Maryland Hospital Rate Setting Is Changing: What HR and Finance Need to Know

A two-page briefing on the transition from Maryland's Total Cost of Care (TCOC) model to the AHEAD model beginning in 2026—and why it matters for employer-sponsored health plans.

EXECUTIVE SUMMARY

Maryland is the only state with an all-payer hospital rate setting system, overseen by the Health Services Cost Review Commission (HSCRC) through a long-standing agreement with the Centers for Medicare & Medicaid Services (CMS). Historically, this approach has standardized hospital prices across payers and supported hospital "global budgets" (predictable annual hospital revenue) tied to quality and cost containment goals. Starting in 2026, Maryland begins transitioning into the federal AHEAD model. AHEAD expands statewide accountability for total cost of care, primary care investment, and population health outcomes—and introduces new payment and oversight features that can affect employer plan costs, provider contracting dynamics, and network access.

- AHEAD begins January 1, 2026, with a multi-year transition period running into the early 2030s.
- The model increases emphasis on outcomes and multi-payer alignment (Medicare, Medicaid, and commercial) through statewide targets.
- Maryland is expected to retain significant all-payer tools for hospital rate setting, while Medicare fee-for-service hospital payment methodology is designed to evolve under AHEAD over time.

BACKGROUND: MARYLAND'S HOSPITAL RATE SETTING IN PLAIN ENGLISH

Under HSCRC rate setting, Maryland hospitals are paid based on state-approved rates rather than payer-by-payer negotiations for most hospital services. A key feature has been hospital global budgets—pre-set annual revenue targets—combined with quality programs and guardrails intended to limit unnecessary volume growth and keep overall spending in check. This structure is often referred to as Maryland's "waiver" because CMS permits Maryland to operate an alternative Medicare hospital payment approach as long as the state meets agreed-upon cost and quality goals.

WHAT'S CHANGING UNDER AHEAD (STARTING 2026)

AHEAD (Achieving Healthcare Efficiency through Accountable Design) is CMS' next-generation state total cost of care model. It builds on Maryland's prior TCOC model but places greater emphasis on (1) statewide accountability for all-payer cost growth, (2) increased and aligned investment in primary care, and (3) measurable population health and health equity outcomes. In practice, AHEAD can change how hospital budgets are set and adjusted, how incentives are distributed across provider types (not only hospitals), and how financial responsibility is shared across payers over time.

Timing	What to expect
2026	AHEAD implementation begins; new statewide targets and program structures start phasing in.
2027–2028	Expanded advanced primary care participation and multi-payer alignment efforts; policy and operational changes continue to roll out.
2028 and beyond	Hospital payment methodology and oversight for Medicare fee-for-service is expected to evolve further under AHEAD; market impacts may become more visible in contracting, access, and premiums.

For employers, the practical question is how changes in hospital financing and incentives ripple into commercial premium trends, network strategy, and employee access. As Maryland adjusts to AHEAD's statewide savings and performance requirements, stakeholders have raised concerns about cost shifting to the commercial market, pressure on financially vulnerable hospitals, and increased variation in provider contracting outcomes across regions.

IMPLICATIONS FOR HR & FINANCE

Key implications to monitor (2026–2030)

1) Cost and premium pressure

- Commercial premiums will face upward pressure as statewide Medicare savings requirements lead to cost shifting into commercial hospital rates.
- Budgeting may become less predictable if hospital payment policies change unevenly by region or hospital system, affecting unit cost and utilization patterns.

- As incentives shift toward primary care and community-based services, some sites of care may change (e.g., more services delivered in ambulatory settings), which can affect plan design and steerage strategies.
- Employer plans should watch for changes in uncompensated care and public program funding that could indirectly affect commercial pricing.
- Provider contracting and network negotiations may change if the balance between regulated rates and negotiated rates shifts for certain services or payers.

2) Network access and disruption risk

- Hospitals under financial stress may reduce service lines or capacity, which can lengthen travel times and wait times for members.
- Specialist and facility availability may shift as systems reconfigure care delivery (more outpatient, more care coordination requirements).
- Networks may change as carriers and provider systems respond to new payment rules; this can disrupt established care relationships for employees and dependents.

Workforce considerations (why HR should care)

When access changes or out-of-pocket costs rise, the effects show up in productivity and talent outcomes—not just claims. HR teams should be prepared for higher employee questions about network changes, longer travel for care, delays in treatment, and perceived benefit competitiveness versus nearby employers.

- Increased travel time and harder-to-access care can drive absenteeism and presenteeism, especially for chronic conditions.
- Benefit satisfaction can influence recruiting and retention; clear communications and navigation support become more important during periods of network disruption.

What plan sponsors can do now (practical next steps)

You do not need to predict every policy detail to prepare. Focus on monitoring, scenario planning, and strengthening your plan’s ability to steer members to high-value care.

- Ask your carrier/TPA for a Maryland hospital cost and utilization baseline (inpatient vs outpatient; top systems; regional mix) and establish a monitoring cadence.
- Model 2–3 scenarios for premium impact (e.g., modest vs higher commercial hospital trend) and align on budget contingencies.

- Review network strategy: confirm which hospitals/systems are most important to your workforce and how narrow-network options could affect employee disruption.
- Strengthen primary care access and navigation (advanced primary care, virtual primary care, care management) to reduce avoidable ED and inpatient use.
- Update employee communications: prepare a plain-language explainer on “why costs/networks might change” and where members can get help.
- Track policy updates from HSCRC and CMS; designate an internal owner (Finance or Benefits) to summarize developments quarterly.

