Maryland
DEPARTMENT OF HEALTH

Decision Memorandum
AHEAD Regulatory Working Group Proposal on Cost-Shifting and Medicare Advantage

Following Governor Moore's September 23, 2025 directive instructing a multi-agency state team to develop proposals on cost-shifting and Medicare Advantage (MA), the resulting Regulatory Working Group–including the Maryland Department of Health (MDH), the Health Services Cost Review Commission (HSCRC), the Maryland Insurance Administration (MIA), the Maryland Health Care Commission (MHCC) and the Maryland Health Benefit Exchange (MHBE)–led an extensive stakeholder engagement effort to develop a policy framework on: 1) cost shifts that may be necessary to meet the negotiated Medicare savings requirements under AHEAD; and 2) stabilization of the MA market.

The multi-agency Regulatory Working Group recommended the policy solutions below for cost-shifting and MA stabilization. Changes to the proposed policies following the public comment period are noted in the summaries below, and the finalized proposal is appended to this memo. The Governor has approved the policy recommendations as finalized.

Cost-Shift Policy
The policy will cost-shift $435 million, approximately half of the amount required to offset decreased reimbursement from Medicare and Medicaid under the new AHEAD model. This figure divides the AHEAD savings responsibility between hospitals and payers. It is estimated that this amount will increase commercial rates by approximately 1.8 percent over seven years, with an annual incremental increase in premiums of about 0.35 percent from 2028 to 2032. The HSCRC will use its annual update factor process to increase commercial hospital rates by $87 million every calendar year (CY) from 2028 through 2032. After this period, the resulting $435 million cost-shift will be maintained in rates. In response to stakeholder concerns that higher commercial rates under the policy would negatively affect provider reimbursement, the Regulatory Working Group expanded the reporting requirements of the final policy proposal to include identification of avenues to provide resources to physicians through value-based programs.

Medicare Advantage Policy
The MA stabilization policy leverages the HSCRC's rate-setting authority to reduce hospital costs for qualified MA plans and maintain hospital funding by increasing commercial rates. Plan eligibility will be determined by factors such as a percentage of eligible beneficiaries in relevant H-contracts, counties with high proportions of underserved beneficiaries and minimum ratings in Centers for Medicare and Medicaid Services' (CMS) quality star program. This proposal emphasizes supporting access to MA plans, particularly for low-income consumers.

Qualified plans will be designated in the first quarter of each year for the following year, starting in 2026.

During the HSCRC's annual update factor process, qualified plans will be confirmed and awarded an additional 11.55 percent in rate relief for their beneficiaries starting in CY 2027. This amount will be offset by increases in rates for other payers. Once fully implemented, this is estimated to increase commercial rates by 0.75 percent. In response to stakeholder suggestions regarding changes to the eligibility criteria for qualified plans, the Regulatory Working Group added a waiver option, which will allow plans to request a waiver to come into compliance with the county-level criteria by 2028.

Overall Impact

Total increases to commercial rates across both proposals will amount to 2.55 percent by 2032, with the largest single year increases occurring in 2028, at 0.6 percent combined for the two programs.

Regulatory Working Group Policy Recommendation: Cost-Shifting and Medicare Advantage

December 2025

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Governor's Directive

In November 2025, the State of Maryland and the Center for Medicare and Medicaid Innovation (CMMI) executed an Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement (AHEAD Model). The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment and population health outcomes results in improved population health and healthier living, enhanced quality outcomes and lowered growth of health care costs.

The AHEAD Model constitutes a shift from the prior Total Cost of Care Model. Among other components, and in addition to modifying Maryland-specific hospital quality programs to align with national requirements, AHEAD will transition rate-setting authority for Medicare FFS from the Maryland Health Services Cost Review Commission (HSCRC) to CMMI under the AHEAD hospital global budget approach. The HSCRC will continue to set hospital rates and implement global budgets for all other payers.

Achieving success under the AHEAD Model demands a coordinated and proactive approach across multiple state agencies. On September 23, 2025, Governor Wes Moore directed the Secretary of Health to form a Regulatory Working Group composed of representatives from the Maryland Department of Health (MDH), Maryland Insurance Administration (MIA), HSCRC, Maryland Health Care Commission (MHCC) and the Maryland Health Benefit Exchange (MHBE) to collaborate on policy proposals that will enable the State of Maryland to achieve the goals and objectives set forth in the AHEAD Model. The Working Group is also charged with assessing and addressing impacts on constituencies throughout the health care landscape, including hospitals, health care providers, insurers, individuals and employers, that arise from the implementation of House Resolution 1 (H.R. 1) and AHEAD.

The Working Group will address six priority topics over the course of its work, including:

- Cost-Shifting Policy
- Medicare Advantage Market Stabilization
- Choice and Competition
- Workforce and Graduate Medical Education
- Post-Acute Care
- Total Cost of Care Growth and Primary Care Investment Targets

The Working Group process will prioritize stakeholder insight, input and guidance to the greatest extent possible through listening sessions, opportunities for public comment and the integration of stakeholder input during the development of policy proposals. Details of the workgroup process and timeline are provided in the multi-agency workplan, as submitted to the Governor in October 2025. The Working Group will provide regular updates on the progress of discussion to members of the General Assembly designated by the Senate President and Speaker of the House as directed in Chapter 615 of the Acts of 2025. A final report with identified policy solutions and proactive steps will be submitted to the Governor by June 2026.

