Maryland
DEPARTMENT OF HEALTH

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AHEAD Medicaid Advanced Primary Care Program:

Milestone 2 – Medicaid Care Transformation Priorities

State of Maryland
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Transmittal

In accordance with the AHEAD Cooperative Agreement Terms and Conditions (T&C) under Section 19 "Milestones," the Maryland Department of Health (MDH) is submitting an update to the July 15, 2025 submission of the State's design for the Medicaid Advanced Primary Care Program (Medicaid Advanced PCP) and care transformation priorities for multi-payer alignment with Primary Care AHEAD. MDH intends for these programmatic elements to be in place at the start of January 2026 (PY1).

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Introduction

The Medicaid Advanced Primary Care Program (Medicaid Advanced PCP) is constructed to align with the Maryland Primary Care Program (MDPCP) and Primary Care AHEAD (PC AHEAD) and to serve as the foundation and driving force for advancing primary care for Medicaid participants in Maryland under the AHEAD model. The first phase of Maryland's Medicaid Advanced PCP launched on August 1, 2025. The program will evolve in preparation for fuller alignment with MDPCP and PC AHEAD starting in January 2026 and in accordance with CMMI's Advanced Payment Model (APM) requirements.

Building off the guidelines in the AHEAD Model Cooperative Agreement, the Medicaid Advanced PCP is designed to allow for growth in both alternative payment mechanisms and care transformation, as well as stepwise inclusion to an expanding pool of primary care practices. Envisioned iterations of the model will foster greater cohesion across payers and the integration of industry standards in primary care investment.

The list of Care Transformation and CRISP Requirements for the Medicaid Advanced PCP, referenced throughout this document, is shown in the Appendix.

I. Vision

Advanced primary care will improve health outcomes and wellbeing in the State of Maryland by:

- Advancing whole-person care;
- Establishing strong linkages across the health care continuum; and
- Building a highly reliable program that sustains advanced primary care as a foundation for all Marylanders.

II. Goals

In alignment with the PC AHEAD goals of increased investment in primary care, targeting populations with high medical and social risk and expanding primary care capacity, the Medicaid Advanced PCP will:

- Simplify administrative burden for primary care providers;
- Leverage Medicare investments while broadening reach to Marylanders covered by Medicaid;
- Foster care transformation through care management for Medicaid participants with high needs, linkages across the continuum of care—including behavioral health and dental services—and health promotion services.

1. Program Eligibility

The Maryland Department of Health (MDH) will conduct a phased approach to growing the eligible provider pool for the Medicaid Advanced PCP, subject to limitations of the State budget. The initial phase, starting on August 1, 2025, will leverage MDPCP practice transformation investments and progress made to date, by offering the Medicaid Advanced PCP to practiceTINs, including FQHC TINs, active in MDPCP in CY 2025 and meeting a minimum assignment of 250 HealthChoice participants. Starting in 2026, MDH will expand eligibility to non-MDPCP TINs who can meet the State vetting criteria and minimum assignment of 250 HealthChoice participants. Future iterations of the model starting in 2027 may expand to TINs with less than 250 HealthChoice participants.

The Medicaid Advanced PCP will utilize PCP assignment–i.e., rather than utilization-based attribution–to fulfill the empanelment requirement. In addition to preserving participant choice and current operations, this approach will encourage practices to conduct outreach to empaneled patients who are lost to follow-up.

I. Eligible provider types

The eligible provider types under Maryland's Medicaid Advanced PCP align with the State's definition of PCPs for the HealthChoice program. These primary care provider types represent those that offer the full spectrum of primary and preventive care, diagnosis, and treatment,, and have the ability to operationalize the advanced primary care model. The eligible types are as follows:

- 01 - General Practice;
- 08 - Family Medicine;
- 11 - Internal Medicine;
- 37 - Pediatric Medicine;
- 38 - Nurse Practitioner; and
- 97 - Physician Assistant

II. Eligible participant organizations

Eligible participant organizations will be Maryland Medicaid HealthChoice primary care practice TINs, including FQHCs. TINs are made up of eligible providers.

Participant organizations (TINs) must meet the following criteria to participate in the initial phase (August-December 2025, or Cohort 1) of the Medicaid Advanced PCP:

1) Serve as Medicaid primary care medical homes, *i.e.,* HealthChoice participants may select or be assigned to them under their selected HealthChoice managed care organization (MCO);
2) Have a minimum of 250 assigned HealthChoice members at the TIN level across all MCOs;
3) Opt in to participate in the Medicaid Advanced PCP; and
4) Have at least one provider participating in MDPCP in CY 2025.

