# Primary Care Investment Workgroup

MARCH 25, 2025

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# Update on Recent Primary Care Investment Efforts

## NATIONAL TRENDS AND STATE ACTIVITIES

# 2025 National Trends in Primary Care Investment

- Primary Care investment is declining; access to care is decreasing
- Based on the most recent data available through the Milbank/Robert Graham Center Scorecard Report, spending on primary care at the national level declined to under 5%
  - Primary care spending in Medicare and Medicaid decreased the most since the previous Scorecard, down to 3.4% and 4.3% in 2022, respectively[1]
- Underinvestment in primary care is impacting patient access to care, with greater access challenges for underserved and rural communities[1,2]
- Recent findings illustrate that people place significant value on primary care and vastly overestimate spending on primary care—public awareness of underinvestment in primary care is very low[3]

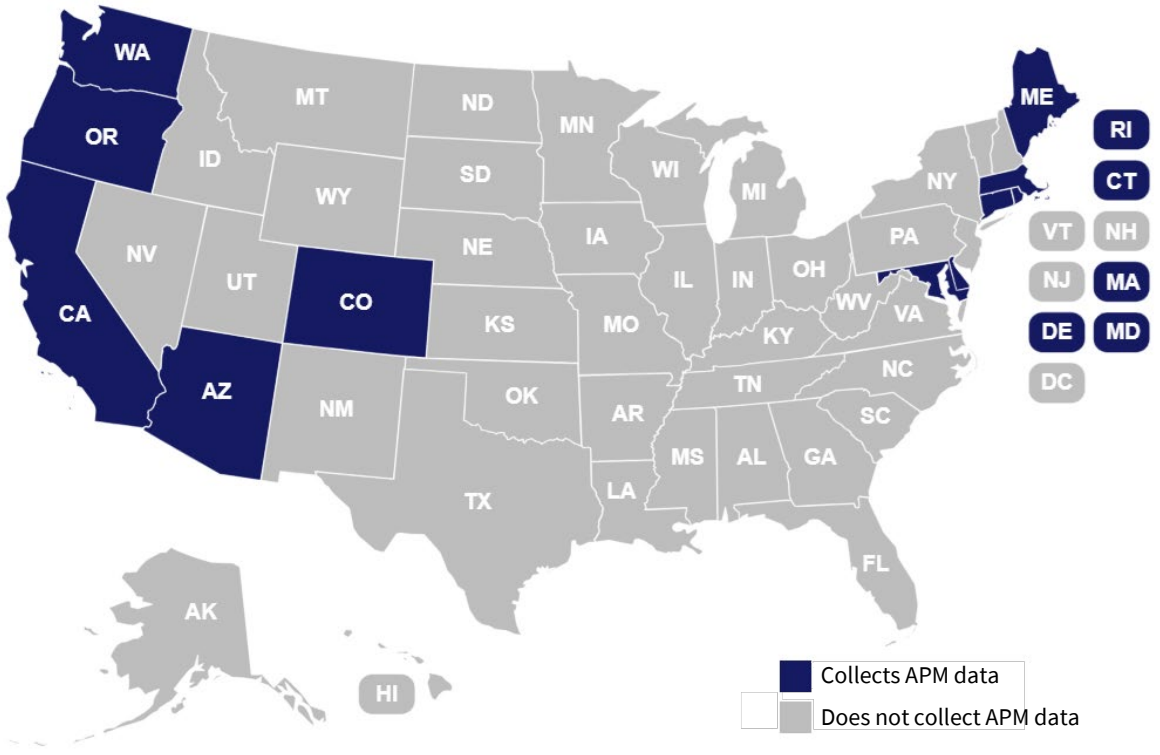
[1] Jabbarpour Y, Jetty A, Byun H, et al. The Health of US Primary Care: 2025 Scorecard Report. Robert Graham Center.
[2] Massachusetts Health Policy Commission. A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action.
[3] Ma M, Etz R, Bazemore A, et al. The General Public Vastly Overestimates Primary Care Spending in the United States. Ann Fam Med 2025;23:online.

# Primary Care Investment Network Technical Assistance

- Maryland will join 14 states in a learning community sponsored by the Primary Care Investment Network, the Milbank Memorial Fund and the Commonwealth Fund
- The goal of the project is to facilitate peer learning and collaboration across states to share strengths, address barriers to measurement, and build capacity to measure and report on primary care investment results
- States will be broken into three smaller groups to support more hands-on learning
- Maryland will join Connecticut, California and other states focused on using the data to demonstrate impact

# Value-based Payment Adoption and National Trends

- Including Maryland, 11 states monitor and collect data on value-based arrangement adoption
  - 8 states publish reports
- Commercial market examples:
  - In 2020, Oregon and Delaware set APM adoption goals for payers within their states
  - Delaware has an adoption goal that is more aggressive than national adoption goals
  - Oregon's adoption strategy among the commercial market is voluntary



# Pending Legislation of Note: 2025

| State | Initiative | Status |
|---|---|---|
| Arkansas | Primary Care Improvement Working Group to establish definition of primary care and recommend spending target; identify data collection and measurement systems. | Pending |
| Connecticut | Requires Office of Health Strategy to consider and adjust for any unintended effects or impacts of primary care spending targets on funding for individuals with developmental disabilities when benchmarking a state-operated reinsurance program. | Pending |
| New York | The Primary Care Investment Act proposes requiring plans and payers to report annually on the percentage of health care spending allocated to primary care. Plans and payers reporting less than 12.5% would need to submit plans to increase spending by 1% annually until meeting or exceeding the target. | Pending |
| Oregon | The Oregon Health Authority shall study primary care and make recommendations for legislation. | Pending |
| Washington | Requires health carriers to report primary care expenditures annually. | Pending |

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# Leading State Primary Care Investment Efforts

# Recent State Activity: California

- In April 2024, the Office of Health Care Affordability (OHCA) Board approved a statewide health care spending target of 3% by 2029
  - Target will be phased-in, beginning with 3.5% for 2025 and 2026 and lowered to 3.2% in 2027 and 2028
  - OHCA can take progressive enforcement action against health care entities that exceed the spending growth target beginning with Calendar Year 2026

# Recent State Activity: California *(continued)*

- In October 2024, OHCA's Board approved an all-payer primary care investment target of 15 % by 2034
  - The annual improvement benchmark was set to require a 0.5% to 1% annual increase in primary care spending as a percentage of total health care spending through 2033
  - No enforcement mechanism exists for the primary care investment target, but OHCA can choose not to apply enforcement to payers that exceed statewide spending targets but are achieving primary care investment targets
- OHCA establishes goals for adoption of alternative payment models (APMs) and has developed standards and implementation guidance to promote adoption and alignment of APMs
  - APM Standards and Adoption Goals were approved by the Board in June 2024

# Recent State Activity: Massachusetts

- The Commonwealth established a new primary care task force through legislation enacted in January 2025
  - The task force will be co-chaired by the Secretary of Health and Human Services or a designee and the Executive Director of the Health Policy Commission or designee
- The taskforce is charged with the following activities to stabilize and strengthen primary care:
  - Define primary care services
  - Develop a standardized set of data reporting requirements for payers, providers, and provider organizations to track payments for primary care services
  - Establish a primary care spending target for public and private payers;
  - Propose payment models to increase primary care reimbursements
  - Assess the impact of health plan design on health equity and patient access to primary care services
  - Monitor and track the needs of and service delivery to Massachusetts residents; and
  - Create workforce development plans to increase the supply and distribution of, and improve the working conditions of, the primary care workforce

# Recent State Activity: Massachusetts *(continued)*

- In January, the Commonwealth also released a special report on Primary Care Workforce, Access, and Spending Trends calling for urgent action. The report highlights:
  - The declining share of health care spending devoted to primary care
  - Concerning trends in primary care access
  - A small and diminishing primary care workforce

# Recent State Activity: Oregon

- Oregon has been reporting on primary care spending since 2016 and established a 12% spending target by 2023
    - The most recent data reported for 2022 demonstrates commercial payers and public employees benefit board (OEBB) falling short of the target, 11.5% and 11.3%, respectively
- Primary care providers (PCP) in the state highlight the limitations of the voluntary investment target and more desire for accountability
- PCPs also point to complexity and burden from expanding value-based contracts that are not standardized and aligned across commercial payers

https://visual-data.dhsoha.state.or.us/t/OHA/views/PCSR_2024_v2_1/Overview?%3Aembed=y&%25
https://olis.oregonlegislature.gov/liz/2025R1/Downloads/PublicTestimonyDocument/151766

# Recent State Activity: Oregon *(continued)*

- Oregon has employed some strategies to promote alignment:
  - The Oregon Health Authority established a roadmap to advance VBP for Medicaid Coordinated Care Organizations
  - Oregon also establishes targets for the percentage of payments in particular categories of the HCP-LAN Alternative Payment Model Framework, depending on type of VBP
  - The roadmap includes requirements specifically for Patient-Centered Primary Care Homes ensuring alignment across CCO contracts with PCPCHs
- New legislation has been introduced to require the Oregon Health Authority to study primary care and make recommendations; the legislation is pending

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# Recent State Activity: Rhode Island

- Rhode Island was the first state to establish primary care investment targets and its approach is evolving with time
- The Office of the Health Insurance Commissioner (OHIC) has been requiring commercial payers to meet primary care expenditure targets since 2010 through its Affordability Standards
  - Payers were required to double baseline spending of 5%  by 2014 and were mandated to increase investments by at least 1% annually to reach a target of 10.7%
  - Affordability Standards also encourage primary care practices to transform into Patient Centered Medical Homes (PCMHs) to take advantage of increased investment in the form of infrastructure development payments approved by the OHIC