The Governor's Directive identified three core values for the process:

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

Overview of Policy Recommendation

This document focuses on the first two policy areas identified in the Governor's Directive: 1) a framework for cost-shifting to help the State achieve the AHEAD savings targets; and 2) Medicare Advantage (MA) market stabilization.

The Working Group respectfully recommends that the Governor request the relevant agencies and commissions to implement the following:

> **(1) Cost-Shifting Proposal** - A $435 million annual cost increase to commercial rates for hospitals to replace dollars lost under other payers (*i.e.*, Medicare FFS and Medicaid), with the amount to be phased in steadily from 2028 to 2032, amounting to $87 million each year. By 2032, it is estimated that this will increase commercial premiums by 1.8% or an annual increase in premiums of 0.30%.
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> **(2) Medicare Advantage Proposal** - A solution that leverages the HSCRC's rate-setting authority to reduce hospital costs for qualified MA plans and maintain hospital funding by increasing commercial rates. Plan eligibility would be determined by factors such as a percentage of eligible beneficiaries in relevant H-contracts, counties with high proportions of underserved

beneficiaries and minimum ratings in Centers for Medicare and Medicaid Services' (CMS) quality star program. Qualified plans would be designated in the first quarter of each year for the following year, starting in 2026. During the HSCRC's annual update factor process, Qualified Plans would be confirmed and awarded an additional 11.55% rate relief for their beneficiaries, and this amount would be offset by increases in rates for other payers. Once fully implemented, this is estimated to increase commercial rates by 0.75%.

Both solutions would also require an annual report on key related factors. The Working Group recommends that these policies remain in place unless changed through a multi-agency public policy process similar to the one by which these recommendations were developed. The remainder of this document provides the background for these recommendations as well as the specific detail for each recommendation that will guide future actions.

Background

Cost-Shifting

Historical Policy

Since the 1970s, the Maryland model has been built on an all-payer concept, where all payers pay the same rate for hospital care with the exception of certain small policy-driven adjustments.[1] Maryland has experienced multiple benefits from the all-payer approach, including a more even distribution of hospital costs across payers, expanded and more equitable access to high-quality care for residents across the state, a reduction in the impact of uncompensated care on hospitals and significantly higher per-service reimbursement rates for Medicare and Medicaid. As a result, commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country.[2] These reduced costs are passed along in reduced premiums to Maryland consumers.

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[1] At the inception of the first Medicare waiver in 1977, a payer differential was established based on business practices of payers that helped to avert bad debt to hospitals such as prompt payment and insuring high-risk individuals. It is referred to as a differential rather than a discount, because the differential in payments is built into hospitals' rate structures. The public payer differential is 5.7% for all public payers. Payers may also be eligible for an additional 2% prompt pay discount. Additionally, the Medicare Performance Adjustment-Savings Component has been a Medicare-specific adjustment that allows the State to produce Medicare-FFS-specific savings without impacting rates set for other payers. There is no permanent adjustment in place under the Medicare Performance Adjustment.

[2] Based on HSCRC commercial total cost of care benchmarking but consistent with data available elsewhere. More information can be found in the benchmarking section of this page: https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx

To date, Maryland has achieved Medicare FFS savings targets by setting all-payer hospital rates in a way that maintained Maryland's higher per service Medicare FFS reimbursement levels while incentivizing reductions in hospital utilization relative to the nation. This has allowed the State to accomplish three key goals: 1) total costs per capita have remained in line with Medicare FFS savings targets; 2) hospitals have remained relatively financially stable while maintaining patient access and quality of care; and 3) commercial hospital rates have remained lower relative to other states. This approach is effective as long as the combination of: 1) incremental savings related to lower cost trend due to reductions in hospital utilization already achieved; and 2) new savings related to continued reduction in hospital utilization compared to national growth rates are sufficient to achieve Medicare FFS targets while maintaining patient access and quality of care. However, if this is no longer feasible, hospital per service reimbursement levels will decline and hospital financial stability will be at risk.

The term "cost-shift" is used throughout this document and reflects impact from a payer perspective. However, from a hospital perspective this same mechanism is a revenue shift; that is, greater revenue comes from one set of payers, and less from others.

Savings Targets Under AHEAD

The AHEAD Model sets a Medicare FFS savings goal that requires Maryland to reduce Medicare FFS spend by 2.66% compared to national trends by Calendar Year (CY) 2032. This has typically been expressed as $460 million, which is the projected impact of a 2.66% trend reduction using current national trend estimates. Because Medicaid and MA rates are tied to Medicare FFS, the Medicare FFS target drives additional changes in those programs.[3] HSCRC has estimated the impact under AHEAD at $870 million versus national trends across all three programs.

