Primary Care Investment Workgroup

2025 Primary Care Investment and Analysis and Recommendations Report

DRAFT

December 2, 2025
5:00 – 6:30 p.m.

Presentation Items

- Overview of State law (2022)
- 2025 PCIW annual report
  - Data findings
  - Recommendations
- Setting 2027 primary care investment targets

MARYLAND
Health Care
Commission

2025 PCIW Report Overview

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 MHCC must convene a Primary Care Investment Workgroup (Workgroup) to inform an annual report on 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

2025 PCIW Report – At a Glance

- The 2025 report marks the second annual analysis of primary care investment
  - Amends the definition of primary care to align with the Centers for Medicare & Medicaid Services (CMS) AHEAD Model (Model)*
  - Examines primary care spending and investment opportunity by ZIP code
  - Explores future considerations for primary care code valuation
  - Recommends activities based on findings to increase investment and accountability

** The CMS Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model is an 11-year program (2024 – 2035) that offers states the opportunity to leverage federal funding to implement broad changes in how health care is delivered and financed, CMS Link - AHEAD Model*

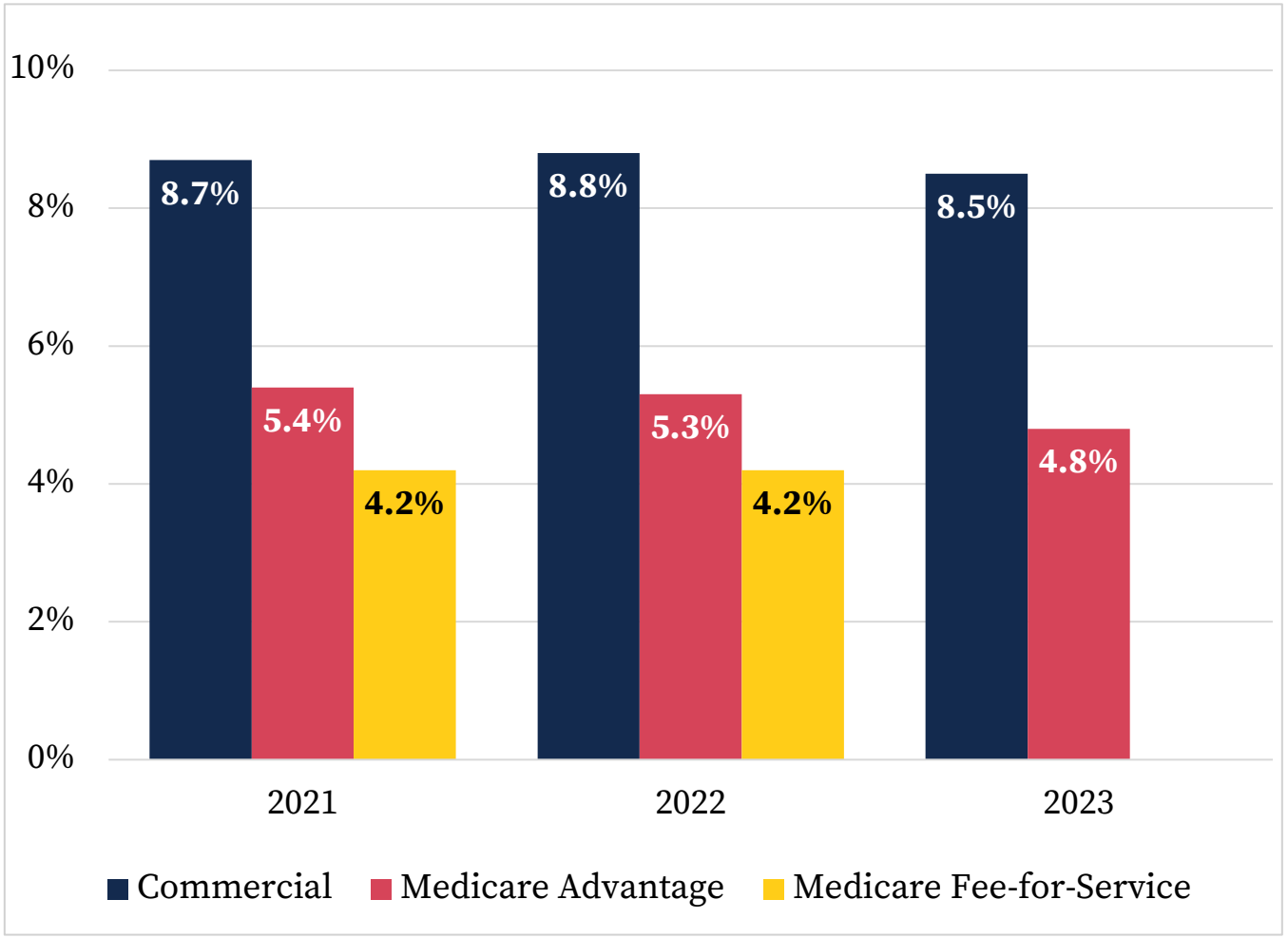
Primary Care Definition Comparison

- The definition of primary care previously included immunization administration, telehealth, pediatric care, and some behavioral health and hospice services
- The Model's definition is broader
  - Includes psychiatry and routine visits and preventive care provided by obstetricians and gynecologists
  - Uses broader CMS specialty codes instead of taxonomy codes

Data and Findings

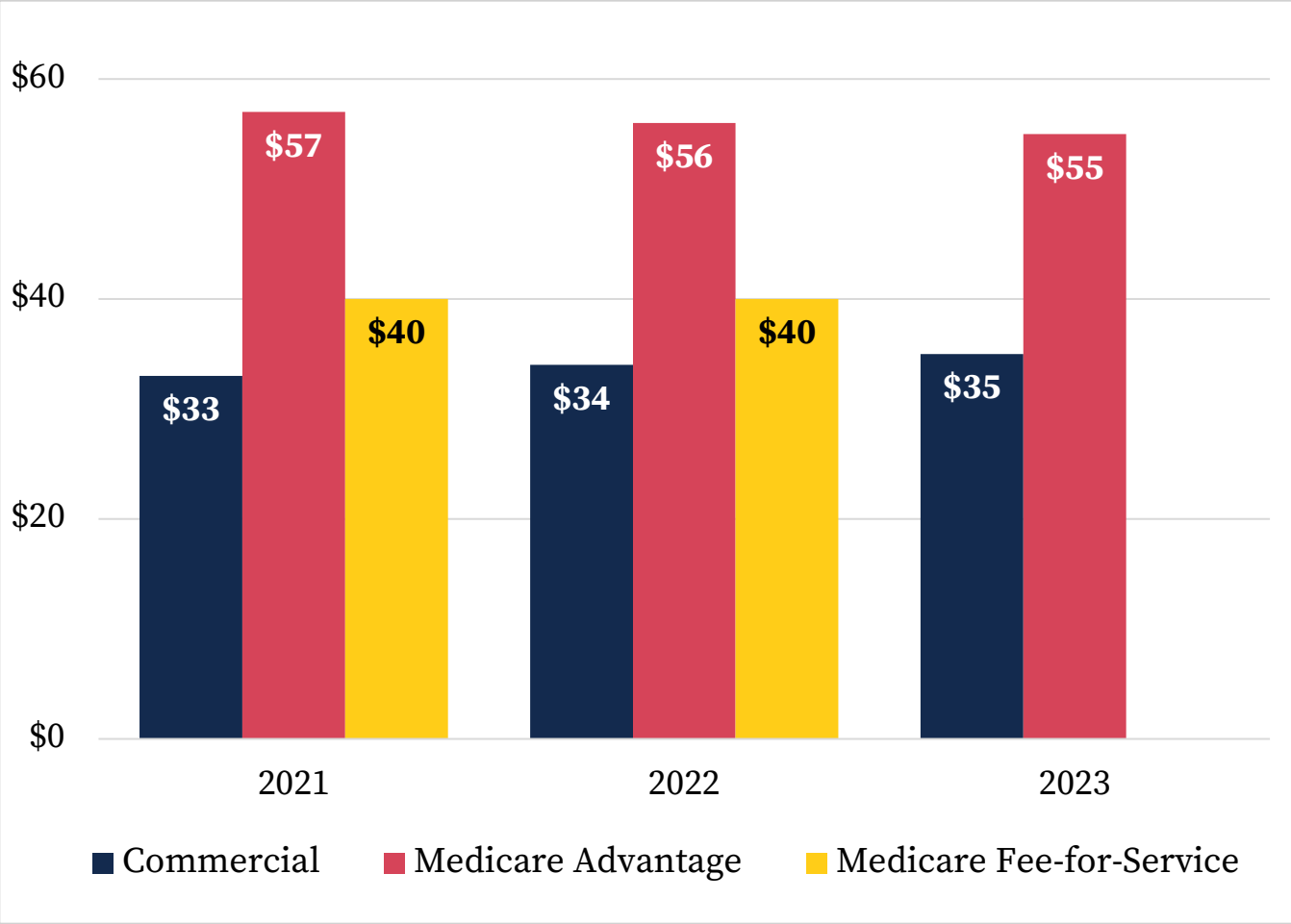
2021-2023

Primary Care Spending as a Percentage of TME



- TME represents the full amount of health care services delivered to a payer's member population paid to providers, including professional and facility services
- Commercial payers' primary care spending as a percentage of TME remained relatively flat from 2021 through 2023
- Medicare Advantage declined from 2021 through 2023
- Medicare FFS remained the same from 2021 through 2022

