

Maryland AHEAD Update

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Background: Maryland's All-Payer Model



Since 1977, Maryland has had an all-payer hospital rate-setting system



In 2014, Maryland updated its approach through the All-Payer Model



5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment



Per capita, value-based payment framework for hospitals



Provider-led efforts to reduce avoidable use and improve quality and coordination



Savings to Medicare without cost shifting



Sustains rural health care with stable revenue base

1970s

Unit Rates

- Efficient Units

1980-2010

Charge Per Case

- Efficient cases

2010-2018

Global/
Episodes

- Population health
- Efficient episodes

Quality Payments

2019+

Global/Total
Cost of
Care

- System-wide alignment
- Person-centered

Prior to 2014, HSCRC Set Prices Per Unit of Service

<u>Functional Center</u>	<u>Approved Rate</u>	<u>Unit</u>		<u>Units of Service</u>	<u>Charge</u>
Medical/Surgical Unit	\$500	Per day	X	5	\$ 2,500
Intensive Care Unit	\$1,000	Per day	X	2	2,000
Admission	\$100	Per case	X	1	100
Operating Room	\$15	Per minute	X	150	2,250
Radiology	\$20	RVU	X	25	500
Pulmonary	\$3.00	RVU	X	10	30
Blood	\$15	RVU	X	5	75
Lab	\$2.00	RVU	X	25	50
Physical Therapy	\$16	RVU	X	5	80
Cost of Drugs Sold	\$1,200	Invoice cost	X	patient	1,200
<u>Medical Supplies</u>	\$2,100	Invoice cost	X	patient	<u>2,100</u>
Total Charge Per Case					<u>\$10,885</u>

Hospital Payments Have Changed: Focus Shifts from Rates to Revenues

Old Model Volume Driven

Units/Cases



Rate Per Unit
or Case

Hospital Revenue

Unknown at the beginning
of year. More units/more revenue

New Model Population & Value Driven

Revenue Base Year



Updates for Trend,
Population, Value

Allowed Revenue Target Year

Known at the beginning of year.
More units does not create
more revenue

Looking AHEAD Committee – MedChi Working on Next Steps



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The Maryland State Medical Society

The AHEAD Model: HEALTHCARE TRANSFORMATION

The Goal

As Maryland's unique Total Cost of Care (TCOC) Model is expanded and improved upon with the new Advancing All-Payer Equity Approaches and Development (AHEAD) Model, it is necessary to ensure that incentive structures do not continue to create unintended impacts, such as long ER wait times, health disparities, and lack of access to mental health and addiction treatment services.

Under the AHEAD Model, MedChi Believes That We Can Transform Healthcare By:

Savings Targets – The Money Should Follow the Patient

- The AHEAD Model should attribute savings to the Maryland patient and reward practitioners with those savings regardless of healthcare setting.
- The AHEAD Model should have a savings target that ensures regulated entities are funded appropriately for inpatient and ambulatory patient care and reduces funding for those regulated entities that do not invest in innovation and modernization of patient care.

Access to Specialty Care in Regulated Entities

For comprehensive and expeditious care, particularly in 2024, Maryland should set standards requiring regulated entities to have specialty physicians available to treat patients and reward regulated entities that meet such standards.

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The AHEAD MODEL: POPULATION HEALTH

Improving Healthcare Under the AHEAD Model

Public Health Goals

The AHEAD Model should create quality measures that apply to all areas of care with a particular focus on health equity and that clearly align with the Statewide Integrated Health Improvement Strategy.

Preventative Health

The AHEAD Model should have additional measures and incentives for all practitioners to increase screening and prevention for various healthcare conditions with a targeted focus on promoting health equity.

Improve the Healthcare Workforce

Maryland needs to expand its healthcare workforce, particularly in primary care. Maryland should also use funds under the AHEAD Model to reward primary care physicians choosing to work Maryland. To further aid in meeting the AHEAD Model's goals, Maryland should also consider reducing barriers to licensure for physicians to practice in Maryland.

Loan Repayment

MedChi believes that the State should request that the AHEAD Model allow for the use of funds for loan repayment to attract physicians to come and stay in Maryland.

Graduate Medical Education Reform

MedChi believes that Maryland's graduate education needs to be protected and promoted by augmenting the current funding mechanisms and adding a rural residency program to increase investment in residency and Maryland's future physicians.

Exogenous Factors

Maryland's current Total Cost of Care Agreement has a strong exogenous factor clause that includes a clause around defensive medicine, payment, and other important issues. This clause needs to be kept in any agreement concerning the AHEAD Model.