The AHEAD Model requires the State to continue building on the successful reductions in hospital utilization achieved under the TCOC Model; each additional dollar of savings is likely to be harder to generate as easier solutions have already been implemented. However, this challenge is mitigated by the fact that the required rate of savings is declining. Through 2023 Maryland achieved reductions of 4.62% over 10 years during TCOC; over the first seven years, the reduction was 3.89%. The savings target under the original AHEAD Model agreement signed in 2024 was 1.15% over nine years. In comparison, the

[3] Medicaid payment rates cannot exceed Medicare FFS payment rates. This requirement has been most recently emphasized via a Presidential Memoranda released on June 6, 2025, which directed the Secretary of Health and Human Services to "[ensure] Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law." Medicare Advantage rates follow Medicare FFS payment rates because the benchmark for how premiums for MA plans are determined is based on Medicare FFS rates.

current agreement includes a seven-year target of 2.66%, roughly two-thirds of the rate achieved in the first seven years of TCOC.

It is also important to note that the required savings are relative to national metrics, which are trending up. In their modeling for AHEAD, CMMI assumed average national trends of 4.99%. To achieve the 2.66% reduction over the seven-year window the State needs to manage trends down to a 4.70% annual increase, a relatively small change.

Factors in Establishing a Cost-Shifting Policy

Given the savings targets, the State identified a need to define a cost-shifting policy, acknowledging that savings resulting from hospital utilization changes alone may not be sufficient and to plan a controlled transition of costs to commercial payers. A policy that explicitly adopts cost-shifting will be a significant departure from State historical practice and may impact affordability through increased premiums and cost-shares in the commercial market.

AHEAD Model Concepts: The AHEAD Model does not have the same restrictions on cost-shifting policy as the TCOC Model. However, the stated goal of the AHEAD Model is to improve the total health of a state's population while lowering costs.[4] Achieving savings solely through a cost-shift approach would dilute the focus of the State and hospitals on reducing acute care costs through incentivizing population health improvements and investing in primary care.

Current Level of Utilization Performance: A complete analysis of care management opportunities is beyond the scope of this discussion; however, HSCRC analyses indicate that hospital utilization, as measured by Inpatient (IP) Days per 1000, is between the 25th and the 50th national percentiles in most regions in Maryland. The readmission rate is above the 25th national percentiles in all regions in Maryland and above the average national percentile for many. The State believes that decreasing both metrics to the 25th percentile is possible while improving health, maintaining access and improving quality.[5]

Long-Term Investments in Care Transformation: The State and hospitals have been investing in care transformation and primary care over the life of the Model and expect that some of these investments will produce greater savings over the long term. For example, in 2019, the State began investing in the Maryland Primary Care Program (MDPCP) under the TCOC Model, with the investment reaching

[4] CMS.gov AHEAD Model, accessed November, 2025
[5] Metrics are derived from HSCRC's benchmarking process as described in footnote 2.

approximately $200 million annually in recent years. According to an analysis conducted for prior Joint Chairmen's Reports on MDPCP, the program performance reflected a net cost of $75 million in 2022, which reduced to a net cost of $31 million in 2023 and became a net savings of $22 million in 2024.[6] In addition, the 2024 TCOC report by Mathematica reflected reductions in admissions and improvements on timely follow-up after acute exacerbation of a chronic condition.[7] Benefits of this kind typically take years to accrue. The State anticipates continuing and expanding care transformation investments under AHEAD.

Medicare Advantage Market Stabilization

Also known as Medicare Part C, MA is a program that provides an alternative to traditional Medicare FFS, through plans offered by private health insurers. MA plans are required to include coverage for all of the benefits within Medicare Parts A and B, except hospice. Many MA plans also provide prescription benefits typically included under Medicare Part D, as well as benefits not included in FFS, such as vision, hearing or dental services. In addition, MA plans may include 'supplemental benefits,' such as transportation, gym memberships or financial support for meal or nutrition services. Beneficiaries in Medicare FFS are generally responsible for premiums for both Part B and Part D, as well as 20% coinsurance after their deductible is met, with no cap on out-of-pocket costs. For example, in 2026, a hospital stay of under 60 days would be subject to a deductible of $1,736 for a beneficiary of Medicare FFS, and additional payments may be required if the beneficiary has more than one hospital stay per year. In contrast, MA plans may offer zero-dollar premium options for Part B and often have annual limits on out-of-pocket costs. However, MA plans are permitted to establish preferred provider networks, which are narrower than Medicare FFS, and they may apply utilization management tools, such as prior authorization and referral requirements, to a broader set of services than Medicare FFS.

Determining MA Plan Payments

CMS pays MA plans a premium for each beneficiary. Premiums are based on two factors; the 'benchmark' for the county in which the plan will operate and the plan's 'bid.' Benchmarks are set annually by CMS and are based on the FFS spending within each county in the United States, with adjustments for geographic area and risk. The benchmark represents the maximum amount that CMS will pay any MA plan for each enrolled beneficiary. Counties are divided into four groups, or 'quartiles,' based on their level of FFS spend. Higher cost counties get lower benchmarks; for example, in the highest cost

[6] HSCRC analysis of MDPCP program developed to support the Joint Chairmen's Report
[7] Evaluation of the Maryland Total Cost of Care Model: Progress Report

tier of counties, the benchmark is set at 95% of the risk-adjusted FFS spending. The lowest cost tier is set at 115% of the risk-adjusted FFS spending–these areas are typically rural, and the high payment is intended to attract plans into rural areas by subsidizing the plan's operations.