Primary Care Spending Per Member Per Month (PMPM)

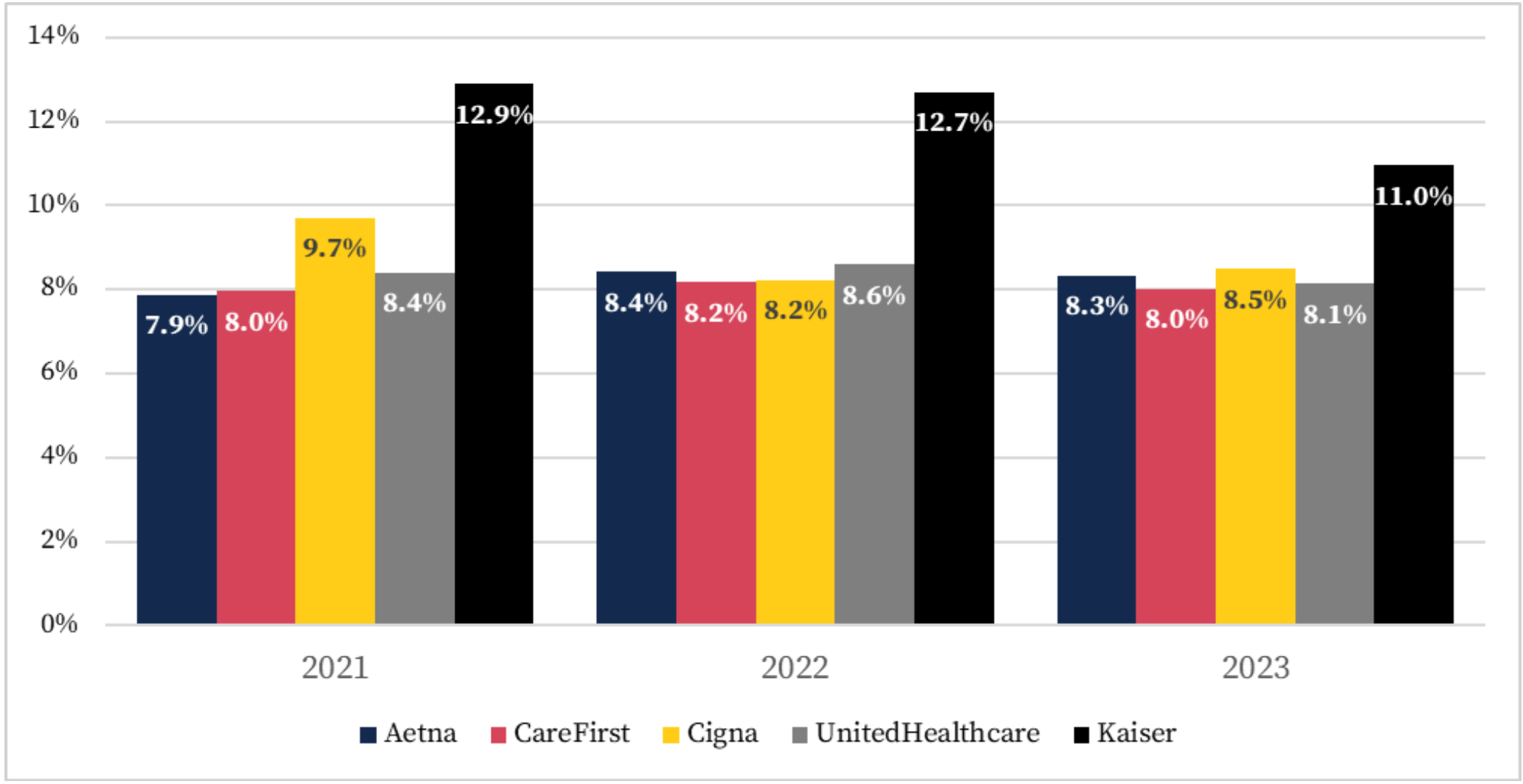


- PMPM varied considerably by payer type
- When primary care spending is measured as a percentage of TME, higher TME will result in a lower percentage of primary care spending
- Medicare Advantage plans, on average, spent the most on a PMPM basis, but commercial plans had the highest percentage of primary care spending

Primary Care Spending as a Percentage of TME by Commercial Payer

- Primary care spending is generally consistent across commercial payers, except Kaiser
- Kaiser's integrated care and coverage model may lead to higher primary care spending patterns than other models
- While Cigna's primary care PMPM increased by about 2.6 percent from 2021 to 2022, TME PMPM increased significantly by about 22.4 percent, the bulk of this increase is driven by institutional claims as PMPM increased by about 49 percent; there was a decrease in primary care spend as a percentage of TME from 2021 to 2022 (see Appendix – Slide 58)

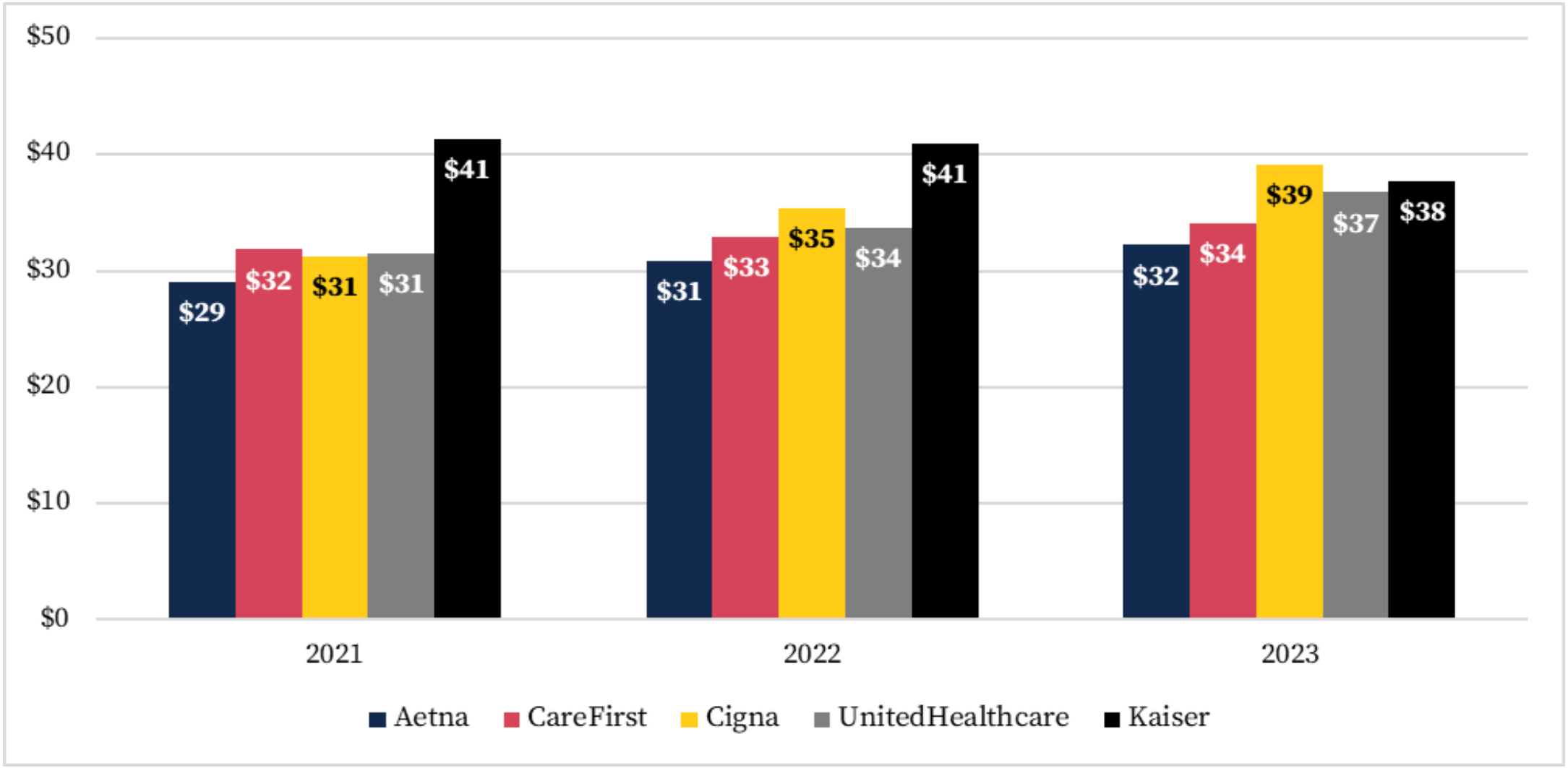
Primary Care Spending as a Percent of TME by Commercial Payer *(continued…)*



