

Policy & Operational Guidance: eCQM Submission via DAVE

Maryland's AHEAD Primary Care Programs

PY 2026

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Program Context & Scope

Overview of Maryland's AHEAD Primary Care Programs

As part of Maryland's participation in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, the State offers eligible primary care providers the opportunity to participate in Maryland's AHEAD Primary Care Programs. These Programs include: the Maryland Primary Care Program AHEAD (MDPCP-AHEAD), Primary Care AHEAD (PC AHEAD), and the Medicaid Advanced Primary Care Program.

To achieve statewide alignment across these programs, participation in a Medicare program (MDPCP-AHEAD or PC AHEAD) mandates concurrent participation in the Medicaid Advanced Primary Care Program. The Medicaid program requirement applies to PC AHEAD participants beginning January 2026 and will be fully implemented for existing MDPCP-AHEAD practices no later than PY 2027.

Operational structures differ across these initiatives:

- **Medicare Models (MDPCP-AHEAD and PC AHEAD):** Participation and program monitoring at the individual **practice site level**.
- **Medicaid Advanced Primary Care Program:** Participation at the **Tax Identification Number (TIN) level**. A single legal TIN may encompass one or multiple practice locations.

Mandated eCQMs & Incentive Structures

Participating entities are required to submit electronic Clinical Quality Measures (eCQMs) across four core clinical domains for Performance Year (PY) 2026. Data collection occurs on an annual cadence; the DAVE submission portal opens in **January 2027** and remains open through **March 31, 2027** (Q1 2027). Quality submissions reflect direct program accountability, though incentive structures differ across programs:

- **MDPCP-AHEAD & PC AHEAD (Medicare):** Evaluated under a **Pay-for-Performance (P4P)** structure, where quality achievement directly influences incentive payments.
- **PC AHEAD (Medicare)**: Evaluated under a Pay-for-Performance (P4P) structure for most participants
    - For PY 2026 eCQM reporting, PC AHEAD practices with fewer than 125 beneficiaries were given the option of P4P or Pay-for-Reporting (P4R)
- **Medicaid Advanced Primary Care Program:** Evaluated under a **Pay-for-Reporting (P4R)** model, prioritizing complete and compliant submission of quality data.

Clinical quality measures must be reported across an **all-payer patient population**, capturing all qualifying patients treated by participating primary care clinicians.

Table 1:

Clinical Quality Measure	MDPCP-AHEAD Only	MDPCP-AHEAD & Medicaid Adv Primary Care	PC AHEAD & Medicaid Adv Primary Care	Medicaid Adv Primary Care Only
CMS 2: Screening for Depression and Follow-Up Plan	Required	Required	Required	Required
CMS 165: Controlling High Blood Pressure	Required	Required	Required	Required
CMS 122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Required	Required	Required	Required
CMS 130: Colorectal Cancer Screening	***Not Required***	Required	Required	Required

Eligible Clinicians Criteria

Data submissions are limited to patients who had at least one encounter with an AHEAD-participating **primary care provider in an affiliated practice**.

For the **Medicaid Advanced Primary Care Program**, data submissions should only include patients who received care from a primary care provider present on the Q4 2026 HealthChoice Assignment List ("MCO Assignment List"). Therefore, data submissions should exclude patients who only received care from a specialist who appears on the MCO Assignment List.

For the **MDPCP-AHEAD and PC-AHEAD Programs**, data submissions should only include patients who received care from primary care providers present on the CMS reported Q4 2026 physician roster.

Primary care providers are defined by the Programs' participation guides and are summarized below. The provider type and specialty is based on the Medicaid Provider details maintained by the State of Maryland.

Table 2: Provider Types, Descriptions, and Specialties

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

Participants are encouraged to work with their EHR vendor to filter out specialists prior to export. However, if your EHR cannot filter out specialists who treated your patients, the DAVE tool includes back-end logic that will automatically exclude non-primary care specialist data from final measure calculations.

> ! **Best Practice:**
>
> Before reporting opens, assess your EHR capabilities to determine whether your EHR can filter out specialists prior to QRDA-I exports.

