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Total Cost of Care Workgroup Meeting

July 22, 2026

Agenda

- Savings Analysis
- HOPE Update
  - Overview
  - Timeline and Review Criteria
  - Methodology Review
  - AHEAD Population Health
- EQIP Important Dates
- Next Steps & Upcoming Meetings

Savings Analysis

2025 and 2026 Savings Update

- Final 2025 number expected to be about $800 M. Increase due to:
  - Addition of Part C savings
  - Finalization of MSSP spending moves savings in State's favor
  - Review and sign off from CMMI
  - Strong results in the last 3 months of the year versus 2013 base
  - Because improvement mostly relates to national, they do not generally help with 2026 results which are based on USPCC.

- 2026 Savings Results and Projections
  - Release first official savings results update in September Commission meeting
  - CMMI has agreed to make adjustment for IME but are currently proposing a much lower impact.

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Drivers of Maryland FFS Medicare Savings

CY 2025 and Recap of Savings Since 2013

June 2026

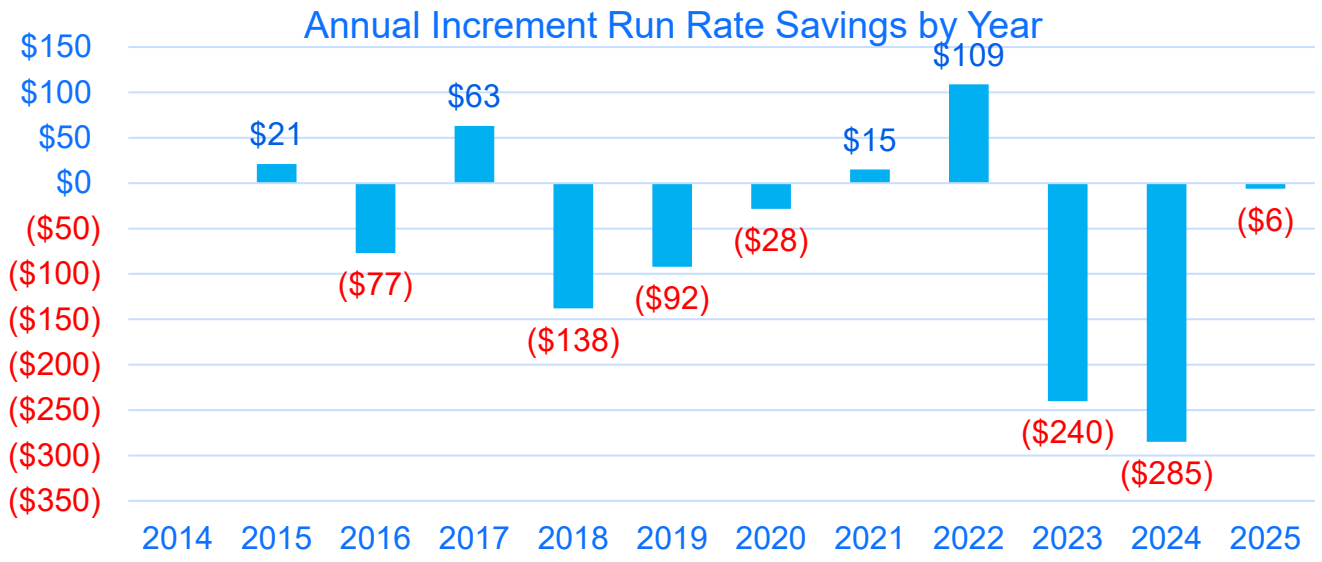
Presentation Context

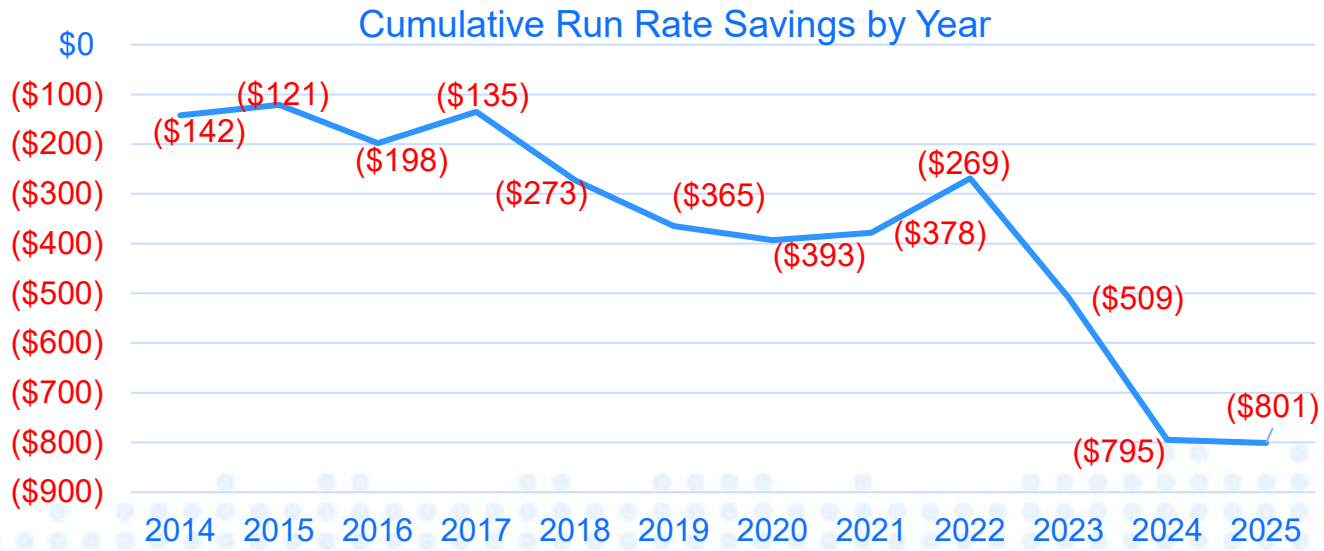
- Presentation displays update comparing previous years to the full year 2025 Maryland Medicare Total Cost of Care.
- Presentation focuses on four periods 2013 to 2019, 2019 to 2022, 2023 to 2024 and 2025
  - TCOC in 2020, 2021, and 2022 showed considerable volatility, complicating 2023 comparison.
    - 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 CY 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
- 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, followed by a leveling off in 2025. CMS has not signed off on 2025 savings, so amounts are not final.
- 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.
- The relative change in Part C enrollment contributed $21 mil in savings and the relative change in other NCBP resulted in $50 mil in dissavings over the life of the contract. In 2025, the relative change in Part C enrollment contributed $12 mil in dissavings and the relative change in other NCBP contributed $18 mil in savings.

