maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

February 25, 2026

Agenda

- Healthcare Outcome Payment Effort
- Savings Analysis
- Next Steps & Upcoming Meetings

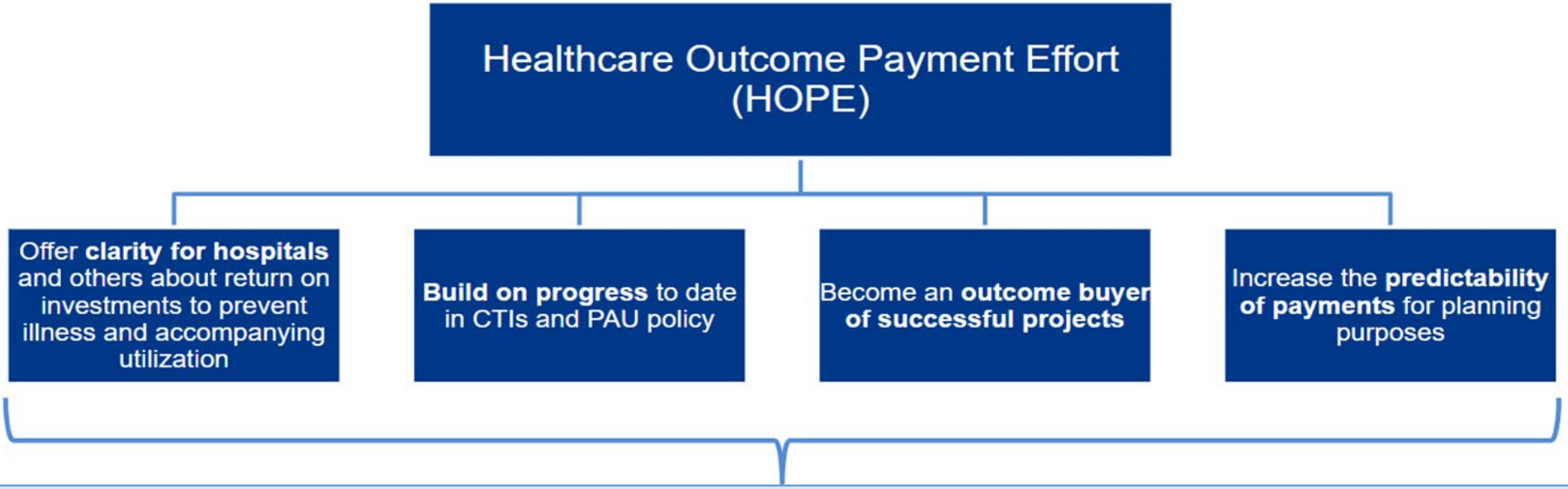
Healthcare Outcome Payment Effort

Agenda

- Framework
- Timeline
- Looking Ahead
- Paths to Participation
- Paths to Participation Detail
- Funding and Savings Measurement
- All-payer Scope & Medicare Inclusion
- Review Committee
- Review Criteria
- Interactions with Other HSCRC Programs and Policies
- Funding Approach

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.



Achieving Healthcare Efficiency through Accountable Design (AHEAD)
is designed to reward prevention, reduce unnecessary hospital utilization, and advance coordinated, statewide population health improvement. The model shifts care beyond hospitals toward prevention, primary care, and community-based services that address whole-person needs. Payer alignment under AHEAD reduces fragmentation, promotes value-based care, and supports sustainable cost growth while improving quality and overall population health.

Timeline

- February 2026
  - Review comments and present revised policy at 2/25 TCOC workgroup meeting
- March 2026
  - Draft Commission recommendation
  - Discuss program operationalization at TCOC workgroup meeting
  - Commission comment letters due on March 25th
- April 2026
  - Review Commission comment letters and discuss any revisions for final recommendation with TCOC workgroup
- May 2026
  - Final commission vote
- April - June 2026
  - Program buildout
- July 2026
  - Measurement period start July 1,2026
- Q2 FY2027
  - Reporting available

Looking Ahead

Two Paths to Participation

Care Transformation Framework (CTF)

- *Maryland Acute Hospitals*

Regional and Statewide Initiatives (RSI)

- *Coordinated by non-hospital organization*
- *Partner with one or more Maryland hospitals*
- *Must have regional scope*

