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Emergency Department Wait Times Reduction Commission Final Report

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List of Abbreviations

ABM	Agent-Based Model
AHEAD	Achieving Healthcare Efficiency through Accountable Design
AMA	American Medical Association
BHA	Behavioral Health Administration
CCLF	Claims and Claims Line Feed
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar Year
ED	Emergency Department
EDDIE	Emergency Department Dramatic Improvement Effort
EMS	Emergency Medical Services
EMR	Electronic Medical Record
FFS	Fee-for-Service
FY	Fiscal Year
GBMC	Greater Baltimore Medical Center
GBR	Global Budget Revenue
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCC	Hierarchical Condition Categories
HCUP	Healthcare Cost and Utilization Project
HOPE	Healthcare Outcome Payment Effort
HSCRC	Health Services Cost Review Commission
IP	Inpatient
LTCH	Long-Term Care Hospital
LOS	Length of Stay
MDH	Maryland Department of Health

MDPCP	Maryland Primary Care Program
MHA	Maryland Hospital Association
MHCC	Maryland Health Care Commission
MIA	Maryland Insurance Administration
MIEMSS	Maryland Institute for Emergency Medical Services Systems
NHSN	National Healthcare Safety Network
OP	Outpatient
P4P	Pay-for-Performance
PAU	Potentially Avoidable Utilization
PQI	Prevention Quality Indicator
QBR	Quality-Based Reimbursement
RY	Rate Year
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SNF	Skilled Nursing Facility
TCOC	Total Cost of Care
YTD	Year-to-Date

Executive Summary

This report, prepared in accordance with Section 20-2406 of the Health-General Article of the Annotated Code of Maryland,[1] provides information on the development and activities of the Maryland Emergency Department Wait Time Reduction Commission (ED Commission). The ED Commission is tasked with researching and understanding factors throughout the health care system that contribute to increased emergency department (ED) length of stay (LOS), making recommendations to reduce ED LOS, and reporting on the impact of its policies and programs to the Maryland General Assembly. This document serves as the ED Commission's final report.

ED Commission Structure and Work

The ED Commission, co-chaired by the Maryland Department of Health (MDH) and the Health Services Cost Review Commission (HSCRC), consists of 13 commissioners appointed by the Secretary of Health in September 2024 and selected to represent the stakeholders specified in the legislation. To support its work, the ED Commission established three Subgroups: Access and Capacity, ED Hospital Throughput Best Practices, and Data. Each Subgroup included commissioners and non-commissioner experts, including hospital leaders, clinicians, payers, and patient representatives, to identify system-wide solutions and advance coordinated policy recommendations.

Key Findings

- Maryland's adjusted ED LOS exceeds national averages, but differences narrow substantially when controlling for hospital size, academic health center status, and patient diagnosis and severity of illness. While adjusting for these factors brings Maryland more in line with the nation, ED LOS remains a persistent, complex, and multi-faceted challenge throughout the nation. Like the nation, Maryland has specific key drivers of ED LOS that contribute significantly to the overall wait time and delays in throughput.
- The ED Commission identified the following four key drivers of ED LOS:

  1) Access to post-acute care - Timely access to appropriate post-acute care impacts hospital throughput. Delays can create bottlenecks that contribute to longer boarding time and increased inpatient and ED LOS.

  2) Denials and authorization delays - Evaluation and consideration of legislative, regulatory, and industry level changes to prior authorization processes and timelines that minimize delays is crucial to improving appropriate and timely care transitions from acute to post-acute facilities.

[1] 2024 MD Laws Chapter 844.

3) Capacity alignment - Statewide, regional, and local approaches to bed capacity management require standardized definitions to ensure validity and reliability of bed count data. Establishing agreed upon standardized definitions is the first step towards a unified statewide capacity data framework that will be the foundation for a statewide bed capacity tracking system. A unified statewide bed capacity data framework presents a critical opportunity to accurately diagnose the root drivers of access constraints. By clearly identifying whether access bottlenecks stem from physical infrastructure, staffing models, capacity utilization, or downstream placement delays, policymakers can deploy targeted solutions to effectively optimize capacity, improve patient flow, and enhance access to care.

4) Best practices for ED and inpatient throughout and care transitions - Statewide collaboration and sharing of best practices focused on adequate community, primary, and behavioral health resources, as well as care coordination across the pre-, intra-, and post-hospital continuum of care, are essential to addressing access barriers that contribute to overutilization of ED services.

Final Recommendations

Based on the key drivers identified, the ED Commission made the following high-priority recommendations.

Access to Post-Acute Care:

- HSCRC should collaborate with the Maryland Health Care Commission (MHCC), post-acute care providers, Maryland Medicaid, commercial payers, the Maryland Institute for Emergency Medical Services Systems (MIEMSS), and the Maryland General Assembly to strengthen value-based payment programs for post-acute providers, as well as increase the number of providers who participate in them. Specifically, the ED Commission recommends:
    - *Collaborate with state and federal agencies and payers to strengthen financial incentives for post-acute facilities by tying rewards and penalties to specific outcome and process measures, such as timely acceptance of referrals, weekend admissions, readmission targets, and increased revenue at risk.*
    - *Review the Nursing Facility Pay-for-Performance (P4P) program's quality measures, assess national best practices, and as applicable, consider potential future enhancements to the quality measures.*
    - *Consider increasing the portion of funds allocated to the Nursing Facility P4P program above 1 percent of the appropriation for Medicaid nursing facility services.*
    - *Prioritize development and implementation of care transformation initiatives that reduce ED and inpatient LOS, such as enhanced care coordination, integrated discharge planning,*

and financial incentives that reduce avoidable hospital utilization from post-acute settings and promote timely transitions from acute to post-acute care.

- *Given the timing of this report and MHCC's* Strengthening Post-Acute Care in Maryland towards Meeting the Goals of AHEAD *report (which was developed through a series of comprehensive focus group meetings as required by the AHEAD Multi-Agency Regulatory Working Group Workplan),[2] this ED Commission also recommends reviewing the final MHCC post-acute report once available for their specific recommendations on Medicaid Value-based purchasing and Care Transformation Initiative programs that will impact care transition to post-acute care.*

- HSCRC, MHCC, MDH, Maryland Medicaid, and the General Assembly should consider addressing reimbursement models, capacity gaps, and regulations for authorization and acceptance. Specifically, the ED Commission recommends:
  - *As follow-up to the information in MHCC's post-acute report, this ED Commission recommends a multi-agency collaboration to evaluate and address the gaps in the capacity of post-acute care, specifically chronic care beds, to manage patients with complex conditions. The ED Commission identified a need to have a better understanding of post-acute, skilled, and chronic care bed and staffing capacity.*
  - *MHCC's focus group reported that skilled nursing facility (SNF) operators attributed some of the decreased acceptance of complex care patients to insufficient payment rates, noting that other states adjust nursing facility payments to account for the higher costs of these patients.[3] The ED Commission recommends that as a state, we evaluate these specific gaps.*

Authorization Delays and Denials:

- The Maryland Insurance Administration (MIA) and Maryland General Assembly should conduct a review of prior authorization laws nationwide, as well as consider alignment with the American Medical Association's (AMA's) Advocacy Resource Document Recommendations, in order to streamline and standardize the process for prior authorizations. The ED Commission further recommends prioritizing items identified in MHCC's post-acute report related to this key driver, as well as the recommendations included in the Adverse Decisions workgroup's upcoming report.
- The following recommendations were sent to the MIA and Maryland General Assembly for consideration based on the AMA guidance mentioned above:

[2] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.
[3] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

- *Mandate the availability of an online prior authorization system for in-hospital and post-acute care (and not only for drugs).*
- *Similar to other medical communication, mandate that all prior authorization-related communication be visible to patients via the patient portal (improve on current requirements in Maryland).*
- *Mandate that non-urgent prior authorization requests be adjudicated within two business days. Urgent requests should be adjudicated within one business day.*
- *If the need for services occurs on a holiday, an insurance plan cannot require notification/request for a prior authorization only on a business day.*
- *After prior authorization approval, an insurance plan cannot retroactively deny the service, unless materially false information was provided.*
- *Similar to any medical decision making, denials should include specific clinical reasons, contact details, department name and credentials, and the persons who had authority over denying or approving the prior authorization request, i.e., the reviewer, and who it can be appealed to.*
- *Appeals should be adjudicated by a physician in the same or similar specialty, within one business day. There should be an electronic portal for appeals.*
- *Statistics should be available on the payer's website regarding the category of denials, rate of denials, etc.*
- *Prior authorization requirements should be based on clinical evidence and should be displayed on the payer's website.*

Capacity Alignment

- Building on the requirements of the Emergency Room Services and Post-Acute Care - Coverage and Studies bill passed in 2026, which requires a standardized bed count study for acute and post-acute facilities in Maryland, assess regional needs for inpatient and post-acute capacity using standardized and validated hospital and post-acute bed count data. The bed count study will follow the timeline in the bill.[4] Specifically, the ED Commission recommends:
  - *Evaluating current bed data reporting and identifying definitional gaps between reporting sources.*
  - *Developing standardized reporting definitions, frequency, and data elements, as well as an auditing process to improve data completeness, accuracy, and comparability.*
  - *Building a reliable data infrastructure that implements consistent reporting and enacting validation and auditing processes.*

[4] 2026 MD Laws Ch. 165.

    - *Evaluating statewide bed capacity by using the data to assess staffed and physical capacity, occupancy patterns, and potential access constraint.*
- Complete a secondary analysis, separate from the legislatively mandated bed count study, to identify and evaluate legislative and regulatory barriers that have led to the absence of Long-Term Care beds in the state of Maryland.
- Any additional analyses and actions recommended within the initial bed capacity study should have associated timelines for completion built into the recommendations, and HSCRC and MHCC should work with stakeholders to build out these timelines and identify resources for next steps, recognizing the importance of understanding capacity to address ED LOS.
- The state should leverage existing infrastructure and systems utilized by MIEMSS and the Maryland Behavioral Health Connect bed tracking systems to develop an interactive, statewide bed capacity tracking system that provides real-time bed availability at both acute and post-acute facilities. The ED Commission recommends legislative action to require submission from all regulated, licensed acute and post-acute care facilities to such a system.
- State stakeholders, including HSCRC and the General Assembly, in collaboration with hospitals, should explore alternate capacity options, such as the Hospital at Home model, the Expanded Home Health Value-Based Purchasing model, and Bridge Clinics.
- HSCRC should continue monitoring IP LOS, along with its partnership with hospitals to understand the drivers of IP LOS and the best practices that can be used to improve it.
- The ED Commission recommends noting that staffing shortages contribute to decreased capacity for some facilities and supports the Safe Staffing Act of 2026's requirements hospitals must complete to ensure safe staffing of beds.
- HSCRC should engage acute care facilities through multi-stakeholder collaboration on coordinating service lines across the state, meaning possibly creating service line networks across the state that could function outside of defined hospital systems in order to leverage available capacity.

ED and Hospital Throughput Best Practices and Care Transitions

- Collaborate between state agencies, the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Multi-Agency Regulatory Working Group, acute care hospitals, post-acute care facilities, and community agencies to address resource allocation and support for long-stay patients and guardianship cases.
- Expand community partnerships and investments in primary care and behavioral health, including pediatrics, and to address social determinants of health.
- Evaluate opportunity to integrate Psychiatric Bed Registry to improve care transitions.
- Strengthen and expand palliative care and hospice services. Specific recommendations include:

    - *As recommended in the MHCC Post-Acute report, MDH should evaluate opportunities to strengthen and better align palliative care services across delivery systems.*
    - *Continued funding and expansion of the ongoing efforts to provide training and services through the established GBMC and Gilchrist hospice programs.*
    - *Legislation to expand training and access to electronic Medical Orders for Life-Sustaining Treatment forms across all healthcare access points (outpatient providers, emergency medical services (EMS), acute care, and post-acute facilities).*
    - *MHCC, HSCRC, and Center for Medicare and Medicaid Innovation collaboration to build advance directives completion into incentive programs such as AHEAD Primary Care.*
- HSCRC should collaborate with stakeholders in transitioning the HSCRC Hospital Best Practices Policy to a learning collaborative that expands the focus from a select group of best practices to broader opportunities and maintains participation from hospitals and post-acute providers.

These recommendations involve collaborative efforts across key stakeholders, including HSCRC, MHCC, MDH, hospitals, post-acute providers, and the legislature.

Section I. Introduction

The Maryland General Assembly enacted legislation in 2024 that established the Maryland Emergency Department Wait Times Reduction Commission (ED Commission).[5] The purpose of the ED Commission was to examine and address factors throughout the health care system that contribute to increased emergency department (ED) wait times (referred to throughout this report as ED length of stay, or ED LOS). Specifically, the ED Commission worked to develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED LOS, including initiatives that:

- Ensure patients are seen in the most appropriate setting
- Improve hospital efficiency by maximizing flow of ED and inpatient (IP) throughput
- Improve post discharge resources to facilitate timely ED and IP discharge
- Identify and recommend improvements for data collection and submission
- Facilitate sharing of best practices

The statute required an interim and final report. The ED Commission's interim report[6] was submitted in November 2025 and contained information on ED performance, IP hospital throughput, post-acute care capacity, workforce and operational challenges, and characteristics that affect patient flow. It also made preliminary recommendations to strengthen data infrastructure, expand modeling and performance measurement tools, and develop strategies to increase post-acute care capacity and improve care transitions across the healthcare system.

This document serves as the ED Commission's final report and contains background information, presents the latest publicly available data on ED LOS, and outlines the key drivers of ED LOS and related ED Commission recommendations. The Health Services Cost Review Commission (HSCRC) provided staff support, facilitating all meetings (including Subgroup meetings), developing and coordinating presentations and meeting materials, and conducting relevant analyses.

Other Related State Initiatives

During the ED Commission's tenure, several other legislative and policy initiatives were enacted that address factors contributing to ED LOS. To promote alignment and maximize the impact of its recommendations, the ED Commission closely monitored these complementary efforts and considered their potential implications for ED throughput and LOS. In policy areas where other dedicated workgroups or agencies held primary responsibility, the ED Commission sought to support and reinforce, rather than

[5] 2024 MD Laws Chapter 844.
[6] HSCRC (November 2025). *The Emergency Department Wait Times Reduction Commission Activities and Findings*. https://hscrc.maryland.gov/Documents/Work%20Group%20Uploads/ED%20WTR%20Commission/Emergency%20Department%20Wait%20Times%20Reduction%20Commission%20Interim%20Report%202025%20HSCRC.pdf

duplicate, those efforts. Key concurrent state-level initiatives related to the ED Commission's charge include the following.

New Legislation

Maryland passed legislation in 2025 that established the Workgroup to Study the Rise in Adverse Decisions in the State Health Care System,[7] jointly staffed by the Maryland Insurance Administration (MIA) and HSCRC. The Workgroup is charged with reviewing existing adverse decision reporting requirements for health payers operating in Maryland; identifying opportunities to improve the consistency, transparency, and usefulness of adverse decision reporting; developing strategies to reduce the number of adverse decisions; and recommending legislative and policy changes to standardize reporting requirements statewide. The Workgroup's report will be submitted in December 2026.

The Emergency Room Services and Post-Acute Care - Coverage and Studies bill took effect on June 1, 2026, and mandated specific interagency studies designed to enhance Maryland's healthcare delivery system and improve access to care.[9] The bill addressed three areas: adverse decisions and grievances related to post-acute services, bed capacity in acute hospital and post-acute care settings, and options to facilitate clinically appropriate transitions from acute to post-acute care settings. In response to the legislation's bed capacity provisions, the Maryland Health Care Commission (MHCC), in conjunction with HSCRC, is conducting a study to assess the quality of bed count data in hospital and post-acute settings across the State and to make recommendations for establishing a process for standardized reporting practices and continuous, audited capacity monitoring. Understanding the accuracy and consistency of reporting on bed counts across the care continuum is a critical step toward assessing whether there is adequate capacity to meet state and regional needs. The legislation also required a study of care transitions from acute to post-acute settings. The recommendations from this study are included in the MHCC *Strengthening Post-Acute Care in Maryland towards Meeting the Goals of AHEAD* report.

The Safe Staffing Act of 2026 established new requirements related to hospital clinical staffing.[10] This legislation requires hospitals to comply with applicable accreditation standards and Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and to establish a clinical staffing committee responsible for developing a comprehensive clinical staffing plan. In developing these plans, staffing committees must consider such factors as current staffing levels, staffing shortages and strategies to address them, patient volume and acuity, staff skill mix and competencies, and methods for ensuring adequate coverage. Hospitals must make clinical staffing plans available to their staff upon request. Beginning July 1, 2028, and annually thereafter, hospitals must implement finalized staffing plans and assign personnel to patient care units in accordance with those plans.

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[7] 2025 MD Laws Ch. 672/671.
[9] 2026 MD Laws Ch. 165.
[10] 2026 MD Laws Ch. 235/Ch. 236.

AHEAD Multi-Agency Regulatory Working Group

On September 23, 2025, Governor Moore directed the Maryland Secretary of Health to convene a Multi-Agency Regulatory Working Group to support Maryland's implementation of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. As part of its initial work plan, the Working Group identified post-acute care as a priority area, with a particular focus on barriers to timely and clinically appropriate hospital discharge placements. The work plan noted that challenges within the post-acute care system have complicated the efficient delivery of hospital services, as hospitals frequently report difficulties securing appropriate discharge placements for patients. To address these concerns, MHCC was charged with developing recommendations focused on quality, access, and cost savings, including consideration of the impact of consolidation within the post-acute care sector. In July 2026, MHCC released a draft report that summarized key challenges facing the post-acute care system, stakeholder perspectives gathered through a series of focus group meetings, and preliminary recommendations to better facilitate hospital discharges to post-acute care settings and strengthen post-acute care.[11] MHCC was also charged with meeting with stakeholders to identify strategic priorities for future health care workforce development efforts by the State that would be most likely to generate the greatest return on investment. MHCC published a draft report with an overview of the Maryland health care workforce landscape, including a review of the effectiveness of various types of health care workforce programs, draft strategic priorities for future state workforce development efforts, and a summary of perspectives shared by stakeholders.[12]

HSCRC Initiatives

In keeping with its mission to ensure access to high-quality, affordable health care for all Marylanders, HSCRC has prioritized reducing ED LOS. This work reflects the central role ED performance plays in patient outcomes, hospital efficiency, and public confidence in the health care system. By examining the underlying drivers of extended ED LOS, HSCRC seeks to develop targeted strategies that strengthen both emergency care and the broader care continuum. Through these sustained efforts, HSCRC has built a foundation of policies, programs, and partnerships that directly address ED LOS, positioning the state to build upon this work under the Commission.

Overall Policies and Programs

HSCRC is uniquely positioned to influence system-wide improvements by addressing hospital throughput, capacity and ED boarding, particularly through efforts to reduce IP LOS and improve care coordination

[11] Strengthening Post-Acute Care towards Meeting the Goals of AHEAD. Available at https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.
[12] Strengthening Maryland's Healthcare Workforce towards Meeting the Goals of AHEAD. Available at https://www.mhcc.maryland.gov/sites/default/files/documents/2026-07/mhcc_ahead_wkforce_rpt_a11y.pdf.

across settings. Recognizing the significant impact that prolonged ED LOS has on patients and providers, HSCRC has advanced a range of policies, initiatives, and programs—outlined below—to improve performance.

- **ED Hospital Throughput Best Practices Policy:** Requires hospitals to implement and report on best practices to improve flow and reduce LOS. Hospitals can be financially penalized for non-reporting on this policy. HSCRC convened a "Best Practices" Subgroup to develop this policy, which was repurposed to serve as a Subgroup for the ED Commission to make additional recommendations on best practices. The policy was implemented in January 2025 and will continue through December 2026, at which time the policy will sunset and a learning collaborative will be established. An overview of the policy is included in Appendix I.
- **Quality-Based Reimbursement (QBR) ED LOS Payment Measure:** One of the core HSCRC pay-for-performance (P4P) programs to promote hospital quality improvement, QBR provides financial incentives for hospitals to enhance performance across three patient-centered quality domains: (1) person and community engagement, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; (2) clinical care; and (3) safety. It incorporates a payment incentive ED LOS measure for rate years (RYs) 2026 and 2027 to reward hospitals with improvement in the median time from ED arrival to departure for admitted patients. The LOS payment measure was implemented in January 2024 using data collected by HSCRC.
- **Potentially Avoidable Utilization (PAU) Program:** Creates an incentive to reduce 30-day all-cause readmissions and avoidable admissions related to the exacerbation of a chronic condition by scaling hospital inflation based on a hospital's deviation from statewide average performance (i.e., hospitals better than the statewide average, which is now better than national performance in both measures, do not incur any reductions to their revenue base, whereas hospitals worse than the statewide average incur an inflationary cut to the administration of these potentially avoidable cases). Previously, this policy reduced revenue for all hospitals but was updated once statewide performance exceeded national performance. HSCRC also reinforces this incentive to reduce readmissions and avoidable admissions by accounting for these services in several other methodologies and policies (e.g., PAU cases are carved out of HSCRC's market shift policy, which realigns revenue among hospitals based on shifting patient choice, and thus ensures hospitals are not penalized for reducing readmissions and avoidable admissions while another facility increases PAU cases).
- **IP LOS Policy:** Measures statewide IP LOS and provides hospitals with a patient level, all-payer, risk-adjusted IP LOS metrics report. The policy begins in RY 2028 on a monitoring-only basis, with financial incentives proposed for RY 2029 or RY 2030 as part of the portfolio of hospital quality and population health incentives for Maryland Global Budgets (i.e., non-Medicare hospital global

budgets). The IP LOS policy was designed to address Maryland's growing IP bed day utilization and its effects on hospital operations, ED crowding, and the sustainability of the State's global budget models. Although Maryland has seen a decline in IP admissions, overall IP utilization has increased because patients remain hospitalized longer, creating capacity constraints and contributing directly to ED boarding and extended ED LOS. This policy aims to bring Maryland hospitals with high IP LOS closer to national averages and ensure efficient care delivery under the AHEAD model.

- **Surge Policy:** During the COVID-19 public health emergency, HSCRC recognized that global budget revenue (GBR) might not adequately cover significant surges in patient volume from infectious diseases. This is because budgeted volumes are based on 2013 utilization rates, trended for population growth and market shifts. For most of the pandemic, this was not a major issue, as direct care for COVID-19 patients represented a small portion of total hospital spending. For instance, in Maryland's Medicare fee-for-service (FFS) population, COVID-19 patients accounted for 5.7 percent of total hospital spending in CY 2020 and 4.7 percent in CY 2021. Additionally, a drop in non-COVID patient volume during much of the pandemic helped offset the increase in COVID-19 patient volume. However, as non-COVID volumes returned later in the pandemic, some hospitals were underfunded when the rates from their non-COVID patient volume, combined with unexpected COVID-19 patient volume, exceeded their GBR. In response, HSCRC staff developed the surge policy to provide additional funding to hospitals when patient volume exceeded their expected GBR-calculated volume due to COVID-19 patients. The surge policy was suspended after the Omicron surge in 2022 when COVID-19 became endemic. However, COVID-19 continues to periodically strain GBR volumes, especially when combined with other respiratory illnesses like RSV, pneumonia, and influenza. Therefore, in 2025, staff reinstated the surge policy as a permanent component of global budgets. This policy now annually provides additional funding for hospitals when patient volume exceeds the expected volume used to calculate their GBR due to surges in respiratory illness volumes.
- **ED LOS Monitoring Dashboard:** This is a tool to monitor ED LOS for all patients visiting the ED and includes the ED LOS for admitted patients used in the QBR payment policy. The dashboard allows stratification of patient populations to identify areas of opportunity and monitor ED LOS for populations such as pediatric patients and patients with psychiatric diagnoses that are not included in the payment measure.
- **HCAHPS Learning Collaborative:** Launched in December 2024, the Collaborative compiles and shares best practices to help Maryland hospitals improve HCAHPS scores through improved evidence-based interventions such as interdisciplinary rounding, better in-hospital communication with patients, and post-discharge calls. Data show that longer ED LOS is associated with worse patient experience ratings, which can be addressed through the implementation of evidence-based

best practices, such as the interventions included in the ED Hospital Throughput Best Practices Policy. The QBR program also incentivizes improvements in HCAHPS.

- **New Paradigms in Care:** This program provides matching funding to hospitals to accelerate innovative solutions that avert the need for traditional hospitalization through targeted investment in transformative approaches to care delivery. As part of the RY 2026 Update Factor, the HSCRC Commission approved a $30 million Transformation Fund to match hospital investments in innovative initiatives that may be too expensive or speculative to support through the normal course of business. The funding was intended as a one-time adjustment to approved hospital rates, with participating hospitals implementing their programs in fiscal year (FY) 2026. The program received 16 proposals spanning a range of innovative approaches, including palliative care, sepsis, heart failure networks, social determinants of health, forensic nursing, and maternal health.
- **The Healthcare Outcome Payment Effort (HOPE):** This is a voluntary, upside-only outcome payment model developed by HSCRC that rewards hospitals and non-hospital partners for measurable reductions in IP and ED spending while improving population health. HOPE creates a clear, predictable, and accountable payment structure that enables hospitals, payers, and community partners to invest in interventions and share in savings. HOPE prioritizes interventions with a potential impact on ED utilization such as new and novel health failure clinics.
- **EQIP**: EQIP is a program under the AHEAD Model. EQIP engages non-hospital Medicare practitioners who care for Medicare beneficiaries in care transformation and value-based payment through an episode-based payment model approach. EQIP uses the Advance Care Plan measure (National Quality Forum Measure #326) as one of three quality measures to determine an EQIP Entity's composite quality score. The Entity's performance on this measure is combined with its performance on the other two measures to produce an overall quality score for each clinical episode category.

HSCRC concluded the Emergency Department Dramatic Improvement Effort (EDDIE), a two-year initiative from June 2023 through July 2025, that incorporated public reporting of ED metrics and quality improvement initiatives. EDDIE has served as a valuable foundation for the inclusion of ED measures in the above policies and initiatives.

In addition, HSCRC participated in the Maryland General Assembly Hospital Throughput Work Group, which was led by the Maryland Hospital Association (MHA) and convened in July 2023. The Work Group submitted a final report with recommendations in March 2024. These efforts involved close collaboration with hospitals, the MHA, legislators, MHCC, the Maryland Department of Health (MDH), patient advocates, and emergency and behavioral health providers.

MDH Initiatives

MDH is leading several initiatives that impact ED LOS, including reducing pediatric overstays, continuing to build the continuum of behavioral health care, investing in primary care, and enhancing advance directives. Each of these is briefly described below.

