MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

June 29, 2018

Mr. Tim Hill
Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Hill,

The Secretary of Health is requesting an amendment to Maryland's §1115 HealthChoice demonstration to: 1) cover National Diabetes Prevention Program (National DPP) services through a limited pilot program; 2) pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutes of Mental Disease (IMD); 3) cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age; 4) expand the cap of the Assisted Community Integration Services; and 5) remove the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

National Diabetes Prevention Program Pilot

A waiver will allow the Department to enable HealthChoice managed care organizations (MCOs) to offer National DPP, an evidence-based, Centers for Disease Control and Prevention (CDC)-established program, on a limited basis to eligible participants. This will allow the Department to evaluate the delivery of National DPP via the HealthChoice MCOs and ensure the desired outcomes are achieved.

Adult Dental Pilot Program

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

Expansion of Substance Use Disorder Residential Services

The Department is requesting expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 21 through 64 years of age who are residing in a private IMD and have a primary SUD diagnosis and a secondary mental health diagnosis by seeking to extend coverage for ASAM level 4.0 (Medically Managed Intensive Inpatient services).

Expansion of Assistance in Community Integration Services (ACIS) Pilot Cap

During the current HealthChoice §1115 Waiver Amendment public comment period, the Department received a request to increase the approved cap. Local government agencies provide general funds for the ACIS. Baltimore City has requested the opportunity to provide additional local funds to expand the program. Based on the supporting data and justification, the Department is requesting an additional 300 participant places for the ACIS Pilot, increasing the total annual cap to 600 participants.

Family Planning Program

The Department seeks to remove the family planning program per Chapters 464 and 465 of the Acts of 2018 (HB0994/SB0774) passed by the Maryland General Assembly, where the Department must apply for a State Plan Amendment (SPA) to expand the eligibility and access to the Family Planning Program.

The Department looks forward to working with CMS to develop a program that will provide high quality, cost-effective care for Medicaid enrollees. Thank you for considering our proposal. If you have any questions, please contact Tricia Roddy, Director of the Planning Administration, at 410-767-5809 or tricia.roddy@maryland.gov.

Sincerely,

[redacted]

Dennis R. Schrader
Chief Operating Officer & Medicaid Director
Maryland Department of Health

Maryland HealthChoice Program
§1115 Waiver Amendment

Submitted by
Maryland Department of Health

July 2, 2018

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Maryland Section 1115 Waiver Amendment Submission

Introduction and Objectives

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

This amendment would authorize the Department to: 1) cover National Diabetes Prevention Program (National DPP) services through a limited pilot program; 2) pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutes of Mental Disease (IMD); 3) cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age; and 4) expand the annual cap of the Assisted Community Integration Services. The Department further seeks the removal of the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

National Diabetes Prevention Program Pilot

Introduction

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

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

Background and Evidence

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

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

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

National DPP

The National DPP is a structured year-long program intended for adults 18 years of age and older who have prediabetes or are at high risk for developing type 2 diabetes. It includes lifestyle health coaching through weekly and monthly classes that teach skills needed to lose weight, become more physically active, and manage stress. People with prediabetes who take part in this evidence-based, CDC-established structured lifestyle change program can cut their risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old) over three years.[3] This is the result of the program helping people lose 5 percent to 7 percent of their body weight through healthier eating and 150 minutes of physical activity per week.

The National DPP includes an initial six-month phase where at least sixteen (16) weekly sessions, including make-up sessions, are offered over a period lasting at least 16 weeks and no more than 26 weeks. The second six-month phase must consist of at least one session each month and six (6) sessions total. Each session must be at least one hour long.

National DPP Eligible Population

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

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

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

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

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

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

AND EITHER 2) Elevated blood glucose level **OR** 3) History of gestational diabetes mellitus (GDM);[4]

AND NEITHER 4) Diagnosed with type 1 or type 2 diabetes; **NOR** 5) Currently pregnant.[5]

National DPP Suppliers—Lifestyle Coaches

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

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

National DPP Modes of Delivery

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

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

Reimbursement Methodology

For the CDC-funded demonstration, the Department worked with four MCOs to develop a reimbursement methodology. Subsequently, Medicare is now covering DPP services through Medicare Diabetes Prevention Program (MDPP) Expanded Model. The Department is working with stakeholders to develop a reimbursement methodology based on the CDC's average cost for National DPP and MDPP Expanded Model, which aligns payment with the CDC's evidence-based weight loss and attendance milestones.[6]

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[4] This refers to a 1)Fasting glucose of 100 to 125 mg/dl ; 2) Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl; 3) A1c of 5.7 to 6.4; or 4) Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy.

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

[6] 82 Fed. Reg. 52976. (2017). Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program. Retrieved from: https://www.federalregister.gov/documents/2017/11/15/2017-23953/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions; Centers for Disease Control and Prevention (CDC). (2016). National Diabetes Prevention Program: Implement a Lifestyle Change Program. Questions and Support: Frequent

The reimbursement model may include the use of modifiers in conjunction with Healthcare Common Procedure Coding System (HCPCS) codes to distinguish between the in-person and online delivery modes, and to facilitate evaluation of the program by delivery mode. A key difference between the Department's pilot program and Medicare is the coverage of online providers. The Department believes this is a critical piece in designing an effective program for Medicaid recipients.

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

Evaluation Design

The National DPP has been shown to reduce the risk of developing type 2 diabetes by 58 percent (71 percent for people over 60 years old) over three years, as well as producing cost savings.[7] The Department anticipates a reduction in incidence of diabetes and other related health care costs. Maryland's annual HealthChoice evaluation will be modified to include an evaluation to determine the effect(s) of National DPP participation on: (a) utilization of emergency medicine services; (b) all-cause hospital admission; (c) medications; (d) total cost of care (per member per month); and (e) incidence of diabetes.

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

Budget Neutrality

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

Questions about Offering a Program. What can organizations do if they feel that the cost of participating in a CDC-recognized lifestyle change program is too burdensome for participants? Retrieved from: https://www.cdc.gov/diabetes/prevention/lifestyle-program/questions_support.html.

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

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

	State FY2019	State FY2020
Total National DPP Allocation	$700,000	$1,400,000
Per Member Per Month	$41.67	$41.67
Estimated Number of Participants Served	1,400	2,800

Expansion of Substance Use Disorder Residential Services

Introduction

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

On October 26, 2017, the Trump Administration declared the opioid crisis a national Public Health Emergency.[8] The continuing rise of opioid addiction and increasing heroin-related deaths nationally over the last several years suggest that the need to improve outcomes and access to SUD treatment is of paramount importance.

Requested Changes, Objectives, and Policy Rationale

The number of drug- and alcohol-related intoxication deaths occurring in Maryland increased in 2016 for the sixth year in a row, reaching an all-time high of 2,089 deaths. This represents a 66 percent increase from the number of deaths in 2015 (1,259) and the largest recorded single-year increase. Eighty-nine percent of all intoxication deaths that occurred in Maryland in 2016 were opioid-related. The number of opioid-related deaths increased by 70 percent between 2015 and 2016 and has nearly quadrupled since 2010.[9]

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

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

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

CMS recently approved IMD exclusion waivers for ten states, including Maryland, California, Indiana, Kentucky, Louisiana, Massachusetts, New Jersey, Utah, Virginia, and West Virginia, which give waiver authority to use federal Medicaid funds to pay for IMD SUD services.[10] Similarly, CMS permits states, under the managed care rule, to make capitation payments for participants with a short term stay (no more than 15 days within a month) in an IMD for SUD and mental health treatment services, permissible under 42 C.F.R. §438.6(e).[11]

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

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

Anticipated Outcomes

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

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

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

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

Table 2. Anticipated Medicaid Participants Served and Amount Paid to IMDs, FY 2018[12]

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

The figures in Table 2 provide estimates of participants served and projected cost to deliver services in the three IMDs in Maryland for Medicaid-eligible participants with a dual diagnosis of SUD and a mental health disorder in SFY 2018. With the expansion of coverage for participants with a primary SUD diagnosis and secondary mental health diagnosis, Maryland expects utilization of IMD facilities to increase.

Evaluation Design

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

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

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

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

- ED utilization or treatment of SUD/MH conditions;
- Access to and average length of stay for acute inpatient settings for treatment of SUD/MH conditions;
- Readmission rates for inpatient treatment;
- Access to care for co-morbid physical health conditions; and

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

- Evaluate whether greater access to and utilization of IMDs affects utilization of acute inpatient, ED, and ambulatory care for non-behavioral health conditions.

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

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

Budget Neutrality

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

Table 3. Number of Medicaid Participants Served and Projected Costs, SFY 2019-2022[13]

State Fiscal Year (SFY)	Estimated Medicaid Participants (19-64) with Dual SUD/Mental Health Disorder Utilizing ASAM 4.0 IMD Services*	Average Length of Stay (ALOS) in Days	Per Member Cost Per Day*	Projected Cost (Total Funds)
SFY 2019 (coverage effective January 1, 2019)	1187	10	$1,435	$8,516,725
SFY 2020	1211	10	$1,449	$17,547,860
SFY 2021	1235	10	$1,464	$18,077,806
SFY 2022 (cost to deliver services through December 31, 2021)	1260	10	$1,478	$9,311,878

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

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

Adult Dental Pilot Program

Introduction

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

Adults with lower incomes are disproportionately impacted by lack of access to dental care. According to the Kaiser Family Foundation, 27 percent of all adults 20 to 64 years of age have untreated dental caries.[14] The highest rate (44 percent) among adults with income below 100 percent of the federal poverty level (FPL) is more than double the rate (17 percent) of adults with an income at or above 200% FPL. Further, in addition to risk of tooth and bone loss, infection, chronic pain, untreated dental disease is also associated with an increased risk of negative health outcomes, including higher incidence of and poorer outcomes for certain conditions, such as diabetes, heart and lung disease, and stroke.[15]

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

Current Dental Coverage and Utilization

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

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

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

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

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

Interest in Adult Dental Coverage in Maryland

In April 2015, the chairmen of the Senate Finance and House Health and Government Operations Committees requested that the Maryland Dental Action Coalition (MDAC) conduct a study on the cost to expand access to oral health care and coverage for adults. MDAC contracted with The Hilltop Institute to conduct the study and presented a summary of its findings to the House Health and Government Operations Committee in February 2016. Table 4 shows the differences between the three examined service plans, including the per member per month (PMPM) cost from the Hilltop Institute report.[16]