Two Paths to Participation Detail

	Care Transformation Framework (CTF)	Regional & Statewide Initiatives (RSI)
Who Participates	Individual hospitals	Regional or statewide initiative with a hospital partner. The initiative which may include provider-led organizations, technology/digital health companies, health plans, community organization, etc. Regional and statewide Initiative partners must have an MOU or contractual agreement in place that outlines how they will work together and funds will be distributed.
Who Applies	Individual hospital or a group of hospitals	Preference is for the non-hospital entity to apply
Level of Intervention	Hospital-level, multiple hospitals could participate in the same intervention.	Regional or statewide – defined regional geography
Approval Process	Program qualification by review committee; no Commission vote required	Program qualification by review committee; Commission vote required
Focus of Work	Hospital-defined populations and interventions focused on reduced ER and inpatient expenditures.	Defined populations and interventions focused on reduced ER and inpatient expenditures.
Savings Model	Share of savings – 50%	Share of savings - 50%
Payout Approach	Average savings achieved over 2 year measurement window are paid out annually over a 3 year payment window.	Average savings achieved over 2 year measurement window are paid out annually over a 3 year payment window.
Payer scope	All-payer beginning FY28, Medicare participation is a goal but TBD	All-payer beginning FY28, Medicare Participation is a goal but TBD

Funding and Savings Measurement

- **Funding**
  - This is not funded through the update factor.
  - Shared savings payments are capped at $50M and are paid regardless of position on the savings test.

- **Participation and Payment Model:**
  - Voluntary, upside-only shared savings model with no downside risk.

- **Shared Savings Distribution:**
  - Average savings achieved over a three year payment window.
  - Hospitals and Statewide and Regional Initiative partners receive 50% of measured savings.

- **Savings Measurement:**
  - Payment levels based on two years of statistically reliable, validated savings performance.
  - Calculated using all-payer claims data.
  - Initially limited to inpatient and emergency department spending.

All-Payer Scope & Medicare Inclusion

- **Goal is for HOPE to operate effectively in an all-payer environment by FY2028.**

- **Medicare participation**
  - HSCRC agrees that Medicare participation is important and will work with CMS to include.
  - HSCRC is committed to this effort even without Medicare

- **Ensure access to comprehensive claims data**
  - Intend to use case-mix to operationalize HOPE or non-Medicare payers in FY28.
  - Limits data to inpatient and ED
  - Interested in working with commercial payers - goal for FY29 and future program years

Review Committee

Committee Members

- Public-private review committee assesses and qualifies interventions and communicates guidance to encourage high-quality submissions.
- Leverage practical expertise by including panel members with hands-on care transformation experience to ensure recommendations are actionable.

Governmental

- 1 HSCRC staff (co-chair)
- 1 MDH staff
- 1 staff from MHCC or CHRC

Non-governmental

- 3 experts in health care transformation or community health
- 1 appointed co-chair

Review Criteria

In assessing applications, the panel will ensure that submissions reflect meaningful and well-designed interventions and that the qualified initiatives are a balance of opportunities across the state given the specific challenges of each region. Specifically, proposals must demonstrate that they:

- are grounded in a strong evidence base;
- address a recognized State health priority;
- target a clearly defined population; and
- have a high likelihood of producing measurable impact that:
  - Improves health outcomes and advances equity for the selected patient population;
  - Achieves projected inpatient savings goals; and
  - Avoids adverse impacts on patient experience or total cost of care.

HSCRC Director makes the final decision on the recommendation of the review committee.

Interactions with other HSCRC Programs and Policies

- **New Paradigms in Care Delivery (NPCD)**
  - Funding can be used for up-front investments to support innovative care delivery initiatives.
- **Revenue for Reform (RfR)**
  - Cannot utilize the same initiative across RfR and this program.
- **Potentially Avoidable Utilization (PAU) Savings Policy**
  - Hospitals can recover dollars previously lost under the PAU framework, supporting reinvestment in care improvement.
- **Episode Care Improvement Program (ECIP)**
  - Ends December 31, 2026, with no savings offset for 7/1/26-12/31/26.
- **Episode Quality Improvement Program (EQIP)**
  - Participation in both is allowed.
- **Efficiency policy**
  - Payments should not count against hospitals in the efficiency policy.
- **Maryland Primary Care Program (MDPCP)**
  - Participation in both is allowed.

Funding Approach

Funding Approach

Care Transformation Framework

- **HSCRC seeks to balance 3 factors:**
  - Promoting continued efforts at care transformation
  - Payment predictability for hospitals
  - Affordable long-term cost growth management

