Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

December 9, 2025

The Honorable Guy Guzzone
Chair, Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes
Chair, House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2025 Joint Chairmen's Report (p. 167) – Evaluation of Primary Care Program and Initiatives in Coordination with AHEAD Model

Dear Chairs Guzzone and Barnes:

Pursuant to the requirements of the 2025 Joint Chairmen's Report (p. 167), the Maryland Department of Health (the Department) respectfully submits this report on the Maryland Primary Care Program (MDPCP) and initiatives in coordination with the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. This report provides information on the implementation of new initiatives and an evaluation of the effectiveness of the existing MDPCP.

If you have any questions or concerns, please contact Meghan Lynch, Office of Governmental Affairs, at Meghan.Lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary of Health

cc: Perrie Briskin, Deputy Secretary, Health Care Financing and Medicaid Director
Alyssa Brown, Director of Innovation, Research, and Development
Rebecca Frechard, Deputy Director, Medicaid Behavioral Health Division
Sarah Albert, Department of Legislative Services (5 copies)

AHEAD Primary Care Programs: Updates

2025 Joint Chairmen's Report Pg. 167

November 2025

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I. Executive Summary

Launched in 2019, the Maryland Primary Care Program (MDPCP or the Program) is a voluntary value-based payment program open to all qualifying Maryland primary care providers. MDPCP is a component of the Total Cost of Care (TCOC) Model and is jointly operated by the Center for Medicare and Medicaid Innovation (CMMI), a Center within the federal Centers for Medicare and Medicaid Services (CMS), and the Office of Advanced Primary Care (OAPC) at the Maryland Department of Health (MDH or the State). MDPCP provides participating practices with value-based payments and technical assistance to deliver advanced primary care. The Program allows primary care providers to play an increased role in preventing unnecessary hospital utilization and managing chronic disease in Marylanders.

At the end of 2023, CMMI announced a new statewide health care transformation model: the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. Maryland has agreed to join AHEAD starting in 2026, In preparation for the transition to AHEAD, MDH is working closely with CMMI to finalize the structure of a suite of primary care programs to be available in Maryland including the continuation of MDPCP.

The 2025 Joint Chairmen's Report (JCR) directed MDH and the Health Services Cost Review Commission (HSCRC) to submit a report on new initiatives, program design, and initial activities under AHEAD. The JCR also asks for an evaluation of MDPCP. Last year, MDH contracted with The Hilltop Institute at the University of Maryland Baltimore County to analyze the program's effectiveness by comparing cost savings, utilization, and the additional payments provided to primary care practices serving Medicare beneficiaries in MDPCP. Since the evaluation was conducted, MDH has continued to monitor key performance indicators including scope and size, utilization, quality, and care management. Key findings include:

- From 2019 to 2024, MDPCP practices had a 14% decrease in Inpatient (IP) per 1,000 beneficiaries and a 19% decrease in Emergency Department (ED) per beneficiaries
- In 2023, 89.7% of MDPCP practices scored in the 50th percentile or higher for the diabetes control quality measure
- At the end of 2023, MDPCP practices reported that 86.3% of beneficiaries received follow-up after a hospital admission within two business days and 86.2% received follow-up after an emergency department visit within one week

The full set of details on MDPCP performance is included in this report. MDH plans to pursue an updated analysis on MDPCP in 2026 to reflect performance through 2025 under the TCOC Model. In addition, this report provides an update on the development and launch of the Medicaid Advanced Primary Care Program (Medicaid Path), a requirement of the State to participate in AHEAD. The Medicaid Path was launched August 1, 2025 and will be fully formed starting in January 2026. This report details the program funding as well as early design and implementation of payments, care transformation requirements, and technical support strategies driven by the State. Finally, this report provides an update on the Population Health Improvement Fund including the status on funding and initial planned strategies.

II. Introduction

The 2025 Joint Chairmen's Report (JCR) directed the Maryland Department of Health (MDH) in collaboration with the Health Services Cost Review Commission (HSCRC) to evaluate the Maryland Primary Care Program (MDPCP) and report on the implementation of new initiatives under the State's Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. Specifically, the JCR included the following language:

> The Maryland Department of Health (MDH) and the Health Services Cost Review Commission (HSCRC) are implementing primary care and population health initiatives in coordination with the State's Achieving Healthcare Efficiency through Accountable Design (AHEAD) model. These efforts include launching the Medicaid Advanced Primary Care Program in fiscal 2026, establishing the Population Health Improvement Fund, and continuing to administer the Maryland Primary Care Program (MDPCP) that was first implemented under the Total Cost of Care model (the federal agreement before the AHEAD model).
>
> The committees request that MDH, in consultation with HSCRC, submit a report on implementation of the new initiatives, including design and initial activities of the programs, uses of any funding allocated to these initiatives, descriptions of fund sources supporting the initiatives, and estimated cost savings and provider incentives under the Medicaid Advanced Primary Care Program. The report should also include an evaluation of the effectiveness of the existing MDPCP. In particular, this evaluation should outline cost savings from the MDPCP reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives.

This report, submitted in response to the 2025 JCR, contains background information on the transition from the Total Cost of Care (TCOC) Model to AHEAD, an update on MDPCP, and a description of new initiatives including the Medicaid Advanced Primary Care Program (Medicaid Path) and the Population Health Improvement Fund. This report was jointly developed by MDH and HSCRC.

III. Background

In Fall 2023, the Centers for Medicare and Medicaid Services (CMS) announced AHEAD, a new state total cost of care model.[1] AHEAD builds upon work of existing Center for Medicare and Medicaid Innovation (CMMI) state-based models including Vermont's All-Payer Accountable Care Organization (VT ACO), Pennsylvania's Rural Heath Model (PARHM), and Maryland's Total Cost of Care Model (TCOC). Maryland is the only state that is participating in Cohort 1, which will kickoff January 2026.

[1] For more information on AHEAD https://www.cms.gov/priorities/innovation/innovation-models/ahead

The goal of AHEAD is for CMS to collaborate with states to curb health care cost growth, improve population health, and promote healthier living.[2] As we approach the inaugural program year, Maryland is collaborating closely with CMS on key program design elements and operational details.