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

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

Chapter 721 of the Acts of 2017 (Senate Bill 169) authorized MDAC to conduct a study of the ED costs to treat dental conditions of adults in Maryland and the advisability of providing coverage for dental services to adults with incomes below 133 percent of Federal Poverty Level (FPL) under Medicaid. MDAC completed the study in December 2017 and found that in SFY 2016, there were 42,327 ED visits for chronic dental conditions among adults with an average charge of $537 and total charges of $22.7 million. The Maryland Medicaid program, according to the study, paid for 53 percent of ED visits for chronic dental conditions with an average charge of $446 and total charges of nearly $10 million in SFY 2016.[17]

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

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

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

Requested Changes, Objectives, and Policy Rationale

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

Anticipated Outcomes

Good oral health is correlated with good health overall. Adults with lower incomes are disproportionately impacted by lack of access to dental care. People with disabilities or chronic health conditions are more likely to have poor oral health. Additionally, research consistently shows associations between chronic oral infections and diabetes, lung and heart disease, stroke, and poor birth outcomes. Oral disease can also exacerbate chronic disease symptoms.[18] Untreated oral health needs can lead to nutritional deficits (due to being unable to eat) and chronic pain. Oral health problems may also result in decreased quality of life that affects an individual's ability to work, especially those in lower-paying industries. Adults in working-class industries lose two to four times more work hours due to oral health issues than adults who have professional positions.[19] Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions.[20] This is why *Healthy People 2020* included increasing the proportion of adults who used the oral health system in the past year as a goal and why the Department seeks to increase access to oral health care.[20]

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

Evaluation Design

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

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

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

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

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

Budget Neutrality

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

Based on this analysis, the PMPM cost for each additional participant for the services is approximately $8.69. Additionally, the administrative cost for each member under the current dental ACO is $0.39 PMPM, making the total cost $9.08 PMPM. Costs are subject to a 50 percent FMAP (Federal Medical Assistance Percentage). The total annual cost for adult dental services for the dual-eligible population 21 to 64 years of age is anticipated to be $4.2 million ($2.1 million Federal Funds, $2.1 million State General Funds) in FY 2019 (Table 5). With a 3 percent annual population increase, the total cost of these services may increase to $4.3 million in FY 2020.

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

Age Group of Dual-Eligible Adults	Total Number of Eligible Participants	Basic Benefits Package as Estimated in FY2019 Dental Update[22]		
		PMPM	Total Cost	Total Federal Funds
21 - 64	38,510	$10.82	$2,500,069	$1,250,035

Assistance in Community Integration Services (ACIS) Pilot - Expansion of Cap

Introduction

As part of Maryland's HealthChoice §1115 Waiver Renewal, the Department is offering local governments the opportunity to request matching federal funds for the Assistance in Community Integration Services (ACIS) Pilot. Each ACIS Pilot program will be managed locally by a lead local governmental entity (Lead Entity) that has the ability to fund fifty percent of total ACIS Pilot costs with local dollars, provide leadership, and coordinate with key community partners to implement the Pilot. Each Lead Entity may also identify other entities that will participate and assist the Lead Entity in providing services in the ACIS Pilot (Participating Entities).

ACIS Pilot implementation has been in effect from July 1, 2017 through present. Following two rounds of competitive funding opportunities, award notifications were offered to four Lead Entities who are currently participating in the ACIS Pilot program: Baltimore City - Mayor's Office of Human Services (Baltimore City MOHS) is partnering with Healthcare for the Homeless to serve up to 100 individuals; Montgomery County Department of Health and Human Services is partnering with the Coordinating Center, EveryMind and Family Services Inc. to serve up to 75 individuals; Cecil County Health

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

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

Department will provide services to up to 15 individuals. One new Lead Entity was selected during Round 2 of the application process; Prince George's County Health Department will partner with participating entities to serve up to 75 individuals. During the Round 2 application process, Montgomery County DHHS was also awarded an additional 35 individuals for a grand total of 110 individuals.

Requested Expansion

During the current HealthChoice §1115 Waiver Amendment public comment period, the Department received a written comment letter from stakeholder and current ACIS Participating Entity, Health Care for the Homeless (HCH), working with Baltimore City MOHS.

Based on this request, and its supporting data and justification, the Department is requesting an additional 300 participant places for the ACIS Pilot, bringing the total cap to 600 participants annually.

Background and Evidence

Health Care for the Homeless currently collaborates with the Baltimore Mayor's Office of Human Services and the Maryland Department of Health to provide services to Assistance in Community Integration Services (ACIS) Medicaid beneficiaries. They are implementing a 100-person pilot in Baltimore City as part of Maryland's 300-person ACIS waiver to deliver the supportive services necessary to end homelessness, improve health, sustain people in housing, and lower Medicaid costs. Baltimore Mayor's Office of Human Services, with its housing partners, has committed to providing housing resources for each enrolled ACIS Pilot beneficiary. Since the launch of the original pilot, public recognition of the relationship between housing and health has continued to grow. HCH believes there are a range of promising opportunities in the coming months and years to leverage additional housing opportunities for vulnerable populations at-risk of homelessness due to institutionalization and associated disability. Additional Medicaid waiver authority would allow them to finance the supportive services necessary to keep people stably-housed and improve health. Among these opportunities:

HUD Mainstream Vouchers: The Department of Housing and Urban Development has recently announced an opportunity for $100 million in new "Mainstream" housing vouchers for non-elderly people with disabilities. The notice specifically encourages applicants to partner with state Medicaid agencies to leverage necessary supportive services. HCH understands that the Housing Authority of Baltimore City has requested 450 additional vouchers, 100 of which would be targeted to people experiencing homelessness. HCH could most effectively use these additional housing vouchers by matching them with supportive housing services through the ACIS Pilot. Together with HCH, Baltimore City and other partners are open to identifying additional local match dollars for the ACIS Pilot to make this possible.

Health Insurers: Health insurers such as UnitedHealthCare and Kaiser Permanente are increasingly recognizing the relationship between housing and health and are launching initiatives aimed at improving the availability of housing for medically frail populations. Kaiser Permanente in particular has expressed interest in Baltimore City's on-going work in this arena.

Health and Hospital Partnerships: Health Care for the Homeless and Baltimore City are approaching hospital leaders to seek their participation in increasing the success of their supportive housing work. As part of these discussions, they are already exploring beneficiary populations that exceed the current 100-person pilot. Additional waiver authority would allow them to prioritize housing Medicaid beneficiaries and achieve additional savings through the provision of ACIS that improve housing stability and thus, health outcomes and rates of hospital utilization.

In June 2018, Health Care for the Homeless successfully used CRISP, the state-designed Health Information Exchange (HIE) to match data for 22 unique Medicaid participants who have been housed for more than a year. Using CRISP, HCH was able to examine health care costs a year prior to placement in housing and a full year after. One year after placement in housing, emergency department costs **decreased by 53%** and total health care spending **decreased by 33%.** HCH is currently expanding the sample size and looks forward to providing additional information about the cost savings associated with ending homelessness of vulnerable Medicaid enrollees.

ACIS Eligible Population

With the exception of the 300 beneficiary cap, the Department proposes to align with current Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for the HealthChoice Medicaid Section §1115 Demonstration (No. 28). Attachment E of the STCs provides additional information about the ACIS Pilot program (See Appendix A).[23]

In summary, ACIS Pilot programs will provide a set of home- and community-based services (HCBS) to a population that meets the needs-based criteria specified below, capped at 300 individuals annually.

As per the current ACIS pilot protocol in the Special Terms and Conditions of the §1115 Waiver, the state's needs-based criteria are specified below.

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

The ACIS Pilot application must be completed by a lead local government entity (Lead Entity), such as a local health department or local management board, with the ability to fund fifty percent of ACIS Pilot costs with local dollars through an intergovernmental transfer (IGT) process. Lead Entities will also be required to provide leadership and coordinate with key community partners to deliver the ACIS Pilot program. The ACIS Pilot will be effective from July 1, 2017 through December 31, 2021 and is scheduled to be funded for the duration of the waiver.

Reimbursement Methodology

With the exception of the 300 beneficiary cap, the Department proposes to align with current Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for the HealthChoice Medicaid Section 1115 Demonstration (No. 28). Attachment E of the STCs provides additional information about the ACIS Pilot program (See Appendix A).

[23] Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for the HealthChoice Medicaid Section 1115 Demonstration (No. 28) is available at: https://mmcp.health.maryland.gov/Documents/HealthChoice%20Community%20Pilots/FINAL%20MD%20HealthChoice%20STCs%20with%20Approved%20ACIS%20protocol%2006162017.pdf

Evaluation Design

With the exception of the 300 beneficiary cap, the Department proposes to align with current Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for the HealthChoice Medicaid Section §1115 Demonstration (No. 28). Attachment E of the STCs provides additional information about the ACIS Pilot program (See Appendix A).

Budget Neutrality

If authority is granted through this waiver amendment, the Department will expand the cap on the program from 300 to 600, and offer a round three competitive funding opportunity. Maryland's HealthChoice Medicaid Section §1115 Demonstration approved by CMS in December 2017 requested up to $1.2 million in matching annual federal funds, and when combined with the local non-federal share, ACIS Pilot expenditures for the approved expansion may total up to $2.4 million annually. No state general funds are necessary to implement the ACIS Pilot expansion.

Total program expenditures necessary to serve up to 600 beneficiaries, would then require up to $2.4 million in matching federal funds requested annually, and when combined with the local non-federal share, ACIS Pilot expenditures would total up to $4.8 million annually.

As according to current protocol, ACIS providers are required to provide a minimum of three services per month to each member to receive reimbursement in a given month. The Department will then pay the Lead Entity for the ACIS services per the monthly ACIS cost-based rate, which shall be the average cost of the total of a minimum of three ACIS tenancy-based case management services/tenancy support services and housing case management services.