Transparency in Reporting

- The AHEAD Model should require increased reporting and transparency on the use of government funds for community benefit programs to ensure funds are being used to further the AHEAD Model's goals of health equity across the State.
- The AHEAD Model should require further reporting and transparency on the use of additional funds requested by regulated entities for physician payments to ensure that funds are used for their intended purpose.

Price Transparency

Maryland should request that the AHEAD Model provide for more transparency for patients regarding the pricing of services and products provided by regulated entities and collect the data on pricing in one readily accessible and user-friendly location.

Increased Access to CRISP and Other Databases

The AHEAD Model should provide physicians and other healthcare practitioners and entities with increased access to the State's health information exchange, Chesapeake Regional Information System for Our Patients (CRISP), Maryland's All Payer Claims Database, and other available data sources. By providing these Model participants with increased access, healthcare practitioners will be encouraged to be involved in the Model and be able to more actively further health equity. Maryland should also request funds to modernize these various data sources to increase user efficiency.

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THE AHEAD MODEL: PRIMARY CARE

About the AHEAD Model

The Centers for Medicare & Medicaid Services (CMS) has selected Maryland to implement the new States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. With this selection, Maryland will move away from its current Total Cost of Care (TCOC) Model and continue to build on its state-wide efforts to improve health equity, quality, and access, and to control healthcare costs through the new AHEAD Model.

Prior to the AHEAD model, the State is Encouraged to:

- Support and Prioritize the Maryland Primary Care Program (MDPCP) by:**
 - Improving and increasing excellent opportunities, including a Medscape program.
 - Maintaining Care Transformation Organizations (CTOs), especially for small and mid-size practices.
 - Using the Episode Quality Improvement Program (EQIP) as a wrap-around tool coordinating with MDPCP to target underserved areas.
- Keep On-Ramp Track**
MDPCP should keep on-ramp track, as new practitioners may be added without risk.
- Augment EQIP with Primary Care Bundles**
MedChi and MDAFP strongly believe that we need to add several bundles targeted at primary care.
- Expand MDPCP**
To further advance the total health of all Marylanders and lower healthcare costs across all payers, MDPCP should be expanded to include Medicaid and private payers in the AHEAD Model.
- Incorporate Transformation and MDPCP Gap Services**
MDPCP will most likely not have open enrollment opportunities for 2025. MedChi and MDAFP strongly encourage incorporating a transformation role for EQIP primary care to get new practices into MDPCP once we have clarity on the future of the Maryland Model.
- Develop an Accessible, Critical Primary Care Program**
Using EQIP, a global benchmark program could be developed to provide accessible primary care for rural and urban settings with shortages. The cost could be covered by Medicaid and the HSJHC to improve outcomes, access, and population health. The program would target creating new pediatric and adult primary care services through a public-private partnership.

AHEAD Model Goals

The AHEAD Model Aims to:

- Improve the total health of a state population
- Expand health equity among all payers including Medicare, Medicaid, and private coverage
- Drive state and regional healthcare transformation and multi-payer alignment
- Increase resources available to participating states
- Support primary care and transform healthcare in communities

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Working to improve Total Cost of Care and AHEAD *Testimony Before HSCRC*



Padmini Ranasinghe, M.D., MPH,
FACP, FACPM, FSH
MedChi President

MedChi

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This week MedChi President Dr. Padamni Ranasinghe testified at the HSCRC on the AHEAD model

"As President of MedChi, I assure you MedChi is dedicated to advancing healthcare transformation in Maryland, emphasizing quality care, while supporting physicians, patients and the public health of Maryland."



8,965
8,918



SIGNED THE WEEK
BEFORE THE
ELECTION.



PROCESS WAS
QUICK.



CMS AND
MARYLAND LEFT A
LOT OF DETAILS TO
FUTURE
NEGOTIATION.

We Had an Election - CMMI vs. State

CMMI wanted – No rate setting, control of global budgets, no Maryland CRP programs, total control.

Maryland wanted – Rate setting, control of global budgets, local CRP programs, shared control.



CMMI Announcement on Models and What it Means

- Caution AHEAD: State officials nervous for Maryland hospitals under Trump administration –Maryland Matters article
- Total Cost of Care (TOC) was scheduled to end 12-31-26, now ending 12-31-25
- Maryland had agreed to leave TOC and move into AHEAD 12-31-27.
- State has created a staff coordinating council.
- Term sheet for amendments created

Press Releases Mar 12, 2025

Statement on CMS Innovation Center Aligning Portfolio with Statutory Obligation

[Administration](#)

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The Centers for Medicare and Medicaid Services (CMS) Innovation Center is committed to testing – and eventually scaling – innovative payment models that meet the statutory goals of reducing program spending while maintaining or improving quality of care.

