Maryland HealthChoice Demonstration

Section 1115 Demonstration Extension Application

Submitted by the Maryland Department of Health

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LIST OF ACRONYMS

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- Affordable Care Act (ACA)
- American Society of Addiction Medicine (ASAM)
- Assistance in Community Integration Services (ACIS)
- Average length of stay (ALOS)
- Calendar year (CY)
- Center for Medicare and Medicaid Innovation (CMMI)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Collaborative Care Model (CoCM)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
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SECTION I. INTRODUCTION

Pursuant to Section 1115 of the Social Security Act, the Maryland Department of Health (the Department) is seeking a five-year extension for its Section 1115 Demonstration (HealthChoice demonstration). The HealthChoice demonstration authorizes Maryland's managed care program, known as HealthChoice, as well as other innovative programs. Maryland's existing demonstration period is from January 1, 2022, through December 31, 2026. With this extension application, the Department is seeking approval for January 1, 2027, through December 31, 2031. The demonstration seeks to align with the national priorities of the Department of Health and Human Services (HHS) including but not limited to primary care, maternal and child health, and mental health.[1]

The HealthChoice demonstration was first implemented in Maryland in July 1997, for an initial period of five years. The Centers for Medicare and Medicaid Services (CMS) approved subsequent demonstration extensions between 2002 through 2021 as described in Section II. Throughout each extension, Maryland has continued to improve the HealthChoice program and develop robust evaluations associated with the demonstration. As of the end of April 2025, of the 1,525,787 participants enrolled in the Maryland Medical Assistance (Medical Assistance) Program, approximately 86 percent (1,306,341) were enrolled in HealthChoice.

The HealthChoice demonstration aims to support the health of Marylanders and to generate health care cost savings at the state and federal levels. At its core, the HealthChoice demonstration is designed to improve health outcomes for eligible populations, maintain affordable whole-person care, and encourage appropriate utilization of health care services–all of which support furthering managed care efficiencies and the long-term fiscal sustainability of the Medical Assistance Program.

This extension request is for the period beginning in January 2027 and effective through December 2031, and focuses on furthering the successes of high quality, patient-centered, and cost-effective care initiated in prior demonstration periods. The benefits of the managed care program and innovative initiatives have been demonstrated through a series of independent evaluations performed by the Hilltop Institute at the University of Maryland, Baltimore County (the Hilltop Institute); please see Attachment I: 2025 HealthChoice Annual Evaluation (CY 2019-2023) for the most current evaluation. In addition, the Department strives to align with statewide efforts designed to reduce health care expenditures and improve health outcomes.

This extension application will review existing programs and relevant modifications for the next demonstration period.

1.1 Five-Year Extension Request

The Department formally requests extension approval for the programs listed below, and their associated expenditure authorities; those with an asterisk (*) indicate a request for modification. The listed years indicate when the program was first implemented as part of Maryland's HealthChoice demonstration. This application discusses each of these existing programs in further detail in Section III.

[1] "HHS Announces Transformation to Make America Healthy Again," US Department of Health and Human Services, Press Release on March 27, 2025, https://www.hhs.gov/press-room/hhs-restructuring-doge.html.

Table 1. Existing HealthChoice Demonstration Programs to be Extended

Program Type	Year
Managed Care	**1997**
Rare and Expensive Case Management (REM)	**1997**
Behavioral Health	
Institutions for Mental Diseases: Residential Treatment for Individuals with Substance Use Disorder	2017
Institutions for Mental Diseases: Services for Adults with Serious Mental Illness	2022
Targeted Pre-Release Services for Justice-Involved Individuals	2025
Preventive Care and Maternal and Child Health	
Inpatient Benefit for Pregnant Individuals Eligible through Hospital Presumptive Eligibility	2014
Dental Services for Former Foster Care Youth	2017
HealthChoice Diabetes Prevention Program	2018
MOM Program	2021
Home and Community-Based Services	
Increased Community Services*	2009
Assistance in Community Integration Services	2017

Further, the Department requests continued approval of the relevant waivers to Section 1902 of the Act, listed below:

- Amount, Duration, and Scope (§1902(a)(10)(B))
- Freedom of Choice (§1902(a)(23)(A))
- Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release (§1902(a)(84)(D))

Additional details regarding waivers to Section 1902 of the Act and expenditure authorities are included in Section VI.

The HealthChoice demonstration is governed by five goals developed in partnership with stakeholders in 1997:

- Improving access to health care for the Medicaid population, including special populations;
- Improving the quality of health services delivered;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single “medical home” through a primary care provider (PCP);

- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Expanding coverage to additional Marylanders with low income through resources generated by managed care efficiencies through Section 1115 demonstration programs and pilots as described in this application.

SECTION II. THE SECTION 1115 DEMONSTRATION IN THE MARYLAND LANDSCAPE

In 1997, the state of Maryland implemented HealthChoice, its statewide mandatory Medicaid managed care program. Under HealthChoice, eligible families and individuals are required to enroll in a managed care organization (MCO) that has been approved by the Department. Currently, there are nine approved MCOs serving Marylanders. Through the years, the Department has strived to meet and exceed quality and access goals for its participants. These achievements have occurred through payment delivery system reform initiatives and innovative programs designed to test cost-effectiveness. This section provides context regarding the history of HealthChoice in Maryland as well as the 2022–2026 demonstration period.

2.1 Demonstration History and Successes

CMS has renewed Maryland's HealthChoice demonstration seven times since its initial implementation in 1997. Over the years, the demonstration has evolved to adapt to shifts in Maryland's health and health care landscape while adhering to the original principles determined by stakeholders at its inception:

1) Develop a system focused on the patient, featuring a medical home (primary care provider);
2) Create comprehensive systems of care that emphasize prevention;
3) Build on the strengths of Maryland's existing health care delivery system;
4) Hold managed care organizations accountable for delivering high-quality care; and,
5) Achieve better value and predictability for the state's dollars.[2]

Key Transitions

The Department has leveraged Section 1115 authority to test innovative programs that result in healthier outcomes for Medical Assistance Program participants. As a result of evaluation findings and legislative action, Maryland has shifted several benefits originally tested through the demonstration into the State Plan in recent years.

Since the 2021 extension, four pilot programs successfully transitioned to the State Plan authority, enabling all Medical Assistance Program participants to receive the benefits and services as applicable. They include: the Home Visiting Services (HVS) Pilot, the Adult Dental Pilot, the Medicaid Alternative Destination Transport Pilot Program, and the Collaborative Care Model (CoCM) Pilot.

- **Home Visiting Services Pilot:** In operation from calendar year (CY) 2018 to CY 2021, this pilot provided support and education for pregnant women and taught parenting skills before and after birth until age three. Evaluation results indicated 75 percent of participating mothers were screened for depression within three months of delivery and all participating children had at least one well-care visit within 15 months of birth. In January 2022, with CMS approval, the

[2] Debbie I Chang et al. "Honesty As Good Policy: Evaluating Maryland's Medicaid Managed Care Program," *Milbank Quarterly* 81, no. 3 (2003): 389-414, doi: https://doi.org/10.1111/1468-0009.t01-1-00061.

Department transitioned this successful pilot to the State Plan.

- **Medicaid Alternative Destination Transport Pilot Program:** The Alternative Destination Transport Pilot Program, based on Medicare's Emergency Triage, Treat and Transport Model, allowed payments for ground transport to alternative destinations such as urgent care providers in addition to the emergency department (ED). In December 2021, the Department began planning the implementation of the program in three jurisdictions in Maryland. During the planning phase, state legislation passed requiring Alternative Destinations to expand statewide effective July 1, 2022. The enabling legislation also allowed Maryland to reimburse Emergency Medical Services Systems for mobile integrated health; both Alternative Destinations and mobile integrated health were added to the State Plan at that time.

- **Adult Dental Pilot:** From 2019 to 2022, this pilot enabled full dual eligibles between the ages of 21 and 64 to receive diagnostic, preventive and restorative dental services up to $800 annually. During the pilot, the percentage of participants with at least one ED visit with a dental diagnosis decreased, and the percentage of users with at least one ED visit with a primary dental diagnosis also declined.[3] Coverage was expanded statewide to all adults through the State Plan on January 1, 2023. The $800 annual limit on services was eliminated, and benefits were expanded to include a wider range of services.

