Primary Care Investment
Analysis and Recommendations Report

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EXECUTIVE SUMMARY

Primary care is the only specialty in which increased supply results in lower mortality and more equitable health outcomes, and thus, should be considered a public good.[1] Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup*, enacted in 2022 and codified at §19-108.4 of the Health-General Article, (the Act)[2] mandates that the Maryland Health Care Commission (MHCC) conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending. The Act requires MHCC to form a stakeholder workgroup (Workgroup)[3] to provide input on the analysis and recommendations.[4] This report is intended to satisfy the second annual reporting requirement.

In alignment with Maryland's participation in the federal Advancing Healthcare Efficiency through Accountable Design (AHEAD) Model (Model), the analysis generated for this year's report utilizes the Model definition of primary care providers and services. The definition utilizes code sets to identify the specific services and providers that define primary care. The MHCC examined primary care investment across commercial payers, Medicare Advantage, and Medicare Fee-for-Service by analyzing data from 2021 to 2023 using the Medical Care Data Base (MCDB), Maryland's all-payer claims database.[5] In addition to the analysis by payer, this year's report also includes findings from a geographic analysis which identified Maryland Zone Improvement Plan (ZIP) codes with the greatest relative opportunity for improving primary care access, quality, and equity through increased investment.

Key Findings

Primary care spending as a percentage of total medical expense (TME) did not increase between 2021-2023. Primary care spending for commercial members was 8.7 percent of TME in 2021 and 8.5 percent in 2023. For Medicare Advantage members, primary care spending was 5.4 percent of TME in 2021 and 4.8 percent in 2023. Primary care spending for Medicare Fee-for-Service remained flat between 2021 and 2022 at 4.2 percent of TME. TME represents all costs for medical services.

Primary care spending on a per member per month (PMPM) basis was relatively flat between 2021-2023. For commercial members, primary care PMPM spending grew from $33 in 2021 to $35 in 2023. PMPM spending decreased slightly for Medicare Advantage from $57 PMPM in 2021 to $55 in 2023. Medicare Fee-for-Service spending remained consistent between 2021 and 2022 at $40 PMPM.[6]

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[1] National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding The Foundation of Health Care*. Washington, DC: The National Academies Press, 2021. https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health. Accessed August 26, 2025.

[2] Chapter 667 of the 2022 Laws of Maryland 2022. https://mgaleg.maryland.gov/2022RS/chapters_noln/Ch_667_sb0734E.pdf. Accessed August 26, 2025.

[3] See Appendix A for a list of workgroup members.

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

[5] The Maryland Primary Care Program (MDPCP) Medicare Fee-For-Service Alternative Payment Model payments, which incentivize high quality, cost-efficient care by rewarding providers for achieving specific outcomes, are not included in the MCDB.

[6] This may be attributed to a national increase in utilization post COVID-19. Additionally, the 2025 Milkbank Scorecard reported a nationwide decline in primary investment in 2022. Spending on primary care was under five percent in 2022 across all payers, with

Variation across commercial payers was minimal. Primary care spending was generally consistent across commercial payers, with all but one spending between 8.0 and 8.5 percent of TME on primary care in 2023. Across commercial payers, primary care spending was approximately $35 PMPM during the same period.

Primary care investment opportunities vary by geography. The MHCC conducted a geographic analysis to evaluate opportunities for improving primary care spending, access, quality, and equity. The results highlighted ZIP codes representing underserved areas in the northwestern, southeastern, and Baltimore regions of the State where primary care spending, utilization, and quality could be improved.

Recommendations

Despite the importance of primary care to the health and wellbeing of Marylanders, investment has stagnated, with geographic imbalances in underserved areas. Increased investment in primary care should be a priority for Maryland, and more needs to be done to get there.

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.***

   The MHCC, through its current authority, will establish a primary care investment target based on TME, adjust for payer-specific factors, and prioritize investments in underserved areas. TME, calculated through a flat dollar rate, is more appropriate compared to a percentage, since a percentage may be more reflective of the age of the population served rather than proactive investment. For this reason, MHCC will also adjust for payer-specific differences, such as age and health status, to offer insight into how resources are currently allocated. Pairing this methodology with measures of deprivation and quality will help identify opportunities to strengthen primary care in communities with the greatest need. This will be especially important to support investment in safety-net primary care clinics, which are likely to face financial challenges if patients lose Medicaid coverage or advance premium tax credits through the Maryland Health Benefit Exchange. A comprehensive approach ensures that investments are data-driven and aligned with the statewide goal of advancing health equity. Continuing the recommendation from 2024, MHCC will work with the legislature to promote accountability towards reaching these targets.

2. ***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.***

   Multi-payer alignment for advanced primary care models provides critical financial incentives for primary care practices to transform the way they deliver care. This is because primary care clinicians may not focus on each individual patient's payer, and investment is required to build

primary care spending in Medicare and Medicaid decreasing the most since the last Scorecard, down to 3.4 percent and 4.3 percent in 2022. https://milbank.org/publications/the-health-of-us-primary-care-2025-scorecard-report-the-cost-of-neglect/. Accessed September 15, 2025.

the infrastructure to best manage the population health of communities. The Model's Primary Care Programs and the APCM payments offer additional revenue opportunities, helping to meet the primary care investment target while offering a defined set of quality measures to promote high-quality primary care. While Medicare currently charges cost sharing for APCM services, recent requests for information suggest the Centers for Medicare & Medicaid Services (CMS) is considering eliminating this requirement. Other payers should eliminate cost sharing, where permitted by law,[7] to encourage greater uptake and incentivize clinicians to adopt APCM coding and payments. Additionally, CMS proposed in the 2026 Medicare Physician Fee Schedule (PFS) to create add-on codes for behavioral health integration and the Collaborative Care Model, allowing for more effective integration in behavioral health settings, and if finalized Maryland payers should cover these services without cost sharing as well. These increased payments—aligned across payers—could help practices hire interprofessional staff, offer competitive salaries, enhance electronic resources for patient communications, expand care management resources, and serve more patients.

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

Recently proposed changes to the 2026 Medicare PFS suggest that CMS is interested in utilizing empirical data to price services instead of its historic reliance on survey data with low response rates. This is important because the PFS is a budget neutral system and longstanding distortions in payment likely undervalue the work of primary care and behavioral health teams, while overvaluing other specific services contributing to workforce shortages and gaps in access. The CMS Potentially Misvalued Codes Process offers a pathway to reexamine how services are priced, especially those that involve care coordination, preventive services, and non-face-to-face interactions. Submitting nominations supported by empirical data can help ensure that payment more accurately reflects the complexity and intensity of all services.

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

Primary care practices are increasingly being acquired by health systems. As such, payer investments in primary care may enter health system general revenue streams, but may not be internally directed towards establishing and supporting a primary care workforce that can adequately meet the needs of the community. Accordingly, assessing how health systems invest in their owned and affiliated primary care teams is key to understanding whether increased financial support is having its intended effect. As coverage shifts threaten access for vulnerable populations, especially through Medicaid disenrollments and changes to the Maryland Health Benefit Exchange, a focused review can identify gaps and determine whether additional accountability mechanisms are needed. Aligning investment with practice-specific patient and community needs ensures care teams are equipped to address health equity goals.

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[7] Waiving of copays may violate the Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)], the False Claims Act [31 U.S.C. § § 3729-3733], the Civil Monetary Penalties Law [42 U.S.C. § 1320a-7a], or federal or State fraud and abuse laws. U.S. Department of Health and Human Services, Office of Inspector General. *Fraud & Abuse Laws*. Physician Education. https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/. Accessed September 3, 2025.

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

Ongoing monitoring by MHCC of the Model helps ensure that the Workgroup's policy recommendations remain responsive to the State's broader vision for transforming primary care. By promoting a holistic, equitable, and community-centered approach, the Model offers a framework for improving care delivery and reducing health disparities. Continuous monitoring will help shape policy approaches that align with Model priorities and remain adaptable to meet the evolving primary care needs in Maryland.

