Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets

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Acronyms

Acronym	Definition
AHEAD Model	Achieving Healthcare Efficiency through Accountable Design Model
CCLF	Claim and Claim Line Feed
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer price index
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar year
E&M	Evaluation and management
EQUIP-PC	Episode Quality Improvement Program - Primary Care
ERISA	Employee Retirement Income Security Act
FEHBP	Federal Employee Health Benefit Program
FFS	Fee-for-service
FHC	Freedman HealthCare
FQHC	Federally Qualified Health Center
FTE	Full time equivalent
FY	Fiscal year
GSP	Gross state product
HCPCS	Healthcare Common Procedure Coding System
HFMR	HealthChoice Financial Monitoring Report
HSCRC	Health Services Cost Review Commission
MCDB	Medical Care Data Base
MCO	Managed care organization
MCTB Model	Maryland Care Team Builder Model
MDH	Maryland Department of Health
MDPCP	Maryland Primary Care Program
MHBE	Maryland Health Benefit Exchange
MHCC	Maryland Health Care Commission
MIA	Maryland Insurance Administration
MMIS	Medicaid Management Information System
OB/GYN	Obstetrics/Gynecology
PC AHEAD	Primary Care AHEAD
PCIW	Primary Care Investment Workgroup
PHAP	Population Health Accountability Plan
PMPM	Per member per month
RHC	Rural health clinic
RHTP	Rural Health Transformation Program
SEHP	State Employee Health Plan
S&P	Standard and Poor's
TCOC	Total cost of care

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Acronym	Definition
TME	Total medical expenses

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Introduction

Statewide accountability requirements under the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model include targets for all-payer total cost of care (TCOC) growth and all-payer primary care investment. Per the timelines required by the AHEAD Model, the State memorialized its commitment to both targets in an Executive Order issued by Maryland Governor Wes Moore in December 2025. The Maryland Health Services Cost Review Commission (HSCRC) is leading the development of the TCOC growth target component, and the Maryland Health Care Commission (MHCC) has built on its historical efforts to lead the primary care investment component.

In November 2025, the State of Maryland and the Center for Medicare and Medicaid Innovation (CMMI) executed an Amended and Restated AHEAD Model Maryland State Agreement. The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment and population health outcomes results in improved population health and healthier living, enhanced quality outcomes and lowered growth of health care costs.

Achieving success under the AHEAD Model demands a coordinated and proactive approach across multiple state agencies. On September 23, 2025, Governor Moore directed the Secretary of Health to form a multi-agency Regulatory Working Group on his behalf composed of representatives from the Maryland Department of Health (MDH), Maryland Insurance Administration (MIA), HSCRC, MHCC and the Maryland Health Benefit Exchange (MHBE) to collaborate on policy proposals that will enable the State of Maryland to achieve the goals and objectives set forth in the AHEAD Model.

The Regulatory Working Group identified the development of state accountability targets under the AHEAD Model–namely, all-payer targets for TCOC growth and primary care investment–among its stated priorities, according to its October 2025 workplan. The workplan also communicated a shared commitment to leveraging stakeholder expertise by soliciting insight, input and guidance to the greatest extent possible through listening sessions, opportunities for public comment and the integration of stakeholder input during the development of policy recommendations.

1. All-Payer Total Cost of Care Growth Target

The AHEAD Model requires participating states to implement an all-payer TCOC growth target. This requirement builds on momentum created by other states in developing and implementing their own targets, in response to the continued rising cost of health care and concerns about affordability and sustainability.[1] Under AHEAD, the State was required to establish the process to set the all-payer TCOC target–*i.e.,* via executive order, legislation or regulation–prior to the end of calendar year (CY) 2026. Governor Moore released Executive Order 01.01.2025.28 on December 19, 2025, thus meeting the model

[1] Fisher, E., Colla, C., Koller, C., & Berube, A. (2024). Addressing health care growth – why and how states should lead. *New England Journal of Medicine, 391*(14), 1271-1273. https://doi.org/10.1056/NEJMp2409365

requirement. (The Executive Order can be found on the [HSCRC's AHEAD Model Website].) Following the issuance of the Executive Order, the State must submit the targets for CY 2027 though CY 2030, at a minimum, to CMMI by September 30, 2026. 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.[2]

The Regulatory Working Group, led by the HSCRC, established the All-Payer Total Cost of Care Target Technical Advisory Committee (Advisory Committee) to inform the target-setting methodology for total cost of care growth (see Stakeholder Engagement, below). The following section describes the draft methodology as recommended by the Regulatory Working Group, in consultation with the Advisory Committee.

1.1 Methodology

1. The cost growth target will comprise a 50/50 blend of wage growth and gross state product (GSP).[3] The target will be derived from the historical trend from CY 2023 through CY 2025. (See Table 1, below.)
2. The analysis will use a single-year baseline of CY 2026.
3. The trend will be measured in cumulative three-year performance periods and will be rebased to a new baseline year after each three-year window.[4] The first three-year window will be 2027 to 2029.
4. The target will be reset based on a more-recent window for the growth benchmark, using a five-year window (*i.e.,* once available vis-a-vis post-pandemic trend stabilization).
5. The target will be compared to actual Maryland total cost of care growth measured across Medicare (both fee-for-service and Medicare Advantage), Medicaid and Commercial health care costs, calculated as described below.
6. Annual reporting to CMMI will include metrics identified to monitor access, affordability and quality derived from existing reporting available in other forums.

[2] Under the AHEAD Model, a determination by CMS that the State has failed to meet the all-payer TCOC growth target in any two years within a period of three consecutive years is considered a triggering event. In such instances, CMS would provide the State with a written warning notice, to which the State must provide a comprehensive response within 30 days. Should CMS not accept the State's response as sufficient, CMS may provide the State with a written enforcement action notice. Potential enforcement actions include a corrective action plan; a request for additional information; additional monitoring, auditing or both; a requirement for the State to propose new safeguards or programmatic features; and modification or termination of a Medicare payment waiver or waivers granted under the model. In the case of a corrective action plan, the State would have 45 days to submit its proposed plan for CMS approval.

[3] The Regulatory Working Group initially preferred median household income; however, the data are not released in time to meet the State's reporting requirements.

[4] Due to data lags the baseline value will not be available until partway through the initial year of each three-year window. The State will develop a process for estimating the value to allow for interim reporting.

Table 1. Recommended All-Payer TCOC Growth Target[5]

Economic Indicator	2023	2024	2025	Target (CY 2027 - CY 2029)
Gross State Product[6]	6.9%	6.0%	4.0%	5.2%
Wage Growth[7]	5.3%	6.4%	2.6%	

The following sections provide additional detail on the proposed methodology and considerations weighed by the Regulatory Working Group, as well as received through stakeholder input. The Regulatory Working Group conclusions described below reflect recommendations reached after consultation with the Advisory Committee and review of written and verbal testimony provided by stakeholders.

1.2 Background and Guiding Principles

Maryland is well-positioned for this initiative, having managed an all-payer hospital growth target–launched under the All-Payer Model–since 2014 and a Medicare TCOC target since 2018, as required by the Total Cost of Care Model. Expanding to all markets and all settings constitutes a natural progression from Maryland's success under the previous models.

Maryland has the opportunity to learn from the experience of other states in setting and implementing all-payer TCOC growth targets. Each state with a growth target has utilized a public process to solicit expertise in establishing their targets. Across the states with cost growth targets, all have tied their targets to a measure of the economy, such as gross state product (GSP) or a measure of affordability such as household income or wage growth.[8,9] Performance has varied, with growth outpacing the benchmark on some occasions. With this in mind, states have built in the flexibility to respond to exogenous factors, as well as mechanisms to identify cost drivers.