TCOC Savings, 2013 to 2019 vs 2019 to 2022 vs 2022 to 2024 vs 2024 to 2025

	2013 to 2019, Average		2020 to 2022, Average		2023 to 2024, Average		2025	
	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%	($57)	25%	$80	59%
SNF	($6)	10%	$2	3%	($1)	0%	$2	1%
Home Health	$8	-12%	$1	1%	($6)	3%	($13)	-10%
Hospice	$3	-6%	($11)	-13%	($0)	0%	($3)	-2%
Total Part A	($31)	51%	$106	122%	($64)	29%	$66	49%
Outpatient Hospital	($59)	95%	($65)	-76%	($123)	55%	$9	7%
ESRD	($2)	4%	$6	7%	$3	-1%	$3	2%
Outpatient Other	($4)	6%	($2)	-3%	($7)	3%	($1)	-1%
Clinic	$0	0%	($1)	-2%	($2)	1%	($0)	0%
Professional Claims	$34	-55%	$43	50%	($30)	13%	$57	42%
Total Part B	($31)	49%	($19)	-22%	($159)	71%	$69	51%
Total	($62)		$86		($224)		$135	

- Hospital claims are driving the majority of Total Dissavings in 2025 with Professional services also swinging back toward dissavings.

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 2025 dissavings of $230 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	
	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%	($7)	-0.6%	$3	0.5%
Avg Case Mix Index	$44	0.2%	$34	0.2%	$16	0.8%	$21	0.9%
Cost per Day	($26)	-0.7%	$47	1.2%	($64)	-3.1%	$46	1.1%
ALOS (CMI Adj)	$11	1.6%	$10	0.9%	($3)	-0.1%	$9	0.8%
Mix Impact	$1		$6		$1		$1	
Total Inpatient	($37)		$114		($57)		$80	

- Cost per day is driving savings fluctuations since 2022
- Admits per 1,000 continued to contribute to dissavings in 2025
- Case-Mix Adjusted Average Length of Stay swung back to contributing to dissavings in 2025

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, CY 2025

2024 to 2025 Cumulative (Savings) Costs $M		% of US Spend	MD Above (Below) National Compound Annual Growth Rate: Utilization	Unit Cost	Total	CY 2025 (Savings) Cost, $M	% of Savings
($494.6)	Part B Rx	29.1%	-5.2%	4.4%	-1.0%	($4.1)	-45.5%
($79.5)	Imaging	11.5%	-1.3%	1.9%	0.6%	$1.1	11.8%
($12.3)	Proc-Major Cardiology	9.1%	-2.6%	-0.4%	-3.0%	($2.6)	-28.9%
($64.7)	Proc-Minor	7.2%	-1.7%	0.1%	-1.5%	($1.6)	-17.5%
($88.2)	E&M - ER	6.8%	0.3%	5.2%	5.5%	$6.7	74.3%
($20.0)	Proc-Major Orthopaedic	7.3%	-3.8%	2.9%	-0.9%	($0.6)	-7.1%
($3.1)	Proc-Major Other	5.7%	-5.0%	5.7%	0.5%	$0.3	3.7%
($17.4)	Proc-Endocrinology	4.8%	0.8%	-0.2%	0.6%	$0.4	3.9%
$46.9	Lab	4.2%	4.1%	4.1%	8.3%	$13.7	152.1%
($108.9)	E&M - Other	4.9%	-5.9%	7.4%	1.1%	$1.6	17.2%
($15.5)	Proc-Ambulatory	3.9%	-0.6%	0.9%	0.3%	$0.2	2.0%
($37.2)	Proc-Oncology	3.1%	-1.9%	3.1%	1.1%	$1.1	11.9%
($10.8)	Other Professional	1.1%	1.7%	-1.8%	-0.1%	($0.1)	-1.5%
($9.2)	Proc-Eye	1.1%	-7.1%	6.8%	-0.8%	($0.1)	-1.0%
($4.9)	DME	0.4%	-4.4%	22.6%	17.3%	$20.5	228.2%
$0.1	Proc-Dialysis	0.0%	-15.9%	13.3%	-4.7%	($0.0)	-0.3%

- Part B Rx Savings in Outpatient hospital setting has continued to see savings, while professional has swung back to dissavings amidst broader dissavings

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.

