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LIST OF ACRONYMS

- Administrative services organization (ASO)
- 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)
- Dental benefits administrator (DBA)
- Department of Health and Human Services (HHS)
- Department of Public Safety and Correctional Services (DPSCS)
- Diabetes Prevention Program (DPP)
- District of Columbia (D.C.)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Emergency Department (ED)
- Employed Individuals with Disabilities (EID)
- External Quality Review Organization (EQRO)
- Federal poverty level (FPL)
- Fee-for-service (FFS)
- Fiscal year (FY)
- Healthcare Effectiveness Data and Information Set® (HEDIS®)
- Hilltop Institute at the University of Maryland, Baltimore County (the Hilltop Institute)
- Home and Community-Based Options Waiver (HCBOW)
- Home and Community-Based Services (HCBS)
- Home Visiting Services (HVS)
- Hospital Presumptive Eligibility (HPE)
- Increased Community Services (ICS)
- Institutions for Mental Disease (IMD)
- Long-term services and supports (LTSS)
- Maintenance of effort (MoE)
- Managed Care Organization (MCO)
- Maryland Children's Health Program (MCHP)
- Maryland Department of Health (the Department)
- Maryland Medicaid Advisory Committee (MMAC)
- Maryland Medical Assistance Program (Medical Assistance Program)
- Maryland's Section 1115 Demonstration (HealthChoice demonstration)
- Mental health (MH)
- Modified Adjusted Gross Income (MAGI)
- Money Follows the Person (MFP)
- Opioid use disorder (OUD)
- Per member per month (PMPM)
- Population Health Incentive Program (PHIP)
- Primary Adult Care (PAC) Program
- Primary care provider (PCP)
- Public health emergency (PHE)
- Rare and Expensive Case Management (REM)
- Serious mental illness (SMI)
- Special Terms and Conditions (STCs)
- Substance use disorder (SUD)
- Social Security Income (SSI)
- Withdrawal Management (WM)
- Women's Breast and Cervical Cancer Program (WBCCHP)

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.

1.2 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 a number of 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. 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 emergency department (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 to carve 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, 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: Approved Evaluation Design Demonstration Hypotheses and Evaluation Measures, 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 rightsized. 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 participants 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

[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.

with no modifications, the Department is requesting approval to modify one program, ICS, further described below.

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;
- Employed Individuals with Disabilities (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 fee-for-service 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 MH 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 for these services to 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 2 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 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

[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.

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 IMD further strengthens the behavioral health continuum of care in Maryland. Table 3 in Attachment IV illustrates the full set of MH services currently covered in Maryland through MCOs, the behavioral health ASO, and on a fee-for-service 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 Emergency Department 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.

As of May 2025, 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 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 fee-for-service 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;

[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

- 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:

- 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 (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 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 home and community-based services (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 home and community-based services 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	Yes

Expenditure Authority	Relevant Statute or Regulation	Associated program and purpose	Currently Approved?
		program 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
		IMDs: 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

[To be added at the close of public comment period]

MARYLAND SECTION 1115 EXTENSION APPLICATION ATTACHMENT LIST

Attachment I: 2025 HealthChoice Annual Evaluation (CY 2019–2023)

Attachment II: Approved Evaluation Design Demonstration Hypotheses and Evaluation Measures, 2022–2026

Attachment III: Post-Award Forum Documentation

Attachment IV: SUD and SMI Continuum of Care

Attachment V: ICS Program Expected Expenditures

Attachment VI: Impact on Expenditures and Enrollment

Attachment VII: Public Process and Indian Consultation Requirements

Attachment VIII: Budget Neutrality Workbook

Attachment I: 2025 HealthChoice Annual Evaluation (CY 2019-2023)

The Hilltop Institute
UMBC

report

Evaluation of the Maryland Medicaid HealthChoice Program: CY 2019 to CY 2023

June 2, 2025

Suggested Citation: The Hilltop Institute. (2025, June 2). *Evaluation of the Maryland Medicaid HealthChoice program: CY 2019 to CY 2023*. Baltimore, MD: UMBC.

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List of Abbreviations

ABD	Aged, Blind, and Disabled
ACA	Affordable Care Act
ACCU	administrative care coordination unit
ACG	Adjusted Clinical Groups
ACIS	Assistance in Community Integration Services
ACS	American Community Survey
AHRQ	U.S. Agency for Healthcare Research and Quality, HHS
AMR	asthma medication ratio
AOD	alcohol and other drug
ART	antiretroviral therapy
ASAM	American Society of Addiction Medicine
ASO	administrative services organization
BHA	Behavioral Health Administration
BMI	body mass index
CD4	A test of the quantity of immune system cells used to diagnose and monitor HIV disease
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CI	confidence interval
CLR	Childhood Lead Registry
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COMAR	Code of Maryland Regulations
COPD	chronic obstructive pulmonary disease
CPS	Coverage of the Total Population
CPT	Current Procedural Terminology
CRISP	Chesapeake Regional Information System for Our Patients
CY	calendar year
DPP	Diabetes Prevention Program
ED	emergency department

EID	Employed Individuals with Disabilities
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	external quality review organization
ET3	Emergency Triage, Treat, and Transport
EVS	Maryland's electronic verification system
F&C	Families and Children
FFCRA	Families First Coronavirus Response Act
FFS	fee-for-service
FOBT	fecal occult blood test
FPL	federal poverty level
FQHC	federally qualified health center
FUA	Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUM	Follow-Up after Emergency Department Visit for Mental Illness
FY	fiscal year
HbA1c	hemoglobin A1c screening
HCBS	home and community-based services
HEDIS®	Healthcare Effectiveness Data and Information Set®
HFA	Healthy Families America
HHS	U.S. Department of Health and Human Services
HPV	human papillomavirus
HR	hazard ratio
HSCRC	Health Services Cost Review Commission
HSI	Health Services Initiatives
HVS	Home Visiting Services
ICD	International Classification of Diseases
ICS	Increased Community Services
IEP	individualized education plan
IFSP	individualized family service plan
IMA	immunizations for adolescents
IMD	institution for mental disease

IUD/IUS	intrauterine device or system
JHU	Johns Hopkins University
LAA	local access area
LE	lead entity
LEPAC	Lead Exposure and Prevention Advisory Committee
LOS	length of stay
LTSS	long-term services and supports
MAGI	modified adjusted gross income
MARR	Maryland Average Reportable Rate
MAT	medication-assisted treatment
MCH	Maternal and Child Health
MCHP	Maryland Children's Health Program
MCO	managed care organization
MDE	Maryland Department of the Environment
MFR	Managing for Results
MHBE	Maryland Health Benefit Exchange
MHD	mental health disorder
MMIS2	Maryland Medicaid Management Information System
MOE	Medicaid maintenance of eligibility
MPC	Maryland Physicians Care
MRR	medical record review
MY	measurement year
NCI	National Cancer Institute
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NYU	New York University
OPA	Office of Population Affairs
OR	odds ratio
OUD	opioid use disorder
Pap	Papanicolaou test for cervical cancer
PCP	primary care provider

PE	participating entity
PH	permanent housing (PH)
PHE	public health emergency
PHIP	Population Health Incentive Program
PHQ-9	Patient Health Questionnaire-9
PMPM	per member per month
PPC	prenatal and postpartum care measure
PQI	Prevention Quality Indicator
PrEP	pre-exposure prophylaxis
REM	Rare and Expensive Case Management
RRH	rapid re-housing (RRH).
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	serious emotional disturbance
SIHIS	Statewide Integrated Health Improvement Strategy
SMI	serious mental illness
SPA	state plan amendment
SSI	Supplemental Security Income
SUD	substance use disorder
TANF	Temporary Assistance for Needy Families
Tdap	tetanus, diphtheria, and pertussis
VBP	Value-Based Purchasing

Evaluation of the Maryland Medicaid HealthChoice Program: CY 2019 to CY 2023

Executive Summary

In 1997, Maryland implemented HealthChoice—a statewide mandatory Medicaid and Children's Health Insurance Program (CHIP) managed care program—under authority of a waiver through §1115 of the Social Security Act. The provisions of the Affordable Care Act (ACA) that went into effect in 2014 marked another milestone by extending quality coverage to many more Marylanders with low income. Over 25 years after its launch, HealthChoice covers close to 90% of the state's Medicaid and Maryland Children's Health Program (MCHP) populations.[1]

Since the inception of HealthChoice, the Maryland Department of Health (the Department) has requested and received seven §1115 waiver renewals. The Hilltop Institute, on behalf of the Department, evaluates the program annually; this evaluation covers the period of calendar year (CY) 2019 through CY 2023.

The goal of the HealthChoice §1115 demonstration is to improve the health status of Marylanders with low income. The following broader goals covered in this evaluation are:

- 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 through the provision of a single medical home
- Emphasizing health promotion and disease prevention
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies

HealthChoice is a mature managed care program that covered one in four Marylanders during CY 2023. The HealthChoice program moves eligible fee-for service (FFS) enrollees into the managed care system while providing the same comprehensive benefits. Participants choose one of the nine participating Managed Care Organizations (MCOs), along with a primary care provider (PCP) from their MCO's network, to oversee their medical care. This evaluation shows that HealthChoice's managed care oversight has made progress towards achievement of the program's stated goals.

During the evaluation period—from CY 2019 to CY 2023—HealthChoice has demonstrated mixed results in providing targeted preventive screenings and ensuring that participants receive care at the appropriate level. Recent successes include a decrease in the rate of children aged 0 to 6 years with an elevated blood lead level and a decline in asthma-related emergency department

[1] Maryland's Children's Health Insurance Program is known as MCHP.

(ED) visits. In CY 2023, 61.4% of children received dental services, which is greater than the national mean as reported in the Healthcare Effectiveness Data and Information Set® (HEDIS®).[2] However, colorectal, breast, and cervical cancer screening rates decreased, which corresponds with a decrease in national rates (Oakes et al., 2023). Among individuals with HIV/AIDS, ambulatory care rates and ED use decreased during the evaluation period. Viral load testing, cluster of differentiation 4 (CD4) testing, and antiretroviral therapy (ART) rates also decreased. The percentage of HealthChoice participants aged 18 to 64 years with at least one inpatient hospital admission declined by 2.3 percentage points during the evaluation period.

The COVID-19 public health emergency (PHE), which began in March 2020, had a significant impact on the HealthChoice program from CY 2020 to CY 2023. Enrollment in the Medicaid program increased notably as a result of the PHE, which expired May 11, 2023 (CMS, 2023). Rates of service utilization and screenings decreased for many measures in CY 2020, and while many have seen subsequent increases through CY 2023, few rates have returned to pre-COVID levels. Maryland will continue to monitor the effects of the COVID-19 PHE on the HealthChoice program.

The state implemented programs aimed at improving access, reducing costs, and improving quality—such as the Residential Treatment for Individuals with Substance Use Disorder (SUD) program and the Evidence-Based Home Visiting Services (HVS) pilot program—which began in July 2017. In March 2019, the Department received approval to extend coverage for the Residential Treatment for Individuals with a primary SUD and a secondary mental health disorder (MHD) to American Society of Addiction Medicine (ASAM) level 4.0. in addition, access to the National Diabetes Prevention Program (National DPP) lifestyle change program was expanded to all eligible HealthChoice participants as of September 1, 2019.

The Department received approval from the Centers for Medicare & Medicaid Services (CMS) for the §1115 waiver renewal in 2021 to expand critical programs and add programs. These included the expansion of SUD residential and inpatient treatment services to remove caps on lengths of stay for SUD in an institution for mental disease (IMD), expansion of IMD services for beneficiaries with serious mental illness (SMI), and modification of the Assistance in Community Integration Services (ACIS) pilot program. In addition, the MOM program (formerly the Maternal Opioid Misuse model) became effective July 1, 2021. The Family Planning program and HVS program were not included in the waiver renewal as they were added to the State Plan.

Program improvements are necessary to ensure that the growing number of Maryland Medicaid participants have access to quality care. The Department is committed to working with CMS and other stakeholders to identify and address changes necessary to meet this goal. Some areas targeted for improvements include ED utilization for conditions that could have been treated in the primary care setting, engagement in diabetes prevention, and prenatal and postpartum care; reduced racial and ethnic disparities; and increased rates of follow-up care after ED visits for MHD and SUD.

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

In 2019, the Department collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish domains of health care quality and delivery through Maryland's Statewide Integrated Health Improvement Strategy (SIHIS) under the Total Cost of Care (TCOC) Model (Maryland Department of Health, 2020a). The SIHIS framework focuses on stakeholder collaboration and investing in improving health, addressing disparities, and reducing health care costs. SIHIS targets improvements in three domains: 1) hospital quality, 2) care transformation across the health care system, and 3) total population health.

Priority areas for the third domain include diabetes, opioid use, and maternal and child health (Maryland Department of Health, 2020a). The SIHIS 2021 goals have been successful in reducing the mean body mass index (BMI) for adults, reducing avoidable inpatient admissions and readmissions, reducing the severe maternal morbidity rate, and improving overdose mortality (Maryland Department of Health, 2023b). The state is focused on improving care coordination for participants with chronic conditions, which was the only 2021 goal that was not met. The Department is developing an annual monitoring plan for the evaluation of the Maternal and Child Health (MCH) Population Health Improvement Fund, which is funded by the Maryland Health Services Cost Review Commission (HSCRC) (Maryland Department of Health, 2023).

On January 1, 2026, Maryland will be transitioning from the TCOC Model to the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.[3] As originally signed, the AHEAD Model:

- Creates a framework for partnership between the state and CMMI
- Ensures CMMI's commitment to Maryland's all-payer hospital rates
- Maintains the State's authority to set policy to manage hospital global budgets, the Maryland Primary Care Program (MDPCP), and health equity policies

There was a substantial change to the quality of the race and ethnicity information beginning with the implementation of the ACA in 2024. Because of a new approach to selecting race and ethnicity on the Medicaid eligibility application, the number of individuals reporting their race or ethnicity decreased, while the proportion represented as "Other" or missing race/ethnicity information continued to increase. In 2023, the Department completed a process of enhancing the Medicaid race and ethnicity data in the Maryland Medicaid Management Information System (MMIS2) using external data sets from the Maryland Health Benefit Exchange (MHBE) and Chesapeake Regional Information System for Our Patients (CRISP), Maryland's health information exchange. The goal of this process was to improve the race and ethnicity data for monitoring health equity and disparities among Medicaid participants. Results showed that the enhanced race and ethnicity data are close to the benchmark of the Medicaid participants in the American Community Survey (ACS).[4] The analyses in this year's evaluation of the HealthChoice program use the enhanced race and ethnicity data.

[3] https://hscrc.maryland.gov/Pages/ahead-model.aspx

[4] American Community Survey Data: https://www.census.gov/programs-surveys/acs/data.html

Coverage and Access

A major goal of the HealthChoice program is to expand coverage to residents with low income and to improve access to health care services for the Medicaid population. HealthChoice has largely succeeded in this area. Overall, program enrollment increased 24.3% over the evaluation period: from 1,202,718 participants in CY 2019 to 1,494,801 participants in CY 2023.[5] Continuous enrollment increased by 15.3 percentage points from CY 2019 to CY 2022, followed by a 7.7 percentage point decrease from CY 2022 to CY 2023, in part due to COVID-19 PHE policy responses propelling enrollment in health insurance. Under the Families First Coronavirus Response Act (FFCRA), states had to meet certain Medicaid maintenance of eligibility (MOE) requirements, which included continuous coverage for participants enrolled in Medicaid as of March 2020 (Dolan et al., 2020). These MOE requirements contributed to an increased Medicaid enrollment in CY 2020 through CY 2022. The continuous eligibility requirement ended on March 31, 2023.[6]

While enrollment increased dramatically from CY 2020 to CY 2023, in part due to the PHE, all MCOs experienced a decrease in overall service utilization and screenings beginning in CY 2020. Nonetheless, trends in service utilization through CY 2019 indicate increased health literacy, in alignment with the overall goals of the HealthChoice demonstration program. HealthChoice facilitates access to care by requiring each MCO to have a provider network capacity of one PCP for every 200 participants. The results of a network adequacy analysis counting the number of PCP offices included in provider networks in each jurisdiction in Maryland showed that all jurisdictions achieved at minimum a 200:1 ratio of participants to PCPs in CY 2023.

Care for Special Populations

HealthChoice continues to seek ways to improve access to health services for vulnerable populations and improve the quality of care they receive. These vulnerable populations include children in foster care, Rare and Expensive Case Management (REM) participants, and racial and ethnic minorities. The Department also monitors demographic characteristics and service utilization among the ACA Medicaid expansion population.

Service utilization, including ambulatory care, ED visits, and inpatient admission, for children in foster care[7] decreased over the evaluation period. In CY 2023, they had a 2.5 percentage point lower rate of ambulatory care service utilization, and a 3.5 percentage point higher rate of ED visits compared to other children in HealthChoice. The REM program, which serves individuals with multiple and severe health care needs, experienced a decrease of 5.2 percentage points in the proportion of enrollees with dental visits during the evaluation period, with the largest decrease (15.9 percentage points) from CY 2019 to CY 2020. The percentage of REM participants

[5] These totals reflect participants enrolled as of December 31 of each respective year, thus providing a snapshot of typical program enrollment on a given day.
[6] H.R. 2617, 117th Cong. (2022) (enacted).
[7] Data include individuals in subsidized adoption and guardianship populations.

who had an ambulatory care visit remained largely stable, while outpatient ED visits and inpatient admissions declined during the evaluation period.

As for racial and ethnic disparities in access to care, children in the Other races/ethnicities category had the lowest rate of ambulatory care visits in CY 2019 and in CY 2023 while Hispanic children had the highest rate for both years. In CY 2019 and CY 2023, Black participants had the highest ED utilization rates, while Asian participants had the lowest.

Enrollment in the ACA Medicaid expansion population, increased by 31.5% during the evaluation period. As of December 2023, 515,121 HealthChoice participants were enrolled under the ACA expansion coverage group. Expansion participants had a lower rate of ambulatory care visits than any other coverage group in the Medicaid population from CY 2019 to CY 2023. The ED visit rates for ACA participants with 12 months of enrollment decreased from 33.5% in CY 2019 to 24.6% in CY 2023. Additional changes occurred in service utilization patterns during the evaluation period, including a decrease in the overall proportion of ACA expansion participants who received services for an SUD or co-occurring MHD and SUD conditions.

Quality of Care

Improving the quality of services delivered to HealthChoice participants is a core aim of the program. This report includes measures that both directly and indirectly indicate the quality of healthcare. Additionally, HealthChoice has two programs focused on measuring and improving quality of care: the Population Health Incentive Program (PHIP)—formerly Value-Based Purchasing (VBP) program—and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Annual Review.

PHIP, which began in CY 2022, provides MCOs with incentive payments according to their scores on specific measures of health care quality outcomes. MCOs that meet or exceed a performance threshold receive incentive payments. The Department may adjust PHIP measures to align with CMS's national Medicaid standards and address population health needs. Overall, PHIP supports quality improvement across the HealthChoice population by basing the incentive levels on average plan performance.

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, and the EPSDT Annual Review measures whether all HealthChoice MCOs achieve minimum levels of performance in delivering EPSDT services. The most recent review shows that the MCOs meet or exceed standards for all five components.

Medical Home

Another goal of the HealthChoice program is to provide patient-focused, comprehensive, and coordinated care by providing each member with a single "medical home" through a PCP. With a greater understanding of the resources available to them, HealthChoice participants should seek 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 and effectively navigate a medical home by avoiding an ED or inpatient admission. During the evaluation period, the rate of potentially avoidable ED visits—an indicator of performance in this area—decreased from 41.4% in CY 2019 to 39.1% in CY 2023. The percentage of HealthChoice adults with Prevention Quality Indicators (PQIs) – measures developed by the Agency for Healthcare Research and Quality (AHRQ) to identify potentially avoidable hospital admissions through improved outpatient care – decreased from 0.7% in calendar year 2019 to 0.5% in calendar year 2023.

The state is working with CMS to monitor several hospital quality measures, including PQI admissions across Medicaid, Medicare, and commercial payers under Maryland's All-Payer Model Agreement—and subsequent Total Cost of Care Model. The model places global budget limits on hospitals, which reduces hospitals' incentives to increase admissions. The Department will use these tools to continue to monitor the rate of PQI admissions and will research policies to reduce their frequency.

Health Promotion and Disease Prevention

The HealthChoice program prioritizes health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care. The HEDIS® compares HealthChoice against nationally recognized performance standards for preventive care utilization and management of chronic disease conditions (MetaStar, Inc., 2024). Since the COVID-19 PHE affected utilization and screening rates from CY 2020 through CY 2023, HealthChoice HEDIS® scores were similarly affected.

Some HealthChoice indicators showed improvement while others remained fairly stable or declined over the evaluation period. Breast cancer screening rates decreased 7.5 percentage points over the evaluation period, with the largest decrease of 5.4 percentage points between CY 2019 and CY 2020. However, breast cancer screening rates remained above the national Medicaid average for the entire evaluation period, contributing to better preventive care utilization for women. Rates for childhood immunizations decreased over the evaluation period but were higher than national Medicaid averages every year except for CY 2020. Blood lead screening rates for children aged 12 to 35 months decreased over the evaluation period.

Although the percentage of women in HealthChoice who received a cervical cancer screening declined from 63.8% in CY 2019 to 57.6% in CY 2023, the rate was above the national HEDIS® mean for all evaluation years except CY 2020. Declines in cervical precancers are associated with widespread vaccinations for human papillomavirus (HPV) (McClung et al., 2019). The proportion of adolescents who received an immunization combination including the HPV vaccine decreased from 45.5% in 2019 to 39.9% in CY 2023, but Maryland performed above the national HEDIS® mean during the evaluation period. Colorectal screening rates declined slightly during the evaluation period.

The state's priorities in preventative care also include the need for improving oral health care and prenatal care. The number of dental visits in child participants decreased between CY 2019 and CY 2023; however, child participants had higher percentages of dental visits among all service types—diagnostic, preventative, and restorative—when compared to adult participants in CY 2023. 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. HealthChoice outperformed the national HEDIS® mean for timely prenatal services in all years except CY 2020.

The HealthChoice program also prioritizes management of chronic conditions such as asthma, diabetes, HIV/AIDS, and behavioral health diagnoses. During the evaluation period, ambulatory care, ED, and inpatient utilization for participants with an asthma diagnosis decreased by 0.9, 3.2, and 1.1 percentage points, respectively. The rate of ED visits with a primary diagnosis of asthma increased by 0.4 percentage points during the evaluation period while inpatient admissions with asthma as the primary diagnosis remained largely stable. The percentage of participants with diabetes who received an eye exam increased slightly by 0.9 percentage points between CY 2019 and CY 2023. HealthChoice was above the HEDIS® average for controlling HbA1c from CY 2019 through CY 2023. During the evaluation period, inpatient, ED, and ambulatory care utilization decreased by 3.3, 6.4, and 0.6 percentage points, respectively, among HealthChoice participants with diabetes. Although receiving an HbA1c screening only was associated with an increased likelihood of experiencing a diabetes-related ED visit, receipt of either an HbA1c test or eye exam the previous year mitigated the likelihood of having a diabetes-related ED visit the following year.

Among participants with HIV/AIDS, ambulatory care service utilization decreased by 4.1 percentage points during the evaluation period. Additionally, the utilization rate for ART decreased by 2.9 percentage points, while viral load and CD4 cell count testing rates decreased by 3.7 and 4.8 percentage points, respectively. However, ED utilization by this population decreased by 9.8 percentage points during the evaluation period.

The percentage of participants with a behavioral health diagnosis, including MHD-only, SUD-only, dual diagnosis of MHD and SUD, decreased slightly from CY 2019 to CY 2023, with MHD-only diagnosis being the most common throughout this period. Utilization of ambulatory care services remained stable during the evaluation period among HealthChoice participants with a behavioral health diagnosis, while inpatient and ED utilization decreased by 2.0 and 6.2 percentage points, respectively.

Demonstration Programs

The HealthChoice program uses the §1115 waiver demonstration authority to test emerging practices through innovation and pilot programs. As part of its waiver renewal in 2016, the Department received CMS approval for new innovative programs including: Residential Treatment for Individuals with SUD; HVS and ACIS community health pilots; Increased Community Services (ICS); and Diabetes Prevention Program (DPP).

With CMS approval, Maryland Medicaid participants aged 21 years and older with SUDs were able to receive residential treatment services—up to two (2) 30-day stays—in IMDs based on American Society of Addiction Medicine (ASAM) residential levels 3.7-WM, 3.7, 3.5, and 3.3. On January 1, 2019, the Department phased in coverage of ASAM level 3.1. Effective January 1, 2021, the cap on length of stay was removed and the criteria is to meet statewide average length of stay (ALOS) of 30 days or less. Given the current opioid epidemic, this allows the state to expand access across the care continuum and deliver critical care to individuals with SUD.

Hilltop analyzed measures related to IMD cost of care, medication-assisted treatment (MAT) utilization, and initiation and engagement in treatment for alcohol and other drug (AOD) dependence. Cost of care per member per month (PMPM) for HealthChoice participants who received IMD treatment for an SUD increased by 26.7% between CY 2019 and CY 2023. Participants aged 65 and older had almost double the cost PMPM compared to other age groups. Overall, the MAT utilization rate among IMD participants decreased 7.8 percentage points between CY 2019 and CY 2023. A logistic regression analyzing the impact of IMD care on the probability of initiation and engagement for AOD treatment indicates that IMD treatment is associated with an increased likelihood of participants initiating treatment; however, it decreases the likelihood of engaging in ongoing treatment.

The ACIS pilot program provides both housing case management and tenancy-based case management services to individuals with two or more chronic health conditions or frequent ED visits and who are at risk of institutionalization and/or homelessness. During the evaluation period, approximately 73.4% of ACIS participants were homeless at the time of their enrollment in the program, and approximately 77% of participants obtained stable housing during their ACIS enrollment. Health service utilization was analyzed for participants from CY 2019 to CY 2023. The percentage of participants with at least one ambulatory care visit decreased by 1.8 percentage points, and the percentage of participants with at least one ED visit decreased by 0.9 percentage points.

The National DPP lifestyle change program was authorized for HealthChoice members beginning September 1, 2019. By participating in HealthChoice DPP, HealthChoice participants who are considered at risk for developing type 2 diabetes and meet the eligibility criteria engage with certified DPP providers to learn how to reduce their risk of developing type 2 diabetes through lifestyle changes to improve their overall health. In partnership with the Department and HealthChoice MCOs, Hilltop developed an algorithm that MCOs can use to search their electronic medical records and identify members who meet eligibility criteria for HealthChoice DPP. This algorithm was provided to the MCOs and implemented in the spring of 2021 after extensive testing.

Hilltop uses Medicaid claims and encounter data to provide the Department with periodic service utilization reports that track current and cumulative DPP enrollment. From its implementation in September 2019 through December 31, 2023, there have been 2,558 DPP encounters. Regression analyses indicate that DPP participants are significantly less likely to

develop diabetes with no association found between DPP participation and total number of ED visits or inpatient admissions.

The Department also renewed the Increased Community Services (ICS) program. The ICS program allows certain adults with physical disabilities to remain in the community as an alternative to institutional care. During the evaluation period, 12.0% of ICS-eligible long-stay nursing facility residents transitioned to a community setting under the ICS program.

The HealthChoice 2016 waiver allowed the Department to provide a limited benefit package of family planning services to eligible women. The program covered medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education, and referrals. Effective July 1, 2018, the Department expanded eligibility under its Family Planning program to lift the age limit and open coverage to include men. The number of participants in the Family Planning program for any period of enrollment decreased by 24.0% during the evaluation period, and the number of participants continuously enrolled dramatically increased by 38.7% from CY 2019 to CY 2022 followed by a significant decrease by 64.0% from CY 2022 to CY 2023, mostly likely due to continuous Medicaid eligibility required under MOE requirements.

In 2021, the Department received approval for the §1115 waiver renewal for the period of January 1, 2022, through December 31, 2026, to focus on maintaining high-quality, cost-effective services and pilot programs initiated in the last waiver renewal period. The Family Planning program was not renewed during the 2021 waiver period as it was incorporated into the State Plan. Key demonstrations components include the following:

- Expansion of IMD services for adults with SMI
- Expansion of SUD Residential and Inpatient Treatment Services
- MOM program
- Modification to ACIS pilot program
- Diabetes Prevention Program (DPP)

Evaluation of the Maryland Medicaid HealthChoice Program: CY 2019 to CY 2023

Section I. Introduction

In 1997, Maryland implemented HealthChoice—a statewide mandatory Medicaid and Children's Health Insurance Program (CHIP) managed care program—as a waiver of standard federal Medicaid rules under authority of §1115 of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS) approved subsequent waiver renewals in 2002, 2005, 2007, 2010, 2013, 2016, and 2021. The Maryland Department of Health (the Department) provides oversight and continually monitors HealthChoice performance on a variety of measures across the demonstration's goals, culminating in an annual evaluation.

This report—the 2025 evaluation—includes data from calendar year (CY) 2019 through CY 2023. The following sections provide a brief overview of the HealthChoice program and recent program updates before addressing these goals:

- Improve access to health care for the Medicaid population, including special populations
- Improve the quality of health services delivered
- Provide patient-focused, comprehensive, and coordinated care through the provision of a single medical home
- Emphasize health promotion and disease prevention
- Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies

This report is a collaborative effort between the Department and The Hilltop Institute at UMBC.

It is important to note that the COVID-19 public health emergency (PHE) in 2020 had a significant impact on the HealthChoice program, resulting in increased enrollment and decreased utilization of services. Because the Families First Coronavirus Response Act (FFCRA) required continuous Medicaid eligibility during the PHE, starting in March 2020, there was a pause in eligibility reviews that led to a large increase in Medicaid enrollment through 2023. Rates of service utilization and screenings decreased in CY 2020 during the COVID-19 PHE, and while many have seen subsequent increases during CY 2021 to CY 2023, few rates have returned to pre-COVID levels. Maryland will continue to monitor the effects of the COVID-19 PHE on the HealthChoice program.

Furthermore, the quality of the race and ethnicity information available changed dramatically with the implementation of the ACA in 2014. A new approach to selecting race and ethnicity on the Medicaid eligibility application reduced the number of individuals reporting their race or ethnicity and increased the proportion represented as "Other." In 2023, the Department completed a process of enhancing the Medicaid race and ethnicity data in the MMIS2 using external data sets from the Maryland Health Benefit Exchange (MHBE) and Chesapeake Regional Information System for Our Patients (CRISP), Maryland's health information exchange, with the

goal of improving the race and ethnicity data for monitoring health equity and disparities among Medicaid participants. Results showed that the enhanced data are close to the benchmark of the Medicaid participants in the American Community Survey (ACS).[8] The analyses in this year's evaluation of the HealthChoice program use the enhanced race and ethnicity data.

Overview of the HealthChoice Program

As of the end of CY 2023, close to 90% of the state's Medicaid and Maryland Children's Health Program (MCHP) populations were enrolled in HealthChoice. HealthChoice participants choose a managed care organization (MCO) and a primary care provider (PCP) from their MCO's network to oversee their medical care. Participants who do not select an MCO or a PCP are assigned to one automatically. The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include the following:

- Families with low income that have children
- Families that receive Temporary Assistance for Needy Families (TANF)
- Children younger than 19 years who are eligible for MCHP
- Adults under the age of 65 with income up to 138% of the federal poverty level (FPL)
- Women with income up to 264% of the FPL who are pregnant or less-than-60-days postpartum
- Individuals receiving Supplemental Security Income (SSI) who are under age 65 and ineligible for Medicare

Not all Maryland Medicaid participants are eligible for the HealthChoice managed care program. Groups that are ineligible for enrollment in the managed care program include the following:

- Medicare beneficiaries
- Individuals aged 65 years and older[9]
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a limited time
- Individuals who require more than 90 days of long-term care services and are subsequently disenrolled from HealthChoice
- Individuals who are continuously enrolled in an institution for mental disease (IMD) for more than 30 days
- Residents of an intermediate care facility for individuals with intellectual disabilities
- Individuals enrolled in the Model Waiver or the Employed Individuals with Disabilities (EID) program

[8] American Community Survey Data, available at https://www.census.gov/programs-surveys/acs/data.html.
[9] Individuals aged 65 and older can be enrolled in a HealthChoice MCO if covered as a parent or caretaker.

There are additional populations covered under the HealthChoice waiver who do not enroll in HealthChoice MCOs, including individuals in the Family Planning and the Rare and Expensive Case Management (REM) programs. The Family Planning program was a limited-benefit program under the waiver and is now part of the state plan amendment (SPA). The REM program allows HealthChoice-eligible individuals with certain rare and expensive diagnoses to receive care on a fee-for-service (FFS) basis. Family Planning is discussed in Section VII, while REM is discussed in more detail in Section III of this report.

HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid participants through the FFS system. MCOs were responsible for coverage of most medical services during 2023, including the following:

- Inpatient and outpatient hospital care
- Physician care
- Federally qualified health center (FQHC) or other clinic services
- Laboratory and X-ray services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under 21
- Prescription drugs, except for behavioral health drugs
- Durable medical equipment and disposable medical supplies
- Home health care
- Vision services, including corrective lens and hearing aids for children under 21[10]
- Dialysis
- The first 90 days of long-term care services

The following services are not covered by the MCOs and instead are covered by the Medicaid FFS system:

- Specialty mental health care and substance use disorder (SUD) treatment services[11]
- Dental care for children, pregnant women, and adults in the REM program
- Health-related services and targeted case management services provided to children when the services are specified in the child's individualized education plan (IEP) or individualized family service plan (IFSP)
- Therapy services (occupational, physical, and speech) for children
- Personal assistance services offered under the Community First Choice program

[10] Although not required by regulation, some MCOs provide adults with limited vision, hearing, and dental benefits.
[11] SUD services were carved out of the MCO benefit package on January 1, 2015. Mental health services have never been included in the MCO benefit package.

- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS
- Behavioral health drugs
- Services covered under 1915(c) home and community-based services (HCBS) waivers[12]

Program Updates

The Department implemented the following programmatic changes to HealthChoice that influenced the evaluation period:

- In 2013, the Department implemented a §2703 Chronic Health Home program, serving adults diagnosed with a serious and persistent mental illness, children diagnosed with a serious emotional disturbance (SED), and individuals diagnosed with an opioid SUD who are at risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use. As of December 2023, MDH had approved 263 Chronic Health Home site applications. The Health Home sites include 192 psychiatric rehabilitation programs, 24 mobile treatment providers, and 47 opioid treatment programs. In December 2023, there were 11,115 participants in the Chronic Health Home program, including 645 children/youth under age 18; 9,518 participants aged 18 to 64; and 952 participants aged 65 and over.
- Under the ACA, Maryland expanded coverage through the Medicaid program to two new populations:
    - Individuals with income up to 138% of the FPL. Over the course of the expansion's first year (CY 2014), 283,716 adults received Medicaid coverage through this expansion. As of December 2023, there were 515,121 individuals enrolled in the ACA expansion.
    - Former foster care children up to the age of 26 years.
- From the inception of the HealthChoice program in 1997, mental health services were carved out of the benefit package, while services for individuals with SUDs were provided by the MCOs. The Department combined mental health and SUD services in an integrated carve-out on January 1, 2015. Under the carve-out, an administrative services organization (ASO) administers and reimburses all specialty mental health and SUD services for Medicaid participants on an FFS basis, under the oversight of the Medicaid program and the Behavioral Health Administration (BHA).

[12] Services covered under the 1915(c) HCBS waivers include assisted living, medical day care, family training, case management, senior center plus, dietitian and nutritionist services, and behavioral consultation.

The Department included several initiatives for innovative programs that were approved for the CY 2019 to CY 2023 waiver period. See Section VII for additional information on the following initiatives:

- Residential Treatment for Individuals with SUDs aged 21 through 64 years in IMDs
- Two community health pilot programs
    - Evidence-Based Home Visiting Services (HVS)
    - Assistance in Community Integration Services (ACIS)
- National Diabetes Prevention Program (DPP)
- Increased Community Services (ICS)
- Family Planning program

The Department submitted a §1115 waiver renewal application in July 2021 and received approval in December 2021 for the period of January 1, 2022, through December 31, 2026. The Family Planning program and HVS program were not renewed because they were added to the State Plan. However, several initiatives were added, expanded, or modified, including the following:

- Addition of the MOM program
- Expansion of IMD services for adults to include primary diagnoses of serious mental illness (SMI)
- Expansion of SUD Residential and Inpatient Treatment Services to remove caps on lengths of stays for SUD treatment in an IMD and aim for a statewide average length of stay (LOS) of 30 days or less
- Modification to the ACIS pilot program to increase the statewide capacity to 900 spaces

The Department, in collaboration with the Center for Medicare and Medicaid Innovation (CMMI), established Maryland's Statewide Integrated Health Improvement Strategy (SIHIS)[13] (Maryland Department of Health, 2020a). To develop the SIHIS proposal, workgroups led by the Department, the Opioid Operational Command Center,[14] and the Health Services Cost Review Commission (HSCRC) collaborated to gather stakeholder input to establish goals, measures, milestones, and targets for SIHIS.

SIHIS is structured to drive improvements in three domains: hospital quality, care transformation across the health care system, and total population health. Reducing avoidable admissions and readmissions is a top priority under hospital quality. Diabetes, opioid use, and maternal and child health were selected as priority areas under the third domain, with the identified goals of improving care coordination for patients with chronic conditions, improving adult body mass

[13] https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx
[14] In 2023, known as the Office of Overdose Response.

index (BMI), improving overdose mortality rates, reducing severe maternal morbidity rates, and decreasing asthma-related emergency department (ED) visits rates for ages 2 to 17. CMMI approved Maryland's proposal in 2021, which includes a detailed plan to achieve "progress milestones and population health outcome targets across all three domains by the end of 2026" (Maryland Department of Health, 2020b, p. 1). The SIHIS 2021 goals and milestones were important building blocks necessary to progress toward the 2023 and 2026 targets. The SIHIS 2021 goals have been successful in reducing the mean BMI for adults, reducing avoidable admissions and readmissions, reducing the severe maternal morbidity rate, and improving overdose mortality (Maryland Department of Health, 2023b). The state is focused on improving care coordination for participants with chronic conditions, which was the only 2021 milestone that was not met.

On January 1, 2026, Maryland will be transitioning from SIHIS to the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.[15]

As a result of the collaboration with CMMI, the Department developed an annual monitoring plan for the evaluation of Maryland Health Services Cost Review Commission (HSCRC)-funded Maternal and Child Health (MCH) Population Health Improvement Fund for July 1, 2021, to June 30, 2025. The plan includes impact measures that align with SIHIS and include the following programs:

- HVS pilot expansion for high-risk pregnant individuals and children under the age of three
- Reimbursement for doula services for pregnant and postpartum women
- MOM program expansion for pregnant individuals with opioid use disorder (OUD)
- CenteringPregnancy, a clinic-based group prenatal care model
- HealthySteps, a clinic-based pediatric primary care model and family case management framework

This will also support expansion of the state's existing community-based asthma programs and Eliminating Disparities in Maternal Health Initiative.

[15] https://hscrc.maryland.gov/Pages/ahead-model.aspx

Section II. Methodology

Due to the varying populations, timeframes, and targets among the measures in this evaluation, Hilltop used different methodologies to evaluate the HealthChoice outcomes being measured. For measuring trends in enrollment and service utilization among demographic and clinical subgroups, Hilltop used Medicaid program data for CY 2019 to CY 2023 from MMIS2 to identify enrollees, their services utilization, and treatment. These measures are expressed either as five-year trends or as comparisons between the first and the last year of the evaluation period (i.e., CY 2019 and CY 2023). Additionally, some analyses distinguish between all ACA Medicaid expansion participants and those enrolled for 12 continuous months. ACA Medicaid expansion participants with 12 continuous months of enrollment provide an MCO with more time and opportunities to intervene in their health care than participants with any period of enrollment.

Hilltop also used data from *LTSSMaryland*—the state's integrated long-term services and supports (LTSS) tracking system—to identify enrollees in the REM program for analyses of this subpopulation's demographics and service utilization.

For standardized definitions of particular clinical, pharmaceutical, and health utilization measures, Hilltop used the Healthcare Effectiveness Data and Information Set (HEDIS®)[16] proprietary software from Cognizant, a National Committee for Quality Assurance (NCQA)-certified software vendor, to define and classify according to standard NCQA measures. Hilltop also uses the MetaStar Executive Summary (2024) to report HEDIS® measures for preventive care and monitoring chronic diseases.

Hilltop developed programming to create person- and visit-level summaries of two HEDIS® measures: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) and Follow-Up after Emergency Department Visit for Mental Illness (FUM). Hilltop also developed programming to create person-level data sets utilizing diagnoses and service definitions from the HEDIS® Asthma Medication Ratio (AMR) measure and the diabetes retinal and hemoglobin A1c screening from the Comprehensive Diabetes Care (CDC) measure.

Hilltop analyzed trends in health services utilization pre- and post-program implementation, pre- and post-program enrollment, and pre- and post-treatment. Hilltop also conducted analyses to compare the differences in trends in health services utilization between program participants and non-participants. Finally, some analyses examined the monthly count of service utilization per participant in a given program.

Regression Analysis

To evaluate the effects of HealthChoice service delivery on outcomes such as hospitalizations or ED visits, a trend analysis would not be sufficient. Numerous factors besides health care treatment—such as age, sex, race, geographic location, and pre-existing health conditions—affect outcomes. To separate these other factors when estimating whether adherence to HEDIS®

[16] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

guidelines is associated with improved outcome measures, Hilltop used a set of statistical techniques known as multivariate regression analysis. The multivariate regression techniques used included logistic and linear regression models.

Logistic regressions are used to analyze relationships when the dependent (outcome) variable has discrete outcomes. The variables that are being measured for their associations with the outcome variable are called independent variables. Independent variables can themselves be discrete (such as race, sex, or region), ordinal (such as rankings from best to worst), interval (such as amounts of a service), or ratio-level (such as a percentage). The coefficients of independent variables produced by logistic regressions are thereafter translated into odds ratios (ORs), which represent the odds that an outcome will occur (given a particular category/level of one of these variables changing) compared to the odds of the outcome occurring in the absence of those categories/levels. For example, in a group of people whose outcome variable is an ED visit, if the OR for females is 0.90, then females have 10% lower odds (or are 10% less likely) to incur an ED visit in this sample when compared to males.

While constructing these regression analyses, Hilltop created programming to identify Medicaid participants who met HEDIS® measure population definitions and their relationship with the following outcomes of interest:

- Relationship between asthma patients with a positive AMR and ED utilization—as well as inpatient admissions—compared to those without a positive AMR
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Receipt of diabetes eye screenings and inpatient admission and ED visit for diabetes
- Among prediabetic adults, relationships between participation in the DPP and diabetes incidence, inpatient admissions, and ED utilization

Methodological Limitations

Regression analyses and other measures used in this evaluation do not establish whether the independent variables measured cause the outcome variable. Multivariate regression models estimate the associations between the independent variables and the outcome variables under the assumptions that certain key conditions are met, such as the absence of selection bias[17] or the use of inappropriate comparison groups. If remain unaddressed, estimation of causal relationship between the treatment conditions (i.e., the main independent variable of interest) and outcome variables without random assignment of the main treatment condition is prone to be statistically biased.[18] Nonetheless, the strength of the association between independent and outcome variables can be measured by the estimated confidence intervals around the

[17] Selection bias occurs when the study sample does not reflect the population of interest. Therefore, any risks/benefits/outcome observed in the analysis does not accurately represent how that risks/benefits/outcome would occur in the target population, affecting the generalizability of the study's results.

[18] Statistical biases due to unmet conditions like sample selection or omitted variables leading to endogeneity issues are addressed using methods like instrumental variable (IV) approaches, and propensity score matching (PSM).

parameter or estimates. A narrower confidence interval indicates that the estimated parameter is more likely to be close to the center of that confidence interval than in the case of a broader confidence interval. In January 2020, the behavioral health ASO for Maryland Medicaid changed from Beacon Health Options to Optum, and technical problems with the transition impacted the submission of behavioral health data for analysis during the evaluation period. Additionally, the effects of the COVID-19 PHE, which began in March 2020, had a large impact on the HealthChoice program from CY 2020 to CY 2023 and posed methodological challenges for the evaluation.

Section III. Improve Access to Care for the Medicaid Population

Section §1115 programs such as HealthChoice depend on MCOs improving access to care for participants. This section measures Maryland's progress toward improving access to care by examining enrollment, network adequacy, and utilization. This section also measures the HealthChoice programs that improve access to care for special populations—including children in foster care and individuals in the REM population—and addresses racial and ethnic disparities in health care and service utilization.

Enrollment

HealthChoice Enrollment

One way to measure the population served by HealthChoice is to count the number of individuals with any period of enrollment during a given calendar year, including individuals who may not have been enrolled for the entire year. Another method is to count individuals enrolled at a particular point in time (e.g., enrollment as of December 31). Program enrollment on a given day is smaller than the number of enrollees served over the course of a year as individuals move in and out of Medicaid eligibility. Unless otherwise stated, the enrollment data in this section of the report use the point-in-time methodology to reflect enrollment as of December 31 of the measurement year.[19] Occasionally, measures will specify that they include persons enrolled at any time during the year.

Table 1 displays demographic characteristics of the HealthChoice population for those with any period of enrollment during the evaluation period (CY 2019 through CY 2023). Table 1 utilized the improved race and ethnicity data. The total number of participants increased by 20.9% during this time. Most of the demographic characteristics stayed consistent over the evaluation period—except for a slight increase in the proportion of enrollees aged 21 to 39 and the proportion of enrollees who reported their race/ethnicity as Hispanic. The percentage of participants who reported their race/ethnicity as "Hispanic" increased by 2.4 percentage points from CY 2019 to CY 2023. The only other racial groups that grew from CY 2019 to CY 2023 were Asian and "Other," with increases of 0.4 and 0.3 percentage points, respectively.

[19] Enrollment data are presented for individuals aged 0 through 64 years. Age is calculated as of December 31 of the measurement year.

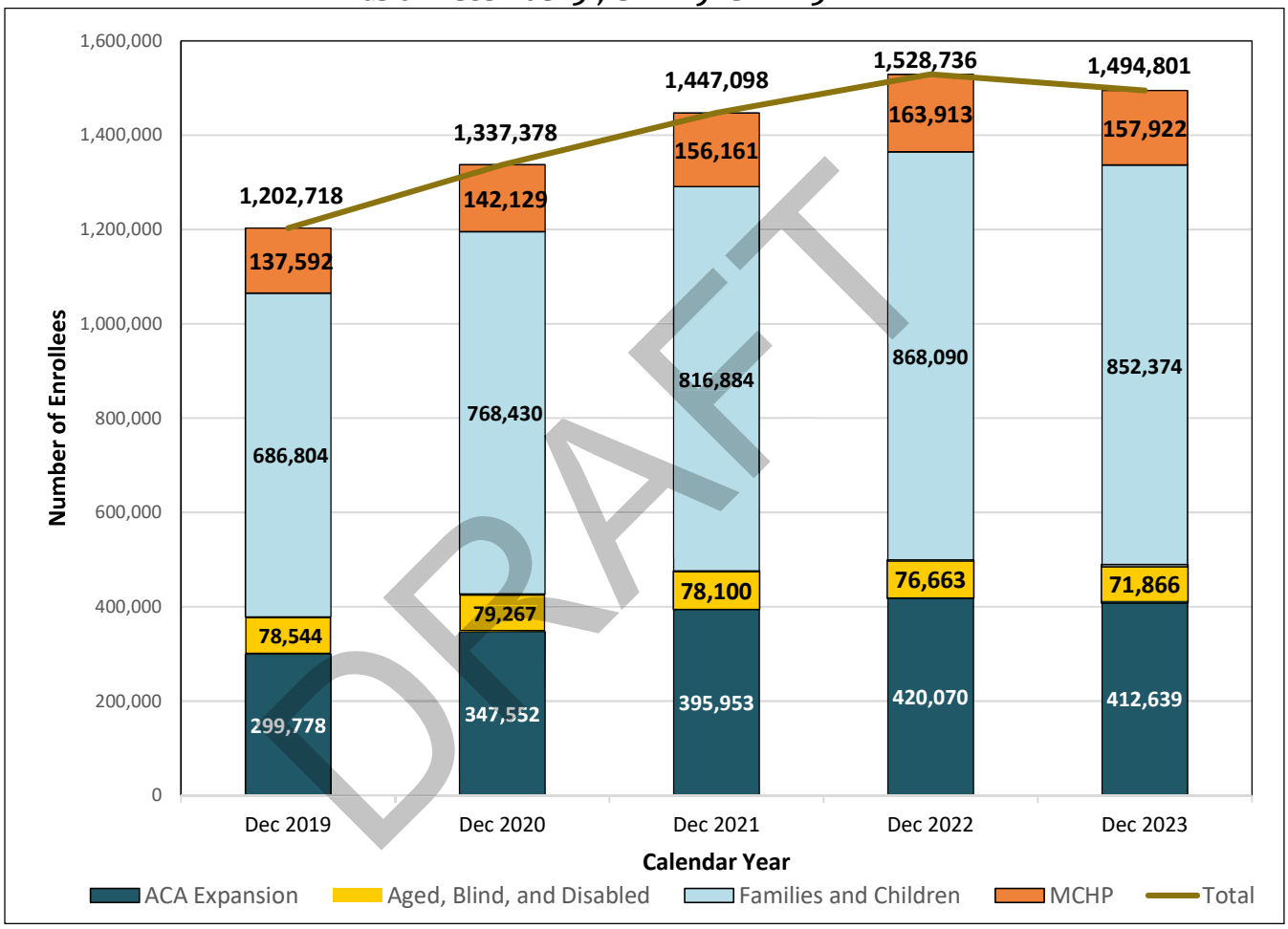
Table 1. HealthChoice Population (Any Period of Enrollment) by Demographics, CY 2019 and CY 2023

Demographic Characteristic	CY 2019		CY 2023	
	# of Participants	% of Total	# of Participants	% of Total
Sex				
Female	738,567	53.6%	893,613	53.7%
Male	638,760	46.4%	771,619	46.3%
Total	**1,377,327**	**100%**	**1,665,232**	**100%**
Age Group (Years)				
0–<1	35,874	2.6%	34,538	2.1%
1–2	77,215	5.6%	77,620	4.7%
3–5	113,351	8.2%	120,233	7.2%
6–9	145,481	10.6%	160,708	9.7%
10–14	180,507	13.1%	195,818	11.8%
15–18	118,241	8.6%	153,677	9.2%
19–20	51,575	3.7%	66,329	4.0%
21–39	377,091	27.4%	501,110	30.1%
40–64	277,992	20.2%	355,199	21.3%
Total	**1,377,327**	**100%**	**1,665,232**	**100%**
Race/Ethnicity				
Asian	70,133	5.1%	91,311	5.5%
Black	609,788	44.3%	720,319	43.3%
White	376,786	27.4%	421,980	25.3%
Hispanic	222,974	16.2%	310,032	18.6%
Native American	13,107	1.0%	15,284	0.9%
Other*	84,539	6.1%	106,306	6.4%
Total	**1,377,327**	**100%**	**1,665,232**	**100%**
Region**				
Baltimore City	236,532	17.2%	261,994	15.7%
Baltimore Suburban	415,966	30.2%	506,396	30.4%
Eastern Shore	127,241	9.2%	148,454	8.9%
Southern Maryland	70,937	5.2%	84,988	5.1%
Washington Suburban	409,288	29.7%	523,393	31.4%
Western Maryland	116,041	8.4%	138,818	8.3%
Out of State	1,322	0.1%	1,189	0.1%
Total	**1,377,327**	**100%**	**1,665,232**	**100%**

*"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.
**Regions are defined as the following: Baltimore City (only), Baltimore Metro (Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties), Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties), Southern Maryland (Calvert, Charles, and St. Mary's Counties), Washington Metro (Montgomery and Prince George's Counties), and Western Maryland (Allegany, Frederick, Garrett, and Washington Counties). Refer to Figure A1.

Figure 1 displays HealthChoice enrollment by coverage category from CY 2019 through CY 2023. There were code changes for the Families and Children coverage category. For a detailed list of the inclusion criteria for each coverage category, see Appendix. Since CY 2019, the overall HealthChoice population enrollment has grown by 24.3%. Enrollment grew by 27.1% from CY 2019 to CY 2022, before decreasing by 2.2% in CY 2023.

Figure 1. HealthChoice Enrollment by Coverage Category as of December 31, CY 2019–CY 2023*



*Enrollment counts in Figure 1 include participants aged 0-64 years who are enrolled in a HealthChoice MCO.

Enrollment Growth

As of December 2023, national enrollment in Medicaid and CHIP was 85.6 million, down from 92.6 million in December 2022 (Kaiser Family Foundation, n.d.b). In fiscal year (FY) 2024, overall enrollment declined by 7.5%, and is expected to continue to decrease by 4.4% in FY 2025, with the trend due in part to the end of the continuous enrollment requirement of FFCRA (Williams et al., 2024). In 2013, before the ACA expansion, more than 10% of Maryland residents were uninsured. The growth in Medicaid enrollment contributed to a decline in Maryland's uninsured rate, which overall remained constant throughout the evaluation period, at around 6.0% (Kaiser Family Foundation, n.d.a, Kaiser Family Foundation, n.d.b).[20]

Table 2 shows the percentage of Maryland's population enrolled in HealthChoice between CY 2019 and CY 2023. The number of HealthChoice participants with any period of enrollment fluctuated throughout the evaluation period but increased overall. The percentage of Maryland's population who were HealthChoice participants also increased by 4.1 percentage points. The number of HealthChoice enrollees and the percentage of Maryland's population who were enrolled as of December 31 increased each year from CY 2019 to CY 2022, with a slight decrease in CY 2023.

Table 2. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2019–CY 2023

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Maryland Population*	6,045,680	6,165,129	6,174,610	6,163,981	6,180,253
Individuals Enrolled in HealthChoice for Any Period of Time during the Year					
HealthChoice Population	1,377,493	1,392,876	1,487,449	1,574,181	1,665,232
% of Population in HealthChoice	22.8%	22.6%	24.1%	25.5%	26.9%
Individuals Enrolled in HealthChoice as of December 31					
HealthChoice Population	1,202,718	1,337,378	1,447,098	1,528,736	1,494,801
% of Population in HealthChoice	19.9%	21.7%	23.4%	24.8%	24.2%

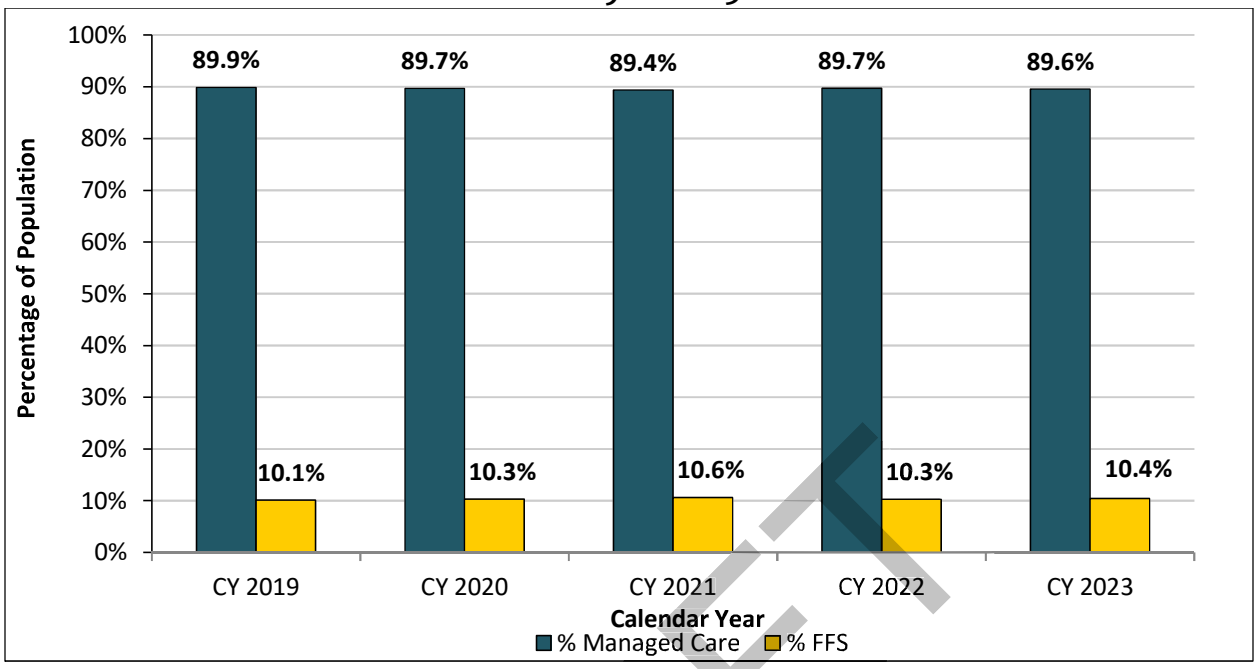
* Data source: U.S. Census Bureau, Population Division. *Annual estimates of the resident population: April 1, 2010, to July 1, 2023*. https://www.census.gov/quickfacts/fact/table/MD,US/PST045218

Managed Care Enrollment

Since its inception, HealthChoice has been expected to enroll a high percentage of Medicaid participants into managed care. Figure 2 compares Medicaid managed care and FFS enrollment. Between CY 2019 and CY 2023, managed care enrollment remained consistently above 89.0%, with the highest rate of 89.9% in CY 2019, and the lowest rate of 89.4% in CY 2021.

[20] The limited data available for CY 2020 suggest that there was a decline in the uninsured rate to 4.3%. The 2020 data are based on the Coverage of the Total Population (CPS) instead of the American Community Survey (ACS) and cannot be compared to CY 2019 and CY 2021 data.

Figure 2. Percentage of Medicaid[21] Participants in Managed Care Compared to FFS, CY 2019–CY 2023



Continuous Enrollment

The Department began monitoring HealthChoice participants to ensure that they did not have a gap or interruption in Medicaid coverage as a result of a change in the system for eligibility redetermination in CY 2015. The Department initiated automated renewals of coverage based on data indicating no substantial changes in participants' financial position to reduce the amount of time Medicaid-eligible individuals were without Medicaid coverage and improve the health and financial status of beneficiaries. Since FFCRA's continuous enrollment requirement affected enrollment from CY 2020 through CY 2022, it is difficult to evaluate the extent to which the auto-enrollment policy affected continuous enrollment or reduced gaps in coverage over the evaluation period. Continuous enrollment for children became effective September 2023. [22]

Table 3 shows the proportion of HealthChoice participants with twelve months of continuous Medicaid enrollment by age group. The percentage of participants with continuous enrollment increased steadily for all age groups over the evaluation period, with overall continuous enrollment among participants of any age rising from 77.4% in CY 2019 to 85% in CY 2023, with a high of 92.7% in CY 2022. Adults aged 19 to 39 years continued to have lower rates of continuous enrollment than other age groups throughout the evaluation period.

[21] "Medicaid" is representative of both Medicaid and MCHP.

[22] https://health.maryland.gov/mmcp/Documents/Public%20Notice/Public%20Notice%20Continuous%20Eligibility%20SPA_Updated.pdf

Table 3. Percentage of HealthChoice Participants with Continuous Medicaid Enrollment, by Age Group, CY 2019–CY 2023

Age Group (Years)	Calendar Year				
	2019	2020	2021	2022	2023
1–2	75.0%	85.8%	92.8%	93.7%	88.9%
3–9	81.9%	91.0%	93.8%	94.2%	90.1%
10–18	82.3%	91.1%	94.5%	94.9%	90.4%
19–39	71.9%	82.2%	89.0%	90.9%	80.1%
40–64	77.3%	83.3%	89.5%	91.6%	82.5%
Total	**77.4%**	**86.3%**	**91.4%**	**92.7%**	**85.0%**

Table 4 displays the number and percentage of HealthChoice participants with a gap in Medicaid enrollment of one or more days from CY 2019 through CY 2023, as well as whether the gap lasted longer than 180 days (i.e., over 6 months).[23] Participants who reapply within 180 days are enrolled into their previous MCO. Participants who reapply after 181 days or more are automatically assigned to an MCO. The percentage of HealthChoice participants with at least one gap in coverage decreased from 4.2% in CY 2019, to 0.3% in CY 2022, but rose to 1.7% in CY 2023. Among participants with a gap in coverage in CY 2023, 76.4% had a gap of 180 days or less, and 23.6% had a gap of 181 days or more.

The decrease in the percentage of enrollees with at least one gap in coverage from 4.7% in CY 2019 to a low of 0.3% in CY 2021 and CY 2022 is likely the result of the FFCRA's continuous enrollment requirements. The subsequent increase to 1.7% in CY 2023 is likely attributable to the resumption of Medicaid redeterminations following the end of the COVID-19 PHE. However, the proportion of enrollees with a gap longer than 6 months in CY 2023 is lower compared to previous years.

Table 4. Number of HealthChoice Participants with a Gap in Medicaid Coverage, by Length of Gap, CY 2019–CY 2023

Calendar Year	Total	At Least One Gap in Medicaid Coverage		Length of Coverage Gap			
				180 Days or Less		181 Days or More	
		#	%	#	%	#	%
2019	1,377,257	64,802	4.7%	47,004	72.5%	17,798	27.5%
2020	1,392,625	16,568	1.2%	11,192	67.6%	5,376	32.4%
2021	1,486,991	4,127	0.3%	2,806	68.0%	1,321	32.0%
2022	1,573,811	5,279	0.3%	3,462	65.6%	1,817	34.4%
2023	1,665,232	27,641	1.7%	21,109	76.4%	6,532	23.6%

Table 5 shows the number of participants in the ACA expansion coverage groups who had a coverage gap during the evaluation period and the lengths of participants' respective coverage

[23] Due to coding error, all years in the measurement period have been updated. Table is not comparable to previous versions.

gaps.[24] Participants in the ACA expansion coverage groups followed a similar trend to the overall population. Over the evaluation period, participants with at least one gap in Medicaid coverage declined from 4.2% in CY 2019 to 1.6% in CY 2023. Excluding CY 2020 to CY 2022, which were affected by the COVID-19 PHE, the percentage of participants in the ACA expansion coverage groups with at least one gap in Medicaid coverage decreased from CY 2019 to CY 2023, and there were 7,511 fewer re-enrollments. From CY 2021 to CY 2022, there was a slight increase in the number of participants in the ACA expansion coverage groups with at least one gap. The respective proportions of gaps that lasted 180 days or less and 181 days or more fluctuated throughout the evaluation period.

Table 5. Number of ACA Expansion HealthChoice Participants with a Gap in Medicaid Coverage, by Length of Gap, CY 2019–CY 2023

Calendar Year	Total	At Least One Gap in Medicaid Coverage		Length of Coverage Gap			
				180 Days or Less		181 Days or More	
		#	%	#	%	#	%
2019	360,998	15,329	4.2%	9,333	60.9%	5,996	39.1%
2020	368,226	4,269	1.2%	2,733	64.0%	1,536	36.0%
2021	412,273	1,403	0.3%	1,021	72.8%	382	27.2%
2022	438,430	1,548	0.4%	1,017	65.7%	531	34.3%
2023	475,133	7,818	1.6%	5,855	74.9%	1,963	25.1%

In addition to encouraging continuity of coverage, the Department sought to improve connection to services for new HealthChoice participants. Table 6 shows the mean number of days until first service for new HealthChoice participants. Between CY 2019 and CY 2023, the mean duration decreased for medical services, pharmacy services, and overall, for any service. There was an increase in the mean duration for all service categories in CY 2020, likely due to the impact of the COVID-19 PHE on the availability of medical services.

Table 6. Mean Duration in Days until First Service for New HealthChoice Participants, CY 2019–CY 2023

Service	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Any	57.5	72.7	48.5	47.9	44.3
Medical	60.8	77.5	53.9	52.6	48.0
Pharmacy	101.3	113.7	98.3	97.9	93.6

Network Adequacy

Another method of measuring enrollee access to care is to examine provider network adequacy. This section of the report examines PCP and specialty provider networks.

[24] Due to coding error, all years in the measurement period have been updated. Table is not comparable to previous versions.

PCP Network Adequacy

The HealthChoice program requires every participant to have a PCP, and each MCO must have an adequate network of PCPs to serve its enrolled population. Under HealthChoice regulations, MCOs must have a ratio of 1 PCP to every 200 participants within each of the up to 40 local access areas (LAAs) in the state for their network to be considered adequate.[25] The Department assesses network adequacy periodically throughout the year and works with the MCOs to resolve capacity issues. In the case of any deficiencies in network adequacy, the Department discontinues new enrollment for that MCO in the affected region until it increases provider contracts to an adequate level.

Table 7 shows PCP network adequacy as of December 2023. The network adequacy analysis counted the number of PCP offices included in provider networks in each county in Maryland. In CY 2023, all jurisdictions were able to achieve a 200:1 ratio of participants to PCPs.

Table 7. PCP Capacity, by County, December 2023[26]

County	Number of PCP Offices	Capacity at 200:1	Total Dec 2023 Enrollment	Excess Capacity
				Difference 200:1 Ratio
Allegany	184	36,800	20,510	16,290
Anne Arundel	1,067	213,400	106,608	106,792
Baltimore City	2,332	466,400	241,839	224,561
Baltimore County	1,908	381,600	221,519	160,081
Calvert	156	31,200	15,217	15,983
Caroline	118	23,600	12,178	11,422
Carroll	300	60,000	24,528	35,472
Cecil	171	34,200	27,775	6,425
Charles	265	53,000	37,622	15,378
Dorchester	88	17,600	12,413	5,187
Frederick	403	80,600	47,478	33,122
Garrett	97	19,400	7,789	11,611
Harford	440	88,000	49,976	38,024
Howard	579	115,800	50,495	65,305
Kent	38	7,600	4,511	3,089
Montgomery	1,704	340,800	200,844	139,956
Prince George's	1,367	273,400	266,257	7,143
Queen Anne's	123	24,600	8,553	16,047

[25] COMAR 10.67.05.05B(8).

[26] Providers were identified by their license numbers. If a license number was unavailable, then the provider's national provider identifier (NPI) was used. If a provider had more than one office location in a county, only one office was counted. If a provider had multiple office locations among different counties, one office was counted in each county. PCPs in Washington, DC were not included in the analysis. Although the regulations apply to each MCO individually, this analysis aggregated data from all nine MCOs.

County	Number of PCP Offices	Capacity at 200:1	Total Dec 2023 Enrollment	Excess Capacity
				Difference 200:1 Ratio
Somerset	64	12,800	8,785	4,015
St. Mary's	212	42,400	23,140	19,260
Talbot	214	42,800	8,219	34,581
Washington	303	60,600	46,834	13,766
Wicomico	257	51,400	37,544	13,856
Worcester	142	28,400	13,222	15,178
Total (in MD)	**12,532**	**2,506,400**	**1,493,856**	**1,012,544**
Other*	555			
Washington, DC	1,377			

* Other includes out of state.

Specialty Care Provider Network Adequacy

In addition to ensuring PCP network adequacy, the Department requires MCOs to provide all medically necessary specialty care. If an MCO does not have the appropriate in-network specialist needed to meet an enrollee's medical needs, then it must arrange for care with an out-of-network specialist and compensate the provider. Regulations for specialty care access require each MCO to have an in-network contract with at least one provider statewide in 14 major medical specialties.[27] These medical specialties include eight core specialties—cardiology, otolaryngology, gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology—and six major specialties—allergy and immunology, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Additionally, for each of the ten specialty care regions throughout the state that an MCO serves, an MCO must include at least one in-network specialist in each of the eight core specialties.