GLOSSARY (QUICK DEFINITIONS)

- **HSCRC:** Maryland’s Health Services Cost Review Commission; the state agency that sets regulated hospital rates in Maryland.
- **All-payer rate setting:** A system where hospital prices are set by a regulator and apply across payers, rather than negotiated separately by each insurer.
- **Global budget:** A hospital’s prospective annual revenue target (a “budget”) that can be adjusted for policy and performance factors.
- **TCOC:** Total Cost of Care model—Maryland’s prior CMS agreement emphasizing per-beneficiary Medicare spending limits and quality.
- **AHEAD:** CMS’ Achieving Healthcare Efficiency through Accountable Design model—state total cost of care framework with primary care investment, quality, and equity targets.

PCORI Fee Amount Adjusted for 2026

The Internal Revenue Service (IRS) has issued Notice 2025-61 to increase the Patient-Centered Outcomes Research Institute (PCORI) fee amount for plan years ending on or after Oct. 1, 2025, and before Oct. 1, 2026. The updated PCORI fee amount is **$3.84** multiplied by the average number of lives covered under the plan.

For plan years that ended on or after Oct. 1, 2024, and before Oct. 1, 2025, the PCORI fee amount is **$3.47** multiplied by the average number of lives covered under the plan.

KEY FACTS

- **Covered Plans:** The PCORI fees generally apply to insurance policies providing accident and health coverage and self-insured group health plans.
- **Applicability Dates:** The PCORI fee applies to plan or policy years ending on or after Oct. 1, 2012, and before Oct. 1, 2029.
- **Payment Deadline:** PCORI fees are due for plan or policy years ending in 2025 on July 31, 2026.

Applicability of PCORI Fee

The PCORI fee was created by the Affordable Care Act (ACA) and first applied for plan or policy years ending on or after Oct. 1, 2012. The fee is imposed on health insurance issuers and self-insured plan sponsors to fund comparative effectiveness research. The PCORI fee was originally scheduled to expire in 2019. However, a federal spending bill extended the PCORI fee for an additional 10 years. As a result, the PCORI fee will apply through the plan or policy year ending before Oct. 1, 2029.

Payment Deadline

PCORI fees are reported and paid annually on IRS Form 720 (Quarterly Federal Excise Tax Return). These fees are due each year by July 31 of the year following the last day of the plan year. For plan years ending in 2025, the PCORI fee is due by **July 31, 2026**. Employers with self-insured health plans should have reported and paid PCORI fees for 2024 by July 31, 2025.

Calculating the PCORI Fee

The PCORI fees are calculated based on the average number of covered lives under the plan or policy. This generally includes employees and their enrolled spouses and dependents, unless the plan is an HRA or FSA. Final rules outline several alternatives for issuers and plan sponsors to determine the average number of covered lives.

IRS Resources

The IRS provides the following resources on PCORI fees:

- PCORI Fee Overview Page
- PCORI Fee: Questions and Answers
- PCORI Fee Due Dates and Applicable Rates
- Chart: Application of the PCORI Fee to Common Types of Health Coverage or Arrangements

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LEGAL UPDATE

Bolton

HIGHLIGHTS

- The IRS has released the penalty amounts for 2027 under the ACA's pay-or-play rules.
- The pay-or-play rules require ALEs to offer affordable, MV health coverage to their full-time employees (and dependents) or risk paying a penalty.
- The penalty amounts for 2027 are an increase from the penalty amounts for 2026.
- ALEs should consider these penalty amounts when reviewing their health plan coverage for each year.

IRS Releases ACA Pay-or-Play Penalties for 2027

On May 4, 2026, the IRS released updated penalty amounts for 2027 related to the employer shared responsibility ("pay-or-play") rules under the Affordable Care Act (ACA). For calendar year 2027, the adjusted $2,000 penalty amount is **$3,780**, and the adjusted $3,000 penalty amount is **$5,670**. This is an increase from the penalty amounts for the 2026 calendar year, which are $3,340 and $5,010, respectively.

Pay-or-Play Rules

The ACA requires applicable large employers (ALEs) to offer affordable, minimum-value (MV) health coverage to their full-time employees (and dependents) or potentially pay a penalty to the IRS. An ALE is an employer with at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year.

An ALE may be subject to a pay-or-play penalty if at least one full-time employee receives a premium tax credit for purchasing individual health coverage through an Exchange and the ALE:

- Did not offer health plan coverage to "substantially all" (generally, at least 95%) of full-time employees and their dependents;
- Offered health plan coverage to substantially all full-time employees, but not to the specific full-time employee receiving the credit; or
- Offered health plan coverage to full-time employees that was unaffordable or did not provide MV.

Pay-or-Play Penalty Calculations

Depending on the circumstances, one of two penalties may apply under the pay-or-play rules, the 4980H(a) penalty or the 4980H(b) penalty, as follows:

1. Under Section 4980H(a), an ALE is subject to a penalty if it does not offer coverage to substantially all of its full-time employees (and dependents) and any one of its full-time employees receives a subsidy toward their Exchange plan. This monthly penalty is equal to **the ALE's number of full-time employees (minus 30) multiplied by one-twelfth of $2,000 (as adjusted) for any applicable month.** For 2027, the adjusted penalty amount is **$3,780**; or
2. Under Section 4980H(b), ALEs that offer coverage to substantially all full-time employees (and dependents) may still be subject to a penalty if at least one full-time employee obtains a subsidy through an Exchange because the ALE did not offer coverage to all full-time employees, or the ALE's coverage is unaffordable or does not provide MV. The **monthly penalty assessed on an ALE for each full-time employee who receives a subsidy is one-twelfth of $3,000 (as adjusted) for any applicable month**. For 2027, the adjusted penalty amount is **$5,670**. However, the total penalty for an ALE is limited to the 4980H(a) penalty amount.

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