maryland
health services
cost review commission

ED Wait Time Reduction Commission Meeting

July 15, 2026

Virtual Meeting Only

Topics

ED WTR Commission CY 2026 Priorities and Updates

Key Drivers and Recommendations for Final Report

Public Comment

ED WTR Commission Members

Co-Chairs:

- Elizabeth Kromm, Maryland Department of Health
- Jon Kromm, Health Services Cost Review Commission (Alyson Schuster, acting designee)

Appointed Members:

- Amanda Bauer, DO, Kaiser Permanente
- Andrew Nicklas, Maryland Hospital Association
- Barbara Maliszewski, RN, DNP, Johns Hopkins Medicine
- Dan Morhaim, MD
- Danielle Knatz, Baltimore County Fire Department's Emergency Medical Service
- Johnathan Davis, MD, CarePoint Response
- Mary Kim, MD, Adventist HealthCare–position vacant as of July 3, 2026
- Neel Vibhakar, MD, University of Maryland Medical System
- Ted Delbridge, MD, Maryland Institute for Emergency Medical Services Systems
- Toby Gordon, ScD, Johns Hopkins School of Medicine
- Wynee Hawk, RN, JD, Maryland Health Care Commission

ED Wait Time Reduction Commission
CY 2026 Priorities and Updates

Commission Priorities & Subgroups - CY 2026

1. Standardize Bed Capacity & Occupancy Metrics

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

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

Subgroup Action Items (Capacity & Access):

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

2. Post-Acute Access

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

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

Subgroup Action Items (Capacity & Access):

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

3. ED-Hospital Throughput Modeling

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

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

Subgroup Action Items (Data & Best Practices):

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

4. ED-Hospital Throughput Best Practices

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

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

Subgroup Action Items (Data & Best Practices):

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

Priority & Subgroup Updates and Next Steps

1. Standardize Bed Capacity & Occupancy Metrics

- MHCC, HSCRC, MIEMSS, & MDH met on April 23 and June 24, 2026 to discuss scope of work and review gap analysis comparing the current collection of hospital and post-acute care bed count data versus what is required by recent legislation (HB1563) and what may be needed to assess capacity alignment to address ED LOS.
    - HSCRC and MHCC will work with hospitals and post-acute providers to get input to standardize definitions for occupancy and capacity reporting.
- Assess potential impact and regulatory concerns for alternative capacity types (e.g., hospital at home)

2. Post-Acute Access

- MHCC currently finalizing draft report on Strengthening Post-Acute Care under the AHEAD model.
    - MHCC draft report will be shared with ED Commissioners when available; encourage stakeholder input on recommendations that may impact ED and hospital throughput.
- ED Commission and Access subgroup were asked to prioritize areas for ED report recommendations for access to post-acute care.
    - Prioritization will be reviewed at today's meeting

Priority & Subgroup Updates (2)

3. ED-Hospital Throughput Modeling

- Expanded empirical assessment of the potential impact of policies/programs focused on improving ED LOS. (see appendix for details on modeling and validation).
    - Review expanded modeling with Data Subgroup (8/19 9-10:30 am) and incorporate results to support ED Commission prioritization and recommendations.

4. ED-Hospital Throughput Best Practices

- HSCRC Commissioners approved Inpatient Length of Stay hospital monitoring policy with recommendation that HSCRC staff propose a payment policy for IP LOS in future rate years.
    - HSCRC working with Commissioners and stakeholders on how to incorporate IP LOS into the portfolio of Hospital Quality and Population Health policies.
- CRISP ED LOS dashboard (Version 1) released that allows hospitals to track ED LOS for all patients including those admitted and those discharged home.
    - Discuss dashboard enhancements, including addition of statewide benchmarks (V2 underway) and additional metrics (e.g., EMS turnaround time) with Data Subgroup.
- HSCRC staff working on reporting requirements for CY 2026 HSCRC Best Practice policy.
    - Develop strategic plan for HSCRC ED LOS payment incentives (Quality-Based Reimbursement) and Best Practice Policy under AHEAD.

