maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

February 18, 2026

Agenda

- Healthcare Outcome Payment Effort
  - Overview
  - Comment Letters
  - FAQ
  - Keys Areas of Consideration
- Next Steps & Upcoming Meetings

Healthcare Outcome Payment Effort

Goals and Key Principles

- Align with AHEAD's goal to **drive state and regional health care transformation** to improve the total health of a state's population while lowering costs.
- Offer **clarity for hospitals** and others about return on investments to prevent illness and accompanying utilization.
- **Build on progress** to date in CTIs and PAU policy.
- Increase the **predictability of payments** for planning purposes.
- Become an **outcome buyer of successful projects**
  - Where needed upfront funds to be provided by philanthropy, hospital funds, other state funds, HSCRC care innovation awards, among other sources.

Funding

- Voluntary, upside only.
- Hospital receives **50%** of the measured savings. Statewide and Regional Initiatives receive **30%** of the measured savings.
- This gives hospitals an opportunity to offset prior PAU reductions. Given the large cumulative amount of PAU reductions to date Staff believe the full amount should not be available for recovery.
- Payment made would be considered in evaluating update factor appropriateness.

New Care Transformation Framework

- Replaces the CTI program which will end in FY26.
- Hospitals define populations, implement interventions that are qualified for the program in advance, and demonstrate reduced ER and hospital expenditures.
- Hospitals can then receive a portion of savings generated for a fixed future period to continue the work.
- Medicare-only for FY27 as we develop review and process for all-payer opportunities.

Regional and Statewide Initiatives

- Rewards statewide and regional innovations that reduce illness and accompanying hospital utilization.
- Each project addresses a specific population, with specific targets for reduced hospital utilization.
- Each project, if successful, would be able to claim a portion of the savings for a fixed future period to continue the work.
- Each project would be reviewed, qualified in advance, and endorsed by a vote of the Commission.
- Some of these projects may relate to AHEAD opportunities to move savings forward.
- Plan is to pilot this path with a small number of projects starting in FY27.

Rollover CTI Overview

Goal:

- Identify existing CTIs that have demonstrated substantial savings in each performance year above the target price and allow them to be a **rollover** CTI (automatically qualified) for FY27.
  - Demonstration of savings will be based on a set of criteria that establish substantial total savings and savings per episode targets.

Illustrative Data:

- Performance years 1 – 3 (July 2021 – June 2024)
  - Overall performance by CTI (e.g., total savings) for each performance year
  - Baseline and performance episode-level data
  - Data will be re-evaluated to uses years 2-4 once available

Longer Term - Phased Implementation Timeline 2026-2028

- FY 2026 — No Changes. CTIs end June 30,2026.
- FY 2027 — Transition Year
  - Measurement will begin for **All-Payer Initiatives and State and Regional Initiatives**.
    - Given time frames, measurement period may be shortened
  - Payment will begin for **Medicare-Only Qualified Initiatives** on July 1, 2026.
- FY 2028 — All-Payer Transition Year

Healthcare Outcome Payment Effort – Comment Letter Summary

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Comment Letters Recap

- Comment Letters Received from:
  - Adventist HealthCare
  - Audacious Capital
  - Baltimore Comprehensive Overdose Response to End the Epidemic (BCORE)
  - The Day Clinic
  - Greater Baltimore Medical Center
  - Johns Hopkins Health System
  - Johns Hopkins School of Nursing
  - LifeBridge Health
  - Maryland Citizens' Health Initiative and United States of Care
  - Maryland Hospital Association
  - MedStar Health
  - Primary Care Coalition
  - University of Maryland Medical System

Common Themes

- Measurement & methodology clarity (9 organizations)
- AHEAD alignment & long-term population health strategy (6 organizations)
- Funding structure & financial impact (6 organizations)
- All-payer implementation (5 organizations)
- CTI rollover & transition concerns (5 organizations)

Areas of Broad Consensus

- Alignment with AHEAD transformation goals
- Desire to maintain momentum from CTI
- Need for clearer methodology and transparency
- Importance of functioning in an all-payer environment