Entity & Provider Inclusion Thresholds

Submission requirements are established based on active participation status at the conclusion of the performance year:

> 📌 **Key Rule:**
>
> If a primary care provider was active at your practice on December 31, 2026, you will report on their full-year patient population.

- **Year-End Active Status:** Submissions are required only for practice locations and individual clinicians who are active as of December 31, 2026. If a clinician relocated between practice sites during the year, their clinical data must be submitted under their active location as of December 31, 2026.
    - **Full-Year vs. Partial-Year Participation:** TINs participating in the Medicaid Advanced Primary Care Program for the full calendar year are required to submit data. All active MDPCP-AHEAD/PC AHEAD practices are required to submit data. If a practice or TIN is terminated, withdraws, or goes through a merger with an effective date before December 31, 2026, it does not have to report eCQMs.
- **All-Payer Population Standard:** Submissions must reflect the complete, all-payer patient population receiving care from participating primary care clinicians during the performance year.

Minimum Denominator Thresholds for Reporting

PY 2026 eCQM reporting is evaluated at the participating organization level across the AHEAD Primary Care Programs. All participants that exceed an all-payer denominator of 20 patients within a given measure are required to submit eCQM data for that measure. Once the all-payer denominator of 20 patients is exceeded, all practices within that participating organization's TIN must submit data for their eligible population, regardless of denominator size. This threshold applies across all eCQMs.

Technical Specifications for Patient-Level Reporting

Patient-level reporting must be submitted using the Quality Reporting Document Architecture Category I (QRDA-I) standard. A QRDA-I file is an HL7-compliant, standardized data file produced directly by certified Electronic Health Record (EHR) systems enabled with eCQM performance tracking.

QRDA-I Standardization & Ease of Extraction

Any EHR configured for eCQM tracking can automatically generate a QRDA-I export.

- **Standardized Architecture (Non-Customizable):** The QRDA-I framework is governed by strict HL7 national standards. The file schema, clinical code structures, and data tags are standardized across certified EHR platforms to ensure consistent quality measurement nationwide. Submitters do not need to build custom files or alter the file architecture.
- **No Manual Data Handling:** Because QRDA-I files are generated directly by the EHR based on structured clinical documentation, participants can export and submit these files without manual data transformation, custom coding, or spreadsheet handling.
- **Machine-Readable Code:** QRDA-I files are designed for direct system-to-system ingestion and are **not human-readable**. The underlying file structure consists of Extensible Markup Language (XML) and clinical code blocks (resembling computer code or database scripts). Opening a raw QRDA-I file on your computer will reveal structured code tags rather than formatted document text; **this code appearance is expected and correct.**

Continuity of Care Document (CCD) files will not be accepted for PY 2026 reporting. CCD files frequently contain proprietary local coding (e.g., internal lab codes) that create substantial processing bottlenecks and calculation discrepancies during ingestion. The inclusion of CCD's may be considered for future years.

QRDA-I Clinical Domains & Optional Extensions

A complete QRDA-I file compiles discrete clinical data elements from structured EHR fields needed to evaluate measure specifications. As the QRDA-I is developed from the same EHR module that displays quality measure results for providers, complete consistency between the QRDA-I calculated quality measure results in the DAVE tool and the quality measure results displayed in your EHR is expected.

Each patient file contains structured modules spanning the following core clinical domains:

- **Patient Demographics & Administrative Data:** Patient identifiers, date of birth, sex, race, ethnicity, and primary/secondary payer details.
- **Provider & Encounter Details:** National Provider Identifiers (NPIs) for rendering and attending clinicians, encounter dates, and service location details.

- **Clinical Diagnoses & Conditions:** Active problem lists, medical history, and coded diagnoses (ICD-10-CM / SNOMED-CT).
- **Procedures, Interventions, & Diagnostic Studies:** Completed clinical interventions, preventive screenings, and procedure coding (CPT / HCPCS).
- **Medications & Laboratory Results:** Prescriptions, active medications (RxNorm), and structured diagnostic lab test results (LOINC, e.g., HbA1c values, blood pressure readings).
- **eCQM Logic Evaluation Data:** Specific clinical criteria utilized to determine initial patient populations, measure denominators, numerators, exclusions, and exceptions.

