



DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

January 2, 2024

The Honorable Pamela Beidle
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

Annapolis, MD 21401-1991
The Honorable Guy Guzzone, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
11 Bladen Street

The Honorable Joseline A. Peña-Melnyk,
Chair
House Health and Government Operations
Committee
241 House Office Bldg.

The Honorable Ben Barnes, Chair
House Appropriations Committee
121 Taylor House Office Building
6 Bladen Street
Annapolis, MD 21401

Re: Report on the “L” codes utilization within the All-Payer Claims Database and cost impact of Orthoses coverage as per the requirements of SB 614 (Chs. 822 and 823 of the Acts of 2024) (MSAR # 15605)

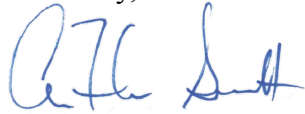
Dear Chairs Beidle, Guzzone, Peña-Melnyk, and Barnes,

In keeping with the requirements of Senate Bill (SB) 614, *Maryland Medical Assistance Program (Medical Assistance) and Health Insurance - Coverage for Prostheses (So Every Body Can Move Act)* (Chs. 822 and 823 of the 2024 Acts), the Maryland Department of Health (MDH), in collaboration with the Maryland Health Care Commission (MHCC), and in consultation with the Maryland Insurance Administration (MIA), respectfully submits this one-time report on the review of the utilization of “L” codes and related codes within the All-Payer Claims Database; as well as, analysis of the cost impact of requiring coverage for orthoses for whole-body health in addition to medical necessity.

This consolidated report addresses the following: 1) existing Medical Assistance coverage and utilization for prostheses and orthoses; 2) commercial market coverage and utilization for prostheses and orthoses; 3) SB 614 expansion of coverage of prosthetics for whole-body health with implications for Maryland Medical Assistance Program and for commercial markets; and 4) study of expansion of coverage of orthotic “L” codes for whole-body health with implications for Maryland Medical Assistance Program and for commercial markets.

If further information about this program is needed, please contact Sarah Case-Herron, Director of Government Affairs at sarah.case-herron@maryland.gov.

Sincerely,

A handwritten signature in blue ink, appearing to read 'LH Scott', written over a light blue horizontal line.

Laura Herrera Scott, MD, MPH
Secretary

cc: Ryan Moran, DrPH, Deputy Secretary, Health Care Financing and Medicaid Director
Tricia Roddy, Deputy Director, Maryland Medicaid Program
Alyssa Brown, Director, Office of Innovation, Research, and Development
Jamie Smith, Director, Office of Long Terms Supports and Services
Sandra Kick, Director, Office of Medicaid Benefits Management Administration
Ben Steffen, Executive Director, Maryland Health Care Commission
Marie Grant, Acting Insurance Commissioner, Maryland Insurance Administration
Sarah Case-Herron, JD, Director of the Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)



**Report on the “L” codes utilization within the All-Payer Claims Database and cost impact
of Orthoses coverage**

Required by SB 614 (Chs. 822 and 823 of the Acts of 2024)

December 2024

Executive Summary

Prosthetic and orthotic devices are assistive devices utilized by individuals who have congenital limb loss or limitation, have experienced amputation, or require devices to assist with mobility and function. Utilization of these devices improves mobility, functionality, independence, and overall quality of life of persons with disabilities who use these assistive devices.

A survey of coverage of prostheses and orthoses across all 50 US states determined that 45 states do not require coverage of these devices for physical activities aside from those determined to be medically necessary, and 29 states do not have payer-wide coverage for prostheses or orthoses for even medical necessity.¹ In Maryland, Medicaid has historically covered prostheses and orthoses when medically necessary to support activities of living in the participant’s home, workplace, or school. Commercial payers have also historically covered prostheses and orthoses via the Affordable Care Act (ACA), the essential health benefits (EHB) under “habilitative services and devices,” and for the large group market under Insurance Article §15-844. While coverage for prosthetic devices for medical necessity is a mandated benefit for both commercial payers and Medicaid in Maryland, coverage of prostheses for whole-body health was not mandated until SB 614, *Maryland Medical Assistance Program (Medical Assistance) and Health Insurance - Coverage for Prostheses (So Every Body Can Move Act)* (Chs. 822 and 823 of the 2024 Acts)², was passed.

SB 614 expanded coverage of prostheses in Maryland when medically necessary for whole-body health effective January 1, 2025. In addition, SB 614 required MDH and MHCC to jointly evaluate the fiscal impact of expanding whole-body health coverage for orthoses through Medical Assistance and commercial payers, respectively. This report provides an overview of historical utilization patterns and costs for prostheses and orthoses through Medical Assistance, as well as estimates of the cost to expand coverage of orthoses for whole-body health by both Medical Assistance and commercial payers.

I. Introduction

This report addresses MDH’s progress to date to assure that the provisions under SB 614 regarding expanding coverage of prosthetic devices for whole-body health will be implemented by January 1, 2025. In addition, this report includes evaluations by MDH and MHCC, in consultation with MIA, on the cost and feasibility of expanding the coverage of orthotic devices for whole-body health. MDH performed the analysis related to financial implications for the Medical Assistance populations. MHCC performed analysis related to implications for the commercial market. MDH estimates that expanding coverage of orthoses for whole-body health will have an annual fiscal impact of at least \$2.9M Total Funds (\$1.1M State General Funds, \$1.8M Federal Funds). Expansion of this benefit within the commercial market is projected to

¹ Malouff, S., et al., (2024). A Multi-State Analysis of the Fiscal Impact of Commercial Insurance Coverage for General-Use & Activity-Specific Prosthetic & Orthotic Devices in the United States. *Medical Research Archives, European Society of Medicine*. <https://esmed.org/MRA/mra/article/view/5104/99193547842>

² Senate Bill 614 - Maryland Medical Assistance Program and Health Insurance - Coverage for Prostheses (*So Every Body Can Move Act*) (Chs. 822 and 823 of the 2024 Acts). <https://mgaleg.maryland.gov/2024RS/bills/sb/sb0614T.pdf>

cost \$3.2M (\$1.22M Fully Insured, \$709K State Health Plan, \$1.25M Local State Govt.) annually for the commercial market (non-Employee Retirement Income Security Act (ERISA)).

II. Background

Individuals who are born without a limb, have lost a limb, or have impaired function of a body part(s) are often prescribed prostheses and orthoses in order to allow them to complete activities of daily living in the home, work, or at school. Examples of prosthetic devices include: artificial devices to replace, in whole or in part, a leg, an arm, an eye, or breast, including surgical brassiere; whereas, orthotic devices are defined as rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.³

One of the key assessments providers use in determining the prostheses or orthoses to prescribe for an individual is an assessment called the Medicare Functional Classification Level (MFCL) (also known as a K-level assessment) which is performed in order to determine the maximum rehabilitation and mobility that an individual could achieve were they to be provided with appropriate physical and occupational therapies as well as prostheses and orthoses.^{4,5,6,7} An individual's MFCL is also used as part of the process of prescribing and reimbursing providers for the aforementioned devices. Studies demonstrate that K-levels can increase as physiotherapies progress, and individuals are more and more able to ambulate and participate in activities.^{8,9,10,11}

³ As described by the The Medicare Benefit Policy Manual (Publication 100-02), Chapter 15, Section 130 reference on the CMS website.

<https://www.cms.gov/medicare/payment/fee-schedules/dmepos/ots-orthotics#:~:text=Section%201847%28a%29%282,not%20require%20expertise%20in%20trimming%2C>

⁴ AHRQ, (2018). Lower Limb Prostheses: Measurement Instruments, Comparison of Component Effects by Subgroups, and Long-Term Outcomes.

https://www.ncbi.nlm.nih.gov/books/NBK531523/pdf/Bookshelf_NBK531523.pdf

⁵ Anderson, K.M., et al., (2021). Custom Dynamic Orthoses and Physical Therapist Intervention for Bilateral Midfoot Amputation: A Case Report, *Journal of the American Physical Therapy Association*.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8054777/>

⁶ Orendurff, M.S., et al., (2016) Functional level assessment of individuals with transtibial limb loss: Evaluation in the clinical setting versus objective community ambulatory activity. *Journal of Rehabilitation and Assistive Technologies Engineering*.

<https://journals.sagepub.com/doi/full/10.1177/2055668316636316#bibr1-2055668316636316>

⁷ AHRQ, (2017). Lower Limb Prosthesis. *Evidence-based Practice Center Systematic Review Protocol*.

https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/prosthesis_research_protocol.pdf

⁸ Gailey, R., et a., (2020). Effectiveness of an Evidence-Based Amputee Rehabilitation Program: a Pilot Randomized Control Trial: *Physical Therapy & Rehabilitation Journal*. <https://academic.oup.com/ptj/article/100/5/773/5707560>

⁹ See e.g., Anderson, K.M., et al., (2021). Custom Dynamic Orthoses and Physical Therapist Intervention for Bilateral Midfoot Amputation: A Case Report, *Journal of the American Physical Therapy Association*.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8054777/>

¹⁰ Jayaraman, C., et. al., (2021). Using a Microprocessor Knee (C-Leg) with Appropriate Foot Transitioned Individuals with Dysvascular Transfemoral Amputations to Higher Performance Levels: A Longitudinal Randomized Clinical Trial. *Journal of NeuroEngineering and Rehabilitation*. <https://link.springer.com/article/10.1186/s12984-021-00879-3>

¹¹ See e.g., Sol-Bi, K., et al., (2017). Relief of Knee Flexion Contracture and Gait Improvement Following Adaptive Training for an Assist Device in a Transtibial Amputee: A Case Study: *Journal of Back and Musculoskeletal Rehabilitation*. <https://content.iospress.com/articles/journal-of-back-and-musculoskeletal-rehabilitation/bmr736>

There is a national effort (*So Every Body Can Move*) to expand coverage of prostheses and orthoses to also allow individuals in need of prostheses or orthoses to participate in activities such as swimming, running, biking, weight lifting, and any other type of physical activity which would maximize the overall health and function of the individual. Prior to the passage of SB 614, coverage for prostheses and orthoses varied by payer. Effective January 1, 2025, SB 614 requires that coverage for prosthetic devices be expanded to include whole-body health uses, which are defined as performing physical activities including: running, biking, swimming, biking, strength training, and other activities to maximize health and lower or upper limb function of the individual. In addition, the legislation required MDH and MHCC to evaluate the cost and feasibility of expanding coverage of orthoses for whole-body health.

III. Prostheses and Orthoses

Medical Assistance - Coverage for Prostheses and Orthoses

Nearly 60,000 Marylanders with Medical Assistance have claims or encounters associated with prostheses and orthoses every year (see Table 1). Historically, Medical Assistance covered orthoses and prostheses when medically necessary for activities associated with daily living including use in the home, work or school. SB 614 expanded the coverage for prostheses (but not orthoses) to include whole-body health. “L” codes for prosthetic and orthotic devices currently covered by Medical Assistance are listed on the [Disposable Medical Supplies and Durable Medical Equipment Fee Schedule](#) (the Fee Schedule).

Medical Assistance - Utilization for Prostheses and Orthoses

The population receiving services through a HealthChoice managed care organization (MCO) utilize the highest volume of services each year; however, FFS participants use prostheses and orthoses at a three-fold higher rate as compared to MCO participants (an average of 4.8 units per FFS participant vs. an average of 1.5 units per MCO enrollee per year). In addition, trends in cost per MCO participant have remained stable for the last three years; whereas, costs per FFS participant have steadily increased (39%) across the same time period.¹² Table 1 on the following page provides data regarding the utilization of prostheses and orthoses by FFS vs MCO participants over three years (Calendar Year (CY) 21-23), as well as the number of units per unduplicated participant, and the overall cost by coverage category per year.

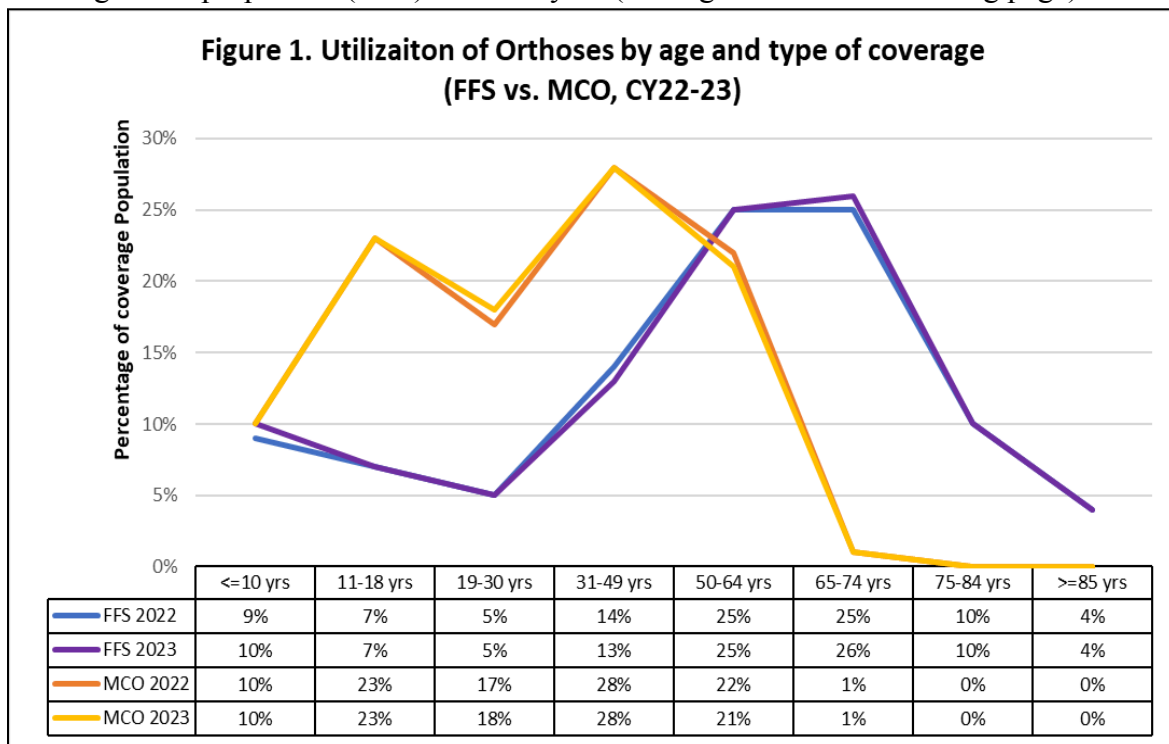
Table 1. Prostheses and Orthoses Utilization, CYs 2021-2023					
CY	Category	Unduplicated Users	Unique HCPCS Used	Total Units	Total Expenditures
2021	FFS	6,403	379	29,470	\$5,927,498
	MCO	50,693	437	78,587	\$15,733,764

¹² MCO cost per participant using prostheses or orthoses: range: \$303 - \$310 CY21-23 vs. FFS cost per participant using prostheses or orthoses: CY21: \$925, CY22: \$1,085, CY23: \$1,284.

