maryland health services cost review commission

All-Payer Total Cost of Care Target Technical Advisory Committee

AHEAD Model

Meeting #1

February 5, 2026

Agenda

- Introduction
  - Committee Membership
  - AHEAD Model Agreement
  - Executive Order
  - Workgroup Role
  - Process Timeline
- Background
- Total Cost of Care All-Payer Growth Targets Discussion
  - Data Parameters
  - Counterfactual Options
- Next Steps

Introduction

Advisory Committee Staff

The Advisory Committee is led by Health Services Cost Review Commission (HSCRC) Executive Director Jon Kromm, Insurance Commissioner Marie Grant and Maryland Health Care Commission (MHCC) Executive Director Doug Jacobs, with support from additional state staff from the HSCRC, Maryland Insurance Administration (MIA), MHCC and Medicaid.

Advisory Committee Members

- Alyssa Penna Williamson – United States of Care
- Andrew Anderson – Johns Hopkins Bloomberg School of Public Health
- Arin Foreman – CareFirst
- Bradley Chambers – MedStar Health
- David Johnson – Mid-Atlantic Business Group on Health
- Dewan Clayborn – Central Maryland Chamber of Commerce
- Ed Beranek – Johns Hopkins Health System
- Gene Ransom – MedChi
- Grace Mannix – CRISP
- John Colmers
- Loraine Arikat – 1199SEIU United Healthcare Workers East
- Matthew Celentano – The League of Life and Health Insurers of Maryland
- Padmini Ranasinghe - Johns Hopkins Hospital
- Sharon Feinstein – University of Maryland Medical System/Maryland Academy of Family Physicians
- Stephanie Klapper – Maryland Citizens' Health Initiative
- Sule Gerovich – Maryland Hospital Association
- Wen Xu – Kaiser Permanente

Guidelines for Workgroup Participation

Constructive feedback:

Offer feedback that is focused, specific, and aimed at improvement.

Active listening:

Listen with the intent to understand.

Awareness of shared time:

Be mindful of the time and the space taken in discussions. Allow others the opportunity to contribute.

Please stay on topic.

Respectful sharing:

Please share your thoughts respectfully and considering the views and opinions of others.

Avoid interrupting others.

Questions are welcome.

Active participation and timely contribution:

Actively engage in discussions and provide feedback throughout the workgroup.

Timely and consistent contributions are essential for collective success of the workgroup- please respect deadlines for comments.

AHEAD Model Agreement

- Statewide accountability requirements under the AHEAD model include targets for all-payer total cost of care (TCOC) growth and all-payer primary care investment.
- Section 10. Statewide Accountability Targets (All-Payer TCOC Growth Targets)
  - Prior to PY1 (CY 2026), the State must establish the process to set all-payer TCOC growth and primary care investment targets through an executive order, legislation or regulation.
  - No later than ninety days prior to the start of PY2 (CY 2027), the State must provide to CMS the all-payer TCOC growth and primary care investment targets for each of PYs 2-5, at a minimum. (The State may opt to propose targets for PYs 6-10 90 days before the start of each performance year.)
  - Failure to meet the targets--*i.e.,* missing two out of three years--may trigger enforcement actions by CMMI, such as a corrective action plan, but would not trigger termination of the model.

Executive Order

- The State's commitment to establishing all-payer TCOC and primary care investment targets, which will apply across all Maryland health care markets and populations, has been memorialized in an Executive Order issued by the Governor. This was a requirement of the AHEAD Model, due prior to the end of December 2025.
- The Executive Order commits the HSCRC, MHCC, MDH, MIA and MHBE to:
  - Collecting and analyzing data and developing a target-setting methodology, as informed and advised by stakeholders; and
  - An initial submission for PYs 2-5 in 2026, followed by annual timeframes for draft and final targets for PYs 6-10.

