prostheses.

Description

This cost center contains the direct expenses incurred in maintaining a Speech-Language Pathology Cost Center. Any expenses related to the sale of speech prostheses or other communication aids and disposable medical supplies must not be included here but accounted for in Medical Supplies Sold cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units (RVU)

Speech- Language pathology RVUs as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted modalities or for procedures should be estimated based on other comparable modalities or procedures.

Data Source

The number of Relative Value Units shall be the actual count maintained by the Speech-Language Pathology cost center.

Reporting Schedule

Schedule D - Line D41

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

ACCOUNT NUMBER	COST CENTER TITLE
7580	AUDIOLOGY

The Audiology relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2024 edition of the Current Procedural Terminology (CPT) manual, and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2023 Medicare Physician Fee Schedule (MPFS) released December 15, 2022, and then assigned using the following protocol. For the new 2024 CPT codes we used the 2024 Medicare Physician Fee Schedule (MPFS) released December 13, 2023.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, basic vestibular evaluation CPT of 92540 has a NON-FAC PE RVU of 1.69. 1.69 * 10 = 16.9. 16.9 rounded = 17. 17 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

a. 92537 Caloric vestibular test, bithermal did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92540 basic vestibular evaluation which is 17 RVUs.

b. 92538 Caloric vestibular test, monothermal did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92537 Caloric vestibular test, bithermal rounded down which is 17 divided by 2= 8.5 rounded down to 8.

c. 92550 Tympanometry and reflex threshold measurements did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) = 5 RVUs.

d. 92557 Comprehensive audiometry threshold did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources

involved that it is a combination of CPT 92553 Pure tone audiometry (13 RVUs) and CPT 92556 Speech audiometry threshold (13 RVUs) = 26 RVUs.

e. 92570 Acoustic immittance testing did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) plus 2 RVUs for decay testing= 7 RVUs.

f. 92579 Visual reinforcement audiometry did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92552 Pure tone audiometry which is 11 RVUs.

g. 92588 Distortion product evoked otoacoustic emissions, comprehensive did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it should be set at double CPT 92587 Distortion product evoked otoacoustic emissions, limited 3*2 = 6 RVUs.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

a. 92630 Auditory rehabilitation, prelingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

b. 92633 Auditory rehabilitation, postlingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

4) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

Other considerations:

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply costs and disposable medical supplies are billable as M/S supplies.
3. Durable Medical Equipment (DME) for inpatient services is billable as M/S supplies. However, DME provided to outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

4. The CPT codes reviewed account for most services provided in audiology. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution and use the RVU assignment protocols listed above.
5. CPT codes are in a process of constant revision and as such providers should review their institution's use of CPT codes and stay current with proper billing procedures.
6. Time increments used in this section of Appendix D are for direct patient time. Direct patient time spent evaluating and treating the patient is billable. Time spent on set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92511	Nasopharyngoscopy with endoscope (separate procedure)	29	Non-Time Based	MPFS
92512	Nasal function studies (e.g., rhinomanometry)	0	Non-Time Based	Zero RVUs. Not SLP/AUD.
92516	Facial nerve function studies (egg, electroneuronography)	17	Non-Time Based	MPFS
92517	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp)	15	Non-Time Based	MPFS
92518	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; ocular (ovemp)	15	Non-Time Based	MPFS
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	15	Non-Time Based	MPFS
92537	Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)	17	Non-Time Based	Mirror CPT 92540 Based on resources
92538	Caloric vestibular test with recording, bilateral; monothermal (i.e., one irrigation in each ear for a total of two irrigations)	8	Non-Time Based	Set at half of CPT 92537 (rounded down) Based on CPT Description and resources

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	17	Non-Time Based	MPFS
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	3	Non-Time Based	MPFS
92542	Positional nystagmus test, minimum of 4 positions, with recording	4	Non-Time Based	MPFS
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	2	Non-Time Based	MPFS
92545	Oscillating tracking test, with recording	2	Non-Time Based	MPFS
92546	Sinusoidal vertical axis rotational testing	35	Non-Time Based	MPFS
92547	Use of vertical electrodes (list separately in addition to code for primary procedure)	3	Non-Time Based	MPFS
92548	Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report	7	Non-Time Based	MPFS
92549	Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (mct) and adaptation test (adt)	6	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92550	Tympanometry and reflex threshold measurements	5	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) Based on CPT Description and resources
92551	Screening test, pure tone, air only	0	Non-Time Based	Zero RVUs. Screening/No Charge/Part of Clinic Visit performed during visit
92552	Pure tone audiometry (threshold); air only	11	Non-Time Based	MPFS
92553	Pure tone audiometry (threshold); air and bone	13	Non-Time Based	MPFS
92555	Speech audiometry threshold	8	Non-Time Based	MPFS
92556	Speech audiometry threshold; with speech recognition	13	Non-Time Based	MPFS
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	26	Non-Time Based	Combination of CPT 92553 (13) + CPT 92556 (13) Based on CPT Description and resources
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	1	Non-Time Based	Typically used for newborn screenings. See DEL rate center when appropriate.
92562	Loudness balance test, alternate binaural or monaural	14	Non-Time Based	MPFS
92563	Tone decay test	10	Non-Time Based	MPFS
92565	Stenger test, pure tone	6	Non-Time Based	MPFS
92567	Tympanometry (impedance testing)	3	Non-Time Based	MPFS
92568	Acoustic reflex testing, threshold	2	Non-Time Based	MPFS
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	7	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) + 2 RVUs for decay testing

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92571	Filtered speech test	9	Non-Time Based	MPFS
92572	Staggered spondaic word test	14	Non-Time Based	MPFS
92575	Sensorineural acuity level test	6	Non-Time Based	MPFS
92576	Synthetic sentence identification test	12	Non-Time Based	MPFS
92577	Stenger test, speech	6	Non-Time Based	MPFS
92579	Visual reinforcement audiometry (vra)	11	Non-Time Based	Mirror CPT 92552 Based on resources
92582	Conditioning play audiometry	24	Non-Time Based	MPFS
92583	Select picture audiometry	16	Non-Time Based	MPFS
92584	Electrocochleography	23	Non-Time Based	MPFS
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	3	Non-Time Based	MPFS
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	6	Non-Time Based	Set at double CPT 92587 Based on resources
92590	Hearing aid examination and selection; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92591	Hearing aid examination and selection; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92592	Hearing aid check; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92593	Hearing aid check; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92594	Electroacoustic evaluation for hearing aid; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92595	Electroacoustic evaluation for hearing aid; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92596	Ear protector attenuation measurements	6	Non-Time Based	MPFS
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	24	Non-Time Based	MPFS
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	17	Non-Time Based	MPFS
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	22	Non-Time Based	MPFS
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	14	Non-Time Based	MPFS
92620	Evaluation of central auditory function, with report; initial 60 minutes	14	Time-Based	MPFS
92621	Evaluation of central auditory function, with report; each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	11	Time-Based	MPFS
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	8	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	12	Time-Based	MPFS.
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92630	Auditory rehabilitation; prelingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92633	Auditory rehabilitation; postlingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	6	Non-Time Based	MPFS
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15	Non-Time Based	MPFS
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	18	Non-Time Based	MPFS
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	14	Non-Time Based	MPFS
92700	Unlisted otorhinolaryngological service or procedure	By Report	Non-Time Based	Unlisted Code
V5240	Dispensing fee, contralateral routing system, binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital

maryland
health services
cost review commission

Revision to the Chart of Accounts and the Accounting & Budget Manual for Speech (STH) & Audiology (AUD)

Background

On October 24, 2023, the HSCRC staff convened a workgroup to review and initiate changes to the Speech -Language Pathology (STH) and Audiology (AUD) Relative Value Units (RVUs) and the guidelines for these rate centers. In addition, the workgroup updated language in the Chart of Accounts for Medical Supplies Sold. The members of this workgroup included representative from Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants.

These changes were initiated for the following reasons:

- To standardize RVUs using the Medicare Physician Fee Schedule weights
- To assign RVUs to procedures that are currently being reported as "By Report."
- To update the new Current Procedural Terminology (CPT) codes and removed inactive CPT codes.

Methodology

- The descriptions of the new codes in Appendix D of the Accounting and Budget Manual were obtained from the 2024 edition of the CPT manual and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs, the group used the 2024 MPFS released November 2023, and then assigned using the following protocol.

- The proposed RVUs were based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there was a Technical (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, the RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 the RVUs were rounded down and all other values were rounded up.

- Unlisted services or services rarely performed have been designated as By Report (BR). RVUs for BR services are to be assigned based on relative RVU value of similar services.

- The BR methodology for each code must be documented and readily available in the event of an audit.

Staff Recommendation

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

maryland
health services
cost review commission

Changes to Relative Value Units for Speech (STH) & Audiology (AUD) Effective July 1, 2024

Draft Recommendation

May 8, 2024

This document contains the draft recommendation for changes to Relative Value Units for Speech & Audiology services effective July1, 2024. Please submit comments on this draft to the Commission by May 15, 2024, via email to William Hoff at William.Hoff@maryland.gov

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

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

Definitions

Current Procedural Terminology (CPT) codes – Describe medical, surgical, and diagnostic services.

Health Care Common Procedure Coding System (HCPCS) – Codes based on the CPT to provide standardized coding when healthcare is delivered.

Relative Value Units (RVUs) – A standard unit of measure. A value or weight assigned to a specific service based on relative resources used for that service relative to other services.

Medicare Physician Fee Schedule (MPFS) – The Centers for Medicare and Medicaid Services ("CMS") use the MPFS for reimbursement of physician services, comprised of resources costs associated with physician work, practice expense, and professional liability insurance.

Background

On October 24, 2023, the HSCRC staff convened a workgroup to review and initiate changes to the STH & AUD RVUs and the guidelines for these rate centers. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. They standardize RVUs using the Medicare Physician Fee Schedule weights; they update new codes using national CPT code definitions; and they remove inactive codes from Appendix D of the Commission's Accounting and Budget Manual.
2. They assign RVUs procedures that are currently being reported as "By Report."
3. They update the RVUs to reflect how STH/AUD services have changed over time. These visits now focus primarily on optimizing a patient's physical function in everyday, meaningful life activities, preventing disability, and maintaining health.

maryland
health services
cost review commission

Speech-Language Pathology

Speech-Language Pathology services, which are required to be implemented or supervised by a licensed speech-language pathologist, include but are not limited to diagnostic assessment and evaluation, treatment, and continued evaluation/periodic re-evaluation.

Diagnostic assessment and evaluation include clinical appraisal of speech (articulation, voice, fluency, motor speech disorders), deglutition (clinical bedside dysphagia exams and instrumental dysphagia assessments, such as flexible endoscopic examination of swallowing or modified barium swallow studies), language competencies (expressive and receptive language domains), and underlying processes (speech perception, visual perception, motor skills, cognitive skills, memory, attention, etc.) through standardized and informal tests, and hearing screening. Treatment includes planning and conducting treatment programs on an individual or group basis, to develop, restore, improve, or augment functional skills of persons disabled in the processes of speech, deglutition, language and/or underlying processes. Continued evaluation/periodic re-evaluation includes both standardized and informal procedures to monitor progress and verify status.

Additional activities may include, but are not limited to, preparation of written diagnostic evaluative and special reports; provisions of extensive counseling and guidance to individuals and their families; and maintaining specialized equipment utilized in evaluation and treatment such as assistive communication devices and speech prostheses.

Other considerations for both STH & AUD.

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply and disposable medical supplies costs are billable as MSS.
3. Durable Medical Equipment (DME) for inpatient services is billable as MSS. However, DME provided to outpatients is not regulated by HSCRC, and all applicable payer DME billing requirements would apply.

Audiology

Audiology diagnoses hearing loss, identifies auditory disorders, and determines the possible etiology of auditory disorders.

Conducted evaluations include, case history (including previous assessments and diagnoses, diagnostic impressions, and management planning); physical examination of the ears and cranial nerve function, gait, and posture; qualitative and/or quantitative classification of communication abilities; assessment and impact of tinnitus and/or decreased sound tolerance; behavioral (psychometric or psychophysical), physical, and electrophysiological tests of hearing, auditory function, balance and vestibular function, and auditory processing that result in the formation of a diagnosis and subsequent management and treatment planning.

Audiologists collaborate with other healthcare providers, patients, and their caregivers to integrate information, test results, and treatment recommendations to develop a comprehensive needs assessment for medical, educational, psychosocial, vocational, or other services. They also design and implement programs to prevent the onset or progression of hearing loss and identify individuals exposed to potentially adverse conditions.

Methodology

The STH & AUD RVUs were developed with the aid of an industry task force working in conjunction with HSCRC staff. The descriptions of the new codes in Appendix D of the Accounting and Budget Manual were obtained from the 2024 edition of the CPT manual and the 2024 edition of the HCPCS. In assigning RVUs, the group used the 2024 MPFS released November 2023, and then assigned using the following protocol.

The proposed RVUs were based on the MPFS Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there was a Technical (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, the RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 the RVUs were rounded down and all other values were rounded up.

1. For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.
2. For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not reflect the facility resources associated with the service), the proposed RVUs were modified.
3. For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

4. Unlisted services or services rarely performed have been designated as By Report (BR). RVUs for BR services are to be assigned based on relative RVU value of similar services.
    a. The BR methodology for each code must be documented and readily available in the event of an audit.

Recommendation

1. That the Commission approves the revisions to the RVU scale for the STH & AUD Rate Centers. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Accounts). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. That the RVU scale be updated to reflect linkages of RVUs to the CPT codes to incorporate the changes in STH & AUD practices. The RVU scale was also updated to link charging guidelines for STH & AUD services to the national definition, consistent with the HSCRC's plan to adopt MPFS RVUs where possible (Attachment 2 – Appendix D);

3. That the new and updated RVUs be effective July 1, 2024, and that the conversion of the STH & AUD RVUs be revenue neutral to the overall Hospital Global Budget Revenues; and

4. That revisions to Appendix-D and the Chart of Accounts for Medical Supplies Sold be effective July 1, 2024.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

ACCOUNT NUMBER	COST CENTER TITLE
7550	Speech Therapy

The Speech Therapy (ST) relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2024 edition of the Current Procedural Terminology (CPT) manual, and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2024 Medicare Physician Fee Schedule (MPFS) released December 15, 2023, and then assigned using the following protocol. For the new 2024 CPT codes we used the 2024 Medicare Physician Fee Schedule (MPFS) released December 13, 2023.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value is used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, treatment of speech CPT of 92507 has a NON-FAC PE RVU of 0.94. 0.94 * 10 = 9.4. 9.4 rounded = 9. 9 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

a. 92521 Evaluation of speech fluency did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92522 Evaluation of speech sound production which is 13 RVUs.

b. 92537 Caloric vestibular test, bithermal did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92540 basic vestibular evaluation which is 17 RVUs.

c. 92538 Caloric vestibular test, monothermal did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92537 Caloric vestibular test, bithermal rounded down which is 17 divided by 2= 8.5 rounded down to 8.

d. 92550 Tympanometry and reflex threshold measurements did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and

resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) = 5 RVUs.

e. 92557 Comprehensive audiometry threshold did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92553 Pure tone audiometry (13 RVUs) and CPT 92556 Speech audiometry threshold (13 RVUs) = 26 RVUs.

f. 92579 Visual reinforcement audiometry did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92552 Pure tone audiometry which is 11 RVUs.

g. 92588 Distortion product evoked otoacoustic emissions, comprehensive did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it should be set at double CPT 92587 Distortion product evoked otoacoustic emissions, limited 3*2 = 6 RVUs.

h. 92611 Motion Fluoroscopic evaluation did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92612 Flexible endoscopic evaluation 46 divided by 2 = 23 RVUs.

i. 97129 Mirror PT/OT- Therapeutic interventions, initial 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.

j. 97130 Mirror PT/OT- Therapeutic interventions, additional 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

a. 92630 Auditory rehabilitation, prelingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

4) For RVUs converting CPT non-time-based codes time-based codes. The time increment selected was 15 minutes. The 15-minute increments used in this Appendix D are subject to the Medicare 8-minute rule. The phrase *"(per HSCRC: each 15 minutes)"* has been added to the CPT description for emphasis.

a. 97150 Therapeutic procedures, group it was determined to use the MPFS RVU of 2 as the base and then double for each 15-minute increment.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

Time	RVU
08-22 MINUTES	2
23-37 MINUTES	4
38-52 MINUTES	6
53-67 MINUTES	8

5) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

Other considerations:

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply (such as TEP, passey-muir speaking valve) and disposable medical supplies costs are billable as MSS.
3. Durable Medical Equipment (DME) for inpatient services is billable as MSS. However, DME provided to outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.
4. The CPT codes reviewed account for most services provided in ST. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as “by report” by the individual institution and use the RVU assignment protocols listed above.
5. CPT codes are in a process of constant revision and as such providers should review their institution’s use of CPT codes and stay current with proper billing procedures.
6. Time increments used in this section of Appendix D are for direct patient time. Direct patient time spent evaluating and treating the patient is billable. Time spent on set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support the services provided.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
31575	Laryngoscopy, flexible; diagnostic	28	Non-Time Based	MPFS
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscope	38	Non-Time Based	MPFS
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	9	Non-Time Based	MPFS
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	4	Non-Time Based	MPFS
92511	Nasopharyngoscopy with endoscope (separate procedure)	29	Non-Time Based	MPFS
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	15	Non-Time Based	MPFS
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)	18	Non-Time Based	MPFS
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	13	Non-Time Based	Mirror CPT 92522 Based on resources
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	13	Non-Time Based	MPFS
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	29	Non-Time Based	MPFS
92524	Behavioral and qualitative analysis of voice and resonance	13	Non-Time Based	MPFS
92526	Treatment of swallowing dysfunction and/or oral function for feeding	12	Non-Time Based	MPFS
92537	Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)	17	Non-Time Based	Mirror CPT 92540 Based on resources

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92538	Caloric vestibular test with recording, bilateral; monothermal (i.e., one irrigation in each ear for a total of two irrigations)	8	Non-Time Based	Set at half of CPT 92537 (rounded down) Based on CPT Description and resources
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	17	Non-Time Based	MPFS
92542	Positional nystagmus test, minimum of 4 positions, with recording	4	Non-Time Based	MPFS
92546	Sinusoidal vertical axis rotational testing	35	Non-Time Based	MPFS
92550	Tympanometry and reflex threshold measurements	5	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) Based on CPT Description and resources
92552	Pure tone audiometry (threshold); air only	11	Non-Time Based	MPFS
92553	Pure tone audiometry (threshold); air and bone	13	Non-Time Based	MPFS
92555	Speech audiometry threshold	8	Non-Time Based	MPFS
92556	Speech audiometry threshold; with speech recognition	13	Non-Time Based	MPFS
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	26	Non-Time Based	Combination of CPT 92553 (13) + CPT 92556 (13) Based on CPT Description and resources
92567	Tympanometry (impedance testing)	3	Non-Time Based	MPFS
92568	Acoustic reflex testing, threshold	2	Non-Time Based	MPFS
92579	Visual reinforcement audiometry (vra)	11	Non-Time Based	Mirror CPT 92552 Based on resources

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92582	Conditioning play audiometry	24	Non-Time Based	MPFS
92584	Electrocochleography	23	Non-Time Based	MPFS
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	3	Non-Time Based	MPFS
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	6	Non-Time Based	Set at double CPT 92587 Based on resources
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	8	Non-Time Based	MPFS
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	24	Non-Time Based	MPFS
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	17	Non-Time Based	MPFS
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	22	Non-Time Based	MPFS
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	14	Non-Time Based	MPFS
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	9	Time-Based	MPFS
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	9	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	18	Time-Based	MPFS
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	7	Time-Based	MPFS
92609	Therapeutic services for the use of speech-generating device, including programming and modification	15	Non-Time Based	MPFS
92610	Evaluation of oral and pharyngeal swallowing function	12	Non-Time Based	MPFS
92611	Motion fluoroscopic evaluation of swallowing function by cine or videorecording	23	Non-Time Based	Set at half of CPT 92612 Based on resources
92612	Flexible endoscopic evaluation of swallowing by cine or video recording	46	Non-Time Based	MPFS
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording	31	Non-Time Based	MPFS
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording	47	Non-Time Based	MPFS
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	8	Non-Time Based	MPFS
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	12	Time-Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92630	Auditory rehabilitation; prelingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	6	Non-Time Based	MPFS
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15	Non-Time Based	MPFS
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	18	Non-Time Based	MPFS
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	14	Non-Time Based	MPFS
92700	Unlisted otorhinolaryngological service or procedure	By Report	Non-Time Based	Unlisted Code
95992	Canalith repositioning procedure(s) (e.g., epley maneuver, semontmaneuver), per day	5	Non-Time Based	Mirror PT/OT
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by boston diagnostic aphasia examination) with interpretation and report, per hour	11	Time-Based	MPFS
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	3	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	10	Time-Based	MPFS
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)	6	Time-Based	MPFS
96125	Standardized cognitive performance testing (e.g., ross information processing assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	13	Time-Based	MPFS
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	4	Time-Based	Mirror PT/OT
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	5	Time-Based	Mirror PT/OT

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	4	Time-Based	Mirror PT/OT
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)	4	Time-Based	Mirror PT/OT
97150	Therapeutic procedure(s), group (2 or more individuals) (per HSCRC: each 15 minutes)	2 +	Non-Time Based	Mirror PT/OT (Starting with 2 and then doubling based on time)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	7	Time-Based	Mirror PT/OT
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes	6	Time-Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (list separately in addition to code for primary service)	2	Time-Based	MPFS
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	4	Time-Based	MPFS
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	9	Time-Based	Mirror PT/OT
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	7	Time-Based	Mirror PT/OT
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	11	Time-Based	Mirror PT/OT

CRISP

FY25 HIE Draft Funding Request

April 2024

7160 Columbia Gateway Drive, Suite 100
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

CRISP Services

1. **POINT OF CARE: Clinical Query Portal & In-context Information**
   - Search for your patients' prior hospital records (e.g. labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine other members of your patient's care team
   - Be alerted to important conditions or treatment information

2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED

3. **POPULATION HEALTH: CRISP Reporting Services (CRS)**
   - Use Case Mix data and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers

Service	Typical Week
Data Delivered into EMRs	1,500,000
Manual Searches	213,000
Patients Searched Manually	128,500
ENS Messages Sent	2.8M
Portal Users	122,000
Live ENS Practices	1,266
Reports Accessed	2,100
Report Users	1,500

4. **PUBLIC HEALTH SUPPORT:**
   - Deploying services in partnership with Maryland Department of Health and Local Health Departments
   - Enabling researchers to appropriately access aggregated data and manage cohort studies
   - Housing the Prescription Drug Monitoring Program (PDMP) for Maryland

5. **PROGRAM ADMINISTRATION:**
   - Making policy discussions more transparent and informed
   - Supporting Care Redesign Programs

Connecting Data to Drive Value

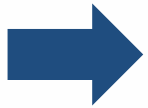
Services

- Enrich Data
  - Link disparate data sets
  - Use multiple sources to fill gaps
  - Improve data feeds
  - Surface key insights
- Distribute Information
  - Create visualizations
  - Control access levels
  - Push individual clinical records
  - Share analytic files
- Enable Interventions
  - Flag patients at the point of care
  - Notify appropriate end users
  - Share relationships between organizations

Value

All data becomes more useful when it is linked, normalized, deduplicated, and cleansed within a single analytics engine

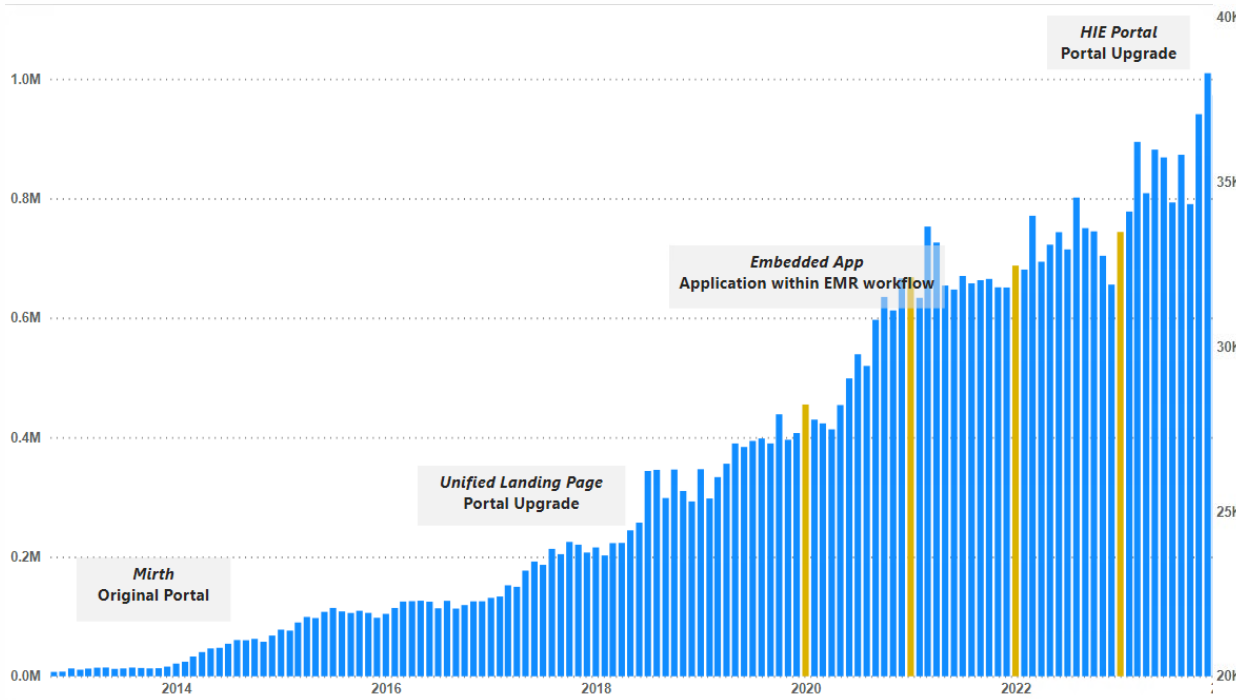
User experience is enhanced and usage increases when a single entity is responsible for governance and distribution