Feedback on Key Drivers and Prioritization of Recommendation Areas

Goal for Today's Meeting

- Determine which ED Key Drivers and broad areas for recommendations have consensus among ED Commissioners for inclusion in the final ED WTR reporting due by November 2026.
  - For each Key Driver for where there is consensus, staff will write up rationale, provide relevant literature and analytics/simulation modeling to support recommendation, list agencies, workgroups, or stakeholders who should receive recommendations, and any specific next steps.
- To accomplish this, we will:
  - Review Key Drivers previously discussed at April 30th ED WTR Commission meeting
  - Review feedback received on prioritization of these Key Drivers and areas for recommendations
  - Link other initiatives/workgroups/modeling underway that relate to the Key Drivers and areas for recommendations
  - Commissioner discussion and voting on Key Drivers and High Priority Areas

Key Drivers of ED LOS & Areas for Potential Recommendations Original

Access to Post Acute Care

MHCC

Post Acute Care Workgroup (Draft recommendations to be released Summer 2026)

- Evaluate Value-Based Payment Programs
- Complete Bed Allocation/Capacity Analysis (aligned with HB1563)

HSCRC

- Evaluate Feasibility of VBP Programs
- Explore Care Transformation Initiatives

Medicaid

- Value Based Programs for Acute & Post-Acute Care Transitions

Commercial Payers

- Value-Based Payment Programs for Acute & Post-Acute Care Transitions

Post Acute Providers

- Improved Care Transitions
- Standardize Referral Platforms & Auth criteria
- Implement Accountability Measures for Acceptance Rates & Target Occupancy Rates (Value Based Programs)

Legislature

- Consider Legislation to address reimbursement models, gaps, regulations for authorization and acceptance, etc. (based on MHCC report)

Hospitals

- Evaluate utilization of post-acute providers (SNF, Home Health)
- Partner in Value Based Arrangements (including partnerships to own post-acute beds)

Denials & Authorization Delays

Multi-Agency Working Group

- Streamline authorization process/platform
- Standardized Criteria for Authorizations
- Evaluate Reimbursement Structure

Maryland Insurance Agency

- Streamline authorization process/platform
- Evaluate Reimbursement Structure

Commercial Payers

- Streamline authorization process/platform
- Standardize Criteria for Authorizations

Capacity Alignment

MHCC and HSCRC

- Assess Regional Inpatient & Post-Acute Bed Needs (Bed count, capacity analysis)
- Partner with hospitals on service line coordination across the state
- Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)
- IP LOS monitoring (indirectly generates capacity)

Hospitals

- Partner with HSCRC on Strategic Service Line Coordination across the state
- Partner with HSCRC to explore Alternate capacity options, throughput improvement and IP LOS gains
- Evaluate staffing metrics as directed by regulatory agencies and recent Safe Staffing Act (SB411, HB624)

MIEMSS

- Support enhanced bed occupancy, capacity reporting

Best Practices/ Care Transitions

HSCRC

- Evaluate reimbursement for case management/ care coordination services (VBP)
- Expansion of Best Practice Policy
- Explore ED LOS incentive transition to ECAT measures
- Consider IP LOS, PAU and Obs Mgmt Incentives
- Collaboration on Long Stay Patients, Guardianship
- Explore Additional Incentives for Palliative Care Coordination and Education

Hospitals

- Collaborate with HSCRC on all actions above
- Expand community partnerships and investments (primary, BH, SDOH)
- Enhance palliative care investments and utilization

MDH

- Continue work on pediatric overstays, BH, chronic disease
- Evaluate opportunity to integrate Psychiatric Bed Registry

