Maryland
Hospital Association

December 22, 2025

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to provide comments to the Health Services Cost Review Commission (HSCRC) on the draft policy proposal for the Rate Year (RY) 2028 Maryland Hospital Acquired Conditions (MHAC) Program.

We commend HSCRC for their continued commitment to advancing patient safety and quality improvement through incentive-based approaches. MHA and our members support the continuation of rewards for hospitals as they work to improve quality of care for Marylanders across the state. We support the RY2028 MHAC Program recommendation and are encouraged by HSCRC's policy design efforts that signal a goal to align with the Centers for Medicare & Medicaid Services (CMS) Hospital Acquired Conditions Reduction Program (HACRP), particularly through the inclusion of the AHRQ Patient Safety Indicators (PSI) 90 measure in the MHAC Program.

We support the staff recommendation and also offer the following feedback for consideration:

1. **Guiding Principles for Quality Policy Design**

   As Maryland prepares for the upcoming transition to the Center for Medicare & Medicaid Services (CMS) national quality programs, MHA urges the Commission to use the guiding principles endorsed by hospital field quality leaders to design MHAC and other HSCRC quality programs:

   - **Maximize Multi-Payer Alignment** – State-based quality policies for Medicaid and commercial should align with CMS Medicare quality design to streamline administration.
   - **Reduce Administrative Complexity** – Policies should be designed to avoid complexity, administrative burden, and higher costs as the state plans for simultaneous operation of state-based and federal quality programs.

- **Ensure Manageable Timelines** – The state should select quality program policy time frames that enable hospitals to adjust their quality infrastructure to optimize performance in the national quality programs.
- **Maintain Quality Incentives** – State-based quality programs should maintain incentives that enable hospitals to design initiatives to improve quality performance.

2. RY2028 Potentially Preventable Complications (PPC) Composite Methodology

MHA supports the continuation of MHAC PPCs for one additional year (RY28) only to allow the hospital field time to partner with Solventum (formerly 3M) on a reasonable exit from the program for RY2029 and beyond. MHA urges the HSCRC to reconsider the ongoing use of the Potentially Preventable Complications (PPCs) composite methodology for evaluating hospital acquired complications. This methodology diverges from the guiding principles widely endorsed by the hospital field as it imposes substantial costs and administrative burden for hospitals. The use of PPCs in the MHAC program requires hospitals to make significant investments to cover costs associated with proprietary grouper software and IT routines and duplicative reporting systems. This methodology design diverts resources away from direct patient care.

3. Planning for RY2029 and Beyond

MHA looks forward to working with the HSCRC on AHEAD Model quality transition planning. In preparation for this immense undertaking, MHA urges HSCRC to identify an alternative approach for RY2029 MHAC that ensures there is alignment with CMS standards including program design, measures, methodologies, performance periods, and reporting timeline. This approach will reduce unnecessary complexity and enhance consistency across payers.

Beginning in RY2029, MHA recommends replacing the PPC composite methodology with the National Healthcare Safety Network (NHSN) measures. NHSN healthcare associated infection measures are nationally standardized, evidence-based, and widely audited, which ensures alignment with national benchmarks and simplifies reporting. This change would also better align the MHAC program for Medicaid and Commercial payers with the CMS HACRP for Medicare. NHSN measures, which are already integral to the CMS HACRP program, would offer a consistent, nationally recognized framework for assessing hospital-acquired conditions. Additionally, the use of NHSN measures would reduce duplicative reporting, measure fragmentation, and allow hospitals to focus on measures that are meaningful, actionable, and comparable across state and federal programs.

We also urge HSCRC to proactively communicate reward and penalty structures for non-Medicare payers well in advance. Early clarity will support hospitals' quality improvement strategies, interventions, and financial planning for a smooth transition. HSCRC should also continue monitoring cumulative program impact as PSI-90 is added to the MHAC program. Finally, HSCRC should maintain timely and transparent data reporting.

As Maryland plans for the transition to the AHEAD Model, we must keep in mind that this will alter quality programming for the next decade. With this change, there is an opportunity to reduce administrative complexity and address costly design requirements in the current MHAC program, while also achieving greater alignment between federal and state programs. Hospitals and health systems are committed to advancing patient safety and look forward to collaborating with HSCRC and to continuing to deliver high quality care and improved outcomes for all Marylanders.

Sincerely,

Tequila Terry
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. Maulik Joshi
Nicki McCann
Dr. Farzaneh Sabi
Alyson Schuster
Dianne Feeney