- **Collaborative Care Model Pilot:** This pilot provided a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings to improve health outcomes for participants with mental illness or substance use disorder (SUD) from 2020 through 2023. Of 425 participants who had a recorded depression screening and were enrolled for 70 days or more, 43 percent reported a substantial decrease in their screening scores. Effective October 1, 2023, the Department expanded the CoCM Pilot to a statewide benefit as mandated by the state legislature.

During the current demonstration period, the Department sunsetted the Women's Breast and Cervical Cancer Program (WBCCHP) effective August 2024. This program provided Medicaid coverage for women with breast and cervical cancer with incomes up to 250 percent of the Federal Poverty Level (FPL). Following passage of the Affordable Care Act (ACA), in 2014, the Department expanded Medical Assistance eligibility to cover adults up to 138 percent of the FPL and launched the Maryland Health Connection to make qualified health plans available to Marylanders. In light of these changes, WBCCHP enrollees had new options for accessing care.

The subsections below outline the major goals and history of the demonstration since the implementation of the HealthChoice demonstration.

Maryland's HealthChoice Demonstration Through the Years: 1997–2026 Waiver Periods

1997 Demonstration Approval (June 1997–June 2002)

In October 1996, CMS approved a Section 1115 demonstration request to establish Maryland's managed care program, HealthChoice, effective in June 1997 for an original five-year period. Maryland first sought to transition to mandatory managed care with the goal of decreasing health care spending and

[3] "Evaluation of the Maryland Medicaid HealthChoice Program: CY 2018 to CY 2022," The Hilltop Institute UMBC, published on June 30, 2024, https://health.maryland.gov/mmcp/healthchoice/Documents/HC-Monitoring-Evaluation/Post-Award-Forum/2024/Evaluation-Report.pdf.

improving outcomes following successful smaller scale initiatives delivering services through health maintenance organizations. This request also included the now longstanding Rare and Expensive Case Management (REM) program.

2002 Demonstration Extension (June 2002–June 2005)

Maryland's first evaluation indicated the success of the HealthChoice demonstration in improving access to care, leading Maryland to request its first extension. An amendment during this demonstration period included the creation of the Family Planning Program which enabled women who lost Medicaid eligibility after pregnancy to receive family planning services.

2005 Demonstration Extension (June 2005–June 2008)

During this demonstration period, Maryland established the Primary Adult Care (PAC) Program. PAC provided a limited benefits package to adults whose incomes were at or below 116 percent of the FPL. This demonstration period also included the implementation of the Employed Individuals with Disabilities (EID) program. An approved amendment during this period enabled the Department to automatically re-enroll participants in an MCO within 120 days of disenrollment, improving continuity of care.

2008 Demonstration Extension (June 1, 2008–June 30, 2011)

The 2008 demonstration extension aimed to continue to build upon the success of the now mature HealthChoice program. This extension period added additional benefits to the PAC Program, specifically physician and emergency services and outpatient hospital services, and requested that the Family Planning Program continue. The Department also continued to strengthen the design of its evaluation. Additionally, an amendment during this period established the Increased Community Services (ICS) Program in September 2009. While initially continued as part of this extension, the EID Program transitioned to the State Plan following the passage of the American Recovery and Reinvestment Act of 2009.

2011 Demonstration Extension (July 1, 2011–December 31, 2013)

The 2011 extension focused on improving quality of care throughout the HealthChoice program, covering new populations, expanding access to care, and implementing the ACA requirements. The extension continued PAC and ICS, expanded the Family Planning Program, and expanded benefits within the REM program.

2013 Demonstration Extension (November 1, 2013–December 31, 2016)

The federal and state health care landscape changed significantly during this time as a result of the ACA expansion, effective January 1, 2014, in Maryland. To effectuate the expansion, the Department sunsetted the PAC Program, and PAC participants transitioned into the ACA expansion coverage; demonstration authority also added the ACA expansion population into mandatory managed care.

Maryland also closed new enrollments to the demonstration's WBCCHP and allowed participants as of December 31, 2013, to remain enrolled. Maryland also modified the REM program, receiving authorization to selectively contract with a single agency for the provision of case management services and to claim REM case management services as medical expenditures, and implemented the inpatient benefit for pregnant women eligible through the hospital presumptive eligibility (HPE) option. Maryland was also given the authority to remove a requirement that children wait six months before being eligible

for Medicaid after losing employer-sponsored coverage.

The process of carving out specialty SUD services from managed care began during this period. With this shift in delivery model, Maryland focused on multiple initiatives designed to improve the continuum of care and enhance behavioral health integration in subsequent demonstration periods.

2016 Demonstration Extension (January 1, 2017–December 31, 2021)

The sixth demonstration extension and related amendments furthered Maryland's commitment to focusing on the behavioral and maternal and child health needs of its population. The Department established the community health pilot programs: HVS and Assistance in Community Integration Services (ACIS), increased the ICS enrollment cap, and expanded dental benefits for former foster youth through age 26.

The Department also received expenditure authority for residential treatment for individuals with SUD in institutions for mental disease (IMD). Maryland phased in coverage of SUD IMD services across populations and American Society of Addiction Medicine (ASAM) levels of care over the course of this demonstration period, significantly expanding the continuum of care.

- Effective July 1, 2017, Maryland implemented reimbursement for up to two 30-day stays annually for ASAM Levels 3.7WM (Withdrawal Management), 3.7, 3.5, and 3.3.
- Effective January 1, 2019, Maryland phased in coverage of ASAM Level 3.1.
- Effective January 1, 2020, Maryland expanded coverage to dual eligibles for all ASAM levels.

Amendments further expanded services to address behavioral and maternal and child health needs:

- 2018 Amendment
    - Allowed certain inpatient treatments for participants with a primary SUD diagnosis and secondary mental health diagnosis for ASAM Level 4.0 for up to 15 days in a month for individuals 21 through 64 years of age;
    - Implemented the National Diabetes Prevention Program (DPP) as an evidence-based, Centers for Disease Control and Prevention (CDC) established lifestyle change program to reduce risk of developing type 2 diabetes;
    - Created a limited adult dental benefit pilot for dual eligible participants aged 21 to 64, subject to a $800/annual cap;
    - Increased ACIS pilot spaces from 300 participants to 600; and,
    - Sunsetted the Family Planning Program from the HealthChoice demonstration as coverage shifted to the State Plan.
- 2019 Amendment
    - Established the CoCM Pilot. CoCM is an evidence-based approach for integrating physical and behavioral health services in primary care settings to improve health outcomes for individuals who have experienced mental illness or have an SUD diagnosis.

2021 Demonstration Extension (January 1, 2022–December 31, 2026)

In the seventh demonstration extension, Maryland established the MOM program and expanded IMD services. The MOM program provides enhanced case management services to improve health outcomes for pregnant and postpartum HealthChoice participants diagnosed with an opioid use disorder (OUD) and their babies. IMD expansions included coverage of inpatient treatment for adults with serious mental illness (SMI) without a co-occurring SUD in private IMD. Additionally, IMD residential treatment

for individuals with SUD was modified to allow ASAM 4.0 coverage in contiguous states and the District of Columbia (D.C.). Based on stakeholder input, Maryland also requested to cover an average length of stay (ALOS) of no more than 30 days across all participants statewide, and no more than 60 days for any individual.

Amendments during this period made a variety of changes to the HealthChoice demonstration. The CoCM Pilot, Adult Dental Pilot Program, Alternative Destination Program, and HVS all transitioned to the State Plan as statewide benefits, indicating the success of these programs. WBCCHP also officially sunsetted. Other amendments included a modification to the existing ACIS pilot program and authorization of the Reentry Demonstration.

2.2 COVID-19 Public Health Emergency and Subsequent Unwinding

Throughout the 2022-2026 demonstration period, the Department made significant progress in meeting or exceeding the quality and access goals of the HealthChoice demonstration, implementing payment and delivery system reform initiatives, and designating new population health priorities along with related measures and performance targets. While there were many positives during this period, the Department experienced the lasting effects of the COVID-19 pandemic.

