



Primary Care Investment Workgroup

Approach for 2027 Payer-Specific Primary Care Investment Targets

February 24, 2026

Presentation Items



- ▶ Establishing Payer-Specific Targets
- ▶ A Process Review: Calculating Targets
- ▶ Calculation of Medicaid Investment Target – Overview and Update
- ▶ 2026 PCIW Report Planning
- ▶ Approach for AHEAD Total Cost of Care Targets
- ▶ AHEAD PC/Maryland Primary Care Program Update



Establishing Payer-Specific Investment Targets

PCIW Feedback – Modifications to the Maryland Care Team Builder Model



- ▶ Age Bands
 - Model reflect revised age bands; 0-4, 5-17, 18-39, 40-64, 65+
- ▶ Physician Salaries
 - Physician salaries updated to reflect OB-GYN and psychiatrist salaries
- ▶ Panel size
 - Panel sizes reflect age-band specific needs, as appropriate
 - Separate percent full time employee for OB-GYN care for adult females
 - Increased expanded care team allocation for pediatrics

PCIW Feedback – Modifications to the Maryland Care Team Builder Model *(Continued)*

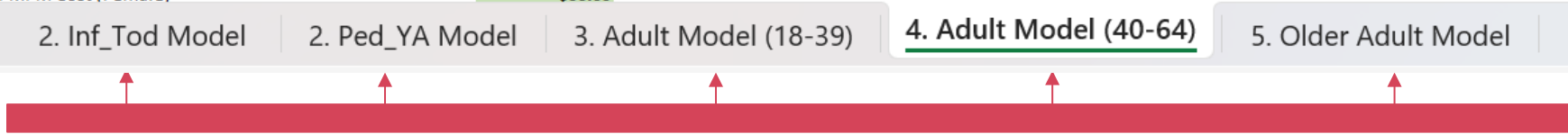


	Cost	FTE	FTE Annual Salary	Annual Full Compensation
12 Expanded Care Team (Female)				
13 RN Care Managers	\$15,450	0.1	\$82,400	\$107,120
14 Behavioral Health Clinician	\$54,206	0.7	\$57,820	\$75,166
15 Community Health Workers	\$57,960	0.9	\$51,520	\$66,976
16 Pharmacist	\$12,708	0.1	\$135,550	\$176,215
17 Nutritionist	\$34,304	0.3	\$78,410	\$101,933
18 Total Expanded Care Team Cost	\$174,628			
19 "Commercial" PMPM Expanded Care Team Cost (Female)	\$1.82			
20 Traditional Care Team				
21 Physician (MD/DO includes limited Psych Care in AHEAD definition)	\$1,501,263	4.3	\$269,458	\$350,295
22 OB-GYN services included in AHEAD model	\$222,515	0.5	\$342,330	\$445,029
23 Mid-Level (e.g., NP, Midwife)	\$241,085	1.4	\$129,815	\$168,760
24 Total PCPs	\$1,742,348	6	n/a	
25 Medical Assistant or Licensed Practical Nurse	\$426,883	6	\$57,465	\$74,705
26 Traditional Care Team Cost	\$2,169,231			
27 "Commercial" Traditional Care Team PMPM Cost (Male)	\$22.60			
28 "Commercial" Traditional Care Team PMPM Cost (Female)	\$27.23			
29				
30 Total "Commercial" PMPM Cost	Cost			
31 Total Number of Patients (Panel size for age/gender = 1400/per PCP)	8,000			
32 Staffing Costs (Traditional&Expanded Care Team) PMPM, Male	\$24.16			
33 Staffing Costs (Traditional&Expanded Care Team) PMPM, Female	\$29.05			
34 Other Administrative and Overhead Costs PMPM	\$21.00			
35 Total "Commercial" PMPM Cost (Male)	\$45.16			
36 Total "Commercial" PMPM Cost (Female)	\$50.05			

The per PCP panel size estimates also reflect the [a Reasonable Patient Panel Annals of Family Medicine](#) limited scope of psychiatr

Difference in PC investment by gender among Maryland residents is far g variation may not be necessary or appropriate. To encourage appropriat among men and women with the exception of OB-GYN services.