Table 6. Total Anticipated Expenditures with Increased Participant Cap

	§1115 Waiver	§1115 Waiver Amendment - Expansion of Cap	New Proposed ACIS Total Computable
Local Share	$1,200,000	$1,200,000	$2,400,000
Federal Match	$1,200,000	$1,200,000	$2,400,000
Total Computable	$2,400,000	$2,400,000	$4,800,000
Approximate Per Member Per Year Cost	$8000	$8000	$8000
Estimated Number of Participants Served	$	300	600

Family Planning Program

Introduction

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

Requested Changes

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

Public Process and Indian Consultation Requirements

The Department provided public notice and solicited stakeholder participation for this §1115 waiver amendment application per the requirements in 42 C.F.R. §431.408. Notice was published in The Maryland Register on April 13, 2018 and May 11, 2018, as well as on the Department's website on April 12, 2018 (See Attachment I: Public Notice and Indian Consultation Documentation). The Department presented highlights of the waiver amendment to the Maryland MCO Liaison Committee at its May 3, 2018 meeting, informing those in attendance of the public notice content and upcoming hearing dates. The Department provided a 30-day public comment period, from May 21, 2018 through June 19, 2018. Given that June 28, 2018 was the original published date for public comment submission, the Department accepted public comments on the §1115 waiver amendment until the close of business on June 28, 2018. Comments, received after this date, were also accepted, to receive the broadest input from stakeholders possible.

In addition to publishing these notices, the Department conducted two public hearings on the amendment application. The first hearing was held in Baltimore City at the Maryland Department of Health on May 24, 2018 following the Maryland Medicaid Advisory Committee (MMAC) meeting in order to facilitate attendance by MMAC members and stakeholders attending this public forum. This hearing was accessible by audio conference and presented as a webinar so that slides would also be visible to participants not present at the Department. The second hearing was held on June 6, 2018, in Annapolis at the Miller Senate Building. During these hearings, the Department presented a summary of the amendment draft and we accepted verbal and written comments from stakeholders (See Appendix B: Summary of Public Comments and Attachment II: Written Comments Received for additional information on comments received). The public was also able to access information about the waiver amendment and submission of comments on the Department's website via the link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Additionally, on May 21, 2018, the Department sent an overview of the §1115 amendment application to Kerry Lessard, of the Office of Urban Indian Health Programs in Maryland, for input and comments. Ms. Leesard acknowledged the receipt on May 21, 2018. As of June 28, 2018, the Department did not receive any comments from Ms. Lessard. (See Appendix B: Summary of Public Comments and Attachment I: Public Notice and Indian Consultation Documentation).

Beyond these requirements, the Department continually consults with stakeholders on the HealthChoice program through the MMAC. The MMAC meets monthly and receives reports on regulatory and waiver changes, including amendments to the §1115 HealthChoice waiver. Annually, the MMAC provides feedback on the HealthChoice evaluation report. Notice of the waiver amendment, and public hearings, was distributed to the MMAC stakeholder email list, with instruction to submit written comments to the Department's stakeholder email address, MDH.healthchoicerenewal@maryland.gov.

Appendices

Appendix A: Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STCs) for the HealthChoice Medicaid Section §1115 Demonstration (No. 28) Attachment E

ATTACHMENT E
Assistance in Community Integration Services Pilot Protocol
Approved: June 16, 2017

Per STC #28, the following protocol outlines the services and payment methodologies for the Assistance in Community Integration Services (ACIS) Pilot Program. Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the needs-based criteria specified below, capped at 300 individuals annually. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA). The protocol outlines the content that would otherwise be documented in a 1915(i) SPA, and includes service definitions and payment methodologies.

Eligibility Criteria

The state's needs based criteria are specified below:

1) Health criteria (at least one)
    a. Repeated incidents of emergency department (ED) use (defined as more than 4 visits per year) or hospital admissions; or
    b. Two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act.

2) Housing Criteria (at least one)
    a. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
    b. Those at imminent risk of institutional placement.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

ACIS providers are required to provide a minimum of three services per month to each member to receive reimbursement in a given month.

Any of the following services may be used to satisfy the minimum payment requirements:

Tenancy-Based Case Management Services/Tenancy Support Services: Assist the target population in obtaining the services of state and local housing programs to locate and support the individual's medical needs in the home.

These services may include:

- Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

- Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. This may include arranging for or providing transportation for services provided in the plan of care. Developing an individualized community integration plan based upon the assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
- Participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed.
- Providing supports and interventions per the person-centered plan (individualized community integration portion).
- Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Housing Case Management Services – may include:

- Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed;
- Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports;
- Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process and coordinating with the entitlement agency; and
- Assistance in accessing supports to preserve the most independent living, including skills coaching, financing counseling, anger management, individual and family counseling, support groups and natural supports.

Federal financial assistance from the Medicaid program cannot be used for room and board in home and community-based services.

The state must comply with all HCBS requirements as outlined in Subpart M ((42 CFR 441.700 through 441.745 including needs-based criteria (42 CFR 441.715), provision of services in home and community-based settings (42 CFR 441.710(a)(1) and (2)), adherence to conflict of interest provisions (42 CFR 441.730(b)), individualized service plans (42 CFR 441.725(a) and (b)) and Quality Improvement Strategy (42 CFR 441.745(b).

ATTACHMENT E
Assistance in Community Integration Services Pilot Protocol
Approved: June 16, 2017

The state's needs based criteria are specified below:

1) Health criteria (at least one)
    a. Repeated incidents of emergency department (ED) use (defined as more than 4 visits per year) and hospital admissions; or
    b. Two or more chronic conditions as defined in Section 1945(h)(2)of the Social Security Act.

2) Housing Criteria (at least one)
    a. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
    b. Those at imminent risk of institutional placement.

ACIS Provider Qualifications for Tenancy-based Case Management Services or Housing Case Management Services:

Provider	Education (typical)	Experience (typical)	Skills (preferred)	Services
Case Manager	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of case management. May also need knowledge of harm-reduction and trauma informed care, principles, methods, and procedures in handling addiction and dual diagnosis populations. Ability to negotiate and maintain positive relationships with co-workers and clients.	Tenancy-based case management or Tenancy Support; housing case management (as outlined above)
Supervisory Case Manager or Team Lead	Master's degree, with licensing, in human services-related field.	Minimum of 2 years experience in social and human services or related field, with hands-on experience working with diverse populations. Previous supervisory experience.	Knowledge of principles, methods, and procedures of case management. May also need knowledge of harm-reduction and trauma informed care, principles, methods, and procedures in handling addiction and dual diagnosis populations. Ability to negotiate and maintain positive relationships with co-workers and clients.	Tenancy-based case management; housing case management (as outlined above); supervise an individual case manager in providing these services, or leads a team in providing these services.

ATTACHMENT E
Assistance in Community Integration Services Pilot Protocol
Approved: June 16, 2017

Description of Payment Methodologies

The Department of Mental Health and Hygiene (DHMH) will pay the Lead Entities (LE) (local health departments/county governments) for the ACIS services provided at the ACIS rate. The ACIS rate shall not exceed the amount expended by the LE for furnishing for the direct service costs incurred by the provider. The monthly ACIS cost-based rate shall be the average cost of the total of a minimum of three ACIS tenancy-based care management/tenancy support services, and housing case management direct services (defined above) and provided per month as described in a Memorandum of Understanding to be executed between the LE and DHMH. The ACIS rate may vary by LE and will be developed based on a target cost per ACIS service, along with variables such as geographic location, salary costs, ACIS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

Start-up costs, if approved by DHMH, will be paid directly to the LE. Start-up costs are available only in the first year of the pilot, and must be limited to no more than 10 percent of the award (i.e., 10 percent of the amount determined as follows: anticipated number of members served by the LE * per member, per month payment to the LE * 12 months). To receive start-up funding, the LE must:

- Conduct a community-based vulnerability assessment that is approved by DHMH in advance. The assessment must evaluate the relevant population for its needs with respect to the criteria identified above;
- Implement a process for verifying members' Medicaid eligibility with DHMH; and
- Implement a process for successfully enrolling members into the ACIS pilot program.

LEs must project an expected average number of individuals who will receive ACIS services on a monthly basis. Payment will be withheld if the LEs do not report required data to DHMH in a timely and complete manner as outlined and agreed upon in applicable data use agreements between DHMH and LE. ACIS providers must provide documentation and participate in the demonstration evaluation activities. As a precondition of payment, LEs must comply with all applicable DHMH audit and review policies, as well as the stated requirements in the HealthChoice 1115 Demonstration Special Terms and Conditions (STCs), ACIS Pilot Post-Approval Protocol, and the Request for Application.

ACIS Pilot LEs are required to submit quarterly reports and an annual report to DHMH. The quarterly and annual reports will be used to determine whether progress toward the Pilot requirements has been made. The purpose of the reports is to demonstrate that the Pilot is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, the approved application, and any agreement between DHMH and the LE and/or policy letters and guidance from DHMH.

The LE will invoice DHMH for ACIS services provided to a specific Medicaid beneficiary. As part of this invoicing process, the LE must submit documentation to DHMH of the Medicaid beneficiary's eligibility status, the dates of service, and the types of service that were provided.

LEs are required to ensure ACIS providers meet minimum documentation standards and cooperate in any evaluation activities by DHMH, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.

Appendix B: Summary of Public Process and Indian Consultation

The Department received a total of 32 comments, from 30 separate organizations, with two organizations submitting comments twice. The majority of the comments expressed support for the initiatives outlined in this waiver amendment. A summary of comments received and the Department responses by topic follows:

National Diabetes Prevention Program Pilot

Many organizations and stakeholders wrote to offer their support for the coverage of National Diabetes Prevention Program (National DPP) services through a limited pilot program. Many noted that the continuation of the National DPP and the potential expansion post-pilot will improve overall health comes and reduce the number of cases of diabetes among Medicaid beneficiaries. One commenter stated that continuation of the National DPP pilot would reduce the number of diabetes cases by 40% within the first year, therefore significantly reducing the overall cost to the Department.

Some respondents highlighted the need for virtual programs to ensure network adequacy and to allow for freedom of choice among beneficiaries. Many commended the Department for the inclusion of the National DPP and its virtual offerings, as it is in innovative approach to healthcare. One commenter noted that the focus on population health through upstream prevention programs such as the National DPP will help to reduce avoidable utilization and decrease costs across the care continuum. Many respondents said they were encouraged by the preliminary positive outcomes from the current Maryland Medical National DPP Demonstration.

One respondent expressed general support for the continuation of the current National DPP pilot, but were unable to comment on the initial budget allocated for pilot continuation since data was not provided in the waiver amendment on the total number of Medicaid enrollees that are potentially eligible for the program. The Department is expecting the number of eligible enrollees to vary by MCO based on the CDC DPRP eligibility criteria, which was used to develop the eligibility algorithm provided in the waiver amendment.

Expansion of Substance Use Disorder Residential Services

The expansion of coverage of Substance Use Disorder (SUD) residential treatment services to include American Society of Addiction Medicine (ASAM) level 4.0 for up to 15 days in a month for Medicaid adults with a primary SUD diagnosis and a secondary mental health diagnosis received strong support from many stakeholders. Many noted that the expansion to include ASAM level 4.0 is a critical enhancement that would ensure the sustainability of the specialized, comprehensive care standing psychiatric hospitals delivers to these vulnerable patients.