Total		57,096	816	108,057	\$21,661,261
2022	FFS	6,346	399	31,115	\$6,884,784
	MCO	53,503	426	78,746	\$16,235,154
Total		59,849	825	109,861	\$23,119,939
2023*	FFS	5,474	353	27,074	\$7,026,846
	MCO	51,128	422	72,263	\$15,804,015
Total*		56,602	775	99,337	\$22,830,860

***Note:** Claims and expenditures for CY23 are subject to runout for FFS claims for 12 months, the total number of unduplicated users, HCPCS codes utilized, total units and total expenditures are not final and may increase once claims run out is complete for CY23.

MDH analyzed utilization by coverage type and age bands and determined that for both FFS and MCO categories, orthoses utilization is seen across all age groups. Among FFS users, individuals aged 50-64 years and 65-74 years accounted for the greatest proportion (25 - 26%) of unique users in CY22 and CY23; whereas among MCO participants, the group aged 31-49 accounted for the greatest proportion (28%) use each year (see Figure 1 on the following page).



Commercial Markets - Coverage for Prostheses and Orthoses

MHCC currently is not authorized to enforce coverage for prostheses and orthoses. Under SB 614, MHCC used the Maryland Medical Care Data Base (MCDB) containing insurance claims for Medicare, Medicaid, and the commercial market to assess utilization and payment trends.

Commercial Markets - Utilization for Prostheses and Orthoses

MHCC studied the utilization of prostheses and orthoses by individuals with commercial insurance. MHCC compared two categories of commercial insurance: 1) “public” insurance market segments which include: (i) State Employees and retirees, and (ii) Local State Government (Cities, county government); and 2) “non-public” insurance market segments which includes the following: 1) Individual Market (individual private insurance, mainly under the ACA for all non-grandfathered plans), 2) Small group (2 - 50 employees); and 3) Large group or private employer-sponsored groups (51+ employees).

On average, individuals enrolled in the public insurance market segments utilize prostheses and orthoses at a rate twice as high than those enrolled in non-public insurance market segments (97 units per 1,000 insured members per year as compared to 47 units per 1,000 respectively). Unit cost trends demonstrate variations across markets between CY21 – 23, with average cost per unit

increasing from \$162 in CY21 to \$172 in CY23; however, when these unit costs are evaluated across total utilization and unduplicated individuals, the unit cost shows a consistent reduction in unit cost (CY21: 3.4% down to 3.0% in CY23). Table 2 provides additional information.

Table 2: Prostheses and Orthoses Utilization, CY21-23													
Year	Market	Unique Individ.	Unique CPTs	Total Units	Total Units/1,000	Plan Paid Costs	Cost-Sharing Expenditures	Total Cost	Total Costs PMPM	Unit Cost	Total PMPM Trends	Utiliz Trends	Unit Cost Trends
2021	Individual	6,857	241	11,566	58	\$893,525	\$1,078,402	\$1,971,927	\$0.83	\$170	21.6%	20.5%	0.8%
	Small Group	10,522	277	17,359	65	\$1,485,696	\$1,412,069	\$2,897,765	\$0.91	\$167	0.3%	-3.8%	4.2%
	Large Group	13,133	249	21,477	40	\$2,138,007	\$1,251,161	\$3,389,168	\$0.53	\$158	15.4%	9.1%	5.8%
	State_Employee	11,528	303	21,279	92	\$3,461,164	\$129,675	\$3,590,839	\$1.29	\$169	-6.3%	-11.4%	5.8%
	Non_State_Employee	23,820	258	45,474	104	\$6,787,498	\$355,480	\$7,142,978	\$1.37	\$157	16.2%	15.0%	1.0%
	Student Health Plan	143	26	222	12	\$23,232	\$16,790	\$40,022	\$0.18	\$180	42.2%	87.3%	-24.1%
	Total	66,003	424	117,377	70	\$14,789,122	\$4,243,577	\$19,032,699	\$0.94	\$162	12.9%	9.1%	3.4%
2022	Individual	6,734	241	11,292	55	\$885,292	\$1,072,887	\$1,958,179	\$0.80	\$173	1.7%	-4.8%	1.7%
	Small Group	10,023	270	15,903	61	\$1,252,796	\$1,358,315	\$2,611,111	\$0.84	\$164	-1.6%	-6.1%	-1.6%
	Large Group	12,158	249	19,592	32	\$1,903,442	\$1,187,833	\$3,091,275	\$0.42	\$158	0.0%	-20.0%	0.0%
	State_Employee	11,043	303	20,526	93	\$3,342,144	\$146,817	\$3,488,961	\$1.32	\$170	0.7%	1.4%	0.7%
	Non_State_Employee	21,066	258	39,763	83	\$6,222,187	\$559,317	\$6,781,504	\$1.18	\$171	8.6%	-20.6%	8.6%
	Student Health Plan	116	26	177	9	\$17,045	\$7,535	\$24,580	\$0.10	\$139	-23.0%	-23.3%	-23.0%
	Total	61,140	424	107,253	60	\$13,622,906	\$4,332,704	\$17,955,610	\$0.83	\$167	3.2%	-14.1%	3.2%
2023	Individual	6,826	241	11,613	55	\$829,923	\$1,086,329	\$1,916,252	\$0.75	\$165	-4.8%	-1.0%	-4.8%
	Small Group	9,787	195	16,077	66	\$1,571,479	\$1,351,665	\$2,923,144	\$1.00	\$182	10.7%	7.7%	10.7%
	Large Group	8,968	249	14,416	38	\$1,590,821	\$790,371	\$2,381,192	\$0.53	\$165	4.7%	19.3%	4.7%
	State_Employee	11,638	303	22,302	96	\$3,823,630	\$138,371	\$3,962,001	\$1.43	\$178	4.5%	3.7%	4.5%
	Non_State_Employee	15,044	258	29,226	120	\$4,830,442	\$124,629	\$4,955,071	\$1.70	\$170	-0.6%	45.3%	-0.6%
	Student Health Plan	73	26	102	6	\$12,973	\$8,081	\$21,054	\$0.11	\$206	48.6%	-29.2%	48.6%
	Total	52,336	424	93,736	71	\$12,659,268	\$3,499,446	\$16,158,714	\$1.02	\$172	3.0%	18.6%	3.0%

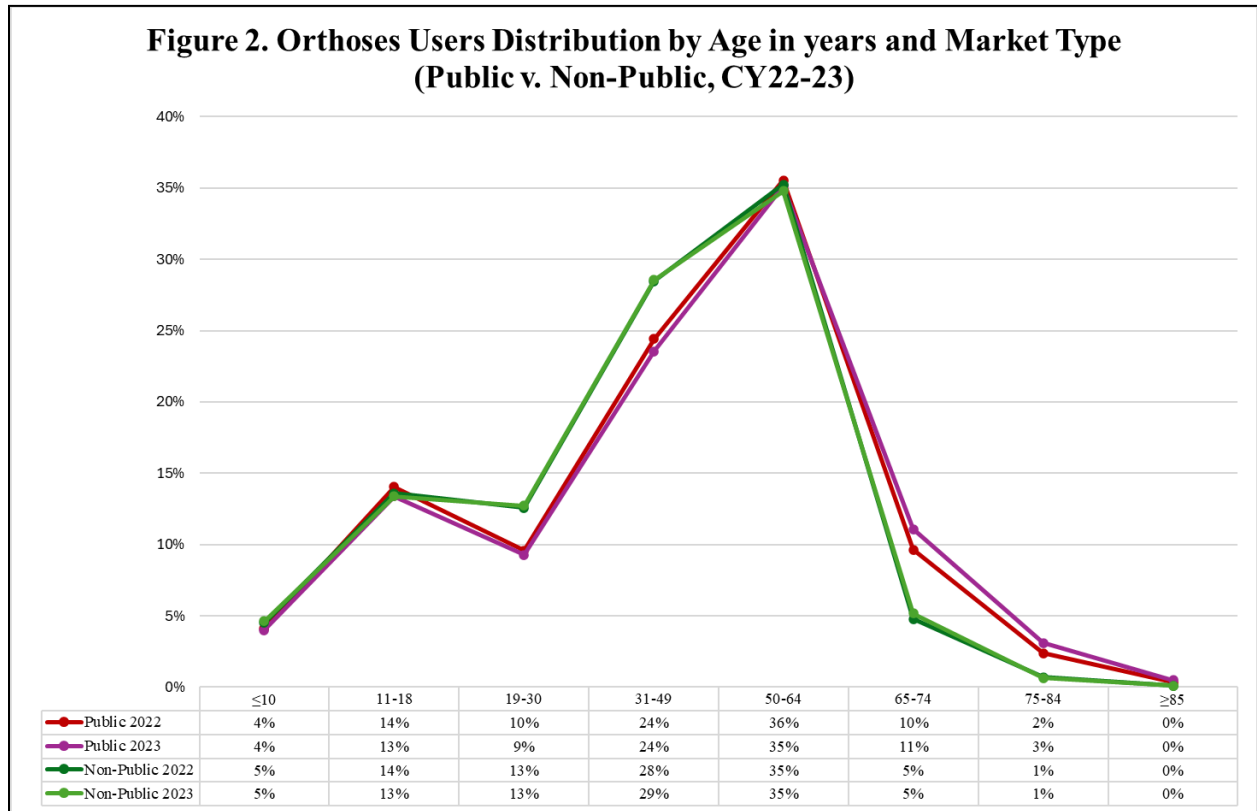
Notes: (i) Non_State_Employee includes City and County Government only.

(ii) State_Employee is the State Health Plan.

(iii) Excludes Self-Insured ERISA and FEHB Plans (≈ 44% of the Commercial Population in the MCDB) due to Federal Decisions.

(iv) The 2021 trends (PMPM, Utiliz—Units/1,000, and Unit Cost) are changes from 2019 to 2021.

Analysis of the distribution of persons utilizing orthoses by market type and age ranges demonstrate similar trends in utilization between age groups. Non-publicly ensured individuals ages 11-49 years used fewer units than publicly ensured individuals, with the opposite being true for individuals aged 50-84 years. Across all markets, persons 50-64 years of age had the highest utilization of orthoses (see Figure 2 below).



Comparing Medicaid Participant Utilization to Commercial Market Utilization by Age

Medicaid FFS participants' orthoses utilization trends are more similar to commercial market utilization trends (includes public and non-public segments of the commercial market) with the exception that FFS participants aged ≥85 yrs use more orthoses than did commercial market enrollees in the same age range (4% as compared to 0%). There are two differences of note when trends are compared across Medicaid Managed Care, FFS, and commercial payers with regard to the utilization of orthoses by age:

- 1) Medicaid Managed Care participants ages 11-18 years used orthoses at a substantially higher rate as compared to other age and payer types (23% as compared to 7% FFS MA, and 14% commercial market).
- 2) Medicaid Managed Care participants ages 31-49 years had the highest rate of utilization than any other MCO age group (28%) suggesting that MCO participants require orthoses earlier in their lives than participants in other groups.

IV. SB 614 Expansion of Coverage of Prosthetics for Whole-Body Health

Medical Assistance Coverage Expansion - Prosthetic “L” codes for Whole-body Health

Effective January 1, 2025, MDH is expanding benefits to include coverage of prosthetic devices and components once annually when medically necessary for the purpose of participating in certain physical activities including running, biking, swimming, strength training, and other activities to maximize their whole-body health and lower or upper limb function. In addition to prefabricated prosthetic devices and components of prosthetic devices, Medical Assistance will cover custom-designed, fabricated, fitted, or modified prosthetic devices to treat partial or total limb loss for purposes of restoring physiological function when medically necessary.

Medical Assistance also provides coverage for repairs of covered prosthetic devices and components of prosthetic devices. Once annually, medically necessary prosthetic devices are covered that are less than three years old if the replacement is necessary for the following reasons:

- because of a change in the physiological condition of the patient;
- unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or the component of the prosthetic device; or
- unless necessitated by misuse, because the condition of the prosthetic device or the component of the prosthetic device requires repairs and the cost of the repairs would be more than 60 percent of the cost of replacing the prosthetic device or the component of the prosthetic device.

MDH conducted an analysis of the “L” codes for prosthetic devices currently covered by Medical Assistance and Medicare. Following this review, MDH identified nineteen (19) additional prosthetic “L” codes which will be added to the Medical Assistance Fee Schedule beginning January 1, 2025. In addition, MDH is amending regulations,¹³ issuing guidance to MCO and FFS providers regarding these changes, as well as adding the new codes to the Maryland Medicaid Information System (MMIS) to allow for billing.¹⁴ A complete list of new prosthetic “L” codes being added to the Fee Schedule is available in Appendix A.

