Medicaid Path Program Manual

Maryland's AHEAD Primary Care Programs

Program Year 2026

Updated December 30, 2025

Glossary

Acronym	Expansion
ADT	Admission, Discharge, and Transfer
CEND	CRISP Event Notification Delivery
CMFs	Care Management Fees
CMS	Centers for Medicare and Medicaid Services
CRISP	Chesapeake Regional Information System for Patients
CRS	CRISP Reporting Services
CTR	Care Transformation Requirements
CY	Calendar Year
ED	Emergency Department
EQIP-PC	Episode Quality Improvement Program for Primary Care
E&M	Evaluation & Management
FAQs	Frequently Asked Questions
HIE	Health Information Exchange
MCO	Medicaid Managed Care Organization
MDH	Maryland Department of Health
MDPCP	Maryland Primary Care Program
MDPCP AHEAD	Maryland Primary Care Program AHEAD
OAPC	Office of Advanced Primary Care
P4P	Pay-for-performance
P4R	Pay-for-reporting
PC AHEAD	Primary Care AHEAD
PCP	Primary Care Provider
PMPM	Per Member Per Month
PY	Program Year
TIN	Tax Identification Number

Introduction

The Medicaid Path is Maryland's Medicaid Alternative Payment Model (APM) for primary care under the State's participation in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. The Medicaid Path launched on August 1, 2025, with its first cohort of practice organizations. This Program Manual describes the program details and requirements, including eligibility criteria, payments, reporting, and care delivery for the 2026 Program Year.

Background

On November 12, 2025, Governor Wes Moore and the Centers for Medicare & Medicaid Services (CMS) Administrator signed Maryland's State Agreement to participate in the federal AHEAD Model from 2026 through 2035. Under the AHEAD model, Maryland envisions building a sustainable advanced primary care system that provides high-quality, whole-person care for all Marylanders and supports strong linkages across the healthcare continuum. Leveraging the success of the Maryland Primary Care Program (MDPCP) established under the Total Cost of Care Model, AHEAD aims to improve health outcomes for all people in Maryland, while simplifying the administrative burdens for providers through all-payer alignment. As a result, the Maryland Department of Health (MDH) has established Maryland's AHEAD Primary Care Programs to drive investment and facilitate implementation of advanced primary care.

A foundational component of the AHEAD Primary Care Programs is the Medicaid Path (Medicaid Advanced Primary Care Program), a new Medicaid primary care APM to incentivize comprehensive primary care for Medicaid members in Maryland. The Medicaid Path is an advanced primary care model. Advanced primary care is a delivery model that expands the role of primary care to include services such as care management, integrated behavioral health, and data-informed care. Advanced primary care focuses on quality over volume, and payments to primary care practices participating in the model reflect this shift.

In addition to the Medicaid Path, Maryland's AHEAD Primary Care Programs include an Infrastructure Path and two Medicare Paths, described briefly below.

Infrastructure Path

The Infrastructure Path, also known as EQIP-PC, is a grant program that supports the building of new or expansion of advanced primary care access in underserved areas of the state. Eleven practice sites were awarded this time-limited funding. The program started in January 2025 and is scheduled to run through 2027.

Medicare Path

The Medicare Path includes two options: one for current MDPCP practices (Medicare Path 2, also known as MDPCP-AHEAD) and an option for practices that are not currently participating in

MDPCP (Medicare Path 1, also known as Primary Care AHEAD (PC AHEAD)). Medicare Path 1 is a new program established by CMS under AHEAD that began in January 2026. Medicare Path 2 is the current, ongoing Medicare advanced primary care program in Maryland, formerly known as MDPCP.

Table 1. State of Maryland vs. AHEAD State Agreement Program Nomenclature.

State Name	AHEAD State Agreement Name	Description	Program Start Date
Infrastructure Path	Episode Quality Improvement Program for Primary Care (EQIP-PC)	Infrastructure program to build new primary care practices (new)	January 2025
Medicare Path 1	Primary Care AHEAD (PC AHEAD)	Medicare entry level advanced primary care program (new)	January 2026
Medicare Path 2	Maryland Primary Care Program AHEAD (MDPCP-AHEAD)	Medicare advanced primary care program (formerly MDPCP Track 2)	Ongoing
Medicaid Path	Medicaid Advanced Primary Care Program (Medicaid Advanced PCP)	Medicaid entry level advanced primary care program (new)	August 2025

This Program Manual describes the features and details of the Medicaid Path for participation from January to December 2026.

