maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

November 19, 2025

Agenda

- AHEAD Model & Regulatory Working Group Updates
- All Payer Total Cost of Care Targets
- CTI & MPA
  - 2026 MPA Recommendation
  - Analysis of CTI Cost Savings – PY1-PY3
  - CTI Comment Letters
  - CTI Brainstorm
- CMS Re-calibration Methodology Overview
- VBCI Tool Demo
- Next Steps & Upcoming Meetings

AHEAD Model & Regulatory Working Group Updates

TCOC Growth and Primary Care Investment Targets

AHEAD Model Requirement (State Agreement)

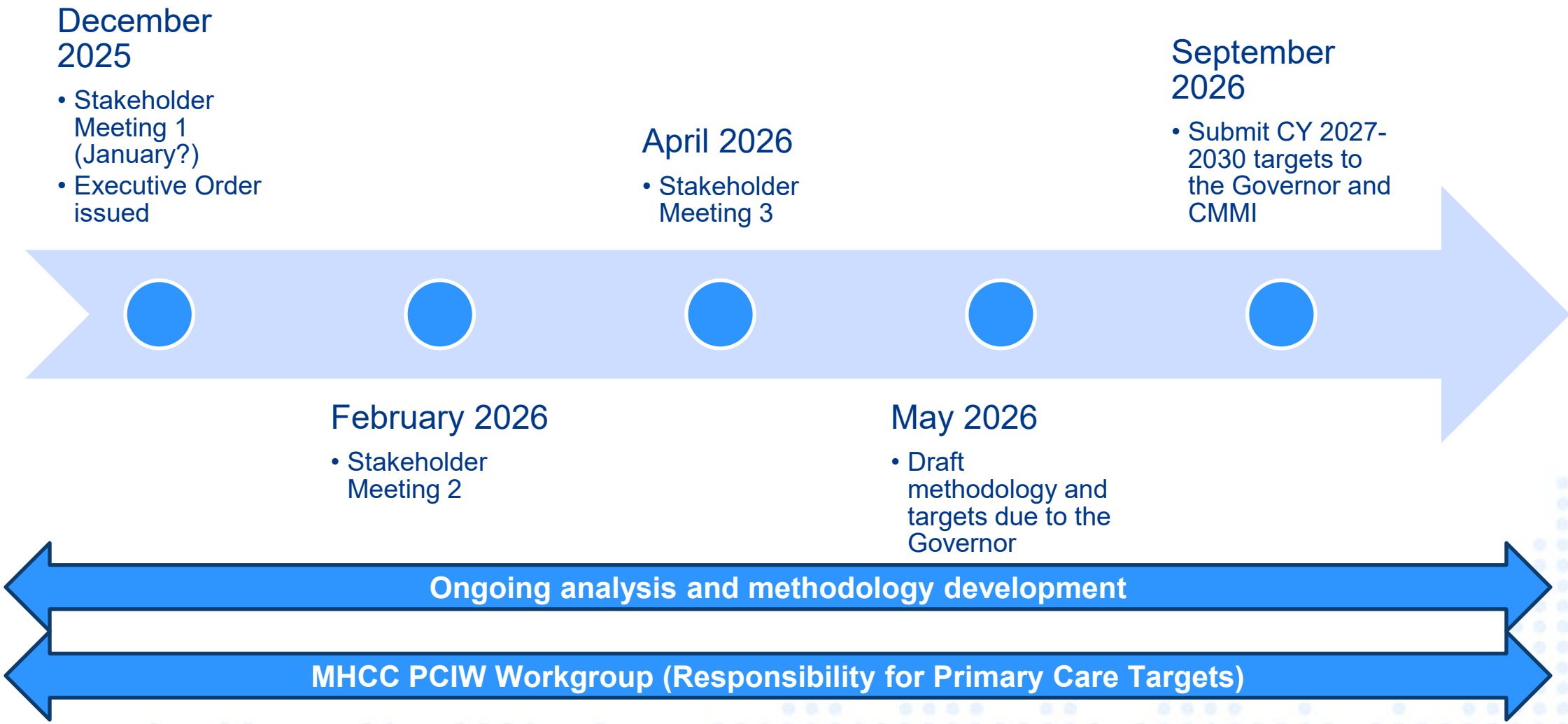
Section 10. Statewide Accountability Targets

- Prior to PY1 (CY 2026), the State must establish the process to set all-payer TCOC growth and primary care investment targets through an executive order, legislation or regulation.
- No later than ninety days prior to the start of PY2 (CY 2027), the State must provide to CMS the all-payer TCOC growth and primary care investment targets for each of PYs 2-5, at a minimum. (The State may opt to propose targets for PYs 6-10 90 days before the start of each performance year.)
- Failure to meet the targets is subject to the agreement's Enforcement Action and Termination language, in Section 22.

