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AHEAD Primary Care Advisory Council Meeting

May 28, 2025

Agenda

- **Welcome and Introductions** (*Djinge Lindsay, MD)*
- **Strengthening Primary Care in Maryland** (*Chris Koller, The Milbank Memorial Fund)*
- **Overview of Maryland's AHEAD Primary Care Programs** (*Chad Perman, Laura Goodman)*
- **Medicaid Path Quality Incentive Approach** *(Mitzi Melendez, Mathematica)*
- **Public Comment** *(Chad Perman)*
- **Wrap-Up and Next Steps** *(Djinge Lindsay, MD)*

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MDH AHEAD Primary Care Work Group

- Dr. Djinge Lindsay - Chief Medical Officer
- Chad Perman - Executive Director, Office of Advanced Primary Care
- Alice Sowinski-Rice - Program Director, Office of Advanced Primary Care
- Emily Gruber - Associate Director, Office of Advanced Primary Care
- Dr. Tere Dickson - Medical Director, Clinical Transformation Unit
- Laura Goodman - Deputy Director, Office of Innovation, Research and Development (IRD)
- Sharon Neely - Division Chief, Delivery Service Reform, IRD
- Edouard Niyonshuti - Health Policy Analyst, IRD
- Ruben Soliz- Project Manager, Mathematica

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Roll Call

Please provide your name, role/position and organization

Dr. Julio Menocal

Dr. Falana Carter

Dr. Kenneth Buczynski

Dr. Mercy Obamogie

Dr. Pankaj Kheterpal

Dr. Ursula McClymont

Dr. Marcee White

Dr. Sandy Chung

Dr. Scott Krugman

Dr. Robin Motter-Mast

Dr. Amar Duggirala

Dr. Jeffrey Bernstein

Linda Raines

Dimitrios Cavathas

Meghan Crosby Budinger

Dr. Magaly Rodriguez de Bittner

Leigh Hunter

Carlene James

Shantel Matthews

Carla Leedy

John Lease

Brian Bailey

Dr. Vicky Parikh

Arumani Manisundaram

Dr. Nkem Okeke

Dr. Chaunte Harris

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Guidelines for Meeting Participation

Constructive feedback:

- Offer feedback that is focused, specific, and aimed at improvement.

Active listening:

- Listen with the intent to understand.

Awareness of shared time:

- Be mindful of the time and the space taken in discussions. Allow others the opportunity to contribute.
- Please stay on topic.

Respectful sharing:

- Please share your thoughts respectfully and considering the views and opinions of others.
- Avoid interrupting others.
- Questions are welcome.

Active participation & timely contribution:

- Actively engage in discussions and provide feedback throughout the workgroup.
- Timely and consistent contributions are essential for collective success of the workgroup- please respect deadlines for comments.

Webinar Platform Tips and Tricks:

- Closed captioning is available using the “CC” icon in the lower left corner
- Advisory council members, feel free to utilize the raise hand feature and meeting chat to submit questions and/or comments
- Members of the public, feel free to use the public comment document

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Strengthening Primary Care in Maryland

AHEAD Primary Care Advisory Council

May 28, 2025

Milbank Memorial Fund

Agenda

- About Milbank
- Primary Care: What's the Problem
- What Needs to be Done
- Forging AHEAD

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve population health and health equity by collaborating with leaders and decision-makers and connecting them with experience and sound evidence.

We advance our mission by:

- Identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness;
- Working with state health policy decision makers to advance primary care transformation and sustainable health care costs, leadership development and
- Publishing high-quality, evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.

What Is Primary Care?

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

The Value of Primary Care

- Only part of the delivery system where the more we have, the better our population health outcomes and the fewer health disparities we have
  - (Not pharma and not hospitals)

The Problem:

The Health of US Primary Care: 2025 Scorecard Report

THE
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FOUNDATION
Empowering Physicians
Improving Healthcare

Milbank
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“The Cost of Neglect: How Chronic Underinvestment in Primary Care Is Failing US Patients”

1. Declining investment and FFS payments are hindering primary care clinicians’ ability to meet patients’ growing needs.

2. Insufficient funding is diminishing the primary care workforce and access to care.

3. Misdirected GME funding is not producing enough new primary care clinicians, exacerbating access issues for patients.

4. Lack of investment in EHRs has led to burdensome systems that drain clinicians’ time, thereby reducing patient access to care.

5. The lack of research dollars to study the practice of primary care is limiting evidence-based improvements in care.

THE PHYSICIANS FOUNDATION
Empowering Physicians Improving Healthcare

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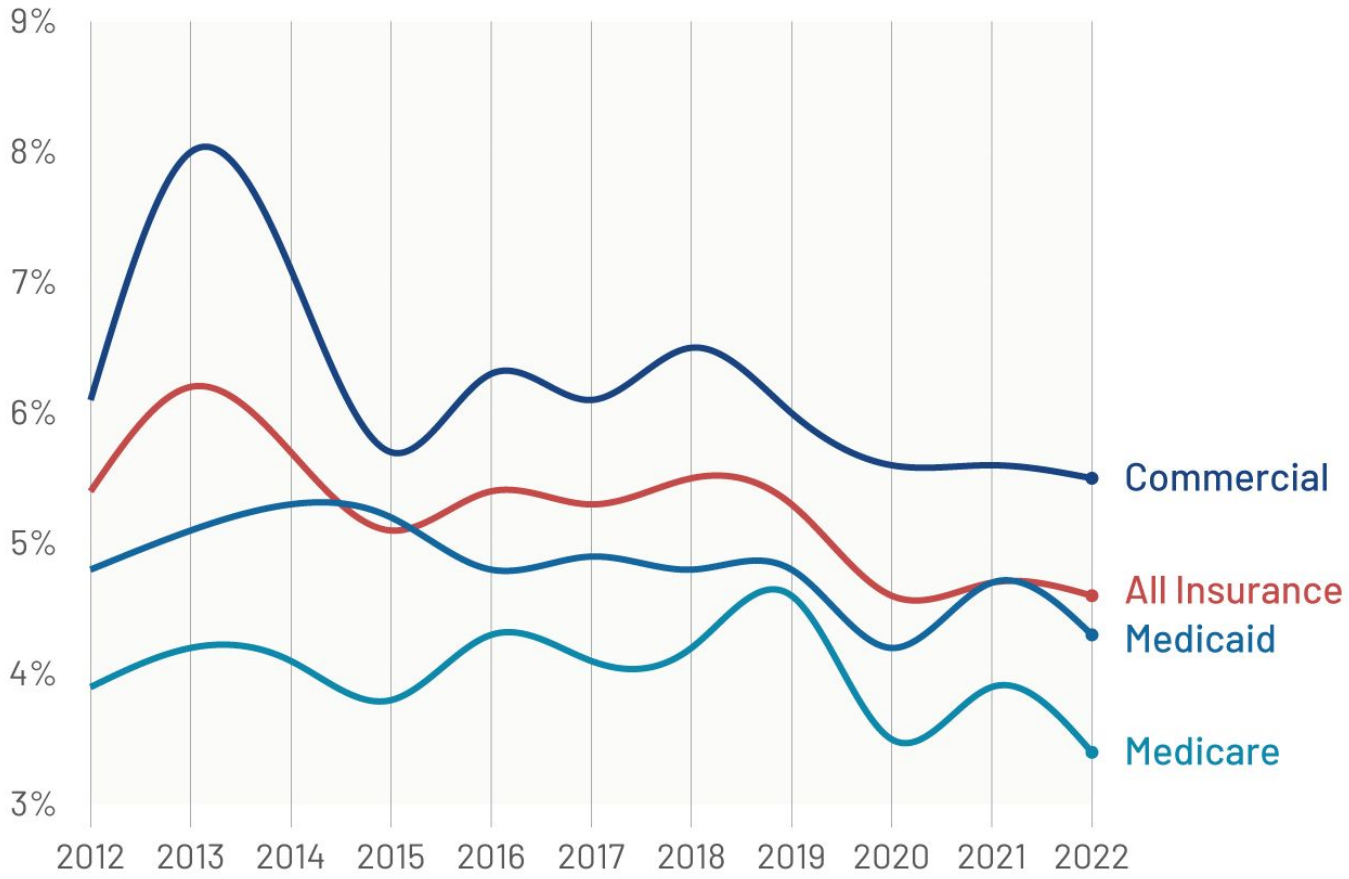
I. Financing