SETTING THE STAGE

In 2023, MHCC submitted a plan to the Governor and the General Assembly to guide its annual analysis and reporting on primary care investment. In 2024, MHCC submitted its first *Primary Care Investment Analysis and Recommendations Report*[8] (2024 Report) to the Governor and the General Assembly. Research finds that investment in primary care improves access to care and health outcomes.[1] Underinvestment causes an insufficient primary care workforce which, in turn, constrains access to quality care. Nearly one-third of American adults do not have a relationship with a primary care doctor.[9] Primary care clinicians face heavy workloads and inadequate funding, contributing to burnout and decisions to choose other specialties.[10]

These challenges are of particular concern because research finds that primary care is the only specialty in which increased supply results in lower mortality and more equitable health outcomes. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, published by the National Academies of Science, Engineering and Medicine (NASEM) in 2021, referenced these findings and identified five objectives to help address the challenges: (1) pay for primary care teams to care for people, not for physicians to deliver services; (2) ensure that high-quality primary care is available to all in every community; (3) train primary care teams where people live and work; (4) design information technology that serves the patient, family, and care team; and (5) ensure that high-quality primary care is implemented in the United States.[1]

Addressing historical underinvestment in primary care requires concerted state and national action, including raising public awareness. For example, a recent study found a significant discrepancy between public perception and actual allocation of health care expenditures to primary care.[11] On average, respondents to a national survey overestimated primary care spending by more than tenfold compared with current estimates of actual spending.[11] Nearly 20 states have initiatives that aim to strengthen their systems of primary care, including through increased investment.[10] Despite these efforts, *The Health of US Primary Care: 2025 Scorecard Report* (Scorecard), published by the Milbank Memorial Fund and the Physicians Foundation, finds that primary care investment

[8] Maryland Health Care Commission. *2024 Primary Care Investment Analysis and Recommendations Report.* https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcw/pci_final_rpt_2024.pdf. Accessed August 26, 2025.
[9] Rakshit S, McGough M, Cotter L, Claxton G. *How does cost affect access to healthcare?* Peterson-KFF Health System Tracker. April 2025. https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care. Accessed August 26, 2025.
[10] Jabbarpour Y, Jetty A, Byun H, et al. *The Health of US Primary Care: 2025 Scorecard Report*. Milbank Memorial Fund; 2025. Available at: https://www.milbank.org/wp-content/uploads/2025/02/Milbank-Scorecard-2025-ACCESS-v07.pdf. Accessed August 26, 2025.
[11] Ma M, Etz R, Bazemore A, Grumbach K. The general public vastly overestimates primary care spending in the United States. *Ann Fam Med*. 2025;23(2):165-167. doi:10.1370/afm.240413.

nationally has continued to decline.[10] According to the Scorecard, primary care spending averaged less than five percent of TME across all payers, compared to more than six percent at its peak in 2013.

The Scorecard finds, using a narrow definition of primary care, that spending by Medicare decreased by .5 percent when compared to 2021 to 3.4 percent in 2022. Medicaid primary care spending in 2022 decreased by .4 percent from the prior year and is reported to be at 4.3 percent. Commercial primary care spending also declined by .1 percent in 2022 compared to the previous year, down to 5.5 percent of TME. The Scorecard's narrow definition excludes several categories of services that are defined as primary care by some state measurements. Some examples of the services that are excluded from the Scorecard definition are immunizations, telehealth, obstetric-gynecological services, pediatric care, behavioral health, and some hospice services.

The MHCC used the Workgroup's definition of primary care in previous reports. It includes immunization administration, telehealth, pediatric care, and some behavioral health and hospice services. Since Maryland is participating in the Model, the analysis generated for this year's report utilizes the Model definition of primary care providers and services. This definition is broader than both the Scorecard and Workgroup definitions. It also includes routine visits and preventive care provided by obstetricians and gynecologists. The Scorecard calculates spending using the Medical Expenditure Panel Survey, a nationwide survey that collects data from individuals and families, providers, and employers to detail health care usage, spending, payment methods, and insurance coverage in the United States.[12] The Workgroup[13] and Model[14] definitions use claims data rather than survey data.

States across the country are taking action to boost primary care investment; however, many are struggling to meet their spending targets. In Massachusetts, a 2025 Health Policy Commission report on primary care issued a stark call to action on primary care spending—which grew half as fast as spending on all other services from 2017 to 2022—and launched a new primary care task force.[15] Connecticut set a primary care spending target in 2020 via an executive order with a series of stairsteps that gradually increased from five percent of spending in 2021 to 10 percent in 2025. Connecticut has yet to meet an annual all-payer target; on the contrary, primary care spending as a percentage of total spending has declined for the State's commercial and Medicare Advantage payers. Although primary care spending has increased, spending on other services has risen even faster. Under the executive order, Connecticut has no recourse to penalize plans that fail to meet the target.[16]

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[12] Milbank Memorial Fund. *2025 Primary Care Scorecard Dashboard*. February 2025. https://www.milbank.org/publications/the-health-of-us-primary-care-2025-scorecard-report-the-cost-of-neglect/2025-primary-care-scorecard-dashboard/. Accessed August 26, 2025.

[13] The codes used the Workgroup definition may be found in the *2024 Primary Care Investment Analysis and Recommendations Report* Data Supplement, at https://pci_final_data_suppl_rpt_2024.pdf.

[14] The codes for the Model Definition may be found in the *2025 Primary Care Investment Analysis and Recommendations Report* Data Supplement, at add link when posted

[15] Massachusetts Health Policy Commission. *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*. January 2025. https://www.masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and. Accessed August 27, 2025.

[16] Milbank Memorial Fund. *Five States Leading Efforts to Increase Primary Care Spending*. March 2025. https://www.milbank.org/publications/states-lead-efforts-to-increase-primary-care-spending/. Accessed August 27, 2025.

Colorado has an investment requirement, rather than a target.[17] Colorado also has not met its primary care investment requirement, which is focused on commercial payers. Primary care spending as a percentage of TME has declined in Colorado, from about nine percent in 2021 to eight percent in 2023; primary care spending also declined slightly in absolute dollars from about $40 PMPM in 2021 to just under $39 PMPM in 2023. The Colorado Department of Insurance has regulatory authority to enforce the requirement but has not used this power.

Delaware and Rhode Island put more emphasis on ensuring that primary care requirements are achieved, including through frequent data collection and regulation. While both states have seen increases in commercial primary care spending, both also still report opportunities to improve primary care investment and access.[18-19] As states grapple with meeting overall spending targets, many are turning their attention to geographic disparities in primary care investment, recognizing that underfunding in certain regions can deepen inequities in access and outcomes.

Maryland has continued its efforts to advance primary care. On November 1, 2024, the Governor signed a State Agreement (Agreement) to participate in the Model.[20] The State is currently in the pre-implementation planning phase, with implementation expected to kick off on January 1, 2026.[21] The Model is a voluntary state-based alternative payment and service delivery model designed to curb health care cost growth, improve population health, and promote healthier living. The Agreement requires that Maryland establish a process to set a Total Cost of Care Growth Target for all payers in the State and an All-Payer Primary Care Investment Target by executive order, legislation, or regulation by October 2025, and establish the targets for 2027-2030 by October 2026. This requirement aligns with the recommendation in the 2024 Report to enact legislation that compels payers to increase investment in primary care as a percentage of TME.

The Model also includes prospective care management payments and requirements for care transformation, such as integrating behavioral health into primary care services. It aims to align Medicare's primary care strategy with states' primary care goals within their Medicaid programs, encouraging participation from both Medicare and Medicaid and promoting alignment with commercial payers. Maryland is the only state to participate in Cohort 1 of the Model, and is expected to be joined by Connecticut, Hawaii, New York (in five downstate counties), Rhode Island, and Vermont in Cohorts 2 and 3.[22] States' participation is subject to change pending adjustments to the Model design under new federal CMS leadership.

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[17] Center for Improving Value in Health Care. *Primary Care Spending and Alternative Payment Model Use in Colorado, 2021-2023*. November 2024. https://civhc.org/wp-content/uploads/2025/01/CIVHC-Report-of-Primary-Care-Spending_2024_FINAL.pdf. Accessed August 27, 2025.

[18] Delaware Department of Insurance Office of Value-Based Health Care Delivery. *Primary Care Reform Collaborative Meeting*. June 2025. https://dhss.delaware.gov/wp-content/uploads/sites/4/2025/06/6.23.25-PCRC-PowerPoint_FINAL.pdf. Accessed August 27, 2025.

[19] Care Transformation Collaborative. *Commissioner King on New Regulations to Strengthen Primary Care*. March 2025. https://ctc-ri.org/03/20/2025/commissioner-king-new-regulations-strengthen-primary-care. Accessed August 27, 2025.

[20] Health Services Cost Review Commission. *Final Maryland AHEAD State AHEAD Agreement*. October 2024. https://hscrc.maryland.gov/Documents/AHEAD/Final%20MD%20AHEAD%20State%20Agreement_102824.pdf. Accessed August 27, 2025.

[21] Centers for Medicare & Medicaid Services, *Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model*. Available at: https://www.cms.gov/priorities/innovation/innovation-models/ahead. Accessed September 3, 2025.

[22] More information on the Model is available at: https://hscrc.maryland.gov/Pages/ahead-model.aspx.

Medicare at a national level has finalized some changes and proposed further modifications to promote investment in primary care. In the 2025 PFS, Medicare finalized the creation of new APCM codes which, for the first time, bundle together care management and communication technology codes to recognize the resources involved in advanced primary care.[23] Unlike existing codes, there are no time-based thresholds, but rather a monthly payment based on the patient's medical and social complexity. The codes incorporate lessons learned from more than 10 years of CMS Innovation Center primary care models into a permanent code set in the PFS and comprise the first set of codes to include a quality reporting requirement. In July 2025, CMS proposed to further build on this code set in the 2026 PFS, creating new behavioral health integration add-on codes to promote integrating these services into primary care, demonstrating an interest in promoting primary care investment across administrations.

