Multi-Agency Regulatory Working Group–Progress Report

June 2026

Background

On September 23, 2025, Governor Wes Moore directed Secretary of Health Meena Seshamini to form a working group of State regulatory agencies, with the aim of achieving the goals and objectives of the State of Maryland under the Achieving Healthcare Efficiency Through Accountable Design (AHEAD) Model. Led by the Secretary, the Multi-Agency Regulatory Working Group (the "working group") consists of the Maryland Department of Health (MDH), the Maryland Insurance Administration (MIA), the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC) and the Maryland Health Benefit Exchange (MHBE). Three core values drive the working group's efforts:

1) Health care quality, access, outcomes and affordability are paramount;
2) No critical health infrastructure should shoulder this burden alone, and the savings requirement will not be borne exclusively by hospitals; and
3) The State will operate as it always does–by being data-driven and heart-led.

The working group submitted an initial workplan on October 17, 2025, outlining the key topics of focus, a timeline for activities and an approach to stakeholder engagement. Information and materials regarding the working group's activities, including policy priorities, workgroup meeting dates and recordings, draft proposals and supporting documents are housed on the page for the AHEAD model within the HSCRC's website.

The working group reports on its progress regularly to the Governor's office and to members of the Maryland General Assembly. A draft proposal was submitted to the Governor on the first policy priorities, Cost Shifting and Medicare Advantage (MA) Stabilization, in December, 2025, and the Governor approved a final policy later that month.

This report serves as a comprehensive update on the activities and policy development completed by the working group, including recommendations that have been finalized, proactive steps that can be taken by the member agencies, State commissions and the Maryland General Assembly and contributions from key stakeholders.

Working Group Membership

- Maryland Department of Health
    - Secretary of Health: Dr. Meena Seshamani

    - Medicaid Director: Perrie Briskin
    - Assistant Secretary for Population Health & Strategic Initiatives: Dr. Elizabeth Kromm
- Health Service Cost Review Commission
    - Executive Director: Dr. Jon Kromm
- Maryland Health Benefit Exchange
    - Executive Director: Michele Eberle
- Maryland Health Care Commission
    - Executive Director: Dr. Douglas Jacobs
- Maryland Insurance Administration
    - Commissioner: Marie Grant

To achieve the goals of the Governor's Directive in fostering cross-agency collaboration, members of the multi-agency workgroup and key staff meet regularly to discuss progress against the workplan, as well as to monitor state and federal movements with regard to AHEAD and House Resolution 1 (H.R. 1) implementation. These regular touchpoints serve in addition to topic-specific meetings among agency leads and subject matter experts to create policy recommendations and garner stakeholder expertise.

AHEAD Model Update

On November 12, 2025, the Centers for Medicare and Medicaid Services (CMS) and Maryland signed the Amended and Restated AHEAD Model Maryland State Agreement, replacing the prior State Agreement signed in 2024. The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment, and population health outcomes, results in improved population health and healthier living, enhanced quality outcomes and lowered growth of health care costs. The AHEAD Model constitutes a shift from the prior Total Cost of Care (TCOC) Model.

Under the Amended and Restated AHEAD Model Maryland State Agreement, the Maryland AHEAD Implementation Period officially began on January 1, 2026. Under AHEAD, Medicare FFS rate-setting authority will transition to the Center for Medicare and Medicaid Innovation (CMMI) in 2028, representing a significant change from prior iterations of the Maryland Model. The HSCRC will continue to set hospital rates and implement global budgets for all payers until 2028, and for all payers other than Medicare FFS throughout the remainder of the model. A three-year transition period (2028-2030) will allow the State to adjust hospital global budget amounts and ensure a smooth conversion to the new approach. Additionally, the State may propose ideas to CMS regarding policies to support stabilization of the MA market during the transition period.