Utilization

With the continued increase in HealthChoice enrollment, it is important to maintain access to care. This section of the report examines service utilization related to ambulatory care, ED visits, and inpatient admissions. Unless otherwise stated, all measures in this section are calculated for HealthChoice participants with any period of enrollment in the program during the calendar year.

Ambulatory Care Visits

The Department monitors ambulatory care utilization as a measure of access to care. When properly accessing care, HealthChoice participants should receive care in an ambulatory care setting rather than use the ED for a non-emergent condition or allow a condition to exacerbate to the extent that it requires an inpatient admission. For this analysis, an ambulatory care visit is

[27] COMAR 10.67.05.05-1.

defined as contact with a doctor, nurse practitioner, or physician assistant in a clinic, physician's office, or hospital outpatient department by an individual enrolled in HealthChoice at any time during the measurement year.

Figure 3 shows the percentage of HealthChoice participants with an ambulatory care visit during the calendar year by age group. Between CY 2019 and CY 2023, children under the age of three had the highest ambulatory care visit rates, while participants aged 19 to 39 years had the lowest rates. While rates decreased for all age groups in CY 2020, they increased in CY 2021 for every age group above age one, with gains ranging from 1.2 percentage points for children aged one to two years to 5.8 percentage points for children aged 10 to 18 years. From CY 2021 to CY 2023, rates for all age groups decreased except for participants under the age of one.

Figure 3. Percentage of the HealthChoice Population Who Had an Ambulatory Care Visit, by Age Group, CY 2019–CY 2023

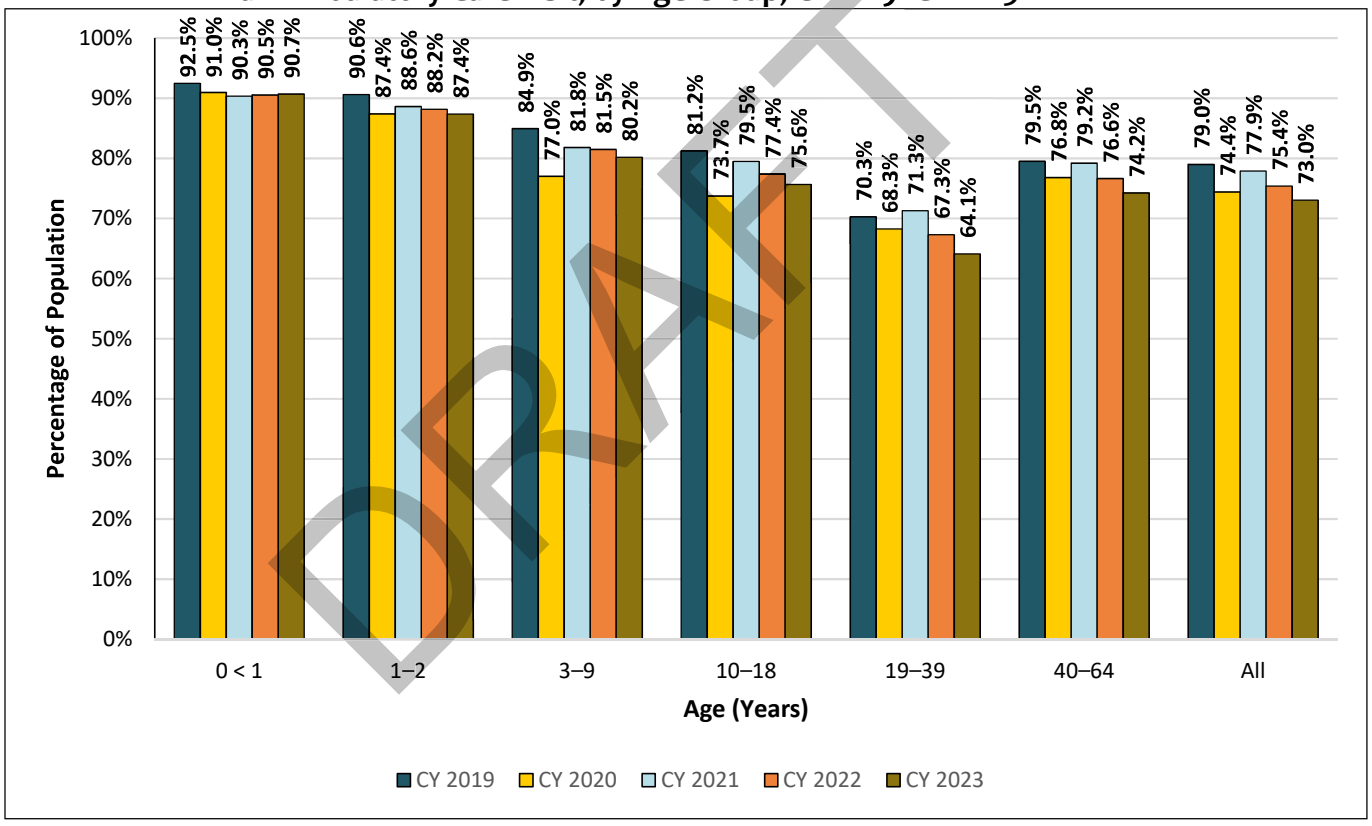


Figure 4 presents ambulatory care use by coverage category. ACA expansion participants accessed ambulatory care services at lower rates than participants in other coverage categories, with their rate decreasing by 5.8 percentage points during the evaluation period. ACA expansion participants constitute more than 25% of the HealthChoice population (Figure 1), so their low utilization of ambulatory care affects the trend for the entire population. All coverage groups experienced declines in ambulatory care visit rates between CY 2019 and CY 2020 but saw increases ranging from 2.3 to 4.1 percentage points between CY 2020 and CY 2021, followed by decreases from CY 2021 to CY 2023. All coverage categories experienced overall decreases ranging from 3.5 to 6.1 percentage points over the evaluation period.

Figure 4. Percentage of the HealthChoice Population Who Had an Ambulatory Care Visit, by Coverage Category, CY 2019–CY 2023

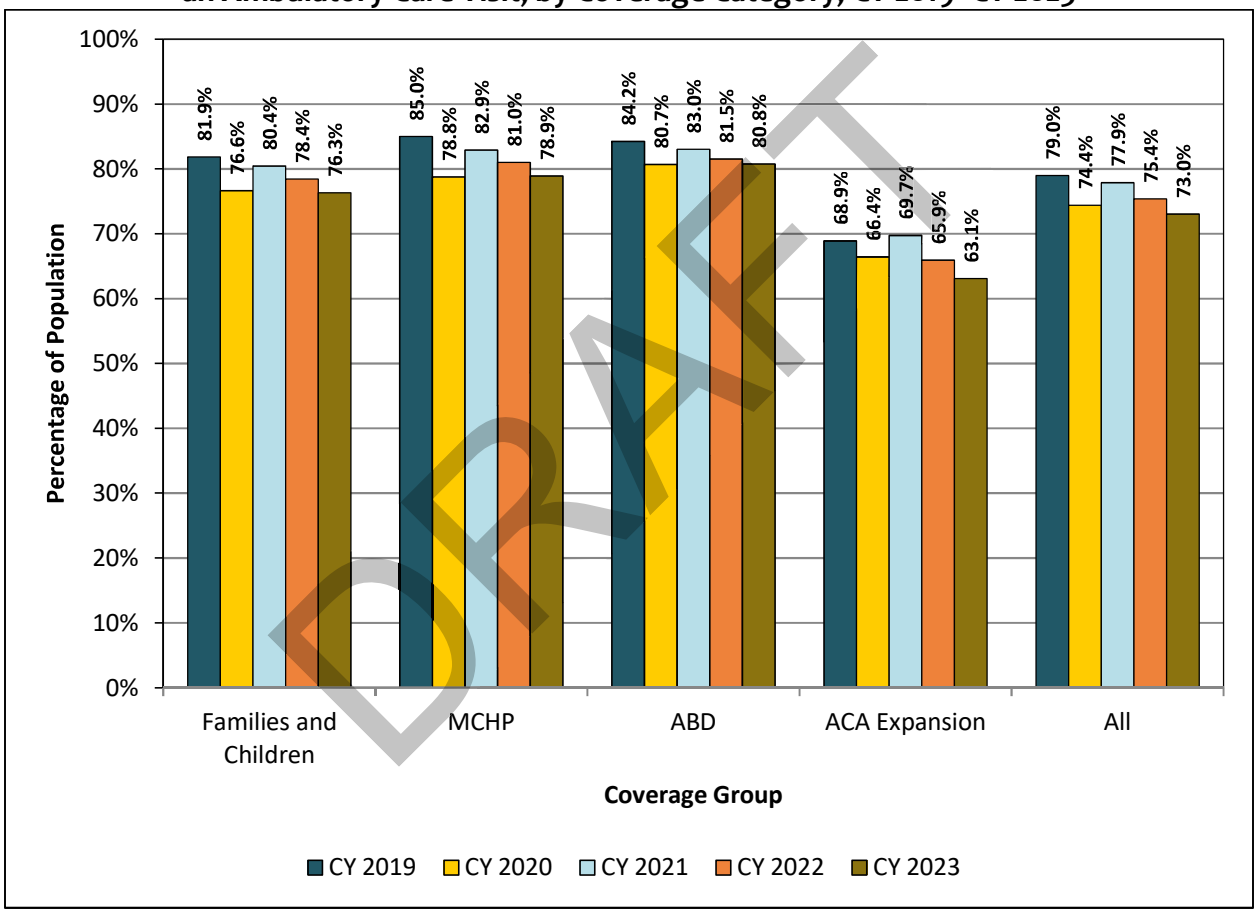
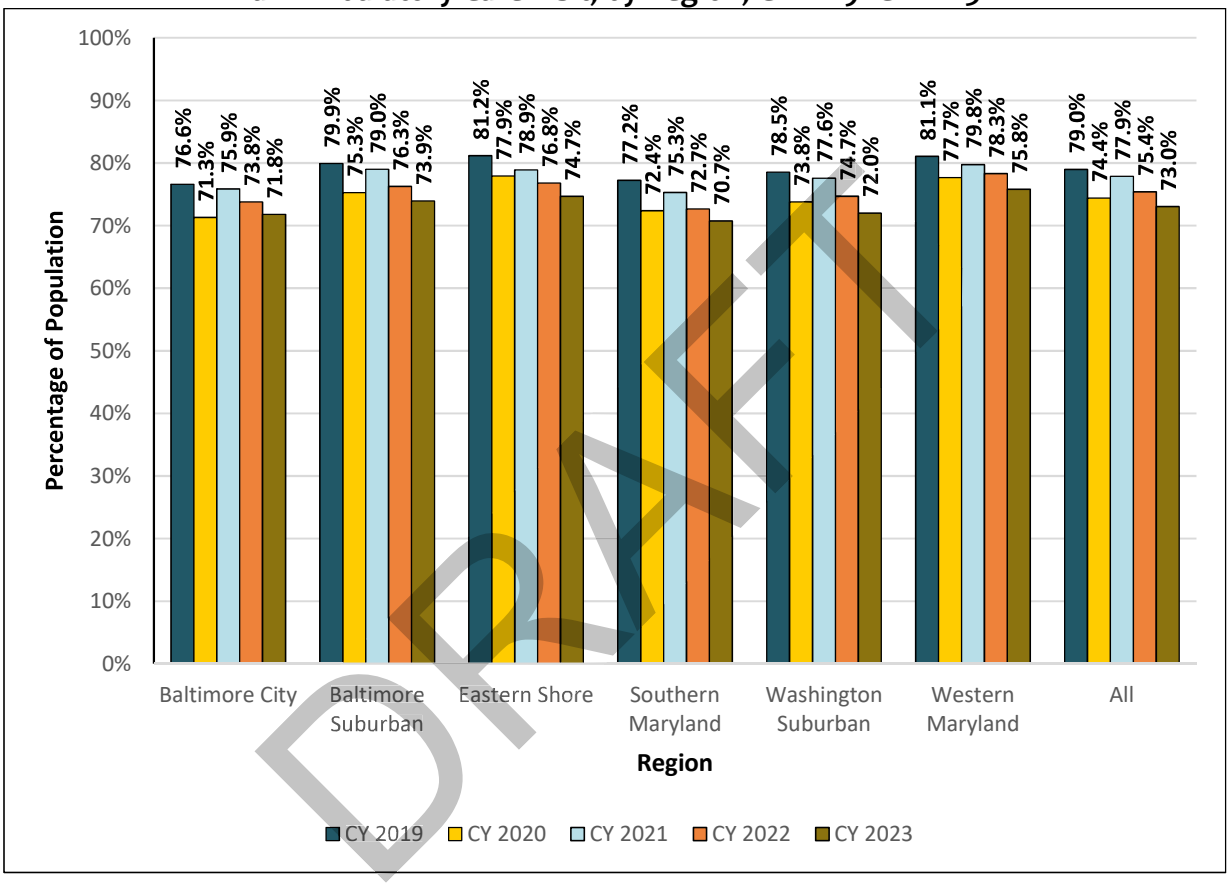


Figure 5 presents the percentage of the HealthChoice population with an ambulatory care visit by region between CY 2019 and CY 2023. Ambulatory care utilization fluctuated across all regions from CY 2019 to CY 2023: rates dropped between 3.3 and 5.3 percentage points between CY 2019 and CY 2020 before increasing in CY 2021 and then decreasing in CY 2022 and CY 2023. In CY 2023, residents of Western Maryland had the highest rate of ambulatory care use, followed by the Eastern Shore region.

Figure 5. Percentage of the HealthChoice Population Who Had an Ambulatory Care Visit, by Region, CY 2019–CY 2023



ED Utilization

As noted earlier, one of the goals of the HealthChoice program is to treat more conditions in an ambulatory care setting, with the promotion of ambulatory and preventative care through managed care systems, thus decreasing the need for emergency services in the ED. To assess overall ED utilization, the Department measures the percentage of individuals with any period of enrollment who visited an ED at least once during the calendar year. Unless otherwise noted, ED utilization measures in this report exclude ED visits that resulted in an inpatient hospital admission.

Figure 6 presents the percentage of HealthChoice participants with an outpatient ED visit by age group. The percentage with an ED visit declined between CY 2019 and CY 2023, despite a slight increase in CY 2021.

Each age group saw an overall decline in ED visits between CY 2019 and CY 2023; the largest declines were observed in the age groups of 19 to 39 years and 40 to 64 years, which experienced decreases of 8.8 and 6.4 percentage points, respectively, over the evaluation period.

Figure 6. Percentage of the HealthChoice Population Who Had an Outpatient ED Visit, by Age Group, CY 2019–CY 2023

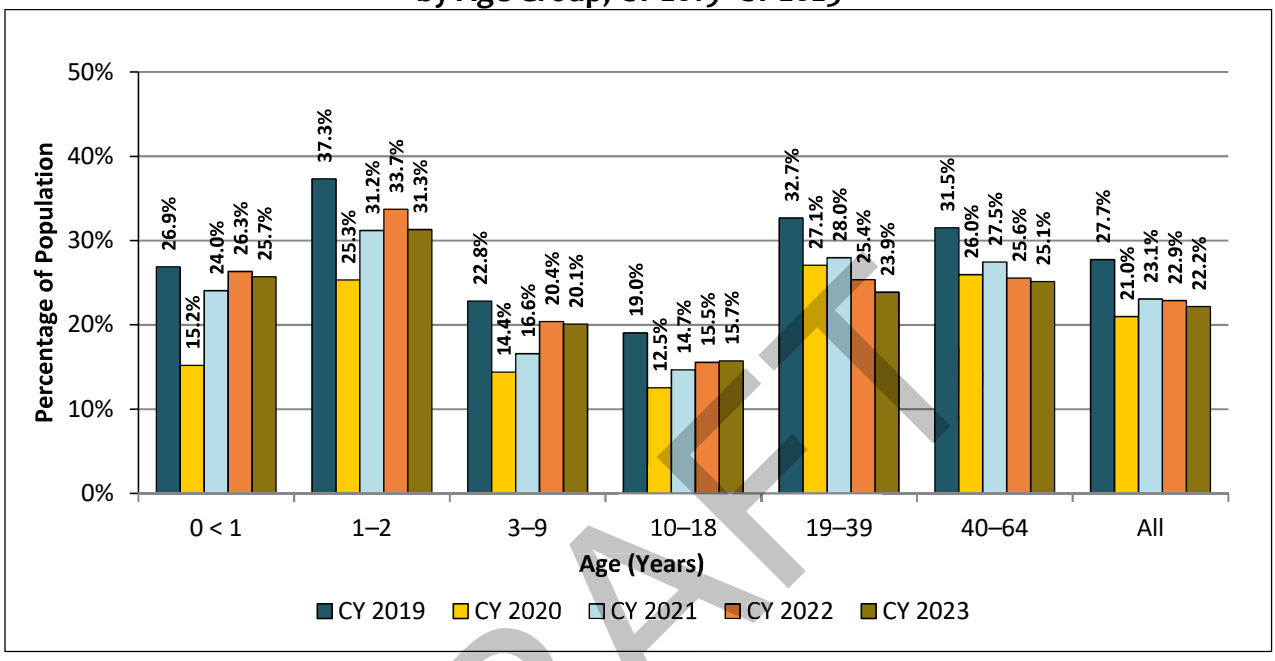


Figure 7 shows ED use by coverage category. Overall, the outpatient ED visit rate among all HealthChoice participants declined from CY 2019 to CY 2023. Among the coverage categories, aged, blind, and disabled (ABD) enrollees were the most likely to utilize ED services, although they still experienced a decrease from 39.5% in CY 2019 to 32.8% in CY 2023.

Figure 7. Percentage of the HealthChoice Population Who Had an Outpatient ED Visit, by Coverage Category, CY 2019–CY 2023

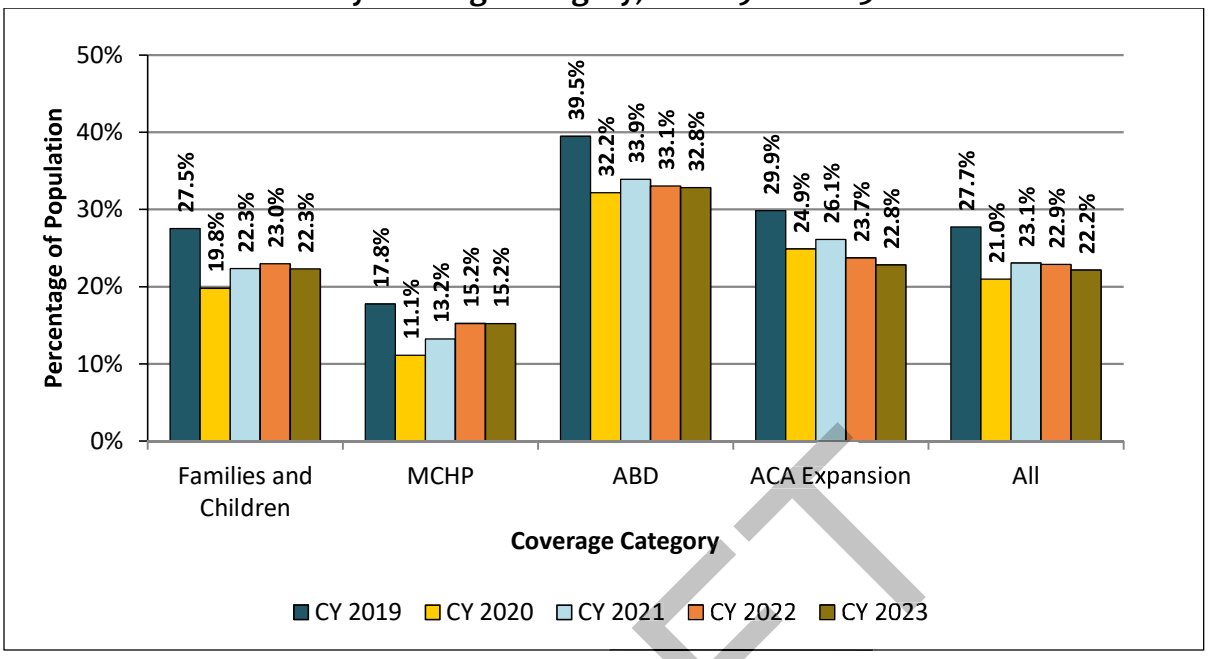


Figure 8 shows the percentage of HealthChoice participants with an ED visit by region between CY 2019 and CY 2023. Participants living in Baltimore City used ED services at the highest rates throughout the evaluation period; however, their rates fell by 7.5 percentage points from CY 2019 to CY 2023. In other regions, rates also declined, ranging from a reduction of 4.2 percentage points in the Washington Suburban area to 7.1 percentage points in the Eastern Shore.

Figure 8. Percentage of the HealthChoice Population Who Had an Outpatient ED Visit, by Region, CY 2019–CY 2023

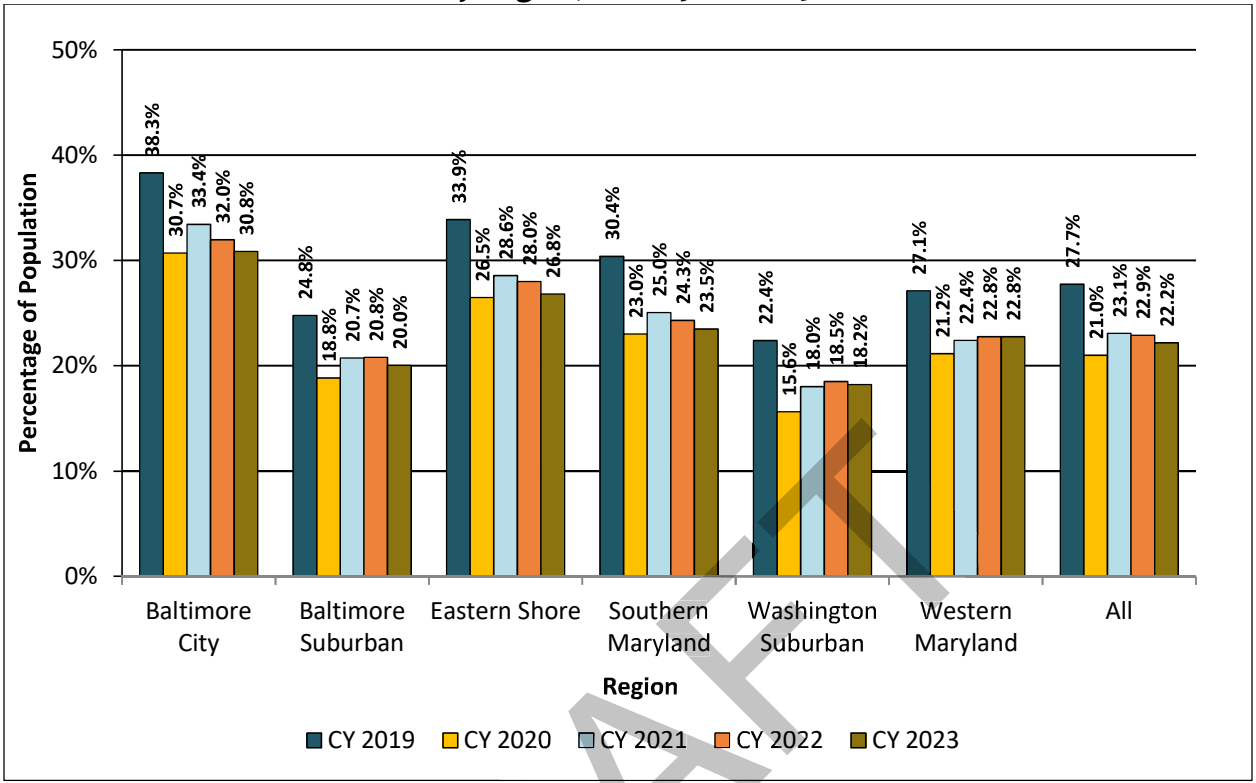


Table 8 presents the number and percentage of HealthChoice participants aged 0 to 64 years with an outpatient ED visit, by age group, during CY 2019 and CY 2023. The percentage of participants with an ED visit decreased across all age groups from CY 2019 to CY 2023, with the largest decline of 8.8 percentage points in the 19-39 years age group. The overall average number of ED visits per user (meaning the average number of ED visits among participants that had at least one ED visit) among all age groups declined by 0.2 during the evaluation period.

Table 8. Percentage of HealthChoice Participants Who Had an Outpatient ED Visit and Average Number of Visits per User, by Age Group, CY 2019 and CY 2023

Age (Years)	Outpatient ED Visits							
	CY 2019				CY 2023			
	# of Participants	# with Visit	% with Visit	Average # Visits by User	# of Participants	# with Visit	% with Visit	Average # Visits by User
0 < 1	35,878	9,645	26.9%	1.7	34,538	8,879	25.7%	1.6
1–2	77,218	28,820	37.3%	1.8	77,620	24,294	31.3%	1.7
3–9	258,838	59,084	22.8%	1.5	280,941	56,432	20.1%	1.5
10–18	298,753	56,885	19.0%	1.6	349,495	54,921	15.7%	1.5
19–39	428,679	140,000	32.7%	2.2	567,439	135,364	23.9%	2.0
40–64	277,998	87,594	31.5%	2.3	355,199	89,295	25.1%	2.1
All	**1,377,364**	**382,028**	**27.7%**	**2.0**	**1,665,232**	**369,185**	**22.2%**	**1.8**

ED Visits with Inpatient Admission

Table 9 shows the number and percentage of HealthChoice participants who had an ED visit that resulted in an inpatient admission by demographic characteristics in CY 2019 and CY 2023. The overall percentage of participants with an ED visit that resulted in an inpatient admission decreased from CY 2019 to CY 2023. That decrease is reflected in the rate for each age group, region, and coverage category, as well as for all MCOs.

In CY 2023, Baltimore City had the highest percentage (4.3%) of participants with an ED visit that resulted in an inpatient hospitalization. Among coverage groups, those in the ABD coverage group had the highest percentage (9.6%) of ED visits that resulted in an inpatient admission.

Table 9. Percentage of the HealthChoice Population Who Had an ED Visit that Resulted in an Inpatient Admission, by Demographic and Coverage Category, CY 2019 and CY 2023

Demographic and Coverage Characteristics	CY 2019			CY 2023		
	Total Participants	# ED Visit with Inpatient Admission	% ED Visit with Inpatient Admission	Total Participants	# ED Visit with Inpatient Admission	% ED Visit with Inpatient Admission
Age Group (Years)						
0 < 1	35,878	1,371	3.8%	34,538	1,088	3.2%
1–2	77,218	1,697	2.2%	77,620	1,382	1.8%
3–9	258,838	1,881	0.7%	280,941	2,021	0.7%
10–18	298,753	2,716	0.9%	349,495	2,839	0.8%
19–39	428,679	19,580	4.6%	567,439	19,773	3.5%
40–64	277,998	21,928	7.9%	355,199	20,596	5.8%
Total	**1,377,364**	**49,173**	**3.6%**	**1,665,232**	**47,699**	**2.9%**
Region*						
Baltimore City	237,736	13,205	5.6%	261,994	11,376	4.3%
Baltimore Suburban	413,760	14,427	3.5%	506,396	15,031	3.0%
Eastern Shore	127,023	4,150	3.3%	148,454	4,106	2.8%
Southern Maryland	70,487	2,950	4.2%	84,988	2,536	3.0%
Washington Suburban	412,039	10,400	2.5%	523,393	10,892	2.1%
Western Maryland	115,113	3,962	3.4%	138,818	3,717	2.7%
Out of State	1,206	79	6.6%	1,189	41	3.4%
Total	**1,377,364**	**49,173**	**3.6%**	**1,665,232**	**47,699**	**2.9%**
Managed Care Organization † **						
Aetna	36,214	1,430	3.9%	71,430	2,002	2.8%
CareFirst Community Health Plan	55,944	2,390	4.3%	107,820	3,686	3.4%

Demographic and Coverage Characteristics	CY 2019			CY 2023		
	Total Participants	# ED Visit with Inpatient Admission	% ED Visit with Inpatient Admission	Total Participants	# ED Visit with Inpatient Admission	% ED Visit with Inpatient Admission
Jai Medical Systems	30,406	1,960	6.4%	32,419	1,591	4.9%
Kaiser	83,720	1,870	2.2%	136,356	2,752	2.0%
Maryland Physicians Care	242,910	9,811	4.0%	270,645	8,605	3.2%
MedStar	105,898	4,451	4.2%	117,284	3,947	3.4%
Priority Partners	341,517	12,268	3.6%	386,286	11,233	2.9%
UnitedHealthcare	167,530	5,714	3.4%	188,556	5,384	2.9%
Wellpoint* **	313,225	9,279	3.0%	354,436	8,499	2.4%
Total	**1,377,364**	**49,173**	**3.6%**	**1,665,232**	**47,699**	**2.9%**
Medicaid Coverage Category**						
Families and Children	764,962	17,249	2.3%	928,415	19,259	2.1%
MCHP	163,947	1,156	0.7%	184,572	1,181	0.6%
ABD	87,472	10,464	12.0%	77,112	7,371	9.6%
ACA Expansion	360,983	20,304	5.6%	475,133	19,888	4.2%
Total	**1,377,364**	**49,173**	**3.6%**	**1,665,232**	**47,699**	**2.9%**

*Regions are defined as the following: Baltimore City (only), Baltimore Metro (Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties), Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties), Southern Maryland (Calvert, Charles, and St. Mary's Counties), Washington Metro (Montgomery and Prince George's Counties), and Western Maryland (Allegany, Frederick, Garrett, and Washington Counties). Refer to Figure A1.
**Participants were assigned to their last recorded MCO and Medicaid coverage category of the calendar year.
†MCO data are shown for total enrollment and not adjusted for enrollees' risk distribution.
***On January 1, 2023, Amerigroup Community Care in Maryland became Wellpoint Maryland.

Inpatient Admissions

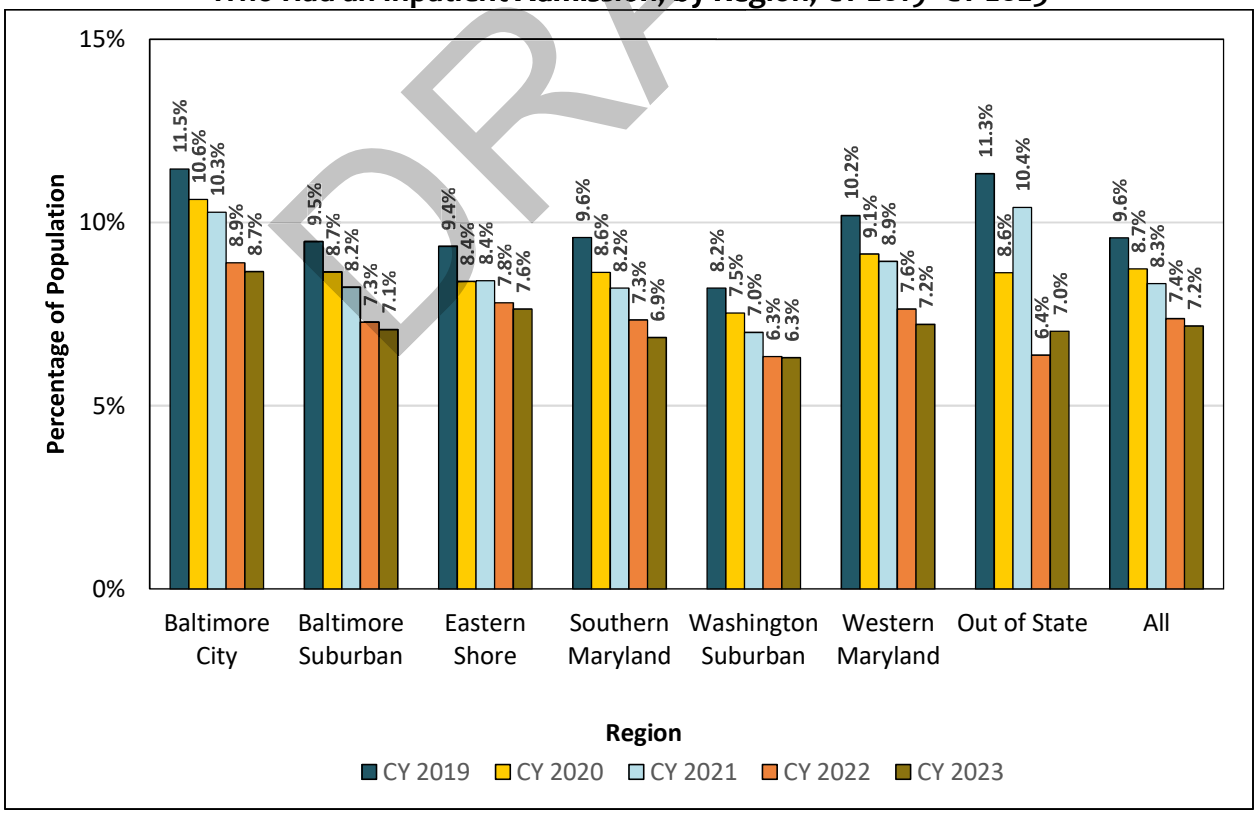
One measure for assessing inpatient utilization is to calculate the percentage of participants aged 18 to 64 years with any period of HealthChoice enrollment who had an inpatient admission during the calendar year. Another measure for assessing inpatient utilization is to calculate the average number of inpatient hospital days. Table 10 presents HealthChoice participants with at least one inpatient hospital admission, by age group, and the average number of days per participant. Participants aged 18 to 40 years had both a lower rate of inpatient admissions and fewer average days compared to participants aged 41 to 64 years. Both age groups decreased in inpatient admissions and average days during the evaluation period.

Table 10. Percentage of HealthChoice Participants Aged 18–64 Years Who Had an Inpatient Admission and Average Inpatient Days, by Age Group, CY 2019 and CY 2023

Age Group	All Inpatient Admissions							
	CY 2019				CY 2023			
	Total Participants	# with Inpatient Admission	% with Inpatient Admission	Average Inpatient Days per Participant	Total Participants	# with Inpatient Admission	% with Inpatient Admission	Average Inpatient Days per Participant
18–40	471,271	43,483	9.2%	0.6	622,508	44,045	7.1%	0.5
41–64	263,736	26,380	10.0%	1.2	335,303	24,680	7.4%	1.0
Total	**735,007**	**69,863**	**9.5%**	**0.9**	**957,811**	**68,725**	**7.2%**	**0.6**

Figure 9 displays the percentages of HealthChoice participants aged 18 to 64 years with an inpatient admission by region. Between CY 2019 and CY 2023, inpatient admission rates decreased overall across all regions. The greatest decline (3.0 percentage points) was observed in Western Maryland. The Washington Suburban region had the lowest admission rate during the evaluation period, with 6.3% in CY 2023 (falling from 8.2% in CY 2019), followed by the Southern Maryland region, with 6.9% in CY 2023. Baltimore City is the only region where admission rates remained above 10.0% throughout the evaluation period until CY 2022, when they dropped to 8.9%.

Figure 9. Percentage of HealthChoice Participants Aged 18–64 Years Who Had an Inpatient Admission, by Region, CY 2019–CY 2023



Care for Special Populations

Another goal of the HealthChoice program is to improve the quality of health services and access to care for special populations. This section of the report assesses services provided to children in foster care, the REM program, access to care stratified by race and ethnicity, and the demographics and health care utilization of the ACA expansion population. Unless otherwise stated, all measures in this section are calculated for HealthChoice participants with any period of enrollment during the calendar year.

Children in Foster Care

This section of the report examines service utilization for children in foster care with any period of enrollment in HealthChoice during the calendar year.[28] It also compares service utilization for children in foster care with other HealthChoice children. Unless otherwise specified, the measures presented here are for foster care children from birth through 21 years.

Table 11 displays HealthChoice children in foster care by age group for CY 2019 and CY 2023. Across the evaluation period, children aged 10 to 21 years made up the largest proportion of HealthChoice children in foster care (66.2% in CY 2019 and 67.0% in CY 2023).

Table 11. Percentage of HealthChoice Children in Foster Care, by Age Group, CY 2019 and CY 2023

Age Group (Years)	CY 2019		CY 2023	
	Number of Participants in Foster Care	Percentage of Total	Number of Participants in Foster Care	Percentage of Total
0 to <1	206	1.4%	140	1.0%
1–2	846	5.7%	637	4.6%
3–5	1,552	10.5%	1,482	10.6%
6–9	2,415	16.3%	2,337	16.7%
10–14	3,687	24.8%	3,388	24.2%
15–18	3,645	24.6%	3,527	25.2%
19–21	2,496	16.8%	2,462	17.6%
Total	**14,847**	**100%**	**13,973**	**100%**

Table 12 shows the percentage of HealthChoice children in foster care by service received and age group. In CY 2019, the rates of outpatient ED visits were highest among adults aged 19 to 21 years, followed by children aged one to two years and children under age one. In CY 2023, the rates of outpatient ED visits were highest among children under one year. Inpatient admission rates declined for all age groups, across the measurement period, except for children aged three to five years, which remained static, and adults aged 19 to 21 years, which rose 0.5 percentage points.

[28] Data includes individuals in subsidized adoption and guardianship populations.

Table 12. Percentage of HealthChoice Children in Foster Care, by Service and Age Group, CY 2019 and CY 2023

Age Group (Years)	CY 2019			CY 2023		
	Total Participants	Number with Service	Percentage with Service	Total Participants	Number with Service	Percentage with Service
Ambulatory Care Visit						
0 to <1	206	196	95.1%	140	128	91.4%
1–2	846	775	91.6%	637	588	92.3%
3–5	1,552	1,332	85.8%	1,482	1,167	78.7%
6–9	2,415	1,975	81.8%	2,337	1,804	77.2%
10–14	3,687	2,947	79.9%	3,388	2,605	76.9%
15–18	3,645	2,876	78.9%	3,527	2,628	74.5%
19–21	2,496	1,643	65.8%	2,462	1,566	63.6%
Total	**14,847**	**11,744**	**79.1%**	**13,973**	**10,486**	**75.0%**
Outpatient ED Visit						
0 to <1	206	71	34.5%	140	57	40.7%
1–2	846	302	35.7%	637	204	32.0%
3–5	1,552	375	24.2%	1,482	311	21.0%
6–9	2,415	408	16.9%	2,337	375	16.0%
10–14	3,687	752	20.4%	3,388	599	17.7%
15–18	3,645	1,102	30.2%	3,527	947	26.9%
19–21	2,496	894	35.8%	2,462	716	29.1%
Total	**14,847**	**3,904**	**26.3%**	**13,973**	**3,209**	**23.0%**
Inpatient Admission						
0 to <1†	206	176	85.4%	140	119	85.0%
1–2	846	61	7.2%	637	32	5.0%
3–5	1,552	28	1.8%	1,482	26	1.8%
6–9	2,415	78	3.2%	2,337	47	2.0%
10–14	3,687	234	6.3%	3,388	175	5.2%
15–18	3,645	344	9.4%	3,527	289	8.2%
19–21	2,496	204	8.2%	2,462	213	8.7%
Total	**14,847**	**1,125**	**7.6%**	**13,973**	**901**	**6.4%**
No Medicaid Service						
0 to <1	206	*	*	140	*	*
1–2	846	*	*	637	*	*
3–5	1,552	131	8.4%	1,482	183	12.3%
6–9	2,415	223	9.2%	2,337	271	11.6%
10–14	3,687	437	11.9%	3,388	408	12.0%
15–18	3,645	416	11.4%	3,527	494	14.0%
19–21	2,496	551	22.1%	2,462	555	22.5%
Total	**14,847**	**1,806**	**12.2%**	**13,973**	**1,945**	**13.9%**

*Cell values of 10 or less have been suppressed.

†Includes admissions tied to infant's (0 to <1) birth.

Table 13 compares the service utilization of HealthChoice children in foster care to those not in foster care. Overall, the percentage of foster children who did not receive a service was higher than non-foster care children in CY 2019 and CY 2023. A higher percentage of children in foster care had an outpatient ED visit compared to non-foster care children, and a higher percentage had an inpatient admission. A higher percentage of non-foster care children had an ambulatory care visit compared to foster care children.

Table 13. Percentage of HealthChoice Foster Care Children vs. Non-Foster Care Children, by Service, CY 2019 and CY 2023

Foster Care Status	CY 2019			CY 2023		
	Total Participants	Number with Service	Percentage with Service	Total Participants	Number with Service	Percentage with Service
Ambulatory Care Visit						
Foster	14,847	11,744	79.1%	13,973	10,486	75.0%
Non-Foster	729,993	605,286	82.9%	826,269	640,538	77.5%
Outpatient ED Visit						
Foster	14,847	4,011	27.0%	13,973	3,209	23.0%
Non-Foster	729,993	171,809	23.5%	826,269	161,323	19.5%
Inpatient Admission†						
Foster	14,847	1,125	7.6%	13,973	901	6.4%
Non-Foster	729,993	44,979	6.2%	826,269	42,828	5.2%
No Medicaid Service						
Foster	14,784	1,806	12.2%	13,973	1,945	13.9%
Non-Foster	729,993	64,789	8.9%	826,269	104,254	12.6%

†Includes admissions tied to infant's (0 to <1) birth.

Table 14 compares the dental utilization rate in CY 2023 for foster care children aged 4 to 20 years to the rate for non-foster care children enrolled in HealthChoice. Overall, children in foster care had a slightly higher dental visit rate (60.0%) than other HealthChoice children (58.7%). The largest differences between the two populations were observed in the youngest two (4 to 5 years and 6 to 9 years) and oldest (19 to 20 years) age groups. The dental visit rate was 64.8% for children in foster care aged 4 to 5 years, 4.0 percentage points higher than for other HealthChoice children in the same age group. The rate for those aged 6 to 9 years, and those 19 to 20 years were 3.9 and 4.6 percentage points higher, respectively, for children in foster care than for non-foster children.

Table 14. Percentage of HealthChoice Foster Care Children Aged 4–20 Years vs. Non-Foster Care Children with a Dental Visit, by Age Group, CY 2023

Age Group (Years)	CY 2023 HealthChoice Foster Care Status					
	Foster Care			Non-Foster Care		
	Total Participants	Number with Dental Visit	Percentage with Dental Visit	Total Participants	Number with Dental Visit	Percentage with Dental Visit
4–5	1,044	676	64.8%	79,045	48,084	60.8%
6–9	2,337	1,641	70.2%	158,371	105,022	66.3%
10–14	3,388	2,226	65.7%	192,430	120,412	62.6%
15–18	3,527	1,944	55.1%	150,150	81,324	54.2%
19–20	1,702	707	41.5%	64,627	23,848	36.9%
Total	**11,998**	**7,194**	**60.0%**	**644,623**	**378,690**	**58.7%**

Table 15 shows the rates of MHDs, SUDs, and co-occurring MHD and SUD conditions among foster care and non-foster care HealthChoice participants in CY 2019 and CY 2023. The percentages of participants with an MHD-only, SUD-only, or co-occurring MHD and SUD diagnosis were higher among foster care participants than non-foster care HealthChoice participants and were considerably higher among foster care children for MHD-only. In CY 2019, the percentages of foster care and non-foster care participants with an SUD-only diagnosis were the same. The percentage of participants with an MHD-only diagnosis, decreased across the evaluation period for both foster care statuses, while SUD-only remained stable for foster care participants, and saw a slight decrease for non-foster care participants.

Table 15. Behavioral Health Diagnosis of HealthChoice Foster Care Children vs. Non-Foster Care Children Aged 0–21 Years, CY 2019 and CY 2023

Foster Care Status	CY 2019			CY 2023		
	Total Participants	Number with Diagnosis	Percentage of Total	Total Participants	Number with Diagnosis	Percentage of Total
MHD-Only						
Foster	14,847	5,799	39.1%	13,973	5,347	38.3%
Non-Foster	729,993	83,275	11.4%	826,269	89,908	10.9%
SUD-Only						
Foster	14,847	65	0.4%	13,973	52	0.4%
Non-Foster	729,993	2,827	0.4%	826,269	1,477	0.2%
Dual Diagnosis (MHD and SUD)						
Foster	14,847	224	1.5%	13,973	242	1.7%
Non-Foster	729,993	1,831	0.3%	826,269	2,077	0.3%
No Behavioral Health Diagnosis						
Foster	14,847	8,759	59.0%	13,973	8,332	59.6%
Non-Foster	729,993	642,060	88.0%	826,269	732,807	88.7%

Rare and Expensive Case Management (REM) Program

The REM program provides case management services to Medicaid participants who have a rare and expensive medical condition from a specified list and require sub-specialty care. The program serves people with specialized medical needs. An individual must be eligible for HealthChoice, have a qualifying diagnosis, and be within the age limit for that diagnosis. Examples of qualifying diagnoses include cystic fibrosis, quadriplegia, muscular dystrophy, chronic renal failure, and spina bifida. REM participants do not receive services through an MCO. The REM program provides the standard FFS Medicaid benefit package and some expanded benefits, such as medically necessary private duty nursing, shift home health aides, and adult dental services. This section of the report presents data on REM enrollment and service utilization. Hilltop used data from *LTSSMaryland*—the state's integrated LTSS tracking system—to identify REM enrollees for these analyses.

REM Enrollment

Table 16 presents REM enrollment by age group, sex, and foster care status for CY 2019 and CY 2023. In both years, most REM participants were males and aged 18 years or younger. Within the REM population, there was a lower percentage of female participants than in the general HealthChoice population. The majority of REM participants were not in foster care.

Table 16. REM Enrollment by Age Group, Sex, and Foster Care Status, CY 2019 and CY 2023

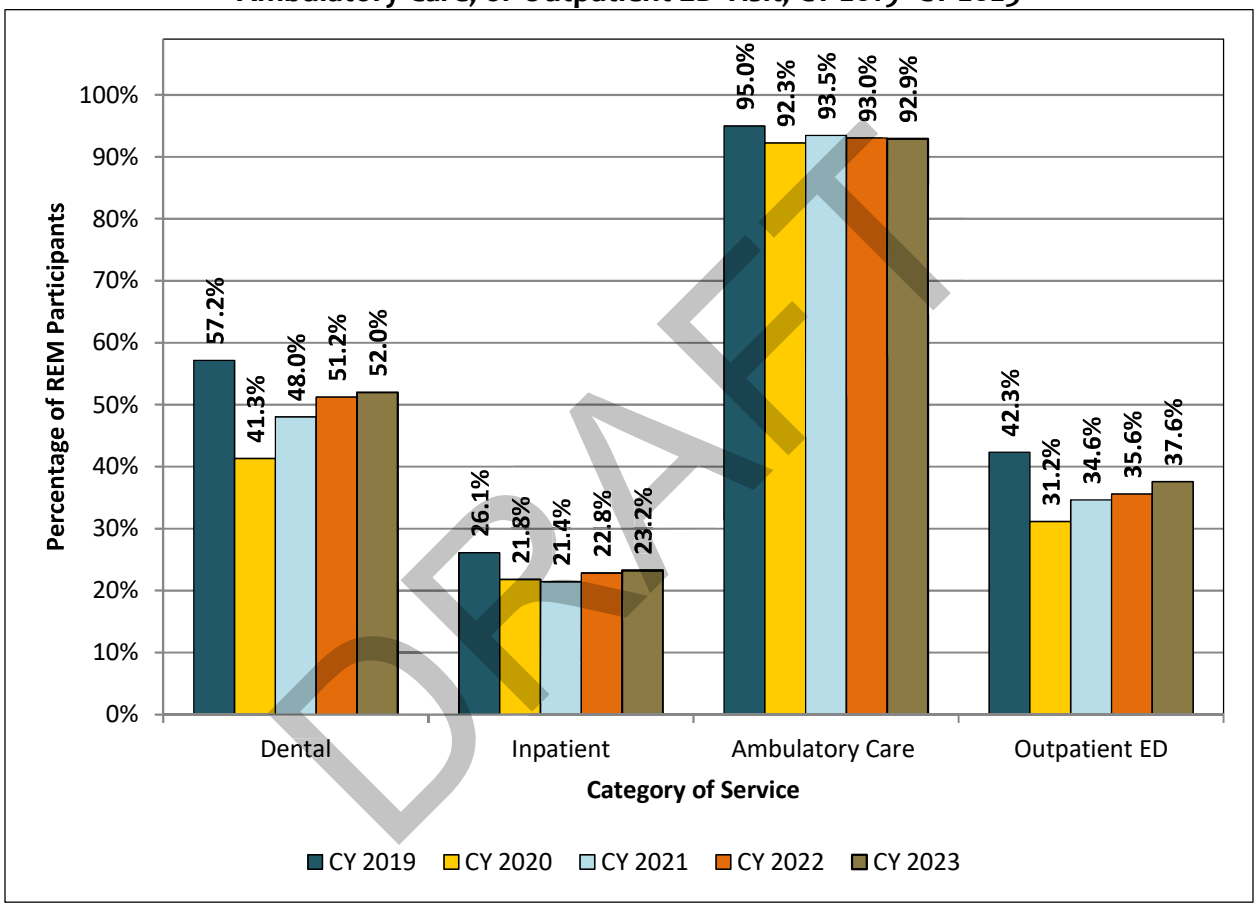
	CY 2019		CY 2023	
Demographic Characteristic	**Number of Enrollees**	**Percentage of Total**	**Number of Enrollees**	**Percentage of Total**
Age Group (Years)				
0–18	3,025	64.8%	3,140	62.9%
19 and over	1,644	35.2%	1,850	37.1%
Total	**4,669**	**100%**	**4,990**	**100%**
Sex				
Female	1,994	42.7%	2,135	42.8%
Male	2,675	57.3%	2,855	57.2%
Total	**4,669**	**100%**	**4,990**	**100%**
Foster Care				
Foster Care	341	7.3%	323	6.5%
Non-Foster Care	4,328	92.7%	4,667	93.5%
Total	**4,669**	**100%**	**4,990**	**100%**

REM Service Utilization

Figure 10 shows the percentage of REM participants who received at least one dental, inpatient, ambulatory care, or outpatient ED visit between CY 2019 and CY 2023. The dental, inpatient, and ambulatory care visit measures serve as indicators of access to care. The percentage of

participants with a dental visit decreased during the evaluation period, from 57.2% in CY 2019 to 52.0% in CY 2023, although it increased from CY 2021 to CY 2023 after a major drop to 41.3% in CY 2020. The percentage of REM participants who had an inpatient visit declined by 2.9 percentage points between CY 2019 and CY 2023, while ambulatory care utilization decreased by 2.1 percentage points. Outpatient ED visits decreased by 4.7 percentage points over the entire evaluation period. Due to the nature of qualifying conditions for the REM program, nearly 100% of REM participants received at least one service a year during the evaluation period.[29]

Figure 10. Percentage of REM Participants with a Dental, Inpatient, Ambulatory Care, or Outpatient ED Visit, CY 2019–CY 2023



[29] Data not shown.

Table 17 shows the behavioral health diagnosis rates among REM participants at the beginning and end of the evaluation period. The rates for MHD-only diagnoses increased slightly by 1.3 percentage points, while the rate of SUD-only diagnoses decreased by 2.8 percentage points. The percentage of REM participants without a behavioral health diagnosis increased by 1.8 percentage points. The results in Table 19 may show a steep decline in the number of participants with an SUD but should be interpreted with caution, since the 2019 and 2023 definitions of SUD differ in many respects. SUD diagnosis definitions have been refined over time, so the results are not comparable across years.

Table 17. Number and Percentage of REM Participants by Behavioral Health Diagnoses, CY 2019 and CY 2023

CY 2019			CY 2023		
Number of Participants	**Total Participants**	**Percentage of Total**	**Number of Participants**	**Total Participants**	**Percentage of Total**
MHD-Only					
907	4,669	19.4%	1,034	4,990	20.7%
SUD-Only					
153	4,669	3.3%	26	4,990	0.5%
Dual Diagnosis (MHD + SUD)					
40	4,669	0.9%	29	4,990	0.6%
No Behavioral Health Diagnosis					
3,569	4,669	76.4%	3,901	4,990	78.2%

Racial and Ethnic Disparities

Racial and ethnic disparities in health care are nationally recognized challenges. The Department is committed to reducing disparities among racial and ethnic groups through its Managing for Results (MFR) program. MFR is a strategic planning and performance measurement process used to improve government programs. The Department's Office of Minority Health and Health Disparities uses MFR to target goals in reducing racial and ethnic disparities. This section of the report presents enrollment trends among racial and ethnic groups and assesses disparities within measures of service utilization.

The data presented in this section were especially impacted by the decline in the quality of race and ethnicity information available due to changes to the approach for selecting race and ethnicity on the Medicaid eligibility application in 2014. Beginning in 2023, Hilltop was able to combine several data sources to enhance the quality of race and ethnicity information available for analysis. The following tables use the enhanced race and ethnicity information to present a more precise assessment of enrollment trends and service utilization disparities for CY 2019 through CY 2023.

Enrollment

Table 18 displays HealthChoice enrollment by race and ethnicity. The percentages of enrolled participants identifying as White and Black decreased between CY 2019 and CY 2023. The percentages of participants who are Hispanic, Asian, and "Other" increased by 2.4, 0.4, and 0.3 percentage points, respectively.

Table 18. HealthChoice Enrollment by Race/Ethnicity, CY 2019 and CY 2023

Race/Ethnicity	CY 2019		CY 2023	
	# of Participants	% of Total	# of Participants	% of Total
Asian	70,133	5.1%	91,311	5.5%
Black	609,788	44.3%	720,319	43.3%
White	376,786	27.4%	421,980	25.3%
Hispanic	222,974	16.2%	310,032	18.6%
Native American	13,107	1.0%	15,284	0.9%
Other	84,539	6.1%	106,306	6.4%
Total	**1,377,327**	**100.0%**	**1,665,232**	**100.0%**

Note: "Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Ambulatory Care Visits

Figure 11 shows the percentage of children aged 0 through 18 years with at least one ambulatory visit in CY 2019 and CY 2023, by race and ethnicity. The overall rate of ambulatory care visits fell from 84.4% in CY 2019 to 79.3% in CY 2023. All racial and ethnic groups experienced a decrease throughout the evaluation period. In CY 2019, the disparity between the racial/ethnic group with the highest rate of ambulatory care visits (Hispanic) and the lowest rate ("Other") was 9.9 percentage points. In CY 2023, "Other" participants were also the racial/ethnic group with the lowest percentage of ambulatory care visits, at 10.6 percentage points lower than the racial/ethnic group with the highest percentage (Hispanic).

Figure 11. Percentage of HealthChoice Participants Aged 0–18 Years with an Ambulatory Care Visit, by Race/Ethnicity, CY 2019 and CY 2023

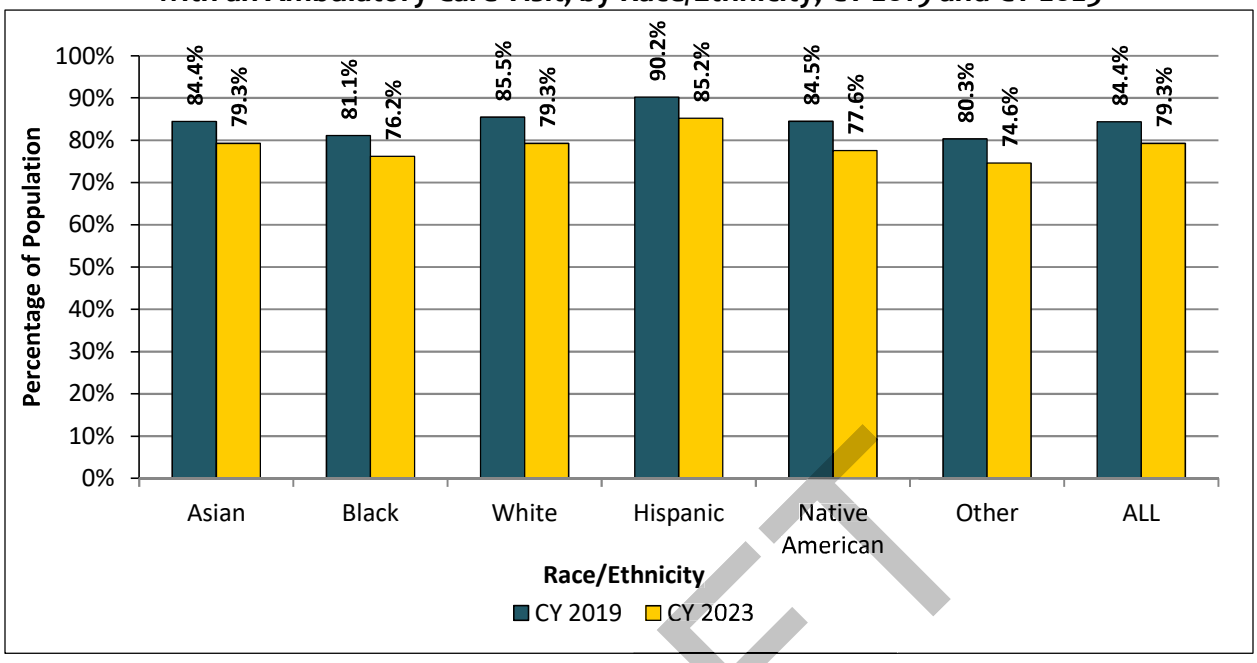
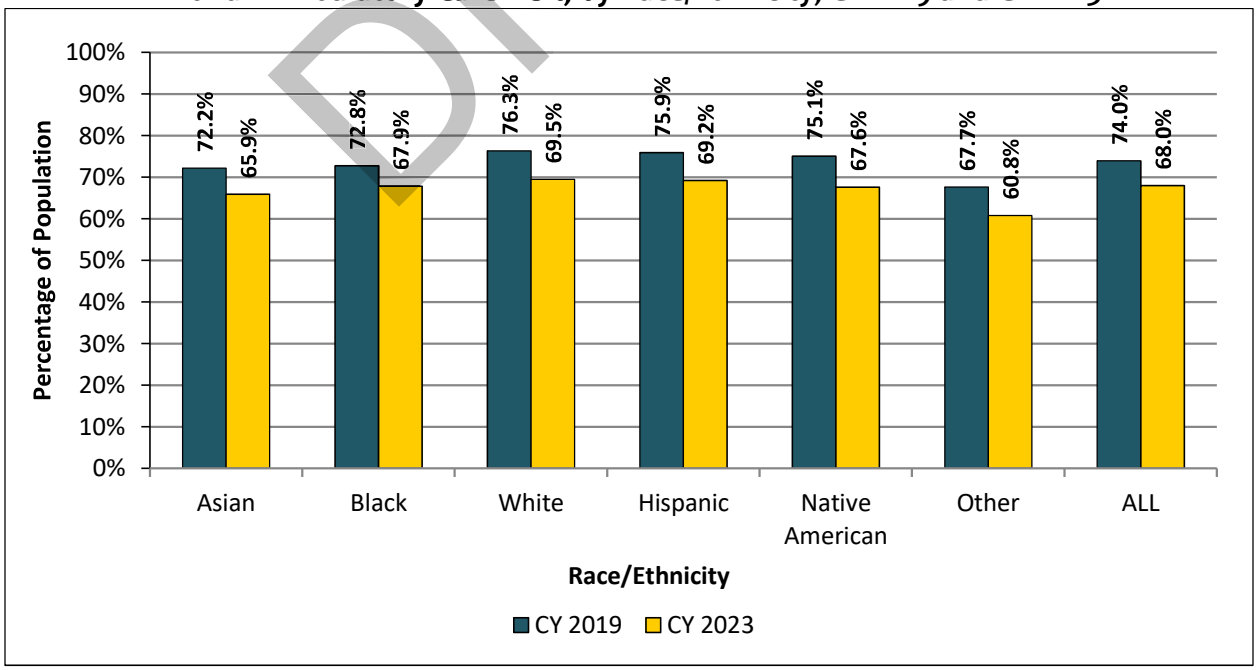


Figure 12 shows the percentage of adults aged 19 to 64 years with at least one ambulatory care visit in CY 2019 and CY 2023, by race and ethnicity. In CY 2019, 74.0% of all adult HealthChoice participants received an ambulatory care visit. This rate decreased to 68.0% in CY 2022. All racial/ethnic groups' rates decreased over the evaluation period.

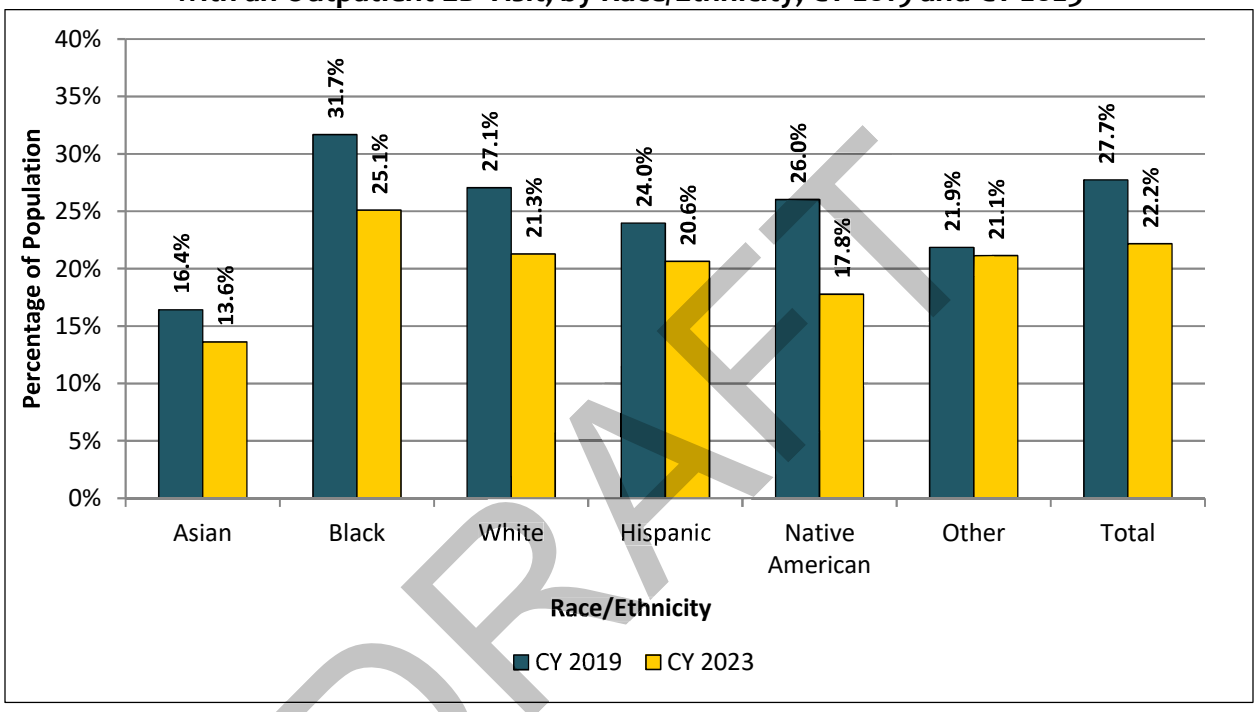
Figure 12. Percentage of HealthChoice Participants Aged 19–64 Years with an Ambulatory Care Visit, by Race/Ethnicity, CY 2019 and CY 2023



Outpatient ED Visits

Figure 13 displays the percentage of HealthChoice participants aged 0 to 64 years with at least one outpatient ED visit by race and ethnicity in CY 2019 and CY 2023. During the evaluation period, each racial and ethnic group experienced a drop in their rate of accessing ED services. Black participants had the highest ED visit rate in both years, while Asian participants had the lowest rate.

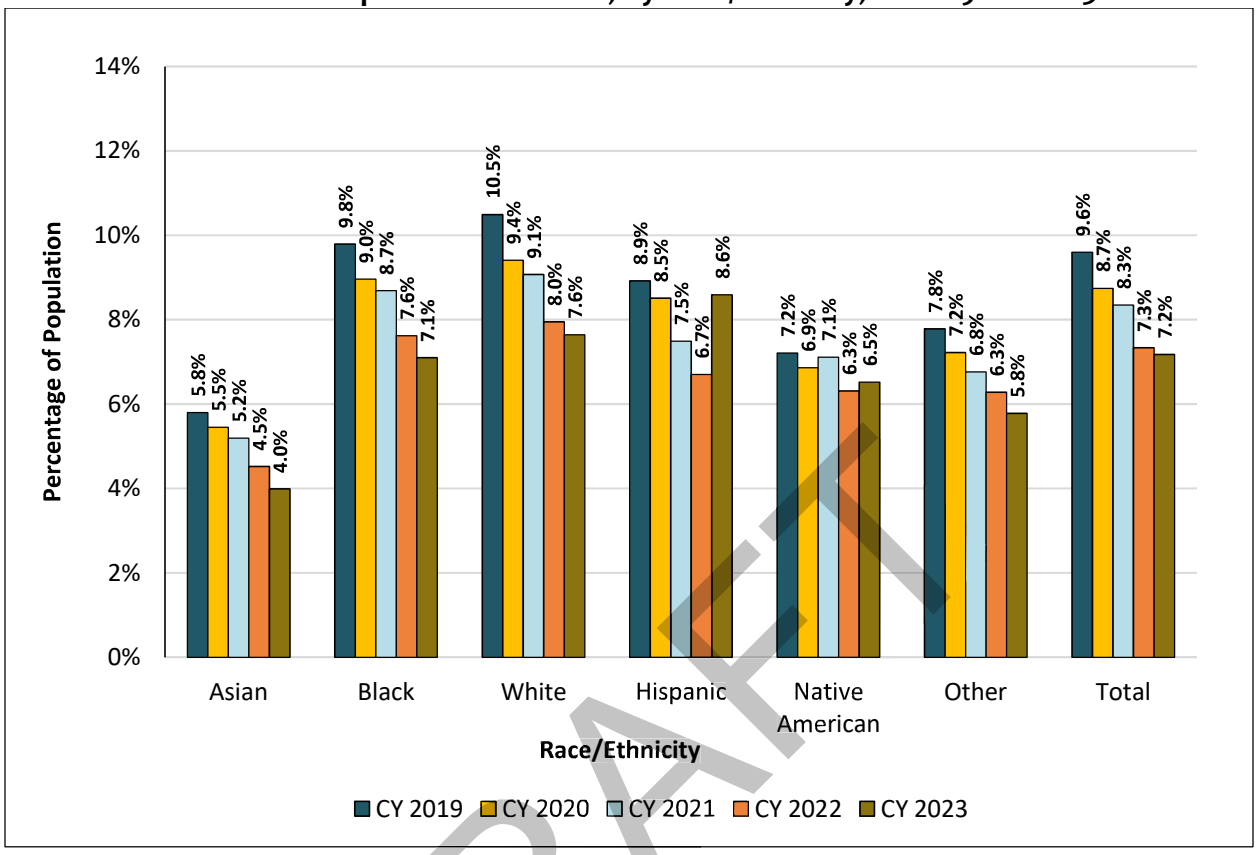
Figure 13. Percentage of HealthChoice Participants Aged 0–64 Years with an Outpatient ED Visit, by Race/Ethnicity, CY 2019 and CY 2023



Inpatient Admissions

Figure 14 presents the percentage of HealthChoice participants aged 18 to 64 years with an inpatient admission between CY 2019 and CY 2023, by race and ethnicity. Each group's rate declined overall between CY 2019 and CY 2023. Asian participants had the lowest rate of inpatient admissions throughout the evaluation period, while White participants had the highest rate throughout.

Figure 14. Percentage of HealthChoice Participants Aged 18–64 Years Who Had an Inpatient Admission, by Race/Ethnicity, CY 2019–CY 2023



ACA Medicaid Expansion Population

This section of the report examines the demographic characteristics and health care utilization of the ACA Medicaid expansion population between CY 2019 and CY 2023. These demographic and service utilization measures are for participants with any period of enrollment in one of the ACA Medicaid expansion coverage groups. Many of these participants were gaining Medicaid coverage for the first time and had limited health care utilization literacy or struggled with homelessness, resulting in reduced access to care until they became more familiar with accessing care through Medicaid.

