Medicaid Quality Incentive Program Methodology

Medicaid Advanced Primary Care Program

January 1, 2026 - December 31, 2026

February 26, 2026

Executive Summary

This document describes the quality incentive methodologies of the Maryland Medicaid Advanced Primary Care Program (Medicaid Path) for performance year (PY) 2026 (January 1 through December 31, 2026). The Medicaid Path is Maryland's Medicaid Alternative Payment Model (APM) for primary care under the State's participation in the Centers for Medicare and Medicaid Services (CMS) Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. An updated Medicaid Path quality incentive methodologies document will be published annually for each AHEAD program year. For more information on program details and requirements, please refer to the Medicaid Path Program Manual.

This document provides a detailed description of the PY2026 Medicaid Quality Incentive Program for Medicaid Path participating practice organizations including the following elements:

- the quality incentive per member per month (PMPM) dollar amount,
- the types of incentives,
- the quality measures and their weight,
- the member-to-provider attribution methodology,
- the target setting process and the targets per measure,
- the quality incentive timeline,
- the process for calculating the final results, and
- the quality incentive disbursement process.

The Appendix includes a detailed overview of the primary care service codes used in the member-to-provider attribution methodology and the PY2026 claims-based measure specifications with codes. For questions about the Medicaid Quality Incentive Program, participants may reach out to the Maryland Department of Health (MDH) at mdh.pcmodel@maryland.gov.

Chapter 1: Quality Incentive Overview

Section 1.1 – Introduction

The Medicaid Path, also known as the Medicaid Advanced Primary Care Program, is Maryland's Medicaid Alternative Payment Model (APM) for primary care under the State's participation in the Centers for Medicare and Medicaid Services' (CMS) Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. The Medicaid Path launched on August 1, 2025 with its first cohort of participating providers and expanded with its second cohort on January 1, 2026. The Medicaid Path is a key component of the State's strategy to ensure increased primary care investment and improved population health over the ten-year term of the Model. The Medicaid Path will be administered by the Maryland Department of Health in partnership with the HealthChoice Managed Care Organizations (MCOs).

This document provides detailed information on the design of the Medicaid Primary Care Quality Incentive Program for PY2026. An updated Medicaid Primary Care Quality Incentive Program Methodology document will be published annually for each of the AHEAD program years. For more information on program details and requirements, including eligibility criteria, payments, reporting, and care delivery for PY2026, please refer to the Medicaid Path Program Manual.

Section 1.2 – Quality Incentive Overview

For PY26, Maryland has allocated $1 PMPM to the Medicaid Primary Care Quality Incentive Program, which will be paid to primary care practices that have signed up to participate in the Medicaid Path Program at the TIN-level (practice organizations) if they meet the target requirements defined in this document. Incentive payments will be made to the Medicaid Path participating organization through its contracted MCOs in accordance to the timeline in Figure 3.

Section 1.3 – Types of Incentives

For PY2026, Medicaid Path participants will be eligible for two types of incentives:

- Pay-for-performance (P4P): The State sets performance targets for each quality measure and awards financial incentives to participating practice organizations that meet or exceed those targets.
- Pay-for-reporting (P4R): The State requires participating practice organizations to report data to qualify for an incentive payment.

Section 1.4 – Quality Incentive Measures

Table 1 below describes the measures that are part of the 2026 Medicaid Quality Incentive Program and defines whether each measure will be for P4P or P4R. The table also identifies which measures MDH will calculate from claims or encounter data received by Maryland's Medicaid Data Warehouse and which measures are electronic Clinical Quality Measures

(eCQMs) that will be submitted directly by Medicaid Path participating organizations to Maryland's state-designated Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP).

Table 1. 2026 Medicaid Quality Incentive Program Measures by Type of Incentive

Population	Domain	Measure Name	Data Source	PY2026
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Claims	P4P
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Claims	P4P
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Claims	P4P
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Claims	P4P
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	eCQMs	P4R
Adults	Chronic Conditions	Controlling High Blood Pressure	eCQMs	P4R
Adults	Prevention & Wellness	Colorectal Cancer Screening	eCQMs	P4R
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan: Ages 12 and older	eCQMs	P4R

Section 1.5 – Measure Descriptions

The following **claims-based measures** will be **pay-for-performance (P4P)** in the 2026 Medicaid Quality Incentive Program:

- **Emergency Department Utilization (EDU) – (Healthcare Effectiveness Data and Information Set (HEDIS))**: For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year.

- **Acute Hospital Utilization (AHU) – (HEDIS)**: For members 18 to 64 years of age, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.

- **Child and Adolescent Well-Care Visits (WCV) – (HEDIS)**: The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP practitioner during the measurement year.

- **Developmental Screening in the First Three Years of Life (DEV-CH) – (CMS Core Set)**: Percentage of children who were screened for risk of developmental, behavioral, or social delays using a standardized screening tool for global developmental screenings in the 12 months preceding or on their first, second, or third birthday.

Measure specifications are provided in Appendix B. The formal scoring will adhere to the measure specifications.

The following **eCQMs** will be **pay-for-reporting (P4R)** in the 2026 Medicaid Quality Incentive Program:

- **Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CMS122v14)**: Percentage of patients 18 to 75 years of age with diabetes who had a glycemic status assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) >9.0% during the measurement period.

- **Controlling High Blood Pressure (CMS165v14)**: Percentage of patients 18 – 85 years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure is adequately controlled (<140/90 mmHg) during the measurement period.

- **Colorectal Cancer Screening (CMS130v14)**: Percentage of adults 45 to 75 years of age who had appropriate screening for colorectal cancer.

- **Screening for Depression and Follow-Up Plan: Ages 12 and older (CMS2v15)**: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

As part of AHEAD Model participation, CMS requires states to incorporate eCQMs into participating practice's performance accountability. For 2026, Medicaid Path participating practice organizations will report eCQM performance across all payers to CRISP following the timeline defined in Figure 3.

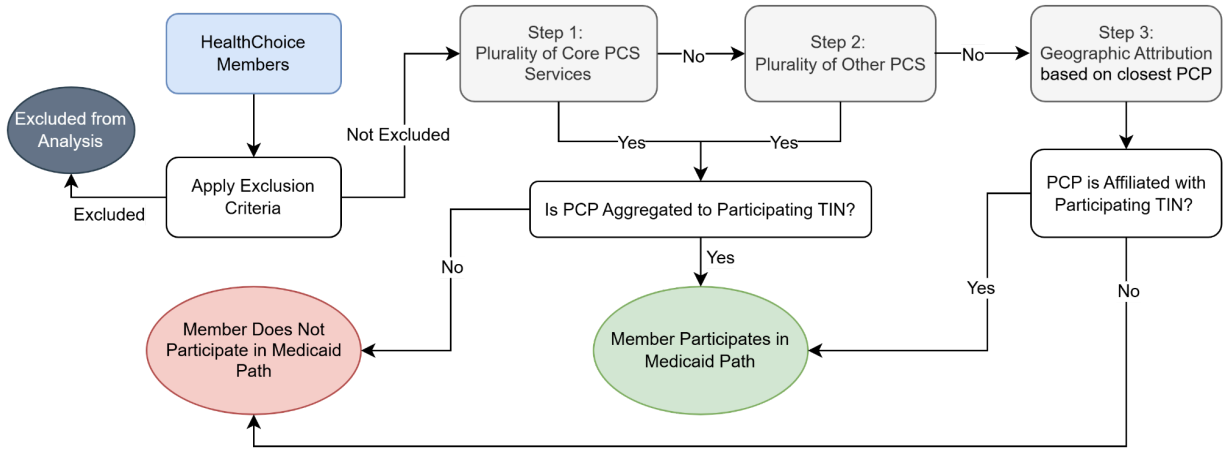
Chapter 2: Member-to-Provider Attribution

MDH has developed a member-to-provider attribution specifically for measuring the quality of care delivered to all HealthChoice members seen by each Medicaid Path practice organization, regardless of whether the member is participating in the Medicaid Path program as documented in the MCO Assignment lists. This member-to-provider attribution methodology applies to the claims-based measures of the Medicaid Quality Incentive Program, which are outlined in Table 1. To calculate provider-specific results, MDH developed a process to attribute members to Medicaid Path participating practice organizations. For this member-to-provider attribution process, Medicaid Path participating practice or "provider" refers to the Tax Identification Number (TIN) of a single or group of primary care providers (PCPs). The goals of the member-to-provider attribution process are to:

- Identify and honor the historical treatment relationships that members have with their providers.
- Align, as appropriate, with the Medicare Paths of Maryland's AHEAD Primary Care programs (Primary Care AHEAD and Maryland Primary Care Program AHEAD [MDPCP]) attribution methodology.
- Ensure all members are attributed to a provider, even members without prior claims history.
    - Note: Members who have their plurality of care with a primary care provider who is not participating in the Medicaid Path will not be included in the Medicaid Path quality incentive program.

An overview of the Medicaid Quality Incentive Program's member-to-provider attribution process is described in Figure 1 below. Members are attributed to a Medicaid Path participating PCP, which is then rolled up to the TIN-level.

