Primary Care AHEAD Payment Specifications: Beneficiary Attribution, Payments, and Performance Assessment

Model Year 2026 – Maryland

Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
State and Population Health Group

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Release Notes

Version Number	Date	Description of Change
Version 1	May 30, 2025	Initial release
Version 2	December 18, 2025	▪ Updated PCS list due to updates in the Medicare Physician Fee Schedule ▪ Updated timeline of the Model for Cohorts 2 & 3 ▪ Updated psychiatric practitioner participation requirements ▪ Adjusted lists of models with allowed overlaps with PC AHEAD ▪ Updated CDI and EDU definition details ▪ Updated HCC Risk Adjustment Model information ▪ Added Benefit Enhancement Waivers chapter

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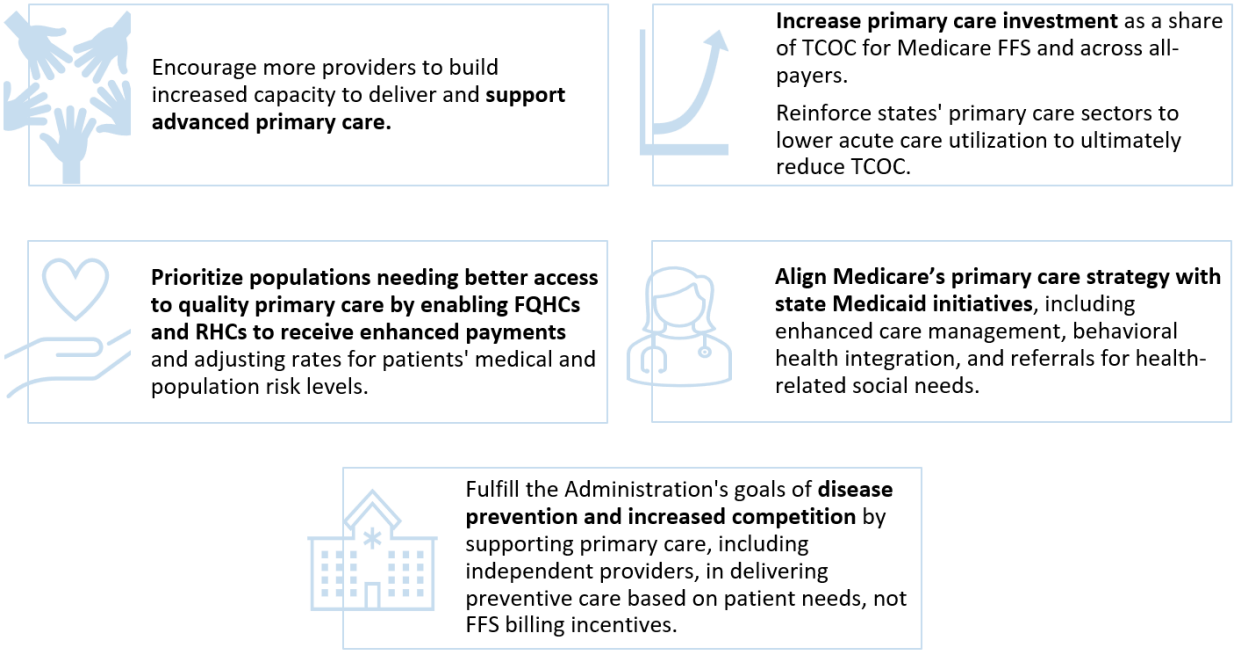
Chapter 1: Introduction

Primary Care AHEAD is a key component of the AHEAD Model and integral to promoting evidence-based preventive care, empowering patients to achieve their health goals, and driving choice and competition for people. Primary Care AHEAD is a voluntary program for Primary Care Practices and Community Health Centers. Community Health Center or "CHC" includes Federally Qualified Health Centers (FQHCs), Health Centers and Health Center Look-Alikes, Rural Health Clinics (RHCs).

The goals of Primary Care AHEAD are to:



Financial Investment in Care Transformation

Primary Care AHEAD provides PC AHEAD Participants with additional financial resources and flexibility to invest in primary care transformation, improve quality, and reduce potentially avoidable utilization of healthcare resources. Financial investment comes in the form of a prospective quarterly per beneficiary per month (PBPM) Enhanced Primary Care Payment (EPCP), to be used toward behavioral health integration, enhancing specialty care coordination, and encouraging health promotion activities, which are central to the AHEAD Model's goals.

Alignment with State Medicaid APM

Participation in Primary Care AHEAD is voluntary. Eligible and interested practices will sign a Participation Agreement with CMS. During Q3 preceding their first Performance Year (PY), eligible practices will be sent a document containing detailed instructions regarding the onboarding process. One condition of eligibility for participation in Primary Care AHEAD is that PC AHEAD Participants participate in a Medicaid patient-centered medical home (PCMH) or other state-based Medicaid advanced primary care program for that same PY. Primary Care AHEAD is considered a Merit-Based Incentive Payment System (MIPS) Alternative Payment Model (APM), and non-

MSSP participants are eligible for certain scoring benefits under MIPS. CMS intends to provide additional pathways under AHEAD that will qualify as an Advanced Alternative Payment Model (AAPM). CMS will release more information about these additional pathways in the future and will update the financial specifications document accordingly.

Care Transformation Requirements and Tie to EPCP

Primary Care AHEAD is intended to facilitate increased statewide investment in primary care and support activities related to the Care Transformation Requirements (CTRs). These primary care transformation activities fall into three categories: (1) behavioral health as a function of primary care, (2) care management and specialty coordination, and (3) health promotion activities. The Quality Based Adjustment (QBA) is a portion of the EPCP that will be at-risk for performance based on a set of quality measures that represent accountable, measurable action on the part of PC AHEAD Participants.

PC AHEAD Participants will be required to submit an annual attestation report tracking progress in meeting CTRs. This requirement will be enumerated in the Participation Agreement.

Section 1.1: AHEAD Payment Design Overview

PC AHEAD Participants will receive a prospective EPCP at the beginning of each quarter for each attributed beneficiary. The EPCP will be paid in addition to the traditional fee-for-service (FFS) payment structure, except for certain care management codes that are considered duplicative of the EPCP, as identified further in **Table 4-3**. A portion of the EPCP is subject to a Quality Based Adjustment (QBA) that is calculated annually after the end of each PY. Any QBA owed to CMS will be recouped by adjusting the EPCP paid in the quarter following the calculation of the QBA (likely the fourth quarter of the following PY).

Calculation of the EPCP is based on established per-beneficiary rate schedules, as discussed further in Chapter 4, that are applied to the group of beneficiaries attributed to the PC AHEAD Participant during the applicable quarter of each PY. CMS uses an attribution methodology that assigns beneficiaries to practices using historical claims. Although beneficiaries do not directly choose the practice to which they will be attributed, beneficiary attribution will likely align to the practice at which they most often receive care. It is important to note that the attribution of beneficiaries is a construct that is used for purposes of estimating the size of a PC AHEAD Participant's Medicare FFS population for payment calculation and does not impose actual limits on a beneficiary's choice of health care practitioner. Beneficiaries may seek care from the practitioner of their choice, regardless of that practitioner's participation in AHEAD.

Section 1.2: AHEAD Payment Elements

The EPCP is a prospective, PBPM amount paid to PC AHEAD Participants at the beginning of each quarter for each attributed beneficiary. The EPCP is a non-visit-based payment that is adjusted for beneficiary medical and population risk. The EPCP is paid to PC AHEAD Participants in addition to FFS payments to help support the provision of advanced primary care services (PCS). See **Table 3-1** for a list of PCS in the AHEAD model. The EPCP is not subject to beneficiary cost-sharing. All PC AHEAD Participants will continue to be paid for PCS on a FFS basis using payment rates tied to the Medicare Physician Fee Schedule (PFS) or the FQHC Prospective

Payment System (PPS); these payments will remain unchanged under the Model, except for services that are considered duplicative of the EPCP, for which practices will not receive payment.

The EPCP amount for each beneficiary-month is determined by statewide, beneficiary, and practice-specific factors. The statewide average EPCP amount for Maryland is shown in **Table 4-1**. The EPCP amount paid to each PC AHEAD Participant each quarter is determined by: 1) the number of beneficiaries attributed to the PC AHEAD Participant at the beginning of the quarter; 2) the Hierarchical Condition Category (HCC) risk scores of the attributed beneficiary population; the 3) the Community Deprivation Index (CDI), Low-Income Subsidy (LIS) eligibility, and Medicare/Medicaid dual eligibility of the attributed beneficiary population; 4) practice performance on quality measures, and 5) statewide hospital global budget participation and statewide performance on total cost of care containment.

The distinctive features of the two beneficiary risk adjustments to the EPCP employed in Primary Care AHEAD are summarized in **Table 1-1**. Each adjustment has a unique purpose.

Table 1-1: Enhanced Primary Care Payment (EPCP) Risk Adjustments

Payment Adjustments	Description
Medical Risk Adjustment	Based on the HCC risk scores of the attributed beneficiary population.
Population Adjustment	Based on the CDI, LIS eligibility, and Medicare/Medicaid dual eligibility of the attributed beneficiary population.

Medical Risk Adjustment: The EPCP is adjusted based on the HCC risk scores of attributed AHEAD beneficiaries to account for the varying complexity and cost associated with the medical needs of beneficiaries (see **Section 4.2.1**).

Population Adjustment: The EPCP is adjusted for population risk to address the care needs of under-served beneficiaries (see **Section 4.2.2**). The population adjustment is based on the number of AHEAD beneficiaries that meet one of the following criteria: eligible for the LIS under the Medicare Part D prescription drug program, dually eligible in Medicare and Medicaid, or beneficiaries with CDI scores in the top 20th most disadvantaged percentile.

Section 1.3: Payment Schedule

The total quarterly amount of all non-claims-based AHEAD payments to PC AHEAD Participants is remitted as a lump sum. Payments are made in the first month of each quarter, reflecting net amounts payable for the quarter after adjustments for any required recoupments.

Section 1.4: AHEAD Term

Maryland is participating in AHEAD in Cohort 1, starting in 2026. For Maryland, AHEAD consists of ten (10) PYs:

- Performance Year 1 (PY1): January 1, 2026 – December 31, 2026

- Performance Year 2 (PY2): January 1, 2027 – December 31, 2027
- Performance Year 3 (PY3): January 1, 2028 – December 31, 2028
- Performance Year 4 (PY4): January 1, 2029 – December 31, 2029
- Performance Year 5 (PY5): January 1, 2030 – December 31, 2030
- Performance Year 6 (PY6): January 1, 2031 – December 31, 2031
- Performance Year 7 (PY7): January 1, 2032 – December 31, 2032
- Performance Year 8 (PY8): January 1, 2033 – December 31, 2033
- Performance Year 9 (PY9): January 1, 2034 – December 31, 2034
- Performance Year 10 (PY10): January 1, 2035 – December 31, 2035

Table 1-2 contains the performance periods for Cohorts 1-3 in relation to the Calendar Years (CY).

Table 1-2: AHEAD Model Timeline with Pre-Implementation and Performance Years

	Calendar Year (CY)											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
Cohort 1		Pre-Implementation (18 months)	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9	PY10
Cohort 2			Pre-Implementation (30 months)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
Cohort 3				Pre-Implementation (24 months)	PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8

The AHEAD terms may vary depending on when a practice begins participation in the AHEAD Model. Since eligible practices may join the AHEAD Model during any of the PYs for which their state is participating, a practice's first Implementation Year (IY) will be the first calendar year in which the practice participates in the AHEAD Model, regardless of the year that the practice's respective state begins participation in AHEAD. For more information on the Agreement Performance Period and IYs, please reference **Section 1.3** of the AHEAD Primary Care Practice Participation Agreement.

Chapter 2: Requirements for Participation

AHEAD is open to qualifying primary care practices, FQHCs, and RHCs that are located within an AHEAD Geographic Area that provide services to Medicare FFS beneficiaries. For purposes of the AHEAD Model, participants are referred to collectively as "PC AHEAD Participants" and are categorized as either a "Participant Primary Care Practice" or "Participant Community Health Center."

A Participant Primary Care Practice (PCP) is a legal entity identified by a single Taxpayer Identification Number (TIN) and the National Provider Identifier (NPI) for a unique list of practitioners on its AHEAD Practitioner Roster. Any relevant primary care services claims (discussed below) billed by the TIN and NPIs appearing on the Practitioner Roster are attributed to the PC AHEAD Participant.

A Participant Community Health Centers (CHC) includes Federally Qualified Health Centers (FQHCs), Health Centers and Health Center Look-Alikes, Rural Health Clinics (RHCs), and are defined by one or more CMS Certification Number(s) (CCN). Participant CHCs are not required to submit a practitioner roster. Participant CHCs may determine whether they are applying to participate at the level of an individual site or the level of their organization that uses one or more CCN(s) and that shares management, resources, and either patients or practitioners. Participant CHCs with out-of-state-sites and those participating at the individual site level must submit claims to CMS that identify place of service accurately, via site-specific CCN or CCN/ZIP Code combination.

In this payment methodology paper, except as differentiated where necessary between Participant CHCs and Participant PCPs, PC AHEAD Participant means all Participant PCPs and Participant CHCs. All PC AHEAD Participants are required to sign a Participation Agreement with CMS and undergo program integrity screening prior to participation and throughout the duration of their participation within the AHEAD Model.

