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Total Cost of Care Workgroup Meeting

August 26, 2026

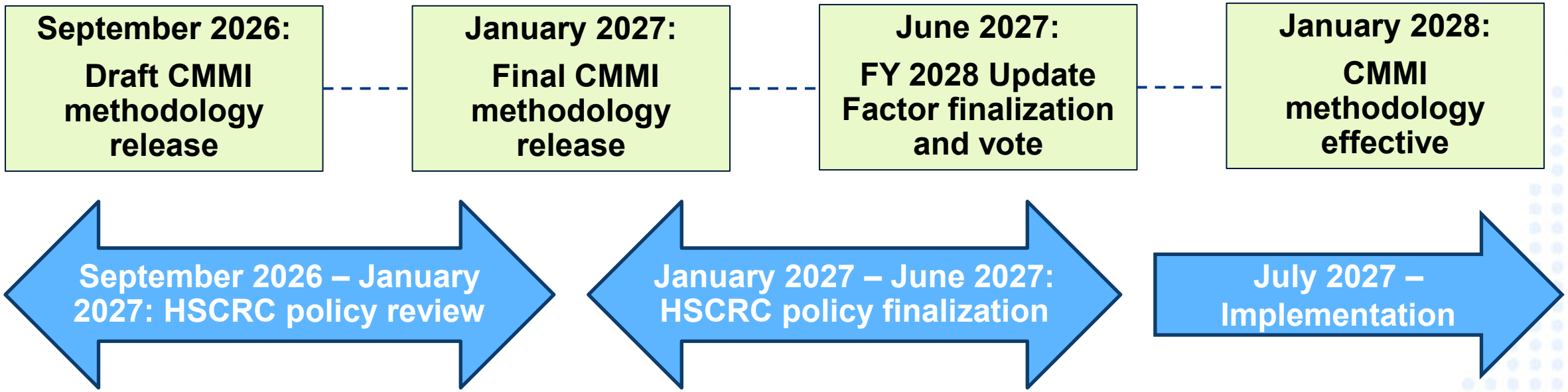
Agenda

- HSCRC & AHEAD Updates
  - HSCRC 2026-2027 Timeline
  - GEO AHEAD
- HOPE Updates
- ROI Savings Methodology Presentation
- Next Steps & Upcoming Meetings

HSCRC & AHEAD Updates

HSCRC High-Level Timeline

HSCRC will manage its policy review and refinement activities in conjunction with ongoing changes in the CMMI methodology, *i.e.,* between the release of the draft and final Medicare FFS Hospital Global Budget methodology.



GEO AHEAD: Overview

- Reflects information copied from documents shared by CMMI as of August 25, 2026
  - Geo AHEAD Fact Sheet
  - Geo AHEAD Specification Preview Beneficiary Attribution
  - Geo AHEAD Specification Preview Entity and Bidding
  - Geo AHEAD Specification Preview Payment Approaches
- The GAPP Survey
  - HSCRC has been told to encourage survey participation by 9/4/2026
  - Corresponding office hours (registration link), scheduled for 3-4pm on 8/25/2026

August – September 2026	October – December 2026

• Geo AHEAD Specifications Previews
  • Payment Approaches ***posted 8/11***
  • Benchmarking
• Geo AHEAD Participation Perspectives (GAPP) Survey Webinar (8/25, 3-4PM ET)
• Geo AHEAD Technical Specifications v1
  • Specifications
  • Webinar
	• Fact Sheets
	  • Geo AHEAD Business Case
	  • Geo AHEAD for Providers
	• Geo AHEAD Technical Specifications v2
	  • Specifications
	  • Webinar
	• Geo Entity Calculator Tool

**GAPP Survey is linked and additional slides on GEO AHEAD are located in the appendix.*

HOPE Updates

HOPE 2026 Timeline

- HSCRC
  - Commission Vote on RSI: December 2026
  - Seed Funding into GBRs: January 2027
- RSI
  - LOIs Due: August 21, 2026
  - Applications Due: September 28, 2026
  - Present RSI Recommendations to Commission: December 2026
- CTF
  - Release RFA: October 1, 2026
  - LOI due: October 22, 2026
  - Applications Due: November 20, 2026

RSI: Letter of Intent

- 16 LOIs received
  - If we did not receive an LOI, you cannot submit a full application
- Next Steps:
  - HSCRC aims to provide a response to those who submitted LOIs by September 1, 2026.
    - If you are moving forward with the full application and requested analytic support, we will coordinate that with you as well.
    - If you are not moving forward, there is no appeals process.

