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Maryland Section 1115 Waiver Amendment Submission

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Contents

Amendment Introduction and Objectives 3

National Diabetes Prevention Program Pilot 3

- Introduction 3
- National DPP 4
- National DPP Eligible Population 4
- Evaluation Design 6
- Budget Neutrality 6

Expansion of Substance Use Disorder Residential Services 7

- Introduction 7
- Requested Changes, Objectives, and Policy Rationale 7
- Anticipated Outcomes 8
- Evaluation Design 9
- Budget Neutrality 9

Adult Dental Pilot Program 10

- Introduction 10
- Current Dental Coverage and Utilization 11
- Interest in Adult Dental Coverage in Maryland 11
- Requested Changes, Objectives, and Policy Rationale 12
- Anticipated Outcomes 12
- Evaluation Design 13
- Budget Neutrality 13

Family Planning Program 14

- Introduction 14
- Requested Changes 14

Appendices 14

- Public Process and Indian Consultation Requirements 14

Maryland Section 1115 Waiver Amendment Submission

Amendment Introduction and Objectives

The Maryland Department of Health (the Department) is pleased to submit this §1115 waiver amendment application for the HealthChoice program. HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in July 1997 under authority of a waiver through §1115 of the Social Security Act. The initial waiver was approved for five years. In January 2002, the Department completed the first comprehensive evaluation of HealthChoice as part of the first §1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during State Fiscal Year (SFY) 1997, the final year without managed care. The Centers for Medicare and Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, 2010, 2013, and 2016.

This amendment would authorize the Department to: 1) cover National Diabetes Prevention Program (National DPP) services through a limited pilot program; 2) pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutes of Mental Disease (IMD); and 3) cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age. The Department further seeks the removal of the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

National Diabetes Prevention Program Pilot

Introduction

The National DPP Pilot would enable HealthChoice managed care organizations (MCOs) to provide the National DPP, an evidence-based, Centers for Disease Control and Prevention (CDC)-established program, on a limited basis to eligible participants beginning in February 2019. Maryland seeks to leverage its extensive knowledge and experience in developing a delivery system for the National DPP within HealthChoice MCOs, gained through work on a two-year demonstration funded through the National Association of Chronic Disease Directors (NACDD) via a cooperative agreement with the CDC, as described below.

Before implementing on a larger scale, the Department is requesting to continue operating the National DPP as a pilot. This will allow the Department to evaluate the current demonstration and ensure the desired outcomes are achieved.

Background and Evidence

Recognizing the critical need to prevent diabetes in the Medicaid population and the growing importance of all-payer alignment and improving population health, Maryland successfully applied in 2016 for funding through NACDD to demonstrate ways of offering the National DPP to the Medicaid population through MCOs. The Department, in collaboration with the CDC, implemented a delivery model for the National DPP to 639 Medicaid participants with four of Maryland's nine HealthChoice MCOs (Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners). With the two-year

demonstration concluding June 30, 2018 and demonstration services ending on January 31, 2019, The Department seeks to continue to provide service coverage to HealthChoice participants through this §1115 waiver amendment. Final Departmental approval will follow review of the demonstration's evaluation, to be published by RTI International on September 30, 2018.

The CDC found that health care costs are 2.3 times higher for those with diabetes compared to those without diabetes. Maryland Medicaid claims (2016) show that 9.5 percent of the HealthChoice population 18 to 64 years of age have type 2 diabetes. The Hilltop Institute at the University of Maryland, Baltimore County (The Hilltop Institute), which serves as Maryland Medicaid's data and claims warehouse, found that the average health care spending for participants with diabetes is approximately $24,387 per participant per year.[1] Thus, the health care cost of the adult HealthChoice population with diabetes is approximately $1.6 billion annually. A peer-reviewed study indicated that if untreated, 5 to 10 percent of those with prediabetes will convert to type 2 diabetes annually.[2] The conversion from prediabetes to diabetes is estimated to cost the Department between $10 and $20 million annually. The Department estimates that providing National DPP to eligible participants would cost $500 per member per year.

National DPP

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 cut their risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old) over three years.[3] This is the result of the program helping people lose 5 percent to 7 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 sixteen (16) weekly sessions, including make-up sessions, are offered over a period lasting at least 16 weeks and no more than 26 weeks. The second six-month phase must consist of at least one session each month and six (6) sessions total. Each session must be at least one hour long.