House Resolution 1 (H.R. 1), signed by President Trump on July 4, 2025, includes a wide range of provisions related to tax law, immigration policy, and social programs. It is expected to result in approximately 10 million Americans losing Medicaid coverage or health insurance coverage through the Affordable Care Act marketplaces.[24] Research finds that individuals without coverage are more likely to delay care, including primary care; individuals of color or with lower incomes are more likely to experience these impacts, exacerbating existing disparities.[25]

KEY LESSONS

A growing number of states have recognized that underinvestment in primary care undermines population health and increases health system costs.[26] Maryland and other states such as California, Colorado, Connecticut, Delaware, Oregon, and Rhode Island are pursuing strategies to increase investment in primary care consistent with recommendations from the 2021 NASEM report.[1] The NASEM report recommends increasing the overall proportion of health care spending in primary care by increasing the PFS payment rates for primary care evaluation and management services and reducing other service rates to maintain budget neutrality. The report also recommends that states use their authority to implement multi-payer collaboration on primary care payment and fee schedules and to measure and increase the overall portion of state health care spending going to primary care.

Investment Approach and Target Challenges

States have set primary care investment targets to help rebalance spending, promote preventive care, and improve population health. General findings suggest that some challenges exist with framing investment targets as a percentage of TME. Notably, when definitions of spending are not standardized across states and when TME differs substantially between payer types, primary care spending targets as a percentage of TME may prove inflationary or inadequate. For example, in a

[23] More information about the APCM codes is available at: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-final-rule.
[24] Burns A, Ortaliza J, Lo J, Rae M, Cox C. *How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?* Kaiser Family Foundation. August 20, 2025. https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/. Accessed August 27, 2025.
[25] Healthy People 2030. *Access to Primary Care*. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care. Accessed August 27, 2025.
[26] Primary Care Collaborative. *State Investment Hub*. https://thepcc.org/policy/state-investment-hub/. Accessed August 27, 2025.

high-cost state, a target based on TME may exceed what is necessary to optimize the primary care system. Separately, a primary care target based on a percentage of TME by a particular payer, such as Medicaid, may be insufficient to improve access, quality, and equity because of lower TME.[10]

Increases in investment are also limited by varying definitions of primary care. States that define primary care more broadly may more quickly meet an investment target set as a percentage TME, whereas a state that defines primary care more narrowly will require more new investment to achieve the same target. To drive adequate investment, targets may need to be updated relative to evolving definitions.[27] States that allow payers to count non-claims-based payments towards primary care investment targets must also develop and test the formula to appropriately allocate those payments.

Primary care providers are increasingly employed by hospitals and private equity firms and less likely to be affiliated with independent practices. Research finds that fee-for-service payments are higher for primary care providers employed by these types of organizations,[28] which are also more likely to have sufficient patients, infrastructure, and risk tolerance to participate in value-based care and receive non-claims payments. However, states report difficulty monitoring whether these increases in fees or non-claims payments are reaching primary care providers in ways that feel meaningful.[29-30]

Alternative Payment Model Approaches

Providers in states where primary care investment targets are achieved through Alternative Payment Models (APMs) alone are forced to rely too heavily on unpredictable payments often paid more than a year after the performance period. Hybrid reimbursement models that include APMs and fee-for-service are viewed more favorably by providers. Some APMs increase the burden on providers, who must achieve APM requirements that span multiple reimbursement models, sometimes with opposing incentives and conditions. To address key challenges of some APM approaches, California,[31] Washington,[32] and Oregon[33] have created voluntary standards, goals, and guidance for payers offering APMs. The California Department of Health Care Access and Information has developed a list of 10 evidence-based best practices for payer-provider APM contracting and implementation guidance for APMs.[31]

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[27] Sinha V, Rourke E, Condon MJ, Brandel W. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending*. Milbank Memorial Fund. April 2024. https://www.milbank.org/wp-content/uploads/2024/04/BH_SPENDING61824.pdf. Accessed August 27, 2025.
[28] Singh Y, Radhakrishnan N, Adler L, Whaley C. Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications. *JAMA Health Forum*. 2025;6(1):e244935. doi:10.1001/jamahealthforum.2024.4935.
[29] Seifert R, Rourke E, Condon MJ. *Lessons Learned from State Efforts to Slow and Shift Health Care Spending*. Milbank Memorial Fund. February 12, 2025. https://www.milbank.org/wp-content/uploads/2025/02/SlowingShiftingSpending_2.18.pdf. Accessed August 27, 2025.
[30] Swan G, Condon MJ, Altman W, et al. Does higher spending on primary care lead to lower total health care spending? *Health Affairs Forefront*. October 8, 2024. doi:10.1377/forefront.20241007.439293.
[31] California Department of Health Care Access and Information. *Alternative Payment Model Standards and Adoption Goals*. https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/apm-standards-and-adoption-goals. Accessed August 27, 2025.
[32] Washington State Health Care Authority. *Paying for Health and Value: Health Care Authority's Long-term Value-based Purchasing Roadmap, 2023-2027*. 2023. https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf. Accessed August 27, 2025.
[33] Oregon Health Authority. *Oregon's Roadmap to Value-Based Payment*. https://www.oregon.gov/oha/hpa/dsi-tc/pages/value-based-payment.aspx. Accessed August 27, 2025.

Some states have prioritized aligned standards for APMs to ensure stronger links between payment, quality, and value. Specifically, aligned standards for APMs strengthen the incentives for provider participation by ensuring that a larger share of revenue is linked to quality and value and that the requirements of APMs are as consistent as possible across payers. Aligned standards aim to mitigate the burden associated with operating in multiple APMs as well as the difficulty of straddling the APM and fee-for-service revenue streams. States have convened coalitions, collaboratives, and stakeholder engagement initiatives to support consensus building towards aligned APM standards.

Vermont's Blueprint for Health[34] Patient-Centered Medical Home (PCMH) program requires commercial payer participation as a condition of doing business in the state, along with Medicaid and Medicare to the extent applicable through federal law, waiver, or demonstration. This approach requires payers to conform with Blueprint for Health's payment methodologies. The payment methodologies include per person, per month payments by each insurer to primary care practices performing PCMH functions such as offering expanded access and care management capabilities. All practices in the state are eligible to participate. Payment is based on the National Committee for Quality Assurance's Physician Practice Connections Patient-Centered Medical Home score, which is a recognition program that evaluates and acknowledges primary care practices that demonstrate a commitment to patient-centered care.[35]

In Rhode Island, the Office of the Health Insurance Commissioner[36] (OHIC) leverages Affordability Standards for commercial insurers to define PCMHs and set an insurer target for adoption. OHIC requires insurers to make supplemental payments to PCMHs for care transformation and operations and requires practices to indicate their participation as an Accountable Care Organization or Accountable Entity (ACO/AE) and meet behavioral health integration criteria. If practices are not participating in an ACO/AE model, they are required to meet PCMH criteria for quality measures, practice transformation, and cost management.

In Maryland, the Maryland Primary Care Program (MDPCP) has been an important element of the Maryland Total Cost of Care Model and will serve as a strong foundation for its evolution under the Model. MDPCP is the largest state-based Medicare advanced primary care program in the nation, with more than 500 practices covering over 50 percent of the State's eligible fee-for-service population. Participating practices receive support and increased payments to strengthen care coordination, implement population health strategies, and prioritize preventive care. The Mathematica and Hilltop Institute evaluations[37-38] for the program provide evidence that this initiative has effectively enhanced access to care for underserved populations and led to better outcomes statewide, including a nearly 30 percent reduction in avoidable hospitalizations.

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[34] Vermont Blueprint for Health. https://blueprintforhealth.vermont.gov/. Accessed August 27, 2025.
[35] National Committee for Quality Assurance. *Patient-Centered Medical Home (PCMH)*. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh . Accessed August 27, 2025.
[36] Rhode Island Office of the Health Insurance Commissioner. https://ohic.ri.gov/. Accessed August 27, 2025.
[37] Peterson G, Rotter J, Machta R, et al. *Evaluation of the Maryland Total Cost of Care Model: Progress Report*. Washington, DC: Mathematica; April 2024. https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt. Accessed August 27, 2025.
[38] Goetschius L, Gill C, Fakeye O, Han F, Henderson M. *Maryland Primary Care Program performance evaluation (2019–2022)*. Baltimore, MD: The Hilltop Institute, UMBC; August 20, 2024.
https://health.maryland.gov/mdpcp/Documents/MDPCPEvaluation_20Aug24_clean.pdf. Accessed August 27, 2025.

Notably, the APCM codes, as described earlier, represent a permanent APM embedded within the PFS, since they are the first payment codes that CMS has created that link quality and payment together. Other carriers—whether commercial insurers, State Medicaid Programs, or employer-based coverage—can elect to utilize these codes today.

PRIOR REPORT RECOMMENDATIONS AND STATUS

The following provides an update on progress toward implementing the 2024 Primary Care Investment Analysis recommendations. As part of a comprehensive strategy to strengthen primary care, the Workgroup recommended a coordinated approach focused on transparency, data alignment, and fiscal accountability. Through enhanced reporting requirements, standardized evaluation frameworks, and statutory investment thresholds, these efforts aim to improve equity, quality, and system performance. The recommendations are grounded in a unified definition of primary care and aligned with federal collaboration under the Model.