Consistent with achieving that mission, the Innovation Center has completed a comprehensive and data-driven review of our model portfolio based on the clear statutory mandate given to the Center by Congress. Based on the review's findings, CMS has identified models that will conclude as scheduled and others that will end early by December 31, 2025 - saving the American taxpayer almost \$750,000,000. CMS will help participants in the selected models to minimize disruption to their operations and the beneficiaries they serve.

The Innovation Center plans to announce a new strategy based on guiding principles to make Americans healthier by preventing disease through evidence-based practices, empowering people with information to make better decisions, and driving choice and competition. This announcement streamlines the focus of CMMI's models and will help build a health system that improves quality and lowers costs while helping Americans live healthier lives.

AHEAD – MedChi has been a major part of the discussion

8,965
8,918



OFFICE OF THE GOVERNOR
Wes Moore

July 3, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Mehmet Oz, M.D.
Administrator, Centers for Medicare & Medicaid
Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Abraham Sutton
Director, Center for Medicare and Medicaid
Innovation
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Kennedy, Administrator Oz, and Director Sutton:

For more than a decade, the Centers for Medicare and Medicaid Services (CMS) and Maryland have been engaged in a highly successful partnership to break free of the flawed fee-for-service Medicare reimbursement model. Under the Maryland Model, the State has evolved towards a structure that incentivizes hospitals to keep people healthy. The Maryland Model has exceeded CMS-established total cost of care savings targets and has delivered these savings in a sustainable way while improving the quality of care delivered to Marylanders, as measured by CMS and independent evaluations.

Maryland wants to work with CMS to accomplish even more cost savings and improved health through the Maryland Model. We share CMS' goal of sustainable financing for the Medicare program to protect the taxpayer, shifting away from a fee-for-service fee schedule to a person-level ACO type model. We also share CMS' goals of digital transformation and evidence-based prevention.

Maryland has a great foundation for this reform.

- Health care costs are growing at one of the slowest rates in the country, both for Medicare and commercial insurers.

AHEAD – AMENDMENT TO TERM SHEET SIGNED

8,965
8,918



CMS Assumes Medicare Rate-Setting Authority (2028)

Beginning in Performance Year 3 (PY3), CMS—not HSCRC—will set Medicare FFS hospital global budgets under a new federal methodology.

HSCRC will retain control of Medicaid and commercial payer rates, which must stay directionally aligned with CMS.

➡ Concern: This change reduces state flexibility and could weaken the alignment between hospital and physician incentives that has historically underpinned Maryland’s success.

2. New Statewide Accountability Targets

Maryland must meet multiple cost, investment, and quality goals or risk federal enforcement actions:

Target	Purpose	Physician Impact
Medicare FFS TCOC	Cap per-beneficiary cost growth	Failure may reduce future funding for transformation programs
All-Payer TCOC	Limit overall cost growth	Potential rate pressure on all payers
Primary Care Investment	Increase primary care share of spending	Possible new funding streams for primary care infrastructure
Quality & Population Health	Six core metrics measuring outcomes and equity	Expanded reporting and performance oversight

CRP Mixed and EQIP Saved



EQIP Continuation and Physician Alignment

CMS has formally committed—through the AHEAD term sheet—to the continuation and expansion of the Episode Quality Improvement Program (EQIP).

EQIP remains the primary pathway for specialists to engage in value-based payment and qualifies as an Advanced Alternative Payment Model (APM) under MACRA.

CMS and HSCRC will:

- Maintain EQIP funding streams and operational infrastructure;
- Align episode methodologies with new AHEAD hospital global budgets;
- Support expansion to additional specialties and episode types.

➡ Implication: EQIP's inclusion ensures that specialists continue to share in statewide savings and quality initiatives.

➡ Advocacy Priority: MedChi must ensure EQIP's stable funding, data transparency, and governance representation during AHEAD implementation.

