Draft Maryland HealthChoice Program §1115 Waiver Amendment

Maryland Department of Health

Public Comment
October 7, 2024 to November 6, 2024

Table of Contents

Maryland Section §1115 Waiver Amendment Submission

Section 1: Amendment Introduction and Objectives

In support of its commitment to advancing health outcomes for Marylanders with complex medical and social needs, the Maryland Department of Health (the Department) is requesting an amendment to its existing §1115 HealthChoice Demonstration Waiver (HealthChoice demonstration) (Project Number: 11-W-00099/3).[1] Specifically, Maryland is seeking approval to authorize: 1) an expansion of the existing Assistance in Community Integration Services (ACIS) pilot program; 2) coverage of fertility preservation services; and 3) an expansion of Express Lane Eligibility (ELE) for non-Modified Adjusted Gross Income (non-MAGI) adults. This proposed amendment seeks to implement these services and anticipates their inclusion in the overarching renewal of the HealthChoice demonstration, effective January 2027.

The amendment covers three programs:

- ACIS Pilot Program: Update existing payment methodologies and increase participant spaces to support statewide expansion of housing and tenancy-based case management services to individuals experiencing or who are at risk of homelessness;
- Fertility Preservation: Coverage of fertility preservation procedures for individuals with, or at risk, for iatrogenic infertility; and
- ELE: Implementation of ELE for Maryland's non-MAGI adult population.

These programs are in close alignment with state and federal priorities of not only considering the broad social determinants of health (SDOH) but also focusing on the individual-level health-related social needs (HRSN). Unmet HRSN results in poorer health outcomes as individuals experience issues in accessing critical care and furthers disparities in underserved populations. These three programs will address unmet community needs of Maryland's Medicaid population by expanding housing support services, providing vital coverage for those with iatrogenic infertility, and improving coverage retention and thus health care access for individuals.

Per CMS guidance, CMS will consider components of the previously-submitted amendments for the Reentry Demonstration and ELE for MAGI, as well as the Four Walls waiver extension with this

[1] HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in July 1997 under the authority of §1115 of the Social Security Act. The initial demonstration was approved for five years. In January 2002, the Department completed the first comprehensive evaluation of HealthChoice as part of the first §1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during State Fiscal Year (SFY) 1997, the final year without managed care. The Centers for Medicare & Medicaid Services (CMS) approved subsequent program renewals in 2005, 2007, 2010, 2013, 2016 and 2021.

amendment request.

Section 2: Program Overview

The components proposed under this amendment will expand access to care for individuals with complex medical and social needs. To do so, this amendment aligns with the Moore-Miller mission and two of the 2024 Maryland's State Plan priorities, both related to health and housing: 6. *Making the State of Maryland a Desirable and Affordable Home for All Residents* and 8. *Ensuring World-Class Health Systems for All Marylanders*.[2]

ACIS Pilot Program

The ACIS Pilot Program has been in effect in Maryland since July 1, 2017. Since its launch, this pilot program has expanded from one to four counties, and now seeks to ensure more coverage options across the state.

Over the last decade, the connection between housing and health has become more clear to the health care system and policymakers across the country. Individuals experiencing homelessness have higher rates of illness and die 12 years earlier on average than the general population.[3] Homelessness negatively impacts an individual's physical and mental health and is a strong predictor of poor health outcomes. Access to treatment and preventive care is more difficult for those experiencing homelessness, which often leads to the overuse of emergency departments (EDs) and other inpatient settings.[4] As an early adopter of housing supports options through Medicaid, Maryland understands this connection and has seen the impact that this work has on its residents.

Priority 6 for Maryland's 2024 State Plan has four key objectives. Expansion of the ACIS pilot specifically aligns with Objective 6.3, to *House the most vulnerable*. By providing housing and tenancy-case management services, the ACIS pilot connects qualifying individuals with stable housing supports and options. ACIS also aligns with Objective 8.1, to *Improve eligibility and access to quality care,* under Priority 8, by specifically partnering with community-based organizations, nonprofits and homeless service providers to provide services and collaborate across sectors to address participant needs.

The ACIS pilot provides tenancy-based case management services/tenancy support services and housing case management services to eligible Medicaid participants to assist them in obtaining the services of state and local housing programs. The Department works with local government agencies, known as Lead Entities (LE), to provide a set of home and community-based services (HBCS) to eligible

[2] https://governor.maryland.gov/priorities/Documents/2024%20State%20Plan.pdf
[3] https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf
[4] https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/SummaryReportACISProgramAssessment-September2023-For%20Dept%20%281%29.pdf

participants.

