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Healthcare Outcome Payment Effort (HOPE)

Final Recommendation

June 10, 2026

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Final Recommendation

This final recommendation outlines the policy framework for the Healthcare Outcomes Payment Effort (HOPE) beginning in Fiscal Year 2027 (FY27). HOPE replaces Care Transformation Initiatives (CTIs) which Health Services Cost Review Commission (HSCRC) is sunsetting on June 30, 2026. The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals and community partners to invest in interventions that improve care and health and enhance the financial sustainability of the health care system. HOPE seeks to sustain and expand population health investments that advance Achieving Healthcare Efficiency through Accountable Design's (AHEAD) goals and drive meaningful system transformation.[1]

Differences from Draft Recommendation

Over the past two months, stakeholders provided extensive comments and feedback that informed the policy refinements and timeline modifications reflected in the draft recommendation. Staff carefully reviewed stakeholder input alongside lessons learned from prior and existing care transformation programs and, based on this analysis, recommend the following key updates to the original HOPE draft recommendation:

1. Shift the implementation and measurement start date from FY27 to FY28.
2. Provide reasonable flexibility in baseline and measurement periods to account for variation in initiatives and differing stages of program maturity across organizations.
3. In FY27, provide one-time infrastructure funding totaling $25 million, distributed proportionately based on hospitals' Global Budget Revenue (GBR), as well as an additional $25 million in seed funding for proposals that are qualified under HOPE.
4. Allow flexibility regarding eligible applicants for Regional and Statewide Initiatives (RSIs), including permitting hospitals to serve as applicants when appropriate.
5. Sunset High-Value Care Plans (HVCPs) at the conclusion of FY26 following completion of final reporting requirements.

[1] https://www.cms.gov/priorities/innovation/innovation-models/ahead

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The objective of HOPE is to create a clear, predictable, and accountable payment structure that enables hospitals, payers, and community partners to invest in interventions and share in savings. HOPE seeks to sustain and expand population health investments that advance AHEAD's goals and drive meaningful system transformation.	HOPE is a voluntary, upside-only outcome payment model that rewards hospitals and non-hospital partners for measurable reductions in inpatient and ER spending while improving population health. It creates predictable, performance-based funding pathways and positions the State as an outcome purchaser of successful projects.	Hospitals benefit from financial predictability, reduced risk, and incentives to invest in prevention and population health initiatives. The program encourages collaboration and supports infrastructure and transformation efforts.	Payers and consumers gain from improved care and health outcomes and greater financial sustainability of the health care system. The model promotes preventive care and community-based interventions that enhance patient experience and reduce unnecessary utilization.	HOPE prioritizes interventions that target defined populations and address upstream health drivers to improve outcomes and reduce disparities.

Hope Alignment with AHEAD

This proposal is designed to align closely with the AHEAD Population Health Accountability Plan (PHAP) and the broader vision advanced by stakeholders.[2] By reinforcing shared accountability for measurable improvements in population health, the framework supports the State's commitment to responsible cost growth, improved outcomes, and transparent performance expectations across the delivery system.

[2] https://health.maryland.gov/mche/pages/default.aspx

It also reflects a deliberate opportunity for prevention and restorative health that emphasizes upstream interventions, chronic disease management, and community-based supports. In addition, the framework seeks to encourage cross-sector collaboration and broader care delivery models. This approach recognizes that meaningful population health gains can benefit from engagement from community providers, social service organizations, and public health partners. Payer alignment under AHEAD reduces fragmentation, promotes value-based care, and supports sustainable cost growth while improving quality and overall population health.

Introduction to the HOPE Policy

The State's participation in AHEAD presents a pivotal opportunity to strengthen the alignment between payment policy and population health improvement. Building on stakeholder feedback regarding the strengths and limitations of prior initiatives including Potentially Avoidable Utilization (PAU) and CTIs, HOPE builds upon progress to date on these policies by offering clearer guidance to hospitals and partners regarding the return on investment. Described in further detail in sections below, it is a voluntary, upside only model that increases payment predictability and supports planning and investment using an annual payout structure of an initial 3 years based on validated savings. At the same time, it represents a model in which the State becomes an outcome purchaser rewarding measurable, successful interventions.