Executive Order

- Commits the State to establishing all-payer TCOC and primary care investment targets, which will apply across all Maryland health care markets and populations
- Commits the HSCRC, MHCC, MDH and MIA to:
  - Collecting and analyzing data and developing a target-setting methodology, as informed and advised by stakeholders
  - An initial submission for PYs 2-5 in 2026, followed by annual timeframes for draft and final targets for PYs 6-10
- Draft Executive Order to be distributed as a meeting follow-up.

TCOC Growth and Primary Care Investment Timeline



CTI/MPA

CY 2026 MPA Recommendation

- No changes from CY 2025 Final Recommendation to CY 2026.
- Rebasing new performance metric to be measured against a blend of 2022 and 2023 base period instead of 2022. *This change does not need to be included in the recommendation*.
  - Population health performance metric
  - Change base year for PQI
- Staff will share a draft recommendation in the December Commission meeting.
  - Draft recommendation will be distributed after the meeting.
  - Will be submitted to CMMI for approval.
  - Final recommendation likely in March.

Analysis of CTI Cost Savings – PY1-PY3

Research Motivation

Questions

- Can we identify why certain CTIs always generate savings (win) while others do not?
- What are commonalities among the CTIs that consistently generate savings?

Definitions

- **Consistent winner -** a CTI active in two or three performance years (PYs), with positive savings in all active PYs.
- **Top 25% consistent winner** - is a consistent winner whose savings across PYs is in the top 25% of savings across all CTIs and PYs.
- Similar for **consistent losers** and **top 25% consistent losers**

Number of CTIs, Episodes per Year, and Payments

	N CTIs (Avg Episodes per CTI)				
Thematic Area	**Any PY**	**PY1**	**PY2**	**PY3**	**Avg Baseline Total Episode Payments ($)**
Care Transitions (01)	105	55 (503)	44 (672)	63 (598)	30,170
Palliative Care (02)	11	5 (185)	6 (303)	7 (260)	46,492
Episodic Primary Care (03a)	8	4 (4,309)	5 (7108)	6 (6173)	8,244
Panel Primary Care (03b)	45	19 (8,747)	20 (6,736)	34 (5,671)	13,901
Community PAC (04a)	13	8 (737)	6 (2,057)	7 (2,182)	30,908
Community Geo (04b)	13	2 (12,541)	4 (16,530)	12 (7,855)	13,786
Emergency Care (05)	19	14 (1,288)	8 (801)	12 (1,031)	13,041
Total	214	107 (2,440)	93 (3,081)	141 (2,775)	16,581

Episodic with APR-DRG-SOI Weights **Episodic without APR-DRG-SOI Weights** **Panel-Based**

Thematic Areas, CTIs, and Consistent Winners and Losers

			Out of CTIs in More than One PY			
Thematic Area	**Distinct CTIs**	**CTIs in More than One PY**	**Consistent Winners**	**Top 25% Consistent Winners**	**Consistent Losers**	**Top 25% Consistent Losers**
Care Transitions (01)	105	41	21 (51%)	1 (2%)	6 (15%)	1 (2%)
Palliative Care (02)	11	4	3 (75%)	1 (25%)	1 (25%)	1 (25%)
Episodic Primary Care (03a)	8	5	3 (60%)	0 (0%)	0 (0%)	0 (0%)
Panel Primary Care (03b)	45	20	3 (15%)	2 (10%)	6 (30%)	3 (15%)
Community PAC (04a)	13	5	0 (0%)	0 (0%)	3 (60%)	0 (0%)
Community Geo (04b)	13	4	3 (75%)	3 (75%)	0 (0%)	0 (0%)
Emergency Care (05)	19	8	3 (38%)	0 (0%)	1 (13%)	0 (0%)