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

1. Health criteria (at least one)
    a. Repeated incidents of emergency department (ED) use (defined as more than four visits per year) or hospital admissions; or
    b. Two or more chronic conditions as defined in §1945(h)(2) of the Social Security Act.
2. Housing Criteria (at least one)
    a. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
    b. Those at imminent risk of institutional placement.

Following three rounds of competitive funding opportunities and the current rolling application process, four LEs have been awarded ACIS participant spaces and currently partake in the pilot to provide services to eligible participants.

In the fall of 2023, the Hilltop Institute published *Assistance in Community Integration Services Program Assessment (Calendar Year (CY) 2018 to CY 2021)*. This evaluation demonstrated positive health and housing outcomes for ACIS participants overall.

Overall, 77 percent of all pilot participants received stable housing. There was also a statistically significant reduction in the mean number of ED visits and inpatient admissions. Additionally, ACIS participants with four or more ED visits in the pre- versus post-ACIS year declined 37 percent[5]. By reaching this high-utilizing population, Maryland has the opportunity to target and close specific health disparities related to housing and ED use.

Additionally, ACIS has higher enrollment with minority populations and has a unique opportunity to affect their individual housing HRSNs. Recent data for the HealthChoice population indicates that 43 percent of the HealthChoice population are Black, 24 percent are Hispanic/Other and 26 percent are white. Male participants represent 47 percent of the population.[6] By comparison, in Hilltop's CY 2018-2021 assessment of ACIS, 58 percent of participants were Black, 21 percent were Hispanic/Unknown/Other and 21 percent were white, with 61 percent of the population being male.

Based on stakeholder requests and the positive evaluation outcomes referenced above, Maryland Governor Wes Moore allocated $5.4 million in State General Funds for the ACIS pilot to expand as a program in State Fiscal Year (SFY) 2025. Previously, state funding was not available for the ACIS pilot;

[5] https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/SummaryReportACISProgramAssessment-September2023-For%20Dept%20%281%29.pdf

[6] https://health.maryland.gov/mmcp/healthchoice/Documents/HealthChoice%20Monitoring%20and%20Evaluation/HealthChoice%20Post-Award%20Forum/2024/Final%20HealthChoice%20Evaluation%20CY%202018-CY%202022.docx.pdf

LEs were required to provide their local dollars to participate in the pilot program and gain access to federal matching dollars. With this funding, the ACIS pilot will transition into a program and provide housing and tenancy-based case management services statewide and allow Medicaid providers to receive reimbursement through the Departmental claiming process.

As of SFY 2024 Q4, 620 of the 900 available ACIS participant spaces have been allocated across the four current LEs. The Department anticipates that the removal of the required local match, now fulfilled by the Governor's State General Fund allocation, will encourage additional LEs to apply to participate in the program. Current LEs and two other jurisdictions have indicated interest in program participation upon the removal of the required local match. The remaining 280 spaces are expected to be allocated to current and new LE applicants during CY 2025.

To further ACIS program sustainability and catalyze expansion, Maryland was competitively selected to participate in the 2024 Housing and Services Partnership Accelerator technical assistance (HSPA TA) opportunity, along with six other states. Convened by the U.S. Department of Housing and Urban Development (HUD) and the Department of Health and Human Services (HHS), the Department is utilizing this opportunity to develop interagency partnerships with the Department of Disabilities, the Department of Aging, and the Department of Housing and Community Development (DHCD), and design strategies to further expand ACIS statewide.

HSPA TA is also supporting Maryland in determining ways to streamline eligibility requirements between programs and ensure strong linkages between the state agencies. TA coaches with significant health and housing policy and program experience are helping Maryland to develop a robust work plan for the year to achieve the key objectives by aligning resources, devising communication strategies as well as determining timelines for implementation. HSPA TA has strengthened the partnership and innovation efforts between Maryland's departments of health, housing, aging, and disabilities to solve some of its hardest challenges in addressing homelessness, housing instability, and health outcomes for the vulnerable, elderly and disabled.

Fertility Preservation Services

House Bill 283–*Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act)*–(Ch. 253 of the Acts of 2023) requires Maryland Medicaid to cover fertility preservation procedures for participants receiving certain gender-affirming services.