Advisory Group Charge and Role

- In accordance with the Executive Order's requirements for stakeholder input, this short-term advisory committee was formed to inform the target-setting methodology for all-payer total cost of care growth under the AHEAD model.
  - The Advisory Committee serves as a forum for discussion to provide informed feedback and recommendations in support of staff and leadership decision-making for the all-payer total cost of care growth target-setting by September 2026.
  - The Advisory Committee functions in an advisory capacity to State leadership.
- The State is managing the commitment to establish targets through the AHEAD Regulatory Working Group established by a Governor's Directive to manage various multi-agency priorities and support the success of the AHEAD model.
- This includes the parallel primary care investment target, led by MHCC.

Process Timeline

Milestone	Action Items	Due Date
Advisory Group Meeting #1	Advisory Committee Introduction	February 5, 2026
Advisory Group Meeting #2	Review Key Considerations and Make Initial Recommendations	February 23, 2026
Written Public Comment Period		February 23 – March 20, 2026
Advisory Group Meeting #3	Public Listening Session and Revise Recommendations as Needed	April 10, 2026
Draft methodology and targets due to the Governor		May 2026
Submit CY 2027-2030 targets to the Governor and CMMI		September 2026

*Ad-hoc meetings may be scheduled prior to the final submission to CMMI

Background

Total Cost of Care Targets

National Landscape

- As health care costs continue to rise more states consider implementing health care cost growth target programs to support affordability
  - Targets or benchmarks outline how much health care spending in the state should grow annually, often as per capita total health care spending
  - States measure and report on annual statewide health care cost growth relative to a target or benchmark
  - Health care cost growth or total cost of care targets differ based on state laws and stakeholder priorities on establishing a target methodology and value
  - Cost growth targets are supported by national efforts in standardizing data collection, cost driver evaluation, and reporting efforts, such as the Peterson-Milbank Program for Sustainable Health Care Costs

Examples of Initiatives in Other States

- Legislatively Mandated
  - California
  - Massachusetts

- Mandated via Executive Order
  - Connecticut
  - New Jersey

California: Legislative Action

Office of Health Care Affordability (OHCA) in conjunction with the Health Care Affordability Board must establish health care cost targets[1].

Key Features:

- Vary by health care sector including fully integrated delivery systems, geographic regions, and individual health care entities
- Promote predictable rates of change in per capita total health care expenditures
- Based on a percentage accounting for economic indicators and population-based measures, such as changes in demographic factors
- For each calendar year, promote affordability to consumers, and maintain quality and equitable care
- Enacted in conjunction with a primary care and behavioral health investment benchmarks and adoption of alternative payment models

Massachusetts: Legislative Action

Massachusetts' long-standing program aligns health care spending growth with overall economic growth by establishing the statewide health care cost growth benchmark:[2, 3]

Key Features:

- Annual benchmark set for the following year between January 15 and April 15 by the Health Policy Commission Board of Commissioners
- Annual reporting on total health care expenditures by the Center for Health Information and Analysis
- Includes three multi-year targets for total health care expenditures growth tied to potential gross state product (PGSP):
  - Years 1-5: Growth rate of PGSP (3.6%)
  - Years 6-10: Growth rate of PGSP – 0.5% (3.1%)
  - Year 10 and beyond: Growth rate of PGSP, with potential for modification, set annually

Connecticut: Executive Order

Executive Order 5 of 2020[4] outlined responsibilities and components of a cost growth benchmark.

Key Features:

- Monitor statewide health care spending growth
- Develop annual health care cost growth benchmarks 2021-2025
- Convene a Technical Advisory Board to assist in development of the benchmark with state and stakeholder representation
- Tie the benchmark to per capita health care expenditures in a calendar year
- Include increases in primary care spending with set annual targets
- Include quality benchmarks on clinical quality, under- and over-utilization, and patient safety measures

New Jersey: Executive Order

Office of Health Care Affordability and Transparency oversees a health care cost growth benchmark program.[5]

Key Features:

- Collective stakeholder action toward a shared goal focused on accessible, affordable, equitable, high-quality health care
- Aligning health care cost growth with the state economy and resident income
- Public reporting of progress toward targets and on health care cost drivers
- Identifying opportunities to promote affordability

The program established a target based on potential gross state product and forecasted median income of residents. Targets decrease over time:

- 2023: 3.5%
- 2024: 3.2%
- 2025: 3.0%
- 2026 and 2027: 2.8%

Trend Comparison – Values in Other States

State	Accountable for Target Setting	Target Methodology	Target Value
California	CA's Office of Health Care Accountability (OHCA) Board based on recommendations from OHCA staff	Weighted average of historical median household income growth 2002-2021 with add-on factors	3.5% for 2025-2026 3.2% for 2027-2028 3% for 2029
Connecticut	Executive Director of the CT Office of Health Strategy	80/20 blend of forecasted median wage and potential gross state product (PGSP) with add-on factors	3.4% for 2021 3.2% for 2022 2.9% for 2023-2025
Delaware	DE Economic and Financial Advisory Council Health Care Spending Benchmark Subcommittee	Rate of PSGP with add-on factors	3.5% for 2020 3.25% for 2021 3% for 2022-2023
Massachusetts	MA Health Policy Commission with engagement of MA Legislature	Rate of PSGP with add-on factors	3.6% for 2013-2017 3.1% for 2018-2022 3.6% for 2023-2024
New Jersey	NJ Dept. of Banking and Insurance with input from Benchmark Implementation Advisory Group	75/25 blend of median projected household income and PGSP with add-on factors	3.5% for 2023 3.2% for 2024 3% for 2025 2.8% for 2026-2027
Oregon	OR Health Authority with input from Health Care Cost Growth Target workgroups	Non-formulaic but considered historical GSP and historical median wage growth	3.4% for 2021-2025 3% for 2026-2030
Nevada	NV Department of Health and Human Services Patient Protection Commission	Mix of median wage growth and GSP	3.19% for 2022 2.98% for 2023 2.78% for 2024 2.58% for 2025 2.37% for 2026
Rhode Island	RI Office of the Health Insurance Commissioner	75/25 blend of PSGP and forecasted median wage + inflation adjustments	6% for 2023 5.1% for 2024 3.6% for 2025
Washington	WA Health Care Cost Transparency Board (Part of Washington Health Care Authority)	70/30 blend of historical median wage growth and PGSP with downward adjustments in out years	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026

Total Cost of Care All-Payer Growth Targets Discussion

Data Parameters
Counterfactual Options

Review of Preliminary Data Decisions: Inclusions and Exclusions

Included Data and Sources

- Medicaid FFS and MCO from Medicaid
- Commercial claims from Maryland Medical Claims Database (MCDB, MCDB excludes ERISA plans and FEHBP, exclude members over 65)
- Medicare FFS from data received under AHEAD contract
- Medicare Advantage from MCDB*
- Pharmacy, including Medicare Part D (estimated using average wholesale price)

Excluded Data

- Dental Plans
- Workers Compensation and other non-health insurance coverage

Preliminary Recommendations: Additional Data and Sources

- Non-claims-based payments
  - Available for Medicare FFS
  - MCDB has initiated data collection
- ERISA and Federal Employee Health Benefit Plans (FEHBP)
  - Near term – use modeling to extrapolate values from MCDB
  - Longer term – leverage Electronic Health Network (EHN) data
- Self-Pay – use modeling to extrapolate values from all-payer hospital data
- Rebates – data collection

* Certain Medicare Advantage plans do not submit data to the MCDB and will be excluded.

Review of Preliminary Data Decisions: Allowed Costs

- The analysis uses allowed costs, therefore:
  - Exclude crossover claims for dual eligibles from the Medicaid analysis
  - Exclude Medicare supplemental (MediGap)
  - Exclude third-party coverage

Review of Preliminary Data Decisions: Medicaid

Include

- Managed Care Participants: Costs for both managed care and FFS benefits, plus member months
- Non-Dual FFS Participants: Costs and member months
- Duals: Costs for Medicaid services

Exclude

- Duals: Member months and costs for Medicare services (already accounted for in Medicare)

Discussion: Medicaid Services

- Developmental Disabilities
- Adult Medical Day Care
- Home- and Community-Based Services