# Recent State Activity: Rhode Island *(continued)*

- In its December 2023 Report on Primary Care in Rhode Island OHIC recommended:
  - Increasing insurer payment through evaluation and management and other medical services provided by primary care to be more competitive with neighboring states and to narrow the gap between primary care payment and other specialties. The OHIC also recommends increasing reimbursement through capitated payment arrangements for primary care
  - Amending OHIC's primary care expenditure target in 2024 to align with emerging consensus definitions of primary care expenditures (NESCO)
  - Accelerating the provision of prospective payment opportunities through consensus standards developed by the Primary Care Alternative Payment Model Work Group

# Recent State Activity: Virginia

- A Virginia nonprofit, Virginia Center for Health Innovation (VCHI) is leading efforts in the state to address primary care system challenges
- VCHI launched the Virginia Task Force on Primary Care in 2020 with funding form the Virginia Department of Health
  - The task force has dedicated its focus to improve data platforms for tracking primary care system performance and raising awareness through the publication of Primary Care Scorecards and a companion Primary Care Scorecard Dashboard
- Instead of establishing a primary care spending target, the Task Force has focused on promoting awareness of primary care spending levels through comparisons  based on narrow and broad definitions of primary care
  - In 2024, Scorecard reporting indicates primary care spending levels between 2.3% and 4.1% of total medical expenditures in the state
- Utilizing its measurement experience to-date, the Task Force will develop a primary care spending threshold target and companion enforcement mechanism to recommend to the legislature in 2026

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# AHEAD Model Primary Care Update

March 25, 2025

# The State signed the AHEAD Model Agreement with CMS in November 2024

The State of Maryland and CMS announced a formal agreement on November 1st for Maryland to participate in the AHEAD Model through 2034

**Pre-Implementation Period**
7/1/2024 – 12/31/2025

**Implementation Period**
9 Performance Years, 1/1/2026 – 12/31/2034

**Transition Period**
After the Implementation Period Ends, up to 60 months (5 years): 1/1/2035-12/31/2039

**Post-Model Options:**

- Make the Model permanent,
- test a new Model, or
- transition to national Medicare fee-for-service system



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# March 2025 Update

- As expected, the Total Cost Of Care Model will end at the end of 2025.
- In partnership with CMMI, Maryland will transition to the AHEAD Model beginning January 1, 2026.
- MDPCP will continue under the AHEAD Model.
- There are no changes to the current MDPCP.



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# 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



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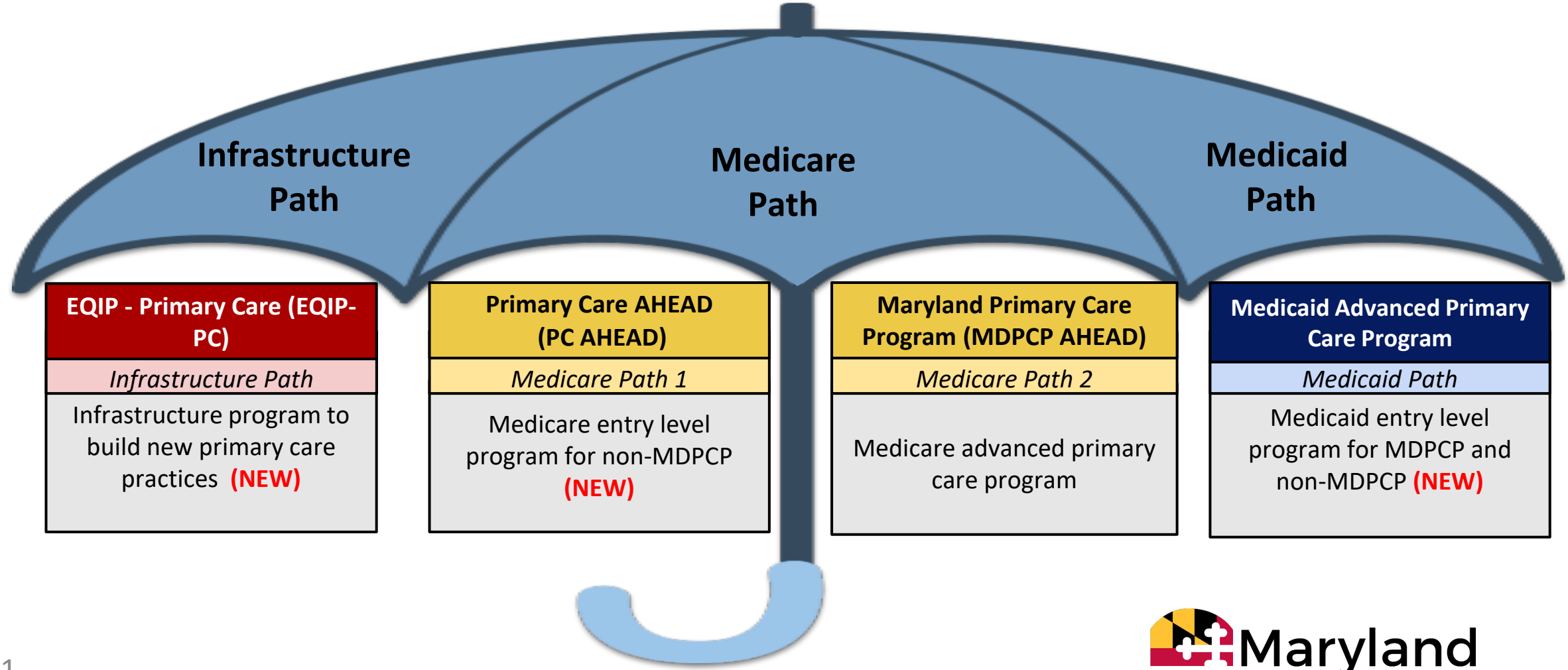
# Maryland's AHEAD Primary Care Programs



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# Three Paths Available under MDPCP

**Medicaid Path**

**Medicaid Advanced Primary Care Program** aka *"Medicaid Path"*
*Begins 7/1/25*

*Requirement to co-participate starts **2026***

*Requirement to co-participate starts **2027***

**Medicare Path**

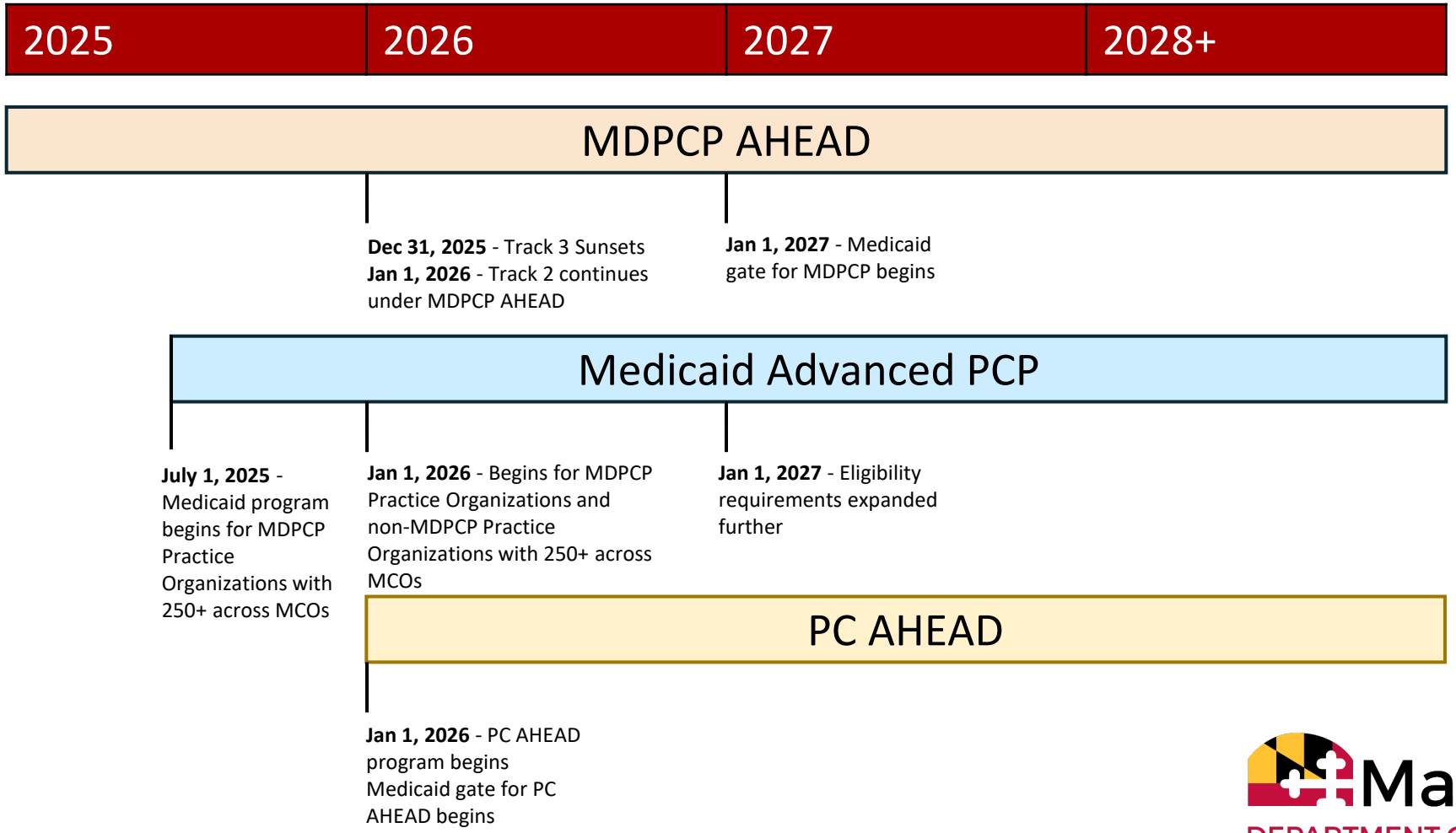
**PC AHEAD-** *"Medicare Path 1"*
*Begins 1/1/26*

**MDPCP AHEAD-** *"Medicare Path 2"*
*Continuation of MDPCP Track 2*

**Infrastructure Path**

**EQIP-Primary Care -** *Funding to establish new or expanded primary care practices in underserved areas (11 participants)*
*2025-2027*

# Program Timeline and Key Milestones



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# Thank you!