Eligibility

Eligible Provider Types

The eligible provider types under Maryland's Medicaid Path align with the State's definition of primary care providers (PCPs) for the HealthChoice program. These primary care provider types represent those that offer the full spectrum of preventative care, diagnosis, and treatment, rather than a narrow specialization. The eligible types are as follows:

- General Practice;
- Family Medicine;
- Internal Medicine;
- Pediatric Medicine;
- Nurse Practitioner; and
- Physician Assistant

Eligible Practice Organizations

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

Practice organizations (TINs) must meet the following criteria to participate in the Medicaid Path:

- Serve as Medicaid primary care medical homes (i.e., HealthChoice members may select or be assigned to them under their selected HealthChoice managed care organization (MCO));
- Have a minimum of 250 assigned HealthChoice members at the TIN level across all MCOs as of March 15, 2025; and
- Opt in to participate in the Medicaid Path by signing a contract addendum with eligible MCOs.

Future Program Years

There will be additional opportunities to apply to the Medicaid Path for future program years. For entrance in January 2027, the State expects additional eligibility pathways to be available for more practices to join. Details on these eligibility criteria will be released as they become available.

Care Transformation Requirements

In the sections below on Primary Care Clinical Standards and Primary Care Coordination Standards, the key functions of primary care transformation are outlined. Practice organizations are expected to work towards fully meeting these requirements. MDH has Care Transformation Requirements (CTR) for the Medicaid Path to ensure that practice organizations implement sustainable transformation efforts and to align program payments with the resources necessary to implement care transformation activities. The detailed list of the Care Transformation Requirements (CTRs) is available in Appendix A. MDH will monitor the practice organizations' progress using an annual reporting tool. For Year 1, MDH will conduct a baseline assessment. Progress reporting will begin in Year 2 (2027).

To support practice organizations in achieving the Care Transformation Requirements, MDH established the Care Management Workgroup, a subgroup of AHEAD PC Advisory Council members, to develop a Medicaid Path Roles and Responsibilities Matrix (see Appendix B). The Roles and Responsibilities Matrix focuses on communication between the practice organization and the MCO, outreach between the practice organization and unengaged Medicaid members, and episodic care management. It is designed to identify the Medicaid Path program requirement and the recommended workflow delineated between the MCO and the practice organizations.

The Care Management Workgroup continues to meet to review best practice standards. Additional guidance will be made available on Maryland's AHEAD Primary Care Programs website in late summer 2026.

Primary Care Clinical Standards

MDH established statewide primary care clinical standards for the Medicaid Path to ensure that participating practice organizations are working towards common goals and frameworks for advanced primary care.

Whole-Person Care Through a Team-Based Model

Practice organizations will employ a team-based model of care to meet the program's Care Transformation Requirements. This 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. Practice organizations may partner with MCOs to integrate additional team supports, such as pharmacists for medication management and certified disease educators.

Practice organizations are required to take a whole-person care approach by prioritizing the needs of the member beyond disease management, and accounting for the physical, mental, emotional, social, and environmental factors that contribute to a person's health. To ensure whole-person care, practice organizations will be required to incorporate health promotion activities into care for Medicaid members, such as screenings for social support services.

Practice organizations will be expected to use a standardized social needs screening tool of their choice and provide referrals as appropriate (CTR 3.4).

Empanelment of Each Patient to a Primary Care Clinician

Empanelment of members in the Medicaid Path will occur via assignment of each HealthChoice member to a primary care provider. Each MCO in Maryland requires its members to select a primary care provider as the initial method of assignment, prioritizing 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 Path are expected to use the MCO assignment of members as their method for empanelment of patients to primary care providers (CTR 1.1).

Data on MCO member assignment to practice organizations will be provided to practices at the beginning of each quarter via the Chesapeake Regional Information System for Patients (CRISP) platform. This will enable practice organizations to access a single list of assigned members across MCOs in one place. Participating practice organizations are required to download this assigned member list in CRISP every quarter (CRISP Req. C.2).