Episodic with APR-DRG-SOI Weights **Episodic without APR-DRG-SOI Weights** **Panel-Based**

Differences from Baseline for Consistent Winners

	Episodic CTIs with APR-DRG-SOI Weights							
	Adjusted for HCC Score and Weights				Unadjusted			
Outcome	Top 25% Winner		Any Winner		Top 25% Winner		Any Winner	
N CTIs (Avg N Episodes)	2 (2,934)		27 (1,125)		2 (2,934)		27 (1,125)	
	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses
Total Payments	-$4,026***	-13%	-$2,365***	-7%	-$6,313***	-20%	-$2,685***	-8%
DME Payments	-$133***	-41%	-$67	-20%	-$152***	-47%	-$68	-21%
ER Payments	$52*	9%	-$56	-10%	$52*	9%	-$53	-9%
Inpatient Payments	-$3,096***	-19%	-$1,220**	-7%	-$4,765***	-29%	-$1,501**	-9%
Outpatient Payments	$82	4%	$11	1%	-$20	-1%	$10	0%
Physician Payments	-$536***	-11%	-394***	-8%	-$757***	-15%	-$407***	-8%
Home Health Payments	-$60	-6%	$23	3%	-$81	-9%	$19	2%
IRF Payments	$79	24%	$55	17%	$52	15%	$50	15%
SNF Payments	-$369	-7%	-$634**	-12%	-$548**	-11%	-$645**	-12%
Other Payments	-$46	-7%	-$82	-12%	-$93	-14%	-$90	-14%
HCC Score	N/A	N/A	N/A	N/A	-0.123***	-3%	0.020	0%
APR-DRG-SOI Weights	N/A	N/A	N/A	N/A	-0.122***	-14%	-0.030	-3%

Notes: ***p<0.01, **p<0.05, *p<0.10

Differences from Baseline for Consistent Winners

	Episodic CTIs without APR-DRG-SOI Weights			
	Adjusted for HCC Score		Unadjusted	
Outcome	Any Winner		Any Winner	
N CTIs (Avg N Episodes)	6 (4,952)		6 (4,952)	
	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses
Total Payments	-$173	-1%	-$877	-6%
DME Payments	-$4	-2%	-$14	-7%
ER Payments	$171***	22%	$153**	19%
Inpatient Payments	-$154	-4%	-$483***	-12%
Outpatient Payments	$62	5%	-$5	0%
Physician Payments	-$189	-5%	-$327*	-9%
Home Health Payments	$146*	28%	$139*	26%
IRF Payments	$13	15%	$7	8%
SNF Payments	-$246	-6%	-$366	-8%
Other Payments	$28	8%	$19	6%
HCC Score	N/A	N/A	-0.129	-5%

Notes: ***p<0.01, **p<0.05, *p<0.10

Differences from Baseline for Consistent Winners

	Panel-Based CTIs Only							
	Adjusted for HCC Score				Unadjusted			
Outcome	Top 25% Winner		Any Winner		Top 25% Winner		Any Winner	
N CTIs (Avg N Episodes)	5 (32,780)		6 (27,446)		5 (32,780)		6 (27,446)	
	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses
Total Payments	-$553***	-4%	-$541***	-4%	-$416***	-3%	-$386***	-3%
DME Payments	-$80***	-21%	-$78***	-20%	-$77***	-20%	-$74***	-19%
ER Payments	-$46***	-9%	-$43***	-8%	-$43***	-8%	-$38***	-7%
Inpatient Payments	-$108***	-3%	-$17****	-3%	-$61	-2%	-$46	-2%
Outpatient Payments	-$221***	-10%	-$228***	-11%	-$205**	-10%	-$208**	-10%
Physician Payments	$2	0%	-$2	0%	$29	1%	$33	1%
Home Health Payments	-$24	-6%	-$23	-6%	-$18	-5%	-$16	-14%
IRF Payments	-$10	-10%	-$11	-11%	-$9	-9%	-$9	-9%
SNF Payments	-$27	-3%	-$27	-3%	-$12	-2%	-$8	-1%
Other Payments	-$21	-4%	-$22	-5%	-$19	-4%	-$19	-4%
HCC Score	N/A	N/A	N/A	N/A	0.009	1%	-0.011	1%

