



maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

April 22, 2026

Agenda

- FY2025 CTIs
- Healthcare Outcome Payment Effort
- High-Value Care Plans
- AHEAD – All-Payer TCOC Target Technical Advisory Committee
- Next Steps & Upcoming Meetings

FY2025 CTIs

Comment Letters – Already Submitted

- **UMMS**
 - Proposed fully winding down the CTI policy and allow for some adjustment in FY28 as a result of FY26 performance
- **Luminis**
 - States current CTI operations and methodology generates substantial savings alongside significant penalties, creating unpredictability and instability within the regulatory model.
 - Concerned the CTI program continues to carry unmitigated risk, as successful hospitals are subject to considerable unforeseen financial penalties, raising concerns over equitable impact.
 - Concerned about the FY25 surge in savings which will increase the statewide offset, resulting in disproportionate penalties that were unforeseen and result in challenges to ongoing care delivery and operations.
 - Concerned about the uncertainty of future outcomes under current CTI program.
 - Recommends discontinuing current CTI program at the end of the FY25 performance period.
- **CalvertHealth**
 - States that introducing methodological changes after performance periods have concluded creates uncertainty and weakens the predictability that hospital rely upon to guide investment decisions.
 - Recommends changes be evaluated prospectively and applied consistently across future performance periods.
 - Recommends proposed changes be review transparently and brought forward to the Commission for approval.
- **Ascension Saint Agnes**
 - Concerned with approach of de-duplicating beneficiaries in zip codes that overlap between CTIs, as it would be a change in the methodology after the performance year has closed.
- **Adventist Health**
 - Encourages HSCRC to prioritize FY25 CTI policy results
 - States concern regarding the volatility of CTI payment outcomes makes it difficult for health systems to responsibly commit to multi-year contracts, workforce investments, and care infrastructure on the basis of these returns.

Background

- The Care Transformation Initiative (CTI) program was established in 2019, under an agreement with CMS, to encourage hospitals to innovate care of Medicare patients and drive total cost of care savings. The Commission's expectation was for some hospital revenue to shift based on CTI performance, but with an expectation that these gains and losses would be reasonable.
- In early 2024, the Commission voted to include a 2.5% stop loss provision to limit the risk to hospitals and volatility of Medicare revenue. However, additional losses could be spread across all hospitals losing revenue under CTIs in order to make the program revenue neutral. Based on historical performance, this additional loss was anticipated to be minimal. However, 2025 performance demonstrates significantly greater volatility than in previous years with a maximum effective stop loss of 5.36%--far more than the expected 2.5%.
- As discussed at the April 15 meeting, the Commission is seeking comments on potential options for addressing these unanticipated and unintended results and for the FY2026 program.

Additional Call Following Commission Meeting

- For FY25 results, please share comments on these potential options:
 - No change.
 - Setting stop loss at the hospital level to 2.5% or another specific level. To maintain the required revenue neutrality, funding would be reduced to the revenue-gaining hospitals.
 - Changing the methodology for attributing savings to CTI programs. If commenting, please explain your suggested methodology changes.
 - No payout at all for FY25.
 - Other suggested options
- For the FY26 program, please share comments on these potential options:
 - No change.
 - Setting stop loss at the hospital level to 2.5% or another specific level. To maintain the required revenue neutrality, funding would be reduced to the revenue-gaining hospitals.
 - Changing the methodology for attributing savings to CTI programs. If commenting, please explain your suggested methodology changes.
 - No payout at all for FY26.
 - Other suggested options

