



Maryland
Hospital Association

May 15, 2026

Douglas Jacobs, M.D.
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Jacobs:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to inform the Maryland Health Care Commission's (MHCC) ongoing analysis, report, and forthcoming recommendations to the Governor's Office regarding post-acute care access and system performance. While Maryland hospitals remain committed to improving patient flow, reducing emergency department boarding, and supporting safe, timely care transitions, persistent post-acute care barriers inhibit these efforts and contribute to discharge delays, constrained patient flow, and higher total cost of care across payers.

In addition to our participation in the MHCC-led Post-Acute Care Workgroup, MHA gathered supplemental hospital input to inform a more comprehensive understanding of operational post-acute care challenges affecting timely discharge, patient flow, and total cost of care. This feedback reflected hospitals' direct experience navigating post-acute placement across multiple payer types and levels of care. The areas of opportunity outlined below identify specific policy levers that could enhance post-acute access, strengthen system accountability, and improve alignment across the care continuum. MHA respectfully asks MHCC to advance a coordinated, system-level strategy to address these priorities:

1. **Administrative Barriers:** address prior authorization delays and denials and advance guardianship process reforms
2. **Placement Support:** require managed care organizations (MCOs) and Medicare Advantage Organizations (MAOs) to provide placement assistance once a defined referral threshold is met
3. **Expanded Resources:** enable expansion strategies for skilled nursing facilities (SNFs), home health, inpatient rehabilitation facilities (IRF) and explore creating long-term acute care facilities as a non-regulated option
4. **Measurement Improvement:** ensure accurate bed capacity monitoring based on realistic assessments of adequacy

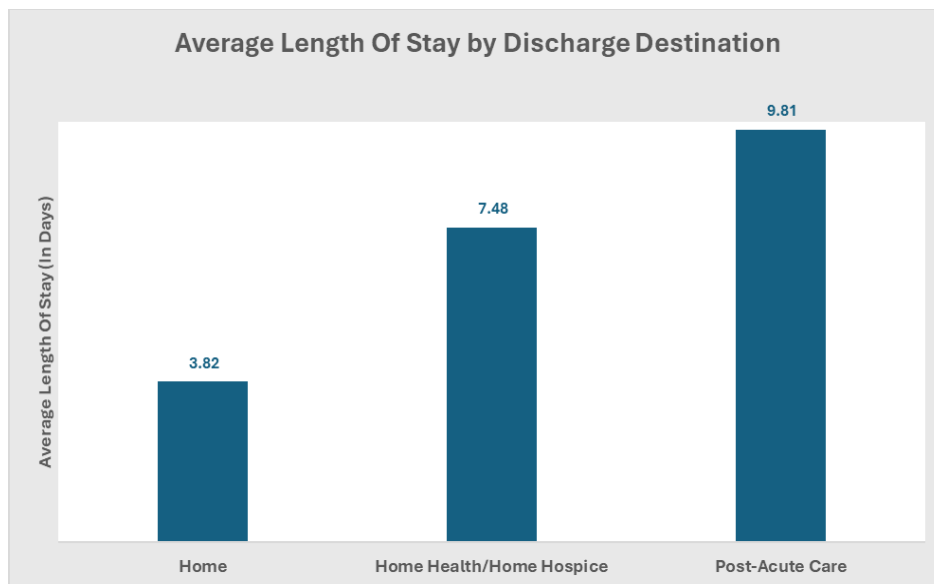
Eliminate Administrative Barriers

Prior Authorization Delays and Denials

Hospitals report that administrative barriers, particularly prior authorization delays and denials, are one of the most significant barriers to timely post-acute placements. These delays frequently extend inpatient length of stay, despite patients being medically ready for discharge, and compound capacity pressures across the continuum. A 2025 systematic review published in the American Journal of Medicine found that prior authorization requirements are associated with prolonged hospital stays, delayed access to post-acute services, and preventable hospitalizations.¹ These findings are reinforced by the national American Medical Association survey, in which a majority of physicians reported that prior authorization frequently delays discharge decisions and contributes to additional hospital days and avoidable inpatient utilization.²

