



Regulatory Working Group: All-Payer Total Cost of Care Growth Targets

Compiled Stakeholder Comments

September 2026

The policy recommendation can be found at <https://hsrc.maryland.gov/Pages/ahead-model.aspx>

Advisory Committee Review

May 2026

These comments respond to key methodological considerations raised during the advisory process and are intended to support the development of a stable, interpretable, and policy-relevant total cost of care benchmark. Below is a set of considerations with rationales.

What benchmark should we compare to?

Differences between GSP, wage growth, and median household income appear relatively small (based on data provided by HSCRC), on the order of one to two percentage points over time. That suggests the choice of anchor may matter more for signaling and volatility than for dramatically changing the benchmark level. GSP appears somewhat more volatile, median household income more stable, and wages somewhere in between. If stability and predictability are priorities, wage growth may offer a reasonable middle ground, conceptually tied to affordability but less volatile than GSP. If the differences are modest, the case for a blended approach may be more about durability and optics than materially changing the growth rate. I would recommend anchoring the benchmark primarily to wage growth, potentially with modest smoothing. Wage growth aligns closely with how health care is financed through employer-sponsored insurance and public revenues tied to labor income, while being less volatile than GSP and more conceptually precise than median household income. Also, someone raised the point about employers covering most of the health care costs among the employer-sponsored insured population. But even when employers pay premiums, those costs are part of total compensation over time. That's why wage growth still matters as an anchor. That said, because health care is financed through pooled employer and public budgets, a blended wage and GSP benchmark may better reflect the full financing structure. Given that the empirical differences across the measures are relatively small, though, the choice is more about stability and signal than about materially changing the target level. A wage-based anchor provides a clear affordability connection while maintaining predictability and durability. I also think a wage-based anchor signals the state cares more about affordability.

What is the best way to estimate self-pay spending?

Because the model is framed as an all-payer total cost of care, excluding self-pay entirely creates a conceptual gap, even if the magnitude is relatively small. More importantly, if the uninsured share changes over time (especially given recent changes to subsidies in the ACA marketplace), failing to account for self-pay could introduce artificial shifts in spending between payer categories that don't reflect real changes in system cost growth. But it should be proportionate. Self-pay is unlikely to drive overall trend, so the goal is not perfect precision it's some level of completeness and stability. I would recommend anchoring the estimate to something real and Maryland-specific. The most defensible starting point might be hospital self-pay using Maryland's all-payer hospital data. Hospital self-pay is likely the largest share of uninsured spending, the data are more complete, and you're not relying on survey estimates which introduce sampling error. From there, we could model the non-hospital component using a fixed, documented ratio. For example, if hospital accounts for about two-thirds of uninsured spending, total self-pay would be about 1.5 times hospital self-pay. The state could calibrate that share once using MEPS or another benchmark and keep it constant over time. It could also be recalculated periodically if there is drift concern. The state could use the MEPS, for example, to help calibrate the relative distribution of hospital versus non-hospital uninsured spending, but I would not rely on survey data as the primary estimator. The modeling approach needs to be stable over time. If we label it explicitly as a modeled component and apply the same methodology year after year, it should preserve the integrity of the "all-payer" construct without overcomplicating the benchmark. A key consideration raised in discussion is that coverage transitions (e.g., moving from self-pay to insured

status) can otherwise appear as artificial spending growth, reinforcing the importance of including a modeled self-pay component.

What is the best way to approach ERISA and FEHBP spending?

Given that ERISA and FEHBP are now going to be included, the key issue becomes methodological stability. Using commercial allowed-cost data as a proxy preserves consistency with the broader benchmark. The critical technical vulnerability is enrollment estimation. If member months are misestimated, per capita spending will be biased regardless of how accurate the PMPM proxy is. For that reason, the enrollment methodology should be documented and perhaps stress-tested. In the short term, treating ERISA and FEHBP as modeled components with transparent assumptions is appropriate. Over time, the state should transition to direct measurement as EHN data mature.

Are there concerns with the proposed baseline year and approach to data run-out?

Starting with the baseline year, it effectively sets the anchor for everything that follows. If the baseline is unusually high or low, it will influence whether future growth appears reasonable or excessive. So, this could introduce reliability issues in the measurement. A single year, like 2023, can also be noisy (since AHEAD Medicare baseline year is 2023), especially in a period still influenced by post-COVID utilization shifts. A two-year average, like 2023–2024 once the data are mature, would smooth the noise and provide a more stable anchor. What I would avoid is frequent rebasing. If the baseline moves too often, it can look like the goalposts are shifting. The state should pick a prespecified rebasing schedule (maybe every 5 years). It sounds like the group is leaning towards resetting the baseline each year following the approach of other states. This seems like a very impactful methods choice. If the baseline is reset every year, the benchmark becomes a rolling annual growth cap rather than a cumulative cost containment trajectory. Annual rebasing increases flexibility and allows adjustment for data revisions or structural shifts, but it also weakens long-term accountability because any overspending becomes embedded in the new baseline. Less frequent, pre-specified rebasing preserves credibility and compounding discipline while still allowing adjustment when necessary. The trade-off is flexibility versus durability: annual rebasing is more adaptive, but scheduled rebasing better sustains long-term cost containment pressure.

On run-out, the concern is comparability. Since claims take time to be submitted and processed, if one payer is measured with only a few months of run-out and another is measured with a full year, the spending totals are not equally complete. That can create artificial differences in measured growth that reflect data timing rather than real cost changes. For that reason, I would suggest using a standardized data freeze date across payers and applying completion factors to adjust for incomplete claims, rather than maintaining different run-out periods by payer.

How should the analysis approach costs for Medicaid developmental disability services, long-term services and supports (LTSS), and home- and community-based services (HCBS)?

It sounds like the group is leaning toward not including these services. However, these services are big in dollar terms and seem structurally different from acute medical care. I would suggest including them in total cost of care to preserve the integrity of the total cost construct but perhaps segmenting them in reporting. Also, if spending in these programs grows, it's important to know whether that's because we're serving more people or because the cost per person increases. Those are different drivers, and they should be interpreted differently. That preserves completeness while improving interpretability and avoiding mischaracterization of policy-driven expansions as system inefficiency.

Is the list of exclusions due to allowed costs comprehensive, or are there other considerations to take into account?

On the exclusions (cross over claims for duals, medigap, and third-party coverage), I think the starting point is that the benchmark is built on an allowed-cost framework, so the exclusions should follow logically from that construct. Those exclusions make sense. If the Medicare allowed amount is already counted once, including Medicaid crossover payments or Medigap contributions would result in double counting. The same logic applies to other third-party payments. The goal is to count each service once at the allowed amount, not once per payer involved. Where I think additional clarity would be helpful is around areas that are less straightforward but potentially material. For example, how will non-claims-based payments be handled? If the framework includes capitation, directed payments, or other supplemental payments, those need to be treated consistently across payers. Similarly, pharmacy measurement might be an important consideration, particularly whether the benchmark reflects gross spending or net spending after rebates. Differences there seem like they could meaningfully affect total spending levels and growth rates. I don't think the current list of exclusions is conceptually wrong. I would emphasize the importance of clearly documenting all inclusion and exclusion rules, especially for non-claims payments, capitation arrangements, and pharmacy, so that the allowed-cost construct is applied consistently and defensibly across the entire benchmark.

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Department of Health Policy & Management
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Kimberly Y. Robinson
Vice President, State Government Affairs



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VIA ELECTRONIC TRANSMISSION

March 20, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Executive Director Kromm:

CareFirst Blue Cross Blue Shield appreciates the opportunity to comment on the AHEAD Model all-payer total cost of care growth target development. We strongly support the state's efforts to limit the growth rate in healthcare costs. Health care affordability remains one of the most pressing challenges facing consumers today. Premiums, out-of-pocket costs, and overall household spending on healthcare have grown at rates that consistently outpace wage growth and broader economic expansion. This dynamic places increasing financial strain on individuals and families, forcing difficult trade-offs between health care and other essential needs such as housing, food, and education.

As the committee develops the target and underlying methodology, we encourage the following principles:

1. **The growth rate of healthcare costs should be limited to the growth rate in gross state product (GSP).** This will ensure that healthcare – already too expensive for many Marylanders – will not become an ever-increasing share of household budgets.
2. **The test should be applied on an annual basis.** Maryland's All-Payer Model and Total Cost of Care Model had cumulative tests, meaning the growth rate in hospital costs could not exceed the cumulative growth in GSP since 2013. However, the use of a 2013 baseline does not reflect the current structure of the health care system or more recent policy and market changes. Over the past decade, the industry has undergone significant transformation, including shifts in care delivery models, pricing dynamics, and regulatory requirements. Holding entities accountable to a growth trajectory tied to conditions from more than a decade ago risks creating misalignment with today's realities and may not accurately capture current performance or improvement efforts. As such, the State and the Centers for Medicare and Medicaid Services (CMS) have recognized that the 2013 baseline is outdated and updated the Medicare savings targets. The State should do the same for consumers and employers in Marylanders, not just the Medicare trust fund.

3. **The Health Services Cost Review Commission (HSCRC) should adopt the annual GSP target as a limit on the annual update factor** and formalize it in regulation or statute. HSCRC has historically adopted informal affordability tests, only for those tests to be waived or changed when challenged. This creates the impression that HSCRC does not prioritize affordability. The AHEAD Model needs fair rules to ensure that healthcare costs remain affordable, and Marylanders must have confidence that those rules will actually be followed.

We appreciate the opportunity to comment on this topic and encourage a continued focus on affordability. Across its various iterations, the Maryland Model has delivered high quality care at a lower cost than would be paid without the Model. This was due in large part to annual Medicare guardrails that kept Maryland accountable for regular, not cumulative savings. The AHEAD Model should continue that tradition and set a clear, fair, and enforceable savings test to ensure that hospital costs grow no faster than the overall economy.

Sincerely,

A handwritten signature in blue ink, appearing to read "Kimberly Robinson", with a stylized flourish at the end.

Kimberly Y. Robinson



Central Maryland Chamber
Conduit of Commerce

March 17, 2026

Dr. Jon Kromm
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dr. Kromm and Members of the Total Cost of Care Target Technical Advisory Committee,

We appreciate the opportunity to offer comment on the topics you have discussed over your first two meetings. We are especially interested in the discussion of the economic metrics you refer to as counterfactuals, for use as points of reference for the State of Maryland's decision making on global budgets.

As a consumer advocate, the Health Means Everything Consumer Alliance (HME) is particularly sensitive that growth in hospital budgets may correspond to growth in the costs that are passed onto consumers, creating potential burdens both for individuals and employers despite already strong indicators their ability to absorb additional cost is at a breaking point.

A poll conducted for HME by OpinionWorks in January of this year ([linked here](#)) returned alarming data on this front. The poll of Marylanders showed:

- 70% experienced increased healthcare costs over the last 2-years
- 31% have delayed or skipped medically necessary care because of cost
- 23% carry medical debt

Importantly, the poll showed strong support for the Health Services Cost Review Commission's (HSCRC) role in regulating healthcare cost increases:

- 76% supported capping prices
- 69% believed the state has a responsibility to intervene on prices

This being the healthcare environment in Maryland, HME feels strongly that the Advisory Committee conversation surrounding counterfactuals is a key opportunity to limit growth in hospital budgets and related costs borne by Maryland consumers.

Counterfactuals Under Consideration

Of the options under consideration for counterfactuals, HME believes Household Income is the strongest variable.

Both Household Income and Wage Growth are far superior measures to Gross State Product, but the greater timeliness in reporting for Household Income also seems to offer improved usability over Wage Growth.

The greater timeliness in reporting for Household Income dovetails with HME's other core recommendation for counterfactuals: **HME supports an annual test rather than multiyear test** for growth.

Though multiyear tests may be the norm in Maryland, precedent indicates that savings in the early years of a multiyear timeline may be "banked" as success towards the multiyear target, effectively serving as a pressure release that takes potential savings in subsequent years off the table. In practice, this may insulate consumers from experiencing the full potential of cost savings from effective planning by the state.

HME is **strongly opposed to the use of Gross State Product as a metric by itself, or as a combined metric with Household Income**, where it may be used to functionally "water down" the cost control potential of Household Income as a counterfactual.

It is well trod ground that economic indicators like Gross State Product function in much the same way as benchmarks like stock market growth, in that they may represent economic activity or assessed increases in value that correspond to little or no material change for the average household's financial growth. This is, of course, because metrics like Gross State Product are easily distorted by the impact of a relative few large economic actors that may internalize the perceived benefits of their activity.

Additional Items for Consideration

Beyond the use of counterfactuals in its goal setting, the HSCRC and Advisory Committee can consider frameworks for robust, public-facing reporting on healthcare costs and their impact on Maryland households.

[Massachusetts offers a worthwhile proof of concept](#) in its assessment of healthcare as a share of household income and ability to meet basic needs as benchmarks for affordability. The state also routinely discusses the primary drivers behind the lack of affordability.

Similar value may be found in considering Household Financial Stress Indicators. These Indicators could provide insight into healthcare affordability by capturing broader economic pressures faced by households than income alone. Metrics could include debt to income ratios, medical debt burden, savings rates, or the general share of income remaining after essential non-health expenses.

Connecticut has operationalized a concept akin to this through the Connecticut Healthcare Affordability Index, which evaluates whether households can meet basic needs after paying total healthcare costs.

As always, we encourage you to keep consumer costs at the core of your decision making on these important questions of policy, as cost ultimately remains the ultimate factor in Marylanders' ability to access care.

We appreciate your thoughtful approach to these issue, and are happy to provide further input should it be of use in your deliberations.

Thank you for your consideration,

Dewan Clayborn,
Central Maryland Chamber of Commerce



March 20, 2026

Dr. Jon Kromm
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

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As always, we encourage you to keep consumer costs at the core of your decision making on these important questions of policy, as cost ultimately remains the ultimate factor in Marylanders' ability to access care.

We appreciate your thoughtful approach to these issue, and are happy to provide further input should it be of use in your deliberations.

Thank you for your consideration,

Marceline White
Executive Director, Economic Action Maryland

Ashiah Parker
Chair, Health Means Everything Consumer Alliance



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
4000 Garden City Drive
Hyattsville, Maryland 20785

March 19, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Comments on the AHEAD Growth Target Methodology

Dear Dr. Kromm:

Kaiser Permanente appreciates the opportunity to provide feedback on the development of the growth target methodology under the AHEAD Model. As a member of the Technical Advisory Committee, we value the collaborative process established to ensure Maryland's healthcare spending remains sustainable while maintaining high-quality access for our members.

Following the Technical Advisory Committee meeting on February 23, 2026, we offer the following reactions to the proposed data parameters and counterfactual options:

Data Parameters and Sources

- **Baseline Year:** We support the staff recommendation of Calendar Year (CY) 2023 as the first reliable baseline year. While alignment with the Medicare FFS TCOC baseline has merits, prioritizing the most recent and reliable data for all-payer modeling is preferable for accuracy.
- **Pharmacy Rebates:** We agree with the recommendation to exclude pharmacy rebates for the initial reporting period. Given the inconsistent reporting across payers and the lack of rebate data for Medicare FFS, reporting spending gross of rebates provides a more consistent and transparent starting point.
- **Inclusion of ERISA and FEHBP:** We recognize the challenge of including ERISA and FEHBP data, which are currently estimated based on commercial claims. We encourage the State to continue exploring the use of Electronic Health Network data to improve the precision of these estimates in the future.
- **Medicaid Populations:** We support the inclusion of managed care participants and non-dual FFS participants. Regarding Developmental Disabilities Services and Adult Medical Day Care, we urge the Commission to carefully consider the unintended consequences of including these high-cost, specialty services, as they may skew growth targets in ways that do not reflect standard medical cost trends.

Counterfactual Options for Growth Targets

- **Benchmark Selection:** Kaiser Permanente leans toward a Gross State Product (GSP) or a Household Income benchmark. While GSP is timely and aligns healthcare growth with the broader economy, Household Income more closely reflects consumer affordability and the purchasing power of Maryland families. A blended approach may offer the most balanced signal.
- **Growth Trend Mechanic:** We support a projected growth trend rather than an actual or fixed historical average. Using a projection methodology allows the target to be more responsive to anticipated economic shifts, even if it requires periodic reconciliation against actual data.
- **Target Structure:** We recommend annual targets over cumulative ones. Annual targets are more actionable for payers and providers and align with how businesses and consumers experience cost changes year-over-year.

Monitoring Access and Quality

As the State moves toward these accountability targets, it is imperative to monitor for any adverse impacts on care delivery. We recommend that the HSCRC adopt metrics similar to those used in other states, such as:

- **Utilization:** Tracking avoidable emergency department use and service mix shifts.
- **Network Adequacy:** Monitoring provider supply to ensure that cost-containment efforts do not inadvertently limit member access.

We look forward to participating in the upcoming public listening session on April 10th and continuing our work with the Advisory Committee to finalize these recommendations. Please feel free to contact me at Allison.W.Taylor@kp.org or (919) 818-3285 with questions.

Sincerely,



Allison Taylor
Head of Government Relations
Kaiser Permanente Mid-Atlantic Region



March 20, 2026

Jonathan Kromm, Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: MDH.Maryland-Model@maryland.gov

Dear Mr. Kromm,

Thank you for the opportunity to comment on the All-Payer Total Cost of Care Target. [Maryland Citizens' Health Initiative](#) (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders. MCHI oversees the Health Care for All Coalition which is comprised of hundreds of faith, business, labor, community, and health care organizations across Maryland.

Under Maryland's all-payer hospital system, consumers have benefitted from the Health Services Cost Review Commission (HSCRC) working to balance consumers' health care costs, access to hospitals and clinicians, and quality of health care. As Maryland shifts to the AHEAD Model, it will be important to continue to achieve a balance of health care cost, quality, and access.

Medicaid Services

We urge you to exclude specific Medicaid services (developmental disabilities, adult medical day care, and home- and community-based services) from the target. The Marylanders who benefit from them arguably could receive more resources and still have unmet needs. For example, the developmental disabilities community has made clear that this year's proposed Medicaid budget cuts to Maryland Developmental Disabilities Administration will be harmful. Furthermore, these specific Medicaid services are already highly managed. The HSCRC has the technical expertise and data access required to exclude these targets from the target and we urge you to do so.

Prescription Drugs

We urge that high-cost prescription drugs be included in the target. High drug costs are a major part of health care spending and the target would not be complete if Maryland were to exclude them. Thankfully Maryland has the expertise to overcome data collection and analysis challenges. HSCRC should consult with Maryland's Prescription Drug Affordability Board (PDAB) on how to supplement Maryland's All Claims Database with other data sources. The PDAB has the authority to set upper payment limits on high-cost drugs for all Marylanders, which will help the State meet the target.



TCOC Growth Target Include Consumer-Focused Metrics

We support HSCRC creating a target which includes consumer-focused metrics such as median household income. Gross State Product (GSP) targets track the economy's overall growth, but a target based on median household income better reflects the financial realities—and spending power—of individuals and families. Therefore, we urge the state to include median household income in its growth target, potentially blending GSP and median household income together as did California and New Jersey for their targets.

Affordability Standard

We encourage the HSCRC to develop a consumer “affordability standard” to be monitored in parallel with the target. This metric, [long used by many peer states](#), will help us to better understand and monitor how affordable health care is for Marylanders. Notably, the [Connecticut Healthcare Affordability Index \(CHAI\)](#) measures the impact of health care costs, including premiums and out-of-pocket expenses, on a household’s ability to afford all basic needs, like housing, transportation, childcare, and groceries. The CHAI is used to establish and adjust Connecticut’s health care spending target, one of many state models that can be used to inform the development of Maryland’s own targets.

Affordability standards can help understand how people are experiencing health care affordability challenges and what role different sectors of the health care system play in driving those experiences. But, importantly, policy actions, like those taken through the implementation of the AHEAD Model, are necessary in ensuring that these standards are achieved and maintained. Controlling the underlying cost of care is inextricably linked to making sure that care is affordable; even with universal coverage and fairly designed subsidies and cost-sharing, ever-rising costs will erode wages and crowd out spending on other important goods and services. As such, the affordability standard should be leveraged to monitor and adjust efforts to rein in health care spending, such as in health insurance rate review and hospital global budget development.

We appreciate all you do to expand access to quality, affordable health care for all Marylanders. Thank you for the opportunity to provide comments on the All-Payer Total Cost of Care Growth Target, and please do not hesitate to reach out if you have any questions.

Sincerely,

Stephanie Klapper, Deputy Director
Catherine Kirk Robins, Deputy Director

Suzanne Schlattman, Deputy Director
Vincent DeMarco, President



Introduction

The Maryland Academy of Family Physicians (MDAFP) appreciates the opportunity to comment on the All-Payer Total Cost of Care (TCOC) target-setting methodology presented at the February 23, 2026 Advisory Committee meeting. MDAFP represents Maryland's family physicians, the state's largest primary care specialty society. Our nearly 1400 members provide first-contact, comprehensive, and continuous care to Marylanders across every region, with particular presence in rural, underserved, and Medicaid-dependent communities.

Our comments focus exclusively on issues that directly affect primary care measurement, investment, and accountability within the TCOC and AHEAD framework. We do not address the broader TCOC growth target methodology where primary care considerations are not at stake. We submit these comments in the spirit of ensuring that the Primary Care Investment (PCI) target, the parallel accountability requirement led by MHCC, is built on a foundation that accurately reflects what is being invested in primary care, rewards practices that deliver high-value primary care, and produces a target ambitious enough to meaningfully strengthen Maryland's primary care infrastructure.