The bifurcation of global budgets in 2028 complicates implementation of global budgets in the state. Medicare FFS rates establish a limit for Medicaid rates and a benchmark for MA premiums. This was relatively straightforward to implement when global budget policy for all payers, including public payers, were set together by the HSCRC. Beginning in 2028, the State will need to develop Medicaid and MA global budget rates in alignment with Medicare FFS, without influence over Medicare FFS rates or the related methodology. The State is working collaboratively with CMMI to understand and provide input on their proposed methodology and plans to re-evaluate its own methodology for non-Medicare FFS payers

prior to 2028, once CMMI's methodology has been finalized. A coordinated and proactive approach by HSCRC, other state agencies and the health care industry is critical to achieving success and easing this transition.

Activities of the Regulatory Working Group

Cost-Shifting Policy

Over the next seven years, the AHEAD Model requires the state to achieve $460 million in Medicare savings. Cost growth in Medicaid and MA will also need to be managed on the same trajectory. Unlike the previous AHEAD agreement, the State now has increased flexibility to shift costs across sectors, *i.e.,* to extend the responsibility for achieving savings to entities other than regulated hospitals. The Governor's Directive identified cost-shifting policy as a priority project of the working group, in recognition of the broad impact of the AHEAD model on the health care system. Given the similarities in both timeline and potential policy levers, the working group addressed cost-shifting and MA stabilization together.

The policy development process was heavily informed by stakeholders through public listening sessions, opportunities to submit written feedback, requests for public comment and responses to comments, as well as public posting of the draft policy and opportunity for stakeholder feedback. A wide range of stakeholders were invited to participate including State agencies, members of agency standing workgroups, payers, hospitals, providers and community advocates. Further, recipients were invited to share the emailed information broadly within their own networks, in an effort to maximize outreach.

The working group developed and distributed the draft policy proposal via email on November 21, 2025 and accepted written comments through December 2, 2025. The resulting policy recommendation was submitted for the Governor's consideration in mid-December with approval communicated by the end of 2025. The policy recommendation, as approved, can be found on the HSCRC's AHEAD Model website.

The cost-shifting policy will be effective January 1, 2028 and will therefore be included as part of the HSCRC's FY 2028 update factor process.

Medicare Advantage Stabilization

In the new AHEAD model, Maryland has the opportunity to propose solutions to CMS to improve the MA market. In 2025 multiple carriers began limiting their MA footprint both nationally and in Maryland for the 2026 plan year. MA plan losses create disruption for beneficiaries, who must either find an alternative plan that meets their care needs or transition to Medicare FFS. MA plans have communicated a need for financial support to stabilize the market. This need is likely to increase as enrollment continues to grow.

The working group committed to developing an MA stabilization policy in time for plans to make decisions for the CY 2027 plan year in spring 2026. Due to the anticipated mechanism, the resulting

policy solution was considered in tandem with cost-shifting through a unified stakeholder engagement process as described above. The policy recommendation, as approved, can be found on the HSCRC's AHEAD Model website.

Eligibility criteria for MA plan participation in the stabilization program was developed to support access, particularly for low-income consumers. Qualified plans will be designated in the first quarter of each year for the following year, starting in 2026. In early 2026, the HSCRC and MIA collaborated to identify qualifying plans for CY 2027. Qualified plans were alerted as to their status on February 20, 2026. Qualifying status was initially preliminarily based on data submitted by the plans to the MIA, then confirmed once data from CMS became publicly available in April 2026.

Qualifying plans for CY 2026 include three MA parent companies with all plans (as identified by H-contract) operating in Maryland, one company that was granted a waiver as described in the full recommendation document, and two companies that were split, with certain H-contracts qualifying. Two parent companies did not qualify. HSCRC is working on implementation of this policy, and has held initial discussions with its Payment Models Workgroup. Rate relief will be effective on January 1, 2027, pending CMMI approval. Beginning in CY 2028 HSCRC will have authority to effectuate rate relief without seeking CMMI approval.

