MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

October 25, 2024

The Honorable Wes Moore
Governor
State House
100 State Circle
Annapolis, Maryland 21401

The Honorable Bill Ferguson
President of the Senate
State House, H-107
100 State Circle
Annapolis, MD 21401

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
State House, H-101
100 State Circle
Annapolis, MD 21401

RE: SB0734 (Ch. 0667), 2022, Maryland Health Care Commission – Primary Care Report and Workgroup (MASAR #14326)

Dear Governor Moore, President Ferguson, and Speaker Jones:

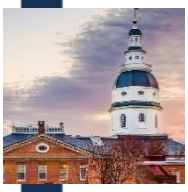
Chapter 667/Bill 734, Maryland Health Care Commission – Primary Care Report and Workgroup (2022) requires the Maryland Health Care Commission to convene a stakeholder workgroup to guide development of an annual primary care investment report. The report must include an analysis of primary care investment over the immediately preceding year and ways to improve quality and access to primary care services, with special attention to increasing health care equity, reducing health care disparities, and avoiding increased costs to patients and the health care system.

This is the first report on findings from the 2024 analysis that includes three recommendations developed in consultation with the workgroup. The recommendations are a starting point and aim to strengthen Maryland's primary care system. Information on the Centers for Medicare and Medicaid Services (CMS) Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is included in the report. The AHEAD Model is a voluntary state-based initiative that builds upon prior demonstrations that change the way care is paid for and provided. Maryland was selected by CMS to participate in the AHEAD Model with implementation beginning in January 2026.

If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at ben.steffen@maryland.gov or 410-764- 3566 or Ms. Tracey DeShields, Director of Policy Development and External Affairs, at tracey.deshields2@maryland.gov or 410-764-3588.

Sincerely,

Ben Steffen
Executive Director, MHCC



Primary Care Investment

Analysis and Recommendations Report

October 17, 2024

Randolph S. Sergent, Esq.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND
Health Care
Commission

MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq., Chairman
Vice President and Deputy General Counsel
CareFirst BlueCross BlueShield

Awawu Agbabiaka, CRNP
Nurse Practitioner
AIM Behavioral Health Services

Arun Bhandari, MD
Chesapeake Oncology Hematology Associates, PA

Hassanatu Blake, PhD, MPH, MBA
Director, Health Equity & Social Justice
National Association of County & City Health Officials

Marcia Boyle, MS
Founder
Immune Deficiency Foundation

Kenneth Buczynski, MD
Founder of Wellspring Family Medicine

Tinisha Cheatham, MD
Physician in Chief of the Mid-Atlantic Permanente Medical Group

Karl Douglas, MBA
Director of Talent Development
Brightview Senior Living

Danielle Stroughton-Duncan, PhD
Education Division Director
COLA, Inc.

Joan Gelrud, RN, MSN, FACHE, CPHQ
Member of the AHRQ National Advisory Council,
Court Appointed Special Advocate for Children

Shante Gilmore, DrPH, MPH
Director, Health Equity Initiatives
The Patient Advocate Foundation

Mark T. Jensen, Esq.
Partner
Bowie & Jensen, LLC

Jovonni Spinner, PhD, MPH, CHES
CEO/Founder
Beacon Public Health

Marcus L. Wang, Esq.
Director, Department of Economic and Workforce
Development, Baltimore County

Karrie M. Wood
Director of Business Development
Community Bank of the Chesapeake

Table of Contents

EXECUTIVE SUMMARY

Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup*, was enacted in 2022 ("the Act")[1, 2] and mandates the Maryland Health Care Commission ("MHCC") conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending. This report provides the 2024 annual analysis and offers recommendations to strengthen Maryland's primary care system for the future. Included in the report is an update on Maryland's participation in the Centers for Medicare and Medicaid Services' ("CMS") Advancing All-Payer Health Equity Approaches and Development ("AHEAD") Model, a voluntary state-based initiative designed to improve population health, advance equity, and reduce disparities.

Research finds that greater investment in primary care improves access and advances health equity. Nearly 20 states have invested in primary care by either enacting voluntary programs, requiring payers to invest in primary care initiatives, or working towards investment in primary care. Maryland has been an early adopter of payment and care delivery models that promote high-quality and cost-efficient primary care. Payers operating in the State continue to see value-based care ("VBC") initiatives as their greatest opportunity to increase primary care investment, particularly in the commercial market.

The MHCC analyzed data from 2020 to 2023 using its All-Payer Claims Database ("APCD") to examine primary care investment across the commercial, Medicare Advantage, and Medicare Fee-for-Service (or "FFS").[3] Medicaid data for 2023 was not available during the analysis.

Key Findings:

Overall Spending Remained Consistent: Primary care spending ranged from an average of 3.0 percent of total medical expenses for Medicare FFS members to 6.1 percent of total medical expenses for commercial members for the most recent year available. Across payer types, primary care spending has been relatively flat as a percent of total spending while declining on a per member per month basis.

Minimal Variation Across Commercial Payers: Primary care spending was generally consistent across commercial payers, with all but one spending between 6.0 percent and 6.3 percent of total medical expenses on primary care in 2023. Across commercial payers, primary care spending equaled approximately $20 per member per month during the same period.

More Variation Across Maryland Counties: Commercial primary care spending as a percent of total spending varied by county in 2023, ranging from 4.1 percent in Allegany County to 7.1 percent in Calvert, Frederick, Saint Mary's, and Wicomico Counties.

---

[1] Chapter 667 of the 2022 Laws of Maryland. Available at: www.mgaleg.maryland.gov/2022RS/chapters_noln/Ch_667_sb0734E.pdf.

[2] The Act requires specific workgroup representation from the Maryland Primary Care Program (MDPCP), Health Services Cost Review Commission (HSCRC), Maryland Insurance Administration (MIA), Maryland Department of Health (MDH), the primary care community, carriers, and managed care organizations and health services researchers with expertise in primary care.

[3] Includes nine months of allowed claims incurred from January 1, 2023, through September 30, 2023, and three months of run-out claims.

In 2024, MHCC's focus was on measuring progress towards increasing investments in primary care. The recommendations, shaped by findings from year one, emphasize the importance of comprehensive payer reporting and evaluating the impact of these investments on quality. Over the next year, MHCC will collaborate with stakeholders to enhance initiatives aimed at achieving target benchmarks for primary care investments.

Recommendations

1. ***Require payers to annually report detailed information on primary care investments via the Alternative Payment Model Data Submission reporting scheme to assess the impact on health equity, quality, and cost resulting from increased investments in primary care.***

   Enables the utilization of a comprehensive reporting structure to assess primary care investments in dollars and as a percentage of spend, integrating both claims and non-claims data, in order to evaluate their impact on access, cost, quality, and equity.

2. ***Develop strategies for harmonizing the use of data to measure investment effectiveness on quality.***

   Establish data use guidelines to supplement payers' internal analyses to support all payers in developing effective investment strategies.

3. ***Enact legislation that requires payers to increase investment in primary care as a percentage of total medical spending to meet annual minimum thresholds in line with the recommendations of the 2024 Primary Care Investment Analysis and Recommendations Report. This legislation should be introduced after the State has agreed on the definition of primary care and signed the AHEAD Model Participation Agreement with the federal government and implementation is underway.***

   Investments are aimed at primary care providers who participate in VBC initiatives or have achieved recognition from the National Committee for Quality Assurance as Patient-Centered Medical Homes. The AHEAD Model will require Maryland to meet primary care investment targets for Medicare, Medicaid, and the commercial market. Setting targets in Maryland law is appropriate given the AHEAD Model requirements.

SETTING THE STAGE

Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup*, was enacted in 2022 ("the Act")[4, 5] and mandates MHCC conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending. The Act requires MHCC to form a stakeholder workgroup ("Workgroup") (Appendix A) to provide input on the analysis and recommendations. In December 2023, MHCC submitted a *Primary Care Investment and Reporting Plan*[6] (or "2023 Plan") to the Governor and the General Assembly. The 2023 Plan guides annual analysis and reporting on primary care investment.

On November 16, 2023, CMS released a Notice of Funding Opportunity for the AHEAD Model.[7] The AHEAD Model is a voluntary state-based alternative payment and service delivery model designed to improve population health, advance equity, and reduce disparities. The AHEAD Model includes an initial investment via a Cooperative Agreement award to support planning and implementation activities, up to $12 million is awarded to each recipient over a six-year period.

The AHEAD Model will operate for 11 years and will test a framework that incorporates state-level accountability for Medicare FFS and All-Payer Total Cost of Care ("TCOC") growth targets. It also establishes targets for primary care investment as a proportion of the total cost of care. The AHEAD Model includes prospective care management payments; requirements for care transformation, such as integrating behavioral health into primary care services; and alignment of private payers and Medicaid with Medicare priorities. Connecticut, Hawaii, Maryland, and Vermont will be the first state participants in the AHEAD Model. The implementation period begins January 1, 2026.

Greater investment in primary care is paramount for ensuring equitable access to care and maintaining high standards of care delivery. Addressing workforce challenges, including shortages and maldistribution of providers particularly in underserved areas, will be paramount to effectively bridging gaps in access to care. Maximizing the efficiency of the primary care workforce holds the promise of cost savings by proactively managing population health needs.[8] Increased funding for primary care will improve the recruitment and retention of primary care providers and will open up investment opportunities. These investments will enable strengthening of care management and coordination as well as implementing technology to improve efficiency, communication, and patient access to care.

The *2024 Primary Care Investment Analysis and Recommendations Report* (or "report") marks the first comprehensive analysis of primary care investment over the preceding year. It aims to update the legislature on the progress of increasing investments in primary care and offers

[4] See n. 1, *Supra*.
[5] See n. 2, *Supra*.
[6] Primary Care Investment Analysis and Reporting Plan. Available at: mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcw/pci_wrkgrp_rpt.pdf .
[7] The Notice of Funding Opportunity is available at: www.cms.gov/priorities/innovation/innovation-models/ahead.
[8] Department of Health & Human Services, *HHS Is Taking Action To Strengthen Primary Care,* November 2023. Available at: www.hhs.gov/sites/default/files/primary-care-issue-brief.pdf.

recommendations. If adopted, these recommendations could help address the urgent challenges within primary care.

NOTABLE CONSIDERATIONS

The recommendations were shaped by national initiatives to advance primary care, various state investment strategies, federal programs, and input from the Workgroup. Key factors included data insights, the Medicaid definition of primary care, alignment of the 2023 Plan definition with the AHEAD Model (Table 1), and the potential mandate for payer investments and relative improvement goals.

Data from MHCC's APCD for 2020-2023 was used to complete the analysis of claims from private payers, Medicare Advantage, and Medicare Fee for Service.[9] Data was segmented by zip code and county and an analysis was completed of primary care investment in relation to the total health care spending from the previous year, overall and by payer. Beneficiary attributes examined include age (over and under 65); Hierarchical Condition Categories ("HCC"); Area Deprivation Index Score ("ADI");[10] gender, race, ethnicity, and select health-related social needs ("HRSN").

Aligning payer VBC initiatives with the AHEAD Model is essential for several key reasons. Firstly, it ensures consistency across quality metrics, reporting criteria, and incentive frameworks, thereby reducing confusion and administrative burden for providers. Secondly, it encourages collaboration among providers as it becomes easier to coordinate care across different settings and specialists. Thirdly, this alignment facilitates efficient data sharing and integration. Lastly, alignment will bolster population health management strategies, prioritizing preventive care and addressing HRSN to enhance overall community well-being.