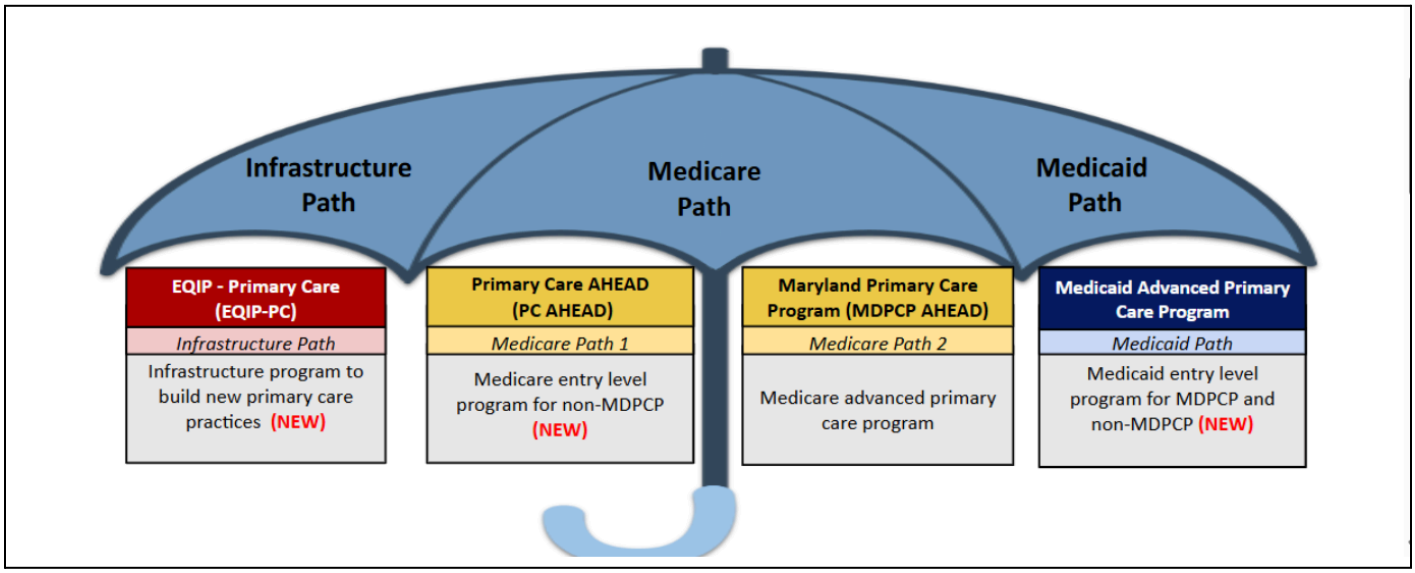
Through AHEAD, Maryland envisions building a sustainable advanced primary care system that provides high-quality whole person care for all Marylanders and supports strong linkages across the healthcare continuum. Leveraging the success of MDPCP established under the TCOC Model, AHEAD aims to improve health outcomes for all people in Maryland, while simplifying the administrative burden for providers through all-payer alignment.

As a participant in the model, Maryland is required to launch a Medicaid Path, which will serve as a gate for practices to access the Medicare value-based primary care programs. In response to this requirement, Maryland has built three main primary care pathways under AHEAD: an infrastructure path, a Medicare path, and a Medicaid Path. As illustrated in Figure 1 below, the Infrastructure path is for a small group of select practices that are building new or expanding advanced primary care in underserved areas of the state. The Medicare path includes two options, one for current MDPCP practices (Medicare Path 2/MDPCP AHEAD) and a supplemental option for practices that are not currently participating in MDPCP (Medicare Path 1/Primary Care (PC) AHEAD). The Medicaid Path is new and has begun operating with current MDPCP practices. Non-MDPCP practices may enroll in the Medicaid Path beginning January 2026.

A brief note about Medicare Path 2. Over the progression of the program, MDPCP offered an advanced track with upside and downside financial risk: Track 3. This Track was launched in 2023, which coincided with the last year of Track 1, the entry-level track. Despite good intentions, the complexity of Track 3's performance methodology has proved challenging in operation and CMS has decided to sunset Track 3 at the end of 2025, mirroring the timeline for the TCOC Model. As Maryland transitions to AHEAD, MDPCP will remain an option for eligible primary care practices, however it will now be called MDPCP AHEAD and it will operate like Track 2 in MDPCP's current design.

[2] For more information on AHEAD https://www.cms.gov/priorities/innovation/innovation-models/ahead

Figure 1: **Diagram of Maryland's AHEAD Primary Care Programs**



IV. Maryland Primary Care Program

MDPCP is a voluntary program open to all qualifying primary care providers that launched in 2019, providing funding and support for the delivery of advanced primary care throughout Maryland. Jointly operated by MDH and CMMI, MDPCP aims to strengthen primary care practices by allowing providers to play an increased role in prevention, management of chronic disease, and the prevention of unnecessary hospital utilization for Medicare beneficiaries.

MDPCP facilitates connections with services such as care coordination, social services, and behavioral health integration at no additional cost to providers. Participating practices receive prospective payments to implement these services, facilitating a shift from volume-based to value-based care. For the purposes of MDPCP, participating practices have the option of partnering with a Care Transformation Organization (CTO), which hires and manages an interdisciplinary care management team to support practices with care transformation assistance and supplemental staffing.

Participating practices are expected to provide their attributed Medicare beneficiaries "advanced primary care." MDPCP practices receive care management fees to fund this expanded set of services. This concept is based on the patient-centered medical home model where primary care physicians act as the quarterback of a patient's care. For the purposes of MDPCP, advanced primary care is defined as providing the following five primary care functions:

- **Care Management**: Practices are required to provide care management for high-risk, high-need, and rising-risk Medicare beneficiaries by integrating a care manager into practice operations. Practices must risk stratify all attributed beneficiaries to determine each beneficiaries' care

management needs. Practices are required to provide long-term care management to beneficiaries with chronic conditions and episodic care management to beneficiaries with acute needs.

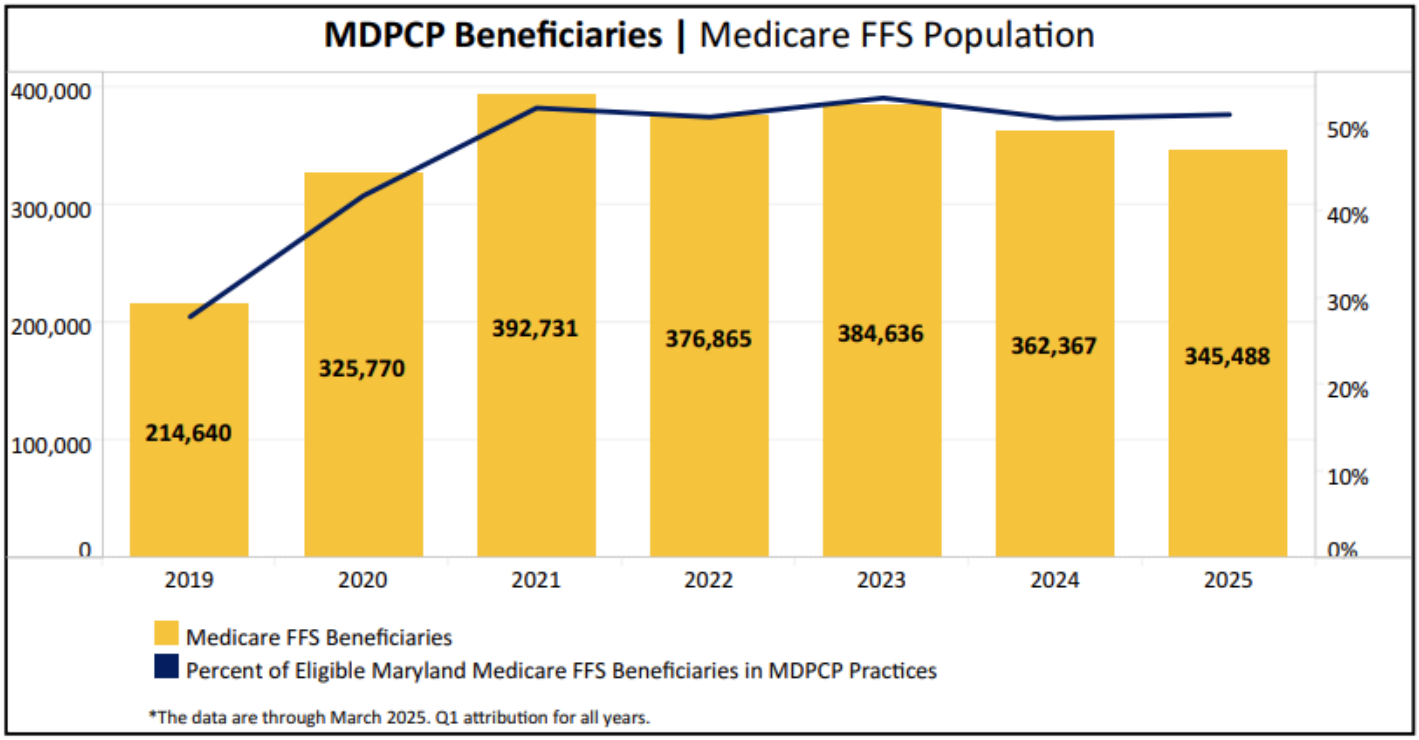
- **Access and Continuity**: Participating MDPCP practices are required to expand access to care through expansion of hours and telehealth. Practices in MDPCP are also required to empanel each Medicare beneficiary attributed to their practice to a provider or care team.
- **Planned Care for Health Outcomes**: Practices use data to develop interventions that engage high-risk beneficiaries, before they require hospitalization, through health coaches and educators (including community health workers) and partnerships with the non-clinical community. All practices are required to utilize evidence-based protocols for screening, diagnosis, and treatment of patients.
- **Beneficiary and Caregiver Experience**: Practices must improve care processes using a Patient-Family/Caregiver Advisory Council to involve beneficiaries and their families in developing the practice's care redesign plans.
- **Comprehensiveness and Coordination across the Continuum of Care**: MDPCP practices integrate behavioral health services into their practices, work with patients to identify and address social needs of their patients, and provide advanced medication management. Practices receive care notifications from Maryland's state-designated health information exchange when their patients visit an emergency department (ED) or are admitted or discharged from the hospital. Practices are expected to identify high-volume/high-cost specialists serving their beneficiaries and strengthen their referral and/or co-management relationships with specialists and with community and social services.

