maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

September 24, 2025

Agenda

- AHEAD Update
- MPA
  - 2026 MPA Update
  - CTI Update
- Update on Data Transition
- Next Steps & Upcoming Meetings

AHEAD Update

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AHEAD State Agreement 2025

Draft Agreement Language for Comment

Overview

September 30, 2025

Timeline and Comments Submission Process

- Maryland and CMS agreed to an AHEAD Model Term Sheet in August 2025.
- CMS has incorporated the term sheet into a revised version of the AHEAD State Agreement and shared a draft of the agreement.
- The HSCRC is collecting feedback on the draft agreement to share with CMS.
- Comments should be sent to **mdh.maryland-model@maryland.gov** on or by **Wednesday, October 1, 2025**.

Governor's Directive: Regulatory Working Group

On September 23, 2025, Governor Moore released a directive, *Creation of Regulatory Working Group*, to address issues that arise from the implementation of H.R. 1 and AHEAD, particularly cost-shifting, stabilization of the Medicare Advantage market and other multi-agency priorities.

Led by the Secretary of Health, represented agencies include:

- Maryland Department of Health
- Maryland Insurance Administration
- Health Services Cost Review Commission
- Maryland Health Care Commission
- Maryland Health Benefit Exchange

The Regulatory Working Group will submit an initial plan–to include programmatic and stakeholder engagement elements–this fall. A final report is due in June 2026. HSCRC will keep the TCOC Workgroup updated on progress and calls for comment.

AHEAD Terms Sheet Categories

- **Medicare Fee-for-Service (FFS) Total Cost of Care (TCOC) Target**
- Medicare FFS Primary Care Investment (PCI) Target
- Primary Care AHEAD
- Maryland Primary Care Program (MDPCP)
- **Population-Based Payments (PBP)**
- **Hospital Global Budget (HGB) Methodology**
- Agreement Term
- Population Health Targets
- Medicaid
- **Medicare Advantage**
- Rural Hospitals

Other Topics of Interest:

- Choice and Competition
- Geo AHEAD
- Cost-Shifting

Topics of Focus

Focus On: Choice and Competition

The State Agreement requires Maryland to select and plan for Choice and Competition policies–*i.e.,* select one of each–by January 1, 2027.

"The State must implement each option selected by the State under Section 8.g.i (described above) in accordance with the requirements for implementation set forth in Appendix J and consistent **with guidance to be issued by CMS prior to PY1**."

Choice *(must pick one)*

1) Implementing Medicaid site neutrality
2) Improving access to new and/or additional modes of care delivery via telehealth
3) Advancing prescription drug price transparency
4) Prohibiting the use of non-compete clauses to increase provider mobility

Competition *(must pick one)*

1) Modifying scope of practice restrictions, including for physician assistants and nurse practitioners
2) Repealing certificate of need (CON) requirements for all non-hospital settings
3) Expanding access to care by revising network adequacy provisions in compliance with federal requirements
4) Expanding contracting flexibilities by repealing any willing provider (AWP) laws

This work will be led by the Regulatory Working Group, as identified in the Governor's Directive, with extensive subject matter expert and stakeholder input.

Focus On: Options for Choice Policy

Option	Milestones (Prior to PY4, *i.e.*, CY 2029)
Implementing Medicaid site neutrality	• Modify Medicaid FFS payment systems to establish uniform payment rates for the same services within the same benefit categories, regardless of care setting
Improving access to and/or additional modes of care delivery via telehealth	• Add Medicaid coverage of remote patient monitoring for postpartum care*; if already covered prior to PY1, must select at least one chronic disease* • Join and implement at least one interstate licensure compact, *i.e.,* Psychology Interjurisdictional Compact, Medical Licensure Compact or Nurses Compact; *prior to PY5, must join and implement all three.*
Advancing prescription drug price transparency	• Require drug supply chain entities to report information for drugs Maryland designates as high-costs and for drugs with planned price increases • Publish statistics on a state-supported website that disclose net revenue and pricing data across the drug supply chain
Prohibiting the use of non-compete clauses to increase provider mobility	• Prohibit both existing and future non-compete clauses for all physicians, advanced practice clinicians and other licensed health-related professionals in Maryland • *May request an exemption to the prohibition for existing non-compete clauses, per a process to be defined by CMS*

