maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

October 22, 2025

Agenda

- AHEAD Update
- CTI Update
- VBCI Tool
- High Value Care Plans Reporting
- Next Steps & Upcoming Meetings

AHEAD Model Updates

Agenda

- High-Level Updates
  - Regulatory Working Group
  - Update on CMMI Modeling
- Summary of Comments on State Agreement
- Hospital Participation Agreements

High-Level Updates

Summary of Comments on State Agreement

Overview

- Comments on the State Agreement were received from the following organizations:
  - Adventist Health System
  - CareFirst
  - Johns Hopkins Health System
  - Maryland Hospital Association
  - TidalHealth
  - University of Maryland Medical System
- The following slides represent the State's current understanding regarding the points raised.

Global Budgets

Comment Summary	Commenter	Response
Concern over quality HGB transition timeline	Adventist	The State has requested language that clarifies that the quality transition may occur later than the rest of the Medicare FFS revenue transition and expects a revision in the next draft.
Better understand HGB methodology (including as relates to GME, capital, re-basing)	Tidal, Hopkins, Adventist	The methodology will be managed through the global budget specifications. CMMI will continue to accept Maryland's feedback and consider revisions to their methodology for 2028, throughout 2026. Final methodology will be available one year before go-live, allowing hospitals and State time to understand and manage final approach. There are no rebasing provisions in the methodology. Maryland expects ongoing conversations on capital, GME and other topics, both regarding the CMS methodology and related revisions required to HSCRC methodologies.
Exclusions (including concerns over limited definition and lower payment rate)	UMMS, Tidal, Hopkins	The State has supported flexibility in the State Agreement. Language is expected in the next draft that allows the State to propose an exclusion approach, including factors that could contribute to exclusions up to 15%–i.e., 85% inclusion–and a payment methodology that may allow for payment at a rate similar to the rest of the HGB.
Confusion/concern about savings adjustment language (guardrail); upside savings adjustment should be guaranteed if excess savings	Adventist	The State has requested language in the State Agreement clarifying the savings adjustment language, including guaranteeing that the upside adjustment will be applied if the Medicare FFS TCOC target is exceeded. The State expects a revision in the next draft.

Global Budgets (Continued)

Comment Summary	Commenter	Response
Alternate Baseline Option should be applied at the state rather than hospital level	Tidal	The State agrees with this interpretation. The State has requested language that clarifies this term and expects a revision in the next draft.
Lack of clarity around MAHA adjustment	Adventist	The State has requested that CMMI clean this section up to clarify its intent and expects a revision in the next draft.
Process / details for State submission of CMS-Approved State-Designed All-Payer Hospital Global Budget Methodology	MHA	The state submitted a set of publicly-available documentation of HSCRC methodologies in the summer of 2024. In the State Agreement, CMMI acknowledged approval of the methodologies outlined in this document.
CMS role in approving AHEAD-related policy changes being considered pre-PY3	MHA	CMMI has the option to review all HSCRC policies that go into effect in 2026 or 2027, which is consistent with their historic practices.
Revenue at Risk structure in PY1 & 2	MHA	The Regulated Revenue described in the State Agreement would be no different than the structure present today.
Clarification whether the redistribution of HGB revenue during the bridge period is intended to include all-payers or just Medicare FFS.	MHA	The State may redistribute a decreasing percentage of total **Medicare** FFS HGB, as set by CMMI, between PY3 and PY5. This was the intention of the terms sheet. The State agrees with this interpretation. The State has requested language that clarifies this term and expects a revision in the next draft.

Payer Alignment under AHEAD

Comment Summary	Commenter	Response
Medicare Advantage		
Low Medicare Advantage penetration attributable to the Model	CareFirst	The State Agreement includes an explicit allowance for the State to submit a proposal to CMS to stabilize the Medicare Advantage market. This allowance is furthered by the State's public commitment to using the Regulatory Working Group outlined in Governor Moore's Directive to thoroughly consider this issue.
What ideas exist for stabilizing Medicare Advantage? Would these apply to PY1 and PY2 only?	MHA	The State will use the Regulatory Working Group outlined in Governor Moore's Directive to develop a policy plan to stabilize the Medicare Advantage market. The state has proposed language to specify that the proposal submission data and application of the policy may be completed and applied during any year of the Model. The State expects a revision in the next draft.
Medicaid compliance		
Medicaid authorities – not sufficient commitment/clarify	UMMS, Hopkins, Adventist, MHA	The State is in ongoing conversations with CMMI and CMCS to ensure the State Agreement has sufficient clarity for Medicaid rates to be tied to Medicare.