On January 31, 2020, former HHS Secretary Alex M. Azar II declared a public health emergency (PHE) to aid the nation's health care community in responding to the COVID-19 pandemic. As part of Maryland's response to this national emergency, the Department applied for and obtained numerous emergency waivers from CMS to enable continued operations and service delivery during the PHE. In addition, the Department followed CMS maintenance of effort (MoE) requirements in order to obtain an enhanced federal match granted during the PHE and to allow continued coverage regardless of redetermination status (*i.e.* "continuous eligibility"). During the PHE, individuals were only disenrolled for the following reasons: participant moved out of state, death of the participant, or participant requested to be disenrolled from coverage. The PHE expired on May 11, 2023.

In a non-pandemic environment, the eligibility status of most Medical Assistance Program participants is reviewed every 12 months through a process called "redetermination." However, due to the continuous eligibility MoE requirement, individuals who were no longer eligible for coverage, based on information reported or due to failure to return to the system to re-apply, had their coverage extended administratively by the Department. As a result, Medical Assistance enrollment grew substantially, from 1,415,631 participants in February 2020 to 1,800,029 participants as of May 31, 2023. In contrast to many states around the country, Maryland continued to perform redeterminations on a monthly basis throughout the PHE. Ex parte rates remained high during this period, with an average of 55 percent of households auto-renewing during the PHE. The continuation of redetermination efforts throughout the pandemic helped mitigate the volume of participants who had not renewed coverage during the PHE and enabled the Department to prioritize redeterminations of individuals who were most likely categorically ineligible for coverage at the expiration of the MoE, such as those who had a substantial increase in income or aged out of Medicaid coverage.

Due to the expiration of the MoE on April 1, 2023, and at the direction of CMS, Maryland began what became known as "unwinding" in April 2023. Standard redetermination processing commenced in April 2023 and the first standard disenrollments post-MoE occurred on May 31, 2023. The Department completed its 12-month unwinding period on April 30, 2024. Normal operations resumed on May 1, 2024.

Throughout Maryland's unwinding period (April 2023 through April 2024), the Department made every effort to effectively and efficiently review the eligibility of Medical Assistance participants, leverage policy flexibilities, and work with stakeholders and partners to minimize the removal of participants who continued to meet all eligibility requirements. Maryland is still experiencing the impacts of the unwinding period as enrollment and acuity of enrolled participants continues to fluctuate while the State returns to normal operations.

2.3 Evaluation of the 2022–2026 Demonstration: Highlights Heading into the Next Extension

Evaluation is a critical component of the HealthChoice demonstration. Initial findings for the current demonstration period of 2022 through 2026 have indicated early successes as well as areas for improvement. The Department will continue to use its evaluations as a tool to improve the HealthChoice demonstration and the Medical Assistance Program as a whole.

2.3.1 HealthChoice Evaluation Interim Results

The Department will study Maryland-specific results as part of the summative evaluation of the 2022-2026 HealthChoice demonstration period, due to CMS in June 2028. The Department worked closely with CMS to implement an evaluation design to effectively measure the various demonstration programs, see Attachment II: §1115 HealthChoice Demonstration Evaluation Design (CY 2022–2026). Note that in the next demonstration period, 2027 through 2031, the Department intends to continue to follow its existing approved evaluation goals. The 2022–2026 HealthChoice evaluation intends to measure if the goal of improving the health status of Marylanders with low income was met by:

- Improving access to health care for the Medicaid population, including special populations;
- Improving the quality of health services delivered;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a PCP;
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Expanding coverage to additional Marylanders with low income through resources generated by managed care efficiencies through Section 1115 demonstration programs and pilots as described in this application.

A key component of the Department's ongoing monitoring efforts is its annual HealthChoice evaluation, which assesses the quality of care delivered to participants in the HealthChoice demonstration. The evaluation includes Healthcare Effectiveness Data and Information Set® (HEDIS®) quality and performance measures selected because they either measure quality of health care directly or indicate utilization and performance indirectly related to providing quality health services. A copy of the most recent evaluation covering CY 2019–2023 is included in this document as Attachment I. Note that the annual report serves as an interim report prior to the summative report being prepared at the expiration of the 2022–2026 demonstration period.

The HealthChoice program covered one in four Marylanders during CY 2023. As noted earlier, HealthChoice participants are required to choose one of the nine participating MCOs, along with a PCP from their MCO's network, to oversee their medical needs. Key highlights of the most recent annual evaluation are noted below. The Department notes that the COVID-19 PHE had a substantial impact on

rates of service utilization and screenings. Many of these rates have yet to return to pre-pandemic levels. The Department continues to monitor these rates:

- **Improving access to care:** During the COVID-19 pandemic, HealthChoice reached an enrollment peak of 1,665,232 in CY 2023, as a result of MoE requirements. After the 12-month unwinding period, enrollment has largely corrected. As of April 30, 2025, HealthChoice enrollment is 1,306,088, suggesting a return to more consistent enrollment levels. During the evaluation period of CY 2019 through CY 2023, trends in service utilization indicate increased health literacy, in alignment with the overall goals of the HealthChoice demonstration program. Additionally, MCO network adequacy shows that all jurisdictions achieved HealthChoice's required ratio of 200:1 participant to PCPs in CY 2023.

- **Provision of a Medical Home:** The HealthChoice demonstration is evaluated in its effectiveness in participants seeking care for non-emergent conditions in an ambulatory care setting rather than using the ED or letting an ailment exacerbate to the extent that it could warrant an inpatient hospital admission. One method to assess this goal is to measure whether participants can identify with and effectively navigate a medical home. During the evaluation period, the rate of potentially avoidable ED visits—an indicator of performance in this area—decreased from 41.4 percent in CY 2019 to 39.1 percent in CY 2023. The percentage of HealthChoice adults with an inpatient admission designated as potentially preventable also decreased slightly, from 0.7 percent in CY 2019 to 0.5 percent in CY 2023.

- **Health Promotion and Disease Prevention:** Some indicators showed improvement while others remained fairly stable or declined over the evaluation period. Rates for well-care visits and childhood immunizations were consistently higher than national Medicaid averages. Blood lead screening rates for children aged 12 to 23 months and 24 to 35 months also improved. The percentage of pregnant women who received prenatal services in a timely manner decreased slightly by 0.3 percentage points from CY 2019 to CY 2023; however, HealthChoice outperformed the national HEDIS® mean for timely prenatal services in all years except CY 2020. Despite slight declines, breast cancer screening rates remained above the national Medicaid average. The Department will continue to analyze this metric and identify actions to increase screening rates once again.

2.3.2 Monitoring and Quality Assurance Activities

In addition to the annual report, the Department engages in regular activities to monitor progress towards demonstration goals and to monitor quality assurance each year. Per the terms of Section 1115 demonstrations, and as required by 42 CFR 431.420(c), the Department must conduct a post-award forum within six months of implementing the demonstration and annually thereafter. That forum is intended to provide the public with the opportunity to offer meaningful comments on the progress of the demonstration. Maryland's most recent post-award forum took place on June 26, 2025, at the Maryland Medicaid Advisory Committee (MMAC) meeting.

Thirty days prior to the post-award forum, the Department posted information on its HealthChoice Monitoring and Evaluation webpage inviting the public to register for the MMAC meeting to solicit comments on the progress of the existing demonstration. Written public comments were requested to be submitted to the Department by emailing to mdh.healthchoicerenewal@maryland.gov. [4] See

[4] https://health.maryland.gov/mmcp/healthchoice/Pages/HealthChoice-Monitoring-and-Evaluation.aspx.

Attachment III: Post Award Forum Documentation for further details.

To ensure continual improvement, the Department has an extensive system for quality measurement that uses nationally recognized performance standards. The Department looks to these metrics to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care received by HealthChoice participants. These activities enable the Department to take remedial steps to address concerning results timely.