HOPE Meeting Schedule

1. TCOC Workgroup Meetings
   - Continue discussions during second half of workgroup meetings.
2. 30-Minute Monthly HOPE Workgroup Check-Ins *(in-between TCOC Workgroup Meetings)*
   - Zoom Registration Link
   - Meeting Dates
     - September 9 – 10AM
     - October 14 – 10AM
     - November 12 – 10AM (Avoids Holiday)
     - December 9 – 10AM

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CTF and RSI – Savings Methodology

August 2026

The Case for Savings Estimation

- A savings estimate and a description of the methodology is a scored application component.
- Reviewers will assess whether proposals have a high likelihood of producing measurable impact, shown by a clear, well-justified methodology for estimating health and cost impact
- Even rough, defensible estimates are better than no estimate, and far better than anecdotal evidence alone.
- You need a clear framework and honest assumptions, and evidence tied to Maryland Case-Mix data.

Retrospective or Prospective Scenarios

- Some analyses use real-world program or administrative data to directly measure impacts either mid-implementation or post-implementation to justify continuation or expansion.
- Others build assumption-driven savings analyses *before* implementation, drawing on peer-reviewed literature, grey literature, pilot data, or recent claims/administrative records to establish baseline rates and a "business as usual" counterfactual.
- The core components of a savings analysis are largely the same in both cases

Three Basic Frameworks for Economic Evaluation

Return on Investment (ROI)

- Net financial return relative to program cost: "For every dollar we spend, how many dollars do we get back?“
- *ROI = (Savings − Program Cost) / Program Cost × 100*
- HOPE applications focus on this type – program costs recouped through reconciliation

Cost-Benefit Analysis (CBA)

- Converts all outcomes into dollar values, including non-financial ones like program effects on productivity gains, quality of life, or reduced caregiver burden.
- Comprehensive program evaluation, policy advocacy

Cost-Effectiveness Analysis (CEA)

- Compares cost per unit of outcome (e.g., cost per hospitalization averted, cost per Quality Adjusted Life Year)
- Comparing two programs or interventions head-to-head
- *ICER = (Cost A – Cost B) / (Outcome A – Outcome B)*

Every Savings Estimate Requires a Counterfactual

What would have happened without your program?

Three approaches, in order of rigor:

- *Randomized Controlled Trial (RCT)* – the gold standard, rarely feasible
- *Quasi-experimental design* – compares to a matched comparison group or use pre/post comparisons with statistical controls.
- *Literature-based baseline* – use published rates for similar populations as the "without program" scenario

Most savings estimates or public health programs use literature-based baselines. This is acceptable but must be clearly disclosed.

Claiming savings without any counterfactual reasoning is not defensible to reviewers.

Costs to Consider

Healthcare Costs

Healthcare utilization is the most common source of savings for population health programs.

- For HOPE, all financial performance is measured against Maryland's all-payer hospital Case-Mix data, which captures inpatient discharges, ED visits, and ambulatory surgical encounters for every Maryland payer. Your projected reductions must map to encounters that appear in this dataset.
- Other references for unit costs:
  - CRISP has utilization data to support baseline estimates and program monitoring
  - Maryland HSCRC hospital discharge data, cost per case by DRG, all-payer model performance data
  - CMS national average costs; HCUP (AHRQ) for national benchmarks

Program Costs

Note: Outcome payments are not designed to reimburse or guarantee coverage of program costs. Outside of separately justified seed funding, your organization bears full responsibility for program costs. HOPE is a voluntary, upside-only model, HSCRC cannot offset your costs if your program's net return is negative. Program cost accounting should be considered in your own ROI analysis but is not an HSCRC funding requirement.

- Supplies, materials, and equipment (and related medical-encounters)
- Staff salaries and benefits, space, utilities, overhead (including those used by all partners)
- Training and onboarding
- Evaluation and data collection
- Include both initial program costs *and* ongoing/continuing-care costs
- Start-up vs. steady-state costs: Year 1 is almost always more expensive, and it's best to distinguish one-time and recurring costs

Other Costs

Note: HSCRC reconciles savings against averted hospital costs in Case-Mix Data. The categories below are useful context for a societal-perspective case but are not what HOPE will validate or pay on. Include only if it strengthens your narrative; don't let it substitute for the required utilization outcome.

