Maryland
Hospital Association

June 27, 2025

Eileen Fleck
Chief, Acute Care Policy and Planning
Maryland Health Care Commission
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Dear Ms. Fleck,

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment on the draft estimates regarding the need for acute psychiatric services for historically underserved populations released by the Maryland Health Care Commission (MHCC) in accordance with COMAR 10.24.21.05.

We appreciate MHCC's diligence in collecting data to develop these estimates and commitment to periodic reviews to verify that the methodology accurately reflects the needs of these underserved populations. However, we are concerned that the draft estimates significantly miscalculate the need for child and adolescent psychiatric beds and for specialized beds (i.e., beds for developmental disability and neuropsychiatric conditions) for all ages.

While the draft acknowledges some level of unmet need, it understates the true extent of the crisis facing Maryland's psychiatric system. For instance, the report estimates a need for only 4.9 adolescent psychiatric beds in the Baltimore Upper Shore Health Planning Region—translating 2,333 emergency department (ED) boarding days into fewer than five beds. This calculation fails to account for the acuity and complexity of the population served. Many psychiatric patients have complex needs, dual diagnoses, and/or exhibit severe aggression or violent behavior. These individuals require specialized, intensive care that many hospitals are not equipped to provide.

Even in regions where MHCC's estimated bed need falls below the threshold for Certificate of Need eligibility, the presence of persistent and acute access barriers calls for a more proactive, statewide response to build capacity, particularly for children under 13 with highly specialized needs. The absence of sufficient child and adolescent psychiatric beds leads to ED boarding, stress for the patients and families, and often out-of-region or out-of-state transfers that further disrupt continuity of care.

A major concern impacting psychiatric care in the state is the shortage of step-down care and community-based treatment options. These draft estimates fail to reflect the volume of patients who are clinically ready for discharge but are unable to be released from hospitals due to lack of appropriate placements. They often occupy inpatient beds for extended periods of time, preventing new admissions and skewing utilization rates. Earlier this year, MHA surveyed member hospitals and found that over a 9-week period, on average, there were 45 children and adolescents unable to be released from hospitals. Approximately 20% of them were in EDs with 75% of them waiting to be discharged to residential treatment centers, group homes, or foster care settings. This bottleneck leads to cascading delays in access to care throughout the behavioral health continuum. The lack of long-term/residential care facilities creates a cycle of readmissions due to lack of follow-up care, further exacerbating the underlying condition.

Furthermore, using boarding days in the ED as a proxy for unmet psychiatric needs does not account for children and adolescents who might be discharged quickly, diverted to other settings, or denied admissions — not due to lack of need but due to lack of available beds. For instance, in 2024 one hospital system alone provided 1,000 bed days of care to children and youth in overstay status who did not need acute hospital care. During this time, 218 transport calls requesting admission for children had to be denied due to lack of sufficient beds. The current methodology would not adequately account for the needs of those 218 patients.

Similarly, these estimates do not appropriately account for tertiary care patients who routinely wait weeks or months for placement in hospitals. Rough estimates from our hospitals suggest that to address high acuity inpatient psychiatric capacity, Maryland needs at least 75–100 tertiary care beds for both adolescents and adults statewide, especially for patients with dual diagnoses, neurodevelopmental disorders, and severe aggression.

We urge MHCC to consider these critical factors to reflect the full scope of need and to consider a statewide, strategic response to address longstanding shortages in pediatric and high-acuity psychiatric capacity. ED boarding metrics, while important, must be complemented with additional data sources to develop a comprehensive and accurate needs assessment.

Maryland's hospitals are committed to collaborating on solutions that expand access, reduce ED boarding, and ensure timely, appropriate care for our most vulnerable behavioral health patients. We thank MHCC for your analysis and transparency in this process and look forward to continued engagement as this work advances.

If you have any questions or would like to discuss these comments further, please contact Natasha Mehu, MHA Vice President, Government Affairs & Policy at nmehu@mhaonline.org.

Sincerely,

Andrew R. Nicklas, Esq.
SVP, Government Affairs & Policy