Figure 1: Overview of the the Medicaid Quality Incentive Program member-to-provider attribution methodology



As described in Figure 1,MDH has adopted the following process to attribute members to Medicaid Path participating providers:

- Identify Maryland Medicaid members enrolled in a HealthChoice MCO as of December 31st of the year prior to the start of the measurement year (e.g., attribution for program year 2026 is based on members enrolled in a HealthChoice MCO as of December 31st, 2025).
- Identify HealthChoice members who received a **primary care service** in the most recent 24-months of Medicaid encounters prior to the start of the program year (referred to as the lookback period). For the 2026 Medicaid Quality Incentive Program, the lookback period for the attribution process will include CY2024 and CY2025.
- Classify all **primary care services (PCS)** as either **Key PCS** or **Other PCS** (as defined in Appendix A).
- Attribute HealthChoice members to TINs as follows:
  - **Step 1:** For HealthChoice members with at least one Key PCS during the lookback period, attribute the member to the TIN that rendered the plurality of the member's Key PCS claims.
    - As members are attributed to a TIN, and not an individual PCP, plurality is based on all participating PCPs within a participating TIN. This protects treatment relationships when members may receive care from several PCPs within a single primary care office.
    - If there is a tie across TINs, attribute the member to the TIN who rendered the most recent key primary care service.
  - **Step 2:** For HealthChoice members with only Other PCS**,** including laboratory services, vaccinations, behavioral health, and women's health, attribute the member to the TIN that rendered the plurality of the member's Other PCS claims.
    - If there is a tie across TINs, attribute the member to the TIN who rendered the most recent other primary care service.
- Identify HealthChoice members without any PCS claims during the lookback period.
  - **Step 3:** Attribute HealthChoice members without a primary care claim during the lookback period to a PCP based on geography.
    - Geographic attribution is done at the PCP level, and aggregated to the TIN for participating PCPs.
    - Identify member's address as of the end of the lookback period; for PY2026, the end of the lookback period is Dec. 31, 2025.
    - Identify and attribute members to PCPs who are geographically closest to the member's residence utilizing the HealthChoice Network Adequacy Standards in the HealthChoice MCO contract (described in Figure 4).
- Members are only geographically attributed to providers who have a relationship with the member's MCO, defined as:
  - That provider has provided the plurality of PCS services (as determined in Steps 1 and 2 of attribution) to other members from the same MCO as the geographically-attributed member, or

        - That provider has entered a participation agreement and is receiving care management payments under the Medicaid Path with the MCO of the geographically-attributed member.
- In the event that two or more PCPs or TINs share the physical address that is closest to the member, members geographically attributed to that address are allocated across Medicaid Path participating providers according to the proportion or members in Steps 1 and 2 who are attributed to those providers.

Following completion of the attribution steps, members attributed to participating TINs are considered attributed members for the Medicaid Quality Incentive Program. Medicaid members attributed to TINs not participating in the Medicaid Path are excluded from the Medicaid Quality Incentive Program for that program year.

Chapter 3: Target Setting Process and Methodology

This chapter describes the Medicaid Quality Incentive Program target setting methodology in detail and includes the targets that practice organizations will need to meet to qualify for the incentive in 2026. One of the main goals for CMS and MDH is to improve the quality of care for all HealthChoice members. The key tenets of MDH's approach to setting targets for the quality incentive are to reward high performance among participating practices and practice-improvement over time, while making the targets achievable. Primary care practice organizations are a key driver of high quality care and will be rewarded accordingly.

For PY26, MDH will set targets for the Medicaid Path claims-based P4P measures listed in Table 1. For the Medicaid Path, MDH is using a similar target setting methodology to CMS' Medicare AHEAD programs. MDH has set targets that will reward practice organization's high-performance and improvement over time. Medicaid Path participating organizations will have to meet either the high-performance target or the practice-specific improvement target per measure, but not both targets per measure.

Section 3.1 – High-performance target setting methodology

This section describes the methodology MDH will use to set targets that will incentivize high-performance among Medicaid Path participating organizations. MDH will set high-performance targets per measure that will be the same for all Medicaid Path participating organizations.

Section 3.1.1 – Historical performance data and process to set high-performance targets

To set the high-performance targets, MDH utilized a combination of the following data:

- **Baseline data –** MDH used encounter data for 2016 to 2024 dates of service submitted to the Medicaid Data Warehouse to set high-performance targets for the 2026 claims-based measures.
- **High-performance Target Setting** – MDH set high-performance targets analyzing Medicaid-specific program-level performance over time. MDH also compared Medicaid Primary Care's performance with other national data available, like the CMS Core Set results, to set measure-specific targets for the 2026 claims-based measures.

Section 3.2 – Improvement target setting methodology

Another key tenet of MDH's approach to setting improvement targets is to provide additional opportunities for practice organizations to be rewarded for performance improvement. MDH is

incentivizing Medicaid Path participating practice organizations for making improvements in their performance, even if they are not able to reach the high-performance target. As a new program, MDH is aware that practice organizations will have different starting points. The improvement targets are intended to offer all practices an opportunity at earning an incentive.

Section 3.2.1 – Methodology Overview

MDH utilized Medicare's PC AHEAD methodology of closing the gap to develop the Medicaid Quality Incentive improvement targets. An overview of the closing the gap methodology used for the Medicaid Quality Incentive improvement goals is described below:

- **Closing the Gap Methodology[1] –** Medicaid Path improvement targets are set at the practice-level based on that practice organization's prior years performance using the closing the gap methodology. The Medicaid Path's improvement targets will be set at 10% of the difference between participating practice organizations score in the baseline year and the high-performance benchmark. The closing the gap methodology gives practice organizations credit for making improvements toward the high-performance goal and accounts for the difficulty of achieving continuous improvement as a practice organization's scores get closer to the high-performance benchmark. The formula and examples below use 10%, which applies to the WCV and DEV measures. For the AHU and EDU measures, -10% will be used since these are inverse measures, meaning lower is better.
    - **Improvement Percentage:** [High-performance Benchmark] – [Practice Organization's Baseline] * 10% = x
    - **Improvement Target:** [Practice Organization's Baseline] + [x]
- **Improvement Target Example**
    - A participating PCP's baseline performance rate for the WCV measure is 70% and MDH has set a high-performance target of 86% for WCV.
    - This participating PCP's improvement percentage for WCV would be: [(86 – 70)] *10% = 1.6%
    - This participating PCP's 2026 Improvement Target for WCV would be: 70% + 1.6% = 71.6%

Section 3.3 – 2026 Quality Incentive Targets

The 2026 high-performance targets for the claims-based measures are listed in Table 2 below, which also includes the 2024 baseline data; targets will be updated annually for each performance year.

[1] CMS, CMMI, Primary Care AHEAD Payment Specifications: Beneficiary Attribution, Payments, and Performance Assessment, Model Year 2026 – Maryland, Version 1.3, July 30, 2025, p. 29 (accessed on Oct. 15, 2025).

The 2026 improvement targets by practice organization are not final as of the date of this publication. MDH will share practice-specific baseline data per measure and improvement targets at the TIN-level in the first quarter of 2026 through CRISP, using the member-to-provider attribution process described in Chapter 2. Medicaid Path participating practice organizations should examine the baseline data to inform the development of interventions that will help them meet the goals of the 2026 Medicaid Quality Incentive Program.

Table 2. 2026 Medicaid Quality Incentive Program High-Performance Targets per Measure

Population	Domain	Measure Name	Data Source	2024 Statewide Performance	PY2026 Performance Level Target
Adults	Healthcare Utilization	Emergency Department Utilization (EDU) *	Claims	0.81	0.81
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU) *	Claims	1.01	1.01
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Claims	59.2%	59.9%
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Claims	59.1%	59.7%

*This is an inverse measure. A lower number is better.

Chapter 4: 2026 Quality Measure Weights and Incentive Distribution

This chapter describes how Medicaid Path participating practice organizations will earn quality incentive payments for 2026 performance. As part of the 2026 Medicaid Quality Incentive Program, MDH has established a $1 PMPM quality incentive that will be awarded to Medicaid Path participating practice organizations in the third quarter of calendar year 2027, after the 2026 performance measures are reported and finalized (per the schedule in Figure 3). Medicaid Path participating practice organizations that meet all the 2026 P4P targets and report all 2026 P4R measures (according to CRISP's timeline and specifications) will be eligible for the full quality incentive PMPM amount.

Section 4.1 – Overview of Measure Weights' Principles

To qualify for the 2026 quality incentive, practice organizations will be assessed on each individual P4P and P4R measure. MDH has established the following weighting principles:

- Performance per measure is independent of each other.
    - For example, if a participating practice organization meets the high-performance target for the WCV, but fails to meet the targets in another measure, the PCP would still be able to earn the **corresponding** P4P amount for the WCV measure.
- Each P4P measure has the same weight, consistent with the Medicare Paths of Maryland's AHEAD Primary Care Programs.
- For the first program year, Medicaid Path participating organizations can earn up to $0.50 for P4R and $0.50 for P4P measures.
- If a Medicaid Path participating organization does not meet the minimum threshold (see Section 4.5) for all P4P measures, that organization will only be able to earn the P4R component of the Quality Incentive PMPM.

Section 4.2 – Measure Weights for Practice Organizations Serving Adults and Children

Medicaid Path participating organizations that serve both adults and children will be accountable for four P4R and four P4P measures listed in Table 3. To calculate the weights per measure, MDH will use the formula below:

Formula for calculating weights per measure:

P4P Weights: *50% ÷ (4 P4P measures) = 12.5%*

P4R Weights: *50% ÷ (4 P4R measures) = 12.5%*

Next, to identify the PMPM per measure, MDH multiplied the weight per measure times the quality PMPM, which is described below (Table 3).

Quality Incentive Amount per P4P Measure: *12.5% of $1 PMPM = $0.125 PMPM*

Quality Incentive Amount per P4R Measure: *12.5% of $1 PMPM = $0.125 PMPM*

Table 3. Medicaid Path PY2026 Quality Incentive Amount and Weights per Measure for Practice Organizations Serving Children and Adults

Population	Domain	Measure Name	Data Source	PY 2026	Measure Weight	Quality Incentive of $1 PMPM
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Claims	P4P	12.5%	$0.125 PMPM
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Claims	P4P	12.5%	$0.125 PMPM
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Claims	P4P	12.5%	$0.125 PMPM
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Claims	P4P	12.5%	$0.125 PMPM
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	eCQMs	P4R	12.5%	$0.125 PMPM
Adults	Chronic Conditions	Controlling High Blood Pressure	eCQMs	P4R	12.5%	$0.125 PMPM
Adults	Prevention & Wellness	Colorectal Cancer Screening	eCQMs	P4R	12.5%	$0.125 PMPM
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan: Ages 12 to 64	eCQMs	P4R	12.5%	$0.125 PMPM

Section 4.3 – Measure Weights for Practice Organizations Serving Children

If a participating practice organization only serves children, the adult measures in the quality incentive will not apply and the pediatric practice organization will only be accountable for measures that impact children and adolescents (Table 4, below).