Pediatric Overstays

MDH has several initiatives underway to reduce pediatric behavioral health overstays in the hospital, including:

- The 211 Press 4 Program provides a single access point for ED and psychiatric IP staff to obtain care coordination services for their most complex behavioral health patients to connect them to clinically appropriate levels of care.
- MDH maintains the Behavioral Health Hospital Coordination Dashboard, which includes an IP psychiatric bed dashboard that is updated at least three times per day to help hospital discharge planners locate available beds. In 2027, MDH will be transitioning bed availability reporting from this dashboard to a web-based bed registry and referral platform, "Maryland Behavioral Health Connect," in alignment with the Maryland Mental Health and Substance Use Disorder Registry and Referral System bill.[13] In November 2025, the Board of Public Works approved a vendor, Bamboo Health, to develop the platform, which will include IP psychiatric bed availability and search capacity and will have the capability for providers to conduct electronic referrals.
- Since February 2024, MDH has piloted the first hospital overstay stabilization program in Maryland at Brook Lane Hospital. This program provides seven beds for high-intensity complex youth ages 8-17 who are overstays at IP hospital units or EDs and have been accepted into a placement. It serves as a bridge care program for youth to step-down from the hospital environment while awaiting placement. Youth receive behavioral health treatment, attend school, and participate in scheduled group activities.
- MDH, along with the Maryland Department of Human Services, established a Pediatric Hospital Overstay Coordinator who closely collaborates with impacted hospitals who have youth in overstay, post-care services and providers, local Department of Social Services where appropriate, and the Governor's Office for Children to actively and swiftly identify an appropriate discharge placement for all youth in overstay. Since the establishment of the coordinator role, the average length of time a youth in overstay has reduced from approximately 70 to 30 days, with a corresponding reduction in the number of youth in pediatric overstay.

[13] 2021 MD Laws Ch. 29.

Behavioral Health

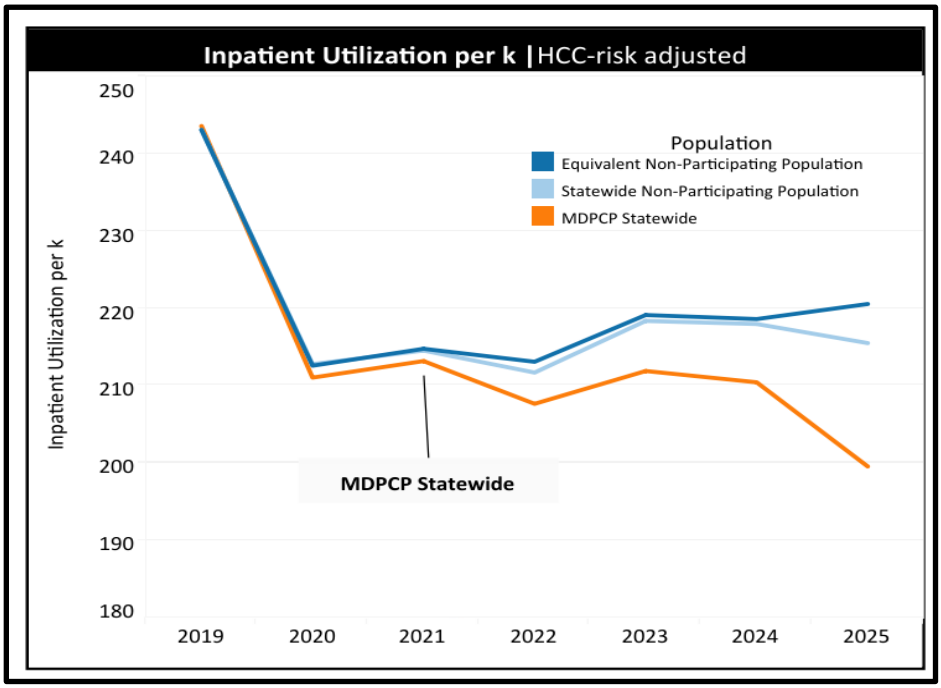
MDH is working to build a continuum of urgent and acute behavioral health services across the state that provide treatment alternatives to going to the hospital for an urgent issue or crisis. The following services provide immediate community- and facility-based support to de-escalate situations, reduce emotional distress, ensure safety, provide treatment interventions, and connect people to ongoing services. They seek to foster a pathway to recovery, improve behavioral health outcomes, and help prevent future crises.

- The 988 Lifeline provides 24/7 confidential support for Marylanders struggling with mental health, emotional distress, and/or alcohol or drug use. Compassionate counselors provide support, along with information on local resources and connections to immediate in-person services if needed. Help is provided via call, text, and chat.
- Mobile Crisis Response and Stabilization Services provide in-person community-based support deployed in real time to the location of a person experiencing an urgent behavioral health issue. Every jurisdiction has these services. As of August 2026, licensed providers are available 24/7 in 20 jurisdictions, and MDH is working with providers in the remaining jurisdictions to become licensed. Some jurisdictions also have stabilization programs to support youth and families in particular for up to eight weeks to reduce the need for a higher level of care.
- Crisis Receiving and Stabilization Facility Services provide immediate, short-term intensive crisis prevention, intervention, and stabilization support. There are a range of services, including behavioral health walk-in urgent care, urgent care by appointment, crisis beds for up to four days, and residential crisis beds for up to ten days. Montgomery County has a licensed Behavioral Health Crisis Stabilization Center that provides urgent walk-in behavioral health services for up to 24 hours to support stabilization and referral to ongoing services.
- HSCRC established the Regional Partnership Catalyst Program to advance Maryland's population health goals under the Total Cost of Care (TCOC) Model and to support investments in behavioral health crisis services infrastructure, in alignment with the Behavioral Health Administration. Between January 2021 and December 2025, HSCRC awarded $79.1 million to three organizations representing 24 hospitals to expand crisis services across Baltimore City, Baltimore County, Howard County, Carroll County, Prince George's County, and the Lower Eastern Shore. The funding has supported construction of crisis centers on the Lower Eastern Shore, expanded access to same-day and next-day behavioral health appointments for Central Maryland residents, increased the number of mobile response teams in Central Maryland and Prince George's County, and enhanced 988 helpline operations.

Primary Care

The Maryland Primary Care Program (MDPCP) began in 2019 under the TCOC Model and has continued into the AHEAD Model as MDPCP-AHEAD. MDPCP-AHEAD is a voluntary program that funds and supports the delivery of advanced primary care for Maryland Medicare recipients. Program evaluations show that MDPCP practices have consistently performed better than two comparison populations (statewide non-participating and equivalent participating populations)[14] on ED visits, IP admissions, and Prevention Quality Indicator (PQI)-like events[15] per 1,000 beneficiaries. Between 2019 and 2025, MDPCP practices had an 18 percent decrease in IP admissions per 1,000 beneficiaries, (Figure 1) and a 21 percent decrease in ED visits per 1,000 beneficiaries (Figure 2).

Figure 1. IP Utilization per 1,000 (Hierarchical Condition Categories (HCC) Risk-Adjusted Scores), 2019-2025

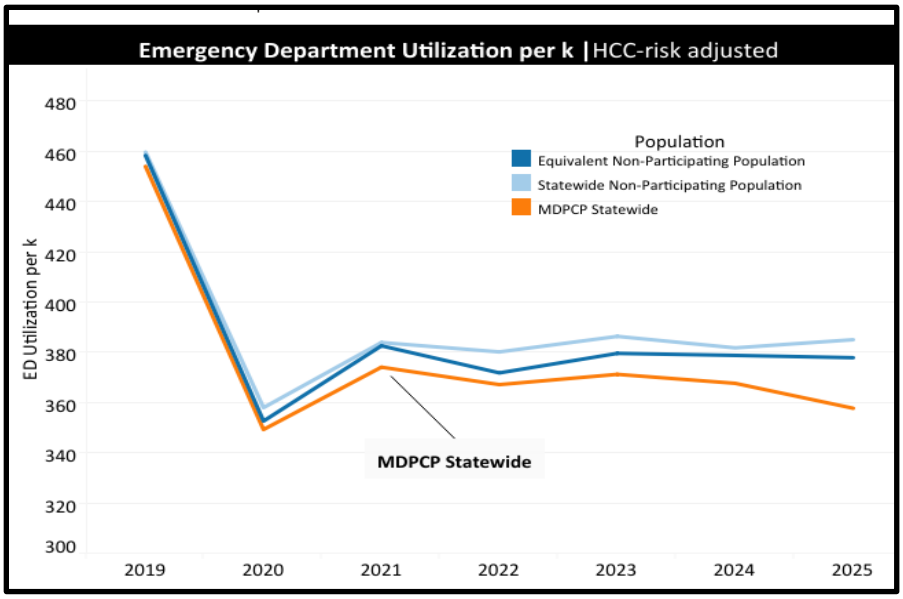


*Data sourced from the Medicare Claims and Claims Line Feed (CCLF)

[14] The statewide non-participating population includes all Medicare FFS beneficiaries who are eligible for MDPCP and attributed to a non-participating provider. The equivalent non-participating population is matched to the participating MDPCP population. This population is a subset of the statewide nonparticipating population, demographically matched to participants.

[15] PQIs measure potentially avoidable hospital events from 10 key conditions known as ambulatory sensitive conditions (ACSCs). ACSCs are conditions that should be treatable in an outpatient setting or that could be less severe if treated and managed at the outpatient level. PQIs are defined by AHRQ (Agency for Healthcare research and Quality). Maryland includes IP and ED events in this definition. For more information on AHRQ's definition of PQI: AHRQ PQI Technical Documentation, Version v2024, Agency for Healthcare Research and Quality, Rockville, MD. https://qualityindicators.ahrq.gov/measures/pqi_resources. Accessed October 21, 2024.

Figure 2. ED Utilization per 1,000 (HCC Risk-Adjusted), 2019-2025



*Data sourced from the CCLF

The Hilltop Institute at the University of Maryland, Baltimore County evaluated MDPCP using 2019–2022 data and a combination of propensity score matching and difference-in-differences analyses. The evaluation found that MDPCP reduced the probability of ED utilization by 1.7 percent.[16] MDH intends to conduct an updated evaluation of MDPCP in calendar year (CY) 2027.

Advance Directives

MDH, in collaboration with a Maryland Cancer Collaborative Workgroup, is driving a statewide program to increase awareness, education, and access to advance directives for all Marylanders, with a special focus on underrepresented groups. MDH and the Maryland Cancer Collaborative Advance Care Planning Workgroup have also engaged advance care planning and palliative care stakeholders, the Maryland State Advisory Council on Serious Illness Care, MHCC, and the Chesapeake Regional Information System for Our Patients (CRISP) in an effort to expand access to electronic advance directives. The number of electronic advance directives increased 115%, from 389,857 in 2022 to 837,196 in 2025. This number includes all the advance directives in MyDirectives (the electronic advance directives service recognized by MHCC), as well as all the data reported by health systems in Maryland. Increasing awareness in the

[16] More information on this evaluation is available here: https://hilltopinstitute.org/wp-content/uploads/publications/MDPCPEvaluation-August2024.pdf

population of the importance of designating a healthcare agent and documenting end-of-life care wishes can significantly impact many areas of healthcare, including ED utilization.

MIEMSS

Finally, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) is another state institution that impacts patients' experience with EDs in the state. MIEMSS works to coordinate Maryland's Emergency Medical Services (EMS) system in accordance with Maryland law through leadership, medical direction, support for EMS educational programs, statewide communications, regulation of trauma and specialty centers and commercial ambulance services, and public education. In addition to collecting and sharing daily bed and occupancy data, MIEMSS also collects EMS turnaround times by hospital, which is anticipated to be added to the CRISP ED Monitoring Dashboard starting in CY 2027. The MIEMSS team has been an integral partner in the work to reduce ED LOS and has representatives who actively participate in the ED Commission and all associated Subgroups.

Background on Emergency Department Wait Times in Maryland

ED LOS has been a longstanding challenge in Maryland, exceeding national averages for more than 20 years. The most recent national data through September 2025 rank Maryland as having the second longest ED LOS in the nation.[17,18] The concerns about ED LOS and the impact on patient experience and hospital efficiency predate the implementation of the AHEAD Model (formerly the All-Payer and TCOC Models). There are many potential reasons for the extended ED LOS that suggest broader, systemic factors are contributing to Maryland's longer LOS. State-level averages are influenced by population density and do not account for acuity. States with a higher number of lower-volume, lower-acuity EDs may have shorter ED LOS, while states with a higher concentration of complex, high-acuity EDs may show longer times than peers.[19]

To effectively assess ED performance, experts recommend evaluating performance against a cohort of similar facilities that account for both patient volume and acuity.[20] Findings to date show that Maryland hospitals, on average, are larger, more complex, and a greater proportion are academic teaching facilities. While these institutions tend to deliver superior outcomes in such areas as risk-adjusted mortality and

[17] CMS Care Compare data, available here: https://data.cms.gov/provider-data/dataset/apyc-v239.
[18] Bean, M., & Jeffries, E. (2026, August 20). Rankings and ratings: ED visit times, by state. *Becker's Hospital Review*. Retrieved September 9, 2026, from https://www.beckershospitalreview.com/rankings-and-ratings/ed-visit-times-by-state/.
[19] Bean, M. (2026, April 24). The quiet gaps in ED performance data — and what execs can do about them. *Becker's Hospital Review*. Retrieved September 11, 2026, from https://www.beckershospitalreview.com/care-coordination/the-quiet-gaps-in-ed-performance-data-and-what-execs-can-do-about-them/
[20] Bean, M. (2026, April 24). The quiet gaps in ED performance data — and what execs can do about them. *Becker's Hospital Review*. Retrieved September 11, 2026, from https://www.beckershospitalreview.com/care-coordination/the-quiet-gaps-in-ed-performance-data-and-what-execs-can-do-about-them/

readmissions, these same structural features that allow these facilities to provide complex care can contribute to increased time for ED throughput and patient flow.[21] When these structural differences are accounted for, Maryland hospitals' ED LOS are found to be more consistent with similar facilities and less of an outlier than a comparison to the unadjusted national average would suggest. Nonetheless, national examples of similarly large and complex hospitals achieving better ED LOS performance indicate that improvement is achievable.

In addition, data from the 2024 American Community Survey show that Maryland's population is aging faster than the nation, which may further exacerbate ED LOS with increased patient acuity and more complex hospitalizations. The state is also expecting shifts in insurance status as Maryland implements the new Medicaid eligibility requirements in H.R.1. Uninsured individuals tend to be more likely to use the ED for routine care.[22] Research has shown that long ED wait times increase the likelihood of patients leaving without being seen, with these patients experiencing higher rates of ED return visits, hospital admission, and morbidity and mortality within 30 days.[23] Specifically, one study showed that extended ED LOS is associated with an increase in all-cause 30-day mortality,[24] and another indicated that, for older patients, waiting overnight in the ED for admission to an IP unit was associated with increased in-hospital mortality and morbidity.[25]

Establishment of the Maryland Emergency Department Wait Time Reduction Commission

Legislative Mandate and Guiding Framework

The ED Commission is charged with working to develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED LOS, including initiatives that:

- Ensure patients are seen in the most appropriate setting
- Improve hospital efficiency by maximizing flow of ED and IP throughput

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[21] Burke, L. G., Frakt, A. B., Khullar, D., Orav, E. J., & Jha, A. K. (2017). Association between teaching status and mortality in US hospitals. *JAMA: The Journal of the American Medical Association, 317*(20), 2105–2113. https://doi.org/10.1001/jama.2017.5702

[22] Scott, K. W., Scott, J. W., Sabbatini, A. K., Chen, C., Liu, A., Dieleman, J. L., Duber, H. C. (2021). Assessing catastrophic health expenditures among uninsured people who seek care in US hospital-based emergency departments. *JAMA Health Forum*, *2*(12). https://doi.org/10.1001/jamahealthforum.2021.4359

[23] Joseph JW, Bukhman AK, Baymon DE, et al. *Mortality and Return Visit Frequency Among Emergency Department Patients Who Leave Without Being Seen at a Regional Health Care System.* Joint Commission Journal on Quality and Patient Safety. 2025;51:466–473.

[24] Jones, S., Moulton, C., Swift, S., Molyneux, P., Black, St., Mason, N., Oakley, R., & Mann, C. (2022). Association between delays to patient admission from the emergency department and all-cause 30-day mortality. Emergency Medical Journal, 39(3), 168-173. https://doi.org/10.1136/emermed-2021-211572

[25] Roussel, M., Teissandier, D., Yordanov, Y., Balen, F., Tazaroute, K., Bloom, B., Catoire, P., Berard, L., Cachanado, M., Simon, T., Laribi, S., & Freund, Y. (2023). Overnight stay in the emergency department and mortality in older patients. JAMA Internal Medicine, 183(12), 1378-1385. https://doi.org/10.1001/jamainternmed.2023.5961

- Improve post discharge resources to facilitate timely ED and IP discharge
- Identify and recommend improvements for data collection and submission
- Facilitate sharing of best practices

Appendix II contains a figure showing the ED Commission's priorities in greater detail.

ED Commission Members and Meetings

The ED Commission is effective from July 1, 2024, through June 30, 2027. To support its work, the ED Commission also established four Subgroups in its first year and three Subgroups in its second year, each charged with completing collaborative projects and reporting on its designated scope of work to the full ED Commission. Table 1 lists the ED Commission members.

Table 1. ED Commission Appointed Members

Required Agency Representative/Subject Matter Expertise	Associated Member
Maryland Department of Health Co-Chair	Laura Herrera-Scott, MD Elizabeth Kromm, PhD
HSCRC Co-Chair	Jonathan Kromm, PhD Alyson Schuster, PhD (current)
Executive Director of the Maryland Institute for Emergency Medical Services Systems	Ted Delbridge, MD
Executive Director of the Maryland Health Care Commission or Designee	Wynee Hawk, RN, JD Douglas Jacobs, MD, MPH
Two individuals who have operations leadership responsibilities over a hospital Emergency Department in the State, including one Emergency Department physician	Neel Vibhakar, MD (University of Maryland Medical System) Dan Morhaim, MD (Independent Physician, Former Delegate)
One individual with professional experience in an Emergency Department who is not a physician or an advanced practice provider	Barbara Maliszewski, RN (Johns Hopkins Health System)
One representative of a local Emergency Medical Service	Danielle Knatz (EMS Baltimore County Fire Department)
One representative of a managed care plan with experience in care management or care coordination	Amanda Bauer, DO (Kaiser Permanente)
One representative of an advanced primary care practice	Mary Kim, MD (Adventist Health System) Vacant as of July 2026
One representative of the Maryland Hospital Association	Andrew Nicklas, JD (Maryland Hospital Association)
One representative of a patient advocacy organization	Toby Gordon, ScD (Johns Hopkins University, Maryland Citizens' Health Initiative)
One representative of a behavioral health provider	Johnathan Demetris Davis (CarePoint Response)

The ED Commission met 11 times in total prior to the submission of the final report, and the subgroups altogether had a total of 28 meetings. The ED Commission and associated Subgroup meetings were

predominantly held virtually and in compliance with the Open Meetings Act. Meeting dates, presentations, and meeting recordings are posted on the ED Commission's webpage.[26] See Appendix III for a detailed list of meeting dates and corresponding agenda topics.

ED Commission Subgroups

Four Subgroups were initially established to report their specific scope of work back up to the ED Commission. Details on the initial Subgroup deliberations are described in the ED Commission's interim report. These were consolidated into three Subgroups in 2026: (1) ED-Hospital Throughput Best Practices, (2) Data, and (3) Access and Capacity. ED Commission Subgroups were scheduled to meet every six to eight weeks as needed. Subgroups included official members of the ED Commission, as well as other subject matter experts on the specific policy areas under consideration. Through their leadership, the Subgroups helped advise on recommendations to build a more responsive, coordinated, and sustainable emergency care infrastructure that supports the state's long-term health care vision. Figure 3 below summarizes each Subgroup's charge.

Figure 3. ED Wait Time Reduction Commission Subgroups

ED-Hospital Best Practices	Data Subgroup	Access and Capacity
Priority Focus: • Development of best practices that will improve hospital and ED throughput and decrease ED LOS • To provide input into the methodology for ED-related pay for performance metrics **Action Items/ Deliverables in Progress:** • Hospital reporting on a minimum of two Best Practices implemented to improve ED-Hospital Throughput • Refine Quality Based Reimbursement (QBR) ED LOS methodology and incentives • Develop a statewide learning collaborative for acute care hospitals that focuses on capacity and throughput opportunities statewide, regionally, and locally	**Priority Focus:** • Identify existing data and develop reports that can be used to identify and quantify opportunities across the continuum of care. **Action Items/Deliverables in Progress:** • Develop a model that quantifies impact of interventions on ED LOS • Develop an ED LOS dashboard to track performance and identify benchmarks for improvement • Support data analysis needs for other subgroups	**Priority Focus:** • Recommendations for improvement opportunities related to capacity, operations and workforce across the continuum of care, with a priority focus on care transition and post-acute access **Action Items/Deliverables in Progress in Progress:** • Proposal & Recommendations to Regulatory Agencies and Legislature on Post-Acute Care Opportunities (in alignment with MHCC led work) • Bed Count and Capacity Analysis/Tracking • Recommendations for alternate capacity types (ex. Hospital at home, Palliative Care, Hospice)

[26] https://hscrc.maryland.gov/pages/ed-wtr-commission.aspx

ED-Hospital Throughput Best Practices Subgroup

The pre-existing HSCRC Best Practice Workgroup transitioned into this Subgroup, with a focus on developing a set of hospital best practices to improve hospital throughput and reduce ED LOS, advise on revenue at-risk and scaled financial incentives for hospitals, and provide input on data collection and auditing. The Best Practices Subgroup met ten times between December 2024 and October 2026. This multidisciplinary group includes hospital leaders, emergency clinicians, behavioral health professionals, and community stakeholders. Together, they guided the development and dissemination of strategies to improve ED and hospital throughput, reduce avoidable utilization, and support more coordinated, patient-centered care. Given the complexity and high resource demands of emergency care, the Subgroup's work is essential to Maryland's broader health system transformation.

Beyond policy development to inform HSCRC quality programs, the Subgroup served as a collaborative platform for sharing data, best practices, and local innovations. This approach allowed hospitals to tailor interventions to their specific needs while advancing system-wide goals. By advising on performance metrics and supporting policies that align incentives with high-value care, the Subgroup reinforced Maryland's AHEAD Model and its focus on outcomes over volume. The HSCRC is proposing to transition this pay-for-reporting policy to a learning collaborative in 2027. The purpose of the collaborative is to engage hospital leaders, as well as post-acute providers, state agencies, and other stakeholders, to identify best practices to address ED and hospital throughput, care transitions, and capacity alignment across the care continuum.

Data Subgroup

The Data Subgroup focused on identifying, developing, and integrating data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data. A key responsibility of the Subgroup includes directing and performing analyses aligned with the ED Commission's priorities. The Subgroup examined how Maryland's ED LOS performance compares to national benchmarks, both prior to and during the implementation of global budgets under the All-Payer Model in 2014. The Data Subgroup met seven times, not including multiple informal working meetings, during which several members contributed to and reviewed more detailed analyses.

This Subgroup also contributed to numerous HSCRC-led projects, including a new ED LOS dashboard that is accessible to stakeholders across the state who have access to the CRISP Reporting Services portal. The ED LOS dashboard allows for tracking and stratification by specific types of ED encounters or other characteristics (e.g., payer, discharge destination). Future enhancements to the dashboard under consideration include incorporation of other outcomes besides ED LOS, such as leaving without being seen or IP LOS. This Subgroup also developed a simulation platform that estimates the expected impact of

targeted interventions on ED LOS and has produced preliminary results on the efficacy of multiple such interventions. This modeling and accompanying results are discussed later in this report.

Access and Capacity Subgroup

The Access and Capacity Subgroup focused on integrating and optimizing best practices and data analytics for care that occurs outside of the acute care facility. The overarching goal is to reduce avoidable ED and hospital utilization while improving care transition workflows throughout the continuum of care. The Subgroup met 11 times.

This Subgroup focused on two key areas: 1) managing care transitions to post-acute healthcare environments that provide ongoing support following an IP or ED discharge (collectively termed post-acute care), and 2) assessing patient care capacity across community, acute care, and post-acute care settings. Ensuring timely, efficient transitions from hospitals to skilled nursing facilities (SNFs) and other post-acute care settings remains an ongoing challenge in Maryland.

Building on the Subgroup's initial work, the MHCC and HSCRC collaborated with the legislature to support the passage of the Emergency Room Services and Post-Acute Care - Coverage and Studies bill.[27] As discussed earlier in this report, this bill contains three core components, two of which align directly with the Subgroup's priorities:

- **Capacity & Bed Availability Assessment:** Accurately tracking bed count data in acute and post-acute facilities statewide are essential for creating targeted interventions that streamline throughput and reduce ED LOS.
- **Care Transitions & Resource Allocation:** Establishing smooth care transitions from acute to post-acute settings, backed by appropriate staffing and resources, forms a vital link in the patient care continuum.

Both priorities are actively being addressed through the initiatives mandated by this bill. Specifically, the care transition component is examined in depth in MHCC's post-acute report, which was developed following a comprehensive series of focus group meetings.[28]

Developing recommendations to address prior authorization delays and denials was identified as a third priority for this group. While several recommendations regarding prior authorizations were drafted, the group elected to defer to the Adverse Decisions Workgroup, which consists of subject matter experts in the payer and utilization domains, and submitted its recommendations to them in August 2026. Due to the timing of the Adverse Decisions Workgroup report, the ED Commission will also make these recommendations directly to the MIA and the Maryland General Assembly.

[27] 2026 MD Laws Ch. 165.
[28] Strengthening Post-Acute Care towards Meeting the Goals of AHEAD. Available at https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

Section II. Key ED Wait Time Metrics and Data Findings

As outlined below, Maryland has sub-optimal performance on ED LOS. However, to understand this concern and drive improvement, it is important to consider other key data elements, including demand for ED services, hospital operational efficiency as evaluated by IP LOS (which can have a negative impact on ED LOS), availability of post-acute beds, and the uniqueness/complexity of Maryland hospitals that allows for greater clinical offerings and physician training opportunities.

