Primary Care Investment Workgroup

Framing the 2027 Primary Care Investment Targets

January 15, 2026

Presentation Items

- Overview of State Law (2022)
- 2025 PCIW Report Recap
- Establishing the 2027 Primary Care Investment Targets
- Key Milestones and Timeline

State Law

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

- Requires the Maryland Health Care Commission (MHCC) to conduct an annual analysis of primary care and make recommendations on the level of primary care investment relative to overall health care spending

- The MHCC must convene a Primary Care Investment Workgroup (PCIW) to inform an annual report on ways to improve quality and access to primary care services, with special attention to increasing health care equity, reducing health care disparities, and avoiding increased costs to patients and the health care system

    - The PCIW members represent primary care clinicians and experts, Commercial payers, medical societies and associations, Medicaid, and State agencies

Executive Order - Overview

Governor Moore signed Executive Order 01.01.2025.28, *Establishing All-Payer Total Cost of Care Growth and Primary Care Investment Targets in Maryland,* on December 19, 2025

- States that primary care is the foundation for high-quality whole-person care for all Marylanders
- Aims to address primary care investment by establishing an all-payer primary care investment target
- All-payer target includes Medicaid, commercial fully insured, Medicare Advantage, State Employee Health Plan, and employer-sponsored health insurance

MARYLAND
Health Care
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2025 PCIW Report Recap

Report – At a Glance

- The 2025 report marks the second annual analysis of primary care investment
  - Amends the definition of primary care to align with the Centers for Medicare & Medicaid Services (CMS) AHEAD Model (Model)*
  - Examines primary care spending and investment opportunity by ZIP Code
  - Explores future considerations for primary care code valuation
  - Recommends activities based on findings to increase investment and accountability

** The CMS Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model is an 11-year program (2024 – 2035) that offers states the opportunity to leverage federal funding to implement broad changes in how health care is delivered and financed, CMS Link - AHEAD Model*

Recommendations

- Establish a primary care investment target based on total medical expense (TME), adjusted for payer-specific variation, that promotes primary care investment in underserved areas; publish annually which payers are meeting the target; enact legislation to hold payers accountable to achieving targets
- Enact legislation requiring payers to participate in the Model primary care programs, including the Maryland Primary Care Program (MDPCP), and to reimburse providers for Advanced Primary Care Management (APCM) services and integrated behavioral health services with no cost sharing, when permitted by law
- Leverage the CMS Potentially Misvalued Codes Process to advocate for more accurate valuation of services
- Assess how health systems are investing in their owned and affiliated primary care teams and examine whether incentives for increased investment are necessary
- Continue to monitor the Model's implementation to ensure that Workgroup investment goals and strategies inform and align with Model objectives

Establishing Primary Care Investment Targets

Related Initiatives In Other States

- Some states have developed primary care investment targets or requirements
  - Oregon, Delaware, and Colorado legislation broadly ties compliance to rate review and/or state contracting but does not prescribe specific penalties
  - Rhode Island only has regulation not legislation
  - After the statute was passed, Delaware followed up the legislation with regulation that includes specific financial penalties in the form of fines
- These efforts have had varying levels of success and offer lessons learned, which Maryland is aiming to reflect in its approach

Lessons Learned and Maryland Approach

State Lessons Learned	Maryland Approach
Multi-payer alignment needed	State participation in AHEAD model; shared use of AHEAD primary care definition
Targets based on a percent of spending can be inflationary	Targets reflect investments necessary to improve outcomes
Single target does not reflect differences in populations and primary care need	Payer targets adjusted for age/gender mix of population
New investments may not reach communities most in need	Payers asked to prioritize investments in communities of greatest need

Approach to Target Development

- Confirm any code set updates with CMS
- Adjust by age and gender and encourage investment in underserved communities
  - Chronic condition prevalence in Maryland,
  - National recommended care guidelines,
  - Best practices in care team configurations,
  - Maryland wages and benefit costs, and
  - Estimates of administrative costs
- Estimate per member per month costs of primary care delivery in Maryland for each age/gender combination
- Develop weighted average based on age/gender mix of each payer's population
- Achieve payer specific targets that reflect the cost of primary care delivery

Calculating Payer Investment Targets – Key Inputs

Step	Description	PCIW Feedback	Staff Considerations
1. Review Literature to Identify Inputs	▶ Maryland disease prevalence rates (Maryland Department of Health, America Health Rankings, peer review literature) ▶ Maryland wages and benefits for primary care providers and care team members (U.S. Bureau of Labor, Maryland median, 30% fringe) ▶ Best practices in panel size, staffing configurations (gray and peer reviewed literature)	▶ Panel size should not be too large ▶ HCC or other risk adjustment	▶ Confirm any code set updates with CMS ▶ Adjust by age and gender to account for differences in payer populations and encourage investment in underserved communities

Calculating Payer Investment Targets – Estimating Costs

Step	Description	PCIW Feedback	Staff Considerations
2. Use Maryland Care Team Builder Model to Estimate Costs	▶ Estimated primary care staffing costs ○ Age bands: <30, 30-65, >65 ○ Gender groupings available in the MHCC all payer claims database: male, female	▶ Include efforts to encourage recommended primary care use among Maryland men ▶ Create more age bands for <30 ▶ Reflect needs of different payer populations (e.g., Medicare, Medicaid, Commercial)	▶ Revise age bands to 0-4, 5-17, 18-39, 40- 64, 65+ ▶ Reflect primary care spending among men and women in other states to encourage improved access for men ▶ Continue with plan to use payer-specific targets to reflect population needs

Calculating Payer Investment Targets – Inflation Factor

Step	Description	PCIW Feedback	Staff Considerations
3. Apply Inflation Factor	▶ Potential Options for Inflation Factor ○ TME ○ Medicare Economic Index (MEI) since specific to health care ○ Maryland Total Cost of Care Growth Target Under AHEAD ○ Other?	○ Growth in TME is most common across states ○ Align with AHEAD; MEI used in AHEAD	▶ Use the MEI, consistent with the AHEAD model; estimates the change in the operating costs for providing physician services

