



maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

January 28, 2026

Agenda

- AHEAD Model Update
- Policy Development Timeline and Regulatory Workgroup Status Report
- All-Payer Total Cost of Care Targets
- Healthcare Outcome Payment Effort
- Savings Analysis
- Next Steps & Upcoming Meetings



AHEAD Model Update

Overview of AHEAD Model Changes in 2025 State Agreement

- The State will continue to set all-payer global budgets for PY1 (2026) and PY2 (2027) and then will be a three-year period (PY3-PY5) to gradually transition to CMMI’s national AHEAD global budget methodology.
- The State must ensure that 85% (down from 95%) of in-state, all-payer, acute care hospital revenue is paid under a global budget methodology.
- The Care Redesign Program (CRP) from the TCOC Model will continue through PY1 and PY2 (2026 and 2027) and then CMS and Maryland will negotiate a new program starting in PY3 (2028).
- Maryland must select two policy changes by 2027 for implementation by 2029 from the following:

Choice (must pick one)
<ul style="list-style-type: none">• Implement Medicaid site neutrality• Expand Telehealth• Advance prescription drug price transparency• Prohibit non-compete clauses

Competition (must pick one)
<ul style="list-style-type: none">• Modify scope of practice restrictions• Repeal certificate of need (CON) requirements• Revise network adequacy provisions• Repeal any willing provider (AWP) laws

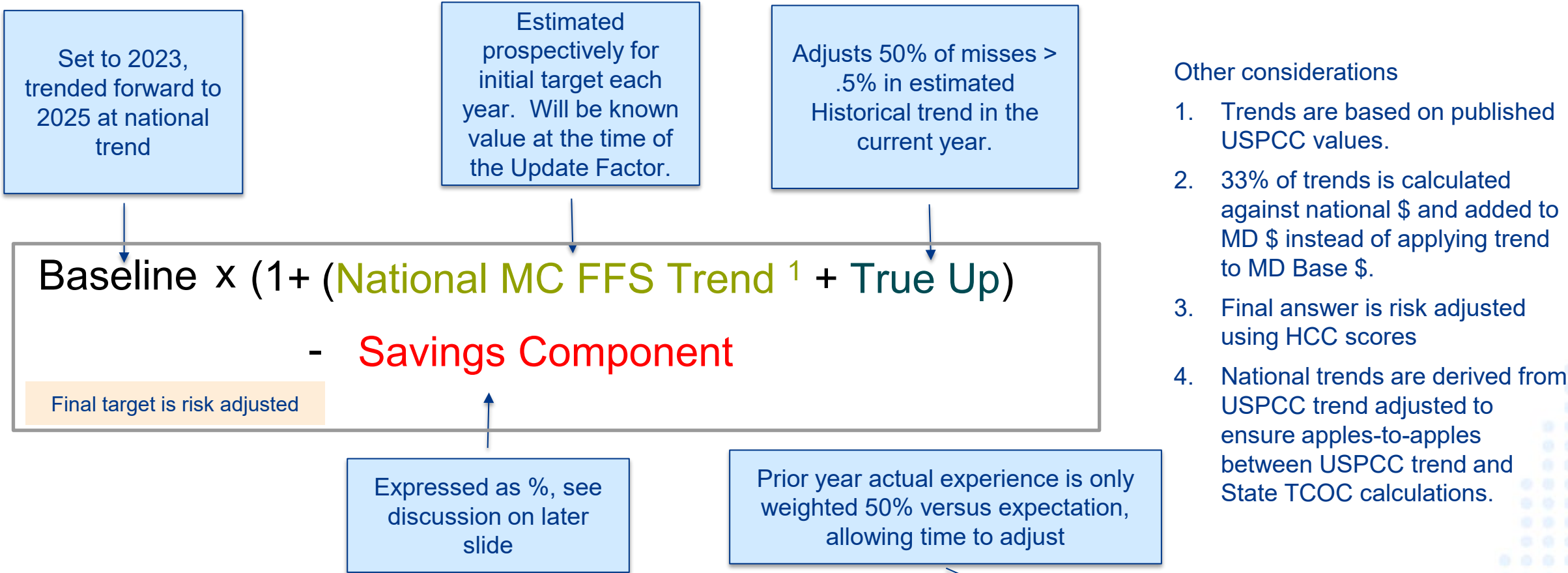
- Given uncertainty created by House Resolution 1 (H.R. 1, 2025), AHEAD crucially provides that Maryland Medicaid will fully participate in AHEAD alongside Medicare, including a commitment that CMS and the State will change Medicaid rates commensurate with Medicare rates in PY3-7.
- Geo AHEAD will be an ACO-like program under which Geo “entities” are accountable for attributable beneficiaries, including those aligned based on geography (aims to attribute 100% of Medicare FFS beneficiaries)