Maryland's all-payer TCOC growth target rests on the foundation of a set of principles, which were discussed and informed by the Advisory Committee (see Stakeholder Engagement, below). These

[5] Based on data accessed May 2026. HSCRC staff will refresh the data as updated numbers are published.
[6] Bureau of Economic Analysis, State Annual GDP Summary.
[7] Bureau of Economic Analysis, Wages and Salaries by NAICS Industry.
[8] Freedman HealthCare. (2026, February 5). *Total Cost of Care Targets* [PowerPoint slides]. https://hscrc.maryland.gov/Documents/AHEAD/Advisory%20Group/All-Payer%20TCOC%20Technical%20Advisory%20Committee%20Meeting%201%201.26.2026%20FINAL.pdf.
[9] Bailit Health. (2026, April 17). *Considerations for Setting Total Cost of Care Spending Growth Targets* [PowerPoint slides]. https://hscrc.maryland.gov/Documents/AHEAD/Advisory%20Group/All-Payer%20TCOC%20Technical%20Advisory%20Committee%20Meeting%204%204.17.2026%20FINAL.pdf. The State also leveraged additional background information provided by Mathematica.

principles guided the development of the target and will also serve as touch points as the State moves forward with implementing the target.

The selected metric should be relevant to the public.
While the design and measurement of an all-payer TCOC growth target are technical in nature, one of the major intended impacts is to benefit consumer affordability. Employing economic indicators such as wage growth or household income creates relevance for the public.

The selected target should be meaningful, achievable and sustainable.
TCOC growth targets aim to foster meaningful sustainability in health care costs by comparing health care growth with broader economic growth. Given continued high rates of health care growth across the nation, other states' experience in meeting such targets, to date, have demonstrated mixed results. This may be a result of variable trends among payers, as well as the impact of the COVID-19 pandemic.[10] Maryland's target must strive to bring health care cost growth more in line with the economy in a sustainable way.

The selected target should serve as an "alert" mechanism for the health care system.
Not all health care spending is unexpected or unavoidable. The growth target will function as a mechanism to alert the health care system, regulatory, policymakers and others of excessive growth and the need for potential intervention.

The selected target should be prospectively set with flexibility to adapt.
A prospectively-set target, rather than one that employs frequent or regular adjustments–*e.g.,* according to trends in inflation–fosters predictability and stability in the health care system. With that said, the target should allow for adjustment in the case of exogenous factors that would merit a departure from the established methodology.

The selected target should reflect systemwide accountability and actionability.
As reflected in the Governor's Directive, the AHEAD Model requires accountability across the health care system from payers, providers, government and other entities. Achieving meaningful and sustainable success demands that no one part of the health care system is responsible alone. State regulatory agencies must work together to identify and apply levers as necessary to address excessive cost growth.

1.3 Counterfactual

The goal of the all-payer total cost of care growth target is to tie growth to affordability. As described above, states have implemented an all-payer total cost of care growth target measure against an economic indicator, such as GSP, projected GSP, wage growth, household income or a blend. Using a health care metric–such as the National Health Care Expenditure trend–is self-referential. If health care spending

[10] Bailit, M., Angeles, J., Block, R. States are exceeding their health care cost growth targets. What does it mean? Health Affairs Forefront. 2026. doi: 10.1377/forefront.20260610.549590

growth consistently exceeds economic growth, it creates affordability challenges for both consumers and businesses.

The Regulatory Working Group considered several factors in recommending a hybrid counterfactual that weighs GSP equally with wage growth. As noted in the Principles section above, wage growth and household income tie more closely to individual experience, with a stronger connection to consumer affordability. As a measure of the broader economy, GSP may better reflect the experience of employers, who pay the biggest share of commercial insurance costs.

After extensive discussion, the Regulatory Working Group also proposes setting the trend based on historic values, rather than projections. Though predicted values may better reflect future direction, they are subject to prediction error and would require a source for predicted values specific to Maryland. Historic values, on the other hand, are not subject to prediction biases. The recommended historical trend will be set using data from CY 2023 through CY 2025 (see Data Sources below). The multi-year trend provides stability, and starting with CY 2023 mitigates impacts from the COVID-19 pandemic. The HSCRC will continue to monitor the trend and proposes resetting the growth benchmark for a longer period, as the post-pandemic trend continues to stabilize.

Because CY 2027 is the first measurement year, the Regulatory Working Group proposes CY 2026 as a baseline. After careful consideration and stakeholder input, the analysis will employ a cumulative, three-year target. Most states utilize annual targets for total cost of care growth, as they may be more actionable if excessive growth is demonstrated, and businesses and consumers experience growth on an annual basis–it is not automatically easier to digest a high increase in one year because there was a low increase in the previous. Cumulative targets also allow for the possibility of "banking," or success or failure where current year targets become meaningless due to cumulative prior successes or failures.

The Regulatory Working Group acknowledged these concerns but recommended a cumulative multi-year target because of concerns that: 1) due to the different factors driving health care cost growth versus general economic growth, it may not be feasible to meet targets on a single-year basis, and the focus should be longer term; and 2) because resetting every year eliminates and thereby devalues the impact of successes and failures in prior years. By limiting the cumulative target to a three-year window, the Regulatory Working Group hopes to avoid the "banking" concern.

Following is an illustration of the proposed trend for CY 2027 - CY 2030.

1) State calculates three-year growth trend (CY 2023 - CY 2025) using wage growth and GSP, weighted equally.
2) State defines the baseline year as CY 2026.
   a) For first report, *i.e.*, of CY 2027 performance, the growth target will be set at CY 2026 * (1 + trend from Step 1)
   b) For second report, *i.e.*, of CY 2028 performance, the growth target will be set at CY 2026 * (1 + trend from Step 1) * (1+ trend from Step 1)
   c) For third report, *i.e.*, of CY 2029 performance, the growth target will be set at CY 2026 * (1 + trend from Step 1) * (1+ trend from Step 1)* (1+ trend from Step 1)

3) Baseline resets to 2029 and growth target is calculated based on CY 2024 - CY 2028 economic indicators.
    a) For fourth report, *i.e.*, of CY 2030 performance, the growth target will be set at CY 2029 * (1 + trend from Step 3)

As outlined in the principles, though set prospectively, the target methodology builds in flexibility to adjust for exogenous factors. This could include global pandemics, unusually high or low inflation or higher-than-expected growth, *e.g.,* in out-of-pocket costs or prescription drugs. Additionally, achieving the AHEAD Model's primary care investment target may elevate expenditures in certain years and cause the State to miss the TCOC growth target. Resulting adjustments should be set at a sensitivity level such that they are only triggered in the case of extreme fluctuations or impacts to trend.

1.4 Data Parameters

This section details the costs that will be included in the all-payer TCOC growth analysis, as well as the data sources that will support the analysis. Additionally, the Regulatory Working Group, in consultation with the Advisory Committee, considered several other factors, which are recommended either for exclusion or for monitoring status, *i.e.,* excluded and tracked separately.

1.4.1 Inclusions

The all-payer TCOC growth target will include costs for health care services that are broadly accessed across populations. The analysis will rely on allowed costs. Because the analysis relies on sources that provide data by health care payer, included populations are categorized by type of health care coverage. Importantly, the recommended policy builds on the success of the All-Payer and Total Cost of Care Models in that it expands to services not historically included in total cost of care calculations in Maryland. Table 2 displays the recommended inclusions, with rationale for each included population or service.

Table 2. Recommended Inclusions for All-Payer Growth Target

Inclusion	Rationale
Commercially-Insured (non-ERISA, non-FEHBP)	Data available from MCDB
Commercially-Insured (ERISA, FEHBP)	Will initially be estimated based on commercial claims (*i.e.,* from the MCDB); Electronic Health Network data and/or other reporting sources may be leveraged in the future.[11]
Medicare FFS	Data available from CMS
Medicare Advantage	Data available from MCDB (excluding one plan)

[11] The State does not believe trends in ERISA and non-ERISA plans will vary materially over time.

