Maryland
Hospital Association

December 18, 2025

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

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for Surge Funding Policy. We applaud the Commission's decision to reinstate and make permanent the surge funding policy recognizing the increased volume of patients with respiratory conditions that hospitals have and will continue to care for.

Unfortunately, the increased intensity of the respiratory season in recent years is becoming the new normal, necessitating a permanent policy responsive to this reality. This policy and routine statewide monitoring of RSV, COVID, pneumonia, influenza, and other life-threatening respiratory illnesses are especially critical as changing federal guidance, losses of coverage, and narrower vaccine eligibility requirements may lead to a reduction in vaccination rates and higher burden of respiratory illnesses in the 2025-2026 respiratory season and future years. The funding from this policy will ensure hospitals can deliver life-saving care to all Marylanders.

RY 2026 Funding

As stated in the draft recommendation, HSCRC previously approved $100.4 million in surge funding for hospitals in RY 2026 based on increased volumes from the first nine months of RY 2025. The amount of funding provided to hospitals under this policy should not be restricted because of the limited data available to the Commission at the time of the July meeting. As with all volume policies, funding should be based on available recent and complete data. As such, the previously approved funding amount should be updated to reflect the experience of the full year. This will ensure the level of support for hospitals is commensurate with the resources needed to address the increased volumes associated with the growth in respiratory illnesses, consistent with the policy's intent.

We also urge HSCRC staff and Commissioners to use the existing calculation methodology—assigning two-thirds weight to patient days and one-third to equivalent case-mix adjusted discharges (ECMADs)—as the basis of RY 2026 hospital funding allocations, resulting in a total funding allocation of $164.6 million when using the full year of RY 2025 data. A change in the methodology should only be considered for the policy in RY 2027 and rate years thereafter.

Inpatient Length of Stay

In their draft recommendation, staff express concern that using patient days to measure volume for the purposes of determining surge funding could potentially reward hospitals for longer length of stay or create a perverse incentive to not manage length of stay to access additional funding. Staff then recommend that Commissioners adopt an independent length of stay incentive to improve length of stay more broadly in the state.

Hospitals are committed to optimizing management of inpatient length of stay and achieving reductions whenever possible. The use of patient days in the surge policy is not a factor or incentive that will impact how hospitals manage care for their patients. Moreover, MHA does not support adoption of an independent incentive to improve length of stay as inpatient length of stay is driven by clinical need and other factors largely out of hospitals' control.

Unique patient care needs and other systemic challenges constrain hospitals' ability to shorten length of stay. The following examples regularly occur when hospitals are caring for patients that are outside hospitals' control.

- ***Complex and Aging Patients:*** Longer inpatient stays may be needed to stabilize patients with complex medical needs, including multiple comorbidities and behavioral health needs. This trend is worsening as Maryland's population continues to age and require more extensive hospital services.
- ***Long-Term and Post-Acute Care Access***: Limited availability of skilled nursing, rehabilitation, and home health services can delay safe discharges. And for the more complex patients who require medical care after discharge, services may not be readily available in the community, particularly for patients who are in socio-economically disadvantaged areas.
- ***Workforce Shortages:*** Staffing constraints for nurses, care managers, and social workers may slow discharge planning and coordination.
- ***Payer Delays***: Prior authorization processes, denials, documentation requirements, and other payer practices can extend hospital stays unnecessarily.
- ***Guardianship and Legal Barriers***: Patients who require guardianship or legal decision-making authority before discharge, court proceedings, appointments of guardians, and coordination with state agencies can extend impatient stays well beyond clinical needs.
- ***Community Resource Gaps:*** Insufficient housing, transportation, and social supports hinder timely transitions out of the hospital.

Because hospitals have a limited ability to impact inpatient length of stay, any independent length of stay initiative should have a monitoring-only focus. With hospitals transitioning to the national CMS Medicare quality programs under AHEAD, HSCRC must prioritize alignment with the national incentive programs and reduction of administrative complexity. Hospitals must devote significant time and resources to implement the transition to AHEAD. All efforts should be aligned to focus on a safe, effective transition. Introducing new policies could further exacerbate hospitals' ability to provide high quality care and access due to financial constraints. There are other efforts underway or planned within the Emergency Department Wait Time Reduction Commission and AHEAD Regulatory Working Group to address barriers that impact

hospital wait times and length of stay including post-acute care. As improvements in access to post-acute care will help to reduce inpatient length of stay, these efforts should be prioritized.

There are, moreover, concerning design features in the inpatient length of stay incentive proposed during the Performance Measurement Workgroup. The proposed, the revenue adjustment methodology would have relied on calendar year (CY) 2018 statewide averages and severity of illness categories within APR-DRG classifications to establish expected length of stay benchmarks. These data are over seven years old and reflect pre-pandemic utilization patterns. The data do not capture profound shifts in patient acuity, case mix, and discharge barriers that have emerged during and since the pandemic. Using out-of-date baseline data would embed unrealistic expectations into the revenue model and could inadvertently penalize hospitals serving higher-acuity or socially complex populations. More recently, staff indicated they are considering baseline data from CY 2021 or CY 2022. The policy should be designed to monitor trends using more recent post-pandemic data or adjustment factors to ensure that length of stay benchmarks reflect current realities and best serve patients and the hospitals they depend on.

Hospitals remain committed to implementing evidence-based best practices for inpatient length of stay management. Because inpatient length of stay is driven by patient care needs and broader systemic factors, the surge policy and any inpatient length of stay or other related initiatives must reflect these limitations.

Thank you for the opportunity to comment on this important policy. We look forward to continuing to work together on policy development in the coming months. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patrick D. Carlson

Patrick Carlson
Vice President, Care Transformation & Finance

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