The Department received several comments regarding the current opioid crisis and need to provide a full continuum of SUD services in order to effectively address the opioid epidemic. One respondent encouraged the Department to continue improving community-based treatment options available under Medicaid and to consider the particular needs of people with both intellectual and developmental disabilities and SUD in developing these treatment options. Another respondent advocated in support of a managed care model that fully integrates somatic care with behavioral and substance use disorder treatment to enable better coordination of care for this population. The Department will continue its efforts in strengthening the Behavioral Health Integration plan.

Adult Dental Pilot Program

The expansion of dental benefits for dually eligible participants received support from many Maryland stakeholders. Respondents identified the proposal as a critical step in decreasing barriers to care for this vulnerable population. Many also noted that this was a population that currently utilizes the emergency department (ED) for care, and expressed hope that it would decrease ED utilization as well as ED wait

times for other patients. Some respondents noted how poor oral health can be a detriment to finding employment, and that this pilot would be a great benefit to the community. Many respondents noted that the pilot program was a step towards comprehensive dental coverage for all adults.

The Department received several comments about the proposed cap. One commenter asked if any potential cap could be waived under special circumstances. Another respondent asked for the Department to factor in the costs of most common services to ensure access. At this time, the Department is still evaluating if there should be any exceptions to the cap.

Several comments were received discussing the adult dental pilot population. One respondent was concerned with the limited scope of the population; they put forward that there were other fee-for-service populations that could also benefit from dental services. Another commenter asked for all adults to be included in the pilot program. While the Department agrees that the population is limited in scope, the Department is not currently considering expanding the pilot to other eligibility groups.

The Department also attended a conference hosted by the Maryland Dental Action Coalition (MDAC) and presented on the adult dental pilot program. There, the Department received several questions about how the adult dental pilot would be implemented; namely how would the Department recruit providers, how would the Department inform patients of the new benefit, what services would be in the benefit package, and how to best utilize new data from this population. The Department received valuable input from providers; specifically surrounding what services they thought should be included. In addition, dental and disability organizations began to discuss how to best work together to ensure the dually eligible population receives the best care. The Department is still in the implementation stages of this program, and looks forward to continuing to work cooperatively with stakeholders to implement the pilot and ensure the success of the benefit.

Expansion of Assistance in Community Integration Services (ACIS) Pilot Cap

During the current HealthChoice §1115 Waiver Amendment public comment period, the Department received a written comment letter from stakeholder and current ACIS Pilot Participating Entity, Health Care for the Homeless (HCH), working with Baltimore City Mayor's Office of Human Services. HCH cited compelling data regarding healthcare cost savings achieved within their own ACIS- aligned programs and similar supportive housing programs in other jurisdictions. Recent HUD funding opportunities has increased the number of available housing units and resources available throughout the state of Maryland. With increased opportunities for housing, HCH stated that there is also a need beyond the current allotment of ACIS Pilot beneficiaries for the types of supportive housing services allowable through the existing Pilot. At the time their public comment letter was received, all 300 available ACIS beneficiary spots have been filled. HCH requested that a minimum of 300 additional ACIS beneficiary spots be added through this waiver amendment process to increase the number of statewide beneficiaries who may enroll in the ACIS Pilot to a total of 600 beneficiaries.

Family Planning Program

One commenter expressed support for the removal of the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services. They noted that removing the family planning Program from the Waiver for inclusion in SPA has been a trend among other states.

Indian Consultation

No comments received.

Appendix C: List of Attachments

Attachment I: Public Notice & Indian Consultation Documentation

Attachment II: Public Comments Documentation

Attachment III: Budget Neutrality Worksheet

Maryland HealthChoice Program

§1115 Waiver Amendment - Attachments

Submitted by

Maryland Department of Health

July 2, 2018

Attachment I

Public Notice & Indian Consultation Documentation

General Notices

Notice of ADA Compliance

The State of Maryland is committed to ensuring that individuals with disabilities are able to fully participate in public meetings. Anyone planning to attend a meeting announced below who wishes to receive auxiliary aids, services, or accommodations is invited to contact the agency representative at least 48 hours in advance, at the telephone number listed in the notice or through Maryland Relay.

ADVISORY COUNCIL ON CEMETERY OPERATIONS

Subject: Public Meeting
Date and Time: April 26, 2018, 10 a.m. — 1 p.m.
Place: Dept. of Labor, Licensing, and Regulation, 500 N. Calvert St., 3rd Fl. Conf. Rm., Baltimore, MD
Contact: Deborah Rappazzo (410) 230-6229
[18-08-01]

CHESAPEAKE BAY TRUST

Subject: Public Meeting
Date and Time: May 16, 2018, 3 — 6 p.m.
Place: Chesapeake Bay Trust Office, 60 West St., Ste. 405, Annapolis, MD
Contact: Heather Adams (410) 974-2941
[18-08-29]

GOVERNOR'S OFFICE OF CRIME CONTROL AND PREVENTION

Subject: Public Meeting
Date and Time: May 7, 2018, 1 — 3 p.m.
Place: 100 Community Pl., Conf. Rm., Side B, Crownsville, MD
Contact: Jessica Wheeler (410) 697-9342
[18-08-09]

COMMISSION ON CRIMINAL SENTENCING POLICY

Subject: Public Meeting
Date and Time: May 8, 2018, 5:30 — 7:30 p.m.
Place: Judicial College Education and Conference Center, 2011D Commerce Park Dr., Annapolis, MD
Contact: David Soule (301) 403-4165
[18-08-07]

GOVERNOR'S COUNCIL ON GANGS AND VIOLENT CRIMINAL NETWORKS

Subject: Public Meeting
Date and Time: May 11, 2018, 11 a.m. — 12:30 p.m.
Place: Governor's Coordinating Offices, 100 Community Pl., Crownsville, MD
Add'l. Info: In accordance with the Open Meetings Act, General Provisions Article, §3-305, Annotated Code of Maryland, a portion of this meeting may be closed to the public.
Contact: Scott Stargel (410) 697-9309
[18-08-15]

GOVERNOR'S COUNCIL ON GANGS AND VIOLENT CRIMINAL NETWORKS

Subject: Public Meeting
Date and Time: June 8, 2018, 11 a.m. — 12:30 p.m.
Place: Governor's Coordinating Offices, 100 Community Pl., Crownsville, MD
Add'l. Info: In accordance with the Open Meetings Act, General Provisions Article, §3-305, Annotated Code of Maryland, a portion of this meeting may be closed to the public.
Contact: Scott Stargel (410) 697-9309
[18-08-16]

GOVERNOR'S OFFICE OF CRIME CONTROL AND PREVENTION

Subject: Public Meeting
Date and Time: May 17, 2018, 1 — 3 p.m.
Place: 100 Community Pl., Conf. Rm., Side A, Crownsville, MD
Add'l. Info: Children's Justice Act Committee Meeting
Contact: Jessica Wheeler (410) 697-9342
[18-08-10]

HALL OF RECORDS COMMISSION

Subject: Public Meeting
Date and Time: May 11, 2018, 12 — 2 p.m.
Place: Maryland State Archives, Annapolis, MD
Contact: Liz Coelho (410) 260-6401
[18-08-19]

MARYLAND DEPARTMENT OF HEALTH

Subject: Public Meeting
Date and Time: May 24, 2018, 3—5 p.m.
Place: 201 W. Preston St., Rm. L-1, Baltimore, MD
Add'l. Info: HEALTHCHOICE POST-AWARD FORUM
Effective January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a 5-year period.

Per the terms of the §1115 HealthChoice demonstration renewal as required by 42 CFR 431.420(c), the Maryland Department of Health (MDH) must conduct a post-award forum within 6 months of implementing the demonstration and annually thereafter. The forum is intended to provide the public with the opportunity to offer meaningful comment on the progress of the demonstration.

Additionally, MDH intends to seek CMS approval for an §1115 demonstration waiver amendment. The post-award forum will also provide the public an opportunity to comment on programs proposed for inclusion in the §1115 demonstration waiver amendment.

A second public hearing for the §1115 amendment will be held in Annapolis in June. Hearing location and time will be published in a forthcoming second public notice and can be found on the waiver amendment website below.

For more information on the post-award forum, please go to

https://mmcp.health.maryland.gov/healthchoice/Pages/HealthChoice-Post-Award-Forum.aspx

For more information on the waiver amendment and how to send comments to MDH, please visit:

https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Contact: Please direct any questions to mdh.healthchoicerenewal@maryland.gov.
[18-08-36]

MARYLAND DEPARTMENT OF HEALTH/MEDICAID PHARMACY AND THERAPEUTICS COMMITTEE

Subject: Public Hearing
Date and Time: May 3, 2018, 9 a.m. — 12 p.m.
Place: West Village Commons— Towson University Ballroom C (4th Fl.), 424 Emerson Dr., Towson, MD 21204
Add'l. Info: Meeting of the Maryland Medicaid Pharmacy Program's Pharmacy and Therapeutics Committee (Preferred Drug List)

As soon as available, classes of drugs to be reviewed, speaker registration guidelines and driving directions to meeting location will be posted on the Maryland Pharmacy Program website at:https://mmcp.health.maryland.gov/pap/Pages/Public-Meeting-Announcement-and-Procedures-for-Public-Testimony.aspx.

Submit email questions to: mdh.marylandpdlquestions@maryland.gov.
Contact: Shawn Singh (410) 767-6896
[18-08-14]

General Notices

Notice of ADA Compliance

The State of Maryland is committed to ensuring that individuals with disabilities are able to fully participate in public meetings. Anyone planning to attend a meeting announced below who wishes to receive auxiliary aids, services, or accommodations is invited to contact the agency representative at least 48 hours in advance, at the telephone number listed in the notice or through Maryland Relay.