It is important to note that the care transformation that occurs within these practices, accrues benefits to all patients, regardless of payer type. Participating practices are monitored by CMS for their progress on the five functions and the State provides technical support to participants. Incentive payments are also provided to MDPCP practices, which are designed to encourage and reward accountability for beneficiary experience, clinical quality, and utilization measures that drive total cost of care. CMS measures performance for all beneficiaries regarding quality and patient experience. CMS also evaluates practices on hospital and ED utilization for attributed Medicare beneficiaries as well as costs. The following sections provide an update on relevant metrics.

Updates on Program Performance

As of January 2025, 481 practices and 25 CTOs are participating in MDPCP. Of the 481 participating practices, 20% are in Track 2 and 80% are in Track 3, the most advanced pathway available to practices. As Figure 2 shows, MDPCP practices were responsible for 345,488 Medicare fee-for-service (FFS) beneficiaries as of Quarter 1 (Q1) 2025, which is a 4.7% decrease in Medicare FFS beneficiaries from Q1 2024.

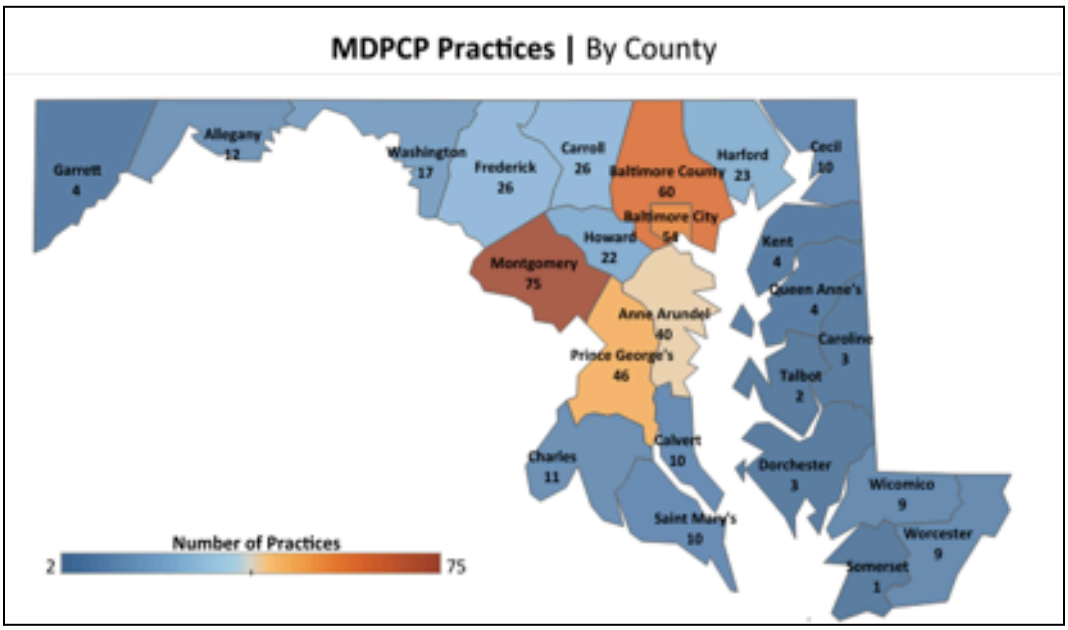
Figure 2: MDPCP Medicare FFS populations, 2019-2025



Note. The graph shows the number of MDPCP Medicare FFS Beneficiaries from 2019 to 2025. The data are through March 2025 and Q1 attribution for all years. Data sourced from Medicare Claims and Claims Line Feed (CCLF).

The number of providers as of February 2025 is 2,087, with a majority of physicians (MD or DO). The number of dual eligibles as of July 2025 is 39,520 which is around a 23.2% decrease from 2024. The decrease in participating practices has led to a decrease in beneficiaries, which is most likely due to a routine number of mergers, acquisitions, practice closures. Additionally, the program did not have a recruitment cycle for program year (PY) 2025 per program regulation set forth by CMMI. Despite this decrease, MDPCP practice sites are still represented in every county in Maryland, with the highest proportions residing in Montgomery County, Baltimore County, Baltimore City and Prince George's County.

Figure 3: MDPCP Practices by County, 2025



Note. The map shows the distribution and number of MDPCP practices by county in Maryland. The marks on the map are labeled by county and number of practices within the county. The data are through January 2025. Data sourced from the CMS portal.

