JAI MEDICAL SYSTEMS
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May 10, 2021

Tricia Roddy
Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

Re: Support of Maryland HealthChoice Program §1115 Waiver Renewal Application

Dear Ms. Roddy,

Jai Medical Systems Managed Care Organization, Inc. (Jai Medical Systems), one of the highest rated Medicaid health plans in the United States according to the National Committee for Quality Assurance (NCQA), would like to offer its full support for the renewal of the §1115 waiver application for the Maryland HealthChoice program.

For over twenty-four years, Jai Medical Systems has served with distinction in the Maryland HealthChoice program. Jai Medical Systems is a physician-sponsored, minority business enterprise that is independently owned and operated in Maryland. With historic roots within the communities in and around Baltimore, Jai Medical Systems aims to provide high quality benefits and services to its members while remaining a positive influence in the communities we serve.

Since the HealthChoice program's inception under the §1115 waiver in 1997, our organization has appreciated the opportunity to participate in the program while collaborating with the Maryland Department of Health (the Department) on many public health priorities. This has included participating with innovative programs such as the Diabetes Prevention Program and more recently assisting in the public health response to the COVID-19 pandemic with ongoing testing and vaccination outreach efforts.

Under the Department's leadership and guidance, Maryland has set a high standard with what is broadly considered a successful Medicaid waiver program. In addition to Maryland being home to the two highest rated Medicaid health plans for quality in the country, the Department has developed a sophisticated and time tested approach to risk adjustment for the HealthChoice program that ensures the actuarial soundness of managed care rates.

We appreciate the opportunity to provide our support as Maryland and the Department seek renewal of the §1115 waiver. Jai Medical Systems applauds the efforts of the Department to provide cost effective, quality health care benefits and services to the 1.3 million Marylanders served by the HealthChoice program and we are hopeful that the §1115 waiver renewal will be received favorably.

Sincerely,

Jai Scunarine
Chief Executive Officer

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Questions on the §1115 Waiver Demonstration Renewal Application

Evelyn Burton <burtonev@comcast.net> Thu, May 27, 2021 at 4:33 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>

Good afternoon,

Since answers to many of the questions submitted by the The Maryland Chapter of Schizophrenia and Related Disorders Alliance of America (SARDAA) were not readily available at the public hearing of May 27, 2017 on Maryland's §1115 Waiver Demonstration Renewal Application, we would appreciate answers to the following questions by email to inform our written comments on Maryland's §1115 Waiver Demonstration Renewal Application.

Thank you very much for your assistance.

Evelyn Burton
Advocacy Chair, Maryland Chapter, Schizophrenia and Related Disorders Alliance of America. (SARDAA)

1. The CMS Waiver announcement allows states to apply for an SMI IMD Waiver with an unlimited number of IMD hospital stays per year where each stay is a maximum of 60 days, as long as the state-wide average length of stay is 30 days. Please explain in detail why Maryland's application is only requesting a maximum of 2 stays per year with a maximum of only 30 days per stay.

2. Has the state calculated what the expected Federal Medicaid contribution would be under the two cases above? If so, how was this calculated and what are the results?

3. What would the Federal Medicaid contribution have been under the 2 plans above for fiscal years 19 & 20?

4. Has Maryland Medicaid talked to CMS about applying for the waiver for unlimited number of stays per year with a max stay of 60 days if the statewide average stay is 30 days? If so what did CMS say?

5. If for any reason CMS were to ask for money back under an approved SMI IMD Waiver, would the state reimburse the IMD hospitals?

The following questions (6-19) pertain to all Maryland Medicaid patients between the ages 21-64 in a psychiatric IMD hospital:

6. What was the average length of stay in FY19, 20, and so far in 21?

7. How many different (unique) Medicaid inpatients had at least one hospital IMD stay in FY 19, and FY 20.?

8. How many total hospital stays were there in FY 19, and FY 20.

9. What was the longest stay in FY 19 and FY 20?

10. How many stays were over 30 days in FY19, in FY20? over 60 days in FY19 and FY20?

11. What was the total state funds paid to IMD hospitals for Medicaid inpatients age 21-64 in FY 19, and FY20?

12. How many patients had more than 3 stays in FY 19 and FY20?

13. How many total days were day #31 or greater in a stay in FY 19 and FY20? ? day #61 or greater in FY 19 and FY20?

14. What does the state currently pay Sheppard Pratt and Brook Lane hospitals per day ?

15. For how many inpatient days did Sheppard Pratt and Brook Lane hospitals not receive state payments in FY 19 a nd FY20?

16. How many inpatient days would not have been paid by Medicaid in FY 19 and FY20 if there was a limit of 2 stays per year and each stay was limited to 30 days?

17. In FY 19 and FY20 what was the longest stay for which the state has paid?

18. Under Maryland's current proposal, is it correct that if a patient had one stay of 3 days and a second stay 2 months later of 5 days, and a third stay 4 months later of 30 days, Maryland would only get the Federal matching funds for 8 days?

19. Does the administration commit to paying the IMD's out of state funds for the cost of all inpatient days not covered by an SMI IMD Waiver? If not, how many days over the Waiver limit does the administration commit to pay with state funds and will there be a cap?

MMCOA

MARYLAND MCO ASSOCIATION

May 27, 2021

Ms. Tricia Roddy, Deputy Medicaid Director
Office of Health Care Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Sent electronically to: mdh.healthchoicerenewal@maryland.gov

Dear Ms. Roddy:

On behalf of the nine managed care plans that arrange for the care of over 1.3 million Marylanders enrolled in the HealthChoice Program, I wish to convey our support of the Maryland HealthChoice Program Section 1115 Waiver Renewal Application.

Throughout the 2017-2021 waiver period, the MCOs worked with the Maryland Department of Health to meet or exceed the quality and access to care goals of the HealthChoice program, supported the implementation of payment and delivery system reform initiatives, as well as implemented new population health priorities and related performance measures. We continued to collaborate on these objectives despite the many unprecedented challenges presented to the Program and those we serve due to the COVID-19 global pandemic.

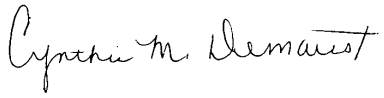
Over the course of the next waiver period, the MCOs are committed to a continued partnership with the Maryland Department of Health to meet the waiver objectives of maintaining high quality, cost-effective services and focusing on the alignment of all efforts in support of statewide population health measures.

The MCOs support the Maryland Department of Health's continued efforts to address social needs, and applaud the expansion of the Assistance in Community Integration Services and Home Visiting Services Pilots. We ask that the Department consider allowing HealthChoice MCOs to provide these support services directly to at-risk populations enrolled in HealthChoice.

The MCOs acknowledge the significant effort put forward by the Maryland Department of Health to provide coverage of dental benefits for fully dually eligible individuals ages 21 through 64. We support expanding dental benefits to all adults enrolled in Medicaid.

We appreciate the opportunity to submit our comments and welcome our continued collaboration and partnership with the Maryland Department of Health.

Respectfully,



Cynthia M. Demarest
President
Maryland Managed Care Organization Association

ANNAPOLIS FIRE DEPARTMENT

OFFICE OF THE CHIEF

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May 27, 2021

Tricia Roddy, Deputy Medicaid Director
Office of the Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore MD 21201
mdh.healthchoicerenewal@maryland.gov

To Whom It May Concern:

The Annapolis Fire Department would like to convey its support of the modification of the Federal §1115 Waiver to include Alternative Destination for Medicaid transports. The modification will allow transport of certain patients to an urgent care clinic in lieu of a hospital emergency room. The result will provide patient care that is more efficient and reduce the strain on hospital emergency rooms. It will also further reduce the impact on an already taxed Emergency Medical System.

Thank you for your consideration of our request and the time spent regarding our concerns. Please do not hesitate to contact me if you have any questions, or I may be of any assistance to you regarding this request.

Sincerely,

Douglas M. Remaley
Fire Chief

DMR/jsc

cc: File Copy

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

May 28, 2021

Tricia Roddy, Deputy Medicaid Director
Office of Health Care Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201
mdh.healthchoicerenewal@maryland.gov

Dear Tricia Roddy,
It is with great enthusiasm that the National Association of Chronic Disease Directors (NACDD) submits this letter of support for the proposed renewal of the Maryland Department of Health (the Department) §1115 demonstration waiver known as HealthChoice, particularly the continuation of the **HealthChoice Diabetes Prevention Program (DPP)**, which provides the Centers for Disease Control and Prevention's (CDC) National DPP lifestyle change program services to eligible HealthChoice participants. NACDD improves the health of the public by strengthening state-based leadership and expertise for chronic disease prevention and control in states and at the national level, and one of our core projects includes furthering Medicaid coverage of the CDC's National DPP through multi-year technical assistance partnerships with states in various stages of obtaining and implementing coverage. NACDD has a longstanding history of working with the Department through the Medicaid Coverage for the National DPP Demonstration Project (2016 – 2019), which led to the inclusion of National DPP services in the Department's §1115 demonstration waiver in July 2019. In 2020, the Department was honored for their work on the Demonstration Project through the CDC's Health Equity Award.

Diabetes prevention is an important focus in Maryland, and with continued support from NACDD, the Department has worked tirelessly to successfully implement the HealthChoice DPP. Some examples of the Department's work include:

- Monthly meetings with HealthChoice managed care organizations (MCO) to support operationalization of the benefit
- Individualized support for CDC-recognized organizations to enroll in Medicaid and provide services to eligible HealthChoice participants; as of May 2021, over 20 organizations have successfully enrolled in Medicaid
- Collaboration with CRISP, the designated Health Information Exchange in Maryland and the District of Columbia, to develop a prediabetes flag that allows health care providers using the CRISP patient portal to see which members of their panel are eligible for HealthChoice DPP
- Development of an eligibility algorithm, with the assistance of the Hilltop Institute at the University of Maryland, Baltimore County, and distribution of technical guidance to MCOs on how to use the algorithm to identify eligible members
- Development and maintenance of a comprehensive communications campaign to reach eligible participants and increase enrollment in the HealthChoice DPP

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
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325 Swanton Way
Decatur, GA 30030
(770) 458-7400
chronicdisease.org

NACDD fully supports the Department's continued implementation of the HealthChoice DPP, and because socioeconomic disparities in the prevalence of type 2 diabetes are notable and increasing, it is imperative that access to and coverage of the National DPP lifestyle change program for all people with prediabetes is increased nationwide.

Sincerely,

John Robitscher, MPH
Chief Executive Officer

THE COORDINATING CENTER
INSPIRED SOLUTIONS

May 27, 2021

Ms. Tricia Roddy
Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Dear Ms. Roddy:

Thank you for the opportunity to comment on the draft application for the 1115 Waiver from the Maryland Department of Health (MDH). The Coordinating Center is in full support of MDH's application including the provisions extending the Rare and Expensive Case Management (REM) Program. We are long-serving provider with the REM Program, and we believe strongly in the continuation of the program as it has a tremendous positive impact on the health and wellbeing of individuals with disabilities. REM also is a cost-effective strategy for the State to lower the cost of institutional care, including hospital admissions.

We also recognize the importance of the HealthChoice Program on the lives of 1.2 million Marylanders. HealthChoice ensures equitable access to health coverage for Marylanders with lower incomes. This vital program supports Maryland's population health initiatives, including the Total Cost of Care Program. Most importantly, HealthChoice means individuals have the access to the health services needed to ensure the wellbeing of themselves and their families.

While the draft application does not specifically pertain to the COVID-19 emergency, we would like to extend our deepest appreciation to the staff at the Maryland Medical Assistance Program. Your tireless efforts made sure that Marylanders continued to have health care coverage when they needed it the most. As a provider, we are particularly grateful for the speed at which Medicaid implemented more flexible telehealth policies. You helped us in our efforts to maintain the continuity of services for our clients.

Thank you again for the opportunity to submit public comments. Please let us know if we can be helpful in supporting your application effort.

Sincerely,

Teresa Titus-Howard, PhD, MHA, MSW
President/CEO

NCADD MARYLAND

June 2, 2021

Ms. Tricia Roddy, Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Re: §1115 Waiver Demonstration Renewal Application Comments

Dear Ms. Roddy:

The Maryland Chapter of the National Council on Alcoholism and Drug Dependence is pleased to submit the following comments in support of Maryland's §1115 Waiver Demonstration Renewal Application. As an organization that works to ensure people with substance use disorders (SUD) and problem gambling have access to treatment and recovery supports, we are grateful for the comprehensive behavioral health benefits that exist in Maryland's Medicaid program.

Specific to the pieces within this renewal application, NCADD-Maryland expresses its support for the continuation of coverage for residential SUD treatment and the proposed expansion to provide inpatient psychiatric coverage for people with mental health diagnoses. The institutions for mental disease (IMD) exclusion that has existed at the federal level has been an unnecessary barrier to treatment. Maryland has significantly improved access to residential levels of care for people with SUD and the waiver approval in 2017, and its expansion in 2019.

In addition, NCADD-Maryland supports the new service for proposed coverage, the Maternal Opioid Misuse (MOM) Model. As attention being paid to maternal health and health disparities grows, this model of service to enhance outreach and case management for pregnant women with opioid use disorders (OUDs) appears to be successful at a local level. As funding becomes available, we support the expansion of this model to other and eventually all communities throughout the state. We support efforts to educate the public, health care providers, and those within managed care organizations about the best clinical practices in this area. Increase the understanding of and reducing the stigma around the use of treatment with medication among pregnant women with OUDs is crucial to the success of this model.

(over)

National Council on Alcoholism & Drug Dependence – Maryland Chapter
28 E. Ostend Street, Suite 303, Baltimore, MD 21230 · 410-625-6482 · fax 410-625-6484
www.ncaddmaryland.org

We are appreciative of the continuation of the adult dental pilot, and urge the expansion of this benefit as well. Every single person needs dental coverage and as its absence often stands in the way of people's overall health as well as confidence and even ability to find employment, we encourage Maryland Medicaid to look at expanding the number of people enrolled in Medicaid who have access. NCADD-Maryland also supports the expansion of the Assistance in Community Integration Services (ACIS) Pilot. The connection between health and housing is significant and Maryland Medicaid's efforts in this area are to be commended. Stable housing is essential for long-term recovery.