Section 4.3.1 - Formula for identifying weights and quality incentive amount per measure

To calculate the weights per measure, MDH counted the total number of P4P and P4R measures. The formula to calculate measure weights is as follows:

P4P Weights: *50% ÷ 2 P4P measures = 25%*

P4R Weights: *50% ÷ 1 P4R measure = 50%*

Next, to identify the PMPM per measure, MDH multiplied the weight per measure times the quality PMPM, which is described below (Table 4).

Quality Incentive Amount per P4P Measure: *25% of $1 PMPM = $0.25 PMPM*

Quality Incentive Amount per P4R Measure: *50% of $1 PMPM = $0.50 PMPM*

Table 4. Medicaid Path PY2026 Quality Incentive Amount and Weights per Measure for Pediatric Practice Organizations

Population	Domain	Measure Name	Data Source	PY2026	Measure Weight	Quality Incentive of $1 PMPM
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Claims	P4P	25%	$0.25 PMPM
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Claims	P4P	25%	$0.25 PMPM
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan: Ages 12 and older	eCQMs	P4R	50%	$0.50 PMPM

Section 4.4 – Measure Weights for Practice Organizations Serving Adults

If a participating practice only serves individuals 21 years of age and older, the pediatric measures in the quality incentive program will not apply and the practice will only be accountable for measures that impact adults (Table 5, below).

Section 4.4.1 –Formula for identifying weights and quality incentive amount per measure

To calculate the weights per measure, MDH counted the total number of P4P and P4R measures. The formula to calculate measure weights is as follows:

P4P Weights: *50% ÷ (2 P4P measures) = 25%*

P4R Weights: *50% ÷ (4 P4R measures) = 12.25%*

Next, to identify the PMPM per measure, MDH multiplied the weight per measure times the quality PMPM, which is described below (Table 5).

Quality Incentive Amount per P4P Measure: *25% of $1 PMPM = $0.25 PMPM*

Quality Incentive Amount per P4R Measure: *12.25% of $1 PMPM = $0.125 PMPM*

Table 5. Medicaid Path PY2026 Quality Incentive Amount and Weights per Measure for Practices Serving Adults

Population	Domain	Measure Name	Data Source	PY2026	Measure Weight	Quality Incentive of $1 PMPM
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Claims	P4P	25%	$0.25 PMPM
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Claims	P4P	25%	$0.25 PMPM
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	eCQMs	P4R	12.5%	$0.125 PMPM
Adults	Chronic Conditions	Controlling High Blood Pressure	eCQMs	P4R	12.5%	$0.125 PMPM

Population	Domain	Measure Name	Data Source	PY2026	Measure Weight	Quality Incentive of $1 PMPM
Adults	Prevention & Wellness	Colorectal Cancer Screening	eCQMs	P4R	12.5%	$0.125 PMPM
Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan: Ages 12 to 64	eCQMs	P4R	12.5%	$0.125 PMPM

Section 4.5 – Minimum Threshold

In order to calculate results for claims-based measures, Medicaid Path participating practice organizations will need to meet a minimum threshold standard per claims-based measure to qualify for the P4P portion of the 2026 Medicaid Quality Incentive Program. Medicaid Path participating organizations may qualify for a payment on some P4P measures but not others based on whether they meet the minimum threshold per measure. If a Medicaid Path participating organization does not meet the minimum threshold for a P4P measure, the organization will not be eligible for the P4P incentive for that measure and the P4P weights are recalculated among remaining measures. See Table 4 for practices that serve children only, Table 5 for practices that serve adults only, and Chapter 5 for additional examples.

4.5.1 WCV and DEV Measures

MDH has set a minimum threshold at 20 observations in the denominator for the Child and Adolescent Well-Care Visits (WCV) and the Developmental Screening in the First Three Years of Life (DEV-CH) measures. The minimum threshold of 20 observations in the denominator for these measures is similar to Medicare's Merit-based Incentive Payment System (MIPS) program requirements for small practice organizations.

4.5.2 AHU and EDU Measures

The Acute Hospital Utilization (AHU) and Emergency Department Utilization (EDU) performance metrics measure the ratio of observed vs. expected acute hospitalizations and emergency department visits. The statistical stability of these measures is driven by the number of members at risk, not by modeled or observed events. Therefore, MDH has defined a minimum threshold for these measures based on the number of eligible members. For the AHU measure, MDH has set a minimum threshold of 150 eligible members and a minimum threshold of 50 eligible members for the EDU measure. In future years, MDH may revise these thresholds.

Chapter 5: 2026 Quality Incentive Payout Examples

This chapter describes various hypothetical scenarios to explain how MDH will calculate the 2026 Medicaid Quality Incentive payments for Medicaid Path participating organizations. It describes how MDH will apply the $1 PMPM quality incentive amount to Medicaid Path participating organizations and how these organizations will earn the quality incentive based on their 2026 performance. It presents several scenarios for Medicaid Path participating organizations that serve children, adults, or both populations; and, describes how much funding would be available to a Medicaid Path participating organization that does meet the minimum threshold for P4P measures or that it does not report all P4R measures.

Section 5.1 – Quality Incentive Member Months Calculation

The first step in calculating a Medicaid Path participating organization's 2026 quality incentive is to determine the total member months that practice is eligible for. MDH will follow the methodology described in Chapter 2 to identify the members that will be attributed to Medicaid Path participating organizations. Afterwards, MDH will count the number of months each member attributed to a Medicaid Path participating organization was enrolled in any HealthChoice MCO in 2026. Lastly, MDH will aggregate member months across all MCO members attributed to a Medicaid Path participating organization in 2026. The section below provides an example of how MDH will determine the member months for Medicaid Path participating organizations in the 2026 quality incentive calculation.

Section 5.1.1 - Medicaid Path 2026 Quality Incentive Member Months Example

Step 1 - Assume that for a Medicaid Path participating organization (for example TIN # - 52-1234567), there are five members attributed for 2026 following the methodology described in Chapter 2.

Step 2 - Count the number of months each individual attributed to that Medicaid Path participating TIN remained enrolled in any HealthChoice MCO in 2026 per Table 6 below.

Table 6. Medicaid Path PY2026 Quality Incentive Member Months Calculation Example

Member Medicaid ID	Aetna	Care First	Jai	Kaiser	Maryland Physicians Care	MedStar Family Choice	Priority Partners	United Healthcare Community Plan	Wellpoint	Total Member Months
1234567891					2			10		12
1234567892				9					1	10
1234567893						4	4			8
1234567894		4							2	6
1234567895	1		3							4

Step 3 - Count the number of months attributed members to TIN # 52- 1234567 were enrolled in a HealthChoice MCO in 2026.
Sum = 12 + 10 + 8 + 6 + 4 = 40
In this example, the total member months this TIN would be eligible for in 2026 are 40.

Step 4 - Multiply the $1 quality incentive PMPM times the total number of member months from Step 3, to estimate the total quality incentive amount this TIN is eligible for in 2026.
Total 2026 quality incentive eligible amount = $1 quality incentive PMPM * 40 = $40.

Section 5.2 – 2026 Medicaid Quality Incentive Calculation Examples by Population Served

This section provides various examples for calculating the 2026 quality incentive payments for Medicaid Path participating organizations serving adults and/or children.

Section 5.2.1 - Medicaid Quality Incentive Calculation Example for Practices that Serve Adults and Children

Step 1: Calculate Member Months
To calculate the 2026 quality incentive payment for Medicaid Path participating organizations, MDH will first calculate the number of Medicaid member months that organization had in 2026 using the methodology described in Section 5.1. Let's assume that a Medicaid Path participating organization that serves both children and adults has 50,000 Medicaid member months in 2026 across all MCOs. In this scenario, the maximum quality incentive amount that this Medicaid Path participating organization is eligible for in 2026 is (50,000 * $1 PMPM) = $50,000.

Step 2: Calculate P4R Incentive
Additionally, assume that this Medicaid Path participating organization reports the four P4R measures in Table 3 and will earn $0.125 PMPM per P4R measure reported. Table 7 below shows that for reporting each P4R measure, this organization receives ($0.125 PMPM * 50,000 member months) = $6,250. For the four P4R measures, this organization receives ($0.125 PMPM * 4 measures * 50,000 member months) = $25,000.

Step 3: Calculate P4P Incentive
To calculate the remaining quality incentive amount for the P4P measures, Table 7 below provides an example to guide Medicaid Path participating practices that serve both adults and children in understanding how MDH will calculate their 2026 quality incentive payment amount.

Table 7. Example to Calculate the Amount of the 2026 Medicaid Quality Incentive for a Practice Organization Serving Children and Adults (Assume 50,000 Member Months in 2026)

Pay-for-Performance									
Population	**Measure Name**	**2026 High-performance Target**	**2026 Improvement Target**	**2026 Practice Result**	**Was the 2026 P4P Target Met?**	**Did practice meet the minimum threshold? (see Section 4.5)**	**Measure Weight**	**Quality Incentive of $1 PMPM**	**Total Incentive earned**
Adults	Emergency Department Utilization (EDU) *	0.81	0.91	0.98	No	No	12.5%	$0	$0
Adults	Acute Hospital Utilization (AHU) *	1.01	1.05	1.04	Yes *(met improvement target)*	No	12.5%	$0.125 PMPM	$6,250
Children	Child and Adolescent Well-Care Visits (WCV)	59.9%	42%	65%	Yes *(met high-performance target)*	No	12.5%	$0.125 PMPM	$6,250
Children	Developmental Screening in the First Three Years of Life (DEV-CH)	59.7%	51%	55%	Yes *(met improvement target)*	No	12.5%	$0.125 PMPM	$6,250

Pay for Reporting					
Population	**Measure Name**	**Measure Reported**	**Measure Weight**	**Incentive of $1 PMPM**	**Total Incentive Earned**
Adults	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	Y	12.5%	$0.125 PMPM	$6,250
Adults	Controlling High Blood Pressure	Y	12.5%	$0.125 PMPM	$6,250
Adults	Colorectal Cancer Screening	Y	12.5%	$0.125 PMPM	$6,250
Children/Adults	Screening for Depression and Follow-Up Plan: Ages 12 to 64	Y	12.5%	$0.125 PMPM	$6,250
Total Incentive Earned for PY2026 Quality					**$43,750**

*This is an inverse measure. A lower number is better.