Patient Data Collection and Management

Practice organizations are required to have a connection with CRISP, enabling the use of several tools for patient data collection and management, including claims-based reports for monitoring cost and utilization trends; event prediction tools; admission, discharge, and transfer

(ADT) notifications through the CRISP Event Notification Delivery (CEND) system; and Prescription Drug Monitoring Program reports.

Practice organizations will also have distinct requirements for using specific tools within CRISP, including CEND and submission of an MCO assignment panel to CEND at least every 90 days (CRISP Req. C.1). Practice organizations will use CEND for real-time data on ADT notifications for their patient panels, enabling practices to follow up with their patients post-discharge. Practice organizations must also use the Prediction Tools reports within CRISP, a set of reports that calculate and show the probability of adverse outcomes for assigned patients, each month (CRISP Req. C.3). Using these reports can help ensure high-risk patients are outreached and engaged in care management, helping to prevent increased unnecessary utilization. The Prediction Tools reports show data for practice organizations' Medicare and Medicaid patients together, enabling multi-payer practice care transformation.

Quality Improvement

Practice organizations in the Medicaid Path are required to use the Multi-Payer Reports Platform within CRISP to monitor quality (CRISP Req. C.4). 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 the use of this tool is for practice organizations to track process and outcome measures, and to use this data for quality improvement over time on a multi-payer basis.

Primary Care Coordination Standards

Primary care coordination standards will focus on planned coordination of chronic and preventive care, risk-stratified care management, and patient access and continuity. 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 practice organizations reporting that they are accomplishing each activity or meeting each requirement.

Planned Coordination of Chronic and Preventive Care

Standards that coordinate chronic and preventive care management will include Care Transformation Requirements for practice organizations to perform transitional care management (CTR 2.2b) and follow-up with patients after inpatient and Emergency Department (ED) discharge (CTR 2.5). Practice organizations are required 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 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. Practice organizations will 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 Req.C.1).

Risk-Stratified Care Management

Practice organizations will coordinate with MCOs to address the wide spectrum of needs for Medicaid members. To support practice organizations in delivering risk-stratified care management, MDH will provide tools in CRISP to help practice organizations more efficiently deploy limited care management resources. In 2026, practice organizations are required to conduct outreach to assigned members and provide episodic or transitional care management. MCOs will continue to provide longitudinal care management. Practice organizations should refer members to MCOs as appropriate and begin building capacity to support this work in the future. Practice organizations should use the Prediction Tools reports within CRISP to identify high-risk members for outreach and engagement in care management, helping to prevent unnecessary utilization.

Coordination of Care Across Clinician Types

MDH has established requirements for practice organizations to have a process to refer patients to necessary appointments with specialists (CTR 3.1). Practice organizations must have a referral relationship with specialists for specialty care, and PCPs will work with specialists to coordinate care. For pediatric practice organizations, MDH also requires practices to complete necessary forms for participation in a school or childcare setting (CTR 6.3).

Patient Access and Continuity

Patient access and continuity are core components of MDH's Care Transformation Requirements. Practice organizations must 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 (CTR 1.4). Practice organizations must conduct outreach to assigned Medicaid members who have not been seen at the practice, in partnership with the MCOs (CTR 1.5). Because assignment in the Medicaid Path uses MCO assignment, a practice organization may be assigned a Medicaid member that they have never seen for care. Outreaching these members, encouraging them to schedule 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 practice organizations with pediatric patients, MDH also has standards for appointment availability for newborns (CTR 6.1), following American Academy of Pediatrics (AAP) guidelines.

Health Promotion Activity Coordination

Practice organizations in the Medicaid Path must incorporate health promotion activities by screening their assigned members for social support services, such as transportation and nutrition supports. Practice organizations are required to use a standardized social support

services screening tool of their choice, and must facilitate referrals and linkages to community-based organizations (CBOs) to address needs as appropriate, including referrals to food and nutrition support services, medical transportation, and supportive housing resources (CTR 3.4). To support these activities, MDH has developed data-sharing tools in CRISP, including the sharing of needs assessment data and analytics reports on sub-populations. These tools can then be used to drive accountability partnerships between primary care and social support services.MDH will provide technical assistance and shared learning forums to help practice organizations 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)

Beyond social supports, practice organizations must 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.