Inclusion	Rationale
Medicaid (Non-Duals)	Managed care data available from HealthChoice Financial Monitoring Reports; FFS data available from MMIS. Analysis will include member months and costs for services provided through both managed care organizations and on a FFS basis.
Medicaid (Full Duals)	Data for Medicaid services provided to full duals available from MMIS. Member months for full duals will be excluded, as they are already counted under Medicare. (Both costs and member months for partial duals will be excluded, as they are already counted under Medicare.)
Non-Claims-Based Payments	Important requirement of AHEAD Model; key feature of primary care investment measurement. Available from CMS, Medicaid and via the MCDB for commercial insurance.
Pharmacy	Major cost driver. Reporting will also display the trend excluding pharmacy and will be monitored as a potential exogenous factor. Available from CMS, Medicaid and via the MCDB for commercial insurance.

1.4.2 Data Sources

Maryland has considerable resources for measuring all-payer total cost of care targets. The current and envisioned data sources accessible to the HSCRC and MHCC have provided the State with the ability to measure all-payer expenditures without having to request new summary reports from commercial payers. A completion factor will be applied to sources with fewer than 12 months of data available for run-out.

Maryland Medical Care Data Base

The Maryland Medical Care Data Base (MCDB)–Maryland's all-payer claims database–is administered by MHCC and includes claims from Medicare, Medicaid, commercial plans not subject to the Employee Retirement Income Security Act (ERISA), Medicare Advantage and state and local government employee plans. All sources include pharmacy data. MHCC administers the MCDB. Run-out: Three months.

Centers for Medicare and Medicaid Services Data

The Centers for Medicare and Medicaid Services (CMS) provides Maryland with the Claim and Claim Line Feed (CCLF) data files, a set of Medicare claims files incorporating all Medicare Part A, B and D claims. These files contain beneficiary claim level data including Medicare payment amounts, diagnoses, procedures, dates of service, provider identifiers and beneficiary copayment amounts. Part D drug information does not contain pricing information; Part D drugs will be priced based on published rates Run-out: Three months.

Maryland Medicaid Management Information System

The Maryland Medicaid Management Information System (MMIS2) includes information on Medicaid enrollment and service utilization, *i.e.,* FFS claims and managed care encounters. The Hilltop Institute at

the University of Maryland, Baltimore County serves as the warehouse for Maryland Medicaid FFS claims and managed care encounters received via MMIS2 (and previously MMIS1). Run-out: 12 months.

HealthChoice Financial Monitoring Report
The HealthChoice Financial Monitoring Report (HFMR) is an annual report submitted to The Hilltop Institute by each managed care organization (MCO) operating in Maryland Medicaid's HealthChoice managed care demonstration. It includes detailed expense and utilization data and serves as a supplemental schedule to an MCO's quarterly and annual reports to the MIA. Run-out: 12 months.

Electronic Health Network Data
Electronic health networks, also known as clearinghouses, exchange electronic health care transactions between providers and payers. Maryland statute requires electronic health networks, with MHCC oversight, to submit data to the Chesapeake Regional Information System for our Patients (CRISP) for public health and clinical purposes. Data submission is envisioned to begin in fall 2026; data quality will be regularly monitored for readiness to support AHEAD Model targets, *e.g.,* ERISA plans and the Federal Employee Health Benefit Program (FEHBP). As noted in Table 2 above, until the EHN data are available, the State will use a proxy trend based on available commercial data from the MCDB. The use of the proxy measure is temporary, and the trend will be closely monitored to ensure the estimate does not distort the overall outcome.

As the state-designated health information exchange, CRISP supports interoperability and data exchange across multiple systems, partners and domains. CRISP will administer the upcoming electronic health network data on behalf of the State.

1.4.3 Exclusions

Certain populations, payments and service types will be excluded from the calculation of the growth target themselves but tracked as part of broader monitoring and reporting. Table 3 displays the recommended metrics that will be followed separately and the rationale for doing so.

Table 3. Recommended Exclusions from All-Payer Growth Target for Separate Tracking

Exclusion for Monitoring	Rationale
Pharmacy Rebates	Data currently not available at the level of granularity needed for the calculation; data are available in the aggregate and will be reported as such.
Self-Pay, *i.e.,* Uninsured	No data source(s) to reliably demonstrate breadth of health care utilization and cost for these individuals; cost of hospital services is already represented in global budget revenue system. Hospital case-mix data may be used to display utilization trend.

The analysis will exclude certain benefit types, payments and services. Table 4 displays recommended exclusions and the rationale for excluding.

Table 4. Recommended Exclusions from All-Payer Growth Target

Exclusion	Rationale
Dental Plans	Not uniformly covered by all payers.
Worker's Compensation and Other Non-Health Insurance Coverage	Relatively small; difficult to quantify; not traditional health care coverage.
Payments Already Included from Other Sources: ● Crossover Claims from Duals Medicaid Analysis ● Medicare Supplemental (*i.e.,* Medigap) ● Third-Party Coverage	Analysis uses allowed costs; excluded to avoid duplication.
Medicaid Specialty Services: ● Developmental Disability Services ● Adult Medical Day Care ● Home- and Community-Based Services	Not traditional health care services; already subject to budget neutrality test.
Cost of Insurance	The complexity in calculating insurance costs across payers led to the decision to focus on the cost of health care services themselves, as opposed to the cost of accessing the services, *i.e.,* insurance costs. Additionally, this information would not be available across all payers, *e.g.,* Medicare FFS.

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1.5 Reporting and Monitoring

Monitoring for unintended consequences, such as decreased access to care, is central to all-payer TCOC target implementation. In its annual compliance reporting to CMMI, which it will submit before December 31st of the following year, the HSCRC will include and reference measures of access and other priorities, which will be sourced from existing measures across the health care system. In advance of the first report–*i.e.,* on CY 2027 performance–the Regulatory Working Group will work with stakeholders to identify measures that will inform quality, access and affordability. Examples may include:

- Quality: AHEAD Population Health Accountability Plan and primary care measures
- Access: Changes in utilization among subpopulations of interest
- Affordability: Out-of-pocket spending, premium growth

1.6 Stakeholder Engagement Process

As noted above, on behalf of the Regulatory Working Group established per the Governor's Directive, the HSCRC established a technical advisory committee to inform the target-setting methodology for total cost of care growth. The Executive Order that memorialized the Regulatory Working Group agencies to establish the methodology and targets specifically requires the process to be informed and advised by stakeholders. The HSCRC has closely collaborated with MHCC in its development of the primary care investment target, with the previously-established Primary Care Investment Workgroup.

1.6.1 All-Payer Total Cost of Care Target Technical Advisory Committee

In December 2025, the HSCRC released a call for applications for the All-Payer Total Cost of Care Target Technical Advisory Committee. The opportunity was sent to stakeholders including State agencies, members of agency standing workgroups, payers, hospitals, providers and community advocates. The communication detailed the envisioned makeup of the Advisory Committee, to include representatives from hospitals, providers, employers, labor, consumers, independent experts (*e.g.,* academic economists) and life sciences experts. Applications were reviewed by members of the Regulatory Working Group; selected applicants were informed the week of January 19, 2026. (See Appendix A for a list of Advisory Committee members.)

The Advisory Committee charge included the following:

- Serve as a forum for discussion to provide informed feedback and recommendations in support of staff and leadership decision-making for the all-payer TCOC growth target-setting by September 2026; and
- Function in an advisory capacity to State leadership.

The Advisory Committee met four times between February and April 2026:

- February 5, 2026: Advisory Committee Introduction and Review of Charge
- February 23, 2026: Review of Key Considerations and Discussion of Initial Recommendations
- *February 23 - March 20, 2026: Written Public Comment Period*
- April 10, 2026: Public Listening Session
- April 17, 2026: Discussion on Recommendations

All meetings were virtual and open to the public; discussion was limited to Advisory Committee members, with an opportunity for public comment at the end of each meeting. In the interim between meetings, leadership and staff from HSCRC, MHCC and MIA met biweekly to discuss takeaways and further design discussion, in addition to several ad hoc meetings to deliberate technical content.

1.6.2 Initial Public Comment and Listening Session

The HSCRC announced a public comment period during the second Advisory Committee meeting on February 23, 2026; to further communicate the opportunity, an email was sent the following day to the broad stakeholder list detailed above. Stakeholders were given four weeks to provide feedback on the

initial discussion, including–but not limited to–data parameters and sources, inclusions and exclusions and options for the counterfactual.