Non-Health Sector Costs

- Public agencies (e.g., social services, housing, law enforcement, transportation, income support)
- Voluntary sector (e.g., community organizations, hospice volunteers, peer support networks)

Patient/Family/Caregiver

- Out-of-pocket costs (e.g., travel, co-payments, home adaptations)
- Time costs (e.g., traveling, receiving care, and informal caregiver support at home)

Productivity Losses

- Time taken from work or leisure

Costs From Who's Viewpoint?

Possible points of view include those of society, federal government, state government, the department/agency providing the program, an employer, or the patient.

A different answer can be obtained depending on the viewpoint adopted

- For example, patients' travel costs are a cost from the patient's point of view and from society's point of view, but not a cost from the health department's point of view.

Note: For HOPE, the perspective that matters is the hospital/all-payer perspective under Maryland's Case-Mix Data. Keep this in mind before investing time building out other viewpoints for your application.

Imputing Values for Non-Market Items

Note: Imputed non-market values below matter for a societal ROI case, but HOPE payments are driven by averted hospital costs in Case-Mix Data — don't substitute these for your required utilization/cost outcomes.

General principle is to default to U.S. government standards and practices to make assumptions easier to defend

- ***Volunteer time*** – "what would it cost to *replace* that volunteer with a paid worker?"
  - Could match the BLS occupational wage to the volunteer's role (see example)
- ***Caregiver time*** – same principle but retired or unemployed caregivers may complicate the choice.
- ***Patient/family leisure time*** – once could argue for zero, average earnings, or overtime rates.
- ***Personal transportation costs*** - IRS/government mileage reimbursement rate for personal vehicle use or average transit fares for public transportation users

Example: A mental health peer support program relies on volunteer counselors. You could use the BLS Occupational Employment and Wage Statistics (OEWS) median hourly wage for *Substance Abuse, Behavioral Disorder, and Mental Health Counselors*, which was approximately $25/hour as of 2023. If each volunteer contributes 4 hours per session and the program runs 500 sessions annually, the imputed volunteer cost would be $50,000 per year.

Other Cost Considerations

- If the costs of two or more programs or treatments are being compared, costs common to all need not be considered as they will not affect the choice between programs.
  - Less data to collect and analyze can save a lot of work.
- If patients' costs are unlikely to change the decision between two program options, omitting them may be justified
- It is not worth investing a great deal of time and effort considering costs that are small and unlikely to change the result
- Document all assumptions, though

Short-Term vs Long-Term Savings

How HOPE Turns Savings Into Payment

RSI and CTF: Approved participants receive 50% of validated annual savings (i.e., "scored" savings). The approved annual payment is fixed for up to 3 years once set

- Example: validated annual savings of $5M → $2.5M/year for 3 years = $7.5M total

CTF: Interventions are scored at actual averted hospital costs, or 125% of projected averted costs, whichever is lower

- Minimum savings rate is 50%: If actual results fall below 50% of projected savings, scored savings = $0 (no partial credit)

Don't inflate your projection to chase a bigger number, over-projecting doesn't help once results are capped, and underdelivering risks zeroing out your payment

Required Utilization Outcome

- Your Savings Methodology Template must report at least one utilization outcome, else your savings methodology cannot be reconciled against Maryland Case-Mix Data and cannot be scored
  - **Examples:** all-cause inpatient admissions per 1,000 attributed patients; disease-specific inpatient admissions; 30-day all-cause readmission rate; ED visits per 1,000 attributed patients; observation stays per 1,000 attributed patients
- Clinical/functional outcomes (e.g., CAT score, PAM-13, exacerbation frequency) are optional; they strengthen your case but don't substitute for the utilization outcome
- Strong responses are specific and pre-committed: name the exact metric, data source, expected magnitude, and time horizon.

Short-Term vs Long-Term Savings

- A public health program costs money *now* but delivers savings over *years*.
- Short-term savings (0–3 years) are tied to near-term utilization changes (e.g., fewer ED visits, fewer hospitalizations)
  - Easier to measure, closer to program activities, more credible to skeptical audiences (e.g., hypertension management program reduces ER visits in year 1)
  - HOPE pays out for 3 years once approved – your savings methodology should demonstrate impact within that window
- Long-term savings (4+ years) often require modeling and assumptions, not direct measurement.
  - Disease prevention, delayed onset, reduced complications — valuable context, but won't be scored as validated savings within your 3-year window

Net Present Value

You can't simply add up future savings without accounting for the time difference; a dollar saved in the future is worth less than a dollar saved today.

- Standard discount rate is 3% (USPSTF / OMB guidance)

The **Net Present Value (NPV)** formula converts all future savings into today's dollars, so you can compare them directly against your upfront program cost.