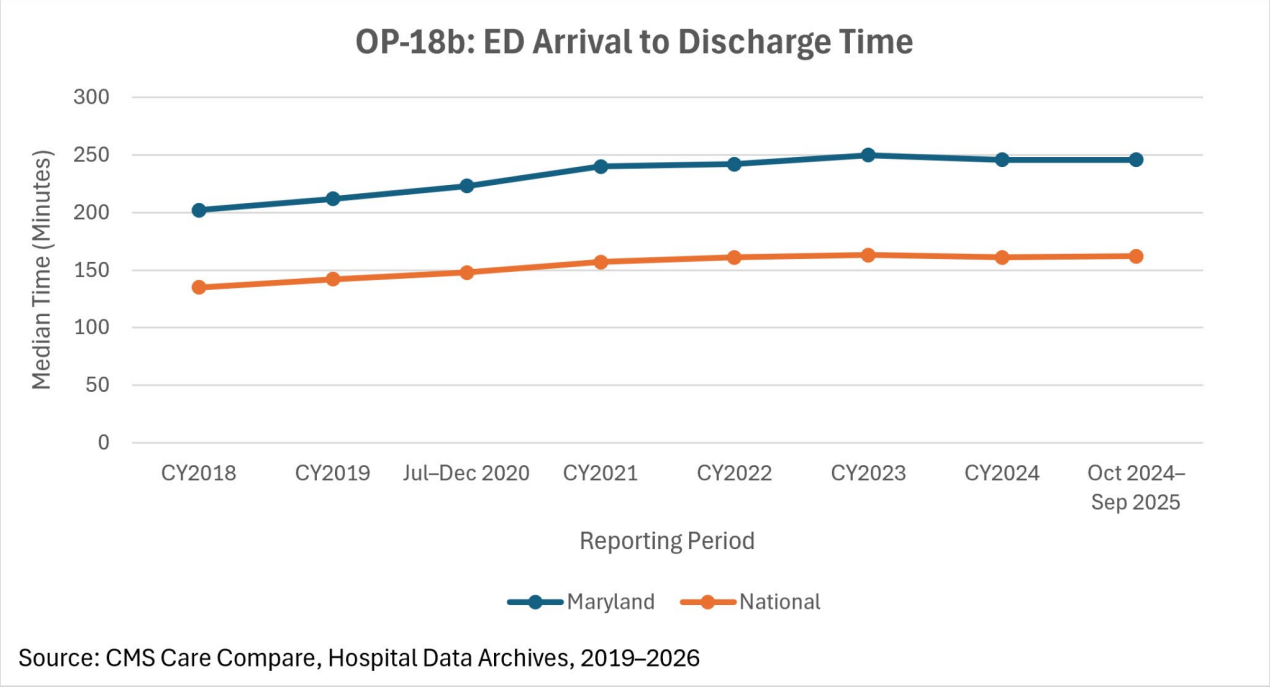
Emergency Department Length of Stay Performance

National data on ED LOS have been limited. CMS has reported several ED throughput measures, including ED-1 (overall ED LOS for admitted patients), ED-2 (time from admission decision to hospital admission), and OP-18 (time from ED arrival to discharge for patients discharged from the ED). However, ED-1 and ED-2 were discontinued in 2019 and 2020 respectively, leaving OP-18 as the primary CMS measure currently available for assessing ED LOS. CMS measures are also based on sampled patient records rather than all ED encounters.[29]

Available CMS data indicate that Maryland has consistently had longer ED LOS than the national average. For OP-18b,[30] which measures time from ED arrival to discharge, Maryland remained above the national average throughout the available reporting periods (Figure 4). From October 2024–September 2025 (the most recently available CMS data), Maryland's ED LOS for discharged patients was 246 minutes, compared with 162 minutes nationally.[31] Although not shown, CMS data on ED LOS for admitted patients, discontinued in 2019, similarly show that Maryland had much longer ED LOS than the nation.

[29] Centers for Medicare & Medicaid Services (CMS), *Hospital Inpatient Quality Reporting Program* and *Hospital Outpatient Quality Reporting Program*, Emergency Department Throughput Measures.
[30] OP-18b excludes psychiatric/mental health patients and patients transferred to another facility. Centers for Medicare & Medicaid Services (CMS), *Hospital Data Dictionary*, Emergency Department Throughput Measures.
[31] Centers for Medicare & Medicaid Services (CMS), *Care Compare, Timely and Effective Care - Emergency Department Throughput*, reporting period October 1, 2024–September 30, 2025.

Figure 4. ED Arrival to Discharge Time (OP-18b),[32] Maryland Compared with the National Average, CY 2018–2025



Source: CMS Care Compare, Hospital Data Archives, 2019–2026

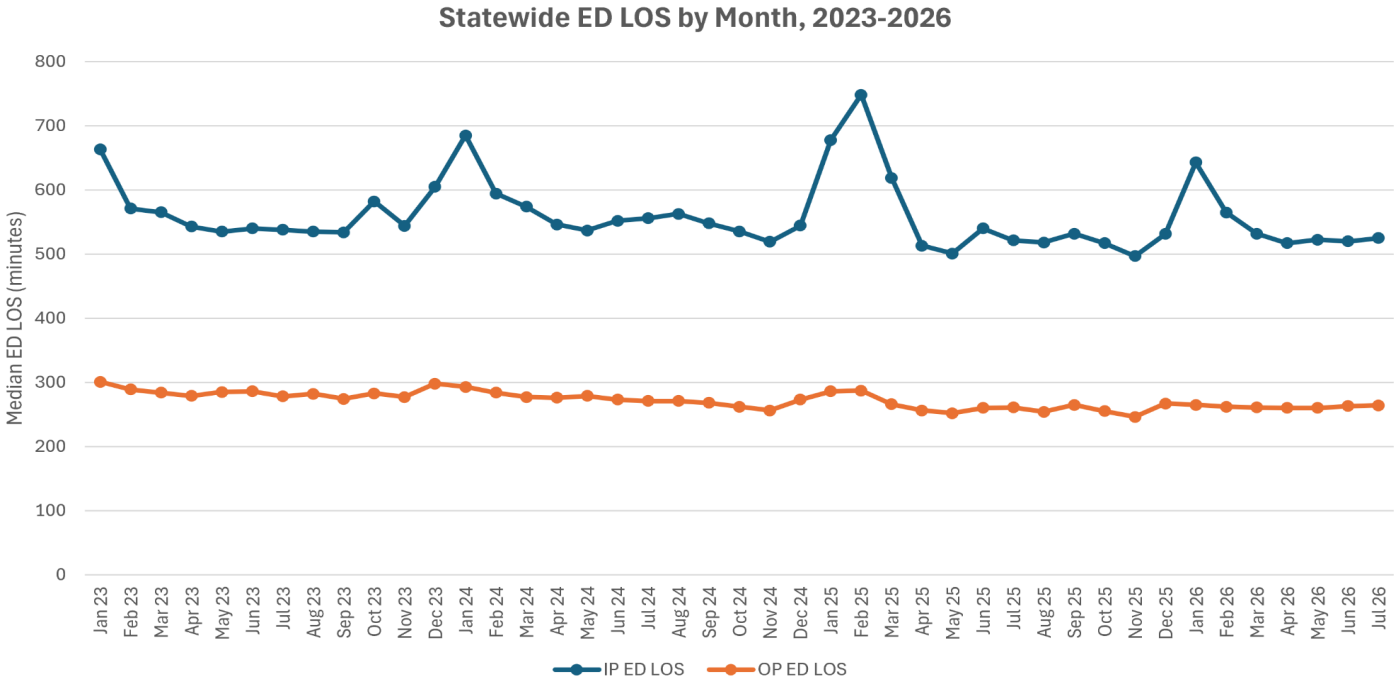
Given the limitations and the lack of consistent national ED LOS data, HSCRC developed its own ED LOS reporting process in conjunction with hospital stakeholders in CY 2024. This was to support an HSCRC vote to add an ED LOS measure for admitted patients to the QBR pay-for-performance program. The process requires hospitals to submit patient-level date and time stamps for all ED encounters. These data allow ED LOS to be calculated across reported encounters and provide more timely monitoring of IP and outpatient (OP) ED LOS.[33]

HSCRC data show that statewide IP ED LOS decreased from 562 minutes in 2023 to 551 minutes in 2025, with some seasonal fluctuations, while OP ED LOS decreased from 285 minutes in 2023 to 262 minutes in 2025 (Figure 5). While the statewide changes are modest, hospital-level performance varied considerably, particularly for the IP ED LOS measure used in the HSCRC QBR payment program (Figure 6a). Between 2023 and 2026 (rolling 12-months through August), 25 of 41 hospitals experienced reductions in IP ED LOS, with improvements ranging from 27 to 508 minutes; one hospital had no change; and 15 hospitals experienced increases. While the largest improvements were seen among hospitals with high ED LOS in 2023, more than 50% of hospitals that improved had an ED LOS in 2023 that was less than the statewide median. For OP ED LOS from 2023 through 2025, 36 of 49 hospitals experienced reductions, with

[32] This measures the median time from ED arrival to ED departure for discharged patients, excluding psychiatric/mental health and transferred patients.
[33] Maryland Health Services Cost Review Commission (HSCRC), *Emergency Department Length of Stay Dashboard*, CRISP Reporting Services.

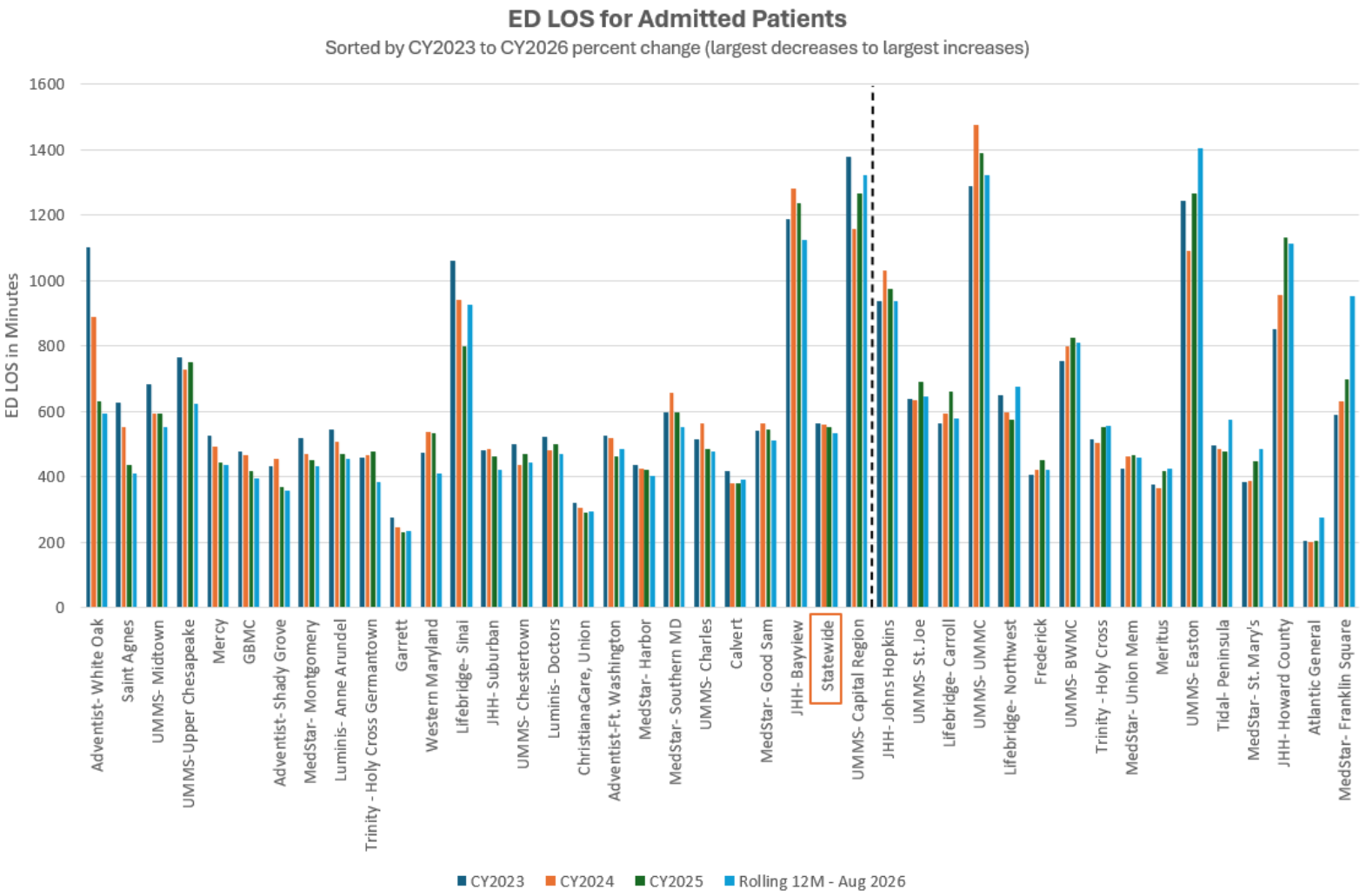
improvements ranging from 1 to 106 minutes; 2 had no change; and 11 had increases (Figure 6b). Appendix IV provides hospital data for IP and OP ED LOS by year.

Figure 5. Statewide Emergency Department Length of Stay by Month, CY 2023–CY 2026 YTD



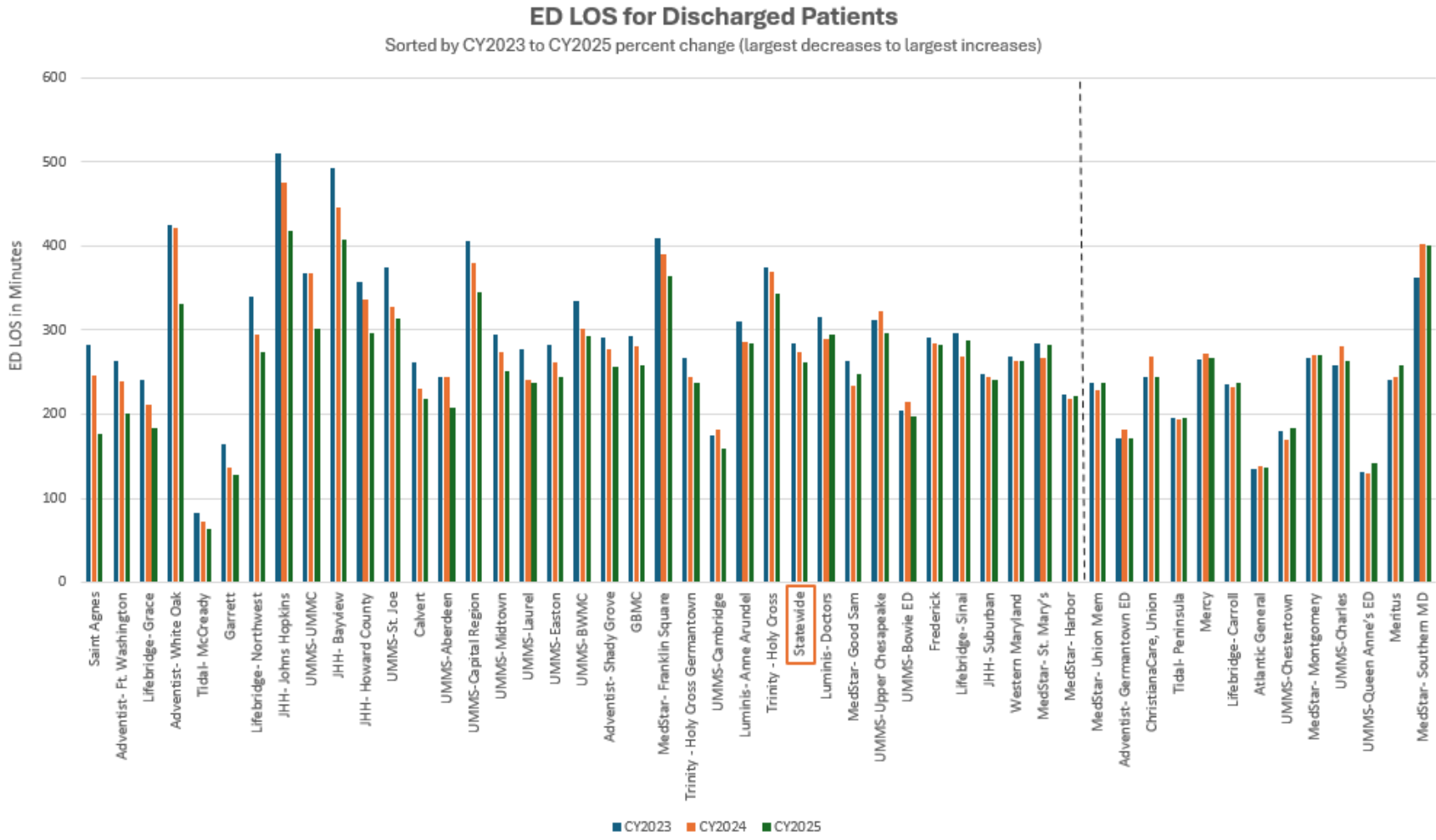
Note: CY 2026 data are YTD through July; April-July data are preliminary.
Source: CRISP Reporting Services, HSCRC ED LOS Dashboard.

Figure 6a. Emergency Department Length of Stay by Hospital, CY 2023–CY 2026



Source: Staff Analysis

Figure 6b. Emergency Department Length of Stay by Hospital, CY 2023–CY 2025

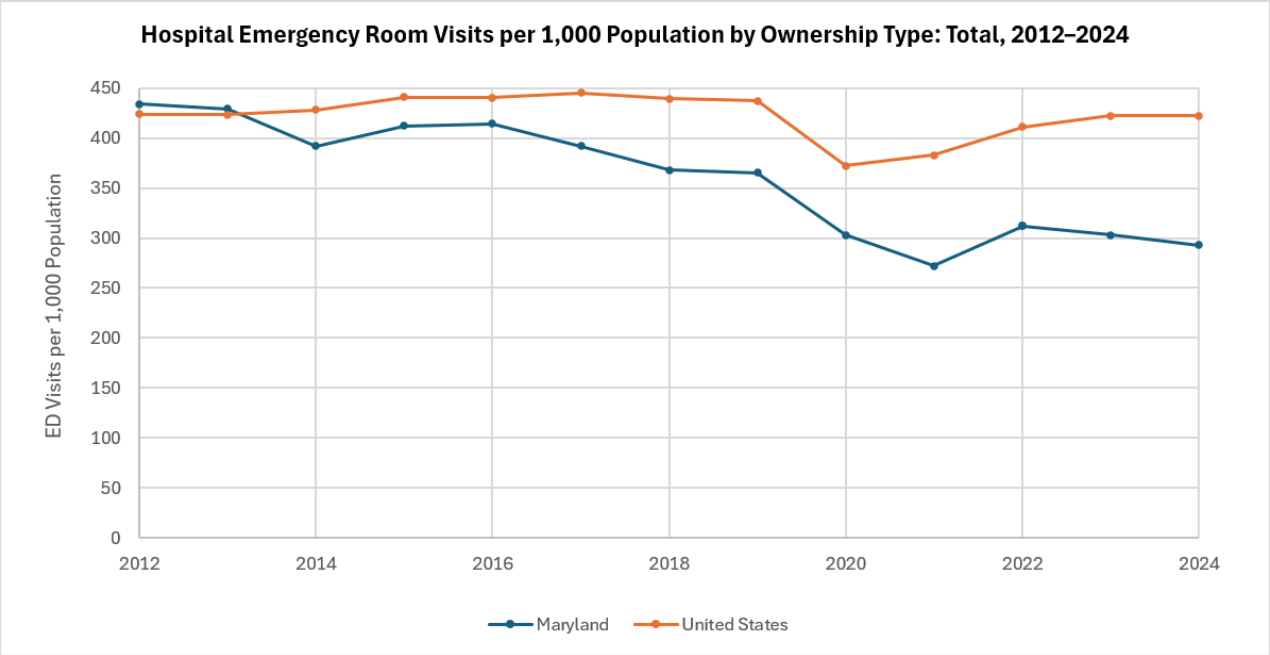


Source: Staff Analysis

Emergency Department Visits Per Capita

Independent analyses show a meaningful decline in ED visits in Maryland since the start of the Maryland model. Specifically, Kaiser Family Foundation data show that since 2012, fewer Maryland residents per capita seek care in the ED compared to national averages.[34] In addition, the Center for Medicare and Medicaid Innovation's (CMMI's) independent evaluation of the TCOC Model found that "the model reduced Medicare fee-for-service outpatient ED visits and observation stays by an average of 24.5 visits per 1,000 beneficiaries or 5.9 percent (90 percent confidence interval: 32.9, 16.1) during the first four years of the TCOC Model."[35]

Figure 7. Hospital ED Visits per 1,000, Maryland Compared with the National Average, CY 2012-2024



Source: KFF Health Facts

These reductions likely reflect the unique Maryland model and Maryland's investments in primary care, behavioral health, and community health programs. By encouraging care outside of hospital settings, like outpatient community clinics, the Maryland Model has contributed to declines in avoidable hospital use, including 30-day all-cause readmissions and avoidable admissions. While the need to coordinate and manage such care may lead to longer stays for some patients, ultimately the goal is to help prevent

[34] Kaiser Family Foundation. *Hospital emergency room visits per 1,000 population by ownership type.* Retrieved August 26, 2025, from https://www.kff.org/other-health/state-indicator/emergency-room-visits-by-ownership

[35] Mathematica. (2024, April). *Evaluation of the Maryland Total Cost of Care Model: Progress Report*. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt

unnecessary hospital visits, move appropriate services to lower acuity settings, and contribute to long-term health improvements. Otherwise stated, Maryland is reducing ED utilization by connecting individuals to appropriate care settings. For patients who still present to the ED with primary or behavioral health needs, care coordination may lengthen the current visit but is intended to reduce future ED utilization.

Additionally, the growth of urgent care centers and other community-based options has helped reduce ED volume among less acute patients. However, the volume of higher acuity patients who need to be admitted to the hospital from the ED has remained relatively unchanged. This means that, while fewer people overall are visiting the ED, the volume of ED visits being admitted is the same. The IP LOS and care transition delays contribute to boarding, which contributes to increased ED LOS. Thus, fewer people coming into the ED does not necessarily equate to shorter ED LOS. Figure 8 shows that the volume of patients admitted from the ED by each hospital ranged from 2-24 percent in FY 2026, which is similar to data for FY 2025. Figure 9 shows the percentage of IP admissions originating in the ED by hospital in FY 2026, which remained similar to FY 2025. Despite declining ED volume, the percentage of patients seen in the ED who are admitted and the percentage of overall inpatients who come through the ED have remained stable.

Figure 8. Percentage of ED Patient Visits Admitted by Hospital, FY 2026

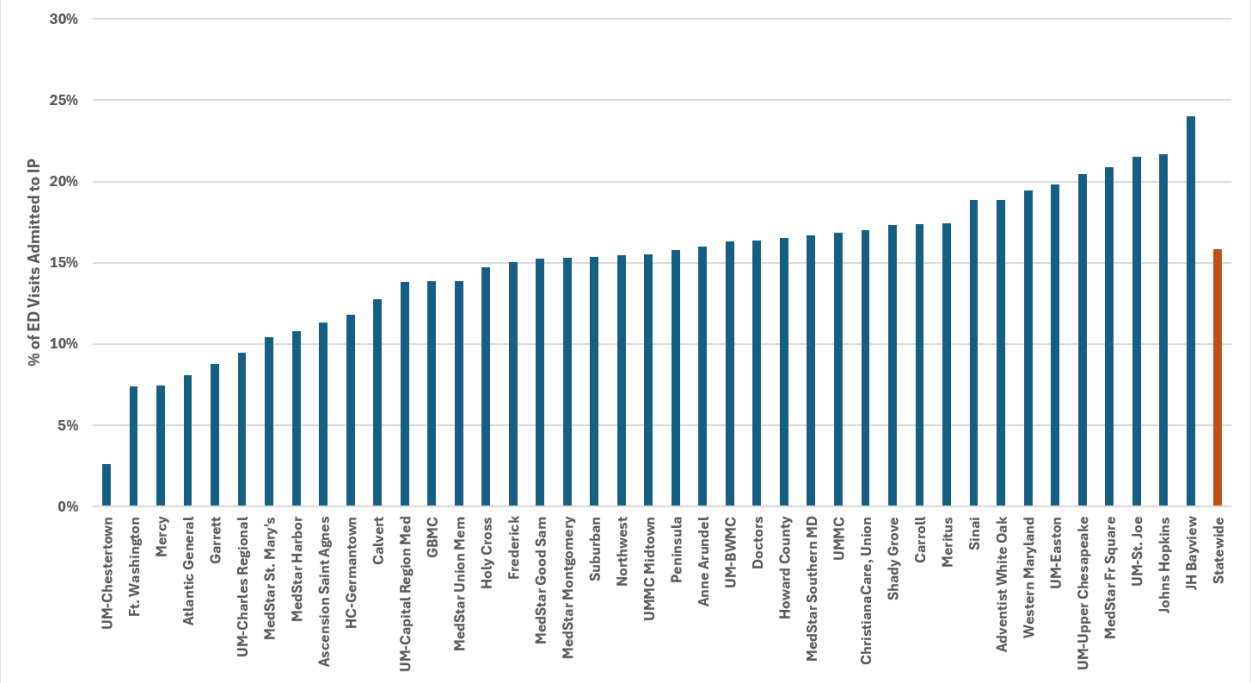
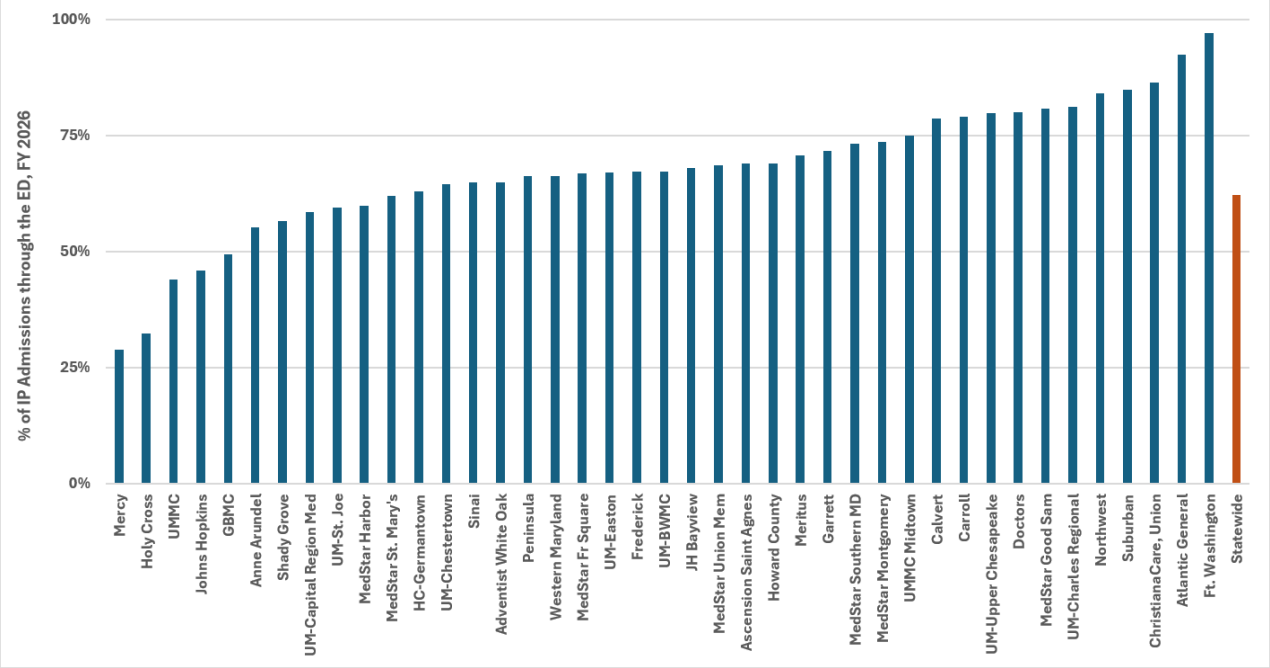


Figure 9. Percentage of Inpatient Admissions Originating in the ED by Hospital, FY 2026



Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Inpatient Length of Stay

Statewide data from 2023 to 2026 year-to-date (YTD) show that the unadjusted, average IP LOS varies significantly based on discharge disposition. Appendix V shows CY 2023 to CY 2025 IP LOS by discharge disposition for Maryland hospitals, as well as the statewide average IP LOS. As shown in the tables in Appendix V, compared to routine home discharge without services, the unadjusted IP LOS was 2.9 to 3.3 days longer for those discharged home with home health, 5.7 to 6.2 days longer for those discharged to SNFs, and 10.1 to 13 days longer for patients discharged to long-term care hospitals (LTCHs). These delays are attributed to numerous factors, including patient acuity and complexity of care, barriers within the prior authorization process, limited weekend admission availability for post-acute facilities, regional shortages of post-acute beds and/or trained staff, and operational opportunities for improvement within both the acute and post-acute facilities. These longer hospital stays slow down how quickly patients are admitted, treated, and discharged from IP units, known as throughput. When throughput is slowed down on the IP side, ED boarding results.