HealthChoice has two initiatives focused on measuring and improving quality of care: the Population Health Incentive Program (PHIP)—formerly the Value-Based Purchasing program—and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) annual review. PHIP, which transitioned from the Value-Based Purchasing program in CY 2022, provides MCOs with incentive payments according to their performance on specific measures of health care quality outcomes. The EPSDT annual review assesses MCO performance in delivering services to children under the age of 21. EPSDT services are a national requirement for Medicaid programs, and the EPSDT review measures whether all HealthChoice MCOs achieve minimum levels of performance in delivering EPSDT services. The most recent review indicates that the MCOs meet or exceed standards for all five components.

As required by Federal regulations, the Department also contracts with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice program.

Additional quality of care activities include: the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, a provider satisfaction survey, a HealthChoice consumer report card, annual Performance Improvement Projects, the state Managing for Results program, and the EPSDT provider compliance review. The Department also initiated plans to evaluate the use of the PCP medical home assignments to better understand their effectiveness and PCP utilization patterns by participants. Finally, the Department will continue to monitor and address the short- and long-term impact of the COVID-19 pandemic on Medicaid Assistance participants, including the care for special populations and those adversely impacted by the virus. Copies of reports associated with many of the Department's quality assurance activities can be found online.[5]

SECTION III. CURRENT DEMONSTRATION AUTHORITY EXTENSION REQUESTS

The Department remains dedicated to the Medical Assistance Program participants who benefit from Section 1115 demonstration authorized programs and managed care mechanisms. With this new HealthChoice demonstration extension application, the Department aims to continue to build upon the success of past demonstration periods. The following section highlights existing programs and services that were either approved as part of the prior demonstration periods or during subsequent amendments, organized by themes: managed care, REM, behavioral health, preventive care and maternal and child health, and home and community-based services (HCBS). The Department requests to continue these programs in this upcoming demonstration period. Each subsection includes a description of the individual program or service and the population it serves. While most are continuing with no modifications, the Department is requesting approval to modify one program, ICS, further described below.

[5] "HealthChoice Quality Assurance Annual Reports," Maryland.Gov, Maryland Department of Health, Accessed April 9, 2025, https://health.maryland.gov/mmcp/healthchoice/Pages/quality.aspx.

3.1 Maryland's Managed Care Program: HealthChoice

HealthChoice, Maryland's statewide mandatory managed care program, provides services to children and adults up to age 65 through MCOs. Under HealthChoice, eligible families and individuals are required to enroll in one of the nine MCOs approved by the Department—Aetna Better Health of Maryland, CareFirst BlueCross BlueShield Community Health Plan Maryland, Jai Medical Systems, Kaiser Permanente, Maryland Physicians Care, MedStar Family Choice, Priority Partners, UnitedHealthcare Community Plan, and Wellpoint Maryland. Each MCO is responsible for ensuring that HealthChoice participants have access to a network of medical providers that can meet the health needs of each participant. Over 25 years after its launch, HealthChoice covers approximately 86 percent of the Medical Assistance Program population.

Certain eligibility groups are excluded from managed care and receive benefits on a fee-for-service (FFS) basis:

- Individuals dually-eligible for Medicare and Medicaid;
- Individuals over 65 years old;
- Individuals determined Medically Needy under a spend-down;
- Individuals expected to be continuously institutionalized for more than ninety (90) successive days in a long-term care or skilled nursing facility except individuals transitioning to community placement under the ICS program;
- Participants enrolled in the Home Care for Disabled Children under a Model Waiver;
- EID participants;
- Certain foster care groups:
    - A child receiving an adoption subsidy who is covered under the parent's private insurance;
    - A child under State supervision receiving an adoption subsidy who lives outside the state; and
    - A child under State supervision who is in an out-of-state placement.

In addition to FFS populations, certain specialty services are carved out of the MCO benefit package and provided on a FFS basis. MCOs are responsible for contracting with providers to provide both mandatory and optional benefits to participants and pay providers for the care their participants receive.

MCOs cover the same comprehensive benefits as the FFS program. Maryland pays MCOs capitation payments to manage the benefits for participants who are enrolled in HealthChoice. Capitation payments are based on MCO enrollment and participant acuity, and MCOs are subject to financial risk based on the services that are provided to participants. In a managed care system, MCOs are incentivized to appropriately manage the care of their participants and ensure they receive high quality, affordable care. Care coordination is an important component of managed care.

3.2 Rare and Expensive Case Management Program

The REM program, implemented in the first HealthChoice demonstration period in 1997, provides case management services to Medical Assistance participants who have a rare and expensive medical condition and require sub-specialty care. REM participants must be HealthChoice-eligible, have a qualifying diagnosis, and be within the age limit for that diagnosis. REM, which is a voluntary program, allows participants to opt out of managed care and receive Medical Assistance services on a FFS basis, including additional benefits, such as medically-necessary private-duty nursing and shift home health aides.

REM participants can request changes in the case management assignment from the contracted Case Management Agency. Certain REM participants may remain in the program after becoming eligible for Medicare; to qualify, individuals must continue to meet the eligibility diagnosis for REM. All REM participants, irrespective of Medicare enrollment, are disenrolled on the age out date of their specific REM diagnosis, or when they turn 65.

The single, statewide Case Management vendor that is contracted to provide REM case management services is The Coordinating Center. As of March 31, 2025, 4,493 Medical Assistance participants were enrolled in the REM Program. This expanded benefit package will continue to be offered to REM participants by the Department during the next demonstration period.

3.3 Behavioral Health

In the Medical Assistance Program, specialty behavioral health services are carved out of managed care and overseen by a behavioral health administrative services organization (ASO). These services are paid on a FFS basis. The behavioral health services authorized under the HealthChoice demonstration, described below, are administered by the behavioral health ASO. This includes both specialty SUD services and mental health services. The behavioral health ASO serves as the hub for the provision of both Medical Assistance and state-funded behavioral health services in Maryland. Since many individuals with behavioral health conditions access both MH and SUD services, the carve out enables service integration, closer coordination of care, and a single entity for provider billing and credentialing. Optum Maryland served as the ASO from 2020 through 2024. In 2024, the Department selected Carelon Behavioral Health as the new ASO through a competitive re-procurement, and Carelon assumed ASO operations January 1, 2025. MCOs in HealthChoice are responsible for delivering primary behavioral health services and referring participants to the behavioral health ASO for specialty services.

Maryland has continued to strengthen the behavioral health continuum of care in an effort to meet the varying needs of all Marylanders. For example, since the last extension period, the Department implemented certified peer recovery support services to improve SUD treatment outcomes and enhance the broader array of SUD treatment services in the community. The Department also implemented coverage of behavioral health crisis services via mobile crisis teams and crisis stabilization centers, helping link individuals to community-based or residential providers for SUD or MH treatment as needed and other resources to address social needs. These expanded services—included in the State Plan—complement the suite of innovative behavioral health programs authorized by the HealthChoice demonstration.

3.3.1 Institutions for Mental Diseases: Residential Treatment for Individuals with Substance Use Disorders

In an effort to combat the national opioid crisis, Maryland previously sought expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures by the State for SUD treatment in non-public IMDs and to have those expenditures regarded as payments under the State's Title XIX plan. Under Section 1903, these expenditures are excluded. The Department requests to continue this authority without modification.

Medical Assistance-funded residential treatment coverage has expanded access and fostered sustainability. Continuing access to these services for individuals with SUD needs resulted in greater and more appropriate clinical treatment options for Medical Assistance participants. The SUD monitoring protocol for the HealthChoice demonstration period of CY 2022 through 2026 was

approved by CMS on April 26, 2022.[6] The protocol includes quarterly and annual measures that Maryland reports to CMS to track progress related to care for Medical Assistance participants with SUD.

Maryland continues to employ an array of treatment options to address substance use and reduce overdose deaths. As noted earlier, since the last extension period, Maryland separately invested heavily in the SUD continuum of care, including expanding coverage for peer support services and 24/7 behavioral health crisis services. In 2023, Maryland recorded a total of 2,511 overdose deaths (with 2,175 opioid-related).[7] That number decreased in 2024 for a preliminary total of 1,636 overdose deaths (with 1,373 opioid-related), reflecting a 38 percent reduction.[8] Maryland offers a comprehensive set of Medicaid-covered SUD benefits based on the ASAM guidelines (see Table 1 in Attachment IV: SUD and SMI Continuum of Care).

