



Maryland
Hospital Association

April 24, 2026

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 our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation for the Inpatient Length of Stay Incentive Program (IPLOS) Policy. Hospitals share HSCRC's goal to improve patient flow, reduce emergency department (ED) boarding, and strengthen the sustainability of the AHEAD Model.

The hospital field agrees that addressing prolonged inpatient stays is essential to improve throughput and patient experience. However, hospitals have significant concerns about the draft policy, its underlying assumptions, and lack of alignment with Maryland's other efforts to improve ED and inpatient throughput. Additionally, the hospital field has not received clarity about Medicare participation as the state moves forward with the AHEAD Model. As outlined below, MHA recommends an alternative, targeted approach that emphasizes direct hospital engagement, monitoring, and reporting, rather than financial incentives or penalties.

We encourage HSCRC to withdraw the proposed IPLOS policy and instead advance the following steps:

1. **Engage Hospitals Directly:** For hospitals that are inpatient length of stay outliers, engage directly to determine root causes and the need for a targeted monitoring and reporting approach
2. **Account for Maryland's Unique Environment:** Conduct a more thorough multi-factor inpatient length of stay analysis to more appropriately compare Maryland hospital performance to national benchmarks
3. **Consider the Impact of Outlier Cases & Structural Barriers:** Exclude outlier cases from the inpatient length of stay analysis and account for other health care system structural issues that are out of hospitals' control

This alternative approach to address inpatient length of stay concerns would support improvement and transparency without creating unintended consequences or misaligned accountability.

MHA Proposal for an Alternative Design Approach: Hospital Direct Engagement

The proposed methodology evaluates performance based on the better of attainment or improvement, with an attainment target set above the national average observed to expected (O/E) ratio and modified by an improvement threshold. As designed, hospitals performing at or better than the national normative values (norm) could still fail to meet the attainment standard and incur penalties, creating expectations that do not reflect current system realities.

Similarly, the improvement framework requires all hospitals, including those with strong baseline performance, to converge toward an O/E of 1.0 over a five-year period. Together, these targets do not sufficiently account for structural constraints, including post-acute care capacity and discharge barriers, which are largely outside of hospitals' control.

Because of these concerns, MHA respectfully recommends that HSCRC first directly engage outlier hospitals to determine root causes and barriers affecting inpatient length of stay. If these are within hospital control, HSCRC could adopt a targeted monitoring and reporting approach with a focus on addressing these factors. This alternative design could focus efforts on hospitals with inpatient length of stay O/E ratios above the national average, promote transparency, more narrowly target analysis, and foster improvement over time without broad punitive application. Additionally, this approach would support policy goals while allowing HSCRC to better assess trends, identify root causes, and consider appropriate future interventions needed to improve inpatient length of stay.

Maryland's Unique Payment Environment

Maryland's all-payer global budget system differs fundamentally from the national fee-for-service (FFS) environment that underpins Healthcare Cost and Utilization Project (HCUP) norms. Evidence from Maryland's global budget experience shows that implementation was associated with reduced hospital admissions, particularly for potentially avoidable conditions.¹

Additionally, recent HSCRC analyses show a decline in hospital admissions alongside an increase in inpatient length of stay. This finding is consistent with the literature showing that global budgets encourage reduction in unnecessary utilization, which in turn concentrates inpatient care among patients with higher acuity and more complex discharge needs.² As a result, length of stay trends in Maryland reflect hospital operations and the expected structural effects of the payment model itself, which should be considered when applying national length of stay norms and setting performance expectations. For example, including outpatient observation stays lasting longer than 24 hours reduced the state average inpatient length of stay by 1.9% in CY 2024.

¹ Roberts, Eric T., et al. "Changes in Hospital Utilization Three Years Into Maryland's Global Budget Program." *Health Affairs* 37, no. 4 (2018): 644–653. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5993431/>

² Ibid

Peer-reviewed research conducted at large academic medical centers have found that increases in average length of stay were driven significantly by highly complex patients with prolonged hospitalizations. The literature demonstrated that when extreme cases were excluded, baseline length of stay continued to rise, underscoring that shifts in patient complexity and discharge barriers influence length of stay independent of hospital efficiency.³

Furthermore, Maryland hospitals report elevated medical and social complexity among inpatients, including behavioral health needs, chronic disease burden, and social risk factors that extend length of stay independent of hospital performance.⁴ Behavioral health boarding contributes to prolonged stays and ED throughput challenges as psychiatric patients experience significantly longer boarding times than medical patients.⁵ Post-acute constraints such as Skilled Nursing Facility (SNF) staffing shortages, limited bed availability, and regional variation in post-acute capacity, also delay discharge for medically complex patients.⁶ These factors are not fully captured in national length of stay norms derived from the FFS healthcare environment. Given these structural differences, national benchmarks alone may not accurately reflect Maryland's operating context. MHA therefore recommends that HSCRC adopt an analytical approach that utilizes peer-grouping and Maryland-specific adjustments to complement HCUP norms and support fair, context-appropriate performance assessment.