Maryland hospitals experienced notable shifts in IP LOS patterns since the COVID-19 pandemic, with important implications for ED performance. Maryland's IP LOS was evaluated against national trends using the Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample, a representative sample of discharge records from non-federal acute-care U.S. hospitals maintained by the federal Agency for

Healthcare Quality and Research. After adjusting for All-Patient Refined Diagnosis-Related Group, severity of illness, and payer mix, 75% of Maryland hospitals fall below the national average on risk-adjusted IP LOS, while 25% are above the national average. Longer IP stays create downstream bottlenecks that directly increase ED LOS by delaying bed availability for admitted patients.

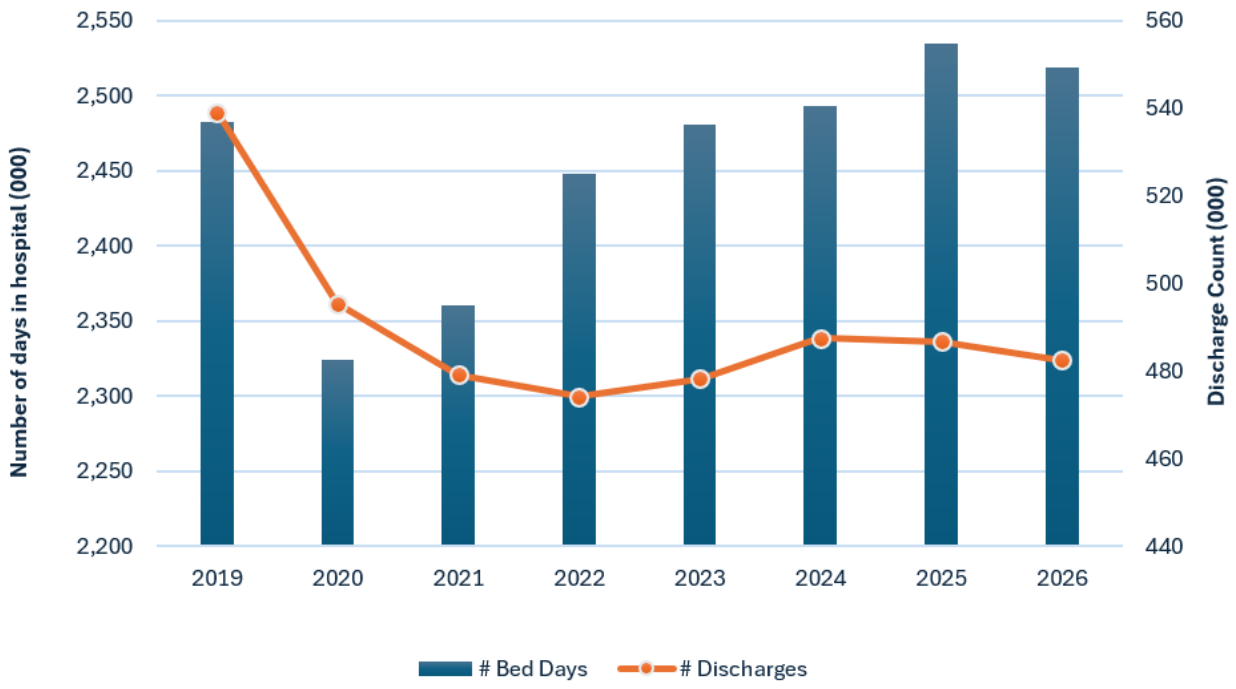
The data trend from FY 2019 to 2026 underscores this challenge: despite a 10 percent reduction in IP admissions between 2019 and 2026, driven largely by the migration of surgical procedures to outpatient and ambulatory surgery centers, total patient bed days increased by approximately 1.5 percent over the same period (Table 2). This difference highlights a shift in hospital throughput, where fewer admissions are occupying more IP capacity (Figure 10). The persistent increase in bed days, despite lower discharge volume, reflects both operational and care-transition constraints. If hospitals were able to return to their 2019 risk-adjusted LOS levels, the Maryland system would effectively gain the equivalent capacity of 144 staffed beds statewide. While this could be an important potential relief to current throughput pressures, some ED Commissioners raised concerns that the aging of the population may not make this realistic. Appendix VI provides data on population aging and trends in IP LOS by age group, showing recent decreases in IP LOS for those aged 75+. The ED Commission recognizes these improvements may not be easy and will require coordinated efforts among hospitals, state agencies, and post-acute care providers. While hospitals hold primary responsibility for patients discharged to home, optimizing transitions to post-acute settings requires partnership across multiple stakeholder groups and is essential for reducing avoidable inpatient days and restoring systemwide flow efficiency.

Table 2. Sum of Bed Days by Type of Daily Hospital Service, Casemix Inpatient, 2019 vs 2026

Hospital Unit	Bed Days FY 2019	Bed Days FY 2026
Medicine	1,358,006	1,529,920
Surgery	289,190	238,372
Newborn	210,696	171,592
Psychiatry	198,620	157,336
Obstetrics	166,446	143,012
Pediatrics	87,008	88,188
Other/Unknown	172,419	190,738
Total	**2,482,385**	**2,519,158**
Bed Count (Total/365)	**6,801**	**6,902**

Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Figure 10. Sum of Patient Bed Days vs Inpatient Discharges, 2019-2026



Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Hospital Bed Capacity

ED Commission members also noted that Maryland's hospital bed capacity contributes to ED LOS. Appendix VII presents data on IP bed totals by state from the American Hospital Association annual survey. In 2024, Maryland ranked 47th in the nation in terms of IP beds per capita (i.e., in 2024, only 4 states had lower beds per capita). However, a simple state-level bed capacity value does not reflect the complexity of the healthcare system. Maryland is a geographically small state with significant potential for border crossing. Further, heavily rural states will have higher bed counts due to the lower population density they serve, and the funding allocated to keep small, local hospitals operational. The Maryland Model creates powerful incentives for hospitals to reduce IP admissions, Thus, a lower bed count in Maryland is not unexpected. Two other indicators provide additional information on the availability of resources for Maryland residents seeking care at hospitals: the number of IP beds per 100 IP admissions and the number of IP beds per 1,000 ED visits. Based on HSCRC analyses, the state ranked 20th in the nation on IP beds per 1,000 ED visits, and 34th on IP beds per 100 IP admissions, according to data from the 2023 American Hospital Association survey.

Maryland vs. Nation – Understanding Structural Differences in ED Performance

When evaluating ED performance in Maryland—particularly such metrics as LOS—it is also important to account for the structural differences between Maryland's hospitals and those in other states. These distinctions extend beyond statistical variation; they influence care delivery and help define the underlying challenges facing the system. In 2023, HSCRC staff conducted an analysis of hospital characteristics and their relative impacts on ED LOS across 4,215 acute care facilities, including 41 Maryland hospitals, 370 hospitals in the Mideast region outside of Maryland, and 3,804 hospitals in other U.S. regions.[36] The study separately examined impacts for patients admitted to the hospital following an ED visit and for those discharged directly from the ED. It also identified key structural differences between Maryland hospitals and those nationwide. Findings included the following:

- **Hospital Size and Volume:** Maryland hospitals are larger, on average, than the nation, caring for more patients in both ED and IP settings and managing more surgical cases. High volume can drive quality in many areas, but it also creates pressure points, especially when IP beds are full and ED patients must wait for admission.
- **Teaching and Academic Complexity:** A higher proportion of Maryland hospitals are affiliated with academic medical centers, which are essential for training, workforce development, and clinical innovation. These institutions are equipped to successfully treat patients with the most severe illnesses, but their size and complexity can slow clinical workflows.
- **ED Size and Scope:** EDs in Maryland are physically larger and serve more patients, on average, relative to the nation. This adds operational complexity and makes smooth patient flow harder to maintain, particularly during periods of increased patient demand due to seasonal respiratory illnesses or other factors, known as "surges."
- **Intensive End-of-Life Care:** Maryland hospitals provide more intensive care unit-level care near the end of life, on average, than hospitals elsewhere. While this may reflect patient needs and preferences, it further strains IP capacity and can contribute to ED overcrowding. Further, this finding suggests limited access to alternative care settings. MDH, in collaboration with the Maryland Cancer Cooperative Workgroup, is driving a statewide program to increase awareness of, education on, and access to advance directives for all Marylanders, with a special focus on underrepresented groups. The impact of increasing awareness in the population of the importance of designating a healthcare agent and documenting end-of-life care wishes impacts many areas of healthcare, including ED utilization.

[36] Health Services Cost Review Commission. (2023, December). Hospital and regional factors associated with ED length of stay [Presentation]. https://hscrc.maryland.gov/Documents/December%202023%20HSCRC%20Public%20Post-Meeting%20Materials%20-%20Final.pdf

- **Post-Acute Resource Gaps:** Maryland faces a relative shortage of post-acute beds compared to other states. This makes it harder to discharge patients who no longer need acute care, leading to bottlenecks on IP units and longer waits for ED patients needing admission. According to the Nursing Home Compare Data released in July 2025, Maryland is ranked 30th in the country for post-acute bed capacity, requiring 1,688 additional LTCH and SNF beds to meet the national average.[37] While we have not yet completed modeling to determine the impact of changes in post-acute bed availability specifically on IP and ED LOS, the ED Commission stressed that concerns regarding post-acute capacity impact the efficiency of acute to post-acute transitions.

This analysis found that these structural differences all contribute to longer ED LOS for both admitted and discharged patients. As noted earlier in this report, Maryland hospitals are generally larger and more complex than hospitals in other states, and there is a higher proportion of academic teaching hospitals. They also often perform well on important measures, such as risk-adjusted mortality and readmissions. However, the same structural features that help these facilities provide complex, high-quality care can also make it harder to move patients quickly through the ED.[38] **When ED LOS comparisons were adjusted for these key characteristics, Maryland's performance changed markedly, falling more in line with national averages.[39]** Nevertheless, there are still improvements that can be made to the delivery system that reduce ED LOS while maintaining its current advantages.

Simulation Modeling of Interventions

HSCRC developed a series of simulation models to estimate how different solutions might reduce ED LOS. This approach was used because standard statistical analyses can show which factors are linked to longer ED stays, but they are often less able to predict what would happen if a particular hospital made a specific change. Hospitals are complex settings, and a change in one area can affect other areas in unexpected ways. For example, statistical models often assume that relationships work in only one direction (e.g., a higher rate of ED arrivals is associated with a longer ED LOS). However, in many cases, these relationships are more complex (a higher arrival rate results in longer LOS, which causes EMS diversions and brings about a lower arrival rate). To better capture these back-and-forth effects, HSCRC developed an Agent-Based Model (ABM), which is a simulation that creates a virtual environment of patients, providers, and

[37] Staff analysis of CMS SNF data retrieved from https://data.cms.gov/provider-data/search?theme=Nursing%20homes%20including%20rehab%20services
[38] Burke, L. G., Frakt, A. B., Khullar, D., Orav, E. J., & Jha, A. K. (2017). Association between teaching status and mortality in US hospitals. *JAMA: The Journal of the American Medical Association, 317*(20), 2105–2113. https://doi.org/10.1001/jama.2017.5702
[39] Hospital and Regional Factors Associated with ED Length of Stay, Staff Presentation at December 2023 meeting of the Health Services Cost Review Commission. Accessed September 3, 2025 at https://hscrc.maryland.gov/Documents/December%202023%20HSCRC%20Public%20Post-Meeting%20Materials%20-%20Final.pdf

hospital resources interacting over time. Unlike standard statistical models, these simulations are designed specifically to estimate the impact of interventions within complex systems.

The ABM simulates key ED and IP characteristics and dynamics at each of the state's 42 acute-care hospitals. The model was intended to help the ED Commission and other policymakers prioritize potential solutions based on which are most likely to work and how results may vary across hospitals. Appendix VIII provides technical details on the data, model validation, and policy rationale for the interventions tested. Table 1 in Appendix VIII provides the percent change in IP and OP ED LOS for the scenarios tested. While the simulations provide a directional indication of the magnitude of a solution on IP and OP ED LOS, some ED Commissioners expressed concern about whether the scenarios tested were realistic in Maryland, and sensitivity analyses should be conducted.

Additional findings:

- Not surprisingly, interventions that successfully reduced IP LOS across the hospital had larger effects on ED-1 LOS (i.e., discharge planning). However, broad-based interventions may be more difficult to effectuate, and reductions in IP LOS for specific populations, such as guardianship patients and patients transitioning from acute to post-acute care, also improved ED LOS for admitted patients.
- The model had mixed results on the benefits of increased staffing. A 10 percent increase in registered nurse staffing helped patients who were treated and released to leave the ED faster (OP-18). However, it had little effect on patients waiting to be admitted (ED-1) because their delays were often caused by a lack of available IP beds rather than ED staffing alone. However, this is an important finding given the majority of patients are treated and released.
- Most interventions that reduced LOS for admitted patients had less impact on LOS for patients who were treated and released. A contributing factor to this difference is that hospitals have used alternative treatment spaces and waiting-room triage to maintain patient flow despite ED boarding. While these strategies provide short-term flexibility, the ED Commissioners raised concerns about the need to routinely triage, treat, and discharge patients in alternate ED spaces.
- Hospitals with the longest ED stays saw the biggest potential gains: Although several interventions improved ED LOS across many hospitals, the largest improvements were seen at hospitals that currently have the longest ED LOS.

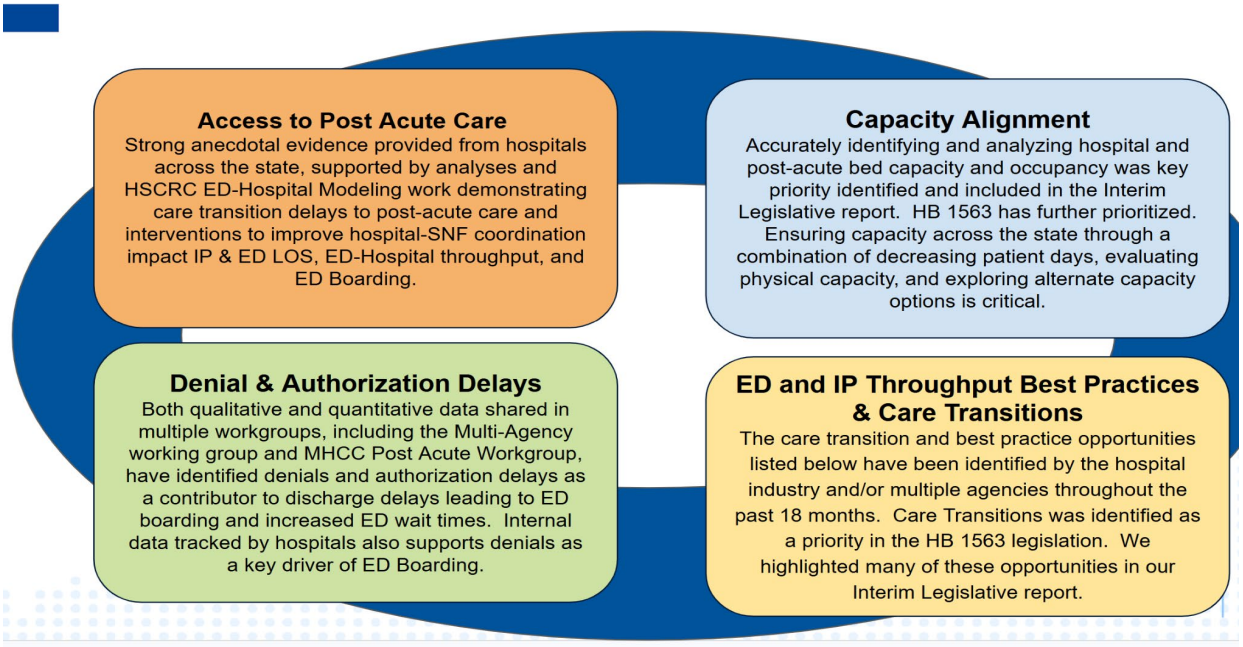
Overall, the hospital ABM gives Maryland policymakers a robust, validated platform to test potential ED LOS interventions using real hospital data before putting them into practice. Moving forward, future work should include an assessment of additional interventions, sensitivity analyses for specific interventions, and expansion of the simulation to other areas of interest, such as examining the impact of increasing

availability of post-acute care. The Data Subgroup's work suggests that Maryland should consider practical policy interventions and operational strategies to make ED care more efficient without reducing the quality of IP care. A key question going forward is how Maryland can keep the benefits of its large, high-performing hospitals while improving ED processes to emulate the responsiveness and efficiency of smaller, streamlined facilities.

Section III. Key Drivers of ED Length of Stay and Recommendations

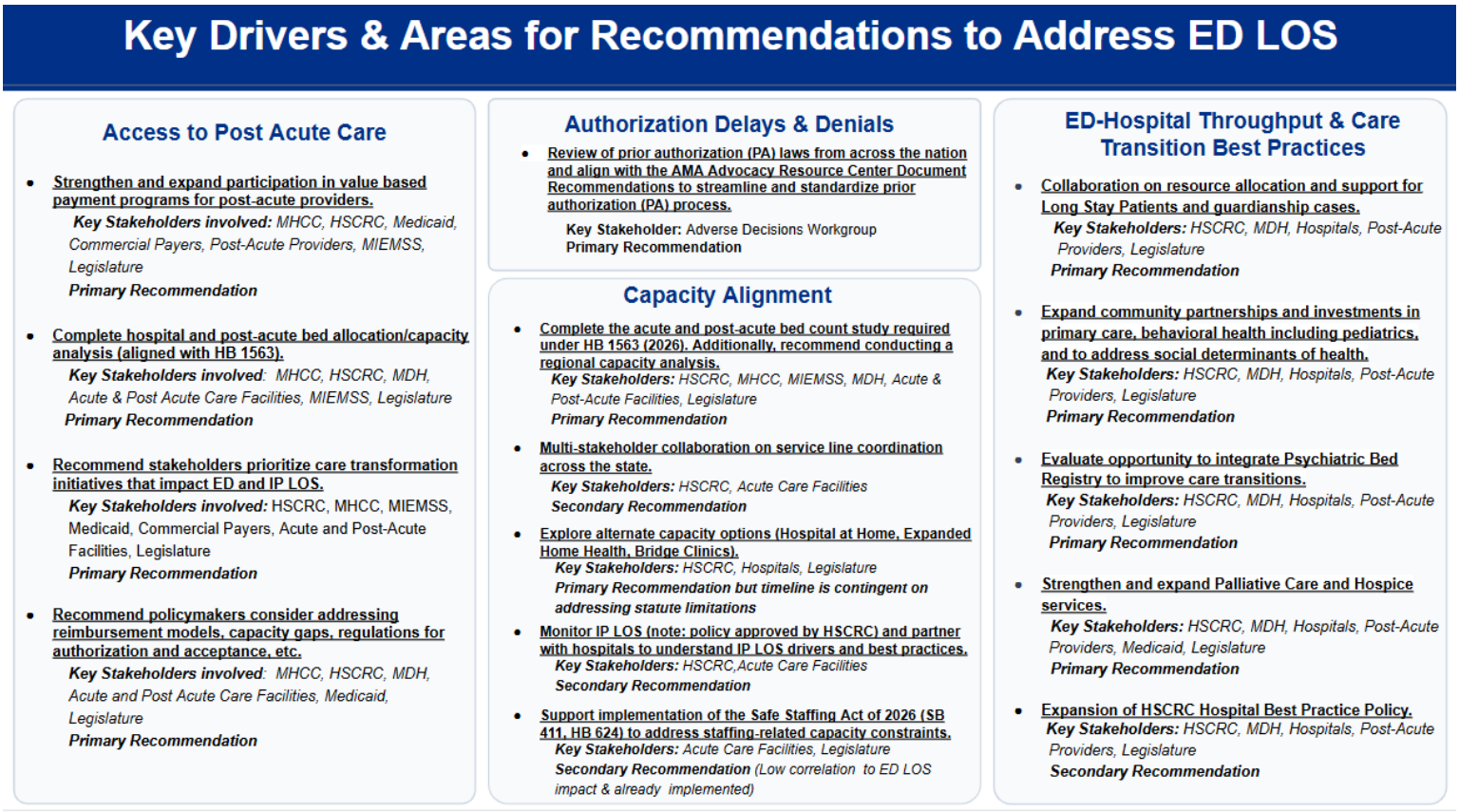
Based on the data and Subgroup deliberations described above, the ED Commission focused on four key drivers of ED LOS (Figure 11): (1) access to post-acute care, (2) denials and authorization delays, (3) capacity alignment, and (4) ED and IP throughput best practices and care transitions. These drivers were prioritized because they represent systemic barriers that contribute to discharge delays, IP bottlenecks, ED boarding, and prolonged ED LOS. These drivers emerged from stakeholder feedback, ED Commission and Subgroup discussions, hospital data, and HSCRC modeling efforts and research.

Figure 11. Maryland Key Drivers of ED LOS with Rationale



The ED Commission used these key drivers as the framework for developing recommendations summarized in Figure 12.

Figure 12. Key Drivers and Recommendations Summary



The following section describes each key driver and its corresponding recommendations. Stakeholders had the opportunity to submit both written and oral comments on these recommendations, and ED Commissioners ranked the recommendations by priority. Recommendations that achieved majority consensus are included in this report, with implementation subject to available resources, stakeholder input, and applicable federal and state requirements. Recommendations are organized by the four key drivers, although some address multiple drivers and are presented only once for simplicity. For example, assessing post-acute bed capacity is included under capacity alignment but also addresses post-acute care access. This report also references and supports recommendations developed through related initiatives and legislative mandates previously described. In particular, the ED Commission reviewed a draft of MHCC's *Strengthening Post-Acute Care in Maryland towards Meeting the Goals of AHEAD* report and recommended prioritizing areas in the MHCC post-acute report that have the greatest potential to improve hospital efficiency and ED LOS. Appendix IX summarizes additional areas suggested by ED Commissioners, as well as feedback on recommendations that did not achieve majority consensus.

Access to Post-Acute Care

Limited access to post-acute services, including SNFs, home health care, and other transition settings, was identified as a significant contributor to delayed hospital discharges and ED boarding. Appendix X contains CY 2025 data on the destinations of Maryland hospital discharges, indicating that over 25 percent of all hospital discharges (140,000+ discharges) are to home health (13.2%), nursing homes (11.1%), and IP rehabilitation (2.2%). Hospitals across Maryland reported persistent challenges in securing timely placement for patients who no longer require acute care but cannot be discharged due to limited post-acute capacity or barriers to admission. HSCRC's ED-hospital throughput modeling and analyses further demonstrated that delays in these care transitions adversely affect LOS and ED throughput (see Appendices V and XI). Table 1 in Appendix V shows that the unadjusted, average IP LOS between 2023-2026 varies significantly based on discharge disposition. Compared to routine home discharge without services, IP LOS was 2.9 to 3.3 days longer for those discharged home with home health, 5.7 to 6.2 days longer for those discharged to SNFs, and 10.1 to 13 days longer for patients discharged to LTCHs.[40] Additionally, the hospital simulation modeling presented in this report, as well as independent statistical analyses performed by Mathematica and the University of Maryland, highlight some important dynamics that should inform state policies and programs aimed at improving ED LOS. These analyses demonstrated that the IP LOS for patients discharged to post-acute care facilities has a significant overall impact on ED LOS for admitted patients.

MHCC's *Strengthening Post-Acute Care in Maryland towards Meeting the Goals of AHEAD* report further describes these issues, including payment variation across payers, eligibility-related overstays, inadequate care coordination, staffing challenges, insufficient quality incentives, mergers and acquisitions, and inconsistent assessment tools and data. The MHCC post-acute report aligns with the recommendation for stronger value-based payment programs. The report includes the recommendations that MDH evaluate and consider the feasibility of incorporating possible enhancements to the measures for the state's Nursing Facility P4P program and that the General Assembly consider increasing the proportion of funds allocated for the program. It further suggests building on the required hospital and post-acute bed capacity study required by the Emergency Room Services and Post-Acute Care - Coverage and Studies bill[41] and recommends strategies to increase the state's capacity to serve patients with complex conditions, expand access to high-quality home health providers in underserved areas, and explore innovative home health models, among other strategies.

[40] See HSCRC's analysis of all-payer hospital casemix data in Appendix VII, Table 1. State Level Average Inpatient Length of Stay by Discharge Disposition.
[41] 2026 MD Laws Ch. 165.

Recommendations

The ED Commission reached majority consensus on the following high-priority recommendations related to post-acute care:

- **HSCRC should collaborate with MHCC, post-acute care providers, Maryland Medicaid, commercial payers, MIEMSS, and the General Assembly to strengthen value-based payment programs for post-acute providers, as well as working to increase the number of providers who participate. These value-based initiatives aim to ensure high quality post-acute care and also promote efficient transitions from acute to post-acute care. Further, the ED Commission recommends development of care transformation initiatives to reduce avoidable hospital utilization from post-acute settings. The ED Commission also supports specific recommendations included in the MHCC post-acute report aimed to strengthen value-based payment incentives for post-acute care,[42] including:**
    - **MDH should review the Nursing Facility P4P program's quality measures, assess national best practices, and as applicable, consider potential future enhancements to the quality measures.**
    - **In considering updates to the Nursing Facility P4P program, MDH should also explore health equity adjustments, including methodologies that recognize facilities serving a high proportion of Medicaid beneficiaries with social risk factors, such as dually-eligible individuals and residents from underserved communities. This should involve reviewing health equity-focused approaches adopted by other states and federal programs, including models that reward both achievement and improvement in quality outcomes among underserved populations. MDH should consider the feasibility, administrative complexity, data availability, and fiscal implications of incorporating health equity measures or adjustments into the existing program.**
    - **The Maryland General Assembly should consider increasing the allocation for the Nursing Facility P4P program above 1 percent of the appropriation for Medicaid nursing facility services.**

  Rationale: Consistent feedback from stakeholders in the Access and Capacity Subgroup, and MHCC's post-acute care focus group, as compiled in MHCC's post-acute report, indicate that strengthening value-based payment programs for post-acute providers could potentially help address the efficiency of acute to post-acute transitions, depending on the incentives included in such programs. As discussed in the MHCC post-acute report, any additional incentives should

[42] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

ensure post-acute providers who serve a more disadvantaged population are not overly penalized under value-based programs by exploring whether health equity adjustment is needed to ensure fairness. In addition, the ED Commission recommends exploring whether other payers, state agencies, or hospitals have or could develop value-based arrangements or care transformation initiatives with post-acute providers. Value-based arrangements or care transformation initiatives should consider measures to address barriers identified by the ED Commission, such as timely acceptance of referrals, limited post-acute facility weekend admission availability, and limited staff and provider training for higher-acuity, complex patients. Care transformation programs designed to change the way care is provided and aimed at reducing the total cost of care, could be used to reduce avoidable ED visits and admissions from nursing homes or other post-acute care. The ED Commission supports further analysis of interventions that could reduce avoidable ED Utilization from SNFs. As a next step, staff can analyze Maryland-specific baseline data and conduct simulation modeling, as some preliminary literature and modeling suggest that reducing the number of nursing home patients arriving at the ED, many of whom are admitted due to their complexity, has the potential to reduce ED LOS.