Table 1

Primary Care Investment – Comparison		
Category	**Workgroup**	**AHEAD Model**
Primary Care Definition & Services	• Encompasses primary care office visits, preventive care, and a broad set of other services performed by a physician specializing in family medicine, general practice, internal medicine, preventive medicine, pediatrics, geriatrics, and includes nurse practitioners and or physician assistants practicing in one of these specialties • Primary care provider taxonomy codes used to calculate payer investments; includes providers delivering primary care services in a nursing home, federally qualified health centers ("FQHC"), urgent care center, retail clinic, or other non-traditional setting; behavioral health	• Uses the same specialties as the definition of primary care developed by the Primary Care Investment Workgroup ("PCIW") and adds 31 psychiatry and obstetrics/gynecology specialties into the definition; these providers can bill either as part of or independent of a primary care practice • Medicare Current Procedural Terminology ("CPT®")/Healthcare Common Procedure Coding System ("HCPCS") codes and specialty codes (aligns with the Medicare Shared Savings Program) • FFS and non-claims-based payments are used to calculate the investment

[9] See n. 3, *Supra*.
[10] HCC is a risk-adjustment tool that categorizes diagnoses based on severity, aiding in predicting future costs and allocating resources efficiently. ADI score quantifies the socioeconomic disadvantage of a geographic area by considering factors like income, education, and housing quality.

Primary Care Investment – Comparison		
Category	**Workgroup**	**AHEAD Model**
	services; and obstetric and gynecologic services, when provided by a primary care provider • Includes services performed by a nurse midwife or behavioral health provider; requires the provider to be integrated into a primary care practice where services are billed under the taxonomy code of the primary care provider	• FQHC or rural health clinics are counted as primary care regardless of provider specialty code as long as they included a primary care CPT®/HCPCS code (includes inpatient, outpatient, professional)
Investment	• Aim to achieve 10 percent increase on total medical spending for primary care by 2030; include a relative improvement goal of approximately one percent annually; adjust relative improvement goal periodically to achieve the aim	• Increases investment in primary care as a proportion of TCOC for Medicare FFS and across all-payers; CMS anticipates that the primary care intended target for Medicare will be between six and seven percent of Medicare TCOC
Strategy & Calculation	• Investment target aligned across commercial payers and a different target for Medicaid and the managed care organizations ("MCO"); review annually and adjust as needed; an accountability mechanism for meeting targets and in using investments to enhance primary care • Spending calculation: per member per month, and as a percent of total medical expense; includes place of service filters; pharmacy spending and rebates, dental, and other supplemental expenditures will be excluded from the calculations; non-FFS spending will be excluded in the 2024 analysis and final report; use of this data will be considered in 2025	• All Medicare FFS spending (Parts A and B) for beneficiaries in the State who meet the eligibility criteria (e.g., residents in the State for a minimum defined timeframe) will be included in the Medicare FFS cost growth target calculation • States will be accountable for meeting both annual improvement targets throughout the duration of the Implementation Period and a final primary care investment target by the end of the Implementation Period
Provider & Billing Codes	• 39 taxonomy codes used to ensure specialty filter is inclusive of all primary care providers • 344 billing codes (CPT/HCPCS) included in the definition. Of these, 113 codes are included in the AHEAD definition.	• 16 provider specialty codes, which are broader than taxonomy codes, are used to identify primary care providers. The 16 specialty codes yield 123 taxonomy codes • 181 billing codes (CPT®/HCPCS) included in the definition

INVESTMENT RATIONALE

Investing in primary care is essential for increasing access to services and advancing health equity.[11] A 2022 retrospective study of over five million patients assigned to a primary care provider in the Veterans Health Administration found each in-person primary care visit was associated with a total cost reduction of $721 per patient per year.[12] The first primary care visit was associated with the largest savings, nearly $4,000 on average. In this study, access to primary care had the greatest impact on the sickest patients. Among the top 10 percent of high-risk patients, the first primary care in-person visit reduced costs more than $16,000. Another study found that for every 10 additional primary care physicians per 100,000 individuals there

[11] California Health Care Foundation, *Primary Care's Essential Role in Advancing Health Equity for California* (2023). Available at: www.chcf.org/wp-content/uploads/2023/03/PrimaryCaresEssentialRoleAdvancingHealthEquity.pdf.
[12] Journal of Primary Care & Community Health (2022), *The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration*. www.ncbi.nlm.nih.gov/pmc/articles/PMC9793026/.

is an associated increase in life expectancy by 51.5 days.[13] Notably, the research demonstrated that greater Black workforce representation was associated with higher life expectancy and reduced all-cause Black mortality and disparities in the mortality rate between Black and White individuals.[14]

States with higher primary care investments have touted better outcomes and lower rates of avoidable hospitalization and emergency department visits.[15] Investment in primary care nationally has declined in recent years. On average, U.S. primary care spending accounted for approximately 4.7 percent of total health care spending in 2021 compared to 5.8 percent in 2010.[16] The U.S. lags behind other industrialized countries that typically spend 12-15 percent of their health care dollar on primary care.[17,18,19] Health care per capita costs more than twice as much as in peer countries and the U.S. experiences worse outcomes on life expectancy, rates of chronic disease, and other critical measures.[20] The late Barbara Starfield, M.D., arguably the most influential figure in the primary care research community, found the effectiveness of health care systems could be measured by the percent of health care dollars dedicated to primary care.[21, 22, 23]

In 2021, the National Academies of Science Engineering and Medicine ("NASEM") (previously referred to as the Institute of Medicine) added to a vast body of literature from Dr. Starfield and others on the importance of high-quality primary care to achieving better outcomes, lower costs, and more equitable care.[24] NASEM convened a Committee on Implementing High-

[13] Journal of American Medicine, Internal Medicine (2019), *Association of Primary Care Physician Supply With Population Mortality in the United States*, 2005-2015. Available at: www.jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393.
[14] Journal of American Medicine Network Open (2023), *Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US*. Available at: www.pubmed.ncbi.nlm.nih.gov/37058307/.
[15] Patient-Centered Primary Care Collaborative & the Robert Graham Center (2019), *Investing in Primary Care: A State-Level Analysis.* Available at: www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf.
[16] Milbank Memorial Fund (2024), *The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now*. Available at: www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/.
[17] More information is available at: www.milbank.org/primary-care-scorecard/.
[18] Organisation for Economic Co-operation and Development (OECD) (2019), *Deriving Preliminary Estimates of Primary Care Spending under the SHA 2011 Framework*. Available at: www.oecd.org/health/health-systems/Preliminary-Estimates-of-Primary-Care-Spending-under-SHA-2011-Framework.pdf.
[19] Baillieu R, Kidd M, Phillips R, et al, BMJ Global Health (2019), *The Primary Care Spend Model: a systems approach to measuring investment in primary care*. Available at: www.pubmed.ncbi.nlm.nih.gov/31354975/.
[20] The Commonwealth Fund (2023), *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes.* Available at: www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.
[21] Starfield, B., Shi, L., & Macinko, J. *Contribution of Primary Care to Health Systems and Health*. The Milbank Quarterly, 83(3), 457-502, 2005. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/.
[22] Shi, L., B. Starfield, B. Kennedy, and I. Kawachi. "*Income inequality, primary care, and health indicators.*" *Journal of Family Practice* 48 (4):275–84, 1999. Available at: www.pubmed.ncbi.nlm.nih.gov/10229252/.
[23] Macinko J, Starfield B, Shi L (2003), *The Contribution of Primary Care Systems to Health Outcomes within Organization for Economic Cooperation and Development (OECD) Countries, 1970–1998*, Health Services Research Review. Available at: www.onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.00149.
[24] National Academies of Sciences, Engineering, and Medicine (2021), *Implementing High-Quality Primary Care: Rebuilding The Foundation Of Health Care*. Available at: nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health.

Quality Primary Care ("Committee")[25] to build on the recommendations from the 1996 Institute of Medicine report, *Primary Care: America's Health in a New Era*. The Committee identified five implementation objectives that focused on reimbursement; quality; training; information technology; and access. The implementation plan incorporates goals and measures aimed at primary care stakeholders. It seeks to balance national needs for scalable solutions, while also allowing flexibility to address local needs effectively. NASEM has played a pivotal role in catalyzing a nationwide effort to acknowledge and tackle obstacles in primary care.[26] National efforts typically focus on increasing investment and improving access.[27]

Investments in primary care drive innovation in care delivery. Most of these investments are directed through non-claims payments, though their effectiveness in achieving investment objectives has shown variability.[28] Valuable insights from state initiatives demonstrate the importance of gradually reallocating funds towards primary care; rapid increases can be overlooked by stakeholders or escalate overall health care costs. Multi-payer investments are essential to ensuring equitable access to high-quality primary care across diverse populations. Notably, managing increases in the total cost of care presents challenges in meeting primary care benchmarks based on a percentage of total medical expenses.

Underinvestment in primary care significantly contributes to workforce challenges. In the U.S., the average number of primary care providers is 232 per 100,000 individuals; Maryland ranks 26th with 239.6 providers per 100,000 individuals while Massachusetts ranks 1st with 322.1 providers per 100,000 individuals.[29] In contrast, Switzerland, which excels in indicators of population health and cost-effectiveness, boasts around 444 primary care providers per 100,000 individuals.[30] Despite prominent differences in health care systems, both countries share similarities in their highly privatized, multi-payer health care models.[31] Some projections suggest that by 2030 there will be a shortage of approximately 35,000 primary care physicians. Investing in primary care addresses workforce challenges by fostering a supportive environment that attracts and retains providers.[32] These investments reduce the strain on providers and enhance the efficiency of care delivery. Additionally, prioritizing primary care bolsters health care system resilience, equipping providers to meet the diverse needs of patients and communities effectively.[33]

---

[25] *Ibid.*

[26] California Health Care Foundation. (2022), *Investing in Primary Care: Lessons from State-Based Efforts – Executive Summary*. Available at: www.chcf.org/publication/investing-in-primary-care-lessons-from-state-based-efforts/#related-links-and-downloads.

[27] More information is available at: Primary Care Collaborative (pcc.org).

[28] California Department of Health Care Access and Information (2024), *Health Care Affordability Advisory Committee Meeting*. Available at: www.hcai.ca.gov/wp-content/uploads/2024/05/Advisory-Committee-Meeting-Presentation-May-14-2024.pdf.

[29] America's Health Rankings, United Health Foundation, Primary Care Providers in the United States (2023). Available at: www.americashealthrankings.org/explore/measures/PCP_NPPES.

[30] World Health Organization's Global Health Workforce Statistics, OECD, supplemented by country data (2021). Available at: //data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=CH.

[31] National Library of Medicine, *Building primary care in a changing Europe: Case studies [Internet]*, (2015). Available at: www.ncbi.nlm.nih.gov/books/NBK459012/.

[32] Milbank Memorial Fund, How Primary Care Investments Can Advance Equity (2023). Available at: www.milbank.org/2023/05/how-primary-care-investments-can-advance-equity/.

[33] The Commonwealth Fund, *Increasing Investment in Primary Care – Lessons from States* (2024). Available at: www.commonwealthfund.org/blog/2024/increasing-investment-primary-care-lessons-states.