Maryland is seeking to retain this authority for otherwise-covered services provided in non-public IMDs to all full-benefit Medical Assistance Program participants, including dual eligibles, as authorized under the previous waiver and its amendments, including coverage for:

- ASAM residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM (Withdrawal Management) for an ALOS of 30 days across participants; and
- ASAM residential level 4.0 for individuals with a primary SUD diagnosis and secondary MH diagnosis IMD for up to 60 days as long as the ALOS across participants is 30 days in non-public IMDs located in Maryland, D.C., and contiguous states.

Per CMS guidance, Maryland requires and ensures that all SUD residential providers continue to meet the program standards set forth by ASAM. The Department remains dedicated to ensuring access to residential treatment for SUD for Medical Assistance Program participants.

3.3.2 Institutions for Mental Diseases: Services for Adults with Serious Mental Illness

Maryland previously received demonstration authority via the HealthChoice demonstration to claim expenditures by the State for MH treatment in non-public IMDs—which are not otherwise included as expenditures under Section 1903—and to have those expenditures regarded as payments under the State's Title XIX plan beginning January 1, 2022. The Department requests to continue this authority without modification.

Currently, Maryland is authorized to cover adults aged 21-64 who have an SMI diagnosis and who are residing in a private IMDs for an ALOS of no more than 30 days across all participants statewide, and no more than 60 days for any individual. The days authorized are based on medical necessity and are covered when delivered by facilities located within Maryland, a contiguous state, or D.C.

The Department covers a comprehensive array of services for MH. The provision of MH services in an

[6] "SUD Monitor Protocol Approval," Medicaid.Gov, Centers for Medicare and Medicaid Services, Sent April 26, 2022, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/md-healthchoice-appvl-04262022.pdf .

[7] "Maryland Department of Health - Overdose Data Portal Fatal Overdose: Historic Trends," Maryland.Gov, Maryland Department of Health, Accessed April 9, 2025, https://health.maryland.gov/dataoffice/Pages/mdh-dashboards.aspx#Overdose.

[8] Ibid.

IMD further strengthens the behavioral health continuum of care in Maryland. Table 2 in Attachment IV illustrates the full set of MH services currently covered in Maryland through MCOs, the behavioral health ASO, and on a FFS basis. The SMI IMD demonstration complements the current services covered by the Medical Assistance Program.

3.3.3 Reentry Demonstration

In Spring 2024, the Department requested an amendment to the existing HealthChoice demonstration to advance health outcomes for people involved with the criminal justice system through state-run facilities operated by the Department of Public Safety and Correctional Services (DPSCS). Specifically, Maryland sought approval to authorize federal matching funds for the provision of targeted Medical Assistance services, to be provided up to 90 days prior to release for eligible people with SUD, SMI, or both. The Department requests to continue this authority without modification.

CMS approved Maryland's amendment authorizing pre-release services for justice-involved individuals on January 13, 2025. The goals of the Reentry Demonstration include:

- Increasing coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional settings just prior to release;
- Improving access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
- Improving coordination and communication between correctional systems, Medical Assistance systems, managed care plans, and community-based providers;
- Increasing additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in correctional settings and in the community to maximize successful reentry post-release;
- Improving connections between correctional settings and community services upon release to address physical health, and behavioral health;
- Reducing all-cause deaths in the near-term post-release; and
- Reducing the number of ED visits and inpatient hospitalizations among recently incarcerated Medical Assistance participants through increased receipt of preventive and routine physical and behavioral health care.

Eligibility for the Reentry Demonstration consists of adults who are:

1. Sentenced and incarcerated in a state-managed prison or jail in the state of Maryland;
2. Within at least 90 days of their release date;
3. Otherwise eligible to receive Medicaid under Title XIX; and
4. Have been assessed and determined to have SUD, are diagnosed with SMI, or both.

Pre-release services include comprehensive case management, medication-assisted treatment for all SUD as clinically appropriate, with accompanying counseling, and provision of all prescribed medications for 30 days upon release, as clinically appropriate. Participants receiving these services will be assigned a case manager that delivers services either on-site in the correctional facility, or via telehealth.

The Department continues to collaborate with DPSCS to implement the Reentry demonstration in its state-run facilities (16 state prisons and one state-managed jail). The Department and DPSCS estimate that approximately 1,450 people each year who are released from state-run facilities will be eligible to participate in the Reentry Demonstration.

The Department anticipates an initial, smaller group of facilities to begin delivering services in the second half of CY 2025, pending Implementation Plan approval. Continued rollout across state-run facilities will be determined based on state budget approval, facility readiness, and facility interest. Future amendments requested by the Department may seek to expand the scope of this component of the demonstration to include other facilities, such as county jails. At this time, the Department requests to continue the reentry program without modification.

3.4 Preventive Care and Maternal and Child Health

The Medical Assistance Program is committed to providing preventive care and maternal and child health care through programs including Dental Services for Former Foster Youth, HealthChoice DPP, Inpatient Benefit for Pregnant Women Eligible through HPE, and the MOM Program.

Preventive care programs allow for early detection of health problems, enable timely interventions, prevent serious complications, improve well-being and ultimately lead to healthier individuals.

Maternal and child health programs and services connect pregnant Medical Assistance participants and families to services and information to support a lifetime of health and wellbeing, resulting in healthier communities. Some of these programs support the mother during pregnancy and delivery, as well as after the birth of the child, supporting postpartum care leading to provision of health care and services required throughout childhood if needed.

3.4.1 Dental Services for Former Foster Youth

Dental service reimbursement for former foster care youth up to age 26 has been authorized via Section 1115 as an EPSDT benefit since 2017. The Department requests to continue this authority without modification.

The Medical Assistance Program's dental benefits, collectively called the Maryland Healthy Smiles Dental Program, are administered by a single statewide dental benefits administrator (DBA). The DBA is responsible for coordinating all dental services for children, pregnant women, adults in the REM program, former foster care youth up to age 26, and all adults 21 and over who receive full Medicaid benefits.

Additionally, the DBA is responsible for all functions related to the delivery of dental services for these populations, including provider network development and maintenance, claims processing, utilization review, authorization of services, outreach and education, and complaint resolution. SKYGEN USA (formerly known as Scion) has been serving as the DBA since CY 2016. Overall utilization rates have increased, and provider networks have expanded since July 1, 2009, when the Department improved and rebranded its dental benefit as the Maryland Healthy Smiles Dental Program. As of January 1, 2023, all adults 21 years of age and older who receive full Medical Assistance benefits, including participants of the adult dental pilot, began receiving full dental benefits under State Plan authority.

Maryland continues to improve its dental program by confronting barriers to providing comprehensive oral health services to Medical Assistance participants.

3.4.2 HealthChoice Diabetes Prevention Program

Since September 2019, HealthChoice DPP enabled MCOs to provide the National DPP to eligible participants statewide. The Department requests to continue this program without modification.

The National DPP is a structured year-long program intended for adults 18 years of age and older who have prediabetes or are at high risk for developing type 2 diabetes. It includes lifestyle health coaching through weekly and monthly classes that teach skills needed to lose weight, become more physically active, and manage stress. People with prediabetes who take part in this evidence-based CDC-established structured lifestyle change program can reduce their risk of developing type 2 diabetes by 58 percent over three years (71 percent for people over 60 years old). The program has been shown to help people lose five to seven percent of their body weight through healthier eating and 150 minutes of physical activity per week.

The National DPP includes an initial six-month phase where at least 16 weekly sessions, including make-up sessions, are offered over a period of 16 weeks to 26 weeks. The second six-month phase consists of at least one session each month (six sessions total). Each session must be at least one hour long. HealthChoice DPP aligns with all aspects of CDC's Diabetes Prevention Recognition Standards, including eligibility, provider recognition, and program delivery modes, among other criteria. Individuals who are pregnant or who have been diagnosed with diabetes are not eligible to participate.

As of March 1, 2025, 75 DPP providers/provider groups are enrolled as Medicaid providers. Additionally, one MCO operates its own DPP.