Primary Care Spending PMPM by Commercial Payer

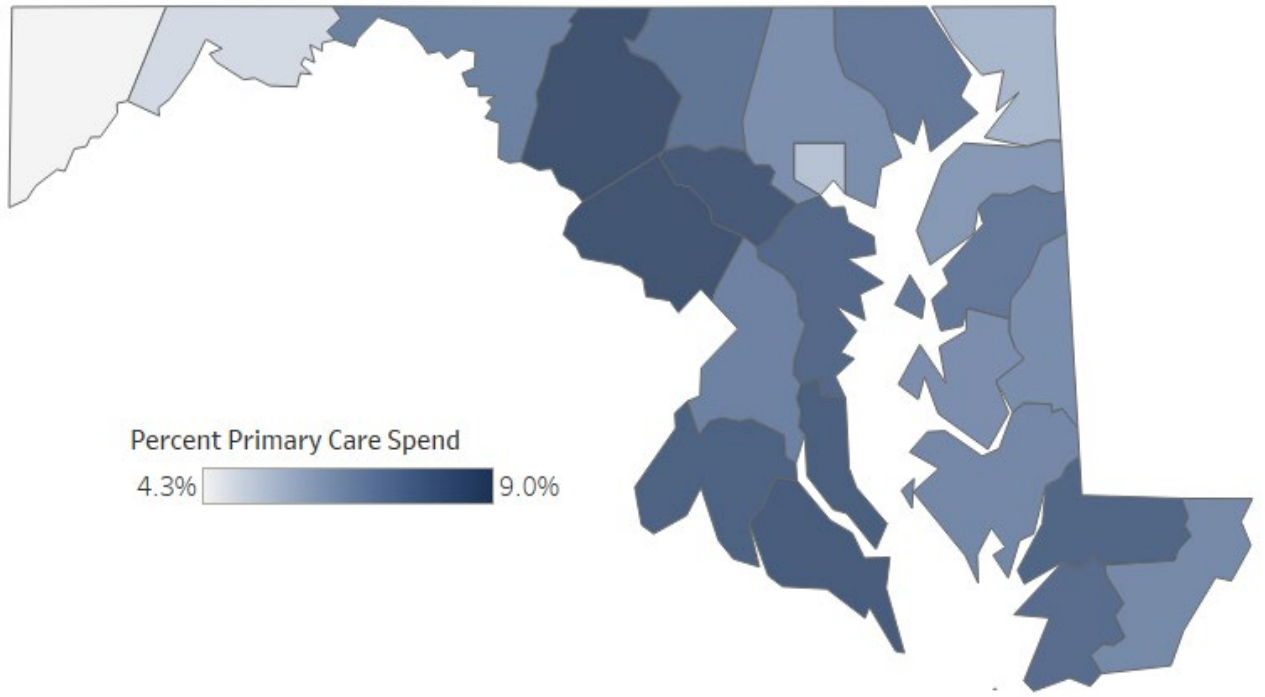
- Across commercial payers, PMPM spending has stalled since 2021
- When primary care spending is measured as a percentage of TME, higher total spending will result in a lower percentage of primary care spending
- Between 2021 and 2023, Cigna's PMPM primary care spending grew the most, mirroring an increase in its overall PMPM spending from $322 PMPM to $460 PMPM

Primary Care Spending PMPM by Commercial Payer
(continued…)



Primary Care Spending as a Percentage of TME by Jurisdiction, 2023

- Commercial primary care spending varied, from 4.3 percent of TME in Garrett County to 9.0 percent in Frederick County
- Spending was low in some of the least populous jurisdictions, Garrett (4.3 percent) and Allegany (4.9 percent), but also in Baltimore City (5.5 percent), the most densely populated jurisdiction in the State
    - Median household income (2022) was less than $60,000 in these counties
- Median household income ranged from $117,000 to $133,000 (2022) in the counties with the highest spending, Frederick (9.0 percent), Montgomery (8.7 percent), and Howard (8.7 percent)



Geographic Analysis Overview

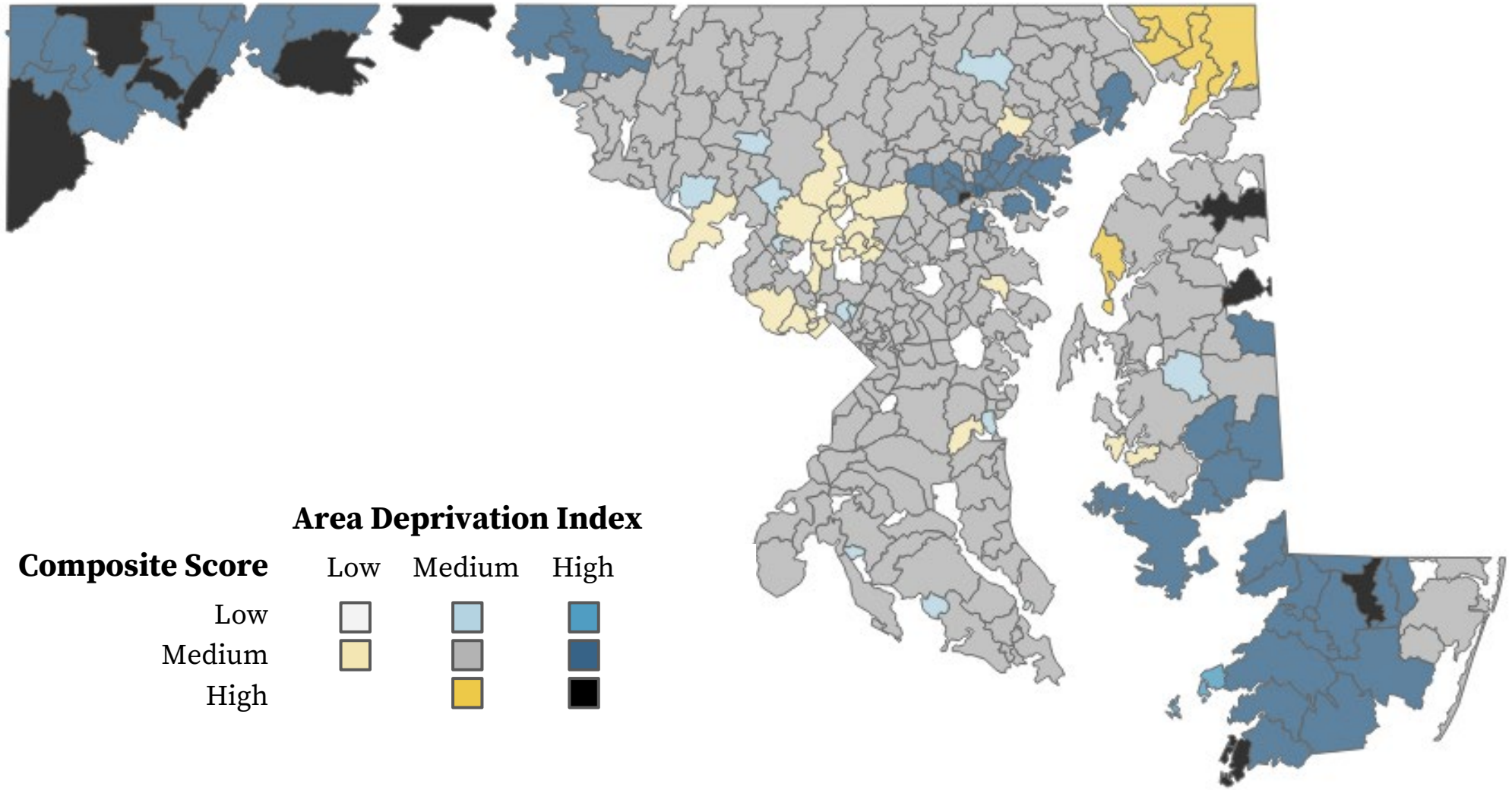
- Identified Maryland ZIP codes with the most opportunity for improving access, quality, and equity through increased investment in primary care
- Included five metrics: primary care spending, primary care utilization, emergency room utilization, colorectal cancer screening, and Area Deprivation Index (ADI) ranking
- ZIP codes received higher scores if they had lower primary care spending, lower utilization of primary care services, higher emergency room use, or lower rates of colorectal cancer screening
- The metrics were adjusted for age and gender and combined into a composite score
- The composite score was then examined alongside ADI, which ranks communities based on measures of social risk

Jurisdictions with Highest Commercial Primary Care Investment Opportunity

Jurisdiction	ZIP Codes	Primary Care Spend (%)	Composite Score
Allegany	21521	2.0	0.78
Allegany	21555	5.4	0.74
Allegany	21557	4.9	0.75
Baltimore City	21223	3.9	0.59
Caroline	21640	4.2	1.15
Garrett	21536	3.1	0.55
Garrett	21550	4.7	0.55
Kent	21651	8.0	0.87
Somerset	21817	7.4	0.63
Washington	21750	7.1	0.59
Wicomico	21849	8.0	0.70

- Eleven ZIP codes had both a higher composite score and a higher ADI, indicating the greatest opportunity to benefit from increased primary care investment
- With the exception of Baltimore City, these geographic areas are concentrated in northwest and southeastern Maryland

Primary Care Investment Opportunity by ZIP Code



MARYLAND
Health Care
Commission

2025 Recommendations

Recommendation 1

Establish a primary care investment target based on TME, adjusted for payer-specific variation, that promotes primary care investment in underserved areas; publish annually which payers are meeting the target; enact legislation to hold payers accountable to achieving targets