For the January 1, 2026 cohort (Cohort 2) of the Medicaid Advanced PCP, these criteria will be adjusted to account for non-MDPCP TINs. Participant organizations (TINs) must meet the following criteria to participate in the 2026 Program Year for the Medicaid Advanced PCP:

1) Serve as Medicaid primary care medical homes;
2) Have a minimum of 250 assigned HealthChoice members at the TIN level across all MCOs;
3) Opt in to participate in the Medicaid Advanced PCP.
4) Currently connect to CRISP (Chesapeake Regional Information System for our Patients), Maryland's State Health Information Exchange, or plan to connect by January 1, 2026; and
5) Have the ability to report electronic clinical quality measures (eCQMs) from their Electronic Health Record (EHR) system;

III. Estimated number of eligible TINs and participants

As outlined in the table below, there are 139 MDPCP TINs eligible for Cohort 1 (August 1, 2025 start). These TINs represent approximately 590,000 participants including 366,000 adults. There are 389 Non-MDPCP TINs eligible for Cohort 2 (January 1, 2026 start), accounting for approximately 662,000 participants, including 182,000 adults. MDH does not expect that all eligible TINs will enroll in the Medicaid Advanced PCP in Y1.

Table: Distribution of HealthChoice Enrollees and PCPs among MDPCP and Non-MDPCP TINs in MCO-Reported PCP Assignment Data, January 2025

TIN Group	Number of TINs	Number of unique NPIs in TIN with ≥1 assigned MCO enrollee	Total*	0-20 years old*	21+ years old*
MDPCP TINs with 250+ assigned enrollees	139	4,423	589,480	223,747	365,583
MDPCP TINs with <250 assigned enrollees	115	308	11,491	1,225	10,265
Non-MDPCP TINs with 250+ assigned enrollees	389	2,932	622,083	439,602	181,950
Non-MDPCP TINs with <250 assigned enrollees	1,188	2,026	54,425	14,561	39,855

*Designates Number of HealthChoice Enrollees Assigned to PCPs in TIN Group

2. Primary Care Clinical Standards

MDH will set statewide primary care clinical standards for the Medicaid Advanced PCP to ensure that participating primary care organizations are working towards common goals and frameworks for advanced primary care. Statewide primary care clinical standards include:

I. Whole-person care through a team-based model

Participating primary care practices will employ a team-based model of care in order to meet the program's Care Transformation Requirements. This team-based model of care allows the primary care provider to take the lead in disease management and medical decision making, while delegating other tasks to team members such as Nurse Care Managers and Medical Assistants. Primary care practice organizations may partner with MCOs to integrate additional team supports, such as pharmacists for medication management and certified disease educators.

Practices will be required to take a whole-person care approach by prioritizing the needs of the patient beyond disease management. Participants will account for the physical, mental, emotional, social, and

environmental factors that contribute to a person's health. To ensure whole-person care, practices will be required to incorporate health promotion activities into care for Medicaid participants, such as screening their assigned participants for social support services. Practices will be expected to use a standardized screening tool of their choice and provide referrals as appropriate (**Care Transformation Requirement 3.4**). Simultaneously, the MCOs are required to use the PRAPARE screening tool to screen all MCO members for social support services as of July 1, 2025. This screening by MCOs will be in addition to the practices' screening efforts. The State will be working with practices and MCOs on streamlining this process to ensure coordinated efforts between practices and MCOs. See Section 4 for more information on Health Promotion Activities.

Behavioral health integration is also an important aspect of whole-person primary care. See Section 5 for more information on behavioral health integration.

II. Empanelment of each patient to a primary care clinician

Empanelment of patients in the Medicaid Advanced PCP will occur via assignment of each HealthChoice member to a primary care provider. Each MCO in Maryland requires their members to select a primary care provider as the initial method of assignment, in order to prioritize patient choice. If the member does not select a provider, the MCO will assign a primary care provider to the member, based on geography, availability, and other factors. Providers in the Medicaid Advanced PCP will be expected to use this MCO assignment of members as their method for empanelment of patients to primary care providers (**Care Transformation Requirement 1.1**).

Data on MCO member assignment to providers will be provided to practices on a quarterly basis via the CRISP platform. This will enable practices to access a single list of assigned members across MCOs in one place. Participating practices will be required to pull down this assigned member list in CRISP every quarter (**CRISP Requirement C.2**).