Finally, NCADD-Maryland would like to urge Maryland Medicaid to closely examine the issue of reimbursement for Certified Peer Recovery Specialists. We know that peers play a significant role in many aspects of intervention, treatment and recovery support services. There are levels of care, such as in residential SUD programs, where Medicaid requires the employment of peers. In that instance, the reimbursement rates were established with considering for this cost. But as peers are used in just about all services for people with SUDs, from street outreach to recovery residences, we believe it is time for Medicaid to examine how to best finance these services and in what settings.

We thank you for your work to provide access to health care to Marylanders and look forward to our continued partnership.

Sincerely,

Nancy Rosen-Cohen, Ph.D.
Executive Director

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's §1115 Waiver Renewal Application (2021)

lizmontaner@gmail.com <lizmontaner@gmail.com> Thu, Jun 3, 2021 at 10:02 AM
To: mdh.healthchoicerenewal@maryland.gov
Cc: Evelyn Burton <burtonev@comcast.net>

To Whom it May concern:

I am a parent of a 36 year old son initially diagnosed with a psychotic disorder not otherwise specified eleven years ago that eventual grew into full blown schizophrenia. For the first five years of his illness, getting him into a hospital with psychiatric care was extremely difficult because like most people with unmedicated psychotic illnesses, he did not have the mental capacity to understand that he was sick and needed to be in a hospital on antipsychotic medicine. I was shocked at how challenging it was to get him into a care facility and keep him there particularly when I remembered my own mental health crisis some 40 years ago. In 1975, I was diagnosed with a psychotic disorder and was admitted into a psychiatric hospital in White Plains NY. I stayed there for three months receiving daily therapy and medication. When I was discharged, I was able to put my life back together and went on to have a successful career in Advertising Sales and Real Estate and have never had another psychiatric incident. Unfortunately, my son was not as fortunate as I. His hospitalizations were intermittent and brief thus allowing his illness to fully develop and ultimately prevented him from having a full rich meaningful life. There is no question in my mind if Maryland's application for an IMD Medicaid Waiver for Mental Illness was revised to include Medicaid coverage of (1) an unlimited number of stays per year, and (2) a 60 day maximum length of stay as long as the statewide average does not exceed 30 days the state would save millions of dollars in long term care of residents with long term psychiatric illnesses.

Please act now – this necessary legislation is too late for my son, but I pray it will help future sons and their families.

Liz Montaner

47 Franklin St Annapolis MD 21401

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's Section1115 Waiver Renewal Application (2021)

Marilyn Martin <batikfreak74@gmail.com> Thu, Jun 3, 2021 at 3:16 PM
To: mdh.healthchoicerenewal@maryland.gov

TITLE: Comments on Maryland's Section1115 Waiver Renewal Application (2021)

FROM: Marilyn Martin
Solomons, MD

I am the mother of an adult child with schizophrenia. I was surprised to learn that Maryland's proposed application for the IMD Medicaid Waiver falls short of requesting the full benefits that are available. During the first four to six years of my son's illness, he was admitted to hospitals for psychiatric care approximately a dozen times. He was never an in-patient long enough to stabilize him. In most cases, he was not kept in the hospital even long enough to know whether new medications would be effective. There have also been times that we could not get him admitted as soon as necessary due to the overall psychiatric bed shortage in our State. That bed shortage could become even worse if Maryland does not maintain adequate funding for private psychiatric hospitals like Sheppard Pratt and Brook Lane. Current Federal law prevents Medicaid from paying for adults 21-64 in private psychiatric hospitals. These waivers are essential for maintaining availability of psychiatric beds, especially where specialized treatment is needed for more than 30 days for stabilization of treatment resistant psychosis.

Please include in Maryland's request for an IMD Medicaid Waiver for Mental Illness an unlimited number of stays per year, and a 60-day maximum length of stay, provided the statewide average does not exceed more than 30 days hospital care for stabilization. Current Maryland law discourages admission of Medicaid patients ages 21-64 to IMD hospitals by requiring an Emergency Room (ER) to first get refusals from the inpatient unit of five general hospitals, thereby delaying treatment and overcrowding the ERs.

Doing so would reap great benefits for Maryland in that our IMDs would have financial stability. They are uniquely qualified to provide specialized care for treatment of psychosis, eating disorders, and dual diagnoses, such as mental illness with developmental disabilities. In addition, the State of Maryland could save millions from the Federal 50 percent matching payment.

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's §1115 Waiver Renewal Application (2021)

Eichenberger, Marianne L. <MEichenberger@ccbcmd.edu> Thu, Jun 3, 2021 at 7:00 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>

Title: Comments on Maryland's §1115 Waiver Renewal Application (2021)

From: Marianne Eichenberger

I have been a mental health nurse for almost 40 years. As an advocate for clients that are struggling with financial problems or hard to treat mental illnesses, it is imperative that Maryland applies for an IMD Medicaid Waiver for Mental Illness. This revision would include Medicaid coverage for an unlimited number of stays per year, and a 60-day maximum length of stay as long as the statewide average does not exceed 30 days. Short stay hospitalizations are all too often inadequate in the provision of necessary care for clients with treatment resistant mental illnesses, psychotic illnesses, neuropsychiatric illnesses, or dual diagnosis (Mental Illness plus substance abuse or developmental disabilities). This could benefit Maryland by providing financial stability for Maryland IMD's (specialty units that care for clients described above) and saving Maryland many millions of dollars by receiving the federal 50% matching payment.
Thanks,

Marianne Eichenberger, RN, PhD

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's S115 Waiver Renewal Application (2021)

1 message

Amy <ohbehaveamy@gmail.com> Thu, Jun 3, 2021 at 7:56 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>

From:

Amy Kerr

592 Riverside Drive

Pasadena, MD 21122

My name is Amy Kerr, and I am a caregiver and mother to my adult son who suffers from a serious neurological brain illness, schizophrenia paranoid type. Today I am requesting Maryland's application for an IMD Medicaid Waiver for Mental Illness be revised to include Medicaid coverage of unlimited number of stays per year, and a 60 day maximum length of stay as long as the statewide average does not exceed 30 days.

My son was admitted 3 times within 3 months when he first presented in florid psychosis. Each and every time we waited no less than 47 hours, in a padded room, with a guard, awaiting an available bed. Each and every time, no treatment was administered until he was transferred to a psychiatric facility. Each and every time, after 4 days he was released. He was a danger not only to myself, and himself, and to family members as well. Each and every time I took off work, attended family meetings, observed my sons disturbing behaviors, and was told he is ready to come home. Each and every time he came home, and I was the medication manager, social worker, psychiatric nurse, advocate, and therapist for my son. He went through 13 medication changes in the last 10 years.

Part of the problem is that the state of Maryland has been paying hospital for Medicaid Patients, but payment has not always been adequate and future funding is insecure. Under the IMD Waiver for Serious Mental Illness, Medicaid and the sate would share the cost equally, saving Maryland millions of dollars. The waiver for my son would ensure , immediate access to hospitals which could keep him, until he is stabilized.

Currently the state discourages admission of Medicaid patients ages 21-64 to IMD hospitals by requiring an ER to first get refusals from the inpatient unit of 5 general hospitals, thus increasing wait times. The longer a person remains in psychosis the more damage is done to the brain. You can not imagine watching your son suffer for 48 hours in a padded room, with a guard, before he's even moved to a hospital that can care for him. Plain and simple this practice is like letting a patient have a full blown heart attack, in a padded cell, with a guard, while waiting for 5 hospitals to refuse care. This is blatant discrimination.

Again I requesting Maryland's application for an IMD Medicaid Waiver for Mental Illness be revised to include Medicaid coverage of unlimited number of stays, financial stability for Maryland IMD's , and accept the 50% matching payment.

Thank you,

Amy Kerr

Sent from Mail for Windows 10

CareFirst BlueCross BlueShield
Community Health Plan Maryland
PO Box 915
Owings Mills, MD 21117
carefirstchpmd.com

CareFirst Community Health Plan Maryland

June 3, 2021

Ms. Tricia Roddy
Deputy Medicaid Director
Office of Health Care Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Dear Tricia:

Thank you for the opportunity to provide comments in support of Maryland's Section 1115 HealthChoice Demonstration Waiver. The waiver proposes to make changes to three existing waiver programs, including expanding slots from 600 to 900 under the Assistance in Community Integration Services (ACIS) Pilot, expanding eligibility from age two to age three under the Home Visiting Services (HVS) Pilot for High-Risk Pregnant Women and Children, and including providers in contiguous states for Residential Treatment for Substance Use Disorder (SUD). The waiver also proposes three new programs, including the expansion of Institutions of Mental Disease (IMD) Services for Adults with Serious Mental Illness (SMI) and implementation of the Maternal Opioid Misuse (MOM) model and Emergency Triage, Treatment, and Support (ET3) model.

CareFirst exists first and foremost to provide accessible and affordable health coverage to the communities we serve. We are committed to driving the transformation of the healthcare experience with and for our members and communities, with a focus on quality, equity, affordability, and access to care. CareFirst believes the waiver is aligned with this vision, and we fully support all the changes to existing programs and proposed new programs.

We support the changes to the ACIS pilot, HVS pilot, and Residential Treatment for SUD; these proposals all aim to increase access to and quality of health care services for low-income Marylanders. We also support the proposed new programs and their innovative strategies to improve health care delivery which are in line with our mission to transform our members' health care experience:

- Expansion of IMD Services for Adults with SMI: CareFirst is acutely aware of the impact the COVID-19 pandemic has had on mental health. Not only does preliminary evidence suggest a significant increase in adults reporting adverse mental health conditions such as anxiety, depression, substance use, and suicide during the pandemic, but new Medicaid and CHIP data also shows a steep decline in use of mental health services among adults and children. We agree access to behavioral health services in our region

needs to continue to be expanded, and this proposal makes significant strides in expanding the continuum of care available to adults with SMI.

- MOM Model: CareFirst looks forward to partnering with MDH to deliver whole person, coordinated care to our pregnant and postpartum members diagnosed with SUD. The model aligns with Maryland's SIHIS goals and our own commitments to improve maternal health and reduce opioid overdoses in our region. We have invested over $20 million in the past decade in maternal health programs across our jurisdictions, and have undertaken several initiatives, including a comprehensive opioid management strategy and workgroup, to develop and implement solutions for SUD.

- ET3 Model: CareFirst supports ET3 and looks forward to understanding how the demonstration improves efficiency and quality of care for Medicaid beneficiaries.

Again, thank you for the opportunity to express our support for the 1115 waiver renewal. We look forward to continuing our partnership with the Maryland Department of Health to improve the access and quality of care for all Marylanders.

Sincerely,

Mike Rapach

President and CEO
CareFirst BlueCross BlueShield
Community Health Plan Maryland

MDAC
Maryland Dental Action Coalition

10015 Old Columbia Road, Suite B-215
Columbia, Maryland 21046
www.mdac.us

June 3, 2021

Ms. Tricia Roddy
Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

Dear Ms. Roddy,

Thank you for the opportunity to comment on the draft application for the 1115 Waiver from the Maryland Department of Health (MDH). The Maryland Dental Action Coalition is in full support of MDH's application, including the provision to continue the Adult Dental Pilot Program, a significant step forward to improving access to dental care for Maryland's most vulnerable adults.

Since the waiver program's launch in June 2019, thousands of dual-eligible adults have received dental treatments, many for the first time in years. In addition, the waiver program has resulted in an increase in the number of Medicaid providers, creating a robust network of clinicians and improving access to oral health care for individuals with disabilities, the population most likely to be dually eligible for Medicaid and Medicare.

The HealthChoice Program supports the well-being of more than 1.3 million Marylanders through equitable access to care. We are grateful to the department for its continued recognition of the importance of oral health to overall health, and to the staff at the Maryland Medical Assistance Program for their efforts and partnership to ensure the success of the Adult Dental Pilot Program.

Thank you again for the opportunity to submit public comments.

Sincerely,

Mary C. Backley
Chief Executive Officer

June 4, 2021

Submitted via email: mdh.healthchoicerenewal@maryland.gov.

Ms. Tricia Roddy
Deputy Medicaid Director,
Office of the Healthcare Financing,
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

Re: DRAFT Maryland HealthChoice Program Section 1115 Waiver Renewal Application

Dear Deputy Director Roddy,

ViiV Healthcare (ViiV), appreciates the opportunity to submit comments to the Maryland Department of Health (DOH) on its Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application 2021.[1]

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people living with HIV (PLWH). From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As an exclusive manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help PLWH to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.[2,3] Furthermore, effective HIV treatment can also prevent the transmission of the disease.[4]

[1] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021 https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[2] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201.
[3] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714.
[4] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 https://dx.doi.org/10.1016/S0140-6736(19)30418-0.

In providing our comments, ViiV wishes to bring attention to the DOH the unique opportunity it has for the waiver's renewal to align with the goals of the nation's public health effort to end the HIV epidemic, which has set a goal to reduce new cases of HIV 90 percent by 2030.[5]

ViiV shared several recommendations with DOH staff during a December 2, 2020 meeting on the topics of HealthChoice antiretroviral (ARV) drug formularies, the Ending the HIV Epidemic (EHE) Initiative,[6] and Maryland's HealthChoice 1115 Waiver extension. As a follow up to that meeting, we submitted our recommendations on these topics to your office. With the draft waiver now out for public comments, ViiV wishes to again share strategies that we believe will help to strengthen the HealthChoice program for enrollees living with HIV and those at risk for acquiring HIV.

