



maryland
health services
cost review commission

Performance Measurement Workgroup

September 16, 2026

HSCRC Quality Team

Meeting Agenda

- Maryland Hospital Acquired Conditions RY 2029
 - Potentially Preventable Complications
- AHEAD Quality Transition & RY 2029 Policy Discussion
 - Commissioner discussion/input at the September Commission meeting
- Quality Based Reimbursement RY2029
- ED-Hospital Best Practice Policy Transition
- Bed Capacity Legislation Update

Workgroup Learning Agreements

- **Be Present** – Make a conscious effort to know who is in the room, become an active listener. Refrain from multitasking and checking emails during meetings.
- **Call Each Other In As We Call Each Other Out** – When challenging ideas or perspectives give feedback respectfully. When being challenged - listen, acknowledge the issue, and respond respectfully.
- **Recognize the Difference of Intent vs Impact** – Be accountable for our words and actions.
- **Create Space for Multiple Truths** – Seek understanding of differences in opinion and respect diverse perspectives.
- **Notice Power Dynamics** – Be aware of how you may unconsciously be using your power and privilege.
- **Center Learning and Growth** – At times, the work will be uncomfortable and challenging. Mistakes and misunderstanding will occur as we work towards a common solution. We are here to learn and grow from each other both individually and collectively.

REMINDER: These
workgroup
meetings are
recorded.

RY 2029 Maryland Hospital Acquired Conditions: Potentially Preventable Complications Update

RY 2029 MHAC Updates

To increase alignment, staff will propose to discontinue the Potentially Preventable Complications measures for payment for Commission consideration

Additional Rationale:

- Under MD model, PPC rates have improved and State has met goals
- Other incentives for complications remain
 - AHRQ PSIs measure similar complications with focus on surgical complications that are more directly linked to care
 - Other complication measures include NHSN HAIs, sepsis bundle, THA-TKA complications
 - Continue to measure all-payer, all-condition mortality and readmissions
 - Hospital Global Budget incentives
- Cost of proprietary grouper and coding review

Next Steps

- Review modeling and determine whether MHAC program will be PSI only or PSI + NHSN
- Assess the options for alignment of scoring methodology
- Set maximum revenue at risk (i.e., should MHAC stay at 2%) and whether there are rewards and penalties
- Continue to provide PPC hospital reports via CRISP portal

AHEAD Quality Transition

Transition Core Principles

- Initially, the HSCRC approach will pursue incremental changes to HSCRC-managed policies. More substantive alterations will be pursued in the near term only where: 1) incremental change is not viable; or 2) there is consensus among hospitals, payers and the State that substantive change is necessary.
- HSCRC will align with CMMI policies where: 1) they are appropriate for populations under HSCRC hospital global budgets; 2) they align with the State's vision and goals for the health care system, as well as HSCRC's legislative mandate; and 3) the administrative cost of the transition to the CMMI approach is merited given the policy outcomes.
- As a result, the goal of the current workplan is to generate a 'Minimum Viable Product' for the bridge period and not a perfect end state. In the meantime, HSCRC will accumulate a list of ideas to incubate as the transition period progresses.

CMS Transition Timeline

Transition Timeline				Performance Year 1				Performance Year 2				Performance Year 3				Performance Year 4				Performance Year 5					
CY ---->	Policy	2025				2026				2027				2028				2029				2030			
RY 2027	MHAC, RRIP, QBR, PAU	Performance Period (varies by measure)						All-Payer Revenue Adjustments																	
RY 2028						Performance Period (varies by measure)						To Be Determined^													
RY 2029										Performance Period (varies by measure)						TBD Non-Medicare FFS HGBs^									
RY 2030													Performance Period (varies by measure)						Medicare FFS HGBs						
FY 2030	HVBP												HVBP PCE & Safety Domains*								Medicare Revenue Adjustments**				
								HVBP Mortality Measures & THA-TKA Complications																	
	HRRP								Medicare Condition Specific Readmissions																
	HACRP							CMS PSI-90																	
								NHSN HAI																	

^{*}Efficiency domain is also on this timeframe. CMMI has indicated MD hospitals may not be measured on efficiency but this needs to be confirmed.

^{**}CMS revenue adjustments for quality programs are implemented on FFY October-September timeframe. AHEAD revenue adjustments implemented on CY; awaiting final decision on whether the timeframe will be moved back one quarter or if multiple years will be averaged.

[^]Need to work with rate setting, CMMI, and stakeholders to figure out timeframe for RY vs. CY revenue adjustments

***State must meet requirements for all-payer programs for RY 2028 and RY 2029**

Maryland Hospital Quality Incentives under AHEAD

Medicare Fee-for-Service

CMS Quality Programs

- Hospital Value Based Purchasing (HVBP)
- Hospital Acquired Conditions Reduction
- Hospital Readmission Reduction

AHEAD Specific Incentives

- **Effectiveness Adjustment:** Revenue linked to unplanned readmissions, ED visits, and avoidable admissions
- **Community Improvement Bonus:** Focus on hospital-wide readmissions and avoidable admissions