In response to this legislation, the State proposes in this amendment to cover these services for all Medicaid eligible participants who have been diagnosed with, or are at risk for, iatrogenic infertility, and whose related treatment may cause a substantial risk of sterility, to receive coverage for fertility preservation services, including storage of sperm and oocytes. This may include Medicaid participants receiving gender-affirming services or cancer treatment, thereby expanding access to the same reproductive services as others and improving their ability to start families.

This amendment will assist the State in bolstering the wellbeing of Marylanders by ensuring a world-class health system for all by aligning with Priority 8 for the 2024 State Plan, *Ensuring World-Class Health Systems For All Marylanders*, specifically Objectives 8.1 *Improving eligibility and access to quality care* and 8.3 *Improving health equity and eliminate disparities*.

The Department notes that implementation of this section is contingent upon enactment of statutory changes by the Maryland General Assembly and availability of State General Funds.

Express Lane Eligibility for the Non-MAGI Population

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorized states to establish ELE to more-efficiently enroll eligible children in Medicaid and the Children's Health Insurance Program (CHIP). ELE permits states to rely on findings, such as income, household size, or other factors of eligibility from another program designated as an express lane agency (ELA) to facilitate enrollment in Medicaid/CHIP. ELAs may include Supplemental Nutrition Assistance Program (SNAP), School Lunch, Temporary Assistance for Needy Families (TANF), Head Start, National School Lunch Program (NSLP), and Women, Infants, and Children (WIC), among others. A state may also use information from state income tax data to identify children in families that might qualify, so that families do not have to submit income information. By decreasing the amount of information and paperwork needed from Medicaid participants, ELE programs increase the likelihood that individuals and families will retain coverage upon renewal.

During unwinding of the continuous eligibility provisions of the Families First Coronavirus Response Act (FFCRA), Maryland received CMS approval under §1902(e)(14)(A) of the Social Security Act to temporarily renew Medicaid eligibility for individuals who are also receiving benefits under SNAP for the non-MAGI population (both children and adults). This authority will expire after June 2025. Medicaid and its sister agency, the Maryland Department of Human Services (DHS), partnered to successfully implement this temporary flexibility. DHS oversees Maryland's SNAP program and manages enrollment and eligibility for the State's non-MAGI participants. Leveraging the (e)(14)(A) authority, the State adopted system enhancements to renew Medicaid eligibility for SNAP participants using gross income as determined by SNAP without conducting a separate income determination.

Although official results are still pending, it is understood that the reduced administrative burden on both MAGI and non-MAGI participants led to individuals more easily keeping coverage, decreased churn, and fewer gaps in coverage. The (e)(14)(A) flexibility resulted in significant improvements to ex parte renewal rates for the non-MAGI population.[7] Maryland has experienced successful ex parte renewals for the non-MAGI population being as high as roughly 80 percent in some months due to the use of SNAP income data.

[7] Ex parte renewal, also known as "autorenewal," refers to Medicaid beneficiaries who can automatically be granted a new 12-month certification period based on information known to the agency, without requiring any action by the beneficiary.

In light of these successes, indicating that barriers to retain health care coverage have been lessened, Maryland seeks to continue this flexibility for non-MAGI adults via this amendment when the (e)(14)(A) authority sunsets on June 30, 2025. The State is pursuing separate SPA authority for the MAGI and non-MAGI child population. Further, ELE aligns closely with Priority 8 for the 2024 State Plan, *Ensuring World-Class Health Systems For All Marylanders*, specifically Objectives 8.1 *Improve eligibility and access to quality care*. Participants continuing to have access to critical health care coverage enables continuity of care for individuals and improves access.

The Department notes that this authority is also being pursued for the MAGI adult population in a previous waiver amendment request, which will be considered alongside the current, non-MAGI, request. Enabling the use of ELE for non-MAGI participants will further align the two Medicaid populations.

Section 3: Requested Policy Changes, Objectives, and Rationale

Assistance in Community Integration Services (ACIS) Pilot

As published in DHCD's 2020/2021 Report on Homelessness, known as the Point in Time Report, homelessness in Maryland was 4,550 in 2021;[8] the Maryland Interagency Council on Homelessness calculated that 5,350 individuals in Maryland experienced homelessness at some point in 2022.[9] This increase in homelessness indicates a growing demand for stable housing and supports for Marylanders. The Department requests an amendment to ACIS' existing Special Terms and Conditions (STCs) to expand the pilot to better serve this population. This expansion is facilitated by an investment by the Moore-Miller Administration of $5.4 million in State General Funds, starting in SFY 2025. To this end, the Department submits a twofold request: 1) update existing payment methodologies to require ACIS LEs to bill through the standard claiming process; and 2) to allow an additional 1,240 participant spaces for the ACIS pilot to facilitate participation from additional jurisdictions within Maryland.

