maryland health services cost review commission

All-Payer Total Cost of Care Target Technical Advisory Committee

AHEAD Model

Meeting #4

April 17, 2026

Agenda

- Welcome and Overview
- Summary of Comments and Listening Session
- Considerations for Setting Total Cost of Care Spending Growth Targets
- Discussion: Recommendations for Methodology Selection
- Next Steps

Welcome and Overview

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	Date(s)
Advisory Group Meeting #1: Advisory Committee Introduction and Review of Charge	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	April 10, 2026
Advisory Group Meeting #4: Discussion on Recommendations	April 17, 2026
Advisory Committee review of draft CY 2027-2031 targets	May 8-22, 2026
Written public comment period of draft CY 2027-2031 targets	June 3-17, 2026
Submit draft CY 2027-2030 targets to the Governor*	July 15, 2026
Submit final CY 2027-2030 targets to the Governor and CMMI	September 2026

* Subject to anticipated approval of extension request.

Summary of Comments and Listening Session

Summary of Comments—Data Parameters

- Medicaid Developmental Disability and Home- and Community-Based Services
  - Commenters were largely supportive of excluding these services.
  - Certain commenters suggested they should be considered but proposed tracking them separately.
- Pharmacy
  - Commenters were split on including drug costs, such as Part D.
  - One commenter agreed to track rebates separately, at least initially.
- Self-Pay
  - Commenters noted the importance of some form of measuring and/or monitoring self-pay.
  - Suggestions included modeling self-pay using hospital case-mix data and including data from federally-qualified health centers, community health centers and free clinic networks.
- ERISA and FEHBP
  - Commenters expressed a need for precise modeling, in the case that completion factors need to be applied.
  - Commenters were also supportive of working toward leveraging Electronic Health Network data.

Summary of Comments—Other

- Baseline and Frequency of Test
  - Two commenters spoke to baseline, with one supporting CY 2023 and the other a blend of CYs 2023-2024.
  - Commenters were split between annual and cumulative targets.
  - This area received particular attention during the listening session, with discussion around actionability and sensitivity to exogenous factors.
- Counterfactual Options
  - Commenters were split on counterfactual options, with most favoring at least a blend of one of the affordability metrics (*i.e.,* household income or wage growth) and gross state product (GSP).
  - Certain commenters strongly suggested a single metric, *e.g.,* household income-only, GSP-only or a health-specific trend.
  - Two commenters wrote in support of a projected target, vs. actual or historical.
- Reporting and Monitoring
  - Commenters overwhelmingly supported parallel monitoring mechanisms, with many encouraging an affordability standard.
  - Commenters proposed a variety of metrics across affordability and access.

Considerations for Setting Total Cost of Care Spending Growth Targets

The following slides were developed by Bailit Health in April 2026 and shared with permission.

Use of Economic Indicators

- States have considered economic indicators when setting their targets. Why?
  - They provide an objective basis for the target values.
  - There is state precedence for using economic indicators.
- States have reviewed a range of indicators and considered the following questions:

What does the indicator measure and is that relevant to the goals?

What is the state signaling if it ties future health care spending growth to a particular indicator *(e.g., health care spending should not grow faster than the economy or what families and individuals can afford)*?

- States have also simultaneously considered historical state spending growth by market (commercial, Medicaid, Medicare).

Economic Indices Typically Considered by States

1. Gross State Product (GSP)
2. Potential Gross State Product (PGSP)
3. Median household income of state residents
4. Average wage of state workers
5. Inflation as measured by the Consumer Price Index (CPI-U)

Other States' Target Values and Methodologies (1 of 3)

- Between 2018 and 2022, states established target values ranging from 2.9 percent to 3.8 percent.
  - Target values were roughly 2 percentage points less than the average annual state health care spending growth over the prior decade in each state.
  - CT and RI made subsequent time-limited adjustments to account for the lagged impact of the post-pandemic inflation spike.
- All states have tied their targets to some measure of the economy, including state economic growth and/or indicators of resident income growth.
  - States have tied their values to a single economic indicator or a combination of indicators.

Other States' Target Values and Methodologies (2 of 3)

State	Benchmark Methodology	Benchmark Value
California	Average annual rate of change in historical median household income from 2002-2022. Add-on factors: +0.5% for CY 2025-2026, +0.2% for CY 2027-2028, +0.0% for CY 2029	3.5% for 2025-2026 3.2% for 2027-2028 3.0% for 2029
Connecticut	80/20 blend of forecasted median wage and PGSP for CY 2025 Projected 2026-2030 median household income for CY 2026-2030	2.9% for 2025 2.8% for 2026-2030
Delaware	PGSP through 2023, with possible adjustment if the CBO's forecasted inflation rate has changed enough to warrant an update to the benchmark. For 2026, PGSP with the inflation element adjusted to account for the 3-year projected annual rate of growth in national Personal Health Expenditures	4.9% for 2026
Massachusetts	2023 and beyond: default rate of PGSP, per statute	3.6% for 2025-2026