EQIP Update



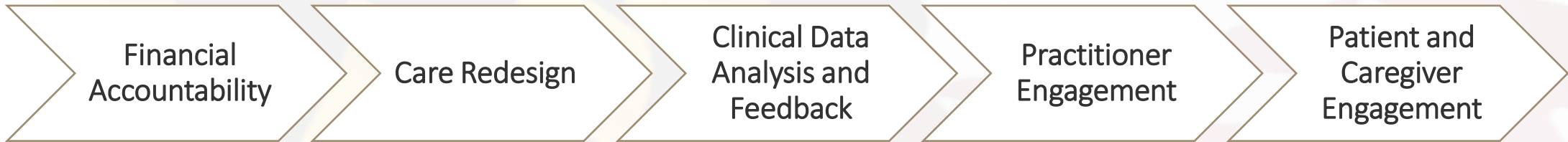
- The Episode Quality Improvement Program (EQIP) is a voluntary, Advanced Alternative Payment Model (AAPM) that engages practitioners who treat Maryland Medicare beneficiaries in care transformation and value-based payment through an episode-based approach.
- EQIP has added 68 new episodes for Performance Year 5 (CY2026) bringing the total episode count to 123 episodes.
- New clinical episode categories include Endocrinology, General Surgery / Wound Care, Hematology / Oncology, Infectious Disease, Nephrology, Neurology.
- The enrollment period for Performance Year 5 (CY2026) of EQIP will be open July 1 through August 29, 2025.
- MedChi continues to support EQIP through advocacy, outreach, education. MedChi also serves as an administrative proxy to 286 practitioners participating in EQIP in Performance Year 4 (CY2025).

Approved PACES Episodes

Clinical Category	short_name	Clinical Category	short_name	Clinical Category	short_name
Alcohol Drug Use or Induced Men	substance abuse alcohol	Endocr, Nutritional & Metabolic	diabetes	Musculoskeletal System & Connec	amputation
	substance abuse other		diabetic circulatory complications		aseptic necrosis
Blood and Blood Forming Organs	anemia chronic		diabetic ketoacidosis dka (acute)		bone nos fx
	aplastic anemia		diabetic neuropathy		carpal tunnel surgery
	neutropenia		diabetic retinopathy		Cervical Fusion
	neutropenia (acute)		diabetic skin complications		Cervical Replacement
Burns	1st/2nd degree burn		ds of lipid metabolism		Fracture/dislocation treatment arm/wrist/hand
Circulatory System	atrial fibrillation/flutter (chronic)		hemochromatosis		Fracture/dislocation treatment knee
	heart failure (chronic)		hyperosmolarity non-ketotic coma (acute)		Fracture/dislocation treatment lower leg/ankle/foot
	hypertension essential (chronic)		Hypoglycemia (acute)		joint nos ganglion/cyst
	pericarditis, inflammatory	Obesity hypoventilation syndrome	knee jnt internal derangement (acute)		
	AV fistula creation and revision	osteoporosis	knee jnt internal derangmnt		
	hypertension complic, malig acute	Eye	macular degeneration	osteomyelitis nos	
hypertension secondary (chronic)	macular hole		osteomyelitis nos (acute)		
Leg vein angioplasty	macular pucker		Lumbar and sacral spine surgery OTHER		
Digestive System, Hepatobiliary	retinal tear		Neoplasms and Myeloproliferativ	airway lung neoplasm malignant	
	anal/rectal fissur/ulcer	breast biopsy		benign neoplasm of uterus	
	crohn's disease	Breast reconstruction		breast neoplasm malignant	
	diverticulitis of colon	General		carcinoma in situ cervix	
	diverticulosis of intestine(chronic)			Appendectomy	colorectal neoplasm malignant
	esophageal varices(chronic)			Repair inguinal hernia	ds of the spleen, neoplasm
esophagitis (chronic)	repair umbilical or ventral hernia	graft vs. host			
Bariatric surgery	Repair ventral hernia	leukemia acute			
small bowel resection	Kidney and Urinary Tract Diseas	acute kidney failure	leukemia chronic		
ERCP		chronic kidney disease - dialysis dependent	malignant neoplasm of uterus		
Ear, Nose, Mouth & Throat		sinusitis acute	chronic kidney disease - not dialysis dependent	neoplasm of uncertain behavior of ovary	
	Pregnancy, Childbirth and Puerp	Mental Behavioral Health	single manic episode	Mastectomy	
Respiratory System			acute uri simple	Nervous System	dementia
			parkinsons ds		
			acute ischemic stroke		
				transient ischemic attack	

The Episode Quality Improvement Program was SAVED!

EQIP is a voluntary program that engages non-hospital Medicare practitioners and suppliers in care transformation and value-based payment through an episode-based approach. EQIP emphasizes:



EQIP will provide incentive payments to practitioners who improve the quality of care and reduce the cost of care they provide to Maryland Medicare patients.