Funding Structure & Financial Impact

- Source and long-term sustainability of funding (MHA, UMMS)
- Impact of HOPE payments on the update factor (MHA, JHHS, UMMS)
- Whether total funding will be capped (MHA)
- Need for prospective, predictable financing (UMMS)
- Concern about funding shared savings through the hospital update factor rather than a predefined funding pool (Adventist, MedStar)
- Questions about impact on inflationary and demographic adjustments if funded through the update factor (Adventist)
- Objection to uncapped shared savings for third parties funded through the update factor (MedStar)
- Support for a voluntary, upside-only structure (GBMC, JHHS, Audacious Capital, Adventist)
- Concern about duplicative payments due to overlapping CTI and HOPE timelines (LifeBridge)

All-Payer Scope & Medicare Inclusion

- How HOPE will operate in an all-payer environment in FY 2028 (MHA, JHHS)
- Need for Medicare inclusion to make the model viable (The Day Clinic, UMMS)
- Questions about access to commercial claims data (MHA)
- Concern that limiting to inpatient/ED data narrows scope (JHHS)
- Questions about how a Medicare-focused design translates into an all-payer framework (Adventist)
- Concern that Medicaid must align with Medicare savings methodology, limiting feasibility (LifeBridge)
- Concern that CMS has not approved CTI within Medicare global budgets and is instead implementing GeoAHEAD (LifeBridge)
- Operational complexity as Medicare global budgets transition out of HSCRC authority in CY2028 (LifeBridge)
- Emphasis on close alignment with Medicare frameworks to reduce administrative burden and avoid conflicting incentives (LifeBridge)
- Request to evaluate long-term alignment with evolving federal AHEAD methodologies (Adventist)
- Suggestion to pause or sunset legacy CTI programs to reduce duplication and administrative burden (Adventist, LifeBridge)

Measurement and Methodology

- Concerns about two-year measurement window being too short (JH School of Nursing, GBMC)
- Desire to measure TCOC rather than only hospital utilization (UMMS)
- Concern that current approach shifts from improvement to peer comparison (UMMS)
- Need for better risk adjustment and data transparency (Audacious Capital)
- Concerns about data granularity (ZIP-code level too broad) (JH School of Nursing)
- Two-year savings window undermines prevention (JH School of Nursing)
- Questions about how hospital-specific savings will be measured (Adventist)
- Concern that modest savings may be offset by large geographic CTIs (LifeBridge)
- Fairness concerns for high-performing regions (Adventist)

CTI Rollover & Transition From Existing Programs

- Rationale for CTI rollover criteria (MHA)
- Need to preserve infrastructure and NPIs (GBMC)
- Concern rollover favors large, high-volume populations (UMMS)
- Maintain strengths of CTI while expanding participation (Audacious Capital)
- Eligibility limitations that could exclude newer initiatives beginning in or after FY2025 (Adventist, LifeBridge, GBMC)
- Support for rollover of high-performing, established CTIs into new framework (MedStar)

State & Regional Initiatives

- Rationale for savings distribution percentages – 50% vs. 30%– consider increasing (MHA, The Day Clinic)
- Need for upfront capital for non-hospital efforts (The Day Clinic)
- Interest in scaling community-based, behavioral health, and chronic care models (Audacious Capital)
- Clarification on eligibility of non-hospital organizations (MHA)
- Questions regarding which entities are eligible to apply (Adventist)
- Strong opposition to excluding hospitals/health systems from serving as anchor entities in regional collaboratives (MedStar)

Alignment With AHEAD & Broader Population Health Strategy

- Alignment with AHEAD Population Health Accountability Plan (MHA, JHHS, UMMS)
- Shift toward prevention and restorative health (JH School of Nursing)
- Move beyond hospital-centered programs (JH School of Nursing)
- Comprehensive review and coordination of overlapping programs – EQIP/ECIP (MHA)
- Patient-first reforms and beneficiary affordability (Maryland Healthcare for All)