Primary Care Spending (on Physicians) Continues to Decline for All Payers

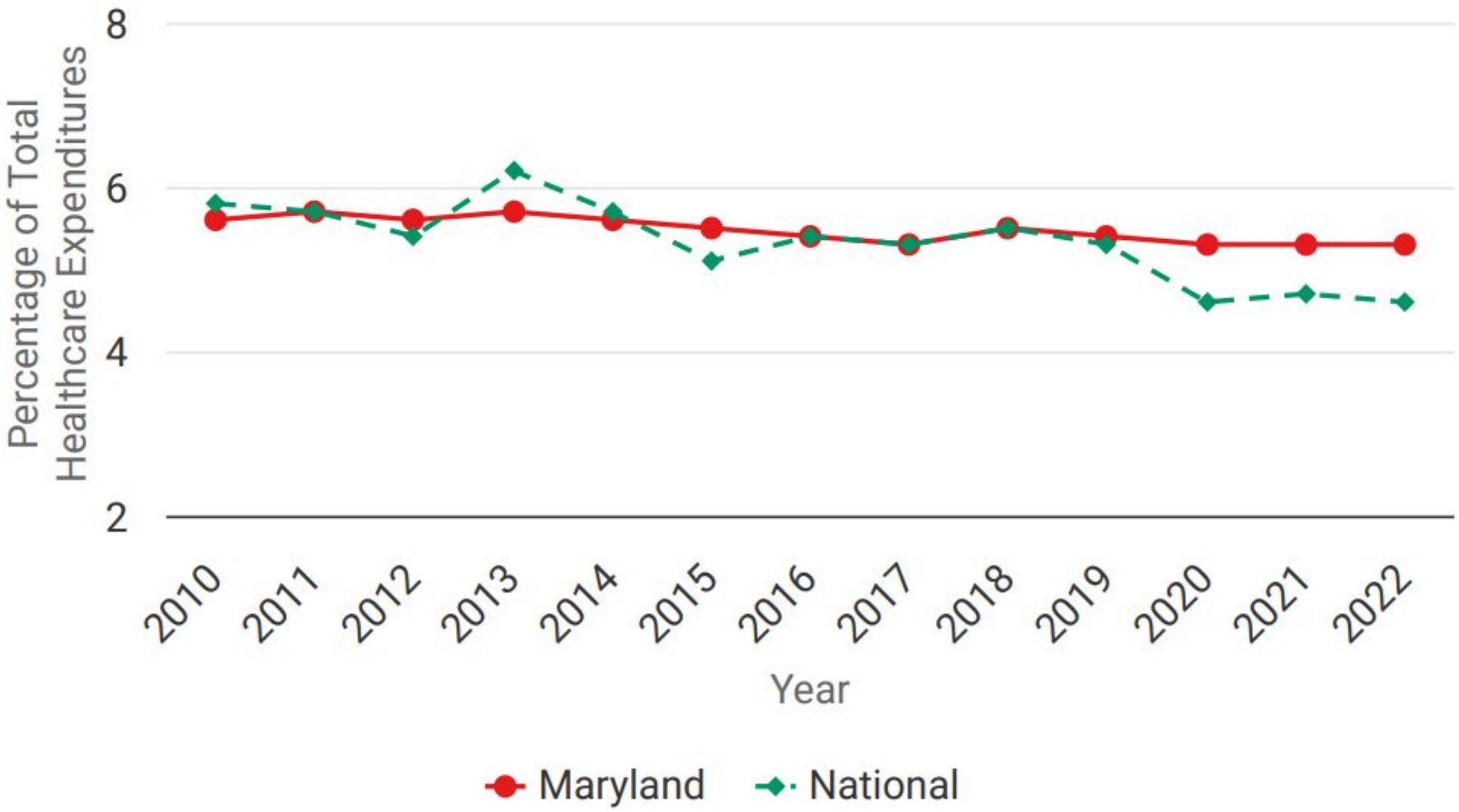
FIGURE 1.

Primary Care Spending (Narrow Definition), 2012–2022



Data Sources: Analyses of Medical Expenditure Panel Survey data, 2012–2022.
Notes: The primary care narrow definition is restricted to primary care physicians only. Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

Primary Care Spending (Narrow Definition) in Maryland (2010 - 2022) - All Insurance Types



Source:
https://www.milbank.org/primary-care-scorecard/

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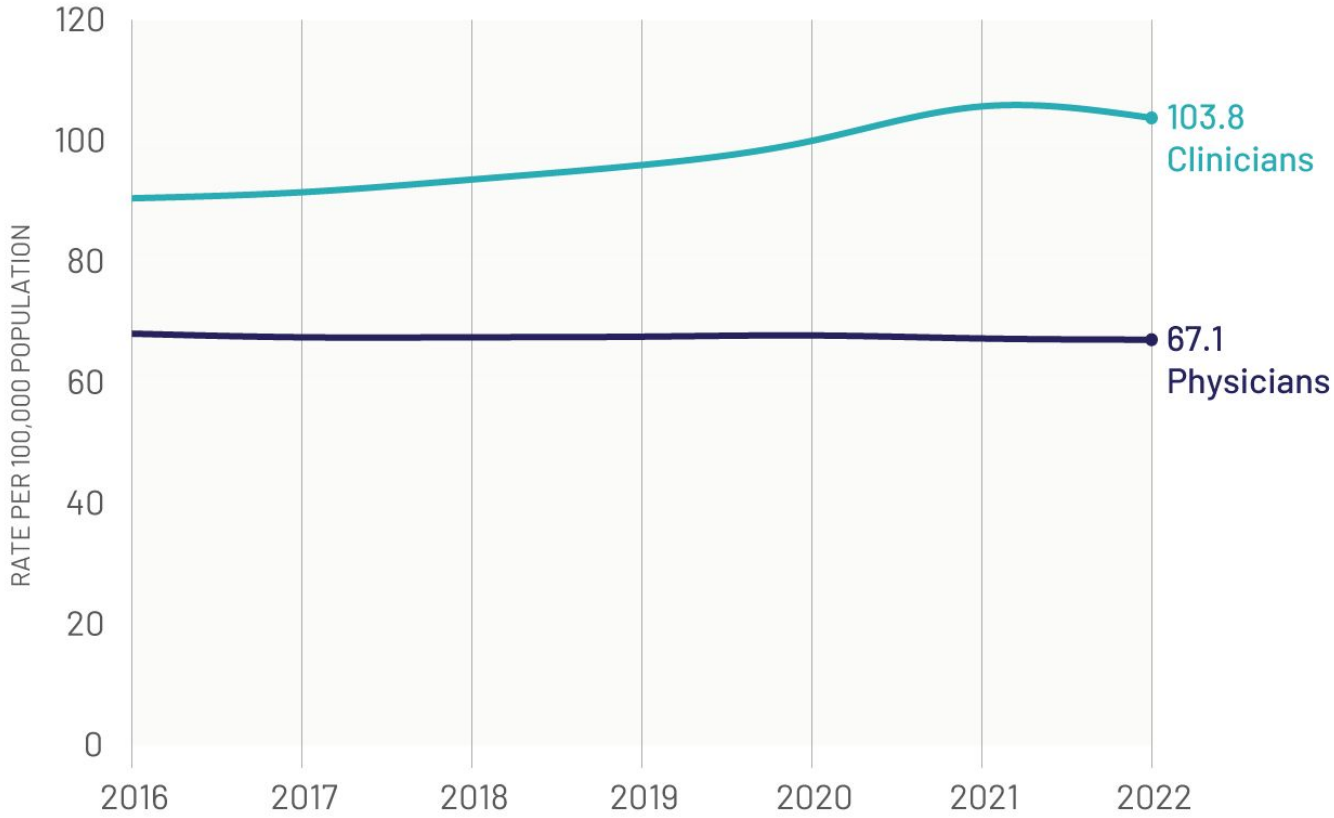
Rate of Primary Care Physicians Continues to Decline as the Rate of Primary Care Clinicians Remains High

FIGURE 5.