ACA Medicaid Expansion Population Demographics

In CY 2019, the Maryland Medicaid program enrolled 391,824 adults (with any period of enrollment) through the ACA Medicaid expansion.[30] By CY 2023, the number of participants (members) who received coverage for at least one month in an ACA expansion coverage group increased to 515,121.

[30] Race and ethnicity values were calculated using the enhanced race/ethnicity variable implemented in 2023 and updated for the entire measurement period. Thus, race and ethnicity totals will not match previous HealthChoice Evaluation results.

Table 19 displays demographic characteristics of the expansion population (with any period of enrollment) during the evaluation period. Participants aged 19 to 34 years composed the largest portion of the ACA expansion population. Black participants were the largest racial/ethnic group, and the Baltimore Suburban region had the largest percentage of participants. The proportion of expansion participants with 12 member months rose by 11.8 percentage points between CY 2019 and CY 2023.

Table 19. ACA Medicaid Expansion Population Aged 19–64 Years, by Demographics and Any Enrollment Period, CY 2019–CY 2023

Demographic Characteristic	CY 2019		CY 2020		CY 2021		CY 2022		CY 2023	
	# of Participants	% of Total	# of Participants	% of Total	# of Participants	% of Total	# of Participants	% of Total	# of Participants	% of Total
Race/Ethnicity										
Asian	22,011	5.6%	24,213	6.1%	27,964	6.4%	30,403	6.5%	31,413	6.1%
Black	176,815	45.1%	178,886	45.0%	198,710	45.3%	212,873	45.3%	236,587	45.9%
White	139,629	35.6%	137,192	34.5%	146,742	33.4%	153,818	32.8%	166,509	32.3%
Hispanic	29,380	7.5%	31,503	7.9%	36,489	8.3%	40,808	8.7%	47,339	9.2%
Native American	3,841	1.0%	4,082	1.0%	4,689	1.1%	5,204	1.1%	5,495	1.1%
Other	20,148	5.1%	21,302	5.4%	24,316	5.5%	26,450	5.6%	27,778	5.4%
Total	**391,824**	**100%**	**397,178**	**100%**	**438,910**	**100%**	**469,556**	**100%**	**515,121**	**100%**
Sex										
Female	182,275	46.5%	182,806	46.0%	200,738	45.7%	213,291	45.4%	234,730	45.6%
Male	209,549	53.5%	214,372	54.0%	238,172	54.3%	256,265	54.6%	280,391	54.4%
Total	**391,824**	**100%**	**397,178**	**100%**	**438,910**	**100%**	**469,556**	**100%**	**515,121**	**100%**
Region										
Baltimore City	77,858	19.9%	77,657	19.6%	83,726	19.1%	88,233	18.8%	94,127	18.3%
Baltimore Suburban	117,356	30.0%	119,032	30.0%	131,648	30.0%	140,923	30.0%	155,226	30.1%
Eastern Shore	36,989	9.4%	36,005	9.1%	39,052	8.9%	41,564	8.9%	45,697	8.9%
Southern MD	20,936	5.3%	21,132	5.3%	23,150	5.3%	24,668	5.3%	26,870	5.2%
Washington Suburban	105,310	26.9%	110,567	27.8%	125,390	28.6%	135,664	28.9%	150,087	29.1%
Western MD	32,624	8.3%	32,107	8.1%	35,214	8.0%	37,687	8.0%	42,169	8.2%
Out of State	751	0.2%	678	0.2%	730	0.2%	817	0.2%	945	0.2%
Total	**391,824**	**100%**	**397,178**	**100%**	**438,910**	**100%**	**469,556**	**100%**	**515,121**	**100%**
***Age Group* (Years)**										
19–34	184,463	47.1%	183,860	46.3%	203,635	46.4%	215,289	45.8%	236,651	45.9%
35–49	93,936	24.0%	96,903	24.4%	108,054	24.6%	118,895	25.3%	134,544	26.1%
50–64	113,425	28.9%	116,415	29.3%	127,221	29.0%	135,372	28.8%	143,926	27.9%
Total	**391,824**	**100%**	**397,178**	**100%**	**438,910**	**100%**	**469,556**	**100%**	**515,121**	**100%**
Member Months										
1	11,477	2.9%	15,012	3.8%	6,676	1.5%	6,178	1.3%	6,698	1.3%
2	11,106	2.8%	11,821	3.0%	5,786	1.3%	5,301	1.1%	6,189	1.2%
3	10,239	2.6%	7,027	1.8%	5,213	1.2%	4,476	1.0%	5,175	1.0%
4	9,689	2.5%	6,514	1.6%	5,050	1.2%	4,748	1.0%	5,128	1.0%
5	10,269	2.6%	6,741	1.7%	6,065	1.4%	4,749	1.0%	9,502	1.8%
6	9,702	2.5%	6,847	1.7%	5,278	1.2%	4,107	0.9%	10,230	2.0%
7	10,499	2.7%	6,805	1.7%	5,476	1.2%	4,382	0.9%	12,776	2.5%
8	11,634	3.0%	6,442	1.6%	5,629	1.3%	4,439	0.9%	9,667	1.9%
9	11,689	3.0%	8,528	2.1%	6,026	1.4%	4,386	0.9%	8,405	1.6%
10	12,972	3.3%	8,377	2.1%	6,784	1.5%	4,865	1.0%	7,694	1.5%
11	15,009	3.8%	6,778	1.7%	5,880	1.3%	5,503	1.2%	21,205	4.1%
12	267,539	68.3%	306,286	77.1%	375,047	85.4%	416,422	88.7%	412,452	80.1%
Total	**391,824**	**100%**	**397,178**	**100%**	**438,910**	**100%**	**469,556**	**100%**	**515,121**	**100%**

Note: "Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

* Race and ethnicity values were calculated using the enhanced race/ethnicity variable implemented in 2023 and updated for the entire measurement period. Thus, race and ethnicity totals will not match previous HealthChoice Evaluation results.

Table 20 displays demographic characteristics of the expansion population with a full 12 months of enrollment during the evaluation period. The racial and regional distribution of this population is similar to the distribution of the expansion population with any period of enrollment. Participants aged 19 to 34 years composed the largest portion of the ACA expansion population with 12 months of enrollment. Black participants were the largest racial/ethnic group, and the Baltimore Suburban region had the largest portion of participants.

Table 20. ACA Medicaid Expansion Population Demographics for Participants Aged 19–64 Years, 12 Months of Enrollment, CY 2019–CY 2023

Demographic Characteristic	CY 2019		CY 2020		CY 2021		CY 2022		CY 2023	
	# of Participants	% of Total	# of Participants	% of Total	# of Participants	% of Total	# of Participants	% of Total	# of Participants	% of Total
Race/Ethnicity										
Asian	15,005	5.6%	17,455	5.7%	23,255	6.2%	26,647	6.4%	25,259	6.1%
Black	122,441	45.8%	140,925	46.0%	172,373	46.0%	192,197	46.2%	194,419	47.1%
White	95,876	35.8%	106,439	34.8%	124,352	33.2%	133,797	32.1%	129,815	31.5%
Hispanic	19,109	7.1%	23,086	7.5%	30,875	8.2%	36,001	8.6%	36,223	8.8%
Native American	2,762	1.0%	3,201	1.0%	4,053	1.1%	4,614	1.1%	4,560	1.1%
Other	12,346	4.6%	15,180	5.0%	20,139	5.4%	23,166	5.6%	22,176	5.4%
Total	**267,539**	**100%**	**306,286**	**100%**	**375,047**	**100%**	**416,422**	**100%**	**412,452**	**100%**
Sex										
Female	124,486	46.5%	140,442	45.9%	171,757	45.8%	188,325	45.2%	184,029	44.6%
Male	143,053	53.5%	165,844	54.1%	203,290	54.2%	228,097	54.8%	228,423	55.4%
Total	**267,539**	**100%**	**306,286**	**100%**	**375,047**	**100%**	**416,422**	**100%**	**412,452**	**100%**
Region										
Baltimore City	55,975	20.9%	63,122	20.6%	73,800	19.7%	80,455	19.3%	79,949	19.4%
Baltimore Suburban	80,243	30.0%	91,709	29.9%	112,187	29.9%	124,455	29.9%	123,631	30.0%
Eastern Shore	25,595	9.6%	28,859	9.4%	33,869	9.0%	37,079	8.9%	36,756	8.9%
Southern Maryland	14,641	5.5%	16,540	5.4%	19,966	5.3%	21,895	5.3%	21,697	5.3%
Washington Suburban	68,903	25.8%	80,572	26.3%	104,752	27.9%	119,018	28.6%	117,019	28.4%
Western Maryland	21,721	8.1%	24,968	8.2%	29,874	8.0%	32,872	7.9%	32,688	7.9%
Out of State	461	0.2%	516	0.2%	599	0.2%	648	0.2%	712	0.2%
Total	**267,539**	**100%**	**306,286**	**100%**	**375,047**	**100%**	**416,422**	**100%**	**412,452**	**100%**
Age Group (Years)										
19–34	120,902	45.2%	139,830	45.7%	173,127	46.2%	189,748	45.6%	188,584	45.7%
35–49	65,415	24.5%	75,783	24.7%	92,915	24.8%	106,426	25.6%	109,778	26.6%
50–64	81,222	30.4%	90,673	29.6%	109,005	29.1%	120,248	28.9%	114,090	27.7%
Total	**267,539**	**100%**	**306,286**	**100%**	**375,047**	**100%**	**416,422**	**100%**	**412,452**	**100%**

* Race and ethnicity values were calculated using the enhanced race/ethnicity variable implemented in 2023 and updated for the entire measurement period. Thus, race and ethnicity totals will not match previous HealthChoice Evaluation results.

ACA Medicaid Expansion Population Service Utilization

This section discusses the health care utilization of participants who received coverage through the ACA Medicaid expansion. Table 21 displays the number and percentage of participants with an ambulatory visit, outpatient ED visit, or inpatient admission in CY 2019 through CY 2023 with any period of enrollment as well as 12 months of enrollment. ACA Medicaid expansion participants with 12 continuous months of enrollment provide an MCO with more time and opportunities to intervene in their health care than participants with any period of enrollment. Key findings from Table 23 include the following:

- In CY 2019, 68.2% of ACA Medicaid expansion participants with any period of enrollment had an ambulatory care visit; this rate increased to 68.6% in CY 2021 and then decreased to 62.4% by CY 2023. Visit rates also decreased from 75.7% to 64.6% over the evaluation period for expansion participants enrolled for the entire year.
- In CY 2019, 30.0% of ACA Medicaid expansion participants with any period of enrollment had an outpatient ED visit. This rate experienced sharp declines in CY 2020 and CY 2022, with an overall decline of 7.1 percentage points during the evaluation period. The rates for participants with 12 months of enrollment decreased from 33.5% in CY 2019 to 24.6% in CY 2023.
- Overall, 8.2% of ACA Medicaid expansion participants with any period of enrollment had an inpatient admission in CY 2019, decreasing to 6.1% in CY 2023. Participants who were enrolled for the entire year also experienced a decrease in inpatient admissions from 8.5% in CY 2019 to 6.2% in CY 2023. The inpatient admission rate for those with 12 months of enrollment was lower in both CY 2021 and CY 2022. In CY 2023, 6.2% of participants enrolled for 12 months had an inpatient admission compared to 6.1% of participants with any enrollment.
- While enrollment increased for ACA Medicaid expansion participants from CY 2022 to CY 2023, utilization decreased for ambulatory visits, outpatient ED visits, and inpatient admissions for both participants enrolled for 12 months and those with any enrollment. The only exception was utilization of outpatient ED visits and inpatient admission for participants enrolled for 12 months, which each increased 0.1 percentage points from CY 2022 to CY 2023.

Table 21. Service Utilization of ACA Medicaid Expansion Population Aged 19–64 Years, by Enrollment Period, CY 2019–CY 2023

Enrollment Period	CY 2019			CY 2020			CY 2021			CY 2022			CY 2023		
	# of Users	# of Participants	% of Total	# of Users	# of Participants	% of Total	# of Users	# of Participants	% of Total	# of Users	# of Participants	% of Total	# of Users	# of Participants	% of Total
Ambulatory Care Visits															
Any	267,294	391,784	68.2%	258,789	396,876	65.2%	300,615	438,293	68.6%	305,241	469,556	65.0%	321,376	515,121	62.4%
12 Months	202,589	267,587	75.7%	215,701	306,207	70.4%	268,048	374,868	71.5%	279,778	416,422	67.2%	266,643	412,452	64.6%
Outpatient ED Visits															
Any	117,383	391,784	30.0%	98,697	396,876	24.9%	114,587	438,293	26.1%	111,625	469,556	23.8%	117,922	515,121	22.9%
12 Months	89,555	267,587	33.5%	82,473	306,207	26.9%	101,526	374,868	27.1%	102,154	416,422	24.5%	101,313	412,452	24.6%
Inpatient Admissions															
Any	31,941	391,784	8.2%	28,419	396,876	7.2%	32,050	438,293	7.3%	30,021	469,556	6.4%	31,275	515,121	6.1%
12 Months	22,876	267,587	8.5%	21,931	306,207	7.2%	26,144	374,868	7.0%	25,573	416,422	6.1%	25,421	412,452	6.2%

Note: The number of users is the number of participants that had at least one visit.

ACA Medicaid Expansion Population with Mental Health and Substance Use Disorders

This section of the evaluation presents the rates of behavioral health diagnoses among ACA expansion participants. Table 22 shows the rates of MHDs, SUDs, and co-occurring MHD and SUD conditions among ACA Medicaid expansion participants aged 19 to 64 years. Rates are shown for those with any period of enrollment and 12 months of enrollment in CY 2019 through CY 2023.

The percentages of participants diagnosed with an MHD, SUD, or co-occurring MHD and SUD were higher among participants who were enrolled for a 12-month period compared to participants with any period of enrollment. However, the difference narrowed across the evaluation period for all participant groups. The percentage of participants with any period of enrollment and an MHD increased by 0.7 percentage points overall. The percentage of participants with any period of enrollment and an SUD decreased from 6.3% in CY 2019 to 4.2% in CY 2023. The percentage of participants with any period of enrollment and a dual diagnosis of MHD and SUD decreased 0.5 percentage points throughout the evaluation period.

Table 22. Behavioral Health Diagnosis of ACA Medicaid Expansion Population Aged 19–64 Years, by Enrollment Period, CY 2019–CY 2023

Enrollment Period	CY 2019			CY 2020			CY 2021			CY 2022			CY 2023		
	# of Participants	Total Participants	% of Total	# of Participants	Total Participants	% of Total	# of Participants	Total Participants	% of Total	# of Participants	Total Participants	% of Total	# of Participants	Total Participants	% of Total
MHD-Only															
Any Period	45,658	391,815	11.7%	45,062	397,346	11.3%	51,980	439,258	11.8%	56,847	470,342	12.1%	63,901	515,121	12.4%
12 Months	34,626	267,536	12.9%	37,814	306,375	12.3%	46,112	375,276	12.3%	51,616	416,449	12.4%	53,282	412,452	12.9%
SUD-Only															
Any Period	24,542	391,815	6.3%	23,236	397,346	5.8%	23,558	439,258	5.4%	22,683	470,342	4.8%	21,829	515,121	4.2%
12 Months	18,605	267,536	7.0%	19,697	306,375	6.4%	20,930	375,276	5.6%	20,746	416,449	5.0%	18,900	412,452	4.6%
Dual Diagnosis (MHD and SUD)															
Any Period	21,737	391,815	5.5%	20,297	397,346	5.1%	21,178	439,258	4.8%	22,252	470,342	4.7%	25,587	515,121	5.0%
12 Months	17,747	267,536	6.6%	17,938	306,375	5.9%	19,222	375,276	5.1%	20,559	416,449	4.9%	22,830	412,452	5.5%
No Behavioral Health Diagnosis															
Any Period	299,878	391,815	76.5%	308,751	397,346	77.7%	342,542	439,258	78.0%	368,560	470,342	78.4%	403,804	515,121	78.4%
12 Months	196,558	267,536	73.5%	230,926	306,375	75.4%	289,012	375,276	77.0%	323,528	416,449	77.7%	317,440	412,452	77.0%

Section III Conclusion

During CY 2023, HealthChoice maintained access to primary care for its members, with all Maryland counties having sufficient PCPs to outperform the benchmark ratio of 200 patients per provider practice. The percentage of Medicaid participants enrolled in managed care remained consistently above 89.0% from CY 2019 to CY 2023, with continuous enrollment increasing significantly in CY 2020 and CY 2021 and then slightly in CY 2022, followed by a decrease in CY 2023. This increase is a result of the PHE and the continuous enrollment provision of FFCRA. Across a wide variety of measures, HealthChoice utilization trends were largely consistent with program goals in CY 2019. However, the COVID-19 PHE in CY 2020 negatively impacted utilization trends. The percentage of HealthChoice participants who received ambulatory care decreased over the evaluation period, with the largest decrease of 4.6 percentage points between CY 2019 and CY 2020, followed by an increase of 3.5 percentage points in CY 2021, a subsequent decrease of 2.5 percentage points in CY 2022, and then a decrease of 2.4 percentage points in CY 2023. Outpatient ED visits and inpatient admissions generally declined over the evaluation period.

HealthChoice prioritizes the delivery of and access to quality health services to special populations—such as children in foster care and REM program participants—as well as reducing racial and ethnic disparities. Utilization of services among these special populations were largely consistent with utilization trends of the overall HealthChoice population. Over the evaluation period, the percentage of children in foster care who received an ambulatory service decreased, and utilization of the ED and inpatient admissions for this population also decreased. However, outpatient ED visits and inpatient admissions were higher for children in foster care than for children not in foster care in CY 2023. The percentage of REM participants with a dental visit, ambulatory care visit, ED visit, or inpatient admission decreased during the evaluation period; however, ED and dental visits increased from CY 2020 to CY 2023.

Section IV. Quality of Care

Population Health Incentive Program

The Center for Health Care Strategies helped the Department develop a Value-Based Purchasing (VBP) initiative for HealthChoice beginning in 1999. The VBP initiative has since been renamed the Population Health Incentive Program (PHIP). PHIP pays incentives to MCOs that demonstrate high-quality care, increased access, and administrative efficiency by using standardized measures of performance on population health goals.

PHIP measures may change according to the Department's priorities and analysis of changing population health needs. The measures selected are intended to improve outcomes for HealthChoice participants—including children, children with special needs, pregnant women, adults with disabilities, and adults with chronic conditions—while being measurable with available data and comparable to national performance measures for benchmarking. PHIP strives for consistency with CMS's national performance measures for Medicaid and should reflect areas in which it is possible for MCOs to effect change. Measures included in the CY 2023 PHIP (see Table 23) were adapted from NCQA's HEDIS®.[31] These measures were chosen using encounter data and data supplied by the HealthChoice MCOs and subsequently validated by the Department's external quality review organization (EQRO) and HEDIS® auditor. Changes in the components of PHIP may result in changes in plan performance with respect to that measure. Therefore, decisions to make changes to the list of PHIP measures are taken with due consideration by the Department. Moreover, the measures are applied to MCOs without adjustments for differing risks in the population each serves. This has the effect of assuming that each MCO's PHIP performance is not affected by differences among an MCO's enrollees.

Table 23. PHIP Measures and Statewide Percentages, CY 2023

Population Health Incentive Program Measure	Statewide Percentage
Ambulatory Care Visits for SSI Adults	79.0%
Ambulatory Care Visits for SSI Children	78.2%
Asthma Medication Ratio	69.9%
Continued Opioid Use (COU): >=31 days covered	3.1%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)	31.9%
Lead Screening in Children (LSC)	74.7%
Prenatal and Postpartum Care (PPC-CH): Timeliness of Prenatal Care	87.9%
Prenatal and Postpartum Care (PPC-AD): Postpartum Care	84.2%

In early 2021, PHIP moved to an incentive-only model for CY 2022. The overall goal remained the same: allocate financial incentives annually to HealthChoice MCOs that demonstrate high-quality care based on standardized measures of performance.

[31] Some of the HEDIS® measures have changed and are different than what was reported in the 2022 HealthChoice Evaluation.

Hilltop developed and proposed an incentive payment structure based on current performance and historical improvement on both standardized performance measures (i.e., HEDIS®) and locally developed (i.e., homegrown) quality measures. Measure selection was informed to align with Maryland's new SIHIS. Hilltop then proposed to allocate available funds through two rounds of incentive payments:

- In Round 1, payments to plans are made from the allocated incentive funding based on performance during the measurement year and improvement from the previous year.
- In Round 2, unallocated funds from Round 1 are redistributed among high-performing MCOs as additional incentives, up to a limit of 1% of the MCO's measurement year capitation as total payment from Round 1 and Round 2.

This methodology was refined in conjunction with the Department and MCOs, and the new payment structure went into effect during the CY 2022 performance year.

Three performance measures were selected to further evaluate PHIP during the evaluation period: 1) Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%), 2) Ambulatory Care Visits for SSI Adults, and 3) Ambulatory Care Visits for SSI Children.

Due to the COVID-19 PHE, there are challenges in evaluating the effects of PHIP on the chosen measures. The Comprehensive Diabetes Care - HbA1c Control measure was removed for PHIP in CY 2023. The measure now evaluates the percentage of participants with Comprehensive Diabetes Care with poor HbA1c Control (>9.0%). The percentage of enrollees with Comprehensive Diabetes Care with Poor HbA1c Control (>9.0%) increased from CY 2019 to CY 2020 in the pre-COVID period (see Table 24). Overall performance improved by CY 2023, with a small uptick in CY 2022. By CY 2023, the Maryland Average Reportable Rate (MARR) for participants with poor Hb1Ac control fell to 31.9%, a 2.9 percentage point decrease from CY 2019. Performance among MCOs varied, ranging from a decrease of 7.3 percentage points (Priority Partners) to an increase of 4.6 percentage points (Jai Medical Systems) over the evaluation period.

Table 24. Percentage of HealthChoice Participants with Comprehensive Diabetes Care (CDC) Poor HbA1c Control (>9.0%), by MCO, CY 2019–CY 2023

MCO	2019	2020	2021	2022	2023
Aetna	38.7%	45.3%	35.5%	38.0%	34.2%
CareFirst Community Health Plan	33.6%	38.9%	38.7%	38.0%	29.0%
Jai Medical Systems	27.3%	35.7%	28.4%	29.2%	31.9%
Kaiser	26.0%	31.7%	29.2%	30.7%	29.1%
Maryland Physicians Care	36.0%	43.6%	32.4%	32.9%	29.2%
MedStar	33.0%	34.2%	34.6%	30.7%	31.4%
Priority Partners	42.6%	51.1%	35.3%	32.4%	35.3%
UnitedHealthcare	37.5%	41.9%	39.7%	36.3%	34.6%
Wellpoint*	38.2%	37.2%	37.5%	37.2%	32.6%
MARR	**34.8%**	**39.9%**	**34.6%**	**33.9%**	**31.9%**

*formerly Amerigroup Community Care

MCOs differed in their performance on the measures of ambulatory care for SSI adults and children. Over the evaluation period, MCOs ranged from a decrease of 14.3 percentage points (CareFirst) to a decrease of 1.7 percentage points (Aetna) in the percentage of SSI adults with an ambulatory visit. The percentage of SSI children with an ambulatory visit ranged from a decrease of 19.5 percentage points (CareFirst) to an increase of 7.2 percentage points (Aetna) over the evaluation period. Jai was the highest performing MCO on the adult measure and remained consistent over the evaluation period. For the child measure, Jai was the highest performing MCO from CY 2019 to CY 2021, and Priority Partners was the highest performing MCO for CY 2022 and CY 2023.

Table 25. Percentage of Ambulatory Care Visits for SSI Adults, by MCO, CY 2019–CY 2023

MCO	2019	2020	2021	2022	2023
Aetna	58.2%	57.0%	59.8%	58.6%	56.5%
CareFirst Community Health Plan	87.7%	76.4%	76.1%	72.6%	73.4%
Jai Medical Systems	90.6%	89.7%	90.1%	87.1%	85.1%
Kaiser	75.5%	69.0%	71.9%	70.9%	69.3%
Maryland Physicians Care	84.7%	83.1%	83.6%	82.6%	82.3%
MedStar	83.5%	80.0%	80.2%	79.6%	79.0%
Priority Partners	86.1%	82.3%	83.6%	82.0%	81.1%
UnitedHealthcare	79.4%	76.8%	78.6%	76.2%	75.7%
Wellpoint*	82.2%	77.2%	80.1%	77.9%	78.1%
All	**83.9%**	**80.3%**	**81.5%**	**79.7%**	**79.0%**

*formerly Amerigroup Community Care

Table 26. Percentage of Ambulatory Care Visits for SSI Children, by MCO, CY 2019–CY 2023

MCO	2019	2020	2021	2022	2023
Aetna	40.7%	37.8%	45.8%	47.0%	47.9%
CareFirst Community Health Plan	88.5%	66.3%	64.3%	70.5%	69.0%
Jai Medical Systems	90.9%	89.8%	89.1%	81.3%	78.8%
Kaiser	79.5%	66.4%	76.0%	71.0%	69.7%
Maryland Physicians Care	84.4%	78.6%	82.7%	81.9%	80.1%
MedStar	78.9%	74.0%	76.4%	75.3%	71.2%
Priority Partners	85.5%	77.1%	84.7%	82.6%	82.2%
UnitedHealthcare	80.2%	70.0%	78.5%	75.2%	75.8%
Wellpoint*	84.2%	74.8%	82.3%	78.8%	79.0%
All	**83.7%**	**75.0%**	**81.2%**	**79.0%**	**78.2%**

*formerly Amerigroup Community Care

EPSDT (Healthy Kids) Review

Federal regulations require EPSDT services for all Medicaid participants under the age of 21 years.[32] The purpose of EPSDT is to ensure that children receive age-appropriate physical

[32] 42 CFR § 440.345.

examinations, developmental assessments, and mental health screenings periodically to identify any deviations from expected growth and development.

Maryland's EPSDT program, Healthy Kids, aims to support access to and increase the availability of quality health care. The Healthy Kids Program includes nurse consultants who certify HealthChoice providers in receiving EPSDT training, support the MCOs, and educate them on new EPSDT requirements. The Healthy Kids Program also collaborates with MCOs to share age-appropriate encounter forms, risk assessment forms, and questionnaires with their provider networks to assist with documenting preventive services according to the Maryland Schedule of Preventive Health Care.

The annual EPSDT Healthy Kids medical record review (MRR) assesses whether EPSDT services are provided to HealthChoice participants in a timely manner. The review is conducted on HealthChoice provider compliance with five EPSDT components: 1) health and developmental history, 2) comprehensive physical exam, 3) laboratory tests/at-risk screenings, 4) immunizations, and 5) health education/anticipatory guidance.

Table 27 demonstrates the change in provider compliance scores for components of the EPSDT/ Healthy Kids Review during the evaluation period. Between CY 2019 and CY 2023, provider compliance increased for all EPSDT components. The HealthChoice aggregate total score increased overall from CY 2019 to CY 2023, with a decrease occurring from CY 2022 to CY 2023 (Qlarant, 2025). The Department achieved the minimum compliance score of 80% for all components for CY 2019 and maintained it through CY 2020, except for two components that were baseline results because of the change in the MRR process stemming from the COVID-19 PHE. Only one component in CY 2020—Laboratory Tests/At-Risk Screenings—remained below the minimum compliance score. In CY 2021 through CY 2023, all components achieved the minimum compliance score. MCOs use the Healthy Kids review results to develop education efforts to inform participants and providers about EPSDT services.

Table 27. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT/Healthy Kids Review, CY 2019–CY 2023

EPSDT Component	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Health and Developmental History	88%	94%	94%	96%	93%
Comprehensive Physical Exam	93%	96%	96%	98%	97%
Laboratory Tests/At-Risk Screenings	66%*	77%	81%	85%	80%
Immunizations	71%*	86%	88%	95%	92%
Health Education/Anticipatory Guidance	92%	94%	94%	97%	96%
HealthChoice Aggregate Total	**83%**	**91%**	**92%**	**95%**	**93%**

*CY 2019 results for these components are baseline because of the change in the MRR process due to the COVID-19 PHE. Underlined scores are below the 80% minimum compliance requirement.

Section IV Conclusion

Although many of the HealthChoice performance measures in this report demonstrate quality of health care already delivered, two HealthChoice programs focus more directly on improving specific quality of care measures.

First, PHIP incentivizes MCOs to maintain and improve performance by awarding additional payments according to their scores on measures of clinical outcomes and care delivery defined in advance. The overall performance of the nine MCOs sets the standards by which each MCO is evaluated. Those MCOs that exceed a performance threshold receive incentive payments, while MCOs with less-than-standard performance receive no additional payments. An evaluation of the Comprehensive Diabetes Care - HbA1c Control measure shows that the MARR decreased by 2.9 percentage points between CY 2019 and CY 2023. Although MCOs may vary with respect to which measures earn incentive payments, PHIP supports overall quality improvement across HealthChoice.

Second, the EPSDT annual review assesses plan performance on services to children under the age of 21. Because EPSDT services are a national requirement for Medicaid, the EPSDT review measures whether all HealthChoice plans achieve minimum levels of performance in delivering these services to eligible children. Results from the most recent review show that the MCOs have met or exceeded standards across the board in CY 2021, CY 2022, and CY 2023 and have recovered from CY 2019 and CY 2020, wherein the MCOs failed to attain the minimum compliance requirement for at least one measure each year. In CY 2019, compliance requirements were not met for two measures: Laboratory Tests/At-Risk Screenings and Immunizations. In CY 2020, one measure—Laboratory Tests/At-Risk Screenings—remained below the minimum compliance requirement. However, these results should be interpreted with caution as only desktop reviews were conducted during those two years due to the COVID-19 PHE. In CY 2023, the MCOs met or exceeded the minimum compliance score for all components.

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Section V. Provide Patient-Focused Comprehensive and Coordinated Care through Provision of a Medical Home

The HealthChoice program's medical home provision offers patient-focused, comprehensive, coordinated care for its participants by matching each member to a single "medical home" through a PCP. A medical home encourages HealthChoice participants to use care settings appropriate to their needs and decrease potentially inappropriate or avoidable utilization of health services. To this end, HealthChoice participants are asked to select an MCO and PCP to oversee their medical care, and those who do not select an MCO or PCP are assigned to one.

This section of the report assesses how adequately HealthChoice provides participants with a medical home and educates them as to their use. The measures analyze appropriate service utilization and participants' ability to connect with their medical homes. Participants should be able to understand the resources available to them and seek care in an ambulatory care setting before resorting to seeking care in the ED or allowing a condition to progress to the extent that it warrants an inpatient admission.

Medical Home Utilization

In December 2015, the Department began collecting information from MCOs on HealthChoice participants' PCP assignments, as well as information on the PCPs within a group practice. This information helps the Department track whether participants visited their assigned PCPs or whether they used other providers to oversee their medical care and provide a medical home.

Table 28 presents the number of participants who had at least one visit with their assigned PCP, their assigned PCP's group practice or partner PCP, or any PCP in the MCO's network from CY 2019 to CY 2023. This section presents these measures by MCO for HealthChoice participants with 12 months of enrollment in an MCO. Participants enrolled for 12 continuous months provide an MCO with enough time to intervene in their health care.

During the evaluation period, all MCOs experienced declines in a) the proportion of their HealthChoice participants with at least one visit to their assigned PCP, b) the proportion with at least one visit to any PCP within the MCO network and c) the proportion of their HealthChoice participants with at least one visit to their assigned PCP, group practice, or partner PCP during the evaluation period.[33]

[33] Excluding Aetna—which only began providing acceptable files in 2021—and Jai—because the percentage of participants with a visit to their assigned PCP could not be reported in CY 2019 due to the use of the billing NPI, which limits ability to capture a participant's assigned PCP.

Table 28. Percentage of HealthChoice Participants (12 Months of Enrollment) with a PCP Visit, by MCO,* CY 2019–CY 2023

MCO	# of Participants* (12 Months of Enrollment)	% of Participants with a Visit with their Assigned PCP	% of Participants with a Visit with Assigned PCP, Group Practice, or Partner PCPs	% of Participants with a Visit with any PCP in MCO's Network
CY 2019**				
Aetna***	10,390	0.8%	1.3%	3.7%
CareFirst Community Health Plan	32,525	28.8%	48.3%	80.0%
Jai Medical Systems****	21,526	4.2%	67.0%	83.5%
Kaiser	46,398	66.4%	73.1%	83.9%
Maryland Physicians Care	167,215	38.5%	60.6%	86.1%
MedStar	68,438	33.3%	62.3%	84.4%
Priority Partners	234,752	57.9%	60.8%	89.3%
UnitedHealthcare	112,874	43.2%	57.4%	86.2%
Wellpoint	217,490	48.7%	73.4%	89.1%
Total	**911,608**	**45.9%**	**63.1%**	**86.2%**
CY 2020**				
Aetna***	24,965	0.4%	0.6%	1.8%
CareFirst Community Health Plan	40,015	29.2%	43.7%	69.0%
Jai Medical Systems	23,967	29.5%	59.6%	77.0%
Kaiser	63,507	56.1%	76.2%	78.3%
Maryland Physicians Care	194,487	35.0%	53.8%	75.2%
MedStar	81,112	29.9%	49.2%	75.5%
Priority Partners	276,317	35.2%	38.1%	74.8%
UnitedHealthcare	130,721	33.1%	47.7%	68.7%
Wellpoint	255,847	46.2%	65.2%	78.1%
Total	**1,090,938**	**37.2%**	**51.3%**	**73.3%**
CY 2021******				
Aetna	40,702	24.5%	35.4%	65.4%
CareFirst Community Health Plan	50,357	28.4%	42.6%	71.7%
Jai Medical Systems	27,073	29.7%	59.1%	78.7%
Kaiser	90,820	59.1%	79.1%	82.6%
Maryland Physicians Care	220,022	33.8%	53.6%	79.5%
MedStar	95,106	28.9%	48.7%	79.3%
Priority Partners	314,309	40.4%	43.2%	81.5%
UnitedHealthcare	151,311	27.6%	41.9%	77.5%
Wellpoint	293,591	46.0%	65.5%	82.3%
Total	**1,283,291**	**38.3%**	**52.9%**	**78.7%**
CY 2022				
Aetna	48,052	26.0%	38.4%	64.5%
CareFirst Community Health Plan	65,871	26.7%	39.7%	69.7%
Jai Medical Systems	27,713	31.7%	59.3%	75.8%
Kaiser	105,096	53.8%	74.6%	78.5%

MCO	# of Participants* (12 Months of Enrollment)	% of Participants with a Visit with their Assigned PCP	% of Participants with a Visit with Assigned PCP, Group Practice, or Partner PCPs	% of Participants with a Visit with any PCP in MCO's Network
Maryland Physicians Care	232,962	33.6%	52.3%	76.7%
MedStar	101,147	27.7%	46.2%	75.9%
Priority Partners	331,354	39.9%	42.0%	79.4%
UnitedHealthcare	159,553	34.0%	48.3%	75.3%
Wellpoint	309,780	43.6%	61.9%	79.8%
Total	**1,381,528**	**37.9%**	**51.8%**	**77.2%**
CY 2023				
Aetna	47,748	23.8%	35.1%	61.6%
CareFirst Community Health Plan	72,232	28.6%	42.7%	68.5%
Jai Medical Systems	26,349	29.7%	56.7%	72.8%
Kaiser	100,625	50.8%	72.0%	75.8%
Maryland Physicians Care	219,295	32.4%	51.1%	75.5%
MedStar	94,275	21.0%	38.8%	73.5%
Priority Partners	310,857	34.9%	60.7%	78.3%
UnitedHealthcare	149,181	33.4%	48.6%	74.8%
Wellpoint	290,229	42.7%	61.1%	79.1%
Total	**1,310,791**	**35.4%**	**55.1%**	**75.8%**

*The number of participants in a HealthChoice MCO only includes participants who were listed in the data files provided by the MCO and in the MCO enrollment files according to MMIS2 data.
**The methodology was updated in 2021 to account for changes in the rendering vs. billing provider fields in MMIS2, so the CY 2019 to CY 2020 numbers have changed significantly in some cases.
***Please read Aetna's results with caution: this MCO only began providing acceptable files in 2021.
****The percentage of participants with a visit to their assigned PCP is not reported for Jai because the use of the billing NPI limits the ability to capture a participant's assigned PCP.
*****CY 2021, % of Participants with a Visit with any PCP in MCO's Network data has been revised to correct an error in reporting.

Table 29 shows the proportion of participants who received at least one ambulatory care visit by MCO in CY 2019 and CY 2023. The total number of participants enrolled in HealthChoice grew by 20.9% between CY 2019 and CY 2023, while the proportion receiving an ambulatory care visit decreased by 6.0 percentage points. There was variation in this measure among MCOs. For CY 2019, in four of the nine MCOs, over 75% of the participants had an ambulatory care visit. For CY 2023, in *two* of the nine MCOs, over 75% of the participants had an ambulatory care visit.

Table 29. Number and Percentage of HealthChoice Participants Aged 0–64 Years Who Had an Ambulatory Care Visit, by MCO, CY 2019 and CY 2023

MCO*	CY 2019			CY 2023		
	Total Participants	# with Ambulatory Care Visit	% with Ambulatory Care Visit	Total Participants	# with Ambulatory Care Visit	% with Ambulatory Care Visit
Aetna	36,226	21,799	60.2%	71,430	41,890	58.6%
CareFirst	55,948	38,707	69.2%	107,820	70,026	64.9%
JAI	30,412	22,691	74.6%	32,419	21,968	67.8%

MCO*	CY 2019			CY 2023		
	Total Participants	# with Ambulatory Care Visit	% with Ambulatory Care Visit	Total Participants	# with Ambulatory Care Visit	% with Ambulatory Care Visit
Kaiser	83,727	62,520	74.7%	136,356	94,720	69.5%
MPC	242,928	192,084	79.1%	270,645	200,674	74.1%
MedStar	105,911	79,292	74.9%	117,284	81,664	69.6%
Priority Partners	341,545	281,112	82.3%	386,286	294,251	76.2%
United	167,542	131,320	78.4%	188,556	136,552	72.4%
Wellpoint	313,254	258,502	82.5%	354,436	274,496	77.4%
ALL MCOs	**1,377,493**	**1,088,027**	**79.0%**	**1,665,232**	**1,216,241**	**73.0%**

*It is important to note that the data contained here have not been risk-adjusted, so they do not account for variances in risk profiles across MCOs.

Table 30 displays the outpatient ED utilization of HealthChoice participants aged 0 to 64 years by MCO during CY 2019 and CY 2023. During the evaluation period, all MCOs experienced a decrease in the percentage of their participants with an ED visit; Jai and CareFirst experienced the largest decreases in ED use: by 8.6 and 7.5 percentage points, respectively. In CY 2019, at least 30% of participants in three of the nine MCOs utilized ED services. By CY 2023, no MCOs had an ED utilization rate above 30%.

Table 30. Percentage of HealthChoice Participants Aged 0–64 Years Who Had an Outpatient ED Visit, by MCO, CY 2019 and CY 2023

MCO*	CY 2019			CY 2023		
	Total Participants	# with ED Visit	% with ED Visit	Total Participants	# with ED Visit	% with ED Visit
Aetna	36,226	8,505	23.5%	71,430	14,603	20.4%
CareFirst	55,948	15,762	28.2%	107,820	22,286	20.7%
JAI	30,412	10,910	35.9%	32,419	8,844	27.3%
Kaiser	83,727	11,616	13.9%	136,356	16,294	11.9%
MPC	242,928	75,361	31.0%	270,645	67,726	25.0%
MedStar	105,911	30,714	29.0%	117,284	25,714	21.9%
Priority Partners	341,545	103,013	30.2%	386,286	94,696	24.5%
United	167,542	45,860	27.4%	188,556	41,693	22.1%
Wellpoint	313,254	80,324	25.6%	354,436	77,329	21.8%
Total	**1,377,493**	**382,065**	**27.7%**	**1,665,232**	**369,185**	**22.2%**

*It is important to note that the data contained here have not been risk-adjusted, so they do not account for variances in risk profiles across MCOs.

Appropriateness of ED Care

A fundamental goal of managed care programs like HealthChoice is the delivery of the appropriate care at the appropriate time in the appropriate setting. One widely used methodology to evaluate progress toward appropriate ED utilization is based on classifications developed by researchers at the New York University (NYU) Center for Health and Public Service

Research (Billings et al., 2000). The original algorithm was created with ICD-9 codes as of 2001 and was not revised to incorporate new ICD-9 and ICD-10 codes that were added each year. Because this resulted in an increase in the percentage of unclassified ED visits over time, researchers revised the algorithm to account for updated ICD-9 and ICD-10 codes released in 2001 through 2014 (Johnston et al., 2017). Hilltop has not yet applied this update for classifying ED visits because the update for ICD-10 was still in the beta version and not classified by NYU. According to Billings et al. (2000), the ED profiling algorithm categorizes emergency visits as follows:

1. *Non-emergent*: Immediate care was not required within 12 hours based on the patient's presenting symptoms, medical history, and vital signs.
2. *Emergent but primary care treatable*: Treatment was required within 12 hours but it could have been provided effectively in a primary care setting (e.g., CAT scan or certain lab tests).
3. *Emergent but preventable/avoidable*: Emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been accessible and received during the episode of illness (e.g., asthma flare-up).
4. *Emergent, ED care needed, not preventable/avoidable*: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis).
5. *Injury*: Injury was the principal diagnosis.
6. *Alcohol-related*: The principal diagnosis was related to alcohol.
7. *Drug-related*: The principal diagnosis was related to drugs.
8. *Mental health-related*: The principal diagnosis was related to mental health.
9. *Unclassified*: The condition was not classified in one of the above categories by the expert panel.

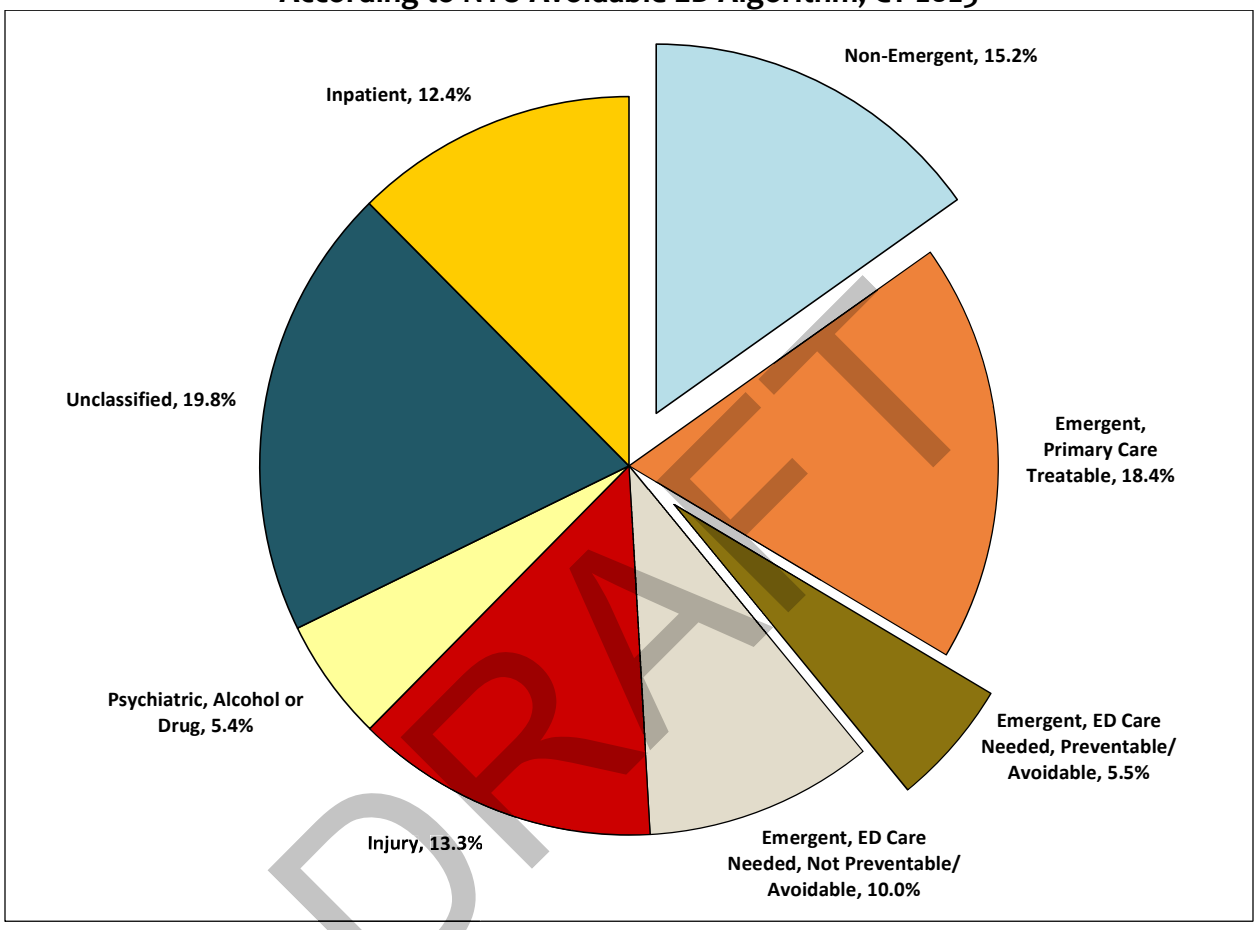
ED visits that fall into the first three categories above may indicate problems with access to primary care, including access during non-traditional work hours. Figure 15 presents the distribution of all CY 2023 ED visits by NYU classification for individuals with any period of HealthChoice enrollment. In CY 2023, 39.1% of all ED visits were for potentially avoidable (preventable) conditions, meaning that the ED visit may have been avoided if the condition had been addressed with high-quality and timely primary care. ED visits in categories 4 (emergent, ED care needed, not preventable/avoidable) and 5 (injury) are the least likely to be prevented with access to primary care. These two categories combined accounted for 23.3% of all ED visits in CY 2023.

Adults aged 40 through 64 years had more ED visits related to category 4 (emergent, ED care needed, not preventable/avoidable) than any other age group; children aged 10 through 14 years had the largest proportion of category 5 (injury) ED visits than other age groups.[34] The inpatient category in Figure 15, which is not a part of the NYU classification, represents ED visits

[34] Data not shown.

that resulted in a hospital admission. Participants with disabilities had a much higher rate of ED visits that led to an inpatient admission than participants in the families, children, and pregnant women (F&C) and MCHP coverage groups.[35]

Figure 15. ED Visits by HealthChoice Participants Classified According to NYU Avoidable ED Algorithm, CY 2023



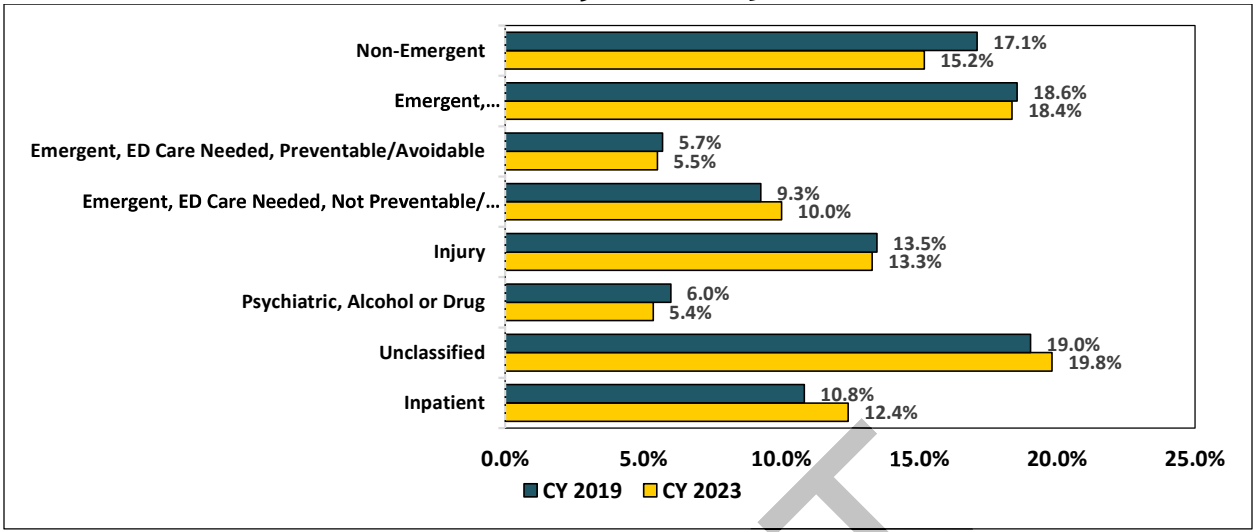
Note: ED visits that result in inpatient stays are not a part of the NYU algorithm and have been added here in their own category. The two categories with ED visits for potentially avoidable/preventable conditions are pulled out in the figure.

Figure 16 compares the ED visit classifications for CY 2019 with the classifications for CY 2023. Potentially avoidable ED visits decreased during the evaluation period: from 41.4% of all ED visits in CY 2019 to 39.1% in CY 2023. The number of unclassified ED visits only increased by 0.8 percentage points between CY 2019 and CY 2023[36]. The Department continues to monitor ED use with the goal of reducing potentially avoidable ED visits. ED visits for psychiatric-, alcohol-, or drug-related reasons decreased from 6.0% in CY 2019 to 5.4% in CY 2023.

[35] Data not shown.

[36] The number of unclassified ED visits increased due to additional new diagnosis codes.

Figure 16. Classification of ED Visits, by HealthChoice Participants, CY 2019 and CY 2023



Preventable or Avoidable Admissions

Ambulatory care sensitive hospitalizations—also referred to as preventable or avoidable hospitalizations—are inpatient admissions that may have been prevented if proper ambulatory care had been provided in a timely and effective manner. According to an Agency for Healthcare Research and Quality (AHRQ) report, one in ten hospital admissions nationwide were avoidable (McDermott & Jiang, 2020). High numbers of avoidable admissions may indicate problems with access to primary and urgent care services or deficiencies in outpatient management, follow-up, and readmission status. The Department monitors potentially avoidable admissions using AHRQ's Prevention Quality Indicators (PQIs) methodology, which aligns with the health quality goals under Maryland's SIHIS. PQIs are a set of measures obtained from hospital discharge records for specific primary diagnoses to identify quality of care for ambulatory conditions based on the conditions listed in each measure. PQIs are for conditions for which ambulatory care can potentially prevent the need for hospitalization. The measures presented are as follows:[37]

PQI #1: Diabetes Short-Term Complications

PQI #3: Diabetes Long-Term Complications

PQI #5: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults

PQI #7: Hypertension

PQI #8: Congestive Heart Failure

PQI #11: Bacterial Pneumonia

[37] The measure estimation logic has been updated using AHRQ PQI Version 2021. A full description of the methodological revisions is available here: https://qualityindicators.ahrq.gov/Modules/Log_Coding_Updates_PQI_v2021.aspx.

PQI #12: Urinary Tract Infection

PQI #14: Uncontrolled Diabetes

PQI #15: Asthma in Younger Adults

PQI #16: Lower-Extremity Amputation in Patients with Diabetes

PQI #90:[38] Prevention Quality Overall Composite

PQI #91:[39] Prevention Quality Acute Composite

PQI #92:[40] Prevention Quality Chronic Composite

PQI #93:[41] Prevention Quality Diabetes Composite

The measure denominators include the number of HealthChoice participants who meet the following enrollment criteria:

- Aged 18 to 64 years as of December 31 of the calendar year
  - For PQI #5: Aged 40 to 64 years as of December 31 of the calendar year
  - For PQI #15: Aged 18 to 39 years as of December 31 of the calendar year
- Enrolled in the same HealthChoice MCO as of December 31 of the calendar year as the MCO that paid for the inpatient admission qualifying the participant for a PQI designation

Table 31 presents the number of potentially avoidable inpatient admissions per 100,000 HealthChoice participants aged 18 to 64 years during the evaluation period. COPD or asthma in older adults (PQI #5) was responsible for the highest number of potentially avoidable admissions for CY 2019 through CY 2023. The number of potentially avoidable admissions for lower-extremity amputation in patients with diabetes (PQI #16) was the smallest for CY 2019 through CY 2020. From CY 2021 to CY 2023, uncontrolled diabetes admissions (PQI #14) were the smallest.

Table 31. Number of Potentially Avoidable Admissions per 100,000 HealthChoice Participants Aged 18–64 Years (Any Period of Enrollment), CY 2019–CY 2023[42]

Any PQI #	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
1: Diabetes Short-Term Complications Admissions	208	198	175	161	149
3: Diabetes Long-Term Complications Admissions	150	123	120	113	127
5: COPD or Asthma in Older Adults Admissions (Ages 40-64)	646	395	346	343	310
7: Hypertension Admissions	76	62	57	67	58
8: Congestive Heart Failure Admissions	243	196	183	190	183

[38] PQI #90 includes PQI #s 1, 3, 5, 7, 8, 10, 11, 12, 14, 15, and 16.
[39] PQI #91 includes PQI #s 11 and 12.
[40] PQI #92 includes PQI #s 1, 3, 5, 7, 8, 14, 15, and 16.
[41] PQI #93 includes PQI #s 1, 3, 14, and 16.
[42] This measure presents the number of potentially avoidable admissions per 100,000 participants. The methodology for calculating inpatient admission rates only counts inpatient stays paid for by an MCO.

Any PQI #	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
11: Bacterial Pneumonia Admissions	122	92	61	57	62
12: Urinary Tract Infection Admissions	73	45	43	31	39
14: Uncontrolled Diabetes Admissions	41	36	31	24	27
15: Asthma in Younger Adults Admissions (Ages 18-39)	82	50	42	34	43
16: Lower-Extremity Amputation in Patients with Diabetes	34	34	33	33	29
90: Prevention Quality Overall Composite*	**1,224**	**949**	**843**	**812**	**802**
91: Prevention Quality Acute Composite*	**195**	**137**	**104**	**89**	**101**
92: Prevention Quality Chronic Composite	**1028**	**812**	**739**	**723**	**701**
93: Prevention Quality Diabetes Composite	**414**	**372**	**342**	**315**	**318**

Note: The rates for PQI #5: Chronic Obstructive Pulmonary Disease (COPD) and Asthma in Older Adults and PQI #15: Asthma in Younger Adults have been corrected for CY 2019 to CY 2021.

Table 32 presents the number and percentage of adults who had at least one inpatient admission and the proportion of PQI admissions during the evaluation period. Overall, the percentage of HealthChoice adults with at least one PQI decreased from 0.7% in calendar year 2019 to 0.5% in calendar year 2023. The percentage of participants with at least one inpatient admission decreased from 7.8% in CY 2019 to 5.9% in CY 2023. Among HealthChoice adults with an inpatient admission, the percentage of participants with a PQI-designated admission decreased from 8.8% in CY 2019 to 8.0 in CY 2023.

Table 32. Potentially Avoidable Admission Rates, Participants Aged 18–64 Years (Any Period of Enrollment), with ≥1 Inpatient Admission, CY 2019–CY 2023*

Calendar Year	# of Participants in HealthChoice (A)	# of Participants with ≥1 MCO Admissions (B)	% of Participants with ≥1 MCO Admission C=(B/A)*100	# of Participants with MCO Admission and Any PQI (D)	% of MCO Participants with Any PQI E=(D/A)*100	% of Participants With ≥1 MCO Admission that had a PQI F=(D/B)*100
2019	734,868	57,585	7.8%	5,075	0.7%	8.8%
2020	755,780	55,072	7.3%	4,220	0.6%	7.7%
2021	826,876	58,682	7.1%	4,301	0.5%	7.3%
2022	889,212	55,223	6.2%	4,338	0.5%	7.9%
2023	957,811	56,823	5.9%	4,522	0.5%	8.0%

*This measure includes only MCO inpatient admissions.

† All five years of the evaluation have been updated to account for a calculation error in the last column.

Section V Conclusion

Over the course of the evaluation period, the percentage of HealthChoice participants who saw their assigned PCPs[43] or their assigned PCP's group practice or partner PCP decreased for all MCOs. When the medical home was defined to include any PCPs within their MCO network, all

[43] Excluding Aetna—which only began providing acceptable files in 2021—and Jai—because the percentage of participants with a visit to their assigned PCP could not be reported in CY 2019 due to the use of the billing NPI, which limits ability to capture a participant's assigned PCP.

the MCOs except for Aetna saw that over 70% of their participants had a visit every year from CY 2019 to CY 2021 but not for CY 2020, CY 2022, and CY 2023.

Avoidable ED use declined between CY 2019 and CY 2023, and the proportion of inpatient admissions with any PQI also decreased slightly over the evaluation period. The Department will continue to provide oversight and monitor this trend to ensure that PQI results are consistent with the continuing use of medical homes to provide preventive care.

Section VI. Emphasize Health Promotion and Disease Prevention

Another goal of the HealthChoice program is to improve the quality of health services delivered through the provision of preventive services and chronic care management. This section assesses the demonstration's performance across quality measures—many measures are nationally recognized, such as HEDIS®—in the areas of preventive health and the management of chronic disease, including behavioral health (MHD and SUD). Preventative care and chronic care management services are also assessed based on their relationship with adverse outcomes. For example, preventive and chronic disease care measures—prenatal and postpartum care, asthma-related and depression-related ED visits, use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, diabetes screenings and care—align with Maryland's SIHIS.

Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, in the tables below, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean, while a "-" sign indicates that Maryland's rate is below the national mean.

Preventive Care

HEDIS® Childhood Measures

The Department uses HEDIS® measures to report childhood immunization status and well-child visit rates. Table 33 presents the immunization and well-child measures for the HealthChoice population (MetaStar, Inc., 2024). HealthChoice performed above the national HEDIS® mean for childhood immunizations and well-care visits for children and adolescents (aged 3 to 21 years) from CY 2021 to CY 2023. HealthChoice performed above the national HEDIS® mean for well-child visits (in the first 15 months of life) in CY 2021 and CY 2022 but not in CY 2023. Childhood Immunization Combination 3 and well-care visits for adolescents are part of PHIP.

Table 33. HEDIS® Immunizations and Well-Child Visits: Percentage of HealthChoice Children Compared with the National HEDIS® Mean, CY 2019–CY 2023

HEDIS® Measure	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Childhood Immunization Status: Combination 3					
HealthChoice	75.4%	70.2%	68.4%	68.9%	68.8%
National HEDIS® Mean*	+	-	+	+	+
Well-Child Visits: 15 Months of Life* **					
HealthChoice		61.1%	54.8%	57.5%	58.4%
National HEDIS® Mean*			+	+	-

HEDIS® Measure	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Child and Adolescent Well-Care Visits (WCV), 3-11 years**					
HealthChoice		57.4%	64.3%	61.5%	62.9%
National HEDIS® Mean*			+	+	+
Child and Adolescent Well-Care Visits (WCV), 12-17 years**					
HealthChoice		53.7%	57.4%	54.1%	55.4%
National HEDIS® Mean*			+	+	+
Child and Adolescent Well-Care Visits (WCV), 18-21 years**					
HealthChoice		38.0%	38.5%	35.4%	36.1%
National HEDIS® Mean*			+	+	+
Child and Adolescent Well-Care Visits (WCV), Total 3-21 years**					
HealthChoice		53.1%	57.7%	54.6%	56.2%
National HEDIS® Mean*			+	+	+

*Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean and a "-" sign indicates that Maryland's rate is below the national mean.
** National HEDIS® means were unavailable in measurement year (MY) 2020. Due to significant changes made to the well-child visits measure in MY 2020, NCQA determined a trending break, so the data for CY 2019 are not available.

Immunizations for Adolescents (IMA)

The Department uses the HEDIS® measure to report the immunizations for adolescents (IMA). The IMA is for adolescents who have had one dose of meningococcal vaccine; had one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine; and completed the human papillomavirus (HPV) vaccine series by their 13th birthday (MetaStar Inc., 2024). The CDC recommends that everyone aged 11 to 12 receive at least one dose of the meningococcal vaccine (CDC, 2024) and one dose of the Tdap vaccine (CDC, 2022). The CDC (2021c) also now recommends that 11- to 12-year-olds receive two doses of the HPV vaccine—rather than three doses—to protect against cancers caused by HPV. HPV is a common virus that spreads by sexual contact and can cause cervical cancer in women and penile cancer in men. HPV can also cause anal cancer, throat cancer, and genital warts in both men and women (CDC, 2022a).

Table 34 presents the percentage of HealthChoice adolescents who received the IMA compared to the national HEDIS® mean for CY 2019 through CY 2023. The measure calculates rates for two combinations: Combination 1 (both meningococcal and Tdap vaccines) and Combination 2 (meningococcal, Tdap, and HPV vaccines). There was an overall decrease of 5.6 percentage points from CY 2019 to CY 2023, with a slight increase in CY 2022 for Combination 2. Maryland performed above the national HEDIS® mean for Combination 1 and Combination 2 for the entire measurement period.

Table 34. Percentage of Adolescents HealthChoice Aged 13 Years Who Had Immunizations for Adolescents, Compared with the National HEDIS® Mean, CY 2019–CY 2023

IMA	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Immunizations for Adolescents (IMA), Combo 1					
HealthChoice	87.7%	82.9%	81.2%	84.6%	83.6%
National HEDIS® Mean*	+	+	+	+	+
Immunizations for Adolescents (IMA), Combo 2					
HealthChoice	45.5%	42.7%	41.6%	41.9%	39.9%
National HEDIS® Mean*	+	+	+	+	+

Childhood Lead Testing

The Department is a member of Maryland's Lead Poisoning Prevention Commission, which advises Maryland executive agencies, the General Assembly, and the Governor on lead poisoning prevention in the state. Maryland's plan to reduce childhood lead poisoning includes ensuring that young children receive appropriate lead risk screening and blood lead testing. The Department's 2017 Joint Chairmen's Report describes its efforts through several initiatives (Maryland Department of Health, 2017).

As part of the EPSDT benefit, Medicaid requires that all children receive a blood lead test at 12 and 24 months of age. The Department measures the blood lead testing rates for children aged 12 to 23 months and 24 to 35 months who are enrolled continuously in the same MCO for at least 90 days. A child's lead test must have occurred during the calendar year or the year prior.

To ensure that the children with elevated blood lead levels receive appropriate follow-up, including case management services and home environmental lead testing, the Department provides each MCO with monthly reports on children who received blood lead tests and those found to have elevated blood lead levels. In 2012, the CDC issued the recommendation to 1) remove the "level of concern" language from 10 micrograms per deciliter and replace it with the "reference level" of five micrograms per deciliter, and 2) require statewide testing of all children. Maryland adopted these recommendations for all children born on or after January 1, 2015, and the reference level of five micrograms per deciliter is currently used. However, the CDC updated the reference level to 3.5 micrograms per deciliter following a unanimous vote in May 2021 by the Lead Exposure and Prevention Advisory Committee in favor of recommending the new threshold. In January 2022, the Department, in addition to complying with the EPSDT mandate for blood lead testing, also included blood lead testing (screening) measures in several of its quality assurance activities, including the MFR and PHIP programs (Maryland Department of Health, n.d.a; Maryland Department of Health, 2025).[44]

In CY 2019, over 50,000 children in HealthChoice aged 0 to 6 years received a lead test as reported to the Maryland Department of the Environment (MDE) Childhood Lead Registry (CLR); however, fewer children were tested in the following years. Over 36,000 children received lead tests in CY 2022, but data feeds from the MDE were interrupted in CY 2023, meaning only partial CLR results are available for that year. Table 35 presents the number of children with lead tests in CY 2019 and CY 2023, as well as the number and percentage of those children who had an elevated blood lead level, defined as greater than or equal to five micrograms per deciliter. The percentage of children aged 0 to 6 years with an elevated blood lead level decreased from 2.1% in CY 2019 to 1.8% in CY 2023.[45]

[44] The lead testing measures count lead tests reported through Medicaid administrative data and the CLR, which is maintained by the MDE.

[45] Due to issues with MDE CLR data access, we have only partial blood lead testing data for CY 2023. The number of children with elevated lead levels is undercounted for 2023.

Table 35. HealthChoice Children Aged 0–6 Years with an Elevated Blood Lead Level, CY 2019 and CY 2023

Calendar Year	Number of Children with a Lead Test	Children with an Elevated Blood Lead Level (≥5µg/dL)	
		#	%
2019	54,341	1,123	2.1%
2023	20,622	363	1.8%

Table 36 presents the percentage of children aged 12 to 23 months and 24 to 35 months who received at least one lead test during the calendar year or the prior year. The rate of lead testing for the 12 to 23 months age group fluctuated throughout the evaluation period but decreased by 1.1 percentage points overall. The rate for children aged 24 to 35 months decreased from CY 2019 through CY 2022 before increasing slightly in CY 2023 for an overall decrease of 5.1 percentage points.

Table 36. Percentage of HealthChoice Children Aged 12–23 and 24–35 Months Who Received a Lead Test During the Calendar Year or the Prior Year, CY 2019–CY 2023

Age Group (Months)	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
12–23	62.4%	58.6%	59.1%	60.4%	61.3%
24–35	81.5%	80.3%	76.4%	76.0%	76.4%

There are currently two CHIP Health Service Initiative (HSI) SPAs implemented in Maryland to complement lead testing efforts (MACPAC, 2019). Maryland uses HSI funding to 1) support the state's poison control centers, and 2) operate programs that identify and remove lead hazards in the homes of low-income children and that provide HVS for children with moderate to severe asthma or elevated blood lead levels.

Breast Cancer Screening

Breast cancer is the most prevalent type of cancer among women of all ages (CDC, 2024). In 2021, Maryland's breast cancer incidence rate was 140.8 cases per 100,000 women, compared to the 133.84 cases per 100,000 women nationally (CDC, 2024). When detected early, breast cancer is easier to treat, and women have a greater chance of survival (CDC, 2024). Mammograms are the most effective technique for early detection of breast cancer.

In 2019, NCQA began incorporating Electronic Clinical Data Systems (ECDS) into the breast cancer screening HEDIS® measure to assess its capabilities alongside traditional administrative reporting. ECDS reporting standards allow for patient-centered, quality-focused measures. After assessing ECDS as a method of breast cancer screening reporting, NCQA observed little to no difference from traditional rates (NCQA, 2021). As a result, the traditional breast cancer screening (BCS) measure was retired for CY 2023. Beginning in MY 2025, NCQA will follow the guidelines of the U.S. Preventive Services Task Force and assess breast cancer screening starting at age 40 instead of 50 (U.S. Prevention Services Task Force, 2024).

Table 37 shows the results of the traditional BCS measure, from CY 2019 to its retirement at the end of CY 2022. From CY 2019 to CY 2022, there was a 7.5 percentage point decrease in the percentage of female HealthChoice participants aged 50 to 64 years who received a mammogram for breast cancer screening (MetaStar, Inc., 2024). However, Maryland performed above the national HEDIS® mean throughout the evaluation period.[46]

Table 37. Percentage of Women in HealthChoice Aged 50–64 Years Who Had a Mammogram for Breast Cancer Screening, Compared with the National HEDIS® Mean, CY 2019–CY 2022

	CY 2019	CY 2020	CY 2021	CY 2022
Maryland Percentage	70.6%	65.2%	63.8%	63.1%
National HEDIS® Mean*	+	+	+	+

Note: Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean, while a "-" sign indicates that Maryland's rate is below the national mean.
*The national HEDIS® mean is based on an assessment of women aged 50 to 74 years.

