

STATE OF MARYLAND

OFFICE OF THE GOVERNOR
Wes Moore

Elizabeth Fowler, PhD, JD
Deputy Administrator and Director for the Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services

Dear Dr. Fowler:

I am proud to submit the State of Maryland's application to the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model Funding Opportunity. This application outlines how Maryland plans to build upon its existing work across healthcare delivery and community settings to achieve a more equitable health system for all Marylanders. The AHEAD Model is a key opportunity to empower all Marylanders to achieve optimal health and wellbeing.

From the start of my administration, we have pledged to leave no one behind. We know that addressing the causes of health inequities can lead to better outcomes. Maryland's participation in the AHEAD Model will advance health equity and ensure that all Marylanders have access to high-quality, affordable health care. Along with our federal partners, AHEAD will continue the work to build a truly equitable, affordable, world-class healthcare delivery system.

Maryland brings many strengths to its AHEAD application, including more than a decade of experience implementing the All-Payer Model and Total Cost of Care Model. Thus Maryland, more than any other state, is well-positioned to make progress towards the AHEAD Model's goals of curbing health care cost growth, improving population health, and advancing health equity.

The application outlines Maryland's primary goals under the AHEAD Model, which align with the priorities and strategies laid out in our Moore-Miller State Plan.

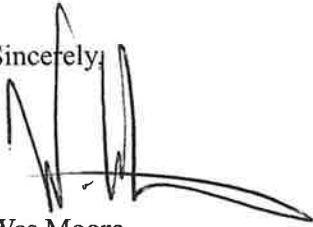
- **Ensure high-value care**, by aligning public and private investments towards population health, incentivizing payment reform across care settings, and constraining total cost of care.
- **Improve access to care** by expanding access to and investment in advanced primary care and supporting efforts to strengthen behavioral healthcare.
- **Promote health equity**, by elevating community voices and shared decision making, addressing health-related social needs, and building community capacity to drive population health improvement.

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This application represents my administration's commitment to building the next iteration of the Maryland Health Model that will serve the evolving needs of Maryland's unique and diverse population.

We look forward to continued engagement with the Centers for Medicare & Medicaid Services on implementing the AHEAD Model.

Sincerely,

A handwritten signature in black ink, appearing to read 'Wes Moore', with a long horizontal flourish extending to the right.

Wes Moore

Governor, State of Maryland

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I. Organizational Capacity of Applicant Organization

Maryland Department of Health Leads With an Integrated Team

Maryland seeks the AHEAD Model opportunity to advance our vision of empowering all Marylanders to achieve optimal health and well-being. As the end of the Total Cost of Care (TCOC) Model approaches, AHEAD benefits Maryland as the pathway to continue our long-term commitment to improving statewide healthcare quality, health outcomes, and health equity - all while controlling cost growth. **Through AHEAD, we will bridge the health care, population health, and social sectors as well as the public and private sectors to implement the solutions Marylanders need, as identified by community members themselves.**

The **Maryland Department of Health (MDH)** will perform Cooperative Agreement activities. MDH is a cabinet-level agency reporting to **Governor Wes Moore**. It is led by **Secretary Laura Herrera Scott, MD, MPH**, a visionary leader experienced in integrating value-based care with clinical and population health strategies. The **MDH Office of the Secretary** centralizes leadership for our integrated team. **Marie Grant, JD**, Assistant Secretary of Health Policy, and **Emily Berg, JD, MPH**, Deputy Chief of Staff, will serve as AHEAD key personnel. **MDH contains many of the key roles and resources critical to achieving AHEAD Model goals**, including the State's Medicaid Agency, the Program Management Office of the Maryland Primary Care Program, the Maryland Office of Minority Health and Health Disparities, the Behavioral Health Administration, and the Public Health Services Administration.

The **State Medicaid Agency** is MDH's Office of the Deputy Secretary for Health Care Financing and Medicaid. It is led by **Ryan Moran, DrPH**, who reports to the Secretary. Maryland Medicaid is a central participant in AHEAD and will be a subrecipient on the Cooperative Agreement. Maryland Medicaid covers nearly 1.7 million Marylanders, 25% of the

State's population, with a FY 2024 budget of \$14.4 billion in total funds. Key Medicaid personnel include **Tricia Roddy**, MHSA, Medicaid Deputy Director and **Laura Goodman**, MPH, Deputy Director of the Office of Innovation, Research, and Development. With its expansive reach, Maryland Medicaid is pivotal to multi-payer alignment. Under AHEAD, Maryland Medicaid will accelerate advancement of delivery models that address **health-related social needs (HRSN)** and improve population health for underserved communities. Maryland Medicaid has participated in all-payer hospital rate setting since the 1970s.

Within MDH, the **Program Management Office (PMO) of the Maryland Primary Care Program (MDPCP)** co-operates MDPCP, a Medicare fee-for-service advanced primary care demonstration, with CMMI. **Chad Perman**, MPP, is PMO Executive Director. Clinical guidance is provided by MDH Chief Medical Officer, **Djinge Linsay, MD, MPH**. The PMO's five years supporting advanced primary care have promoted behavioral health integration and addressed HRSN through the innovative HEART payment.

MDH's **Maryland Office of Minority Health and Health Disparities (MHHD)** directs efforts to address social determinants of health, reduce health disparities, and advance health equity. MHHD collects and analyzes health outcomes data, fosters community and other partnerships to promote health equity advocacy and education, and guides policy, practice, and program decisions within MDH. **Camille Blake Fall**, JD, is MHHD Director.

The MDH **Behavioral Health Administration (BHA)** led by Deputy Secretary **Alyssa Lord**, MA, MSc, sets policy for, and provides oversight and regulation of, the State's public behavioral health system (PBHS). Historically, the PBHS has operated as a system of care for individuals in need of specialty mental health and substance use disorder treatment. The Moore-Miller

Administration is elevating and expanding the reach of BHA as a critically important component of the Maryland Model. We have realigned our work to support a continuum of behavioral health care, inclusive of prevention and promotion, primary behavioral health and early intervention services, urgent and acute care, and long-term treatment and recovery services. Underpinning the continuum are data, quality, health equity, and workforce initiatives.

The **Public Health Services Administration (PHS)** is led by Deputy Secretary **Nilesh Kalyanaraman**, MD, FACP. PHS partners with Maryland's 24 local health departments, providers, community-based organizations, and public and private sector agencies to oversee vital public health services, with special attention to at-risk and underserved populations. Its **Prevention and Health Promotion Administration (PHPA)**, led by **Elizabeth Edsall Kromm**, PhD, MSc, is responsible for core public health and population health initiatives in the areas of cancer and chronic diseases; maternal and child health; infectious disease prevention, epidemiology, and outbreak response; and environmental health. The **Office of Population Health Improvement (OPHI)** within PHS supports Maryland's health care workforce. OPHI is building a comprehensive State health workforce strategy emphasizing recruitment and retention of providers, especially those in provider shortage areas.

MDH's Leadership Ensures Synergy Among State Entities

Independent Agencies within MDH: The **Health Services Cost Review Commission (HSCRC)** leads Maryland's existing **Total Cost of Care (TCOC) Model**. The HSCRC is an independent state agency responsible for regulating the quality and cost of hospital services in Maryland. A seven-member Commission (appointed by the Governor) makes policy decisions, representing a diverse expertise in health care (including hospital, physician, and payer experience), as well as diversity based on gender, race, and geographic distribution throughout

the State. HSCRC staff implement the all-payer hospital rate setting system, regulating over \$20 billion in annual acute care hospital revenue. The HSCRC implements hospital global budgets, administers hospital quality programs, implements value-based payment programs, manages hospital data infrastructure, and drives population health investments through incentives. **Jon Kromm**, PhD, MHS, is HSCRC Executive Director. Dr. Kromm is a highly skilled leader with extensive experience in health care delivery, policy development, and health insurance. Additional key HSCRC personnel are **William Henderson**, MA, Principal Deputy Director Medical Economics and Data Analytics; **Allan Pack**, MPA, Principal Deputy Director Population-Based Methodologies; **Christa Speicher**, MPH, Deputy Director Payment Reform; and **Erin Schurmann**, MPA, PMP, Chief Provider Alignment and Special Projects.

The **Maryland Community Health Resources Commission (CHRC)** is statutorily directed to expand access to health services in underserved communities by supporting programs that promote health equity and HRSN and boost the capacity of safety-net providers. The **Maryland Health Care Commission (MHCC)** plans for health system needs and promotes informed decision-making by providing information on availability, cost, and quality of services to policy makers, payers, providers, and the public. MHCC administers the **Medical Care Data Base (MCDB)**, Maryland's all-payer claims database, and convenes the State's **Primary Care Investment Workgroup**. Both are important to furthering the goals of AHEAD.

MDH will coordinate with other State entities that are part of the AHEAD governance structure, including the **Maryland Department of Budget and Management (DBM)** and the **Maryland Insurance Administration (MIA)**. Additionally, close collaboration with **CRISP** (the Chesapeake Regional Information System for our Patients), Maryland's Health Information

Exchange will help advance AHEAD implementation. CRISP is statutorily designated as the State's Health Data Utility Tool with a suite of benefits that supports the health care continuum.

Experienced Project Director and Key Personnel

Secretary Herrera Scott and **Dr. Jon Kromm** will serve as co-directors of the AHEAD Model Project and primary liaisons to CMMI. **Appendix C** is an organizational chart identifying the **Authorized Organizational Representative (AOR) Emily Berg** and reporting relationships of key personnel. AHEAD Model key personnel named above are experienced with developing and monitoring statewide financial TCOC metrics, driving hospital quality improvement, transforming primary care, facilitating multi-payer alignment, and advancing population health and health equity priorities. Job descriptions are included with curriculum vitae in **Appendix B**. As AOR, Ms. Berg will ensure timely completion of deliverables within budget and upload deliverables in Grants.gov.

II. Description of State

Maryland's State Population

Maryland will implement AHEAD to serve our population of 6.2 million. Our State is characterized by a high degree of racial and ethnic diversity, an aging population, and economic strength. The U.S. Census ranked Maryland **third most diverse in the nation** in 2020. As of 2021, 51% of the population belonged to non-white racial and ethnic groups: 30% Black, 11% Hispanic, 7% Asian, and 3% multi-racial. By 2040, 27% of Marylanders will be 60 or older. Maryland's high performing economy tops the nation in several key economic categories including highest median household income, lowest unemployment rate, and one of the lowest poverty rates.¹ Insurance coverage reflects strong employment (**Table 1**).

¹ Cited in <https://www.marylandtaxes.gov/reports/static-files/SOTE.pdf>

Table 1: 2022 Maryland and U.S. Health Care Insurance Coverage (Source: KFF)

	Employer	Non-Group	Medicaid	Medicare	Military	Uninsured
Maryland	53.9%	5.4%	19.8%	13.4%	1.5%	6.0%
U.S.	48.7%	6.3%	21.2%	14.6%	1.3%	8.0%

Existing Economic and Health Disparities

Despite economic strengths, subsets of Maryland’s population face significant economic and health disparities. Median income is 38% higher for White than Black households and 27% higher for White than Hispanic households. Baltimore City’s poverty rate is 20% overall (compared to 11.5% nationally) and 35% among children. In six of Maryland’s counties, 20% or more of children live in poverty; 11 counties have 15% or more living in poverty². Minority populations comprise 49% of low-income older adults in the State. Some racial and ethnic health disparities have improved. Heart disease and cancer disparities between blacks and whites decreased by 54% and 52% respectively between 2001 and 2016.³ However, large disparities remain for other key health indicators, including infant mortality and preventable health care utilization.