Note: Medicaid Path participating organizations can meet either the high-performance or the improvement target to earn the quality incentive for that measure.

Final Calculation
P4P: This practice met the 2026 P4P targets for three measures qualifying for ($0.125 PMPM * 3) = $0.375 PMPM and for a total P4P incentive of ($0.375 PMPM * 50,000 member months) = $18,750.

P4R: This practice reported all four of the P4R measures ($0.125 PMPM * 4) = $0.50 PMPM and for a total PRP incentive of ($0.50 PMPM * 50,000 member months) = $25,000.

Total: This Medicaid Path participating organization would receive a 2026 quality incentive equivalent to the P4R funding ($25,000) plus the P4P funding ($18,750) for a total of $43,750.

Section 5.2.2 - Medicaid Quality Incentive Calculation Example for Practices that Serve Children

Step 1: Calculate Member Months
Let's assume that a Medicaid Path participating organization that serves children has 20,000 Medicaid member months in 2026 across all MCOs. In this scenario, the maximum quality incentive amount that this Medicaid Path participating organization is eligible for in 2026 is (20,000 * $1 PMPM) = $20,000.

Step 2: Calculate P4R Incentive
Additionally, assume that this Medicaid Path participating organization reports the depression eCQM P4R measure in Table 4 and will earn $0.50 PMPM for reporting it for a total of ($0.50 PMPM * 20,000 member months) = $10,000.

Step 3: Calculate P4P Incentive
To calculate the remaining quality incentive amount for the P4P measures, Table 8 below provides an example to guide Medicaid Path participating practices that serve children in understanding how MDH will calculate their 2026 quality incentive payment amount.

Table 8. Example to Calculate the P4P Amount of the 2026 Medicaid Quality Incentive for a Practice Organization Serving Children

Population	Measure Name	2026 High-performance Target	2026 Improvement Target	2026 Practice Result	Was the 2026 P4P Target Met?	Did practice meet the minimum threshold? (see Section 4.5)	Measure Weight	Quality Incentive of $1 PMPM
Children	Child and Adolescent Well-Care Visits (WCV)	59.9%	56%	75%	Yes *(met high-performance target)*	No	25%	$0.25 PMPM
Children	Developmental Screening in the First Three Years of Life (DEV-CH)	59.7%	55%	51%	No	No	25%	$0

Final Calculation
P4P: This practice met the 2026 P4P targets for one of the P4P measures qualifying for $0.25 PMPM for a total P4P incentive of ($0.25 PMPM * 20,000 member months) = $5,000.

P4R: This practice reported the depression eCQM P4R measure and will earn a total of ($0.50 PMPM * 20,000 member months) = $10,000.

Total: This Medicaid Path participating organization would receive a 2026 quality incentive amount equivalent to the P4R funding ($10,000) plus the P4P funding ($5,000) for a total of $15,000.

Section 5.2.3 - Medicaid Quality Incentive Calculation Example for Practices that Serve Adults

Step 1: Calculate Member Months
Let's assume that a Medicaid Path participating organization that serves adults has 30,000 Medicaid member months in 2026 across all MCOs. In this scenario, the maximum quality incentive amount this Medicaid Path participating organization is eligible for in 2026 is (30,000 * $1 PMPM) = $30,000.

Step 2: Calculate P4R Incentive
Additionally, assume that this Medicaid Path participating organization reports the four P4R measures in Table 5 and will earn $0.125 PMPM per P4R measure reported. For reporting the four P4R measures, this organization receives ($0.125 PMPM * 4 * 30,000 member months) = $15,000.

Step 3: Calculate P4P Incentive
To calculate the remaining quality incentive amount for the P4P measures, Table 9 below provides an example to guide Medicaid Path participating practices that serve adults in understanding how MDH will calculate their 2026 quality incentive payment amount.

Table 9. Example to Calculate the P4P Amount of the 2026 Medicaid Quality Incentive for a Practice Organization Serving Adults

Population	Measure Name	2026 High-performance Target	2026 Improvement Target	2026 Practice Result	Was the 2026 P4P Target Met?	Did practice meet the minimum threshold? (see Section 4.5)	Measure Weight	Quality Incentive of $1 PMPM
Adults	Emergency Department Utilization (EDU)*	0.81	0.91	0.98	No	No	25%	$0
Adults	Acute Hospital Utilization (AHU)*	1.01	1.05	1.04	Yes *(met improvement target)*	No	25%	$0.25 PMPM

*This is an inverse measure. A lower number is better.

Final Calculation
P4P: This practice met the 2026 P4P targets for one measure qualifying for $0.25 PMPM and for a total P4P incentive of ($0.25 PMPM * 30,000 member months) = $7,500.

P4R:This organization reported the four P4R measures and would receive ($0.125 PMPM * 4 * 30,000 member months) = $15,000.

Total: This Medicaid Path participating organization would receive a 2026 quality incentive payment equivalent to the P4R funding ($15,000) plus the P4P funding ($7,500) for a total of $22,500.

Section 5.3 – 2026 Medicaid Quality Incentive Calculation Examples of Not Meeting the Minimum Threshold

This section provides various examples for calculating the 2026 quality incentive payments for Medicaid Path participating organizations that do not meet the minimum threshold for the P4P measures.

Section 5.2.1 - Medicaid Quality Incentive Calculation Example for Practices that Serve Adults and Children with P4P Measures that Do Not Meet the Minimum Threshold

This section provides an example of a Medicaid Path participating practice that serves both adults and children that does not meet the minimum threshold for one P4P measure. In this example, the WCV measure has less than 20 observations in the denominator. Since the WCV is below the minimum threshold for participation, WCV will not be eligible for the 2026 quality

incentive payment and the P4P measure weights will be distributed among the three remaining measures, as described on Table 10. Use the formula below to calculate the new weights:

Formula for calculating weights per measure:

P4P Weights: *50% ÷ (Total number of remaining P4P measures) = 50% ÷ 3 = 16.7%*

P4R Weights: *50% ÷ (Total number of P4R measures) = 50% ÷ 4 = 12.5%*

Table 10. Medicaid Path PY2026 Quality Incentive Amount and Weights per Measure for Practice Organizations Serving Children and Adults

Population	Domain	Measure Name	Did practice meet the minimum threshold?	PY 2026	Measure Weight	Quality Incentive of $1 PMPM
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	No	P4P	16.7%	$0.167 PMPM
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	No	P4P	16.7%	$0.167 PMPM
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Yes	P4P	Not applicable	Not applicable
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	No	P4P	16.7%	$0.167 PMPM
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	No	P4R	12.5%	$0.125 PMPM
Adults	Chronic Conditions	Controlling High Blood Pressure	No	P4R	12.5%	$0.125 PMPM
Adults	Prevention & Wellness	Colorectal Cancer Screening	No	P4R	12.5%	$0.125 PMPM
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan: Ages 12 to 64	No	P4R	12.5%	$0.125 PMPM

Step 1: Calculate Member Months

Building on the example in section 5.2.1, let's assume that a Medicaid Path participating organization serving both adults and children has 50,000 member months in 2026 and can earn a maximum of $50,000 in quality incentive payments.

Step 2: Calculate P4R Incentive
Assume that this Medicaid Path participating organization reports three out of the four P4R measures and would receive ($0.125 * 3 * 50,000) = $18,750.

Step 3: Calculate P4P Incentive
To estimate the P4P component of this Medicaid Path participating organization, Table 11 provides an example with the P4P measures that apply to this practice.

Table 11. Example to Calculate the P4P Amount of the 2026 Medicaid Quality Incentive for a Practice Organization Serving Children and Adults with P4P Measure Under the Minimum Threshold

Population	Measure Name	2026 High-performance Target	2026 Improvement Target	2026 Practice Result	Was the 2026 P4P Target Met?	Did practice meet the minimum threshold? (see Section 4.5)	Measure Weight	Quality Incentive of $1 PMPM
Adults	Emergency Department Utilization (EDU) *	0.81	0.91	0.98	No	No	16.7%	$0
Adults	Acute Hospital Utilization (AHU) *	1.01	1.05	1.04	Yes *(met improvement target)*	No	16.7%	$0.167 PMPM
Children	Child and Adolescent Well-Care Visits	59.9%	42%	65%	Yes *(met high-performance target)*	No	16.7%	$0.167 PMPM
Children	Developmental Screening in the First Three Years of Life (DEV-CH)	59.7%	51%	55%	Not applicable	Yes	Not applicable	Not Applicable

*This is an inverse measure. A lower number is better.

Final Calculation
P4P: This practice met the 2026 P4P targets for two of three eligible measures qualifying for ($0.167 PMPM * 2) = $0.334 PMPM and for a total P4P incentive of ($0.334 PMPM * 50,000 member months) = $16,700.

P4R: This Medicaid Path participating organization reports three out of the four P4R measures and would receive ($0.125 * 3 * 50,000) = $18,750.

Total: This Medicaid Path participating organization would receive a 2026 quality incentive payment equivalent to the P4R funding ($18,750) plus the P4P funding ($16,700) for a total of $35,450.

Chapter 6: 2026 Quality Incentive Timeline and Incentive Payout

This chapter describes the process MDH will utilize to calculate the 2026 quality incentive results for Medicaid Path participating practice organizations.

Section 6.1 – Claims-based P4P Measures

MDH will utilize encounter data for 2026 dates of service submitted by HealthChoice MCOs to the Medicaid Data Warehouse by June 30, 2027. Participating practice organizations will work on timely claims submissions with HealthChoice MCOs, which in turn will submit timely and accurate encounter data to MDH for the calculation of the 2026 P4P results for claims-based measures.

According to the 2026 Medicaid Quality Incentive Program Timeline in Figure 3, MDH will calculate 2026 results for the P4P claims-based measures and share them with participating practice organizations in September 2027 via CRISP.