- **HSCRC, MHCC, MDH, Maryland Medicaid, and the General Assembly should consider addressing reimbursement models, capacity gaps, and regulations for authorization and acceptance. Specifically, the ED Commission recommends:**
    - **As follow-up to the information compiled in MHCC's post-acute report, the ED Commission recommends a multi-agency collaboration to evaluate and address the gaps in the capacity of post-acute care, including chronic care beds, to manage patients with complex conditions. The ED Commission identified a need to have a better understanding of post-acute, skilled, and chronic care bed and staffing capacity.**
    - **Additionally, the MHCC focus groups attributed some of the decreased acceptance of complex care patients to insufficient payment rates according to some SNF operators. Operators reported that other states provide nursing facility payment adjustments to account for the additional costs associated with caring for complex patients.[43] The ED Commission supports the MHCC recommendation that MDH evaluate the feasibility of additional payments to SNFs for high-acuity patients to increase post-acute access and reduce placement time.**

  Rationale: According to the MHCC focus group, as well as stakeholders in the Access and Capacity Subgroup, complex care patients who require transition to a long-term care facility frequently have

[43] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

a longer IP LOS, with avoidable days that are not medically necessary but cannot technically be avoided because the patients cannot safely be discharged to another lower-level facility.[44,45] *While staff do not currently have access to each hospital's internal avoidable day data, the IP LOS data for patients discharged to LTCHs are consistent with this assertion. As previously stated, the IP LOS for patients discharged to LTCHs is 10-13.1 days longer than for patients discharged to home. The ED Commission discussed the need to have a better understanding of post-acute, skilled and chronic care, bed capacity and availability, which is addressed further in the section below on capacity alignment. Additional ideas that were discussed, and are included in Appendix IX, include requiring SNFs with available beds to accept any patient and developing a multisystem SNF modeled after the Mt. Washington Pediatric Hospital, but feasibility and funding for these types of efforts would need to be further explored. Therefore, these ideas did not have consensus to be recommended, but additional research and analysis of these ideas should be considered. In addition, recommendations in the MHCC post-acute report, such as exploring adoption of the SNF 3-day rule available under the AHEAD model, were not specifically discussed by the ED Commission but align with efforts to increase hospital capacity by promoting efficient and safe discharges to lower acuity settings.*

Denials & Authorization Delays

Prior authorization requirements and insurance denials were identified as important operational barriers that contribute to discharge delays and prolonged hospital stays. Feedback from hospitals, the AHEAD Multi-Agency Regulatory Working Group, and the MHCC Post-Acute Workgroup consistently highlighted the impact of delayed authorization decisions on patient movement through the care continuum. The ED Commission therefore identified authorization reform as a key area where policy changes could have meaningful impacts on ED throughput.

As previously noted, the Workgroup to Study the Rise in Adverse Decisions in the State Health Care System was charged with reviewing existing adverse decision reporting requirements for health payers operating in Maryland; identifying opportunities to improve the consistency, transparency, and usefulness of adverse decision reporting; developing strategies to reduce the number of adverse decisions; and recommending legislative and policy changes to standardize reporting requirements statewide. The Workgroup's report will be submitted in December 2026, and the ED Commission elected to defer to the Workgroup as the subject matter experts in the payer and utilization domains.

Given the alignment between the Workgroup's charge and the ED Commission's findings, the ED Commission reviewed the American Medical Association (AMA) Advocacy Resource Center's compilation

[44] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

[45] For more information on the Access and Capacity subgroup's discussions on this topic, see the meeting slides and recordings saved on the ED Commission's website: https://hscrc.maryland.gov/pages/ed-wtr-commission.aspx

of state prior authorization laws and accompanying recommendations to streamline and standardize prior authorization processes,[46] and submitted the following recommendations to the Adverse Decisions Workgroup in August, 2026.

Recommendations

To address denials and authorization delays as a driver of ED LOS, the ED Commission reached consensus on the following high-priority recommendations:

- **The MIA and the Maryland General Assembly should conduct a review of prior authorization laws nationwide, as well as considering alignment with the AMA's Advocacy Resource Document Recommendations, in order to streamline and standardize the process for prior authorizations.**

  Rationale: Stakeholders in multiple forums, including the ED Commission's Access and Capacity Subgroup, the AHEAD Multi-Agency Regulatory Working Group, and the MHCC Post-Acute Workgroup, consistently highlighted the impact of delayed authorization decisions on patient throughput across the continuum of care.[47] Refer to the upcoming report of the Workgroup to Study the Rise in Adverse Decisions in the State Health Care System for final recommendations.

- **The MIA and Maryland General Assembly should consider the following recommendations based on the AMA guidance mentioned above:**
  - Mandate the availability of an online prior authorization system for in-hospital and post-acute care (and not only for drugs).
  - Similar to other medical communication, mandate that all prior authorization-related communication be visible to patients via the patient portal (improve on current requirements in Maryland).
  - Mandate that non-urgent prior authorization requests be adjudicated within two business days. Urgent requests should be adjudicated within one business day.
  - If the need for services occurs on a holiday, an insurance plan cannot require notification/request for a prior authorization only on a business day.
  - After prior authorization approval, an insurance plan cannot retroactively deny the service, unless materially false information was provided.

[46] American Medical Association. (2024). *2024 prior authorization (PA) state law chart*. AMA Advocacy Resource Center. https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf

[47] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

- Similar to any medical decision making, denials should include specific clinical reasons, contact details, department name and credentials, and the persons who had authority over denying or approving the prior authorization request, i.e., the reviewer, and who it can be appealed to.
- Appeals should be adjudicated by a physician in the same or similar specialty, within one business day. There should be an electronic portal for appeals.
- Statistics should be available on the payer's website regarding the category of denials, rate of denials, etc.
- Prior authorization requirements should be based on clinical evidence and should be displayed on the payer's website.

Additional recommendations to address denials and authorization delays that impact hospital throughput and increase ED LOS are included in the MHCC post-acute report. As mentioned previously, the ED Commission reviewed a draft of this report and voted to recommend prioritization of areas in the MHCC report that have the greatest potential to improve hospital efficiency and ED LOS. For example, the report contains specific recommendations related to analysis of denied claims data across all payers to identify reasons for post-acute denials and Medicaid managed care organization assistance when a hospital cannot find an appropriate post-acute placement for a Medicaid patient, as well as recommendations to address Medicaid eligibility determination delays, continue addressing wait times for approval of assisted living and home and community-based services, and extend retroactive Medicaid reimbursement for nursing facility services. These recommendations align with the ED Commission's goal to address operational barriers that contribute to discharge delays and prolonged hospital stays. The ED Commission understands that additional work is underway through the Adverse Decisions Workgroup and ultimately defers to the recommendations that will be included in their upcoming report.

Capacity Alignment

Accurately measuring and analyzing hospital and post-acute bed capacity and occupancy was a key priority identified by the Access and Capacity Subgroup and included in the ED Commission's Interim Legislative report. In addition, the Emergency Room Services and Post-Acute Care - Coverage and Studies bill has further prioritized this important work by requiring a study of the data on licensed, physical, and staffed beds available in both the acute and post-acute settings, as discussed further below.[48] Increasing hospital and post-acute capacity across the state through a combination of decreasing patient days, evaluating physical capacity, expanding workforce supply, and exploring alternate capacity options is critical to addressing ED LOS improvement and addressing access concerns that may be broader than simply capacity.

To achieve these goals, Maryland should enhance standardization and continuity of bed capacity data to achieve comprehensive, population-level visibility. While organizations and hospitals currently maintain

[48] 2026 MD Laws Ch. 165.

internal systems to monitor bed occupancy, there are differences in reporting conventions. For example, standardizing bed classification guidelines, such as the distinction between temporary surge capacity and traditional staffed beds, could reduce reporting inconsistencies across facilities. Moving toward continuous data collection can also transform current point-in-time snapshots into a dynamic view of system-wide capacity. A unified statewide bed capacity data framework could enable more accurate identification of the underlying causes of access constraints, such as physical infrastructure, staffing models, capacity utilization, or downstream placement delays. Stakeholders emphasized the importance of accurately measuring and understanding IP and post-acute bed availability, occupancy, and utilization patterns across Maryland. This focus aligns with the requirements of the Emergency Room Services and Post-Acute Care - Coverage and Studies bill and ongoing efforts by HSCRC, MHCC, MDH, and MIEMSS to develop standardized capacity metrics and auditing processes to ensure the reliability and validity of bed data.

Recommendations

The ED Commission reached consensus on the following medium/high priority recommendations related to capacity:

- **HSCRC, in collaboration with MHCC, MIEMSS, and MDH, should complete the acute and post-acute bed count study required by the Emergency Room Services and Post-Acute Care - Coverage and Studies bill.[49] Additionally, the ED Commission recommends conducting a regional capacity analysis to assess IP and post-acute care needs and establish standardized processes for ongoing capacity monitoring. Related to the completion of this study, the ED Commission recommends the following next steps:**
    - **Evaluate current bed data reporting and identify definitional gaps across data sources.**
    - **Standardize reporting definitions, frequency, and data elements, and develop auditing processes to improve data completeness, accuracy, and comparability.**
    - **Build a reliable data infrastructure with consistent reporting, validation, and auditing processes.**

Given the January 1, 2027, deadline for the analysis required by this bill, specific recommendations on the evaluation and standardization of bed reporting and auditing processes are under development. However, the ED Commission strongly recommends that the HSCRC and MHCC should establish timelines for additional analyses that link capacity to need for services to identify potential access constraints statewide or by region. See Appendix XII for additional information on the Bed Capacity Analysis Workplan and the future report for discussion of next steps for evaluating capacity and access.

[49] 2026 MD Laws Ch. 165.

- **The ED Commission supports the bed capacity study in its entirety and additionally recommends a secondary analysis to identify and evaluate legislative and regulatory barriers that have led to concerns about the availability of chronic and long-term care beds in the state. As highlighted earlier, the unadjusted IP LOS for patients discharged to LTCHs is 10 to 13 days longer than for patients who are discharged to home. This is consistent with the MHCC post-acute report recommendation to increase statewide capacity to serve patients with complex conditions.**
- **The ED Commission recommends that the state leverage existing infrastructure and systems utilized by MIEMSS and the Maryland Behavioral Health Connect bed tracking system to develop an interactive, statewide bed capacity tracking system that provides real-time bed availability at both acute and post-acute facilities. The ED Commission recommends legislative action to require submission from all regulated, licensed acute and post-acute care facilities to such a system.**
    - **Maryland Behavioral Health Connect[50] and the behavioral health bed registry provides an opportunity to learn how best to implement technology-enabled approaches that can improve visibility into available resources while minimizing administrative burden.**
    - **Likewise, the current MIEMSS bed reporting process has provided valuable support for emergency preparedness, response, and situational awareness, particularly during the COVID-19 pandemic. This process relies heavily on manual hospital reporting and was not designed as a long-term capacity monitoring solution; future efforts should focus on developing sustainable, automated approaches that deliver real-time operational value while reducing reporting burden.**

Rationale: Stakeholders from the Access and Capacity Subgroup, MHCC's Post-Acute Care Workgroup, and other hospital and post-acute care organizations consistently identified limitations in Maryland's bed capacity data. Current datasets lack standardization across facilities and bed types, including licensed, physical, and staffed beds, and do not provide a reliable statewide view of acute and post-acute capacity. The bed capacity study provides an important starting point for addressing these gaps by establishing baseline supply. Additional work to link supply with demand data and identify potential capacity and access constraints was consistently emphasized by ED Commission members. This should include assessing factors affecting capacity and patient flow, including outpatient and pre-acute care utilization, population health needs, post-acute delays,

[50] For more information on Maryland Behavioral Health Connect, please refer to the Commission's September meeting presentation, available here: https://hscrc.maryland.gov/Documents/Work%20Group%20Uploads/ED%20WTR%20Commission/ED%20WTR%20Commission%20Meeting-September%2023,%202026.pdf

facility or service-line closures, inpatient capacity constraints, behavioral health capacity, and other resource or operational barriers.[51] *In addition, out-of-state capacity and interstate utilization should be considered given Maryland's small size, proximity to several border states, and several multi-state health systems with presence in Maryland. The expansion of a statewide bed capacity tracking system, similar to the system that MIEMSS currently uses and that MDH is developing, should facilitate appropriate patient placement and potentially better utilization of capacity across the state.*[52] *The state should also explore the federal initiatives through the CDC National Healthcare Safety Network (NHSN) system to collect more real-time bed data.*[53] *The CDC NHSN system was proposed for implementation several years ago but was not implemented based on concerns from several hospital systems that the process did not accurately reflect updates from their internal capacity management systems. If the General Assembly takes action to mandate a statewide tracking system, the ED Commission recommends that the key stakeholder group include hospitals, along with MIEMSS, MDH, MHCC, and HSCRC, so that previously identified barriers can be addressed.*

- **The ED Commission recommends that state stakeholders, including MDH, HSCRC and the General Assembly, in collaboration with providers, explore alternate capacity options, such as the Heart Failure Day Clinics, Bridge clinics, Hospital at Home model, and the Expanded Home Health Value-Based Purchasing model. This is consistent with recommendations in the MHCC post-acute report.**

  Rationale: Community-based programs such as day clinics and hospital-at-home and home health models are a lower cost of care setting than institutionalized care such as nursing facility care, so there may be opportunities through some of these innovative models to reduce health care spending while enabling patients to remain in the comfort of their home. For example, according to a recent JAMA article, "Hospital at Home" outcomes in several trials, compared to brick-and-mortar hospital outcomes, are associated with lower rates of hospital-associated complications, better patient and family member care experience, lower post-acute health service utilization, and lower costs.[54] *Similarly, the MHCC Post-Acute report also recommended that MDH should explore innovative approaches to home health such as "hospital-at-home" or "SNF-at-home" models to support higher-acuity care. This recommendation currently has a medium level of priority because it would require a thorough review of state and federal authority.*

[51] 2026 MD Laws Ch. 165.
[52] For more information on the Access and Capacity subgroup's discussions on this topic, see the meeting slides and recordings saved on the ED Commission's website: https://hscrc.maryland.gov/pages/ed-wtr-commission.aspx
[53] U.S. Centers for Disease Control and Prevention. (2023, April 25). *About NHSN*. https://www.cdc.gov/nhsn/about-nhsn/index.html
[54] Leff, B., Siu, A., DeCherrie, L. V., & Levine, D. M. (2026). Hospital at home and transforming US health care delivery. *JAMA*, *335*(20), 1747-1748. doi.org/10.1001/jama.2026.4791

- **HSCRC should continue monitoring IP LOS, along with its partnership with hospitals to understand the drivers of IP LOS and the best practices that can be used to improve it**.

  Rationale: The HSCRC approved an IP LOS monitoring policy in June 2026. The monitoring policy is designed to address Maryland's growing IP bed day utilization and its effects on hospital operations, ED crowding, and the sustainability of the State's global budget models. This policy was highlighted as a priority because, despite having a decline in IP admissions in Maryland, overall IP utilization has increased because patients remain hospitalized longer. This creates capacity constraints and contributes directly to ED boarding and extended ED LOS. This policy aims to bring Maryland hospitals with high IP LOS closer to national averages and ensure efficient care delivery under the AHEAD model. This recommendation was graded as a secondary priority because the IP LOS policy was developed and approved in CY 2026 and some ED Commissioners recommended that time is needed to evaluate the policy before any additional changes or development of a payment policy.

- **The ED Commission recommends noting that staffing shortages are a contributing factor to decreased capacity in some facilities. The ED Commission agrees with and supports the Safe Staffing Act of 2026, which requires hospitals to establish clinical staffing committees that can include ancillary services in addition to nursing, develop and implement annual staffing plans, and comply with safe staffing standards established by accreditation bodies and CMS Conditions of Participation.**

  Rationale: Physical bed availability alone is insufficient to increase capacity. Beds need to be safely staffed to actually benefit patients. While there was no consensus to make additional recommendations, the ED Commission discussed the timeline for implementation of the Safe Staffing Act, debated the effort and ability to collect standardized data on clinical and non-clinical staff, and noted that staffing concerns are a national issue as well. See Appendix IX for additional discussion.

- **An additional secondary recommendation is that HSCRC should engage acute care facilities through multi-stakeholder collaboration on coordinating service lines across the state, meaning possibly creating service line networks across the state that could function outside of defined hospital systems in order to leverage available capacity.**

  Rationale: Based on feedback from hospital stakeholders across the state, service line opportunities have less overall impact on throughput than the other recommendations prioritized. The impact of service line opportunities can be evaluated as part of the learning collaborative, with

input from hospital stakeholders, as service lines vary across facilities and opportunities may be unique to certain facilities.[55]

Best Practices/Care Transitions

Operational and clinical best practices that improve patient movement through hospitals and strengthen care transitions have been a key area of focus since the establishment of the ED Commission. Over the past 18 months, hospitals, regulators, and healthcare stakeholders have identified many opportunities to address throughput, including improvements in discharge planning, care coordination, management of long-stay patients, behavioral health transitions, guardianship processes, palliative care services, and community-based supports. HSCRC's modeling suggests that interventions targeting hospital-wide IP LOS can improve ED performance, while care transformation initiatives that further reduce avoidable utilization (i.e., preventing potentially avoidable ED visits) often yield the largest improvements in both admitted and discharged patient wait times.

The ED Commission concluded that broader adoption of evidence-based best practices, coupled with stronger community partnerships and targeted investments in behavioral health, primary care, and social supports, represents an important strategy for addressing social determinants of health, reducing avoidable ED utilization, and improving patient outcomes. See Appendix I for a description of HSCRC's efforts to collect and disseminate ED hospital best practices.

Recommendations

The ED Commission recommends several high-priority steps for HSCRC, MDH, and the General Assembly to take, in collaboration with hospitals and post-acute care providers, to help align with best practices and support care transitions.

- **Stakeholders should collaborate to allocate the necessary resources to support long-stay patients and guardianship cases.**

  Rationale: While casemix data do not capture guardianship status, staff analyzed long-stay patients as a percentage of total bed days. Staff also tested the impact of a reduction in long-stay patients as part of the simulations and found it did have an impact on the ED-1 measure of patients waiting to be admitted in FY 2026. While patients with IP LOS >= 30 days represented only 1.4 percent of discharges, these discharges accounted for 13.4 percent of bed days. Additionally, hospital stakeholders who can identify guardianship status in their individual data shared in multiple forums, including the Access and Capacity subgroup, the MHCC Post-Acute Care Workgroup, and the

[55] For more information on the Access and Capacity subgroup's discussions on this topic, see the meeting slides and recordings saved on the ED Commission's website: https://hscrc.maryland.gov/pages/ed-wtr-commission.aspx

AHEAD Multi-Agency Regulatory Working Group, that guardianship patients are a significant percentage of their long-stay patient population. As discussed in the MHCC post-acute report, hospitals may pursue guardianship to facilitate placement of cognitively impaired patients into a post-acute setting, but this is highly restrictive and can be a costly and time consuming process. Analyses to identify variation by hospital and/or region, as well as the types of patients with longer stays who may require guardianship, should be undertaken and considered in the development of specific interventions and policy recommendations. The ED Commission's recommendation to allocate resources to support hospitals with patients who have long stays due to compromised decision-making abilities and may require guardianship aligns with the MHCC post-acute report recommendations to decrease the complexity and length of time it takes to place these types of patients and for education of hospital staff on alternatives to guardianship when pursuing post-acute placement.

- **The ED Commission recommends expanding community partnerships and investments in primary care, behavioral health (including pediatrics), and efforts to address the social determinants of health.**

  Rationale: Stakeholders across the state in various forums have noted the impact of enhanced primary care, care coordination, and behavioral health resources. Ongoing MDH initiatives, including MDPCP, have had a demonstrated impact on both hospital admissions and ED visits. Between 2019 and 2025, MDPCP practices saw an 18 percent decrease in IP admissions per 1,000 beneficiaries and a 21 percent decrease in ED visits per 1,000 beneficiaries. Further, broader public health interventions to address social determinants of health and prevention (e.g., immunizations, nutrition/food insecurity) were discussed, but specific recommendations were beyond the scope of the ED Commission. See Appendix IX for additional discussion.

- **Stakeholders should evaluate the opportunity to integrate a Psychiatric Bed Registry to improve care transitions.**

  Rationale: Similar to the recommendation to develop a statewide capacity management system/bed tracking system for all beds, availability of specific psychiatric beds has been a consistent issue noted by stakeholders in multiple forums, including the Access and Capacity Subgroup. MDH maintains the Behavioral Health Hospital Coordination Dashboard, which includes an IP psychiatric bed dashboard that is updated at least three times per day to help hospital discharge planners locate available beds. In 2027, MDH will be transitioning bed availability reporting from the dashboard to a web-based bed registry and referral platform, "Maryland Behavioral Health Connect," in alignment with the Maryland Mental Health and Substance Use Disorder Registry and

Referral System bill passed in 2021.[56] *The expansion of a statewide bed capacity tracking system that aligns with or integrates the Psychiatric Bed Registry could further facilitate appropriate patient placement and potentially better utilization of capacity across the state. Furthermore, as HSCRC, MHCC, and MIEMSS assess acute and post-acute bed capacity systems, they should consult with MDH and the Behavioral Health Administration (BHA) on lessons learned from the Psychiatric Bed Registry.*

- **Focus on strengthening and expanding palliative care and hospice services. Specific recommendations include:**
    - **As recommended in the MHCC Post-Acute report, MDH should evaluate opportunities to strengthen and better align palliative care services across delivery systems. This includes consideration of potential approaches such as State Plan amendments, managed care organization requirements, or targeted waiver-based strategies (including 1915(c) and 1115 authorities), as appropriate and consistent with federal requirements and available resources.**
    - **Continued funding and expansion of the ongoing efforts to provide training and services through the established GBMC and Gilchrist hospice programs.**
    - **Legislation to expand training and access to electronic Medical Orders for Life-Sustaining Treatment forms across all healthcare access points (outpatient providers, EMS, acute care, and post-acute facilities).**
    - **MHCC, HSCRC, and CMMI collaboration to build advance directives completion into incentive programs such as AHEAD Primary Care.**

  Rationale: Expansion of palliative care and hospice services is an important part of increasing access and ensuring patients are seen in the most appropriate setting. A representative of the Subgroup participated in MHCC's Hospice Workgroup in the summer of 2025 and also participated in the Workgroup to finalize the State Hospice Workplan in the summer of 2026. In addition, the focus group for the MHCC workgroup[57] *stressed how palliative care can improve quality of life for individuals with serious illness, including symptom management, enhanced care coordination, hospitalization prevention, and increases in appropriate hospice placements.*

  As noted in this ED Commission's interim report, HSCRC has a program called New Paradigms in Care Delivery that has funded Greater Baltimore Medical Center (GBMC), in partnership with Gilchrist, Maryland's largest non-profit provider of serious illness and end-of-life palliative care. Expansion of this program includes enhanced services and staff that will double the number of

[56] 2021 MD Laws Ch. 29.
[57] Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf

patients served, enhance the quality and experience for patients and families, and further improve total cost of care performance. This funding and program remains in place in 2026. Gilchrist presented to the HSCRC Commission in the spring of 2026, showing preliminary results indicating that the program is on track to successfully meet metrics. There are opportunities for Gilchrist to apply for continued funding through the HOPE program in 2027, but no awards have been made yet for 2027. HOPE will consider the impact of ED use and hospital throughput when evaluating programs to fund in 2027. The ED Commission supports this initiative and ongoing prioritization and funding of these efforts, and the focus on palliative care and hospice aligns with recommendations in the MHCC Post-Acute Care report.

- **HSCRC should collaborate with stakeholders in expanding the HSCRC Hospital Best Practice Policy by transitioning it to a learning collaborative, with participation from hospitals, post-acute providers, and other state agencies as appropriate.**

  Rationale: As previously noted, operational and clinical best practices that improve transitions through hospitals and strengthen care transitions have been a key area of focus since the establishment of the Commission. With the implementation of the ED-Hospital Best Practice policy in March 2025, healthcare stakeholders have identified numerous opportunities to improve throughput. However, the policy has been narrowly focused on specific interventions. In an effort to leverage the strong collaboration fostered by this subgroup, the HSCRC is proposing to transition this pay-for-reporting policy to a learning collaborative to share best practices in 2027. The purpose of the collaborative is to engage hospital leaders, as well as post-acute providers, state agencies, and other stakeholders, to identify best practices to address ED and hospital throughput, care transitions, and capacity alignment across the care continuum. This learning collaborative should consider ways to bring in the perspectives of front-line staff and other stakeholders and to identify minor delays in processes that can add up to more significant delays. Furthermore, the collaborative should monitor data on ED LOS and related metrics on a regular basis and consider enhancements to the CRISP ED Dashboard.

Section IV. Conclusion

In summary, this document serves as the ED Wait Time Reduction Commission's final report, summarizing ED Commission and Subgroup deliberations and data analysis conducted during the ED Commission's tenure and presenting recommendations. Reducing ED LOS remains a complex challenge in Maryland and across the nation that cannot be addressed through changes within the ED alone. Although Maryland's hospital size, patient acuity, and academic and teaching status help explain some of the difference between Maryland and national performance, opportunities remain to improve patient flow and reduce delays while preserving access to high-quality, complex care.

