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Emergency Department Wait Time Reduction Commission

March 4, 2026
11am-1pm
Virtual Meeting Only

Agenda

- Commission CY 2026 Priorities (20 min)
- ED-Hospital Statistical Modeling Update (15 min)
- Aligned Efforts Update (50 min)
  - Maryland Health Care Commission (MHCC)
  - HSCRC Policies
- Discussion (20 min)
- Public Comment (10 min)

ED Wait Time Reduction Commission
CY 2026 Priorities

ED Wait Time Reduction Commission Selected Priorities

CY 2026 Priority Focus Areas:

- Standardize Hospital Bed Capacity & Occupancy Metrics
  - Inputs: Commission to hear updates from MHCC, MIEMSS, HSCRC on related work.
  - Action Item: Commission to develop recommendations re: standardization and uses of metrics for monitoring and making policy recommendations.
- Post Acute Access
  - Inputs: : Commission to review current work in this space from MHCC, MDH, HSCRC.
  - Action Item: Commission to develop recommendations and key considerations for regulators developing post acute strategy.
- ED-Hospital Throughput Modeling
  - Inputs: : Commission to review HSCRC modeling work.
  - Action Items: Commission to consider the need for additional analyses in order to prioritize interventions/initiatives ripe for policy development. Commission to consider making initiative recommendations directly to hospital industry.
- ED-Hospital Throughput Best Practices
  - Inputs: : Commission to review summary of results from the HSCRC ED-Hospital Throughput Best Practices Reporting Policy.
  - Action Item: Commission to consider recommendations for regulators to utilize other key performance indicators (e.g., intermediate outcomes measures) in policy development.

Subgroup Updates

- Capacity, Operations & Staffing and Access to Non-Hospital Care Subgroups
  - First combined meeting occurred on Feb 6, 2026. Priority focus of this group will be acute to post-acute care transitions and completion of bed count and capacity analysis.
- Data Subgroup
  - ED Modeling optimization is in progress and testing of interventions has begun. A progress update will be provided during today's (March 4th) meeting.
  - ED LOS Dashboard on CRISP is targeted for March/April 2026. Phase 1 demo will be presented at April Meeting.
- HSCRC Best Practices Subgroup
  - As priorities of ED WTR Commission have been defined to focus on access, capacity and data modeling, the Best Practice subgroup will continue its work as a designated HSCRC workgroup and can report any relevant updates through the scheduled HSCRC report outs at the ED WTR Commission meetings.
  - All Maryland hospitals submitted their 2025 ED-Hospital Throughput Best Report by the 12/31 submission deadline. Reports are in review and a summary and next steps will be shared at April Meeting.

ED-Hospital Statistical Modeling Update

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The Challenge

- Hospitals are complex systems
  - Nonlinear dynamics, including threshold effects, feedback loops, bidirectional causation and interactions
  - These features violate key assumption of regression models. Despite that, most studies evaluating ED interventions rely on regression analysis.
  - This makes it difficult to assess the effect interventions will have in the real world
- Researchers often address this type of challenge using agent-based modeling
- We are using this approach, combined with real-world ED data, to identify interventions that may be particularly impactful for Maryland's hospitals