The American Academy of Family Physicians (AAFP) documents that primary care spending in the United States is approximately 5-8% of total health expenditures across all payers, compared to roughly 14% in most other high-income nations. Maryland's commercial data show spending at 8.0-8.5% of Total Medical Expenditures (TME), above the national average but well below the 12-14% of TME that AAFP identifies as necessary to reduce downstream costs and improve population health. The 2025 Milbank Memorial Fund Primary Care Scorecard confirmed a nationwide decline in primary care investment in 2022, with spending falling below 5% of TME across all payers. Maryland's target must move the needle meaningfully.

MDAFP commends the Advisory group's thorough presentation of data parameters. The proposed inclusions (Medicaid FFS and MCO claims, commercial claims via MCDB, Medicare FFS, Medicare Advantage, and pharmacy) represent a comprehensive foundation. We offer the following observations to strengthen the framework.

I. Data Parameters: What Is and Is Not Being Counted as Primary Care Investment

A. Non-Claims-Based Payments Are the Most Important Missing Element

For the Primary Care Investment target, the most consequential data gap is not a demographic exclusion, it is the systematic omission of non-claims-based payments that constitute a large and growing share of actual primary care investment in Maryland. The current Maryland Claims Data Base (MCDB) framework captures traditional fee-for-service claims well, but misses the payment streams that represent Maryland's most deliberate investments in primary care transformation:

- Maryland Primary Care Program (MDPCP) prospective per-beneficiary-per-month (PBPM) care management fees paid by CMS to participating practices. The 2024 MHCC Primary Care Investment Analysis Report explicitly acknowledged that MDPCP Medicare FFS APM payments are not included in the MCDB. This means that the state's flagship primary care investment program, the centerpiece of the TCOC Model's primary care strategy, is currently invisible in the PCI baseline measurement.

- AHEAD Model prospective care management payments, which will be the primary mechanism for primary care investment under the new model beginning in 2026.
- Commercial and Medicaid MCO value-based payments to primary care practices: quality bonuses, shared savings distributions, care coordination fees, patient-centered medical home (PCMH) supplemental payments, and behavioral health integration add-on payments. These vary significantly across payers and are not uniformly captured in the MCDB.
- Practice transformation grants and supplemental funding provided through state programs, hospital Care Redesign Program partnerships, and federal programs such as HRSA Health Center Fund payments to FQHCs.

If these payment streams are excluded from the PCI numerator, Maryland will systematically undercount primary care investment and set a baseline that makes the investment gap appear smaller than it actually is, while simultaneously making future investment growth appear larger than it is when these streams are eventually added. This would undermine the integrity of the entire target-setting framework.

MDAFP strongly recommends:

- Explicit inclusion of MDPCP PBPM payments and all AHEAD care management payments in the PCI numerator from the outset of baseline measurement, using CMS data for Medicare FFS and direct payer reporting for commercial and Medicaid MCO equivalents.
- Adoption of a standardized non-claims payment reporting template, consistent with the Expanded Non-Claims Payment Framework that MHCC adopted in 2025 and aligned with NAHDO standards, that all regulated payers submit to MHCC annually as a condition of operating in Maryland.
- Clear definitional guidance specifying which non-claims payment categories count toward the PCI numerator (e.g., care management fees, behavioral health integration payments, PCMH supplemental payments) and which do not, with public documentation of all categorization decisions so that practices and payers can plan accordingly.

B. Completion Factors Must Account for APM Payment Timing

The Advisory Committee's plan to develop completion factors to standardize disparate run-out periods is appropriate for claims data. However, APM and non-claims-based payments operate on entirely different reporting timelines than claims. They are typically paid prospectively or on a quarterly reconciliation cycle, not billed and adjudicated like individual service claims.

MDAFP recommends that the completion factor methodology address APM payment timing explicitly:

- MDPCP PBPM payments are made prospectively by CMS on a monthly basis. These should not require a run-out completion factor in the same way claims do, but reporting lags in how they flow into state data systems must be accounted for.
- Quality incentive and shared savings payments are typically reconciled annually, often six to twelve months after the performance year ends. A specific completion factor or accrual methodology is needed to attribute these payments to the correct performance year.
- MDAFP recommends that MHCC convene a technical workgroup, including MDPCP practice representatives, Medicaid MCOs, and commercial payers, specifically to develop APM payment timing standards before the PCI baseline is finalized.

C. The MCDB Exclusion of ERISA Plans Understates Primary Care Investment for Working Marylanders

ERISA self-insured employer plans cover a substantial share of Maryland's commercially-insured working-age population, and Maryland's proximity to the federal government means FEHBP enrollees represent an

unusually large segment of the insured population statewide. From a primary care perspective, this exclusion matters for two specific reasons:

- Working-age adults enrolled in ERISA plans are among the highest utilizers of primary care for preventive services, chronic disease management, and annual wellness visits. Their exclusion from the denominator understates total primary care need and total primary care spending.
- Many independent and small-group family medicine practices have patient panels that are heavily weighted toward commercial and ERISA-insured patients. A PCI measurement framework that misses ERISA spending will systematically undercount the investment flowing through these practices.

MDAFP supports the plan to estimate ERISA and FEHBP spending based on commercial claims as an interim step, but urges the Council to treat this as a time-limited bridge with a committed timeline for direct data capture, whether through the Electronic Health Network (EHN), voluntary payer reporting agreements, or OPM data partnerships for FEHBP.

D. FQHCs and Safety-Net Primary Care Must Be Fully Represented

The proposal to model self-pay and uninsured spending from all-payer hospital data will significantly underrepresent primary care for uninsured and low-income Marylanders. Uninsured and Medicaid patients disproportionately access primary care through Federally Qualified Health Centers (FQHCs), free clinics, and sliding-scale practices, settings whose encounters do not appear in hospital-based claims data.

MDAFP recommends supplementing hospital-based extrapolation for the self-pay/uninsured population with:

- HRSA Uniform Data System (UDS) data for Maryland FQHCs, which captures patient visits, payer mix, and encounter costs annually and is publicly available at the facility level.
- Data from the Maryland Association of Community Health Centers (MACHC) and from free clinic networks, to capture uncompensated and sliding-scale primary care encounters that do not generate claims.

Without this supplement, the PCI baseline will undercount investment in the primary care settings serving Maryland's most vulnerable patients, the very populations that AHEAD's equity goals are designed to reach.

II. Counterfactual Benchmark: What It Should Mean for Primary Care

A. The Counterfactual Must Not Constrain Necessary Primary Care Investment Growth

MDAFP's most important concern about the counterfactual structure is this: for the overall TCOC growth target, the counterfactual is designed to constrain spending growth. For the Primary Care Investment target, the opposite logic applies. Investment must grow faster than the economy, not merely in line with it, to close the existing gap between Maryland's current primary care investment level and the level required to support the AHEAD Model's goals.

Tying the PCI target to GSP, household income, or wage growth as a ceiling, rather than a floor, would lock Maryland into the status quo rather than driving the transformation AHEAD requires.

We urge the Advisory Council to ensure the PCI counterfactual is explicitly structured as a minimum floor that rises annually, not as a cap.

B. Recommended Structure: An Ascending Percentage-of-TME Floor

MDAFP recommends that the Primary Care Investment target be structured as a percentage-of-TME floor that increases annually over the AHEAD model period, with a goal of reaching at least 10% of all-payer TME by 2030, noting that with AAFP's national recommendation is 12% and with investment levels in high-performing health systems internationally.

Starting from Maryland's commercial baseline of approximately 8.0-8.5% of TME, this implies annual step-ups of approximately 0.5-0.75 percentage points per year across the payer mix. This is ambitious but achievable – and it is the level of ambition that AHEAD's population health goals require.

This structure differs appropriately from the TCOC growth target, which constrains total spending. The PCI target is directional – investment must grow as a share of TME and should be designed, enforced, and reported as such. MDAFP recommends these two targets be clearly distinguished in Maryland's AHEAD reporting framework with separate compliance thresholds and accountability mechanisms.

C. Economic Indicators Should Inform the Rate of Step-Up, Not Cap It

Among the counterfactual options presented (GSP, household income, wage growth), MDAFP supports using a blend of these indicators – not to cap PCI growth, but to calibrate the pace of the annual step-up in a way that is economically grounded and achievable for payers. Specifically:

- In years when Maryland's economy is growing robustly (high GSP, rising household income), the annual PCI step-up should be at the higher end of the target range, as payers have greater capacity to absorb increased investment requirements.
- In years of economic contraction or stagnation, the step-up should be at the lower end, with a floor that still ensures forward progress toward the 12% goal.
- Median household income deserves particular weight as a counterfactual input for primary care specifically, because consumer affordability of primary care – copays, deductibles, and insurance premiums – is directly tied to what Maryland families can absorb. If primary care costs grow faster than household income, access suffers even when investment nominally increases.

MDAFP supports a three-year rolling average of each counterfactual metric to smooth year-to-year volatility, using nominal values consistent with peer state practice and with HSCRC's existing rate-setting methodology.

D. Primary Care Investment Must Be Protected in the TCOC Growth Calculation

MDAFP urges the Advisory Council to explicitly address an important structural risk: if payers increase primary care investment to meet PCI targets, those increased payments will also increase the numerator of the all-payer TCOC spending calculation. Without a carve-out or credit mechanism, payers face a perverse incentive, investing more in primary care could put them out of compliance with the TCOC growth target.

The prior TCOC Model's Outcomes-Based Credits framework established the principle that investments generating measurable population health improvements can be credited against performance targets. MDAFP recommends an analogous mechanism for the AHEAD framework: demonstrated primary care investment increases that generate verified downstream savings in ED utilization, avoidable hospitalizations, and ambulatory care-sensitive condition admissions should be credited against the all-payer TCOC growth target, so that payers are rewarded rather than penalized for investing in primary care.

III. Metrics to Monitor Primary Care Access and Quality

The All-Payer TCOC Technical Advisory Committee correctly identifies monitoring of access and quality as an essential complement to cost growth compliance, and notes that "implementing complementary primary care investment programs" is a key contributor to success in other states. MDAFP offers specific primary care metric recommendations grounded in validated, publicly available data sources.

A. Primary Care Access

- Primary care clinician supply per 100,000 population, stratified by county and Health Professional Shortage Area (HPSA) designation. Source: HRSA Area Health Resource File (annual).

- Percentage of Maryland residents reporting a usual source of primary care. Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS), annual.
- Rate of primary care visits per 1,000 attributed members, by payer type and geographic area. Source: MCDB.
- Number of patients attributed to a primary care provider in Maryland, by payer. Source: MCDB; MDPCP CMS attribution data.
- Percentage of Medicaid beneficiaries with an assigned primary care provider. Source: Maryland Department of Health Medicaid MCO performance reporting.
- Median days to next available new patient appointment with a primary care physician. Source: Maryland Insurance Administration market conduct surveys, or a new annual MDAFP and MedChi primary care practice survey.

B. Primary Care Quality

- Preventive care completion rates: annual wellness visits, colorectal cancer screening, breast cancer screening, diabetes HbA1c testing, and childhood immunizations – stratified by payer, race/ethnicity, and geography. Source: HEDIS via NCQA; MDPCP quality dashboard.
- Avoidable emergency department visit rate per 1,000 attributed members. Source: HSCRC all-payer ED data; CRISP.
- Ambulatory care-sensitive condition (ACSC) hospitalization rate. Source: HSCRC; AHRQ Prevention Quality Indicators.
- Chronic disease control rates: hypertension, diabetes (HbA1c and blood pressure control), and asthma. Source: HEDIS; MDPCP quality dashboard.
- Patient experience with primary care: access, communication, and care coordination. Source: CAHPS Clinician and Group Survey.

C. Primary Care Equity

- Primary care spending PMPM and PCI as a percentage of TME, stratified by race/ethnicity, payer type, and ZIP code. Source: MCDB with race/ethnicity linkage via CRISP.
- Disparities in ACSC hospitalization rates and avoidable ED utilization between high- and low-social vulnerability ZIP codes. Source: HSCRC; CDC Social Vulnerability Index.
- FQHC capacity, patient volume, and payer mix trends in Maryland. Source: HRSA Uniform Data System (UDS); MACHC.

D. Primary Care Workforce

- Active family physicians, general internists, and general pediatricians licensed and practicing in Maryland, with trend data. Source: Maryland Board of Physicians; HRSA NPPES; annual.
- Maryland family medicine residency match rate and percentage of graduates remaining in Maryland for practice. Source: AAFP residency match data; Maryland Board of Physicians.
- Number of Maryland primary care practices participating in MDPCP and AHEAD advanced primary care programs. Source: CMS; HSCRC.
- Proportion of primary care physicians in independent vs. employed vs. FQHC settings, as a proxy for practice stability and sustainability. Source: AAFP Practice Profile data; Maryland Board of Physicians.

E. Annual Primary Care Practice Survey

MDAFP recommends that MHCC and HSCRC commission – or co-develop with MDAFP and MedChi – an annual primary care practice survey covering financial sustainability, staffing capacity, payer mix changes, patient panel capacity, and barriers to participating in value-based programs. This would provide the

qualitative and contextual monitoring that Slide 24 identifies as a key contributor to success in other states, while generating Maryland-specific data that no claims database can provide.

IV. Additional Recommendations Specific to Primary Care

A. Legislative Floor for Primary Care Investment

The 2024 MHCC Primary Care Investment Analysis Report recommended legislation requiring payers to meet minimum primary care investment thresholds as a percentage of TME. MDAFP fully endorses this recommendation. Regulatory targets and Executive Order commitments provide a framework, but statutory requirements create the durable enforcement mechanism that has proven necessary in states like Rhode Island, Connecticut, and Oregon to drive sustained payer behavior change. MDAFP stands ready to work with the Governor's Office and the General Assembly to advance this legislation.

B. Predictability for Primary Care Practices

One of MDAFP's most practical concerns about the target-setting framework is the impact of uncertainty on primary care practice investment decisions. Family medicine practices, most of which are small businesses with limited capital reserves, cannot expand capacity, hire additional staff, or invest in care transformation technology without multi-year revenue predictability. MDAFP strongly supports:

- Fixed, prospectively-set PCI targets for PY 2-5, announced well in advance of each performance year, so that practices and payers can plan accordingly.
- Clear, published timelines for when payer reporting requirements, target thresholds, and compliance assessments will take effect, ideally at least 18 months before any payer accountability mechanism is triggered.
- A technical assistance program, coordinated through MHCC and the HSCRC, to help small and independent primary care practices understand how PCI targets affect their payer contracts and how to participate in value-based arrangements that count toward the target.

C. Federal Policy Uncertainty and Scenario Planning

MDAFP notes that the federal policy environment in early 2026 creates significant uncertainty for Maryland's primary care infrastructure. Ongoing Medicare physician payment cuts (the 2025 conversion factor continued a multi-year trend of compounding reductions that the AAFP has characterized as untenable for family practices) threaten the financial stability of the practices that Maryland's PCI target depends upon. Potential Medicaid coverage reductions could shift a significant portion of Maryland's patient population to uninsured or self-pay status, reducing the insured TME denominator and distorting PCI calculations.

MDAFP urges the Advisory group to build scenario analyses into the PCI target-setting framework that account for federal coverage and payment changes, so that Maryland's targets remain meaningful and achievable under a range of federal policy conditions rather than becoming obsolete if the federal landscape shifts significantly during the AHEAD model period.

Conclusion

The Maryland Academy of Family Physicians submits these comments to ensure that the Primary Care Investment target is built to achieve what it is designed to achieve: a durable, meaningful, and measurable increase in the resources flowing to primary care in Maryland, resources that reach practices and patients, not just data systems.

The research evidence from AAFP, the Milbank Memorial Fund, and Maryland's own experience under the TCOC Model is clear: adequate primary care investment reduces total health care costs, improves population health, narrows health disparities, and makes the entire health care system more efficient. The AHEAD Model has made primary care investment a statewide accountability commitment. MDAFP's goal in

these comments is to ensure that commitment is measured accurately, benchmarked ambitiously, and monitored rigorously.

MDAFP respectfully urges the Advisory group to:

- Include non-claims-based APM payments, especially MDPCP PBPM fees and AHEAD care management payments, in the PCI numerator from baseline
- Supplement hospital-based self-pay/uninsured modeling with HRSA UDS and FQHC data
- Structure the PCI target as an ascending percentage-of-TME floor, with a goal of at least 10% of all-payer TME by 2030 (with a 12% aspirational goal)
- Ensure primary care investment increases are credited, not penalized, in the TCOC growth calculation
- Adopt primary care-specific access, quality, equity, and workforce metrics as mandatory monitoring elements
- Provide predictability for primary care practices through fixed, prospectively-set targets announced well in advance

We look forward to participating in the April 10, 2026 Public Listening Session and remain available to provide additional data, testimony, or technical assistance.



Maryland
Hospital Association

March 19, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the state's efforts, led by the Health Services Cost Review Commission (HSCRC), to develop a methodology for setting the statewide all-payer Total Cost of Care (TCOC) targets under the AHEAD Model. Over the last decade, Maryland, through the All-Payer and TCOC Models, pioneered approaches that hold the state and hospitals accountable for controlling costs while preserving access to high-quality care. Establishing all-payer TCOC targets for AHEAD continues this legacy and reinforces the state's commitment to improve transparency and understanding of health care spending trends across the health care system.

As the state considers how to set these targets, it is important to recognize that Maryland's hospital global budget revenue system already incorporates strong cost containment measures that have meaningfully limited hospital cost growth and contributed to one of the lowest average commercial hospital reimbursement rates in the nation. Additionally, under AHEAD, Medicare TCOC spending targets will be achieved through reductions in hospital global budgets. While Maryland hospitals have led the way in controlling cost growth, commercial health plans are increasingly unaffordable due to high and increasing premiums and cost-sharing requirements. Hospitals remain committed to controlling costs under the AHEAD Model; payers and other stakeholders in the health care system should also be held accountable for their contributions to the costs consumers incur when accessing health care services.

The statewide targets, and the benchmark that informs those targets, must reflect Maryland's experience and focus on drivers of health care spending beyond hospital utilization. The targets should support transparency and monitoring of system-wide spending trends with a focus on the areas driving affordability challenges while ensuring continued access to life-saving acute care and system sustainability to improve the health and wellbeing of Marylanders. We urge the All-Payer Total Cost of Care Target Technical Advisory Committee to consider the following principles as it continues discussions about data parameters and benchmarking options.

Monitoring: Any policy effort to control total cost of care growth should have a monitoring focus until the data is complete and actionable.

Cost growth benchmarks from other states have typically been used to monitor health care spending trends, identify cost drivers, and inform policy discussions and decisions. States such as Massachusetts, Oregon, Delaware, and Washington primarily use their benchmarks as analytical tools that trigger additional review and reporting when spending exceeds targets, rather than automatic regulatory action. A monitoring-only focus is most appropriate, especially when taking into consideration data limitations. Claims-based spending data often requires a significant run-out period—between six and 12 months for commercial claims—before final spending can be accurately measured. While these limitations make it difficult to use benchmark results for real-time policy intervention, they support a monitoring and transparency focus.

Achievable: The benchmark should consider expected inflation and other projected cost increases in national trends to ensure the state’s success under the AHEAD Model.

All-payer TCOC growth targets set by the state must be achievable in order to serve their intended purpose of managing cost growth while avoiding unintended consequences. Targets that are unattainable are not only less actionable, but they may also threaten access to hospital care and trigger corrective action under the AHEAD state agreement.

The experiences of other states with similar cost growth targets highlight the importance of setting targets that reflect economic realities, contemporary health care spending trends, and data limitations. Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island established annual cost growth targets, ranging from 2.9% to 6% for 2022 and 2023, all of which were based on one or a blend of three economic indicators: Gross State Product (GSP), wage growth, and median household income. While there are important differences in how each state structured their cost growth targets, including spending definitions, data sources, and the economic indicators on which their targets were based, available data shows that all five states failed to meet their established targets (Table 1). The consequences of missing these targets and enforcement of those consequences vary by state but have generally been limited to date.

Table 1. State Cost Growth Benchmarks and Performance, 2022-2023

State (Year)	Benchmark	Actual*	Result	Benchmark Growth Rates Basis
MA (2023)	3.6%	8.6%	✗	Potential GSP
OR (2023)	3.4%	5.2%	✗	GSP + median wage
CT (2022)	2.9%	3.4%	✗	Potential GSP + median wage + inflation
RI (2023)	6.0%	7.8%	✗	Potential GSP + median income + inflation**
DE (2023)	3.8%	9.1%	✗	Potential GSP

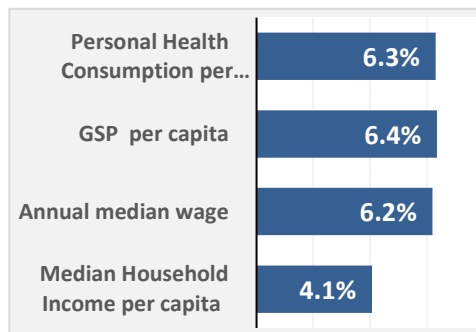
* Actuals based on limited data available; ** Added in 2023

The Advisory Committee has been asked to consider the same three economic indicators in use by these other states as potential options for a counterfactual that could be used to establish Maryland’s cost growth targets. While these represent economic growth measures against which health care spending growth can be evaluated, use of any one of the three may result in

unattainable targets that could have unintended negative consequences for the state. While per-capita health expenditures have grown slightly lower than GSP in recent years, health care cost growth has historically outpaced GSP largely due to medical innovation, changes in demographics, and rising workforce costs: a trend that is expected to continue over the next decade (Figures 1, 2). At the same time, per-capita health care expenditures have grown at a considerably slower rate than the nation in recent years (Figure 3).¹ Wage growth and median household income have their own limitations, including significant lags in the availability of data, as noted by HSCRC, that make the targets less actionable and monitoring performance more difficult.