STATE APPROACHES

Nearly 20 states have either enacted primary care investment initiatives, have them pending, or a combination thereof.[34] Investment strategies vary between voluntary and required. Colorado, Connecticut, Delaware, Oregon, and Rhode Island stand out as states with some of the longest-standing primary care investment targets. Each state has endeavored to raise investment targets as payers achieve cost savings. These states couple increased investments with advances in care delivery. Colorado established for primary care providers and payers a set of annual priorities to guide investment and care delivery.[35] Connecticut defines core functions for primary care teams, includes methods for assessing and recognizing performance, and defines a voluntary payment option in addition to Fee-for-Service.[36] Delaware focuses new investment on providers engaging in care transformation activities.[37] Oregon's Collaborative Care Organizations highlight the benefits of coordinating across primary care and behavioral health while prioritizing efforts to address patients' social needs.[38] Lastly, Rhode Island has a long-standing primary care medical home program that offers primary care providers the opportunity to earn additional payments.[39] Maryland, Nebraska, New Mexico, North Carolina, and Oklahoma have more recently established requirements or targets for primary care investment and are in the process of identifying strategies to achieve those goals.[40]

States are uniquely positioned to drive increased investments in primary care through their convening authority, governance capabilities, and resource allocation.[41] They have the authority to develop and enforce policies tailored to the specific needs and demographics of their populations.[42] States function as incubators for innovative care delivery models that promote investments in primary care with an aim to improve equitable access to care across diverse populations. States employ a variety of design approaches and financing strategies that can significantly influence national policy. By piloting new programs, rigorously evaluating their impact, and scaling successful initiatives, states fulfill a pivotal role as policy leaders in responding effectively to evolving health care trends and challenges.

---

[34] Primary Care Collaborative, *State Primary Care Investment Initiatives Map*. Available at: www.thepcc.org/primary-care-investment/legislation/map.
[35] Colorado's Primary Care Payment Reform Collaborative (2024), *Fifth Annual Recommendations Report*. Available at: www.drive.google.com/file/d/1OuZ5NytZJUbNWE-nOaLmcdBDwZzkb4m8/view?pli=1.
[36] Connecticut Office of Health Strategy (2021), *Roadmap for Strengthening and Sustaining Primary Care*. Available at: https://portal.ct.gov/ohs/-/media/ohs/primary-care-and-community-health-reforms/ohs-primary-care-roadmap-draft-2021.pdf.
[37] Delaware Department of Insurance, *Office of Value Based Health Care Delivery (OVBHCD)*. Available at: www.insurance.delaware.gov/divisions/consumerhp/ovbhcd/.
[38] Oregon Health Authority, *Coordinated Care: the Oregon Difference*. Available at: www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx.
[39] State of Rhode Island Office of the Health Insurance Commissioner, Department of Business Regulation. *Patient-Centered Medical Home Definition And Requirements*. Available at: www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php.
[40] See n. 33, *Supra*.
[41] Milbank Memorial Fund, *Defining the State Role in Primary Care Reform* (2024). Available at: www.milbank.org/publications/defining-the-state-role-in-primary-care-reform/#:~:text=Whether%20investing%20in%20the%20state's,and%20quality%20of%20primary%20care.
[42] Center for American Progress, *How Investing in Public Health Will Strengthen America's Health* (2022). Available at: www.americanprogress.org/article/how-investing-in-public-health-will-strengthen-americas-health/.

A national definition of primary care is gradually emerging, as evidenced by recent CMS Innovation Center payment and service delivery models.[43] Over the last several years CMS has introduced new care delivery and payment models to support health care transformation and increase access to high-quality care. In general, these models bolster investment in primary care and encourage multi-payer alignment within states.[44] Concurrently, efforts are underway to standardize the measurement of primary care investment to establish a clear framework for evaluating the delivery and outcomes of investments in primary care.[45] A standardized approach facilitates benchmarking and empowers stakeholders to identify best practices, learn from successful models, and implement necessary improvements.[46]

VALUE-BASED CARE IN MARYLAND

Maryland is considered an early adopter of payment and care delivery models that reward primary care providers for delivering high-quality and cost-efficient care. In 2011, MHCC launched a pilot, the Maryland Multi-Payor Patient Centered Medical Home Program. A 2010 law mandated MHCC test whether paying primary care providers to develop the infrastructure and workflows to support care coordination and key elements of the medical home model would result in higher quality, and more cost-effective care.[47] The pilot required participation by Medicaid and the five largest carriers in the State: Aetna; CareFirst BlueCross BlueShield; Cigna Health Care, Mid-Atlantic Region; Coventry Health Care; and UnitedHealthcare, Mid-Atlantic Region. The Federal Employees Health Benefit Plan, Maryland State Employees Health Benefit Plan, and TRICARE participated voluntarily.[48] Fifty-two primary care practices participated in the pilot, which was extended through 2016.[49]

Although other states have introduced diverse payment reform initiatives with the goal of enhancing health care delivery and cost management, none have embraced an All-Payer Model comparable to Maryland's.[50] Global budgets for specific hospitals were introduced as a measure to constrain Medicare hospital expenditures. Under this model, hospitals receive a predetermined budget for the year, which incentivizes them to minimize unnecessary

[43] A list of CMS Innovation Models. Available at: http://www.cms.gov/priorities/innovation/models.
[44] See n. 33, *Supra.*
[45] JAMA Network, *Measuring Primary Care Spending in the US by State* (2024). Available at: www.jamanetwork.com/journals/jama-health-forum/fullarticle/2818721.
[46] National Library of Medicine, *Measuring Primary Healthcare Spending [Internet],* (2024). Available at: www.ncbi.nlm.nih.gov/books/NBK604102/.
[47] Chapters 5 and 6, 2010 laws of Maryland. Available at: www.mgaleg.maryland.gov/2010rs/billfile/sb0855.htm and mgaleg.maryland.gov/2010rs/billfile/hb0929.htm.
[48] Maryland Annotated Code. Health-General. § 19-1A-02., (Senate Bill 855 | House Bill 929 - 2010). Carriers with over $90M in premiums for health benefit plans in the State in the most recent reporting year were classified as large carriers.
[49] Program findings indicated the pilot met goals related to improvements in care coordination, communication, monitoring, and standardization that contributed to successful practice transformation: MHCC, *Evaluation of the Maryland Multi-Payor Patient Centered Medical Home Program, Final Report* (2015). Available at: mhcc.maryland.gov/mhcc/pages/apc/apc/documents/MMPP_Evaluation_Final_Report_073115.pdf.
[50] HSCRC, Maryland and CMS entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services (2014). Available at: www.hscrc.maryland.gov/Pages/About-Us.aspx.

hospitalizations and control spending.[51] Maryland achieved noteworthy Medicare savings while simultaneously improving quality.[52]

In 2019, Maryland and CMS entered into the TCOC Model agreement. The TCOC Model's goals are to enhance the health of Marylanders, reduce hospital readmissions and emergency department visits, and enrich the patient experience in health care settings. The TCOC Model has had a favorable impact on Medicare expenditures and has shown that State accountability and provider incentives can improve care.[53] The TCOC Model holds the State fully at risk for Medicare beneficiaries' total cost of care while incentivizing hospitals and other providers to engage in care transformation partnerships across care settings.[54]

The Maryland Primary Care Program ("MDPCP") is a key element of the TCOC Model. Participating practices receive additional resources and support to strengthen care coordination, implement population health strategies, and prioritize preventive care.[55] Primary care providers receive increased payments to strengthen team-based care, facilitate care transformation, and advance primary care. The MDPCP holds practices accountable through quality and efficiency metrics and aims to address the root causes of poor outcomes and diminish disparities. Program evaluations provide evidence that this initiative has effectively enhanced access to care for underserved populations and led to better outcomes statewide. Since its implementation in 2019, the MDPCP has seen participation increase to about 511 practices.[56]

Maryland's MCOs are vital to the State, delivering managed care services to Medicaid beneficiaries. The MCOs have been a pioneer in implementing VBC initiatives that incentivize high-quality, cost-effective care tailored to meet the diverse needs of the Medicaid population. The MCOs have largely transitioned away from traditional Fee-for-Service models towards VBC arrangements. Approximately nine MCOs operate in the State and provide comprehensive care to about 1.6 million Medicaid beneficiaries, almost half of which are children.[57] The MCOs have been able to enhance quality and drive improvements in outcomes for the Medicaid population.[58]

---

[51] Centers for Medicare & Medicaid Services, *Maryland All-Payer Model.* Available at: www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model.
[52] Health Services Cost Review Commission, *All-Payer Model Results, CY 2014-2018*. Available at: www.hscrc.maryland.gov/Documents/Updated%20APM%20results%20through%20PY5.pdf.
[53] Centers for Medicare & Medicaid Services, *Maryland Total Cost of Care Model.* Available at: www.cms.gov/priorities/innovation/innovation-models/md-tccm#:~:text=The%20Maryland%20Total%20Cost%20of%20Care%20Model%20(MD%20TCOC)%20builds,and%20specialists%20across%20all%20payers.
[54] More information is available at: www.innovation.cms.gov/innovation-models/md-tccm.
[55] The Health Services Cost Review Commission: *Maryland's Total Cost of Care Model* is a contract between the State and the CMS that holds the State at risk for the total cost of care for Medicare Beneficiaries and commits the State to a sustainable growth rate in per capita total cost of care spending. Available at: www.hscrc.maryland.gov/Pages/tcocmodel.aspx.
[56] Information about the MDPCP is available at: www.health.maryland.gov/mdpcp/Pages/practices.aspx.
[57] Maryland Department of Health Medicaid Managed Care Program. Available at: www.health.maryland.gov/mmcp/healthchoice/pages/home.aspx#:~:text=Maryland%20Medicaid%20has%20nine%20HealthChoice,the%20best%20one%20for%20you.
[58] Maryland Department of Health, HealthChoice Quality Strategy. Available at: www.health.maryland.gov/mmcp/healthchoice/Pages/quality-strategy.aspx.

Chapter 298 (Senate Bill 834) *Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments - Authorization* (2022) allows commercial payers to establish payment models incorporating two-sided provider risk and capitation arrangements, previously prohibited in Maryland.[59] The legislation opens the door to enhanced accountability and innovation in care delivery. The law requires payers to disclose data on advanced alternative payment model arrangements ("APMs")[60] to promote transparency and facilitate ongoing monitoring of progress in advancing VBC while prohibiting a mandate on provider participation in two-sided risk payment models. Maryland recently joined seven other states (Colorado, Connecticut, Delaware, Maine, Massachusetts, Oregon, and Rhode Island) in monitoring and collecting APM data. California is currently developing its approach. In 2023, MHCC released a baseline report on the adoption of APMs.[61] This report serves as a crucial starting point for evaluating progress and informing future strategies to advance VBC in Maryland.