Primary Care Physicians and Clinicians per 100,000 Population

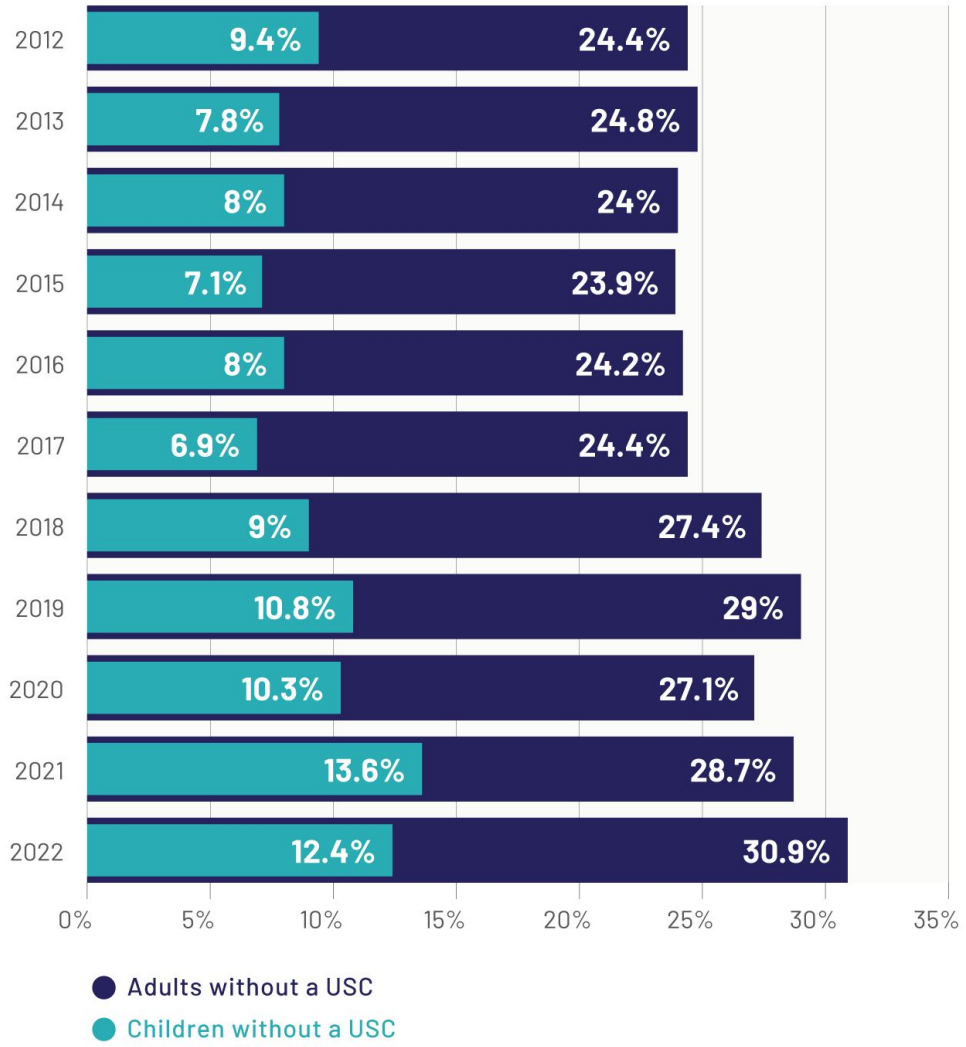


Data Sources: Analyses of American Medical Association Masterfile (2016–2022), Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System data (2016–2022), National Plan and Provider Enumeration System data (2016–2022), Centers for Medicare and Medicaid Services Physician and Other Practitioners data (2016–2022), and the American Community Survey Five-Year Summary Files (2016–2022). **Notes:** Primary care specialties included family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy. Estimates of nurse practitioners and physician assistants working in primary care were calculated and are included in this figure. (See Appendix for detailed methodology.)

II. Access

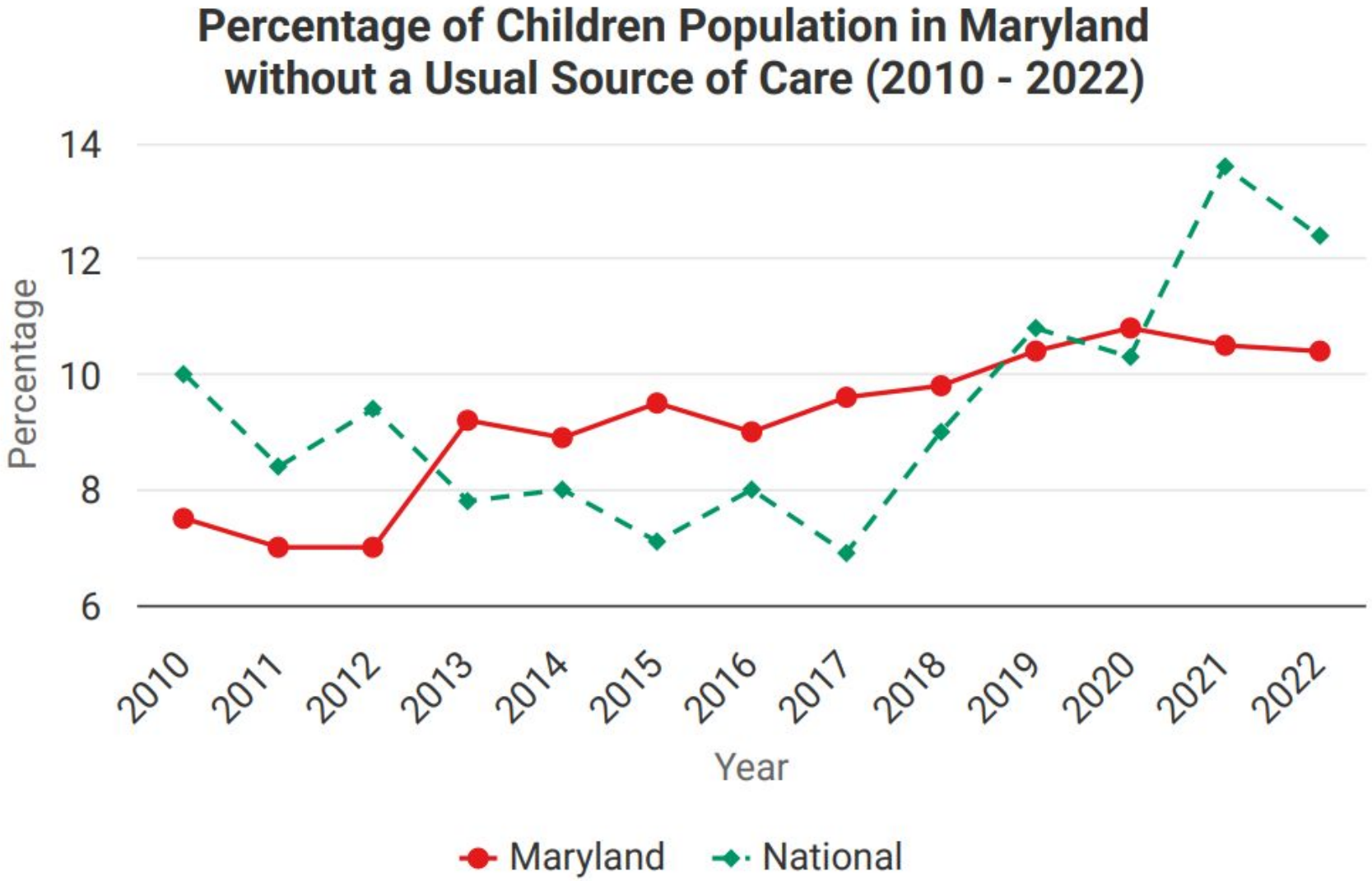
FIGURE 4.

Percentage of US Population Without a Usual Source of Care



Data Sources: Analyses of Medical Expenditure Panel Survey data, 2012–2022.
Notes: Usual source of care (USC) ascertained whether that is a particular doctor's office, clinic, health center, or other place where the individual usually goes when sick or in need of health advice. No usual source of care includes those who reported no usual source of care and those who indicated the emergency department as their usual source of care.

Percentage of US Population Without a Usual Source of Care Rises to Highest Level in Last Decade



Source:
https://www.milbank.org/primary-care-scorecard/

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What is the cost of neglect?

