

ED Wait Time Reduction Commission Meeting

September 23, 2026

Agenda

- Psychiatric Bed Registry Presentation
- Review Draft of Legislative Report
- Public Comment

Psychiatric Bed Registry



MD Behavioral Health Connect: Streamlining Access to Care

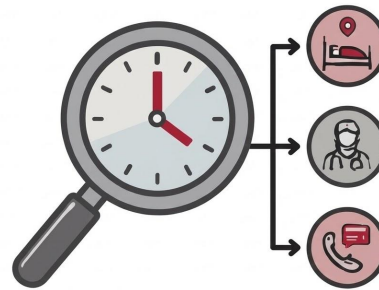
September 23, 2026

Authority

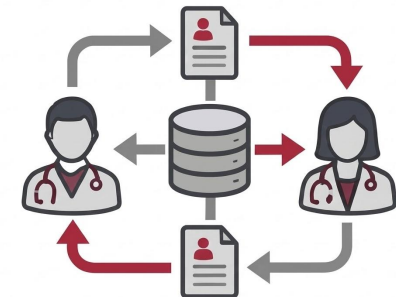
[House Bill 1121 of 2020](#) and [Health-General Article §7.5-802](#)



Provide a statewide system for health care providers



To identify and access available inpatient and outpatient behavioral health services



For patients in a seamless manner

MD Behavioral Health Connect: Key Elements



**1. Behavioral Health
Directory**

Service

**2. Inpatient Psychiatric
Bed Availability**

3. Electronic Referrals

1. Behavioral Health Service Directory



55

Licensed Hospital Locations



1,200+

Licensed Provider Entities



2,000+

Licensed Service Locations



Treatment Level
Community
Crisis
Short-Term Stabilization
Longer-Term Residential
Hospitalization

1. Behavioral Health Service Directory

Contact



Treatment Organization	Bluejay Hospital
Primary Service	Psychiatric Inpatient
Service Address	📍 1000 Bluebird Way , Baltimore, MD, 12345
Service e-mail	test@hbu.co
Service Phone	📞 (123) 456-7891
Additional Services	Outpatient Mental Health Center
Substances Treated	Alcohol, Sedatives, Hallucinogens, Stimulants, Opioids, Cannabis, Nicotine, Synthetics
Placement Considerations	IDD/DD and MH
Inpatient Specialized Programming	Neuropsych/Neurodevelopmental/Autism programming

1. Behavioral Health Service Directory

Accommodation	Handicap Accessible, Language Interpreter
Gender and Age Focus	Gender-Specific: Male, Gender-Specific: Female, 0-7 years old, 8-12 years old (children), 13-17 (adolescent), 18 and older (adults)
Languages Served	English, Spanish
Providers on Site	Case Manager/Care Coordinator, Licensed Mental Health Practitioner, Physician, Registered Nurse
Health Insurance Accepted	No Insurance, Medicare, Medicaid, State Children's Health Insurance Program, VA/Military Health Benefits (Tricare), State Health Insurance for Adults, Indian Health Services Program, Commercial - Aetna, Commercial - Allegiant, Commercial - Anthem, Commercial - Blue Cross Blue Shied, Commercial - Care First, Commercial - Cigna, Commercial - Cigna Healthspring, Commercial - Evercare, Commercial - Humana, Commercial - Independence, Commercial - Jai Medical Systems, Commercial - Kaiser, Commercial - Maryland Physicians Care, Commercial - Medstar Family Choice, Commercial - Optima Health, Commercial - Optum, Commercial - Priority Partner, Commercial - UMR United Healthcare, Commercial - United Healthcare, Commercial - WellPoint, Commercial - Other
Operational Beds	14

Service Details

Inpatient Psych - children & adolescents

2. Inpatient Psychiatric Bed Availability

Unique Hospital
Inpatient Providers

14

Total Hospital
Inpatient Provider
Sites

33

*Source: MDH Behavioral Health
Administration*

Inpatient psychiatric hospitals provide bed availability

- Based on hospital's bed structure (age, gender)
- Manual and automated options

Emergency departments can view bed availability

2. Inpatient Psychiatric Bed Availability



Service Availability

Referral Request Status

Search Criteria

Additional Search Criteria

Search by Distance

Primary Service

Substances Treated

Health Insurance Accepted

Gender and Age

Enter Organization

Search

Clear

Service Availability

Check to make a referral to up to 10 facilities ☐

Submit Request	Organization ▲	Primary Service ▼	Telehealth	Available Beds					Outpatient		Comments	Contact and Service Info	Last Updated ▲	
				Adult		Under Age 18		Total	Next Available Appointment	Walk-in Access				
				M	F	M	F							
➡	Bluejay Hospital	Psychiatric Inpatient		✓	✓	✓	✓	14			Hospital Floor 1	i	16	09:47 08-05-2026
➡	Oriole Hospital	Psychiatric Inpatient-1		⊖	⊖	2	6	8			Psychiatric care for children under the age 18	i		09:47 08-05-2026
➡	Sparrow Residential Treatment Center	Residential Treatment Center		⊖	⊖	6	4	10				i		10:45 08-05-2026
➡	Raven Residential Crisis Center	Residential Crisis Services Program		3	2	⊖	⊖	5				i		16:21 08-12-2026
➡	Finch Outpatient Mental Health Center	Outpatient Mental Health Center	📺	⊖	⊖	⊖	⊖	⊖	08-14-2026	●	Multiple appointments available this week; walk-ins accepted M-F; 9am - 5pm	i		16:35 08-12-2026

3. Electronic Referrals

- Referrals can be sent over the platform across treatment levels
- Standardized information provided
- Communicate and collaborate across providers



3. Electronic Referrals

Zip Code:*

21201

Health Insurance Status *

* No Insurance

Time of Arrival at Referral Facility*

15:25

☐ If above patient identifiers are included in Patient Information required.

