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The Emergency Department Wait Times Reduction Commission Activities and Findings

Required by Health General § 20-2406

November 2025

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Table of Contents

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Executive Summary

This report, mandated by Maryland law,[1] provides information on the development and activities of the Maryland Emergency Department Wait Time Reduction Commission (Commission). The 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 interim report, with the final report on these issues due in 2026.

Commission Structure and Work

The Commission, chaired by the Maryland Department of Health and the Health Services Cost Review Commission (HSCRC), is supported by the following four Subgroups:

- **Best Practices** – Developing hospital operational standards to improve ED throughput
- **Access to Non-Hospital Care** – Assessing access barriers to care outside of the acute care setting. The initial priority focus is on opportunities in post-acute care transitions that delay discharge, leading to prolonged ED boarding and extended ED waits
- **Data** – Building statewide analytic tools and simulation models to identify drivers of ED LOS and test policy interventions
- **Capacity, Operations, and Staffing** – Evaluating hospital and post-acute bed availability, workforce challenges, and real-time capacity management strategies

Each Subgroup brings together hospital leaders, clinicians, payers, and patient representatives to identify system-wide solutions and advance coordinated policy recommendations.

Key Findings

- Maryland's adjusted ED LOS is longer than national averages, but differences narrow substantially when controlling for hospital size, academic status, and patient mix.
- Post-acute care shortages in both long-term care hospitals (LTCHs) and skilled nursing facilities (SNFs) are significant drivers of delayed discharges, with inpatient (IP) stays 11 days longer on average for patients requiring LTCH and 6-6.4 days longer for patients requiring SNF placement. While the IP LOS for patients requiring LTCH placement is substantially longer than for those requiring SNF placement, SNF placement delays have an overall greater impact due to the larger annual volume of patients transferred to SNF vs. LTCH (~30K to ~6K).
- Data fragmentation across acute, post-acute, and community settings hampers system coordination and policy design.

[1] 2024 MD Laws Chapter 0844

- Maryland residents seek care in the ED at lower rates per capita compared to national averages.[2] This likely reflects the benefits of the Total Cost of Care Model's investments in primary and community care; however, patients who do present to the ED often face longer stays. This is likely due to factors outside the ED itself, such as discharge delays from inpatient beds to post-acute care and/or the use of prior authorization for discharges.

Preliminary Recommendations

The Commission identified three priority areas for further development:

1. Strengthen data infrastructure by creating a validated capacity reporting system spanning acute and post-acute care.
2. Leverage statistical modeling and simulation to test the impact of hospital interventions, performance measures, and guide future HSCRC pay-for-performance programs.
3. Develop a formal post-acute care proposal with regional capacity targets and infrastructure recommendations for complex patient populations.

Next Steps

The Commission will continue meeting through 2027, refining Subgroup analyses and advancing policy proposals. The final report will present comprehensive recommendations to reduce ED LOS, improve hospital throughput, expand post-acute and community capacity, and modernize data systems. These efforts aim to strengthen Maryland's emergency care system, enhance patient outcomes, and ensure the resilience of the state's health care infrastructure.

[2] Hospital Emergency Room Visits Per 1,000 Population by Ownership Type, KFF, Accessed September 3, 2025

Section I. Introduction

The Maryland General Assembly passed House Bill 1143 (Chapter 0844) during the 2024 legislative session, which established the Maryland Emergency Department Wait Times Commission (Commission).[3] The purpose of the Commission is to examine and address factors throughout the health care system that contribute to increased emergency department (ED) wait times. Specifically, the Commission is working to develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED wait times, including initiatives that:

- Ensure 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 also required the Commission to produce an annual report on its activities, findings, and recommendations, including an update on the development, implementation, and impact of the recommended policies, with the first report due November 1, 2025.

The Health Services Cost Review Commission (HSCRC) has served as primary staff of the Commission, facilitating all meetings, developing and coordinating presentations and meeting materials, and conducting relevant analyses to support the Commission.

Background on Emergency Department Wait Times in Maryland

ED wait times have been a longstanding challenge in Maryland, with ED length of stay (LOS) exceeding national averages for more than 20 years. The concerns about ED LOS and the impact on patient experience and hospital efficiency predate the implementation of the Maryland Model (formerly the All-Payer Model and now the Total Cost of Care Model). There are many potential reasons for the extended ED wait times and LOS that suggest broader, systemic factors are contributing to Maryland's difficulties in reducing wait times. In addition, recent Census data show that Maryland's population is aging faster than the nation, which is an external population factor that may further exacerbate ED wait times with increased patient acuity and more complex hospitalizations. In addition to monitoring the impact of an aging population, the state is expecting shifts in insurance status as Maryland implements the new Medicaid eligibility requirements in H.R. 1. The Commission should also consider how social drivers of health,

[3] 2024 MD Laws Chapter 0844

especially those influencing rural communities, contribute to variations in ED wait times. It will be important for the Commission and staff to project and monitor Maryland population demographics.

Key ED Wait Time Metrics and Data Findings

As outlined in the graphs below, Maryland has sub-optimal performance on ED LOS. However, to understand and incentivize 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

Centers for Medicare & Medicaid Services (CMS) data show that Maryland EDs perform worse than the national average on two measures: ED-2b (time from admission decision to hospital admission) and OP-18b (time from arrival to discharge home). Since CMS began publicly reporting these measures, Maryland's performance has consistently lagged behind the nation, with little change in the performance gap over time (see Figures 1 and 2 below).

Figure 1. Time from Admission Decision to Hospital Admission, Maryland Compared with the National Average, CY 2012-2019

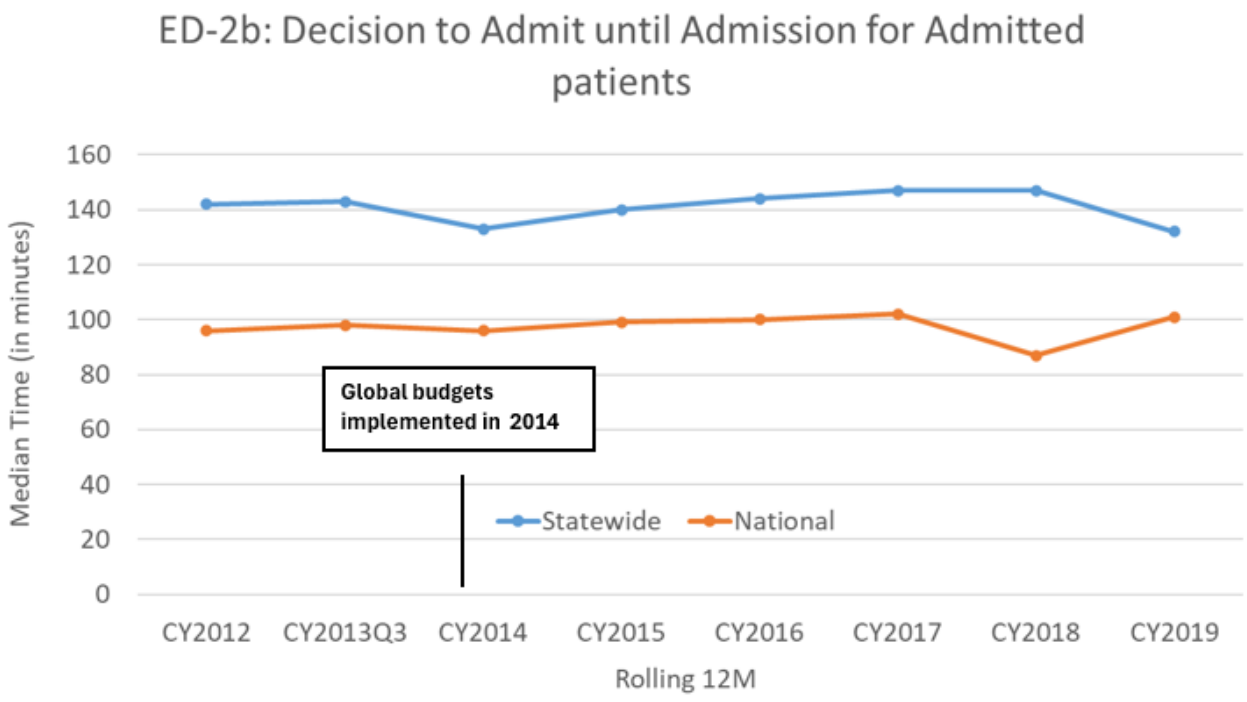
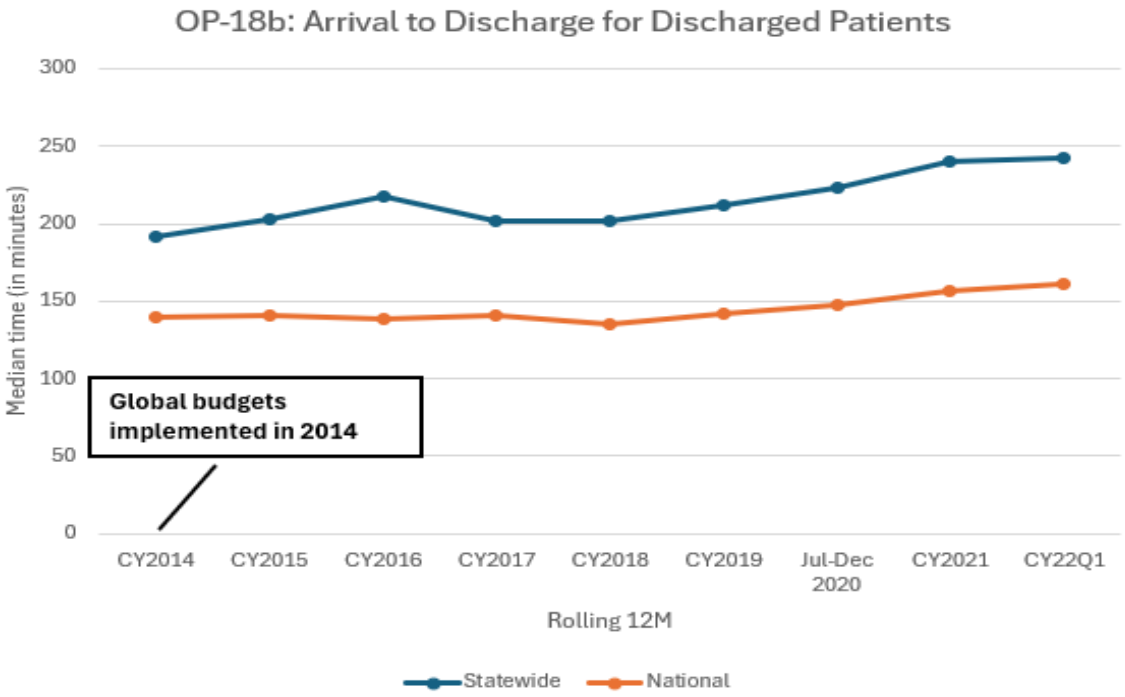


Figure 2. Time from ED Arrival to Discharge Home, Maryland Compared with the National Average, CY 2014-2022 Quarter 1[4]



Emergency Department Visits Per Capita

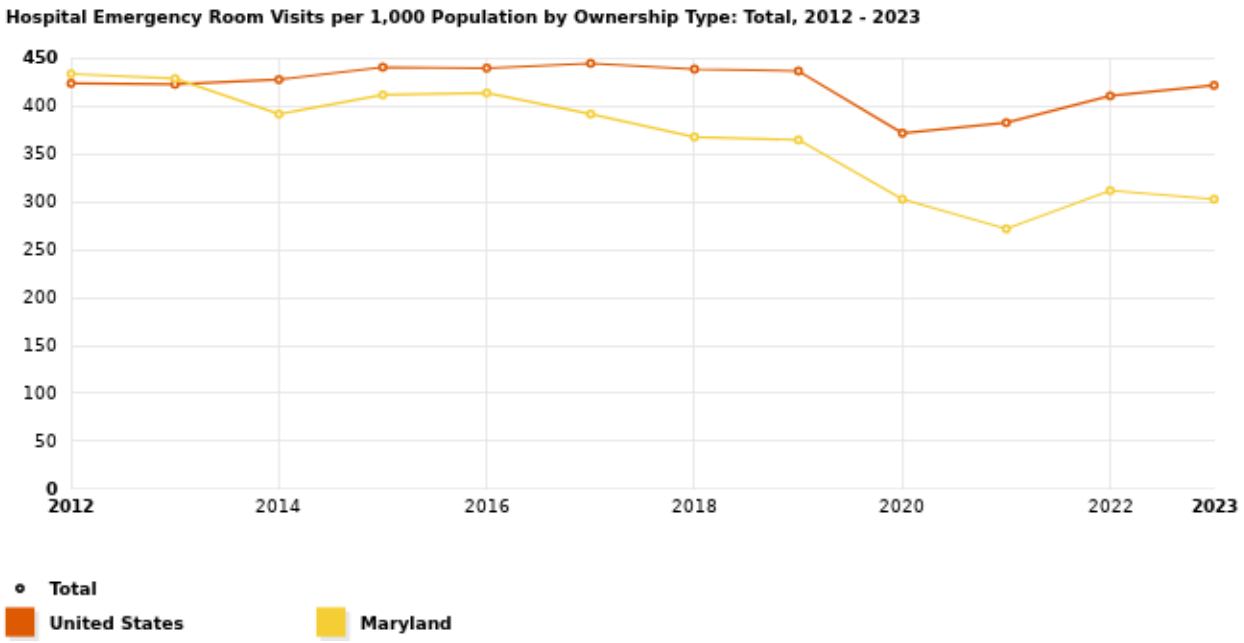
Independent analyses show a meaningful decline in ED visits in Maryland over the past decade. In the Center for Medicare and Medicaid Innovation's (CMMI's) independent evaluation of the Total Cost of Care Model, evaluators found that "the model reduced Medicare Fee For Service outpatient ED visits and observation stays by an average of 24.5 visits per 1,000 beneficiaries or 5.9% (90% CI: 32.9, 16.1) during the first four years of the TCOC Model."[5] Additionally, Kaiser Family Foundation data shows that fewer Maryland residents seek care in the ED compared to national averages on a per capita basis.[6]

[4] The latest available data was through 2019 for ED-2 and through 2018 for ED-1. CMS discontinued public reporting of the ED-2 measure (Median Admit Decision Time to ED Departure Time for Admitted Patients) under the Inpatient Quality Reporting Program.