The ED Commission identified and prioritized four key drivers of ED LOS: improving access to post-acute care, reducing denials and authorization delays, aligning capacity across care settings, and strengthening hospital throughput and care transitions. These drivers were prioritized because they represent systemic barriers that contribute to discharge delays, IP bottlenecks, ED boarding, and prolonged ED LOS. These drivers emerged from stakeholder feedback, ED Commission and Subgroup discussions, hospital data, and HSCRC modeling efforts and research. Meaningful improvement in these key drivers will require sustained collaboration among state agencies, hospitals, payers, post-acute providers, community organizations, and patient representatives. It will also require continued monitoring, data development, evaluation, and refinement to ensure that interventions account for differences across hospitals and regions and produce measurable improvements in ED and IP LOS. The modeling and analytic tools developed through the ED Commission provide a foundation for testing potential interventions, targeting resources, and tracking progress over time.

The recommendations in this report seek to align incentives, expand access to appropriate services, improve data and capacity planning, and implement effective care-transition practices to reduce ED LOS and improve patient outcomes. In summary, the ED Commission recommends the following across the priorities identified:

- **Improve care transitions:** Enhance resource allocation and support for long-stay patients, expand community partnerships in primary and behavioral health, integrate the psychiatric bed registry, and strengthen palliative and hospice services.
- **Streamline authorization processes:** Align prior authorization laws and consider national AMA advocacy recommendations to reduce delays and denials.
- **Optimize capacity and throughput:** Conduct regional bed allocation analyses (as per the Emergency Room Services Coverage and Facility Studies bill),[58] explore alternate capacity models like Hospital at Home, and collaborate on service line coordination.
- **Advance payment and transformation initiatives:** Increase participation in value-based payment programs for post-acute providers and prioritize care transformation initiatives that positively impact ED and inpatient LOS.
- **Address policy and regulatory gaps:** Policymakers should focus on the post-acute reimbursement models as noted in the MHCC report, prior authorization regulations, and capacity gaps to optimize overall system throughput.

[58] 2026 MD Laws Ch. 165.

Appendices

Appendix I. ED Throughput Best Practices

Appendix II. ED Wait Time Reduction Commission Priorities

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Appendix XI. Acute and Post-Acute Bed Counts by Region

Appendix XII. Bed Capacity Analysis Workplan

Appendix XIII. List of References

Appendix I. ED Hospital Best Practices

Figure 1. RY 2028 ED Best Practices Policy Overview

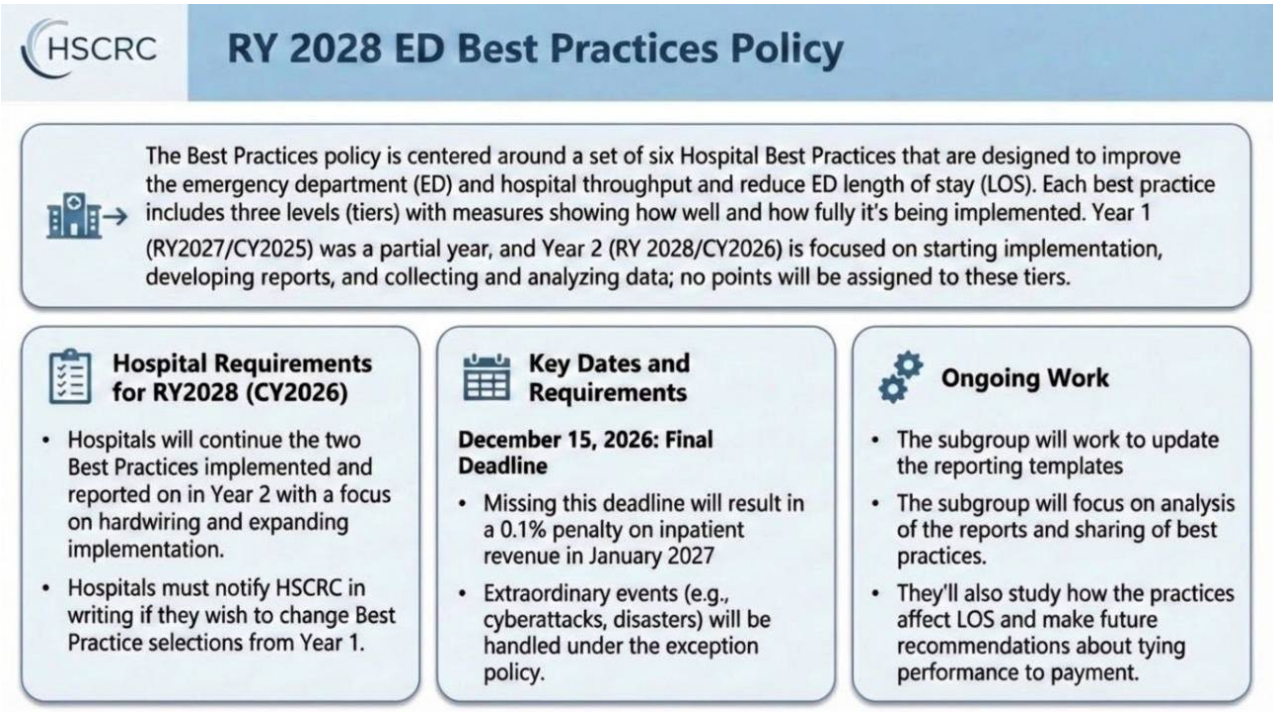
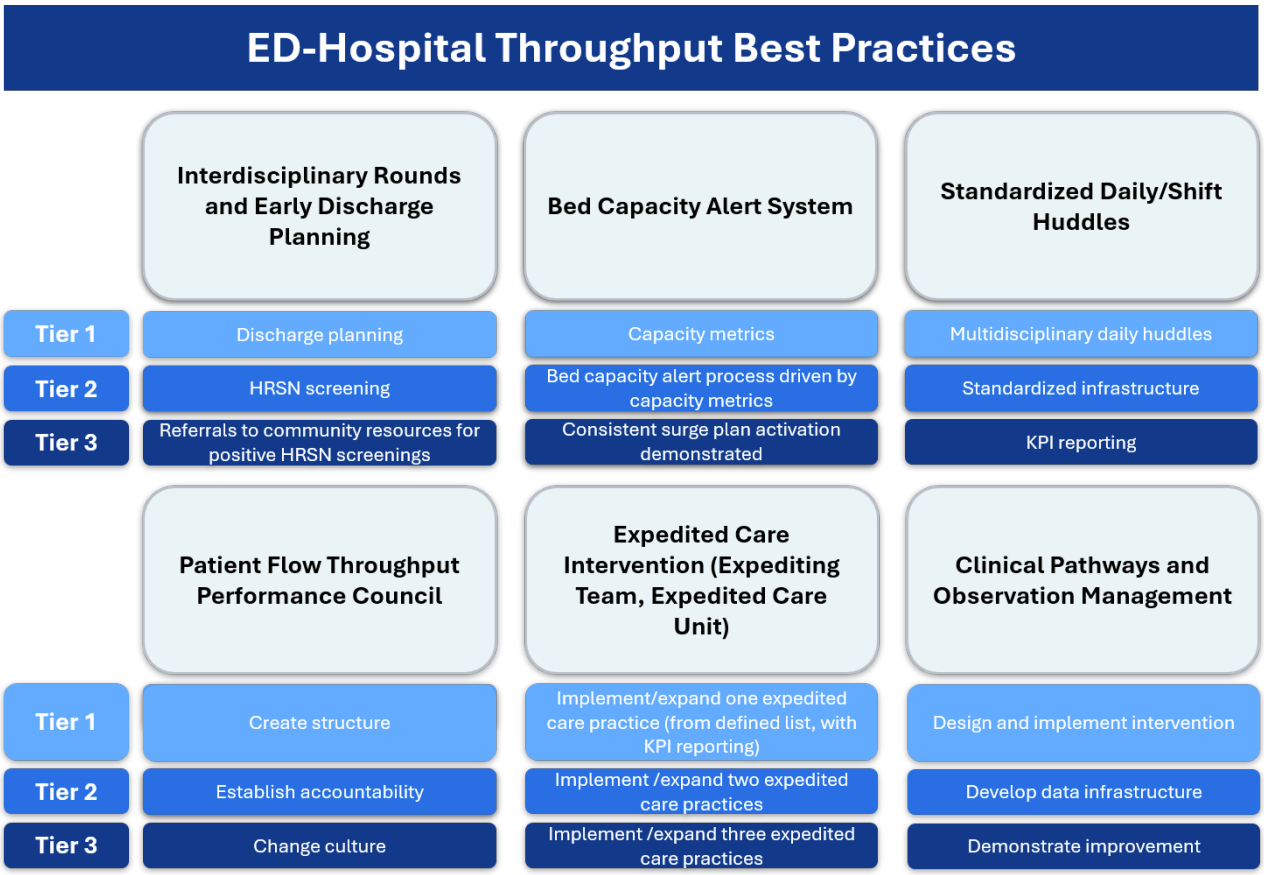
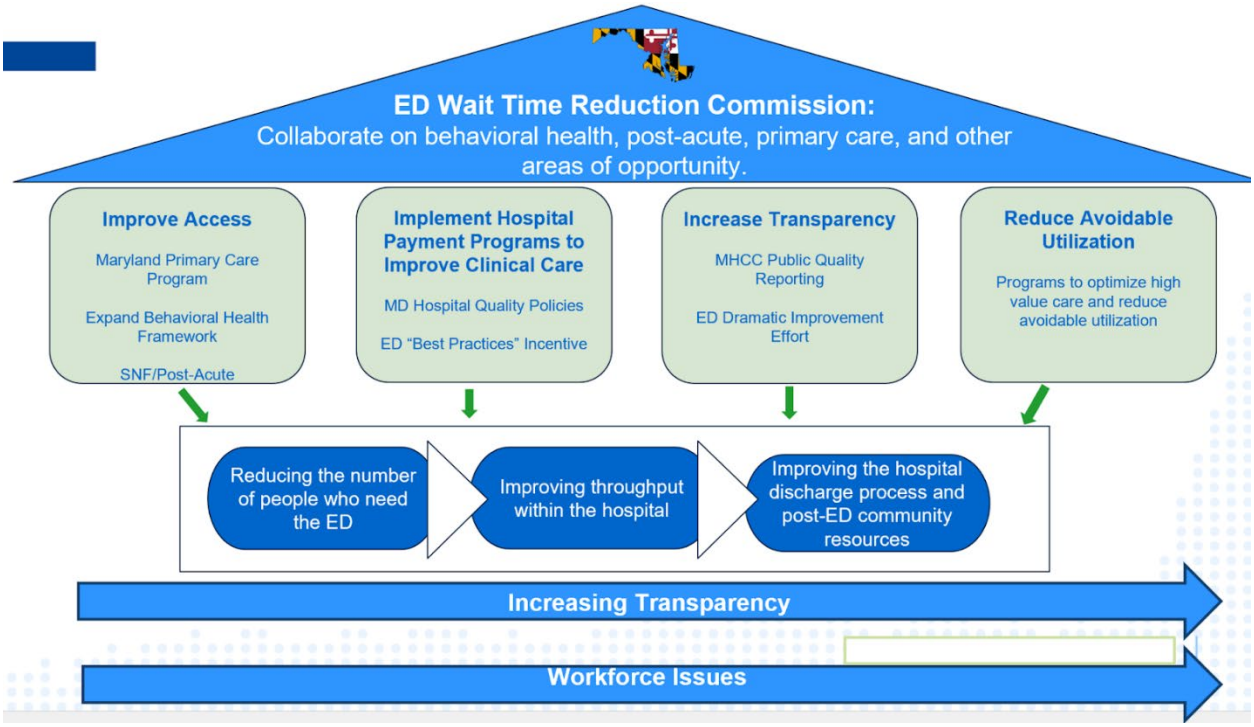


Figure 2. ED-Hospital Throughput Best Practices



Appendix II. ED Wait Time Reduction Commission Priorities

Figure 1. Maryland ED Wait Time Reduction Commission Priorities



Appendix III. ED Commission Meeting Details

Table 1. 2026 ED Commission Meeting Dates and Topics

Meeting Date	Meeting Priority Topics
January 7, 2026	• Introductions • Overview of ED Wait Times Reduction Commission and Discussion
March 4, 2026	• ED Commission CY 2026 Priorities • ED-Hospital Statistical Modeling Update • Aligned Efforts Update • Discussion
April 30, 2026	• 2026 Legislative Session Updates • ED Commission CY 2026 Priorities Update & Recommendations Discussion • HSCRC ED-Hospital Throughput Best Practice Policy Year 1 Summary • Adventist White Oak Medical Center Best Practice Presentation
July 15, 2026	• ED Commission CY 2026 Priorities and Updates • Key Drivers and Recommendations for Final Report
September 23, 2026	• Review Draft of Final Legislative Report • Presentation from BHA on the Psychiatric Bed Registry

Appendix IV. Hospital-Level Inpatient and Outpatient ED Length of Stay, CY2023–CY2026

Hospital ID	Hospital	IP CY2023	IP CY2024	IP CY2025	IP Rolling 12M Aug 2026	IP Minutes Change 2023–2025	IP % Change 2023–2025	IP Minutes Change 2023–Rolling 12M	IP % Change 2023–Rolling 12M	OP CY2023	OP CY2024	OP CY2025	OP CY2026 YTD Jul	OP Minutes Change 2023–2025	OP % Change 2023–2025
210001	Meritus	378	365	418	424	40	10.58%	46	12.2%	241	245	258	277	17	7.1%
210002	UMMS- UMMC	1289	1475	1389	1323	100	7.76%	34	2.6%	367	367	301	291	-66	-18.0%
210003	UMMS- Capital Region	1380	1157	1268	1321	-112	-8.12%	-59	-4.3%	406	380	345	331	-61	-15.0%
210004	Trinity - Holy Cross	514	505	551	555	37	7.20%	41	8.0%	374	369	343	311	-31	-8.3%
210005	Frederick	405	421	453	422	48	11.85%	17	4.2%	292	285	282	266	-10	-3.4%
210008	Mercy	526	492	444	435	-82	-15.59%	-91	-17.3%	265	272	267	255	2	0.8%
210009	JHH- Johns Hopkins	939	1032	975	939	36	3.83%	0	0.0%	510	476	418	426	-92	-18.0%
210011	Saint Agnes	627	553	438	411	-189	-30.14%	-216	-34.4%	282	246	176	138	-106	-37.6%
210012	Lifebridge- Sinai	1062	941	801	926	-261	-24.58%	-136	-12.8%	297	269	288	301	-9	-3.0%
210015	MedStar- Franklin Square	589	631	698	953	109	18.51%	364	61.8%	409	390	365	344	-44	-10.8%
210016	Adventist- White Oak	1101	889	632	593	-469	-42.60%	-508	-46.1%	425	421	331	355	-94	-22.1%
210017	Garrett	277	244	231	234	-46	-16.61%	-43	-15.5%	164	136	128	136	-36	-22.0%
210018	MedStar- Montgomery	519	470	450	434	-69	-13.29%	-85	-16.4%	266	271	271	279	5	1.9%
210019	Tidal- Peninsula	498	485	478	575	-20	-4.02%	77	15.5%	195	193	196	209	1	0.5%
210022	JHH- Suburban	483	484	461	423	-22	-4.55%	-60	-12.4%	247	245	240	232	-7	-2.8%
210023	Luminis- Anne Arundel	546	509	471	457	-75	-13.74%	-89	-16.3%	311	286	285	306	-26	-8.4%
210024	MedStar- Union Mem	424	463	465	459	41	9.67%	35	8.3%	237	228	237	216	0	0.0%
210027	Western Maryland	473	539	533	410	60	12.68%	-63	-13.3%	269	263	264	252	-5	-1.9%
210028	MedStar- St. Mary's	383	389	447	485	64	16.71%	102	26.6%	284	267	282	296	-2	-0.7%
210029	JHH- Bayview	1189	1281	1237	1126	48	4.04%	-63	-5.3%	492	445	407	410	-85	-17.3%
210030	UMMS- Chestertown	501	437	471	444	-30	-5.99%	-57	-11.4%	180	170	183	180	3	1.7%
210032	ChristianaCare, Union	321	306	289	294	-32	-9.97%	-27	-8.4%	244	269	245	257	1	0.4%
210033	Lifebridge- Carroll	564	592	659	577	95	16.84%	13	2.3%	235	232	237	244	2	0.9%
210034	MedStar- Harbor	437	427	420	402	-17	-3.89%	-35	-8.0%	223	219	222	219	-1	-0.4%
210035	UMMS- Charles	516	562	486	478	-30	-5.81%	-38	-7.4%	258	281	264	283	6	2.3%
210037	UMMS- Easton	1244	1091	1266	1406	22	1.77%	162	13.0%	282	262	244	232	-38	-13.5%
210038	UMMS- Midtown	684	594	595	551	-89	-13.01%	-133	-19.4%	294	273	251	213	-43	-14.6%
210039	Calvert	419	380	380	391	-39	-9.31%	-28	-6.7%	261	230	218	234	-43	-16.5%
210040	Lifebridge- Northwest	650	598	576	676	-74	-11.38%	26	4.0%	339	295	273	286	-66	-19.5%
210043	UMMS- BWMC	754	798	827	812	73	9.68%	58	7.7%	335	301	293	341	-42	-12.5%
210044	GBMC	476	467	417	395	-59	-12.39%	-81	-17.0%	293	280	259	263	-34	-11.6%
210048	JHH- Howard County	853	958	1133	1112	280	32.83%	259	30.4%	358	337	297	278	-61	-17.0%
210049	UMMS-Upper Chesapeake	766	728	750	624	-16	-2.09%	-142	-18.5%	312	322	297	291	-15	-4.8%
210051	Luminis- Doctors	523	481	501	470	-22	-4.21%	-53	-10.1%	316	289	295	274	-21	-6.6%
210056	MedStar- Good Sam	541	565	544	511	3	0.55%	-30	-5.5%	263	234	248	248	-15	-5.7%
210057	Adventist- Shady Grove	431	454	370	359	-61	-14.15%	-72	-16.7%	291	277	256	251	-35	-12.0%
210060	Adventist-Ft. Washington	528	520	464	484	-64	-12.12%	-44	-8.3%	264	239	200	192	-64	-24.2%
210061	Atlantic General	206	201	204	275	-2	-0.97%	69	33.5%	135	138	137	145	2	1.5%
210062	MedStar- Southern MD	597	657	597	552	0	0.00%	-45	-7.5%	363	402	401	353	38	10.5%
210063	UMMS- St. Joe	637	635	689	645	52	8.16%	8	1.3%	375	327	313	314	-62	-16.5%
210065	Trinity - Holy Cross Germantown	458	466	476	386	18	3.93%	-72	-15.7%	266	244	238	221	-28	-10.5%
	Lifebridge- Grace									241	211	183	158	-58	-24.1%
	Tidal- McCready									82	72	64	69	-18	-22.0%
	UMMS-Aberdeen									245	244	207	211	-38	-15.5%
	UMMS- Laurel									277	240	238	229	-39	-14.1%
	UMMS- Cambridge									175	182	159	161	-16	-9.1%
	UMMS-Bowie ED									204	215	197	192	-7	-3.4%
	Adventist-Germantown ED									172	181	172	150	0	0.0%
	UMMS- Queen Anne's ED									132	129	141	140	9	6.8%
	Statewide	**562**	**561**	**551**	**535**	**-11**	**-2.0%**	**-27**	**-4.8%**	**285**	**273**	**262**	**262**	**-23**	**-8.1%**

Appendix V. IP LOS Performance

Table 1. State-Level Average Inpatient Length of Stay by Discharge Disposition

DISPOSITION	2023		2024		2025		2026 (Jan - Jun)	
	N	Ave. IP LOS	N	Ave. IP LOS	N	Ave. IP LOS	N	Ave. IP LOS
ROUTINE DISCHARGE TO HOME OR SELF CARE	333,459	3.7	335,827	3.7	331,186	3.8	160,716	3.8
HOME HEALTH CARE	59,010	6.8	61,884	6.7	62,633	6.8	32,277	6.7
SNF	57,771	9.5	58,507	9.4	56,480	9.4	28,425	9.5
INPATIENT REHAB FACILITY	9,509	9.2	10,233	9.2	11,155	9	5,825	9.1
HOSPICE DEFINED AS A MEDICAL FACILITY	5,631	10	5,934	10.3	6,399	10.1	3,219	9.9
HOSPICE AT HOME	4,897	8.5	5,423	8.3	5,695	8.4	2,897	8.4
FACILITY THAT PROVIDES CUSTODIAL OR SUPPORTIVE CARE	2,940	9.4	3,472	8.4	4,064	9.4	2,707	9.7
HEALTH CARE INSTITUTION NOT DEFINED	2,643	7.5	2,650	7.7	2,619	7.6	1,310	7.7
PSYCHIATRIC HOSPITAL	1,699	7.1	1,776	7.1	1,447	6.2	850	6.5
COURT/LAW ENFORCEMENT	956	6.1	1,023	6.2	1,262	5.6	695	5.5
LONG TERM CARE HOSPITAL (LTCH)	967	14.5	984	13.7	852	16.8	426	14.8
DESIGNATED CANCER CENTER OR CHILDRENS HOSPITAL	872	24.3	920	22.9	888	22.2	403	22.7
FEDERAL HEALTH CARE FACILITY	113	9.5	139	8.1	137	6	73	7.6
NURSING FACILITY CERTIFIED UNDER MEDICAID	112	8.6	115	7.6	101	7.5	47	5.9
DESIGNATED DISASTER ALTERNATE CARE SITE	9	3.4	8	14.9	8	5.8	1	12
Other	11	5.9	8	3.9	6	4.3	5	8.8

Note: N is the number of discharges. Data exclude discharges from chronic and rehabilitation beds, transfers to other acute care and psychiatric facilities, expired cases, patients that left against medical advice, and unknown discharge dispositions.

Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Table 2. CY 2023 Hospital-Level Case-Mix Data–Unadjusted Average Inpatient Length of Stay (days) by Discharge Disposition

Hospital	State Average 2023	Routine Home Discharges	Home Health Care	SNF	LTCH	Hospice	Other
Adventist White Oak	5.3	3.5	7.2	11.2	40.1	10.9	8.6
Anne Arundel	4	2.8	6.1	8.6	9.4	9	6.5
Ascension Saint Agnes	4.4	3.1	6.5	8.7	.	7.3	6.8
Atlantic General	4	3.1	4.1	7.1	.	5.5	4.7
Calvert	3.7	3.1	5	6	17.2	6.4	3.8
Carroll	4.5	3.3	5.6	7.2	8	7.6	6
ChristianaCare, Union	4.2	3.1	5.1	7	17.1	7.3	4.9
Doctors	5.7	4.3	6.4	10.1	13.5	10.6	8.3
Frederick	4.6	3.5	5.9	7.9	14.9	7.7	7
Ft. Washington	4.9	3.6	5	8	17.3	7.3	4.7
GBMC	4.1	3	6.5	8	11.3	6.8	8.2
Garrett	3.2	2.4	3.9	4.9	.	4.7	7
HC-Germantown	4.3	3.2	6.1	8.8	13.5	9.5	5.8
Holy Cross	4.5	3.6	6.4	10.1	11.8	10.4	10.5
Howard County	4.2	3.1	5.4	7.9	10	7.6	6.3
JH Bayview	6.4	4	7.6	12.1	.	12.1	10.8
Johns Hopkins	7.4	5.1	10.4	16.1	48.4	14.6	18.6
MedStar Fr Square	5.2	3.9	6.1	10	24.1	9.3	10.1
MedStar Good Sam	5.8	3.9	6.5	9.2	11	8.6	6.7
MedStar Harbor	4.7	3.8	5.3	7.7	7	9.9	7.1
MedStar Montgomery	4.9	3.4	5.5	7.1	16.5	8.1	6.1
MedStar Southern MD	4.8	3.5	5.9	11.3	12	8.9	8.4
MedStar St. Mary's	3.8	2.9	6.8	7.3	1	7.5	5.1
MedStar Union Mem	5.6	3.7	6.9	9	5.9	11	8.3
Mercy	4.1	3.1	7	6.6	.	10.9	12.1
Meritus	4	2.8	5.7	7.8	11.5	6	5.1
Northwest	6.7	5.3	6.5	9.7	18	8.2	8.3
Peninsula	4.1	2.9	5.5	7.9	12.2	6.9	6
Shady Grove	5	4	6.2	9.4	32.5	9.8	9
Sinai	7.3	5.2	10.3	14	17.4	14.9	8.6
Suburban	5.4	3.6	5.2	8.1	40.7	8.1	7.9
UM-BWMC	4.8	3.4	5.9	9.6	11.4	8.8	7.9
UM-Capital Region Med	5.1	3.7	7.2	12.4	33.3	10.9	9.5
UM-Charles Regional	4.9	3.1	6.3	8.7	16.2	8.4	6.4
UM-Chestertown	4.9	3.7	4.5	6.7	.	6.9	4.4
UM-Easton	4.7	3.2	5.9	9.1	11.8	8.1	7.3
UM-Harford	5.3	4.4	5	7.6	5.4	8	8.3
UM-St. Joe	4.1	3	5.9	6.9	10	7.1	7.3
UM-Upper Chesapeake	4.5	3.1	5.5	7.8	13.8	7.5	6.3
UMMC	7.5	4.8	10	16.9	39.4	15.1	18
UMMC Midtown	7.9	6.3	8.6	12.4	45	14.2	10.9
Western Maryland	4.9	3.7	6	8.1	19.5	7.9	6.6

Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Table 3. CY 2024 Hospital-Level Case-Mix Data–Unadjusted Average Inpatient Length of Stay by Discharge Disposition