- For more details on Maryland's AHEAD Primary Care Programs, please visit https://health.maryland.gov/mdpcp/Pages/AHEAD-Model.aspx
- For questions or comments, email us at mdh.pcmodel@maryland.gov, using subject: "Maryland's AHEAD Primary Care Programs"

**Additional Resources**

- HSCRC AHEAD model webpage
- CMMI AHEAD model webpage



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# Payer Investments in Primary Care: Maryland

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# Key Findings

## 2025 APCD ANALYSIS OF PRIMARY CARE INVESTMENT

# Definition Background

- MHCC has measured primary care spending for the previous two years, first using a definition developed by the PCIW in 2023
- In 2024, MHCC added a definition developed by the CMS for the AHEAD Model
- This year, MHCC has added a third definition, developed by Maryland Medicaid in partnership with the Hilltop Institute

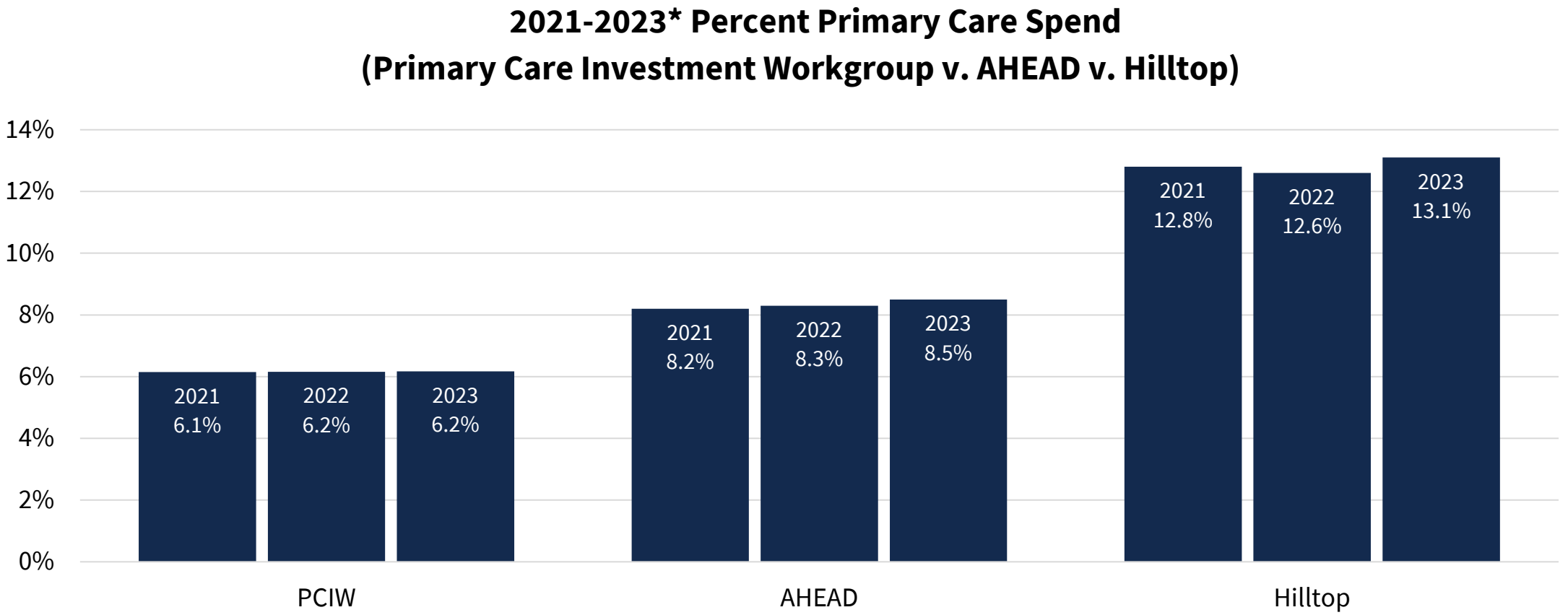
# Comparison Table – Key Elements

| Primary Care Investment Comparison Table: Key Elements | | | |
|---|---|---|---|
| **Category** | **PCIW *(Multistate Definition)*** | **AHEAD** | **MEDICAID/HILLTOP** |
| **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<br>• 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 services; and obstetric and gynecologic services, when provided by a primary care provider<br>• 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 | • Uses the same specialties as the definition of primary care developed by the Primary Care Investment Workgroup ("PCIW") and adds 30 psychiatry and obstetrics/gynecology specialties into the definition; these providers can bill either as part of or independent of a primary care practice<br>• Medicare Current Procedural Terminology ("CPT®")/Healthcare Common Procedure Coding System ("HCPCS") codes and specialty codes (aligns with the Medicare Shared Savings Program)<br>• FFS and non-claims-based payments are used to calculate the investment<br>• 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) | • Defined using the Medicaid Management Information System (MMIS) provider type and specialty<br>• Includes: Medicaid identified Primary Care Physicians (Physicians, NPs, Certified Nurse-Midwives [CNMs], PAs, including OB/GYNs), as well as School-Based Health Clinics and any providers providing: vaccines, certain family planning services, certain OB/GYN services<br>• SBHCs are counted as primary care for any code that they bill<br>• FFS and non-claims-based payments are used to calculate the investment |
| **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 | • N/A |

# Comparison Table – Key Elements *(continued)*

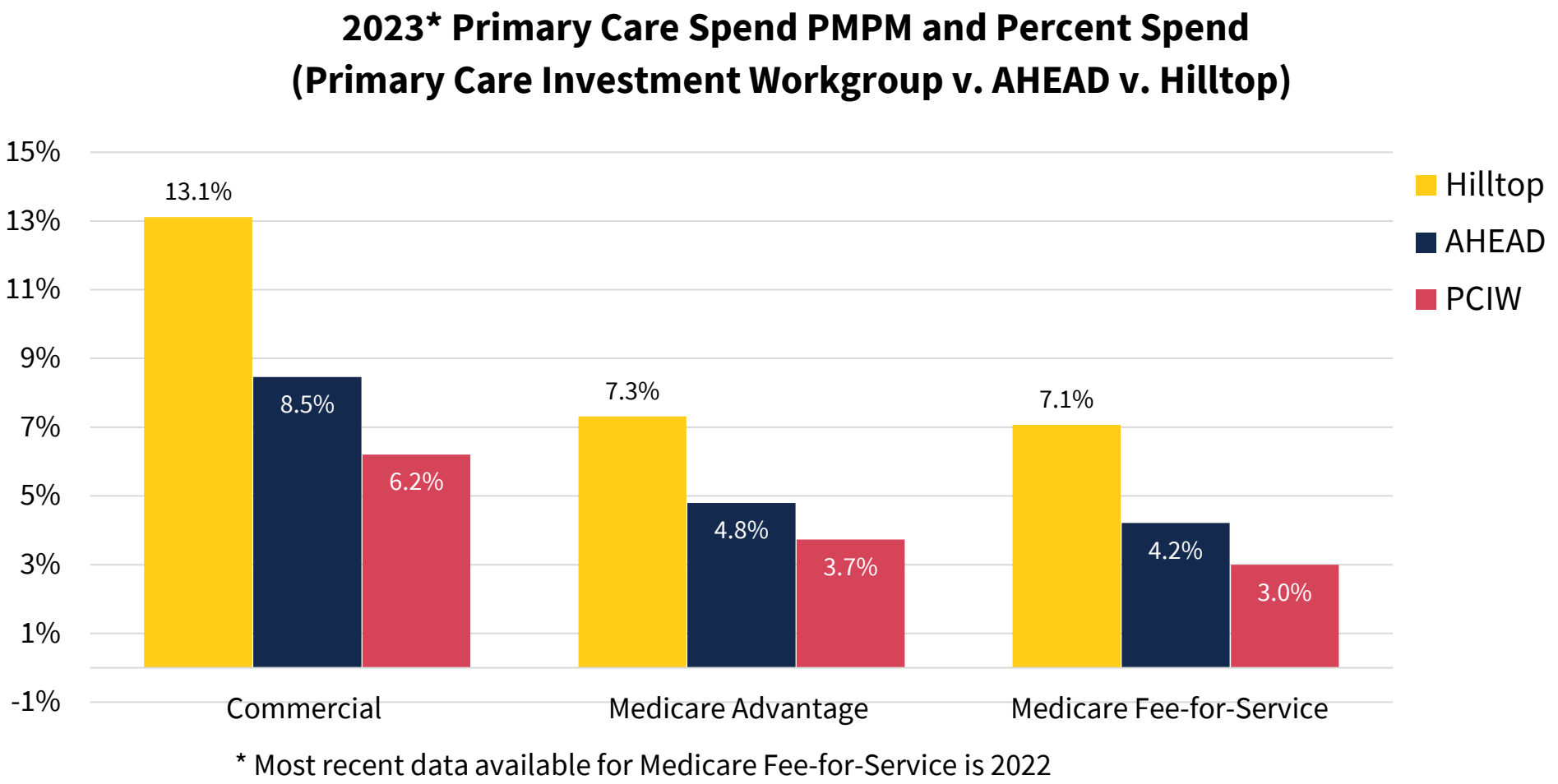
| Primary Care Investment Comparison Table: Key Elements | | | |
|---|---|---|---|
| **Category** | **PCIW *(Multistate Definition)*** | **AHEAD** | **MEDICAID/HILLTOP** |
| **Strategy & Calculation** | • Investment target aligned across commercial payers and a different target for Medicaid and the managed care organizations ("MCO"); review annually and adjust as needed; an accountability mechanism for meeting targets and in using investments to enhance primary care<br>• 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<br>• 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 | • N/A |
| **Provider and Billing Codes** | • 39 taxonomy codes used to ensure specialty filter is inclusive of all primary care providers<br>• 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 57 taxonomy codes<br>• 181 billing codes (CPT®/HCPCS) included in the definition | • 236 billing Codes (CPT®/HCPCS) included in the definition<br>• PCPs only (67 codes): E&M ,Screenings, In-office labs<br>• PCPs and **any other** provider type are included for 169 codes for: Vaccines, certain family planning services, certain OB/GYN services<br>• **Any** code billed by a School-Based Health Center |