Calculating Payer Investment Targets – Payer Specific Glidepaths

Step	Description	PCIW Feedback	Staff Considerations
4. Develop Payer-Specific Glidepaths	▶ Distribute increases across three years ▶ Year over year (YoY) increases in primary care spend of approximately 12% to 25% depending on the payer/year ▶ Year 1 increases smallest in dollar value to allow payers time to adopt	▶ None at this time	▶ Develop an initial 3-year glidepath, consistent AHEAD All-Payer Primary Care Investment Target ▶ Increase investment gradually to allow payers and providers time for contracting and care delivery redesign

Calculating Payer Investment Targets – Increasing Investment in Underserved Areas

Step	Description	PCIW Feedback	Staff Considerations
5. Stepwise Payer Guidance to Ensure More Equitable Geographic Investment	▶ Initially, use maps to highlight geographic distribution of primary care spend and Area Deprivation Index ▶ Next, collaborate with payers to increase primary care investment in underserved areas ▶ Over time, hold payers accountable for increasing investment in underserved areas	▶ Mobile clinics ▶ FQHCs and other efficient providers of high-quality primary care services ▶ Integrate opportunities identified in the State's Rural Health Transformation Plan	▶ Utilize MHCC maps showing areas of opportunity to expand provider network participation ▶ Encourage payers to invest creatively in new sites of care

Path Forward and Timeline

Key Milestones

- Convene the PCIW every four to six weeks in Q1 2026 and about once every quarter thereafter
- Complete geographic analyses to identify areas where targeted community investments can address disparities and improve outcomes
- Establish payer specific primary care investment targets in collaboration with stakeholders
  - Convene listening sessions on proposed targets in 2026
  - Track payer performance against the targets and publish progress beginning in 2027
- Present the proposed investment target recommendations to the Commission

Tentative Timeline

Step	Tentative Timeline
Reviewed draft primary care investment target framework with the PCIW	December 2nd
Distributed the Maryland Care Team Builder Model to the PCIW for comment	December 23rd
Consider the PCIW feedback on the Maryland Care Team Builder Model	Week of January 12th
Complete data analysis to support recommendations for primary care investment targets	Week of January 12th
Present draft primary care investment target framework to the PCIW	January 27th
Consider the PCIW feedback on the draft primary care investment target framework	February 2nd – February 13th
Convene the PCIW to discuss proposed changes to the draft primary care investment target framework	Week of February 24th

Questions?

Appendix

PCIW Membership

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Maryland General Assembly	Senate	Clarence Lam
Maryland Primary Care Program	MDPCP/MDH	Chad Perman
Health Services Cost Review Commission	HSCRC	Laura Goodman William Henderson Christa Speicher
Maryland Insurance Administration	MIA	Brad Boban
Health Care Financing Division of the Maryland Department of Health	Medicaid	Vacant
Office of Care Transformation, Maryland Department of Health	MDH	Djinge Lindsay
Maryland Academy of Family Physicians	MDAFP	Amar Duggirala *Poolesville Family Practice*
Maryland Chapter of the American Academy of Pediatrics	MDAAP	Jeffrey Bernstein *Pediatric and Adolescent Care of Silver Spring*
Maryland Section of the American College of Obstetricians and Gynecologists	MDACOG	Ishrat Rafi *Ascension Saint Agnes*
Maryland Nurses Association	MNA	Christie Simon-Waterman *The Johns Hopkins Hospital*
Maryland Affiliate of American College of Nurse Midwives	Maryland Affiliate of ACNM	Mette Ramanathan *University of Maryland St. Joseph Medical Center*
Maryland Community Health System	MCHS	Salliann Alborn

PCIW Membership

MEMBERSHIP CATEGORY	ORGANIZATION	NAME
Mid-Atlantic Association of Community Health Centers	MACHC	Nora Hoban
Maryland Hospital Association	MHA	Tequila Terry
Accountable Care Organization	Aledade	Tyler Blanchard
Primary Care	MEDIS, LLC	Michael Barr
Primary Care	Patient First	Chris Barker
Primary Care	Johns Hopkins Clinical Alliance	Sarah Johnson Conway
Primary Care	LifeBridge	Kimberly Johnston Deltuva
Primary Care	University of Maryland School of Medicine	Niharika Khanna
Primary Care	COLA, Inc.	Danielle Stroughton Duncan
Payor	CareFirst BlueCross BlueShield	Seiji Hayashi
Payor	Funk & Bolton P.A.	Matthew Celentano
Payor	Kaiser Permanente of the Mid-Atlantic	Tinisha Cheatham
Payor	Amerigroup Maryland, Inc. & Maryland MCO Association	Kathleen Loughran
Health Services Researcher with Expertise in Primary Care	Johns Hopkins Bloomberg School of Public Health	Jill Marsteller
Other Representatives	Health Care for All	Rev. William Johnson, Jr. *Community Chaplain for the Johns Hopkins Health System*
Other Representatives	Perdue Farms	Dawn Carey
Other Representatives	State of Maryland	Christina Kuminski
Other Representatives	Independent Consultant/ Retired Senior Health Actuary at U.S. Office of Personnel Management	Ronald Gresch