MHA’s analysis on calendar year 2024 case-mix data across all payers indicates that patients discharged to a post-acute care facility had approximately 2.57 times longer length of stay compared to those discharged home, while home health or home hospice had a length of stay approximately 1.96 times that of patients discharged home (Figure 1). Across post-acute care categories, patients discharged to skilled nursing facilities had longer lengths of stay, with Medicaid SNF and Medicare SNF discharges averaging 2.08 and 2.55 additional days, respectively, compared to those discharged home (Figure 2).

Figure 1: Average Length of Stay Comparison by Discharge Destination

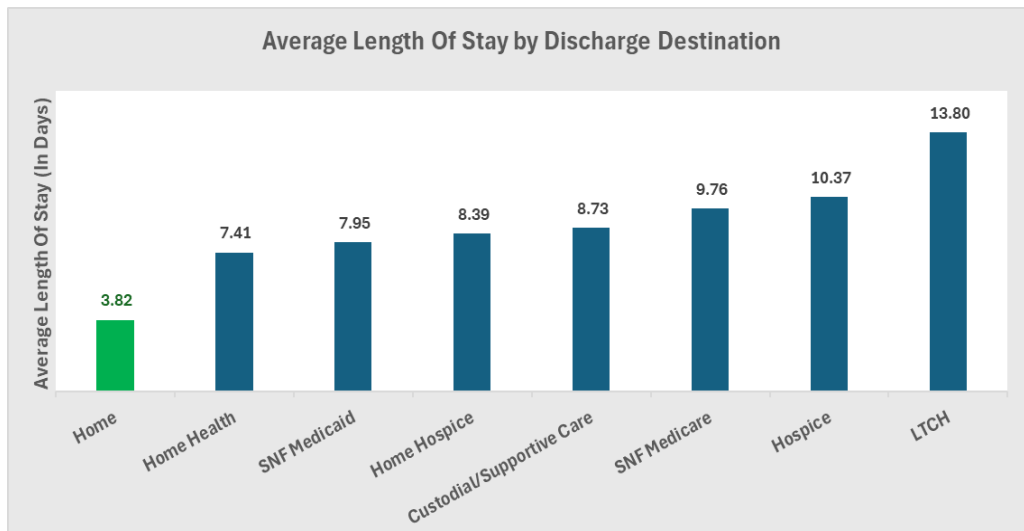


Key: Home = Home; Home Health/Home Hospice = Home Health, Home Hospice; Post-Acute Care = SNF Medicare, Custodial/Supportive Care, LTCH and SNF Medicaid.

¹ Jacob Murphy et al., [“Adverse Effects of Health Plan Prior Authorization on Clinical Effectiveness and Patient Outcomes,” American Journal of Medicine](#) 139, no. 1 (2025).

² American Medical Association, [2024 AMA Prior Authorization Physician Survey](#) (2024).