Focus On: Options for Competition Policy

Option	Milestones (Prior to PY4, *i.e.*, CY 2029)
Modifying scope of practice restrictions, including for physician assistants and nurse practitioners	• Remove scope of practice restrictions to independent practice for physicians assistants and nurse practitioners; and • *If already effective prior to PY1, Maryland must work with CMS to identify other provider types for this option.*
Repealing CON requirements for all non-hospital settings (see legal language on next slide)	• Hospitals: Provide administrative relief for all CON processes (*e.g.,* fee reduction, simplified reporting requirements, clear and efficient timelines); raise expenditures thresholds that trigger a CON and adjust for inflation; develop and implement conflict of interest safeguards; ensure transparency. **Fee relief amounts and threshold increase amounts must by finalized by the end of PY1.** • Non-Hospitals: Repeal CON requirements for non-hospital services and facilities.
Expanding access to care by revising network adequacy provisions in compliance with federal requirements	• Create flexibilities for Medicaid and commercial (*i.e.,* individual and small group) markets; validate provider directories using claims data • **By the end of PY1, develop and submit proposed modifications to distance requirements**–with input from plans–*e.g.,* distance ranges, proportions, considering telehealth providers
Expanding contracting flexibilities by repealing any-willing provider laws	• Repeal AWP laws that require commercial insurers or Medicaid MCOs to contract with any provider who agrees to the terms and conditions of a standard contract, regardless of whether the provider meets the quality and geographic access needs of the plan.

In Depth: CON Policy for Competition

Appendix J. Promoting Choice and Competition
Implementation Requirements - Competition

2. If the State selects the “Repealing certificate of need requirements for all non-hospital settings” option, the State must implement the following requirements prior to PY4:

2a. For hospitals:

i. The State, subject to approval from CMS, must provide administrative relief for all certificate of need processes which may include: fee reduction, simplified reporting requirements, and clear and efficient timelines. The fee relief amounts will be mutually agreed upon by CMS and the State by the end of PY1.

ii. If the State determines an immediate repeal would result in market disruptions that would adversely affect the Model, CMS would accept a 2-year phase-out repeal for non-hospital facilities, with such phase-out period to be mutually agreed upon by CMS and the State by the end of PY1.

iii. The State must raise the expenditures thresholds that trigger a CON and adjust for inflation. The threshold increase amounts will be mutually agreed upon by CMS and the State during PY1.

iv. The State must develop and implement conflict of interest safeguards applicable to CON regulators, including but not limited to disclosing regulatory board’s financial ties and excluding competitors from participation in CON decision-making (i.e., eliminate the “competitor’s veto”).

v. The State must ensure transparency in all administrative processes, internal review, and outcomes related to CON processes.

2b. For non-hospitals; State must repeal its CON requirements for non-hospital facilities and services.

Focus On: Geo AHEAD

Geo AHEAD is a geographic-based ACO program to support TCOC performance under the AHEAD Model.

- Ownership, management and control of Geo Entities is not required to be provider-led; organizations such as health plans or technology and digital health companies may collaborate to form and lead Geo Entities.
- Geo AHEAD will test use of a discounted bid in relation to a CMS-determined TCOC benchmark.
- Hospitals and Primary Care AHEAD providers can participate in Geo AHEAD.

Source: AHEAD Model Frequently Asked Questions. Available: https://www.cms.gov/priorities/innovation/ahead/faqs; accessed 29 Sept. 2025.

Focus On: Geo AHEAD

The State Agreement requires Maryland implement the Geo AHEAD geographic ACO program from January 1, 2028 through December 31, 2035.

CMS will launch Geo AHEAD beginning in PY3, *i.e.,* with any Geo Entities that have entered into Participation Agreements.

