Maryland Community Health System

Workgroup to Study Rise in Adverse Decisions in State Health Care System

Maryland Insurance Administration

July 9, 2026

Maryland Community Health System (MCHS) Background

MCHS is a Health Center Controlled Network (HCCN)

- Founded in 1996 through HRSA grant to support Federally Qualified Health Centers' (FQHC) adapting to Medicaid transition to 1115 waivers

MCHS is comprised of seven (7) FQHCs serving 273,884 patients at 45 locations throughout urban, suburban & rural Maryland

- Baltimore Medical System – Baltimore City/County
- Chase Brexton Health Care – Baltimore City & Baltimore, Talbot, Howard, & Anne Arundel Counties
- Choptank Community Health – Mid/Upper-Eastern Shore - Talbot, Caroline, Dorchester, Queen Anne's & Kent Counties
- CCI Health – Montgomery & Prince George's Counties
- Greater Baden Medical Services – Prince George's, Charles, Calvert, & St. Mary's Counties
- Bay Community Health – Southern Anne Arundel & Northern Calvert Counties
- Chesapeake Health Care – Lower Eastern Shore - Worcester, Wicomico & Somerset Counties

MCHS provides clinical quality transformation, data management & administrative support to enhance patient access & health outcomes

Federally Qualified Health Center (FQHC) Overview

FQHCs are Maryland's & the nation's primary care safety net providing comprehensive primary care services regardless of a person's ability to pay

- Adult & Pediatric medicine
- OB/GYN services
- Infectious Disease services
- Behavioral Health services
- Eye Services
- Pharmacy services
- Psychiatry
- Podiatry
- Oral Health services
- Care management/SDOH
- Nutrition
- Lab services

MCHS FQHCs employ 800+ clinicians

- Internal Medicine & Family Practice physicians
- Infectious Disease specialists
- Nurse Practitioners
- Podiatrists
- Physician Assistants
- Psychiatrists
- Nurses
- Behavioral Health specialists
- Pharmacists
- Dentists

Federally Qualified Health Center Overview

FQHCs are supported by multiple revenue sources

- HRSA grants – fixed dollars representing <10% of annual budgets
- Claims reimbursement
- Sliding scale fees from uninsured patients
- Program grants – special initiatives
- Private philanthropy

FQHCs contract with multiple carriers

- Commercials insurers
- Medicaid fee for service
- Medicaid managed care
- Medicare fee for service
- Medicare Advantage

Federally Qualified Health Center Payer Concerns

- FQHCs experience a higher-level administrative burden due to the comprehensive service mix, breadth of provider types & payer mix than typical primary care practices
  - Claims- Payer Issues
    - Not maintaining accurate information for practice locations, then denying claims
    - Billing rule variances by payer
    - Denied claims
      - i.e., claim denied as OON when provider in-network
    - Timely filing issues
      - Payer takes months to resolve claims issues, then rejects refiled adjusted claims for timely filing
    - Coordination of Benefits
      - Payers not providing documentation needed to process COB
    - Timely notification of policy changes
  - Prior Authorization
    - Requests for additional information/documentation
    - Partial approval
    - Initial denial, need to resubmit
    - Denied inappropriately for medical necessity (medical necessity for labs)

Commercial Insurance Carrier Example

Network enrollment & out-of-network claims — timeline of issues

Jan 2023

SITE ADDED

First of 3 new practice locations opened and submitted for network enrollment. First notified carrier in March and many times since.

Jan 2024

SITE ADDED

Second location opened and submitted to the carrier.

Dec 2024

SITE ADDED

Third location opened and submitted to the carrier.

Jun 2025

ESCALATION

Packages with designated prefixes processing out of network — shifting 50% of cost to the patient. Carrier first notified in July 2025 remains unresolved.

Jul 2025

ESCALATION

Carrier randomly shifts an established site to out-of-network status. Sent carrier a number of examples; unable to give explanation of why its occurring.

Ongoing: despite three location additions, sites have still not been correctly loaded into the carrier's network correctly - processing claims OON and passing balance to patient.

MEDICAID MANAGED CARE CARRIER

MCO Example

Timeliness of correcting issues

Sep-Nov 2022

- *Payor updated claim platform; began having significant claim issues.*
- *Notified carrier of first significant issue — secondary claims not paying or underpaying.*

Early 2023

Claims Issues Escalate Exponentially:

- *Underpaying claims*
- *Improper claim denials*
- *Improper takebacks by payment integrity team*
- *Delays in setting up sites*
- *Improper denials for credentialed providers as OON*
- *Non-payment of vaccines*

Sept/Oct 2023

Notified payor of additional claims issues surrounding payment for services at hospital for deliveries and surgeries at surgery center.

2024

Various claim issues continue and payor assigns resources to fix system and help reprocess claims. At its high point, tracking over 25k claims.

Dec 2025

Final claims cleanup performed by carrier.

- **Over 3 years to get all claims paid and system processing claims correctly.**
- **Enormous administrative burden to track, report, reprocess and post claims.**

MEDICAID MANAGED CARE CARRIER

MCO Example

Timeliness of correcting issues

June 2025

Notified carrier that claims were being paid at the Fee for Service rate versus the PPS rate as our providers had been set up incorrectly on the carrier's side.

July 2025

Notified the State Department of Health of our payment issue as we had not received replies from the carrier

Aug – Nov 2025

Continued communication with the Department of Health regarding attempts to contact carrier and address issues.

Dec 2025

Assigned Network Manager by carrier as direct contact to support issue resolution.

Jan - June 2026

Multiple meetings with carrier to review credentialling and provider contract assignment. Provider assignment corrected and retroactive correction payment pending.

- **Over 1 year and corrective payment is still pending.**
- **Enormous administrative burden to track, report, reprocess and post claims.**

Federally Qualified Health Center Payer Concerns

While not all claim & prior authorization denials meet the test of an “adverse decision” the administrative impact is no less burdensome

- Impacts financial stability
  - Cash flow
  - Claim non-payment write-offs
  - Reduced patient access
  - Lost revenue from lower provider productivity
  - Additional staff for referrals/prior authorizations & claims issues
- Increased administrative workload
  - Track volume of denials with multiple payers
  - Learn & manage various payer portals documentation rules
  - Research & prepare appeal documentation
  - Spend time on long telephone holds; effective use of staff time
  - Increased clinician time to prepare documentation
  - Creates staff burnout & increased turnover

Recommendations for Improvement

Streamlining claim & prior authorization policies/processes will benefit patients, provider & payers

- Clarify definitions
- Standardize prior authorization policies
  - Consider reducing unnecessary prior authorizations
- Standardize claim submission policies
- Review timely filing policies to ensure resolved/adjusted claims are not rejected
- Rapid response team for specific types of denials; 30 days not required to respond
- Provide direct access to payers for issue resolution
- Decrease response times for claims & prior authorization issues
- Improve payer staff
- Collaborate to improve coding accuracy
- Collaborate to reduce root causes of claims denials

- Streamline MIA process for provider complaints
  - Providers report process cumbersome
  - Burden on provider

- Questions?

Thank You

Contact Information

Salliann Alborn, CEO
Maryland Community Health System
5850 Waterloo Road, Suite 140
Columbia, Maryland 21045
salborn@mchsmd.com (Email)
410-480-7173 (Office)
443-386-1452 (mobile)