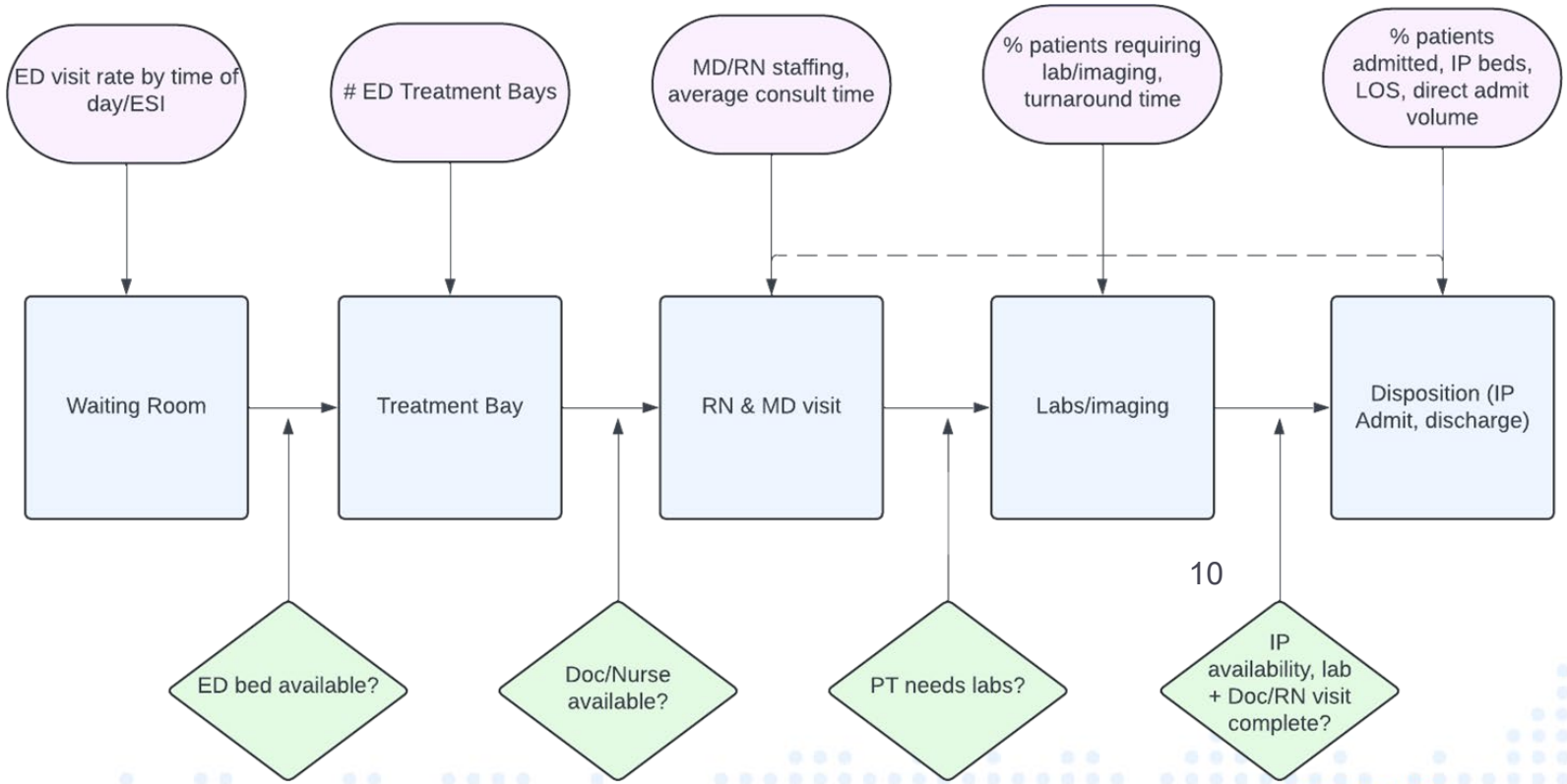
Agent-Based Model Basics

- The agent-based model creates a simulated universe of patients that interact with each other and the environment over time
- Must be validated to real-world conditions prior to exploring changes
- Accounts for emergent properties, bidirectional causality, and complex interactions that cannot be addressed with traditional statistical models
- Allows the investigator to specify different agent and/or environmental characteristics and evaluate their impact on model outcomes

Areas of Study

- The overarching goal is to provide the Commission with estimates of the relative potential impact on ED performance/patient experience of policies incentivizing changes in:
  - ED patient volume and acuity
  - IP length of stay, unit structure and bed count
  - MD/APP/RN staffing patterns
  - Admission rates for ED patients
  - Lab/Imaging utilization and turnaround time
  - Direct admit volume

Model Overview



How will we know if the model is valid?

- Does the model reproduce historical data on ED length of stay for discharged and admitted patients?
- Does the model reproduce observed data on other important ED dynamics?
- Is the model consistent with existing literature?
- Review by clinical and analytics experts at JHHS/UMMS

Current Status

- Results for HGH and Meritus indicate acceptable validity
- Initial results of interventions targeting IP LOS indicate that reducing IP LOS has a marked impact on ED1 for two hospitals
- Initial work on staffing indicates that a 5% increase in ED RN staffing does not impact ED1 or OP18
- Initial results on reducing direct admit volume during high-demand times indicates this could be a productive strategy

Next Steps

- Update validity and initial intervention results using new ED1 data from casemix
- Expand validity to work to additional hospitals that have submitted data (JHH, Bayview, Suburban)
- Provide additional analytics around initial interventions
  - Does reducing IP LOS for patients discharged to SNF have similar results?
  - Does addressing long LOS patients improve ED dynamics?
- Test additional interventions
  - Reduction in ED volume from enhanced primary care
  - ED admission detailing

MHCC Collaborative Work

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Acute Care Hospital Bed Capacity

Background

- In 2001 Maryland initiated a standardized annual licensure renewal process to document and track changes in the licensed bed inventory. The MHCC publishes an annual report showing the changes in Maryland hospitals licensed acute care hospital beds.
- The process is based on inpatient census and involves notifying hospitals prior to the beginning of each fiscal year concerning the calculated total number of licensed acute care beds for the coming fiscal year. In turn, the hospitals identify the allocation of the total licensed acute care beds across four (4) service categories:
  - Medical / Surgical / Gynecological / Addictions ("MSGA");
  - Obstetric;
  - Pediatric; and
  - Acute Psychiatric services.
- Over time, additional information on hospital service capacity has been added to the survey, covering emergency department services, surgical services, obstetric, perinatal services, dental services, observation services, and non-acute care and non-general hospital bed capacity.

Process – Licensed Bed Survey (prospective)

- Around May 15, HSCRC calculates the average daily census (ADC) of acute care patients for each hospital for the 12-month period ending with the first quarter of each calendar year and total licensed acute care bed capacity is established for the next fiscal year at 140% of the hospital's average daily census.*
- Around June 1, MHCC notifies each hospital of its licensed bed allotment, as calculated by HSCRC, for the upcoming fiscal year. Subsequently, the hospitals specify how they ***plan*** to allocate their total licensed acute care beds across the four (4) service categories in the ***upcoming*** fiscal year.
- The MHCC publishes the annual survey results on the website: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/hcfs_hospital_acute_services.aspx
  - Licensed Acute Care Beds by Hospital and Service
- July / August – Updated Hospital License transmitted to facility by OHCQ

**Md. Code Ann. Health General §19-307.2(b)*

Process – Supplemental Surveys (retrospective)

- Hospitals provide data regarding beds, rooms and other resources that ***were available in the prior fiscal year*** and how they were used
- The MHCC publishes the annual survey results on its website: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/hcfs_hospital_acute_services.aspx
- A hospital completes anywhere from 1 – 8 Supplemental Surveys Depending on the facility type and services offered:
  - Chartbook of Maryland General and Special Hospital Facilities and Services
    - Dental Services
    - Emergency Department
    - Monitored Beds / Bassinets
    - Obstetric Services
    - Observation Services
    - Psychiatric Services
    - Rehabilitation Services
    - Surgical Services

Survey Respondents

- MHCC's Annual Hospital Surveys are completed by 4 types of hospitals:
  - 42 - Acute Care General Hospitals
  - 8 - Freestanding Medical Facilities (FMFs)
  - 10 - Special Psychiatric Hospitals
  - 10 - Special Rehabilitation Hospitals
- Only Acute Care General Hospitals complete the Licensed Bed Survey. All facility types complete the one or more supplemental surveys.

Trends in Total Licensed Acute Care Beds

Figure 2: Total Licensed Acute Care Beds: Maryland Hospitals, FY 2016 – FY 2025

Source: MHCC ACHIs, FY 2016 – FY 2025

- While MD experienced an overall 4.1% decline in licensed acute care beds (LBs) between FY 16 and FY 25; it appears relatively flat over a 9-yr period
- Changes in bed capacity were regional rather than uniform statewide
- Eastern Shore had the highest volatility and largest cumulative decline in LB capacity
- LB capacity in Montgomery County experienced major drop b/w FY16 and FY17 and regained stability in FY 23-24
- Western Maryland experienced major drop in LB capacity between FY 23 and FY 24 followed by modest recovery in FY 25
- Central and Southern MD appear relatively stable
- Trends may reflect restructuring, service reconfiguration, consolidation, or demographic shifts.