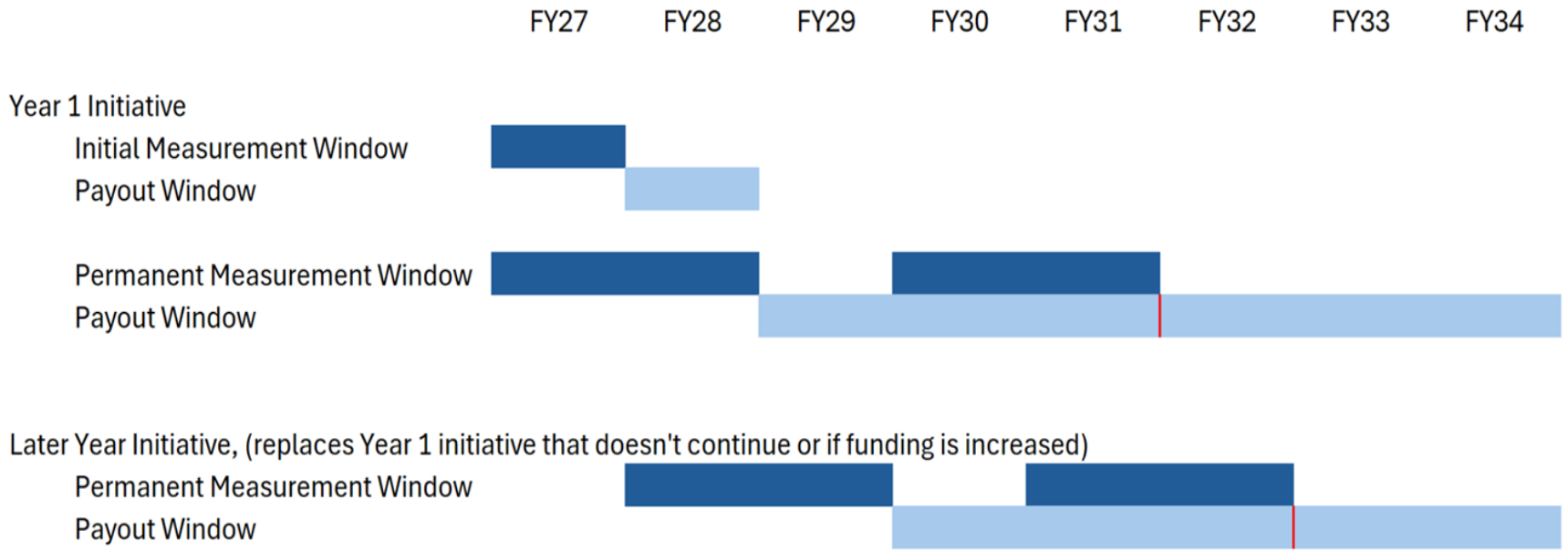
Regional and Statewide Initiatives - Funding approved individually by Commission.

- **Does not count in process on next slide.**

Funding Approach - Care Transformation Framework

- **Commission establishes now, a funding level for FY27, FY28 and FY29 of $50 M per year.**
- **Initiatives approved for the program by the Review Committee can not materially exceed projected savings of $100 M per year.**
  - Each initiative will be required to project total savings.
  - Projections will be independently validated by staff.
  - Baseline will be CY2025 for all initiatives in first year.
- **Payouts are made at the lesser of 50% of measured savings or the share that yields payouts no greater than $50 Million across successful initiatives.**
  - If measured savings = $150M then payout would be at 33%
  - If measured savings = $80M payout would still be at 50%
- **Commision commits to making earned payouts regardless of position on the relevant savings and affordability tests.**
- **Once set, payouts for individual initiatives are fixed for the following three years (see exception on next slide).**
- **Statewide funding level could be increased in subsequent years based on level of success.**

Payout and Measurement Schedule



Special 1 year measurement and 2028 payout during program startup.

No payouts in FY27 under schedule above, see transition year proposal on slide.

FY27 Transition Year Options

Goal was to provide continued support for care transformation infrastructure in the absence of an all-payer program measurement in FY27.

- Option 1: Original Approach - Establish payments based on a review of existing CTIs with only top performers receiving payments (CTI Rollover).
- Option 2: Potential Alternative - Make one-time payment spread proportional to GBRs to support care maintaining transformation infrastructure.
- Option 3: No FY27 payouts as CTI adjustments will still be paying out.

Further Questions/Comments for Consideration

- **Review Committee and Intervention Criteria**
  - Clarify and formalize technical review panel selection, eligibility, and conflict-of-interest safeguards to ensure transparency and fairness. Also clarify criteria and process for qualifying initiatives.
- **Savings measurement windows and timing (currently two-year validated savings window)**
  - Will it allow for demonstration of meaningful impacts?
  - Will it support long-term prevention efforts or favor short term gains?
- **Evaluation metrics (currently reduced ED and hospital expenditures)**
  - Expand beyond hospital utilization to include TCOC and broader population health outcomes.
  - Ensure methodology prioritizes improvement over peer comparison, maintaining focus on absolute gains and equitable outcomes across hospitals.
- **Savings calculations (using all-payer claims data)**
  - How are hospital-specific and regional savings calculated?
  - Do they account for modest contributions versus large geographic CTIs?
  - Do they protect high-performing regions from unintended disadvantage?
  - Consider enhancing risk adjustment and data granularity to allow fair comparisons, accurate savings measurement, and actionable insights at the population level.