Primary care services undervalued, undermining ability to provide high-quality care

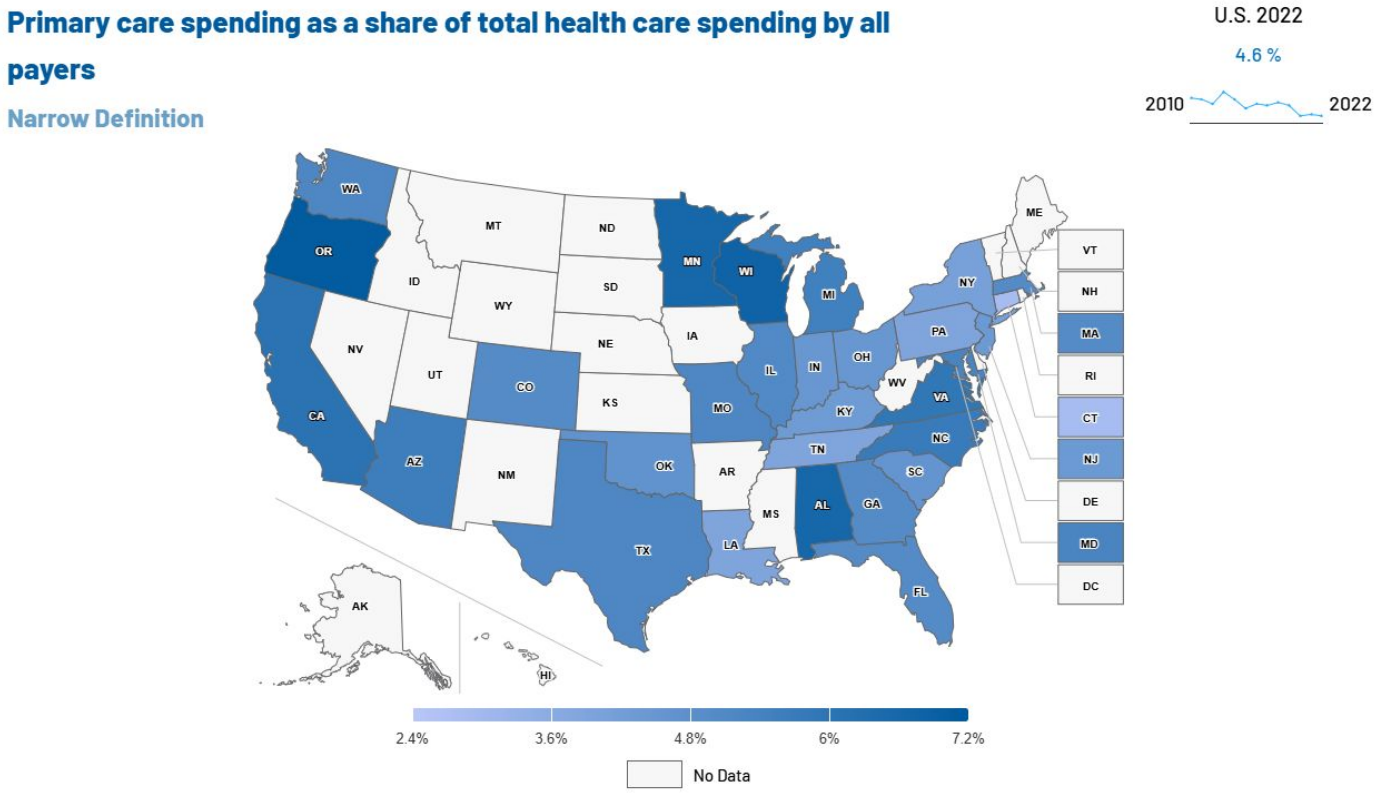
Increasing workloads and practice inefficiencies

Financially strained primary care practices

Burdensome EHR and lack of innovation

Limited evidence-based improvements in primary care

Find the report and data dashboard on milbank.org



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What is to be Done?

National Academy of Science Engineering and Medicine Committee: "Implementing High Quality Primary Care"

"NASEM committee will examine the current state of primary care in the United States and **develop an implementation plan** to build upon the recommendations from the 1996 IOM report, *Primary Care: America's Health in a New Era*, **to strengthen primary care services** in the United States, especially for underserved populations, and **to inform primary care systems** around the world. "

Primary Care as a Common Good

High quality primary care has high societal value among health care services yet is in a precarious status

Requires public policy for oversight and monitoring - we will not innovate our way out of this problem

Needs strong advocacy, organized leadership, and public awareness

5 Objectives for Achieving High-Quality Primary Care

1 PAYMENT
Pay for primary care teams to care for people, not doctors to deliver services

2 ACCESS
Ensure that high-quality primary care is available to every individual and family in every community

3 WORKFORCE
Train primary care teams where people live and work

4 DIGITAL HEALTH
Design information technology that serves the patient, family, and interprofessional care team

5 ACCOUNTABILITY
Ensure that high-quality primary care is implemented in the United States

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

1

PAYMENT

Pay for primary care teams to care for people, not doctors to deliver services.

Action 1.1: Payers should evaluate and disseminate payment models based on their ability to promote the delivery of high-quality primary care, not short-term cost savings.

Action 1.2: Payers using fee-for-service models for primary care should shift toward hybrid reimbursement models, making them the default over time. For risk-bearing contracts, payers should ensure that sufficient resources and incentives flow to primary care.

Action 1.3: CMS should increase overall portion of health care spending for primary care by improving Medicare fee schedule and restoring the RUC to advisory nature.

Action 1.4: *States should facilitate multi-payer collaboration and increase the portion of health care spending for primary care.*

2

ACCESS

Ensure that high-quality primary care is available to every individual and family in every community.

Action 2.1: Payers should ask all beneficiaries to declare usual source of care. Health centers, hospitals, and primary care practices should assume ongoing relationship for the uninsured they treat.

Action 2.2: HHS should create new health centers, rural health clinics, and Indian Health Service facilities in shortage areas.

Action 2.3: CMS should revise access standards for primary care for Medicaid beneficiaries and provide resources to state Medicaid agencies for these changes.

Action 2.4: CMS should permanently support COVID-era rule revisions.

Action 2.5: Primary care practices should include community members in governance, design, and delivery, and partner with community-based organizations.