Attachment:

Browse

You may attach several documents

[Supported File Types](#)

Please note: Attachments will get auto deleted

Primary Diagnosis*

Bipolar and related disorders

Substances Being Referred For *

* Hallucinogens

Placement Considerations

* IDD/DD and MH

Accommodations

If Yes, Custodial County*

Request (Maximum 500 characters) *

John needs support

- ☒ Check If referral is voluntary
☐ Check If referral is non-voluntary

Co-occurring Diagnoses*

* Neurodevelopmental Disorders: Intellectual disability, Autism Spectrum Disorder (ASD)

Inpatient Specialized Programming

* Neuropsych/Neurodevelopmental/Autism programming

DSS Custody Status / Guardianship

No

Submit

Cancel

1. Behavioral Health Service Directory

2. Inpatient Psychiatric Bed Availability

3. Electronic Referrals

Step 1. Hospitals sign a no-cost Subscription Agreement/Business Associate Agreement with Bamboo Health

**By Sept.
30, 2026**

Step 2. Hospitals and Providers validate service information and add details as needed

**By Dec. 31,
2026**

Step 3. Hospitals submit and view bed availability on platform, replacing Smartsheet/Hospital Care Coordination Dashboard

Jan. 2027

Step 4. Providers send and receive referrals electronically

2027/2028

Questions? Contact
MDH.BHConnect@maryland.gov

Final Report – Commission Recommendations & Rationales

Key Drivers & Rationale

Access to Post Acute Care

Strong anecdotal evidence provided from hospitals across the state, supported by analyses and HSCRC's ED-Hospital Modeling work demonstrating care transition delays to post-acute care and interventions to improve hospital-SNF coordination impact IP & ED LOS, ED-Hospital throughput, and ED Boarding.

Capacity Alignment

Accurately identifying and analyzing hospital and post-acute bed capacity and occupancy was key priority identified and included in the Interim Legislative report. HB1563 has further prioritized. Ensuring capacity across the state through a combination of decreasing patient days, evaluating physical capacity, and exploring alternate capacity options is critical.

Denial & Authorization Delays

Both qualitative and quantitative data shared in multiple workgroups, including the Multi-Agency working group and MHCC Post Acute Workgroup, have identified denials and authorization delays as a contributor to discharge delays leading to ED boarding and increased ED wait times. Internal data tracked by hospitals also supports denials as a key driver of ED Boarding.

ED and IP Throughput Best Practices & Care Transitions

The care transition and best practice opportunities listed below have been identified by the hospital industry and/or multiple agencies throughout the past 18 months. Care Transitions was identified as a priority in the HB1563 legislation. We highlighted many of these opportunities in our Interim Legislative report.

Access to Post Acute Care

Strong anecdotal evidence provided from hospitals across the state, supported by analyses and HSCRC's ED-Hospital Modeling work demonstrating care transition delays to post-acute care and interventions to improve hospital-SNF coordination impact IP & ED LOS, ED-Hospital throughput, and ED Boarding.

Recommendations:

1. Strengthen and expand participation in value based payment programs for post-acute providers.
2. Prioritize care transformation initiatives that impact ED and inpatient length of stay.
3. Complete the hospital and post-acute bed allocation and capacity analysis required by HB 1563 (2026) in collaboration with MHCC, MDH, and MIEMSS.
4. Consider addressing reimbursement models, capacity gaps, and regulations affecting authorization and acceptance into post-acute care.

Access to Post-Acute Care: Recommendation 1

Recommendation:

- Strengthen and expand participation in value based payment programs for post-acute providers.

Rationale:

- HSCRC data show substantially longer inpatient stays for patients discharged to post-acute settings compared with routine home discharge. Between 2023 and 2026 YTD, average IP LOS was approximately 2.9–3.3 days longer for patients discharged home with home health, 5.7–6.2 days longer for SNF discharges, and 10.1–13 days longer for LTCH discharges.
- Stakeholder feedback also identified limited weekend admissions and challenges caring for higher-acuity patients as barriers to timely post-acute placement. Modeling and independent analyses further demonstrate that delays in post-acute transitions contribute to ED LOS for admitted patients.

Access to Post-Acute Care: Recommendation 2

Recommendation:

- Prioritize care transformation initiatives that impact ED and inpatient length of stay.

Rationale:

- HSCRC modeling and independent analyses demonstrate that inpatient LOS, particularly for patients transitioning to post-acute care, has a significant impact on ED LOS for admitted patients.
- Care transformation initiatives that improve discharge planning, care coordination, and transitions across settings can reduce avoidable utilization, improve patient flow, and help address ED and inpatient throughput challenges.