- Performance Period 1: CY 2028 - CY 2031
- Performance Period 2: CY 2032 - CY 2035

Under Geo AHEAD, Maryland is responsible for:

- Consulting with CMS on marketing and learning materials for Geo AHEAD, with opportunities for co-branding; CMS may consult with Maryland on the marketing and learning materials it has developed for communication with providers, suppliers and other entities.
- Providing an assessment of opportunities for alignment with the Maryland Medicaid program in the PY2 Annual Progress Report;
- Consulting with CMS on the use and content of sub-state divisions, to align with state initiatives;
- Using information shared by CMS, ensuring any Geo Entities are either incorporated in the state or are registered in the state as a foreign corporation;
- Notifying CMS within 30 days in the case of any adverse actions or exclusion determinations for Geo Entities or their board members, *i.e.,* due to fraud and/or abuse related to state or federal programs; and
- As applicable, licensing and performing oversight of Geo AHEAD risk-bearing entities and notifying CMS within 30 days in the case of any adverse actions or revocation of licensure by Geo AHEAD risk-bearing entities.

Cost-Shifting

- Over the next seven years, the AHEAD Model requires the state to drive approximately $230 million more in Medicare savings than the previous AHEAD State Agreement.
- Cost growth in Medicaid and Medicare Advantage will also need to be managed on the same trajectory.
- Hospitals believe that some proportion of these savings requirements should be passed on to commercial rate payers rather than be driven by reductions in hospital utilization.

Cost-shifting policy is a priority project of the AHEAD Regulatory Working Group, in recognition of the broad impact on the health care system.

HGB Methodology

Term: Care Redesign Program (CRP)

Term Sheet:

- EQIP will continue to operate under the CRP through the end of 2027.
- Beginning in 2028, EQIP will transition to operate under the CMS-designed HGB methodology, in partnership with at least one participating hospital.
- During this transition, CMMI and the state will collaborate to ensure that the necessary funding and safe harbor mechanisms exist to support EQIP and that EQIP is fully aligned with the CMS-designed HGB requirements and initiatives.

Draft State Agreement:

11.i.ii:

The CRP Tracks, developed and implemented under the Maryland Total Cost of Care Model, specifically the Episode Care Improvement Program (ECIP) and Episode Quality Improvement Program (EQIP), shall be considered approved CRP Tracks and shall survive upon the termination of the Maryland Total Cost of Care Model. Any and all key documents and information related to these CRP Tracks are incorporated herein by reference and will form a part of this Agreement as if set forth herein in their entirety. The parties agree to amend any such key documents as may be necessary to ensure the CRP Tracks are properly integrated into this Model for PY1 and PY2.

12.g.a Care Redesign Program in PY3 – PY10.

a. CMS and the State agree to use good faith efforts to modify the CRP as needed to align with adjustments made to State and Hospital payments starting in PY3. The Parties agree to amend the Agreement and any other documents implementing the CRP to reflect any such mutually agreed upon modifications to the CRP.

Primary Care

- The State Agreement includes several provisions related to primary care programs and targets, in particular:
  - MDPCP will be evaluated for continuation beyond 2028; and
  - CMMI is launching a new program called Primary Care AHEAD (link to additional information).
- The Maryland Department of Health is coordinating the comments process for primary care.

Medicare Fee-for-Service Total Cost of Care Target

Medicare FFS TCOC Target

Term: Trend factor, accountable care prospective trend and national growth benchmark blend

Term Sheet:

- Maryland will use a 2023 baseline year, weighted at 100 percent.
- The baseline per beneficiary, per year (PBPY) for 2023 in nominal dollars is $14,107.
- Maryland will rely solely on the U.S. Per Capita Cost (USPCC).

Draft State Agreement:

The language in the draft agreement is consistent with the original negotiation methodology, which was discussed with the TCOC Workgroup in 2024.

Medicare FFS TCOC Target

Term: Cumulative savings/average savings component

Term Sheet:

- Expectation of savings in PY1 (2026)
- Maryland will be expected to deliver $460 million (savings component) in savings in PY7 (2032).
- Spend from PY7 forward to increase in line with national trend of USPCC through PY10

PY	Savings Component	Projected Savings ($M)
PY1	0.13	17
PY2	0.21	47
PY3	0.30	92
PY4	0.38	153
PY5	0.46	234
PY6	0.55	335
PY7	0.63	460
PY8-PY10: Maryland Medicare FFS cost expected to grow at the national trend of USPCC.		

Population-Based Payments

Population-Based Payments

Term: Revenue under PBP and excluded services

Term Sheet:

CMS will require 90 percent of all in-state, all-payer acute hospital revenue under a PBP.