Commercial Coverage Expansion - Prosthetic “L” codes for Whole-body Health

MHCC does not have the authority to set specific reimbursement rates for the commercial market in Maryland. The General Assembly could require MHCC to take specific actions, but to date, the General Assembly has not taken any such action. MHCC notes that Insurance Article § 15-844 (Benefits for Prosthetic Devices) mandates coverage for these services in the commercial market. The Maryland Insurance Administration enforces coverage of mandated benefits.

¹³ COMAR 10.09.12 Disposable Medical Supplies and Durable Medical Equipment; COMAR 10.67.01 Maryland Medicaid Managed Care Program: Definitions; and COMAR 10.67.06 Maryland Medicaid Managed Care Program: Benefits.

¹⁴ HCPCS codes for prosthesis added to the fee schedule: L5703, L5971, L5973, L6715, L6721, L6722, L6880, L6883, L7404, L7405, L8041, L8044, L8047, L8515, L8609, L8612, L8641, L8642, and L8658.

V. Study of Expansion of Coverage of Orthotic “L” Codes for Whole-body Health

Medical Assistance Program

MDH conducted a review of the utilization of “L” codes for orthoses by the FFS and MCO populations and estimated the cost of expanding coverage for orthoses for whole-body health. Medical Assistance currently covers 370 orthotic “L” codes on the Fee Schedule. MDH conducted an analysis of these codes, those covered by Medicare, and a list of orthotic “L” codes provided by stakeholders to assess if expansion of coverage to include additional orthotic “L” codes would be necessary to implement coverage for whole-body health purposes. The fiscal impact of adding these codes to the Fee Schedule has been incorporated into the estimates discussed below.

Estimating the cost of expanding orthoses coverage to include whole-body health

MDH’s clinicians reviewed the Fee Schedule and determined that 258 orthotic “L” codes on the Fee Schedule met the criteria wherein a provider might prescribe an individual multiple sets of the same orthotic “L” code: one set for activities covered today (e.g., orthoses to fit work shoes) and another set of the same type of orthoses for whole-body health purposes (e.g., a set that would be used in concert with running shoes).

To determine a baseline from which to estimate the cost of expanding coverage to include whole-body health, the Hilltop Institute at the University of Maryland Baltimore County (Hilltop) conducted an analysis of the current utilization of 258 orthotic “L” codes identified as relevant for purposes of the expansion. Utilization was assessed by MCO vs. FFS participants. Hilltop determined the number of unduplicated FFS and MCO participants, the units per year, as well as the cost per year by MCO and FFS populations (see Table 3).

Table 3 shows trends in the utilization of select “L” codes by Medicaid participants in CY22 and CY23. In CY22, there were 37,396 total Medicaid participants who utilized the aforementioned list of 258 “L” codes for orthoses; in CY23 this number increased to 38,420. MCO participants used approximately 81% of the total service units each year and accounted for 85% and 81% of the total expenditure in CY22 and CY23, respectively.

Table 3. Utilization of Select “L” codes for Orthoses, CY 2022-2023					
Calendar Year	Category	Unique Users	Codes Used	Units of Services	Expenditures
2022	FFS	3,689	160	11,582	\$1,471,680
	MCO	33,715	174	52,419	\$8,188,491
	TOTAL	37,396	192	64,001	\$9,660,171
2023	FFS	3,742	133	11,368	\$1,766,130
	MCO	34,702	173	46,988	\$7,704,774
	TOTAL	38,420	184	58,356	\$9,470,904

Note: A participant can be in one or both years during the study period. FFS providers have up to twelve months to submit claims, and therefore, utilization for CY23 may change in subsequent data runs. For FFS claims, Hilltop estimated payments by multiplying units of service by the corresponding rate based on posted fee schedule and limiting to 5% of costs to account for Medicare as a secondary payer for duals (approximately 66% of FFS users). Partial Medicaid reimbursement was only applied to duals. Full rates applied for non-duals. Payments for MCO encounters were estimated by multiplying units of service by the corresponding full Medicaid rates. Source: MMIS2 data as of September 30, 2024.

Table 4 on the following page shows utilization for CY23 and projected utilization, rates and costs for CY24, CY25, and CY26.¹⁵ These projections account for both increases in baseline expenditures from CY23 and the projected costs associated with expanding coverage to include orthoses for whole-body health purposes in CY26.

Establishing a Baseline

Using CY23 data as a baseline, MDH projected expected orthoses costs for CY24, CY25, and CY26 under the existing coverage policy. For CY24 and CY25, MDH applied a 3% increase in participants utilizing services and a 3% growth rate in units of services utilized above CY23. Expenditure projections for CY24 were based on the fee schedule for the current year and assumed a 3% reimbursement rate increase in CY25 (See Tables 4 and 5 on the following pages for additional information).

Projecting Increases in Costs to Account for Benefit Expansion

To account for the cost associated with expanding the orthoses benefit to include whole-body health coverage, MDH utilized the baseline projection for CY26 and conservatively assumed the number of units utilized would increase by 30%.¹⁶ This assumption reflects research indicating

¹⁵ To the extent rate increases and utilization exceed the projections for CY25, actual costs to implement this expansion in CY26 may be higher.

¹⁶ Analysis performed by other states, as well as studies published in the peer-reviewed literature, estimate that over the course of 10 years, between 50-60% of the population utilizing orthoses will utilize additional orthoses for whole-body health if the benefit is expanded. Minnesota Commerce Department, (2024). HF 3339/ SF 3351 – Evaluation of Coverage for Orthotic and Prosthetic Devices Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26 and Malouff, S et al., (2024). A Multi-State Analysis of the Fiscal and Social Impact of Commercial

that among amputees receiving a prosthesis, approximately 95% are initially assessed at a K-level of 2 or 3,¹⁷ and with physical therapy, a subset of individuals are able to increase their mobility by at least one K-level, potentially resulting in the need for new orthoses paired with higher K-level prostheses required to participate in whole-body health activities.^{18,19} Among Maryland Medicaid MCO participants, 68% of the population utilizing orthoses are less than 50 years of age, suggesting that they may be more likely to reap the benefits of therapies that would allow them to expand their capacity to participate in whole-body health activities potentially requiring new orthoses.²⁰

For CY26, MDH estimates that 42K unique users will utilize 80K units of orthoses, 16,718 of these units are projected to be for purposes of whole-body health. The associated fiscal impact is estimated at \$2.9M Total Funds (\$1.1M General Funds, \$1.8M Federal Funds). Costs for the FFS population are estimated at \$552K Total Funds (\$276K General Funds, \$276K Federal Funds) and the fiscal impact for the MCO population is estimated to account for approximately \$2.4M (\$825K General Funds, \$1.6M Federal Funds). Please see Appendix C for the assumptions underlying this work and the limitations that should be considered in interpreting this analysis. Tables 4 and 5 on the following pages provide additional detail specific to the additional cost of expanding the benefit.

Fairness & Activity Specific Insurance Coverage for Prosthetic & Orthotic Devices in the United States, European Society of Medicine. <https://esmed.org/MRA/mra/article/view/5104/99193547842>

¹⁷ Highest K-level rating is a "4" which is defined as: the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. https://www.ncbi.nlm.nih.gov/books/NBK531523/pdf/Bookshelf_NBK531523.pdf

¹⁸ Dobson and DeVanzo (2015). Summary Findings: K-level analysis (administrative claims for prostheses). <https://www.aopanet.org/wp-content/uploads/2016/01/K2-K3-Dobson-Preliminary-Results-K-Level-Analysis-1-15-15.pdf>

¹⁹ Gailey, R., et al., (2020). Effectiveness of an Evidence-Based Amputee Rehabilitation Program: A Pilot Randomized Trial, *Physical Therapy*, (100)(5), pp 773-787.

²⁰ It is important to note that the majority of the peer reviewed literature, as well as available reports from stakeholders and other states, focus on costs associated with expanding coverage of prostheses for whole-body health among commercial market enrollees with amputations; therefore, it is difficult to estimate the cost of expansion of orthoses among the Medical Assistance population. This further bolstered MDH's conservative approach to estimating an uptake of 30% among the population of focus. As more states expand coverage of prostheses and orthoses for whole-body health purposes across payers, more accurate projections will be possible.

Table 4. Projected Increase in Utilization and cost of Select “L” Codes for Orthoses*

Category	ACTUAL				PROJECTED											
	CY 2023				CY 2024				CY 2025				CY 2026–Orthoses Expansion			
	Users	Service Units	Avg. Unit Cost	Cost	Users	Service Units	Avg. Unit Cost	Cost	Users	Service Units	Avg. Unit Cost	Cost	Users	Service Units	Avg. Unit Cost	Cost
FFS	3,742	11,378	\$155	\$1,766,130	3,854	11,719	\$160	\$1,873,687	3,970	12,071	\$165	\$1,987,795	4,089	15,692	\$170	\$2,661,657
MCO	34,702	46,988	\$164	\$7,704,774	35,743	48,398	\$169	\$8,173,995	36,815	49,850	\$174	\$8,671,791	37,920	64,804	\$179	\$11,611,528
Total	38,420	58,366	\$162	\$9,470,904	39,597	60,117	\$167	\$10,594,242	40,785	61,920	\$72	\$10,659,586	42,009	80,497	\$177	\$14,273,185

*Please note there are small discrepancies related to rounding.

Notes: Projections are based on baseline utilization data, unit rate and number of participants utilizing services from CY23. FFS providers have up to twelve months to submit claims, and therefore, utilization for CY23 may change in subsequent data runs; [1] Estimated as a 3% increase in users in projected calculations for CY24, CY25 and CY 26; [2] Estimated as a 3% increase in units of services for CY24 and CY25 while a 30% increase in units of services in CY26 due to the implementation of coverage for orthoses for whole-body health purposes in CY26; [3] Applied an average 3% increase in per-unit costs based on fee schedule for CY23 and projected a 3% increase in per unit cost for CY24, CY25 and CY26; [4] Expenditure is estimated as new units of service times new average per-unit cost. For FFS claims, Hilltop estimated payments by multiplying units of service by the corresponding rate based on posted fee schedule and limiting to 5% of costs to account for Medicare as a secondary payer for duals (approximately 66% of FFS users). Partial Medicaid reimbursement was only applied to duals. Full rates applied for non duals. Payments for MCO encounters were estimated by multiplying units of service by the corresponding full Medicaid rates. Source: MMIS2 data as of September 30, 2024.

Table 5. Comparison of Projected Baseline Costs to Projected Costs Associated with Expansion of Orthoses Benefit to include Whole-body health (CY26)*

	Unique users	Units of Service	Expenditures*		
			Total Funds	State General Funds	Federal Matching Funds
FFS Baseline	4,089	12,433	\$2,108,852	\$1,054,426	\$1,054,426
FFS Expanded	4,089	15,692	\$2,661,657	\$1,330,829	\$1,330,829
FFS New Costs for Orthoses Expansion	-	3,259	\$552,806	\$276,403	\$276,403
MCO Baseline	37,920	51,345	\$9,199,903	\$3,147,287	\$6,052,616
MCO Expanded	37,920	64,804	\$11,611,528	\$3,972,304	\$7,639,224
MCO New Costs for Orthoses Expansion	-	13,459	\$2,411,625	\$825,017	\$1,586,608
Total Baseline	42,009	63,778	\$11,308,755	\$4,201,713	\$7,107,042
Total Expanded	42,009	80,496	\$14,273,185	\$5,303,133	\$8,970,053
Total Projected Expansion Cost for Orthoses Expansion**	-	16,718	\$2,964,430	\$1,101,420	\$1,863,011

* Please note there are small discrepancies related to rounding

**Total Projected Expansion Cost is for CY26, actual costs for CY26 may be higher based on uptake, unit cost, and Medicaid enrollment, in addition these projections are subject to a number of limitations listed as noted in the report and Appendix C.

Commercial Market -MHCC Study

MHCC used a similar approach to MDH in estimating the cost of expanding orthoses coverage to include whole-body health. Specifically, MHCC used the 258 orthotic “L” codes provided by MDH.

Table 6 below demonstrates trends in the utilization of select “L” codes by commercial participants for CYs 21-23. The number of commercial participants who used orthoses decreased over these years. Specifically, in CY21, 44,436 participants utilized orthoses across all markets (public: 24,851 and non-public: 19,575), this number decreased to 41,446 in CY22 (public: 22,939 and non-public: 18,507), and in CY23 this number decreased further to 34,845 (public: 18,770 and non-public: 16,075). It is important to note that the data for CY23 may not be complete given that claims for orthoses for some publicly insured groups are still being processed; therefore the CY23 reduction in utilization should be interpreted as potentially an underestimate for the year (see Table 6 for additional information).