# Commercial Spending Increased Slightly Across All Definitions




* Most recent data available for Medicare Fee-for-Service is 2022

# Differences by Payer Type

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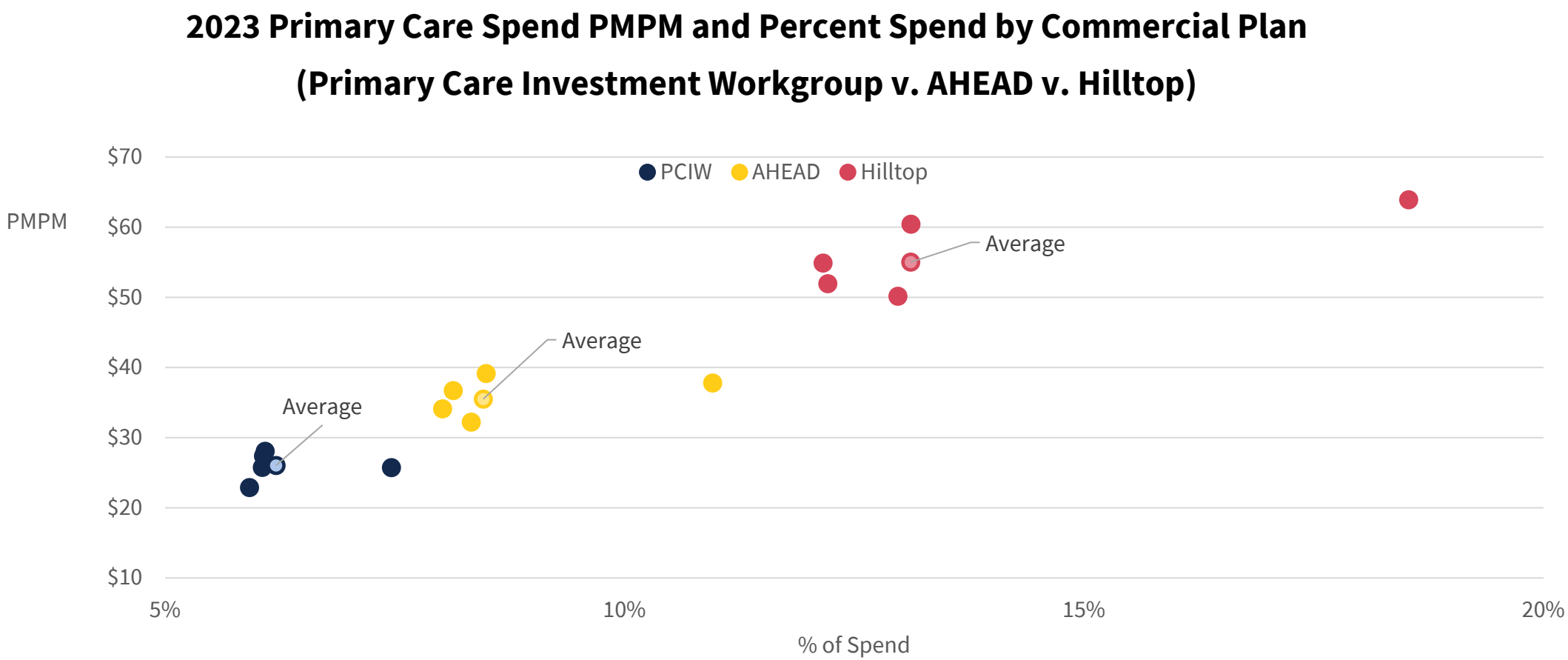
# Commercial Payers

# Variation Across Commercial Payers



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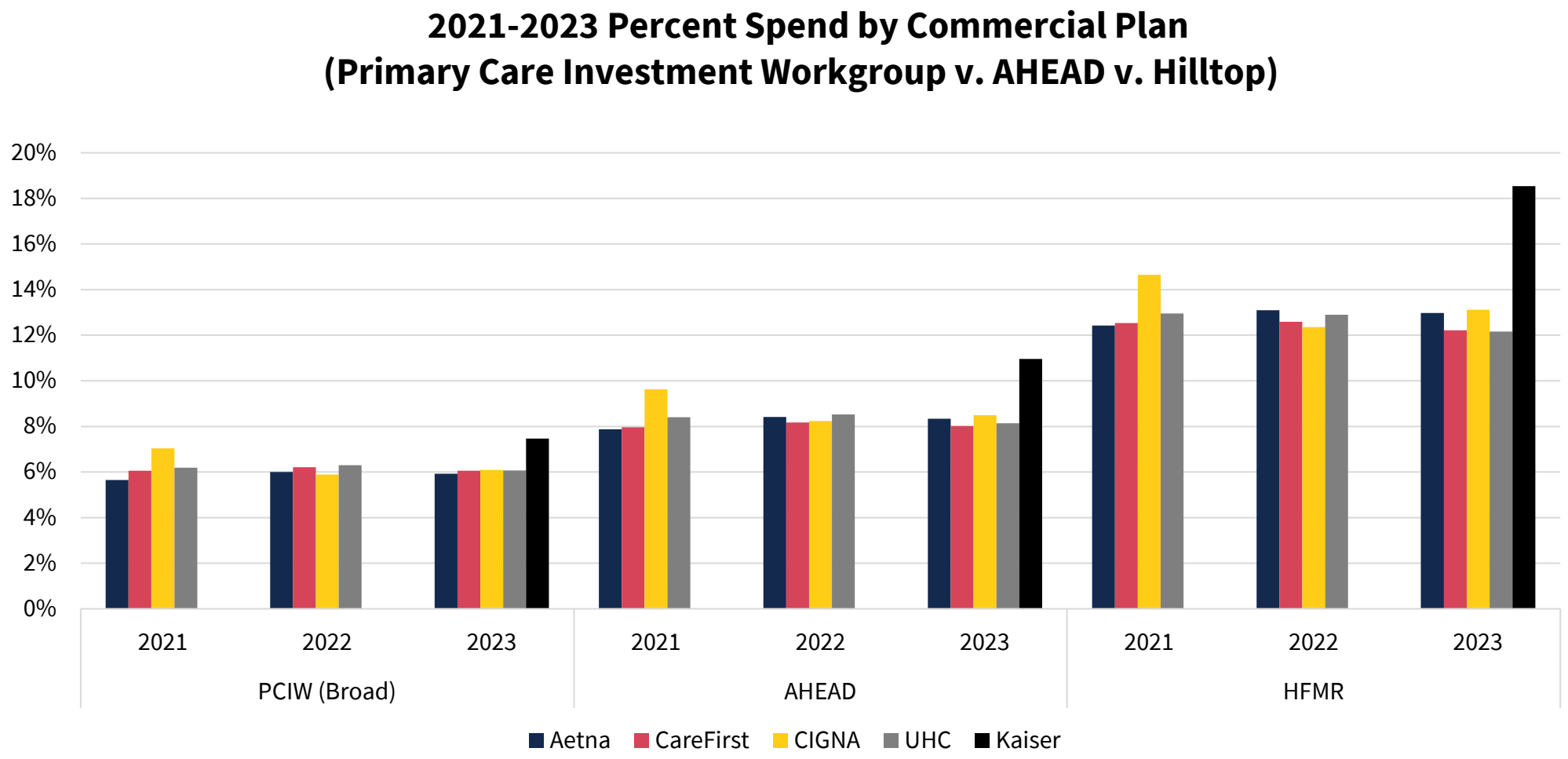

