



2025 Primary Care Investment Analysis and Recommendations Report

SEPTEMBER 18, 2025

DRAFT

Presentation Overview



- ▶ Overview of Maryland Law (2022)
- ▶ Report at a Glance
- ▶ Review of 2024 PCIW Report Recommendations
- ▶ Data and Findings
- ▶ Recommendations



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

Rationale



► INVESTMENT

Higher investment in primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality*



► INSIGHT

Examining primary care spending as a percent of total medical expense (TME) can provide valuable insight when assessing access to primary care and measuring the overall effectiveness of a health care system



► ACCESS

Underinvestment in primary care gives rise to patient access and workforce issues*

*Primary Care Collaborative, Available at: www.pcpcc.org/primary-care-investment

2025 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*
 - 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) offering states the opportunity to make broad changes in the way health care is provided and paid for

Primary Care Definition Comparison



- ▶ The Workgroup's definition of primary care in previous reports included immunization administration, telehealth, pediatric care, and some behavioral health and hospice services

- ▶ The Model definition is broader than the Workgroup definition
 - Includes psychiatry and routine visits and preventive care provided by obstetricians and gynecologists

 - Uses broader CMS specialty codes instead of taxonomy codes

Approach and Limitations



- ▶ Data from MHCC's Medical Claims 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)
 - A consensus-based approach considered the diverse perspectives of the Workgroup, which informed development of the recommendations; does not reflect full unanimity

** Employee Retirement Income Security Act of 1974*



2024 Recommendations Status Update

2024 Recommendation 1



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

- ▶ The MHCC developed a new data submission template for 2025 to enable primary care APMs to be isolated from other APMs, and to calculate non-claims-based primary care spending paid
- ▶ New, enhanced data collection will be completed in late 2025; trend data (3 years) will be necessary to inform policy

2024 Recommendation 1 *(continued...)*



- ▶ In 2025, MHCC began to classify APM payments using the Expanded Non-Claims Payment Framework adopted by the National Association of Health Data Organizations as the standard for non-claims data collection
 - Positions the State to more effectively assess the current primary care APM landscape
 - Allows MHCC to organize APMs by purpose of the payment (e.g., performance incentive, integrated behavioral health) and by the amount of clinical and financial risk assumed by the provider
 - Maps to the HCP-LAN categories of payment created to drive alignment in payment approaches across the public and commercial payers
 - Provides additional insight about how dollars were intended to be used

2024 Recommendation 2



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

- ▶ The MHCC is combining a variety of data sources into a dashboard to better track and monitor primary care investments, which will feature standardized measures of payer progress and year-over-year investment by payer type and geography
- ▶ Future phases will incorporate quality and performance metrics, along with access measures to highlight geographic disparities and strengthen understanding of the link between investment and outcomes

2024 Recommendation 3



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

- ▶ The Governor signed the AHEAD Model State Agreement on November 1, 2024
 - Requires Maryland to establish a process through executive order, legislation, or regulation that sets all-payer primary care investment targets prior to 2026 (Performance Year 1)
 - The process is anticipated to be finalized by October 2025
- ▶ The State anticipates establishing investment targets for Performance Years 2 through 5 by October 2026