HIV and Medicaid

An estimated 1.2 million people in the United States are living with HIV, and at least thirteen percent are unaware that they have the virus.[7] Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of diagnosed and undiagnosed PLWH are retained in medical care, according to the CDC.[8]

Since the earliest days of the epidemic, Medicaid has played a critical role in HIV care since the epidemic began. Nationally, Medicaid is the largest source of coverage for people with HIV.[9] In fact, more than 42 percent of PLWH who are engaged in medical care have incomes at or below the federal poverty level.[10] Medicaid is an essential source of access to medical care and antiretroviral therapy (ART) drug coverage for people living with HIV. This medical care and drug treatment not only preserves the health and wellness of PLWH and improves health outcomes, but it also prevents new HIV transmissions.

In 2019, the U.S. Department of Health and Human Services (DHHS) released the "Ending the HIV Epidemic: A Plan for America (EHE)." [11] This plan proposes to use scientific advances in antiretroviral therapy to treat people with HIV and expand proven models of effective HIV care and prevention. The EHE Initiative[12] is not only a landmark policy by all federal health agencies, it is also supported by the HIV community, and the President's Advisory Council on HIV/AIDS (PACHA).[13] The plan coordinates efforts across government agencies to stop the HIV epidemic, but focuses its efforts on local areas. Seven states and 48 counties with high rates of transmission are targeted by the EHE initiative[14] including three

[5] HIV.gov "Ending the HIV Epidemic" https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview (Accessed: April 20, 2021)
[6] HIV.gov "Ending the HIV Epidemic" https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview (Accessed: April 20, 2021)
[7] Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). http://www.cdc.gov/hiv/library/reports/ hiv-surveillance.html. Published May 2021. Accessed June 2, 2021.
[8] Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). http://www.cdc.gov/hiv/library/reports/ hiv-surveillance.html. Published May 2021. Accessed June 2, 2021.
[9] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/
[10] Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. https://www.cdc.gov/hiv/ library/reports/hiv-surveillance.html. Published June 2019. Accessed February 2021. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf
[11] HIV.gov "Ending the HIV Epidemic" https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview (Accessed: April 20, 2021)
[12] Ending the HIV Epidemic: A Plan for America https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview
[13] Presidential Advisory Council on AIDS (PACHA) Resolution in Support of "Ending the HIV Epidemic: A Plan for America" https://files.hiv.gov/s3fs-public/PACHA-End-HIV-Elimination-Resolution-passed.pdf
[14] Ending the HIV Epidemic Counties and Territories, https://files.hiv.gov/s3fs-public/Ending-the-HIV-Epidemic-Counties-and-Territories.pdf Accessed March 12, 2020.

jurisdictions located in Maryland – the city of Baltimore, Prince George's County and Montgomery County.[15]

In 2019, the DHHS, through the CDC, awarded $13.5 million to state and local planning efforts for the EHE initiative.[16] The targeted jurisdictions in Maryland received new federal funding and additional resources to facilitate EHE efforts, including $492,370 to conduct state and local planning and kick off community involvement for the EHE initiative.[17] Maryland also received seven awards totaling $1,845,933 in FY 2020 for Primary Care HIV Prevention (PCHP),[18] and further funding for the state's Ryan White program.[19] Given the substantial federal investment in, and the focus on Maryland in the EHE plan, we urge DOH to consider new requirements for HealthChoice Managed Care Organizations to embrace these goals through effective programing to expand testing, link HIV enrollees to high quality care & treatment, increase the health plan's viral suppression rates, and expand efforts to increase PrEP use for enrollees at greater risk for HIV.

HIV in Maryland

Maryland remains highly impacted by HIV, ranking 6th among states and territories, in adult/ adolescent diagnosis rate per 100,000 residents.[20] By the end of 2019, there were approximately 31,630 people with HIV in Maryland and an estimated additional 3,830 undiagnosed.[21]

Through June of 2019, Maryland's National HIV/AIDS Strategy Progress Report showed that statewide 85 percent of those identified as living with HIV were linked to care, 75 percent were retained in care, and 61 percent were virally suppressed through 2017. [22] By 2020 the State hopes to achieve increases in all three metrics including 85 percent linkage to care, 90 percent retained in care, and 80 percent virally suppressed.[23]

HIV continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities.[24] In 2018, Black people with HIV comprised 71.1 percent of known cases, 12.7 percent were White, and 7.1 percent were Hispanic/Latinx statewide.[25]

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[15] HIV.gov "Ending the HIV Epidemic" https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview Accessed July, 15, 2019.
[16] HHS.gov, "HHS Awards $13.5 Million to Accelerate State and Local Planning Efforts for Ending the HIV Epidemic: A Plan for America" Press Release, October 2, 2019. https://www.hhs.gov/about/news/2019/10/02/hhs-awards-13.5-million-dollars-to-accelerate-state-and-local-planning-efforts.html. Accessed March 31,2020.
[17] HHS.gov, "HHS Awards $13.5 Million to Accelerate State and Local Planning Efforts for Ending the HIV Epidemic: A Plan for America" Press Release, October 2, 2019. https://www.hhs.gov/about/news/2019/10/02/hhs-awards-13.5-million-dollars-to-accelerate-state-and-local-planning-efforts.html Accessed March 31,2020.
[18] Bureau of Primary Health Care, HRSA.gov, "FY 2020 Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Awards," https://bphc.hrsa.gov/program-opportunities/primary-care-hiv-prevention/fy2020-awards Accessed March 31,2020.
[19] HIV/AIDS Bureau, HRSA.gov, "FY 2020 Ending the HIV Epidemic Awards" https://hab.hrsa.gov/about-ryan-white-hivaids-program/fy2020-ending-hiv-epidemic-awards Accessed March 31,2020.
[20] Quick Maryland HIV Statistics. Maryland Department of Health, 2020https://phpa.health.maryland.gov/OIDEOR/CHSE/Pages/statistics.aspx accessed 12/7/2020
[21] Quick Maryland HIV Statistics. Maryland Department of Health, 2020 https://phpa.health.maryland.gov/OIDEOR/CHSE/Pages/statistics.aspx accessed 12/7/2020
[22] Maryland NHAS Progress Table, Reported through June 30, 2019 https://phpa.health.maryland.gov/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-NHAS-Progress-Table.pdf accessed July 2, 2020
[23] Maryland NHAS Progress Table, Reported through June 30, 2019 https://phpa.health.maryland.gov/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-NHAS-Progress-Table.pdf accessed July 2, 2020
[24] HIV.gov "Standing Up to Stigma" https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma
[25] AIDS Vu Maryland https://aidsvu.org/local-data/united-states/south/maryland/ accessed Jul 1, 2020

Based on the 2016-2017 Maryland HealthChoice Annual Report, Managed Care Organization (MCO) member plans had 6,503 beneficiaries living with HIV.[26] While the report contained only limited HIV data, it did, nevertheless, provide a glimpse into the overall quality of care and services being delivered to people with HIV, as well as the adoption of proven HIV prevention tools—specifically HIV pre-exposure prophylaxis (PrEP). Noteworthy improvements between 2012-2016, included a 4 percent decrease in emergency department utilization and a 5.6 percent increase in CD4 testing.

However, despite these gains, there remain opportunities for improvement in services that align with the State HIV goals and the federal EHE Initiative. For example:

- The percent of HealthChoice beneficiaries who were screened for HIV increased modestly during the five-year demonstration period and by 2016 only 16.2 percent of enrollees were tested.[27] This rate is well short of the CDC's recommendation that everyone between the ages of 13 and 64 get tested for HIV at least once as part of routine health care, and for those with specific risk factors, more often.[28]
- The percentage of all HealthChoice beneficiaries who received PrEP declined and by 2016, only 0.19 percent were on PrEP therapy, a total of 2,983 patients.[29]
- While the percentage of HealthChoice beneficiaries with HIV/AIDS on antiretroviral therapy was 86.8 percent in 2019, only 72.9 percent had received viral load testing in the same year. [30]

In its Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application, the state indicates that, "progress is being made with respect to management of chronic conditions prioritized by the Department such as … HIV/AIDS."[31] While the above data supports this claim to some degree, ViiV believes that there are areas for improvement that if implemented should help to improve the above and other EHE metrics.

We therefore wish to suggest six specific policies to improve the care and treatment of the HealthChoice HIV beneficiaries in the next waiver extension request to CMS:

1. Expand Current Programs to Improve HIV Care Quality by Requiring reporting on HIV Viral Load Suppression (VLS)

In its Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application,[32] the state lists gains in HIV among the program's successes:

> Among individuals with HIV/AIDS, a test for the quantity of immune system cells used to diagnose and monitor HIV/AIDS—referred to as viral load testing—as well as cluster of

[26] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/Health-Choice/md-healthchoice-state-annl-rpt-2017-2018.pdf Accessed July 24, 2020
[27] Same as above. Page 80. Accessed July24, 2020. P. 80
[28] "Getting Tested". CDC https://www.cdc.gov/hiv/basics/hiv-testing/getting-tested.html Accessed July 24, 2020.
[29] Same as citation #21. P. 80
[30] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application, May 4, 2021, page 180, Figure 19. 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 2015–CY 2019: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[31] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application, May 4, 2021, page 7: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[32] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021 https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)

differentiation 4 (CD4) testing rates increased, while emergency department (ED) utilization dropped. [33]

We applaud the state for tracking the percentage of participants screened for HIV and the percentage of HIV patients who have received PrEP and ART. This signals an interest in measuring the feasibility of collecting HIV quality measures, as well as in measuring several steps in the CDC's HIV Care Continuum. We encourage the state to progress its HIV quality efforts to understand not only who has been diagnosed with HIV and linked or retained in care but focus on health outcomes relative to identifying those patients who are/are not virally suppressed.

Viral Load Suppression (VLS) NQF #2082/ NQF#3210e is the quality measure associated with achievement of viral suppression in people with HIV - the ultimate goal of HIV treatment. When a patient is virally suppressed, it means that the virus has been reduced to an undetectable level in the body with standard tests.[34]

We understand the state uses HEDIS measurement, [35] and that Maryland requires HealthChoice MCO member plans to have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services to enrollees. This program must contain a focus on provider networks, utilization of services, and identification and management of individuals with special health care needs, including but not limited to individuals with HIV. While there are no HIV specific measures described within the contract, annual evaluation reports from the Hilltop Institute at the University of Maryland include HIV-specific metrics. We urge the state to require MCOs to report the viral suppression rates publicly and to CMS.

Many states use contracts between Medicaid agencies and Medicaid Managed Care Organizations (MMCOs) to deliver health benefits and services to beneficiaries while reducing care costs and utilization.[36] Several state Medicaid programs have linked HIV quality measures to MMCO performance, thus incentivizing achievement of viral suppression for people with HIV. For example, the New York State's Ending the Epidemic Plan recommends that HIV providers, facilities, and managed care plans report and monitor viral suppression rates and provide financial incentives for performance. [37] Consequently, New York State's Department of Health requires that MMCOs report HIV-specific measures, including Viral Load Suppression (VLS), and awards financial incentives based on performance on these HIV metrics.[38] New York MMCO's efforts have significantly improved rates of viral suppression among Medicaid beneficiaries; by linking many people with HIV to care the MMCOs report that more than 40 percent of their Medicaid beneficiaries have achieved viral suppression.[39]

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[33] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021, page 7: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[34] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression.
[35] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021, page 7: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[36] Medicaid. Managed Care. Retrieved from https://www.medicaid.gov/medicaid/managed-care/index.html
[37] New York State Department of Health. 2015 Blueprint. Retrieved from https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf
[38] NASHP. December 2017. Prioritizing Care: Partnering with Providers and Managed Care Organizations to Improve Health Outcomes of People Living with HIV. Retrieved from https://nashp.org/wp-content/uploads/2017/09/HIV-Affinity-Provider-MCO-Engagement-Brief.pdf
[39] New York State Department of Health. Ending the Epidemic Progress Report: March 2018. Retrieved from https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Executive_Summary_2018_.pdf

Louisiana's Medicaid managed care program, Bayou Health, has included the VLS outcome measure in its contracts with MMCOs. To further drive improvement, the MMCOs have incorporated resources from the Louisiana Office of Public Health's (OPH) STD/HIV Program into disease management programs after the state added measures to their contracts. This participation by the MMCOs in supporting HIV care and treatment programs has achieved 79 percent viral suppression among people with HIV engaged in medical care in Louisiana.[40]

For states that have difficulty in measuring VLS, retention in care for people with HIV could serve as an alternative measure of high-quality HIV care. People with HIV who receive long-term clinical care are more likely to begin antiretroviral therapy and achieve viral suppression, dramatically lowering the risk of transmitting HIV to others.[41,42,43] Conversely, people with HIV who are diagnosed but not retained in medical care transmit the virus to an average of 5.3 people per 100-person years.[44] Because long-term HIV care is strongly associated with viral suppression and optimal health outcomes for people with HIV, states should consider measuring retention in care as an initial step in HIV quality measurement, and move towards the goal of VLS measurement and reporting.

State governments are important partners in preventing and combating HIV through quality initiatives and reporting. HIV quality measures are critical to elevating the importance of the care and treatment of people living with HIV and for reducing the incidence of new HIV infections.