Further detail/guidance will be provided during operationalization

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Drivers of Maryland FFS Medicare Savings

1H 2025 and Recap of Savings Since 2013

January 2026

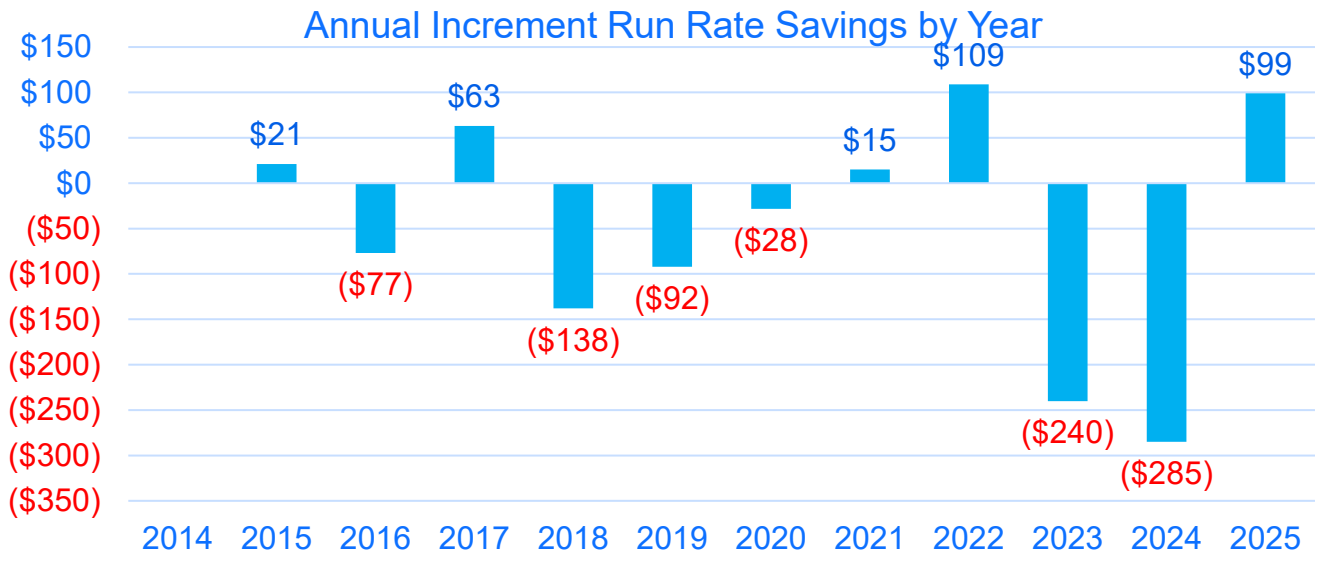
Presentation Context

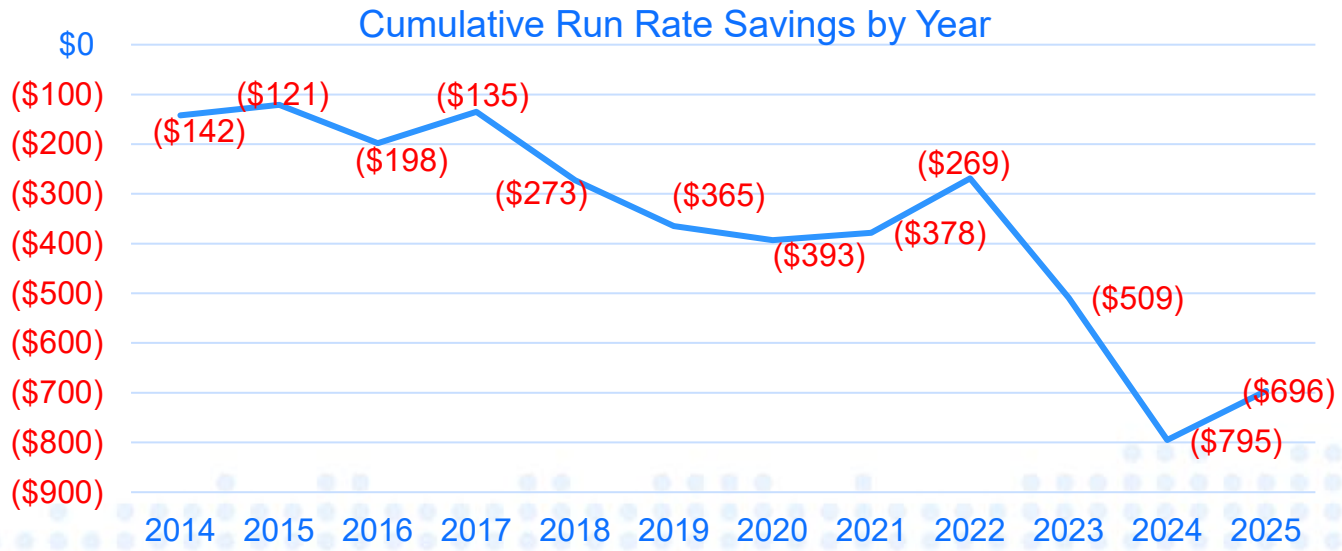
- Presentation displays update comparing previous years to the 1st half 2025 Maryland Medicare Total Cost of Care.
- Presentation focuses on four periods 2013 to 2019, 2019 to 2022, 2023 to 2024 and 2025
  - TCOC in 2020, 2021, and 2022 showed considerable volatility, complicating 2023 comparison.
    - In addition to the unusual conditions of the COVID public health emergency in 2020-2021
    - 2022 Base Year MD Hospital Costs had significant increases in Feb & March due to one-time recoupment of undercharges not expected to repeat in the second half of the year
    - 2023 Performance Year MD Hospital costs had several one-time reductions to the GBR as well as a 1% increase to the Public Payer Differential in April