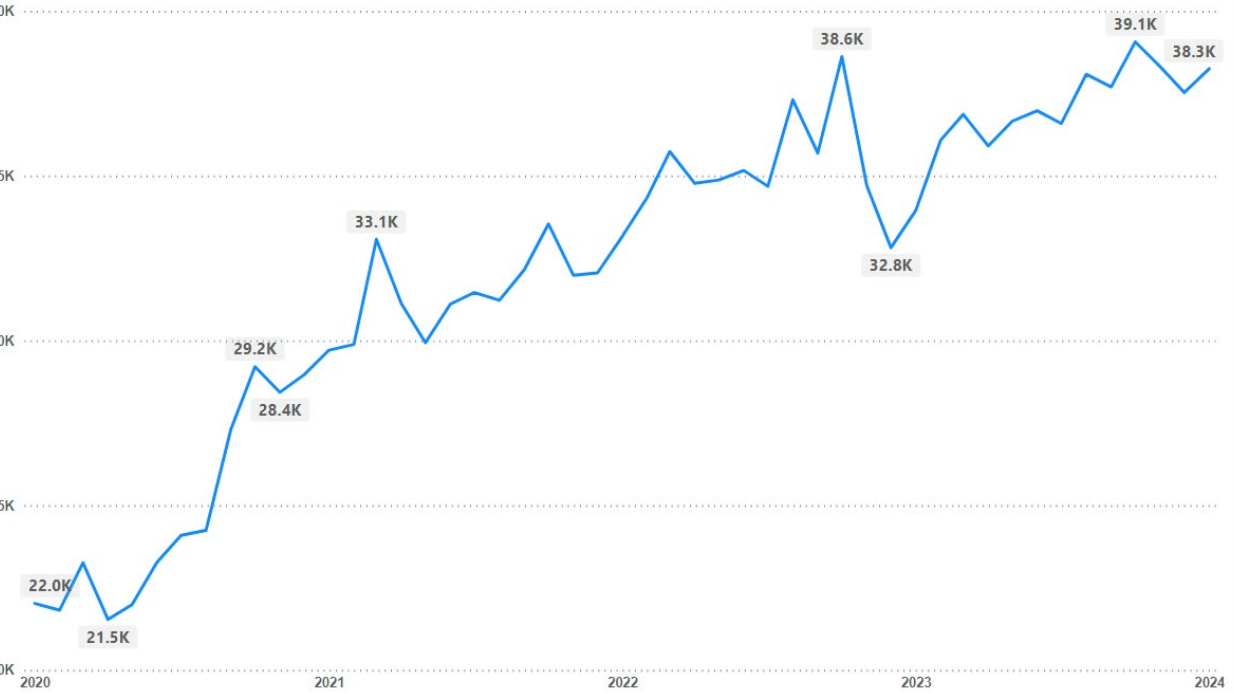
Alignment between population level reports and actionable individual experiences is more likely to result in positive change

CRISP Utilization Trends

Patient Queries Over Time

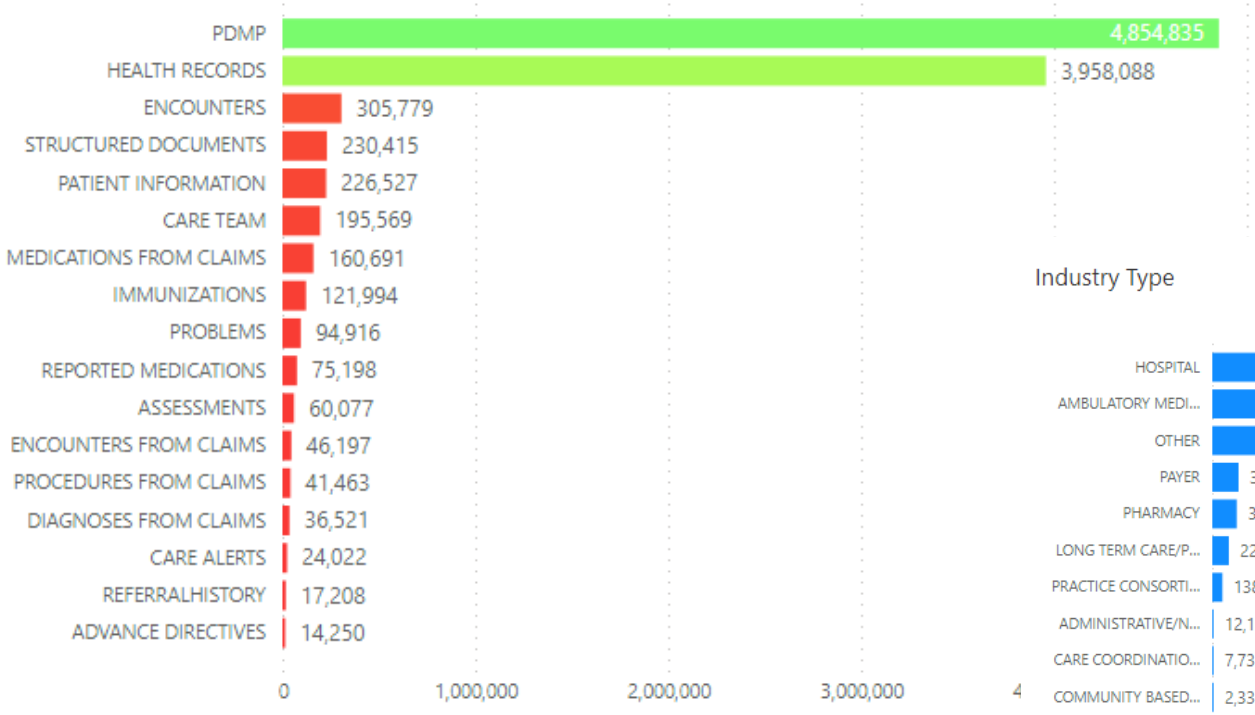


Active Users per Month

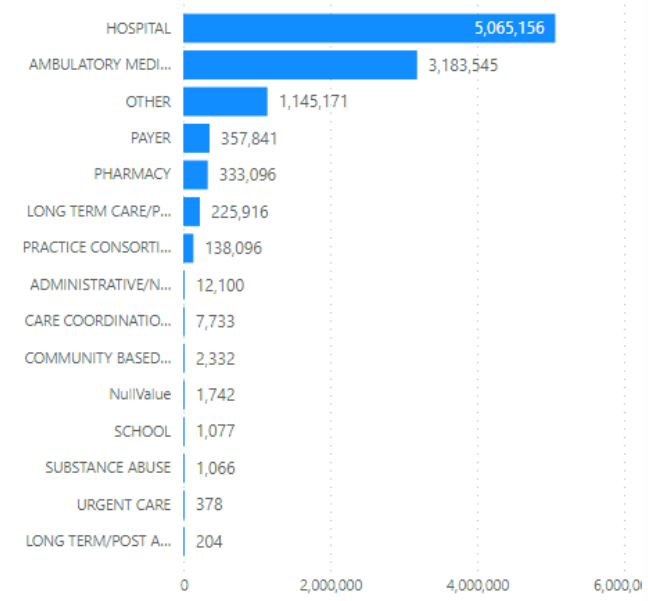


inContext navigation over last 6 months

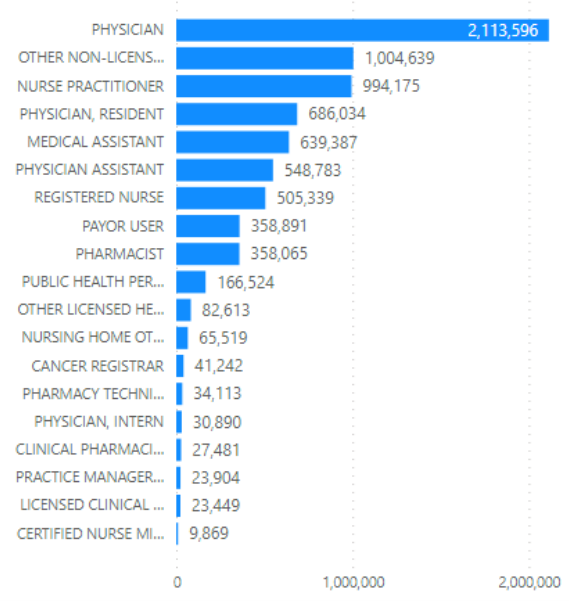
Sub Tab



Industry Type



Member Title



Maryland Program Support

ECIP

CTIs

Regional Partnerships

eCQMs

MDPCP

EQIP

EQIP – Primary Care

AHEAD*

HSCRC Staff Funding Recommendation

Direct HIE Operations	$3,080,000
Reporting and Program Administration	$6,340,000
Maryland Total	**$9,420,000**
Reserves	*$1,000,000*
Funding Request	**$8,420,000**

Maryland Revenue	Hospital Rates	Federal Funds	User Fees	MDH	Total
HIE Operations	$3.1M	$9.8M	$5.7M	$3.1M	**$21.7M**
Reporting and Program Admin	$6.3M	$10.3M	----	$4.3M	**$20.9M**
Other Non-HSCRC Programs	----	$2.8M	----	*$1.2M*	**$4.0M**
Total Funding	**$9.4M**	**$22.9M**	**$5.7M**	**$8.6M**	**$46.6M**
Percent of Total	*20%*	*49%*	*13%*	*18%*	*100%*

Note: This schedule does not include CRISP projects anticipated to be funded entirely by MDH or federal grants

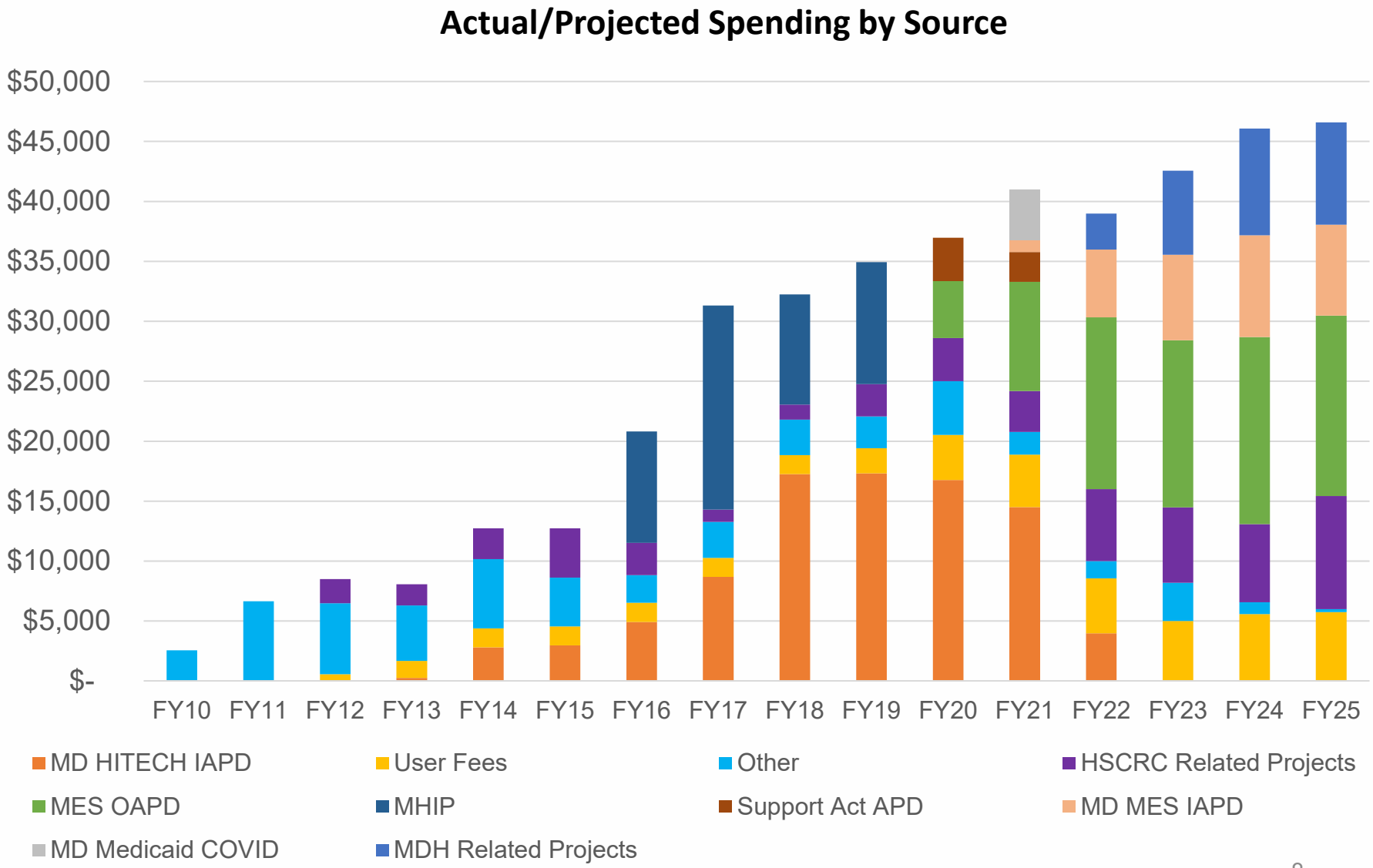
Key Takeaways:

1. Direct HIE Operations funding is consistent with prior years, including project investments to enhance operations and maintain compliance with federal standards.
2. The federal Medicaid Cost Allocation Methodology is projected to decrease slightly from 84% in FFY24 to 75% in FFY25 and FFY26.
3. New priorities are anticipated as they relate to equity and access components of the pending AHEAD model.

Long-term Funding Trend

HSCRC CRISP Funding	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023	$6,300,000
FY 2024	$6,500,000
FY 2025	**$9,420,000**

**Requested funding not including $1M to be used from reserves*



maryland
health services
cost review commission

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2024 Funding

Draft Recommendation

May 8, 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by May 15, 2024, to william.henderson@maryland.gov

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

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

List of Abbreviations

AHEAD	Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRS	CRISP Reporting Services
EQIP	Episode Quality Improvement Program
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

maryland
health services
cost review commission

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To fund and sustain a robust Health Information Exchange, CRISP, for activities related to the HSCRC and the Maryland Model.	Include an assessment in hospital rates to generate funding to support CRISP projects and operations to further the goals of the Maryland Model	Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals.	CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided.	Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes in order to further the goals of improved health equity under the Model.

Summary of the Recommendation

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

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

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

[1] MD. CODE ANN., Health-Gen §19-219(c).

Federal funding change. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

This recommendation continues the approach used in prior years of spending down reserve funds accumulated due to a better than anticipated Federal match, but the amount pulled from reserves has been reduced to retain greater reserves for potential unanticipated costs related to the State's expected participation in the Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model model.

This recommendation also approves funding for a practice transformation grant program in support of Episode Quality Improvement Program.

Background – Past Funding

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 10 Years

CRISP Budget: HSCRC Funds Received	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023	$4,800,000
FY 2024	$4,800,000
FY 2025	$8,420,000

The funding request for FY 2025 is similar to that for FY 2022 which is when the State first anticipated a change in the Federal matching requirements. That change did not materialize at that time.

Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process – which includes

bi-weekly update meetings, monthly written reports, and auditing of the expenditures – has created transparency and accountability. Starting in FY 2023, CRISP's reimbursement from the HSCRC was provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. This change is made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

Funding Through Federal Matching

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below. The HITECH IAPD program was previously the source of most federal funding, and it was terminated September 30, 2021. Funding has now moved to the MES program described below. The MES program requires 25 percent match for ongoing programs versus the 10 percent in place under IAPD

Medicaid Enterprise System (MES) Matching Funds

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

Under MES, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match as well as the State's Fair Share amount. The Fair Share represents the amount that benefits Medicaid before considering the federal and state match. Starting in FY 2024 the methodology for calculating the State's Fair Share amount was changed resulting in a greater portion being borne by the State and driving the increase in this assessment.

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue and have remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of $300,000 in payer fees, which now represents 15% of user fee revenue.

Description of Activities Funded

Activities funded directly by this assessment and from earned federal matching fall into the two categories described below. The descriptions below outline, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

Category 1: HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.[2] In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2022 HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Total Cost of Care Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by Staff for FY 2025 for the HIE function is $3,080,000.

Category 2: Reporting and Program Administration Related to Population Health, the Total Cost of Care Model, and Hospital Regulatory Initiatives

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under

[2] MD. CODE ANN., Health-Gen §19-143(a).

the Total Cost of Care (TCOC) Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

(1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the TCOC Model;

(2) Funding for program administration related to programs under the TCOC Model; and

(3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

For FY2025 the CRISP program administration work will include the implementation of a practice transformation grant program in support of a wide range of EQIP entities for EQIP participation. This program was identified, based on stakeholder feedback, as a way to encourage smaller practices to participate in EQIP and to improve readiness for EQIP engagement. Under this program CRISP shall award up to $8,000,000 of grants to practices who participate in EQIP and have a demonstrated need for practice support, based on guidelines developed by CRISP and approved by HSCRC staff. Staff recommends funding for the grants be provided using the Medicare Performance Adjustment Reconciliation Component, this CRISP assessment would only fund the administration of the program. Working with CRISP Staff will provide an update on this program during the Fall of 2024.

The total amount recommended by Staff for FY 2025 for the activities described above is $5,340,000

Staff Recommendation

Staff is recommending the Commission approve a total of $8,420,000 in funding through hospital rates in FY 2025 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds. Staff anticipates actual CRISP spending of $9,420,000 but proposes to use $1,000,000 of prior reserves, limiting the actual assessment to $8,420,000. Staff also recommend funding the EQIP practice transformation grants via the Medicare Performance Adjustment Reconciliation Component.

Table 2 shows the funding through hospital rates and the federal match that will be generated from the MES funding as well as the user fee and MDH funding.

Table 2. FY 2025 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

Project Name	Hospital Rates	Budgeted Federal Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	$3,080,000	$9,830,000	$5,746,000	$3,020,000	$21,676,000
Reporting and Program Administration	$6,340,000	$10,306,000	$0	$4,270,000	$20,916,000
Other non-HSCRC programs	$0	$2,760,000	$0	$1,230,000	$3,990,000
Total Funding	**$9,420,000***	**$22,896,000**	**$5,746,000**	**$8,520,000**	**$46,582,000**
% Of Total	**20%**	**49%**	**13%**	**18%**	**100%**

*Note: Prior to reduction for use of accumulated reserves to reduce FY2025 assessment.

maryland
health services
cost review commission

Emergency Department Dramatic Improvement Effort (EDDIE)

May Commission Meeting

Today's Presentation

- EDDIE data update
- Multi-Visit Patient Survey Results

ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for April 2024 was received from 41 out of 44 hospitals (IP and OP data).
- There was a slight increase in Median Wait Times in April compared to March.
    - April Average Median Wait Time:

ED1a: 582.5 minutes **ED1b: 580.1 minutes minutes** **ED1c: 782.4**

    - Christiana Care shows great improvement from base month (June 2023) to latest (April 2024) for ED1a and ED1c
    - These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month) and the data have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital.
- April 2024 EMS Turnaround Data was not provided. Results will be included next month.

See Appendix for graphs and data for all measures

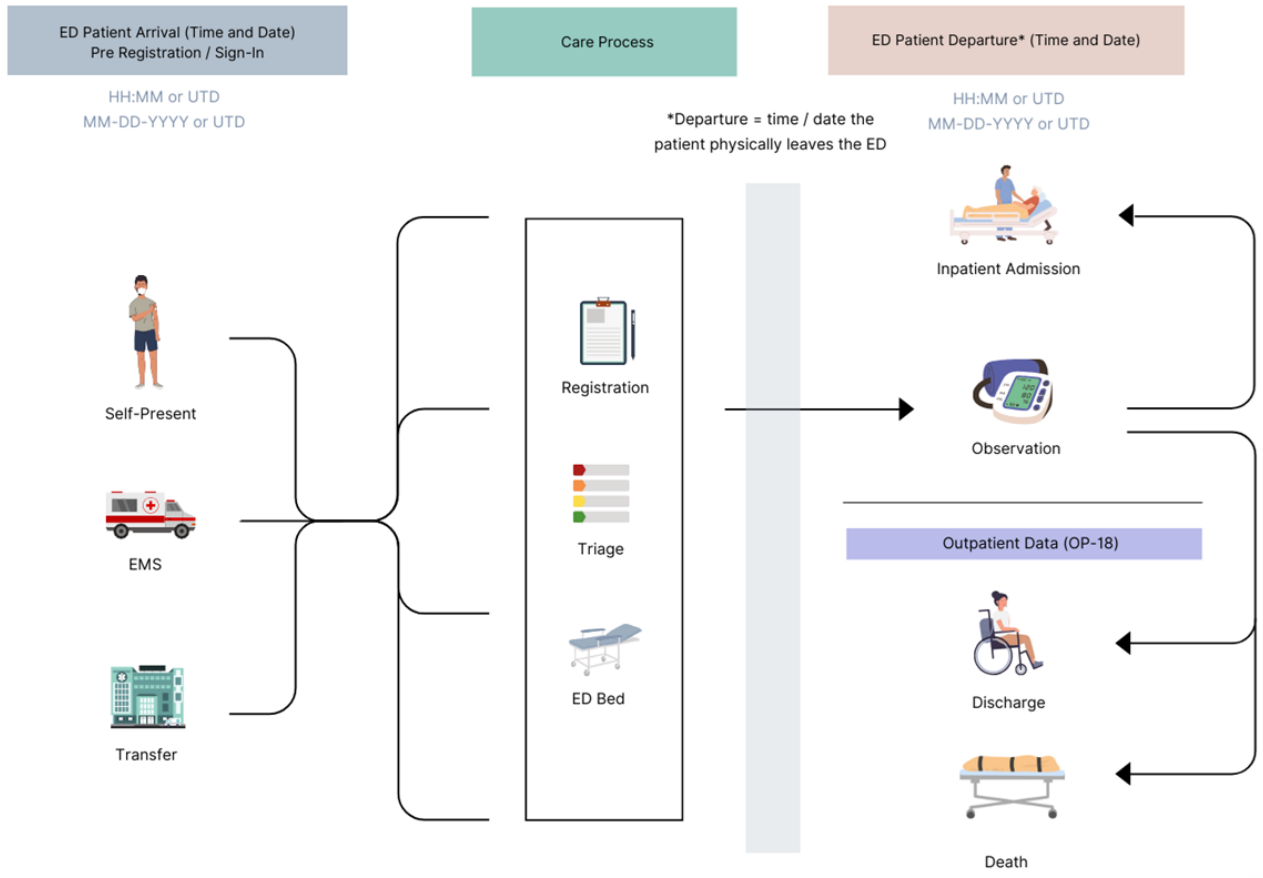
Appendix

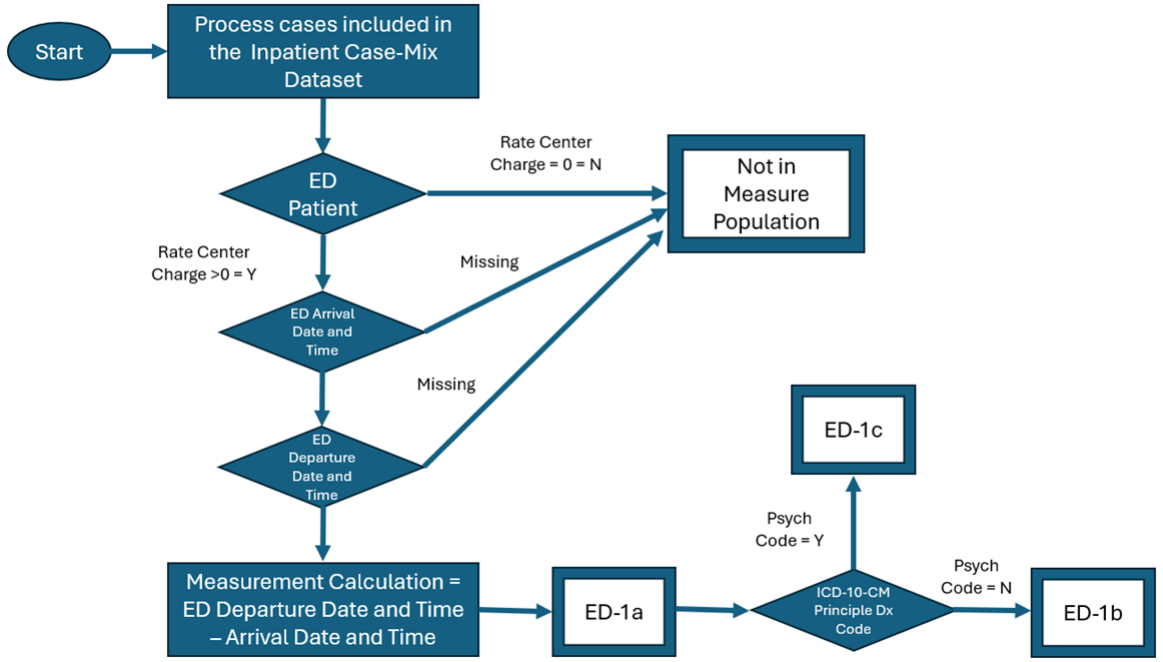
ED LOS Subgroup Update

- ED LOS data will be collected by using monthly HSCRC case-mix data, in addition to adding date and time stamps and other needed variables.
  - ED Arrival Date
  - ED Arrival Time
  - ED Departure Date
  - ED Departure Time
- Subgroup 2 Methodology and Incentive meeting was held on April 26th
  - Discussion on measure name change to focus more on Inpatient ED
  - Which strata is appropriate for payment only
  - Risk adjustment considerations
  - Improvement only considerations