Paths to Participation

Participation can occur through one of two primary pathways: the Care Transformation Framework (CTF) or Regional & Statewide Initiatives (RSI). Both pathways aim to improve population health while reducing emergency room and inpatient expenditures and share savings with participants. They differ in who leads the effort, how approval is obtained, and the scale of intervention.

Path 2: Care Transformation Framework (CTF)

Under the CTF pathway, participation begins at the individual hospital level. A single hospital—or a group of hospitals—applies directly to implement a hospital-defined intervention. Although multiple hospitals may participate in the same intervention, the focus remains hospital specific. The hospital identifies the target population and designs interventions aimed at reducing emergency room and inpatient costs in the state of Maryland (not limited to their own emergency room and inpatient costs). Applications are reviewed by a committee for program qualification, and Commission votes for each intervention are not required. If approved, participating hospitals share in the savings generated. Outcome payments based on savings are calculated over a measurement window and paid for three years, at which time a review will be completed and consideration given for extension. The model is intended to be all-payer, with the goal of working with CMMI to include Medicare.

Path 2: Regional & Statewide Initiatives (RSI)

The RSI pathway operates at a broader geographic scale. Interventions focus on defined regional populations and aim to reduce emergency room and inpatient expenditures across a broader geography. Participation is through a regional or statewide entity and must include at least one hospital partner. The entity may be technology or digital health companies, health plans, community-based organizations, etc. The entity is preferred as the applicant, rather than a hospital, and all partners involved must have a formal Memorandum of Understanding (MOU) or contractual agreement in place outlining collaboration and funds distribution. Unlike the CTF pathway, RSI proposals require both review committee qualification and a Commission vote for approval. Like CTF, participants are eligible for outcome payments over a certain measurement period. Outcome payments based on savings will be made for three years, at which time a review will be completed, and consideration will be given for extension. The model is intended to be all-payer, with the goal of working with CMMI to include Medicare.

Funding and Payment Structure

Based on continued stakeholder feedback, the funding and payment structure was intentionally designed to provide clarity, predictability, and reduced financial risk. Stakeholders emphasized the importance of ensuring that participation would not affect the hospital update factor. In response, the model is not funded through the update factor, separating it from base rate updates. To further promote certainty, outcome payments will be initially anticipated to be $50 million each year, with the commission only able to qualify interventions with up to $100 million in possible outcome payments, recognizing that initiatives may not be successful in reducing costs. Payments will be made regardless of position on the Medicare savings test or other affordability tests. Outcome payments for Regional and Statewide initiatives are individually approved by the Commission and will not count towards the $50 million.

As the policy developed through the workgroup process, stakeholders expressed strong support for a model that encourages participation without exposing providers to financial risk like the CTI offset. As a result, the program is voluntary and structured as an upside-only outcome payment model, with no downside risk. The approach laid out below lowers barriers to entry and enables hospitals and initiative partners to focus on transformation efforts without the concerns of an offset or penalty. HOPE rewards sustained performance rather than short-term fluctuations. Outcome payments are therefore based on average savings achieved over a performance window. Hospitals and Statewide and Regional Initiative partners receive 50% of measured savings, ensuring aligned incentives across participating entities.

The Care Transformation Framework is designed to advance the HSCRC's central objective: balancing three critical priorities—promoting continued investment in care transformation, ensuring payment predictability for hospitals, and maintaining affordable, long-term cost growth. For the Care Transformation

Framework, the Commission proposes to establish a fixed statewide funding of $50 million per year for FY27, FY28, and FY29. At the same time, approved initiatives collectively may not materially exceed projected annual savings of $100 million. Each initiative seeking participation must submit projected total savings, which will be independently validated by Commission staff and reviewed by the committee to ensure methodological rigor. Interventions will be scored at actual averted hospital costs, or 125% of projected averted hospital costs, whichever is lower. If the score is less than half of the projected averted hospital costs, there will be no scored savings, i.e. minimum saving rate for projections is 50%. Payments will equal 50% of scored savings. Once established, payouts for individual initiatives will remain fixed for the subsequent three years (with continuation of the initiatives). Additionally, the statewide funding level may be increased in future years if the program demonstrates sufficient success.