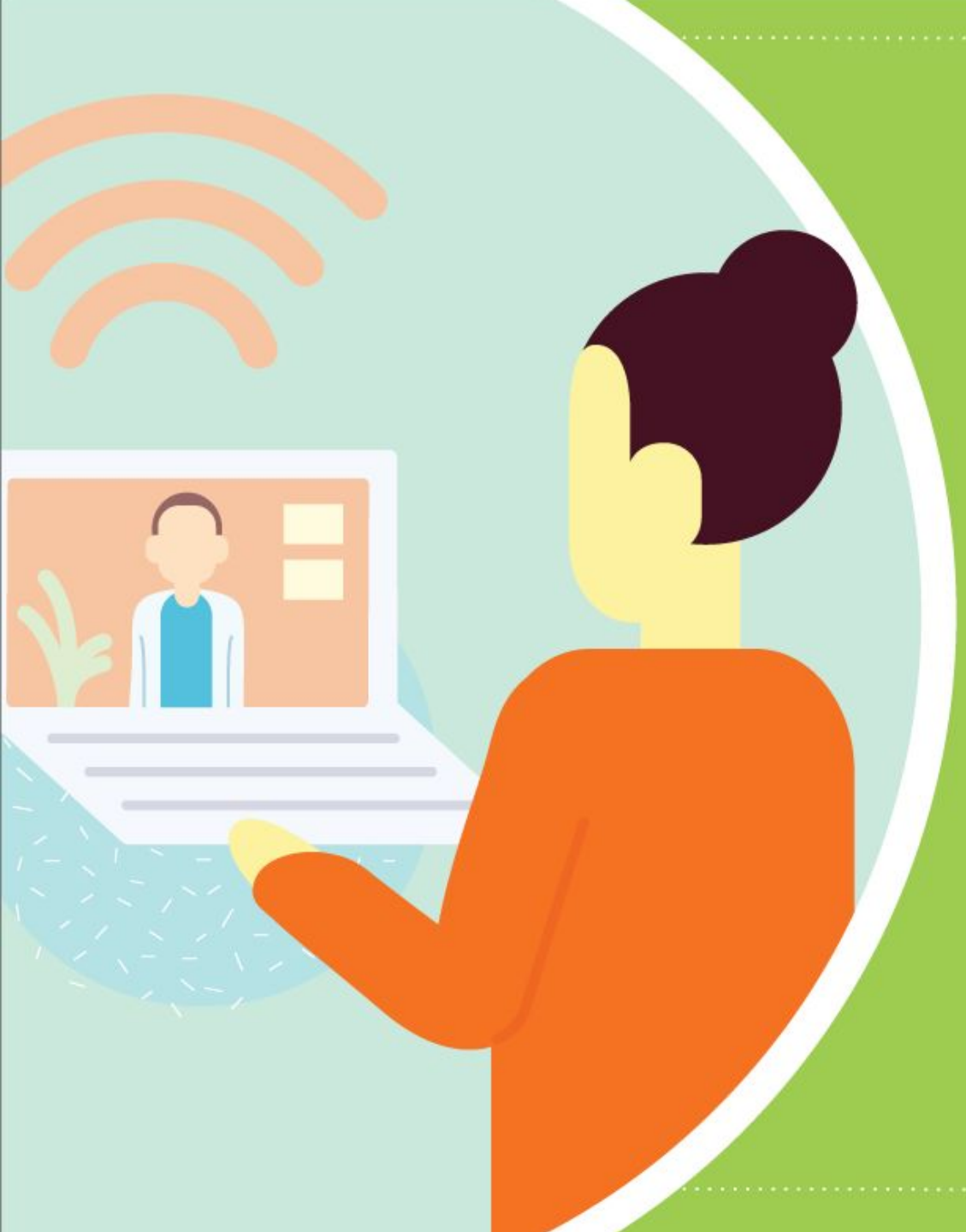
3

WORKFORCE

Train primary care teams where people live and work.

Action 3.1: Health care organizations should strive to diversify the primary care workforce and customize teams to meet the needs of the populations they serve. Government agencies should expand educational pipeline models and improve economic incentives.

Action 3.2: CMS, the Department of Veterans Affairs, HRSA, and states should redeploy or augment Title VII, Title VIII, and GME funding to support interprofessional training in community-based, primary care practice environments.



4

DIGITAL HEALTH

Design information technology that serves the patient, family, and interprofessional care team.

Action 4.1: ONC and CMS should develop next phase of digital health certification standards that support relationship-based, continuous and person-centered care; simplify the user experience; ensure equitable access and use; and hold vendors accountable.

Action 4.2: ONC and CMS should adopt a comprehensive aggregate patient data system that is usable by any certified digital health tool for patients, families, clinicians, and care team members.

5

ACCOUNTABILITY

Ensure that high-quality primary care is implemented in the United States.

Action 5.1: The HHS Secretary should establish a Secretary's Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders.

Action 5.2: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ.

Action 5.3: Primary care professional societies, consumer groups, and philanthropies should assemble, regularly compile, and disseminate a "High-quality primary care implementation scorecard" to improve accountability and implementation.

Forging AHEAD

(Don’t Bury the Lede)

MDPCP experience + AHEAD = Opportunity for:

- Stronger Primary Care in MD
- Better Health for Marylanders
- National Model All Payer Alignment

MDPCP Works….

- "The study found that the MDPCP group had a lower incidence of COVID-19 diagnosis (4.3% of beneficiaries vs. 4.6%), a lower rate of COVID-19–related inpatient admissions (1.29% vs. 1.43%), and a lower COVID-19 death rate (0.41% vs. 0.5%)."

From Hilltop Evaluation:

- A 4.33% decrease in total Medicare Part A and B expenditures
- A 7.18% decrease in inpatient utilization
- A 1.70% decrease in emergency department utilization
- Total spending was budget neutral (program payments are balanced by cost savings)

Primary Care in AHEAD

- "The overarching goals of Primary Care AHEAD are to …**increase investments** in primary care as a percent of the total cost of care (TCOC) …across all payers and to **support advanced primary care initiatives** through capacity-building efforts. "

- The (Primary Care in AHEAD) Model includes a strong focus on strengthening advanced primary care, promoting behavioral health integration, and improving care coordination.
  - Includes **enhanced payments** to practices to promote advanced primary care.
  - …(P)ractices must be participating in the state's … primary care alternative payment model and must meet certain care transformation requirements that will be **aligned across Medicaid and Medicare.**
  - **Performance goals** for practices on identified quality measures.

Source: From NASHP

MDPCP plus AHEAD Checks the Boxes for What is Needed to Build Strong Primary Care for Everybody

- Enhanced and Hybrid, All payer alignment, Increased PCP spend
- Medicaid and FQHC Engagement
- Empanelment

Care Transformation Organizations and CRISP

Evaluation

Some Things for an AHEAD Primary Care Advisory Council Keep an Eye On

- Goldilocks level of *standards* and *alignment* across payers for payment and advanced primary care elements
- Empanelment (lessons of ACOs)
- Public accountability for health plans and health systems for implementation and performance
- Making sure dollars to health systems support primary care (The employed clinician challenge)
  - Monitoring of system expenditures
- Scope Creep
- Building consumer engagement and a primary care constituency

Parting Thoughts

- Great opportunity for the Old Line State
- Think about the primary care ecosystem in the state
- Hold health plans and state accountable for implementation and monitoring
- Thank you for your service