PC AHEAD Participants and Practitioner Rosters

Primary Care AHEAD participation will be at the practice level. For Participant CHCs, a practice will be defined as a collection of CCN(s) all enrolled under the same Medicare-enrolled TIN, and Participant PCPs are defined as a single Medicare-enrolled billing TIN and practitioners (NPIs) that bill at that practice site. Beneficiary attribution in the AHEAD Model is based on the alignment of both the practice and the practitioner. While beneficiaries may continue to seek care from a familiar provider, attribution—and the associated EPCPs—remain with the practice at which the care was rendered. Only claims rendered after the effective date that a provider is rostered at a new practice will count towards attribution for the new practice. This means that if a practitioner leaves a practice, their historical claims remain with the original practice, and they will not carry attributed beneficiaries with them to the new practice, except in the case of practice mergers.

Practitioners at Participant PCPs may be added or withdrawn at any point during the PY. If a PC AHEAD Participant adds a practitioner, the practice is required to update the AHEAD Portal with the new practitioner information. Newly added practitioners will begin to contribute claims to the attribution algorithm starting with claims rendered on the effective date of the practitioner's addition to the PC AHEAD Participant. For instance, if the practitioner is added as of August 1st

and begins providing care for the practice on that day, the claims from August 1st will first be considered in the beneficiary attribution process for the first quarter of the following year, where the two-year look back period for claims would end on August 31st. Newly added practitioners will be unable to bill for the list of care management services which are duplicative of EPCP (see **Section 4.3.2**) starting on the effective date of the addition.

The Practitioner Roster is based on the list of practitioner names submitted to CMS by the PC AHEAD Participant. New PC AHEAD Participants who submit practitioners by November 1st in advance of their first IY will contribute all of their historical claims to the attribution algorithm. In general, the more claims that enter into the attribution algorithm for a PC AHEAD Participant, the more beneficiaries are attributed to that practice. More beneficiaries, in turn, mean larger payments per practice.

In contrast, practitioners that are added mid-way through a PC AHEAD Participant's first IY or beyond (i.e., added after the PC AHEAD Participant begins participation in the AHEAD Model) do not contribute their historic claims to attribution. Instead, claims that occur on or after the date of roster addition contribute towards attribution. Newly joining practices may therefore want to include the maximum number of eligible practitioners in their initial participant roster by November 1st to maximize attribution and payments.

Practices may document practitioner withdrawals or additions through the AHEAD Portal at any time. However, data intake for each quarter will end mid-quarter, on the 45th day to allow sufficient time for processing. Requests made after this time will be incorporated into the next quarter's processing. CMS uses the same timeframe to process business changes that occur during the PY. For example, roster changes and business changes need to be in place by February 15 to be included for the 2nd quarter attribution and payment cycle.

Practitioners must be identified on the practice's Practitioner Roster by an NPI. Individual practitioners can be listed on Practitioner Rosters for multiple PC AHEAD Participants at any given time, as long as the practices have distinct TINs. This has the following implications:

- PC AHEAD Participants who share a TIN must choose a single practice for each practitioner, even if a practitioner works across multiple sites. In this case, practices sharing practitioners may consider applying as a single practice.
- Claims rendered by participating practitioners under other TINs will be considered non-participating practices and will not count towards attribution for the PC AHEAD Participant.

Section 2.1: Requirements for Individual Practitioner to Be Added to a PC AHEAD Participant's Roster

Approval for individual practitioner inclusion on a practice's Practitioner Roster is solely at the discretion of CMS. At a minimum, an individual practitioner must meet all of the following inclusion criteria and none of the exclusion criteria at the time of nomination to be a Primary Care AHEAD Practitioner:

Section 2.1.1: AHEAD Practitioner Inclusion Criteria

- Medicare-enrolled practitioner in good standing, based on information in the Provider Enrollment, Chain and Ownership System (PECOS).
- Specializes in primary care, family medicine, general medicine, internal medicine, or a small number of medical specialties that provide primary care services. A list of eligible specialties is included in **Appendix C**. Practitioner specialty will be verified by CMS using the NPI included on the Practitioner Roster and all available specialty codes listed as active in the Medicare PECOS. Psychiatrists must be co-located with a practitioner with another eligible specialty to be eligible to participate in PC AHEAD. If an NPI's primary or one of their secondary specialties as indicated in PECOS is eligible, then the practitioner is eligible.
- Actively participate in a Medicaid Advanced Primary Care Program, as defined by CMS.
- Practitioners may simultaneously participate in the Medicare Shared Savings Program and Primary Care AHEAD.
- CMMI models that practitioners may simultaneously participate in with Primary Care AHEAD are the Accountable Care Organization Realizing Equity, Access and Community (ACO REACH), Guiding an Improved Dementia Experience (GUIDE), and Transforming Maternal Health (TMaH).

Section 2.1.2: AHEAD Practitioner Exclusion Criteria

- Medicare-enrolled practitioner is not approved to bill Medicare in their state, based on information in the PECOS.
- Participates in Primary Care FLEX, Maryland Primary Care Program (MDPCP), or any other CMMI models with a no-overlaps policy with AHEAD.

Practitioner specialty and participation in other CMMI models will be assessed before adding a practitioner to the practice's roster.

Section 2.2: Requirements for Participation as an AHEAD PC AHEAD Participant

Practice participation is solely at the discretion of CMS. At a minimum, practices must meet all of the following inclusion criteria and none of the exclusion criteria at the time the Practices execute a Primary Care AHEAD Participation Agreement to qualify for participation in Primary Care AHEAD:

Section 2.2.1: Practice Inclusion Criteria

- Medicare-enrolled practice in good standing with CMS.
- A PC AHEAD Participant must have at least one active practitioner on its Practitioner Roster at all times. An active practitioner is a practitioner that is providing primary care services to Medicare beneficiaries and is on the roster of the PC AHEAD Participant. Withdrawal of an individual practitioner has no effect on a PC AHEAD Participant's continued participation in the AHEAD Model so long as it continues to have at least one active AHEAD Practitioner and continues to meet all other eligibility criteria.

- Actively participate in a Medicaid Advanced Primary Care Program in Maryland, as defined by CMS.
- Address of PC AHEAD Participant's physical location is within Maryland.
- Practices that are Hospital-Affiliated Primary Care Practices (HAPCP) and are physically located in the hospital's market service area are only eligible to participate if the hospital participates in AHEAD hospital global budgets in the same PY. If a practice is contractually affiliated with a hospital that is part of a broader health system that has multiple hospitals, the practice may participate if any of the hospitals in the health system participate, regardless of whether it is included in the health system's market service area. Participant CHCs are exempt from this requirement. A HAPCP is defined as a primary care practice that meets any of the four criteria below:
    1. Direct or Indirect Ownership (≥5%) - Does any hospital or any organization that owns or operates a hospital:
        a. Hold, directly or indirectly, an ownership or control interest of five percent (5%) or more in this practice, and
        b. Itself hold, directly or indirectly, an ownership or control interest of five percent (5%) or more in that hospital?
    2. Majority Control (Voting/Board/Membership) - Is the hospital or health-system entity:
        a. Able to appoint a majority of the governing board, or
        b. Able to hold more than fifty percent (50%) of voting rights, or
        c. The sole member of the practice's LLC or equivalent?
    3. Provider-Based Billing or Common TIN - Are any of the practice's Medicare claims submitted:
        a. Under the hospital's Type 2 (organizational) NPI, or
        b. Under the same TIN/EIN used by the hospital entity?
    4. Long-Term Management Agreement with Operational Control — Does the practice have a written management or professional services agreement of at least 3 years that gives a hospital or health-system entity authority over two or more of the following:
        a. Budget approval,
        b. Hiring and/or firing of key personnel, or
        c. Quality improvement activities?
- A PC AHEAD Participant participating in the Medicare Shared Savings Program may simultaneously participate in AHEAD. Additionally, EPCP non-claims-based payments received by the PC AHEAD Participant for the year are not included as a component of Total Cost of Care in determination of shared savings under the Medicare Shared Savings Program.

Section 2.2.2: Practice Exclusion Criteria

- Medicare-enrolled TIN is not approved to bill Medicare in their state, based on information in the PECOS.

Chapter 3: Beneficiary Attribution

Each PC AHEAD Participant is assigned a unique list of attributed beneficiaries prior to the start of each quarter during a PY. The purpose of beneficiary attribution is to assign each Medicare FFS beneficiary to a single PC AHEAD Participant that provides the majority of primary care for that beneficiary. Although practices may see changes to their patient panels (taking on new patients; losing others due to relocation or death), the general size of the Medicare FFS population that a PC AHEAD Participant has the capacity to serve is relatively constant.

This prospective attribution also has the purpose of:

- Shifting PC AHEAD Participants from FFS-only payment mechanisms to taking on management of attributed beneficiaries and identifying those beneficiaries for the quarter.[1]
- Calculating EPCPs to PC AHEAD Participants.
- Measuring PC AHEAD Participant performance when calculating utilization performance scores for the Quality Based Adjustment.

This chapter describes key elements of beneficiary attribution. **Section 3.1** describes criteria for inclusion in the beneficiary claim sample universe; **Section 3.2** describes the attribution algorithm; and **Section 3.3** describes quarterly adjustments to attribution for removals.

Section 3.1: Performance Year Claim Sample Universe

All attributed beneficiaries are drawn from a sample universe of claims for PCS delivered to Medicare FFS beneficiaries residing within Maryland. The claim must be for one of the PCS listed in **Table 3-1**.

Table 3-1: Primary Care Service Claims

Service	HCPCS Codes	Additional Practitioner Specialty Requirements
Adult preventive medicine	90750	Yes
Advance care planning	99497, 99498	Yes
Advanced Primary Care Management	G0556 - G0558	No
Advanced Primary Care Management Add-On for Behavioral Health Condition(s)	G0568 - G0570	No
Annual Wellness Visit (AWV)	G0438, G0439	No
Assessment of and care planning for a patient with cognitive impairment	99483	Yes
Assessment/care planning for patients requiring CCM services	G0506	No
Cardiovascular Risk Assessment	G0537	No
Cardiovascular Risk Management	G0538	No

[1] The PC AHEAD Participant agrees to be accountable for the health outcomes and services used by its attributed beneficiaries over the course of the quarter or year, regardless of whether they seek care from its practitioners or elsewhere. It is important to note that attribution to a PC AHEAD Participant does not impose actual limits on a beneficiary's choice of health care practitioner.

Service	HCPCS Codes	Additional Practitioner Specialty Requirements
CCM services	99490, 99491, 99437, G0511	No
CCM Services for PCM	99424 - 99427	No
Cervical/vaginal cancer screening; pelvic and clinical breast exam	G0101	Yes
Chronic Pain Management	G3002, G3003	No
Complex CCM services	99487, 99489	No
Complex E&M visit add-on	G2211	Yes
Detection tests relating to Influenza	87804, 87275, 87276	Yes
Digital E&M: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days	99421 - 99423	Yes
Distant site telehealth services Rural Health Clinics or Federally Qualified Health Centers (RHC/FQHC)	G2025	No
Established patient periodic preventive medicine examination, age 18-39 years	99395	Yes
Established patient periodic preventive medicine examination, age 40-64 years	99396	Yes
Established patient periodic preventive medicine examination, age 65 years and older	99397	Yes
Federally qualified health center (FQHC) visit, established patient	G0467	No
Federally qualified health center (FQHC) visit, initial preventive physical examination (IPPE), or annual wellness visit (AWV)	G0468	No
Federally qualified health center (FQHC) visit, new patient	G0466	No
FQHC Virtual Communication Services	G0071	No
Glucose, blood, by glucose monitoring device(s) cleared by the FDA specifically for home use	82962	Yes
Hemoglobin; glycosylated	83036	Yes
Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use	83037	Yes
Home Care	99341, 99342, 99344, 99345, 99347 - 99350	Yes
Interprofessional Consultation	99446 - 99449, 99451 - 99452	No
Management of behavioral health condition(s), timed, per month	99484, 99492 - 99494, G2214, G0323	No
Non-complex CCM clinical staff time	99439	No
Office/outpatient visit evaluation and management (E&M)	99202 - 99205, 99211 - 99215	Yes
Preexposure Prophylaxis (PrEP) to prevent HIV, treatment and counseling	J0739, G0011 - G0013	No

Service	HCPCS Codes	Additional Practitioner Specialty Requirements
Preventive medicine services	99385 - 99387, 99401 - 99402, 96160	Yes
Prolonged E&M visit for visits that required an additional 15 minutes, including face-to-face or non-face-to-face	G2212	Yes
Prolonged non-face-to-face evaluation and management (E&M) services	99358 - 99359	Yes
Relating to COVID-19 virus vaccine	90480, 91300 - 91309, 91311 - 91322, 0001A - 0004A, 0011A - 0013A, 0031A, 0034A, 0041A, 0042A, 0044A, 0051A - 0054A, 0064A, 0071A - 0074A, 0081A - 0083A, 0091A - 0094A, 0111A - 0113A, 0121A, 0124A, 0134A, 0141A, 0142A, 0144A, 0151A, 0154A, 0164A, 0171A - 0174A, M0201	Yes
Relating to Hepatitis-B virus vaccine	90739, 90740, 90743, 90744, 90746, 90747, 90759, G0010	Yes
Relating to Influenza virus vaccine	90630, 90653 - 90658, 90660 - 90662, 90672 - 90674, 90682, 90685 - 90689, 90694, 90756, G0008, G8482, Q2034 - Q2039	Yes
Relating to Pneumococcal Vaccine	G0009, 90670 - 90671, 90677, 90732	Yes
Remote evaluation of video or images	G2010	Yes
Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate)	99445, 99453 - 99454	Yes
Remote Physiologic Monitoring Treatment Management Services (RPM), Development and management of a plan of treatment based upon patient physiologic data	99457 - 99458, 99470,99091	No
Telephone Evaluation and Management Service Provided by A Physician	99441 - 99443	Yes
Transitional care management services	99495 - 99496	Yes
Virtual Check-in	G2012	Yes
Welcome to Medicare (WTM)	G0402	No

All claims for FQHC and RHC medical visits, Chronic Care Management (CCM), Welcome to Medicare (WTM) visits, and Annual Wellness Visits (AWV) that satisfy inclusion and exclusion criteria are included in the sample universe. Visits containing claims for all other PCS listed in **Table 3-1** are subject to additional restrictions on the rendering practitioner of record in order to be included in the sample. For these visits, the rendering practitioner must meet the practitioner inclusion criteria described in **Section 2.1**. Additionally, claims with an urgent care, pharmacy, or mass immunization center place of service are excluded.