Recognizing that FY27 represents a transition year and all-payer program measurement is not available, HSCRC would like to maintain support for care transformation infrastructure by providing a one-time $25M payment distributed proportionally based on Global Budget Revenues (GBRs) to sustain transformation infrastructure across all hospitals in Maryland (if systems wish to designate this funding within their system, other than the GBR, they will be given that option). In addition, HSCRC will provide $25M in seed funding for HOPE applicants whose proposals are approved by the review committee and whose applications justify the need for seed funding. Seed funding may be allocated to non-hospital initiatives. In FY28 the measurement period starts and potentially new seed funding may be provided to approved applicants.

Savings Measurement

Stakeholders called for a measurement methodology that is rigorous, transparent, and data driven. Payment levels will be based on statistically reliable, validated savings performance, calculated using all-payer claims data to ensure consistency and broad accountability. Statistical methodologies will incorporate risk adjustment to account for differences in patient complexity and case mix across participants. Expected spending will be adjusted using established clinical risk indicators (e.g., APR-DRG risk scores) derived from claims data to ensure that performance comparisons reflect true efficiency gains rather than underlying population differences. As outlined above, HSCRC will afford organizations and initiatives flexibility in their baseline for measuring performance. Staff will collaborate with industry and measurement experts to develop and document a transparent, statistically defensible approach. While staff will continue to prioritize reliable measurement, they may allow payouts based on varying years of certified savings performance.

All-Payer Scope

The overarching goal is for HOPE to operate effectively in an all-payer environment by FY2028. HSCRC agrees that including Medicare in the future strengthens the model and will work with CMS to pursue

participation. At the same time, HSCRC is committed to moving forward with implementation even if Medicare participation is not finalized, ensuring progress toward an all-payer structure regardless of federal timing.

A central component of this effort is ensuring access to comprehensive claims data. For FY2028, the intent is to use case-mix data to operationalize HOPE for non-Medicare payers if necessary. Initially, data and measurement will focus on inpatient and emergency department spending, providing a clear and manageable starting point. Over time, the model is expected to expand in scope as data capabilities and payer alignment evolve. HSCRC is interested in partnering with commercial payers and Medicaid, with a goal of deeper engagement beginning in FY2029 and in subsequent program years. The program's design and operational infrastructure are being developed to accommodate hospitals, Medicare, Medicaid, and commercial payers in a coordinated manner. This approach is intended to minimize administrative complexity, reduce conflicting financial incentives across payers, and maintain feasibility as Medicare global budgets transition under AHEAD in CY2028.

Review Committee and Qualifying Initiative Criteria

The review committee will be established to ensure that proposed interventions are rigorously evaluated, practically grounded, and aligned with program goals before moving forward. The goal of the committee is that it brings informed perspectives to the assessment and qualification of initiatives. The committee not only evaluates proposals against established standards but also will help the HSCRC to communicate guidance to applicants, helping to strengthen submissions and encourage high-quality, well-designed interventions over time.

Importantly, the committee is designed to leverage practical expertise. Including members with experience in care transformation ensures that recommendations are not merely theoretical, but actionable and implementable in real-world settings. This blend of public accountability and operational insight helps promote initiatives that are feasible, impactful, and positioned to deliver meaningful results.

Review Committee

Initiative proposals will be evaluated by a formal review committee, with the HSCRC Director making the final determination based on the committee's recommendation. The body serves as a review panel rather than a public decision-making entity.

The panel will consist of six members, evenly divided between governmental and non-governmental representatives. Governmental members will include one HSCRC staff member (serving as co-chair), one representative from MDH, and one representative from either MHCC or CHRC. The three non-governmental members will be experts in health care transformation or community health, with one

serving as co-chair. Conflict-of-interest standards will apply. Panel experts may not be involved in any pending applications and must recuse themselves where appropriate. The panel will also establish and apply the process by which recommendations are made.