Factors Outside Hospitals' Control

Maryland hospitals continue to experience structural barriers that extend inpatient length of stay independent of hospital performance. These factors differentiate Maryland from the national fee for service environment underlying HCUP benchmarks and are not fully addressed in the current exclusions' framework. Any IPLOS policy must consider these inputs to ensure fair and accurate performance assessment.

Misalignment With Ongoing State Efforts on Post-Acute Care Capacity

Significant post-acute care access challenges, such as limited availability of specialized placements (including ventilator capable facilities), denied and delayed Medicaid eligibility determinations and authorizations, workforce shortages, constrained bed capacity, and regional variation in post-acute infrastructure, are key drivers of prolonged length of stay and ED throughput challenges. These issues have been identified by both the Emergency Department Wait Time Reduction (ED WTR) Commission and the Maryland Health Care Commission (MHCC) led Regulatory Working Group on Post Acute Care, which are actively developing recommendations to address these system level constraints.

³ Andrew H. Hughes, David Horrocks Jr., Curtis Leung, Melissa B. Richardson, and Ann M. Sheehy, "The Increasing Impact of Length of Stay 'Outliers' on Length of Stay at an Urban Academic Hospital," *BMC Health Services Research* 21, no. 1 (2021): 940, <https://doi.org/10.1186/s12913-021-06972-6>.

⁴ Ryan, Andrew M., et al. "Changes in Patient Characteristics and Hospital Utilization After Implementation of Maryland's Global Budget Program." *JAMA Internal Medicine* 179, no. 11 (2019): 1423–1429.

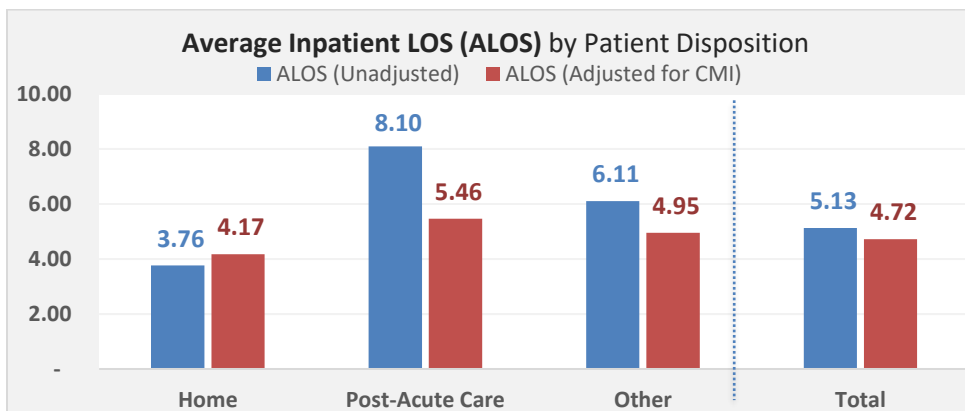
⁵ Nicks, Bret A., and David M. Manthey. "The Impact of Psychiatric Patient Boarding in Emergency Departments." *Emergency Medicine International* (2012). <https://onlinelibrary.wiley.com/doi/10.1155/2012/360308>

⁶ Medicare Payment Advisory Commission (MedPAC). Skilled Nursing Facility Services Payment System. Chapter 7. March 2023. <https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/>

In 2025, the ED WTR Commission reported that Maryland faces a shortage of post-acute beds compared to peer states, contributing to discharge delays for patients no longer requiring acute care and creating inpatient and ED bottlenecks.⁷ The report identified multiple drivers of post-acute delays, including prior authorization barriers, limited weekend admissions, regional workforce and bed shortages, and operational opportunities for improvement across both acute and post-acute settings. Importantly, the Commission emphasized the need for coordinated, statewide solutions and recommended development of a formal proposal to improve post-acute access and capacity, with particular focus on regional needs and complex patient populations.

The proposed IPLOS policy, however, is misaligned with this body of work by introducing a pay-for-performance framework that holds hospitals financially accountable for length of stay drivers that are largely outside their control and remain the subject of ongoing statewide policy development. The analysis underlying the proposed policy also does not sufficiently consider regional dynamics contributing to inpatient length of stay. While the HSCRC analysis finds that inpatient length of stay, at the hospital level, is minimally correlated with the volume of post-acute discharges, it analyzes regional groupings at a level of imprecision that risks not capturing more granular regional access challenges for patients in need of post-acute facility or home health services. Moreover, regression analyses confirm that patient disposition has a statistically significant correlation with IPLOS. If left as the only independent variable, patient disposition explains 50.9% of IPLOS (Figure 1).