While the QRDA-I schema is standardized nationally, base EHR exports may leave specific metadata fields disabled by default. To ensure data ingested through DAVE accurately maps to organizational quality agreements, participating entities must instruct their EHR vendor or IT team to **enable the following standard optional fields** in export settings:

- **Type 2 Organization NPI** *(Mandatory identifier to resolve billing TIN and site mappings)*
- **Physical Practice Site Street Address** *(Mandatory for mapping multi-site practice locations)*
- **Rendering Primary Care Clinician NPI**

> 💡 **Action Item for IT Staff and EHR Vendors:**
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> Ensure CY 2026 eCQM QRDA-I export settings have the following standard optional fields enabled: (1) Type 2 Organizational NPI, (2) Physical Practice Site Address, and (3) Rendering Primary Care Clinician NPI.

Privacy Considerations & Sensitive Data Handling

The protection of patient privacy and the security of clinical data are foundational to the operation of the DAVE platform. DAVE is hosted within the secure, web-based CRISP Reporting Services (CRS) Portal environment. All data transmissions, file uploads, and storage processes utilize enterprise-grade encryption and security controls specifically designed for health data governance and regulatory compliance. Data sharing with CRISP through the eCQM DAVE tool is covered under the CRISP Quality Improvement & Care Coordination use case.

Patient-level Protected Health Information (PHI) extracted in QRDA-I files is used strictly within the secure DAVE environment to perform automated measure calculation, patient deduplication across practice sites within a TIN, and data quality validation. Patient-level data is required to allow for across and within practice measure calculation aggregation. **Patient-level PHI is never shared with CRISP, the Office of Advanced Primary Care (OAPC), the Maryland Department of Health (MDH), or CMS**[1]. All official quality reporting outputs delivered for MDPCP-AHEAD, PC AHEAD, and Medicaid Advanced Primary Care Program evaluations are provided strictly as aggregated performance rates (numerators, denominators, and exclusions) and are expected to be provided at the practice-level for OAPC and CMS.

[1] CRISP Policy: Use Case Description: eCQM Reporting Tool

Modern EHR platforms often utilize automated suppression logic to shield sensitive health records (e.g., behavioral health, substance use, or confidential adolescent care). However, submitting suppressed QRDA-I files inadvertently strips out required clinical criteria, leading to artificial deflation of quality scores. Participating organizations **must ensure quality extraction workflows utilize unsuppressed datasets to reflect true clinical performance**.

CMS 2 (Depression Screening): State and clinical leaders recognize that extracting adolescent behavioral health details presents technical and legal privacy challenges. To eliminate administrative burden, all participating organizations are expected to submit manual aggregate data for CMS 2 directly in DAVE without applying for an OAPC exemption. Participants whose EHR systems support privacy-compliant extractions remain welcome to also submit standard QRDA-I files.

> ⭐ **Special Consideration for CMS 2 (Depression Screening):**
>
> All participating organizations are expected to submit manual aggregate data for CMS 2 directly in DAVE without applying for an OAPC exemption.

Implementation & Operational Readiness Timeline

Phase 1: Mandatory Registration Process (November 2026)

November 2026, OAPC will initiate a mandatory Registration Process via the CRS portal. Every participating TIN (or independent MDPCP-AHEAD-only practice) must complete registration by December 11, 2026.

> 💡 **Action Item for All Practice Organizations:**
>
> Complete mandatory Registration Process via CRS Portal.

Registration establishes the baseline organizational structure for all participants and requires submitters to provide:

1. Legal TIN and Organizational (Type 2) NPI.
2. Official Program Identifiers (MDPCP-AHEAD Practice ID / PC AHEAD Practice ID).
3. Physical street addresses for every participating practice site under the TIN.
4. Roster of active primary care clinician NPIs as of December 31, 2026.
    a. For MDPCP-AHEAD and PC AHEAD, this is based on your provider roster on file with CMS for Q4 2026. For the Medicaid Advanced Primary Care Program, this is based on the primary care (not specialist) providers on your MCO Assignment Lists for Q4 2026.
5. Patient population served across all participating practice sites (i.e., pediatrics under 18, pediatrics and young adults 18-21, adults only, or all ages)

6. Designated submission method (QRDA-I vs. Aggregate) for each population-eligible measure.

To aid in the collection of this information, the Registration module will auto-populate with known fields, such as the physical address and roster of active primary care clinicians for MDPCP-AHEAD and PC AHEAD participating practices, and roster of assigned primary care clinicians for practices participating in the Medicaid Advanced Primary Care Program.