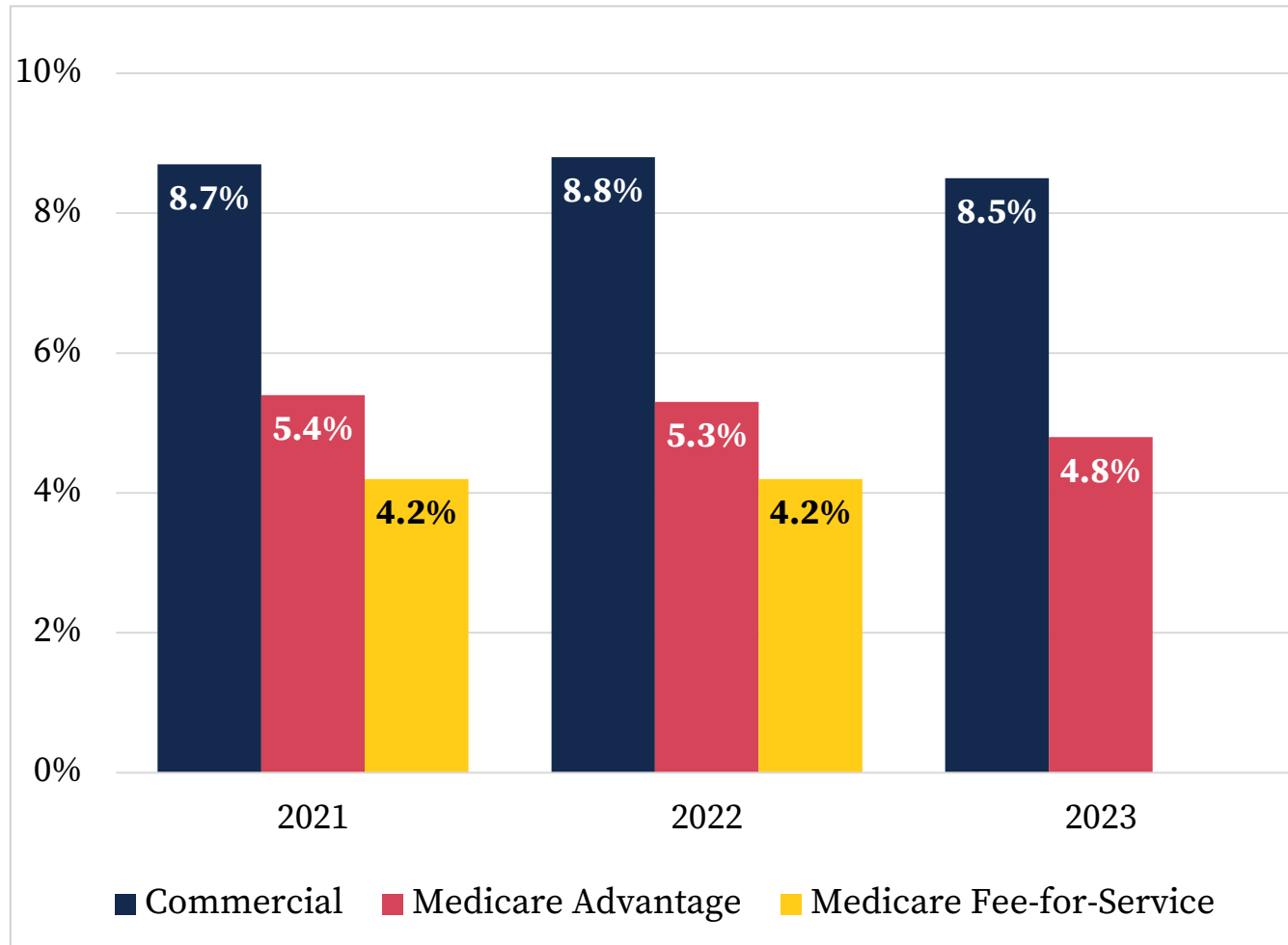


Data and Findings

2021-2023*

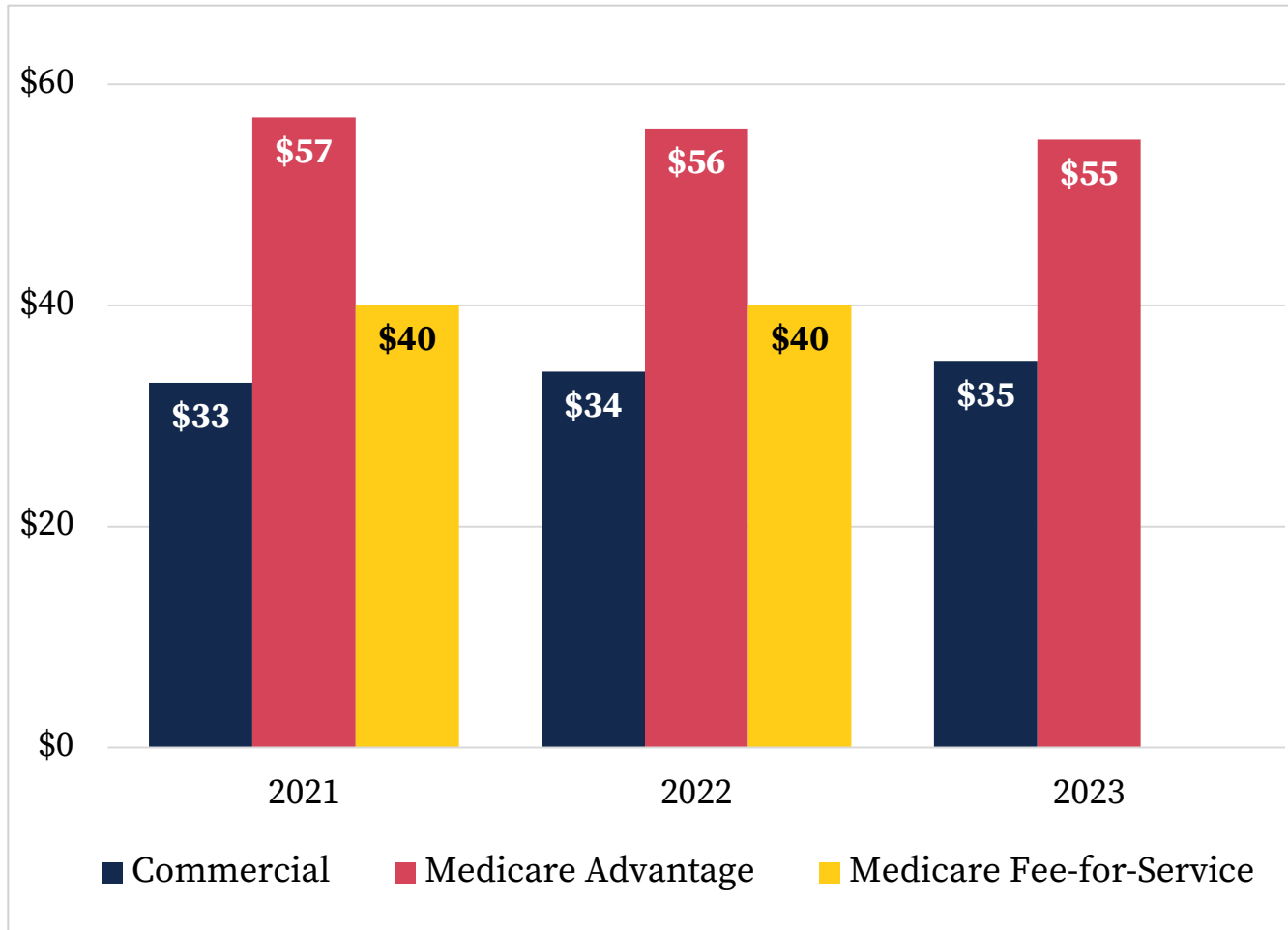
**Medicare FFS 2021-2022*

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 to 2023
- ▶ Medicare FFS was flat from 2021-2022

Primary Care Spending Per Member Per Month (PMPM)