Governor Moore is fighting generational wealth disparities and childhood poverty with the recently introduced ENOUGH Act, a first-in-the-nation effort to end concentrated poverty. Through place-based interventions in select communities across the state, the ENOUGH initiative will give communities the support and private and public resources they need to

²<https://www.countyhealthrankings.org/explore-health-rankings/maryland?year=2020&measure=Children+in+poverty&tab=1>

³<https://health.maryland.gov/mhhd/Documents/2018%20Minority%20Health%20and%20Health%20Disparities%20Annual%20Report%20.pdf>

identify the root causes of poverty in their neighborhoods and begin to address them through a locally-focused plan of action.

Maryland's Population Health Needs and Disparities

Maryland monitors evolving population health needs with ongoing data analysis. In 2020, as part of the Total Cost of Care (TCOC) Model, Maryland submitted to CMMI the **Statewide Integrated Health Improvement Strategy (SIHIS)** to address key population health indicators. SIHIS brought together hospital and public health communities, identifying diabetes, opioid use disorder, and maternal and child health as top population needs. The Maryland Department of Health (MDH) is working with an array of partners to revitalize its **State Health Assessment and State Health Improvement Plan** in Spring 2024. **These efforts serve as an important base for further community engagement and advancement of key population health goals and health equity under AHEAD.**

Maryland's Leadership in Health Care Delivery System Redesign

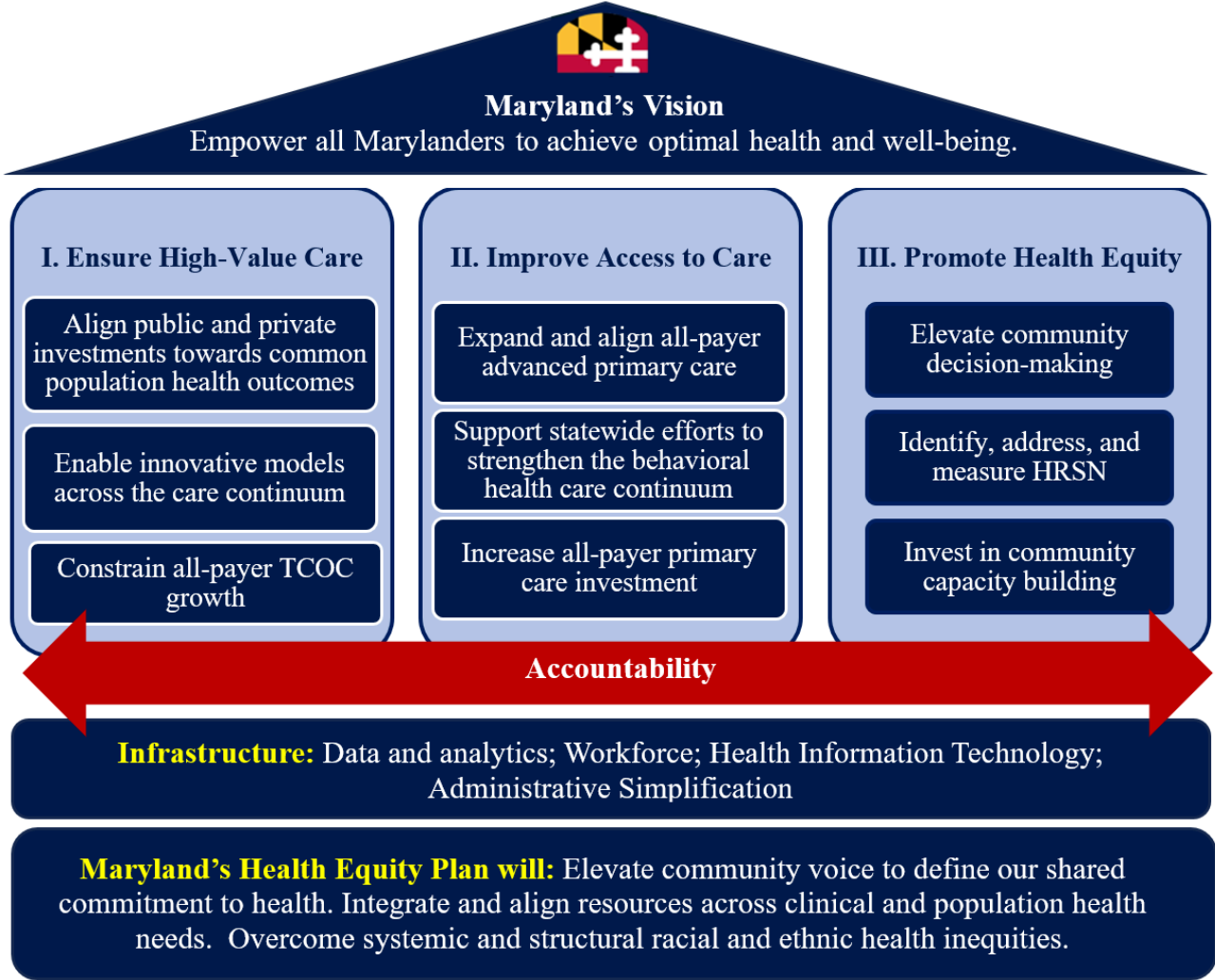
Maryland's leadership in successfully financing health care on an all-payer basis is unmatched. Over 40 years ago, Maryland began setting hospital rates for all payers, including Medicare, Medicaid, commercial, and self-pay patients. For decades, the State has effectively deployed statutory, regulatory, and other policy levers to engage all payers and all hospitals.

AHEAD Furthers Our Vision of Optimal Health and Well-Being for Marylanders

The AHEAD Model advances our vision of empowering all Marylanders to achieve optimal health and well-being. As the end of the TCOC Model approaches, AHEAD benefits Maryland as the pathway to continue its long-term commitment to improving statewide healthcare quality, health outcomes, and health equity all while controlling cost growth. **As a decades-long**

innovator in delivery system transformation, Maryland is poised to launch the next phase of our model in Cohort 1 of the AHEAD Model.

Figure 1: Maryland’s Vision Under AHEAD



As shown in **Figure 1**, Maryland will undertake interconnected actions to achieve our vision under the AHEAD Model and beyond. We will bridge the health care, population health, and social sectors as well as the public and private sectors to **implement the solutions Marylanders need, as identified by community members themselves**. Maryland will

leverage AHEAD Model tools for three pillars: ensuring high-value care, improving access to care, and promoting health equity.

Ensuring High-Value Care: To ensure high-value care, we will (1) align public and private investments towards common population health outcomes, (2) enable innovative models across the care continuum, and (3) constrain all-payer TCOC growth to sustainable levels. Driving principles include benchmarking our success according to outcomes, evolving and evaluating all-payer hospital global budgets to align with equity-centered population health goals inclusive of community health needs, and addressing challenges across the health care system such as post-acute care quality and alignment.

Improving Access to Care: To improve access to care, we will (1) expand and align all-payer advanced primary care, (2) support statewide efforts to strengthen the behavioral health care continuum, and (3) increase all-payer primary care investment. Driving principles include recognizing primary care as the foundation of our health care delivery system; integrating behavioral health into primary care; and growing, attracting, and retaining a diverse primary care workforce through investment in provider support multi-payer alignment.

Promoting Health Equity: To promote health equity, we will (1) elevate community decision-making, (2) identify, address, and measure HRSN, and (3) invest in community capacity building. Our driving principles are centering community knowledge and solutions, empowering community voice, and prioritizing community-based alternative funding models.

The principle of **accountability** will underlie all of our actions to achieve our vision. Our definition of accountability is comprehensive:

- Accountability for outcomes tied to investments,
- Accountability for health care affordability for Maryland consumers,

- Accountability for implementing the solutions communities need,
- Accountability for simplifying administrative burden and supporting infrastructure for health care providers, and
- Accountability for fostering capacity-building among community-based organizations.

Our **infrastructure** investments will support the actions needed to achieve our vision:

- Workforce, a foundational issue to promote health equity, ensure high-value care, and improve access to care.
- Health information technology, data, and analytics. We will strengthen and grow this area to achieve intentionality, transparency, and collaboration across the care continuum.
- Administrative simplification for health care providers, supported by multi-payer alignment across payment models and quality measurement.

Maryland’s Health Equity Plan (State HEP) is the foundation for all actions and investments under AHEAD. We will develop our State HEP to elevate community voice in defining our shared commitment to health; integrate and align resources across clinical and population health needs; and work to overcome systemic and structural racial and ethnic health inequities.

Community Engagement and Support for AHEAD

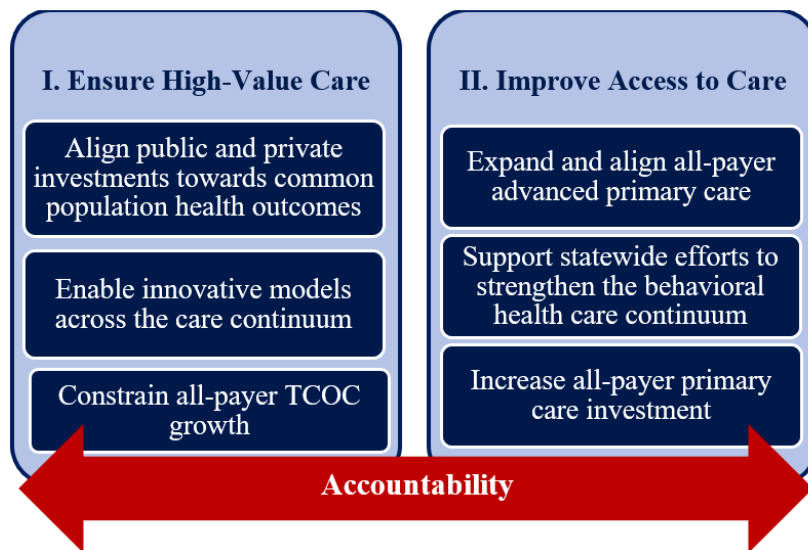
Maryland convened three Transformation Advisory Committees to advise on this application, focusing on equity-centered health care transformation, primary care, and population health.

More than 60 Committee members represent health systems; commercial insurers; Medicaid managed care organizations (MCOs); primary care and specialty providers including behavioral health; community-based organizations; philanthropy; consumers; the Maryland General Assembly; and Maryland State agencies.

Prior to convening the Transformation Advisory Committees, Maryland convened six stakeholder workgroups in 2022 and 2023 to address the future of the Maryland Model. The workgroups aligned with AHEAD priorities, focusing on cost containment, population health and health equity, payer alignment, physician engagement and alignment, post-acute care, and consumer engagement. **Recommendations from the Transformation Advisory Committees and the Maryland Model workgroups are informing Maryland’s AHEAD Model development.**

III. Statewide Accountability Targets

All-payer statewide accountability targets are important tools in our AHEAD pillars I & II (Figure 1) of **ensuring high-value care by constraining all-payer TCOC growth, and improving access to care by increasing all-payer primary care investment.**



Constraining all-payer TCOC also ultimately helps ensure affordability among consumers, which in turn increases access.

Demonstrated Success Meeting Statewide Accountability Targets

Maryland has a long history of successfully financing health care on an all-payer basis.

The **All-Payer Model** launched in 2014, fundamentally changing hospital payment from a cost per case methodology to population-based global budgets based on hospital revenue. Under the

global budget revenue (GBR) system, Maryland hospitals receive a prospective, fixed amount of revenue for each year. Maryland’s All-Payer Model, in effect through 2018, met or exceeded all key financial and quality tests, providing savings to Medicare without cost shifting to other payers. Financial tests included all-payer hospital revenue growth, Medicare hospital and TCOC savings, and hospital revenue under population-based payment. Quality tests included improvement in all-payer potentially preventable conditions and readmissions reductions for Medicare. RTI International’s 2019 independent evaluation concluded the Model reduced Medicare hospital admissions by 7%, saved CMS almost \$1.4 billion in hospital spending, and generated \$869 million in net savings on all Medicare Part A and B spending.⁴ The All-Payer Model helped lay the foundation for hospital delivery system transformation. Its stable revenue base improved the overall financial performance of Maryland hospitals, with an approximately 50% increase in regulated hospital margins. Maryland experienced no hospital closures at a time when rural facility closures were widespread across the U.S.