[5] 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

[6] 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

Figure 3. Hospital ED Visits per 1,000, Maryland Compared with the National Average, CY 2012-2023



Source: KFF Health Facts

These reductions are likely related in large part to Maryland's investments in primary care, behavioral health, and community health programs. The Maryland Model encourages hospitals to help patients access care outside of hospital settings, like outpatient community clinics. This approach has led to a sharp decline in avoidable hospital use, especially in 30-day all-cause readmissions and avoidable admissions caused by worsening chronic conditions. While the need to coordinate and manage such care may lead to longer stays for some patients, ultimately the goal is to help prevent unnecessary hospital visits and contribute to long-term health improvements.

Additionally, the rise of urgent care centers has helped reduce ED volume of less acute patients. While the shift of less acute patients from the ED to primary care, community health centers, and urgent care centers has decreased the overall ED volume, 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 IP admissions 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 4 shows the volume of patients admitted from the ED by each hospital in FY 2025, which is similar to data for FY 2024 and FY 2023. Figure 5 shows the percentage of inpatient admissions originating in the ED by each hospital in FY 2025.

Figure 4. Percentage of ED Patients Admitted by Hospital, FY 2025

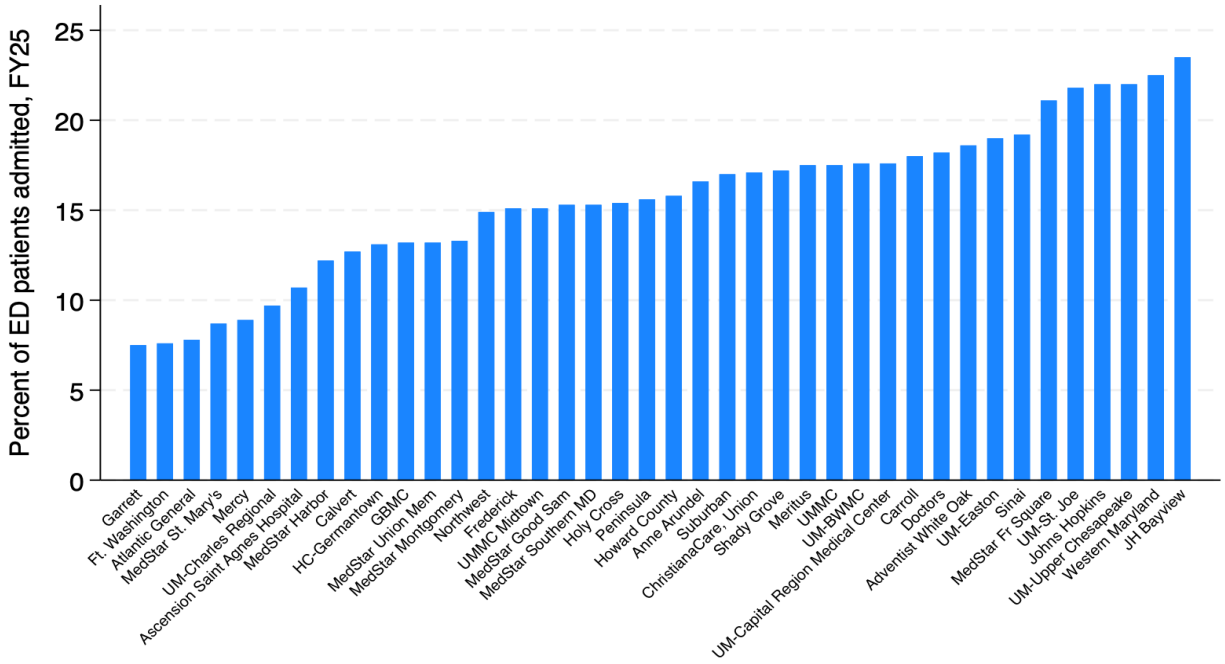
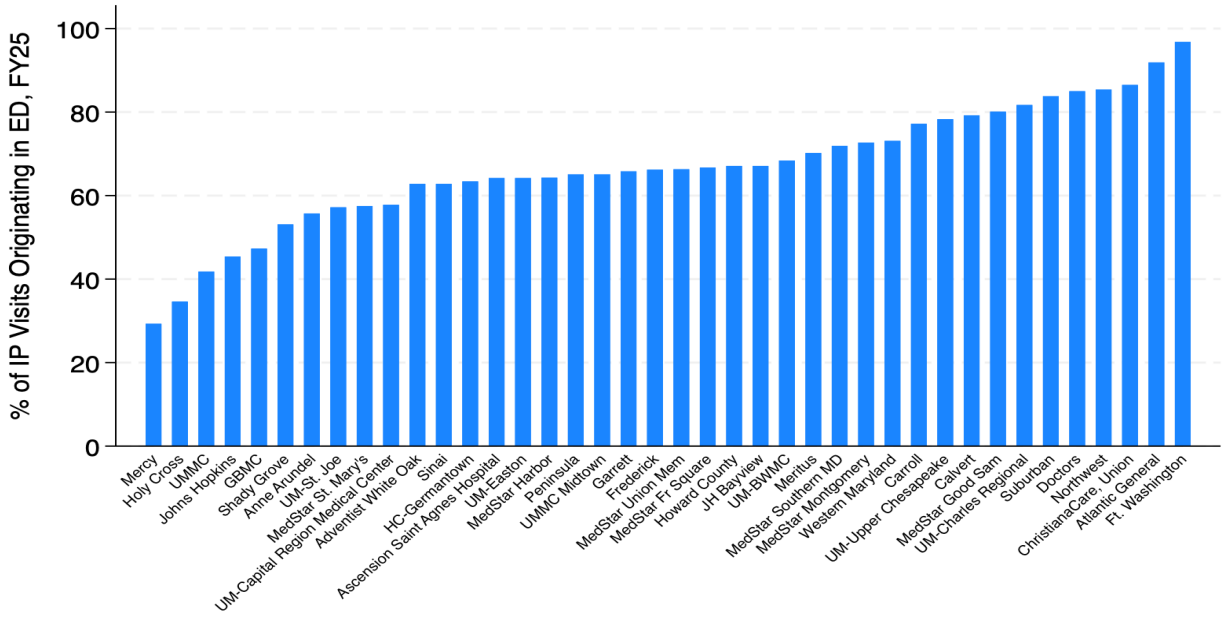


Figure 5. Percentage of Inpatient Admissions Originating in the Emergency ED by Hospital, FY 2025



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

Inpatient Length of Stay

Discharge to post-acute settings also has a substantial impact on IP LOS. Statewide data from CYs 2023 to 2025 show that the unadjusted, average IP LOS was 3.6 to 3.8 days higher for patients discharged home with home health, 6 to 6.4 days higher for patients discharged to a skilled nursing facility (SNF), and 11 to 12 days higher for patients discharged to long-term care hospitals (LTCHs). These delays are attributed to numerous factors, including 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 inpatient side, patients who are waiting in the ED for a hospital bed end up waiting even longer after they have been approved for admission. This delay is called ED boarding. Throughput and ED boarding, in turn, significantly increase ED LOS and ED wait times. Appendix III shows calendar year (CY) 2023 to CY 2025 IP LOS by discharge disposition for Maryland hospitals, as well as the statewide average IP LOS.

There is a significant opportunity to improve ED LOS by addressing the increase in IP LOS that has emerged since the COVID-19 pandemic. Longer IP stays cause bottlenecks in hospital throughput that worsen ED LOS. Between 2019 and 2022, after adjusting for changes in acuity and patient mix (how sick patients are, age, etc.), Maryland experienced a 4.26% increase in risk- and mix-adjusted LOS. This increase in LOS occurred despite the shift of surgical volume to outpatient and ambulatory surgery centers. While the unadjusted LOS rose by approximately 16%, the adjusted increase still suggests an efficiency gap. This 4.26% difference reflects both internal and external operational opportunities that, if addressed, could yield substantial capacity gains. If hospitals were able to return to their 2019 risk-adjusted LOS, the system would effectively gain the equivalent of 246 staffed beds statewide—more than the average licensed bed size of a hospital (220 beds in fiscal year [FY] 2024), which in turn would help alleviate the hospital throughput problem (see Table 1 below). While hospitals have primary accountability for patients who are discharged to home, a collaborative effort is needed from stakeholders within the state and local agencies, hospitals, and post-acute facilities to address challenges in patient care transitions from the hospital to post-acute care settings in order to realize these improvements.

Table 1. Observed LOS Increases by Type of Bed Day from CY 2019 to CY 2022

Type of Bed Day	2022 Bed Days	Added Days (Current Bed Days X 4.26%)
Medical Surgical Acute	1,665,578	70,876
Medical Surgical Intensive Care	245,980	10,467
Oncology	45,511	1,937
Definite Observation	60,499	2,574
Shock Trauma	34,391	1,463
Pediatrics Acute	34,002	1,447
Pediatric Intensive Care	17,831	759
Burn Care	1,755	75
Coronary Care	5,070	216
Total	2,110,617	89,813
Bed Count (Total/365)	**5,783**	**246**

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

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.[7] 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 generally larger than the national average, 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

[7] 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

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 often physically larger and serve more patients 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 (ICU)-level care near the end of life 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. The Maryland Department, in collaboration with the Maryland Cancer Cooperative 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. 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.
- **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 national average.[8]

This analysis found that these structural differences all contribute to longer ED LOS. **When ED LOS comparisons were adjusted for these key characteristics, Maryland's performance changed markedly, falling more in line with national averages.**[9] Nevertheless, there are still improvements that can be made to the delivery system that reduce ED LOS while maintaining its current advantages.

HSCRC's Initiatives that Impact ED Length of Stay

In keeping with its mission to ensure access to high-quality, affordable health care for all Marylanders, the 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 wait times, the HSCRC seeks to develop targeted strategies that strengthen both emergency care and the broader care continuum. Through these sustained efforts, the HSCRC has

[8] Staff analysis of CMS SNF data retrieved from https://data.cms.gov/provider-data/search?theme=Nursing%20homes%20including%20rehab%20services

[9] 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

built a foundation of policies, programs, and partnerships that directly address ED wait times, positioning the state to build upon this work under the Commission.

Overall Policies and Programs

The 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 across settings. Recognizing the significant impact that prolonged ED LOS has on patients and providers, the 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. The HSCRC convened a "Best Practices" subgroup to develop this policy, which was repurposed to serve as a subgroup for the Commission to make additional recommendations on best practices. The policy was implemented in January 2025 and is described further in this section.
- **Quality-Based Reimbursement (QBR) ED LOS Payment Measure:** 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 the HSCRC. The policy is described further in this section.
- **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. The 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 the 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).

- **Surge Policy:** During the COVID-19 public health emergency, the 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% of total hospital spending in CY 2020 and 4.7% 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 experienced underfunding 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 Length of Stay Monitoring Measures:** Ongoing development of measures and tools to monitor ED LOS for all patients who are admitted to the hospital from the ED (e.g., patients with psychiatric diagnosis or pediatric patients).
- **Maryland Primary Care Program (MDPCP):** Launched in 2019, MDPCP is a core element of Maryland's Total Cost of Care Model and is administered by the Maryland Department of Health. It reduces downstream acute care demand through stronger primary and community care.
- **Hospital Consumer Assessment of Healthcare Providers and Systems (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 shows 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.

The HSCRC recently 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, the 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 Maryland Hospital Association, legislators, the Maryland Health Care Commission, the Maryland Department of Health, patient advocates, and emergency and behavioral health providers.

ED Hospital Throughput Best Practices Policy

A major recent policy accomplishment implemented by the HSCRC is the ED-Hospital Throughput Best Practices Policy, mentioned above, which outlines six hospital best practices designed to reduce ED LOS, improve patient flow, and enhance coordination between ED, IP, and post-acute services. The program was developed throughout 2024 and approved by HSCRC Commissioners for implementation starting March 2025. These structure- and process-focused practices offer a framework for hospitals to identify operational bottlenecks and implement scalable solutions that lead to more efficient and effective care. Under this policy, all hospitals select and must implement at least two of the following six designated best practices.