Subgroup 1: ED1 Data

Final meeting was Friday, April 12th; Subgroup 2 convened Friday, April 26th





EDDIE Overview

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

EDDIE: Improved ED Experience for Patients

Quality Improvement

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

Commission Reporting

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

April Data 2024 Reporting

Monthly, public reporting of three measures:

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

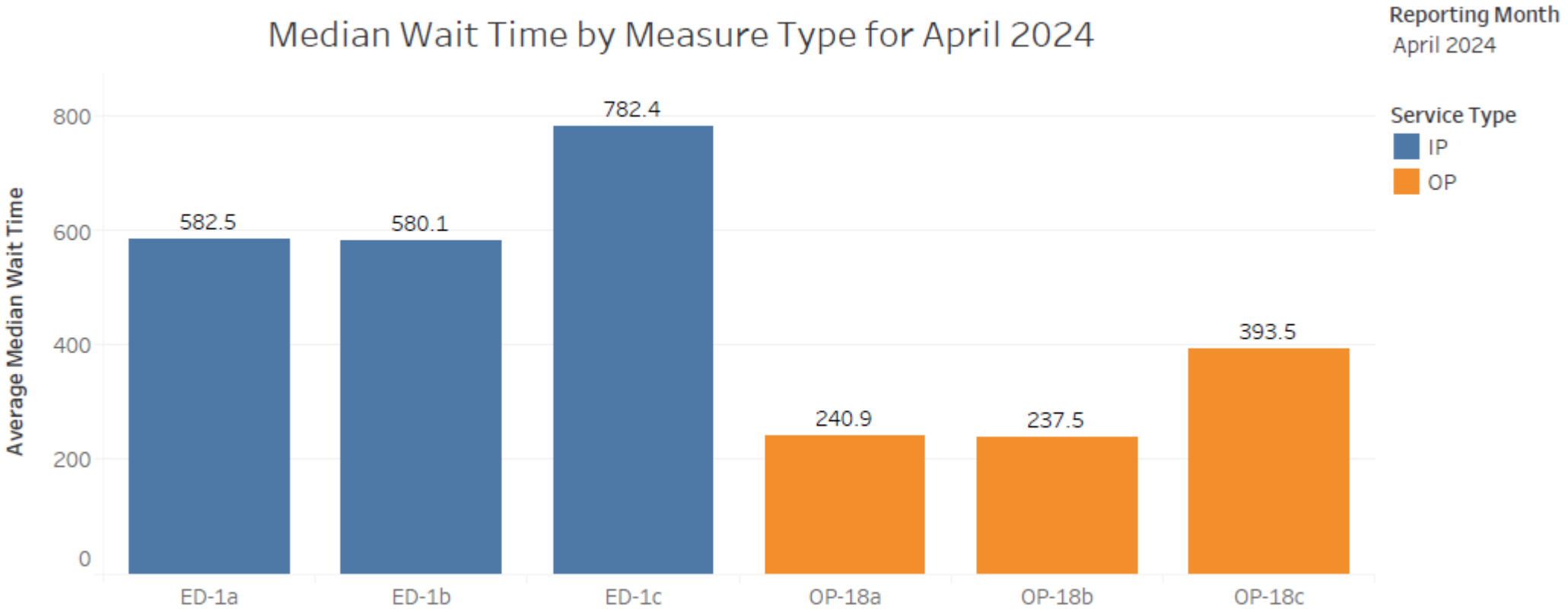
April data received for 37 out of 40 hospitals

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

Graphs:

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

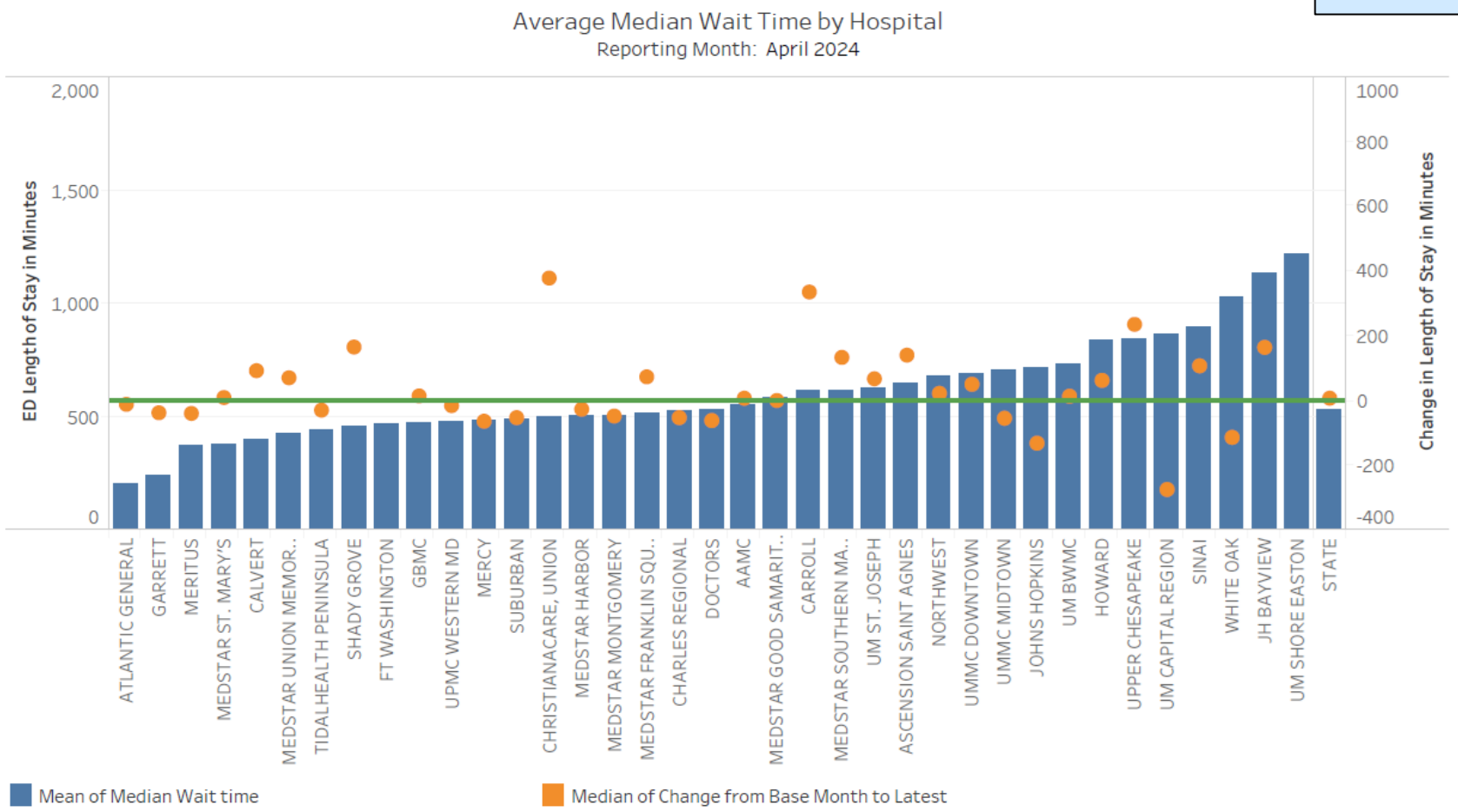
ED Median Wait Time



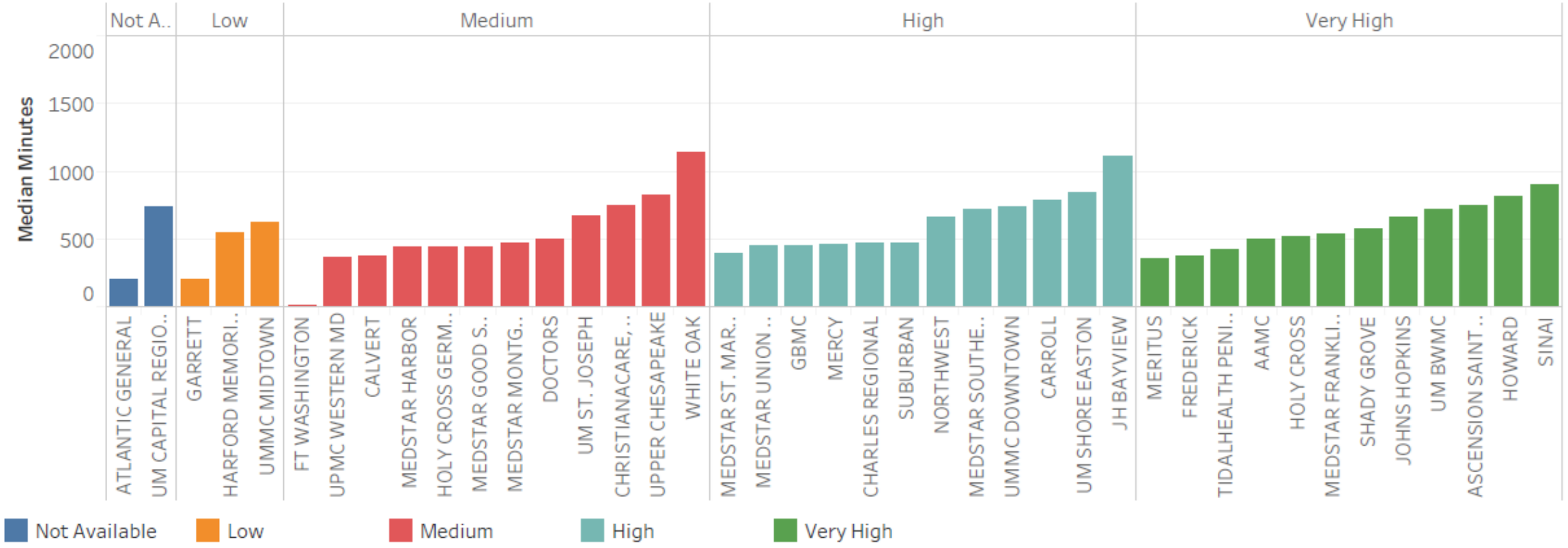
ED 1a: ED Arrival to Inpatient Admission

There are 7 hospitals that were not included for all ED1 strata graphs. However, this data is available and can be pulled. We are working through minor adjustments with our contractual team that populates the graphs for the EDDIE project. Please note that Holy Cross and Frederick's data presented for April's report is using March's data due to late submission.

Measure
ED-1a

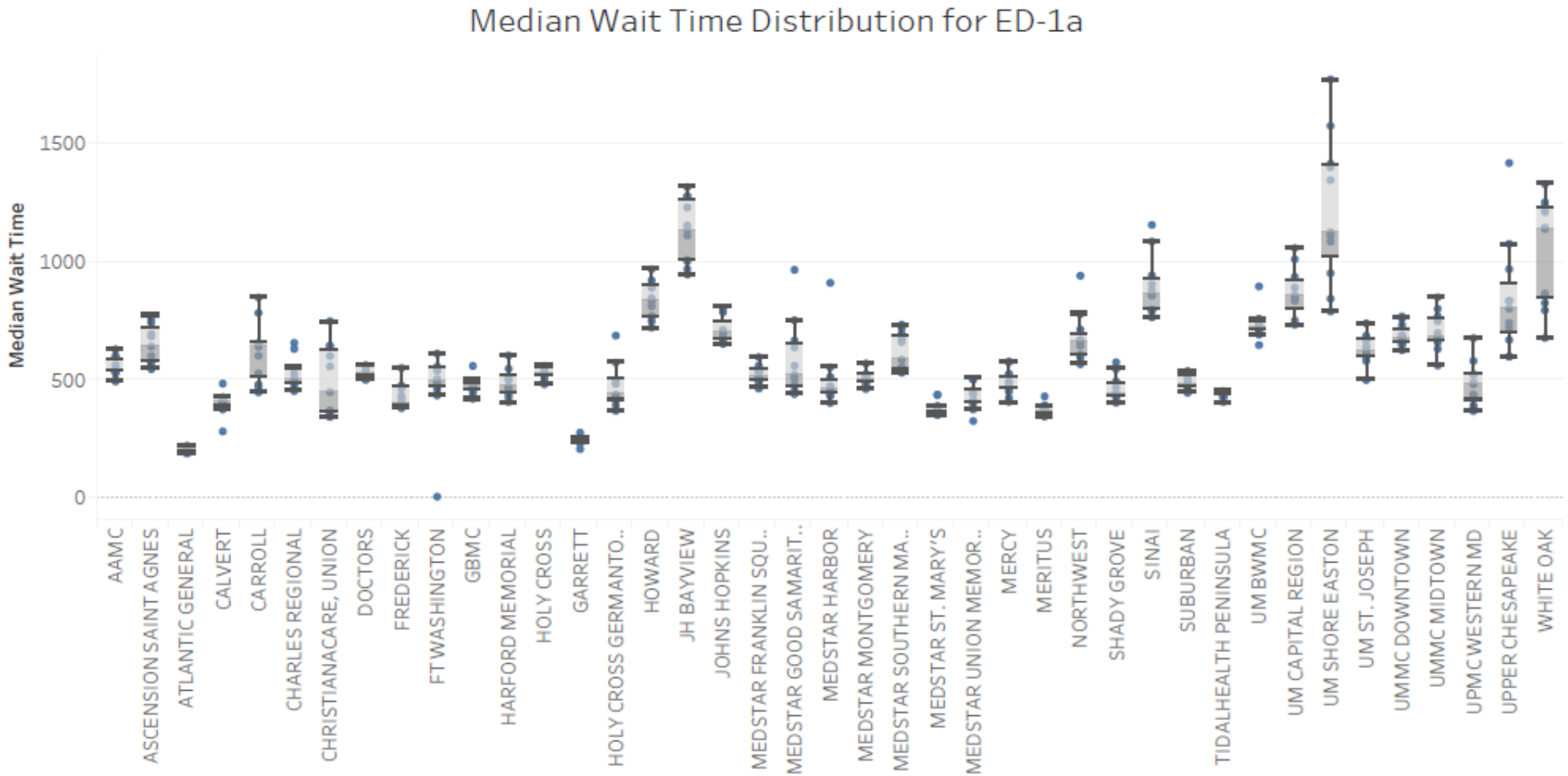


ED 1a: ED Arrival to Inpatient Admission Time
Latest Month Median By Volume--Latest Month



ED 1a: ED Arrival to Inpatient Admission

Measure
ED-1a



ED 1a: ED Arrival to Inpatient Admission

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

Red = higher wait time
Green = lower wait time

Average Median Wait Time All Hospitals for ED-1a

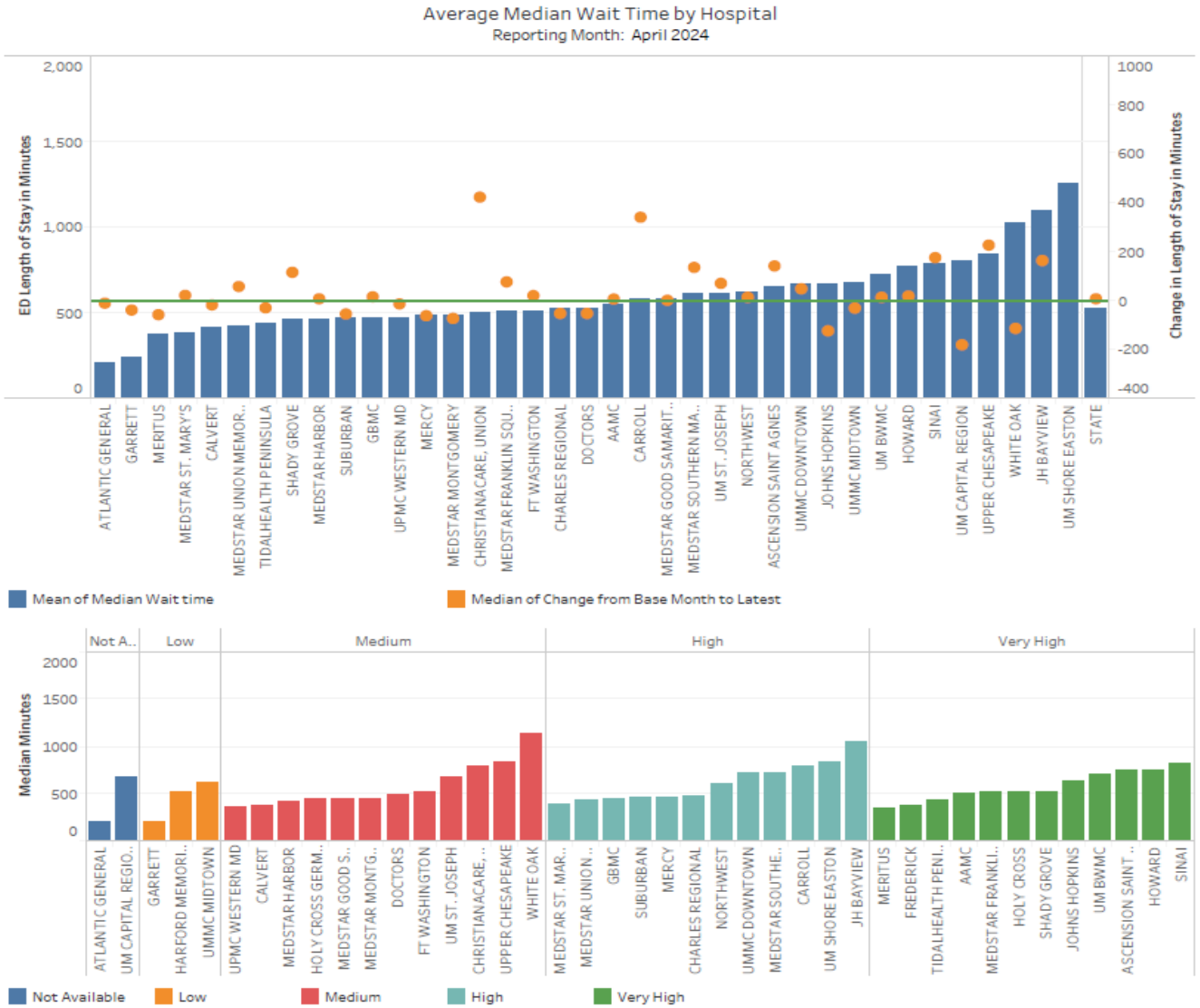
Measure
ED-1a

Change from Base
-610 819

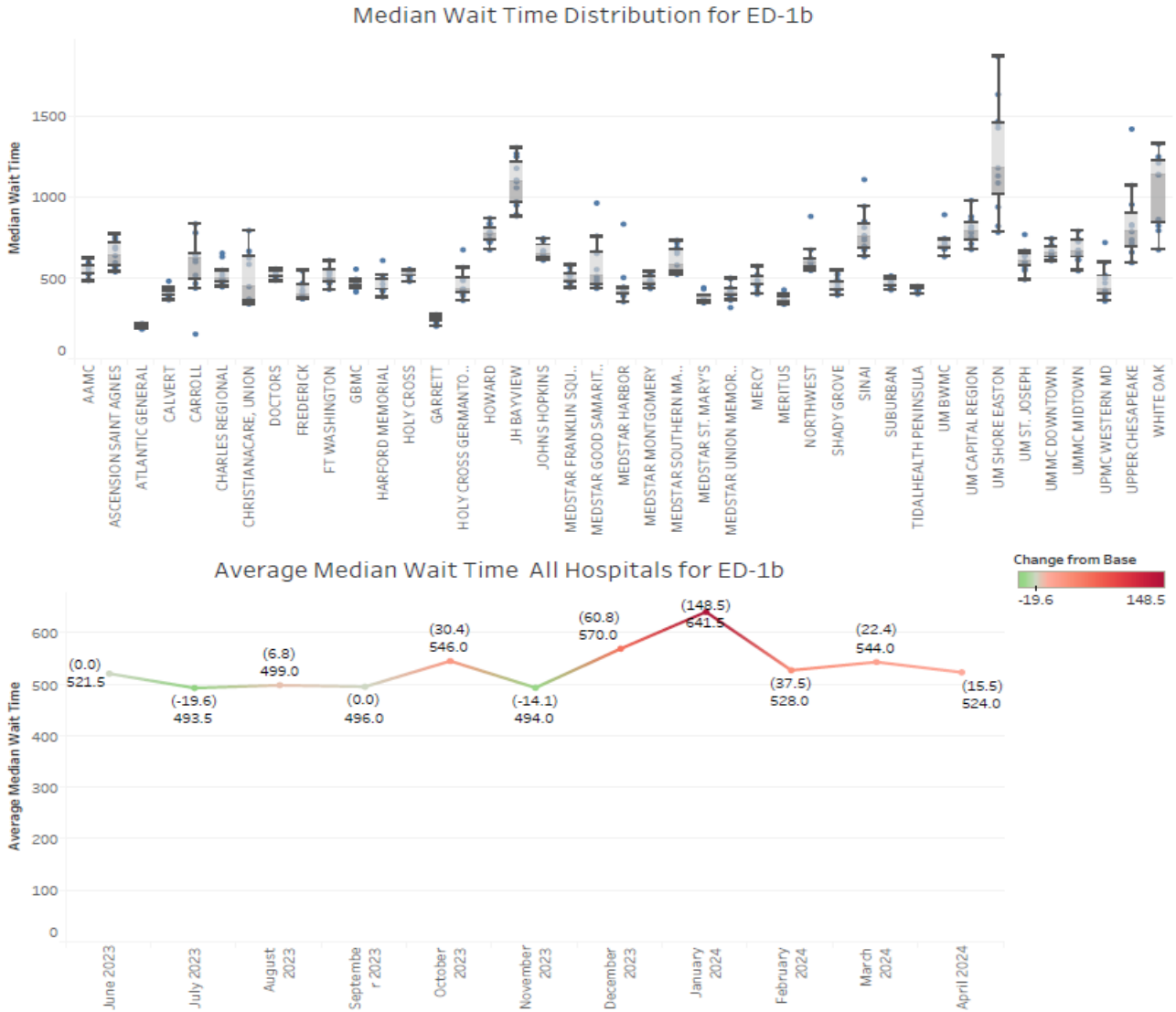
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024
AAMC	493	532	540	534	563	601	629	597	530	544	501
ASCENSION SAINT AGNES	601	564	545	574	641	576	755	772	684	694	742
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191	199
CALVERT	282	383	411	425	405	409	484	426	408	402	375
CARROLL	447	527	481	640	602	470	654	848	656	649	783
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551	475
CHRISTIANACARE, UNION	369	351	370	343	360	448	641	601	645	557	748
DOCTORS	561	514	537	503	559	529	555	559	513	512	500
FREDERICK	392	388	382	395	416	432	464	550	476	381	
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556	6
GARRETT			244		246	244	277	254	231	237	207
GBMC	439	467	456	475	482	420	476	559	497	474	454
HARFORD MEMORIAL	406	499	424	437	472	459	515	603	547		
HOLY CROSS	524	481	540	513	547	518	546	559	496	524	
HOLY CROSS GERMANTO..	435	393	428	369	483	414	573	687	499	437	
HOWARD	748	770	765	834	968	921	902	889	721	845	811
JH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001	1,110
JOHNS HOPKINS	794	680	652	697	704	708	661	804	786	710	663
MEDSTAR FRANKLIN SQUA..	463	467	493	492	532	509	560	596	539	512	537
MEDSTAR GOOD SAMARIT..	441	479	522	456	559	506	667	965	752	637	442
MEDSTAR HARBOR	458	553	474	910	513	402	441	457	436	437	432
MEDSTAR MONTGOMERY	518	461	486	495	525	497	505	569	518	480	471
MEDSTAR SOUTHERN MA..	585	544	539	530	542	554	660	733	695	673	719
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372	390
MEDSTAR UNION MEMORI..	375	456	412	326	407	400	504	500	439	410	446
MERCY	526	577	575	407	450	423	466	492	461	476	463
MERITUS	393	370	354	386	379	345	368	430	370	354	354
NORTHWEST	645	778	669	566	602	608	661	940	713	593	668
SHADY GROVE	408	427	446	435	545	494	428	437	403	470	574
SINAI	796	796	877	861	764	856	791	1,155	1,085	942	904
SUBURBAN	527	462	467	480	537	469	499	521	497	445	475
TIDALHEALTH PENINSULA		453	448	447	432	430	445	450	438	406	424
UM BWMC	711	740	691	708	717	647	756	895	758	731	725
UM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838	736
UM SHORE EASTON	1,399	951	1,344	1,414	1,109	789	1,574	1,770	1,084	1,124	843
UM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585	672
UMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758	731
UMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669	631
UPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392	368
UPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741	834
WHITE OAK	1,251	865	1,143	855	1,328	1,210	794	825	677	1,233	1,138

