



maryland
health services
cost review commission

Total Cost of Care Workgroup Meeting

May 27, 2026

Agenda

- TCOC Workgroup
 - AHEAD Update
 - Healthcare Outcome Payment Effort
 - Other Updates & Upcoming Meetings
- Volume Workgroup



AHEAD Update

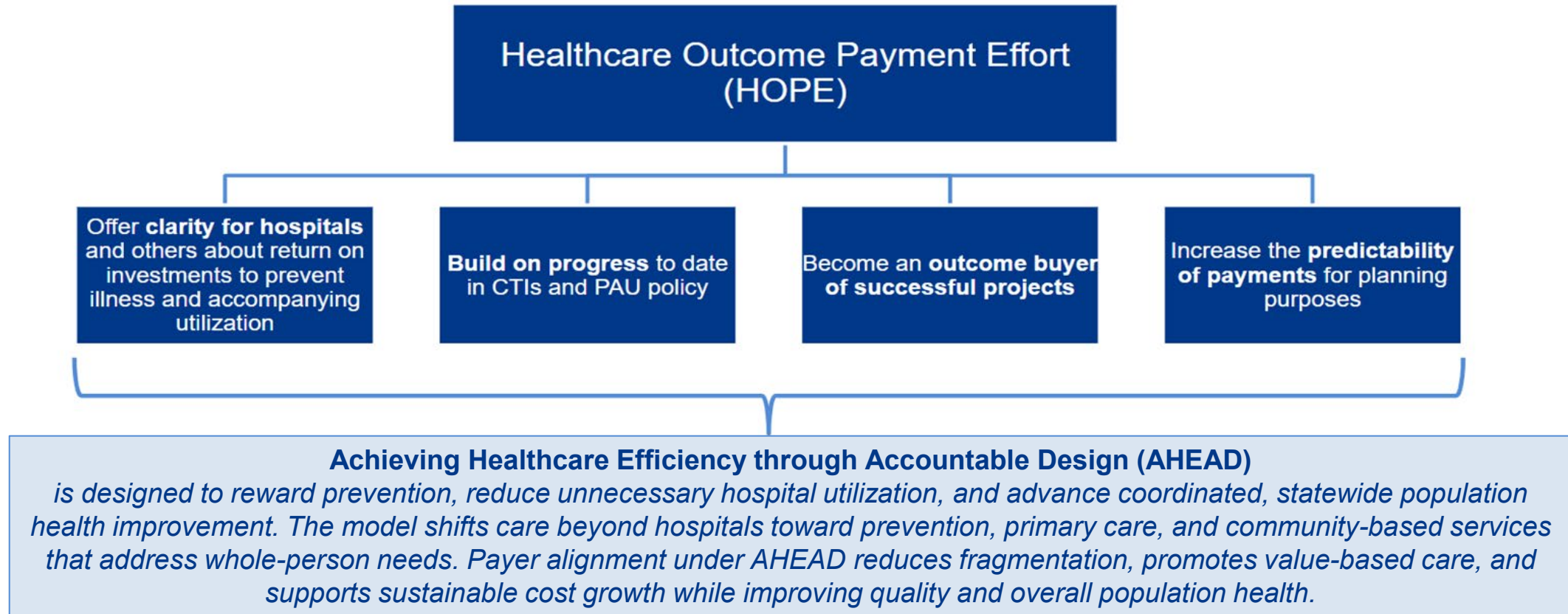
GEO AHEAD Planned Events & Resources

- Available:
 - **Geo AHEAD Factsheet:** 5-page introduction to Geo AHEAD elements and mechanics
 - **Geo AHEAD Specification Previews:** Individual documents covering attribution, and Bidding Preview
- Q2 2026:
 - **Geo AHEAD Specification Previews:** Individual documents covering payment policy and benchmarking
 - **Geo AHEAD Participation Perspective Survey:** Soliciting input from interested parties following At-A-Glance release
- Q3 2026:
 - **Geo AHEAD Specs 1.0 Release:** Model specifications covering attribution and payment methodology. Will have an associated webinar.
- Q4 2026:
 - **Geo AHEAD Specs 2.0 Release:** Specifications updated with detail on benchmarking including Trend Factor and Risk Adjustment.
 - **Participating Provider & Beneficiary TA:** Education materials for practices and beneficiaries
- Q1/Q2 2027:
 - **RFA release:** Opportunity for Bidding Entities to submit application. Will include ratebook and technical assistance.
- Q1 2028:
 - **Model Start**

Healthcare Outcome Payment Effort

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.