1. **Interdisciplinary Rounds and Early Discharge Planning**
    a. Implement and document discharge planning for IP admissions.
    b. Create documentation of health-related social needs (HRSN) screening for IP admissions.
    c. Create documentation of referrals to community resources made prior to discharge for IP admissions screened for HRSN.
2. **Bed Capacity Alert System**
    a. Establish capacity metrics, such as total number of patients, percentage of hospital beds occupied, etc.
    b. Establish a bed capacity alert process driven by capacity metrics that activate defined actions aimed at improving patient throughput.
    c. Demonstrate consistent activation of bed capacity alert process in response to capacity alerts.
3. **Standardized Daily/Shift Huddles**
    a. Implement daily huddles utilizing a multidisciplinary team approach with a focus on throughput and discharges.
    b. Develop and include standardized infrastructure for huddles, including standard scriptwriting, documentation, and/or use of huddle boards.
    c. Develop an escalation process for addressing clinical and/or non-clinical barriers to discharge or throughput.

   d. Develop and include monitoring and reporting of key performance indicators (KPIs) as drivers of process improvements.

4. **Expedited Care Intervention (Expediting Team or Expediting Care Unit)**
   a. Implement or expand expedited care practices and report KPIs determined by the hospital.
5. **Patient Flow Throughput Performance Council**
   a. Establish a formal structure, leveraging multidisciplinary teams, an executive sponsor, and formal evidence-based KPIs to measure progress.
   b. Encourage accountability for performance through regular meetings to review capacity and throughput related projects and KPIs.
   c. Change hospital culture around patient throughput by engaging all nursing units to ensure frontline staff awareness and engagement.
6. **Clinical Pathways and Observation Management**
   a. Design and implement a clinical pathway tailored to a specific patient population.
   b. Develop robust data collection and analyses systems.
   c. Demonstrate measurable improvements in outcomes for the chosen clinical pathway and target patient population.

Hospitals will report associated performance data for CY 2025 to the HSCRC by December 31, 2025. Each Best Practice is structured into a three-tier framework associated with a pay-for-performance incentive structure to be considered after the initial data collection and monitoring period. This approach supports continuous improvement and allows hospitals to align interventions with their unique operational priorities. Appendix I shows the full policy matrix and scoring for each best practice by tier.

Quality-Based Reimbursement Program

QBR is one of the core HSCRC pay-for-performance programs to promote hospital quality improvement. The program provides financial incentives for hospitals to enhance performance across three patient-centered quality domains: (1) Person and Community Engagement, as measured by HCAHPS; (2) Clinical Care; and (3) Safety. The QBR program incorporates an outcome-focused payment incentive ED LOS measure into the Person and Community Engagement domain for RYs 2026 and 2027 to reward hospitals with improvements in the median time from ED arrival to departure for admitted patients. Hospitals have revenue at risk based on performance on this measure.

The HSCRC approved the addition of an ED LOS measure into the RY 2026 QBR program, in recognition of the need for Maryland to reduce ED LOS.[10] HSCRC staff convened a data subgroup to develop the data submission requirements, as well as a measure and incentive methodology to assess improvement in ED

[10] Due to the discontinuation of the CMS ED1 and ED2 measures, the HSCRC added requirements for collection of date and time stamps for all ED visits to the Inpatient and Outpatient Case-Mix data.

LOS from CY 2023 to CY 2024. The continued use of this measure was approved for RY 2027. The payment incentive measures the amount of time a patient spends in the ED from the time of arrival to the time of physical departure from the ED for non-psychiatric patients who are admitted to the hospital from the ED. Appendix II summarizes statewide and hospital-specific QBR performance on ED LOS.

Section II. Establishment of the Maryland Emergency Department Wait Time Reduction Commission

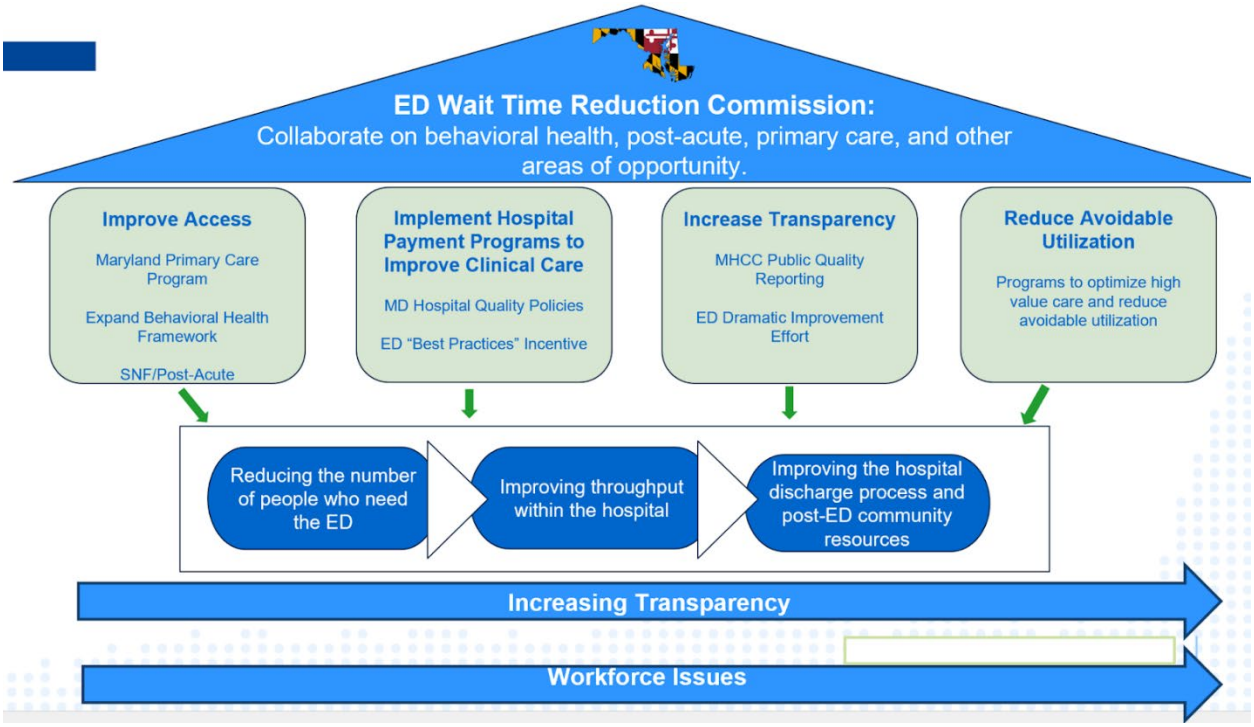
Legislative Mandate and Guiding Framework

The 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 wait times, including initiatives that:

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

To carry out the charge, Commission members built a visual guide that captures the different priorities and overall plan for reducing ED wait times in Maryland (Figure 6). The Commission coordinates work across behavioral health, post-acute, primary care, and other areas of opportunity. Overarching strategies include improving access, implementing hospital payment programs, increasing transparency, and reducing avoidable utilization. These strategies feed into three main goals of reducing the need for the ED, improving throughput within the hospital, and improving the discharge process and post-ED resources.

Figure 6. Maryland ED Wait Time Reduction Commission Priorities



Commission Members and Meetings

The Commission is effective from July 1, 2024, through June 30, 2027. It is co-chaired by Maryland Department of Health Secretary Meena Seshamani and HSCRC Executive Director Jonathan Kromm. To support its work, the Commission also established four Subgroups, each charged with meeting more frequently and reporting on its designated scope of work to the full Commission. Table 2 lists the Commission members.

Table 2. Commission Appointed Members

Title	Associated Member
Maryland Department of Health Chair	Meena Seshamani, MD
HSCRC Chair	Jonathan Kromm, PhD
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
Two individuals who have operations leadership responsibilities over a hospital Emergency Department in the State, including one Emergency Department physician	Dan Morhaim, MD Neel Kiran Vibhakar, MD
One individual with professional experience in an Emergency Department who is not a physician or an advanced practice provider	Barbara Maliszewski, RN
One representative of a local Emergency Medical Service	Danielle Marie Knatz
One representative of a managed care plan with experience in care management or care coordination	Amanda Leigh Bauer, DO
One representative of an advanced primary care practice	Mary Kim, MD
One representative of the Maryland Hospital Association	Andrew Nicklas, JD
One representative of a patient advocacy organization	Toby Ann Gordon, ScD
One representative of a behavioral health provider	Johnathan Demetris Davis

The Commission gathered formally for the first time in October 2024 and meets every other month. Meeting dates and corresponding agenda topics are listed in Table 3.

Table 3. Commission Meeting Dates and Topics

Meeting Date	Meeting Priority Topics
October 23, 2024	• Introduction of Commission • Overview of Commission Focus and Objectives • Discussion of Subgroups • Meeting Frequency & Schedule
January 22, 2024	• Complexity Score Presentation • Hospital & Regional Factors Associated with ED LOS • Prioritization Discussion • Legislative Updates • Subgroup Updates
March 26, 2025	• State of the State • Subgroup Updates & Recommendations • Site Visit Updates • Open Forum
June 3, 2025	• Subgroup Updates & Deliverables • Ongoing Activities • Open Forum
July 30, 2025	• Subgroup Updates & Deliverables • Legislative Report Discussion • Open Forum
September 24, 2025	• Subgroup Updates & Deliverables • Legislative Report Edits & Recommendations • Open Forum

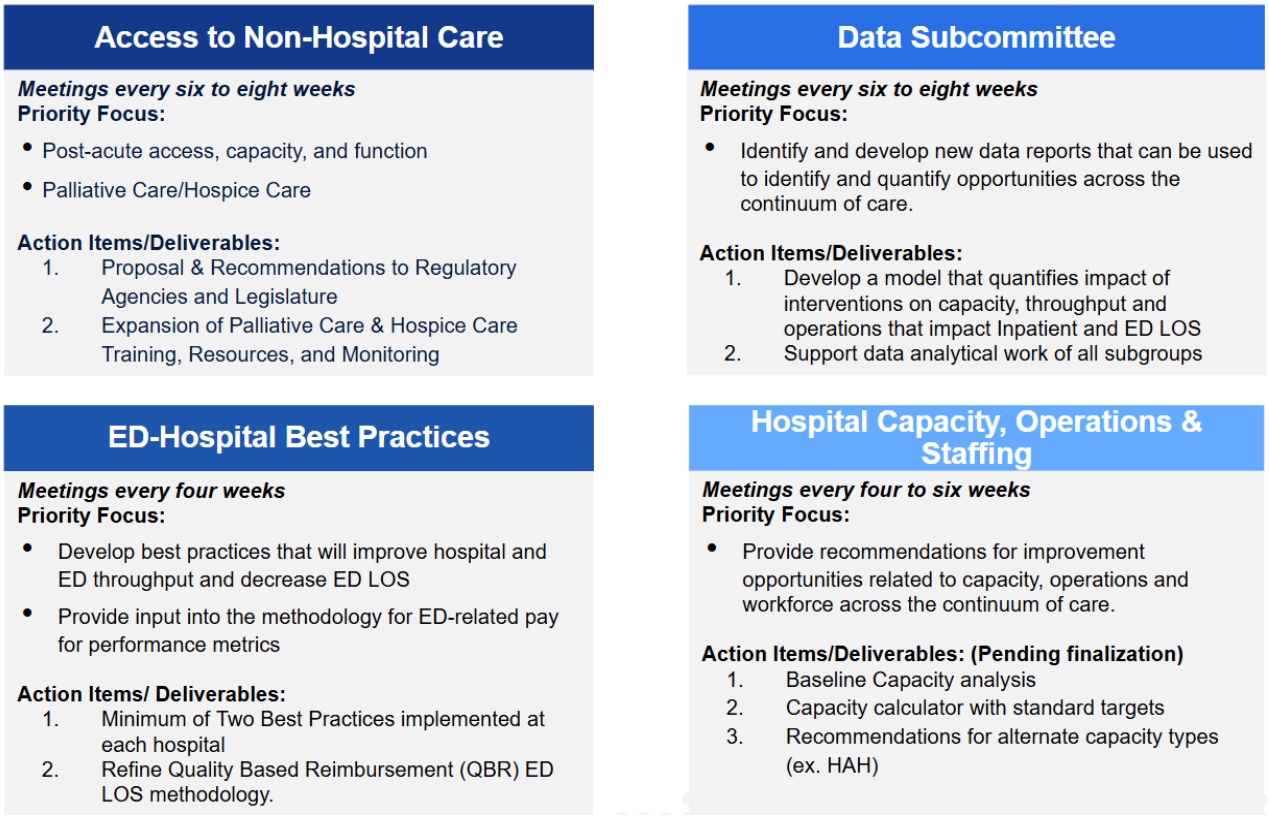
The Commission and associated subgroup meetings were predominantly held virtually and in compliance with the Open Meetings Act. Meeting dates, presentations, and meeting recordings are posted on the Commission's webpage.

Commission Subgroups

Four Subgroups were established to report their specific scope of work back up to the Commission. These Subgroups include (1) access to non-hospital care, (2) data, (3) ED hospital "throughput" best practices, and (4) hospital capacity, operations & staffing. Of note, there are several other areas that also have a significant impact on ED LOS that were not addressed through an official subgroup of the Commission. These areas include challenges with increasing access to primary care, leveraging advance directives, addressing pediatric overstays, and improving access for behavioral health patients and guardianship cases. These issues are being evaluated and addressed by Maryland Department of Health-led initiatives outside of the Commission, so the decision was made to collaborate as needed on these issues but to establish subgroups to focus on issues that did not already have allocated resources. See Appendix V for more information on these Department of Health initiatives.