All-Payer Total Cost of Care Growth and Primary Care Investment Targets

Statewide accountability requirements under the AHEAD model include targets for all-payer TCOC growth and all-payer primary care investment. Per the timelines required by the AHEAD Model, the State memorialized its commitment to both targets in an Executive Order issued by Governor Moore in December 2025. The State must set the targets for CY 2027 through CY 2030 via Executive Order 90 days prior to the start of 2027. The HSCRC is leading the development of the TCOC growth target component, and MHCC has built on its historical efforts to lead the primary care investment component. MHCC and HSCRC have been actively working together to ensure compatibility of methodological approaches and will continue to collaborate through the submission of the targets and longer-term implementation and measurement under the AHEAD Model.

All-Payer Total Cost of Care Growth Target

On behalf of the working group, the HSCRC established a short-term, multi-sector advisory council to inform the methodology for setting the TCOC growth target. The advisory committee was charged with: 1) serving as a forum to provide informed feedback and recommendations in support of staff and leadership as they set an all-payer TCOC growth target by September 2026; and 2) functioning in an advisory capacity to State leadership.

The Advisory Committee met four times between February and April 2026. In addition to deliberating the methodology, the committee received input from consultants who have developed similar targets in other states. In the interim between meetings, leadership and staff from the HSCRC, MHCC and MIA met biweekly to discuss takeaways and further design discussion, in addition to several ad hoc meetings to discuss technical content.

In addition to the Advisory Committee meetings, the HSCRC held an initial public comment period in March 2026 and listening session in April 2026, to provide feedback on the initial discussion, including–but not limited to–data parameters and sources, inclusions and exclusions and options for the counterfactual. In advance of the submission of the draft methodology and targets to the Governor, Advisory Committee members were given the opportunity to review the draft policy proposal. This was followed by a broader public comment period, in tandem with the primary care investment target, described below. The draft methodology and targets, as released for public comment, can be found on the HSCRC's AHEAD Model website.

The working group will submit draft methodology and targets to Governor Moore in July 2026.

Primary Care Investment Target

The AHEAD Model's primary care investment requirement reflects a growing national emphasis on strengthening primary care as a foundation for high-quality, cost-effective health systems. The requirement draws from momentum generated through similar targets in other states and recognizes the importance of primary care as the only specialty in which increased supply results in lower mortality and more equitable health outcomes.[1]

Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup*, enacted in 2022 and codified at §19-108.4 of the Health-General Article, (the Act)[2] mandates that MHCC conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending. The Act requires MHCC to form a stakeholder workgroup (PCIW)[3] to provide input on the analysis and recommendations.[4]

The PCIW met four times between December 2025 and April 2026. The PCIW's charge includes serving as a forum for discussion to guide MHCC in developing policy and recommendations, including the establishment of the all-payer primary care investment target. In carrying out this role, the PCIW reviewed emerging analyses, considered stakeholder perspectives and identified practical approaches for implementing the target. Its deliberations were intended to support thoughtful decision making and ensure that the investment target is both achievable and aligned with broader efforts to strengthen primary care. In conjunction with the all-payer TCOC growth target effort, leadership and staff from HSCRC, MHCC and MIA met as needed to discuss the draft targets and ensure alignment.

In addition to the PCIW meetings, MHCC conducted outreach with stakeholders, which included presenting at MHCC's January 2026 Commission meeting and hosting one-on-one meetings with payers.

[1] National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding The Foundation of Health Care*. Washington, DC: The National Academies Press, 2021. Accessed August 26, 2025. https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

[2] Chapter 667 of the 2022 Laws of Maryland 2022. Accessed August 26, 2025. https://mgaleg.maryland.gov/2022RS/chapters_noln/Ch_667_sb0734E.pdf.

[3] See Appendix D for a list of workgroup members.

[4] The Act requires specific workgroup representation from the Maryland Primary Care Program (MDPCP), HSCRC, MIA, MDH, the primary care community, payers, and managed care organizations and health services researchers with expertise in primary care.