The beneficiary claim sample universe is selected from a 24-month historical "lookback" period that ends 4 months prior to start of the quarter. The lookback period allows for claim runout and is updated quarterly. PCS claims are extracted from the National Medicare FFS claims database in the CMS Integrated Data Repository (IDR). Beneficiary end stage renal disease (ESRD) and enrollment in hospice are also identified using data from IDR and are respectively verified using the Master Beneficiary Summary File (MBSF) and Medicare FFS Hospice claims databases.

The attributed patient panel is updated quarterly using the updated claim sample universe based on the latest updated lookback period. The removal of beneficiaries mid-year is discussed in **Section 3.3**.

Section 3.2: Attribution Algorithm

A PC AHEAD Participant's attributed beneficiary list consists of beneficiaries represented in the most recent claim sample universe who are expected to receive key PCS visits or the plurality of their PCS services at the PC AHEAD Participant during the next quarter. All eligible Medicare FFS beneficiaries residing within Maryland may be attributed either to a PC AHEAD Participant or to a non-participating practice during the attribution process. Attribution to a non-participating practice implies that the beneficiary does not have an ongoing care relationship with any PC AHEAD Participant and therefore should be excluded from the population used to calculate AHEAD payments; it has no implications for the non-participating practice or the beneficiary.

Unless otherwise specified as below, a beneficiary is attributed to a PC AHEAD Participant for the duration of a calendar quarter. A beneficiary may be removed mid-quarter due to a change in eligibility status (e.g., death, relocation out of Maryland) or be attributed in a later quarter (e.g., relocation into Maryland). Beneficiary status is reassessed prior to each quarter and those who do not meet eligibility criteria are removed. This is described in **Section 3.3**.

The attribution algorithm emphasizes the importance of an ongoing and substantive relationship with a primary care practice. In Step 1, all claims are assigned to a PC AHEAD Participant by virtue of the claims' CCN (for Participant CHCs), TIN and rendering NPI (for Participant PCPs), or the claims' TIN and 5-digit ZIP Code (for non-participating practices). Then, all beneficiaries with claims for CCM, WTM, IPPE, or AWV services during the lookback period are identified. These beneficiaries are then attributed to the practice that submitted the most recent claim for CCM, WTM, or AWV, regardless of whether the practice is a PC AHEAD Participant.

In Step 2, all remaining unattributed beneficiaries are attributed to the practice that provided the plurality of their PCS visits. All visits used to identify plurality must be assigned to the Participant CHC by the CCN, the Participant PCP by the TIN/NPI, or to a non-participating practice by the TIN/5-digit ZIP Code. Certain claims must be rendered by practitioners with eligible specialties

(per **Table 3-1** above) in order to be used in attribution. The complete list of eligible practitioner taxonomies can be found in **Appendix C**. Any ties, where two or more practices have rendered the same number of PCS visits, are broken by examining the most recent visit. The beneficiary is attributed to the practice at which they had the most recent PCS visit.

In Step 3, CMS examines all claims for beneficiaries to identify: The TIN that is used the most often for PCS visits and the TIN and NPI that appears on the most recent visit. If these match the TIN/NPI roster from a PC AHEAD Participant, the beneficiary is attributed to that practice, regardless of their attribution from Step 1 or 2. This step mitigates a particular challenge that PC AHEAD Participants have faced with respect to attribution—the possibility of historical claims that occurred at a PC AHEAD Participant but are not counted because the rendering NPI is no longer on the PC AHEAD Participant's Practitioner Roster. This approach allows such a claim to contribute to the attribution of a beneficiary when identifying the TIN that appears the most often. So long as the most recent visit was from an NPI listed on the current Practitioner Roster, attribution can take place. Any beneficiary identified in Step 3 is attributed to the identified PC AHEAD Participant, replacing any attribution from Step 1 or 2.

Figure 3-1 provides illustrative examples of beneficiary attribution to a PC AHEAD Participant based on CCM, WTM, IPPE and AWV services. Beneficiary 1's claims history includes WTM and AWV claims, but the most recent AWV/WTM claim is from a non-participating practitioner; therefore, this beneficiary is not attributed to a PC AHEAD Participant. Beneficiary 2 cannot be attributed on the basis of CCM, WTM, or AWV services since there are no CCM, WTM, or AWV services in their claims history; this beneficiary may be attributed on the basis of plurality of PCS visits. Lastly, Beneficiary 3 is attributed to a PC AHEAD Participant since a CCM claim is rendered by an AHEAD Practitioner at a PC AHEAD Participant. All claims examined occurred in the lookback period consisting of the 24-month period ending 4 months prior to the quarter.

Figure 3-1: Attribution by CCM Fees, WTM, or AWV for PC AHEAD Participants or IPPE for FQHCs (Step 1)

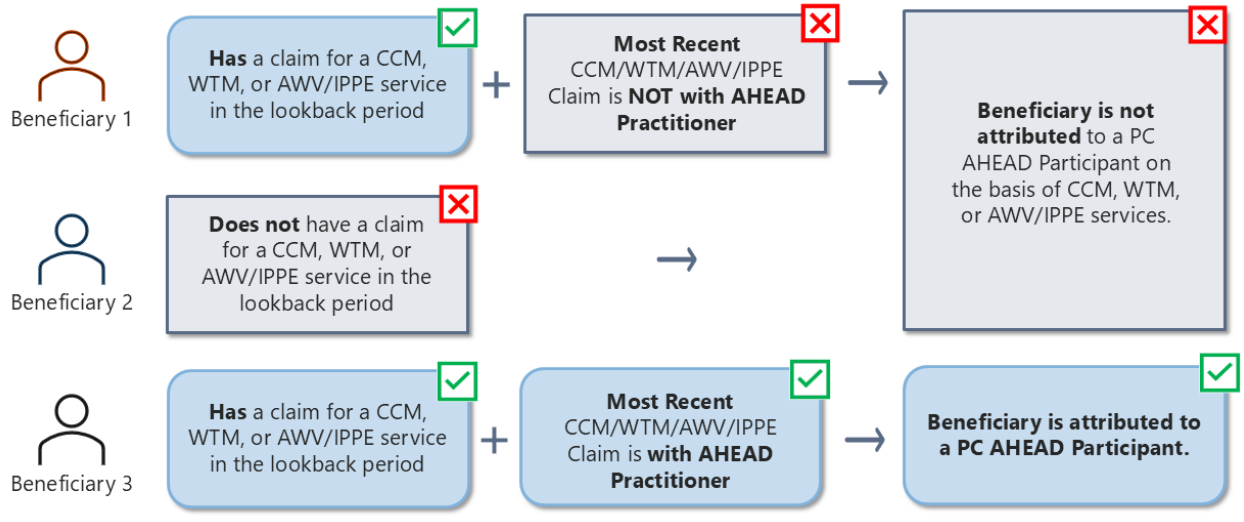


Figure 3-2 illustrates an example beneficiary that did not include claims for CCM fees, WTM, or AWV services and, therefore, may be attributed on the basis of plurality of PCS visits. In this

scenario, the beneficiary is attributed to the practice that delivers the plurality of PCS visits based on historic claims in the sample universe.

Figure 3-2: Attribution by Plurality of PCS Visits (Step 2)

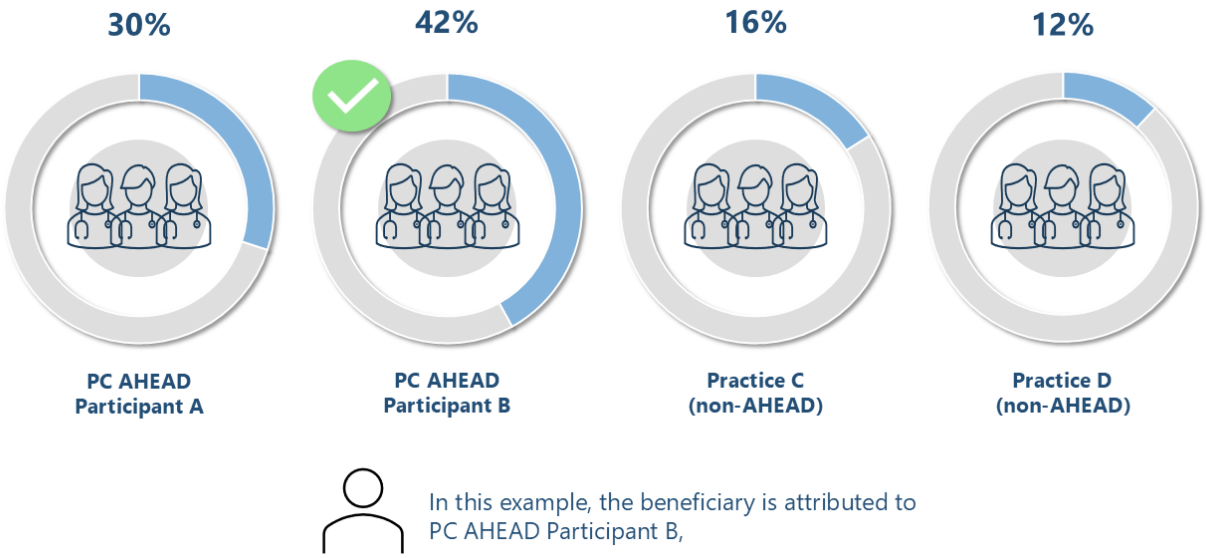
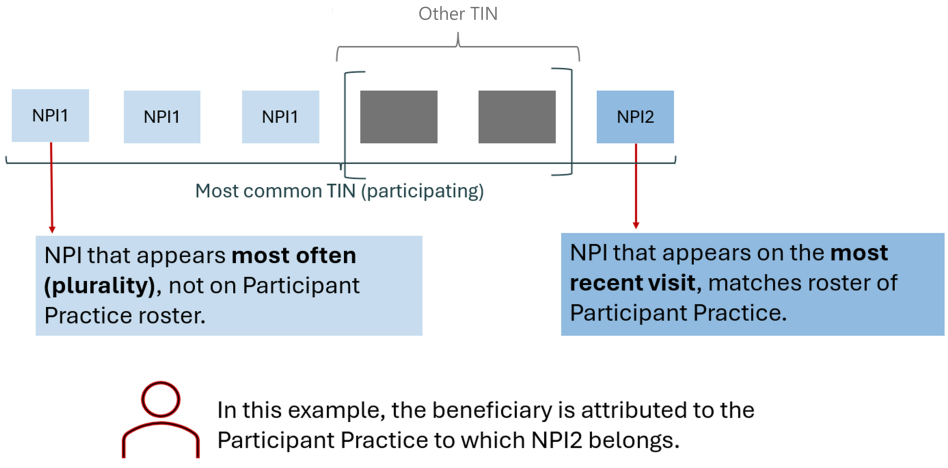


Figure 3-3 provides an example scenario of beneficiary attribution to a PC AHEAD Participant based on attribution by the most common TIN and most recent NPI. Based on Step 2 of the attribution algorithm, this beneficiary would be attributed to NPI1, who is not a participating practitioner, because they provided the majority of the beneficiary's PCS visits in the lookback period. However, Step 3 allows for the overriding of Step 1 and Step 2 attribution. Additionally, the most recent claim for a PCS visit was by an NPI on the Standard AHEAD Practice's roster. Thus, this beneficiary is attributed to the Standard AHEAD Practice as a result of Step 3.

Figure 3-3: Attribution by Most Common TIN and Most Recent NPI (Step 3)



Section 3.3: Adjustment to Practice Attribution

Beneficiaries must meet all of the inclusion criteria and none of the exclusion criteria listed in **Section 3.3** prior to the start of the quarter to be included in the practice attribution for that quarter. All criteria are verified using data from the Medicare Enrollment Database except where another source is indicated.

Section 3.3.1: Beneficiary Inclusion Criteria

- Enrolled in both Medicare Parts A and B.
- Medicare is designated primary payer.
- Address of beneficiary primary residence is within a Maryland ZIP Code or a Maryland hospital PSA Zip Code.

Section 3.3.2: Beneficiary Exclusion Criteria

- Death.
- Incarceration.
- Enrolled in Medicare Advantage.
- Admitted to hospice, verified using the Hospice RIF file.
- ESRD entitlement, verified using the Master Beneficiary Summary File.
- Has long-term institutional (LTI) status. This information is obtained from the Medicare Skilled Nursing Facility Assessment Minimum Data Set (MDS) which reports a monthly LTI status indicator.
- Enrolled in the ACO REACH model through a practice other than the Participant Practice to which the beneficiary is attributed. “Enrollment in ACO REACH” is determined using Medicare’s Master Data Management (MDM) system.
- Enrolled in the MSSP program through a practice other than the Participant Practice to which the beneficiary is attributed. “Enrollment in MSSP” is determined using Medicare’s Master Data Management (MDM) system.
- Enrollment in any of the following programs: Primary Care FLEX, , Maryland Primary Care Program (MDPCP), or any other CMMI models with a no-overlaps policy with AHEAD.