Behavioral Health Integration

Behavioral health integration is a key feature of the Medicaid Path. Practice organizations are required to establish a routine screening process for behavioral health needs. Practice organizations will use measurement-based care for behavioral health, leveraging standard screening tools to diagnose behavioral health conditions. For Medicaid members, practice organizations will facilitate referrals and warm handoffs to specialists or community organizations. This may include referring eligible members for those in need of specialty behavioral health services beyond the scope of the primary care provider, to care coordination with Maryland's Behavioral Health Administrative Services Organization (BHASO), Carelon (CTR 3.3).

Pediatric practices in the Medicaid Path are required to screen children for autism or developmental disorders, within the scope of primary care (CTR 6.2). Providers are expected to administer a brief standardized, validated tool to aid the identification of children at risk of a developmental disorder 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 visits, practice organizations are required to administer a structured autism-specific screening.

Specialty Care Coordination

Practice organizations will establish routine screening processes for specialty care needs to facilitate referrals of members to necessary appointments with specialists (CTR 3.1). This coordination between primary care and specialists generally involves timely referrals, clear communication protocols between providers, assisting members with identifying appropriate specialists and getting into specialist appointments, and information sharing between primary care and specialty providers.

Performance Accountability

Quality Incentives

Starting in 2026, participating practice organizations will be eligible for a quality incentive payment. Below is a brief overview of the quality incentive component of the program. The detailed methodology will be made available on Maryland's AHEAD Primary Care Programs website in early 2026.

Approach and Measures

The first measurement period begins January 1, 2026. Performance Year 1 will be for 2026 dates of service (1/1/26 - 12/31/26), calculated in the summer or fall of 2027. Measures will be a combination of claims-based and electronic Clinical Quality Measures (eCQMs). MDH will assess claims-based measures automatically and will not require additional reporting from practice organizations for these measures. eCQMs will be reported by the practice organization in the first quarter of the following year (2027). MDH used the following key principles to develop the measure set:

- Align measures and methodology with other AHEAD Primary Care Programs
- Select validated measures aligned with population health priorities
- Minimize administrative burden on practice organizations

MDH will utilize two payment arrangements in its Medicaid AHEAD Primary Care Quality Incentive program for 2026. Figure 1 outlines the combination of Pay for Performance (P4P) and Pay for Reporting (P4R) measures. Participating TINs will receive the quality incentive, separate from Care Management Fee payments, paid out retrospectively after the Program Year end.

Figure 1. Overview of Quality Incentive Design

Pay-for-Performance (P4P) - Claims	Pay-for-Reporting (P4R) - eCQMs

• MDH will provide incentives for performance on specific claims-based measures.
• No reporting required.
• 4 measures - 2 Child, 2 Adult.
• P4P Domains
  ○ Health Care Utilization
  ○ Primary Care Access and Preventive Care
	• MDH will provide incentives for reporting specific clinical quality measures.
	• Participating practice organizations must report their performance measures to MDH via CRISP.
	• 4 measures - 1 Child, 4 Adult.
	• P4R Domains
	  ○ Behavioral Health
	  ○ Chronic Conditions
	  ○ Prevention and Wellness

The measures for the Medicaid Path are listed in the table below:

Table 2. Quality Measures for 2026

Population	Measure Domain	Measure Title	Data Source	2026
Adults	Healthcare Utilization	Emergency Department Utilization (EDU)	Medicaid claims	P4P
Adults	Healthcare Utilization	Acute Hospital Utilization (AHU)	Medicaid claims	P4P
Children	Primary Care Access and Preventive Care	Child and Adolescent Well-Care Visits (WCV)	Medicaid claims	P4P
Children	Primary Care Access and Preventive Care	Developmental Screening in the First Three Years of Life (DEV-CH)	Medicaid claims	P4P
Children and Adults	Behavioral Health (BH)	Screening for Depression and Follow-Up Plan (CDF-CF and AD): Ages 12 to 64	eCQMs through CRISP	P4R
Adults	Chronic Conditions	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (CDC-HbA1c Poor Control)	eCQMs through CRISP	P4R
Adults	Chronic Conditions	Controlling High Blood Pressure (CBP)	eCQMs through CRISP	P4R
Adults	Prevention & Wellness	Colorectal Cancer Screening	eCQMs through CRISP	P4R

All participating primary care practice organizations that meet the minimum threshold of members or events in each measure's denominator will be subject to P4P. If a participating practice organization does not meet the minimum threshold, that measure will not apply to that provider. Maryland will follow the National Committee for Quality Assurance (NCQA) guidelines to define the minimum threshold per measure. Participating practice organizations 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.