Data submitters will also need to attest to the accuracy of their registration information and provide contact information if follow-up for clarifications are required.

Phase 2: Aggregate Reporting Exemption Process (November 2026)

Organizations whose EHR systems lack technical capabilities to produce valid QRDA-I files for one or multiple measures must submit a formal Exemption Request Application directly to OAPC.

Exemption applications are evaluated by OAPC. Approved participating organizations will be provisioned in DAVE to enter manual aggregate eCQM values. Exemptions are granted at the individual practice site level and require the applicant to detail their technical remediation plan to achieve QRDA-I capability for PY 2027.

Phase 3: Pre-Submission Technical Audit & Readiness Checklist

Prior to the opening of the DAVE platform in January 2027, organization leads should execute the following operational readiness steps:

1. **Identify Eligible Clinicians & Practices:** Reconcile active primary care providers against official program rosters (provider rosters for MDPCP-AHEAD and PC AHEAD and MCO Assignment Lists for Medicaid) and filter out non-primary care specialists.
2. **Ensure Minimum Thresholds are Met**: Evaluate whether your participating organization (across all participating practices) meets the all-payer denominator of 20 patients for each measures you are expected to report for PY 2026.
3. **EHR Capability Audit:** Confirm with EHR vendor whether the software can generate compliant PY 2026 QRDA-I exports.
4. **Role Assignment:** Designate a primary Data Submitter for file uploads and final submission attestation. By default, DAVE access will be provisioned for the CRISP Reporting Services (CRS) Point of Contact (POC) for each participating TIN and MDPCP-AHEAD-only participating practice. The CRS POC can add and/or credential additional users for access to DAVE via the Reports Role Manager application if needed.
5. **Test Extraction:** Work with your EHR vendor or internal IT team to ensure that QRDA-I extraction routines are properly configured to include the mandatory program extension

fields (Type 2 NPI, physical practice site address, and rendering PCP NPI) and that privacy filters do not inadvertently strip out clinical data.

Phase 4: Data Submission, Testing, & Attestation (Q1 2027)

When the application goes live in January, participants will have access to an embedded testing feature (referred to as a Sandbox) within DAVE before finalizing their production submission. This Sandbox is not the final submission area and is only a testing environment. Participants can upload draft or trial QRDA-I files into the integrated Sandbox environment prior to formal filing. **DAVE submissions can be at either the complete TIN-level or at the single or multi-practice level**. DAVE will automatically check XML schema formatting, syntax, and mandatory extension fields (Type 2 NPI, physical address, rendering NPI) and identify any warnings to the user. DAVE will also allow users to view real-time calculated eCQM rates, powered by the embedded calculation engine that has been validated against the official CMS Cypress testing engine.

> **! Best Practice:**
>
> Upload your trial QRDA-Is in January to ensure ample time for review, modifications, and validation. Aim for final data submission by March 15th to allow time for any unforeseen technical questions or issues before the deadline

Participants are encouraged to cross-check measure rates generated in DAVE directly against quality metrics displayed in your EHR's population health or eCQM module. Because QRDA-I files reflect true structured documentation within the EHR, score calculations between DAVE and a properly configured EHR module should align. Discrepancies highlight opportunities to refine internal EHR documentation or adjust export parameter filters prior to final filing.

Any automated warnings or data quality details can be reviewed and addressed in the DAVE platform. If errors or formatting issues are detected, DAVE flags specific details, allowing the participant to correct underlying EHR data or export settings and re-upload files into DAVE.

Once a participant has verified its test results in the testing area and resolved any data quality flags, the authorized Data Submitter can submit the verified file to the production environment for final submission. After upload, the final submission requires the Data Submitter to complete an online electronic attestation confirming the completeness and accuracy of the submitted clinical data, to the best of their knowledge.