Consumer & Beneficiary Engagement

- Prioritize beneficiary input and consumer engagement (Maryland Citizens' Health Initiative and United States of Care)
- Prioritize affordability alongside cost containment (Maryland Citizens' Health Initiative and United States of Care)

Program Timeline & Implementation

- Timeline too aggressive (GBMC)
- Need structured ECIP transition (GBMC, UMMS)
- Recommendation to sunset CTI after FY27 and not implement HOPE (LifeBridge)

Governance & Transparency

- Request for formal draft policy and public comment process before final adoption (Adventist)
- Requests for clarity on technical review panel selection and eligiblity and conflict-of-interest safeguards (Adventist, MHA))
- Request for transparent decision-making standards (Adventist)
- Support for expert review panel but request for members with practical care transformation experience (MedStar)
- Need for clear, transparent savings methodology (JHHS, Audacious Capital, MHA)

Frequently Asked Question Topics

- Program Overlaps and Transitions
  - HSCRC will create an overlaps document outlining how HOPE overlaps with existing programs.
  - Acknowledge that there are questions and concerns about ending of ECIP 12/31/26 and what that transition looks like.
- Review Panel/Criteria
  - There will be a formal process for deciding who will be on the panel and criteria will be developed for qualifying initiatives. More information will be shared in the next two weeks.
- Draft Policy Recommendation
  - Draft policy will go to the Commission in March.
  - Workgroup will be able to comment during the public comment period.
  - Final policy due to the Commission in April.
- Program Eligibility
  - Hospitals are eligible for Care Transformation Framework. Hospitals and non-hospitals entities (ex. provider-led organizations, technology/digital health companies, health plans, community organization) can participate in the State & Regional Initiatives. Preference is for the non-hospital entity to be the applicant.
    - State & Regional Initiative partners must have an MOU or contractual agreement in place that outlines how they will work together and funds will be distributed.
- Rollover CTI Criteria
  - HSCRC will allow hospitals to propose how to frame CTIs they want to use for consideration as a rollover CTI for FY27.
  - HSCRC will release specific guidance in the coming weeks.

Key Areas of Consideration

- Timeline
- All-Payer Scope
- Funding/Update Factor
- Funding Levels for Community Initiatives
- Timing Windows for Measuring Savings

Appendix – Comment Letters

Comment Letters Recap contd.

- Adventist HealthCare
  - Program Design and Funding: Requests input on how HSCRC will ensure the update factor continues to fulfil its core purpose of supporting inflation and demographic change if outcome payments are funding through the update factor. Requests input if funding from an all-payer update mechanism create cross-subsidization concerns. Requests input on hospitals savings contribution scoring separately from broader system savings to ensure aligning between update factor funding and policy.
  - Incentive Structure and Equity: Requests more info behind improvement-only without attainment structure, rollover eligibility for newer interventions, and risk of reinforcing low utilization driven by medically necessary care access constraints.
  - Scope Alignment with Federal Frameworks: Requests more information on the all-payer structure, alignment with Geo AHEAD and federal methodologies, and considerations for sunsetting legacy CTI structures.
  - Governance, Process, and Transparency: Requests more information on technical review panel, formal draft policy for public comment prior to Commission action, and transparency standards.
  - Regional and Statewide Initiative Structure: Requests more information on HSCRC assessment of projected impact, upfront investment costs, savings distribution methodology, applications leads, and savings measurements reflecting intent-to-treat populations.

Comment Letters Recap contd.

- Audacious Capital
  - States continued innovation under HOPE positions the state to align with evolving federal models while exporting successful approaches beyond its borders.
  - States Maryland can scale what already works, including the following opportunity areas meriting continued focus:
    - Leveraging statewide encounter data and post-acute performance tools to strengthen transitions of care, reduce avoidable readmissions, and lower emergency department utilization.
    - Scaling high-performing care management programs for patients with complex chronic conditions and frequent hospital utilization.
    - Expanding behavioral health crisis response and community-based alternatives to emergency department utilization through coordinated regional approaches.
  - Design considerations for HOPE:
    - States clear measurement frameworks, rigorous risk adjustment, and transparent savings methodologies will support participation and investment while ensuring fairness across systems serving diverse populations.
    - States rapid scaling of successful pilots will allow benefits to be realized statewide more quickly.
    - Proposes shortened performance feedback loops. Prior HSCRC programs relied on long measurement cycles that are difficult for health system leadership to actively manage toward targets.
    - Proposes more frequent reporting and interim performance signals.