CMS and Maryland launched the existing **Total Cost of Care (TCOC) Model** in 2019 to drive population health improvements and delivery system transformation across the care continuum. CMS conducted two evaluations of the TCOC Model.^{5,6} The 2021 evaluation found hospital global budgets strongly incentivized care transformation and provided financial stability for hospitals during the pandemic. The 2022 evaluation found substantially-reduced rates of all-cause hospital admissions, a \$781 million reduction in total Medicare spending, and improvements in several quality measures. **For most outcomes, results were even more favorable for the TCOC Model than the All-Payer Model.**

⁴ <https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf>

⁵ <https://www.cms.gov/priorities/innovation/data-and-reports/2021/md-tcoc-imp-eval-report>

⁶ <https://www.cms.gov/priorities/innovation/data-and-reports/2022/md-tcoc-qor2>

The TCOC Model requires Maryland to meet six annual performance targets: annual Medicare TCOC savings, TCOC guardrail test, all-payer hospital revenue limit, hospital revenue under population-based payment, improvement in all-payer potentially preventable conditions, and readmissions reductions for Medicare. In both 2019 and 2020, Maryland met or exceeded all six targets. In 2021, Maryland met or exceeded all but one target. The readmissions reduction test is potentially outdated; on a risk-adjusted basis Maryland outperforms the nation due to the relatively enhanced acuity of Maryland patients. In 2022, Maryland failed to meet one additional performance measurement, the TCOC guardrail test, because Maryland guaranteed GBR during the pandemic which necessitated increased, one-time outlays in subsequent years.

Plan for Measuring All-Payer TCOC and Primary Care Spending

With years of experience monitoring and meeting statewide accountability targets, Maryland has considerable resources for measuring all-payer TCOC and primary care spending. We will initially measure TCOC and primary care spending for all payers by leveraging the **State’s Medical Care Data Base (MCDB)** to build aggregate reports from granular data. The MCDB includes Medicare claims, Medicaid claims, and commercial payer claims from non-ERISA plans, Medicare Advantage, and State and local government employee plans. All sources include pharmacy data, making inclusion of pharmacy in accountability targets a potential option.

MDH is increasing the quality of Medicaid reporting by working with all MCOs to standardize primary care reporting on HealthChoice Financial Monitoring Reports and collecting cost information on MCO encounter data. The State may pursue additional tools, including legislative or regulatory action, for more complete commercial reporting. The MIA’s statutory

authority process for commercial insurance rate review can facilitate development of future tools for commercial reporting.

Leveraging the MCDB claims-based approach has a number of advantages over requiring new summary reports from commercial payers.

- **Flexible:** Claims data provide tremendous flexibility to define metrics, understand trends, and manage interventions. Building from granular claims to aggregate reports offers the State freedom to adjust the parameters of analysis to address evolving questions. This approach also enables us to validate results against other data sources, such as Maryland’s all-payer hospital data. In contrast, new summary reports from commercial insurers would be static and our ability to drill below the content of summary reports would be limited.
- **Tested:** Maryland already uses MCDB data for a number of reporting functions, including primary care spending analytics and benchmarks for HSCRC methodologies.
- **Connected:** The MCDB is mapped to CRISP’s Enterprise ID, connecting information across multiple datasets. This enables us to understand care patterns across payers and over time. New summary reports would not provide this capability.
- **Historical:** The MCDB was established in 2011 with the dataset going back to 2013. We are able to examine historical trends to provide context to ongoing monitoring.

Maryland identifies solutions for the three primary gaps in the data aggregation strategy:

- **Non-claims-based payments** are made outside of traditional claims processes. The MCDB initiated reporting on non-claims-based payments for 2023. The State expects to refine this process by 2026 for usable reporting by the time of AHEAD Model implementation. We anticipate Medicare and Medicaid non-claims-based payments will also be available.

- **Unpriced encounters** represent claims where no dollar information is available. This is due to (1) staff-model health plans where there is no charge amount, or (2) capitated Medicaid plans where the dollar value of individual claims is currently unavailable to the State. Maryland is already working with the relevant payers to estimate these amounts based on total costs and expects to populate reasonable proxies by AHEAD implementation.
- **Missing ERISA claims** from MCDB data. For the most complete analysis, Maryland needs ERISA claims in the future. Without ERISA claims, the State MCDB currently represents 50% of all commercial claims. This is a sufficient sample to evaluate TCOC. The Health Services Cost Review Commission's (HSCRC's) collection of all-payer hospital data will help validate MCDB findings across all commercial experience. Maryland may also need CMS technical assistance to periodically utilize national survey data, such as the Medical Expenditure Panel Survey, to validate findings from claims-based analytics lacking ERISA claims. To date, the Federal Employee Health Benefit Plan has elected not to participate in the State MCDB. However, the participation of this Plan would meaningfully reduce the gap in missing ERISA claims in Maryland.

Plan for Memorializing All-Payer TCOC and Primary Care Targets

Bending the cost curve on an all-payer basis is essential to drive affordability. Maryland will work with stakeholders in 2024 and 2025 to explore how best to memorialize all-payer TCOC and primary care targets. Maryland is already accountable for Medicare TCOC savings and all-payer hospital spending. By statute, the HSCRC has legal authority to set rates for Maryland hospitals and to promote efficiency through alternative methods of rate determination and payment. All Maryland payers must reimburse regulated Maryland hospitals on the basis of

HSCRC-established rates. **Maryland will build on our experience and broaden TCOC targets beyond Medicare to include all payers.**

Maryland has invested resources to define and set primary care investment targets and will build on this effort under AHEAD. In 2022 the Maryland legislature enacted a law requiring the Maryland Health Care Commission (MHCC) to analyze primary care annually and recommend primary care investment targets. The statutorily-required Primary Care Investment Workgroup guides analysis and recommends ways to improve primary care access and quality, with attention to increasing equity and reducing disparities. Workgroup members represent primary care providers including FQHCs, commercial and MCO payers, employers, and State entities. The Workgroup recently proposed spending 10% of total medical spending on primary care investment, using a primary care definition similar to AHEAD's but tailored to Maryland. It excludes psychiatry and obstetrics/gynecology. Covered services are billed under a primary care provider's taxonomy rather than Medicare CPT/HCPCS codes and specialty codes.

We will build on the Primary Care Investment Workgroup's foundation, incorporating additional feedback to develop a primary care investment approach that fits with AHEAD principles. Maryland's Primary Care Transformation Advisory Committee emphasized the need to consider primary care measurement and target setting to align incentives and goals across payers and providers. The State is still in the early stages of analyzing primary care spending for primary care investment targets and will refine methodologies to reflect different population groups across insurance type and geography.

Levers to Increase and Enforce Commercial and Medicaid Primary Care Investment

Maryland’s existing policy levers promote commercial alignment with the Maryland Primary Care Program (MDPCP) and increase primary care spending. We will explore additional tools to increase primary care spending, potentially involving legislation. In 2020, Maryland’s largest commercial payer CareFirst BlueCross BlueShield signed an MOU with CMS committing to MDPCP alignment. AHEAD’s focus on commercial alignment serves as a catalyst for Maryland to recruit additional commercial payers. Maryland will also ensure its State employee plan, covering 237,000 lives, aligns with MDPCP and AHEAD Model goals of a strong primary care delivery system inclusive of medical, behavioral, and social needs.

The HSCRC released a Request for Information in December 2023 to initiate a pilot program to increase access to advanced primary care in underserved areas of Maryland. The pilot would begin January 1, 2025 with funding of up to \$19 million for start-up infrastructure spending. It would supplement MDPCP’s focus on strengthening existing primary care access by adding resources to extend primary care access to underserved areas.

In 2025 Maryland Medicaid will align with MDPCP; Maryland’s §1115 HealthChoice demonstration emphasizes primary care access via a number of regulatory and policy levers.

Maryland Medicaid will align quality performance measures with the AHEAD Model.

Medicaid is addressing participants’ complex needs by working towards standardizing HRSN screening tools. More information on this alignment is described in Section VI. Vision for Primary Care Transformation.

Levers to Enforce All-Payer TCOC Targets

Maryland has a number of mechanisms in place to meet all-payer TCOC targets, including managing health care cost growth and promoting care transformation. The strongest lever for enforcing current Medicare TCOC targets is the annual update factor under the GBR system. **However, controlling the growth of hospital spending through all-payer rate setting and global budgets is a powerful but insufficient tool for bending the all-payer cost curve under AHEAD**, as it reaches only 36%⁷ of all-payer TCOC. As the model evolves, we will work to broaden the levers Maryland has beyond GBR.

Our **current initiatives to manage all-payer health care cost growth** include the following.

- **Annual update factor:** The annual update factor provides hospitals with reasonable changes to rates to maintain operational readiness while containing hospital cost growth for all payers, limiting inflation if additional savings are required. The update factor ensures that hospital rate increases are affordable for purchasers, including consumers.
- **Medicare Performance Adjustment:** Designed by HSCRC to adjust GBRs based on their performance on Medicare TCOC.
- **Insurance Rate Review:** Maryland law requires carriers in the individual, small, and large group markets to prospectively file rates for Maryland Insurance Administration (MIA) approval. Carriers must demonstrate that rates are reasonable and adequate, do not unfairly discriminate, and are not excessive in relation to benefits. This promotes affordability for payers and consumers alike.

⁷ Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. [National Health Expenditure Data: Health Expenditures by State of Residence] (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>), August 2022.

- **Maryland Health Benefit Exchange (MHBE) and Reinsurance Program:** MHBE carriers annually submit accountability reports documenting cost containment and quality improvement efforts consistent with State population health goals. MHBE administers the Reinsurance Program, leveraging federal savings through a §1332 waiver to stabilize the individual insurance market. The Reinsurance Program premiums are 25% to 30% lower than that of similar plans across the nation. Compared to other states, Maryland has the lowest-cost Bronze and Gold plans and among the most affordable Silver plans.
- **Maryland Prescription Drug Affordability Board:** The General Assembly created the Board to protect Marylanders from high drug costs. The first of its kind in the nation, it studies the pharmaceutical distribution and payment system in Maryland, examines policy options to lower the list price of pharmaceuticals, and recommends legislative action.
- **Transparency in Pricing and Quality Reporting:** Maryland prioritizes reporting transparency to promote health system accountability and informed decision-making by policy makers, payers, providers, and consumers. MHCC reports on health care utilization and provider payments. Commercial spending reports are based on the MCDB. MHCC publicly shares information on the quality and performance of health care facilities.

Within the **Update Factor** are additional policy levers that determine the overall allocation of State global budget revenue.

- **Potentially Avoidable Utilization (PAU) Shared Savings Program** limits inflation on revenue related to PAU visits.
- **Integrated Efficiency Policy** evaluates whether hospitals are “technically efficient” on a cost per case basis and are effective in controlling total cost per capita. Hospitals deemed to be relatively inefficient in both assessments are not granted access to a portion of inflation

as part of the annual update factor, which will generate savings to payers and/or will create investments in population health, e.g., subsidized housing, when a hospital buys out of the efficiency adjustment through the **Revenue for Reform policy**. In effect, the policy narrows variation in hospital cost per case and total cost per capita over time by earmarking inflation for Model savings and/or population health investments.

- **Quality Pay-for-Performance Programs** that put all-payer inpatient hospital revenues at risk include: **Maryland Hospital Acquired Conditions** (based on performance for 14 potentially preventable complications); **Readmission Reduction Incentive Program** (includes a **Disparities Component**, a within-hospital disparities readmissions measure where hospitals earn rewards for reducing readmission rate disparities related to socioeconomic status); **Quality Based Reimbursement** (based on quality improvement across three patient-centered quality measurement domains: person and community engagement, clinical care, and patient safety).

Under AHEAD, we will broaden care transformation to invest in population health and community-based resources that bridge the health and social sectors to address entrenched challenges. We will lift up community-based services, connecting Marylanders to the resources they need for health and well-being. Our **current initiatives to promote care transformation** include the following.