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



PCIW Feedback – Modifications to the Maryland Care Team Builder Model *(Continued)*



Expanded Care Team	Cost	FTE	FTE Annual Salary	Annual Full Compensation
RN Care Managers, LCSWs	\$41,200	0.38	\$82,400	\$107,120
Behavioral Health Clinician	\$130,095	1.7	\$57,820	\$75,166
Community Health Workers/Lactation Consultant	\$125,194	1.9	\$51,520	\$66,976
Total Expanded Care Team Cost	\$296,489			
"Commercial" PMPM Expanded Care Team Cost (Male & Female)	\$3.09			

Traditional Care Team	Cost	FTE	FTE Annual Salary	Annual Full Compensation
Physician (MD/DO)	\$2,706,080	10.0	\$208,160	\$270,608
Mid-Level (e.g., NP)	\$562,532	3.3	\$129,815	\$168,760
Total PCPs	\$3,268,612	13	n/a	
Medical Assistant or Licensed Practical Nurse	\$996,060	13	\$57,465	\$74,705
Traditional Care Team Cost	\$4,264,672			
"Commercial" Traditional Care Team PMPM Cost (Male & Female)	\$44.42			

Total "Commercial" PMPM Cost	Cost
Total Number of Patients (Panel size for age/gender = 600/per PCP)	8,000
Staffing Costs (Traditional&Expanded Care Team) PMPM, Male & Female	\$47.51
Other Administrative and Overhead Costs PMPM	\$21.00
Total "Commercial" PMPM Cost, Male & Female	\$68.51

The "Other Administrative and Overhead Costs" sourced from [Workforce Configurations to Provide High-Quality, Primary Care: a Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices](#); adjusted for inflation using the [Calculator](#); Administrative costs include staffing for data analysis.

1. Overview | **2. Inf_Tod Model** | 2. Ped_YA Model | 3. Adult Model (18-39) | 4. Adult Model (40-64) | 5. Older Adult Model | 6. Expanded C ...

Accessibility: Investigate Display



PCIW Feedback – Modifications to the Maryland Care Team Builder Model *(Continued)*



Original Maryland Care Team Builder*

Age Band	PCP Panel Size including OB-GYN	Male Ideal	Female Ideal
<30	2000	\$34.07	\$36.22
30 to 65	1428	\$38.51	\$42.05
>65	900	\$47.50	\$52.90

Revised Maryland Care Team Builder*

Age Band	PCP Panel Size	OB-GYN Per PCP FTE	Male Ideal	Female Ideal
0-4	600		\$68.51	\$68.51
5-17	1600		\$41.40	\$41.40
18-39	1500	~.2	\$43.52	\$50.73
40-64	1400	~.1	\$45.16	\$50.05
65+	1400	~.05	\$46.40	\$49.71

*AHEAD Model includes limited scope of psychiatry and OB-GYN services. All dollars reflect per member, per month spending in 2024 dollars.



Key Discussion Questions

- ▶ Do the revised panel sizes better reflect differences in population needs, especially pediatrics?
- ▶ Do the salaries better reflect the mix of clinicians included in the AHEAD definition?
- ▶ Are there further adjustments that you would recommend?



A Process Review: Calculating Targets



Process for Developing the Targets

- ▶ **Step 1:** Use Maryland Care Team Builder model to calculate the age band/gender ideal for each age band/gender combination
- ▶ **Step 2:** Apply factor to adjust for inflation
- ▶ **Step 3:** Multiply by payer's member months for each age band/gender combination
- ▶ **Step 4:** Calculate weighted average target for each payer based on its population
- ▶ **Step 5:** Develop stepwise approach to reach target