Beneficiary eligibility status is assessed quarterly as of a single point in time 4 months prior to the start of the quarter, using data available at that time. Beneficiaries that do not meet eligibility criteria as of the check date are removed from attribution for the duration of the quarter; prospective EPCPs, which is a function of the number of attributed beneficiaries for the quarter, are adjusted appropriately.

Chapter 4: Calculation of the Enhanced Primary Care Payment

The EPCP is a prospective PBPM payment paid to practices at the beginning of each quarter. A PC AHEAD Participant's total quarterly EPCP amount is determined by statewide, beneficiary, and practice-specific factors. For Maryland, the PY1 statewide base EPCP amount is outlined in Maryland's State Agreement. The statewide base EPCP amount may be adjusted prior to the start of the PY for hospital participation, as outlined in **Table 4-1** below. For subsequent PYs, the statewide EPCP amount will be adjusted for inflation and hospital participation, if applicable.

The statewide base EPCP is then used to calculate a PBPM amount for each attributed beneficiary based on the beneficiary's medical and population risk. A small proportion of EPCP dollars, the QBA, is not adjusted by the beneficiary's medical and population risk but is at-risk based on performance on quality and utilization measures during the PY. The percentage of the EPCP that is at risk for each PY will be 5% at the beginning of the AHEAD Model and will scale up over the course of the AHEAD Model until it reaches 10%.

Each beneficiary's PBPM amount is then summed to calculate the total practice-specific EPCP amount. The practice EPCP amount is calculated on a quarterly basis to reflect changes in beneficiary attribution and risk information. Finally, beginning in the second IY, the practice EPCP amount is subject to recoupment based on practice performance on quality and utilization measures from their prior IY.

This chapter describes the methodology used to calculate the quarterly EPCP paid to PC AHEAD Participants.

- **Section 4.1** describes the statewide EPCP amount;
- **Section 4.2** describes how the practice-specific EPCP amount is determined;
- **Section 4.3** describes the EPCP rates;
- **Section 4.4** describes the calculation of retrospective debits;
- **Section 4.5** describes the zero payment of claims for EPCP duplicative services;
- **Section 4.6** describes calculation of EPCP payable;
- **Section 4.7** addresses risk score growth; and
- **Section 4.8** describes the QBA.

Section 4.1: Statewide Average EPCP Amount

Any adjustments based on hospital participation in future PYs will be made at CMS' discretion and will be communicated to PC AHEAD Participants in the quarter preceding the beginning of the upcoming PY through the payment methodology paper, as well as through an additional communication to practices.

Beginning in PY2, the statewide average EPCP amount will also be adjusted annually to reflect changes in inflation. The inflation adjustment is applied first, followed by any hospital participation adjustment. Primary Care AHEAD will adjust the EPCP for inflation using the Medicare Economic Index (MEI), a measure of inflation that estimates the change in the operating costs for providing physician services. The MEI reflects changes in input prices for goods and services required to deliver care, including physician compensation, practice expenses, medical

supplies, and professional liability insurance. It is calculated using a fixed-weight input price index methodology to isolate pure price changes from shifts in resource utilization.

Table 4-1: EPCP Scaling Based on Hospital Participation in AHEAD

Medicare FFS Hospital NPR in HGB	10% - <20% NPR	20% - <30% NPR	30% - 100% NPR
PY1	$21 avg. EPCP	$21 avg. EPCP	$21 avg. EPCP
PY2	-$1 from avg. EPCP	No adjustment to avg. EPCP	No adjustment to avg. EPCP
PY3	Corrective action; -$2 from avg. EPCP	No adjustment to avg. EPCP	No adjustment to avg. EPCP
PY4+	-$2 from avg. EPCP (minimum).States will be put on a Corrective Action Plan (CAP). Failure to address CAP will result in termination; states that fall below 30% will have one year to remediate and recruit additional hospitals to meet target.	-$1 from avg. EPCP. States will be put on a Corrective Action Plan (CAP). Failure to address CAP will result in termination; states that fall below 30% will have one year to remediate and recruit additional hospitals to meet this target.	No adjustment to avg. EPCP

Because Maryland PC AHEAD Participants already receive the maximum statewide average EPCP amount, they are not eligible for positive hospital recruitment performance adjustments. In PY2 and each subsequent year, the statewide base EPCP amount from the previous PY is updated for inflation and hospital participation. Therefore, the payments shown in **Table 4-1** above reflect payment differences, rather than payment amounts, for PY2 and beyond.

Section 4.2: Determining the Practice Specific PBPM EPCP Amount

After the annual statewide base EPCP amount is determined, the QBA is determined. In PY1, the QBA will be 5% of the statewide base EPCP amount. After the QBA amount is determined, beneficiary-specific adjustments are then applied to the remaining 95% of the EPCP to determine the practice-level EPCP amount. These beneficiary-specific adjustments include: (1) the CMS Hierarchical Condition Categories (HCC) risk scores and diagnoses of attributed beneficiaries for the quarter (i.e., the distribution across risk tiers); and (2) the Low-Income Subsidy (LIS), Medicare and Medicaid simultaneous dual eligibility, and CDI of attributed beneficiaries[2] for the quarter in which the PC AHEAD Participant is participating for that PY.

Section 4.2.1 Medical Risk Adjustment

The statewide base EPCP amount, after adjustments for inflation and hospital participation, is risk-adjusted to reflect the clinical profile and care needs of the PC AHEAD Participant's attributed

[2] The LIS, dual status, and CDI only contribute to calculation of the population adjustment (covered in **Section 4.2.2)**.

beneficiaries. Beneficiaries are assigned to one of five medical "risk tiers" prior to the start of each quarter. Each tier is assigned a specific per beneficiary monthly EPCP rate; higher medical risk tiers reflect greater disease burden and are associated with higher EPCP rates due to the increased complexity of the primary care needs of these beneficiaries.

For the majority of beneficiaries, medical risk tier assignment is based on a measure of disease burden calculated by the CMS-HCC community risk adjustment model. The HCC community risk adjustment model is described in **Appendix E**. HCC risk scores are calculated by CMS quarterly. Medical risk tier assignment is made based on where a beneficiary's score falls within the distribution of HCC scores for Maryland's eligible Medicare reference population.[3] Tier assignments are made prior to the start of each quarter.

Table 4-2 summarizes tier assignments by beneficiary HCC risk score relative to a state reference population, and the EPCP PBPM rates. The payment rates shown are based on the Maryland statewide average EPCP for PY1.

Section 4.2.1.1: Automatic Assignment of Medical Risk Tier

Under certain circumstances, beneficiaries will be assigned to a medical risk tier automatically, irrespective of HCC risk score. These include beneficiaries without an HCC risk score due to insufficient data and beneficiaries with a diagnosis of dementia.

Due to the inherent lag in the calculation and availability of risk score data, some beneficiaries may not have a risk score when they are attributed to a PC AHEAD Participant. As described earlier, these beneficiaries are automatically assigned to Medical Risk Tier 2.

Beneficiaries with a diagnosis of dementia are automatically assigned to Medical Risk Tier 5 regardless of their risk score. Diagnosis of this condition is defined as having at least one claim with International Classification of Diseases, Tenth Revision (ICD-10) codes from a select list during the attribution lookback period, which is a two-year lookback period ending four months prior to the start of the PY. Qualifying diagnosis codes are listed in **Appendix D**.

Section 4.2.2: Population Adjustment

To better support practices in addressing beneficiary risk factors, the EPCP will be adjusted to account for population risk for all qualifying beneficiaries, irrespective of their HCC risk score. The aim of this adjustment is to provide additional support to PC AHEAD Participants to identify complex, and socioeconomically disadvantaged beneficiaries, address the intricate health needs of these beneficiaries, and improve their clinical outcomes.

Beneficiary eligibility for the population adjustment is based on beneficiary eligibility for LIS, dual enrollment in both Medicare and Medicaid, and the beneficiary's CDI score. CMS's use of LIS, dual, and CDI score to assess population needs allows CMS to consider both broader

[3] HCC risk scores are determined quarterly using a rolling 12 months of claims data. There is a 12-month gap between the end of the claims lookback period and the start of the quarter in which the HCC scores will be used. This allows for sufficient claims run out. As an example, risk scores based on diagnoses reported in 2024 claims will be available in the fall of 2025 for use in the quarter starting January 1, 2026.

neighborhood level characteristics and individual characteristics to identify CMS beneficiaries with high needs.

The CDI measure is intended to capture local socioeconomic factors correlated with medical disparities and underservice, providing insight into the community-level challenges faced by beneficiaries. The CDI, based on the Area Deprivation Index (ADI), was created to provide a more up-to-date and standardized measure of community-level deprivation. The CDI contains updated variables to reflect changes in education and income levels, replaces outdated measures (e.g., telephone access was updated to high-speed internet access), applies a shrinkage adjustment, standardizes all input variables, and uses population data from 2019 instead of 1990. Meanwhile, CMS uses individual beneficiary LIS and dual status to identify beneficiaries facing direct socioeconomic challenges and complex care needs that could impede their access to care.

The population adjustment assignment is based on a tiering strategy, similar to the medical risk tier assignment by HCC score. Beneficiaries are placed into population adjustment tiers depending on their LIS eligibility, dual status, and CDI score. Dual status and LIS eligibility are treated as binary factors—beneficiaries are, or are not, eligible based on their dual/LIS status. CDI eligibility is based on the percentile of the beneficiary, relative to the entire Medicare population attributed to MDPCP-AHEAD and PC AHEAD. Beneficiaries within the top 20th percentile of CDI will qualify for the population adjustment.

Section 4.3: EPCP Rates

Example medical risk and population payment adjustments are listed in **Table 4-2**. Beneficiaries will be assigned to one of five medical risk tiers based on their individual HCC risk score, with which specific payment amounts are associated. This payment amount increases if a beneficiary is eligible for one of the two population adjustment tiers. Beneficiaries are eligible for the first population adjustment tier (PA1) if they meet the LIS or dual criteria, or if their CDI score is within the top 20th percentile. Beneficiaries are only eligible for the second population adjustment tier (PA2) if they meet the LIS or dual criteria, and their CDI score is within the top 20th percentile.

Table 4-2: Risk Tier Criteria and EPCP Per Beneficiary Per Month Rates

Medical Risk Tier	Risk Score Criteria	Payment without PA	Payment with PA1	Payment with PA2
Tier 1	Risk score < 25th percentile of State Reference Population	$5	$19	$46
Tier 2	25th percentile <= risk score < 50th percentile of State Reference Population	$6	$20	$47
Tier 3	50th percentile <= risk score < 75th percentile of State Reference Population	$12	$26	$53
Tier 4	75th percentile <= risk score < 90th percentile of State Reference Population	$23	$37	$64
Tier 5	Risk score >= 90th percentile of State Reference Population or diagnosis of dementia	$38	$52	$79

Note: Shown payments are based on Maryland's statewide average EPCP of $21 for PY1.

Section 4.4: Calculation of Retrospective Debits for Recoupments

The prospective quarterly EPCP implicitly assumes that a PC AHEAD Participant's beneficiary roster does not change over the course of the quarter. Since the EPCP is paid in advance for three months at the beginning of each quarter, PC AHEAD Participants are effectively "overpaid" whenever an attributed beneficiary is removed or loses eligibility mid-quarter.[4] A retrospective reconciliation is performed after each quarter ends and the amount of EPCP paid two quarters later is reduced by the amount of overpayment (e.g. Q1 overpayments reduce Q3 payments), referred to as the *EPCP Eligibility Debit*. Eligibility is determined at an individual beneficiary level for each month of attribution. Additionally, recoupments may occur across PY. In rare instances, due to data delays in CMS systems, recoupments from additional quarters may be included. New practices experience a delay in recoupments, and any adjustments for Quarters 3 and 4 are handled in the subsequent PY. See **Table 4-3** for a timeline of when payment adjustments will be applied to the EPCP over the first three PYs (see **Appendix A** for more detail).

Table 4-3: AHEAD Payment Adjustment Timeline

		EPCP Eligibility Debit (2-quarter lag)	**QBA** (2-year lag)	**Hospital Participation** (No lag)	**Inflation** (No lag)
Risk		*(-)*	*5-10% (+/-)*	*$1-2 (+/-)*	*(+)*
PY1	*Q1*			Adjustment applied based on participation at start of PY1	No PY1 adjustment
	Q2				
	Q3	Based on PY1 Q1 Data			
	Q4	Based on PY1 Q2 Data			
PY2	*Q1*	Based on PY1 Q3 Data		Adjustment applied based on participation at start of PY2	Adjustment for inflation at beginning of PY
	Q2	Based on PY1 Q4 Data			
	Q3	Based on PY2 Q1 Data			
	Q4	Based on PY2 Q2 Data	Recoup based on PY1 P4P*		
PY3	*Q1*	Based on PY2 Q3 Data		Adjustment applied based on participation at start of PY3	Adjustment for inflation at beginning of PY
	Q2	Based on PY2 Q4 Data			
	Q3	Based on PY3 Q1 Data			
	Q4	Based on PY3 Q2 Data	Recoup based on PY2 P4P		
PY4	*Q1*	Based on PY3 Q3 Data		Adj. applied based on start of PY4	Adj. for inflation at beginning of PY

*Notes: The payment adjustment timeline shown is applicable to Cohort 1. Adjustment timelines for Cohorts 2 and 3 may differ slightly; * In 2026, certain practices will have the option to request an exemption from the pay-for-performance scoring structure (See **Section 4.8.1**).*

[4] For example, due to relocation outside of Maryland, death, loss of Medicare eligibility, etc. See **Section 3.3**.