In response to the request, the HSCRC received 11 comment letters from 12 organizations. All commenters were invited to speak to their feedback at a listening session, held on April 10, 2026. Advisory Committee members received the submitted comments in advance and were allowed to ask questions of the speakers. Seven organizations opted to provide verbal comments at the listening session.

A summary of the written comments, as submitted, follows. This draft recommendation resulted from discussion between the Regulatory Working Group and the Advisory Committee, after review of the submitted comments.

- Medicaid Developmental Disability and Home- and Community-Based Services
    - Commenters were largely supportive of excluding these services.
    - Certain commenters suggested they should be considered but proposed tracking them separately.
- Pharmacy
    - Commenters were split on including drug costs, such as Part D.
    - One commenter agreed to track rebates separately, at least initially.
- Self-Pay
    - Commenters noted the importance of some form of measuring or monitoring self-pay.
    - Suggestions included modeling self-pay using hospital case-mix data and including data from federally-qualified health centers, community health centers and free clinic networks.
- ERISA and FEHBP
    - Commenters expressed a need for precise modeling, in the case that completion factors need to be applied.
    - Commenters were also supportive of working toward leveraging electronic health network data.
- Baseline and Frequency of Test
    - Two commenters spoke to baseline, with one supporting CY 2023 and the other a blend of CYs 2023-2024.
    - Commenters were split between annual and cumulative targets.
- Counterfactual Options
    - Commenters were split on counterfactual options, with most favoring at least a blend of one of the affordability metrics (*i.e.*, household income or wage growth) and GSP.
    - Certain commenters strongly suggested a single metric, *e.g.*, household income-only, GSP-only or a health-specific trend.
    - Two commenters wrote in support of a projected target, vs. actual or historical.
- Reporting and Monitoring
    - Commenters overwhelmingly supported parallel monitoring mechanisms, with many encouraging an affordability standard.
    - Commenters proposed a variety of metrics across affordability and access.

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During the listening session, many of the Advisory Committee's questions focused on the technical question of annual vs. cumulative targets. In addition, among other areas, members also discussed the importance of timely availability of the counterfactual, as well as the idea of an affordability standard. A list of commenters can be found in Appendix B.

1.6.3 Advisory Committee Review of Draft Methodology

In advance of the submission of the draft methodology and targets to the Governor, Advisory Committee members were given the opportunity to review the draft policy proposal in May 2026. Eight Advisory Committee members submitted comments; a summary of the feedback, as received, follows.

- Medicaid Developmental Disability and Home- and Community-Based Services
  - Commenters were supportive of the decision to exclude these services.
- Pharmacy
  - Commenters continued to be split on the inclusion of Part D.
  - One commenter suggested excluding initially and working toward including once rebate information becomes available.
  - *The State acknowledges the complexity of including pharmacy costs in model tests. As stated above, due to this complexity, pharmacy trends will be monitored separately as well as included in the analysis.*
- Self-Pay
  - One comment was received on the proposed approach to self-pay, *i.e.,* exclusion for monitoring; the commenter supported the approach.
- ERISA and FEHBP
  - One commenter urged caution that the use of proxies could contribute substantial actuarial risk, due to share of these plans in Maryland's commercial market.
  - *The State agrees with the comment and will ensure to monitor the trend to ensure the proxy measure does not distort the overall outcome. The State is open to comment on alternative approaches to solicit data and trends from ERISA and FEHBP plans.*
- Administrative Costs
  - One commenter urged the inclusion of the administrative cost of private insurance.
  - *The all-payer TCOC growth test is designed to monitor the growth of health care costs; the administrative cost of private insurance falls outside of this scope. Health insurance plans are governed by a medical loss ratio, which sets a minimum threshold for plan spending on medical care.*
- Measurement
  - Certain commenters advocated to maintain the CY 2026 baseline and not to rebase in CY 2029, as proposed.
  - Certain commenters cautioned the State to understand actual performance before setting the trend, *i.e.,* to assess for achievability.
  - One commenter expressed agreement with the multi-year historical trend as proposed but cautioned against adverse dilution effects of three-year cumulative target (*e.g.,* early cost surges or successes).

   - *The State believes a three-year cumulative target balances the ability to react to adverse trends as well as to mitigate the effect of atypical issues. Additionally, although the State proposes setting a three-year target, the analysis and reporting will be conducted and submitted on an annual basis.*
- Counterfactual
   - Certain commenters advocated for switching from wage growth to median household income, as an indicator of impact to consumers.
   - Other commenters supported the counterfactual as proposed, and another agreed with the hybrid approach but recommended reducing the weighting of wage growth proportionate to GSP.
   - *As noted, the State considered using median household income as the economic metric to measure impact to consumers; however, the annual data are not released in time for the required reporting to CMMI.*
   - One commenter advocated to exclude CY 2025 due to the impact of federal job losses on wage growth. *The three-year trend was established to mitigate for single-year impacts such as the federal job losses observed in CY 2025.*
- Primary Care Investment
   - Though this comment period focused on the all-payer TCOC growth targets, certain commenters provided feedback on primary care investment. These comments have been shared with MHCC.
- Reporting and Monitoring
   - Commenters appreciated the focus on access, affordability and quality. One commenter urged the inclusion of metrics for adverse impacts on primary care access and primary care destabilization; another suggested metrics related to insurance design and trends. *The State agrees with the importance of affordability. While affordability is already built into the analysis vis-à-vis the inclusion of wage growth in the metric, the State is committed to considering other metrics in its annual report.*
   - While some commenters encouraged the State to develop an enforcement mechanism to make the target fully-binding, others advocated that the program be limited to monitoring and evaluation. *At this time, the AHEAD Model requirement, as memorialized in the Executive Order, is to submit the results of this analysis to CMMI on an annual basis.*
   - One commenter advised that investments under the model—*e.g.,* population health, care transformation, primary care, capital infrastructure and underserved communities—be excluded or somehow built into the reporting. *The scope of the all-payer TCOC growth target is the cost of health care, which is inclusive of investments in population health financed by the health care payment system.*

1.6.4 Public Review of Draft Methodology

[PLACEHOLDER: Following the Advisory Committee review, the Regulatory Working Group released the draft methodology and targets for a public comment period. Summary of public comments will be merged with the Advisory Committee comments following the public comment period. Commenters will be added to the list found in Appendix B.]

2. All-Payer Primary Care Investment Target

The AHEAD Model requires participating states to implement a primary care investment target.[12] This approach reflects a growing national emphasis on strengthening primary care as a foundation for high-quality, cost-effective health systems. The requirement draws from momentum generated through similar targets in other states and recognizes the importance of primary care as the only specialty in which increased supply results in lower mortality and more equitable health outcomes.[13]

An Executive Order issued by Governor Wes Moore in December 2025[14] affirmed the importance of primary care and directed MHCC to work collaboratively with stakeholders to develop an all-payer primary care investment target. While the Medicare Fee-for-Service target was established by CMMI and included in the AHEAD Model agreement, MHCC led the development of targets for Commercial, State Employee Health Plan (SEHP), Medicaid, and Medicare Advantage beginning in calendar year 2027. The State must submit the primary care investment targets for CY 2027 through CY 2030, to CMMI by September 30, 2026. As previously noted, failure to meet the targets, i.e., missing two out of three years, may trigger a corrective action plan by CMMI; however, such action would not trigger termination of the model.[15]

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)[16] mandates that MHCC conduct an annual analysis of primary care and make recommendations on the level

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[12] Health Services Cost Review Commission, *Amended and Restated AHEAD Model Maryland State Agreement* (Baltimore: Health Services Cost Review Commission, 2025), PDF, accessed May 21, 2026, https://hscrc.maryland.gov/Documents/AHEAD/Amended%20and%20Restated%20AHEAD%20Model%20Maryland%20State%20Agreement_vFinal_State%20signed_CMMI%20Signed_vPublic.pdf.

[13] 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. Accessed August 26, 2025. https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health.