Payer Alignment under AHEAD

Comment Summary	Commenter	Response
All-Payer Revenue Limit / Differential		
All-Payer Revenue Limit – support 2013 base, concerned about Medicare exclusion starting in 2028	UMMS	The 2013 base is carried over from the prior version of the State Agreement. Due to concerns about including Medicare Advantage but not Medicare FFS payments in the calculation, CMMI and the State have discussed removing the Medicare exclusion altogether.
All-Payer Revenue Limit - 3.58%	Adventist	The State notes that the all-payer revenue limit is not a triggering event. The State has evaluated State GSP growth and has found that over the full length of the TCOC Model, it was similar to 3.58%.
All-Payer Revenue Limit - Use of 2013 base	CareFirst	The State notes that the all-payer revenue limit is not a triggering event. This was not updated in the prior AHEAD State Agreement. CMS did not propose to update it.
Differential/cost-shift should have enough flexibility and/or ensure financial viability of hospitals	UMMS, Hopkins, MHA	The State believes the current language implicitly removes the federal government from the public payer differential after PY2. The State has asked for language clarifying that the State may set its own differential, without the need for CMMI approval, after PY3. The State expects a revision in the next draft. The level of cost-shift will be established via the process outlined in Governor Moore's Directive.
Other		
Source of CMS authority to require Commercial payer and Medicaid action	MHA	The inclusion of Commercial and Medicaid actions in the State Agreement is consistent with requirements in prior agreements and the stated objectives of the AHEAD Model.

Primary Care/Population Health – MHA Comments

Comment Summary	Commenter	Response
Would PC AHEAD State technical assistance include supporting monitoring and gathering data for the quality programs?	MHA	The State currently intends to provide support to PC AHEAD practices in a similar way to how the State supports MDPCP, subject to State resource limitations.
How will PCP offices capture quality data? What is MDH doing to get eCQM data?	MHA	MDPCP practices report eCQM data to CRISP. The State is in discussions with CMMI over whether PC AHEAD practices will report eCQM data to CRISP or a national portal. CMS scores all other quality measures based off claims data from participating practices.
Can PHAP, multi-payer, and PC AHEAD measures under AHEAD be the same?	MHA	For some of these, the State must choose from a list selected by CMMI. The State will try to streamline where possible.
What type of event or action could compromise the State's ability to function as a Health Oversight Agency?	MHA	HSCRC and MDH both qualify as a Health Oversight Agency, as defined by HIPAA.
How will the Population Health Fund be administered? What criteria will be used?	MHA	We have proposed streamlined language in the State Agreement. MDH will administer the fund with input from other stakeholders.

Structure of the Agreement

Comment Summary	Commenter	Response
Term of the Agreement – purpose of expiration date 2 years after Transition Period	MHA	The State's understanding is similar to MHA's – the two years would likely be used for purposes such as reporting close-out.
Length of Transition Period, transition to PPS	MHA	The length of the Transition Period for the State would consist of 60 months unless the Transition Period is terminated under Section 22 (including by the State), the Model is expanded, or a new model test performance period begins prior to the end of the Transition Period. While the State believes the existing language is sufficient, the State has requested clarification of these terms and expects a revision in the next draft.
Concern that material compliance requirement could make anything a termination event	MHA	This term is similar to one in the TCOC Model. CMS has previously indicated they will keep this, but the State has requested revisions.
90% provision should not be a terminable event, to reflect flexibility for services that will be excluded	MHA	State has requested additional flexibility to account for additional exclusions, if approved by CMMI, and expects a revision in the next draft.
Concern over CMS' ability to make unilateral changes to the Model	MHA	This language was in the TCOC Agreement and reflects that CMMI can change its models. CMS has previously indicated they will keep this term.
Concern that Fraud and Abuse waivers sections are removed	Adventist	CMMI has indicated that the waivers that the State could previously request under the Fraud and Abuse subsection of the "5. Waivers and Safe Harbor Authority" section can now be requested under the "Federal Anti-kickback Statute Safe Harbor" subsection of that section.