Access to Post-Acute Care: Recommendation 3

Recommendation:

- Complete the hospital and post-acute bed allocation and capacity analysis required by HB 1563 (2026) in collaboration with MHCC, MDH, and MIEMSS.

Rationale:

- Stakeholders consistently identified limitations in Maryland's existing bed capacity data, including inconsistent definitions and a lack of standardized information across hospitals and bed types.
- The analysis will establish baseline supply and demand information and help identify capacity barriers related to post-acute delays, service-line or facility closures, behavioral health capacity, resource constraints, inpatient capacity, and other factors contributing to ED wait times and throughput challenges.

Access to Post-Acute Care: Recommendation 4

Recommendation:

- Consider addressing reimbursement models, capacity gaps, and regulations affecting authorization and acceptance into post-acute care.

Rationale:

- Post-acute stakeholders identified gaps in the ability to care for patients with complex conditions. These challenges were attributed to factors including reduced chronic care hospital capacity and insufficient reimbursement for higher-acuity patients.
- Stakeholders noted that reimbursement approaches that better account for the additional resources required to care for complex patients may help improve acceptance and access to appropriate post-acute settings.

Denial & Authorization Delays

Both qualitative and quantitative data shared in multiple workgroups, including the Multi-Agency working group and MHCC Post Acute Workgroup, have identified denials and authorization delays as a contributor to discharge delays leading to ED boarding and increased ED wait times. Internal data tracked by hospitals also supports denials as a key driver of ED Boarding.

Recommendations

1. Review prior authorization laws nationwide and align Maryland practices with the AMA Advocacy Resource Center recommendations to streamline and standardize prior authorization processes.

Denials & Authorization Delays: Recommendation 1

Recommendation:

- Review prior authorization laws nationwide and align Maryland practices with the AMA Advocacy Resource Center recommendations to streamline and standardize prior authorization processes.

Rationale:

- Stakeholders across the ED Wait Time Reduction Commission, Multi-Agency Working Group, and MHCC Post-Acute Workgroup consistently identified delayed authorization decisions as a barrier to patient throughput.
- Potential reforms include standardized electronic processes, timely adjudication of requests and appeals, greater transparency around denials, evidence-based authorization requirements, and protections against inappropriate retroactive denials.

AMA Advocacy Resource Center Recommendations

- 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 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 can this 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 payor'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 payor's website.

Capacity Alignment

Accurately identifying and analyzing hospital and post-acute bed capacity and occupancy was key priority identified and included in the Interim Legislative report. HB1563 has further prioritized. Ensuring capacity across the state through a combination of decreasing patient days, evaluating physical capacity, and exploring alternate capacity options is critical.

Recommendations

1. Assess regional inpatient and post-acute capacity needs using the HB 1563 bed allocation and capacity analysis and evaluate development of a statewide bed capacity tracking system with real-time bed availability.
2. Explore alternate capacity options, including Hospital at Home, Expanded Home Health Value-Based Purchasing, and Bridge Clinics.
3. Continue monitoring inpatient LOS and partnering with hospitals to understand the drivers of prolonged LOS and identify best practices for improvement.
4. Evaluate staffing metrics as directed by regulatory agencies and the Safe Staffing Act of 2026 (SB 411, HB 624). The Safe Staffing Act requires each hospital to comply with the staffing standards of its accreditation body and with the CMS Conditions of Participation (COP). Hospitals are further required to establish and maintain clinical staffing committees, and to develop and implement clinical staffing plans on an annual basis.

Capacity Alignment: Recommendation 1

Recommendation:

- Assess regional inpatient and post-acute capacity needs using the HB 1563 bed allocation and capacity analysis and evaluate development of a statewide bed capacity tracking system with real-time bed availability.

Rationale:

- Maryland needs greater visibility into acute and post-acute bed availability, occupancy, and utilization. The HB 1563 analysis will provide a starting point for understanding statewide capacity and informing future capacity decisions. *See appendix for additional information.*
- A statewide bed capacity tracking system could facilitate appropriate patient placement and potentially improve utilization of available capacity across the state.

Capacity Alignment: Recommendation 2

Recommendation:

- Explore alternate capacity options, including Hospital at Home, Expanded Home Health Value-Based Purchasing, and Bridge Clinics

Rationale:

- Alternative care models can expand effective capacity beyond traditional hospital settings. Evidence cited in the report indicates that Hospital at Home models are associated with lower rates of hospital-associated complications, better patient and family experience, lower post-acute utilization, and lower costs.
- Opportunities may be limited by current statutory authority because HSCRC rate-setting does not extend to certain outpatient services delivered outside the hospital.

Capacity Alignment: Recommendation 3

Recommendation:

- Continue monitoring inpatient LOS and partnering with hospitals to understand the drivers of prolonged LOS and identify best practices for improvement.

Rationale:

- Despite declining inpatient admissions, Maryland's overall inpatient utilization has increased because patients are remaining hospitalized longer. Longer stays constrain inpatient capacity and contribute to ED boarding and extended wait times.
- The IP LOS monitoring policy approved in June 2026 is intended to identify improvement opportunities and support more efficient care delivery under the AHEAD Model.