Nationally, the State is regarded as a leader in advancing the electronic exchange of health information through health information exchange ("HIE") entities, an essential underpinning of VBC. HIEs offer value to providers and patients by facilitating the seamless sharing of patient data.[62, 63] Chapter 689 (House Bill 706), *Electronic Health Records - Regulation and Reimbursement* (2009)[64] requires MHCC and HSCRC to designate a statewide HIE, a process that occurs every three years. The Chesapeake Regional Information System for our Patients ("CRISP") was competitively selected to serve in this role in 2009 and has been chosen at each designation cycle based on its performance.[65] CRISP enables the sharing of electronic health records among providers and also operates as a health data utility.[66] Chapter 718 (House Bill 213), *Health Information Exchanges – Definition and Privacy Regulations* (2022)[67] aligned Maryland's definition of an HIE with the federal definition. The law resulted in an increase in the number of HIEs operating in the State and subject to MHCC oversight. As of the report publication date, 17 HIEs are operating in Maryland.[68]

PAYER – ENVIRONMENTAL SCAN

In May 2024, MHCC asked private payers to share information regarding their primary care investment strategies. Payers responded, addressing approximately five questions (Appendix

[59] Chapter 298 of the 2022 Laws of Maryland. Available at: www.mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0834/?ys=2022rs.
[60] APMs are a specific type of payment arrangement within the broader framework of VBC, which encompasses a comprehensive approach to improving health care delivery and outcomes while controlling costs.
[61] The 2023 report is available at: www.mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/lgst_sb0834.pdf.
[62] The Office of the National Coordinator for Health Information Technology, *Health Information Exchange.* Available at: www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange.
[63] MHCC *Health Information Exchange in Maryland.* Available at: mhcc.maryland.gov/mhcc/pages/hit/hit_hie/documents/HIE_Lunch_Learn_20180809.pdf.
[64] Chapter 689 of the 2009 Laws of Maryland. Available at: www.mgaleg.maryland.gov/2009rs/chapters_noln/Ch_689_hb0706T.pdf.
[65] CRISP, the State-Designated HIE, *Welcome to CRISP.* Available at: www.crisphealth.org/about-crisp/
[66] Chapter 296 (House Bill 1127), *Public Health - State Designated Exchange - Health Data Utility* (HDU) (2022) requires the State-Designated HIE to operate as an HDU for the State to assist in the evaluation of public health interventions, advance health equity, facilitate communication of data between public health officials and health care providers, and enhance interoperability of health information throughout the State.
[67] Chapter 718 of the 2022 Laws of Maryland. Available at: www.mgaleg.maryland.gov/2022RS/bills/hb/hb0213T.pdf.
[68] MHCC, Registered HIEs. Available at: mhcc.maryland.gov/mhcc/Pages/hit/hit_hie/hit_hie_registration.aspx.

B); MHCC extracted select information from these responses. Overall, payers have focused their efforts on increasing investment in primary care largely through VBC models, which have shown modest adoption over time. They are predominantly implemented within large health systems, often through Accountable Care Organization ("ACO") structures that emphasize population health strategies. For the most part, smaller providers participate through VBC arrangements, such as pay-for-performance, episode-based payments for procedures, capitation, and patient-center medical homes ("PCMH"). Payers collectively reported 47 primary care APM contracts. Among these contracts, approximately 12 were shared savings programs with downside risk covering about 117,747 members of the nearly 2.2 million commercial fully insured residents.

Aetna

Aetna is actively enhancing its services and capabilities to support primary care providers in delivering high-quality, coordinated care for patients. This includes expanding the availability of high-performing and advanced primary care practices within its networks. Aetna is also focusing on utilizing care teams and services that complement primary care delivery, alongside leveraging data analytics to empower providers in optimizing their practice capabilities. Moreover, Aetna is increasing participation among providers who serve older adults and low-income individuals, particularly in urban areas like Baltimore and Maryland suburbs of Washington, D.C.

Aetna is expanding non-traditional delivery systems through recent acquisitions, including Oak Street Health, a national primary care startup, and Signify Health, which specializes in home visits. A component of Aetna's strategic focus centers around investing in medical groups that have a primary care concentration. Aetna reported 10 APM contracts in the Maryland commercially insured market.

CareFirst BlueCross BlueShield ("CareFirst")

CareFirst's PCMH program incentivizes providers by furnishing resources, data, and comprehensive support to enable delivery of high-quality, cost-effective care. The PCMH program utilizes primary care provider panels as the performance unit, with incentives tied to achieving rigorous quality and engagement benchmarks.[69] CareFirst has significantly enhanced reimbursement rates, offering up to 120 percent of FFS rates through its PCMH program, incentivizing providers to prioritize patient-centered care practices and improve overall health outcomes.

CareFirst is transitioning away from FFS models towards prospective per member per month payments. Its practice transformation initiatives leverage data to strengthen population health strategies and improve management of patients with multiple chronic conditions. CareFirst assesses provider care capabilities to position practices along a continuum of advanced, patient-centered primary care. This assessment helps identify the competencies and resources

[69] More information is available at: provider.carefirst.com/carefirst-resources/provider/pdf/adult-2023-pcmh-program-description-and-guidelines-final.pdf.

necessary for success within the PCMH program. CareFirst reported 18 APM contracts in the Maryland commercially insured market.

Cigna

Cigna's primary care investment strategy includes strengthening effectiveness and risk management within VBC models. Its ACO initiatives aim to improve quality outcomes, affordability, and the overall experiences of patients and providers. Cigna prioritizes the management of at-risk members by employing comprehensive quality metrics that include health equity measures and assessing social determinants of health. To ensure alignment with provider needs and community health goals, Cigna works closely with primary care providers through the establishment of a local Provider Advisory Council ("Council"). Cigna collaborates with the Council to develop programs and conducts annual surveys to identify opportunities for enhancing its VBC programs, ensuring continuous improvement and responsiveness to evolving health care needs.

Cigna evaluates the success of its primary care strategies by assessing patient experience, quality outcomes, and program savings. The resulting provider performance reports, which encompass an evaluation of cost and quality, allow for ongoing effectiveness reviews and are regularly shared with practices. Cigna reported 19 APM contracts in the Maryland commercially insured market, 11 APM contracts are part of Cigna's ACO model.

UnitedHealthcare ("UHC")

UHC's ACO models are aimed at empowering primary care providers to act as central coordinators of care. The ratio of primary care provider visits to specialist visits is closely monitored to ensure robust engagement of primary care providers in overseeing patient care. UHC leverages technology to support personalized care to enhance primary care delivery, tailoring treatments and interventions to individual patient needs. UHC directs patients towards high-quality, cost-effective care that includes primary, specialty, urgent, post-acute, behavioral, and ambulatory services.

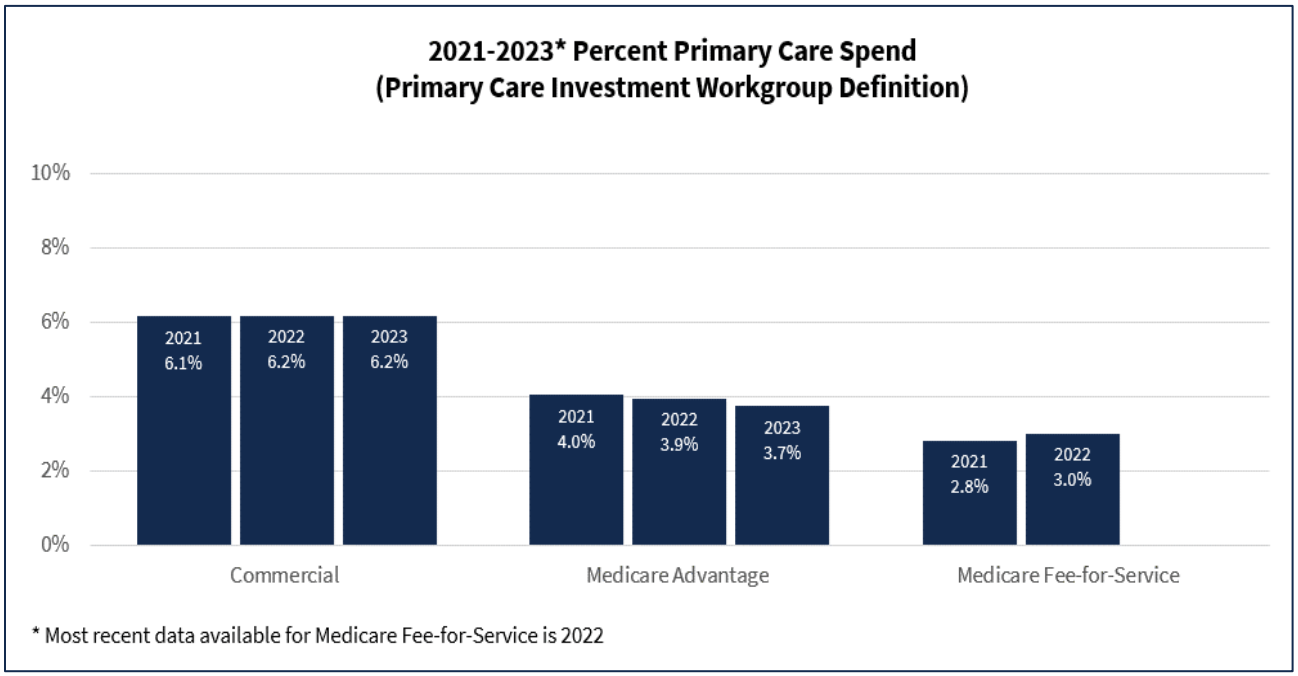
By prioritizing comprehensive, whole-person care, UHC enhances care quality while reducing costs. UHC makes available grants to select providers to advance care delivery; one example is funding to participating FQHCs to establish food pharmacies.[70] UHC is actively exploring opportunities to introduce VBC programs tied to quality in the Maryland commercial insurance market.

[70] An umbrella term for programs designed to increase public access to fruits and vegetables by integrating or coordinating nutrition interventions with the healthcare system. For more information visit: www.sciencedirect.com/science/article/pii/S2666667720301458.

DATA – FINDINGS

By employing stratification based on zip code and county, alongside detailed data on TCOC spending, a robust framework for evaluating primary care investments was established.[71, 72] These analyses helped to identify recommendations to improve health outcomes and address inequities. Primary care spending ranged from an average of 3.0 percent of total medical expenses for Medicare FFS members to 6.2 percent of total medical expenses for commercial members for the most recent year available, as shown in Figure 1.[73] Data for 2023 is shown for commercial and Medicare Advantage. The most recent data available for Medicare FFS is 2022. The portion of the health care dollars spent on primary care services remained relatively flat across the period with very slight increases for commercial plans and Medicare FFS and a very slight decrease for Medicare Advantage plans. The differences across payer types reflect differences in total medical expenses more than investment in primary care.