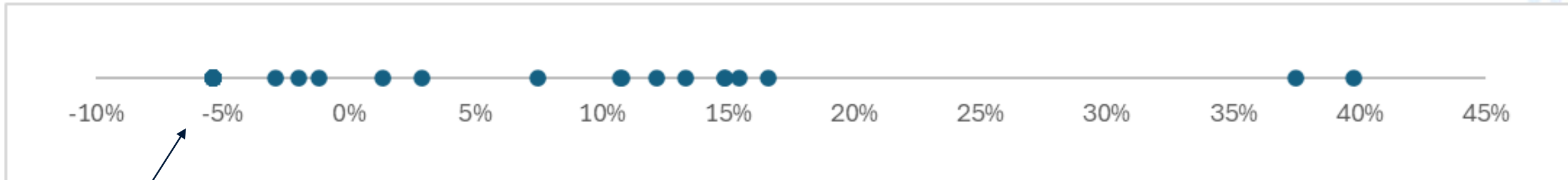
The Commission's Intent: Incentivizing greater efficiency while limiting volatility

- The Commission's expectation was for there to be winning hospitals and losing hospitals, but with limits to the amount of wins and losses each year.
- In March 2024, the Commission voted unanimously, with the support of the Maryland Hospital Association, to include a 2.5 percent stop loss provision to limit the amount of Medicare funds each hospitals could lose.
- This provision was not a hard cap on losses, as additional losses would be spread across all the losing hospitals.
- However, at the time, such additional losses were understood to lead to “slightly higher” losses – but not major, material changes.

2025 Results: Volatility

- The results from 2025 demonstrate significant volatility compared to prior years – with double the amount of money – more than \$160 million – to shift between hospitals than had ever shifted in the past.
- 27 hospitals would lose 5.36 percent of Medicare revenue – far more than 2.5 percent.
- Community Care deduping strategies to not have a significant impact on this outcome

Preliminary Net CTI (Losses) Gains by Hospital as a % of Medicare Savings



27 hospitals at the maximum effective stop loss of 5.36%

Impact of Hard Cap at 2.5%

- Losses over 2.5% are redistributed to hospitals with positive savings prior to the redistribution (Based on Preliminary 2026 results, as distributed)

	Revenue	New \$	\$ As Is	% New	% As Is	Gain (Loss)
UM	\$1,152,369,211	\$15,918,119	\$27,440,698	1.4%	2.4%	-\$11,522,579
JHHS	\$889,928,949	-\$12,298,896	-\$11,221,874	-1.4%	-1.3%	-\$1,077,021
Medstar	\$625,897,927	-\$2,309,930	-\$7,101,774	-0.4%	-1.1%	\$4,791,845
Lifefridge	\$406,780,635	-\$10,169,516	-\$21,794,744	-2.5%	-5.4%	\$11,625,228
Luminis	\$255,410,464	-\$6,385,262	-\$13,684,540	-2.5%	-5.4%	\$7,299,278
Holy Cross	\$104,692,676	-\$2,617,317	-\$5,609,289	-2.5%	-5.4%	\$2,991,972
Adventist	\$218,428,655	-\$5,460,716	-\$11,703,105	-2.5%	-5.4%	\$6,242,389
Tidal	\$178,587,377	-\$2,536,336	-\$3,373,165	-1.4%	-1.9%	\$836,830
Frederick	\$113,983,031	-\$2,849,576	-\$6,107,053	-2.5%	-5.4%	\$3,257,478
Meritus	\$116,646,537	-\$2,916,163	-\$6,249,760	-2.5%	-5.4%	\$3,333,597
St. Agnes	\$110,590,992	\$9,504,648	\$18,339,237	8.6%	16.6%	-\$8,834,589
Garret	\$21,056,863	-\$526,422	-\$1,128,198	-2.5%	-5.4%	\$601,776
Union	\$45,208,411	-\$1,130,210	-\$2,422,204	-2.5%	-5.4%	\$1,291,994
GBMC	\$125,683,393	\$25,913,947	\$50,001,014	20.6%	39.8%	-\$24,087,067
Calvert	\$54,698,413	\$3,775,880	\$7,285,569	6.9%	13.3%	-\$3,509,688
UPMC	\$114,799,492	-\$2,869,987	-\$6,150,798	-2.5%	-5.4%	\$3,280,811
Mercy	\$121,690,563	-\$3,042,264	-\$6,520,012	-2.5%	-5.4%	\$3,477,748