Capacity Alignment: Recommendation 4

Recommendation:

- Evaluate staffing metrics as directed by regulatory agencies and the Safe Staffing Act of 2026 (SB 411, HB 624). The Safe Staffing Act requires each hospital to comply with the staffing standards of its accreditation body and with the CMS Conditions of Participation (COP). Hospitals are further required to establish and maintain clinical staffing committees, and to develop and implement clinical staffing plans on an annual basis.

Rationale:

- Stakeholders consistently identified staffing challenges as a contributor to ED LOS and hospital throughput.
- However, HSCRC modeling found mixed effects from increased staffing. A 10% increase in ED RN staffing produced a small improvement in LOS for patients treated and released but had little impact on patients waiting for inpatient admission, whose delays were more strongly associated with inpatient bed availability.

Capacity Alignment: Recommendation 5

Recommendation:

- Engage acute care facilities through multi-stakeholder collaboration to explore coordination of service lines and potential service-line networks across Maryland.

Rationale:

- Hospital stakeholders indicated that service-line opportunities may have less overall impact on throughput than other prioritized interventions.
- However, service-line needs and available capacity vary across facilities. These opportunities can be evaluated through the learning collaborative to identify facility-specific, regional, or statewide opportunities for improved coordination.

ED and IP Throughput Best Practices & Care Transitions

The care transition and best practice opportunities listed below have been identified by the hospital industry and/or multiple agencies throughout the past 18 months. Care Transitions was identified as a priority in the HB1563 legislation. We highlighted many of these opportunities in our Interim Legislative report.

Recommendations

1. Collaborate to allocate the necessary resources and support for long-stay patients and guardianship cases.
2. Expand community partnerships and investments in primary care, behavioral health, including pediatrics, and social determinants of health.
3. Evaluate opportunities to integrate a Psychiatric Bed Registry to improve care transitions.
4. Strengthen and expand palliative care and hospice services.
5. Collaborate with stakeholders to expand the HSCRC Hospital Best Practice Policy, with participation from hospitals and post-acute providers.

Best Practices/Care Transitions: Recommendation 1

Recommendation:

- Collaborate to allocate the necessary resources and support for long-stay patients and guardianship cases.

Rationale:

- Patients with LOS of 30 days or more represented 1.4% of discharges but accounted for 13.4% of total bed days. Simulation modeling also found that reducing long-stay patients improved ED-1 performance for patients waiting to be admitted.
- Hospital stakeholders further reported that patients requiring guardianship represent a meaningful portion of their long-stay patient population.

Best Practices/Care Transitions: Recommendation 2

Recommendation:

- Expand community partnerships and investments in primary care, behavioral health, including pediatrics, and social determinants of health.

Rationale:

- Stakeholders consistently identified access to primary care, care coordination, behavioral health services, and community resources as important to reducing avoidable hospital utilization.
- Between 2019 and 2024, Maryland Primary Care Program practices experienced a 14% decrease in inpatient admissions per 1,000 beneficiaries and a 19% decrease in ED visits per 1,000 beneficiaries.

Note: Updated numbers through 2025 are pending.

Best Practices/Care Transitions: Recommendation 3

Recommendation:

- Evaluate opportunities to integrate a Psychiatric Bed Registry to improve care transitions.

Rationale:

- Psychiatric bed availability has been consistently identified as a barrier to timely placement and care transitions.
- MDH currently maintains the Behavioral Health Hospital Coordination Dashboard and plans to transition bed availability reporting to Maryland Behavioral Health Connect in 2027. Aligning or integrating this registry with broader statewide capacity tracking could improve patient placement and utilization of available psychiatric capacity.

Best Practices/Care Transitions: Recommendation 4

Recommendation:

- Strengthen and expand palliative care and hospice services.

Rationale:

- Expanding palliative care can help ensure that patients receive care in the most appropriate setting. Palliative care can improve symptom management and care coordination, prevent avoidable hospitalization, and increase appropriate hospice placement.
- Maryland's New Paradigms in Care Delivery program provides an existing example of investment in serious-illness and end-of-life care, with preliminary results indicating progress toward program goals.

Best Practices/Care Transitions: Recommendation 5

Recommendation:

- Collaborate with stakeholders to expand the HSCRC Hospital Best Practice Policy, with participation from hospitals and post-acute providers.

Rationale:

- Since implementation of the ED-Hospital Best Practice Policy in March 2025, stakeholders have identified numerous opportunities to improve hospital throughput and care transitions.
- In 2027, the policy will transition into a learning collaborative with an expanded focus on overall ED and IP LOS, care transitions, and capacity alignment. Existing infrastructure and stakeholder collaboration provide a foundation for this expansion. Additionally, staff will meet individually with hospitals or health systems to develop the learning collaborative and focus on ways to include perspectives from wider front line staff.