All payers were offered the opportunity to weigh in on the targets via one-on-one meetings or through written comments. The draft recommendation was released for public comment in June 2026, jointly with the all-payer TCOC growth target recommendation. The draft methodology and targets, as released for public comment, can be found on MHCC's website.

Post-Acute Strategy

Challenges in the post-acute space have complicated the efficient delivery of hospital services, with hospitals reporting difficulties confirming clinically appropriate discharge placements for patients. These challenges can be more significant depending on discharge timing (*e.g.*, near or during the weekend) and clinical needs. Solutions to these concerns are likely to be multi-variate and extend beyond the purview of the HSCRC, likely involving the Medicaid program and other payers. Exploring and leveraging alignment across existing programs, such as value-based purchasing programs for skilled nursing facilities and hospital readmissions payment policies, will be foundational to the success of this effort.

The AHEAD agreement may provide some flexibility for the State to gain savings credits for initiatives that impact care beyond the hospital. The working group workplan identified the MHCC as best-positioned to lead the development of a report with recommendations, working with the HSCRC, MIA and MDH, *i.e.,* the Medicaid program.

To better understand factors that may contribute to delays in clinically-appropriate hospital discharges to post-acute care settings, as well as factors that may affect post-acute care performance, MHCC met one-on-one with a broad set of partners. Partners included state health officials and representatives of direct care workers, post-acute care service providers, hospitals, payers and health information technology companies. These conversations helped inform the topics discussed during a series of three focus group meetings in the month of March 2026 involving the same set of partners. The purpose of these meetings was to identify recommendations to better facilitate hospital discharges and optimize acute care networks. Below are some of the topics discussed during these meetings:

- The capacity of the post-acute care sector to accept patients with complex conditions discharged from hospitals, potential regulatory requirements that might limit such capacity and potential challenges in accepting clinically complex patients such as reimbursement levels;
- Workforce staffing challenges related to recruitment, retention and training;
- Delays in coverage due to obstructions related to Medicaid eligibility determinations, approvals for home- and community-based services and prior authorization;
- Lack of Medicaid coverage for most assisted living facilities, palliative care and hospice room-and-board;
- Limitations on home health services arising from the 30-day home health Patient Driven Groupings Model (PDGM);
- Lack of awareness of lesser known post-acute settings such as adult medical day care and residential treatment centers;
- Disorganized care planning and coordination during hospital discharge, lack of supports for post-discharge care navigation and issues related to assigning guardianship;
- Potential impacts of mergers and acquisitions; and

- Opportunities to enhance value-based care through implementation of dashboards/scorecards and stronger payment incentives to promote better outcomes.

MHCC is currently preparing a report summarizing progress to date that will include draft recommendations to improve hospital discharge placements and strengthen post-acute care. The recommendations will focus on prioritizing critical and feasible issues.

Workforce and Graduate Medical Education

CMS policy on graduate medical education (GME) in the AHEAD hospital global budgets will have important implications for Maryland. HSCRC received a number of comments about potential new approaches for GME investment in a recent public engagement process; however, the comments did not lead to consensus on an approach. Sustainable funding for GME is deeply related to plans for a statewide workforce development strategy, to involve MDH and MHCC. Over the past several years, various agencies and commissions have touched components of workforce strategy within discrete spaces of public health and the health care delivery system. MDH is consolidating those efforts to develop one strategic plan that holistically addresses workforce development needs across the health ecosystem. Strengthening the health care workforce is also a key element of Maryland's Rural Health Transformation Program.

Working with MDH, MHCC has led efforts to solicit stakeholder input regarding strategic priorities for future State workforce development efforts. In future work, the agencies may consult with the HSCRC on how payment policies may be leveraged to effectuate the identified initiatives and to coordinate with any changes to HSCRC GME policies that may result from the transition to Medicare global budgets in 2028.