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.

Status

The MHCC has required commercial payers to submit APM data for two years. The data collection and analysis process informed development of a new data submission template for 2025. This template will enable primary care APMs to be isolated from all other APMs and allow MHCC to calculate non-claims-based primary care spending paid via APMs. This new, enhanced data collection is underway and will be completed in late 2025. The MHCC anticipates that two to three years of trend information will be necessary for the data to inform policy.

In 2025, MHCC began to utilize the Expanded Non-Claims Payment Framework (Expanded Framework)[39] to classify APM payments. This Expanded Framework allows MHCC to organize APMs by payment purpose (e.g., performance incentive, integrated behavioral health) and by the amount of clinical and financial risk assumed by the provider. The Expanded Framework maps to the HCP-LAN categories of payment[40] created to drive alignment in payment approaches across the public and private payers. The Expanded Framework provides additional information about how the dollars were intended to be used. In 2024, the Expanded Framework was adopted by the National Association of Health Data Organizations as the standard for non-claims data collection.[41] This expanded data collection positions the State to more effectively assess the current primary care APM landscape.

[39] The framework integrates and refines elements from two existing models: the Health Care Payment Learning and Action Network (HCP-LAN) and Milbank Memorial Fund-Bailit (Milbank).
[40] Alternative Payment Model Framework and Progress Tracking Work Group. *Alternative Payment Model (APM) Framework: Final White Paper*. Health Care Payment Learning & Action Network. Published January 12, 2016. https://www.milbank.org/wp-content/uploads/2017/11/HCP-LAN-White-Paper-APM-Framework.pdf. Accessed August 27, 2025.
[41] National Association of Health Data Organizations is a national non-profit membership and educational association dedicated to improving health care data collection and use. More information is available at https://www.nahdo.org/.

2024 Recommendation 2

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

Status

The MHCC is combining a variety of data sources into a dashboard to better track and monitor investment. Phase 1 will feature standardized measures to track payer progress and evaluate year-over-year investment by payer type, payer, and geography. Future phases will incorporate quality and performance metrics, along with access measures to highlight geographic disparities and strengthen 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. This legislation 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.

Status

The Governor signed the Model State Agreement on November 1, 2024. Under the Agreement, Maryland must establish a process through executive order, legislation, or regulation to set all-payer primary care investment targets prior to Performance Year One (2026). The State is on target to finalize this process by October 2025. At this time, the State anticipates it will establish investment targets by October 2026 for Performance Years Two through Five.

DATA AND FINDINGS

The MHCC has focused this year's primary care spending report on analysis aligned with the Model's definition of primary care. This shift from prior approaches is intended to support greater investment and alignment across payer programs, while also enabling more meaningful comparisons with other Model states. Several states, including some not participating in the Model, are considering adopting the Model definition to improve comparability.

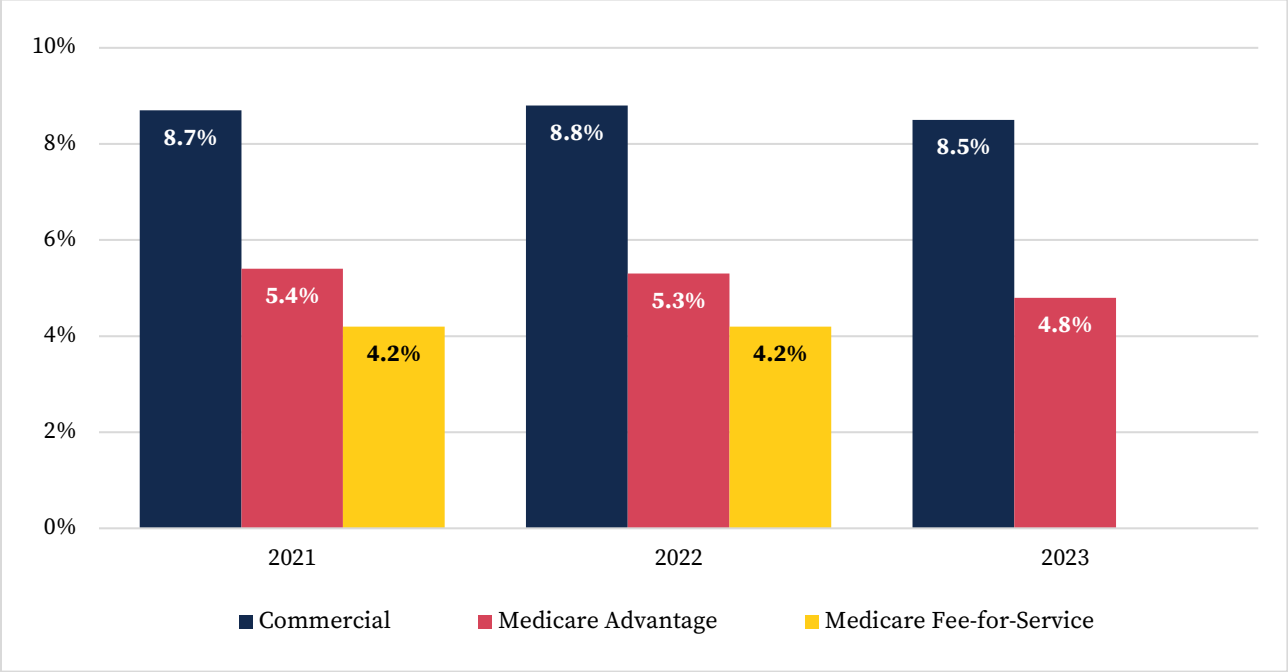
The MHCC has measured primary care spending for the past two years using a definition developed by the Workgroup based on a framework created by a multistate collaboration convened by the New England States Consortium Systems Organization.[42] This definition includes a specific set of services delivered by providers in designated specialties (identified by taxonomy codes) and has served as a foundation for statewide spending measurement. The analysis established a baseline across commercial payers, Medicare Advantage, and Medicare Fee-For-Service and were used to examine variation by jurisdiction, age group, gender, race, and ethnicity. Maryland is the first state to publish detailed spending data by race and ethnicity.

[42] The New England States Consortium Systems Organization is a non-profit organization governed by the New England State Health and Human Services (HHS) agencies and the University of Massachusetts Chan Medical School. It is designed to connect HHS staff with opportunities to learn from peers in neighboring states and colleagues within their state. More information is available at https://nescso.org/.

Total and PMPM Spending

Using the Model definition, primary care spending by commercial payers remained relatively flat from 2021 through 2023. Medicare Advantage spending declined from 5.4 percent of TME in 2021 to 4.8 percent in 2023 and Medicare Fee-for-Service primary care spending was flat from 2021 to 2022, as shown in Figure 1.[6] This year's report includes 12 months of spending for 2021 through 2023 for commercial and Medicare Advantage coverage. Commercial and Medicare Advantage data for 2024 was not used and will be available in late 2025. Data for Medicare Fee-for-Service lags one year behind commercial and Medicare Advantage.

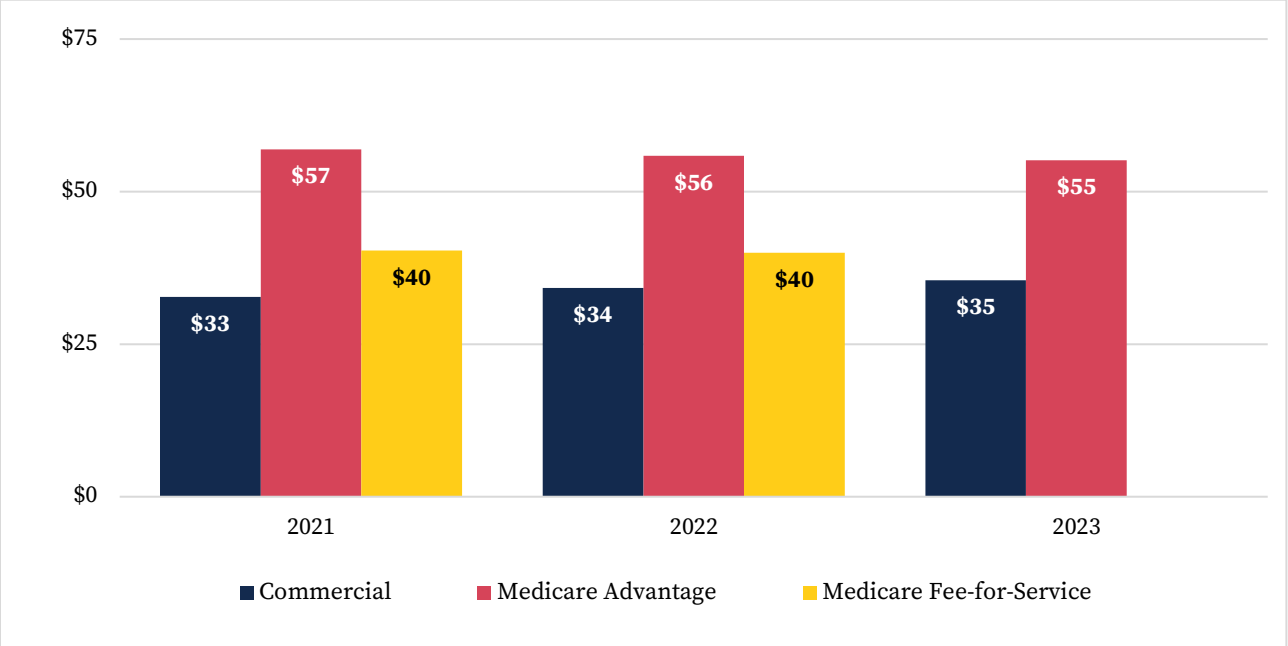
Figure 1: 2021-2023* Primary Care Spending as a Percentage of TME (Model Definition)