Utilization

MDPCP practices have consistently performed better than both established comparison populations (Statewide Non-Participating and Equivalent Participating Population)[3] with regard to Emergency Department (ED) per 1,000 beneficiaries, Inpatient (IP) per 1,000 and Prevention Quality Indicator (PQI)-like events[4] per 1,000 beneficiaries metrics. From 2019 to 2024, MDPCP practices saw a 14% decrease in IP per 1,000 beneficiaries utilization *(Figure 4)*, a 19% decrease in ED per 1,000 beneficiaries *(Figure 5)*, and a 27% decrease in PQI-Like events per 1,000 beneficiaries *(Figure 6)*.[5] From 2023 to 2024, MDPCP practices saw a 1.1% decrease in IP per 1,000 beneficiaries utilization *(Figure 4)*, a 1.6%

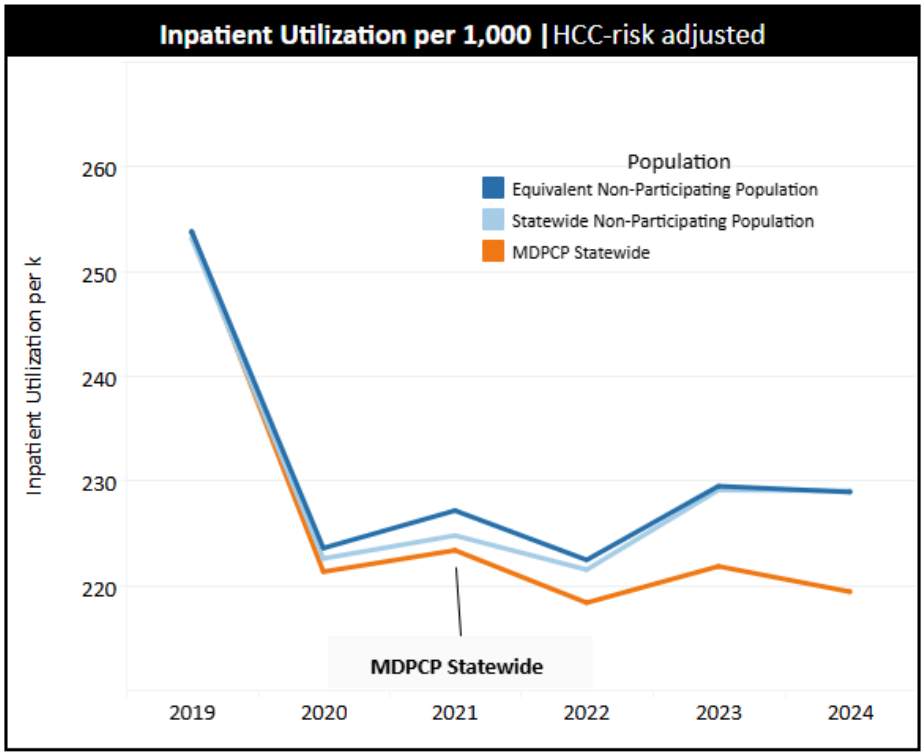
[3] Population definitions: **Statewide Non-Participating Population:** All Medicare FFS beneficiaries who are eligible for MDPCP and attributed to a provider who is not participating in MDPCP. **Equivalent Non-Participating Population**: Represents a non-participating MDPCP population matched to the participating MDPCP population. This population is a subset of the statewide nonparticipating population, demographically matched to participants by age band, sex, dual eligibility, and county of residence. **State – MDPCP:** Represents all Medicare FFS beneficiaries attributed to MDPCP participating practices.

[4] PQI-Like Events per 1,000 beneficiaries: Prevention Quality Indicators (PQIs) are a set of metrics measuring potentially avoidable hospital events from 10 key conditions known as ambulatory sensitive conditions (ACSCs). ACSCs are conditions that should be treatable in an outpatient setting or that could be less severe if treated and managed at the outpatient level. PQIs are defined by AHRQ (Agency for Healthcare research and Quality). Maryland includes Inpatient and ED events in this definition. *
* For more information on AHRQ's definition of PQI: AHRQ PQI Technical Documentation, Version v2024, Agency for Healthcare Research and Quality, Rockville, MD. https://qualityindicators.ahrq.gov/measures/pqi_resources. Accessed October 21st, 2024

[5] PQI-Like Events per 1,000 beneficiaries: PQIs are a set of metrics measuring potentially avoidable hospital events from 10 key conditions known as ACSCs.

decrease in ED per 1,000 beneficiaries *(Figure 5)*, and a 1.5% decrease in PQI-Like Events per 1,000 beneficiaries *(Figure 6)*.

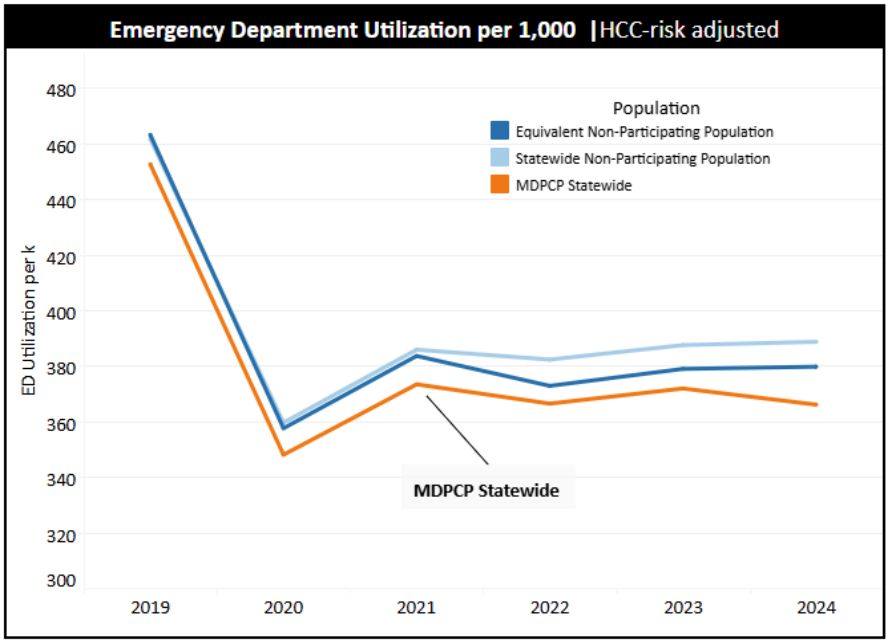
Figure 4: Inpatient Utilization per 1,000 (Hierarchical Condition Categories (HCC) Risk Score (HCC) risk-adjusted), 2019-2024



Note. The graph shows the inpatient utilization per 1,000 beneficiaries from 2019-2024 of MDPCP Statewide and the comparison populations (Equivalent Non-Participating Population and Statewide Non-Participating Population).[6] Data are through December 2024. Data sourced from Medicare Claims and Claims Line Feed (CCLF).

[6] Population definitions: **Statewide Non-Participating Population:** All Medicare FFS beneficiaries who are eligible for MDPCP and attributed to a provider who is not participating in MDPCP. **Equivalent Non-Participating Population:** Represents a non-participating MDPCP population matched to the participating MDPCP population. This population is a subset of the statewide nonparticipating population, demographically matched to participants by age band, sex, dual eligibility, and county of residence. **State – MDPCP:** Represents all Medicare FFS beneficiaries attributed to MDPCP participating practices.