III. Patient data collection and management

MDH will require participating practices to have a connection with CRISP, the state health information exchange (HIE). A connection to CRISP enables use of many tools for patient data collection and management, including: claims-based reports for monitoring cost and utilization trends; Admission, Discharge, and Transfer (ADT) notifications; and Prescription Drug Monitoring Program reports.

Practices will also have distinct requirements for using specific tools within CRISP. Practices must use the CRISP Event Notification Delivery (CEND) system and submit a patient panel to CEND at least every 90 days (**CRISP Requirement C.1**). CEND is CRISP's ADT notification tool, which provides users with real-time alerts about their patients' hospital encounters. Primary care practices use CEND to get real-time data about ED and hospital encounters for their patient panels, enabling practices to follow up with their patients post-discharge.

Practices must also use the Prediction Tools reports within CRISP, a set of reports that calculate and show risk stratification scores for assigned patients, on a monthly basis (**CRISP Requirement C.3**). Using these reports can help ensure high-risk patients are outreached and engaged in care managed, helping to prevent increased unnecessary utilization. The Prediction Tools reports show data for a practice's Medicare and Medicaid patients together, enabling multi-payer practice care transformation.

IV. Quality improvement

Practices in the Medicaid Advanced PCP will be required to use the Multi-Payer Reports Platform within CRISP to monitor quality **(CRISP Requirement C.4)**. Developed in tandem with the design phase of the Medicaid Advanced PCP, the Multi-Payer Reports Platform provides 15 reports populated using both Medicare and Medicaid claims data. The goal of the reporting suite is to allow users to view population-health metrics and access care management tools across their entire Medicare and Medicaid patient population, agnostic to payer. The reporting suite provides population-level, aggregate views, as well as beneficiary and claim-level details. The goal of requiring use of this tool is to have participating practices track process and outcome measures, and to use this data for quality improvement over time on a multi-payer basis. Practices can use data tools at the aggregate level, patient-level, and by sub-population, driving population-specific quality improvement. Practices can see aggregate and patient-level information only for patients for which they have a care relationship. Practices must actively submit a patient panel with details to CRISP in order to access data on those patients.

3. Primary Care Coordination Standards

MDH plans on phasing in Care Transformation Requirements for the Medicaid Advanced PCP to ensure that practices have sufficient time to implement sustainable transformation efforts and to align program payments with the resources necessary to implement care transformation activities. Beginning in PY1, primary care coordination standards will focus on planned coordination of chronic and preventive care, risk-stratified care management and patient access and continuity.

MDH plans to align monitoring for these CTRs (Section 4: Health Promotion Activities, Section 5: Behavioral Health Integration, and Section 6: Specialty Care Coordination) and specific activities under each CTR with current monitoring processes for MDPCP. Monitoring under MDPCP is currently done through semi-annual CTR reporting through the CMS Portal, and will take place annually beginning in PY2026. MDH is establishing a similar reporting infrastructure to monitor the progress of practice organizations on CTR activities and intends to align all advanced primary care models with annual reporting on CTR progress in Quarter 1 of each year. Additionally, Maryland is planning to implement a baseline assessment for Medicaid Advanced PCP practice TIN organizations to complete at launch. As with MDPCP, MDH will use the data and insights gained from these reports to provide ongoing technical assistance to practice organizations.

MDH will use process measures to evaluate progress and maturity on CTR implementation over time. MDH plans to use data collected from the baseline assessment as a baseline and evaluate for improvement as subsequent CTR reports are submitted. MDH will define success by reported improvement in implementing CTRs over time, as well as the percentage of practices reporting that they are accomplishing each activity or meeting each requirement.

I. Planned coordination of chronic and preventive care

Initial standards that coordinate chronic and preventive care management will include Care Transformation Requirements for participating practices to perform transitional care management (**Care Transformation Requirement 2.2b**) and follow-up with patients after inpatient and Emergency Department (ED) discharge (**Care Transformation Requirement 2.5**). Practices are expected to follow up with patients within two days after hospital discharge, and within seven days after ED discharge. These requirements aim to ensure smooth transitions of care in order to provide continuity of treatment plans between settings and ensure that patients understand and are up-to-date on any new medications or

care instructions. Practices will also be required to use the CRISP CEND tool, which provides real-time alerts about patients' hospital and ED encounters, providing necessary data for timely post-discharge follow up (**CRISP Requirement C.1**).

II. Risk-stratified care management

Maryland will be communicating guidance and expectations to practices on how to coordinate with MCOs to address the wide spectrum of needs for Medicaid participants. To support practices in delivering risk-stratified care management, MDH will also be providing tools on CRISP to support risk-stratified care management, which help practices more efficiently deploy limited care management resources. Practices will be required to use the Prediction Tools reports within CRISP, which helps practices ensure high-risk patients are outreached and engaged in care managed, helping to and prevent increased unnecessary utilization.