National DPP Eligible Population

To qualify for the DPP Pilot, adults (18-64) must be enrolled in HealthChoice MCOs and meet CDC Diabetes Prevention Recognition Program's (DPRP) criteria for eligibility which are as follows:

INCLUDE: 18 years or older; **AND**

1) Overweight or obese (have a BMI of $\geq$ 25 kg/m^2 ($\geq$ 23 kg/m^2, if Asian)

AND EITHER 2) Elevated blood glucose level **OR** 3) History of gestational diabetes;

[1] The Hilltop Institute. (2016). Briefing report: An examination of service utilization and expenditures among adults with diabetes enrolled in Maryland's Medicaid Managed Care program. Baltimore, MD: The Hilltop Institute, University of Maryland Baltimore County.

[2] Tuso, P. (2014). Prediabetes and Lifestyle Modification: Time to Prevent a Preventable Disease. *The Permanente Journal*, *18*(3), 88–93. http://doi.org/10.7812/TPP/14-002.

[3] The Diabetes Prevention Program Research Group. (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 346 (6): 393-403.

AND NEITHER 4) Diagnosed with type I or type II diabetes; **NOR** 5) Currently pregnant.[4]

National DPP Suppliers—Lifestyle Coaches

Lifestyle coaches, who have been trained on the current version of the CDC-approved National DPP curriculum, or Prevent T2 curriculum, will implement this curriculum. This curriculum is designed to offer effective lifestyle change methods for preventing or delaying onset of type 2 diabetes and provide support and guidance to participants in the program.

Lifestyle coaches will have the ability to deliver the program (or specific components within the program) in a way that increases the capacity of participants to make and sustain positive lifestyle changes. This includes understanding and being sensitive to issues and challenges for participants trying to make and sustain significant lifestyle changes.

National DPP Modes of Delivery

Organizations may offer the program through different delivery modes as defined by CDC's DPRP Standards. The Department proposes allowing two of the four CDC-recognized delivery modes: in-person and online.

1. **In-person.** Year-long lifestyle change program delivered 100 percent in-person for all participants by trained Lifestyle coaches; participants are physically present in a classroom or classroom-like setting. Lifestyle coaches may supplement in-person sessions with handouts, emails, or texts, although none of these may be the sole method of participant communication. Organizations that conduct make-up sessions over the phone, online, or via some other virtual modality are still considered to be delivering the program in-person
2. **Online.** Year-long lifestyle change program delivered 100 percent online for all participants; participants log into course sessions via a computer, laptop, tablet, or smartphone. Participants also must interact with Lifestyle coaches at various times and by various communication methods including online classes, emails, phone calls, or texts.

Reimbursement Methodology

For the CDC-funded demonstration, the Department worked with four MCOs to develop a reimbursement methodology. Subsequently, Medicare is now covering DPP services through Medicare Diabetes Prevention Program (MDPP) Expanded Model. The Department is working with stakeholders to develop a reimbursement methodology based on the CDC's average cost for National DPP and MDPP Expanded Model, which aligns payment with the CDC's evidence-based weight loss and attendance milestones.[5] The reimbursement model may include the use of modifiers in conjunction with Healthcare Common Procedure Coding System (HCPCS) codes to distinguish between the in-person and online delivery

[4] Centers for Disease Control and Prevention (CDC). (2018) Centers for Disease Control and Prevention Diabetes Prevention Recognition Program: Standard Operating Procedures. Retrieved from: https: //www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf.

[5] 82 Fed. Reg. 52976. (2017). Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program. Retrieved from: https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions; Centers for Disease Control and Prevention (CDC). (2016). National Diabetes Prevention Program: Implement a Lifestyle Change Program. Questions and Support: Frequent Questions about Offering a Program. What can organizations do if they feel that the cost of participating in a CDC-recognized lifestyle change program is too burdensome for participants? Retrieved from: https://www.cdc.gov/diabetes/prevention/lifestyle-program/questions_support.html.

modes, and to facilitate evaluation of the program by delivery mode. A key difference between the Department's pilot program and Medicare is the coverage of online providers. The Department believes this is a critical piece in designing an effective program for Medicaid recipients.

The Department plans on offering grants to MCOs in order to operate the program. The MCOs who have participated in the CDC-pilot will be prioritized in the award process. The Department will work with the MCOs to receive National DPP utilization information.