Table 38 shows the percentage of female HealthChoice participants who received a mammogram for breast cancer screening (BCS-E) using the ECDS in CY 2023 (MetaStar, Inc., 2024). The percentage of female HealthChoice participants aged 50 to 64 who received a mammogram for breast cancer screening was 59.2%. Maryland performed above the national HEDIS® mean for CY 2023.

Table 38. Percentage of Women in HealthChoice Aged 50–64 Years Who Had a Mammogram for Breast Cancer Screening, Compared with the National HEDIS® Mean, CY 2023

	CY 2023
Maryland Percentage	59.2%
National HEDIS® Mean*	+

Note: Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean, while a "-" sign indicates that Maryland's rate is below the national mean.

Cervical Cancer Screening

Cervical cancer is preventable and treatable. The CDC recommends cervical cancer screenings for women starting at age 21. According to the National Cancer Institute (NCI) (2024), women aged 21 to 29 years should be screened with a Papanicolaou (Pap) test every three years. Women aged 30 to 65 years can then be screened every five years with Pap and HPV co-testing, or every three years with a Pap test alone. Women with certain risk factors may need to have more frequent screening or continue screening beyond age 65 years.

Table 39 presents the percentage of women aged 21 to 64 years in HealthChoice who received a cervical cancer screening in CY 2019 through CY 2023. There was an overall decrease of 6.2 percentage points during the measurement period, with a slight increase in CY 2021 and CY 2022

[46] CY 2023 could not be included for comparison, as it utilized ECDS.

(MetaStar, Inc., 2024). HealthChoice performed above the national HEDIS® mean in all evaluation years except CY 2020.

Table 39. Percentage of Women in HealthChoice Aged 21–64 Years Who Had a Cervical Cancer Screening, Compared with the National HEDIS® Mean, CY 2019–CY 2023

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Maryland Percentage	63.8%	57.9%	58.1%	59.4%	57.6%
National HEDIS® Mean*	+	-	+	+	+

Note: Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean, while a "-" sign indicates that Maryland's rate is below the national mean.

Colorectal Cancer Screening

According to the CDC's U.S. Cancer Statistics Working Group (2024), colorectal cancer is one of the most common cancers in both men and women. In the U.S. and in Maryland, colorectal cancer is the fourth most diagnosed cancer, as well as the fourth-leading cause of cancer mortality as of 2021 (CDC, 2024). Maryland's rank in overall cancer mortality has been steadily improving compared to other states and the District of Columbia (Maryland Department of Health, 2020; CDC, n.d.). Colorectal cancer deaths can be prevented through screening tests, which find precancerous polyps that can be removed before they become cancerous (CDC, 2024a). The expansion of Medicaid coverage to childless adults and additional parents and caretakers under the ACA removed a major access barrier for age-eligible adults with low income to be screened for colorectal cancer.

Table 40 shows the percentage of HealthChoice participants who received at least one of three appropriate colorectal cancer screenings—fecal occult blood test (FOBT), flexible sigmoidoscopy, or colonoscopy—during the study period.[47] The colorectal cancer screening rate decreased by 0.8 percentage points between CY 2019 and CY 2023.

Table 40. Percentage of HealthChoice Participants Aged 50–64 Years Who Had a Colorectal Cancer Screening, CY 2019–CY 2023

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Percentage of HealthChoice Participants	41.5%	39.3%	39.1%	39.4%	40.7%

[47] HEDIS® defines an appropriate screening as follows: an FOBT during the measurement year, a flexible sigmoidoscopy during the measurement year or the prior four years, a colonoscopy during the measurement year or the prior nine years, a CT colonography during the measurement year or the prior four years, and a FIT-DNA test during the measurement year or the prior two years. Only participants who met the HEDIS® eligibility requirements were included in the population for this measure. These participants were enrolled continuously in Medicaid during the calendar year and the preceding calendar year. Participants must have been enrolled as of the last day of the measurement year and could not have more than one gap of enrollment exceeding 45 days during each year of continuous enrollment. The group of newly enrolled ACA participants did not have the full length of time to complete screenings compared to participants who had been eligible for HealthChoice for a longer period.

Dental Services

Maryland continues to improve its dental program by confronting barriers to providing comprehensive oral health services to Medicaid participants. The Department prepared data for its 2024 Annual Oral Health Legislative Report, which includes Medicaid dental care and access measures from CY 2019 through CY 2023 (Maryland Department of Health, 2024). The Medicaid program delivered oral health services to 613,561 children and adults (aged 0 to 64) during CY 2023—up from 506,830 in CY 2022. In CY 2023, 61.4% of children enrolled in Medicaid for at least 320 days received dental services, which is greater than the national HEDIS® mean.

Table 41 shows the percentage of children who were enrolled in Medicaid for any period and who had at least one dental visit by age group in CY 2019 through CY 2023. The percentage of children aged 0 to 20 years enrolled in Medicaid for any period who had at least one dental visit decreased by 11.0 percentage points from CY 2019 to CY 2020 and then increased from CY 2020 through CY 2023 by 7.8 percentage points. The total number of participants with a dental visit decreased by 3.2 percentage points during the evaluation period.

Table 41. Percentage of Children Aged 0–20 Years Enrolled in Medicaid* for Any Period Who Had at Least One Dental Visit, by Age Group, CY 2019–CY 2023

Age Group (Years)	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
0–3	32.0%	24.3%	28.8%	29.5%	30.9%
4–5	66.6%	52.2%	60.3%	61.6%	60.9%
6–9	70.7%	56.7%	64.2%	66.2%	66.4%
10–14	67.0%	54.0%	61.0%	61.9%	62.6%
15–18	57.3%	48.0%	53.7%	53.9%	54.2%
19–20	38.9%	33.1%	37.8%	37.1%	37.0%
Total	**56.7%**	**45.7%**	**52.1%**	**53.0%**	**53.5%**

* The percentages reported for CY 2023 may be different than what is reported in the Dental JCR due to the timing of the data run.

Table 42 shows the number and percentage of children and adult HealthChoice participants who had any dental visit (service) by age group in CY 2023. Among children aged 0 to 20 years, those aged 6 to 9 years had the highest percentage of any dental visit at 66.4%. In adult participants aged 21 to 64 years, the percentage of any dental service remained constant at 19.7%. Children had a higher percentage of any dental service (53.5%) when compared to adults (19.7%).

Table 42. Number and Percentage of HealthChoice Participants Who Had Any Dental Visits, by Age Group, CY 2023

Age Group (Years)	Total Number of Enrollees	Number with Any Service	Percentage with Any Service
0–3	152,302	47,022	30.9%
4–5	80,089	48,760	60.9%
6–9	160,708	106,663	66.4%
10–14	195,818	122,638	62.6%
15–18	153,677	83,268	54.2%
19–20	66,329	24,555	37.0%

Age Group (Years)	Total Number of Enrollees	Number with Any Service	Percentage with Any Service
Children Total	**808,923**	**432,906**	**53.5%**
21–39	501,110	98,929	19.7%
40–64	355,199	70,141	19.7%
Adult Total	**856,309**	**169,070**	**19.7%**
Summative Total	**1,665,232**	**601,976**	**36.1%**

Table 43 shows the number and percentage of HealthChoice participants who had dental visits by age group and service type in CY 2023. Dental visits with a diagnostic service made up the largest proportion of dental visits for both children and adult participants at 52.1% and 19.3%, respectively. Dental visits with a preventive service made up the second largest proportion of dental visits for both children and adults, followed by dental services with a restorative service. Among children aged 0 to 20 years, those aged 6 to 9 years had the highest percentage of dental visits for any service type. Among adult participants, there was a slight difference in the percentage of dental visits across service type between participants aged 21 to 39 years and participants aged 20 to 64 years.

Table 43. Number and Percentage of HealthChoice Participants Who Had Dental Visits, by Age Group and Type of Service, CY 2023

Age Group (Years)	Total # of Enrollees	# with Diagnostic Service	% with Diagnostic Service	# with Preventative Service	% with Preventative Service	# with Restorative Service	% with Restorative Service
0–3	152,302	46,731	30.7%	43,451	28.5%	2,331	1.5%
4–5	80,089	48,250	60.2%	45,628	57.0%	11,245	14.0%
6–9	160,708	104,870	65.3%	99,893	62.2%	36,726	22.9%
10–14	195,818	119,458	61.0%	114,000	58.2%	34,990	17.9%
15–18	153,677	79,132	51.5%	73,858	48.1%	27,321	17.8%
19–20	66,329	23,248	35.0%	20,660	31.1%	8,104	12.2%
Children Total	**808,923**	**421,689**	**52.1%**	**397,490**	**49.1%**	**120,717**	**14.9%**
21–39	501,110	96,580	19.3%	64,749	12.9%	39,773	7.9%
40 –64	355,199	68,827	19.4%	40,722	11.5%	27,482	7.7%
Adult Total	**856,309**	**165,407**	**19.3%**	**105,471**	**12.3%**	**67,255**	**7.9%**
Summative Total	**1,665,232**	**587,096**	**35.3%**	**502,961**	**30.2%**	**187,972**	**11.3%**

Maternal Health and Reproductive Health

The Department and the HealthChoice MCOs engage pregnant women in care through individualized outreach, community events, and prenatal case management, which aligns with the population health goals under Maryland's SIHIS. Pregnant HealthChoice participants are qualified as a Special Needs Population under Code of Maryland Regulations (COMAR) 10.67.04.08. This requires that they receive timely access to care as well as informational materials, dental benefits, and other resources. The Department also operates a dedicated help

line for pregnant women. Women who contact the help line are referred to Medicaid-funded administrative care coordination units (ACCUs) at local health departments. The ACCUs connect HealthChoice participants to both their MCOs and other services, such as dental services and local home-visiting programs.

Timeliness of Prenatal Care

Early prenatal care is linked to better overall health outcomes for both the mother and child. Table 44 shows the percentage of deliveries for which the mother received a prenatal care visit in the first trimester or within 42 days of HealthChoice enrollment for CY 2019 through CY 2023 (MetaStar, Inc., 2023). HealthChoice outperformed the national HEDIS® mean in every year except for CY 2020.

Table 44. HEDIS® Timeliness of Prenatal Care, HealthChoice Compared with the National HEDIS® Mean, CY 2019–CY 2023

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Percentage of deliveries in which the mother received a prenatal care visit in the 1st trimester or within 42 days of HealthChoice enrollment	88.2%	87.0%	88.9%	87.9%	87.9%
National HEDIS® Mean**	+	-	+	+	+

**Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean, while a "-" sign indicates that Maryland's rate is below the national mean.

Contraceptive Care

Contraception is a highly effective clinical preventive service that can help women fulfill their personal health goals, including preventing teen and unintended pregnancies, as well as achieving healthy spacing of births. The U.S. Department of Health and Human Services (HHS) Office of Population Affairs (OPA) has developed contraceptive care measures that assess the provision of contraception to women aged 15 to 44 years (OPA, n.d.a).

Table 45 presents the percentage of women at risk of unintended pregnancy that are provided the following methods of contraception (OPA, n.d.b):

1. Most effective contraception: female sterilization, hormonal implants, or intrauterine devices or systems (IUD/IUS)
2. Moderately effective contraception: oral pills, injectables, patch, or ring

The table includes women enrolled in HealthChoice aged 15 to 44 as of the end of the calendar year who had no more than one gap in Medicaid enrollment of up to 45 days during the year. The percentage of women enrolled in HealthChoice with at least one type of contraception classified as most effective decreased from 4.7% in CY 2019 to 3.0% in CY 2023. The percentage of women enrolled in HealthChoice with at least one moderately effective type of contraception decreased from 22.1% in CY 2019 to 16.5% in CY 2023.

Table 45. Contraceptive Care Rates, Women Enrolled in HealthChoice Aged 15–44 Years, CY 2019–CY 2023*

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Percentage receiving most effective contraception	4.7%	3.8%	3.5%	3.1%	3.0%
Percentage receiving moderately effective contraception	22.1%	20.7%	19.4%	17.5%	16.5%
Number of HealthChoice women at risk of unintended pregnancy	271,321	309,772	359,074	392,591	379,700

*The codes defining the most or moderately effective contraceptive care were updated by the HHS Office of Population Affairs, changing the data for CY 2019 to CY 2021 from the 2023 HealthChoice Evaluation. Please note that, as of FY 2022, the diaphragm is no longer considered a moderately effective contraception.

Care for Chronic Diseases

The HealthChoice program focuses on improving the quality of health services delivered through chronic care management. This section of the evaluation assesses the demonstration's performance across quality measures—many nationally recognized, such as HEDIS®—in the areas of medication management for people with asthma, diabetes screenings, HIV/AIDS, and behavioral health (MHD and SUD).

Service Utilization and Medication Management for People with Asthma

Asthma is a common chronic disease that affected close to 25 million Americans in 2021, including 4.7 million children under the age of 18 and over 10.1 million aged 35 to 64 years (CDC, 2022d).[48] In 2021, 451,158 adults aged 18 years and older (9.4%) in Maryland had asthma (CDC, 2022d). Moreover, an estimated 139,499 children aged under 18 years (10.7%) in Maryland had asthma in 2021 (CDC, 2023).

The Department monitors service utilization for HealthChoice participants with asthma and uses HEDIS® to report their medication management. The diagnosis of asthma was defined based on MY 2022 HEDIS® clinical criteria for AMR. If asthma medications are used correctly, asthma-related hospitalizations, ED visits, and missed school and workdays decrease (CDC, 2009).

Asthma has one of the largest racial and ethnic health disparities in terms of ED visit rates and is responsible for more ED visits than other major chronic diseases, including hypertension and diabetes (Maryland Department of Health, 2023). As part of Maryland's initiatives, including SIHIS and the CHIP HSI SPA, the Department has made reducing the number of childhood asthma-related ED visits a priority. Through these initiatives, the Department provides asthma prevention and an environmental home visiting program for HealthChoice participants to identify environmental triggers and provide interventions to reduce asthma severity (Maryland Department of Health, 2023a).

[48] The asthma prevalence data comes from the national and state surveillance systems administered by the CDC.

Although asthma is often thought of as predominantly a condition that affects children, the proportion of individuals with asthma who are older increased as a result of the ACA expansion; specifically, persons aged 40 to 64 years now represent the largest share of HealthChoice participants with asthma. See Table 46 for the percentage of HealthChoice participants with an asthma diagnosis[49] and their distribution by race/ethnicity, sex, region, and age group.

Table 46. Demographic Characteristics of HealthChoice Participants with an Asthma Diagnosis, CY 2019–CY 2023

Demographic Characteristic	Calendar Year				
	2019	2020	2021	2022	2023
Race/Ethnicity					
Asian	2.8%	2.9%	2.9%	3.2%	3.3%
Black	49.6%	49.7%	50.9%	50.4%	50.2%
White	31.5%	31.0%	30.9%	30.2%	29.0%
Hispanic	10.5%	10.9%	9.8%	10.5%	11.5%
Native American	1.1%	1.1%	1.1%	1.1%	1.2%
Other	4.4%	4.4%	4.5%	4.7%	4.8%
Sex					
Female	58.1%	60.5%	60.5%	60.5%	60.5%
Male	41.9%	39.5%	39.5%	39.5%	39.5%
Region					
Baltimore City	24.9%	25.0%	26.0%	25.8%	23.3%
Baltimore Suburban	29.4%	29.3%	29.6%	30.0%	30.3%
Eastern Shore	10.3%	9.8%	10.1%	9.9%	9.4%
Southern Maryland	4.9%	4.7%	4.6%	4.5%	4.9%
Washington Suburban	21.6%	22.1%	20.6%	20.4%	22.9%
Western Maryland	8.8%	9.0%	9.1%	9.3%	9.1%
Out of State	0.1%	0.1%	0.1%	0.1%	0.0%
Age Group (Years)					
5–9	16.0%	12.3%	10.8%	12.7%	13.5%
10–14	15.7%	13.6%	12.5%	12.0%	12.0%
15–18	7.1%	7.1%	7.3%	7.4%	7.2%
19–20	2.2%	2.3%	2.3%	2.3%	2.4%
21–39	18.9%	21.3%	22.4%	21.8%	22.4%
40–64	40.1%	43.3%	44.7%	43.8%	42.4%
Total Number of Participants	**54,767**	**51,474**	**47,329**	**42,429**	**38,244**

* Race and ethnicity values were calculated using the enhanced race/ethnicity variable implemented in 2023 and updated for the entire measurement period. Thus, race and ethnicity totals will not match previous HealthChoice Evaluation results.

[49] The methodology for identifying participants with asthma was revised due to the HEDIS® measure Medication Management for People with Asthma (MMA) being retired and instead using AMR. Diagnosis codes and medication lists were revised.

Table 47 presents the number and percentage of HealthChoice participants with an asthma diagnosis who had an ambulatory care visit. The proportion of participants with an ambulatory care visit decreased by 0.9 percentage points between CY 2019 and CY 2023.

Table 47. Number and Percentage of HealthChoice Participants with an Asthma Diagnosis Who Had an Ambulatory Care Visit, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Ambulatory Care Visit	
		Number	Percentage of Total
2019	55,106	53,892	97.8%
2020	51,902	50,027	96.4%
2021	47,755	46,416	97.2%
2022	42,429	41,269	97.3%
2023	38,244	37,070	96.9%

Table 48 presents the percentage of HealthChoice participants with asthma who had at least one outpatient ED visit for any diagnosis and at least one ED visit with asthma as the primary diagnosis. Overall, the ED visit rate for participants with asthma decreased from 46.7% to 43.5% during the evaluation period. Asthma-related ED visit rates declined from 10.4% in CY 2019 to 9.3% in CY 2022 before increasing to 10.8% in CY 2023.

Table 48. HealthChoice Participants Who Had an Outpatient ED Visit, by Asthma-Related Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One ED Visit		At Least One ED Visit with Asthma Primary Diagnosis	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total
2019	55,106	25,726	46.7%	5,736	10.4%
2020	51,902	19,633	37.8%	3,627	7.0%
2021	47,755	19,627	41.1%	3,682	7.7%
2022	42,429	18,133	42.7%	3,942	9.3%
2023	38,244	16,630	43.5%	4,144	10.8%

Table 49 shows the number and percentage of HealthChoice participants with asthma who had at least one inpatient admission, as well as participants with asthma who had at least one inpatient admission with asthma as the primary diagnosis. The percentage of participants with asthma who had an inpatient admission decreased from 13.0% to 11.9% during the evaluation period. The percentage of participants with asthma who had an inpatient admission with asthma as the primary diagnosis decreased from 1.6% in CY 2019 to 0.9% in CY 2020 but gradually increased back to 1.6% in CY 2023.

Table 49. HealthChoice Participants Who Had an Inpatient Admission, by Asthma-Related Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Inpatient Admission		At Least One Inpatient Admission with Asthma Primary Diagnosis	
		Number	Percentage of Total	Number of Participants	Percentage of Total
2019	55,106	7,167	13.0%	876	1.6%
2020	51,902	5,704	11.0%	469	0.9%
2021	47,755	5,742	12.0%	546	1.1%
2022	42,429	4,800	11.3%	522	1.2%
2023	38,244	4,536	11.9%	624	1.6%

Asthma Medication Ratio (AMR) for People with Asthma

Table 50 presents the results for AMR: specifically, a logistic regression using HEDIS® standard measures[50] that examines ED utilization among HealthChoice asthma patients between the ages of 5 and 64 years with a positive AMR versus those without a positive AMR from CY 2019 to CY 2023.[51] Controller medications are medications that reduce the inflammation in the lungs, and preventing asthma symptoms (NIH, 2022). A positive AMR is defined as a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Overall, HealthChoice participants aged 5 to 64 years who had an AMR of at least 0.50 during the calendar year were less likely to experience an ED visit with a primary diagnosis of asthma that same calendar year compared to participants who had an AMR below 0.50. Similarly, participants who had an AMR of at least 0.50 the prior year (i.e., AMR lagged) were less likely to experience an ED visit with a primary diagnosis of asthma the following calendar year compared to participants who had an AMR below 0.50 the prior year. The regression controlled for demographic characteristics (race/ethnicity, age, and gender), comorbidity levels, participant region, and the number of inpatient admissions the previous year. The population only includes participants with persistent asthma, defined as those who had asthma encounters in the measurement year or the year prior. It is important to note that AMR is a measure of medication load of the entire year, while an asthma-related ED visit can occur at any point during the measurement year.

Participants who had a positive AMR had 42.5% lower odds of having an ED visit with a primary diagnosis of asthma than those who did not (OR 0.575, $p<0.001$). Similarly, participants who had a positive AMR the previous year had 20.1% lower odds of experiencing an ED visit with a primary diagnosis of asthma during the current measurement year (OR 0.799, $p<0.001$). Increased inpatient admissions the previous year, regardless of associated diagnosis, increased the odds of having an asthma-related ED visit. Each additional inpatient stay increased a participant's odds of an asthma-related ED visit by 19.9% (OR 1.199, $p<0.001$). Young

[50] This measure was calculated using the HEDIS® proprietary software from Cognizant.
[51] CY 2018 data is included as a look back period.

participants had higher odds of ED use; with each additional year of age, participants were 4.1% less likely to have an ED visit (OR 0.959 $p<0.001$). Enrollees in the Families & Children coverage category and the ACA expansion coverage category had increased odds of an asthma-related ED visit compared to the ABD coverage category (OR 1.422, $p<0.001$; OR 1.975, $p<0.001$).

Residents in all regions, except for out of state, were less likely to have an ED visit than Baltimore City residents, with the Washington Suburban area having the lowest odds (OR 0.538 $p<0.001$). Asian, Hispanic, Black, and Other participants were more likely to have an ED visit compared to White participants; further, Black participants were more than two times as likely (OR 2.775, $p<0.001$). All comorbidity groups[52] were between three and four times more likely to have an ED visit with a primary diagnosis of asthma than participants with low comorbidity ($p<0.001$).

Model 2 includes an interaction term that estimates the impact of having a current AMR greater than 0.50 and an AMR greater than 0.50 in the previous calendar year (i.e., AMR x AMR lagged) on the probability of experiencing an ED visit in the current measurement year. According to the logistic regression, having a positive AMR in both the current and previous calendar year reduced the probability of experiencing an ED visit by an additional 42.9% (OR 0.571, $p< 0.001$).

To establish direction of the relationship and that the main independent variable is effectuating the dependent variable, the independent variable must occur prior to the dependent variable (i.e., have temporal precedence). Without temporal precedence, there is a risk that the relationship is reversed in that the dependent variable is driving or causing the relationship. Therefore, it is arguable there are ambiguous temporal precedence issues surrounding an enrollee's current AMR status and their ED utilization because AMR is assessed over the entire year whereas an asthma-related ED visit is a point-in-time measurement. However, the direction and strength of the odds ratio of the AMR and lagged AMR variables supports a conclusion that, for most participants, achieving a positive AMR is not caused by experiencing an asthma-related ED visit.

Table 50. Associations between Asthma Medication Ratio and ED Visits with a Primary Asthma Diagnosis, HealthChoice Participants Aged 5–64 Years, CY 2019–CY 2023

Variables	ED Visit with Asthma as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95 % CI		OR	95 % CI	
Asthma Med Ratio (AMR)	0.575***	0.54	0.62	0.803***	0.73	0.88
AMR Lagged	0.799 ***	0.74	0.86			
AMR X AMR_lag				0.571***	0.52	0.63
Age	0.959***	0.96	0.96	0.960***	0.96	0.96
Female	1.072	0.994	1.16	1.071	0.99	1.16
Coverage Category						
Families & Children	1.422***	1.25	1.62	1.412***	1.24	1.61

[52] A person's comorbidity level is estimated based on the Johns Hopkins Adjusted Clinical Groups (ACG) methodology. For this analysis, Hilltop assigned individuals to one of four comorbidity categories (Low, Moderate, High, Very High) based on their claims records in the measurement years (2019 to 2023).

Variables	ED Visit with Asthma as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95 % CI		OR	95 % CI	
MCHP	1.015	0.86	1.20	1.012	0.86	1.20
ACA	1.975***	1.72	2.27	1.971***	1.71	2.27
Region†						
Baltimore Suburban	0.624***	0.57	0.68	0.627***	0.57	0.69
Eastern Shore	0.606***	0.52	0.70	0.612***	0.53	0.71
Southern Maryland	0.596***	0.49	0.72	0.602***	0.50	0.73
Washington Suburban	0.538***	0.48	0.60	0.539***	0.48	0.60
Western Maryland	0.595***	0.50	0.71	0.598***	0.50	0.71
Out of State	1.611	0.46	5.60	1.668	0.49	5.72
Race/Ethnicity†						
Asian	1.786***	1.38	2.31	1.776***	1.38	2.29
Black	2.775***	2.47	3.11	2.737***	2.44	3.07
Hispanic	1.718***	1.46	2.02	1.693***	1.44	1.99
Native American	1.363	0.96	1.93	1.353	0.96	1.91
Other	1.714***	1.41	2.08	1.711***	1.41	2.08
Comorbidity Score†						
Moderate Comorbidity	3.660***	3.21	4.17	3.662***	3.22	4.17
High Comorbidity	4.815***	4.19	5.54	4.823***	4.19	5.55
Very-High Comorbidity	4.736***	4.00	5.61	4.736***	4.00	5.61
Inpatient Stays Count _lag	1.199***	1.13	1.27	1.199***	1.13	1.27
Year†						
2021	1.136**	1.05	1.23	1.166***	1.08	1.26
2022	1.351***	1.25	1.46	1.379***	1.28	1.49
2023	1.587***	1.47	1.72	1.621***	1.50	1.76
Constant	0.048	0.04	0.06	0.044	0.04	0.06

*** p<.001, **p<.01, *01, *p<.05

†, Reference Groups: Aged, Blind, and Disabled (ABD), Baltimore City, White, Low, 2019

Table 51 examines the relationship between HealthChoice participants aged 5 to 64 years with a positive medication ratio and asthma-related inpatient stays compared to those without a positive AMR.

There was no association between a positive AMR and the odds of experiencing an asthma-related inpatient admission. Participants with a positive AMR the previous year were 36.3% less likely to have an asthma-related inpatient stay in the current measurement year (OR 0.637 p<0.001). Each additional ED visit the prior year was associated with a 3.4% increase in the likelihood of incurring an asthma-related inpatient stay (p<0.01). Participants in all regions were less likely to have an inpatient admission compared to participants in Baltimore City, with participants in Eastern Shore having the lowest odds (OR 0.379, p<0.001). Black participants, Hispanic participants and those categorized as "Other" were more likely to incur an inpatient admission compared to White participants, with Black participants being over two times are likely to have an asthma-related inpatient admission (OR 2.689, p<0.001). Higher comorbidities were associated with higher odds of inpatient admission; participants with a very high

comorbidity score had over 55 times higher odds of incurring an inpatient admission (OR 55.585, $p<0.001$).

Model 2 added an interaction term that estimates the impact of having an AMR greater than 0.50 in the previous and current calendar years on the probability of incurring an inpatient stay in the present. Unlike in the first regression without the interaction term, a positive AMR was associated with a 35.5% increase in the probability of having an inpatient stay the same year (OR 1.355, $p<0.05$). However, having a positive AMR the previous year and in the current year reduced the probability of having an inpatient stay by an additional 62.3% (OR 0.377, $p< 0.001$). Taken together, holding other factors constant, the probability would decrease 26.8% if an individual had a positive AMR the previous year and in the current year.

Similar to the ED visit logistic regression, there are ambiguous temporal precedence issues. However, the diverging odds ratios of the positive AMR versus the lagged AMR support the conclusion that an inpatient stay could initiate the need to increase the amount of asthma controller medications prescribed. Further, having a positive AMR the previous year lowers the odds of an inpatient stay the following year, indicating that high asthma controller medication load has lasting positive effects.

Table 51. Associations between Asthma Medication Ratio and Inpatient Admissions with a Primary Asthma Diagnosis, HealthChoice Participants Aged 5–64 Years, CY 2019–CY 2023

Variables	Inpatient Stay with Asthma as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95 % CI		OR	95 % CI	
Asthma Med Ratio (AMR)	0.807	0.62	1.05	1.355*	1.03	1.78
AMR Lagged	0.637**	0.49	0.83			
AMR X AMR_lag				0.377***	0.28	0.50
Age	0.945***	0.94	0.95	0.946***	0.94	0.96
Female	1.065	0.86	1.33	1.066	0.85	1.33
Coverage Category						
Families & Children	1.298	0.93	1.80	1.271	0.92	1.77
MCHP	0.913	0.58	1.43	0.905	0.58	1.42
ACA	1.062	0.69	1.62	1.052	0.69	1.61
Region†						
Baltimore Suburban	0.669**	0.51	0.89	0.676**	0.51	0.90
Eastern Shore	0.379***	0.23	0.63	0.389***	0.23	0.65
Southern Maryland	0.491*	0.26	0.91	0.500*	0.27	0.93
Washington Suburban	0.644**	0.47	0.88	0.648**	0.47	0.89
Western Maryland	0.400**	0.22	0.73	0.405**	0.22	0.74
Race/Ethnicity†						
Asian	1.511	0.67	3.41	1.495	0.66	3.37
Black	2.689***	1.84	3.93	2.613***	1.79	3.82
Hispanic	1.955**	1.20	3.19	1.906*	1.17	3.12
Native American	1.511	0.33	6.85	1.501	0.33	6.83
Other	2.084*	1.14	3.80	2.073*	1.14	3.78

Variables	Inpatient Stay with Asthma as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95 % CI		OR	95 % CI	
Comorbidity Score†						
Moderate Comorbidity	10.838***	4.44	26.43	10.817***	4.43	26.40
High Comorbidity	30.371***	12.47	73.99	30.458***	12.49	74.26
Very-High Comorbidity	55.585***	22.27	138.75	55.458***	22.20	138.54
ED Visits _lagged	1.034**	1.01	1.06	1.035**	1.01	1.06
Year†						
2021	1.333*	1.01	1.76	1.406*	1.06	1.86
2022	1.052	0.78	1.42	1.093	0.81	1.47
2023	1.589**	1.20	2.10	1.657***	1.25	2.19
_cons	0.001	0.00	0.00	0.001	0.00	0.00

*** $p<.001$, ** $p<.01$, * $p<.05$

Reference Groups: Aged, Blind, and Disabled (ABD), Baltimore City, White, Low, 2019

Comprehensive Diabetes Care

The Department combines health care utilization and quality measures to evaluate HealthChoice's performance in diabetes management. This section of the report analyzes demographic characteristics of HealthChoice participants with diabetes, as well as measures of their outpatient ED visits, inpatient admissions, and ambulatory care service utilization. HEDIS® clinical criteria for the Comprehensive Diabetes Care measure identified participants with diabetes. In addition, this section investigates whether the completion of recommended diabetes screenings affects ED service use.

Table 52 shows HealthChoice participants with a diabetes diagnosis according to the numbers and percentages within categories of race/ethnicity, sex, region, and age group. Black participants with diabetes exceeded the proportion of White participants with diabetes by more than 20 percentage points throughout the evaluation period. The proportion of White HealthChoice participants with diabetes decreased by 2.4 percentage points during the evaluation period, while the proportion of Black participants decreased by 1 percentage point. The proportion among the "Other" race category increased from 3.6% in CY 2019 to 3.8% in CY 2023. The proportion of male HealthChoice participants with diabetes decreased from 43.8% in CY 2019 to 43.2% in CY 2023. The distribution of participants with diabetes between age groups stayed relatively consistent throughout the evaluation period.

Table 52. Demographic Characteristics of HealthChoice Participants with Diabetes, CY 2019–CY 2023

Demographic Characteristic	Calendar Year				
	2019	2020	2021	2022	2023
Race/Ethnicity					
Asian	6.2%	6.5%	6.7%	7.0%	6.9%
Black	51.8%	51.6%	51.5%	51.2%	50.8%
White	29.5%	28.8%	27.9%	27.4%	27.1%
Hispanic	8.1%	8.7%	9.2%	9.7%	10.5%

Demographic Characteristic	Calendar Year				
	2019	2020	2021	2022	2023
Native American	0.8%	0.8%	0.9%	0.9%	0.8%
Other	3.6%	3.7%	3.8%	3.9%	3.8%
Sex					
Female	56.2%	55.8%	56.0%	56.4%	56.9%
Male	43.8%	44.2%	44.0%	43.6%	43.2%
Region					
Baltimore City	22.6%	22.0%	21.4%	20.6%	19.8%
Baltimore Suburban	28.0%	28.1%	28.1%	28.3%	28.6%
Eastern Shore	9.8%	9.6%	9.3%	9.2%	9.3%
Southern Maryland	5.3%	5.3%	5.4%	5.5%	5.5%
Washington Suburban	26.2%	26.9%	27.8%	28.2%	28.6%
Western Maryland	8.0%	7.9%	8.0%	8.2%	8.2%
Out of State	0.2%	0.1%	0.1%	0.1%	0.1%
Age Group (Years)					
18-40	22.3%	22.3%	22.9%	23.4%	23.7%
41-64	77.7%	77.7%	77.1%	76.6%	76.4%
Total Number of Participants	**58,810**	**59,456**	**64,920**	**70,131**	**73,790**

* Race and ethnicity values were calculated using the enhanced race/ethnicity variable implemented in 2023 and updated for the entire measurement period. Thus, race and ethnicity totals will not match previous HealthChoice Evaluation results.

**"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Table 53 presents the number and percentage of HealthChoice participants with diabetes who had an ambulatory care visit. The rate decreased from 94.9% in CY 2019 to 94.3% in CY 2023.

Table 53. Number and Percentage of HealthChoice Participants with Diabetes Who Had an Ambulatory Care Visit, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Ambulatory Care Visit	
		Number	Percentage of Total
2019	58,767	55,787	94.9%
2020	59,423	55,891	94.1%
2021	64,857	61,915	95.5%
2022	70,131	66,376	94.6%
2023	73,790	69,600	94.3%

Table 54 presents the number and percentage of HealthChoice participants with diabetes who had an outpatient ED visit. The percentage of participants with diabetes who had an ED visit decreased from 44.0% in CY 2019 to 37.6% in CY 2023.

Table 54. Number and Percentage of HealthChoice Participants with Diabetes Who Had an Outpatient ED Visit, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One ED Visit	
		Number	Percentage of Total
2019	58,767	25,846	44.0%
2020	59,423	22,370	37.6%
2021	64,857	25,602	39.5%
2022	70,131	26,435	37.7%
2023	73,790	27,751	37.6%

Table 55 presents the number and percentage of HealthChoice participants with diabetes who had at least one inpatient admission. This measure decreased during the evaluation period—from 20.3% in CY 2019 to 17.0% in CY 2023—indicating the potential success of the HealthChoice program in proactively targeting diabetes management.

Table 55. Number and Percentage of HealthChoice Participants with Diabetes Who Had an Inpatient Admission, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Inpatient Admission	
		Number	Percentage of Total
2019	58,767	11,956	20.3%
2020	59,423	11,519	19.4%
2021	64,857	12,772	19.7%
2022	70,131	11,957	17.0%
2023	73,790	12,522	17.0%

The CDC recommends that people with diabetes monitor blood glucose levels, look out for damaged nerve tissue in the eyes that may threaten sight, and check their blood pressure regularly in order to control their diabetes (CDC, 2024). Table 56 presents the annual HealthChoice performance on these measures for CY 2019 through CY 2023 (MetaStar, 2024). HEDIS® analyses use medical chart reviews, whereas the diabetes analyses presented in the rest of this section rely on administrative data (MCO encounter and FFS claims). HealthChoice performed above the national HEDIS® average on HbA1c testing in CY 2019 but fell below the average in CY 2020 before surpassing it again in CY 2021. This measure was retired in CY 2022. HealthChoice also fell below the HEDIS® average on eye (retinal) exams from CY 2019 through CY 2023. For controlling HbA1c, HealthChoice was above the HEDIS® average for the entire measurement period. For controlling blood pressure, HealthChoice was above the HEDIS® average in CY 2022 only.

Table 56. Percentage of HealthChoice Members Aged 18–64 Years with Diabetes Who Received Comprehensive Diabetes Care, Compared with the National HEDIS® Average, CY 2019–CY 2023

HEDIS® Measure	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Eye (Retinal) Exam					
HealthChoice	54.7%	51.7%	50.3%	53.1%	55.6%
National HEDIS® Average	-	-	-	-	-
HbA1c Test*					
HealthChoice	88.3%	82.9%	87.1%		
National HEDIS® Average	+	-	+		
HbA1c Control					
HealthChoice	55.6%	51.0%	56.3%	57.3%	59.0%
National HEDIS® Average	+	+	+	+	+
Blood Pressure Control**					
HealthChoice		55.9%	57.5%	63.6%	66.7%
National HEDIS® Average		-	-	+	-

Note: Because of the NCQA restrictions, national HEDIS® means cannot be published. Therefore, a "+" sign indicates that Maryland's rate is above the national HEDIS® mean, while a "-" sign indicates that Maryland's rate is below the national mean.
*This measure was retired in CY 2022.
**National HEDIS® means were unavailable in MY 2019. Due to significant changes made to measure in MY 2020, NCQA determined a trending break, so the data for CY 2019 are not available.

Under the HealthChoice demonstration waiver, the Department received approval to expand coverage of the National DPP Lifestyle Change program to all eligible HealthChoice participants as of September 1, 2019. See Section VII for more information on the DPP and an analysis of its impact.

Diabetes Screenings and Utilization

Table 57 presents the logistic regression results for estimating the odds of a HealthChoice participant with diabetes who received an eye (retinal) exam or a hemoglobin A1c (HbA1c) test —using HEDIS® standard screening measures—of having a diabetes-related ED visit that year or the following year, as compared with the odds of a participant who did not have a screening having a diabetes-related ED visit. In addition to the screening conditions, the regression controlled for demographic characteristics (race/ethnicity and sex), comorbidity levels,[53] and region of residence (Model 1). Model 2 also controlled for whether the enrollee had an ED visit with a primary diagnosis of diabetes the previous year.

In Model 1, participants who received an HbA1c test had 24.0% increased odds of experiencing a diabetes-related ED visit compared to those who did not receive a test (p<0.001). However,

[53] A person's comorbidity level is estimated based on the Johns Hopkins ACG methodology. For this analysis, Hilltop assigned individuals to one of five comorbidity categories (Low, Moderate, High, Very High, Other) based on their claim records in the measurement years (2019 to 2023).

receiving either an HbA1c test or an eye exam the previous year reduced the likelihood of having a diabetes-related ED visit the next year by 20.4% and 11.1%, respectively (p<0.001). Older participants had lower odds of having an ED visit compared to younger participants (p<0.001), and female participants were 26.1% less likely to experience a diabetes-related ED visit compared to males (p<0.001). The likelihood that those in the MCHP and ACA coverage categories would have a diabetes-related ED visit did not differ in a statistically significant way from participants in the ABD coverage category. However, participants in the Families & Children coverage groups were 11.7% less likely than those in the ABD group to experience an ED visit with a primary diagnosis of diabetes (p<0.01).

Residents of the Baltimore Suburban (p<0.001), Washington Suburban (p<0.001), and Western Maryland (p<0.01) regions all had between 16.9% and 29.9% lower odds of experiencing a diabetes-related ED visit compared to Baltimore City residents. Asian participants were 37.8% less likely to incur a diabetes-related ED visit compared to White participants (p<0.001). However, Black participants were 39.3% more likely to experience a diabetes-related ED visit (p<0.001). All participants with moderate to very high comorbidity scores were more likely to incur a diabetes-related ED visit compared to those with a low comorbidity score (p<0.001); in particular, participants scoring very high were over 39 times more likely to have an ED visit compared to participants scoring low (OR= 39.121, p<0.001).

Model 2 added a lagged dependent variable that captured whether the participant had a diabetes-related ED visit the previous year. It also added an interaction term that reflects whether the participant had an eye exam and an HbA1c test in the same year. With the addition of these variables to the analysis, receiving an eye test's impact on the odds of experiencing a diabetes-related ED visit reached statistical significance (OR= 0.868, p<0.05). Enrollees who incurred a diabetes-related ED visit the previous year were over 5 times more likely to experience one the following year (OR=5.889, p<0.001). Receiving both an eye exam and an HbA1c test in the same year had no statistically significant impact on the odds of having a diabetes-related ED visit.

These results suggest that receiving an HbA1c test does not prevent ED visits for those with existing diabetes health issues. However, the direction and strength of the odds ratio on the lagged HbA1c test and eye exam variables suggest that previous screenings may protect participants from diabetes-related ED visits the following year.

Table 57. Associations between Diabetes Screenings and ED Visits with a Primary Diagnosis of Diabetes, HealthChoice Participants Aged 5–64 Years, CY 2019–CY 2023

Effect	ED Visit with Diabetes as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95% CI		OR	95% CI	
Screenings						
HbA1c Test	1.240***	1.17	1.31	1.244***	1.16	1.33
Eye exam	0.973	0.93	1.02	0.868*	0.76	0.99
HbA1c Test and Eye exam				1.146	0.99	1.32
HbA1c Test (1 year Lag)	0.796***	0.75	0.84	0.735***	0.70	0.78

Effect	ED Visit with Diabetes as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95% CI		OR	95% CI	
Eye exam (1 year Lag)	0.889***	0.85	0.93	0.875***	0.84	0.92
ED Visit with Diabetes PDX (1 year Lag)				5.889***	5.55	6.25
Age	0.949***	0.95	0.95	0.958***	0.96	0.96
Female†	0.739***	0.70	0.78	0.782***	0.75	0.82
Last Coverage Category†						
Families & Children	0.883**	0.82	0.95	0.908**	0.85	0.97
MCHP	0.855	0.71	1.03	0.867	0.72	1.05
ACA	1.001	0.94	1.06	0.999	0.95	1.05
Region†						
Baltimore Suburban	0.804***	0.75	0.86	0.841***	0.79	0.89
Eastern Shore	0.994	0.91	1.09	0.984	0.91	1.07
Southern Maryland	1.074	0.96	1.20	1.089	0.99	1.20
Washington Suburban	0.701***	0.65	0.75	0.742***	0.69	0.79
Western Maryland	0.831**	0.75	0.92	0.866**	0.79	0.95
Out of State	0.868	0.47	1.61	0.888	0.50	1.57
Race/Ethnicity†						
Asian	0.622***	0.53	0.73	0.653***	0.56	0.76
Black	1.393***	1.31	1.48	1.347***	1.27	1.42
Hispanic	1.013	0.91	1.13	1.036	0.94	1.14
Native American	0.968	0.71	1.32	0.961	0.73	1.27
Other	0.981	0.85	1.13	0.986	0.87	1.12
Comorbidity Score†						
Moderate	4.966***	3.63	6.80	5.518***	4.01	7.59
High	14.943***	10.92	20.46	15.675***	11.41	21.54
Very High	39.121***	28.58	53.55	36.425***	26.52	50.02
Year†						
2021	0.921**	0.87	0.97	0.961	0.90	1.02
2022	0.849***	0.80	0.90	0.884***	0.83	0.94
2023	0.852***	0.81	0.90	0.909**	0.86	0.96
Constant	0.047	0.03	0.07	0.023	0.02	0.03

*** $p<.001$, ** $p<.01$, * $p<.05$

†, Reference Groups: Aged, Blind, and Disabled Baltimore City, White, Low, 2020

Table 58 presents the results of a logistic regression that examined the odds of a HealthChoice participant with diabetes who received an eye exam or HbA1c test having a diabetes-related inpatient admission the current year and the following year, as compared with a participant who did not receive a screening. Similar to the diabetes ED visit analysis, the regression controlled for demographic characteristics (race/ethnicity and sex), comorbidity levels,[54] and region of

[54] A person's comorbidity level is estimated based on the Johns Hopkins ACG methodology. For this analysis, Hilltop assigned individuals to one of five comorbidity categories (Low, Moderate, High, Very High, Other) based on their claim's records in the measurement years (2019 to 2023).

residence (Model 1). Model 2 also controlled for whether the enrollee had an inpatient stay with a primary diagnosis of diabetes the previous year.

In Model 1, participants who received an HbA1c test were 24.3% less likely to have a diabetes-related inpatient stay that year compared to those who did not receive an HbA1c test (p<0.001). Having an eye exam also reduced the odds of an inpatient admission for diabetes by 10.6% (p<0.001). Receiving an HbA1c test the previous year reduced the likelihood of experiencing a diabetes-related inpatient stay the following year by 13.2% (p<0.001). Furthermore, receiving an eye exam the previous year reduced the likelihood of experiencing a diabetes-related inpatient stay the following year (OR= 0.937, p<0.05). Older participants were less likely to experience a diabetes inpatient stay, as were female participants (p<0.001). The coverage category Families and Children had a decreased likelihood of incurring an inpatient stay with a diabetes primary diagnosis by 10.2% compared to those in the ABD coverage category (p<0.05).

Residents in Baltimore Suburban, Eastern Shore, and Western Maryland had lower odds of experiencing a diabetes-related inpatient stay compared to the reference group of Baltimore City residents. Eastern Shore residents were 36.2% (p<0.001) less likely to have one than Baltimore City residents, the most significant odds reduction for any region. Asian and Hispanic participants were less likely to incur a diabetes-related inpatient stay, with Asian participants having 42.7% lower odds compared to White participants, and Hispanic enrollees having 33.1% lower odds (p<0.001). Compared to participants with a low comorbidity score, participants with a moderate to very high comorbidity score were roughly between 3 and 300 times more likely to experience a diabetes-related inpatient stay (p<0.001).

As in the ED visit analysis, Model 2 added a lagged dependent variable that captured whether the enrollee had a diabetes-related inpatient stay the previous year and an interaction variable that shows whether they had an HbA1c test and an eye exam in the same year. In Model 2, there was no statistically significant interactive impact of receiving both an eye exam and an HbA1c test. Enrollees who incurred a diabetes-related inpatient stay the previous year were over 9 times more likely to experience one the following year (OR=9.366, p<0.001). In Model 2, the odds ratio for the HbA1c test and eye exam stayed consistent with the Model 1 results, as did the odds ratio for the lagged screenings.

Unlike the diabetes ED visit analysis, receiving an HbA1c test is associated with reduced odds of existing diabetes health issues leading to an inpatient hospital admission. Furthermore, the direction and strength of the odds ratio on the lagged HbA1c test and eye exam variables indicate that this protection may carry over to the following year.

Table 58. Associations between Diabetes Screenings and Inpatient Admissions with a Primary Diagnosis of Diabetes, HealthChoice Participants Aged 5–64 Years, CY 2019–CY 2023

Effect	Inpatient Admission with Diabetes as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95% CI		OR	95% CI	
Screenings						
HbA1c Test	0.757***	0.71	0.81	0.758***	0.70	0.82

Effect	Inpatient Admission with Diabetes as a Primary Diagnosis					
	Model 1			Model 2		
	OR	95% CI		OR	95% CI	
Eye exam	0.894***	0.84	0.95	0.825*	0.71	0.96
HbA1c Test and Eye exam				1.065	0.90	1.25
HbA1c Test (1 year Lag)	0.868***	0.81	0.93	0.895**	0.83	0.96
Eye exam (1 year Lag)	0.937*	0.88	0.99	0.927*	0.87	0.99
Inpt Admit with Diabetes PDX (1 year Lag)				9.366***	8.68	10.10
Age	0.939***	0.94	0.94	0.950***	0.95	0.95
Female†	0.694***	0.65	0.74	0.755***	0.71	0.80
Last Coverage Category†						
Families & Children	0.898*	0.82	0.98	0.968	0.89	1.05
MCHP	0.889	0.66	1.20	0.876	0.65	1.18
ACA	0.979	0.91	1.06	1.002	0.94	1.07
Region†						
Baltimore Suburban	0.843***	0.77	0.92	0.883**	0.81	0.96
Eastern Shore	0.638***	0.56	0.73	0.691***	0.62	0.77
Southern Maryland	0.921	0.79	1.08	0.948	0.83	1.09
Washington Suburban	0.923	0.84	1.01	0.954	0.88	1.04
Western Maryland	0.732***	0.64	0.84	0.795***	0.70	0.90
Out of State	1.107	0.58	2.12	1.164	0.63	2.16
Race/Ethnicity†						
Asian	0.573***	0.45	0.72	0.668***	0.54	0.83
Black	1.026	0.95	1.11	1.040	0.97	1.12
Hispanic	0.669***	0.58	0.78	0.754***	0.66	0.87
Native American	1.082	0.73	1.61	1.121	0.80	1.57
Other	0.901	0.75	1.09	0.967	0.82	1.14
Comorbidity Score†						
Moderate	3.168**	1.41	7.14	3.825**	1.69	8.63
High	45.961***	20.57	102.70	54.199***	24.23	121.25
Very High	307.937***	137.85	687.89	317.588***	142.06	709.98
Year†						
2021	0.925*	0.86	0.99	0.984	0.91	1.07
2022	0.881***	0.82	0.94	0.943	0.87	1.02
2023	0.859***	0.80	0.92	0.930	0.86	1.00
Constant	0.015	0.01	0.03	0.005	0.00	0.01

*** $p<.001$, ** $p<.01$, * $p<.05$

†, Reference Groups: Aged, Blind, and Disabled, Baltimore City, White, Low, 2020

HIV/AIDS

The Department continuously monitors service utilization for HealthChoice participants with HIV/AIDS. This section of the report presents the enrollment distribution of HealthChoice participants with HIV/AIDS by age group and race/ethnicity, as well as measures of ambulatory care service utilization, outpatient ED visits, cluster of differentiation 4 (CD4) testing, and viral load testing. CD4 testing is used to determine how well the immune system is functioning in

individuals diagnosed with HIV. The viral load test monitors the progression of the HIV infection by measuring the level of immunodeficiency virus in the blood. Antiretroviral Therapy (ART) is a combination of HIV medications used to reduce the viral load of HIV. ART is recommended for everyone with HIV and should begin as soon as possible after diagnosis (CDC, 2022c). Early initiation of ART lowers the risk of an individual with HIV of developing AIDS and other complications and lowers the risk of transmitting HIV to other individuals (Lundgren et al., 2015).

Table 59 presents the percentage of participants with HIV/AIDS by age group and race/ethnicity for CY 2019 and CY 2023. In both years, the majority of participants with HIV/AIDS were aged 40-64 years, and the majority were Black (making up 79.8% of participants with HIV/AIDS in CY 2023), followed by White participants. The total number of participants with HIV/AIDS increased over the evaluation period.

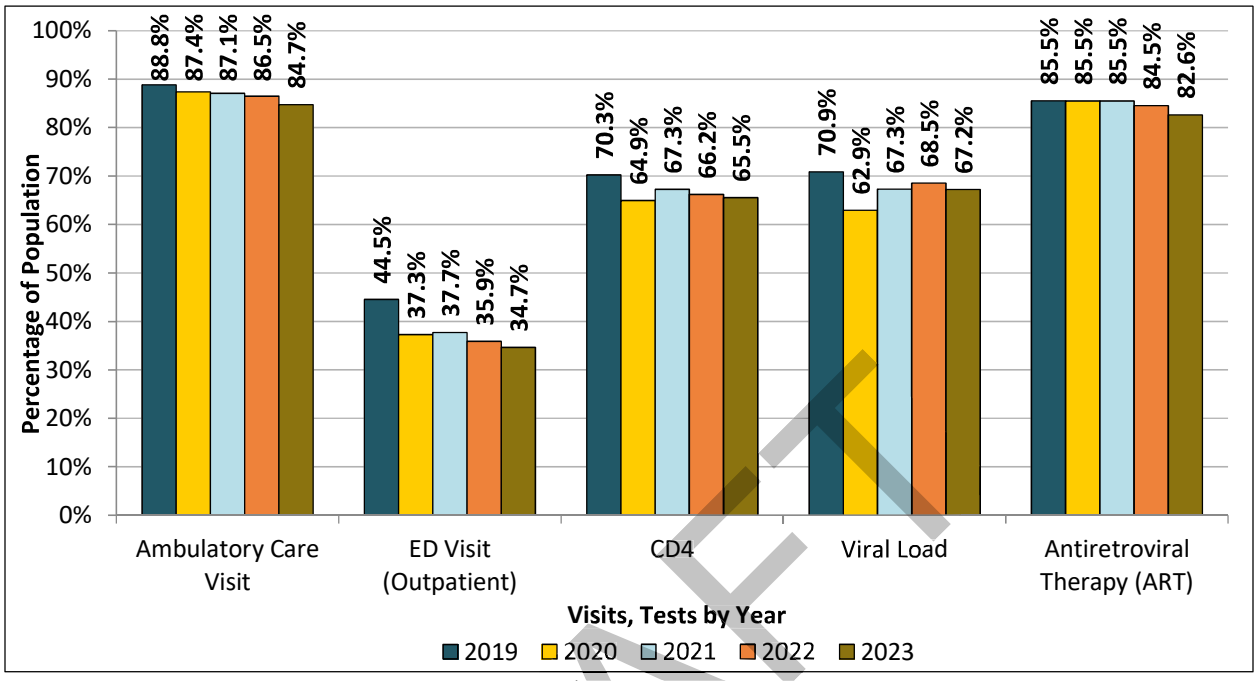
Table 59. Distribution of HealthChoice Participants with HIV/AIDS, by Age Group and Race/Ethnicity, CY 2019 and CY 2023

Demographic Characteristic	CY 2019		CY 2023	
	Number of Participants	Percentage of Total	Number of Participants	Percentage of Total
Age Group (Years)				
0–18	140	1.6%	107	1.2%
19–39	3,343	38.4%	4,034	39.2%
40–64	5,219	60.0%	6,010	59.6%
Total	**8,702**	**100%**	**10,151**	**100%**
Race/Ethnicity				
Asian	120	1.4%	219	2.2%
Black	7,114	81.8%	8,105	79.8%
White	942	10.8%	1,063	10.5%
Hispanic	241	2.8%	384	3.8%
Native American	63	0.7%	80	0.8%
Other*	222	2.6%	300	3.0%
Total	**8,702**	**100%**	**10,151**	**100.0%**

Note: The counts of HealthChoice enrollees with HIV/AIDS for CY 2019 to CY 2022 were updated to include all enrollees receiving capitation payments for HIV/AIDS. Previously, childless adults with HIV/AIDS were erroneously excluded from the analysis. Thus, data may not match previous HealthChoice Evaluation results.
*"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Figure 17 shows service utilization by HealthChoice participants with HIV/AIDS during the study period. The percentage of participants with HIV/AIDS who utilized all service types decreased over the evaluation period. The most significant decrease in service utilization was outpatient ED visits, which decreased from 44.5% in CY 2019 to 34.7% in CY 2023. ART saw the smallest decrease in service utilization, with a drop of 2.9 percentage points over the evaluation period.

Figure 17. Percentage of HealthChoice Participants with HIV/AIDS Who Had an Ambulatory Care Visit, Outpatient ED Visit, CD4 Testing, Viral Load Testing, or Antiretroviral Therapy, CY 2019–CY 2023



Note: The counts of HealthChoice enrollees with HIV/AIDS for CY 2019 to CY 2022 were updated to include all enrollees receiving capitation payments for HIV/AIDS. Previously, childless adults with HIV/AIDS were erroneously excluded from the analysis. Thus, data may not match previous HealthChoice Evaluation results.

According to the CDC's annual HIV Surveillance Report (2021b), for people aged 13 and older, there was a national HIV incidence rate of 13.2 per 100,000 people in 2019. In Maryland, the incidence rate of HIV diagnoses for 2019 was 18.0 per 100,000 people, a decrease from the previous year's rate of 19.6 (CDC, 2021b). The CDC (2022b) estimates that nearly 40% of new HIV infections are transmitted by people who have undiagnosed HIV. Thus, HIV screening is an important step in determining HIV status and starting appropriate treatment. The CDC currently recommends that everyone between 13 and 64 years of age be tested for HIV at least once—or more frequently if they are at high risk.

Table 60 shows HIV screenings for HealthChoice participants aged 15[55] to 64 years from CY 2019 through CY 2023. The number and percentage of participants who received a screening fluctuated throughout the evaluation period. While the number of participants with a screening increased by 14,187 between CY 2019 and CY 2023, the percentage with a screening decreased by 2.9 percentage points overall.

[55] HIV tests are recommended starting at age 15 for Maryland Medicaid recipients: https://health.maryland.gov/mmcp/epsdt/Documents/Maryland%20EPSDT%20Schedule-01-01-22%20HealthRiskAssessment.pdf

Table 60. HIV Screening in the HealthChoice Population for Participants Aged 15–64 Years, CY 2019–CY 2023

HealthChoice Participants	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Total Number	824,976	847,412	927,415	999,256	1,076,315
Number Received HIV Screening	148,213	127,875	148,052	151,185	162,400
Percentage Received HIV Screening	18.0%	15.1%	16.0%	15.1%	15.1%

* The definition of HIV screening was modified in 2022 to include additional procedure codes.

For people who are not HIV positive but are at risk of contracting the infection, pre-exposure prophylaxis (PrEP)—a daily medication—can help prevent HIV (CDC, 2019). Table 61 presents the number and percentage of HealthChoice participants who received PrEP from CY 2019 to CY 2023. The number of participants who received PrEP dropped significantly between CY 2019 and CY 2021, with less than 0.1% of participants receiving PrEP in CY 2021. While the number of participants who received PrEP increased in CY 2022 and CY 2023.

Table 61. HealthChoice Participants, Aged 0–64, Who Received HIV PrEP, CY 2019–CY 2023

HealthChoice Participants	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Total Number	1,377,493	1,392,876	1,487,449	1,574,181	1,665,232
Number Received PrEP	1,958	990	478	1,574	1,848
Percentage Received PrEP	0.1%	0.1%	0.0%	0.1%	0.1%

* The definition of PrEP was modified in 2022 to include additional National Drug Codes.

Behavioral Health

The Department contracts with an ASO to administer specialty MHD and SUD services, collectively called behavioral health services. Although the managed care benefit package excludes these services, MCOs are mandated to ensure that their enrollees receive all needed health services, including those that are carved out. In taking a whole-person view, this section includes behavioral health services paid on an FFS basis by the ASO but provided to individuals enrolled in the HealthChoice program.

Behavioral Health Demographics and Service Utilization

Table 62 presents the number and percentage of HealthChoice participants by behavioral health diagnosis group. These groups include MHD-only, SUD-only, dual diagnosis of MHD and SUD, and no behavioral health diagnoses.[56] The percentage of HealthChoice participants without a behavioral health diagnosis increased from 81.9% in CY 2019 to 83.0% in CY 2023. After those with no behavioral health diagnosis, MHD-only diagnoses were the most common throughout the evaluation period.

[56] Due to changes in how behavioral health diagnoses are defined, all five years of data have been updated. Results in this section may differ from previous iterations of the HealthChoice Evaluation.

Table 62. Number and Percentage of HealthChoice Participants with a Behavioral Health Diagnosis, by Diagnosis, CY 2019–CY 2023

Diagnosis	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
MHD-Only	176,929 (12.8%)	172,655 (12.4%)	183,468 (12.3%)	196,664 (12.5%)	209,509 (12.6%)
SUD-Only	36,934 (2.7%)	35,197 (2.5%)	35,275 (2.4%)	33,865 (2.2%)	32,679 (2.0%)
Dual Diagnosis (MHD + SUD)	35,604 (2.6%)	33,128 (2.4%)	34,277 (2.3%)	35,891 (2.3%)	40,470 (2.4%)
No Behavioral Health Diagnosis	1,127,790 (81.9%)	1,151,645 (82.7%)	1,233,971 (83.0%)	1,307,391 (83.1%)	1,382,574 (83.0%)
Total	**1,377,257**	**1,392,625**	**1,486,991**	**1,573,811**	**1,665,232**

The Department monitors the extent to which participants with a behavioral health diagnosis had access to ambulatory care services. In CY 2023, 91.3% of participants with a behavioral health condition visited a health care provider for an ambulatory care visit (Table 63).

From CY 2019 through CY 2023, the ambulatory care visit rate among participants with an MHD-only diagnosis decreased slightly from 92.8% to 92.2%, as did the rate among participants with an SUD-only diagnosis. Participants with a dual diagnosis of MHD and SUD were consistently more likely to receive an ambulatory care visit than participants in the other diagnosis groups across the evaluation period.

Table 63. HealthChoice Participants with a Behavioral Health Condition Who Had an Ambulatory Care Visit, by Behavioral Health Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Ambulatory Care Visit	
		Number of Participants	Percentage of Total Participants
MHD-Only			
2019	176,929	164,252	92.8%
2020	172,655	156,252	90.5%
2021	183,468	170,664	93.0%
2022	196,664	182,097	92.6%
2023	209,509	193,069	92.2%
SUD-Only			
2019	36,934	29,948	81.1%
2020	35,197	28,008	79.6%
2021	35,275	29,020	82.3%
2022	33,865	27,783	82.0%
2023	32,679	26,426	80.9%
Dual Diagnosis (MHD + SUD)			
2019	35,604	33,664	94.6%
2020	33,128	31,257	94.4%
2021	34,277	32,729	95.5%
2022	35,891	34,443	96.0%
2023	40,470	38,528	95.2%

Calendar Year	Total Number of Participants	At Least One Ambulatory Care Visit	
		Number of Participants	Percentage of Total Participants
Total			
2019	249,467	227,864	91.3%
2020	240,980	215,517	89.4%
2021	253,020	232,413	91.9%
2022	266,420	244,323	91.7%
2023	282,658	258,023	91.3%

Table 64 shows the number and percentage of HealthChoice participants with a behavioral health diagnosis who had at least one outpatient ED visit.[57] ED utilization rates fell for all diagnosis groups between CY 2019 and CY 2023. In each year, participants with co-occurring diagnoses had a higher rate of ED utilization than participants with an MHD-only or SUD-only diagnosis.

Table 64. HealthChoice Participants with a Behavioral Health Condition Who Had at Least One Outpatient ED Visit, by Behavioral Health Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One ED Visit	
		Number of Participants	Percentage of Total Participants
MHD-Only			
2019	176,929	69,486	39.3%
2020	172,655	54,201	31.4%
2021	183,468	62,204	33.9%
2022	196,664	66,514	33.8%
2023	209,509	70,188	33.5%
SUD-Only			
2019	36,934	16,902	45.8%
2020	35,197	14,387	40.9%
2021	35,275	15,036	42.6%
2022	33,865	13,338	39.4%
2023	32,679	12,760	39.0%
Dual Diagnosis (MHD + SUD)			
2019	35,604	22,631	63.6%
2020	33,128	19,159	57.8%
2021	34,277	20,458	59.7%
2022	35,891	20,183	56.2%
2023	40,470	23,054	57.0%
Total			
2019	249,467	109,019	43.7%
2020	240,980	87,747	36.4%
2021	253,020	97,698	38.6%
2022	266,420	100,035	37.5%
2023	282,658	106,002	37.5%

[57] This measure excludes ED visits that resulted in an inpatient hospital admission.

Table 65 displays the number and percentage of HealthChoice participants with a behavioral health diagnosis who had at least one inpatient admission. Overall, the percentage of participants with a behavioral health diagnosis who had an inpatient admission declined from 13.6% in CY 2019 to 11.6% in CY 2023. Each of the behavioral health diagnosis groups experienced the same downward trend during this period. In each year of the evaluation period, participants with co-occurring diagnoses had a higher rate of inpatient admissions than participants with an MHD-only or SUD-only diagnosis.

Table 65. HealthChoice Participants with a Behavioral Health Condition Who Had an Inpatient Admission, by Behavioral Health Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Inpatient Visit	
		Number of Participants	Percentage of Total Participants
MHD-Only			
2019	176,929	19,606	11.1%
2020	172,655	17,351	10.0%
2021	183,468	18,443	10.1%
2022	196,664	19,171	9.7%
2023	209,509	19,825	9.5%
SUD-Only			
2019	36,934	4,667	12.6%
2020	35,197	4,418	12.6%
2021	35,275	4,511	12.8%
2022	33,865	3,775	11.1%
2023	32,679	3,482	10.7%
Dual Diagnosis (MHD + SUD)			
2019	35,604	9,676	27.2%
2020	33,128	8,440	25.5%
2021	34,277	8,555	25.0%
2022	35,891	8,307	23.1%
2023	40,470	9,474	23.4%
Total			
2019	249,467	33,949	13.6%
2020	240,980	30,209	12.5%
2021	253,020	31,509	12.5%
2022	266,420	31,253	11.7%
2023	282,658	32,781	11.6%

Table 66 shows the rates of MHD-only, SUD-only, and co-occurring MHD and SUD diagnoses among HealthChoice participants by race and ethnicity during CY 2019 and CY 2023. Throughout the evaluation period, White participants had the highest rates of MHD-only, SUD-only, and co-occurring diagnoses. Native American participants experienced each type of diagnosis at the second highest rate and Black participants at the third highest. Native Americans had the largest increase (1.8 percentage points) in MHD-only diagnoses from CY 2019 to CY 2023. Asian participants were the most likely to have no behavioral health diagnosis, followed by Hispanics.

Table 66. Distribution of HealthChoice Participants Aged 0-64 Years, by Race/Ethnicity and Behavioral Health Conditions, CY 2019 and CY 2023

Race/Ethnicity	CY 2019		CY 2023	
	Number of Participants	Percentage of Total Race/Ethnicity	Number of Participants	Percentage of Total Race/Ethnicity
MHD-Only				
Black	82,805	13.5%	99,638	13.8%
White	62,630	16.5%	67,644	16.0%
Hispanic	16,930	7.6%	22,184	7.2%
Asian	3,265	4.8%	5,347	5.9%
Native American	1,707	13.9%	2,397	15.7%
Other	9,592	11.5%	12,299	11.6%
Total	**176,929**	**12.8%**	**209,509**	**12.6%**
SUD-Only				
Black	12,966	2.1%	11,160	1.5%
White	21,161	5.6%	18,022	4.3%
Hispanic	993	0.4%	1,471	0.5%
Asian	340	0.5%	406	0.4%
Native American	301	2.5%	330	2.2%
Other	1,173	1.4%	1,290	1.2%
Total	**36,934**	**2.7%**	**32,679**	**2.0%**
Dual Diagnosis (MHD + SUD)				
Black	13,925	2.3%	16,800	2.3%
White	19,223	5.1%	19,987	4.7%
Hispanic	854	0.4%	1,357	0.4%
Asian	271	0.4%	393	0.4%
Native American	297	2.4%	436	2.9%
Other	1,034	1.2%	1,497	1.4%
Total	**35,604**	**2.6%**	**40,470**	**2.4%**
No Behavioral Health Diagnosis				
Black	503,291	82.1%	592,721	82.3%
White	276,153	72.8%	316,327	75.0%
Hispanic	202,894	91.5%	285,020	91.9%
Asian	64,097	94.3%	85,165	93.3%
Native American	9,961	81.2%	12,121	79.3%
Other	71,394	85.8%	91,220	85.8%
Total	**1,127,790**	**81.9%**	**1,382,574**	**83.0%**

Note: "Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Mental Health Services

Table 67 displays the key demographic characteristics of HealthChoice participants with a diagnosis of an MHD.[58] The proportion of White participants with an MHD decreased across the evaluation period from 38.5% in CY 2019 to 35.1% in CY 2023. The remaining race and ethnic groups saw minor increases in MHD diagnoses during the measurement period. In CY 2019, children and adults made up 38.8% and 61.2%, respectively, of participants with an MHD; the proportion of adults rose to 66.6% in CY 2023.