Table 6: Utilization of Select "L" codes for Orthoses, CY21 - 23											
Year	Market	Unique Patients	Unique CPTs	Total Units	Units/ 1000	Total Allowed Costs	Total costs PMPM	Unit Cost	Total PMPM Trends	Utiliz Trends	Unit Cost Trends
2021	Individual	4,447	99	7,200	36	\$1,037,288	\$0.43	\$144	37.9%	31.8%	4.7%
	Small Group	6,754	110	10,583	40	\$1,510,677	\$0.47	\$143	1.1%	0.2%	0.9%
	Large Group	8,288	97	12,756	24	\$1,795,022	\$0.28	\$141	12.7%	9.7%	2.7%
	State_Employee	8,071	119	14,170	61	\$2,114,908	\$0.76	\$149	-7.6%	-7.3%	-0.4%
	Non_State_Employee	16,790	116	31,215	72	\$4,640,936	\$0.89	\$149	21.5%	19.6%	1.6%
	Student Health Plan	86	16	141	7	\$21,675	\$0.10	\$154	100.2%	98.7%	0.7%
	Total	44,436	163	76,065	45	\$11,120,506	\$0.55	\$146	15.4%	13.5%	1.7%
2022	Individual	4,318	99	6,774	33	\$974,254	\$0.40	\$144	-8.4%	-8.3%	-0.2%
	Small Group	6,452	110	9,841	38	\$1,452,764	\$0.47	\$148	-1.5%	-4.7%	3.4%
	Large Group	7,665	97	11,787	19	\$1,716,279	\$0.23	\$146	-16.1%	-18.9%	3.5%
	State_Employee	7,835	119	13,553	61	\$2,068,877	\$0.78	\$153	2.9%	0.6%	2.3%
	Non_State_Employee	15,104	116	27,656	58	\$4,291,241	\$0.74	\$155	-16.0%	-19.6%	4.4%
	Student Health Plan	72	16	120	6	\$14,166	\$0.06	\$118	-37.1%	-18.1%	-23.2%
	Total	41,446	159	69,731	39	\$10,517,581	\$0.49	\$151	-11.1%	-13.8%	3.2%
2023	Individual	4,326	99	6,920	33	\$999,527	\$0.39	\$144	-1.2%	-1.6%	0.4%
	Small Group	6,224	110	9,599	39	\$1,471,846	\$0.50	\$153	7.9%	3.9%	3.9%
	Large Group	5,478	97	8,145	22	\$1,184,433	\$0.26	\$145	11.9%	12.0%	-0.1%
	State_Employee	8,229	119	14,777	64	\$2,306,841	\$0.83	\$156	6.4%	4.0%	2.3%
	Non_State_Employee	10,541	116	19,945	82	\$3,098,586	\$1.06	\$155	42.8%	42.6%	0.1%
	Student Health Plan	47	16	71	4	\$13,556	\$0.07	\$191	17.6%	-27.3%	61.7%
	Total	34,845	154	59,457	45	\$9,074,789	\$0.57	\$153	17.1%	15.7%	1.2%

Notes:

- (i) Non_State_Employee includes City and County Government only
- (ii) State_Employee is the State Health Plan
- (iii) Excludes Self-Insured ERISA and FEHB Plans (≈ 44% of the Commercial Population in the MCDB) due to Federal Decisions
- (iv) The 2021 trends (PMPM, Utiliz—Units/1,000, and Unit Cost) are changes from 2019 to 2021

Establishing a Baseline

Using CY23 data as baseline, MHCC projected expected orthoses costs for CY24, CY25, and CY26. CY23 data excludes self-insured ERISA and Federal Employees Health Benefits (FEHB) health plans as per federal decisions. MHCC applied a 3% increase in orthoses recipients across all markets. Expenditure projections for CY24 and CY25 are based on the average long-term utilization trends (units per 1,000 insured members per year).

Projecting Increase in Costs to Account for Whole-body Health Benefit Expansion

MHCC used baseline data to project costs associated with expanding orthoses coverage to include whole-body health in a manner similar to MDH (see Appendix D for additional information regarding the assumptions and limitations). To evaluate the cost associated with expanding the orthoses benefit to include whole-body health coverage, MHCC used a similar approach to what MDH used. Specifically, MHCC used the projected CY25 as the baseline for CY26, assuming a 30% increase in service units across all markets due to expanding the benefits coverage to include whole-body health. As noted earlier by MDH, this assumption of a 30% increase in units of measure for whole-body health orthoses originated from an actuarial study prepared for the Minnesota legislature. Also, MHCC used MDH’s assumption of a 3% increase in unit cost across all markets. We chose this assumption because of the wearing of the long-term utilization trends assumption by CY26. These assumptions imply an overall 33.9% increase in expenditure across all markets for CY26 (see Tables 7 and 8 for additional information).

Table 7: Projected Increase in Utilization of Select "L" codes for Orthoses, CY23-26																
Market	2023				2024				2025				2026			
	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs
Individual	4,326	6,920	\$144	\$999,527	4,456	7,417	\$144	\$1,064,901	4,589	7,950	\$143	\$1,134,552	4,727	10,335	\$147	\$1,519,165
Small Group	6,224	9,599	\$153	\$1,471,846	6,411	10,130	\$155	\$1,572,116	6,603	10,691	\$157	\$1,679,216	6,801	13,899	\$162	\$2,248,471
Large Group	5,478	8,145	\$145	\$1,184,433	5,642	9,154	\$147	\$1,347,051	5,812	10,289	\$149	\$1,531,996	5,986	13,375	\$153	\$2,051,342
State_Employee	8,229	14,777	\$156	\$2,306,841	8,476	15,410	\$157	\$2,425,602	8,730	16,071	\$159	\$2,550,478	8,992	20,892	\$163	\$3,415,090
Non_State_Employee	10,541	19,945	\$155	\$3,098,586	10,857	23,786	\$157	\$3,728,743	11,183	28,366	\$158	\$4,487,056	11,518	36,876	\$163	\$6,008,167
Student Health Plan	47	71	\$191	\$13,556	48	83	\$223	\$18,507	50	97	\$261	\$25,268	51	126	\$268	\$33,833
Total	34,845	59,457	\$153	\$9,074,789	35,890	65,981	\$154	\$10,156,921	36,967	73,464	\$155	\$11,408,565	38,076	95,504	\$160	\$15,276,068

For CY26, MHCC estimates that 38,076 unique participants will use 95,504 units of orthoses and 19,835 of these units are forecasted to be for the purposes of whole-body health (see Table 8 on the following page for additional information). The estimated associated fiscal impact is \$3.2M. The breakdown of the \$3.2M by market is as follows: \$1.22M for non-public (individual, small group, large group, student health plan); \$709K for State Health Plan, and \$1.25K for Local State Gov't (Non-State Employee).

VI. Conclusion

MDH and MHCC are committed to the successful implementation of SB 614's requirements. MDH and MHCC have engaged with stakeholders during the implementation planning process. Additionally, MDH has made needed system changes, initiated amendments to regulations, and issued guidance to the DMS/DME Providers as well as MCOs regarding the changes they need to implement beginning January 1, 2025. Further expansion of benefits to include coverage for orthoses for whole-body health purposes would conservatively cost the Medical Assistance Program at least \$2.9M Total Funds (\$1.1M State General Funds, \$1.8M Federal Funds) annually, with a similar estimate for the commercial market of \$3.2M in additional costs annually.

Implications for the Medical Assistance Program

MDH evaluated the 370 orthoses codes on the Fee Schedule to determine which "L" codes were likely to see an increase in utilization were MDH to expand the orthoses benefit to include whole-body health. Using this subset of "L" codes, MDH established historical utilization by both the FFS and MCO populations and projected the cost of expanding the orthoses benefit to include whole-body health in CY26. MDH conservatively estimates that expansion of orthoses benefits to include whole-body health at a 50% Federal Medical Assistance Percentage (FMAP) for FFS costs and 65.79% blended FMAP for MCOs would cost approximately \$2.9M Total Funds (\$1.1M State General Funds, \$1.8M Federal Funds) annually. There are limitations to MDH's analysis; therefore, these projected costs likely underestimate the actual cost of benefit expansion.²¹

Implications for Commercial Market

MHCC utilized the same "L" code subset as MDH to project the cost of expanding coverage of whole-body health for orthoses for the commercial market. MHCC conservatively estimates that the cost to expand orthoses coverage to include whole-body health for the commercial market would cost approximately \$3.2M annually. There are limitations to the MHCC's analysis as well; therefore, these projected costs likely underestimate the actual cost of benefit expansion (see Appendix D for assumptions and limitations).

²¹ See Appendix C for additional detail regarding the limitations associated with MDH's estimates.

Appendix A: List of Prosthetic “L” codes to be covered by Medical Assistance effective January 1, 2025

Additional Prosthetic Procedure Codes to be covered effective January 1, 2025		
No.	HCPCS	Description of Prosthetic "L" codes
1	L5703	Symes ankle w/o (sach) foot
2	L5971	Sach foot, replacement
3	L5973	Ank-foot sys dors-plant flex
4	L6715	Term device, multi art digit
5	L6721	Hook/hand, hvy dty, vol open
6	L6722	Hook/hand, hvy dty, vol clos
7	L6880	Elec hand ind art digits
8	L6883	Replc sockt below e/w disa
9	L7404	Add ue prost a/e acrylic
10	L7405	Add ue prost s/d acrylic
11	L8041	Midfacial prosthesis
12	L8044	Hemi-facial prosthesis
13	L8047	Nasal septal prosthesis
14	L8515	Gel cap app device for trach
15	L8609	Artificial cornea
16	L8612	Aqueous shunt prosthesis
17	L8641	Metatarsal joint implant
18	L8642	Hallux implant
19	L8658	Interphalangeal joint spacer

Appendix B: Medical Assistance Program Orthoses Utilization by Age

Orthoses Utilization by Age, CYs 2022-2023					
Age Group	Category	Unique Users			
		2022		2023	
		#	%	#	%
<=10	FFS	345	9%	360	10%
	MCO	3,254	10%	3,382	10%
11-18	FFS	260	7%	260	7%
	MCO	7,761	23%	8,138	23%
19-30	FFS	172	5%	191	5%
	MCO	5,813	17%	6,149	18%
31-49	FFS	530	14%	494	13%
	MCO	9,298	28%	9,622	28%
50-64	FFS	937	25%	917	25%
	MCO	7,420	22%	7,209	21%
65-74	FFS	910	25%	974	26%
	MCO	169	1%	202	1%
75-84	FFS	380	10%	391	10%
	MCO	-	-	-	-
>=85	FFS	155	4%	155	4%
	MCO	-	-	-	-

Appendix C: Medical Assistance Program Assumptions and Limitations to estimate the cost of coverage expansion to include whole-body health.

Assumptions used to estimate the cost of expanding coverage to include whole-body health

- Annual growth in the Medicaid enrolled population at 3%;
- Cost of orthoses will increase annually at 3% based on estimated changes to the Medicare Fee schedule;
- FFS and MCO populations will increase their use of orthoses equally at a rate of 30% if the orthoses benefit is expanded to include whole-body health;^{22,23}
- Maryland will continue to reimburse for orthoses at 85% of the Medicare rate; and
- Blended FMAP for MCO costs: 65.79%, FMAP for FFS: 50%.

Limitations in determining implications of expanding orthoses coverage to include whole-body health

- **K-levels:** MDH has no way to capture the K-level of MCO or FFS participants. Studies demonstrate that K-levels can increase as physiotherapies progress, and individuals are more and more able to ambulate and participate in whole-body health activities.²⁴
- **Utilization by MCO participants:** Current utilization of orthoses reflects utilization authorized for activities of daily living at home, school, and work. Historically, FFS participants use orthoses and prosthetics at substantially higher rates than MCO participants. What is unclear is whether expanding orthoses coverage for whole-body health will change these historical utilization patterns or if MDH will see a higher uptake by MCO participants given that these individuals may be more able to pursue whole-body health activities. This analysis assumes uniform growth in utilization by both populations. To the extent actual utilization increases at a higher rate for MCO enrollees, state general fund costs may be higher as the majority of FFS participants who use orthoses (66%) are dually eligible for Medicare.
- **Interactions between expansion of benefits:** There is a dearth of literature regarding whether expanding access to both prostheses and orthoses for whole-body health results in an interaction; whereby states observe an increased volume of prostheses and orthoses when access is expanded to both, as opposed to only prostheses. It may be reasonable to assume that for some individuals, expansion will result in increased utilization of both prostheses and orthoses based on the whole-body health activity they choose to pursue. Increased utilization across both benefit categories could further increase the fiscal impact.
- **Impact of Age on Utilization:** There is a dearth of information in the literature regarding the impact of age on the use of prostheses or orthoses for whole-body health. There are

²² Minnesota Commerce Department, (2024). HF 3339/ SF 3351 – Evaluation of Coverage for Orthotic and Prosthetic Devices Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26 <https://www.house.mn.gov/comm/docs/MPM-owNuSkukbbGUchfa7w.pdf>

²³ Malouff, S et al., (2024). A Multi-State Analysis of the Fiscal and Social Impact of Commercial Fairness & Activity Specific Insurance Coverage for Prosthetic & Orthotic Devices in the United States, *European Society of Medicine* <https://esmed.org/MRA/mra/article/view/5104>

²⁴ Anderson, K.M., et al., (2021). Custom Dynamic Orthoses and Physical Therapist Intervention for Bilateral Midfoot Amputation: A Case Report, *Journal of the American Physical Therapy Association* <https://pmc.ncbi.nlm.nih.gov/articles/PMC8054777/>

indicators that MDH might see high levels of uptake among young adults and children under the age of 18.²⁵ On the other hand, there are studies demonstrating that persons 45-64 account for 42% of amputations, the second highest rate behind persons aged 65+ (44%); therefore, it is possible that this age group might also see a substantial increase in utilization were the orthoses benefit to be expanded to include whole-body health as the majority of these amputations are foot related.²⁶

²⁵ Birth Defects (2024). Limb reduction defects, *Center for Disease Control and Prevention*.
<https://www.cdc.gov/birth-defects/about/limb-reduction-defects.html>

²⁶ Caruso, M., & Harrington, S., (2024). Prevalence of Limb Loss and Limb Difference in the United States: Implications for Public Policy. *Funded by a Grant from the Administration for Community Living, Department of Health and Human Services*.
https://www.amputee-coalition.org/wp-content/uploads/2024/05/Prevalence-of-Limb-Loss-and-Limb-Difference-in-the-United-States_Implications-for-Public-Policy.pdf

Appendix D: MHCC Assumptions and Limitations to estimate the cost of coverage expansion to include whole-body health.

Using current benefits coverage, MHCC used the CY23 as a baseline to project expected orthoses costs for CY24-26 if Maryland were to expand commercial coverage to include orthoses for whole-body health.