STATE ANATOMY BOARD

Subject: Public Meeting
Date and Time: May 25, 2018, 2 — 5 p.m.
Place: University of MD School of Medicine, Health Science Facility II, 20 Penn St., Rm. S241, Baltimore, MD
Contact: Rita M. Gross (410) 706-3313
[18-10-18]

CHESAPEAKE BAY TRUST

Subject: Public Meeting
Date and Time: May 16, 2018, 3 — 6 p.m.
Place: Chesapeake Bay Trust Office, 60 West St., Ste. 405, Annapolis, MD
Contact: Heather Adams (410) 974-2941
[18-10-11]

BOARD OF DIETETIC PRACTICE

Subject: Public Meeting
Date and Time: May 17, 2018, 10 — 11 a.m.
Place: 4201 Patterson Ave., Baltimore, MD
Add'l. Info: Regulatory review will be discussed in the open session. A portion of this meeting will be closed for the administrative session.
Contact: Marie Savage (410) 764-4741
[18-10-14]

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS

Subject: Listing of Primary Stroke Center Requesting Reverification of Status and Call for Applications from Those Wishing to Be Considered for Designation
Place: Office of Hospital Programs, 653 W. Pratt St., Baltimore, MD 21201
Add'l. Info: Pursuant to COMAR 30.08.02C, the Maryland Institute for Emergency Medical Services Systems gives notice that the following hospitals have requested reverification as a Primary Stroke Center:

- Carroll Hospital Center
- Frederick Memorial Hospital
- Union Hospital of Cecil County
- Northwest Hospital

Any person with knowledge of any reason why any of the above listed hospitals should not be reverified and redesignated is requested to submit a written statement of the reason to MIEMSS by June 11, 2018.

In addition, pursuant to COMAR 30.08.02.03C, hospitals not designated but who wish to be considered for designation as Primary Stroke Centers should submit a written letter of intent to the office listed above. Letters of intent are due to MIEMSS by July 6, 2018. For more information contact Anna Aycock, Chief, Health Facilities and Special Programs, at (410) 706-3930 or email aaycock@miemss.org.
Contact: Leandrea Gilliam (410) 706-4449
[18-10-09]

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS

Subject: Listing of Primary Stroke Center Requesting Reverification of Status and Call for Applications from Those Wishing to Be Considered for Designation
Place: Office of Hospital Programs, 653 W. Pratt Street, Baltimore, MD 21201
Add'l. Info: Pursuant to COMAR 30.08.02C, the Maryland Institute for Emergency Medical Services Systems gives notice that the following hospital has requested reverification as a Comprehensive Stroke Center:

- University of Maryland Medical Center

Any person with knowledge of any reason why the above-listed hospital should not be reverified and redesignated is requested to submit a written statement of the reason to MIEMSS by June 11, 2018.

In addition, pursuant to COMAR 30.08.02.03C, hospitals not designated who wish to be considered for designation as Comprehensive Stroke Centers should submit a written letter of intent to the office listed above. Letters of intent are due to MIEMSS by July 6, 2018. For more information contact Anna Aycock, Chief, Health Facilities and Special Programs, at (410) 706-3930 or email aaycock@miemss.org.
Contact: Leandrea Gilliam (410) 706-4449
[18-10-10]

GOVERNOR'S COUNCIL ON GANGS AND VIOLENT CRIMINAL NETWORKS

Subject: Public Meeting
Date and Time: June 8, 2018, 11 a.m. — 12:30 p.m.
Place: Governor's Coordinating Offices, 100 Community Pl., Crownsville, MD
Add'l. Info: In accordance with the Open Meetings Act, General Provisions Article, §3-305, Annotated Code of Maryland, a portion of this meeting may be closed to the public.
Contact: Scott Stargel (410) 697-9309
[18-10-08]

MARYLAND DEPARTMENT OF HEALTH

Subject: Public Hearing
Date and Time: June 6, 2018, 10 a.m. — 12 p.m.; May 24, 2018, 3 — 5 p.m.
Place: Miller Senate Office Bldg., 3 East, Senate Finance Committee Hearing Rm., Annapolis, MD
Add'l. Info: WAIVER AMENDMENT HEARING

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021. HealthChoice, first implemented in 1997 under the authority of §1115 of the Social Security Act, is Maryland's Statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll in a managed care organization (MCO) that has been approved by the Department. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet their health needs.

The State's 30-day public comment period will open on May 21, 2018. Electronic copies of the draft waiver amendment application will be available on that date and may be downloaded from https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments concerning the waiver

amendment to Tricia Roddy, Planning Administration, Office of Health Care Financing, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201, or via email to mdh.healthchoicerenewal@maryland.gov. The Department will accept comments from May 21, 2018, until June 28, 2018.

The following public hearings will discuss the content of the waiver amendment and solicit feedback and input from public stakeholders:

Baltimore City

Thursday, May 24, 2018; 3—5 p.m.
(Joint meeting with the HealthChoice Post-Award Forum)
Maryland Department of Health
201 West Preston Street
Baltimore, MD
Room L-1
Webinar Access: To participate in the public hearing remotely, please visit: https://mdhealth.webex.com/mdhealth/j.php?MTID=m23601df8ae310f05e9370629f401ee90
Audio Conference Line: +1-240-454-0887
Meeting Number (access code): 643 289 553

Annapolis

Wednesday, June 6, 2018; 10 a.m.—12 p.m.
Senate Finance Committee Hearing Room
3 East Miller Senate Building
Annapolis, MD

Contact: Alyssa Brown (410) 767-9795

[18-10-31]

MARYLAND STATE LOTTERY AND GAMING CONTROL COMMISSION

Subject: Public Meeting
Date and Time: May 24, 2018, 10 a.m. — 12 p.m.
Place: Montgomery Park Business Center, 1800 Washington Blvd., Studio Conf. Rm., Baltimore, MD
Contact: Kathy L. Lingo (410) 230-8790

[18-10-15]

MARYLAND COMMISSION ON ARTISTIC PROPERTY

Subject: Public Meeting
Date and Time: May 16, 2018, 10:30 a.m. — 12:30 p.m.
Place: Maryland State Archives, 350 Rowe Blvd., Annapolis, MD
Add'l. Info: General meeting for discussion of matters relating to the State-Owned Art Collection.
Contact: Christopher J. Kintzel (410) 260-6475

[18-10-16]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: May 17, 2018, 1 — 4 p.m.
Place: 4160 Patterson Ave., Baltimore, MD
Contact: Valerie Wooding (410) 764-3570

[18-10-05]

MARYLAND HEALTH CARE COMMISSION

Subject: Public Meeting
Date and Time: June 21, 2018, 1 — 4 p.m.
Place: 4160 Patterson Ave., Baltimore, MD
Contact: Valerie Wooding (410) 764-3570

[18-10-06]

MARYLAND HEALTH CARE COMMISSION

Subject: Receipt of Application
Add'l. Info: On April 6, 2018 the Maryland Health Care Commission (MHCC) received a Certificate of Need application submitted by:

Encompass Health Rehabilitation Hospital — Matter No. 18-16-2423 — Construction of a new 60-bed inpatient rehabilitation hospital to be located at Melford Boulevard at Marconi Drive (southeast corner), Bowie, Maryland; Estimated Project Cost: $36,698,894.

The MHCC shall review the application under Health-General Article, §19-101 et seq., Annotated Code of Maryland, and COMAR 10.24.01.

Any affected person may make a written request to the Commission to receive copies of relevant notices concerning the application. All further notices of proceedings on the application will be sent only to affected persons who have registered as interested parties.

Please refer to the Matter No. listed above in any correspondence on the application. A copy of the applications are available, for review, in the office of the MHCC, during regular business hours by appointment, or on the Commission's website at www.mhcc.maryland.gov.

All correspondence should be addressed to Paul Parker, Deputy Director, Center for Health Care Facilities Planning and Development, MHCC, 4160 Patterson Avenue, Baltimore, Maryland 21215.
Contact: Ruby Potter (410) 764-3276

[18-10-19]

MARYLAND HEALTH CARE COMMISSION

Subject: Exemption from CON Review
Add'l. Info: The Maryland Health Care Commission has received on April 13, 2018, a request from:

Dimensions Health Corporation d/b/a University of Maryland Capital Regional Health, University of Maryland Laurel Regional Hospital — Conversion of Laurel Regional Hospital to a Freestanding Medical Facility; Estimated Cost: $53,100,000.

A copy of the Exemption Request is available for review in the office of the MHCC, during regular business hours by appointment, or on the Commission's website at www.mhcc.maryland.gov.

All correspondence should be addressed to Paul Parker, Director, Center for Health Care Facilities Planning and Development, Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215-2299.
Contact: Ruby Potter (410) 764-3276

[18-10-20]

DEPARTMENT OF NATURAL RESOURCES/FISHING AND BOATING SERVICES

Subject: Public Notice — Commercial Spiny Dogfish Landing Limits — Effective 5/1/18
Add'l. Info: The Secretary of the Maryland Department of Natural Resources, pursuant to the Code of Maryland Regulations (COMAR) 08.02.05.24I, announces the catch limits for the 2018 — 2019 commercial spiny dogfish fishery. Effective 12:01 a.m. on May 1, 2018, the commercial catch limits of spiny dogfish are as follows:

1. For an individual licensed to catch finfish: 1,000 pounds per vessel per day caught from Maryland waters.

2. For an individual licensed to catch finfish who is also in possession of a Maryland striped bass permit that has been registered in the Atlantic Ocean fishery:

a. That does not currently hold a federal spiny dogfish permit from the National Marine Fisheries Service: 2,500 pounds per vessel per day caught from Maryland waters; or

b. That also holds a federal spiny dogfish permit from the National Marine Fisheries Service: 2,500 pounds per vessel per day regardless of whether the fish were caught from Maryland waters and/or federal waters of the Exclusive Economic Zone.

Enter search term

PROGRAM INFORMATION

- State Innovation Model (SIM)
- About our programs
- Apply for Medicaid
- Applications for Long Term Care (all9709 versions available)
- Medicaid Renewals
- Provider Information

CHILDREN'S HEALTH

- Maryland Children's Health Program
- Provider Search

HEALTHCHOICE

- EPSDT
- Maryland HealthChoice Program
- Provider Search

FAMILY PLANNING

- Maryland Family Planning Program

PHARMACY

- Maryland Medicaid Pharmacy Program

LONG TERM SERVICES AND SUPPORTS

- Community Support Services
- Maryland Money Follows the Person Program
- Home and Community-Based Services

Nursing Facility Services
Maryland Access Point

1115 HealthChoice Waiver Renewal

GENERAL NOTICE – WAIVER AMENDMENT

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021. HealthChoice, first implemented in 1997 under the authority of §1115 of the Social Security Act, is Maryland's statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll in a managed care organization (MCO) that has been approved by the Department. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet their health needs.

The State's 30-day public comment period will open on May 21, 2018. The draft waiver amendment application is available here. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments concerning the waiver amendment to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov. The Department will accept comments from May 21, 2018 until June 19, 2018.