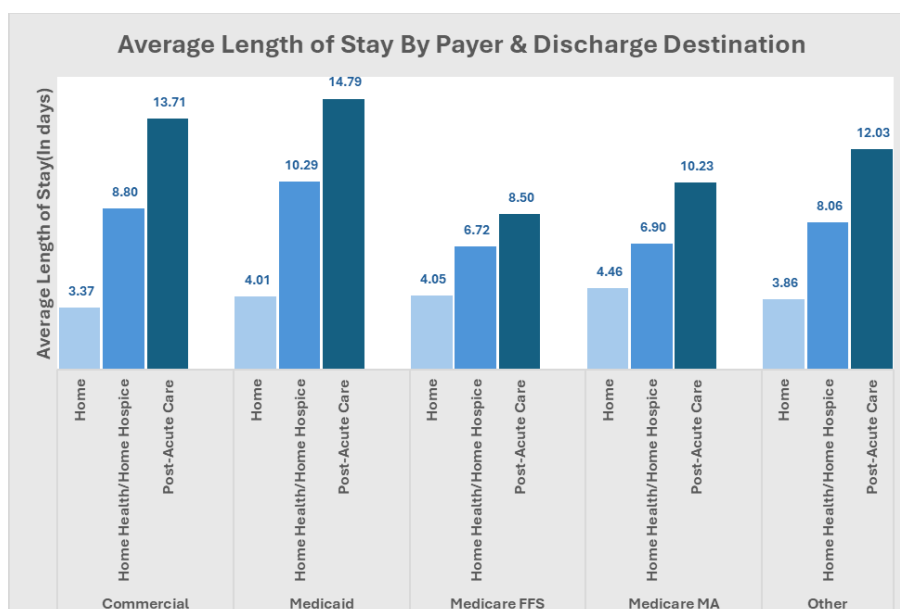
Figure 2: Average Length of Stay Comparison by Patient Discharge Destination



Key = Home: a routine discharge to home or self-care, includes home oxygen without home health services (Medicare FAQ# 4), group care, foster care, independent living, shelter, and other residential care arrangements, outpatient programs such as partial hospitalization (Medicare FAQ #5) or outpatient chemical dependency programs, DSS referral, social services placement, SARC sexual assault/spousal abuse resource center and House of Ruth; Home Health: to home under care of an organized home health service organization in anticipation of covered skilled care; SNF Medicaid: a nursing facility certified under Medicaid but not certified under Medicare; Home Hospice: to Hospice at home; Custodial; Custodial/Supportive Care: a facility that provides custodial or supportive care (includes intermediate care facilities if state designated, nursing facilities that are not certified by Medicare or Medicaid, and assisted living facilities); SNF Medicare: to SNF with Medicare certification in anticipation of skilled care; Hospice: a medical facility (certified) providing hospice level of care (including hospice unit of an acute care hospital); LTCH: a Medicare certified long term care hospital (LTCH), defined as certified under Medicare as short-term acute care hospitals with an average IP LOS of a greater than 25 days.

These administrative delays compound the underlying variation in length of stay by discharge destination, as patients requiring post-acute care remain hospitalized longer while awaiting authorization and placement.

Figure 3: Average Length of Stay Comparison Amongst Payer & Patient Discharge Destination.



Key = Commercial: Blue Cross of Maryland, Commercial Insurance (HMO/POS/PPO/PPN/TPA); HMO; Blue Cross -National Capital Area; Blue Cross - Other State (NON-MD); Medicaid : Behavioral, Medicaid FFS and Medicaid MCO; Medicare FFS: Medicare: Medicare MA: Medicare Advantage; Other: Other Government Programs (Out-Of-State (non-MD) Medicaid, Tri-Care, Champs and Title), Workmen's Compensation, Self-Pay Charity (patient was not charged for care), Other (grant/donor funding) donor, International Insurance, Not Applicable, Unknown, Self Pay and Charity

Figure 3 illustrates the distribution of patients across discharge destinations by payer type. Across the five payers, discharges to post-acute care are associated with the highest average length of stay, while discharges to home are the shortest. Among patients discharged to post-acute care, Medicaid patients experience the longest average length of stay followed by commercial payers. This pattern suggests administrative hurdles, such as obtaining prior authorization for care transitions, significantly extend stays for patients awaiting post-acute placement.