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

Measure
ED-1b



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



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

Average Median Wait Time All Hospitals for ED-1b

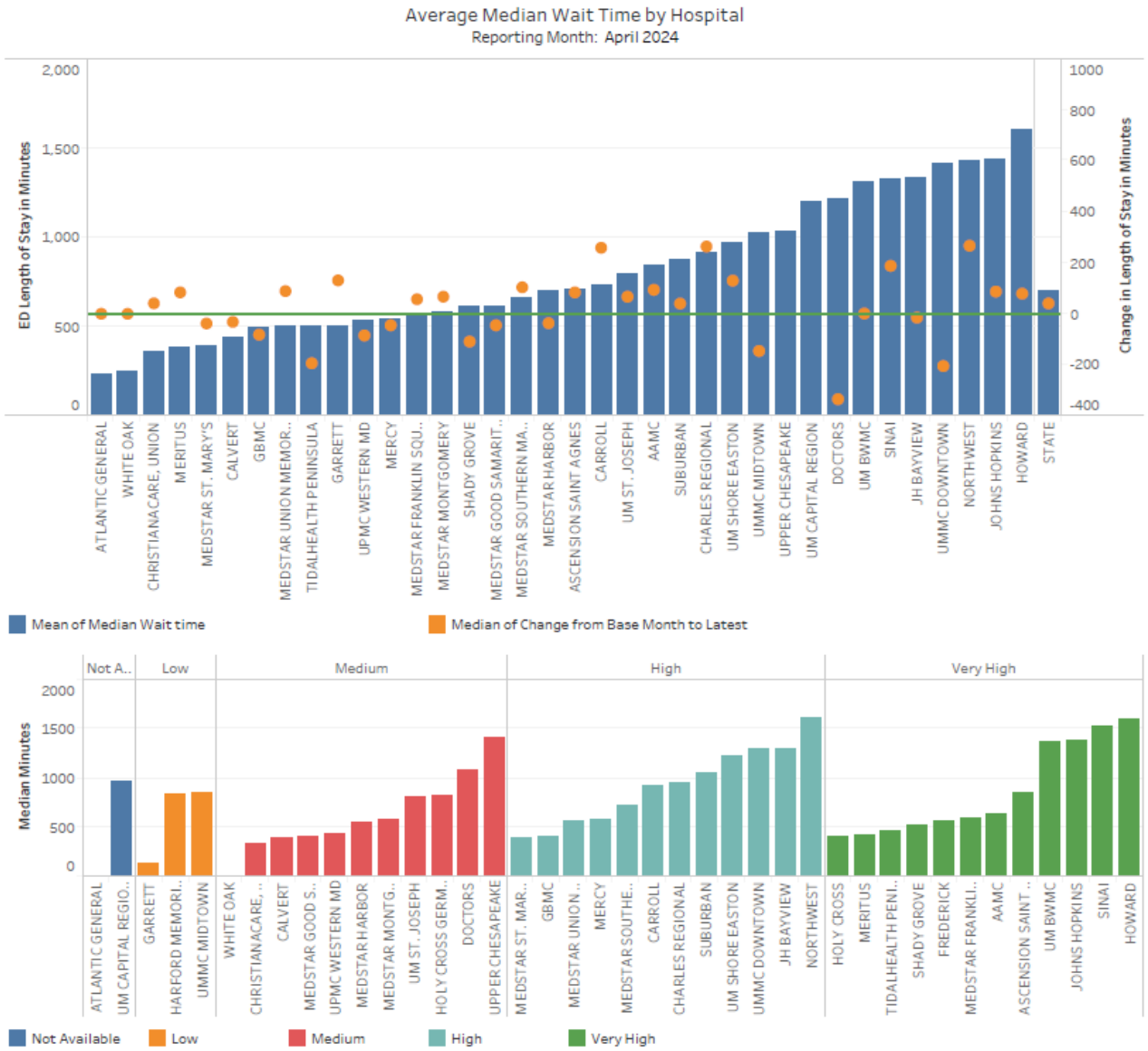
Measure
ED-1b

Change from Base
-668 822

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024
AAMC	488	527	536	529	565	597	623	591	528	539	495
ASCENSION SAINT AGNES	599	563	541	573	641	576	755	772	683	694	741
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199
CALVERT		386	403	420	390	408	484	443	404	395	369
CARROLL	441	520	470	623	603	158	653	837	648	648	782
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474
CHRISTIANACARE, UNION	372	351	370	343	356	450	640	627	669	588	795
DOCTORS	541	503	525	499	559	523	547	543	510	509	489
FREDERICK	388	376	378	391	410	427	458	546	472	375	
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556	524
GARRETT			244		246	244	277	255	227	236	206
GBMC	438	467	455	475	481	417	476	558	496	475	454
HARFORD MEMORIAL	386	466	432	429	435	421	496	611	517		
HOLY CROSS	524	482	540	513	544	518	546	557	495	524	
HOLY CROSS GERMANTO..	435	396	427	365	487	414	568	677	498	436	
HOWARD	722	734	729	776	871	839	836	785	676	785	741
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623
MEDSTAR FRANKLIN SQUA..	445	471	492	484	516	471	570	585	538	492	522
MEDSTAR GOOD SAMARIT..	440	474	512	449	556	494	654	965	761	664	442
MEDSTAR HARBOR	407	506	424	835	391	357	399	447	416	432	415
MEDSTAR MONTGOMERY	520	459	478	477	525	438	490	540	495	454	448
MEDSTAR SOUTHERN MA..	584	542	536	525	540	533	654	735	691	668	720
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390
MEDSTAR UNION MEMORI..	367	442	397	321	398	389	498	503	434	413	425
MERCY	523	576	574	404	450	421	464	490	461	476	462
MERITUS	404	371	357	386	377	341	368	430	364	352	347
NORTHWEST	595	676	613	558	575	561	600	883	624	549	609
SHADY GROVE	408	424	446	434	546	493	427	437	397	468	524
SINAI	638	636	759	699	675	765	737	1,110	945	852	814
SUBURBAN	510	441	445	457	516	455	485	506	474	429	456
TIDALHEALTH PENINSULA		452	446	447	429	430	447	448	437	405	423
UM BWMC	684	704	681	683	699	635	740	893	747	721	698
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132	823
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550	669
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742	707
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640	617
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394	360
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739	826
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233	1,138

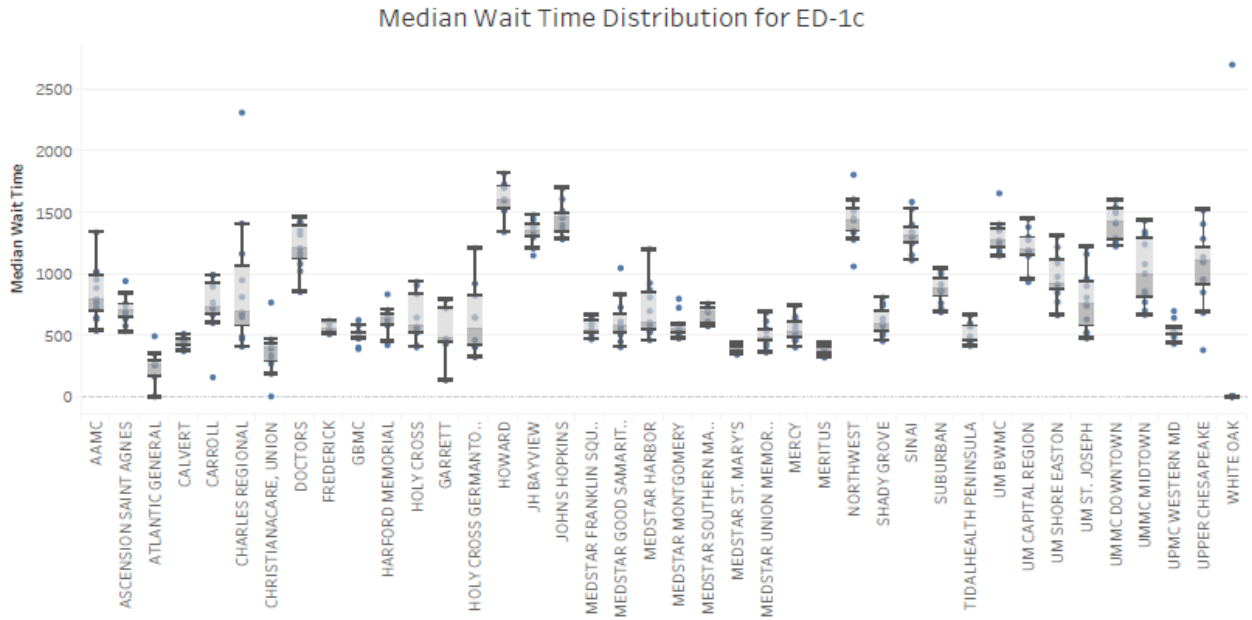
ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

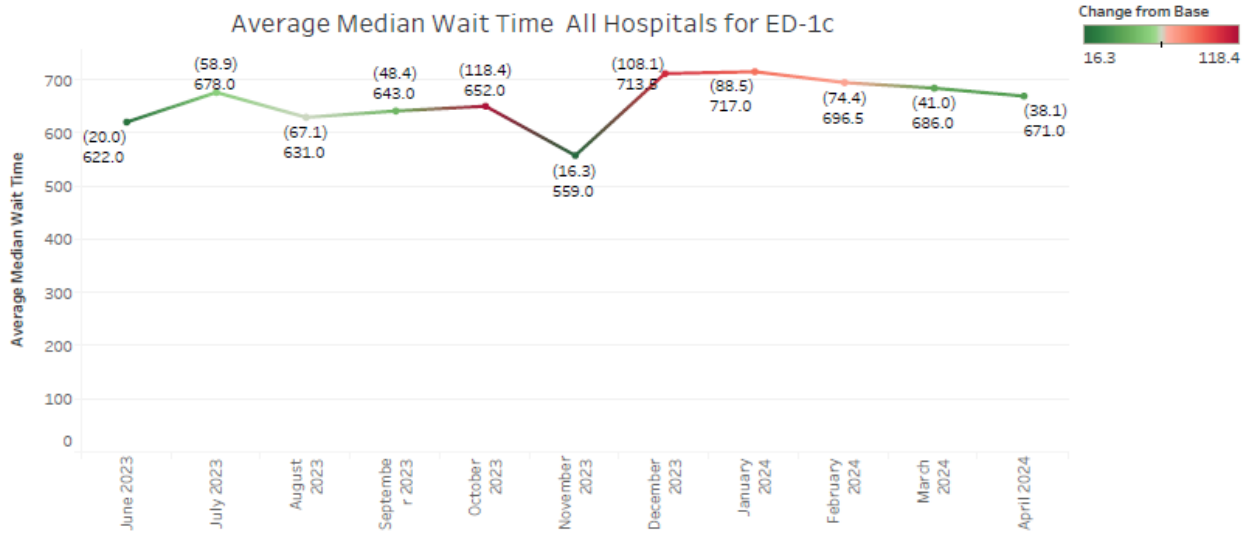
Measure
ED-1c



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

ED-1c





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

Average Median Wait Time All Hospitals for ED-1c

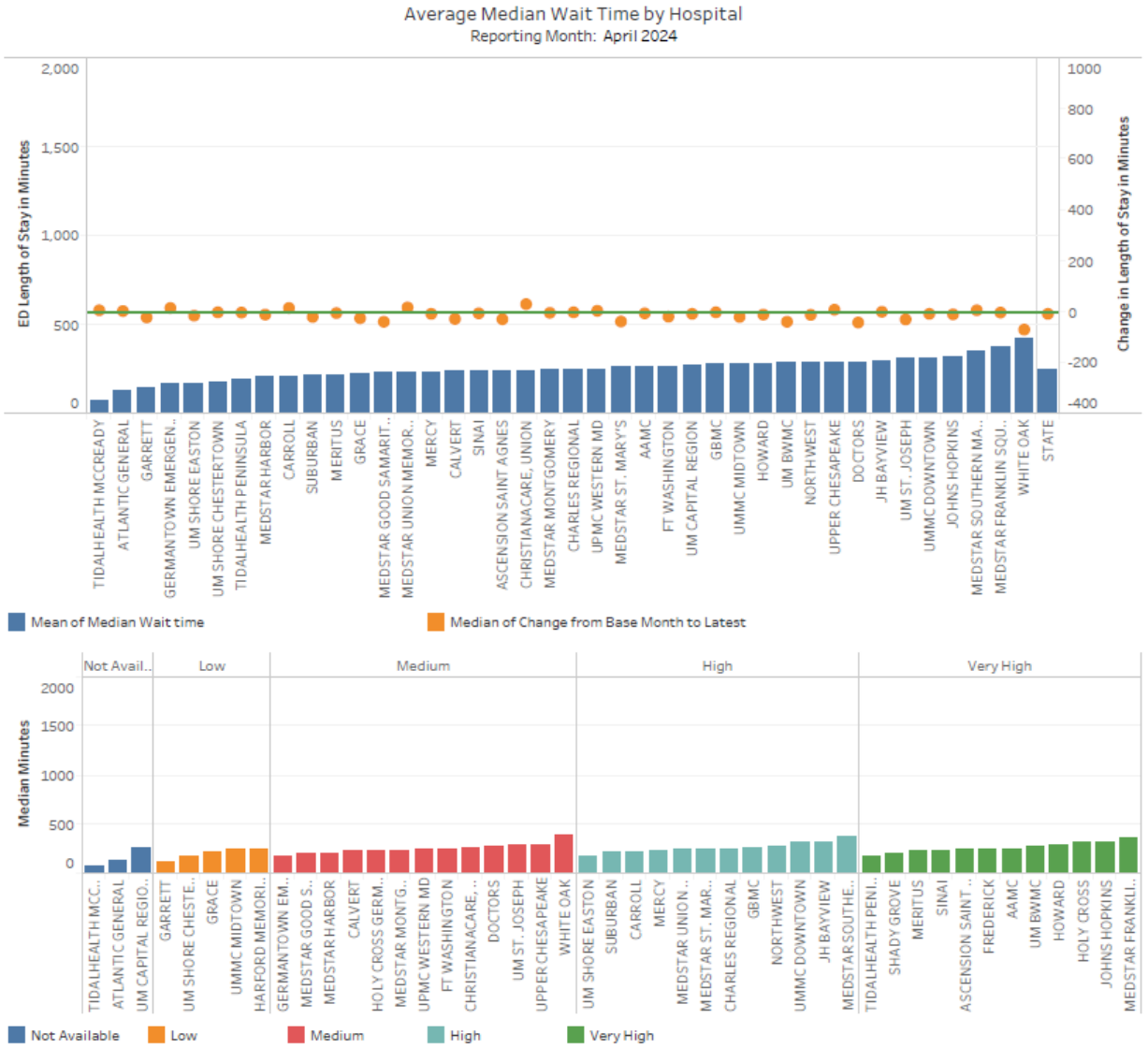
Measure
ED-1c

Change from Base
-564 2,701

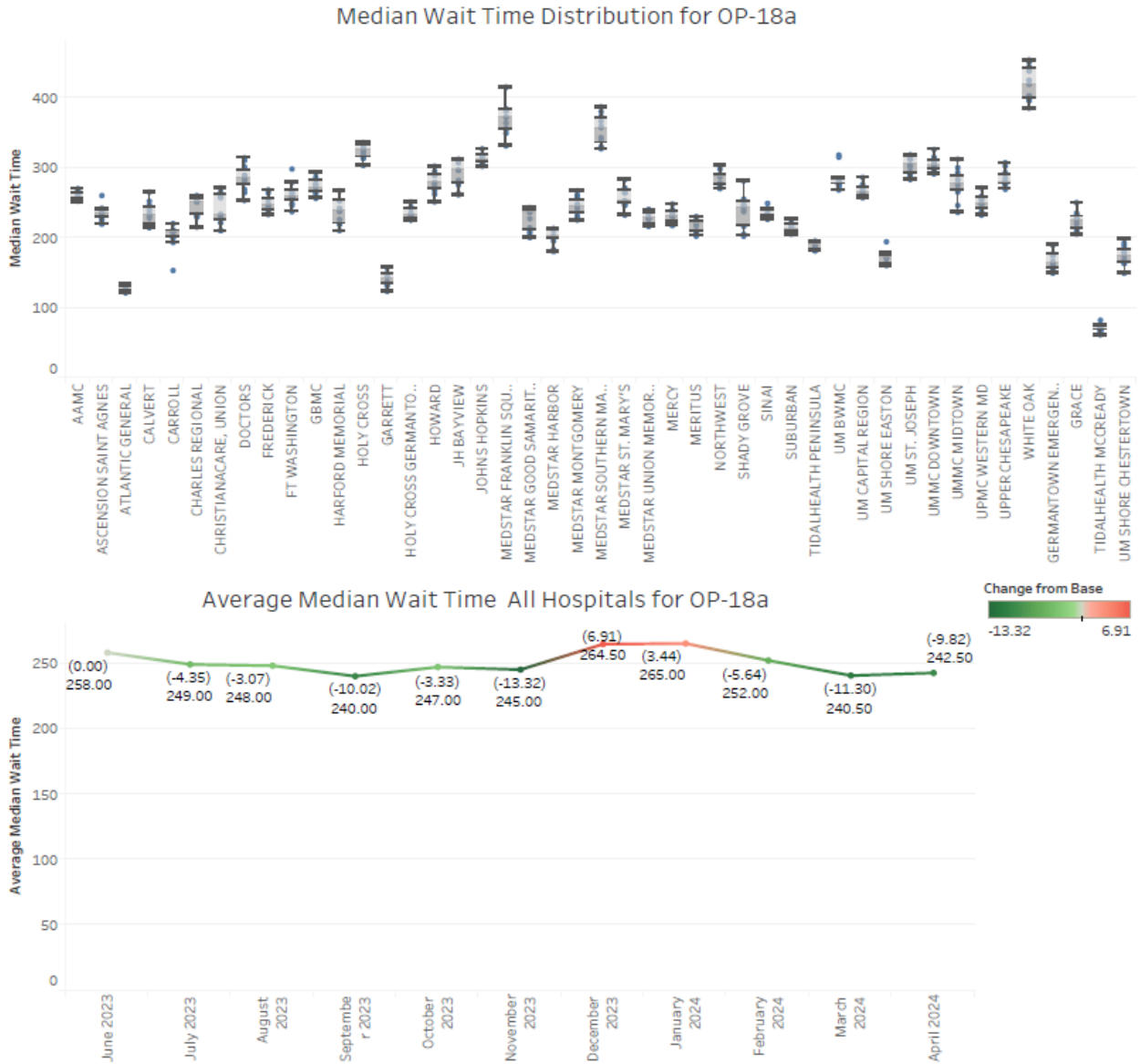
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629
ASCENSION SAINT AGNES	755	939	631	691	652	531	682	745	698	574	839
ATLANTIC GENERAL		345	160	262	286	490	255		0	254	0
CALVERT	425	379	457	471	508	427	501	369	449	458	393
CARROLL	665	667	764	893	598	156	724	988	989	717	924
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946
CHRISTIANACARE, UNION	290	184	268	0	424	422	764	431	463	388	331
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079
FREDERICK	506	517	540	514	613	534	586	609	613	557	
GARRETT							470	717	428	786	131
GBMC	480	387	479	476	508	526	498	621	578	471	398
HARFORD MEMORIAL	448	601	418	630	667	654	703	577	831		
HOLY CROSS	642	416	518	568	903	559	532	933	831	400	
HOLY CROSS GERMANTO..	410	320	643	400	412	458	1,208	919	643	818	
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519	1,603
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147	1,294
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396	1,368
MEDSTAR FRANKLIN SQUA..	532	465	500	532	627	662	469	642	542	583	589
MEDSTAR GOOD SAMARIT..	446	502	590	549	608	522	827	1,045	725	577	401
MEDSTAR HARBOR	577	868	923	1,199	806	520	695	531	603	458	540
MEDSTAR MONTGOMERY	512	472	498	532	531	722	550	795	588	568	579
MEDSTAR SOUTHERN MA..	609	575	586	573	601	714	683	717	754	722	713
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396
MEDSTAR UNION MEMORI..	464	681	473	358	475	431	612	470	530	407	553
MERCY	622	648	738	490	458	531	518	556	398	456	577
MERITUS	329	344	317	385	423	395	363	434	397	362	413
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343	1,604
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	524
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309	1,525
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040
TIDALHEALTH PENINSULA		659	490	441	473	415	415	567	440	596	465
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183	1,360
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253	1,286
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953	1,404
WHITE OAK	0	0	2,701	0	0	0	0	0	0	0	0

OP18a: ED Arrival to Discharge Time by Month

Measure
OP-18a



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month

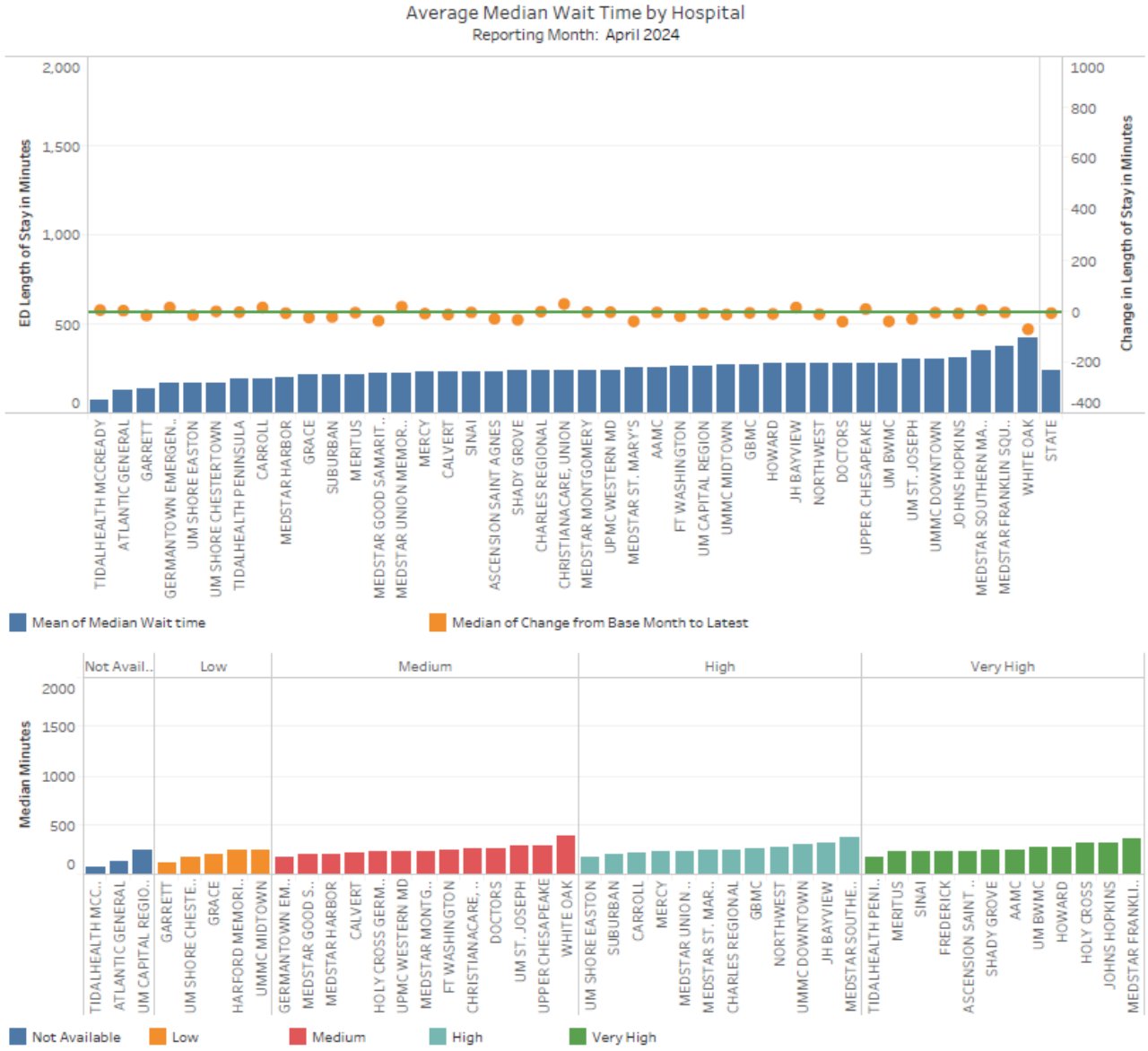
Average Median Wait Time All Hospitals for OP-18a