[14] Maryland Health Services Cost Review Commission. *Executive Order 01.01.2025.28: Establishing All-Payer Total Cost of Care Growth and Primary Care Investment Targets in Maryland*. Baltimore: Health Services Cost Review Commission, 2025. PDF. Accessed May 21, 2026. https://hscrc.maryland.gov/Documents/AHEAD/EO%2001.01.2025.28%20Establishing%20All-Payer%20Total%20Cost%20of%20Care%20Growth%20and%20Primary%20Care%20Investment%20Targets%20in%20Maryland_Accessible.pdf.

[15] Under the AHEAD Model, a determination by CMS that the State has failed to meet the all-payer primary care investment target in any two years within a period of three consecutive years is considered a triggering event. In such instances, CMS would provide the State with a written warning notice, to which the State must provide a comprehensive response within 30 days. Should CMS not accept the State's response as sufficient, CMS may provide the State with a written enforcement action notice. Potential enforcement actions include a corrective action plan; a request for additional information; additional monitoring, auditing or both; a requirement for the State to propose new safeguards or programmatic features; and modification or termination of a Medicare payment waiver or waivers granted under the model. In the case of a corrective action plan, the State would have 45 days to submit its proposed plan for CMS approval.

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

of primary care investment relative to overall health care spending. The Act requires MHCC to form a stakeholder workgroup, the Primary Care Investment Workgroup (PCIW)[17] to provide input on the analysis and recommendations.[18]

The PCIW and other stakeholders informed the draft target-setting methodology for primary care investment (see Stakeholder Engagement, below). The following section describes the methodology as recommended by MHCC, informed by the recommendations in the report,[19] in consultation with the PCIW and with input from MDH, HSCRC and the MIA.

2.1 Background and Guiding Principles

Maryland is well-positioned for this initiative considering its long-standing focus on the State's primary care system. Maryland is considered an early adopter of payment and care delivery models that reward primary care providers for delivering high-quality and cost-efficient care, such as the Maryland Multi-Payor Patient Centered Medical Home Program and MDPCP.[20] Maryland is now expanding on those efforts through the AHEAD Model and Rural Health Transformation Program (RHTP). Newer programs include the Episode Quality Improvement Program Primary Care (EQIP-PC), Primary Care AHEAD (PC AHEAD), and the Medicaid Advanced Primary Care Program (Medicaid Path).[21]

EQIP-PC is a voluntary value-based payment initiative that engages Maryland practitioners who treat Medicare beneficiaries in efforts to improve care quality and reduce costs through increased access to advanced primary care.[22] PC AHEAD and MDPCP-AHEAD are the State's advanced primary care programs under the AHEAD Model, designed to strengthen comprehensive, team based primary care and improve population health outcomes for Medicare beneficiaries. Medicaid Path is designed to strengthen primary care delivery for Medicaid beneficiaries through aligned payments, care management supports, and practice transformation resources.[23] These efforts provide additional funding to expand resources, improve care coordination, and support practices in adopting more advanced models of care.

Since 2023, MHCC has conducted an annual analysis of primary care spending and convened the PCIW to inform recommendations on the level of primary care investment relative to overall health care spending.[24] Adopting a statewide primary care investment target is an appropriate and well-timed

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[17] See Appendix C for a list of workgroup members.
[18] The Act requires specific workgroup representation from the Maryland Primary Care Program (MDPCP), HSCRC, MIA, MDH, the primary care community, payers, and managed care organizations and health services researchers with expertise in primary care.
[19] Chapter 667 of the 2022 Laws of Maryland 2022. Accessed August 26, 2025. https://mgaleg.maryland.gov/2022RS/chapters_noln/Ch_667_sb0734E.pdf.
[20] The Maryland Multi-Payor Patient Centered Medical Home Program ran from 2011-2016 and the MDPCP was launched in January 2019 and continues to be part of the Maryland AHEAD model.
[21] More information about the Maryland AHEAD primary care programs is available at https://health.maryland.gov/mdpcp/Pages/AHEAD-Model.aspx.
[22] CRISP. EQIP Primary Care. Accessed on April 8, 2026. https://www.crisphealth.org/eqip/pc/.
[23] Maryland Department of Health. Medicaid Path Program Manual: Maryland's AHEAD Primary Care Programs, Updated December 2025. April 8, 2026. https://health.maryland.gov/mdpcp/Documents/Medicaid_Path_Program_Manual_PY_2026.pdf
[24] PCIW reports are available at https://mhcc.maryland.gov/category/primary-care-investment-workgroup.

continuation of this work. Similar to the Maryland all-payer TCOC growth target, the Maryland all-payer primary care investment target rests on the foundation of a set of principles informed by its experiences and other states. These principles were informed by the PCIW.

Payer Achievement of Investment Targets is Essential to Effect Change
Payer achievement of primary care investment targets is essential to shift the U.S. healthcare system from reactive, episodic treatment to proactive, preventative care. By meeting these targets, payers shift funds from fee-for-service models to robust, sustainable primary care, driving change through several critical mechanisms. To increase accountability for achieving spending targets, a 2025 report from the National Academy for State Health Policy recommends requiring commissions, payer collaboratives, Medicaid agencies, insurance regulators, or departments of health to issue annual public reports on primary care spending by payer.[25] The reports should track progress toward spending targets, setting absolute and relative spending goals for primary care spending that include both FFS and non-FFS spending, and requiring Medicaid and State insurance regulators to measure and increase the portion of health care dollars going into primary care across all payers, with penalties for noncompliance.

Approach to Reflect Population Health Needs Investment Targets
To date, states have not established primary care spending targets that consider population characteristics. Different patient populations require different types of services, at different frequencies, and from different types of providers, in part due to differences in age or gender. For example, the Bright Futures and American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care require more frequent visits with a pediatric care team and additional services for infants and toddlers[26] than for older teens. Similarly, females of childbearing age frequently require more care related to reproductive health and maternity services, which increases spending as compared to men of a similar age.

The MHCC used a standardized approach to calculating payer specific targets that reflect the actual cost of providing primary care to that payer's population rather than a fixed, arbitrary percentage of total medical expenditures. As discussed in the Methodology section, the MCTB Model uses publicly available data, grey literature, and peer reviewed research to estimate chronic condition prevalence in Maryland and the provider time necessary to deliver care in accordance with national recommended care guidelines and best practices in care team configurations. An earlier version of the MCTB was first developed by Freedman HealthCare (FHC) for Connecticut and then later revised by FHC to meet the needs of stakeholders in Rhode Island. FHC developed the MCTB Model to reflect Maryland-specific data and stakeholder preferences. Maryland is the first state to use this approach to guide primary care investment targets. This approach creates payer alignment, ensures that investment levels support the delivery of high-quality care, and promotes payers being able to achieve the targets.

Target Design Should Prevent Unnecessary Inflationary Pressure

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[25] National Academy for State Health Policy. Implementing High Quality Primary Care: A Policy Menu for States September 2025. Accessed May 25, 2026. Available at https://nashp.org/implementing-high-quality-primary-care-a-policy-menu-for-states/.
[26] Bright Futures Guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. American Academy of Pediatrics; 2017). Accessed May May 26, 2026. Available at periodicity_schedule.pdf.

Primary care investment targets need to avoid the inflationary pressures observed in other states that rely on fixed percentages of TME. To address this concern, MHCC calculated the current cost of providing accessible, high quality primary care, and an inflation rate specific to physician services was applied to project future costs. The targets are expressed as a PMPM amount, which offers a clearer and more stable basis for planning because it reflects the actual dollars available to primary care providers to support improvements in access, coordination, and quality. This approach aligns with research showing that PMPM investments create predictable funding streams and better support long-term delivery system transformation. By comparison, frequently used percentage-based targets require primary care spending to rise whenever TME increases. Under percentage methods, increases in hospital, specialty, or pharmacy spending automatically increase primary care spending targets although the same drivers may not exist thereby, risking unnecessary inflationary pressure.