For more details on the quality incentive component, please review the Medicaid Path Quality Incentive Methodologies on Maryland's AHEAD Primary Care Programs website.

Payments

Evaluation & Management (E&M) Rate Increase for all Maryland Medicaid PCPs

To increase Maryland's competitiveness in recruiting PCPs and retain the existing primary care workforce, MDH increased E&M rates for all PCPs that accept Maryland Medicaid, effective August 1, 2025. The one-time 103% of Medicare Physician Fee Schedule (PFS) rate increase for the 2025 baseline rates applies to 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 the Medicaid Path. The enhanced E&M rate applies to CPT codes 99202-99499 and G2211. Increases do not affect the FQHC prospective payment rates.

For more information, see the Maryland Medical Assistance Program Provider Transmittal 88-25 dated June 27, 2025.

Care Management Fees (CMFs)

Primary care practice organizations that participate in Medicaid Path will receive a per-member, per-month (PMPM) payment for HealthChoice members assigned to them. To receive the payment for assigned members from a particular MCO, practice organizations must sign a contract addendum with that MCO to participate in the Medicaid Path with that MCO. The PMPM will be a flat fee of $2 PMPM across all qualifying HealthChoice members. In an effort to support practice-wide transformation for your Medicaid members, the practice organization is expected to use this CMF to meet the care delivery expectations described in the Care Transformation Requirements section of this Program Manual.

To effectuate the CMF payments, MDH will calculate the payment amount for each practice organization every quarter. These calculations are based on MCO practice - primary care provider assignment data. MDH will process payments to each MCO and communicate amounts for each practice organization to the MCOs, who will pay those amounts to the practice

organizations, prospectively, quarterly. The Care Management Fees are not at-risk. However, if appropriate, MDH may adjust payments due to error or other discrepancies.

The table below shows the CMF payment schedule for the calendar year 2026. Note that the table includes when the list of assigned members will be available on CRISP for practice organizations' review.

Table 3. Medicaid Path CMF payment schedule for 2026

Program Quarter	Prospective Payments Date Period	HealthChoice Member Assignment List Available on CRISP	Payments from MCOs to PCPs (est.)
CY 2026 Q1	Late-January 2026	January 2026 release	Mid-January 2026
CY 2026 Q2	Late-April 2026	April 2026 release	Mid-April 2026
CY 2026 Q3	Late-July 2026	July 2026 release	Mid-July 2026
CY 2026 Q4	Late-October 2026	October 2026 release	Mid-October 2026

Data Infrastructure

Platforms

CRISP HIE Portal

The Chesapeake Regional Information System for Patients (CRISP) health information exchange (HIE) Portal is a secure, web-based tool for healthcare providers to access and share patient health information; labs, radiology reports, and discharge summaries, in real-time, improving care coordination by connecting disparate systems for better, safer, and more efficient patient-centered care. It allows clinicians to view a consolidated patient record from multiple organizations on one platform, supporting immediate clinical decisions and population health initiatives. The CRISP Portal allows users with access to clinical data to search patients directly from the home page and launch searched patient data into various applications.

Your practice organization is expected to meet care delivery expectations, as outlined in the Care Transformation Requirements section of this Program Manual.

Multi-Payer Reports

The Multi-Payer Reporting Suite includes 15 top-level, Tableau-based 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 patient population, agnostic to payer. The reporting suite provides population-level, aggregate views, as well as beneficiary and claim-level details. Population Navigator allows users to custom-curate their own patient lists within their CRISP patient panels to investigate sub-populations more easily.

Tools and Data

CEND Panels

The CEND tool provides users with real-time alerts about members' hospital encounters by matching an organization's member panel with up-to-date encounter admission, discharge, and transfer (ADT) data. These alerts are delivered directly into the practice organization's workflow via CRISP Population Explorer. CEND can also create alerts beyond just ADT data, tailored to each practice's specific needs. This can include real-time alerts for health factors such as A1C levels, diabetes risk, hospitalizations, and social determinants of health.