Figure 1:

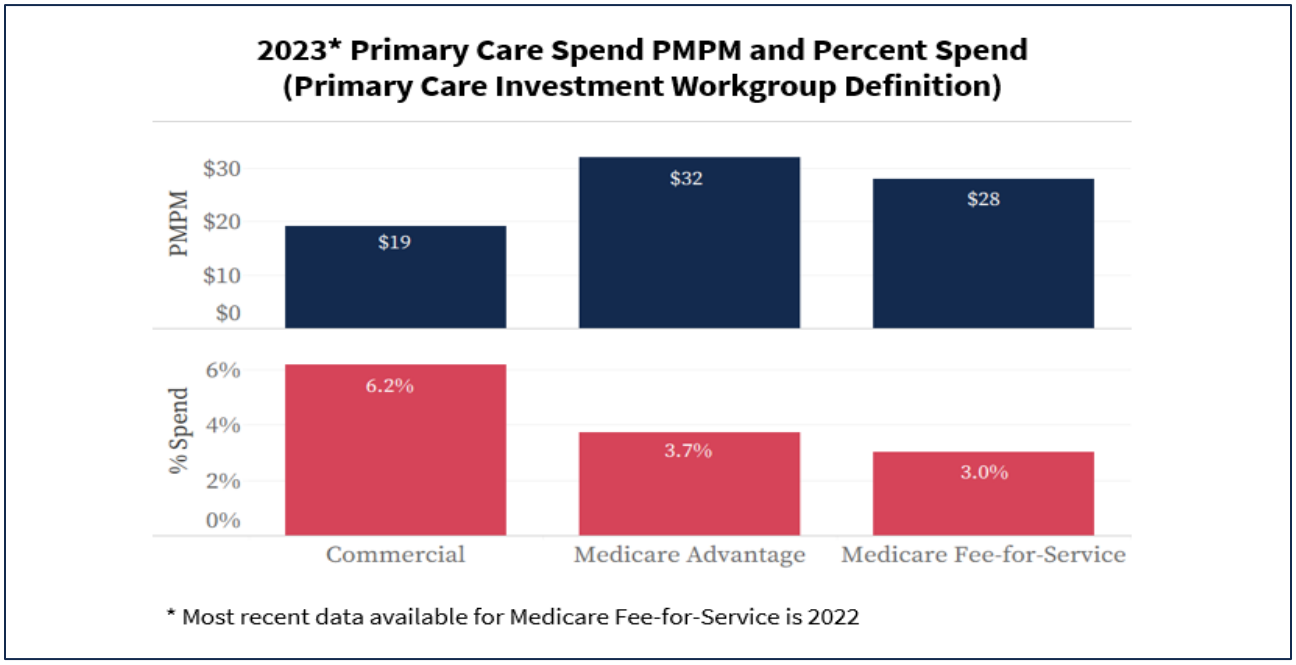


Average per member per month spending on primary care services ranged from an average of $19 for commercial members to $32 for Medicare Advantage members in 2023, as shown in Figure 2.[74] Commercial members had lower primary care spending on a per member per month basis than the other payer types. However, commercial members' primary care spend as a percent of total medical expenses was higher because their total medical spending was lower. This is consistent with other spending analyses, which typically find older adults spend more

[71] Journey of Health Care Finance, Vol 41, No2, *Health Needs Assessment In Inner Cities: Does Zip Code Analysis Reveal Better Results?* July 2014. Available at www.healthfinancejournal.com/index.php/johcf/article/view/3.
[72] NCQA, *Health Equity and Social Determinants of Health in HEDIS: Data for Measurement, June 2021. Available at:* ncqa.org/wp-content/uploads/2021/06/20210622_NCQA_Health_Equity_Social_Determinants_of_Health_in_HEDIS.pdf.
[73] See n. 3, *Supra*.
[74] See n. 3, *Supra*.

on a variety of health care services. Primary care spending as a percent of total medical spending is typically lower for older adults.

Figure 2:

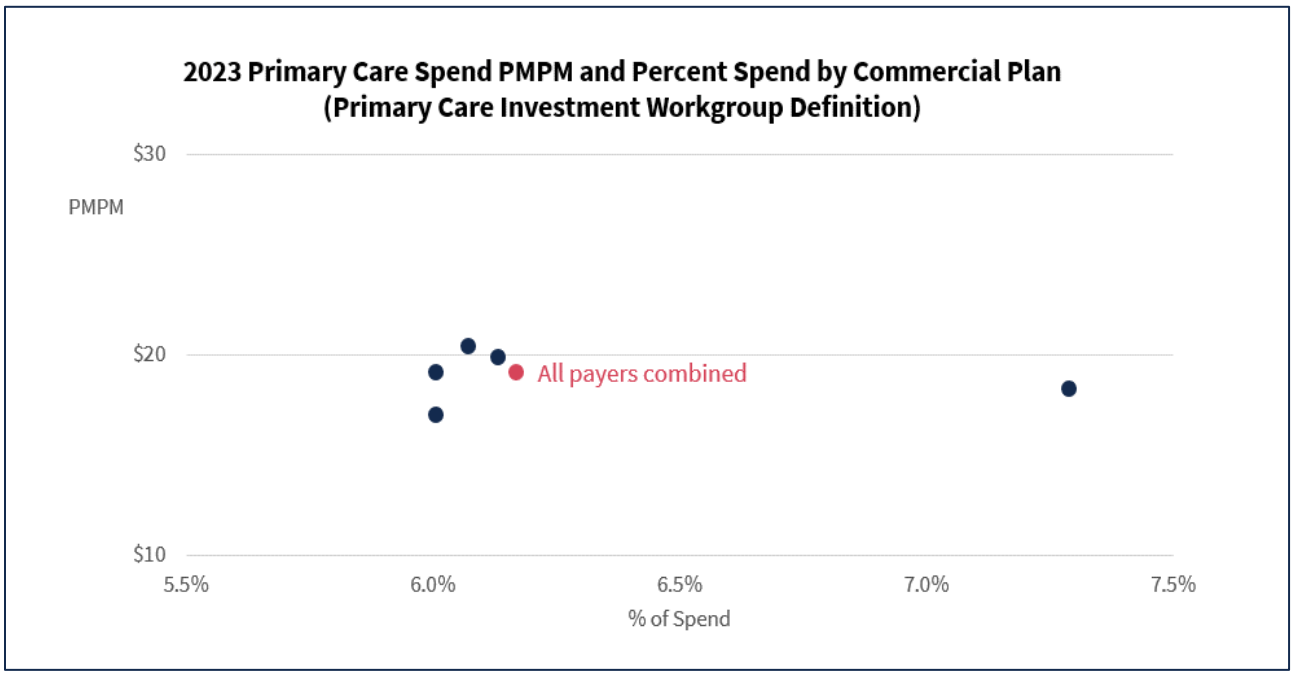


Primary care spending declined on per member per month basis from $24 in 2021 to $19 in 2023 for commercial members. Medicare Advantage primary care spending also declined, from $41 in 2021 to $32 in 2023. Medicare FFS decreases were smaller, from $29 in 2021 to $28 in 2022, the most recent year available.

Primary care spending was generally consistent across commercial payers, with all but one spending between 6.0 percent and 6.3 percent of total medical expense on primary care in 2023, as shown in Figure 3.[75] Across commercial payers, primary care spending equaled approximately $20 per member per month during the same period.

[75] See n. 3, *Supra.*

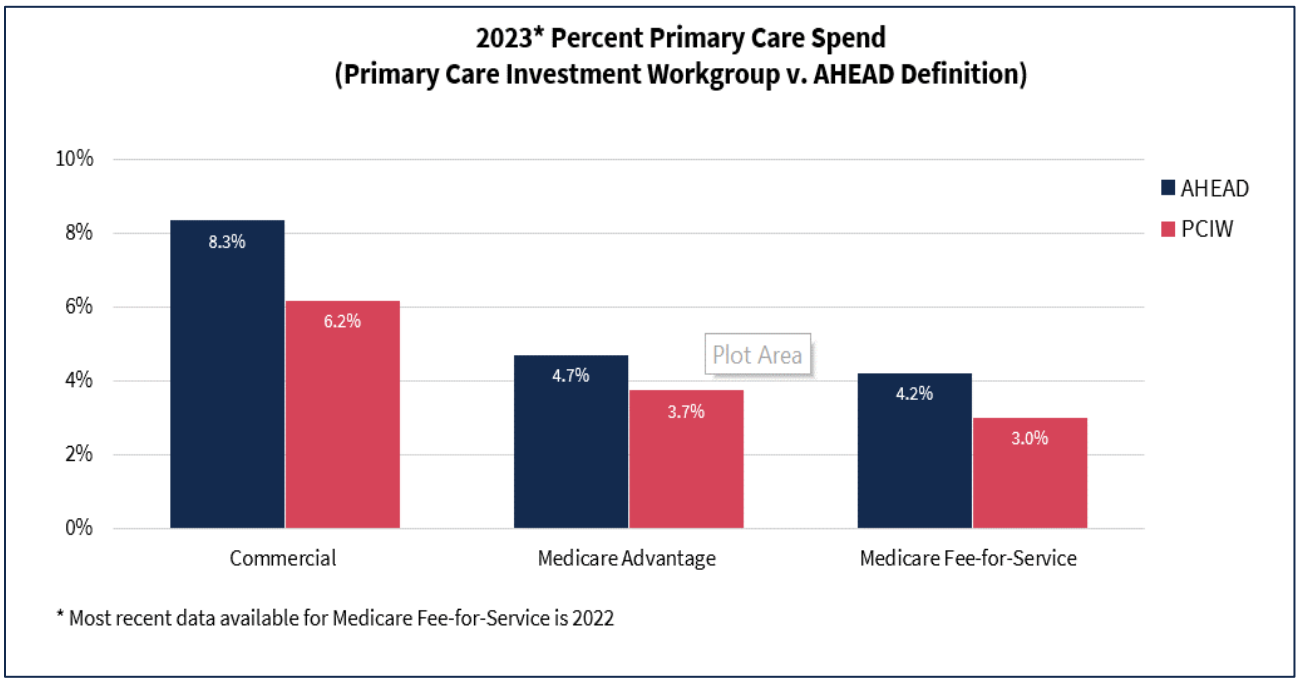
Figure 3



The analyses focused on the Workgroup's definition of primary care, which was developed last year and released as part of the *Primary Care Investment Analysis and Reporting Plan*[76]. The definition is well-aligned with primary care measurement definitions used nationally, including The New England States' All-Payer Report on Primary Care Payments,[77] which was developed in collaboration with five New England states by the New England States' Consortium Systems Organization, the Milbank Memorial Fund, and OnPoint Health Data. The definition includes primary care office visits, preventive care, and a broad set of other services when performed by physicians specializing in family medicine, general practice, internal medicine, preventive medicine, pediatrics, and geriatrics, as well as nurse practitioners, and physician assistants. It also encompasses behavioral health, as well as obstetric and gynecologic services, when delivered by a primary care provider. Additionally, MHCC conducted the same analyses using the primary care definition from the AHEAD Model. Typically, the results from these analyses showed a one to two percent increase in primary care spending as a percentage of total spending, as shown in Figure 4.[78] The AHEAD Model results are higher primarily because it encompasses a broader definition of primary care provider compared to the Workgroup definition (see Table 1, page 6).

