



maryland
health services
cost review commission

All-Payer Total Cost of Care Target Technical Advisory Committee

AHEAD Model

Meeting #2

February 23, 2026

Agenda

- Welcome and Advisory Committee Review
- Total Cost of Care All-Payer Growth Targets Discussion
 - Data Parameters
 - Counterfactual Options
- Next Steps



Introduction

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.

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
- Joe Winn – Maryland MCO Association
- John Colmers
- Loraine Arikat – 1199SEIU United Healthcare Workers East
- Madeline Jackson-Fowl – University of Maryland Medical System
- Matthew Celentano – The League of Life and Health Insurers of Maryland
- Padmini Ranasinghe - Johns Hopkins Hospital
- Sharon Feinstein – University of Maryland School of Medicine/Maryland Academy of Family Physicians
- Stephanie Klapper – Maryland Citizens' Health Initiative
- Sule Gerovich – Maryland Hospital Association
- Wen Xu – Kaiser Permanente

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

Total Cost of Care All-Payer Growth Targets Discussion

Data Parameters Counterfactual Options

Timeframe: Recommended Parameters

Topic	Discussion	Status
Baseline year	<ul style="list-style-type: none">● Calendar year (CY) 2023 first reliable year● Does not need to align with Medicare FFS TCOC baseline—discuss pros and cons	Needs discussion
Run-out	<ul style="list-style-type: none">● State datasets mostly have three months run-out; Medicaid has 12 months● State will develop a completion factor so that all data have 12-month run-out	Confident

Data and Sources: Recommended Inclusions

Topic	Discussion	Status
Medicaid fee-for-service (FFS) and managed care organization (MCO) claims	Include <i>Source: Medicaid</i>	Confident
Commercial claims (other than ERISA and FEHBP)	Include <i>Source: MCDB*</i>	Confident
Commercial claims - ERISA and FEHBP	Include <i>Source: Estimated based on commercial claims; potentially Electronic Health Network data in the future</i>	Likely
Medicare FFS claims	Include <i>Source: CMS</i>	Confident
Medicare Advantage	Include <i>Source: MCDB*</i>	Confident
Pharmacy, including Medicare Part D	Include <i>Source: CMS</i>	Confident

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

Data and Sources: Recommended Exclusions

Topic	Discussion	Status
Dental Plans	Exclude <i>Not uniformly covered by most payers</i>	Confident
Worker's Compensation and other non-health insurance coverage	Exclude <i>Relatively small; harder to quantify</i>	Confident
Crossover claims from duals Medicaid analysis	Exclude <i>Analysis uses allowed costs; already included</i>	Confident
Medicare supplemental (MediGap)	Exclude <i>Analysis uses allowed costs; already included</i>	Confident
Third-party coverage	Exclude <i>Analysis uses allowed costs; already included</i>	Confident

Data and Sources: Needs Discussion

Topic	Discussion	Status
Non-claims-based payments	<ul style="list-style-type: none">• Available for Medicare FFS• MCDB has initiated data collection	Likely
Self-Pay/Uninsured	<ul style="list-style-type: none">• Use modeling to extrapolate values from all-payer hospital data• Consider additional data sources	Likely
Rebates	<ul style="list-style-type: none">• There is no pharmacy rebate data for Medicare FFS, and reporting by other payers is inconsistent.• Other states (NJ, CA) have started by reporting spending gross of rebates, with select exhibits that show spending net of rebates.• Likely to exclude for now.	Confident

Medicaid Populations: Recommended Inclusions and Exclusions

Topic	Discussion	Status
Managed care participants	Include <i>Member months and costs for services both provided through MCOs and on a FFS basis</i>	Confident
Non-dual FFS participants	Include <i>Member months and costs</i>	Confident
Full duals	Include <i>Costs for Medicaid services only</i> Exclude <i>Member months</i>	Confident
Partial duals	Exclude*	Confident

* May be overestimated, due to Medicaid pricing of co-payments for Medicare-covered services.

Medicaid Services: Needs Discussion

Topic	Discussion	Status
Developmental Disabilities Services	<ul style="list-style-type: none"> ● Other states with all-payer growth targets include these specialty Medicaid services. ● Consideration of unintended consequences of including these services. ● In Maryland, they are reported on a FFS basis, meaning they are easier to parse out and exclude. <ul style="list-style-type: none"> ○ Need to account for any ‘other’ types of long-term care covered by commercial and MA ○ Need to separate out professional versus facility fees/institutional costs. 	Needs discussion
Adult Medical Day Care		Needs discussion
Home- and Community-Based Services		Needs discussion

Additional information about these services can be found in the appendix.

