



Maryland  
Hospital Association

December 2, 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's (MHA) member hospitals and health systems, we extend our thanks to the Health Services Cost Review Commission (HSCRC) for the opportunity to comment on the Draft Recommendations for the Quality-Based Reimbursement (QBR) Program for RY 2028. We appreciate the Commission's commitment to transparency, inclusive governance, and stakeholder engagement. We welcome the opportunity to provide feedback on these recommendations and to continue to advance quality across Maryland hospitals.

The QBR draft recommendation comes at an unprecedented time in Maryland as the state transitions to the AHEAD Model. Under this new Model, hospitals will be required to move to the national Centers for Medicare & Medicaid Services (CMS) Medicare Inpatient Prospective Payment System and Outpatient Prospective Payment System (IPPS/OPPS) quality programs. Given this, hospitals propose that program elements for QBR align with the federal quality requirements to ease the challenge of simultaneous operation of state-based and federal quality programs and result in equal, improved quality for all patients. More specifically, the hospital field has endorsed key principles that should guide this policy and other state-based quality policies.

- **Maximize Multi-Payer Alignment** – State-based quality policies should align Medicare, Medicaid, and commercial quality approaches 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 to improve quality performance.

Additionally, as the state plans the design of other quality programs that coincide with the launch of the AHEAD Model, use of these principles will be essential for a successful and sustainable quality program over the ten-year AHEAD Model.

### **MHA Proposal for an Alternative Alignment Approach**

While the QBR Program draft recommendation includes some areas where the program would align with the Medicare Hospital Value-Based Purchasing Program (HVBP) in CY2026, there is an opportunity to do more to achieve alignment between Medicare, Medicaid, and commercial quality programs. Without additional steps to align the federal and state quality programs, hospitals will face increased burden and complications with the AHEAD Model transition.

To address these concerns, MHA respectfully proposes an alternative approach that is guided by the aforementioned principles with two components:

1. Modification of QBR Domain Weights and Measure Approaches
2. Creation of a State-Based Monitoring Program

#### *QBR Domain Weights & Measure Approaches*

While MHA appreciates the intent behind the proposed reweighting of the Person and Community Engagement domain, we urge the Commission to mirror the HVBP program wherever possible to eliminate avoidable operational challenges. MHA recommends the following domain and measure weights:

- **Person and Community Engagement Domain (33.3%)**
  - HCAHPS Top Box (23.3%)
  - HCAHPS Consistency (10%)
- **Clinical Care Domain (33.3%)**
  - All Payer 30-Day Mortality Measure (14.15%)
  - All Payer Inpatient Mortality Measure (14.15%)
  - THA-TKA Complication Measure (5%)\*
- **Safety Domain (33.3%)**
  - NHSN (26%)
  - Sepsis Bundle (7.3%)\*

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\*The THA-TKA Complication and Sepsis Bundle measures apply only to Medicare, while all other measures are all-payer.

### *State-Based Monitoring Program*

In addition to mirroring the HVBP domain and measure weights, MHA recommends that HSCRC create a new “State-Based Monitoring Program” for key measures that are of importance to the state but are not in Medicare HVBP. This approach allows the state to maintain alignment with Medicare, track performance trends, and evaluate impacts of other initiatives without imposing payment adjustments during the transition period. MHA recommends the following measures be included in a State-Based Monitoring Program:

- Emergency Department Length of Stay (ED LOS)
- Inpatient Length of Stay (IP LOS)
- Medicaid Timely Follow Up
- Any new measures proposed by HSCRC

For measures in the State-Based Monitoring program, MHA recommends a moratorium be placed on payment policy for measures that are not part of the Medicare HVBP. Hospitals are currently managing significant operational pressures and resource constraints. Introducing Maryland-specific measures with payment implications would increase complexity and risk, especially as these metrics are influenced by external factors such as post-acute care placement and managed care coordination—issues under review by the AHEAD Multi-Agency Regulatory Working Group. Additionally, recent federal legislation (H.R.1) is likely to negatively affect ED utilization and uncompensated care, further straining hospital resources.

Given these considerations, MHA recommends that no payment adjustments be applied to these measures during the transition to the CMS IPPS/OPPS quality system from CY 2026 to 2029, and potentially 2030 if Medicare program alignment is delayed. This approach allows hospitals time to adapt systems, train staff, and reduce administrative complexity while minimizing reporting burden. It also aligns Maryland’s QBR program with CMS’ HVBP, supports Maryland-specific initiatives through dedicated monitoring, and ensures consistency across federal and state programs.

### **Digital Measure Incentive**

The RY2028 QBR program recommendation proposes maintaining the existing digital measure incentive. MHA and its member hospitals support the continuation of the digital measure incentive in RY2028 and appreciate HSCRC’s commitment to aligning electronic clinical quality measure (eCQM) reporting with CMS requirements. We recognize the value of early submission incentives as a tool to promote timely data collection and infrastructure readiness. The benefits of implementing eCQMs in Maryland at a pace that is misaligned with CMS should, however, be balanced with the process complexity and expense that is being created.

Using an accelerated timeline for Maryland-specific eCQM submissions imposes operational challenges for hospitals, requiring extensive coordination, staffing, and system capacity at a time when hospitals face competing priorities and resource constraints. While the incentive helps to mitigate the financial burden, the underlying policy and misaligned timing with CMS adds operational demands and administrative burdens.

MHA urges HSCRC to maintain close engagement with hospitals to ensure future digital reporting requirements remain feasible and aligned with national standards and timing. For RY2029 and beyond, HSCRC should follow the same schedule as CMS for implementation of digital measures. Additionally, any future expansion of digital reporting must be achievable through existing infrastructure and supported by technical assistance and realistic timelines to safeguard operational sustainability.

**RY 2028 QBR Reward/Penalty “Cut-Point”**

MHA appreciates HSCRC staff’s plan to retrospectively adjust the RY 2026 QBR cut-point to 32.68% but suggests additional modifications to better reflect national average performance. The table below presents the retrospective adjustments to the cut-point for national performance over the past three rate years:

Rate Year	Pre-set Cut-point	Retrospective Adjustment (based on national performance)
RY24	41%	32%
RY25	41%	32%
RY26	41%	32.68%

Given this consistent national trend, MHA recommends using a cut-point of 32% in the RY2028 QBR program. This revised cut point would improve predictability, enhance fairness, and align with HVBP, thereby reducing the likelihood for annual retrospective adjustments within the QBR program.

We value the Commission’s commitment to collaborative policymaking and data-driven decisions. As Maryland hospitals prepare for evolving national standards and the AHEAD transition, we look forward to continued partnership with HSCRC to ensure quality programs remain equitable, transparent, and aligned with our shared goal of improving patient care statewide.

Thank you for your consideration of these recommendations.

Sincerely,



Tequila Terry  
Senior Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair  
Jonathan Blum  
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