Measure
OP-18a

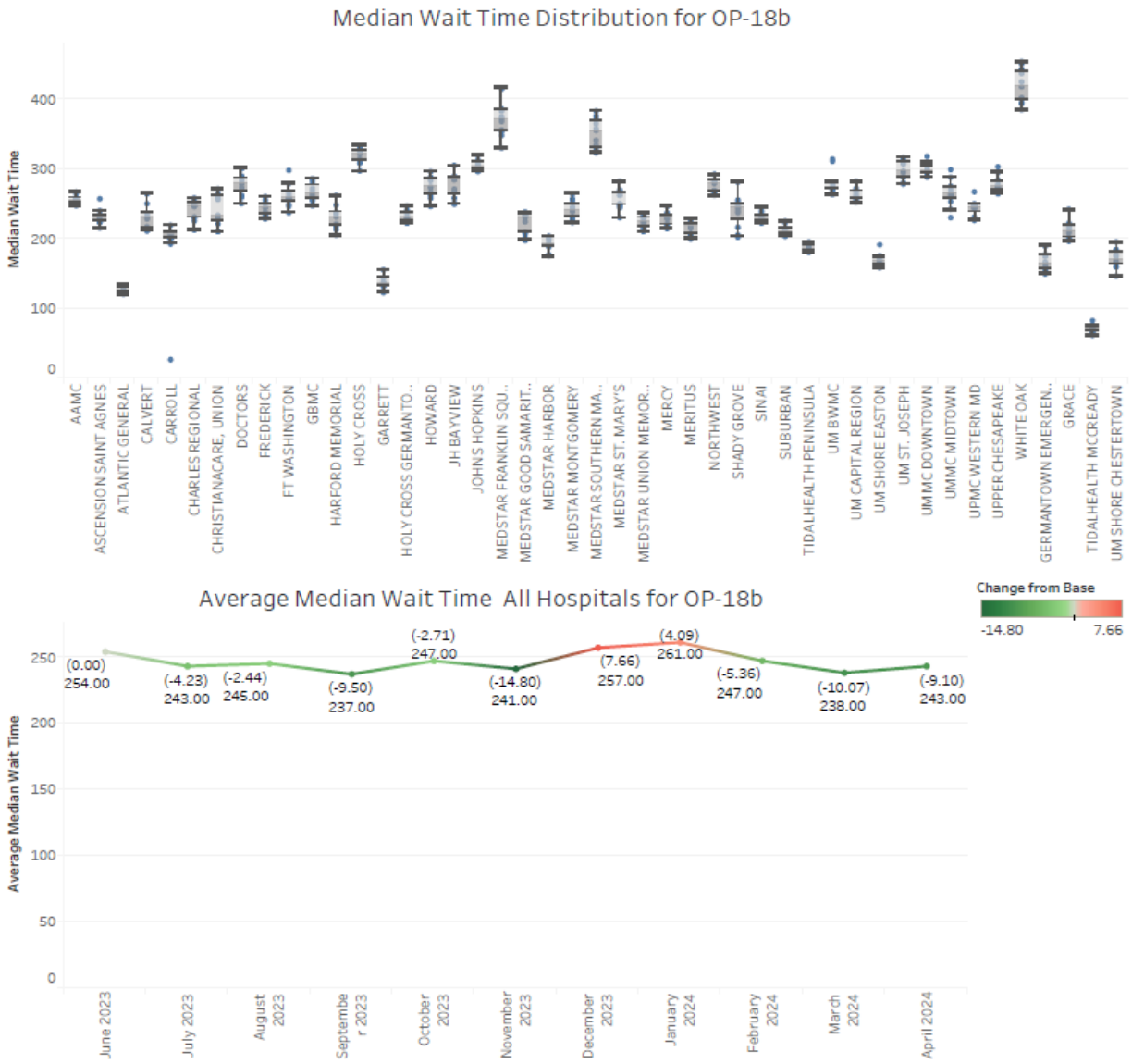
Change from Base
-79.0 59.0

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024
AAMC	258.0	255.0	260.0	254.0	266.0	263.0	271.0	268.0	256.0	258.0	253.0
ASCENSION SAINT AGNES	261.0	238.0	236.0	243.0	220.0	226.0	239.0	238.0	232.0	227.0	233.0
ATLANTIC GENERAL	124.0	127.0	131.0	133.0	128.0	123.0	134.0		125.0	122.0	128.0
CALVERT	247.0	229.0	240.0	233.0	253.0	235.0	266.0	218.0	215.0	216.0	220.0
CARROLL	194.0	203.0	201.0	201.0	221.0	154.0	212.0	209.0	211.0	209.0	210.0
CHARLES REGIONAL	254.0	253.0	232.0	216.0	230.0	234.0	258.0	261.0	252.0	258.0	253.0
CHRISTIANACARE, UNION	229.0	234.0	222.0	211.0	211.0	234.0	271.0	265.0	272.0	258.0	260.0
DOCTORS	311.0	288.0	280.0	265.0	281.0	285.0	315.0	302.0	290.0	254.0	270.0
FREDERICK		249.0	248.0	236.0	240.0	244.0	265.0	269.0	256.0	234.0	
FT WASHINGTON	268.0	238.0	262.0	247.0	260.0	259.0	299.0	280.0	266.0	259.0	250.0
GARRETT			145.0		150.0	147.0	158.0	134.0	132.0	138.0	124.0
GBMC	267.0	257.0	261.0	273.0	279.0	266.0	287.0	276.0	294.0	294.0	266.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0
GRACE	236.0	251.0	226.0	221.0	228.0	206.0	233.0	227.0	209.0	215.0	212.0
HARFORD MEMORIAL	220.0	227.0	211.0	238.0	221.0	254.0	268.0	243.0	254.0		
HOLY CROSS	320.0	304.0	335.0	333.0	327.0	314.0	329.0	337.0	324.0	315.0	
HOLY CROSS GERMANTO..	242.0	227.0	252.0	233.0	235.0	228.0	245.0	234.0	226.0	227.0	
HOWARD	290.0	290.0	303.0	252.0	275.0	263.0	296.0	280.0	271.0	269.0	280.0
JH BAYVIEW	312.0	312.0	308.0	281.0	283.0	262.0	264.0	298.0	276.0	297.0	313.0
JOHNS HOPKINS	328.0	319.0	318.0	309.0	312.0	303.0	305.0	313.0	311.0	309.0	319.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	382.0	365.0	374.0	385.0	416.0	416.0	332.0	350.0	355.0
MEDSTAR GOOD SAMARIT..	239.0	237.0	244.0	228.0	239.0	207.0	239.0	241.0	215.0	210.0	201.0
MEDSTAR HARBOR	213.0	213.0	211.0	202.0	214.0	181.0	196.0	200.0	184.0	202.0	203.0
MEDSTAR MONTGOMERY	232.0	226.0	247.0	238.0	259.0	246.0	262.0	268.0	249.0	244.0	229.0
MEDSTAR SOUTHERN MA..	367.0	344.0	331.0	328.0	340.0	329.0	388.0	381.0	358.0	360.0	374.0
MEDSTAR ST. MARY'S	284.0	269.0	272.0	251.0	254.0	249.0	265.0	265.0	252.0	233.0	247.0
MEDSTAR UNION MEMORI..	218.0	227.0	230.0	221.0	241.0	219.0	241.0	235.0	229.0	217.0	236.0
MERCY	232.0	241.0	231.0	219.0	218.0	222.0	233.0	249.0	236.0	237.0	225.0
MERITUS	225.0	207.0	207.0	221.0	211.0	203.0	225.0	231.0	221.0	218.0	221.0
NORTHWEST	288.0	291.0	304.0	279.0	291.0	290.0	299.0	272.0	271.0	273.0	277.0
SHADY GROVE	282.0	256.0	252.0	242.0	247.0	246.0	238.0	217.0	203.0	206.0	
SINAI	232.0	240.0	250.0	232.0	233.0	233.0	243.0	236.0	229.0	232.0	227.0
SUBURBAN	227.0	216.0	227.0	217.0	219.0	210.0	209.0	214.0	213.0	206.0	208.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	67.0	75.0	68.0	74.0	70.0	69.0
TIDALHEALTH PENINSULA		184.0	190.0	196.0	195.0	191.0	192.0	184.0	190.0	182.0	182.0
UM BWMC	316.0	319.0	285.0	282.0	277.0	280.0	278.0	272.0	269.0	276.0	278.0
UM CAPITAL REGION	265.0	277.0	271.0	265.0	269.0	260.0	287.0	274.0	262.0	259.0	258.0
UM SHORE CHESTERTOWN	169.0	175.0	164.0	180.0	193.0	150.0	189.0	199.0	180.0	164.0	168.0
UM SHORE EASTON	178.0	165.0	172.0	174.0	163.0	161.0	178.0	195.0	164.0	173.0	164.0
UM ST. JOSEPH	313.0	305.0	313.0	319.0	319.0	291.0	318.0	302.0	295.0	287.0	284.0
UMMC DOWNTOWN	310.0	312.0	306.0	299.0	292.0	293.0	304.0	316.0	327.0	298.0	303.0
UMMC MIDTOWN	266.0	294.0	277.0	279.0	270.0	237.0	301.0	313.0	284.0	270.0	247.0
UPMC WESTERN MD	233.0	236.0	248.0	250.0	272.0	260.0	259.0	256.0	256.0	250.0	238.0
UPPER CHESAPEAKE	278.0	280.0	278.0	270.0	280.0	282.0	308.0	303.0	294.0	277.0	287.0
WHITE OAK	455.0	404.0	420.0	397.0	452.0	402.0	426.0	445.0	439.0	397.0	386.0

OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric

Average Median Wait Time All Hospitals for OP-18b

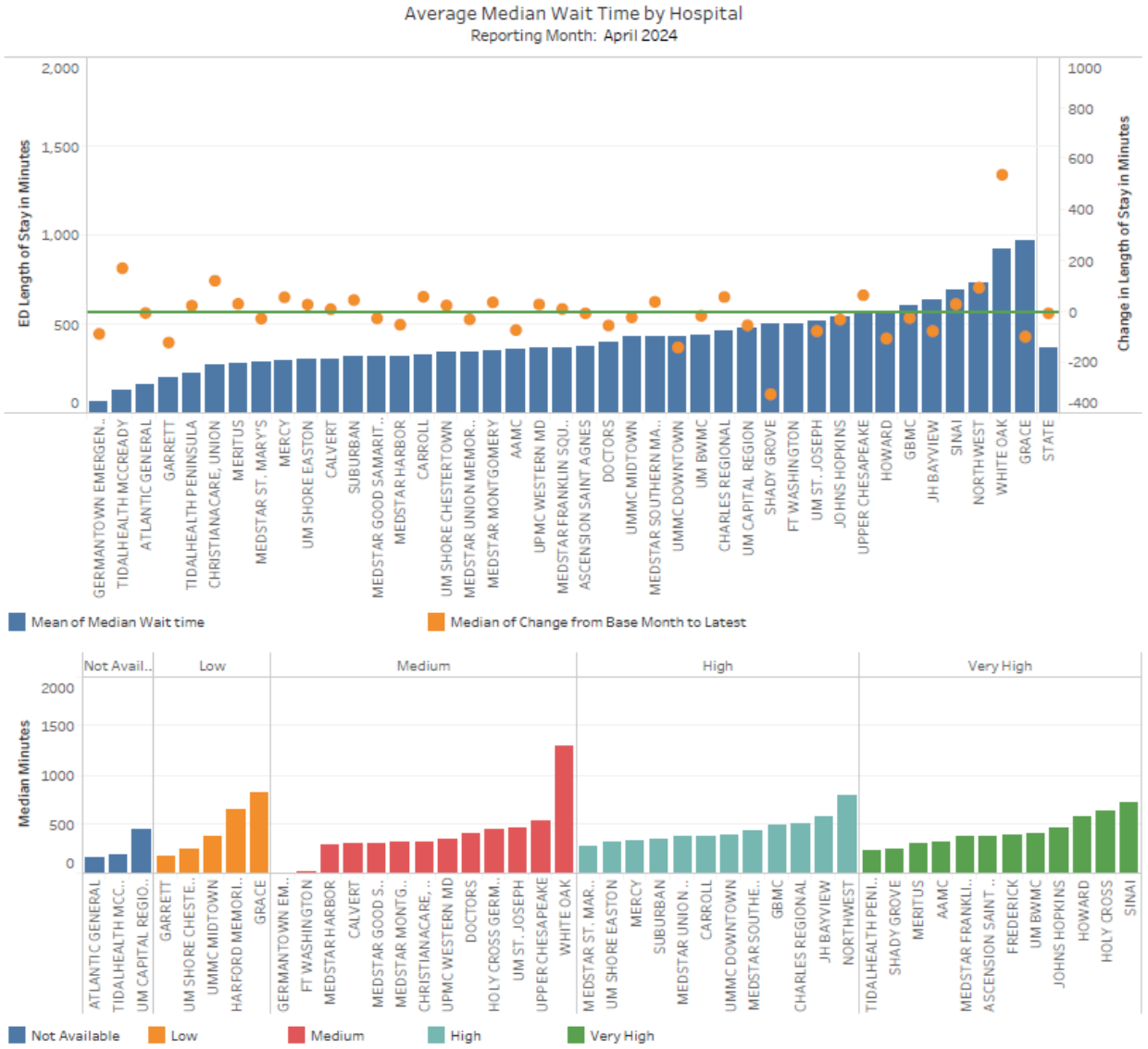
Measure
OP-18b

Change from Base
-166.0 60.0

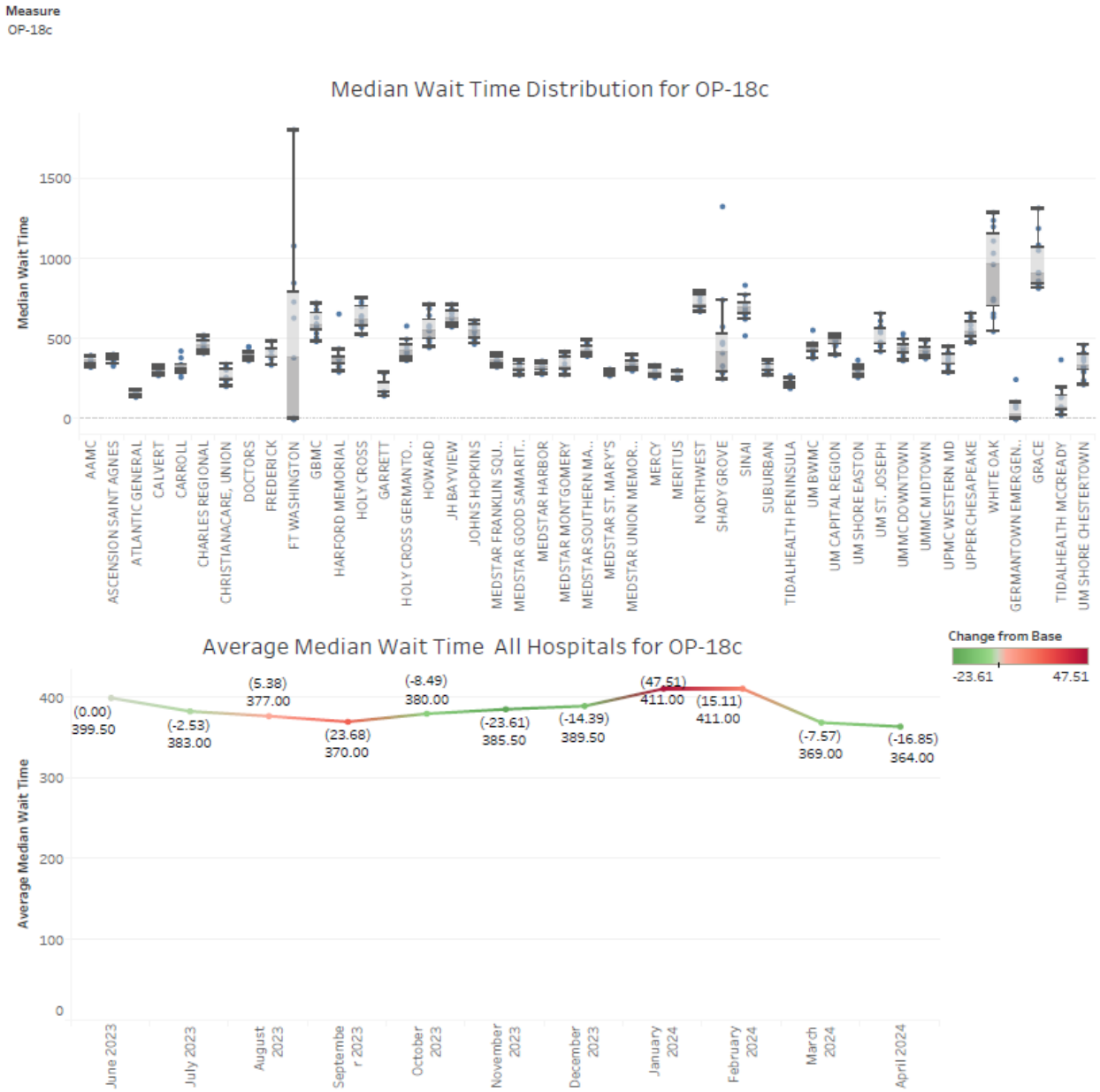
Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0	251.0
ASCENSION SAINT AGNES	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0	230.0
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0	209.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0	250.0
CHRISTIANACARE, UNION	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0	260.0
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0	263.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0	250.0
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0	257.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0	197.0
HARFORD MEMORIAL	218.0	222.0	206.0	232.0	214.0	249.0	263.0	236.0	239.0		
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0	
HOLY CROSS GERMANTO..	237.0	224.0	248.0	232.0	232.0	225.0	242.0	230.0	223.0	226.0	
HOWARD	284.0	287.0	297.0	247.0	268.0	259.0	289.0	275.0	264.0	265.0	275.0
JH BAYVIEW	290.0	290.0	288.0	268.0	272.0	252.0	250.0	285.0	259.0	286.0	306.0
JOHNS HOPKINS	320.0	312.0	308.0	299.0	304.0	297.0	298.0	302.0	304.0	302.0	313.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	384.0	369.0	376.0	387.0	417.0	416.0	331.0	349.0	354.0
MEDSTAR GOOD SAMARIT..	234.0	231.0	239.0	225.0	234.0	202.0	237.0	238.0	210.0	208.0	198.0
MEDSTAR HARBOR	204.0	204.0	201.0	190.0	203.0	176.0	189.0	193.0	178.0	193.0	198.0
MEDSTAR MONTGOMERY	230.0	224.0	245.0	233.0	256.0	243.0	258.0	265.0	246.0	240.0	228.0
MEDSTAR SOUTHERN MA..	366.0	342.0	328.0	324.0	335.0	325.0	384.0	377.0	356.0	359.0	372.0
MEDSTAR ST. MARY'S	283.0	268.0	271.0	250.0	251.0	247.0	263.0	263.0	250.0	231.0	245.0
MEDSTAR UNION MEMORI..	211.0	221.0	226.0	218.0	235.0	215.0	237.0	232.0	225.0	212.0	230.0
MERCY	230.0	238.0	229.0	217.0	215.0	219.0	233.0	247.0	233.0	236.0	222.0
MERITUS	223.0	205.0	205.0	219.0	209.0	200.0	224.0	229.0	220.0	216.0	219.0
NORTHWEST	280.0	282.0	293.0	270.0	284.0	283.0	293.0	266.0	263.0	266.0	270.0
SHADY GROVE	282.0	256.0	252.0	241.0	247.0	245.0	238.0	217.0	203.0	206.0	250.0
SINAI	226.0	236.0	245.0	226.0	228.0	230.0	240.0	232.0	225.0	228.0	223.0
SUBURBAN	226.0	214.0	224.0	214.0	217.0	207.0	207.0	211.0	211.0	204.0	205.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0	68.0
TIDALHEALTH PENINSULA		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0	182.0
UM BWMC	312.0	315.0	282.0	279.0	271.0	277.0	274.0	269.0	264.0	273.0	274.0
UM CAPITAL REGION	261.0	273.0	267.0	260.0	264.0	256.0	283.0	270.0	259.0	253.0	254.0
UM SHORE CHESTERTOWN	166.0	171.0	160.0	176.0	184.0	147.0	185.0	196.0	177.0	161.0	167.0
UM SHORE EASTON	176.0	162.0	169.0	171.0	161.0	159.0	175.0	192.0	161.0	169.0	162.0
UM ST. JOSEPH	308.0	296.0	309.0	314.0	313.0	289.0	317.0	298.0	290.0	281.0	279.0
UMMC DOWNTOWN	301.0	306.0	298.0	293.0	289.0	290.0	299.0	311.0	319.0	294.0	297.0
UMMC MIDTOWN	254.0	276.0	267.0	265.0	262.0	231.0	289.0	300.0	271.0	263.0	243.0
UPMC WESTERN MD	229.0	232.0	246.0	244.0	268.0	249.0	251.0	249.0	247.0	244.0	227.0
UPPER CHESAPEAKE	269.0	275.0	272.0	265.0	275.0	276.0	304.0	296.0	285.0	269.0	279.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0	386.0

OP18c: ED Arrival to Discharge Time by Month

Measure
OP-18c



OP18c: ED Arrival to Discharge Time by Month



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

Average Median Wait Time All Hospitals for OP-18c

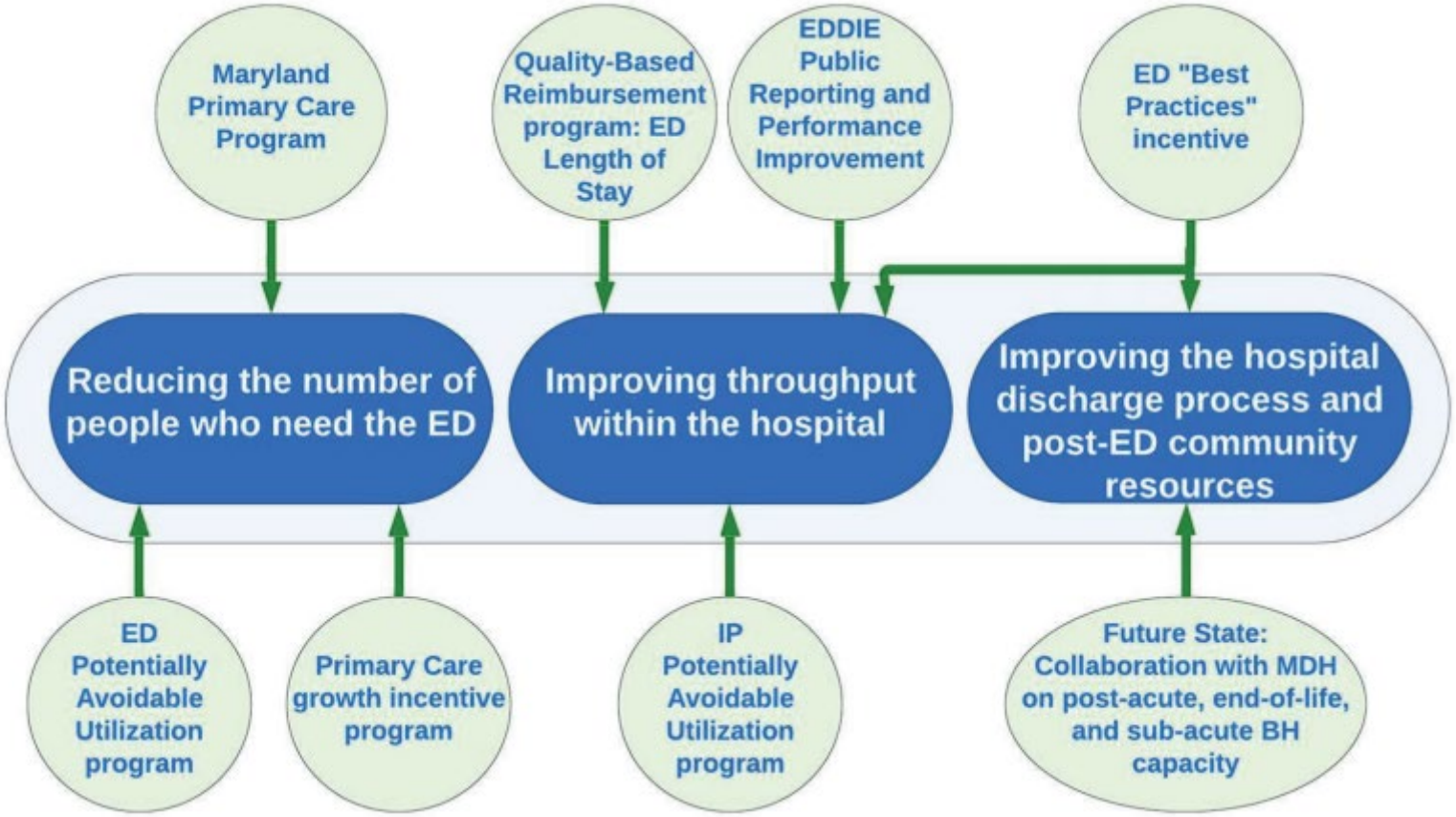
Measure
OP-18c

Change from Base
-729 1,(

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024
AAMC	394	383	353	385	393	372	363	349	344	330	322
ASCENSION SAINT AGNES	379	342	389	330	371	384	387	391	402	365	373
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159
CALVERT		282	302	302	318	270	328	283	301	307	292
CARROLL	322	423	323	260	296	339	325	329	286	320	381
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502
CHRISTIANACARE, UNION	202	236	238	260	253	250	237	341	306	316	324
DOCTORS	451	363	389	393	380	397	404	447	411	389	397
FREDERICK		343	335	376	426	395	435	484	433	396	
FT WASHINGTON	729	847	1,078	0	0	0	0	1,801	629	381	6
GARRETT			288		288	167	154	144	166	169	167
GBMC	506	681	587	631	534	714	592	586	576	723	482
GERMANTOWN EMERGEN..	87	69	0	0	0				246	105	0
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814
HARFORD MEMORIAL	325	375	292	347	380	387	437	371	654		
HOLY CROSS	751	609	726	701	586	642	524	577	569	633	
HOLY CROSS GERMANTO..	579	496	386	364	426	434	383	406	415	454	
HOWARD	687	445	503	550	571	496	549	714	644	479	582
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574	583
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466
MEDSTAR FRANKLIN SQUA..	353	365	337	324	328	370	405	406	398	366	364
MEDSTAR GOOD SAMARIT..	324	333	292	314	364	285	337	351	315	273	298
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310	282
MEDSTAR MONTGOMERY	276	320	302	345	386	309	392	416	322	396	313
MEDSTAR SOUTHERN MA..	390	426	422	399	467	432	479	491	398	412	429
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275
MEDSTAR UNION MEMORI..	401	332	307	325	359	299	359	346	342	303	371
MERCY	276	302	287	274	289	275	269	324	326	258	333
MERITUS	269	251	246	262	266	301	284	293	256	283	300
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288	250
SINAI	692	672	648	717	622	518	698	659	833	773	722
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346
TIDALHEALTH MCCREADY			24	52	140	369	74	133	74	37	195
TIDALHEALTH PENINSULA		202	225	254	189	270	227	208	197	226	226
UM BWMC	413	469	377	446	420	446	553	443	440	434	397
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455
UM SHORE CHESTERTOWN	214	313	411	329	382	293	363	411	459	324	239
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109	1,286

Update: Emergency Department MVP Program

HSCRC Programs Impacting Emergency Departments



Background

- CY 2021: The Commission asked staff to develop a policy providing hospital payment incentives for reduction of avoidable ED utilization
- CY 2022: Performance Measurement Workgroup was convened to evaluate policy options for the reduction of ED potentially avoidable utilization
  - Stakeholders recommended the development of policy focused on ED multi-visit patients (MVPs).
- CY23: Staff developed MVP measure, placed into monitoring status, began providing monthly reports to hospitals on CRISP portal
- February 2024: The Commission asked staff to provide information on proposed or ongoing MVP intervention programs at the hospital EDs.