MCO Assignment List

The MCO Assignment List provides each practice organization with the official accounting of all Medicaid MCO members for whom you are responsible for providing advanced primary care under the Medicaid Path. This list also represents the members for whom you will be receiving care management payments. The MCO Assignment List is made available through CRS and updated quarterly. Practice organizations will download the updated assignment list each quarter.

Each practice organization's designated CRISP point of contact can download the MCO Assignment List as an Excel file from the All-Payer Population tile in CRS. This file will help you understand your assigned patient population by providing member demographic characteristics as well as pertinent program information, such as the specific assigned primary care provider.

Practice organizations will submit the MCO Assignment List to CRISP's Panel Processor via the HIE Portal to create a panel of their designated members to be viewed in the Multi-Payer Reporting Suite. The Multi-Payer Reporting Suite is powered by the most recent 36 months of Medicaid encounters. The Multi-Payer Reporting Suite contains numerous utilization- and quality-focused reports to help users understand populations' and members' patterns of care to better inform care management interventions. By creating a panel exclusively of MCO assigned members, users can investigate the population-specific patterns related to the Medicaid Path.

Practice organizations are encouraged to create a single CRISP Medicaid Path specific panel for all assigned members within the TIN and then create individual rosters to help users focus

on a subset of the patient population. For example, you could create a roster of members for each primary care provider or look within or across providers to isolate members with select chronic conditions or utilization patterns. Additional information on how to download the MCO Assignment List and create an updated panel is available in the MCO Assignment List Quick Guide and in the CRS All-Payer Population tab. For more information, please visit the CRISP AHEAD Maryland Primary Care Programs page.

Practice Organization Supports

One of the primary supports the MDH provides for practice organizations in the Medicaid Path is Practice Transformation Coaches (hereinafter referred to as "Practice Coaches"). Practice Coaches are a no-cost, State-funded resource available to provide a variety of assistance to practice organizations, including: technical assistance with CTRs, connection to resources and materials, help with reporting and compliance, coordination of other support vendors, and targeted workflow review. Practice Coaches are part of MDH's Office of Advanced Primary Care (OAPC), an office dedicated to supporting primary care practice participation in State-run advanced primary care payment models.

In addition to Practice Coaches, OAPC provides a suite of support to practice organizations in the form of educational materials, resources, and technical assistance. These supports are expected to include:

- A suite of data tools and reports, created in partnership with CRISP. Practice organizations can access claims-based data reports to assist with member risk stratification, to view performance on utilization and cost trends, and more. Refer back to the Data Infrastructure section for additional details.
- An interactive State-led, MDPCP Learning System, designed to provide support meetings and live virtual learning events to enable peer-to-peer learning and subject matter expert presentations on topics relevant to advanced primary care. Please visit the 2026 Learning Live Calendar to view upcoming events.
- Additional assistance on key focus areas, such as behavioral health integration.

OAPC provides these resources as part of your participation in Maryland's AHEAD Primary Care Programs. In early 2026, Practice Coaches will reach out to your organization to introduce themselves to current MDPCP points of contact or the contacts listed on your State vetting application.

Reporting and CRISP Requirements

MDH will use process measures to evaluate progress and maturity on Care Transformation Requirement (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 practice organizations reporting that they are accomplishing

each activity or meeting each requirement. MDH may require other information or add additional requirements as deemed necessary.

Reporting Requirements

Baseline Assessment

In quarter one of 2026, practice organizations will complete a baseline assessment Practice organizations will report on the Advanced Primary Care Functions of: Access and Continuity, Care Management, Comprehensiveness and Coordination, Pediatric Requirements (as applicable), and the CRISP Requirements. See Appendix A.

Annual Care Transformation Requirements

Beginning in the first calendar quarter of 2027, practice organizations will complete reporting on Care Transformation Requirements with a measurement period of the entire previous program year. MDH will use the data collected to evaluate the practice organizations' progress and maturity over time. See Appendix A.

Electronic Clinical Quality Measures

Beginning in the first quarter of calendar year 2027, with a measurement period of the entire previous program year, practice organizations will report to MDH a performance rate and the values used to calculate the performance rate for each eCQM in the set of Medicaid Path eCQM measures in the Approach and Measures section (Tab. 2), using data from all months of the measurement period. Practice organizations will report the data described to MDH through CRISP.