Review Criteria

In assessing applications, the committee will ensure that submissions reflect meaningful and well-designed interventions. They will ensure that qualified initiatives are a balance of opportunities across the state given the specific challenges of each region and consider the resources already dedicated when considering how to prioritize funding. Specifically, proposals should demonstrate that they:

- Are grounded in a strong evidence base. This may be shown by citing peer-reviewed literature, prior evaluations, pilot studies, established practice standards, or technical assistance supporting the proposed intervention.
- Address a recognized State health priority. This may be shown by aligning with the state's AHEAD PHAP or the State Health Improvement Plan (SHIP) or other policies established by the Maryland Department of Health.
- Target a clearly defined population, by specifying eligibility criteria and defining characteristics of the target population, such as diagnoses, prior utilization of healthcare services, HCC score, geography, demographics, etc.
- Have a high likelihood of producing measurable impact related to the intervention. This may be shown by a clear and well-justified methodology for estimating the impact of the initiative on health and averted costs.
- Avoid adverse impacts on patient experience or total cost of care.

Program Overlaps and Transitions

The following reflects areas where this program overlaps with other existing HSCRC initiatives and policies. These intersections are important to acknowledge, as participation rules, funding, and operational requirements may interact in nuanced ways. Staff will provide more detailed guidance, as necessary, on any specific parameters of these overlaps in subsequent communications to ensure clarity and alignment.

- **New Paradigms in Care Delivery (NPCD)**
    - Funding can be used for up-front investments to support qualified programs under HOPE
- **Revenue for Reform (RfR)**
    - Generally, Revenue for Reform initiatives should not also receive funding under HOPE to avoid duplicative funding.
- **Episode Care Improvement Program (ECIP)**

  - Ends December 31, 2026, with no savings offset for 7/1/26–12/31/26.
- **Episode Quality Improvement Program (EQIP)**
  - Participation in both programs is allowed.
- **Efficiency Policy**
  - Payments should not count against hospitals under the efficiency policy.
- **Maryland Primary Care Program (MDPCP)**
  - Participation in both programs is allowed.
  - The review committee will need to consider that resources are already dedicated to primary care to prioritize other strategies.

High-Value Care Plans (HVCP)

High-Value Care Plans were established as part of the FY25 Update Factor to support the development and reporting of new and existing strategies aimed at reducing potentially avoidable utilization in priority areas identified through the VBCI tool or other approved tools. Hospitals were subject to a clawback of funds if reporting requirements were not met.

As HSCRC transitions to the next generation of care transformation through HOPE, Staff recommend sunsetting HVCPs at the conclusion of FY26, following completion of final reporting. Beginning in FY27, hospitals will retain this revenue within their GBR as long as they designate a senior executive responsible for the hospital's population health efforts.

Discussions of Comments Received

HOPE Comment Letters Summary

The Commission received 22 comment letters from a diverse group of organizations in response to the Healthcare Outcome Payment Effort (HOPE) proposal. Overall, commenters were generally supportive of the goals and direction of HOPE, while identifying areas where additional clarification, refinement, or operational flexibility may strengthen implementation. Themes raised across comments included implementation timing, funding and financial structure, scoring methodology, review committee composition, interaction with CTIs, funding caps, all-payer participation, and administrative considerations.

Implementation Timeline

Several organizations expressed concerns regarding the proposed implementation timeline. The Maryland Hospital Association (MHA) strongly urged delaying HOPE implementation until FY 2028 to allow for more deliberate development and stakeholder engagement. Similarly, the University of Maryland Medical System

(UMMS) recommended delaying enrollment until FY 2028. Johns Hopkins Health System (JHHS) recommended eliminating HOPE altogether, citing concerns regarding the unpredictability of the CTI-based methodology and potential risks to stability during the transition to the AHEAD Model. Luminis Health indicated reluctance to support HOPE without first resolving existing CTI-related issues.

HSCRC response: Staff appreciate commenters' feedback regarding the proposed implementation timeline and recognize the competing priorities facing hospitals and other stakeholders as the State continues its transition to the AHEAD Model. In response to these concerns, staff recommends delaying HOPE implementation until FY 2028, with an application period beginning in the second half of CY 2026. This revised timeline will provide additional opportunities for stakeholder engagement, program refinement, and operational planning. Staff intend to continue refining HOPE through the TCOC Workgroup during CY 2026 and CY 2027 to ensure that stakeholders have meaningful opportunities to inform implementation and that the model is appropriately aligned with broader care transformation and population health goals.