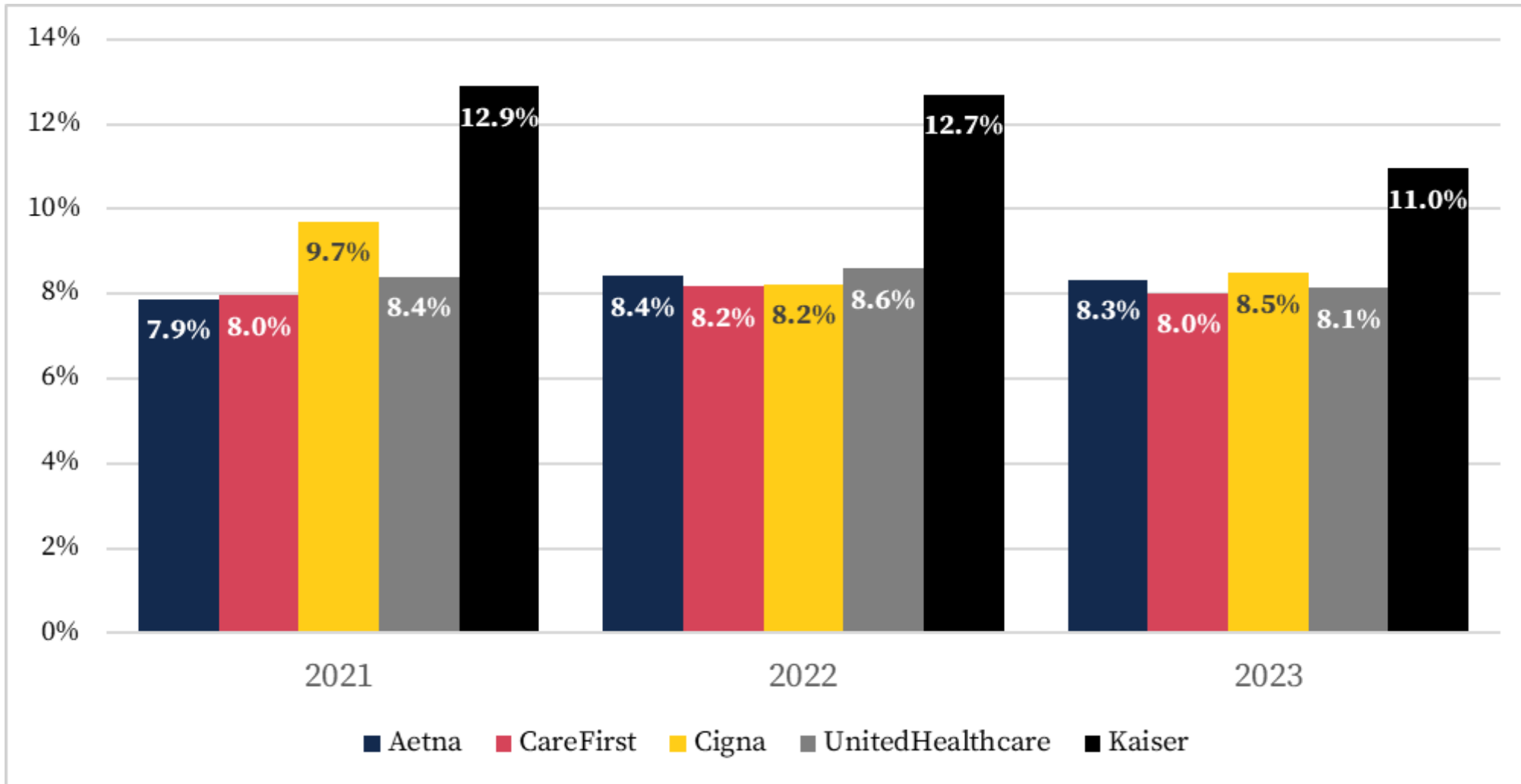
- ▶ PMPM varied considerably by payer type
- ▶ When primary care spending is measured as a percentage of TME, higher TME will result in a lower percentage of primary care spending
- ▶ Medicare Advantage plans, on average, spent the most on a PMPM basis, but commercial plans had the highest percentage 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
- ▶ Spending for Cigna declined as a percentage of TME after 2021; as its TME grew substantially, the percentage of primary care investment declined
 - Further analysis is necessary to understand the drivers behind the increase in Cigna's TME