- There is an **upside-only** risk for EQIP Entities.
- Participating Care Partners bill CMS and receive reimbursement for their services as **normal**.
- Financial performance is assessed approximately **six months** after the program year ends.

EQIP participants are eligible for AAPM status and bonuses.

- Qualify into the **Quality Payment Program (QPP)**.
- **Exclusion from the MIPS** reporting requirements and MIPS payment adjustments.

What happens with Primary Care in the New Model?

MedChi is fighting for Primary Care! The new model will have:



- Medicare MDPCP Program for at least two years.
- Medicaid APM ongoing, and
- A new Primary Care AHEAD program.

MedChi wants to protect the Maryland Primary Care Program (MDPCP).



MDPCP is a voluntary program open to all qualifying Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state.

Concerns that remain:



- MDPC Medicare goes away.
- Medicaid program attribution and payment issues
- Primary Care AHEAD payment issues

Key Takeaways

- Maryland has had rate setting in some form for hospital payments since 1977. We will stay on that for two more years.
- Maryland hospitals are on global budgets; those Medicare budgets are scheduled to be set by CMMI starting in 2028. Other budgets will remain with HSCRC – How does that work?
- Maryland has the largest value-based primary care program (MDPCP) per capita in America. It is scheduled to possibly end in 2028.
- MedChi, CRISP and the HSCRC manage the EQIP program developing over 120 federally approved AAPMs. This was saved and is now part of the model.
- The AHEAD term sheet has been signed with an amendment to the State AHEAD agreement.

Center for Value-Based Care



AHEAD

Care Transformation Initiative

EQIP

Maryland Insurance Issues on Value-Based Care

MDPCP

Total Cost of Care

Center for Private Practice of Medicine

MedChi is committed to helping practices remain independent. As your Medical Society, MedChi developed the Center for the Private Practice of Medicine to provide business support tailored to the time constraints of your practice. Our goal is to strengthen your practice by providing credible support that meets your needs with key business services and resources, such as:

- Insurance
- Collections
- HIPAA & Medical Records
- MedChi CTO
- Practice Management Help
- Ancillary Suggestions Insurance Needs
- Technology Help



PRACTICE MANAGEMENT SERVICES

MedChi is committed to helping practices remain independent. As your Medical Society, MedChi developed the CENTER FOR THE PRIVATE PRACTICE OF MEDICINE to provide business support tailored to the time constraints of your practice. Please take a moment to review some of the key business services we provide to strengthen your practice. Our goal is to help your practice by providing credible support that meets your needs.

PRACTICE MANAGEMENT SERVICES

- Practice Operations and Workflows Assessment
- Workflow optimization and improvement.
- Recruiting- Administrative staff and Clinical staff
- Practice Acquisition Project Management.
- Chronic Care Management set up guidance.

COMPLIANCE

- HIPAA policy review, training and improvement recommendations.
- OSHA policy review, training and improvement recommendations.
- Medical Charts coding review and improvement recommendations.
- Billing review analysis and improvement recommendations.

TECHNOLOGY

- EHR selection support and implementation guidance.
- MACRA/MIPS Assistance.
- IT Support and Infrastructure recommendations from our current vendors.

INSURANCE

- Payor credentialing.
- Payor contract negotiations.
- Necessary insurance coverage recommendations for the practice, including business insurance, workers compensation and malpractice insurance.

NEW PRACTICE

- Comprehensive guide for opening a new practice, including infrastructure development.

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Center for the Private Practice of Medicine

PLEASE CHOOSE ONE:

☐ PRACTICE MANAGEMENT SERVICES ☐ COMPLIANCE ☐ TECHNOLOGY ☐ INSURANCE ☐ NEW PRACTICE

Practice Name: _____ Practice Contact: _____
Email address: _____ Phone number: _____

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Center for the Employed Physician

CONTRACT REVIEW EDUCATION – Provided targeted educational seminars and resources to employed physicians and those negotiating employment contracts, leveraging our Model Employment Contract and negotiation tools.

UPDATED MODEL CONTRACT – Released an updated version of our Model Employment Contract this year to reflect current trends in compensation, duties, benefits, termination clauses and physician autonomy in Maryland employment arrangements.

SALARY SURVEY – Published the 2024 Maryland Physician Compensation Survey showing average physician salary of ~\$356K, an increase of ~29% since 2021; offers detailed breakdowns by compensation structure, productivity bonus, pay transparency, and demographic variation.



Salary Survey

Maryland
Model
Employment
Contract

Maryland
Health Survey

Physician Job
Opportunities

Physician
Loan
Repayments

Policy &
Guidance

Thank You!!

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