Legislature

- Legislation to support above initiatives

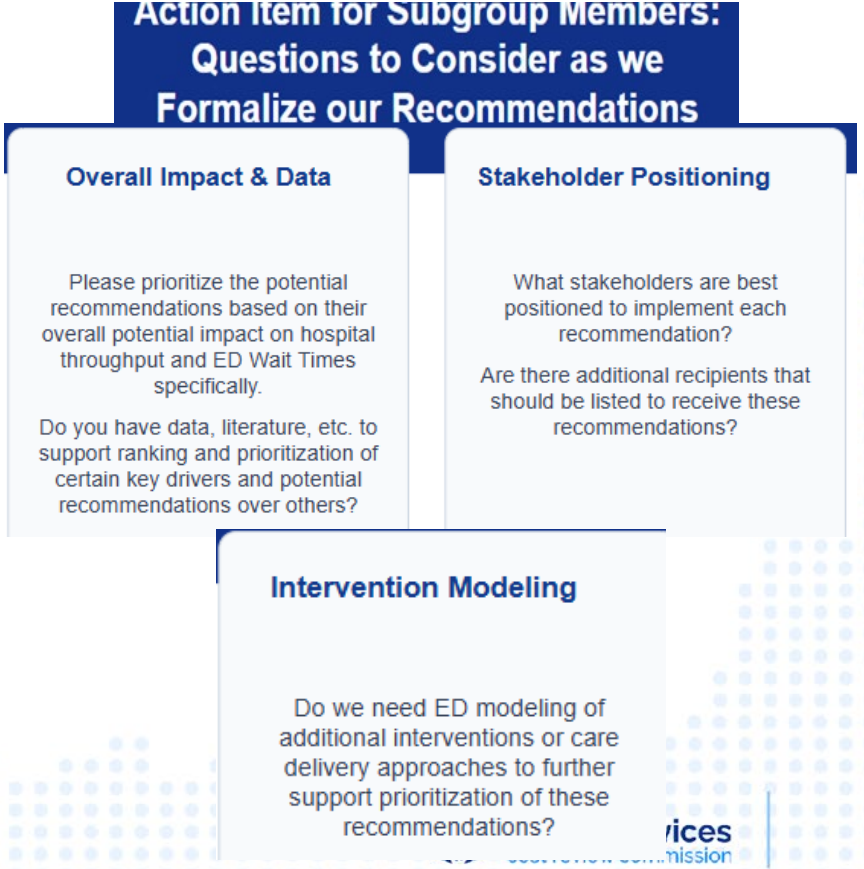
Process for Input on Key Drivers and Recommendations

Key Drivers and Recommendations were reviewed and discussed with the ED WTR Commissioners during the April 30, 2026 ED WTR Commission meeting.

- Feedback was recorded during the meeting and an additional call for feedback was made when meeting materials were distributed after the meeting.

Key Drivers and Recommendations were also shared with the Access and Capacity subgroup on May 28, 2026.

- Feedback was requested by June 24, 2026.



Feedback on Key Drivers and Recommendations

- Written feedback with prioritization was received from:
  - UMMS (ED Commission representative Neel Vibhakar, MD)
  - JHHS (ED Commission representative Barb Maliszewski, RN)
  - Dan Morhaim, MD
- Feedback received is provided in Appendix slides
- The following slides include general feedback received and then there is a summary slide for each of the Key Drivers and areas of recommendation
  - ED Commissioners will vote on whether they agree or disagree with the Key Driver and high priority areas for recommendations to be included in Final ED Report

General Feedback

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

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

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

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

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

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

General Feedback

- The current data indicates very small statewide improvement in ED LOS for admitted patients (HSCRC payment measure).
    - Questions raised include: What would a significant change be? What is the national standard for this? What should Maryland's goals be?
- Additional legislative actions that are relevant to ED wait times need to be referenced, including:
    - **SB411/HB624** "Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026)".
    - **SB707** (enacted) "Mental Health Law - Definition of Danger to the Life or Safety of the Individual or of Others and Reports on Emergency Evaluation Petitions (Right to Treatment)".
- Recommend the ED Commission consider how to address the challenges of placement for pediatric patients with mental health problems and guardianship cases, both of which result in long ED and inpatient stays.
- Concern that current wording makes some of the recommendations appear optional and/or fall short of definitive plan, which may be appropriate for some recommendations, but where possible be more definitive.

Key Drivers & Rationale

Access to Post Acute Care

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

Capacity Alignment

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

Denial & Authorization Delays

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

ED and IP Throughput Best Practices & Care Transitions

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

Preliminary Intervention Modeling Takeaways

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

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

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

Key Driver: Access to Post Acute Care

VOTE

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

High Priority Areas:

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

Key Driver: Authorization Delays and Denials

VOTE

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

High Priority Areas:

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

Prior Authorization (PA) Suggestions

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

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

Key Driver: Capacity Alignment

VOTE

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

High Priority Areas:

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

Lower Priority Areas (for discussion):

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

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

VOTE

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

High Priority Areas:

- Collaboration on resource allocation and support for Long Stay Patients and guardianship cases
- Expand community partnerships and investments in primary care, behavioral health including pediatrics, and to address social determinants of health
- Evaluate opportunity to integrate Psychiatric Bed Registry to improve care transitions
- Strengthen and expand Palliative Care and Hospice services

Lower Priority Areas (for discussion):