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



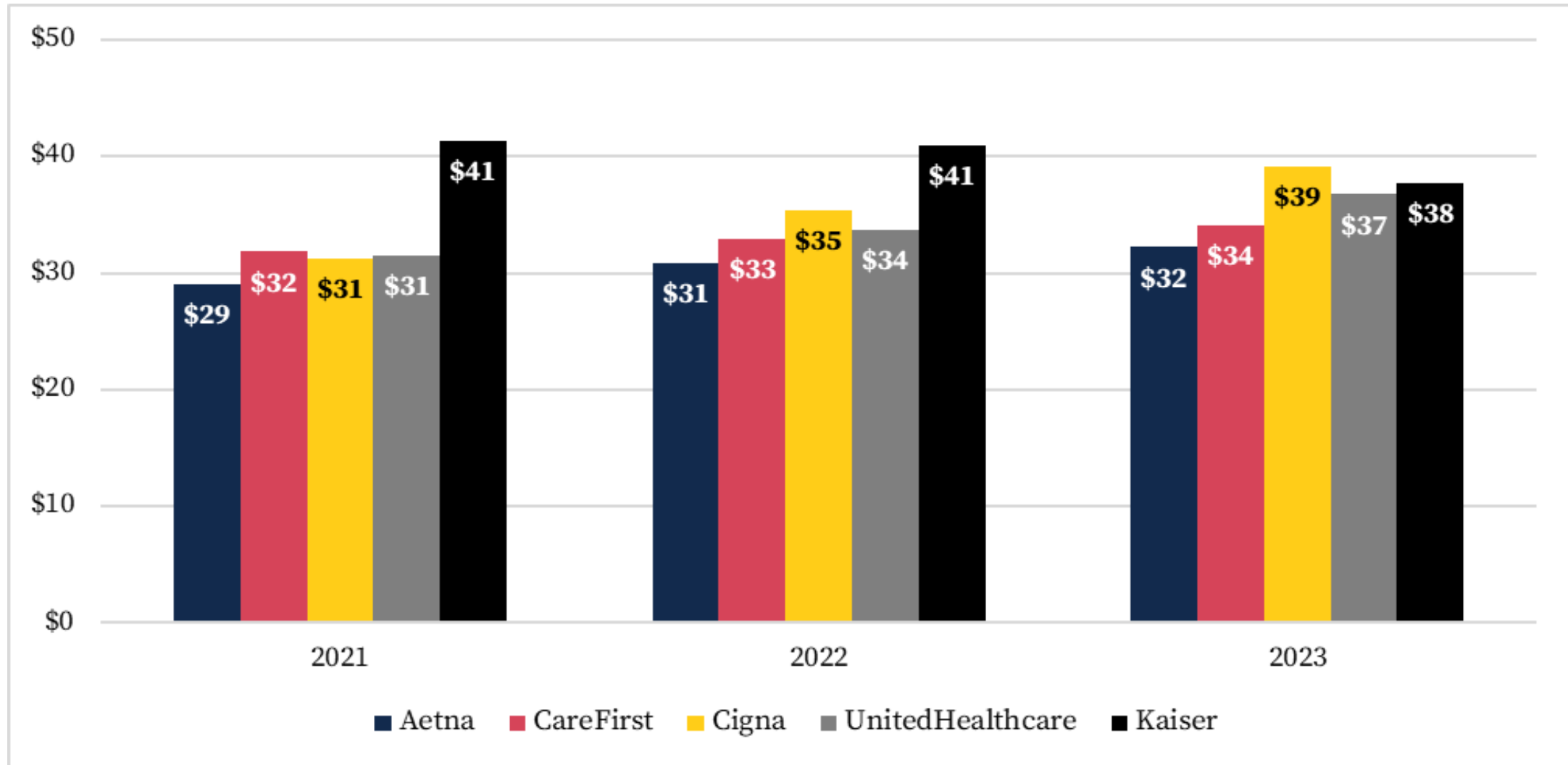
Primary Care Spending PMPM by Commercial Payer



- ▶ Across commercial payers, PMPM spending has stagnated 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

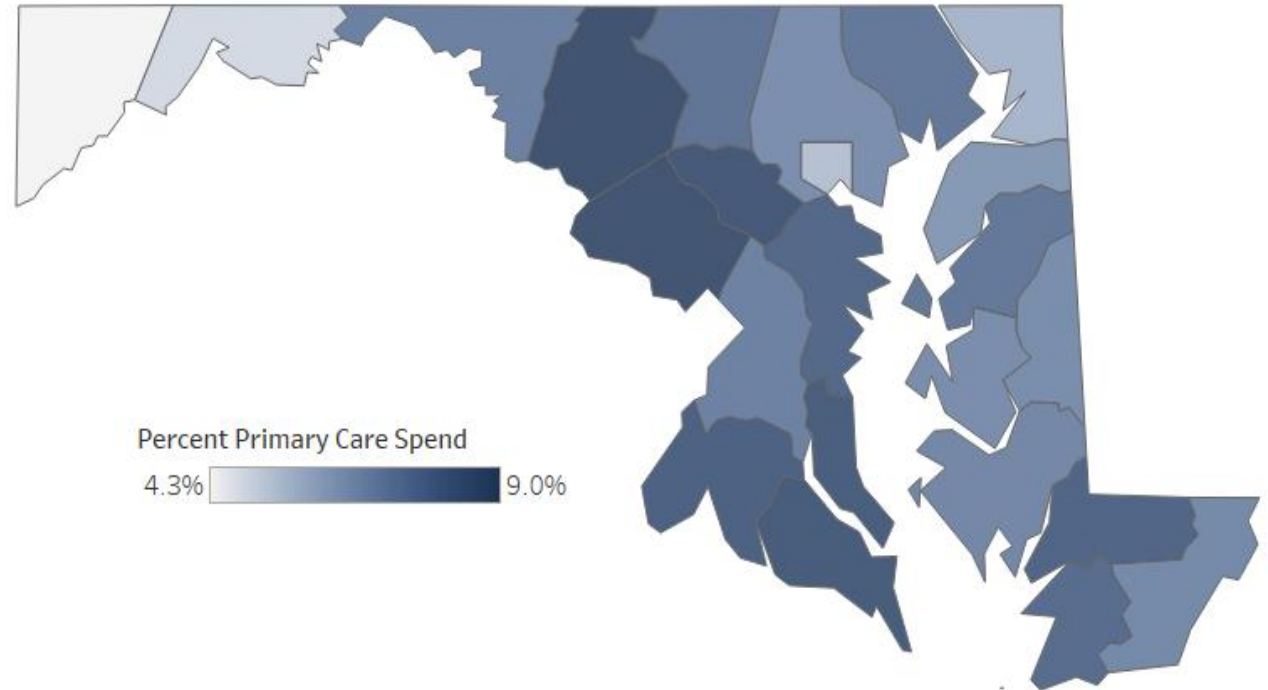
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Primary Care Spending as a Percentage of TME by County, 2023