Additions / Challenges

- New for FY27: Primary Care Investment Questions
- New for FY27: FY26 staffed beds

- Data is self-reported and not audited
- Utilize regulatory opportunities to add temporary capacity - ECON and surge regulations
- Licensed Beds ≠ Staffed Beds
- MHCC does not collect actual usage / occupancy data for most services

Post Acute:

Nursing Homes
Chronic Care
Hospice

Comprehensive Care Facility - Nursing Homes

- There are 221 nursing homes in the State of Maryland, with a total of 27,902 beds
- In 2024 the average occupancy of nursing homes was 83.6% (collected by jurisdiction)
- The 2024 average Medicaid Participation rate was 47.3 (collected by jurisdiction and health planning region)

Chronic Care Hospitals

Jurisdiction/Facility	Licensed Beds	Patient Days	Discharges	Average Length of Stay (Days)	Average Annual Occupancy Rate
PRIVATE HOSPITALS					
Baltimore City					
Levindale Hebrew Geriatric Center and Hospital	100	26,908	586	46	**73.7%**
University of Maryland Medical Center Midtown Campus	22	2,985	74	40	**37.2%**
University of Maryland Rehabilitation & Orthopaedic Institute	56	7,850	277	28	**38.4%**
SUBTOTAL: Private Chronic Hospitals	178	37,743	937	114	**58.1%**
STATE-OPERATED HOSPITALS					
Washington County					
Western Maryland Hospital Center	60	1,690	8	211	**7.7%**
Wicomico County					
Deer's Head Hospital Center	66	1,415	29	49	**5.9%**
SUBTOTAL: State-Operated Chronic Hospitals	126	3,105	37	260	**6.8%**
MARYLAND TOTAL	304	40,848	974	374	**36.8%**

There are a total of 5 chronic care hospitals in Maryland.

Three chronic care hospitals are private, and two are State operated.

In total Maryland has 304 chronic care beds, with an ALOS of 374 days and a 36.8% occupancy rate.

The number of chronic care hospitals with chronic care beds has been declining each year.

In the most recent 3 years, chronic care beds have closed at UM Capital Region Medical Center and Hopkins Bayview.

Hospice

As of Dec 2024:

- There are 27 Hospices in State of MD, 9 of which are Inpatient facilities (212 Beds)[1]
- 2024 Average Annual Medicare Hospice Occupancy: 48.5%[2]
- 2024 Annual Medicaid participation rate: 6.2%[3]

Notes:

1. Source: MHCC Annual Hospice Survey 2024
2. Source: CMS MBSF Summary file, CMS Hospice Base Claims; Occupancy defined as total Hospice deaths as % of total Medicare deaths (annually) across all jurisdictions
3. Source: MHCC Annual Hospice Survey 2024; Medicaid participation defined as Medicaid Hospice patients served as a % of total Hospice patients served (annually) across all jurisdictions; includes Traditional Medicaid Patients, Medicaid MCO Patients, Commercial MCO Patients, Blue Cross Blue Shield MCO Patients

AHEAD Multi-Agency Work Plan Post-Acute Care Priority

- Last September, Governor Moore issued a directive creating a working group of State regulatory agencies to develop a workplan identifying priority topics to be addressed that have implications for Maryland's performance under the AHEAD Model
- Post-Acute Care (PAC) Priority Topic:
  - PAC spending included in TCOC under AHEAD Model, plus PAC can affect hospital spending, e.g., bottlenecks in hospital discharges to clinically appropriate PAC settings can lead to patients remaining longer in the hospital which increases TCOC
  - MHCC tasked with developing a report with recommendations addressing PAC quality, access, and cost savings, including the impact of mergers and acquisitions
  - Hosting three focus group meetings in March to discuss these and other related topics
  - Final report due in June

HSCRC Overview

HSCRC – Agency Responsibilities and Vision

The Maryland Health Services Cost Review Commission (HSCRC) is an independent state agency responsible for regulating the cost of hospital services and ensuring that all Marylanders have access to high quality, efficient healthcare.

VISION

- Enhance the quality of health care and the patient experience
- Improve population health and health outcomes
- Reduce the total cost of care for Marylanders

Maryland's Unique Healthcare System: Overview

Maryland Model

All-Payer Hospital Rate Setting System

- The HSCRC has set hospital rates, on an all-payer basis, since the 1970s.
- The system can be adjusted to meet the requirements of the CMS-MD agreement and achieve other statewide priorities.

Commission Policies

CMS-MD Agreement

- A commitment between the State and Federal Government to use global budgets for hospitals, reform the health care and delivery system, and improve population health.
  - All-Payer Model (2014-2018)
  - Total Cost of Care Model (2019-2025)
  - AHEAD Model (2026-2035)

HSCRC Standing Workgroups

HSCRC uses both standing and short-term workgroups, incorporating stakeholder feedback into its decision-making. HSCRC has the following standing workgroups:

Payment Models Workgroup

Develops recommendations on policies related to global budgets, including development of the annual update factor

Performance Measurement Workgroup

Develops recommendations on measures that are reliable, informative, and practical for assessing hospital quality

Total Cost of Care Workgroup

Develops recommendations on value-based programs and provides input to the HSCRC on managing the overall Model agreement with the federal government

Ad Hoc Workgroups and Commissions

Participates in statewide commissions, sub-workgroups, and task forces to discuss technical, data-driven matters related to specific policies aligned with Model goals, which report back to the larger standing workgroups and legislators

Key Components of the Global Budget Revenue (GBR)

Common GBR Methodology

Components of the Update Factor

Fixed revenue base

Adjustments for Inflation
Typically around 3% and includes changes in drug costs

Population and Volume Adjustments
Ensures GBRs reflect population growth, hospital patient demographics, and growth in innovative care

Adjustments for Quality and PAU Savings
Adjusts hospital revenues based on quality outcomes and levels of potential avoidable utilization (PAU)

Efficiency, Capital, and Rate Adjustments
Measures efficiency of care delivery, provides budgetary advances to cover non-variable expenses and investments, and allows for other adjustments to rates

Special Funding Programs
Provides funding to hospitals to support statewide goals

Other GBR Components

Hospital GBR includes funding to help pay for CRISP, HSCRC (user fees), Medicaid Deficit Assessment, and other programs (e.g. Nurse Support Program)

Other Impacts on Hospital GBRs

Medicare Performance Adjustment
Includes a Traditional MPA program and the MPA Framework

Value Based Payment Programs
Care Transformation Initiatives and Care Redesign Programs (includes the Episode Care Improvement and Episode Quality Improvement Programs)

TCOC Model Years 1-6 Performance

Performance Measures	Annual Targets	2019	2020	2021	2022	2023	2024
Annual Medicare TCOC Savings	$120M (2019), $156M (2020), $222M (2021), $267M (2022), and $300M (2023) in annual Maryland Medicare TCOC per beneficiary of savings	✓	✓	✓	✓	✓	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	✓	✓	✓	*	✓	✓
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	✓	✓	✓	✓	✓	✓
Improvement in All-Payer Potentially Preventable Conditions	Improve upon the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	✓	✓	✓	✓	✓	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries***	✓	✓	**	**	✓	✓
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓	✓	✓	✓	✓	✓

*0.9 percentage points above the National growth rate in 2022 and 0.6 percentage points above in 2021. CMS did not ask the State to take additional corrective action in part because, in December 2022, HSCRC took steps to reduce 2023 growth (should allow the State to meet their 2023 TCOC Guardrail requirement), and because Maryland's 2022 growth was partly based on CMS OACT estimates of growth that were significantly larger than actual growth.