Initially, longitudinal care management will mainly be the responsibility of the MCO. For the future, the State is working with MCOs and the provider community to determine the right level of coordination of care management resources between the MCO and the practice. MDH expects it will take up to two years to iron out the best approach to this coordination, based on initial feedback received from both MCOs and providers.

In the future, requirements may be added for practices related to delivering longitudinal care management, care planning, and comprehensive medication management. The State will also explore risk stratifying payments after the initial launch.

III. Coordination of care across clinician types

Maryland is establishing requirements for practices to have a process to refer patients to necessary appointments with specialists (**Care Transformation Requirement 3.1**). Practices must have a referral relationship with specialists for specialty care and PCPs will work with specialists to coordinate care. For pediatric practices, MDH will also require practices to complete necessary forms for participation in a school or childcare setting (**Care Transformation Requirement 6.3**). In the future, MDH may explore additional opportunities for specialist coordination in partnership with MCOs. See Section 6 for additional information on speciality care coordination.

IV. Patient access and continuity

Patient access and continuity is a core component of Maryland's Care Transformation Requirements. Initially, practices will be required to offer at least one alternative care strategy to Medicaid members, including telehealth access, after hours and weekend care, and same or next day appointment scheduling (**Care Transformation Requirement 1.4**). MDH will also require practices to conduct outreach to assigned Medicaid participants who have not been seen at the practice, in partnership with the MCOs (**Care Transformation Requirement 1.5**). Because attribution in the Medicaid Advanced PCP uses MCO assignment, a practice may be assigned a Medicaid member that they have never seen for care. Outreaching these patients, encouraging them to make an appointment at the practice, and establishing regular care will be transformative in improving the health of Medicaid members, ensuring they have a regular primary care medical home.

For practices seeing pediatric patients, MDH will also set standards for appointment availability for newborns (**Care Transformation Requirement 6.1**), following American Academy of Pediatrics (AAP) guidelines.

V. Patient and caregiver engagement

In the future, practices may be required to convene a Patient Family Advisory Council (PFAC) at least annually; however, this will not be a formal requirement at the onset of the Medicaid Advanced PCP. More details will be developed in partnership with stakeholders in the coming years.

VI. Patient and clinician shared decision-making

In the future, MDH may set standards for ensuring shared decision making between patients and clinicians to ensure meaningful patient participation and engagement in care decisions; however, this will not be a formal requirement at the onset of the Medicaid Advanced PCP.

4. Health Promotion Activity Coordination

Practices in the Medicaid Advanced PCP will be required to incorporate health promotion activities by screening their assigned participants for social support services, such as transportation and nutrition supports. Practices will be required to use a standardized social support services screening tool of their choice. Practices will also be required to facilitate referrals and linkages to community-based organizations to address needs as appropriate, including referrals to food and nutrition support services, medical transportation, and supportive housing resources (**Care Transformation Requirement 3.4**). To support these activities, MDH has developed data sharing tools in CRISP including the sharing of needs assessments data and analytics reports on sub-populations. These tools can then be used to drive accountability partnerships between primary care and social support services. Maryland's advanced primary care programs will align with the comprehensive state-wide approach driven by the State Population Health Accountability Plan. This includes leveraging health technology for coordinating care between primary care and social support services, supporting efforts to address the chronic disease epidemic and reform Maryland's food system. Finally, MDH will provide technical assistance and shared learning forums to help practices plan for building out the capacity to implement the following health promotion activities :

- Establishing shared workflows, protocols, and training materials for social support referral workflow protocols
- Integrating primary care teams with social support navigators (e.g., community health workers, social workers)

At the same time, MCOs are required, as of July 1, 2025, to ensure that their members receive screening for social support services using a version of the standardized social supports needs screening tool. MCOs will ensure that members of all ages will be screened for social support services at least once a year. By January 1, 2026, MCOs must share all collected social support services data weekly with CRISP. Providers with HealthChoice participants on their panels and access to CRISP may access the social support services data to support comprehensive care delivery and avoid duplicative screening efforts.

As detailed above in Section 3, and in alignment with MDPCP, practices will be required to complete screening and referral for social supports (i.e., health promotion needs) and report on their activities through annual CTR reporting. MDH will monitor practice improvement by assessing progress on the CTRs over time, as well as the percentage of practices reporting that they are accomplishing the activity.