Evidence on MVP Interventions

Author	Study	Intervention	Outcome
Tsai et al. 2018.	Retrospective cohort study.	Primary care intervention including in-hospital, free, adult clinic for poor uninsured patients.	High-users' mean annual ED visit rates were 5.43 pre intervention vs versus 3.21 post intervention
Althaus et al. 2010	Meta-analysis of experimental and observational studies.	Case Management.	1. Six of the 8 studies reported a significant reduction in ED use 2. ED cost reductions were demonstrated in 3 studies 3. Social outcomes were favorable in 3 of 3 studies 4. clinical outcomes trended toward positive results in 2 of 3 studies.

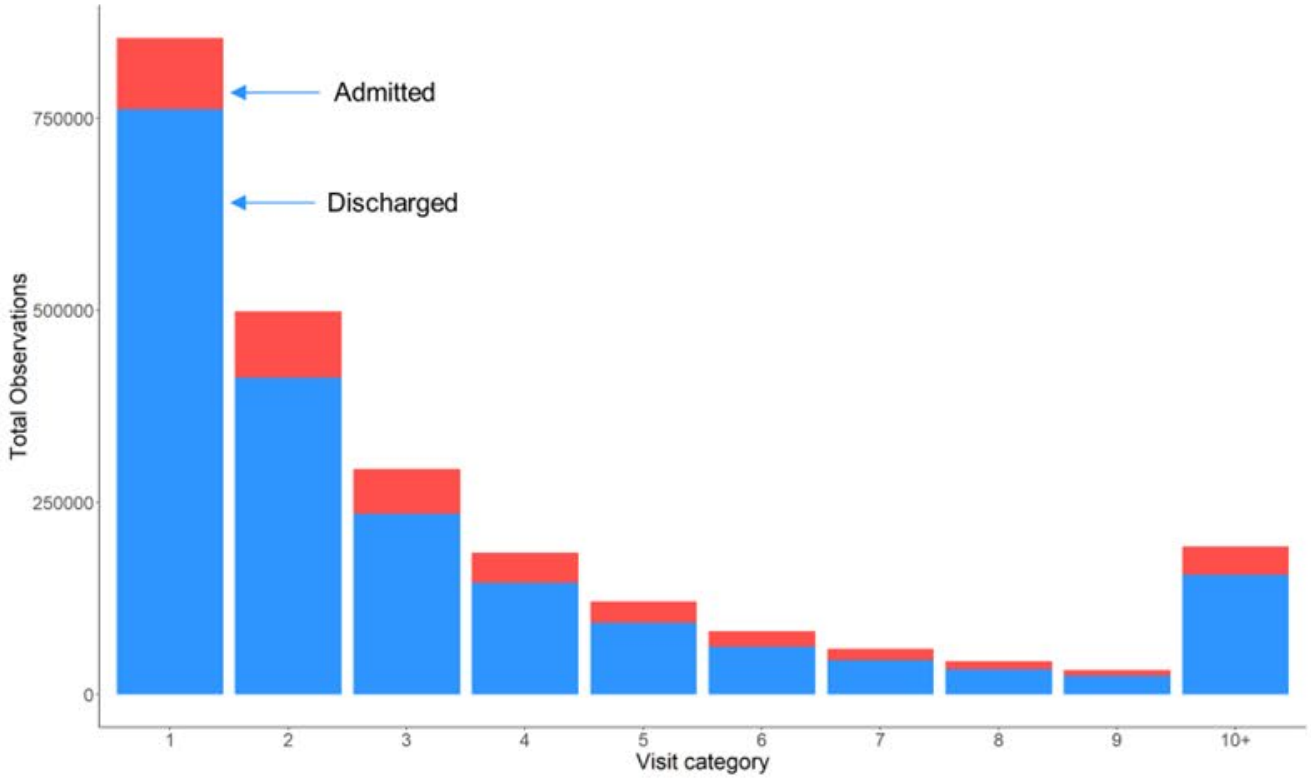
HSCRC Definition of ED MVPs

- MVPs are patients with four or more ED visits in a calendar year at **any** hospital, regardless of their disposition.
- Most MVPs visited one or two hospitals during the year for all of their care
- When those visits involved multiple hospitals, the hospitals tended to be within the same health system.

Characteristics of MVP Visits in 2019

- 40% are covered by Medicaid
- 37% involve patients in the top quartile of Area Deprivation Index
- 41% involve Black patients
- 1% involve homeless patients
- 38% (of admitted visits) are also flagged as PQI's

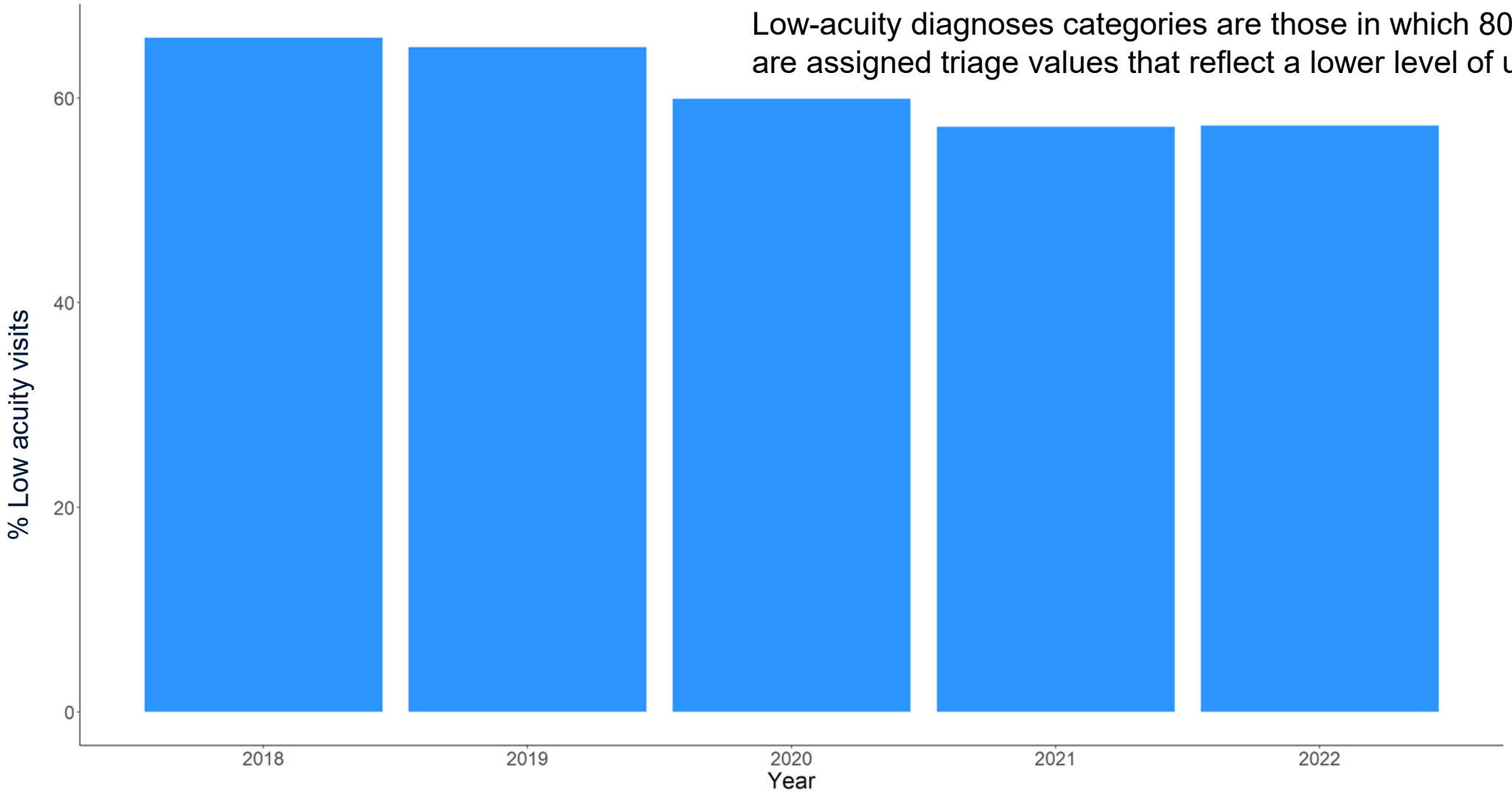
MVPs accounted for 30% of all ED visits in 2019



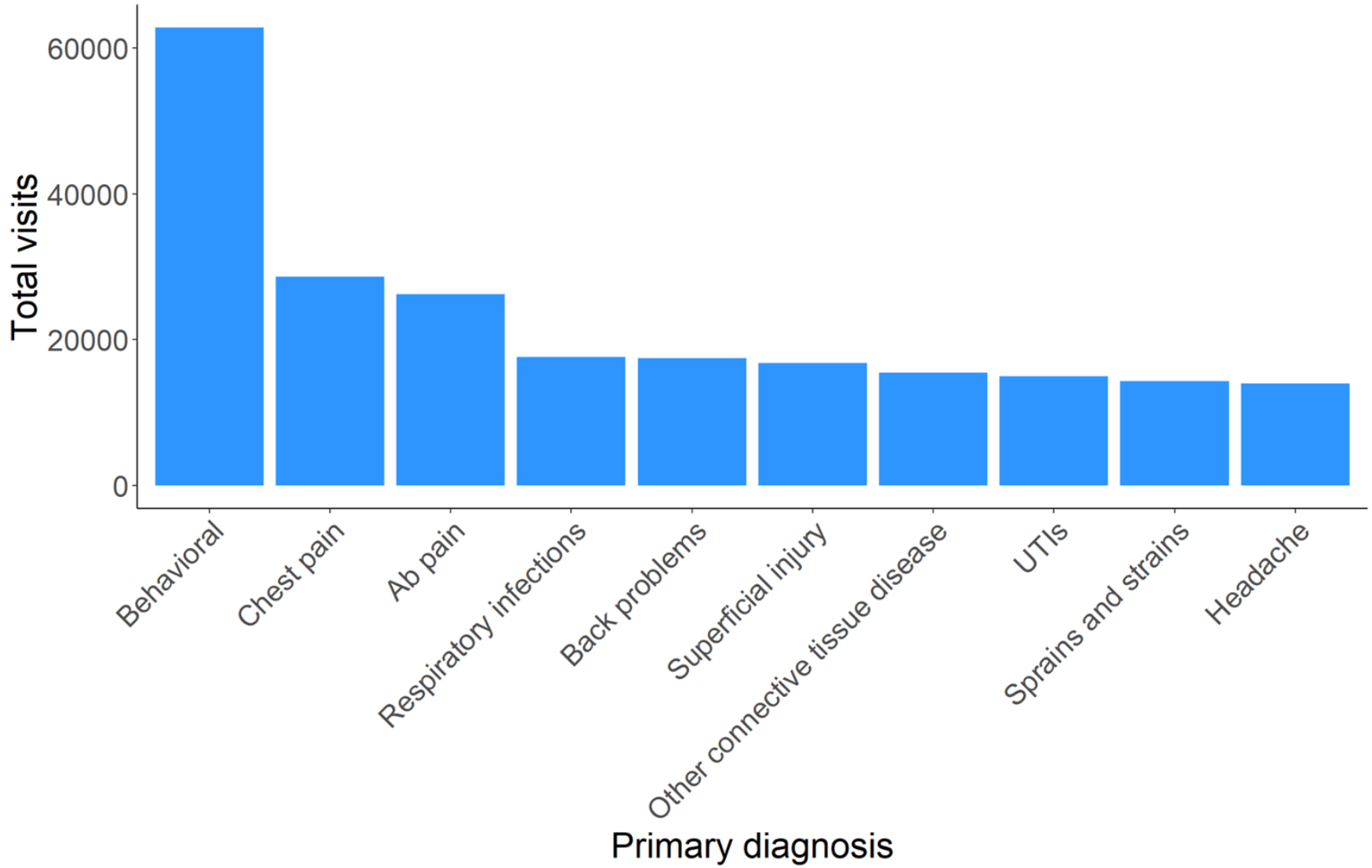
- Bulk of frequent flier visits are discharged from ED
- Indicates lower-acuity problems are common in frequent flier population
- Limited overlap with PAU

Of MVP outpatient visits, 62% are for low-acuity principal diagnoses

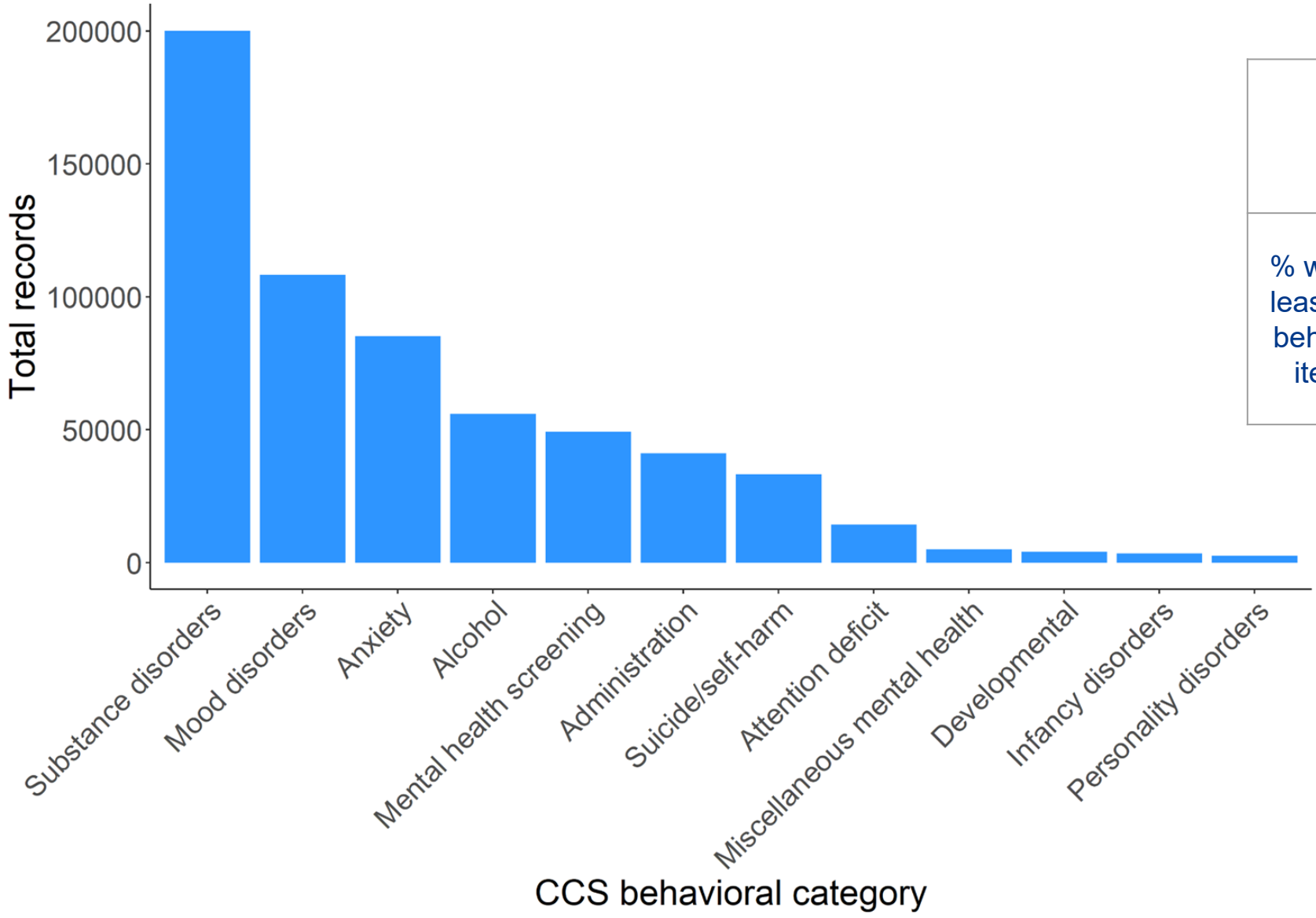
Low-acuity diagnoses categories are those in which 80% of visits are assigned triage values that reflect a lower level of urgency



MVP Visits by primary diagnosis for ED all sources in 2019

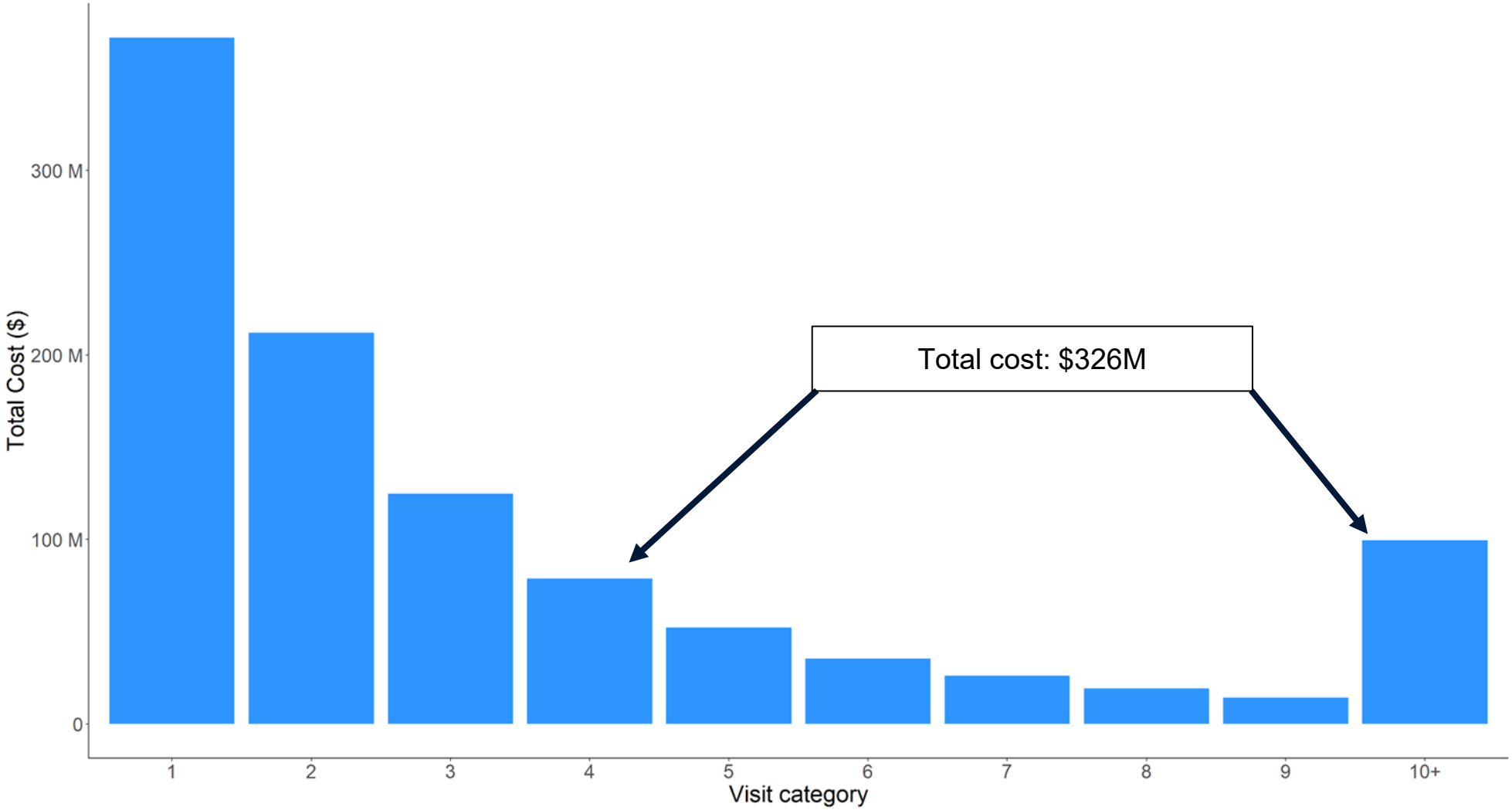


Most MVP visits have a behavioral health component

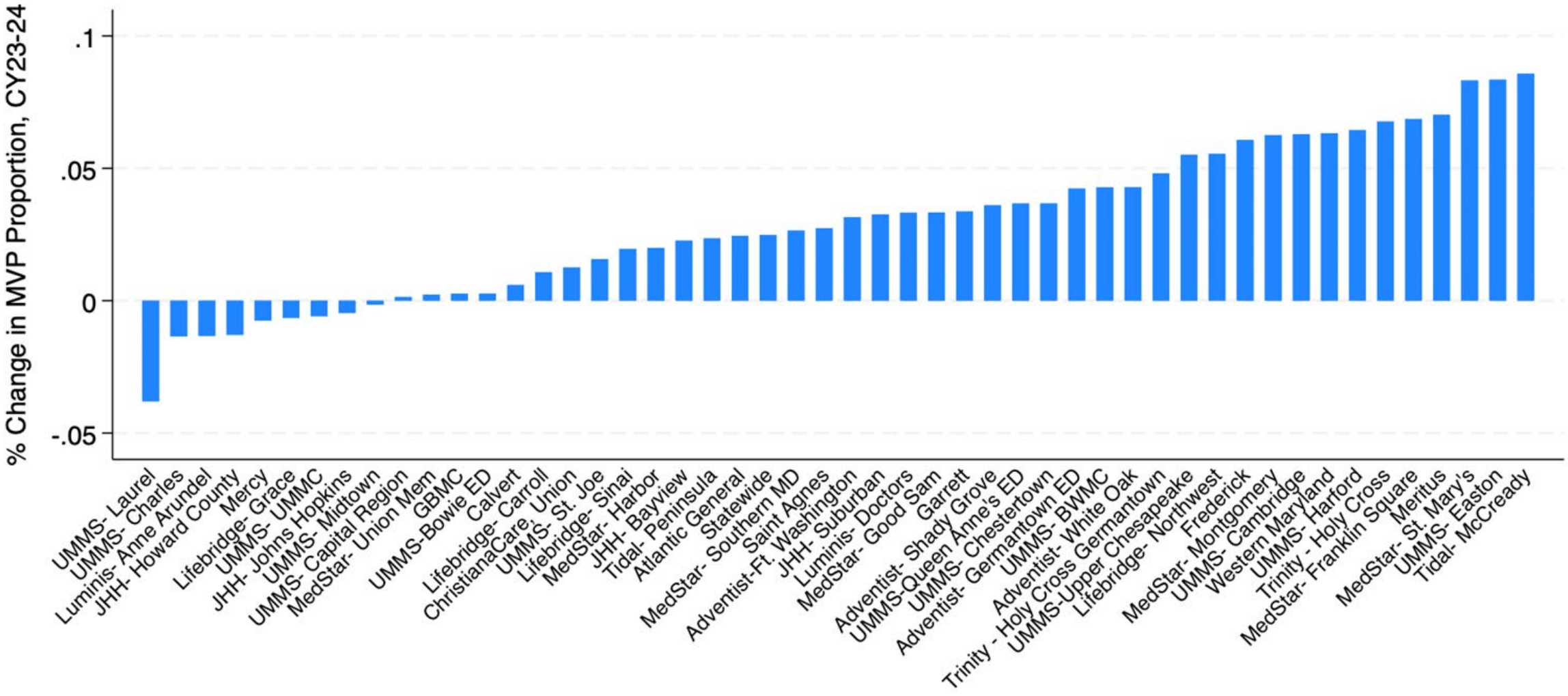


	Non MVP	MVP
% with at least one behavior items	29	67

MVPs accounted for 32% of discharged ED costs in 2019

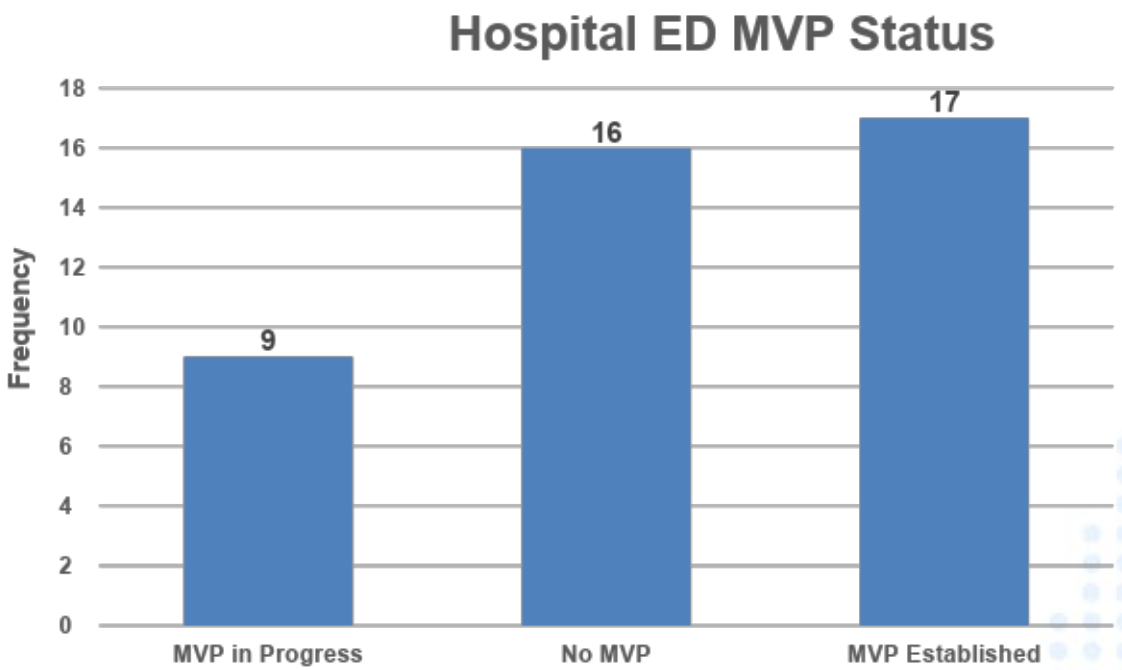


MVP Performance for Most Hospitals Worsened in CY23



Survey Responses

- Responses to the ED MVP program survey were received from 42 hospitals.
- 17 hospitals reported that they had a dedicated ED MVP program.
- 25 hospitals either do not have an ED MVP program or were in the process of establishing one(Fig.1)