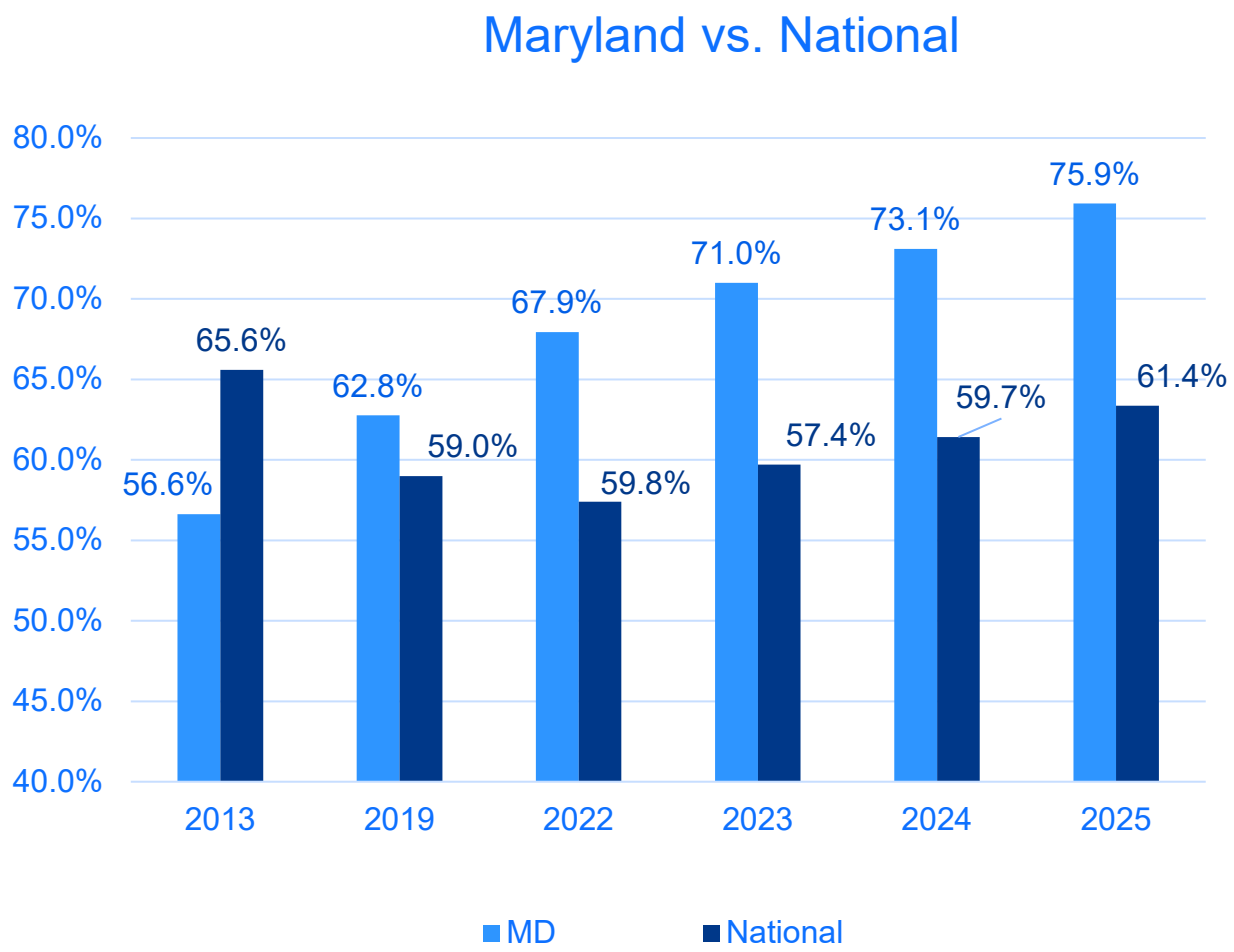
Professional Savings, CY 2025

Cumulative (Savings) Costs $M		2024 to 2025 % of US Spend	MD Above (Below) National CAGR Utilization	Unit Cost	Total	Run Rate (Savings) Cost, $M	% of Savings
$191.4	Part B Rx	28.0%	-1.6%	7.5%	5.8%	$68.0	117.5%
($6.0)	E&M - Specialist	14.8%	-1.3%	0.4%	-0.9%	($6.0)	-10.4%
$35.7	E&M - PCP	9.3%	-0.3%	3.3%	3.0%	$12.3	21.2%
$6.4	Lab	8.3%	-0.3%	-1.7%	-1.9%	($7.0)	-12.1%
$10.4	Imaging	5.7%	0.3%	0.3%	0.6%	$1.7	2.9%
$63.7	DME	10.1%	2.0%	-2.7%	-0.7%	($2.8)	-4.9%
$29.2	Other Professional	5.2%	-5.1%	8.9%	3.4%	$6.2	10.7%
($6.8)	Proc-Minor	4.9%	-0.2%	-0.3%	-0.6%	($1.1)	-1.9%
($13.4)	ASC	4.4%	-3.1%	5.2%	1.9%	$4.2	7.3%
($12.9)	Proc-Ambulatory	2.7%	-0.8%	2.3%	1.6%	$1.5	2.6%
$3.6	Proc-Major Other	1.5%	1.1%	1.6%	2.7%	$1.8	3.1%
$7.2	Proc-Major Cardiology	0.9%	-1.4%	-0.8%	-2.2%	($1.2)	-2.1%
($4.2)	Proc-Eye	1.1%	-1.9%	1.6%	-0.3%	($0.1)	-0.2%
($3.3)	Proc-Major Orthopaedic	1.1%	-2.5%	-0.6%	-3.1%	($1.2)	-2.1%
($3.7)	Proc-Endocrinology	0.8%	0.0%	0.0%	0.0%	($0.0)	0.0%
$8.3	Proc-Oncology	1.0%	-0.3%	-3.4%	-3.7%	($1.7)	-2.9%
$2.4	Proc-Dialysis	0.3%	1.3%	1.3%	2.7%	$0.4	0.8%

- Part B Rx savings in Professional setting has reversed a multi year trend and experienced dissavings in 2025
- E&M – Specialist and Lab claims were only significant sources of savings in 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 almost 20% 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 about the same as 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 $801 M of savings compared to the national run rate. While there are varying ways to calculate and allocate savings, savings can generally be attributed to the following ($ in M):