Other States' Target Values and Methodologies (3 of 3)

State	Benchmark Methodology	Benchmark Value
New Jersey	75/25 blend of median projected household income and PGSP, with a downward adjustment starting in 2025	3.0% for 2025 2.8% for 2026-2027
Oregon	50/50 blend of the 5-year historic average annual growth in Oregon's median wage and the 5-year historic average annual growth in regional inflation (as measured by the Consumer Price Index – West), minus one percentage point to bend the cost curve.	3.4% for 2025 3.75% for 2026-2028
Rhode Island	75/25 blend of PGSP and forecasted median household income growth for 2023-2027. *Accounted for the lagged impact of inflation on health care costs by adjusting the PGSP inflation input with inflation experience on a two-year lagged basis for 2023-2025.*	3.6% for 2025 3.3% for 2026-2027
Washington	70/30 blend of historical median wage and PGSP, with a downward adjustment.	3.0% for 2025 2.8% for 2026

Discussion: Recommendations for Methodology Selection

Principles for Discussion: Lessons 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.

Recommended Populations by Coverage Type

- Commercial Claims (other than ERISA and FEHBP)
  Source: Maryland Medical Care Data Base (MCDB)
- Commercial Claims (ERISA and FEHBP):
  Source: Estimated based on commercial claims; potentially Electronic Health Network data in the future
- Medicare Fee-for-Service (FFS)
  Source: CMS data
- Medicare Advantage
  Source: MCDB
- Medicaid
  Source: Medicaid (Hilltop Institute)
- Self-Pay, *i.e.,* Uninsured
  Will be addressed in a standalone discussion

Medicaid Sub-Populations

- Managed Care Participants: Include member months and costs for services provided both through managed care organizations (MCOs) and on a FFS basis
- Non-Dual FFS Participants: Include member months and costs
- Full Duals: Include costs for Medicaid services only; exclude member months (already counted under Medicare)
- Partial Duals: Exclude both member months and costs (already counted under Medicare)

Recommended Inclusions by Service/Payment Type

- Non-Claims-Based Payments

  Will be reported in period in which they are paid.

- Pharmacy

  Will be included in the targets; reporting will also display trend excluding pharmacy.

- Pharmacy Rebates

  Will be addressed in a standalone discussion.

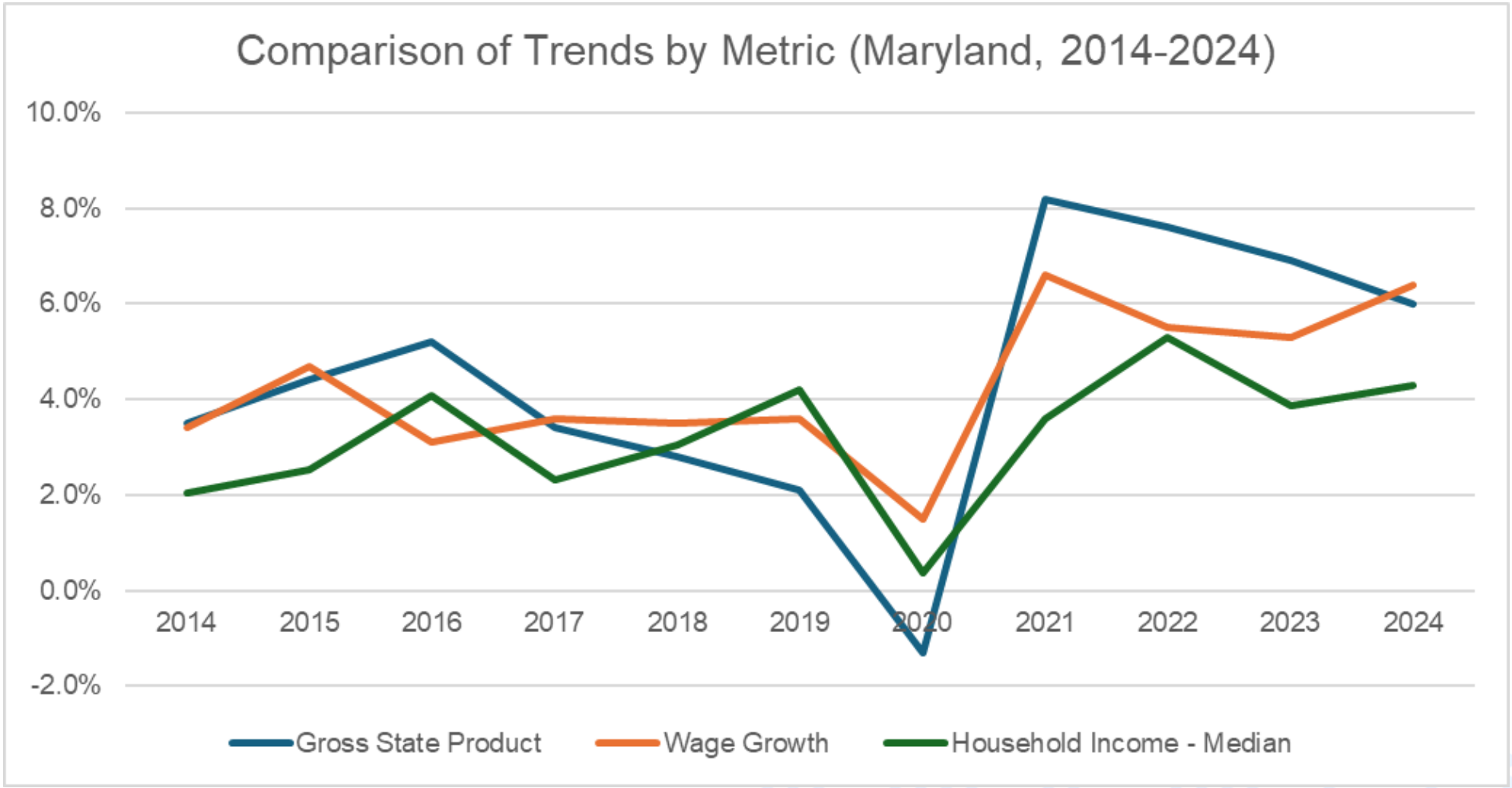
Recommended Exclusions by Payment/Service Type