2. Require HealthChoice Managed Care Organizations to Align their Antiretroviral Formularies to Maryland's AIDS Drug Assistance Program

We note that the Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application, includes an interim evaluation by the Hilltop group.[45] Although the evaluation provides a useful look at some aspects of the program, the report only captures the program up to year 2019,[46] and so, does not provide a complete look at changes to the drug formulary coverage in the program that have had a significant and negative effect on HIV access to treatment within some MCO plans. For example, most of the DHHS HIV Treatment Guidelines regimens that are recommended by the panel for initial HIV treatment [47]are listed as nonpreferred agents on Maryland Physician's Care drug formulary.[48]

[40] Louisiana HIV/AIDS Strategy 2017-2021, published by the Louisiana HIV Planning Group; August, 2016. Accessed at https://www.louisianahealthhub.org/wp-content/uploads/2018/10/LouisianaHIVAIDSStrategy.pdf
[41] Crawford TN (2014). Poor retention in care one-year after viral suppression: a significant predictor of viral rebound. *AIDS Care. 26*(11):1393-9. https://www.ncbi.nlm.nih.gov/pubmed/24848440
[42] Yehia BR, French B, Fleishman JA, Metlay JP, Berry SA, Korthuis PT, Agwu AL, Gebo KA (2014). Retention in care is more strongly associated with viral suppression in HIV-infected patients with lower versus higher CD4 counts. *Journal of Acquired Immune Deficiency Syndromes. 65*(3):333-9. https://www.ncbi.nlm.nih.gov/pubmed/24129370
[43] Robertson M, Laraque F, Mavronicolas H, Braunstein S, Torian L (2015). Linkage and retention in care and the time to HIV viral suppression and viral rebound – New York City. *AIDS Care. 27*(2):260-7. https://www.ncbi.nlm.nih.gov/pubmed/25244545
[44] Skarbinski, et al. "Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States," *JAMA Intern Med*. 2015;175(4):588-596.
[45] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021 https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[46] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021 https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)
[47] Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/what-start-initial-combination-regimens-antiretroviral-naive Accessed June 3, 2021.
[48] MPC HIV Quick Reference Guide https://mk0marylandphyssm418.kinstacdn.com/wp-content/uploads/2020/12/MPC_Providers-HIV_Drug-_Chart_Quick_Reference_Guide.pdf Accessed June 3, 2021

ViiV was disappointed when DOH decided to carve-in antiretrovirals to HealthChoice MMCOs at the beginning of 2020.[49] We believe eliminating the risk for ARV coverage by the MCO plans was a best practice that provided HealthChoice beneficiaries and their providers access to a full complement of ARV drugs and timely access to new treatment innovations without having to go through an often, unnecessary and time consuming prior authorization process.

In one study, people with HIV who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality.[50] Drug benefits for people with HIV and other complex medical conditions should be given special consideration within system efforts that may create potential disruptions in access to necessary medications. Given the tendencies for fluctuations in eligibility for the Medicaid population, we encourage policies that promote continuity of coverage for people with HIV in order to prevent potential disruptions in care and treatment.

Additionally, as one strategy to advance public health, when successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated. In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy, there were no linked infections observed when the HIV+ partner's HIV viral load was below the limit of detection.[51] The National Institute of Allergy and Infectious Diseases (NIAID) supported research that demonstrated when people with HIV achieve and maintain viral suppression, there is no risk scientifically of transmitting HIV to their HIV-negative sexual partner.[52] Multiple subsequent studies also showed that people with HIV on ART who had undetectable HIV levels in their blood, had essentially no risk of passing the virus on to their HIV-negative partners sexually.[53, 54, 55] As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.[56]

Unfortunately, for people with HIV enrolled in Maryland Physician Care,[57] the health plan has gone in the opposite direction of the state's long held policy of providing open access to all ARV treatments. Instead they have decided to eliminate, as preferred agents, several standard of care medicines as outlined in the DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS Treatment Guidelines) [58] and implement strict prior authorizations on non-preferred agents.

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[49] Maryland Department of Health: Maryland Medicaid Program HIV Service Delivery page 3. https://mmcp.health.maryland.gov/Documents/MMAC/2019/10_October/HIV%20Drug%20Carve-In.pdf Accessed November 13, 2020.

[50] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1

[51] Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 http://dx.doi.org/10.1016/S0140-6736(19)30418-0 .

[52] NIAID, https://www.niaid.nih.gov/news-events/science-clear-hiv-undetectable-equals-untransmittable. Accessed April 30, 2021

[53] Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. BMC Public Health. 2014; 14: 917. doi: 10.1186/1471-2458-14-917.

[54] Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. N Engl J Med 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693.

[55] "HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention" National Institute of Allergy and Infectious Diseases https://www.niaid.nih.gov/diseases-conditions/treatment-prevention.

[56] Centers for Disease Control and Prevention (CDC) "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV" https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html Accessed September 20, 2019.

[57] MPC Quick Reference HIV Drug Chart https://www.marylandphysicianscare.com/content/dam/centene/maryland/pdfs/hiv-carve-in-chart.pdf

[58] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, HIV.gov https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/what-start-initial-combination-regimens-antiretroviral-naive Accessed June 3, 2021.

ViiV believes that this is an unintended consequence of DOH's decision to carve ARV's back to managed care. Nevertheless, as a result of this decision, people with HIV who are enrolled in one of the HealthChoice nine contracted MCO's are subject to dramatically different drug benefits based on their plan membership.

We therefore ask DOH to consider one-of-two remedies:

- Require HealthChoice MCOs to align their ARV formularies to the Maryland AIDS Drug Assistance Program in order to prevent interruptions in a patient treatment when patients move from one source of coverage to another; or
- The Department of Health should have a minimum standard before approving HealthChoice ARV formularies. ViiV encourages the state to refer to the DHHS HIV Treatment Guidelines [59] as a minimum standard for all policy decisions that affect access to HIV drug treatment. Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are updated to reflect advances in medical science.

ViiV Healthcare supports an open formulary for ARV treatment so that an appropriate treatment decision can be made between a patient and their healthcare provider and not subject to a health plans formulary or prior authorization process for non-preferred agents.

3. Improve HIV Testing Rates

Nationally, it is estimated that 40 percent of new HIV infections are transmitted by people who have undiagnosed HIV.[60] The CDC recommends routine opt-out HIV screening in health care settings as a normal part of medical practice, but those with specific risk factors for the disease (such as injection drug users) should be tested more frequently.[61]

In 2018, Maryland's HIV incidence rate was 653 people with HIV per 100,000 individuals.[62] The following year, the State reported that approximately 11.6 percent of people with HIV in Maryland remained undiagnosed, and the majority of new diagnoses come from Baltimore City and Prince George's County.[63]

We encourage DOH to promote routine HIV testing as recommended by the CDC in the goals of the waiver extension given the high rate of new HIV infections in Maryland.

4. Improve Percentage of High-Risk Beneficiaries on PrEP

ViiV encourages Maryland to align with EHE prevention goals by encouraging PrEP coverage by all payers and promoting PrEP utilization by at-risk populations. Use of PrEP by at-risk populations is a key part of the EHE national plan and three Maryland counties were represented in Phase I of the project. Unfortunately, PrEP is an underutilized biomedical tool to reduce the incidence of new HIV cases. In 2019, according to the Center for Disease Control and Prevention (CDC), approximately 23 percent of the

[59] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, HIV.gov https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/what-start-initial-combination-regimens-antiretroviral-naive Accessed June 3, 2021
[60] CDC.gov https://www.cdc.gov/hiv/testing/index.html
[61] CDC. Revised Recommendations for HIV Testing of Adolescents, and pregnant Women in Health-Care Settings. MMWR 2006; http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm
[62] AIDS Vu- Maryland https://aidsvu.org/local-data/united-states/south/maryland/ accessed December 15, 2020.
[63] HIV in Maryland—Fact Sheet September 2018. Maryland Department of Health https://phpa.health.maryland.gov/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-HIV-Fact-Sheet-2019.pdf Accessed July 28, 2020

more than 1.2 million individuals who are in the United States that were indicated for PrEP actually were prescribed PrEP and just over 19 percent in Maryland.[64]

Additionally, the US Preventive Services Taskforce (USPSTF) recently issued a "Grade A" rating of HIV PrEP treatment.[65] The new USPSTF recommendation means that Medicaid programs that cover PrEP without cost-sharing along with other preventive services can receive an FMAP increase under the ACA, similar to coverage of HIV testing.

Therefore, ViiV encourages DOH to identify ways to improve PrEP utilization for at-risk HealthChoice enrollees, including ongoing collaborations with the State Office of AIDS and the three Maryland counties identified in Phase I of the EHE national plan.

5. New Scientific Innovations in HIV Treatment into Medicaid

Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are changed and updated to reflect advances in medical science.

In addition to the most current DHHS Treatment Guidelines[66] as the clinical standard for coverage and treatment decisions, we encourage state officials to become familiar with the latest scientific information on HIV treatment, such as how daily single table regimens (STRs) can improve adherence, two-drug regimens, "treatment-naïve" options, new treatment options for patients with multi-class resistance, and the coming pipeline of long-acting treatments.

ViiV encourages the state to consider how Medicaid will incorporate innovative HIV treatments and preventive therapies in the future, especially those that are administered by physicians or other health care professionals.[67] The first ever long-acting HIV treatments are now available to patients, and their arrival requires new considerations by coverage programs, as it is provider-administered.[68, 69] The long-acting HIV treatments offer an enhanced treatment option for a population which requires high levels of adherence.[70]

6. Maternal Health, Opioid Misuse and HIV

In the Draft Renewal Application,[71] the state shares its ambitious efforts to improve care for pregnant and postpartum Medicaid participants diagnosed with opioid use disorder (OUD) via a CMMI demonstration called the Maternal Opioid Misuse Model (MOM) program. One of the goals is for each participant to receive a minimum of one of the five components of care coordination per month, one of which is

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[64] Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). http://www.cdc.gov/hiv/library/reports/ hiv-surveillance.html. Published May 2021. Accessed June 2, 2021.
[65] US Preventive Services Task Force Final Recommendation Statement, "Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis," June 11, 2019 https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/prevention-of-humanimmunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
[66] DHHS HIV Treatment Guidelines, HIV.gov https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/what-start-initial-combination-regimens-antiretroviral-naive Accessed June 3, 2021.
[67] HIV.gov "Long-Acting HIV Prevention Tools" https://www.hiv.gov/hiv-basics/hiv-prevention/potential-future-options/long-acting-prep
[68] AmfAR "Long-Acting HIV Treatment and Prevention Are Coming" https://www.amfar.org/long-acting-arv/
[69] HIV.gov "Long-Acting HIV Prevention Tools" https://www.hiv.gov/hiv-basics/hiv-prevention/potential-future-options/long-acting-prep
[70] National Institutes of Health (NIH "NIH Trial Evaluates Long-Acting HIV Medication in People Unable to Adhere to Strict Daily Regimens" May 9, 2019: https://aidsinfo.nih.gov/news/2486/nih-trial-evaluates-long-acting-hiv-medication-in-people-unable-to-adhere-to-strict-daily-regimens
[71] Draft Maryland HealthChoice Program Section 1115 Waiver Renewal Application May 4, 2021, page 28: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Medicaid/Maryland%20Draft%201115%20Renewal%20Application%202021_5.4.21.pdf (accessed May 25, 2021)

education about sexually-transmitted infections (STIs) and other infectious diseases including HIV/AIDS preventive health care education.

The opioid epidemic represents a significant public health crisis in the United States, with an estimated 2.1 million Americans having an opioid use disorder in 2016.[72,73] The opioid epidemic also indicates an increased risk of HIV transmission. While many individuals with opioid use disorder start with pills, an estimated 10-20 percent of people who abuse prescription opioids move on to inject opioids or heroin.[74,75] Substance misuse can lead to increases in risky behaviors for disease transmission, and injection drug use in a population can fuel transmission of blood-borne infectious diseases such as HIV.[76] The CDC estimates that 19 percent of the more than 1 million people living with HIV in the United States are injection drug users,[77] and injection drug users accounted for 9 percent (3,425) of new diagnoses of HIV in the United States in 2016.[78] Individuals who inject drugs intravenously in their lifetime are over 30 times as likely to have HIV/AIDS.[79] In 2015, there was an increase in new HIV diagnoses among injection drug users for the first time in two decades.[80] Health officials in some states and regions have reported increased HIV transmissions as a result of the opioid epidemic.[81,82,83] As policymakers and public health officials work towards the goal of "Ending the HIV Epidemic," the impact of the opioid epidemic on these efforts must be considered.

We applaud the state's demonstration for identifying the need and opportunity for HIV education in maternal populations with substance use disorders. However, we encourage the state, in addition to educational efforts, to implement HIV testing within this population, and also to add prevention education specific to HIV around the use of pre-exposure prophylaxis (PrEP).

HIV testing is a vital yet overlooked part of substance use treatment efforts. The CDC recommends routine opt-out HIV screening for all adults, adolescents, and pregnant women in health care settings as a normal part of medical practice, but those with specific risk factors for the disease (such as injection drug users) should be tested more frequently.[84] It is possible that many new HIV infections are not being detected due to a lack of routine testing for those at risk due to the opioid epidemic. Some individuals may not be aware of the highly increased risk factor for HIV due to substance misuse.