- Use current MHCC authority to establish a primary care investment target based on TME calculated through a flat dollar rate rather than a percentage
- Adjust for payer-specific factors such as age and health status
- Prioritize investments in underserved areas
- Offer insight into how resources are currently allocated
- Help identify opportunities to strengthen primary care in communities with the greatest need
- Support investment in safety-net primary care clinics
- Ensure that investments are data-driven and aligned with the Statewide goal of advancing health equity
- Work with the legislature to promote accountability, continuing the recommendation from 2024

Recommendation 2

Enact legislation requiring payers to participate in the Model primary care programs, including the Maryland Primary Care Program (MDPCP), and to reimburse providers for Advanced Primary Care Management (APCM) services and integrated behavioral health services with no cost sharing, when permitted by law

- Multi-payer alignment is critical to have the financial incentive to transform the way that care is delivered
  - Primary care clinicians may not focus on each patient's payer
  - Investment is required to build the infrastructure to best manage the population health of communities

Recommendation 2 *(continued…)*

Enact legislation requiring payers to participate in the Model's primary care programs and to reimburse providers for Advanced Primary Care Management (APCM) services and integrated behavioral health services with no cost sharing, when permitted by law

- Both MDPCP and the APCM payments offer additional revenue opportunities and a discrete set of quality measures to promote high quality primary care
  - Commercial payers and Medicaid can decide to eliminate APCM cost sharing, as permitted by law, to improve uptake and incentivize clinicians to adopt the coding and payments
  - New PFS add-on codes for Behavioral Health Integration and the Collaborative Care Model allow for more effective integration and should be covered without cost sharing if finalized
  - Increased payments could help practices hire interprofessional staff, offer competitive salaries, enhance electronic resources for patient communications, expand care management resources, and serve more patients

Recommendation 3

Leverage the CMS Potentially Misvalued Codes Process to advocate for more accurate valuation of services

- Longstanding distortions in the Medicare Physician Fee Schedule (PFS) likely undervalue the work of primary care and behavioral health teams and overvalue other specific services
- PFS distortions contribute to workforce shortages and gaps in access
- This process offers a pathway to reexamine how care coordination, preventive services, and non-face-to-face interactions and other services are priced
- Submitting nominations supported by empirical data can help ensure that payment more accurately reflects the complexity and intensity of all services

Recommendation 4

Assess how health systems are investing in their owned and affiliated primary care teams and examine whether incentives for increased investment are necessary

- Assess how health systems invest in their owned and affiliated primary care teams to understand whether increased financial support is having its intended effect
- Conduct a focused review to identify gaps and determine whether incentives are needed, especially as coverage shifts threaten access for vulnerable populations
- Align investment with practice-specific patient and community needs to ensure care teams are equipped to address equity goals

Recommendation 5

Continue to monitor the Model's implementation to ensure that Workgroup investment goals and strategies inform and align with Model objectives

- Helps ensure that Workgroup policy recommendations remain responsive to the State's broader vision for transforming primary care
- Helps shape policy approaches that align with Model priorities
- Supports policy that remains adaptable to meet the evolving primary care needs

Setting Primary Care Investment Targets

Recommendation 1

Establish a primary care investment target based on TME, adjusted for payer-specific variation, that promotes primary care investment in underserved areas; publish annually which payers are meeting the target; enact legislation to hold payers accountable to achieving targets

National Context

- More than a half dozen states have developed primary care investment targets or requirements
- Multiple states now have more than 5 years of experience; Rhode Island, the first state to implement, did so in 2010
- These efforts have had varying levels of success and offer lessons learned, which Maryland is aiming to reflect in its approach

State Lessons Learned and Maryland Approach

State Lessons Learned	Maryland Approach
Multi-payer alignment needed	State participation in AHEAD model and shared use of AHEAD primary care definition
Targets based on a percent of spending can be inflationary	Targets reflect investments necessary to improve outcomes
A single target for all does not reflect differences in payer populations and related primary care need	Payer targets adjusted for age/gender mix of population
New investments may not reach communities most in need	Payers shown geographic variation in investment and communities with highest social risk; asked to prioritize investments in communities of greatest need

Overview of Proposed Approach to Target Development

- Develop a model that estimates the cost of providing high quality, accessible primary care in Maryland. Inputs include:
  - Chronic condition prevalence in Maryland,
  - National recommended care guidelines,
  - Best practices in care team configurations,
  - Maryland wages and benefit costs, and
  - Estimates of administrative costs
- Use the model to estimate per member per month costs of primary care delivery in Maryland for each age group/gender combination
- Develop weighted average based on age group/gender mix of each payer's population
- Achieve payer specific targets that reflect the cost of primary care delivery

Discussion of Proposed Approach to Target Development

Step	Description	Discussion
1. Review Literature to Identify Model Inputs	▸ Maryland disease prevalence rates (Maryland Department of Health, America Health Rankings, peer review literature) ▸ Maryland wages and benefits for primary care providers and care team members (U.S. Bureau of Labor, Maryland median, 30% fringe) ▸ Best practices in panel size, staffing configurations (gray and peer reviewed literature)	▸ Are there other inputs or specific sources to consider?
2. Use Model to Estimate Costs	▸ Estimated primary care staffing costs necessary to care for each age/gender combination ○ Age groupings for commercial comparison: <30, 30-65, >65 ○ Gender groupings available in the MHCC all payer claims database: male, female	▸ Maryland men tend to spend less on primary care relative to women than in other states. ▸ Should the model reflect the relative difference in Maryland or other states and efforts made to encourage recommended primary care use among Maryland men?

Proposed Approach to Target Development

Step	Description	Discussion
3. Apply Inflation Factor	▶ Potential Options for Inflation Factor ○ TME ○ Medicare Economic Index since specific to health care ○ Maryland Total Cost of Care Growth Target Under AHEAD ○ Other?	▶ Thoughts on the options for an inflation factor? ▶ How often should it be adjusted?

Proposed Approach to Target Development

Step	Description	Discussion
4. Develop Payer-Specific Glidepaths	▶ Distribute increases across three years ▶ Year over year (YoY) increases in primary care spend of approximately 12% to 25% depending on the payer/year ▶ Year 1 increases smallest in dollar value to allow payers time to adopt	▶ Should increases start slower or faster? ▶ What is an appropriate YoY increase?
5. Develop Stepwise Approach to Ensure More Equitable Investment	▶ Initially, use maps to highlight payers' geographic distribution of current primary care spend and Area Deprivation Index score at the ZIP code level (Note: First three digits used when member months do not meet minimum thresholds) ▶ Next, collaborate with payers to identify strategies to increase primary care investment in underserved areas ▶ Over time, hold payers accountable for increasing investment in underserved areas	▶ How might payers focus investment in a particular geography?

Example Care Team Builder

	A	B	C	D	E
12	**Expanded Care Team (Female)**	**Cost**	**FTE**	**FTE Annual Salary**	**Compensation**
13	RN Care Managers	$83,080	0.7	$96,830	$125,879
14	Behavioral Health Clinician	$49,610	0.7	$57,820	$75,166
15	Community Health Workers	$33,488	0.5	$51,520	$66,976
16	Pharmacist	$88,537	0.5	$136,210	$177,073
17	Nutritionist	$76,450	0.8	$78,410	$101,933
18	Total Expanded Care Team Cost	$331,164			
19	**"Commercial" PMPM Expanded Care Team Cost (Female)**	**$2.76**			
20	**Traditional Care Team**	**Cost**	**FTE**	**FTE Annual Salary**	**Annual Full Compensation**
21	Physician (MD/DO)	$1,353,800	4.9	$211,039	$274,351
22	Mid-Level (e.g.,NP)	$267,289	1.6	$125,000	$162,500
23	Total PCPs	$1,621,088	7	n/a	
24	Medical Assistant or Licensed Practical Nurse	$385,409	7	$45,060	$58,578
25	Traditional Care Team Cost	$2,006,497			
26	"Commercial" Traditional Care Team PMPM Cost (Male)	**$14.38**			
27	"Commercial" Traditional Care Team PMPM Cost (Female)	**$16.72**			
28					
29	**Total "Commercial" PMPM Cost**	**Attributed Patients**			
30	All Payer Practice Panel Size	10,000			
31	Staffing Costs (Traditional&Expanded Care Team) PMPM, Male	$16.16			
32	Staffing Costs (Traditional&Expanded Care Team) PMPM, Female	$19.48			
33	Other Administrative and Overhead Costs PMPM	$21.00			
34	Total "Commercial" PMPM Cost (Male)	**$37.16**			
35	Total "Commercial" PMPM Cost (Female)	**$40.48**			
36					
37					
38	**Expanded Care Team Use Assumptions**	**FTE (Male)**	**FTE (Female)**	**Estimated Use**	**Supporting Research**
				Assumes nurse	

The per PCP panel size estimate of 2000 is based on recent literature Determining Patient Panel Size in Primary Care: A Meta-Narrative Review - PMC identifying poorer outcomes in larger panel sizes.