Key AHEAD Model Changes: Medicare FFS TCOC Target

Amended and Restated State Agreement (2025)	AHEAD State Agreement (2024)	TCOC Model
<p>Incremental reduction versus national trend in Medicare FFS spending each year, additions each year:</p> <ul style="list-style-type: none"> • PY1: 0.13% • PY2: 0.21% • PY3: 0.30% • PY4: 0.38% • PY5: 0.46% • PY6: 0.55% • PY7: 0.63% • PY8-10: 0% <p>= ~2.66% savings over seven years against a 2023 base = The difference between a 5% and 4.7% trend over the 7 years based on CMS' national growth trends.</p>	<p>0.128% incremental reduction versus national trend in MC FFS spending each year, resulting in ~1.1% savings over the 10 years against a 2023 base</p>	<p>~4% savings over prior 10 years</p>

NEW: Any savings beyond these targets must be returned to the State (via hospital global budgets)

Medicare FFS TCOC Target: Current Understanding



1. National MC FFS Trend = Product of Estimated National MC FFS for the current year, the average of the Estimated National MC FFS Trend and the Actual National MC FFS Trend for the prior year and the Actual National MC FFS Trend for previous years.

CMMI Webinar

CMMI is holding a webinar 3 – 4 pm on February 10 that will be open to all stakeholders and during which CMMI will:

Review the AHEAD Model strategies and approaches

Provide an overview of the new components and updates, including:

Addition of a two-sided risk accountable care organization (ACO) program incorporating novel elements of geographic alignment and bids against a discounted benchmark (Geo AHEAD);

Addition of three new pathways in Primary Care AHEAD (PC AHEAD);

State implementation of at least two policies focused on promoting choice and competition in their health care markets;

Population Health Accountability Plans (PHAP) with a focus on preventative care, including chronic disease prevention; and

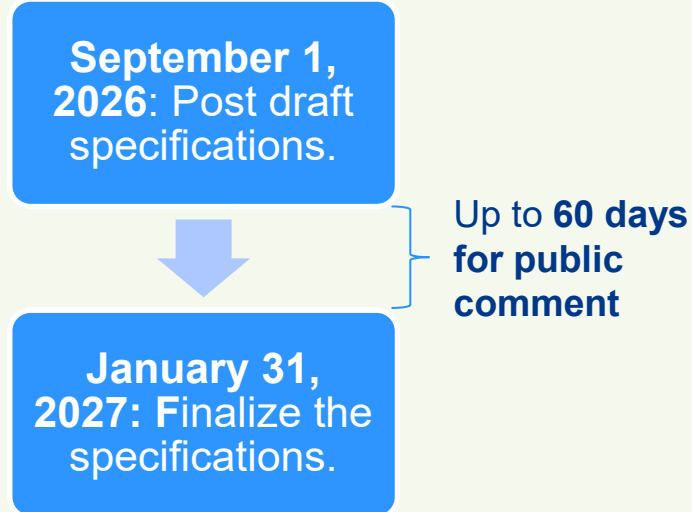
Extension of the end date of the model through December 31, 2035.

[*Registration Link:](#) Questions must be sent in advance when registering through the link.

HSCRC Work: Medicare Fee-for-Service Hospital Global Budget

HSCRC will collaborate with CMMI and stakeholders to provide input on CMMI's Medicare FFS AHEAD financial specifications (e.g., market shift) for 2028 (PY 3)

Deadlines for CMMI to develop the Financial Specification Document describing their Hospital Global Budget methodology for PY3¹:



- At the State's request, CMMI has agreed to meet with the State and hospitals monthly through September to review global budget methodologies and other policy decisions.
- The first of these meetings will be held on February 19.
- HSCRC will share additional details (including time and agenda items) as they ironed out in advance of the meeting, but we anticipate one of the first topics for discussion will be global budget carve-outs (high-cost drugs, complex care, etc).