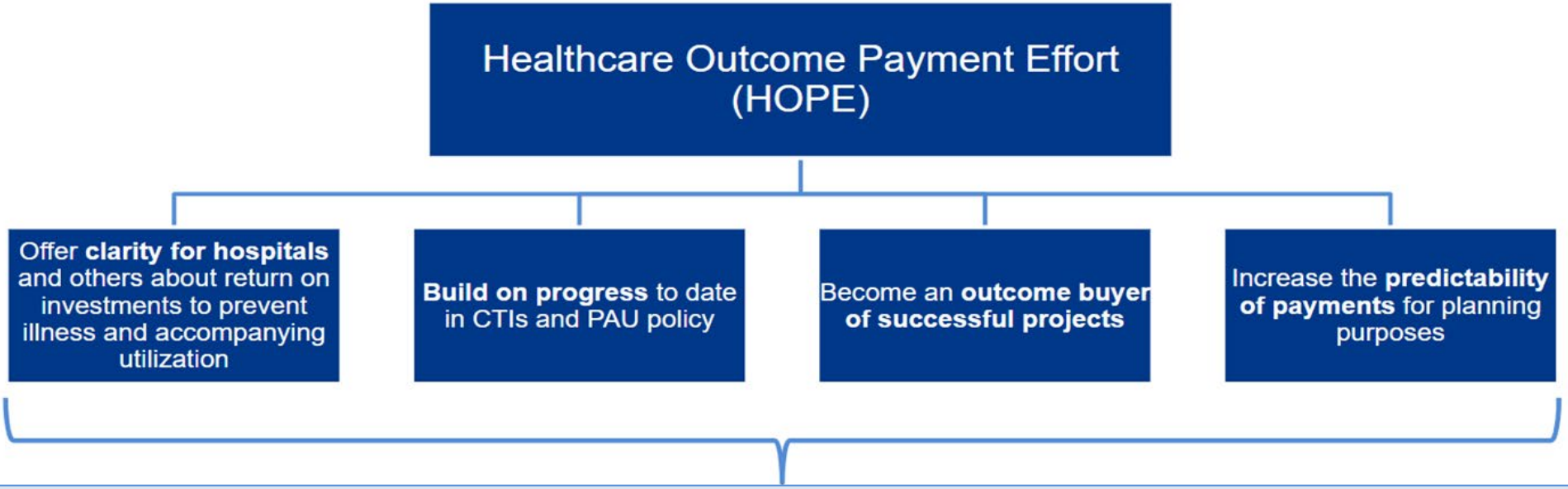
IP: Reduced IP admits and cost per day somewhat offset by higher LOS	($77)
OP Hospital (excl. ED & Part B Rx): Reductions in imaging, minor procedures, hospital clinics	($423)
PAC: Skilled Nursing, Home Health & Hospice	($15)
ED: Reduction in ED per Visit Costs	($73)
Part B Drugs: Shift to lower cost, office POS	($89)
Other Part B: Clinics, FQHCs, Dialysis Centers, etc.	($90)
MDPCP, CPC+, PCF Fees	$114
Other Professional: Some additional Primary Care plus Specialists and other professional categories	$16
Other AAPM Dollars: MSSP, NGACO, OCM, CJR, CEC, Direct Contracting, VTACO, etc.*	($164)
Net Savings	($801)

*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.

Healthcare Outcome Payment Effort

HOPE Framework

Care Transformation Initiatives (CTI) ended 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.

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*

FAQ

- Competitive outcome buyer model
  - Not traditional funding from HSCRC
  - Must be able to demonstrate savings to receive payments
- Anticipate 2-4 RSIs in the first performance year
  - Require individual approval by the Commission and customized attention from staff
  - Larger initiatives aligned with state health priorities with strong regional backing and customized savings methodology.
  - Applications will not be submitted through CRISP portal.
  - HSCRC will provide technical one on one support .
- Up to 2 CTF submissions per hospital in the first performance year
  - Fixed statewide funding of $50 million per year for FY27, FY28, and FY29.
  - Approved initiatives collectively may not materially exceed projected annual savings of $100 million.
  - Applications will be submitted through CRISP portal.
  - Interventions will have to meet specified criteria as outlined in each thematic area.

Timeline and Review Criteria

HOPE 2026 Timeline

- HSCRC
  - Commission Vote on RSI: December 2026
  - One-Time Infrastructure Funding into GBRs: July 2026
  - One-Time Seed Funding into GBRs: January 2027
- RSI
  - Release RFA: Early August 2026
  - Release LOI: Late August 2026
  - RSI Applications Due: Late September 2026
  - RSI Committee Review: October 2026
  - Staff Preliminary Awards: November 2026
  - Present RSI Recommendation to Commission: December 2026
- CTF
  - Release RFA: Early October 2026
  - Release LOI: Mid October 2026
  - CTF Applications Due: Mid November 2026
  - CTF Committee Review: November 2026 – December 2026
  - Notify CTF Awardees: January 2027

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
     - August 12 – 10AM
     - September 9 – 10AM
     - October 14 – 10AM
     - November 12 – 10AM (Avoids Holiday)
     - December 9 – 10AM
   - **Staff welcome suggestions for discussion topics during these meetings. Please send your ideas to christa.speicher@maryland.gov.**

Letter of Intent

- The letter of intent is designed to assist HSCRC in screening proposals to ensure general alignment with the criteria.
- RSI
  - What is the intervention? Who are the partners? Does it align with a state health priority area?
  - What is the proposal to measure savings?
  - Do you expect to request seed funding and if so, approximately how much?
  - Is the LOI signed by a regional entity or entities and a hospital?
  - Provide any constituent support including MOUS.
- CTF
  - What is the intervention?
  - What are the key criteria for the expected population?
  - Do you expect to request seed funding and if so, approximately how much?

Review Criteria*

Criteria	Overview
Strong Evidence Base	*Does the proposal cite peer-reviewed literature, prior evaluations, pilot studies, or established practice standards supporting the intervention?* • Peer-reviewed literature cited and relevant • Prior evaluation(s) of this or a comparable intervention cited • Pilot/demonstration data provided • Alignment with an established practice standard shown
Addresses a Recognized State Health Priority	*Does the proposal align with the AHEAD Population Health Accountability Plan (PHAP), the State Health Improvement Plan (SHIP), or another established MDH policy?* • Explicit alignment with AHEAD PHAP stated and explained • Explicit alignment with SHIP stated and explained • Alignment with another named MDH policy/priority stated and explained • Alignment claim is specific (names the priority/goal) rather than generic
Clearly Defined Target Population	*Does the proposal specify eligibility criteria and defining characteristics of the population it will serve?* • Eligibility criteria explicitly stated • Clinical characteristics defined (e.g., diagnoses, HCC score, prior utilization) • Geographic scope defined • Demographic characteristics defined (as relevant) • Estimated population size/reach quantified
High Likelihood of Measurable Impact	*Does the proposal present a clear, well-justified methodology for estimating impact on health outcomes and averted costs?* • Specific, measurable outcomes other than cost identified • Methodology for estimating health impact described and justified • Methodology for estimating cost impact/averted costs described and justified • Baseline data identified (template will be provided)
No Adverse Impact on Patient Experience or Total Cost of Care	*Does the proposal address potential unintended effects on patient experience and total cost of care (TCOC), and how they will be monitored or mitigated?* • Potential risks to patient experience identified and addressed • Potential risks to TCOC identified and addressed • Monitoring plan for adverse effects described • Mitigation/contingency plan described if risks materialize

*Review committee finalized and review criteria details to be fleshed out in RFA.