**The most recent data available for Medicare Fee-for-Service is 2022.*

As depicted in Figure 2 below, spending levels on a PMPM basis varied considerably by payer type. In 2023, PMPM spending ranged from an average of $35 for commercial members to an average of $55 for Medicare Advantage members. Note that when primary care spending is measured as a percentage of TME, higher total spending will result in a lower percentage of primary care spending. While Medicare Advantage plans, on average, spent the most on primary care services on a PMPM basis, these plans did not have the highest percentage of primary care spending.

Figure 2: 2021-2023* Primary Care Spending PMPM (Model Definition)



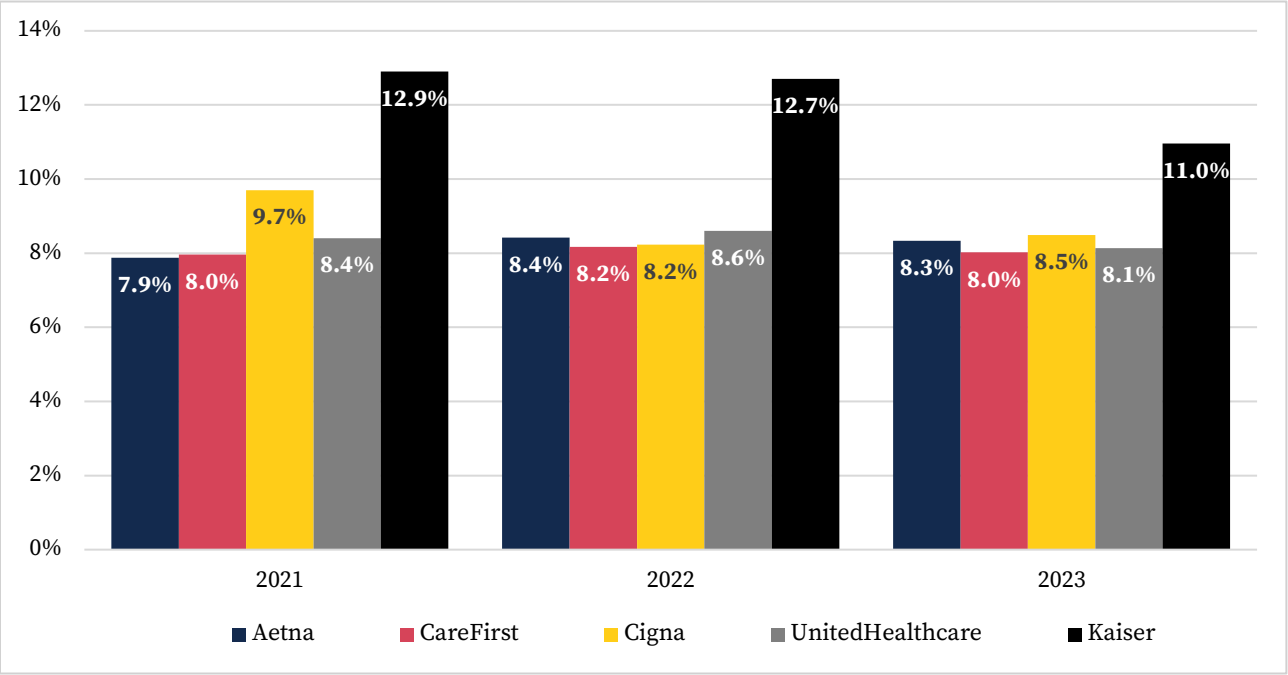
**The most recent data available for Medicare Fee-for-Service is 2022.*

Commercial Payer Spending

Primary care spending was generally consistent across commercial payers. All payers except Kaiser were within one percent of one another's primary care spending as a percentage of TME in years 2021-2023, as shown in Figure 3. Kaiser Permanente operates an integrated care and coverage model, where the health plan, hospitals, and Permanente Medical Groups work together.[43] This allows for care coordination, aligned incentives, and a focus on population health management, which may lead to higher primary care spending patterns compared to other models. Cigna had slightly higher investment in 2021 than all other payers except Kaiser. Meanwhile, Cigna's PMPM primary care spending was similar to all other payers except Kaiser. In 2022 and 2023, Cigna's TME grew substantially, and its proportion of primary care investment declined. Further analysis is necessary to understand which factors contributed most to the increase in Cigna's TME: increased primary care utilization or increased reimbursement for primary care services.

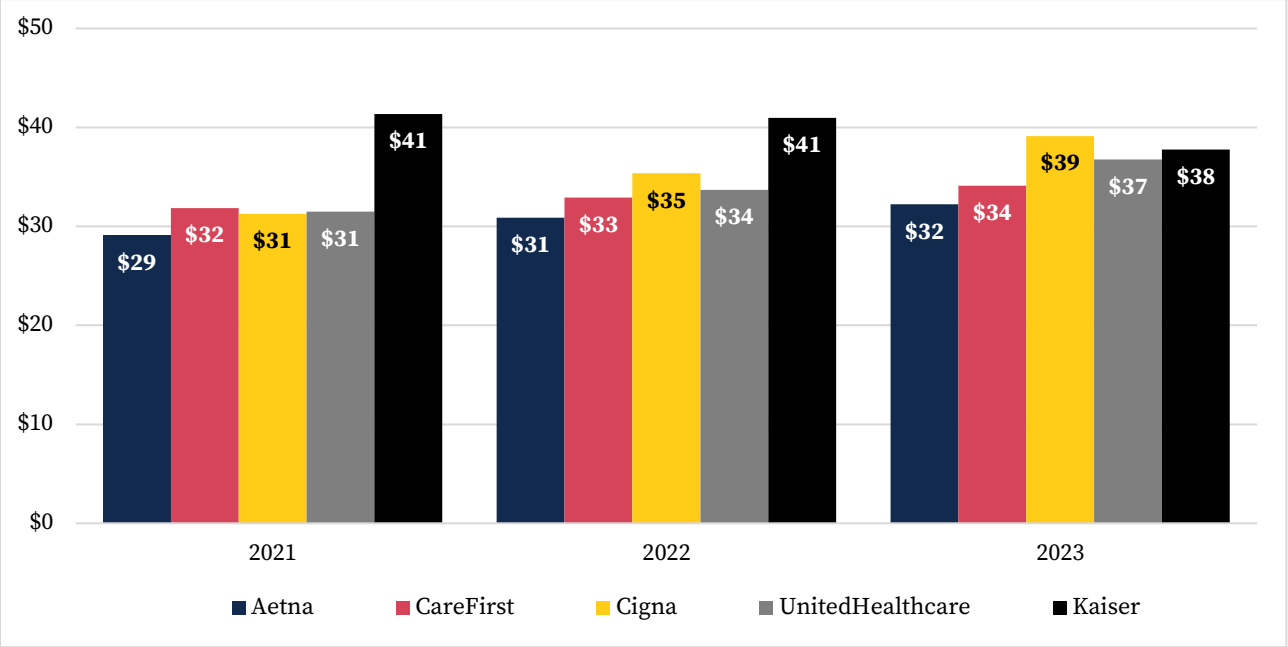
[43] More information about Kaiser Permanente's model is available at https://permanente.org/medical-excellence/value-based-care/.

Figure 3: 2021-2023 Primary Care Spending as a Percentage of TME by Commercial Payer (Model Definition)



Across commercial payers, PMPM spending was relatively consistent in each year from 2021 through 2023. Between 2021 and 2023 Cigna's PMPM primary care spending changed the most, increasing from $31 to $39, as shown in Figure 4. This mirrors an increase in Cigna's overall spending, as its TME rose from $322 PMPM to $460 PMPM for all medical expenses, surpassing other payers' growth during the same period.