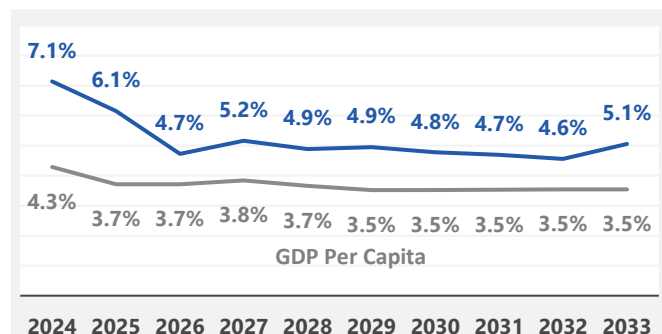
A more attainable target could be derived from the projected National Health Care Expenditure trend, which is expected to grow between 5% and 6% over the next decade. This approach balances the need for cost containment that supports affordability to health care access to hospital services, while also considering Maryland's progress in managing cost growth.

Figure 1. Annual Average Growth Rates, 2021 to 2024



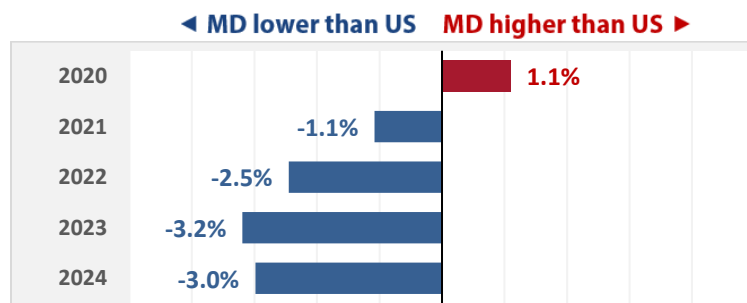
Source: U.S. Bureau of Economic Analysis

Figure 2. Annual Growth Rate Projections, 2024 to 2033



Source: CMS National Health Expenditures Data (NHE)

Figure 3. Health Expenditures Per Capita – Maryland vs. Nation, 2020 to 2024



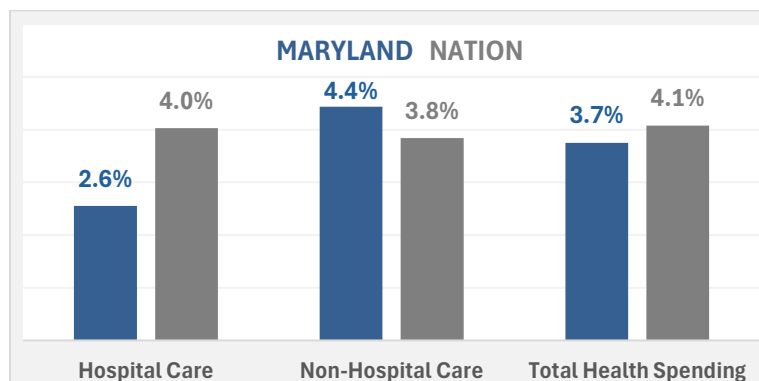
Source: U.S. Bureau of Economic Analysis

¹ Data sources: U.S. Bureau of Economic Analysis, Per Capita Personal Consumption Expenditures: Services: Health Care (PCE), Annual, Not Seasonally Adjusted; Gross domestic product per capita, Dollars, Annual, Not Seasonally Adjusted; U.S. Census Bureau, Median Household Income, Current Dollars, Annual, Not Seasonally Adjusted; U.S. Census Bureau Annual Median Wage; retrieved from FRED, Federal Reserve Bank of St. Louis.

Affordability: The benchmark framework should focus on health plan affordability and other drivers of cost growth beyond hospital spending.

Maryland hospitals have successfully limited hospital spending growth. The average annual hospital growth rate rose 2.6% in Maryland compared to 4% across the nation from 2013 to 2019 (Figure 4). Additionally, hospital spending will continue to be constrained under AHEAD’s global budgets. Under the renegotiated terms of the AHEAD Model, Maryland is expected to achieve \$460 million in Medicare savings through progressively greater annual savings targets between 2026 and 2033. These targets will be addressed through reductions to Medicare hospital global budget payments. These savings targets have been projected to result in a total hospital payment reduction of \$870 million over the next seven years when accounting for corresponding reductions in hospital payments from Medicaid and Medicare Advantage.

Figure 4. Average Annual Growth Rates – Maryland vs. Nation, 2013 to 2019



Source: CMS National Health Expenditures Data (NHE)

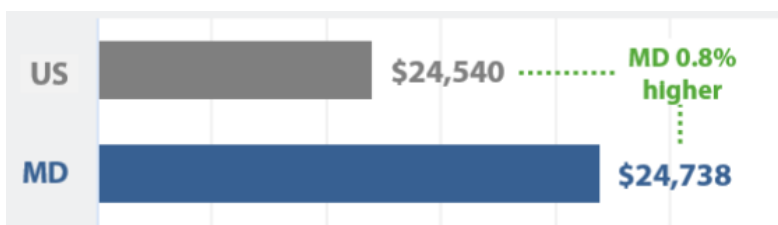
While Maryland hospitals continue to lead the way in controlling cost growth, recent premium filings highlight growing affordability pressures within Maryland’s insurance markets. For plan year 2026, carriers in the individual market increased premiums by 13.4%, on average.² Additionally, Maryland’s average annual commercial insurance premium for a family was 0.8% higher than the United States average in 2024 (Figure 5), yet commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country as noted by the Regulatory Working Group.³

Significant premium increases often reduce coverage affordability and can increase the number of uninsured Marylanders. Coverage losses can lead to increases in uncompensated care across the health system and cause patients to delay or forgo necessary care. This would also exacerbate burdens on the health care system and ultimately increase health care costs.

² Maryland Insurance Administration Approves 2026 Affordable Care Act Premium Rates, available [here](#).

³ AHEAD Regulatory Working Group Proposal on Cost-Shifting and Medicare Advantage, available [here](#).

**Figure 5. Average Annual Family Premium,
Employer-Based Health Insurance, 2024**



Source: Center for Financing, Access and Cost Trends.
Medical Expenditure Panel Survey Insurance Component (MEPS).

Premium rates are but one measure of plan affordability. In addition to high premiums, Marylanders pay more out-of-pocket for care. The Maryland Health Benefit Exchange reports that due to high premium costs, more consumers are shifting from gold plans with \$1,000 deductibles to bronze plans with \$10,000 deductibles.⁴ Deductibles for single and family coverage in employer-sponsored insurance in 2024 are almost six and five times higher than deductibles in 2002, respectively.⁵ In addition, the medical loss ratio (MLR) works to protect consumers by ensuring that premiums are used to cover medical claim costs. The average MLR in Maryland's group market in 2024 was 78.9%, the lowest ratio of any state for plan year 2024, according to the National Association of Insurance Commissioners.⁶

Considering these trends, the benchmark methodology should evaluate affordability and cost growth across the full health care system rather than focusing solely on hospital spending. This includes examining how insurance premiums, plan designs, insurance administrative costs, and other payer practices increase the total costs Maryland residents pay for coverage and care.

Alignment: The benchmark methodology should measure spending consistently across payers and sectors to accurately identify cost drivers to align with the current measures of total cost of care for the AHEAD Model.

The TCOC benchmark should capture spending across Medicare, Medicaid, and the commercial insurance market, align with the AHEAD Model's measurement of total costs, and allow policymakers to understand spending growth across sectors, including hospital services, physician services, and insurance administrative costs. The methodology should exclude retail pharmacy and additional Medicaid benefits. Retail pharmacy datasets often report gross drug spending without accounting for manufacturer rebates and may overstate spending growth. Estimates of pharmaceutical costs may not adequately account for emerging pharmaceutical technologies and associated costs. If retail pharmacy spending is included, it should be reported separately or both gross and net spending should be reported when possible.

⁴ MHBE January 20, 2026 Briefing to the House Appropriations Committee. Available [here](#).

⁵ SHADAC Analysis of Average Annual Employer Sponsored Insurance Deductible. Available [here](#).

⁶ NAIC. U.S. Health Insurance Industry Analysis Report – 2024 Annual Results. Available [here](#).

Self-funded ERISA plans also represent a significant portion of the commercial insurance market, though these plans are not always fully captured in existing claims databases. Other states with existing cost growth targets estimate these expenditures when calculating total spending. If HSCRC utilizes estimation in their methodology, any assumptions should be tested using external benchmarks. Additionally, assumptions and limitations should be clearly documented to ensure transparency.

Predictability: The benchmark methodology should be transparent, predictable, and stable to support long-term planning across the health care system.

The benchmark framework must be predictable to allow policymakers and stakeholders to evaluate performance and implement adjustments in a timely manner should spending trends deviate from expectations. To improve the benchmark's stability, several states have incorporated additional methodological adjustments, including blended economic indicators, inflation adjustments, and multi-year trend calculations. These approaches can help reduce volatility and ensure that benchmark targets remain predictable and achievable over time. The growth target methodology should be based on projected growth rates with a potential add-on adjustment for unexpected changes.

MHA supports HSCRC's efforts to improve transparency and understanding of health care spending trends through the development of all-payer TCOC growth targets. The methodology used to establish these targets should reflect Maryland's unique all-payer system, recognize the broader drivers of health care spending growth, and provide meaningful insights into affordability challenges facing Maryland residents.

We look forward to continuing to work with HSCRC, the Maryland Insurance Administration, and the Maryland Health Care Commission as the methodology is developed.

Sincerely,



Melony G. Griffith
President & CEO

Cc: Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission



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CORPORATE OFFICE

March 23rd, 2026

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Members of the All-Payer Total Cost of Care Growth Advisory Committee,

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, thank you for the opportunity to provide comments on the development of statewide accountability targets for All-Payer Total Cost of Care (AP TCOC) growth under the AHEAD Model. UMMS remains committed to partnering with the State to ensure Maryland's continued leadership in advancing high-value, equitable care while maintaining access and system sustainability.

As the State considers AP TCOC growth targets, we offer the following principles and considerations to support successful implementation:

1. Maintain a Monitoring-Focused Approach in Early Years

Given the novelty of the AHEAD Model, limited regulatory levers beyond hospital rate-setting, and material financial risks to the system, AP TCOC targets should initially function as monitoring and evaluation tools rather than direct drivers of regulatory action.

Other states' experience demonstrates that TCOC benchmarks are most effective when used for transparency and learning, not immediate enforcement, particularly where data completeness and policy levers remain underdeveloped. UMMS is concerned the State's ambitious timeline and our own personal experience from accountable care model work comparing commercial claims across payers will delay insight into self-insured payer growth and insights to improve/manage this target will remain limited for quite some time. Until we have full transparency in monitoring total cost of care equally across payers, we should exercise caution and monitoring only approaches for AP TCOC. Early-year

targets/policy commitments to CMS should reflect data limitations and prioritize improved payer transparency.

While this target triggers only corrective action under AHEAD, as opposed to Model termination, there is still significant risk in ambitious target commitments that differentiates Maryland's experience from peer states. Should the State need to implement corrective action with CMS, there are limited regulatory levers in Maryland outside of hospital rates to solve a missed target problem. This poses a risk for destabilization of hospital financing and misalignment with payer behavior and warrants a conservative, adjustable, and achievable target framework. Additionally, Maryland has experience with annual targets that can fluctuate financial decision-making with the prior guardrails test in the TCOC Model. These guardrails have caused instability in the Model, despite continued results on Medicare TCOC and overall Model targets. Maryland should aim to ensure stability and minimize risk fluctuations in the AHEAD model with retrospective targets like the All-Payer TCOC growth target.

2. Ensure Alignment Across AHEAD Metrics and Methodologies

AP TCOC targets must align with Medicare TCOC growth targets and hospital all-payer revenue constraints. This includes consistent methodologies for inflation and utilization, exclusion of prescription drugs, and alignment with federal definitions. Retail pharmacy and Part D costs have never been a part of the cost management proposals of the Maryland Models, and are not domains in which the State nor the Federal government have exhibited strong levers of control. The proposed addition of these components will create an even higher hill to climb to maintain consistent performance.

3. Promote Full-System Accountability for Affordability

Hospital cost growth is not the sole driver of TCOC, and the AP TCOC growth target will not be able to guarantee affordability to Marylanders. The State should complement AP TCOC commitments to CMS with a plan to examine payer plan design, administrative costs, and patient premium/out of pocket affordability, ensuring accountability across all stakeholders. Payer transparency and data availability remains a problem where the policy action and solution for Maryland is unknown. This will impede Maryland's ability to perform on not just total cost commitments, but also affordability examination and improvement. Creating a TCOC growth analysis gives the State the opportunity to explore where other components of the system are eroding affordability, such as insurer's plan design or private equity investments in unregulated settings of care. The State will need to be clear with CMS and their policy proposals to the governor that hospital cost growth and HSCRC regulatory oversight is not the sole lever of impact for healthcare affordability, nor AP TCOC Growth in MD.

7. Preserve Investment in Transformation, Access, and Sustainability

AP TCOC targets should not constrain necessary investments in primary care, population health/care transformation, capital infrastructure, and underserved communities. The State should specifically note to CMS that these purposeful investments should be excluded or built into proposals and reporting on this target. This will allow Maryland to purposefully invest in our healthcare system's transformation and future in partnership with the Model, instead of under limits.

In closing, UMMS supports a measured, aligned, and transparent framework for AP TCOC targets that recognizes current limitations, ensures shared accountability, and preserves system sustainability.

Sincerely,

A handwritten signature in cursive script, reading "Alicia Cunningham", followed by a vertical line.

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services



March 20, 2025

Jonathan Kromm
Executive Director, Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: MDH.Maryland-Model@maryland.gov

RE: Response to the All-Payer Total Cost of Care Target Technical Advisory Committee public comment opportunity

Dear Executive Director Kromm,

Thank you for the opportunity to provide public comments in response to the Maryland Multi-Agency Regulatory AHEAD Work Group's ("Work Group") [request for additional information](#) related to the state's total cost of care (TCOC) growth target under the AHEAD Model.

United States of Care (USofCare) is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of health status, social need, or income. We know from our [listening work](#) that affordability [tops the list](#) of people's concerns about our country's health care system. Cost concerns are especially acute in Maryland, where [more than half](#) (55%) of all people have experienced difficulty affording their health care over the past year and [more than four-in-five](#) worry about affording care in the future. Marylanders have long benefitted from the state's unique system of [all-payer rate setting](#) and, more recently, its innovative [Total Cost of Care Model](#), which has lowered health care spending by [more than \\$700 million](#). Unfortunately, due to the increasing cost of care, more is needed to ensure health care remains affordable for Maryland families. This underscores the importance of pursuing additional policies to lower health care costs to improve Marylanders' everyday health care affordability.

The AHEAD Model will do just this. Building on the success of the Total Cost of Care Model, which sunset at the end of last year, the AHEAD Model will provide much-needed financial certainty to health care providers while also benefitting Maryland families across the state by shifting the way in which care is delivered in order to expand access to primary care, prioritize population health, improve health outcomes, and lower health care costs in the State. As consumer advocates, we appreciate the Maryland Health Services Cost Review Commission's (HSCRC) collaborative approach to implementation of the AHEAD Model. We also appreciate HSCRC's efforts to ensure that a wide array of impacted stakeholders have a seat at the table alongside industry to provide feedback as the state implements the AHEAD Model and, in particular, constructs its TCOC growth target. Furthermore, we appreciate the opportunity to

share the consumer perspective more broadly as one of two consumer representatives on the All-Payer TCOC Target Technical Advisory Committee (“Advisory Committee”). Moving forward, we encourage the Work Group to continue to elevate the consumer perspective and provide opportunities for further beneficiary engagement as the state moves forward with full implementation of the AHEAD Model.

Support for the AHEAD Model’s Total Cost of Care Growth Target

We believe the Model’s all-payer TCOC growth target will provide an important framework to allow agencies, providers, and insurers to continue to work together to rein in health care cost growth and improve care delivery; and we appreciate the HSCRC’s thoughtful approach to establishing it. A TCOC growth target will provide important insights on health care cost growth in the state and can help inform progress and policies associated with the AHEAD Model. While a TCOC growth target alone won’t solve the health care affordability challenges Marylanders face, pairing it with additional policies that are complementary to the goals of the AHEAD Model, such as an affordability standard (see below), ensures that any system-wide savings are translated into cost savings for people through more affordable premiums and lower out-of-pocket costs.

The Work Group presented several proposals and questions to the Advisory Committee to solicit feedback and inform its development of the state’s all-payer TCOC growth target. Our responses are outlined below and are shaped by [insights](#) gleaned from listening to people:

What economic measurements should Maryland use to define the TCOC growth target (or “counterfactual”)?

We strongly support the development of a TCOC growth target that relies – at least in part – on consumer-focused metrics that reflect broader statewide economic growth, including household resources. Individual TCOC growth target methodologies vary by state, with most relying on gross state product (GSP) or household income growth. **While targets tied to GSP capture overall economic growth, we believe one largely tied to median – and not average – household income is more representative of individuals’ or families’ experiences and their household’s ability to spend, so we encourage the state to base its growth target on this metric.** To account for periods where household income growth may stagnate and any unforeseen affordability challenges facing state residents, the Work Group should consider blending household income with GSP, similar to [California](#) or [New Jersey’s](#) TCOC growth targets.

How should the analysis approach costs for specific Medicaid services (including developmental disability services and home- and community-based services (HCBS))?

[More than 40,000 Marylanders](#) receive HCBS through Medicaid, including more than 18,000 people with developmental disabilities. Looming federal Medicaid cuts threaten to make the program’s [years-long](#) waiting list even longer. **To avoid further limiting access to these programs for Marylanders, we recommend excluding certain Medicaid services, and in particular developmental disability services and other HCBS, from the growth target calculation.**

While we understand the value of a TCOC growth target that encompasses *all* health care spending, we believe these services are fundamentally different because their cost growth is driven by policy decisions or eligibility changes rather than price increases or changes in utilization. We believe incorporating these services under a TCOC growth target could unintentionally limit access to care for these often-marginalized populations. In the event that this spending is included under its TCOC growth target, we recommend that agencies, in addition to breaking down spending by market and service category, take into account external factors or policy changes if/when certain entities exceed the benchmark, as [Connecticut](#) does. Doing so would allow the state to keep its focus on controlling spending in the broader health care market while also preserving access to needed Medicaid services.

Additional comments related to prescription drugs and the TCOC growth target

Nationwide, health care spending on prescription drugs [grew 8.6%](#) between 2020 and 2023, and the cost of prescription drugs continues to contribute to affordability challenges for people. Depending on the circumstances, higher spending on prescription drugs may lead to cost savings by reducing hospitalizations or emergency department visits or further increase costs without any corresponding offsets. **Because of this, we strongly support prescription drug spending being included in a TCOC growth target to understand its impact on overall health care spending.**

With the fractured nature of pharmaceutical spend data, we recognize that quantifying current prescription drug spending may pose unique challenges, but we believe HSCRC can supplement all-payer claims database (APCD) data with other sources to estimate the net cost of drugs to help inform the TCOC growth target. Looking ahead, we encourage the Working Group to think creatively how it can leverage alternative sources, such as data collected by the [Prescription Drug Affordability Board \(PDAB\)](#), to further drill down the data to identify specific drugs contributing to the cost increase and intervene to lower costs where appropriate. It is also important to note that Maryland is uniquely positioned to control prescription drug spending in the state through its PDAB, which has authority to apply upper payment limits to certain high-cost prescription drugs in the commercial insurance market.

Consumer Affordability Standard

Despite health care affordability being a top issue affecting families' day to day lives and budgets, cost containment efforts across many states have failed to adequately measure real world impact of these solutions on consumers. **While the TCOC growth target being developed under this workgroup will be important in monitoring cost growth in the health care system overall, we strongly encourage the HSCRC to also develop a consumer "[affordability standard](#)" to be monitored in parallel.** This standard can help Maryland understand how people are experiencing health care affordability challenges and, paired with the TCOC growth target and other efforts, how policy solutions embedded in the AHEAD Model translate to improved affordability and what role different sectors of the health care system play in driving those experiences.

Affordability standards have [long been used by many peer states](#), all taking varying approaches to the development and implementation. In Connecticut, the state Comptroller's office worked

with the Office of Health Strategy to develop the [Connecticut Healthcare Affordability Index \(CHAI\)](#), which builds upon the state's [self-sufficiency standard index](#) to measure the impact of health care costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs, like housing, transportation, childcare, and groceries. The CHAI is used to establish and adjust Connecticut's [household health care spending target](#), inform their healthcare benchmarking initiative, and set primary care spending targets. Rhode Island adopted a [health care affordability standard](#) in 2010, based on the Consumer Price Index for Urban Consumers and other market factors. This metric, set annually by the Office of the Health Insurance Commissioner, informs their review and approval of contracted rates between providers and insurers. Notably, the state [has also leveraged](#) this affordability standard to incentivize payment reforms similar to those under the AHEAD Model, such as primary care investments and risk sharing agreements between providers and commercial payers.