3.4.3 Inpatient Benefit for Pregnant Women Eligible through Hospital Presumptive Eligibility

Under the ACA, qualified hospitals were given the option to determine eligibility for Medicaid for Modified Adjusted Gross Income (MAGI) populations, including pregnant women through 264 percent of the FPL. The HPE option enables timely access to necessary health care services, immediate temporary medical coverage while full eligibility is being determined, a pathway to longer-term Medicaid coverage, and a coverage determination based on minimal eligibility information. The Department permits individuals to qualify for one HPE period every 12 months, and pregnant women are allowed one period of coverage per pregnancy. Regardless of the ultimate Medicaid eligibility determination, federal rules require that state Medicaid programs reimburse hospitals and other providers for services provided during the temporary HPE period, except for inpatient services provided to pregnant women. The Department received authority to waive 42 CFR 435.1103(a), enabling the Department to cover inpatient services for pregnant women found eligible through HPE. The Department requests to continue this authority without modification

As of April 30, 2025, 39 hospitals have executed an HPE agreement with the Department. During the current demonstration period, of the 39 hospitals that are able to submit applications, five actively submitted HPE applications. The Department continues to provide training and resources to the participating hospitals as needed.

3.4.4 MOM Program

The MOM program, formerly associated with the CMS Center for Medicare and Medicaid Innovation (CMMI) initiative under the name the Maternal Opioid Misuse model, focuses on improving clinical resources and enhancing care coordination for pregnant and postpartum HealthChoice participants diagnosed with OUD. In Maryland, with over 21,000 individuals of childbearing age diagnosed with an OUD, substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to HealthChoice participants with OUD in the state each year.

Between July 1, 2021, to June 30, 2022, the MOM program services were funded as part of a CMMI demonstration and limited to one county (St. Mary's). The CMMI demonstration required participating states to identify a sustainable payment model effective July 1, 2022, and the program successfully transitioned to the HealthChoice demonstration. Under the demonstration, the MOM program expanded statewide as of January 1, 2023, utilizing MCOs as care delivery partners.

The HealthChoice MCOs receive a per member per month (PMPM) payment to provide a distinct set of enhanced case management services, standardized behavioral health and wellbeing screenings, and care coordination. MCO case managers provide a minimum of at least one monthly connection with MOM participants and ensure that each participant receives at least one somatic or behavioral health service per month. As of February 2025, MOM case managers have provided enhanced case management for 142 pregnancies from 140 participants across the state. Preliminary evaluations have shown positive outcomes for participants' infants, most notably for neonatal intensive care unit admissions, as well as newborn birth weight. The program has demonstrated positive externalities including securing housing, earning a General Education Diploma and pursuing specialty behavioral health treatment.

The Department requests the program to continue under its current approved structure. Given the MCO-centric program model, the Department continues to seek Section 1115 authority to waive the comparability requirements described in Section 1902(a)(10)(B) of the Social Security Act in order to limit the MOM program to the MCO-enrolled population.

3.5 Home and Community-Based Services

Maryland's Medical Assistance Program covers a wide array of HCBS designed to improve whole-person health of participants. The two HealthChoice demonstration programs discussed in this section are part of the overarching HCBS continuum of care and further the goal of enabling participants to live in the community. Both ACIS and ICS allow participants who are at risk of institutionalization to thrive in their communities–ACIS participants receive a temporary set of HCBS while ICS expands participant eligibility for HCBS, allowing additional participants to live and receive the care they require in the community setting, rather than an institutional setting.

3.5.1 Assistance in Community Integration Services

The ACIS program has been in effect in Maryland since July 1, 2017. Since its launch, this pilot program has expanded from one to four counties. The ACIS program provides housing and tenancy-based case management services to eligible participants to assist them in obtaining the services of state and local housing programs. The Department works with local governmental agencies to provide certain HCBS to eligible participants. The Department requests to continue this authority without modification.

To qualify for ACIS, participants must meet specific health and housing needs-based criteria:

1. Health criteria (at least one)
    a. Repeated incidents of ED use (defined as more than four visits per year) or hospital admissions; or
    b. Two or more chronic conditions as defined in §1945(h)(2) of the Social Security Act.

2. Housing Criteria (at least one)
    a. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or

b. Those at imminent risk of institutional placement.

In fiscal year (FY) 2024, ACIS served a total of 525 individuals. A 2023 evaluation of the program demonstrated positive health and housing outcomes for ACIS participants. This report is available online.[9] Overall, 77 percent of all pilot participants received stable housing. There was also a statistically significant reduction in the mean number of ED visits and inpatient admissions.

In January 2025, CMS approved an additional 1,240 participant spaces for this program, bringing total spaces authorized to 2,140, which will support expansion of ACIS across the state. CMS also approved changes to the ACIS payment methodology, shifting the program from a grant program that leveraged local matching dollars to a FFS benefit. The ACIS program continues to operationalize across Maryland and provide housing and tenancy-based case management services to the Medicaid-enrolled individuals.

3.5.2 Increased Community Services

The ICS Program has been in operation since 2009 and is currently authorized to enroll up to 100 individuals. The ICS Program serves Maryland residents who reside in nursing facilities and would like to receive services in their homes and communities. The Department requests to continue this authority with one technical modification to eligibility criteria to shorten the length of stay required in a nursing home prior to enrollment in ICS.

The ICS Program provides the same set of services and supports as the Home and Community-Based Options Waiver (HCBOW) Program to ensure an individual's successful community living. The array of services includes: case management; family training; medical day care; respite care; Senior Center Plus; assisted living; behavior consultation services; and nutritionist/dietitian services. ICS Program participants are also eligible to receive Community First Choice State Plan services if living in a community setting.

An individual's services in the community may not cost the Medical Assistance Program more than the individual's services in the nursing facility, and an individual must not be eligible for an existing Medicaid 1915(c) waiver. The ICS Program cost neutrality parameters are individualized, meaning all Medicaid services received by the participant may not exceed 100 percent of the costs to the State to provide nursing facility services to that individual.

To qualify for ICS, individuals must:

- Be at least 18 years old;
- Have income that exceeds the threshold for participation in Medicaid's HCBOW program;
- Contribute income in excess of 300 percent of Social Security Income (SSI) to the cost of care in the community; and
- Meet the Program's asset limits ($2,000 or $2,500 depending on eligibility category).

Additionally, individuals must:

[9] "Summary Report: Assistance in Community Integration Services (ACIS) Program Assessment, CY 2018 to CY 2021, The Hilltop Institute, UMBC, Published on September 15, 2023, https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/SummaryReportACISProgramAssessment-September2023-For%20Dept%20%281%29.pdf

- Reside, and have resided for a period of not less than six months, in a nursing facility and is receiving Medicaid benefits for nursing facility services for at least 30 days.
    - Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the six-month nursing facility stay requirement; OR
- Currently receive services through the HCBOW and have income that exceeds the HCBOW income eligibility threshold by no more than five percent, because, for instance, the individual received an automatic cost-of-living adjustment.
    - These individuals will be permitted to transition directly into the ICS Program as long as they continue to meet the nursing facility level-of-care standard. The six-month nursing facility stay requirement would not apply to these individuals.

Requested Policy Change

To continue to support long term services and supports (LTSS) rebalancing (*e.g*., shifting spending and delivery of LTSS from institutions to HCBS) and increase enrollment into the 100 ICS slots authorized today, the Department requests a technical amendment to ICS Program eligibility criteria. Specifically, the Department requests to reduce the length of time an individual must reside in a nursing facility from six-months to 60 consecutive days. Under the amended eligibility criterion, an individual would need to have resided in a nursing facility for at least 60 consecutive days, 30 days of which are eligible to be covered by Medicaid in order to qualify for ICS.

All other eligibility requirements will remain the same.

Hypothesis and Evaluation Design

The proposed change will not impact the existing overall program hypothesis. As such, the evaluation design specific to the ICS program will remain the same. Specific to the proposed eligibility modification to the ICS program, the Department hypothesizes the following:

- Reducing the length of time an individual must reside in a nursing facility to be eligible for the ICS program will improve and increase transitions from the Money Follows the Person (MFP) program (*i.e.* institutional care) to the ICS program.

The Department intends to track the transitions of MFP participants to the ICS program through transition data already available to the State.