**HSCRC staff believe the unadjusted readmission rate has increased due to increases in patient acuity in Maryland's hospitals, relative to the nation, an expected effect of GBRs. CMMI has agreed to consider to a risk-adjusted measure but also requested that the State conduct activities related to readmission improvements.

***I

The Next Phase of the Maryland Model: Moving AHEAD

Agreement Term & Definitions

Pre-Implementation Period
July 1, 2024 – December 31, 2025

Implementation Period
10 Performance Years, January 1, 2026 – December 31, 2035

Transition Period
After the Implementation Period Ends, up to 60 months (five years), January 1, 2036 – December 31, 2039

Post-Model Options:

- Make the Model permanent
- Test a new model
- Transition to national Medicare fee-for-service system

Agreement Term: Date of final signature – two years after the last day of the Transition Period.

Opt-out period – Between June 1, 2027 and September 30, 2027, hospitals may elect to discontinue participation in the AHEAD model.

Key State Roles

Continue to set all-payer global budgets for PY1 (2026) and PY2 (2027). Set global budgets for commercial payers and Medicaid only for PY3-PY10 (2028-2035).

- There will be a three-year transition (PY3-PY5) to Medicare's new global budget methodology in the national AHEAD Model.
- The agreement includes provisions for the State to adjust hospital global budget amounts during the transition to ensure financial stability.

Control all payer cost growth through total cost of care targets.

- All-payer TCOC targets did not exist under the TCOC Model. This provides for slower growth in overall health care expenditures, beyond just Medicare FFS.

Continue to implement Maryland Primary Care Program (MDPCP), with additional Medicaid advanced primary care alignment components.

- Continuation of MDPCP will be evaluated by the State and CMS (with CMS having ultimate decision-making authority) in 2028.
- Design and administer Medicaid advanced primary care program, in alignment with MDPCP and Primary Care AHEAD.

Ensure that 85 percent of in-state, all-payer, acute care hospital revenue is paid under a global budget methodology.

- TCOC required 95 percent. This change will allow hospitals to continue pursuing cutting-edge treatment and providing high-quality complex care, while maintaining accountability for outcomes and constraining costs.

Statewide Accountability Targets

The State remains accountable for performance on **several targets**.

All-payer and primary care investment targets did not exist under the TCOC Model. AHEAD also includes more extensive population health requirements.

- Medicare FFS TCOC Target
- All Payer TCOC Growth Target — Maryland will establish this target before 2027.
- Medicare FFS Primary Care Investment Target
- All-Payer Primary Care Investment Target — Maryland will establish this target for PYs 2-5 before 2027.
- Statewide Quality and Population Health Targets
- All-Payer Revenue Limit*

* Hospital revenue only, not included in enforcement provisions.

Surge Funding Policy

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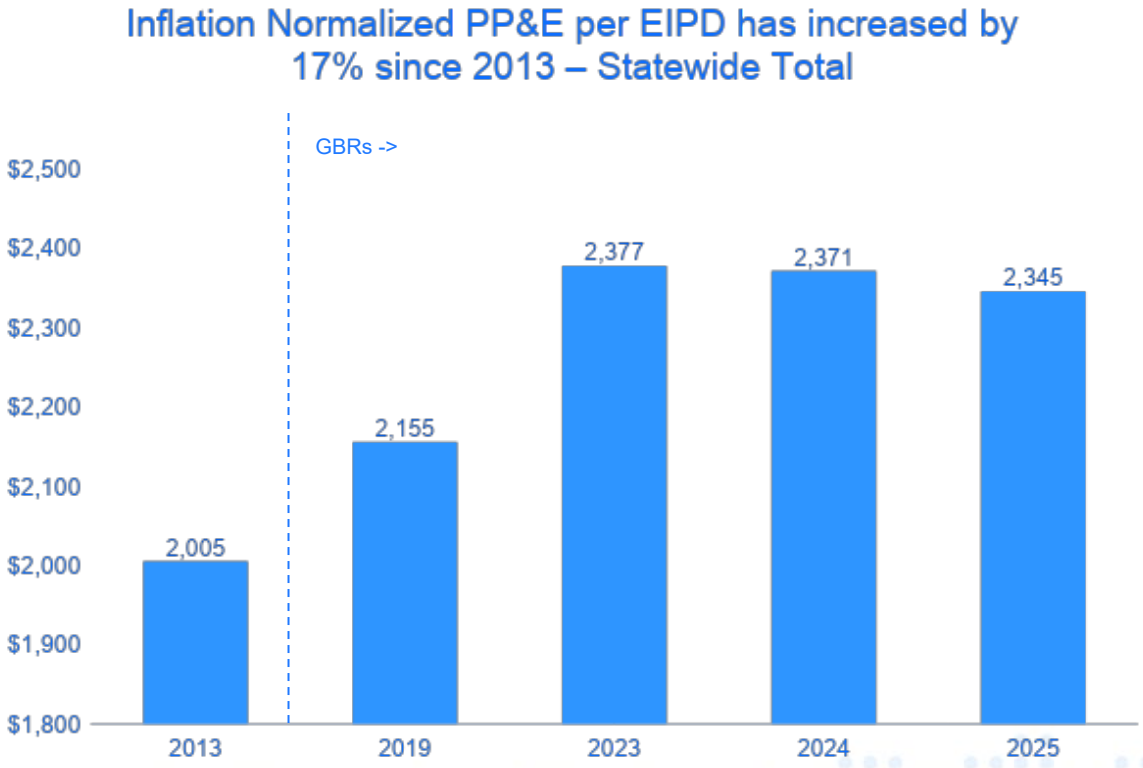
Statewide Capital Investment In Relation to Volume



- Metric measures the ratio of system level invested capital per unit of service delivered in the MD system.
- Metric shows significantly more investment in capital versus unit of service delivered in 2025 compared to 2019 or 2013.
- Outcomes will vary considerably by region of the state.