Counterfactual Options: Structure

Topic	Discussion	Status
Tie to broader measure of economic growth	<ul style="list-style-type: none"> • Most states use broader measures of the economy to set the target. • AHEAD model aims to bend the cost curve; tying to national health care growth would create a circular reference. • Could include add-ons for health care-specific factors 	Confident
Growth trend mechanic options	<ul style="list-style-type: none"> • 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 	Confident
Annual vs. cumulative targets	<ul style="list-style-type: none"> • Fixed baseline: Allows tracking of progress over time • Year-over-year measure: Reflects how consumers and businesses think about their cost experience—more actionable 	Confident

Options in bold are current State preference.

Counterfactual Options: Gross State Product

- Description
 - Aggregate measure of the value added in production by labor and capital located in a state*
 - Gross Output: Value added for an industry (*i.e.*, sales plus changes in inventories and taxes on products), **MINUS**
 - Intermediate Inputs: Cost of goods and services purchased from other industries
 - Both current-dollar (nominal) and real (inflation-adjusted) are produced
 - Signals that health care spending should not grow faster than the economy
- Frequency: State-level gross state product published quarterly, about 3-4 months after the end of a given quarter
- Pros
 - Timeliness
 - Aims to stabilize health care growth on par with other market segments
- Cons
 - Not closely tied with household income, less relevant to the consumer
 - Can be distinct from household purchasing power; growth may be concentrated among a small segment of the population
 - Health care spending often exceeds gross state product, potentially leading to unrealistic targets

* Source: U.S. Department of Commerce, Bureau of Economic Analysis

Counterfactual Options: Household Income

- Description
 - Income of householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.*
 - Utilizes a randomly-selected sample of about 3.5 million addresses; intended to be representative of the U.S. population
 - Signals that health care spending should not grow faster than family income
- Frequency: Data released around a year following the close of the year when data were collected, in one-year and five-year reports
- Pros
 - Closely relates to consumer affordability—proxy of household purchasing power of middle-income families and earners
 - Available at state and county levels
- Cons
 - Data lag of over a year from American Community Survey
 - Sample-based

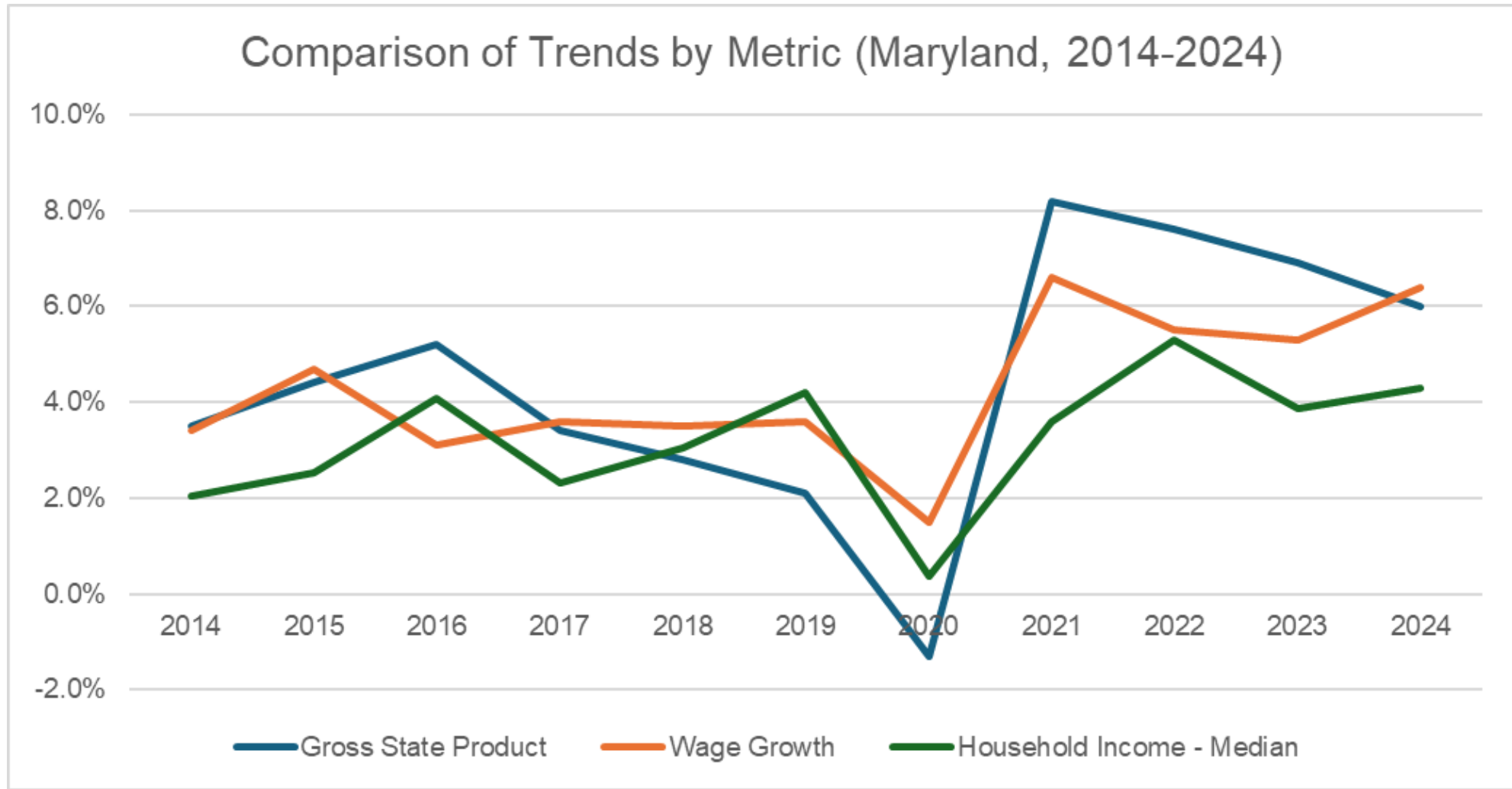
*Household income as defined by the U.S. Census Bureau, American Community Survey