Survey Response

- Although 17 respondents reported that they have an established MVP program, the definition of MVPs varied across hospitals.
  - One hospital requires at least 6 visits per quarter for a patient to be flagged as an MVP
  - Six hospitals require 4 visits per quarter
  - Four hospitals require 2 or more discharges from any hospital or ED visit in a 6 month period
  - One hospital requires 2 visits per year
  - One hospital that reported they have an established MVP stated that they have no threshold number but consider Medicaid patients with potentially avoidable ED visits as MVPs

Limited Resources Allocated to MVP Programs

- Out of 16 hospitals that reported FTE counts, four hospitals have <=1 FTE
- The annual expenditure per FTE ranged from about $25,000 to $120,000/year.
- Total annual expenditure dedicated to MVP by all hospitals with an established program that provided spending data was $973,500.
  - 0.30% of total annual hospital spend on MVP's

MVP FTEs and Estimated Annual Expenditure

Hospital Name	# FTEs	Annual Expenditure
Atlantic General Hospital	2	$55,500
Carroll Hospital	2	$120,000
JHH, Bayview, Howard Cty General and Suburban	19.2	No Response
MedStar Franklin Square Medical Center	2	$60,000
MedStar Good Samaritan Hospital	3	$100,000
MedStar Harbor Hospital	3	$150,000
MedStar Union Memorial Hospital	3	$100,000
Mercy Medical Center		No Response
Saint Agnes	2	$100,000
Saint Joseph Medical Center	1	$100,000
Tidal Health Peninsula Regional	0	$70,000
UM Charles Regional Medical Center	1	$118,000
White Oak /Shady Grove Medical Center	0.5	No Response
Total	**38.7**	**$973,500**

Takeaways from Survey

- Less than half of the state hospitals have an established MVP program
- While hospitals have invested in care management, MVPs are a unique population that can benefit from specialized programs. Resources committed to MVP are not in line with the size of the problem and potential ROI from addressing it
- No uniformity in defining and identifying MVPs
- No clear outcome measurement metrics
- Global budgets alone have not compelled the hospitals to significantly address multi-visit patients
- Thus, staff is working on an updated recommendation for building a policy around MVP's and will be back to the Commission shortly
  - What considerations should we have for that recommendation?

maryland
health services
cost review commission

Draft Update Factor Recommendation

May 8, 2024

FY 2025 Update Factor Model

- High Level Goals:
  - Ensures affordability for the Marylanders
  - Include adjustments for inflation and other specific adjustments
  - Adjustments affect all payers
  - Ensure that the provisions of the Total Cost of Care (TCOC) model are met
  - Continue to provide incentives to invest in Population Health and Health Equity
  - Provide hospital with reasonable increases to Global Budgets and Rates
- Additional Considerations:
  - Inflation True Up Methodology
  - PAU Redistribution
  - Set Aside for Hardship

Reasons to Adjust Update Factor Formula

- **Update Factor Formula** = Lesser of Proposed Total Update or Revenue Required to Achieve Savings Tests
  - Inflation is the largest component of the Update Factor
- Staff is considering an adjustment to how we consider inflation in the Update Factor Formula in light of:
  - Recent inflation forecasting errors
  - Performance of the PAU policy

Inflation Catch Up Methodology

- Staff believe a review of underfunded inflation is warranted, but any adjustments for underfunding of inflation should have the following guiding principles:
  - Consider historical overfunding allowances
  - Allow for two-sided risk
  - Utilize multi-year solutions to ensure savings tests are met
  - Establish formulaic methods that are predictable to hospitals and payers
- Staff's proposed methodology takes these guiding principles into account:
  - Establishes the cumulative overfunding value that the Commission allowed without revising future funded inflation downwards (1.18%), i.e., the two-sided risk corridor or max tolerance.
  - Evaluates current 5 year over/underfunding through 2023 (2.16%)
  - Reconciles current over/underfunding to two-sided risk corridor
  - Yields additional inflation of 0.98%

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%
(Under)/Over Funding	(0.10%)	0.56%	0.74%	(0.37%)	0.20%	(0.08%)	0.65%	0.40%	(2.22%)	(1.03%)
5 Year Cumulative Difference	(0.10%)	0.45%	1.18%	0.82%	1.01%	1.03%	1.12%	0.78%	(1.00%)	**(2.16%)**
Max Tolerance **(A)**	1.18%				Absolute of 5 Year Cumulative 2018-2023 **(B)**			2.16%		
Max Funding Solution **C = B-A**					**0.98%**					

- All additional inflation values still need to be considered against required savings

maryland health services cost review commission

Potential Access Issues from PAU & Requirements

- Maryland's risk-adjusted Medicare readmission rate is below the national average.
  - In CY 2022, Maryland had an actual readmission rate that was 1.07 percent lower than the predicted readmission rate
  - Twice as much as the gap between predicted and actual seen nationally (0.49 percent lower)
  - Annual predicted readmission risk was calculated for CYs 2019 through 2022 by applying the 2018 coefficients for each comorbidity using 38 Elixhauser comorbidity flags

- As of December 2023, Maryland has experienced an 18% decrease across all PQIs from its 2018 baseline rate of 1348 admits per 100k residents
  - The current PQI rate is -3.7% below the 2023 year 5 target rate

- PAU volumes at individual hospitals are low and asking facilities to reduce more through the PAU Shared Savings program could lead to potential access problems
  - Hospital A: PQI/PDI rate - 8.73; non-PQI readmission rate - 2.49%
  - Hospital B: PQI/PDI rate - 9.84; non-PQI readmission rate - 4.97%
  - Statewide average - PQI/PDI rate -11.74; non-PQI readmission rate - 5.81%

- While staff think this change to the PAU policy is an important step forward, we are also concerned about potential reduced focus on avoidable admissions. Thus, we are recommending the following:
  - An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU
  - Establishment of a single point of executive accountability for the PAU reduction strategy
  - Agreement to engage in future analyses of PAU performance

Potentially Avoidable Utilization Shared Savings

- The PAU Program was originally a statewide reduction necessary to achieve required savings in the Model and to recoup the ~$200M built into rates for “infrastructure” investments (e.g., care management)
  - Annual reductions were originally not formulaic
  - Advancement in RY2020 tied annual reductions to inflation and population growth
  - To date, the Commission has removed ~$600M through the Shared Savings Program.

- Staff believe the PAU program should continue as a policy to recognize differential margin opportunities in the Model, but staff are concerned that using PAU to generate additional savings is problematic:
  - To date, the State has generated a 3:1 return on its infrastructure investment
  - Ongoing PAU reductions can compromise access

Hospitals	Current Policy	Staff Proposal (Hospital Specific PAU Reduction - Statewide PAU Redction)
RY 2022 Statewide	-0.49%	0.00%
Hospital with Average PAU Performance	-0.48%	0.01%
Hospital with Above Average PAU Performance	-0.34%	0.15%
Hospital with Below Average PAU Performance	-0.70%	-0.21%

Considerations for Set Aside

- The set-aside has historically been used for:
  - Permanent Adjustments - Relatively efficient hospitals that are making investments in population health and/or were disadvantaged by a methodology, per the Integrated Efficiency Policy
  - One-time Adjustments - Extraordinary circumstances and unplanned expenses (e.g., cyberattacks)
- Given the increased frequency of hospital requests exceeding ~$100m, which have accelerated in the past month and are outside of normal adjustment channels (e.g. market shift, demographic adjustment), staff are requesting Commissioner feedback on potential parameters for set-aside distribution

1) Should the Commission establish a gatekeeper test for one-time adjustments (similar to Integrated Efficiency) that only provides funding to hospitals with a clear financial hardship
   - Example of Potential Approach:
     - Below State Average Margin
     - Regulated Margin decline of more than 3%
     - Total Operating Margin decline of more than 1%
     - Liquidity less than 125 days cash on hand
2) Should the Commission create a process where the set aside is distributed through a competitive process?
   - Would assist with allocation of set-aside (both permanent and one-time), which currently does not have a sound methodology for distribution
   - Example of Potential Approach:
     - Twice per year (depending on funding availability) hospitals submit applications citing either relative efficiency performance or financial hardship and the details of their revenue request
     - Staff provide recommendations in subsequent meeting
     - Commissioners vote on requests
     - Hospital must submit a corrective action plan approved by their Board

Balanced Update Model for RY 2025

Components of Revenue Change Link to Hospital Cost Drivers /Performance

			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 4.00% for Wages and Salaries)			3.05%	$645.1	$212.9
- Additional Inflation Support			0.65%	$137.5	$45.4
- Outpatient Oncology Drugs			0.10%	$21.4	$7.1
Gross Inflation Allowance	**A**		**3.80%**	**$804.0**	**$265.3**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.21%	-$45.1	-$14.9
- Grant Funding RY25: RP for Behavioral Health & Maternal and Child Health			0.14%	$29.7	$9.8
Total Care Coordination/Population Health	**B**		**-0.07%**	**-$15.4**	**-$5.1**
Adjustment for Volume					
-Demographic /Population			0.25%	$52.9	$17.5
-Drug Population/Utilization			0.00%	$0.0	$0.0
Total Adjustment for Volume	**C**		**0.25%**	**$52.9**	**$17.5**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.15%	$31.7	$10.5
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		-0.01%	-$3.1	-$1.0
-Reversal of one-time adjustments for drugs	G		-0.10%	-$21.9	-$7.2
-Capital Funding & Estimated Increase for Full Rate Applications	H		0.17%	$36.5	$12.0
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.20%**	**$43.2**	**$14.3**
Quality and PAU Savings					
-PAU Redistribution (-.37%)	J		0.00%	$0.0	$0.0
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		0.08%	$17.6	$5.8
-Current Year Quality Incentives	L =		-0.12%	-$25.2	-$8.3
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.04%**	**-$7.6**	**-$2.5**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**N=**	Sum of A + B + C + I + M	**4.15%**	**$877.1**	**$289.5**
Per Capita	**O=**	(1+N)/(1+0.25%)	**3.89%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
-Uncompensated care, net of differential	P		0.14%	$29.6	$9.8
-Deficit Assessment	Q		0.00%	$0.0	$0.0
Net decreases	**R =**	P + Q	**0.14%**	**$29.6**	**$9.8**
Total Update First Half of Rate Year 25					
Revenue growth, net of offsets	**S =**	N + R	**4.29%**	**$906.8**	**$299.2**
Per Capita Revenue Growth	**T =**	(1+S)/(1+0.25%)	**4.03%**		
Adjustments in Second Half of Rate Year					
- Transformation Funding					
Total Adjustments Second Half of Rate Year	**U**		**0.09%**	**$20.0**	**$6.6**
Total Update Full Rate Year					
Revenue growth, net of offsets	**V =**	Q + U	**4.38%**	**$926.8**	**$305.8**
Per Capita Revenue Growth	**W =**	(1+V)/(1+0.25%)	**4.12%**		

- Staff have elected to only reflect 0.65% for catchup inflation to ensure TCOC savings are being met in all projections
- Under Scenario 2, the Model would fall ~$9M short of the required savings in CY 2024 using the full 0.98% inflation catch up

Revenue Scenarios

Estimated Position on Medicare Test		
Actual Revenue January - June 2023		10,280,594,777
Actual Revenue July-December 2023		10,452,399,742
Actual Revenue CY 2023		20,732,994,519
Step 1:		
Approved GBR RY 2024		21,159,064,172
Actual Revenue 7/1/23-12/31/23		10,452,399,742
Approved Revenue 1/1/24-6/30/24		10,706,664,430
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/24-6/30/24	**A**	**10,706,664,430**
Expected Revenue Growth 1/1/24-6/30/24		**4.14%**
Step 2:		
Final Approved GBR RY 2024		21,159,064,172
Reverse All Payer Rate Reduction:		20,000,000
Final Adjusted GBR Base for RY 2025		21,179,064,172
Projected Approved GBR RY 2025		22,086,677,298
Permanent Update RY 2025		4.29%
Step 3:		
Estimated Revenue 7/1/24-12/31/24 (after 49.73% & seasonality)	**B**	**10,983,704,620**
Expected Revenue Growth 7/1/24 - 12/31/24		***5.08%***
Step 4:		
Estimated Revenue CY 2024	**A+B**	**21,690,369,051**
Increase over CY 2024 Revenue		**4.62%**
Per Capita Increase over CY 2024		**4.36%**

maryland health services cost review commission

MC FFS Guardrail Tests - Proposed Scenarios

- All scenarios uses HSCRC revenue projection for Part A and Part B MD Hospital
- For MD Non-Hospital and US Hospital and Non-Hospital

Scenario 1: 2023 Trended forward at 2017 - 2019 Trend

Scenario 2: 2023 Trended forward at 2015 - 2019 Trend

Scenario 3: 2023 Trended forward at 2022 - 2023 Trend

CY 24 Guardrail Scenario 1: 2023 Trended forward at 2017 - 2019 Trend

TCOC Estimate (Scenario 1)

Scenario 1 Guardrail Projections			
	Maryland	US	
2023	$13,972	$12,347	
2024	$14,605	$12,826	Predicted Variance
YOY Growth	4.5%	3.9%	0.6%
Estimated CY2024 Savings Run Rate			$402.2 M

CY 24 Guardrail Scenario 2: 2023 Trended forward at 2015 - 2019 Trend

TCOC Estimate (Scenario 2)

Scenario 2 Guardrail Projections			
	Maryland	US	
2023	$13,972	$12,347	
2024	$14,531	$12,694	Predicted Variance
YOY Growth	4.0%	2.8%	1.2%
Estimated CY2024 Savings Run Rate			$336.7M

CY 24 Guardrail Scenario 3: 2023 Trended forward at 2022 - 2023 Trend

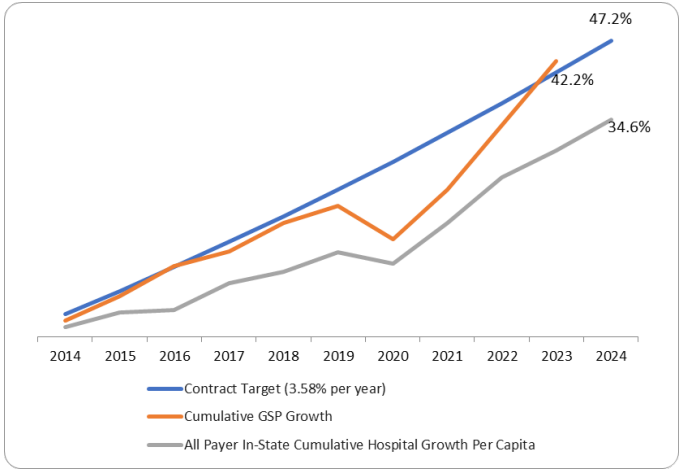
TCOC Estimate (Scenario 3)

Scenario 3 Guardrail Projections			
	Maryland	US	
2023	$13,972	$12,347	
2024	$14,744	$12,967	Predicted Variance
YOY Growth	5.5%	5.0%	0.5%
Estimated CY2024 Savings Run Rate			$427.4M

All-Payer Affordability

- The Total Cost of Care contract all-payer test aims to limit all-payer in-state hospital charge growth to 3.58 percent per annum over the life of the contract.
- Actual growth through CY 2024 is 29.8 percent, below the cumulative target of 47.2 percent. When inflated to 2024, it reaches 34.6 percent, indicating Maryland is 13 percentage points below the target.
- In-state hospital charges are not just below the target but also below the actual cumulative GSP growth through 2023 of 42.2 percent, indicating savings generated by the model.
- Staff compared the 5-year cumulative growth in hospital charges (18.7 percent) to the 5-year GSP growth (21.8 percent) to ensure healthcare remains affordable in Maryland. This comparison highlights efforts to control healthcare costs and ensure they do not outpace economic growth, benefiting all payers and consumers.

Table 7
Affordability Scorecard – Cumulative GSP Test with CY 2024 Projection



Update Factor Recommendation for Non-Global Budget Revenue Hospitals

	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.15%
Productivity Adjustment	SUSPENDED
Additional Inflation Support	N/A
Proposed Inflation Update	3.15%

Recommendations

- For Global Revenues:
  - Provide all hospitals with a base inflation increase of 3.15 percent, with an additional 0.65 percent for additional revenue support based on historic underfunding of inflation.
  - Provide an overall increase of 4.38 percent for revenue (including a net increase to uncompensated care) and 4.12 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.
- For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:
  - Provide an overall update of 3.15 percent for inflation.
  - Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

maryland
health services
cost review commission

maryland
health services
cost review commission

Draft Recommendation for the Update Factors for Rate Year 2025

May 8, 2024

Please submit all comments to hscrc.payment@maryland.gov by COB May 15, 2024.

Table of Contents

List of Abbreviations

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
GSP	Gross State Product
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
OACT	Office of the Actuary
PAU	Potentially avoidable utilization
QBR	Quality-Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The draft recommendation provides an annual update factor of 4.12 percent per capita, a revenue increase of 4.38 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.15 percent for hospitals not under Global Budgets, which includes psychiatric hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2025. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	The annual update factor contains the growth of costs for all payers and reflects ongoing investments in population health and health equity. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Executive Summary

The following report includes a draft recommendation for the Update Factor for Rate Year (RY) 2025. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability for consumers and purchasers of hospital services, as well as meeting all of the State's contractual obligations with the federal government.

Staff requests that Commissioners consider the following draft recommendations:

For Global Revenues:

(a) Provide all hospitals with a base inflation increase of 3.15 percent, with an additional 0.65 percent for additional revenue support based on historic underfunding of inflation.

(b) Provide an overall increase of 4.38 percent for revenue (including a net increase to uncompensated care) and 4.12 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

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

(a) Provide an overall update of 3.15 percent for inflation.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

Introduction & Background

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

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. The TCOC Model requires that the State reach an annual total cost of care savings of $408 million relative to the national growth rate by 2026, relative to a 2013 base year. In addition, the State committed to continue to limit the growth in hospital costs in line with economic growth, continue quality improvements, and improve the health of the population. The annual savings target for CY 2024 is $336 million.

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

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

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

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

This recommendation proposes Rate Year (RY) 2025 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Draft Update Factors Recommendations

For RY 2025 HSCRC staff is proposing an update of 4.12 percent per capita for global budget revenues and an update of 3.15 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Fourth Quarter 2023 market basket growth estimate with a capital growth estimate. For RY 2025, HSCRC Staff combined 91.20 percent of Global Insight's Fourth Quarter 2023 market basket growth of 3.20 percent with 8.80 percent of the capital growth estimate of 2.60 percent, calculating the gross blended amount as a 3.15 percent inflation adjustment. Global Insights has not yet released its CY 2024 First Quarter book, which historically is the reference staff use to determine annual inflation. In the RY 2025 Final Recommendation, the inflation number may be updated to reflect the First Quarter inflation amount.

Consideration of Hospital Financial Condition

Hospital industry representatives have raised concerns over hospital financial performance in several forums. Staff recognize that recent Fiscal Years have been more financially challenging for hospitals than prior years and that several hospitals are challenged to meet their system debt service coverage ratios. Staff's review of audited hospital financial data shows that profits on regulated activities remained unchanged, from 6.46 percent of regulated net operating revenue in RY 2022 to 6.60 percent of regulated net operating revenue in RY 2023. Profits on hospital operations, which include profits and losses from

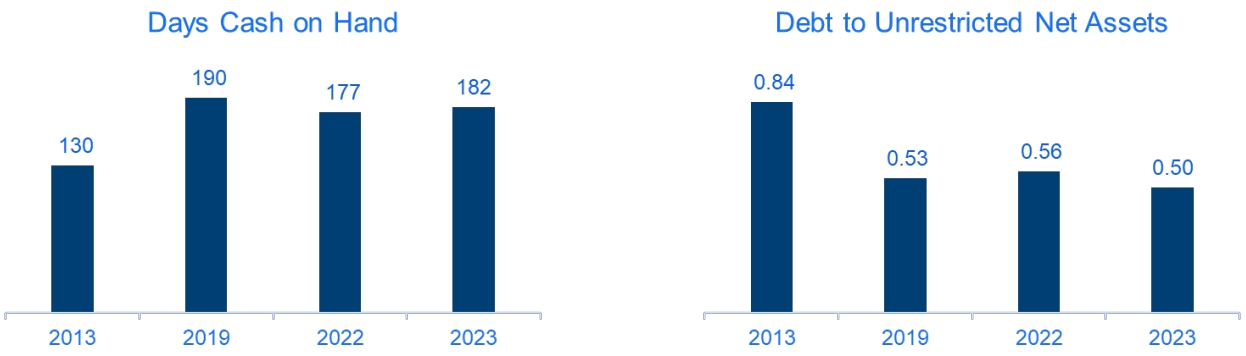
regulated and unregulated day-to-day activities, decreased from 0.77 percent of total net operating revenue in RY 2022 to 0.01 percent of total net operating revenue in RY 2023.

Unaudited data received by the HSCRC shows that fiscal year-to-date RY 2024 regulated margins through February are 5.90 percent, although that is below last year's audited amount of 6.60 percent, unaudited regulated margins are typically understated, and staff anticipate fiscal year end audited regulated RY 2024 margins will be at or above RY 2023.

Unaudited data received by the HSCRC shows that fiscal year-to-date RY 2024 total operating margins through February are 1.31 percent, an improvement over the break-even results for RY 2023. Unaudited and audited total operating margins are typically consistent. While average margins are positive, the median unaudited total operating margin for year-to-date RY 2024 is approximately break-even meaning half of all hospitals are losing money. These losses are concentrated among smaller, independent hospitals resulting in the median under-performing the average.

Despite relatively weak financial performance in RY 2023 and, to a lesser extent year-to-date RY 2024, hospital balance sheets, on average, remain stronger than they were prior to GBRs. Figure 1 shows days cash on hand and debt to unrestricted net asset ratio for Maryland domiciled health systems as of June 30, 2013 (pre-GBR), 2019 (pre-pandemic), 2022, and 2023 (most recent years)[1].

Figure 1: Balance Sheet Metrics



Staff generally review industry wide-values in assessing financial condition but note that statewide strength does not mean individual hospitals do not have significant challenges. Despite the overall balance sheet strength, if operating margins continue to be weak, as in recent fiscal years, select hospitals may experience worsening financial conditions.

[1] Days cash on hand reflects the number of days of cash operating expenses an organization could pay with its unrestricted cash and investments. Debt to Unrestricted Net Assets measures how much debt an organization carries relative to its total balance sheet. Balance sheet metrics are reported at a system level as debt and cash are typically managed at a system level. Only primarily Maryland-domiciled systems are included to avoid swamping the statistics with the results of large national systems that have limited representation in Maryland.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC Staff proposes applying the inflation adjustment of 3.15 percent and continuing suspension of the productivity reduction. The pandemic's effect on hospitals continues to result in volume declines compared to a pre-pandemic period. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years. Hospitals not under Global Budget revenues are provided updates similar to what is proposed nationally. Staff are not recommending providing them with additional inflation support but do recommend withholding the productivity adjustment. These hospitals are volume variable and have the ability to grow volumes to increase revenues.