Difference in PC investment by gender among Maryland residents is far greater than other states, suggesting some of the variation may not be necessary or appropriate. To encourage appropriate use, the model assumes the differential for costs associated with traditional care team members found in national published research The New England States' All-Payer Report on Primary Care Payments

The "Other Administrative and Overhead Costs" sourced from Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices; adjusted for inflation CPI Inflation Calculator;

Inputs

- Costs of traditional and expanded care team members
- Ideal panel sizes and care team configurations
- Disease prevalence estimates
- Estimated care team usage
- Administrative and overhead costs

Path Forward and Milestones

Next Steps

- Convene the PCIW every four to six weeks in Q1 2026 and about once every quarter thereafter
- Complete geographic analyses to identify areas where targeted community investments can address disparities and improve outcomes
- Establish payer specific primary care investment targets in collaboration with stakeholders
  - Convene listening sessions on proposed targets in 2026
  - Track payer performance against the targets and publish progress beginning in 2027

Timeline

Initiative	Timeline - Week
Share draft investment target methodology	December 1st
Share commercial care teambuilder for feedback	December 8th
Receive commercial care teambuilder feedback	December 15th
Calculate payer age/gender adjusted targets and develop zip code level maps of recommended primary care investment by payer	January 12th
Convene listening sessions	January 19th
Review draft investment targets and maps in collaboration with the PCIW	January 26th
Finalize draft targets in collaboration with the PCIW	February 24th
Convene listening sessions	March 2nd

Questions?

Update on Maryland's AHEAD Primary Care Programs

Agenda

- Overview of AHEAD Primary Care Programs
- Outreach and Enrollment
- Focus in upcoming months

MDH AHEAD Primary Care Work Group

Chief Medical Officer

Office of Advanced Primary Care

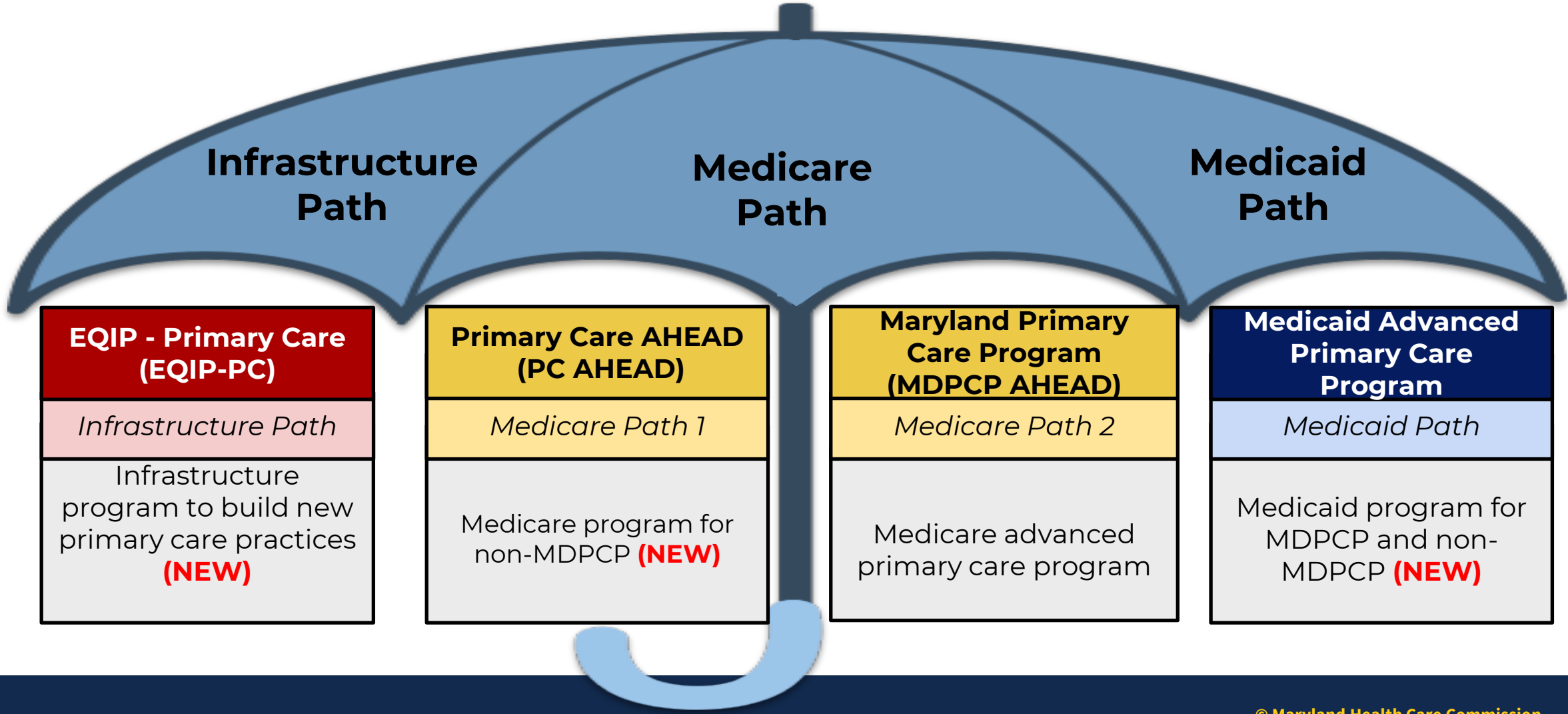
Clinical Transformation Unit

Office of Innovation, Research, and Design

Hilltop Institute

Consultants - Mathematica, CRISP/hMetrix

Maryland's AHEAD Primary Care Programs



October 2025 - 2026 Medicaid Path Approved by CMS!

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

AHEAD Medicaid Advanced Primary Care Program:
Milestone 2 – Medicaid Care Transformation Priorities

State of Maryland
September 30, 2025

Transmittal

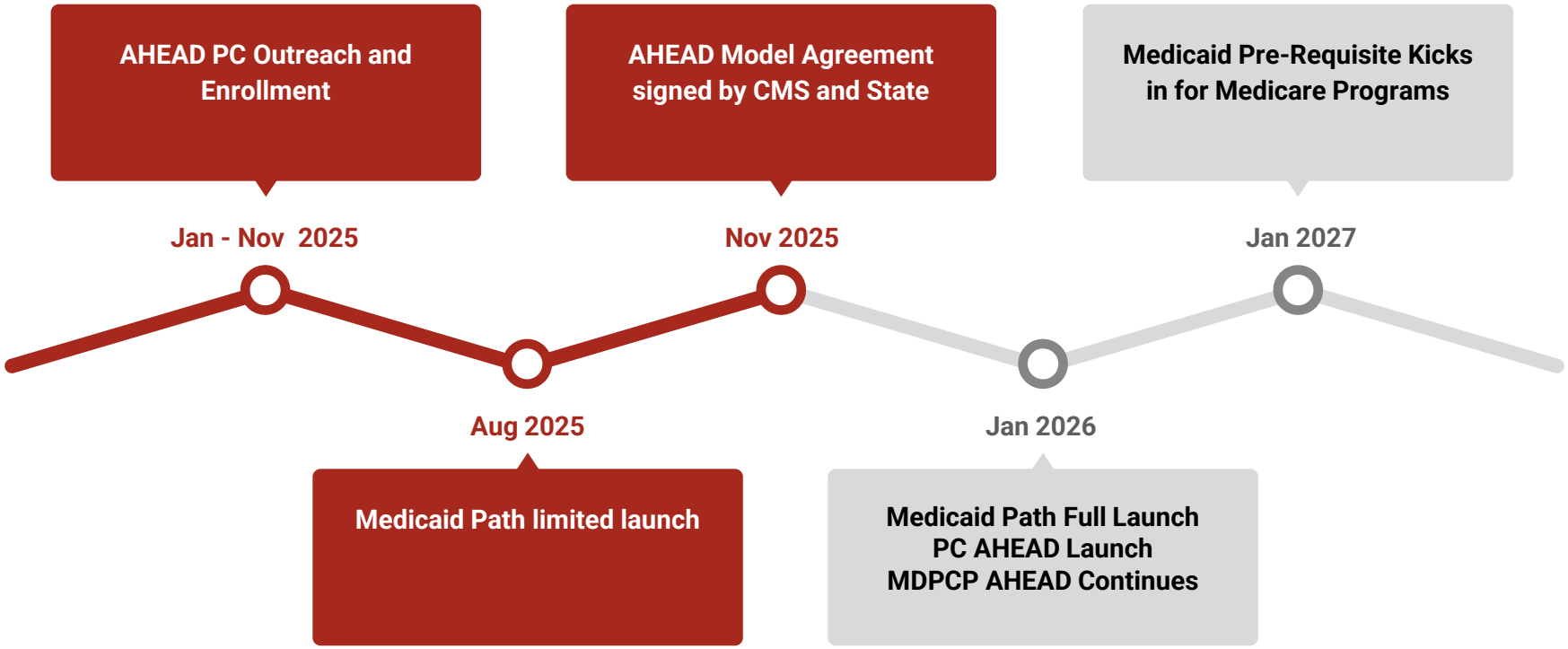
In accordance with the AHEAD Cooperative Agreement Terms and Conditions (T&C) under Section 19 "Milestones," the Maryland Department of Health (MDH) is submitting an update to the July 15, 2025 submission of the State's design for the Medicaid Advanced Primary Care Program (Medicaid Advanced PCP) and care transformation priorities for multi-payer alignment with Primary Care AHEAD. MDH intends for these programmatic elements to be in place at the start of January 2026 (PY1).