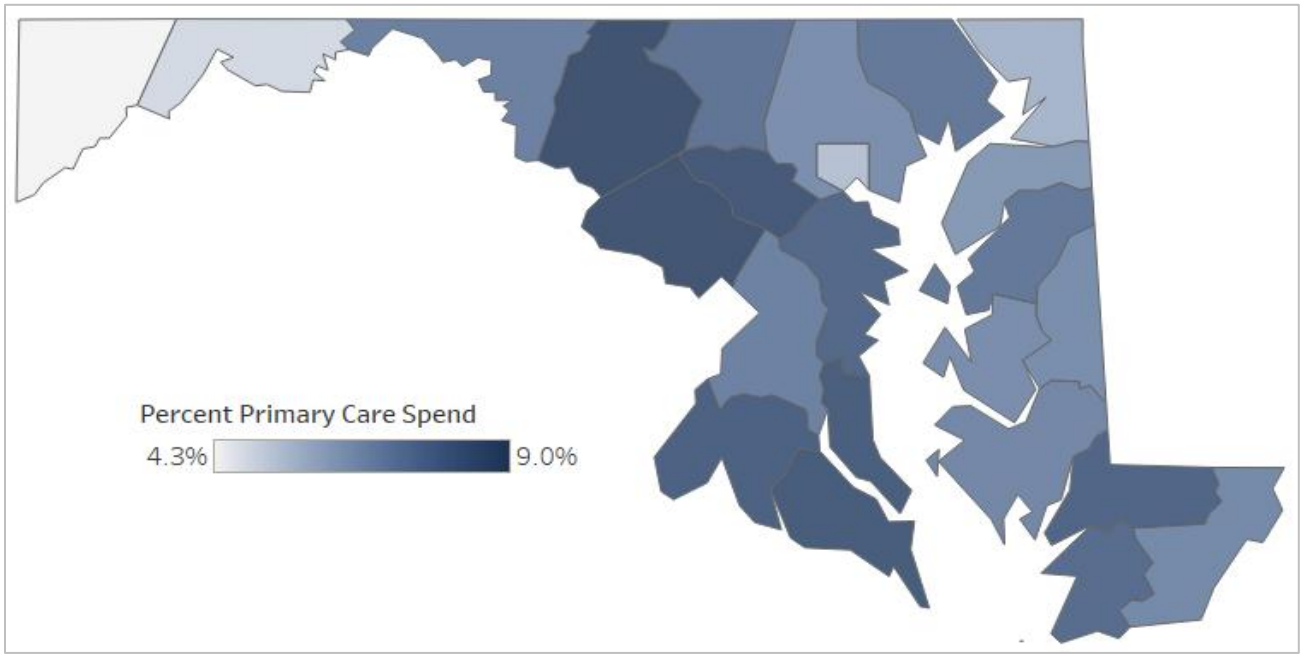
Figure 4: 2021-2023 Primary Care Spending PMPM by Commercial Payer (Model Definition)



Geographic Spending

The MHCC conducted several analyses to better understand differences in primary care investment across jurisdictions and ZIP codes. Commercial primary care spending varied by jurisdiction, ranging from 4.3 percent of TME in Garrett County to a high of 9.0 percent in Frederick County, as shown in Figure 5. Spending was low in some of the least populous jurisdictions—Garrett (4.3 percent) and Allegany (4.9 percent)—but was also low in Baltimore City (5.5 percent), the most densely populated jurisdiction in the State. In all jurisdictions with the lowest spending, median household income was less than $60,000 per year in 2022. Median household income in the three jurisdictions with the highest spending—Frederick (nine percent), Montgomery (8.7 percent), and Howard (8.7 percent)—ranged from $117,000 to $133,000 in 2022.[44]

Figure 5: 2023 Primary Care Spending as a Percentage of TME by Jurisdiction (Model Definition)



Demographic Spending

An evaluation of 2023 commercial payer spending by gender found a two percent difference between females (9.3 percent) and males (7.4 percent). For the Medicare Advantage population, spending was also higher for females (5.3 percent) compared to males (4.2 percent). This difference may be partly attributed to costs related to maternity care and obstetric or gynecological services.[45] National and international research also consistently finds that men use fewer health care services than women and tend to be less likely to schedule preventive care or seek care for chronic illnesses.[46]

[44]Maryland Department of Planning State Data and Analysis Center. *Median Household Income for Maryland's Jurisdictions and Places*: *Median Household Incomes 2013-2022 for Maryland and 24 jurisdictions.* Maryland Department of Planning; 2023. https://planning.maryland.gov/MSDC/Documents/HH_Income/2022_SAIPE_Median_Household_Income.pdf. Accessed August 27, 2025.

[45] Centers for Medicare & Medicaid Services. *U.S. Personal Health Care Spending By Age and Sex: 2020 Highlights*. Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ageandgenderhighlights.pdf. Accessed August 27, 2025.

[46] Ouyang H. *What Does It Take to Get Men to See a Doctor?* The New York Times Magazine. August 25, 2025. https://www.nytimes.com/2025/08/25/magazine/mens-health-doctor-masculinity.html Accessed August 27, 2025.

Primary care spending as a percentage of TME by age was highest among individuals under 30 and lowest among those aged 65 and older; this is consistent with observed patterns in primary care spending, where children have the highest percentage of primary care spending as a proportion of TME as they also tend to have lower medical expenses overall.[47] Commercial payer spending ranged from 11.8 percent to 15.6 percent for individuals under 30, and from 4.5 percent to 8.1 percent for those over 65. The share of primary care spending for people over 65 is lower as a proportion of TME due to higher medical expenses overall. Primary care spending PMPM is more similar across age categories. For Medicare Advantage, spending was lower for individuals under 65 (3.7 percent) than for those over 65 (5.0 percent).

Geographic Investment Analysis

The MHCC identified several jurisdictions as having increased opportunity to improve access, quality, and equity. The geographic analysis included five metrics. 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 the Area Deprivation Index (ADI),[48] which ranks communities based on measures of social risk.

Eleven ZIP codes had both a higher composite score and a higher ADI, indicating the greatest opportunity to benefit from increased primary care investment (Appendix C, Table C2). Table 1 and Figure 6 illustrate the ZIP codes with the highest investment opportunity as a function of multiple indicators included in the composite score. With the exception of Baltimore City, these geographic areas are concentrated in northwest and southeastern Maryland. Primary care spending within a ZIP code alone does not indicate performance in access, quality, or equity, as some ZIP codes with the greatest investment opportunity also show relatively high levels of primary care spending. Communities with high ADI scores are often associated with multiple health disparities and higher ADI scores were a strong indicator of investment opportunity.

The analysis also identified 10 ZIP codes with comparatively low opportunity to benefit from increased primary care spending. These ZIP codes are located primarily in Montgomery County, with one ZIP code each in Anne Arundel and Howard Counties.

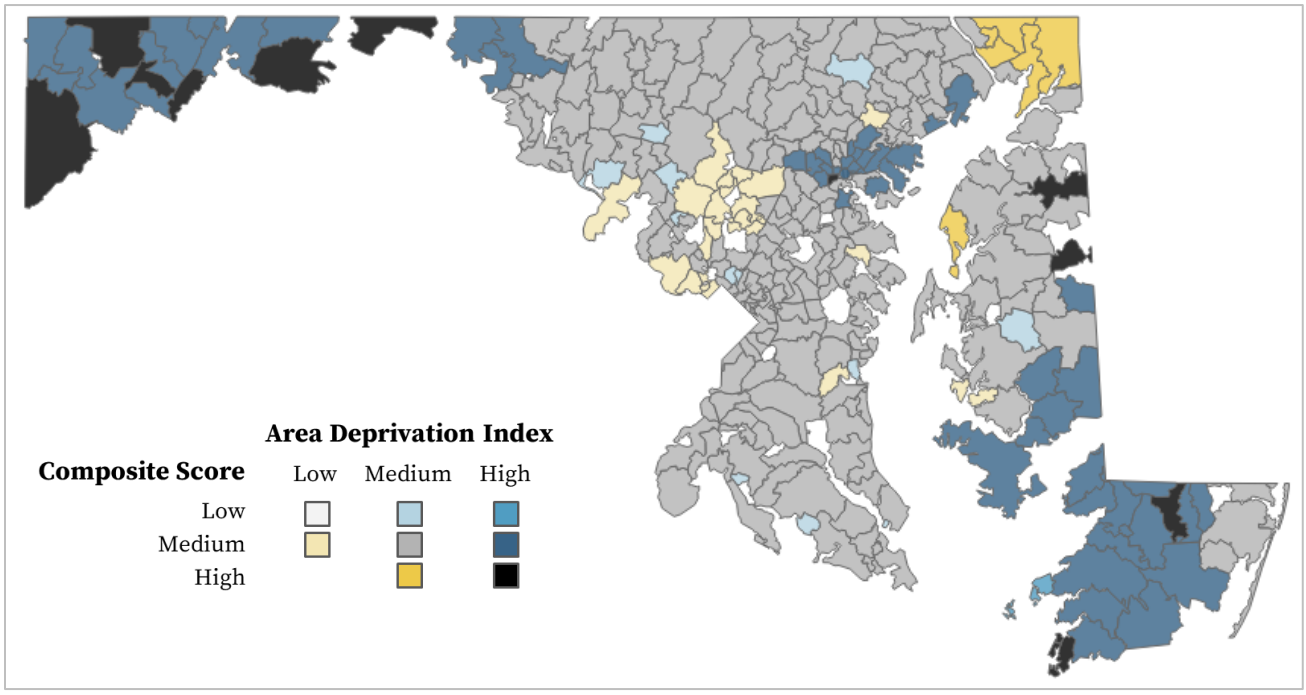
[47] Reiff J, Brennan N, Fuglesten Biniek J. Primary Care Spending in the Commercially Insured Population. *JAMA*. 2019;322(22):2244–2245. doi:10.1001/jama.2019.16058

[48] The University of Wisconsin-Madison's Neighborhood Atlas® calculates an ADI to evaluate multiple factors associated with socioeconomic disadvantage at the ZIP code level. Available at: https://www.neighborhoodatlas.medicine.wisc.edu/.