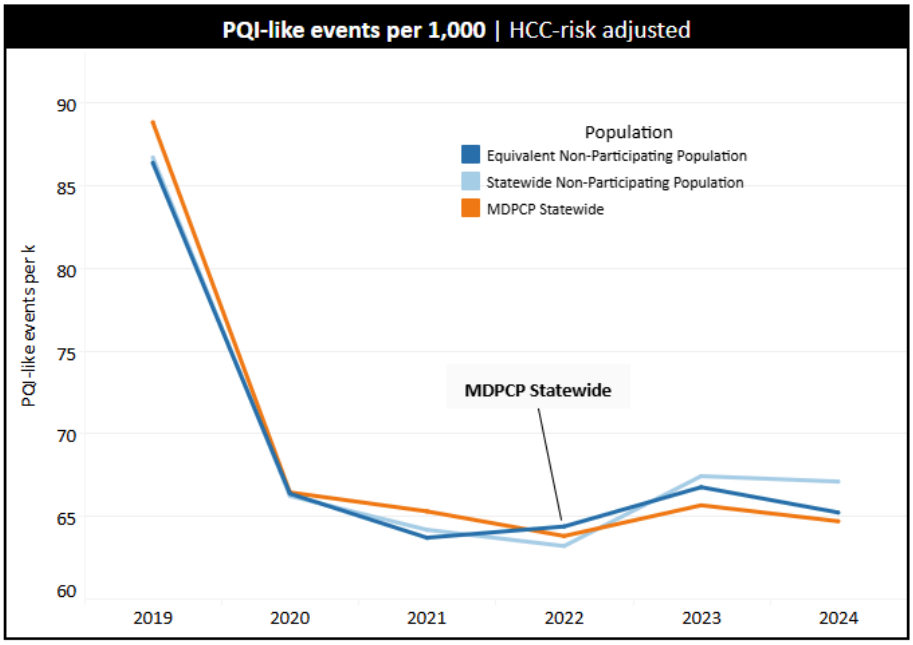
Figure 5: Emergency Department Utilization per 1,000 (HCC risk-adjusted), 2019-2024



Note. The graph shows the emergency department utilization per 1,000 beneficiaries from 2019-2024 of MDPCP Statewide and the comparison populations (Equivalent Non-Participating Population and Statewide Non-Participating Population).[7] Data are through December 2024. Data sourced from Medicare Claims and Claims Line Feed (CCLF).

[7] Population definitions: **Statewide Non-Participating Population:** All Medicare FFS beneficiaries who are eligible for MDPCP and attributed to a provider who is not participating in MDPCP. **Equivalent Non-Participating Population:** Represents a non-participating MDPCP population matched to the participating MDPCP population. This population is a subset of the statewide nonparticipating population, demographically matched to participants by age band, sex, dual eligibility, and county of residence. **State – MDPCP:** Represents all Medicare FFS beneficiaries attributed to MDPCP participating practices

Figure 6: PQI-Like Events per 1,000 (HCC risk-adjusted), 2019-2024[8]



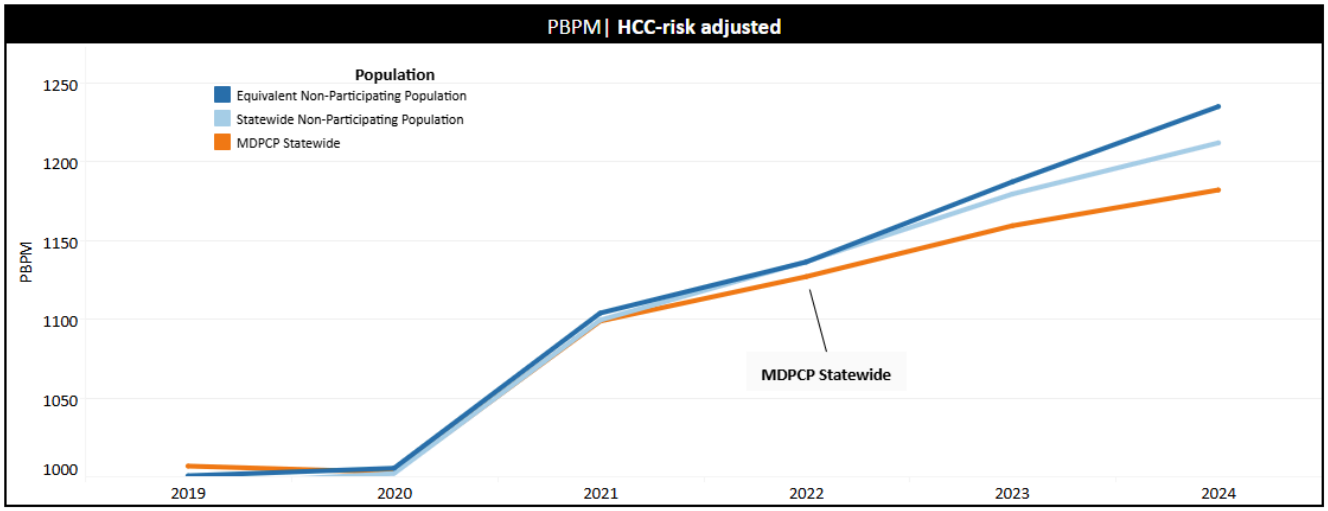
Note. The graph shows the PQI-Like Events per 1,000 beneficiaries from 2019-2024 of MDPCP Statewide and the comparison populations (Equivalent Non-Participating Population and Statewide Non-Participating Population).[9] Data are through December 2024. Data sourced from Medicare Claims and Claims Line Feed (CCLF).

Cost

In regard to beneficiary expenditures, MDPCP practices have maintained lower Per Beneficiary Per Month (PBPM) costs than the comparison populations. MDPCP practices saw a 17.4% increase in PBPM from 2019 to 2024 *(Figure 7)*, which is a similar trend as to those seen in the comparison populations. From 2023 to 2024, MDPCP practices had a 1.96% increase in PBPM *(Figure 7)*. Despite these increases, the MDPCP PBPM remains lower than that of the comparison populations from 2021 to 2024. MDPCP had a better overall percent change from 2019 vs 2024 than the comparison populations. Specifically MDPCP had a 4.4% lower overall percent change (2019 vs 2024) for PBPM than the statewide non-participating population and 6.0% lower overall percent change (2019 vs 2024) for PBPM than the equivalent non-participating population (*Figure 7).*

[8] PQI-Like Events per 1,000 beneficiaries: PQIs are a set of metrics measuring potentially avoidable hospital events from 10 key conditions known as ACSCs.
[9] Population definitions: **Statewide Non-Participating Population**: All Medicare FFS beneficiaries who are eligible for MDPCP and attributed to a provider who is not participating in MDPCP. **Equivalent Non-Participating Population**: Represents a non-participating MDPCP population matched to the participating MDPCP population. This population is a subset of the statewide nonparticipating population, demographically matched to participants by age band, sex, dual eligibility, and county of residence. **State – MDPCP**: Represents all Medicare FFS beneficiaries attributed to MDPCP participating practices

Figure 7: Per Beneficiary Per Month (PBPM) HCC Risk-Adjusted, 2019-2024



	2019	2020	2021	2022	2023	2024	Overall Percent Change (2019 vs 2024)
Statewide Non-Participating Population	$994.58	$1,001.75	$1,098.98	$1,136.11	$1,178.94	$1,211.39	21.80%
Equivalent Non-Participating Population	$1,000.26	$1,005.05	$1,103.44	$1,135.82	$1,186.68	$1,234.44	23.41%
MDPCP Statewide	$1,006.41	$1,002.51	$1,098.36	$1,126.56	$1,158.82	$1,181.53	17.40%