Methodology Review

Datasets

Maryland "Case Mix" data will be used to identify the HOPE population, construct episodes, and calculate *total inpatient and outpatient hospital costs* during episodes.

- Inpatient and Outpatient case-mix data sets are abstracted from the medical records of approximately 700,000 inpatient discharges and 5.7 million outpatient visits annually.
- Hospitals report clinic, surgery and emergency room data as part of the outpatient data set.

Data spans a given "target period" and a participant-specified "look-back" period to determine whether the CTI criteria were met.

Target Price

For each participant and HOPE thematic area, the target price is calculated as the predicted level of inpatient and outpatient hospital episode spending during the performance period, based on:

- The participant's average inpatient and outpatient hospital episode spending during a selected one-year or two-year baseline period: Fiscal Year 2025 or Calendar Years 2024, 2025, or 2024-2025
- Risk-adjusted for hospital-level variation using multivariate regression, controlling for hospital fixed effects and differences in patient complexity
  - APR-DRG, Severity of Illness, and Risk of Mortality for inpatient triggered episodes
  - Patient comorbidity (Elixhauser Index)
  - Insurance coverage and demographic factors (potentially)

HOPE Episodes

- “Triggered” by an inpatient or outpatient hospital discharge and a specific patient profile
- All case-mix payers except for Medicare
- Attributed to providers involved in the medical encounter
- Participants may specify the length of the “episode window”: 30, 60, 90 (default), 120, or 180 days
- Episodes that end during the performance period will be attributed

HOPE Episodes: Two Thematic Areas

	Description
Care Transitions for Inpatient Discharges	• Interventions focusing on transitional care management (e.g., home assessments, hospital screenings, discharge coordination, telehealth transition services). • Triggered when a beneficiary is discharged from a short-term acute care hospital.
Emergency Care for Inpatient and Outpatient ED Discharges	• Interventions to improve access to clinical and social services for users of the emergency department (e.g., deployment of community-based teams, nurse home visits, connection to resources to address SDOH). • Triggered when a beneficiary is admitted to the ED. Participants can choose to use as the trigger inpatient ED visits, outpatient ED visits (i.e., visits not leading to inpatient hospital admission), or both types of ED visits.

- Applicants are limited to two submissions

Selection Criteria For HOPE Episodes

Type of Criteria	Options	Default	Example
Geographic Service Area	• 5-digit ZIP codes in which targeted patients must reside	No restrictions	20 Maryland ZIP codes
Primary Dx, APR-DRG, SOI, or ROM	• Inpatient ICD-10-CM primary diagnosis codes • APR-DRG, SOI, ROM codes *[Care Transitions only]*	No restrictions	Cardiac APR-DRG codes (no SOI, ROM, ICD-10-CM specified)
Prior Utilization	• Setting (Inpatient hospital, outpatient observation, or ED), threshold (e.g., 2 inpatient discharges), and time window for when the threshold was reached (e.g., 2 discharges in past 60 days)	No restrictions	1 inpatient hospital discharge during the 365 days preceding the episode begin date
Chronic Conditions	• Minimum number of the 30 CCW Chronic Conditions* identified by principal and secondary diagnosis codes on IP or OP case-mix records over a 1- or 2- year look-back period.	No restrictions	1 or more CCW Chronic Conditions

* Chronic Conditions Data Warehouse. Chronic Conditions: https://www2.ccwdata.org/web/guest/condition-categories-chronic.

Selection Criteria For HOPE Episodes

Type of Criteria	Options	Default	Example
Beneficiary Age	• Any age range(s)	No restrictions	55 years or older
Discharge Destination	• Patient was discharged directly to post-acute care (nursing facility, custodial/supportive care, LTCH, acute hospital, IRF, Psych hospital), SNF, Home Health, Hospice, or Community *[Care Transitions only]*	No restrictions	Include beneficiaries discharged from the hospital to Nursing Facility, SNF, or Home Health
Prior Ambulance Transports	• Threshold for number of ambulance transports that led to an inpatient or outpatient hospital encounter, and time window for when the threshold was reached (e.g., 2 transports in past 60 days) *[Emergency Care only]*	No restrictions	2 ambulance transports to hospital during the 365 days preceding the episode begin date

Selection Criteria For HOPE Episodes

Type of Criteria	Options	Default	Example
Beneficiary Death	• Hospitals may include beneficiaries who die during the episode window beginning *[Care Transitions only]*	Exclude	Include beneficiaries who die during the episode
Include or Exclude Index Hospital Stay Costs	• Participant may elect to include or exclude the costs of the index inpatient hospital stay in its total episode costs *[Care Transitions only]*	Include Index Hospital Stay Costs	Default

General Criteria for Both Thematic Areas

Criteria	Description
Maryland Resident	• Beneficiaries must reside in Maryland during the index hospitalization or ED visit
Deaths Excluded	• Episodes where the beneficiary died during or within 30 days of the index hospitalization or ED visit *[for Emergency Care only; Care Transitions allows an option to forego this exclusion]*

Exploratory Data Will be Provided to Participants

- Two analytic data sets, one for each thematic area
  - Baseline Care Transition Episodes: Every inpatient hospital discharge from the participant's hospital meeting general criteria during 2024–2025
  - Baseline Emergency Care Episodes: Every inpatient and outpatient ED discharge from the participant's hospital meeting general criteria during 2024-2025
- These will characterize each of the optional criteria for the thematic area and include total 90-day inpatient and outpatient hospital costs for each episode
  - Baseline Care Transition Episodes will include total 90-day hospital costs with and without including the index hospital stay costs
- Applicants will be required to sign a DUA with HSCRC. Send a request to HSCRC and instructions will follow. Expect delivery of data in late August.