Sustainable Financial Structure and Fund Allocation

Many commenters supported the concept of HOPE as a stable funding mechanism for successful preventive care programs that often lose support when funding expires. The Abell Foundation strongly supported HOPE as a bridge to sustain effective interventions over time. CalvertHealth emphasized that base funding remains consistent for hospitals under the proposal, while Meritus Health highlighted the importance of predictable, multi-year funding to support long-term infrastructure investments. Several organizations requested additional clarity regarding funding sources and mechanics. MHA sought definitive guidance on both near- and long-term funding sources. MedStar Health supported the use of a pre-specified, fixed reward pool but requested clarification regarding any potential impact on annual update factors. MedStar also advocated reinvesting state savings generated through the program back into HOPE to accelerate future gains. Commenters also addressed the proposed funding cap and allocation methodology. JHHS supported the proposed $50 million annual funding cap. MedStar Health recommended that FY 2027 infrastructure funding be allocated to hospitals that generated gross shared savings through CTIs and demonstrated a commitment to future HOPE participation, rather than distributing funds based on market share. UMMS recommended incorporating $50 million in infrastructure payments proportional to the GBRs in both FY 2027 and FY 2028 to sustain existing interventions during the transition period.

HSCRC response: Staff agree with commenters that funding should be predictable and that sustainable funding is necessary for success. Staff believe that the combination of the commitment to the three-year outcome payout window and assurances regarding the handling of HOPE payments in the savings test address funding sustainability comments.

Staff note that HOPE is separate from CTIs and therefore the proposed split between Infrastructure and seed are meant to assist hospitals with continuing care transformation efforts in transition years while beginning to invest in interventions that show promise and will reduce pressure on the system as a whole. Staff recommend that in FY27 HSCRC provides $25M for infrastructure payments and $25M for seed funding for approved applicants. For FY28 the measurement period starts, prior to the advent of outcome payments Staff intend to continue funding via additional seed investments or other measures suggested by stakeholders.

Measurement, Scope, and Methodology

Program Scope and Focus

Several comments focused on the scope and intended focus of HOPE. Adventist HealthCare urged the HSCRC to prioritize addressing latent demand, uncompensated care, and physician reimbursement before implementing HOPE. UMMS strongly opposed narrowing program measurement to inpatient and emergency department expenditures, arguing that the Total Cost of Care (TCOC) framework should remain central. Similarly, MHA requested clarification regarding how the program would drive reductions in total cost of care if measurements are limited to inpatient and emergency department spending. CalvertHealth emphasized that program methodologies, including funding availability and distribution approaches, should be transparent, predictable, and consistently applied. The Maryland Department of Aging (MDOA) recommended prioritizing Upstream Drivers of Health, such as nutrition and transportation supports, within project review criteria.

HSCRC response: Staff agree that the policies and methodology behind HOPE should be transparent and consistent and is committed to using the TCOC workgroup for discussions and updates on the HOPE program. Staff recognize there are myriad policy concerns outside of HOPE and believe they can explored further regardless of HOPE implementation. Staff also understand commenters' concerns about the data limitations and the use of inpatient and emergency department spending in the near term however HSCRC is limited in what data can be utilized but committed to expanding data capabilities in the future. HSCRC will continue to work with CRISP to incorporate more robust data that is available to participants.

Scoring and Payouts

A number of commenters focused on the proposed scoring methodology. JHHS supported scoring interventions based on actual averted hospital costs rather than projected savings or hybrid approaches. MedStar Health supported scoring interventions at either actual averted hospital costs or 125% of projected

averted hospital costs, whichever is lower, consistent with HSCRC's proposed framework. MedStar noted that this approach appropriately rewards interventions that outperform projections. MedStar also recommended reducing the proposed minimum savings rate for projected savings from 50% to between 10 and 20%. The Primary Care Coalition opposed the use of minimum dollar thresholds for savings or performance when approving projects and similarly opposed requiring minimum performance thresholds for organizations to receive payouts.

HSCRC response: Staff agree with commenters that scoring should be tied as closely as possible to demonstrated outcomes and actual performance. Consistent with comments from MedStar Health, staff believe that scoring interventions based on actual averted hospital costs, capped at 125% of projected averted hospital costs, balances rewarding strong performance while maintaining accountability for projections. This approach recognizes interventions that outperform expectations without creating incentives for unrealistic projections.