- ▶ 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 counties, Garrett (4.3 percent) and Allegany (4.9 percent), but also in Baltimore City (5.5 percent), the most densely populated county in the state
- ▶ In all counties with the lowest spending, median household income was less than \$60,000 in 2022
- ▶ Median household income in the counties with the highest spending, Frederick (9.0 percent), Montgomery (8.7 percent), and Howard (8.7 percent), ranged from \$117,000 to \$133,000 in 2022



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

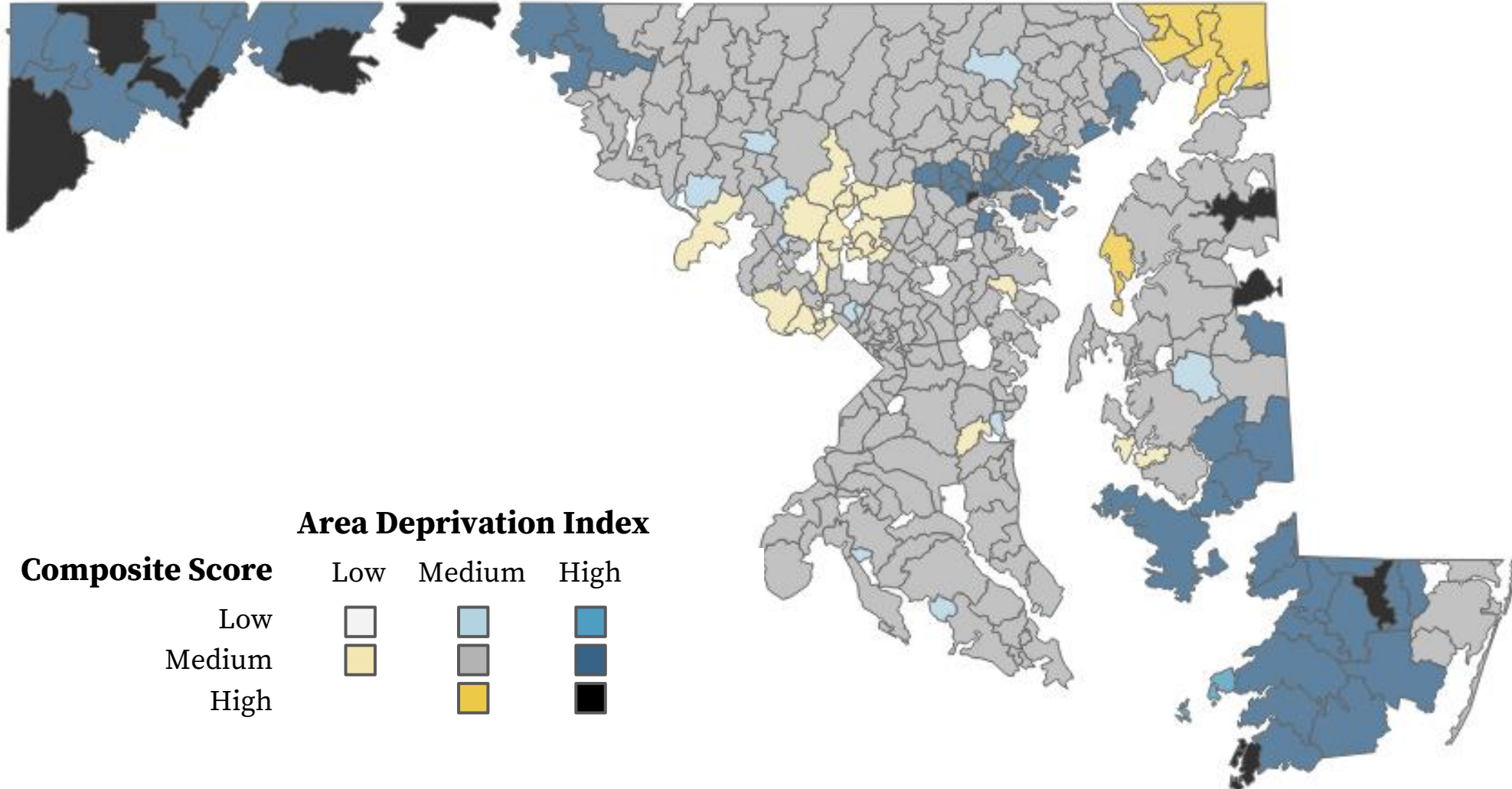
- ▶ Eleven ZIP codes had both a higher composite score and a higher ADI, indicating the greatest opportunity to benefit from increased primary care investment
- ▶ With the exception of Baltimore City, these geographic areas are concentrated in northwest and southeastern Maryland