Comment Letters Recap contd.

- BCORE
  - Community-initiated programs require startup funds: Proposes the commission to continue to provide such funds through programs such as New Paradigms in Care Delivery.
  - All-payer approach is essential: States limiting the payer base for the purposes of calculating shared savings will greatly underestimate the true health economic impact of programs targeted at managing and mitigating chronic disease.
  - Align the incentives of community-based initiatives with those of the state's hospitals and health systems: States misaligned incentives, or a diminishment of the rewards available to particular components of the system, threaten the landscape for innovation.

Comment Letters Recap contd.

- The Day Clinic
  - All-Payer Inclusion: Proposes including Medicare in the payment model is integral to success.
  - Regional Initiative Savings Participation: Encourages exploring setting the savings participation at 50% as aligning the payment model with investment will increase changes of success.
  - Start-Up Funding: States upfront funding for regional initiatives will be important to get initiatives off the ground (similar to NPCD type funding).
  - Performance Payment Timing: Proposes considering a year 2 payment based on year 1 performance that can then be reconciled as necessary based on claims run-outs or other adjustments, as these efforts may have limited working capital to fund operations and waiting 2 years could create operational cash flow challenges.

Comment Letters Recap contd.

- GBMC
  - CTI Rollover Criteria: States proposed CTI rollover criteria may be overly stringent as transformation work of this scale often requires a multi-year runway before savings stabilize and become statistically visible. Requests consideration of more recent, performance-optimized CTIs for rollover to preserve program momentum and protect prior infrastructure investments.
  - NPI Stability and Minimal Savings Rate Risk: States concerns regarding the loss of attributed NPIs if older-year CTIs are prioritized. Provider composition shifts annually and a structure that inadvertently reduces stability may unintentionally penalize otherwise effective clinical transformation efforts.
  - ECIP Transition and Preserving Savings: Proposes consideration of a structured transition pathway for high-performing ECIP initiatives so that successful care redesign efforts are not discontinued due to programmatic restructuring.
  - Program Development Timeline: States concern of proposed timeline for finalizing and operationalizing the new program. Requests that program clarity and structural stability be prioritized over speed of implementation. States appreciation for pursuing an upside-only model and the decision not to include a 2% offset in FY2027.

Comment Letters Recap contd.

- Johns Hopkins Health System
  - Supports the voluntary and upside-only approach: Encourages the HSCRC to preserve it as the framework is finalized.
  - Concerned about the proposed treatment of the outcome payments in the context of the annual update factor: States incorporating the outcome payments into the model should not take dollars away from some hospitals in order to reward others through any mechanism.
  - Looks forward to further detail about implementation into an all-payer environment: States limiting only to inpatient and emergency department data will narrow the scope and potential to measure the impact of meaningful efforts across the care continuum.
  - Supports the intent of the program and looks forward to further detail around savings and measurement methodology.

Comment Letters Recap contd.

- Johns Hopkins Schools of Nursing
  - Program Timeline: States calculating savings using two years as the measurement period for savings will capture short term impact on utilization but will not reflect prevention strategies that support health and well-being over the medium to long term. Proposes HSCRC to consider how it could evolve the program, particularly for new participants in later years, to incentivize approaches that shift the system toward prevention and restorative health so that hospitals can focus on appropriate utilization. Also, encourages consideration of layering outcome measures on the savings targets to determine payouts.
  - Outcome Measurements: States supporting localized interventions that offer longer term gains will also require measurable population-level outcomes at meaningfully smaller spatial scales than are currently available to program evaluators.

Comment Letters Recap contd.