- **Enhanced Care Management Infrastructure:** Maryland has invested for decades in data infrastructure to improve health outcomes. CRISP gives health care providers actionable, patient-level information across institutions at the point of care to support clinical decision-making. Diagnostic images are available in one central location. Providers can access an at-a-glance view of a patient’s clinical history. Increasingly, care management

includes HRSN. CRISP offers providers a suite of **screening and closed-loop referral tools** to share patient social needs information with the care team, reduce duplication of screening, and connect Marylanders to resources.

- **Value-Based Programs:** The TCOC Model makes value-based programs available to align incentives across hospitals, physicians, and other providers. For example, the **Episode Quality Improvement Program (EQIP)** ties health care payments to the quality and cost of services provided under a clinical episode. EQIP holds participants accountable for achieving cost and quality targets. Now in its third year, more than 3,200 physicians participate. PHIP is a value-based program within Maryland Medicaid.

We will expand efforts under the AHEAD Model and work with CMMI to explore better alignment of post-acute care costs and payment methodologies in managing TCOC. This reflects feedback from the State’s Health Care Transformation Advisory Committee, which is helping develop the AHEAD Model approach.

Future Spending Flexibility

Over the course of the AHEAD Model the State requests the flexibility to add spending in the near term on interventions that represent new strategies for addressing population health, managing costs, improving quality and/or addressing equity. Such additions would be limited to investments that, over the life of the Model, could provide net benefits either through lower costs or improved outcomes. Such up front investments would be permitted either through less aggressive savings targets in earlier years or the ability to “carry” investment costs forward to offset against future years.

IV. Hospital Recruitment Plan

All Hospitals Participate in Global Budgets

Hospitals in Maryland have operated under global budgets for a decade. Maryland successfully convinced all hospitals to adopt global budgets in 2014, the first year of the All-Payer Model.

Every year Maryland hospitals have universally participated in global budgets. The State envisions continuing hospital global budgets—a key tool to drive cost savings and improve health outcomes over time—as a core element of its system.

Hospitals Engage in Evolving Value-Based Opportunities

Maryland hospitals continue to engage with voluntary value-based payment model

opportunities. The Care Redesign Program of the Total Cost of Care (TCOC) Model provides hospitals with tools for greater provider alignment, including sharing incentives and resources with physicians and post-acute facilities, for example to establish standardized care protocols upon discharge. Hospitals engage over 5,000 physicians and other providers during a given performance period. The Care Redesign Program includes the **Episode Care Improvement Program**, allowing hospitals to link payments across providers during an episode of care. Up to 24 hospitals have participated annually.

Beginning in 2021, Maryland offered hospitals the opportunity to participate in **Care Transformation Initiatives (CTIs)**. CTIs test hospital interventions that address clinical needs and promote efficient use of health care resources. Hospitals that produce savings earn a positive payment adjustment on future Medicare payments. All hospitals participate in CTIs, with 174 CTIs currently implemented. A 2023 evaluation identified care management processes—including discharge planning, ambulatory, follow-up, and wrap-around services—as key interventions, noting “[i]t was important for all patients to have the appropriate clinical care

pathways following their inpatient stay.” Early evaluation results show CTIs focusing on HRSN perform better on average.⁸

Intensive State and Industry Collaboration

The State’s partnership with the hospital industry is a hallmark of the success of Maryland’s all-payer rate setting system and global budgets. **Maryland is leveraging its infrastructure and experience in coalition-building to engage new partners (such as transportation and housing resources at the State and local level) and advance AHEAD model goals.** The Health Services Cost Review Commission (HSCRC) has a culture of emphasizing a cooperative relationship with the hospital industry and incorporating a diverse range of perspectives.

The Care Redesign Program is an example of the State’s direct response to industry needs. Since global budgets do not include physician payments, hospitals requested autonomy to financially reward physicians for engaging in care redesign to improve quality and reduce hospital costs. Maryland negotiated the Care Redesign Amendment to the All-Payer Model with CMS to provide hospitals this ability. **The waivers associated with the Care Redesign Program are an important component of Maryland’s Model and will be key to future participation in AHEAD. Maryland requests the ability to continue and evolve the flexibilities enabled through the Care Redesign Program.**

The HSCRC incorporates feedback from individual hospitals, the Maryland Hospital Association, payers, consumers, and others into all of its policy development and decision making. The State recognizes the importance of intensive communication and feedback to navigate complex technical and clinical policy details. The HSCRC receives public comment in

⁸https://www.crisphealth.org/wp-content/uploads/2023/04/MD_CTI_Evaluation_to_CRISP_Clean_032723.pdf

all Commission meetings, meets directly with stakeholders as staff develop new policy ideas, and regularly convenes a number of workgroups open to the public. While some workgroups are ongoing, others provide temporary guidance on specific policy issues.

Anticipated Hospital Services and TCOC Under AHEAD Global Budget

Under the current TCOC Model, 95% or more of all regulated revenue for Maryland residents must be paid according to a population-based methodology. Maryland has met this goal each year from 2019 through 2022. In 2022, 98% of regulated revenues and an estimated 48% of TCOC were under global budgets. **Maryland is committed to continuing to meet targets to be defined under the AHEAD Model.**

Goals and Timeline for Continued Collaboration

Maryland’s hospitals, including rural hospitals, already universally participate in hospital global budgets. The State’s goal is to continue universal hospital participation in global budgets. The HSCRC will continue to engage all hospitals in policy development and planning through its stakeholder engagement processes. Given the level of commitment to global budgets among individual hospitals and the Maryland Hospital Association, a contingency plan in the event hospitals cannot be recruited to participate in global budgets is not applicable. Maryland has no critical access hospitals.

Strategies and Regulatory Levers for Ongoing Participation

Maryland attributes its ongoing success engaging all hospitals in global budgets to a combination of strategies and policy levers.

- **Clear, shared goals.** Maryland policies are based on a shared commitment to equity and fairness across hospitals and payers. Policies balance the need to provide sufficient

investments and resources for hospital operational readiness with affordability for consumers and payers while simultaneously meeting federal requirements.

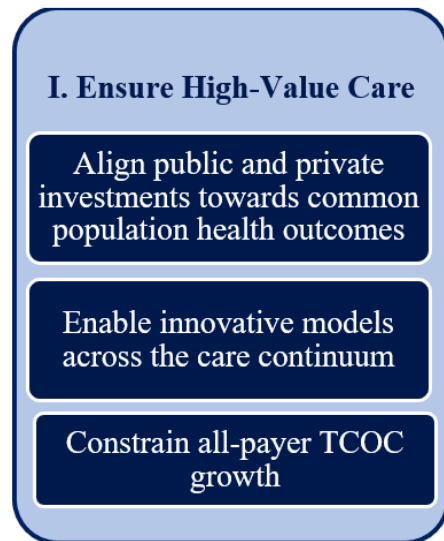
- **Flexibility to achieve goals, with safeguards.** Maryland’s all-payer rate setting system was established with an enabling statute characterized by broad language focused on policy objectives and principles rather than prescriptive methodological details. The State extended flexibility to the hospital industry to achieve stated goals. Hospitals have autonomy to design their own initiatives, tailored to local and organizational strengths and priorities. The State establishes safeguards such as quality-based incentives.
- **Data, transparency, and accountability.** From the beginning of its rate setting system Maryland has emphasized collection of timely and accurate data from hospitals, and hospitals have contributed case mix and financial data for decades. Data infrastructure has been essential to the design, implementation, and sustainability of the All-Payer and TCOC Models, and will continue to play this key role under the AHEAD Model. As described in **VIII. State Data and Health IT Infrastructure**, CRISP links data systems for real time monitoring to identify opportunities for improving value.

V. Hospital Global Budget Methodology Development

Continued Use of State-Designed Medicare FFS Methodology

Under AHEAD, Maryland intends to use its current authorities for hospital rate setting and its State-designed Medicare fee-for-service hospital global budget methodology, subject to CMS approval. **The State will continue to evaluate and evolve all-payer hospital global budgets to promote high-value care aligned with the State’s equity-centered population health goals, inclusive of community health needs.**

All-payer hospital global budgets help ensure high-value health care, a key action to achieve Maryland’s vision shown in Pillar I (Figure 1). In the future we will explore new options for global budgets. For example, a hospital could choose to take expanded risk for TCOC for a designated cohort of beneficiaries. Other options could consider financial incentives to support innovation, population health investments, and coordination with providers across the care continuum.



Established Statewide Hospital Rate Setting Authority

Maryland’s all-payer hospital rate setting authority was established in statute in 1971. The Health Services Cost Review Commission (HSCRC) has the legal authority under Title 19 of the Health General Article of the Annotated Code of Maryland to require all regulated Maryland hospitals to charge rates in accordance with the rules and regulations of the HSCRC, to promote the greatest efficiency in Maryland hospitals, and to approve alternative methods of both rate determination and payment to achieve the greatest efficiency. Specifically, §19–212 of the Health General Article states the HSCRC shall develop guidelines for the establishment of global budgets for each facility.

Under Title 15 of the Insurance Article and Title 15 of the Health General Article of the Annotated Code of Maryland, all Maryland payers are required to reimburse regulated Maryland hospitals on the basis of rates established by the HSCRC. The Maryland Department of Health (MDH) has legal authority under Title 2 of the Health General Article of the

Annotated Code of Maryland to promote and guide physical and behavioral health care development for the State.

Unparalleled Global Budget Experience

Maryland’s technical expertise and infrastructure in establishing and improving global budgets is unparalleled. The State launched hospital global budgets across all payers in 2014. All 47 acute care hospitals receive quality-adjusted population-based global budget payments. Over time, Maryland gradually built adjustments that improve efficiency and access to health care services, focus hospital business models on improving population health, and encourage coordination with community providers. As described in **IV. Hospital Recruitment Plan**, partnership among the State and hospital industry is a hallmark of Maryland’s success. The HSCRC incorporates feedback from hospitals and others into methodology development, prioritizing intensive communication to navigate complex technical and clinical details.

Maryland Methodology Aligns with AHEAD Criteria

Table 2 below shows that Maryland’s current hospital global budget methodology almost completely matches the AHEAD Model’s CMS-designed hospital global budget methodology.

Table 2: Alignment of CMS-Designed Global Budget Methodology With Maryland

CMS-Designed Hospital Global Budget Methodology	Maryland
Annual GBs instead of volume-based reimbursement to incentivize reduced unnecessary hospital utilization	✓
GB includes facility services in hospital inpatient, outpatient, and emergency departments, at a minimum	✓
Available to short-term acute care hospitals	✓
Designed to meet annual Medicare FFS TCOC targets and multi-year savings. Includes a process by which GBs can be adjusted in the event the state misses the statewide Medicare FFS TCOC target(s) and is on a Corrective Action Plan	✓

Consider incentives to recruit and retain hospitals early into the Model and facilitate hospital investment in infrastructure	All hospitals participate
Adjusted for both medical and social risk for either the beneficiaries the hospital serves or the hospital's geographic area	✓
Adjusted for population growth, demographic changes, other factors	✓
Adjusted for hospital-level quality performance based on CMS national hospital quality programs or similar	✓
Adjusted for performance on disparities-sensitive quality measures for improving health equity	✓
Hold hospitals accountable for Medicare FFS TCOC	✓
Account for changes in service line and unplanned volume shifts, while not incentivizing FFS-oriented utilization	✓
Account for annual changes, such as inflation	✓

The AHEAD Model incorporates many aspects from Maryland, such as using a historical base period for baseline budgets, adjustments for inflation, population demographics, modifications to reflect changes in service line levels, market shift infrastructure requirements, and performance in quality-based or efficiency-based programs. AHEAD Model provisions for critical access hospitals do not apply; Maryland does not have critical access hospitals.