https://health.maryland.gov/mdpcp/Documents/Maryland_AHEAD_Medicaid_PC_Care_Transformation_Priorities_Memo.pdf

AHEAD State Agreement and Updates on Primary Care

- State Agreement signed Nov. 12, 2025
- Medicaid Path participation remains the pre-requisite for Medicare program participation
- MDPCP AHEAD will continue through 2028 and then CMS and State will determine whether to continue until 2035
- MDPCP AHEAD - PC AHEAD interaction - PC AHEAD participants will have the opportunity to apply for MDPCP for PY 2027*
- PC AHEAD will now have 4 pathways with increasing payments and risk:
  - Basic - starts in 2026
  - Advanced - starts in 2027
  - Partial Capitation - starts in 2028
  - Full Capitation - starts in 2028

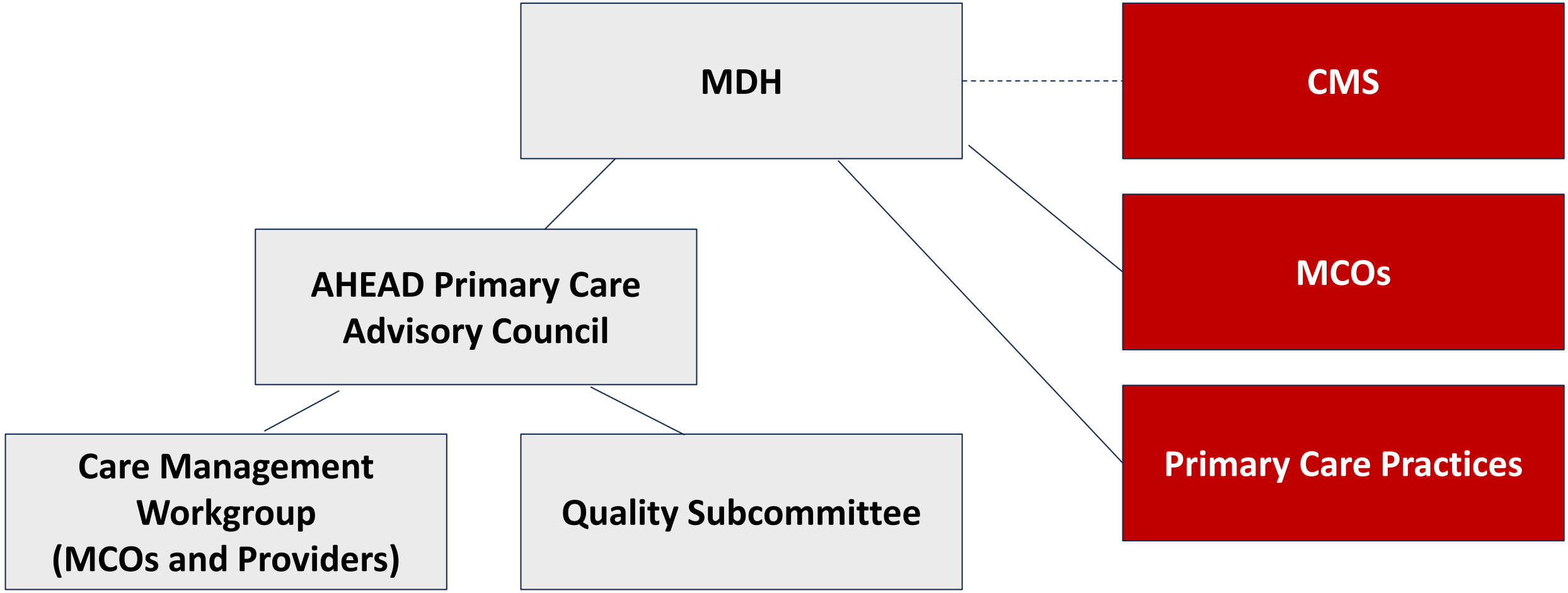
AHEAD Primary Care - Key Dates



Medicaid Path Outreach and Enrollment in 2025

- Provider Town Halls in February and July
- Eligibility determinations began in March
- Monthly meetings with MCOs to implement enrollment process
- Quarterly Advisory Council Meetings
- Pediatrics focused extension through November
    - Extended enrollment opportunity for pediatric practices that may have missed original deadline

Partners and Stakeholder Groups



Medicaid Path by the Numbers

	TINs	Medicaid HealthChoice Participants
MDPCP TINs	115 TINs, (includes 89 TINs currently in the program, and 26 TINs newly joining)	485,467
Non-MDPCP TINs	77 TINs	163,000 **
Expected TOTAL for January 1, 2026*	**192 TINs**	**648,000 ****

**Final total Jan 2026 numbers are subject to change*

**Awaiting data from 7 additional pediatric and FQHC TINs

Medicare Path by the Numbers (Estimates)

	PC AHEAD	MDPCP AHEAD	TOTAL
Practices	~25-50 practices	~460 practices*	**~500 practices**
Attributed Medicare FFS Beneficiaries	TBD	350,000**	**400,000**

**Final total Jan 2026 numbers are subject to change*

Focus in Upcoming Months

- Medicaid Path Quality incentive program
  - Finalizing Methodologies for 2026
  - Developing quality reporting infrastructure for 2027
- Care management workflows
  - Developing standards and workflows for MCOs and practices
- Onboarding new practices
  - Supporting new practices implement workflows and processes to meet program requirements
  - Training new practices on data tools
  - Education on advanced primary care

Update: National and State Primary Care Initiatives

National Landscape

- The federal government will invest in rural primary care through the Rural Health Transformation Program (RHTP)[1]
  - The program emphasizes workforce development, integrated care models, preventive care and health promotion, and technology adoption
  - Maryland proposes supporting net-new rural primary care access points, behavioral health and primary care integration, and workforce development
- The 2026 Medicare Physician Fee Schedule Final Rule begins to rebalance investment in primary care[2]
  - The efficiency adjustment captures evolving clinical practices and better informs the valuation of services, including primary care
  - New add-on codes for integrated behavioral health make it easier to bill with Advanced Primary Care Management services (APCM)

State-led Multistakeholder Initiatives

- **Vermont:** 2025 legislation created a 16-member Steering Committee for Comprehensive Primary Care[3]
  - The Committee is charged with informing annual targets for primary care spending as a percent of overall health care spending in the state
- **Massachusetts**: a 25-member Primary Care Task Force was created in 2025 to make recommendations to stabilize and improve primary care access, delivery, and payment
  - Three newly proposed bills would make the Task Force permanent and require it to outline a voluntary prospective, per-member per-month payment model[4]

Primary Care Spending Targets and Reporting

- **Rhode Island:** updated its target in August to direct insurers to spend at least 10 percent of annual medical expenses on primary care (8 percent through claims-based and capitation payments) by the end of 2028; includes a year-over-year target beginning in 2025[5]

- **Massachusetts:** in September, the Task Force discussed a hybrid model primary care spending target that includes a year-over-year target and an aggregate statewide target of 15 percent of total medical spending by 2034[6]

- **Colorado:** the 2025 Primary Care and Alternative Payment Model (APM) spending report released in November shows increasing primary care spending overall, decreasing commercial investment, and value-based APMs accounting for 58 percent of total primary care spending in 2024[7]

Primary Care Dashboards

- **Arkansas:** The Arkansas Center for Health Improvement recently updated an interactive dashboard that illustrates the rate of primary care providers by county[8]
    - This work aligns with Maryland's geographic analysis of primary care and jurisdictions with the greatest primary care investment opportunity
- **Colorado:** the Primary Care Payment Reform Collaborative has shown interest in states with primary care dashboards[9]
    - Virgina, Massachusetts, New York
- **Rhode Island**: The Rhode Island Health Care System Planning initiative has prioritized construction of a Primary Care System Performance Dashboard[10]

References

[1]https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

[2]https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f

[3]https://legislature.vermont.gov/Documents/2026/Docs/ACTS/ACT068/ACT068%20As%20Enacted.pdf

[4]https://masshpc.gov/sites/default/files/2025-10/20251029_PCTFMeeting_Presentation_0.pdf

[5] https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-08/RI%20TME%20%26%20PC%20DSG_CY23-24.pdf

[6] https://masshpc.gov/sites/default/files/2025-09/20250917_PCTF_Presentation.pdf

[7] https://doi.colorado.gov/sites/doi/files/documents/PCPRC-Slide-Deck-11.13.25.pdf

[8] https://achi.net/publications/arkansas-primary-care-physician-workforce/

[9]https://doi.colorado.gov/sites/doi/files/documents/PCPRC-Slide-Deck-11.13.25.pdf