Commission Subgroups meet every four to eight weeks. Subgroups include official members of the Commission, as well as other subject matter experts on the specific policy areas under consideration. Through their leadership, the four Subgroups are helping to build a more responsive, coordinated, and sustainable emergency care infrastructure that supports the state's long-term health care vision.

Figure 7. ED Wait Time Reduction Commission Subgroups



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 and scoring criteria to improve overall hospital throughput and reduce ED LOS, advise on revenue at-risk and scaled financial incentives, and provide input on data collection and auditing. The Best Practices Subgroup met seven times between December 2024 and September 2025 and will continue to meet through 2027.

This multidisciplinary group includes hospital leaders, emergency clinicians, behavioral health professionals, and community stakeholders. Together, they guide 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 serves as a collaborative platform for sharing data, best practices, and local innovations. This approach allows 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 reinforces Maryland's All-Payer Model and its focus on outcomes over volume.

Access to Non-Hospital Care Subgroup

The Access to Non-Hospital Care Subgroup is 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 Access to Non-Hospital Care Subgroup met three times between March 2025 and October 2025 and will continue to meet through 2027.

While the subgroup is not currently working explicitly on palliative care initiatives as a top priority, expansion of palliative care 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 this summer.[11] In addition, the HSCRC has a program called New Paradigms in Care Delivery (NPCD) that has awarded funding to 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 patients served to 16,000, enhance the quality and experience for patients and families, and further improve total cost of care performance.

This Subgroup's initial priority area of focus is on post-acute healthcare settings that continue to care for patients after discharge from IP or ED care, referred to collectively as post-acute care. Maryland continues to face challenges in ensuring timely and efficient transitions from hospitals to SNFs and other post-acute care settings.

Recent capacity mapping, analysis of hospital case-mix data, stakeholder feedback, discussions with care management experts, and ongoing data collection from the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and the Maryland Health Care Commission (MHCC), highlight regional disparities, occupancy bottlenecks, payer-related barriers, and information gaps. Despite ongoing data gaps, the Subgroup identified several contributing factors to the increased ED and IP LOS for patients who require post-acute care after discharge. These include payer and authorization delays, as well as

[11] This Workgroup is charged with revising the state health plan for hospice services. More information is available here.

specialized placement challenges and misaligned regional bed capacity. The Subgroup identified key regional and systemic challenges that often result in denied referrals and waits of two to five days for placement approval in this hospital. The Subgroup is working to develop a comprehensive post-acute care proposal to address these barriers over the coming months.

A summary of challenges identified is discussed below:

- **Limited Data Access:** Limited information on staffed vs. licensed beds and facility capabilities hinders targeted interventions and quality improvement. Facility-specific details on staffing, service capabilities, and bed types (e.g., isolation, ventilators) are lacking. More robust tracking by payer type and diagnosis is needed to pinpoint high-need, underserved populations.
- **High Occupancy and Staffing Shortages:** Post acute bed occupancy rates are consistently high (at times above 90%), leaving little flexibility for specialized or emergency placements. Many "available" beds are not staffed, reducing functional capacity. As noted in the bullet above, additional data is needed to distinguish staffed vs. licensed beds and whether other factors such as shared toilets between rooms, gender cohabitation issues, and infection control are exacerbating capacity issues.
- **Payer-Related Delays:** Lengthy insurance authorization processes and insurance denials prolong IP stays and slow systemic throughput.[12,13,14]
- **Regional Post-Acute Bed Imbalances:** Ratios of acute care beds to sub-acute beds range dramatically by region, contributing to transition delays. Limited post-acute bed resources also contribute to extended hospital stays (e.g., staff numbers, level of training, and availability of specialized equipment such as beds and lifts for obese patients).

The Access to Non-Hospital Care Subgroup is working to advance statewide strategies to address these challenges. The Subgroup is particularly focused on developing proposals and recommendations for policy development and resource allocation to address identified systemic barriers and support improved patient throughput statewide. The Commission intends to produce a formal proposal with recommendations in the Final Report. In addition, this Subgroup should align efforts with the Governor's multi-agency Regulatory

[12] Kaiser Family Foundation. (2025). Analysis of Prior Authorization Requests and Denials in Medicare Advantage, 2022–2023. Retrieved August 19, 2025, from https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

[13] Centers for Medicare & Medicaid Services. (2024). Comprehensive Error Rate Testing (CERT) Report: Skilled Nursing Facility Denials. Washington, DC: CMS. Available from https://www.cms.gov/medicare/compliance-and-audits/comprehensive-error-rate-testing

[14] American Medical Association. (2024). AMA Prior Authorization Physician Survey. Chicago, IL: AMA. Retrieved from https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-nearly-40-prior-authorizations-week-way

Workgroup, which is charged with addressing several high-priority issues impacting healthcare, including post-acute bed occupancy, care transitions, and prior authorization opportunities.

Data Subgroup

The Data Subgroup is focused on identifying, developing, and integrating data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data. Key responsibilities of the Subgroup include directing and performing analyses aligned with the Commission's priorities. This includes examining how Maryland's performance on ED LOS 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 five times between December 2024 and October 2025 and will continue to meet through 2027.

This Subgroup has contributed to numerous HSCRC-led projects, including an ED LOS dashboard that will be accessible to stakeholders across the state and a statewide acute and post-acute capacity analysis that is in development using the HSCRC IP and outpatient case-mix data. However, the key priority of this Subgroup is the development of an ED-Hospital Predictive Simulation model that aims to quantify the influence of external and internal hospital-specific factors on ED LOS and assess the expected impact of targeted interventions.

As indicated earlier in this report, findings to date reveal that Maryland hospitals, on average, are larger, more complex, and more likely to be academic teaching facilities. While these institutions tend to deliver superior outcomes in areas such as risk-adjusted mortality and readmissions, these same structural features that allow these facilities to provide complex care can contribute to increased time for ED throughput and patient flow.[15] When these structural differences are accounted for, Maryland hospitals' ED LOS is 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 strong ED LOS performance indicate that improvement is achievable.

Taking these factors into consideration, the Data Subgroup's work points toward the need for thoughtful policy interventions and operational strategies aimed at improving ED efficiency without compromising IP quality. A central question moving forward is how Maryland can retain the clinical advantages of large, high-performing hospitals while redesigning ED processes to emulate the responsiveness and efficiency of smaller, streamlined facilities.

[15] 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.

In an attempt to answer this and other questions, the HSCRC staff is working with stakeholders to build a simulation platform that can be used to understand how various types of policies could change ED LOS. Staff and Subgroup members are planning to test the potential impact of programs that would:

- Reduce IP LOS for patients discharged from the hospital to skilled nursing
- Reduce admissions from SNFs through the use of telemedicine
- Reduce avoidable admissions for patients with chronic conditions through enhanced primary care

This work uses real-world data on ED volume, staffing, and patient acuity, as well as IP capacity and other hospital-specific variables, to simulate patient pathways through the ED and IP services. Modeling can provide estimates that allow the Commission to compare the relative effects of policies discussed at the General Assembly Task Force on ED LOS.

Capacity, Operations, & Staffing Subgroup

The Capacity, Operations, and Staffing Subgroup convened for the first time in May 2025, with subsequent meetings in July 2025 and October 2025. The Subgroup is focused on assessing access and capacity across the care continuum throughout the State, collaborating with commercial payers, Medicare, and Medicaid, and optimizing workforce development opportunities.

Several data streams and analytical tools are currently in use to support the Commission's understanding of real-time capacity challenges and opportunities for ED wait time improvement:

- **Bed Capacity Data:** MHCC collects and tracks acute and post-acute facility capacity across the state, with the most recent data set in CY 2022.
- **MIEMSS Daily Bed Status and Occupancy Reporting:** Provides real-time visibility into hospital bed availability, ED status, and overall capacity, supporting situational awareness for system-wide coordination, particularly during periods of high demand or diversion. More detail is shown in Appendix VI.
- **Draft Occupancy and Capacity Analysis (Mathematica):** In development, this tool aims to provide a data-driven assessment of statewide hospital occupancy trends and capacity constraints. It includes IP and ED data metrics and could potentially inform modeling of how current system stressors contribute to ED throughput delays and boarding.
- **Pilot Hospital Capacity Calculator (University of Maryland Medical System):** Designed to estimate and simulate real-time capacity across hospital units, this tool could be further developed to allow hospitals to assess internal patient flow dynamics and identify operational bottlenecks. The tool could be useful for scenario planning and testing interventions aimed at improving patient movement from the ED to IP units.

Although these resources establish a baseline, discrepancies across data sources and gaps in specialty bed reporting remain. Addressing these limitations are critical to build a validated baseline that can guide future policy and operational improvements. Because the Subgroup is newly formed, it focuses primarily on information gathering and will use the rest of 2025 and 2026 to gather more data and discuss formal recommendations to put forth in the final report.

Section III. Continuing Work and Recommendations

The Commission continues to meet, tour EDs, and assess Subgroup recommendations. The Commission will address state-level opportunities related to access to hospital, post-acute, and community-based services that impact hospital throughput and ED wait times. In addition, the Commission will align to support the work of other agencies in addressing access to behavioral health care and behavioral health placement, primary care, and access barriers leading to pediatric overstays. The Commission will support hospital best practices to address ED wait times and throughput across Maryland hospitals and will seek opportunities to collect and integrate consumer feedback on these issues. The Commission will also evaluate available data on workforce and staffing across the healthcare industry.

Based on a review of ongoing data collection, analysis, and workflow development across the four Subgroups, as well as stakeholder input and guidance from Commission members, the Commission has identified its top priority opportunities. These areas will guide the Commission's work as it moves into CY 2026. The Commission offers the following recommendations to guide its immediate work priorities.

1. **Strengthen the State's data infrastructure by developing a reliable and user-friendly reporting mechanism to comprehensively assess capacity across all healthcare settings, both in real-time and in annual assessments.**
    a. This should include investments in facility-level data collection with real-time updates on acute and post-acute bed capacity, distinguishing between staffed and licensed beds, bed specialty, and referral or denial patterns.
    b. The State should verify bed counts through state agency reporting and expand data collection on post-acute beds through MHCC's regulatory authority.
    c. The State can leverage and expand existing MHCC and MIEMSS reports to help accomplish this.
2. **Conduct additional statistical modeling and simulations to guide decision-making around hospital ED priorities and performance measures.**
    a. Statistical modeling will help identify and incentivize strategies and measures that improve outcomes, such as reducing IP LOS. It will also allow the State to test and quantify the impact of specific programs and incentives, including efforts to:
        i. Shorten hospital stays for patients discharged to SNFs
        ii. Decrease admissions from SNFs through the use of telemedicine

iii. Lower avoidable hospitalizations for patients with chronic conditions by expanding access to enhanced primary care

b. Results of the modeling can inform the development and implementation of future HSCRC pay-for-performance programs and measures.

c. Develop an IP and ED LOS monitoring tool leveraging HSCRC case-mix data feeds to support evaluation of hospital interventions and performance measures.

3. **Develop a formal proposal on opportunities to improve post-acute care access and capacity with a focus on regional capacity and proposed infrastructure for complex patient populations.**

   a. First, regional capacity recommendations will guide the State in directing additional resources and incentives to regions with low post-acute-to-hospital bed ratios and consistently high occupancy.

   b. Second, the Commission will identify complex patient populations with specialized needs, such as ventilation or isolation, and propose infrastructure investments to expand access in regions where current shortages impact system-wide flow.

   c. The Commission will explore options related to value-based care arrangements between hospital and post-acute facilities, collaboration with managed care organizations to address payer and referral processes, and opportunities to advance palliative care based on opportunities identified in the 2023 legislative report on palliative care.[16]

Section IV. Conclusion

Prolonged ED LOS is a long-standing issue in Maryland and across the nation. Creating opportunities to bridge gaps and enhance capacity measurement and reporting across the continuum of care from community to acute and post-acute care facilities will provide critical input for the development of value-based incentive programs across the state. Policy recommendations to increase capacity and effective utilization of post-acute resources is also critical. Addressing these issues will require a comprehensive approach that considers the full range of influences on patients, providers, and the health system. To that end, the Maryland Department of Health and the HSCRC must continue working closely with hospitals, local health departments, other state agencies, patient advocates, and emergency and behavioral health providers to strengthen emergency care statewide.

To capture this opportunity to improve ED performance, policymakers and healthcare leaders must explore options focused on:

[16] Maryland Health Care Commission. (2023, November 1). *Palliative care services in Maryland: Final report*. https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2023/palliative_care_rpt_2023.pdf

- **Optimizing capacity across the care continuum**, including ambulatory, acute, post-acute, and community-based services
- **Improving care transitions within the hospital**, guided by a best practice Subgroup focused on internal handoffs and discharge planning processes
- **Enhancing transitions to post-acute care**, with emphasis on timely placement in SNFs, palliative care, and home health services
- **Increasing access to outpatient and community-based care** through greater investment in primary care, behavioral health, and community health resources to support patient access to care in non-hospital settings. This work will continue to be led by the Maryland Department of Health and supported as appropriate by this Commission.