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[72] Kaiser Family Foundation HIV and the Opioid Epidemic: 5 Key Points https://www.kff.org/hivaids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/
[73] SAMHSA. 2016 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf
[74] Peters, P., et al. (2016.) "HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014–2015." *New England Journal of Medicine. 375:229-239.*
[75] Van Handle, M., et al. (2016). "County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States." *Journal of AIDS. 73:3, 323-331*
[76] "Drug Use and Viral Infections (HIV, Hepatitis)" National Institute of Drug Abuse, NIH, April 2018 https://www.drugabuse.gov/publications/drugfacts/drug-use-viral-infections-hiv-hepatitis
[77] The National Survey of Substance Abuse Treatment Services (N-SSATS) Report: HIV Services Offered by Substance Abuse Treatment Facilities. https://www.samhsa.gov/sites/default/files/hiv-services-offered-by-sa-facilities.pdf
[78] CDC, HIV Among People Who Inject Drugs, https://www.cdc.gov/hiv/group/hiv-idu.html
[79] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (December 1, 2010). The National Survey on Drug Use and Health (NSDUH) Report: HIV/AIDS and Substance Use. Rockville, MD. https://www.samhsa.gov/sites/default/files/hiv-aids-and-substance-use.pdf
[80] Kaiser Family Foundation HIV and the Opioid Epidemic: 5 Key Points https://www.kff.org/hivaids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/
[81] Northern Kentucky Health Department. Press Release: *"Health Officials See Increase in HIV Infection Among Individuals Who Inject Drugs."* January 9, 2018. https://nkyhealth.org/2018/01/09/health-officials-see-increase-in-hiv-infection-among-individuals-who-inject-drugs/
[82] Massachusetts, Department of Public Health, MDPH Clinical Advisory, HIV Transmission through Injection Drug Use, November 27, 2017 https://hmccreg3.org/wp-content/uploads/sites/90/2017/12/112707ClinicalAdvisory_HIV.pdf
[83] Morbidity and Mortality Weekly Report (MMWR), "Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone — Indiana, 2015" May 1, 2015 https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6416a4.htm
[84] CDC. Revised Recommendations for HIV Testing of Adolescents, and pregnant Women in Health-Care Settings. MMWR 2006; 55 (No. RR-14). Accessible via the web at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

HIV testing as a part of interventions targeting those with opioid use disorder represents an important public health opportunity for both the health of people with HIV and for those at risk for the disease. Studies show that the earlier a person is diagnosed and treated for HIV, the better their health outcomes. Early initiation of antiretroviral therapy significantly improves survival, as compared with deferred therapy.[85] Effective HIV treatment can help people living with HIV to live longer, healthier lives.[86] When treated effectively, HIV can be managed similar to a chronic disease. In an analysis across six major American cities, targeted on-site HIV testing for patients receiving medication for opioid use disorder was projected to be cost saving or highly cost-effective.[87]

The USPSTF and the American Society of Addiction Medicine (ASAM) have both recommended frequent HIV screening for people who inject drugs, as well as screening for HIV while assessing and diagnosing opioid use disorders.[88,89] The CDC recommends HIV screening as routine care for all adults and adolescents, but advocates for more frequent screening for people who inject drugs.[90]

The goal of HIV testing in this population is simultaneously to identify and provide effective care and treatment for HIV-positive mothers, and also to prevent transmission to babies of HIV-positive women. ART can prevent transmission of HIV to a baby. Taking HIV medicine as prescribed throughout pregnancy and childbirth and treating the baby with HIV medication immediately after birth reduces the risk of a mother transmitting HIV to her baby to 1 percent or less.[91]

For pregnant women at high risk for HIV (such as pregnant women with SUD), counseling, education, and utilization of PrEP is an important consideration. According to DHHS, PrEP may offer an effective option to protect mother and baby from getting HIV during pregnancy and while breastfeeding. [92]

For these reasons, ViiV encourages the state to ensure the HIV counseling and education within this demonstration also includes counseling on HIV PrEP and encourages HIV testing for patients consistent with ASAM and CDC guidelines.

Conclusion

Thank you for your considering our recommendations. We look forward to continuing this conversation in the very near future and hope that we can collaborate and partner with the state to improve the lives and

[85] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. N Engl J Med. 2009 Apr 30 National Institutes of Health; US National Library of Medicine https://www.ncbi.nlm.nih.gov/pubmed/19339714
[86] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201
[87] Krebs E, et al. The impact of localized implementation: determining the cost-effectiveness of HIV prevention and care interventions across six United States Cities. *AIDS* 2020, 34:447-458.
[88] American Society of Addiction Medicine (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Accessed at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24.
[89] USPSTF (2019). Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement. *JAMA 321*(23):2326-2336. https://jamanetwork.com/journals/jama/fullarticle/2735345.
[90] Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, Clark JE (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR. 55*(RR14);1-17. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.
[91]HIV.gov "Preventing Mother-to-Child Transmission of HIV," https://www.hiv.gov/hiv-basics/hiv-prevention/reducing-mother-to-child-risk/preventing-mother-to-child-transmission-of-hiv (Accessed May 26, 2021)
[92]HIV.gov "Preventing Mother-to-Child Transmission of HIV," https://www.hiv.gov/hiv-basics/hiv-prevention/reducing-mother-to-child-risk/preventing-mother-to-child-transmission-of-hiv (Accessed May 26, 2021)

health of people with HIV in Maryland's HealthChoice program, and to advance the goals of the EHE in the state. Please feel free to contact me with any questions.

Sincerely,

Steve Novis
Director, Government Relations
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201-306-2394 (c)

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's 1115 Waiver Renewal Application (2021)

rita smith <ritahb3212@yahoo.com> Fri, Jun 4, 2021 at 4:12 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>

After years of recovery, relapse, and mental health emergencies my son, Dylan, died of a heroin overdose at the age of 41. Dylan was diagnosed with addiction at age 15 and a serious mental illness at age 21. Throughout his life Dylan was chronically unemployed, and by age 26 he was no longer eligible for coverage under my health insurance and was without insurance until approved for Medicaid.

Dylan had as many or more than 20 hospitalizations, mostly in IMDs, where he often waited hours and sometimes days in an Emergency Room for an available bed. Once he was finally admitted and became more stabilized he would then often be discharged without a long term plan for transitioning back to his living situation. In the early days of his diagnosis with an SMI, he lived at home and for a precious two years was able to maintain his sobriety. However, he eventually and regularly relapsed and had to find other places to live including homeless shelters and eventually a basement room he rented. During one of Dylan's relapses he committed a sex offense and was incarcerated for several years. Following his release from prison, his options for long term treatment and housing virtually disappeared.

My experience with the futility of trying to help my son leads me to respectfully request that Maryland revise its application for an IMD Medicaid Waiver for Mental Illness. This revision should include Medicaid coverage of an unlimited number of stays per year and a 60 day maximum length of stay as long as the statewide average does not exceed 30 days (that did not have needed specialized care or needed more than 30 days hospital care for stabilization). Such a Medicaid waiver would provide increased financial stability for Maryland IMDs which are unique in providing many specialized services, such as treatment for resistant psychosis, eating disorders, and dual diagnosis of mental illness with developmental disabilities. Such a Medicaid Waiver would also help Maryland save millions of dollars after receiving federal matching payments of 50%.

Maryland citizens, and there are many of us, desperately need these additional resources to improve the long term outcomes for our family and friends with mental illness.

Rita Tonner

12017 Galena Road
Rockville, Md 20852

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland HealthChoice Program Section 1115 Waiver Renewal Application

Dineen, Rebecca (BCHD) <Rebecca.Dineen@baltimorecity.gov> Fri, Jun 4, 2021 at 5:16 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>
Cc: "Tuck, Stacey (BCHD)" <Stacey.Tuck@baltimorecity.gov>

Dear Ms. Roddy,

Thank you for the opportunity to comment on the *Maryland HealthChoice Program 1115 Waiver Renewal Application*. Given Baltimore City's longstanding commitment to the B'More for Healthy Babies (BHB) initiative to reduce infant mortality and improve infant and maternal health, I am very pleased that the Maryland Department of Health (MDH) is continuing to take advantage of the federal opportunity to establish a Medicaid Evidence-Based Home Visiting Pilot program (HV Pilot). We also strongly concur with the Maryland Health Services Cost Review Commission's (HSCRC) recommendations to invest in improving maternal and child health, including through home visiting services, and look forward to guidance from the state. We hope that MDH will consider these comments in developing future policies and guidance.

MDH has the opportunity to improve the health and well-being of many more women, infants, and their families and we believe that the Centers for Medicare & Medicaid Services would support this augmented approach. Below are our comments on how Maryland's HV Pilot can be structured to expand its impact to better support families across the state. The Baltimore City Health Department encourages MDH to:

- **Use the Targeted Case Management State Plan Amendment or Section 1915(b) Authority to Cover Home Visiting Services under Medicaid**
- **Provide State Medicaid Funding for Home Visiting Programs**
- **Increase the Impact of the Home Visiting Pilot by Permitting Jurisdictions to Use Medicaid Funding for Existing Slots**
- **Require Medicaid Managed Care Organizations to Coordinate with HV Pilots**
- **Formally Connect HV Pilots to the Maternal Opioid Misuse Model**

As they have always been, home visiting programs are on the ground meeting families where they are and ensuring they receive the prenatal care, postnatal care, and physical and mental health support services that they need. They are also connecting families to needed social services, which we know is critical to supporting their overall health. This one-on-one interaction is invaluable to families facing multiple life challenges.

Waiver Application. The waiver application notes that 43 families are currently being served through the state's Home Visiting Pilot. While this is a good start, the HV pilot opportunity should be expanded to additional counties and families to fully realize its impact. There are currently home visiting programs in all 24 Maryland jurisdictions, and nearly all women and families who receive home visiting services are enrolled in Medicaid.

There are two significant barriers to jurisdictions' ability to participate in the HV Pilot. As noted in the HSCRC recommendations, the requirement that they must provide the state share of Medicaid matching funds poses a major challenge to already stretched counties and municipalities. In addition, the current structure of the pilot only supports the addition of new home visiting slots and

prohibits funding to cover services provided to families who are currently enrolled in home visiting programs. As evidenced by the low participation rate in the current HV pilot program, these two factors have made it virtually impossible for most Maryland jurisdictions to take advantage of this opportunity.

MDH has the opportunity to improve the health and well-being of many more women, infants, and their families and we believe that the Centers for Medicare & Medicaid Services would support this augmented approach. Below are our comments on how Maryland's HV Pilot can be structured to expand its impact to better support families across the state.

Use the Targeted Case Management State Plan Amendment or Section 1915(b) Authority to Cover Home Visiting Services under Medicaid

We strongly encourage MDH to consider submitting a Targeted Case Management State Plan Amendment, or a 1915(b) waiver, to CMS in lieu of a HV Pilot under the Section 1115 waiver. This aligns with the HSCRC State Plan Amendment recommendation to ensure sustainability for home visiting programs. Many other states have used these Medicaid authorities to cover home visiting services. We believe that using these authorities would enhance the positive impact of home visiting services on women, infants, and families across the state – and would integrate these services into the Medicaid program rather than having to separately administer HV Pilots.

Provide State Medicaid Funding for Home Visiting Programs

The proposed Section 1115 waiver renewal does not include any allocation of state funds to support the HV Pilots; all state Medicaid matching funds must be provided by local jurisdictions. The absence of a state investment in home visiting programs severely limits the potential for success of the HV Pilots. Given the dire economic situation that the country has endured over the past 15 months, and the new availability of critical federal stimulus dollars through the American Rescue Plan, an investment in these programs could not be more well-timed.

State support for home visiting programs in Baltimore City and across the state would help guarantee access to needed services to Medicaid-enrolled women, infants, and their families. We request that Maryland follow other states and make an investment in home visiting because of the positive impact it has on the health and well-being of families. We are encouraged by the Maryland Health Services Cost Review Commission's recommendations to use Maternal and Child Health Population Health Improvement Funds to support Medicaid home visiting services.

Increase the Impact of the Home Visiting Pilot by Permitting Jurisdictions to Use Medicaid Funding for Existing Slots

The state's HV Pilot went into effect in July 2017, with awards to local Lead Entities first granted in November 2017. After 3 ½ years of implementation, only 43 families in two counties are enrolled in an HV Pilot. However, the 2020 Maryland MIECHV Home Visiting Needs Assessment found that demand for home visiting services is actually greater than the current capacity of programs. It identified 10 jurisdictions that are "at-risk", compared to five that were found to be at-risk in the 2010 Needs Assessment. The HV Pilot can and should be leveraged to help meet this demand.

In order for the HV Pilot to maximize its impact and enrollment, we request that jurisdictions be permitted to leverage Medicaid funding for existing home visiting slots as well as for new slots. Providing Medicaid funding to home visiting programs will enable them to enhance their current

services for Medicaid-enrolled women, infants, and families – it will also enable them to expand and add home visiting slots over time to help more Medicaid enrollees. Without making this change, it is unclear how MDH plans to increase enrollment and expenditures for the HV Pilot as demonstrated in the waiver application Appendix A.

Require Medicaid Managed Care Organizations to Coordinate with HV Pilots

Medicaid managed care organizations (MCOs) play a critical role as the infrastructure of the state's delivery system. However, to date, MCOs have not played a connecting role in facilitating access to home visiting services for their members. Home visiting programs provide intensive services to Medicaid enrollees, who are also generally MCO members. Although MCOs have case management departments, the support they provide is low-touch; many of these women and families need more intensive care coordination, health, and social service support. Since this is a pilot program, the 1115 renewal is a ripe opportunity for building these formal connections, collecting and analyzing performance measures, and working together to support women, infants, and families get a healthy start.

Additionally, HV Pilots can play an important role in supporting MCO HEDIS measures related to maternal and infant health, particularly for prenatal visits, first trimester prenatal care and birth weight outcomes, as well as contraceptive care rates.

If MCOs are not required to engage, and/or do not have an incentive to coordinate with HV Pilots, we are concerned that the HV Pilots will not be able to reach their full potential. This has proven to be the case in the Garrett County HV Pilot. The ability for home visiting programs to connect with MCOs is critical to the success of these HV Pilots and to improving maternal and infant health.

Formally Connect HV Pilots to the Maternal Opioid Misuse Model

We are pleased to see the inclusion of the Maternal Opioid Misuse (MOM) model pilot in the Section 1115 waiver renewal application. We in Baltimore City and through BHB are committed to supporting pregnant and postpartum women who have opioid use disorders, as well as their babies. While we appreciate that the 1115 waiver application mentions that MCO case managers will work with participants to develop an individualized plan when transitioning off MOM model services, we encourage MDH to consider how existing on-the-ground care coordination efforts, HV Pilots, and home visiting services could play an integrated role in working with MCOs and families – to identify women who need services and to help them access needed services. As previously noted, we believe that it is critical for MCO and local efforts should be connected and coordinated to best support women and families.

Finally, particularly given the events of the last year between the impacts of the COVID-19 pandemic and calls for racial justice, we call on MDH to continue to expand efforts across all of its programs to strive for health equity across the state.

Thank you again for your consideration and for the opportunity to comment on the state's proposal. Please reach out to Rebecca Dineen at 443 562 0910 you would like to discuss my comments.