Executive Order – Important Dates

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

Primary Care Definition Comparison Table – Key Elements

Primary Care Investment Comparison Table: Key Elements			
CATEGORY	**MULTISTATE**	**Model**	**MEDICAID/HILLTOP**
Primary Care Definition & Services	• Encompasses primary care office visits, preventive care, and a broad set of other services performed by a physician specializing in family medicine, general practice, internal medicine, preventive medicine, pediatrics, geriatrics, and includes NPs and or PAs practicing in one of these specialties • Primary care provider taxonomy codes used to calculate payer investments; includes providers delivering primary care services in a nursing home, federally qualified health centers (FQHC), urgent care center, retail clinic, or other non-traditional setting; behavioral health services; and obstetric and gynecologic services, when provided by a primary care provider • Includes services performed by a nurse midwife or behavioral health provider; requires the provider to be integrated into a primary care practice where services are billed under the taxonomy code of the primary care provider	• Uses the same specialties as the definition of primary care developed by the Primary Care Investment Workgroup (PCIW) and adds 30 psychiatry and obstetrics/gynecology specialties into the definition; these providers can bill either as part of or independent of a primary care practice • Medicare Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) codes and specialty codes (aligns with the Medicare Shared Savings Program) • FFS and non-claims-based payments are used to calculate the investment • FQHC or rural health clinics are counted as primary care regardless of provider specialty code as long as they included a primary care CPT®/HCPCS code (includes inpatient, outpatient, professional)	• Defined using the MMIS provider type and specialty • Includes: Medicaid identified Primary Care Physicians (Physicians, NPs, Certified Nurse-Midwives [CNMs], PAs, including OB/GYNs), as well as School-Based Health Clinics and any providers providing: vaccines, certain family planning services, certain OB/GYN services • SBHCs are counted as primary care for any code that they bill • FFS and non-claims-based payments are used to calculate the investment
Investment	• Aim to achieve 10 percent increase on total medical spending for primary care by 2030; include a relative improvement goal of approximately one percent annually; adjust relative improvement goal periodically to achieve the aim	• Increases investment in primary care as a proportion of TCOC for Medicare FFS and across all-payers; CMS anticipates that the primary care intended target for Medicare will be between six and seven percent of Medicare TCOC	• N/A

Primary Care Definition Comparison Table – Key Elements *(continued)*

Primary Care Investment Comparison Table: Key Elements			
CATEGORY	**MULTISTATE**	**Model**	**MEDICAID/HILLTOP**
Strategy & Calculation	• Investment target aligned across commercial payers and a different target for Medicaid and the managed care organizations (MCO); review annually and adjust as needed; an accountability mechanism for meeting targets and in using investments to enhance primary care • Spending calculation: per member per month, and as a percent of total medical expense; includes place of service filters; pharmacy spending and rebates, dental, and other supplemental expenditures will be excluded from the calculations; non-FFS spending will be excluded in the 2024 analysis and final report; use of this data will be considered in 2025	• All Medicare FFS spending (Parts A and B) for beneficiaries in the State who meet the eligibility criteria (e.g., residents in the State for a minimum defined timeframe) will be included in the Medicare FFS cost growth target calculation • States will be accountable for meeting both annual improvement targets throughout the duration of the Implementation Period and a final primary care investment target by the end of the Implementation Period	• N/A
Provider and Billing Codes	• 39 taxonomy codes used to ensure specialty filter is inclusive of all primary care providers • 344 billing codes (CPT®/HCPCS) included in the definition. Of these, 113 codes are included in the AHEAD definition.	• 16 provider specialty codes, which are broader than taxonomy codes, are used to identify primary care providers. The 16 specialty codes yield 57 taxonomy codes • 181 billing codes (CPT®/HCPCS) included in the definition	• 236 billing Codes (CPT®/HCPCS) included in the definition • PCPs only (67 codes): E&M ,Screenings, In-office labs • PCPs and **any other** provider type are included for 169 codes for: Vaccines, certain family planning services, certain OB/GYN services • **Any** code billed by a School-Based Health Center

Example Maryland Care Team Builder

	A	B	C	D	E
12	**Expanded Care Team (Female)**	**Cost**	**FTE**	**FTE Annual Salary**	**Compensation**
13	RN Care Managers	$83,080	0.7	$96,830	$125,879
14	Behavioral Health Clinician	$49,610	0.7	$57,820	$75,166
15	Community Health Workers	$33,488	0.5	$51,520	$66,976
16	Pharmacist	$88,537	0.5	$136,210	$177,073
17	Nutritionist	$76,450	0.8	$78,410	$101,933
18	Total Expanded Care Team Cost	$331,164			
19	**"Commercial" PMPM Expanded Care Team Cost (Female)**	**$2.76**			
20	**Traditional Care Team**	**Cost**	**FTE**	**FTE Annual Salary**	**Annual Full Compensation**
21	Physician (MD/DO)	$1,353,800	4.9	$211,039	$274,351
22	Mid-Level (e.g.,NP)	$267,289	1.6	$125,000	$162,500
23	Total PCPs	$1,621,088	7	n/a	
24	Medical Assistant or Licensed Practical Nurse	$385,409	7	$45,060	$58,578
25	Traditional Care Team Cost	$2,006,497			
26	"Commercial" Traditional Care Team PMPM Cost (Male)	**$14.38**			
27	"Commercial" Traditional Care Team PMPM Cost (Female)	**$16.72**			
28					
29	**Total "Commercial" PMPM Cost**	**Attributed Patients**			
30	All Payer Practice Panel Size	10,000			
31	Staffing Costs (Traditional&Expanded Care Team) PMPM, Male	$16.16			
32	Staffing Costs (Traditional&Expanded Care Team) PMPM, Female	$19.48			
33	Other Administrative and Overhead Costs PMPM	$21.00			
34	Total "Commercial" PMPM Cost (Male)	**$37.16**			
35	Total "Commercial" PMPM Cost (Female)	**$40.48**			
36					
37					
38	**Expanded Care Team Use Assumptions**	**FTE (Male)**	**FTE (Female)**	**Estimated Use**	**Supporting Research**
				Assumes nurse	

The per PCP panel size estimate of 2000 is based on recent literature Determining Patient Panel Size in Primary Care: A Meta-Narrative Review - PMC identifying poorer outcomes in larger panel sizes.