Additionally, developing a primary care target using an evidence-based cost basis, converted to a PMPM, makes more sense when we consider that the targets must be across all payers. There are vastly different total medical expenditures across lines of business, with Traditional Medicare and Medicare Advantage TME inclusive of more costly end-of-life care, for example. As such, while Traditional Medicare and Medicare Advantage might have low percentages of primary care investment compared to overall TME, the relative contributions on a PMPM are higher on a dollar amount. This means that if the state were to set overall TME targets across payers, the percentage of spending change would end up being driven more by existing line-of-business and patient population mix than on achieving targets that meaningfully ensure access to high quality primary care. The PCIW reflected that it is most important to the individual primary care practices, and arguably Maryland patients, that primary care practices receive the right investment to hire multidisciplinary teams, and develop the practice infrastructure, to provide high-quality primary care to a diverse Maryland patient population.

2.2 Methodology

1) The all-payer primary care investment target reflects the weighted average of targets developed for the Commercial, Medicaid, Medicare Advantage, and Medicare FFS populations. All of these populations will be subject to the targets.
2) SEHP and a subset of the self-insured population that reports data to the Medical Care Database (MCDB), Maryland's All-Payer Claims Database, are included in the Commercial target projections. The analysis found primary care spending for the fully insured and self-insured Commercial populations were nearly identical on a per member per month (PMPM) basis, within $1.
3) Targets reflect PMPM claims and non-claims primary care spending for each payer type.
4) Targets span 2027 through 2030 and will be reconsidered for possible adjustments for 2031 through 2035. Projections for 2025 and 2026 provide a baseline.
5) Each payer's target is set to equal the resource necessary to provide accessible, high-quality primary care to the population the payer serves without putting unnecessary inflationary pressure on total spending.
6) For all payers except Medicaid, primary care spend was calculated using the Maryland Care Team Builder Model (MCTB Model). The MCTB Model is discussed in items 8 and 9 below.

7) The Medicaid targets reflect spending projections for its primary care value-based care program, the Medicaid Advanced Primary Care Program. The program began in Fiscal Year (FY) 2026. Current Medicaid funding projections span FY 2026 – FY 2029. The targets assume FY 2029 funding projections carry forward through CY 2030, the end of the initial performance period. Program components that started in 2026 included: 1) increasing primary care Evaluation and Management (E&M) reimbursements to 103 percent of Medicare rates; 2) supporting practice care transformation activities through $2 PMPM care management fees for participating practices; and, 3) a quality incentive program for participating practices.[27] We note that the state will adhere to federal state-directed payment requirements as they become effective.
8) The MCTB Model estimates the cost of providing high quality, accessible primary care to the payer's membership based on the age group and gender distribution of its population. Steps 1-4 are repeated for each of 10 age group and gender combinations to reflect differences in need and associated cost.

   Step 1. Calculate cost of traditional care team members including physicians, nurse practitioners, physician assistants, medical assistants, and licensed practical nurses.
   - Peer reviewed research is used to estimate the appropriate panel size for each of the 10 age group and gender combinations.[28, 29, 30] For example, if a pediatric practice cared for only infants, it could care for fewer patients than if it cared for only 9-year-olds because infants tend to require more primary care than elementary school age children.
   - The number of necessary full time equivalents (FTEs) derived from the panel size estimates is multiplied by the Maryland median wage for the clinical specialty as reported by the Maryland Department of Labor.[31] A 30-percent fringe benefit rate is added.

   Step 2: Calculate the cost of expanded care team members such as pharmacists, nurse care managers, behavioral health clinicians, and community health workers.[32, 33]
   - Maryland-specific estimates of chronic and behavioral health condition prevalence, infant hospitalizations, and percentage of patients with unmet social needs are multiplied by treatment frequency and duration included in recommended care guidelines. Sources for Maryland disease prevalence include the Maryland Department of Health, America's

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[27] Maryland Department of Health. Medicaid Path Program Manual: Maryland's AHEAD Primary Care Programs, Updated December 2025. April 8, 2026. https://health.maryland.gov/mdpcp/Documents/Medicaid_Path_Program_Manual_PY_2026.pdf.
[28] Abu Dabrh, A. et al. (2025). Determining patient panel size in primary care: A meta-narrative review. Journal of Primary Care & Community Health. doi: 10.1177/21501319251321294.
[29] Abd Moain Abu Dabrh et al., "Determining Patient Panel Size in Primary Care: A Meta-Narrative Review," Journal of Primary Care & Community Health 16 (2025), https://doi.org/10.1177/21501319251321294.
[30] Justin Altschuler, David Margolius, Thomas Bodenheimer, and Kevin Grumbach, "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation," Annals of Family Medicine 10, no. 5 (2012): 396–400, https://doi.org/10.1370/afm.1400.
[31] Maryland Department of Labor, Division of Workforce Development and Adult Learning. (2025). Maryland occupational employment and wage statistics. https://labor.maryland.gov/lmi/wages/.
[32] Hogan, L., Rutherford, B., Neall, R. Maryland Maternal Mortality Review 2019 Annual Report. Maryland Department of Health; 2019; https://hcup-us.ahrq.gov/reports/statbriefs/sb299-Hospital-Stays-Children-2019.jsp.
[33] Falconi, A., Johnson, M., Chi, W., Stephenson, J., Overhage, J, Agrawal, S. Health related social needs and whole person health. Prev Med Rep. 2023;36:102491. doi:10.1016/j.pmedr.2023.102491.

Health Rankings, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality.

- The number of hours necessary to fulfill recommended care guidelines is then translated into FTEs and multiplied by the Maryland median wage for the clinical specialty as reported by the Maryland Department of Labor.[34] A 30 percent fringe benefit rate is added.

Step 3: Estimates of administrative costs are sourced from peer reviewed research[35] and adjusted for inflation using the US Bureau of Labor Consumer Price Index (CPI) Inflation Calculator.[36]

Step 4:

- Administrative costs and costs for traditional and expanded care team members are summed together. The analysis uses 2024, the most recent available year for wage data, as a baseline year and multiplies the baseline by the Standard & Poor's (S&P) Global Market Intelligence Healthcare Cost Service.[37] Physician Services inflation factor trend was forwarded to 2030, the final performance year of the first performance period. This inflation factor is used to trend forward the ideal primary care spend because it is specific to physician services.
- Note: When trending forward total medical expenses (TME), the targets leverage the same inflation factor used for the Maryland All-Payer TCOC Growth Target, which is a 50/50 blend of wage growth and GSP derived from the historical trend from CY 2023 through CY 2025 (Section 1).

Step 5:

- For each payer, the 2030 ideal primary care spend for each age group and gender combination is multiplied by the number of member months for the age group and gender combination.
- For each payer, costs for all age group and gender combinations are summed and divided by the total number of member months for the payer, creating a weighted average.

9) The MCTB Model was considered in relation to the targets for Commercial, Medicare Advantage and Medicare Fee-for-Service. It also informed the statewide target so that, when all the targets were considered together, the statewide target reflected an average of $58 for providing high quality care for Marylanders.
    - Commercial: The MCTB Model calculated ideal primary care spend for all Commercial targets ranging between $56 and $57 PMPM, with the variation only due to differences in age and gender combinations across payers. Most stakeholders supported setting the

[34] Maryland Department of Labor, Division of Workforce Development and Adult Learning. (2025). Maryland occupational employment and wage statistics. https://labor.maryland.gov/lmi/wages/.
[35] Abd Moain Abu Dabrh et al., "Determining Patient Panel Size in Primary Care: A Meta-Narrative Review," Journal of Primary Care & Community Health 16 (2025), https://doi.org/10.1177/21501319251321294.
[36] U.S. Bureau of Labor Statistics. CPI Inflation Calculator. Accessed May 2026. https://www.bls.gov/data/inflation_calculator.htm#.
[37] S&P Global Market Intelligence, Healthcare Cost and Utilization Service, Quarter 4, percent change over previous year for Physician Services.

target within this range, finding it reasonable to encourage Commercial payers to reach this ideal primary care spend by 2030. The target is equal to slightly less than 10 percent of TME, and therefore lower on a percent TME basis than all other states with primary care investment targets that only focus on the commercial population.