Impact of Primary Care Investment

- ▶ Primary care is a public good because an increased supply of primary care clinicians is the only specialty type that is associated with improved mortality and more equitable health outcomes
- ▶ Investment in primary care has stagnated across the State
- ▶ Thousands are expected to lose access to health coverage in the form of Medicaid or the Exchange with passage of HR1 and the possible expiration of advanced premium tax credits
- ▶ The Federally Qualified Health Centers and Rural Health Clinics that have historically provided primary care to low-income and immigrant populations will likely see significantly reduced investment
- ▶ Many of the same neighborhoods that experience health disparities are also less likely to see primary care investment creating geographical imbalance
- ▶ Receipt of a usual source of primary care has been shown to decrease longstanding disparities

Map Highlighting Areas of High Primary Care Investment Opportunity



2025 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
- ▶ Offers insight into how resources are currently allocated
- ▶ Helps identify opportunities to strengthen primary care in communities with the greatest need
- ▶ Supports investment in safety-net primary care clinics
- ▶ Ensures that investments are data-driven and aligned with the Statewide goal of advancing health equity
- ▶ The MHCC will work with the legislature to promote accountability, continuing the recommendation from 2024

2025 Recommendation 2



Enact legislation requiring payers to participate in the Maryland Primary Care Programs (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

2025 Recommendation 2 *(continued...)*



Enact legislation requiring payers to participate in the Model's Primary Care Programs (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

- ▶ 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

2025 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

2025 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 financial support 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 ensures care teams are equipped to address equity goals

2025 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

Next Steps



- ▶ Establish a primary care investment target; work with legislature to hold payers accountable to meeting or exceeding the primary care investment target; track payer performance against the targets and publish progress
- ▶ Enhance geographic analyses to identify areas where targeted community investments can address inequities, improve outcomes, and reduce disparities
- ▶ Begin the process of formulating and submitting recommendations to CMS for Potentially Misvalued Codes
- ▶ Make the Primary Care Performance Dashboard available to promote transparency in primary care investment by payer type, geography, and demographic factors; regular updates (at least annually) will provide an accountability mechanism for payer targets
- ▶ Collaborate with legislature to expand multipayer coverage of APCM services and investigate other codes for coverage and payment
- ▶ Explore opportunities to use data to better understand health system investments in primary care to ensure investment dollars reach primary care providers in meaningful ways

Commission Action



Staff requests the Commission to approve the draft 2025 Primary Care Investment Analysis and Recommendations Report