Should the State decide to pursue the development of an affordability standard, Maryland should be deliberate about which consumer health care costs are included and should strive to include both premiums and other out of pocket costs to accurately capture the ways Marylanders pay for their health care and, in turn, accurately evaluate the impact on affordability. Recognizing that what is "affordable" varies significantly based on factors such as income, location, age, and health status, we would also encourage Maryland to consider a standard that blends multiple measures to account for these differences. USofCare is happy to partner with the State on this issue.

Importantly, policy actions, like those taken through the implementation of the AHEAD Model, are necessary in ensuring that these standards are achieved and maintained. Controlling the underlying cost of care is inextricably linked to making sure that care is affordable; even with low uninsured rates and fairly adjusted premiums and cost-sharing, ever-rising costs will erode wages and crowd out Marylander's spending on other important goods and services. **As such, we strongly encourage the agencies comprising the Regulatory Work Group to identify opportunities for the affordability standard to inform the development and monitoring of AHEAD Model implementation and its impact on health care spending, including in health insurance [rate review](#) and hospital global budget development.**

By developing the all-payer TCOC cost growth target under the AHEAD Model along with a consumer-focused affordability standard, Maryland can continue to build upon the success of the Total Cost of Care Model to improve health outcomes while lowering health care costs for state residents. We thank the members of the Advisory Committee, Work Group, and HSCRC for their commitment to successful implementation of the AHEAD Model. We appreciate the opportunity to provide feedback. Please don't hesitate to reach out with any questions.

Sincerely,

Alyssa Penna
Director of Federal Policy
United States of Care

Initial Public Comment

February-March 2026



For Review (May 5/27): All-Payer TCOC Growth Target Recommendation

Foreman, Arin

Fri, May 29, 2026 at 9:42 PM

Hi Laura,

Thanks for the opportunity. Upon initial review, the draft seems reasonable. I know there was plenty of discussion about economic indicators, and I think landing on a blend of wage growth and GSP growth makes sense as it incorporates true affordability into the limit. I also think a pre-programmed multi-year period that rebases on a schedule is reasonable.

I think this is a good first step, but I would recommend the technical committee spend some time talking through the actual implementation and enforcement of the recommendation. The target will only be as effective as its enforcement, so where does the accountability sit and what are the plans for intervention or correction if the state's growth exceeds the target in a given year?

While the document notes that Maryland is well-positioned because we've long dealt with an all-payer target, my understanding is that the all-payer target has never really been addressed because of the intersection between a binding Medicare savings target and all-payer rate-setting. When AHEAD bifurcates Medicare and other payer rate-setting in 2028, this target becomes critical, and Maryland does not have experience tracking toward an all-payer savings target without a Medicare governor to which other rates are tethered.

Thanks for your work on this. I look forward to our next discussion.

Arin

June 2, 2026

Jonathan Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215



Dear Dr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide feedback on the draft methodology paper shared with members of the Multi-Agency Regulatory Working Group's All-Payer Total Cost of Care Growth Technical Advisory Committee on May 29. As a member of the committee, I am pleased to submit the following comments. In addition to the comments in our March 20th comment letter (attached), JHHS also notes the following comments related to the most recent draft document.

Inclusion of Part D Pharmacy Costs in All Payor TCOC Targets

JHHS continues to urge the State to align the All-Payer TCOC Growth Target methodology with the Medicare TCOC targets, as cost growth should be assessed consistently across payers. As mentioned in our previous comment letter, JHHS is concerned about the inclusion of Medicare Part D pharmacy expenditures in the all-payer TCOC target. Pharmacy costs are largely outside the control of hospitals and health systems; Maryland hospitals do not set drug prices, do not drive pharmacy benefit design, and have no meaningful lever to reduce Medicare Part D expenditures. Incorporating pharmacy costs into the growth target risks producing a benchmark that Maryland cannot achieve due to factors outside hospital control.

Maintaining a consistent base year for the TCOC Target

JHHS believes that maintaining CY 2026 as the fixed base year for future target-setting is important for maintaining consistency of the measurement of TCOC. Shifting the base year from CY 2026 to CY 2029 after three years would reduce predictability and introduce unnecessary volatility into future trend calculations.

A fixed base year is more consistent with Maryland's historical benchmarking approach, including the AHEAD total cost of care and all-payer hospital revenue benchmarks, which rely on fixed baseline periods.

JHHS appreciates the opportunity to provide feedback on the draft recommendation. We urge the State to carefully consider these issues we have raised before finalizing the methodology. The methodology must be aligned with Medicare targets, structured to distribute accountability appropriately, grounded in complete and reliable data, and designed to ensure that impact is felt by consumers the model is intended to serve. JHHS welcomes further collaboration on this issue and looks forward to continued engagement in the process.

Sincerely,

Ed Beranek

Ed Beranek
Vice President Revenue Management and Reimbursement
Johns Hopkins Health System



15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

May 29, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Comments on Regulatory Working Group Proposed Recommendations

Dear Executive Director Kromm:

The League of Life & Health Insurers of Maryland is the state trade association representing life and health insurance companies in the State. The League appreciates the opportunity to provide comments on the Regulatory Working Group's policy draft recommendations on the all-payer total cost of care growth and primary care investment targets released to members on May 14th.

As Maryland transitions to the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model, the critical benchmark for success must be long-term consumer affordability. While League members recognize that hospital rate adjustments are occasionally necessary to account for broader inflationary pressures, we urge the HSCRC to recognize that reining in hospital spending is the single most vital component to achieving the AHEAD model's cost growth targets.

Our specific comments are as follows:

- **Counterfactual and Growth Target Methodology.** The League supports the Regulatory Working Group's goal to lower health care cost growth to a hybrid economic counterfactual that blends Gross State Product (GSP) and wage growth equally. Since GSP reflects the economic realities faced by the employers who fund commercial insurance, and wage growth directly links to consumer affordability, this balanced mechanism correctly shifts the focus toward real-world affordability rather than specific healthcare indicators. Furthermore, we agree with using a multi-year historical trend (CY 2023–CY 2025) to smooth out post-pandemic data anomalies. Our member health insurance companies work every day to advance this goal by promoting affordability,

improving care coordination, and supporting efforts to slow the growth of healthcare costs while maintaining access to high-quality care.

- **Cumulative vs. Annual Targets and the Risk of Banking.** The draft proposal outlines a cumulative, three-year target window (CY 2027–CY 2029) instead of strict annual targets. If a commercial plan or the state overall experiences a major cost surge in year one, it should not automatically dilute the urgency of corrective actions in years two and three. Accordingly, early success should not permit unchecked growth later in the cycle.
- **ERISA/FEHBP Estimates and Completion Factors.** The draft notes that ERISA and FEHBP data will initially be estimated based on non-ERISA commercial claims available in the Medical Care Data Base (MCDB). Since ERISA plans represent a substantial portion of the commercial market in Maryland, relying on proxies introduces actuarial risk if completion factors or assumptions vary significantly from actual trends.
- **Pharmacy Rebates and Self-Pay.** The League agrees with the decision to include pharmacy spending in the TCOC calculations, as prescription drugs continue to be an undeniable cost driver. Additionally, tracking self-pay and uninsured populations via hospital case-mix data is appropriate to ensure that uncompensated care costs are monitored for their downstream impact on commercial premium loading.
- **Monitoring Access and Quality.** As the State moves toward these accountability targets, it is imperative to monitor any adverse impacts on care delivery. We recommend that the HSCRC adopt metrics similar to those used in other states, such as utilization and network adequacy.
- **Alignment with the Primary Care Investment Target.** Finally, while Section 2 of the document remains a placeholder, the League stresses that any mandatory primary care investment targets must be carefully harmonized with the overarching TCOC growth target. Increased primary care spending should serve to reduce total expenditure through improved chronic disease management and averted emergency utilization; it should not simply function as a flat cost-add that pushes commercial plans closer to breaching the TCOC growth ceiling.
- **Enforcement Mechanism.** The League strongly urges the multi-agency workgroup to make the TCOC growth target fully binding. Under the current framework, staff is directed to monitor costs against the established benchmark, leaving the state without an enforcement mechanism if expenditures exceed the target. We recommend that the Commission work with stakeholders to include the target that cannot be ignored. Transforming this test from a passive monitoring tool into a requirement will compel hospital accountability and guarantee that stakeholders operate within the state's affordability limits.

The League and its members strongly support the overarching goal of enhancing health care accessibility and affordability for all Maryland consumers. We believe that achieving this aim necessitates active participation from all stakeholders, including payers, hospitals, providers,

pharmaceutical manufacturers, and policymakers. These stakeholders play a crucial role in determining the cost and accessibility for the communities we collectively serve. We stand ready to collaborate on legislative policy changes that will have a meaningful impact on our collective ability to contain healthcare cost growth and increase affordability.

On behalf of the health plans operating in Maryland and supporting Maryland residents, we are very grateful for your attention on this matter. If you have any questions or would like to speak with us further on these topics, please reach out to me at mcelentano@fblaw.com.

Very truly yours,

A handwritten signature in black ink, appearing to read "Matt Celentano", with a long horizontal flourish extending to the right.

Matthew Celentano
Executive Director



May 29, 2026

Jonathan Kromm, Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: MDH.Maryland-Model@maryland.gov

Dear Mr. Kromm,

Thank you for the opportunity to comment on the All-Payer Total Cost of Care Target. Maryland Citizens' Health Initiative (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders. We are pleased that the Draft Recommendation:

- excludes specific Medicaid services (developmental disabilities, adult medical day care, and home- and community-based services) from the target
- includes prescription drugs. High drug costs are a major part of health care spending and the target would not be complete if Maryland were to exclude them.
- commits HSCRC to identifying measures for quality, access, and affordability alongside stakeholders. This provision lays the foundation for an affordability standard that must account for all Marylanders' health care costs—including premium growth and out-of-pocket spending. We are eager to partner with HSCRC to provide the necessary feedback and assistance for developing this standard.

We are also pleased that the target includes a consumer-focused metric in the target combined with Gross State Product. **However, we suggest that HSCRC consider replacing wage growth with household income to better measure the financial realities and spending power of individuals and families, similar to how California and New Jersey have developed their targets.**

We appreciate all you do to expand access to quality, affordable health care for all Marylanders. Thank you for the opportunity to provide comments on the All-Payer Total Cost of Care Growth Target, and please do not hesitate to reach out if you have any questions.

Sincerely,

Stephanie Klapper, Deputy Director

May 29, 2026

Secretary Meena Seshamani, M.D., Ph.D.
Maryland Department of Health
Herbert R. O'Connor State Office Building
201 W. Preston Street
Baltimore, MD 21201

Re: Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets

Dear Secretary Seshamani and Members of the Regulatory Working Group,

On behalf of MedChi, The Maryland State Medical Society, I am pleased to submit the following comments on the May 2026 draft "Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets." MedChi is a statewide professional association for licensed physicians with the mission of serving as Maryland's foremost advocate and resource for physicians, their patients, and the public health. MedChi serves on the Regulatory Working Group, and we appreciate the opportunity to submit further written feedback on the model targets for all-payer total cost of care (TCOC) growth and all-payer primary care investment.

We thank the Maryland Department of Health (MDH) and the Regulatory Working Group for developing a comprehensive, multi-agency approach to aligning health care cost growth with broader economic indicators and for simultaneously recognizing primary care investment as a central pillar of Maryland health care goals and the requirements under the Achieving Healthcare Efficiency through Accountable Design Model (AHEAD). MedChi believes that the draft reflects thoughtful stakeholder engagement, a clear methodological framework, and an appropriate emphasis on affordability, sustainability, and accountability. However, MedChi believes there needs to be a stronger commitment from the State to ensuring access to primary care services, given the challenges faced by both physicians and patients in obtaining needed services.

Primary care physicians are an essential driver of success in both cost containment and population health improvement, a role that MDH and the Working Group must recognize as the State moves from methodology to the implementation of growth and investment targets. While the Draft Recommendations emphasize that the AHEAD Model seeks to improve population health outcomes while moderating cost growth, achieving that goal is not possible without a robust, adequately supported physician workforce. However, Maryland's trajectory is in a downward trend. According to a recent report, the Maryland Health Care Commission noted that Maryland has already seen a significant reduction in independent physician practices, a decrease of 45.9 percent from 2018 to 2023. Primary care physicians serve as the foundation of the health care system in numerous ways, including managing chronic conditions and preventing disease progression, coordinating care across settings, including specialty, hospital, and community-based services, and serving as the primary point of access for most patients. To that end, we highlight that the effectiveness of the TCOC growth target will depend heavily on

reversing this trend and physicians' ability to influence utilization patterns and guide appropriate care, ensuring that costly services, such as emergency department visits and hospitalizations, are minimized.

We have several recommendations regarding the all-payer primary care investment target to ensure the State is achieving its objectives under AHEAD. **First and foremost, MedChi's top priority is preserving value-based care models that empower physicians.** Value-based models and programs such as the Maryland Primary Care Program (MDPCP) and the Episode Quality Improvement Program (EQIP) play a crucial role in the overall health transformation process and enable primary care providers to take a greater role in prevention, chronic disease management, and reducing unnecessary hospital utilization. If the federal government discontinues these programs, it is essential that investments in similar programs be replaced to ensure adequate support for small practices. We must maintain some sort of value-based or Care Transformation Organization (CTO) model to continue the viability of primary care practices. Continuing to support these programs will be essential in achieving our goals under the growth and primary care investment targets.

Additionally, we stress the importance of health insurers in Maryland directing more spending toward primary care. This is why MedChi strongly supported *House Bill 494* in the 2026 Session, which would have required insurers to reimburse primary care providers in a manner that meets the annual primary care investment targets that MDH and the Regulatory Working Group are trying to establish. *House Bill 494* passed the House of Delegates, but unfortunately did not make it out of the Senate. Passing this bill would have strengthened access to primary care and ensured the financial stability of independent primary care practices. While we support the goals of primary care investment targets, this bill would have enhanced their effectiveness by requiring insurers to meet the targets. MedChi encourages MDH and the Regulatory Working Group to support a policy like the one proposed in *House Bill 494* going forward.

Finally, MedChi cautions that we must monitor implementation to ensure that efforts to contain costs do not inadvertently erode access to physician services or destabilize primary care practices. We recommend monitoring metrics such as primary care panel sizes and capacity, appointment wait times, physician workforce trends (including practice closure rates), and geographic disparities in access to primary care services. Protecting primary care physicians and their ability to deliver care is essential to maintaining system stability and achieving our long-term goals under AHEAD.

Maryland has long been a national leader in health care delivery reform, and this proposal represents an important next step in advancing affordability and population health. Realizing the promise of the AHEAD Model will depend on a strong, well-supported primary care physician workforce capable of leading care transformation at the patient and community levels. We appreciate your consideration of these comments and look forward to continued collaboration in strengthening Maryland's health care system.

Sincerely,



Ashton DeLong, Esq.
General Counsel
MedChi, The Maryland State Medical Society

cc: Members, Health Services Cost Review Commission
Doug Jacobs, Executive Director, Maryland Health Care Commission



Maryland
Hospital Association

June 3, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

As a member of the Multi-Agency Regulatory Working Group's All-Payer Total Cost of Care Growth Technical Advisory Committee, I am pleased to submit the following comments on the draft methodology paper shared with the members. Thank you for the privilege of serving on this important committee.

MHA supports HSCRC's efforts to improve transparency in health care spending and to establish all-payer total cost of care (TCOC) growth targets that reflect Maryland's unique all-payer system. The methodology should account for the non-hospital drivers of spending growth and provide meaningful insight into the affordability challenges facing Maryland residents. We appreciate staff's incorporation of the guiding principles discussed during prior meetings, including recommendations submitted by MHA. Based on the initial review of the recommendations, I offer the following recommendations to further align the methodology with those principles and support Maryland's success under the AHEAD Model:

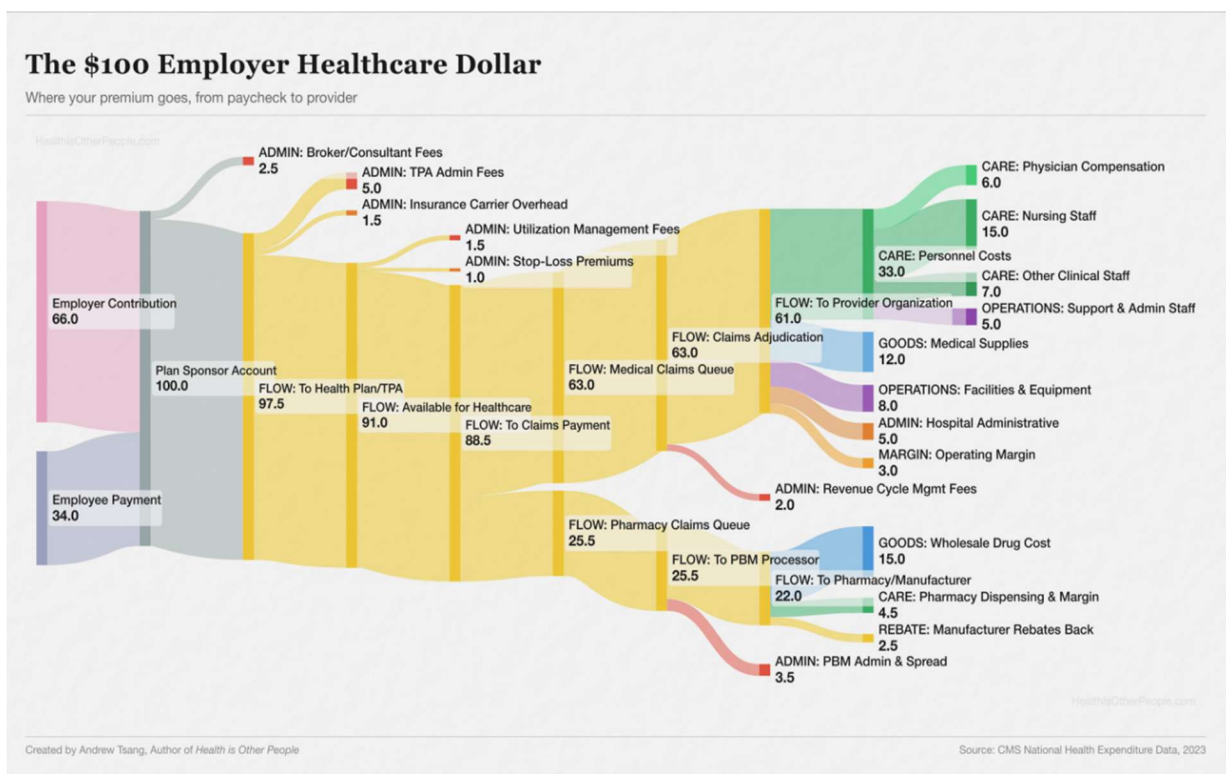
- Include the administrative cost of private insurance in the all-payer TCOC calculation
- Set the initial target without pharmacy costs and work toward the inclusion of rebate information after three years
- Exclude 2025 from the historical trend calculation to mitigate the impact of the changes in federal workforce for that year and reduce the weighing of wage growth
- Maintain CY 2026 as the fixed base year for future target setting
- Evaluate the methodology after the state has produced a historical trend of all-payer TCOC

Recommendation: Include the administrative cost of private insurance in the all-payer TCOC calculation

Unlike any other state, Maryland's all-payer model already constrains hospital prices and volume through revenue budgets for acute care hospitals, making it essential that any all-payer TCOC benchmark captures the non-hospital drivers of health care spending. Gov. Wes Moore's directive to form a multi-agency regulatory work group also guided the working group's focus to ensure "no critical health infrastructure should shoulder this burden alone, and the savings

requirement will not be borne exclusively by hospitals.”¹ For commercial payers, hospital costs are lower in Maryland (20% lower) than they are for comparable areas across the country, yet premiums are only 4% lower than the U.S. average for an individual plan and on par with the national average for a family plan. Affordability measures should be designed to produce a comprehensive analysis of all cost-drivers, including non-hospital and carrier administrative costs, to inform development of policies to lower premium costs for Marylanders. Excluding the administrative cost of private insurance would understate total spending and limit the state’s ability to assess affordability comprehensively. Administrative costs account for an estimated 15% to 20% of premium spending and are included in comparable measures used by other states. As shown in Exhibit 1, these costs reflect substantial administrative complexity and may present opportunities to improve efficiency, patient experience, and clinical care while preserving system sustainability.

Exhibit 1: A diagram of health care spending



Source: [Health is Other People blog - by Andrew Tsang](#)

Recommendation: Set the initial target without pharmacy costs and work toward the inclusion of rebate information after three years

Prescription drug spending is an important and growing contributor to health care costs and an increasing affordability challenge for patients, employers, and public programs. National data show that prescription drug spending increased **7.9% to \$467 billion in 2024**, following **10.8%**

¹ [2025-10-10_AHEAD RWG Initial Plan v5](#)

growth in 2023, while net U.S. medicine spending rose **11.4% in 2024 to \$487 billion**, driven largely by greater use of high-cost therapies such as obesity drugs rather than broad-based price inflation.^[1] Given these trends, retail pharmacy costs should not be incorporated into the benchmark until rebate information is available. Rebates represent a significant portion of prescription drug spending and can materially affect net costs. Including pharmacy spending without accounting for rebates could result in an incomplete and potentially misleading measure of spending growth.

We therefore recommend establishing the initial benchmark without pharmacy spending and developing a pathway to incorporate pharmacy costs once rebate information becomes available and the state has gained several years of experience with the benchmark methodology.