Difference in PC investment by gender among Maryland residents is far greater than other states, suggesting some of the variation may not be necessary or appropriate. To encourage appropriate use, the model assumes the differential for costs associated with traditional care team members found in national published research The New England States' All-Payer Report on Primary Care Payments

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

Inputs

- Costs of traditional and expanded care team members
- Ideal panel sizes and care team configurations
- Disease prevalence estimates
- Estimated care team usage
- Administrative and overhead costs

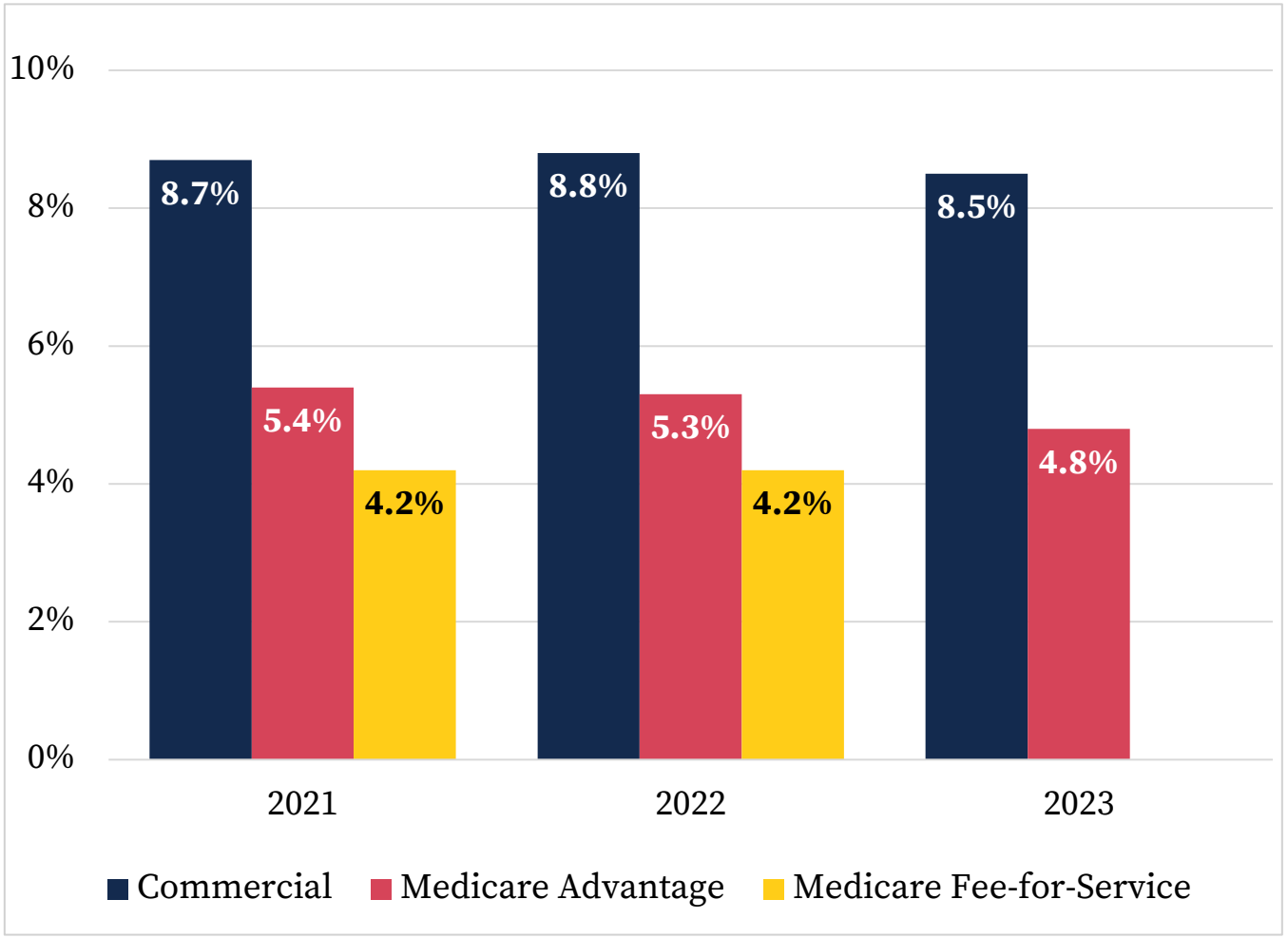
Limitations

- Data from MHCC's Medical Care Data Base (MCDB) for 2021-2023 was used to analyze claims for commercial payers and Medicare Advantage
  - Medicare Fee-for-Service (FFS) data was not available for 2023
  - The MCDB excludes claims for self-insured plans governed by ERISA (2016 U.S. Supreme Court ruling in Gobeille vs. Liberty Mutual Insurance Company) and Federal Employees Health Benefits plans (2019 U.S. Office of Personnel Management)
  - Diverse perspectives of the Workgroup informed development of the recommendations