Taken together, these strategies underscore that reducing ED wait times is not solely a hospital challenge but a system-wide responsibility. By advancing coordinated solutions across the full continuum of care, Maryland can alleviate pressure on EDs, improve patient outcomes, and strengthen the overall resilience of its health care system. This Commission will continue to partner with key stakeholders to identify and further develop recommended interventions to improve ED and hospital throughput, patient experience and flow, and overall outcomes.

Appendix

Appendix I. ED Hospital Throughput Best Practices (Measures and Points/Tiers)

Appendix II. QBR Summary

Appendix III. IP LOS Performance

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

Appendix V. Maryland Department of Health Initiatives

Appendix VI. MIEMSS Daily Bed Status & Occupancy Reporting

Appendix I. ED Hospital Throughput Best Practices (Measures and Points/Tiers)

Figure 1. ED-Hospital Throughput Best Practices

<table>
<tr><th>Best Practice</th><th>Measures</th><th>Points (0-10 scale)</th></tr>
<tr><td>Interdisciplinary Rounds & Early Discharge Planning</td><td>
<table>
<tr><th></th><th>Tier One</th><th>Tier Two</th><th>Tier Three</th></tr>
<tr><td>Criteria</td><td>• Discharge Planning Adult General Medical and Surgical Inpatient Admissions</td><td>• Adult inpatients offered screening for the 5 HRSN prior to discharge</td><td>• Adult inpatients that have screened positive for HRSN are given referrals to community resources prior to discharge</td></tr>
<tr><td>Accountable measure or outcome</td><td>✓ Documentation within 48 hours of admission discharge plan, example estimated discharge date (EDD) and/or disposition
✓ KPI: 70% of inpatient admissions have documented discharge planning or 10% improvement from baseline.</td><td>✓ Documentation of food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety screenings for inpatients who are screened
✓ KPI: 50% or 10% improvement from baseline of all inpatients identified in tier one offered screening for HRSN</td><td>✓ Documentation of community resource access or referral for patients screening positive for 1 or more of HRSN
✓ KPI: 75% or 10% improvement from baseline of all positive screens for HRSN are given referral prior to discharge identified from tier two.</td></tr>
</table>
</td><td>Tier 1 earns 0-2 points

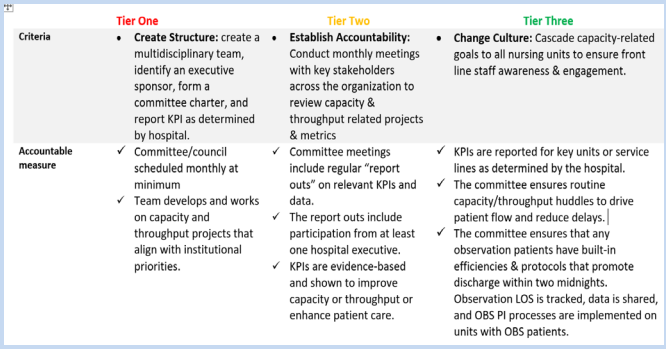
Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)

Tier 3 earns up to 4 additional points</td></tr>
<tr><td>Bed Capacity Alert System</td><td>Tier 1: Organization establishes one or more capacity metrics, examples could include: total number of patients in hospital, % hospital beds occupied, % of ED border c/w overall ED beds, NEDOC score, other hospital defined metrics.
Tier 2: Organization establishes a bed capacity alert process (aka surge plan) driven by capacity metrics that triggers defined actions to achieve expedited throughput. Actions could include: Enhanced inpatient huddles to expedite discharges, rapid admission order turnarounds, hospitalist care in the ED, executive escalation, opening surge units, etc.
Tier 3: Organization quantitatively demonstrates consistent activation of surge plans in response to bed capacity triggers. Internal metrics to be hospital defined and specific to hospital surge protocol. Examples could include: #/% of protocol activations, % discharges by specific time- maybe 1 p.m. and/or 3 p.m., etc.</td><td>Tier 1 earns 0-2 points

Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)

Tier 3 earns up to 4 additional points</td></tr>
</table>

Best Practice	Measures	Points (0-10 scale)
Standardized Daily/Shift Huddles	The AHRQ defines a huddle as a short, standing meeting that is typically used in clinical settings to quickly share important information and touch base with a team, typically held at the beginning of each workday or shift. **Tier 1:** Implementation of, at minimum, daily huddles utilizing a multidisciplinary team approach with a focus on throughput and discharges. KPI: Multidisciplinary daily huddles are being completed at X frequency as defined by each organization. **Tier 2:** Tier 1 requirements with the addition of a standardized infrastructure (standard scripting, documentation, and/or use of huddle boards). Tier 2 would also include an escalation process for addressing clinical and/or non-clinical barriers to discharge or throughput. **Tier 3:** Tier 1 and Tier 2 requirements, with the addition of monitoring and reporting of key performance indicators (KPIs) as drivers of process improvement r/t throughput. Example KPIs could include but are not limited to, percent of discharge orders written by noon, or percent patients leaving the facility by a designated time as determined by each facility.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Expedited Care Intervention (Expediting team, expedited care unit)	**Many best practices are proven to reduce Hospital Length of Stay and Boarding. Select one or more of the expediting practices listed below:** • Nurse Expediter • Discharge Lounge • Observation Unit (ED or Hospital based) • Provider Screening in Triage / Early Provider Screening Process • Dedicated CM and/or SW Resources in the ED **Tier 1:** Implement/Expand one (1) expedited care practice from the list above and report KPI as determined by the hospital. For example, LWBS, Inpatient LOS, Door to Provider Time, etc. **Tier 2:** Implement/Expand two (2) expedited care practices from the list above and report KPI for each practice as determined by the hospital. **Tier 3:** Implement/Expand three (3) expedited care practices from the list above and report KPI as determined by the hospital.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

Best Practice	Measures	Points (0-10 scale)
Patient Flow Throughput Performance Council		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Clinical Pathways & Observation Management	**Tier 1: Design and Implement Intervention** Hospitals will select and implement a clinical pathway tailored to a specific patient population. This clinical pathway should be based on the facility's unique patient needs and can incorporate existing pathways if already in place. **Tier 2: Develop Data Infrastructure** Hospitals will establish robust data collection and analysis systems to monitor and evaluate outcomes. These systems should emphasize comparing the effectiveness of inpatient and ambulatory management strategies for the selected patient population, enabling data-driven decision-making and continuous improvement. **Tier 3: Demonstrate Improvement** Hospitals will demonstrate a measurable decrease in unwarranted clinical variation and/or measurable improvement in outcomes specific to their chosen intervention.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

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Appendix II. QBR Summary

Figure 1. CY 2024 Quality Based Reimbursement (QBR) Performance Summary

2024 QBR Performance Summary

- 2024 results on ED-1b, the performance measure included in QBR were mixed
  - Note: The ED-1b measure includes non-psych adult patients admitted through the emergency department
  - 23 hospitals reduced the median ED LOS from CY23 - CY24 (range 0.3% to 19%), resulting in 106k fewer hours spent waiting in emergency rooms.
  - 17 hospitals experienced increases in the median ED LOS (range from 0.4% to 14%), resulting in an additional 127k hours spent waiting in emergency rooms.
  - 1 hospital saw no change and 1 hospital was excluded because it converted to a FMF.
- Mixed results are likely due to performance improvements and influence of 2024 respiratory season.
- If hospitals with performance that was more heavily influenced by case growth are removed (n=9), the remaining hospitals (n=31) improved median wait times on average by 3%, resulting in 33k fewer hours spent waiting in emergency rooms
  - Excluded - Hospitals with worse performance and less than 3% growth in cases (n=7) AND
  - Excluded - Hospitals with better performance and less than a 3% decline in cases (n=2)

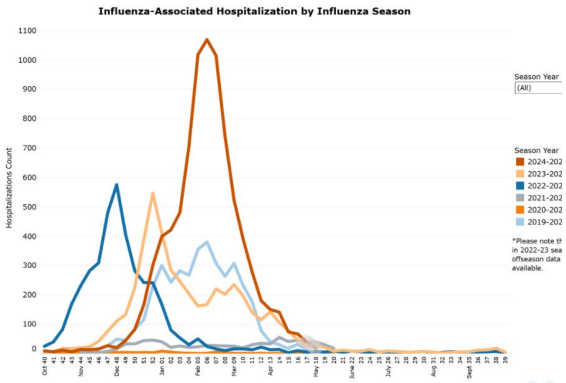

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Figure 2. Hospital Level ED Length of Stay Comparison for Patients Included in the Performance Measure, CY 2024 vs. CY 2023

ED LOS By Hospital

Arrayed by hospital ID Lists

- Number of cases (includes adult, non-psych, admitted patients)
- Median ED LOS
- Average ED LOS
- % change in Median ED LOS
- Change in Minutes Waiting = Change in Average ED LOS X 2024 cases

	2023			2024					
HOSPID	n	mean	median	n	mean	median	% chang	Minutes Shaved/(Gained)	% Increase in Cases
210001	9545	407.24	374.0	10585	404.53	362.0	-3.21%	28,682	10.90%
210002	6610	1238.37	1289.0	7243	1343.79	1474.0	14.35%	(763,569)	9.58%
210003	5737	1197.50	1142.0	6275	1109.45	1015.0	-11.12%	552,505	9.38%
210004	8210	576.41	514.0	8674	574.96	505.0	-1.75%	12,533	5.65%
210005	9423	447.04	405.0	10097	476.53	421.0	3.95%	(297,737)	7.15%
210008	3297	561.15	526.0	3604	526.44	492.0	-6.46%	125,083	9.31%
210009	14044	1049.36	917.0	14433	1109.72	1006.0	9.71%	(871,055)	2.77%
210011	6481	722.88	627.0	6313	676.12	553.0	-11.80%	295,157	-2.59%
210012	7917	1153.33	1046.0	9561	1121.05	936.0	-10.52%	308,633	20.77%
210015	10625	722.90	589.0	11925	781.23	632.0	7.30%	(695,693)	12.24%
210016	6851	1166.81	1102.0	7490	1020.67	889.0	-19.33%	1,094,603	9.33%
210017	1017	479.52	277.0	1175	294.07	244.0	-11.91%	217,907	15.54%
210018	3702	672.49	519.0	4015	568.11	470.0	-9.44%	419,089	8.45%
210019	10242	607.57	491.0	10391	602.98	478.0	-2.65%	47,644	1.45%
210022	8985	584.67	480.0	9153	581.58	480.0	0.00%	28,281	1.87%
210023	12807	679.64	546.0	15102	635.72	509.0	-6.78%	663,276	17.92%
210024	5824	564.37	424.0	5717	645.76	462.0	8.96%	(465,347)	-1.84%
210027	6541	601.70	473.0	6125	675.62	539.0	13.95%	(452,770)	-6.36%
210028	3951	423.90	383.0	3386	445.09	389.0	1.57%	(71,740)	-14.30%
210029	9983	1155.95	1082.0	10329	1200.02	1157.0	6.93%	(455,208)	3.47%
210030	222	702.92	501.0	330	626.60	437.0	-12.77%	25,186	48.65%
210032	4570	442.63	321.0	5063	329.43	306.0	-4.67%	573,131	10.79%
210033	7211	757.70	564.0	7088	789.78	592.0	4.96%	(227,409)	-1.71%
210034	3906	540.14	437.0	4558	491.59	427.0	-2.29%	221,277	16.69%
210035	4144	615.41	516.0	4343	683.85	562.0	8.91%	(297,231)	4.80%
210037	3738	1250.28	1243.5	4610	1190.66	1091.5	-12.22%	274,861	23.33%
210038	2061	826.59	684.0	2233	738.33	594.0	-13.16%	197,086	8.35%
210039	3697	474.53	419.0	3585	437.74	380.0	-9.31%	131,863	-3.03%
210040	5643	805.19	650.0	5985	735.62	598.0	-8.00%	416,401	6.06%
210043	10921	866.54	754.0	10921	925.50	799.0	5.97%	(643,935)	0.00%
210044	7275	542.70	476.0	5598	565.24	478.0	0.42%	(126,142)	-23.05%
210048	11045	977.26	853.0	10626	1041.26	958.0	12.31%	(679,990)	-3.79%
210049	8698	967.09	766.0	10673	932.28	728.0	-4.96%	371,532	22.71%
210051	8072	591.34	523.0	7894	534.68	481.0	-8.03%	447,251	-2.21%
210056	6050	693.12	541.0	6174	760.31	565.0	4.44%	(414,859)	2.05%
210057	8401	535.12	431.0	8771	596.67	454.0	5.34%	(539,887)	4.40%
210060	1727	644.31	528.0	1778	627.28	519.5	-1.61%	30,282	2.95%
210061	2467	224.50	206.0	2464	222.40	201.0	-2.43%	5,168	-0.12%
210062	7152	693.45	597.0	6234	761.18	657.0	10.05%	(422,231)	-12.84%
210063	7342	789.85	637.0	7951	803.33	635.0	-0.31%	(107,168)	8.29%
210065	3619	629.56	458.0	3807	688.60	466.0	1.75%	(224,763)	5.19%
210006--converted to	2787	544.73	439.0	230	820.19	625.0	42.37%	(63,357)	-91.75%