Once the Medicare FFS methodology is clear, the State must evaluate the interaction of non-Medicare policies with Medicare methodologies (e.g., PAU Shared Savings, Effectiveness Adjustment).

¹See Section 12(a)(v) of the State Agreement

Policy Development Timeline and Regulatory Workgroup Status Report

HSCRC Future Focus Areas

Workstream	Status/Timeline*	Expected Workgroup
All-Payer Global Budget Revenue		
Define Global Budget Carve-outs (volumes counted against the required 85% of hospital revenue under GBR)	Memo in Jan 2026. Workgroup in Feb 2026.	Payment Models
Adjustments and Assessments (UCC, Deficit Assessment Etc.)	Likely Fall 2026, some discussion during RY2027 update factor process	Payment Models
Financial policies, including Market Shift, Efficiency, etc.	Likely Fall 2026	Payment Models
Quality policies, including Length of Stay	Ongoing	Performance Measurement
Policies, including Avoidable Use, Care Transformation, EQIP 2028	CT: Q1 2026 EQIP: Q3 2026	TCOC
Data and Reporting	TBD	Quarterly Data Forum
Impact of Medicare FFS GBRs on Medicaid and Medicare Advantage	Depends on CMS	Payment Models
Capital Policy Refinement	Fall 2026	Payment Models
Other		
Physician Costs	Recapped comments in January Commission meeting, summary to be passed on to the legislature	

Multi-Agency Regulatory Working Group

- Governor Moore directed the creation of a multi-agency State regulatory working group to advance Maryland's goals under the AHEAD Model.
- Stakeholder Engagement Opportunities
 - Early engagement to inform policy priorities
 - Dedicated public input process for each initiative
 - Opportunities to review and comment on draft policy proposals
 - Ongoing, bi-directional feedback between public meetings and presentations
 - Additional feedback through agency-specific forums



Policy Priorities

- Cost Shifting Policies
- Medicare Advantage Market Stabilization
- Choice and Competition
- Workforce and Graduate Medical Education
- Post-Acute Care
- Total Cost of Care and Primary Care Targets



State Agency Composition

- Maryland Department of Health (MDH)
- Health Services Cost Review Commission (HSCRC)
- Maryland Insurance Administration (MIA)
- Maryland Health Care Commission (MHCC)
- Maryland Health Benefit Exchange (MHBE)

Multi-Agency Priorities: Updates and Upcoming Opportunities

Workstream	Status/Timeline	Expected Workgroup
Maryland-Specific Metrics for AHEAD	Awaiting measure feedback from CMMI	Led by MDH
Denials	Initial meeting of the Adverse Decisions Workgroup held November 2025; report due December 2026	Adverse Decisions Workgroup
ED Wait Times	Strategic planning meeting held January 7, 2026	ED Wait Times Commission
Medicare Advantage Market Stabilization	Policy recommendation approved by Governor December 2025; Approved by Commission January 2026	Oversight - Regulatory Working Group
Cost-Shifting	Policy recommendation approved by Governor December 2025; Approved by Commission January 2026	Policy Implementation - HSCRC Payment Models in coordination with MIA
Workforce including Graduate Medical Education	<i>Slated to kick off Spring 2026</i>	Regulatory Working Group
Post-Acute Strategy	<i>Slated to kick off Spring 2026</i>	
All-Payer TCOC Growth and Primary Care Investment Targets	Advisory Committee selected; meetings scheduled for January, February and April	
Choice and Competition	<i>Slated to kick off Spring 2026</i>	

Cost-Shifting and MA Stabilization: Public Input Process

- October 20, 2025: Call for public comment and notice of listening sessions
- October 29, 2025 and November 5, 2025: Listening sessions
- November 21, 2025: Draft policy recommendations released for public comment
- December 2, 2025: Public comments due
- December 30, 2025: Final policy recommendation, as approved by the Governor, released to the public

Commenters across both rounds included members of agency standing workgroups, payers, hospitals, providers, community advocates, unions, insurance brokers and others.