Beyond social supports, Maryland will require practices to engage in health promotion activities to prioritize chronic disease prevention and management, aligning with clinical disease management and

prevention. The primary care system in Maryland is a critical component in driving comprehensive health improvement by combining traditional medical management with lifestyle management that focuses on diet, nutrition and physical activity. The table below provides additional information related to diet, nutrition and physical activity resources that Maryland Medicaid members can be connected to. MDH intends to leverage the existing infrastructure that is in place to drive better outcomes.

Service	**Description**
Lifestyle management programs - Screen and refer to lifestyle management programs	**MCOs** - make referrals to programs including the Diabetes Prevention Program (DPP), which is covered by Medicaid. MCOs must cover exercise programs for weight loss, only when medically necessary. **Practices** - screen and refer to lifestyle management programs like DPP, Diabetes Self Management Education and Support (DSMES), and other Chronic Disease Self-Management Programs (CDSMPs). Practices may have direct partnerships with community based organizations (CBOs), which provide the service. Practices may also direct patients to other health professionals such as diabetic educators, exercise counselors or therapists.
Food insecurity - Screen and refer for social supports that include food insecurity	**MCOs** - As of July 2025, MCOs are required to screen all HealthChoice members using a standardized tool identified by MDH. MCOs then make referrals which may include programs like SNAP and food pantries. **Practices** - screen and refer for food insecurity using standardized tools. Practices typically build this as a standard workflow for all patients, though some may only do it with associated value-based care models. Referrals may include programs like SNAP, WIC or local food pantries.
Nutrition - Screen and refer to nutrition programs or professionals	**MCOs** - screen and refer for nutrition. Nutrition counseling is covered for perinatal and diabetic populations, as well as children. Under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), children are assessed for nutrition, and referred to programs like Women Infants and Children (WIC). **Practices -** screen and refer to programs such as SNAP, WIC, or local food pantries. They may also refer to professionals including registered dietitians or nutritionists for nutritional counseling.

5. Behavioral Health Integration

Under the Medicaid Advanced Primary Care Program, behavioral health integration will be a key feature. MDH has long supported the evidence-based model Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the Medicaid program. In July 2016, Medicaid introduced new SBIRT codes to give providers greater flexibility when billing for SBIRT services. The State intends to build upon this

foundation, as well as leverage the support developed in MDPCP practices to deliver mental health and substance use disorder care within primary care. This includes the incorporation of evidence-based workflows to address behavioral health in the primary care setting, as well as the prescribing and management of medications for opioid use disorder (MOUD) within primary care.

Initially, practices in the Medicaid Advanced PCP will be required to establish a routine screening process for behavioral health needs. Practices will use measurement-based care for behavioral health, leveraging standard screening tools to diagnose behavioral health conditions. For Medicaid members, practices will facilitate referrals and warm handoffs to specialists or community organizations to increase consultations. This may include referring eligible members as necessary to care coordination with Maryland's Behavioral Health Administrative Services Organization (BHASO), Carelon (**Care Transformation Requirement 3.3**).

In addition, pediatric practices in the Medicaid Advanced PCP will be required to screen children for autism or developmental disorders, within the scope of primary care (**Care Transformation Requirement 6.2**). Providers will be expected to administer a brief standardized, validated tool to aid the identification of children at risk of a developmental disorder in order to address the following areas, as age-appropriate: 1) speech and language development, 2) gross and fine motor development, 3) self-help and self-care skills, 4) social development, 5) cognitive development, and 6) presence of learning disabilities. At the 18 and 24 month well child visit, it is also required for practices to administer a structured autism-specific screening.

In the future, practices may be required to integrate behavioral health providers into primary care settings via co-location or through teleconsultation. MDH may pursue a menu of options for addressing mental health and/or substance use disorder. Leveraging the existing Office of Advanced Primary Care, MDH will continue to develop education materials and protocol training with partner agencies. MDH will also provide technical assistance to practices on establishing shared workflows, protocols, and training materials across provider/ community care teams for all staff, encouraging the use of evidence-based approaches to addressing behavioral health including SBIRT, MOUD and the Collaborative Care Model (CoCM). Maryland Medicaid expanded CoCM as a statewide benefit (from an initial pilot) and aligned billing (codes and rates) with Medicare, to streamline for providers. In addition, to increase access to the behavioral health workforce, the State will facilitate connections with behavioral health resources and vendors in the community. MDH will work to connect practices with existing behavioral health providers and resources to help meet the behavioral health needs of their population. For example, through MDPCP, MDH currently connects practices to technical assistance vendors in the community to support Collaborative Care Model integration. MDH also funds the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP), a free, state-wide program that supports pediatric primary care and emergency department providers in addressing pediatric behavioral health issues. MDH plans to ensure that Medicaid Advanced PCP providers are also aware of these resources for their patients.