Payer Target



STEP 1

STEP 2

STEP 3

Age Band	Male Ideal (in 2024 dollars, PMPM)	Female Ideal (in 2024 dollars, PMPM)	Male Ideal (in 2030 dollars, PMPM)	Female Ideal (in 2030 dollars, PMPM)	Female Payer Member Months	Female Target Spend	Male Payer Member Months	Male Target Spend
0-4	\$68.51	\$68.51	\$82.51	\$82.51	28,000	\$2,310,280	32,000	\$2,640,320
5-17	\$41.40	\$41.40	\$49.86	\$49.86	90,000	\$4,487,400	95,000	\$4,736,700
18-39	\$43.52	\$50.73	\$52.42	\$61.10	240,000	\$12,580,800	240,000	\$14,664,000
40-64	\$45.16	\$50.05	\$54.39	\$60.28	280,000	\$15,229,200	280,000	\$16,878,400
65+	\$46.40	\$49.71	\$55.88	\$59.87	30,000	\$1,676,400	30,000	\$1,796,100
All Age Bands/Genders Ideal Spend								\$76,999,600
All Age Bands/Genders Member Months								1,345,000
2030 Payer-Specific Target								\$57

STEP 4

Payer Progression Timeline



STEP 5

	2024	2025	2026	2027	2028	2029	2030
PC PMPM	\$35	\$37	\$40	\$43	\$47	\$52	\$57
% Increase		6%	7%	8%	9%	10%	10%
TME PMPM	\$412	\$464	\$480	\$497	\$514	\$532	\$551
% Spend	8%	8%	8%	9%	9%	10%	10%

Key Discussion Questions



- ▶ The largest proposed increases would be for adult men and children (5-17); does this resonate based on your experience?
- ▶ What strategies could payers and others use to increase primary care spend, specifically related to?
 - ▶ Increasing available workforce
 - ▶ Encouraging men to use more primary care
 - ▶ Improving access in underserved areas



Calculation of Medicaid Investment Target – Overview and Update



The Hilltop Institute

Medicaid AHEAD Primary Care Investment

The Hilltop Institute
February 24, 2026



UMBC

Overview

- Medicaid Primary Care Spend
 - Compare FFS vs. MCO approaches
- Discuss Member Counts
 - Full Benefit vs. Partial Benefit Member Counts
- Alignment Across AHEAD Projects

Data Sources

- Fee-for-service (FFS) participants
 - Medicaid Management Information System (MMIS)
 - AHEAD primary care specifications
- Managed care organization (MCO) participants
 - Primary care expenditures reported on the HealthChoice Financial Monitoring Report (HFMR) (audited MCO financial statements)
 - The HFMR primary care definition was recently updated to align with MHCC's primary care efforts in 2023; and
 - With extensive feedback and buy-in from the 9 MCOs