Cost-Shifting: Policy Recommendation

- Use HSCRC's annual update factor process to increase commercial hospital rates by \$87 million each calendar year from FY 2028 to FY 2032
- This will increase commercial premiums by approximately 1.8 percent by FY 2032.
- Maintain the \$435 million in rates after 2032
- Amounts to half the anticipated Medicare FFS savings and the equivalent impact on MA and Medicaid

Cost-Shifting: Next Steps

- Implementation: Increase commercial hospital rates by \$87 million via the annual update factor process, starting in FY 2028
- Monitoring: Identify sources and specifications for annual monitoring activities including commercial insurance affordability; hospital affordability, access and viability; emerging opportunities for value-based reimbursement for physicians and population health investment

MA Stabilization: Policy Recommendation

- Through the HSCRC's rate-setting authority, reduce hospital costs for qualified MA plans
- Qualified Plans will be designated annually in Q1 for the following year, starting in 2026:
 - At least 50 percent of MA beneficiaries in the relevant H-contract reside in Maryland
 - At least 5,000 beneficiaries or 20 percent of MA beneficiaries residing in Maryland in that H-contract reside in eight jurisdictions*
 - Have a star rating of at least 3.5 (2028 plan year data release)
- Qualified Plans will receive an additional 11.55 percent in rate relief, starting in CY 2027
- Will be offset by both Medicaid and commercial rates in CY 2027; CY 2028 and beyond, just commercial
- Once fully implemented, anticipated to increase commercial rates by 0.75 percent

* Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington, Wicomico. Plans may request a waiver to come into compliance with the county-level requirement by 2028.

MA Stabilization: Next Steps

- **Implementation:**
 - **Plan Qualification:** By January 23, 2026, finalize plan qualification criteria; by February 20, 2026, identify final Qualified Plans for 2027
 - **Rate Relief:** Identify avenue to provide 11.55 percent in additional rate relief for Qualified Plans for the FY 2027 update factor
- **Monitoring:** Identify sources and specifications for annual monitoring activities including commercial insurance affordability; total cost of MA rate relief and impact on underserved individuals; impact on MA plan availability, enrollment and quality; additional requirements to improve the efficiency of the MA market or promote population health or quality outcomes

All-Payer TCOC Growth and Primary Care Investment Targets

Executive Order

- The State's commitment to establishing all-payer TCOC and primary care investment targets, which will apply across all Maryland health care markets and populations, has been memorialized in an [Executive Order](#) issued by the Governor. This was a requirement of the AHEAD Model, due prior to the end of December 2025.
- The Executive Order commits the HSCRC, MHCC, MDH, MIA and MHBE to:
 - Collecting and analyzing data and developing a target-setting methodology, as informed and advised by stakeholders; and
 - An initial submission for PYs 2-5 in 2026, followed by annual timeframes for draft and final targets for PYs 6-10.

Process Timeline

Milestone	Action Items	Due Date
Advisory Group Meeting #1	Advisory Committee Introduction	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 and Revise Recommendations as Needed	April 10, 2026
Draft methodology and targets due to the Governor		May 2026
Submit CY 2027-2030 targets to the Governor and CMMI		September 2026

***Zoom Series Registration Link:** https://us06web.zoom.us/meeting/register/-3zcmOW7Qb6gk72_WXIVfQ

*Ad-hoc meetings may be scheduled prior to the final submission to CMMI

Healthcare Outcome Payment Effort

Foundational Context

- AHEAD is designed to reward prevention of illness and accompanying unnecessary hospital utilization.
- Taking advantage of this fundamental incentive is critical for success in meeting the goals of improving health outcomes and reducing costs.
- Feedback from stakeholders on the strengths and weaknesses of PAU, CTIs, and other HSCRC initiatives has led to the development of this draft of a next generation framework. We look forward to further feedback.

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.

Two Paths to Participation

New Care Transformation Framework

- *Maryland Acute Hospitals*

Regional and Statewide Initiatives

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

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.

New Care Transformation Methodology

FY27

Only Existing CTIs (rollover CTIs) with proven results that are qualified by the technical panel can participate.

- CTIs that have demonstrated success in PY2-4 and have a clear intervention strategy can be qualified as a rollover CTI and share in savings annually via outcome payment.
- Outcome payments are provided for a fixed future period starting in July 2026, based on two years of calculated levels of savings .