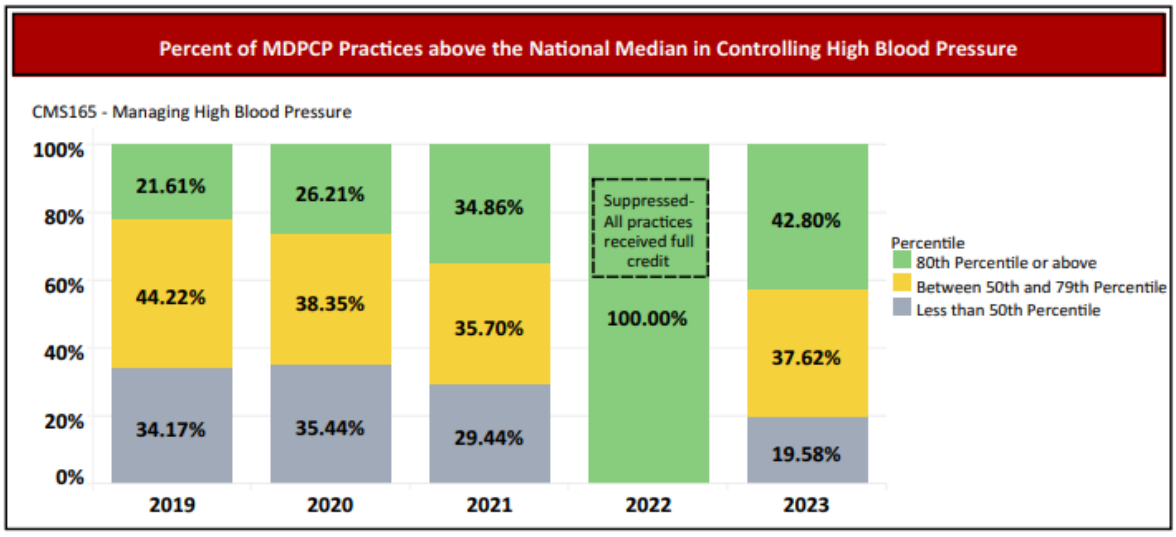
Note. The graph and table shows the Per Beneficiary Per Month from 2019-2024 of MDPCP Statewide and the comparison populations (Equivalent Non-Participating Population and Statewide Non-Participating Population).[10] Data are through December 2024. Data sourced from Medicare Claims and Claims Line Feed (CCLF).

[10] Population definitions: **Statewide Non-Participating Population**: All Medicare FFS beneficiaries who are eligible for MDPCP and attributed to a provider who is not participating in MDPCP. **Equivalent Non-Participating Population**: Represents a non-participating MDPCP population matched to the participating MDPCP population. This population is a subset of the statewide nonparticipating population, demographically matched to participants by age band, sex, dual eligibility, and county of residence. **State – MDPCP**: Represents all Medicare FFS beneficiaries attributed to MDPCP participating practices

Quality

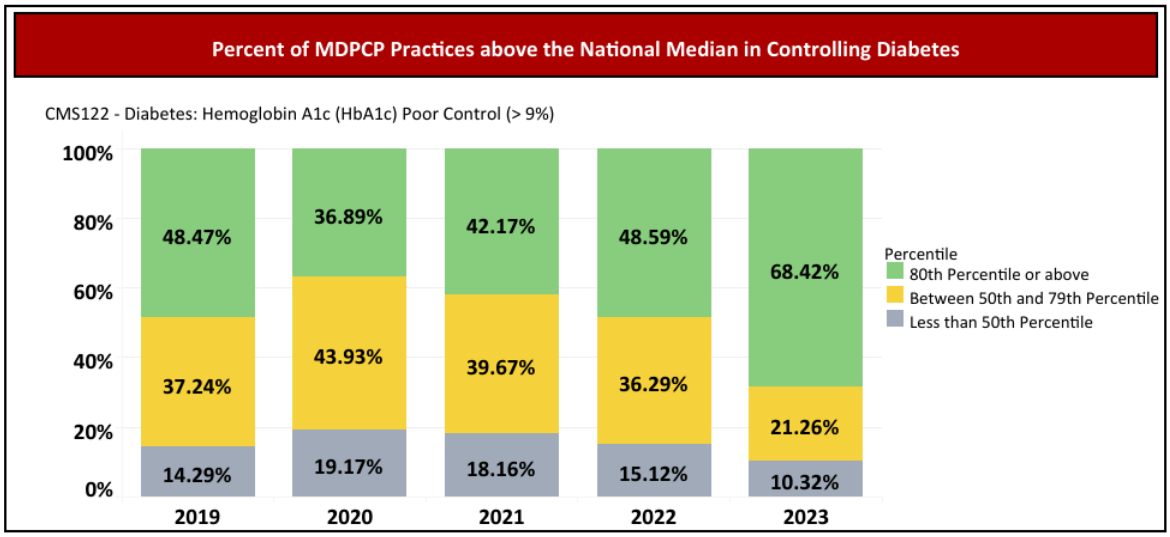
Since 2019, MDPCP performance has improved on two electronic Clinical Quality Measures (eCQMs): CMS165 (Managing High Blood Pressure) and CMS122 (Diabetes: Hemoglobin A1c (HBA1c) Poor Control). In MDPCP, CMMI compares practice performance to a national benchmark. For CMS165, from 2019 to 2023, there has been a 21.2% increase in the percentage of MDPCP practices scoring in the 80th percentile and above (*Figure 8)*. In 2023, 80.4% of MDPCP practices scored in the 50th percentile and higher for CMS165 (*Figure 8)*. For CMS122, in 2023, 89.7% of practices scored in the 50th percentile and higher for the CMS122 (*Figure 9)*

Figure 8: Percent of MDPCP Practices above the National Median in Controlling High Blood Pressure, 2019-2023



Note. The graph shows the distribution of the percent of MDPCP practices above the National Median in Controlling High Blood Pressure by percentile from 2019 to 2023. Data sourced from practice-reported eCQM measure data.

Figure 9: Percent of MDPCP Practices above the National Median in Controlling Diabetes, 2019-2023



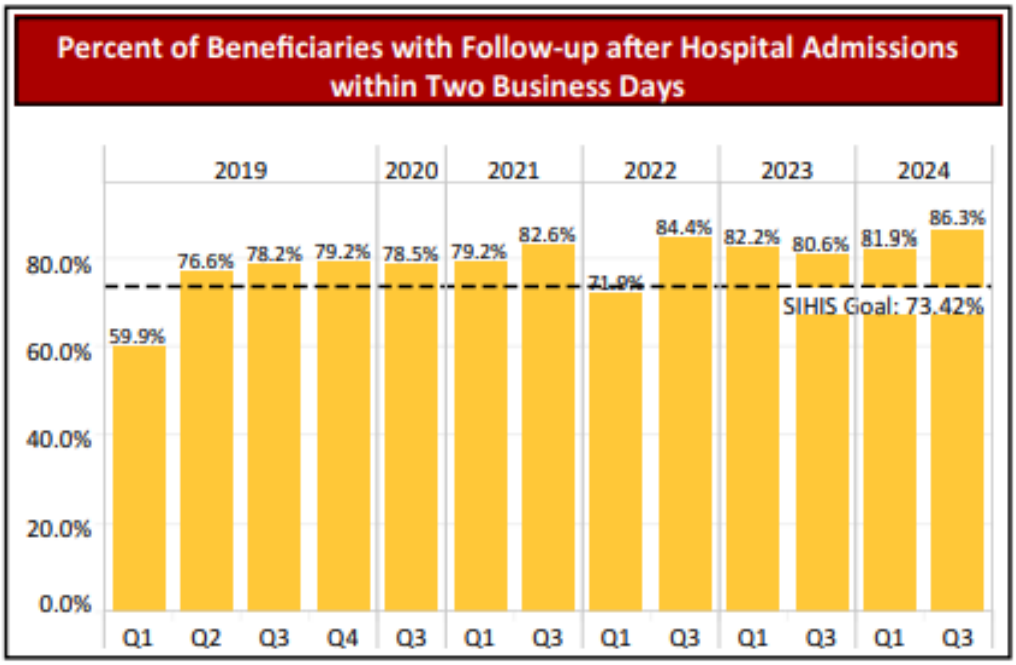
Note. The graph shows the distribution of the percent of MDPCP practices above the National Median in Controlling Diabetes by percentile from 2019 to 2023. Data sourced from practice-reported eCQM measure data.