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*

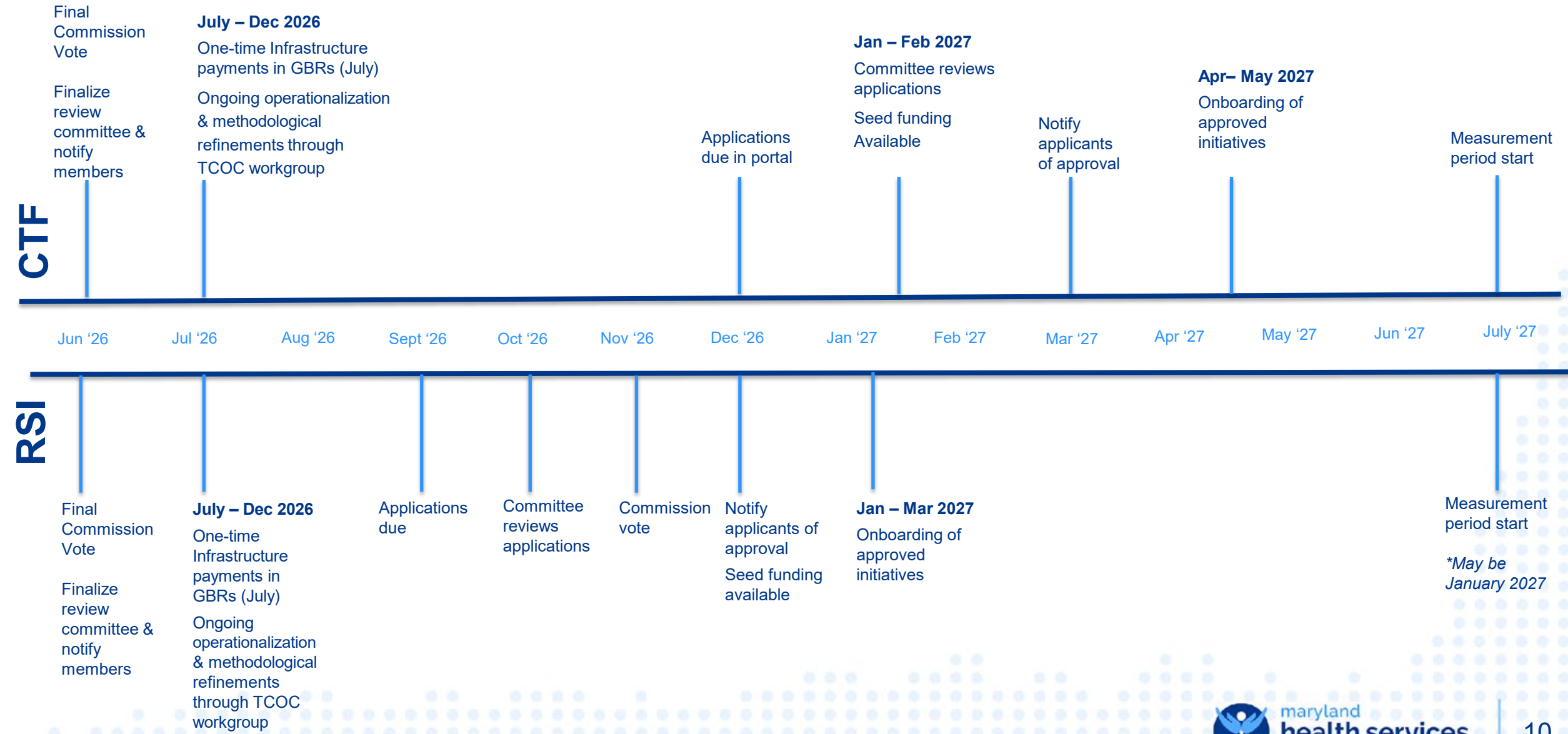
Two Paths to Participation Detail

	Care Transformation Framework (CTF)	Regional and 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	Base share of savings is 50%	Base share of savings is 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

Policy Revisions

- **Timeline**
 - Delay implementation until FY2028 with application period in second half of CY2026.
- **Scoring and Payments**
 - Qualify interventions up to \$100 million in projected averted hospital costs.
 - Score interventions at actual averted hospital costs, or 125% of projected averted hospital costs, which ever is lower.
 - If the score is less than half of the projected averted hospital costs, there will be no scored savings, i.e. minimum saving rate for projections is 50%
- **Infrastructure payments and seed funding**
 - FY 27 - \$25M for infrastructure payments and \$25M for seed funding for approved applicants
 - FY 28 - Measurement period starts and potentially new seed funding provided to approved applicants

Draft Standard Revised Timeline*



*Timelines could vary to accommodate specific applicant's specifications

Policy Clarifications

- **Anchor entities**

- While it is preferred that community organizations are the anchor entity, hospitals can be the anchor entity in an RSI but they must have meaningful partnerships with community organizations, e.g. engage via MOU.
- The request for formal recognition of Area Agencies on Aging (AAAs) as RSI anchor entities will be incorporated into the final policy implementation.
- HSCRC agrees that “Community Partner” language should be strengthened to explicitly include Local Health Departments and will work to ensure this is reflected in the final guidance.