- Expansion of HSCRC Hospital Best Practice Policy

Key Drivers & Areas for Recommendations to Address ED LOS Updated

Access to Post Acute Care

Note: Will integrate MHCC Post Acute Workgroup Output

- **Strengthen and expand participation in value based payment programs for post-acute providers**
  Key Stakeholders involved: *MHCC, HSCRC, Medicaid, Commercial Payers, Post-Acute Providers, MIEMSS, Legislature*
  Priority: *High*

- **Complete hospital and post-acute bed allocation/capacity analysis (aligned with HB1563)**
  Key Stakeholders involved*: MHCC, HSCRC, MDH, Acute & Post Acute Care Facilities, MIEMSS, Legislature*
  Priority: *High*

- **Recommend stakeholders prioritize care transformation initiatives that impact ED and IP LOS**
  Key Stakeholders involved: HSCRC, MHCC, MIEMSS, Medicaid, Commercial Payers, Acute and Post-Acute Facilities, Legislature
  Priority: *High*

- **Recommend policymakers consider addressing reimbursement models, capacity gaps, regulations for authorization and acceptance, et.**
  Key Stakeholders involved*: MHCC, HSCRC, MDH, Acute and Post Acute Care Facilities, Medicaid, Legislature*
  Priority: *High*

Authorization Delays & Denials

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

  Key Stakeholder: Adverse Decisions Workgroup
  Priority: High

Capacity Alignment

- **Assess Regional Needs for Inpatient & Post-Acute Capacity using hospital and post-acute bed allocation/capacity analysis conducted as part of HB1563**
  Key Stakeholders: *HSCRC, MHCC, MIEMSS, MDH, Acute & Post-Acute Facilities, Legislature*
  Priority*: High*

- **Multi-stakeholder collaboration on service line coordination across the state**
  Key Stakeholders: *HSCRC, Acute Care Facilities*
  Priority*: Low*

- **Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)**
  Key Stakeholders: *HSCRC, Hospitals, Legislature*
  Priority*: Medium (some statute limitations to address)*

- **Monitor IP LOS (note: policy approved by HSCRC) and partner with hospitals to understand IP LOS drivers and best practices**
  Key Stakeholders: *HSCRC,Acute Care Facilities*
  Priority*: Low; already implemented*

- **Evaluate staffing metrics as directed by regulatory agencies and recent Safe Staffing Act (SB411, HB624)**
  Key Stakeholders: *Acute Care Facilities, Legislature*
  Priority*: Low related to ED LOS impact & already implemented*

Best Practices/Care Transitions

- **Collaboration on resource allocation and support for Long Stay Patients and guardianship cases**
  Key Stakeholders: *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  Priority*: High*

- **Expand community partnerships and investments in primary care, behavioral health including pediatrics, and to address social determinants of health**
  Key Stakeholders: *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  Priority*: High*

- **Evaluate opportunity to integrate Psychiatric Bed Registry to improve care transitions**
  Key Stakeholders: *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  Priority*: High*

- **Strengthen and expand Palliative Care and Hospice services**
  Key Stakeholders: *HSCRC, MDH, Hospitals, Post-Acute Providers, Medicaid, Legislature*
  Priority*: High*

- **Expansion of HSCRC Hospital Best Practice Policy**
  Key Stakeholders: *HSCRC, MDH, Hospitals, Post-Acute Providers, Legislature*
  Priority*: Low*

Next Steps

- ED-Hospital Throughput Best Practice Subgroup Meeting 8/5/2026- will review recommendations and data to integrate into the report
- Capacity and Access Subgroup Meeting 8/12/2026 - will review the prioritization of the final key drivers and recommendations approved at the commission meeting
- Data Subgroup Meeting 8/19/2026–will review expanded modeling and how to incorporate results to support ED Commission prioritization and recommendations
- ED WTR Commission Meeting 9/2/2026 to review final recommendations for Legislative Report

Appendix

Stakeholder Feedback on Key Drivers and Areas for Recommendations

Feedback on Key Drivers and Recommendations

Overall

- We believe that this document does a nice job of identifying the key drivers of increased ED wait times – with a particular focus on inpatient and post-acute care challenges.
- As the slides are currently set up, it appears that there are 39 distinct recommendations. However, the same recommendation can appear more than once because it is influenced by more than one agency/organization.
- In order to promote collaboration across organizations, would recommend making the list more "patient-centric" by leading with the intervention and then listing the multiple organizations that need to be involved. While perhaps a minor point, the current layout promotes a siloed approach rather than a collaborative one in our opinion.
- Using the words "evaluate," "explore," or "consider" make some of the recommendations appear optional and/or fall short of a definitive plan. While it may be appropriate for some of the interventions, it may help to make some more definitive.
- Rather than adding several new interventions, we prioritized the existing list. However we do recommend adding language that addresses the challenges with guardianship cases.