Section 4.5: Zero Payment for Duplication of Services

CMS considers certain care management services to be duplicative of the services and supports covered by the EPCP. **Table 4-4** lists the services that are considered duplicative and their associated HCPCS codes. Any claim submitted to the Medicare Administrative Contractor for a HCPCS listed in **Table 4-4** for attributed beneficiaries by AHEAD practitioners will be "zero paid" by Medicare. Participants should still bill the services in order to receive beneficiary cost-sharing for the service, but Medicare will not pay the standard FFS rate because the claim will not be paid by Medicare. The PC AHEAD Participant may continue to submit claims for these services for unattributed beneficiaries and receive the full Medicare FFS amount.

Table 4-4: Care Management Services that are Duplicative of the EPCP

Service	HCPCS Codes
CCM Services	99490, 99491, 99437, 99439
Complex chronic care coordination services	99487, 99489
Prolonged non-face-to-face evaluation and management (E&M) services	99358, 99359
Assessment/care planning for patients requiring CCM services	G0506
CCM services for a single high-risk disease (Principal Care Management or PCM)	99424, 99425, 99426, 99427
Remote Physiologic Monitoring Treatment Management Services (RPM), Development and management of a plan of treatment based upon patient physiologic data	99457, 99458, 99091
Interprofessional Consultation	99446, 99447, 99448, 99449, 99451, 99452

Section 4.6: Calculation of EPCP Payable

The total amount of the EPCP a PC AHEAD Participant can expect to receive at the beginning of the quarter includes the prospective EPCP for the next 3 months, less any debits for changes in the PC AHEAD Participant's attributed beneficiaries' eligibility (**Section 4.4**). As with all Medicare payments, EPCPs are also subject to budgetary sequestration requirements, if active. See **Figure 4-1** for sample EPCP calculations for two hypothetical beneficiaries with different risk adjustment eligibility.

Figure 4-1: Sample Beneficiary EPCP Calculations

The Base Medical EPCP and the Base Population EPCP dollar amounts below are derived from the dollar amounts displayed in **Table 4-2**.

Assuming Beneficiary 1 belongs to Medical Risk Tier 2, and does not belong to either Population Adjustment tier, their EPCP would be calculated as:

$6 (Base Medical EPCP – MRA Tier 2)
+ **$0** (Base Population EPCP – PA Unqualified)
+ **$1.05** (EPCP At-Risk for Quality – 5% of Base EPCP)
= $7.05 (EPCP Amount)

Assuming Beneficiary 2 belongs to Medical Risk Tier 4 and Population Adjustment Tier 2, their EPCP would be calculated as:

$23 (Base Medical EPCP – MRA Tier 4)
+ **$41** (Base Population EPCP – PA Tier 2)
+ **$1.05** (EPCP At-Risk for Quality – 5% of Base EPCP)
= $65.05 (EPCP Amount)

Section 4.7: Risk Score Growth and EPCP Cap

Changes to HCC risk scores at a beneficiary level and across all PC AHEAD Participants are monitored closely throughout the PY and compared to similar changes in the state reference population on a regular basis. CMS may, at its discretion, adjust EPCP rates if the magnitude of observed changes is significant, unexpected, or if changes compared to the reference population suggest inaccurate coding. In the event that CMS decides to modify the AHEAD payment framework in response to evolving changes in the distribution of HCC scores, the changes will be announced prior to the payment quarter in which they are implemented.

Examples of how CMS might address high risk score growth, based on experiences in other Medicare programs, include the following:

- Apply a coding pattern adjustment factor to each beneficiary's risk score, as in the Medicare Advantage program.
- Cap the risk score growth rate by which each practice's EPCP is allowed to change.
- Use diagnosis-based risk adjustment for updating newly attributed beneficiaries' risk scores and demographic-based risk adjustment for updating continuously attributed beneficiaries' risk scores, as in the Medicare Shared Savings Program.

Section 4.8: Quality Based Adjustment Portion of EPCP

This section outlines the methodology for calculating the Quality Based Adjustment (QBA) for PC AHEAD Participants under the AHEAD Model. A defined portion of the EPCP is placed at

financial risk and tied to performance on specified quality and utilization metrics, constituting the QBA. These at-risk funds are paid prospectively in alignment with the EPCP over the course of the PY. After the PY, practices are assessed against the established quality and utilization benchmarks. Based on this evaluation, practices may be required to repay some or all of the QBA if performance targets are not met. PC AHEAD Participants that also participate in the Medicare Shared Savings Program are eligible to receive the QBA.

A large majority of EPCP revenue, the non-QBA funds, will not be at risk and will be intended to fund the primary care transformation requirements. PC AHEAD Participants will be required to attest on an annual basis to progressing along the levels of care transformation using these funds but will not be expected to report in-depth how they are spending the EPCP funds.

The percentage of base EPCP revenue that is at risk for each Performance Year is listed in **Table 4-5**. The amount at risk will scale up over the course of the Model.

Table 4-5: EPCP Proportion At Risk During the AHEAD Model, by Year

PC AHEAD Year	Percent of EPCP for QBA (At Risk)	Percent of EPCP for CTR (Not At Risk)
2026	5%	95%
2027	5%	95%
2028	6%	94%
2029	7%	93%
2030	8%	92%
2031	9%	91%
2032	10%	90%
2033	10%	90%
2034	10%	90%
2035	10%	90%

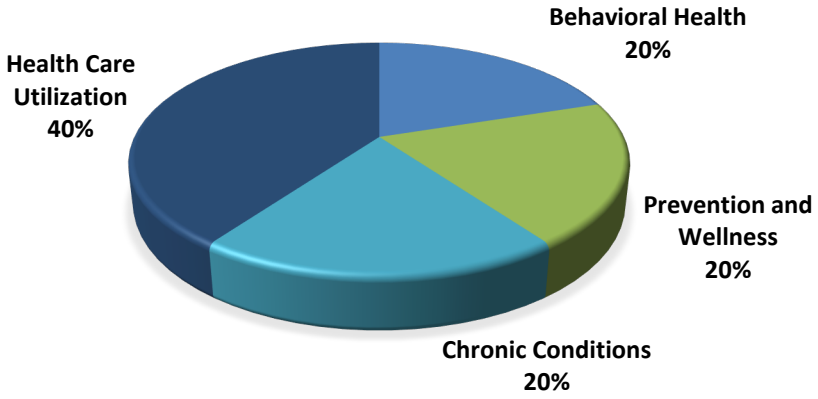
The approach toward calculating the quality and utilization performance measures may be adjusted at the discretion of CMS to account for external exogenous factors (such as a Public Health Emergency) on the state and PC AHEAD Participant populations. PC AHEAD Participants will be notified of any changes to the methodology described below at the earliest possible date.

Section 4.8.1: QBA Design Principles and Features

The QBA consists of two components: quality and utilization. The quality component contributes 60% to the total QBA score and the utilization component contributes 40%. The quality component can be further divided into 3 domains: 1) behavioral health, 2) prevention and wellness, and 3) chronic conditions (see **Section 4.8.4**). Each quality domain contributes 20% to the overall QBA (or 1/3 of the quality component). The utilization component consists of two measures, Acute

Hospital Utilization (AHU) and Emergency Department Utilization (EDU), each contributing 20% to the overall QBA (see **Section 4.8.5**).

Figure 4-2: QBA Portion of EPCP by Quality Measure Domain



A practice must report all quality measures to be eligible to earn the full QBA. Throughout the AHEAD Model, practices will be scored based on their performance across the quality and utilization measures. However, for a state's first year of participation in the AHEAD Model, smaller Participant PCPs (practices with less than 125 beneficiaries attributed before the start of the PY) and Participant CHCs will have the option to request an exemption to the pay-for-performance scoring structure. Under this exemption, eligible and approved practices will be scored on a pay-for-reporting basis during 2026. Per CMS policy, practices that elect for pay-for-reporting would not achieve Qualified APM Participant (QP) status under any existing models. In subsequent years, quality scores for all Participant CHCs and smaller Participant PCPs will be calculated based on performance. The assessment of quality will be conducted annually and will impact QBA payments once a year in Q4 after the end of the year (e.g., 2027 Q4 for 2026 PY). An example of how the QBA is calculated and recouped is shown in **Figure 4-3**.

Figure 4-3: Calculation of QBA Recoupment

For example, a practice may receive a **$21 PBPM EPCP**.

If that practice has **250 beneficiaries**, their annual EPCP would be calculated as:

$21 PBPM x 250 beneficiaries x 12 months = $63,000 Total EPCP Paid

However, if a practice does not meet any of the performance measures for the QBA, 5% of the EPCP would be recouped in Q4 of the following performance year.

($21 PBPM x 5%) x 250 beneficiaries x 12 months = $3,150 QBA Recouped

Table 4-6 summarizes the measures used to calculate the QBA and they are further explained in **Section 4.8.4** and **Section 4.8.5**. CMS may, in consultation with the State, revise the quality and utilization measures to align with the statewide population health goals or CMS' quality measure strategy. To the extent practicable, CMS will notify PC AHEAD Participants regarding any such changes prior to when the revised quality and utilization measures take effect.

Table 4-6: AHEAD QBA Quality and Utilization Measures

Measure Component and Domain	Measure Title	Data Source for Benchmarking
Quality – Chronic Conditions	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	PCA Practice Performance in 2026
Quality – Prevention and Wellness	Colorectal Cancer Screening	PCA Practice Performance in 2026
Quality - Behavioral Health	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	PCA Practice Performance in 2026
Utilization	Acute Hospital Utilization	Medicare claims data
Utilization	Emergency Department Utilization	Medicare claims data

Section 4.8.2: QBA Scoring Methods Overview

AHEAD utilizes both achievement and improvement targets for the QBA. PC AHEAD Participants have three possible methods for earning full QBA credit for a measure. PC AHEAD Participants must meet the requirements of at least one method for each measure to earn credit for that measure. The methods available to PC AHEAD Participants to earn QBA credit vary by year.

- In their first year, PC AHEAD Participants are only assessed against the high-performance benchmark for QBA retention. In order to earn credit on each measure the PC AHEAD Participants will have to meet or exceed the 40th percentile of performance for each measure.

- In their second year, PC AHEAD Participants are eligible for QBA credit via both the high-performance benchmark and the improvement target methods. The high-performance benchmark will shift to the 70th percentile in IY2 and beyond. The improvement target is a unique threshold based off the PC AHEAD Participant's prior year performance (see **Section 4.8.2.2.1** for additional information). If the PC AHEAD Participant meets or exceeds the threshold for either the high-performance benchmark or the improvement target, they will earn QBA credit for the measure(s) that met the target(s).

- In their third year and beyond, PC AHEAD Participants are able to earn QBA credit by meeting one of the following 1) the high-performance benchmark, 2) the improvement target, and 3) longitudinal continuous improvement (CI).

Longitudinal CI requires two consecutive years of meeting the AHEAD minimum improvement amount (see **Section 4.8.2.2.2** for additional information). If a PC AHEAD Participant meets or exceeds the threshold of any scoring method, then they earn their QBA for the measure(s) that met the target(s).

See **Table 4-7** for a summary of the QBA scoring methods by year.

Table 4-7: AHEAD QBA Retention Methods by IY

Implementation Year	Available Pathways for Full or Partial QBA Retention
IY1	Meeting or exceeding the high-performance benchmark
IY2	Meeting or exceeding the high-performance benchmark or improvement target
IY3	Meeting or exceeding the high-performance benchmark, or improvement target, or longitudinal CI

Section 4.8.2.1: QBA High-Performance Benchmark

The high-performance benchmark is set based on practice-reported data. For a PC AHEAD Participant to earn QBA credit via the high-performance benchmark for a measure in a given PY, they must meet or exceed the benchmark percentile for that measure. The benchmarks are created for all quality and utilization measures separately. For IY1, the high-performance benchmark is set at the 40th percentile. For IY2 and subsequent years the high-performance benchmark is set at the 70th percentile. **Section 4.8.3** provides additional details on the benchmarking population and expected release dates for the benchmarks.

Section 4.8.2.2: QBA Improvement

AHEAD utilizes two methods in the QBA scoring to potentially reward PC AHEAD Participants for improvement in measure performance, rather than just from high performance. These methods allow PC AHEAD Participants that may be new to quality measurement and scoring to earn QBA credit so long as they make improvements over time. The two pathways for improvement-based credit are the improvement target and longitudinal CI. The process for attaining improvement is outlined below.

Section 4.8.2.2.1: QBA Improvement Target

The improvement target applies a "closing the gap" methodology in which PC AHEAD Participants will be measured against their own unique improvement target. PC AHEAD Participants who meet their improvement target on a measure will be given full credit for that measure. The improvement target will be set at 10% of the distance between a PC AHEAD Participant's baseline score and the 70th percentile benchmark. Practices that exceed the high-performance benchmark on a measure will not have an improvement target calculated for the following performance year.