Medicaid Services Description

Program Name	Cost	Population	Services
(Developmental Disabilities Administration) Community Pathways Waiver	Total cost: $3.1 billion Cost per user: $130,254	Participants with intellectual and developmental disabilities	Meaningful Day, Support and Residential Services that promote community living, including a self-directed service model and traditional, agency-based service model.
Medical Day Care Services Waiver	Total cost: $158.9 million Cost per user: $23,438	Functionally-disabled adults, age 16 and older	Medical care during the day in a community-based setting offering individuals an alternative to nursing facility care.
Home- and Community-Based Services	Total cost: $750.5 million Cost per user: $27,372 (May include some non-waiver services)		
	Autism Waiver	Children and youth with Autism Spectrum Disorder	Adult life planning, environmental accessibility adaptations, family consultation, intensive individual support services, residential habilitation, respite care and therapeutic integration.
	Brain Injury Waiver	Individuals with brain injury who have significant needs related to behavior, cognition, physical impairment and/or behavioral health conditions	Residential habilitation, day habilitation, supported employment, individual support services and case management.
	Home- and Community-Based Options Waiver	Older adults and individuals with disabilities	Assisted living, behavior consultation, case management, family training, medical day care and senior center plus.
	Model Waiver	Medically-frail children	Case management, home health aid services and private duty nursing.

Review of Preliminary Data Decisions: Timeframe

- Years
  - Maryland has the flexibility to define its own baseline year.
  - Limited analysis to 2023 and 2024, as data from one payer (Kaiser Permanente) was not available prior to CY 2023. Also, COVID begins to impact earlier windows
  - AHEAD Medicare baseline year is 2023 but a more recent baseline could be substituted as data becomes available.
  - Current bias: Revisit baseline year in conjunction with discussion of target setting approach
- Run-Out
  - Standard approach for Medicare and commercial uses a run-out date of March 31st of the following year; Medicaid uses a full year of data.
  - Ability to include additional data will vary with source—completion of Medicaid data will be most reliable with a year's run-out.
  - State could:
    - Calculate and apply completion factors (preliminary recommendation)
    - Maintain differing run-out periods by payer

Counterfactual Options

- Goal is to suggest structure not an actual value
- Most States Use Broader Measures of the Economy to Set the Target
  - Gross State Product: Aggregate measure of the value of goods and services produced in a state
  - Household Income: Income of householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.*
  - Wage Growth: Change in average hourly earnings
- Develop alternative approach, *e.g.,* comparing to national health care cost growth
- Growth Trend Mechanic Options:
  - Actual – unpredictable and subject to data lag
  - Projected – requires projection methodology, may not track actual
  - Fixed based on historical average or other analysis – may not be relevant to future situation
- Could include add-ons for health care-specific factors

*Household income as defined by the American Community Survey

Next Steps

Issues for Consideration before the February 23rd Meeting

- What is the best way to estimate self-pay spending?
- What is the best way to approach ERISA and FEHBP spending?
- Are there concerns with the proposed baseline year and approach to data run-out?
- How should the analysis approach costs for Medicaid developmental disability services, long-term services and supports and/or home- and community-based services?
- Is the list of exclusions due to allowed costs comprehensive, or are there other considerations to take into account?
- For the counterfactual…
  - What are the pros and cons of each potential definition for growth, as well as for using actuals vs. projected vs. fixed? What is the right reference point for measuring household spending?
  - Should the methodology include add-ons for health care-specific factors?

Advisory Group Workplan

- Next Meeting Date: February 23, 2026 - 1:00-2:30
- For the February 23rd Meeting: Review the topics on Slide 28 with your organizations and come prepared to provide feedback
- Future Meeting Topics
  - February: Review key considerations and make initial recommendations, in preparation for public comment period (anticipated for March)
  - April: Conduct public listening session and revise recommendations as needed

Appendix

National Landscape and Initiatives in Other States - References

[1] https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=107.&title=&part=2.&chapter=2.6.&article=3.

[2] https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

[3] https://masshpc.gov/cost-containment/benchmark

[4] https://portal.ct.gov/-/media/office-of-the-governor/executive-orders/lamont-executive-orders/executive-order-no-5.pdf?la=en&hash=D94E97781672A65208C7BED8F46EA316

[5] https://cshp.rutgers.edu/sites/default/files/2024-04/Benchmark_Blueprint_March_31_2022.pdf