Volume Pressures

Last year's respiratory season was particularly intense, straining hospitals seeing large numbers of RSV, influenza, and COVID patients.

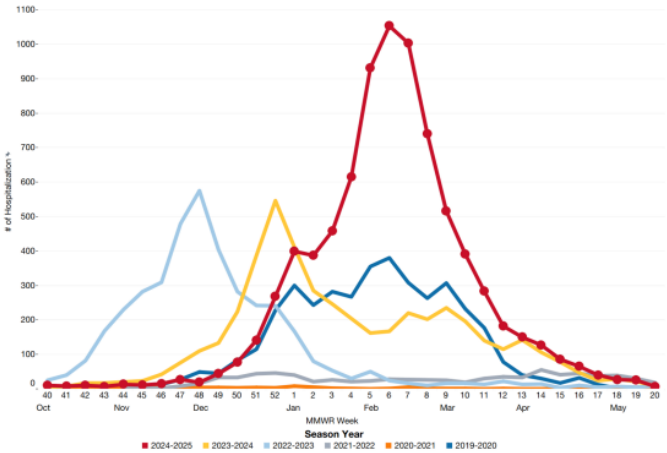
Flu Cases Surge in Maryland as Vaccination Rates Decline

Rise of pediatric flu cases is sending more children to the hospital

This flu season has been particularly bad for children, with many experiencing severe complications such as pneumonia, dehydration and organ failure.

Yesterday at 6:00 a.m. EST

Figure 18: Influenza-Associated Hospitalizations in Maryland by Week and Season



Early warning signs for 2025-2026 (southern hemisphere flu season and H3N2 outbreaks underway in Canada and the UK) suggest there could be significant respiratory related hospitalizations again this year

Flu cases surge in the DMV: Here's what medical experts want you to know

by Kellye Lynn | Tue, February 11th 2025 at 5:07 AM
Updated Tue, February 11th 2025 at 6:56 AM

A doctor listening to a child's heartbeat. (FILE)

Maryland Flu Cases 'Very High'

If you have the flu or know someone who has the virus, you are not alone. Maryland is experiencing an explosion in cases in recent weeks.

Statewide data shows flu activity in Maryland is very high. Dr. Andy Catanzaro, Chief of Infectious Diseases at Adventist Healthcare White Oak Medical Center, said, "One in ten emergency room visits are related to flu-like illnesses. Since November 2024, more than 3,000 Maryland residents have been hospitalized because of respiratory viruses."

Respiratory Surge Considerations

- Staff suspended the surge policy because COVID had become endemic after the Omicron surge in 2022.

- However, COVID continues to create periodic strains on GBR volumes, particularly with the confluence of other respiratory illnesses:
  - RSV
  - Pneumonia
  - Influenza

- In light of sustained cost increases in respiratory cases the surge policy was reinstituted in RY 2025 to fund volumes surges in respiratory conditions on a retrospective basis.

Review of Marketshift Volumes from 2019 by Service Line

Service Line	2022 over 2019	2023 over 2022	2023 over 2019	2024 over 2023 (six months)	June 2024 over 2019
Infectious Disease	$48,559,520	$26,233,049	$74,792,569	$28,012,705	$102,805,274
Pulmonary	$127,753,002	-$62,564,090	$65,188,912	$3,935,821	$69,124,734
PAU	-$42,609,926	$76,513,501	$33,903,575	$13,278,714	$47,182,289
General Medicine	$13,097,906	$12,649,054	$25,746,960	$6,407,197	$32,154,157
General Surgery	-$5,021,696	$27,438,747	$22,417,052	$919,167	$23,336,219
Neurological Surgery	$3,846,382	$15,041,696	$18,888,078	$6,058,832	$24,946,910
Neurology	$7,111,569	$11,422,694	$18,534,263	-$470,379	$18,063,884
Invasive Cardiology	$2,921,608	$9,901,208	$12,822,816	$1,371,284	$14,194,100
Gastroenterology	-$3,373,475	$14,430,305	$11,056,830	-$929,175	$10,127,655
Cardiovascular	$645,568	$9,092,981	$9,738,549	$2,319,288	$12,057,837
Trauma	$2,356,650	$5,699,374	$8,056,024	$3,859,356	$11,915,380
Major Surgery	-$25,482,632	$30,504,230	$5,021,597	-$624,373	$4,397,224
Oncology_IP	-$5,922,949	$7,519,023	$1,596,074	$3,780,083	$5,376,156
Clinic		$1,235,956	$1,235,956	$130,156	$1,366,112
Transplant Surgery	$645,440	-$36,968	$608,471	$0	$608,471
Injuries/complic. of prior care	-$793,270	$1,284,213	$490,943	-$331,471	$159,472
Urology	-$543,012	$929,703	$386,691	$254,930	$641,621
Hematology	-$3,563,415	$3,652,177	$88,762	$1,116,051	$1,204,814
Ophthalmology	$104,625	-$23,301	$81,325	$136,030	$217,354
Ophthalmologic Surg	-$147,797	-$201,558	-$349,355	$216,325	-$133,030
Psychiatry_OP		-$1,350,074	-$1,350,074	-$1,157,985	-$2,508,059
Vascular Surgery	-$2,598,514	$913,817	-$1,684,697	$5,537,912	$3,853,214
Thoracic Surgery	-$3,811,709	$1,752,675	-$2,059,034	$5,902	-$2,053,132
Cardiothoracic Surgery	-$3,704,582	$774,428	-$2,930,154	$9,019,314	$6,089,160
ENT Surgery	-$4,939,900	$890,231	-$4,049,669	$2,159,596	-$1,890,074
Rehabilitation_IP	-$11,403,761	$6,646,718	-$4,757,043	$2,013,362	-$2,743,681
Gynecological Surg	-$6,680,782	$1,083,987	-$5,596,795	-$1,040,823	-$6,637,618
CT/MRI/PET	-$6,209,844	$313,892	-$5,895,952	-$1,103,765	-$6,999,717
Ventilator Support	$17,398,411	-$23,772,640	-$6,374,229	-$3,246,326	-$9,620,555
Spinal Surgery	-$11,015,461	$4,038,760	-$6,976,700	$1,415,317	-$5,561,383
Cardiology	-$5,674,340	-$1,355,273	-$7,029,613	-$1,611,036	-$8,640,649
Endocrinology Surgery	-$5,769,351	-$1,365,718	-$7,135,069	-$4,339,886	-$11,474,955
Rehab & Therapy	-$9,072,000	-$357,334	-$9,429,335	$764,455	-$8,664,880
Urological Surgery	-$9,413,824	-$1,431,680	-$10,845,504	-$40,369	-$10,885,873
Radiology	-$10,928,167	-$1,664,981	-$12,593,148	-$1,402,165	-$13,995,314
Neonatology	-$9,513,832	-$4,859,500	-$14,373,331	-$3,549,146	-$17,922,477
OB/GYN	$271,141	-$16,560,418	-$16,289,277	$1,319,400	-$14,969,877
Oncology Related Services	-$29,852,806	$13,159,228	-$16,693,578	-$5,334,389	-$22,027,967
Minor Surgery	-$34,593,780	$15,508,279	-$19,085,501	-$1,635,909	-$20,721,410
Orthopedic Surgery	-$70,147,142	$50,440,635	-$19,706,507	$3,808,415	-$15,898,091
Other	-$23,199,753	-$392,764	-$23,592,518	-$1,432,515	-$25,025,033
Lab	-$15,007,330	-$9,256,067	-$24,263,397	-$3,173,929	-$27,437,326
Psychiatry_IP	-$32,405,456	$5,120,183	-$27,285,274	-$3,558,881	-$30,844,155
ED	-$138,987,478	$39,440,978	-$99,546,501	$19,120,990	-$80,425,511
Total	-$307,676,163	$268,439,355	-$39,236,808	$81,978,079	$42,741,270
Total without ID, Pulm, and PAU	-$441,378,760	$228,256,895	-$213,121,865	$36,750,839	-$176,371,026