Evaluation Design

The National DPP has been shown to reduce the risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old) over three years, as well as producing cost savings.[6] The Department anticipates a reduction in incidence of diabetes and other related health care costs. Maryland's annual HealthChoice evaluation will be modified to include an evaluation to determine the effect(s) of National DPP participation on: (a) utilization of emergency medicine services; (b) all-cause hospital admission; (c) medications; (d) total cost of care (per member per month); and (e) incidence of diabetes.

Outcomes of interest will be evaluated for the 24 months prior to National DPP enrollment, during National DPP participation, and for the first phase of this study, in the 12 months after National DPP participation. Health outcomes and costs will also be compared between groups of National DPP participants utilizing attendance and percent of weight loss.

Budget Neutrality

The Department and the Department of Budget Management (DBM) have allocated an initial budget of $700,000 Total Funds annually to provide National DPP services to eligible Medicaid participants in the HealthChoice program. This would limit the number that could be served annually to 1,400 participants. Based on DBM approval, this may be increased up to $1.4 million Total Funds annually, which could serve up to 2,800 participants.

Table 1. **Anticipated Participants Served with Funding Allocation of $700K - $1.4M**

	Allocation 1	**Allocation 2**
Total National DPP Allocation	$700,000	$1,400,000
Per Member Per Year Cost	$500	$500
Estimated Number of Participants Served	1,400	2,800

[6] The Diabetes Prevention Program Research Group. (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 346 (6): 393-403; Centers for Medicare and Medicaid Services (CMS). (2016). Certification of the Medicare Diabetes Prevention Program (Memo). Baltimore, MD: Office of the Actuary, Centers for Medicare and Medicaid Services. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf

Expansion of Substance Use Disorder Residential Services

Introduction

As part of the §1115 waiver renewal application submitted on June 30, 2016, the Department sought an amendment to authorize Medicaid funds to be used for SUD services in IMDs. CMS approved this amendment, permitting the Department to expand coverage to include treatment in IMDs. More specifically, the Department applied for expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 to 64 years of age who are enrolled in a Medicaid MCO and reside in a non-public IMD for ASAM Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM (licensed at 3.7D in Maryland). Effective July 1, 2017, the Department provides reimbursement for up to two non-consecutive 30-day stays annually for ASAM levels 3.1, 3.3, 3.5, 3.7, and 3.7WM. The Department intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019 and extend coverage of benefits for dual-eligibles at these levels of care no later than January 1, 2020.

On October 26, 2017, the Trump Administration declared the opioid crisis a national Public Health Emergency.[7] The continuing rise of opioid addiction and increasing heroin-related deaths nationally over the last several years suggest that the need to improve outcomes and access to SUD treatment is of paramount importance.

Requested Changes, Objectives, and Policy Rationale

The number of drug- and alcohol-related intoxication deaths occurring in Maryland increased in 2016 for the sixth year in a row, reaching an all-time high of 2,089 deaths. This represents a 66 percent increase from the number of deaths in 2015 (1,259) and the largest recorded single-year increase. Eighty-nine percent of all intoxication deaths that occurred in Maryland in 2016 were opioid-related. The number of opioid-related deaths increased by 70 percent between 2015 and 2016 and has nearly quadrupled since 2010.[8]

Maryland SUD residential treatment facilities are not "fixed length of stay" programs; they offer services with individualized lengths of stay according to patient needs. These facilities and the State are committed to implementing treatment plans that include outpatient services designed to provide ongoing treatment and treating SUDs as chronic conditions.

CMS recently approved IMD exclusion waivers for ten states, including Maryland, California, Indiana, Kentucky, Louisiana, Massachusetts, New Jersey, Utah, Virginia, and West Virginia, which give waiver authority to use federal Medicaid funds to pay for IMD SUD services.[9] Similarly, CMS permits states, under the managed care rule, to make capitation payments for participants with a short term stay (no more than 15 days within a month) in an IMD for SUD and mental health treatment services, permissible under 42 C.F.R. §438.6(e).[10]

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[7] Opioid Crisis. Retrieved from: https://www.whitehouse.gov/opioids/.