- LifeBridge Health
  - Recommends sunsetting CTI program after FY 2027 and not implementing the healthcare outcome payment effort program due to the growing operations complexities that will emerge once Medicare global budgets transition out of HSCRC authority. Supports establishing a final payout model that allocates a defined share of positive savings while considering Medicare TCOC requirements under the AHEAD model.
  - Proposes implementing the final CTI payout for FY 2027 through a defined percentage of upside-only payments.
  - States HSCRC payment programs should align with Medicare methods and requirements instead of creating duplicative work and administrative burden.
  - States concern over program limiting eligibility to CTIs with multi-year consistent savings – penalizing hospitals investing in innovative care-management strategies.

Comment Letters Recap contd.

- Maryland Citizens' Health Initiative and United States of Care
  - Encourages incorporating the unique needs of beneficiaries through “patient-first care” during program design by:
    - Hosting listening sessions with beneficiaries to ensure consumer input
    - Consider previous recommendations that have prioritized beneficiaries
    - Promote beneficiary affordability

Comment Letters Recap contd.

- MHA
  - Source of Funding: Requests clarification on how program will be funded in the near term and long term including: impact on annual payment update; impact on hospitals that do not have qualifying rollover CTIs; capping of rewards; funding structure operationalize with CMS Medicare hospital global budgets; and funding for non-Medicare payers through HSCRC-administered hospital global budgets.
  - New Care Transformation Framework: Requests clarification on rationale for selecting the proposed rollover CTI criteria and how the criteria considers new initiatives that show promise but are yet to demonstrate savings.
  - Regional and Statewide Initiatives: MHA seeks further detail on: assessing potential impact of new interventions; upfront investment costs; savings distributions; application lead; eligibility of nonhospital organizations; and savings measurement.
  - Technical Panel: Requests further information on technical panel eligibility, criteria, and HSCRC processes to ensure transparency in panel decisions.
  - All-Payer Evaluation Data: Requests details on HSCRC's plan to obtain commercial claims information to support the all-payer approach being contemplated.
  - Comprehensive Population Health Strategy: Urges a review of all HSCRC-led hospital population health programs to identify needed changes and alignment with AHEAD statewide Population Health Accountability Plan.

Comment Letters Recap contd.

- MedStar Health
  - Program Governance: Requests more information on technical review panel and states need for individuals with experience in operationalize care transformation programs to be involved.
  - Financial Structure: Supports fixed payments for earned savings. Requests transparent allocation of funds for payments and recommends payments for savings be guaranteed as a share of a prespecified available funding amount that is transparently developed.
  - Rollover CTIs: Supports current plan.
  - Regional Collaboratives: States proposed regional structure should not exclude hospitals and/or health systems from being the anchor entity. Also, strongly opposes to the funding of shared savings via update factor as funding in an uncapped fashion would be destabilizing.

Comment Letters Recap contd.

- Primary Care Coalition
  - Suggests setting the statewide and regional initiatives to 50% of measured savings as well.
  - Encourages allowing multiple hospitals to participate in a single new care transformation framework to offer the efficiency of shared initiatives while measuring individual hospital performance.
  - Requests clarification on Medicare only limitations for statewide and regional initiatives in FY 2027. Suggests additional inclusion of Medicaid and Self-Pay.

Comment Letters Recap contd.

- University of Maryland Medical System
  - Suggests continuing to define intent-to-treat populations and measure TCOC.
  - Suggests shared savings structure should build from a recognition of TCOC growth and lower hospital charge benefits currently provided to payers.
  - Suggests required all-payer engagement to fill ACOS and commercial value-based gaps in MD.
  - Suggests financing through hospital rate controls and identifying max annual pool with room for growth.
  - Encourages HSCRC to commit to a ceiling or pool of investment developed with the industry to transform under AHEAD and sustain hospital transformation.
  - States moving from TCOC to only potentially avoidable utilization in the hospital setting will regress from Model's progress.
  - Discourages HSCRC from duplicating investments in primary care.
  - Concerns regarding proposed rollover methodology for FY2027.
  - Urges HSCRC to extend ECIP through December 31, 2026.