Notes: ***p<0.01, **p<0.05, *p<0.10

Differences from Baseline for Consistent Losers

	Episodic CTIs with APR-DRG-SOI Weights							
	Adjusted for HCC Score and Weights				Unadjusted			
Outcome	Top 25% Loser		Any Loser		Top 25% Loser		Any Loser	
N CTIs (Avg N Episodes)	2 (3,235)		7 (1,134)		2 (3,235)		7 (1,134)	
	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses
Total Payments	$2,165**	7%	$2,263**	7%	$2,597*	8%	$2,770**	9%
DME Payments	-$81***	-25%	-$79**	-24%	-$74***	-23%	-$71**	-22%
ER Payments	$49**	9%	$54**	9%	$58**	10%	$65**	11%
Inpatient Payments	-$232	-1%	$93	1%	-$19	0%	$333	2%
Outpatient Payments	-$6	0%	-$15	-1%	$41	2%	$43	7%
Physician Payments	$206	4%	$213	4%	$287	6%	$311	6%
Home Health Payments	$-585***	-63%	-$507***	-54%	-$582***	-62%	-$503***	-54%
IRF Payments	-$94**	-28%	-$124**	-36%	-$91**	-27%	-$121**	-35%
SNF Payments	$3,008***	60%	$2,714***	54%	$3,071***	61%	$2,791***	56%
Other Payments	-$100	-15%	-$86	-13%	-$94	-14%	-$79	-12%
HCC Score	N/A	N/A	N/A	N/A	0.102	3%	0.130*	3%
APR-DRG-SOI Weights	N/A	N/A	N/A	N/A	-0.005	-1%	-0.009	-1%

Notes: ***p<0.01, **p<0.05, *p<0.10

Differences from Baseline for Consistent Losers

	Episodic CTIs without APR-DRG-SOI Weights			
	Adjusted for HCC Score		Unadjusted	
Outcome	Any Loser		Any Loser	
N CTIs (Avg N Episodes)	4 (673)		4 (673)	
	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses
Total Payments	$564	4%	$3,951***	26%
DME Payments	-$24	-11%	$23	11%
ER Payments	$53	7%	$143***	18%
Inpatient Payments	$528**	13%	$2,112***	52%
Outpatient Payments	-$198**	-16%	$125**	10%
Physician Payments	$337	9%	$1,000***	27%
Home Health Payments	-$135	-25%	-$9	-18%
IRF Payments	$81**	92%	$109***	123%
SNF Payments	$215	5%	$790	18%
Other Payments	-$295***	-83%	-$254***	-71%
HCC Score	N/A	N/A	0.620***	26%

Notes: ***p<0.01, **p<0.05, *p<0.10

Differences from Baseline for Consistent Losers

	Panel-Based CTIs Only							
	Adjusted for HCC Score				Unadjusted			
Outcome	Top 25% Loser		Any Loser		Top 25% Loser		Any Loser	
N CTIs (Avg N Episodes)	3 (17,988)		6 (10,740)		3 (17,988)		6 (10,740)	
	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses	N (Savings)/Losses	% (Savings)/Losses
Total Payments	$619***	4.5%	$610***	3%	$455***	3%	$491***	4%
DME Payments	-$12	-3%	$2	-3%	-$16	-4%	$0	0%
ER Payments	-$2	0%	$12	2%	-$7	-1%	$9	2%
Inpatient Payments	$194***	6%	$154***	4%	$130***	4%	$107***	3%
Outpatient Payments	$200	10%	$245*	9%	$178	9%	$229*	11%
Physician Payments	$193**	3%	$121*	1%	$156*	3%	$94	2%
Home Health Payments	$35*	9%	$31	3%	$28	7%	$25	6%
IRF Payments	-$19	-19%	-$21	-17%	-$21	-21%	-$23	-23%
SNF Payments	$26	3%	$63*	6%	$6	1%	$49**	6%
Other Payments	$4	1%	$2	-3%	$1	0%	$0	0%
HCC Score	N/A	N/A	N/A	N/A	-0.012	-1%	-0.009	-1%