Other Payers

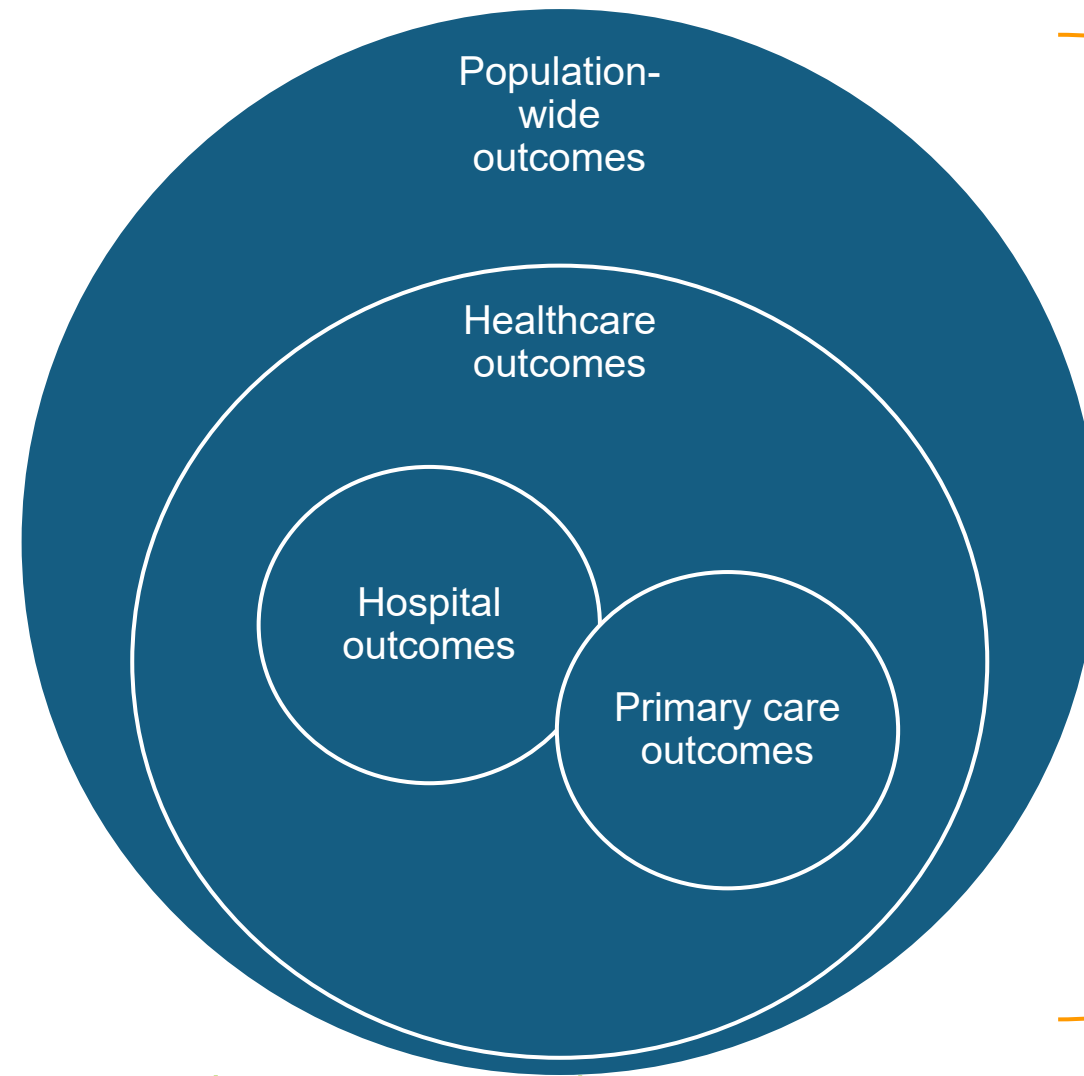
Medicaid, Commercial, & Medicare Advantage

HSCRC Quality Programs

- Quality Based Reimbursement (QBR)
- Maryland Hospital Acquired Conditions (MHAC) Program
- Readmission Reduction Incentive Program (RRIP)
- Potentially Avoidable Utilization (PAU)



Outcome Based
Credits



Statewide Population
Health Accountability Plan

MDPCP quality and utilization
measures
Medicaid path MDPCP quality
and utilization measures
PC AHEAD MDPCP quality and
utilization measures

CMS Hospital Quality and AHEAD performance
adjustments for Medicare FFS (CMMI)
Hospital Quality for Other Payers (HSCRC)
Hospital Population Health Accountability Plan

Future Alignment of CMS and State Quality Programs

What Do We Mean By Alignment?

Alignment can be exact match or conceptual and focus on areas of quality and program design.

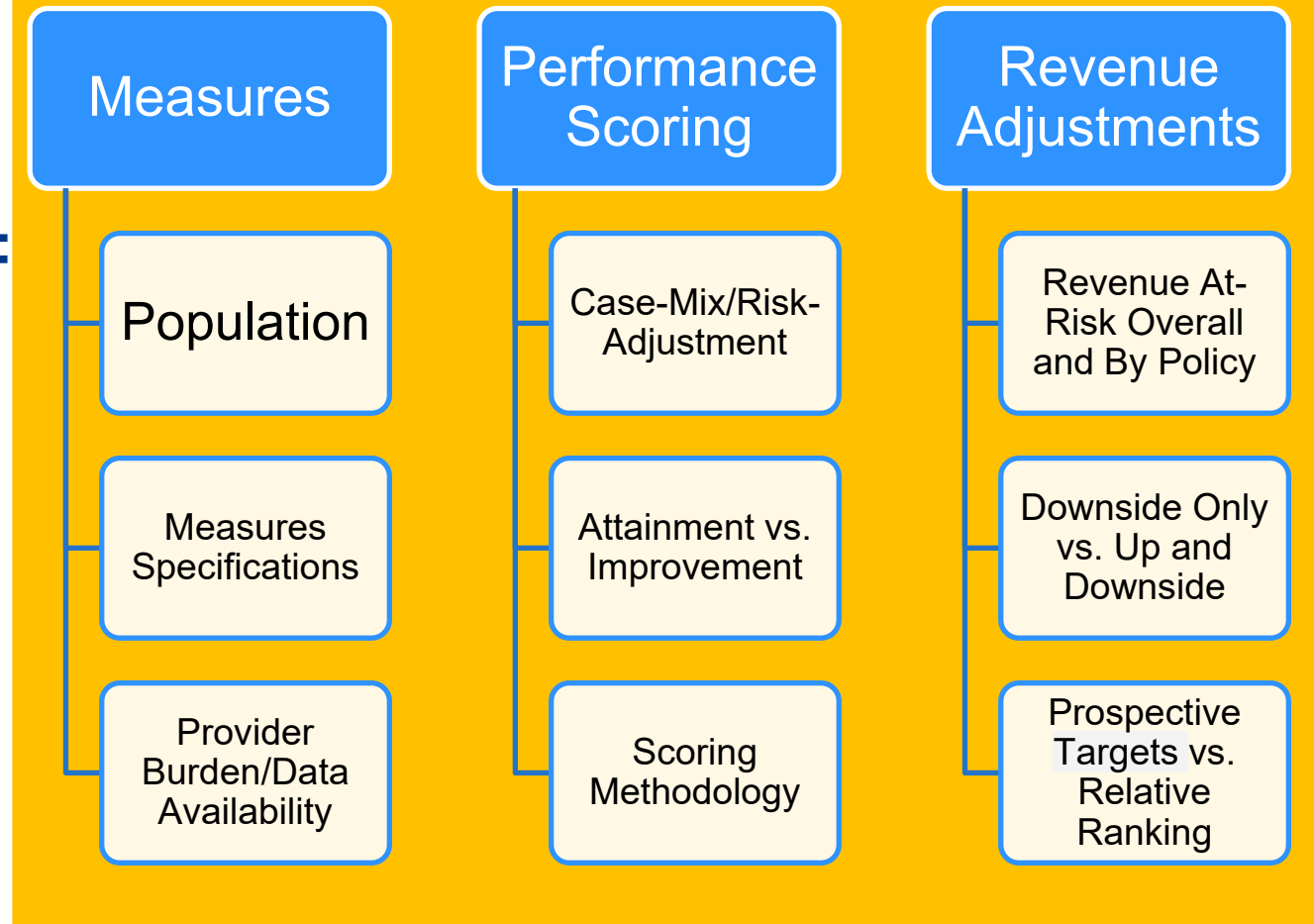
Industry Principles related to Alignment:

(proposed by MHA at August PMWG, see Appendix for additional principles)

“Align with federal quality programs to reduce administrative burden, promote consistency, and focus hospital resources on patient care and improvement efforts”

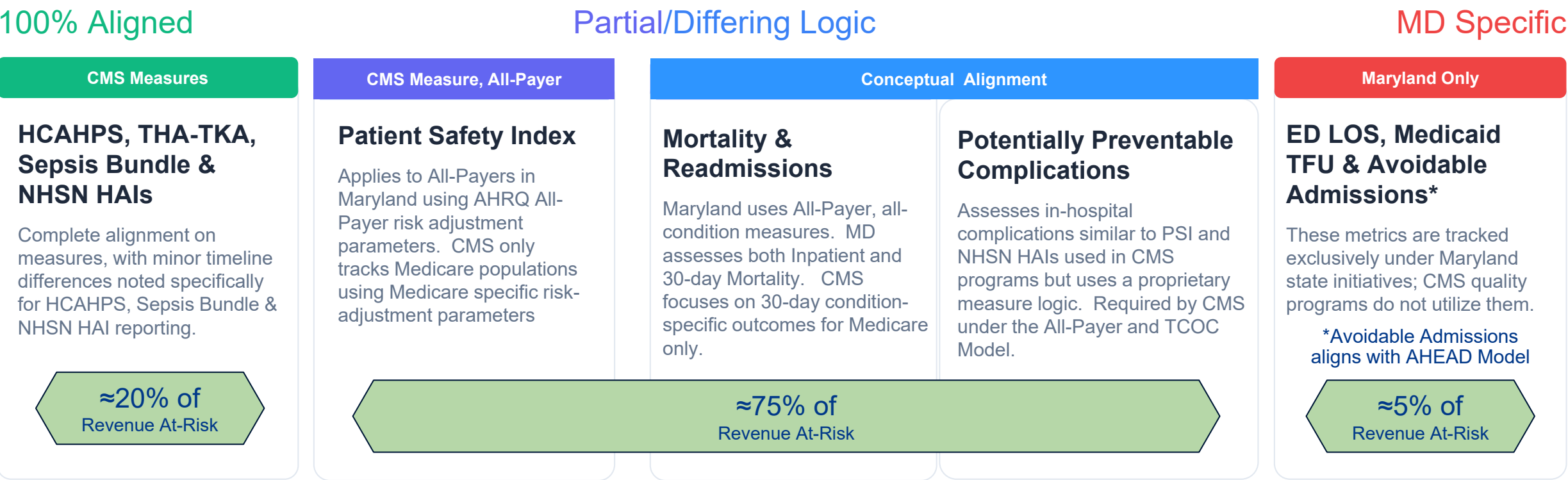
“Limit downside financial risk to enable investment in efforts to preserve access to care and drive quality improvement”

Areas for Alignment



Maryland vs. CMS Quality Program Alignment Continuum: Measures

Mapping quality measures from full national alignment to unique state measures



Some differences in measure weighting due to different components and efficiency measures in MD not included in quality programs (included in other HSCRC methodologies)

Revenue At-Risk as a % of Total Revenue

- MD 6% upside and downside on all payer revenue
- CMS 2% upside and 6% downside on Medicare FFS revenue with varying exposure on other payers

Maryland vs. CMS Quality Program Alignment Continuum: Scoring

Mapping scoring methodologies from full national alignment to Maryland specific methodology

100% Aligned

CMS Scoring

HVBP:

- Better of Improvement and attainment
- Retrospective standards
- Points: 0-10 per measure

HACRP:

- Attainment only
- Concurrent standards
- Winsorized z-scores

HRRP:

- Attainment only stratified by dual peer groups
- Concurrent standards
- Risk-adjusted excess readmissions (no credit for better performance)

Generally Aligned; ED LOS is improvement only

Not Aligned; uses retrospective standards and HVBP/QBR point system instead of z-scores

Not Aligned; assesses improvement and attainment, uses retrospective data for case-mix adjustment

Current Maryland

Maryland Scoring

QBR:

- Better of Improvement and attainment
- Retrospective standards
- Points: 0-10 per measure

MHAC:

- Attainment only
- Retrospective standards
- Points: 0-100

RRIP:

- Better of improvement or attainment
- Retrospective standards

Maryland vs. CMS Quality Program Alignment Continuum: Revenue Adjustments

100% Aligned

CMS Revenue Adjustments

HVBP:

- Relative ranking
- Rewards and penalties scaled up to 2%
- Revenue neutral

HACRP:

- Relative ranking
- Full 1% penalty for bottom quartile of hospitals

HRRP:

- Scaled penalties up to 3% for excess readmission for any of the conditions (e.g., FY26 >75% of hospitals had some penalty)

Should MD continue to align on total revenue at-risk (i.e., 6%)?

Should MD maintain rewards for MHAC and RRIP?

Should MD continue to prioritize the ability to track financial implications during performance period?

Current Maryland

Maryland Revenue Adjustments

QBR:

- Preset scale based on national data (i.e., not relatively ranked)
- Rewards and penalties scaled up to 2%

MHAC:

- Concurrent scale using state average as cut point
- Rewards and penalties scaled up to 2%

RRIP:

- Preset scales for improvement and attainment
- Rewards and penalties scaled up to 2%

Commissioner Discussion from September Meeting

- Recognition of the significant transition facing hospitals under AHEAD and support for later transition to national programs
- Support for continuing financial incentives for multi-payer global budgets
- Measures
 - Alignment is a priority for measures during the transition period particularly for QBR and MHAC programs
 - Need for any state-specific measures should be very limited since all patients will benefit from quality improvements targeted by CMS measures
 - Support to continue to use all payer, all condition readmission measure
 - Measures addressing non-Medicare quality areas such as maternal complication or digitally specified measures should be considered after transition
 - Should we have explicit quality criteria for non-aligned measures, discontinuing measures?
- Program Scoring
 - Support for scoring better of attainment or improvement, especially for readmissions
- Revenue Adjustments
 - Continue to have both rewards and penalties or consider upside only during transition
 - Do not increase revenue at-risk from current risk, consider capping revenue at-risk for non-aligned measures during transition
 - Support for not relatively ranking hospitals

RY 2029 Quality Program Priorities

RY 2029 Quality Program Policy Timelines

Tentative Commission Meeting Timelines										
	September	October	November	December	January	February	March	April	May	June
QBR	RY 2029 Quality Overview	Draft		Final						
MHAC			Draft		Final					
RRIP				Draft		Final				
ED Best Practices**			Draft		Final	For stakeholder discussion: Transition from Monitoring Policy to Learning Collaborative				
PAU*									Draft	Final

*PAU is included in update factor policy; PMWG will need to discuss future PAU adjustment including potential alignment with AHEAD PAU measures (e.g., effectiveness adjustment)