# Primary Care Spending by County as a Percent of TME

| County | *Primary Care Spending as a Percent of Total Medical* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *PCIW (Broad)* | | | *AHEAD* | | | *HFMR* | | |
| | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| Allegany | 4.4% | 4.4% | 4.1% | 5.6% | 5.6% | 5.1% | 9.0% | 8.9% | 8.1% |
| Anne Arundel | 6.7% | 6.7% | 6.7% | 8.6% | 8.7% | 8.7% | 13.4% | 13.3% | 13.4% |
| Baltimore | 5.7% | 5.6% | 5.6% | 7.8% | 7.6% | 7.7% | 12.1% | 11.8% | 12.4% |
| Baltimore City | 5.0% | 4.9% | 5.1% | 6.9% | 6.9% | 7.0% | 10.3% | 10.2% | 11.0% |
| Calvert | 5.9% | 6.2% | 7.1% | 7.7% | 7.9% | 8.7% | 12.1% | 12.1% | 13.4% |
| Caroline | 5.9% | 6.2% | 6.2% | 7.1% | 7.6% | 7.5% | 10.1% | 10.7% | 10.2% |
| Carroll | 5.9% | 6.1% | 5.9% | 8.1% | 8.4% | 7.9% | 13.0% | 12.9% | 12.6% |
| Cecil | 4.6% | 4.8% | 4.6% | 6.1% | 6.4% | 6.1% | 9.3% | 9.4% | 9.1% |
| Charles | 6.7% | 6.7% | 6.9% | 8.5% | 8.6% | 8.9% | 13.0% | 13.0% | 13.7% |
| Dorchester | 6.3% | 6.0% | 6.6% | 7.7% | 7.4% | 8.0% | 11.1% | 10.4% | 10.7% |
| Frederick | 7.1% | 7.5% | 7.1% | 9.5% | 10.1% | 9.6% | 14.1% | 14.6% | 14.2% |
| Garrett | 4.5% | 4.1% | 3.7% | 5.5% | 5.1% | 4.4% | 8.1% | 7.4% | 6.6% |
| Harford | 6.3% | 6.2% | 6.2% | 8.2% | 8.1% | 8.2% | 13.0% | 12.6% | 12.9% |
| Howard | 6.1% | 6.1% | 6.3% | 8.4% | 8.4% | 8.8% | 14.3% | 13.7% | 14.3% |
| Kent | 4.5% | 5.0% | 5.3% | 5.8% | 6.5% | 6.5% | 8.6% | 9.1% | 8.8% |
| Montgomery | 6.9% | 6.7% | 6.7% | 9.4% | 9.3% | 9.4% | 15.1% | 14.5% | 15.2% |
| Prince Georges | 6.0% | 6.0% | 5.9% | 7.9% | 7.9% | 8.0% | 12.3% | 12.2% | 12.9% |
| Queen Annes | 6.1% | 6.2% | 6.3% | 7.4% | 7.8% | 7.9% | 11.5% | 11.7% | 11.8% |
| Saint Marys | 6.8% | 7.2% | 7.1% | 8.9% | 9.2% | 9.0% | 13.5% | 13.9% | 13.7% |
| Somerset | 5.6% | 6.8% | 6.4% | 7.6% | 9.0% | 8.3% | 10.9% | 12.3% | 11.2% |
| Talbot | 5.8% | 5.6% | 6.0% | 7.1% | 6.8% | 7.3% | 10.7% | 9.8% | 10.4% |
| Washington | 5.9% | 6.3% | 6.3% | 7.9% | 8.3% | 8.2% | 12.1% | 12.2% | 11.9% |
| Wicomico | 6.7% | 7.2% | 7.1% | 8.8% | 9.5% | 9.1% | 12.8% | 13.2% | 12.6% |
| Worcester | 5.2% | 5.9% | 5.9% | 7.1% | 7.9% | 7.7% | 12.8% | 13.2% | 12.3% |
| **Total** | **6.1%** | **6.2%** | **6.2%** | **8.2%** | **8.3%** | **8.3%** | **12.8%** | **12.6%** | **13.1%** |

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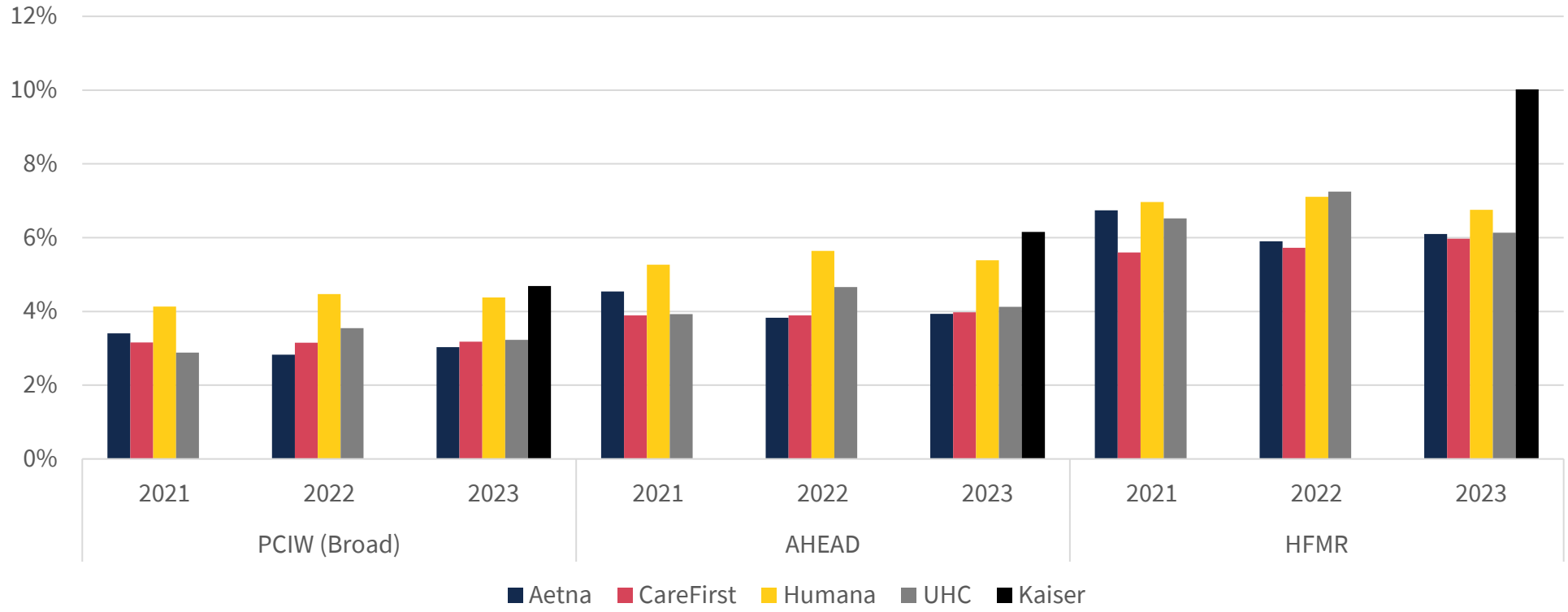
# Medicare Advantage

# Variation Across Medicare Advantage Payers

**2021-2023 Primary Care Percent Spend by Medicare Advantage Plan**
**(Primary Care Investment Workgroup v. AHEAD v. Hilltop)**



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# Medicare FFS

# Primary Care Spending by County as a Percent of TME

| County | *Primary Care Spending as a Percent of Total Medical* | | | | | | | | |
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| | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Allegany | 2.4% | 2.7% | 2.8% | 3.5% | 3.7% | 3.7% | 5.2% | 5.8% | 5.7% |
| Anne Arundel | 3.3% | 3.4% | 3.4% | 4.7% | 4.9% | 4.8% | 7.0% | 7.8% | 7.4% |
| Baltimore | 2.6% | 2.7% | 2.7% | 3.7% | 3.9% | 3.8% | 5.8% | 6.8% | 6.5% |
| Baltimore City | 1.9% | 2.0% | 2.1% | 2.6% | 2.8% | 2.8% | 4.2% | 5.0% | 4.9% |
| Calvert | 2.7% | 3.1% | 3.1% | 4.2% | 4.6% | 4.6% | 6.8% | 8.1% | 7.8% |
| Caroline | 2.7% | 2.9% | 2.6% | 3.6% | 3.8% | 3.4% | 5.1% | 5.6% | 5.0% |
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| Cecil | 2.7% | 2.9% | 3.0% | 3.5% | 3.8% | 4.0% | 5.5% | 6.3% | 6.4% |
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| Kent | 3.0% | 3.6% | 3.2% | 3.9% | 4.5% | 3.9% | 6.2% | 8.1% | 7.8% |
| Montgomery | 3.2% | 3.3% | 3.4% | 5.0% | 5.1% | 5.0% | 7.9% | 9.2% | 8.9% |
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| Queen Annes | 3.5% | 3.5% | 3.1% | 4.5% | 4.5% | 4.2% | 6.9% | 7.6% | 7.0% |
| Saint Marys | 3.1% | 3.3% | 3.3% | 4.4% | 4.7% | 4.7% | 7.4% | 8.9% | 8.8% |
| Somerset | 2.5% | 2.9% | 2.8% | 3.5% | 3.8% | 3.7% | 5.2% | 5.9% | 5.7% |
| Talbot | 3.0% | 3.2% | 3.0% | 3.9% | 4.1% | 3.8% | 6.0% | 6.6% | 6.0% |
| Washington | 3.1% | 3.3% | 3.7% | 4.3% | 4.6% | 5.0% | 6.5% | 7.4% | 7.4% |
| Wicomico | 2.8% | 3.0% | 2.9% | 3.9% | 4.2% | 4.1% | 5.8% | 6.5% | 6.2% |
| Worcester | 2.7% | 3.1% | 3.1% | 3.9% | 4.3% | 4.3% | 6.6% | 7.6% | 7.4% |
| **Total** | **2.8%** | **3.0%** | **3.0%** | **4.0%** | **4.2%** | **4.2%** | **6.3%** | **7.4%** | **7.1%** |

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# PCIW Discussion Questions

CONSIDERATIONS FOR DISCUSSION

# Structuring a Primary Care Target

- MHCC has seen some moderate increases in primary care spending, consistent with its goal of increasing this spending 1 percent of TME per year
  - All definitions shown have the same TME; therefore, this one percent of TME per year increase is consistent across all definitions
- Why focus on percent of TME?
  - Signals increases in primary care spending should be the result of shifting existing spending; not increase total spending
  - Allows a single target to reflect differences across payers and payer types
  - Offers consistency with all other state targets
  - Aligns with previous Workgroup recommendations
  - Definition agnostic; all definitions use the same denominator