- A review of volume changes from 2019-2024 shows significant rise in respiratory volumes.
- 2024 is the first year since the pandemic that case volumes have returned to a 2019 baseline such that there is use rate growth beyond marketshift.
- This is largely driven by three service lines:
  - Infectious Disease
  - Pulmonary
  - PAU (largely with COVID diagnosis)

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Review of Marketshift Volumes from 2019 by Hospital

Hospital ID	Hospital Name	2024 six months over 2019 Use Rate Growth (Infectious Disease, Pulmonary, Readmissions)	2024 six months over 2019 Use Rate Growth in Marketshift (Total)	2024 six months over 2019 % Attributable to ID, Pulm, and Readm)
210001	Meritus	$9,570,949	$18,244,340	52%
210009	Johns Hopkins	$20,175,089	$17,049,021	118%
210022	Suburban	$6,461,320	$11,966,879	54%
210062	MedStar Southern MD	$5,976,672	$10,490,995	57%
210049	UM-Upper Chesapeake	$7,365,017	$8,760,336	84%
210003	PG Hospital	$4,427,965	$8,756,863	51%
210005	Frederick	$6,006,729	$8,573,227	70%
210037	UM-Easton	$6,147,992	$8,439,041	73%
210065	HC-Germantown	$4,603,320	$8,344,366	55%
210019	Peninsula	$4,544,731	$7,992,261	57%
210033	Carroll	$7,284,388	$7,143,304	102%
210063	UM-St. Joe	$5,428,735	$6,957,324	78%
210018	MedStar Montgomery	$3,769,349	$6,065,897	62%
210015	MedStar Fr Square	$13,655,884	$5,789,858	236%
210048	Howard County	$6,221,690	$3,990,985	156%
210004	Holy Cross	$5,818,225	$2,662,319	219%
210034	MedStar Harbor	$6,174,810	$2,103,076	294%
210024	MedStar Union Mem	$5,017,880	$1,979,719	253%
210016	Washington Adventist	$5,348,373	$961,485	556%
210056	MedStar Good Sam	$5,060,429	$814,062	622%
210028	MedStar St. Mary's	$2,451,585	$773,098	317%
210002	UMMC	$10,838,310	$551,563	1965%
210043	UM-BWMC	$6,671,782	$281,763	2368%
210061	Atlantic General	$1,164,900	$53,474	2178%
210011	St. Agnes	$5,932,313	-$156,861	
210030	UM-Chestertown	$949,136	-$364,374	
210035	UM-Charles Regional	$2,547,107	-$389,872	
210017	Garrett	$479,061	-$406,177	
210045	McCready	$0	-$1,037,980	
210055	Laurel Regional	-$25,605	-$1,060,550	
210032	Union of Cecil	$2,313,466	-$1,204,496	
210060	Ft. Washington	$969,093	-$1,304,919	
210040	Northwest	$5,452,559	-$1,325,380	
210039	Calvert	-$455,576	-$1,788,874	
210029	JH Bayview	$6,155,460	-$1,883,445	
210051	Doctors	$2,732,976	-$3,016,865	
210038	UMMC Midtown	$1,723,064	-$3,136,741	
210058	UMROI	$80,852	-$4,185,260	
210057	Shady Grove	$5,848,140	-$4,251,716	
210010	UM-Dorchester	$6,816	-$5,200,333	
210027	Western Maryland	$2,461,416	-$6,675,258	
210008	Mercy	$2,049,123	-$6,852,042	
210006	UM-Harford	$2,369,733	-$7,118,984	
210023	Anne Arundel	$8,502,112	-$7,284,220	
210012	Sinai	$9,093,236	-$11,820,909	
210044	GBMC	$2,483,509	-$15,972,417	
210013	Grace	-$3,568,746	-$17,944,748	
		$218,285,363	**$44,362,833**	**492%**

- Out of 50 facilities, 24 had net growth from 2019 through June 2024.
- For 13 of them over 100% of the use rate growth was due to infectious disease, pulmonary, and PAU cases.
- For 11 of them, 50-84% of use rate growth was due to infectious disease, pulmonary, and PAU cases.

HSCRC Quality Incentive Programs

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HSCRC Pay for Performance Quality Programs

Maryland Hospital Acquired Conditions (MHAC) Program

Motivates hospitals to reduce infections and complications acquired during a hospital stay

Quality Reimbursement Program (QBR)

Focuses on patient experience, patient safety, and clinical quality outcomes

Readmissions Reduction Incentive Program (RRIP)

Encourages hospitals to reduce readmissions within 30 days of discharge

Potentially Avoidable Utilization (PAU)

Focuses on improving patient care and health through reducing potentially avoidable utilization

Maryland's all-payer hospital quality programs provide financial incentives to provide high quality care and reduce avoidable utilization. Improvements in quality and reductions in avoidable utilization can positively impact patients and ED and hospital throughput.

