Maryland
Hospital Association

November 4, 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 our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendations for the Rate Year (RY) 2029 Quality-Based Reimbursement (QBR) Program. Maryland's hospitals remain steadfast in their mission to deliver safe, high-quality, and equitable care to every patient. We appreciate HSCRC staff's collaborative approach through the Performance Measurement Workgroup to engage the hospital field in meaningful discussions on opportunities to improve quality of care across the state.

As Maryland implements the AHEAD Model, HSCRC staff have taken a thoughtful approach to align with the Centers for Medicare & Medicaid Services (CMS) quality programs while also maintaining program stability in the RY 2029 QBR recommendations. MHA supports the overall proposal and offers several refinements to strengthen program design, enhance hospitals' ability to improve quality, and better support Maryland's transition to the AHEAD Model. Additionally, as Maryland moves towards 2030 and receives more clarity on the implications of a bifurcated quality program structure, MHA appreciates HSCRC staff's willingness to reconsider its quality programs to streamline administrative burden while continuing to focus on quality improvement. MHA welcomes the opportunity to partner with HSCRC staff on new ideas for the future of quality programs.

For RY 2029, MHA respectfully offers the following recommendations for consideration.

Medicaid Timely Follow-Up (TFU) Measure

While MHA recognizes the importance of timely post-discharge care and effective care transitions, we recommend retiring the Medicaid TFU measure from the QBR program and transitioning it to a monitoring only measure. We appreciate and support HSCRC's efforts to strengthen care coordination and follow-up for vulnerable populations. However, as Maryland transitions under the AHEAD Model, these goals can be achieved through greater alignment with existing care management and population health programs. Rather than maintaining a state-specific hospital measure, we respectfully urge HSCRC to explore shifting accountability for timely follow-up activities to Maryland's Medicaid Managed Care Organizations (MCOs).

Hospitals play an important role in discharge planning and facilitating care transitions. However, successful completion of post-discharge follow-up frequently depends on external entities coordinating patient outreach, care management, appointment scheduling, transportation assistance, and ongoing engagement after discharge. These functions align more closely with the responsibility of MCOs, and other entities charged with managing patient populations, including providing case management, member support services and special needs coordination across the continuum of care.

Mortality Measures

MHA supports the continued use of the all-payer inpatient mortality measure and recommends retiring the all-payer 30-day mortality measure. Unlike the 30-day mortality measure, inpatient mortality reflects outcomes that occur during hospitalization and are more directly attributable to the care delivered within hospital settings. As noted during stakeholder discussions, this measure provides hospitals with actionable insights and supports target quality improvement and patient safety interventions.

While the all-payer 30-day mortality measure was adopted largely to approximate alignment with the CMS Value-Based Purchasing Program, full alignment with the CMS mortality measure is not feasible. CMS evaluates mortality using condition-specific Medicare measures, while Maryland's QBR program applies an all-payer, all-condition methodology. As staff have acknowledged, these methodological differences prevent true comparability between the state and federal approaches. Moreover, CMS's measures primarily reflect health conditions and outcomes relevant to the Medicare population, whereas Maryland's inpatient mortality measure better captures performance across the state's broader all-payer environment, including Medicaid and commercially insured populations.

As Maryland prepares for participation in CMS-administered quality programs under AHEAD, HSCRC should prioritize measures that are clinically meaningful, actionable, and clearly attributable to hospital performance. Retiring the all-payer 30-day mortality measure would reduce reliance on a metric that cannot achieve true CMS alignment while preserving focus on the inpatient mortality measure, which offers greater value for quality improvement and accountability.

Total Hip Arthroplasty - Total Knee Arthroplasty (THA/TKA) Complications Measure

MHA supports HSCRC staff’s recommendation to retain the THA/TKA measure in the QBR program. As Maryland transitions under the AHEAD Model, maintaining aligned measures will promote stability and allow hospitals to remain focused on performance improvement and patient outcomes. We strongly encourage HSCRC to work with CMS to secure ongoing access to the Hospital Value-Based Purchasing Program data to support this measure. Timely, reliable, and actionable data are essential for hospitals to monitor performance, identify improvement opportunities, and implement targeted quality initiatives.

Emergency Department Hospital Throughput Learning Collaborative

MHA strongly supports HSCRC's proposal to transition the Emergency Department (ED) and Hospital Best Practices Throughput Policy into a Learning Collaborative. Maryland hospitals continue to face persistent challenges related to ED crowding, patient boarding, capacity constraints, behavioral health placement, post-acute care access, and workforce shortages, many of which extend beyond the control of any single hospital as acknowledged by the ED Wait Time Reduction Commission.

Given these system-wide challenges, a learning collaborative offers a more effective approach by convening hospitals, post-acute providers, state agencies, Emergency Medical Services leaders, behavioral health partners, and other stakeholders to identify and implement system-wide solutions. MHA particularly supports the collaborative's focus on ED throughput, care transitions, and capacity alignment across the care continuum. Hospitals welcome the opportunity to share best practices, examine statewide data trends, and work collaboratively toward sustainable improvements in patient flow and access to care.

Planning for the Future of Quality Programs

MHA appreciates HSCRC's commitment to preparing hospitals for the transition to AHEAD and national quality programs. As this work progresses, we encourage the Commission to partner with stakeholders to develop a long-term roadmap for the future of Maryland's quality programs.

Maryland has been a national leader in quality innovation. The transition under AHEAD presents a unique opportunity to simplify program design, reduce administrative burden, and focus resources on initiatives that deliver meaningful improvements in patient outcomes. MHA appreciates HSCRC staff's thoughtful approach to maintaining program stability during this transition period. Collectively, our recommendations seek to strengthen QBR by prioritizing actionable measures, reducing unnecessary complexity, and supporting a successful transition to the AHEAD Model. MHA and Maryland hospitals remain committed to improving quality and patient outcomes and look forward to continued collaboration with HSCRC and stakeholders to shape the next iteration of Maryland's quality programs.

Sincerely,

Tequila Terry
Senior Vice President, Care Transformation & Finance

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