Staff also considered comments regarding the proposed minimum savings threshold. While some commenters recommended reducing or eliminating minimum performance requirements, staff believe that a minimum threshold remains an important safeguard to ensure that scored savings reflect meaningful performance and are not driven by normal variation or small changes in utilization. At the same time, staff recognizes concerns regarding overly stringent requirements and the recommended approach seeks to balance flexibility with accountability

Program Design and Operational Clarity

General Support and Structure

Several commenters expressed general support for the structure of the program while requesting additional detail. Ascension Saint Agnes and Audacious Capital noted that the proposal remains preliminary and would benefit from additional information regarding payment distribution and total cost of care impacts. Greater Baltimore Medical Center (GBMC) requested additional detail regarding initiative approval processes, savings measurement methodologies, and any impact on the annual update factor. Meritus Health commended the voluntary, upside-only structure, citing its ability to lower barriers to participation. JHHS similarly supported the foundational design principle that HOPE operates as a voluntary, upside-only model, consistent with the structure of EQIP.

HSCRC response: Staff appreciate commenters' support for the overall structure of the HOPE model, particularly the voluntary, upside-only design. Staff agree that this approach lowers barriers to participation, encourages innovation, and allows hospitals and other participants to engage in care transformation

activities without the financial risks associated with downside accountability. Consistent with comments from Meritus Health and JHHS, staff believe that maintaining HOPE as a voluntary, upside-only model aligns with the principles of EQIP.

Staff also agree with commenters that additional operational details regarding payment distribution, intervention qualification, and the model's interaction with total cost of care goals will be important for successful implementation. Throughout model development, staff has sought to balance providing sufficient detail while maintaining flexibility to incorporate stakeholder feedback and lessons learned during implementation and maintain forward momentum. This final recommendation includes additional information regarding funding, payment methodologies, and scoring, and staff will continue to engage stakeholders as operational details are refined.

Administrative and Data Requirements

Commenters also highlighted operational and administrative considerations. Audacious Capital recommended reducing administrative burden and encouraging broader multi-payer participation. MHA requested development of a comprehensive crosswalk demonstrating how HOPE would interact with existing programs such as Revenue for Reform and the Population Health Advancement Program (PHAP) to avoid duplication and administrative complexity. UMMS opposed the proposed exclusion of Revenue for Reform initiatives and overlap with other primary care investments, including the Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, and Rural Health Transformation initiatives. MDOA expressed support for interoperability efforts, including CRISP integration, closed-loop referrals, and shared savings approaches.

HSCRC response: Staff agree with commenters that coordination with existing initiatives, payer alignment, and operational infrastructure are critical to success. Staff agree that successful implementation of HOPE requires careful integration with existing programs and resources to avoid duplication, maximize impact, and support sustainable care transformation. In response to stakeholder concerns regarding overlap with existing initiatives such as Revenue for Reform, staff included a revised overlaps crosswalk to provide greater clarity regarding how HOPE will interact with other HSCRC programs. While staff agrees that duplicative funding should be avoided, the final recommendation does not categorically exclude participation by organizations involved in other primary care or care transformation initiatives. Rather, the review committee will consider existing resources in a hospital or region and investments available to determine whether additional HOPE funding is appropriate.

Staff also agree that broad payer participation is important to maximize the effectiveness and sustainability of care transformation efforts. The Commission will continue to work with CMS to explore opportunities for

Medicare participation and alignment, recognizing that multi-payer engagement can strengthen incentives and support greater system-wide impact. Finally, staff agree that leveraging existing data and operational infrastructure will be critical to reducing administrative burden and supporting program evaluation. To that end, staff intend to continue to utilize and build upon existing CRISP capabilities.

Recommended Interventions and Focus Areas

Several organizations recommended expanding the focus on palliative care and serious illness interventions. The Maryland State Advisory Council on Serious Illness Care recommended explicitly identifying palliative care, hospice services, and advance care planning as priority HOPE initiatives. The University of Maryland School of Medicine recommended including at least one palliative care expert on the review committee and incorporating patient-reported outcome measures into program evaluation. The School of Medicine also recommended explicitly listing CAPC- and NHPCO-aligned palliative care interventions as qualifying examples in final program guidance.