MA plans generate and offer bids for counties they select based on their estimate of the cost of providing coverage in that area. If the bid amount is lower than the benchmark, CMS retains a portion of the savings. The remainder is returned to the MA plan's enrollees through either reduced cost sharing or supplemental benefits offered by the plan. If the bid amount is above the benchmark, the balance is covered by beneficiaries in the form of a premium, which would be in addition to any Medicare Part B premium. MA plans with high quality ratings, also known as 'star ratings,' may receive positive adjustments to the benchmark and higher levels of rebate.

Maryland MA Market Overview

The breadth of coverage offered, and the limits on out-of-pocket costs, make MA an attractive option for many Medicare beneficiaries. Accordingly, enrollment in MA has increased steadily over the past 15 years. A recent analysis indicates that 51 percent of Medicare beneficiaries nationally, and 25% of Maryland beneficiaries, are enrolled in MA plans.[8] Although MA enrollment in Maryland has historically been lower than national levels, the Maryland market has seen steady growth over the past several years with enrollment increasing by 115% since 2020 to 298,000 Marylanders in September 2025.

In line with national trends, multiple carriers have already limited their footprint in Maryland for 2026. The impact of these changes on consumers can be significant, including reduced access to benefits, increased costs and disrupted access to their known care providers. Further, beneficiaries in these circumstances who consider transitioning to Medicare FFS may find that they are no longer eligible for guaranteed issue of a Medigap plan unless they quickly enroll through a special enrollment period.[9] Medigap plans provide supplemental coverage that assist beneficiaries with out-of-pocket costs such as deductibles and copays, so a lack of access to this coverage can have a significant impact.

Historically, MA plans in Maryland have struggled to be financially profitable. MIA analysis shows that, in 2024, plans would have needed to increase revenue by over $200 million to cover their medical expenses, and increase by over $551 million to also cover administrative expenses and generate margins.

[8] Medicare Advantage Market Growth Slows Amid Intensified Headwinds, Chartis, March 25, 2025, accessed June 5, 2025

[9] See Code of Maryland Regulations 31.10.06.09-1B(2).

Potential Impact of the AHEAD Model on MA

CMMI is concerned about the impact of the Maryland Model on MA and included provisions in the AHEAD Model agreement for the State to propose solutions. The Governor's Directive requires the State to explore options to stabilize the MA market in Maryland and to ensure that Maryland residents continue to have access to MA as an option for their coverage. Under the AHEAD Model agreement, Maryland has the opportunity to propose solutions to CMMI to improve the MA market in the state.

Any policy solutions for MA stabilization will need to be considered within the framework of cost-shifting and may require approval by CMMI or CMS, even for temporary stabilization efforts. The State is committed to developing a policy in time for MA plans to make decisions for the CY 2027 plan year, *i.e.*, in early 2026.

Stakeholder Engagement Process

The Working Group scheduled two listening sessions on the topics of cost-shifting policy and MA stabilization, held virtually on October 29th and November 5th. Email messages with instructions for submitting comments and participating in each session were sent to a wide range of stakeholders including State agencies, members of agency standing workgroups, payers, hospitals, providers and community advocates. Further, recipients were invited to share the emailed information broadly within their own networks, in an effort to maximize outreach.

Stakeholders were asked to submit written comments on one or both topics, and to also prepare a short verbal summary of their comments for presentation at one of the listening sessions. Stakeholders who did not choose to submit written input were invited to attend the sessions and to speak as time allowed. The initial email invitation also included the timeline and process for developing policy proposals, setting a mid-November goal for publicly posting the draft proposal and early December for submission of the final recommendation to the Governor, with a decision from the Governor anticipated in late December.

The Working Group developed and distributed via email a draft policy proposal on November 21, 2025, with a request for written comments by December 2, 2025.

Stakeholder Comments

Listening Sessions

Over 130 participants attended each listening session. Written and verbal comments reflected a consensus that policy proposals must thoughtfully balance health care accessibility and affordability, keeping in mind the needs of a wide range of stakeholders, including consumers, employers, hospitals, providers and payers. In addition, respondents agreed that policy proposals must be sufficiently flexible to allow adaptation and refinement over time, given the difficulty of predicting impacts of recent and ongoing changes in state and federal health care policy. (See Appendix A for a list of respondents and link to comment letters).

Input on the development of a cost-shifting policy emphasized the need to consider likely changes in Medicaid eligibility and levels of uncompensated care, other impacts of H.R. 1 and hospital rate changes related to the planned transition to a CMMI-led methodology for the Medicare FFS portion of hospital global budgets in CY 2028. Respondents provided varying estimates for the magnitude of these changes, the recommended amount of shift and the associated timeline. Representatives of the commercial market suggested that a cost-shift policy would be burdensome for consumers and potentially undermine the value of the Model; as such, they indicated that such a policy should only be considered as a last resort. In contrast, hospital representatives proposed a full cost-shift of the potential reduction in Medicare FFS, Medicaid and MA payments, estimated at $855 million (later recalculated to approximately $870 million), and anticipated that such a policy would have minimal impacts on affordability. Several respondents suggested that the payer differential, which currently exists within the HSCRC's regulatory authority, would be an appropriate mechanism to effect these changes. Multiple respondents highlighted the need for close tracking and ongoing study of the impacts of any cost-shifting policy across the health care sector.