Due to federal decisions, please note that the CY23 base year data excludes self-insured ERISA and FEHB health plans. For each projected year (CY24-26) MHCC assumed a 3% increase in the population using orthoses across all markets. For CY24-25, MHCC used average long-term utilization trends (units per 1,000 insured members per year), including CY19-23 to forecast units of service by market as follows:

- 7.2% increase in units of service for the individual market
- 5.5% for small group
- 12.4% for large group
- 4.3% for State Health Plan (State Employee)
- 19.3% for Local State Gov't (Non-State Employee)
- 16.9% for Student Health Plans (a small market segment)
- Resulting in an assumed 11.0% increase in units of service across all markets

Similarly, using average long-term allowed PMPM trends for CY19-22, and CY23 for CY24-25, the following assumptions were used regarding increases in expenditures by market: 6.5% increase in spending for the individual market; 6.8% for small group; 13.7% for large group; 5.1% for State Health Plan; 20.3% for Local State Gov't; and 36.5% increase for Student Health Plan (note that Student Health Plan is about 0.2% of total expenditures). These assumed increases in spending by market imply an overall assumed increase of the expenses of about 12% across all markets. Considering the average long-term allowed PMPM and utilization trends for CY19-22, and CY23 for CY24-25 imply the following assumed changes in unit cost by market:

- A 0.6% decrease in unit costs for the individual market
- 1.2% increase in unit cost for small group and large group
- 0.8% increase in unit costs for the State Health Plan
- 0.9% increase for Local State Gov't
- There was a 16.8% increase in unit cost for the Student Health Plan (a small market that accounts for about 0.2% of total expenditure).
- The resulting overall assumed increase in unit cost across all markets is about 0.9%.



**Report on the “L” codes utilization within the All-Payer Claims Database and cost impact
of Orthoses coverage**

Required by SB 614 (Chs. 822 and 823 of the Acts of 2024)

December 2024

Executive Summary

Prosthetic and orthotic devices are assistive devices utilized by individuals who have congenital limb loss or limitation, have experienced amputation, or require devices to assist with mobility and function. Utilization of these devices improves mobility, functionality, independence, and overall quality of life of persons with disabilities who use these assistive devices.

A survey of coverage of prostheses and orthoses across all 50 US states determined that 45 states do not require coverage of these devices for physical activities aside from those determined to be medically necessary, and 29 states do not have payer-wide coverage for prostheses or orthoses for even medical necessity.¹ In Maryland, Medicaid has historically covered prostheses and orthoses when medically necessary to support activities of living in the participant's home, workplace, or school. Commercial payers have also historically covered prostheses and orthoses via the Affordable Care Act (ACA), the essential health benefits (EHB) under "habilitative services and devices," and for the large group market under Insurance Article §15-844. While coverage for prosthetic devices for medical necessity is a mandated benefit for both commercial payers and Medicaid in Maryland, coverage of prostheses for whole-body health was not mandated until SB 614, *Maryland Medical Assistance Program (Medical Assistance) and Health Insurance - Coverage for Prostheses (So Every Body Can Move Act)* (Chs. 822 and 823 of the 2024 Acts)², was passed.

SB 614 expanded coverage of prostheses in Maryland when medically necessary for whole-body health effective January 1, 2025. In addition, SB 614 required MDH and MHCC to jointly evaluate the fiscal impact of expanding whole-body health coverage for orthoses through Medical Assistance and commercial payers, respectively. This report provides an overview of historical utilization patterns and costs for prostheses and orthoses through Medical Assistance, as well as estimates of the cost to expand coverage of orthoses for whole-body health by both Medical Assistance and commercial payers.

I. Introduction

This report addresses MDH's progress to date to assure that the provisions under SB 614 regarding expanding coverage of prosthetic devices for whole-body health will be implemented by January 1, 2025. In addition, this report includes evaluations by MDH and MHCC, in consultation with MIA, on the cost and feasibility of expanding the coverage of orthotic devices for whole-body health. MDH performed the analysis related to financial implications for the Medical Assistance populations. MHCC performed analysis related to implications for the commercial market. MDH estimates that expanding coverage of orthoses for whole-body health will have an annual fiscal impact of at least \$2.9M Total Funds (\$1.1M State General Funds, \$1.8M Federal Funds). Expansion of this benefit within the commercial market is projected to

¹ Malouff, S., et al., (2024). A Multi-State Analysis of the Fiscal Impact of Commercial Insurance Coverage for General-Use & Activity-Specific Prosthetic & Orthotic Devices in the United States. *Medical Research Archives, European Society of Medicine*. <https://esmed.org/MRA/mra/article/view/5104/99193547842>

² Senate Bill 614 - Maryland Medical Assistance Program and Health Insurance - Coverage for Prostheses (*So Every Body Can Move Act*) (Chs. 822 and 823 of the 2024 Acts). <https://mgaleg.maryland.gov/2024RS/bills/sb/sb0614T.pdf>

cost \$3.2M (\$1.22M Fully Insured, \$709K State Health Plan, \$1.25M Local State Govt.) annually for the commercial market (non-Employee Retirement Income Security Act (ERISA)).

II. Background

Individuals who are born without a limb, have lost a limb, or have impaired function of a body part(s) are often prescribed prostheses and orthoses in order to allow them to complete activities of daily living in the home, work, or at school. Examples of prosthetic devices include: artificial devices to replace, in whole or in part, a leg, an arm, an eye, or breast, including surgical brassiere; whereas, orthotic devices are defined as rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.³

One of the key assessments providers use in determining the prostheses or orthoses to prescribe for an individual is an assessment called the Medicare Functional Classification Level (MFCL) (also known as a K-level assessment) which is performed in order to determine the maximum rehabilitation and mobility that an individual could achieve were they to be provided with appropriate physical and occupational therapies as well as prostheses and orthoses.^{4,5,6,7} An individual's MFCL is also used as part of the process of prescribing and reimbursing providers for the aforementioned devices. Studies demonstrate that K-levels can increase as physiotherapies progress, and individuals are more and more able to ambulate and participate in activities.^{8,9,10,11}

³ As described by the The Medicare Benefit Policy Manual (Publication 100-02), Chapter 15, Section 130 reference on the CMS website.

<https://www.cms.gov/medicare/payment/fee-schedules/dmepos/ots-orthotics#:~:text=Section%201847%28a%29%282,not%20require%20expertise%20in%20trimming%2C>

⁴ AHRQ, (2018). Lower Limb Prostheses: Measurement Instruments, Comparison of Component Effects by Subgroups, and Long-Term Outcomes.

https://www.ncbi.nlm.nih.gov/books/NBK531523/pdf/Bookshelf_NBK531523.pdf

⁵ Anderson, K.M., et al., (2021). Custom Dynamic Orthoses and Physical Therapist Intervention for Bilateral Midfoot Amputation: A Case Report, *Journal of the American Physical Therapy Association*.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8054777/>

⁶ Orendurff, M.S., et al., (2016) Functional level assessment of individuals with transtibial limb loss: Evaluation in the clinical setting versus objective community ambulatory activity. *Journal of Rehabilitation and Assistive Technologies Engineering*.

<https://journals.sagepub.com/doi/full/10.1177/2055668316636316#bibr1-2055668316636316>

⁷ AHRQ, (2017). Lower Limb Prosthesis. *Evidence-based Practice Center Systematic Review Protocol*.

https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/prosthesis_research_protocol.pdf

⁸ Gailey, R., et a., (2020). Effectiveness of an Evidence-Based Amputee Rehabilitation Program: a Pilot Randomized Control Trial: *Physical Therapy & Rehabilitation Journal*. <https://academic.oup.com/ptj/article/100/5/773/5707560>

⁹ See e.g., Anderson, K.M., et al., (2021). Custom Dynamic Orthoses and Physical Therapist Intervention for Bilateral Midfoot Amputation: A Case Report, *Journal of the American Physical Therapy Association*.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC8054777/>

¹⁰ Jayaraman, C., et. al., (2021). Using a Microprocessor Knee (C-Leg) with Appropriate Foot Transitioned Individuals with Dysvascular Transfemoral Amputations to Higher Performance Levels: A Longitudinal Randomized Clinical Trial. *Journal of NeuroEngineering and Rehabilitation*. <https://link.springer.com/article/10.1186/s12984-021-00879-3>

¹¹ See e.g., Sol-Bi, K., et al., (2017). Relief of Knee Flexion Contracture and Gait Improvement Following Adaptive Training for an Assist Device in a Transtibial Amputee: A Case Study: *Journal of Back and Musculoskeletal Rehabilitation*. <https://content.iospress.com/articles/journal-of-back-and-musculoskeletal-rehabilitation/bmr736>

There is a national effort (*So Every Body Can Move*) to expand coverage of prostheses and orthoses to also allow individuals in need of prostheses or orthoses to participate in activities such as swimming, running, biking, weight lifting, and any other type of physical activity which would maximize the overall health and function of the individual. Prior to the passage of SB 614, coverage for prostheses and orthoses varied by payer. Effective January 1, 2025, SB 614 requires that coverage for prosthetic devices be expanded to include whole-body health uses, which are defined as performing physical activities including: running, biking, swimming, biking, strength training, and other activities to maximize health and lower or upper limb function of the individual. In addition, the legislation required MDH and MHCC to evaluate the cost and feasibility of expanding coverage of orthoses for whole-body health.

III. Prostheses and Orthoses

Medical Assistance - Coverage for Prostheses and Orthoses

Nearly 60,000 Marylanders with Medical Assistance have claims or encounters associated with prostheses and orthoses every year (see Table 1). Historically, Medical Assistance covered orthoses and prostheses when medically necessary for activities associated with daily living including use in the home, work or school. SB 614 expanded the coverage for prostheses (but not orthoses) to include whole-body health. “L” codes for prosthetic and orthotic devices currently covered by Medical Assistance are listed on the [Disposable Medical Supplies and Durable Medical Equipment Fee Schedule](#) (the Fee Schedule).

Medical Assistance - Utilization for Prostheses and Orthoses

The population receiving services through a HealthChoice managed care organization (MCO) utilize the highest volume of services each year; however, FFS participants use prostheses and orthoses at a three-fold higher rate as compared to MCO participants (an average of 4.8 units per FFS participant vs. an average of 1.5 units per MCO enrollee per year). In addition, trends in cost per MCO participant have remained stable for the last three years; whereas, costs per FFS participant have steadily increased (39%) across the same time period.¹² Table 1 on the following page provides data regarding the utilization of prostheses and orthoses by FFS vs MCO participants over three years (Calendar Year (CY) 21-23), as well as the number of units per unduplicated participant, and the overall cost by coverage category per year.

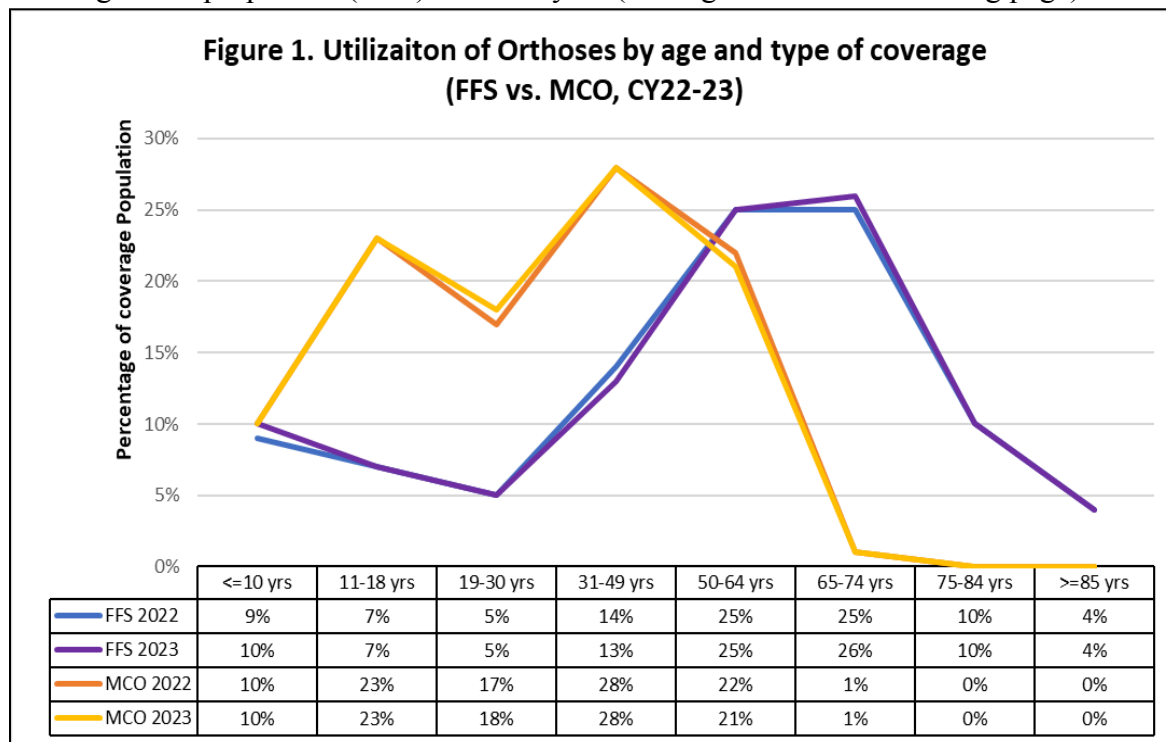
Table 1. Prostheses and Orthoses Utilization, CYs 2021-2023					
CY	Category	Unduplicated Users	Unique HCPCS Used	Total Units	Total Expenditures
2021	FFS	6,403	379	29,470	\$5,927,498
	MCO	50,693	437	78,587	\$15,733,764

¹² MCO cost per participant using prostheses or orthoses: range: \$303 - \$310 CY21-23 vs. FFS cost per participant using prostheses or orthoses: CY21: \$925, CY22: \$1,085, CY23: \$1,284.

Total		57,096	816	108,057	\$21,661,261
2022	FFS	6,346	399	31,115	\$6,884,784
	MCO	53,503	426	78,746	\$16,235,154
Total		59,849	825	109,861	\$23,119,939
2023*	FFS	5,474	353	27,074	\$7,026,846
	MCO	51,128	422	72,263	\$15,804,015
Total*		56,602	775	99,337	\$22,830,860

***Note:** Claims and expenditures for CY23 are subject to runout for FFS claims for 12 months, the total number of unduplicated users, HCPCS codes utilized, total units and total expenditures are not final and may increase once claims run out is complete for CY23.