To better understand the breadth of priorities related to the health workforce, MHCC met one-on-one with a broad set of partners. Partners included state health officials and representatives of academic medical centers, hospitals, physicians, area health education centers, post-acute care facilities, community health centers, local health departments, direct care workers and community colleges. These conversations helped inform the topics discussed during a series of two focus group meetings in the month of April involving the same set of partners. The purpose of these meetings was to identify strategic priority areas for future health care workforce development efforts by the State that would be most likely to generate the largest return on investment. Below are some of the topics discussed during these meetings:

- Size and distribution of the health workforce in Maryland and factors affecting the supply of professionals across specialties and geographic areas such as:
    - Physicians;
    - Nurse practitioners;
    - Physician assistants;
    - Registered nurses;
    - Behavioral health professionals;
    - Members of the allied health workforce;
- The health workforce pipeline, including early exposure to health careers during K-12 education, work-based pathways for career training and development such as apprenticeships and career

ladders/lattices, graduate medical education policy, scholarships and loan repayment and alignment of these pathways with Maryland's workforce needs;
- Entry into practice including licensure, credentialing, certification and employer recruitment with a focus on how these processes may impact the timing of individuals entering the workforce, including potential delays and redundancies;
- Factors affecting the well-being, retention and performance of the health workforce such as workplace conditions, structure and compensation; and
- Workforce data systems and performance measures to assess workforce outcomes and the effectiveness of workforce programs, such as tracking what happens to individuals at different stages in the workforce pipeline.

MHCC is currently preparing a report summarizing progress to date that will include identification of strategic priority areas for future health care workforce development efforts.

Choice and Competition

The State Agreement requires Maryland to select one Choice and one Competition policy from a menu of available options by January 1, 2027. The options must be implemented by 2029; some of the options have interim milestones.

Choice	**Competition**
Implementing Medicaid site neutrality	Modifying scope of practice restrictions, including for physician assistants and nurse practitioners
Improving access to new and/or additional modes of care delivery via telehealth	Repealing certificate of need (CON) requirements for all non-hospital settings
Advancing prescription drug price transparency	Expanding access to care by revising network adequacy provisions in compliance with federal requirements
Prohibiting the use of non-compete clauses to increase provider mobility	Expanding contracting flexibilities by repealing any willing provider (AWP) laws

MHCC has identified an initial set of draft policy opportunities under each of the Choice and Competition options that it is currently reviewing with state partners to assess their feasibility and to further refine them. These potential policy opportunities will be included in a future report to the Governor and will be subsequently socialized with the legislature, through public listening sessions and posted for public comment.

Other Multi-Agency Initiatives

This section summarizes efforts that were named in the workplan but are not directly led by the working group, as they had previously-existing structures.

Maryland-Specific Metrics for AHEAD

Lead Agency: MDH

On October 15, 2025, MDH submitted the State's Population Health Accountability Plan (PHAP). The PHAP includes the all-payer quality and population health measures and targets chosen by the State and is a required element of the AHEAD Model. Maryland completed a structured and inclusive process to guide measure selection and target setting for the PHAP.

The Data Advisory Committee (DAC) of the Maryland Commission on Health Equity (MCHE, the AHEAD governance structure) worked to select measures from the options provided by CMS and set targets. (Additional information can be found on the MCHE website.) DAC includes data and technical experts as well as stakeholders representing hospitals, primary care practices, public health, health plans and community representatives. MDH's Chief Data Officer and the Executive Director for the Maryland state-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP) co-chair the committee. Over the course of nine meetings in 2025, DAC established the criteria to evaluate and prioritize measures and applied a formal rubric to assess metrics relevance, differences between subpopulations, validity, feasibility and alignment with other state programs. After selecting measures from the options provided by CMS, the advisory committee considered several different target-setting options for each measure. The State modeled different target setting approaches and conducted a literature review on the measures selected, effective interventions, and the feasibility of change. DAC made target recommendations based on the various target setting approaches and feasibility of change.