CRISP Requirements

This section will cover the four CRISP requirements to support advanced primary care. Practice organizations in the Medicaid Path will have two types of CRISP panels: 1) the Practice Panel is a list of all active primary care patients at the practice organization; and 2) the MCO Assignment List is the panel of HealthChoice members that may include some patients not currently active at your practice organization, but practice organizations are expected to outreach to and attempt to engage in primary care.

Upload Practice Panel

Practice organizations must upload their CEND Practice Panel to the CRISP Panel Processor every 90 days (CRISP Req. C.1). The CEND tool provides users with real-time alerts about patients' hospital encounters by matching an organization's patient roster (or "panel") with up-to-date encounter ADT data. Panels uploaded via the Panel Processor drive access to provider patient lookup without requiring additional verification of the treatment relationship in

the Portal. For more information on creating and managing panels, please view the CEND & Population Explorer User Guide, Panel Processor User Guide, or email support@crisphealth.org.

Download MCO Assignment List

Practice organizations must download their MCO Assignment at the beginning of every quarter via the CRISP Multi-Payer Platform (CRISP Req. C.2). As a reminder, MCO Assignment Lists are a compilation of all HealthChoice members assigned to your practice organization, which may be different from the CRISP Practice Panels. Practice organizations will review the MCO Assignment List to identify any members who are not active at their practice and conduct outreach to engage these members in primary care. Practice organizations must contact support@crisphealth.org to request second panel access to the MCO Panel. Once the practice organization has second panel access, they will upload the MCO Assignment List and a CEND panel via the CRISP Panel Processor before the end of each quarter in which the MCO Assignment List was downloaded. For additional information, please review the orientation webinar recordings on Multi-Payer Training Part One and Multi-Payer Training Part Two.

Review Prediction Tools

Practice organizations must review the prediction tools available in the CRISP Multi-Payer Report Platform at least every 30 days (CRISP Req. C.3). The predictive models are updated monthly with the release of Claim and Claim Line Feed (CCLF) files. Scores can be used by practice organizations to identify members with the highest risk of potentially avoidable events, allowing practice organizations to target their care management and interventions.

Monitor Quality Data on the Multi-Payer Report Platform

Practice organizations must review and monitor the Multi-Payer Report Platform report data for quality improvement over time (CRISP Req. C.4). Practice organizations have access to several reports that cover metrics of interest for Medicare and/or Medicaid members. As available, reports contain metrics for comparison group populations to help the user view their trends with an overall perspective within Medicare or Medicaid utilization across the state of Maryland.

Appendix A

Care Transformation Requirements Table

The Care Transformation Requirement table below is for Performance Year 2026.

Advance Primary Care Function	CTR #	Care Transformation Requirements	Care Transformation Requirements (Full Text)	Aligns with CMS Criteria #	CMS Criteria Language
Access and Continuity	1.1	Empanelment of Medicaid members 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%**	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%	3.1	Planned coordination of chronic and preventive care

Advance Primary Care Function	CTR #	Care Transformation Requirements	Care Transformation Requirements (Full Text)	Aligns with CMS Criteria #	CMS Criteria Language
		threshold).	threshold for hospital & ED follow-up rates)		
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

Advance Primary Care Function	CTR #	Care Transformation Requirements	Care Transformation Requirements (Full Text)	Aligns with CMS Criteria #	CMS Criteria Language
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 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 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.	3.3	Coordination of care across clinician types

Advance Primary Care Function	CTR #	Care Transformation Requirements	Care Transformation Requirements (Full Text)	Aligns with CMS Criteria #	CMS Criteria Language
CRISP Requirements	C.1	Submit the 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 'AllPayer 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# 1.1-3.4 use the aligned requirements number from MDPCP.