2026 Results

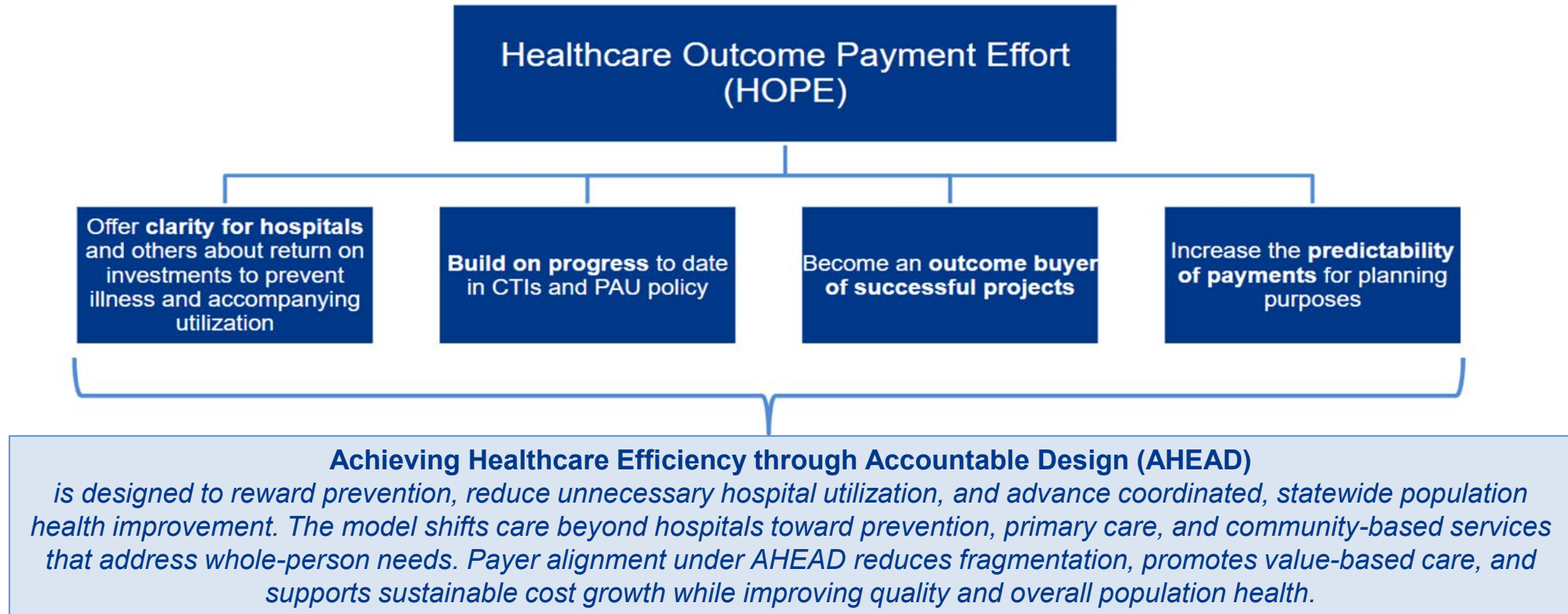
- Results will be volatile as only half the period is completed (7 months)
- Project episode counts are consistent with 2025 and show only modest growth

	2026 YTD	2025	2026 as a % of 2025
Care Transitions	115,043	174,771	65.8%
Community-Based Care	883,887	1,573,911	56.2%
Emergency Care	70,998	93,629	75.8%
HOPD Services	18,574	6,345	292.7%
Palliative Care	5,109	7,343	69.6%
Primary Care	169,541	427,279	39.7%
Total	1,263,152	2,283,278	55.3%

Healthcare Outcome Payment Effort

HOPE FRAMEWORK

Care Transformation Initiatives (CTI) are ending June 30, 2026 and this program is the replacement, aligned with AHEAD, to further the goals of the Model.