Other Report Housekeeping Updates

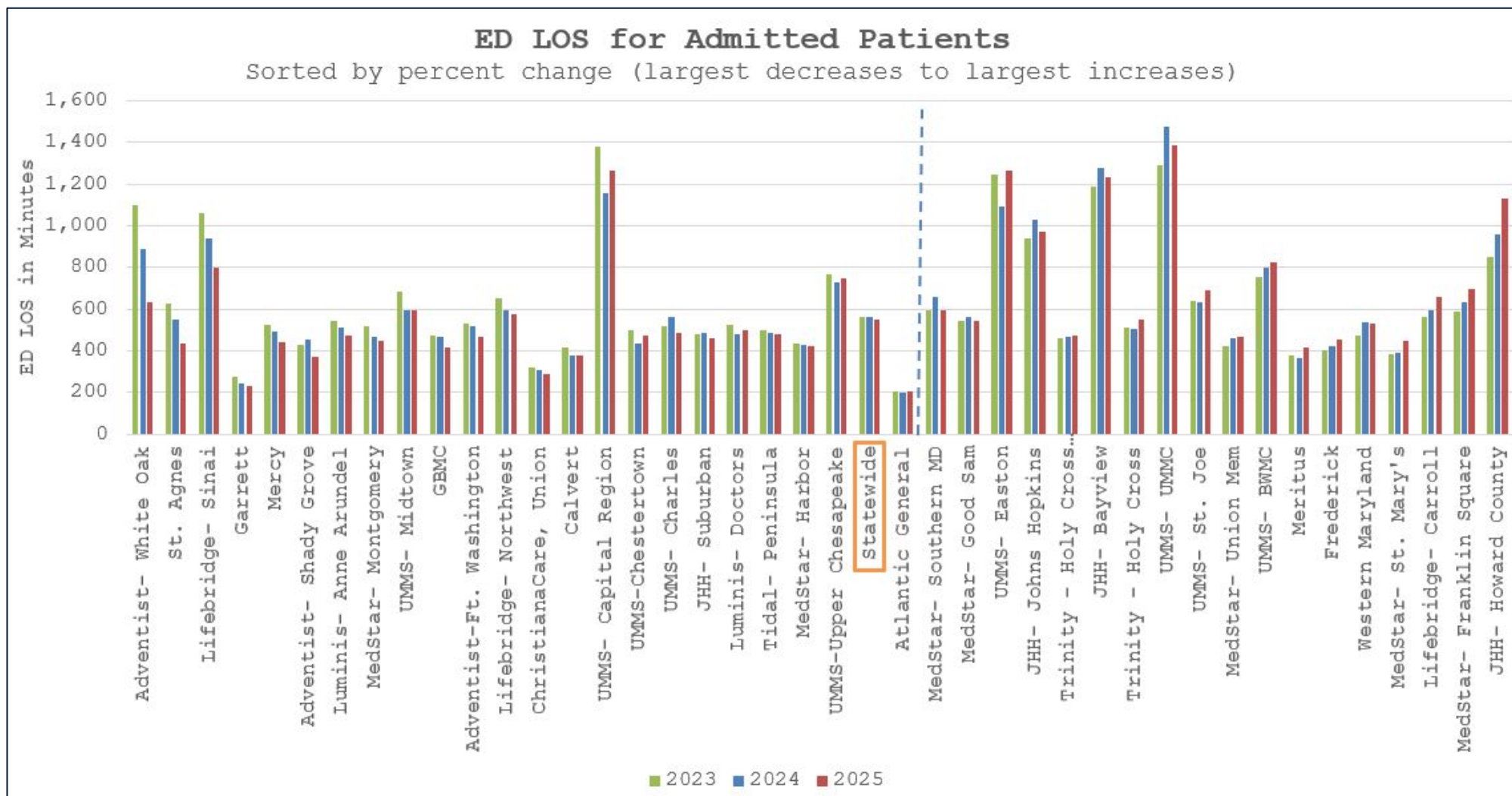
- Addition of by hospital data using HSCRC ED LOS measure included in pay for performance program (see appendix for graph)
- Awaiting data from MDH on MDPCP and advance directives (if updates are available)
- Suggest deleting reference to VBP as part of CTI since this is another recommendation
- Ensure all recommendations in final section are listed in executive summary
- MHCC Post Acute Report is still being finalized as of the submission date of the ED report, therefore we will cite the report as draft and not final

November Report

- Please provide any additional written feedback by Monday 9/28
- Incorporate feedback and submit to MDH and the Governor's office (10/2)
- Reconvene ED Commission to address questions from legislature on recommendations

Appendix

ED LOS for admitted patients (QBR payment measure)



ED Wait Time Reduction Commission CY 2026 Priorities and Updates

Commission Priorities & Subgroups - CY 2026

1. Standardize Bed Capacity & Occupancy Metrics

Inputs: Updates from MHCC, MIEMSS, HSCRC on availability of bed capacity data and occupancy metrics.

Outcome: Develop recommendations re: standardization and uses of metrics for monitoring and making policy recommendations. Align work with HB1563 requirements.

Subgroup Action Items (Capacity & Access):

- Bed Count and Capacity Analysis.
- Recommendations for alternate capacity types.

2. Post-Acute Access

Inputs: Review current work in space from MDH, MHCC, HSCRC, and Multi-Agency Working Group.

Outcome: Develop recommendations and key considerations for regulators developing post-acute strategy.