Commenters broadly supported the emphasis on prevention and community-based interventions. Healthcare for All and the Maryland Citizens' Health Initiative Coalition (MCHI) highlighted HOPE's alignment with the AHEAD Model and its focus on shifting care toward prevention and community-based services. MedChi emphasized the importance of increasing physician awareness and strengthening community-based partnerships. Johns Hopkins Tele-Dizzy recommended including diagnostic excellence within the scope of HOPE-supported interventions. The organization also suggested adding "presenting symptoms" to the illustrative list of target population characteristics used in project review criteria.

HSCRC response: Staff appreciate commenters' recommendations regarding palliative care, prevention, community-based services, diagnostic excellence, and intervention evaluation. Staff agree that these areas represent important opportunities to improve outcomes and reduce avoidable utilization. The final recommendation is intended to provide flexibility for a broad range of evidence-based interventions, including those focused on serious illness care and community-based prevention. Staff will consider stakeholder feedback as implementation details are developed and believe many of these recommendations may be appropriately addressed through program guidance and the review process. Additionally, the review committee will consider intervention design, target populations, available community resources, and subject matter expertise when evaluating proposed projects.

Regional and Statewide Initiatives (RSI)

Several comments addressed the proposed Regional and Statewide Initiatives (RSI) track. JHHS recommended limiting RSI funding to between 20 and 25% of total HOPE funding, expressing concerns that regional initiatives may be less accountable and less directly patient facing. In contrast, the Primary Care Coalition argued that RSI payments should remain uncapped. UMMS expressed concern regarding the absence of an RSI funding cap and broader concerns about funding leaving the hospital. UMMS also noted potential misalignment with the Geo AHEAD Model. The Day Clinic indicated that the RSI framework is necessary to sustain and scale high-acuity, low-volume services and care settings.

Several commenters recommended expanding participation requirements and governance structures for RSI projects. MedStar Health opposed excluding hospitals from serving as anchor entities within regional collaboratives. MDOA requested formal recognition of Area Agencies on Aging (AAAs) as eligible RSI anchor entities. The Maryland Association of County Health Officers (MACHO) recommended requiring Local Health Department participation in Regional and Statewide Initiatives, strengthening the definition of community partners to explicitly include Local Health Departments, and establishing regional governance structures that incorporate public health representation.

HSCRC response: Staff appreciates the range of feedback on the proposed Regional and Statewide Initiatives (RSI) track, including comments on funding structure, accountability, governance, and eligible entities. With respect to funding levels and caps, staff notes that the Commission will vote on the RSI initiatives on an individual basis and can provide feedback on the appropriate scale and structure of funding, as part of the voting process. Staff also agree with commenters emphasizing the importance of accountability and meaningful patient-facing impact for RSI projects. While RSI is intended to support regional coordination and system-level interventions, all projects will be subject to review to ensure appropriate accountability and alignment with program objectives.

Regarding participation and governance, staff support a flexible but structured approach. Hospitals may serve as applicants or anchor entities where appropriate; however, this will be contingent on review committee determination that the proposed structure is justified and that required community partnerships are in place. RSI projects will be expected to demonstrate meaningful engagement with relevant community partners and cannot be hospital-led in isolation. Staff also agree that participation of public health entities and community organizations, including Local Health Departments and other stakeholders such as Area Agencies on Aging where appropriate, is an important component of effective regional collaboration and will be considered within the review process.

Conclusion

HOPE creates a clear, accountable, and financially predictable framework to advance Maryland's participation in AHEAD. Through two participation pathways, the Care Transformation Framework and Regional & Statewide Initiatives, the model supports both hospital-led and cross-sector transformation efforts while maintaining standards for savings validation and performance measurement. Its voluntary, upside-only structure, capped and stable funding approach, and commitment to earned payouts are designed to reduce financial risk and encourage sustained investment in prevention and utilization reduction. By prioritizing all-payer alignment, transparent, data-driven measurement, and thoughtful coordination with existing programs, HOPE positions the State to transition toward a model in which it acts as an outcome purchaser rewarding interventions that demonstrably improve health outcomes, advance equity, control costs, and strengthen system sustainability.