- Each year's savings is divided by a discount factor that grows with time; then program costs are subtracted
- *NPV = (Year 1 Savings ÷ 1.03) + (Year 2 Savings ÷ 1.03^2) + … + (Year N Savings ÷ 1.03^N) − Total Program Cost*

Analysis

Setting Up Your Analysis

Step 1	**Define the program clearly** – Who does it serve? What does it do? Over what period?
Step 2	**Identify your comparison group (counterfactual)** – What happens without the program?
Step 3	**Identify your costs / select your outcomes** – Which outcomes will change?
Step 4	**Find unit cost estimates** – Use real-world data or published reference values
Step 5	**Estimate effect size** – Use your own data if available; otherwise use literature-based estimates with citation
Step 6	**Apply attribution** – What fraction of the outcome change is due to your program versus other factors? Attribution factor is typically 25–50% for conservative estimates.
Step 7	**Calculate gross savings, subtract program costs, report net savings and ROI**
Step 8	**Conduct a sensitivity analysis** – What if your effect size is halved, you double the cost, or reduce the attribution factor? Does the program still generate net savings?

Hypothetical: Hypertension Management Program

- **Program:** Community health worker outreach + home BP monitoring for 200 high-risk adults, 12 months, cost = $180,000
- **Required Utilization Outcome:** Hypertension-related ED visits, per 1,000 attributed patients – baseline 400/1,000 (Maryland Case-Mix Data), target 280/1,000 (30% reduction) at 12 months post-enrollment.
  - Target grounded in published reductions of 25–35% from comparable CHW/home-monitoring hypertension programs (made up, cite your specific sources)
  - Expected visits without program: 200 × 0.4 = 80 ED visits
  - Visits avoided (30% reduction): 24 ED visits
  - Average ED visit cost (Maryland): $2,200
  - Gross savings: 24 × 2,200 = $**52,800**
- **RSI/CTF Scoring**: 50% of scored savings – gross utilization savings alone don't cover the $180,000 cost in Year 1. The applicant should consider including either a larger population/region or a companion clinical/functional outcome to strengthen the case.
- **CTF Scoring:** Scored at actual averted costs or 125% of projection, whichever is lower; if actuals fall below 50% of projected ($26,400), scored savings = $0

TCOC Workgroup Next Steps

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
  - September 23
    - Meeting Agenda TBD
  - 2026 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage

Thank You
Next Meeting September 23, 8-10 am

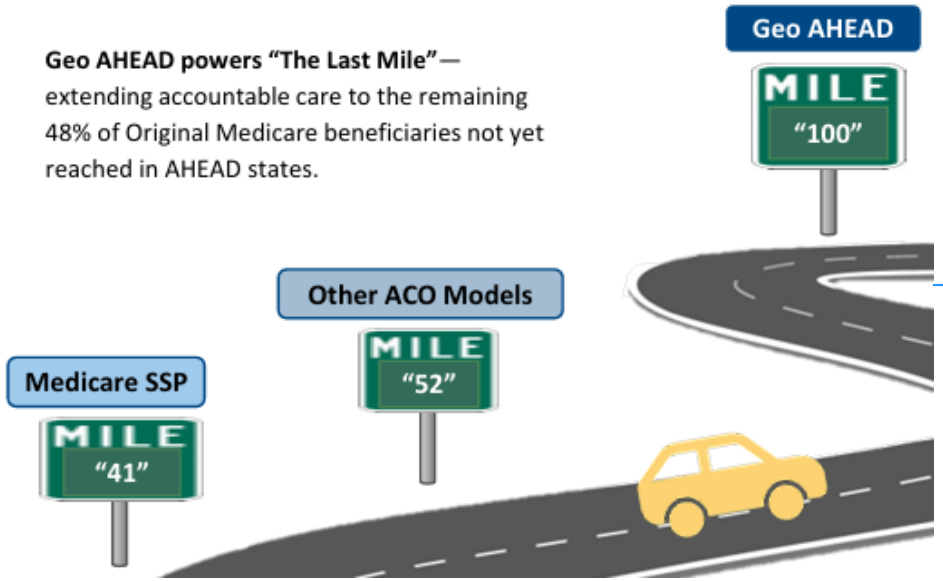
Appendix

Geo AHEAD Overview

Geo AHEAD is a geographically-based ACO program administered by CMMI over two contract periods:

- January 1, 2028, to December 31, 2031
- January 1, 2032, to December 31, 2035

Geo AHEAD powers "The Last Mile"— extending accountable care to the remaining 48% of Original Medicare beneficiaries not yet reached in AHEAD states.