MDH analyzed utilization by coverage type and age bands and determined that for both FFS and MCO categories, orthoses utilization is seen across all age groups. Among FFS users, individuals aged 50-64 years and 65-74 years accounted for the greatest proportion (25 - 26%) of unique users in CY22 and CY23; whereas among MCO participants, the group aged 31-49 accounted for the greatest proportion (28%) use each year (see Figure 1 on the following page).



Commercial Markets - Coverage for Prostheses and Orthoses

MHCC currently is not authorized to enforce coverage for prostheses and orthoses. Under SB 614, MHCC used the Maryland Medical Care Data Base (MCDB) containing insurance claims for Medicare, Medicaid, and the commercial market to assess utilization and payment trends.

Commercial Markets - Utilization for Prostheses and Orthoses

MHCC studied the utilization of prostheses and orthoses by individuals with commercial insurance. MHCC compared two categories of commercial insurance: 1) “public” insurance market segments which include: (i) State Employees and retirees, and (ii) Local State Government (Cities, county government); and 2) “non-public” insurance market segments which includes the following: 1) Individual Market (individual private insurance, mainly under the ACA for all non-grandfathered plans), 2) Small group (2 - 50 employees); and 3) Large group or private employer-sponsored groups (51+ employees).

On average, individuals enrolled in the public insurance market segments utilize prostheses and orthoses at a rate twice as high than those enrolled in non-public insurance market segments (97 units per 1,000 insured members per year as compared to 47 units per 1,000 respectively). Unit cost trends demonstrate variations across markets between CY21 – 23, with average cost per unit

increasing from \$162 in CY21 to \$172 in CY23; however, when these unit costs are evaluated across total utilization and unduplicated individuals, the unit cost shows a consistent reduction in unit cost (CY21: 3.4% down to 3.0% in CY23). Table 2 provides additional information.

Table 2: Prostheses and Orthoses Utilization, CY21-23													
Year	Market	Unique Individ.	Unique CPTs	Total Units	Total Units/1,000	Plan Paid Costs	Cost-Sharing Expenditures	Total Cost	Total Costs PMPM	Unit Cost	Total PMPM Trends	Utiliz Trends	Unit Cost Trends
2021	Individual	6,857	241	11,566	58	\$893,525	\$1,078,402	\$1,971,927	\$0.83	\$170	21.6%	20.5%	0.8%
	Small Group	10,522	277	17,359	65	\$1,485,696	\$1,412,069	\$2,897,765	\$0.91	\$167	0.3%	-3.8%	4.2%
	Large Group	13,133	249	21,477	40	\$2,138,007	\$1,251,161	\$3,389,168	\$0.53	\$158	15.4%	9.1%	5.8%
	State_Employee	11,528	303	21,279	92	\$3,461,164	\$129,675	\$3,590,839	\$1.29	\$169	-6.3%	-11.4%	5.8%
	Non_State_Employee	23,820	258	45,474	104	\$6,787,498	\$355,480	\$7,142,978	\$1.37	\$157	16.2%	15.0%	1.0%
	Student Health Plan	143	26	222	12	\$23,232	\$16,790	\$40,022	\$0.18	\$180	42.2%	87.3%	-24.1%
	Total	66,003	424	117,377	70	\$14,789,122	\$4,243,577	\$19,032,699	\$0.94	\$162	12.9%	9.1%	3.4%
2022	Individual	6,734	241	11,292	55	\$885,292	\$1,072,887	\$1,958,179	\$0.80	\$173	1.7%	-4.8%	1.7%
	Small Group	10,023	270	15,903	61	\$1,252,796	\$1,358,315	\$2,611,111	\$0.84	\$164	-1.6%	-6.1%	-1.6%
	Large Group	12,158	249	19,592	32	\$1,903,442	\$1,187,833	\$3,091,275	\$0.42	\$158	0.0%	-20.0%	0.0%
	State_Employee	11,043	303	20,526	93	\$3,342,144	\$146,817	\$3,488,961	\$1.32	\$170	0.7%	1.4%	0.7%
	Non_State_Employee	21,066	258	39,763	83	\$6,222,187	\$559,317	\$6,781,504	\$1.18	\$171	8.6%	-20.6%	8.6%
	Student Health Plan	116	26	177	9	\$17,045	\$7,535	\$24,580	\$0.10	\$139	-23.0%	-23.3%	-23.0%
	Total	61,140	424	107,253	60	\$13,622,906	\$4,332,704	\$17,955,610	\$0.83	\$167	3.2%	-14.1%	3.2%
2023	Individual	6,826	241	11,613	55	\$829,923	\$1,086,329	\$1,916,252	\$0.75	\$165	-4.8%	-1.0%	-4.8%
	Small Group	9,787	195	16,077	66	\$1,571,479	\$1,351,665	\$2,923,144	\$1.00	\$182	10.7%	7.7%	10.7%
	Large Group	8,968	249	14,416	38	\$1,590,821	\$790,371	\$2,381,192	\$0.53	\$165	4.7%	19.3%	4.7%
	State_Employee	11,638	303	22,302	96	\$3,823,630	\$138,371	\$3,962,001	\$1.43	\$178	4.5%	3.7%	4.5%
	Non_State_Employee	15,044	258	29,226	120	\$4,830,442	\$124,629	\$4,955,071	\$1.70	\$170	-0.6%	45.3%	-0.6%
	Student Health Plan	73	26	102	6	\$12,973	\$8,081	\$21,054	\$0.11	\$206	48.6%	-29.2%	48.6%
	Total	52,336	424	93,736	71	\$12,659,268	\$3,499,446	\$16,158,714	\$1.02	\$172	3.0%	18.6%	3.0%

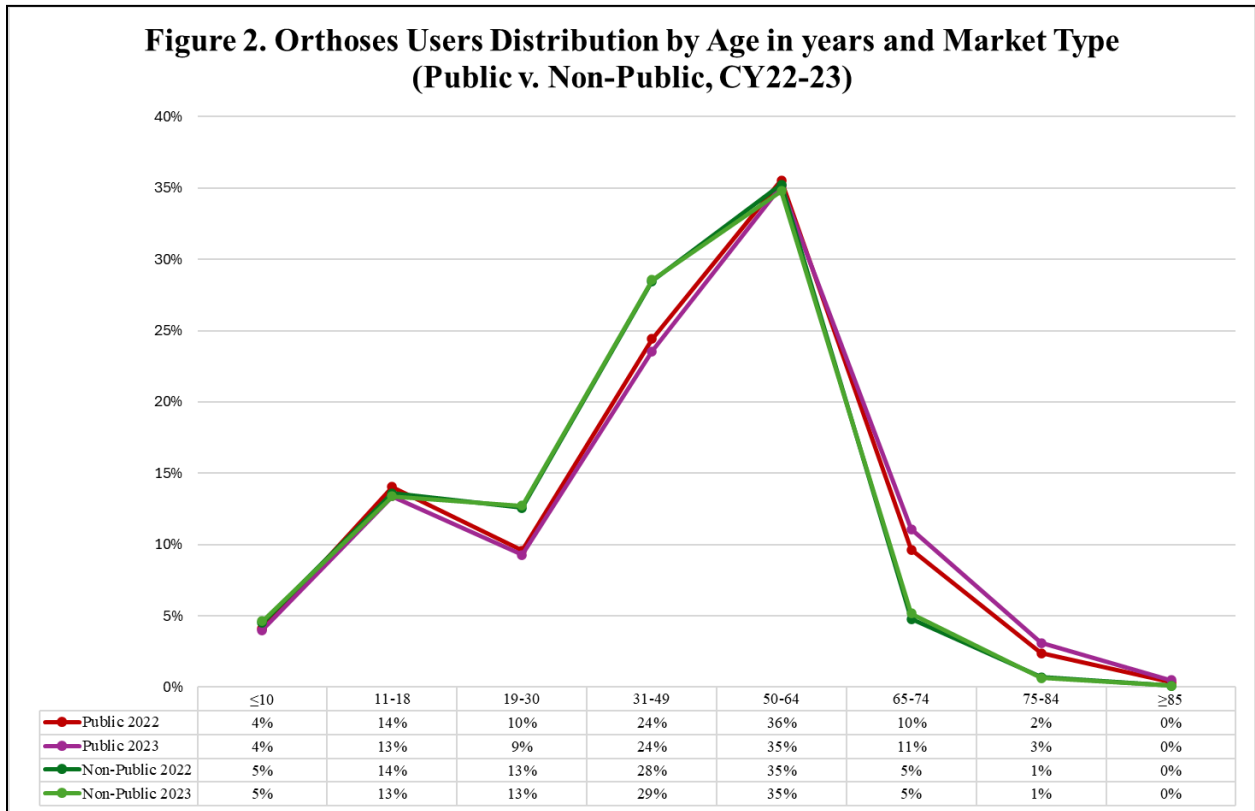
Notes: (i) Non_State_Employee includes City and County Government only.

(ii) State_Employee is the State Health Plan.

(iii) Excludes Self-Insured ERISA and FEHB Plans (~ 44% of the Commercial Population in the MCDB) due to Federal Decisions.

(iv) The 2021 trends (PMPM, Utiliz—Units/1,000, and Unit Cost) are changes from 2019 to 2021.

Analysis of the distribution of persons utilizing orthoses by market type and age ranges demonstrate similar trends in utilization between age groups. Non-publicly ensured individuals ages 11-49 years used fewer units than publicly ensured individuals, with the opposite being true for individuals aged 50-84 years. Across all markets, persons 50-64 years of age had the highest utilization of orthoses (see Figure 2 below).



Comparing Medicaid Participant Utilization to Commercial Market Utilization by Age

Medicaid FFS participants' orthoses utilization trends are more similar to commercial market utilization trends (includes public and non-public segments of the commercial market) with the exception that FFS participants aged ≥85 yrs use more orthoses than did commercial market enrollees in the same age range (4% as compared to 0%). There are two differences of note when trends are compared across Medicaid Managed Care, FFS, and commercial payers with regard to the utilization of orthoses by age:

- 1) Medicaid Managed Care participants ages 11-18 years used orthoses at a substantially higher rate as compared to other age and payer types (23% as compared to 7% FFS MA, and 14% commercial market).
- 2) Medicaid Managed Care participants ages 31-49 years had the highest rate of utilization than any other MCO age group (28%) suggesting that MCO participants require orthoses earlier in their lives than participants in other groups.

IV. SB 614 Expansion of Coverage of Prosthetics for Whole-Body Health

Medical Assistance Coverage Expansion - Prosthetic “L” codes for Whole-body Health

Effective January 1, 2025, MDH is expanding benefits to include coverage of prosthetic devices and components once annually when medically necessary for the purpose of participating in certain physical activities including running, biking, swimming, strength training, and other activities to maximize their whole-body health and lower or upper limb function. In addition to prefabricated prosthetic devices and components of prosthetic devices, Medical Assistance will cover custom-designed, fabricated, fitted, or modified prosthetic devices to treat partial or total limb loss for purposes of restoring physiological function when medically necessary.

Medical Assistance also provides coverage for repairs of covered prosthetic devices and components of prosthetic devices. Once annually, medically necessary prosthetic devices are covered that are less than three years old if the replacement is necessary for the following reasons:

- because of a change in the physiological condition of the patient;
- unless necessitated by misuse, because of an irreparable change in the condition of the prosthesis or the component of the prosthetic device; or
- unless necessitated by misuse, because the condition of the prosthetic device or the component of the prosthetic device requires repairs and the cost of the repairs would be more than 60 percent of the cost of replacing the prosthetic device or the component of the prosthetic device.

MDH conducted an analysis of the “L” codes for prosthetic devices currently covered by Medical Assistance and Medicare. Following this review, MDH identified nineteen (19) additional prosthetic “L” codes which will be added to the Medical Assistance Fee Schedule beginning January 1, 2025. In addition, MDH is amending regulations,¹³ issuing guidance to MCO and FFS providers regarding these changes, as well as adding the new codes to the Maryland Medicaid Information System (MMIS) to allow for billing.¹⁴ A complete list of new prosthetic “L” codes being added to the Fee Schedule is available in Appendix A.

Commercial Coverage Expansion - Prosthetic “L” codes for Whole-body Health

MHCC does not have the authority to set specific reimbursement rates for the commercial market in Maryland. The General Assembly could require MHCC to take specific actions, but to date, the General Assembly has not taken any such action. MHCC notes that Insurance Article § 15-844 (Benefits for Prosthetic Devices) mandates coverage for these services in the commercial market. The Maryland Insurance Administration enforces coverage of mandated benefits.

¹³ COMAR 10.09.12 Disposable Medical Supplies and Durable Medical Equipment; COMAR 10.67.01 Maryland Medicaid Managed Care Program: Definitions; and COMAR 10.67.06 Maryland Medicaid Managed Care Program: Benefits.

¹⁴ HCPCS codes for prosthesis added to the fee schedule: L5703, L5971, L5973, L6715, L6721, L6722, L6880, L6883, L7404, L7405, L8041, L8044, L8047, L8515, L8609, L8612, L8641, L8642, and L8658.

V. Study of Expansion of Coverage of Orthotic “L” Codes for Whole-body Health

Medical Assistance Program

MDH conducted a review of the utilization of “L” codes for orthoses by the FFS and MCO populations and estimated the cost of expanding coverage for orthoses for whole-body health. Medical Assistance currently covers 370 orthotic “L” codes on the Fee Schedule. MDH conducted an analysis of these codes, those covered by Medicare, and a list of orthotic “L” codes provided by stakeholders to assess if expansion of coverage to include additional orthotic “L” codes would be necessary to implement coverage for whole-body health purposes. The fiscal impact of adding these codes to the Fee Schedule has been incorporated into the estimates discussed below.