Counterfactual Options: Wage Growth

- Description
 - Measure of the nominal wage growth of individuals*
 - Median of the year-over-year percent change in hourly wage rates computed at the individual level using linked wage records
 - Signals that health care should not grow faster than consumer paychecks
- Frequency: Longer data lag
- Pros
 - Closely relates to consumer affordability—proxy of household purchasing power of middle-income families and earners
- Cons
 - Timeliness: Several-year lag for wage data from the Bureau of Labor Statistics

* Source: U.S. Bureau of Labor Statistics

Counterfactual Options: Comparison of Trends



Counterfactual Options: Technical Considerations from Other States

- Most states derive a fixed number from historical levels, using a judgmental blend of the relevant metrics.
 - GSP has been most popular and is timely, but certain states have moved away from it.
 - Ex) Oregon, which switched to regional inflation after its first five years.
- Some states rely on projection values from bodies such as the federal reserve.
- Most states use nominal (vs. real) values to incorporate inflation.
- Most states revisit the benchmark after five years.
- There is only one instance of a state using a cumulative target; most use annual.

Counterfactual Options: Additional Considerations from Other States

The selected metric should be understandable by the public.

Predictability should be prioritized: Best practice is to prospectively set the target, rather than adjusting the target according to trends in inflation

Selected target should be achievable and sustainable.

Keep in mind that not all health care spending is unexpected or unavoidable—this target will serve as a litmus test for excessive growth.

Reporting and Monitoring for Impact on Access—Other States

Compliance with the total cost of care growth target is calculated and reported independently. Measures of access and other priorities, *i.e.*, from other sources, will be identified and referenced in the State's reporting.

- Example metrics from other states
 - Cost: Per member, per month expenditures, payment per unit, *i.e.*, by service category
 - Utilization: Per 1,000 individuals, avoidable emergency department use
 - Network adequacy: Provider supply, hospital capacity
 - Contextual: Qualitative information from patients, providers and payers
- Contributors to success in other states
 - Track cost drivers and shifts in volume and service mix
 - Implement complementary primary care investment programs



Next Steps

Public Comment: Process

Members of the public—including the Advisory Committee—are invited to submit public comment on or by Friday, March 20th to mdh.maryland-model@maryland.gov.

Individuals who wish to speak at the April 10th meeting are required to submit written comments. Comments will be shared in advance with the Advisory Committee, who will have the opportunity to ask questions during meeting.

Advisory Committee members are welcome and encouraged to submit comments. The HSCRC requests that, in such instances, members identify another representative from their organization to provide the verbal comments at the meeting.

Public Comment: Suggested Areas for Comment

- **Data (Slides 11-16): Parameters, sources, inclusions, exclusions**
 - Additional data elements (sources, services, etc.) that have not been considered
 - Suggestions for completion factors to address disparate run-out periods, ERISA and FEHBP, self-pay/uninsured and other missing elements, e.g., non-claims-based payments
- **Counterfactual (Slides 17-24): Benchmark option(s) for growth**
 - Support for GSP, household income, wage growth or a blend
 - Additional discussion regarding structure (e.g., fixed based on historical average, annual vs. cumulative)
 - Suggestions for metrics—including sources—to monitor access and quality

Advisory Group Workplan

- Next Meeting Date: April 10, 2026 - 1:30-3:00
- Next Steps
 - Today-March 20th: Written public comment period. *Please consider submitting written comments on behalf of your organizations.*
 - April 10th: Advisory Committee meeting to conduct public listening session and revise recommendations as needed. *Please have reviewed public comments and come prepared to discuss.*
 - April-May: Development of final recommendation for the Governor's consideration.



Appendix

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.