Voluntary Attribution

- Prioritize beneficiary choice by attributing beneficiaries with a Geo Participant as their primary or main clinician.
- Supersedes claims-based and geographic attribution.

Claims-based Attribution

- Attribute beneficiaries who receive key services from a Geo Participant.
- Attribute beneficiaries who receive a plurality of primary care qualified evaluation and management (PQEM) services from a Geo Participant.

Geographic Attribution[2]

- Attribute beneficiaries who have a care relationship with a Geo Affiliate.
- Attribute beneficiaries who have a household member who receives care from a primary care Geo Participant.
- Attribute remaining beneficiaries based on weighted random geographic attribution.

**All PC AHEAD-attributed beneficiaries will be geographically attributed.*

Reflects information copied from documents shared by CMMI as of August 25, 2026

Role: Geo Entity (GE)

- Includes provider-led organizations, technology/digital health companies, health plans, hospitals, or other entities
- Eligible for shared savings if they remain below the competitively bid TCOC target and meet quality goals

Criteria for Selection

Domain	Description
Compliance Infrastructure	Demonstrated organizational readiness to meet regulatory compliance and governance structure requirements, including in cases when deploying technology safely at scale.
Financial Soundness & Benchmark Alignment	Bid discount and savings trajectory based on transparent pricing assumptions, beneficiary-specific risk mitigation, and, as appropriate, technology-enabled efficiency.
Population Health Strategy and Preparedness	Demonstrated strategies for targeting high-needs populations using evidence-based care transformation approaches, innovative technology, and/or interoperable data infrastructures aligned to population health needs and goals.
Care Navigation Infrastructure	Breadth and depth of safe and secure technology, tools, and/or care delivery partnerships to connect beneficiaries to high-value care, including operational alignment and engagement of HGB Hospitals and PC AHEAD practices.
Beneficiary Protections & Experience	Beneficiary engagement, through technology or other approaches, communication, and safeguards that support consumer experience, commitment, and choice protections.

Types of Geo Entities

Substate Division Geo Entity

- Provider-led organization
- Can bid on AHEAD state or substate division(s),
- CMS will set aside one award in each state/substate region or substate division for a provider-led Geo Entity

Statewide Geo Entity

- Organization such as a provider-led organization, health plan, or technology and digital health company
- Expected but not required that any non provider-led Geo Entities include providers

- CMS will select at least 3 GE's
- CMS will select at least 2 GE's per substate division

Other Roles

Medicare-enrolled providers?	Yes	Yes
Participate with only one Geo Entity?	Yes	No
Participate in other ACO Models with the same NPI?	Yes	No
Contribute to claims-based attribution?	Yes	No
Receive primary care capitated and PBPM payments through Geo Entity?	Yes	No
More responsibility (e.g., TCOC accountability, Medicaid Advanced PCP participation?	Yes	No
Eligible for shared savings and benefit enhancements through GE?	Yes	Yes

Non-Medicare-enrolled providers and organizations that provide supportive services, can share in savings

Reflects information copied from documents shared by CMMI as of August 25, 2026

Payment

CMS funds Geo Entities through multiple mechanisms, including:

PC capitation (replacing traditional Medicare FFS)

Enhanced Primary Care Payments (EPCP) for care management

Shared savings based on TCOC performance against a CMS-established benchmark*

- Geo Entities do not receive PC capitation or EPCP for geographically attributed beneficiaries.
- Geo Entities without broad delivery systems may focus on platforms that inform beneficiaries of lower-cost/higher-quality care options and assist with lifestyle changes
- Geo Entities are encouraged to engage geographically attributed beneficiaries so that they elect to be attributed; Geo Entities may enroll as Medicare Part B suppliers in order to do so.
- Geo Affiliates who also participate in PC AHEAD will receive PC capitation and EPCP through PC AHEAD implementation (i.e., not through the Geo Entity)

*Subject to risk corridors (CMS absorbs a larger financial share as savings/losses grow), which may differ based on factors such as the Geo Entity because provider-led, or new to risk-bearing.

$$\textit{Shared Savings or Losses} = [(\textit{TCOC Benchmark} \times (1 - \textit{Discount Factor}) - \textit{Actual PY TCOC})] \times \textit{Quality Adjustment Factor}$$

Geo Entities bid a percent discount or a flat discount in their application

Includes PC AHEAD capitation, HGB AHEAD, and other model FFS and NCB payments. EPCP is excluded.

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