Stakeholder input regarding the stabilization of the MA market in Maryland encompassed both short- and long-term concerns. Suggested long-term solutions included recommendations that the State negotiate changes to CMS' benchmarking process (described above) in Maryland in an attempt to address perceived misalignment between how CMS pays MA plans and the Maryland Model, provide additional State support for MA plans through grant programs and consider aligning hospital payments by MA plans with Medicare rates. In addition, multiple respondents observed that MA carriers in Maryland are following a national trend of adjusting plan benefits and premiums, limiting broker commissions and withdrawing from selected markets, in response to struggles with financial instability.

Several stakeholders noted that plan withdrawals are estimated to impact approximately 100,000 Maryland MA enrollees in 2026. Representatives of some of the remaining MA plans in Maryland expressed concern about their ability to absorb and adequately serve these beneficiaries. Although the listening sessions were intended to consider input for long-term MA market stabilization, respondents also requested that the Working Group agencies evaluate options to address these more immediate-term needs, including suggestions such as a temporary 'grant' or 'bridge' program, while a longer-term solution is developed.

Finally, several commenters offered suggestions for improved stakeholder communication and engagement, including targeted outreach to strengthen partnerships with community organizations, particularly in underserved areas, establishing consistent and timely opportunities for sharing information with and seeking input from regulatory agencies and ensuring that any changes are communicated clearly and with sufficient time for thoughtful implementation. Stakeholders representing commercial payers and employers particularly emphasized the importance of predictability and timely information to allow their members to make informed decisions balancing quality of care with affordability and long-term stability for their consumers.

Comments on Draft Policy Proposals

The Working Group received 18 comment letters in response to the draft proposal, with input from representatives of hospitals, primary care providers, consumer advocates, unions, commercial payers and insurance brokers.

The proposed cost-shifting policy generated mixed responses, with hospital representatives expressing concern that the amount of the proposed shift would be insufficient to support hospital financial stability, and payer representatives asserting that hospital cost structures should be evaluated before considering cost-shifting as a last resort. Several stakeholders also highlighted the anticipated impacts of H.R. 1 on both insurance coverage and uncompensated care. In addition, consumer advocates expressed concern about the potential impact of increases to commercial premiums, and primary care providers highlighted the possibility that increased commercial payer costs could result in decreased payments to providers.

Recommended adjustments to the cost-shifting proposal included establishing a 'cap' or guardrails on the growth of commercial rates, increasing the amount of shifted cost or making the amount flexible for future increases as necessary and eliminating the proposed cost-shift, with a preference for evaluating opportunities within hospital cost structures or further decreases in utilization. Several stakeholders recommended taking additional time to evaluate the need for and scope of any cost-shifting policy,

including some recommendations for external evaluations of the system. Additionally, certain commenters noted the potential disproportionate impact of the increase to the differential in markets with a relatively-high public payer mix, recommending the State investigate how to smooth out the impact as part of its implementation activities.

Responses to the proposed MA stabilization policy were similarly mixed, with some respondents expressing reluctance to 'subsidize' plans and other respondents calling for more immediate action in 2026. Stakeholders who were supportive of the MA proposal suggested adjusting eligibility requirements to allow greater plan participation, such as broadening the definition of lower-income counties, removing the county-level threshold, adding more counties or reducing the required star rating from 3.5 to 3.0. In contrast, stakeholders who expressed concern or opposition to the proposed policy cited challenges with MA plans, such as high levels of care denials and utilization review procedures, and recommended additional requirements in these areas if the policy proposal were implemented. Additionally, it may be difficult to forecast the needed budget for the policy, as MA enrollment increases due either to the policy itself or federal actions to promote MA.

Finally, several stakeholders noted the significance of these changes to Maryland's longstanding all-payer model and expressed concern about potential negative impacts on population health, preventative care and access to care for all communities. Organizations focused on the needs of health care consumers in particular stressed the importance of close monitoring and routine evaluations of impacts in these areas as policy proposals are implemented. Commenters also raised concern about the anticipated effects of H.R. 1, including increases to uncompensated care and increased volatility in rate-setting due to more-frequent Medicaid eligibility verifications.

Response to Stakeholder Comments on Draft Policy Proposal

The Working Group was pleased to receive robust feedback across a wide array of stakeholder respondents. As noted earlier, commenters were divided in their response to both proposals, citing concerns about access, affordability and the financial stability of both hospitals and MA plans. Certain groups advocated for more-immediate action, and others suggested delaying and monitoring or even canceling the policies. (See Appendix A for a list of respondents and link to comment letters.)

Generally, the reporting aspects of this policy recommendation provide an opportunity for the State to assess and address emerging concerns raised by commenters regarding affordability and access, such as the impact of H.R. 1 and MA prior authorization policies. The Working Group also views the

recommended monitoring activities as an avenue to identify when policy changes may be required, as opposed to fixing timelines in this recommendation.

In addition, the component agencies of the Working Group are already addressing many of these topics, as part of their ongoing regulatory work. For example, the HSCRC–in consultation with MHCC–has already begun more work on a more formal assessment of access as part of ongoing development of global budget policies. With regard to H.R. 1, the State has established a comprehensive, cross-agency team led by MDH and Department of Human Services (DHS), as well as MHBE and MD Benefits, to implement the bill's requirements in partnership with providers, plans and stakeholders, with the goal of mitigating disruption to coverage and access to benefits.