Table 1: Jurisdictions with the Highest Primary Care Investment Opportunity

Jurisdiction	ZIP Codes	Primary Care Spending (%)	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

Figure 6: Map Highlighting Jurisdictions with Highest Primary Care Investment Opportunity



DISCUSSION

Because an increased supply of primary care clinicians is the only specialty type that is associated with improved mortality and more equitable health outcomes, primary care is a public good. Unfortunately, investment in primary care has stagnated across the State. Some payers have increased their investment, while others have decreased their investment, and forces are at play

that may reduce primary care access even further. With passage of H.R. 1 and the possible expiration of advanced premium tax credits, thousands are expected to lose access to health coverage in the form of Medicaid or the Maryland Health Benefit Exchange, especially amongst low-income and immigrant populations.

This lack of investment is also geographically imbalanced, with many of the same neighborhoods that experience health disparities also less likely to see primary care investment. This is especially problematic since receipt of a usual source of primary care has been shown to decrease longstanding disparities. 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, and some may close, further reducing access.

Increased investment in primary care should be a priority for Maryland, and more needs to be done to get there. Since primary care spending naturally fluctuates across a person's life, with increased spending more common at younger ages, it is most appropriate to develop primary care investment targets as a PMPM dollar amount instead of a percentage. Doubling down on primary care investment during an uncertain time, with a focus on underserved communities, can also help support vulnerable health centers and maintain critical primary care access. There are a series of federal reforms—including changes in service valuation methodologies in the PFS and new Medicare coding and payment for advanced primary care—that Maryland can take advantage of to synergistically support primary care spending in a thoughtful and aligned way. Additionally, Maryland can build on an important history of supporting primary care through the MDPCP model. Finally, as more primary care practices are acquired by health systems, the State should begin to take steps to assess and hold accountable health systems for providing high-quality primary care to their surrounding communities.

RECOMMENDATIONS

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.***

   The MHCC, through its current authority, will establish a primary care investment target based on TME, adjust for payer-specific factors, and prioritize investments in underserved areas. TME, calculated through a flat dollar rate, is more appropriate compared to a percentage, since a percentage may be more reflective of the age of the population served rather than proactive investment. For this reason, MHCC will also adjust for payer-specific differences, such as age and health status, to offer insight into how resources are currently allocated. Pairing this methodology with measures of deprivation and quality will help identify opportunities to strengthen primary care in communities with the greatest need. This will be especially important to support investment in safety-net primary care clinics, which are likely to face financial challenges if patients lose Medicaid coverage or advance premium tax credits through the Maryland Health Benefit Exchange. A comprehensive approach ensures that investments are data-driven and aligned with the statewide goal of advancing health equity. Continuing the

recommendation from 2024, MHCC will work with the legislature to promote accountability towards reaching these targets.

2. ***Enact legislation requiring payers to participate in the Model's Primary Care Programs and to reimburse providers for APCM services and integrated behavioral health services with no cost sharing, when permitted by law.***

   Multi-payer alignment for advanced primary care models provides critical financial incentives for primary care practices to transform the way they deliver care. This is because primary care clinicians may not focus on each individual patient's payer, and investment is required to build the infrastructure to best manage the population health of communities. The Model's Primary Care Programs and the APCM payments offer additional revenue opportunities, helping to meet the primary care investment target while offering a defined set of quality measures to promote high-quality primary care. While Medicare currently charges cost sharing for APCM services, recent requests for information suggest CMS is considering eliminating this requirement. Other payers should eliminate cost sharing, where permitted by law,[7] to encourage greater uptake and incentivize clinicians to adopt APCM coding and payments. Additionally, CMS proposed in the 2026 Medicare PFS to create add-on codes for behavioral health integration and the Collaborative Care Model, allowing for more effective integration in behavioral health settings, and if finalized Maryland payers should cover these services without cost sharing as well. These increased payments—aligned across payers—could help practices hire interprofessional staff, offer competitive salaries, enhance electronic resources for patient communications, expand care management resources, and serve more patients.

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

   Recently proposed changes to the 2026 Medicare PFS suggest that CMS is interested in utilizing empirical data to price services instead of its historic reliance on survey data with low response rates. This is important because the PFS is a budget neutral system and longstanding distortions in payment likely undervalue the work of primary care and behavioral health teams, while overvaluing other specific services contributing to workforce shortages and gaps in access. The CMS Potentially Misvalued Codes Process offers a pathway to reexamine how services are priced, especially those that involve care coordination, preventive services, and non-face-to-face interactions. Submitting nominations supported by empirical data can help ensure that payment more accurately reflects the complexity and intensity of all services.

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

   Primary care practices are increasingly being acquired by health systems. As such, payer investments in primary care may enter health system general revenue streams, but may not be internally directed towards establishing and supporting a primary are workforce that can adequately meet the needs of the community. Accordingly, assessing how health systems invest in their owned and affiliated primary care teams is key to understanding whether increased

financial support is having its intended effect. As coverage shifts threaten access for vulnerable populations, especially through Medicaid disenrollments and changes to the Maryland Health Benefit Exchange, a focused review can identify gaps and determine whether additional accountability mechanisms are needed. Aligning investment with practice-specific patient and community needs ensures care teams are equipped to address equity goals.

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

Ongoing monitoring by MHCC of the Model helps ensure that the Workgroup's policy recommendations remain responsive to the State's broader vision for transforming primary care. By promoting a holistic, equitable, and community-centered approach, the Model offers a framework for improving care delivery and reducing health disparities. Continuous monitoring will help shape policy approaches that align with Model priorities and remain adaptable to meet the evolving primary care needs in Maryland.

ON THE HORIZON

Over the next year, MHCC will work with payers to establish a primary care investment target. It will continue to track payer performance against the target and publish progress updates. The MHCC will broaden its analysis of primary care spending to better identify the drivers of spending differences and to identify areas where targeted community investments can address inequities, improve outcomes, and reduce disparities. It will work to begin submitting recommendations to CMS for Potentially Misvalued Codes.

The MHCC will publish the Primary Care Performance Dashboard (dashboard) to provide additional transparency into trends in primary care investment by payer type, geography, and demographic factors. The dashboard is poised for annual updates to provide an accountability mechanism for payer targets. The MHCC also will also work with the legislature to expand multipayer coverage of APCM services, affiliated behavioral health integration services, and investigate other codes that should be considered for coverage and payment. Finally, to ensure those funds reach primary care providers in meaningful ways, MHCC will identify opportunities to use data to better understand health system investments in primary care.

LIMITATIONS

Diverse perspectives from the Workgroup were considered in shaping the report. While a consensus-based approach was used to develop the recommendations, they do not reflect full unanimity. The MHCC conducted its analysis for this report using the MCDB, which provides unique opportunities for calculating primary care investments. However, the database excludes data from self-insured ERISA health plans, the uninsured, and workers' compensation. Therefore, this analysis does not reflect primary care delivered to these individuals. Data is available through 2023 for commercial and Medicare Advantage and through 2022 for Traditional Medicare due to claims lag.

ACKNOWLEDGEMENTS

The MHCC commends the dedication of the stakeholders who serve on the Workgroup and contributed to preparation of the report. It also extends sincere thanks to the Freedman HealthCare LLC team for their valuable contributions.

APPENDIX A: WORKGROUP MEMBERSHIP

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

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Accountable Care Organization	Aledade	Tyler Blanchard
Primary Care	MEDIS, LLC	Michael Barr
	Johns Hopkins Clinical Alliance	Sarah Johnson Conway
	Patient First	Chris Barker
	University of Maryland School of Medicine	Niharika Khanna
Payer	CareFirst BlueCross BlueShield	Seiji Hayashi
	Funk & Bolton P.A.	Matthew Celentano
	Kaiser Permanente of the Mid-Atlantic	Tinisha Cheatham
	Amerigroup Maryland, Inc. & Maryland MCO Association	Kathleen Loughran
Health Services Researcher with Expertise in Primary Care	Johns Hopkins Bloomberg School of Public Health	Jill Marsteller
Other Representatives	Health Care for All	Rev. William Johnson, Jr. Community Chaplain for the Johns Hopkins Health System
	Perdue Farms	Dawn Carey
	State of Maryland	Christina Kuminski
	Independent Consultant/ Retired Senior Health Actuary at U.S. Office of Personnel Management	Ronald Gresch

Biographies

Salliann Alborn, BSN– MCHS Representative

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

Chris Barker – Primary Care Representative

Mr. Barker currently serves as the Vice President of Payer Relations & Value-Based Care at Patient First. His responsibilities include maintaining payer relationships, managing value-based care contract performance, as well as oversight for their business intelligence unit. His previous experience includes inpatient administration with HCA as well as operations management for their first clinically integrated network, Virginia Care Partners.

