Maryland
Hospital Association

August 10, 2026

William Henderson
Interim Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Henderson,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, thank you for the opportunity to comment on the implementation of the $50 million in funding to support hospital readiness for the AHEAD Model (AHEAD Transition Funds) approved as part of the Rate Year 2027 update factor. MHA appreciates the Commission's recognition of the investments hospitals will need to make to manage the AHEAD Model transition.

The transition to AHEAD Model policies and programs is unprecedented and resource intensive. For decades, Maryland's all-payer system has relied on consistent payment policies across all payers. In less than 18 months, however, hospitals will operate under two payment systems, one for Medicare and another for Medicaid and commercial payers. To prepare for the transition to this bifurcated system, hospitals are allocating additional resources to finance, revenue cycle, and clinical operations teams to support Medicare cost reporting, clinical documentation, and new payment processes. Hospitals are also making significant investments to support various technology upgrades to ensure operational readiness, as well as assess national quality programs and modify workflows to manage different quality programs across payers.

These and other necessary hospital investments will exceed the $50 million approved by the Commission. Given this, we respectfully urge HSCRC to consider increasing the amount of funding provided under this policy to support a successful transition to the AHEAD Model.

We offer the following additional comments for consideration by HSCRC.

Allocation of Funding
While HSCRC could allocate funding strictly in proportion to each hospital's share of statewide global budget revenue, the funding should be distributed in a manner that ensures all hospitals have sufficient resources to make necessary transition-related investments. As noted by HSCRC staff, some transition costs may not necessarily be correlated with hospital size, and small, independent hospitals may not be able to achieve the same economies of scale as their peers that are affiliated with systems. To address this challenge, HSCRC should consider establishing a

minimum funding level for these hospitals and distribute the remaining funding amount to all other hospitals in proportion to their GBR.

On the question of whether funding should be directed to a shared services pool, MHA recommends that a substantial portion of the funding be provided directly to hospitals and a more limited portion be set aside to support shared technical assistance. While there may be some services that could be shared across all hospitals in the state, such as high-level education on Medicare prospective payment systems or Medicare cost reporting, hospitals are in different places in terms of their operational readiness for AHEAD and have unique transition needs based on their resources, patient populations served, and payer mix. MHA stands ready to assist HSCRC as a neutral service provider to procure shared technical support if HSCRC decides to allocate a portion of the funding for this purpose.

Accountability for Use of Funding

As with all policies, it is important to ensure any funding allocation is being used for its intended purposes for the sake of accountability and transparency. This goal can and should be achieved without placing undue administrative strain on HSCRC staff and hospitals, particularly at a time when their efforts are focused on the Model transition. We encourage HSCRC to limit hospital reporting to the estimated amount of funding used for staffing, operations, technology, and other activities including but not limited to technical assistance. More robust reporting requirements, such as detailed accounting on the use of funds, would divert valuable resources from preparing for the transition to AHEAD and be counterintuitive to the purpose of the funding.

Continued Funding in RY 2028

Many of the investments hospitals must make in RY 2027 in preparation for the new AHEAD policies and programs are not one-time investments and will carry over into RY 2028. While the start of bifurcated hospital global budgets and the transition to national quality programs in CY 2028 and federal FY 2030, respectively, represent key transition milestones, hospitals will need to sustain many of the aforementioned investments in future years, with some becoming a permanent part of hospitals' operating budgets, to successfully operate under AHEAD. Hospitals will need to permanently expand revenue cycle and clinical documentation improvement (CDI) resources and obtain MS-DRG grouper software programs, to name a few. For this reason, it is critical that the increase in rates to support these efforts continue in RY 2028.

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MHA appreciates the steps HSCRC has taken to support hospitals in the transition to AHEAD policies and programs and stands ready to assist HSCRC with the implementation of this funding. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

cc: Kevin Sexton, Chair
Jonathan Blum
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi
Dr. Benjamin Stallings