Table 1: Base Inflation Inputs

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.15%	3.15%
Productivity Adjustment	N/A	SUSPENDED
Additional Inflation Support	0.65%	N/A
Proposed Inflation Update	3.80%	3.15%

Update Factor Recommendation for Global Budget Revenue Hospitals

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

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

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates revenue growth for the full rate year to be 4.38 percent with a corresponding per capita growth rate of 4.12 percent.

The revenue growth that will impact CY 2024 is expected to be 4.29 percent with a corresponding per capita growth of 4.03 percent. The 4.29 percent revenue growth will be used to measure the proposed update against financial tests, which are performed on Calendar Year results, Staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2025 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC Staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2: Update Factor Schedule

Balanced Update Model for RY 2025					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 4.00% for Wages and Salaries)			3.05%	$645.1	$212.9
- Additional Inflation Support			0.65%	$137.5	$45.4
- Outpatient Oncology Drugs			0.10%	$21.4	$7.1
Gross Inflation Allowance	**A**		**3.80%**	**$804.0**	**$265.3**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.21%	-$45.1	-$14.9
- Grant Funding RY25: RP for Behavioral Health & Maternal and Child Health			0.14%	$29.7	$9.8
Total Care Coordination/Population Health	**B**		**-0.07%**	**-$15.4**	**-$5.1**
Adjustment for Volume					
-Demographic /Population			0.25%	$52.9	$17.5
-Drug Population/Utilization			0.00%	$0.0	$0.0
Total Adjustment for Volume	**C**		**0.25%**	**$52.9**	**$17.5**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.15%	$31.7	$10.5
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		-0.01%	-$3.1	-$1.0
-Reversal of one-time adjustments for drugs	G		-0.10%	-$21.9	-$7.2
-Capital Funding & Estimated Increase for Full Rate Applications	H		0.17%	$36.5	$12.0
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.20%**	**$43.2**	**$14.3**
Quality and PAU Savings					
-PAU Redistribution (-.38%)	J		0.00%	$0.0	$0.0
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		0.08%	$17.6	$5.8
-Current Year Quality Incentives	L =		-0.12%	-$25.2	-$8.3
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.04%**	**-$7.6**	**-$2.5**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**N=**	Sum of A + B + C + I + M	**4.15%**	**$877.1**	**$289.5**
Per Capita	**O=**	(1+N)/(1+0.25%)	**3.89%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
-Uncompensated care, net of differential	P		0.14%	$29.6	$9.8
-Deficit Assessment	Q		0.00%	$0.0	$0.0
Net decreases	**R =**	P + Q	**0.14%**	**$29.6**	**$9.8**
Total Update First Half of Rate Year 25					
Revenue growth, net of offsets	**S =**	N + R	**4.29%**	**$906.8**	**$299.2**
Per Capita Revenue Growth	**T =**	(1+S)/(1+0.25%)	**4.03%**		
Adjustments in Second Half of Rate Year					
- Transformation Funding					
Total Adjustments Second Half of Rate Year	**U**		**0.09%**	**$20.0**	**$6.6**
Total Update Full Rate Year					
Revenue growth, net of offsets	**V =**	Q + U	**4.38%**	**$926.8**	**$305.8**
Per Capita Revenue Growth	**W =**	(1+V)/(1+0.25%)	**4.12%**		

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC Staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.15 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2023 market basket growth of 3.20 percent with 8.80 percent of the capital growth index change of 2.60 percent. The adjustment for inflation includes 4.00 percent for wage and compensation. Staff anticipates that the gross blended statistic of 3.15 percent will change once Global Insight releases its First Quarter 2024 book, which is historically the basis for the Commission's Update Factor recommendation. Due to the delayed release of the book, staff did

not reflect the updated market basket growth statistics in the Draft Recommendation but will update the Final Recommendation in line with historical practice.

- **Additional Inflations Support:** Staff recommend providing an additional 0.65 percent to account for historical underfunding of inflation. It should be noted that this allowance follows several guiding principles including: considering historical overfunding allowances, allowing for two-sided risk, utilizing multi-year solutions to ensure savings targets are met, and establishing formulaic methods for hospital and payer predictability. Using these principles, Staff developed a methodology that calculates a five-year cumulative value of under or over funding. Staff then notes the maximum risk tolerance, which is the max 5-year overfunding in any given year since 2014, i.e., the cumulative overfunding value that the Commission allowed without revising future funded inflation downwards. In effect, Staff are creating a risk corridor by which the Commission would not adjust future inflation if the variance between actual inflation and funded inflation was within 1.18 percent. Conversely, if the variance between actual inflation and funded inflation is within 1.18 percent, this methodology would not recommend any adjustments, as that level of variance was "tolerated" in prior years.

  Staff are utilizing the RY 2014 to RY 2023 time period for this review. The RY 2024 period has not been included in this review, as it still requires 4 more quarters of data to be deemed complete. . To this end, any additional funding provided in RY 2025 will need to be included in the calculation of over or under funding of inflation for RY 2026, which will utilize 2024 data. It is also worth noting that this formulaic approach enshrines two-sided risk, meaning if staff finds cumulative funded inflation exceeds actual inflation by more than 1.18 percent, it will be removed from future inflation funding. It should also be noted that any additional inflation value still needs to be considered against required savings. Utilizing the RY 2025 update, Maryland was projected to miss the savings target by approximately $9 million under Scenario 2 modeling using the max inflation solution of 0.98 percent seen in Table 3 below. Staff reduced the 0.98 percent by an additional 0.33 percent to ensure savings in all savings scenarios. Therefore, this draft recommendation provides an additional 0.65 percent for inflation.

Table 3: Inflation Risk Corridor Methodology

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%
(Under)/Over Funding	(0.10%)	0.56%	0.74%	(0.37%)	0.20%	(0.08%)	0.65%	0.40%	(2.22%)	(1.03%)
5 Year Cumulative Difference	(0.10%)	0.45%	**1.18%**	0.82%	1.01%	1.03%	1.12%	0.78%	(1.00%)	**(2.16%)**
Max Tolerance **(A)**	**1.18%**				Absolute of 5 Year Cumulative 2018-2023 **(B)**			2.16%		
Max Funding Solution **C = B-A**					**0.98%**					

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in Rate Year 2021, Staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2024 continues this practice. Price inflation on these drugs declined considerably starting in the late-2010s. In response to this trend Staff gradually lowered the drug inflation amount from 10 percent down to 0 percent over the period from RY 2019 to RY 2023 based on data from RY 2018 to RY 2022. Starting in RY 2022 the price inflation began to accelerate again, and this trend accelerated into RY 2023. While staff have previously evaluated providing hospital specific inflation, historically, all hospitals have received an equal drug inflation because analysis has shown the experienced inflation was relatively consistent across hospitals. However, the inflation beginning in 2022 appears to be concentrated in the more specialized drugs

that are primarily delivered by academic institutions. Therefore, staff is recognizing this new round of inflation by recommending a small increase from 0 percent to 2.5 percent for all hospitals but a larger increase for just the academic centers of 7.5 percent. The 5 percent point gap reflects the observed gap between academic and non-academic trends in 2022 and 2023.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2024 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, and Maternal and Child Health Improvement Fund Assessment. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2024 of -0.21 percent. RY 2025 funding is expected to be approximately 0.14 percent and includes continued funding for Behavioral Health and Maternal and Child Health.

- **Adjustments for Volume:** Staff are proposing a population growth estimate of 0.25 percent for RY 2025 (July 1, 2022 to June 30, 2023), which is based on the Maryland Department of Planning's estimate for 2023 over the projected value noted in 2022.[2] For RY 2025 the staff is proposing to use Claritas' projected CY 2024 growth estimate for distributing the Demographic Adjustment at a zip code level, in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per-case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy. Staff has earmarked 0 percent reduction for this item, because low-efficient hospitals are encouraged to buyout of their reductions through investments in Revenue for Reform and if buyouts do not occur, relatively efficient hospitals can petition the Commission for funding that is withheld from relatively inefficient hospitals.

- **Set-Aside for Unforeseen Adjustments:** The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals. Staff is recommending 0.15 percent for RY 2025. Staff will work to define hardship to better distribute this funding source.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC Staff developed an approach to provide a higher variable cost factor (100 percent

[2] https://planning.maryland.gov/MSDC/Pages/s2_estimate.aspx

for drugs and supplies, 50 percent for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center from RY 2017 to RY 2023. Based on this analysis, staff concluded that the historical average growth rate was 0.35 percent, which equates to a combined state impact of -0.01 percent for the RY 2025 Update Factor.

- **PAU Redistribution:** For RY 2025, Staff is proposing to continue utilizing the PAU Shared Savings program, as the policy 1) has successfully generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and 2) has recognized that hospitals in a fixed revenue model do not have the same opportunity to improve profitability by reducing avoidable utilization, i.e., the range in hospital revenue attributable to readmissions and avoidable admissions is large. However, Staff are concerned that the current construct of the program, which reduces inflation and population funding for readmissions and avoidable admissions in perpetuity so as to generate Model savings, is potentially problematic, because it may cause access issues for hospitals with low levels of potentially avoidable utilization. Thus, Staff are proposing to discontinue the inflation and population reduction through the PAU Shared Saving Program. The PAU value for RY 2025 is -0.37 percent. The proposed refinement to this methodology would be revenue-neutral to the State, and for this reason the value represented on Table 2 is 0 percent.

- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). . Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The January QBR adjustments may also include changes to the preset revenue adjustment scale to reflect reduced performance standards in line with lower scores nationally, as approved in the RY 2025 final policy. The current revenue adjustments across the three programs is -0.12 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of 0.08 percent.

- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately $36.5 million through the Full Rate Application Policy. This value is subject to change based on quality assurance reviews of Inter-hospital Cost Comparison (ICC) methodology and the Marketshift Policy, which has an effect on the final revenues evaluated in the ICC. Staff, with input from Stakeholders, will work to determine how this funding should be distributed and any considerations that may accompany such a decision.

- **Transformation Funding:** One of the paths to success under global budgets is to find innovative solutions that avert the need for traditional hospitalization. While significant progress has been

made in averting these admissions Staff believe there is an opportunity to accelerate these efforts through targeted investment in transformative solutions that may be too expensive or speculative to be funded in the normal course of business. For example, hospital-at-home approaches in rural areas could reduce cost, while also eliminating the travel burden on patients, but can't be tested at scale and therefore require extra investment to develop a proof of concept. The Transformation Fund will provide approximately $20 M to match investments committed by hospitals or other entities to pursue these transformative ideas. The funding shall be awarded based on a competitive process to be administered by HSCRC staff as an extension of the Care Transformation Initiative program; both Maryland hospitals and other entities, in partnership with a Maryland hospital, will be eligible. Staff shall select at most 3 proposals based on documented criteria that will include but not be limited to (1) degree of innovation and risk involved (i.e. why the approach is hard to implement in the absence of this funding), (2) speed of implementation, (3) the share of funding provided by the applicant versus requested from the State, (4) likelihood of scalability and (5) estimated long-term impact on lowering total cost of care and/or increasing quality. The impact in RY 2025 is approximately 0.09 percent; however, this funding will not be available for award before January 2025 and will be input into rates at that time. For this reason, staff are not including this line item in the calculation of calendar year 2024 growth or projections of calendar year 2024 savings.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2025 will be 0.14 percent. The amount in rates was 4.35 percent in RY 2024, and the proposed amount for RY 2025 is 4.49 percent, an increase of 0.12 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.
- **Deficit Assessment:** This line item is 0 percent, the Legislature approved a funding level of $294,825,000, which is the same as previous years.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Redistribution - Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY 2020, the calculation of the statewide value of

the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2025, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This will result in a RY 2025 permanent PAU savings reduction of -0.37 percent statewide, or $72,466,925. Hospital performance on avoidable admissions per capita and 30-day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 4: PAU Shared Savings Adjustment

Statewide PAU Reduction	Formula	Value
RY 2023 Total Estimated Permanent Revenue	A	$19,585,655,296
RY 2024 Inflation Factor**	B	3.55%
CY 2022 Total Experienced PAU $	C	$2,066,535,838
RY 2024 Proposed Revenue Adjustment $	D = B*C	-$73,362,022
RY 2024 Proposed Revenue Adjustment %	E = D/A	-0.37457%
RY 2024 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.370000%**
RY 2024 Adjusted Proposed Revenue Adjustment $ *	G = F*A	**-$72,466,925**
Total PAU %	H	10.44%
Total PAU $	I = A*H	$2,044,485,050
Required Percent Reduction PAU	J = G/I	-3.54

*Does not include revenue from McCready, or freestanding EDs.
** Inflation factor is subject to revisions related to updated data and Commission approval

As previously noted, Staff are proposing to continue utilizing the PAU Shared Savings program in order to recognize differential opportunities in a fixed revenue model; however, Staff are recommending that the PAU Shared Savings program should not be used to generate Model savings, as the policy has already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and future reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions.

Staff believe this change to the PAU policy is an important step forward but have concerns that it could potentially reduce focus on avoidable admissions. As a result, staff are recommending the following: 1) An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU; 2) Establishment of a single point of executive accountability for the PAU reduction strategy; and 3) Agreement to engage in future analyses of PAU performance.

Change in Differential

In December 2022 the Commission voted, and CMMI subsequently approved, an increase of 1 percent to the public payer differential, from 7.7 percent to 8.7 percent, effective April 1, 2023 to June 30, 2024. The public payer differential will revert to 7.7 percent, effective July 1, 2024. The overall impact to hospitals

will be revenue neutral, however, hospital markups, rates, and GBRs will be adjusted to account for the updated public payer payment. The adjustments will be hospital specific, as they are based on the percentage of services attributable to public payers.

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the Staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

This test requires the Model to generate $336 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by the end of CY 2024. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital-only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care savings of $408 million relative to the national growth rate by 2026, relative to a 2013 base year. Thus, there must be continued improved performance overtime to meet the 2026 TCOC Medicare Savings Requirements. In addition the State has begun planning for the next phase of the TCOC Model. This will likely occur under CMS's new multi-state model known as AHEAD.[3] The State expects to have further savings targets beyond the $408 million under the new model and it is important that State enters these negotiations in a strong position versus current savings targets.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, Staff obtained calendar year growth estimates for Medicare Fee-for-Service growth from the Office of the Actuary. Staff then converted these estimates to an All-Payer value by calculating a difference statistic, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach, whereby the prior year national trend was used as the stand-in to estimate national trends. However, due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, Staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care

[3] https://hscrc.maryland.gov/Pages/ahead-model.aspx

guardrails for RY 2023. For RY 2025 Staff are using a combination of these approaches. Scenario 3 represents the prior year trend test used prior to the pandemic; the other two scenarios are similar to those used in the more recent Update Factor recommendations.

Actual revenue resulting from RY 2025 updates affects the CY 2024 results. As a result, Staff must convert the recommended RY 2025 update to a calendar year growth estimate. Table 5 below shows the current revenue projections for CY 2024 to assist in estimating the impact of the recommended update factor together with the projected RY 2025 results. The overall increase from the bottom of this table is used in Tables 6a-6c.

Table 5: CY 2024 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2023		10,280,594,777
Actual Revenue July-December 2023		10,452,399,742
Actual Revenue CY 2023		20,732,994,519
Step 1:		
Approved GBR RY 2024		21,159,064,172
Actual Revenue 7/1/23-12/31/23		10,452,399,742
Approved Revenue 1/1/24-6/30/24		10,706,664,430
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/24-6/30/24	**A**	**10,706,664,430**
Expected Revenue Growth 1/1/24-6/30/24		**4.14%**
Step 2:		
Final Approved GBR RY 2024		21,159,064,172
Reverse All Payer Rate Reduction:		20,000,000
Final Adjusted GBR Base for RY 2025		21,179,064,172
Projected Approved GBR RY 2025		22,086,677,298
Permanent Update RY 2025		4.29%
Step 3:		
Estimated Revenue 7/1/24-12/31/24 (after 49.73% & seasonality)	**B**	**10,983,704,620**
Expected Revenue Growth 7/1/24 - 12/31/24		***5.08%***
Step 4:		
Estimated Revenue CY 2024	**A+B**	**21,690,369,051**
Increase over CY 2024 Revenue		**4.62%**
Per Capita Increase over CY 2024		**4.36%**

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2023.

Step 1: The table uses global revenue for RY 2024 and actual revenue for the last six months for CY 2023 to calculate the projected revenue for the first six months of CY 2024 (i.e., the last six months of RY

2024). Hospitals currently project they will be able to charge all of RY 2024 revenue, for this reason, staff have kept the projected RY 2024 compliance line at zero.

Step 2: The final approved GBR for RY 2024 is $21,159,064,172. This step applies the proposed update of 4.62 percent, as shown in Table 2, to the RY 2024 GBR amount to calculate the projected revenue for RY 2025.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2025 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2025

Step 4: This step shows the resulting estimated revenue for CY 2024 and then calculates the increase over actual CY 2023 Revenue. The CY 2024 increase based on this year's recommended update is 4.79 percent. The 4.79 percent is used to estimate CY2024 hospital spending per capita for Maryland in our guardrail and savings policy, which is explained in the next section.

Staff modeled three different scenarios to project the CY 2024 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, Staff applied the estimated CY 2024 growth of 4.62 percent, shown in Table 5 to Maryland hospital spending per capita from 2023. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 6a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2023 as the base.

Table 6a: TCOC Estimate (Scenario 1)

Scenario 1 Guardrail Projections			
	Maryland	US	
2023	$13,972	$12,347	
2024	$14,605	$12,826	Predicted Variance
YOY Growth	4.5%	3.9%	0.6%
Estimated CY2024 Savings Run Rate			$402.2 M

Scenario 2, shown in Table 6b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend

from 2015 - 2019 and trends the data forward using 2023 as the base. This is the most conservative estimate of the three scenarios as average national trends for that period were low. Utilizing a longer period to establish the "typical" trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 6b: TCOC Estimate (Scenario 2)

Scenario 2 Guardrail Projections			
	Maryland	US	
2023	$13,972	$12,347	
2024	$14,531	$12,694	Predicted Variance
YOY Growth	4.0%	2.8%	1.2%
Estimated CY 2024 Savings Run Rate			$336.7M

Scenario 3, shown in Table 6c, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 3 takes the trend from the prior period (2022-2023) and trends the data forward using 2023 as the base. This approach is consistent with the pre-pandemic approach of using the prior year trend to guide current-year savings targets. This approach results in a slightly higher estimate of national trends and slightly larger projected savings than Scenario 2.

Table 6c: TCOC Estimate (Scenario 3)

Scenario 3 Guardrail Projections			
	Maryland	US	
2023	$13,972	$12,347	
2024	$14,744	$12,967	Predicted Variance
YOY Growth	5.5%	5%	0.5%
Estimated CY 2024 Savings Run Rate			$427.4 M

In addition to modeling the CY 2024 guardrail position, Staff also modeled estimated savings under each scenario; these are shown in each table above. The guardrail can not be above the Nation by 1 percent in any year or above the Nation by any percent in two consecutive years. The guardrail position in CY 2023 was below the Nation, so Maryland is not at risk of tripping the guardrail two years in a row. In addition, the estimated savings for CY 2023 is projected to be $480 million (this amount is pending final review and may change). The savings target for CY 2024 is $336 million.

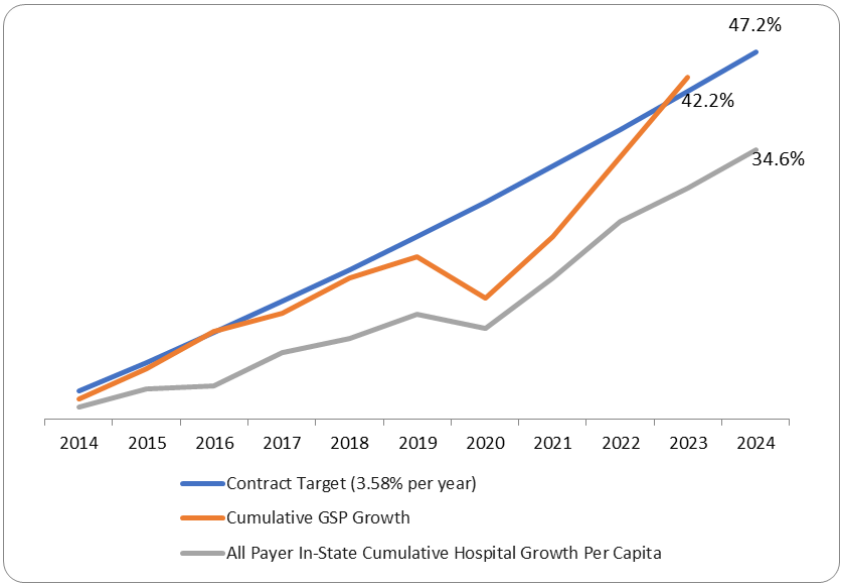
In all three above scenarios, Maryland is set to achieve the savings target for CY 2024 with varying degrees of cushion. In the most conservative scenario, shown in Table 6b, estimated savings is projected to hit the savings target exactly. This scenario also exceeds the guardrail by 0.2 percent, because Maryland is expected to grow faster than the Nation by 1.2 percent. It is important to note that savings are closely monitored during the year and the Commission has time to take action to correct the course should a small short fall materialize. Staff note that the projections released by OACT also suggest higher trends into 2024 nationally that would yield higher savings.

In all three scenarios presented the range in savings varies between $336.7 million to $427.4 million which is a $90.7 million dollar spread. The average of these three scenarios is $389 million.

All-Payer Affordability

Under the Total Cost of Care Contract all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). As shown in Table 7 the cumulative value of this target through CY 2024 is 47.2 percent. Actual all-payer in-state hospital charge growth through CY 2024 is 29.8 percent, inflating this to 2024 using the recommended update factor on a per capita basis yields 34.6 percent. This means that Maryland is approximately 13 percentage points below this target, as seen in Figure 2. Staff also notes that all-payer in-state hospital charges are not just well below the all-payer target but also below the actual cumulative GSP growth through 2023 of 42.2 percent, which is an indication of the savings generated by the Model that accrue to all payers and consumers.

Figure 2
Affordability Scorecard – Cumulative GSP Test with CY 2024 Projection



Staff also compared the all-payer in-state hospital charges to economic growth in Maryland as measured by the GSP for the most recent 5 years. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose Staff believes it is not sufficient to only look at the cumulative test embedded in the Total Cost of Care Contract. Therefore, Staff calculated the cumulative growth for five years using the most updated State GSP numbers available (CY19-CY23). The 5-year calculation shows a cumulative per capita growth of 21.8 percent. Staff then compared that number to the 5-year cumulative growth in in-state acute hospital charges using (CY20-CY24). Staff was able to estimate CY 2024 charges using the proposed RY 2024 update factor. The cumulative growth for in-state hospital charges also equated to 18.7 percent, meaning the recommended update factor would keep the cumulative in-state hospital charge less than the GSP growth over a 5-year window.

Medicare's Proposed National Rate Update for FFY 2025

CMS released its proposed rule for the Inpatient Prospective Payment System's (IPPS) payment rate on April 10, 2024. In the proposed rule, CMS would increase rates by approximately 2.60 percent which includes a market basket increase of 3.00 percent, and a productivity reduction of -0.40 percent. This proposed increase will not be finalized until August 2024 and will not go into effect until October 1, 2024. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Stakeholder Comments

Staff are working with the Payment Model Workgroup to review and provide input on the proposed RY 2025 update. This section will be updated for the Final Recommendation to reflect formal comments received.

Recommendations

Based on the currently available data and the Staff's analyses to date, the HSCRC Staff provides the following draft recommendations for the RY 2025 update factors.

For Global Revenues:

(a) Provide all hospitals with a base inflation increase of 3.15 percent, with an additional 0.65 percent for additional revenue support based on historic underfunding of inflation.

(b) Provide an overall increase of 4.38 percent for revenue (including a net increase to uncompensated care) and 4.12 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

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

(a) Provide an overall update of 3.15 percent for inflation.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

maryland
health services
cost review commission

Open Cases Overview

May 8 , 2024

Open Cases

- 2630R: UM Shore Medical Center at Easton - Full Rate Application - **Withdrawn**
- 2645A: Johns Hopkins Health System - ARM - Accarent Health- *Bariatric surgery, Oncology Surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, join replacements, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, Cochlear implants, gallbladder surgery, CAR-T, ankle repairs, hernia and nephrectomy* **- Approved for 1 Year**
- 2646N: UM Shore Medical Center at Easton - Partial Rate Application - **No action needed at this time**

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2024**
SYSTEM	*****	**FOLIO:**	**2455**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2645A**

Staff Recommendation

May 8, 2024

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 28, 2024, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) to combine arrangements with Accarent Health, Proceedings 2613A and 2525A, into a single arrangement. The current agreements include: bariatric surgery, oncology surgical procedures, rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, cochlear implants, gall bladder surgery, CAR-T, nephrectomy and would add ankle repairs and hernia. The approval would be for one year effective May 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates 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.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will 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 the experience under both arrangements has been favorable for the last year.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination to include: bariatric surgery, oncology surgical procedures, rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, eating disorders, cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy to be effective for one-year beginning May 1, 2024. 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.

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
May 8, 2024

RE:
Hearing and Meeting Schedule

June 14, 2024 To be determined - Zoom

July 10, 2024 To be determined - Zoom

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.