# APMs as a Primary Care Investment Strategy: A Look Forward for Maryland

- In 2024, payers shared with MHCC an interest in increasing primary care investment through APMs
- In 2025, MHCC will begin collecting information on non-claims payments to primary care; analysis will include:
  - Percent of members covered under an APM, to reflect importance of population health management
  - Percent of total spending tied to a contract with APM, to track progress consistent with national APM adoption targets
  - Percent of primary care and total investment paid via non-claims to measure percent of primary care spend paid through flexible and/or predictable non-claims payments and encourage meaningful APM adoption

# APMs as a Primary Care Investment Strategy: Experiences in Other States

- Experiences in other states find APMs can be a pathway to meaningfully increase primary care investment
- Increased APM adoption allows payers to increase primary care investment while providing more flexible payments to primary care providers
- However, there are lessons learned:
  - Some primary care providers are not well-positioned for or interested in value-based care
  - Primary care providers prefer predictable, prospective payments to support practice infrastructure, expanding care teams and implementing new workflows
  - It can be difficult to isolate the portion of non-claims payments that supported primary care versus other activities
  - Varying payer requirements for APMs may increase administrative burden

# Discussion Items

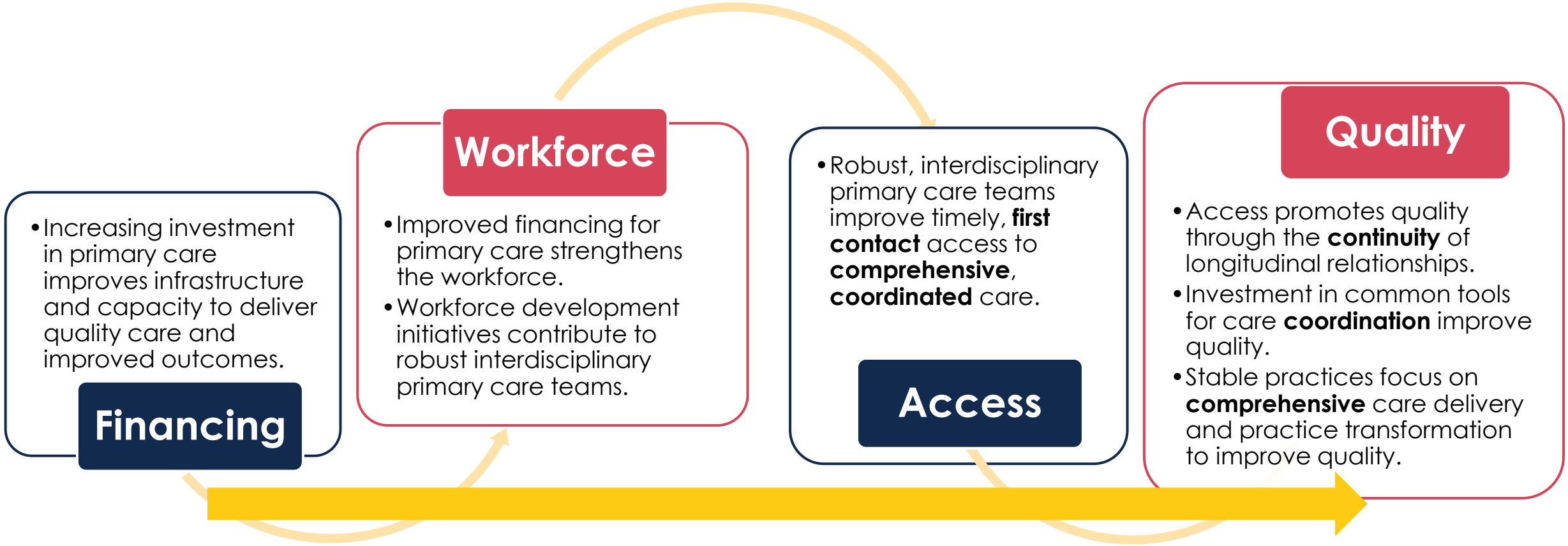
- Should the workgroup consider the following:
  - Is one percent of TME still the appropriate rate of increase for primary care investment?
  - Setting a voluntary target for APM spending as a percent of TME?
  - Establishing a voluntary target for increasing the percent of members participating in an APM with primary care investment?
  - Other strategies to increase primary care investment?

# Primary Care System Monitoring: Dashboard Opportunities for Maryland

# Multi-Domain Dashboards for Comprehensive Primary Care System Performance Monitoring

- A small group of states are tracking primary care performance, in multiple domains, through a single, dynamic dashboard tool
  - State-level dashboards avoid the limitations of national scorecards which are helpful for comparison of workforce and spending, but do not take state-specific definitions and measurement approaches into consideration
  - State level dashboards create a more comprehensive assessment by integrating state-specific data from disparate reports and sources, into an interactive, multi-domain system assessment. Domains often include:
    - Primary care investment
    - Workforce
    - Access to care
    - Quality of care
- States with primary care system dashboards include: Massachusetts, Virginia, and New York (Primary Care Development Corporation, no data available on spending)

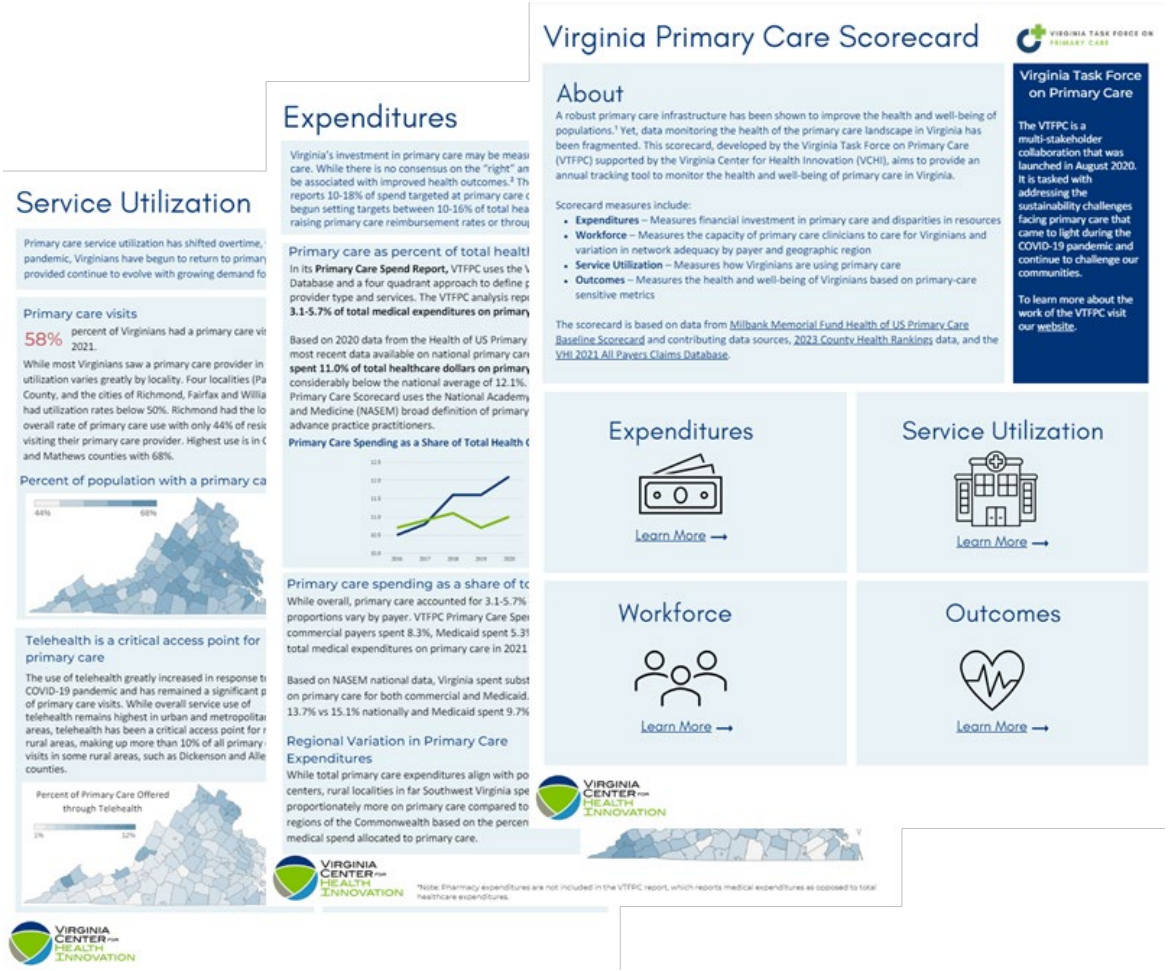
# Interdependencies of Primary Care System Performance Domains