[8] Drug-and Alcohol-Related Intoxication Deaths in Maryland, 2016. Retrieved from: https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/Maryland%202016%20Overdose%20Annual%20report.pdf

[9] Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers. Retrieved from: https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/

[10] Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e). Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/faq08172017.pdf

Maryland is seeking expenditure authority under §1115(a)(2) of the Social Security Act to claim expenditures by the State for SUD treatment in non-public IMDs for an additional level of care—which are not otherwise included as expenditures under §1903—and to have those expenditures regarded as payments under the State's Title XIX plan.

Specifically, Maryland is requesting expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 through 64 years of age who are residing in a private IMD and have a primary SUD diagnosis and a secondary mental health diagnosis. The Department is seeking to extend coverage for ASAM Level 4.0 (Medically Managed Intensive Inpatient services) for up to 15 days in a month. The days authorized would be based on medical necessity, but would not exceed 15 days per month. For the large cohort of Medicaid adults with co-occurring disorders, private IMDs can deliver specialized services for participants whose active psychiatric symptoms limit their access to many SUD treatment programs.

Anticipated Outcomes

Based on utilization to date, MDH estimates Adventist Behavioral Health, Brook Lane Health Services, Inc., and Sheppard Pratt Health Systems, Maryland's three private standing psychiatric hospitals, will treat approximately 3,391 Medicaid participants, 21 to 64 years of age, in SFY 2018. Of these individuals, approximately one-third, or 1,130 are being treated for co-occurring substance use and psychiatric disorders. In SFY 2017 the average length of stay was ten (10) days. The overall 30-day readmission rate for the three IMDs in FY 2017 was 9.8 percent (see Table 2 below). The majority of these patients are referred to IMDs from Maryland emergency departments (EDs) following the diagnoses of an active psychiatric disorder.

The data demonstrates that limiting services to SUD-only or mental health-only would create a barrier for recovery and the quality of care to an increasing number of people. From CY 2015 to CY 2016, the number of Maryland HealthChoice participants with a dual diagnosis of SUD and mental health disorders grew from 27,660 to 30,728. To mitigate this barrier, Maryland is requesting that its IMD exclusion waiver amendment cover ASAM Level 4.0 services in private IMDs for participants diagnosed with a primary SUD diagnosis and a secondary mental health diagnosis.

Table 2. **Anticipated Medicaid Participants Served and Amount Paid to IMDs, FY 2018**[11]

Medicaid Participants (19-64) with Dual SUD/Mental Health Disorder Utilizing ASAM 4.0 IMD Services	**Average Length of Stay (ALOS) in Days**	**Average Per Member Cost Per Day**	**Total Projected State Cost**
1,130	10	$1,435	$16,215,500

The figures in Table 2 provide estimates of participants served and projected cost to deliver services in the three IMDs in Maryland for Medicaid-eligible participants with a dual diagnosis of SUD and a mental

[11] Based on claims paid through March 31, 2018, extrapolated through close of FY (June 30, 2018).

health disorder in SFY 2018. With the expansion of coverage for participants with a primary SUD diagnosis and secondary mental health diagnosis, Maryland expects utilization of IMD facilities to increase.

Evaluation Design

Maryland's annual HealthChoice evaluation will be modified to incorporate the IMD exclusion waiver amendment and track the measures described below. The Hilltop Institute performs an annual evaluation of the HealthChoice program, as mandated by Maryland's § 1115 waiver. This demonstration will test whether authorizing the provision of emergency SUD and psychiatric services in IMDs at an ASAM Level 4.0 affects the existing quality and cost measures against which the broader HealthChoice demonstration is evaluated. The evaluation of IMD exclusion waiver will be housed under the Special Topics section of the annual HealthChoice evaluation.

The Hilltop Institute will track data through the Healthcare Effectiveness and Data Information Set (HEDIS) measures. The Department anticipates that several of the current HEDIS measure will directly capture some of the impact of the IMD exclusion waiver, including, but not limited to:

- Mental Health Utilization – Inpatient Utilization;
- Initiation and Engagement of Alcohol and Other Drug Dependency;
- Follow-up after Discharge from ED for Mental Health or Alcohol or Other Drug Dependence; and
- Plan All-Cause Readmission.

Additionally, the Department has designed an evaluation focused on assessing the impact an IMD waiver will have on utilization of SUD IMD services and other types of care. The Department will assess measures, including but not limited to the following:

- ED utilization or treatment of SUD/MH conditions;
- Access to and average length of stay for acute inpatient settings for treatment of SUD/MH conditions;
- Readmission rates for inpatient treatment;
- Access to care for co-morbid physical health conditions; and
- Evaluate whether greater access to and utilization of IMDs affects utilization of acute inpatient, ED, and ambulatory care for non-behavioral health conditions.