Example File Layout for Baseline Care Transitions Episodes

Episode ID	Month_Year	Cost_90d_wIP	Cost_90d_woIP	Service Area Zip	CC_AMI	CC_Alzh	CC_Anemia	…	N_IP_p365	N_ED_p365	N_Obs_p365	N_IP_p90	N_ED_p90	N_Obs_p90	Prime_ICD10	APRDRG_SOI_ROM	Disch_To
123456	Jun-24	$32,105	$27,053	21201	1	0	0	...	1	1	1	0	1	0	I21.1	140-02-02	HHA
7891011	Feb-25	$19,564	$19,564	20850	0	0	1	...	0	2	1	0	1	0	J18.9	139-01-01	Comm

AHEAD Population Health

Maryland
DEPARTMENT OF HEALTH

AHEAD Population Health

July 22, 2026

PHAP Overview

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Overview - State Population Health Accountability Plan (PHAP)

PHAP is a required element of the AHEAD model.

- Based on a template provided by CMMI with narrow range of measure options to choose from across six domains.
- The State was required to set biannual targets for 6 measures.
- The target-setting and measure selection has occurred through the AHEAD model governance structure (Maryland's Commission on Health Equity or MCHE).
- If the State fails to reach targets, this results in a corrective action plan.
- Maryland submitted the measures and targets to CMMI on October 15, 2025.
- CMMI provided comments on June 10, 2026.

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MCHE Roster

Meena Seshamani, MD, PhD Secretary of Health (Co-Chair)	**Elinor J. Petrocelli, MBA** Mercy Health Service	**Meg Sullivan, MD, MPH** Deputy Secretary for Public Health Services (PHS)
Jonathan (Jon) Kromm, PhD, MS Health Services Cost Review Commission (HSCRC) (Co-Chair)	**Elizabeth Chung, MS** Asian American Center of Frederick	**Melony G. Griffith, MSW** Maryland Hospital Association
Anna Maria Izquierdo-Porrera, MD, PhD Care 4 Your Health Inc.	**G. Johnson Koilpillai, MD** Frederick City Health Center	**Perrie Briskin, MBA, MPH** **Deputy Secretary for Health Care Financing & Medicaid**
Bryan Buckley, DrPH, MPH, MBA CareFirst BlueCross BlueShield	**Jefferson Vasquez-Reyes** University of Maryland	**Rachel Talley, MD** **Deputy Secretary for Behavioral Health Administration (BHA)**
Chanté Richardson, PhD, MBA Meritus Health	**Kelsey Goering, MPP** Department of Budget & Management	**Richard Lichenstein, MD** Department of Human Services
Cynthia Calixte, MD, MPH Wicomico County Health Department	**Kirsten C. Bosak** Department of Disabilities	**Sara Seitz, MPH** State Office of Rural Health
Danielle Meister Department of Housing & Community Development	**Kisha N. Davis, MD, MPH** American Academy of Family Physicians (AAFP)	**Sen. Mary Washington, PhD, MA** Maryland Senate
Darrell Gray II, MD, MPH Wellpoint Maryland	**Kristin Fleckenstein** Department of Planning	**Shondelle Wilson-Frederick, PhD,** Director, Office of Minority Health & Health Disparities (MHHD)
Del. Jamila Woods, MSW, MDiv Maryland House of Delegates	**Leslie Ray** Department of Aging	**Tiffany Wiggins, MD, MPH** University of Maryland Medical System (UMMS)
Deneen Richmond, MHA, RN Luminis Health	**Marie L. Grant, JD** Maryland Insurance Administration	**Tonya B. Wigfall** Department of Commerce
Douglas Jacobs, MD, MPH Maryland Health Care Commission	**Mark Luckner, MA** Maryland Community Health Resources	**Melony G. Griffith, MSW** Maryland Hospital Association

DAC Roster

Shondelle Wilson-Frederick, PhD (Co-Chair) Director, Office of Minority Health and Health Disparities	**Julie Kornmann** University of Maryland Medical System	**Nikardi Hynes, MPH** Prevention and Health Promotion Administration, MDH
Megan Priolo, DrPh, MHS (Co-Chair) CRISP (Chesapeake Regional Information System for our Patients)	**La Stelshia Speaks, MSW** Baltimore County Public Schools	**Terris King, ScD, MS** Maryland Community Health Resources Commission (CHRC)
Christina Gray, MS Wicomico County Health Department	**Margo Coruzzi, MA** Meals on Wheels of Central Maryland	**Tiffany Deprospero** Behavioral Health Administration, MDH
Chris Haffer, PhD, MA U.S. Equal Employment Opportunity Commission	**Nikardi Hynes, MPH** Prevention and Health Promotion Administration, MDH	
Bianca D. Smith-Black, PhD, MPH CareFirst BlueCross BlueShield	**Shante' Gilmore, MPH** Maryland Health Care Commission	
G. Johnson Koilpillai, MD Frederick City Health Center	**Shawnta Jackson, MPH** Cause Engagement Associates	
Geoff Dougherty, PhD, MPH Health Services Cost Review Commission (HSCRC)	**Sherita Hill Golden, MD, MHS** Johns Hopkins University School of Medicine	
Jennifer Bailey, RN, MS Johns Hopkins Community Physicians	**Sule Gerovich, PhD, MPP** Maryland Hospital Association	
Jessica Galarraga, MD, MPH MedStar Health	**Susan Elerding** Tidal Health	

Hospital Participation on MCHE and DAC

Maryland Hospital Association

Luminis Health

Mercy Health Services

Meritus Health

University of Maryland Medical System

TidalHealth

Johns Hopkins

MedStar

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Process for Selecting PHAP Measures

- The Data Advisory Committee (DAC) of MCHE met at least once per month from Jan-May 2025 and then again in Sept and Dec of 2025.
- **For each measure option provided by CMMI, DAC reviewed:** measure definition; current baselines and trends over time by subpopulation; relevant background info and other measures; data limitations; feedback from SMEs; possible target trajectories and feasibility of change.
- DAC members voted on measure options.
- MDH also conducted a thorough literature review on evidence-based interventions for each chosen measure.