Appendix III. IP LOS Performance

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

	CY2023		CY2024		CY2025	
PAT_DISP	N	Average IP LOS (days)	N	Average IP LOS (days)	N	Average IP LOS (days)
ROUTINE DISCHARGE TO HOME OR SELF CARE	166685	3.8	168676	3.8	166986	3.9
TO ANOTHER ACUTE CARE HOSPITAL FOR INPATIENT CARE	5896	7.2	6411	6.8	6157	6.7
TO SNF WITH MEDICARE CERTIFICATION IN ANTICIPATION OF SKILLED CARE	29867	10.2	31252	9.8	30128	10.0
TO A FACILITY THAT PROVIDES CUSTODIAL OR SUPPORTIVE CARE	1436	9.7	1717	9.1	1820	9.0
TO A DESIGNATED CANCER CENTER OR CHILDREN'S HOSPITAL	462	28.6	493	24.1	491	23.9
TO HOME UNDER CARE OF AN ORGANIZED HOME HEALTH SERVICE ORGANIZATION	32150	7.6	34947	7.4	34607	7.6
LEFT AGAINST MEDICAL ADVICE OR DISCONTINUED CARE	3950	3.1	3978	3.1	3873	3.4
	4	1.3	2	3.0	2	0.5
EXPIRED	5759	8.9	5863	8.9	5604	9.1
TO COURT/LAW ENFORCEMENT	491	7.1	541	6.2	660	6.0
TO FEDERAL HEALTH CARE FACILITY	59	7.8	69	7.7	76	6.1
	3	44.0	3	38.7	3	23.7
TO HOSPICE AT HOME	2402	8.5	2761	8.3	2839	8.8
TO HOSPICE DEFINED AS A MEDICAL FACILITY (CERTIFIED) PROVIDING HOSPICE LEVEL OF CARE	3003	10.4	2984	10.4	3262	10.3
TO AN INPATIENT REHABILITATION FACILITY (IRF) OR REHABILITATION DISTINCT PART UNITS OF ANOTHER HOSPITAL	4992	9.6	5446	9.6	5884	9.4
TO A MEDICARE CERTIFIED LONG TERM CARE HOSPITAL (LTCH)	481	15.8	501	14.8	460	15.2
TO A NURSING FACILITY CERTIFIED UNDER MEDICAID BUT NOT CERTIFIED UNDER MEDICARE	35	9.0	58	7.5	57	8.5
TO A PSYCHIATRIC HOSPITAL OR PSYCHIATRIC DISTINCT PART UNIT OF AN ACUTE CARE HOSPITAL	906	7.4	916	7.1	753	5.9
DISCHARGED/TRANSFERRED TO A DESIGNATED DISASTER ALTERNATE CARE SITE	8	3.9	4	7.3	3	5.0
TO ANOTHER TYPE OF HEALTH CARE INSTITUTION NOT DEFINED ELSEWHERE IN CODE LIST.	1318	8.5	1511	8.9	1409	9.3
UNKNOWN	44	8.8	32	8.5	29	10.2

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

Row Labels	Average IP LOS (days)	Average IP LOS - SNF (days)	Average IP LOS - home (days)	Average IP LOS - home health (days)	Average IP LOS - hospice (days)	Average IP LOS - Other (days)
Adventist White Oak	5.9	12.5	3.7	7.7	12.1	9.8
Anne Arundel	4.1	8.6	2.8	6.2	9.0	5.9
Ascension Saint Agnes	4.3	8.7	3.0	5.9	7.3	4.3
Atlantic General	4.1	7.0	3.1	4.3	5.4	4.6
Calvert	3.8	6.1	3.1	5.1	7.6	4.3
Carroll	4.4	7.0	3.4	6.0	7.3	4.7
ChristianaCare, Union	4.1	6.9	3.1	5.2	8.1	4.5
Doctors	6.0	10.3	4.4	6.4	11.6	8.1
Frederick	4.6	8.1	3.4	6.0	7.7	4.8
Ft. Washington	5.3	8.9	3.9	5.8	8.4	4.7
Garrett	3.1	5.0	2.2	3.9	4.6	3.2
GBMC	4.2	8.3	3.0	6.8	6.7	7.4
HC-Germantown and Germantown ED	4.4	8.9	3.2	6.6	7.7	5.7
Holy Cross	4.7	9.9	3.6	6.2	10.8	10.5
Howard County	4.3	7.8	3.1	5.5	7.8	5.7
JH Bayview	6.9	13.3	4.2	9.1	12.7	7.8
Johns Hopkins	7.9	16.3	5.1	10.9	15.8	16.8
MedStar Fr Square	5.5	10.8	3.9	6.6	10.0	7.9
MedStar Good Sam	6.4	9.7	4.3	7.9	7.7	5.4
MedStar Harbor	4.8	7.9	4.0	5.4	9.7	5.3
MedStar Montgomery	5.2	7.7	3.5	5.8	9.4	6.3
MedStar Southern MD	4.9	11.4	3.6	5.9	8.4	6.3
MedStar St. Mary's	3.8	7.4	2.9	6.5	6.8	3.5
MedStar Union Mem	5.6	9.3	3.6	6.7	10.1	5.9
Mercy	4.2	6.2	3.1	6.9	13.6	8.2
Meritus	4.1	8.0	2.8	6.4	5.7	4.6
Northwest	6.6	9.6	5.4	7.0	7.6	6.7
Peninsula	4.2	7.9	2.8	5.7	7.4	5.9
Shady Grove	5.2	9.9	4.1	5.9	10.4	8.4
Sinai	7.8	14.3	5.6	12.5	14.0	8.8
Suburban	5.6	7.9	3.6	5.2	8.0	8.1
UM-BWMC	4.9	10.2	3.3	5.9	8.9	6.5
UM-Capital Region Med	5.2	13.0	3.6	7.7	10.2	8.1
UM-Charles Regional	4.9	8.7	3.0	6.1	7.9	6.1
UM-Chestertown	5.0	7.2	3.9	4.8	3.0	4.4
UM-Easton	5.1	9.1	3.3	6.7	7.6	6.6
UMMC	7.6	16.9	4.7	9.9	16.1	13.9
UMMC Midtown	9.1	15.2	6.3	11.3	21.2	12.4
UM-St. Joe	4.2	7.0	3.1	5.8	7.7	7.0
UM-Upper Chesapeake	4.5	7.7	3.1	5.5	7.4	6.3
Western Maryland	5.3	8.5	3.9	6.7	7.4	6.6

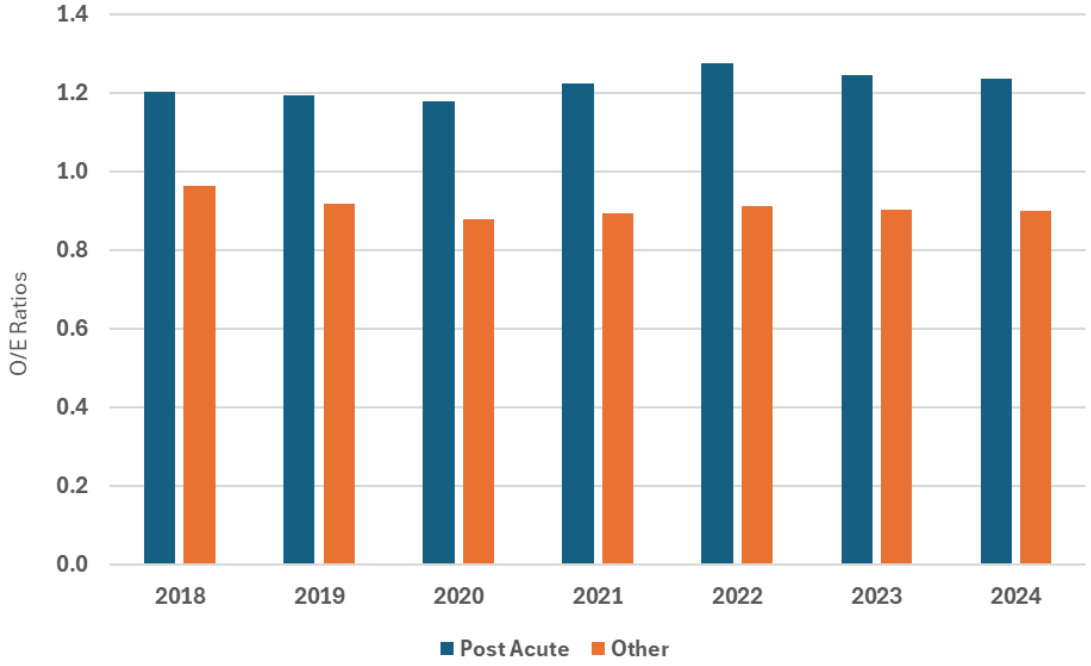
Table 3. CY 2024 Hospital Level Case-Mix Data–Unadjusted Average Inpatient Length of Stay by Discharge Disposition

Row Labels	Average IP LOS (days)	Average IP LOS - SNF (days)	Average IP LOS - home (days)	Average IP LOS - home health (days)	Average IP LOS - hospice (days)	Average IP LOS - Other (days)
Adventist White Oak	5.0	9.5	3.3	6.3	11.0	7.8
Anne Arundel	4.1	8.6	2.8	5.8	8.6	6.5
Ascension Saint Agnes	4.6	9.3	3.2	6.7	7.8	6.0
Atlantic General	3.9	6.1	3.2	3.8	4.8	4.5
Calvert	3.9	6.4	3.3	4.5	7.8	4.2
Carroll	4.7	7.5	3.3	6.0	7.7	5.5
ChristianaCare, Union	4.3	7.1	3.4	5.0	6.7	4.3
Doctors	5.8	10.2	4.4	6.6	8.3	7.0
Frederick	4.4	8.0	3.3	5.5	6.8	4.5
Ft. Washington	4.2	6.1	3.3	4.5	3.7	4.6
Garrett	3.3	4.9	2.7	3.8	4.8	3.0
GBMC	4.3	8.3	3.1	6.6	8.5	6.9
HC-Germantown and Germantown ED	4.7	8.5	3.5	6.1	8.0	6.3
Holy Cross	4.7	10.0	3.6	6.6	10.3	10.0
Howard County	4.3	7.4	3.1	5.4	8.5	6.0
JH Bayview	6.8	13.1	4.2	8.3	14.1	7.4
Johns Hopkins	7.5	16.9	5.1	9.9	15.1	14.6
MedStar Fr Square	5.3	9.3	4.1	5.3	9.2	7.0
MedStar Good Sam	6.4	9.8	4.1	7.8	9.9	5.6
MedStar Harbor	4.5	7.4	3.9	4.8	7.4	3.8
MedStar Montgomery	4.3	6.2	3.2	4.9	7.0	4.3
MedStar Southern MD	5.1	10.4	3.9	6.8	10.0	6.3
MedStar St. Mary's	3.7	7.4	3.0	5.7	7.2	3.8
MedStar Union Mem	5.6	9.0	3.8	6.7	13.8	6.2
Mercy	4.2	8.3	3.1	6.8	9.0	6.3
Meritus	4.3	7.7	3.1	6.6	6.9	4.6
Northwest	6.9	10.3	5.7	6.9	7.5	7.0
Peninsula	4.0	7.7	2.9	5.0	6.3	5.7
Shady Grove	5.1	8.7	4.0	6.2	10.4	7.7
Sinai	7.2	12.8	4.9	9.8	13.9	8.4
Suburban	5.5	7.9	3.5	5.1	7.9	7.5
UM-BWMC	4.7	10.0	3.3	5.9	8.9	6.8
UM-Capital Region Med	5.5	11.3	3.8	7.8	10.9	9.4
UM-Charles Regional	5.6	9.1	3.6	6.4	8.4	6.9
UM-Chestertown	4.7	6.3	3.4	4.9	8.7	4.2
UM-Easton	5.2	9.2	3.4	6.5	7.8	6.8
UMMC	8.1	16.7	4.8	10.4	15.5	15.9
UMMC Midtown	8.8	15.2	5.6	9.6	15.9	12.0
UM-St. Joe	4.2	7.3	3.0	6.1	7.3	6.6
UM-Upper Chesapeake	4.6	8.3	3.1	5.3	7.8	5.4
Western Maryland	5.1	7.9	3.8	6.5	8.3	5.7