FY28 and beyond

Rollover CTIs can continue and new initiatives can apply on an annual basis.

- Outcome payments are given for a fixed future period based on two years of calculated levels of savings.
- Savings based on all-payer claims and limited to inpatient and emergency department initially.

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.

Panel Review and Criteria

- Panel will include public-private experts who will:
 - assess and qualify interventions, and
 - communicate to the field to encourage successful submissions.
- Submission should reflect:
 - meaningful interventions that
 - have a strong evidence base,
 - address a State health priority,
 - have a clearly defined population, **and**
 - a strong likelihood of impacting that population.

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

CTI Rollover Criteria

For each CTI calculated the following:

- Lowest dollar savings achieved across the 3 performance years for that CTI
- Lowest percent savings-to-MSR ratio achieved across performance years for that CTI
 - Percent savings: total savings as a percent of total target price
- Per-episode savings achieved relative to baseline after accounting for trends across all other CTIs, averaged across performance years:
 - Savings in all categories (total episode payments)
 - Savings in inpatient spending

Proposed Criteria (Top Savings in Each Area)

- Total dollar savings and percent savings fell in the **top 25%** of all CTIs, and per-episode savings (all-category and inpatient) fell in the **top 30%** of all CTIs each performance year.

Thematic Area	Care Transitions (01)	Palliative Care (02)	Episodic Primary Care (03a)	TOTAL
Number of CTIs Meeting All Criteria	6	1	1	8
Percent Meeting All Criteria (among CTIs active in PY5)	7%	8%	6%	3%

- Average savings based on PY2 and PY3: \$7,699,785 (Min: \$1,148,356; Max: \$28,345,780)
- Total based on average savings for CTIs: **\$61,598,280**

Interactions with other HSCRC Programs and Policies

New Paradigms in Care Delivery (NPCD)

- This funding can be used for up front investment

Revenue for Reform (RfR)

- Cannot utilize the same initiative across R4R and this program

Potentially Avoidable Utilization (PAU) Savings Policy

- This program allows hospitals to recover dollars previously lost under PAU

Episode Care Improvement Program (ECIP)

- Ends June 30, 2026

Episode Quality Improvement Program (EQIP)

- No program overlap

Efficiency policy

- Payments should not count against hospitals in the efficiency policy

Next Steps and Timeline - 2026

February

- Comments due by 2/13
- Additional TCOC workgroup meeting on 2/18 to discuss comments
- Review comments and present revised policy at 2/25 TCOC workgroup meeting

March

- Draft commission recommendation
- Review comments received from commission meeting with TCOC workgroup

April

- Final commission vote and program buildout

July

- Start July 1, 2026

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



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Drivers of Maryland FFS Medicare Savings 1H 2025 and Recap of Savings Since 2013