In 2026, MDH will fund Local Health Departments to convene community members and key stakeholders to create Local Action Plans. Each Local Action Plan will serve as a roadmap for implementation, identifying activities, accountable owners and timelines. AHEAD also requires hospitals to create Hospital Accountability Plans, which will be closely linked to the Local Action Plans and reviewed and approved by MCHE. To support implementation planning, MDH's State Health Improvement Plan (SHIP) was updated to include the PHAP measures and a literature review of evidence-based strategies for each measure. The State is also publishing a public Health Indicators Dashboard that demonstrates the State's performance on the PHAP measures and is building a reporting suite that can be used by providers to monitor and improve performance.

Adverse Decisions in the State Health Care System, *i.e.*, Denials

Lead Agency: MIA

Adverse decisions for insurance coverage of health care services have been a major challenge for health systems and health care providers for several years, with multiple different requirements for payment for certain services across different payers and different government programs. In response to these concerns, in 2025 the General Assembly established the Workgroup to Study the Rise in Adverse Decisions in the State Health Care System. The workgroup is composed of representatives from the General Assembly, relevant state agencies and representatives of hospitals, payers, physicians, pharmacy services providers, behavioral health providers and patient advocates.

The workgroup met for the first time in late November 2025, with a final report anticipated in December 2026. During 2026, the workgroup will hear from stakeholders including insurers and providers, and will discuss current state and federal law and practice regarding adverse decisions in the commercial market, Medicaid and Medicare.

Emergency Department Wait Times

Lead Agencies: MDH, HSCRC

House Bill 1143 of the 2024 session of the Maryland General Assembly (Chapter 844 of the Acts of 2024) established the Maryland Emergency Department Wait Time Reduction Commission. The Commission is tasked with researching and understanding factors throughout the health care system that contribute to increased Emergency Department (ED) length of stay (LOS), making recommendations to reduce ED LOS and reporting on the impact of its policies and programs to the Maryland General Assembly. The Commission is co-chaired by MDH and the HSCRC and includes representatives from emergency medical service providers and systems, including non-physician providers, state agencies, hospitals, behavioral health providers, managed care plans, primary care providers and patient advocates.

The ED Wait Times Reduction Commission established subgroups to address specific areas of need, including: 1) Access and Capacity; 2) Data; and 3) ED-Hospital "Throughput" Best Practices, the last of which developed from a pre-established HSCRC workstream. The Commission also collaborates regularly with MDH on joint areas of focus that impact ED wait times, such as access to primary care, leveraging advance directives, addressing pediatric overstays and improving access for behavioral health patients and guardianship cases.

HSCRC staffs the ED Wait Times Reduction Commission, provides necessary data for the Commission's analyses and work and supports statistical modeling and simulations to guide decision-making. The HSCRC incorporates the work of the Commission as it evaluates related policies including capacity analysis, efforts to reduce potentially avoidable utilization (PAU) and efforts to reduce inpatient length of stay (IP LOS). The Commission provided an interim report on its findings in November 2025 and will provide a final report in November 2026.

Next Steps

The establishment of the working group formalized the role and importance of multiple state agencies in building a policy base for the health care system in Maryland, as the state transitions into the AHEAD Model.

Looking forward, the agencies will continue to collaborate on the programs identified in the workplan as well as collaborate on additional initiatives to maximize access, affordability and quality of health care in Maryland. Before the end of CY 2026, the working group aims to:

- Create a framework and metrics for annual reports on cost-shifting and MA stabilization;

- Submit draft all-payer TCOC growth and primary care investment targets and methodology to the Governor, then final versions to CMMI; and
- Issue a report listing recommendations to address hospital discharge delays to post-acute care settings and to otherwise strengthen post-acute, a report outlining strategic priorities for health workforce development and proposed policies to address Choice and Competition options under the AHEAD State Agreement which need to be finalized by January 1, 2027.

The working group values community and industry expertise and will continue to hold robust opportunities for stakeholder input and review.