Updated Payment Methodologies

The existing ACIS pilot STCs indicate a local match requirement and outline the manual invoicing process and requirements. The allocation of $5.4 million in the Governor's budget allows the Department to remove the local match component and replace it with State General Funds. With this inclusion of sustainable funding, the Department will require the LEs to enroll as Medicaid providers and bill for ACIS services using the standard claiming process. The Department will create a standard billing code and unit rate based on past pilot expenditures and cost based budgeting.

[8] https://dhcd.maryland.gov/HomelessServices/Documents/2021AnnualReport.pdf
[9] https://homeless.baltimorecity.gov/sites/default/files/MD%20CoC%20PIT%20Report%202022.pdf

Requested Expansion

With the addition of dedicated State General Funds for the ACIS program in the SFY 2025 budget and stronger interagency collaboration to improve housing stability for homeless Marylanders, facilitated by the HSPA TA opportunity, the Department is well poised to expand the ACIS pilot.
Maryland's DHCD is leading the development of a comprehensive Permanent Supportive Housing (PSH) strategy and needs assessment for Maryland, which identifies new funding for housing rental subsidies. They are also building capacity to dedicate more PSH units within affordable housing properties. This work will ensure increased capacity and housing stability for individuals at risk for or experiencing homelessness. The launch of the new PSH strategy will result in an increased demand for housing case management services to support homeless Marylanders.

Based on allocated state funding, positive evaluation results indicated in the pilot overview, interagency collaboration from HSPA TA work and stakeholder requests, the Department is requesting an additional 1,240 participant spaces for the ACIS Pilot, bringing the total cap to 2,140 participants annually. The Department seeks continued authority to waive Section 1902(a)(10)(B) and Section 1902(a)(23)(A) of the Social Security Act to enable the State to provide benefits specified in the STCs to participants enrolled in the ACIS pilot which are not available under the Medicaid State Plan.

The table below indicates the current federal funding participation and new federal funding participation based on the expansion request.

Table 1. Total ACIS Pilot Budget with Increased Participant Cap

	Current Pilot	Requested Addition	Proposed Expansion Budget
State General Funds	$3,600,000 (local match)	N/A	$5,400,000
Matching Federal Funds	$3,600,000	$1,800,000	$5,400,000
Total Pilot Expenditures	$7,200,000	N/A	$10,800,000
Maximum participants served	900	1,240	2,140

Fertility Preservation Services

The Department requests authority to provide fertility preservation services for Medicaid eligible individuals who have been diagnosed with, or are at risk for, iatrogenic infertility, and whose related treatment may cause a substantial risk of sterility, to receive coverage for fertility preservation services, including storage of sperm and oocytes.

"Fertility preservation services" are defined as procedures that are considered medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. "Iatrogenic Infertility" is the impairment of fertility by surgery, radiation, chemotherapy or

other medical treatments or interventions affecting reproductive organs or processes. Examples include, but are not limited to, treatments for cancer and certain gender-affirming procedures. Fertility preservation services are distinct and different from infertility services.

The Department proposes to cover the following fertility preservation services:

- Fertility preservation consultation;
- Fertility preservation procedures such as applicable laboratory assessments, medications and medically-necessary treatments;
- Ovulation induction, monitoring and oocyte retrieval;
- Oocyte cryopreservation and evaluation;
- Ovarian tissue cryopreservation and evaluation;
- Transposition of the ovary(s);
- Sperm extraction, cryopreservation and evaluation;
- Gonadal suppression with GNRH analogs; and
- Storage of cryopreserved sperm and oocytes for up to three years on a non-renewable basis, *i.e.,* a single payment in a one-time increment.

Eligible Medicaid participants under this program must meet the following requirements:

1. The individual is of reproductive age (*i.e.*, between puberty and menopause); and
2. The individual is diagnosed by a reproductive endocrinologist as having an active diagnosis requiring treatment that may cause a substantial risk of iatrogenic infertility.

The Department seeks authority to waive Section 1902(a)(10)(B) to allow Medicaid to provide fertility preservation services to eligible participants which are not available under the Medicaid State Plan.