Notes: ***p<0.01, **p<0.05, *p<0.10

Takeaways

	Episodic CTIs with APR-DRG-SOI Weights	Episodic CTIs without APR-DRG-SOI Weights	Panel-Based CTIs
Takeaways	**Takeaway Details**	**Takeaway Details**	**Takeaway Details**
Drivers of savings for consistent winners are:	- Lower inpatient spending - Lower physician and SNF spending	- Lower inpatient spending - Lower physician spending	- Lower outpatient spending - Lower ER and DME spending
Drivers of losses for consistent losers are:	- Increases in SNF spending - Increases in ER spending	- Increases in inpatient spending - Increases in physician spending - Increases in average HCC score	- Increases in inpatient spending - Increases in physician and/or SNF spending
Differences in payments per episode are:	Thousands of dollars per episode	Hundreds of dollars per episode	Hundreds of dollars per episode

Comment Letters

- LifeBridge
  - Implementation of the program has produced unintended consequences.
  - Created inequities by allowing certain health systems to realize substantial savings opportunities primarily due to geographic location and lower population acuity – rather than dedicated population health management efforts.
  - Program's net-neutral nature remains a concern, as smaller health systems may experience significant offsets even when their CTIs achieve only modest savings, effectively penalizing them for factors beyond control.
  - Expressed difficulty of accurately predicating performance, which limits ability to make real-time clinical and operational changes.
  - Recommends sunsetting the CTI program immediately to better position hospital for success under the forthcoming AHEAD agreement.
  - Recommends reversing any negative revenue adjustments for hospitals in FY 2026.

Comment Letters

- GBMC
  - Appreciates the opportunity to be rewarded for care transformation initiatives through program participation.
  - Concerns do align with LifeBridge's comments noting that smaller health systems may experience significant revenue offsets even when their CTIs achieve only modest savings, penalizing them for factors beyond control.
  - An additional barrier is access to performance data on real-time basis for defined CTIs as data available does not assist with driving real-time clinical changes for these populations throughout the performance periods.
  - Recommends expanding the reward distribution to include a greater number of hospitals that have demonstrated cost savings. Currently, a small percentage of hospitals receive disproportionately large rewards, which overlooks the meaningful contributions made by many others. States a more inclusive approach would better recognize the collective impact and encourage broader participation in cost-saving efforts.

Comment Letters

- UMMS
  - Believes the intended creation of CTI policy is missing the mark of achieving population-anchored and locally targeted investment returns that assist hospitals in diversifying their revenue base and contribute to achievement of statewide goals around population health and total cost improvements
  - Concerned about the lack of opportunity under the AHEAD Model for upside and value-based rewards for total cost of care impacts created by Maryland hospitals.
  - Against net-neutral offsets and the quality measurement applied.
  - Supports a CTI policy state that might eventually accommodate an all-payer posture- or at least provide a practical pathway toward one- so that improvement efforts reflect the mixed-payer reality of panels and the broad reach of the community and care transformation work.
  - Suggests policy design should preserve room for deeper return on investment where burden is greatest. Encourages an explicit equity lens.
  - Supports simplicity, transparency, and timing for rules and policy documentation process. Suggests CTI policy should remain flexible at the level of population selection while offering straightforward options and instructions to ease adoption and evaluation. Suggests rules are to be finalized before enrollment for a given year.

Comment Letters

- JHHS
  - Cautions against including the CTI program in the AHEAD model.
  - States ending the CTI program in the AHEAD model would reduce unpredictable performance and financial impact and would not impact patient care.
  - States that since CTI performance is unpredictable and retrospective, hospitals do not rely on or account for potential upside funding to support patient programs.
  - Included more specific feedback previously shared:
    - Instituting a cap would ensure that any savings generated were largely the result of utilization or cost declines rather than coding adjustments.
    - A panel-based measurement approach would directly identify patients enrolled in programs and allow for a more robust assessment of effectiveness.
    - The amount of Medicare FFS revenue measured for purposes of the CTI savings pool should be reduced for AMCs to reflect their unique and specialized role in the system.
    - Restructure program incentives to better align with model goals and encourage dissemination of best practices