Hospital	State Average 2024	Routine Home Discharges	Home Health Care	SNF	LTCH	Hospice	Other
Adventist White Oak	4.8	3.2	6.6	9.4	23.1	10.4	7.6
Anne Arundel	4	2.8	5.8	8.4	9.1	8.7	6.5
Ascension Saint Agnes	4.5	3.2	6.6	9.2	15.5	7.9	6.8
Atlantic General	3.9	3.1	3.8	6.1	.	5.7	4.9
Calvert	3.8	3.3	4.4	5.9	6.6	6.5	4.7
Carroll	4.6	3.3	5.8	7.7	2	8	7.3
ChristianaCare, Union	4.3	3.4	4.9	7	14.1	6.4	5.4
Doctors	5.6	4.4	6.1	9.7	16.1	8.2	6.5
Frederick	4.4	3.3	5.6	7.9	6.8	7.1	5.9
Ft. Washington	4.5	3.3	4.6	6.6	37	4.9	6.9
GBMC	4.2	3.1	6.3	8.1	7.4	8.6	8.1
Garrett	3.4	2.7	3.9	5.2	.	4.9	3.3
HC-Germantown	4.6	3.5	6	8.2	13.7	8.3	6.2
Holy Cross	4.5	3.6	6.7	10.1	11.2	11.3	9.4
Howard County	4.3	3.2	5.3	7.7	14	8.3	6.8
JH Bayview	6.5	4.1	7.4	12.5	106	13.5	11.1
Johns Hopkins	7.4	5.1	10.2	17.2	63.2	15.9	18.6
MedStar Ft Square	5.3	4.2	5.5	9.7	4.8	9.4	9.2
MedStar Good Sam	5.7	3.9	5.6	9.2	6.9	9.8	6.5
MedStar Harbor	4.7	4	5	7.8	5.5	8.5	5.3
MedStar Montgomery	4.3	3.2	4.7	6.3	4	6.7	5.3
MedStar Southern MD	5.1	3.9	6.2	10.7	.	9.6	8.8
MedStar St. Mary's	3.7	3	5.9	7.2	3	6.8	4.7
MedStar Union Mem	5.7	3.8	6.9	9.1	8.1	12.7	8.8
Mercy	4.2	3.2	6.9	8.2	6	9.2	8.6
Meritus	4.2	3.1	5.7	7.6	10.9	6.9	5.6
Northwest	7	5.7	6.8	10.1	.	8	8.8
Peninsula	4	2.9	5.1	7.7	7.9	6.6	5.9
Shady Grove	4.9	3.9	6.1	8.8	32.2	10.2	8.5
Sinai	6.8	4.8	8.6	13	21.8	12	8.5
Suburban	5.5	3.7	5.1	8.2	27.5	7.7	7.5
UM-BWMC	4.7	3.3	6.1	9.6	13.4	8.7	8.1
UM-Capital Region Med	5.3	3.7	7.9	11.7	32.1	10.3	9.8
UM-Charles Regional	5.3	3.4	6.5	9	15.6	9.2	6.2
UM-Chestertown	4.3	3.3	4.4	5.5	.	8.3	4
UM-Easton	4.7	3.3	5.6	8.6	7.7	7.4	6.9
UM-Harford	7.3	6.2	5.4	12.9	4	7.1	8.8
UM-St. Joe	4.1	3	6.2	7	8.5	7.2	7
UM-Upper Chesapeake	4.6	3.1	5.3	8.4	10.1	7.6	7.6
UMMC	7.8	4.9	10.6	17.2	29.4	17.7	18.4
UMMC Midtown	7.3	5.8	7.8	11.5	17	16.4	9.9
Western Maryland	4.7	3.6	5.9	7.7	24.5	7.9	6

Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Table 4. CY 2025 YTD Hospital-Level Case-Mix Data–Unadjusted Average Inpatient Length of Stay by Discharge Disposition

Hospital	State Average 2025	Routine Home Discharges	Home Health Care	SNF	LTCH	Hospice	Other
Adventist White Oak	4.8	3.3	7	9.3	22.5	9.6	7.5
Anne Arundel	4	2.9	5.8	8.5	10.9	8.4	6.4
Ascension Saint Agnes	4.6	3.2	5.7	9.3	27	7.7	7.4
Atlantic General	4	2.9	4.1	6.8	.	5.5	5.2
Calvert	3.7	3.2	4.4	5.7	7	5.4	4.5
Carroll	4.5	3.1	5.5	7.6	.	6.9	7
ChristianaCare, Union	4.4	3.5	5.6	6.9	14.3	6.6	5.3
Doctors	5.6	4.3	5.6	8.9	39.2	8.3	7.5
Frederick	4.6	3.3	5.9	8.5	8.1	7.9	6.5
Ft Washington	4.7	3.2	4.4	7.7	25.6	7.8	7.8
GBMC	4.2	3.1	6.5	7.8	8.2	7.8	10.5
Garrett	3.5	2.8	4.3	5	8	3.7	5.5
HC-Germantown	5	3.7	6.2	8.4	10.4	8.3	6.7
Holy Cross	4.8	3.8	6.6	10.5	14	11.3	10.3
Howard County	4.3	3.2	5.3	7.9	.	8.2	7.2
JH Bayview	6.6	4.3	7.8	12.3	55.6	14	12.1
Johns Hopkins	7.3	5.1	11	18.2	62.8	15.5	17.9
MedStar Fr Square	5.3	4	6.2	10.3	9.3	9.2	9.8
MedStar Good Sam	5.9	3.8	6.3	9	8.3	9.4	7.3
MedStar Harbor	4.7	3.9	5.8	8.3	9.3	10.9	5.4
MedStar Montgomery	4.3	3	4.7	6.7	.	7.8	5.8
MedStar Southern MD	4.7	3.7	5	9.1	9.2	8.7	6.6
MedStar St Mary's	3.7	2.8	5.7	7.8	6.5	9.4	4.6
MedStar Union Mem	5.6	3.9	6.8	9.1	5.8	12.5	9.4
Mercy	4.2	3.1	7.3	8.1	30	12.8	14.9
Meritus	4.3	3.2	5.6	8.1	17.1	6.9	5.8
Northwest	6.7	5.7	6.4	9.5	65	8.5	8
Peninsula	4	2.9	4.9	7.4	13.1	6.6	5.8
Shady Grove	4.9	3.9	6.5	9.1	20	9.6	8.1
Sinai	6.3	4.6	7.9	11.4	19.9	9.9	7.4
Suburban	5.5	3.8	5.1	8.1	83.7	8.7	7.2
UM-BWMC	4.8	3.4	5.9	8.8	26.9	9.4	7.7
UM-Capital Region Med	5.4	3.8	7.1	12.4	43.6	10.6	10.2
UM-Charles Regional	4.8	3.2	5.7	8.5	19.6	8.3	5.8
UM-Chestertown	4.1	3.1	4.2	5.4	.	5.4	4.3
UM-Easton	4.8	3.3	6	9	16.8	8.7	6.7
UM-St. Joe	4.3	3.2	5.6	7.2	6.4	7.7	7.6
UM-Upper Chesapeake	4.8	3	5.4	8.1	12.6	8	7.8
UMMC	8.2	5.2	11.6	18.1	24.3	18	17
UMMC Midtown	8.1	6.3	8.2	15.9	5	15.5	9.6
Western Maryland	5	3.7	6.1	8.4	7.7	7.6	7.4

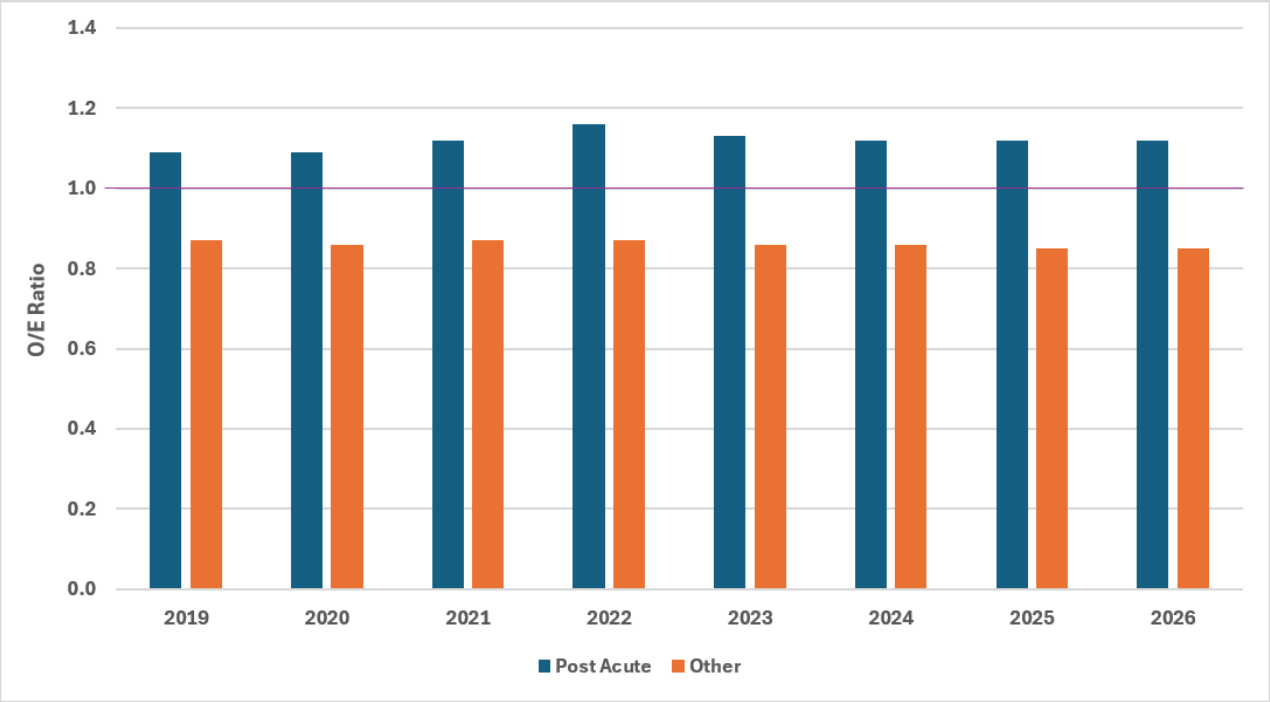
Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Table 5. CY 2026 YTD Hospital-Level Case-Mix Data–Unadjusted Average Inpatient Length of Stay by Discharge Disposition

Hospital	State Average 2026 (Jan-Jun)	Routine Home Discharges	Home Health Care	SNF	LTCH	Hospice	Other
Adventist White Oak	5	3.4	6.2	9.2	20.2	10.5	7.2
Anne Arundel	4.1	3	5.4	8	10.1	8.7	5.6
Ascension Saint Agnes	4.7	3.2	6.1	9.2	12.5	7.7	6.3
Atlantic General	4	2.8	4.1	7.8	2	6.3	5.2
Calvert	3.9	3.3	4.7	5.8	12.8	5.8	4.3
Carroll	4.4	3.2	5.3	7.4	.	6.7	6.8
ChristianaCare, Union	4.3	3.4	5	6.5	41	6.3	5.3
Doctors	5.5	4.3	5.6	8.9	11.8	7.9	6.2
Frederick	4.5	3.4	5.6	8.2	4.8	7.6	9
Ft Washington	5.6	3.5	5.3	9.4	17	8.9	7.5
GBMC	4.1	3.1	6.6	6.9	4.5	7.6	10.7
Garrett	3.5	2.8	4.8	5.3	4	4.8	3.6
HC-Germantown	4.8	3.4	6.4	8.4	6.6	8.8	5.2
Holy Cross	4.9	3.7	6.6	11.1	15.5	11.5	8.5
Howard County	4.3	3.2	5.6	7.7	.	7.4	6.1
JH Bayview	6.8	4.4	7.6	13	.	12.7	11.3
Johns Hopkins	7.4	5.3	10.6	16.9	74.2	16.1	18.7
MedStar Fr Square	5.6	4.1	6.7	10.9	9.8	9.8	10.2
MedStar Good Sam	5.8	3.9	6.5	8.4	11.9	9.1	7
MedStar Harbor	4.9	4	5.6	9.8	8.7	13.4	6.5
MedStar Montgomery	4.1	2.9	4.1	6.6	3.5	7.5	4.6
MedStar Southern MD	4.6	3.5	4.8	9.2	12.8	7.1	5.8
MedStar St Mary's	3.8	2.9	5.2	8.3	3.8	7.6	4.2
MedStar Union Mem	5.8	3.8	6.6	8.9	8.8	13.9	11.3
Mercy	4.5	3.2	8.5	8.9	.	10.4	15.3
Meritus	4.5	3.3	6.5	8.1	26.9	7	5.6
Northwest	6.8	5.2	6.9	10.2	13	10.5	8.4
Peninsula	4.3	2.9	5.5	7.9	22	6.2	6.5
ShadyGrove	5.2	4.2	6.4	8.6	18.6	9	8.2
Sinai	6.6	4.9	8.1	12	17.5	11.5	7.5
Suburban	5.5	3.8	5.4	8.1	22	7.6	7.8
UM-BWMC	4.8	3.4	5.6	9.3	10.5	9.4	7.7
UM-Capital Region Med	5.5	3.8	7.1	11.3	35.8	9.2	13.7
UM-Charles Regional	4.7	3.1	5.9	8.2	9.8	7.5	5.4
UM-Chestertown	3.9	2.5	3.6	5.8	.	7.4	4.6
UM-Easton	5	3.4	5.8	9.2	11.6	8.5	6.5
UM-St. Joe	4.5	3.3	5.6	7.1	8.9	7.3	8.4
UM-Upper Chesapeake	4.9	3.1	5.5	8.1	10.8	8.2	8.8
UMMC	8.5	5.4	11.8	20	20.6	17.7	18.9
UMMC Midtown	7.7	5.6	8.8	12.6	13.5	14.4	9.4
Western Maryland	5	3.8	6.2	.	9.1	8	7.3

Source: HSCRC Analysis of All-Payer Hospital Case-Mix Data

Figure 1. Trends in Observed over Expected Ratios of Discharges to Post-Acute Care vs. Others, CY 2019-2026, Jan-Jun



Source: HSCRC Case-Mix All-Payer Inpatient Data CY 2019-2026 YTD and HCUP 2023 norms.

Appendix VI. Trends in Aging and Inpatient Length of Stay by Age Group

Table 1 shows state planning estimates of the proportion of Marylanders that are projected to be in each of several older adult age groups in 2020 through 2040. These estimates show 1.14 million people aged 65+ in 2025, roughly 18% of the population, rising to 1.30 million in 2030 and 1.44 million in 2040. Furthermore, the growth in Maryland's older population is accelerating, with the state's 85+ population projected to more than double from about 122,000 in 2020 to 264,000 in 2040. These changes will place a burden on the healthcare system, which could result in more acute, more complex hospitalizations with longer lengths of stay. However, this has not been the recent trend observed in Maryland. As shown in Figure 1, after the pandemic, average LOS for those 75 and older has declined and is modestly lower than for patients between 65 and 74.

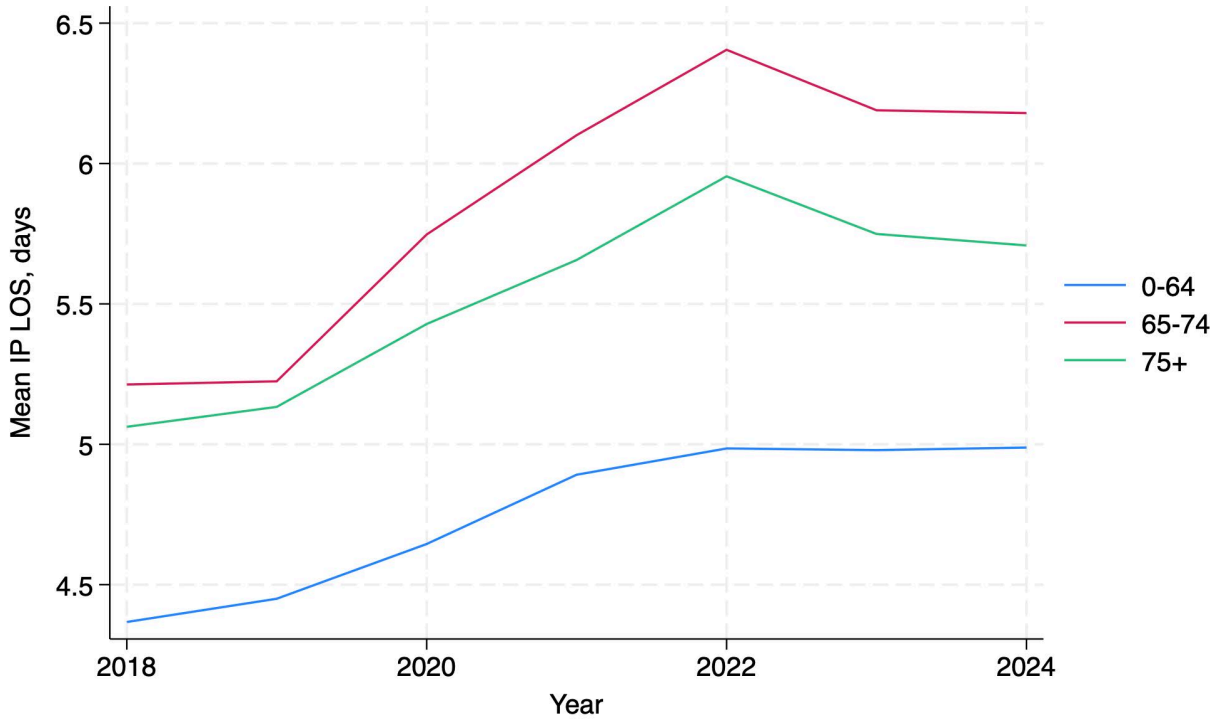
Table 1. Projected Changes of Maryland's Older Adult Population from 2020 to 2040

	Total Population in 2020	Share of Total Population in 2020	Total Population in 2025	Share of Total Population in 2025	Total Population in 2030	Share of Total Population in 2030	Total Population in 2040	Share of Total Population in 2040	Overall Change 2020-2040
55-64	838,038	13%	813,009	13%	745,846	12%	751,238	11%	-10%
55-59	438,926	7%	397,928	6%	365,024	6%	399,604	6%	
60-64	399,112	6%	415,081	7%	380,822	6%	351,634	5%	
65-74	576,744	12%	648,843	10%	707,550	11%	646,204	10%	12%
65-69	322,390	5%	363,987	6%	382,878	6%	327,746	5%	
70-74	254,354	7%	284,856	5%	324,672	5%	318,458	5%	
75-84	276,143	4%	354,066	6%	421,634	7%	528,526	8%	91%
75-79	170,511	3%	218,675	4%	246,604	4%	300,408	4%	
80-84	105,632	2%	135,391	2%	175,030	3%	228,118	3%	
85+	122,092	2%	136,727	2%	167,491	3%	264,209	4%	116%
85+	122,092	2%	136,727	2%	167,491	3%	264,209	4%	
Statewide 55+ Population	1,813,017	30%	1,952,645	31%	2,042,521	32%	2,190,177	33%	21%
Statewide 60+ Population	1,374,091	23%	1,554,717	25%	1,677,497	26%	1,790,573	27%	30%
Statewide 65+ Population	974,979	16%	1,139,636	18%	1,296,675	20%	1,438,939	21%	48%
Statewide Total Population	**6,074,725**		6,244,960		6,413,698		6,739,376		

Source: National Center for Smart Growth[59]

[59] Finio, N., Dawkins, C., Howell, K., Desir, W., McManus, S., Garman, R., Prendergast, C., Shultz, C., McRoberts, A., & Hoffman, K. (2025). *Maryland housing needs assessment update*. National Center for Smart Growth. https://dhcd.maryland.gov/media/1135

Figure 1. Average Inpatient Length of Stay in Maryland by Year and Age Group



Source: HSCRC casemix data for patients with acute-care inpatient stays

Appendix VII. Inpatient Beds by State

Table 1. Rankings of State Inpatient Beds Per 1,000 Population, 2024

Location	Beds per 1,000 Population	Location	Beds per 1,000 Population
51. Washington	1.57	26. Maine	2.32
50. Oregon	1.64	25. Michigan	2.34
49. New Mexico	1.67	24. Illinois	2.35
48. Utah	1.68	23. Florida	2.44
47. Maryland	**1.71**	22. New York	2.51
46. Wisconsin	1.76	21. Indiana	2.57
45. Idaho	1.8	20. Delaware	2.58
44. California	1.81	19. Pennsylvania	2.59
43. Rhode Island	1.88	18. Tennessee	2.6
42. Colorado	1.92	17. Iowa	2.6
41. Hawaii	1.94	16. Ohio	2.62
40. Arizona	1.97	15. Oklahoma	2.67
39. Nevada	1.97	14. Missouri	2.85
38. Virginia	1.99	13. Alabama	2.97
37. North Carolina	2	12. Kansas	3.03
36. Alaska	2.01	11. Arkansas	3.05
35. South Carolina	2.04	10. Louisiana	3.14
34. New Hampshire	2.05	9. Kentucky	3.16
33. Connecticut	2.05	8. Wyoming	3.19
32. Vermont	2.06	7. Montana	3.26
31. Texas	2.13	6. Nebraska	3.34
30. Georgia	2.17	5. Mississippi	3.58
29. Massachusetts	2.22	4. West Virginia	3.63
28. New Jersey	2.24	3. North Dakota	4.05
27. Minnesota	2.25	2. District of Columbia	4.19
United States	2.28	1. South Dakota	4.38

Appendix VIII. Agent-Based Simulation Modeling

HSCRC developed a series of simulation models to estimate how different solutions might reduce ED LOS. This approach was used because standard statistical analyses can show which factors are linked to longer ED stays, but they are often less able to predict what would happen if a particular hospital made a specific change. Hospitals are complex settings, and a change in one area can affect other areas in unexpected ways. For example, statistical models often assume that relationships work in only one direction (e.g., a higher rate of ED arrivals is associated with a longer ED LOS). However, in many cases, these relationships are more complex (a higher arrival rate results in longer LOS, which causes EMS diversions and brings about a lower arrival rate). To better capture these back-and-forth effects, HSCRC developed an Agent-Based Model (ABM), which is a simulation that creates a virtual environment of patients, providers, and hospital resources interacting over time. Unlike standard statistical models, these simulations are designed specifically to estimate the impact of interventions within complex systems.

The ABM simulates key ED and IP characteristics and dynamics at each of the state's 42 acute-care hospitals. The model was intended to help the ED Commission and other policymakers prioritize potential solutions based on which are most likely to work and how results may vary across hospitals.

The model relies on real-world data collected and submitted by the state's hospitals, including ED visit counts, staffing details, and patient volume and LOS in IP units. For each ED, the model generates simulated patients, assigns them an Emergency Severity Index triage level based on how urgent their conditions are, and simulates their path through the hospital—from the triage and waiting queues to diagnostic testing (accounting for turnaround times), assignments to providers (MDs [medical doctors] and RNs [registered nurses]), and eventual admission to an IP bed or discharge from the ED.

To ensure the results were reliable, the model was tested against historical HSCRC casemix data. A hospital model was considered valid only if its key results–such as ED LOS for admitted and discharged patients, ED volume, percent admitted, and wait times–were within 10 percent of actual historical values across 100 simulation runs, each replicating 120 days of operations. After validation, interventions were tested by changing model inputs and measuring how ED LOS changed for admitted and discharged patients over 500 simulations of 120-day runs at each hospital. Following are the interventions recommended by ED Commission and Subgroup members for modeling.

- Discharge Planning Teams
    - Policy Rationale: Expediting inpatient discharge planning clears hospital beds faster, reduces downstream ED boarding, and improves overall hospital throughput.

    - Model Inputs Altered: Reduced the average IP LOS by 10 percent across all inpatient units, based on findings from Artenstein et al. (2017).[60]
- ED Nurse Staffing Increases
    - Policy Rationale: Adding ED nurses could reduce delays for patients who are treated and released from the ED (OP-18) and shorten the time it takes for patients to see a provider.
    - Model Inputs Altered: Increased Registered Nurse (RN) staffing in EDs by 10 percent across all shifts.
- Direct Admit Volume Restrictions
    - Policy Rationale: Limiting non-ED direct admissions during busy periods can help preserve inpatient beds for patients waiting in the ED and reduce ED boarding.
    - Model Inputs Altered: Restricted new direct admissions when the medical/surgical IP unit was more than 80 percent full.
- Guardianship Policy Changes
    - Policy Rationale: Some patients who lack decision-making capacity stay in the hospital longer because they are waiting for legal guardianship decisions before they can be discharged. Reducing these delays can free up inpatient beds for other patients.
    - Model Inputs Altered: Capped IP LOS at 30 days.
- Prior Authorization Improvements
    - Policy Rationale: Delays in insurance prior authorization can slow transfers to post-acute care settings, such as SNFs. Making this process faster can open acute beds faster.
    - Model Inputs Altered: Reduced IP LOS by 20 percent for patients discharged to SNFs.
- Inpatient Capacity Expansion
    - Policy Rationale: Adding acute care beds could reduce ED boarding, but it may also increase demand if more patients are admitted directly to the hospital.
    - Model Inputs Altered: Increased inpatient bed capacity by 10 percent and also increased direct admissions by 10 percent based on literature from Helm et al. (2011).[61]

The simulation results showed how each intervention could affect ED and hospital operations. Table 1 shows the percent change in IP and OP ED LOS that resulted from each of the interventions tested (sorted by highest to lowest impact on ED LOS for admitted patients). Additionally, literature and preliminary

[60] Artenstein, A., Rathlev, N., Neal, D., Townsend, V., Vemula, M., Goldlust, S., Schmidt, J., & Visintainer, P. (2017). Decreasing Emergency Department Walkout Rate and Boarding Hours by Improving Inpatient Length of Stay. *Western Journal of Emergency Medicine*, 18(6), 982-992, https://pubmed.ncbi.nlm.nih.gov/29085527/

[61] Helm, J. E., AhmadBeygi, S., & Van Oyen, M. P. (2011). Design and analysis of hospital admission control for operational effectiveness. *Production and Operations Management, 20*(3), 359-374. https://doi.org/10.1111/j.1937-5956.2011.01231.x

simulation modeling suggest that interventions targeted at reducing avoidable ED utilization from SNFs can reduce both ED and IP LOS. Further modeling of these interventions is proposed as a next step analysis.

Table 1: Simulated Interventions and Associated Changes in Mean ED LOS for Maryland Hospitals

Intervention	Hospital Parameters Altered	% Change in Mean ED LOS, Admitted Patients	% Change in Mean ED LOS, Discharged Patients
Discharge Planning Team	Reduce average IP LOS by 10%	-4.7	0
IP Capacity Increase	10% increase in IP beds, 10% increase in direct admits	-4.5	0
Direct Admit Volume	Restrict direct admits when med/surg unit is at >80% capacity	-4.1	0
Guardianship Policy Change	Limit long LOS patients to 30 days	-2.9	0
Prior Authorization Improvement	Reduce IP LOS by 20% for SNF transitions	-2.6	0
Home Health Expansion	20% reduction in discharges to SNF	-1.8	0
ED RN Staffing	10% increase in RN staffing across all shifts	-0.2	-1.4

Interventions were simulated using 2025 HSCRC Casemix data for 42 Maryland hospitals

1. Generally, interventions that successfully reduced IP LOS across the hospital had larger effects on ED-1 LOS (i.e., discharge planning). However, broad-based interventions may be difficult to effectuate, and reductions in IP LOS for specific populations, such as guardianship patients and patients transitioning from acute to post-acute care, also improved ED LOS for admitted patients.
2. Having more ED nurses helped certain patients more than others. A 10 percent increase in RN staffing helped patients who were treated and released to leave the ED faster (OP-18). However, it had little effect on patients waiting to be admitted (ED-1) because their delays were often caused by a lack of available inpatient capacity rather than ED staffing alone.
3. Most interventions that reduced LOS for admitted patients had less impact on LOS for patients who were treated and released. A contributing factor to this difference is that hospitals have used alternative treatment spaces and waiting-room triage to maintain patient flow despite ED boarding. While these strategies provide short-term flexibility, the ED Commission raised concerns about the need to routinely triage, treat, and discharge patients in alternate ED spaces.

4. Hospitals with the longest ED stays saw the biggest potential gains: Although several interventions improved ED LOS across many hospitals, the largest improvements were seen at hospitals that currently have the longest ED LOS.