Data and Findings

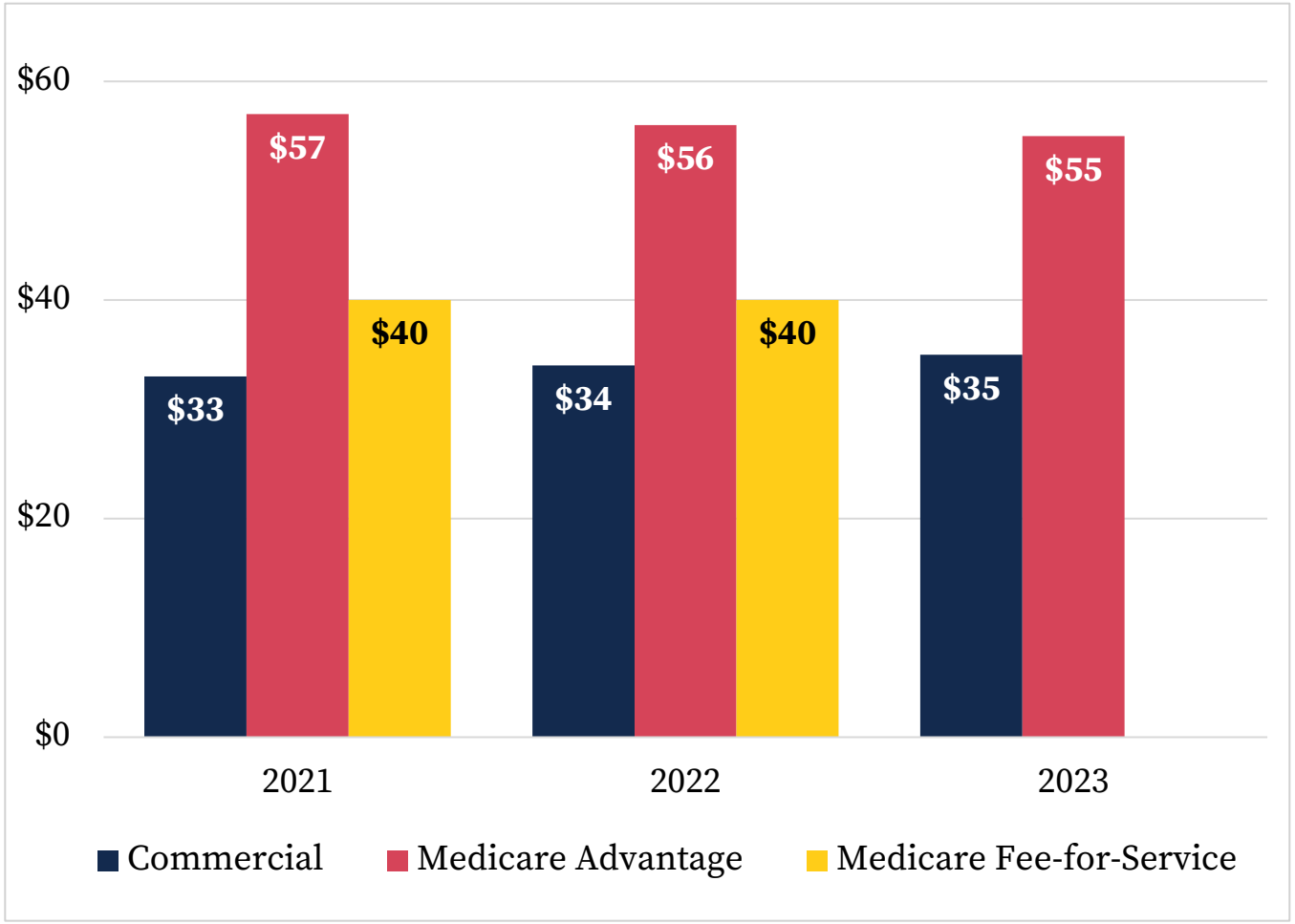
2021-2023

Primary Care Spending as a Percentage of TME



- TME represents the full amount of health care services delivered to a payer's member population paid to providers, including professional and facility services
- Commercial payers' primary care spending as a percentage of TME remained relatively flat from 2021 through 2023
- Medicare Advantage declined from 2021 through 2023
- Medicare FFS remained the same from 2021 through 2022

Primary Care Spending Per Member Per Month (PMPM)



- PMPM varied considerably by payer type
- When primary care spending is measured as a percentage of TME, higher TME will result in a lower percentage of primary care spending
- Medicare Advantage plans, on average, spent the most on a PMPM basis, but commercial plans had the highest percentage of primary care spending

Primary Care Spending as a Percentage of TME by Commercial Payer

- Primary care spending is generally consistent across commercial payers, except Kaiser
- Kaiser's integrated care and coverage model may lead to higher primary care spending patterns than other models
- While Cigna's primary care PMPM increased by about 2.6 percent from 2021 to 2022, TME PMPM increased significantly by about 22.4 percent, the bulk of this increase is driven by institutional claims as PMPM increased by about 49 percent; there was a decrease in primary care spend as a percentage of TME from 2021 to 2022 (see Appendix – Slide 29)