Both the quality and utilization evaluation approaches may allow the Department to identify opportunities to improve the usage of IMD facilities and generate best practices for the state.

The Department will continue to collaborate with the Lieutenant Governor's Heroin and Opioid Emergency Task Force to monitor any impact on heroin- and other opioid-related deaths and ED visits.

Budget Neutrality

The Department estimates that 1,130 Medicaid participants will receive ASAM Level 4.0 services for co-occurring SUD and mental health disorders in private IMDs under this proposed expansion at a cost of approximately $16.2 million Total Funds annually. The Department estimates that the number of participants accessing care will grow by approximately 2 percent and per member per day costs will increase by approximately 1 percent each SFY. Anticipated costs through the remainder of the current waiver period are included in Table 3.

Table 3. **Number of Medicaid Participants Served and Projected Costs, SFY 2019-2022**[12]

State Fiscal Year (SFY)	Estimated Medicaid Participants (19-64) with Dual SUD/Mental Health Disorder Utilizing ASAM 4.0 IMD Services*	Average Length of Stay (ALOS) in Days	Per Member Cost Per Day*	Projected Cost (Total Funds)
SFY 2019 (coverage effective January 1, 2019)	565	10	$1,435	$8,107,750
SFY 2020	1,153	10	$1,449	$16,705,208
SFY 2021	1,176	10	$1,464	$17,209,705
SFY 2022 (cost to deliver services through December 31, 2021)	600	10	$1,478	$8,864,719

**Estimates assume 2 percent utilization growth and 1 percent cost growth annually.*

Adult Dental Pilot Program

Introduction

The Department is seeking an amendment that will allow an adult dental pilot program for those eligible for both Medicaid and Medicare services ("dual-eligible" participants), 21 through 64 years of age. The basic benefit package will offer limited services and will have an overall spend cap per person. The Department's objective in seeking this amendment is to determine whether offering an adult dental benefit will improve health outcomes for this vulnerable population.

Adults with lower incomes are disproportionately impacted by lack of access to dental care. According to the Kaiser Family Foundation, 27 percent of all adults 20 to 64 years of age have untreated dental caries.[13] The highest rate (44 percent) among adults with income below 100 percent of the federal poverty level (FPL) is more than double the rate (17 percent) of adults with an income at or above 200% FPL. Further, in addition to risk of tooth and bone loss, infection, chronic pain, untreated dental disease is also

[12] Based on claims paid through March 31, 2018, extrapolated through close of FY (June 30, 2018).

[13] Kaiser Family Foundation (2016). Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults. Retrieved from: https://www.kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/.

associated with an increased risk of negative health outcomes, including higher incidence of and poorer outcomes for certain conditions, such as diabetes, heart and lung disease, and stroke.[14]

Federal law does not mandate any minimum requirements for adult dental coverage under Medicaid. While other Medicaid populations in Maryland, including adults enrolled in HealthChoice, have access to limited dental services, dual-eligible participants do not. The Department is seeking to address this gap in dental coverage.

Current Dental Coverage and Utilization

The Maryland Medicaid program covers dental benefits through the Maryland Healthy Smiles Dental Program for children, pregnant women, Rare and Expensive Case Management (REM) adult populations, and former foster care children until they turn 26. Since 2009, an administrative services organization (ASO) has administered the Maryland Healthy Smiles Dental Program, and dental benefits are carved out from the MCO benefit package. The dental ASO handles credentialing, billing, and dental provider issues, which streamlines the process for providers and has been effective in encouraging dentists to participate in the Maryland Medicaid dental network.

MCOs that participate in HealthChoice have the option to offer additional benefits, including a limited dental benefit. Currently, all nine MCOs elect to offer some adult dental services. The Department does not reimburse MCOs for these services; the MCOs pay for these services out of their own profits and services may be discontinued at an MCO's discretion. Typically, the adult dental benefit package for those in managed care includes an oral exam and cleaning twice each year, x-rays, extractions, and fillings. Some MCOs also designate the maximum benefit a participant may receive annually (between $250-$750) or require the participant to pay coinsurance. Additional information regarding dental utilization in the Maryland Medicaid Program can be found in the Department's most recent chartbook, available online https://mmcp.health.maryland.gov/Documents/JCRs/2017/Dental%20JCR%20PPT_%20Final%202018%204%2025.pdf.