**Based on PMWG/ED Subgroup and September Commission discussion: If transitioning to learning collaborative then draft and final policy may not be required

RY2029 Priorities

QBR

Staff supports major changes

Continue ED LOS and Medicaid timely follow-up

MHAC

Consider removing PPCs from payment

Explore methodology alignment

Total amount at-risk



Focus of RY 2029 Alignment

RRIP

Consider measure changes for alignment

Determine improvement and attainment goal

Best Practices

Sunset pay for reporting and develop learning collaborative to address ED and hospital throughput

Assist CMMI and industry with transition to CMS programs and AHEAD quality adjustments

Quality Based Reimbursement Program RY 2029

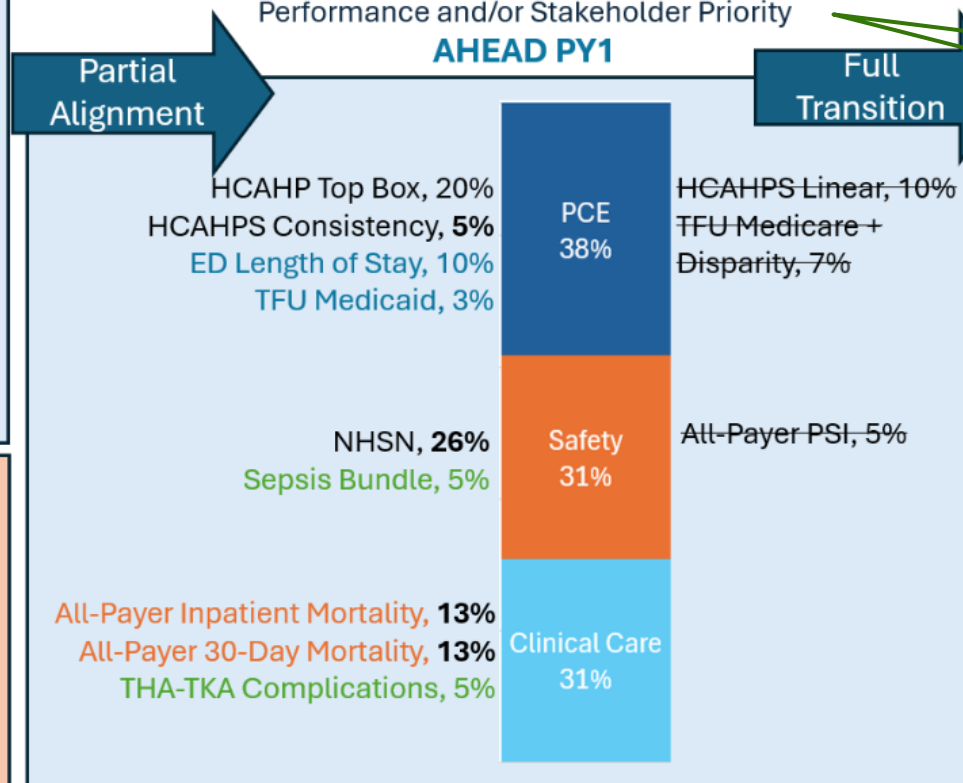
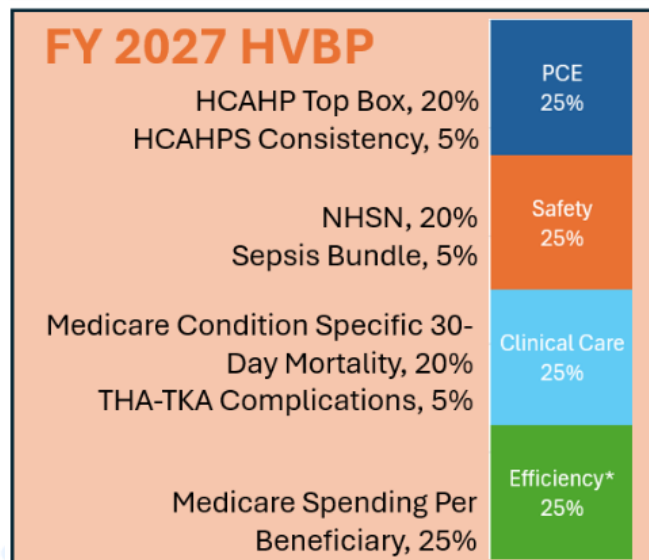
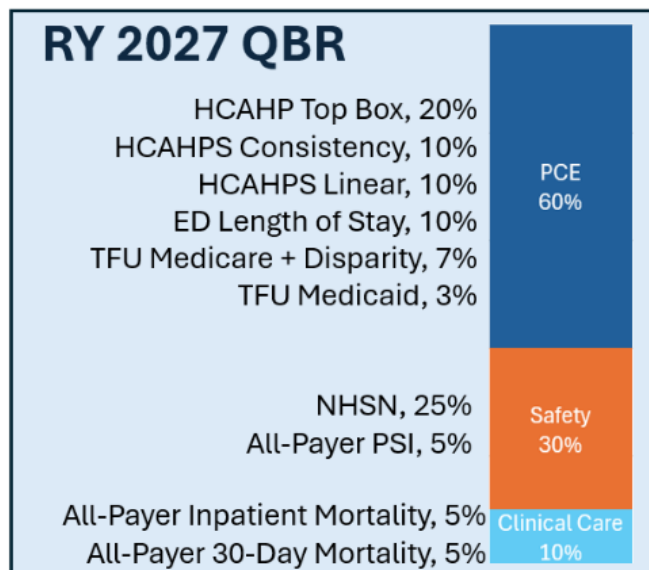
RY 2029 QBR Program

- Staff proposes no major changes to the RY 2029
 - Major alignment of QBR with HVBP occurred in RY2028
 - Staff will recommend continued inclusion of ED LOS and Medicaid timely follow up with same weighting (i.e., do not increase revenue at-risk on non-aligned measures)
 - THA-TKA data and performance standard concerns
 - Discuss mortality alignment
 - Maintain digital measure incentive