Recommendation: Exclude 2025 from the historical trend calculation due to the impact of federal employment and reduce the wage growth

HSCRC staff recommended excluding the COVID period from the trend calculation and starting with a three-year average. However, wage growth in 2025 could also be considered as a unique trend due to changes in the federal workforce. Maryland has the third largest federal workforce in the nation and has long relied on federal jobs for economic stability. Federal workers earn significantly above the median wage, and their presence supports local businesses through spending. Maryland has lost more federal jobs than any other state due to federal government cutbacks, more than 25,000 positions.² Compared with a 2.6% growth rate, private nonfarm wages and salaries grew at 3.59 % in 2025. If the state will exclude 2021-2022 from the historical trend, we recommend excluding 2025 to mitigate the impact of changes in the federal workforce.

Exhibit 2: Historical Economic Indicators

	2020	2021	2022	2023	2024	2025
State GDP	-1.3%	8.2%	7.6%	6.9%	6.0%	4.0%
Wage Growth	1.5%	6.6%	5.5%	5.3%	6.4%	2.6%
2025-2023 Average-State Proposal						5.27%
2025-2021 Five-year Average						5.92%
2023-2024 Average						6.15%

In addition to contemporaneous issues with wage growth, including wage growth in the all-payer total cost benchmark may have an unintended consequence for the disincentivizing wage growth in the health care sector in the state. Health care and social services employs more Marylanders

than any other sector and has added over 51,000 jobs since 2022 – nearly as many as all other industries combined.³ We recommend reducing the weight of wage growth to 20 percent due to the complexity of the relationship between wages and health care sector, and developing affordability targets based on wage growth, premium costs and out-of-pocket spending.

Recommendation: Maintain CY 2026 as the fixed base year for future target-setting

We recommend maintaining CY 2026 as the fixed base year for future target-setting. Shifting the base year from CY 2026 to CY 2029 after three years would reduce predictability and introduce unnecessary volatility into future trend calculations.

A fixed base year is more consistent with Maryland’s historical benchmarking approach, including the AHEAD total cost of care and all-payer hospital revenue benchmarks, which rely on fixed baseline periods.

Recommendation: Evaluate the methodology after the state has produced a historical trend of All-payer TCOC

We recommend that future methodology decisions be informed by actual performance experience under the benchmark. Statewide targets should reflect Maryland’s experience, improve transparency into systemwide spending trends, and focus on the drivers of affordability beyond hospital utilization. At the same time, we recommend that the benchmark preserve continued access to acute care and support the long-term sustainability of Maryland’s health care system.

Thank you for the opportunity to comment on this important matter. We appreciate the thoughtful engagement throughout this process and look forward to continuing to contribute to the development and refinement of the all-payer total cost of care methodology.

Sincerely,

Sule Gerovich, Ph.D.
Senior Vice President, Health Care Analytics

Cc: Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission

^{3,3} [Maryland Industry Analysis: Healthcare and the Economy, April 2026](#)



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CORPORATE OFFICE

June 3rd, 2026

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Members of the All-Payer Total Cost of Care Growth Advisory Committee,

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, thank you for the opportunity to provide comments on the development of statewide accountability targets for All-Payer Total Cost of Care (AP TCOC) growth under the AHEAD Model. UMMS remains committed to partnering with the State to ensure Maryland's continued leadership in advancing high-value, equitable care while maintaining access and system sustainability.

As the State has released its initial proposal for AP TCOC growth targets, we again offer the following principles and considerations to support successful implementation. UMMS is concerned the proposed methodology has created a target that is neither achievable based on historic and other state experiences, nor operational in its measurability, understanding of policy levers and current level of health system participation, beyond hospital regulation.

1. Ensure the Methodology Creates a Measure that is Impactable through Available Regulatory Levers and Does not Allow Hospitals to Solely Bear the Burden of Performance, per Governor's Directive.

Given the novelty of the AHEAD Model, limited regulatory levers beyond hospital rate-setting, and material financial risks to the system, AP TCOC targets should initially function as monitoring and evaluation tools rather than direct drivers of regulatory action.

UMMS would prefer to have actual performance under the benchmark methodology available and assessed before committing to an approach. The methodology proposed has not been assessed for achievability; based on publicly available data for health care expenditures per capita, MD would have been far above the proposed three-year target of

5.2% all-payer total cost of care growth. As a State, we should transparently understand if Maryland has been near or off target in prior years to support a stable approach to the AHEAD Model.

Other states' experience demonstrates that TCOC benchmarks are most effective when used for transparency and learning, not immediate enforcement, particularly where data completeness and policy levers remain underdeveloped. UMMS is concerned the State's ambitious timeline and our own personal experience from accountable care model work comparing commercial claims across payers will delay insight into self-insured payer growth and insights to improve/manage this target will remain limited for quite some time. Until we have full transparency in monitoring total cost of care equally across payers, we should exercise caution and monitoring only approaches for AP TCOC. Early-year targets/policy commitments to CMS should reflect data limitations and prioritize improved payer transparency.

While this target triggers only corrective action under AHEAD, as opposed to Model termination, there is still significant risk in ambitious target commitments that differentiates Maryland's experience from peer states. Should the State need to implement corrective action with CMS, there are limited regulatory levers in Maryland outside of hospital rates to solve a missed target problem. This poses a risk for destabilization of hospital financing and misalignment with payer behavior and warrants a conservative, adjustable, and achievable target framework. Additionally, Maryland has experience with annual targets that can fluctuate financial decision-making with the prior guardrails test in the TCOC Model. These guardrails have caused instability in the Model, despite continued results on Medicare TCOC and overall Model targets. Maryland should aim to ensure stability and minimize risk fluctuations in the AHEAD model with retrospective targets like the All-Payer TCOC growth target.

2. Do not Rebase this Target and do not Include Pharmacy Costs: Ensure Alignment Across AHEAD Metrics and Methodologies

AP TCOC targets must align with Medicare TCOC growth targets and hospital all-payer revenue constraints. This includes consistent methodologies for inflation and utilization, baseline, exclusion of prescription drugs, and alignment with federal definitions.

- Rebasing this target is the first time we have considering a re-setting of a base target in this Model. We should keep the AP TCOC Target, an experimental target with data and accountability limitations already, to this same standard and use 2026. Shifting the target every three years would reduce stability and create a volatile policy management space for the state. By the time data is available, results are reconciled and reported and any policy and/or corrective actions are determined between the

State and CMS, the State will likely be moving onto a new target. This dynamic does not create a more accurate target, rather it creates a hamster wheel nearly impossible to manage/problem solve to.

- Retail pharmacy and Part D costs have never been a part of the cost management proposals of the Maryland Models, and are not domains in which the State nor the Federal government have exhibited strong levers of control. The proposed addition of these components will create an even higher hill to climb to maintain consistent performance. The State should set the initial targets without pharmacy costs and work toward including rebate costs, if there is intention to eventually include pharmacy in the target. Without rebate incentives balanced into the scorekeeping, this component of our target will introduce erroneous headwinds to performance tracking.

3. Promote Full-System Accountability for Affordability

Hospital cost growth is not the sole driver of TCOC, and the AP TCOC growth target will not be able to guarantee affordability to Marylanders. The State should complement AP TCOC commitments to CMS with a plan to examine payer plan design, administrative costs, and patient premium/out of pocket affordability, ensuring accountability across all stakeholders. Payer transparency and data availability remains a problem where the policy action and solution for Maryland is unknown. This will impede Maryland's ability to perform on not just total cost commitments, but also affordability examination and improvement. Creating a TCOC growth analysis gives the State the opportunity to explore where other components of the system are eroding affordability, such as insurer's plan design or private equity investments in unregulated settings of care. The State will need to be clear with CMS and their policy proposals to the governor that hospital cost growth and HSCRC regulatory oversight is not the sole lever of impact for healthcare affordability, nor AP TCOC Growth in MD.

7. Preserve Investment in Transformation, Access, and Sustainability

AP TCOC targets should not constrain necessary investments in primary care, population health/care transformation, capital infrastructure, and underserved communities. The State should specifically note to CMS that these purposeful investments should be excluded or built into proposals and reporting on this target. This will allow Maryland to purposefully invest in our healthcare system's transformation and future in partnership with the Model, instead of under limits.

June 3, 2026

Page 4

In closing, UMMS supports a measured, aligned, and transparent framework for AP TCOC targets that recognizes current limitations, ensures shared accountability, and preserves system sustainability.

Sincerely,

A handwritten signature in cursive script, reading "Alicia Cunningham", followed by a vertical line.

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services



USofCare Comments: Maryland's All-Payer TCOC Growth Target Recommendation

Alyssa Penna Williamson

Thu, May 28, 2026 at 3:49 PM

To whom it may concern,

As one of two consumer representatives on the All-Payer Total Cost of Care Target Technical Advisory Committee, thank you for the opportunity to comment on HSCRC's Regulatory Working Group All-Payer Total Cost of Care Growth Draft Recommendation ("Draft Recommendation"). [United States of Care](#) (USofCare) is a multi-state, non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care regardless of who they are, where they live, or how much money they make. We've worked with stakeholders and agencies, including HSCRC, to ensure the consumer perspective is heard as Maryland builds upon the success of its unique [Total Cost of Care \(TCOC\) Model](#) through implementation of the [Achieving Healthcare Efficiency through Accountable Design \(AHEAD\) Model](#).

To that end, our [comments](#) submitted on March 20 focused on several areas that could positively benefit consumers as HSCRC considered the development of a TCOC growth target:

- **The TCOC growth target should be tied to median household income**, blended with gross state product (GSP) to account for any unforeseen household income growth stagnation.
- **The TCOC growth target should exempt certain Medicaid services**, including developmental disability services and other HCBS, from the growth target calculation.
- **The TCOC growth target should include prescription drug spending** in order to understand its impact on overall health care spending.
- **HSCRC should consider establishing an affordability standard to be monitored in parallel with the TCOC growth target** to measure its impact on consumer affordability.

We were pleased to see the Draft Recommendation align with our recommendations on exempting certain Medicaid services and including prescription drug spending in the overall TCOC growth target calculation. More broadly, we recognize that the Draft Recommendation chose to establish a TCOC growth target informed by a 50/50 blend of wage growth and GSP, which differs from our recommendation of a blend of household income and GSP. We believe household income is more representative of people's experiences and is a better measure of a household's ability to spend. More broadly, other states, including [California](#) and [New Jersey](#), have relied on household income to inform the development of their health care cost growth targets, and we encourage HRCRC to do the same.

Should the Draft Recommendation maintain the wage growth metric over median household income, we believe this only strengthens the need for an affordability standard to ensure people's affordability experiences are reflected in the cost growth target, with proper adjustments as needed. To that end, we are very pleased to see the Draft Recommendation include language that commits HSCRC to working with stakeholders to "identify measures that inform quality, access, and affordability." We believe this lays the groundwork for such an affordability standard that takes into account Marylanders' health care costs, including both premium growth and out-of-pocket costs, and their impact on overall health care affordability. We are happy to partner with HSCRC and provide feedback and assistance on further development of an affordability standard as needed.

Thank you for the chance to provide feedback and the opportunity to serve on this Advisory Committee. Please do not hesitate to reach out with any questions.

Sincerely,
Alyssa Penna

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Alyssa Penna (she/her)
Director of Federal Policy
571.455.0321

Public Review of Draft Methodology

July 2026



To: Health Services Cost Review Commission

From: Robyn Elliott on behalf of the American College of Nurse Midwives – Maryland Affiliate

Date: July 16, 2026

RE: ACNM Comments on Regulatory Workgroup Policy Draft Recommendations on All Payor Total Cost of Care Model

The American College of Nurse Midwives – Maryland Affiliate (ACNM) appreciates the opportunity to submit comments on the draft recommendations regarding the methodology utilized in the All-Payor Total Cost of Care Model. We have two recommendations to ensure the methodology appropriately reflects the role of midwifery in primary care:

Recommendation 1 - Modify the AHEAD Primary Care Definition to Include Licensed Certified

Midwives: We agree with the inclusion of certified nurse midwives (CNMs) in the definition of primary care providers, as consistent with Medicare, Medicaid, and Maryland state policy. We would recommend that the definition be updated to include licensed certified midwives (CMs) to reflect Maryland’s licensure law. In 2021, the Maryland General Assembly established the CM licensure category.ⁱ Since CMs share the same scope of practice as CNMs, we believe that their scope falls under the definition of primary care midwifery for the Maryland Health Care Commission’s Primary Care Workgroup.ⁱⁱ Also, the Maryland General Assembly recently clarified that health maintenance organizations must recognize both CNMs and CMs as primary care providers in the *2026 Physician Assistants and Midwives Parity Act*.ⁱⁱⁱ

We would note that the Maryland Board of Nursing did not begin licensing CMs until February 2026, so CM claims will not be included in any historical claims data. However, we recommend capturing any CM data prospectively.

Recommendation 2 – Recognize the value of primary care midwifery services in the methodology:

Both Medicare and the Maryland Medical Assistance Program reimburse midwives at 100% of the fee schedule, which appropriately reflects that value of midwifery. However, commercial payors vary in reimbursement rates for midwives as compared to physician rates; and as a result, commercial claims data may not accurately reflect the value of

midwifery services. We recommend that the HSCRC work with the Maryland Health Care Commission to ensure its methodology reflects the value of primary care, rather than just the claims data. We understand that the HSCRC has cited that the State may not always be in a position to meet its primary care investment goals, but the goals should be accurate and not perpetuate the undervaluing of midwifery services.

Thank you again for the opportunity to submit these comments. If we can provide any further information, please contact our policy and legislative consultant, Robyn Elliott, at relliott@policypartners.net.

cc:

Douglas Jacobs, M.D., MHCC
Senator Clarence Lam
Chair Heather Bagnall
Delegate Jennifer White Holland

ⁱ Chapters 462 and 463 of 2021.

ⁱⁱ Chapters 667 of 2022.

ⁱⁱⁱ Chapters 222 and 223 of 2026



Request for clarification — AHEAD all-payer TCOC growth target and surgical specialty care

Mostafa Ahmed

Tue, Jun 30, 2026 at 11:38 AM

Dear HSCRC AHEAD Model Team,

I am writing during the public comment period on the June 2026 draft recommendation, All-Payer Total Cost of Care Growth and Primary Care Investment Targets. I am a board-certified otolaryngologist and head and neck surgeon practicing in Montgomery County with a focus on nasal surgery to improve sleep apnea management. I appreciate the Regulatory Working Group's careful, stakeholder-informed approach, and I am writing to request clarification on how the all-payer TCOC growth target is expected to affect surgical and procedural specialty care.

My core question concerns the relationship between the target and long-term health outcomes. As drafted, the growth target is benchmarked to a 50/50 blend of gross state product and wage growth — economic indicators of affordability rather than measures of clinical outcome. The draft is candid that the target functions as an "alert" mechanism. I would be grateful for clarification on what, if any, evidence supports the expectation that holding cost growth to an economic benchmark improves long-term patient outcomes, and on what safeguards will prevent payers, now accountable for total cost of care across Commercial, Medicare Advantage, and Medicaid, from responding with utilization management that suppresses procedures with demonstrated downstream health and cost benefit.

I raise this with a concrete example from my own field. Nasal airway obstruction is a well-documented barrier to CPAP tolerance and adherence in patients with obstructive sleep apnea. Improving nasal patency can meaningfully improve a patient's ability to use CPAP, and sustained CPAP adherence is associated with reduced cardiovascular and metabolic risk — precisely the downstream, high-cost morbidity that drives total cost of care. A minimally invasive nasal procedure that enables CPAP adherence is therefore a plausible example of an upfront specialty expenditure that lowers long-term system cost while improving health.

The recent evidence base for these procedures is robust. Two three-year studies published in 2025 are directly relevant:

- The VATRAC randomized controlled trial (Otolaryngology–Head and Neck Surgery) evaluated 108 patients with severe-to-extreme nasal airway obstruction due to nasal valve collapse and demonstrated durable improvements in nasal airflow, sleep quality, and quality of life at three years, including a significant reduction in daytime sleepiness (Epworth Sleepiness Scale mean change of –4.85).
- The AERWAY study (OTO Open), conducted across 12 U.S. sites, showed sustained symptom relief with an 83.3% responder rate, a 52.6% improvement in NOSE scores, a 3.2% reintervention rate, and no serious adverse events at three years.

While these trials measured nasal and sleep outcomes rather than CPAP adherence directly, they establish durable, high-quality evidence for the upstream intervention; the adherence and downstream-cost link is well supported in the OSA literature and is the subject of ongoing research I am pursuing locally.

With that context, I would appreciate clarification on the following:

1. How will the methodology distinguish between cost growth that reflects waste and cost growth that reflects value-generating procedures expected to lower total cost of care over a multi-year horizon?
2. Given the three-year cumulative measurement window, will procedures whose savings accrue beyond that window (e.g., averted cardiovascular events from improved CPAP adherence) be accounted for, and if so, how?
3. What monitoring is planned to detect reduced access to medically necessary specialty procedures as an unintended consequence, and would the Working Group consider adding a specialty-access measure to the access metrics referenced in Section 1.5?
4. Will specialists have a channel to submit cost-effectiveness evidence relevant to the target's design and reporting?

Thank you for your work on this and for considering these comments. Respectfully,

Mostafa Ahmed, MD

Board-Certified Otolaryngology – Head & Neck Surgery

July 20, 2026

Jonathan Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215



Dear Dr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to comment on the Regulatory Working Group's draft policy recommendation on the All-Payer Total Cost of Care (TCOC) Growth and Primary Care Investment Targets. JHHS appreciates the Regulatory Working Group's engagement with stakeholders through this process. As noted in prior comments, JHHS would note the following concerns, as this methodology has direct implications for the viability of the AHEAD Model and for healthcare access and quality in Maryland.

Consistency with Medicare TCOC Targets

JHHS continues to urge the State to align the All-Payer TCOC Growth Target methodology with the Medicare TCOC targets, as cost growth should be assessed consistently across payers. JHHS remains concerned about the inclusion of pharmacy expenditures, including Medicare Part D, in the all-payer TCOC target. Pharmacy costs are largely outside the control of hospitals and health systems; Maryland hospitals do not set drug prices, do not drive pharmacy benefit design, and have no meaningful lever to reduce Part D expenditures. Incorporating pharmacy costs into the growth target risks producing a benchmark that Maryland cannot achieve due to factors outside hospital control.

JHHS appreciates that the draft recommendation proposes to display the trend excluding pharmacy and to monitor pharmacy as a potential exogenous factor. However, JHHS recommends that the State entirely exclude pharmacy from the target calculation itself, tracking it separately as proposed for pharmacy rebates and self-pay populations. If pharmacy remains within the target, the State should include in the final recommendation that pharmacy trend in excess of a defined threshold will trigger the exogenous factor adjustment, rather than leaving that determination to be made retrospectively.

Additionally, pharmacy expenditures are included while pharmacy rebates are excluded for lack of data granularity. Measuring gross pharmacy spending without netting rebates will overstate Maryland's cost growth and further distance the measured trend from the affordability the target is intended to capture.

Multi-Stakeholder Accountability

JHHS strongly supports the draft's guiding principle that the target should reflect systemwide accountability and that no one part of the health care system alone is responsible. However, the draft recommendation does not yet translate that principle into concrete accountability for payors. As noted previously, hospital care constitutes approximately 31% of Maryland's personal health care expenditures. Given the impact of non-hospital spending on performance, and given that hospitals are the only sector already operating under a binding revenue constraint, hospitals should not bear the full

burden of total cost of care accountability. The TCOC Growth Target framework must include meaningful accountability for payors to achieve the model's intent to improve affordability for Marylanders. As noted in the workgroup's discussions, Maryland families pay higher health insurance premiums than the national average. If the State meets its TCOC growth target, those savings must be passed along to consumers in the form of lower premiums.

As MHA notes as well, JHHS recommends that the final framework include benchmarks for health insurance premium growth and administrative cost ratios, together with a defined process to report and monitor consumer affordability. The draft recommendation identifies premium growth and out-of-pocket spending as examples of *potential* measures that may be selected in advance of the first performance report. However, JHHS recommends that the final recommendation commit to premium growth and administrative cost measures explicitly, and that the Maryland Insurance Administration's role in acting on those measures be specified.

Data Concerns

JHHS continues to have significant concerns related to the completeness and reliability of the data underlying the proposed target. The draft recommendation confirms several of the gaps identified in workgroup discussions and earlier comments. A reliance on estimates and modeling introduces uncertainty that could have meaningful consequences for how performance against the target is measured and reported. JHHS recommends that the State establish a process for updating completion factors and estimation methodologies as better data sources become available, and communicate any revisions to stakeholders before applying these to performance measurement.

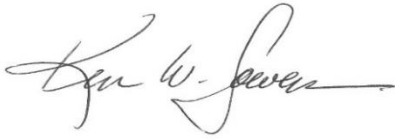
Additionally, JHHS would caution the State against using TCOC target performance results for enforcement or corrective action purposes until the data infrastructure is sufficiently complete and validated to support reliable conclusions. As MHA has noted, this should be a monitoring-focused approach in the near term.

Exogenous Factor Adjustments

JHHS supports the draft recommendation's recognition that a prospectively set target must retain flexibility to adjust for exogenous factors, and appreciates the acknowledgment that achieving the primary care investment target may itself elevate expenditures and cause the State to miss the TCOC growth target. To be meaningful, however, this flexibility must be operationalized. JHHS recommends that the final recommendation describe the criteria, evidence and process by which the State will determine that an exogenous factor warrants adjustment, rather than reserving that determination to an undefined future judgment. A clearly specified adjustment process will strengthen the credibility of the target.