Background

- Analysis reflects 1H 2025 with 3 months run out
- Analysis compares Maryland trend to US trend using the 5% national Medicare sample in each cost bucket and thus differs from the savings disclosed in Commission reporting
  - Effects of differences in relative shares of cost buckets between MD and National data is not shown
  - 5% sample differs from CMMI true national numbers used in overall scorekeeping
  - Non-Claims Based Payments are not included in 5% sample analyses and for mid-year summary, Non-Claims Based Payments are assumed to be the same as the prior year
- Comparison is to US total with no risk adjustment or modification - reflects overall scorekeeping approach under TCOC model
- Visit counts are based on a count of services and are intended as approximations
- Savings are reported as negative numbers – i.e. MD spending below the nation.

Run Rate (Savings) by Year, Official Scorekeeping





- Maryland's results have typically fluctuated by year for the first 5 years. 2019 was the first two-year gain in savings. Then Covid-19 impacts to utilization led to further volatility
- We significantly exceeded our run rate requirement from CMS in both 2023 and 2024 and have pulled back a bit in 2025.
- The source for the graphs are the CMMI national reporting data and will not tie to other slides in this presentation that use the 5% sample.
- Part C savings and Outcome Based Credits are included on this slide but excluded from subsequent slides.

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TCOC Savings, 2013 to 2019 vs 2019 to 2022 vs 2023 to 2024 vs 1H 2024 to 2025

	2013 to 2019, Average		2020 to 2022, Average		2023 to 2024, Average		2025 1st half	
	Average Run Rate (Savings) Cost $ M	% of Savings	Average Run Rate (Savings) Cost $ M	% of Savings	Run Rate (Savings) Cost $ M	% of Savings	Run Rate (Savings) Cost $ M	% of Savings
Inpatient Hospital	($37)	59%	$114	132%	($58)	26%	$57	43%
SNF	($6)	10%	$2	3%	($1)	0%	$8	6%
Home Health	$8	-12%	$1	1%	($6)	3%	($3)	-2%
Hospice	$3	-6%	($11)	-13%	($0)	0%	($3)	-2%
Total Part A	($31)	51%	$106	122%	($65)	29%	$59	45%
Outpatient Hospital	($59)	95%	($65)	-76%	($123)	55%	$14	11%
ESRD	($2)	4%	$6	7%	$3	-1%	$5	4%
Outpatient Other	($4)	6%	($2)	-3%	($7)	3%	($1)	-1%
Clinic	$0	0%	($1)	-2%	($2)	1%	($1)	-1%
Professional Claims	$34	-55%	$43	50%	($31)	13%	$56	42%
Total Part B	($31)	49%	($19)	-22%	($160)	71%	$73	55%
Total	($62)		$86		($225)		$132	

- The shift from savings to dissavings is fairly consistent across the board in the categories that have typically been major drivers of savings.

Note: amounts above reflect change in each individual bucket. Change in shares of total of each bucket would also impact overall savings. Amounts based on 5% sample data. CMMI total expenditure data show 2024 savings of $285 million.

Amounts may not add up due to rounding.

IP Savings, 2013 to 2019 vs 2020 to 2022 vs 2023 to 2024 vs 2025

	2013 to 2019, Average		2020 to 2022, Average		2023 to 2024, Average		2025 1st half	
	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US	Run Rate (Savings) Cost $ M	Growth Rate, MD vs US
Admits per K	($66)	-2.0%	$17	0.5%	($4)	-0.2%	$3	0.2%
Avg Case Mix Index	$44	0.2%	$34	0.2%	$16	0.4%	$17	0.1%
Cost per Day	($26)	-0.7%	$47	1.2%	($67)	-2.1%	$32	1.1%
ALOS (CMI Adj)	$11	1.6%	$10	0.9%	($4)	-0.1%	$4	0.6%
Mix Impact	$1		$6		$1		$1	
Total Inpatient	($37)		$114		($58)		$57	

- Cost per Day is driving savings fluctuations since 2022
- Admits per 1,000 was more volatile from 2013 to 2022 and a driver of savings/dissavings, but has recently followed national trends more closely

Note: amounts above reflect change in each individual bucket. Change in shares of total of each bucket would also impact overall savings. Amounts based on 5% sample data.

Amounts may not add up due to rounding.