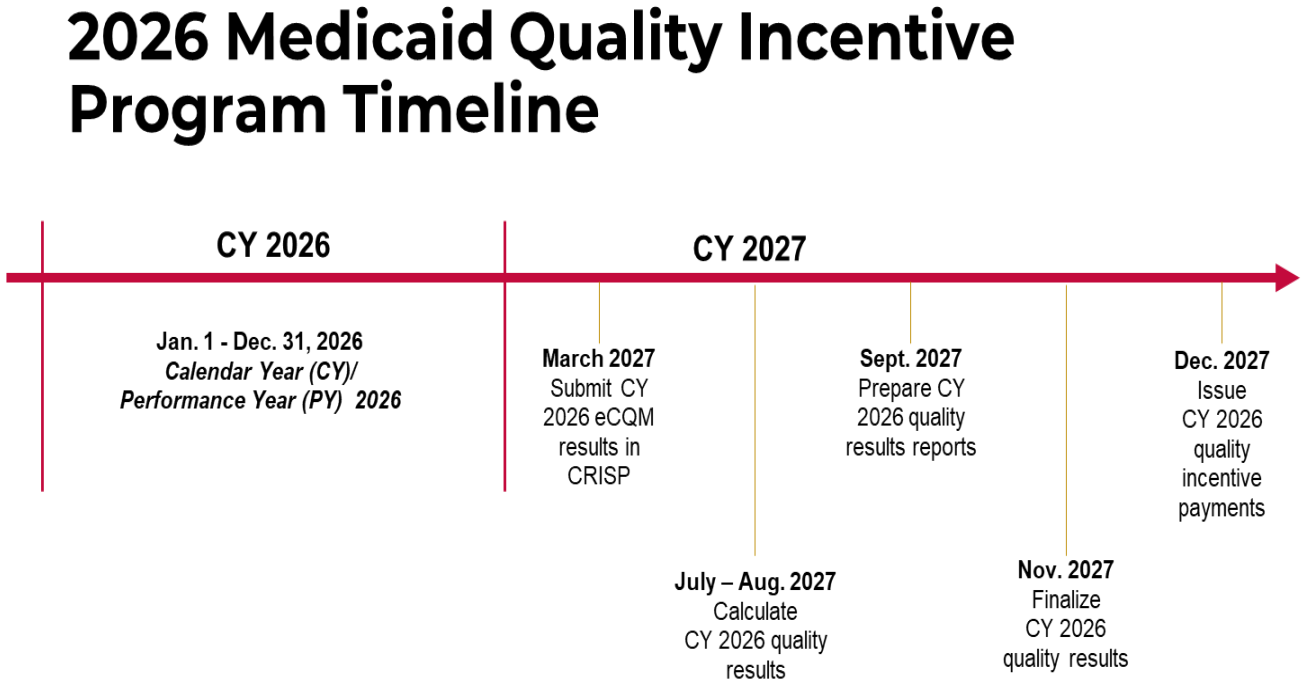
Section 6.2 – eCQMs P4R Measures

To qualify for the PY26 P4R incentive, Medicaid Path participating organizations will submit eCQM all-payer data for the populations they serve as described in Chapter 4. Medicaid Path participating organizations are required to share their 2026 performance with MDH via the CRISP platform by March 31, 2027. Practice organizations should submit all measure denominators, numerators, rates, and additional information as requested by CRISP. A detailed guide on eCQM submission will be provided in advance.

Section 6.3 –2026 Quality Incentive Payout

After the 2026 results for the claims-based P4P measures and the eCQM P4R measures are finalized, MDH will calculate the quality incentive amount each practice organization qualifies for and will notify each practice organization via CRISP. MDH will issue the 2026 quality incentive payments to participating practice organizations by late Fall 2027, paid through the MCOs. Subject to Medicaid budget availability, MDH may issue a bonus payment for exceptional performance beyond the previously described 2026 quality incentive payment methodology. If applicable, the bonus would be paid out to eligible participating practice organizations as part of the 2026 quality incentive payments. Figure 3 below describes the 2026 Medicaid Path Quality Incentive Timeline.

Figure 3. 2026 Medicaid Quality Incentive Program Timeline



Appendix A – Primary Care Services (PCS) Codes

This section provides more detail about the Medicaid Quality Incentive Program member-to-provider attribution methodology including (a) the various codes MDH will utilize to calculate 2026 practice-specific results for claims-based measures and (b) the geographic distance standards to assign members who did not have primary care utilization during the lookback period.

First, MDH deems the Medicaid **provider types and specialties** in Table 12 as primary care providers. MDH will only consider services rendered by these provider types and specialties as primary care services.

Table 12. Medicaid provider types and specialties that qualify as a primary care provider in the Medicaid Path

Provider Type #	Provider Type Description	Provider Specialty #	Provider Specialty Description
20	Physician	16	Pediatrics
		28	General Practice
		29	Family Practice
		30	Internal Medicine
23	Nurse Practitioner	171	Nurse Practitioner
80	Physician Assistant		
34	Clinic, Federally Qualified Health Center (FQHC)		

MDH will include claims with place of service codes listed in Table 13 below as primary care services in the Medicaid Quality Incentive Program member-to-provider attribution process.

Table 13. Place of service codes to be included in the Medicaid Quality Incentive Program member-to-provider attribution process

Place of Service #	Place of Service Description
02	Telehealth
11	Office
12	Patient's Home
14	Group Home

Place of Service #	Place of Service Description
16	Mobile Unit
17	Walk-in Retail Clinic
27	Outreach-site/street
49	Independent Clinic
50	FQHC
71	Public Health Clinic
72	Rural Health Clinic

MDH will exclude primary care claims with the place of service codes listed in Table 14.

Table 14. Place of service codes to be excluded in the Medicaid Path member-to-provider attribution process

Place of Service #	Place of Service Description
20	Urgent Care Facility
22	Outpatient Hospital
23	Emergency Room
81	Independent Laboratory

MDH will consider the codes from the Current Procedural Terminology (CPT) category I and Healthcare Common Procedure Coding System (HCPCS) level I listed in Table 15 as **key primary care services** utilized in Step 1 of the Medicaid Quality Incentive Program member-to-provider attribution methodology.

Table 15. Key primary care services procedure codes

Procedure Code #	Procedure Code Description
92551	Pure Tone Hearing Test Air
96110	Developmental screen w/score
96127	Brief behavioral assessment (including PHQ 2 and 9)
96160	Patient-focused health risk assessment instrument
96161	Caregiver-focused health risk assessment instrument
99173	Visual Screening Test
99202	Office/Outpatient Visit New
99203	Office/Outpatient Visit New
99204	Office/Outpatient Visit New
99205	Office/Outpatient Visit New

Procedure Code #	Procedure Code Description
99211	Office or other outpatient visit for an established patient. It represents the lowest level of service for such visits, typically performed by nurses, and involves minimal complexity, such as checking a patient's blood pressure, monitoring their condition, administering a routine injection, or changing a dressing (<5 mins, 10 -19 mins, 20 – 29 min, 30- 39 mins, 40 + mins)
99212	Office or other outpatient visit for an established patient. It represents the lowest level of service for such visits, typically performed by nurses, and involves minimal complexity, such as checking a patient's blood pressure, monitoring their condition, administering a routine injection, or changing a dressing (<5 mins, 10 -19 mins, 20 – 29 min, 30- 39 mins, 40 + mins)
99213	Office or other outpatient visit for an established patient. It represents the lowest level of service for such visits, typically performed by nurses, and involves minimal complexity, such as checking a patient's blood pressure, monitoring their condition, administering a routine injection, or changing a dressing (<5 mins, 10 -19 mins, 20 – 29 min, 30- 39 mins, 40 + mins)
99214	Office or other outpatient visit for an established patient. It represents the lowest level of service for such visits, typically performed by nurses, and involves minimal complexity, such as checking a patient's blood pressure, monitoring their condition, administering a routine injection, or changing a dressing (<5 mins, 10 -19 mins, 20 – 29 min, 30- 39 mins, 40 + mins)
99215	Office or other outpatient visit for an established patient. It represents the lowest level of service for such visits, typically performed by nurses, and involves minimal complexity, such as checking a patient's blood pressure, monitoring their condition, administering a routine injection, or changing a dressing (<5 mins, 10 -19 mins, 20 – 29 min, 30- 39 mins, 40 + mins)
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient (ages 1-4, 5-11, 12-17, 18-39, 40-64)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient (ages 1-4, 5-11, 12-17, 18-39, 40-64)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient (ages 1-4, 5-11, 12-17, 18-39, 40-64)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient (ages 1-4, 5-11, 12-17, 18-39, 40-64)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient (ages 1-4, 5-11, 12-17, 18-39, 40-64)

Procedure Code #	Procedure Code Description
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient (ages 1-4, 5-11, 12-17, 18-39, 40-64)
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (ages 1-4, 5-11, 18-39, 40-64)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (ages 1-4, 5-11, 18-39, 40-64)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (ages 1-4, 5-11, 18-39, 40-64)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (ages 1-4, 5-11, 18-39, 40-64)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (ages 1-4, 5-11, 18-39, 40-64)
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (ages 1-4, 5-11, 18-39, 40-64)
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) (15, 30 mins)
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) (15, 30 mins)
99461	For the initial care, per day, for the evaluation and management of a normal newborn infant seen in a setting other than a hospital or birthing center. This code is used for an initial assessment of a healthy newborn outside of a traditional hospital setting, such as in a home or outpatient clinic, to ensure the infant's well-being, monitor health, and provide guidance to parents. The service must occur in a location other than a hospital or birthing center.
G2211	Complex E&M visit add-on
T1015	FQHC Clinic visit/encounter, all-inclusive

MDH will consider the CPT and HCPCS codes listed in Table 16 as **other primary care services** utilized in Step 2 of the Medicaid Quality Incentive Program member-to-provider attribution methodology. Other primary care services include some laboratory tests, vaccinations, women's health services, and behavioral health services delivered by primary care providers.