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

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

Jeffrey Bernstein, MD – MDAAP Representative

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

Tyler Blanchard, BS – Accountable Care Organization Representative

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

Brad Boban – MIA Representative

Mr. Boban is Chief Actuary in the Office of the Chief Actuary at the MIA. He has over 22 years of experience in the health insurance industry. Mr. Boban oversees and manages the review of health insurance rate filings, including Affordable Care 4 Act, long term care and Medicare Supplement. Prior to joining the MIA, Mr. Boban worked as a pricing actuary at CareFirst BlueCross BlueShield.

Dawn Carey, MBA – Consumer (Employer) Representative

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

Matthew Celentano – Payer Representative

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

Tinisha Cheatham, DO – Payer Representative

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

Sarah Johnson Conway, MD – Primary Care Representative

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

Amar Duggirala, DO, MPH, FAAFP – MDAFP Representative

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

Ronald Gresch, MAAA, ASA – Consumer Representative

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

William Henderson – HSCRC Representative

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

Seiji Hayashi, MD – Payer Representative

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

Nora Hoban – MACHC Representative

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

William Johnson, Jr., DDiv – Consumer Representative

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

Niharika Khanna, MBBS, MD, DGO – Primary Care Representative

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

Christina Kuminski – Consumer (Employer) Representative

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

Clarence Lam, MD, MPH – Maryland General Assembly Representative

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

Kathleen Loughran – Payer Representative

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

Jill Marsteller, PhD, MPP – Health Services Researcher with Expertise in Primary Care Representative

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

Chad Perman, MPP – MDPCP Representative

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

Ishrat Rafi, MD, MPH – MDACOG Representative

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

Mette Ramanathan, CNM, FNP – Maryland Affiliate of ACNM Representative

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

Tricia Roddy, MHSA – Medicaid Representative

Ms. Roddy is the Deputy Medicaid Director at the Maryland Department of Health and has served a 23-year tenure with the Maryland Medicaid program. She has extensive knowledge and applied experience in Medicaid operations and innovation and health service transformation. Prior to joining the Maryland Department of Health, Ms. Roddy worked in management consulting and strategy services.

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

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

Tequila Terry, MHA – Maryland Hospital Association Representative

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

APPENDIX B: PRIMARY CARE DEFINITION COMPARISON: KEY ELEMENTS

Category	Workgroup	Model	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 (NPs) and physician assistants (PAs) practicing in one of these specialties • Primary care provider taxonomy codes used to calculate payer investments; includes providers delivering primary care services in a nursing home, Federally-Qualified Health Centers (FQHCs), 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 • Includes services performed by a nurse midwife or behavioral health provider; requires the provider to be integrated into a primary care practice	• Uses the same specialties as the definition of primary care developed by the Workgroup and adds 30 psychiatry and OB/GYN specialties into the definition; these providers can bill either as part of or independent of a primary care practice • Medicare CPT®/HCPCS codes and specialty codes (aligns with the Medicare Shared Savings Program) • Fee-for-service (FFS) and non-claims-based payments are used to calculate the investment • FQHC or rural health clinics are counted as primary care regardless of provider specialty code as long as they include a primary care CPT®/HCPCS code (includes inpatient, outpatient, professional)	• Defined using the MMIS provider type and specialty • Includes: Medicaid identified primary care physicians as physicians, NPs, certified nurse-midwives, PAs, OB/GYNs, as well as School-Based Health Centers (SBHCs) and any providers providing vaccines, certain family planning services, certain OB/GYN services • SBHCs are counted as primary care for any code that they bill • FFS and non-claims-based payments are used to calculate the investment

Category	Workgroup	Model	Medicaid/Hilltop
	where services are billed under the taxonomy code of the primary care provider		
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 TME 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 TME	• N/A
Strategy & Calculation	• Investment target aligned across commercial payers and a different target for Medicaid and the managed care organizations (MCO); review annually and adjust as needed; an accountability mechanism for meeting targets and in using investments to enhance primary care • Spending calculation: PMPM, and as a percent of TME; includes place of service filters; pharmacy spending and rebates, dental, and other supplemental expenditures will be	• All Medicare FFS spending (Parts A and B) for beneficiaries in the State who meet the eligibility criteria (e.g., residents in the State for a minimum defined timeframe) will be included in the Medicare FFS cost growth target calculation • States will be accountable for meeting both annual improvement targets throughout the duration of the	• N/A

Category	Workgroup	Model	Medicaid/Hilltop
	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	implementation period and a final primary care investment target by the end of the implementation period	
Provider & Billing Codes	• 39 taxonomy codes used to ensure specialty filter is inclusive of all primary care providers • 344 billing codes (CPT®/HCPCS) included in the definition; of these, 113 codes are included in the Model 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 • 181 billing codes (CPT®/HCPCS) included in the definition	• 236 billing Codes (CPT®/HCPCS) included in the definition • Primary care providers (PCPs) only (67 codes): evaluation and management, screenings, in-office labs • PCPs and any other provider type are included for 169 codes for vaccines, certain family planning services, certain OB/GYN services • Any code billed by a SBHC

APPENDIX C: GEOGRAPHIC ANALYSIS METHODOLOGY

The analysis was conducted to provide an integrated review of primary care spending, quality, and access by ZIP code to assess disparities in quality of and access to primary care services across geographic regions of the State, as well as the potential opportunity to target investment towards those communities with relatively lower primary care spending and utilization. Data for this analysis was derived from the MCDB. This data enabled study at the member level and by ZIP code and represents commercially insured Maryland residents with payers contributing claims to the MCDB. The analysis utilized the most recent information available at the time the study was conducted, with data from 2023.

Summary tables were developed to aggregate member data for each Maryland ZIP code and to break out the following demographic characteristics: age group (< 30, 30-65, >65), gender (male, female), race (African American, American Indian, Asian, Native Hawaiian or other Pacific Islander, two or more races, white), and ethnicity (not Spanish/Hispanic origin, Spanish/Hispanic origin). Payer name and plan liability type were also fields in the data tables. The following data was combined, and key metrics were computed for the analysis: primary care spending (Model definition of PMPM and percentage of TME), primary care utilization (Model definition), emergency department (ED) utilization (HEDIS© measure), and colorectal cancer screening (HEDIS© measure). There were 598 distinct ZIP codes in the data set; however, subpopulations with fewer than 360 member months were omitted from the analysis, resulting in representation from 336 ZIP codes.

A composite score based on the metrics above was developed to predict geographies with the greatest opportunity to benefit from increased primary care investment. The analysis also examined the relationship between geographies with the most opportunity to improve primary care and those with relatively higher social risk as defined by ADI. Table C1 below offers a description of each domain, metric, and rationale for selection. Metrics 1 through 4 were included in a composite score to rank opportunity for primary care investment. Metric 5, ADI score, was examined in combination with and in relation to the composite score ranking.

Table C1: 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

Prior to calculating the composite score, each identified metric was given an initial score. For each measure, the number of standard deviations between the ZIP code's observation and the statewide average was calculated (i.e., z-scores). The direction of each z-score was adjusted so that positive values were associated with either more deprivation or opportunity to improve primary care related outcomes.

Geographic Analysis Composite Score

A general linear model, or composite score, was constructed by combining the metrics of interest to assess performance across Maryland ZIP codes relative to primary care spending, access and quality; a higher composite score is associated with more opportunity to improve access and quality of care through additional primary care investment. Data indicated that primary care visits per year and primary care spending PMPM were strongly correlated. Primary care spending PMPM was removed from the model due to its collinearity, as well as to scale relative spending on primary care.

ADI

The most recent available ADI data is from 2022 and includes two variables for each ZIP code: an intrastate ranking (from 1 to 10) and a national percentile (from 1 to 100). Using the national percentile allows for the most nuance and granularity in assessing which Maryland ZIP codes have socioeconomic factors that could benefit the most from sufficient and appropriate levels of primary care investment.

The ADI was viewed as the most influential variable in modeling. More deprivation is associated with less primary care and ADI explains approximately half of the variation. As such, examining interactions between ADI and the attributes of the composite score best identifies the geographic locations in Maryland that may benefit from increased primary care investment. There are instances where one 5-digit ZIP code is associated with more than one ADI value. These values were weighted based on census-tract level population estimates and the weighted ADI was included in the data set, repeating for each subpopulation within the same 5-digit ZIP code.

Results

Results are reported in Table C2. Eleven ZIP codes were identified as having high composite scores and high social risk as measured by ADI, suggesting a greater opportunity to reduce inequities and disparities in communities with greater primary care investment.

Table C2: 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**

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