HSCRC Quality Policies Specific to ED and Hospital Throughput

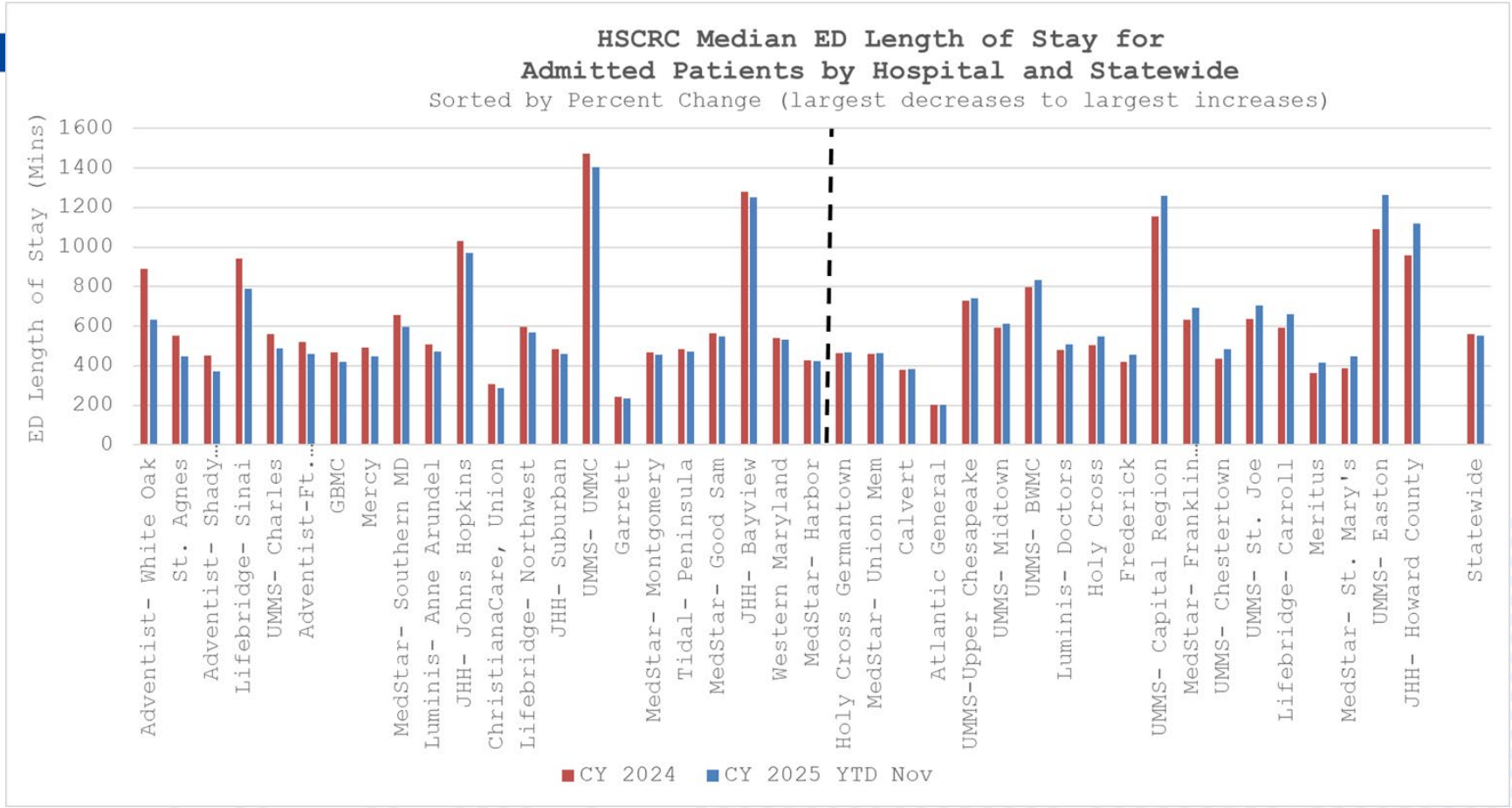
Quality Based Reimbursement:

- Holds 0.20 percent of inpatient revenue at-risk (approximately +/- $25 M statewide)
- Assesses annual improvement in ED LOS for admitted patients
- Goal is 5-10 percent improvement to receive full reward

Best Practice Policy:

- Pay for reporting policy that assesses hospital implementation of 2 out of 6 best practices identified to improve patient care and flow

HSCRC Quality Based Reimbursement Program ED LOS Performance


HSCRC Median ED Length of Stay for
Admitted Patients by Hospital and Statewide
Sorted by Percent Change (largest decreases to largest increases)
ED Length of Stay (Mins)
1600
1400
1200
1000
800
600
400
200
0
Adventist- White Oak
St. Agnes
Adventist- Shady...
Lifebridge- Sinai
UMMS- Charles
Adventist-Ft....
GBMC
Mercy
MedStar- Southern MD
Luminis- Anne Arundel
JHH- Johns Hopkins
ChristianaCare, Union
Lifebridge- Northwest
JHH- Suburban
UMMS- UMMC
Garrett
MedStar- Montgomery
Tidal- Peninsula
MedStar- Good Sam
JHH- Bayview
Western Maryland
MedStar- Harbor
Holy Cross Germantown
MedStar- Union Mem
Calvert
Atlantic General
UMMS-Upper Chesapeake
UMMS- Midtown
UMMS- BWMC
Luminis- Doctors
Holy Cross
Frederick
UMMS- Capital Region
MedStar- Franklin...
UMMS- Chestertown
UMMS- St. Joe
Lifebridge- Carroll
Meritus
MedStar- St. Mary's
UMMS- Easton
JHH- Howard County
Statewide
CY 2024
CY 2025 YTD Nov

Preliminary data through November 2025 indicates that **22 of 41 Maryland hospitals (54%)** have had some **improvements** compared to CY 2024.