The following public hearings will discuss the content of the waiver amendment and solicit feedback and input from public stakeholders.

Baltimore City
Thursday, May 24, 2018; 3PM–5PM *(Joint meeting with the HealthChoice Post-Award Forum)*
Maryland Department of Health
201 West Preston Street
Baltimore, Maryland 21201
Room L-1
Webinar Access: To participate in the public hearing remotely, please visit:
https://mdhealth.webex.com/mdhealth/j.php?MTID=m23601df8ae310f05e9370629f401ee90

Audio Conference Line: +1-240-454-0887
Meeting Number (access code): 643 289 553

Please click here for the agenda.
Please click here for the presentation.

Annapolis
Wednesday, June 6, 2018; 10AM–12PM
Senate Finance Committee Hearing Room
3 East Miller Senate Building
11 Bladen Street
Annapolis, Maryland 21401

Please click here for the agenda.
Please click here for the presentation.

Please click here for information about the Community Health Pilots.

Effective January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a period of five years.

HealthChoice, first implemented in 1997 under the authority of Section 1115 of the Social Security Act, is Maryland's statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll in a managed care organization that has been approved by the Maryland Department of Health and Mental Hygiene. Each managed care organization is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet the health needs of each enrollee.

The 2017 extension made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorder (SUD) program as part of a comprehensive SUD strategy;
- Created two community health pilot programs:
  - Evidence-based Home Visiting Services (HVS) pilot program to provide home visiting services for high-risk pregnant women and children up to two years of age; and
  - Assistance in Community Integration Services (ACIS) pilot program to provide housing-related support services for high-risk, high utilizers who are either transitioning to the community from institutionalization or at high-risk of institutional placement;
- Raised the enrollment cap for the Increased Community Services program from 30 to 100; and
- Expanded dental benefits for former foster youth.

Application Resources
Summary of the §1115 Waiver Renewal Application
Full Waiver Renewal Application
HealthChoice Special Terms & Conditions (STCs) (Corrected version; updated 6/16/17)
HealthChoice Extension Approval Letter (Corrected version; updated 5/10/17)
HealthChoice Extension Waiver Authority (Corrected version; updated 5/10/17)
HealthChoice Extension Expenditure Authorities (Corrected version; updated 5/10/17)

Stakeholder Resources
May 26, 2016: Public Hearing Presentation

Hard copies may be obtained by calling: (410) 767-1439.
For additional information or questions, please email mdh.healthchoicerenewal@maryland.gov.

Contact Us

201 W. Preston Street, Baltimore, MD 21201-2399

(410) 767-6500 or 1-877-463-3464

Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

1115 Waiver Amendment General Notice

Carrol Barnes -MDH- <carrol.barnes@maryland.gov> Tue, May 1, 2018 at 5:40 AM
To: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>
Bcc: katherine.roulston@maryland.gov

Attached

--
Carrol Barnes
Health Policy Analyst
Office of Planning
Maryland Department of Health
410-767-5647
carrol.barnes@maryland.gov

Maryland Department of Health is committed to customer service. Click here to take the Customer Satisfaction Survey.

1GENERAL NOTICE for Maryland Registrar– 1115 WAIVER AMENDMENT.pdf
121K

Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

For Distribution to the MMAC - Proposed §1115 Waiver Amendment

Carrol Barnes -MDH- <carrol.barnes@maryland.gov> Mon, May 21, 2018 at 2:15 PM
To: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>
Bcc: katherine.roulston@maryland.gov

We would like to issue a correction to the end of the public comment period (**ending June 19, 2018**) for the following notice:

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.
The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until **June 19, 2018 (corrected)**.

Information about our two upcoming public forums on May 24th and June 6th can be obtained here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

If you have questions please let me know. Thank you for your time and assistance.

Respectfully,

Sian Goldson-Desabaye, MPH, DrPH, CPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
P:410-767-5119|F: 410-333-7505
Email: sian.goldson@maryland.gov

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reading, disseminating, distributing, or copying this communication. If you have received this email in error, please notify the sender immediately and destroy the original transmission.

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Carrol Barnes
Health Policy Analyst
Office of Planning
Maryland Department of Health
410-767-5647
carrol.barnes@maryland.gov

Maryland Department of Health is committed to customer service. Click here to take the Customer Satisfaction Survey.

[Quoted text hidden]

GENERAL NOTICE – WAIVER AMENDMENT

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021. HealthChoice, first implemented in 1997 under the authority of §1115 of the Social Security Act, is Maryland's statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll in a managed care organization (MCO) that has been approved by the Department. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet their health needs.

The State's 30-day public comment period will open on May 21, 2018. Electronic copies of the draft waiver amendment application will be available on that date and may be downloaded from https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments concerning the waiver amendment to Tricia Roddy, Planning Administration, Office of Health Care Financing, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov. The Department will accept comments from May 21, 2018 until June 28, 2018.

The following public hearings will discuss the content of the waiver amendment and solicit feedback and input from public stakeholders.

Baltimore City
Thursday, May 24, 2018; 3PM–5PM *(Joint meeting with the HealthChoice Post-Award Forum)*
Maryland Department of Health
201 West Preston Street
Baltimore, Maryland 21201
Room L-1
Webinar Access: To participate in the public hearing remotely, please visit:
https://mdhealth.webex.com/mdhealth/j.php?MTID=m23601df8ae310f05e9370629f401ee90

Audio Conference Line: +1-240-454-0887
Meeting Number (access code): 643 289 553

Annapolis
Wednesday, June 6, 2018; 10AM–12PM
Senate Finance Committee Hearing Room
3 East Miller Senate Building
11 Bladen Street
Annapolis, Maryland 21401

Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

Fwd: Proposed §1115 Waiver Amendment

Amy A. Woodrum -MDH- <amy.woodrum@maryland.gov> Thu, Jun 28, 2018 at 8:25 AM
To: Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

---------- Forwarded message ---------
From: Amy A. Woodrum -MDH- <amy.woodrum@maryland.gov>
Date: Tue, May 22, 2018 at 8:19 AM
Subject: Re: Proposed §1115 Waiver Amendment
To: Scott Rose <srose@waystationinc.org>

Good Morning Scott Rose,

We would like to issue a correction to the end of the public comment period (**ending June 19, 2018**) for the following notice:

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until **June 19, 2018 (corrected)**.

Information about our two upcoming public forums on May 24th and June 6th can be obtained here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Amy Woodrum, MSW
Health Policy Analyst
Planning Administration, Health Care Financing
Maryland Department of Health
410-767-0657
amy.woodrum@maryland.gov

Maryland Department of Health is *committed to customer service. Click here to take the Customer Satisfaction Survey.*

On Tue, May 22, 2018 at 8:10 AM, Amy A. Woodrum -MDH- <amy.woodrum@maryland.gov> wrote:
Good Morning Scott Rose,

I am with Maryland Medicaid Planning Administration and wanted to share that the Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers

for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

We would love to hear your comments, if you have any, and possibly set up a phone call to discuss with you. You may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until June 28, 2018.

Information about our upcoming two public forums on May 24th and June 6th can be obtained on our here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Respectfully,

Amy Woodrum, MSW
Health Policy Analyst
Planning Administration, Health Care Financing
Maryland Department of Health
410-767-0657
amy.woodrum@maryland.gov

Maryland Department of Health is *committed to customer service. Click here to take the Customer Satisfaction Survey.*

--
Amy Woodrum, MSW
Health Policy Analyst
Planning Administration, Health Care Financing
Maryland Department of Health & Mental Hygiene
410-767-0657
amy.woodrum@maryland.gov

Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

Fwd: Proposed §1115 Waiver Amendment

Amy A. Woodrum -MDH- <amy.woodrum@maryland.gov> Thu, Jun 28, 2018 at 8:25 AM
To: Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

---------- Forwarded message ---------
From: Amy A. Woodrum -MDH- <amy.woodrum@maryland.gov>
Date: Tue, May 22, 2018 at 8:19 AM
Subject: Re: Proposed §1115 Waiver Amendment
To: <BKatz@sheppardpratt.org>

Good Morning Bonnie Katz,

We would like to issue a correction to the end of the public comment period (**ending June 19, 2018**) for the following notice:

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until **June 19, 2018 (corrected)**.

Information about our two upcoming public forums on May 24th and June 6th can be obtained here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Amy Woodrum, MSW
Health Policy Analyst
Planning Administration, Health Care Financing
Maryland Department of Health
410-767-0657
amy.woodrum@maryland.gov

Maryland Department of Health is *committed to customer service. Click here to take the Customer Satisfaction Survey.*

On Tue, May 22, 2018 at 8:10 AM, Amy A. Woodrum -MDH- <amy.woodrum@maryland.gov> wrote:
Good Morning Bonnie Katz,

I am with Maryland Medicaid Planning Administration and wanted to share that the Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers

for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

We would love to hear your comments, if you have any, and possibly set up a phone call to discuss with you. You may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until June 28, 2018.

Information about our upcoming two public forums on May 24th and June 6th can be obtained on our here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Respectfully,

Amy Woodrum, MSW
Health Policy Analyst
Planning Administration, Health Care Financing
Maryland Department of Health
410-767-0657
amy.woodrum@maryland.gov

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--

Amy Woodrum, MSW
Health Policy Analyst
Planning Administration, Health Care Financing
Maryland Department of Health & Mental Hygiene
410-767-0657
amy.woodrum@maryland.gov

Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

Proposed §1115 HealthChoice Waiver Amendment

Sian A. Goldson -MDH- <sian.goldson@maryland.gov> Thu, Jun 28, 2018 at 8:13 AM
To: Katherine Roulston -DHMH- <katherine.roulston@maryland.gov>

If you have questions please let me know. Thank you for your time and assistance.