RY 2028 Alignment Accomplishments

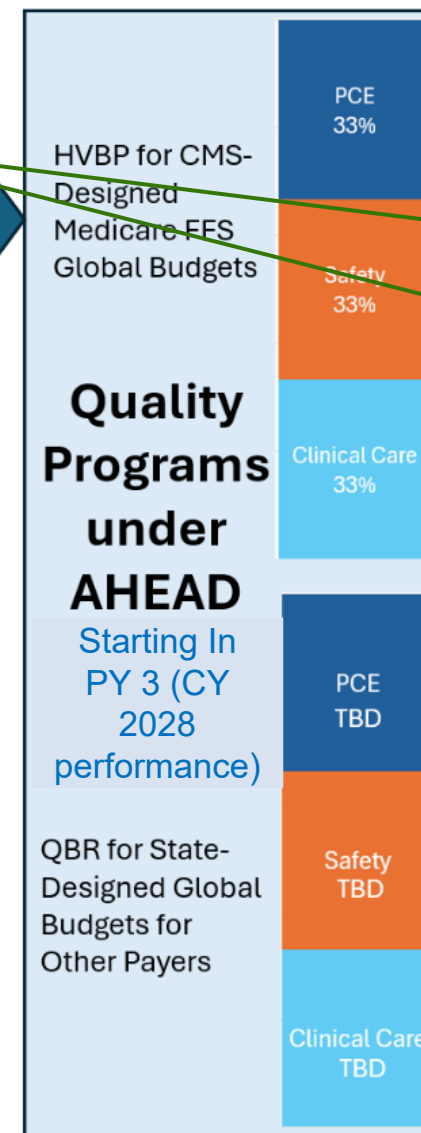
RY 2028 QBR Draft Recommendations

Criteria: 1. Alignment with CMS HVBP, 2. All-Payer Accountability, 3. Reduce retrospective measure evaluation, 4. Area of Poor Performance and/or Stakeholder Priority



Key
Measure Addition (Green)
Weight Change (Blue)
Removed (Orange)
All-Payer or MD Priority (Light Blue)

*HVBP Efficiency Domain is not used for MD Hospitals in HVBP. Remaining domains are weighted at 1/3rd.



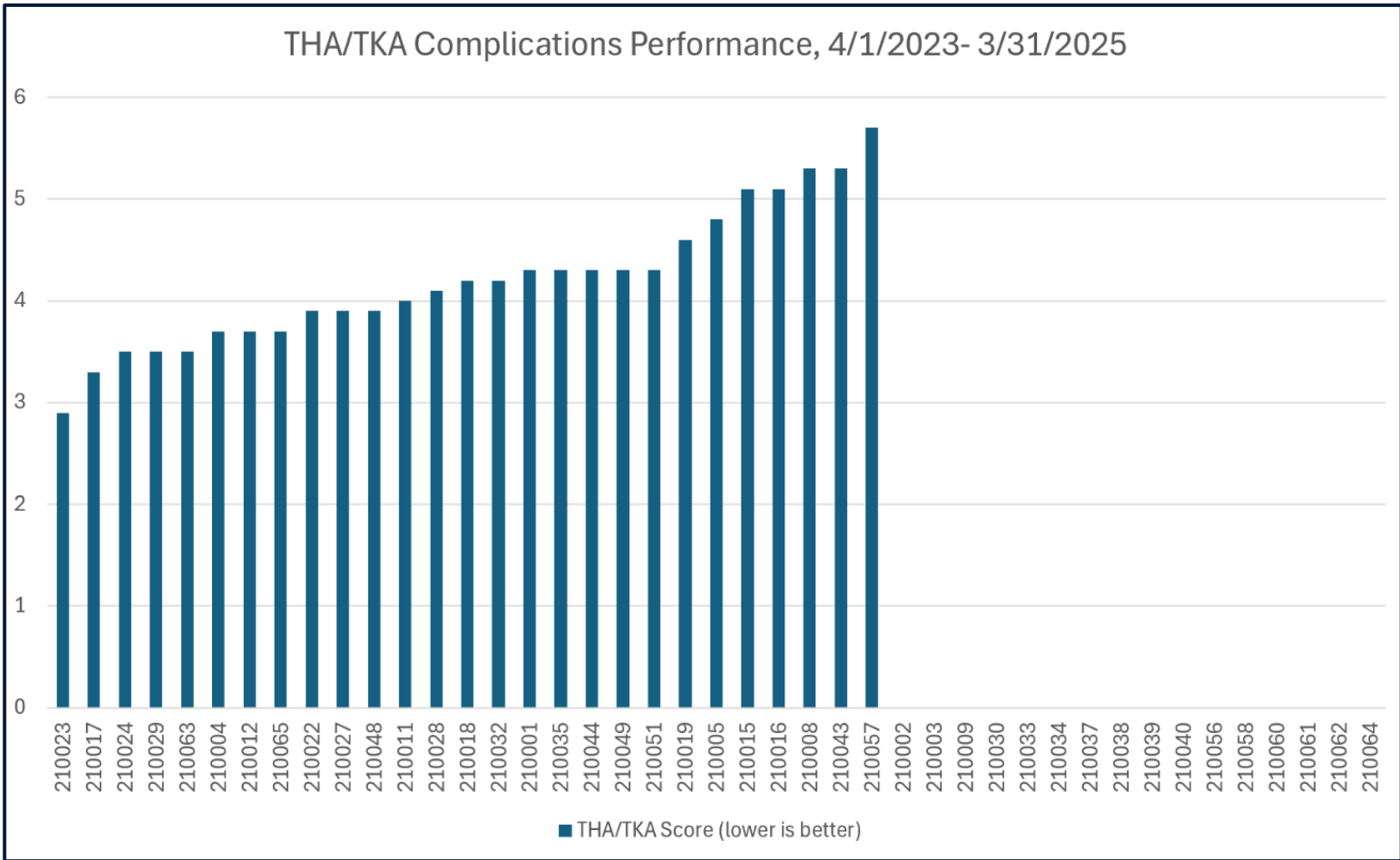
RY 2028 Approved Updates

Maryland Specific QBR Measures

- ED LOS continues to be a legislative, consumer, and regulatory priority
 - Assess improvement and attainment goals
 - Maintain current revenue at-risk of 10% of the total QBR Scores
 - Consider ECAT measure in future years
- Medicaid Timely Follow-Up
 - Focuses on area of disparity by placing 3% of the total QBR Score at-risk for this measure
 - Consider adding mental health follow-up in future years to align with PHAP measure

THA/TKA Complications Measurement

- Two versions of the THA-TKA measure are currently in use by CMS
 - QBR uses the IQR version of the THA/TKA Complications
- IQR version was updated for FY 2027 to include MA patients which led to a shorter performance period (i.e. 2 years instead of the original 3)
 - Need to determine attainment performance standards for RY 2028 QBR and onward
 - Not able to calculate improvement using same measure
- Options for performance measurement:
 - Assess attainment only using concurrent national performance using IQR version of the measure
 - Retrospectively remove THA/TKA in RY 2028 and propose not including in RY 2029 or beyond or until base period data under new version is available
 - Request HVBP official data from CMMI for performance period