Table 67. Demographic Characteristics of HealthChoice Participants with an MHD, CY 2019–CY 2023

Demographic Characteristic	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
	% of Total	% of Total	% of Total	% of Total	% of Total
Race/Ethnicity*					
Asian	1.7%	1.9%	2.1%	2.2%	2.3%
Black	45.5%	45.4%	45.4%	46.2%	46.6%
White	38.5%	38.0%	37.3%	36.0%	35.1%
Hispanic	8.4%	8.6%	8.8%	9.1%	9.4%
Native American	0.9%	1.0%	1.1%	1.1%	1.1%
Other**	5.0%	5.2%	5.4%	5.4%	5.5%
Total	**100%**	**100%**	**100.0%**	**100%**	**100%**
Sex					
Female	54.9%	56.0%	57.8%	58.3%	58.2%
Male	45.1%	44.0%	42.2%	41.8%	41.8%
Total	**100%**	**100%**	**100%**	**100.0%**	**100%**
Region					
Baltimore City	24.9%	24.6%	24.0%	24.0%	24.1%
Baltimore Suburban	31.7%	32.1%	32.6%	33.0%	33.1%
Eastern Shore	11.0%	10.8%	10.4%	10.4%	10.4%
Southern Maryland	4.6%	4.6%	4.7%	4.6%	4.5%
Washington Suburban	17.7%	17.7%	18.1%	18.0%	18.2%
Western Maryland	10.0%	10.2%	10.2%	10.0%	9.7%
Out of State	0.1%	0.1%	0.1%	0.1%	0.1%
Total	**100%**	**100%**	**100.0%**	**100%**	**100%**
Age Group (Years)					
0–18	38.8%	37.2%	34.6%	34.1%	33.4%
19–64	61.2%	62.8%	65.4%	65.9%	66.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Total Participants	**212,533**	**205,783**	**217,745**	**232,555**	**249,979**

*Race and ethnicity values were calculated using the enhanced race/ethnicity variable implemented in 2023 and updated for the entire measurement period. Thus, race and ethnicity totals will not match previous HealthChoice Evaluation results.

[58] Individuals are identified as having an MHD if they meet the COMAR definition of MHD.

**"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Table 68 displays the number and percentage of HealthChoice participants with an MHD diagnosis who had at least one ambulatory care visit, as well as participants with at least one ambulatory care visit with an MHD as a primary diagnosis. The percentage of HealthChoice participants with an MHD-only diagnosis who had an ambulatory care visit with an MHD as a primary diagnosis decreased by 3.8 percentage points over the evaluation period, while the rate of overall ambulatory care visits decreased by only 0.5 percentage points. Among those with a dual diagnosis of MHD and SUD, the rate of overall ambulatory care visits increased by 0.6 percentage points between CY 2019 and CY 2023, while the rate of ambulatory care visits with an MHD as a primary diagnosis decreased by 3.4 percentage points. Between CY 2019 and CY 2023, the overall percentage of participants with an MHD or a dual diagnosis who had at least one ambulatory care visit decreased slightly, while the percentage with at least one ambulatory care visit where MHD was the primary diagnosis decreased from 17.0% in CY 2019 to 13.2% in CY 2023.

Table 68. HealthChoice Participants with an MHD Who Had an Ambulatory Care Visit, by MHD Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Ambulatory Care Visit (Any Diagnosis)		At Least One Ambulatory Care Visit with MHD as Primary Diagnosis	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total Participants
MHD-Only					
2019	176,929	164,252	92.8%	30,946	17.5%
2020	172,655	156,252	90.5%	27,257	15.8%
2021	183,468	170,664	93.0%	29,152	15.9%
2022	196,664	182,097	92.6%	28,051	14.3%
2023	209,509	193,069	92.2%	28,776	13.7%
Dual Diagnosis (MHD + SUD)					
2019	35,604	33,664	94.6%	5,224	14.7%
2020	33,128	31,257	94.4%	4,546	13.7%
2021	34,277	32,729	95.5%	4,512	13.2%
2022	35,891	34,443	96.0%	4,294	12.0%
2023	40,470	38,528	95.2%	4,583	11.3%
Total					
2019	212,533	197,916	93.1%	36,170	17.0%
2020	205,783	187,509	91.1%	31,803	15.5%
2021	217,745	203,393	93.4%	33,664	15.5%
2022	232,555	216,540	93.1%	32,345	13.9%
2023	249,979	231,597	92.6%	33,359	13.3%

Table 69 displays the number and percentage of HealthChoice participants who had at least one outpatient ED visit with either any diagnosis or a primary diagnosis of an MHD. Between CY 2019

and CY 2023, the overall percentage of participants with an MHD or a dual diagnosis who had at least one outpatient ED visited decreased by 6.0 percentage points. The percentage that had an ED visit with a primary diagnosis of an MHD decreased by 3.2 percentage points.

The percentages of HealthChoice participants with a dual diagnosis (MHD and SUD) and at least one outpatient ED visit decreased by 6.6 percentage point between CY 2019 and CY 2023. Similarly, the percentage of participants with an MHD-only diagnosis and at least one outpatient ED visit decreased by 5.8 percentage points over the evaluation period. The percentage of HealthChoice participants with a dual diagnosis and at least one outpatient ED visit with a primary diagnosis of an MHD decreased by 4.6 percentage points, whereas the corresponding rate among participants with an MHD-only diagnosis decreased by 3.0 percentage points.

Table 69. HealthChoice Participants with an MHD Who Had an Outpatient ED Visit, by MHD Diagnosis, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Outpatient ED Visit (Any Diagnosis)		At Least One Outpatient ED Visit with MHD as Primary Diagnosis	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total Participants
MHD-Only					
2019	176,929	69,486	39.3%	12,721	7.2%
2020	172,655	54,201	31.4%	9,081	5.3%
2021	183,468	62,204	33.9%	10,307	5.6%
2022	196,664	66,514	33.8%	9,017	4.6%
2023	209,509	70,188	33.5%	8,848	4.2%
Dual Diagnosis (MHD + SUD)					
2019	35,604	22,631	63.6%	4,120	11.6%
2020	33,128	19,159	57.8%	2,934	8.9%
2021	34,277	20,458	59.7%	3,178	9.3%
2022	35,891	20,183	56.2%	2,625	7.3%
2023	40,470	23,054	57.0%	2,845	7.0%
Total					
2019	212,533	92,117	43.3%	16,841	7.9%
2020	205,783	73,360	35.6%	12,015	5.8%
2021	217,745	82,662	38.0%	13,485	6.2%
2022	232,555	86,697	37.3%	11,642	5.0%
2023	249,979	93,242	37.3%	11,693	4.7%

The Department monitors the extent to which HealthChoice participants who had an ED visit with a primary diagnosis of an MHD receive a follow-up outpatient visit with any practitioner within 7 or 30 days.

Table 70 displays the number of ED visits with a primary diagnosis of an MHD among participants aged 6 to 64 years and the percentage of visits where appropriate follow-up care was provided:

i.e., an outpatient visit within 7 or 30 days (FUM).[59] A higher percentage of participants with only an MHD completed follow-up visits than participants with a dual diagnosis of MHD and SUD (within both 7 and 30 days) throughout the evaluation period. Among all participants with an MHD or dual diagnosis, the percentage of ED visits with a primary MHD diagnosis and a follow-up appointment within 7 days increased from 37.1% in CY 2019 to 39.0% in CY 2023. The overall percentage of follow-up visits within 30 days increased from 57.9% in CY 2019 to 58.8% in CY 2023.

Table 70. Number and Percentage of ED Visits for MHD and a Follow-Up Visit within 7 or 30 Days, CY 2019–CY 2023

Calendar Year	Total Number of Visits	At Least One Follow-Up within 7 Days		At Least One Follow-Up within 30 Days	
		Number of Visits	Percentage of Visits	Number of Visits	Percentage of Visits
MHD-Only					
2019	9,045	3,713	41.1%	5,556	61.4%
2020	7,465	2,493	33.4%	4,194	56.2%
2021	7,440	2,936	39.5%	4,429	59.5%
2022	7,404	3,065	41.4%	4,536	61.3%
2023	6,635	2,677	40.3%	3,918	59.1%
Dual Diagnosis (MHD + SUD)					
2019	3,895	1,093	28.1%	1,937	49.7%
2020	3,274	861	26.3%	1,561	47.7%
2021	3,271	998	30.5%	1,663	50.8%
2022	2,995	1,037	34.6%	1,692	56.5%
2023	2,695	959	35.6%	1,566	58.1%
Total					
2019	12,940	4,806	37.1%	7,493	57.9%
2020	10,739	3,354	31.2%	5,755	53.6%
2021	10,711	3,934	36.7%	6,092	56.9%
2022	10,399	4,102	39.4%	6,228	59.9%
2023	9,330	3,636	39.0%	5,484	58.8%

Substance Use Disorder Services

This section evaluates the quality and comprehensiveness of SUD-related care provided to HealthChoice participants. SUD services are carved out and administered by the ASO in alignment with specialty mental health services.[60]

Table 71 presents the demographic characteristics of HealthChoice participants with a diagnosis of SUD. Among racial and ethnic groups, White participants made up the highest proportion of

[59] This measure—Follow-Up after Emergency Department Visit for Mental Illness, or FUM—was calculated using the HEDIS® proprietary software from Cognizant.

[60] Individuals were identified as having an SUD if they had a claim that met the COMAR 10.67.08.02 definition of SUD.

persons with an SUD, followed by Black participants. The share of Black participants with an SUD increased by 1.1 percentage points between CY 2019 and CY 2023, while the share of White participants decreased by 3.7 percentage points. Between CY 2019 and CY 2023, males remained the majority of participants with an SUD, making up 57.4% of participants with an SUD in CY 2023. The Baltimore Suburban region had the highest share of persons with an SUD during the evaluation period, with the distribution among regions remaining steady.

Table 71. Demographic Characteristics of HealthChoice Participants with an SUD, CY 2019–CY 2023

Demographic Characteristics	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
	% of Total	% of Total	% of Total	% of Total	% of Total
Race/Ethnicity					
Asian	0.8%	0.9%	1.0%	1.0%	1.1%
Black	37.1%	35.7%	35.5%	36.2%	38.2%
White	55.7%	56.6%	56.2%	54.8%	52.0%
Hispanic	2.6%	2.6%	2.8%	3.3%	3.9%
Native American	0.8%	0.9%	0.9%	1.0%	1.1%
Other*	3.0%	3.3%	3.6%	3.7%	3.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Sex					
Female	42.5%	42.8%	42.7%	42.6%	42.6%
Male	57.5%	57.2%	57.3%	57.4%	57.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Region					
Baltimore City	30.0%	29.3%	28.3%	28.1%	28.6%
Baltimore Suburban	32.4%	32.8%	33.2%	33.1%	32.8%
Eastern Shore	13.0%	12.7%	12.8%	12.7%	12.1%
Southern Maryland	5.6%	5.6%	5.7%	5.6%	5.5%
Washington Suburban	7.0%	7.1%	7.2%	7.7%	8.7%
Western Maryland	12.0%	12.4%	12.8%	12.7%	12.2%
Out of State	0.1%	0.2%	0.1%	0.1%	0.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Age Group (Years)					
0-18	2.4%	1.9%	1.8%	2.2%	3.1%
19-64	97.6%	98.1%	98.2%	97.8%	96.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Total Participants	**72,538**	**68,325**	**69,652**	**69,756**	**73,149**

*"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health approach for delivering population screening, early intervention, and treatment services[61] targeting SUDs. Health care providers using SBIRT ask participants about substance use during routine medical and dental visits, provide brief advice, and then, if appropriate, refer participants who are at risk of SUDs to more intensive treatment (SAMHSA, 2022). In July 2016, new SBIRT codes were introduced to give providers greater flexibility when billing for SBIRT services (Maryland Department of Health, 2016).

Table 72 presents the number of HealthChoice participants who received an SBIRT service during the evaluation period. The number of participants who received services per 1,000 HealthChoice participants decreased by 1.9 between CY 2019 and CY 2023. The total number of participants receiving services increased by 6.7% over the evaluation period.

Adolescents aged 12 to 14 years had the highest number of participants receiving services per 1,000 HealthChoice participants in CY 2019 through CY 2023. Among the group aged 12 to 14 years, the number of participants receiving services per 1,000 HealthChoice participants increased by 2.8 between CY 2019 and CY 2023.

Table 72. Number of HealthChoice Participants Who Received an SBIRT Service, by Age Group, CY 2019–CY 2023

	Age Group (Years)						Total
	11 and under	12–14	15–18	19–20	21–39	40–64	
CY 2019							
# of Participants	446,952	105,434	118,234	51,568	377,077	277,992	**1,377,257**
# with Service	1,064	5,532	6,074	1,279	4,166	4,540	**22,655**
Per 1000	2.4	52.5	51.4	24.8	11.0	16.3	**16.4**
CY 2020							
# of Participants	436,498	108,778	120,118	51,947	385,594	289,690	**1,392,625**
# with Service	941	4,946	5,019	1,024	2,664	2,909	**17,503**
Per 1000	2.2	45.5	41.8	19.7	6.9	10.0	**12.6**
CY 2021							
# of Participants	445,936	113,761	130,916	57,602	424,493	314,283	**1,486,991**
# with Service	1,042	6,479	6,869	1,511	3,957	4,391	**24,249**
Per 1000	2.3	57.0	52.5	26.2	9.3	14.0	**16.3**
CY 2022							
# of Participants	458,379	116,289	142,354	62,236	460,196	334,357	**1,573,811**
# with Service	995	5,471	6,233	1,293	3,595	4,331	**21,918**
Per 1000	2.2	47.0	43.8	20.8	7.8	13.0	**13.9**

[61] An SBIRT service is identified by the following procedure codes: 99408, 99409, W7000, W7010, W7020, W7021, and W7022 during the calendar year.

CY 2023							
# of Participants	470,764	118,153	153,677	66,329	501,110	355,199	**1,665,232**
# with Service	1,067	6,537	7,731	1,495	3,505	3,836	**24,171**
Per 1000	2.3	55.3	50.3	22.5	7.0	10.8	**14.5**

The Department also monitors the extent to which HealthChoice participants with an SUD access ambulatory care services. Table 73 displays the percentage of HealthChoice participants with an SUD who had an ambulatory care visit, as well as those having at least one ambulatory care visit with a primary diagnosis of SUD. Participants with a co-occurring MHD and SUD were consistently more likely to receive an ambulatory care visit. The rate of ambulatory care utilization among participants with a co-occurring MHD and SUD increased from 94.6% in CY 2019 to 95.2% in CY 2022. Alternatively, ambulatory care utilization by participants with an SUD-only diagnosis decreased by 0.2 percentage points. The overall percentage of participants with an SUD or a dual diagnosis who had at least one ambulatory care visit increased from 87.7% in 2019 to 88.8% in CY 2023, and the overall percentage with at least one ambulatory care visit with a primary diagnosis of an SUD decreased 2.8 percentage points during the measurement period.

Table 73. HealthChoice Participants with an SUD Who Had an Ambulatory Care Visit, by SUD Status, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Ambulatory Care Visit		At Least One Ambulatory Care Visit with Primary Diagnosis of SUD	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total Participants
SUD-Only					
2019	36,934	29,948	81.1%	5,629	15.2%
2020	35,197	28,008	79.6%	4,471	12.7%
2021	35,275	29,020	82.3%	4,691	13.3%
2022	33,865	27,783	82.0%	4,557	13.5%
2023	32,679	26,426	80.9%	4,214	12.9%
Dual Diagnosis (MHD + SUD)					
2019	35,604	33,664	94.6%	7,744	21.8%
2020	33,128	31,257	94.4%	5,827	17.6%
2021	34,277	32,729	95.5%	5,800	16.9%
2022	35,891	34,443	96.0%	6,111	17.0%
2023	40,470	38,528	95.2%	7,170	17.7%
Total					
2019	72,538	63,612	87.7%	13,373	18.4%
2020	68,325	59,265	86.7%	10,298	15.1%
2021	69,552	61,749	88.8%	10,491	15.1%
2022	69,756	62,226	89.2%	10,668	15.3%
2023	73,149	64,954	88.8%	11,384	15.6%

Table 74 shows the percentage of HealthChoice participants with an SUD who had at least one outpatient ED visit, as well as the percentage with at least one ED visit with SUD as a primary diagnosis.[62] Throughout the evaluation period, those with dual diagnoses were more likely to have an ED visit and to have an SUD-related ED visit. From CY 2019 to CY 2023, the percentages of participants with an SUD-only and dual diagnosis (MHD and SUD) who had at least one ED visit decreased by 6.8 and 6.6 percentage points, respectively. The overall percentage of participants who had at least one ED visit with a primary diagnosis of SUD decreased from 12.3% in CY 2019 to 11.4% in CY 2023.

Table 74. HealthChoice Participants with an SUD Who Had an Outpatient ED Visit, by SUD Status, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One ED Visit		At Least One ED Visit with SUD Primary Diagnosis	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total Participants
SUD-Only					
2019	36,934	16,902	45.8%	3,515	9.5%
2020	35,197	14,387	40.9%	3,082	8.8%
2021	35,275	15,036	42.6%	3,445	9.8%
2022	33,865	13,338	39.4%	3,082	9.1%
2023	32,679	12,760	39.0%	3,124	9.6%
Dual Diagnosis (MHD + SUD)					
2019	35,604	22,631	63.6%	5,430	15.3%
2020	33,128	19,159	57.8%	4,684	14.1%
2021	34,277	20,458	59.7%	5,381	15.7%
2022	35,891	20,183	56.2%	4,798	13.4%
2023	40,470	23,054	57.0%	5,223	12.9%
Total					
2019	72,538	39,533	54.5%	8,945	12.3%
2020	68,325	33,546	49.1%	7,766	11.4%
2021	69,552	35,494	51.0%	8,826	12.7%
2022	69,756	33,521	48.1%	7,880	11.3%
2023	73,149	35,814	49.0%	8,347	11.4%

Table 75 displays the percentage of HealthChoice participants with an SUD who had at least one inpatient visit, as well as the percentage with at least one inpatient visit with an SUD as a primary diagnosis. Those with a dual diagnosis were more likely to have an inpatient visit and more likely to have an SUD-related inpatient visit each year during the evaluation period. From CY 2019 to CY 2023, the percentages of participants with an SUD-only and a dual diagnosis (MHD and SUD) who had at least one inpatient visit decreased by 1.9 and 3.8 percentage points, respectively. The overall percentage of participants who had at least one inpatient visit with a primary diagnosis of an SUD decreased slightly, from 2.8% in CY 2019 to 2.4% in CY 2023. The percentage

[62] This measure excludes ED visits that resulted in an inpatient hospital admission.

of participants with a dual diagnosis who had an inpatient visit with a primary diagnosis of SUD decreased from 7.3% in CY 2019 to 6.1% in CY 2023.

Table 75. HealthChoice Participants with an SUD Who Had an Inpatient Admission, by SUD Status, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Inpatient Visit		At Least One Inpatient Visit with SUD Primary Diagnosis	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total Participants
SUD-Only					
2019	36,934	4,667	12.6%	1,044	2.8%
2020	35,197	4,418	12.6%	1,050	3.0%
2021	35,275	4,511	12.8%	1,089	3.1%
2022	33,865	3,775	11.1%	859	2.5%
2023	32,679	3,482	10.7%	799	2.4%
Dual Diagnosis (MHD + SUD)					
2019	35,604	9,676	27.2%	2,612	7.3%
2020	33,128	8,440	25.5%	2,358	7.1%
2021	34,277	8,555	25.0%	2,429	7.1%
2022	35,891	8,307	23.1%	2,233	6.2%
2023	40,470	9,474	23.4%	2,449	6.1%
Total					
2019	72,538	14,343	19.8%	3,656	5.0%
2020	68,325	12,858	18.8%	3,408	5.0%
2021	69,552	13,066	18.8%	3,518	5.1%
2022	69,756	12,082	17.3%	3,092	4.4%
2023	73,149	12,956	17.7%	3,248	4.4%

Table 76 presents the number and percentage of HealthChoice participants with an SUD who received at least one methadone replacement therapy or at least one medication-assisted treatment (MAT).[63] The rate of methadone replacement therapy and MAT decreased overall among both groups during the evaluation period. The percentage of participants with an SUD-only diagnosis who received at least one methadone replacement therapy decreased from 39.7% in CY 2019 to 33.0% in CY 2023, alongside smaller decreases in the use of methadone replacement therapy among those with a dual diagnosis. The percentage of participants with a dual diagnosis who received at least one MAT decreased during the evaluation period—from 67.2% in CY 2019 to 63.8% in CY 2023.

[63] MAT was defined as any treatment with buprenorphine, naloxone, methadone, or naltrexone.

Table 76. Number and Percentage of HealthChoice Participants with an SUD Who Received Methadone Replacement Therapy or MAT, by SUD Status, CY 2019–CY 2023

Calendar Year	Total Number of Participants	At Least One Methadone Replacement Therapy		At Least One MAT	
		Number of Participants	Percentage of Total Participants	Number of Participants	Percentage of Total Participants
SUD-Only					
2019	36,934	14,656	39.7%	25,202	68.2%
2020	35,197	14,688	41.7%	25,520	72.5%
2021	35,275	14,110	40.0%	25,379	71.9%
2022	33,865	12,511	36.9%	23,777	70.2%
2023	32,679	10,795	33.0%	21,690	66.4%
Dual Diagnosis (MHD + SUD)					
2019	35,604	10,940	30.7%	23,933	67.2%
2020	33,128	10,585	32.0%	23,089	69.7%
2021	34,277	10,602	30.9%	23,844	69.6%
2022	35,891	10,420	29.0%	24,310	67.7%
2023	40,470	10,807	26.7%	25,808	63.8%
Total					
2019	72,538	25,596	35.3%	49,135	67.7%
2020	68,325	25,273	37.0%	48,609	71.1%
2021	69,552	24,712	35.5%	49,223	70.8%
2022	69,756	22,931	32.9%	48,087	68.9%
2023	73,149	21,602	29.5%	47,498	64.9%

The Department also monitors the extent to which HealthChoice participants with an ED visit and a primary diagnosis of SUD receive a follow-up outpatient visit with any practitioner within 7 or 30 days. Table 77 shows the number and percentage of ED visits with a primary diagnosis of SUD that had an outpatient follow-up visit from CY 2019 to CY 2023.[64] The results are displayed by the participant's status as having an SUD-only or co-occurring MHD and SUD. In CY 2019, 22.5% of all ED visits with a primary diagnosis of SUD had a follow-up visit within 7 days, and 34.5% had an appointment within 30 days; by CY 2023, these values had increased overall to 47.2% and 64.7%, respectively, despite decreases in both in CY 2020. The overall percentage of ED visits with a primary diagnosis of SUD with a follow-up appointment within 7 and 30 days increased for both participants with an SUD-only and those with a co-occurring diagnosis during the evaluation period. Between CY 2021 and CY 2022, the recorded numbers of follow-up visits increased significantly for both timelines and both diagnosis types, in part due to changes in how the HEDIS® measure used to count the visits is calculated.

[64] This measure was calculated using the HEDIS® proprietary software from Cognizant.

Table 77. Number and Percentage of ED Visits by HealthChoice Participants with an SUD Who Had a Follow-Up Visit within 7 or 30 days, CY 2019–CY 2023

Calendar Year	Total Number of Visits	At Least One Follow-Up within 7 Days		At Least One Follow-Up within 30 Days	
		Number of Visits	Percentage of Visits	Number of Visits	Percentage of Visits
SUD-Only					
2019	4,294	647	15.1%	989	23.0%
2020	3,587	483	13.5%	758	21.1%
2021	3,928	593	15.1%	926	23.6%
2022	3,967	1,216	30.7%	1,818	45.8%
2023	3,791	1,151	30.4%	1,679	44.3%
Dual Diagnosis (MHD + SUD)					
2019	7,490	2,008	26.8%	3,082	41.1%
2020	6,497	1,562	24.0%	2,467	38.0%
2021	7,217	1,961	27.2%	3,048	42.2%
2022	7,393	4,178	56.5%	5,696	77.0%
2023	6,914	3,900	56.4%	5,243	75.8%
Total					
2019	11,784	2,655	22.5%	4,071	34.5%
2020	10,084	2,045	20.3%	3,225	32.0%
2021	11,145	2,554	22.9%	3,974	35.7%
2022	11,360	5,394	47.5%	7,514	66.1%
2023	10,705	5,051	47.2%	6,922	64.7%

Section VI Conclusion

The HealthChoice program focuses on providing a variety of preventive services to participants. Over the evaluation period, with some exceptions, performance measures declined. HealthChoice remained above the national HEDIS® mean on all measures of child and adolescent immunizations and well-care visits, except for well-child visits in 15 months of life, despite ending the evaluation period with decreased performance on 5 out of 8 sub-measures. While the percentage of children who had an elevated blood lead level decreased between CY 2019 and CY 2023, the percentage of children receiving blood lead tests also decreased. Rates of screening for breast cancer, cervical cancer, and colorectal cancer all declined during the evaluation period. These trends correspond with the sharp decline in the number of breast, cervical, and colon cancer screenings received nationally during CY 2020 and the failure to return to pre-COVID levels in CY 2021 (Oakes et al., 2023; Star et al., 2023). The number of dental visits for child participants decreased between CY 2019 and CY 2023; however, child participants had higher percentages of dental visits among all service types—diagnostic, preventative, and restorative—when compared to adult participants in CY 2023. Greater adherence to asthma medication was associated with reductions in asthma-related ED use in the current year, as well as reductions in the following year, when adherence had been higher in the prior year. However, the effects of AMR on asthma inpatient admissions only had associations with admissions in the

following year. Measures of maternal and reproductive health similarly showed decreased performance from CY 2019 to CY 2023.

HealthChoice covers a broad range of populations with low income and various service needs. Therefore, health promotion activities under HealthChoice have an extensive scope. From care for persons with chronic diseases like asthma, diabetes, and HIV infection to those with behavioral health conditions, most measures of performance were improving until the COVID-19 PHE in CY 2020 negatively impacted service utilization, and few measures have returned to pre-COVID levels. While the percentage of HealthChoice participants with a behavioral health diagnosis decreased slightly during the evaluation period, these participants continue to have ED visits and inpatient admissions at a higher rate compared to the general HealthChoice population, particularly for participants with a dual diagnosis of MHD and SUD. This may represent the need for better access to care for persons with MHD and SUD. The Department will monitor the use of services to assure that necessary care is being delivered and that, where possible, prevention and early intervention minimizes the severity and duration of such conditions. The Department considers constant monitoring of performance measures for each aspect of health promotion and disease prevention to be a necessary part of demonstrating the HealthChoice program's effectiveness.

Section VII. Expanding Coverage to Additional Low-Income Marylanders with Resources Generated through Managed Care Efficiencies

Section §1115 demonstrations, like HealthChoice, can use calculated cost savings under budget neutrality provisions to fund a federal match for services otherwise not covered by Medicaid. In addition to testing the effectiveness of a managed care program to improve health outcomes and generate expenditure savings, the HealthChoice demonstration can test new services anticipated to benefit the enrolled population. This section of the report analyzes the innovative programs designed to address the social determinants of health and improve the health and wellbeing of the Maryland population using savings from the HealthChoice managed care program. These programs include Residential Treatment for Individuals with SUD, ACIS, DPP, ICS, and the Family Planning program.

In mid-2018, the Department submitted an amendment to the approved waiver containing requests to expand the Residential Treatment for Individuals with SUD and ACIS programs, implement the DPP, and adjust the criteria for the Family Planning program. CMS approved the amendment application in March 2019.

The Department submitted its application for §1115 waiver renewal in July 2021 for the five-year period of January 1, 2022, through December 31, 2026—which was approved by CMS in December 2021. This approval allows Maryland to modify existing programs and add new programs.

Under the 2022 to 2026 waiver period, Residential Treatment was expanded to include individuals with SMI and SED who are primarily receiving treatment for an SMI/SED and residing in short-term facilities that meet the definition of an IMD. The ACIS pilot program increased the statewide capacity to 900 spaces. Residential and inpatient treatment services for SUD were expanded to remove caps on lengths of stays (LOS) for SUD treatment in an IMD and aim for a statewide average LOS of 30 days or less. The MOM program, approved July 1, 2021, was established to address the fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD. The Family Planning program and HVS program were not renewed because they were added to the State Plan.

Residential Treatment for Individuals with Substance Use Disorders (SUD)

In 2016, CMS approved Maryland Medicaid to expand coverage to include SUD treatment in IMDs. Effective July 1, 2017, the approval permitted otherwise-covered services to be provided to Medicaid-eligible individuals aged 21 to 64 who are enrolled in an MCO and reside in a non-public IMD based on American Society of Addiction Medicine (ASAM) residential levels 3.7-WM, 3.7, 3.5, and 3.3 for up to two non-consecutive 30-day stays annually. On January 1, 2019, the Department phased in coverage of ASAM level 3.1. In March 2019, the Department received approval for a waiver amendment to allow coverage for ASAM level 4.0 for beneficiaries with a primary SUD and a secondary MHD in inpatient hospital settings only for up to 15 days per month. The Department extended coverage to individuals dually eligible for Medicare and

Medicaid as of January 1, 2020. Residential Treatment was expanded in the 2022 to 2026 waiver renewal to include individuals with SMI and SED, and the waiver renewal removed caps on LOS, with the aim of a statewide average LOS of 30 days or less.

Table 78 presents the total cost of care by member month for HealthChoice participants who received SUD-related IMD treatment in CY 2019 and CY 2023.[65] The total number of member months for participants increased by 37.9% between CY 2019 and CY 2023, whereas total cost of care increased by 74.7%. The cost per member per month (PMPM) increased by $719 (26.7%) between CY 2019 and CY 2023. In CY 2019 and CY 2023, participants aged 65 and over had the highest PMPM cost and female enrollees had slightly higher PMPM costs than males.[66] Black participants had the highest PMPM cost in CY 2019 but Native Americans had the highest PMPM costs in CY 2023. Baltimore City participants had the highest PMPM cost in CY 2019 and CY 2023.

Table 78. Cost of Care of HealthChoice Participants Who Received SUD-Related IMD Treatment, CY 2019 and CY 2023

Demographics	Total Member Months	Total Medicaid Cost	Cost Per Member Month	Total Member Months	Total Medicaid Cost	Cost Per Member Month
	CY 2019			CY 2023		
Age Group (Years)						
00–18	85	$186,733	$2,197	488	$1,307,466	$2,679
19–39	59,939	$141,322,355	$2,358	74,911	$224,763,332	$3,000
40–64	49,490	$152,687,433	$3,085	75,181	$285,234,657	$3,794
65+	115	$657,015	$5,713	553	$3,847,130	$6,957
Total	**109,629**	**$294,853,536**	**$2,690**	**151,133**	**$515,152,585**	**$3,409**
Sex						
Female	38,452	$104,989,429	$2,730	48,721	$168,687,648	$3,462
Male	71,177	$189,864,106	$2,667	102,412	$346,464,937	$3,383
Total	**109,629**	**$294,853,536**	**$2,690**	**151,133**	**$515,152,585**	**$3,409**
Race/Ethnicity						
Asian	898	$2,205,178	$2,456	1,494	$4,323,210	$2,894
Black	44,912	$127,777,154	$2,845	65,541	$235,738,380	$3,597
White	57,733	$150,331,469	$2,604	71,753	$239,815,315	$3,342
Hispanic	2,145	$5,260,992	$2,453	5,359	$14,865,550	$2,774
Native American	875	$2,343,284	$2,678	1,401	$16,057,158	$11,461
Other*	3,066	$6,935,458	$2,262	5,585	$4,352,972	$779
Total	**109,629**	**$294,853,536**	**$2,690**	**151,133**	**$515,152,585**	**$3,409**
Region*						
Baltimore City	37,258	$119,578,826	$3,209	44,576	$186,637,703	$4,187
Baltimore Suburban	32,209	$80,814,459	$2,509	43,709	$147,143,080	$3,366
Eastern Shore	13,345	$29,517,162	$2,212	18,681	$54,520,984	$2,919
Southern Maryland	6,283	$12,886,582	$2,051	8,190	$22,067,234	$2,694
Washington Suburban	8,173	$19,516,059	$2,388	16,803	$46,387,781	$2,761
Western Maryland	12,205	$32,104,359	$2,630	18,909	$57,687,272	$3,051
Out of State	156	$436,089	$2,795	265	$708,530	$2,674
Total	**109,629**	**$294,853,536**	**$2,690**	**151,133**	**$515,152,585**	**$3,409**

[65] Costs are rounded to the nearest whole dollar.

[66] For data available.

*"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

Table 79 displays the rate of MAT among HealthChoice participants who received IMD care, by race and ethnicity. Overall, the rate of MAT decreased 7.8 percentage points between CY 2019 and CY 2023, with a drop of 4.1 percentage points between CY 2021 and CY 2022. White participants in an IMD consistently had MAT rates greater than 70% over the measurement period. Only Native American participants had higher rates in CY 2019, 2020, and 2021. Hispanic participants in an IMD had the lowest MAT rates over the measurement period, except for CY 2019 and CY 2023, when Asian participants had the lowest rate. The percentage of Hispanic participants in an IMD with MAT fell from a high of 71.3% in CY 2019 to 66.9% in CY 2023.

Table 79. Use of Medication Assisted Treatment among HealthChoice Enrollees with an IMD Placement, by Race and Ethnicity, CY 2019–CY 2023

Race/Ethnicity	Total IMD Participants	Number of Participants w/ MAT	Percentage of Participants w/ MAT
CY 2019			
Asian	75	51	68.0%
Black	3,596	2,512	69.9%
White	4,956	3,924	79.2%
Hispanic	174	124	71.3%
Native American	72	58	80.6%
Other*	252	203	80.6%
Total	**9,125**	**6,872**	**75.3%**
CY 2020			
Asian	72	51	70.8%
Black	3,520	2,430	69.0%
White	4,570	3,600	78.8%
Hispanic	198	131	66.2%
Native American	67	57	85.1%
Other	270	199	73.7%
Total	**8,697**	**6,468**	**74.4%**
CY 2021			
Asian	91	68	74.7%
Black	3,847	2,662	69.2%
White	4,927	3,882	78.8%
Hispanic	243	163	67.1%
Native American	81	64	79.0%
Other	313	218	69.6%
Total	**9,502**	**7,057**	**74.3%**
CY 2022			
Asian	105	65	61.9%
Black	4,301	2,717	63.2%
White	5,437	4,167	76.6%
Hispanic	308	182	59.1%
Native American	94	69	73.4%
Other	410	284	69.3%

Race/Ethnicity	Total IMD Participants	Number of Participants w/ MAT	Percentage of Participants w/ MAT
Total	**10,655**	**7,484**	**70.2%**
CY 2023			
Asian	116	65	56.0%
Black	4,963	2,948	59.4%
White	5,836	4,369	74.9%
Hispanic	417	279	66.9%
Native American	111	70	63.1%
Other	426	284	66.7%
Total	**11,869**	**8,015**	**67.5%**

*"Other" race/ethnicity category includes Pacific Islanders, Alaskan Natives, Two or More Races, Prefer Not to Say, and Unknown.

As part of the waiver, Hilltop performed an analysis to determine the impact of IMD treatment on the health and wellbeing of the Maryland population: namely, whether receiving IMD services impacted the likelihood of a participant initiating or engaging in AOD dependence treatment post-diagnosis.[67] Table 80 is a logistic regression that presents the results of said analysis. Of the HealthChoice enrollees with an AOD dependence diagnosis, those who received IMD treatment were 12% more likely than participants who did not receive IMD treatment to initiate treatment post diagnosis (p<0.001). However, IMD treatment had no statistically significant impact on the likelihood of enrollees engaging in ongoing treatment after their initiation visit. Other associations found by the regression analysis include that participants in the Families and Children and ACA Expansion coverage categories were more likely than those in the ABD coverage category to initiate and to stay engaged in drug dependence treatment (p<0.001), while those in the MCHP coverage category were less likely to take each of those steps (p<0.01). Residents of every other Maryland region were less likely to take either step than Baltimore City residents (p<0.001), and participants in every other racial group were less likely to take either step than White participants (p<0.001 and p<0.01).

Table 80. Impact of IMD Care on Probability of Initiation and Engagement of AOD Dependence Treatment CY 2019–CY 2023

Effect	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
	Initiation			Engagement		
	OR	95% CI		OR	95% CI	
IMD	1.120***	1.08	1.17	1.009	0.97	1.05
Age	1.007***	1.01	1.01	1.008***	1.01	1.01
Female†	1.004	0.97	1.04	1.002	0.97	1.03
Last Coverage Category†						
Families & Children	1.171***	1.11	1.23	1.197***	1.14	1.26
MCHP	0.815**	0.71	0.94	0.777**	0.67	0.90

[67] Initiation of AOD Treatment: Members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. Engagement of AOD Treatment: members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

Effect	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
	Initiation			Engagement		
	OR	95% CI		OR	95% CI	
ACA	1.234***	1.18	1.29	1.261***	1.21	1.32
Region†						
Baltimore Suburban	0.881***	0.85	0.92	0.872***	0.84	0.91
Eastern Shore	0.663***	0.63	0.69	0.676***	0.64	0.71
Out of State	0.894	0.61	1.31	0.888	0.61	1.29
Southern Maryland	0.578***	0.54	0.61	0.584***	0.55	0.62
Washington Suburban	0.628***	0.60	0.66	0.614***	0.58	0.64
Western Maryland	0.767***	0.73	0.81	0.805***	0.76	0.85
Race/Ethnicity†						
Asian	0.644***	0.58	0.72	0.657***	0.59	0.74
Black	0.706***	0.68	0.73	0.722***	0.70	0.75
Hispanic	0.755***	0.70	0.81	0.757***	0.71	0.81
Native American	0.858***	0.75	0.99	0.811**	0.71	0.93
Other	0.875*	0.81	0.94	0.857**	0.80	0.92
Comorbidity Score†						
Moderate	1.078**	1.02	1.14	1.045	0.99	1.10
High	0.859***	0.81	0.91	0.807***	0.76	0.85
Very High	0.902**	0.85	0.96	0.678***	0.64	0.72
Other	1.197	0.91	1.57	0.988	0.76	1.29
Year†						
2020	1.122***	1.07	1.17	0.983	0.94	1.03
2021	1.133***	1.09	1.18	1.038	1.00	1.08
2022	1.362***	1.30	1.42	2.470***	2.36	2.58
2023	1.374***	1.32	1.44	2.481***	2.374	2.594
Constant	1.231	1.12	1.35	0.719	0.66	0.79

*** p<.001, ** p<.01, * p<.05

†, Reference Groups: Male, Aged, Blind, or Disabled (ABD), Baltimore City, White, Low, 2019

Table 81 presents the results of a logistic regression analyzing the impact of IMD care on the probability of initiation and engagement of AOD treatment for enrollees with a mental health diagnosis. These results mirror those found for enrollees with an SUD diagnosis. HealthChoice enrollees with a mental health condition and an AOD dependence diagnosis who received IMD care were 14.3% more likely to initiate treatment post-diagnosis compared to those who did not receive IMD care (p<0.001). However, IMD treatment had no statistically significant impact on the likelihood of enrollees engaging in ongoing treatment. Other findings include that participants in the Families and Children and ACA Expansion coverage categories were more likely than participants in the ABD coverage category to initiate and to engage in AOD dependence treatment (p<0.001); that residents of every other Maryland region were less likely than Baltimore City residents to take each step (p<0.001); and that participants of all other races and ethnicities were less likely than White participants to initiate treatment and to engage in treatment (p<0.05). However, the results for Native American participants were not statistically significant. The results from these regression analyses indicate that, while usage of IMD care is associated with an increased likelihood of participants initiating AOD dependence treatment, it

has no statistically significant impact on the likelihood of engaging in ongoing treatment. The cause of this association requires additional investigation.

Table 81. Impact of IMD Care on Probability of Initiation and Engagement of AOD Dependence Treatment for Enrollees with a Mental Health Diagnosis CY2019–CY 2023

Effect	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
	Initiation			Engagement		
	OR	95% CI		OR	95% CI	
IMD	1.143***	1.09	1.20	1.036	0.99	1.09
Age	1.008***	1.01	1.01	1.009***	1.01	1.01
Female†	0.960	0.92	1.00	0.977	0.94	1.02
Last Coverage Category†						
Families & Children	1.268***	1.19	1.36	1.285***	1.20	1.38
MCHP	1.054	0.88	1.27	0.957	0.79	1.16
ACA	1.330***	1.26	1.41	1.378***	1.30	1.46
Region†						
Baltimore Suburban	0.823***	0.78	0.87	0.795***	0.75	0.84
Eastern Shore	0.657***	0.61	0.70	0.666***	0.62	0.71
Out of State	0.691	0.42	1.15	0.612	0.36	1.03
Southern Maryland	0.573***	0.52	0.63	0.579***	0.53	0.63
Washington Suburban	0.611***	0.57	0.66	0.540***	0.50	0.58
Western Maryland	0.724***	0.67	0.78	0.739***	0.69	0.79
Race/Ethnicity†						
Asian	0.789**	0.66	0.94	0.815*	0.68	0.97
Black	0.797***	0.76	0.83	0.805***	0.77	0.84
Hispanic	0.862**	0.78	0.96	0.847**	0.76	0.94
Native American	0.896	0.74	1.08	0.876	0.72	1.06
Other	0.894*	0.81	0.99	0.838**	0.76	0.93
Comorbidity Score†						
Moderate	1.030	0.94	1.13	1.028	0.94	1.13
High	0.816***	0.74	0.90	0.769***	0.70	0.85
Very High	0.839***	0.76	0.92	0.649***	0.59	0.72
Other	1.305	0.86	1.99	1.028	0.69	1.53
Year†						
2020	1.144***	1.08	1.21	0.987	0.93	1.05
2021	1.217***	1.15	1.29	1.089**	1.03	1.16
2022	1.473***	1.39	1.57	2.701***	2.54	2.88
2023	1.482***	1.39	1.57	2.708***	2.55	2.88
Constant	1.198	1.05	1.36	0.698	0.61	0.79

*** $p<.001$, ** $p<.01$, * $p<.05$

†, Reference Groups: Male, Aged, Blind, or Disabled (ABD), Baltimore City, White, Low, 2019

Assistance in Community Integration Services (ACIS) Community Health Pilot Program

The goals of the ACIS pilot program, which began in late 2017, are to reduce unnecessary health services use, increase housing stability, and improve health outcomes for individuals at risk of institutional placement or homelessness.[68] Four jurisdictions, referred to as lead entities (LEs), currently participate in the pilot program: the Baltimore City Mayor's Office of Homeless Services (Baltimore City), the Cecil County Health Department (Cecil County), the Montgomery County Department of Health and Human Services (Montgomery County), and the Prince George's County Health Department (Prince George's County).

Hilltop recently completed the sixth annual review of the ACIS pilot program, with a focus on the living situations of ACIS participants at enrollment, obtainment of stable housing, ACIS billing and ACIS service utilization, and health service utilization. This evaluation focuses on CY 2019 through CY 2023.

Hilltop analyzed ACIS service utilization and MMIS2 health service utilization for the 799 program participants enrolled during CY 2019 to CY 2023. Table 82 shows the number of ACIS enrollments by sex, race/ethnicity, and age group during each calendar year. During the study period, more males (55.6%) were enrolled than females (44.4%). Similarly, more Black participants (63.6%) were enrolled than any other racial category. Finally, more 51- to 60-year-olds (30.7%) were enrolled compared to any other age group.

Table 82. Demographics of Newly Enrolled ACIS Participants, CY 2019–CY 2023

Demographic Characteristic	CY 2019 N=164		CY 2020 N=160		CY 2021 N=176		CY 2022 N=120		CY 2023 N=179		Total N=799	
	#	%	#	%	#	%	#	%	#	%	#	%
Sex												
Female	85	51.8%	44	27.5%	67	38.1%	53	44.2%	106	58.6%	355	44.4%
Male	79	48.2%	116	72.5%	109	61.9%	67	55.8%	73	40.3%	444	55.6%
Race/Ethnicity												
Black	108	65.9%	98	61.3%	128	72.7%	64	53.3%	110	60.8%	508	63.6%
Other*	**	**	23	14.4%	18	10.2%	26	21.7%	33	18.2%	100	12.5%
White	**	**	39	24.4%	30	17.0%	30	25.0%	36	19.9%	135	16.9%
Age Category at Enrollment												
> 30	24	14.6%	19	11.9%	22	12.5%	16	13.3%	42	23.2%	123	15.4%
31–40	**	**	35	21.9%	37	21.0%	24	20.0%	33	18.2%	129	16.1%
41 –50	41	25.0%	30	18.8%	36	20.5%	19	15.8%	43	23.8%	169	21.2%
51–60	49	29.9%	56	35.0%	63	35.8%	40	33.3%	37	20.4%	245	30.7%
61+	**	**	20	12.5%	18	10.2%	21	17.5%	24	13.3%	83	10.4%

*"Other" race/ethnicity category includes Asian, Hispanic, Pacific Islander, Native American, Two or More Races, Other, and Unknown.
**Cell values of 10 or less have been suppressed.

[68] See ACIS press release at https://health.maryland.gov/newsroom/Pages/Maryland-Medicaid-Announces-Community-Health-Pilot-Selections.aspx

The ACIS data analyzed included:

- General living situation at time of enrollment
- Specific living situation at time of enrollment
- ACIS participants stably housed
    - Number of days from ACIS enrollment date to stable housing
    - First stable housing obtained
- ACIS billing review
- ACIS service delivery
- ACIS participant discharges

The MMIS2 services analyzed included:

- ED visits
- Avoidable ED visits
- Inpatient admissions
- MHD inpatient admissions
- SUD inpatient admissions
- Nursing facility admissions
- Ambulatory care visits
- Participants with a diagnosis of an MHD
- Participants with a diagnosis of an SUD
- MHD outpatient community visits
- SUD outpatient community visits

ACIS Data Measures

Figure 18 illustrates the general living situation of participants at the time of program enrollment. On average across all study years, approximately 73.4% of ACIS participants were homeless at the time of enrollment. The proportion of homeless participants at the time of enrollment decreased from 70% in CY 2022 to 60.9% in CY 2023.

Figure 18. ACIS Participants General Living Situation at Time of Enrollment, CY 2019–CY 2023

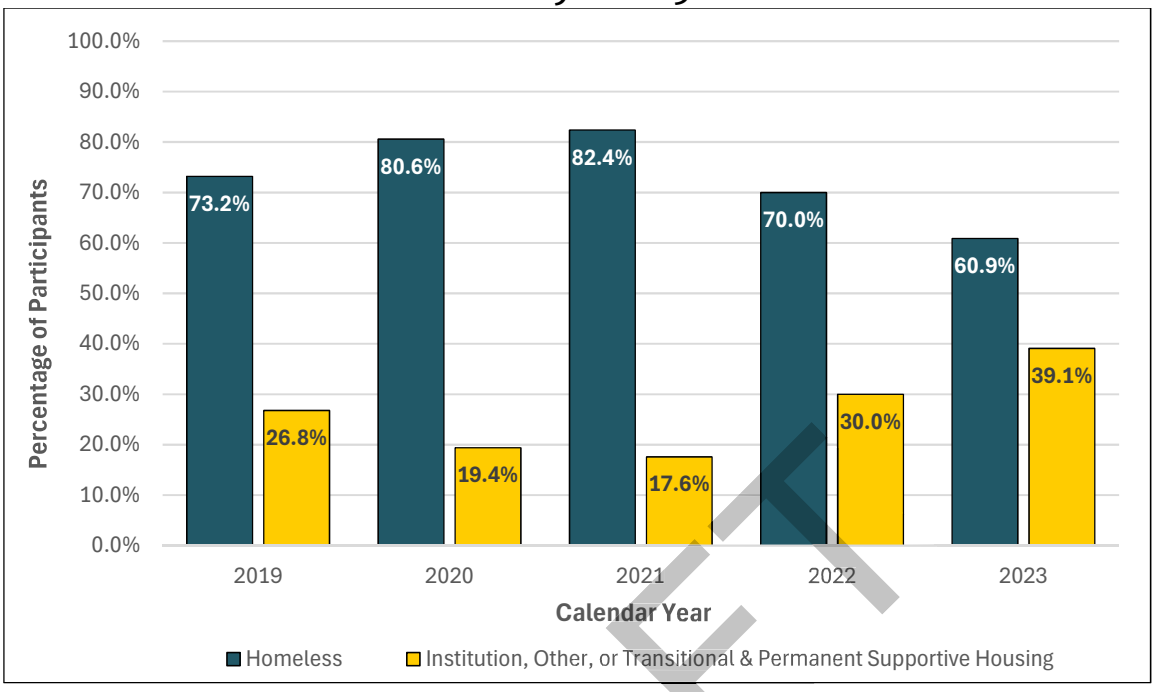
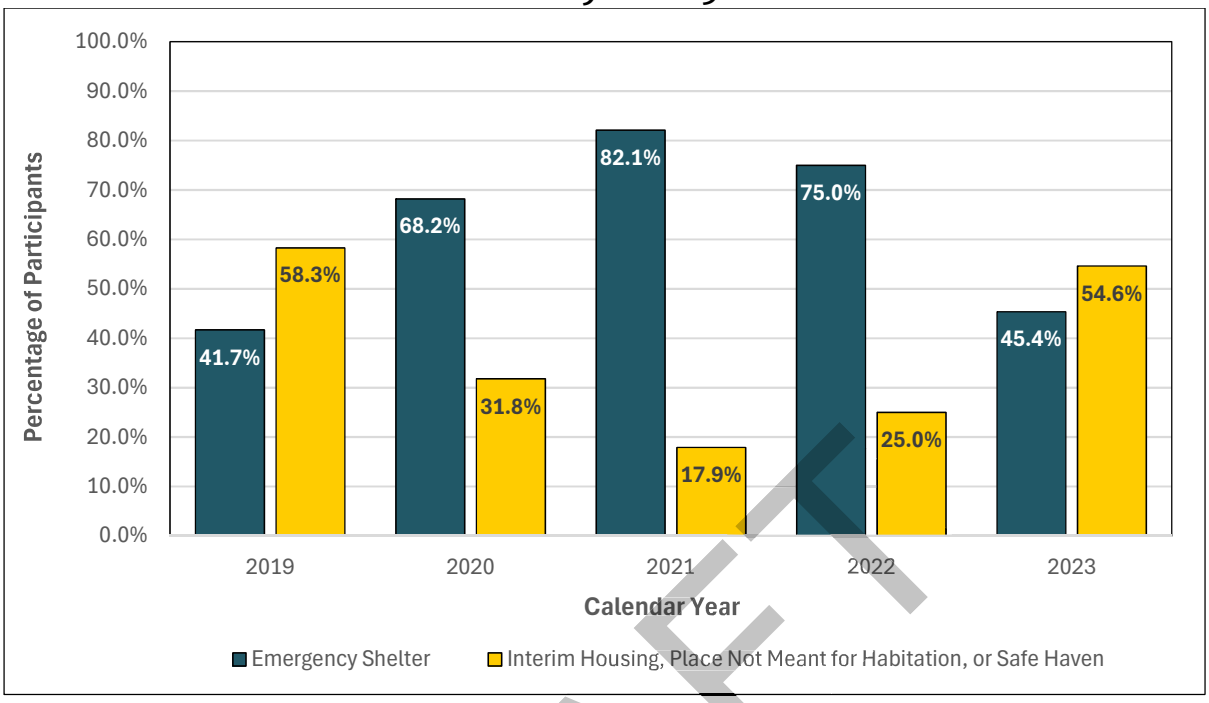


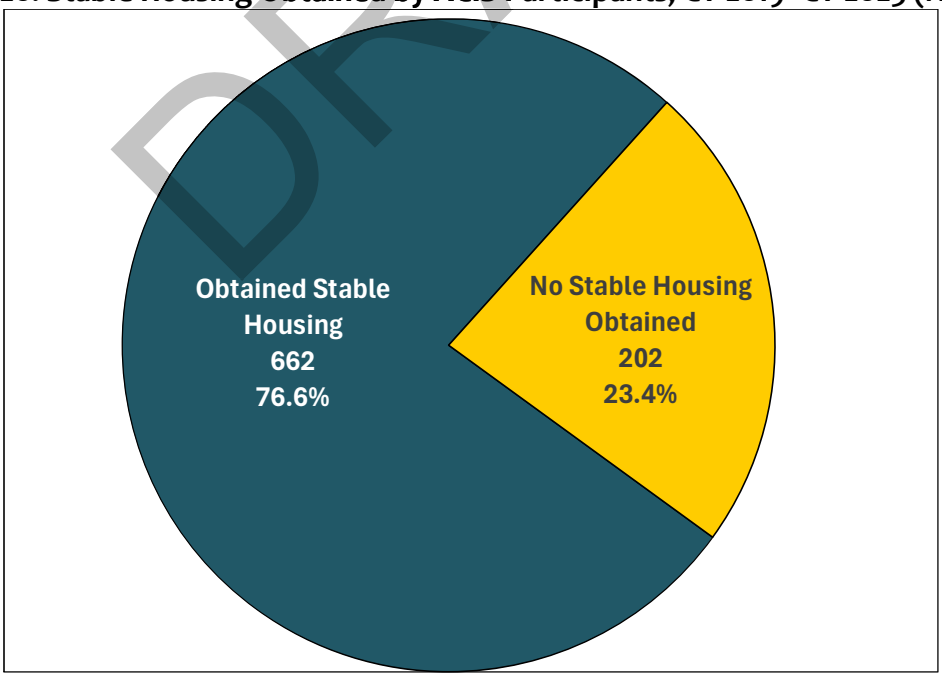
Figure 19 shows that, of the ACIS participants who were homeless, the proportion utilizing emergency shelter vouchers was 41.7% in CY 2019 before increasing to 82.1% in CY 2021, potentially due to service providers expanding hotel or motel placements in response to the COVID-19 PHE. The proportion of participants in an emergency shelter decreased significantly from 75% in CY 2022 to 45.4% in CY 2023.

Figure 19. ACIS Participants Specific Living Situation at Time of Enrollments, CY 2019–CY 2023



Of the 864 ACIS participants enrolled during the period between CY 2019 and CY 2023, approximately 77% of participants obtained stable housing (Figure 20).

Figure 20. Stable Housing Obtained by ACIS Participants, CY 2019–CY 2023 (N = 864)



Note: Based on ACIS service data through CY 2024 for ACIS participants enrolled during CY 2019 to CY 2023.

Table 83 shows the average, median, maximum, and minimum number of months that it took participants to obtain stable housing, by LE. There was considerable variation between different LEs in the average and maximum lengths of time before clients were stably housed, but the minimum number of days before a client was housed with each LE was zero. The LEs have varied approaches to helping participants obtain housing: Baltimore City and Montgomery County typically will not enroll a participant in the pilot program if they do not have a housing voucher available, and even with a housing voucher, it may still take some time getting a participant physically housed due to wait lists, housing stock issues, etc.

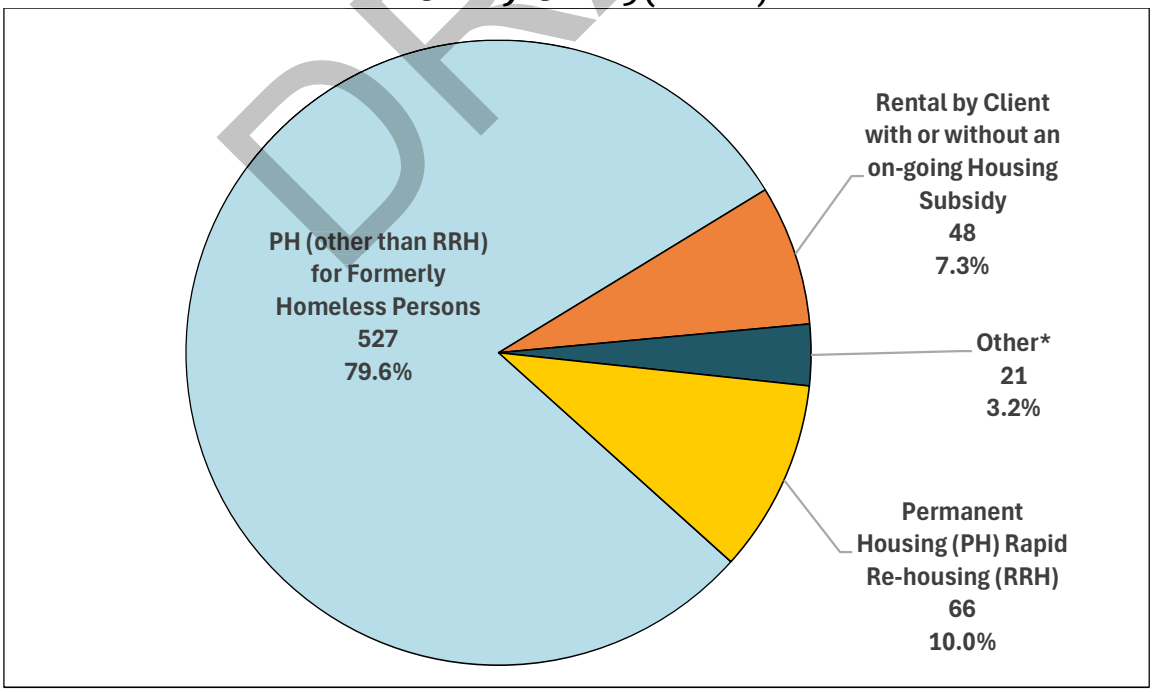
Table 83. Average, Median, Maximum, and Minimum Number of Months to Obtain Stable Housing for ACIS Participants, by Lead Entity, CY 2019 – 2023 (N = 662)

Lead Entity	Number of Months			
	Average	Median	Maximum	Minimum
Baltimore City	2.5	2	28	0
Cecil County	4.2	3	22	0
Montgomery County	2.2	1	16	0
Prince George's County	5.7	4	21	0

Note: Based on ACIS service data through CY 2024 for ACIS participants enrolled during CY 2019 to CY 2023.

Figure 21 shows the type of living situation of the ACIS participants when they first obtained stable housing. The majority (79.6%) began living in permanent housing (PH) other than rapid re-housing (RRH).

Figure 21. ACIS Participants Living Situation upon Obtaining Stable Housing, CY 2019–CY 2023 (N = 662)



*Other includes host home (non-crisis), owned by client, no ongoing housing subsidy, rental by client in a public housing unit, or rental by client with housing choice voucher.

LEs are only reimbursed for ACIS services delivered when a participant is Medicaid-eligible and the LE provided three or more ACIS services to that participant in a given month. This is a PMPM reimbursement model. Figure 22 shows the percentage of participants served by PMPM eligibility status for each CY 2023 quarter, by LE. Over the four quarters, Cecil County had the highest average of participants served who were PMPM-eligible (98%), followed by Prince George's County (94%), Montgomery County (87%), and Baltimore City (85%).

Figure 22. Percentage of Participants Served by PMPM Eligibility Status, by Lead Entity and CY 2023 Quarter

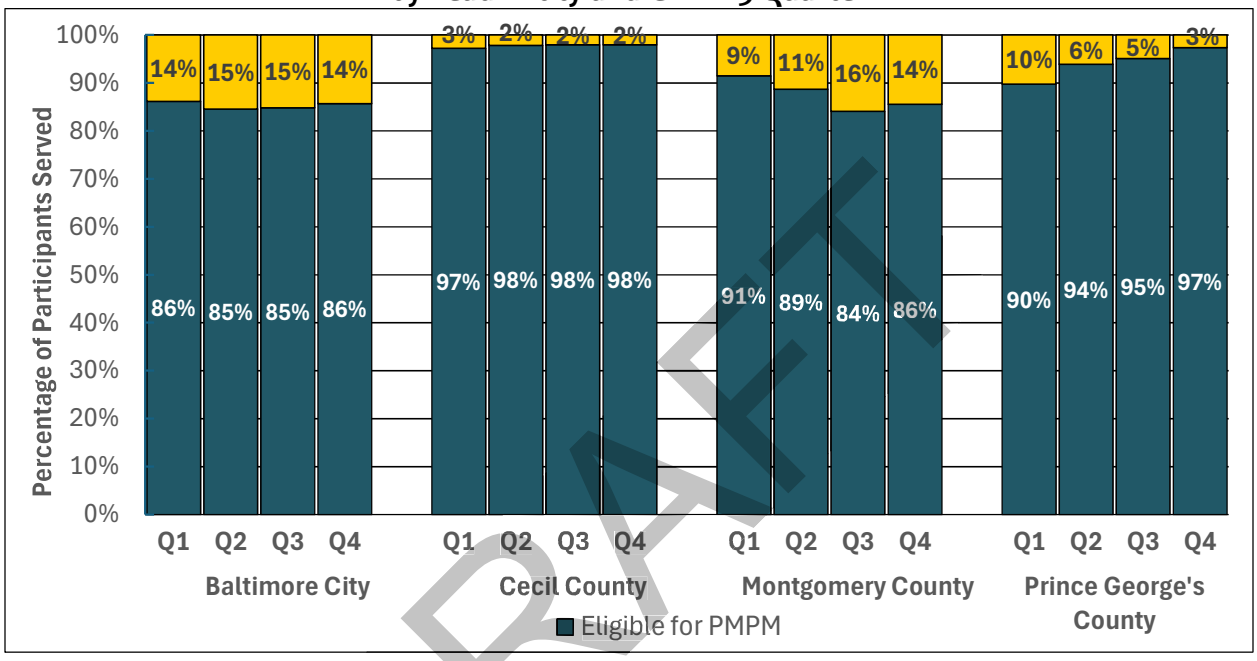


Figure 23 shows the percentage of services delivered by PMPM eligibility status for each CY 2023 quarter, by LE. Over the four quarters, Prince George's County had the highest average percentage of services delivered that were PMPM-eligible (98%), followed by Baltimore City and Cecil County (both at roughly 97% of services), and Montgomery County (which had an average of 96%).

Figure 23. Percentage of Services Delivered by PMPM Eligibility Status, by Lead Entity and CY 2023 Quarter

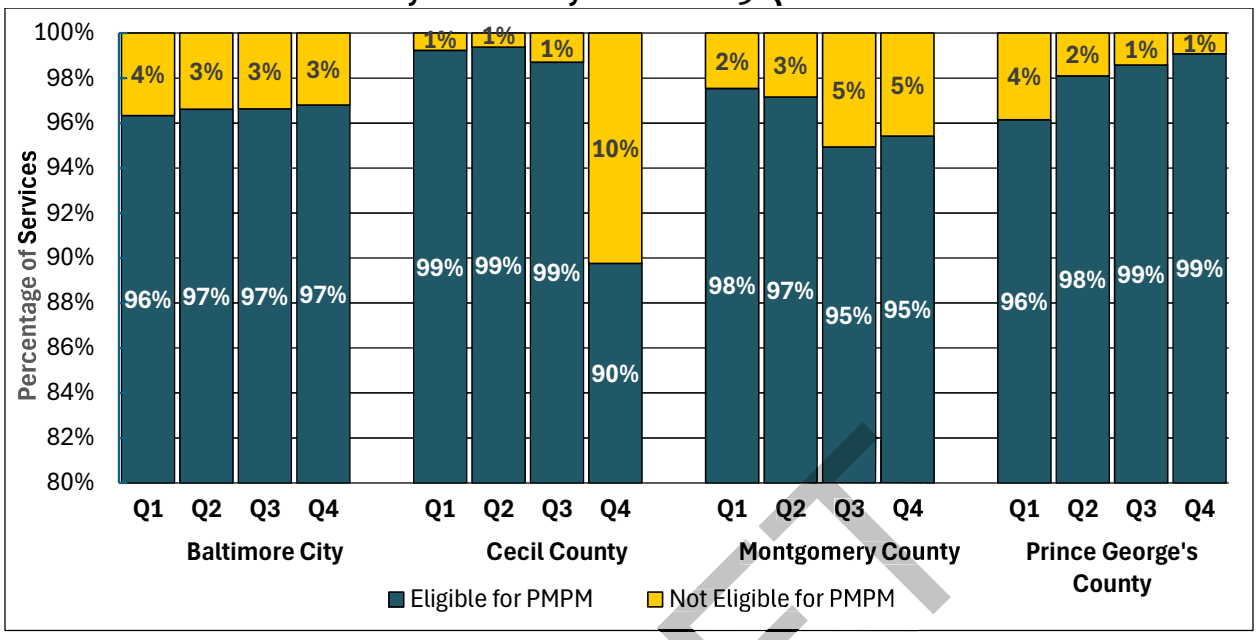


Table 84 shows the average eligible and non-eligible services per person by PMPM eligibility status for CY 2023. Baltimore City had the highest average eligible services per person (8.1), followed by Montgomery County (5.7).

Table 84. Average Eligible Services Per Person by PMPM Eligibility Status, CY 2023

Lead Entity	Average Eligible Services per Person	Average Non-Eligible Services per Person
Baltimore City	8.1	1.6
Cecil County	3.4	0.8
Montgomery County	5.7	1.5
Prince George's County	3.7	1.1

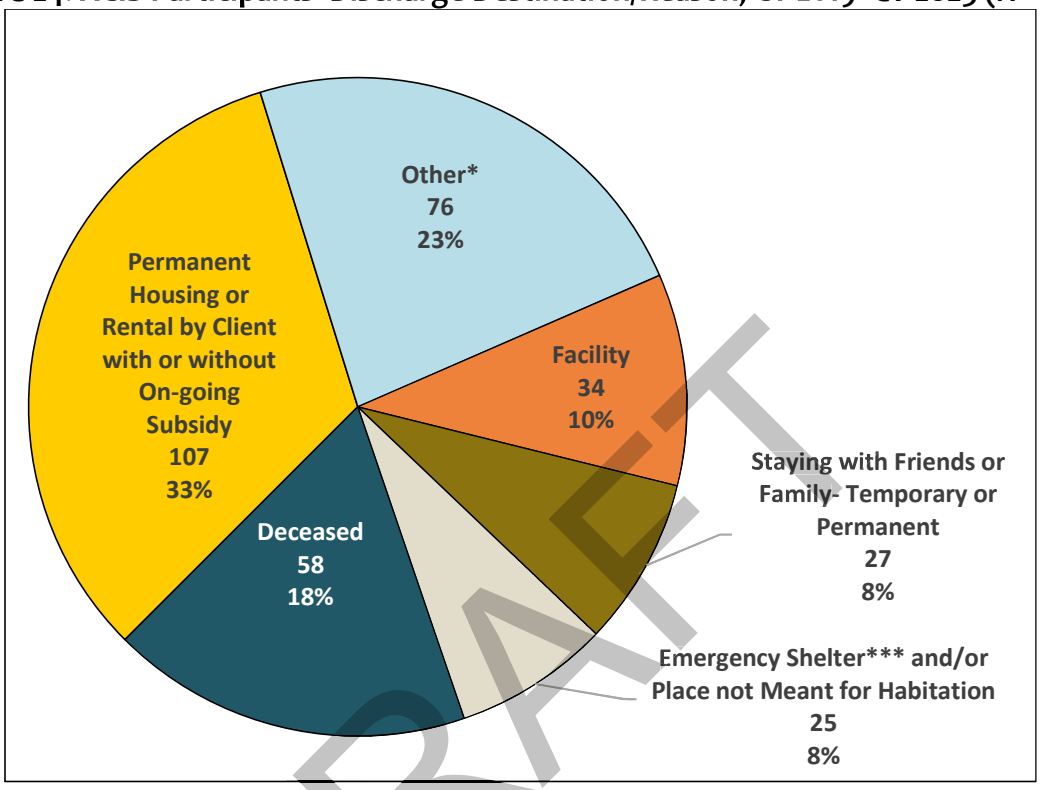
Housing case management was the most frequently delivered ACIS service during CY 2023, accounting for 69.3% of ACIS services (Table 85).

Table 85. ACIS Services Delivered, CY 2023

Type of ACIS Service	Frequency	Percentage
Housing Case Management	19,191	69.3%
Intake/Assessment	179	0.6%
Separation from Program—with and without Service	75	0.3%
Tenancy-Based Case Management	8,252	29.8%
Total	**27,697**	**100.0%**

Of ACIS participants enrolled between CY 2019 and CY 2023, 327 left the program by the end of CY 2023. Participants obtaining PH or renting with or without a housing subsidy accounted for the highest percentage (33%) of discharge destinations (Figure 24).