Incorporation of Social Risk Adjustments

In addition to adjusting for medical risk, Maryland global budget methodology adjusts for social risk. The HSCRC formed global budgets based on 2013 hospital revenues, premised on long-standing efficiency evaluations that considered increased costs associated with higher social risk (e.g., share of hospital services attributable to Medicaid, dual eligibles, and charity care). This continues with full rate and integrated efficiency policies. The HSCRC uses Area Deprivation Index to determine distribution of uncompensated care funding. Use of TCOC to directly set hospital rates incorporates adjustments for social risk including deep poverty and median income. Beginning State FY 2027, the acuity weighting methodology that is the basis

for most global budgets adjustments will use Z codes to group cases. The State will consider ways to increase social risk adjustment as richer patient level data becomes available.

Policy Initiatives to Promote Value and Reduce Disparities

Maryland has tested, evolved, and strengthened its global budget methodology over the past decade and will continue to further these efforts under AHEAD. Examples of policy initiatives promote value-based care and/or reduced disparities include the following.

- Maryland implemented a value-based payment adjustment, the **Medicare Performance Adjustment (MPA)**, beginning with CY 2018 performance. The MPA brings direct financial accountability to hospitals based on attributed Medicare beneficiaries' TCOC.
- The **Readmissions Reduction Incentive Program Disparities Component** rewards hospitals for reducing disparities related to socioeconomic status using the Patient Adversity Index. Maryland plans to expand this methodology to other measures including timely follow-up, avoidable admissions, and maternal morbidity.
- **Revenue for Reform (R4R)** is a recently implemented strategy allowing hospitals to offset reductions in the annual update factor with approved population health investments. MDH and HSCRC approve R4R investments to ensure initiatives support population health priorities and are evidence-based and accountable for delivering impact. In the future the State may refine this mechanism for promoting hospital investment in communities.
- Value-based programs such as the **Episode Quality Improvement Program (EQIP)** tie payments to the quality and cost of services provided for a clinical episode for a set period. **Care Transformation Initiatives (CTIs)** test hospital interventions that address clinical and health-related needs and promote efficient use of health care resources. Hospitals that produce savings earn a positive payment adjustment on future Medicare payments.

- The TCOC Model drives investment in population health with **outcomes-based credits**.

Maryland receives a financial credit towards its TCOC savings targets by limiting incidence of population health conditions. Maryland has an approved methodology for diabetes and is developing methodologies for opioid use disorder and hypertension. Maryland will explore expanding and aligning outcomes-based credits with AHEAD goals.

Medicaid's Long Standing Participation in All-Payer Hospital Global Budgets

Maryland's Medicaid program has partnered for decades with the HSCRC to implement innovative payment models and align quality initiatives. **Medicaid has participated in the State's all-payer hospital rate setting system since the 1970s, and in the global budget system since the inception of the All-Payer Model in 2014.** All payers in Maryland, including Medicaid managed care (covering close to 90% of Medicaid participants) and Medicaid fee-for-service are part of the HSCRC's ongoing global budget implementation.

Maryland's Medicaid managed care program prioritizes ongoing improvement, conducting a comprehensive annual evaluation as well as targeted evaluations on topics of interest. Maryland prioritizes data-driven decision-making. Maryland Medicaid partners closely with its MCOs, many of whom have worked with the State for over twenty years. MCOs representatives participate in HSCRC workgroups described in **IV. Hospital Recruitment Plan** and are members of Maryland's AHEAD Model Transformation Advisory Committees. Maryland will engage MCOs and others through AHEAD pre-implementation and on an ongoing basis.

Existing Medicaid Regulatory Authority

Title 15 of the Health General Article of the Annotated Code of Maryland requires all Maryland Payers, including Maryland Medicaid, to reimburse regulated Maryland hospitals on the basis of

rates established by the HSCRC. Under the TCOC Model, Maryland ensures that its Medicaid State Plan and §1115 HealthChoice waiver are updated to accommodate changes in payment methodologies that the State implements pursuant to the agreement with CMS. All current Medicaid authorities reflect the implementation of global budgets. **No changes are needed.**

VI. Vision for Primary Care Transformation

TCOC Model Drives Multi-Payer Primary Care Transformation

Primary care is the foundation of our health care delivery system, and primary care transformation is core to achieving Maryland’s vision of empowering all Marylanders to achieve optimal health and well-being. To **improve access to care**, Pillar II (Figure 1), we must expand and align all-payer advanced primary care across payers, payment model structures, quality measures, and in a focus on outcomes. **Bolstering the primary care**

workforce is essential. We will grow, attract, and retain a diverse primary care workforce throughout our State to achieve collaborative, high-value care. We will ensure that primary care providers are well supported to achieve the State’s population health goals and optimal patient outcomes. We will consider how best to reduce administrative burden and provide resources to meet the needs of different providers, including those in small practices and underserved areas.

Maryland launched the Maryland Primary Care Program (MDPCP) in 2019 as part of the Total Cost of Care (TCOC) Model, recognizing the essential role of primary care in broader health care transformation. Maryland’s long-established partnership with CMMI to operate MDPCP includes the dedicated Program Management Office (PMO) at the Maryland Department of



Health (MDH). Maryland's largest commercial payer, CareFirst, is an aligned MDPCP payer.

MDPCP is the largest state-based advanced primary care program in the nation and a model for how a federal program can benefit from state-level operation. **MDPCP improves health outcomes and quality.** MDPCP:

- Facilitated early and consistent communication during the COVID-19 pandemic and coordinated equitable resource distribution to lower COVID-19-related health impacts relative to a comparison group.
- For a majority of MDPCP practices, improved performance to above the national median in electronic Clinical Quality Measures for diabetes and hypertension control (2019–2022).
- Through 2022, significantly decreased rates of Prevention Quality Indicator-like events, inpatient utilization, and ED utilization among attributed beneficiaries.
- As reported to CMMI by participants, supported 100% of practices in implementing a strategy to integrate behavioral health into practice workflows.

Multi-payer alignment amplifies impact. As complementary approaches apply to more patients, practices experience reduced administrative burden and greater incentive to invest in care delivery and improve patient experience, quality, and ultimately health outcomes.

Medicaid Alignment is the Next Step in Multi-Payer Progression

Maryland is leveraging its more than five years of experience co-operating MDPCP to include Medicaid as an aligned payer. **Expanding alignment to Medicaid is core to ensuring equity and promoting advanced primary care for underserved populations.** CMS approved Maryland's proposal to reverse the one-time reduction in the 2023 Medicare Performance Adjustment Savings Component and set aside funding for targeted primary care investment. For

the CY 2025 contract, MDH envisions requiring MCOs to offer the following supplemental reimbursement structure to certain eligible primary care practices in their networks:

- **Care Management Fees.** Providers participating in the advanced primary care program will be eligible for care management fees consisting of 5% of primary care spend.
- **Quality Incentives.** Participating practices will qualify for incentive payments based on quality performance. Medicaid and MDPCP are committed to aligning quality measures with Primary Care AHEAD and across programs and payers, while adding pediatric and other measures important to the Medicaid population.

Maryland Medicaid will also **increase Evaluation and Management (E&M) payments** above Medicare for all primary care providers, regardless of participation in advanced primary care.

Alignment on Behavioral Health Integration

Medicaid primary care alignment supports a strong primary care delivery system, inclusive of medical, behavioral, and HRSN. Primary care practices are integral in the behavioral health continuum of care, providing preventive care, early intervention and support directly or through referral to specialty services. **Maryland Medicaid and MDPCP address substance use disorder and mental health in the primary care setting.**

MDPCP and Medicaid have both implemented Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based protocol for substance use disorder. In 2016, the state Medicaid agency rolled out a new policy and billing structure to promote SBIRT implementation in non-behavioral health settings. In 2019, MDH built on its Medicaid experience to deploy SBIRT in MDPCP practices including FQHCs. The SBIRT roll-out in MDPCP employed a three-fold strategy including: implementing SBIRT in geographic hot

spots; supporting MDPCP practice improvement to review data to ensure practices meet SBIRT performance targets; and monitoring SBIRT data in CRISP to review each practice's progress. MDH is piloting Medication for Opioid Use Disorder protocols in MDPCP practices.

Medicaid and MDPCP also support the Collaborative Care Model (CoCM) implementation to integrate behavioral health care into primary care settings, and continue to engage with industry stakeholders to scale implementation. Medicaid and Medicare participants with mild or moderate depression, anxiety, or substance use disorder, including individuals with co-occurring diagnoses, are the target population for CoCM services. Since 2020, the MDPCP PMO has worked with Maryland CoCM vendors to provide technical assistance and help scale practice participation in CoCM. The PMO develops resource guides, includes CoCM content in practice learning opportunities, and engages CTOs to expand implementation. In CY 2022, 121 MDPCP practices provided over 977 beneficiaries with CoCM services.

After piloting CoCM in 2020, Maryland Medicaid expanded coverage statewide in October 2023. Medicaid follows the CoCM rates and codes for Medicare, creating alignment for providers. MDH estimates that more than 46,000 Medicaid participants with a behavioral health diagnosis are eligible for CoCM services under the new benefit; including participants with a substance use disorder diagnosis would increase utilization even further.

Medicaid Supports Primary Care Access

Over 20 years after its launch, Maryland's §1115 HealthChoice Medicaid managed care program covers close to 90% of the State's Medicaid and Maryland Children's Health Program populations. Most individuals outside of managed care are dually eligible for Medicare and

Medicaid. Dually eligible participants receive primary health care services through Medicare, and in many cases are served by providers participating in MDPCP.

Most Medicaid participants can select their MCO and primary care provider at the time of enrollment. **In 2021, 79% of the nearly 1.3 million HealthChoice participants visited with a PCP in their MCO network.** In comparison, Healthy People 2030 shows that nationally 76% of people simply have a usual primary care provider. HealthChoice requires each MCO to have one PCP for every 200 participants. A 2022 network adequacy analysis showed that all jurisdictions achieved this except in Prince George’s County. As described above, the State is investing \$19 million in start-up infrastructure to expand advanced primary care to underserved areas beginning in 2025.

MDPCP Paves the Way for Multi-Payer Primary Care Transformation

Maryland is implementing the principles of AHEAD’s Medicare Enhanced Primary Care Payment (EPCP) through MDPCP. MDPCP is an established Medicare advanced primary care program in its sixth year of providing resources for primary care providers to better manage and coordinate care. It employs a hybrid payment design of FFS and non-claims-based payments, aligned with the seminal 2021 NASEM report, *Implementing High Quality Primary Care*.⁹

Participation is solid, with more than 500 practices inclusive of approximately 2,300 providers. Maryland opened MDPCP to FQHCs beginning in 2021, extending the program to more practices serving under-resourced communities. Maryland and CMS jointly made this possible by developing the FQHC pathway to participate in an advanced primary care program for Medicare. **Currently 13 FQHC organizations participate, representing 77 site locations across Maryland.** Services for Medicare FFS beneficiaries include:

⁹ <https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care>

- Integration of behavioral health needs within primary care under a care team led by each patient’s primary care provider;
- Linkage to HRSN such as transportation, food, and housing;
- Convenient care options, such as telemedicine, group visits and home visits;
- Interdisciplinary care teams to coordinate smooth transitions of care, including follow up after hospital admissions and emergency department visits, and management of chronic conditions; and
- Coordination for specialty care, with practices required to have and report on coordinated referral management with at least one specialty type; CRISP reports help practices understand their specialist referral patterns.

While MDPCP is funded specifically for Medicare FFS beneficiaries, it has steadily created a multi-payer approach to care transformation, holding practices accountable for quality for patients on an all-payer basis. Aligned policy and tools, such as the CRISP multi-payer reporting suite discussed in **VIII. State Data/Health IT Infrastructure**, center primary care providers and the patients they serve across payers.