Overview of Maryland's AHEAD Primary Care Programs

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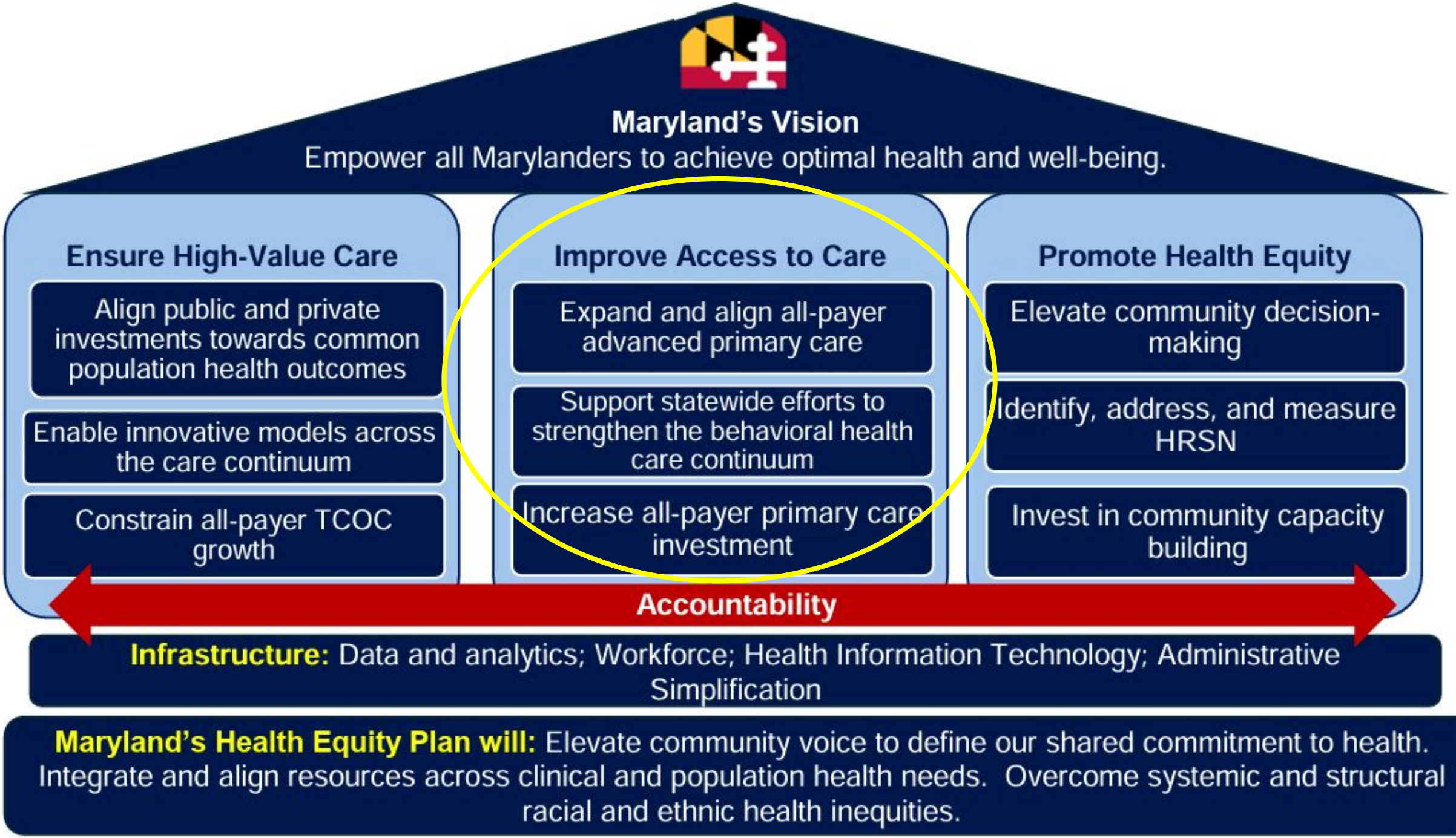
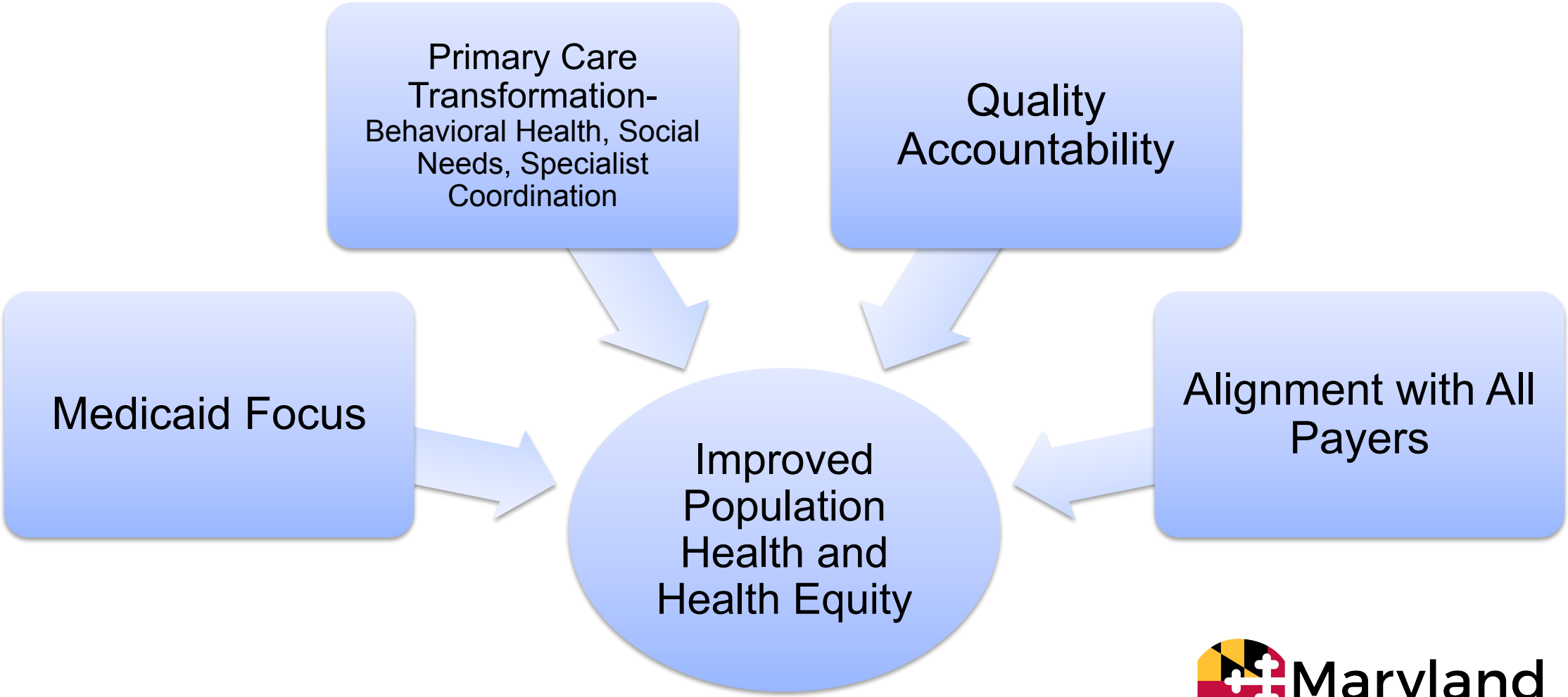

Maryland's Vision
Empower all Marylanders to achieve optimal health and well-being.
Ensure High-Value Care
Align public and private investments towards common population health outcomes
Enable innovative models across the care continuum
Constrain all-payer TCOC growth
Improve Access to Care
Expand and align all-payer advanced primary care
Support statewide efforts to strengthen the behavioral health care continuum
Increase all-payer primary care investment
Promote Health Equity
Elevate community decision-making
Identify, address, and measure HRSN
Invest in community capacity building
Accountability
Infrastructure: Data and analytics; Workforce; Health Information Technology; Administrative Simplification
Maryland's Health Equity Plan will: Elevate community voice to define our shared commitment to health. Integrate and align resources across clinical and population health needs. Overcome systemic and structural racial and ethnic health inequities.

AHEAD Requirements for Primary Care



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MDH's Vision and Goals for Primary Care AHEAD

VISION

- Advance whole-person care
- Establish strong linkages across the healthcare continuum
- Build a highly reliable program that sustains advanced primary care as a foundation for Marylanders

GOALS

- Simplify administrative burden for primary care providers
- Continue Medicare investment while broadening reach to Marylanders covered by Medicaid and commercial insurance
- Improve health outcomes for all Marylanders

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Design Principles

Leverage Successes of MDPCP

Initial model starts with MDPCP practices with substantial Medicaid mix (250 or more members from across MCOs)

Medicaid Leads

Ensure multi-payer access - Agreement requires participation in Medicaid Advanced PCP to access Medicare Path

Inclusion of pediatric practices

Simple "Rules"

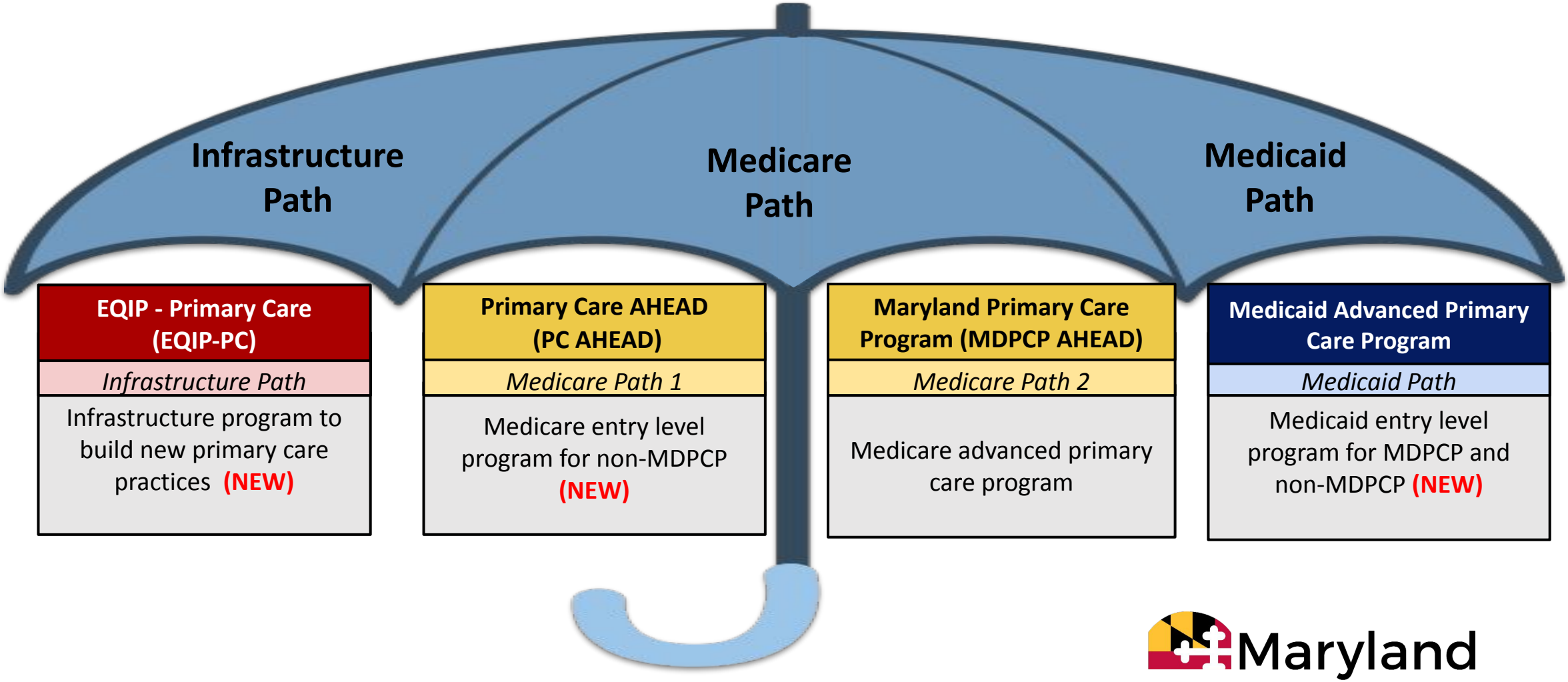
Administrative simplification to maximize provider participation