Subgroup Action Items (Capacity & Access):

- Recommendations on Post-Acute Care Opportunities (aligned with MHCC).

3. ED-Hospital Throughput Modeling

Inputs: Review HSCRC modeling work on impact of interventions on ED LOS.

Outcome: Consider need for additional analysis to prioritize interventions ripe for policy development and consider making recommendations to hospital industry, payers, regulators and others based on modeling.

Subgroup Action Items (Data & Best Practices):

- Develop modeling to estimate impact of interventions on Inpatient and ED LOS.

4. ED-Hospital Throughput Best Practices

Inputs: Review HSCRC Best Practices policy and Yr 1 Reporting.

Outcome: Consider recommendations on additional best practices to consider and/or other key performance indicators needed for policy development and monitoring.

Subgroup Action Items (Data & Best Practices):

- Summarize hospital best practice submissions.
- Recommend refinements to (QBR) ED LOS pay-for-performance methodology.

General Feedback

- ED Commission is urged to consider the “critical transition in CY2028” to a bifurcated hospital global budget system where CMS will manage Medicare fee-for-service hospital global budgets and State will manage hospital global budgets.

“With substantial policy development, operational infrastructure, and stakeholder alignment work still required before the CY2028 AHEAD model implementation and transition, the system urges the Commission to carefully sequence priorities, ensuring that foundational model readiness workstreams are sufficiently advanced before directing attention and resources to the design and implementation of any new or emerging programs.”

- ED Commission should prioritize those interventions that individual stakeholders would otherwise not be able to accomplish on their own.

“The value of the ED Wait Time Commission is to bring together different agencies and organizations to achieve the common goal of reducing ED wait times through the stated interventions.”

- The current presentation of the Key Drivers is siloed and recommendations are duplicative.

“In order to promote collaboration across organizations, would recommend making the list more “patient-centric” by leading with the intervention and then listing the multiple organizations that need to be involved.”

Key Drivers & Rationale

Access to Post Acute Care

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ED and IP Throughput Best Practices & Care Transitions

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Preliminary Intervention Modeling Takeaways

Data Subgroup to Review modeling updates and findings at August subgroup meeting. Results can be used in ED report to support prioritization of Key Drivers and areas for recommendations.

- Reductions in utilization by SNF patients through care transformation initiatives (e.g., telemedicine) resulted in the largest improvement in both ED-1 and OP-18
- Interventions targeting hospital-wide IP LOS (e.g., discharge planning teams) also improved ED-1 but had little impact on OP-18
- Increases in ED RN Staffing had modest impact on OP-18 and little impact on ED-1
- Interventions were most impactful at hospitals with largest ED-1 values, and less impactful at those with lower ED-1

ED-1 is wait time for admitted patients; OP-18 is wait time for discharged patients
ED metrics calculated using HSCRC case-mix data

Key Driver: Access to Post Acute Care

ED Final report should make recommendations to prioritize areas in upcoming MHCC report “Strengthening post-acute care towards meeting the goals of the AHEAD Model” that have greatest potential to improve ED LOS. The priority areas below were identified and prioritized through the ED WTR Commission stakeholder & subgroup process.

High Priority Areas:

- Strengthen and expand participation in value based payment programs for post-acute providers
 - ED Stakeholder feedback emphasized the need for programs that incentivize management of increasingly complex populations, set forth requirements and/or monitoring of patient acceptance rates and target occupancy, and improved quality outcomes, such readmission and avoidable admissions.
- Complete hospital and post-acute bed allocation/capacity analysis (aligned with HB1563)
- Recommend stakeholders prioritize care transformation initiatives that impact ED and IP LOS
- Recommend policymakers consider addressing reimbursement models, capacity gaps, regulations for authorization and acceptance, etc. -- **incorporate or reference specific Recommendations from MHCC Report**

Key Driver: Authorization Delays and Denials

ED Final report should make recommendations to the Adverse Decisions Workgroup to consider impact of authorization delays and denials on emergency department and hospital throughput.

High Priority Areas:

- Review of prior authorization (PA) laws from across the nation and align with the AMA Advocacy Resource Center Document Recommendations to streamline and standardize prior authorization (PA) process.
 - See next slide for specific suggestions that could be recommended to Adverse Decisions Workgroup.

Prior Authorization (PA) Suggestions

Does ED Commission feel comfortable sending these suggestions, along with the overall recommendation to prioritize areas with potential impact to ED wait times, to the Adverse Decisions Workgroup?

- Mandate availability of online PA system for in-hospital and PAC care (and not only for drugs)
- Similar to other medical communication, mandate all PA related communication be visible to patients via the patient portal (improve on current requirements in MD)
- Mandate that non-urgent requests be adjudicated within 2 business days. Urgent request be adjudicated within 1 business day
- If need for services arise on a holiday, plan cannot require notification only on a business day
- After approval, plan cannot retroactively deny, unless materially false information has been 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 of denying or approving the PA request, i.e. the reviewer, and who can this be appealed to.
- Appeals should be adjudicated by a physician in the same or similar specialty, within 1 business day. There should be an electronic portal for appeals
- Statistics should be available on the payor's website regarding the category of denials, rate of denials, etc.
- PA requirements should be based on clinical evidence and should be displayed on the payor's website.