Sincerely,

Rebecca

Rebecca S. Dineen, MS

Assistant Commissioner

Bureau of Maternal & Child Health

Baltimore City Health Department

rebecca.dineen@baltimorecity.gov

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Read our White Paper on the State of Health in Baltimore

MedStar Family Choice

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June 4, 2021

Ms. Tricia Roddy
Deputy Medicaid Director,
Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

Re: Comments on the Maryland HealthChoice Program 1115 Waiver Renewal Application

Dear Ms. Roddy,

Thank you for the opportunity to comment on the Maryland HealthChoice Program 1115 Waiver Renewal Application. MedStar Family Choice supports the renewal of the Waiver and would like to offer a suggestion to address a challenge common in the Medicaid population - namely access to healthy food. We would propose that this submission of the Waiver include a request to pilot a "Food and Medicine" program for the HealthChoice population. There are active community based organizations in Maryland such as Moveable Feast and Food and Friends that are already working in this space under grants from the Maryland Community Health Resource Commission that MedStar Family Choice has been partnering with to provide services on a very limited scale. Expanding this effort would meet an important need.

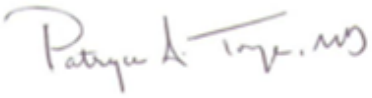
"Food as Medicine" programs are being initiated across the country as a means to improve the health of people with chronic conditions where diet is a significant factor in the outcome of the disease process. Disease appropriate prepared meals is one kind of service often provided. In another version of a "Food as Medicine" program, individuals with diabetes, high blood pressure, obesity, and sometimes pregnant women with inadequate access to food are written "prescriptions" for supplies of fresh fruits and vegetables. The programs vary in length but often extend to 12 months and are accompanied by nutrition education. The "prescriptions" need to be renewed, usually every three months, and thus the program has an added advantage of fostering stronger ties between the individual and the practitioner.

The recent Maryland Diabetes Action Plan called out the need to address diabetes, obesity, prediabetes and women with a history of gestational diabetes as important populations to address to achieve the goal of a healthier Maryland. The Plan documented the racial and ethnic disparities of these conditions in minority populations in Maryland. Additionally, it notes in the section on Social Determinants of Health and Diabetes Risk that food insecurity is a contributor. The Plan goes on to say that unhealthy food and food insecurity are potential areas for intervention.

MedStar Family Choice

Thank you again for the opportunity to contribute to the 1115 Waiver process. We hope that you will consider our suggestion. We would be happy to answer any questions or provide additional information on the topic.

Yours truly,



Patryce A. Toye, MD
Chief Medical Officer, MedStar Health Plans

It's how we treat people.

Tricia Roddy, Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 W. Preston St. Room 224
Baltimore, MD 21201

Director Roddy,

The Treatment Advocacy Center supports Maryland's intention to apply for expenditure authority under Section 1115 of the Social Security Act to cover adult Medicaid recipients receiving treatment for serious mental illness (SMI) in institutions for mental disease (IMDs), but recommends amending its renewal application to broaden the scope of both length of individual stays in an IMD and the number of stays allowed in a year. The expansion of Maryland's 1115 waiver to include psychiatric services for people with SMI will lead to greater access to inpatient psychiatric care. However, amending the application language to reflect what the Centers for Medicare and Medicaid Services (CMS) has approved for other states regarding length of stays in IMDs will lead to even better outcomes for people living with SMI and is within the guidance provided by CMS to every other state that has obtained this authority.

Recommended Changes to the Renewal Application

The renewal application draft requests "expenditure authority to cover Medicaid adults aged 21-64 that have an SMI diagnosis who are residing in a private IMD for up to two nonconsecutive 30-day stays annually." This language is a significant contrast to the six states and D.C. that are already operating under an SMI/SED IMD Exclusion waiver. Specifically, all seven of the other Medicaid departments currently administering these waivers—D.C., Idaho, Indiana, Oklahoma, Utah, Vermont, and Washington—claim FFP for stays of up to 60 days, as long as the statewide average length of stay (ALOS) is 30 days or less.

There are two major differences in the way that other states are using their waivers and the language in Maryland's renewal application draft. First, other states have no limit on the number of stays for one Medicaid recipient in a year. Second, there is no maximum number of days in a year that an individual may receive treatment in an IMD. The only restriction in other states is that the ALOS does not exceed 30 days for all Medicaid recipients receiving services for SMI in IMDs and that states may not claim FFP for single stays exceeding 60 days. This difference in language means that CMS has allowed every other state with authority under the waiver to claim FFP for as many stays in a year as an individual patient needs for a total of as many days as medically necessary. We respectfully recommend that MDH amend the draft before submitting it to CMS to reflect the operative language from other states. Specifically, Maryland can request authority to claim FFP for individual stays up to 60 days, and for more than two stays in a given year, as long as it shows at its midpoint assessment that it is meeting the requirement of a 30 day or less ALOS.

This change in language would mean better outcomes for Medicaid recipients living with SMI and would be within CMS guidance for SMI/SED waivers.

Thank you for considering these comments.

Michael Gray
Legislative & Policy Counsel
Treatment Advocacy Center
graym@treatmentadvocacycenter.org

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's Sec. 1115 Waiver Renewal Application (2021)

Mary Moran <me.moran@verizon.net> Fri, Jun 4, 2021 at 7:22 PM
To: mdh.healthchoicerenewal@maryland.gov

Title : Comments on Maryland's §1115 Waiver Renewal Application (2021)

From: Mary Ellen Moran

1. I am a parent of an adult who is disabled by schizophrenia.

2. As such, I am requesting that Maryland's application for an IMD Medicaid Waiver for Mental Illness be revised to include Medicaid coverage of (1) an unlimited number of stays per year, and (2) a 60 day maximum length of stay as long as the statewide average does not exceed 30 days.

3. My son was admitted to Sheppard Ptratt after a long period of increasingly bizarre behavior. He was treated for six weeks before he was stable enough to be released. He cannot live independently, drive a car, cook or perform other activities of daily living. His health is otherwise very good and his hygiene is excellent. If he were to need hospitalization again for psychosis, I think it is essential that he be treated on an in-patient basis until he is stable, even if it takes 6 or more weeks.

4. Benefits to Maryland :

a. Financial stability for Maryland IMD's which are unique in providing many specialized treatment units such as for treatment- resistant psychosis, eating disorders and dual diagnosis of mental illness with developmental disabilities.

b. State savings of millions of dollars by receiving the federal 50% matching payment.

Your consideration of my comments will be appreciated.

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

§1115 Waiver Renewal Application (2021)

Jill Burgholzer <jillburgholzer@gmail.com> Fri, Jun 4, 2021 at 7:25 PM
To: mdh.healthchoicerenewal@maryland.gov

Greetings,
Please revise Maryland's application for an IMD Medicaid Waiver for mental illness to include Medicaid coverage of unlimited number of stays per year and a 60 day maximum length of stay provided the statewide average isn't greater than 30 days. As a psychiatric nurse practitioner with privileges in 5 hospitals in our state I have seen first hand the issues of excessive emergency department boarding of mental health patients as well as the premature discharge from inpatient units which is both heartbreaking and pervasive. The hours, sometimes days these vulnerable patients have to wait and the significant numbers who are later discharged before they are stable is well documented as evidenced by emergency department logs and hospital readmission rates. In many cases those who wait the longest are also the most vulnerable patients such as our elderly or those with intellectual disabilities making the need for timely, specialized treatment crucial. Patients who are discharged before they are stable can present a significant risk of harm to themselves and or others.
Thank you in advance for your consideration and please feel free to contact me if you have any questions.
Kind regards,
Dr. Jill Burgholzer, DNP, CRNP-PMH, FNP

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Maryland's §1115 Waiver Renewal Application (2021)

Carolyn Knight <ccknight04@gmail.com> Fri, Jun 4, 2021 at 9:00 PM
To: mdh.healthchoicerenewal@maryland.gov

From: Carolyn Knight
Olney, MD 20832

Comments:
I am the sister of an adult man with paranoid schizophrenia. He has been stable for 17 years on depot medication but prior to that was hospitalized repeatedly.

I congratulate the Department on its application for the Federal Medicaid IMD Exclusion Waiver for adults with serious mental illness. Approval of the waiver would help patients gain access to hospitals that specialize in the harder to treat cases and can provide for longer admissions. It takes time to evaluate a patient's needs, taper down medications that are not working, taper up an alternative treatment, and ensure that treatment is working prior to discharge. Discharging someone who is not yet fully stable is a terrible disservice to the individual, the family, and society.

However, it seems short sighted to limit the number of admissions to two (2) for each individual patient. That will be adequate for some but not all. I encourage you to take advantage of the option to request an unlimited number of stays per patient as long as the state average does not exceed 30 days for IMD hospitals. Not only will this provide the most flexibility to individualize patient care, this would be financially beneficial to the hospitals involved, and save the state money.

Thank you for your consideration of my comments.

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Maryland's §1115 Waiver Renewal Application (2021) - comments

1 message

Janet Edelman <jedelman@comcast.net> Fri, Jun 4, 2021 at 11:08 AM
To: mdh.healthchoicerenewal@maryland.gov

My brother has schizophrenia and has been ill for over 50 years. He lives successfully in the community in an RRP, but many people who are sick like he is need hospitalization at times. I have been an advocate for people living with a mental illness for decades and have watched Maryland families struggle to get proper care for their loved ones.

Please revise Maryland's application for an IMD Medicaid Waiver for Mental Illness to include Medicaid coverage of both an unlimited number of stays per year, and a 60-day maximum length of stay as long as the statewide average does not exceed 30 days.

This revision will not only save Maryland money by receiving the federal 50% matching payment when longer or more frequent stays are required, but it will allow some patients who can truly benefit from a longer stay to get more of the treatment that they require. Please revise the section 1115 waiver to take full advantage of the opportunities for Medicaid mental illness coverage offered by the federal government.

Thank you.

Janet Edelman

12038 White Cord Way

Columbia, MD 21044

Tricia Roddy, Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 W. Preston St. Room 224
Baltimore, MD 21201
Deputy Director Roddy,

The Maryland chapter of The Schizophrenia and Related Disorders Alliance of America (SARDAA) supports the Maryland Department of Health's intention to apply for Medicaid expenditure authority to cover psychiatric treatment for people with serious mental illness (SMI) in institutions for mental disease (IMDs). However, we request that the state change its renewal application to claim federal financial participation (FFP) for an unlimited number of stays of up to 60 days each, as long as the statewide average length of stay (ALOS) is 30 days or less per year. This is different from the current language in the draft Waiver Renewal Application that would limit a Medicaid recipient with mental illness to two stays per year of no more than 30 days each. The Maryland Chapter of SARDAA, drawing on both objective information and our personal experiences helping loved ones in need of psychiatric treatment, believes that this change in language would lead to better administrative and medical outcomes.

Some individuals with SMI need more than two hospital stays in a year, especially if some of the hospital stays are extremely short. It is not uncommon for the number of stays to vary widely. Individual stays of more than 30 days are also sometimes required to achieve stabilization. Our members report that it is not unusual for stays in the psychiatric unit of a general hospital (non IMDs) to be extremely short, such as two to five days. For someone experiencing severe psychosis, these short stays are generally inadequate to resolve the psychosis and enable the ability to live successfully in the community. Sometimes several medication trials are needed to find an effective medication that can be tolerated and then many antipsychotics can take four-eight weeks to resolve the psychosis to the point where successful community living is likely.

Longer stays, when medically necessary, help the patient in the short-run by allowing their condition to fully stabilize before being discharged, and in the long-run by decreasing the likelihood that they will quickly be in need of inpatient treatment again. Decreasing the need for future hospitalizations not only helps the patient but will also save money.

The language in the draft application is too restrictive to allow FFP for the necessary amount of time for those patients. For example, if an individual with SMI needed inpatient psychiatric treatment to be stable three different times in one year—one stay of 7 days, a second stay of 14 days, and a third stay of 60 days—only the first two shorter stays would utilize FFP under that draft application. Thus under the current proposed plan, Maryland would only receive FFP for 21 days. Making our recommended change to the application, Maryland would receive FFP for 81 days, resulting in significant savings for the state.

Maryland currently covers the costs of relatively longer stays for Medicaid recipients that are not allowed without a SMI/SED IMD Exclusion Waiver. Currently the state is trying to reduce these expenditures by discouraging placement of Medicaid ER patients in an IMD by requiring five denials from psychiatric units of general hospitals before IMD placement. This highly discriminatory practice delays critical treatment and causes unnecessary suffering and increases the risk of harm to the individual and ER staff. Reducing state costs by maximizing FFP as suggested above, is a much more humane approach to reducing state costs.

The state will continue to miss out on millions of dollars of FFP for stays in excess of 30 days and stays for patients needing inpatient care on more than two occasions annually unless it makes our recommended change to the application. Those general fund dollars are dependent on the legislature and/or gubernatorial administrations that are subject to political circumstances; changing the application to request FFP for stays of up to 60 days, as long as the statewide ALOS is 30 days or less would create a more stable funding source to cover these badly needed medical costs. It is also likely that CMS will accept that broader language because every other state—Idaho, Indiana, Oklahoma, Utah, Vermont, Washington—and D.C. that have the SMI/SED IMD Exclusion Waiver has had identical language approved.

Thank you for considering our comments and request for changes to the Waiver application.

Sincerely,

Evelyn Burton

Advocacy Chair, Maryland Chapter of Schizophrenia and Related Disorders Alliance of America.

Maryland

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov>

Comments on Maryland's §1115 Waiver Renewal Application (2021)

Gina Beck <garnerflowers@gmail.com> Fri, Jun 4, 2021 at 9:32 PM
To: mdh.healthchoicerenewal@maryland.gov

My name is Gina Beck and I care for a close loved one who is 30 years old and suffers from Severe Mental Illness (SMI) - Schizophrenia. It is extremely important that you protect all Maryland citizens suffering from SMI, their families, and Maryland communities by applying for expanded coverage for the IMD Waiver for Serious Mental Illness.