- Medicare Advantage: Current Medicare Advantage average primary care spend PMPMs exceeds the MCTB Model target for older adults. The Medicare Advantage primary care investment target uses the current average Medicare Advantage primary care spend PMPMs and only increases investment equal to increases in inflation to ensure resources available to primary care remain at this ideal. The Medicare Advantage targets assume an increase in primary care investment equal to the inflation factor used by the HSCRC for the TCOC Growth Target (Section 1).
- Medicare FFS: Similar to Medicare Advantage, current average Medicare FFS primary care spend PMPMs exceeds the MCTB Model target for older adults in today's dollars. The Medicare FFS target is defined in the AHEAD Model agreement and aims to hold primary care investment steady as a percent of TME, at 4.9 percent through 2030. This pace of increase will result in Medicare FFS primary care spend remaining on par with the MCTB Model target for older adults throughout the performance period.

Table 5. All-Payer Primary Care Investment Target

	2025	2026	2027	2028	2029	2030
Category	**Primary Care PMPM**					
Statewide Target	$43	$45	$48	$51	$55	$58
Commercial	$38	$40	$44	$48	$52	$57
Medicare Advantage	$57	$60	$63	$66	$70	$73
Medicaid	$41	$44	$46	$47	$48	$50
Medicare Fee for Service	$50	$52	$55	$58	$61	$64
State Employee Health Plan	*Included in Commercial*					

Potential Risks to Achieving the Targets

- Payers may fall short of their target to increase spending on primary care. This risk can be mitigated with public reporting of progress, technical assistance and if needed, a statutory or regulatory requirement.
- Increasing primary care investment may put some inflationary pressure on total medical spending and result in increased premiums or payers exiting the market completely. However, it is important to recognize the limited nature of this risk. For example, on a percent of TME basis, Commercial primary care spending only increases 1.5 percentage points, from 8.3 percent to 9.8 percent, in total across the five years. It is not possible for the primary care investment target to raise TME more than 1.5 percent across the Commercial market across the five-year period. Furthermore, the primary care investment target should be taken in the overall context of a total

cost of care target as part of AHEAD. Since premium increases are driven by total medical spending, and not primary care spending in isolation, so long as the state meets its TCOC obligations it should have no impact on premiums. Finally, since primary care investment can also reduce the total cost of care by reducing potentially preventable emergency department visits and inpatient admissions, this can create synergistic savings that make it more feasible to achieve a lower TCOC.[38]
    - This is a far more gradual increase than sought by other states such as Delaware, Rhode Island, and Colorado. Most states seek an increase of 1 percent to 1.5 percent of TME each year for several consecutive years.
    - The experiences of these states including payers not meeting targets and/or feeling inflationary pressures, contributed to Maryland deciding to pursue a more gradual increase.
- Payers may need to dedicate some internal resources to data collection and measurement to track progress to achieving targets throughout the year so adjustments can be made if they project they will not meet their target. Payers can collaborate closely with MHCC to minimize new or duplicative analyses.
- Payers, particularly government payers, may face changing federal and state policies such as loss of funding or programs, which may impact their ability to achieve the targets.

2.3 Absolute (PMPM) vs. Relative (%) Improvement

The AHEAD Model all-payer primary care investment target is designed to provide sufficient resources to primary care practices to expand access, particularly in underserved areas, and improve care quality without putting undue inflationary pressure on health care spending. Some states that have implemented a primary care investment target based on a percent of spending have found it difficult to limit increases in total spending, especially in the early years as the benefits of improvements in primary care have yet to translate into lower costs.[39] To avoid this unintended consequence, the PCIW supported expressing the targets as a PMPM amount and tying investment growth to a consistent inflation standard rather than allowing percentage-based targets to shift with unrelated cost trends.

2.4 Data Parameters

This section details the costs that will be included in the all-payer primary care investment analysis, as well as the data sources that support the analysis. Additionally, the PCIW emphasized the importance of monitoring all-payer spending on a quarterly basis to assess progress toward meeting the primary care investment targets. Regular review allows the State to identify emerging trends, address barriers early, and ensure that payers remain on track to achieve the required level of investment.

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[38] Milbank Memorial Fund."The Pathway to Primary Care Investment Is Bolstered by Accountable Care." December 2025. Accessed May 29, 2026. https://www.milbank.org/2025/12/the-pathway-to-primary-care-investment-is-bolstered-by-accountable-care/.
[39] Milbank Memorial Fund. *Slowing and Shifting Health Care Spending: Lessons Learned from State Government Initiatives*. Milbank Memorial Fund; February 2025. Accessed May 26, 2026. Available at: https://www.milbank.org/wp-content/uploads/2025/02/SlowingShiftingSpending_2.18.pdf.

2.4.1 Data Sources

The same data sources were used for the primary care investment and total cost of care targets. More information on each of the data sources used can be found in section 1.4.2 Data Sources.

2.4.2 Exclusions

The analysis will exclude certain benefit types, payments, and services. Table 6 displays recommended exclusions and the rationale for excluding.

Table 6. Recommended Exclusions from Primary Care Investment Target

Exclusion	Rationale
Dental Plans	Not included in the AHEAD Model definition of primary care
Pharmacy Benefit Plans	Retail prescription drugs are not included in AHEAD Model definition of primary care.
Payments Already Included from Other Sources: ● Crossover Claims from Duals Medicaid Analysis ● Medicare Supplemental (Medigap) ● Third-Party Coverage	● Analysis uses allowed costs ● Excluded to avoid duplication
Medicaid Specialty Services: ● Developmental Disability Services ● Adult Medical Day Care ● Home and Community-Based Services	Already subject to budget neutrality test and are not included in the primary care definition

2.4.3 AHEAD Primary Care Definition

CMMI has constructed a working "definition" of primary care for the purposes of measuring primary care spending under the AHEAD Model. The definition is a combination of specialty codes and Healthcare Common Procedure Coding System (HCPCS) codes. Only claim lines that meet both provider and service conditions are counted as primary care. The only exception is for claims associated with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). These claims are counted as primary care regardless of provider specialty code if they include a HCPCS code in the definition. The AHEAD model does not restrict to certain place of service codes.

The definition captures office/outpatient evaluation and management and preventive visits, care management services, vaccinations, certain screenings and tests, family planning services and certain

OB/GYN-related services. CMS's eligible primary care specialty-code list includes general practice, family practice, internal medicine, OB/GYN, hospice and palliative care, psychiatry, geriatric psychiatry, pediatric medicine, geriatric medicine, certified nurse midwife, nurse practitioner, addiction medicine, preventive medicine, neuropsychiatry, certified clinical nurse specialist, and physician assistant.

2.5 Reporting and Monitoring

The MHCC's *2026 Primary Care Investment Analysis and Recommendations* draft report to be released in Quarter 4 2026 will include a proposed recommendation that a low-burden quarterly payer reported process be established that includes non-claims and self-insured data, as well as progress toward achieving investment targets. A specific focus on additional work that MHCC is doing with regards to ensuring primary care investments in underserved areas, given that primary care investments can reduce disparities. This is also consistent with the charge in the executive order.

Additionally, MHCC developed a methodology for collecting non-claims based payments in the MCDB, but at the same time, many payers have indicated that they believe their non-claims based payments to be higher than what has been reported. As such, MHCC is continuing to work through how to collect non-claims based payments, and intends to have a few workgroup sessions to discuss this. The report would include specific recommendations on other policies that can help support primary care investment in a meaningful way, so that the goal here is to truly expand access to high-quality, advanced primary care.

2.6 Stakeholder Engagement Process

As previously mentioned, the Governor's Directive and the Act requires MHCC to engage the PCIW and other stakeholders to develop and advise on the development of the primary care investment target. A synopsis of the input and feedback received is provided below.