As detailed above in Section 3, and in alignment with MDPCP, practices will be required to complete screening and referral to behavioral health, as indicated, and report on their activities through annual CTR reporting. MDH will monitor practice improvement by assessing progress on the CTRs over time, as well as the percentage of practices reporting that they are accomplishing the activity.

6. Specialty Care Coordination

For the start of the Medicaid Advanced PCP, participating practices will be required to establish routine screening processes for specialty care needs to facilitate referrals of patients to necessary appointments with specialists (**Care Transformation Requirement 3.1**). This coordination between primary care and specialists generally involves timely referrals, clear communication protocols between providers, assisting patients with identifying appropriate specialists and getting into specialist appointments, and information sharing between primary care and specialty providers. Regarding MCO coordination, MDH will facilitate discussions to create efficient workflows between practice organizations and MCOs to ensure specialist access. These discussions will explore leveraging health technology in CRISP and beyond for coordinating care between primary care providers and specialists. MDH will also prioritize ongoing patient monitoring opportunities (e.g. remote patient monitoring) between primary and specialists/care management programs.

In addition, MDH has worked with CRISP to implement the Specialist and Ancillary services report in an effort to drive value-based referrals and help providers manage utilization and costs. This report presents beneficiary counts, claim counts, and claim payment amount by type of procedure code. Using this report allows practices to identify specialty providers and services to which a primary care provider can refer their patient population, in consultation with the MCO. Currently, this resource is available to participants in MDPCP, and MDH may expand this report for all Medicaid Advanced PCP participants.

In the future, MDH will explore additional opportunities for improving coordination between primary care and specialists, in coordination with MCOs. This may include setting up systems for specialist e-consults or other advanced coordination workflows.

As detailed above in Section 3, and in alignment with MDPCP, practices will be required to refer to and coordinate with specialists as appropriate and report on their activities through annual CTR reporting. MDH will monitor practice improvement in monitoring the CTRs over time, as well as the percentage of practices reporting that they are accomplishing the activity.

7. Performance Accountability

I. Quality Measures

Primary care is widely recognized as the foundation of an equitable, efficient and high-quality health system. Establishing the right quality measures and monitoring them on a regular basis helps to keep track of the level and quality of primary care offered to beneficiaries. To determine quality measures, MDH identified measures that are actionable by primary care practices and that support both Medicaid and Medicare priorities. In addition, selecting a reasonable number of measures to minimize overburdening practices and ensuring consistency is critical to the success of the program.

In this context, the measures align with existing initiatives at federal and state level, such as PC AHEAD MDPCP, the Universal Foundation, CMS Core Sets, and state population health priorities. Measures already represented in other Maryland Medicaid quality improvement efforts received consideration,

including the Population Health Incentive Program, Performance Monitoring Plan and the HealthChoice Quality Strategy.

Measure selection also depends on availability of data and measure feasibility to ease regular reporting. The Department is analyzing the evolution of measure reporting methodologies—*i.e.,* administrative, electronic clinical quality measures and digital measures—and will work with state partners and CMS to determine an iterative approach for reporting.

Maryland is establishing a quality incentive program to start in calendar year (CY) 2026 (PY1). Measures are closely aligned to PC AHEAD and MDPCP. For PY1, Maryland's Medicaid Advanced PCP will have a mix of claims-based utilization measures, used on a pay-for-performance (P4P) basis as well as eCQMs, used on a pay-for-reporting (P4R) basis.

MDH will use the following measures for the Medicaid Advanced PCP in 2026:

II. Measures, Measure Details, and Payment Arrangements for the Medicaid Advanced PCP for 2026

Target Population	Measure Domain	Measure Title	Measure Identifier	Data Source	Payment Arrangement
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	CMIT 234	Medicaid claims	P4P
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	CMIT 14	Medicaid claims	P4P
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	CMIT 24	Medicaid claims	P4P
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	CMIT 1003	Medicaid claims	P4P
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan (CDF-CF and AD): Ages 12 to 64	CMIT 672	eCQMs through CRISP	P4R
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CDC-HbA1c Poor Control)	CMIT 204	eCQMs through CRISP	P4R
Adults	Chronic	Controlling High Blood	CMIT 167	eCQMs through	P4R