Outpatient Facility Savings, 1st half 2025

IH 2024 to 2025 Cumulative (Savings) Costs $M		% of US Spend	MD Above (Below) National Compound Annual Growth Rate: Utilization	Unit Cost	Total	1st half 2025 (Savings) Cost, $M	% of Savings
($157.9)	Part B Rx	27.6%	-6.8%	8.1%	0.7%	$1.3	9.1%
($24.9)	Imaging	11.3%	-1.4%	5.3%	3.8%	$3.2	22.8%
($6.2)	Proc-Major Cardiology	9.4%	-5.8%	0.9%	-5.0%	($2.2)	-15.2%
($24.5)	Proc-Minor	7.3%	-1.6%	-0.5%	-2.1%	($1.1)	-7.4%
($41.1)	E&M - ER	6.8%	-1.1%	7.9%	6.7%	$3.8	26.9%
($6.4)	Proc-Major Orthopaedic	7.7%	-2.4%	2.3%	-0.2%	($0.1)	-0.4%
($0.2)	Proc-Major Other	5.8%	-6.1%	7.6%	0.9%	$0.3	2.3%
($6.4)	Proc-Endocrinology	4.9%	0.7%	0.9%	1.6%	$0.5	3.5%
$20.2	Lab	4.2%	3.2%	6.7%	10.1%	$8.1	56.6%
($33.0)	E&M - Other	4.7%	-6.6%	8.8%	1.5%	$1.1	7.5%
($9.9)	Proc-Ambulatory	3.9%	-1.9%	5.5%	3.6%	$1.2	8.1%
($16.3)	Proc-Oncology	3.1%	1.3%	2.5%	3.8%	$1.8	12.4%
$14.0	Other Professional	1.8%	3.4%	-39.2%	-37.1%	($61.9)	-434.2%
($4.4)	Proc-Eye	1.1%	-11.4%	4.8%	-7.1%	($0.4)	-2.8%
($16.7)	DME	0.4%	-4.3%	36.2%	30.4%	$15.7	109.9%
$0.3	Proc-Dialysis	0.0%	-20.1%	15.6%	-7.6%	($0.0)	-0.1%

- Other Professional, primarily driven by significant increase in National unit cost, is an outlier driver of savings. This will be something to keep an eye on as full year experience comes in to focus.

Note: amounts above reflect change in each individual bucket, mix impact of different shares of each bucket would also impact overall savings, also amounts represent 5% sample data.