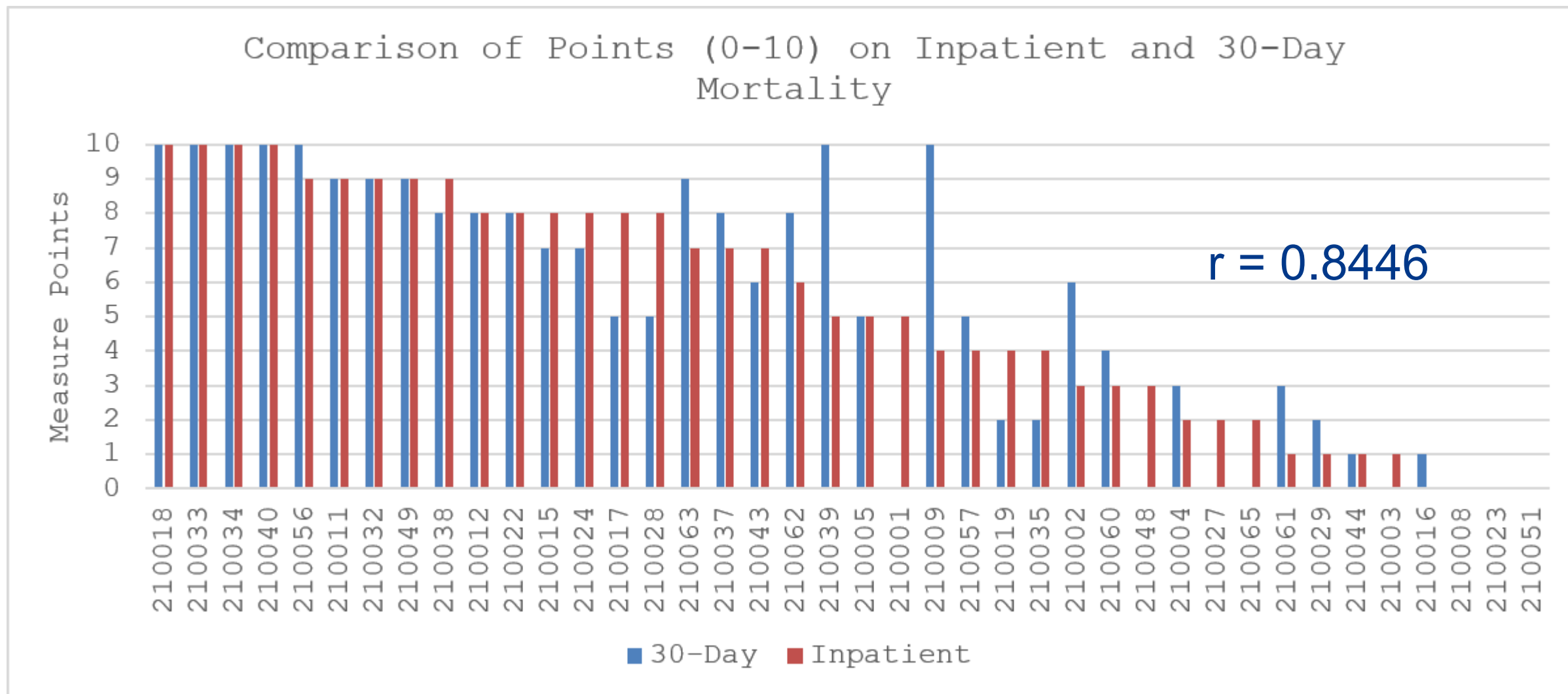
What are hospitals' preferences for handling this measure in RY 2028? RY2029?

Hospitals with performance listed as “Not Available” are blank on the graph

Mortality Measurement

- QBR evaluates mortality using two measures: 30-Day Mortality and IP Mortality
- Discussion questions:
 - Given the high correlation in performance between 30-Day and IP mortality, do we want to move to using only one measure?
 - Given the small range in performance standards for 30-Day, do we want to move to just IP mortality?
 - Should we focus our efforts on developing the **hybrid all-payer** hospital-wide mortality measure?

Inpatient and 30-Day Mortality



Mortality Performance Standards- RY 2027

All-Condition	HSCRC 30-Day	HSCRC Inpatient	CMS Hybrid HWM
Threshold (median)	96.2284*	95.5530*	96.1000***
Benchmark (avg of top decile)	96.7204*	97.3720*	97.2469***
Difference	0.4920	1.8190	1.1469

Condition Specific	AMI	CABG	COPD	HF	PN
Threshold	87.7824**	97.1149**	91.7395**	88.7571**	84.4826**
Benchmark	89.3133**	98.0752**	93.2640**	91.3388**	87.7204**
Difference	1.5309	0.9603	1.5245	2.5817	3.2378

*Calculated by HSCRC staff using FY2024 data

**Calculated by CMS using FY2018-FY2020 data

***Calculated by HSCRC staff using FY2025 data

QBR RY 2029: Propose Maintaining Digital Measures Positive Incentive for Complete and Timely Reporting

- For CY 2027 HSCRC will require 6 mandatory eCQM Measures and 3 self-selected measures, consistent with CMS requirements (See measures tables on next two slides)
- For July 2027-June 2028, HSCRC will require continued reporting of the Core Clinical Data Elements (CCDE) for Hybrid Hospital Wide Readmission and Hospital Wide Mortality Measures for patients age 18+
- Continue positive incentive for hospitals that report the first six months of data and then quarterly for the third and fourth quarters during the specified reporting windows.
- Hospitals that **do not opt for the expedited reporting bonus** must report all required eCQM data for the CY 2027 reporting period and Hybrid CCDE data for the July 2027 to June 2028 reporting period consistent with the CMS reporting timelines (within 90 days after the annual reporting periods).
- Hospitals unable to comply with the specified measure submissions or non-expedited timelines must submit an Extraordinary Circumstance Exception request in accordance with the [Maryland Hospital Extraordinary Circumstances Exception \(ECE\) Policy](#) for HSCRC's consideration.
- Of note, there are five Optional eCQMs that hospitals can self-select for 2027 that are planned by CMS for mandatory reporting in 2028:
 - Hospital Harm – Pressure Injury
 - Hospital Harm – Acute Kidney Injury
 - Hospital Harm – Falls with Injury
 - Hospital Harm – Postoperative Respiratory Failure
 - Malnutrition Care Score (MCS)

QBR RY 2029 Policy: Inpatient eCQM and Hybrid Digital Measures

Title	Short Name	CMS eCQM ID	CBE ID*	Notes	X Indicates Mandatory
Anticoagulation Therapy for Atrial Fibrillation/Flutter	STK-3	CMS71v15	Not Applicable		
Antithrombotic Therapy by End of Hospital Day 2	STK-5	CMS72v14	Not Applicable		
Cesarean Birth	PC-02	CMS334v7	0471e		X
Discharged on Antithrombotic Therapy	STK-2	CMS104v14	Not Applicable		
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Facility Inpatient)	IP-ExRad	CMS1074v3	3663e	Beginning with the Calendar Year 2025 performance period, hospitals and clinicians who choose to report this... Read more	
Hospital Harm - Acute Kidney Injury	HH-AKI	CMS832v3	3713e	This is a risk adjusted measure. Risk Adjustment Methodology Report: Acute Kidney Injury's Risk Adjustment Methodology Report	
Hospital Harm - Falls with Injury	HH-FI	CMS1017v2	4120e	This is a risk adjusted measure. Risk Adjustment Summary Report: Hospital Harm – Falls with Injury	
Hospital Harm - Opioid-Related Adverse Events	HH-ORAE	CMS819v4	3501e		X
Hospital Harm - Postoperative Respiratory Failure	HH-RF	CMS1218v2	4130e	This is a risk adjusted measure. Risk Adjustment Summary Report: Hospital Harm – Postoperative Respiratory Failure	
Hospital Harm - Pressure Injury	HH-PI	CMS826 v3	3498e		