Figure 24. ACIS Participants' Discharge Destination/Reason, CY 2019–CY 2023 (N = 327)



*Other includes no exit interview completed, other, client refused, and client does not know.
**Emergency shelter includes hotels/motels paid for with or without an emergency voucher.
***Facility includes jail or prison, nursing home, substance abuse treatment center, hospital or other non-psychiatric facility, psychiatric facility, halfway house, or safe haven.

Health Service Utilization Measures

Table 86 shows that 79.4% of participants in CY 2023 had an ambulatory care visit. Inpatient admissions for ACIS participants decreased from 22.4% in CY 2019 to 16.7% in CY 2023, as did MHD inpatient admissions (7.2% in CY 2019 to 4.3% in CY 2023). The rate of ED visits for ACIS participants decreased from 51.6% in CY 2019 to 50.7% in CY 2023, while the percentage of participants with at least one avoidable ED visit also decreased from 35.6% in CY 2019 to 29.3% in CY 2023. The rate of nursing facility admissions decreased from 4.7% in CY 2020 to 2.5% in CY 2023.

Table 86. Health Service Utilization of ACIS Participants, CY 2019–CY 2023

Health Service Utilization	CY 2019 N = 250		CY 2020 N = 406		CY 2021 N = 483		CY 2022 N = 520		CY 2023 N = 611	
	#	%	#	%	#	%	#	%	#	%
Ambulatory Care Visits										
At Least One Visit	203	81.2%	336	82.8%	387	80.1%	418	80.4%	485	79.4%
No Visits	47	18.8%	70	17.2%	96	19.9%	102	19.6%	126	20.6%
Inpatient Admissions										
At Least One Visit	56	22.4%	109	26.9%	91	18.8%	85	16.4%	102	16.7%
No Visits	194	77.6%	297	73.2%	392	81.2%	435	83.7%	509	83.3%
MHD Inpatient Admissions										
At Least One Visit	18	7.2%	33	8.1%	22	4.6%	17	3.3%	26	4.3%
No Visits	232	92.8%	373	91.9%	461	95.5%	503	96.7%	585	95.7%
ED Visits										
At Least One Visit	129	51.6%	223	54.9%	261	54.0%	269	51.7%	310	50.7%
No Visits	121	48.4%	183	45.1%	222	46.0%	251	48.3%	301	49.3%
Avoidable ED Visits										
At Least One Visit	89	35.6%	129	31.8%	141	29.2%	158	30.4%	179	29.3%
No Visits	161	64.4%	277	68.2%	342	70.8%	362	69.6%	432	70.7%
Nursing Facility Admissions										
At Least One Visit	*	*	19	4.7%	19	3.9%	15	2.9%	15	2.5%
No Visits	*	*	387	95.3%	464	96.1%	505	97.1%	596	97.5%

* Cell values of 10 or less and those that can be used to calculate them have been suppressed.

Table 87 shows the number of ACIS participants with any SUD diagnosis. The percentage of ACIS participants with an SUD diagnosis in CY 2023 increased to 48.6% from 46.4% in CY 2022. Of those with an SUD diagnosis during the study period, those with at least one outpatient SUD visit decreased, from 34.7% in CY 2019 to 30.3% in CY 2023.

Table 87. ACIS Participants with Any SUD Diagnosis and SUD Outpatient Visit, CY 2019–CY 2023

Any Substance Use Disorder Diagnosis and Outpatient Visits	CY 2019 N = 250		CY 2020 N = 406		CY 2021 N = 483		CY 2022 N = 520		CY 2023 N = 611	
	#	%	#	%	#	%	#	%	#	%
Any SUD Diagnosis										
Yes	124	49.6%	208	51.2%	248	51.4%	241	46.4%	297	48.6%
No	126	50.4%	198	48.8%	235	48.7%	279	53.7%	314	51.4%
SUD Outpatient Visits										
At Least One Visit	43	34.7%	62	29.8%	82	33.1%	81	33.6%	90	30.3%
No Visits	81	65.3%	146	70.2%	166	66.9%	160	66.4%	207	69.7%

Table 88 shows the number of ACIS participants with any MHD diagnosis. The percentage of ACIS participants with an MHD diagnosis decreased from 72.0% in 2019 to 61.9% in CY 2023. Of those with an MHD diagnosis during the study years, those with at least one outpatient MHD visit increased, from 49.4% in CY 2019 to 52.9% in CY 2023.

Table 88. ACIS Participants with Any MHD Diagnosis and MHD Outpatient Visits, CY 2019–CY 2023

Any Mental Health Disorder Diagnosis and Outpatient Visits	CY 2019 N = 250		CY 2020 N = 406		CY 2021 N = 483		CY 2022 N = 520		CY 2023 N = 611	
	#	%	#	%	#	%	#	%	#	%
Any MHD Diagnosis										
Yes	180	72.0%	292	71.9%	294	60.9%	300	57.7%	378	61.9%
No	70	28.0%	114	28.1%	189	39.1%	220	42.3%	233	38.1%
MHD Outpatient Visits										
At Least One Visit	89	49.4%	153	52.4%	159	54.1%	164	54.7%	323	52.9%
No Visits	91	50.6%	139	47.6%	135	45.9%	136	45.3%	288	47.1%

National Diabetes Prevention Program (DPP)

The Department expanded coverage of the National DPP lifestyle change program to all eligible HealthChoice participants as of September 1, 2019. The National DPP is an evidence-based program established by the CDC to prevent or delay the onset of type 2 diabetes through healthy eating and physical activity. Hilltop partnered with the Department and MCOs to develop an algorithm that MCOs can use to search their members' electronic medical records to identify individuals who may be at risk of developing type 2 diabetes and therefore potentially be eligible for enrollment in the DPP. The Department is also focusing on establishing needed infrastructure, such as provider enrollment and MCO contracting. By identifying participants early through screening and testing for prediabetes, the Department hopes to reduce the incidence of diabetes and increase the quality of life for participants in the Maryland Medicaid program. This program also aligns with the population health goals under Maryland's Total Cost of Care Model and the SIHIS initiative.

Since its implementation in September 2019 through December 31, 2025, there have been 2,558 DPP encounters. The earliest date of service was June 3, 2020. Of the 2,558 DPP encounters, 1,441 (56.3%) were in-person, 718 (28.1%) were in-person makeup sessions, and 392 (15.3%) were conducted virtually. The average age of DPP participants was 47 years old (standard deviation: 12 years). The majority were women (85.4%), self-identified as Black/African American (64.6%), resided in Prince George's County (28.6%) and were in the Families and Children Medicaid coverage group (91.8%).

Association between DPP Participation and Diabetes Incidence and Utilization

Multivariate logistic models and multivariate linear models were used to analyze the impact of DPP participation on diabetes incidence, number of ED visits, and number of inpatient admissions. Table 89 presents the impact of DPP participation, defined as receiving at least one DPP encounter/service by a licensed DPP provider, on diabetes incidence when controlling for demographic characteristics (race/ethnicity, age, gender, and county of residence), comorbidity levels, coverage group, MCO, and year fixed effects.

Participation in DPP was associated with significantly lower odds of developing diabetes (OR = 0.516, $p<0.001$). A marginal increase in age was associated with an increase in the odds of developing diabetes (OR = 1.019, $p<0.001$).

Regarding race/ethnicity, individuals classified as Asian (OR = 1.357, $p<0.001$), Black (OR = 1.292, $p<0.001$), Hispanic (OR = 1.272, $p<0.001$), and Two or More Races (OR = 1.388, $p<0.001$) had significantly higher odds of developing diabetes compared to White enrollees.

County of residence was also significantly associated with diabetes incidence. Compared to residents of Baltimore City, residents of Allegany (OR = 1.415, $p<0.001$), Calvert (OR = 1.184, $p<0.05$), Caroline (OR = 1.258, $p<0.01$), and Garrett County (OR = 1.638, $p<0.001$) had higher odds of developing diabetes. In contrast, residents of Frederick (OR = 0.875, $p<0.01$), Howard (OR = 0.780, $p<0.001$), Montgomery (OR = 0.848, $p<0.001$), Prince George's (OR = 0.92, $p<0.01$), Wicomico (OR = 0.678, $p<0.001$), and Worcester County (OR = 0.777, $p<0.01$) had significantly lower odds of developing diabetes.

Individuals in the ABD coverage category had the highest odds of developing diabetes (OR = 1.384, $p<0.001$), while those in the MCHP category had significantly lower odds (OR = 0.692, $p<0.01$).

As expected, increasing comorbidity levels were strongly associated with higher odds of diabetes incidence. Compared to individuals with low comorbidity, those with moderate (OR = 2.819, $p<0.001$), high (OR = 4.267, $p<0.001$), and very high (OR = 10.638, $p<0.001$) comorbidity levels had substantially greater odds of developing diabetes.

Finally, year fixed effects indicate a declining trend in diabetes incidence over time, with significantly lower odds of diabetes in 2022 (OR = 0.910, $p<0.001$) and 2023 (OR = 0.879, $p<0.001$) compared to the reference year (2020).

Table 89. Associations between DPP Participation and Diabetes Incidence among HealthChoice Participants Aged 18-64 Years with Prediabetes, CY 2020–CY 2023

Effect	Diabetes Incidence		
	Odds Ratio	95% CI	
In DPP	0.516***	0.376	0.71
Age	1.019***	1.017	1.02
Male†	1.022	0.99	1.055
Race/Ethnicity†			
Asian	1.357***	1.266	1.454
Black	1.292***	1.239	1.347
Black and White	1.248	0.99	1.575
Hispanic	1.272***	1.198	1.351
Native American	1.158	0.979	1.37
Other	1.09	0.98	1.212
Pacific Islander	1.348	0.927	1.96
Two or More Races	1.388***	1.172	1.644
Unknown	0.77	0.53	1.118

Effect	Diabetes Incidence		
	Odds Ratio	95% CI	
County†			
Allegany	1.415***	1.242	1.611
Anne Arundel	0.984	0.916	1.058
Baltimore County	0.979	0.927	1.034
Calvert	1.184*	1.022	1.371
Caroline	1.258**	1.059	1.495
Carroll	0.901	0.787	1.03
Cecil	0.97	0.845	1.114
Charles	0.937	0.844	1.04
Dorchester	1.166	0.995	1.365
Frederick	0.875**	0.797	0.961
Garrett	1.638***	1.329	2.018
Harford	0.949	0.867	1.038
Howard	0.780***	0.712	0.855
Kent	0.986	0.78	1.248
Montgomery	0.848***	0.8	0.899
Out of State	1.175	0.739	1.87
Prince George's	0.92**	0.873	0.969
Queen Anne's	1.03	0.83	1.277
Somerset	0.884	0.752	1.04
St. Mary's	0.948	0.845	1.065
Talbot	0.988	0.804	1.214
Washington	0.937	0.844	1.041
Wicomico	0.678***	0.612	0.751
Worcester	0.777**	0.675	0.896
Last Coverage Cat.†			
ABD	1.384***	1.321	1.449
Families and Children	1.086***	1.049	1.126
MCHP	0.692**	0.549	0.872
Last MCO†			
Aetna	0.982	0.901	1.071
CareFirst	1.082*	1.01	1.159
Jai	0.976	0.883	1.079
Kaiser	0.712***	0.658	0.772
MPC	1.146***	1.091	1.205
MedStar	0.999	0.94	1.061
United	0.917**	0.869	0.967
Wellpoint	1.042	0.992	1.094
Comorbidity Score†			
Moderate	2.819***	2.573	3.089
High	4.267***	3.871	4.702
Very High	10.638***	9.685	11.684
Year†			
2021	0.963*	0.932	0.995

Effect	Diabetes Incidence		
	Odds Ratio	95% CI	
2022	0.910***	0.88	0.941
2023	0.879***	0.85	0.909
Constant	0.016***	0.014	0.018

***p<0.001, **p<0.01, *p<0.05

†, Reference Groups: Female, White, Baltimore City, Affordable Care Act, Priority Partners, Low, 2020

Table 90 presents the results of a linear regression model that was used to examine the association between DPP participation and the number of ED visits, controlling for demographic characteristics (race/ethnicity, age, gender, and county of residence), comorbidity levels, coverage group, MCO, and year fixed effects. In this model, coefficient values represent the predicted change in the number of ED visits associated with either 1) a one-unit increase in a continuous independent variable or 2) a categorical variable compared to the reference group.

The analysis found no statistically significant association between DPP participation and the number of ED visits (β = -0.066, 95% CI: -0.261, 0.129). However, age was significantly associated with a decrease in ED visits, with each additional year of age corresponding to 0.022 fewer ED visits (p<0.001). Male individuals had significantly higher ED utilization than females (β = 0.122, p<0.001).

Race/ethnicity was a significant predictor of ED utilization, with Black (β = 0.199, p<0.001) and Black-White multiracial (β = 0.255, p<0.05) individuals experiencing higher ED visit rates compared to White individuals. In contrast, Asian (β = -0.096, p<0.001), "Other" race (β = -0.101, p<0.001), and individuals with unknown race (β = -0.273, p<0.001) had significantly lower ED utilization. Coverage category also played a role.

Comorbidity levels were the strongest predictors of ED utilization. Compared to enrollees with low comorbidity, those with moderate (β = 0.379, p<0.001), high (β = 0.788, p<0.001), and very high (β = 2.884, p<0.001) comorbidity scores had significantly higher numbers of ED visits.

Table 90. Associations between DPP Participation and Number of ED Visits among HealthChoice Participants Aged 18-64 Years with Prediabetes, CY 2020–CY 2023

Effect	Number of ED Visits		
	Coefficient	95% CI	
In DPP	-0.066	-0.261	0.129
Age	-0.022***	-0.024	-0.021
Male†	0.122***	0.089	0.155
Race/Ethnicity†			
Asian	-0.096***	-0.138	-0.054
Black	0.199***	0.15	0.248
Black and White	0.255*	0.04	0.47
Hispanic	0.025	-0.021	0.071
Native American	0.102	-0.024	0.229
Other	-0.101***	-0.152	-0.051
Pacific Islander	-0.061	-0.234	0.113

Effect	Number of ED Visits		
	Coefficient	95% CI	
Two or More Races	-0.008	-0.097	0.081
Unknown	-0.273***	-0.339	-0.207
County†			
Allegany	-0.370***	-0.518	-0.222
Anne Arundel	-0.508***	-0.584	-0.432
Baltimore County	-0.500***	-0.569	-0.431
Calvert	-0.360***	-0.489	-0.231
Caroline	-0.542***	-0.655	-0.428
Carroll	-0.518***	-0.621	-0.414
Cecil	-0.142*	-0.284	-0.001
Charles	-0.448***	-0.536	-0.36
Dorchester	-0.047	-0.223	0.13
Frederick	-0.529***	-0.633	-0.425
Garrett	-0.404***	-0.6	-0.207
Harford	-0.531***	-0.617	-0.445
Howard	-0.598***	-0.669	-0.527
Kent	-0.167	-0.359	0.025
Montgomery	-0.525***	-0.589	-0.46
Out of State	-0.159	-0.819	0.501
Prince George's	-0.581***	-0.646	-0.517
Queen Anne's	-0.142	-0.31	0.027
Somerset	-0.262***	-0.412	-0.112
St. Mary's	-0.351***	-0.46	-0.242
Talbot	-0.280**	-0.479	-0.081
Washington	-0.414***	-0.633	-0.195
Wicomico	-0.309***	-0.407	-0.21
Worcester	-0.409***	-0.516	-0.301
Last Coverage Cat.†			
ABD	0.506***	0.411	0.601
Families and Children	-0.034**	-0.057	-0.011
MCHP	-0.536***	-0.598	-0.474
Last MCO†			
Aetna	0.054*	0.001	0.107
CareFirst	-0.013	-0.077	0.052
Jai	0.142	-0.01	0.294
Kaiser	-0.140***	-0.187	-0.092
MPC	0.045	-0.009	0.099
MedStar	0.004	-0.09	0.099
United	0.070**	0.02	0.119
Wellpoint	0.057*	0.011	0.103
Comorbidity Score†			
Moderate	0.379***	0.363	0.396
High	0.788***	0.76	0.816
Very High	2.884***	2.819	2.949

Effect	Number of ED Visits		
	Coefficient	95% CI	
Year†			
2021	0.029	-0.007	0.066
2022	0.013	-0.024	0.049
2023	0.095***	0.059	0.131
Constant	1.395***	1.304	1.487

***p<0.001, **p<0.01, *p<0.05
†, Reference Groups: Female, White, Baltimore City, Affordable Care Act, Priority Partners, Low, 2020

Table 91 shows the impact of DPP participation on the number of inpatient admissions, controlling for demographic characteristics (race/ethnicity, age, gender, and county of residence), comorbidity levels, coverage group, MCO, and year fixed effects. The analysis found no statistically significant association between DPP participation and the number of inpatient admissions (β = -0.040, 95% CI: -0.091, 0.011).

Age was significantly associated with a decrease in inpatient admissions, with each additional year of age corresponding to 0.003 fewer admissions (p<0.001). Male individuals had significantly higher inpatient admissions compared to females (β = 0.062, p<0.001).

Race/ethnicity was also a significant predictor of inpatient admission. Compared to White individuals, Asian (β = -0.036, p<0.001), Black (β = -0.015, p<0.05), Hispanic (β = -0.026, p<0.001), "Other" (β = -0.037, p<0.001), and Unknown race individuals (β = -0.064, p<0.001) had significantly lower inpatient utilization.

MCO enrollment showed mixed effects. Kaiser (β = 0.041, p<0.001) and CareFirst (β = 0.036, p<0.001) enrollees had significantly higher inpatient utilization, while those in MPC (β = -0.015, p<0.05) and MedStar (β = -0.016, p<0.05) had slightly lower inpatient admissions compared to those in Priority Partners.

Comorbidity levels were the strongest predictors of inpatient utilization. Compared to enrollees with low comorbidity, those with moderate (β = 0.018, p<0.001), high (β = 0.063, p<0.001), and very high (β = 0.833, p<0.001) comorbidity scores had significantly higher inpatient admissions.

Table 91. Associations between DPP Participation and Number of Inpatient Admissions among HealthChoice Participants Aged 18-64 Years with Prediabetes, CY 2020–CY 2023

Effect	Number of Inpatient Admissions		
	Coefficient	95% CI	
In DPP	-0.040	-0.091	0.011
Age	-0.003***	-0.003	-0.003
Male†	0.062***	0.054	0.07
Race/Ethnicity†			
Asian	-0.036***	-0.048	-0.025
Black	-0.015*	-0.027	-0.003
Black and White	0.040	-0.051	0.131

Effect	Number of Inpatient Admissions		
	Coefficient	95% CI	
Hispanic	-0.026***	-0.038	-0.014
Native American	-0.010	-0.05	0.03
Other	-0.037***	-0.055	-0.02
Pacific Islander	0.007	-0.057	0.07
Two or More Races	-0.01	-0.045	0.025
Unknown	-0.064***	-0.08	-0.049
County†			
Allegany	-0.027	-0.073	0.018
Anne Arundel	-0.070***	-0.089	-0.05
Baltimore County	-0.057***	-0.073	-0.042
Calvert	-0.070***	-0.109	-0.031
Caroline	-0.094***	-0.133	-0.055
Carroll	-0.087***	-0.12	-0.054
Cecil	-0.029	-0.072	0.014
Charles	-0.093***	-0.114	-0.072
Dorchester	-0.108***	-0.148	-0.068
Frederick	-0.105***	-0.127	-0.083
Garrett	-0.129***	-0.193	-0.066
Harford	-0.049***	-0.074	-0.023
Howard	-0.049***	-0.07	-0.029
Kent	-0.093**	-0.159	-0.028
Montgomery	-0.077***	-0.092	-0.062
Out of State	-0.008	-0.16	0.144
Prince George's	-0.063***	-0.078	-0.048
Queen Anne's	-0.101**	-0.163	-0.038
Somerset	-0.149***	-0.184	-0.115
St. Mary's	-0.082***	-0.108	-0.056
Talbot	-0.073*	-0.13	-0.016
Washington	-0.094***	-0.127	-0.062
Wicomico	-0.123***	-0.145	-0.1
Worcester	-0.178***	-0.205	-0.151
Last Coverage Cat.†			
ABD	0.149***	0.128	0.171
Families and Children	-0.033***	-0.04	-0.027
MCHP	-0.069***	-0.089	-0.049
Last MCO†			
Aetna	0.016	-0.001	0.033
CareFirst	0.036***	0.014	0.057
Jai	0.018	-0.016	0.051
Kaiser	0.041***	0.026	0.056
MPC	-0.015*	-0.028	-0.002
MedStar	-0.016*	-0.03	-0.001
United	-0.001	-0.014	0.012
Wellpoint	0.000	-0.012	0.012

Effect	Number of Inpatient Admissions		
	Coefficient	95% CI	
Comorbidity Score†			
Moderate	0.018***	0.014	0.022
High	0.063***	0.057	0.069
Very High	0.833***	0.817	0.85
Year†			
2021	-0.008	-0.017	0.001
2022	-0.016***	-0.025	-0.007
2023	-0.011*	-0.02	-0.002
Constant	0.226***	0.201	0.251

***p<0.001, **p<0.01, *p<0.05

†, Reference Groups: Female, White, Baltimore City, Affordable Care Act, Priority Partners, Low, 2020

Total Cost of Care

Table 92 compares the PMPM cost for HealthChoice enrollees with a prediabetes diagnosis in DPP to enrollees with a prediabetes diagnosis not in DPP. Analysis was restricted to enrollees aged 18 to 65 who are not currently pregnant.

PMPM costs for DPP participants fluctuated over the years, peaking in CY 2022 at $1,079.23 before decreasing slightly to $981.15 in CY 2023. This represents an overall increase of 46.4% from CY 2020 to CY 2022, followed by a 9.1% decrease in CY 2023.

For non-DPP participants, PMPM costs remained consistently higher than those of DPP participants. The PMPM cost for non-DPP participants decreased from $1,155.98 in CY 2020 to $1,107.58 in CY 2022, before slightly increasing to $1,122.76 in CY 2023.

By CY 2023, the gap between DPP and non-DPP PMPM costs had widened to $141.61, reversing the trend from CY 2022, when the cost difference had narrowed to $28.35. Overall, these cost trends suggest potential cost savings associated with the DPP program.

Table 92. Total Cost of Care for HealthChoice DPP Participants vs Non-DPP Participants with a Prediabetes Diagnosis, CY 2020–CY 2023

Calendar Year	Total FFS Cost	Total Capitation	Total Medicaid Cost	PMPM Cost
DPP Participants				
2020	$13,482.43	$300,145.18	$313,627.61	$670.14
2021	$410,927.94	$1,072,040.02	$1,482,967.96	$989.30
2022	$506,978.31	$1,857,603.59	$2,364,581.90	$1,079.23
2023	$2,824,248.38	$7,734,875.91	$10,559,124.29	$981.15
Non-DPP Participants				
2020	$309,057,095.10	$667,741,874.10	$976,798,969.10	$1,155.98
2021	$406,556,325.60	$870,495,894.40	$1,277,052,220.00	$1,130.36
2022	$477,611,292.20	$1,026,711,637.00	$1,504,322,929.00	$1,107.58
2023	$719,303,634.80	$1,446,400,393.00	$2,165,704,028.00	$1,122.76

Increased Community Services (ICS)

The ICS program provides cost-effective HCBS to certain adults with physical disabilities as an alternative to institutional care in a nursing facility. The goal of the program is to provide quality services for individuals aged 18 and over in the community, ensure the safety and wellbeing of its participants, and increase opportunities for self-advocacy and self-reliance. The ICS program was initially approved as part of the HealthChoice demonstration in 2009. While the ICS program offers the same service package as the Department's Community Options §1915(c) waiver, the ICS program differs in financial eligibility and some technical requirements. To participate in the ICS program, individuals must have a nursing facility stay of 90 days or more and be Medicaid-eligible in the last 30 days before transition. Once transitioned, participants contribute any income they have above 300% of their Supplemental Security Income to the cost of their care in the community. The 2016 waiver renewal expanded the program from 30 to 100 potential participants, and the ICS program was included in the 2021 waiver renewal. Hilltop analyzed the transitions of former long-stay nursing facility residents to community settings after they applied to the ICS program.

Methodology

The ICS measure utilized two data sources: MMIS2 and *LTSSMaryland*. *LTSSMaryland* was used to define those who meet the technical eligibility requirements to apply for the ICS program. This includes Community Options Waiver applicants who were denied due to overscale income who also applied for the ICS program from a nursing facility during the evaluation period: CY 2019 through CY 2023. To identify which of these people went on to transition from a nursing facility to the community under the ICS program, MMIS2 data on special program enrollment were examined. Hilltop also calculated the average Medicaid costs per member per year (PMPY) and per member per month (PMPM) for the identified ICS waiver participants and nursing facility residents during CY 2019 through CY 2023.

Results

Between CY 2019 and CY 2023, 108 long-stay nursing facility residents were eligible to transition from a nursing facility to a community setting under the ICS program. During this time, 13 people (12.0% of those eligible) successfully transitioned under the ICS program. In addition, during the measurement period, total PMPY Medicaid costs for ICS program participants averaged $43,068 while nursing facility costs averaged $67,335 per resident annually, a difference of $24,266 PMPY. On average, the total Medicaid PMPM costs for nursing facility residents were $3,710 higher than the total Medicaid costs for an ICS Waiver participant. While this program is small, it is contributing to the rebalancing effort moving participants from nursing facility living to the community with use of HCBS.

Family Planning Program

The 2016 HealthChoice waiver allowed the Department to provide a limited benefit package of family planning services to eligible participants through the end of 2021. As of January 2022,

family planning services were no longer covered through the §1115 waiver as they were incorporated into the State Plan. The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education, and referrals.

In CY 2017, women younger than 51 years—regardless of postpartum status—who were not otherwise eligible for Medicaid, CHIP, or Medicare and who had a family income at or below 200% of the FPL were eligible for the Family Planning program. The Department expanded eligibility under its Family Planning program to lift the age limit, open coverage to include men, and cover services for postpartum individuals effective July 1, 2018. Specifically, the §1115 waiver allowed women to receive full Medicaid benefits for two months postpartum. As of April 2022, the Department has expanded postpartum care services to 12 months regardless of any changes in income or household size through an SPA.[69] This aligns with Maryland's SIHIS priority to improve maternal and child health. Those who no longer qualify for Medicaid pregnancy benefits after the end of the postpartum period because they exceed income limits will be automatically enrolled in the Family Planning program for 12 months. After 12 months, these women can re-apply to continue their enrollment.

Table 93 shows that the number of family planning participants with any period of enrollment decreased from CY 2019 to CY 2023 by 24.0%. The percentage of participants with at least one service decreased by 5.6 percentage points during the evaluation period, with the rate remaining stable from CY 2022 to CY 2023.

Table 93. Number and Percentage of Family Planning Participants (Any Period of Enrollment) Who Received a Corresponding Service, CY 2019–CY 2023

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Number of Participants	16,375	14,748	13,838	13,486	12,437
Number with at Least 1 Service	2,034	1,634	1,156	914	848
Percentage with at Least 1 Service	12.4%	11.1%	8.4%	6.8%	6.8%

The number of participants with 12 months of enrollment in the Family Planning program decreased from CY 2019 to CY 2023 by 50.1% (Table 94). The percentage of participants enrolled in the program for 12 months (continuous enrollment) with at least one service increased slightly from 8.5% in CY 2019 to 8.6% in CY 2023, with a low of 5.5% in CY 2022.

Table 94. Number and Percentage of Family Planning Participants (12-Month Enrollment) Who Received a Corresponding Service, CY 2019–CY 2023

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Number of Participants	5,962	10,331	11,171	8,268	2,976
Number with at Least 1 Service	507	1,083	897	455	255
Percentage with at Least 1 Service	8.5%	10.5%	8.0%	5.5%	8.6%

[69] https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-announces-expanded-Medicaid-coverage-for-new-mothers.aspx.

The number of women enrolled in the Family Planning program for both any period of enrollment and 12 months of enrollment decreased from CY 2019 to CY 2023. However, the number of women enrolled continuously decreased sharply from CY 2022 to CY 2023, most likely due to continuous Medicaid eligibility ending in March 2023. Women who lose Medicaid coverage after their postpartum period are automatically enrolled in the Family Planning program, and their coverage auto-renews annually (previously coverage was limited up to five years). However, some women may be unaware that they are enrolled in the program because no action is required on their part. Consequently, they may not seek services or know they are eligible to receive them.

Section VII Conclusion

Throughout the demonstration period, resources generated through managed care efficiencies allowed the Department to establish innovative programs to improve the health status of the HealthChoice population. Residential Treatment for Individuals with SUD was made possible through a §1115 waiver of Medicaid's limitations for coverage of care in IMDs and is intended to improve outcomes for those with SUD. The PMPM cost of care for HealthChoice participants who received IMD treatment for an SUD increased by 26.7% between CY 2019 and CY 2023. Participants aged 65 and older had almost double the cost PMPM compared to other age groups. The MAT utilization rate among IMD participants decreased 7.8 percentage points between CY 2019 and CY 2023 with a 4.1 percentage point decrease between CY 2021 and CY 2022. Logistic regressions analyzing the impact of IMD care on the probability of initiation and engagement for AOD treatment indicate that IMD treatment is associated with an increased likelihood of participants initiating treatment but with no impact on the likelihood of engaging in ongoing treatment.

Hilltop recently completed the sixth annual review of the ACIS pilot program, whose goals are to help optimize housing stability, health services use, and health outcomes for individuals at risk of institutional placement or homelessness. Around 73.4% of ACIS participants were homeless when they enrolled in the program but around 77% of participants enrolled between CY 2019 and CY 2023 obtained stable housing, with the majority moved to permanent housing. The rates of ambulatory care visits, inpatient admissions, ED visits, and avoidable ED visits among the ACIS population decreased over the evaluation period.

Access to the National DPP lifestyle change program was expanded to all eligible HealthChoice participants as of September 1, 2019, to reduce the risk of type 2 diabetes and improve their health. Regression analyses indicate that participants in the DPP are significantly less likely to develop diabetes but found no association between DPP participation and ED visits inpatient admissions. PMPM costs were lower for DPP participants than for non-DPP participants each year between CY 2020 and CY 2023.

The Department monitors several ongoing programs, including the ICS program for ABD adults, where nearly 12.0% of participants transitioned to a community setting during the evaluation period. In the long-running Family Planning program, eligibility was expanded by removing the

age limit and opening coverage to men as well. As of 2023, more than 12,400 participants (with any period of enrollment) were enrolled in the program, and 6.8% received a family planning service.

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Appendix. Definitions and Specifications

Table A1. Coverage Category Inclusion Criteria

Coverage Category	Inclusion Criteria		
Aged, Blind, and Disabled (ABD)	Coverage Group = A04, H01, H98, H99, L01, L98, L99, S01, S02, S03, S04, S05, S06, S07, S08, S10, S14, S15, S16, S17, S18, S19, S20, S21, S98, S99		
MCHP	Coverage Group = D02, D04, P13, P14		
	OR		
	Coverage Group = F05, P06, P07	AND	Coverage Type = "S"
ACA Expansion	Coverage Group = A01, A02, A03		
Families & Children	All other Coverage Groups/Coverage Types		

Table A2. Medicaid Coverage Group Descriptions

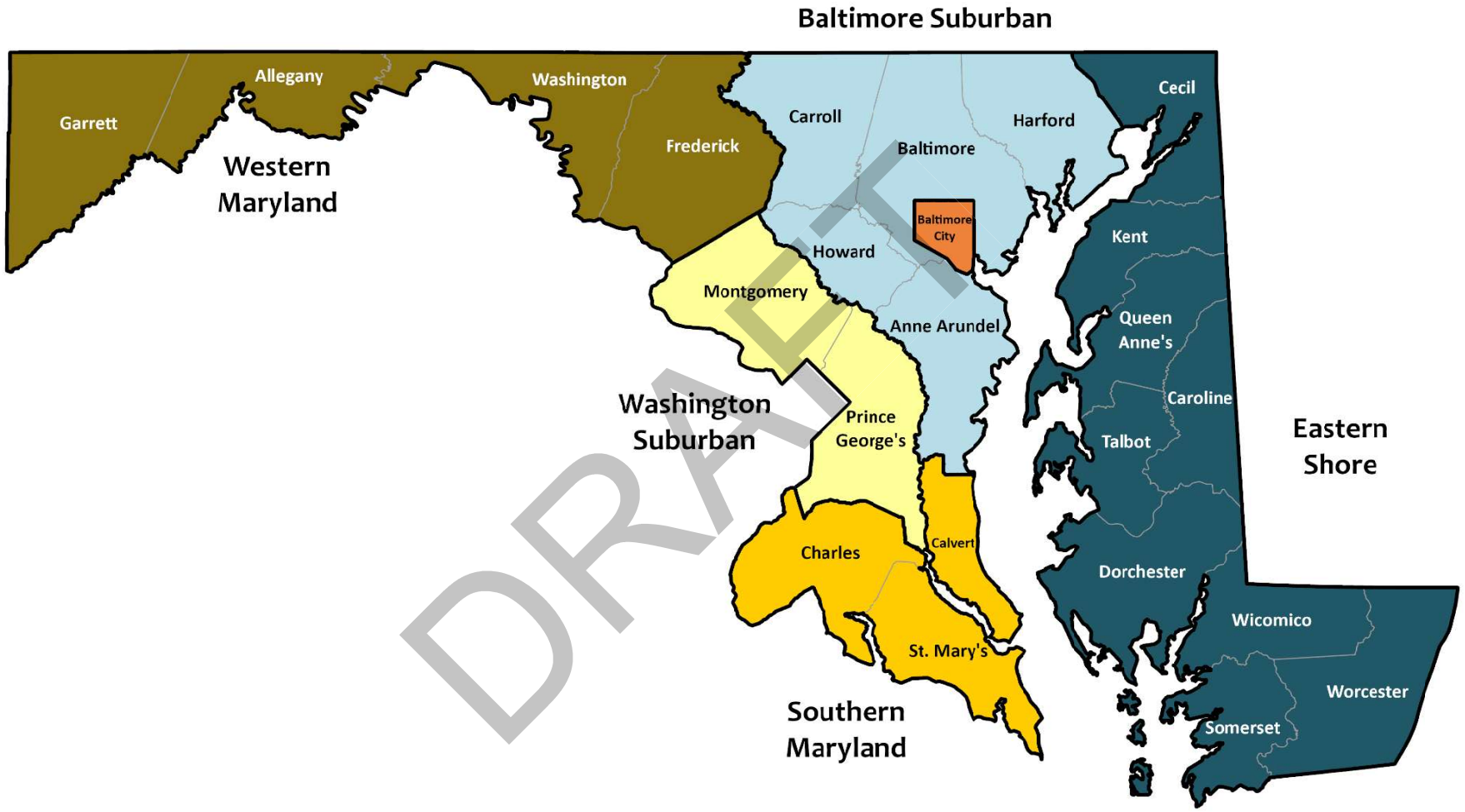
Coverage Group	Description
A02	Childless Adults < 65, 138% FPL, inc disabled
A03	Parents and Caretaker Relative 124%-138% FPL
A04	Disabled Adults, no Medicare 77% FPL
C10	Family Planning Presumptive Eligibility (FPPE)
C13	Presumptive Eligibility
D02	MCHP Premium, 212%-264% FPL
D04	MCHP Premium, 265%-322% FPL
E01	IV-E Adoption & Foster Care
E02	FAC Foster Care
E03	State-Funded Foster Care
E04	State-Funded Subsidized Adoption
E05	Former Foster Care up to 26 years old
F02	Post-TCA: Earnings Extension
F05	Parents/Primary Caretakers and Children <123% FPL
F98	Children 19 and 20 123% FPL
F99	FAC - Med Needy Spenddown
G01	Refugee Cash Assistance
G02	Post RCA: Earnings Extension
G98	Refugee Med Needy Non-Spenddown
G99	Refugee Med Needy Spenddown
H01	HCB Waiver
H02	HCBS Waiver Participants Processed on E&E
H13	Walter Lomax- Healthcare to Individual Erroneously Convicted
H98	HCB Waiver Med Needy
L01	SSI Recipient in LTC

Coverage Group	Description
L98	ABD Long Term Care
L99	ABD Long Term Care Spenddown
P02	Pregnant Women up to 189% FPL
P06	Newborns of Elig Mothers and their < 1
P07	Children 1-19, 1-6 143% FPL, 6-19 138% FPL
P10	Family Planning Program
P11	Pregnant Women 190% - 264% of FPL
P13	Child Under 19, up to 189% FPL
P14	Title XXI MCHP. under 19, 190-211% FPL
S01	Public Assistance to Adults (PAA)
S02	SSI Recipients
S03	Qualified Medicare Beneficiary (QMB)
S04	Pickle Amendment
S05	Disabled Widowed Beneficiaries (DWB)
S06	Qualified Disabled Working Individuals
S07	Specified Low Income Medicare Beneficiaries (SLMB) group I
S13-D	Employed Individuals with Disabilities Program (EID)
S14	Specified Low Income Medicare Beneficiaries (SLMB) group II
S16	Increased Community Services Program (ICS) formerly MPDP
S19	Disabled Adult Children (DAC)
S20	Disabled Widowed Beneficiaries (DWB)
S21	Temporary Category for Children Losing SSI Transitioning to Other Children's Medicaid Coverage Groups
S98	ABD - Med Needy
S99	ABD – Spenddown
T02	Family LTC Med Needy
T03	Medicaid Child Under 1 in LTC
T04	Medicaid Child Under 6 in LTC
T05	Medicaid Child Under 19 in LTC
T99	Family LTC Med Needy Spenddown
W01	Women's Breast & CC
X02	MAGI and Non-MAGI Undocumented or Ineligible Aliens, Emergency Medical Services
X11	Healthy Babies Act Prenatal (as of 7/1/2023)
X12	Healthy Babies Act Postpartum. (as of 7/1/2023)

Table A3. Medicaid Coverage Type Descriptions

Coverage Type	Description
A	Aged
B	Blind
C	Complimentary Coverage
D	Disabled
E	FC and SA
F	Family
G	Refugee
H	HCB Waiver
M	Medicaid Only
N	Not in CARES
P	Pregnant
R	Regular
T	Family LTC
U	Unemployed
X	Miscellaneous

Figure A1. Maryland Map with Regions and Counties



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Attachment II: Approved Evaluation Design Demonstration Hypotheses and Evaluation Measures, 2022–2026

Maryland Department of Health

§1115 HealthChoice Demonstration Evaluation Design

August 24, 2023

Table of Contents

Acronyms

ACA	Patient Protection and Affordable Care Act
ACIS	Assistance in Community Integration Services
AIDS	Acquired immunodeficiency syndrome
ASO	Administrative services organization
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CLR	Childhood Lead Registry
CMC	Corrective Managed Care
CMS	Centers for Medicare and Medicaid Services
CoCM	Collaborative Care Model
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar year
DPP	Diabetes Prevention Program
ED	Emergency department
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External quality review organization
FFS	Fee-for-service
HEDIS®	Healthcare Effectiveness Data and Information Set
HMO	Health maintenance organization
HIE	Health information exchange
HIV	Human immunodeficiency virus
HSI	Health Services Initiative
ICS	Increased Community Services
IMD	Institutions for mental disease
IT	Information technology
LARC	Long-acting reversible contraceptive
MCO	Managed care organization
MDH	Maryland Department of Health
NCQA	National Committee for Quality Assurance
OUD	Opioid use disorder
REM	Rare and Expensive Case Management
SBIRT	Screening, Brief Intervention and Referral to Treatment
SMI	Serious Mental Illness
SUD	Substance use disorder

Background and History of Maryland's §1115 Demonstration

Following approval of the §1115 waiver by the Centers for Medicare and Medicaid Services (CMS) in October 1996, Maryland implemented the HealthChoice program and moved its fee-for-service (FFS) and health maintenance organization (HMO) enrollees into a managed care payment system in July 1997.[1] HealthChoice managed care organizations (MCOs) receive a predetermined monthly capitated payment in exchange for providing covered services to participants. Since the program's inception, HealthChoice has provided oversight to the continuing standards of high-quality coordination of care and controlling Medicaid costs by providing a patient-focused system with a medical home for all beneficiaries; building on the strengths of the established Maryland health care system; providing comprehensive, prevention-oriented systems of care; holding MCOs accountable for high-quality care; and achieving better value and predictable expenses.

Subsequent to the initial grant, the Maryland Department of Health[2] (MDH) requested and received several program renewals—in 2002, 2005, 2008, 2011, 2013, 2016, and 2021. In June 2021, Maryland applied for its seventh extension of the HealthChoice demonstration, which CMS approved for the period of calendar years (CYs) 2022 to 2026. Approved effective January 1, 2022 through December 31, 2026, the current waiver period builds on the innovations of the previous extensions by focusing on developing cost-effective services that target the significant and complex health care needs of individuals enrolled in Maryland Medicaid. Specifically, the demonstration will implement initiatives to address the social determinants of health, such as those encountered by individuals with severe mental illness (SMI), substance use disorders (SUD), high-risk pregnant women and former foster care participants, among others.

As of May 2022, HealthChoice served over 1.75 million participants, constituting nearly 86 percent of Medicaid recipients in Maryland, over 452,000 of whom receive coverage under the ACA's Medicaid expansion.

Initial evaluation of new participants in HealthChoice due to the ACA expansion have suggested that not only does this population have significant, complex health needs, but they may also have limited health literacy or struggle with homelessness, leading to challenges in the appropriate use of care. Therefore, in addition to assuring that efforts to improve the quality of care throughout the HealthChoice demonstration continue during the current waiver period, MDH requested—and CMS approved—to implement or continue the following program expansions:

1) Collaborative Care Model Pilot Program which integrates primary care and behavioral health services for HealthChoice participants who have experienced a behavioral health need (either a mental health condition or SUD).
2) Community Health Pilots: Assistance in Community Integration Services (ACIS) for individuals residing in institutions or at imminent risk of institutional placement.
3) Increased Community Services (ICS) for individuals over the age of 18 who were determined

[1] CMS was then known as the Health Care Financing Administration.
[2] Formerly known as the Maryland Department of Health and Mental Hygiene.

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.

4) Diabetes Prevention Program (DPP) for individuals (18-64) who have prediabetes or are at high risk of developing type 2 diabetes.
5) Dental Services for Former Foster Care Individuals up to 26 years old.
6) Expansion of SUD Residential and Inpatient Treatment Services to remove caps on lengths of stays for SUD treatment in an IMD and aim for a statewide average length of stay of 30 days or less.

Two additional programs have been approved for the demonstration period:

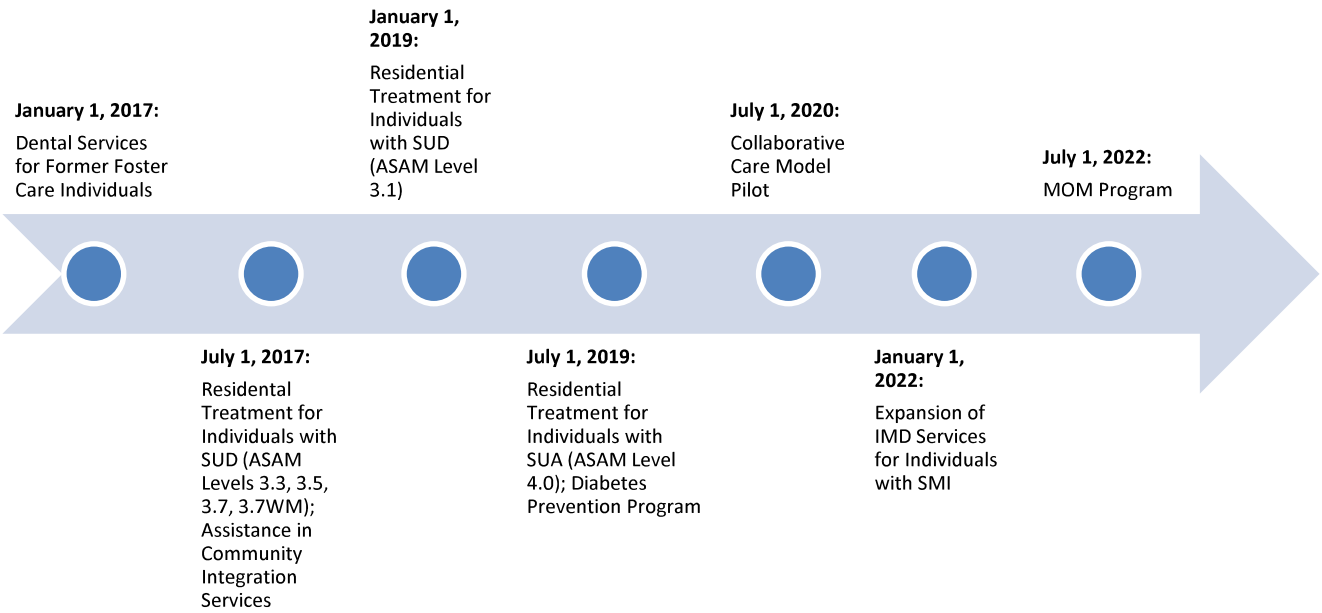
1) Expansion of IMD Services for Beneficiaries with SMI to cover short term stays of adults (21-64) who reside in a private IMD with an SMI diagnosis.
2) Maternal Opioid Misuse (MOM) program to provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination to pregnant and postpartum beneficiaries with opioid use disorder (OUD).

Due to being expanded statewide and incorporated into Maryland's state plan, the following programs are no longer included in the demonstration and will not be included in the evaluation:

1) Medicaid Alternative Destination Transport Pilot Program.
2) Evidence-Based Home Visiting Services Pilot Program.
3) Adult Dental Pilot Program.

Figure 1 provides a timeline for the implementation of the components associated with the seventh waiver extension and amendments.

Figure 1. Implementation Timeline for HealthChoice Demonstration Components



CMS requires evaluations of all §1115 waiver demonstrations. MDH and its Independent Evaluator (the Hilltop Institute at the University of Maryland, Baltimore County) will prepare a summative evaluation comparing HealthChoice's performance results with the research hypotheses.

Through the implementation and continuation of the HealthChoice demonstration, MDH aims to improve the health status of low-income Marylanders by meeting the following goals:

1) Improve access to health care for the Medicaid population;
2) Improve the quality of health services delivered;
3) Provide patient-focused, comprehensive and coordinated care by providing Medicaid participants with a single medical home;
4) Emphasize health promotion and disease prevention; and
5) Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies.

MDH aims to meet the following goals related to SUD:

1) Increased rates of identification, initiation, and engagement in treatment for SUD;
2) Increased adherence to and retention in treatment;
3) Reductions in overdose deaths, particularly those due to opioids;
4) Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5) Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6) Improved access to care for physical health conditions among beneficiaries with SUD.

MDH also aims to meet the following goals related to SMI/serious emotional disturbance (SED):

1) Reduced utilization and lengths of stay in EDs among beneficiaries with SMI while awaiting mental health treatment in specialized settings;
2) Reduced preventable readmissions to acute care hospitals and residential settings;
3) Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4) Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
5) Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Evaluation Questions and Hypotheses

As discussed above, the Maryland §1115 HealthChoice demonstration is a mature program, providing services to over one million participants annually. Evaluation questions will therefore focus on changes implemented during the waiver renewal period. The following three major questions, stated as hypotheses, will be addressed:

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.

Hypothesis 1 represents the continuing need for HealthChoice to assure and improve coverage and access to eligible populations. Because Maryland Medicaid participants, with a few excepted groups, are nearly completely covered by MCOs, improvements to access must now address more subtle and difficult barriers to enrollment and obtaining access to services. The evaluation study will ask whether the following two policy changes made an impact in improving access:

- Did the initiation of automated renewals of coverage—based on data indicating no substantial changes in participants' financial position—reduce the amount of time Medicaid-eligible individuals were without Medicaid coverage and improve the health and financial status of beneficiaries? The policy change commenced in CY 2016.
- Does automated selection of an MCO after one day for new participants, who in the past were permitted up to twenty-eight days to select an MCO, speed new participants' ability to access services? The policy change commenced in July 2018.

Hypothesis 2 concerns how incentivizing providers through larger and quicker payment would increase their provision of high-priority, high-quality care. This hypothesis will generate questions regarding these three policy initiatives:

- Do changes to the population health incentive program (formerly known as the value-based purchasing program) to an incentive only program result in higher rates of achievement of the program goals, without reducing the outcomes achieved by previously existing goals? Changes to the Value-Based Purchasing program went into effect starting in CY 2022.
- Do programs incentivizing greater attention to problems of particular concern among children (*e.g.*, asthma and lead exposure) help to reduce the incidence of those problems? Maryland's Health Services Initiative (HSI) went into effect on July 1, 2017.
- Do programs restricting access to prescription drugs that may be subject to misuse control the rates of such misuse? The policy change commenced on March 1, 2016.

Hypothesis 3 involves the largest number of policy initiatives, although many are currently being implemented as pilot programs and so will have relatively limited enrollment. Therefore, the research

questions around pilot programs will benefit from the ability to compare participants' results with the results of a control group. This hypothesis will produce the following policy questions:

- Does the opportunity to treat acute cases of SUD and SMI in residential treatment in institutions for mental disease (IMDs) improve the control of SUDs? The SUD benefit was phased into effect beginning in July 2017, covering ASAM Levels 3.3, 3.5, 3.7 and 3.7WM.[3] ASAM Levels 3.1 and 4.0 were phased in beginning in January and July 2019, respectively. The SMI benefit began January 2022.
- Does the ACIS pilot improve the living situations and reduce potentially unnecessary health care utilization for persons at risk of institutionalization or homelessness? This program went into effect in July 2017, with awards to local Lead Entities first granted in November 2017.
- If dental benefits are extended young adults aged out of foster care would these benefits also result in reduced incidence and costs of conditions related to dental disease? This program went into effect in January 2017.
- Does the Increased Community Services program increase transitions to the community? This program is a continuation from previous waiver periods and has been operating since 2009; the current waiver increased the program's cap to 100 slots.
- Does implementation of the National Diabetes Prevention Program (National DPP), proven to be sufficiently-effective to become a covered service under Medicare, work equally well with preventing diabetes diagnoses for a Medicaid population? The HealthChoice DPP was approved effective April 2019.
- Does a service model that integrates primary and behavioral health care and provides evidence-based therapeutic intervention and case management services for individuals with behavioral health conditions through the Collaborative Care Model result in improved outcomes for the target population? This pilot program went into effect on July 1, 2020 and will be transitioned out of the 1115 waiver to operate statewide on October 1, 2023.
- Does a service model that provides a set of enhanced case management services, standardized social determinants of health screenings and care coordination through the MOM program result in improved outcomes for the target population? This program went into effect on July 1, 2022.

All of these hypotheses and the research questions they generate are consistent with the goals of Title XIX and XXI in improving the health and wellbeing of low-income and chronically-ill populations.

Driver Diagram

Table 1 provides a driver diagram, offering a visual representation of the aims of the 2022-2026 waiver period, along with a closer look at the measures that MDH intends to employ to assess HealthChoice's performance against the stated hypotheses. In addition to the proposed measures, MDH will continue to

[3] 3.7WM licensed as 3.7D in Maryland.

monitor the development and release of new sources of information—such as upcoming surveys or HEDIS® measures—that may serve to evaluate the demonstration.

Table 1. Driver Diagram for Maryland §1115 Waiver Evaluation

Aims	Goals	Primary Drivers	Secondary Drivers
Eligibility and enrollment changes implemented during the current HealthChoice waiver period increase coverage and access to care for HealthChoice participants.	Improve access to health care for the Medicaid population; Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies	Auto-renewal process	Health status at enrollment
			Financial status of beneficiaries
			Periods of continuous enrollment without interruption
			Decreases in the frequency of disenrollment and reenrollment (churn)
		MCO auto-assignment after one day policy	Improved service utilization of new participants (>120 day six-month enrollment gap)
Payment approaches implemented during the current HealthChoice waiver period improve quality of care for HealthChoice participants	Improve access to health care for the Medicaid population; Improve the quality of health services delivered; Emphasize health promotion and disease prevention;	Value-Based Purchasing (VBP) Program/Population Health Incentive Program (PHIP)	Improved VBP/PHIP measures, such as diabetes management
			Increased preventive care visits, such as ambulatory care for children and adults with disabilities
		CHIP Health Services Initiative addressing lead and asthma	Healthy Homes for Healthy Kids (Program 1)
			Childhood Lead Poisoning Prevention and Environmental Case Management Program (Program 2)
		Statewide health IT solutions	Streamlined Corrective Managed Care (CMC) targeting prescription drug abuse
Innovative programs address the social determinants of health and improve the health and wellbeing of the Maryland population	Increased rates of identification, initiation, and engagement in treatment for SUD	Residential Treatment of Adults with SUD	Improving rates of initiation and engagement of alcohol and other drug dependence treatment among members with SUD

Aims	Goals	Primary Drivers	Secondary Drivers
			Improved rates of members receiving any addiction treatment for SUD
	Increased adherence to and retention in treatment		Better follow-up care after ED visit for alcohol and other drug abuse or dependence
			Increased rates of medication-assisted treatment (MAT) among participants with OUD
	Reductions in overdose deaths, particularly those due to opioids		Reduction in opioid-related mortality
	Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services		Lower rates of acute inpatient stays that had any SUD/opioid use disorder (OUD) diagnosis
			Reduced lengths of stay in acute inpatient and residential settings for treatment for SUD
	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate		Decreased rates of readmission to the same level of care or higher among members discharged from residential treatment facilities.
	Improved access to care for physical health conditions among beneficiaries with SUD		Decreased cost of care for individuals with SUD including co-morbid physical and mental health conditions
	Reduced utilization and lengths of stay in EDs among beneficiaries with	IMD Services for Adults with SMI	Lower rates of ED visits and reduced ED lengths of stay for adults with SMI

Aims	Goals	Primary Drivers	Secondary Drivers
	SMI while awaiting mental health treatment in specialized settings Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care		
	Reduced preventable readmissions to acute care hospitals and residential settings Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities		Reduced preventable readmissions to acute care hospitals among adults with an SMI
	Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric		Increased number of call centers and mobile crisis units

Aims	Goals	Primary Drivers	Secondary Drivers
	hospitals, and residential treatment settings throughout the state		
	Improve access to health care for the Medicaid population; Improve the quality of health services delivered; and Emphasize health promotion and disease prevention	Assistance in Community Integration Services Pilot	Decreased ED visits (incl. potentially avoidable utilization)
			Decreased inpatient admissions
			Better follow-up care after hospitalization
			Reduced admissions to CFR 578.3 facilities
	Improve access to health care for the Medicaid population; Improve the quality of health services delivered	Increased Community Services Program	Reduction in nursing facility admissions and lengths of stay
	Provide patient-focused, comprehensive and coordinated care by providing Medicaid participants with a single case manager; Emphasize health promotion and disease prevention; Increased rates of identification, initiation, and engagement in treatment for SUD; Improved access to care for physical health conditions	MOM Program	Improved care coordination including comprehensive case management, care coordination, health promotion, individual and family supports, and linkages to community and support services

Aims	Goals	Primary Drivers	Secondary Drivers
	among beneficiaries with SUD.		
	Improve access to health care for the Medicaid population; Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies	Dental benefits for former foster care children	Increased use of dental services, including preventive/diagnostic, and restorative visits
			Reduction in ED use for dental-related conditions
	Improve access to health care for the Medicaid population; Improve the quality of health services delivered; and Emphasize health promotion and disease prevention	HealthChoice Diabetes Prevention Program	Reduction in total cost of care for prediabetic patients
			Decreased diabetes incidence
			Reduction in ED admissions for prediabetic patients.
			Reduction in hospital admissions where diabetes is the primary diagnosis
	Improve access to health care for the Medicaid population; Provide patient-focused, comprehensive and coordinated care by providing Medicaid participants with a single medical home; Expand coverage to	Collaborative Care Model Pilot Program	Increased rate of depression screening
			Increased monthly contact with enrolled pilot participants
			Improvement in depression diagnostic scores
			Increased case and treatment plan review
			Increased proportion of enrolled pilot participants in remission

Aims	Goals	Primary Drivers	Secondary Drivers
	additional low-income Marylanders with resources generated through managed care efficiencies.		Increased referral to and utilization of specialty behavioral health services by participants identified with high levels of acuity that cannot be appropriately addressed through the Collaborative Care Model

Methodology

Evaluation Design

Depending on the specific sub-population affected by policies and their related research questions, the evaluation will apply a mixed-method approach to create valid and rigorous tests of the programs in question. MDH recognizes that implementing a policy in pursuit of the driver diagram's predicted results must test whether those results occurred because of the policy or as a result of other factors (changes in economic or social conditions that could change the mix of participants, externally-driven trends in disease incidence and prevalence, or policies implemented outside of the HealthChoice program that pursue the same goals, among other factors). An environmental survey could identify policy changes and other economic and technological trends of potential impact.

Target and Comparison Populations

Because Medicaid is fluid in its enrollment of individuals, it is not always possible to maintain the programs' focus on particular participants or participant groups. Some of these programs evaluated apply to the HealthChoice populations as a whole, or a subpopulation which intrinsically cannot be divided into intervention and comparison groups, such as new participants. In this case, the best way to measure effects is to compare trends before and after the implementation of the program, using statistical methodologies such as pooled cross-section time series that separate between fixed effects and time-varying effects to control for exogenous changes outside of the program implementation.

On the other hand, a number of the programs are pilot studies with limited enrollment or implementation in specific geographic areas, for example, the Childhood Lead Poisoning Prevention and Environmental Case Management Program and the HealthChoice Diabetes Prevention Program components. Such programs can identify non-participants to serve as a comparison group. Specific decisions about which approach might be used to create a comparison group may need to await the availability of sufficient data on the number of program participants and their clinical, demographic, and geographic characteristics.

While mindful of these caveats, Table 2 (below) specifies how outcomes for each policy initiative will be measured, according to whether and how control groups will be specified, and which statistical techniques are best suited to measure outcomes validly and reliably.

Evaluation Period

The evaluation period covers outcomes measured during the renewal period of Maryland Medicaid's §1115 waiver. The time periods of analysis for most outcomes will be the years of the demonstration, CYs 2022-2026. In some cases (*i.e.*, for certain measures), it may be necessary to look at data from before the renewal period to better identify trends in the measure in question, such as with policies that were implemented before the start of the demonstration extension period and are continuing under the extension (such as the Diabetes Prevention Program). The pre-implementation period for these policies may extend 1-2 years prior to implementation. Because The Hilltop Institute at the

University of Maryland, Baltimore County is the repository for Maryland Medicaid's MMIS, it would require little additional effort to incorporate these additional data to improve the validity of an analysis relying on trends over time, such as pooled cross-section time series.

Data Sources

In general, Maryland's evaluation of the HealthChoice demonstration includes the entire population of participants, which supports a more robust evaluation than does a sampling-based methodology. This approach is facilitated by Hilltop, the Independent Evaluator. Hilltop maintains managed care encounters and FFS claims for the entirety of the Maryland Medicaid program. An overview of these and other data sources MDH will utilize follows. As with past reports, the evaluation will disaggregate certain sub-populations—such as foster care participants and dual eligibles—to assess programs focusing on these particular populations. The evaluation will also identify measures for stratification across MCOs to determine differences in the provision and quality of care.

Due to the distinct attributes of the HealthChoice population, the evaluation will not take into consideration any additional populations for purposes of comparison. MDH believes that year-to-year trend comparisons of the enrolled population provide a more meaningful analysis. Over 86 percent of Maryland Medicaid participants are enrolled in managed care. The remaining 14 percent consists largely of much smaller populations with greater health complexities: dual eligibles, spend-down recipients and participants in other partial benefit programs. Hence, the evaluation will not compare participants in the HealthChoice program with either the non-HealthChoice FFS population, Medicare beneficiaries or the commercially-insured.

Table 2 (Measurement Framework) identifies the anticipated source for each measure.

Fee-For-Service Claims and Managed Care Encounters (MMIS2)

MDH will leverage its existing relationship with Hilltop, which, in addition to conducting research, analysis and evaluation of publicly-funded health care, serves as the warehouse for Maryland Medicaid FFS claims and managed care encounters received via MMIS2 (and previously MMIS1). Claims and encounter data have been collected since Maryland began the HealthChoice demonstration in 1997, and are updated monthly and stored in analytic, SAS-ready data sets. Because these data are the basis for calculating payment rates under managed care, the data are validated through automated testing algorithms by MDH's information technology office on receipt from providers, by Hilltop on the receipt of data from MDH and by the consulting actuaries who assess the validity and actuarial soundness of managed care rate development. Hilltop has access to claims and encounter data from 1997 onwards to continue its evaluation and analysis of HealthChoice.

Hilltop's data warehouse contains person-level demographic information, which allows for matching with other databases. In addition, this arrangement facilitates a variety of analyses, including cost, service utilization, provider network adequacy, enrollment trends and access to and quality of care.

Because 86 percent of Maryland Medicaid recipients participate in HealthChoice and are enrolled with

an MCO, the majority of their somatic health services are covered through the managed care benefit and quantified via encounter submissions. Maryland's somatic MCO encounter reporting has been shown to be robust, correct and timely, with MCOs given six months to submit encounter data to MDH. Encounter data are used to determine medical loss ratios and, in rate-setting, give MCOs significant incentive to provide complete and accurate encounter data.

Several Medicaid benefits are carved out from the managed care package so that, even if enrolled with a HealthChoice MCO, a participant might receive some services outside of the MCO. Some of the key carved-out services include dental and behavioral health benefits, both of which are administered by administrative services organizations (ASOs), in addition to certain pharmacy benefits. Individuals participating in the Rare and Expensive Case Management (REM) program also receive their benefits on an FFS basis. FFS providers are allotted up to 12 months to submit claims, meaning that it is important to allow at least a year for claims run-out.

Cost data for FFS claims have been reliably captured since the beginning of Medicaid in Maryland. Since the beginning of the HealthChoice demonstration in 1997, encounter data have been continually improved and validated and are used for setting actuarially-sound capitation rates. Shadow-pricing for institutional claims relies on the all-payer payment rates set by the Maryland Health Services Cost Review Commission and are thus available to all MCOs. Physician and professional shadow prices are based on the current FFS Medicaid professional fee schedule, which is the most reliable source for estimating MCO payment rates to health care professionals.

Notes on data: Within the HealthChoice evaluation, measures identified as part of an established domain—such as HEDIS®—will follow the specifications of those domains unless otherwise noted. Measures evaluating the emergent nature of ED visits will utilize the classification methodology identified by Billings et al from New York University.[4] Individuals with behavioral health diagnoses will be identified using the criteria outlined in Maryland regulation.[5]

Vital Statistics Administration

One of the key requirements of the HealthChoice demonstration's Residential Treatment for Individuals with SUD is to monitor the incidence of opioid-related mortality. Maryland's MMIS2 does not contain information regarding cause of death. MDH will collaborate with Maryland's Vital Statistics Administration to obtain the data necessary to populate this measure. Hilltop has data available from CY 2015 onwards to use for evaluation.

Department of Human Services

Hilltop, while able to identify foster care participants by their coverage group in MMIS2, does not maintain access to foster care participants in the subsidized adoption program. Subsidized adoption

[4] Billings J, Parikh N, Mijanovich T. (2000). Emergency room use: The New York story. The Commonwealth Fund. Available https://wagner.nyu.edu/files/admissions/Billings%20-%20Emergency%20Room%20Use%20-%20The%20New%20York%20Story.pdf; accessed 5 April 2017.
[5] COMAR 10.09.70.02(L).

participants are excluded from MDH's analysis of foster care in the HealthChoice evaluation; therefore, MDH coordinates with the Maryland Department of Human Services to obtain updated foster care subsidized adoption lists on an annual basis, which will be available for all years of the demonstration period.

Maryland Department of the Environment

While Medicaid claims and encounters contain information regarding blood lead testing, they do not include information on the results of those tests. To report on the number of HealthChoice children with elevated blood lead levels, MDH will utilize the statewide Childhood Lead Registry (CLR). Maintained by the Maryland Department of the Environment, the CLR performs childhood blood lead surveillance for Maryland and provides results to MDH, including to Medicaid and local health departments as needed for case management. Hilltop has data from FY 2008 onwards to use for evaluation.

HealthCare Effectiveness Data and Information Set (HEDIS®)

MDH requires HealthChoice MCOs to report all Medicaid measures applicable to Medicaid, except measures exempted by MDH or if the services are carved out of the managed care benefit package (see Fee-for-Service Claims and Managed Care Encounters, above). HEDIS® requires input of high-quality encounter and enrollment data to construct comparison groups based on specific clinical criteria, as defined by diagnosis and procedure codes, and demographic characteristics such as age. MCOs follow the guidelines for HEDIS® data collection and specifications for measure calculations and receive an annual HEDIS® compliance audit by a competitively-procured organization licensed by the National Committee for Quality Assurance (NCQA). The Hilltop Institute uses a competitively- procured HEDIS® software (HEDIS Volume 2: Technical Specifications for Health Plans) to efficiently generate both HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS) sample survey data used for Medicaid program monitoring and evaluation.

Maryland Department of Health Sources

Several of the measures proposed for the HealthChoice evaluation will rely on systems and programs internal to MDH, including the *LTSSMaryland* system and internal program quality surveys. ACIS enrollment data are submitted by participating entities, and data are available for 2018 and all subsequent years. At present, MDH is actively investigating the possibility of obtaining and sharing with Hilltop quantitative data from other sources, such as state-only claims in support of evaluating the IMD exclusion waiver (residential SUD treatment). If this is not possible, MDH will make a note in the Methodological Limitations section. Residential SUD treatment may also be covered in commercial behavioral health claims, but the Maryland All-Payer Claims Database relies on submissions from fully-insured carriers and voluntary submission from self-funded plans. In addition to potential bias from the data excluded, before submission to Maryland's APCD system there is a lag at least 18 months from dates of service delivery. These factors will result in challenges for comparing to Medicaid claims. Data to support the evaluation of the CoCM Pilot Program will be sourced from the contracted CoCM vendor for the years of the demonstration period. The point of sale pharmacy system provides real-time claims processing continuity to providers and recipients, which includes the comprehensive prescription

pharmacy needs of the HealthChoice population, including data on patients in the CMC program as well as overdose information. Hilltop will have access to reports from the point-of-sale system to evaluate the CMC program for CYs 2022-2026. Hilltop will also use beneficiary surveys conducted as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Experience Survey to evaluate the perceived health and financial status of beneficiaries. The State of Maryland Executive Summary Reports on the CAHPS Member Experience Survey include beneficiary ratings of overall health, overall mental/emotional health, and several CAHPS survey measures of beneficiary access, quality of care, and satisfaction for the HealthChoice population. Reports will be available for all years of the demonstration. To support evaluation of the MOM program, Hilltop will use newborn processing data (1184), a monthly dataset of newborns and their birthing parent that includes information on birth weight and other outcomes. Hilltop has access to these files from December 2017 onwards.

Analytic Methods

Where there are pilot interventions or benefits limited to certain populations, a sample of participants and non-participants may be selected based on demographic characteristics, such as age, race and ethnicity, sex, and county of residence, enrollment factors, like coverage duration and coverage group, and service utilization, such as diagnosis or procedure criteria. Cases and controls can then be analyzed to compare the effects of the interventions using descriptive analysis. For interventions that effect the entire HealthChoice population, or where a comparison group cannot be created, descriptive analysis and event count models will be used to analyze changes over the course of the demonstration. Subgroup analysis will be conducted for various demographic sub-populations to enrich the evaluation of certain programs.