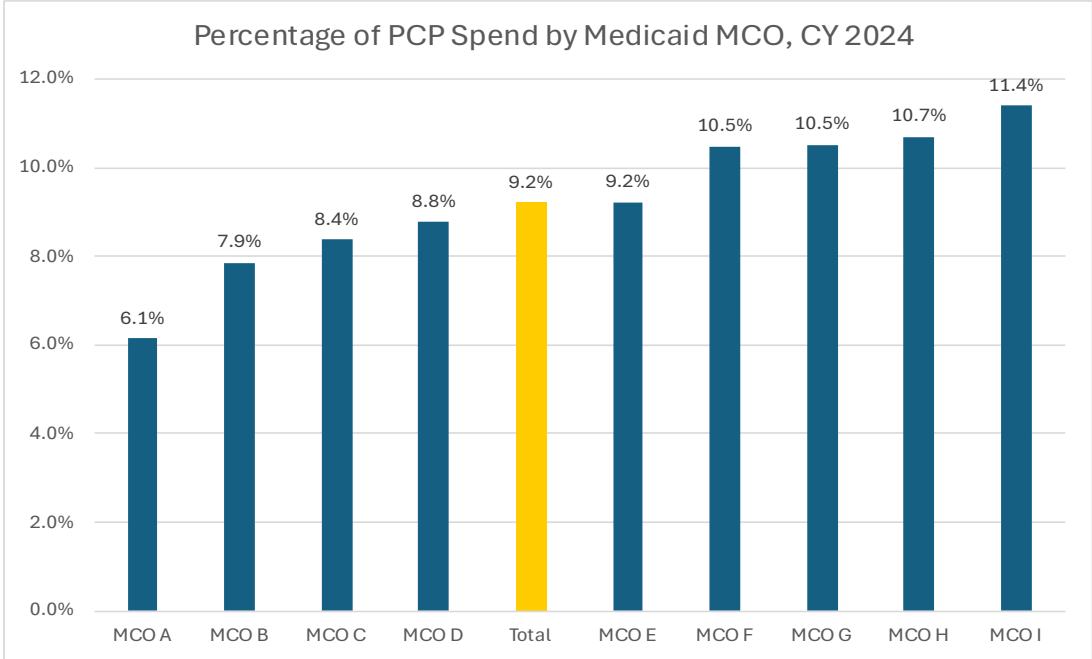
Comparing AHEAD and HFMR Approaches

- MCOs do not always report the amount spent on primary care on MMIS claims due to various reasons, such as sub-capitated arrangements or staff physicians, etc.

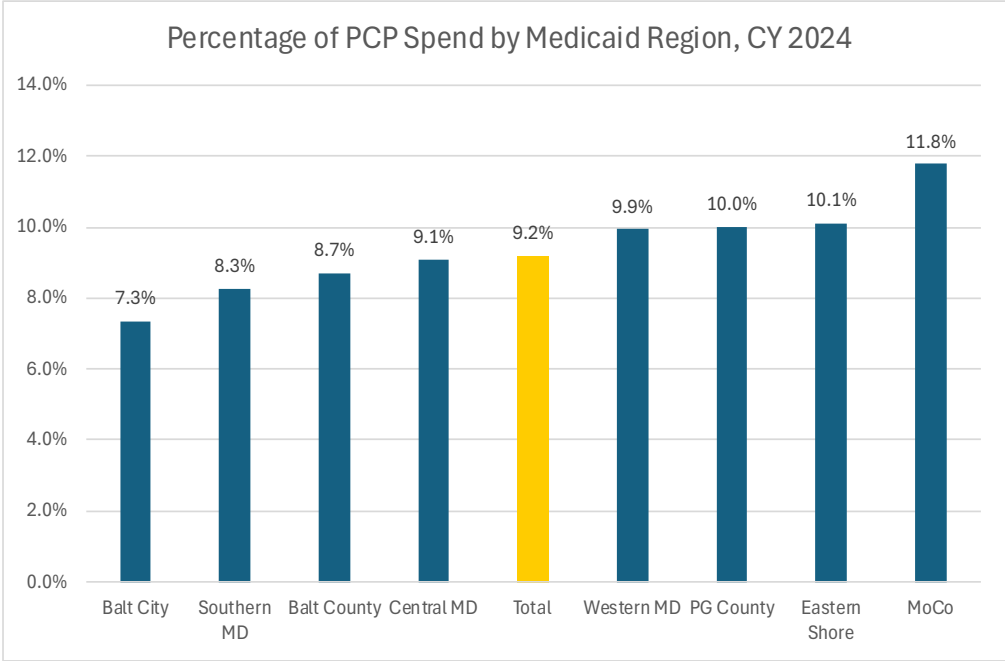
Percent of Total Spend for Primary Care, CY 2024

MCO	HFMR Method	AHEAD Method
MCO A	11.4%	1.8%

Medicaid Managed Care PCP Spend By Medicaid MCO



Medicaid Managed Care PCP Spend By Region



Measures

- Summarize total costs, members, and member months:
 - Total Medicaid expenditures
 - Total primary care expenditures
- Further breakdown:
 - Members who receive a full Medicaid benefit
 - Members who receive a partial Medicaid benefit, e.g., family planning only, members receiving emergency Medicaid benefits, and dual Medicaid and Medicare eligibles

Alignment Across Projects

- Where possible, ensure measure alignment across the various AHEAD projects
 - AHEAD Primary Care Investment
 - AHEAD Total Cost of Care

About Hilltop

The Hilltop Institute is a nonpartisan research organization at the University of Maryland, Baltimore County (UMBC) dedicated to improving the health and wellbeing of people and communities. We conduct cutting-edge data analytics and translational research on behalf of government agencies, foundations, and nonprofit organizations to inform public policy at the national, state, and local levels.