Express Lane Eligibility for the Non-MAGI Population

The Department requests for ELE authority for renewal purposes effective July 1, 2025, allowing the State to avoid a gap in renewal functionality after the §1902(e)(14)(A) authority expires on June 30, 2025.

Under the ELE process, eligible non-MAGI adults who receive SNAP benefits and meet Medicaid income thresholds may be automatically renewed in Medicaid, contingent on meeting other Medicaid eligibility criteria as defined by the Department. The process applies to the following population, which is a continuation of current §1902(e)(14)(A) waiver authority:

1. Adults aged 19 to 64 whose SNAP verified income is at or below 300 percent of the Federal Benefit Rate (FBR).

The Department seeks to waive Section 1902(a)(10)(A), Section 1902(a)(10)(C)(i)-(iii), and Section 1902(a)(17) of the Social Security Act governing eligibility standards and procedures to enable streamline eligibility procedures for the adult non-MAGI population.

Section 4: Goals and Evaluation Design

Maryland's HealthChoice demonstration evaluation design will be modified to incorporate the proposed changes as relevant and outlined in this amendment proposal.

These programs aim to promote the mission of the Moore-Miller Administration and of the Maryland Medicaid program by improving SDOH and overall access to care. Through the amendment, Maryland Medicaid will promote this objective through the following goals:

1. Expanding housing and tenancy-based case management to reduce unnecessary healthcare utilization and address housing related SDOH;
2. Improving access to medically necessary services; and
3. Reducing the administrative burden on Medicaid participants, diminish churn, and improve customer service by using available eligibility information.

Table 2. Goals and Objectives

Program	Program Goal	Amendment Objective
ACIS Pilot	The goals of the ACIS program are to reduce unnecessary health services use, increase housing stability, and improve health outcomes for Medicaid participants at risk of institutional placement or homelessness.	To expand existing participant spaces and simplify payment methodologies thereby encouraging additional LEs to participate in ACIS and serve more Medicaid participants.
Fertility Preservation Services	The goal of this program is provide these services for eligible Medicaid participants who have been diagnosed with, or are at risk for, iatrogenic infertility, and whose related treatment may cause a substantial risk of sterility, to receive coverage for fertility preservation services, including storage of sperm and oocytes. This may include participants receiving gender-affirming services or cancer treatment, thereby expanding access to the same reproductive services as others and improving their ability to start families.	To improve access to medically necessary services by increasing the number of health care visits and rendered services for Medicaid participants who are diagnosed with, or at risk for, iatrogenic infertility.
Express Lane Eligibility	ELE for the non-MAGI population will reduce the administrative burden, diminish churn, and improve customer service by using available eligibility information, thereby improving participants' health care access, and ultimately their health.	To increase the proportion of non-MAGI adults who are renewed through the ex parte, or automatic, renewal process.

Evaluation Design

The Department will test the following proposed research questions and hypotheses as part of each program's evaluation, in alignment with the goals and objectives of the overall HealthChoice demonstration.

The table below outlines the proposed research questions, hypotheses, and potential data sources for this amendment that would allow the Department to effectively test each of the specific hypotheses.

Table 3. Research Questions and Hypotheses

Program	Research Question	Hypothesis	Potential Data Source
ACIS Pilot	Does the ACIS pilot improve health outcomes for participants?	The ACIS pilot reduces unnecessary health services use, increases housing stability, and improves health outcomes for Medicaid participants at risk of institutional placement or homelessness.	Continue to utilize approved §1115 HealthChoice Demonstration Waiver (Project Number: 11-W-00099/3) evaluation design for the ACIS pilot
Fertility Preservation Services	Do fertility preservation services increase the number of health care visits to address iatrogenic infertility for Medicaid participants?	This amendment will allow individuals who are diagnosed with, or at risk for, iatrogenic infertility to preserve their ability to have children in the future.	MMIS, data from regional health information exchange (CRISP)
Express Lane Eligibility	How does the use of available SNAP data impact the proportion of non-MAGI participants whose coverage is automatically renewed; therefore eliminating the need to complete a manual renewal process?	This amendment will improve health care access for the non-MAGI population by enabling participants to remain enrolled in their Medicaid coverage automatically, without requiring a manual renewal.	State eligibility and enrollment data

Section 5: §1115 Waiver and Expenditure Authorities Proposed for Amendment

The State is requesting the below list of waivers and expenditure authorities pursuant to section 1115(a)(1) of the Social Security Act to enable Maryland to implement the amendment:

Table 4. Waiver and Expenditure Authorities

Waiver Authority	Rationale for Waiver
Section 1902(a)(10)(B) Amount, Duration, and Scope of Services and Comparability	To enable the State to provide benefits specified in the special terms and conditions to HealthChoice demonstration participants enrolled in the ACIS Pilot program which are not available to other individuals under the Medicaid State Plan. To enable the State to vary the amount, duration, and scope of services provided to eligible Medicaid participants seeking fertility preservation services.
Section 1902(a)(10)(A), Section 1902(a)(10)(C)(i)-(iii), and Section 1902(a)(17) - Eligibility Procedures and Standards	To enable the State to use streamlined eligibility procedures for the non-MAGI adult population.
Expenditure Type	**Rationale for Expenditure Authority**
Expenditures Related to Fertility Preservation Services	Expenditures for fertility preservation services, including storage of sperm and oocytes, rendered to eligible Medicaid participants.

Section 6: Demonstration Budget Neutrality

ACIS Program

Based on service utilization to date, if the ACIS pilot program spaces were expanded to 2,140, the Department estimates that it would service an additional 250 ACIS participants each subsequent year of the waiver period.

Pending CMS approval, the Department will expand the cap on the program from 900 to 2,140, and offer ongoing, competitive funding opportunities. Total program expenditures necessary to serve up to 2,140 participants, would require up to $5.4 million in matching Federal Funds requested annually, and when combined with the newly appropriated $5.4 million in State General Funds, ACIS Pilot expenditures would total up to $10.8 million annually.

According to existing STCs, ACIS LEs are required to provide a minimum of three services per month to each ACIS participant to receive reimbursement in a given month. The Department will then pay the LE for the ACIS services per a standard monthly ACIS unit rate which shall be the average cost of the total of a minimum of three ACIS tenancy-based case management services/tenancy support services and housing case management services. Since 2018, the pilot has utilized a cost based budgeting model, with annual, individual budget negotiations to determine each LEs unit rate. Moving forward, the Department will create a standard billing code and unit rate based on past pilot expenditures and the prior cost based budgeting work.

Table 5. Total Anticipated Expenditures with Increased Participant Cap

Amendment Component	Estimated Projected Expenditures				
	DY01*	DY02**	DY03**	DY04**	DY05**
ACIS					
Enrollment	900	1,150	1,400	1,650	1,900
Projected Expenditures	$4,532,999	$5,792,165	$7,051,331	$8,310,498	$9,569,664

*Assumes an effective date beginning July 1, 2025.
**Assumes award allocation of existing 280 spaces during SFY 2025.

Fertility Preservation Services

Multiple conditions have the potential to cause iatrogenic infertility; however, the majority of examples found based on publicly available information are procedures for cancer for those under the age of 50 and as a result of gender-affirming care. A small number of individuals may seek care due to other conditions, such as sickle cell disease. The Department estimates that annually, an average of 1,978 individuals will access these services due to iatrogenic infertility, including 150 individuals following receipt of certain gender-affirming services. The estimated fiscal impact of covering these services is $6,410,118 annually, including the cost for storage of sperm or oocytes.

Table 6. Total Anticipated Expenditures and Enrollment for Fertility Preservation

Amendment Component	Estimated Projected Expenditures				
	DY01*	DY02	DY03	DY04	DY05
Fertility Preservation					
Enrollment	1,978	1,978	1,978	1,978	1,978
Projected Expenditures	$6,410,118	$6,410,118	$6,410,118	$6,410,118	$6,410,118

*Assumes an effective date of July 1, 2025.

ELE for the Non-MAGI Population

Due to the maintenance of effort requirements enacted by FFCRA during the COVID-19 Public Health Emergency, this program will not result in additional costs.

Table 7. Total Anticipated Expenditures and Enrollment for ELE

Amendment Component	Estimated Projected Expenditures				
	DY01*	DY02	DY03	DY04	DY05
Non-MAGI ELE*					
Enrollment					
Projected Expenditures	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

*Assumes an effective date beginning July 1, 2025.

Section 7: State Public Process and Indian Consultation Requirements

Anticipated: To be finalized prior to submission.

Section 8: State Contact Information

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Section 9: Appendices

Appendix A: Summary of Public Comments

Anticipated: To be finalized prior to submission.

Appendix B: List of Attachments

Anticipated: To be finalized prior to submission.

Attachment 1: Budget Neutrality Worksheet
Attachment 2: Public Notice & Indian Consultation Documentation
Attachment 3: Public Comments Documentation

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