Budget Neutrality

In the 2021 HealthChoice extension application, the Department expanded the limit on ICS participation from 30 to 100 individuals. The Department will maintain the limit of 100 individuals in this renewal. As of February 28, 2025, there were 10 participants in the ICS Program. Enrollment was impacted by attrition as the Department completed its PHE unwinding period.

The policy change is intended to increase program enrollment. The Department estimates that this policy change will increase enrollment in the ICS Program by five participants annually. The Hilltop Institute assisted the Department with calculating a per member per year cost based on actual claims data through March 31, 2024, for ICS Program participants. In FY 2024 (*i.e.,* July 1, 2023, through June 30, 2024), the ICS Program per member per year cost was $46,635 for ICS Program expenditures and

other Medicaid costs (*i.e.*, pharmacy, durable medical equipment, etc.). The per member per year cost for institutionalized participants for that same time period was $79,104, which indicates the ICS Program supports Maryland's rebalancing efforts by providing a cost-effective home and community-based alternative to institutional care.

Projected expenditures for all participants are detailed in Table 2 below. Additional information on the calculation is available in Attachment V: ICS Program Projected Expenditures.

Table 2: ICS Program Projected Expenditures

Amendment Component	Projected Expenditures				
	CY 2027	CY 2028	CY 2029	CY 2030	CY 2031
Enrollment*	20	25	31	36	41
PMPM Cost**	$ 50,959	$ 52,488	$ 54,063	$ 55,685	$ 57,355
Projected Program Expenditures**	$ 1,019,180	$ 1,312,200	$ 1,675,953	$ 2,004,660	$ 2,351,555

*Assumes a 1% growth factor in enrollment and 5 additional participants each year for proposed policy change.
**Assumes a 3% rate increase for Program services.

SECTION IV. DEMONSTRATION EXTENSION EVALUATION

The Department plans to continue its approved evaluation process for the 2027-2031 extension period. Annually, the Hilltop Institute completes an evaluation of HealthChoice which includes available data from the last five calendar years. The 2025 HealthChoice Annual Evaluation (CY 2019-2023) is included in this application as Attachment I.

The HealthChoice demonstration evaluation provides evidence that the Department successfully provides oversight and continually monitors HealthChoice performance on a variety of measures across the demonstration's goals. As described in Section II, to ensure consistent improvement, the Department has an extensive system for quality measurement that uses nationally recognized performance standards. The Hilltop Institute, as the Department's independent evaluator, evaluates the HealthChoice program annually. The evaluation includes HEDIS® quality and performance measures as they either measure quality of health care directly or indicate utilization and performance indirectly related to providing quality health services.

This focus further affirms Maryland's priority to supporting a managed care program that effectively serves the needs of vulnerable Marylanders while aligning with the overall goals of the Maryland health care system. Maryland is committed to accomplishing these overarching HealthChoice demonstration objectives by continuing the following goals:

- Improving access to health care for the Medicaid population, including special populations;
- Improving the quality of health services delivered;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider;

- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Expanding coverage to additional Marylanders with low income through resources generated by managed care efficiencies through 1115 waiver programs and pilots as described in this application.

4.1 Design of Hypotheses and Evaluation Measures

The Department intends to consult with CMS on its currently approved evaluation design to ensure continuity (see Attachment II). The hypotheses will drive the evaluation of the program. The evaluation will use a mixed-method approach to create valid and rigorous tests of the programs within the HealthChoice demonstration. The current hypotheses, listed below, are not anticipated to change:

1. Eligibility and enrollment changes implemented during the current HealthChoice waiver period will increase coverage and access to care for HealthChoice participants;
2. Payment approaches implemented during the current HealthChoice waiver period will improve quality of care for HealthChoice participants; and
3. Innovative programs address the social determinants of health and will improve the health and wellbeing of the Maryland population.

4.2 Evaluation Data Sources

The evaluation will continue to use a variety of data sources. Maryland's evaluation of the HealthChoice demonstration includes the entire population of participants, rather than utilizing a sampling-based methodology. Data sources include: FFS claims and managed care encounters from Maryland Medicaid Information System 2, the Vital Statistics Administration, the Department of Human Services, the Maryland Department of the Environment, HEDIS®, and the Department.

SECTION V. IMPACT ON ENROLLMENT, FINANCING, AND BUDGET NEUTRALITY

Demonstration projects under Section 1115(a) waivers are expected to be budget neutral, *i.e.,* do not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration. CMS requires states to demonstrate that actual expenditures do not exceed certain cost thresholds. *i.e.*, they may not exceed what the costs of providing those services would have been under a traditional Medicaid FFS program. The budget neutrality expenditure limits are based on projections of the amount of Federal Financial Participation that the state would likely have received in the absence of the demonstration.

The Department is not proposing any changes that would negatively impact enrollment between CY 2027 through CY 2031. Enrollment and expenditures for the current demonstration period and projections for the renewal period are explicitly outlined in Attachment VI: Impact on Expenditures and Enrollment.

For the duration of the existing HealthChoice demonstration, the Department continued to maintain strong positive variance and met budget neutrality requirements. These tables in Attachment VI contain considerable detail regarding cost projections associated with each of the various proposed authorities.

SECTION VI. PROPOSED WAIVER AND EXPENDITURE AUTHORITIES

As outlined in Tables 3 and 4, Maryland is requesting extension of federal waiver and expenditure authorities, all of which have been previously approved in its HealthChoice demonstration. To the extent that CMS advises the State that different or additional authorities are needed to implement the requested Section 1115 demonstration improvements, the State is requesting such waiver or expenditure authority, as applicable.

Table 3. Request for Continuation of Existing Waiver Authorities

Waiver Authority	Relevant Statute/ Regulation	Associated Program and Purpose	Currently Approved?
Amount, Duration, and Scope	§1902(a)(10)(B)	To enable the state to provide benefits specified in the Special Terms and Conditions (STCs) to demonstration participants in the REM program which are not available to other individuals under the Medicaid State plan.	Yes
Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release	§1902(a)(84)(D)	To enable the state not to provide coverage of the targeted case management services identified in Section 1902(a)(84)(D) of the Act for eligible juveniles described in Section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in Section 1902(nn)(2) in alignment with Section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.	Yes
Freedom of Choice	§1902(a)(23)(A)	To enable the State to restrict freedom of choice of provider, other than for family planning services, for children with special needs, as identified in Section 1932(a)(2)(A)(i-v) of the Act, who are participants in the Demonstration. To enable the State to require that all populations participating in the Demonstration receive outpatient specialty mental health and substance use services from providers with the public behavioral health system.	Yes

Table 4. Request for Continuation of Existing Expenditure Authorities

Expenditure Authority	Relevant Statute or Regulation	Associated program and purpose	Currently Approved?
Expenditures	§1115(a)(2)	**ACIS-**Expenditures for HCBS and related services as described in the STCs.	Yes
		Dental Services for Former Foster Youth-Expenditures for additional dental benefits beyond those specified in the state plan for former foster care youth ages 21 up to (but not including) age 26.	Yes
		Demonstration Operations for Automatic Reenrollment into the MCO-Provide an enrollee with the disenrollment rights required by Sections 1903 (m)(2)(A)(vi) and 1932(a)(4) of the Act, when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the beneficiary has no liability, as required by Sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2).	Yes
		HealthChoice DPP-Expenditures for a diabetes prevention program for Medicaid eligible individuals 18-64 who have pre-diabetes or who are at high risk for developing type 2-diabetes as set forth in the STCs, effective July 1, 2019.	Yes
		Inpatient Benefit for Pregnant Women Eligible through Hospital Presumptive Eligibility-As of January 1, 2014, expenditures to provide full Medicaid State plan benefits to presumptively eligible pregnant women with incomes up to 250 percent of the FPL.	Yes
		ICS-Expenditures for HCBS provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the program	Yes