PC AHEAD Participants with a baseline score close to, but not meeting, the high-performance benchmark would be assigned a very small improvement target (see below). To ensure improvement targets are substantive, there is a minimum (floor) of 1% that PC AHEAD Participants must improve by to earn measure credit. The improvement target strategy for AHEAD is applied to each individual eCQM and utilization measure.

Briefly, calculation of the QBA improvement target proceeds as follows:

1. Calculate the improvement percentage for each PC AHEAD Participant and each measure.

$$X = (high - performance\ benchmark - practice\ baseline) * 0.10$$

2. Calculate the improvement target based on the improvement percentage for each PC AHEAD Participant and each measure.

$$Improvement\ Target = practice\ baseline + X$$

3. The PC AHEAD Participant's current performance rate is compared to the calculated improvement target for each measure. A PC AHEAD Participant will earn full credit for each measure on which it meets or exceeds the improvement target.

As an example, if the high-performance benchmark for a quality measure is 75% (70th percentile) and the PC AHEAD Participant had a performance rate of 62% in the prior year, then the improvement percentage for the PC AHEAD Participant's current year would be (75%-62%) * 0.1 = 1.3 percentage points. Next, the improvement percentage will be added to the PC AHEAD Participant's prior-year performance rate (baseline), resulting in the following calculation: 1.3 percentage points (increase percentage required for improvement) + 62% (prior attainment) = 63.3% targeted improvement performance rate. Thus, if the PC AHEAD Participant has a performance rate of 63.3% or higher on the quality measure, they would meet the improvement target and receive full credit for the measure. For a more detailed example, see **Table 4-12**.

Section 4.8.2.2.2: QBA Continuous Improvement

The longitudinal CI target aims to reward PC AHEAD Participants for continuous positive quality gains, even if they do not attain the high-performance benchmark or improvement target. The CI target is met if a PC AHEAD Participant's quality score improves by the minimum amount in two consecutive years (e.g., from IY1 to IY2 and IY2 to IY3). The CI target is assessed on a rolling basis throughout the duration of the model. The CI target reflects PC AHEAD Participants' individual quality improvements, rather than broad national or regional healthcare trends. The CI strategy for AHEAD is applied to each individual eCQM and utilization measure.

The CI amount is not the same as the PC AHEAD Participant improvement target (see **Section 4.8.2.2.1**). The CI amount will be set by CMS and remain consistent throughout the duration of the AHEAD Model. Additional updates will be made as the policy details are finalized.

Briefly, calculation of the CI target proceeds as follows:

1. Measure scores are tabulated for the selected eCQMs based on PC AHEAD Participants' reported data.

2. Observed-to-expected ratios are calculated for the AHU and EDU measures. Expected measure scores for each PC AHEAD Participant are effectively adjusted to reflect differences in disease burden across practices using the approaches specified by NCQA.
3. The difference in year-over-year score is assessed for each measure to determine if the minimum improvement standard has been met for two consecutive years. If the minimum standard has been met, the PC AHEAD Participants will receive full credit for the measure in the third IY.

For example, assume the CI amount is 1 percentage point for a measure. If a PC AHEAD Participant had measure performance rates of 60.2%, 62.4%, and 63.5% in their previous three years, respectively, then they would have quality improvements of greater than or equal to the CI amount for three consecutive years and would earn QBA for that measure in IY3. For a more detailed example, see **Table 4-12**.

Section 4.8.3: Benchmark Populations

The high-performance benchmarks for 2026 will be generated using concurrent data from 2026 and thus are not available in this current Financial Specification. The high-performance benchmarks will be set to the 40th percentile in IY1 (see **Table 4-8**). Beginning in IY2, and in future years, the high-performance benchmarks will be set at the 70th percentile. The high-performance benchmarks for 2026 will be created using the performance data from 2026 and announced at the end of 2027. Beginning in 2028, the high-performance benchmarks will be announced prior to the start of the year. In IY2, the improvement target will be introduced to allow multiple paths for practices to earn measure credit. Beginning in 2028, PC AHEAD Participants that started in 2026 will be eligible for longitudinal CI. The improvement and longitudinal CI targets will not have universal benchmarks as they are PC AHEAD Participant specific. CMS will reassess the benchmarks annually and determine any necessary changes.

Table 4-8: AHEAD Quality and Utilization Measures Benchmarking Criteria

Model Year	Benchmark Threshold	Data Source for Benchmarking[3]	Time Period for Benchmark Release
2026	40th Percentile	PCA Practices in 2026	2027Q4
2027[1]	70th Percentile	PCA Practices in 2026	2027Q4
2028[2]	70th Percentile	PCA Practices in 2026	2027Q4
2029	70th Percentile	PCA Practices in 2026	2028Q4
2030	70th Percentile	PCA Practices in 2026	2029Q4
2031	70th Percentile	PCA Practices in 2026	2030Q4
2032	70th Percentile	PCA Practices in 2026	2031Q4
2033	70th Percentile	PCA Practices in 2026	2032Q4
2034	70th Percentile	PCA Practices in 2026	2033Q4

Model Year	Benchmark Threshold	Data Source for Benchmarking[3]	Time Period for Benchmark Release
2035	70th Percentile	PCA Practices in 2026	2034Q4

Notes: [1] Addition of improvement target for earning QBA credit; [2] Addition of longitudinal continuous improvement for earning QBA credit; [3] Benchmark population is subject to change due to changes in overall population, year of benchmark, or other factors.

Section 4.8.4: Quality Component of the QBA

The amount of the quality component payment that is retained by a PC AHEAD Participant is determined by measure performance scores across three (3) domains: (1) behavioral health, (2) preventions and wellness, and (3) chronic conditions, measured using performance scores from at least three eCQMs. Performance scores for each measure will receive a weight of 20% towards the QBA, for a total quality weight of 60% of the QBA. If any quality measure is suppressed by CMS for the PY, practices will receive credit for half the measure weight and the remaining weight of the measure will be reweighed across the remaining non-suppressed measures. CMS will communicate to practices if a measure is suppressed. If a practice does not report one of the required eCQMs the full QBA will be recouped for that year.

Section: 4.8.4.1: Clinical Quality

Improving health outcomes and care quality is a core objective of the AHEAD Model. The quality portion of the QBA is assessed with three electronic clinical quality measures (see **Table 4-9**), all aligned with the state's population health goals. Each eCQM score is calculated using the latest MIPS measure specifications issued by the Center for Clinical Standards and Quality (CCSQ) in effect at the start of the performance year. PC AHEAD Participants must submit numerator, denominator, and exclusion data for all three eCQMs, as defined by the measure specification. Collectively, the eCQMs contribute 60% of the total quality score, with each measure weighted at 20%. A practice that does not report a measure receives a score of 0% for that measure.

Table 4-9: eCQM Measures, Types, Weights, Domains, and Benchmarks for 2026

Identifier	Measure Title	Measure Type	Weight Within Overall Quality Component	Domain	Benchmark (40th Percentile)
CBE 0059; CMIT 204; eCQM 122	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*	Outcome	20%	Chronic Conditions	TBD
CBE 0034; CMIT 139; eCQM 130	Colorectal Cancer Screening (COL-AD)	Process	20%	Prevention & Wellness	TBD

Identifier	Measure Title	Measure Type	Weight Within Overall Quality Component	Domain	Benchmark (40th Percentile)
CBE 0418e; CMIT 672; eCQM 2	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	20%	Behavioral Health	TBD

*Notes: * Denotes an inverse score measure; lower performance rate is indicative of better performance.*

Briefly, calculation of the quality component of the QBA proceeds as follows:

- Measure performance rates are tabulated for the selected eCQMs based on PC AHEAD Participant reported data. These performance rates are assessed against the different QBA scoring methodologies, outlined in **Section 4.8.2**, to determine the PC AHEAD Participant's QBA.

Section 4.8.5: Utilization Component of the QBA

The utilization component of the QBA is designed to reward PC AHEAD Participants that take sustained actions to improve the overall health of their attributed beneficiaries and reduce potentially avoidable utilization of healthcare resources. By investing in effective, coordinated primary care, the AHEAD Model aims to improve health outcomes and reduce the frequency of clinically significant complications that require more intensive care and intervention, such as hospitalization. The utilization component of the QBA is evaluated using two measures of utilization, see **Table 4-10**. The measures are part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set® (HEDIS®).

Table 4-10: Utilization Measures, Types, Weights, Domains, and Benchmarks for 2026

Identifier	Measure Title	Measure Type	Weight Within Overall Quality Component	Domain	Benchmark (40th Percentile)
CMIT 14	Acute Hospital Utilization (AHU)	Utilization	20%	Utilization	TBD
CMIT 1755	Emergency Department Utilization (EDU)	Utilization	20%	Utilization	TBD

Each utilization measure contributes 20% of credit toward the total QBA. A PC AHEAD Participant's performance on these measures will be calculated using Medicare claims data and are based on NCQA's HEDIS® measures. Some modifications were necessary to make the measures applicable to the AHEAD Model. Since the AHEAD Model has its own set of beneficiary

eligibility requirements and its own specifically defined patient population, we use the AHEAD patient panel as the eligible population for the measures.

Since the AHEAD patient panel varies quarter to quarter, and even month to month as beneficiary eligibility is retroactively examined, we also do not require a full 12 months of continuous eligibility to calculate the measures. As a result, we look for EDU and AHU in any month in which a patient is on a panel. The final measure result continues to be based on 12 months of data, but the individual requirement of 12 months of continuous eligibility for beneficiaries is relaxed. This means that practices are responsible only for the months in which a beneficiary is active on their panel. The amount of the utilization component that is earned by a PC AHEAD Participant is determined by their performance on each utilization measure (20% weight per measure).

Both the AHU and EDU measures are calculated using Medicare Part A and Part B claims. The EDU is limited to outpatient visits that do not result in hospital admission so that there is no duplication in the utilization measures. Refer to the NCQA HEDIS® Technical Specifications for more information on these measures.[5] CMMI will calculate these measures for PC AHEAD Participants using claims data; these measures require no reporting on the part of practices.

As with calculation of the quality components, PC AHEAD Participants retain a share of the maximum payment for the utilization component based on how their utilization scores compare to the high-performance benchmark, their improvement target, and their longitudinal CI scores. The proposed reference period for PY1 is CY2026, but CMMI may decide to use a different data source if AHEAD data are not sufficiently reliable. Evaluation of either utilization measure is independent of performance on the other.

Utilization scores for PC AHEAD Participants are expressed as observed-to-expected ratios. The expected value is a risk-adjusted utilization rate that reflects the characteristics of each PC AHEAD Participant's attributed beneficiaries. An observed-to-expected ratio greater than 1 represents utilization that is higher than the expected average for a comparable beneficiary population, and a ratio less than 1 represents utilization that is less than the expected average.

Like eCQMs, the high-performance benchmark population for EDU and AHU includes PC AHEAD Participants within Maryland. For any beneficiary attributed to a PC AHEAD Participant for at least one month of the year, we include their utilization information for the practice for the entire year. If a beneficiary is attributed to multiple practices within the same year, then their utilization would contribute to only one practice based on attribution and primary care service use.

Briefly, calculation of the utilization component of the QBA proceeds as follows:

1. Observed-to-expected ratios are calculated for the AHU and EDU measures. Expected measure scores for each PC AHEAD Participant are effectively adjusted to reflect differences in disease burden across practices using the approaches specified by NCQA.
2. These performance rates are assessed against the different QBA scoring methodologies, outlined in **Section 4.8.2**, to determine the amount of credit the PC AHEAD Participant earned.

[5] HEDIS specifications may be obtained from NCQA: https://www.ncqa.org/hedis

Section 4.8.6: QBA Scoring

QBA scores are calculated to evaluate the amount of QBA retained for each PC AHEAD Participant. Each quality and utilization measure contributes 20% towards the total QBA score. A score of 100% indicates full QBA credit and a score of 0% indicates no QBA credit. A PC AHEAD Participant's score can be 0%, 20%, 40%, 60%, 80%, or 100%, which will indicate different levels of QBA earned. **Table 4-11** illustrates the QBA components and the associated percentages earned for each measure.

Table 4-11: PC AHEAD Participant Performance and Percentage of QBA Earned for Utilization Measures

Measure	Practice Performance on Measure	Measure Credit	Summary Score Range
Quality and Utilization Measures	No QBA Earned	No	Did not meet requirements for Achievement, Improvement, or CI
	High-Performance Benchmark	Yes	40th percentile IY1 and 70th percentile IY2 and beyond calculated annually
	Improvement Target*	Yes	Target calculated per practice annually
	Longitudinal Continuous Improvement**	Yes	Improvement by 1% for two consecutive years

*Notes: *Available in IY2; **Available in IY3.*

For a practice to earn 20% (full credit) for each of the five measures, they must meet the metrics to earn the QBA via the high-performance benchmark, improvement target, or longitudinal CI methods. If a PC AHEAD Participant meets the metrics for attainment under multiple scoring methods for a measure (e.g., achievement and improvement) they do not receive additional credit, they are still only awarded 20% of overall QBA.

The QBA earned by the PC AHEAD Participant is summarized by the following equation:

$$(Q_1 + Q_2 + Q_3 + AHU + EDU) * PBPM * MM$$

- Q_1 = Credit for Hemoglobin A1c (HbA1c) Poor Control; 0 or 20%.
- Q_2 = Credit for Colorectal Cancer Screening; 0 or 20%.
- Q_3 = Preventive Care and Screening: Screening for Depression and Follow-Up Plan; 0 or 20%.
- AHU = Credit for the acute hospital utilization measure; 0 or 20%.
- EDU = Credit for the emergency department utilization measure; 0 or 20%.
- $PBPM$ = Per beneficiary per month QBA payment during the PY.
- MM = The number of beneficiaries attributed to the PC AHEAD Participant during the PY.