- **Interventions**

- Palliative care, hospice, and advance care planning should be explicitly identified as priority HOPE initiatives and palliative care interventions (aligned with CAPC and NHPCO) will be listed as qualifying examples in the final policy.
- Review criteria will include assessing if projects are grounded in a strong evidence base and address state health priorities. Staff will explore adding diagnostic excellence within the scope of HOPE supported interventions.

- **Review Committee/Criteria**

- HSCRC will explore including at least one palliative care expert on the review committee and will also explore incorporating patient-reported outcome measures where feasible and appropriate.
- We agree that review criteria should prioritize upstream drivers of health, such as nutrition and transportation, and will incorporate this into the final framework.
- Staff will explore adding “presenting symptoms” to the list of illustrative target population characteristics in the review criteria.

Policy Clarifications

- **Regional and State Initiatives**

- HSCRC will work to ensure that Local Health Departments are engaged and included in regional and statewide initiatives.
- HSCRCs agree that regional governance structures should include public health participation and will work to incorporate this into the RSI requirements as feasible and appropriate.

- **Interoperability**

- HSCRC agrees with supporting interoperability (e.g., CRISP and closed-loop referrals) and will work with CRISP to ensure that HOPE initiatives are able to incorporate these capabilities, as appropriate, in the implementation.

- **Crosswalk/Overlaps**

- We agree with the need for a comprehensive crosswalk demonstrating how HOPE intersects with existing initiatives (e.g., Revenue for Reform, PHAP) to reduce administrative burden and duplication and will work to generate this document before implementation.
- HSCRC agrees that HOPE should not exclude or unnecessarily limit overlap with existing initiatives (e.g., Revenue for Reform, Maryland Primary Care Program, Primary Care AHEAD, EQIP Primary Care, Rural Health Transformation) if there is not duplication of payments for similar activities.

All-Payer Scope & Medicare Inclusion

- Launch HOPE as an all-payer model by FY2028
- Medicare participation is a priority, but implementation will proceed regardless of CMS timing
- Use case-mix data in FY2028
- Initial focus on inpatient and ED spending
- Engage Medicaid and commercial payers more deeply beginning FY2029
- Supports transition of Medicare global budgets under AHEAD (CY2028)

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 committee will ensure that:
 - Submissions reflect meaningful and well-designed interventions
 - Qualified initiatives are a balance of opportunities across the state given the specific challenges of each region and consider the resources already dedicated when considering how to prioritize funding
 - Total projected savings does not exceed payout cap
- HSCRC Executive Director makes the final decision on the recommendation of the review committee.

Review Criteria

- Specifically, proposals should demonstrate that they:
 - **Are grounded in a strong evidence base.**
 - This may be shown by citing peer-reviewed literature, prior evaluations, pilot studies, established practice standards, or technical assistance supporting the proposed intervention.
 - **Address a recognized State health priority.**
 - This may be shown by aligning with the state's AHEAD PHAP or the State Health Improvement Plan (SHIP) or other policies established by the Maryland Department of Health.
 - **Target a clearly defined population.**
 - Specify eligibility criteria and defining characteristics of the target population, such as diagnoses, prior utilization of healthcare services, HCC score, geography, demographics, etc.
 - **Have a high likelihood of producing measurable impact.**
 - This may be shown by a clear and well-justified methodology for estimating the impact of the initiative on health and averted costs.
 - **Avoid adverse impacts on patient experience or total cost of care.**

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 (R4R)**
 - Cannot utilize the same initiative across RfR and this program.
- **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.
 - The review committee will need to consider that resources are already dedicated to prioritize other strategies.

High-Value Care Plans Update

- HOPE final recommendation proposes that HVCPs will sunset at the conclusion of FY26, following completion of final reporting.
- Beginning in FY27, hospitals will retain this revenue within their GBR without additional programmatic obligations, other than maintaining a designated senior executive responsible for the hospital's population health efforts.
 - Please email hscrc.tcoc@maryland.gov with contact information by June 10, 2026.



Additional Updates

High Value Care Plans – Reporting Reminder

- Final reporting due June 1, 2026
 - HSCRC recently circulated the final reporting template.
 - Failure to report on targets and outcomes will result in a take back of 0.27 percent of inflation removed in the July rate orders.
- All final report submissions should be sent to hscrc.tcoc@maryland.gov.

EQIP Important Dates

- PY6 EQIP Open Enrollment Webinar: Friday, June 12 at 12:00 PM ET
 - Register [here](#)
- 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.
- Next EQIP Subgroup Meeting: Friday, July 17 at 9:00 AM ET
- If you have any questions or concerns, please direct them to the CRISP EQIP Support Team at equip@crisphealth.org.

TCOC Workplan for Upcoming Months

- Upcoming TCOC Workgroup Dates
 - June 24th
 - Updates on savings through CY2025
 - HOPE next steps
 - 2026 Meeting Dates (Tentative) posted on [TCOC Workgroup Webpage](#)



Volume Workgroup

Thank You
Next Meeting June 24, 8-10 am