Care Management

Since the program's inception, MDPCP practices have generally shown improvement in care management metrics. Care management is a fundamental component of advanced primary care for which CMMI makes quarterly, prospective payments for practices to manage the Medicare FFS population. This data is derived from semiannual Care Transformation Requirement (CTR) Reporting, conducted by CMMI in Q1 and Q3 of every program year since 2020. This reporting was also conducted in 2019, but on a quarterly basis. The CMMI goal for percent of beneficiaries under longitudinal care management is 5%, which MDPCP practices have, on average, exceeded every reporting period since 2019. While there has been continuous improvement in the percentage of beneficiaries under longitudinal care management since 2019, there was a slight decline (~1.4%) from Q1 to Q3 2024.

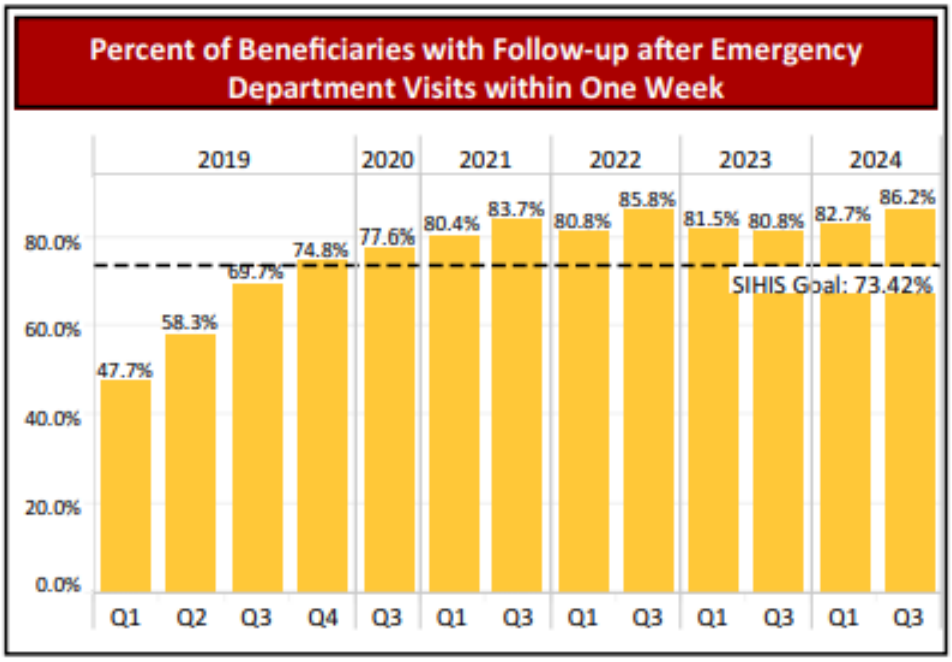
Besides long-term care management, practices are also responsible for providing transitional care management when beneficiaries are discharged from the hospital. Under the TCOC Model, Maryland's official population health plan or Statewide Integrated Health Improvement Strategy (SIHIS) goal for percent of beneficiaries with a follow-up after hospital admissions within two business days is 73.42%. With the exception of Q1 2019 (the inception of the program) and Q1 2022 (Omicron variant spike in the COVID-19 pandemic, MDPCP has exceeded this goal (*Figure 10)*. The highest reported average for MDPCP was 86.3% in Q3 2024, an improvement of 4.4% from Q1 2024 and an improvement of 26.4% from Q1 2019 (*Figure 10)*. Similarly, the SIHIS goal for percent of beneficiaries with a follow-up after ED visits within one week is 73.42%. MDPCP has consistently met this goal since Q4 2019, with the top performance being a score of 86.2% in Q3 2024 (*Figure 11)*. From Q1 to Q3 2024, MDPCP practices improved on this metric by 3.5% (*Figure 11)*. Since 2019, MDPCP has improved on this metric by 38.5% (*Figure 11)*.

Figure 10: Percent of Beneficiaries with Follow-up after Hospital Admissions within Two Business Days, 2019-2024



Note. The graph shows the percent of beneficiaries with follow-up after hospital admissions within two business days. Data are through September 2024. Data sourced from CTR Reporting

Figure 11: Percent of Beneficiaries with Follow-up after Emergency Department Visits within One Week, 2019-2024



Note. The graph shows the percent of beneficiaries with follow-up after Emergency Department Visits within One Week. Data are through September 2024. Data sourced from Care Transformation Requirement (CTR) Reporting

Evaluation and Next Steps

In 2024, MDH commissioned an independent evaluation from The Hilltop Institute.[11] Hilltop's evaluation looked at the impact of MDPCP on Medicare expenditures and utilization rates for Medicare beneficiaries. This study focused on the first four years of the program: 2019-2022. Overall, this assessment highlights the MDPCP's effect on enhancing health care quality and efficiency as the State's advanced primary care program for Medicare fee-for-service beneficiaries.

The evaluation found that MDPCP resulted in a 4.33% decrease in spending (measured by Part A and Part B Medicare costs) over the measurement period. Additionally, they found a 7.18% decrease in inpatient hospital admissions and a 1.70% decrease in emergency department visits. Overall, the impact of MDPCP is associated with an estimated Medicare savings of $162 million. MDH plans on updating this evaluation in 2026 with data through the end of the TCOC Model (2025). MDH expects to identify lessons learned and data findings will be shared with the Maryland General Assembly and other stakeholders.

[11] https://health.maryland.gov/mdpcp/Documents/MDPCPEvaluation_20Aug24_clean.pdf

V. Launch of the Medicaid Path

Design and Initial Activities

There are three components to the increase in Medicaid primary care investment: Enhanced evaluation and management (E&M) rates for all primary care providers, and the two parts of the Medicaid Path: a per member per month (PMPM) payment and the quality incentive payment.

Enhanced E&M Rates

Effective August 1, 2025, the State instituted increased E&M rates for all primary care providers that bill Medicaid in Maryland, including both FFS and or the HealthChoice managed care program. These increased rates are available to all primary care providers, regardless of whether they are part of a practice organization that is participating in the Medicaid Path.[12]

Medicaid Path - PMPM payment

As Maryland prepares for the transition to AHEAD, the State has developed a Medicaid Path per the requirements of the AHEAD State Agreement signed November 2024.[13] This program launched on August 1, 2025, ahead of CMS' January 1, 2026 deadline, with a cohort of 94 primary care practice organizations. All 94 currently participate in MDPCP, representing 256 primary care sites statewide. For calendar year (CY) 2026, the Medicaid Path will expand to include eligible organizations that do not currently participate in MDPCP, including pediatric practices.

As noted earlier, eligible participants in the Medicaid Path included adult primary care practices actively participating in MDPCP and have a minimum of 250 assigned HealthChoice members from any of the Maryland Managed Care Organizations (MCOs). For the secondary round of recruitment, eligibility has expanded to include any practice organization that has a minimum of 250 assigned HealthChoice members from any of the MCOs. Pending federal approvals, there will be additional phases of eligibility beginning on January 1, 2027, to allow for more practices to join. Details on these phases will be released as they become available.