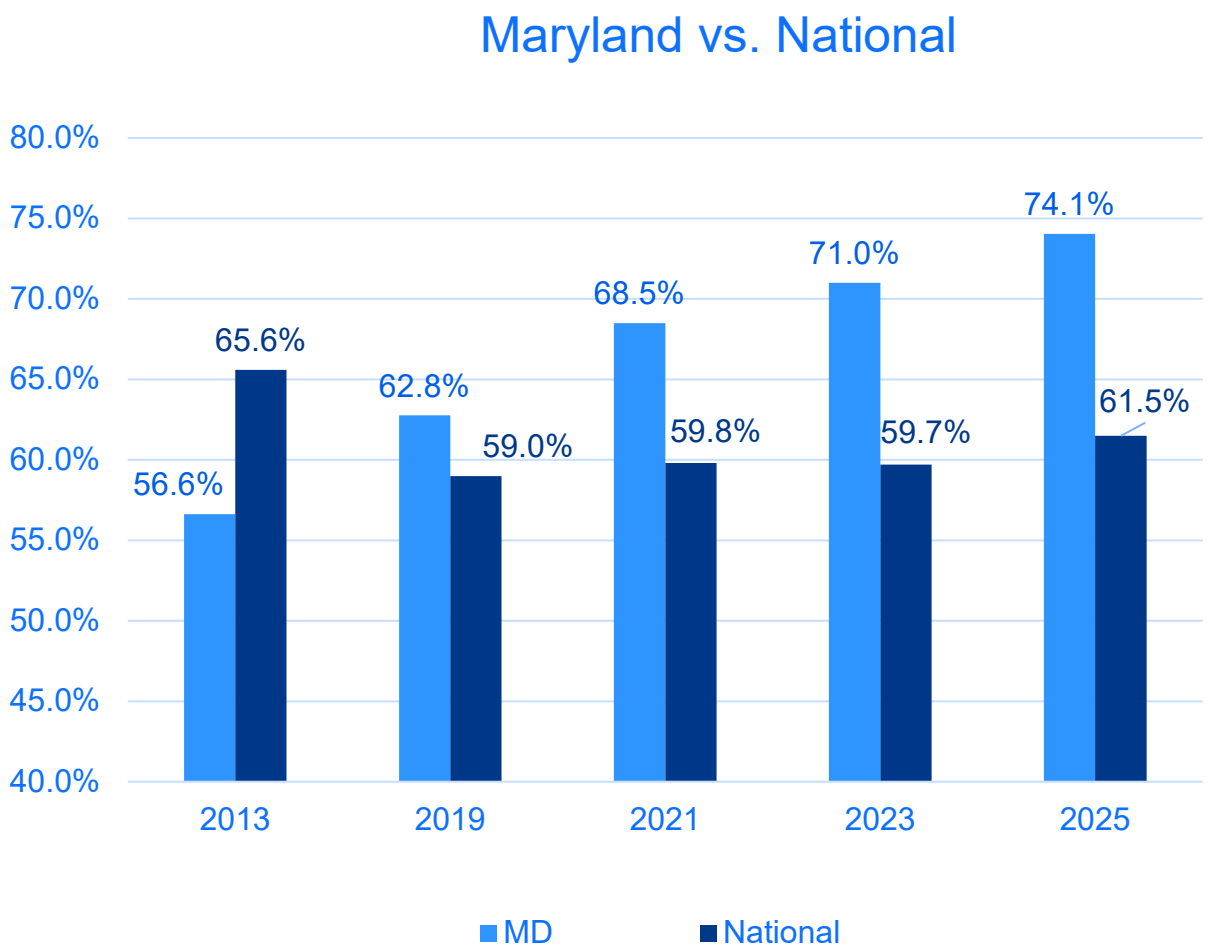
Professional Savings, 1st half 2025

1H 2024 to 2025			MD Above (Below) National CAGR				
Cumulative (Savings) Costs $M		% of US Spend	Utilization	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
$63.03	Part B Rx	26.19%	-0.73%	0.76%	0.02%	$0.13	0.23%
$0.86	E&M - Specialist	15.04%	-1.80%	0.22%	-1.59%	($4.69)	-8.44%
$12.22	E&M - PCP	9.30%	0.45%	2.84%	3.30%	$6.09	10.96%
$6.16	Lab	8.88%	-0.75%	-1.39%	-2.13%	($3.75)	-6.75%
$2.86	Imaging	5.91%	-0.43%	-0.52%	-0.95%	($1.35)	-2.43%
$9.82	DME	8.51%	7.04%	29.01%	38.09%	$52.57	94.62%
$5.00	Other Professional	6.27%	-1.96%	14.89%	12.64%	$11.54	20.78%
($2.16)	Proc-Minor	5.10%	0.09%	-0.30%	-0.21%	($0.21)	-0.37%
($7.39)	ASC	4.80%	-4.31%	5.78%	1.22%	$1.31	2.36%
($6.38)	Proc-Ambulatory	2.80%	-0.87%	2.92%	2.03%	$0.95	1.70%
$0.77	Proc-Major Other	1.59%	0.93%	2.75%	3.70%	$1.20	2.15%
$4.49	Proc-Major Cardiology	1.02%	-2.65%	1.00%	-1.67%	($0.48)	-0.86%
($2.30)	Proc-Eye	1.14%	-3.18%	1.64%	-1.59%	($0.30)	-0.54%
($1.24)	Proc-Major Orthopaedic	1.18%	-2.52%	-0.15%	-2.67%	($0.52)	-0.94%
($1.82)	Proc-Endocrinology	0.86%	0.53%	-1.33%	-0.81%	($0.11)	-0.19%
$4.18	Proc-Oncology	1.06%	-1.28%	-1.89%	-3.15%	($0.68)	-1.22%
$0.96	Proc-Dialysis	0.35%	0.89%	4.16%	5.10%	$0.40	0.72%

- DME and Other Professional are the primary drivers of dissavings.
- No categories with significant savings through 1H 2025.

Note: amounts above reflect change in each individual bucket, mix impact of different shares of each bucket would also impact overall savings, also amounts represent 5% sample data. Amounts may not add up due to rounding.

% of Part B Spending in a Professional Setting



- Since 2013, Maryland's use of the professional setting has increased by greater than 15% while the nation's decreased by about 4%. After a brief slow down during the pandemic the nation has gone back to the secular trend.
- On a PMPY basis Maryland has gone down from 19% greater than the nation to just over 1% less than the nation*. This is the intent of the model, higher hospital Medicare rates are maintained and covered by more efficient resource utilization.

*See Appendix for detail

High Level Summary of Savings Impact

- Since 2013 Maryland has generated approximately $696 M of savings compared to the national run rate. While there are varying ways to calculate and allocate savings, savings can generally be attributed to the following ($ in M):

IP: Reduced IP admits and cost per day somewhat offset by higher LOS	($71)
OP Hospital (excl. ED & Part B Rx): Reductions in imaging, minor procedures, hospital clinics	($419)
PAC: Skilled Nursing, Home Health & Hospice	($0)
ED: Reduction in ED per Visit Costs	($76)
Part B Drugs: Shift to lower cost, office POS	($152)
Other Part B: Clinics, FQHCs, Dialysis Centers, etc.	($89)
MDPCP, CPC+, PCF Fees (net of lower claims-based reimbursement)	$181
Other Professional: Some additional Primary Care plus Specialists and other professional categories	$74
Other AAPM Dollars: MSSP, NGACO, OCM, CJR, CEC, Direct Contracting, VTACO, etc.*	($144)
Net Savings	($696)

*Reflects only MDPCP fees, other analysis shows that MDPCP has contributed to cost reductions in other areas. According to HSCRC analysis net impact of the program was ~$31 M.