[10] https://eohhs.ri.gov/RI-Health-Care-System-Planning/Reports

Closing Remarks

Appendix

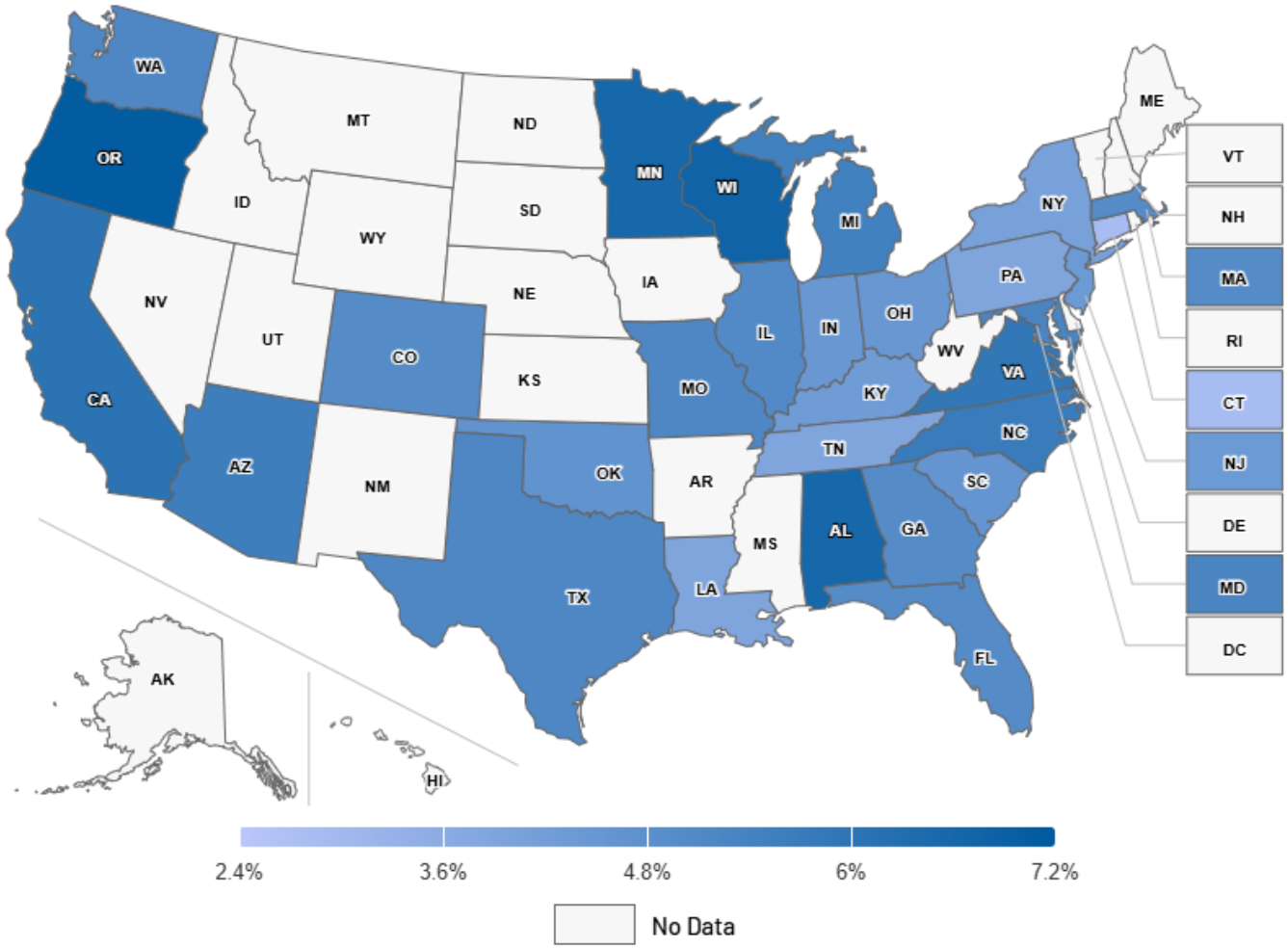
Cigna Spending 2021-2022

CIGNA Claims and Enrollment Experience (2021 - 2022)

Data From AHEAD High-Level Buckets (No Age Restrictions)

	Allowed Amount		Member Exposure			PMPM			PC % of TME		
Claim Category	2021	2022	2021	2022	% Change	2021	2022	% Change	2021	2022	% Change
Primary Care	$63,825,617	$65,647,262				$29.26	$30.02	2.6%	9.6%	8.0%	-1.5%
Professional	$373,625,081	$380,290,415				$171.31	$173.90	1.5%			
Institutional	$293,799,938	$438,856,195				$134.71	$200.68	49.0%			
Total Medical	$667,425,019	$819,146,610	2,181,042	2,186,896	0.3%	$306.01	$374.57	22.4%			

Primary Care Spending by State as a Percentage of TME For All Payers



Source: Milbank Memorial Fund, 2025 Primary Care Scorecard Data Dashboard; available at: https://www.milbank.org/primary-care-scorecard/

Geographic Analysis: Composite Score Metrics and ADI

Domain	Metric	Rationale
1. Spending	Lower primary care spending (PMPM or percentage of TME (Model definition)	Given systemic underfunding of primary care, relatively lower primary care spending may be an indicator of larger disparities and inadequate primary care
2. Access	Lower current utilization of primary care services (Model definition)	Relatively lower utilization of primary care services by geography may be an indicator of primary care capacity concerns or barriers to access care
3. Access	Higher ED utilization per 1,000 (HEDIS© measure)	Relatively higher ED utilization may be an indicator of inadequate access to primary care, as patients seek health care services where they are available or require more emergency care because they are sicker
4. Quality	Worse performance on colorectal cancer screening measure (HEDIS© measure)	Relatively worse performance on colorectal cancer screening may be an indicator of barriers to timely, appropriate, and quality primary care and preventive services
5. Social Risk	Higher ADI score	The ADI identifies underserved communities with socioeconomic characteristics that impact health outcomes

Geographic Analysis: ZIP Code Rankings by Composite Score and ADI

Composite Score	ADI				
		Low	**Medium**	**High**	**Total (%)**
	Low	10	13	1	**24 (7%)**
	Medium	23	216	56	**295 (88%)**
	High	0	6	11	**17 (5%)**
	ADI TOTAL	**33 (10%)**	**235 (70%)**	**68 (20%)**	**336**

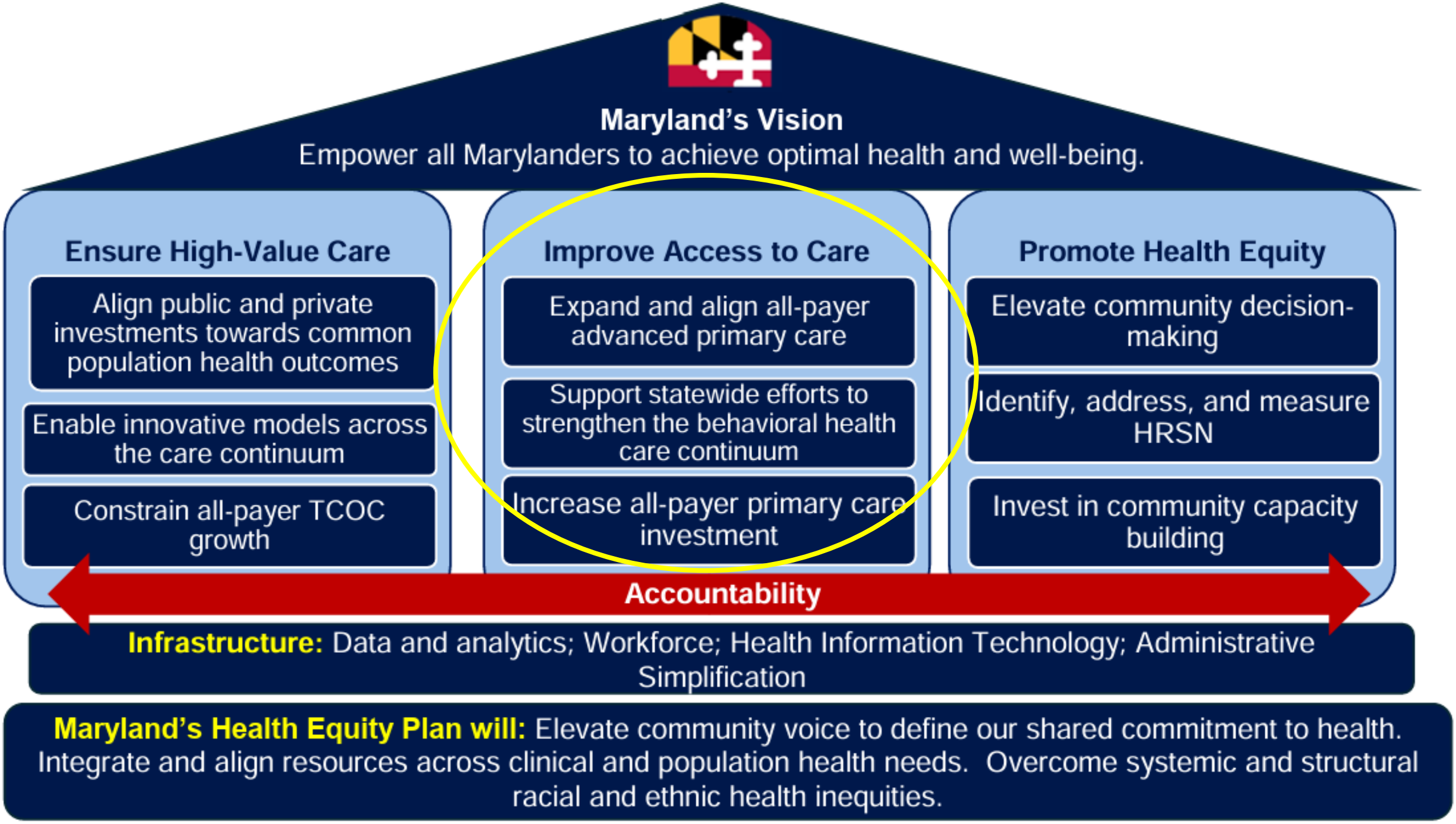
Limitations

- Data from MHCC's Medical Care Data Base (MCDB) for 2021-2023 was used to analyze claims for commercial payers and Medicare Advantage
  - Medicare Fee-for-Service (FFS) data was not available for 2023
  - The MCDB excludes claims for self-insured plans governed by ERISA (2016 U.S. Supreme Court ruling in Gobeille vs. Liberty Mutual Insurance Company) and Federal Employees Health Benefits plans (2019 U.S. Office of Personnel Management)
  - Diverse perspectives of the Workgroup informed development of the recommendations