Adults dually eligible for Medicare and Medicaid do not have access to non-emergency dental services because they receive their Medicaid benefits under fee-for-service (FFS) coverage and are not eligible for HealthChoice. Medicare does not cover most dental care, dental procedures, or supplies, such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Medicare Part A pays for certain dental services that are obtained when a Medicare participant is in a hospital. The Department does not currently reimburse for dental services for this population.

Interest in Adult Dental Coverage in Maryland

In April 2015, the chairmen of the Senate Finance and House Health and Government Operations Committees requested that the Maryland Dental Action Coalition (MDAC) conduct a study on the cost to expand access to oral health care and coverage for adults. MDAC contracted with The Hilltop Institute to conduct the study and presented a summary of its findings to the House Health and Government Operations Committee in February 2016. Table 4 shows the differences between the three examined service plans, including the per member per month (PMPM) cost from the Hilltop Institute report.[15]

[14] MACPAC Medicaid and CHIP Payment and Access Commission (June 2015). Report to Congress on Medicaid and CHIP. Retrieved from: https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

[15] Betley, C., Idala, D., James, P., Mueller, C., Smirnow, A., Tan, B. (2016, February 1). Adult dental coverage in Maryland Medicaid. Baltimore, MD: The Hilltop Institute, UMBC.

***Table 4*. Service Plans and Estimated Costs of Adult Dental Services**

	Cleanings Only	Basic	Extensive + $1,000 Cap
Covered Services	Services Limited to Dental Prophylaxis Codes	Basic dental services include diagnostic, preventive, and restorative dental services (D0100-D2999)	Extensive dental services includes all dental service categories except Orthodontics and Dentofacial Orthopedics (D8000 - D8999)
Estimated PMPM	$0.65 to $1.65	$5.64 to $12.94	$6.23 to $20.36
Total Estimated Cost	$5.6 to $14.3 million	$48.7 to $112.0 million	$53.8 to $176.3 million

Chapter 721 of the Acts of 2017 (Senate Bill 169) authorized MDAC to conduct a study of the ED costs to treat dental conditions of adults in Maryland and the advisability of providing coverage for dental services to adults with incomes below 133 percent of Federal Poverty Level (FPL) under Medicaid. MDAC completed the study in December 2017 and found that in SFY 2016, there were 42,327 ED visits for chronic dental conditions among adults with an average charge of $537 and total charges of $22.7 million. The Maryland Medicaid program, according to the study, paid for 53 percent of ED visits for chronic dental conditions with an average charge of $446 and total charges of nearly $10 million in SFY 2016.[16]

In 2018, the Maryland Legislature passed Senate Bill 284, requiring the Department to apply for a waiver amendment to CMS, by September 1, 2018, to implement a pilot program to provide limited dental coverage. The Department may limit the pilot to participants that are dually eligible through Medicaid and Medicare up to a certain age. The Department also has the authority to limit eligibility by number of participants and geographic location (though at least one rural area must be included). The goal is for the Adult Dental program to begin offering services on January 1, 2019.

Requested Changes, Objectives, and Policy Rationale

The Department requests an amendment to the current §1115 waiver in order to pilot the dually-eligible adult (21 through 64 years of age) dental benefit that has been mandated by state law in order to address a gap in coverage. The benefit package will be limited, focusing on basic dental services including diagnostic, preventive, and limited restorative dental services, along with extraction services. In addition, the Department may set an overall cap on expenditures per person.

Anticipated Outcomes

Good oral health is correlated with good health overall. Adults with lower incomes are disproportionately impacted by lack of access to dental care. People with disabilities or chronic health conditions are more likely to have poor oral health. Additionally, research consistently shows associations between chronic oral infections and diabetes, lung and heart disease, stroke, and poor birth outcomes. Oral disease can also exacerbate chronic disease symptoms.[17] Untreated oral health needs can lead to nutritional deficits (due to being unable to eat) and chronic pain. Oral health problems may also result in decreased quality of life

[16] Maryland Dental Action Coalition. Retrieved from: http://www.mdac.us/research_report.aspx.