HOPE Comment Letters Summary

- Received 22 comments letters from various organizations
- Generally, organizations are supportive of HOPE with some revisions and clarity on scoring and methodology. A few organizations suggested delaying the program.
- Themes included timeline, funding, scoring structure, review committee, interaction with CTIs, funding caps, all-payer scope, etc. Summarized in the following slides.

Funding and Financial Structure

- **Sustainable and Stable Funding**

- Strong support for HOPE as a stable funding bridge for successful preventive care programs that are often discontinued when pilot funding ends. (Abell Foundation)
- Base funding remains consistent to hospitals. (CalvertHealth)
- Supports predictable, multi-year funding to enable long-term infrastructure investment. (Meritus Health)
- Seeks definitive guidance on near- and long-term funding sources. (MHA)
- Approves of the pre-specified, fixed reward pool but seeks clarity on its impact on annual update factors. (MedStar Health)
- Advocates for reinvesting savings accrued to the state back into the program to accelerate long-term gains. (MedStar Health)
- Recommends incorporating \$50M of infrastructure payments proportional to GBRs in both FY27 and FY28 funding to support current interventions during the transition. (UMMS)

Funding and Financial Structure

- **Funding Caps and Allocation**

- Supports the \$50M annual funding cap. (JHHS)
- For the FY27 infrastructure funding, funds should be allocated to hospitals that achieved gross shared savings in CTIs and committed to future HOPE participation, rather than allocating by market share. (MedStar Health)

Measurement, Scope, and Methodology

- **Program Scope and Focus**

- Urges HSCRC to focus on latent demand, uncompensated care, and physician reimbursement before implementing HOPE. (Adventist HealthCare)
- Strongly opposes narrowing measurement to inpatient/ED costs, arguing for a continued TCOC framework. (UMMS)
- Requests clarity on how the program drives TCOC reductions if limited to inpatient/ED expenditures. (MHA)
- Emphasizes that program methodologies must be transparent (i.e., available funding and distribution) predictable and consistently applied. (CalvertHealth)
- Recommends that review criteria prioritize upstream drivers of health like nutrition and transportation. (Maryland Department of Aging (MDOA))

Measurement, Scope, and Methodology

- **Scoring and Payouts**

- Supports scoring each intervention based on actual averted hospital costs, rather than on projected savings or a hybrid. (JHHS)
- Supports scoring each intervention at actual averted hospital costs, or 125% of projected averted hospital costs, whichever is lower Option C in Step 2 for scoring because it rewards outperforming projections. (MedStar Health)
- Suggests lowering the proposed minimum saving rate for projections from 50% to 10-20%. (MedStar Health)
- Argues against setting minimum dollar thresholds for savings or performance for project approval, or minimum performance thresholds required to receive a payout. (Primary Care Coalition)

Implementation Timeline

- Strongly urge delaying HOPE implementation to FY2028 for deliberate development. (MHA)
- Recommends delaying HOPE enrollment to FY2028. (UMMS)
- Recommends eliminating HOPE due to unpredictable CTI-based methodology and the risk to stability during the AHEAD transition.(JHHS)
- Reluctant to support HOPE without a resolution to CTI issues. (Luminis Health)

Program Design and Operational Clarity

- **General Support and Structure**

- Believes the HOPE proposal is preliminary and requires more detail on distribution and TCOC impact. (Ascension Saint Agnes, Audacious Capital)
- Commends the voluntary, upside-only structure for lowering barriers to participation. (Meritus Health)
- Supports the foundational design principle that HOPE functions as a voluntary, upside-only program, consistent with the EQIP framework. (JHHS)

Program Design and Operational Clarity

- **Administrative and Data Requirements**

- Recommends reducing administrative burden and encouraging multi-payer participation. (Audacious Capital)
- Requests more detail on initiative approval, savings measurement, and impact on annual update factors. (GBMC)
- Urges a "comprehensive crosswalk" showing how HOPE intersects with other existing initiatives (Revenue for Reform, PHAP) to prevent administrative burden and duplication. (MHA)
- Does not support the proposed exclusion of Revenue for Reform initiatives or overlap with primary care investments (Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, Rural health transformation) in potential HOPE applications. (UMMS)
- Supports interoperability (e.g., CRISP and closed-loop referrals) and Shared Savings. (MDOA)