JHHS urges the State to carefully consider these issues before finalizing the methodology for submission to CMMI. The methodology must be aligned with Medicare targets, structured to distribute accountability appropriately, grounded in complete and reliable data, and designed to ensure that impact is felt by the consumers the model is intended to serve. JHHS welcomes further collaboration on this issue, and looks forward to continued engagement in the process.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin W. Sowers". The signature is fluid and cursive, with a long horizontal stroke at the end.

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Marie Grant, Maryland Insurance Commissioner, Maryland Insurance Administration
Doug Jacobs, Executive Director, Maryland Health Care Commission



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

July 20, 2026

Jon Kromm, Ph.D.
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets

Dear Dr. Kromm:

Kaiser Permanente appreciates the opportunity to comment on the Regulatory Working Group's draft recommendation for all-payer total cost of care and primary care investment targets. Our comments will focus on the primary care investment proposal.

Kaiser Permanente is the largest private not-for-profit integrated health care delivery system in the United States, delivering health care to over 12.9 million members in nine states and the District of Columbia.¹ Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, Virginia, and the District of Columbia, provides and coordinates complete health care services for over 766,000 members. In Maryland, we deliver care to approximately 436,000 members.

All-Payer Total Cost of Care Growth Target

Kaiser Permanente appreciates the Regulatory Working Group's thoughtful analysis and ongoing efforts to support implementation of the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model. Rising prescription drug costs continue to be a significant driver of increased spending in the commercial insurance market. We thank the Working Group for recognizing the importance of pharmacy spending by monitoring it both as a distinct category and as a component of the total cost of care target. This approach will help ensure transparency and accountability in assessing the impact of drug costs on overall health care spending.

Primary Care Investment Target

Kaiser Permanente appreciates Maryland's resource-based methodology for estimating the cost of comprehensive primary care. By basing primary care investment levels on the resources needed to deliver comprehensive, team-based care, the approach provides a structured

¹ Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and over 610 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

framework for estimating primary care costs independent of changes in overall health care spending.

Definition of Primary Care

We are concerned that the definition of primary care is too narrow to fully encapsulate the advanced primary care system the state envisions. The definition relies on a combination of provider specialty and HCPCS billing codes, capturing services such as evaluation and management, preventative care, care management, vaccinations, screenings, family planning, and certain OB/GYN services provided by a defined set of primary care specialties.

This code- and provider-based approach does not fully reflect the range of primary care activities Kaiser Permanente performs. The Maryland Department of Health (MDH) has recognized Kaiser Permanente as engaging in advanced primary care activities, such as providing post-Emergency Department follow-up care management, as a part of the AHEAD Medicaid Advanced Primary Care Program.

The current definition does not include many provider specialties that are important to team-based care and typical of an integrated system, such as pharmacists, community health workers, care coordinators, behavioral health providers, and non-practitioner nurses. It also fails to recognize integrated primary care team roles and instead focuses only on billing taxonomy. Maryland should also include additional services that are hallmarks of an integrated system, such team-based, virtual, care-management/care coordination, behavioral health integration into primary care, and community social needs support services in this definition. Also, when considering vaccinations, the physical costs of the serum and tools required to provide the vaccine should be included in addition to the administration cost.

Additionally, Maryland includes Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) claims regardless of provider specialty code if the claim includes a qualifying HCPCS code. That may be appropriate for those settings, but we are concerned that similar team-based or clinic-based primary care activity in other delivery models does not receive the same treatment. Integrated delivery systems should not be disadvantaged relative to FQHC and RHC billing structures if the scope of services provided are functionally primary care. We encourage the Working Group to ensure that functionally equivalent primary care services delivered through other integrated care models receive comparable treatment. We welcome the opportunity to meet with the Working Group to discuss these concerns.

Other Non-Claims-Based Investments in Primary Care

Kaiser Permanente also recommends that the Working Group develop a methodology for recognizing non-claims-based primary care investments that occur within integrated delivery systems. Reliance on the Medical Care Database (MCDB) claims data alone, will substantially understate the primary care services that organizations finance through provider salaries, capitation, care management programs, technology infrastructure, quality improvement initiatives, and population health programs rather than fee-for-service reimbursement. The Working Group should consider supplemental reporting methodologies that more accurately capture these investments and provide clear reporting specifications, validation processes, and

opportunities for integrated care systems to explain how primary care resources are allocated. We welcome continued dialogue with the Working Group to determine how this can be measured and recorded.

Further, Kaiser Permanente recommends that the methodology recognize payer-funded investments in primary care that are financed through HSCRC-regulated hospital rates as qualifying primary care investments. Recent HSCRC proposals have added funding to FQHCs and local health departments providing primary care services and recognize that targeted investments in primary care can improve population health while reducing downstream costs. Excluding these expenditures would understate the level of investment already being made by payers. Recognizing these investments would more accurately reflect total payer investment in primary care, maintain consistency with the purpose of the investment target, and preserve incentives to support innovative financing approaches that expand access to primary care.

Conclusion

Kaiser Permanente respectfully requests a more expansive definition of primary care that better captures the multidisciplinary nature of primary care delivered through integrated systems. We encourage the Working Group to ensure that the methodology accurately recognizes primary care investment across diverse payment and delivery models.

Kaiser Permanente welcomes the opportunity to meet with the Working Group to discuss these recommendations in greater detail. Thank you for the opportunity to comment. Please feel free to contact me at christopher.e.west@kp.org or (804) 525-8105 with questions.

Sincerely,



Christopher E. West
Head of Government Relations
Kaiser Permanente Mid-Atlantic Region



The **League** of Life
and Health Insurers
of Maryland

July 17, 2026

Jon Kromm, Ph.D.
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Regulatory Working Group Policy Draft Recommendation: Primary Care Investment Targets

Dear Dr. Kromm:

The League of Life and Health Insurers appreciates the opportunity to comment on the Regulatory Working Group's draft recommendation establishing primary care investment targets under Maryland's AHEAD Model. The League and its member companies share the State's commitment to strengthening primary care and recognize the important role that primary care investment can play in improving health outcomes and reducing avoidable utilization over the long term.

Proposed Primary Care Investment Targets

The League supports the Working Group's decision to develop a resource-based methodology for establishing primary care investment targets. Basing investment targets on the estimated resources necessary to deliver comprehensive, team-based primary care is a thoughtful approach that more directly links funding to care delivery needs than a methodology based solely on total medical expenditures (TME). By avoiding an automatic connection between primary care spending and growth in hospital, specialty, or pharmaceutical expenditures, the proposed methodology represents an important advancement in how primary care investment can be measured.

While the methodology is well conceived, the proposed commercial PMPM targets raise questions regarding the pace of implementation. The methodology estimates the financial resources required to support comprehensive primary care but does not evaluate whether those investment levels are operationally achievable within the proposed timeframe. In particular, the analysis assumes that Maryland's provider workforce can expand sufficiently to support the multidisciplinary care teams envisioned by the model.¹ If workforce constraints limit providers' ability to recruit physicians, advanced practice clinicians, behavioral health professionals,

¹ See *Maryland Physician Shortage Facts*, Cicero Inst. (Feb. 15, 2024), <https://ciceroinstitute.org/research/maryland-physician-shortage-facts/>; *Health Workforce Shortage Areas*, Health Res. & Servs. Admin., <https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard> (last visited July 9, 2026).

pharmacists, and other care team members, increased funding alone may not produce the improvements in access, care coordination, and avoidable utilization that the investment targets are intended to achieve.

The League also encourages the State to establish a framework for evaluating whether increased primary care investment is producing the intended improvements in access, utilization, quality, and health outcomes. Investment levels are an important policy input, but the ultimate measure of success should be whether more Maryland residents are able to establish relationships with primary care providers, receive timely preventive and chronic care, and experience reductions in avoidable emergency department utilization and hospitalizations. Establishing meaningful outcome measures and a timeline for evaluating progress would strengthen the accountability framework and help inform future adjustments to the investment targets.

The proposed investment trajectory also represents a significant departure from recent spending patterns. According to the Maryland Health Care Commission's 2025 Primary Care Investment Analysis and Recommendations Report, statewide primary care spending increased from \$33 PMPM to \$35 PMPM between 2021 and 2023, representing an annual growth rate of approximately 3 percent. By comparison, the Working Group proposes increasing the commercial target from \$40 PMPM in 2026 to \$57 PMPM in 2030, an annual growth rate of approximately 9.3 percent. Although we recognize the Working Group's intent to address historical underinvestment in primary care, this level of acceleration would require commercial carriers to substantially increase primary care investment over a relatively short period while simultaneously maintaining affordability for employers and consumers.

The draft recommendation appropriately acknowledges implementation risks, including the possibility that payers may not achieve the proposed targets and that changing fiscal conditions could affect implementation. These considerations underscore the importance of adopting investment targets that are both ambitious and achievable.

The League recommends aligning annual growth in the commercial primary care investment target with the proposed 5.2% all-payer cost growth target. This approach would preserve the State's resource-based methodology while moderating the pace of investment growth, allowing primary care investment to grow faster than historical trends while remaining consistent with the State's broader affordability framework. It would also reduce implementation risk by making the targets more achievable for commercial and government payers in the face of workforce constraints and fiscal uncertainty.

If we assume that primary care spending continued to grow at a rate of 3% through 2026 and then increased to 5.2% thereafter, the PMPM would be:

Year	League Proposal (5.2% CAGR)
2026	\$38 PMPM
2027	\$40 PMPM
2028	\$42 PMPM
2029	\$44 PMPM
2030	\$47 PMPM

Recognition of Primary Care Investments Funded Through Hospital Rates

The League also recommends that the methodology fully recognize payer-funded investments in primary care that are financed through HSCRC-regulated hospital rates.

At the July 9 Payment Models Workgroup, HSCRC staff proposed adding \$25 million to hospital rates to support Federally Qualified Health Centers (FQHCs) and local health departments in providing primary care services intended to reduce avoidable hospital utilization. The proposal appropriately recognizes that targeted investments in primary care can improve population health while reducing downstream healthcare costs.

The League requests that these expenditures be recognized as qualifying commercial primary care investments for purposes of calculating compliance with the primary care investment targets. The purpose of the investment target is to measure the total level of payer investment in primary care, not simply the payment mechanism through which those investments are made. Health plans will finance this \$25 million investment through HSCRC-regulated hospital rates, and those funds are explicitly designated to support the delivery of primary care services.

Excluding these expenditures from the calculation of commercial primary care investment would understate the level of investment already being made by commercial carriers and would effectively require carriers to finance the same policy objective twice—once through increased hospital rates and again through additional spending to satisfy the PMPM investment target. Recognizing these investments would more accurately reflect total payer investment in primary care, maintain consistency with the purpose of the investment target, and preserve incentives to support innovative models that use hospital financing to expand access to primary care and reduce avoidable utilization. Failing to recognize these investments could unintentionally discourage future initiatives that use hospital financing to support primary care and population health.

Conclusion

The League respectfully encourages the Working Group to retain its innovative resource-based methodology while adopting a more gradual phase-in of the commercial primary care investment targets by aligning annual growth with the proposed 5.2% all-payer cost growth target. In addition, the League requests that the proposed \$25 million investment in primary care through Federally Qualified Health Centers and local health departments be recognized as qualifying commercial primary care spending for purposes of meeting the investment targets. Together, these recommendations would preserve the integrity of the State's resource-based methodology while improving its practicality, ensuring that commercial primary care investment is measured consistently regardless of the payment mechanism and that the proposed growth trajectory remains achievable within Maryland's workforce and affordability constraints. As implementation proceeds, the League also encourages the State to evaluate the success of these investments using meaningful measures of primary care access, utilization, quality, and health outcomes.

On behalf of the health plans operating in Maryland and supporting Maryland residents, we are very grateful for your attention on this matter. If you have any questions or would like to speak with us further on these topics, please reach out to me at mcelentano@fblaw.com.

Very truly yours,

A handwritten signature in black ink, appearing to read "Matthew Celentano", with a long horizontal flourish extending to the right.

Matthew Celentano
Executive Director

July 20, 2026

Jon Kromm, PhD Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

Thank you for the opportunity to comment on the Regulatory Working Group's draft recommendations regarding Maryland's All-Payer Total Cost of Care (TCOC) Growth Target and Primary Care Investment Target.

These targets are of critical importance to hospitals and health systems across Maryland as we operate under a global, value-based, and capitated payment model. We respectfully recommend several modifications to the proposed methodology to ensure the benchmark promotes long-term healthcare stability, accurately reflects healthcare spending, with the State's and the AHEAD broader transformation goals, and controlled by hospitals.

1. Do Not Rebase the TCOC Benchmark

We respectfully disagree with the proposal to rebase the benchmark after each three-year performance period. A cost growth benchmark is most effective when established from a stable baseline and updated through trend adjustments rather than periodic resets. Rebasings would undermine consistency, introduce uncertainty into performance expectations, and make it more difficult to evaluate long-term progress against a clear and predictable standard.

Recommendation: Maintain the initial benchmark methodology throughout the initial AHEAD implementation period and limit adjustments to circumstances involving significant exogenous economic events or other extraordinary factors.

2. Exclude Pharmacy Spending from the TCOC Benchmark Unless Net Costs Can Be Measured

We recommend excluding pharmacy expenditures from the TCOC benchmark calculation until reliable data are available to measure pharmacy spending on a net-cost basis. We want to reinforce the importance of this modification as discussed and documented by members of the regulatory work group throughout the working sessions.

Pharmacy spending reported through claims data frequently reflects gross expenditures rather than actual net costs after manufacturer rebates, formulary discounts, and other post-sale price concessions. As a result, pharmacy costs may be materially overstated relative to the actual amounts paid by purchasers and health plans. Drug spend trends have been volatile and can materially or inappropriately cap other healthcare sectors jeopardizing healthcare delivery.

Including pharmacy spending without accounting for rebates may:

- Overstate overall healthcare spending growth.
- Distort comparisons between medical and pharmacy cost trends.
- Create accountability for spending categories that providers and health systems cannot meaningfully influence.
- Produce inaccurate assessments of statewide performance under the AHEAD Model.

The risk is particularly significant given the increasing impact of specialty pharmaceuticals and manufacturer pricing decisions, which are largely outside the control of Maryland providers and healthcare systems.

Recommendation: Exclude pharmacy spending from the TCOC benchmark until net-cost data are available, or develop a separate pharmacy methodology that appropriately incorporates rebates, discounts, and other price concessions.

3. Hold Primary Care Investment Harmless in the TCOC Benchmark

We strongly support the State's goal of increasing investment in primary care. However, primary care spending growth required to meet the proposed Primary Care Investment Target should not simultaneously count against performance under the TCOC growth benchmark. The AHEAD Model establishes accountability for both total cost growth and primary care investment.

Absent a hold harmless provision, stakeholders may face conflicting incentives:

- Invest additional resources in primary care to achieve the State's investment target; and
- Reduce overall healthcare spending growth to remain below the TCOC benchmark.

Primary care investments often require near-term spending increases before generating longer-term savings through improved care coordination, chronic disease management, preventive care, and reduced avoidable utilization. Penalizing those investments within the TCOC benchmark could discourage the very activities the State is attempting to promote.

A hold harmless approach would better align Maryland's dual AHEAD objectives and provide certainty for providers, payers, and purchasers making long-term investments in primary care transformation.

Recommendation: Exclude incremental spending attributable to achievement of the Primary Care Investment Target from the TCOC growth calculation or establish an adjustment methodology that holds primary care investment growth harmless for purposes of benchmark performance assessment.

Conclusion

Maryland has a unique opportunity to establish a durable and credible statewide accountability framework under the AHEAD Model. To strengthen the effectiveness and stability of the proposed methodology, we respectfully recommend that the State:

1. **Maintain a consistent TCOC benchmark and avoid routine rebasing.**
2. **Exclude pharmacy spending unless net costs can be accurately measured.**
3. **Hold primary care investment growth harmless within the TCOC benchmark.**

We thank the State for its thoughtful consideration of these recommended changes and its commitment to ensuring a stable benchmark that promotes fair and meaningful accountability by aligning performance expectations with hospitals' and health systems' ability to affect costs and outcomes.

Sincerely,



Kathy Talbot
Vice President of Revenue Strategy and Optimization

Cc:

Marie Grant, MIA Commissioner
Dr. Doug Jacobs, MHCC Executive Director
[Dr. Doug Jacobs, MHCC Executive Director](#)
[Marie Grant, MIA Commissioner](#)



July 20, 2026

Jonathan Kromm, Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: MDH.Maryland-Model@maryland.gov

Dear Mr. Kromm,

Thank you for the opportunity to comment on the All-Payer Total Cost of Care Target draft recommendation. Maryland Citizens' Health Initiative (MCHI) is a consumer health advocacy nonprofit whose mission is achieving quality, affordable health care for all Marylanders. MCHI oversees the Health Care for All Coalition which is comprised of hundreds of faith, business, labor, community, and health care organizations across Maryland.

Under Maryland's all-payer hospital system, consumers have benefitted from the Health Services Cost Review Commission (HSCRC) working to balance consumers' health care costs, access to hospitals and clinicians, and quality of health care. As Maryland shifts to the AHEAD Model, it will be important to continue to achieve a balance of health care cost, quality, and access.

Medicaid Services

We are pleased that the draft recommendation excludes specific Medicaid services (developmental disabilities, adult medical day care, and home- and community-based services) from the target. The Marylanders who benefit from them arguably could receive more resources and still have unmet needs. For example, the developmental disabilities community has made clear that this year's proposed Medicaid budget cuts to Maryland Developmental Disabilities Administration will be harmful. Furthermore, these specific Medicaid services are already highly managed. We know that HSCRC has the technical expertise and data access required to exclude these targets from the target.

Prescription Drugs

We are pleased that high-cost prescription drugs be included in the target. High drug costs are a major part of health care spending and the target would not be complete if Maryland were to exclude them. Thankfully Maryland has the expertise to overcome data collection and analysis challenges. We are glad that HSCRC has been collaborating with Maryland's Prescription Drug Affordability Board (PDAB) on ideas for how to supplement Maryland's All Claims Database with other data sources. The PDAB has the authority to set upper payment limits on high-cost drugs for all Marylanders, which will help the State meet the target.



TCOC Growth Target Include Consumer-Focused Metrics

We are pleased that the target includes a consumer-focused metric in the target combined with Gross State Product. We believe that replacing wage growth with household income would better measure the financial realities and spending power of individuals and families, similar to how California and New Jersey have developed their targets, but understand that there are challenges with accessing current household income data. Moving forward, we encourage HSCRC to keep our comments in mind if more data becomes available and there is an opportunity to rebase the TCOC growth target to tie it, in part, to household income.

Affordability Standard

We are pleased that the draft recommendation commits HSCRC to identifying measures for quality, access, and affordability alongside stakeholders. This provision lays the foundation for an affordability standard that must account for all Marylanders' health care costs—including premium growth and out-of-pocket spending. We are eager to partner with HSCRC to provide the necessary feedback and assistance for developing this standard.

Affordability standards can help understand how people are experiencing health care affordability challenges and what role different sectors of the health care system play in driving those experiences. But, importantly, policy actions, like those taken through the implementation of the AHEAD Model, are necessary in ensuring that these standards are achieved and maintained. Controlling the underlying cost of care is inextricably linked to making sure that care is affordable; even with universal coverage and fairly designed subsidies and cost-sharing, ever-rising costs will erode wages and crowd out spending on other important goods and services. As such, the affordability standard should be leveraged to monitor and adjust efforts to rein in health care spending, such as in health insurance rate review and hospital global budget development.

We appreciate all you do to expand access to quality, affordable health care for all Marylanders. Thank you for the opportunity to provide comments on the All-Payer Total Cost of Care Growth Target, and please do not hesitate to reach out if you have any questions.

Sincerely,

Stephanie Klapper, Deputy Director, Maryland Citizens' Health Initiative

July 20, 2026

Secretary Meena Seshamani, M.D., Ph.D.
Maryland Department of Health
Herbert R. O'Connor State Office Building
201 W. Preston Street
Baltimore, MD 21201

Via Email: mdh.maryland-model@maryland.gov

Re: Public Comment – AHEAD Model All-Payer Targets Draft Recommendation

Dear Secretary Seshamani and Members of the Regulatory Working Group,

On behalf of MedChi, The Maryland State Medical Society, I am pleased to submit the following comments on the May 2026 draft “Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets,” (the “Draft Recommendations”). MedChi is a statewide professional association for licensed physicians with the mission of serving as Maryland’s foremost advocate and resource for physicians, their patients, and the public health. We thank the Maryland Department of Health (MDH) and the Regulatory Working Group for developing a comprehensive, multi-agency approach to aligning health care cost growth with broader economic indicators and for simultaneously recognizing primary care investment as a central pillar of Maryland health care goals and the requirements under the Achieving Healthcare Efficiency through Accountable Design Model (AHEAD). MedChi believes that the draft reflects thoughtful stakeholder engagement, a clear methodological framework, and an appropriate emphasis on affordability, sustainability, and accountability.

MedChi serves on the All-Payer Total Cost of Care Target Technical Advisory Committee (“the “Advisory Committee”), and we were pleased to submit comments on the Draft Recommendations in May 2026. We appreciate that the current Draft Recommendations acknowledge these comments, found on pages 17 and 18 of the report. Specifically, MedChi’s comments pertained to the importance of investment in primary care and the need to include metrics to monitor adverse impacts on primary care access and destabilization. We thank the Working Group for acknowledging these comments by stating, *“While affordability is already built into the analysis vis-à-vis the inclusion of wage growth in the metric, the State is committed to considering other metrics in its annual report.”* MedChi is prepared to work with the State in the development of these metrics.