To measure program effects for populations that cannot be separated into case and control groups, an interrupted time-series analysis is suitable for program measurements that are frequently repeated and can be measured prior to the initiation of the HealthChoice policy intervention. Policies evaluated using an interrupted time-series approach will utilize at least eight data points across the pre and post implementation periods, and outcomes will be measured monthly, quarterly, or annually depending on the timeframe of program implementation.

Sole reliance on quantitative techniques risks missing some critical aspects of the projects undertaken. Policy context will be included in the narrative portions of the evaluation for certain measures. For example, Maryland is unique in that the Health Services Cost Review Commission (HSCRC) builds uncompensated care costs into the hospital rates that are paid by all payers (including Medicaid). Additionally, Maryland is a Medicaid-expansion state that has recently taken legislative action to reduce medical debt. Policy context will be important to include in an assessment of the demonstration on measures such as provider uncompensated care and beneficiary medical debt. Data such as the reports of the qualitative impressions of key informants on implementation issues and program outcomes, program documents and literature or site visits by the evaluators, can be collected systematically and analyzed along with quantitative measures (although certain analyses are administrative and not suitable for qualitative approaches). MDH and its Independent Evaluator will use such mixed-methods as described in Table 2.

Methodological Limitations

Within evaluation study designs, multiple potential limitations to data and analytic techniques threaten the validity of conclusions drawn from the measures that rely on them. Among these are limits on the data itself: transcription and input errors, variable definitions that are too broad or not well-specified and missing data that may be random or systematic and must be evaluated to determine how best to compensate for them. Some data may be missing because they represent populations or services not served through Medicaid. The target populations for a policy themselves may be difficult to identify and might be identified only when they come forth to receive waiver services, so that there is a threat to validity from biased selection. Although techniques such as matching controls to participants can help in part to hold measures affected by selection bias constant, there are not techniques that can completely control for all threats to validity.

One major concern is whether the effects of an intervention can be separated from other activities and external influences that may affect the measured outcomes of that intervention. External changes that may affect HealthChoice performance include the following:

- Economic trends, such as changes in employment or inflation;
- Introduction of new medical care standards or technology (*e.g.*, a new pharmaceutical protocol for behavioral health issues);
- Epidemiology of disease patterns, such as a flu epidemic or COVID-19;
- Simultaneous implementation of other physical health and behavioral health models, such as accountable health organizations and behavioral health homes;
- Changes in case-mix (*e.g.*, relative severity of illness); and
- State and federal policy changes.

Any external changes beyond the control of the HealthChoice program make isolating the effects of HealthChoice more difficult. MDH and the Independent Evaluator will consult with interest groups in communities of concern to define the counterfactual; *i.e.*, if measurable changes observed would have occurred without the HealthChoice program, and if those changes could be explained by the causes suggested in a systematic survey of alternatives. If not, then the analysis can conclude that the HealthChoice program had an impact.

The effects of the COVID-19 pandemic pose methodological challenges for evaluation. The public health emergency (PHE) led to increased enrollment in HealthChoice, as participants werenot disenrolled from the program during the PHE. Enrollment measures, such as spans of coverage without interruptions and persons disenrolling and reenrolling within six months, are likely to be most affected by the PHE and subsequent unwinding. Hilltop will describe the overall effects of the PHE and unwinding periods on HealthChoice eligibility trends during the evaluation period. To account for potential confounding effects of the PHE and unwinding periods, Hilltop will use sensitivity analyses to analyze policies with implementation periods during these timeframes. Hilltop may exclude time periods most affected by the PHE and unwinding or adjust time periods for evaluation purposes.

Special Methodological Considerations

Certain pilot studies are small in scope, having relatively-low enrollment observable at this point in time. The analysis will likely need to pool the experience of pilot program participants over several years, along with that of any comparison group than can be constructed. Pooled cross-sectional time series may be used when the outcomes of interest—*e.g.*, a healthy birth weight or cumulative expenditures—can be measured on a yearly (or some other regular) basis.

Nevertheless, even pooled over the five-year time period, some of the pilots may not have attained enough participation to have sufficient statistical power in order to measure whether the outcomes observed are truly the effect of the intervention or simply occurred by chance. There may also be a lack of data necessary to build a truly "comparable" comparison group. This will limit the external validity of the evaluation and not allow for drawing conclusions about the policy's effectiveness or ineffectiveness. Although we cannot predict which policy evaluations will face this dilemma, should evaluators be unable to observe statistically-significant differences in a given pilot, we will report whether the policy results occurred in the expected direction and magnitude.

Table 2. Measurement Framework

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Hypothesis 1: Eligibility and enrollment changes implemented during the current HealthChoice waiver period increase coverage and access to care for HealthChoice participants.							
Did the initiation of automated renewals of coverage—based on data indicating no substantial changes in participants' financial position—reduce the amount of time Medicaid-eligible individuals were without Medicaid coverage?	Spans of coverage without interruptions	All HealthChoice participants are subject to autorenewal. Separate analysis will be performed for the ACA expansion coverage groups Subgroup analysis can be performed by gender, age, race, ethnicity and geographic location.	Uninterrupted Coverage Spans	All coverage spans coming due during a specific measurement year	N/A	MMIS	Descriptive analysis Multiple linear regression to analyze effects by subgroup
	Persons disenrolling and reenrolling within six months	All HealthChoice participants are subject to autorenewal. Separate analysis will be performed for the ACA expansion coverage groups Subgroup analysis can be performed by gender, race, ethnicity, age and	Persons disenrolling and reenrolling within six months	All Persons disenrolling within a specific measurement year	N/A	MMIS	Descriptive analysis Multiple linear regression to analyze effects by subgroup

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
		geographic location.					
	Process Measures Total cost of care for all Medicaid beneficiaries under the demonstration over time Total health expenditures and administrative costs over time Provider uncompensated care: policy context/narrative Incidence of beneficiary medical debt: policy context/narrative Perceived health and financial status of beneficiaries over time: use of CAHPS survey reports						
Does automated selection of an MCO after one day for new participants, who in the past were permitted up to twenty-eight days to select an MCO, speed new participants' ability to access services?	Mean duration until services first used by new participants	New participants (>120 day six-month enrollment gap)	Duration Data	N/A	N/A	MMIS	Descriptive analysis of trends over the demonstration period

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Hypothesis 2: Payment approaches implemented during the current HealthChoice waiver period improve quality of care for HealthChoice participants.							
Do changes to the population health incentive program (formerly known as the value-based purchasing program) to an incentive only program result in higher rates of achievement of the program goals, without reducing the outcomes achieved by previously existing goals?	HPC-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Population eligible for measure, with possible sub analysis by MCO	Persons in denominator with HbA1c >9.0%	Persons identified with diabetes ages 18 to 64 based on NCQA's Comprehensive Diabetes Care measure	NCQA	MMIS, HEDIS	Descriptive quantitative analysis of trends over time during the demonstration
	Ambulatory Care Visits for SSI Adults and Children	Participants with SSI, with possible subanalysis by MCO	Persons in the denominator with ambulatory care visits	Participants with SSI	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Do programs incentivizing greater attention to problems of particular concern among children (*e.g.*, asthma and lead exposure) help to reduce the incidence of those problems?	Percentage of children with elevated blood lead levels (BLL) who have received a follow-up lead test	Participants in Healthy Homes for Healthy Kids versus non- participants (Program 1)	Children receiving lead remediation	Children with elevated blood lead >=5µg/dL	N/A	MMIS using ICD-10 coding of BLL, Blood Lead matching, Local Health Departments, Childhood Lead Registry	Descriptive quantitative analysis of trends over time during the demonstration
	Among those will elevated BLL, the proportion whose follow up blood lead test was below 5µg/dL	Expansion of the Childhood Lead Poisoning Prevention and Environmental Case Management Program versus non-participants (Program 2). Non-participant comparison group will be selected from counties not participating in the program. Subgroup analysis can be performed by gender, age and geographic location.	Children in the denominator with a follow up blood test below 5µg/dL	Children with elevated blood lead >=5µg/dL	N/A	MMIS using ICD-10 coding of BLL, Blood Lead matching, Local Health Departments, Childhood Lead Registry	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Asthma: Fewer nights awakened; fewer days with shortness of breath; fewer days of rescue inhaler use; Reduced asthma- related ED and inpatient use	Expansion of the Childhood Lead Poisoning Prevention and Environmental Case Management Program versus non-participants (Program 2). Non-participant comparison group will be selected from counties not participating in the program. Subgroup analysis can be performed by gender, age and geographic location.	Children in the denominator with asthma-related ED visits Children in the denominator with asthma-related inpatient use Children in the denominator with fewer nights awakened, fewer days with shortness of breath, and fewer days of rescue inhaler use	Children with asthma	N/A	Local Health Departments; MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Process Measures ***Program 1 (Lead Remediation)*** • IA and DUA signed between DHCD and MDH • DHCD procurement of abatement companies to work on program • DHCD procurement of lead inspector company to perform work for Program 1 • Successful completion of invoicing and billing payment • No. of lead remediation contractors procured for task order according to National HUD and local MDE guidelines • New provider type established in Maryland Medicaid's provider enrollment system: Lead Risk Assessor						

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Program 2 (Environmental Case Management) • IA and DUA IRD to EHB • No. of IAs and DUAs established between IRD, EHB and LHDs • Successful completion of billing and payment mechanism, i.e. through IGT • No. of LHDs with MMIS and EVS access to screen for current Medicaid enrollment • No. of LHDs with staff onboarded based on quotas established by MDH • No. of LHDs with staff that have been trained						
Do programs restricting access to prescription drugs that may be subject to misuse control the rates of such misuse?	No. of persons on CMC	Subgroup analysis can be performed by gender, age and geographic location.	N/A	N/A	N/A	Point of Sale Pharmacy System	Descriptive quantitative analysis of trends over time during the demonstration
	No. of overdoses	Subgroup analysis can be performed by gender, age and geographic location.	N/A	N/A	N/A	Point of Sale Pharmacy System	Descriptive quantitative analysis of trends over time during the demonstration
Hypothesis 3: Innovative programs address the social determinants of health and improve the health and wellbeing of the Maryland population.							
Does the opportunity to treat acute cases of SUD and SMI in residential treatment in institutions for mental disease (IMDs) improve the control of SUDs?	Probability of initiation and engagement in SUD treatment following IMD discharge	IMD users with a primary diagnosis of SUD in each year Subgroup analysis can be performed by level of care in the IMD as well as gender, age and geographic location.	Number of IMD users in the year with claims for non-emergency department, non-inpatient SUD treatment within 45 days of discharge from IMD where SUD was	All IMD users with primary diagnosis of SUD	N/A	MMIS, HEDIS	Descriptive analysis of percentage, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
			primary diagnosis				
	ED visit for SUD	Newly enrolled or first time IMD users with primary diagnosis of SUD pre/post participation Subgroup analysis can be performed by gender, age and geographic location.	Number of ED visits for SUD for IMD users	All newly enrolled or first time IMD users with a primary diagnosis of SUD	N/A	MMIS or HEDIS	Event count models with interrupted time series, controlling for level of care in the IMD
	Probability of initiation and engagement in SMI treatment following IMD discharge	IMD users in each year with primary SMI diagnosis Subgroup analysis can be performed by level of care in the IMD as well as gender, age and geographic location.	Number of IMD users with primary SMI diagnosis in the year with claims for non-emergent, non-inpatient SMI treatment within 45 days of discharge from IMD where SMI was primary diagnosis	All IMD users in the year with primary diagnosis of SMI	N/A	MMIS, HEDIS	Descriptive analysis of percentage, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	ED visits for SMI	Newly enrolled or first time IMD users with SMI primary diagnosis pre/post participation Subgroup analysis can be performed by gender, age and geographic location.	Number of ED visits for SMI	All newly enrolled or first time IMD users with a primary diagnosis of SMI	N/A	MMIS or HEDIS	Event count models with interrupted time series, controlling for level of care in IMD
	ED visits and ED length of stay for SMI immediately following IMD	IMD users in each year with SMI primary diagnosis Subgroup analysis can be performed by level of care in the IMD as well as gender, age and geographic location.	Persons in denominator who are admitted or transferred from an IMD for ED visit with	IMD users in the year	N/A	MMIS or HEDIS	Descriptive analysis of percentage, reported annually
	Use of MAT services among persons with OUD and IMD placement	IMD users with primary diagnosis of SUD Subgroup analysis can be performed by gender, age and geographic location.	Persons in denominator receiving MAT	IMD users with opioid SUD diagnoses before and after IMD placement	N/A	MMIS or HEDIS	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Use of Intensive Outpatient and Partial Hospitalization Mental Health Services	IMD users with MH diagnosis Subgroup analysis can be performed by gender, age and geographic location.	Persons in denominator with IOP utilization	IMD users with MH diagnoses before and after IMD placement	N/A	MMIS or HEDIS	Descriptive quantitative analysis of trends over time during the demonstration
	Readmission frequency to the same level of care or higher	IMD users	IMD users having readmissions	IMD users	N/A	MMIS or HEDIS	Descriptive quantitative analysis of trends over time during the demonstration.
	Overall cost of care for individuals with SMI/SUD including co- morbid physical and mental health conditions Tabulations of spending inclusive of IMD and outpatient treatment	Persons with SMI/SUD, users of IMD Subgroup analysis can be performed by gender, age and geographic location.	N/A	N/A	N/A	MMIS or HEDIS	Summary statistics of spending inclusive of IMD and outpatient treatment, reported annually
	Death by OUD	Deaths by OUD among IMD users with SUD diagnoses Subgroup analysis can be performed by gender, age and geographic location.	Deaths of individuals in the denominator	All IMD users with SUD diagnoses		Vital Statistics	Summary statistics of incidence of OUD death, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Number of crisis call centers and mobile crisis units	IMD users	IMD users indicating use of crisis call centers and mobile crisis units	IMD users	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration

	Process Measures
	• Fee schedule created of Medicaid reimbursement rates
	• No. of IMDs billing Medicaid under the demonstration
	  ○ By region
	  ○ By ASAM level
	  ○ Compared with before demonstration implementation
	• No. of IMDs having participated in a Medicaid onboarding training (*e.g.*, how to bill):
	  o 3.3 - 3.7D
	  o 3.1
	  o 4.0
	  o Duals expansion
	• No. of grievances, appeals and critical incidents related to SUD treatment services
	  o 3.1
	  o 4.0
	  o Duals expansion
	• No. of grievances, appeals and critical incidents related to SUD treatment services						

Does the ACIS pilot improve the living situations and reduce potentially unnecessary health care utilization for persons at risk of institutionalization or homelessness?	Achieved stable housing	Newly enrolled ACIS participants in each year	Number of ACIS participants newly enrolled in the year who achieved stable housing	Number of newly enrolled ACIS participants in the year	N/A	ACIS data collected by LEs; Specifically, living situation at enrollment and at ACIS service delivery	Descriptive analysis of percentage, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	ED visits (incl. potentially-avoidable utilization)	ACIS participants pre/post participation	Number of ED visits	All ACIS participants	N/A	MMIS	Event count models with interrupted time series
	Inpatient admissions	ACIS participants pre/post participation	Number of inpatient admissions	All ACIS participants	N/A	MMIS	Event count model with interrupted time series. If outcome frequency is insufficient, then descriptive analysis.
	Inpatient admissions with substance abuse or mental health primary diagnosis	ACIS participants pre/post participation	Inpatient admissions with substance abuse or mental health primary diagnosis	All ACIS participants	N/A	MMIS	Descriptive analysis of event counts
	Nursing facility admissions	ACIS participants pre/post participation	Number of nursing facility admissions	All ACIS participants	N/A	MMIS	Event count model with interrupted time series
	Ambulatory care services	ACIS participants pre/post participation	Number of ambulatory care services	All ACIS participants	N/A	MMIS	Event count model with interrupted time series

	Process Measures
	• No. of Lead Entities participating
	  ○ Signed IA/DUA
	  ○ Successful completion of inter-governmental transfer (IGT) of funds for local match
	  ○ Completion rate of monthly implementation report						

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	• No. of Learning Collaboratives held and Lead Entity participation rate in each • No. of Lead Entities and Participating Entities with signed DUAs/contracts • No. of Lead Entities trained, licensed, and using Homeless Management Information System						
If dental benefits are extended young adults aged out of foster care would these benefits also result in reduced incidence and costs of conditions related to dental disease?	Frequency of ED visits with dental diagnoses	Former foster care children	N/A	N/A	N/A	MMIS	Compare ED use for dental services over the demonstration period
	Frequency of dental services, including preventive/di agnostic and restorative visits	Former foster care children	N/A	N/A	N/A	MMIS	Compare to similar age groups (REM and pregnant women) over the demonstration period
Does the Increased Community Services program increase transitions to the community?	Transitions of long stay nursing facility residents to community settings who are eligible to apply to the ICS program	ICS participants	ICS participants with transition from nursing facility to community	Individuals who meet the technical eligibility to apply for the ICS program	N/A	MMIS	Descriptive analysis
Does implementation of the National Diabetes Prevention Program (National DPP), proven to be sufficiently-effective to become a covered service under	All-cause hospital admissions	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	All-cause hospital admissions for DPP participants vs. prediabetic participants not in DPP	All prediabetic individuals	N/A	MMIS	Event count models

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Medicare, work equally well with preventing diabetes diagnoses for a Medicaid population?	Total cost of care	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	Total cost of care for DPP participants vs. eligible enrollees vs. prediabetic participants not in DPP	All prediabetic individuals	N/A	MMIS	Pooled cross- section time series analysis of costs
	Diabetes incidence	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	Diabetes incidence for DPP participants vs. prediabetic individuals not in DPP	All prediabetic individuals	N/A	MMIS	Binary outcome regression
	ED visit rate	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	ED visits for DPP participants vs. prediabetic patients not in DPP	All prediabetic individuals	N/A	MMIS	Event count models

	Process Measures
	• New provider type established in Maryland Medicaid's provider enrollment system: DPP provider
	• No. of DPP providers enrolled in Maryland Medicaid, by delivery mode (in-person or virtual)
	• No. of MCOs with at least one DPP provider contracted in their network
	• No. of DPPs contracted with each MCO, disaggregated by in-person and virtual, and in each:
	  ○ No. of individuals enrolled
	  ○ No. of individuals retained at six months
	  ○ No. of individuals with at least one follow-up visit
	  ○ No. of individuals with 5 or more visits
	  ○ No. of individuals with 10 or more visits						

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Does a service model that integrates primary and behavioral health care and provides evidence- based therapeutic intervention and case management services for individuals with behavioral health conditions through the Collaborative Care Model result in improved outcomes for the target population?	Monthly contact: Counts of contacts each month and proportion of participants receiving active treatment in CoCM each quarter	CoCM Pilot Program participants	No. of participants with at least one clinical contact per month[6]	Total no. of CoCM Pilot Program-enrolled participants in that quarter	N/A	CoCM provider	Event counts
	Depression screening rate: Proportion of participants receiving a depression screening per quarter	CoCM Pilot Program participants	No. of participants who received a PHQ-2 or PHQ-9 screening per quarter	No. of participants enrolled in CoCM Pilot Program who had a clinical contact during the quarter	N/A	CoCM provider	Event count models
	Depression diagnosis: Proportion of participants demonstrating clinically- significant improvement	CoCM Pilot Program participants	No. of participants enrolled in CoCM Pilot Program for 70 days or greater with either: 1) a 50% reduction from first recorded to last recorded PHQ-9; or 2) a drop from first recorded to last recorded	No. of participants enrolled in CoCM Pilot Program for 70 days or more	N/A	CoCM provider	Descriptive analyses

[6] A "clinical contact" is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement as long as treatment is delivered.

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
			PHQ-9 to less than 10				

	Process Measures
	• Signed contract with at least one entity to implement CoCM Pilot Program
	• No. of pilot sites established
	  ○ No. of rural sites
	  ○ No. of urban sites
	  ○ No. of Ob/Gyn provider sites
	• No. of participants enrolled per site						

Does a service model that provides a set of enhanced case management services, standardized social determinants of health screenings and care coordination through the MOM Model result in improved outcomes for the target population?	Postpartum Care: The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	MOM program participants	No. of participants with a delivery with a postpartum visit on or between 7 and 84 days after delivery	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Rate of Cesarean Sections: The percentage of deliveries that were cesarean section	MOM program participants	No. of participants with a delivery by cesarean section	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Severe maternal morbidity (SMM): Percentage of pregnancies associated with Severe Morbidity CDC-defined codes	MOM program participants	No. of participants with SMM	No. of participants	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Rate of birth complications: Percentage of deliveries that had birth complications	MOM program participants	No. of participants with birth complications	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Birth weight: Percentage of children born normal, low and very low birth weight	MOM program participants	No. of children born to participants by birth weight	No. of children born to participants	N/A	MMIS, 1184 newborn processing data	Descriptive quantitative analysis of trends over time during the demonstration
	Timeliness of Prenatal Care: The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid.	MOM program participants	No. of participants with a delivery with timely prenatal care	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Caregiver risk assessment: Participants who had at least one caregiver-focused	MOM program participants	No. of participants with a caregiver-focused risk	No. of participants with a delivery	N/A	MMIS, 1184 newborn processing data	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	risk assessment completed during a follow-up visit after the child's birth.		assessment after birth				
	Neonatal intensive care unit (NICU) average length of stay	MOM program participants	No. of days in NICU for children born to participants with a NICU admission	No. of children born to participants with a NICU admission	N/A	MMIS, 1184 newborn processing data	Descriptive quantitative analysis of trends over time during the demonstration

Attachments

Independent Evaluator and Evaluation Budget

Selection of the Independent Evaluator

The Hilltop Institute is an independent non-partisan health research organization dedicated to advancing the health and wellbeing of people and communities. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, innovative and objective research analysis. Hilltop follows the professional, ethical, and conflict of interest expectations and responsibilities outlined in the Code of Ethics of the University of Maryland, Baltimore County. The Code of Ethics complies with the Maryland Public Ethics Law, the Maryland Whistleblower Law, and policies of the Board of Regents of the University System of Maryland (USM).

MDH chose Hilltop as the evaluator due to Hilltop's extensive experience and knowledge of Maryland Medicaid data and program policy. Hilltop has provided impartial consultation, technical support and program assistance to MDH since 1994 with the overarching goal of objectively evaluating and improving the Maryland Medicaid program without conflict of interest. The responsibilities of Hilltop are to: 1) assist MDH in analysis of the HealthChoice program, including conducting evaluations; 2) provide data analyses, rate-setting support and policy development of innovative proposals for the delivery of long-term services and supports; 3) provide administrative support activities; 4) facilitate database development; and 5) produce and disseminate studies, reports and analyses. While Hilltop provides support for various activities, MDH holds ultimate responsibility for determining program policy and operations independent of Hilltop.

While MDH and Hilltop work closely together, MDH makes all of the policy choices regarding the HealthChoice program.

Evaluation Budget

The list of assigned personnel and their respective contributions and work effort is contained in Appendix A. The cost for the evaluation, inclusive of salary, fringe benefits and university overhead totals approximately $683,205.

The relationship between MDH and The Hilltop Institute is governed by a multi-year Master Agreement and Business Associate Agreement, with a scope of work and budget negotiated on an annual basis.

Timeline and Major Milestones

As described in the Data Sources section above, Medicaid claims and encounters for health care services are not immediately available for analysis. FFS providers are allowed 12 months to submit claims for payment, and MCOs are permitted six months to submit encounters. MMIS2 data are not considered completed until 12 months have passed for submission of FFS claims. Hilltop receives MMIS2 data on a

monthly basis. For example, a claim or encounter paid on May 15, 2022 would be included in the data submission to Hilltop in early June 2022.

The evaluation period for participants will extend thru December 31, 2026. To accommodate the FFS claims run-out period, Hilltop will delay its analysis until 12 months have passed from the culmination of the demonstration period, until after January 1, 2028. With the summative evaluation due to CMS in June 2028, this will allow approximately six months for data processing and analysis for those measures that rely on claims and encounters. Maryland receives data from Local Health Departments—for the Community Health Pilots and HSI—on an ongoing, quarterly basis.

The interim evaluation report will be completed by July 2026. The report will cover the research questions and hypotheses above for an evaluation period covering CYs 2022-2024. Table 3 provides a summary of the schedule of state deliverables for the demonstration period.

Table 3. Summary of Milestones for Completion of the Summative Evaluation Report

Milestone	Date
Draft evaluation design submitted	June 30, 2022
Last day for MCO providers to submit encounters for inclusion in interim analysis	June 30, 2025
Last day for fee-for-service providers to submit claims for inclusion in interim analysis	December 31, 2025
Last day for Vital Statistics Administration data run-out for interim analysis	December 31, 2025
Last day for Maryland Department of the Environmental data run-out for interim analysis	December 31, 2025
Due date for interim evaluation report	June 30, 2026
Last day of the HealthChoice demonstration Period	December 31, 2026
Last day for MCO providers to submit encounters for inclusion in analysis	June 30, 2027
Last day for fee-for-service providers to submit claims for inclusion in analysis	December 31, 2027
Last day for Vital Statistics Administration data run-out	December 31, 2027
Last day for Maryland Department of the Environmental data run-out	December 31, 2027
Due data for draft of summative evaluation report	June 30, 2028
Due date for final summative evaluation report	*(Within 30 days of receipt of CMS comments)*
Final approved summative evaluation posted to the MDH's website	*(Within 30 days of CMS approval)*

Appendix A. Budget Justification for The Hilltop Institute

Estimated Personnel Effort and Other Costs for Summative HealthChoice Evaluation
Period of Performance: 7/1/27 – 6/30/28
Budget Justification

This is the estimated budget for the final HealthChoice Summative evaluation due June 30, 2028. During years 1-4 of the waiver, data collection and analysis will be ongoing and will culminate in interim annual reports.

Personnel and Other Costs:

Executive Direction, .21 FTE ($52,455): The executive direction team will be responsible for overall supervision of the project and will provide assistance with project management and coordination with MDH. The team will provide management oversight of the evaluation team and final review and approval of the evaluation analysis.

Project Supervision and Direction, .32 FTE ($55,280): This team will be responsible for overall supervision of the project and will provide assistance with project management and expertise on the analysis of Medicaid utilization data and risk adjustment.

Methodology and Methods Team, .29 FTE ($35,043): The methodology and methods team will develop methodologies needed for the evaluation, and will work with the Maryland Department of Health to coordinate new data collection outside of encounter reporting. The team will advise on the application of appropriate statistical methods to the analysis of the evaluation data.

Programming Team, .7 FTE ($75,101): The programming team will have primary responsibility for SAS programming to calculate HealthChoice outcome measures, including HEDIS and other quality measures.

Policy Analysts, 1.42 FTE ($169,024): The policy analyst team will collaborate with MDH on stakeholder communication, analyze Medicaid utilization data, participate in the development of information needed for the evaluation, and will work with MDH to coordinate new data collection outside of encounter reporting. The team will provide technical support to SAS programmers on data analysis and risk adjustment and will contribute to data analysis, regression analysis, and interrupted time series analyses.

Editor, .03 FTE ($2,849): The editor will provide editorial services and graphics support for the evaluation report.

Fringe Benefits: Fringe benefit charges are estimated at 35%.

Travel and Conference Calls: Local travel and conference calls are estimated at $400 annually to meet with MDH.

Programming Subcontracts: Additional programming subcontracting costs are estimated at $20,000 annually.

Overhead: Facilities and Administrative (F&A) recovery rate applied to this project is 25%.

Annual Estimated Budget in FY 2028: $683,205

Attachment III: Post-Award Forum Documentation

HealthChoice Monitoring and Evaluation

Find information and reports related to HealthChoice monitoring and evaluation.

- The Centers for Medicare and Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a five-year period effective January 1, 2022 through December 31, 2026.
- Maryland Medicaid must conduct an annual public forum that provides the public with the opportunity to offer comment on the demonstration's progress.

For more information, please visit the 1115 Waiver Renewal and Amendment website or email mdh.healthchoicerenewal@maryland.gov.

2025 Post-Award Forum

The 2025 Post-Award Forum will be on Thursday, June 26th, 2025, during the Maryland Medicaid Advisory Committee meeting, from 1:00 - 3:00 PM via GoToWebinar. Interested attendees may register for the meeting.

The Post-Award Forum will include time for public comment and written comments may be submitted to mdh.healthchoicerenewal@maryland.gov. If you are interested in signing up to provide public comment during the meeting, please email Meredith Lawler at meredith.lawler@maryland.gov prior to the meeting on June 26th, 2025.

Post-Award Forums and Annual Evaluation Reports

2024

2023

2022

2021

2020

2019

2018

Summary Reports 2017-2021

HealthChoice Quick Links

- Community Liaison and Care Coordination
- HealthChoice for Members
- HealthChoice Independent Review
- HealthChoice Quality Assurance Annual Reports
- HealthChoice Quality Strategy
- MCO Newborn Coordinator
- Medical Loss Ratio and Audited Financial Statements

Give Feedback

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Maryland Department of Health
201 W. Preston Street, Baltimore, MD 21201
(410)767-6500 or 1-877-463-3464

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Governor Wes Moore
Maryland Cabinet Agencies
All State Agencies
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Maryland State Jobs
Report State Government Fraud

Policies

Accessibility
Privacy & Security

Connect

State Employee Directory
Maryland News
Customer Service Survey

Alerts

Emergency Alerts
Travel Alerts
Report Cybersecurity Incident
Report Human Trafficking
Key Bridge

Give Feedback

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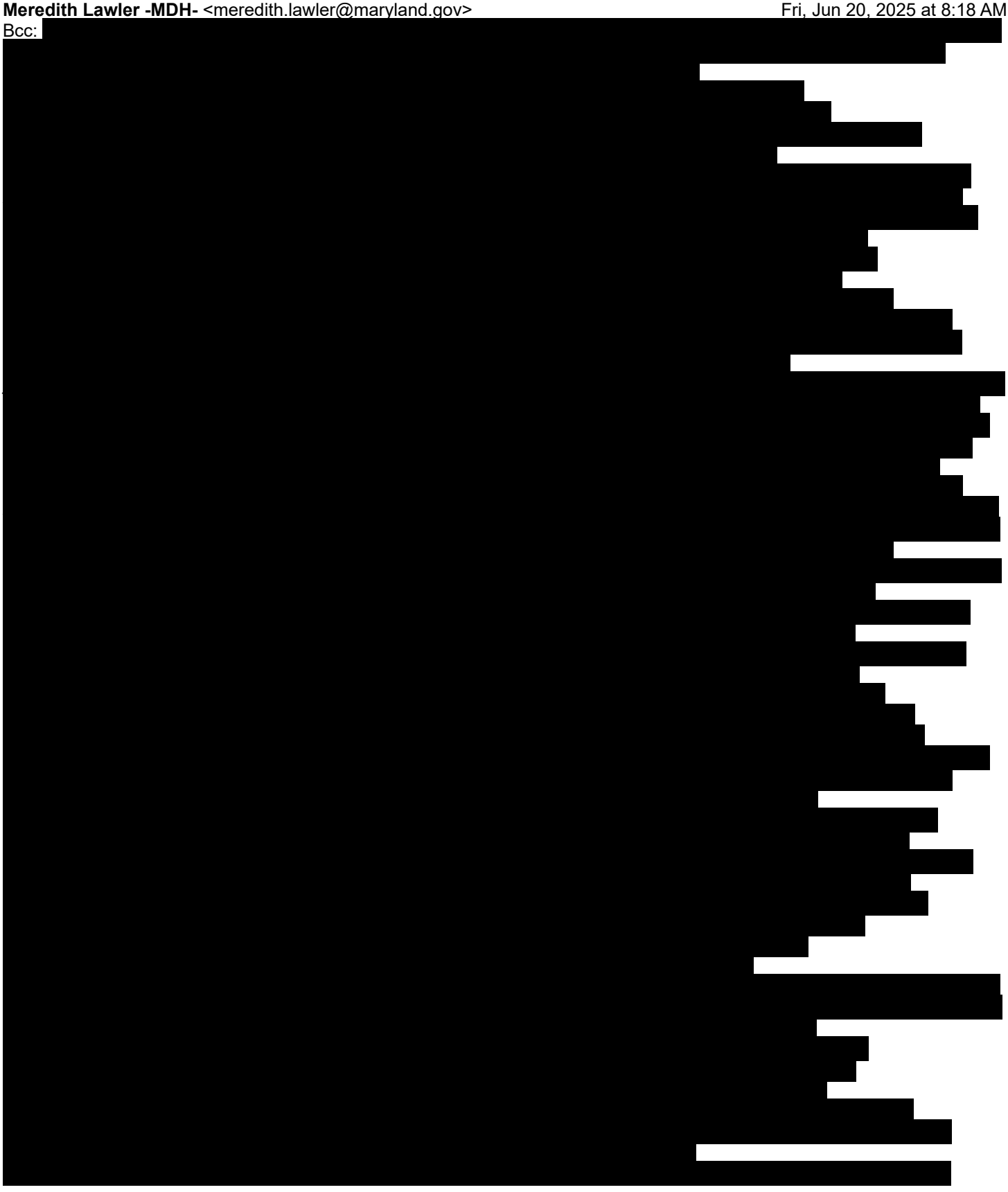
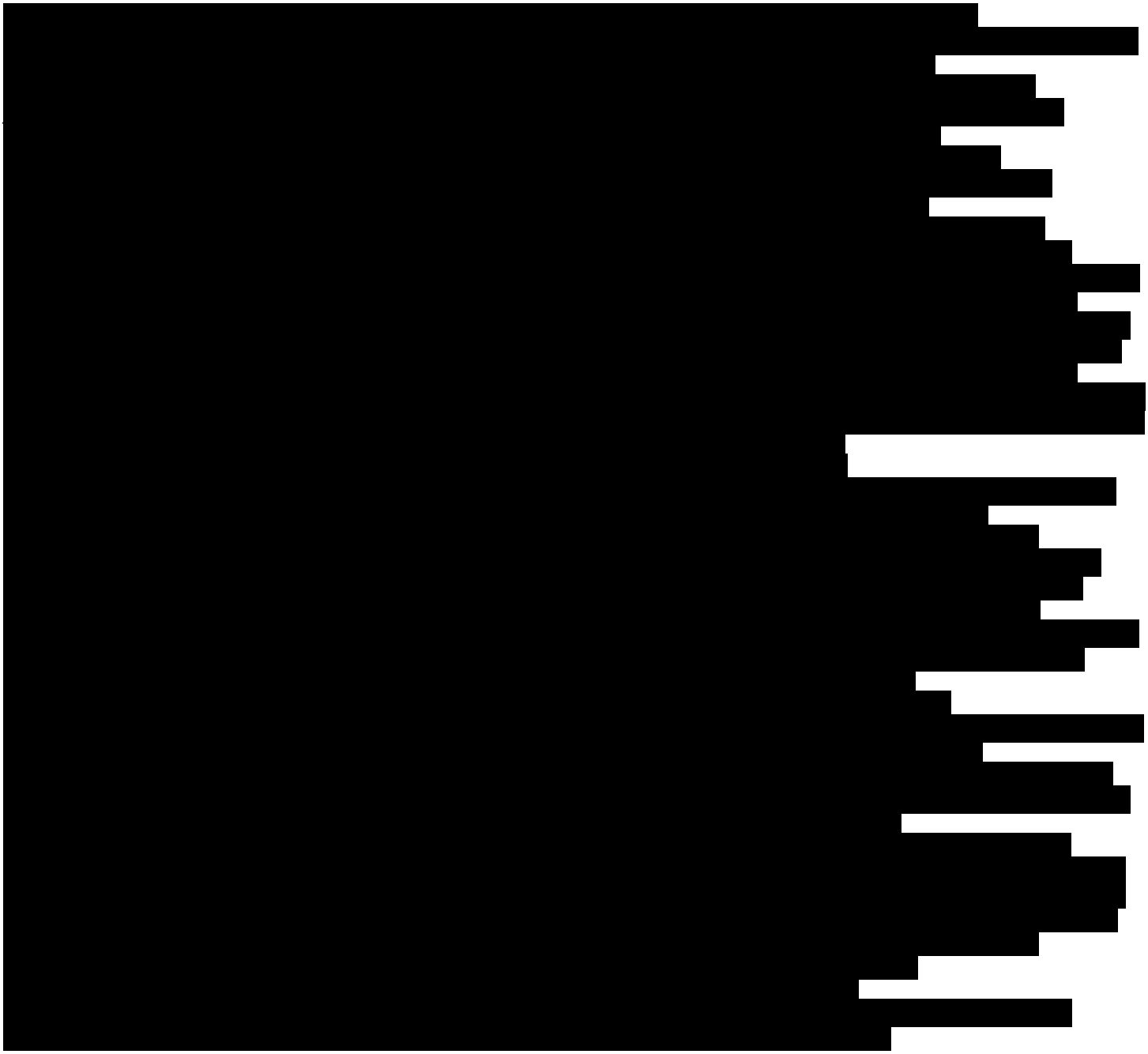
Meredith Lawler -MDH- <meredith.lawler@maryland.gov>

June 2025 MMAC Meeting Announcement

Meredith Lawler -MDH- <meredith.lawler@maryland.gov> Fri, Jun 20, 2025 at 8:18 AM
Bcc:





Good morning,

The Thursday, June 26th, MMAC meeting (1:00-3:00pm) will be held via GoToWebinar. All 2025 MMAC Meetings will be held virtually until further notice.

Registration information is at the bottom of this email and also within the attached agenda. Please limit this information to yourself and your direct staff.

This email contains the June agenda with May minutes, and the June Regulation, SPA, and Waiver reports. Please note all MMAC meeting materials are uploaded to the MDH MMAC Webpage within one week after each meeting.

In regards to public comment, interested parties may email me ahead of the meeting or use the question feature in GoToWebinar during the meeting to alert the host to your desire to participate in the public comment portion of the meeting.

Please register for MMAC Meeting on June 26, 2024 1:00 p.m. EST at:

https://attendee.gotowebinar.com/register/6578830412660151382

After registering, you will receive a confirmation email containing information about joining the webinar. Please pay specific attention to the information concerning how to join for audio.

Best,

Meredith

--
Meredith Lawler, MPH
Special Assistant to the Director | Innovation, Research, and Development
Office of Health Care Financing
Maryland Department of Health
201 W Preston Street
Baltimore, MD 21201
meredith.lawler@maryland.gov

We encourage you to check our website and social media often for updates.
For Medicaid-related Coronavirus updates, visit mmcp.health.maryland.gov.
For questions about the Coronavirus, visit coronavirus.maryland.gov.
Follow us @MDHealthDept facebook.com/MDHealthDept and twitter.com/MDHealthDept.

The Maryland Department of Health is committed to customer service. Click here to take the Customer Satisfaction Survey.

4 attachments

MMAC Reg Report June 2025.pdf
96K

MMAC Monthly Waiver Report 2025.06.pdf
119K

MMACMIN25 MAY.doc.pdf
190K

MMAC SPA Report June 2025.pdf
187K

MARYLAND MEDICAID ADVISORY COMMITTEE

DATE: Thursday, June 26, 2025
TIME: 1:00 - 3:00 p.m.
LOCATION: GoToWebinar

MMAC meetings will continue to be held through GoToWebinar only.

Please register for MMAC Meeting on June 26, 2025, 1:00 p.m. EST at:

https://attendee.gotowebinar.com/register/6578830412660151382

After registering, you will receive a confirmation email containing information about joining the webinar.

Those who would like to make public comment should email Ms. Meredith Lawler at, meredith.lawler@maryland.gov or use the question feature to submit questions to the host.

AGENDA

I. Introduction of Secretary Meena Seshamani

II. Departmental Report

III. HealthChoice Evaluation/Post-Award Forum

IV. Waiver, State Plan and Regulations Changes

V. Public Comments

VI. Adjournment

Next Meeting: Thursday, July 24, 2025, 1:00 – 3:00 p.m.

Staff Contact: Ms. Meredith Lawler
meredith.lawler@maryland.gov

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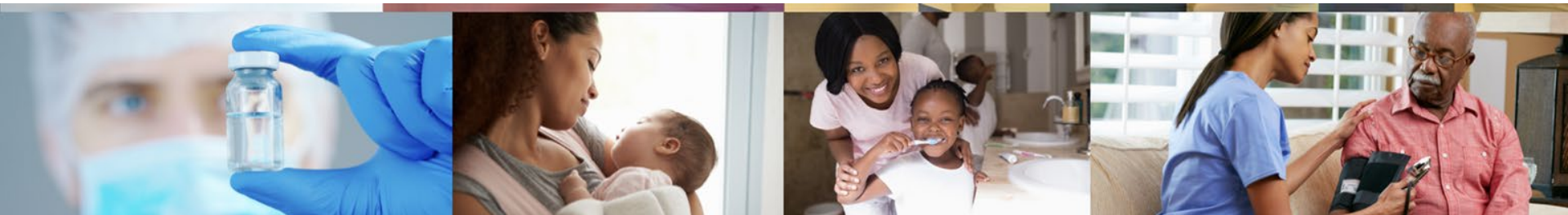
2025 Post-Award Forum & HealthChoice Evaluation (CY 2019 – CY 2023)

Nancy Brown

Medicaid Office of Innovation, Research and Development

June 26, 2025



Overview: Demonstration Goals

- Improve access to health care for the Medicaid population
- Improve the quality of health services delivered
- Provide patient-focused, comprehensive and coordinated care through the provision of a medical home
- Emphasize health promotion and disease prevention
- Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies

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2025 Evaluation Overview

- Evaluation period: CY 2019 – CY 2023
- Waiver programs covered in the evaluation
  - Residential Treatment Services for Individuals with Substance Use Disorders (SUD)
  - Assistance in Community Integration Services (ACIS)
  - National Diabetes Prevention Program (DPP)
  - Increased Community Services (ICS)
  - MOM (Formerly known as the Maternal Opioid Misuse) Model Pilot Program
  - Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI)
  - Former Foster Care Dental Services
- Waiver Programs that Sunset:
  - Evidence-Based Home Visiting Services (HVS)
  - Adult Dental Pilot Program
  - Collaborative Care Model Pilot (CoCM)

Coverage and Access

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Enrollment Growth

Between 2019 and 2023, HealthChoice enrollment increased by 24.3 percent, from 1,202,718 to 1,494,801.

- Enrollment grew by 27.1% from CY 2019 to CY 2022, before decreasing by 2.2% in CY 2023
- The percentage of Maryland Medicaid enrollees in managed care remained high, decreasing slightly from 89.9 percent to 89.6 percent.
- The **percentage of Maryland's population enrolled in HealthChoice grew from 19.9 percent to 24.2 percent**.

- There was also a sharp increase of 11.2% from CY 2019 to CY 2020 and 5.6% from CY 2021 to CY 2022, in part due to the Medicaid Maintenance of Eligibility (MOE) requirements.
- During CY 2023, the ending of the PHE and resumption of Medicaid redeterminations contributed to reduced enrollment.

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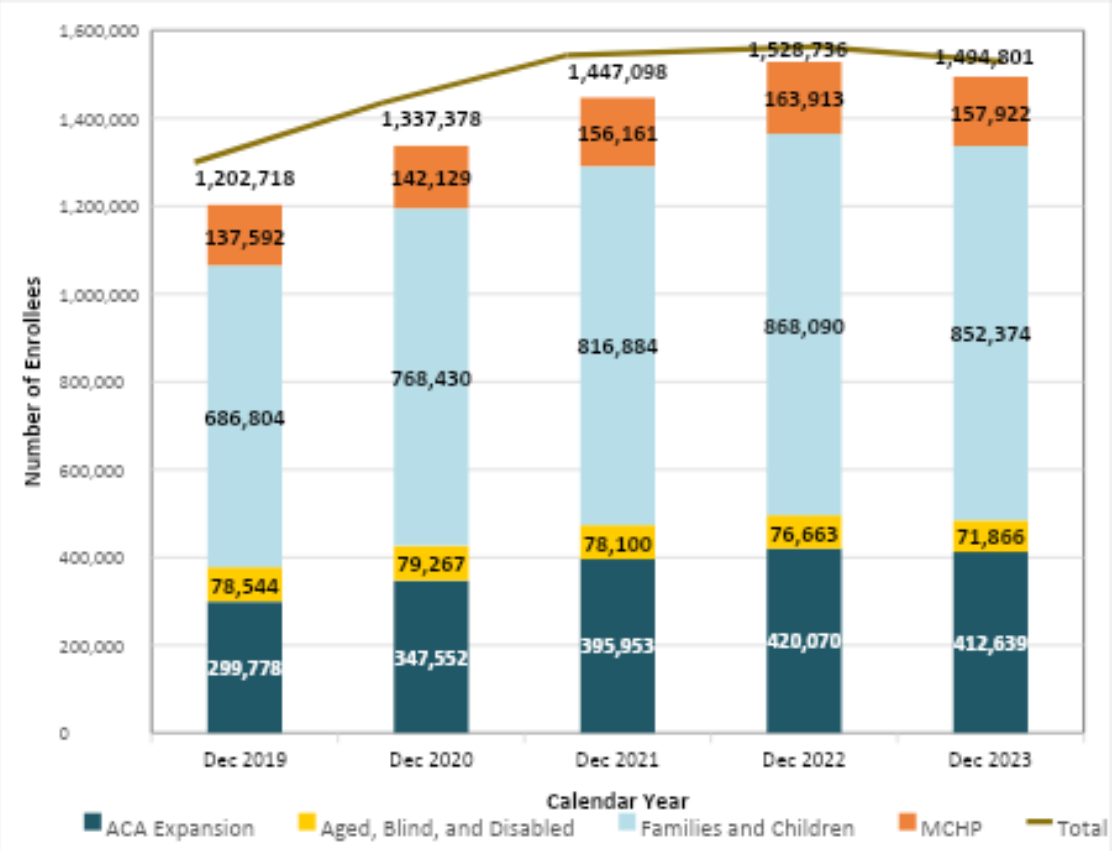
Enrollment Growth

HealthChoice Enrollment by Coverage Category as of December 31, CY 2019–CY 2023*



*Enrollment counts include participants aged 0-64 years who are enrolled in a HealthChoice MCO.

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Gaps in Coverage

Calendar Year	Total	At Least One Gap in Medicaid Coverage		Length of Coverage Gap			
				180 Days or Less		181 Days or More	
		#	%	#	%	#	%
2019	1,377,257	64,802	4.7%	47,004	72.5%	17,798	27.5%
2020	1,392,625	16,568	1.2%	11,192	67.6%	5,376	32.4%
2021	1,486,991	4,127	0.3%	2,806	68.0%	1,321	32.0%
2022	1,573,811	5,279	0.3%	3,462	65.6%	1,817	34.4%
2023	1,665,232	27,641	1.7%	21,109	76.4%	6,532	23.6%

- The percentage of HealthChoice participants with a gap in coverage decreased from 4.7 percent in CY 2019 to 1.7 percent in CY 2023.
- The overall number of those with a gap has significantly decreased.
- CY 2021 and CY 2022 had fewer enrollment gaps due to Medicaid MOE requirements; Medicaid redeterminations resumed in CY 2023

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Ambulatory Care Utilization

- Between CY 2019 and CY 2023, participants with an ambulatory care visit decreased from 79.0 percent to 73.0 percent, with the lowest observed rates among 19-39 year-olds (64.1 percent) and the ACA Expansion population (63.1 percent).
- Ambulatory care visit rates decreased among children of all racial and ethnic groups from 84.4 percent in CY 2019 to 79.3 percent in CY 2023; adult rates also decreased among all racial and ethnic groups, from 74.0% to 68.0%.

Inpatient Utilization

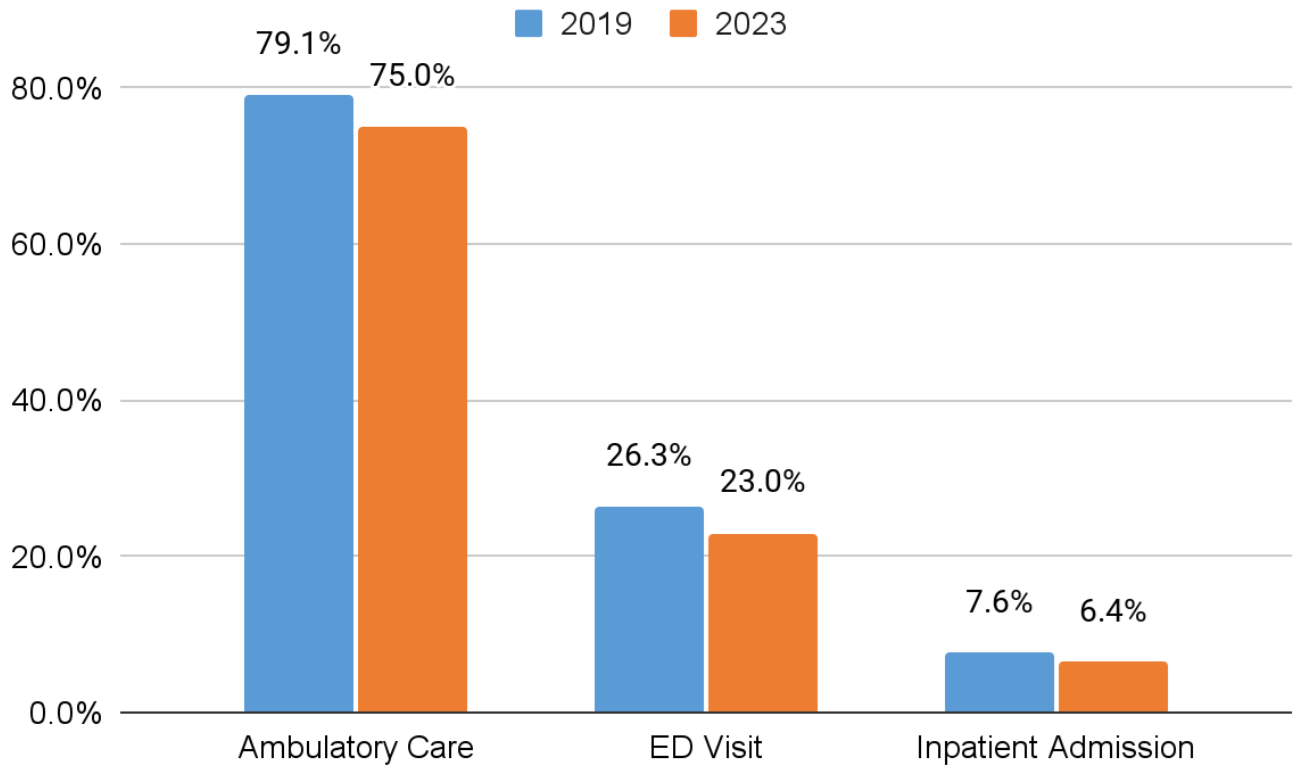
- **Inpatient admissions decreased by 2.4 percentage points**, from 9.6 percent in CY 2019 to 7.2 percent in CY 2023, with the greatest declines in Western Maryland by 3.0 percentage points.
- In CY 2023, Hispanics had the highest inpatient admission rate (8.6 percent), followed by Whites (7.6 percent), Black participants (7.1 percent), and Native Americans (6.5 percent)

Emergency Department Utilization

- The **emergency department (ED) visit rate in CY 2023 was 22.2 percent, a decrease from 27.7 percent in CY 2019**; the average no. of visits per ED user declined from 2.0 to 1.8.
- Black participants continued to have the highest ED rate in CY 2023 (25.1 percent)—though with a major decrease of 6.6 percentage points compared to CY 2019 —while Asians had the lowest (13.6 percent).
- **ED visits that resulted in an inpatient admission decreased from 3.6 percent in CY 2019 to 2.9 percent in CY 2023**, with the highest rate in Baltimore City (4.3 percent).

Children in Foster Care

Healthcare Utilization by Children in Foster Care (CY 2019 and CY 2023)



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Children in Foster Care

Behavioral Health Diagnosis of HealthChoice Foster Care Children vs. Non-Foster Care Children Aged 0–21 Years, CY 2019 and CY 2023

	CY 2019		CY 2023	
Foster Care Status	**Number of Participants**	**Percentage of Total**	**Number of Participants**	**Percentage of Total**
MHD-only				
Foster	5,799	39.1%	5,347	38.3%
Non-Foster	83,275	11.4%	89,908	10.9%
SUD-Only				
Foster	65	0.4%	52	0.4%
Non-Foster	2,827	0.4%	1,477	0.2%
MHD + SUD				
Foster	224	1.5%	242	1.7%
Non-Foster	1,831	0.3%	2,077	0.3%

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REM Program

Utilization

- The percentage of REM participants receiving dental visits decreased from CY 2019 to CY 2023 by 5.2 percentage points, from 57.2 percent to 52.0 percent.
- Ambulatory care visits decreased by 2.1 percentage points over the study period, from 95.0 percent to 92.9 percent.
- ED utilization rate decreased by 4.7 percentage points, from to 42.3 percent to 37.6 percent.
- Inpatient admissions decreased from 26.1 percent to 23.2 percent.

Behavioral Health Diagnoses (CY 2023)

- MHD-only: 20.7 percent
- SUD-only: 0.5 percent
- MHD + SUD: 0.6 percent

ACA Expansion Population

Service Utilization of ACA Medicaid Expansion Population (aged 19-64 years) by Any Enrollment Period

Service type	CY 2019	CY 2023
Ambulatory care	68.2%	62.4%
ED visits	30.0%	22.9%
Inpatient admissions	8.2%	6.1%
MHD-only	11.7%	12.4%
SUD-only	6.3%	4.2%
MHD + SUD	5.5%	5.0%

ACA expansion enrollment increased from 391,824 adults in CY 2019 to 515,121 adults in CY 2023, with participants aged 19-34 comprising the largest portion of the ACA expansion population.*

**Any period of enrollment*

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Quality of Care

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Population Health Incentive Program (PHIP)

Population Health Incentive Program Measure CY 2023	Statewide Percentage
Ambulatory Care Visits for SSI Adults	79.0%
Ambulatory Care Visits for SSI Children	78.2%
Asthma Medication Ratio	69.9%
Continued Opioid Use (COU): >=31 days covered	3.1%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)	31.9%
Lead Screening in Children (LSC)	74.7%
Prenatal and Postpartum Care (PPC-CH): Timeliness of Prenatal Care	87.9%
Prenatal and Postpartum Care (PPC-AD): Postpartum Care	84.2%

Healthy Kids Review

EPSDT Component	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Health and Developmental History	88%	94%	94%	96%	93%
Comprehensive Physical Exam	93%	96%	96%	98%	97%
Laboratory Tests/At-Risk Screenings	66%*	77%	81%	85%	80%
Immunizations	71%*	86%	88%	95%	92%
Health Education/Anticipatory Guidance	92%	94%	94%	97%	96%
HealthChoice Aggregate Total	**83%**	**91%**	**92%**	**95%**	**93%**

* CY 2019 results for these components are baseline as a result of the change in the MRR process due to the COVID-19 public health emergency. Underlined scores are below the 80% minimum compliance requirement.

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Medical Home

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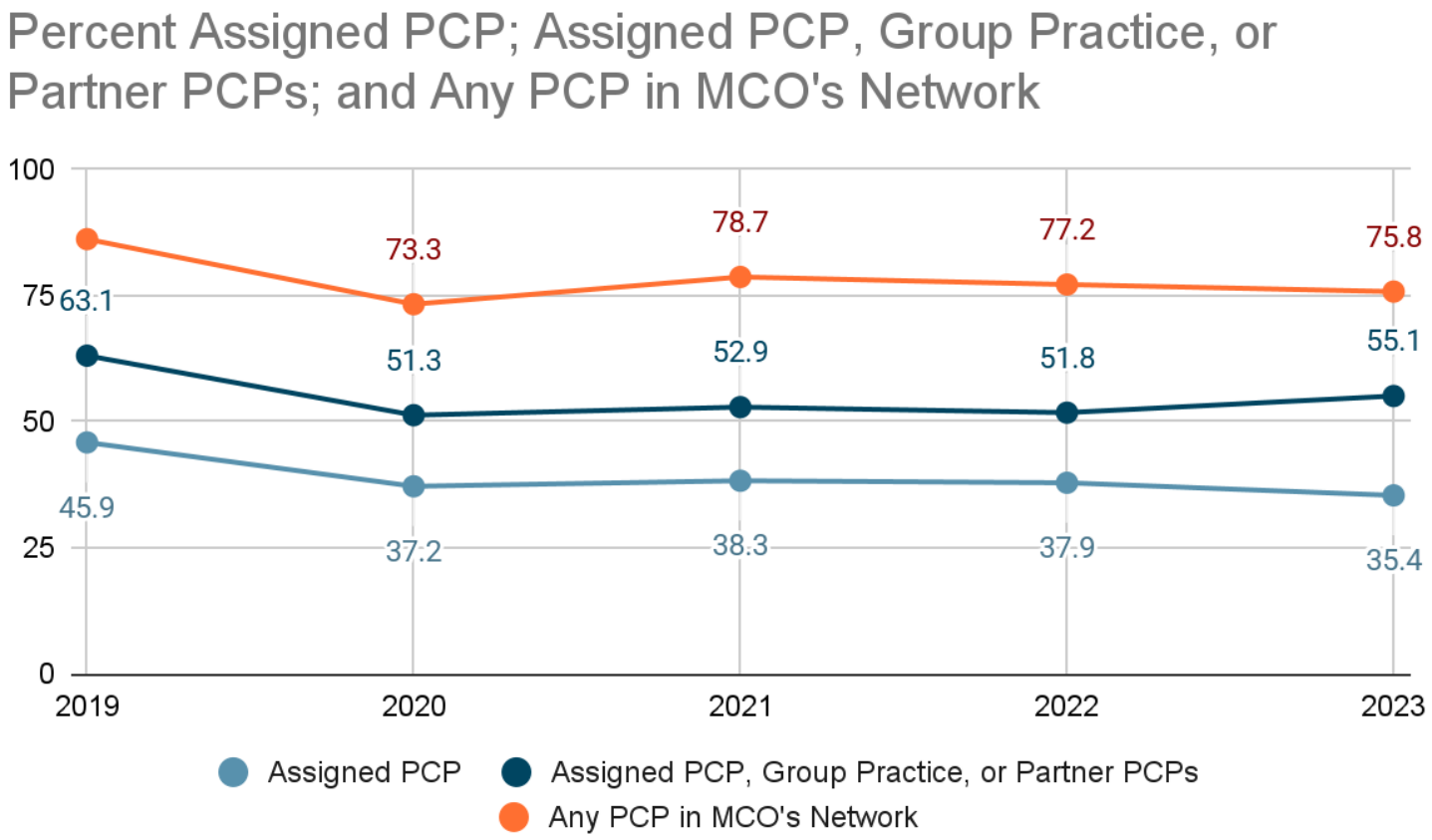
Medical Home Utilization



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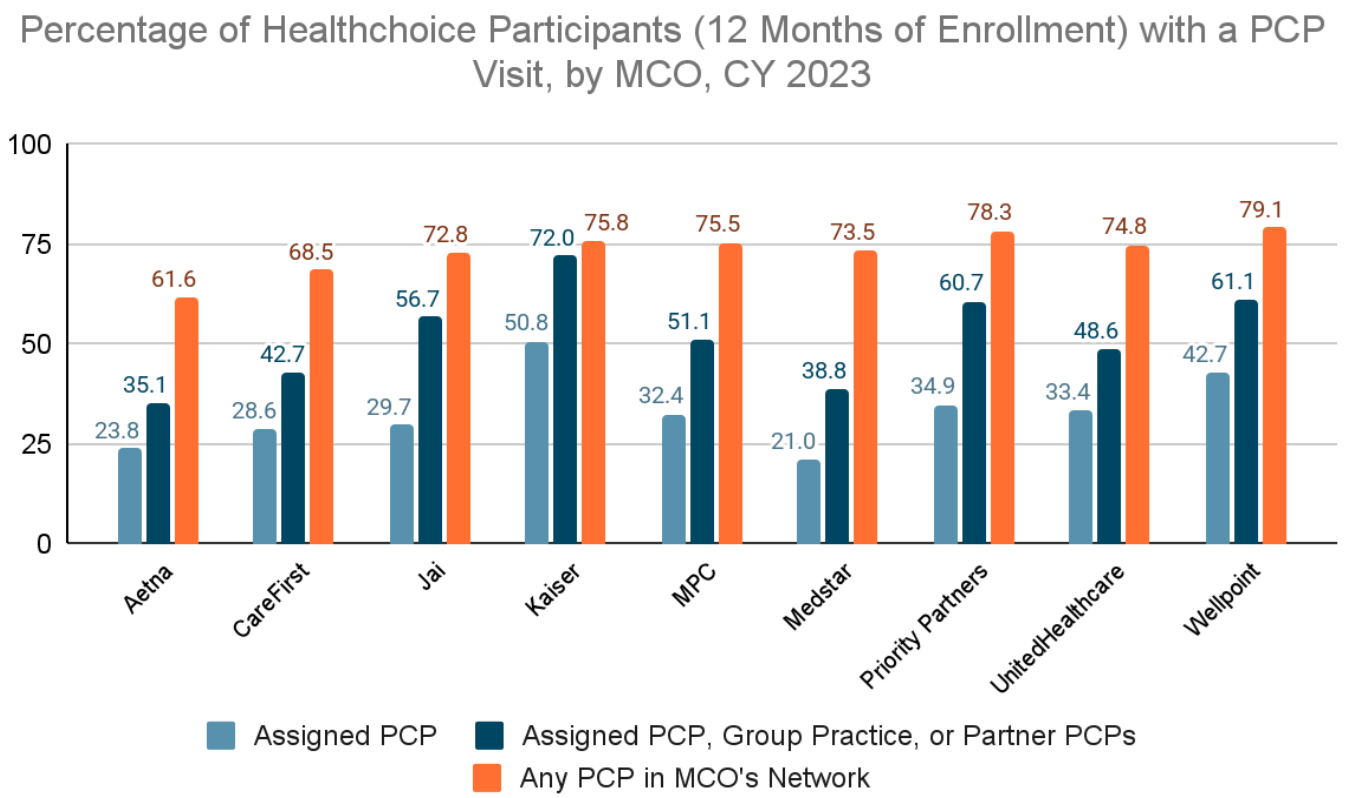
Medical Home Utilization



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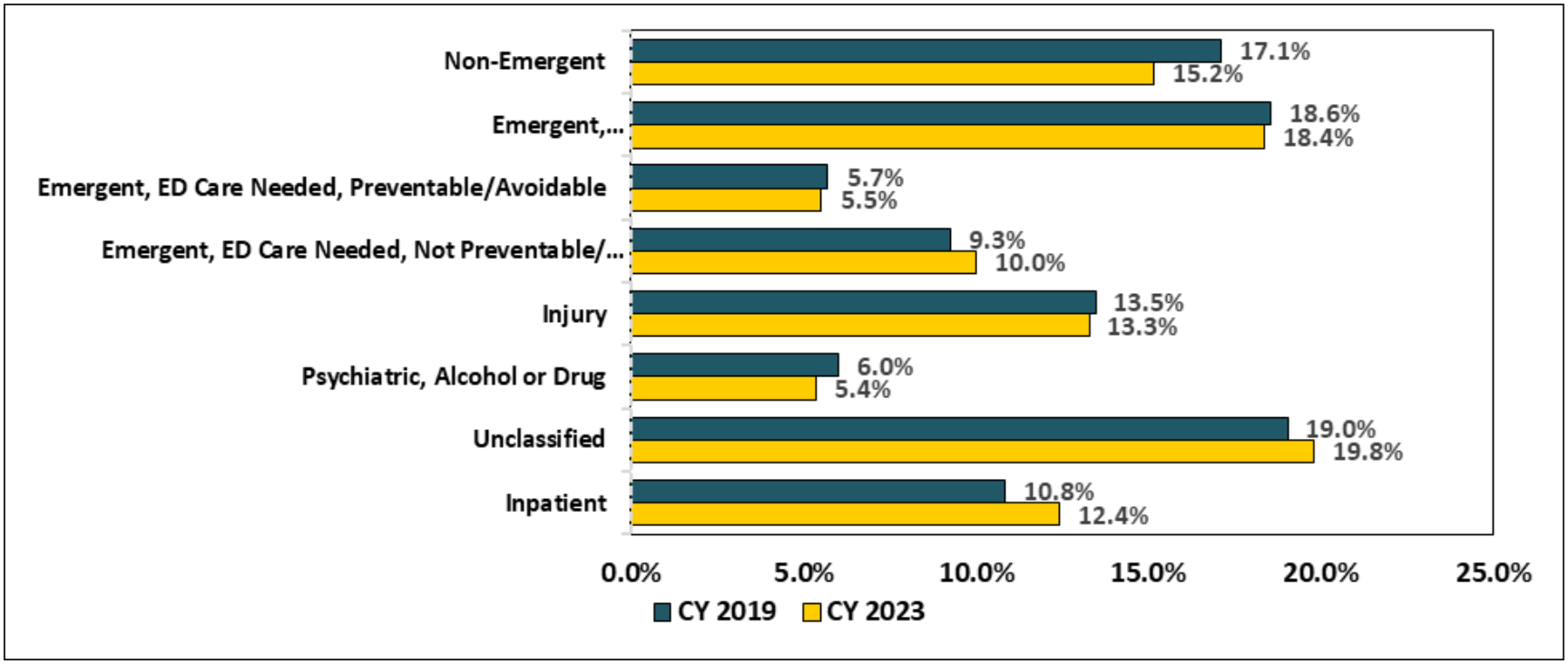
ED Utilization

Between CY 2019 and CY 2023, potentially-avoidable ED utilization decreased from 41.4 percent to 39.1 percent.