Figure 1: Average Inpatient Length of Stay by Patient Discharge Disposition



Source: MHA’s analysis of CY 2024 Case-mix data. Analysis excluded IPLOS >18 days, left against medical advice, expired patients.

As noted above, hospitals frequently encounter barriers when discharging patients due to limited in-network post-acute placement options and other authorization delays. More detailed analysis is needed on the extent to which specific payer practices are driving inpatient length of stay. If these structural constraints and analytical limitations are not resolved, a policy that penalizes hospitals for prolonged inpatient lengths of stay would misplace accountability, undermining

⁷ HSCRC. “The Emergency Department Wait Times Reduction Commission Activities and Findings” November 2025.
<https://hscrc.maryland.gov/Documents/Work%20Group%20Uploads/ED%20WTR%20Commission/Emergency%20Department%20Wait%20Times%20Reduction%20Commission%20Interim%20Report%202025%20HSCRC.pdf>

policy effectiveness, and introduce unmanageable financial risk for hospitals rather than advancing meaningful system improvement.

Outlier Patient Cases

In addition to system-wide post-acute capacity constraints, inpatient length-of-stay measurement should account for challenging patient cases that materially extend stays but fall outside hospitals' ability to control. These cases include behavioral health boarding, patients with high social needs, guardianship related delays, and pediatric overstays. Behavioral health patients continue to experience substantially longer boarding times in emergency departments and inpatient units due to limited psychiatric bed availability and insufficient community-based crisis stabilization capacity.⁸ These challenges persist independent of hospital performance and disproportionately affect inpatient throughput.

Hospitals are also increasingly caring for patients who are medically ready for discharge but cannot safely transition due to social complexity, housing instability, or the absence of a legally authorized decision-maker. For patients requiring guardianship authorization, Maryland's multi-step legal process, encompassing petitions, evaluations, and court proceedings, cannot be expedited by hospitals and frequently extends well beyond the point of medical readiness.⁹ Federal oversight findings similarly document that guardianship delays result in prolonged institutional stays unrelated to clinical need.¹⁰ Pediatric overstays represent an additional outlier case. Children who are medically ready for discharge may remain inpatient due to limited foster care or family placement delays or behavioral health service gaps. These circumstances are highly individualized, structurally driven, and not reflective of hospital operational performance.

Collectively, these outlier cases represent structural barriers that are outside hospital control and are not adequately captured by standard length-of-stay measurement approaches. Absent appropriate exclusions or adjustments, inclusion of these cases risks distorting performance assessment and undermining policy equity.

Unintended Consequences

The proposed IPLOS policy may create unintended operational pressures, including incentives to accelerate discharges before safe placements are secured. The Centers for Medicare and Medicaid Services' discharge planning requirements emphasize that hospitals must ensure safe transitions of care and recognize that discharge may appropriately be delayed when the necessary services or supports are unavailable.¹¹ Without careful design, monitoring, and coordination, this state-based IPLOS policy risks unintended impacts on care quality and patient safety.

⁸ Nicks, Bret A., and David M. Manthey. "[The Impact of Psychiatric Patient Boarding in Emergency Departments.](https://www.hindawi.com/journals/eml/2012/360308/)" *Emergency Medicine International* (2012). <https://www.hindawi.com/journals/eml/2012/360308/>

⁹ Maryland Judiciary. "Court Appointed Guardians." <https://www.mdcourts.gov/family/guardianship/courtappointedguardians>.

¹⁰ U.S. Government Accountability Office (GAO). Highlights of GAO 11 678. <https://www.gao.gov/assets/gao-11-678-highlights.pdf>.

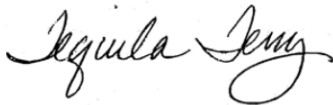
¹¹ Federal Register. "[Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care.](#)"

Addressing hospital inpatient length of stay requires a coordinated, cross-sector strategy involving payers, post-acute providers, and state agencies to address the systemic drivers and make meaningful progress. Hospital inpatient length of stay trends in Maryland are shaped by the state's unique payment model, post-acute care capacity constraints, behavioral health boarding, guardianship delays, pediatric overstays, and other structural factors beyond hospitals' control. These issues are being examined by the MHCC Post Acute Care Workgroup and the ED WTR Commission, with recommendations forthcoming.

Given these considerations, MHA respectfully urges HSCRC to withdraw the IPLOS draft policy and instead work directly with outlier hospitals to identify barriers and solutions. This approach would provide more visibility into drivers of inpatient length of stay and support improvement, while allowing sufficient time to assess policy impacts, avoid unintended consequences, and align future action with broader statewide efforts to strengthen post-acute capacity and care transitions.

Thank you for the opportunity to provide input. MHA looks forward to continued collaboration with HSCRC to ensure quality programs remain equitable, transparent, and aligned with our shared goal of improving patient care and system performance statewide.

Sincerely,



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