Hospital	CY 2025 Median (min)	CY 2024 Median (min)	% Change CY2024 to CY2025
Adventist- White Oak	634.0	889	-28.68%
St. Agnes	446.0	553	-19.35%
Adventist- Shady Grove	373.0	454	-17.84%
Lifebridge- Sinai	791.0	941	-15.94%
UMMS- Charles	490.0	562	-12.81%
Adventist-Ft. Washington	461.0	519.5	-11.26%
GBMC	420.0	467	-10.06%
Mercy	447.0	492	-9.15%
MedStar- Southern MD	597.0	657	-9.13%
Luminis- Anne Arundel	472.0	509	-7.27%
JHH- Johns Hopkins	970.0	1032	-6.01%
ChristianaCare, Union	289.0	306	-5.56%
Lifebridge- Northwest	568.0	598	-5.02%
JHH- Suburban	461.0	484	-4.75%
UMMS- UMMC	1405.0	1474	-4.68%
Garrett	233.0	244	-4.51%
MedStar- Montgomery	456.5	470	-2.87%
Tidal- Peninsula	472.0	485	-2.68%
MedStar- Good Sam	550.0	565	-2.65%
JHH- Bayview	1252.0	1281	-2.26%
Western Maryland	532.0	539	-1.30%
MedStar- Harbor	423.0	427	-0.94%
Holy Cross Germantown	468.5	466	0.54%
MedStar- Union Mem	465.0	462	0.65%
Calvert	383.0	380	0.79%
Atlantic General	204.0	201	1.49%
UMMS-Upper Chesapeake	740.0	728	1.65%
UMMS- Midtown	613.5	594	3.28%
UMMS- BWMC	835.0	799	4.51%
Luminis- Doctors	507.0	481	5.41%
Holy Cross	548.0	505	8.51%
Frederick	457.0	421	8.55%
UMMS- Capital Region	1259.0	1156	8.91%
MedStar- Franklin Square	694.0	632	9.81%
UMMS- Chestertown	485.0	437	10.98%
UMMS- St. Joe	707.0	635	11.34%
Lifebridge- Carroll	663.0	592	11.99%
Meritus	416.0	365	13.97%
MedStar- St. Mary's	448.0	389	15.17%
UMMS- Easton	1265.0	1091.5	15.90%
JHH- Howard County	1121.0	958	17.01%
Statewide	553	562	-1.60%

Next Steps

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Next Steps

- Next ED Wait Time Reduction Commission Meeting: April 30, 2026 11AM-1PM
- ED WTR Commission Agendas
  - Work related to identified 2025/2026 priorities will be a standing item on meeting agendas
  - Any commissioner can propose agenda items; all proposals will be discussed by the commissioners at the next meeting to obtain consensus for approval
  - Final agenda is approved by the co-chairs from HSCRC and MDH
- Please visit the ED Wait Time Reduction Commission Webpage for all materials.
  - 2026 Calendar

Appendix

RECAP - Commission Origin Story

Bill went into effect July 1, 2024, and terminates June 30, 2027, Annual Reports due Nov 2025 and Nov 2026

- ***Purpose:*** To address factors throughout the health care system that contribute to increased Emergency Department wait times
- ***Specific focus:*** Develop strategies and initiatives to *recommend* to state and local agencies, hospitals, and health care providers to reduce ED wait times, including initiatives that:
  - *ENSURE THAT PATIENTS ARE SEEN IN THE MOST APPROPRIATE SETTING TO REDUCE UNNECESSARY USE OF EMERGENCY 7 DEPARTMENTS*
  - *IMPROVE HOSPITAL EFFICIENCY, INCLUDING BY INCREASING EMERGENCY DEPARTMENT AND INPATIENT THROUGHPUT*
  - *IMPROVE POSTDISCHARGE RESOURCES TO FACILITATE TIMELY EMERGENCY DEPARTMENT AND INPATIENT DISCHARGES*
  - *IDENTIFYING AND RECOMMENDING IMPROVEMENTS FOR THE COLLECTION AND SUBMISSION OF DATA THAT IS NECESSARY TO MONITOR AND REDUCE EMERGENCY DEPARTMENT WAIT TIMES*
  - *MAKE RECOMMENDATIONS TO STATE AND LOCAL AGENCIES, HOSPITALS, AND HEALTH CARE PROVIDERS*
  - *FACILITATE THE SHARING OF BEST PRACTICES FOR REDUCING EMERGENCY DEPARTMENT WAIT TIMES.*

RECAP - Commission Structure and Process

- Legislation designated co-chairs - Secretary of Health and Executive Director of HSCRC or Designees
- All Appointments made by MDH for specific representatives designated in the bill
- Legislation states the HSCRC shall provide staff for the Commission.
- **Commission is tasked with making recommendations to the Legislature and/or the appropriate agencies with regulatory authority and resources to implement recommendations.**
- By November 1, 2025, and November 1, 2026, the commission must report to the Governor and the General Assembly on its activities, findings, and recommendations.
  - If the commission identifies work that is not being adequately addressed or is constrained by authority or resource, this will be highlighted in the annual report.

Link to 2025 Interim ED Wait Time Reduction Commission Report

Links

- https://conferences.beckershospitalreview.com/transform-hospital-operations-feb-2026/ondemandcontent (Webinar recording)
- https://www.beckershospitalreview.com/webinar-types/upcoming-webinars/?oly_enc_id=4212C2488078G8I# (Upcoming webinars; note Webinar on March 11th)
- https://www.beckershospitalreview.com/healthcare-information-technology/ochsners-virtual-ed-had-a-big-year-one/?origin=CIOE&utm_source=CIOE&utm_medium=email&utm_content=newsletter&oly_enc_id=9006I5348767H0D (Beckers Hospital Review Article)
- https://www.beckershospitalreview.com/rankings-and-ratings/hospitals-with-the-most-ed-visits-in-2025/?origin=QualityE&utm_source=QualityE&utm_medium=email&utm_content=newsletter&oly_enc_id=4212C2488078G8I (Becker Hospital Review Article)
- https://assets.asccommunications.com/whitepapers/trusted-health-wp-october-2025.pdf?utm_campaign=26162745-Trusted_Health_WP_October_2025&utm_medium=email&_hsenc=p2ANqtz-_IJNQ9UvOoDP2P12OU3eDRgZFM0R1aC9I_av86V_1ZDkosNXolimopMjKFyW0R_6x2_5KmPIy-rk8dn8nLLMV4MgC0hg&_hsmi=386354307&utm_content=386354307&utm_source=hs_automation (White Paper)
- https://www.ihi.org/library/white-papers/achieving-hospital-wide-patient-flow (White paper)