Recommended Intervention and Focus Areas

- **Palliative Care and Serious Illness**

- Recommends explicitly identifying palliative care, hospice, and advance care planning as priority HOPE initiatives. (Maryland State Advisory Council on Serious Illness Care)
- Recommends including at least one palliative care expert on the review committee and using patient-reported outcome measures. (University of Maryland School of Medicine)
- Explicitly list palliative care interventions (CAPC- and NHPCO-aligned) as qualifying examples in final guidance. (University of Maryland School of Medicine)

Recommended Intervention and Focus Areas

- **Community and Prevention**

- Focuses on health outcomes and aligns with the AHEAD Model to shift focus toward prevention and community-based services. (Healthcare for All/Maryland Citizens' Health Initiative (MCHI))
- Emphasizes increasing physician awareness and community-based partnerships. (MedChi)
- Recommends adding diagnostic excellence within the scope of HOPE supported interventions. HSCRC should add “presenting symptoms” to the list of illustrative target population characteristics in the review criteria. (Johns Hopkins - Tele-Dizzy)

Regional and Statewide Initiatives (RSI)

- **RSI Caps and Structure**

- Recommends capping the RSI track at 20–25% of total HOPE funding. (JHHS)
- Views regional initiatives as less accountable and not necessarily patient-facing. (JHHS)
- RSI payments should remain uncapped. (Primary Care Coalition)
- Concerned with lack of cap for RSI and generally with financing leaving the hospital; notes risk of misalignment with Geo AHEAD. (UMMS)
- RSI framework is needed to sustain and scale high-acuity, low-volume services/settings. (The Day Clinic)

Regional and Statewide Initiatives (RSI)

- **Partner Inclusion and Engagement**

- Opposes excluding hospitals from being anchor entities in regional collaboratives. (MedStar Health)
- Requests formal recognition of Area Agencies on Aging (AAAs) as RSI anchor entities. (MDOA)
- Requires Local Health Department (LHD) Engagement in Regional & Statewide Initiatives. (MACHO)
- Strengthen and Specify “Community Partner” Language to explicitly include Local Health Departments. (MACHO)
- Requires Regional Governance Structures with Public Health Participation (RSI). (MACHO)

Policy Revisions

- **Timeline**
 - Delay implementation until FY2027 with application period in second half of CY2026.
- **Scoring and Payments**
 - Qualify interventions up to \$100 million in projected averted hospital costs.
 - Score interventions at actual averted hospital costs, or 125% of projected averted hospital costs, which ever 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%
- **Infrastructure payments and seed funding**
 - FY 27 - \$25M for infrastructure payments and \$25M for seed funding for approved applicants
 - FY 28 - Measurement period starts and potentially new seed funding provided to approved applicants

Policy Clarifications

- **Anchor entities**

- While it is preferred that community organizations are the anchor entity, hospitals can be the anchor entity in an RSI but they must have meaningful partnerships with community organizations, e.g. engage via MOU.
- The request for formal recognition of Area Agencies on Aging (AAAs) as RSI anchor entities will be incorporated into the final policy implementation.
- HSCRC agrees that “Community Partner” language should be strengthened to explicitly include Local Health Departments and will work to ensure this is reflected in the final guidance.

- **Interventions**

- Palliative care, hospice, and advance care planning should be explicitly identified as priority HOPE initiatives and palliative care interventions (aligned with CAPC and NHPCO) will be listed as qualifying examples in the final policy.
- Review criteria will include assessing if projects are grounded in a strong evidence base and address state health priorities. Staff will explore adding diagnostic excellence within the scope of HOPE supported interventions.