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Report Planning

Milestones



- ▶ Complete geographic analyses to identify areas where targeted community investments can address disparities and improve outcomes
- ▶ Establish payer specific primary care investment targets in collaboration with stakeholders
 - Convene listening sessions on proposed targets
 - Track payer performance against the targets and publish progress beginning in 2027
- ▶ Present the proposed investment target recommendations to the Commission

Timeline



Step	Timeline
Consider the PCIW feedback on the draft payer-specific primary care investment target model	February 25th – March 1st
Complete all-payer, Medicare Advantage, Commercial, Medicaid and State Health Plan Targets	February – March
Meetings with payers to discuss individual targets	March 9th – March 20th
Convene the PCIW to review draft all-payer, Commercial Fully Insured, Medicaid and State Employee Health Plan targets	March – April
Convene Listening Session	April – May
Submit draft calendar year 2027 – 2030 primary care investment methodology and targets to the Governor	May



Approach for AHEAD Total Cost of Care Targets



maryland
health services
cost review commission

All-Payer Total Cost of Care Target Technical Advisory Committee Overview for the Primary Care Investment Workgroup

William Henderson

February 24, 2026

AHEAD Model Agreement

- Statewide accountability requirements under the AHEAD model include targets for all-payer total cost of care (TCOC) growth and all-payer primary care investment.
- Section 10. Statewide Accountability Targets (All-Payer TCOC Growth Targets)
 - Prior to PY1 (CY 2026), the State must establish the process to set all-payer TCOC growth and primary care investment targets through an executive order, legislation or regulation.
 - No later than ninety days prior to the start of PY2 (CY 2027), the State must provide to CMS the all-payer TCOC growth and primary care investment targets for each of PYs 2-5, at a minimum. (The State may opt to propose targets for PYs 6-10 90 days before the start of each performance year.)
 - Failure to meet the targets--*i.e.*, missing two out of three years--may trigger enforcement actions by CMMI, such as a corrective action plan, but would not trigger termination of the model.

Executive Order

- The State's commitment to establishing all-payer TCOC and primary care investment targets, which will apply across all Maryland health care markets and populations, has been memorialized in an [Executive Order](#) issued by the Governor. This was a requirement of the AHEAD Model, due prior to the end of December 2025.
- The Executive Order commits the HSCRC, MHCC, MDH, MIA and MHBE to:
 - Collecting and analyzing data and developing a target-setting methodology, as informed and advised by stakeholders; and
 - An initial submission for PYs 2-5 in 2026, followed by annual timeframes for draft and final targets for PYs 6-10.

Advisory Group Charge and Role

- In accordance with the Executive Order's requirements for stakeholder input, this short-term advisory committee was formed to inform the target-setting methodology for all-payer total cost of care growth under the AHEAD model.
 - The Advisory Committee serves as a forum for discussion to provide informed feedback and recommendations in support of staff and leadership decision-making for the all-payer total cost of care growth target-setting by September 2026.
 - The Advisory Committee functions in an advisory capacity to State leadership.
- The State is managing the commitment to establish targets through the AHEAD Regulatory Working Group established by a Governor's Directive to manage various multi-agency priorities and support the success of the AHEAD model.
- This includes the parallel primary care investment target, led by MHCC.

Advisory Committee Composition

- Leadership: Health Services Cost Review Commission (HSCRC) Executive Director Jon Kromm, Insurance Commissioner Marie Grant and Maryland Health Care Commission (MHCC) Executive Director Doug Jacobs
- Staff: HSCRC, Maryland Insurance Administration (MIA), MHCC, Medicaid
- Representatives from:
 - Hospitals
 - Providers
 - Payers
 - Labor
 - Consumers
 - Academia/Independent
 - Employers
 - Maryland Hospital Association
 - MedChi
 - CRISP
 - League of Life and Health Insurers

Process Timeline

Milestone	Action Items	Due Date
Advisory Group Meeting #1	Advisory Committee Introduction	February 5, 2026
Advisory Group Meeting #2	Review Key Considerations and Make Initial Recommendations	February 23, 2026
Written Public Comment Period		February 23 – March 20, 2026
Advisory Group Meeting #3	Public Listening Session and Revise Recommendations as Needed	April 10, 2026
Draft methodology and targets due to the Governor		May 2026
Submit CY 2027-2030 targets to the Governor and CMMI		September 2026