CTI Timelines

PY5/FY26 – No Action Required

July 1, 2025 – June 30, 2026

- Final data – May 2027
  - Payout: Implemented in MPA July 2027-December 2027

PY6/FY27 – Requires Rethinking – MPA no longer available

July 1, 2026 – June 30, 2027

- Final data (9 months runout) – May 2028
  - Payout: Implemented ? (MPA ends December 2027)

CTI Brainstorm

- Cancel CTIs and no new program for FY27 and beyond.
  - Set direction by March 2026
- Continue care transformation programming with a new approach, considerations include:
  - Conversations with CMMI about program goals – is CMMI interested in continuing care transformation efforts?
  - Conversations with Commissioners about program goals
  - Upside only multi-payer CTI-like program that leverages resources already invested
  - Is redesign for FY27 feasible or focus on FY28?
  - Pilot program for FY27
  - Continue as is in FY27 and use GBR bridge to settle pay outs
  - Cancel for one year in FY27 and restart program in FY28 (lost momentum/infrastructure)
- Reconvene in January to begin discussions.

CMS Re-Calibration Methodology Overview

Methodology Summary (State Understanding)

1. Remove “public good” items from Maryland HGB amount, which include IME, DME, DSH/UCC, C&I, capital and facility conversions, and AMC additional growth factor (unclear what this is)
2. Calculate IPPS/OPPS equivalent for each hospital
3. Compare results from (1) to the results of (2) and calculate a percent ratio
4. Determine “immunity” band based on the middle two quartiles of facilities
5. For facilities outside the “immunity” band, increase or reduce the MD amount by the amount by which they are outside the “immunity” band
6. Add back “public good” items to derive a new MD baseline amount

Updated Baseline Modeling: Summary Statistics

- "Immunity" band (22 hospitals): 138%-115% of MD-PPS ratio
  - Max: 246% MD-PPS ratio
  - Min: 76% MD-PPS ratio
- Most expensive band/"quartile" (10 hospitals):
  - Total MD FY24 HGB: $926,499,766
  - Weighted average percent change: -7%
- Least expensive band/"quartile" (11 hospitals):
  - Total MD FY24 HGB: $1,803,755,726
  - Weighted average percent change: +11%
- Net Rate Normalization Impact – Base: +$140,362,002

Updated Baseline Modeling: Potential Areas of Concern

- Potential areas for miscalculation
  - Treatment of services/facilities that would not be paid at traditional PPS rates for acute care hospitals, including:
    - Rehab hospitals, FMFs, CAHs
    - Rehab or distinct part units, cancer center designation, etc
  - Fully adjusting for payment differences in the following areas
    - Graduate Medical Education (direct and indirect)
    - DSH / uncompensated care; Charity Allowance, Provision for Bad Debts
  - Does not align with previous HSCRC re-pricing estimates
- Accounting for all facility conversions (including identification of capital)

Updated Baseline Modeling: Potential Areas of Concern (continued)

- Accounting for gross charges vs payments
- Explanation of “AMC additional growth factor”
- Plan for net neutrality?
- Timeline or integration with previous modeling
- Other underlying concerns
  - Optimized cost reporting to support PPS payment (e.g., wage index)
  - Optimized reporting for DRG Grouper and other grouping
- CMS is willing to discuss individual hospital modeling
  - Contact Abid Khan at Abid.Khan@cms.hhs.gov

VBCI Tool Demo

Agenda

- Background
- Data Source
- Accessing VBCI
- Updates to VBCI
- Walkthrough of Dashboard Updates