Table 16. Other primary care services procedure codes

Procedure Code #	Procedure Code Description
11981	INSERT DRUG IMPLANT DEVICE
11982	REMOVE DRUG IMPLANT DEVICE
11983	REMOVE/INSERT DRUG IMPLANT
36415	COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE
57170	DIAPHRAGM FITTING WITH INSTRUCTIONS
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
77061	BREAST TOMOSYNTHESIS UNI
77062	BREAST TOMOSYNTHESIS BI
77063	BREAST TOMOSYNTHESIS BI
77065	DX MAMMO INCL CAD UNI
77066	DX MAMMO INCL CAD BI
77067	SCR MAMMO BI INCL CAD
77072	Bone age studies, an X-ray exam used to determine the skeletal maturity and growth rate of a child's bones, typically of the hand and wrist
80047	Glucose lab test
80048	Glucose lab test
80053	Comprehensive metabolic panel
80061	LDL-C Lab Test
80069	Glucose lab test
81000	URINALYSIS NONAUTO W/SCOPE
81001	URINALYSIS AUTO W/SCOPE
81002	URINALYSIS NON-AUTOMATED WITHOUT MICRO
81003	URINALYSIS AUTO W/O SCOPE
81005	URINALYSIS QUALITATIVE OR SEMIQUANT
81007	Urinalysis; bacteriuria screen, except by culture or dipstick
81020	URINALYSIS GLASS TEST
81025	URINE PREGNANCY TEST VISUAL COLOR COMP
81025	URINE PREGNANCY TEST VISUAL COLOR COMP
82270	OCCULT BLOOD FECES
82272	OCCULT BLD FECES 1-3 TESTS
82465	ASSAY BLD/SERUM CHOLESTEROL
82943	Glucagon test in plasma
82945	Glucose test
82946	Glucagon tolerance test
82947	Glucose lab test
82948	GLUCOSE, BLOOD, STICK TEST
82948	Glucose lab test

Procedure Code #	Procedure Code Description
82950	Glucose lab test
82951	Glucose lab test
82962	Glucose Blood by FDA Cleared Devices
82962	Glucose, blood, by glucose monitoring device(s) cleared by the FDA specifically for home use
83036	Hemoglobin; glycosylated
83036	HbA1c Lab Test
83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
83037	HbA1c Lab Test
83051	HEMOGLOBIN PLASMA
83655	LEAD [-QUANTITATIVE-BLOOD]
83700	LDL-C Lab Test
83701	LDL-C Lab Test
83704	LDL-C Lab Test
83718	Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol)
83719	Laboratory code for the direct measurement of very low-density lipoprotein (VLDL) cholesterol in a patient's specimen
83721	LDL-C Lab Test
84702	GONADOTROPIN CHORIONIC QUANTITATIVE
84703	GONADOTROPIN CHORIONIC QUALITATIVE
84703	GONADOTROPIN CHORIONIC QUALITATIVE
85018	BLOOD COUNT HEMOGLOBIN
85018	BLOOD COUNT HEMOGLOBIN
85025	BLOOD COUNT HEMOGRAM AUTO COMPLETE DIFF
85025	BLOOD COUNT HEMOGRAM AUTO COMPLETE DIFF
86308	HETEROPHILE ANTIBODY SCREEN
86308	HETEROPHILE ANTIBODY SCREEN
86318	IMMUNOASSAY INFECTIOUS AGENT
86318	IMMUNOASSAY INFECTIOUS AGENT
86580	SENSITIVITY TEST-TUBERCULOSIS
86580	SENSITIVITY TEST-TUBERCULOSIS
87086	CULTURE BACT URINE QUANTITATIVE COLONY
87086	CULTURE BACT URINE QUANTITATIVE COLONY
87110	Chlamydia Test
87210	SMEAR WET MOUNT SALINE/INK (examining a sample under a microscope)
87210	SMEAR WET MOUNT SALINE/INK
87270	Chlamydia Test
87275	Detection tests relating to Influenza
87276	Detection tests relating to Influenza
87320	Chlamydia Test
87400	INFLUENZA A/B EACH AG IA
87400	INFLUENZA A/B EACH AG IA
87426	SARSCOV CORONAVIRUS AG IA
87428	SARSCOV & INF VIR A&B AG IA
87430	STREP A AG IA
87490	Chlamydia Test
87491	Chlamydia Test

Procedure Code #	Procedure Code Description
87492	Chlamydia Test
87623	HPV LOW-RISK TYPES
87624	HPV HIGH-RISK TYPES
87625	HPV TYPES 16 & 18 ONLY
87804	Influenza Immunoassay Dir opt obs
87807	RSV ASSAY W/OPTIC
87810	Chlamydia Test
87811	SARS-COV-2 COVID19W/OPTIC
87880	INF AGENT AG BY EIA DOO; STREPTOCOCCUS,A
88141	CYTOPATH C/V INTERPRET
88142	CYTOPATH C/V THIN LAYER
88143	CYTOPATHOLOGY C/V TP AUTO MS&RS PS
88147	CYTOPATH C/V AUTOMATED
88148	CYTOPATH C/V AUTO RESCREEN
88150	CYTOPATH C/V MANUAL
88152	CYTOPATH C/V AUTO REDO
88153	CYTOPATH C/V REDO
88164	CYTOPATH TBS C/V MANUAL
88165	CYTOPATH TBS C/V REDO
88166	CYTOPATH TBS C/V AUTO REDO
88167	CYTOPATH TBS C/V SELECT
88174	CYTOPATH C/V AUTO IN FLUID
88175	CYTOPATH PATHOLOGY C/V TLP AUTO & MAN SC
90378	RSV MAB IM 50MG
90380	BEYFORTUS 50MG/0.5ML
90381	BEYFORTUS 100MG/ML
90480	ADMN SARSCOV2 VACC 1 DOSE
90611	SMALLPOX&MONKEYPOX VAC 0.5ML
90619	MENACWY-TT VACCINE IM
90620	MENINGOCOCCAL RECOMBINANT PROTEIN AND
90621	MENINGOCOCCAL RECOMBINANT LIPOPROTEIN
90630	FLU VACC IIV4 NO PRESERV ID
90632	HEPA VACCINE ADULT IM
90633	HEPA VACC PED/ADOL 2 DOSE IM
90636	HEP A/HEP B VACC ADULT IM
90647	HIB PRP-OMP VACC 3 DOSE IM
90648	HIB PRP-T VACCINE 4 DOSE IM
90650	2VHPV VACCINE 3 DOSE IM
90651	9VHPV VACCINE 2/3 DOSE IM
90653	IIV3 VACC NO PRSV (6-35 MO, 3 YRS+) IM
90655	IIV3 VACC NO PRSV (6-35 MO, 3 YRS+) IM
90656	IIV3 VACC NO PRSV (6-35 MO, 3 YRS+) IM
90657	IIV3 VACC NO PRSV (6-35 MO, 3 YRS+) IM
90658	IIV3 VACC NO PRSV (6-35 MO, 3 YRS+) IM
90660	LAIV3 VACCINE INTRANASAL
90661	LAIV3 VACCINE INTRANASAL
90662	LAIV3 VACCINE INTRANASAL

Procedure Code #	Procedure Code Description
90663	LAIV3 VACCINE INTRANASAL
90664	LAIV3 VACCINE INTRANASAL
90665	LAIV3 VACCINE INTRANASAL
90666	LAIV3 VACCINE INTRANASAL
90667	LAIV3 VACCINE INTRANASAL
90668	LAIV3 VACCINE INTRANASAL
90670	PCV13 VACCINE IM
90671	PCV15 VACCINE IM
90672	LAIV4 VACCINE INTRANASAL
90673	Trivalent influenza virus vaccine that is derived from recombinant DNA, contains hemagglutinin (HA) protein only, and is free of preservatives and antibiotics
90674	CCIIV4 VAC NO PRSV 0.5 ML IM
90677	PNEUMOCOCCAL CONJUGATE VACCINE (PCV20)IM
90678	RSV VACC PREF BIVALENT IM
90679	AREXVY (RSV vaccine for adults 60 and older)
90680	RV5 VACC 3 DOSE LIVE ORAL
90681	RV1 VACC 2 DOSE LIVE ORAL
90682	Quadrivalent (IIV4) influenza virus vaccine
90682	Quadrivalent Influenza Virus Vaccine
90683	mRESVIA (mRNA-based) respiratory syncytial virus (RSV) vaccine
90684	Pneumococcal 21-valent conjugate vaccine (PCV21)
90685	IIV4 VACC NO PRSV 6-35 M IM
90686	IIV4 VACC NO PRSV 3 YRS+ IM
90687	IIV4 VACCINE 6-35 MONTHS IM
90688	IIV4 VACCINE 3 YRS PLUS IM
90689	VACC IIV4 NO PRSRV 0.25ML IM
90694	VACC AIIV4 NO PRSRV 0.5ML IM
90696	DTAP-IPV VACCINE 4-6 YRS IM
90697	DTAP-IPV-HIB-HEPB VACCINE IM 0.5ML
90698	DTAP-IPV/HIB VACCINE IM
90700	DTAP VACCINE < 7 YRS IM
90702	DT VACCINE UNDER 7 YRS IM
90707	MMR VACCINE SC
90710	MMRV VACCINE SC
90713	POLIOVIRUS IPV SC/IM
90714	TD VACC NO PRESV 7 YRS+ IM
90715	TDAP VACCINE 7 YRS/> IM
90716	VAR VACCINE LIVE SUBQ
90723	DTAP-HEP B-IPV VACCINE IM
90732	PPSV23 VACC 2 YRS+ SUBQ/IM
90733	Meningococcal Vaccine Procedure
90734	MENACWYD/MENACWYCRM VACC IM
90736	HZV VACCINE LIVE SUBQ
90739	HEPB VACC 2 DOSE ADULT IM
90740	Hepatitis B vaccine (HepB) for a dialysis or immunosuppressed patient dosage, administered via a three-dose schedule for intramuscular use
90743	HEPB VACC 2 DOSE ADOLESC IM