FAQs

Q1: What is the formal submission timeframe for PY 2026 data?
A1: The DAVE platform opens for PY 2026 reporting on **January 4, 2027**, and closes on **March 31, 2027**. Final aggregated results are reported by OAPC to CMS in April 2027.

Q2: May an organization submit a combination of patient-level files and aggregate data?
A2: Yes. Multi-site TINs may submit QRDA-I files for capable practice locations and aggregate data for practice locations granted a formal OAPC exemption.

Q3: How does the platform handle patient deduplication when a patient receives care across multiple practice locations within a TIN?
A3: Patient deduplication at the TIN level is handled automatically within the DAVE tool using a combined TIN and Medical Record Number (MRN) algorithm, provided the data originates from a single EHR system. If an organization operates multiple distinct EHR systems with disparate MRN structures, deduplication across those sites cannot occur, and patients will be calculated within their respective site submissions. Furthermore, if the TIN submits aggregate data only, the data cannot be deduplicated and the patient will remain included in all practice-level details where they are reported.

Q4: A primary care physician left our practice mid-year. Do we include their patients in our PY 2026 submission?
A4: No. eCQM reporting rules are based on active provider rosters as of the close of the calendar year (December 31, 2026). Because the physician was not actively practicing at your practice on that date, patients who only received services from that physician must be excluded from your practice's submission. If that physician relocated to another participating practice within your TIN and was active there as of December 31, their full-year patient encounters will be reported under that practice and would still be rolled into the overall TIN calculation.

Q5: How are mid-year EHR transitions handled?
A5: Practice sites that transitioned to a new EHR system during performance year 2026 are evaluated on a case-by-case basis. Organizations facing this scenario must contact OAPC at mdh.pcmodel@maryland.gov prior to the submission window for specific guidance.

Q6: Is patient-level PHI submitted to the DAVE tool available to, transferred, or shared with any state or federal officials?
A6: No. Patient-level QRDA-I files uploaded to DAVE are utilized strictly for validation, deduplication, and measure calculation within the secure tool environment. Final reporting outputs delivered to OAPC and CMS contain aggregate rates only. Neither CRISP nor OAPC will have access to PHI-level data.

Q7: A specialist (e.g., a Cardiologist or OB/GYN) appears on our official Medicaid MCO Assignment List. Are we required to submit quality data for them?
A7: No. eCQM reporting for PY 2026 is strictly confined to primary care physicians. Even if a specialist is attributed to your organization on an MCO Assignment List, they must be excluded from your eCQM submissions. Primary care status is confirmed through the provider specialty taxonomy filed on your Medicaid claims provider master file.

Q8: Why is the Type 2 Organization NPI mandatory during registration?
A8: Many health systems have multiple clinical sites associated with a single TIN. While MDPCP-AHEAD and PC AHEAD assign unique Practice IDs to these locations, those identifiers do not align with billing identifiers captured in QRDA-Is. Collecting the Type 2 Organization NPI provides an unambiguous identifier, ensuring that data processed by DAVE accurately maps to your organization's practices.

Q9: When will the DAVE Sandbox feature become available for testing files?
A9: The interactive DAVE Sandbox feature will become available inside the application when

the portal officially opens. During the data submission window, participants can upload draft QRDA-I files into the sandbox to test formatting, review score calculations, compare results against their internal EHR modules, and resolve errors prior to promoting their submission to production.

Q10: How do I know the DAVE tool will calculate my quality measure results correctly?
A10: The DAVE tool's calculation logic has been thoroughly tested and validated against the official CMS Cypress tool, which is the national benchmark for eCQM calculation verification. Additionally, because QRDA-I files are standardized exports of your structured EHR clinical documentation, DAVE's calculations will directly mirror the rates calculated by your EHR's certified eCQM module when evaluating the same patient population. Participants can verify this alignment during the data submission window by uploading test files into the interactive DAVE Sandbox to review scores before finalizing their submission.

Q11: What is the minimum threshold for an eCQM? My participating TIN organizations sees very few adult patients.
A11: The minimum all-payer denominator threshold is 20 patients for each individual measure. If your TIN organization has more than 20 patients for a given measure's denominator, then your TIN will be required to report that measure and all practices within that TIN should submit patient data for that measure.