While MedChi submitted comments during the Advisory Committee comment opportunity, we are resubmitting the following comments for inclusion in the public comment period as well. Generally, MedChi believes there needs to be a stronger commitment from the State to ensuring access to primary care services, given the challenges faced by both physicians and patients in obtaining needed services.

Primary care physicians are an essential driver of success in both cost containment and population health improvement, a role that MDH and the Working Group must recognize as the State moves from methodology to the implementation of growth and investment targets. While the Draft Recommendations emphasize that the AHEAD Model seeks to improve population health outcomes while moderating cost growth, achieving that goal is not possible without a robust, adequately supported physician workforce. However, Maryland's trajectory is in a downward trend. According to a recent report, the Maryland Health Care Commission noted that Maryland has already seen a significant reduction in independent physician practices, a decrease of 45.9 percent from 2018 to 2023. Primary care physicians serve as the foundation of the health care system in numerous ways, including managing chronic conditions and preventing disease progression, coordinating care across settings, including specialty, hospital, and community-based services, and serving as the primary point of access for most patients. To that end, we highlight that the effectiveness of the TCOC growth target will depend heavily on reversing this trend and physicians' ability to influence utilization patterns and guide appropriate care, ensuring that costly services, such as emergency department visits and hospitalizations, are minimized.

We have several recommendations regarding the all-payer primary care investment target to ensure the State is achieving its objectives under AHEAD. **First and foremost, MedChi's top priority is preserving value-based care models that empower physicians.** Value-based models and programs such as the Maryland Primary Care Program (MDPCP) and the Episode Quality Improvement Program (EQIP) play a crucial role in the overall health transformation process and enable primary care providers to take a greater role in prevention, chronic disease management, and reducing unnecessary hospital utilization. If the federal government discontinues these programs, it is essential that investments in similar programs be replaced to ensure adequate support for small practices. We must maintain some sort of value-based or Care Transformation Organization (CTO) model to continue the viability of primary care practices. Continuing to support these programs will be essential in achieving our goals under the growth and primary care investment targets.

Additionally, we stress the importance of health insurers in Maryland directing more spending toward primary care. This is why MedChi strongly supported *House Bill 494* in the 2026 Session, which would have required insurers to reimburse primary care providers in a manner that meets the annual primary care investment targets that MDH and the Regulatory Working Group are trying to establish. *House Bill 494* passed the House of Delegates, but unfortunately did not make it out of the Senate. Passing this bill would have strengthened access to primary care and ensured the financial stability of independent primary care practices. While we support the goals of primary care investment targets, this bill would have enhanced their effectiveness by requiring insurers to meet the targets. MedChi encourages MDH and the Regulatory Working Group to support a policy like the one proposed in *House Bill 494* going forward.

Finally, MedChi cautions that we must monitor implementation to ensure that efforts to contain costs do not inadvertently erode access to physician services or destabilize primary care practices. We recommend monitoring metrics such as primary care panel sizes and capacity, appointment wait times, physician workforce trends (including practice closure rates), and geographic disparities in access to primary care services. Protecting primary care physicians and

their ability to deliver care is essential to maintaining system stability and achieving our long-term goals under AHEAD.

Maryland has long been a national leader in health care delivery reform, and this proposal represents an important next step in advancing affordability and population health. Realizing the promise of the AHEAD Model will depend on a strong, well-supported primary care physician workforce capable of leading care transformation at the patient and community levels. We appreciate your consideration of these comments and look forward to continued collaboration in strengthening Maryland's health care system.

Sincerely,



Ashton DeLong, Esq.
General Counsel
MedChi, The Maryland State Medical Society

cc: Members, Health Services Cost Review Commission
Doug Jacobs, Executive Director, Maryland Health Care Commission



MedStar Health

8094 Sandpiper Circle
Nottingham, MD 21236

[MedStarHealth.org](https://www.MedStarHealth.org)

**Revenue Management and
Reimbursement**

July 20, 2026

Dr. Jon Kromm
Executive Director
Health Service Review Commission
4601 Patterson Avenue
Baltimore, Md

Dear Dr. Kromm:

On behalf of MedStar Health, thank you for the opportunity to comment on the draft Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets. MedStar Health strongly supports the comment letter submitted separately by the Maryland Hospital Association (MHA) and writes to reinforce the importance of MHA's recommendations to a workable and sustainable benchmark.

MedStar operates across both Maryland's all-payer Global Budget Revenue (GBR) system and the fee-for-service environment in the District of Columbia. That vantage point gives us direct, day-to-day visibility into the non-hospital cost drivers this benchmark is intended to capture. We share MHA's view that the draft recommendations move in the right direction, and we urge the Commission to adopt the refinements outlined by MHA.

All-Payer Total Cost of Care Growth

MedStar joins MHA in supporting HSCRC's effort to establish an all-payer TCOC growth target that reflects the full scope of Maryland's spending drivers, not hospital costs alone. Under global budgets, Maryland hospitals already operate under fixed, regulator-approved constraints on price and volume. A benchmark that does not also capture non-hospital and administrative cost growth would place a disproportionate share of the state's affordability burden on the one sector (hospitals) already under direct control. We support MHA's five recommendations and highlight the following as most consequential for MedStar:

- Include private insurance administrative costs in the all-payer TCOC calculation. Administrative costs represent an estimated 15–20% of premium spending and are excluded from meaningful oversight for self-funded, mini-med, and expatriate plans under the MLR framework. A benchmark that omits this category cannot support a credible affordability narrative, and every other state with an all-payer TCOC limit already includes it.
- Set the initial target without pharmacy costs, with a defined pathway to incorporate rebate-adjusted spending after three years. Measuring retail pharmacy cost on Average Wholesale Price, rather than net-of-rebate cost, would overstate true spending growth and could produce a benchmark that is unachievable for reasons entirely outside hospitals' or the state's control.
- Exclude 2025 from the historical trend calculation and reduce the weight assigned to wage growth. Maryland's federal workforce reductions in 2025 — more than 25,000 positions, the largest loss of any state — are a one-time

It's how we treat people.

exogenous shock that a three-year average will not adequately smooth. Health care is also the state's largest employer and has added more jobs than nearly every other sector combined since 2022; an uncorrected wage-growth input risks penalizing the sector for its own labor market strength.

- Maintain CY 2026 as a fixed base year for future target setting, consistent with the fixed baselines already used for the AHEAD total cost of care and all-payer hospital revenue benchmarks. A rolling base year introduces volatility that undermines multi-year financial planning for regulated hospitals.
- Evaluate and, if necessary, recalibrate the methodology once the state has produced an actual historical trend of all-payer TCOC. Target-setting in the absence of that data should be treated as provisional.

Primary Care Investment Targets

MedStar supports the Maryland Health Care Commission's effort to establish measurable, cross-payer primary care investment targets, and agrees with MHA that thoughtful design is essential to avoid undermining the goals of the TCOC benchmark itself.

Exclude primary care investment from the all-payer TCOC growth target

A policy that simultaneously requires overall spending growth to slow and primary care investment to rise will, unless primary care is excluded from the TCOC measurement, create direct financial pressure on hospitals and other providers asked to absorb the difference. MedStar supports MHCC excluding primary care investment from the all-payer TCOC growth calculation to remove this structural tension.

Establish payer transparency and enforcement protocols

MedStar agrees that payer achievement of investment targets is essential to effect change, and that this cannot rest on provider action alone. We support regular payer reporting, public primary care scorecards, and a defined enforcement plan — developed with the Maryland Insurance Administration and Maryland Department of Health — given that missed primary care investment targets are a triggering event for corrective action under the Amended and Restated AHEAD Model Maryland State Agreement.

MedStar appreciates HSCRC's continued engagement with hospitals throughout this process and welcomes the opportunity to serve as a resource as the Commission finalizes this methodology. We urge the Commission to adopt a benchmark that reflects Maryland's actual spending experience, holds all cost drivers accountable, and preserves the long-term sustainability of the state's health care system.

Sincerely,



Michael Wood
VP – Revenue Management & Reimbursement, MedStar Health

cc: William Henderson, HSCRC
Cait Cooksey, HSCRC



Maryland
Hospital Association

July 20, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, we appreciate the opportunity to comment on the draft report on the Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets.

MHA supports the overall direction of the draft recommendations and appreciates the incorporation of many principles discussed throughout the Regulatory Working Group process. Maryland hospitals respectfully recommend several modifications to better align the methodology with the AHEAD Model, improve the accuracy of spending measures, strengthen accountability across the health care ecosystem, and ensure the benchmark supports affordability without compromising access to care.

All-Payer Total Cost of Care Growth

MHA supports the Health Services Cost Review Commission's (HSCRC) efforts to improve transparency in health care spending and to establish all-payer total cost of care (TCOC) growth targets that reflect Maryland's unique all-payer system. The methodology should account for the non-hospital drivers of spending growth and provide meaningful insight into the affordability challenges facing Maryland residents. We appreciate staff's incorporation of the guiding principles discussed during prior meetings, including recommendations submitted by MHA. We offer the following recommendations to further align the methodology with those principles and support Maryland's success under the AHEAD Model:

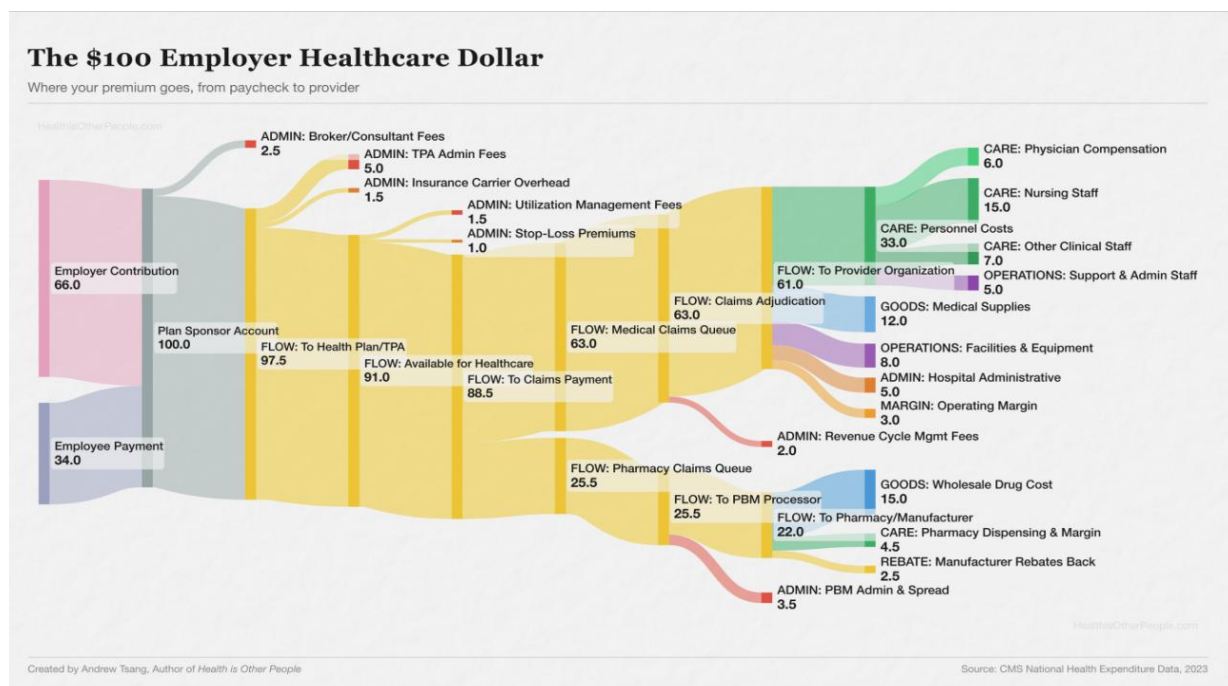
- Include the administrative cost of private insurance in the all-payer TCOC calculation
- Set the initial target without pharmacy costs and work toward the inclusion of rebate information after three years
- Exclude 2025 from the historical trend calculation to mitigate the impact of the changes in the federal workforce for that year and reduce the weighting of wage growth
- Maintain CY 2026 as the fixed base year for future target setting
- Evaluate the methodology after the state has produced a historical trend of all-payer TCOC

Recommendation: Include the administrative cost of private insurance in the all-payer TCOC calculation

Unlike any other state, Maryland's all-payer model already constrains hospital prices and volume through global budgets for acute care hospitals, making it essential that any all-payer TCOC benchmark captures the non-hospital drivers of health care spending. Gov. Wes Moore's directive to form a multi-agency regulatory work group also guided the working group's focus to ensure "no critical health infrastructure should shoulder this burden alone, and the savings requirement will not be borne exclusively by hospitals."¹ For commercial payers, hospital costs are lower in Maryland (20% lower) than they are for comparable areas across the country, yet premiums are only 4% lower than the U.S. average for an individual plan and on par with the national average for a family plan. Affordability measures should be designed to produce a comprehensive analysis of all cost-drivers, including non-hospital and carrier administrative costs, to inform policies to lower premium costs for Marylanders.

Excluding the administrative cost of private insurance would understate total spending and limit the state's ability to assess affordability comprehensively. Administrative costs account for an estimated 15% to 20% of premium spending and are included in comparable measures used by other states. As shown in Exhibit 1, these costs reflect substantial administrative complexity and may present opportunities to improve efficiency, patient experience, and clinical care while preserving system sustainability.

Exhibit 1: A diagram of health care spending



Source: [Health is Other People blog - by Andrew Tsang](#)

¹ [2025-10-10_AHEAD RWG Initial Plan v5](#)

In order to improve affordability and access to care, we must tackle the administrative complexity that misdirects care resources and adds billions in unnecessary costs each year. Simplifying and accelerating prior authorization for medicines and procedures, standardizing billing processes, and reducing duplicative, outdated regulations and administrative burdens would free up resources for patient care rather than paperwork.² The medical loss ratio (MLR) is an important policy lever for states and the federal government to control administrative cost of private health insurance. However, MLR does not extend to self-funded health insurance plans, which are plans for which the employer is responsible for the payment of covered claims; “mini-med” plans, which have total annual benefits of \$250,000 or less; or expatriate plans ([45 CFR § 158.120](#)). Recognizing the limitation of these regulations, all other states with all-payer TCOC growth limits include administrative costs in their measurement. Consistent with that approach, the AHEAD agreement provides enough flexibility for states to include administrative costs in the TCOC measurement.

Recommendation: Set the initial target without pharmacy costs and work toward the inclusion of rebate information after three years

Prescription drug spending is an important and growing contributor to health care costs and an increasing affordability challenge for patients, employers, and public programs. National data show that prescription drug spending increased **7.9% to \$467 billion in 2024**, following **10.8% growth in 2023**, while net U.S. medicine spending rose **11.4% in 2024 to \$487 billion**, driven largely by greater use of high-cost therapies such as obesity drugs rather than broad-based price inflation.³ The work group recommended measuring retail pharmacy cost using the Average Wholesale Price (AWP). However, AWP does not represent the average price pharmacies pay wholesalers. Instead, it functions much like a manufacturer's suggested retail price (MSRP) or “sticker price” and is usually higher than the actual acquisition cost.⁴ Given the high rate of growth in prescription drug spending, the state’s limited ability to influence those costs, and current data limitations in measuring the actual cost of prescription drugs, retail pharmacy costs should not be incorporated into the benchmark until rebate information is available. Rebates represent a significant portion of prescription drug spending and can materially affect net costs. Including pharmacy spending without accounting for rebates could result in an incomplete and potentially misleading measure of spending growth.

MHA therefore recommends establishing the initial benchmark without pharmacy spending and developing a pathway to incorporate pharmacy costs once rebate information becomes available and the state has gained several years of experience with the benchmark methodology.

² [Op-ed: Tackling health affordability is a shared responsibility](#)

³ [National Health Expenditures Fact Sheet](#)

⁴ [Average Wholesale Price \(AWP\)](#)

Recommendation: Exclude 2025 from the historical trend calculation due to the impact of federal employment and reduce wage growth

MHA supports starting with 2023 to measure the historical period for target setting to exclude the impact of exogenous factors due to the COVID-19 pandemic. Similarly, MHA recommends additional adjustments for wage growth in 2025, when the federal workforce was reduced as using three-year average does not adequately control for this exogenous event (Exhibit 2). Maryland has the third largest federal workforce in the nation and has long relied on federal jobs for economic stability. Federal workers earn significantly above the median wage, and their spending contributes substantially to local economies. Maryland has lost more federal jobs than any other state due to federal government cutbacks, more than 25,000 positions.⁵

Exhibit 2: Historical Economic Indicators

	2020	2021	2022	2023	2024	2025
State GDP	-1.3%	8.2%	7.6%	6.9%	6.0%	4.0%
Wage Growth	1.5%	6.6%	5.5%	5.3%	6.4%	2.6%
2025-2023 Average-State Proposal						5.2%
2025-2021 Five-year Average						5.9%
2024-2023 Two-year Average						6.2%

In addition, MHA suggests the regulatory working group consider potential unintended consequences of including wage growth in the all-payer total cost benchmark. Health care and social services employs more Marylanders than any other sector and has added over 51,000 jobs since 2022—nearly as many as all other industries combined.⁶ We recommend reducing the weight of wage growth to 20% due to the complexity of the relationship between wages and the health care sector and developing affordability targets based on wage growth, premium costs, and out-of-pocket spending.

Recommendation: Maintain CY 2026 as the fixed base year for future target setting

MHA recommends maintaining CY 2026 as the fixed base year for future target setting. Shifting the base year from CY 2026 to CY 2029 after three years would reduce predictability and introduce unnecessary volatility into future trend calculations.

A fixed base year is more consistent with Maryland’s historical benchmarking approach, including the AHEAD total cost of care and all-payer hospital revenue benchmarks, which rely on fixed baseline periods.

^{5,6} [Maryland Industry Analysis: Healthcare and the Economy, April 2026](#)

Recommendation: Evaluate the methodology after the state has produced a historical trend of All-Payer TCOC

Without historical analysis of all-payer TCOC trends, it is not possible to assess whether the proposed methodology aligns with the proposed principles of achievable targets. MHA recommends that future methodology decisions be informed by actual performance experience under the benchmark. Statewide targets should reflect Maryland's experience, improve transparency into systemwide spending trends, and focus on the drivers of affordability beyond hospital utilization. At the same time, we recommend that the benchmark preserve continued access to acute care and support the long-term sustainability of Maryland's health care system.

MHA supports the Regulatory Working Group's intent to develop a robust reporting and monitoring framework that detects unintended consequences of all-payer TCOC growth limits on access and quality. Regional and subpopulation level analysis will be critical for a comprehensive monitoring approach for this effort.

Primary Care Investment Targets

MHA appreciates the Maryland Health Care Commission's (MHCC) work to establish primary care investment targets that are intended to support critical community-based health care services. Strategic investment in primary care is essential to build a resilient, equitable health system that improves population health while controlling overall health care costs. The proposed targets reflect a thoughtful approach to addressing longstanding underinvestment in primary care, which accounted for only 4% of national health care spending across all payers in 2023.⁷ Despite this relatively low level of investment, substantial evidence demonstrates that robust primary care improves health outcomes, reduces hospitalizations, and advances health equity.⁸ Establishing measurable targets, aligned across public and private payers, sets a clear expectation for accountability and can catalyze multi-payer collaboration.

MHA supports investments in primary care to enhance access (particularly in shortage or underserved areas), expand provider capacity, and align with other efforts intended to reduce preventable hospitalizations and avoidable use of hospital emergency departments. MHA offers the following recommendations to strengthen MHCC's proposed approach to primary care investment.

Recommendation: Exclude primary care investment from all-payer TCOC growth target

As Maryland considers establishing an all-payer TCOC growth limit to cap per-capita health care spending across all payers and slow the overall rate of cost growth, it should also consider the implications of primary care investments. Maryland will be working to reduce overall TCOC while simultaneously increasing investment in primary care. The interaction of these policies could create financial pressure for hospitals and other parts of the health care system. To avoid this risk and mitigate tension between these two targets, MHA respectfully suggests that MHCC

⁷ [2026 Primary Care Scorecard Data Dashboard | Milbank Memorial Fund](#)

⁸ [National Academies of Science Engineering and Medicine \(NASEM\) 2021 Report](#)

and HSCRC consider excluding primary care investment from the all-payer TCOC growth measurement.

Recommendation: Establish payer transparency and enforcement protocols

MHA agrees with the MHCC principle that “payer achievement of investment targets is essential to effect change.”⁹ As primary care investment targets are finalized, MHA recommends establishing protocols to promote payer data transparency and ongoing monitoring. This could include regular payer reporting and public-facing primary care scorecards to track progress toward the investment targets, assess impacts on premiums, and guide future investments.

In addition, because failure to meet the primary care investment targets is identified as a triggering event and could result in corrective action under the Amended and Restated AHEAD Model Maryland State Agreement, MHA recommends developing a payer enforcement plan. MHA encourages MHCC to collaborate with the Maryland Insurance Administration and Maryland Department of Health to consider appropriate performance incentives, corrective actions, or payment reforms that support adherence to the targets and help ensure Maryland’s success under the AHEAD Model.

Thank you for the opportunity to comment on this important matter. The AHEAD Model statewide accountability targets, and the benchmark that informs those targets, should reflect Maryland’s experience and focus on drivers of health care spending beyond hospital utilization. We encourage the state to establish targets that promote transparency and monitoring of systemwide spending trends, focus attention on the primary drivers of affordability challenges, and preserve access to life-saving acute care while supporting the long-term sustainability of Maryland’s health care system.