The End





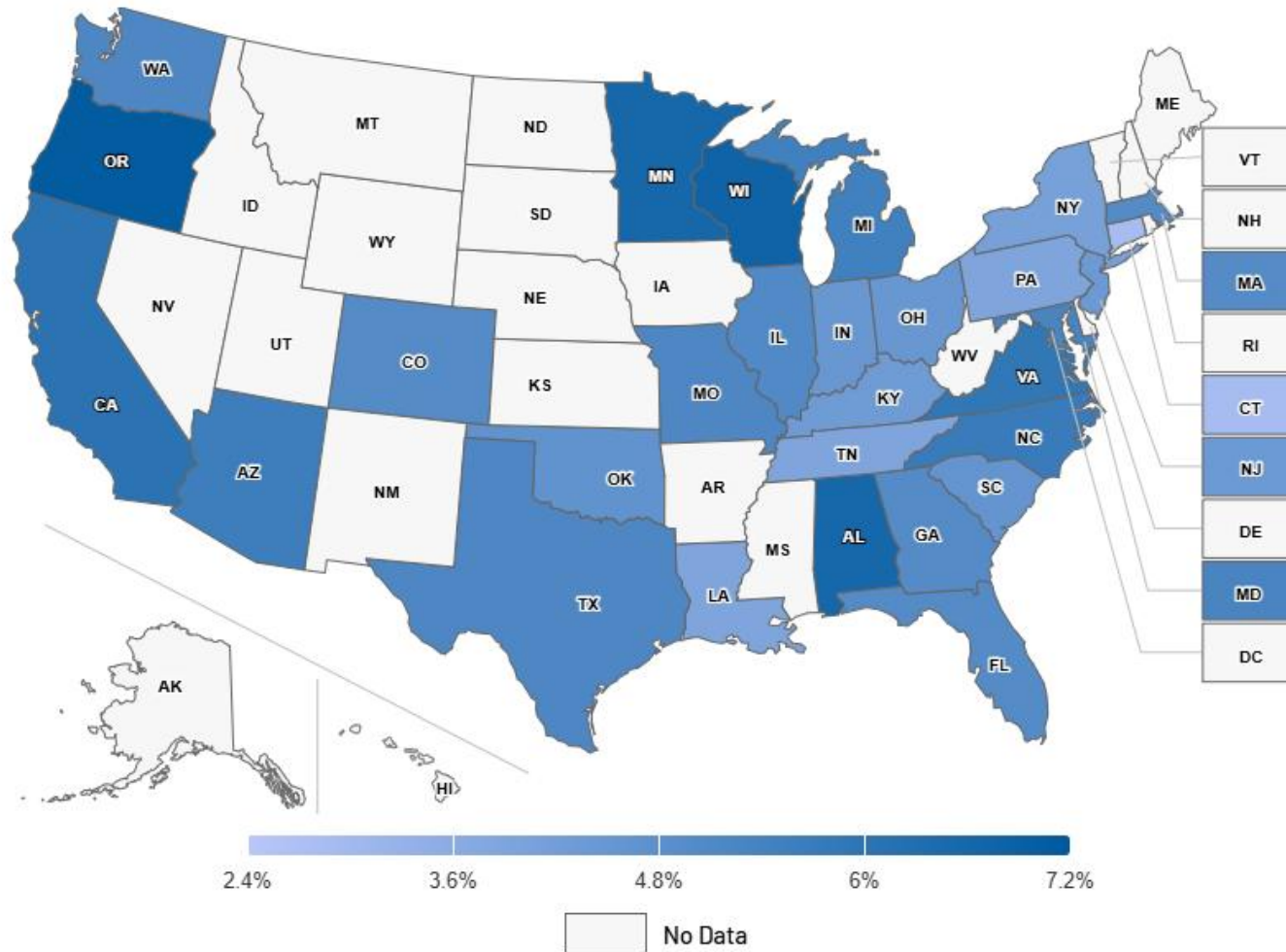
Appendix

Primary Care Investment Workgroup Membership



Membership Category	Organization (28 Members)
Maryland General Assembly	Senate
Maryland Primary Care Program	MDPCP/MDH
Health Services Cost Review Commission	HSCRC
Maryland Insurance Administration	MIA
Health Care Financing Division of the Maryland Department of Health	Medicaid
Maryland Academy of Family Physicians	MDAFP
Maryland Chapter of the Maryland Academy of Pediatrics	MDAAP
Maryland Section of the American College of Obstetricians and Gynecologists	MDACOG
Maryland Nurses Association	MNA
Maryland Affiliate of American College of Nurse Midwives	Maryland Affiliate of ACNM
Maryland Community Health System	MCHS
Mid-Atlantic Association of Community Health Centers	MACHC
Maryland Hospital Association	MHA
Accountable Care Organization	Aledade
Primary Care	MEDIS, LLC; Johns Hopkins Clinical Alliance; Patient First; University of Maryland School of Medicine
Payer	CareFirst BlueCross BlueShield; Funk & Bolton P.A.; Kaiser Permanente of the Mid-Atlantic; Amerigroup Maryland, Inc. & Maryland MCO Association
Health Services Researcher with Expertise in Primary Care	Johns Hopkins Bloomberg School of Public Health
Other Representatives	Health Care For All; Perdue Farms; State of Maryland; Independent Consultant/Retired Senior Health Actuary at U.S. Office of Personnel Management

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. Spend	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



	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