Expenditure Authority	Relevant Statute or Regulation	Associated program and purpose	Currently Approved?
		conditions.	
		IMD: Residential Treatment for Individuals with SUDs- Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD and withdrawal management in facilities that meet the definition of an IMD.	Yes
		IMD: Services for Adults with SMI-Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals, who are primarily receiving treatment for an SMI/SED who are short-term residents in facilities that meet the definition of an institution for mental diseases as specified in the STCs.	Yes
		MOM Program-Expenditures to provide services under the MOM Program, including enhanced case management services, standardized social determinants of health screenings, and care coordination, as specified in the STCs.	Yes
		Reentry ***Pre-Release Services-***Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the reentry demonstration initiative. ***Pre-Release Administrative Costs-***Capped expenditures for payments for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 5.12, which may not be recognized as medical assistance under Section 1905(a) and may not otherwise qualify for federal matching funds under Section 1903, to the extent such activities are authorized as part of the reentry demonstration initiative.	Yes
		REM-Expenditures for benefits specified in the STCs provided to enrollees participating in the Rare and Expensive Case Management program which are not available to individuals under the Medicaid State plan.	Yes

Expenditure Authority	Relevant Statute or Regulation	Associated program and purpose	Currently Approved?
Title XIX Requirements Not Applicable to Increased Community Services			
Amount, Duration, and Scope	§1902(a)(10)(B)	To the extent necessary, to enable the state to provide a limited benefit package to demonstration participants in the ICS programs.	Yes
Title XIX Requirements Not Applicable to the Population in the REM Program			
Any Willing Provider	§1902(a)(23)(A) insofar as it incorporates 42 CFR 431.55(f)	To the extent necessary, to permit the state to selectively contract with a single entity for the provision of the Rare and Expensive Case Management benefit as authorized under this demonstration.	Yes
Title XIX Requirements Not Applicable to the Population in the Assistance in Community Integration Services			
Statewideness	§1902(a)(1)	To the extent necessary, to allow the state to offer Assistance in Community Integration Services and on less than a statewide basis.	Yes
Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services			
Amount, Duration, and Scope of Services and Comparability	§1902(a)(10)(B)	To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.	Yes
Freedom of Choice	§1902(a)(23)(A)	To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.	Yes
Statewideness	§1902(a)(1)	To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.	Yes

SECTION VII. STATE PUBLIC PROCESS AND INDIAN CONSULTATION REQUIREMENTS

Maryland's 30-day public comment period opened June 30, 2025 and comments were accepted through July 30, 2025. Pursuant to 42 CFR 431.408, the Department provided public notice and solicited stakeholder feedback for this extension application. Abbreviated public notice was published in the Maryland Register in both the May 30, 2025 and June 27, 2025 editions (see Attachment VII: Public Process and Indian Consultation Requirements). The Department posted the full public notice to its HealthChoice demonstration-specific webpage on June 30, 2025, along with the draft narrative of the demonstration extension application.

In keeping with the federal requirements for the public notice and comment process, Maryland completed the following activities with respect to the public comment process:

7.1 Stakeholder Notification

Prior to the public comment period, the Department announced the upcoming period at both the May and June MMAC meetings and its standing MCO Liaison meetings in an effort to ensure that stakeholders throughout Maryland were aware of the Department's upcoming application. On June 30, 2025, the State emailed its public stakeholder listserv and additional interested parties to notify them of the extension application and opportunities to provide feedback. These emails included information on the demonstration application, public notice and comment process, attendance information for the two public hearings, and links to read the draft extension application on the State's website. The Department also included the announcement in its "Maryland Medicaid News and Announcements" banner on the Maryland Medicaid Administration webpage and via a LinkedIn post.

7.2 Public Hearings

The Department conducted two public hearings on the extension application. The first hearing was held on July 9, 2025 and the second on July 24, 2025. Stakeholders were able to participate and provide public comment via the different modalities. Both hearings were administered using a hybrid format; participants could attend the person in-person, virtually via webinar link, and via a dial-in phone number.

The hearings were held in different locations in the state to enable flexibility for Marylanders. The first hearing was held in Annapolis, the State capital. The second hearing was held at the Department's headquarters in Baltimore during the monthly MMAC meeting. MMAC meetings are well attended by both Committee members as well as the public. Utilizing this forum for the second public hearing enabled the Department to reach a wide range of stakeholders to solicit input.

- **Public Hearing #1**
  Wednesday, July 9, 2025; 1:00PM–2:00PM
  Michael E. Busch Annapolis Library
  1410 West Street
  Annapolis, MD 21401

- **Public Hearing #2**
  Thursday, July 24, 2025; 1:00PM–3:00PM
  Maryland Department of Health
  201 West Preston Street, Level L-Room L1

Baltimore, Maryland 21201

During these hearings, the Department presented a summary of the draft application and accepted verbal and written comments from stakeholders. Hearing slides were subsequently sent to attendees and posted to the Department's website for reference (see Attachment VII).

7.3 Summary of Public Comments

The Department received a total of 16 public comments, including one written comment from Indian Consultation partners. One of the comments was a personal testimony from a community member directly impacted by the HealthChoice demonstration. Organizations that sent public comments include three MCOs and the Maryland MCO Association, advocacy groups, professional organizations, and a health care system.

Table 5. Received Public Comments by Source

Source	Number of Comments Received
Public Hearing #1	2
Public Hearing #2	3
Written Comments via Email	11
Total Comments	**16**

A majority of the comments were supportive of the proposed Section 1115 demonstration extension. Stakeholders specifically noted that they welcomed the continuation of the former foster youth dental program, the REM benefit, the HealthChoice program, and the ACIS program.

Stakeholders raised considerations to the Department regarding the dually eligible population, medically tailored meals supported by the Food is Medicine approach, and Maryland's carve out of behavioral health services from managed care. The Department expressed a desire to further discuss these topics with our stakeholders and partners.

Additionally, the Department received a comment related to a Developmental Disabilities Administration (DDA) waiver program. As DDA waivers are outside the scope of the HealthChoice demonstration, the comment was rerouted to the appropriate administration within the Department. The Department appreciates that the stakeholder took the opportunity to comment and provide feedback to the Department as a whole.

The comments received during the public comment period were largely in support of the HealthChoice demonstration and did not warrant inclusion of new initiatives in the State's application at this time. Table 6 describes several key themes that emerged during the public comment period.

Table 6. Key Themes from Public Comments

Key Themes	Summary of Public Comments
General Overall Support	The majority of comments received expressed support for the extension application, with many noting the success of previous iterations.
Considerations for Amendments	Stakeholders expressed interest and appreciation for future amendments during the upcoming demonstration period, if necessary.
Attention to Special Populations	Commenters appreciated Maryland's focus on special populations and programs, such as REM, ACIS, and dental coverage for former foster youth.

The Department appreciates all of the feedback provided by stakeholders. At this time, the Department is not considering adding any additional programs to the HealthChoice demonstration but will continue to collaborate with stakeholders about future initiatives.

7.4 Indian Consultation Requirement

The Department contacted Ms. Jessica Dickerson and Ms. Kerry Hawk Lessard of Native American LifeLines, to ask for review of the draft extension application. On June 30, 2025, the Department sent an overview of the draft application, information on both public hearings, and a link to the State's HealthChoice demonstration website. On July 17, 2025, Ms. Dickerson submitted comments via email to provide support of the extension application and offer opportunities to improve American Indian and Alaska Native health outcomes.

Specifically, Native American LifeLines requested that the State investigate and address appointment availability within HealthChoice networks to improve access to timely appointments for American Indian and Alaskan Native patients. In addition, the organization highlighted that State data systems should consistently and accurately capture race and ethnicity data, allowing for further disaggregated analysis and inclusion of American Indian and Alaska Native participants in SUD utilization and outcomes-based data. Native American LifeLines offered to collaborate to further support culturally ground services and strengthen the partnership between the State, HealthChoice Providers, and Urban Indian Health Programs. The Department looks forward to continuing conversations. Full email correspondence has been provided within Attachment VII.

Beyond these requirements, the Department continually consults with stakeholders on the HealthChoice program through the MMAC. The MMAC meets monthly and receives reports on regulatory and waiver changes, including amendments to the HealthChoice demonstration. Annually, the MMAC provides feedback on the HealthChoice evaluation report. The Department welcomes feedback and comments throughout the year from our partners and stakeholders and is committed to providing quality care to vulnerable Marylanders.