Appendix IX. Feedback Received that Did Not Reach Majority Consensus

This appendix summarizes input and recommendations submitted by ED Commission members for which there was not majority consensus. General feedback included that there should be greater specificity in each of the recommendations, including identifying stakeholders with whom the recommendation is directed, as well as a suggested timeline for completion. While some recommendations were expanded in response to ED Commissioner feedback, implementation will require the relevant stakeholders and state agencies to assess appropriate resources and timelines. Furthermore, some Commissioners recommended a measured, data-driven approach that builds on existing initiatives, allows recently enacted policies to mature, and leverages validated data to inform future actions. This viewpoint supports continued efforts to address capacity and staffing challenges while encouraging policymakers to prioritize the ongoing capacity analyses, evaluate the impact of recently enacted staffing requirements before pursuing additional mandates, and allow new IP LOS and collaborative improvement initiatives to demonstrate results before considering new policy interventions. While all ED Commissioners supported continuing existing initiatives, views differed on whether additional initiatives and policies should be pursued before the impacts of these recently implemented measures are fully assessed.

Additional specific recommendations proposed by individual ED Commissioners that did not have majority consensus are listed below.

- Conduct additional data analysis to further quantify each key driver of ED LOS and assess the magnitude, feasibility, and expected impact of proposed interventions.
- Study minor hospital operational issues and delays, such as delays in patient transports or environmental services (e.g., cleaning and disinfecting rooms), so that additional opportunities for operational efficiencies can be identified.
- Engage and involve additional stakeholder groups that were not included in the ED Commission's process, including frontline health care workers and their representative organizations. While Commissioners had several hospital site visits, one ED Commissioner recommended providing an opportunity for them to testify before the full ED Commission.
- Require SNFs with available beds to accept any patient when beds are available.
- Develop a multisystem SNF modeled after the Mt. Washington Pediatric Hospital to address post-acute bed concerns.
- Evaluate and streamline the current regulatory processes to provide hospitals with greater flexibility to open and close beds.
- Establish "disaster" modeled alternate capacity areas such as overflow tents and trailers that could be used during "surge" occupancy. Consensus was not reached due to logistical and regulatory

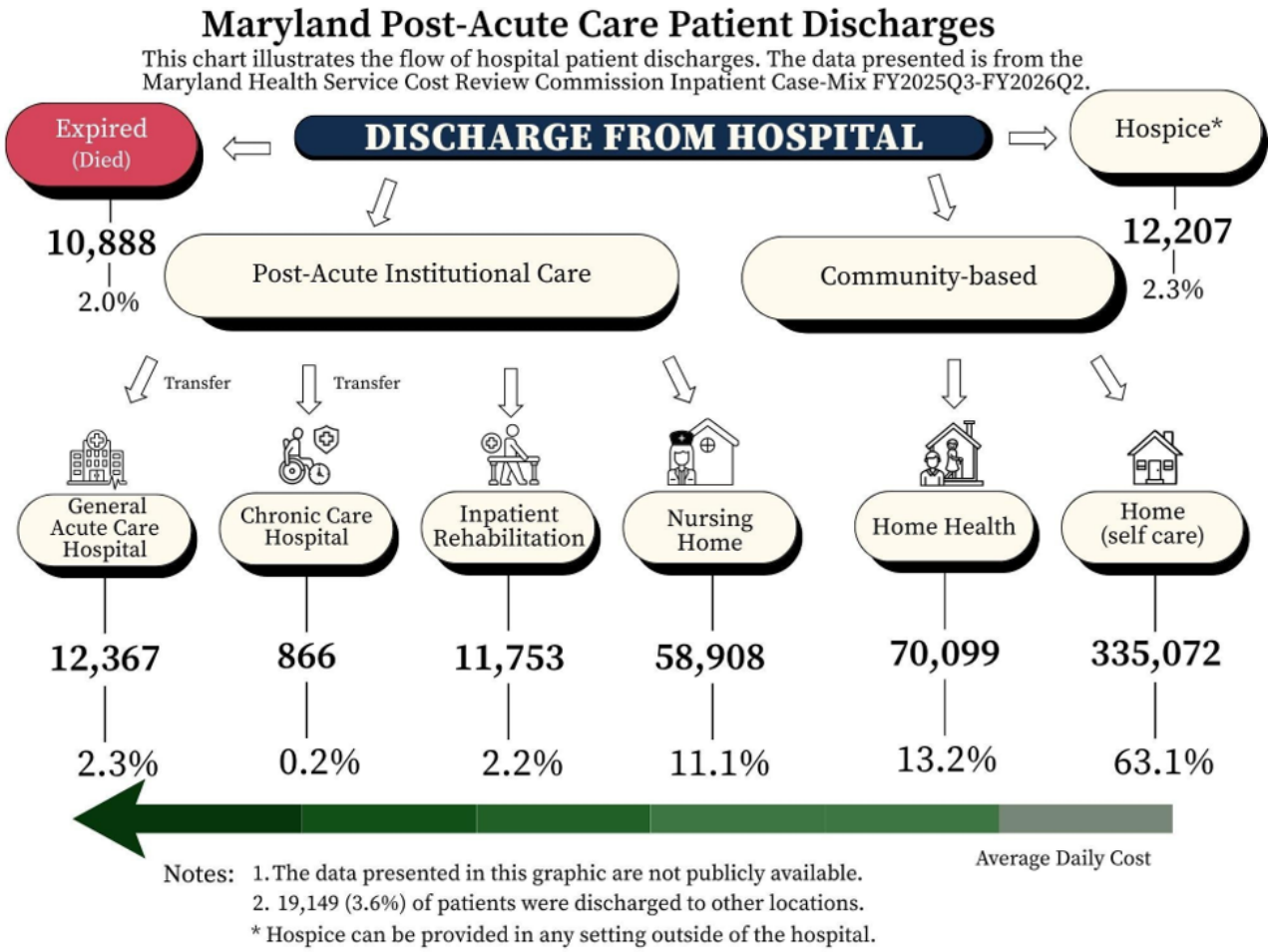
concerns, including hospital accreditation requirements, OSHA requirements, and infrastructure and staffing challenges.

- Make Screening, Brief Intervention, and Referral to Treatment (SBIRT) available at all times in all EDs. No Commissioners opposed this suggestion, but the majority did not believe it would decrease ED LOS. Some Commissioners noted that SBIRT is already integrated into some hospital systems' electronic medical records (EMRs). However, EMR design for various hospital units is an organizational decision.
- Increase salaries for hospital workers, particularly those at the bottom of the pay scale, and reduce salaries for administrative staff earning more than $500,000 annually. Review hospital salary structures from the top down.
- Support public health initiatives, including providing iron supplements in the ED, implementing home-based fall prevention programs, and addressing patients' SDOH. While most ED Commissioners agreed that these initiatives may be beneficial for specific patient populations in the long-term, they would have limited direct impact on ED LOS.
- Monitor implementation of the Safe Staffing Act, considering implementation is not required until July 2028. Consider including all hospital workers in staffing analyses, including frontline and support positions, and consider collecting and comparing staffing information across hospitals. The majority of the ED Commissioners instead supported allowing time to assess the impact of the recently implemented Safe Staffing Act recommendations before considering additional recommendations.
- Support additional resources for EDs as needed in response to the additional demands associated with legislation enacted in 2026, which defined "danger to the life or safety of the individual or of others" for provisions of law regarding the emergency evaluation of an individual with a mental disorder and their involuntary admission to a facility.[62] The Commissioners acknowledged that this, along with other legislation, may have an impact in the ED but had no specific recommendations at this time.

[62] 2026 MD Laws Ch. 177.

Appendix X. Maryland Hospital Discharge Destinations

Figure 1. Number and Percentage of Patients Discharged From Maryland Hospitals to Post-Acute Care Facilities, Hospice, and Home[63]



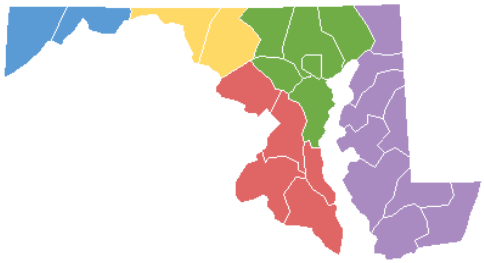
[63] This figure was drawn from: Maryland Health Care Commission. (2026). Strengthening post-acute care towards meeting the goals of AHEAD. https://mhcc.maryland.gov/sites/default/files/2026-07/mhcc_ahead_pac_rpt_a11y.pdf.

Appendix XI. Acute and Post-Acute Bed Counts by Region

Figure 1. Illustrative Maryland Map with the 5 MIEMSS Regions Identified[64]

Maryland Acute Care Beds

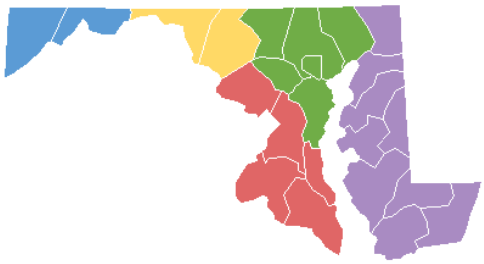
Maryland counties by assigned region



Region	Counties	2024	2025	Δ	%Δ
Region I	Allegany, Garrett	237	234	-3	-1.3%
Region II	Washington, Frederick	502	501	-1	-0.2%
Region III	Carroll, Harford, Anne Arundel, Howard, Baltimore, Baltimore City	5,315	5,289	-26	-0.5%
Region IV	Dorchester, Kent, Queen Anne's, Somerset, Talbot, Caroline, Worcester, Cecil, Wicomico	541	610	+ 69	+12.8%
Region V	Calvert, Charles, St. Mary's, Montgomery, Prince George's	1,996	1,952	-44	-2.2%

Maryland Post-Acute Care Beds

Maryland counties by assigned region



Region	Counties	2024	2025	Δ	%Δ
Region I	Allegany, Garrett	1,225	1,225	0	0.0%
Region II	Washington, Frederick	2,008	2,008	0	0.0%
Region III	Carroll, Harford, Anne Arundel, Howard, Baltimore, Baltimore City	12,318	12,206	-112	-0.9%
Region IV	Dorchester, Kent, Queen Anne's, Somerset, Talbot, Caroline, Worcester, Cecil, Wicomico	2,504	2,512	+ 8	+0.3%
Region V	Calvert, Charles, St. Mary's, Montgomery, Prince George's	8,695	8,823	+ 128	+1.5%

[64] Sources: 2024-2025 HSCRC casemix data; MIEMSS “Maryland Emergency Medical Services - Regions” Dataset found at: https://data.imap.maryland.gov/datasets/maryland-emergency-medical-services-regions/about; MDH Office of Long Term Services And Support CY 2025 Nursing Facility Occupancy Report

Figure 2. Median Inpatient ED Length of Stay by Hospital, CY 2024 and CY 2025

Region	Hospital	2024 Median IP ED LOS (minutes)	2025 Median IP ED LOS (minutes)	Change in Median IP ED LOS (2025-2024)
Region I	Garrett County Memorial Hospital	244	231	-13
Region I	Western Maryland Regional	539	533	-6
Region II	Fredrick Memorial Hospital	421	453	32
Region II	Merritus Health System	365	418	53
Region III	Anne Arundel Medical Center	509	471	-38
Region III	Ascension Saint Agnes	553	438	-115
Region III	Carroll Hospital Center	592	659	67
Region III	Greater Baltimore Medical Center	467	417	-50
Region III	Howard County	958	1134	176
Region III	Johns Hopkins Bayview	1281	1236.5	-44.5
Region III	Johns Hopkins Hospital	1032	973	-59
Region III	MedStar Fr Square	632	698	66
Region III	MedStar Good Samaritan Hospital	565	544	-21
Region III	MedStar Harbor Hospital	427	420	-7
Region III	MedStar Union Memorial	462	465	3
Region III	Mercy Medical Center	492	444	-48
Region III	Northwest Hospital Center	598	576	-22
Region III	Sanai Hospital of Baltimore	941	801	-140
Region III	UM-Baltimore Washington Medical	799	827	28
Region III	UMMC	1474	1388	-86
Region III	UMMC Midtown	594	595	1
Region III	UM-St. Joeseph Medical Center	635	689	54
Region III	UM-Upper Chesapeake	728	750	22
Region IV	Atlantic General Hospital	201	204	3
Region IV	ChristianaCare Union Hospital	306	288.5	-17.5
Region IV	Peninsula Regional Medical Center	485	478	-7
Region IV	UM-Shore Medical Center at Chester	437	471	34
Region IV	UM-Shore Medical Center at Easton	1091.5	1266	174.5
Region V	Adventist White Oak	889	632	-257
Region V	Calvert Memorial Hospital	380	380	0
Region V	Doctors Community Hospital	481	501	20
Region V	Ft. Washington Hospital	519.5	464	-55.5
Region V	Holy Cross-Germantown Hospital	466	476	10
Region V	Holy Cross Hospital	505	550	45
Region V	Medstar Montgomery Medical Cente	470	450	-20
Region V	MedStar Southern MD	657	597	-60
Region V	MedStar St. Mary's Hospital	389	447	58
Region V	Adventist Shady Grove	454	370	-84
Region V	Suburban Hospital	484	461	-23
Region V	UM-Capital Region Medical Center	1156	1267	111
Region V	UM-Charles Regional Medical Cente	562	486	-76
	AVERAGE Across all Regions	615.6341463	608.5121951	

Figure 3. Median Inpatient ED Length of Stay by Hospital and Region, CY 2025

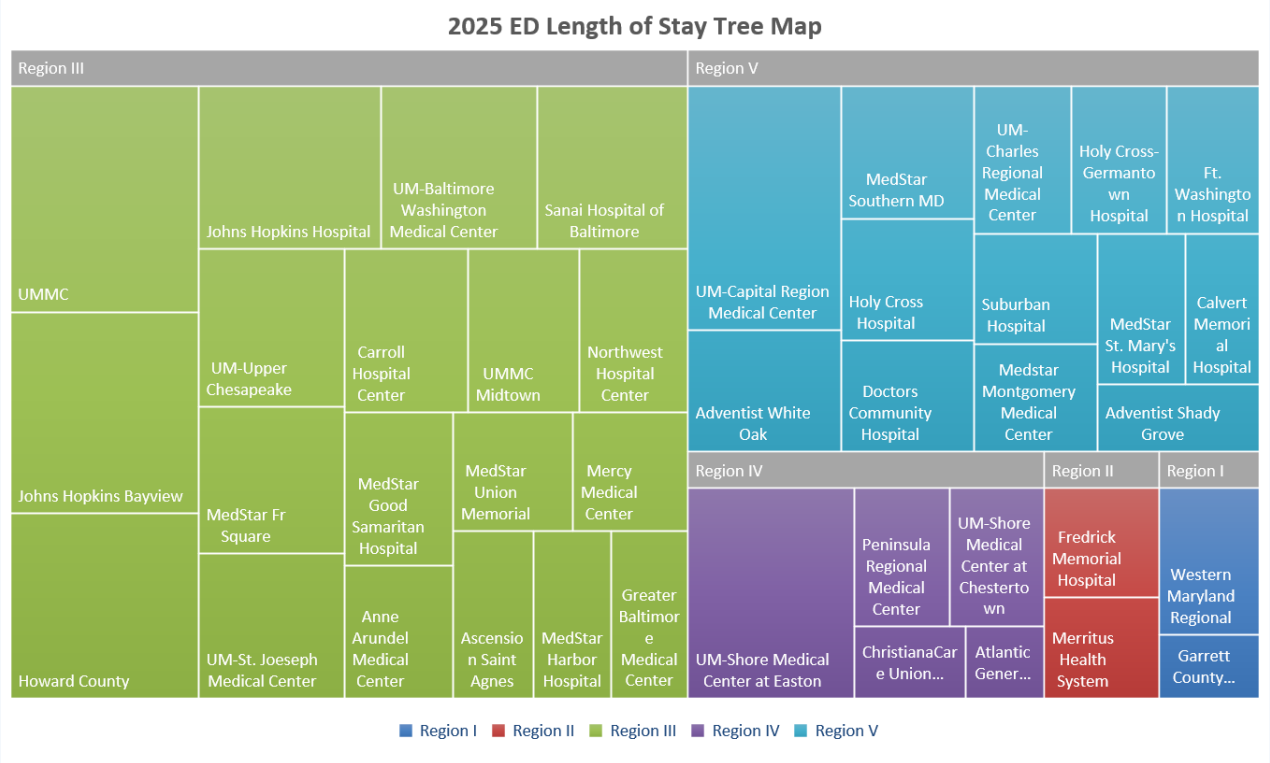


Figure 4. Median Inpatient ED Length of Stay and Percent of PAC Beds Occupied by Region, CY 2024–2025

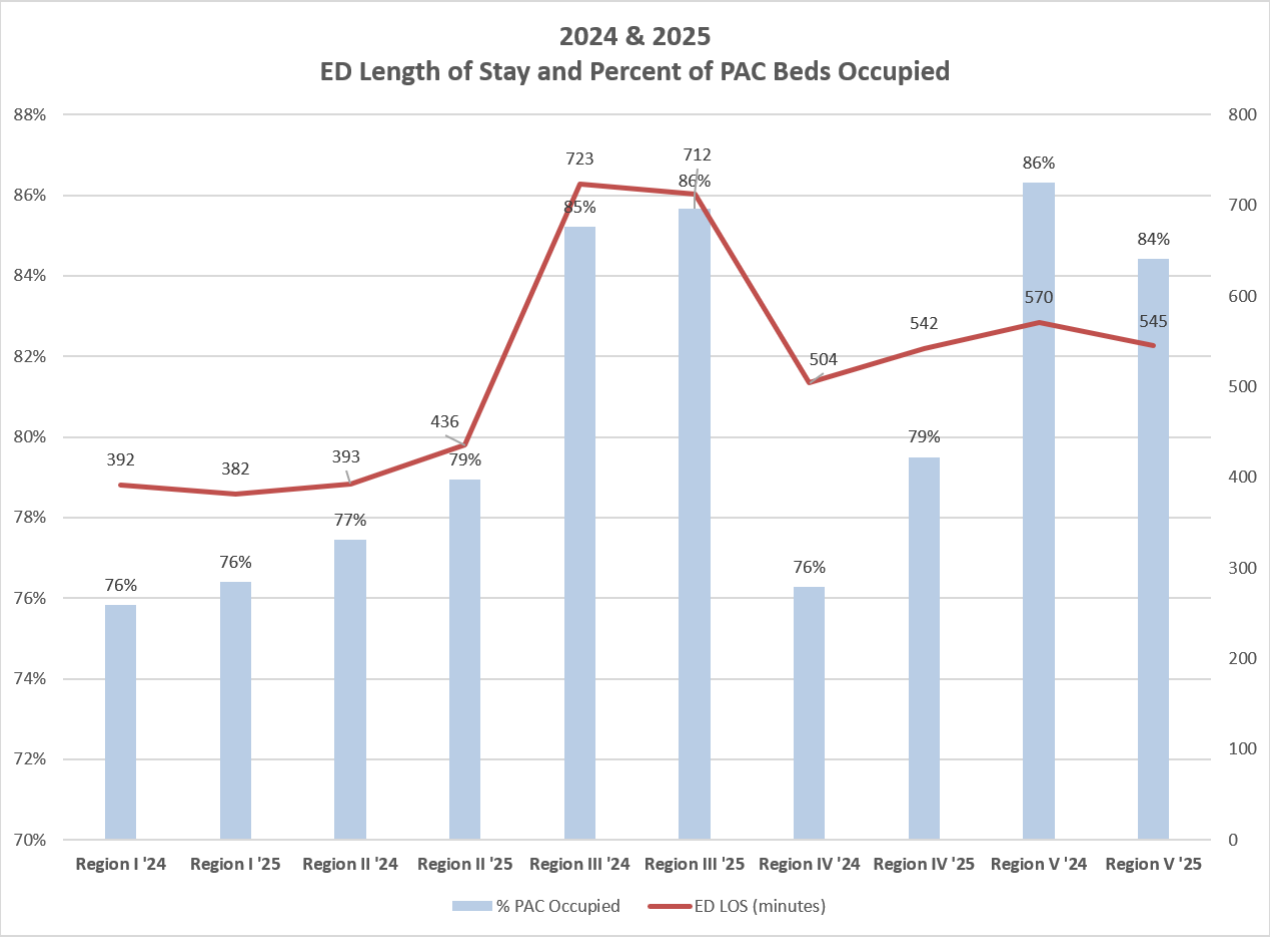
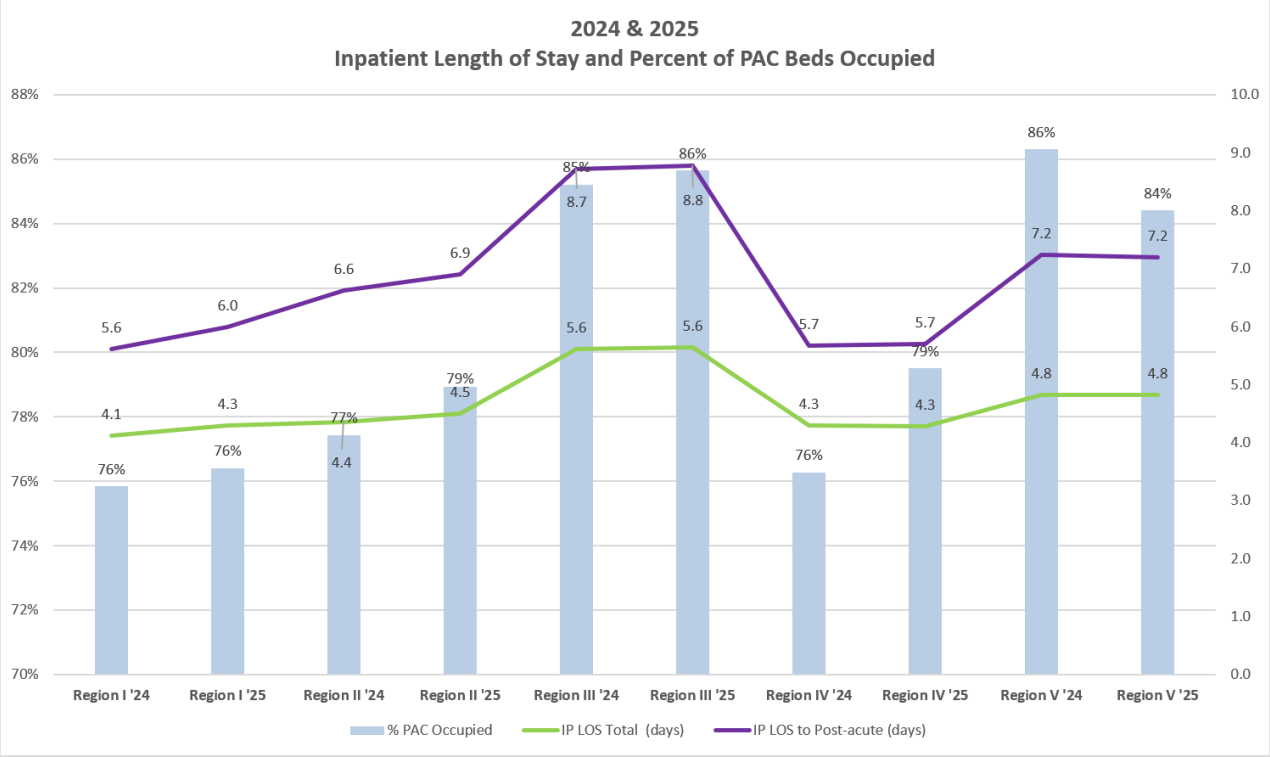


Figure 5. Inpatient Length of Stay and PAC Bed Occupancy by Region, CY 2024–2025



Appendix XII. Bed Capacity Analysis Work Plan

Figure 1: Rationale for Bed Capacity Study

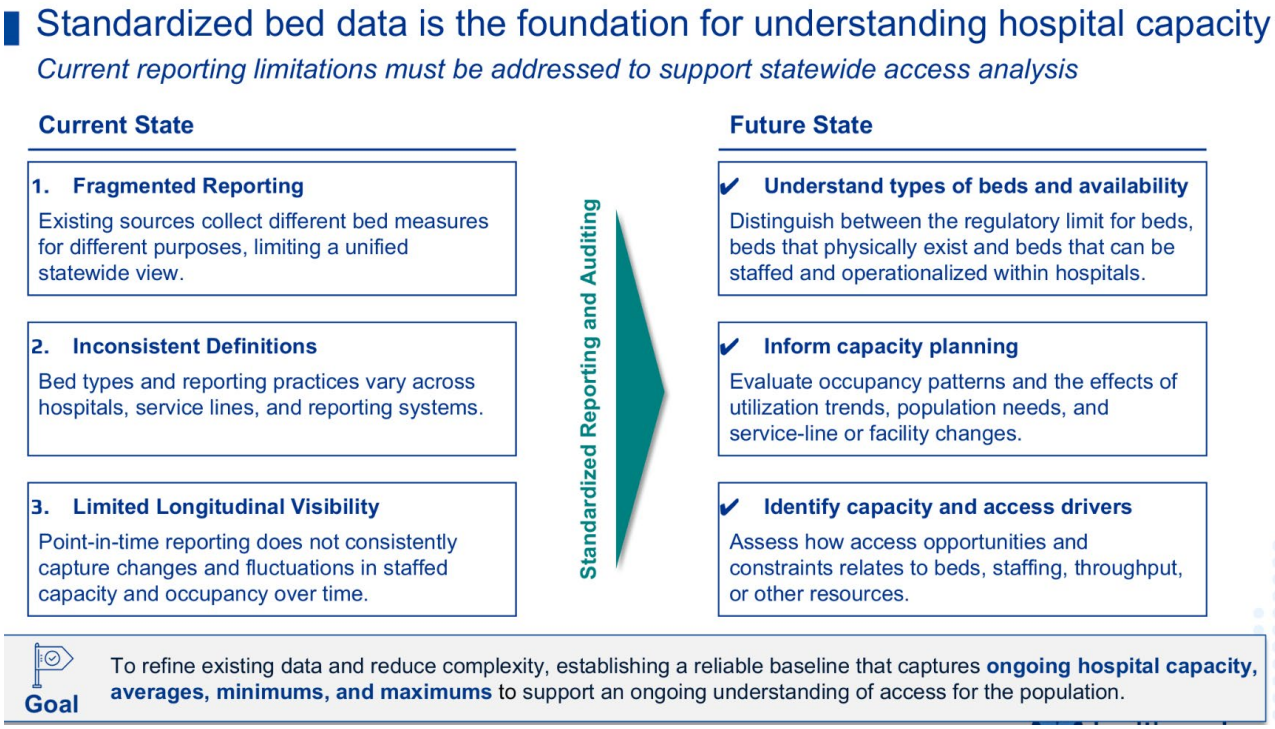


Figure 2: Objectives for Bed Capacity Study

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 (*data available at the statewide level*)
BH Admin	Real-time psychiatric bed availability by hospital *(site specific reporting; clarity required on reporting path, retrospective views, and total staffed beds)*

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