Target Population	Measure Domain	Measure Title	Measure Identifier	Data Source	Payment Arrangement
	Conditions	Pressure (CBP)		CRISP	
Adults	Prevention & Wellness	Colorectal Cancer Screening	CMIT 139	eCQMs through CRISP	P4R

Notes: P4P = pay-for-performance; P4R = pay-for reporting

All participating primary care providers (PCPs) that meet the minimum threshold of members or events in each measure's denominator will be subject to P4P. If a participating PCP does not meet the minimum threshold, that measure will not apply to that provider. Maryland will follow NCQA guidelines to define the minimum threshold per measure. Participating PCPs will be encouraged to report the four eCQM measures through the state's health information exchange, CRISP. If they do not, they will not qualify to earn the P4R incentive.

III. Incentive Methodology

Quality incentive payments will be made retrospectively after the Performance Year, once scoring on the claims and eCQMs are complete. Regarding **target setting,** MDH aims to align strongly with PC AHEAD methodology. MDH will set targets that reward primary care organizations for either 1) being high-performers compared to a fixed benchmark; or 2) improvements in their performance from the previous year. MDH will utilize Medicaid claims and encounter data from 2024 dates of service as **baselines** to set targets for program year 2026. Regarding **incentive distribution,** MDH will first set a quality incentive PMPM amount. This PMPM amount will be determined once all TINs have committed to Program Year 2026 participation and the budget can be finalized. Each measure will have an equal weight in the quality incentive PMPM amount, with P4P measures having the same weight and P4R measures weighing 50% of one P4P measure.

MDH is choosing to make eCQM measures pay-for-reporting in the first two Performance Years of the Medicaid Advanced PCP. Using pay-for-reporting will allow MDH to understand the capacity of practices to report eCQM measures using their EHRs and develop strategies to overcome barriers to eCQM reporting. The Maryland primary care provider community has advised MDH that practices currently have various technical and operational challenges pulling eCQM data from EHRs. MDH plans to transition to pay-for-performance for eCQMs in Performance Year 3, once MDH has deployed a strategy to assist practices with overcoming technical barriers. MDH will also welcome guidance from CMMI and other technical experts on implementing this transition which may include partnership with EHR vendors.

Participating TINs will receive the quality incentive, separate from Care Management Fee payments, paid out retrospectively after the Program Year end.

8. Enhanced Primary Care Payment

I. Payments

To support the State's goals of increasing primary care investment through the Medicaid Advanced PCP, MDH will provide a hybrid of fee-for-service and population-based payments. The alternative payment model for the Medicaid Advanced PCP consists of three funding streams:

1) Increased E&M rates for all primary care providers that accept Maryland Medicaid;
2) Care Management Fees for practices participating in the Medicaid Advanced PCP; and
3) Performance-based incentives for practices participating in the Medicaid Advanced PCP, beginning in Calendar Year 2026, as described in the Performance Accountability section.

II. E&M Rate Increase for All Medicaid PCPs

To increase Maryland's competitiveness in recruiting PCPs and retain the existing primary care workforce, MDH will increase E&M rates for all PCPs that accept Maryland Medicaid. The increased rates will be for all PCPs billing Medicaid in the state, both on a fee-for-service (FFS) basis or through the HealthChoice managed care program and regardless of participation in Medicaid Advanced PCP. The enhanced E&M rate applies for CPT codes 99202-99499 and G2211.

III. Care Management Fees

Primary care practices that participate in Medicaid Advanced PCP will also receive a per member, per month (PMPM) payment for HealthChoice participants assigned to the practice. The Care Management Fee is a population-based payment, according to the HCPLAN APM Framework. To receive the payment for assigned members from a particular MCO, practices must contract with that MCO. The PMPM will be a flat fee of $2 per-member-per-month across all qualifying HealthChoice participants, which the practice will apply to meeting the Medicaid Advanced PCP Care Transformation Requirements (Appendix).

To effectuate the PMPM payments, MDH will calculate the amount for each practice on a quarterly basis. MDH will process payments to each MCO and communicate amounts for each practice organization to the MCOs, who will pay those amounts to the practices, prospectively, on a quarterly basis. Once paid, MCOs will not recoup Care Management Fees from the primary care organizations.