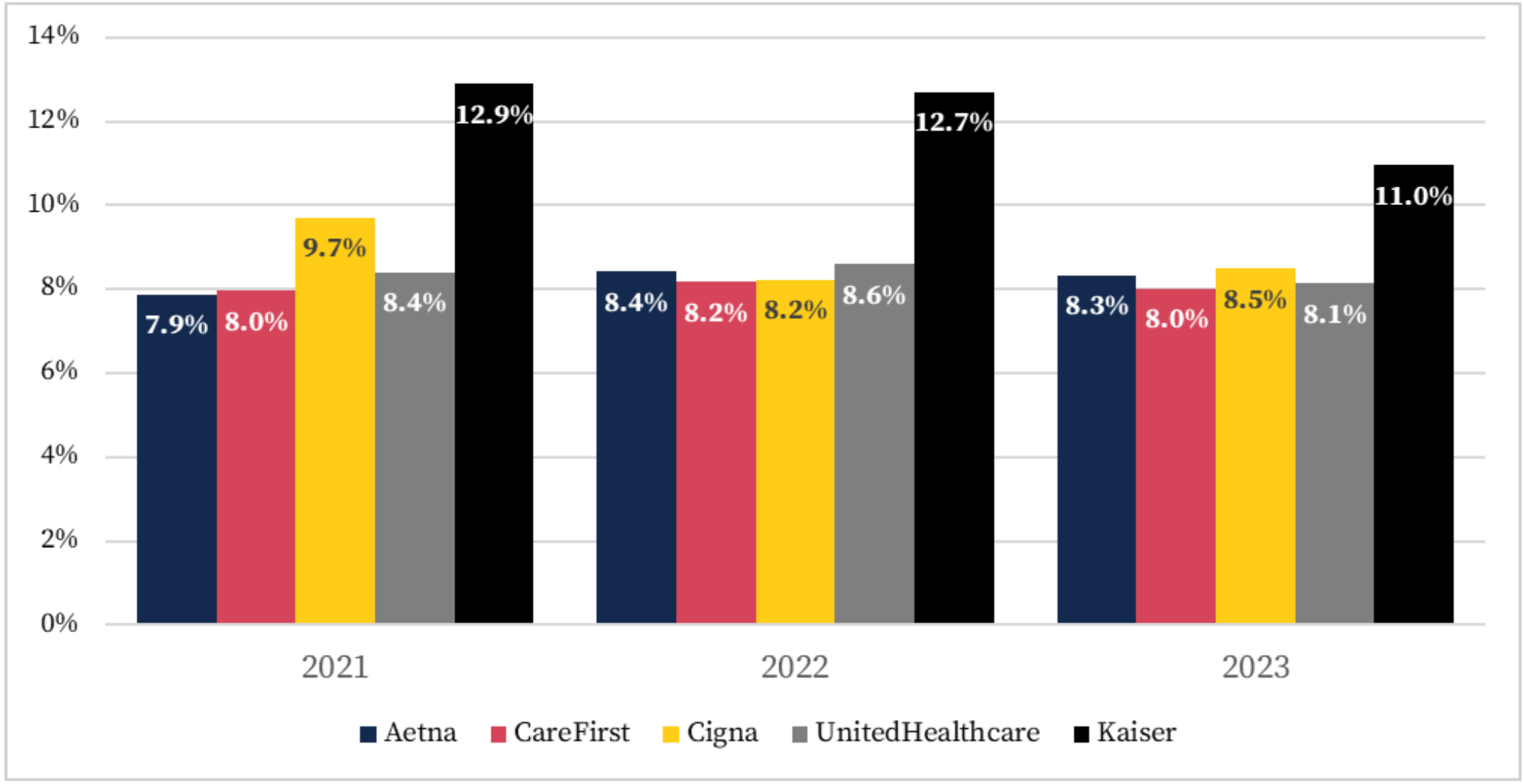
Cigna Spending 2021-2022

CIGNA Claims and Enrollment Experience (2021 - 2022)

Data From AHEAD High-Level Buckets (No Age Restrictions)

	Allowed Amount		Member Exposure			PMPM			PC % of TME		
Claim Category	2021	2022	2021	2022	% Change	2021	2022	% Change	2021	2022	% Change
Primary Care	$63,825,617	$65,647,262				$29.26	$30.02	2.6%	9.6%	8.0%	-1.5%
Professional	$373,625,081	$380,290,415				$171.31	$173.90	1.5%			
Institutional	$293,799,938	$438,856,195				$134.71	$200.68	49.0%			
Total Medical	$667,425,019	$819,146,610	2,181,042	2,186,896	0.3%	$306.01	$374.57	22.4%			

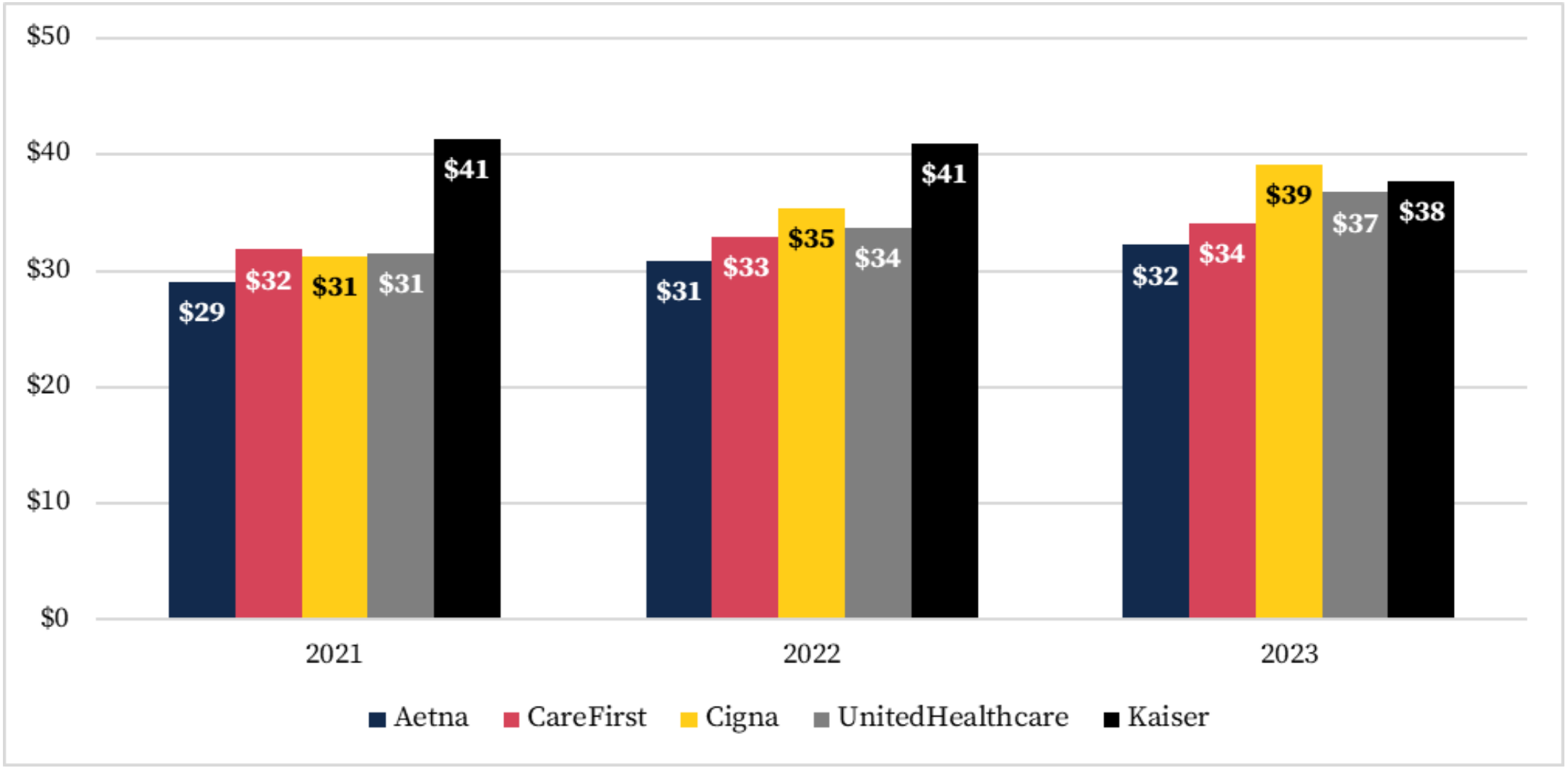
Primary Care Spending as a Percent of TME by Commercial Payer *(continued…)*