QBR RY 2029 Policy: Inpatient eCQM and Hybrid Digital Measures

Title	Short Name	CMS eCQM ID	CBE ID*	Notes	X Indicates Mandatory
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871v5	3533e		X
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816v5	3503e		X
Intensive Care Unit Venous Thromboembolism Prophylaxis	VTE-2	CMS190 v14	Not Applicable		
Malnutrition Care Score	MCS	CMS986 v5	3592e		
Safe Use of Opioids - Concurrent Prescribing	None	CMS506v8	3316e	There is a known issue on CMS506v8. See issue EKI-45 on the ONC... Read more	X
Severe Obstetric Complications	PC-07	CMS1028v4	Not Applicable	This is a risk adjusted measure: Severe Obstetric Complications Methodology Report There are known issues for CMS1028v4. See issues EKI-43 and... Read more	X
Venous Thromboembolism Prophylaxis	VTE-1	CMS108v14	Not Applicable		
Core Clinical Data Elements for the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data	Hybrid HWR	CMS529	Not Applicable	This is a risk adjusted measure: The CMS Hybrid Measures Methodology Maryland: Denominator Patients age 18+	X
Core Clinical Data Elements for the Hybrid Hospital-Wide All-Condition All-Procedure Risk-Standardized Mortality Measure	Hybrid HWM	CMS844	Not Applicable	This is a risk adjusted measure: The CMS Hybrid Measures Methodology Maryland: Denominator Patients age 18+	X

CMS CY 2027 Outpatient eCQM Measures

Title	CMS eCQM ID	CBE ID*	Notes
Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)	CMS996v7	3613e	
Emergency Care Access & Timeliness (HOQR)	CMS1244v2	4625e	
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Facility Outpatient)	CMS1206v4	3663e	Beginning with the Calendar Year 2025 performance period, hospitals and clinicians who choose to report this ... Read more

QBR RY 2029 Draft Recommendations

1. Maintain Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 38 percent, Safety (NHSN measures) - 31 percent, Clinical Care - 31 percent.
2. Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and set the revenue adjustment scale from 0 to 80 percent with a preset cut-point at 32 percent.
 - a. Retrospectively evaluate the preset cut-point using more recent data to calculate national average score for RY 2027 and RY 2028.
3. Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures.
 - a. Add a bonus incentive of \$150,000 in hospital rates for hospitals that fully meet the State-specified expedited reporting timeline, provided that all required measures are reported.

Best Practice Policy

Future of ED & Hospital Throughput Best Practice Policy

Development of Learning Collaborative

Sunset Best Practices as a policy and develop a learning collaborative as a forum for continuing to share best practices and results.

Partner with front-line representatives to better understand ED & IP LOS key drivers to be addressed with Collaborative.

Strong support from hospitals and stakeholders for discontinuation of pay-for-reporting policy and development of formal learning collaborative.

Options to codify this decision:

1. Add specific recommendation to another existing quality policy (e.g., RY2029 QBR)
2. Submit a draft and final recommendation specific to this learning collaborative or more broadly for monitoring and learning collaboratives (i.e., HCAHPS)

Hospital CCN Key

Hospital ID	Hospital
210001	Meritus
210002	UMMS- UMMC
210003	UMMS- Capital Region
210004	Trinity - Holy Cross
210005	Frederick
210008	Mercy
210009	JHH- Johns Hopkins
210011	Saint Agnes
210012	Lifebridge- Sinai
210015	MedStar- Franklin Square
210016	Adventist- White Oak
210017	Garrett
210018	MedStar- Montgomery
210019	Tidal- Peninsula
210022	JHH- Suburban
210023	Luminis- Anne Arundel
210024	MedStar- Union Mem
210027	Western Maryland
210028	MedStar- St. Mary's
210029	JHH- Bayview
210032	ChristianaCare, Union
210033	Lifebridge- Carroll
210034	MedStar- Harbor
210035	UMMS- Charles
210037	UMMS- Easton
210038	UMMS- Midtown
210039	Calvert
210040	Lifebridge- Northwest
210043	UMMS- BWMC
210044	GBMC
210048	JHH- Howard County
210049	UMMS-Upper Chesapeake
210051	Luminis- Doctors
210056	MedStar- Good Sam
210057	Adventist- Shady Grove
210060	Adventist-Ft. Washington
210061	Atlantic General
210062	MedStar- Southern MD
210063	UMMS- St. Joe
210065	Trinity - Holy Cross Germantown



State PHAP Targets Update

Domain	Measure	2023 Baseline	State's <i>Original</i> Target for 2036 (PY10)	CMMI's Recommended Target for 2036 (PY10)	State's <i>Revised</i> Target for 2036 (PY10)
Population Health	CDC HRQOL-4 Healthy Days Core Module (Self-reported Health Status)	16.5% with poor or fair health	16.5% with poor or fair health	N/A	N/A
Prevention and Wellness	Colorectal Cancer Screening	49.3% with screening	54.6% with screening	71.5% with screening	59.8% with screening
Chronic Conditions	Hemoglobin A1c Control for Patients with Diabetes (>9.0%)	67.8% with poor control	60.3% with poor control	15.7% with poor control	60.3% with poor control for those without missing test results
Behavioral Health	Follow-up After Hospitalization for Mental Illness	64.3% at 30 days; 38.0% at 7 days	66.8% follow-up at 30 days; 40.5% at 7 days	72.2% follow-up at 30 days; 51.5% at 7 days (accepted)	N/A
Utilization	Plan All-Cause Unplanned Readmission	O/E= 1.01	O/E=0.98	N/A	N/A
"Optional"	Food Insecurity	16.4% food insecure	15.0% food insecure	N/A	N/A

Bed Data Validation and Reporting

HB 1563 Bed Capacity Requirements

Key Commission Mandates

The Maryland Health Care Commission and Health Services Cost Review Commission must collaborate to:

- Conduct a study to quantify bed capacity across hospitals and post-acute settings.
- Establish recommendations for an annual auditing and reporting process for all bed types.
- Implement standardized definitions for inpatient and outpatient bed types.