Appendix B

Care Management Roles and Responsibilities Matrix PY 2026

Medicaid Path Program Requirements				**Recommended Best Practice Workflow**	
Advanced Primary Care Function	CTR #	Care Transformation Requirement	Defined As	MCO Responsibility	Practice Organization Responsibility
Comprehensiveness and Coordination	N/A	N/A	Communication between the MCO and practice organization.	**Care Team Updates - Contacts:** Provide the practice organization with the contact information for care team members. • Examples include: name(s), email address(es), and telephone number(s). **Routine meetings:** Establish a routine communication to review members engaged with the care team, changes to the care team, or other pertinent updates. • Examples include: bi-weekly, monthly, or quarterly.	**Care Team Updates - Contacts:** Provide the MCO with the contact information for care team members. • Examples include: name(s), email address(es), and telephone number(s). **Routine meetings:** Review and respond to communications to review members engaged with the care team, changes to the care team, or other pertinent updates. • Examples include: bi-weekly, monthly, or quarterly.
Access and Continuity	1.5	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.	Outreach to Medicaid members who are not already engaged with the practice organization.	**MCO Assignment List**: Provide members with contact information for the selected practice Organization. Inform members about the services available and the importance of annual and routine visits with their selected provider. Receive referrals from the practice organization and outreach to patients. • Examples include: telephone call, secured text messaging, email,	**MCO Assignment List:** Download the MCO Assignment List in the CRISP Multi-Payer Suite, quarterly. Review the assignment and outreach to members who are not active in the practice organization. • Examples include: telephone call, secured text messaging, email, mail, or secure messaging via EHR. • Minimum of two

Medicaid Path Program Requirements				Recommended Best Practice Workflow	
Advanced Primary Care Function	CTR #	Care Transformation Requirement	Defined As	MCO Responsibility	Practice Organization Responsibility
				mail, or member portal.	attempts. Refer members you are not able to contact to the MCO for outreach.
Care Management	2.5 2.2b	Ensure Medicaid members receive a follow-up interaction from the practice within one week for ED discharges and two business days for hospital discharges **(minimum of 50% threshold for hospital & ED follow-up rates*)**. 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.	Provision of short-term (less than 30 days), targeted services for patients experiencing a specific medical event, such as an acute illness, injury, or an exacerbation of a chronic condition.	**Referrals from Practice**: ● Receive referrals from the practice organization for members who are unable to be contacted. ● Outreach to members via telephone or mail. ● Provide members with contact information for the selected practice organization. ● Inform members about services available and the importance of annual and routine visits with their selected provider.	**CEND Notifications - ED or Urgent Care Visits**: Contacts the member within 1 week of discharge. ● PCP Visit: Schedule member for an office visit, as appropriate. **Inpatient or Skilled Nursing Facility Discharge**: Contacts member within 2 business days of discharge. ● PCP Visit: Schedule member for an office visit, as appropriate. **Care Management -** Engage members with an acute illness or diagnosis of a new, serious medical condition or injury. Engagement is time-limited, with a foreseeable endpoint and a goal-oriented approach. ● Examples include: coordination of services between care settings, flu or other uncomplicated bacterial infections, or non-complex musculoskeletal injuries.

* Denotes program requirement, reportable metric.

Appendix C

Resources

I. American Academy of Pediatrics (AAP) guidelines - Recommendations for Preventive Pediatric Health Care.

II. CRISP Consent Tool - Flexible, secure solution for managing patient consent.

III. CRISP CSS Event Notification Delivery (CEND) - Delivers real-time, customizable health event alerts.

IV. CRISP HIE Admin Tool - Empower HIE administrators to efficiently manage user access, services, and security.

V. CRISP HIE Portal - All-in-one portal to securely search patients, launch applications, and navigate tools.

VI. CRISP InContext - Embeds real-time, cross-organizational clinical data directly into the EHR workflow & Portal.

VII. CRISP Panel Processor - Upload patient panels for use in tools.

VIII. CRISP Prescription Drug Monitoring Program (PDMP) - Equips providers with timely, integrated insights into controlled substance prescriptions.

IX. Learning Live Calendar - view and register for upcoming learning events.

X. Maryland Department of Education - School Health Services in Maryland Fact Sheets.

XI. Maryland Healthy Kids Provider Manual - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

XII. Medicaid Path Quality Incentive Manual on Maryland's AHEAD Primary Care Programs website.

XIII. Medicaid Path Roles and Responsibilities Matrix on Maryland's AHEAD Primary Care Programs website.

Appendix D

Frequently Asked Questions (FAQs)

To see an updated list of FAQs on the Medicaid Path, please scroll to the bottom of the 'Maryland's AHEAD Primary Care Programs' web page. FAQs will be updated on an ongoing basis to reflect any changes in program information as needed.

If you have questions, please email mdh.pcmodel@maryland.gov.