# Example Dashboard: Virginia Primary Care Scorecard

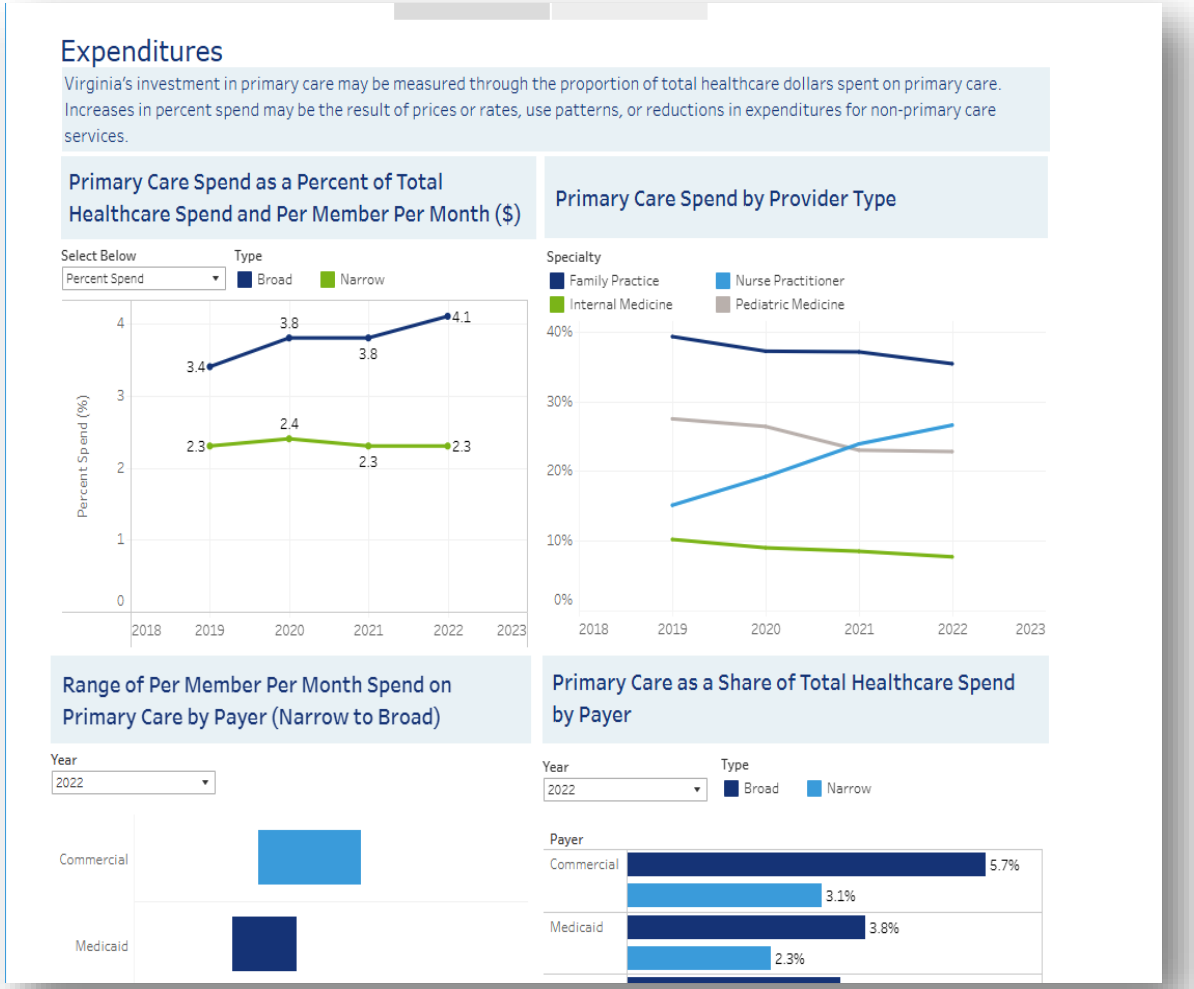
Virginia's primary care scorecard focuses on **expenditures**, **workforce**, **utilization** and **outcomes**

- Built under the Virginia Task Force on Primary care
- Utilizes data sources reported by the state and available from national public reporting



# Example Dashboard: Virginia Primary Care Scorecard Interactive Dashboard

- Virginia also produces a dynamic dashboard that reports on primary care system performance
- The Dashboard enables the user to focus on different views of system performance and to look at performance by year

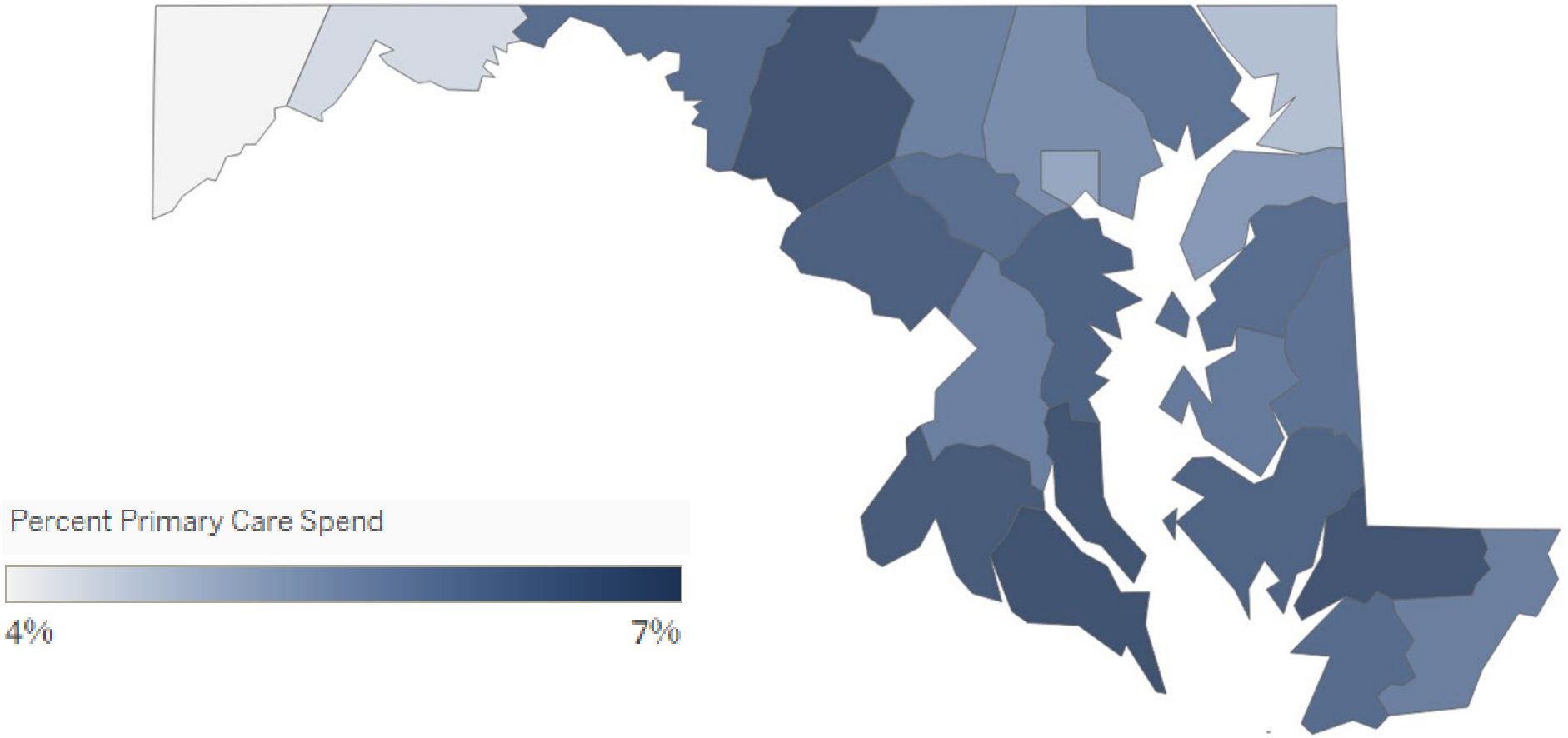


# Maryland's Opportunity

- Maryland could be the first state with a primary care investment target to track primary care spending investment in conjunction with interdependent system performance indicators.
  - A Phase 1 Dashboard, based on currently available information from multiple domains, is poised for production
- Maryland's monitoring of primary care system performance will be distinguished by the state's deeper data to examine primary care access by  geography, race and ethnicity
  - Maryland's data model for assessing primary care spending enables a comprehensive exploration of disparities in access; the state is already measuring and reporting on primary care spending relative to these factors through the Primary Care Investment Analysis and Recommendations Report
- Maryland is well-positioned to widen its examination of access to care to include analyses of access by race, ethnicity, geography, AND by practice type: hospital-owned, large-group, small-group, independent provider, Federally Qualified Health Center (FQHC)

# MD Example: Primary Care Spend by Geography

**2023 Commercial Percent Primary Care Spend**
**(Primary Care Investment Workgroup Definition)**



# Example: Primary Care Spend by Race

| 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** |

# Example Phase I Dashboard Framework

| Domain | Phase I: Maryland Primary Care System Performance Dashboard Measures | Medicare Path 1 (PC AHEAD) | Medicare Path 2 (MDPCP) | Medicaid Path |
|---|---|---|---|---|
| **Investment** | Primary Care Spend Year-Over-Year, in total and PMPM, by commercial, MA, Medicare FFS | Can be aligned w/AHEAD | | |
| | Total Primary Care Spend Year-Over-Year, by region, by commercial MA, Medicare FFS | | | |
| | Primary Care Spend by Race, in total and PMPM, by commercial, MA, Medicare FFS | | | |
| **Quality** | 1. Preventive Care and Screening: Screening for depression and follow-up plan, year-over-year performance | X | X | X |
| | 2. Appropriate colorectal cancer screening, year-over-year performance | X | | X |
| | 3. Appropriate mammography for breast cancer screening, year-over-year performance | Choose at least 2 or 3 | | |
| | 4. Diabetes Hemoglobin A1c (HbA1c) Poor control (>9%), year-over-year performance | X | X | X |
| | 5. Adequate control of blood pressure for adults with a diagnosis of hypertension, year-over-year performance | Choose at least 4 or 5 | X | X |
| | 6. Emergency Department Utilization; year-over-year performance | X | X | X |
| | 7. Acute Hospital Utilization rates relative to members' health history, observed-to-expected, year-over-year performance | X | X | X |