Rubric for Measure Selection

1. Does this measure align with your work or the work of your organization?
2. Do large population health disparities exist with this measure? Consider data presented to DAC and any other quantitative or qualitative data available to you?
3. Based on CMS AHEAD specs, are there data limitations which would impact data analysis and/target setting? Consider challenges with data definition, frequency, data collection practices etc.
4. Does this metric and its definition enable measurable progress over a 10-year span and allow for biannual targeting, considering the baseline and scale of change?
5. What target setting approach would you recommend for this?
6. Of the measure options in this domain, which is your preferred measure? If there is only one option, do you recommend that the State explore an alternative measure? Why?

Target Setting Process

- Mathematica developed a number of possible targets, incorporating feedback from DAC rubric submissions.
  - Approaches included trends-based, within Maryland performance-based, national performance-based, and subpopulations.
- MDH discussed target options with internal stakeholders (Medicaid, HSCRC, program staff) to understand what would be necessary to achieve different targets. Maryland's approach was to be realistic about possible change with existing resources.
- Target setting for some measures was significantly hampered by data limitations.
- DAC and MCHE provided feedback on targets in 3 separate meetings.

Final PHAP Measures and Targets

Measure	Data Source	All-Payer 2023 Baseline	Maryland All-Payer Target for 2035
Self-Reported Health Status *Note: significant data limitations*	BRFSS	16.5% with poor or fair health	16.5% with poor or fair health
Colorectal Cancer Screening *Note: significant data limitations*	Claims w/ supplemental lab data	49.3%	55.3% with screening
Hemoglobin A1c Control for Patients with Diabetes (>9.0%) *Note: significant data limitations*	Claims w/ supplemental lab data	67.8%	59.3% with poor control
Follow-up After Hospitalization for Mental Illness	Claims	64.3% at 30 days; 38.0% at 7 days	67.3% follow-up at 30 days; 41% at 7 days
Plan All-Cause Unplanned Readmission	Claims	O/E= 1.01	<1
Food Insecurity *Note: significant data limitations*	BRFSS	16.4% food insecure	15% food insecure

Implementation

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Local Action Plans

- Each jurisdiction will create a Local Action Plan that clearly outlines the actions that will be taken by different organizations to make progress on the 6 measures in that jurisdiction.
- The Local Action Plan process is being led by Local Health Departments, in coalition with community members and partners.

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Hospital PHAPs

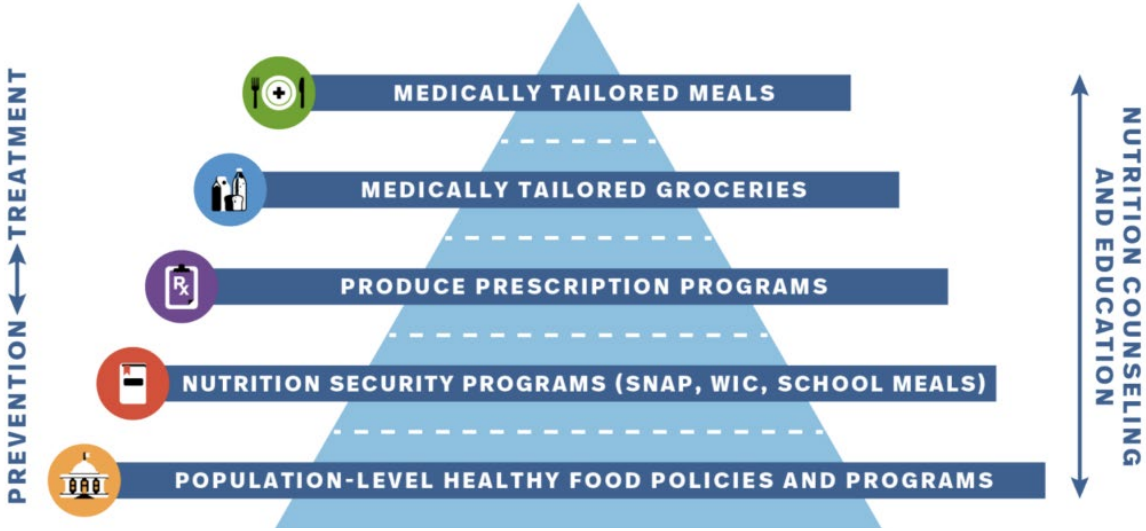
- Hospitals are required under the State Agreement to create hospital-specific PHAPs.
- These hospital PHAPs should align with the Local Action Plans.
- We are waiting on a template from CMS for the hospital planning.

Population Health Improvement Fund (PHIF)

- **Legislative Authority:** Established by HB 1104 as a special, nonlapsing fund that supports investment to reach population health targets under AHEAD and any successor models.
- **Governance:** MDH and HSCRC jointly administer the Fund
  - HSCRC Commissioners voted (Dec. 2024) for a one-time, statewide adjustment of $25 million in CY 2025, designed to advance Maryland's population health goals. This investment was structured outside of hospitals' existing rate structures to avoid any reduction in hospital resources.
  - Allowed to accept funds from public and private sources
  - The initial funds are being used for Food Is Medicine.

Why Food Is Medicine?

- Food Is Medicine is a set of evidence-based interventions that can support Maryland's progress towards meeting the AHEAD pop health targets. Food Is Medicine is being implemented across many states and can generate significant cost savings.
- By focusing on one upstream driver at a time with PHIF, Maryland can demonstrate impact and work towards sustainability, including through Medicaid reimbursement.



Deuman KA, Callahan EA, Wang L, Mozaffarian D. True Cost of Food: Food is Medicine Case Study. Food is Medicine Institute, Friedman School, Tufts University: Boston, MA; 2023.