In the Medicaid Path, participating practice organizations receive a quarterly prospective payment that is calculated as a PMPM basis and is derived from the HealthChoice members assigned to that specific practice organization. This payment is a flat $2 PMPM and is calculated and disbursed to MCOs, which then pay participating organizations on a quarterly basis.

[12] These rates do not affect the Federally Qualified Health Center (FQHC) prospective payment rates. The enhanced rates apply to Current Procedural Terminology (CPT) codes 99202-99499 and G2211, which are standard E&M codes provided by primary care providers for preventative care.
[13] The State and CMS are renegotiating the terms of the AHEAD agreement as of September, 2025, with expected signature in October 2025. As of this drafting, the Department does not anticipate substantial changes to the Medicaid Path in these new terms.

Medicaid Path - Quality Incentive

The third component of increased primary care investment is the quality incentive payment for the Medicaid Path participants. The quality payment will reward practices for good patient outcomes, starting with CY 2026 performance data. MDH identified a small number of measures that are actionable by primary care practices and that support both Medicaid and Medicare priorities in Maryland. These measures are also closely aligned to PC AHEAD and MDPCP. For CY 2026, Maryland will have a mix of claims-based utilization measures, used on a pay-for-performance (P4P) basis as well as clinical quality measures, used on a pay-for-reporting (P4R) basis.

Program Funding

To launch the enhanced E&M rates and the Medicaid Path, the State identified a special fund for FY 2026, which provided up to $16 million of state funds to leverage federal matching dollars for a total of $34 million. Based on the early response to recruiting efforts, MDH projects that the program will grow in subsequent years.

Care Transformation Requirements

During the initial launch of the Medicaid Path, the program requirements reflect core competencies of advanced primary care. For August - December 2025 participation in the Medicaid Path, the care delivery expectations for participating practice organizations are focused on data and outreach to HealthChoice members to drive access to care and care coordination for members transitioning from acute care settings. This approach allows the State and participants to start the program gradually, with realistic expectations for practice organizations in the first five months of the program.

The State is in the process of obtaining CMS approval for a more comprehensive set of CTRs for 2026. Requirements for 2026 will expand the breadth of services for Medicaid participants including:

1. Access and Continuity
2. Care Management
3. Comprehensiveness and Coordination
4. Beneficiary and Caregiver Experience
5. Planned Care for Health Outcomes
6. Pediatric Requirements
    a. Newborn appointment availability
    b. Developmental and autism screenings within the scope of primary care
    c. Complete forms for care delivered in school and/or childcare

In tandem with the CTRs, practices will be required to leverage data tools developed specifically for the program that leverages the MDPCP data infrastructure. Built in partnership with CRISP, the State's regional Health Information Exchange (HIE) and Health Data Utility (HDU), practices will receive a variety of tools and analytics to support population health management. MDH will require reporting on these requirements and monitor progress over time to ensure practices are delivering an expanded set of primary care services to their assigned members.

As the Medicaid Path continues to evolve, these care delivery requirements will expand and are currently being crafted based on stakeholder feedback.

Stakeholder Informed Approach

In the early development of this path, the State has engaged in conversations and garnered feedback from a wide variety of stakeholders including primary care practices, provider groups, CTOs, health systems, FQHCs, MCOs, and other community members. The OAPC redesigned and relaunched the MDPCP Advisory Council as the AHEAD Primary Care Advisory Council. This Advisory Council includes representatives from all of these stakeholder groups and continues to review program design and policy options. Care management and quality are cornerstones of the Medicaid Path and as such, subgroups have been created to further work through program design. These subgroups will bring back proposed details to the Advisory Council in future meetings.

Beyond the Advisory Council, the OAPC and MDH's Medicaid Office of Innovation, Research and Development (IRD) have held routine meetings with CTOs, Office Hours, and Town Halls which have focused on sharing updates and soliciting feedback. All of these avenues have yielded feedback that has helped shape the future of AHEAD and has been a tool to engage potential participants with the State. This has been a particularly important tool for recruiting practices outside of MDPCP to the Medicaid Path.

Now that the Medicaid Path has officially started, the State has released the first iteration of the Medicaid Path Program Manual.[14] This Manual is the first program document outside of the contracts held between practice organizations and MCOs. The Manual includes background information, details on eligibility, a description of payments, the current care transformation requirements, and information on data infrastructure that's available to participants. As the Medicaid Path continues to progress, the State will continue to prepare technical assistance based on the needs of participants. The success of MDPCP has largely informed the initial approach and has allowed the OAPC to build a reputation as a trusted organization that can support advanced primary care programs. In the coming months, the State intends to finalize the quality methodology, which will then be added to all pertinent program documents including the Program Manual.

VI. Population Health Improvement Fund

The Population Health Improvement Fund was established in the 2025 legislative session.[15,16] The Fund will support the population health goals of the model.

[14] https://health.maryland.gov/mdpcp/Documents/Medicaid_Path_Program_Manual_-_8_1_25_Start.pdf
[15] This differs from the Maternal and Child Health Population Health Improvement Fund (MCH PHIF) created by the 2021 Budget Reconciliation and Financing Act (BRFA), funded through the Health Services Cost Review Commission (HSCRC).
[16] https://legiscan.com/MD/text/HB1104/id/3250954

Funds will be transferred and will become available to distribute on January 1, 2026. Maryland has entered into the National Governors Association (NGA) Rx For a Healthier America Policy Academy to plan for the launch of the Population Health Improvement Fund.[17]

VII. Conclusion

Over the past year, MDH has worked to develop primary care programs under AHEAD and ensure a smooth transition from the TCOC Model to AHEAD. In doing so, the State has reflected on lessons learned that are relevant for the next model. CMMI designed AHEAD based on fundamental pieces of the TCOC Model, indicating that preliminary observations of the TCOC Model are favorable and elements of the Model are important to maintain.

The independent evaluation from Hilltop demonstrated that MDPCP yielded Medicare cost savings, as well as a reduction in inpatient hospital admissions and emergency department visits. The State intends to update this evaluation in 2026, once the TCOC Model has concluded so the entire model period can be evaluated.

The launch of Maryland's Medicaid Path is a major new initiative to expand advanced primary care to over 1.4 million HealthChoice participants. This path already includes 94 participating primary care organizations and will expand in 2026. As the Medicaid Path fully comes online, the State will continue to increase primary care investment. By 2027, participation in the Medicaid Path will be a prerequisite for primary care practices to continue or start participating in a Medicare path, such as MDPCP.

At the same time, MDH is making progress to take a broad approach to improving health through the Population Health Fund. This Fund will guide Maryland's approach to reaching population health targets. The State is developing the details and strategies for the chronic disease prevention work, but intends to announce more information at the end of 2025.

As the State of Maryland transitions from the TCOC Model to AHEAD, it brings tremendous knowledge including lessons learned, identified opportunities, and a strong foundation to continue to work toward controlling Maryland's healthcare costs, improving the delivery and quality of healthcare, and improving population health. MDPCP has allowed the State to create strong trusting relationships with primary care practices, which will serve as the key to launching the Medicaid Path and successfully transitioning Maryland to AHEAD.

[17] https://www.nga.org/projects/rx-for-a-healthier-america-policy-academy/