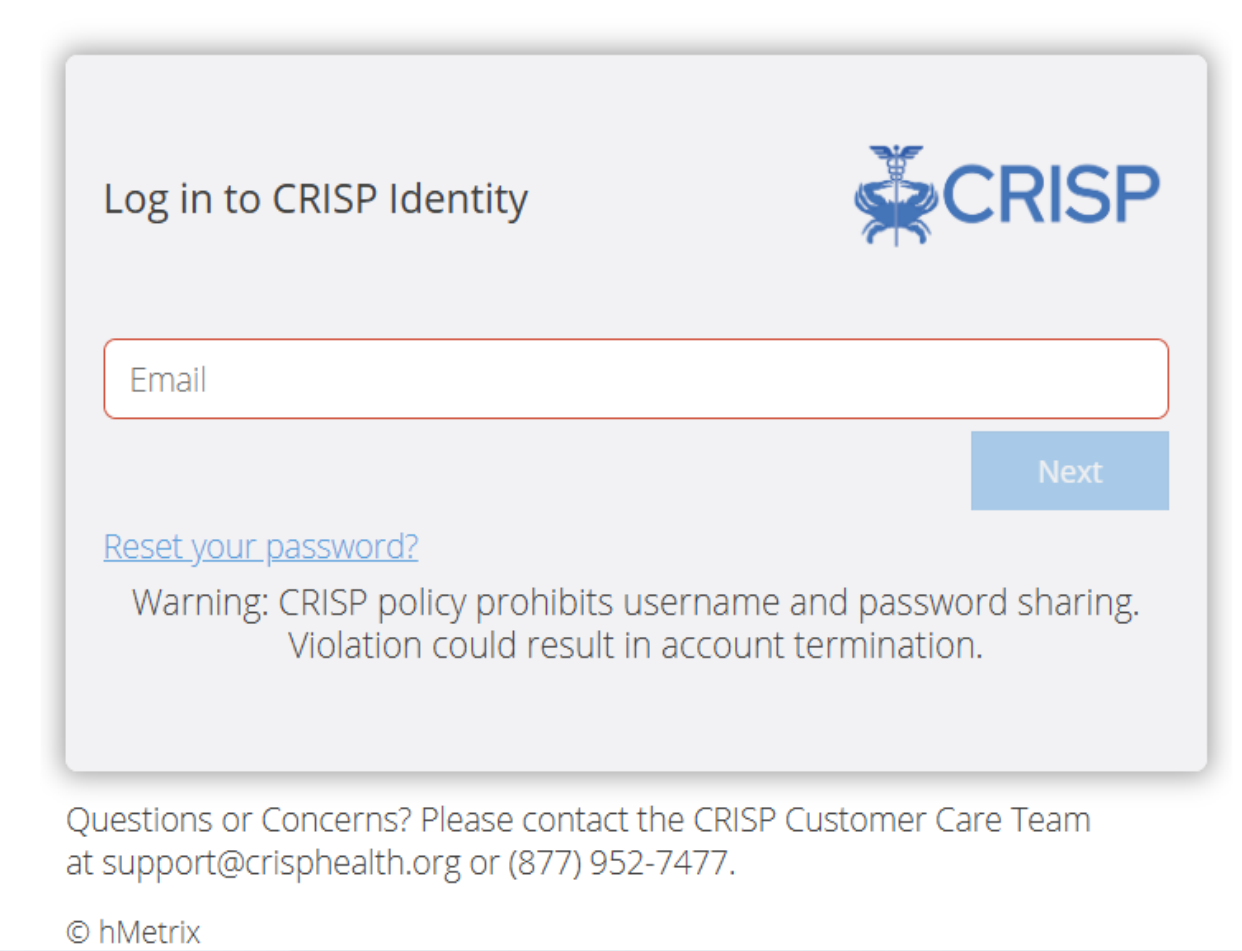
Background

- The Milliman MedInsight® VBCI Tool enables **hospitals** to analyze total cost and utilization trends for their Medicare FFS beneficiaries using Claim and Claim Line Feed (CCLF) data.
- The report features interactive dashboards that allow users to drill down from summary metrics to individual patient details and filter reports by service category, avoidable services, and post-acute care.
- By leveraging both a national Well Managed Medicare and State of Maryland benchmark, VBCI helps identify cost savings opportunities and actionable strategies to lower the total cost of care.