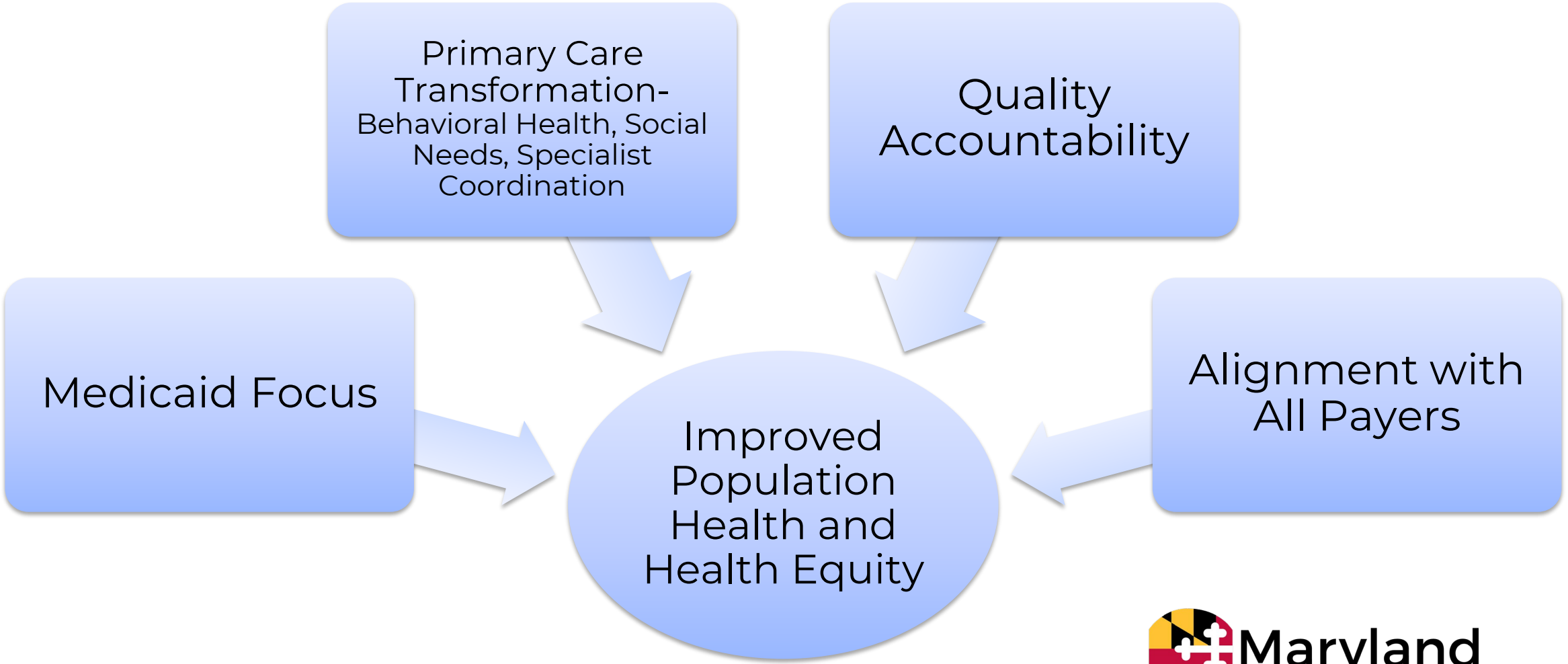
2026 Quality Incentive Program

The 2026 Quality Incentive will include four (4) P4P measures calculated from Medicaid claims and encounters and four (4) electronic clinical quality measures (eCQMs) as P4R that PCPs will submit to CRISP:

Population	Domain	Measure Name	Data Source	2026
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Medicaid claims	P4P
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Medicaid claims	P4P
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Medicaid claims	P4P
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Medicaid claims	P4P
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan (CDF-CF and AD): Ages 12 to 64	eCQMs through CRISP	P4R
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CDC-HbA1c Poor Control)	eCQMs through CRISP	P4R
Adults	Chronic Conditions	Controlling High Blood Pressure (CBP)	eCQMs through CRISP	P4R
Adults	Prevention & Wellness	Colorectal Cancer Screening (COL)	eCQMs through CRISP	P4R


Maryland's Vision
Empower all Marylanders to achieve optimal health and well-being.
Ensure High-Value Care
Align public and private investments towards common population health outcomes
Enable innovative models across the care continuum
Constrain all-payer TCOC growth
Improve Access to Care
Expand and align all-payer advanced primary care
Support statewide efforts to strengthen the behavioral health care continuum
Increase all-payer primary care investment
Promote Health Equity
Elevate community decision-making
Identify, address, and measure HRSN
Invest in community capacity building
Accountability
Infrastructure: Data and analytics; Workforce; Health Information Technology; Administrative Simplification
Maryland's Health Equity Plan will: Elevate community voice to define our shared commitment to health. Integrate and align resources across clinical and population health needs. Overcome systemic and structural racial and ethnic health inequities.

AHEAD Requirements for Primary Care



Maryland DEPARTMENT OF HEALTH

MDH's Vision and Goals for Primary Care AHEAD

VISION

- Advance whole-person care
- Establish strong linkages across the healthcare continuum
- Build a highly reliable program that sustains advanced primary care as a foundation for Marylanders

GOALS

- Simplify administrative burden for primary care providers
- Continue Medicare investment while broadening reach to Marylanders covered by Medicaid and commercial insurance
- Improve health outcomes for all Marylanders

Maryland
DEPARTMENT OF HEALTH

Medicaid Path Design Principles

Leverage Successes of MDPCP

Initial model starts with MDPCP practices with substantial Medicaid mix
(250 or more members from across MCOs)

Medicaid Leads

Ensure multi-payer access - Agreement requires participation in Medicaid Advanced PCP to access Medicare Path

Inclusion of pediatric practices

Simple "Rules"

Administrative simplification to maximize provider participation

Aligned quality measures, payments and data sharing across Medicare/Medicaid

Allow for Growth

Use an incremental approach to allow for growth and innovation

Medicaid Path Payment Structure Overview

Medicaid Path

Medicaid Advanced Primary Care Program

Payment structure:

- Enhanced E&M Fees *(All PCPs)*
- Care Management Fees
- Quality Incentives

Medicare Path

PC AHEAD

Payment structure:

- FFS billing
- Care Management Fees (Enhanced Primary Care Payment)
- Quality component

MDPCP AHEAD

Payment structure:

- Comprehensive Primary Care Payments (hybrid FFS)
- Care Management Fees (includes HEART)
- Performance-Based Incentive Payments

Maryland
DEPARTMENT OF HEALTH

Measures by AHEAD Primary Care Program

Target Population	Measure Domain	Measure Title	Measure Identifier	Data Source	Medicaid Payment Arrangement	PC AHEAD	MDPCP	Medicaid
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	CMIT 234	Medicaid claims	P4P	X	X	X
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	CMIT 14	Medicaid claims	P4P	X	X	X
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	CMIT 24	Medicaid claims	P4P			X
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	CMIT 1003	Medicaid claims	P4P			X
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan (CDF-CF and AD): Ages 12 to 64	CMIT 672	eCQMs through CRISP	P4R	X	X	X
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CDC-HbA1c Poor Control)	CMIT 204	eCQMs through CRISP	P4R	X	X	X
Adults	Chronic Conditions	Controlling High Blood Pressure (CBP)	CMIT 167	eCQMs through CRISP	P4R		X	X
Adults	Prevention & Wellness	Colorectal Cancer Screening	CMIT 139	eCQMs through CRISP	P4R	X		X

Resources

- PC Advisory Council Members and Bios
- Maryland's AHEAD Primary Care Programs webpage
- AHEAD Model Overview
- Hilltop MDPCP Evaluation, 2019-2022
- CMS PC-AHEAD Factsheet
- AHEAD Model Primary Care Town Hall Slide Deck

Maryland
DEPARTMENT OF HEALTH

Arkansas Primary Care Physician Workforce Dashboard