- Dental Plans
  Not uniformly covered by all payers.
- Worker's Compensation and Other Non-Health Insurance Coverage
  Relatively small; difficult to quantify.
- Payments Already Included from Other Sources
  Analysis uses allowed costs.
  - Crossover Claims from Duals Medicaid Analysis
  - Medicare Supplemental, *i.e.,* Medigap
  - Third-Party Coverage
- Medicaid Specialty Services
  Not traditional health care services; already subject to budget neutrality test.
  - Developmental Disabilities Services
  - Adult Medical Day Care
  - Home- and Community-Based Services

Counterfactual Considerations

- As described above, most states use an economic indicator.
  - Goal is to tie cost growth to a broader measure of the economy/affordability.
  - Using health care metric is self-referential—higher growth rates of health care spending (vs. an economic indicator) run counter to consumer affordability.
- There are various considerations in selecting an economic indicator.
  - Median income or wage growth ties more closely to individual experience.
  - GSP may better reflect the experience of employers who pay the biggest share of commercial insurance costs.
- The indicator can reflect historic or predicted values.
  - Predicted values may better reflect future direction but are subject to prediction error and would need a source of Maryland predicted values.
  - Historic values are not subject to prediction biases.

Counterfactual Options: Comparison of Trends



Recommended Counterfactual Structure for Discussion

Growth Benchmark

- Target will comprise of a blend of Median Household Income and Gross State Product.
- Target will be derived from a specific previous period, *e.g.,* 2023 to 2025.
- A longer window is preferable but may not be feasible post-pandemic.

Baseline Period

- The baseline for performance will be a single year.

Reset

- Cumulatively three-year performance periods and then every three years.
- Rebase to most recent available baseline year.
- Reset target based on more recent window for selected growth benchmark, using a five-year window.

Example Target

1. State calculates three-year growth trend (CY 2023 – CY 2025) using median household income and gross state product, weighted equally.
2. State defines the baseline year as CY 2026.
   A. For first report, *i.e.,* of CY 2027 performance, the growth target will be set at CY 2026 * (1 + trend from Step 1)
   B. For second report, i.e., of CY 2028 performance, the growth target will be set at CY 2026 * (1 + trend from step 1) * (1+ trend from step 1)
   C. For third report, i.e., of CY2029 performance, the growth target will be set at CY 2026 * (1 + trend from step) * (1+ trend from step 1)* (1+ trend from step 1)
3. Baseline resets to 2029 and growth target is calculated based on CY 2024 – CY 2028 economic indicators.
   A. For fourth report, *i.e.,* of CY 2030 performance, the growth target will be set at CY 2029 * (1 + trend from step 3)

Reporting and Monitoring

- Compliance with the total cost of care growth target will be calculated and reported independently.
- Measures of access and other priorities, *i.e.,* from other sources, will be identified and referenced in the reporting of the target to CMMI.
- The Regulatory Working Group will work with stakeholders to identify measures that will inform quality, access and affordability.

Next Steps

Next Steps and Timeframe*

- Advisory Committee Comment Period: May 8-22, 2026
- Public Comment Period: June 3-17, 2026
- Draft Recommendation Submitted to Governor: July 15, 2026
- Final Recommendation Submitted to Governor and CMMI: September 2026

** Anticipated timeline; subject to change.*