I am requesting that Maryland's application for an IMD Medicaid Waiver for Mental Illness be revised to include Medicaid coverage of;
(1) An unlimited number of stays per year and;
(2) A 60 day maximum length of stay as long as the statewide average does not exceed 30 days.

Seeking long term in-patient care for our loved ones is outrageously difficult in Maryland. Many psychiatrists, psychologists, and therapists do not work with Schizophrenia patients. Many also do not accept Medicaid. Even psychiatric units in many "regular" hospitals lack qualified professionals, and are not equipped or staffed to provide adequate care for seriously mentally ill patients. My loved one and our family have experienced this on multiple occasions.

My loved one suffers from persistent treatment resistant psychosis and requires specialized care. Three day or even seven day stays in a hospital psychiatric unit has proven to do very little to control the psychosis and achieve stability.

Earlier this year my loved one was involuntarily admitted to one of these units. He was forcibly medicated upon arrival, however beyond that the law does not allow for a patient to be forcibly medicated unless court ordered or if he is an immediate threat. On Feb 12 he had a hearing before a judge who ordered that he be held and medicated. The hospital tried to release him prior to seeing the judge, during the hearing public defender tried to convince the judge to release him to a homeless shelter during a pandemic. The medication ordered by the judge did not begin until Feb 16 and on Feb 17 the hospital tried to release him again. They attempted to release him a total of 4 times before his actual release on March 8. Even though, as I understand it, the law allows for a patient to be kept up to six months once admission is ordered by a judge, I had to fight with and threaten the hospital, and my insurance company every day to keep him hospitalized until we could secure a safe place for him to be released to. This takes considerable time and considerable money and does not help anyone!

Taking the action I am requesting will benefit the State of Maryland and it's citizens by providing financial stability for Maryland IMD’s. They are unique in providing many specialized treatment units, such as for treatment resistant psychosis, eating disorders and dual diagnosis of mental illness with developmental disabilities. Maryland will save many millions of dollars by receiving the federal 50% matching payment.

Thank you,

Gina Beck
301-518-2841
Poolesville, Montgomery County, MD

Maryland
Hospital Association

June 4, 2021

Tricia Roddy
Deputy Director, Maryland Medicaid
Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

RE: Maryland Medicaid §1115 Waiver Renewal Application

Dear Ms. Roddy:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, I write in support of the Maryland Medicaid §1115 demonstration waiver renewal application submission.

MHA greatly appreciates the waiver demonstration's renewed focus on population health management, which aligns with Maryland's Total Cost of Care Model. The new Maternal Opioid Misuse (MOM) Model; proposed expansions for the Home Visiting Services Pilot and for the Institutions of Mental Disease (IMD) coverage to include Serious Mental Illness (SMI); and continuation of existing diabetes and substance use disorder programs are essential to Maryland's success in this phase of the Model. They will also be vital as the state looks to enhance its arrangement with the Centers for Medicare and Medicaid Services under the next phase of the Model. These programs are critical to ensure the right stakeholders are actively engaged in advancing positive change for the Medicaid population, which accounts for nearly a quarter of all Marylanders.

We applaud the proposed expansion of IMD coverage to include SMI diagnoses. As noted in the submission, this measure will reduce utilization and lengths of stay in emergency departments among Medicaid participants with such diagnoses. It will also allow patients to access the appropriate, specialized level of care, thereby reducing preventable readmissions to acute care hospitals. In this light, we are concerned with recent restrictions placed on accessing IMD services, which require hospital emergency departments to receive five denials before contacting the state's administrative services organization for placement authorization in an IMD. Such a requirement places significant pressures on hospitals attempting to connect individuals with specialty behavioral health treatment and, more importantly, on the individuals' ability to access vital care. This practice is at odds with the spirit of the waiver, and we urge the Department of Health to rescind the restrictions.

We support the development of the MOM Model, as its objectives align with the goals of Maryland's Statewide Integrated Health Improvement Strategy (SIHIS)—particularly goals focused on total population health, and in relation to opioid use and maternal health. Success under the SIHIS will require all stakeholders to be engaged in improving the health of Marylanders. Hospitals appreciate that this model will charge and empower managed care organizations to target interventions and amplify care coordination efforts for a significant component of vulnerable Marylanders.

We endorse the Medicaid coverage for the Emergency Transport, Triage, and Treatment Model sought in the submission to facilitate a continuation of scale across payers. A subgroup of Maryland's Stakeholder Innovation Group, composed of hospitals, emergency transport professionals, other health care providers, and payers has supported alternative emergency transport programs as viable methods to get patients to the right level of care and to decrease emergency room wait times. Many factors contribute to lengthy emergency department wait times, but one of the main causes is the high volume of visits by non-emergent patients, or patients who could be better served in alternative care settings. Hospitals support the continued development of thoughtful emergency medical service and transport innovations to guarantee accurate patient placement along the continuum of care.

We thank you for your leadership on this effort and for the opportunity to comment. We look forward to working with you on these important issues. Please contact me should you need additional information.

Sincerely,

Maansi K Raswant

Maansi K Raswant
Vice President, Policy

June 4, 2021

Tricia Roddy, Deputy Medicaid Director, Office of Healthcare Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201
Sent via email to: mdh.healthchoicerenewal@maryland.gov

HEALTH CARE for the HOMELESS

Re: Support for Maryland's Section 1115 HealthChoice Demonstration Waiver Renewal

Dear Ms. Roddy:

Health Care for the Homeless writes in support of the Maryland Department of Health (the Department) request to the Centers for Medicare and Medicaid Services (CMS) to renew Maryland's section 1115 HealthChoice Demonstration Waiver (1115 Waiver).

Health Care for the Homeless works to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. We deliver integrated medical care, mental health services, state-certified addiction treatment, dental care, social services, and housing support services for over 10,000 Marylanders annually at sites in Baltimore City and Baltimore County. Since 1985, Health Care for the Homeless has grown from one small clinic in the heart of the city, to multiple clinic sites (downtown, West Baltimore, Baltimore County) and a mobile clinic providing care to seven partner sites throughout the Greater Baltimore area.

While we support The Department's full application, given our extensive work in permanent supportive housing and dental care for our clients, we write in support of two programs in particular:

1. Assistance in Community Integration Services (ACIS) Pilot program; and
2. Adult Dental Pilot Program

We support the extension and expansion of the ACIS program

Health Care for the Homeless is a participating entity in the ACIS program, working collaboratively with the Baltimore Mayor's Office of Homeless Services and the Maryland Department of Health. We currently have 186 enrollees. Through this pilot, we have been able to leverage our strength as a service provider to open up new low-income housing opportunities our clients by providing housing and tenancy-based case management services to individuals formerly experiencing homelessness or those at high risk for institutionalization. These services include assisting clients in locating and maintaining housing in

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@hchomeless

the community. Services are provided by case managers, therapists, and peers to ensure housing stability and integration into the community. This includes both office and home-visits to ensure we 'meet the client where they are' and maintain frequent contact. Clients are also offered the full range of services through the health center including primary care, occupational therapy, dental, and psychiatry.

We know housing works. From our earliest days, we've known that our clients need to be housed in order to get and stay healthy. But public policy said that people with significant medical and behavioral health problems were not "housing ready." Still, we helped our clients apply for governmental disability assistance to secure modest room rentals—and their health and stability improved. Research has since backed up the "housing first" approach and supported our belief that *housing is health care*.

Your home is the most powerful determinant for how long you will live and what quality of life you'll have. Sadly, 75% of the 10,000 people we see each year lack a safe and stable home. On a given night in Baltimore, thousands of people lack a safe, stable place to live and in need of health care. While the annual Baltimore City count of people experiencing homelessness usually shows between 2,500 to 3,000 individuals at a given point in time, this number is likely a significant undercount. This number doesn't include people who are doubling up, staying in hotels or motels or living in another unsustainable situation out of sight of the volunteers conducting the count. It's safe to say that hundreds—if not thousands—more people than the official count lack stable housing each night.

While thousands of our neighbors are experiencing homelessness, thousands more are in danger of losing their homes. Nearly 22% of Baltimoreans—approximately 135,000 people—live below the poverty line ($12,760 a year for an individual, $26,200 a year for a family of four). About 50,000 households pay more than 30% of their income for rent, an amount that makes them housing insecure.[1]

While the problem remains that there is not enough affordable housing, the increased support for people experiencing homelessness through the ACIS waiver has been a lifeline for our clients. Through our permanent supportive housing work, and the ACIS program in particular, overall we see reductions in hospitalizations, improvements in mental health symptoms, and reducing the stress associated with living on the streets or in shelter. In the fall of 2017, we celebrated the opening of Episcopal Housing Corporation's Sojourner Place at Argyle, which is a 12-unit development dedicated to people experiencing chronic homelessness where all residents receive supportive housing services from Health Care for the Homeless. The project has been an unmitigated success, with over 90% housing retention after two years. And in a preliminary study of 22 Health Care for the Homeless clients, spanning one full year before

[1] *See also National Low Income Housing Coalition, Out of Reach 2020: Maryland*, available at https://reports.nlihc.org/oor/maryland.

placement in housing to one full year after, analyzed through Maryland's CRISP health information exchange, we found a 53% reduction in emergency department costs and a 33% reduction in total cost of care.

Maryland is one of the first states to have the Medicaid waiver program and it has been an immense success. The program has proven so successful to health outcomes that in July of 2019, Baltimore area hospitals collectively invested $2 million to cover Baltimore's 50 percent match for the next two years.[2] The funding addresses the costs for a client fund that helps people cover application fees and electric bills for housing units. Hospital systems understand the efficacy of the ACIS program and its critical role in curbing homelessness in Baltimore City.

Combining housing with health care and supportive services helps our clients navigate the dramatic change of regaining housing, often after years—if not decades—without a home. The ACIS program has unquestionably demonstrated improved health outcomes and system-wide cost savings. As such, we **support the Department's request to expand the program and we look forward to working with The Department to hopefully make ACIS permanent Medicaid program**.

We support the extension of the Adult Dental Program

The Department's dental pilot program has been a game-changer for our clients' health and lives. We strongly support continuation of the program and eventually expansion of the program to make dental care a permanent Medicaid benefit.

Oral health care is basic health care.

Dental care is a proven gateway to better overall health, confidence, jobs and even stable housing. Oral disease and tooth loss are associated with an increased risk of death, poor overall health,difficulty obtaining and retaining employment and a decreased quality of life.[3]

In and of itself, these disparities are alarming. But studies show that the cost of NOT delivering dental care is high. Lack of dental care threatens not only the mouth and teeth, but also overall health and quality of life:

- Untreated dental disease causes pain, constant discomfort, drastic changes in diet and a loss of self-esteem.
- Oral disease has been associated with increased risk of cardiovascular disease, stroke and poor diabetes control.[4]

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[2] https://www.bizjournals.com/baltimore/news/2019/07/02/baltimore-hospitals-provide-2-million-to-help-curb.html.

[3] Romandini M, Baima G, Antonoglou G, Bueno J, Figuero E, Sanz M. Periodontitis, Edentulism, and Risk of Mortality: A Systematic Review with Meta-analyses. J Dent Res. 2021 Jan;100(1):37-49. doi: 10.1177/0022034520952401. Epub 2020 Aug 31. PMID: 32866427

[4] *See COVID-19 & the HCH Community: Maintaining Access to Dental Services*, available at https://nhchc.org/wp-content/uploads/2021/04/NHCHC-COVID-Dental-Issue-Brief-April-2021.pdf

- Poor maternal oral health has been correlated both with preterm birth and early tooth decay in children.[5]

Not only can dental infections spread and lead to death, oral health problems can have a negative impacton overall health, particularly for clients who have been diagnosed with cardiovascular disease and diabetes. Studies also demonstrate that dental care during pregnancy is safe and improves maternal oral health and that of their newborn. Moreover, partial or complete edentulism (lacking teeth) makes it difficult to maintain a healthy diet, further compounding the consequences of poor oral health on overall health.[6]

Chronic pain and infection, in addition to lack of access to much needed dental care, drastically affect the lives and general health of clients. Clients rely on routine dental care to maintain functionality, appearances, and self-esteem. Painful or missing teeth can prevent clients from biting into or chewing food properly, obtaining or keeping jobs, going out in public, communicating clearly (verbally or non-verbally), and/or seeking additional behavioral healthor medical care. Dental services are especially crucial in times of crisis and can be provided to clients during COVID-19 in a way that is safe for both clients and staff.

People without homes experience dramatic disparities in oral health outcomes. They report dental care as their most common unmet health need and are 12 times more likely than their housed counterparts to have dental concerns. As many as 90% of individuals who lack housing struggle with untreated tooth decay or missing teeth.[7]

In Baltimore, a city deemed both a Dental Health Professional Shortage Area and a Medically Underserved Area, these barriers put dental care entirely out of reach for adults living in poverty. As a result, people without homes ***wait an average of 5.7 years*** before being able to access dental care.[8]

To meet this urgent need, in 2010, Health Care for the Homeless opened the only dental clinic in Maryland devoted to providing comprehensive dental care to people experiencing homelessness. In the last two years, we expanded from one clinic to three, but the need far outstrips our capacity. **The establishment of the Medicaid dental pilot has been critical in that expansion**. However, at present, just 14% of our 10,000 clients each year are served by our dental clinic.

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[5] *See id.*

[6] *See id.*

[7] Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. 2010. "The unmet health care needs of homeless adults: a national study." American Journal of Public Health: 2010 Jul; 100(7): 1326-33.

[8] Conte, Michael, Hillary L Broder, George Jenkins, Rebecca Reed, and Malvin N Janal. 2006. "Oral health, related behaviors and oral health impacts among homeless adults." Journal of Public Health Dentistry 66(4): 276-278

Despite how critical oral health care is to a person's life and the drastic shortage of dental care for people experiencing homelessness, ***Maryland is one of only 14 states without an adult Medicaid dental benefit***, which compounds the challenges people without homes face when it comes to oral health. People simply cannot afford the dental care they need.