Procedure Code #	Procedure Code Description
90744	HEPB VACC 3 DOSE PED/ADOL IM
90746	HEPB VACCINE 3 DOSE ADULT IM
90747	Hepatitis B vaccine, specifically the four-dose schedule for dialysis or immunosuppressed patients
90750	HZV VACC RECOMBINANT IM
90756	CCIIV4 VACC A BX FREE 1M
90759	HEP B VAC 3AG 10MCG 3 DOS IM
91304	SARSCOV2 VAC SAPONIN-BSD 5MCG/0.5ML IM
91318	SARSCOV2 VAC 3MCG TRS-SUC
91319	SARSCV2 VAC 10MCG TRS-SUC IM
91320	2ARSCV2 VAC 30MCG TRS-SUC IM
91321	SARSCOV2 VAC 25MCG/.25ML IM
91322	SARSCOV2 VAC 50 MCG/0.5ML IM
93000	ELECTROCARDIOGRAM COMPLETE
93976	Diagnostic ultrasound (duplex scan) that evaluates blood flow to and from specific organs or areas
99341	Evaluation and management (E/M) of a new patient in a home or residence, involving low-level medical decision-making. This code is used by healthcare providers for house calls and covers services like history-taking and examination within the patient's home environment. (15 min, 30 min)
99342	Evaluation and management (E/M) of a new patient in a home or residence, involving low-level medical decision-making. This code is used by healthcare providers for house calls and covers services like history-taking and examination within the patient's home environment. (15 min, 30 min)
99344	A home or residence visit for the evaluation and management (E/M) of a new patient, requiring a medically appropriate history and/or examination, and a moderate level of medical decision-making (60 mins)
99345	A home or residence visit for the evaluation and management (E/M) of a new patient, requiring a medically appropriate history and/or examination, and a moderate level of medical decision-making. This code requires the healthcare provider to be physically present at the patient's private residence (75 mins).
99347	An evaluation and management (E/M) service for an established patient during a visit to their home or residence. This specific code requires a medically appropriate history and/or examination and involves straightforward medical decision making, or a minimum of 20 minutes
99348	Home Visit for Established Patient with Low Medical Decision Making". It is used to report an in-person visit to an established patient's home for evaluation and management of medical conditions that require low complexity medical decision making (30 mins)
99349	A home or residence visit for the evaluation and management of an established patient with moderate to high complexity medical decision making or requiring at least 40 minutes of total face-to-face time with the patient and/or family on the date of the encounter
99350	A home or residence visit for the evaluation and management (E/M) of an established patient, requiring a medically appropriate history and/or examination along with a high level of medical decision-making (60 mins)

Procedure Code #	Procedure Code Description
99358	A physician or other qualified health care professional's first hour of prolonged evaluation and management (E/M) services that occur without direct patient contact and on a different date than the face-to-face encounter. This time can be spent on activities like extensive record review, coordination with other providers, and detailed analysis of patient history to develop treatment plans. (30 – 60 mins, 60 mins +)
99359	A physician or other qualified health care professional's first hour of prolonged evaluation and management (E/M) services that occur without direct patient contact and on a different date than the face-to-face encounter. This time can be spent on activities like extensive record review, coordination with other providers, and detailed analysis of patient history to develop treatment plans. (30 – 60 mins, 60 mins +)
99366	Medical team conference with a direct, face-to-face meeting with the patient and/or family, lasting at least 30 minutes, that includes a nonphysician qualified health care professional and an interdisciplinary team of other health care professionals. This code is used for documentation and billing purposes for services provided by non-physicians in these complex care coordination meetings
99415	Add-on code used to report the first hour of prolonged clinical staff services with direct patient contact and physician supervision in an outpatient or office setting, and it must be billed with an underlying Evaluation and Management (E/M) code from 99202-99215. This code is for the time that extends beyond the highest required time for the E/M service, and it requires direct patient contact under the supervision of a physician or other qualified healthcare professional (30 mins blocks)
99416	Add-on code used to report the first hour of prolonged clinical staff services with direct patient contact and physician supervision in an outpatient or office setting, and it must be billed with an underlying Evaluation and Management (E/M) code from 99202-99215. This code is for the time that extends beyond the highest required time for the E/M service, and it requires direct patient contact under the supervision of a physician or other qualified healthcare professional (30 mins blocks)
99417	Prolonged office or outpatient evaluation and management (E/M) services beyond the typical time of a primary service, billed in 15-minute increments and used for non-Medicare patients. This add-on code is for use with specific high-level E/M services (like 99205 and 99215) when the patient encounter requires additional time for complex documentation, care coordination, or extended patient counseling. (15 mins increments)
99418	Prolonged office or outpatient evaluation and management (E/M) services beyond the typical time of a primary service, billed in 15-minute increments and used for non-Medicare patients. This add-on code is for use with specific high-level E/M services (like 99205 and 99215) when the patient encounter requires additional time for complex documentation, care coordination, or extended patient counseling. (15 mins increments)
99492	Management of behavioral health conditions(s), timed, per month
99493	Management of behavioral health conditions(s), timed, per month
99494	Management of behavioral health conditions(s), timed, per month
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST DOSE
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND DOSE

Procedure Code #	Procedure Code Description
0003A	ADM SARSCOV2 30MCG/0.3ML 3RD DOSE
0004A	ADM SARS COV2 30MCG/0.3ML BST
0011A	ADM SARSCOV2 100MCG/0.5ML 1ST DOSE
0012A	ADM SARSCOV2 100MCG/0.5ML 2ND DOSE
0013A	ADM SARSCOV2 100MCG/0.5ML 3RD DOSE
0034A	ADM SARSCOV2 VAC AD26 ,5 ML BOOSTER
0041A	ADM SARSCOV2 5MCG/0.5ML IM 1ST
0042A	ADM SARSCOV2 5MCG/0.5ML IM 2ND
0044A	ADM SARSCOV2 5MCG/0.5 BST
0051A	ADM SARSCV2 30MCG TRS-SUCR 1
0052A	ADM SARSCV2 30MCG TRS-SUCR 2
0053A	ADM SARSCV2 30MCG TRS-SUCR 3
0054A	ADM SARSCV2 30MCG TRS-SUCR B
0064A	ADM SARSCOV2 50MCG/0.25MLBST
0071A	ADM SARSCV2 10 MCG TRS-SUCR 1
0072A	ADM SARSCV2 10 MCG TRS-SUCR 2
0073A	ADM SARSCV2 10MCG TRS-SUCR 3
0074A	ADM SARSCV2 10 MCG TRS-SUCR B
0081A	ADM SARSCOV2 VAC 3MCG TRS-SUCR1
0082A	ADM SARSCOV2 VAC 3MCG TRS-SUCR2
0083A	ADM SARSCOV2 VAC 3MCG TRS-SUCR3
0091A	ADM SARSCOV2 VAC 50MCG/.5ML 1ST
0092A	ADM SARSCOV2 VAC 50MCG/.5ML 2ND
0093A	ADM SARSCOV2 VAC 50MCG/.5ML 3RD
0094A	ADM SARSCOV2 50MCG/.SML BOOSTER
0111A	ADM SARSCOV2 VAC 25MCG/0.25ML 1ST
0112A	ADM SARSCOV2 VAC 25MCG/0.25ML 2ND
0113A	ADM SARSCOV2 VAC 25MCG/0.25ML 3RD
0121A	ADM SARSCV2 BVL 30MCG/.3ML 1
0124A	ADM SARSCV2 BVL 30MCG/.3ML B
0134A	ADM SARSCV2 BVL 50MCG/.5ML B
0141A	ADM SRSCV2 BVL 25MCG/.25ML 1
0142A	ADM SRSCV2 BVL 25MCG/.25ML 2
0144A	ADM SRSCV2 BVL 25MCG/.25ML B
0151A	ADM SARSCV2 BVL 10MCG/,2ML 1
0154A	ADM SARSCV2 BVL 10MCG/.2ML B
0164A	ADM SRSCV2 BVL 10MCG/0.2ML B
0171A	ADM SARSCV2 BVL 10MCG/.2ML 1
0172A	ADM SARSCV2 BVL 3MCG/0.2ML 2
0173A	ADM SCARSCV2 BVL 3MCG/0.2.2ML 3
0174A	ADM SARSCV2 BVL 3MCG/0.2ML B
99401-CR	PREVENTIVE COUNSELING, UP TO 15 MIN
A4261	CERVICAL CAP FOR CONTRACEPTIVE USE
A4266	Diaphragm for contraceptive use

Procedure Code #	Procedure Code Description
G0512	Rural health clinic (RHCs) or federally qualified health center (FQHC) only, psychiatric collaborative care model, 60 minutes or more of clinical staff time for psychiatric services directed by an FQHC practitioner and including services rendered by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.
J1050	Injection, medroxyprogesterone acetate
J7296	KYLEENA, 19.5 MG
J7297	LEVONORGESTREL IU 52MG 3 YR
J7298	LEVONORGESTREL IU 52MG 5 YR
J7300	INTRAUTERINE COPPER CONTRACEPTIVE DEVICE
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7303	CONTRACEPTIVE VAGINAL RING
J7304	CONTRACEPTIVE HORMONE PATCH
J7306	LEVONORGESTREL (CONTRACEPTIVE) IMPLANT
J7307	ETONOGESTREL IMPLANT SYSTEM
M0201	COVID-19 VACCINE HOME ADMIN
W7000	SBIRT SCREEN; SELF ADMIN
W7010	SBIRT SCREENING; PROV ADMIN
W7020	SBIRT INTERVENTION; 3-10 MIN
W7021	SBIRT INTERVENTION; 10-20 MIN
W7022	SBIRT INTERVENTION; >20 MIN

Lastly, Figure 4 describes the geographic distance requirements that MDH will utilize to attribute a member to a provider for the Medicaid Quality Incentive Program if the member has no primary care utilization during the look back period.

Figure 4. 2025 HealthChoice MCO Primary Care Network Adequacy Standards

HEALTHCHOICE NETWORK ADEQUACY STANDARDS

To comply with the requirements of 42 CFR 438.68, MDH is responsible for developing minimum time and distance standards for HealthChoice MCO provider networks. MDH developed these standards by adapting the Health Service Delivery (HSD) standards for Maryland Medicare Advantage plans and the current HealthChoice regional and distance network standards. For each provider type, MCOs must meet either the time or distance standard for each county in the MCO's service area.