Key Driver: Capacity Alignment

Capacity alignment is also addressed by other Key Drivers including Post Acute Care Access and Authorization Delays and Denials.

High Priority Areas:

- Assess Regional Needs for Inpatient & Post-Acute Capacity using hospital and post-acute bed allocation/capacity analysis conducted as part of HB1563

Lower Priority Areas (for discussion):

- Multi-stakeholder collaboration on service line coordination across the state
- Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)
- Monitor IP LOS (note: policy approved by HSCRC) and partner with hospitals to understand IP LOS drivers and best practices
- Evaluate staffing metrics as directed by regulatory agencies and recent Safe Staffing Act (SB411, HB624)

Key Driver: ED and IP Throughput Best Practices & Care Transitions

VOTE

ED Commission report should note HSCRC ED LOS payment incentives and IP LOS monitoring policy. Could address feedback and difficulties in setting goals for improvement and national comparisons.

High Priority Areas:

- Collaboration on resource allocation and support for Long Stay Patients and guardianship cases
- Expand community partnerships and investments in primary care, 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

Lower Priority Areas (for discussion):

- Expansion of HSCRC Hospital Best Practice Policy

Key Drivers & Areas for Recommendations to Address ED LOS Updated

Access to Post Acute Care

Note: Will integrate MHCC Post Acute Workgroup Output

- Strengthen and expand participation in value based payment programs for post-acute providers
Key Stakeholders involved: MHCC, HSCRC, Medicaid, Commercial Payers, Post-Acute Providers, MIEMSS, Legislature
Priority: High
- Complete hospital and post-acute bed allocation/capacity analysis (aligned with HB1563)
Key Stakeholders involved: MHCC, HSCRC, MDH, Acute & Post Acute Care Facilities, MIEMSS, Legislature
Priority: High
- Recommend stakeholders prioritize care transformation initiatives that impact ED and IP LOS
Key Stakeholders involved: HSCRC, MHCC, MIEMSS, Medicaid, Commercial Payers, Acute and Post-Acute Facilities, Legislature
Priority: High
- Recommend policymakers consider addressing reimbursement models, capacity gaps, regulations for authorization and acceptance, et.
Key Stakeholders involved: MHCC, HSCRC, MDH, Acute and Post Acute Care Facilities, Medicaid, Legislature
Priority: High

Authorization Delays & Denials

- Review of prior authorization (PA) laws from across the nation and align with the AMA Advocacy Resource Center Document Recommendations to streamline and standardize prior authorization (PA) process.

Key Stakeholder: Adverse Decisions Workgroup
Priority: High

Capacity Alignment

- Assess Regional Needs for Inpatient & Post-Acute Capacity using hospital and post-acute bed allocation/capacity analysis conducted as part of HB1563
Key Stakeholders: HSCRC, MHCC, MIEMSS, MDH, Acute & Post-Acute Facilities, Legislature
Priority: High
- Multi-stakeholder collaboration on service line coordination across the state
Key Stakeholders: HSCRC, Acute Care Facilities
Priority: Low
- Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)
Key Stakeholders: HSCRC, Hospitals, Legislature
Priority: Medium (some statute limitations to address)
- Monitor IP LOS (note: policy approved by HSCRC) and partner with hospitals to understand IP LOS drivers and best practices
Key Stakeholders: HSCRC, Acute Care Facilities
Priority: Low; already implemented
- Evaluate staffing metrics as directed by regulatory agencies and recent Safe Staffing Act (SB411, HB624)
Key Stakeholders: Acute Care Facilities, Legislature
Priority: Low related to ED LOS impact & already implemented

Best Practices/Care Transitions

- Collaboration on resource allocation and support for Long Stay Patients and guardianship cases
Key Stakeholders: HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature
Priority: High
- Expand community partnerships and investments in primary care, behavioral health including pediatrics, and to address social determinants of health
Key Stakeholders: HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature
Priority: High
- Evaluate opportunity to integrate Psychiatric Bed Registry to improve care transitions
Key Stakeholders: HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature
Priority: High
- Strengthen and expand Palliative Care and Hospice services
Key Stakeholders: HSCRC, MDH, Hospitals, Post-Acute Providers, Medicaid, Legislature
Priority: High
- Expansion of HSCRC Hospital Best Practice Policy
Key Stakeholders: HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature
Priority: Low

HB1563 Bed Capacity Study Update

HB1563–Emergency Room Services and Post–Acute Care – Coverage and Facility Studies (Effective 7/1/26)

<https://mgaleg.maryland.gov/2026RS/bills/hb/hb1563t.pdf>

Requires Multiple Agencies to work together to complete a number of item, including:

- Authorizing the Maryland Insurance Commissioner to conduct an examination of certain decisions by carriers related to claims or authorization requests for services in, or related to services in, emergency departments;
- Authorizing the Commissioner to have certain decisions independently reviewed under certain circumstances;
- Requiring that a certain report required to be compiled by the Maryland Insurance Commissioner include data on certain adverse decisions and grievances;
- ***Requiring the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, to conduct a study to quantify bed capacity in hospitals and post–acute settings in the State and make a recommendation on a certain collection and auditing process;***
- ***Requiring the Maryland Health Care Commission, in consultation with the Health Services Cost Review Commission, to study analyzing options to facilitate clinically appropriate transitions from acute to post–acute care settings in the State; and generally relating to emergency room services and post–acute care.***