Draft State Agreement:

On September 23, 2025, HSCRC staff discussed adding language that acknowledges alternative carve-out strategy proposed by the state. CMS agreed to consider additional language.

Hospital Global Budget Methodology

HGB Methodology

Term: Removal of Medicare rate-setting waiver

Term Sheet and Draft State Agreement Reflect:

- CMS will permanently revoke the waiver that allows HSCRC to set Medicare FFS hospital rates on January 1, 2028.
- The HSCRC will not have any role in determining Medicare FFS hospital payments from 2031 onward, following a bridge period.

HGB Methodology

Term: Baseline revenue and trend to 2028

Term Sheet:

- The baseline revenue for the 2028 HGB will be 2026 actual Medicare FFS hospital revenue in the state.
- However, if the update factor for 2025 and 2026 are greater than USPCC, CMS will use 2024 baseline revenue.
- The trend applied to the baseline revenue will be the annual payment adjustment that CMS calculates as part of the CMS methodology.
- **Update:** State asked CMS to revise this term so the remedy for higher than USPCC trend would not be using a 2024 baseline but adjusting 2026 down.

Draft State Agreement:

Language in the draft agreement is not exactly aligned with the term sheet and previous discussions. HSCRC is working with CMMI to revise and believes the parties are aligned in intent.

HGB Methodology

Terms: Savings Adjustment & Guardrail

Term Sheet:

- CMS will ensure that the downward savings adjustment to the statewide HGB revenue does not exceed the required annual TCOC savings target.
- An upward adjustment would be applied in a subsequent year if TCOC savings exceed statewide TCOC targets in a given performance year.
- CMS will apply a savings adjustment to the HGB to ensure the state meets its annual Medicare FFS TCOC savings target.
- Adjustment will be scaled, *i.e.,* hospitals with larger revenue will have a greater downward adjustment as a percent of revenue vs. smaller hospitals
- **Update:** State asked CMS to not lock in on a size-based scaling adjustment.
- If the state is under its target in a given year, funds would be added in the following year.

Draft State Agreement:

Language in the draft agreement is not exactly aligned with the term sheet and previous discussions. HSCRC is working with CMMI to revise and believes the parties are aligned in intent.

HGB Methodology

Term: Bridge period from HSCRC to CMS methodology

Term Sheet:

- Starting in 2028, Medicare FFS HGB will be calculated according to the CMS methodology.
- CMS will allow HSCRC to direct a portion of the total HGB revenue for participant hospitals in the state, *i.e.,* 30 percent in 2028, 20 percent in 2029 and 10 percent in 2030.
- The amount of the HSCRC portion is calculated by applying the percentage to the total HGB revenue across all participant hospitals in the state.
- The savings adjustment will be applied after the HSCRC portion is disbursed.

Draft State Agreement:

Language in the draft agreement is not exactly aligned with the term sheet and previous discussions. HSCRC is working with CMMI to revise and believes the parties are aligned in intent.

HGB Methodology

Term: Medicare Performance Adjustment (MPA): Revenue at Risk and TCOC attribution

Term Sheet and Draft State Agreement reflect:

- MPA will be a minimum of two percent while HSCRC controls the Medicare FFS HGB methodology. MPA quality adjustments must align with statewide population health/equity targets (and meet advanced alternative payment model requirements).
- Maryland may propose an alternative that attributes 99 percent of costs rather than 95 percent of beneficiaries.
- The MPA will not be part of the CMS HGB methodology.
- It will be replaced in 2028 with the TCOC performance adjustment.

HGB Methodology

Term: Hospital Quality

Terms Sheet:

- Including a new reference that in the statewide quality targets, performance must be better than under Maryland TCOC.
- Under the CMS methodology, hospitals' quality performance will be assessed by the CMS quality programs.
- During the bridge period, hospitals will have their quality performance assessed by the CMS quality programs.

Draft State Agreement:

CMMI is working with HSCRC staff–in consultation with the Performance Measurement Workgroup–to align and transition Maryland's existing hospital quality programs where appropropriate.

HGB Methodology

Term: Public Comment Process

Term Sheet:

- CMS will outline a process that will be used to solicit stakeholder input into the HGB methodology as it is updated regularly over the course of the model.
- CMS will have final say on any changes to the methodology.
- **Update:** The State asked CMS to enhance the specificity of these terms in the State Agreement.