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

Row Labels	Average IP LOS (days)	Average IP LOS - SNF (days)	Average IP LOS - home (days)	Average IP LOS - home health (days)	Average IP LOS - hospice (days)	Average IP LOS - Other (days)
Adventist White Oak	5.2	9.8	3.4	7.3	8.9	8.5
Anne Arundel	4.2	8.5	2.9	5.9	8.4	6.9
Ascension Saint Agnes	4.7	9.6	3.2	6.2	8.2	5.8
Atlantic General	4.1	6.5	2.9	4.0	5.6	4.9
Calvert	3.8	5.9	3.2	4.5	5.5	4.2
Carroll	4.5	7.7	3.1	5.6	7.0	5.3
ChristianaCare, Union	4.4	7.0	3.5	6.0	7.5	3.9
Doctors	5.5	9.3	4.3	5.4	8.6	6.8
Frederick	4.7	8.7	3.4	6.1	7.8	5.3
Ft. Washington	4.5	7.2	3.3	4.3	6.4	5.0
Garrett	3.5	5.3	2.9	4.6	3.3	3.4
GBMC	4.2	8.1	3.1	6.2	6.9	7.6
HC-Germantown and Germantown ED	5.2	8.5	3.7	6.3	9.1	6.7
Holy Cross	5.1	10.6	3.8	6.5	11.1	11.3
Howard County	4.5	8.0	3.3	5.3	8.1	6.8
JH Bayview	7.1	13.4	4.5	9.0	13.9	8.4
Johns Hopkins	7.6	18.4	5.1	11.1	15.6	15.5
MedStar Fr Square	5.3	10.0	4.1	6.1	8.4	6.9
MedStar Good Sam	6.4	9.1	4.0	7.9	9.0	5.6
MedStar Harbor	4.7	8.3	4.0	5.5	11.5	4.5
MedStar Montgomery	4.5	7.1	3.0	4.8	8.7	4.5
MedStar Southern MD	5.0	9.6	3.9	5.6	10.2	5.5
MedStar St. Mary's	3.7	7.7	2.8	5.7	10.5	4.0
MedStar Union Mem	5.6	8.8	3.9	7.1	13.8	6.9
Mercy	4.4	9.0	3.1	7.3	16.0	8.1
Meritus	4.5	8.2	3.3	6.6	7.1	4.9
Northwest	6.9	9.9	6.0	6.4	8.4	6.4
Peninsula	4.1	7.3	2.9	4.8	6.8	6.2
Shady Grove	5.0	9.0	3.8	6.5	9.5	7.3
Sinai	6.8	12.1	4.8	9.1	10.2	7.1
Suburban	5.6	8.4	3.9	5.0	8.7	7.0
UM-BWMC	4.9	9.1	3.5	6.1	9.0	6.9
UM-Capital Region Med	5.5	12.3	3.8	6.5	9.7	9.9
UM-Charles Regional	5.1	8.7	3.4	5.7	8.7	6.0
UM-Chestertown	4.2	5.5	3.1	4.4	6.0	3.8
UM-Easton	5.1	9.3	3.4	6.8	8.3	5.8
UMMC	8.6	17.6	5.3	12.6	19.1	14.7
UMMC Midtown	9.0	18.0	6.4	10.7	20.3	9.6
UM-St. Joe	4.3	7.0	3.2	5.6	7.2	6.5
UM-Upper Chesapeake	4.6	8.1	3.0	5.3	8.0	6.0
Western Maryland	5.1	8.7	3.6	6.9	8.7	5.2

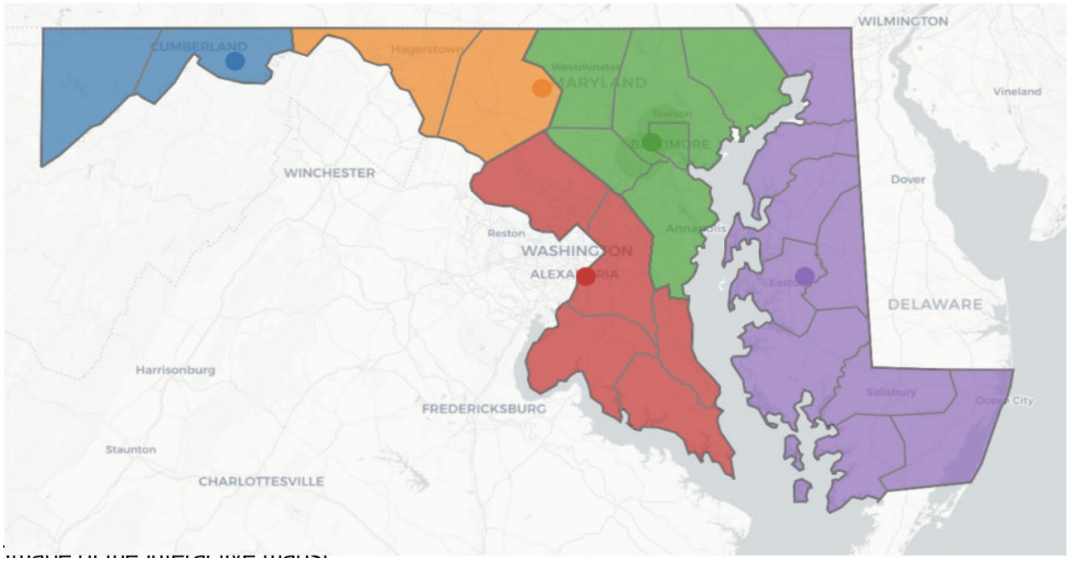
Figure 1. Trends in Observed over Expected Ratios of Discharges to Post Acute Care vs. Others



Source: HSCRC Case-Mix All-Payer Inpatient Data

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

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



Data Sources: The 2024 Skilled Nursing Facility Report CY 2023 and CY 2024 Hospital Case-Mix Data and the MIEMSS EMS regional database

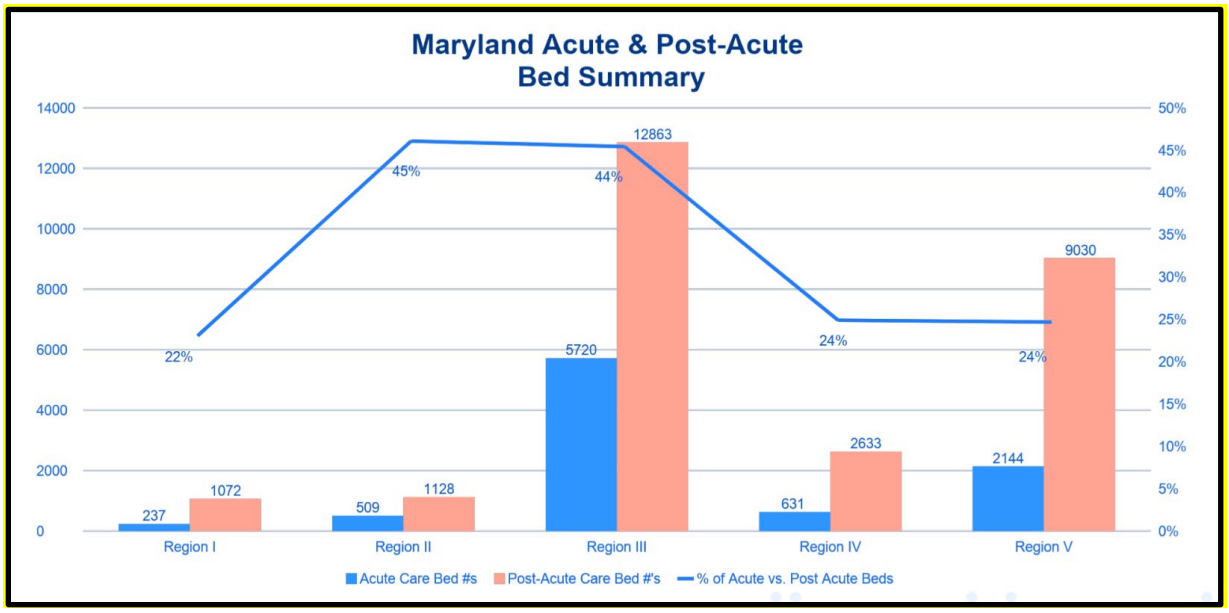
Figure 2. Current Baseline Data for Maryland Licensed Bed Counts for Acute and Skilled Nursing Beds

Maryland Licensed Beds

- The data and corresponding Maryland map is organized into 5 regions based on grouped counties
- Data sources
  - Acute Care Beds – Maryland Institute of Emergency Medical Services Systems (MIEMSS) licensed hospital beds
  - Post-Acute Care Beds – Maryland Healthcare Commission Public Use Files

Region	County	Acute Care Beds	Post-Acute Care Beds (SNF)
Region I	Allegany Garrett	237	1072
Region II	Washington Fredrick	509	1128
Region III	Anne Arundel Carroll Harford Howard Baltimore Baltimore City	5720	12863
Region IV	Dorchester Kent Queen Anne's Somerset Talbot Caroline Worcester Cecil Wicomico	631	2633
Region V	Calvert Charles St. Mary's Montgomery Prince George's	2144	9030

Figure 3. Percentage of Acute vs. Post-Acute Beds Per Region in Maryland



Appendix V. Maryland Department of Health Initiatives

As discussed earlier in this report, the Maryland Department of Health (the Department) is leading several initiatives that impact ED wait times, 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

The Department 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 staff to obtain care coordination services for their most complex behavioral health patients to connect them to clinically appropriate levels of care.
- The Department maintains the Behavioral Health Hospital Coordination Dashboard, which includes an inpatient psychiatric bed dashboard that is updated three times per day to help hospital discharge planners locate available beds. MDH is building on this dashboard in alignment with HB1121 of 2020 to procure a software vendor to develop a Bed Registry and Referral System (BRRS) that will include bed search capacity and an electronic referral system.
- Since February 2024, the Department 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 inpatient 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.

Behavioral Health

The Department 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 Suicide & Crisis Lifeline provides 24/7 confidential support for Marylanders struggling with mental health, emotional distress, or alcohol or drug use. Compassionate counselors provide

support and 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 October 2025, licensed providers are available 24/7 in 19 jurisdictions, and the Department is working with providers in the remaining jurisdictions to become licensed. Some jurisdictions also have stabilization programs particularly to support youth and families 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.
- The HSCRC established the Regional Partnership Catalyst Program to advance Maryland's population health goals under the Total Cost of Care Model and to support investments in behavioral health crisis services infrastructure, in alignment with the Behavioral Health Administration. Between January 2021 and December 2025, the 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

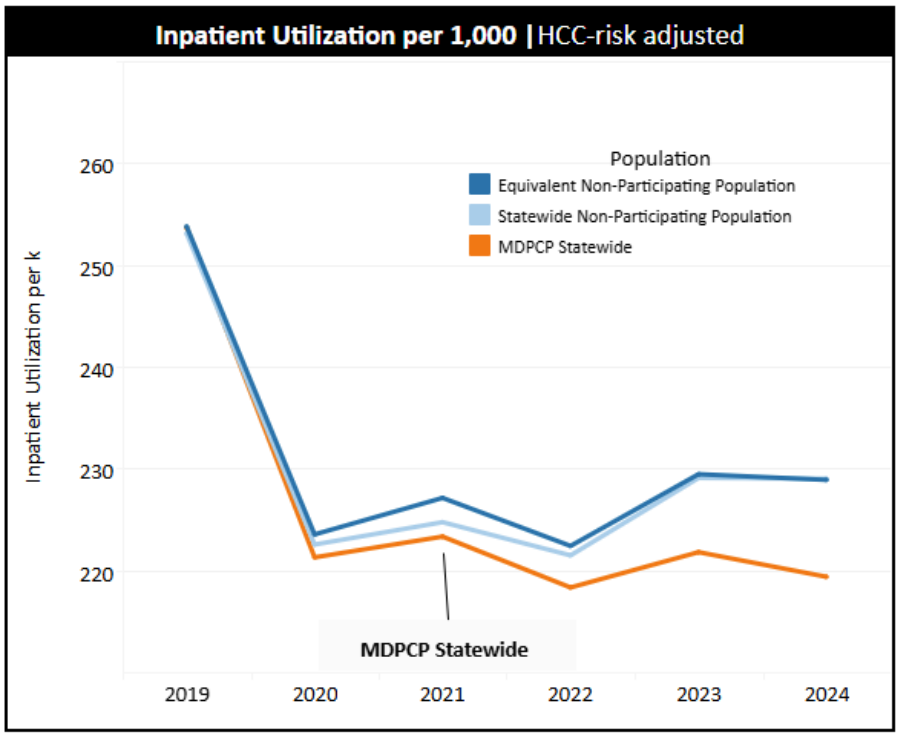
The Maryland Primary Care Program (MDPCP) began in 2019 and is a key component of the Total Cost of Care Model. MDPCP is a voluntary program that provides funding and support for the delivery of advanced primary care throughout the state. Program evaluations show that MDPCP practices have consistently performed better than two comparison populations (statewide non-participating and equivalent participating populations)[17] with regard to emergency department (ED) visits per 1,000 beneficiaries, inpatient admissions per 1,000, and Prevention Quality Indicator (PQI)-like events[18] per 1,000 beneficiaries. Between

[17] 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.

[18] PQIs are a set of metrics measuring 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

2019 and 2024, MDPCP practices saw a 14% decrease in inpatient admissions per 1,000 beneficiaries, (Figure 1) and a 19% decrease in ED visits per 1,000 beneficiaries (Figure 2).