Deadline: HB 1563 took effect June 1, 2026. Report containing findings and recommendations is due by January 1, 2027.

Bed Count Specifications in the HB 1563 Legislation

The study required under subsection (a) of this section shall include:

1. a count of the number of physical beds within each post–acute care facility in the State;
2. the use of a standardized definition for each inpatient and outpatient bed type including Adult Medical, Adult Surgical, Adult Gynecological, Adult Addictions, Adult Obstetric, Adult Psychiatric, Adult Rehabilitation, Pediatric, Inpatient Observation, Outpatient Observation, Observation Swing, and other types as determined jointly by the Commissions

****Note:** we need to determine how discuss recategorization of some of the above bed types, as they are not designated bed types

1. a count of the number of physical beds, using the standardized definition, within each hospital in the State, by bed type;
2. a count of the number of staffed beds, using the standardized definition, within each post–acute care facility in the State;
3. a count of the number of staffed beds, using the standardized definition, within each hospital in the State, by bed type;
4. a count of the number of licensed beds within each post–acute care facility in the State;
5. a count of the number of licensed beds within each hospital in the State, by bed type;
6. a count of the number of other types of beds as determined appropriate; and
7. any other information necessary for the Maryland Health Care Commission and the Health Services Cost Review Commission to quantify bed capacity in the State.

Standardized bed data is the foundation for understanding hospital capacity

Current reporting limitations must be addressed to support statewide access analysis

Current State

1. Fragmented Reporting

Existing sources collect different bed measures for different purposes, limiting a unified statewide view.

2. Inconsistent Definitions

Bed types and reporting practices vary across hospitals, service lines, and reporting systems.

3. Limited Longitudinal Visibility

Point-in-time reporting does not consistently capture changes and fluctuations in staffed capacity and occupancy over time.

Standardized Reporting and Auditing

Future State

✓ Understand types of beds and availability

Distinguish between the regulatory limit for beds, beds that physically exist and beds that can be staffed and operationalized within hospitals.

✓ Inform capacity planning

Evaluate occupancy patterns and the effects of utilization trends, population needs, and service-line or facility changes.

✓ Identify capacity and access drivers

Assess how access opportunities and constraints relates to beds, staffing, throughput, or other resources.



Goal

To refine existing data and reduce complexity, establishing a reliable baseline that captures **ongoing hospital capacity, averages, minimums, and maximums** to support an ongoing understanding of access for the population.

The current stage is the first step in a broader bed capacity workplan

CURRENT STAGE

Evaluate Current Bed Data



Evaluate current bed data reporting and identify definitional gaps between reporting sources

Develop Reporting Standards and Auditing Processes



Develop standardized reporting definitions, frequency, and data elements and an auditing process to improve data completeness, accuracy, and comparability

MEDIUM TERM

Build a Reliable Data Infrastructure



Implement consistent reporting and enact validation and auditing processes

LONG TERM

Evaluate Statewide Bed Capacity Capability



Use the data foundation to assess staffed and physical capacity, occupancy patterns, and potential access constraints

THANK YOU!

Next Meeting: Possibly need to reschedule due to Commission Meeting being rescheduled from 10/14 to 10/21

Option 1: Keep meeting on October 21st

Option 2: Move PMWG to October 28th

Staff will take into account workgroup member preferences and send out updated meeting information

Appendix

Current work is underway to build the statewide bed data foundation

Analysis of existing reporting and bed-count data to set the baseline and shape future standards

Analysis Objectives

1 Standardize bed type definitions

- Clarify licensed, physical, staffed, and occupied beds
- Address observation, surge, swing, overflow, and specialty beds types

2 Develop data reporting standards

- Determine appropriate timing and reporting frequency
- Balance improved information with hospital operational capacity

3 Establish validation and audit standards

- Define checks for completeness, consistency, and accuracy
- Identify practical audit or spot-check approaches
- Support consistent interpretation across hospitals

Data Sources

Definitional Comparison: Compare reported bed types, measures, service-line distinctions, timing, and availability across sources

MIEMMS	Physical, staffed, and occupied beds; patient days and patients waiting for acute or ICU beds
MHCC	Licensed, physical, and staffed beds by service, including observation beds
NHSN	Inpatient and ICU staffed-bed and occupancy information (<i>data available at the statewide level</i>)
BH Admin	Real-time psychiatric bed availability by hospital (<i>site specific reporting; clarity required on reporting path, retrospective views, and total staffed beds</i>)

High-level bed type definitions

Supply			Demand	
Licensed Beds	Physical Beds	Staffed Beds	Occupied Beds	Unmet Demand
<i>Regulatory limit (excluding potential surge)</i>	<i>Existing beds within a facility</i>	<i>Point in time operational, useable capacity</i>	<i>Census; utilized capacity at a point in time</i>	
Beds which a hospital or health system is licensed or authorized to operate by the state or licensing authority.	Beds which exist and that can be set up for operational use without needing significant room renovations	Beds set up with available staff and able to be used to provide care for a patient, which can either be occupied or available for incoming patients.	Beds that are staffed and currently in use by patients; referred to as " census " in reporting for a given point in time or day; Across all beds	Not Reported. Requires analysis methodology to estimate.
Should not fluctuate frequently		May fluctuate by hour, day, season, etc.		

Illustrative Example:

12 Licensed Beds

>

10 Physical Beds

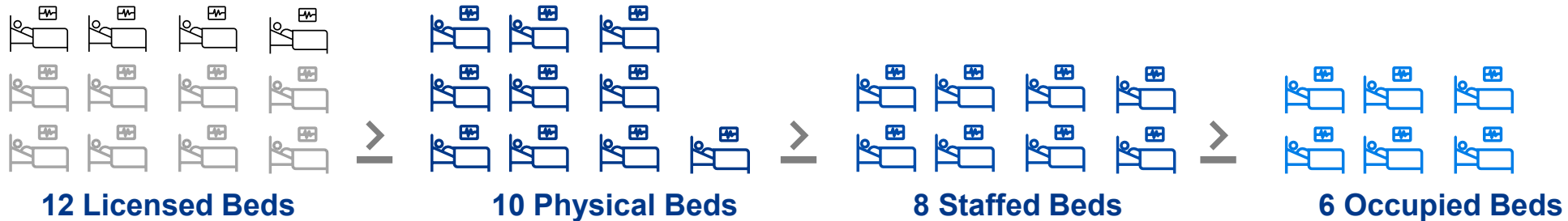
>

8 Staffed Beds

>

6 Occupied Beds

Illustrative Example:



While there are 12 physical beds, a subset may not be able to be staffed. **Example:** a unit of 4 beds in 2 semi-private rooms, may only consider 2 of those beds able to be staffed due to post-Covid private room recommendations. This leaves a **total of only 10 physical beds which are "staffable"**