Aligned quality measures, payments and data sharing across Medicare/Medicaid

Allow for Growth

Use an incremental approach to allow for growth and innovation

Maryland's AHEAD Primary Care Programs



EQIP - Primary Care (EQIP-PC)	Primary Care AHEAD (PC AHEAD)	Maryland Primary Care Program (MDPCP AHEAD)	Medicaid Advanced Primary Care Program
Infrastructure Path	*Medicare Path 1*	*Medicare Path 2*	*Medicaid Path*
Infrastructure program to build new primary care practices **(NEW)**	Medicare entry level program for non-MDPCP **(NEW)**	Medicare advanced primary care program	Medicaid entry level program for MDPCP and non-MDPCP **(NEW)**

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Three Paths Available

Medicaid Path

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

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

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

Medicare Path

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

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

Infrastructure Path

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

Payment Structure Overview

Medicaid Path

Medicaid Advanced Primary Care Program

Payment structure:

- Enhanced E&M Fees *(All PCPs)*
- Care Management Fees
- Quality Incentives

Medicare Path

PC AHEAD

Payment structure:

- FFS billing
- Care Management Fees (Enhanced Primary Care Payment)
- Quality component

MDPCP AHEAD

Payment structure:

- Comprehensive Primary Care Payments (hybrid FFS)
- Care Management Fees (includes HEART)
- Performance-Based Incentive Payments

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Medicaid Path (Medicaid Advanced PCP)

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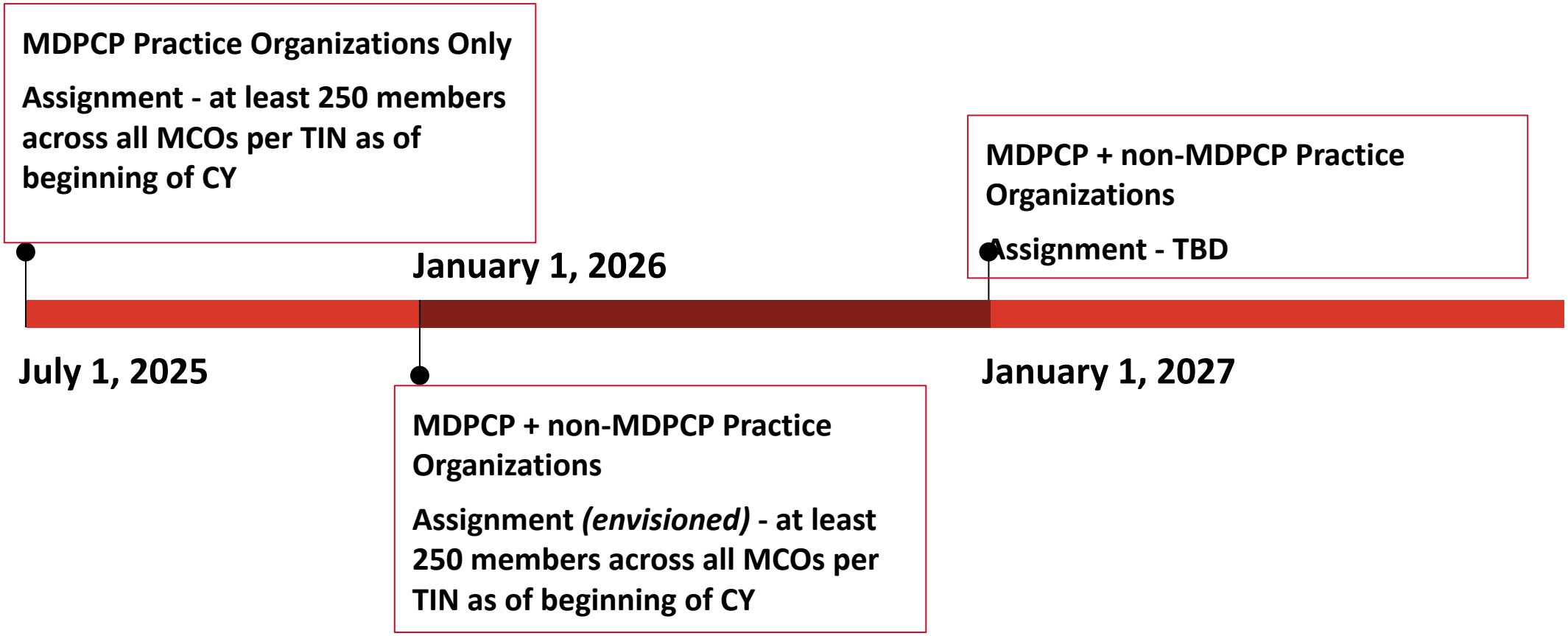
Medicaid Path Eligibility



Note: Participation in the Medicaid model is voluntary

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Medicaid Path Payments Overview

- Care management payments go through existing MCO contracts with PCP organizations
- Quality incentives to be managed by MDH

E&M Increases

Care Management Fees

Quality Incentives (Begin in 2026)

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Medicaid Path List of Measures

Measure Name	Adult/Peds	Claims or eCQM?
Emergency Department Utilization (EDU)	Adult	Claims
Acute Hospital Utilization (AHU)	Adult	Claims
Child and Adolescent Well-Care Visits	Peds	Claims
Developmental Screening in the First Three Years of Life	Peds	Claims
Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (> 9.0%)	Adult	eCQM
Controlling High Blood Pressure	Adult	eCQM
Preventative Care and Screening: Screening for Depression and Follow-Up Plan	Adult/Peds	eCQM
Colorectal Cancer Screening	*Adult*	*eCQM*
Follow-Up After Acute Care Visits for Asthma (AAF-E)	*Peds*	*TBD*

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Mathematica®
Progress Together

Maryland Medicaid AHEAD Primary Care Quality Incentive Approach

May 28, 2025

Agenda

- Guiding Principles
- Component 1: Quality Measures
- Component 2: Target Setting Methodology
- Component 3: Quality Incentive Distribution
- CY2026 Quality Incentive Timeline
- Topics for Future Meetings

Guiding Principles

Quality Incentive Methodology

Design Criteria

- Align measures and methodology with other AHEAD Primary Care Programs
- Select validated measures aligned with population health priorities
- Incentivize both high-performance and performance improvements
- Set achievable benchmarks and disseminate in advance of the performance year
- Minimize administrative burden on practices

Component 1 – Quality Measures

Component 1 – Quality Measures

Calendar Year (CY) 2026 Claims-Based Quality Measures

MDH has proposed the following claims-based measures to be included in the CY2026 quality incentive for the Medicaid Path:

- Pay-for-performance (P4P) measures for CY2026.