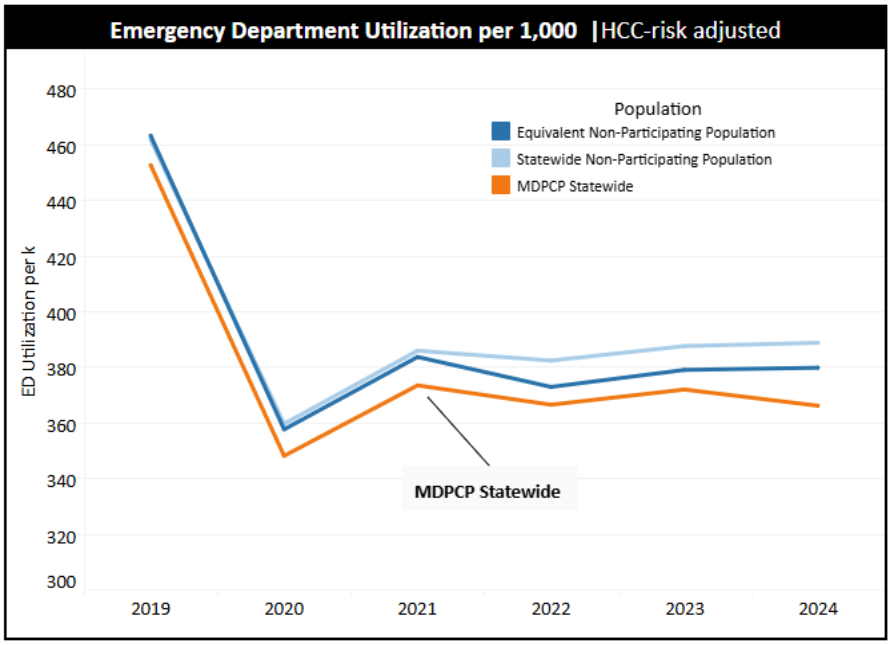
Figure 1. Inpatient Utilization per 1,000 (Hierarchical Condition Categories (HCC) Risk-Adjusted Scores), 2019-2024



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

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 inpatient 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 21st, 2024.

Figure 2. ED Utilization per 1,000 (HCC Risk-Adjusted), 2019-2024



*Data sourced from the CCLF

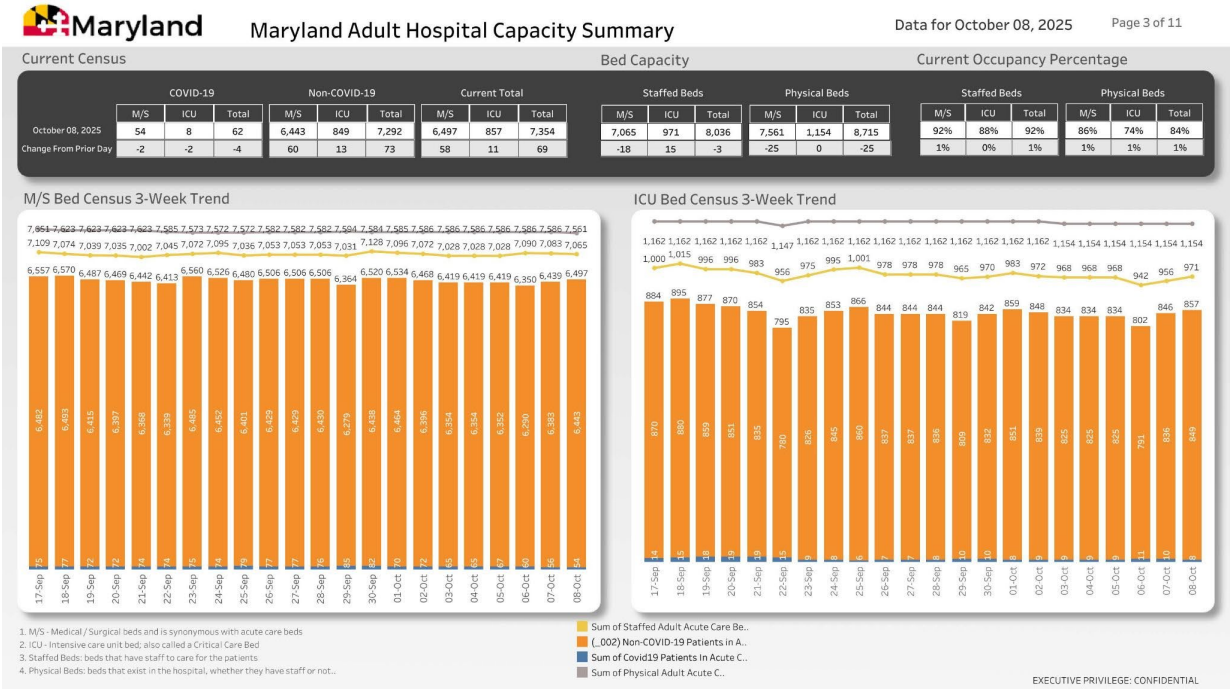
A recent causal evaluation of MDPCP conducted by The Hilltop Institute at UMBC used data from 2019 through 2022 to estimate the impact of the program on utilization and expenditure for Medicare beneficiaries. Using a combination of propensity score matching and difference-in-differences analyses, Hilltop identified the effect of MDPCP by examining changes in outcomes for individuals attributed to MDPCP-participating primary care practices, net of concurrent changes in outcomes for comparable individuals in Maryland over the first four years of the program implementation period. Results of this evaluation found that MDPCP reduced the probability of any ED utilization by 1.7%. More information on this evaluation is available here.

Advance Directives

The Department, in collaboration with the Maryland Cancer Cooperative 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. The Department and the Maryland Cancer Cooperative Workgroup have also engaged MHCC and CRISP in an effort to expand access to electronic advance directives. 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.

Appendix VI. MIEMSS Daily Bed Status & Occupancy Reporting

Since the beginning of the COVID-19 pandemic, MIEMSS has been collecting daily hospital bed status and occupancy data from the hospitals and compiling it into a daily *Hospital Surge Engagement Team* report. The report includes information about total hospital bed occupancy (staffed v. physical beds), COVID-related hospitalizations, intensive care unit (ICU) occupancy, acute bed occupancy, and ED occupancy. Examples of the data collected are presented below.



Maryland Maryland Adult Hospital Capacity Summary Data for October 08, 2025 Page 3 of 11

Current Census

	COVID-19			Non-COVID-19			Current Total		
	M/S	ICU	Total	M/S	ICU	Total	M/S	ICU	Total
October 08, 2025	54	8	62	6,443	849	7,292	6,497	857	7,354
Change From Prior Day	-2	-2	-4	60	13	73	58	11	69

Bed Capacity

	Staffed Beds			Physical Beds		
	M/S	ICU	Total	M/S	ICU	Total
October 08, 2025	7,065	971	8,036	7,561	1,154	8,715
Change From Prior Day	-18	15	-3	-25	0	-25

Current Occupancy Percentage

	Staffed Beds			Physical Beds		
	M/S	ICU	Total	M/S	ICU	Total
October 08, 2025	92%	88%	92%	86%	74%	84%
Change From Prior Day	1%	0%	1%	1%	1%	1%

M/S Bed Census 3-Week Trend

ICU Bed Census 3-Week Trend

1. M/S - Medical / Surgical beds and is synonymous with acute care beds
2. ICU - Intensive care unit bed; also called a Critical Care Bed
3. Staffed Beds: beds that have staff to care for the patients
4. Physical Beds: beds that exist in the hospital, whether they have staff or not...

Sum of Staffed Adult Acute Care Be..
(...002) Non-COVID-19 Patients in A..
Sum of Covid19 Patients In Acute C..
Sum of Physical Adult Acute C..

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Maryland Pediatric Hospital Capacity Summary

Data for October 08, 2025

Current Census

	COVID-19			Non-COVID-19			Current Total		
	M/S	ICU	Total	M/S	ICU	Total	M/S	ICU	Total
October 08, 2025	2	0	2	143	39	182	145	39	184
Change From Prior Day	0	0	0	-4	-4	-8	-4	-4	-8

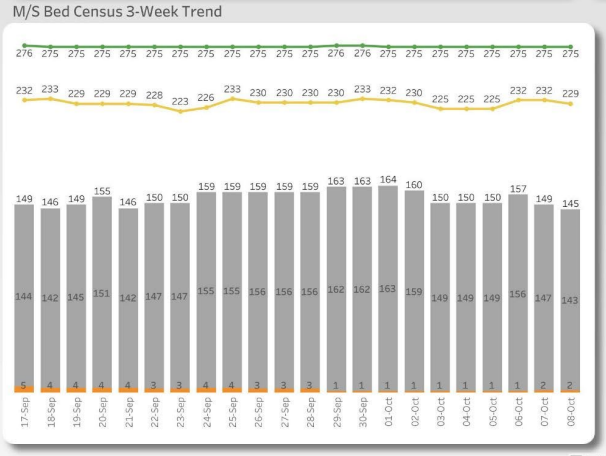
Bed Capacity

	Staffed Beds			Physical Beds		
	M/S	ICU	Total	M/S	ICU	Total
	229	56	285	275	68	343
	-3	-3	-6	0	2	2

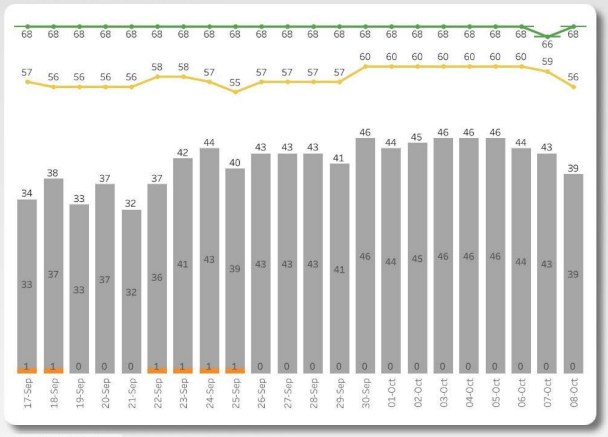
Current Occupancy Percentage

	Staffed Beds			Physical Beds		
	M/S	ICU	Total	M/S	ICU	Total
	63%	70%	65%	53%	57%	54%
	-1%	-3%	-1%	-1%	-8%	-3%

M/S Bed Census 3-Week Trend



ICU Bed Census 3-Week Trend



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(_015) Ped Non-COVID-19 Patients..
Sum of Pediatric Covid Patients In ..
Sum of Staffed Pediatric Acute Car..
Sum of Physical Pediatric Acute C..

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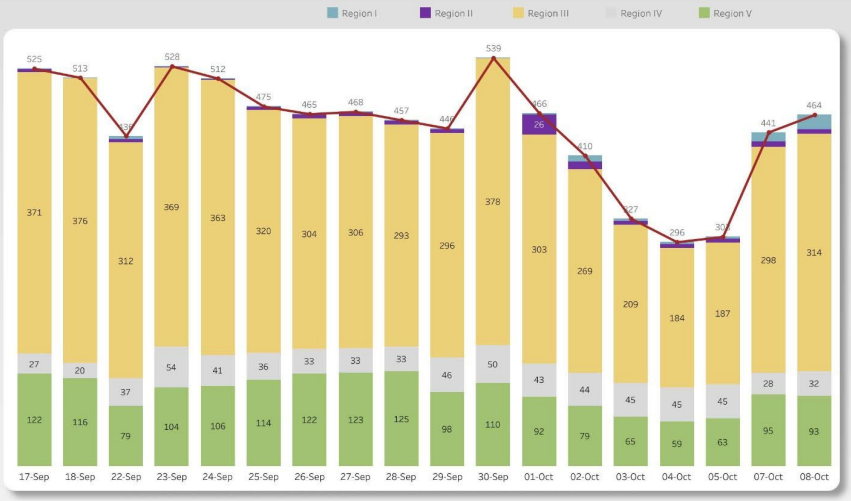
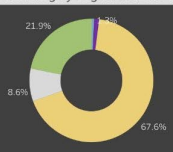
21-Day Overview - Emergency Department Patient Boarding



	17-Sep	18-Sep	19-Sep	20-Sep	21-Sep	22-Sep	23-Sep	24-Sep	25-Sep	26-Sep	27-Sep	28-Sep	29-Sep	30-Sep	01-Oct	02-Oct	03-Oct	04-Oct	05-Oct	06-Oct	07-Oct	08-Oct
Region I	0	0				4	1	0	1	0	0	0	0	0	2	8	3	3	3		12	19
Region II	5	1				4	0	2	4	6	6	6	6	1	26	10	5	5	5		8	6
Region III	371	376				312	369	363	320	304	306	293	296	378	303	269	209	184	187		298	314
Region IV	27	20				37	54	41	36	33	33	33	46	50	43	44	45	45	45		28	32
Region V	122	116				79	104	106	114	122	123	125	98	110	92	79	65	59	63		95	93
Grand Total	525	513				436	528	512	475	465	468	457	446	539	466	410	327	296	303		441	464

ED Patient Boarding by Region in a 21 Day Period



Difference of total ED patient boarding at a state level

Prior Day: **5.2%**
7 Days Ago: **-0.4%**
14 Days Ago: **-9.4%**
21 Days Ago: **-11.6%**

Detail by Region:

Region	Facility Name	Today
Region III	University of Maryland Medical Center	42
	Sinai Hospital of Baltimore	39
	Upper Chesapeake Medical Center (UMU..	33
Region V	Prince George's Hospital Center	28
	White Oak Medical Center	18
	Suburban Hospital	11

		21 Days
Region III	University of Maryland Medical Center	752
	Baltimore Washington Medical Center	540
	Howard County General Hospital (JHM)	454
Region V	Prince George's Hospital Center	291
	Shady Grove Adventist Hospital	270
	Holy Cross Hospital	264

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Emergency Room Boarding and Census by Region

ED Census

	10/8/2025				
	ICU	M/S	Psychiatric	Awaiting...	Total
Region I	0	18	1	0	19
Region II	0	2	4	0	6
Region III	5	266	34	9	314
Region IV	4	19	7	2	32
Region V	3	63	15	12	93
Grand Total	**12**	**368**	**61**	**23**	**464**

Emergency Room Boarding by Region