Other Themes

Comment Summary	Commenter	Response
Data		
Will the State bolster data security to safeguard identifiable beneficiary data and prevent breaches?	MHA	The State will continue to prioritize data security for beneficiaries.
Concerns over data used for operationalizing global budgets (prefer use of CCLF)	Tidal	CMMI has expressed an intent to replace the current CCLF with a new file. The State is working with CMS on the lay out of the new file and anticipates it meeting all the current functionality. The State will share additional information as it is received.
New Components of AHEAD		
Interest in understanding choice and competition better; process that the State will use to build out plan; confirm information received to-date	MHA	Section 10.g and Appendix J outline the "Choice" and "Competition" requirements. No information has been officially shared beyond what is in this State Agreement. The State will use the Regulatory Working Group outlined in Governor Moore's directive to review the Choice and Competition Options, with input from stakeholders. The State has requested some additional flexibility under these requirements, re: timelines and options.
Confirm scope of CON requirements to non-hospital and hospital settings	MHA	CMMI has indicated that the CON option does pertain to both hospital and non-hospital CON, despite the overall name referring to non-hospital settings. The specific aspects for hospitals and non-hospitals are described within the language in Appendix J.
Better understand Geo AHEAD	Tidal	The State has shared all of the official information that CMS has shared on Geo AHEAD. The State will continue to solicit information from CMS on this program.

Other MHA Questions - Quick Answers

Question	Response (reflects State understanding only)
Public availability of Cooperative Agreement	The State has not released this publicly and does not believe CMS typically releases these documents publicly. The State Agreement will be the ruling document, and the State will ensure terms are in alignment.
Method of memorializing all-payer primary care investment and TCOC targets	Process for setting targets - Executive Order, due 12/31/25 Targets themselves - Executive Order, due 9/30/2026
Confirm MCHE is designated State-selected governing body going forward for Statewide Quality and Population Health targets	Confirm
Confirm that State OBC work will continue	Confirm, next areas of focus have not been determined
State agency responsible for collecting participating hospitals' Population Health Accountability Plans (PHAPs)	MDH
Maryland state agency that will perform Geo AHEAD entity licensing function?	Being determined
Confirmation that terminating events first require offering of a corrective action plan before escalated enforcement actions such as Model termination?	Confirm – there is also a 'warning letter' phase prior to the corrective action plan

Hospital Participation Agreement

Hospital Participation Agreement Overview

- All hospitals must sign a participation agreement to participate in AHEAD.
- Signing parties are CMS, the State of Maryland and the participating hospital.
- The draft version of the Participation Agreement is subject to change from CMS.

Comments Process

- CMS welcomed comments from hospitals.
- CMS is not guaranteeing they will respond to every comment.
- Participation agreements will not be negotiated at a hospital level. Any changes would be applicable across all hospitals.
- HSCRC has highlighted to CMMI issues related to:
  - Alignment of Participation Agreement language with the State Agreement;
  - Clarity of the State's role per the Participation Agreement.

CTI Update

- Current Status
  - HSCRC staff are continuing background work to identify tools for further planning.
- Call for Comments
  - Comments extended to November 12th
  - More robust discussions are planned for November 19th meeting.
    - Staff do not anticipate incorporating any CTI changes in the 2026 MPA recommendation because Staff believe likely changes to the program will not require changes to the overall framework approved by CMMI.

VBCI Tool

Updates to Value-based Care Insights (VBCI)

- 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

Questions? Contact VBCI-support@crisphealth.org

High Value Care Plans

Interim Report

- HSCRC has sent out interim reporting templates from the hscrc.tcoc@maryland.gov inbox.
- Reports are due December 31, 2025
- Please follow the outlined format and response prompts provided. All interim report submissions should be sent to hscrc.tcoc@maryland.gov.
- Please ensure this information is shared with the appropriate members of your team.

Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
  - November 19
  - 2025 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage
- Future Meetings Topics
  - November
    - CTI Next Steps
    - Demo on VBCI Tool

Upcoming Important CTI and EQIP Dates

- CTI
  - 2027 Program Change Discussion – Will begin conversations in the November TCOC workgroup
- EQIP
  - EQIP Subgroup Meetings
    - Nov 21st

Thank You
Next Meeting November 19, 8-10 am

Appendix: Hospital Participation Agreement Summary

Hospital Participation Agreement: Sections 1-5

- **Section 1 – Agreement Term:** Specifies the effective date, agreement term and implementation years of AHEAD (through 2035), as well as the transition period.
- **Section 2 – Definitions**
- **Section 3 – Participant Hospital Requirements:** Outlines limitations on participation in existing and future CMS programs, Medicare quality reporting, submission of the Hospital Population Health Accountability Plan, data collection and reporting and requirements around change in control and hospital type.
- **Section 4 - Beneficiary Protections:** Specifies that hospitals must provide medically necessary services to beneficiaries and not avoid providing care; protects beneficiary freedom in choosing alternate healthcare providers; outlines HIPAA requirements to protect beneficiaries; specifies that AHEAD activities should not discriminate or selectively target beneficiaries based on defined characteristics.
- **Section 5 – Hospital Global Budget:**
  - Specifies that the State will continue to implement hospital global budgets in 2026 and 2027;
  - Specifies that Medicare FFS Hospital Global Budgets will be implemented in 2028-2035 based on CMS methodology, that CMS will make biweekly Medicare payments to hospitals and the process for hospitals to provide notice of errors in the Medicare HGB to CMS, as well as the financial settlement process if the Model expires or is terminated.
  - Specifies the process for planned service line adjustment requests and exogenous factor adjustment requests (Appendix G)
- **Section 6 – Other AHEAD Model Programs** - Omitted

Hospital Participation Agreement: Sections 6-10

- **Section 7 – Financial Arrangements:** CMS is updating content on CRP.
- **Section 8 – Benefit Enhancements and Beneficiary Engagement Incentives:** Outlines hospital opportunities and the process to offer specific benefit enhancements, including telehealth benefit enhancements, to preferred providers, as well as implementation requirements and reporting. (Appendices E & F).
- **Section 9 – Participation in Evaluation and Site Visits:** Specifies that hospitals shall participate in Model evaluation activities, including data reporting and participation in site visits. Requires hospitals to obtain CMS approval for publication/release of any public document that substantively references the hospital's participation in AHEAD.
- **Section 10 – Data Sharing and Reporting:** Specifies that CMS will provide hospitals with access to certain requested data and reports, as well as hospital requirements around appropriate management and protection of data.

Hospital Participation Agreement: Sections 11-14

- **Section 11 – Monitoring and Compliance:** Specifies that hospitals must comply with CMS monitoring and oversight, comply with all applicable laws, CMS authority to audit and inspect and maintenance of records requirements.
- **Section 12 – Remedial Action and Termination:** Describes the circumstances that may warrant remedial action and the potential actions CMS may take if such action is required, as well as Corrective Action Plan (CAP) requirements and terms for terminations by CMS or by a participating hospital.
- **Section 13 – Limitation on Review and Dispute Resolution**: Specifies exceptions for administrative or judicial review, reconsideration process and standards for CMS determinations and CMS Administrator review of reconsiderations.
- **Section 14 – Miscellaneous:** Language on notice of bankruptcy, severability, survival of rights and obligations under the agreement, among others.

Hospital Participation Agreement: Appendices

- **Appendix A – Participant Hospital Proprietary and Financial Information**: Hospital provides specific examples to CMS of proprietary information
- **Appendix B – Medicare Payment Waivers**: List of waivers necessary for operationalizing Model and Medicare FFS HGB
- **Appendix C – CAH Quality Program Measures** - N/A
- **Appendix D – Medicare FFS Hospital Global Budget Methodology**: Defines terminology and outlines specific adjustments in CMS-Designed Medicare HGB, but is not a comprehensive methodology.
- **Appendix E – Telehealth Benefit Enhancement**: Outlines waivers and beneficiary eligibility requirements and parameters for participation.
- **Appendix F – Nurse Practitioner and Physician Assistant Services Benefit Enhancement**: Outlines waivers required to provide benefit enhancements to NP and PAs and parameters for participation.
- **Appendix G – Planned Service Line Adjustment Requests**: Appendix for Section 4, Hospital Global Budgets. Outlines request and approval process for making Planned Service Line Adjustment.
- **Appendix H – Care Redesign Program**: To be updated by CMS.
- **Appendix I – HIPAA-Covered Data Disclosure Request Attestation**: For hospital completion.