# The End

# Questions?

# Appendix

# State Primary Care Target Setting: Approach Review

| State | Primary Care Spending Target (as a percentage of total health care spending) | Incremental Target | Performance |
|---|---|---|---|
| California | 15% of total health care spending by 2034 | 0.5 to 1% per year increase in primary care spending as a percent of total medical expense for each payer for performance years 2025 through 2033 | TBD |
| Connecticut | 10% of total health care spending by 2025 | 2021: 5.0%<br>2022: 5.3%<br>2023: 6.9%<br>2024: 8.5% | 2022 Performance:<br>• All Payer: 4.9%<br>• Commercial: 4%<br>• Medicare Advantage: 3.2%<br>• Medicaid: 7% |
| Delaware | 11.5% of total health care spending by 2025 | 2022: 7%<br>2023: 8.5%<br>2024: 10% | • All carriers met requirements for 2023. Finalizing 2023 results |
| Oregon | 12% of total health care spending by 2023 | | 2022 Performance:<br>• 11.5% Commercial<br>• Medicare Advantage: 13.9%<br>• PEBB: 11.3%<br>• OEBB 13.3%<br>• Medicaid Coordinated Care Organizations: 15% |
| Rhode Island | 10% of total medical expenses per year, based on New England consensus definition for primary care (2024) | | TBD |

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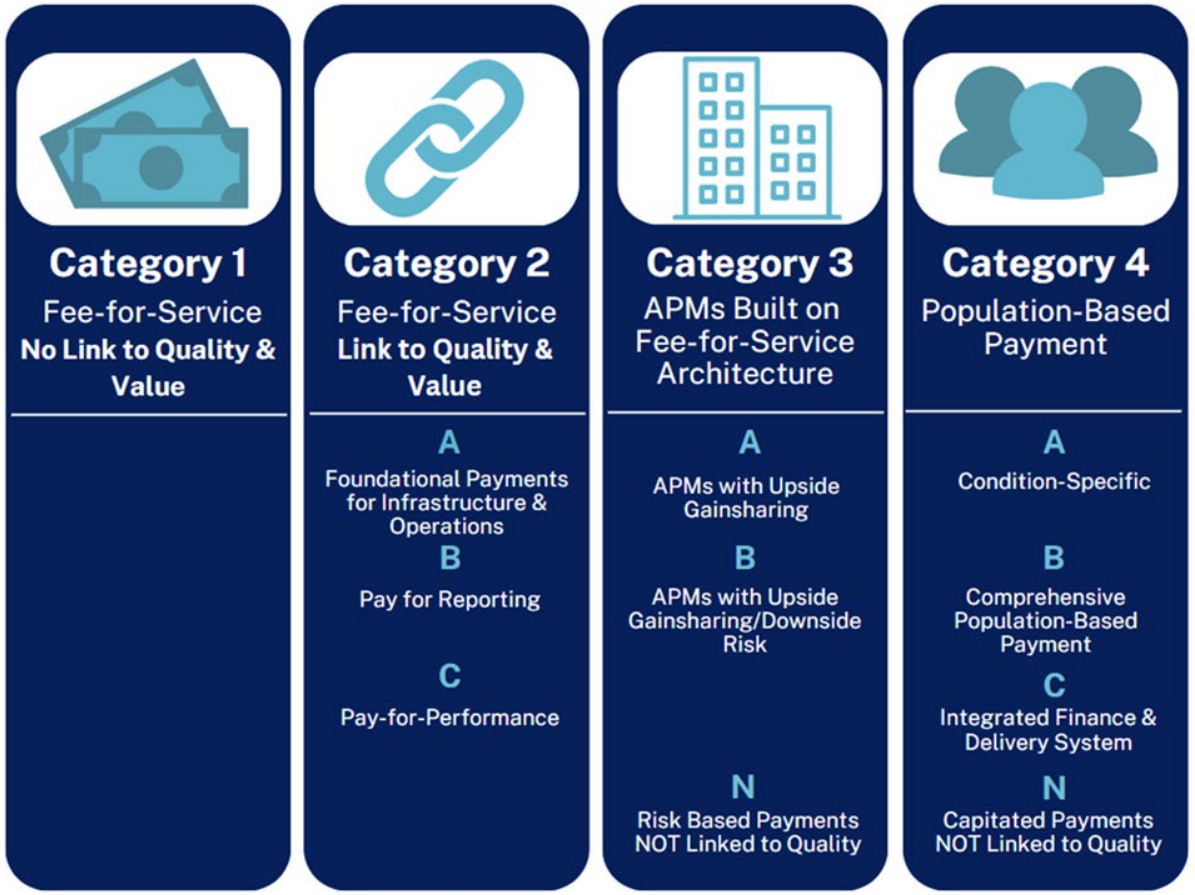
# APMs

# HCPLAN APM Framework

- Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Framework standardizes and categorizes payment models, and help stakeholders assess progress in moving away from traditional fee-for-service (FFS) payment methods
  - Categorizes payments made to providers based on its linkage to quality and type of risk associated
- As of 2023, nearly 60% of payments made by health plans, states, and traditional Medicare to providers fell under HCPLAN Category 2C or above
  - Approximately 40% of these payments included some level of upside gain sharing and/or shared risk with providers
  - HCPLAN reported nearly identical adoption rates in 2022



# Expanded Non-Claims Payment Framework

| | Expanded Non-Claims Payments Framework | Corresponding HCP-LAN Category |
|---|---|---|
| **1** | **Population Health and Practice Infrastructure Payments** | |
| a | Care management/care coordination/population health/medication reconciliation | 2A |
| b | Primary care and behavioral health integration | 2A |
| c | Social care integration | 2A |
| d | Practice transformation payments | 2A |
| e | EHR/HIT infrastructure and other data analytics payments | 2A |
| **2** | **Performance Payments** | |
| a | Retrospective/prospective incentive payments: pay-for-reporting | 2B |
| b | Retrospective/prospective incentive payments: pay-for-performance | 2C |
| **3** | **Payments with Shared Savings and Recoupments** | |
| a | Procedure-related, episode-based payments with shared savings | 3A |
| b | Procedure-related, episode-based payments with risk of recoupments | 3B |
| c | Condition-related, episode-based payments with shared savings | 3A |
| d | Condition-related, episode-based payments with risk of recoupments | 3B |
| e | Risk for total cost of care (e.g., ACO) with shared savings | 3A |
| f | Risk for total cost of care (e.g., ACO) with risk of recoupments | 3B |

# Expanded Non-Claims Payment Framework

| | Expanded Non-Claims Payments Framework | Corresponding HCP-LAN Category |
|---|---|---|
| **4** | **Capitation and Full Risk Payments** | |
| a | Primary Care capitation | 4A |
| b | Professional capitation | 4A |
| c | Facility capitation | 4A |
| d | Behavioral Health capitation | 4A |
| e | Global capitation | 4B |
| f | Payments to Integrated, Comprehensive Payment and Delivery Systems | 4C |
| **5** | **Other Non-Claims Payments** | |
| **6** | **Pharmacy Rebates** | |

# Membership for Population-Based APMs

- Membership in APMs increased 65% from 2022 to 2023, reflecting an overall market shift toward APM adoption
- Participation in APMs in Maryland totaled approximately 187,000 attributed members, 21% of the market based on TME
  - Most of the growth was driven by CareFirst's HCPLAN 3B APM, representing approximately a 72,000 member increase
- In 2023, CareFirst accounted for 59% of the overall membership in APMs and engaged with five new provider organizations

| HCPLAN Category and payer | 2022 | 2023 | Percent Change |
|---|---|---|---|
| **HCPLAN 2C – FFS (Pay for Performance)** | **1,387** | **1,627** | **17%** |
| Aetna | 1,387 | 753 | -46% |
| CareFirst | - | 874 | - |
| **HCPLAN 3A – APM built on FFS (Upside Gainsharing)** | **73,966** | **75,219** | **2%** |
| Aetna | 2,434 | 3,789 | 56% |
| CareFirst | 36,362 | 35,085 | -4% |
| Cigna | 35,170 | 36,345 | 3% |
| **HCPLAN 3B – APM built on FFS (Upside Gainsharing/Downside Risk)** | **38,531** | **110,917** | **188%** |
| CareFirst | 38,531 | 110,917 | 188% |
| **Total** | **113,884** | **187,763** | **65%** |

# Aggregate TME Across HCPLAN Categories

- For 2023, spending associated with HCPLAN Categories 2C through 3B represented just under 21% of overall TME, up from 13% the year prior
- From 2022 to 2023, there was:
  - A marginal increases in FFS
  - A decrease in FFS (Pay for Performance)
  - A moderate increase in APMs built on FFS (Upside Gainsharing)
  - A significant increase in APMs built on FFS (Upside  Gainsharing/ Downside Risk)

| HCPLAN Category | 2022 Aggregate TME | 2023 Aggregate TME | Percent TME Change 2022 to 2023 |
|---|---|---|---|
| **HCPLAN 1 – FFS** | $3,237,011,009 | $3,315,233,729 | 2% |
| **HCPLAN 2C – FFS (Pay for Performance)** | $4,426,405 | $3,438,075 | -22% |
| **HCPLAN 3A – APM built on FFS (Upside Gainsharing)** | $263,219,773 | $291,585,797 | 11% |
| **HCPLAN 3B – APM built on FFS (Upside Gainsharing/ Downside Risk)** | $207,679,008 | $581,093,667 | 180% |
| **Total** | $3,712,336,195 | $4,191,351,269 | 13% |

# Expanded Framework Basis for National Non-Claims Payment Data Layout

**National Association of Health Data Organizations (NAHDO) Non-Claims Payment Data Layout™**

- NAHDO, the leading national association that convenes and represents state and non-profit health data organizations, has based its non-claims data layout on the Expanded Framework
- This layout aims to harmonize NCP data collection efforts across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs, and improve accuracy in healthcare payment data