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Inpatient Admissions

- The Department uses the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQI) methodology, which looks for specific primary diagnoses in hospital admission records.
- The percentage of participants with at least one inpatient admission initially decreased from 7.8 percent in CY 2019 to 5.9 percent in CY 2023.
- PQI-designated discharges with the highest rates:
    - COPD or Asthma in Older Adults Admissions (Ages 40-64) (PQI #5)
    - Congestive Heart Failure (PQI #8)

Health Promotion and Disease Prevention

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Immunizations and Well-Child Visits

HEDIS Measure	CY 2020	CY 2023	National HEDIS Mean CY 2023
Childhood Immunization Status: Combination 3	70.2%	68.8%	+
Well-Child Visits: 15 Months of Life	61.1%	58.4%	-
Child and Adolescent Well-Care Visits (WCV), 3-11 years	57.4%	62.9%	+
Child and Adolescent WCV, 12-17 years	53.7%	55.4%	+
Child and Adolescent WCV, 18-21 years	38.0%	36.1%	+

Maryland
DEPARTMENT OF HEALTH

Lead Test Screening

- Lead test screening rates between CY 2019 and CY 2023:
  - Decreased for children aged 12-23 months: 62.4 percent to 61.3 percent
  - Declined for children aged 24-35 months: 81.5 percent to 76.4 percent
- Blood lead levels: The percentage of children aged zero to six with an elevated blood lead level decreased from 2.1 percent in CY 2019 to 1.8 percent in CY 2023.
- CHIP Health Services Initiative (HSI) State Plan Amendment (SPA)
  - Program 1: Healthy Homes for Healthy Kids (lead identification and abatement); and
  - Program 2: Childhood Lead Poisoning Prevention & Environmental Case Management (identify environmental asthma triggers and conditions that contribute to lead poisoning)

Cancer Screening

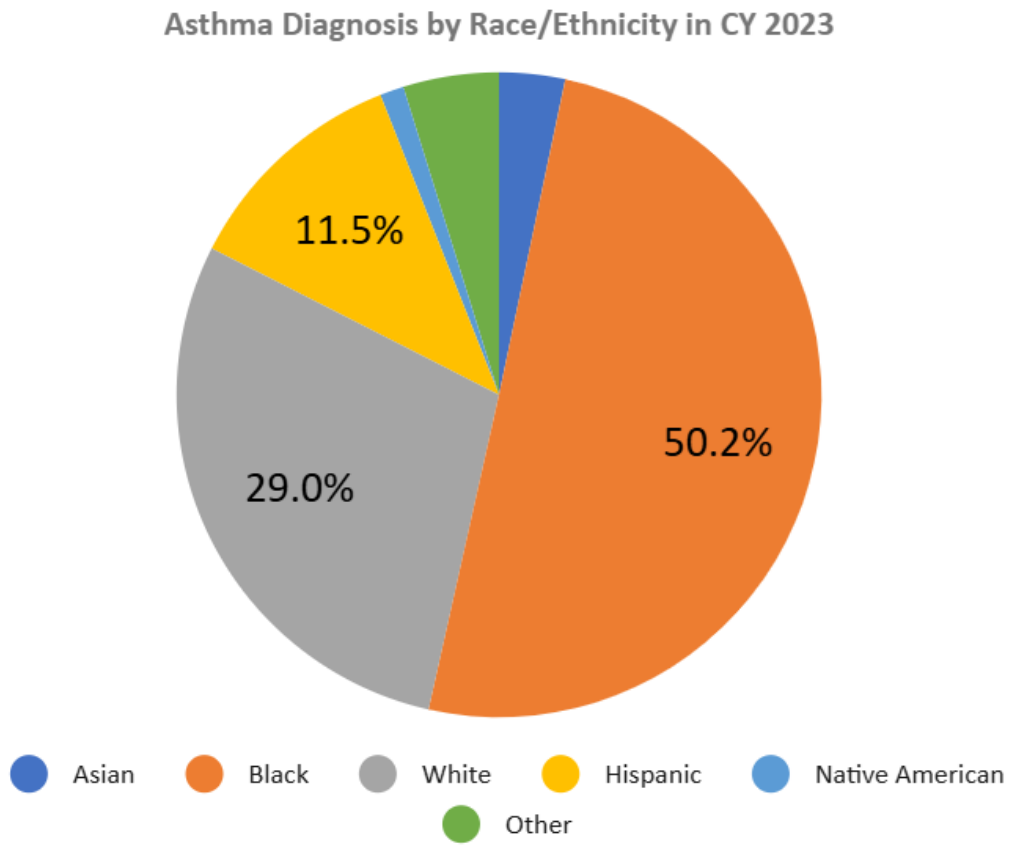
Breast Cancer	• 59.2% in CY 2023
Cervical Cancer	• 63.8 percent in CY 2019 to 57.6 percent in CY 2023 • *Decreased by 6.2 percentage points*
Colorectal Cancer	• 41.5 percent in CY 2019 to 40.7 percent in CY 2023 • *Decreased by 0.8 percentage points*

Maryland
DEPARTMENT OF HEALTH

Maternal and Reproductive Health

- From CY 2019 to CY 2023, the percentage of deliveries in which the mother received a prenatal care visit in the first trimester or within 42 days of HealthChoice enrollment decreased from 88.2 percent to 87.9 percent.
- From CY 2019 to CY 2023, the percentage of women enrolled in HealthChoice
  - with at least one type of contraception classified as most effective decreased from 4.7% to 3.0%.
  - with at least one moderately effective type of contraception decreased from 22.1% to 16.5%.
- The number of HealthChoice women at risk of unintended pregnancy increased from 271,321 to 379,700 from CY 2019 to CY 2023.

Asthma



Maryland
DEPARTMENT OF HEALTH

Diabetes

Percentage of HealthChoice Members Aged 18–64 Years with Diabetes Who Received Comprehensive Diabetes Care, Compared with the National HEDIS® Average (CY 2019 – CY 2023)

HEDIS® Measure	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Eye (Retinal) Exam					
HealthChoice	54.7%	51.7%	50.3%	53.1%	55.6%
National HEDIS® Average	-	-	-	-	-
HbA1c Test*					
HealthChoice	88.3%	82.9%	87.1%		
National HEDIS® Average	+	-	+		
HbA1c Control**					
HealthChoice	55.6%	51.0%	56.3%	57.3%	59.0%
National HEDIS® Average	+	+	+	+	+
Blood Pressure Control***					
HealthChoice		55.9%	57.5%	63.6%	66.7%
National HEDIS® Average		-	-	+	-

*This measure was retired in CY 2022

Maryland DEPARTMENT OF HEALTH

Regression Analysis

- Participants with a positive asthma medication ratio (AMR) the previous year were 36.3% less likely to have an asthma-related inpatient stay in the current measurement year (OR 0.637 $p<0.001$)
- Participants receiving either an HbA1c test or an eye exam the previous year reduced the likelihood of having a diabetes-related ED visit the next year by 20.4% and 11.1%, respectively ($p<0.001$)
- Participants who had an HbA1c test were 24.3% less likely to have a diabetes-related inpatient stay that year. Participants who had an HbA1c test the previous year were 13.2% less likely to have a diabetes-related inpatient stay.

HIV/AIDS

Screening and Prevention

- HIV screening (15-64) decreased from 18.0 percent in 2019 to 15.1 percent in 2023.
- HIV pre-exposure prophylaxis (PrEP) use remains at 0.1 percent.

Chronic Condition Management

- CD4 testing decreased by 4.8 percentage points, from 70.3 percent to 65.5 percent.
- Viral load testing decreased by 5.5 percentage points, from 70.9 percent to 67.2 percent.
- Antiretroviral therapy utilization decreased by 2.9 percentage points, from 85.5 percent to 82.6 percent.

*all measures compared to 2018

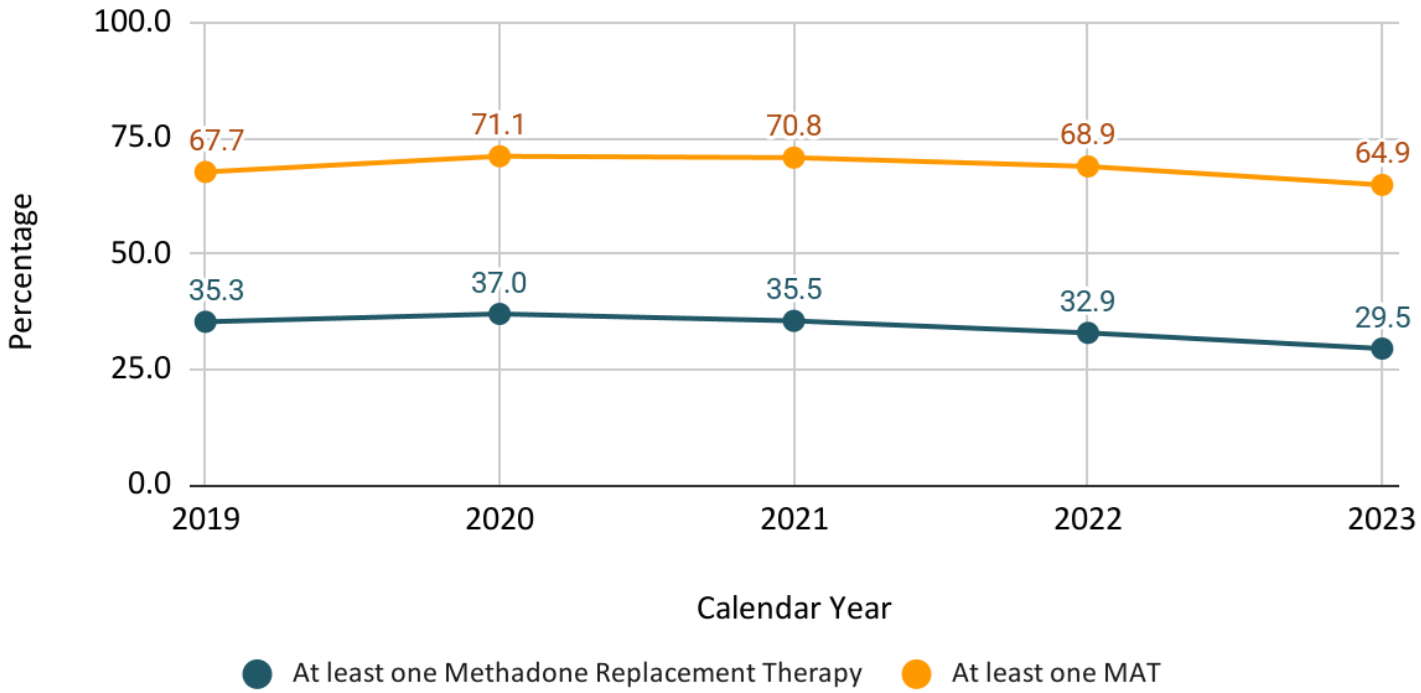
Behavioral Health

The percentage of HealthChoice participants with:

- A mental health disorder (MHD) diagnosis decreased by 0.2 percentage points, from 12.8 percent in CY 2019 to 12.6 percent in CY 2023.
- A substance use disorder (SUD) diagnosis decreased by 0.7 percentage points, from 2.7 percent in CY 2019 to 2.0 percent in CY 2023.
- Co-occurring behavioral health diagnoses (MHD and SUD) decreased by 0.2 percentage point, from 2.6 percent in CY 2019 to 2.4 percent in CY 2023.

Substance Use

Percentage of HealthChoice Participants with an SUD Who Received at least one Methadone Replacement Therapy and At least one MAT



Maryland
DEPARTMENT OF HEALTH

Substance Use

- Screening, Brief Intervention and Referral to Treatment (SBIRT): The rate per 1,000 receiving an SBIRT service decreased from 16.4 in CY 2019 to 14.5 in CY 2023.
- Outpatient follow-up after SUD-related ED visits (CY 2019 to CY 2023):
  - Within seven days: Increased from 15.1 percent to 30.4 percent for SUD-only and 26.8 percent to 56.4 percent for dual diagnosis
  - Within 30 days: Increased from 23.0 percent to 44.3 percent for SUD-only and 41.1 percent to 75.8 percent for dual diagnosis

Demonstration Programs

Maryland
DEPARTMENT OF HEALTH

Residential Treatment for SUD

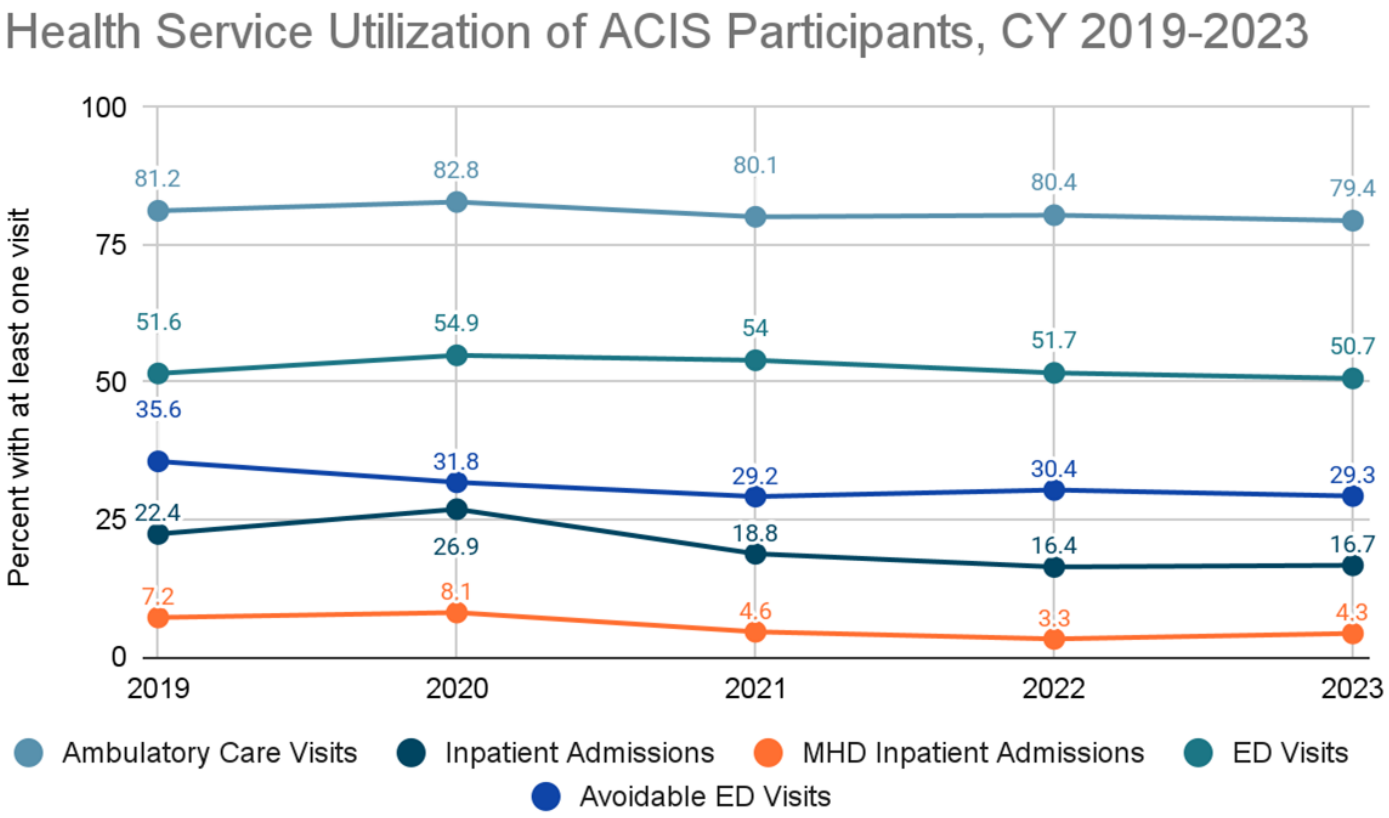
- Among enrollees with an IMD placement, medication-assisted treatment decreased by 7.8 percent from CY 2019 to CY 2023, from 75.3% to 67.5%
- Healthchoice enrollees with an AOD dependence diagnosis who received IMD treatment were 12% more likely to initiate treatment post diagnosis

Residential and Inpatient Treatment for Serious Mental Illness (SMI)

- In 2021, Maryland received approval to expand coverage of institution of mental disease services for beneficiaries with serious mental illness (SMI)
- Effective January 1, 2022, the state began to cover short term stays for Medicaid adults 21-64 who reside in a private IMD with an SMI diagnosis
- With this expansion, beneficiaries now have access to the full range of SMI services, ranging in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings

Maryland
DEPARTMENT OF HEALTH

Assistance in Community Integration Services



Maryland
DEPARTMENT OF HEALTH

National Diabetes Prevention Program (DPP)

- The National DPP is an evidence-based program established by the CDC to prevent or delay the onset of type 2 diabetes through healthy eating and physical activity.
  - Expanded to all eligible HealthChoice participants as of September 1, 2019
- From September 2019 through December 2025, there have been 2,558 DPP encounters:
  - 56.3% were in-person visits (as opposed to virtual)
  - 84.5% of those served were women
  - 64.6% self-identified as Black/African American

Questions?

HealthChoice evaluations can be found here: https://mmcp.health.maryland.gov/healthchoice/pages/HealthChoice-Evaluation.aspx

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Maryland
DEPARTMENT OF HEALTH

Attachment IV: SUD and SMI Continuum of Care

Table 1. Current Continuum of Care in Maryland

CURRENT CONTINUUM OF CARE IN MARYLAND	
SUD Services	**ASAM Criteria**
SBIRT	N/A
Substance Use Disorder Assessment (CSAA)	N/A
Peer Recovery Support Services	N/A
Group Outpatient Therapy	Level 1-Outpatient Service
Individual Outpatient Therapy	Level 1-Outpatient Service
Ambulatory Detoxification	Level 1-Outpatient Service
Intensive outpatient (IOP)	Level 2.1- Intensive Outpatient Service
Partial Hospitalization	Level 2.5- Partial Hospitalization
Clinically Managed Low-Intensity Residential Services	Level 3.1 - Residential/Inpatient Services
Clinically Managed Population-Specific High-Intensity Residential Services	Level 3.3 - Residential/Inpatient Services
Clinically Managed High-Intensity Residential Services	Level 3.5 - Residential/Inpatient Services
Medically Monitored Intensive Inpatient Services	Level 3.7 - Residential/Inpatient Services
Medically Monitored Intensive Inpatient Services	Level 3.7-WM (Withdrawal Management) - Residential/Inpatient Services
Medically Managed Intensive Inpatient Services	Level 4.0 - Inpatient Services
Methadone/Buprenorphine: Induction and Maintenance	Level OMT- Opioid Maintenance Therapy
Medicaid covers all FDA-covered pharmaceuticals. Additional medication-assisted treatment covered with clinical criteria: ● Buprenorphine/Naloxone combination therapies: Bunavail, Suboxone, Suboxone Film, and Zubsolv ● Campral ● Naltrexone ● Subutex – Buprenorphine ● Vivitrol ● Brixadi	N/A
ICF-A: Under 21	Medically monitored intensive inpatient treatment Level 3.7-WM Level 3.7 Level 3.5
Intensive Inpatient Services	Level 4 – Inpatient Services and Level 4.0 WM

Table 3. The Current Continuum of Coverage for Mental Health Services in Maryland

Emergency	Inpatient	Outpatient
Fee-for-Service	***Administrative Service Organization***	***Managed Care Organization***
Emergency Transportation (Ambulance)	Acute Care Services	Primary Mental Health Services (EPSDT: Assessment, Clinical Evaluation, CoCM, Referral to ASO)
	Ancillary Services—MH*	Health Behavior Assessment and Reassessment for Somatic Conditions
	Anesthesia—Inpatient	***Fee-for-Service***
	Electroconvulsive therapy (ECT)--Inpatient	Traumatic Brain Injury (TBI) Day Habilitation
Administrative Service Organization	Patient Consultation	***Administrative Service Organization***
Emergency Room—All-Inclusive Ancillary Services	Psychological/Neuropsychological Testing and Evaluation—Inpatient	Biofeedback
Emergency Room—Medications	Individual Therapy—MH Inpatient	Educational Therapy
Emergency Room—Beyond EMTALA Screening	Group Therapy—MH Inpatient	Electroconvulsive Therapy (ECT)—Outpatient
Emergency Room—EMTALA Screening	Family Therapy—MH Inpatient	Family Psycho-Educational Therapy
Emergency Room—Post-stabilization	Special Psychiatric Hospital	Family Therapy—Outpatient
Emergency Room—Stabilization services	Residential Treatment Centers	Group Therapy—Outpatient
Emergency Room—Clinical Laboratory	Nursing Facility: MH Services	Individual Psycho-Educational Therapy
Emergency Room—General Services		Individual Therapy—Outpatient
Observation Stay—24 hour		Intensive Outpatient (IOP)
		Mental Health Assessment
		Mental Health Reassessment
		Multiple Family Group Therapy
		Partial Hospitalization (PHP)

Emergency	Inpatient	Outpatient
		Psychiatric Rehabilitation Services (PRP)
		Psychological or Neuropsychological Testing and Evaluation
		Therapeutic Behavioral Services (TBS)
		Transcranial Magnetic Stimulation (TMS)
		Evaluation and Management—Outpatient
		Laboratory Services
		Mobile Treatment—Assertive Community Treatment (ACT)
		Mobile Treatment—non-ACT
		Targeted Case Management
		Health Home Services for MH Reasons [Serious and Persistent Mental Illness (SPMI) – Services by Mobile Treatment Services (MTS) or Psychological Rehabilitation Programs (PRP)]
		Mobile Crisis Team Services
		Mobile Crisis Team Follow-Up Services
		Behavioral Health Crisis Stabilization Centers

*MCOs are responsible for any ancillary MH services for somatic IP admissions.

Attachment V: ICS Program Expected Expenditures

Attachment V: ICS Program Expected Expenditures

Amendment Component	Estimated Expenditures				
	DY01 (CY 2027)	DY02 (CY 2028)	DY03 (CY 2029)	DY04 (CY 2030)	DY05 (CY 2031)
Enrollment*	20	25	31	36	41
Per Member Per Month 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.

2024 PMPY Cost	$	46,635		
2025 PMPY Cost (3% rate increase)	$	48,034	2025 Enrollment	10
2026 PMPY Cost (3% rate increase)	$	49,475	2026 Enrollment	15
2027 PMPY Cost (3% rate increase)	$	50,959	2027 Enrollment	20
2028 PMPY Cost (3% rate increase)	$	52,488	2028 Enrollment	25
2029 PMPY Cost (3% rate increase)	$	54,063	2029 Enrollment	31
2030 PMPY Cost (3% rate increase)	$	55,685	2030 Enrollment	36
2031 PMPY Cost (3% rate increase)	$	57,355	2031 Enrollment	41

Attachment VI: Impact on Expenditures and Enrollment

[Note: detailed expenditure and enrollment data will be provided at the time of formal submission.]

The Department's proposed changes to the HealthChoice demonstration are not expected to have a material impact on Medical Assistance Program enrollment or associated expenditures. Please see the table below for current information.

Table 1. Demonstration Years (DY) HealthChoice Actual and Projected Member Months and Expenditures (Prior Demonstration Period)

	Prior Demonstration Period					
	DY 26 (6 months)	DY 27	DY 28	DY 29	DY 30 Projected	DY 31 (6 months) Projected
	Jan. 1, 2022- June 30, 2022	July 1, 2022- June 30, 2023	July 1, 2023- June 30, 2024	July 1, 2024- June 30, 2025	July 1, 2025- June 30, 2026	July 1, 2026- Dec. 31, 2026
Member Months	8,832,360	18,346,095	17,874,723	14,938,761	15,160,801	7,693,070
Expenditures	$3,765,883,977	$7,786,723,609	$7,727,764,925	$6,599,592,001	$7,086,207,374	$3,804,320,429

*Note, DY 29 expenditures reflect expenditures through May 2025.

Table 2. Demonstration Years HealthChoice Projected Member Months and Expenditures (Current Demonstration Period)

	Current Demonstration Period					
	DY 31 (continued, 6 months)	DY 32	DY 33	DY 34	DY 35	DY 36 (6 months)
	Jan. 1, 2027- June 30, 2027	July 1, 2027- June 30, 2028	July 1, 2028- June 30, 2029	July 1, 2029- June 30, 2030	July 1, 2030- June 30, 2031	July 1, 2031- Dec. 31, 2031
Member Months	7,807,415	15,846,918	16,082,456	16,321,495	16,564,087	8,405,142
Expenditures	$4,084,795,480	$8,771,897,335	$9,418,608,988	$10,112,999,718	$10,858,584,683	$5,829,569,100

Attachment VII: Public Process and Indian Consultation Requirements

SECTION I. OVERVIEW OF MARYLAND'S PUBLIC NOTICE AND COMMENT PERIOD

The State's 30-day public comment period opened June 30, 2025 and accepted comments through July 30, 2025. The Department provided public notice and solicited stakeholder participation for this renewal application pursuant to 42 C.F.R. §431.408. Notice was published in the Maryland Register, on May 30, 2025, and June 27, 2025. The full draft narrative of the waiver application was published on the Department website on June 30, 2025.

The Department presented highlights of the waiver renewal to the Maryland Medicaid Advisory Committee (MMAC) at its June 26, 2025 meeting, informing those in attendance of the public notice content. The Department presented again at the July 24, 2025 meeting. The Department provided a 30-day public comment period, from June 30, 2025 through July 30, 2025. Comments received after this date were also accepted, to receive the broadest input from stakeholders possible.

In addition to publishing these notices, the Department conducted two public hearings on the renewal application. These hearings were accessible by audio conference and were presented as webinars so that slides are visible to participants. The first hearing was held on July 9, 2025 and the second hearing was held on July 24, 2025, during the MMAC meeting. During these hearings, the Department presented a summary of the renewal application and accepted verbal and written comments from stakeholders. The public is able to access information about the waiver renewal and submission of comments on the Department website via this link: https://health.maryland.gov/mmcp/pages/1115-healthchoice-waiver-renewal.aspx

Though the State has no federally recognized tribes, Jessica Dickerson, of the Office of Urban Indian Health Programs in Maryland, was contacted for review of the current Maryland HealthChoice Program section 1115 Waiver Renewal Application. On June 30, 2025, the Department sent an overview of the draft section 1115 demonstration extension application and summary document to Jessica Dickerson and Kerry Lessard of the Office of Urban Indian Health Programs in Maryland, for input and comments. On July XX, 2025, Ms. Dickerson submitted comments via email. [Additional information to be added at the close of the public comment period]

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 section 1115 demonstration. Annually, the MMAC provides feedback on the HealthChoice evaluation report. Notice of the 1115 demonstration extension renewal was distributed to the MMAC stakeholder email list, with instruction to submit written comments to the Department stakeholder email address, mdh.healthchoicerenewal@maryland.gov.

SECTION II. SUMMARY OF PUBLIC COMMENTS RECEIVED

[Additional information and documentation to be added at the close of the public comment period]

Maryland Register

Issue Date: May 30, 2025
Volume 52 • Issue 11 • Pages 513 — 584

IN THIS ISSUE

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before May 12, 2025 5 p.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of May 12, 2025.

Gail S. Klakring
Administrator, Division of State Documents
Office of the Secretary of State

Information About the Maryland Register and COMAR

MARYLAND REGISTER

The Maryland Register is an official State publication published every other week throughout the year. A cumulative index is published quarterly.

The Maryland Register is the temporary supplement to the Code of Maryland Regulations. Any change to the text of regulations published in COMAR, whether by adoption, amendment, repeal, or emergency action, must first be published in the Register.

The following information is also published regularly in the Register:

- Governor's Executive Orders
- Attorney General's Opinions in full text
- Open Meetings Compliance Board Opinions in full text
- State Ethics Commission Opinions in full text
- Court Rules
- District Court Administrative Memoranda
- Courts of Appeal Hearing Calendars
- Agency Hearing and Meeting Notices
- Synopses of Bills Introduced and Enacted by the General Assembly
- Other documents considered to be in the public interest

CITATION TO THE MARYLAND REGISTER

The Maryland Register is cited by volume, issue, page number, and date. Example:

- 19:8 Md. R. 815—817 (April 17, 1992) refers to Volume 19, Issue 8, pages 815—817 of the Maryland Register issued on April 17, 1992.

CODE OF MARYLAND REGULATIONS (COMAR)

COMAR is the official compilation of all regulations issued by agencies of the State of Maryland. The Maryland Register is COMAR's temporary supplement, printing all changes to regulations as soon as they occur. At least once annually, the changes to regulations printed in the Maryland Register are incorporated into COMAR by means of permanent supplements.

CITATION TO COMAR REGULATIONS

COMAR regulations are cited by title number, subtitle number, chapter number, and regulation number. Example: COMAR 10.08.01.03 refers to Title 10, Subtitle 08, Chapter 01, Regulation 03.

DOCUMENTS INCORPORATED BY REFERENCE

Incorporation by reference is a legal device by which a document is made part of COMAR simply by referring to it. While the text of an incorporated document does not appear in COMAR, the provisions of the incorporated document are as fully enforceable as any other COMAR regulation. Each regulation that proposes to incorporate a document is identified in the Maryland Register by an Editor's Note. The Cumulative Table of COMAR Regulations Adopted, Amended or Repealed, found online, also identifies each regulation incorporating a document. Documents incorporated by reference are available for inspection in various depository libraries located throughout the State and at the Division of State Documents. These depositories are listed in the first issue of the Maryland Register published each year. For further information, call 410-974-2486.

HOW TO RESEARCH REGULATIONS

An Administrative History at the end of every COMAR chapter gives information about past changes to regulations. To determine if there have been any subsequent changes, check the "Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed" which is found online at http://www.dsd.state.md.us/PDF/CumulativeTable.pdf. This table lists the regulations in numerical order, by their COMAR number, followed by the citation to the Maryland Register in which the change occurred. The Maryland Register serves as a temporary supplement to COMAR, and the two publications must always be used together. A Research Guide for Maryland Regulations is available. For further information, call 410-260-3876.

SUBSCRIPTION INFORMATION

For subscription forms for the Maryland Register and COMAR, see the back pages of the Maryland Register. Single issues of the Maryland Register are $15.00 per issue.

CITIZEN PARTICIPATION IN THE REGULATION-MAKING PROCESS

Maryland citizens and other interested persons may participate in the process by which administrative regulations are adopted, amended, or repealed, and may also initiate the process by which the validity and applicability of regulations is determined. Listed below are some of the ways in which citizens may participate (references are to State Government Article (SG),
Annotated Code of Maryland):

- By submitting data or views on proposed regulations either orally or in writing, to the proposing agency (see "Opportunity for Public Comment" at the beginning of all regulations appearing in the Proposed Action on Regulations section of the Maryland Register). (See SG, §10-112)
- By petitioning an agency to adopt, amend, or repeal regulations. The agency must respond to the petition. (See SG §10-123)
- By petitioning an agency to issue a declaratory ruling with respect to how any regulation, order, or statute enforced by the agency applies. (SG, Title 10, Subtitle 3)
- By petitioning the circuit court for a declaratory judgment

on the validity of a regulation when it appears that the regulation interferes with or impairs the legal rights or privileges of the petitioner. (SG, §10-125)

- By inspecting a certified copy of any document filed with the Division of State Documents for publication in the Maryland Register. (See SG, §7-213)

Maryland Register (ISSN 0360-2834). Postmaster: Send address changes and other mail to: Maryland Register, State House, Annapolis, Maryland 21401. Tel. 410-260-3876. Published biweekly, with cumulative indexes published quarterly, by the State of Maryland, Division of State Documents, State House, Annapolis, Maryland 21401. The subscription rate for the Maryland Register is $225 per year (first class mail). All subscriptions post-paid to points in the U.S. periodicals postage paid at Annapolis, Maryland, and additional mailing offices.

Wes Moore, Governor; **Susan C. Lee**, Secretary of State; **Gail S. Klakring**, Administrator; **Tracey A. Johnstone,** Editor, Maryland Register; **Tarshia N. Neal**, Subscription Manager; **Tami Cathell**, Help Desk, COMAR and Maryland Register Online.

Front cover: State House, Annapolis, MD, built 1772—79.
Illustrations by Carolyn Anderson, Dept. of General Services

Closing Dates for the Maryland Register

COMAR Research Aids

Index of COMAR Titles Affected in This Issue

PERSONS WITH DISABILITIES

Individuals with disabilities who desire assistance in using the publications and services of the Division of State Documents are encouraged to call (410) 974-2486, or (800) 633-9657, or FAX to (410) 974-2546, or through Maryland Relay.

The Governor

The General Assembly

Emergency Action on Regulations

Final Action on Regulations

Withdrawal of Regulations

Proposed Action on Regulations

Special Documents

General Notices

COMAR Online

The Code of Maryland Regulations is available at www.dsd.state.md.us as a free service of the Office of the Secretary of State, Division of State Documents. The full text of regulations is available and searchable. Note, however, that the printed COMAR continues to be the only official and enforceable version of COMAR.

The Maryland Register is also available at www.dsd.state.md.us.

For additional information, visit www.dsd.maryland.gov, Division of State Documents, or call us at (410) 974-2486 or 1 (800) 633-9657.

Availability of Monthly List of Maryland Documents

The Maryland Department of Legislative Services receives copies of all publications issued by State officers and agencies. The Department prepares and distributes, for a fee, a list of these publications under the title "Maryland Documents". This list

is published monthly, and contains bibliographic information concerning regular and special reports, bulletins, serials, periodicals, catalogues, and a variety of other State publications. ‘‘Maryland Documents’’ also includes local publications.

Anyone wishing to receive ‘‘Maryland Documents’’ should write to: Legislative Sales, Maryland Department of Legislative Services, 90 State Circle, Annapolis, MD 21401.

CLOSING DATES AND ISSUE DATES THROUGH December 2025†

Issue Date	Emergency and Proposed Regulations 5 p.m.*	Notices, etc. 10:30 a.m.	Final Regulations 10:30 a.m.
June 13	May 23**	June 2	June 4
June 27	June 9	June 16	June 18
July 11	June 23	June 30	July 2
July 25	July 7	July 14	July 16
August 8	July 21	July 28	July 30
August 22	August 4	August 11	August 13
September 5	August 18	August 25	August 27
September 19	August 29**	September 8	September 10
October 3	September 15	September 22	September 24
October 17	September 29	October 6	October 8
October 31	October 10**	October 20	October 22
November 14	October 27	November 3	November 5
December 1***	November 10	November 17	November 19
December 12	November 24	December 1	December 3
December 26	December 8	December 15	December 17

† Please note that this table is provided for planning purposes and that the Division of State Documents (DSD) cannot guarantee submissions will be published in an agency’s desired issue. Although DSD strives to publish according to the schedule above, there may be times when workload pressures prevent adherence to it.

* Also note that proposal deadlines are for submissions to DSD for publication in the Maryland Register and do not take into account the 15-day AELR review period. The due date for documents containing 8 to 18 pages is 48 hours before the date listed; the due date for documents exceeding 18 pages is 1 week before the date listed.

NOTE: ALL DOCUMENTS MUST BE SUBMITTED IN TIMES NEW ROMAN, 9-POINT, SINGLE-SPACED FORMAT. THE PAGE COUNT REFLECTS THIS FORMATTING.

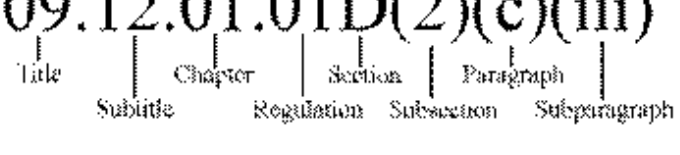
** Note closing date changes due to holidays.

*** Note issue date changes due to holidays.

The regular closing date for Proposals and Emergencies is Monday.

REGULATIONS CODIFICATION SYSTEM

Under the COMAR codification system, every regulation is assigned a unique four-part codification number by which it may be identified. All regulations found in COMAR are arranged by title. Each title is divided into numbered subtitles, each subtitle is divided into numbered chapters, and each chapter into numbered regulations.



A regulation may be divided into lettered sections, a section divided into numbered subsections, a subsection divided into lettered paragraphs, and a paragraph divided into numbered subparagraphs.

Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed

This table, previously printed in the Maryland Register lists the regulations, by COMAR title, that have been adopted, amended, or repealed in the Maryland Register since the regulations were originally published or last supplemented in the Code of Maryland Regulations (COMAR). The table is no longer printed here but may be found on the Division of State Documents website at www.dsd.state.md.us.

Table of Pending Proposals

The table below lists proposed changes to COMAR regulations. The proposed changes are listed by their COMAR number, followed by a citation to that issue of the Maryland Register in which the proposal appeared. Errata and corrections pertaining to proposed regulations are listed, followed by “(err)” or “(corr),” respectively. Regulations referencing a document incorporated by reference are followed by “(ibr)”.

None of the proposals listed in this table have been adopted. A list of adopted proposals appears in the Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed.

[25-11-07]

General Notices

Notice of ADA Compliance

The State of Maryland is committed to ensuring that individuals with disabilities are able to fully participate in public meetings. Anyone planning to attend a meeting announced below who wishes to receive auxiliary aids, services, or accommodations is invited to contact the agency representative at least 48 hours in advance, at the telephone number listed in the notice or through Maryland Relay.

STATE COLLECTION AGENCY LICENSING BOARD

Subject: Public Meeting
Date and Time: June 17, 2025, 2— 3 p.m. Thereafter, the public meetings will take place the second Tuesday of every month, accessed via the Google Meet information below.
Place: Google Meet joining info:
Video call link: https://meet.google.com/ahz-mgnk-jsu
Or dial: ‪(US) +1 530-738-1353‬ PIN: ‪815 799 863‬#
More phone numbers: https://tel.meet/ahz-mgnk-jsu?pin=1097700804795
Add'l. Info: If necessary, the Board will convene in a closed session to seek the advice of counsel or review confidential materials, pursuant to General Provisions Article, Maryland Annotated Code §3-305.
Contact: Ayanna Daugherty 410-230-6019

[25-11-13]

COMMISSIONER OF FINANCIAL REGULATION

Subject: Bank Merger
Add'l. Info: On May 9, 2025, The Peoples Bank, a Maryland state-chartered bank located in Chestertown, Maryland, filed an application with the Office of Financial Regulation (the "Office"), pursuant to Financial Institutions Article, §3-703 and §5-504, Annotated Code of Maryland, for approval of the sale of substantially all of the assets of The Peoples Bank to, and assumption of substantially all of the liabilities of The Peoples Bank by Hanscom Federal Credit Union, a federally chartered credit union in Littleton, Massachusetts. The application is on file at the Office of Financial Regulation, 100 S. Charles Street, Suite 5300, Baltimore, MD 21201.

Comments regarding this application must be submitted in writing and must be received by the Office within 20 calendar days of the date of publication of this notice in the Maryland Register. For further information, contact Stephen J. Clampett, Assistant Commissioner at 410-230-6104.
Contact: Stephen J. Clampett 410-230-6014

[25-11-11]

FIRE PREVENTION COMMISSION

Subject: Public Meeting
Date and Time: June 4, 2025, 10 a.m.—
Place: Eastport Fire Station, 914 Bay Ridge Avenue, Annapolis, MD
Add'l. Info: Special Meeting to reconsider adoption of the 2024 State Fire Prevention Code COMAR 29.06.01
Contact: Heidi Ritchie 877-890-0199

[25-11-12]

MARYLAND HEALTH BENEFIT EXCHANGE

Subject: Public Meeting
Date and Time: July 23, 2025, 1— 2 p.m.
Place: Virtual. Register in advance for this meeting:
https://maryland-gov.zoomgov.com/meeting/register/1sW9oeKsRI2jzsc-LoTajw, MD
Add'l. Info: MHBE will host its Seventh Annual Reinsurance Forum pursuant to 31 CFR §33.120(c) and 45 CFR §155.1320(c) to give the public an opportunity to give comment on the progress of the 1332 State Innovation Waiver.
Register in advance for this meeting:
https://maryland-gov.zoomgov.com/meeting/register/1sW9oeKsRI2jzsc-LoTajw
After registering, you will receive a confirmation email containing information about joining the meeting.
Contact: Becca Lane 410-547-7371

[25-11-14]

MARYLAND DEPARTMENT OF HEALTH

Subject: Public Hearing

Date and Time: July 9, 2025, 1PM — 2PM Thursday, July 24, 2025, 1–3 PM
Maryland Department of Health
201 West Preston Street, Level L – Room L1, Baltimore, MD 21201
Place: Michael E. Busch Annapolis Library, 1410 West Street, Annapolis, MD
Add'l. Info: GENERAL NOTICE – §1115 DEMONSTRATION EXTENSION
The Maryland Department of Health (the Department) is proposing to extend its §1115 demonstration, known as the HealthChoice demonstration. The Centers for Medicare and Medicaid Services (CMS) has authorized the Department's existing §1115 demonstration through December 31, 2026.

The HealthChoice demonstration authorizes Maryland's managed care program, known as HealthChoice, as well as other innovative programs. The Department intends to seek authorization to continue the pilots and programs permitted under the current §1115 demonstration, as well to seek a technical amendment to the Increased Community Services (ICS) program eligibility requirements, which will expedite potential enrollment in ICS.

The State's 30-day public comment period will open on June 30, 2025. Electronic copies of the draft demonstration extension application will be available on that date and may be downloaded from https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx. Hard copies of the application may be obtained by calling (410) 767-1439. The public comment period will run through July 30, 2025.

Interested parties may send written comments concerning the demonstration extension to Alyssa Brown, Office of Innovation, Research and Development, Office of Health Care Financing, Maryland Department of Health, 201 West Preston Street, Room 223, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov. The Department will accept comments from June 30, 2025 until July 30, 2025.

The following public hearings will discuss the content of the demonstration extension and solicit feedback and input from public stakeholders. Both hearings will be held on a hybrid basis; information for both in-person and remote participation is below. Please note, public hearing #2 will take place during the Department's monthly Maryland Medicaid Advisory Committee (MMAC) meeting.

Public Hearing #1, Thursday, July 9, 2025, 1–2 p.m.
Michael E. Busch Annapolis Library,1410 West Street, Annapolis, MD 21401

To participate in the public hearing remotely, please visit: https://register.gotowebinar.com/register/551564956546745696

Please note that if you wish to make a public comment, you will need to register via the link above. After registering, you will receive a confirmation email containing audio and visual information about joining the webinar.

Call-in number: 562-247-8321
Access code: 597-057-147
The call-in number and access code presented above is for attendees who wish to join in listen-only mode:
Public Hearing #2
Thursday, July 24, 2025, 1–3 p.m.
Maryland Department of Health
201 West Preston Street, Level L – Room L1, Baltimore, MD 21201

To participate in the public hearing remotely, please visit: https://attendee.gotowebinar.com/register/1992114303299564896
Please note that if you wish to make a public comment, you will need to register via the link above. After registering, you will receive a confirmation email containing audio and visual information about joining the webinar.

Call-in number: (415) 655-0052
Access code: 706-439-047

The call-in number and access code presented above is for attendees who wish to join in listen-only mode.
Contact: Alyssa Brown 410-767-9795

[25-11-17]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: June 12, 2025, 1—4 p.m.
Place: 4160 Patterson Avenue, Room 100, Baltimore, MD
Add'l. Info: Meeting will be hybrid. To attend via Zoom, please register on the Commission webpage www.mhcc.maryland.gov
Contact: Valerie Wooding 410-764-3570

[25-11-01]

MARYLAND INSURANCE ADMINISTRATION

Subject: Public Hearing
Date and Time: June 10, 2025, 1— 4 p.m.
Place: The Zoom and dial-in information is below:
Zoom Gov link: https://maryland-insurance.zoomgov.com/j/1617657827
Dial-In: 646-828-7666
Webinar ID: 161 765 7827, MD
Add'l. Info: The Maryland Insurance Administration will conduct a public hearing on specific rate increase requests being made by certain Long-Term Care Insurance carriers operating in Maryland. The hearing will focus on several rate increase requests before the Maryland Insurance Administration. In the individual long-term care market, this include requests from Mutual of Omaha Insurance Company, The Prudential Insurance Company of America and Transamerica Life Insurance Company. In the group long-term care market, this includes requests from Metropolitan Life Insurance Company and The Prudential Insurance Company of America. The purpose of the hearing is for insurance company officials to explain the reasons for the rate increases, and for the MIA to consider whether the proposed rate increase is in

compliance with Maryland's laws and regulations relating to long-term care insurance. Interested stakeholders will also have the opportunity to provide comments at the hearing. Prior to the hearing, copies of each company's actuarial memorandum will be posted to the Maryland Insurance Administration's website.

The hearing will be held via Zoom.

Information about the Maryland Relay Service can be found at doit.maryland.gov/mdrelay

If you wish to provide oral testimony, please RSVP to Nancy Muehlberger. Testimony will only be heard from those who have RSVP'd in advance of the public hearing. Written comments and RSVPs should be sent to Nancy Muehlberger by June 6, 2025, either by email to longtermcare.mia@maryland.gov or by mail to 200 St. Paul Place, Suite 2700, Baltimore, Md. 21202 or by fax to 410-468-2038.

Any questions regarding this matter should be directed to Nancy Muehlberger, Analyst, by June 6, 2025 by email to Nancy.Muehlberger@maryland.gov.

For more information on the hearing, please see the following link:
https://insurance.maryland.gov/Consumer/Pages/Long-Term-Care-Hearing-June-10-2025.aspx
Contact: Nancy Muehlberger 410-468-2050

[25-11-08]

STATE BOARD OF INDIVIDUAL TAX PREPARERS

Subject Public Meeting
Date and Time: June 9, 2025, 10 a.m.— 12 p.m.
Place: Via Google Meets
https://meet.google.com/yai-nvov-tdm?hs=122&authuser=0,
Contact: Christopher Dorsey 410-230-6318

[25-11-02]

STATE BOARD OF INDIVIDUAL TAX PREPARERS

Subject: : Public Hearing
Date and Time: June 9, 2025, 11a.m.— 12 p.m.
Place: Via Google Meets
meet.google.com/duk-vsdy-zno,
Contact: Christopher Dorsey 410-230-6318

[25-11-03]

Maryland Register

Issue Date: June 27, 2025
Volume 52 • Issue 13 • Pages 643 — 702

IN THIS ISSUE

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before June 9, 2025 5 p.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of June 9, 2025.

Gail S. Klakring
Administrator, Division of State Documents
Office of the Secretary of State

Information About the Maryland Register and COMAR

MARYLAND REGISTER

The Maryland Register is an official State publication published every other week throughout the year. A cumulative index is published quarterly.

The Maryland Register is the temporary supplement to the Code of Maryland Regulations. Any change to the text of regulations published in COMAR, whether by adoption, amendment, repeal, or emergency action, must first be published in the Register.

The following information is also published regularly in the Register:

- Governor's Executive Orders
- Attorney General's Opinions in full text
- Open Meetings Compliance Board Opinions in full text
- State Ethics Commission Opinions in full text
- Court Rules
- District Court Administrative Memoranda
- Courts of Appeal Hearing Calendars
- Agency Hearing and Meeting Notices
- Synopses of Bills Introduced and Enacted by the General Assembly
- Other documents considered to be in the public interest

CITATION TO THE MARYLAND REGISTER

The Maryland Register is cited by volume, issue, page number, and date. Example:

• 19:8 Md. R. 815—817 (April 17, 1992) refers to Volume 19, Issue 8, pages 815—817 of the Maryland Register issued on April 17, 1992.

CODE OF MARYLAND REGULATIONS (COMAR)

COMAR is the official compilation of all regulations issued by agencies of the State of Maryland. The Maryland Register is COMAR's temporary supplement, printing all changes to regulations as soon as they occur. At least once annually, the changes to regulations printed in the Maryland Register are incorporated into COMAR by means of permanent supplements.

CITATION TO COMAR REGULATIONS

COMAR regulations are cited by title number, subtitle number, chapter number, and regulation number. Example: COMAR 10.08.01.03 refers to Title 10, Subtitle 08, Chapter 01, Regulation 03.

DOCUMENTS INCORPORATED BY REFERENCE

Incorporation by reference is a legal device by which a document is made part of COMAR simply by referring to it. While the text of an incorporated document does not appear in COMAR, the provisions of the incorporated document are as fully enforceable as any other COMAR regulation. Each regulation that proposes to incorporate a document is identified in the Maryland Register by an Editor's Note. The Cumulative Table of COMAR Regulations Adopted, Amended or Repealed, found online, also identifies each regulation incorporating a document. Documents incorporated by reference are available for inspection in various depository libraries located throughout the State and at the Division of State Documents. These depositories are listed in the first issue of the Maryland Register published each year. For further information, call 410-974-2486.

HOW TO RESEARCH REGULATIONS

An Administrative History at the end of every COMAR chapter gives information about past changes to regulations. To determine if there have been any subsequent changes, check the "Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed" which is found online at http://www.dsd.state.md.us/PDF/CumulativeTable.pdf. This table lists the regulations in numerical order, by their COMAR number, followed by the citation to the Maryland Register in which the change occurred. The Maryland Register serves as a temporary supplement to COMAR, and the two publications must always be used together. A Research Guide for Maryland Regulations is available. For further information, call 410-260-3876.

SUBSCRIPTION INFORMATION

For subscription forms for the Maryland Register and COMAR, see the back pages of the Maryland Register. Single issues of the Maryland Register are $15.00 per issue.

CITIZEN PARTICIPATION IN THE REGULATION-MAKING PROCESS

Maryland citizens and other interested persons may participate in the process by which administrative regulations are adopted, amended, or repealed, and may also initiate the process by which the validity and applicability of regulations is determined. Listed below are some of the ways in which citizens may participate (references are to State Government Article (SG), Annotated Code of Maryland):

- By submitting data or views on proposed regulations either orally or in writing, to the proposing agency (see "Opportunity for Public Comment" at the beginning of all regulations appearing in the Proposed Action on Regulations section of the Maryland Register). (See SG, §10-112)
- By petitioning an agency to adopt, amend, or repeal regulations. The agency must respond to the petition. (See SG §10-123)
- By petitioning an agency to issue a declaratory ruling with respect to how any regulation, order, or statute enforced by the agency applies. (SG, Title 10, Subtitle 3)
- By petitioning the circuit court for a declaratory judgment on the validity of a regulation when it appears that the regulation interferes with or impairs the legal rights or privileges of the petitioner. (SG, §10-125)
- By inspecting a certified copy of any document filed with the Division of State Documents for publication in the Maryland Register. (See SG, §7-213)

Maryland Register (ISSN 0360-2834). Postmaster: Send address changes and other mail to: Maryland Register, State House, Annapolis, Maryland 21401. Tel. 410-260-3876. Published biweekly, with cumulative indexes published quarterly, by the State of Maryland, Division of State Documents, State House, Annapolis, Maryland 21401. The subscription rate for the Maryland Register is $225 per year (first class mail). All subscriptions post-paid to points in the U.S. periodicals postage paid at Annapolis, Maryland, and additional mailing offices.

Wes Moore, Governor; **Susan C. Lee**, Secretary of State; **Gail S. Klakring**, Administrator; **Tracey A. Johnstone,** Editor, Maryland Register; **Tarshia N. Neal**, Subscription Manager; **Tami Cathell**, Help Desk, COMAR and Maryland Register Online.
Front cover: State House, Annapolis, MD, built 1772—79.
Illustrations by Carolyn Anderson, Dept. of General Services

Closing Dates for the Maryland Register

COMAR Research Aids

Index of COMAR Titles Affected in This Issue

PERSONS WITH DISABILITIES

Individuals with disabilities who desire assistance in using the publications and services of the Division of State Documents are encouraged to call (410) 974-2486, or (800) 633-9657, or FAX to (410) 974-2546, or through Maryland Relay.

The Governor

Regulatory Review and Evaluation

Final Action on Regulations

Withdrawal of Regulations

Proposed Action on Regulations

Special Documents

General Notices

COMAR Online

The Code of Maryland Regulations is available at www.dsd.state.md.us as a free service of the Office of the Secretary of State, Division of State Documents. The full text of regulations is available and searchable. Note, however, that the printed COMAR continues to be the only official and enforceable version of COMAR.

The Maryland Register is also available at www.dsd.state.md.us.
For additional information, visit www.dsd.maryland.gov, Division of State Documents, or call us at (410) 974-2486 or 1 (800) 633-9657.

Availability of Monthly List of Maryland Documents

The Maryland Department of Legislative Services receives copies of all publications issued by State officers and agencies. The Department prepares and distributes, for a fee, a list of these publications under the title "Maryland Documents". This list is published monthly, and contains bibliographic information concerning regular and special reports, bulletins, serials, periodicals, catalogues, and a variety of other State publications. "Maryland Documents" also includes local publications.

Anyone wishing to receive "Maryland Documents" should write to: Legislative Sales, Maryland Department of Legislative Services, 90 State Circle, Annapolis, MD 21401.

CLOSING DATES AND ISSUE DATES THROUGH December 2025†

Issue Date	Emergency and Proposed Regulations 5 p.m.*	Notices, etc. 10:30 a.m.	Final Regulations 10:30 a.m.
July 11	June 23	June 30	July 2
July 25	July 7	July 14	July 16
August 8	July 21	July 28	July 30
August 22	August 4	August 11	August 13
September 5	August 18	August 25	August 27
September 19	August 29**	September 8	September 10
October 3	September 15	September 22	September 24
October 17	September 29	October 6	October 8
October 31	October 10**	October 20	October 22
November 14	October 27	November 3	November 5
December 1***	November 10	November 17	November 19
December 12	November 24	December 1	December 3
December 26	December 8	December 15	December 17

† Please note that this table is provided for planning purposes and that the Division of State Documents (DSD) cannot guarantee submissions will be published in an agency's desired issue. Although DSD strives to publish according to the schedule above, there may be times when workload pressures prevent adherence to it.

* Also note that proposal deadlines are for submissions to DSD for publication in the Maryland Register and do not take into account the 15-day AELR review period. The due date for documents containing 8 to 18 pages is 48 hours before the date listed; the due date for documents exceeding 18 pages is 1 week before the date listed.

NOTE: ALL DOCUMENTS MUST BE SUBMITTED IN TIMES NEW ROMAN, 9-POINT, SINGLE-SPACED FORMAT. THE PAGE COUNT REFLECTS THIS FORMATTING.

** Note closing date changes due to holidays.

*** Note issue date changes due to holidays.

The regular closing date for Proposals and Emergencies is Monday.

REGULATIONS CODIFICATION SYSTEM

Under the COMAR codification system, every regulation is assigned a unique four-part codification number by which it may be identified. All regulations found in COMAR are arranged by title. Each title is divided into numbered subtitles, each subtitle is divided into numbered chapters, and each chapter into numbered regulations.

09.12.01.01D(2)(c)(iii)

Title | Subtitle | Chapter | Regulation | Section | Subsection | Paragraph | Subparagraph

A regulation may be divided into lettered sections, a section divided into numbered subsections, a subsection divided into lettered paragraphs, and a paragraph divided into numbered subparagraphs.

Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed

This table, previously printed in the Maryland Register lists the regulations, by COMAR title, that have been adopted, amended, or repealed in the Maryland Register since the regulations were originally published or last supplemented in the Code of Maryland Regulations (COMAR). The table is no longer printed here but may be found on the Division of State Documents website at www.dsd.state.md.us.

Table of Pending Proposals

The table below lists proposed changes to COMAR regulations. The proposed changes are listed by their COMAR number, followed by a citation to that issue of the Maryland Register in which the proposal appeared. Errata and corrections pertaining to proposed regulations are listed, followed by "(err)" or "(corr)," respectively. Regulations referencing a document incorporated by reference are followed by "(ibr)". None of the proposals listed in this table have been adopted. A list of adopted proposals appears in the Cumulative Table of COMAR Regulations Adopted, Amended, or Repealed.

02 OFFICE OF THE ATTORNEY GENERAL

02.06.04 .01—.06 • 52:6 Md. R. 270 (3-21-25)

05 DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

05.24.01.01—.04 • 52:13 Md. R. 660 (6-27-25)

07 DEPARTMENT OF HUMAN SERVICES

07.02.25.01—.24 • 51:19 Md. R. 861 (9-20-24)

08 DEPARTMENT OF NATURAL RESOURCES

08.02.22.02 • 51:10 Md. R. 534 (5-17-24)
08.03.08.01,.04—.09 • 52:11 Md. R. 536 (5-30-2025)
08.08.05.03 • 52:7 Md. R. 326 (4-4-2025)
08.18.19.05 • 52:11 Md. R. 539 (5-30-2025)
08.18.26.07 • 52:11 Md. R. 540 (5-30-2025)

09 MARYLAND DEPARTMENT OF LABOR

09.03.06.02,.04 • 52:1 Md. R. 27 (1-10-25)
09.03.06.02,.04 • 52:2 Md. R. 79 (1-24-25) (corr)
09.03.06.02,.06,.16 • 51:14 Md. R. 685 (7-12-24)
09.03.09.06 • 52:7 Md. R. 328 (4-4-2025)
09.09.02.02 • 52:7 Md. R. 328 (4-4-2025)

Make	Model	Caliber	Additional Comments
MOSSBERG	990 AfterShock	12 Gauge	Model addition
CARACAL INTERNATIONAL (CARACAL USA)	CMP9 Pistol	9 mm	Model addition
CARACAL INTERNATIONAL (CARACAL USA)	CMP9K Pistol	9 mm	Model addition
SIG SAUER/SIGARMS INC.	M17	9 mm	Model addition
SIG SAUER/SIGARMS INC.	M18	9 mm	Model addition
B. King's Firearms	BKF-15 Pistol	300 BLK, 5.56 NATO, 223 Rem, 7.62X39mm, 350 LEGEND, 458 SOCOM, 6.5 Grendel, 22 LR, 9 mm, 10 mm, 6.8 SPC, 224 Valkyrie, 6mm ARC, 5.7x28mm	
MASTERPIECE ARMS	DS9/38 Open	9 mm/38 Super Comp	Model addition
AB Prototype, LLC	1911DW	9 mm, 10 mm	Model addition
SIG SAUER/SIGARMS INC.	M400-SDI X PISTOL	5.56 NATO	Model addition
SIG SAUER/SIGARMS INC.	P320 Carry Pro	40 S&W	Model addition
Cheely Custom Gunworks	Infinity 2011	9 mm	Model addition
ITHACA	Stakeout Model 87	12 Gauge	
SMITH & WESSON	PERFORMANCE CENTER MODEL 686 PLUS	357 Mag, 38 S&W SPL +P	Model addition
SMITH & WESSON	686 PLUS	357 Mag, 38 S&W SPL +P	Model addition
NIGHTHAWK CUSTOM	Double Agent	9 mm	Model addition
ACCURACY X, INC.	X SERIES DEFENDER	38 Super, 40 S&W, 9 mm	Caliber addition
Warrior Armament MFG.	WA 15 Pistol	300 BLK, 5.56 NATO, 223 Rem, 338 Spectre, 6.5 Grendel, 6mm ARC, 7.62X39mm	Model addition
Warrior Armament MFG.	WABK 15 Pistol	300 BLK	Model addition
RPG AERO	RPG PISTOL	7.62X39mm	Caliber addition
CBC [ROSSI] (BRAZTECH INTERNATIONAL, LC)	BRAWLER	5.56 NATO	Caliber addition
CBC [ROSSI] (BRAZTECH INTERNATIONAL, LC)	BRAWLER	300 BLK	Caliber addition
TAURUS ARMAS (TAURUS INTERNATIONAL MFG.)	DEPUTY	357 MAG/9 mm	Caliber addition
TAURUS ARMAS (TAURUS INTERNATIONAL MFG.)	817	38 Spl	Model addition
TAURUS ARMAS (TAURUS INTERNATIONAL MFG.)	66C	357 Mag	Model addition
TAURUS ARMAS [ROSSI] (BRAZTECH INTERNATIONAL, LC)	RP62	357 Mag	Model addition
TAURUS ARMAS [ROSSI] (BRAZTECH INTERNATIONAL, LC)	RP82	38 Spl	Model addition
KRISS, USA, INC	Vector SDP Gen 3	10 mm, 45 ACP, 9 mm	Model addition
ALDO UBERTI & CO. (TAYLOR & CO.)	1873 CATTLEMAN	45 LC	Caliber addition
Hugtek Arms Company (GFORCE ARMS)	LVR357	357 Mag	Model addition
CZ USA	CZ Scorpion Evo 3 S2	9 mm	Model addition
CANIK (CENTURY ARMS)	SIGNATURE SERIES METE SF	9 mm	Model addition
CANIK (CENTURY ARMS)	SIGNATURE SERIES METE SFT	9 mm	Model addition
CANIK (CENTURY ARMS)	SIGNATURE SERIES METE SFX	9 mm	Model addition
Miller Precision Firearms	Ranger 9C	9 mm	
CNC Gunworks	Akira	9 mm	
COMBAT PRECISION	M5	9 mm	
D&L Sports	Professional	45 ACP	
ELITE WARRIOR ARMAMENT	1911	45 ACP	
Miller Precision Firearms	Ranger 9SC	9 mm	Model addition
Miller Precision Firearms	Ranger 9XC	9 mm	Model addition

[25-13-06]

General Notices

Notice of ADA Compliance

The State of Maryland is committed to ensuring that individuals with disabilities are able to fully participate in public meetings. Anyone planning to attend a meeting announced below who wishes to receive auxiliary aids, services, or accommodations is invited to contact the agency representative at least 48 hours in advance, at the telephone number listed in the notice or through Maryland Relay.

MARYLAND BOARD OF AIRPORT ZONING APPEALS

Notice of Hearing

Date and Time: The Maryland Board of Airport Zoning Appeals (BAZA) Case 436 hearing teleconference will be held via Microsoft Teams on July 14, 2025. The hearing will begin at 10:30AM. The public call-in number is +1 667-262-2962; Conference ID: 134 790 218#

The Board will hear the following case(s):

Docket Number **436**

BAZA #436 (Single Family Dwelling at 529 Queenstown Road, Severn, MD 21144)

Charles and Donna Dailey are proposing to construct a single-family dwelling at 529 Queenstown Road, Severn. This location is approximately 1.1 miles southeast of the arrival end of Runway 33L at Baltimore Washington Thurgood Marshall International Airport (BWI Marshall). The proposed structure is to be located within the 65 Ldn Noise Zone for the BWI Marshall Airport. The proposed land use at this location is found to be incompatible with the certified Airport Noise Zone. The Maryland Airport Noise Control Program Regulations (COMAR 11.03.03) enables the proponent to seek a variance from the Board of Airport Zoning Appeals to this regulation. The petition for the case has been received from the appellant. Therefore, the Maryland Aviation Administration anticipates requesting to present this case to the Board of Airport Zoning Appeals on July 14, 2025, at 10:30AM.

Add'l. Info: For additional information, please contact Sharese Ricks at 410-865-1233.

Publication/Dates:
The Maryland Register
June 27, 2025

Appropriate auxiliary aids and services for qualified individuals with disabilities will be provided upon request.
Contact: Please call 410-865-1233 (voice) or MD Relay (TTY Users).

STATE COLLECTION AGENCY LICENSING BOARD (SCALB)

Subject: Public Meeting
Date and Time: Tuesday, July 8th, 2025, 2—3 p.m.

Thereafter the public meetings will take place the second Tuesday of every month, accessed via the Google Meet information given below.

If necessary, the Board will convene in a closed session to seek the advice of counsel or review confidential materials, pursuant to General Provisions Article, Maryland Annotated Code §3-305.

Place: State Collection Agency Licensing Board (SCALB) Monthly Meeting
Tuesday, July 8th, 2025, 2—3 p.m.

Google Meet joining info:
Video call link: https://meet.google.com/ahz-mgnk-jsu
Or dial: (US) +1 530-738-1353 PIN: 815 799 863#
More phone numbers: https://tel.meet/ahz-mgnk-jsu?pin=1097700804795,

Contact: Ayanna Daugherty 410-230-6019

MARYLAND DEPARTMENT OF HEALTH

Subject: Public Hearings
Dates and Times: July 9, 2025, 1—2 p.m.; July 24, 2025; 1—3 p.m.

Date and Time: July 9, 2025, 1—2 p.m.
Place: Michael E. Busch Annapolis Library
1410 West Street
Annapolis, MD, Annapolis, MD

Date and Time: Thursday, July 24, 2025; 1—3 p.m.
Place: Maryland Department of Health
201 West Preston Street, Level L-Room L1
Baltimore, MD

Add'l. Info: GENERAL NOTICE – §1115 DEMONSTRATION EXTENSION
The Maryland Department of Health (the Department) is proposing to extend its §1115 demonstration, known as the HealthChoice demonstration. The Centers for Medicare and Medicaid Services (CMS) has authorized the Department's existing §1115 demonstration through December 31, 2026.

The HealthChoice demonstration authorizes Maryland's managed care program, known as HealthChoice, as well as other innovative programs. The Department intends to seek authorization to continue the pilots and programs permitted under the current §1115 demonstration, as well to seek a technical amendment to the Increased Community Services (ICS) program eligibility requirements, which will expedite potential enrollment in ICS.

The State's 30-day public comment period will open on June 30, 2025. Electronic copies of the draft demonstration extension application will be available on that date and may be downloaded from https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx. Hard copies of the application may be obtained by calling (410) 767-1439. The public comment period will run through July 30, 2025.

Interested parties may send written comments concerning the demonstration extension to Alyssa Brown, Office of Innovation, Research and Development, Office of Health Care Financing, Maryland Department of Health, 201 West Preston Street, Room 223, Baltimore, MD 21201 or via email to mdh.healthchoicerenewal@maryland.gov. The Department will accept comments from June 30, 2025 until July 30, 2025.

The following public hearings will discuss the content of the demonstration extension and solicit feedback and input from public stakeholders. Both hearings will be held on a hybrid basis; information for both in-person and remote participation is below. Please note, public hearing #2 will take place during the Department's monthly Maryland Medicaid Advisory Committee (MMAC) meeting.

Public Hearing #1
Wednesday, July 9, 2025; 1–2 p.m.
Michael E. Busch Annapolis Library
1410 West Street
Annapolis, MD 21401

To participate in the public hearing remotely, please visit: https://register.gotowebinar.com/register/551564956546745696
Please note that if you wish to make a public comment, you will need to register via the link above. After registering, you will receive a confirmation email containing audio and visual information about joining the webinar.

Call-in number: (562) 247-8321
Access code: 597-057-147
The call-in number and access code presented above is for attendees who wish to join in listen-only mode.

Public Hearing #2
Thursday, July 24, 2025; 1–3 p.m.
Maryland Department of Health
201 West Preston Street, Level L-Room L1
Baltimore, MD 21201

To participate in the public hearing remotely, please visit: https://attendee.gotowebinar.com/register/1992114303299564896
Please note that if you wish to make a public comment, you will need to register via the link above. After registering, you will receive a confirmation email containing audio and visual information about joining the webinar.

Call-in number: 415-655-0052

Access code: 706-439-047
The call-in number and access code presented above is for attendees who wish to join in listen-only mode.
Contact: Alyssa Brown 410-767-9795

[25-13-05]

BOARD OF DIETETIC PRACTICE

Subject: Public Meeting
Date and Time: July 17, 2025, 10 a.m.—12 p.m.
Place: Google Meet Teleconference.
Please see the Board's website for details:
health.maryland.gov/dietetic
Contact: Lenelle Cooper 410-764-4733

[25-13-03]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: July 17, 2025, 1— 4 p.m.
Place: 4160 Patterson Avenue, Room 100, Baltimore, MD
Add'l. Info: Meeting will be hybrid. To attend via Zoom, please register on the Commission webpage www.mhcc.maryland.gov
Contact: Valerie Wooding 410-764-3570

[25-13-01]

MARYLAND HEALTH CARE COMMISSION

Subject: Receipt of Application
Add'l. Info: Add'l Info: On June 5, 2025, the Maryland Health Care Commission (MHCC) received a Certificate of Need application submitted by:

Residences at Vantage Point—Matter No. 25-13-2472

RVP is a CCRC that is licensed for 44 nursing home beds that are restricted to use by its Continuing Care Retirement Community (CCRC) residents. RVP seeks approval to convert 13 of those nursing home beds to beds also available to the public by using the 13 beds currently projected by MHCC to be needed in Howard County.

The MHCC shall review the applications under Maryland Health-General Code Annotated, Section 19-101 et. seq. and COMAR 10.24.01.

Any affected person may make a written request to the Commission to receive copies of relevant notices concerning the application. All further notices of proceedings on the application will be sent only to affected persons who have registered as interested parties.

Please refer to the Matter No. listed above in any correspondence on the application. A copy of the application is available, for review, in the office of the MHCC, during regular business hours by appointment, or on the Commission's website at www.mhcc.maryland.gov. All correspondence should be addressed to:

Wynee Hawk, Director
Center for Health Care Facilities Planning & Development
MHCC
4160 Patterson Avenue
Baltimore, Maryland 21215
Contact: Deanna Dunn 410-767-3276

[25-13-07]

MARYLAND COLLEGE COLLABORATION FOR STUDENT VETERANS COMMISSION

Subject: Public Meeting
Date and Time: July 23, 2025, 10 a.m.—12 p.m.
Place: Loyola College4501 N. Charles Street, Baltimore, MD
Contact: Denise Nooe 410-260-3840

[25-13-02]

MARYLAND VETERANS COMMISSION

Subject: Public Meeting
Date and Time: July 15, 2025, 10:30 a.m.—1 p.m.
Place: 1420 Spring Street, Silver Spring, MD
Contact: Denise Nooe
Phone: 410-260-3840

[25-13-23]

Attachment VIII: Budget Neutrality Workbook

[Maryland will submit its most recent Budget Neutrality excel workbook with its Fall 2025 Section 1115 Demonstration Extension application]