Next Steps

High Value Care Plans

- High Value Care Plan interim reporting requirements were met by all submissions. HSCRC staff will follow up with any questions if needed.
- Annual reporting will be due June 1, 2026. HSCRC staff will circulate a final reporting template in April. Failure to report on targets and outcomes will results in a take back of 0.27 percent of inflation removed in the July rate orders.

CY 2026 MPA Final Recommendation

- CMS confirmed receipt and approval of the Medicare Performance Adjustment (MPA) submitted by the HSCRC for implementation starting Jan 1, 2026. The proposed MPA satisfies the requirements as described in Section 11, Subpart e. i of the AHEAD Model Maryland State Agreement.
- No changes from Calendar Year 2025.

Rural Health Update

- On December 29, 2025, Maryland was pleased to receive a notice of award from the Centers for Medicare and Medicaid Services (CMS) for $168,180,837.61 for the first year, of five, of the Rural Health Transformation Program (RHTP).
- Maryland is currently in discussion with CMS regarding approved programs and adjusted budget details.
- The goals of the RHTP are: (1) Transform the Rural Health Workforce, (2) Promote Sustainable Access and Innovative Care for Rural Marylanders, and (3) Empower Rural Marylanders to Eat for Health.
- Please follow the Maryland Rural Health Transformation Program webpage for updates, including competitive grant opportunities.

CCLF Data Updates

- Maryland will start receiving a new, modified Medicare CCLF file under the AHEAD model in 2026.
  - Changes to format, layout, and variable names
  - Current CCLF file available through Dec 2026
- CRISP is partnering with HSCRC and hMetrix to:
  - Analyze updates in the CCLF files
  - Evaluate policy implications of the new data
  - Review CRS reports and tools to determine potential impacts
- A subgroup of the CRISP Reporting and Analytics Committee (RAC) will provide user feedback and suggestions on proposed changes.
- Report changes to occur in mid-2026 through early 2027.

CCLF Based Reports
Medicare Analytics Data Engine (MADE & DEX)
Value Based Care Insights (VBCI)
Care Redesign
Medicare Performance Adjustment (MPA)
Maryland Primary Care Program (MDPCP)
Multi-Payer Reporting Suite

List includes the primary CCLF-based reports. Reports using few variables from CCLF data not listed.

Reconstitution of Workgroup

- Purpose
  - The **Total Cost of Care Workgroup** focuses on the development and oversight of value-based programs and provides input on HSCRC's Model agreements with the Centers for Medicare & Medicaid Innovation (CMMI). The Workgroup serves as the primary forum for updates and in-depth discussion on new value-based initiatives and AHEAD policies. Its work includes reviewing policy recommendations, supporting management of the federal Model agreement, and designing, implementing, and evaluating initiatives that advance care transformation and promote high-quality, efficient health care delivery across settings.
  - The charge of the TCOC workgroup is to provide technical feedback to HSCRC on the methodologies and calculations that underpin care transformation and total cost of care management activities.

Workgroup Members

- Arin Foreman, CareFirst
- Armando DelToro, Kaiser Permanente
- Benjamin Lowentritt, MedChi Representative
- David Johnson, Bolton
- Ed Beranek, Johns Hopkins Health System
- Eric Wargotz, MedChi Representative
- Gene Ransom, MedChi CEO
- Jerry Reardon, Independent Member
- John Colmers, Independent Member
- Joshua Repac, Meritus Health
- Kathy Talbot, TidalHealth
- Katie Eckert, Adventist HealthCare
- Kenneth Yeates-Trotman, Maryland Health Care Commission
- Madeline Jackson-Fowl, University of Maryland Medical System
- Marcella Bailey, Mercy Medical Center
- Michael Myers, LifeBridge Health
- Mike Wood, MedStar Health
- Niharika Khanna, University of Maryland School of Medicine
- Padmini Ranasinghe, MedChi Representative
- Patrick Carlson, Maryland Hospital Association
- Paul Miller, LifeSpan
- Ryan Anderson, MedStar Health
- Shelby Boggs, Frederick Health
- Robin Motter-Mast, Greater Baltimore Medical Center

***Please let us know if you would like to be removed as an official member.**

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
  - March 25
  - 2026 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage
- Future Meetings Topics
  - March 25
    - Policy Development Timeline and Regulatory Workgroup Status Report Update
    - Healthcare Outcome Payment Efforts
      - Draft Recommendation to Commission
      - Discuss program operationalization
      - Commission comment letters due on March 25th

Thank You
Next Meeting March 25, 8-10 am