Respectfully,

Sian Goldson-Desabaye, MPH, DrPH, CPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
P:410-767-5119|F: 410-333-7505
Email: sian.goldson@maryland.gov

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---------- Forwarded message ----------
From: **Sian A. Goldson -MDH-** <sian.goldson@maryland.gov>
Date: Mon, May 21, 2018 at 2:58 PM
Subject: Proposed §1115 HealthChoice Waiver Amendment
To: Nisa Maruthur <maruthur@jhmi.edu>, heather.worthy@ymcadc.org, Eliza Gibson <eliza.gibson@omadahealth.com>, "Renner, Angela" <angelarenner@ymaryland.org>, ftimbo1@jhmi.edu, tricia.isennock@medstar.net, "Pettway, Kathy" <kpettwa@jhhc.com>, eric.johnson@leavittpartners.com, karen.polite-lamma@medstar.net, Wendy Childers <wchilders@chronicdisease.org>, Kathryn Toone <kathryn.toone@leavittpartners.com>, NDPP Evaluator <ndppevaluator@chronicdisease.org>, Megan Brown <mbrown61@jhmi.edu>, ruthheltne@ymaryland.org, Stephanie Scharpf <stephanie@jaimedical.com>, Kelly McCracken <kmccracken@chronicdisease.org>, dawnavan.davis@medstar.net, elsa.cain@medstar.net, Monisha Kota <monisha.kota@jaimedical.com>, "Janeece.Flournoy@amerigroup.com" <janeece.flournoy@amerigroup.com>, DIANE COLLINS <ladydi2123@verizon.net>, deborah.bena@medstar.net, "Mayer, Jennifer" <jmayer@jhhc.com>, "Shea, Patricia (CDC/ONDIEH/NCCDPHP)" <gzt0@cdc.gov>, Kathy Michalski <kmichalski1@jhmi.edu>, "Tessema, Zaena A" <zaena.a.tessema@medstar.net>, "Cooper-Booze, Shalena M." <shalena.cooper-booze@amerigroup.com>, "Toye, Patryce" <patryce.toye@medstar.net>, "Brandt, Regina" <regina.brandt@amerigroup.com>, angela.d.thomas@medstar.net, jpeterson@livongo.com
Cc: Sandra Kick -DHMH- <sandra.kick@maryland.gov>, "Tiffany M. Wedlake -DHMH-" <tiffany.wedlake@maryland.gov>, Kristi Pier -DHMH- <kristi.pier@maryland.gov>, Sue Vaeth -DHMH- <sue.vaeth@maryland.gov>

Good Afternoon,

As we have previously shared, the Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until June 19, 2018.

Information about our two upcoming public forums on May 24th and June 6th can be obtained here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

If you have questions please let me know. Thank you for your time and assistance.

Respectfully,

Sian Goldson-Desabaye, MPH, DrPH, CPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
P:410-767-5119|F: 410-333-7505
Email: sian.goldson@maryland.gov

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[Quoted text hidden]

---------- Forwarded message ----------
From: **Nancy C. Brown -MDH-** <nancyc.brown@maryland.gov>
Date: Mon, May 21, 2018 at 2:17 PM
Subject: Re: §1115 Waiver Amendment Open for Public Comment
To: Diane Teigiser <dteigiser@mdac.us>

Hi Diane,

I just want to issue a correction to the previous notice. The end of the public comment period is **June 19, 2018,** not June 28 as previously listed. My apologizes for the error.

Kindest Regards,

Nancy

Nancy Brown
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
nancyc.brown@maryland.gov
410-767-5208

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On Mon, May 21, 2018 at 11:52 AM, Diane Teigiser <dteigiser@mdac.us> wrote:

> Thank you, Nancy, for forwarding this to us – it is very much appreciated.
>
> Best regards,
>
> Diane
>
> Diane Teigiser
> Administrator
> Maryland Dental Action Coalition
> 10015 Old Columbia Road, Suite B-215
> Columbia, MD 21046
> E-mail: dteigiser@mdac.us
> Phone: (410) 312-5456
> Check out the new 2018-2023 Maryland Oral Health Plan!
>
> **From:** Nancy C. Brown -MDH- [mailto:nancyc.brown@maryland.gov]
> **Sent:** Monday, May 21, 2018 11:18 AM
> **To:** info@mdac.us
> **Cc:** Alyssa L. Brown -DHMH- <alyssa.brown@maryland.gov>; Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>
> **Subject:** §1115 Waiver Amendment Open for Public Comment
>
> Good morning,
>
> I am with Maryland Medicaid Planning Administration and wanted to share that the Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.
>
> The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

We would love to hear your comments, if you have any, and possibly set up a phone call to discuss with you. You may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until June 28, 2018.

Information about our upcoming two public forums on May 24th and June 6th can be obtained on our here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf
Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Kindest Regards,

Nancy Brown
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
nancyc.brown@maryland.gov
410-767-5208

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Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

Proposed §1115 HealthChoice Waiver Amendment

Sian A. Goldson -MDH- <sian.goldson@maryland.gov> Wed, Jun 20, 2018 at 2:11 PM
To: Kerry Lessard <Kerry@nativelifelines.org>
Cc: Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>, "Alyssa L. Brown -DHMH-" <alyssa.brown@maryland.gov>, Sandra Kick -DHMH- <sandra.kick@maryland.gov>, Katherine Roulston -DHMH- <katherine.roulston@maryland.gov>

Good Afternoon Ms. Lessard,

We are following up with regards to our proposed amendment to the §1115 demonstration waiver known as HealthChoice. In your May 21st email, you indicated you would be submitting written comments. Our comment period ended yesterday Tuesday June 19th, 2018 and it appears we may not have received your written comments. We wanted to check:

1. To ensure that we had not missed you submission, or
2. If you had not submitted, are you still planning to submit comments.

We request that you please send/re-send your comments as soon as possible via email to mdh.healthchoicerenewal@maryland.gov. If you have no comments at this time, please let us know.

The proposed waiver amendment is available here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

If you have questions please let me know.

Respectfully,

Sian Goldson-Desabaye, MPH, DrPH, CPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
P:410-767-5119|F: 410-333-7505
Email: sian.goldson@maryland.gov

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On Mon, May 21, 2018 at 2:22 PM, Kerry Lessard <Kerry@nativelifelines.org> wrote:

> Thank you. I plan to review the document and, for as long as possible, attend this week's hearing after the MMAC meeting. I will provide written comment thereafter.
>
> Best regards,

Kerry Hawk Lessard, MAA

(Shawnee)

Executive Director

Native American LifeLines, Baltimore

106 W. Clay Street

Baltimore, MD 21201

410.837.2258

410.837.2692 (*fax*)

kerry@nativelifelines.org

The mission of Native American LifeLines is to promote health and social resiliency within Urban American Indian communities. Using principles of trauma informed care and decolonial praxis, we provide culturally centered behavioral health, dental, and outreach and referral services. Native American Lifelines is a Title V Indian Health Service funded Urban Indian Health Program.

From: Sian A. Goldson -MDH- [mailto:sian.goldson@maryland.gov]
Sent: Monday, May 21, 2018 2:19 PM
To: Kerry Lessard
Cc: Tricia Roddy -DHMH-; Alyssa L. Brown -DHMH-; Sandra Kick -DHMH-; Katherine Roulston -DHMH-
Subject: Re: Proposed §1115 HealthChoice Waiver Amendment

Good Afternoon Ms. Lessard,

We would like to issue a correction to the end of the public comment period (**ending June 19, 2018**) for the following notice:

The Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.
We would love to hear your comments, if you have any, and possibly set up a phone call to discuss with you. You may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until **June 19, 2018 (corrected)**.

Information about our upcoming two public forums on May 24th and June 6th can be obtained on our here.

Thank you for your time and consideration.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf
Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

If you have questions please let me know.

Respectfully,

Sian Goldson-Desabaye, MPH, DrPH, CPH

Health Policy Analyst

Planning Administration

Office of Health Care Financing

Maryland Department of Health (MDH)

201 W. Preston Street, 2nd Floor

Baltimore, MD 21201

P:410-767-5119|F: 410-333-7505

Email: sian.goldson@maryland.gov

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On Mon, May 21, 2018 at 11:00 AM, Sian A. Goldson -MDH- <sian.goldson@maryland.gov> wrote:

Good Morning Ms. Lessard,

I am with Maryland Medicaid Planning Administration and wanted to share that the Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.
We would love to hear your comments, if you have any, and possibly set up a phone call to discuss with you. You may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

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Information about our upcoming two public forums on May 24th and June 6th can be obtained on our here.

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Public Forums Information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Respectfully,

Sian Goldson-Desabaye, MPH, DrPH, CPH

Health Policy Analyst

Planning Administration

Office of Health Care Financing

Maryland Department of Health (MDH)

201 W. Preston Street, 2nd Floor

Baltimore, MD 21201

P:410-767-5119|F: 410-333-7505

Email: sian.goldson@maryland.gov

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Katherine Roulston -MDH- <katherine.roulston@maryland.gov>

Proposed §1115 HealthChoice Waiver Amendment

Sandra Kick -MDH- <sandra.kick@maryland.gov> Mon, Jun 25, 2018 at 3:26 PM
To: Kerry Lessard <Kerry@nativelifelines.org>
Cc: "Sian A. Goldson -MDH-" <sian.goldson@maryland.gov>, Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>, "Alyssa L. Brown -DHMH-" <alyssa.brown@maryland.gov>, Katherine Roulston -DHMH- <katherine.roulston@maryland.gov>

Hi Kerry,

I hope you are well!

I just left you a voice mail, and also wanted to follow-up with this email to check whether you were still planning to submit written comments on the proposed section 1115 HealthChoice waiver amendment. If so, we would need to receive them this week to meet our submission deadlines.

If you do not have any comments to submit at this time, it would be helpful to know that as well!

My direct phone number is 410-767-1439. Please feel free to call or email me if you have any questions.

Many thanks,

Sandy

On Mon, May 21, 2018 at 2:22 PM, Kerry Lessard <Kerry@nativelifelines.org> wrote:
[Quoted text hidden]

--
Sandy Kick, MSPH
Administrative Program Manager II
MDH - Office of Health Care Financing - Planning Administration
201 W. Preston St., 2nd floor
Baltimore, MD 21201
sandra.kick@maryland.gov
410-767-1439

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[Quoted text hidden]

§1115 Waiver Post-Award Forum and Public Hearing for Proposed Waiver Amendment
May 24, 2018 3:00pm-5:00pm
201 West Preston Street
Baltimore, Maryland 20201
Room L-1

Sign-in/Sign-up Sheet for Public Comment: To sign-in and/or submit either written or verbal comment on the 1115 Waiver Amendment, please complete the information requested below:

NAME	TITLE	ORGANIZATION	EMAIL	Check if submitting Written Comments	Check if you wish to present oral comments or ask questions at this hearing
Robin Rivkind	Sr. Director of Policy and Public Affairs	JHHC	rrivkind@jhmi.edu		
Dan Martin	Sr Director	MHAMD	dmartin@mhamd.org		
Kerry Hawk Lessard	Exec Dir	Native American Lifelines	kerry@nativelifelines.org		
Kathy Pethuda	SR. Director	Priority Partners	Kpethuda@jhhc.com		
Jennifer Mayer	Project Mang	Priority Partners	Jmayer@JHHC.com.		