Table 4-12 provides an example calculation for a PC AHEAD Participant in their first (IY1) and fourth (IY4) years in AHEAD. In IY1, the entirety of the QBA is based on whether the high-performance benchmark is met because there is no comparison period to measure improvement. Beginning in IY3 and beyond, all three awards are included.

Table 4-12: Example Calculation for IY1 and IY4 QBA Earned

Year	QBA Method	Diabetes Poor Control*	Colorectal Cancer Screening	Screening for Depression and Follow-Up Plan	AHU*	EDU*	Final QBA Earned
IY1	High-Performance Benchmark (40th Percentile)	27%	32%	45%	1.19	1.25	**100% QBA Earned** (Full QBA Earned)
	Practice Performance Score	19%	57%	63%	1.07	1.02	
	Practice Improvement Target	N/A	N/A	N/A	N/A	N/A	
	Met High-Performance Benchmark	Yes	Yes	Yes	Yes	Yes	
	Met Improvement Target	N/A	N/A	N/A	N/A	N/A	
	Met CI Target	N/A	N/A	N/A	N/A	N/A	
IY4	High-Performance Benchmark (70th Percentile)	16%	72%	81%	0.92	0.95	**60% QBA Earned** (40% QBA Recouped)
	Practice Performance Score	17%	69%	89%	0.99	1.05	
	Practice Improvement Target	60%	70%	92%	0.97	1.01	
	Met High-Performance Benchmark	No	No	Yes	No	No	
	Met Improvement Target	Yes	No	No	No	No	
	Met CI Target	No	No	No	Yes	No	

*Note: *Indicates an inverse measure – a lower score is better.*

In the **Table 4-12** example, the PC AHEAD Participant score higher than the 40th Percentile on each measure in their first IY. Thus, the practice earned their full QBA and no QBA is recouped for that year. In IY4, the PC AHEAD Participant scored higher than the high-performance benchmark for the Depression Screening Measure and therefore received credit for meeting the high-performance benchmark for that measure. Although IY2 and IY3 data are not shown, we assume they meet the improvement target for the Diabetes HbA1c Control measure and meet the CI minimum standard for two consecutive years for the AHU measure. Overall, in IY4, they

receive a QBA score of -2 since they did not earn credit for Colorectal Screening or EDU via any QBA scoring method, and therefore 40% of their overall QBA from IY4 would be recouped and they would earn 60%.

Section 4.8.7: Recoupment of the QBA

PC AHEAD Participants will receive a QBA Financial Report detailing their measure performance and earned QBA. Because the QBA requires data for measures that are claims-based, which require extended periods of time after the end of the PY to mature, recoupments for the QBA will be calculated during Q3 of the following PY and executed in the Q4 payment cycle. Thus, any unearned QBA will be offset as a one-time adjustment in the following PY's Q4 payment cycle. Any quality domains not reported by a PC AHEAD Participant will result in zero QBA earned for that domain. PC AHEAD Participants that withdraw mid-way through the year will automatically earn 0% of their QBA and will have their QBA fully recouped.

Chapter 5: Benefit Enhancement Waivers

PC AHEAD Participants may elect to provide Benefit Enhancements for the Performance Year. For 2026, there will be two Benefit Enhancements offered to PC AHEAD Participants: Section 5.1 will cover the Telehealth Benefit Enhancement, and Section 5.2 will cover the Nurse Practitioner and Physician Assistant Services Benefit Enhancement.

Section 5.1: Telehealth Benefit Enhancement

Standard PC AHEAD Participants can elect the Telehealth Benefit Enhancement Waiver for the performance year. Any practitioners on the electing PC AHEAD Participant roster will automatically participate in the waiver as long as the PC AHEAD Participant's election has not been rejected. The Telehealth Benefit Enhancement waiver waives the originating site requirement and allows for Medicare-approved Telehealth procedure code to be billed by a rostered practitioner for an attributed beneficiary with a Place of Service (POS) of 10 (the patient's home or place of residence) instead of only restricting these procedure codes to be billed with a POS of 02 (at a site other than the patient's home or place of residence). Legislation, such as the Full-Year Continuing Appropriations and Extensions Act, 2025, has extended telehealth flexibilities introduced during COVID. This Benefit Enhancement Waiver may be superseded by future Congressional legislation that includes the waiving of originating Telehealth site of service.

FQHC PC AHEAD Participants can also elect the Telehealth Benefit Enhancement Waiver for the performance year. FQHCs will be permitted to bill for non-behavioral Medicare-approved telehealth services under G2025 by a rostered CCN of the FQHC. Similarly, this Benefit Enhancement Waiver may be superseded by future Congressional legislation or PFS updates that extend the use of G2025 for FQHCs.

Section 5.2: Nurse Practitioner and Physician Assistant Services Benefit Enhancement

Standard PC AHEAD Participants can elect the Nurse Practitioner and Physician Assistant (NP/PA) Services Benefit Enhancement Waiver for the performance year. This waiver includes three sub-components: Medical Nutrition Therapy, Individualized Cardiac or Pulmonary Rehabilitation Care Plan, and Home Infusion Therapy. Any Nurse Practitioner or Physician

Assistant on the PC AHEAD Participant roster will automatically participate in the waiver as long as the PC AHEAD Participant's election has not been rejected.

The Medical Nutrition Therapy component of the NP/PA Services Benefit Enhancement Waiver waives the requirement that a referral for medical nutrition therapy services must be made by a physician and extends this to include rostered Nurse Practitioners and Physician Assistants, as long as the referral is made for an attributed beneficiary.

The Individualized Cardiac or Pulmonary Rehabilitation Care Plan component of the NP/PA Services Benefit Enhancement Waiver waives the requirement that a physician must establish, review, and sign an individualized cardiac or pulmonary rehabilitation care plan and extends this to include rostered Nurse Practitioners and Physician Assistants, as long as the referral is made for an attributed beneficiary.

The Home Infusion Therapy component of the NP/PA Services Benefit Enhancement Waiver waives the requirement that a physician must establish a home infusion therapy plan of care and extends this to include rostered Nurse Practitioners and Physician Assistants, as long as the referral is made for an attributed beneficiary.

FQHC PC AHEAD Participants cannot elect the Nurse Practitioner and Physician Assistant Services Benefit Enhancement Waiver.

Appendix A: EPCP Adjustments and Performance Measurement Timeline

			QBA Risk: 5-10% (+/-)		Hospital Participation Risk: $1-2 (+/-)		
		EPCP Eligibility Debit (+)	**Financial Impact**	**Performance Period**	**Financial Impact**	**Performance Period**	**Inflation (+)**
PY1	*Q1*			Performance Measured for PY3 QBA Recoupment*	Adjustment applied based on PY1 participation at start of PY	Participation Measured for PY1	
	Q2						
	Q3	Based on PY1 Q1 Data					
	Q4	Based on PY1 Q2 Data					
PY2	*Q1*	Based on PY1 Q3 Data		Performance Measured for PY4 QBA Recoupment	Adjustment applied based on PY2 participation at start of PY	Participation Measured for PY2	Adjustment for inflation at beginning of PY
	Q2	Based on PY1 Q4 Data					
	Q3	Based on PY2 Q1 Data					
	Q4	Based on PY2 Q2 Data	Recoup based on PY1 P4P				
PY3	*Q1*	Based on PY2 Q3 Data		Performance Measured for PY5 QBA Recoupment	Adjustment applied based on PY3 participation at start of PY	Participation Measured for PY3	Adjustment for inflation at beginning of PY
	Q2	Based on PY2 Q4 Data					
	Q3	Based on PY3 Q1 Data					
	Q4	Based on PY3 Q2 Data	Recoup based on PY2 P4P				
PY4	*Q1*	Based on PY3 Q3 Data		Performance Measured for PY6 QBA Recoupment	Adjustment applied based on PY4 participation at start of PY	Participation Measured for PY4	Adjustment for inflation at beginning of PY

*Note: * In 2026, certain practices will have the option to request an exemption to the pay-for-performance scoring structure (See **Section 4.8.1**).*

Appendix B: Glossary of Terms

Active Practitioner: A practitioner that is providing primary care services to Medicare beneficiaries and is on the roster of the Participant PCP.

Acute Hospital Utilization (AHU): The earned utilization component of QBA is evaluated using two measures of hospital utilization, one of which is the AHU. AHU is calculated using the Medicare claims based on HEDIS®-like specifications.

AHEAD Beneficiary: An Eligible Beneficiary who is attributed to an AHEAD Practice by CMS.

AHEAD Practice Activities: Activities, including but not limited to the Care Transformation Requirements, Quality Reporting Requirements, and learning network, conducted by the Practice, at the direction of the Practice, under the terms of this Agreement.

AHEAD Practitioner: A Medicare-enrolled practitioner identified by an individual NPI who bills under the TIN of the Practice and who meets all of the following criteria:

a. Is a physician (as defined in section 1861(r) of the Act) or non-physician practitioner (as defined in section 1842(b)(18)(C) of the Act).

b. Has an Eligible Specialty Code with a primary or secondary specialty code listed in **Appendix C**.

c. Is identified on the Practitioner Roster.

d. Is approved by CMS to participate in AHEAD.

Attribution: A method to assign beneficiaries to a PC AHEAD Participant, with no actual limits on a beneficiary's choice of health care practitioners. In the AHEAD Model, attributed beneficiaries are used to estimate the amount of EPCPs. Medicare claims and eligibility data are used to conduct beneficiary attribution.

Base Enhanced Primary Care Payment (EPCP): The AHEAD Model EPCP, positively or negatively adjusted based on the state's performance on hospital participation goals and state Medicare FFS total-cost-of-care cost growth targets under the State Agreement.

Behavioral Health Integration: A person-centered approach to the integration of behavioral and physical health services, with an emphasis on team-based care.

Beneficiary: An individual who is enrolled in Medicare.

Care Transformation Requirements: The requirements that the Practice must ensure the Practice meets under the terms of the Participant Agreement.

CHC Practice Sites: Multiple locations, identified by their CCN, through which a Participant CHC participates in PC AHEAD.

CMS Certification Number (CCN): The number assigned by CMS and used to verify Medicare/Medicaid certification for survey and certification, assessment-related activities, and communications.

Community Deprivation Index (CDI): A validated community-level composite measure of social circumstances and social determinants of health, where high values represent relatively greater socio-economic deprivation. The CDI used here was developed using state-specific Census data at the Census-block level and principal component analysis. Beneficiaries are assigned a CDI on the basis of their Zip Code of residence, which are then cross-walked to Census-block. CDI developed for State Medicare beneficiaries have been demonstrated to have significant explanatory power for mortality and other health measures.

Community Health Center (**CHC**): An FQHC, Health Center, Health Center Look-Alike, or RHC as those terms are defined here.

Diagnosis of Dementia: A diagnosis identified by having at least one Medicare claim with International Classification of Diseases, Tenth Revision (ICD-10) codes from a select list during a two-year lookback period ending four months prior to the start of the Performance Year. The select list of ICD-10 codes are further described in **Appendix D** of the Primary Care AHEAD Payment Specifications paper.

Electronic Clinical Quality Measure (eCQM): Clinical quality measures that use data from electronic health records (EHR), administrative claims, and/or health information technology systems to measure health care quality. CMS uses eCQMs in a variety of quality reporting and incentive programs including AHEAD.

Eligible Beneficiary: A Beneficiary who:

a. Is enrolled in both Medicare Parts A and B.

b. Has Medicare as his or her primary payer.

c. Address of beneficiary primary residence is within a Maryland ZIP Code or a Maryland hospital PSA Zip Code.

d. Is not entitled to Medicare on the basis of an end stage renal disease (**"ESRD"**) diagnosis.

e. Is not enrolled in hospice.

f. Is not covered under a Medicare Advantage, Program of All-Inclusive Care for the Elderly (PACE), or other Medicare health plan.

g. Is not institutionalized.

h. Is not incarcerated.

i. Is not assigned or aligned to a participant in any program or model.

j. Has not elected to receive Medicaid Health Home Services (as defined in Section 1945(h)(4) of the Act) from a Section 1945 Medicaid Health Home, unless CMS notifies the Practice otherwise prior to the start of the applicable Performance Year in a form and manner to be determined by CMS.

Eligible Practitioner: A Medicare-enrolled practitioner identified by an individual NPI who bills under the TIN of the Practice and who:

a. Is a physician (as defined in section 1861(r) of the Act) or non-physician practitioner (as defined in section 1842(b)(18)(C) of the Act).

b. Has an Eligible Specialty Code with a primary specialty code.

Eligible Specialty Code: The specialization code that health care practitioners must select when enrolling their National Provider Identifier (NPI) into the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

Emergency Department Utilization (EDU): The earned utilization component of QBA is evaluated using two measures of hospital utilization, one of which is the EDU. EDU is calculated using Medicare claims based on HEDIS®-like specifications.

Enhanced Primary Care Payment (EPCP): A quarterly, per-beneficiary-per-month payment to the Practice for an attributed Beneficiary population.

Enhanced Primary Care Payment (EPCP) Fee Reduction: A 100% reduction in Medicare FFS payments to AHEAD Practitioners for all EPCP Services.

Enhanced Primary Care Payment (EPCP) Reference Population: The State Medicare FFS beneficiary population used to determine the risk tier thresholds on which the care management fee amounts are based. The EPCP reference population includes Medicare FFS beneficiaries who meet AHEAD eligibility requirements.