MDPCP’s Evolution to More Advanced Payment Models

MDPCP had three tracks, **evolving to now require participants to participate in more advanced Tracks 2 or 3**. All FQHC participants are in Track 2. Track 1, phased out at the end of 2023, provided practices with prospective, non-claims-based payments for care management services (risk adjusted) and performance incentives. Practices continued to bill Medicare Physician Fee Schedule (PFS) for all services. Track 2 required greater expectations for care transformation. It includes a hybrid payment for E&M services, paying a portion of historical E&M volume up front with the remainder billed at the time of service, in addition to the

prospective non-claims-based payments for care management services and performance. All other Medicare services are billed at the regular PFS rate.

Track 3 builds on Track 2 and lessons from CMS's Primary Care First Model. Practices receive a prospective, population-based payment to manage care for their attributed population and a concurrent Flat Visit Fee to standardize E&M billing across all practices. Practices continue to bill Medicare PFS for all other services. Both of the non-claims based payments are subject to an asymmetric, upside-downside risk framework. The population-based payment and Flat Visit Fee are subject to a quarterly negative or positive adjustment for quality, utilization, and cost performance. Track 3 advances the State's commitment to shifting funding into value-based payment to encourage holistic, population health management of patients. While Track 3 makes progress to non-claims-based payments, it has not been without challenges for MDPCP providers. Providers have raised concerns about payment structure complexity and challenges relating to delayed receipt of performance data to support quality improvement.

MDPCP is a Health Equity Pioneer

MDPCP is a pioneer in addressing health equity through payment innovation. The Health Equity Advancement Resource and Transformation (HEART) payment was developed by CMS and the PMO in 2022 to provide additional financial support to MDPCP practices serving socioeconomically disadvantaged populations. The HEART Payment is risk-adjusted for the medical and social complexity of beneficiaries. **This is one of the first times a CMS program is directly targeting payments to address social risk.** The Primary Care Transformation Advisory Committee noted the importance of HEART payments in addressing HRSN to improve health outcomes. However, challenges implementing this novel payment should be addressed with further design refinements and flexibilities.

MDPCP Practice Supports

Maryland helps practices thrive in value-based care by minimizing administrative burden.

MDPCP has instituted a number of support mechanisms. These are especially important for small and under-resourced practices. Care Transformation Organizations (CTOs) are private entities that hire and manage interdisciplinary care management teams and provide operational and administrative support to practices. The State's Primary Care Transformation Advisory Committee conveyed the importance of CTOs, particularly for small practices. MDPCP and its CTO model serves as a strong foundation for primary care transformation. Maryland will work with CMS to evaluate and explore the optimal role and contribution of CTOs in realizing a broad multi-payer approach to primary care transformation. Additional practice supports include health IT infrastructure with care coordination tools and analytics, dedicated practice coaching, and vendors and partners to help practices implement key services such as SBIRT.

Tools to Increase Medicaid Primary Care Investment and Access

Maryland is deploying multiple policy tools to increase primary care investment and access to primary care services, including **enhanced reimbursement to primary care providers**. In July 2024, MDH will update **MCO contract language** to require MCOs to increase primary care investment by offering advanced primary care to certain network primary care providers beginning in 2025. As discussed in **III. Statewide Accountability Targets**, Maryland's Primary Care Investment Workgroup is charged with analyzing and reporting on primary care investment and ways to improve access to primary care services with special attention on increasing health care equity and reducing health care disparities.

As Maryland develops its AHEAD Model State Agreement with CMS, the State will consider how MDPCP and Medicaid primary care alignment may evolve into the future to identify the

optimal path for investing in primary care and advancing AHEAD Model goals. In the meantime, activities to improve access include the following:

- **Medicaid Value-Based Purchasing:** Medicaid’s Population Health Incentive Program (PHIP) is a value-based purchasing initiative providing incentives to MCOs for high performance on standardized quality of care measures. Maryland will evolve PHIP measures to align with AHEAD and include reporting by race and ethnicity.
- **Addressing HRSN:** HRSN can create barriers to primary care access and drive health disparities. All MCOs have strategies to identify and address members’ HRSN, with referral processes for unmet needs. Many MCOs actively collaborate with CBOs, offering navigation assistance through case management. MCOs also have specific procedures to address HRSN for special populations such as pregnant people. Many MCOs contract with closed-loop referral systems—IT platforms integrated across organizations to identify an individual’s HRSN, refer them to appropriate and available CBOs, and confirm support is received.
- **Strengthening Efforts to Meet HRSN:** MDH is fostering uniformity and efficiency in meeting Medicaid members’ HRSN. In 2024, MDH is working towards a coordinated HRSN screening and referral strategy for its Medicaid managed care program.

Medicaid Primary Care Alignment Implementation Timeline

Maryland is poised to implement Medicaid primary care alignment in January 2025. **This is a full year in advance of the AHEAD Model’s January 2026 timeframe, jumpstarting achievement towards AHEAD goals.** Planning for Medicaid primary care alignment is in process for January 2025 implementation.

FQHC Participation in Medicaid Primary Care Transformation

Maryland has successfully engaged FQHCs in MDPCP advanced primary care since 2021. Currently 13 FQHC organizations representing 77 site locations participate. **MDH prioritizes FQHC engagement in Medicaid primary care transformation, given their important role in meeting the needs of Medicaid participants in under-resourced areas.** MDH will continue to engage CMCS and Health Resources and Services Administration (HRSA) in further developing the FQHC element of Medicaid primary care alignment. There are no Rural Health Centers (RHCs) in Maryland.

VII. Primary Care Practice Recruitment Plan

Success Recruiting Primary Care Practices

Maryland will build on its past Maryland Primary Care Program (MDPCP) success to recruit providers for Medicaid alignment. **MDPCP is the largest state-based Medicare advanced primary care program in the nation.** In 2024, more than 500 Maryland primary care practices representing approximately 2,300 primary care clinicians are participating, along with 13 FQHC organizations representing 77 different site locations. MDPCP reaches approximately 52% of Medicare fee-for-service (FFS) beneficiaries across the State. Over half of practices participate in Track 3, an Advanced Alternative Payment Model. **Many MDPCP providers already participate in Medicaid.** As of 2023, MDPCP served approximately 64,700 patients dually eligible for Medicaid and Medicare. The Maryland Department of Health (**MDH**) **intends to maintain and grow participation of MDPCP practices in the Medicare FFS program while maximizing participation in an aligned Medicaid program.**

MDPCP practices serve all Maryland counties and jurisdictions, including areas designated by HRSA as underserved. As of 2022, 173 practices were in rural areas, 111 were in primary care Health Professional Shortage Areas (HPSAs), 151 were in mental health HPSAs, and 139 were

in Medically Underserved Areas. Among practices participating in 2024, 45% are small (1 to 2 providers), 43% are medium (3 to 7 providers), and 12% are large (8 or more providers).

Medicaid Recruitment Plan Strategies

Maryland Medicaid will lead the recruitment plan to extend MDPCP’s reach to more Medicaid participants, building on the success of MDPCP’s recruitment and relationships with providers and stakeholders. **The State is experienced in educating providers on advanced primary care and providing technical assistance and practice learning resources** including synchronous virtual education and in-person opportunities. MDH outreach will target certain primary care providers serving Medicaid participants, not just those in current MDPCP practices. Medicaid advanced primary care recruitment strategies include:

- **Support for MCOs** to ensure uniform messaging as they outreach their network providers.
- **Direct marketing to primary care practices** to educate about advanced primary care benefits and opportunities.
- **Conducting outreach through PMO practice coaches and care transformation organizations** (CTOs), especially for small practices. MDPCP deploys CTOs to hire and manage interdisciplinary care management teams and provide operational and administrative support to practices.
- **Partnering with provider associations**, which have worked with MDPCP for many years to promote advanced primary care participation. This includes the Maryland chapters of the American Academy of Family Physicians and the American College of Physicians; MedChi, The Maryland State Medical Society; and the Mid-Atlantic Association of Community Health Centers. Maryland Medicaid will also work with its longtime partner, the Maryland Chapter of the American Academy of Pediatrics.

- **Continuing to partner with CareFirst**, Maryland’s largest commercial insurer, on multi-payer alignment. This includes connecting with CareFirst’s network to recruit pediatric practices.
- Exploring adding primary care **practices participating in dual eligible special needs plans** (D-SNPs) to the integration workflow employed by Maryland D-SNPs. This connects D-SNPs with Medicaid long-term services and supports case managers to better serve duals.

Maryland Medicaid has already analyzed the distribution of MCO primary care practices to promote statewide representation in the advanced primary care program.

Summary of Anticipated Medicaid Interest

Primary care providers have adopted MDPCP at a high rate. Over 90% of current MDPCP providers participate in at least one Medicaid MCO. **We anticipate that synergy for primary care practices through multi-payer Medicare and Medicaid alignment will drive interest.**

Proposed Medicaid Practice Recruitment Timeline

Maryland will implement Medicaid primary care alignment with MDPCP prior to the January 2026 AHEAD Model timeframe. The State is updating MCO contracts in 2024 for January 2025 implementation. **Primary care provider outreach and education will occur in 2024**, with MCO negotiations with providers occurring throughout 2024. MDH prioritizes FQHC engagement in Medicaid primary care transformation, given their important role in meeting the needs of Medicaid participants in under-resourced areas. **Maryland will target Medicaid primary care outreach to FQHCs, small practices, and other providers serving under resourced communities. Many of these providers already participate in MDPCP.** Outreach will leverage CTOs to engage small practices. There are no Rural Hospital Centers in Maryland.

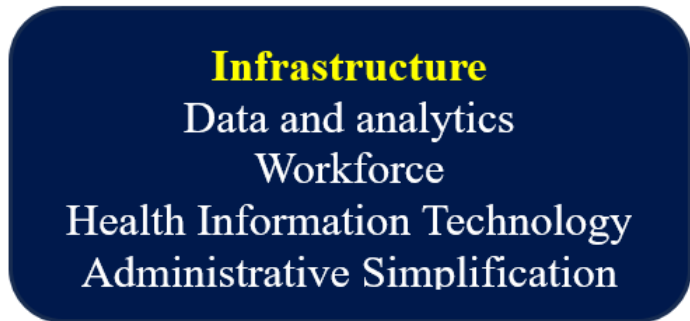
Recruitment Goals and Strategies for Overcoming Challenges

Within MDH, Maryland Medicaid and the PMO will continue closely collaborating to align Medicare and Medicaid advanced primary care. As noted above, Maryland Medicaid is requiring all MCOs to offer advanced primary care to certain network primary care providers. Anticipated enrollment of Medicaid primary care practices expands advanced primary care to underserved areas. In addition, Maryland recently initiated a pilot outside of Medicaid – targeted to begin January 1, 2025 – to provide start-up infrastructure funds to extend primary care access to new geographic areas. Maryland will continue to need the waivers associated with the Care Redesign Program to implement this, and requests the ability to continue and evolve the flexibilities associated with this work.

The State will apply lessons from MDPCP to anticipate and overcome recruitment challenges. For example, the PMO identifies and encourages provider leaders to recruit providers in underserved communities through their professional networks. The State will continue applying data-driven approaches to increase advanced primary care access for all.