2.6.1 Primary Care Investment Workgroup

The PCIW Workgroup's charge includes serving as a forum for discussion to guide MHCC in developing policy and recommendations, including the establishment of the all-payer primary care investment target. In carrying out this role, the PCIW reviewed emerging analyses, considered stakeholder perspectives, and identified practical approaches for implementing the target. Its deliberations were intended to support thoughtful decision making and ensure that the investment target is both achievable and aligned with broader efforts to strengthen primary care.

The PCIW met four times between December 2025 and April 2026:

- December 2, 2025: Overviewed the MCTB Model and considered select enhancements to the Model
- January 27, 2026: Discussed additional revisions to the MCTB Model
- February 24, 2026: Reviewed additional Model refinements and deliberated on the approach to calculating the targets
- April 28, 2026: Reviewed proposed draft targets
- June 10, 2026: Discussed finalized draft targets

All meetings were virtual and open to the public. Leadership and staff from HSCRC, MHCC, and MIA also met as needed to discuss the draft targets and ensure alignment.

2.6.2 Stakeholder Feedback and Public Comment

During each PCIW meeting, MHCC invited members to weigh in on key questions regarding the design of the MCTB Model, the targets and their implementation. In addition to the PCIW meetings, outreach to stakeholders occurred, which included presenting at MHCC's monthly Commission meeting on January 15, 2026, and hosting one-on-one meetings with payers. In April 2026, all payers were offered the opportunity to weigh in on the targets via one-on-one meetings and/or through written comments. Five payers have participated in these calls. A summary of this feedback and how it informed updates follows:

- Modifications to the MCTB Model
    - Adjust physician salaries to reflect median for each physician specialty
    - Reduce panel sizes to reflect more recent peer-reviewed research
    - Add additional care team members as options such as LCSWs and behavioral health counselors
    - Clarify administrative costs would include staffing for data analysis
    - Establish more granular age bands; 0 – 4, 5 – 17, 18 – 39, 40 – 64, 65+
      All suggestions were incorporated

- Setting targets as a PMPM amount versus a percent of TME
    - Stakeholders differed on their preference
    - Stakeholders shared that states have found percent of TME targets to be unpredictable and inflationary
    - Several stakeholders appreciated how the PMPM approach reflected resources needed to achieve primary care goals and felt that PMPM is more meaningful to providers
    - Several stakeholders said that regardless of whether the target is expressed as a PMPM or a percent of TME, it is helpful to monitor both
      Target is expressed as a PMPM to reflect resources needed to achieve primary care goals, as it is more predictable and less risk of it being inflationary

- Target level
    - Some payers noted concerns that increasing primary care investment too quickly would result in increases in health care spending that could lead to payers exiting the Maryland market
    - A few stakeholders indicated that Commercial payers might be expected to increase primary care investment more or more quickly than other payers
    - Providers expressed concerns that primary care investment would not increase enough to support care delivery goals and recruit and retain the workforce need to provide advanced primary care
      Target is calculated to reflect the resources needed to achieve primary care goals without being inflationary

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2.6.3 Primary Care Investment Workgroup Review of Draft Methodology

In advance of the submission to the Governor in July, workgroup members and other stakeholders were invited to review the draft policy proposal.

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Appendices

- Appendix A. All-Payer Total Cost of Care Advisory Committee Membership
- Appendix B. All-Payer TCOC Growth Target: Stakeholder Respondents
- Appendix C. Primary Care Investment Workgroup Membership

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Appendix A. All-Payer Total Cost of Care Advisory Committee Membership

Name	Affiliation	Category
Alyssa Penna Williamson	US of Care	Consumers
Andrew Anderson	Johns Hopkins Bloomberg School of Public Health	Independent Experts
Arin Foreman	CareFirst	Payers
Bradley Chambers	MedStar Health	Hospitals
David Johnson	Mid-Atlantic Business Group on Health	Employers
Dewan Clayborn	Central Maryland Chamber of Commerce	Employers
Ed Beranek	Johns Hopkins Health System	Hospitals
Gene Ransom	MedChi	Providers
Grace Mannix	CRISP	State-Designated Health Information Exchange
Joe Winn	Maryland MCO Association	Payers
John Colmers	Independent	Independent Experts
Loraine Arikat	1199 SEIU	Labor
Madeline Jackson-Fowl	University of Maryland Medical System	Hospitals
Matt Celantano	League of Life & Health Insurers of Maryland	Payers
Padmini Ransinghe	Johns Hopkins Medicine	Providers
Sharon Feinstein	University of Maryland School of Medicine/American Academy of Family Practitioners	Providers
Stephanie Klapper	Maryland Citizens Health Initiative	Consumers
Sule Gerovich	Maryland Hospital Association	Hospitals
Wen Xu	Kaiser Permanente of the Mid- Atlantic	Payers

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Appendix B. All-Payer TCOC Growth Target: Stakeholder Respondents

Comment letters will be posted on the HSCRC AHEAD Model Website at the time of submission: https://hscrc.maryland.gov/Pages/ahead-model.aspx.

Organization Name	Initial Public Comment	Public Comment
CareFirst	X	
Central Maryland Chamber of Commerce	X	
Economic Action Maryland Fund	X	
Health Means Everything Coalition	X	
Kaiser Permanente Mid-Atlantic Region	X	
Johns Hopkins Bloomberg School of Public Health	X	
Johns Hopkins Health System	X	
League of Life & Health Insurers of Maryland		
Maryland Academy of Family Physicians	X	
Maryland Citizens Health Initiative	X	
Maryland Hospital Association	X	
MedChi		
University of Maryland Medical System	X	
US of Care		

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Appendix C. Primary Care Investment Workgroup Membership

Name	Affiliation	Category
Clarence Lam	Senate	Maryland General Assembly
Vacant	MDH	Office of Advanced Primary Care
Laura Goodman William Henderson	HSCRC	Health Services Cost Review Commission
Brad Boban	MIA	Maryland Insurance Administration
Vacant	Medicaid	Health Care Financing Division of the Maryland Department of Health
Amar Duggirala *Poolesville Family Practice*	MDAFP	Maryland Academy of Family Physicians
Jeffrey Bernstein *Pediatric and Adolescent Care of Silver Spring*	MDAAP	Maryland Chapter of the American Academy of Pediatrics
Ishrat Rafi *Ascension Saint Agnes*	MDACOG	Maryland Section of the American College of Obstetricians and Gynecologists
Christie Simon-Waterman *The Johns Hopkins Hospital*	MNA	Maryland Nurses Association
Mette Ramanathan *University of Maryland St. Joseph Medical Center*	Maryland Affiliate of ACNM	Maryland Affiliate of American College of Nurse Midwives
Salliann Alborn	MCHS	Maryland Community Health System
Nora Hoban	MACHC	Mid-Atlantic Association of Community Health Centers
Tequila Terry	MHA	Maryland Hospital Association
Tyler Blanchard	Aledade	Accountable Care Organization
Michael Barr	MEDIS, LLC	Primary Care
Chris Barker	Patient First	Primary Care
Sarah Johnson Conway	Johns Hopkins Clinical Alliance	Primary Care
Kimberly Johnston Deltuva	LifeBridge	Primary Care

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Name	Affiliation	Category
Niharika Khanna	University of Maryland School of Medicine	Primary Care
Danielle Stroughton Duncan	COLA, Inc.	Primary Care
Seiji Hayashi	CareFirst BlueCross BlueShield	Payor
Matthew Celentano	Funk & Bolton P.A.	Payor
Tinisha Cheatham	Kaiser Permanente of the Mid-Atlantic	Payor
Vacant	Amerigroup Maryland, Inc. & Maryland MCO Association	Payor
Jill Marsteller	Johns Hopkins Bloomberg School of Public Health	Health Services Researcher with Expertise in Primary Care
William Johnson, Jr. *Community Chaplain for the Johns Hopkins Health System*	Health Care for All	Other Representatives
Dawn Carey	Perdue Farms	Other Representatives
Christina Kuminski	State of Maryland	Other Representatives
Ronald Gresch	Independent Consultant/ Retired Senior Health Actuary at U.S. Office of Personnel Management	Other Representatives