There is an opportunity for MHCC to consider the following policy solutions to streamline prior authorization processes:

- Standardize prior authorization requirements and timelines across payers, with a maximum 48-hour turnaround for post-acute authorization decisions
- Leverage a centralized information technology clearinghouse function that allows hospitals to submit required information once, with automatic routing to the appropriate payer(s)
- Allow expedited MCO authorization submission without a facility national provider identifier (NPI) for certain post-acute services (e.g., SNF, subacute rehab, home health, etc.), provided the placement is within the MCO's network and the NPI is submitted prior to discharge
- Modernize the Assessment, Evaluation, and Review Services (AERS) clearance process by permitting desk reviews, telephonic assessments, or limited electronic health record access to social workers where appropriate, reducing unnecessary in person delays and expediting the process
- Pursue federal flexibility under the AHEAD Model, including a Medicare three-day SNF stay waiver, to allow direct SNF admissions where clinically appropriate

Guardianship Process Reform

Hospitals also experience discharge delays related to guardianship and legal authority barriers. Patients who lack an available decision-maker or guardian of property often remain hospitalized while courts adjudicate limited financial or placement authority. The American Bar Association has described a national “hospital-to-guardianship pipeline” in which non-clinical legal barriers result in extended hospital stays that are not medically necessary.³ Maryland hospitals report similar challenges, particularly when SNFs are unwilling to accept patients without a legally authorized representative to manage payment and benefits.

MHA encourages MHCC to recommend that the state:

³ Anita Raymond, [“The Hospital to Guardianship Pipeline,” *Bifocal*, American Bar Association](#) (2023).

- Establish an expedited, temporary guardianship of property process consistent with models used in Massachusetts, New York, Minnesota, or the District of Columbia

Managed Care Organization Placement Support

Hospitals face increasing difficulty placing medically complex patients covered by Medicaid and Medicare Advantage due to limited in-network options and the absence of payer-directed placement assistance. This challenge is particularly acute for “hard-to-place” patients with high clinical needs. While networks may appear adequate, real-world access frequently falls short, particularly for patients with complex medical, behavioral health, or social needs. Research by the Kaiser Family Foundation demonstrates that Medicaid managed care network adequacy standards and provider directories often overstate actual access to care, with inaccuracies masking real placement constraints.⁴ Hospitals report repeated outreach to in-network providers without success, leaving patients remaining in acute-care beds despite payer attribution.

Similarly, the Health Services Cost Review Commission Emergency Department Wait Time Reduction Commission has identified post-acute placement delays as a key contributor to inpatient boarding and emergency department throughput challenges.⁵ Proposed policy solutions should reinforce payer accountability for network adequacy and reduce inappropriate financial risk shifted to hospitals. **Recommendations include:**

- Require MCOs and MAOs to provide active placement assistance once a defined referral threshold is met
- Establish clear expectations that MCOs and MAOs will support placement by analyzing network capacity, engaging post-acute providers directly, assigning case managers to higher-complexity patients, and pursuing special single-case arrangements when necessary
- Prohibit denial of inpatient claims when an in-network post-acute placement is unavailable despite good-faith efforts by the hospital

Expanded Post-Acute Resources for Medically Complex Patients

Post-acute capacity constraints continue to pose a significant barrier to timely discharge for medically complex patients. Hospitals report persistent staffing shortages in skilled nursing facilities, limited availability of post-acute beds capable of supporting high-acuity needs, and delays in arranging home-based services. These challenges have been exacerbated in the post-pandemic environment, as existing capacity has not kept pace with rising patient acuity and complexity.

Consistent with hospital experience, analyses from the American Hospital Association demonstrate that reductions in post-acute operating capacity and workforce shortages are

⁴ Elizabeth Hinton and Jada Raphael, [Medicaid Managed Care Network Adequacy and Access](#), Kaiser Family Foundation (2023).