Federally Qualified Health Center (FQHC): A legal entity identified by an organizational NPI, a CMS Certification Number (CCN), and a Taxpayer Identification Number (TIN), and that is certified as an FQHC as defined under section 1861(aa)(4) of the Act.

Fee-For-Service (FFS): A method in which doctors and other health care practitioners are paid for each service performed based on a payment fee schedule whereby payment is the same regardless of volume and/or quality.

FQHC Prospective Payment System (PPS): The PPS is the system by which Medicare pays FQHCs. Payments for healthcare services, including mental health, are the lesser of the FQHC's charge amount and a predetermined, fixed amount. The amount varies geographically and is adjusted annually based on the actual costs of services.

Hierarchical Condition Categories (HCC) Risk Score: The CMS-HCC model, a prospective model using demographic and diagnosis information from a base year to estimate expenditures in

the next year, produces a risk score that measures a person's or a population's health status relative to the average, as applied to expected medical expenditures.

Hospital-Affiliated Primary Care Practice (HAPCP): Defined as a primary care practice that meets any of the four criteria below:

1. Direct or Indirect Ownership (≥5%) - Does any hospital or any organization that owns or operates a hospital:
    a. Hold, directly or indirectly, an ownership or control interest of five percent (5%) or more in this practice, and
    b. Itself hold, directly or indirectly, an ownership or control interest of five percent (5%) or more in that hospital?
2. Majority Control (Voting/Board/Membership) - Is the hospital or health-system entity:
    a. Able to appoint a majority of the governing board, or
    b. Able to hold more than fifty percent (50%) of voting rights, or
    c. The sole member of the practice's LLC or equivalent?
3. Provider-Based Billing or Common TIN - Are any of the practice's Medicare claims submitted:
    a. Under the hospital's Type 2 (organizational) NPI, or
    b. Under the same TIN/EIN used by the hospital entity?
4. Long-Term Management Agreement with Operational Control - Does the practice have a written management or professional services agreement of at least 3 years that gives a hospital or health-system entity authority over two or more of the following:
    a. Budget approval,
    b. Hiring and/or firing of key personnel, or
    c. Quality improvement activities?

Implementation Year (IY): Refers to the year of participation in the AHEAD Model for a given practice, beginning with Implementation Year 1 in the practice's first year of participation. The Implementation Year is specific to each practice and does not necessarily correspond to the overall duration of the AHEAD Model.

Medical Risk Adjustment: Adjustment made to the Base EPCP, based on the AHEAD Beneficiaries' HCC medical risk scores.

Medicaid Primary Care Alternative Payment Model (APM): A patient-centered medical home (PCMH) program or another primary care value-based alternative payment arrangement that includes increased accountability and care transformation structure for care coordination, health-related social needs, and behavioral health/specialty integration, that aims to improve and advance coordinated, whole-person and team-based primary care for Medicaid beneficiaries.

Medicare Physician Fee Schedule (PFS): Medicare Part B Physician Fee Schedule, used to pay physicians and other Part B practitioners for primary care services on a FFS basis.

Medicare Shared Savings Program: The Medicare Shared Savings Program (Shared Savings Program) was established by section 3022 of the Affordable Care Act. The Shared Savings Program is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act and is a new approach to the delivery of health care. Practices participating in the Medicare Shared Savings Program are allowed to simultaneously participate in the AHEAD Model.

Model Enhanced Primary Care Payment (EPCP): The average per-beneficiary-per-month payment for all PC AHEAD Participants in the AHEAD Geographic Area.

AHEAD Geographic Area: The geographic boundaries in which the AHEAD Model operates within the state, which is identified in the State Agreement.

Model Year: Refers to one of ten Model Years during the term of the AHEAD Model.

National Provider Identifier (NPI): The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care practitioners. Covered health care practitioners and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).

Participant Community Health Center (Participant CHC): **A**n Eligible PC AHEAD Participant that is a Community Health Center and has executed a participation agreement with CMS to participate in Primary Care AHEAD.

Participant Primary Care Practice (**Participant PCP**): An Eligible PC AHEAD Participant that is a primary care practice and has executed a participation agreement with CMS to participate in Primary Care AHEAD.

PBPM Benchmark Claim Sample Universe: Primary Care Services claims from the PBPM Lookback Period and limited to beneficiaries that received one or more PCS at the PC AHEAD Participant. Along with member months, the PBPM benchmark claim sample universe is used to calculate the CPCP PBPM rate.

PC AHEAD Participant: An Eligible PC AHEAD Participant that is a primary care practice and has executed a participation agreement with CMS to participate in Primary Care AHEAD. "Participant Primary Care Practice" and "Participant Community Health Center" are collectively referred to as "PC AHEAD Participants."

PCP Practice Site: A single location, identified by its TIN and provider National Provider Identifiers (NPIs), through which a Participant Primary Care Practice will participate in Primary Care AHEAD.

Performance Year (PY): Refers to the sequential year of participation for a cohort within the AHEAD Model, beginning with Performance Year 1 in the cohort's first year of participation. Performance Years are defined at the cohort level and may not align with the Model Year or an individual practice's Implementation Year.

Practice Site: The physical street address of a PC AHEAD Participant. For Participant PCPs, a practice site is identifiable by the unique combination of the practice TIN and its practitioners, identified by their NPIs. For Participant CHCs, a practice site is identifiable by the CCN and Zip Code.

Practitioner Roster: The list of nominated practitioners found in an AHEAD practice application or via subsequent practitioner addition request made via the AHEAD Portal and who meet AHEAD eligibility criteria.

Primary Care: Routine health services that cover a range of preventative and wellness care, such as cancer screenings, vaccines, check-ups, and patient counseling to prevent illnesses, disease, or other health problems, and treatment for common illnesses.

Primary Care Services: The services described by the evaluation and management code set, as modified from time to time, that is used to bill for office and outpatient visits under the Medicare Physician Fee Schedule, as well as the FQHC Services defined in Section 1861(aa)(3) of the Act payable under the Federally Qualified Health Center Prospective Payment System, as described.

Quality Based Adjustment (QBA): The portion of the EPCP that is at-risk based on quality and utilization performance.

Quality Component: The component of the QBA that measures practice performance on quality of care. Quality will be measured using three eCQMs: chronic conditions (Controlling High Blood Pressure or Hemoglobin A1c (HbA1c) Poor Control), prevention & wellness (Colorectal Cancer Screening or Breast Cancer Screening: Mammography), and behavioral health (Preventive Care and Screening: Screening for Depression and Follow-Up Plan).

Recoupment: Amounts from prior payments that must be repaid to CMS by the practice, if applicable, when a beneficiary is removed, or a practitioner withdraws from the AHEAD Model or when they no longer meet eligibility criteria for participation, or to remove unearned or redundant payments for the same services. Repayment is done by reducing or withholding (debiting) from future prospective payments.

RHC All-Inclusive Rate (AIR): A bundled payment made to RHCs for qualified primary care and preventive health services provided by RHC practitioners.

Risk-Adjusted Enhanced Primary Care Payment (EPCP): The individual, beneficiary-level EPCP that has been adjusted for both medical and population risk.

Rural Health Clinic (RHC): A clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases and meets all other requirements of 42 CFR 405 and 491.

Sequestration: The Budget Control Act of 2011 mandates across-the-board reductions in Federal spending, also known as sequestration. Sequestration affects net amounts paid to practitioners under Medicare Part A and Part B for services delivered after April 1, 2011.

Population Adjustment: Adjustment made to the Base EPCP based on the number of AHEAD Beneficiaries eligible in the AHEAD Geographic Area.

Taxpayer Identification Number (TIN): A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. It is issued either by the Social Security Administration (SSA) or by the IRS.

Utilization Component: The component of the QBA portion of the EPCP that measures practice performance on two measures: AHU and EDU. These measures are equally weighted, each contributing to 20% of the total QBA.

Appendix C: AHEAD Eligible Primary Care PECOS Specialty Codes

Specialty Code	Specialty Description
01	GENERAL PRACTICE
08	FAMILY PRACTICE
11	INTERNAL MEDICINE
16	OBSTETRICS/GYNECOLOGY
17	HOSPICE AND PALLIATIVE CARE
26	PSYCHIATRY
27	GERIATRIC PSYCHIATRY
37	PEDIATRIC MEDICINE
38	GERIATRIC MEDICINE
42	CERTIFIED NURSE MIDWIFE
50	NURSE PRACTITIONER
79	ADDICTION MEDICINE
84	PREVENTIVE MEDICINE
86	NEUROPSYCHIATRY
89	CERTIFIED CLINICAL NURSE SPECIALIST
97	PHYSICIAN ASSISTANT

Appendix D: Diagnosis of Dementia

The criterion for dementia is the presence of any ICD-10 diagnosis code during the lookback period in the list below on at least one inpatient, skilled nursing facility, outpatient, home health, or carrier claim.

Table C-1: ICD-10 Diagnoses Indicating the Presence of Alzheimer's Disease and Related Disorders or Senile Dementia

ICD-10	Condition Description
F01.50	Vascular dementia without behavioral disturbance
F01.51	Vascular dementia with behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
F03.90	Unspecified dementia without behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
F04	Amnestic disorder due to known physiological condition
G13.2	Systemic atrophy primarily affecting the central nervous system in myxedema
G13.8	Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere
F05	Delirium due to known physiological condition
F06.1	Catatonic disorder due to known physiological condition
F06.8	Other specified mental disorders due to known physiological condition
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.1	Senile degeneration of brain, not elsewhere classified
G31.2	Degeneration of nervous system due to alcohol
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
G91.4	Hydrocephalus in diseases classified elsewhere
G94	Other disorders of brain in diseases classified elsewhere
R41.81	Age-related cognitive decline
R54	Age-related physical debility

Appendix E: CMS-Hierarchical Condition Categories (HCC) Risk Adjustment Model

CMS uses the CMS Hierarchical Condition Categories (HCC) risk adjustment model[6] to adjust capitation payments made to Medicare Advantage (MA) and certain demonstration programs, with the intention of paying health plans appropriately for their predicted relative costs. For example, a health plan enrolling a relatively healthy population receives lower payments than one enrolling a relatively sick population, other things equal.

The CMS-HCC model produces a risk score, which measures a person's or a population's health status relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. It is important to note that the model is accurate at the group level and that actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

Long-term conditions such as diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), and diabetes will fall within an HCC; whereas acute illnesses and injuries will not because acute conditions are not reliably predictive of ongoing healthcare costs. To factor into risk adjustment, a diagnosis must be based on clinical medical record documentation from a face-to-face encounter, documented at least once per year, and coded according to the ICD-10-CM guidelines.

The CMS-HCC model is a prospective model using demographic and diagnosis information from a base year to estimate expenditures in the next year. New Medicare enrollees (defined here as beneficiaries with less than 12 months of Medicare enrollment in the base year) receive a risk score from the new enrollee risk adjustment model, which is a demographic-only model. If a beneficiary does not have 12 months of enrollment in the base year, the beneficiary cannot have had a complete diagnosis profile in the base year, and hence the CMS-HCC model cannot be used for the beneficiary. Because of the amount of time required to ensure that as many diagnoses are captured in the risk score development as possible, risk scores for any year are not available until at least 9 months after the close of the base year.

The demographic characteristics used in the risk model are age, sex, Medicaid status, and originally disabled status. The diagnosis information used is the set of diagnosis codes reported on Medicare claims in the base year. Not all types of Medicare claims are used; only Hospital Inpatient, Hospital Outpatient, Physician, and some non-Physician claims are considered. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an Inpatient hospitalization have equal weight as those from a Physician visit), nor does the frequency with which the diagnosis code has been reported.

In 2024, CMS created v28 of the CMS-HCC model, which MDPCP-AHEAD has adopted. Condition categories have been rebuilt in this new version, where each diagnosis code and

[6] CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment and Payment Under the Medicare Physician Fee Schedule. Version 2. Center for Medicare & Medicaid Innovation. February 17, 2017. https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf

grouping codes have been reviewed and updated. The updates serve to better predict costs by reflecting coding practices, current disease prevalence, and current costs of disease treatments.

Hierarchies are imposed among related Clinical Conditions (CCs) so that a person is coded for only the most severe manifestation among related diseases. After imposing hierarchies, CCs become Hierarchical Condition Categories (HCCs). For example, diabetes diagnosis codes are organized in the Diabetes hierarchy, consisting of three CCs arranged in descending order of clinical severity and cost, from (1) Diabetes with Severe Acute Complications to (2) Diabetes with Chronic Complications to (3) Diabetes with Glycemic, Unspecified, or No Complications. Thus, a person with diagnosis code of Diabetes with Severe Acute Complications is excluded from being coded with Diabetes with Chronic Complications and is also excluded from being coded with Diabetes with Glycemic, Unspecified, or No Complications. Similarly, a person with a diagnosis code of Diabetes with Chronic Complications is excluded from being coded with Diabetes with Glycemic, Unspecified, or No Complications. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate, i.e., the model is "additive." For example, a female with both Rheumatoid Arthritis and Breast Cancer has (at least) two separate HCCs coded, and her predicted cost will reflect increments for both conditions.

Because a single individual may be coded for no HCCs, one, or more than one HCC, the CMS-HCC model can individually price tens of thousands of distinct clinical profiles. The model's structure thus provides, and predicts from, a detailed comprehensive clinical profile for each individual.

For more information on the CMS-HCC risk model, see the following web page:
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html