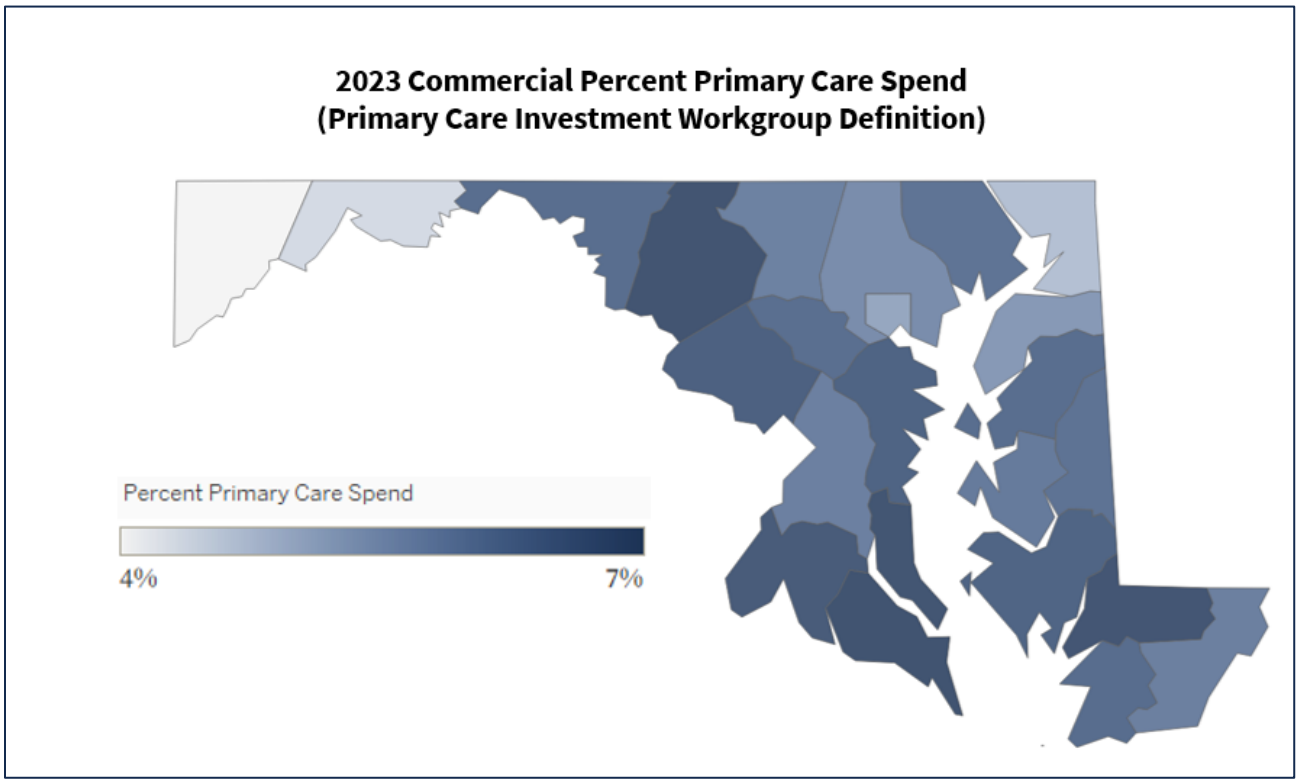
[76] See n. 5, *Supra*.
[77] NESCO, *The New England States' All-Payer Report on Primary Care Payments* (2020). Available at: nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf
[78] See n. 3, *Supra.*

Figure 4:



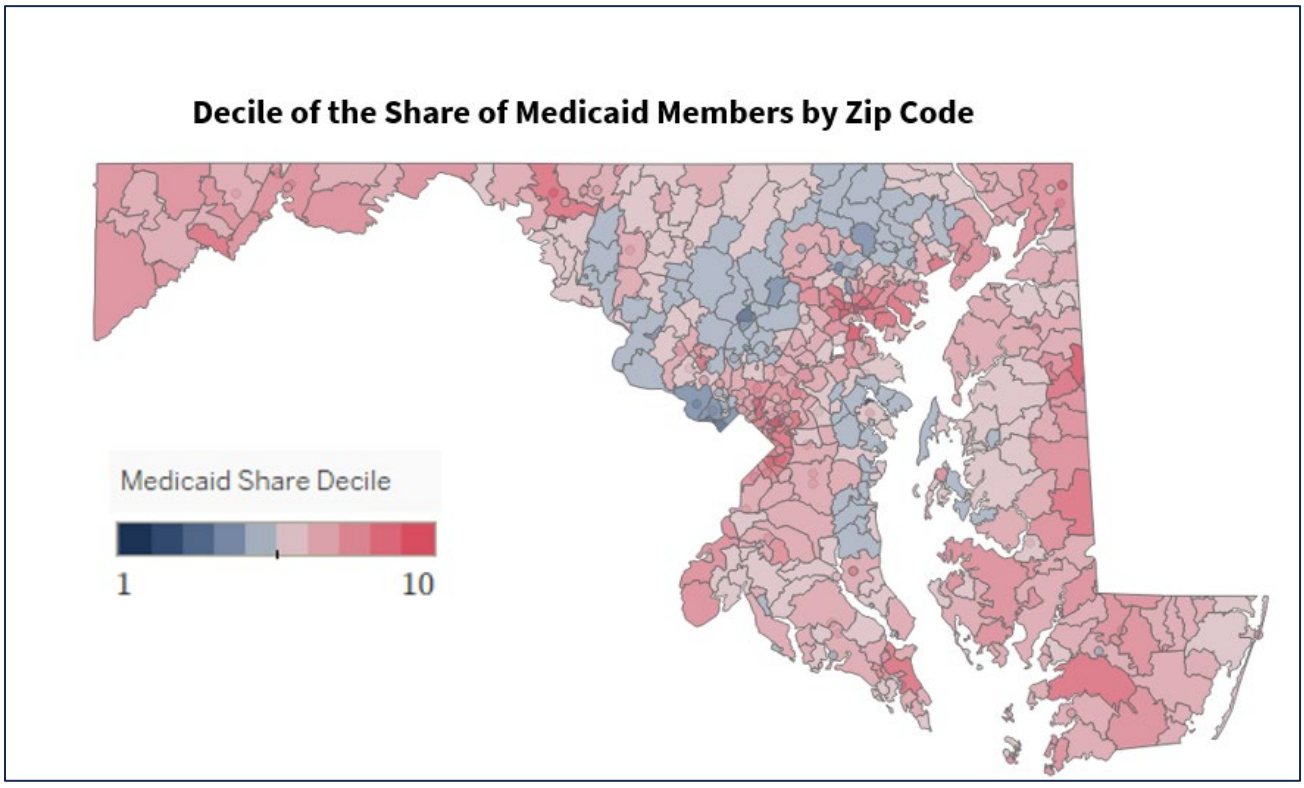
Several analyses were performed to better understand the differences across Maryland counties and zip codes. Commercial primary care spending as a percent of total spending varied by county in 2023, ranging from 4.1 percent in Allegany County to 7.1 percent in Calvert, Frederick, Saint Mary's, and Wicomico Counties, as shown on the map in Figure 5.

Figure 5:



The differences in primary care spending at the zip code level was assessed. These analyses categorized zip codes into one of 10 deciles based on the percentage of Medicaid members in the zip code. These categories served as a proxy for the Area Deprivation Index ("ADI"), a mapping tool that displays the relative socioeconomic conditions of neighborhoods. The ADI aims to identify areas with the highest levels of disadvantage that should be prioritized for future investment. Figure 6 displays the Medicaid percentage rankings across zip codes. The MHCC analyses of commercial and Medicare Advantage data found that zip codes with the highest ranking, meaning the most disadvantaged, had lower-than-average levels of primary care investment both as a percentage of total spending and on a per member per month basis. Zip codes with the lowest ranking, meaning the least disadvantaged, reported average levels of primary care investment as a percent of total spending and a per member per month primary care spend. The results suggest that primary care spending was similar for individuals living in the zip codes with the highest and lowest rankings. However, individuals living in zip codes with the highest ranking likely had lower overall health care spending, resulting in a higher percent primary care spend.

Figure 6:



An evaluation on the differences in primary care spending by race was performed. This analysis found no dramatic disparities, with the average primary care spending for White individuals tending to fall near the average on a percent spend and per member per month basis for all races for commercial and Medicare Advantage in 2023. The average percent primary care spend and per member per month primary care spending for African-American individuals was slightly lower than for White individuals. Individuals of other races including Asian, American Indian, and Native Hawaiian, or other Pacific Islanders tended to report higher primary care spending, particularly as a percent of total spend. Results by race on a per member per month

and percent of spending basis for commercial and Medicare Advantage members are shown below in Table 2. Variations in primary care spending can reflect differences in access, the age and health care needs of the population, services used, and pricing. Future analyses will aim to better understand the factors driving these differences in spending.

Table 2:

Race	2023 Primary Care Spending (PCIW Broad)			
	% of Medical Spend		Per Member Per Month	
	Commercial	Medicare Advantage	Commercial	Medicare Advantage
White	6.0%	3.9%	$20	$37
African-American	5.7%	3.3%	$20	$33
Asian	7.1%	6.2%	$19	$31
American-Indian	9.8%	6.4%	$18	$31
Other	6.6%	4.7%	$21	$36
Two or More Races	5.5%	3.2%	$25	$44
Native Hawaiian or Other Pacific Islander	8.7%	5.9%	$18	$29
Unknown	7.4%	3.7%	$14	$24
Total	**6.2%**	**3.7%**	**$19**	**$32**

RECOMMENDATIONS

1. ***Require payers to annually report detailed information on primary care investments via the Alternative Payment Model Data Submission reporting scheme to assess the impact on health equity, quality, and cost resulting from increased investments in primary care.***

   Enables the utilization of a comprehensive reporting structure to assess primary care investments in dollars and as a percentage of spend, integrating both claims and non-claims data, in order to evaluate their impact on access, cost, quality, and equity.

2. ***Develop strategies for harmonizing the use of data to measure investment effectiveness on quality.***

   Establish data use guidelines to supplement payers' internal analyses to support all payers in developing effective investment strategies.

3. ***Enact legislation that requires payers to increase investment in primary care as a percentage of total medical spending to meet annual minimum thresholds in line with the recommendations of the 2024 Primary Care Investment Analysis and Recommendations Report. This legislation should be introduced after the State has agreed on the definition of primary care and signed the AHEAD Model Participation Agreement with the federal government and implementation is underway.***

   Investments are aimed at primary care providers who participate in VBC initiatives or have achieved recognition from the National Committee for Quality Assurance as Patient-Centered Medical Homes. The AHEAD Model will require Maryland to meet primary care investment targets for Medicare, Medicaid, and the commercial market. Setting targets in Maryland law is appropriate given the AHEAD Model requirements.

ON THE HORIZON

In 2025, MHCC will continue its support for payers in identifying methods to boost investment in primary care and assessing the outcomes of these investments. This effort will involve integrating primary care investment measurement and aligning primary care payer models with the AHEAD Model. Over the next year, MHCC plans to engage stakeholders in discussions on refining primary care investment goals and determining how these funds should be allocated among primary care providers. Additionally, MHCC will continue to explore effective approaches for recognizing non-claims payments for primary care services.

The MHCC began collecting APM spending data in 2023 and refined its methodology in 2024. Moving forward, MHCC plans to review and enhance payer reported data on APMs to gain deeper insights into primary care investments. In collaboration with the Workgroup, MHCC will draw on experiences from other states to identify the most effective strategy for Maryland.

LIMITATIONS

Diverse perspectives from the Workgroup were considered in shaping the report. While a consensus-based approach was used to develop the recommendations, they do not reflect full unanimity. The analysis is based on the multi-state definition of primary care adopted by the Workgroup. A decision on a unified definition for primary care investment across payer programs (commercial, AHEAD Model,[79] and Medicaid MCOs) is anticipated in 2025. The APCD provides unique opportunities for calculating primary care investments. However, it excludes data from self-insured ERISA health plans, the uninsured, and workers' compensation.

[79] AHEAD Model, Notice of Funding Opportunity available at: www.hscrc.maryland.gov/Documents/Modernization/Model%20Documents/AHEAD%20NOFO%20Final%2011.15.2023%20508.pdf.