Feedback on Key Drivers and Recommendations

1. Access to Post Acute Care Top Priorities:

- Value based payment programs for post-acute providers that further incentivizes management of increasingly complex populations, patient acceptance rates, target occupancy, improved quality outcomes, readmission reduction, etc… (MHCC, HSCRC, Medicaid, Commercial Payers)
- Payor accountability to address inappropriate denial of medically necessary services and delays in care transitions from the acute to post-acute setting. (HSCRC)
- Care Transformation initiatives (HSCRC)
- Bed allocation/capacity analysis against national benchmarks across all levels of care (MHCC)
- Address Maryland's licensure/capacity gaps to support care transitions for complex populations including LTAC and Psychiatric operators (MHCC & HSCRC)
- Standardize care transitions processes and referral platforms (Hospitals & Post acute Care Providers)
    - In order to address access issues and LOS drivers comprehensively, suggest an increased focus on multi-stakeholder collaboration across the state. For example, efforts could be focused to collaborate with MCOs on supportive post-acute placement, and streamlining the authorization process / platforms. There are currently 9 different platforms to request authorization. In May 2026, one hospital had 304 avoidable days due to lack of post-acute facility placement, and another had 230 avoidable days for the same reason. Additional detail is available upon request.
- Evaluate reimbursement structure (Multi-Agency, Maryland Insurance Agency)
- Legislation to address reimbursement models, capacity gaps, regulations for authorization and acceptance, etc. (Legislature)
- For "Post Acute Care Providers", another aspect would be to consider requirements and/or monitoring for these facilities to accept patients as part of their licensing process. Note: This could be part of the value-based program recommendation that is prioritized on our list.

Feedback on Key Drivers and Recommendations

3.Capacity Top Priorities

- Assess Regional Inpatient & Post-Acute Capacity Needs to include bed count and capacity analysis (MHCC/HSCRC)
- One respondent flagged the addition of **SB411/HB624** (enacted) "Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2026). This had already been added to the Capacity Recommendations. Noting the suggestion here as it was probably an issue of timing of feedback.
- **SB707** (enacted) "Mental Health Law - Definition of Danger to the Life or Safety of the Individual or of Others and Reports on Emergency Evaluation Petitions (Right to Treatment)" should be added as it will result in more patients being brought to ERs for evaluations even as earlier treatment will be beneficial.
- **HB1181** and **HB1559** were mentioned, but the central issue of placement of pediatric patients with mental health problems having extensive stays in ERs was not specifically addressed. It should be.

4. Care Transition and Best Practices Top Priorities

Collaboration on Long Stay Patients (HSCRC)
Address lack of resources and timely support/intervention for Guardianship cases to ensure timely care transitions for this population
Expand community partnerships and investments (primary, BH, SDOH)
Evaluate opportunity to integrate Psychiatric Bed Registry (MDH)
Enhanced presence of Palliative Care and Hospice services through investment and organizational alignment across all care settings. Improve hospice utilization to align with national benchmarks (Hospitals & Post-Acute)

Feedback on Key Drivers and Recommendations

Lower on the priority list

(based on the reasoning that the ED Wait Time Commission should prioritize those interventions that individual stakeholders would otherwise not be able to accomplish on their own. The value of the ED Wait Time Commission is to bring together different agencies and organizations to achieve the common goal of reducing ED wait times through the stated interventions.)

1. Post Acute Section

   Track utilization of post-acute care resources
   Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)

2. Capacity Section

   Partner with hospitals on service line coordination across the state (MHCC, HSCRC, Hospitals)
   Partner with HSCRC to explore Alternate capacity options, throughput improvement and IP LOS gains
   Evaluate staffing metrics as directed by regulatory agencies and recent Safe Staffing Act (SB411, HB624)
   Support enhanced bed occupancy, capacity reporting

3. Best Practices Section

   Expansion of Best Practice Policy

HB1563 Bed Capacity Study Update

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

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

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

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

HB1563 Overlap with ED WTR Commission

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