Appendix. Medicaid Advanced PCP Care Transformation Requirements and CRISP Requirements Table

Advanced Primary Care Function	CTR #	Care Transformation Requirement	Care Transformation Requirement (Full Text)	Aligns with CMS Criteria #	CMS Criteria Language
Access and Continuity	1.1	Empanelment of Medicaid participants to a provider using MCO assignment	Use Managed Care Organization (MCO) assignment of a Medicaid member to a PCP to empanel Medicaid participants to a provider	2.2	Empanelment of each patient to a primary care clinician
Access and Continuity	1.4	At least one alternative care strategy (includes same or next-day appointments, telehealth, patient portal, after hours or weekend visit)	Ensure Medicaid members have regular access to the care team or provider through at least one alternative care strategy (e.g. same or next-day appointments, telehealth, patient portal, after hours or weekend visit)	3.4	Patient access and continuity
Access and Continuity	1.5	Assigned member outreach to those not engaged with primary care	Outreach to assigned Medicaid members who have not been seen by primary care, with the goal of getting them in for a visit and maintaining regular contact.	3.4	Patient access and continuity
Care Management	2.2b	Provide transitional care management	Ensure Medicaid members who have received follow-up after ED, hospital discharge, or other triggering event receive short-term (episodic) care management	3.1	Planned coordination of chronic and preventive care
Care Management	2.5	Follow up within 2 business days post hospital discharge and within 1 week post ED discharge (50% threshold)	Ensure Medicaid members receive a follow-up interaction from the practice within one week for ED discharges and two business days for hospital discharges (expect a 50% threshold for hospital & ED follow-up rates)	3.1	Planned coordination of chronic and preventive care
Comprehensiveness and Coordination	3.1	Specialist referral management - use a process to refer patients to necessary appointments with specialists	Specialist referral management - use a process to refer patients to necessary appointments with specialists	3.3; 6	Coordination of care across clinician types; Specialty Care Integration

Comprehensiveness and Coordination	3.3	Behavioral health screening and referral - use measurement-based care for behavioral health leveraging standardized screening tools	Behavioral health screening and referral - use measurement-based care for behavioral health for Medicaid members, leveraging standardized screening tools. Refer members as necessary to the behavioral health Administrative Services Organization (ASO), Carelon, for care coordination.	5	Behavioral Health Integration
Comprehensiveness and Coordination	3.4	Social support services screening and linkages	Screen Medicaid members for social support services needs using a standardized screening tool. Facilitate access to resources that are available in the practice's community for Medicaid members with identified needs.	2.1; 4	Whole-person care through a team-based model; Health Promotion Activity Integration
Pediatrics Requirements	6.1	Newborn appointment availability	Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice (AAP)	3.4	Patient access and continuity
Pediatrics Requirements	6.2	Developmental and autism screenings within the scope of primary care	Providers should administer a brief standardized, validated tool to aid the identification of children at risk of a developmental disorder in order to address the following areas, as age-appropriate: 1) speech and language development 2) gross and fine motor development, 3) self-help and self-care skills, 4) social development, 5) cognitive development, and 6) presence of learning disabilities. At the 18 and 24 month well child visit, it is also required to administer a structured autism specific screening. For recommended screening tools and more information, please refer to the Maryland HealthyKids manual here.	5	Behavioral Health Integration
Pediatrics Requirements	6.3	Complete forms for participation in school and/or childcare	In a timely manner, providers should complete forms needed for participation in school, early childcare, and sports as appropriate. These may include the Maryland Department of Education Health Inventory form, Medication Administration Authorization form, or the	3.3	Coordination of care across clinician types

			Immunization Certification form. These forms may be provided by the parent/legal guardian, but can also be downloaded from the Maryland Department of Education website.		
CRISP Requirements	C.1	Submit CRISP Event Notification Delivery (CEND) panel every 90 days	Submit or update a CRISP Event Notification Delivery (CEND) panel every 90 days.	2.3; 3.1	Patient data collection and management; Planned coordination of chronic and preventive care
CRISP Requirements	C.2	Pull MCO assignment list from CRISP and upload as a panel to the CRISP Multi-payer platform.	Download the practice organization's MCO assignment list from the CRISP 'All-Payer Population' tile on a quarterly basis to understand Medicaid member assignment.	2.3	Patient data collection and management
CRISP Requirements	C.3	Review Prediction Tools on a monthly basis	View the Prediction Tools reports in the Multi-Payer Reports platform within CRISP at least every 30 days.	2.3	Patient data collection and management
CRISP Requirements	C.4	Use the Multi-Payer Reports Platform at least quarterly to monitor data for quality improvement over time	Use the Multi-Payer Reports Platform in CRISP at least quarterly to monitor data for quality improvement over time	2.4	Quality improvement

Note: CTR#s 1.1-3.4 use the aligned requirement number from MDPCP.