Population	Domain	Measure Name	Data Source	CY2026
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Claims in Medicaid Enterprise System (MES)	P4P (upward incentive)
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Medicaid claims (MES)	P4P (upward incentive)
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Medicaid claims (MES)	P4P (upward incentive)
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Medicaid claims (MES)	P4P (upward incentive)

- In P4P, MDH will define the performance measures in the quality incentive, set targets for each quality measure, and award financial incentives to participating PCPs that meet or exceed those targets.

Component 1 – Quality Measures

Potential Electronic Clinical Quality Measures (eCQMs) for CY2026

Population	Domain	Measure Name	Notes
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan (CDF-AD): Ages 12 to 64	CMS Core Set MDPCP measure currently being reported for Medicare through CRISP. One measure for children and adults with different age groups.
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CDC-HbA1c Poor Control)	eCQM MDPCP measure currently being reported for Medicare through CRISP.
Adults	Chronic Conditions	Controlling High Blood Pressure (CBP)	eCQM MDPCP measure currently being reported for Medicare through CRISP.

Question for Discussion

- Do participating PCPs have the capability to pull Medicaid-only eCQM data for these three measures through EHRs?

Component 1 – Quality Measures

Future Digital Quality Measures

Population	Domain	Measure Name	Comments
Adults	Prevention & Wellness	Colorectal Cancer Screening (COL)	This is a NCQA HEDIS measure and an eCQM measure. PC AHEAD will have this measure in 2026.
Children	Care for Acute and Chronic Conditions	Follow-Up After Acute Care Visits for Asthma (AAF-E)	This is a future NCQA HEDIS measure collected via electronic clinical data system (ECDS).

Component 2 – Target Setting Methodology

Component 2 – Target Setting Methodology

What is baseline data?

Data source used to calculate the targets upon which participating primary care providers will be measured. MDH will use data for dates of service 1/1/24 to 12/31/24.

Medicaid-only Data

Claims-based measures baselines and results will be captured directly from the Medicaid data warehouse.

Same measure specifications will be used to calculate baselines and results

Target Setting Methodology

Targets should reward high-performance (or attainment) and improvement in performance over time.

Component 2 – Target Setting Methodology

Targets will reward high-performance

Source Data for Target Setting

National data for NCQA HEDIS measures.

Statewide data for measures when national data is not available.

NCQA HEDIS Measures

MDH will use Medicaid data from NCQA Quality Compass to set targets for these measures.

Non-NCQA HEDIS Measures

MDH will utilize CY2024 state-wide data and calculate the mean and percentiles to set targets for these measures.

Component 2 – Target Setting Methodology Improvement Target

- **Targets should also reward PCPs for improvement in their performance.**
- **Reduction in Error Methodology**
  - Methodology similar to proposed methodology for PC AHEAD.
  - For example, primary care practice A has a Child and Adolescent Well-Care Visits (WCV) rate of 70% in CY2024 (baseline).
  - Error = 100% - 70% = 30%
  - 10% Reduction in Error (RIE) = 30% - 3% = 27%
  - 10% RIE Target for primary care practice A = 100% - 27% = 73%
- **If MDH cannot calculate practice-specific baseline data by December 2025, then MDH can introduce improvement targets for CY2027.**

Component 3 – Quality Incentive Distribution

Component 3 – Quality Incentive Distribution

Weights per Measure

- Each measure in the quality incentive will have an equal weight.

P4P vs. P4R Measures

- P4P measures should each have the same weight and P4R measures should weigh 50% of one P4P measure.

Don’t adopt an all-or nothing approach

- Performance per measure is independent of each other.
  - If a PCP meets the target for Child and Adolescent Well-Care Visits (WCV), but fails to meet targets for other measures, the PCP would still be able to earn the corresponding amount for the WCV measure.

MDH will establish a quality PMPM for participating PCPs.

Component 3 – Quality Incentive Distribution

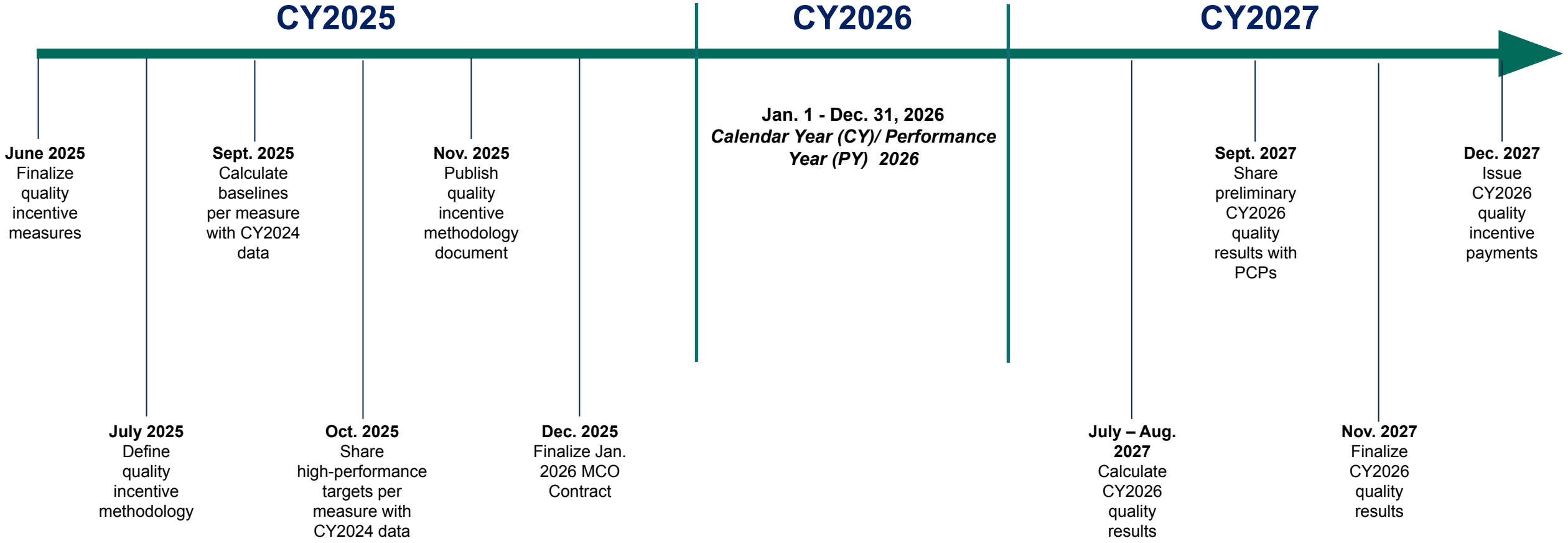
Hypothetical Example of Measure Weights and Potential Incentive Amount per Measure for CY2026 with P4P Measures Only

- To calculate the weight per measure, use this formula: 100%/Total number of P4P measures

Number of Measures	Population	Domain	Measure Name	CY2026	Potential Weight (hypothetical example of $1 PMPM quality incentive)
1	Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	P4P (upward incentive)	25% of $1 PMPM = $0.25 PMPM
2	Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	P4P (upward incentive)	25% of $1 PMPM = $0.25 PMPM
3	Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits	P4P (upward incentive)	25% of $1 PMPM = $0.25 PMPM
4	Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	P4P (upward incentive)	25% of $1 PMPM = $0.25 PMPM

CY2026 Quality Incentive Timeline

CY2026 Medicaid AHEAD Primary Care Quality Incentive Timeline



Topics for Future Meetings

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CY2026 Quality Incentive

- Finalize CY2026 quality incentive measures and methodology
- Review CY2026 quality incentive methodology document

CY2026 Quality Targets

- Review CY2024 baseline data that will be used to set CY2026 quality incentive targets
- Share CY2026 quality incentive high-performance targets

PCP Capabilities

- Discuss what PCP practices would need to be successful and qualify for quality incentive

Questions?

Public Comments

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Next Steps

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Future Agenda and Meeting Dates

Upcoming topics

- Medicaid care management requirements and workflows with MCOs
- Performance measure methodology
- Implementing care transformation requirements
- Transition to digital quality measures

Upcoming meetings

- July 2025
- Sept 2025

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Appendix

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Resources

- PC Advisory Council Members and Bios
- Maryland's AHEAD Primary Care Programs webpage
- AHEAD Model Overview
- Hilltop MDPCP Evaluation, 2019-2022
- CMS PC-AHEAD Factsheet
- AHEAD Model Primary Care Town Hall Slide Deck