Estimating the cost of expanding orthoses coverage to include whole-body health

MDH’s clinicians reviewed the Fee Schedule and determined that 258 orthotic “L” codes on the Fee Schedule met the criteria wherein a provider might prescribe an individual multiple sets of the same orthotic “L” code: one set for activities covered today (e.g., orthoses to fit work shoes) and another set of the same type of orthoses for whole-body health purposes (e.g., a set that would be used in concert with running shoes).

To determine a baseline from which to estimate the cost of expanding coverage to include whole-body health, the Hilltop Institute at the University of Maryland Baltimore County (Hilltop) conducted an analysis of the current utilization of 258 orthotic “L” codes identified as relevant for purposes of the expansion. Utilization was assessed by MCO vs. FFS participants. Hilltop determined the number of unduplicated FFS and MCO participants, the units per year, as well as the cost per year by MCO and FFS populations (see Table 3).

Table 3 shows trends in the utilization of select “L” codes by Medicaid participants in CY22 and CY23. In CY22, there were 37,396 total Medicaid participants who utilized the aforementioned list of 258 “L” codes for orthoses; in CY23 this number increased to 38,420. MCO participants used approximately 81% of the total service units each year and accounted for 85% and 81% of the total expenditure in CY22 and CY23, respectively.

Table 3. Utilization of Select “L” codes for Orthoses, CY 2022-2023					
Calendar Year	Category	Unique Users	Codes Used	Units of Services	Expenditures
2022	FFS	3,689	160	11,582	\$1,471,680
	MCO	33,715	174	52,419	\$8,188,491
	TOTAL	37,396	192	64,001	\$9,660,171
2023	FFS	3,742	133	11,368	\$1,766,130
	MCO	34,702	173	46,988	\$7,704,774
	TOTAL	38,420	184	58,356	\$9,470,904

Note: A participant can be in one or both years during the study period. FFS providers have up to twelve months to submit claims, and therefore, utilization for CY23 may change in subsequent data runs. For FFS claims, Hilltop estimated payments by multiplying units of service by the corresponding rate based on posted fee schedule and limiting to 5% of costs to account for Medicare as a secondary payer for duals (approximately 66% of FFS users). Partial Medicaid reimbursement was only applied to duals. Full rates applied for non-duals. Payments for MCO encounters were estimated by multiplying units of service by the corresponding full Medicaid rates. Source: MMIS2 data as of September 30, 2024.

Table 4 on the following page shows utilization for CY23 and projected utilization, rates and costs for CY24, CY25, and CY26.¹⁵ These projections account for both increases in baseline expenditures from CY23 and the projected costs associated with expanding coverage to include orthoses for whole-body health purposes in CY26.

Establishing a Baseline

Using CY23 data as a baseline, MDH projected expected orthoses costs for CY24, CY25, and CY26 under the existing coverage policy. For CY24 and CY25, MDH applied a 3% increase in participants utilizing services and a 3% growth rate in units of services utilized above CY23. Expenditure projections for CY24 were based on the fee schedule for the current year and assumed a 3% reimbursement rate increase in CY25 (See Tables 4 and 5 on the following pages for additional information).

Projecting Increases in Costs to Account for Benefit Expansion

To account for the cost associated with expanding the orthoses benefit to include whole-body health coverage, MDH utilized the baseline projection for CY26 and conservatively assumed the number of units utilized would increase by 30%.¹⁶ This assumption reflects research indicating

¹⁵ To the extent rate increases and utilization exceed the projections for CY25, actual costs to implement this expansion in CY26 may be higher.

¹⁶ Analysis performed by other states, as well as studies published in the peer-reviewed literature, estimate that over the course of 10 years, between 50-60% of the population utilizing orthoses will utilize additional orthoses for whole-body health if the benefit is expanded. Minnesota Commerce Department, (2024). HF 3339/ SF 3351 – Evaluation of Coverage for Orthotic and Prosthetic Devices Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26 and Malouff, S et al., (2024). A Multi-State Analysis of the Fiscal and Social Impact of Commercial

that among amputees receiving a prosthesis, approximately 95% are initially assessed at a K-level of 2 or 3,¹⁷ and with physical therapy, a subset of individuals are able to increase their mobility by at least one K-level, potentially resulting in the need for new orthoses paired with higher K-level prostheses required to participate in whole-body health activities.^{18,19} Among Maryland Medicaid MCO participants, 68% of the population utilizing orthoses are less than 50 years of age, suggesting that they may be more likely to reap the benefits of therapies that would allow them to expand their capacity to participate in whole-body health activities potentially requiring new orthoses.²⁰

For CY26, MDH estimates that 42K unique users will utilize 80K units of orthoses, 16,718 of these units are projected to be for purposes of whole-body health. The associated fiscal impact is estimated at \$2.9M Total Funds (\$1.1M General Funds, \$1.8M Federal Funds). Costs for the FFS population are estimated at \$552K Total Funds (\$276K General Funds, \$276K Federal Funds) and the fiscal impact for the MCO population is estimated to account for approximately \$2.4M (\$825K General Funds, \$1.6M Federal Funds). Please see Appendix C for the assumptions underlying this work and the limitations that should be considered in interpreting this analysis. Tables 4 and 5 on the following pages provide additional detail specific to the additional cost of expanding the benefit.

Fairness & Activity Specific Insurance Coverage for Prosthetic & Orthotic Devices in the United States, European Society of Medicine. <https://esmed.org/MRA/mra/article/view/5104/99193547842>

¹⁷ Highest K-level rating is a “4” which is defined as: the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. https://www.ncbi.nlm.nih.gov/books/NBK531523/pdf/Bookshelf_NBK531523.pdf

¹⁸ Dobson and DeVanzo (2015). Summary Findings: K-level analysis (administrative claims for prostheses). <https://www.aopanet.org/wp-content/uploads/2016/01/K2-K3-Dobson-Preliminary-Results-K-Level-Analysis-1-15-15.pdf>

¹⁹ Gailey, R., et al., (2020). Effectiveness of an Evidence-Based Amputee Rehabilitation Program: A Pilot Randomized Trial, *Physical Therapy*, (100)(5), pp 773-787.

²⁰ It is important to note that the majority of the peer reviewed literature, as well as available reports from stakeholders and other states, focus on costs associated with expanding coverage of prostheses for whole-body health among commercial market enrollees with amputations; therefore, it is difficult to estimate the cost of expansion of orthoses among the Medical Assistance population. This further bolstered MDH’s conservative approach to estimating an uptake of 30% among the population of focus. As more states expand coverage of prostheses and orthoses for whole-body health purposes across payers, more accurate projections will be possible.

Table 4. Projected Increase in Utilization and cost of Select “L” Codes for Orthoses*

Category	ACTUAL				PROJECTED											
	CY 2023				CY 2024				CY 2025				CY 2026–Orthoses Expansion			
	Users	Service Units	Avg. Unit Cost	Cost	Users	Service Units	Avg. Unit Cost	Cost	Users	Service Units	Avg. Unit Cost	Cost	Users	Service Units	Avg. Unit Cost	Cost
FFS	3,742	11,378	\$155	\$1,766,130	3,854	11,719	\$160	\$1,873,687	3,970	12,071	\$165	\$1,987,795	4,089	15,692	\$170	\$2,661,657
MCO	34,702	46,988	\$164	\$7,704,774	35,743	48,398	\$169	\$8,173,995	36,815	49,850	\$174	\$8,671,791	37,920	64,804	\$179	\$11,611,528
Total	38,420	58,366	\$162	\$9,470,904	39,597	60,117	\$167	\$10,594,242	40,785	61,920	\$72	\$10,659,586	42,009	80,497	\$177	\$14,273,185

*Please note there are small discrepancies related to rounding.

Notes: Projections are based on baseline utilization data, unit rate and number of participants utilizing services from CY23. FFS providers have up to twelve months to submit claims, and therefore, utilization for CY23 may change in subsequent data runs; [1] Estimated as a 3% increase in users in projected calculations for CY24, CY25 and CY 26; [2] Estimated as a 3% increase in units of services for CY24 and CY25 while a 30% increase in units of services in CY26 due to the implementation of coverage for orthoses for whole-body health purposes in CY26; [3] Applied an average 3% increase in per-unit costs based on fee schedule for CY23 and projected a 3% increase in per unit cost for CY24, CY25 and CY26; [4] Expenditure is estimated as new units of service times new average per-unit cost. For FFS claims, Hilltop estimated payments by multiplying units of service by the corresponding rate based on posted fee schedule and limiting to 5% of costs to account for Medicare as a secondary payer for duals (approximately 66% of FFS users). Partial Medicaid reimbursement was only applied to duals. Full rates applied for non duals. Payments for MCO encounters were estimated by multiplying units of service by the corresponding full Medicaid rates. Source: MMIS2 data as of September 30, 2024.

Table 5. Comparison of Projected Baseline Costs to Projected Costs Associated with Expansion of Orthoses Benefit to include Whole-body health (CY26)*

	Unique users	Units of Service	Expenditures*		
			Total Funds	State General Funds	Federal Matching Funds
FFS Baseline	4,089	12,433	\$2,108,852	\$1,054,426	\$1,054,426
FFS Expanded	4,089	15,692	\$2,661,657	\$1,330,829	\$1,330,829
FFS New Costs for Orthoses Expansion	-	3,259	\$552,806	\$276,403	\$276,403
MCO Baseline	37,920	51,345	\$9,199,903	\$3,147,287	\$6,052,616
MCO Expanded	37,920	64,804	\$11,611,528	\$3,972,304	\$7,639,224
MCO New Costs for Orthoses Expansion	-	13,459	\$2,411,625	\$825,017	\$1,586,608
Total Baseline	42,009	63,778	\$11,308,755	\$4,201,713	\$7,107,042
Total Expanded	42,009	80,496	\$14,273,185	\$5,303,133	\$8,970,053
Total Projected Expansion Cost for Orthoses Expansion**	-	16,718	\$2,964,430	\$1,101,420	\$1,863,011

* Please note there are small discrepancies related to rounding

**Total Projected Expansion Cost is for CY26, actual costs for CY26 may be higher based on uptake, unit cost, and Medicaid enrollment, in addition these projections are subject to a number of limitations listed as noted in the report and Appendix C.

Commercial Market -MHCC Study

MHCC used a similar approach to MDH in estimating the cost of expanding orthoses coverage to include whole-body health. Specifically, MHCC used the 258 orthotic “L” codes provided by MDH.

Table 6 below demonstrates trends in the utilization of select “L” codes by commercial participants for CYs 21-23. The number of commercial participants who used orthoses decreased over these years. Specifically, in CY21, 44,436 participants utilized orthoses across all markets (public: 24,851 and non-public: 19,575), this number decreased to 41,446 in CY22 (public: 22,939 and non-public: 18,507), and in CY23 this number decreased further to 34,845 (public: 18,770 and non-public: 16,075). It is important to note that the data for CY23 may not be complete given that claims for orthoses for some publicly insured groups are still being processed; therefore the CY23 reduction in utilization should be interpreted as potentially an underestimate for the year (see Table 6 for additional information).

Table 6: Utilization of Select "L" codes for Orthoses, CY21 - 23											
Year	Market	Unique Patients	Unique CPTs	Total Units	Units/ 1000	Total Allowed Costs	Total costs PMPM	Unit Cost	Total PMPM Trends	Utiliz Trends	Unit Cost Trends
2021	Individual	4,447	99	7,200	36	\$1,037,288	\$0.43	\$144	37.9%	31.8%	4.7%
	Small Group	6,754	110	10,583	40	\$1,510,677	\$0.47	\$143	1.1%	0.2%	0.9%
	Large Group	8,288	97	12,756	24	\$1,795,022	\$0.28	\$141	12.7%	9.7%	2.7%
	State_Employee	8,071	119	14,170	61	\$2,114,908	\$0.76	\$149	-7.6%	-7.3%	-0.4%
	Non_State_Employee	16,790	116	31,215	72	\$4,640,936	\$0.89	\$149	21.5%	19.6%	1.6%
	Student Health Plan	86	16	141	7	\$21,675	\$0.10	\$154	100.2%	98.7%	0.7%
	Total	44,436	163	76,065	45	\$11,120,506	\$0.55	\$146	15.4%	13.5%	1.7%
2022	Individual	4,318	99	6,774	33	\$974,254	\$0.40	\$144	-8.4%	-8.3%	-0.2%
	Small Group	6,452	110	9,841	38	\$1,452,764	\$0.47	\$148	-1.5%	-4.7%	3.4%
	Large Group	7,665	97	11,787	19	\$1,716,279	\$0.23	\$146	-16.1%	-18.9%	3.5%
	State_Employee	7,835	119	13,553	61	\$2,068,877	\$0.78	\$153	2.9%	0.6%	2.3%
	Non_State_Employee	15,104	116	27,656	58	\$4,291,241	\$0.74	\$155	-16.0%	-19.6%	4.4%
	Student Health Plan	72	16	120	6	\$14,166	\$0.06	\$118	-37.1%	-18.1%	-23.2%
	Total	41,446	159	69,731	39	\$10,517,581	\$0.49	\$151	-11.1%	-13.8%	3.2%
2023	Individual	4,326	99	6,920	33	\$999,527	\$0.39	\$144	-1.2%	-1.6%	0.4%
	Small Group	6,224	110	9,599	39	\$1,471,846	\$0.50	\$153	7.9%	3.9%	3.9%
	Large Group	5,478	97	8,145	22	\$1,184,433	\$0.26	\$145	11.9%	12.0%	-0.1%
	State_Employee	8,229	119	14,777	64	\$2,306,841	\$0.83	\$156	6.4%	4.0%	2.3%
	Non_State_Employee	10,541	116	19,945	82	\$3,098,586	\$1.06	\$155	42.8%	42.6%	0.1%
	Student Health Plan	47	16	71	4	\$13,556	\$0.07	\$191	17.6%	-27.3%	61.7%
	Total	34,845	154	59,457	45	\$9,074,789	\$0.57	\$153	17.1%	15.7%	1.2%

Notes:

- (i) Non_State_Employee includes City and County Government only
- (ii) State_Employee is the State Health Plan
- (iii) Excludes Self-Insured ERISA and FEHB Plans (≈ 44% of the Commercial Population in the MCDB) due to Federal Decisions
- (iv) The 2021 trends (PMPM, Utiliz—Units/1,000, and Unit Cost) are changes from 2019 to 2021

Establishing a Baseline

Using CY23 data as baseline, MHCC projected expected orthoses costs for CY24, CY25, and CY26. CY23 data excludes self-insured ERISA and Federal Employees Health Benefits (FEHB) health plans as per federal decisions. MHCC applied a 3% increase in orthoses recipients across all markets. Expenditure projections for CY24 and CY25 are based on the average long-term utilization trends (units per 1,000 insured members per year).