Lastly, the Working Group appreciated additional suggestions provided by commenters–such as smoothing the impact of the differential change vis-a-vis public payer mix and updating the uncompensated care policy, among others–and will prioritize these as the agencies shift from policy design to implementation planning.

Cost-Shifting

Following review of public comment, which lacked any consensus for alternative policy approaches, the Working Group intends to finalize the cost-shifting recommendation largely as proposed, with the following notations. In response to feedback from the provider community, while not a change to the policy, the Working Group would like to identify avenues to provide resources to physicians through value-based programs and has identified that as another area of reporting within the recommendation below. The Working Group appreciated the suggestion that the State set caps or guardrails on commercial rate growth. While not specifically a cap or guardrail, the Working Group will be launching a public process to inform all-payer TCOC growth targets–as required by the AHEAD Model–starting in January 2026. In response to comments suggesting flexibility for the cost-shifting figure, as noted below, one of the State's guiding principles is that this policy foster predictability to the extent feasible.

Medicare Advantage

The Working Group proposes one change to the Medicare Advantage policy recommendation, in response to stakeholder comments and with regard to the eligibility requirements for plan participation. The policy will maintain that at least 50% of an H-contract's members need to reside in Maryland, and it will also keep the county-level requirements to prioritize access for vulnerable populations. The proposed change will give plans–both existing and new entrants to the Maryland market–an opportunity to apply for a

waiver committing to come into compliance with the county-level requirements in 2028 if they are not currently in compliance. The State intends to maintain all other qualifying criteria, including the 3.5-star rating threshold and starting the policy to support plans in the CY 2027 plan year. Initiating rate support at this late date for the CY 2026 plan year would require an unanticipated increase on Medicaid and commercial rates.

Policy Proposals

The two issues addressed in this policy recommendation–cost-shifting and MA stabilization–require state-level investment. The Working Group is challenged to identify a source or sources of funding for these policies that are both meaningful enough to achieve their aims while not increasing budgetary pressure on consumers, risking the AHEAD Model's financial tests or putting pressure on the State's General Fund, particularly in the context of the anticipated impact of H.R. 1 on Medicaid. In developing these policies, MDH, MIA, MHCC, MHBE and HSCRC considered three primary funding options: cost-shifts from commercial (*i.e.,* non-MA, non-Medicare FFS, non-Medicaid) plans, hospital revenue and State General Funds.

Cost-Shifting

The AHEAD Model agreement details the methodology for calculating the Medicare FFS total cost of care savings targets against which Maryland's performance under the Model will be assessed. Savings targets are moderate in the early years before accelerating in the later years, reaching a maximum of 2.66% in 2032, which is equivalent to approximately $460 million. Failing to meet the annual Medicare FFS TCOC target may result in changes in payment to the State, issuance of a warning notice and enforcement action notice and potentially even a requirement for the State to submit a Corrective Action Plan describing action the State will take to correct its non-compliance.

As described above, the savings in Medicare FFS also require equivalent trend reductions in Medicaid and MA, resulting in a total target of approximately $870 million. The Governor's Directive indicated that the Working Group should maintain affordability and access while not allowing any segment of the health care system to bear all the burden. To balance these concerns and address the various pressures on commercial insurance rates and hospital funding, the Working Group adopted the following principles:

- The approach should support the overall goals of the model;

- The approach should value predictability for payers, hospitals, Maryland consumers and businesses;
- Any effect on annual premiums for consumers and businesses should serve the goal of maintaining affordability and not lead to further loss in coverage; and
- Annual amounts must be finalized in time for payer and hospital rate-setting.

Policy Recommendation - Cost-Shifting

The Working Group recommends a cost-shift approach that commits to a fixed level of cost-shift now and establishes criteria for future revisions. The Working Group respectfully submits the following recommendation for the Governor's consideration:

1. Request that the HSCRC:
    a. During the Fiscal Year (FY) 2028 HSCRC update factor process, whereby hospital revenues are adjusted for items like inflation and population related volume growth, increase commercial hospital rates by $87 million annually beginning January 1, 2028.[10] This will increase hospital commercial revenue to offset anticipated slower growth in governmental payer revenue.
    b. During the annual update factor process, increase another $87 million for each year from 2029 to 2032 such that by 2032, the total is equal to $435 million or half the anticipated required Medicare FFS savings when those savings are extended across all public payers (Medicare FFS, Medicaid and MA).
    c. Maintain the cost-shift, as described herein, unless modified by the Working Group through a public policy process similar to the one by which this recommendation was established based on cost drivers identified through the monitoring activities described below.
    d. Implement the change through a combination of the available policy tools (*e.g.,* payer differential) as determined to be appropriate by the HSCRC.

[10] The annual update factor policy is a revenue update that incorporates adjustments for items like inflation and population related volume growth hospital revenue under Global Budget Revenues (GBR). This policy is a stakeholder involved process that begins early in the calendar year and culminates with a Commission vote in June to ensure implementation for the next fiscal year, which begins in July. Beginning January 1, 2028 the Medicare FFS payments will transition to Hospital Global Budget Methodologies, but the remaining population will remain under a GBR methodology. There will still be an annual update factor policy/process to help determine the appropriate revenue update for the next fiscal year.