ACKNOWLEDGEMENTS

The MHCC commends the dedication of the stakeholders who serve on the Workgroup and contributed to the preparation of the report. We also extend our sincere thanks to Mary Jo Condon, Principal Consultant at Freedman HealthCare LLC, for her valuable contributions.

APPENDIX A: WORKGROUP MEMBERSHIP

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Maryland General Assembly	Senate	Clarence Lam
Maryland Primary Care Program	MDPCP/MDH	Chad Perman
Health Services Cost Review Commission	HSCRC	William Henderson
Maryland Insurance Administration	MIA	Karen Lam
Health Care Financing Division of the Maryland Department of Health	Medicaid	Tricia Roddy
Maryland Academy of Family Physicians	MDAFP	Amar Duggirala Poolesville Family Practice
Maryland Chapter of the American Academy of Pediatrics	MDAAP	Jeffrey Bernstein Pediatric and Adolescent Care of Silver Spring
Maryland Section of the American College of Obstetricians and Gynecologists	MDACOG	Ishrat Rafi Ascension Saint Agnes
Maryland Nurses Association	MNA	Christie Simon-Waterman The Johns Hopkins Hospital
Maryland Affiliate of American College of Nurse Midwives	Maryland Affiliate of ACNM	Mette Ramanathan University of Maryland St. Joseph Medical Center
Maryland Community Health System	MCHS	Salliann Alborn
Mid-Atlantic Association of Community Health Centers	MACHC	Nora Hoban

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Maryland Hospital Association	MHA	Tequila Terry
Accountable Care Organization	Aledade	Tyler Blanchard
Primary Care	MEDIS, LLC	Michael Barr
	Johns Hopkins Clinical Alliance	Sarah Johnson Conway
	Patient First	Theresa Noe
	University of Maryland School of Medicine	Niharika Khanna
Payor	CareFirst BlueCross BlueShield	Seiji Hayashi
	Funk & Bolton P.A.	Matthew Celentano
	Kaiser Permanente of the Mid-Atlantic	Tinisha Cheatham
	Amerigroup Maryland, Inc. & Maryland MCO Association	Kathleen Loughran
Health Services Researcher with Expertise in Primary Care	Johns Hopkins Bloomberg School of Public Health	Jill Marsteller
Other Representatives	Health Care for All	Rev. William Johnson, Jr. Community Chaplain for the Johns Hopkins Health System
	MidAtlantic Business Group on Health	John Miller
	Perdue Farms	Dawn Carey
	State of Maryland	Christina Kuminski

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
	Independent Consultant/ Retired Senior Health Actuary at U.S. Office of Personnel Management	Ronald Gresch

Biographies

Salliann Alborn, BSN– MCHS Representative

Ms. Alborn is the Chief Executive Officer for Maryland Community Health System (MCHS) and has over 30 years of experience advising governmental, health insurance, and managed care organizations. Prior to joining MCHS, Ms. Alborn served as the Executive Director of the Robert Wood Johnson Foundation's Health Impaired Elderly Program and Chair of the Maryland Dental Action Coalition.

Michael Barr, MD, MBA, MACP, FRCP – Primary Care Representative

Dr. Barr is a board-certified internist and President of MEDIS, LLC, a health care consulting company. He has over 30 years of health care related experience. Previously, he served as the Executive Vice President of the Quality Measurement & Research Group at the National Committee for Quality Assurance and as Senior Vice President at the American College of Physicians. Dr. Barr also served as an MHCC Commissioner.

Jeffrey Bernstein, MD – MDAAP Representative

Dr. Bernstein is a Managing Partner at Pediatric and Adolescent Care of Silver Spring. He has over 34 years of experience practicing primary care general pediatrics. Dr. Bernstein also serves on several boards and committees, including the Board of Governors for the Privia Quality Network—Mid-Atlantic and the Clinical Performance, Payer, and Finance Committees of Privia Medical Group.

Tyler Blanchard, BS – Accountable Care Organization Representative

Mr. Blanchard led Aledade's multi-payer Accountable Care Organizations in Delaware, Maryland, and the District of Columbia as Market President. He leads Aledade's Care Transformation Organization within the Maryland Primary Care Program. Mr. Blanchard serves as a Payment and Attribution Committee Member on the Delaware Health Care Commission's Primary Care Reform Collaborative.

Dawn Carey, MBA – Consumer (Employer) Representative

Ms. Carey is the Senior Director of Health and Wellness Programs at Perdue Farms. She has more than 10 years of experience supporting Perdue Farms' onsite wellness centers, which provides primary care to associates and dependents. Previously, Ms. Carey served as Perdue Farms' Corporate Healthworks Manager.

Matthew Celentano – Payor Representative

Mr. Celentano served as Government Relations Specialist with Funk & Bolton, P.A. for more than five years. He manages and advises State trade associations and works with stakeholders on legislation and matters related to the regulation of insurance in Maryland. Prior to joining the firm, Mr. Celentano served for 16 years as Deputy Director of the Maryland Citizens' Health Initiative.

Tinisha Cheatham, DO – Payor Representative
Dr. Cheatham is a board-certified family medicine physician with over 17 years of experience. She serves as Physician in Chief of the Mid-Atlantic Permanente Medical Group for the Baltimore service area. In this role, Dr. Cheatham is responsible for a staff of clinicians that provide care to over 134,000 patients across the Baltimore metropolitan area.

Sarah Johnson Conway, MD – Primary Care Representative
Dr. Conway is the Chief Medical Officer of the Johns Hopkins Clinical Alliance, a clinically integrated network of physicians driving value-based care and quality efforts. She has been practicing internal medicine for more than seven years. Previously, Dr. Conway served as the Medical Director of Care Coordination for the Johns Hopkins Care Transformation Organization.

Amar Duggirala, DO, MPH, FAAFP – MDAFP Representative
Dr. Duggirala is a board-certified family physician with more than 18 years of experience in primary care delivery, including two years at the University of Maryland Medical Center. He is the owner and Medical Director of Poolesville Family Practice and has extensive experience in primary care reimbursement. Dr. Duggirala also serves as an adjunct clinical instructor at the University of Maryland School of Medicine.

Ronald Gresch, MAAA, ASA – Consumer Representative
Mr. Gresch is a consultant for the U.S. Office of Personnel Management (OPM) where he focuses on improving Medicare integration and participation, long term care insurance, and the Postal Service Reform Act of 2022. He has 42 years of federal government experience. Prior to his retirement, Mr. Gresch served as a Senior Health Actuary at OPM and was the primary negotiator of health insurance premiums for the Federal Employees Health Benefits Program.

William Henderson – HSCRC Representative
Mr. Henderson is the Principal Deputy Director for Medical Economics and Data Analytics at the Health Services Cost Review Commission (HSCRC). In this role, he gathers, manages, and analyzes data for the Maryland Total Cost of Care Model and the regulatory operations of HSCRC. Mr. Henderson has over 20 years of experience in data research and analytics. Previously, he led analytics for a national specialty managed care company.

Seiji Hayashi, MD – Payor Representative
Dr. Hayashi is Lead Medical Director for Government Programs at CareFirst BlueCross BlueShield. He is a board-certified family physician and an experienced leader in primary care, quality improvement, and health policy at the local and national levels. Prior to CareFirst, he spearheaded health services integration and transformation at two area federally qualified health centers. His national health policy experience comes from his role as Chief Medical Officer for the federal Health Center Program at the Health Resources and Services Administration.

Nora Hoban – MACHC Representative
Ms. Hoban is the Chief Executive Officer of the Mid-Atlantic Association of Community Health Centers (MACHC) where she oversees the overall operations. She has 10 years of executive management experience and more than 25 years of policy and data analytics, project and financial management, and provider payment expertise. Prior to joining MACHC, Ms. Hoban served as Senior Vice President at the Maryland Hospital Association.

William Johnson, Jr., DDiv – Consumer Representative
Dr. Johnson is a community chaplain for the Johns Hopkins Health System. He works to improve community health outcomes by connecting faith communities to health system resources, as well as providing compassionate spiritual care to patients and community members. Dr. Johnson has held various positions within the State of Maryland for nearly 33 years.

Niharika Khanna, MBBS, MD, DGO – Primary Care Representative
Dr. Khanna is a board-certified family care physician with over 30 years of experience. She serves as a Professor of Family and Community Medicine and as the Associate Chair, Population Health Sciences at the University of Maryland School of Medicine. Dr. Khanna has worked in various aspects of practitioner and graduate education, including as Director of the Maryland Learning Collaborative.

Christina Kuminski – Consumer (Employer) Representative
Ms. Kuminski is the Director of Employee Benefits at the State of Maryland. She has over 25 years of account management experience in the insurance industry. Before joining the State, Ms. Kuminksi served in various managerial and executive positions including as an Account Manager for Sedgwick and as an Account Executive for Hodge, Hart & Schleifer, Inc.

Clarence Lam, MD, MPH – Maryland General Assembly Representative
Dr. Lam is Maryland's 12th Legislative District representative for the counties of Anne Arundel and Howard. He is a board-certified physician in preventive medicine at the Johns Hopkins Bloomberg School of Public Health and serves as the program director of the preventive medicine residency program. Dr. Lam is an attending physician at the occupational health clinic at the Johns Hopkins Applied Physics Laboratory.

Karen Lam, MBA – MIA Representative
Ms. Lam is Chief, Health Insurance and Managed Care, in the Life and Health Division at the Maryland Insurance Administration (MIA). She has over 30 years of experience in the insurance industry. Ms. Lam oversees and manages the review of insurance form filings and contracts including providers and pharmacy benefit managers. Prior to joining MIA, Ms. Lam worked as an independent compliance consultant.

Kathleen Loughran – Payor Representative
Ms. Loughran is the Vice President of Government Relations for Amerigroup. She has more than 28 years of experience advising government and for-profit organizations on health care issues in commercial and Medicaid markets. Prior to joining Amerigroup, Ms. Loughran was Associate Commissioner of Policy and Government Affairs at the Maryland Insurance Administration.

Jill Marsteller, PhD, MPP – Health Services Researcher with Expertise in Primary Care Representative
Dr. Marsteller is a Professor of Health Policy and Management at the Johns Hopkins (JH) Bloomberg School of Public Health with joint appointments in the JH School of Medicine and the Carey School of Business. Dr. Marsteller has over 30 years of experience in health services research with a focus on how to provide best-evidence care in a range of health care delivery settings.

John Miller – Health Care Association (Employer) Representative
Mr. Miller is the Executive Director of MidAtlantic Business Group on Health (MABGH). MABGH is an organization for business and health collaboration that helps employers design health benefits to maximize employee health while controlling cost. Mr. Miller has more than 25 years of experience working with employer groups on health-related matters.

Theresa Noe, MBA – Primary Care Representative
Ms. Noe has been the Vice President, Strategic Innovation and Partnerships at Patient First for about over 10 years. She is responsible for managing executive relationships with health plans, brokers, employers, health systems, and community providers. Ms. Noe's prior positions include serving as principal architect of HCA's Virginia Care Partners, LLC, and Vice President of Strategic Planning at HCA Healthcare – Capital Division.

Chad Perman, MPP – MDPCP Representative
Mr. Perman is the Executive Director of the Maryland Primary Care Program Management Office (MDPCP PMO) with over seven years of experience in integrating public health and primary care. He oversees Maryland's partnership with the Centers for Medicare & Medicaid Services, including negotiations with federal partners. Mr. Perman previously served as the Director of Health Systems Transformation within the Maryland Department of Health's Office of Population Health Improvement.