HB1563 Overlap with ED WTR Commission

- Access & Capacity Subgroup previously discussed similar recommendations and had begun assessing current state bed capacity data and occupancy metric availability and identified gaps.
 - MHCC, HSCRC, MIEMSS, & MDH met on April 23, 2026 to discuss scope of the work and next steps for collection and standardization. A gap analysis was performed. A follow up meeting occurred on June 24, 2026. The steering committee is in the process of addressing these gaps and a follow up meeting will occur in early August.
- HSCRC and MHCC will determine the process for standardizing bed type definitions and reporting. HSCRC will reach out to designated hospital reporters as a first step in working towards standardizing definitions for occupancy and capacity reporting. MHCC will reach out to post acute facility reporters.
- We will provide an update as this work develops.
- The ED WTR Commission will provide recommendations related to this work in the 2026 November Final Legislative Report.

HB 1563 Bed Capacity Requirements

Key Commission Mandates

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

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



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

Bed Count Specifications in the HB 1563 Legislation

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

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

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

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

Standardized bed data is the foundation for understanding hospital capacity

Current reporting limitations must be addressed to support statewide access analysis

Current State

1. Fragmented Reporting

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

2. Inconsistent Definitions

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

3. Limited Longitudinal Visibility

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

Standardized Reporting and Auditing

Future State

✓ Understand types of beds and availability

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

✓ Inform capacity planning

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

✓ Identify capacity and access drivers

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



Goal

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

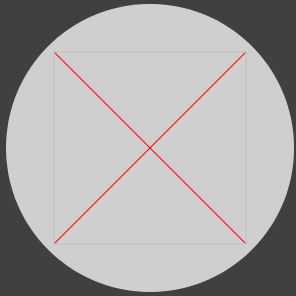
The current stage is the first step in a broader bed capacity workplan

CURRENT STAGE

MEDIUM TERM

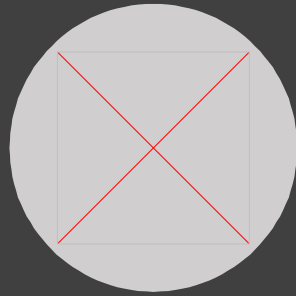
LONG TERM

Evaluate Current Bed Data



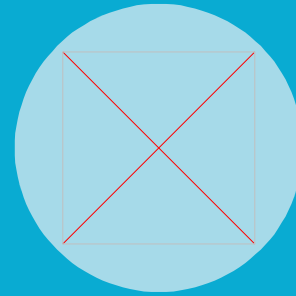
Evaluate current bed data reporting and identify definitional gaps between reporting sources

Develop Reporting Standards and Auditing Processes



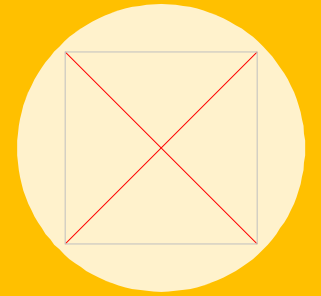
Develop standardized reporting definitions, frequency, and data elements and an auditing process to improve data completeness, accuracy, and comparability

Build a Reliable Data Infrastructure



Implement consistent reporting and enact validation and auditing processes

Evaluate Statewide Bed Capacity Capability



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

Current work is underway to build the statewide bed data foundation

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

Analysis Objectives

1 Standardize bed type definitions

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

2 Develop data reporting standards

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

3 Establish validation and audit standards

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

Data Sources

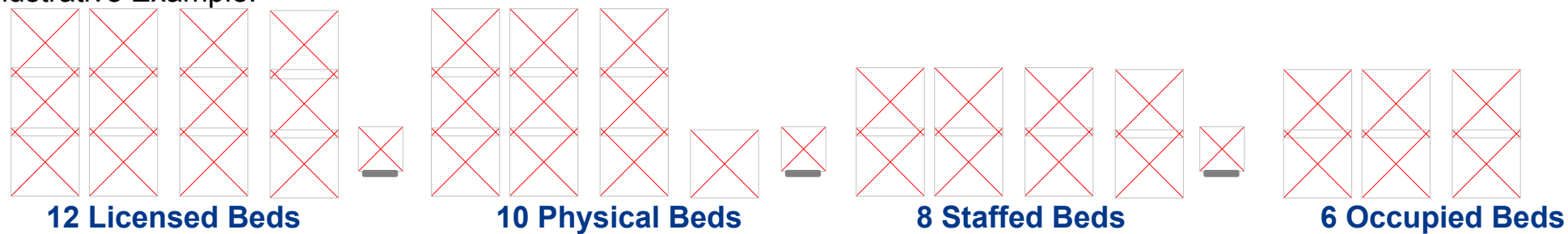
Definitional Comparison: Compare reported bed types, measures, service-line distinctions, timing, and availability across sources

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

High-level bed type definitions

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

Illustrative Example:



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