[17] MACPAC Medicaid and CHIP Payment and Access Commission (June 2015). Report to Congress on Medicaid and CHIP. Retrieved from: https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

that affects an individual's ability to work, especially those in lower-paying industries. Adults in working-class industries lose two to four times more work hours due to oral health issues than adults who have professional positions.[18] Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions.[19] This is why *Healthy People 2020* included increasing the proportion of adults who used the oral health system in the past year as a goal and why the Department seeks to increase access to oral health care.[20]

If implemented, the Department anticipates that the dually-eligible adult dental pilot will improve health outcomes, increase dental services utilization, and reduce ED utilization.

Evaluation Design

Maryland's annual HealthChoice evaluation design will be modified to incorporate the dually-eligible adult dental pilot waiver amendment. The Hilltop Institute performs an annual evaluation of the HealthChoice program as mandated by Maryland's §1115 waiver. This pilot will test whether an adult dental benefit will increase access to and utilization of dental services, improve health outcomes, and reduce dental related ED utilization for dually-eligible adult participants as previously stated.

Pursuant to Health-General Article §13-2504(b), Annotated Code of Maryland, the Department is required to submit a comprehensive oral health report in conjunction with the Maryland Office of Oral Health. The report must address the availability of dentists participating in the Maryland Healthy Smiles Dental Program, access to care and utilization for Medicaid populations under the ASO, and services offered by local health departments to low-income residents in dental Health Professional Shortage Areas (HPSAs). Included in that report is data tracking the utilization of preventive and restorative services, dental-related ED utilization, and the cost of dental care. An evaluation of the dual-eligible adult dental pilot program will be incorporated into this report as well.

Budget Neutrality

Under the Pilot, an additional 38,510 participants may be eligible for dental services. The Hilltop Institute calculated the financial impact of this expansion based on evaluation of four different states' dental benefits, utilization rates, and costs. Specifically, they calculated an estimated population utilization rate for individual dental procedures codes for participants 21 years of age and older within each state. This number was then applied to the Maryland Medicaid participants 21 years of age and older enrolled in CY 2014.[21]

Based on this analysis, the PMPM cost for each additional participant for the services is approximately $8.69. Additionally, the administrative cost for each member under the current dental ACO is $0.39 PMPM, making the total cost $9.08 PMPM. Costs are subject to a 50 percent FMAP (Federal Medical Assistance Percentage). The total annual cost for adult dental services for the dual-eligible population 21 to 64 years of age is anticipated to be $4.2 million ($2.1 million Federal Funds, $2.1 million State General

[18] Hinton, E., and Paradise, J. (2016, March 17). Access to Dental Care in Medicaid: Spotlight on Nonelderly Adults. Kaiser Family Foundation. Retrieved from: https://www.kff.org/medicaid/issue-brief/access-to-dental-care-in-medicaid-spotlight-on-nonelderly-adults/

[19] Healthy People 2020 Topics and Objectives – Oral Health. Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health

[20] Ibid.

[21] Betley, C., Idala, D., James, P., Mueller, C., Smirnow, A., Tan, B. (2016, February 1). Adult dental coverage in Maryland Medicaid. Baltimore, MD: The Hilltop Institute, UMBC.

Funds) in FY 2019 (Table 5). With a 3 percent annual population increase, the total cost of these services may increase to $4.3 million in FY 2020.

***Table 5*. FY 2019 Estimated Costs of Dental Benefits Packages for Dual-Eligible Adults**

Age Group of Dual-Eligible Adults	Total Number of Eligible Participants	Basic Benefits Package as Estimated in 2019 Dental Update[22]		
		PMPM	Total Cost	Total Federal Funds
21 - 64	38,510	$9.08	$4,196,050	$2,098,025

Family Planning Program

Introduction

Pursuant to Chapters 464 and 465 of the Acts of 2018 (HB0994/SB0774) passed by the Maryland General Assembly, the Department must apply for a State Plan Amendment (SPA) to expand the eligibility and access to the Family Planning Program, which is currently a part of the §1115 waiver.

Requested Changes

Consistent with the law's requirements, the Department seeks to remove the Program from the waiver in order to apply for a SPA. The SPA will include the same or expanded eligibility and access as is currently effective in the waiver.

Appendices

Public Process and Indian Consultation Requirements

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

[22] Basic dental services to comprise certain diagnostic, preventive, and restorative dental services. Service cost $8.69; administrative cost $0.39.