VIII. Description of State Data/Health IT Infrastructure

Maryland has, and continues to, invest in implementing its data infrastructure action plans. Infrastructure in **Figure 1** includes health IT along with data and analytics to as the base of our efforts to **ensure high-value care, improve access to care, and promote health equity.** The



State of Maryland cross-collaborates with key health IT partners to advance its population health goals. Partners include (1) **CRISP** (the Chesapeake Regional Information System for our

Patients) **one of the nation’s leading health information exchanges** and the State’s Health Data Utility, and (2) the **Hilltop** Institute, a non-partisan research organization at the University of Maryland, Baltimore County. The Health Services Cost Review Commission (HSCRC) and Maryland Medicaid have a four-way data use agreement with CRISP and Hilltop that allows for data exchange. Maryland will continue to strengthen and grow its data systems and analytic capabilities with a focus of intentionality, transparency, and collaboration across the health care and social services continuums. Additionally, MDH has adopted a measured approach to the recent increased growth and interest in artificial intelligence across all spectrums of government and the private sector. plans to align its Artificial Intelligence (AI) Strategy closely with the strategy laid out by the Maryland Department of Information Technology (DoIT) as well as with the recent [Executive Order – Executive Order 01.01.2024.02 – Catalyzing the Responsible and Productive Use of Artificial Intelligence in Maryland State Government.](#)

HSCRC Hospital Data is the Best in the Nation

Maryland leads the nation in hospital data availability. By legislative mandate, the HSCRC collects financial and patient-level administrative data—known as case mix data—on all inpatient and outpatient hospital visits from all acute care hospitals and licensed specialty hospitals in Maryland. **For decades, the HSCRC has used case mix data and audited financial data in rate setting activities, performance measurement, and policy development and validation.** The HSCRC leverages predictive analytics, for example working with CRISP to establish a beneficiary risk score evaluating the likelihood of future admissions. The score is included in the analytic suite available to hospitals.

Maryland Department of Health (MDH) Leadership in Data/Health IT

MDH is investing in data/health IT to better understand disparities and identify solutions.

This aligns with feedback from the State’s Population Health Transformation Advisory Committee regarding the need for more granular data. The MDH Data Office collects and analyzes data to monitor trends in health outcomes for all Marylanders. It tracks priority metrics across different racial and ethnic groups as well as in each jurisdiction. The Data Office supports the MDH Office of Minority Health and Health Disparities (MHHD) and the Maryland Commission on Health Equity (MCHE) regarding disparities reporting strategies. **MDH is increasing funding for this work and adding two new data scientists to the MDH Data Office, deepening its capacity as a centralized entity to scale projects across MDH.** The State envisions developing a public facing health disparities dashboard and health equity index.

Maryland Medicaid has rich claims and encounter data to evaluate performance and inform policymaking. For decades, Medicaid data has been used to develop risk-adjusted MCO capitation payments.

MDH has developed tools to support advanced primary care. Through the **Maryland Primary Care Program (MDPCP) reporting suite** in CRISP, MDH provides continuous improvement data to primary care practices. This allows MDPCP practices to share multi-payer patient panels while using HIE tools at the point of care. It also provides a platform for practices to report quality measures to CMS. The State is enhancing support for MDPCP practices to understand and address health disparities and improve tools to meet patients’ HRSN.

Maryland’s All-Payer Claims Database

The Medical Care Data Base (MCDB), established in 2011 by the Maryland Health Care Commission (MHCC), is Maryland’s all-payer claims database. It includes Medicare and

Medicaid claims as well as commercial payer claims including non-ERISA, Medicare Advantage, and State and local government employee plans. **The MCDB will support measurement of all-payer TCOC and primary care spending targets.**

State Partnership with CRISP

CRISP has long supported interoperability and data exchange across multiple systems, partners, and domains to improve efficiency and quality of care. CRISP is an independent non-profit governed by a board of directors. It connects thousands of providers across Maryland, including all hospitals, ambulatory providers, long term care facilities, pharmacies, payers, and local health departments. **The State and provider community work with CRISP to develop tools to support high-value care and improve access to care:**

- CRISP's **point-of-care tools for health care providers** help reduce duplication of efforts and services, increase efficiency, enhance care coordination and care management, and support medical homes.
- **Maryland is the first state to accept eCQM** (electronic clinical quality measure) data from hospitals, with mandatory quarterly reporting. Work is ongoing to voluntarily receive eCQMs from primary care practices, with race and ethnicity stratification.
- CRISP **population health reports** leverage administrative claims and hospitalization data to allow users to look at disparities in race, ethnicity, geography, gender, and other metrics. As the host of **Maryland's Health Equity Data Set**, CRISP shares data among State departments to ensure disparities are identified and addressed.
- CRISP supports **Medicaid redeterminations** by linking Medicaid panels with clinical and public health data for FQHCs and other Medicaid providers to outreach members at risk for losing coverage.

- The CRISP **multi-payer reporting suite** enables users to view Medicare and Medicaid empanelled patients in one dashboard. Users can better understand trends in hospital utilization, facilitate care coordination, and monitor population health across Medicare and Medicaid. Demographic, clinical, and utilization characteristics including CMS Core Set measures are available for each patient on a user's panel.

MDH's 30-year Partnership With Hilltop

Hilltop has a strong relationship with the State to help inform their policy decisions. It warehouses State data and performs extensive data analytics for Maryland Medicaid for program development, monitoring, rate setting, and evaluation. Hilltop performs a wide array of ad hoc data analytics upon request. Hilltop is at the forefront in the use of artificial intelligence. Its **Pre-AH Model™** predicts the risk of avoidable hospitalizations and assists MDPCP providers in triaging care coordination resources. To develop the model, Hilltop researchers created an algorithm that identifies a given individual's relative risk of avoidable hospitalization and designed a monthly scoring process.

Diverse and Extensive Staff Capacity Across State Health Agencies

Given Maryland's history of implementing all-payer global budgets and advanced primary care, **State staff have deep experience supporting value-based payment models and quality reporting.** State staff include population health experts, economists, accountants, and analysts. They are experienced contract managers for procuring external expertise and support from actuaries, and programmers and others who offer expertise in health policy, data analytics, modeling, and building innovative IT solutions.

Maryland State staff work closely with CRISP and Hilltop in identifying data/health IT needs and solutions. For example, HSCRC staff work with CRISP to provide monthly performance reports to all Maryland hospitals and analyze hospital trends and utilization. MDH worked with Hilltop to develop **DataPort**, a decision support system for State policymakers. Hilltop developed a similar tool for the HSCRC.

Maryland’s Existing Health Oversight Agencies

The HSCRC has been designated as a health oversight agency since the inception of the All-Payer Model. This allows sharing of Medicare Claims data with hospitals and providers to monitor progress under the Model. MDH is a HIPAA covered entity, ensuring that all of the data it shares is appropriate. Within MDH, the Behavioral Health Administration is a health oversight agency for the public behavioral health system. **The State will continue meeting all requirements to maintain health oversight agency status for the purposes of data sharing.**

IX. Description of Health Equity Activities

Maryland will **promote health equity**—a key pillar to empower all Marylanders to achieve optimal health and well-being, (Pillar III, Figure 1). Alongside Maryland’s current and ongoing health equity promotion activities, myriad opportunities remain to enhance efforts and develop innovative approaches to address the significant health care disparities that exist for black and brown communities and other marginalized, underserved, and unserved populations across the State. We recognize the pressing call to transform our statewide systems of care to meet the needs of our most vulnerable residents, and we will capitalize on the opportunity presented by the AHEAD



model to evolve how Maryland defines equity-centered population health improvement strategies.

A key element of promoting health equity is elevating community decision-making and investing in community capacity building. We will adopt community-centered approaches to health care decision-making that elevate and empower community voices and utilize innovative methods for capacity building, funding and investments. We intend to **leverage data to help communities in their decision-making.** This will be a priority as Maryland strengthens its health IT, data, and analytics infrastructure

Maryland’s Existing Initiatives to Promote Health Equity and Address HRSN

The State increasingly embeds efforts to promote health equity and address HRSN through many different avenues, as described throughout this project narrative. These initiatives will be important inputs into **Maryland’s Health Equity Plan (State HEP)**, which will guide all actions and investments under AHEAD.

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.

As described in section **X. Proposed Model Governance Structure**, the Maryland General Assembly recently introduced legislation to tailor the existing **Maryland Commission on Health Equity (MCHE)** specifically to **elevate community voice and align with AHEAD’s requirements for the State HEP**. MCHE was originally established by the General Assembly in 2021 to implement policies and laws to reduce health disparities and promote health equity statewide. Currently, MCHE’s Data Advisory Committee develops, maintains, and utilizes a Health Equity Data Set. MCHE’s Health Equity Policy Committee is developing a health equity

framework, expanding upon the CMS Framework and CDC Core Commitment to establish systems and programs addressing health disparities. This framework will inform Maryland's development of a Health Equity Plan under the AHEAD Model. Maryland's Population Health Transformation Advisory Committee, which is helping to develop the AHEAD Model approach, recommends that Maryland build on the CMS Framework to more broadly consider community wellbeing in addition to individual health.

Maryland prioritizes health equity funding initiatives. The Community Health Resources Commission oversees several such grant opportunities. The 2021 **Maryland Health Equity Resource Act** provided **\$13.5 million** via a pilot grant program, **Pathways to Health Equity**. Funds support programs to reduce health disparities, improve health outcomes, increase primary care access, promote primary and secondary prevention, and reduce costs. The **Health Equity Resource Communities** grants will build upon these pilot programs and provide **\$42 million** over five years for long term interventions to address social determinants of health. Awards will be made in Spring 2024.

State entities incorporate health equity into their core missions, described in **I. Organizational Capacity of Applicant Organization**. Twenty years ago, the General Assembly passed groundbreaking legislation establishing the **Maryland Office of Minority Health and Health Disparities (MHHD)**. MHHD's mission is to address social determinants of health, reduce health disparities, and advance health equity; collect and analyze race and ethnicity data to improve health outcomes; foster robust community, public, and private partnerships to advance health equity advocacy and education; and guide policy, practice, and program decisions within MDH. In addition to data-related initiatives, MHHD runs a number of grant programs. Key

upcoming initiatives include promoting practices to address structural racism, partnering with community health workers, and planning to increase racial and ethnic minority professionals.

MDH's **Prevention and Health Promotion Administration (PHPA)** embeds health equity into its everyday work to implement public health and population health initiatives in partnership with local health departments and community-based organizations. PHPA's core areas of responsibility include cancer and chronic disease; maternal and child health; infectious disease prevention, epidemiology, and outbreak response; and environmental health. Through its Root Causes of Health initiative, PHPA programs in each of the five bureaus completed a QI process (using the Equity Action Lab framework) to analyze equity of reach and equity of impact by assessing enrollment and outcome data, comparing it to statewide and county population estimates by race/ethnicity. **The analysis resulted in new grant requirements for target populations and revised outcome measures and funding allocations.**

Maryland conducts planning and evaluation efforts with a health equity lens. For example, MDH's Spring 2024 update to its **State Health Assessment and State Health Improvement Plan** will focus on health equity. The **Statewide Integrated Health Improvement Strategy (SIHIS)** developed in 2019 as part of the Total Cost of Care Model aligned statewide efforts across hospital quality, system-wide care transformation, and total population health. It targets diabetes, opioid use disorder, and maternal and child health, tracking racial disparities as part of ongoing monitoring, with a dashboard of performance on each measure by race and ethnicity.

Maryland's unique all-payer hospital global budget revenue system builds in health equity components, described in **III. Statewide Accountability Targets** and **V. Hospital Global Budget Methodology Development**. The **Readmissions Reduction Incentive Program**

Disparities Component rewards hospitals for reducing disparities related to socioeconomic status using the Patient Adversity Index (PAI). PAI incorporates information on patient race, Medicaid status, and the Area Deprivation Index. This is the only known statewide program in the nation with an incentive for reducing within hospital disparities in all-payer readmission rates.¹⁰ Maryland recently expanded this methodology to include timely follow-up after hospital visit, and continues to explore adapting this methodology for additional measures.

Promoting a Diverse Workforce

A key strategy to promote health equity and improve access to care is building and retaining the health care workforce to meet community needs and reflect Maryland’s diversity. Part of the strategy is simplifying administrative complexity through multi-payer alignment. Maryland’s other efforts to develop the workforce include loan repayment programs and investing in community health workers (CHWs). Maryland’s CHW training and certification process has resulted in 1,534 CHWs certified since 2019. A legislatively created workgroup is addressing diversity in the behavioral health workforce with recommendations to increase the number of students and health professionals who are Black, Latino, Asian American Pacific Islander, or otherwise underrepresented.