*Ad-hoc meetings may be scheduled prior to the final submission to CMMI



Update on Maryland's AHEAD Primary Care Programs

The End





Appendix



State Law

Chapter 667 (Senate Bill 734), *Maryland Health Care Commission – Primary Care Report and Workgroup (2022)*

- ▶ Requires the Maryland Health Care Commission (MHCC) to conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending
- ▶ The MHCC must convene a Primary Care Investment Workgroup (PCIW) 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
 - The PCIW members represent primary care clinicians, commercial payers, medical societies, Medicaid, and select State agencies

Executive Order



The State of Maryland Executive Department

EXECUTIVE ORDER

01.01.2025.28

Establishing All-Payer Total Cost of Care Growth and Primary Care Investment Targets in Maryland

- WHEREAS, Affordable and accessible health care is essential to the health and overall well-being of Maryland residents, families, and communities and is the foundation on which we build safer neighborhoods and more vibrant communities;
- WHEREAS, The Moore-Miller Administration is committed to strengthening Maryland's economic competitiveness in health care through policies, regulations, and actions;
- WHEREAS, Marylanders report worrying about affording health care in the future, and low-income residents and residents with disabilities are more likely to delay or forego needed health care due to costs;
- WHEREAS, Advancing a comprehensive, all-payer approach to addressing total cost of care growth is critical to expanding on work initiated by the Total Cost of Care model, and to fulfilling contractual obligations with the Centers for Medicare and Medicaid Services required by the AHEAD model; and
- WHEREAS, Primary care is the foundation for high-quality whole-person care for all Marylanders, and investment and support of primary care is necessary to ensure prevention and treatment of illness, early detection of health issues to avoid longer-term complications, and proper management of chronic conditions.
- NOW, THEREFORE, I, WES MOORE, GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

- A. Establishing all-payer total cost of care and primary care investment targets.
1. It is the policy of the State to address the rate of health care spending growth by establishing an all-payer total cost of care growth target annually starting in calendar year 2027 and each calendar year thereafter.
 2. It is the policy of the State to address primary care investment by establishing an all-payer primary care investment target annually starting in calendar year 2027 and each calendar year thereafter, informed by the recommendations in the report required under Chapter 667 of the Acts of 2022 and codified at §19-108.4 of the Health-General Article.
 3. These targets shall apply across all Maryland health care markets and populations.
- B. The Multi-Agency Regulatory Working Group, established by the Governor's Directive: *Creation of Regulatory Working Group*, issued September 23, 2025, shall:
1. By no later than February 2026, initiate engagement with stakeholders to develop and advise on the development of the statewide all-payer total cost of care growth target;
 2. By no later than February 2026, initiate engagement with the Maryland Health Care Commission's Primary Care Investment Workgroup and other stakeholders to develop and advise on development of a primary care investment target;
 3. Update legislators on the development of the statewide all-payer total cost of care growth target and primary care investment target;
 4. Assess data assets and data authorities, including those held by the State-designated health information exchange, and determine which data can be utilized to assess performance relative to a target;
 5. Engage relevant regulated entities to assess data assets and furnish data required to assess performance relative to a target, within the limits of statutory authority;

Executive Order *(Continued)*



6. Establish and engage in data collection, verification, analysis, and reporting processes;
7. Document a Statewide all-payer total cost of care growth target and primary care investment target methodology;
8. Develop, in consultation with stakeholders, policies and strategies to support attainment of the all-payer total cost of care growth targets and primary care investment targets.
9. Submit draft calendar year 2027-2030 all-payer total cost of care growth methodology and targets and primary care investment methodology and targets to the Governor no later than May 2026;
10. Submit final calendar year 2027-2030 all-payer total cost of care growth methodology and targets and primary care investment methodology and targets to the Governor no later than September 2026;
11. Starting in 2030 and applicable for all years thereafter, submit draft all-payer total cost of care growth targets and primary care investment targets to the Governor no later than May of calendar year preceding the target; and
12. Starting in 2030, submit final all-payer total cost of care growth targets and primary care investment targets to the Governor no later than September of the calendar year preceding the target.