January 2026

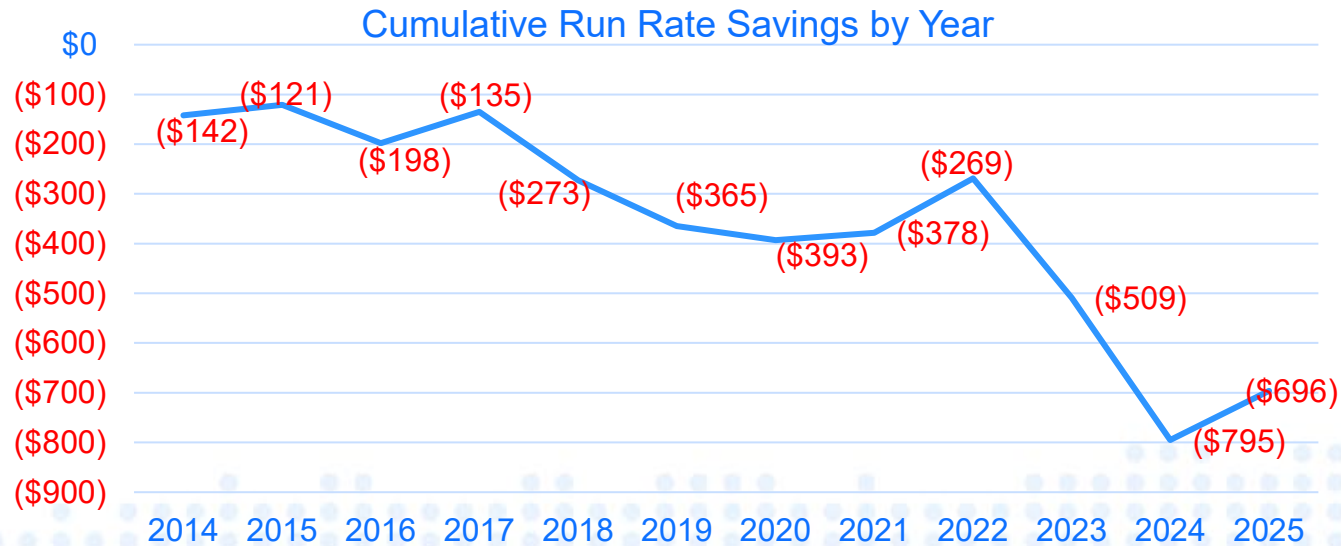
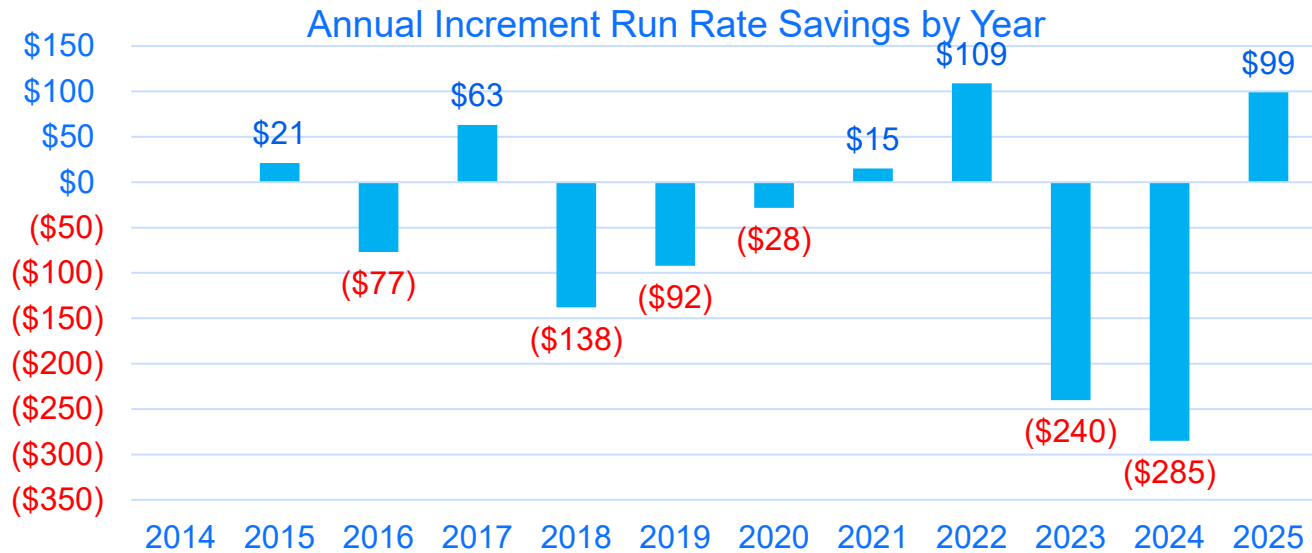
Presentation Context

- 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.

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 1 st 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 1 st 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			MD Above (Below) National Compound Annual Growth Rate				
Cumulative (Savings) Costs \$M		% of US Spend	Utilization	Unit Cost	Total	1 st 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%
	Proc-Major						
(\$6.2)	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%
	Proc-Major						
(\$6.4)	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