- **Review Committee/Criteria**

- HSCRC will explore including at least one palliative care expert on the review committee and will also explore incorporating patient-reported outcome measures where feasible and appropriate.
- We agree that review criteria should prioritize upstream drivers of health, such as nutrition and transportation, and will incorporate this into the final framework.
- Staff will explore adding “presenting symptoms” to the list of illustrative target population characteristics in the review criteria.

Policy Clarifications

- **Regional and State Initiatives**

- HSCRC will work to ensure that Local Health Departments are engaged and included in regional and statewide initiatives.
- HSCRCs agree that regional governance structures should include public health participation and will work to incorporate this into the RSI requirements as feasible and appropriate.

- **Interoperability**

- HSCRC agrees with supporting interoperability (e.g., CRISP and closed-loop referrals) and will work with CRISP to ensure that HOPE initiatives are able to incorporate these capabilities, as appropriate, in the implementation.

- **Crosswalk/Overlaps**

- We agree with the need for a comprehensive crosswalk demonstrating how HOPE intersects with existing initiatives (e.g., Revenue for Reform, PHAP) to reduce administrative burden and duplication and will work to generate this document before implementation.
- HSCRC agrees that HOPE should not exclude or unnecessarily limit overlap with existing initiatives (e.g., Revenue for Reform, Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, Rural Health Transformation) if there is not duplication of payments for similar activities.

Draft Standard Revised Timeline*

CTF

- May/July 2026
 - Final commission vote
- June 2026
 - Finalize review committee and notify committee members
- July - December 2026
 - One-time Infrastructure payments in GBRs (July)
 - Ongoing operationalization and methodological refinements through TCOC workgroup
- December 2026
 - Applications due in portal
- January-February 2027
 - Committee review applications
 - Seed funding available
- March 2027
 - Notify applicants of approval
- April-May 2027
 - Onboarding of approved initiatives
- July 2027
 - Measurement period start

RSI

- May/July 2026
 - Final commission vote
- June 2026
 - Finalize review committee and notify committee members
- July - December 2026
 - Ongoing operationalization and methodological refinements through TCOC workgroup
- October 2026
 - Applications due in portal
- November- December 2026
 - Committee review applications
- January 2027
 - Notify applicants of approval
 - Seed funding available
- February-March 2027
 - Onboarding of approved initiatives
- January/July 2027
 - Measurement period start

*Timelines could vary to accommodate specific applicant's specifications



High Value Care Plans

High Value Care Plans

- HVCPs will end June 30, 2026 assuming HOPE is approved.
 - Final reporting due June 1, 2026
 - HSCRC recently circulated the final reporting template.
 - Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the July rate orders.
- Final funding decisions will be made as part of the RY27 Update Factor and shared in the June TCOC workgroup.
- All final report submissions should be sent to hscrc.tcoc@maryland.gov.



AHEAD

All-Payer TCOC Target Process Timeline

Milestone	Date(s)
Advisory Group Meeting #1: Advisory Committee Introduction and Review of Charge	February 5, 2026
Advisory Group Meeting #2: Review Key Considerations and Make Initial Recommendations	February 23, 2026
Written Public Comment Period	February 23 – March 20, 2026
Advisory Group Meeting #3: Public Listening Session	April 10, 2026
Advisory Group Meeting #4: Discussion on Recommendations	April 17, 2026
Advisory Committee review of draft CY 2027-2031 targets	May 8-22, 2026
Written public comment period of draft CY 2027-2031 targets	June 3-17, 2026
Submit draft CY 2027-2030 targets to the Governor*	July 15, 2026
Submit final CY 2027-2030 targets to the Governor and CMMI	September 2026

* Subject to anticipated approval of extension request.



Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
 - May 27
 - Update on HOPE
 - Address any issues with HVCP
 - Update on New Paradigms
 - 2026 Meeting Dates (Tentative) posted on [TCOC Workgroup Webpage](#)

Thank You
Next Meeting May 27, 8-10 am