Projecting Increase in Costs to Account for Whole-body Health Benefit Expansion

MHCC used baseline data to project costs associated with expanding orthoses coverage to include whole-body health in a manner similar to MDH (see Appendix D for additional information regarding the assumptions and limitations). To evaluate the cost associated with expanding the orthoses benefit to include whole-body health coverage, MHCC used a similar approach to what MDH used. Specifically, MHCC used the projected CY25 as the baseline for CY26, assuming a 30% increase in service units across all markets due to expanding the benefits coverage to include whole-body health. As noted earlier by MDH, this assumption of a 30% increase in units of measure for whole-body health orthoses originated from an actuarial study prepared for the Minnesota legislature. Also, MHCC used MDH’s assumption of a 3% increase in unit cost across all markets. We chose this assumption because of the wearing of the long-term utilization trends assumption by CY26. These assumptions imply an overall 33.9% increase in expenditure across all markets for CY26 (see Tables 7 and 8 for additional information).

Table 7: Projected Increase in Utilization of Select "L" codes for Orthoses, CY23-26																
Market	2023				2024				2025				2026			
	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs	Unique Individ.	Total Units	Unit Cost	Total Allowed Costs
Individual	4,326	6,920	\$144	\$999,527	4,456	7,417	\$144	\$1,064,901	4,589	7,950	\$143	\$1,134,552	4,727	10,335	\$147	\$1,519,165
Small Group	6,224	9,599	\$153	\$1,471,846	6,411	10,130	\$155	\$1,572,116	6,603	10,691	\$157	\$1,679,216	6,801	13,899	\$162	\$2,248,471
Large Group	5,478	8,145	\$145	\$1,184,433	5,642	9,154	\$147	\$1,347,051	5,812	10,289	\$149	\$1,531,996	5,986	13,375	\$153	\$2,051,342
State_Employee	8,229	14,777	\$156	\$2,306,841	8,476	15,410	\$157	\$2,425,602	8,730	16,071	\$159	\$2,550,478	8,992	20,892	\$163	\$3,415,090
Non_State_Employee	10,541	19,945	\$155	\$3,098,586	10,857	23,786	\$157	\$3,728,743	11,183	28,366	\$158	\$4,487,056	11,518	36,876	\$163	\$6,008,167
Student Health Plan	47	71	\$191	\$13,556	48	83	\$223	\$18,507	50	97	\$261	\$25,268	51	126	\$268	\$33,833
Total	34,845	59,457	\$153	\$9,074,789	35,890	65,981	\$154	\$10,156,921	36,967	73,464	\$155	\$11,408,565	38,076	95,504	\$160	\$15,276,068

For CY26, MHCC estimates that 38,076 unique participants will use 95,504 units of orthoses and 19,835 of these units are forecasted to be for the purposes of whole-body health (see Table 8 on the following page for additional information). The estimated associated fiscal impact is \$3.2M. The breakdown of the \$3.2M by market is as follows: \$1.22M for non-public (individual, small group, large group, student health plan); \$709K for State Health Plan, and \$1.25K for Local State Gov't (Non-State Employee).

VI. Conclusion

MDH and MHCC are committed to the successful implementation of SB 614's requirements. MDH and MHCC have engaged with stakeholders during the implementation planning process. Additionally, MDH has made needed system changes, initiated amendments to regulations, and issued guidance to the DMS/DME Providers as well as MCOs regarding the changes they need to implement beginning January 1, 2025. Further expansion of benefits to include coverage for orthoses for whole-body health purposes would conservatively cost the Medical Assistance Program at least \$2.9M Total Funds (\$1.1M State General Funds, \$1.8M Federal Funds) annually, with a similar estimate for the commercial market of \$3.2M in additional costs annually.

Implications for the Medical Assistance Program

MDH evaluated the 370 orthoses codes on the Fee Schedule to determine which "L" codes were likely to see an increase in utilization were MDH to expand the orthoses benefit to include whole-body health. Using this subset of "L" codes, MDH established historical utilization by both the FFS and MCO populations and projected the cost of expanding the orthoses benefit to include whole-body health in CY26. MDH conservatively estimates that expansion of orthoses benefits to include whole-body health at a 50% Federal Medical Assistance Percentage (FMAP) for FFS costs and 65.79% blended FMAP for MCOs would cost approximately \$2.9M Total Funds (\$1.1M State General Funds, \$1.8M Federal Funds) annually. There are limitations to MDH's analysis; therefore, these projected costs likely underestimate the actual cost of benefit expansion.²¹

Implications for Commercial Market

MHCC utilized the same "L" code subset as MDH to project the cost of expanding coverage of whole-body health for orthoses for the commercial market. MHCC conservatively estimates that the cost to expand orthoses coverage to include whole-body health for the commercial market would cost approximately \$3.2M annually. There are limitations to the MHCC's analysis as well; therefore, these projected costs likely underestimate the actual cost of benefit expansion (see Appendix D for assumptions and limitations).

²¹ See Appendix C for additional detail regarding the limitations associated with MDH's estimates.

Appendix A: List of Prosthetic “L” codes to be covered by Medical Assistance effective January 1, 2025

Additional Prosthetic Procedure Codes to be covered effective January 1, 2025		
No.	HCPCS	Description of Prosthetic "L" codes
1	L5703	Symes ankle w/o (sach) foot
2	L5971	Sach foot, replacement
3	L5973	Ank-foot sys dors-plant flex
4	L6715	Term device, multi art digit
5	L6721	Hook/hand, hvy dty, vol open
6	L6722	Hook/hand, hvy dty, vol clos
7	L6880	Elec hand ind art digits
8	L6883	Replc sockt below e/w disa
9	L7404	Add ue prost a/e acrylic
10	L7405	Add ue prost s/d acrylic
11	L8041	Midfacial prosthesis
12	L8044	Hemi-facial prosthesis
13	L8047	Nasal septal prosthesis
14	L8515	Gel cap app device for trach
15	L8609	Artificial cornea
16	L8612	Aqueous shunt prosthesis
17	L8641	Metatarsal joint implant
18	L8642	Hallux implant
19	L8658	Interphalangeal joint spacer

Appendix B: Medical Assistance Program Orthoses Utilization by Age

Orthoses Utilization by Age, CYs 2022-2023					
Age Group	Category	Unique Users			
		2022		2023	
		#	%	#	%
<=10	FFS	345	9%	360	10%
	MCO	3,254	10%	3,382	10%
11-18	FFS	260	7%	260	7%
	MCO	7,761	23%	8,138	23%
19-30	FFS	172	5%	191	5%
	MCO	5,813	17%	6,149	18%
31-49	FFS	530	14%	494	13%
	MCO	9,298	28%	9,622	28%
50-64	FFS	937	25%	917	25%
	MCO	7,420	22%	7,209	21%
65-74	FFS	910	25%	974	26%
	MCO	169	1%	202	1%
75-84	FFS	380	10%	391	10%
	MCO	-	-	-	-
>=85	FFS	155	4%	155	4%
	MCO	-	-	-	-

Appendix C: Medical Assistance Program Assumptions and Limitations to estimate the cost of coverage expansion to include whole-body health.

Assumptions used to estimate the cost of expanding coverage to include whole-body health

- Annual growth in the Medicaid enrolled population at 3%;
- Cost of orthoses will increase annually at 3% based on estimated changes to the Medicare Fee schedule;
- FFS and MCO populations will increase their use of orthoses equally at a rate of 30% if the orthoses benefit is expanded to include whole-body health;^{22,23}
- Maryland will continue to reimburse for orthoses at 85% of the Medicare rate; and
- Blended FMAP for MCO costs: 65.79%, FMAP for FFS: 50%.

Limitations in determining implications of expanding orthoses coverage to include whole-body health

- **K-levels:** MDH has no way to capture the K-level of MCO or FFS participants. Studies demonstrate that K-levels can increase as physiotherapies progress, and individuals are more and more able to ambulate and participate in whole-body health activities.²⁴
- **Utilization by MCO participants:** Current utilization of orthoses reflects utilization authorized for activities of daily living at home, school, and work. Historically, FFS participants use orthoses and prosthetics at substantially higher rates than MCO participants. What is unclear is whether expanding orthoses coverage for whole-body health will change these historical utilization patterns or if MDH will see a higher uptake by MCO participants given that these individuals may be more able to pursue whole-body health activities. This analysis assumes uniform growth in utilization by both populations. To the extent actual utilization increases at a higher rate for MCO enrollees, state general fund costs may be higher as the majority of FFS participants who use orthoses (66%) are dually eligible for Medicare.
- **Interactions between expansion of benefits:** There is a dearth of literature regarding whether expanding access to both prostheses and orthoses for whole-body health results in an interaction; whereby states observe an increased volume of prostheses and orthoses when access is expanded to both, as opposed to only prostheses. It may be reasonable to assume that for some individuals, expansion will result in increased utilization of both prostheses and orthoses based on the whole-body health activity they choose to pursue. Increased utilization across both benefit categories could further increase the fiscal impact.
- **Impact of Age on Utilization:** There is a dearth of information in the literature regarding the impact of age on the use of prostheses or orthoses for whole-body health. There are

²² Minnesota Commerce Department, (2024). HF 3339/ SF 3351 – Evaluation of Coverage for Orthotic and Prosthetic Devices Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26 <https://www.house.mn.gov/comm/docs/MPM-owNuSkukbbGUchfa7w.pdf>

²³ Malouff, S et al., (2024). A Multi-State Analysis of the Fiscal and Social Impact of Commercial Fairness & Activity Specific Insurance Coverage for Prosthetic & Orthotic Devices in the United States, *European Society of Medicine* <https://esmed.org/MRA/mra/article/view/5104>

²⁴ Anderson, K.M., et al., (2021). Custom Dynamic Orthoses and Physical Therapist Intervention for Bilateral Midfoot Amputation: A Case Report, *Journal of the American Physical Therapy Association* <https://pmc.ncbi.nlm.nih.gov/articles/PMC8054777/>

indicators that MDH might see high levels of uptake among young adults and children under the age of 18.²⁵ On the other hand, there are studies demonstrating that persons 45-64 account for 42% of amputations, the second highest rate behind persons aged 65+ (44%); therefore, it is possible that this age group might also see a substantial increase in utilization were the orthoses benefit to be expanded to include whole-body health as the majority of these amputations are foot related.²⁶

²⁵ Birth Defects (2024). Limb reduction defects, *Center for Disease Control and Prevention*.
<https://www.cdc.gov/birth-defects/about/limb-reduction-defects.html>

²⁶ Caruso, M., & Harrington, S., (2024). Prevalence of Limb Loss and Limb Difference in the United States: Implications for Public Policy. *Funded by a Grant from the Administration for Community Living, Department of Health and Human Services*.
https://www.amputee-coalition.org/wp-content/uploads/2024/05/Prevalence-of-Limb-Loss-and-Limb-Difference-in-the-United-States_Implications-for-Public-Policy.pdf

Appendix D: MHCC Assumptions and Limitations to estimate the cost of coverage expansion to include whole-body health.

Using current benefits coverage, MHCC used the CY23 as a baseline to project expected orthoses costs for CY24-26 if Maryland were to expand commercial coverage to include orthoses for whole-body health.

Due to federal decisions, please note that the CY23 base year data excludes self-insured ERISA and FEHB health plans. For each projected year (CY24-26) MHCC assumed a 3% increase in the population using orthoses across all markets. For CY24-25, MHCC used average long-term utilization trends (units per 1,000 insured members per year), including CY19-23 to forecast units of service by market as follows:

- 7.2% increase in units of service for the individual market
- 5.5% for small group
- 12.4% for large group
- 4.3% for State Health Plan (State Employee)
- 19.3% for Local State Gov't (Non-State Employee)
- 16.9% for Student Health Plans (a small market segment)
- Resulting in an assumed 11.0% increase in units of service across all markets

Similarly, using average long-term allowed PMPM trends for CY19-22, and CY23 for CY24-25, the following assumptions were used regarding increases in expenditures by market: 6.5% increase in spending for the individual market; 6.8% for small group; 13.7% for large group; 5.1% for State Health Plan; 20.3% for Local State Gov't; and 36.5% increase for Student Health Plan (note that Student Health Plan is about 0.2% of total expenditures). These assumed increases in spending by market imply an overall assumed increase of the expenses of about 12% across all markets. Considering the average long-term allowed PMPM and utilization trends for CY19-22, and CY23 for CY24-25 imply the following assumed changes in unit cost by market:

- A 0.6% decrease in unit costs for the individual market
- 1.2% increase in unit cost for small group and large group
- 0.8% increase in unit costs for the State Health Plan
- 0.9% increase for Local State Gov't
- There was a 16.8% increase in unit cost for the Student Health Plan (a small market that accounts for about 0.2% of total expenditure).
- The resulting overall assumed increase in unit cost across all markets is about 0.9%.