Draft State Agreement:

- It was anticipated that the State Agreement only include high-level parameters of the HGB methodology.
- The final methodology is expected to be released by the end of 2026, with an opportunity for public comment.
- The date for CMMI to release the final HGB methodology did not align with previous discussions and commitments. HSCRC is working with CMMI to update the language.

CMMI has indicated it will share financial estimates according to AHEAD HGB (version 3.0); HSCRC will extend the opportunity for hospitals to review in the coming weeks.

Medicare Advantage

Medicare Advantage

Term: Medicare Advantage market stabilization

Term Sheet:

- Maryland to propose an idea to CMS

Medicare Advantage was called out in the Governor's Directive for the AHEAD Model Regulatory Working Group, which involves the state agencies responsible for regulating Medicare Advantage plans in Maryland.

Draft State Agreement:

- **Section 12.a.vii:** The State may propose ideas to CMS regarding policies to support stabilization of the Medicare Advantage market during the transition from the CMS-Approved, State-Designed Hospital Global Budget Methodology to the CMS-Designed Medicare FFS Hospital Global Budget Methodology starting in PY3 as described in this Section 12.
- The State has requested the limitation on timing be removed.

Comments Submission Process

Please send feedback on the draft AHEAD State Agreement 2025 to **mdh.maryland-model@maryland.gov**.

Comments are due on or by **Wednesday, October 1, 2025**.

2026 MPA Planning

Recap of current traditional MPA

1. **Attribute Medicare FFS beneficiaries to hospitals on a geographic basis**
   1. AMCs have extra layer focused on high-acuity individuals
2. **MPA penalizes or rewards hospitals based on a subtracting:**
   1. The cumulative growth since 2019 in their attributed per capita TCOC from
   2. Cumulative national growth in per capita TCOC, including non-claims based payments into savings targets calculation, less a hospital specific growth rate adjustment
3. **Each hospital's growth rate adjustment is set based on their position versus target in 2019.**

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

4. **The result is then divided by 3 and capped at 2% of Medicare revenue (per current recommendation) then adjusted for quality to derive the final value.**

2026 MPA Update

- Current Status
  - MPA remains in contract for the next 2 years.
- Staff Perspective
  - HSCRC's staff's current position is to avoid introducing any changes to the MPA for upcoming years.
- Next Steps
  - Confirm rollover of the 2025 MPA into 2026.
  - Formally included confirmation as part of the upcoming MPA recommendation to HSCRC's Commission.

CTI Update

- Current Status
  - HSCRC staff are continuing background work to identify tools for further planning.
- Call for Comments
  - Comments due by October 15th
  - More robust discussions are planned for October and November.
    - 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.

Comments

- LifeBridge – CTI Comments
  - CTI's net-neutral nature is problematic, as smaller health systems may experience significant revenue offsets even when their CTIs achieve only modest savings, penalizing them for factors beyond control.
  - Difficult to accurately predict performance, limiting ability to make real-time clinical and operation changes.
  - Recommend sunsetting the CTI program immediately.
  - Recommend reversing any negative revenue adjustments for hospitals in FY 2026.
  - Recommend TCOC workgroup discussions align the goals and incentives of the AHEAD model with tools and programs that enable more effective clinical engagements, and outcome measurement and reporting mechanisms that support timely operational changes.

Data Transition

Data Transition Update

- CMS has proposed changes to CCLF data. CCLF data are used as formal scorekeeping data source for key Maryland programs (MPA, EQIP, ECIP, and CTIs)
- Implications
  - Since file structures and field names are very different, staff believe reporting will have to be taken offline for a period of transitioning and rebuilding of reports. This could potentially create a quarter without reporting.
  - Staff are asking CMMI about the possibility to do parallel runs of new and old files for awhile after implementation, but this can be costly.
  - The overall transition may temporarily disrupt reporting for some programs; staff will provide updates when available.

Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
  - October 22 – May be rescheduled
  - November 26 – May be rescheduled
  - 2025 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage
- Future Meetings Topics
  - October
    - Further Discussion on MPA
    - CTI Next Steps
    - Update on VBCI Tool

Upcoming Important CTI and EQIP Dates

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

Thank You
Next Meeting October 22, 8-10 am