⁵ Health Services Cost Review Commission, [Emergency Department Wait Time Reduction Commission Interim Report](#) (2025).

associated with longer hospital lengths of stay and increased inpatient boarding.⁶ Additionally, peer-reviewed research has further linked post-pandemic declines in skilled nursing capacity to prolonged hospitalizations and delayed discharges.⁷ Strategic expansion aligned with patient complexity would reduce inappropriate hospital days and improve care transitions. **MHA recommends the following policy solutions:**

- Create a supportive regulatory and reimbursement environment for “enhanced” or “super” SNFs, such as facilities with extended-hours community pharmacy access capable of caring for high-acuity patients, including those requiring ventilator support, behavioral health or substance use disorder services, complex infection control, and high-cost drugs
- Accelerate pathways for home health agencies to achieve Medicare certification, including technical assistance, funding, and quality readiness supports
- Allow MCOs to include a limited number of state-only approved home health providers within their networks to improve access. Maryland can leverage existing Medicaid waiver authorities that could expand home-based capacity. Under the 1915(c) waiver, the state may define provider qualifications, enabling the creation of a state-approved home-based provider category for MCO network adequacy.⁸ While Maryland’s current 1115 waiver authority^{9,10} does not explicitly include this provision, it could be pursued to pilot expanded provider types and delivery models.
- Explore the creation of long-term acute care facilities as a non-regulated option for patients whose needs exceed traditional SNF capabilities

Improve Post-Acute Bed Capacity Measurement and Transparency

Hospitals consistently report that current methods for assessing post-acute bed capacity overstate functional capacity and do not reflect operational realities that limit actual acceptance capacity, including staffing limitations, infection control requirements, and patient acuity constraints.

Hospital and national analyses have shown that facilities operating at or above approximately 80% occupancy may be functionally full, yet capacity metrics often assume near-total availability.¹¹ The HSCRC Emergency Department Wait Time Reduction Commission has also highlighted how inaccurate capacity visibility contributes to discharge barriers and ED boarding.¹²

⁶ American Hospital Association, [Patients and Providers Faced with Increasing Delays in Timely Discharges \(2022\)](#).

⁷ Brooke McCormick, [“Post-Pandemic Nursing Home Capacity Declines Tied to Longer Hospital Stays.”](#) *Journal of the American Medical Association* (2026).

⁸ Congressional Research Service, [Medicaid Section 1915\(c\) Home- and Community-Based Services Waivers \(2025\)](#).

⁹ Medicaid, [Maryland HealthChoice Program 1115 Waiver Amendment](#) (2024).

¹⁰ KFF, [Medicaid Waiver Tracker](#)

¹¹ Ron Southwick, [“Hospitals Are Forced to Keep Patients Who Could Be Released.”](#) *Chief Healthcare Executive* (2023).

¹² See n. 5, *Supra*.

Given that accurate and dynamic capacity measurement is foundational to effective system planning and aligning expectations across hospitals, payers, and post-acute providers, **MHA respectfully urges MHCC to consider the following policy solutions:**

- Ensure that Certificate of Need (CON) assessments are grounded in realistic, sustainable occupancy assumptions, recognizing that 100 percent utilization is neither feasible nor appropriate
- Recognize that facilities operating at 80% capacity or higher may not be able to safely accept additional patients without quality impacts
- Establish a centralized, real-time reporting dashboard requiring post-acute providers to submit daily capacity data that reflects actual availability by acuity and service type

Meaningful improvement in patient flow and discharge timeliness will require policies that extend beyond hospital operations alone. Collectively, these four priorities—eliminating administrative barriers, providing placement support, expanding appropriate post-acute resources, and improving capacity measurement—represent actionable policy levers that can improve patient flow, reduce unnecessary hospital days, and lower total cost of care.

Hospitals strongly support MHCC's leadership in advancing a coordinated, cross-sector approach to post-acute access challenges and remain committed to partnering with the Commission to promote pragmatic, system-level solutions that facilitate safe, timely transitions of care for Maryland patients. We appreciate MHCC's continued engagement and look forward to ongoing collaboration as the Commission advances its post-acute care report and recommendations.

Sincerely,



Melony G. Griffith
President & CEO

cc: Dr. Jon Kromm
Dr. Andre Chappel
Dr. Stacy Howes
Jeanne Marie Gawel