C. General Provisions

1. This Executive Order shall be implemented in a manner that is consistent with all applicable statutes and regulations. Nothing in this Executive Order shall operate to contravene any State or federal law or to affect the State's receipt of federal funding.
2. If any provision of this Executive Order or its application to any person, entity, or circumstance is held invalid by any court of competent jurisdiction, all other provisions or applications of the Executive Order shall remain in effect to the extent possible without the invalid provision or application. To achieve this purpose, the provisions of this Executive Order are severable.

3

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, Anne Arundel County, this 19th Day of December, 2025.

Wes Moore
Governor

ATTEST:



Susan C. Lee
Secretary of State

4

Executive Order – Important Dates



- ▶ By no later than February 2026, initiate engagement with the PCIW and other stakeholders to develop and advise on development of a primary care investment target
- ▶ Submit draft calendar year 2027-2030 all-payer total cost of care growth methodology and targets and primary care investment methodology and targets to the Governor no later than May 2026
- ▶ Submit final calendar year 2027 – 2030 all-payer total cost of care growth methodology and targets and primary care investment methodology and targets to the Governor no later than September 2026
- ▶ Starting in 2030 and applicable for all years thereafter, submit draft all-payer total cost of care growth targets and primary care investment targets to the Governor no later than May of calendar year preceding the target
- ▶ Starting in 2030, submit final all-payer total cost of care growth targets and primary care investment targets to the Governor no later than September of the calendar year preceding the target

House Bill 494 *Health Insurance - Primary Care Investment Targets - Reimbursement and Reporting*



- ▶ Introduced during 2026 session
- ▶ Requires carriers to provide reimbursement to health care providers in a manner that meets the annual primary care investment targets established by the State on or after February 1, 2026
- ▶ Carrier must submit a description of the carrier's progress in meeting the annual primary care investment targets when filing a premium rate or premium rate change with the Insurance Commissioner



Example Target Scenarios

Ideal Target Scenario



Year Over Year (YoY) Increases of 10% to 20% (Plan Year (PY) 2 – PY5)	Commercial Payers – Per Member Per Month (PMPM)
2024	\$35
2025	\$35
2026	\$35
PY 2 2027	\$37
PY 3 2028	\$40
PY 4 2029	\$44
PY 5 2030	\$50
<i>Ideal Target 2030</i>	\$50
<i>Variance to Target</i>	\$0
TME 2030	\$501
% TME 2030	10.0%

- The Medical Economic Index is applied to the Maryland Care Team Builder Model for all example target scenarios to calculate years 2025-2030
- Primary care spend for 2024-2026 assumes no increases from 2023 in all example target scenarios
- Achieves Ideal Target
- Increases from 8.5% to 10.0% total medical expense
- Faster pace of increase than Medicare AHEAD primary care target, which is flat as a percent of total medical expense through 2031

Progressive Target Scenario



YoY Increases of 7% to 12% (PY2 – PY5)	Commercial Payers – PMPM
2024	\$35
2025	\$35
2026	\$35
PY 2 2027	\$36
PY 3 2028	\$39
PY 4 2029	\$43
PY 5 2030	\$48
<i>Ideal Target 2030</i>	\$50
<i>Variance to Target</i>	-\$2
TME 2030	\$501
% TME 2030	9.6%

- Significant progress towards Ideal Target
- Increases from 8.5% to 9.6% total medical expense
- Faster pace of increase than Medicare AHEAD primary care target, which is flat as a percent of total medical expense through 2031

Moderate Target Scenario



YoY Increases of 7% to 12% (PY2 – PY5)	Commercial Payers – PMPM
2024	\$35
2025	\$35
2026	\$35
PY 2 2027	\$36
PY 3 2028	\$38
PY 4 2029	\$41
PY 5 2030	\$45
<i>Ideal Target 2030</i>	\$50
<i>Variance to Target</i>	-\$5
TME 2030	\$501
% TME 2030	9.0%

- Some progress towards Ideal Target
- Increases from 8.5% to 9.0% total medical expense
- Faster pace of increase than Medicare AHEAD primary care target, which is flat as a percent of total medical expense through 2031