Sincerely,



Melony G. Griffith
President & CEO

Cc: Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission

⁹ [Multi-Agency Regulatory Working Group–Progress Report \(June 2026\) v2](#)



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July 20, 2026

Maryland Department of Health
Maryland Health Services Cost Review Commission
Maryland Health Care Commission
Attn: AHEAD Multi-Agency Regulatory Working Group
Submitted via email to: mdh.maryland-model@maryland.gov

Re: Public Comment on the Draft Policy Recommendation — All-Payer Total Cost of Care Growth and Primary Care Investment Targets (June 2026)

Dear Members of the Regulatory Working Group:

SocialRx is a national social prescribing organization working in partnership with Maryland's arts, cultural, and community organizations to expand access to therapeutic, community-based arts and cultural engagements across the State through social prescribing. At SocialRx, we connect primary care practices and payers with a curated network of community-based activities (arts, cultural, movement, and volunteer programs) and provide the care navigation and behavioral support that helps patients actually reach and sustain those connections. I write both on behalf of SocialRx and as a Maryland resident. We are submitting these comments in partnership with, and with the support of, the Executive Director of Maryland Citizens for the Arts, reflecting a shared interest in the role that community, arts, and cultural assets play in Marylanders' health.

We commend the Working Group, HSCRC, and MHCC on a thoughtful and well-constructed draft. We strongly support both the all-payer total cost of care (TCOC) growth target and the primary care investment target, and we especially appreciate the Maryland Care Team Builder (MCTB) Model's grounding of the primary care target in the actual resources needed to deliver high-quality, team-based care. Our comments are offered in that spirit: they are designed to reinforce the methodology the State has proposed, and to help the State meet both targets.

Social isolation and loneliness are now recognized as a public health priority. The U.S. Surgeon General's 2023 advisory found that the mortality impact of social disconnection is comparable to smoking up to 15 cigarettes a day and increases the risk of premature death by roughly 29%, with elevated risk of cardiovascular disease, dementia, stroke, and depression. These are precisely the chronic conditions that drive avoidable utilization and cost. AARP's Public Policy Institute estimated that social isolation is associated with approximately \$6.7 billion in additional Medicare spending each year, or about \$1,608 more per isolated beneficiary — driven largely by hospital and skilled-nursing use. Social prescribing and care navigation that connect patients to existing community-based activity are among the most direct, lowest-cost tools available to address these drivers, and a growing body of evidence links them to reduced primary and emergency care demand among frequent attenders.

With that context, we respectfully offer four recommendations. Each is anchored in language already in the draft, requires no increase in the proposed per-member-per-month (PMPM) targets, and adds little or no new reporting burden.

1. Confirm that care navigation and community health worker time devoted to community-based referrals are recognized within the MCTB “expanded care team” cost basis and count toward the primary care investment target.

The draft's MCTB methodology (Section 2.2, Step 2) already provides for “expanded care team members such as pharmacists, nurse care managers, behavioral health clinicians, and community health workers,” and explicitly builds the cost estimate around the “percentage of patients with unmet social needs... multiplied by treatment frequency and duration included in recommended care guidelines.” Care navigation to community-based activities that address social isolation is exactly this kind of expanded-team activity. We ask MHCC to state explicitly, in the final methodology and any accompanying payer guidance, that (a) community health worker and navigator time spent screening for, referring to, and following up on community-based social, arts, and cultural activities is an eligible component of the primary care investment target, and (b) practices and payers may count these services toward the target. This is a clarification of existing methodology, not a new requirement, and it gives payers and practices a clear, actionable signal about how the resources the model already funds may be deployed.

2. Ensure that non-claims-based payments for care navigation and social prescribing are captured in primary care investment measurement.

The draft identifies non-claims-based payments as an “important requirement of the AHEAD Model” and a “key feature of primary care investment measurement” (Table 2), and Section 2.5 candidly notes that MHCC is still refining how it collects non-claims-based payments and that “many payers... believe their non-claims based payments to be higher than what has been reported.” A substantial share of care navigation, community health worker services, and social prescribing is financed through non-claims mechanisms — for example, PMPM care management fees like the \$2 PMPM fee already used in the Medicaid Advanced Primary Care Program — rather than standard fee-for-service claims. We recommend that MHCC's forthcoming non-claims-based payment workgroup sessions explicitly enumerate care navigation, community health worker, and community-referral (social prescribing) payments as reportable categories of primary care spend. Doing so improves the accuracy of the very measurement gap the draft already flags, and ensures these investments are neither invisible nor undercounted.

3. Add social-connection and community-referral measures to the access and quality monitoring set — using existing, low-burden instruments.

Both the TCOC section (Section 1.5) and the primary care section commit the State to monitoring quality, access, and affordability using measures “sourced from existing measures across the health care system,” with the Advisory Committee to identify specific measures before the first (CY 2027) report. We recommend that this measure set include: (a) documentation of social isolation or loneliness risk, using instruments already in wide use such as the three-item UCLA Loneliness Scale or the social connection domains of standardized health-related social needs screeners (e.g., PRAPARE / the Accountable Health Communities screening tool); (b) rates of referral to and connection with community-based activities; and (c) avoidable emergency department and inpatient utilization – which the State already tracks through its PAU framework

– examined, where feasible, for populations connected to community-based programs. These measures rely on data instruments that already exist, impose minimal new burden, and align directly with the draft's stated intent to monitor for access and to detect unintended consequences.

4. Explicitly connect the primary care investment target to social isolation and loneliness within AHEAD's population health goals.

The AHEAD Model's stated purpose includes “improved population health and healthier living,” and the draft references the AHEAD Population Health Accountability Plan among its quality measures. Social isolation and loneliness are upstream drivers of the chronic disease and avoidable utilization that AHEAD is designed to address, yet they are rarely named in accountability frameworks. We recommend the State recognize social connection as a population health priority under AHEAD and treat community-based social prescribing as one delivery mechanism through which primary care investment advances population health. This positions Maryland — consistent with its history as an early adopter — as a national leader and strengthens the narrative the State will present to CMMI without committing to any new binding target.

A note on synergy between the two targets

The draft acknowledges a legitimate concern that increased primary care investment could add modest pressure to TCOC, while also noting (citing the Milbank Memorial Fund) that primary care investment can *reduce* TCOC by cutting potentially preventable emergency department visits and inpatient admissions. Community-based social prescribing and navigation are among the clearest examples of this dynamic: by addressing isolation and unmet social needs, they target the frequent-attender population that drives avoidable utilization. We therefore encourage the State to view community-based navigation not as a competing cost, but as a shared lever that helps Maryland meet both the primary care investment target and the TCOC growth target.

SocialRx and Maryland Citizens for the Arts would welcome the opportunity to serve as a resource to the Working Group, including by sharing Maryland-specific implementation experience, connecting the State to the community asset network already operating here, and participating in the non-claims-payment and measure-selection discussions referenced in the draft. Thank you for your consideration and for your leadership on this important work.

Respectfully submitted,

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In partnership with:

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CORPORATE OFFICE

July 20th, 2026

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Members of the All-Payer Total Cost of Care Growth Advisory Committee,

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, thank you for the opportunity to provide comments on the development of statewide accountability targets for All-Payer Total Cost of Care (AP TCOC) growth under the AHEAD Model. UMMS remains committed to partnering with the State to ensure Maryland's continued leadership in advancing high-value, equitable care while maintaining access and system sustainability.

As the State has released its initial proposal for AP TCOC growth targets, we again offer the following principles and considerations to support successful implementation. UMMS is concerned the proposed methodology has created a target that is neither achievable based on historic and other state experiences, nor operational in its measurability, understanding of policy levers and current level of health system participation, beyond hospital regulation.

1. Ensure the Methodology Creates a Measure that is Impactable through Available Regulatory Levers and Does not Allow Hospitals to Solely Bear the Burden of Performance, per Governor's Directive.

Given the novelty of the AHEAD Model, limited regulatory levers beyond hospital rate-setting, and material financial risks to the system, AP TCOC targets should initially function as monitoring and evaluation tools rather than direct drivers of regulatory action.

UMMS would prefer to have actual performance under the benchmark methodology available and assessed before committing to an approach. The methodology proposed has not been assessed for achievability; based on publicly available data for health care expenditures per capita, MD would have been far above the proposed three-year target of

5.2% all-payer total cost of care growth. As a State, we should transparently understand if Maryland has been near or off target in prior years to support a stable approach to the AHEAD Model.

Other states' experience demonstrates that TCOC benchmarks are most effective when used for transparency and learning, not immediate enforcement, particularly where data completeness and policy levers remain underdeveloped. UMMS is concerned the State's ambitious timeline and our own personal experience from accountable care model work comparing commercial claims across payers will delay insight into self-insured payer growth and insights to improve/manage this target will remain limited for quite some time. Until we have full transparency in monitoring total cost of care equally across payers, we should exercise caution and monitoring only approaches for AP TCOC. Early-year targets/policy commitments to CMS should reflect data limitations and prioritize improved payer transparency.

While this target triggers only corrective action under AHEAD, as opposed to Model termination, there is still significant risk in ambitious target commitments that differentiates Maryland's experience from peer states. Should the State need to implement corrective action with CMS, there are limited regulatory levers in Maryland outside of hospital rates to solve a missed target problem. This poses a risk for destabilization of hospital financing and misalignment with payer behavior and warrants a conservative, adjustable, and achievable target framework. Additionally, Maryland has experience with annual targets that can fluctuate financial decision-making with the prior guardrails test in the TCOC Model. These guardrails have caused instability in the Model, despite continued results on Medicare TCOC and overall Model targets. Maryland should aim to ensure stability and minimize risk fluctuations in the AHEAD model with retrospective targets like the All-Payer TCOC growth target.

2. Do not Rebase this Target and do not Include Pharmacy Costs: Ensure Alignment Across AHEAD Metrics and Methodologies

AP TCOC targets must align with Medicare TCOC growth targets and hospital all-payer revenue constraints. This includes consistent methodologies for inflation and utilization, baseline, exclusion of prescription drugs, and alignment with federal definitions.

- Rebasing this target is the first time we have considering a re-setting of a base target in this Model. We should keep the AP TCOC Target, an experimental target with data and accountability limitations already, to this same standard and use 2026. Shifting the target every three years would reduce stability and create a volatile policy management space for the state. By the time data is available, results are reconciled and reported and any policy and/or corrective actions are determined between the

State and CMS, the State will likely be moving onto a new target. This dynamic does not create a more accurate target, rather it creates a hamster wheel nearly impossible to manage/problem solve to.

- Retail pharmacy and Part D costs have never been a part of the cost management proposals of the Maryland Models, and are not domains in which the State nor the Federal government have exhibited strong levers of control. The proposed addition of these components will create an even higher hill to climb to maintain consistent performance. The State should set the initial targets without pharmacy costs and work toward including rebate costs, if there is intention to eventually include pharmacy in the target. Without rebate incentives balanced into the scorekeeping, this component of our target will introduce erroneous headwinds to performance tracking.

3. Promote Full-System Accountability for Affordability

Hospital cost growth is not the sole driver of TCOC, and the AP TCOC growth target will not be able to guarantee affordability to Marylanders. The State should complement AP TCOC commitments to CMS with a plan to examine payer plan design, administrative costs, and patient premium/out of pocket affordability, ensuring accountability across all stakeholders. Payer transparency and data availability remains a problem where the policy action and solution for Maryland is unknown. This will impede Maryland's ability to perform on not just total cost commitments, but also affordability examination and improvement. Creating a TCOC growth analysis gives the State the opportunity to explore where other components of the system are eroding affordability, such as insurer's plan design or private equity investments in unregulated settings of care. The State will need to be clear with CMS and their policy proposals to the governor that hospital cost growth and HSCRC regulatory oversight is not the sole lever of impact for healthcare affordability, nor AP TCOC Growth in MD.

7. Preserve Investment in Transformation, Access, and Sustainability

AP TCOC targets should not constrain necessary investments in primary care, population health/care transformation, capital infrastructure, and underserved communities. The State should specifically note to CMS that these purposeful investments should be excluded or built into proposals and reporting on this target. This will allow Maryland to purposefully invest in our healthcare system's transformation and future in partnership with the Model, instead of under limits.

July 20, 2026

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In closing, UMMS supports a measured, aligned, and transparent framework for AP TCOC targets that recognizes current limitations, ensures shared accountability, and preserves system sustainability.

Sincerely,

A handwritten signature in cursive script, reading "Alicia Cunningham", followed by a vertical line.

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services



July 20, 2026

Jonathan Kromm
Executive Director, Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Submitted to: MDH.Maryland-Model@maryland.gov

RE: Response to Regulatory Working Group All-Payer Total Cost of Care Growth and Primary Care Investment Targets Policy Draft Recommendation

Dear Executive Director Kromm,

Thank you for the opportunity to provide public comments in response to the Maryland Multi-Agency Regulatory AHEAD Work Group's ("Work Group") public comment opportunity related to the state's [draft recommendation](#) for the all-payer total cost of care (TCOC) growth and primary care investment targets under the AHEAD Model.

[United States of Care](#) (USofCare) is a non-partisan, non-profit organization working to ensure everyone has access to quality, affordable health care, regardless of who they are, where they live, or how much money they make. We know from our [listening research](#) that affordability [tops the list](#) of people's concerns about our country's health care system. We appreciate HSCRC's efforts to ensure that a wide array of impacted stakeholders have a seat at the table alongside industry to provide feedback as the state implements the AHEAD Model and, in particular, constructs its TCOC growth target. Furthermore, we appreciate the opportunity to share the consumer perspective more broadly through our colleague, Alyssa Penna, as one of the consumer representatives on the All-Payer TCOC Target Technical Advisory Committee ("Advisory Committee").

Cost concerns are especially acute in Maryland, where [more than half](#) (55%) of all people have experienced difficulty affording their health care over the past year and [more than four-in-five](#) worry about affording care in the future. Marylanders have long benefitted from the state's unique system of [all-payer rate setting](#) and, more recently, its innovative [Total Cost of Care Model](#), which has lowered health care spending by [more than \\$700 million](#). Unfortunately, due to the increasing cost of care, more is needed to ensure health care remains affordable for Maryland families. This underscores the importance of pursuing additional policies to lower health care costs to improve Marylanders' everyday health care affordability.

The AHEAD Model will do just this. Building on the success of the Total Cost of Care Model, which sunset at the end of last year, the AHEAD Model continues Maryland on a path outside of the fee-for-service system [we know](#) is not working for patients. The AHEAD Model will provide much-needed financial certainty to health care providers while also benefiting Maryland families across the state by shifting the way in which care is delivered in order to expand access to primary care, prioritize population health, improve health outcomes, and lower health care

costs. These efforts ensure that Marylanders are not forced into a fee-for-service health care system resulting in people experiencing fragmentation, little coordination between providers, and a value of quantity over quality, some of the biggest pain points we [hear from people](#).

Support for the AHEAD Model's Total Cost of Care Growth Target

We appreciate the HSCRC's thoughtful, collaborative approach to constructing the Model's all-payer TCOC growth target. We believe this will provide an important framework to allow agencies, providers, and insurers to continue to work together to rein in health care cost growth and improve care delivery. A strong TCOC growth target will provide important insights on health care cost growth in the state and can help inform progress and policies associated with the AHEAD Model.

TCOC growth target methodology

We agree with the HSCRC in that a TCOC growth target must – at least in part – rely on consumer-focused metrics that reflect broader statewide economic growth, including household resources. **We recognize that the Draft Recommendation established a TCOC growth target informed by a 50/50 blend of wage growth and gross state product (GSP), which differs from our recommendation of a blend of household income and GSP.** While targets tied to GSP capture overall economic growth, we believe one largely tied to median household income, as is done in [California](#) or [New Jersey](#), is more representative of individuals' or families' experiences and their household's ability to spend. Despite this, we recognize that HSCRC identified data access challenges that would make it difficult to capture the needed household income information necessary to implement a target based, in part, on household income.

We recognize the Work Group initially shared our preference for household income over wage growth given that it's a better measure of a household's ability to spend. **Moving forward, we encourage HSCRC to keep our comments in mind should the opportunity arise to rebase the TCOC growth target to tie it, in part, to household income.** Other states have adapted their growth target methodology over time; while initially tied solely to GSP, Rhode Island's growth target [shifted to](#) a blended metric that combined GSP with household income in 2022, showing that later revisions are possible should circumstances, such as greater data availability, change.

Prescription drug spending

We were pleased to see the Draft Recommendation align with our recommendation that prescription drug spending be included as part of the TCOC growth target calculation. Health care spending on prescription drugs [grew 8.6%](#) nationwide between 2020 and 2023 and [approximately six-in-ten adults](#) worry about the cost of these prescriptions. Depending on the circumstances, higher spending on prescription drugs may lead to cost savings by reducing hospitalizations or emergency department visits or further increase costs without any corresponding offsets. **Because of this, HSCRC is right to include prescription drug spending as part of a robust growth target metric to capture this fast-growing segment of medical spend and its impact on overall health spending.**

Certain Medicaid spending

At the same time, we recognize there are certain circumstances where it makes sense to exempt certain forms of medical spending. While we support an inclusive, comprehensive growth target, we recognize that, given looming federal Medicaid cuts and the unique nature of Medicaid's developmental disability and other home and community based services (HCBS), these certain Medicaid services should be treated differently. **We were pleased to see the Draft Recommendation align with our recommendation that certain Medicaid services be excluded from the overall TCOC growth target calculation.** Without this exemption, we believe incorporating these services under a TCOC growth target could unintentionally limit access to care for these often-marginalized populations and had the potential to make the program's [years-long](#) waiting list even longer. It stands to be said that these services are fundamentally different from other forms of medical spending in that their cost growth is driven not by price increases or changes in utilization, but rather by policy decisions or eligibility changes.

Consumer Affordability Standard

Despite health care affordability being a top issue affecting families' day to day lives and budgets, cost containment efforts across many states have failed to adequately measure real world impact of these solutions on consumers. Given the choice to use the wage growth metric over median household income, we believe this only strengthens the need for an affordability standard to ensure people's affordability experiences are reflected in the cost growth target, with proper adjustments as needed. **To that end, we are very pleased to see the Draft Recommendation include language that commits HSCRC to working with stakeholders to "identify measures that inform quality, access, and affordability."** We believe this lays the groundwork for such an affordability standard that takes into account Marylanders' health care costs, including both premium growth and out-of-pocket costs, and their impact on overall health care affordability. We are happy to partner with HSCRC and provide feedback and assistance on further development of an affordability standard as needed.

Affordability standards have [long been used by many peer states](#), all taking varying approaches to the development and implementation. In Connecticut, the state Comptroller's office worked with the Office of Health Strategy to develop the [Connecticut Healthcare Affordability Index \(CHAI\)](#), which builds upon the state's [self-sufficiency standard index](#) to measure the impact of health care costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs, like housing, transportation, childcare, and groceries. The CHAI is used to establish and adjust Connecticut's [household health care spending target](#), inform their healthcare benchmarking initiative, and set primary care spending targets. Rhode Island adopted a [health care affordability standard](#) in 2010, based on the Consumer Price Index for Urban Consumers and other market factors. This metric, set annually by the Office of the Health Insurance Commissioner, informs their review and approval of contracted rates between providers and insurers. Notably, the state [has also leveraged](#) this affordability standard to incentivize payment reforms similar to those under the AHEAD Model, such as primary care investments and risk sharing agreements between providers and commercial payers.

This standard can help Maryland understand how people are experiencing health care affordability challenges and, paired with the TCOC growth target and other efforts, how policy solutions embedded in the AHEAD Model translate to improved affordability and what role different sectors of the health care system play in driving those experiences. Importantly, policy actions, like those taken through the implementation of the AHEAD Model, are necessary in ensuring that these standards are achieved and maintained. Controlling the underlying cost of care is inextricably linked to making sure that care is affordable; even with low uninsured rates and fairly adjusted premiums and cost-sharing, ever-rising costs will erode wages and crowd out Marylanders' spending on other important goods and services. **As such, we strongly encourage the agencies comprising the Work Group to identify opportunities for an affordability standard to inform the development and monitoring of AHEAD Model implementation and its impact on health care spending, including in health insurance [rate review](#) and hospital global budget development.**

Support for AHEAD Model All-Payer Primary Care Investment Target

Primary care is the foundation of a high-performing health care system that addresses people's health care needs and is associated with better [health outcomes](#), [lower costs](#), and [greater health equity](#). Despite these benefits, [less than five percent](#) of all health care spending goes to primary care, and that number is [declining](#). This lack of primary care investment is driven by an unsustainable payment model that continues to undervalue primary care and threatens the financial viability of independent practices nationwide. **USofCare supports the proposed primary care investment target under the AHEAD Model**, which seeks to [address these issues](#) head on by strengthening people's access to primary and preventive care, promoting care coordination, and, paired with Primary Care AHEAD, support independent practices. Additionally, the target will help Maryland to monitor primary care spending across populations and payer types and reduce costs by avoiding unnecessary specialty care and hospitalizations.

By packaging Maryland's all-payer TCOC cost growth target under the AHEAD Model alongside a consumer-focused affordability standard and a primary care investment target, Maryland will continue to build upon the success of the Total Cost of Care Model to improve health outcomes while lowering health care costs for state residents. We thank the members of the Advisory Committee, Work Group, and HSCRC for their commitment to successful implementation of the AHEAD Model. We appreciate the opportunity to provide feedback. Please don't hesitate to reach out with any questions.

Sincerely,

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