Supporting Performance on Statewide Measures

Maryland’s ongoing investment in health IT, data, and analytics infrastructure enables the State to identify and address disparities and HRSN. This level of sophistication puts Maryland on the path to develop AHEAD Model core and optional statewide measures. Examples of how Maryland already leverages data for health equity include the following.

¹⁰Rice K. *et al.* (2023) Development and Implementation of a Maryland State Program Providing Hospital Payment Incentives for Reduction in Readmission Disparities, *Medical care*, 61(7), pp. 484–489.

- The **Health Services Cost Review Commission (HSCRC)** collects **race and ethnicity data as part of hospital case mix data** for use in incentive payments. The HSCRC Health Equity Workgroup invites stakeholder input on quality measurement and hospital incentives to address disparities. It is exploring collecting sexual orientation and gender identity data.
- As described above, CRISP’s **population health reports** show disparities in race, ethnicity, geography, gender, and other metrics.
- CRISP hosts **Maryland’s Health Equity Data Set** and also enhances the availability of race and ethnicity data for a number of initiatives such as the Prescription Drug Monitoring Program and vaccine tracking.
- **Maryland Medicaid has rich data on race and ethnicity**, enabling the State to conduct analyses of different populations. Maryland Medicaid and Hilltop collaborated on a health equity index incorporating HRSN domains to enhance payments to MCOs operating in higher need counties.

Investments in Identifying and Addressing HRSN

While government programs cannot fully solve social and economic inequities, Maryland’s health care delivery systems have an important role to play in identifying and addressing social determinants of health and HRSN as part of whole person care. As shown in Pillar III, Figure 1, we will identify, address, and measure HRSN to promote health equity. **As Maryland continues to address HRSNs, we will center community knowledge and solutions, prioritize**



community-based investments and alternative funding models, and empower community voice in decision-making.

Since 2001, the Maryland General Assembly has required the HSCRC to collect and publicly share community benefit information from hospitals. In 2020, new legislation updated reporting related to **Community Health Needs Assessments (CHNAs)**. In FY 2022, all hospitals conducted CHNAs, addressing HRSN related to health care access and quality, mental health, and diabetes. Many hospitals have equity plans in place.

In recent years, Maryland has invested in identifying and addressing HRSN. Governor Moore’s administration has proposed spending \$5.4 million in FY 2025 to expand the Assistance in Community Integration Services (ACIS) program statewide. ACIS is a Medicaid program that pairs case management and tenancy support services to complement housing for Marylanders experiencing homelessness who have chronic conditions and high hospital use. As a pilot, ACIS showed strong evaluation results.¹¹

As noted above, Maryland Medicaid and the MCOs are working towards standardizing HRSN screening tools and requiring MCOs to universally share HRSN data with CRISP.

CRISP’s suite of **screening and closed-loop referral tools** offers point of care information inclusive of social needs, social care intervention data, and clinical data. It captured 4,500 referrals in 2023 and continues to expand its network each month. CRISP’s approach supports interoperability and integrations; is agnostic to vendor, tool, and workflow; and creates a whole-person record that includes clinical and social care data. CRISP’s HRSN suite of tools:

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<https://health.maryland.gov/mmcp/Pages/Assistance-in-Community-Integration-Services-Pilot.aspx>

- Automatically shares patient social needs information with other members of the care team.
- Categorizes HRSN questions and responses at the point of care, organized by social domain.
- Facilitates sharing of screenings across providers to reduce duplication.
- Aligns with MDPCP requirements for social needs screening and linkage to resources.
- Is available via EHR or web-based application, for community-based organizations to provide real-time updates to the care team.
- Connects to Maryland 211, with over 7,000 resources across the State.

How AHEAD Model Components Will Advance Maryland Health Equity

As described in the **Budget Narrative**, Maryland’s requested AHEAD Model Cooperative Agreement funding focuses on health equity and HRSN. This includes: (1) Five regional population health improvement coordinators to support regional community-based population health hubs that identify community-level population health investments and efforts to address HRSN; (2) Community grants to address HSRN and population health; and (3) Support for a statewide coordinated HRSN screening and referral tool.

X. Description of Proposed Model Governance Structure

Maryland will Expand Existing Governance Structures

The mission of Maryland’s recently established **Commission on Health Equity (MCHE)** aligns with AHEAD’s requirements for a Model Governance Structure and establishment of a Statewide Health Equity Plan (State HEP). In February 2024 the Maryland legislature introduced **House Bill 1333 - Maryland Commission on Health Equity – Membership and Statewide Health Equity Plan** to alter MCHE membership to meet AHEAD requirements and slightly modify MCHE’s duties. **The State HEP will serve as the touchstone for all AHEAD activities including all-payer TCOC and primary care Statewide Accountability Targets.**

The State HEP will identify health disparities and population health focus areas. **MCHE will allocate resources to implement strategies for State and local governments to improve health by considering HRSN** including housing, education, employment, economic stability, environmental factors, public safety, and food security. MCHE will define parameters of a State health equity data set, with required reporting from hospitals and all payers. This will facilitate setting goals and measuring progress to reduce disparities and improve population health.

The Maryland Department of Health (MDH) Secretary and Health Services Cost Review Commission (HSCRC) Executive Director will co-chair MCHE, facilitating close coordination among the key entities implementing AHEAD Model activities. MDH is the AHEAD Model applicant and incorporates the State Medicaid agency, the Program Management Office of the Maryland Primary Care Program, and the State Public Health Agency among other operational units. Maryland will also leverage the existing governance structure for the Maryland Model. The HSCRC is well-respected for its independence, data-driven decision making, and incorporation of stakeholder perspectives through workgroups. The Maryland Health Care Commission's (MHCC's) Primary Care Investment Workgroup provides another vehicle to incorporate expertise.

Composition of the Expanded Governance Structure

HB 1333 creates **specific requirements for MCHE composition to obtain diverse points of view**. In addition to being co-chaired by MDH Secretary and HSCRC Executive Director, members include representatives from both houses of the General Assembly, the Medicaid Director, and the Secretary (or designee) from a number of public agencies: Aging, Budget and Management, Disabilities, Schools, Housing and Community Development, Human Services, Planning, Behavioral Health, Public Health, Insurance, Minority Health and Health Disparities,

MHCC, Rural Health, and a local health department. Health care provider representatives include hospitals, hospital-based population health experts, FQHCs, and multiple independent clinical providers. A commercial insurer and an MCO will offer payer perspectives. Other members include multiple community-based organizations, multiple patients from underserved communities, and a tribal community.

HB 1333 intentionally restructures MCHE to amplify community voice in developing the State HEP. This is consistent with feedback from the Population Health Transformation Advisory Committee, one of Maryland’s three Transformation Advisory Committees providing counsel on AHEAD Model development. The Committee emphasized the need for community members to have greater decision-making power regarding population health investment and accountability for outcomes. The State will continue to provide opportunities for community input during the pre-implementation period and throughout the implementation of AHEAD.

Role of the AHEAD Model Governance Structure

MCHE together with MDH (including Maryland Medicaid) and the HSCRC will plan and implement the core components of AHEAD as well as address other pressing challenges in our health care system, namely behavioral health, workforce, and post-acute care. **HB 1333 charges MCHE with multiple tasks in addition to developing and monitoring the Statewide Health Equity Plan.** MCHE will make recommendations and provide advice to the MDH Secretary on implementing laws and policies to improve health and reduce health inequities in time for the 2025 legislative session. MCHE will also advise the MDH Secretary and the State’s independent health regulatory commissions on health disparities and facilitate coordination across State agencies. Other key state agencies that will directly assist with AHEAD activities include the Maryland Insurance Administration, the Maryland Health Benefit Exchange, the

Department of Budget and Management, the Maryland Health Care Commission, and the Community Health Resources Commission.

XI. Commercial Payer Alignment

Commercial Payers Participate in the All-Payer Hospital Global Budget System

Commercial payers have been part of Maryland’s rate setting for over 40 years. Our experience sets us up for success in achieving all-payer TCOC and primary care investment targets to ensure high-value care and improve access to care. This will help us ensure affordability and equity and achieve our vision of empowering all Marylanders to achieve optimal health and well-being. Maryland will explore whether changes to State law will help galvanize further alignment.

Commercial Payer Alignment with MDPCP

Since 2020, Maryland’s largest commercial payer, CareFirst BlueCross BlueShield, has aligned with the Maryland Primary Care Program (MDPCP). **Almost all practices in MDPCP participate in CareFirst value-based programs.** MDPCP and CareFirst align priorities and processes for financial incentives, care management, quality measures, data sharing, and practice learning to decrease administrative burden and make it easier for practices to focus on patient care. MDPCP Practice Coaches and CareFirst Practice Consultants share best practices to reduce duplication, for example via quarterly collaboratives where all regional support staff convene with practices. Future goals include eliminating the need to log into multiple sources for information via unified data tools.

The AHEAD Model’s focus on commercial alignment serves as a catalyst for Maryland to recruit additional commercial payers to align with MDPCP. Maryland also commits to ensuring

its State employee health plan, covering approximately 237,000 lives, aligns with MDPCP and AHEAD Model goals of building a strong and equitable primary care delivery system.

The State's Primary Care Investment Workgroup, established by law, provides an opportunity to impact primary care through investment strategies that align across payers. It specifically addresses an aligned primary care investment target for commercial payers.

Policy Levers to Align Commercial Payers with AHEAD Model Activities

For decades, the State has effectively deployed statutory and regulatory policy levers to engage all payers. **Maryland law requires payers in Maryland to pay Health Services Cost Review Commission (HSCRC)-approved rates for the provision of hospital services and to comply with the terms of the State's agreement with CMS.** The law refers to the "all-payer contract" which includes any successor agreement such as the Total Cost of Care (TCOC) Agreement or the AHEAD Model. Maryland's hospital rate setting applies broadly to all payers, including ERISA plans. In addition to HSCRC's hospital rate setting authority, Maryland has a number of policy levers available to hold commercial payers accountable for TCOC cost growth targets and primary care investment. **A key lever is Maryland's insurance rate review.** Maryland law requires commercial carriers to file rates and have them approved by the Maryland Insurance Administration (MIA) before implementation. Coverages in the individual, small group, and large group markets are subject to rate review.

Marketplace Plans & State Employee Plan in All-Payer Hospital Global Budget System

Like all other payers in the State, marketplace plans and the State employee plan are included in the all-payer hospital global budget system. The Maryland Health Benefit Exchange (MHBE) Board has broad statutory authority to set requirements for qualified health

plans to be certified for sale through the marketplace. MHBE’s statute identifies “higher standards of care, continuity of care, delivery system reforms, health equity, improved patient experience and outcomes, and meaningful cost controls within the health care system,” directly aligning with AHEAD goals. Examples of the MHBE Board’s promotion of affordability and population health goals include requiring Value Plans to cover primary care visits, outpatient behavioral health visits, and generic drugs pre-deductible, as well as diabetic care and supplies at no cost to enrollees. The Secretary of Health chairs the MHBE Board. MHBE will work with sister State agencies to identify future plan certification standards to support AHEAD. The State Department of Budget and Management oversees the State Employee Health Benefit Plan, which covers approximately 237,000 lives. Maryland will ensure that this Plan aligns with the goals of AHEAD.

Alignment with Medicare Advantage Plans

The State believes all-payer participation in global budgets has been critical to the success of the Maryland Model and will be necessary for the State’s continued success under AHEAD. In addition to Medicaid and commercial payers, Maryland intends to explore potential levers to incentivize alignment of Medicare Advantage plans to these goals.

Conclusion

The AHEAD Model will help Maryland advance our vision of empowering all Marylanders to achieve optimal health and well-being. In this next phase of delivery system transformation, we will **bridge the health care, population health, and social sectors as well as the public and private sectors to implement the solutions Marylanders need, as identified by community members themselves**. This is essential to ensure high-value care, improve access to care, and promote health equity.