2. Direct the Working Group to report back to the Governor annually on the following related to cost-shift:
    a. The affordability of commercial insurance compared to other states to assess the impact of existing cost-shifts and other policies on Maryland's historic premium cost advantage.
    b. Metrics regarding hospital affordability, health care access and hospital viability that could be used to assess the need to change the cost-shift in future periods, considering other changes in the market impacting these topics such as Medicare reimbursement levels, uncompensated care and clinical delivery trends.
    c. Strategies the State could pursue to provide resources to value-based physician programs such as MDPCP and Episode Quality Improvement Program (EQIP) that promote high quality, cost effective care through enhanced reimbursement to physicians and also generate total-cost-of-care savings to payers and reduce the need for hospitals to underwrite physician expenses.
    d. The opportunity for additional investments in population health that could reasonably be expected to result in declines in spending over the life of the model.

Discussion

MIA and the HSCRC modeled the impact on commercial premiums of cost-shifting $435 million of public payer payments to commercial payers. Based on this modeling, commercial premiums would be expected to increase by approximately 1.8% over seven years, with an annual incremental increase in premiums of approximately 0.35% from 2028 to 2032. This would be in addition to increases due to other health cost drivers, *e.g.,* anticipated reductions in federal credits for the ACA market and the cost of emerging drugs.

The recommendation to implement the cost-shift on a steady basis is intended to provide predictability for insurers, consumers and businesses, as well as to provide some forward funding to hospitals against the savings under AHEAD that are concentrated in the later years.

Under existing HSCRC tools, the impact of this cost-shift on commercial patient costs and insurance premiums will be greatest in those markets where fewer consumers have coverage through commercial insurance, because in those areas a smaller group of commercial patients is covering added costs for a larger group of public patients. The HSCRC estimates the 1.8% total increase could range from 1% to 4% by market. As part of the implementation of the cost-shift policy, the HSCRC and MIA will work to better

understand the potential for these impacts, including approaches to mitigate the disproportionate effect across markets.

Medicare Advantage

The ultimate aim of stabilizing the MA market in Maryland is to prevent further disruption and foster continuity of care for Marylanders who select MA for their health coverage, particularly for low-income Marylanders. The goal of the Working Group is to determine a mechanism and funding source(s) to mitigate the unique challenges faced by MA plans in Maryland.

Although MA offerings are shrinking nationwide, MA plans have historically struggled to make a profit in Maryland. Commenters stated that several plans that operated in 2025 are departing Maryland or decreasing their service areas in 2026; they estimated that this could leave as many as 100,000 older adults needing to seek coverage with a different plan or switch to Medicare FFS. As described above, in 2024 Maryland MA plans were $551 million away from covering administrative expenses and generating margins. However, there are many reasons why Maryland plans struggle, and many plans outside Maryland also struggle. Therefore, the Working Group does not believe the State should subsidize all MA plan losses.

Instead, the HSCRC quantified the amount of lost premium in Maryland by calculating the difference between the actual weighted state average MA benchmark and the benchmark that would be generated if each Maryland county had the benchmark of demographically similar counties in the rest of the country under the national Medicare FFS reimbursement system.[11] This calculation indicates that weighted average Maryland premiums are approximately 4.6% below the levels of their geographic peers. This correlates to an estimated funding shortfall of approximately $350 million.

Policy Recommendation - Medicare Advantage

The Working Group proposes a solution that leverages the HSCRC's rate-setting authority to generate reduced hospital costs equal to this amount for qualified plans and maintain hospital funding by increasing commercial rates. The Working Group respectfully submits the following recommendation for the Governor's consideration:

1. Request that the HSCRC and MIA designate Qualified Plans each year as follows:

[11] Similar counties were derived from the counties used in the HSCRC's Medicare benchmarking process, the same process used to evaluate Maryland utilization performance as discussed in footnote 2.

a. Qualified Plans will meet all of the following:
    i. At least 50% of MA beneficiaries in the relevant H-contract reside in Maryland;
    ii. At least (1) 5,000 beneficiaries or (2) 20% of MA beneficiaries residing in Maryland in that H-Contract reside in these eight jurisdictions: Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington and Wicomico;[12]
        1. Plans not meeting the county-level requirements outlined in 1.a.ii, above, may submit a waiver request, with a commitment to coming into compliance by the 2028 plan year, *i.e.,* with sufficient enrollment in qualifying counties by CY 2028 Q1, to qualify for the program in CY 2029 and beyond.
        2. Waiver submissions requesting to come into compliance after CY 2028 will not be considered.
    iii. After the release of 2028 plan year data - at least 3.5 stars in the Medicare Stars quality program.[13]
b. To allow for the inclusion of resulting savings in MA bids, Qualified Plans will be designated for the following year in the first quarter of each year, starting in 2026, using the most recent available beneficiary counts.
c. For 2027, finalize plan qualification criteria, via memo, by January 23, 2026 and identify final Qualified Plans for CY 2027 by February 20, 2026.