However, with the availability of the The Department dental pilot program, we have seen a tangible difference in the lives of our clients. Being able to see a dentist for the first time in years, if not decades, is a life-changing experience. Whether it's immediate relief from an infected tooth or dentures to restore confidence and the ability to eat healthy foods, dental care is truly transformative. In the links below are a few of the thousands of dental care stories from Health Care for the Homeless:

- Being able to see a dentist regularly has been critical to helping Vanessa strive toward her health, housing and educational goals. Watch her story: https://www.hchmd.org/videos/my-past-not-my-future
- Thomas hadn't had access to a dentist in his entire life, but at 70 years old, he got the dentures that helped him rediscover his infectious laugh: https://www.hchmd.org/news/when-i-laugh-its-big-laugh
- Chris not only got transformative dental care, but through Health Care for the Homeless advocacy efforts, he became a powerful advocate for increased access to dental benefits in Maryland. Read his testimony: https://www.hchmd.org/news/chris%E2%80%99s-message-his-legislators%E2%80%94and-you

Given the vastly unmet demand and the severe consequences for a lack of oral health care in a person's life, **we strongly support The Department's request to continue the dental pilot program**. And we also look forward to working with The Department to make dental care a permanent Medicaid benefit. Thank you for your consideration. Should you have any questions, please don't hesitate to reach out to Joanna Diamond, Director of Public Policy, jdiamond@hchmd.org or 443-838-7876.

JOHNS HOPKINS
MEDICINE

June 4, 2021

Steven Schuh
Deputy Secretary, Health Care Financing
Maryland Department of Health
Office of the Secretary
201 West Preston Street, 5th Floor
Baltimore, MD 21201
Delivered electronically

Dear Mr. Schuh:

Johns Hopkins Medicine (JHM) appreciates the opportunity to comment on the draft Maryland HealthChoice Program §1115 Waiver Renewal Application. Encompassing both the Johns Hopkins Health System and Johns Hopkins Health Care, JHM provides both provider and payer perspectives, respectively. JHM serves thousands of Medicaid recipients throughout Maryland and remains deeply committed to ensuring these patients have access to high-quality care. The Maryland Department of Health (MDH) should be applauded for their work on this application, as the programs outlined in this application do an excellent job of achieving MDH's defined goals. We are supportive of this application, and would like to highlight a few key areas where we believe improvements can be made to impact care and access for Maryland's Medicaid population.

Johns Hopkins Medicine supports the continuation of all existing programs identified in the application, and would like to highlight the importance of the Adult Dental Program and the Collaborative Care Pilot Program. The Adult Dental Program has been in effect since June 1, 2019 and has proven to be incredibly valuable by bringing dental benefits to vulnerable adults. The Collaborative Care Pilot Program is a unique program that creates a positive patient experience by integrating physical and behavioral health services in primary care settings in a patient-centered, evidence-based manner. Notably, both programs provide important care to Medicaid recipients that patients may not have received otherwise.

There is also significant value in the programs requesting modifications. For example, the Assistance in Community Integration Services (ACIS) Pilot is an innovative and comprehensive way to serve high-risk, high-utilizing Medicaid enrollees through patient-friendly home- and community- based services and expanding the program will only create greater access. As a system with two Baltimore City hospitals that participate in a larger hospital collaborative to provide matching funds, JHM believes evaluation of the program would provide Baltimore City

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hospitals and others with greater insight into the Pilot. In addition to this evaluation, it may be helpful to provide information about how matching funds are secured in other jurisdictions.

Expansion of residential services for both mental health and substance use is also a key component of this application. Residential behavioral health services are critical in addressing the needs of those struggling with substance use and mental health issues. Understanding the value of these services, Johns Hopkins Medicine supports the Institutions for Mental Disease (IMD) Waiver proposal to expand residential mental health services to Medicaid recipients 21-64 years of age with a serious mental illness. We also support the State's request to allow Medicaid funds to cover more residential substance use services with the inclusion of ASAM Level 4.0, but would appreciate greater insight into the State's request to include providers from contiguous states as allowable for residential substance use services. This expansion request is likely due to a lack of access to residential services for some Maryland residents, particularly those in jurisdictions that border other states, however a better understanding of this need would be appreciated.

The IMD Waiver is essential to providing a full continuum of care for Medicaid members. The current exclusion has a tremendous impact on the state budget, which ultimately impacts patients. For example, there are limited beds available depending on availability of State funds, which results in long wait times for services or the inability to obtain important care. While Johns Hopkins Medicine is supportive of the IMD Waiver, it should be noted that if Maryland were not a carve-out state for behavioral health services, Medicaid managed care plans would be allowed to cover short-term IMD stays. Johns Hopkins Medicine agrees with the Department's assessment that allowing Medicaid to reimburse IMDs will result in expanded treatment availability, reduce hospital and emergency department utilization and save lives. However, Johns Hopkins Medicine fundamentally disagrees with the State's policy decision to segregate behavioral health care from somatic care. The need to request a waiver from the IMD exclusion highlights the barriers that carve-outs create in achieving integrated, person centered care. Should Maryland continue to pursue a waiver from the IMD exclusion due to the behavioral health carve out, it will be crucial to pursue a fully integrated system of care where somatic and behavioral health care are no longer financed and managed in silos. A single entity is the ideal choice for managing and facilitating high-quality, comprehensive care of the whole person given the considerable overlap between mental health, substance abuse and other medical disorders.

The Emergency Triage, Transport and Treat model, a new Medicaid program in the application, provides greater flexibility to ambulance care teams to address emergency health care needs following a 911 call by allowing for payment for ground transports to alternative destinations such as urgent care providers in addition to the ED. There is significant clinical value in implementing such a model across the State, and Johns Hopkins Medicine encourages the Department to evaluate lessons learned from similar programs as well as collaborate with their MCO partners to determine safe guards are put in place to ensure appropriate utilization of services.

Lastly, Johns Hopkins Medicine would like to recommend two additional considerations for inclusion within the Medicaid program. The first is the CAPABLE program, which provides time-limited services of occupational therapists, registered nurses and a handy worker to help older adults living with disabilities. Currently, the Johns Hopkins Hospital funds CAPABLE to support high risk patients who are discharged home from the hospital. This program has been successful in reducing readmissions, and having CAPABLE as a Medicaid benefit could prevent the initial hospital admission. From a patient care perspective, Johns Hopkins Medicine researchers found that 75% percent of program participants see improvement in their quality of life, and reduction of the impact of their disabilities by half[1]. Additionally, from a payer perspective, CMS evaluators found that this program saves $10k per year per Medicare participant for up to 2 years[2]. Further research found that the CAPABLE program provides similar savings to the Medicaid program[3]. Massachusetts has already added CAPABALE to their Medicaid program and two other states are considering it. Johns Hopkins would fully support Maryland doing so as well due to the first hand benefits we have seen with our patients in CAPABLE.

Johns Hopkins Medicine also encourages the Department to consider programs and strategies to address the dually eligible population, whether through managed care or other innovative dual program options. Frequently, the dually eligible Medicaid participants are the highest cost and highest utilizing members; therefore, developing a unique program for this population could provide benefits to both the State and some of Maryland's most vulnerable residents. Johns Hopkins Medicine welcomes the opportunity to discuss expansion of CAPABLE as well as strategies for the long-term care and dually eligible populations in greater detail, either as part of the §1115 Waiver renewal or through other potential Medicaid coverage options.

Thank you again for the opportunity to comment on Maryland's HealthChoice Waiver renewal application. Johns Hopkins Medicine values our partnership with the Maryland Department of Health and welcomes the opportunity to collaborate on the implementation of programs in the application.

Sincerely,

Kevin W. Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

James P. Holland
President, Johns Hopkins HealthCare

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0140
[2] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1305
[3] https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.15143

MedChi
The Maryland State Medical Society

June 7, 2021

Tricia Roddy
Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 W. Preston Street, Room 224
Baltimore, MD 21201

Via Email: mdh.healthchoicerenewal@maryland.gov

RE: § 1115 Waiver Renewal Application

Dear Ms. Roddy:

On behalf of the Maryland State Medical Society (MedChi), the largest organization representing Maryland physicians and their patients, I would like to express the physician community's strong support for the State's "HealthChoice" §1115 Waiver Renewal Application. Since its implementation in 1997, HealthChoice has consistently achieved its goals of improved coverage and access to care and is structured to pay careful attention to assuring improved health outcomes and program accountability. The continuation of Maryland's current programmatic framework as well as the requested modifications to several existing programs and the addition of three new programs reflected in the proposed Waiver Renewal Application will serve to build upon the strength and responsiveness of the HealthChoice program.

MedChi is pleased to see the State's continued efforts to focus on specific health care service access and delivery systems that directly impact overall health outcomes including the continuation and expansion of several innovative pilot programs. MedChi believes the renewal application reflects the Department's focus on aligning the HealthChoice program with statewide efforts and measures designed to achieve success on population health measures required by CMMI for Maryland's Total Cost of Care Model.

MedChi is particularly pleased to see the continuation of the HealthChoice Diabetes Prevention Program as well as the Collaborative Care Pilot Program. MedChi also supports continuation of the Adult Dental Pilot Program, the Breast and Cervical Cancer Program, increased community services and the hospital presumptive eligibility process. MedChi also applauds the Department for the proposed expansion of the Home Visiting Services Pilot for High Risk Pregnant Women and Children and the Assistance in Community Integration Services Pilot as well as the expansion of coverage of ASAM Level 4.0 services (Residential Treatment for Substance Use Disorder) to include providers in contiguous states.

The new programs reflected in the renewal application are also strongly supported by MedChi. Approval of the request for the State to have expenditure authority to cover Medicaid adults aged 21-64 that have a serious mental illness (SMI) diagnosis that reside in a private Institution of Mental Disease (IMD) recognizes the continuing need to effectively address severe mental illness, not just co-occurring

disorders and will provide the program access to the full continuum of mental health and substance use disorder services necessary to address the continuing escalation of the State's behavioral health crisis.

The Maternal Opioid Misuse (MOM) Model, which originally was approved as a pilot program in St. Mary's designed to reduce the burden and cost of neonatal abstinence and improve maternal health outcomes by providing case management services to pregnant women diagnosed with opioid use disorder, is to transition to become available statewide effective July 1, 2021. The State's request for funding to provider PMPM payments to participating MCOs will enable the provision of these during pregnancy and the postpartum period, thereby dramatically enhancing the effectiveness and cost-savings of the program.

Finally, the Emergency Triage, Treat and Transport Model will provide enhanced flexibility to emergency transport teams to transport patients following a 911 call to the most appropriate destination and still be eligible for reimbursement. This flexibility will directly address the ongoing challenges of providing the appropriate response to behavioral health and other health needs that often trigger a 911 call.

MedChi commends the Department for its commitment to creatively enhance and expand current services. The continuation and expansion of existing programs as well as the implementation of the newly proposed programs will undoubtedly have a substantial impact on the health outcomes of HealthChoice enrollees. MedChi looks forward to working with the Department to implement these initiatives upon approval and is confident they will not only enhance health outcomes but also improve the cost-effectiveness of the HealthChoice program.

Sincerely,

Gene M Ransom III

Gene Ransom
Chief Executive Officer, MedChi

cc: Dennis Schrader, Secretary, MDH
Steve Schuh, Medicaid Director, MDH

Robbyn Lewis
Legislative District 46
Baltimore City

Environment and Transportation
Committee

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THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

10 June 2021

Tricia Roddy, Deputy Medicaid Director
Office of Healthcare Financing
Maryland Department of Health
201 W. Preston St. Room 224
Baltimore, MD 21201

Re: Medicaid IMD Exclusion Waiver

Dear Director Roddy:

I am glad to see that Maryland Medicaid is applying for the Institute for Mental Disease (IMD) Exclusion waiver for Serious Mental Illness/Serious Emotional Disturbance as part of the Section 1115 HealthChoice Demonstration Waiver Renewal. However, I do have some concerns and questions about the scope of expenditure authority Maryland is requesting from CMS.

The draft renewal application requests "expenditure authority to cover Medicaid adults aged 21-64 that have a SMI diagnosis who are residing in a private IMD for up to two non-consecutive 30-day stays annually." Other states have requested different terms, specifically they have asked for federal funds to partially pay for stays of up to 60 days, as long as the statewide average length of stay is 30 days or less. In those states, there is no limit on the number of stays in a year. Furthermore, federal fund participation (FFP) would still apply for hospital days 31-60, whereas Maryland would have to use exclusively state funds for those days. My concern is that Maryland would not receive as much money through FFP as we could to cover these costs.

I appreciate that Maryland Medicaid has the compassion to realize that some people with serious mental illness need stays that would still exceed the limitations of the expenditure authority requested in the draft renewal application, and that Maryland has historically found state dollars to cover what the federal government will not. I also appreciate that you have stated that this administration commits to continuing this policy. However, as a member of the House of Delegates, I must ask why we would leave federal money on the table and continue to cover services with state funds that could be alleviated with federal funds.

If Maryland Medicaid believes that the language in the draft renewal application would result in as much or more FFP as the language approved for other states, please provide me with the data and analysis used to reach that conclusion. I am also interested in learning what the statewide IMD

average length of stay was in the last fiscal year for Medicaid recipients aged 21-64. If Maryland Medicaid has concerns about meeting a 30 day average length of stay requirement, on what data and analysis are you basing those concerns?

I believe a waiver that maximizes federal funding and allows the most possible treatment flexibility according to need will best serve those with SMI and all Maryland taxpayers.

Thank you for your time. I look forward to hearing from you soon.

Sincerely,

Delegate Robbyn Lewis
District 46 – Baltimore City
6 Bladen Street, Room 304
Annapolis, MD 21401
(o)410-841-3772

cc: Del. Shane Pendergrass, Chair, Health and Government Operations Committee
Del. Joseline Peña-Melnyk, Vice-Chair, Health and Government Operations Committee