Primary Care Spending PMPM by Commercial Payer

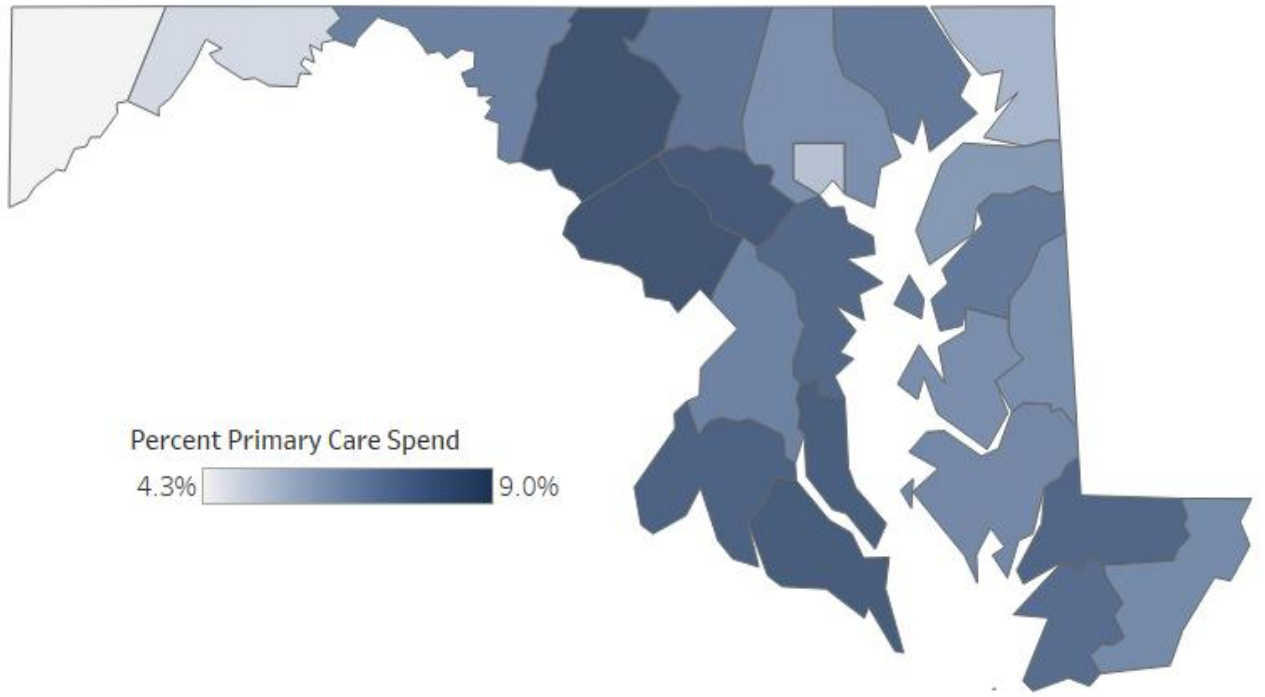
- Across commercial payers, PMPM spending has stalled since 2021
- When primary care spending is measured as a percentage of TME, higher total spending will result in a lower percentage of primary care spending
- Between 2021 and 2023, Cigna's PMPM primary care spending grew the most, mirroring an increase in its overall PMPM spending from $322 PMPM to $460 PMPM

Primary Care Spending PMPM by Commercial Payer
(continued…)



Primary Care Spending as a Percentage of TME by Jurisdiction, 2023

- Commercial primary care spending varied, from 4.3 percent of TME in Garrett County to 9.0 percent in Frederick County
- Spending was low in some of the least populous jurisdictions, Garrett (4.3 percent) and Allegany (4.9 percent), but also in Baltimore City (5.5 percent), the most densely populated jurisdiction in the State
    - Median household income (2022) was less than $60,000 in these counties
- Median household income ranged from $117,000 to $133,000 (2022) in the counties with the highest spending, Frederick (9.0 percent), Montgomery (8.7 percent), and Howard (8.7 percent)