2. Request that the HSCRC:
    a. During the HSCRC's annual update factor process, starting with FY 2026, award Qualified Plans an additional 11.55% rate relief implementing the change through a combination of the available policy tools (*e.g.*, payer differential) as determined to be appropriate by the HSCRC. (11.55% is derived by calculating the impact of closing the 4.6% premium gap noted above across the 40% of MA plan costs that are at hospitals.)
    b. Offset the cost of this rate relief to hospitals by increasing rates for other payers sufficient to offset the impact. This offset must be sufficient to cover the rate relief in commercial and Medicaid revenue in CY 2027 and just commercial revenue

[12] These areas were selected based on an evaluation across a set of metrics related to income.
[13] Specific Star standard may be subject to change based on program adjustments during federal rulemaking.

thereafter. The HSCRC will also establish a plan to monitor, on an ongoing basis, the amount of rate relief provided by plan and hospital, the amount of offset at a statewide and by hospital level and report publicly on the impact and if feasible, implement remedies to reduce the variability among hospitals.

c. Make any necessary request to CMS or CMMI to implement this change and to offset any cost to Medicare FFS such that Medicare FFS will not bear any of the cost of the MA rate relief. In the event CMS/CMMI does not approve the needed changes, the Working Group will revise this proposal.
d. Unless modified through a multi-agency public policy process similar to the one by which this request was established, continue this process into the future.
e. Consider, and if feasible, implement an alternative approach.

3. Direct the Working Group to monitor the impact of rate relief to MA plans and report back to the Governor annually on the following:
    a. The impact on the affordability of commercial insurance compared to other states to assess the impact of existing MA rate relief and other policies on Maryland's historic premium cost advantage in order to frame the decision regarding continued MA rate relief.
    b. Total cost of MA rate relief including an assessment of trends and the degree to which rate relief is supporting MA for underserved individuals.
    c. The impact of changes in the MA rate relief on metrics regarding MA plan availability, enrollment and quality.
    d. Plans to add to the requirements for Qualified Plans to improve the efficiency of the MA market or promote population health or quality outcomes.

Discussion

The plan eligibility criteria were selected to ensure the benefits accrue to low-income Marylanders by providing rate relief only to Qualified Plans that provide services primarily to Maryland residents and who serve a significant number of residents in lower-income areas. The addition of a waiver option giving plans a two-year window to come into compliance with the county-level requirement has the potential to both mitigate disruption as well as increase plan options available to Marylanders.

As of September 2025, plans representing approximately half of the MA beneficiaries in Maryland would qualify, resulting in a program cost of approximately $175 million. This amount is likely to increase if this program is effective in stabilizing the MA market.

MIA and the HSCRC estimated the impact on commercial premiums of providing $175 million of rate relief to MA and adding the cost to commercial payers. Based on this modeling, the impact on commercial premiums would be an increase by approximately 0.5% in CY 2027 and a further 0.25% in CY2028 resulting in a total increase of 0.75%. This would bring total increases across both proposals to 2.55% by 2032 with the largest single year increases occurring in 2028, at 0.60% combined for the two programs. This would be in addition to increases due to other health cost drivers, *e.g.,* anticipated reductions in federal credits for the ACA market and the cost of emerging drugs.

Effective January 1, 2028, CMMI will take responsibility for setting Medicare FFS global budgets. Due to operational changes related to this shift, the cost of the rate relief to MA will be borne by Medicaid and commercial payers for 2027 and only commercial payers starting in 2028. Medicaid would experience an increase in 2027 totaling approximately $60 million.

Similar to the cost-shift, under existing HSCRC tools the impact of this MA rate relief on commercial patient costs and insurance premiums will vary by market, in this case depending on the penetration of MA plans. The HSCRC will adopt an approach providing rate relief to minimize this impact on the consumer based on various factors including the predictability of the outcome, the feasibility under relevant legislation.

Additionally, the federal government released its annual MA and Part D rulemaking and advance notice in late November. Pending finalization, the effects of any resulting rule changes by CMS–*e.g.,* star ratings, risk adjustment processes–may require changes to this approach.

Appendix A. List of Stakeholder Respondents

Comment letters can be found on the HSCRC AHEAD Model Website: https://hscrc.maryland.gov/Pages/ahead-model.aspx.

Respondent Name	Listening Session	Policy Proposal
1199SEIU and Economic Action MD		X
Adventist HealthCare	X	X
AHIP	X	
Alterwood Advantage	X	X
CareFirst	X	X
Health Means Everything Coalition	X	X
Health Resource Advisors	X	X
Johns Hopkins Health Plans	X	X
Johns Hopkins Health System	X	X
Kaiser Permanente Mid-Atlantic	X	X
Dr. Terris King	X	
League of Life & Health Insurers of Maryland	X	X
Maryland Academy of Family Physicians		X
Maryland Health Care for All! Coalition	X	X
Maryland Hospital Association	X	X
Maryland Primary Care Physicians		X
Mattes Insurance & Financial Services, LLC	X	
MedChi	X	
MedStar Health		X
National Association of Benefits and Insurance Professionals of Maryland	X	
Dr. Mercy Obamogie		X
Step Up Maryland	X	
United States of Care		X
University of Maryland Medical System	X	X