	Urban[1]		Suburban[2]		Rural[3]	
Provider Type	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)
Primary Care	15	10	30	20	40	30
Primary Care - Pediatric	15	10	30	20	40	30

[1] Urban Counties: Baltimore City
[2] Suburban Counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's
[3] Rural Counties: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester

Appendix B - 2026 Claims-based Measures Detailed Specifications

Emergency Department Utilization (EDU)

- **Description:** Medicaid members between 18 and 64 years of age, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year.
- **Measure steward**: NCQA
- **Data source**: Administrative or claims data
    - Include all paid, suspended, pending, and denied claims (with exceptions as listed below under Step 1 – 4 of Calculation of Observed Events).
- **Definitions**
    - **Nonoutlier:** Medicaid members between 18 and 64 years of age with five or fewer ED visits during the measurement year.
    - **Outlier:** Medicaid members between 18 and 64 years of age with six or more ED visits during the measurement year.
    - **Classification Period:** The year prior to the measurement year.
    - **Predicted Probability of a Visit (PPV):** The predicted probability of a member having an ED visit in the measurement year.
    - **Predicted unconditional count of visits (PUCV):** The unconditional count of ED visits for members during the measurement year.
- **Eligible Population**
    - **Product Line:** Medicaid.
    - **Ages:** Between 18 and 64 years of age as of December 31 of the measurement year.
    - **Continuous Enrollment Criteria:** Members must be Medicaid eligible during the measurement year and the year prior to the measurement year. The member must reside in Maryland at the end of the measurement year.
    - **Allowable Gap:** No more than one gap in Medicaid eligibility of up to 45 days during each year of continuous enrollment.
    - **Anchor Date:** December 31st of the measurement year.
    - **Benefit:** Medical.
    - **Event Diagnosis:** None.
    - **Required Exclusions:** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.
- **Calculation of Observed Events**
    - **Step 1:** Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement year using either of the following:

        - An ED Visit (ED Value Set).
        - A procedure code (ED Procedure Code Value Set) with an ED place of service code (POS code 23).
        - Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set) or an observation stay (Observation Stay Value Set).
    - **Step 2:** Exclude encounters with any of the following:
        - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
        - Psychiatry (Psychiatry Value Set).
        - Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
    - **Step 3:** For the remaining ED visits, calculate the number of visits per member and remove visits for outlier members. Report these members as outliers**.**
    - **Step 4:** Calculate the total using all ED visits identified after completing steps 1–3. Assign each remaining ED visit to an age and stratification category using the remaining HEDIS specifications.
- **Risk-adjustment –** Follow the same risk-adjustment methodology for the Medicare population, since HEDIS has not defined a Medicaid-specific risk-adjustment methodology.
- **Follow NCQA HEDIS measure specifications and value sets for measurement year (MY) 2025.**

Acute Hospital Utilization (AHU)

- **Description:** For Medicaid members between 18 and 64 years of age, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.
- **Measure steward**: NCQA
- **Data source**: Administrative or claims data
    - Include all paid, suspended, pending, and denied claims (with exceptions as listed below under Step 1 – 4 of Calculation of Observed Events).
- **Definitions**
    -
    - **Nonoutlier:** Medicaid members with five or fewer inpatient or observation stay discharges during the measurement year.
    - **Outlier:** Medicaid members with six or more inpatient or observation stay discharges during the measurement year.
    - **Classification Period:** The year prior to the measurement year (2024 dates of service).

  - **Planned Hospital Stay:** A hospital stay is considered planned if it meets the criteria as described in step 3 of the calculation of observed events.
  - **Predicted probability of discharge (PPD):** The predicted probability of a member having any discharge in the measurement year.
  - **Predicted unconditional count of discharge (PUCD):** The predicted unconditional count of discharges for members during the measurement year.
- **Eligible Population**
  - **Product Lines:** Medicaid.
  - **Ages:** Between 18 and 64 years of age as of December 31st of the measurement year.
  - **Continuous Enrollment:** Members need to maintain Medicaid eligibility during the measurement year and the year prior to the measurement year. The member must reside in Maryland at the end of the measurement year.
  - **Allowable Gap:** No more than one gap in Medicaid eligibility of up to 45 days during each year of continuous enrollment.
  - **Anchor Date:** December 31st of the measurement year.
  - **Benefit:** Medical.
  - **Event Diagnosis:** None.
  - **Required Exclusions:** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.
- **Calculation of Observed Events**
  - **Step 1:** Identify all acute inpatient and observation discharges during the measurement year. To identify acute inpatient and observation discharges:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
    - Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    - Identify the discharge date for the stay
  - **Step 2:** ***Direct transfers:*** For discharges with one or more direct transfers, use the last discharge.
    - Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation, or between observation and acute inpatient, using the definition in the *Guidelines for Risk Adjusted Utilization Measures*.
  - **Step 3:** For the remaining observation and inpatient discharges, exclude inpatient and observation discharges with any of the following on the discharge claim:
    - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).

        - A principal diagnosis of live-born infant (Deliveries Infant Record Value Set).
        - A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
        - A maternity-related stay (Maternity Value Set).
        - A planned hospital stay using any of the following:
        - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
        - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
        - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
        - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).
        - Inpatient and observation stays with a discharge for death.
        - ***Note:*** For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.
    - **Step 4:** For the remaining observation and inpatient discharges, remove discharges for outlier members and report these members as outliers. *Note:* Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.
    - **Step 5:** Calculate the total using all discharges identified after completing steps 1–4.
- **Risk-adjustment –** Follow the HEDIS risk-adjustment methodology for the Medicaid population.
- **Follow NCQA HEDIS measure specifications and value sets for measurement year (MY) 2025**.

Child and Adolescent Well-Care Visits (WCV)

- **Description:** Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.
- **Measure steward**: NCQA
- **Data source**: Administrative data
    - Include all paid, suspended, pending, and denied claims.
    - NCQA provides an appendix for the definition of a PCP, OB/GYN, and other prenatal care practitioners.

- **Eligible Population**
  - **Age:** Ages 3 to 21 as of December 31 of the measurement year.
  - **Continuous Enrollment:** Members need to remain Medicaid eligible throughout the measurement year, from January 1 to December 31. The member must reside in Maryland at the end of the measurement year.
  - **Allowable Gap:** No more than one gap in Medicaid eligibility of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
  - **Anchor Date:** December 31 of the measurement year.
  - **Benefit:** Medical.
  - **Event/Diagnosis:** None.
  - **Exclusions:** Beneficiaries who use hospice services and beneficiaries who die during the measurement year.
- **Denominator:** The eligible population.
- **Numerator**
  - One or more well-care visits (Well Care Value Set) during the measurement year by either:
    - A well-care visit (Well Care Value Set).
    - An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).
  - The well-care visit must occur with a PCP or OB/GYN, not necessarily the one assigned to the child.
- **Follow NCQA HEDIS measure specifications and value sets for measurement year (MY) 2025.**

Developmental Screening in the First Three Years of Life (DEV-CH)

- **Description:** Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.
- **Measure steward**: Oregon Health and Sciences University (OHSU) (https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1755712878)
- **Data Source:** Administrative
- **Guidance for Reporting**
  - This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays.

  - When calculating the numerator, modified claims can be included depending on the intent of the modifier.
  - Include all submitted claims (e.g., paid, suspended, pending, or denied) as the claims reflect services that were rendered.
- **Eligible Population**
  - **Age:** Children aged 1, 2, or 3 between January 1 and December 31 of the measurement year.
  - **Continuous Enrollment:** Children who remain Medicaid eligible continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday. The member must reside in Maryland at the end of the measurement year.
  - **Allowable Gap:** No more than one gap in Medicaid eligibility of up to 45 days during the 12 months prior to the child's first, second, or third birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).
  - **Anchor Date:** Enrolled on the child's first, second, or third birthday.
- **Denominators**
  - **Denominator 1:** The children in the eligible population who turned 1 during the measurement year.
  - **Denominator 2:** The children in the eligible population who turned 2 during the measurement year.
  - **Denominator 3:** The children in the eligible population who turned 3 during the measurement year.
  - **Denominator 4:** All children in the eligible population who turned 1, 2, or 3 during the measurement year, e.g., the sum of denominators 1, 2, and 3.
- **Numerators**
  - The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. This measure is based on three age-specific indicators.
  - **Numerator 1:** Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.
  - **Numerator 2:** Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.
  - **Numerator 3:** Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.
  - **Numerator 4:** Children in the entire eligible population who had a claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2, and 3).
- **Claims data:** CPT code 96110 (Developmental testing, with interpretation and report).

Glossary

Acronym	Expansion
AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
AHU	Acute Hospital Utilization
APM	Alternative Payment Model
BH	Behavioral Health
CAH	Critical Access Hospital
CBP	Controlling High Blood Pressure
CDC-HbA1c Poor Control	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)
CDF	Screening for Depression and Follow-Up Plan: Ages 12 and older
COL-AD	Colorectal Cancer Screening
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CRISP	Chesapeake Regional Information System for Patients
CY	Calendar Year
DEV-CH	Developmental Screening in the First Three Years of Life
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDU	Emergency Department Utilization
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
MCO	Managed Care Organization *A health plan operating in Maryland's HealthChoice program*
MDH	Maryland Department of Health
MDPCP AHEAD	Maryland Primary Care Program AHEAD
Medicaid Path	Maryland Medicaid Advanced Primary Care Program
MIPS	Merit-based Incentive Payment System
NCQA	National Committee of Quality Assurance
OAPC	Office of Advanced Primary Care
OB/GYN	Obstetrician and gynecologist
OHSU	Oregon Health and Sciences University
PC AHEAD	Primary Care AHEAD
P4P	Pay-for-performance
P4R	Pay-for-reporting
PCP	Primary Care Provider
PCS	Primary Care Services
PMPM	Per Member Per Month
PPD	Predicted probability of discharge
PPV	Predicted Probability of a Visit

Acronym	Expansion
Practice Organization	Primary care practice that signed up for Medicaid Path participation at the TIN-level
PUCD	Predicted unconditional count of discharge
PUCV	Predicted unconditional count of visits
PY	Performance Year
RHC	Rural Health Center
TIN	Tax Identification Number *A TIN may be assigned to an individual practice, a group of practices, or an entire network.*
WCV	Child and Adolescent Well-Care Visits