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PHIF 2026 Plan: Food Is Medicine

Launch 2 initiatives:

1) ***Medically tailored meals*** (MTMs) for high-risk patients: generate short-term savings and demonstrate value of FIM in MD. *Launched in April 2026.*
2) ***Place-based produce prescriptions*** (Produce Rx): build FIM capacity and prevent chronic disease in high-poverty areas. *Currently open RFA.*

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Rural Health Transformation (RHT)

- Aligned Maryland's RHT pillars, goals, and measures with the PHAP
- RHT RFAs have been designed to support Maryland in making progress on PHAP measures
- RHT Rooted & Resilient funding opportunity has parallels with HOPE and may serve as seed money to start HOPE projects

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Reporting

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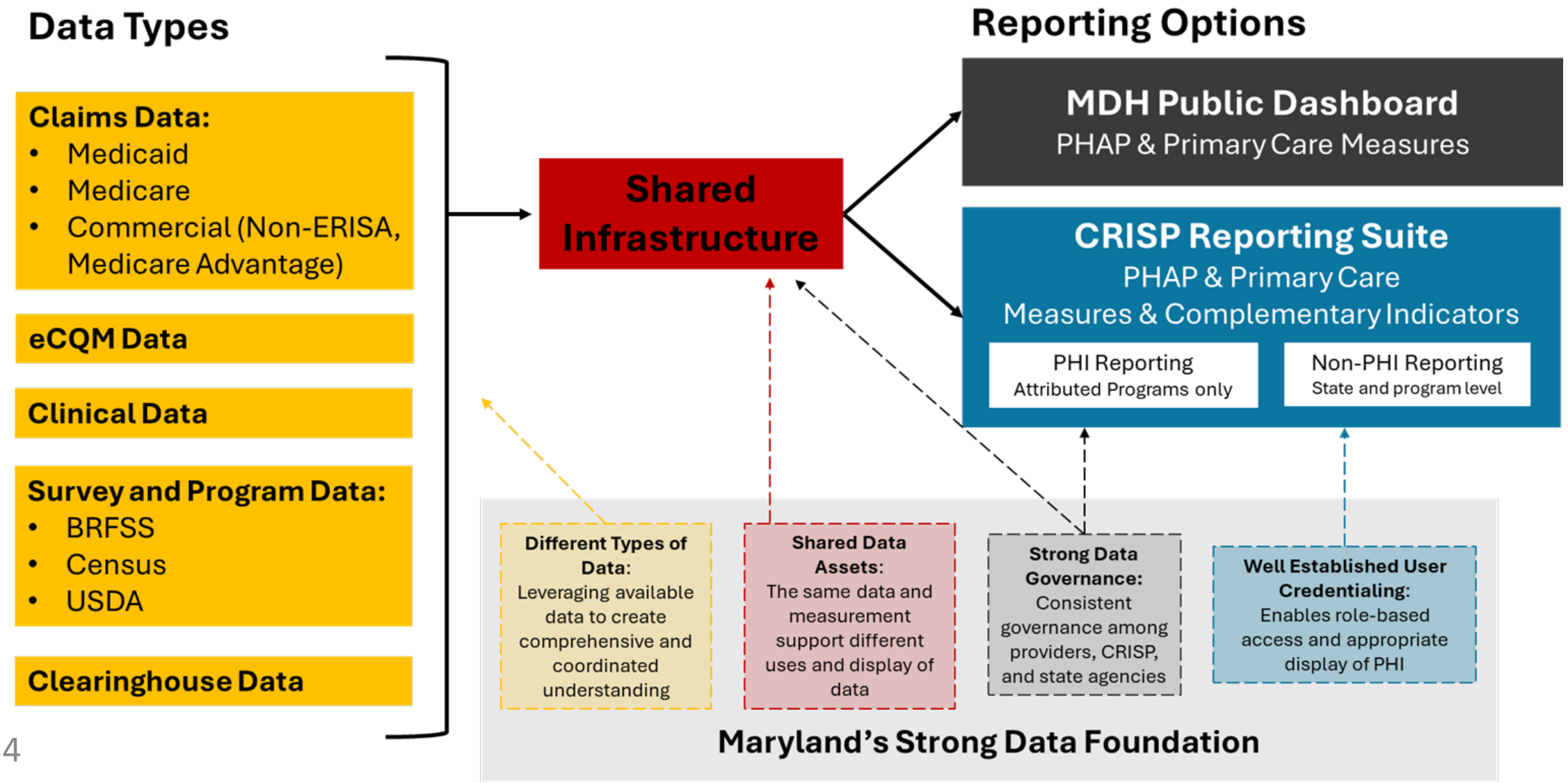
Reporting System: Future State



MDH Public Dashboard

AHEAD Measures Included: PHAP and Primary Care

Audience: Public

Data Granularity: Aggregate and by subpopulations

Location: Dashboard on MDH website

Uses: Transparent understanding of Maryland's performance with the AHEAD model

Status: Live, available at https://health.maryland.gov/dataoffice/mdh-dashboards/Pages/hid.aspx

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CRISP Reporting Suite

AHEAD Measures Included: PHAP, Primary Care AHEAD, and supporting indicators

Audience (2-views):

- **Non-PHI:** Health depts, state agencies, hospital systems, insurers
- **PHI:** Participating Providers

Data Granularity:

Non-PHI: Aggregate and by subpopulations

PHI: Patient-level, with ability to aggregate by subpopulations

Location: CRISP

Uses:

- **Non-PHI:** Closer examination of trends for population-level intervention planning
- **PHI:** Patient-level intervention

Status: In progress, Version 1 in fall 2026

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EQIP Updates

EQIP Important Dates

- PY6 EQIP Pre-Enrollment Form: Due August 7, 2026
  - Required only for organizations new to CRISP or those forming a new EQIP Entity
  - Note: The Pre-Enrollment Form is not the official EQIP application
  - Complete form here
- PY6 EQIP Open Enrollment: June 29 – August 21, 2026
  - All *new and returning* entities must submit an enrollment application during this period.
  - PY6 EQIP Application Live in the EQIP Enrollment Portal (EEP). Eligible participants can now submit their applications through the portal.
- Next EQIP Subgroup Meeting: Friday, September 18 at 9:00 AM ET
- If you have any questions or concerns, please direct them to the CRISP EQIP Support Team at eqip@crisphealth.org.

TCOC Workgroup Next Steps

TCOC Workplan for Upcoming Months

- First HOPE meeting is 8/12
- Upcoming TCOC Workgroup Dates
  - August 26
    - Meeting Agenda TBD
  - 2026 Meeting Dates (Tentative) posted on TCOC Workgroup Webpage

Thank You
Next Meeting August 26, 8-10 am