Data Source

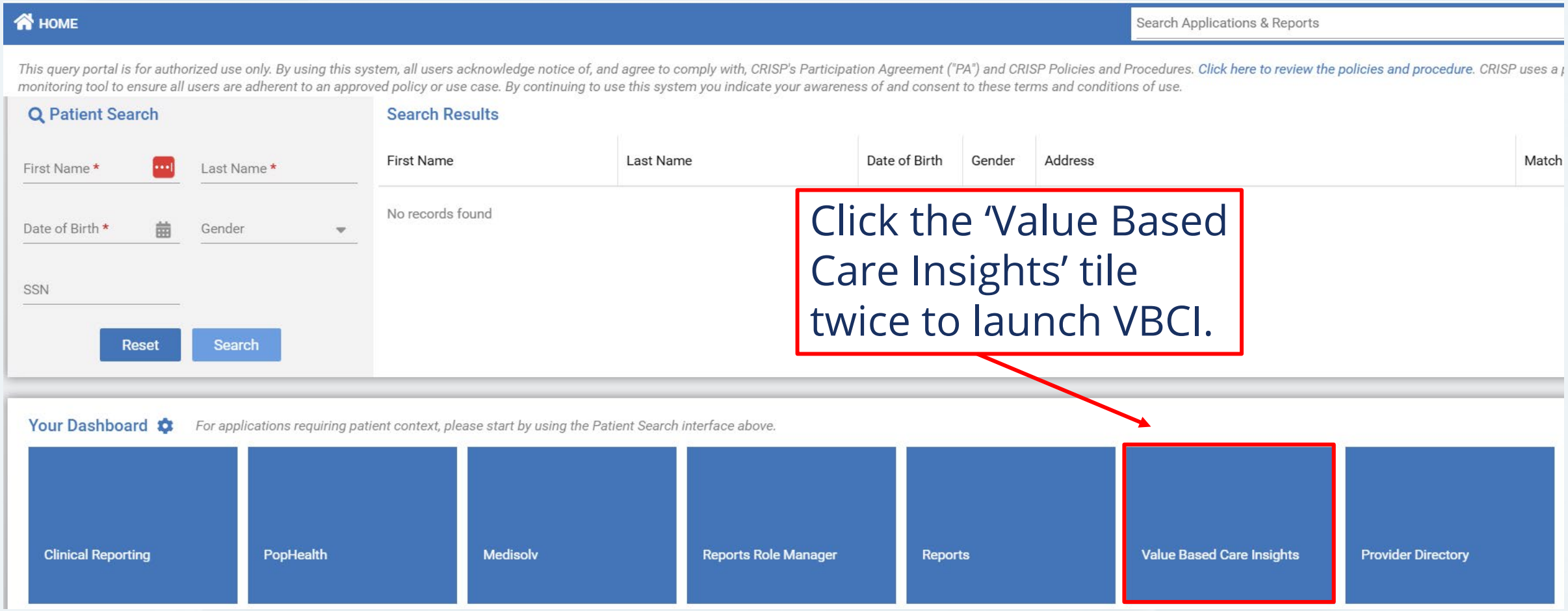
- VBCI contains the last 36 months of CCLF data with a two-month data lag.
  - Based on the CCLF data runout, there is an additional 3-month data lag for the MPA attribution. For example, if the CCLF claims data is through April 2024, the report will show Medicare FFS beneficiaries through January 2024.
- Hospitals are assigned beneficiaries based on zip code, following a 100% geographic attribution model similar to HSCRC's MPA approach.

Accessing VBCI



- To access VBCI, users must first log into the HIE Portal (portal.crisphealth.org).
- If you do not have access to HIE Portal or the 'Value Based Care Insights' tile, please reach out to VBCI-support@crisphealth.org

Accessing VBCI



Updates to Value-based Care Insights (VBCI)

CRISP
Chesapeake Regional Information System for our Patients

- New Global filter for Chronic Conditions
- New Dashboards for Care Management, Pharmacy, Leakage
- Added Ambulatory Care Sensitive Admissions (ACSA) tab to the IP dashboards
- New Measures added to the Provider Performance Dashboard
  - % follow-up within 7 days of medical discharge
  - % follow-up within 7 days of surgical discharge
  - 30-day readmit rate
  - ACSA admits/1000
  - Clinic visits/1000
- New columns added to Provider Performance Dashboard – SNF & IP Rehab
- New App library with VBCI tool and other resources

Questions? Contact VBCI-support@crisphealth.org

CRISP
Chesapeake Regional Information System for our Patients

Live Demo

Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
  - December – canceled
  - 2026 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage
- Reminders
  - HVCP Interim Reporting Templates are due December 31 to hscrc.tcoc@maryland.gov
- Future Meetings Topics
  - January 28
    - CTI discussions
    - AHEAD update

Thank You
Next Meeting January 28, 8-10 am