Geographic Analysis Overview

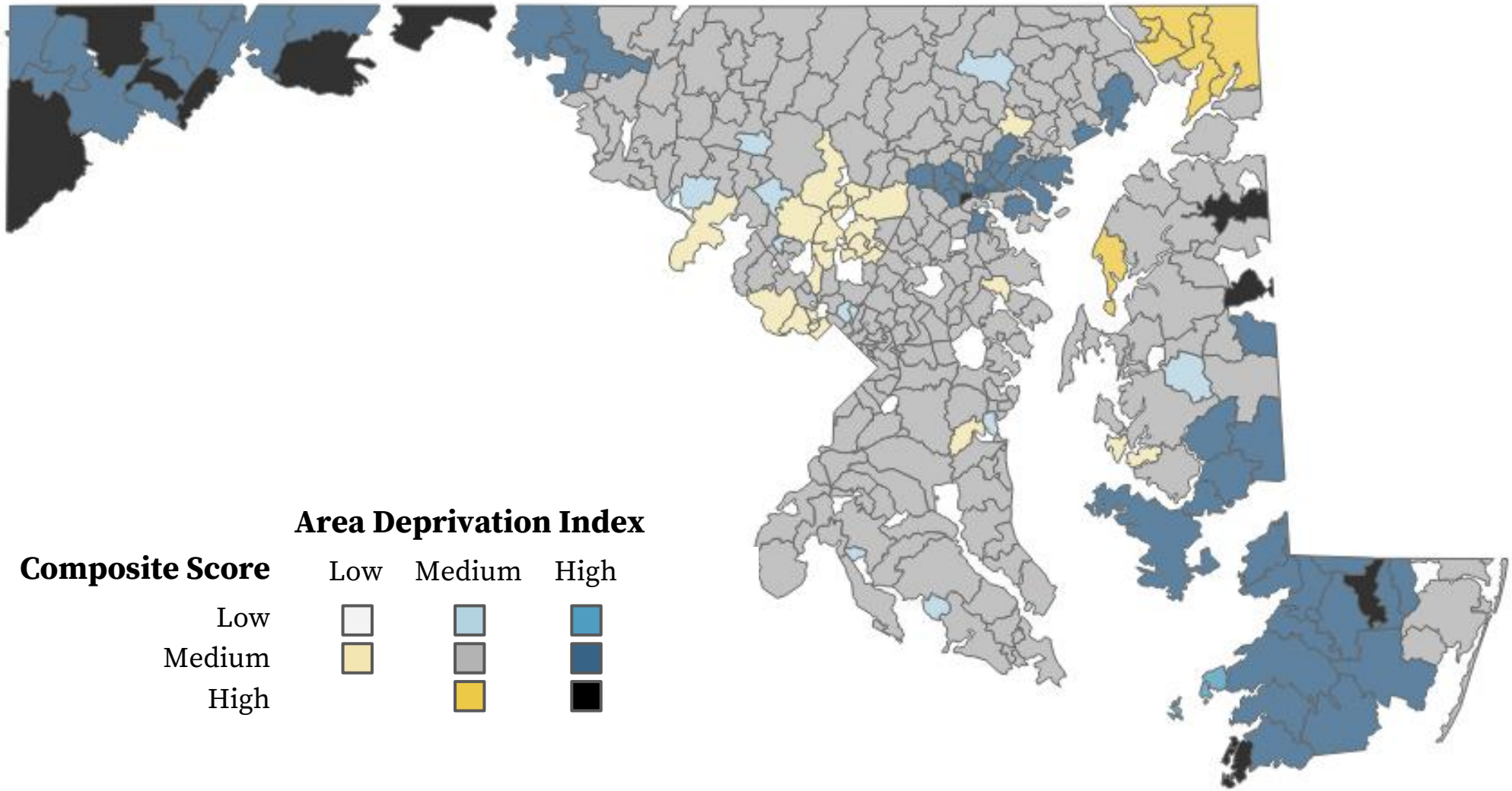
- Identified Maryland ZIP Codes with the most opportunity for improving access, quality, and equity through increased investment in primary care
- Included five metrics: primary care spending, primary care utilization, emergency room utilization, colorectal cancer screening, and Area Deprivation Index (ADI) ranking
- ZIP Codes received higher scores if they had lower primary care spending, lower utilization of primary care services, higher emergency room use, or lower rates of colorectal cancer screening
- The metrics were adjusted for age and gender and combined into a composite score
- The composite score was then examined alongside ADI, which ranks communities based on measures of social risk

Jurisdictions with Highest Commercial Primary Care Investment Opportunity

Jurisdiction	ZIP Codes	Primary Care Spend (%)	Composite Score
Allegany	21521	2.0	0.78
Allegany	21555	5.4	0.74
Allegany	21557	4.9	0.75
Baltimore City	21223	3.9	0.59
Caroline	21640	4.2	1.15
Garrett	21536	3.1	0.55
Garrett	21550	4.7	0.55
Kent	21651	8.0	0.87
Somerset	21817	7.4	0.63
Washington	21750	7.1	0.59
Wicomico	21849	8.0	0.70

- Eleven ZIP Codes had both a higher composite score and a higher ADI, indicating the greatest opportunity to benefit from increased primary care investment
- With the exception of Baltimore City, these geographic areas are concentrated in northwest and southeastern Maryland

Primary Care Investment Opportunity by ZIP Code



Geographic Analysis: Composite Score Metrics and ADI

Domain	Metric	Rationale
1. Spending	Lower primary care spending (PMPM or percentage of TME (Model definition)	Given systemic underfunding of primary care, relatively lower primary care spending may be an indicator of larger disparities and inadequate primary care
2. Access	Lower current utilization of primary care services (Model definition)	Relatively lower utilization of primary care services by geography may be an indicator of primary care capacity concerns or barriers to access care
3. Access	Higher ED utilization per 1,000 (HEDIS© measure)	Relatively higher ED utilization may be an indicator of inadequate access to primary care, as patients seek health care services where they are available or require more emergency care because they are sicker
4. Quality	Worse performance on colorectal cancer screening measure (HEDIS© measure)	Relatively worse performance on colorectal cancer screening may be an indicator of barriers to timely, appropriate, and quality primary care and preventive services
5. Social Risk	Higher ADI score	The ADI identifies underserved communities with socioeconomic characteristics that impact health outcomes

Geographic Analysis: ZIP Code Rankings by Composite Score and ADI

Composite Score	ADI				
		Low	**Medium**	**High**	**Total (%)**
	Low	10	13	1	**24 (7%)**
	Medium	23	216	56	**295 (88%)**
	High	0	6	11	**17 (5%)**
	ADI TOTAL	**33 (10%)**	**235 (70%)**	**68 (20%)**	**336**