IH 2024 to 2025

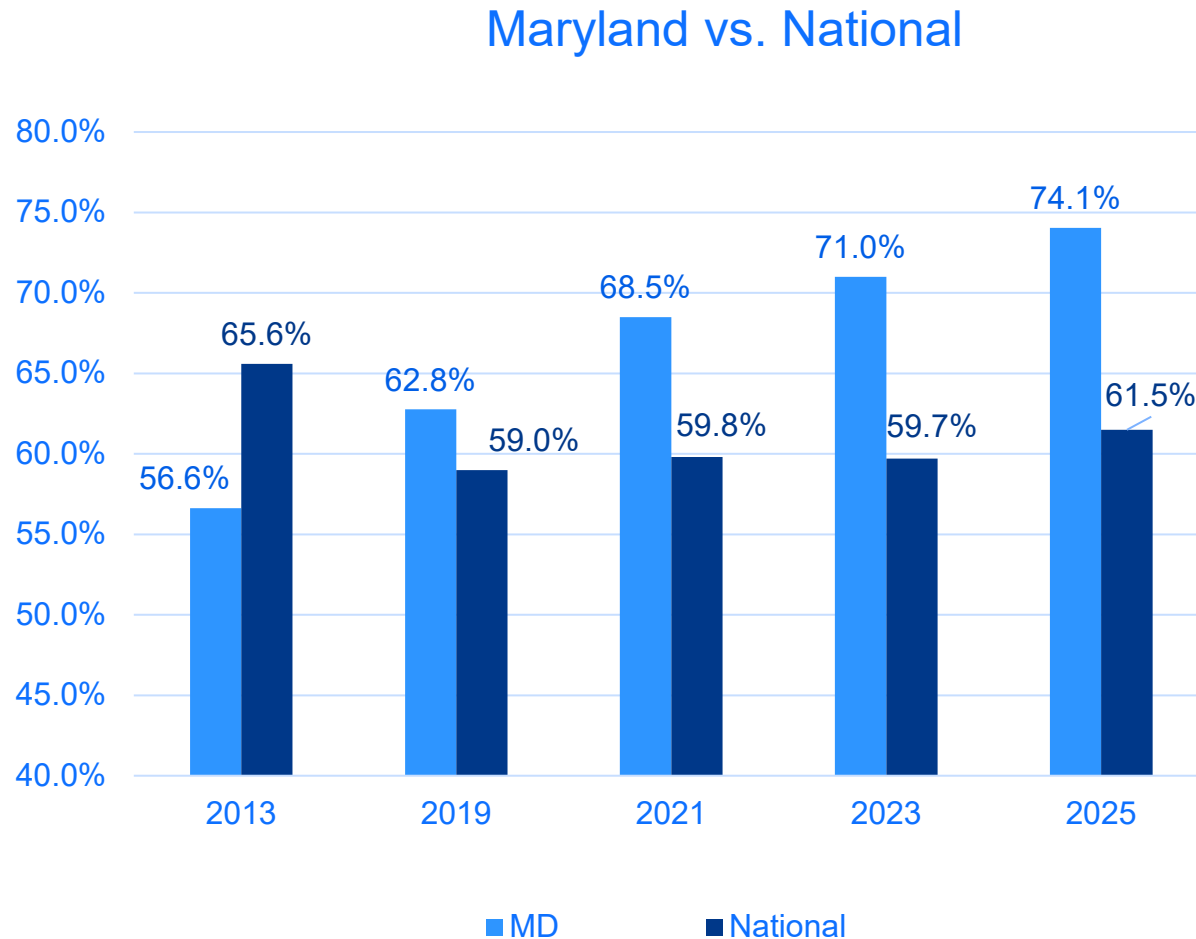
MD Above (Below) National CAGR

Cumulative (Savings) Costs		% of US Spend	Utilization	Unit Cost		Run Rate (Savings) Cost,	
\$M				Cost	Total	\$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%
	Other						
\$5.00	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%
	Proc-Major						
\$4.49	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%
	Proc-Major						
(\$1.24)	Orthopaedic	1.18%	-2.52%	-0.15%	-2.67%	(\$0.52)	-0.94%
	Proc-						
(\$1.82)	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 \$663 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

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 Membership

- HSCRC will be reaching out to current members regarding participation for 2026/2027.
- Will finalize membership and do introductions in the February 25th meeting.

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
 - February 18 – Added as New Meeting
 - February 25
 - 2026 Meeting Dates (Tentative) posted on [TCOC Workgroup Webpage](#)
- Future Meetings Topics
 - February
 - 18th – Healthcare Outcome Payment Effort - Discuss comments received
 - 25th
 - Healthcare Outcome Payment Effort - Present revised policy
 - HVCP Update
 - MPA Final recommendation

Thank You
Next Meeting February 18, 8-10 am