Ishrat Rafi, MD, MPH – MDACOG Representative
Dr. Rafi is a clinical and administrative obstetrician and gynecologist with more than 20 years of experience. Her prior positions include serving in leadership positions at Saint Agnes Ascension as Department Chairperson for OB/GYN, and Operating Room and Surgical Director. She is currently the Saint Agnes Ascension's Patient Safety Quality Medical Director and Minimally Invasive Gynecology Director. Dr. Rafi is the current MD Section Vice Chairperson of the American Congress of Obstetricians and Gynecologists.

Mette Ramanathan, CNM, FNP – Maryland Affiliate of ACNM Representative
Ms. Ramanathan is dual certified as a nurse-midwife and a family nurse practitioner. She has been working clinically as a dual practitioner for over 15 years. Ms. Ramanathan currently serves as a nurse-midwife at Saint Joseph Hospital within the University of Maryland Medical System. Before joining Saint Joseph Hospital, she held clinical positions in urgent care and school-based health clinics.

Tricia Roddy, MHSA – Medicaid Representative
Ms. Roddy is the Deputy Medicaid Director at the Maryland Department of Health and has served a 23-year tenure with the Maryland Medicaid program. She has extensive knowledge and applied experience in Medicaid

operations and innovation and health service transformation. Prior to joining the Maryland Department of Health, Ms. Roddy worked in management consulting and strategy services.

Christie Simon-Waterman, DNP, CRNP, RN – MNA Representative

Dr. Simon-Waterman is the President of the Maryland Nurses Association (MNA) and a certified registered nurse practitioner at The Johns Hopkins Hospital. She has over 26 years of experience in the health care industry and serves on multiple health care committees for the MNA and the Nurse Practitioner Association of Maryland. Dr. Simon-Waterman previously served as Director of Nursing at Future Care Health and Management Corporation.

Tequila Terry, MHA – Maryland Hospital Association Representative

Ms. Terry is MHA's Senior Vice President of Care Transformation and Finance. She leads MHA's advocacy strategy for Maryland hospitals in quality improvement, health equity, health care payment, and population health. Ms. Terry's prior positions include the director of the federal CMS Innovation Center's state innovation and population health portfolio and principal deputy director with HSCRC, where she led the Center for Payment Reform & Provider Alignment.

APPENDIX B: PAYER PRIMARY CARE INVESTMENT DISCUSSION GUIDE

Payer Primary Care Investment Discussion Guide

April 30, 2024

BACKGROUND

State law (Chapter 667/Senate Bill 734 - *Maryland Health Care Commission – Primary Care Report and Workgroup, 2022)* requires the Maryland Health Care Commission (MHCC) to conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending. The law tasks MHCC with convening a workgroup with representation from select stakeholders to obtain input on the scope and methodology for the analysis. A Primary Care Investment Analysis and Reporting Plan (Plan) was submitted to the Governor and General Assembly in October 2023. The Plan will guide annual reporting to the Governor and General Assembly beginning December 1, 2024.

ABOUT THE DISCUSSION GUIDE

Thank you in advance for your willingness to participate in this discussion. Your responses will provide MHCC with valuable insights to understand payer primary care investment strategies. This discussion is designed to be interactive, allowing MHCC to gain insights into your strategies and experiences. The questions below will help guide our discussion. Please answer questions to the best of your knowledge and experience. Please feel free to provide additional information in writing in responses to the questions before or within five business days of the discussion. If you have any questions, feel free to contact Mary Jo Condon at: mcondon@freedmanhealthcare.com.

DISCUSSION QUESTIONS

1. **Payer Information**
    a. Name of Payer:
    b. Lines of Business:
    c. Please describe the types of payment models your organization currently uses to support increased investment in primary care.

2. **Investment Strategies**

    a. Please describe your strategy to achieve the State's proposed primary care investment target. If you have not yet developed a strategy, please describe where you are in the planning process and any challenges you have faced.

    b. Please describe how your organization determines how to allocate primary care investment.

    c. How much is your primary care investment expected to increase in 2024 as a percent of spending compared to the previous year?

3. **Alignment with Goals**

    a. Please describe how your organization's primary care investment strategies align with its goals.

    b. How are primary care providers engaged in the development and implementation of your organization's investment strategies?

4. **Target Populations**

    a. Which populations does your organization target for primary care investments, if any?

    b. How are primary care investment strategies tailored to meet the specific needs of different population groups?

    c. How does your organization address disparities and inequities in access to primary care services among various population groups?

5. **Payer Measurement and Evaluation**

    a. Does your organization measure the effectiveness of primary care investment strategies? If so, how is it measured?

    b. What metrics or indicators does your organization use to evaluate the impact of these strategies on outcomes, patient experience, and cost savings?

    c. Does your organization measure the impact of primary care investment strategies on equity? If yes, please describe your approach.

    d. How does your organization assess the impact of primary care investment strategies on access and utilization?

6. Challenges and Opportunities

a. What challenges has your organization encountered when implementing and managing primary care investment strategies?

b. What investment opportunities for innovation and improvement exist?

7. Future Directions

a. What initiatives is your organization taking to advance primary care in alignment with broader strategies, such as expanding value-based payment models or improving health equity?

b. Please describe any emerging initiatives being considered or planned by your organization.

c. What State support is most crucial for greater investment in primary care?

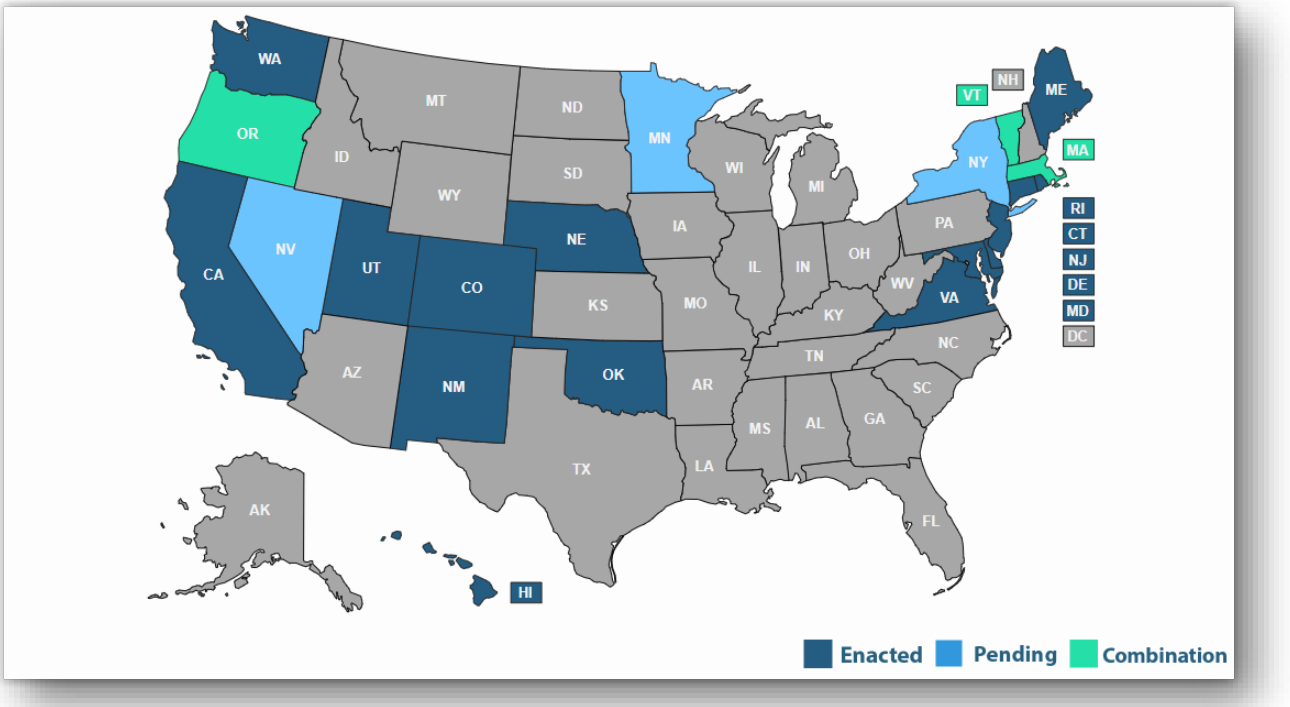
8. Additional Comments

Do you have any additional comments, insights, or suggestions related to primary care investment strategies that you would like to share?

The MHCC thanks you for your participation. Your feedback is greatly appreciated.

APPENDIX C: STATE-LEVEL PRIMARY CARE INVESTMENT LEGISLATION

As of August 2024



Source: Primary Care Collaborative, *State Primary Care Investment Initiatives*. Available at: https://thepcc.org/primary-care-investment/legislation/map .

APPENDIX D: FOUR PILLARS OF PRIMARY CARE

Measuring Progress Towards Primary Care Goals

PILLAR 1: FIRST CONTACT		
Operational Element	**Approach**	**Source**
Modality – how the patient interacts with or accesses primary care	Define primary care services; calculate the proportion of those services delivered in various care settings	PCAT APCD
Personnel involved – provider receiving or engaging with the patient	Define primary care services; define primary care providers; calculate the proportion of those services delivered by clinician type	PCAT APCD
Level of first contact – individual provider	Define primary care; calculate the proportion of those services delivered by the same health care professional	PCAT APCD
Level of first contact – assigned care team	Define primary care; calculate the proportion of those services delivered by health care professionals within the same organization	PCAT APCD

PILLAR 2: COMPREHENSIVENESS		
Operational Element	**Approach**	**Source**
Scope of services offered	Analyze claims to see variation in scope of services provided by primary care providers (“PCPs")	PCAT APCD
Depth and breadth of conditions managed by the primary care team, based on the prevalence of health concerns/conditions in the population served	Chronic condition quality measures, admissions, readmissions, emergency department (“ED”), ambulatory care sensitive conditions (“ASCs”)	PCAT APCD

PILLAR 2: COMPREHENSIVENESS		
Integrated behavioral health ("BH")	Measure primary care providers performance on standardized measures of quality related to behavioral health	PCAT APCD
	Analyze utilization of recommended BH screenings	PCAT APCD
	Rates of Social Determinants of Health ("SDoH") screening	PCAT APCD

PILLAR 3: COORDINATION		
Operational Element	**Approach**	**Source**
Links between primary and secondary/tertiary levels of care	Readmission rates	PCAT APCD
Links between primary care and behavioral health	Analyze utilization of psych collaborative care codes and other behavioral health integration codes	PCAT APCD
Workforce managing coordination and transitions of care	Readmission rates	PCAT APCD
Long term care management for chronic disease	Chronic condition quality measures, admissions, readmissions, ED, ASCs	PCAT APCD

PILLAR 4: CONTINUITY		
Operational Element	**Approach**	**Source**
Level of continuity	Define and apply primary care attribution; calculate the proportion of those services delivered by the same	PCAT APCD

PILLAR 4: CONTINUITY		
	health care professional and/or health care professionals within the same organization	
Advanced care planning	Analyze use of advanced care planning CPT®codes	PCAT APCD

MARYLAND
Health Care
Commission

4160 Patterson Avenue
Baltimore, MD 21215

mhcc.maryland.gov