§1115 Waiver Post-Award Forum and Public Hearing for Proposed Waiver Amendment
May 24, 2018 3:00pm-5:00pm
201 West Preston Street
Baltimore, Maryland 20201
Room L-1

Sign-in/Sign-up Sheet for Public Comment: To sign-in and/or submit either written or verbal comment on the 1115 Waiver Amendment, please complete the information requested below:

NAME	TITLE	ORGANIZATION	EMAIL	Check if submitting Written Comments	Check if you wish to present oral comments or ask questions at this hearing
Pam Kasemeyer		Schwartz Katz & Wise	pmetz@smwpa.com		
Elizabeth Gibson		Amerigroup Health	elizabeth.gibson@amerigroup.com		X
Nisa Maruthur		Johns Hopkins	maruthur@jhmi.edu		
Sadie Peters		MDH	sadie.peters@maryland.gov		
Lesley Wallace		MFC	Lesley.wallace@medstar.net		
Matt Celentano		League of Life & Health Insurers	mcelentano@fblaw.com		
Karen Shablin		FEI System	karen.shablin@FEISystems.com		
William Kowalski		FEI SYSTEMS	b.w.kowalski@FEISystems.com		

Public Hearing for Proposed §1115 Waiver Amendment

Wednesday, June 6, 2018; 10AM–12PM
Senate Finance Committee Hearing Room
3 East Miller Senate Building
11 Bladen Street
Annapolis, Maryland 21401

Sign-in/Sign-up Sheet for Public Comment: To sign-in and/or submit either written or verbal comment on the 1115 Waiver Amendment, please complete the information requested below:

NAME	TITLE	ORGANIZATION	EMAIL	Check if submitting Written Comments	Check if you wish to present oral comments or ask questions at this hearing
Robert Axelrod	Sr. Manager, Gov't Relations	Kaiser Permanente	Robert.Axelrod@kp.org		
Matt Celentano	Gov't Relations Specialist	Alliance of MD Dental Plans	mcelentano@FBlaw.com		
S Powell	MANAGER	DLS	SIMON.POWELL@MLIS.STATE.MD.US		
Robyn Elliott	Consultant	Planned Parenthood of Maryland, Maryland Dental Action Coalition			

Sian A. Goldson -MDH- <sian.goldson@maryland.gov>

Notice of Proposed Section §1115 Waiver Amendment, Public Forums and Comment Period

Sandra Kick -MDH- <sandra.kick@maryland.gov> Tue, May 22, 2018 at 5:00 PM
To: "Howard M. Haft -DHMH-" <howard.haft@maryland.gov>
Cc: Donna Gugel -DHMH- <donna.gugel@maryland.gov>, Courtney Lewis -MDH- <courtney.lewis@maryland.gov>, Kristi Pier -DHMH- <kristi.pier@maryland.gov>, Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>, "Alyssa L. Brown -DHMH-" <alyssa.brown@maryland.gov>, Mariana Marques -DHMH- <mariana.marques1@maryland.gov>
Bcc: sian.goldson@maryland.gov

Good afternoon Dr. Haft,

As you may know, the Maryland Department of Health (the Department) is proposing an amendment to its §1115 demonstration waiver known as HealthChoice, which the Centers for Medicare and Medicaid Services (CMS) has authorized through December 31, 2021.

The proposed waiver amendment is available here for public comment. Hard copies of the application may be obtained by calling (410) 767-5677.

Interested parties may send written comments to Tricia Roddy, Director of Planning, Maryland Medicaid Program, Maryland Department of Health, 201 West Preston Street, Room 224, Baltimore, Maryland 21201 or via email to mdh.healthchoicerenewal@maryland.gov.

The Department will accept comments from May 21, 2018 until June 19, 2018.

As part of the public notice requirements, we will hold two public forums on May 24th and June 6th. Your attendance would be welcome, of course, but is not required. Information and details about the forums are listed on our website here. The first forum this Thursday, May 24th from 3-5pm (L-1) is actually a combined event comprised of both the Post-Award Forum for the HealthChoice waiver, and the public hearing for the proposed waiver amendment. The agenda for that combined event is here. The second public hearing will be held in Annapolis. For convenience, we have also sent you a calendar invite separately for both events.

Finally, we would appreciate your assistance to please forward, as soon as possible, this information regarding our proposed waiver amendment, public notice forums, and open comment period to the Local Health Officers and Local Health Administrators.

Thank you for your time and consideration. I'm happy to answer any questions you may have.

Proposed waiver amendment link: https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

Public forums information link: https://mmcp.health.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

--
Sandy Kick, MSPH
Administrative Program Manager II
MDH - Office of Health Care Financing - Planning Administration
201 W. Preston St., 2nd floor
Baltimore, MD 21201
sandra.kick@maryland.gov
410-767-1439

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Attachment II

Public Comments Documentation

June 13, 2018

Ms. Janet Abrahams
Executive Director
Housing Authority of Baltimore City
417 E. Fayette Street
Baltimore, MD 21202

Dear Ms. Abrahams: Janet

As you and I have discussed, the opportunities for strengthened collaboration between the "health" and "housing" sectors in Baltimore are both promising and unprecedented. Health Care for the Homeless is in full support of the Housing Authority of Baltimore City's (HABC) application to the U.S. Department of Housing and Urban Development for new Section 811 Housing Choice Vouchers (Mainstream Vouchers) to assist non-elderly persons with disabilities in Baltimore City.

As a partner in this initiative, Health Care for the Homeless will work closely with HABC to ensure that the funds will assist non-elderly persons with disabilities who are transitioning out of institutional or other segregated settings, at serious risk of institutionalization, homeless, or at risk of becoming homeless. We are particularly excited by the opportunity to leverage Medicaid resources through Maryland's unique Assistance in Community Integration Services (ACIS) supportive housing waiver to deliver the supportive services necessary and proven to help our most vulnerable neighbors remained stably housed and off the streets.

Health Care for the Homeless has worked with HABC for decades, but has engaged in a close partnership since 2005, when we moved 30 individuals living in a downtown park directly into their own apartments with HABC Housing Choice vouchers. A year later, all 30 people remained stably housed. The overall health of participants improved and emergency room and hospital costs decreased. That pilot project was replicated through a grant from the Substance Abuse and Mental Health Services Administration and through ongoing collaborations among HABC, Health Care for the Homeless, and the Mayor's Office of Human Services. Today, Health Care for the Homeless supports more than 325 vulnerable individuals (those who met the definition of "chronic homelessness) in housing, most with housing support from HUD and HABC. We are a partner agency in the City's coordinated access process (through which HABC has helped house hundreds of people experiencing homelessness) and serve on the Board of Directors of the Baltimore City Continuum of Care.

Last year, Health Care for the Homeless partnered with the nonprofit housing developer Episcopal Housing Corporation (EHC) to place individuals at Sojourner at Argyle, a 12-unit permanent supportive housing project for people experiencing homelessness. HABC provided the project based vouchers to make the project work. And this year, HABC committed additional vouchers for a future project to integrate 20 permanent supportive housing units for people experiencing homelessness in a larger multi-population downtown housing project developed by EHC.

421 Fallsway
Baltimore, MD 21202
phone: 410-837-5533
fax: 410-837-8020
www.hchmd.org
@hchomeless

Supportive Housing: Data from Various Studies

Recommended reading

- American Hospital Association (August 2017): Housing and the Role of Hospitals

Emergency Department visits

- Rand study (2017): 890 people. 67.5% decrease
- Chicago (#1, 2018 findings not yet published): 62% decrease
- Chicago study (2012 #2): 407 people, 33% decrease
- Portland study (2016 #1): 58 people, 43% decrease
- Portland study (2016 #2): 278 people. 37% decrease
- Charlotte, NC study (2014): 58 people, 78% decrease
- San Diego study (2015): 28 people. 76% decrease
- Massachusetts Home & Healthy for Good program (2018 report): 713 people. 56% decrease in visits

Inpatient Hospital visits

- Rand study (2017): 890 people. 77% decrease in LOS days
- Chicago study #1: 60% decrease in LOS days (2018 findings not yet published)
- Chicago study #2 (2012): 407 people, 23% fewer days inpatient
- Portland study (2016 #1): 58 people, 23% decrease in days
- Portland study (2016, #2): 278 people. 30% reduction in visits
- Charlotte, NC study (2014): 58 people, 79% reduction in hospitalizations
- San Diego study (2015): 28 people. 80% decrease in hospitalization; 63% decrease in hospital days
- Massachusetts Home & Healthy for Good program: 713 people. 50% decrease in inpatient days

Health Care costs

- Rand study (2017): 890 people. 66% decrease in emergency costs; 76% decrease in inpatient costs
- Chicago #1 (2018, unpublished): 26% decrease in total hospital costs
- Chicago #2 (2012): 407 people, $6,307 reduction in total costs per person, $9,809 reduction per person in the “chronic homeless group”
- Portland study (2016, #1): 58 people, $8,724 reduction in yearly expenditures to health system
- Portland study (2016, #2): 278 people. 14% reduction to Medicaid expenditures

Readmission Rates for Homeless Patients

- Doran study (2013): 113 people, 51% of all hospitalizations for homeless patients resulted in a 30-day hospital inpatient readmission; 70% resulted in either an inpatient readmission, observation

status stay, or emergency department visit within 30 days of hospital discharge. Most readmissions occurred early after hospital discharge (53.9% within 1 week, 74.8% within 2 weeks).

Hospital Collaborations

Chicago: Better Heath Through Housing initiative. University of Illinois partnering with Center for Housing and Health to demonstrate a health care to supportive housing model. Hospital donated $250,000 and is issuing a PMPM for supportive services.

Portland: Housing is Health Initiative. Six hospital systems dedicating $21.5 million toward supportive housing for 382 units of housing.

HABC has already been a strong partner in the implementation of our current ACIS Medicaid supportive housing pilot to house 100 vulnerable individuals and families this year by leveraging Medicaid supportive services. If HABC is awarded new mainstream Housing Choice vouchers, we are eager to work with the state of Maryland to seek expansion of the ACIS supportive housing waiver authority to house at least 100 more of our most vulnerable neighbors and to further demonstrate the success of this initiative in ending homelessness, improving health, and reducing Medicaid expenditures.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. Last year, we provided comprehensive medical care, mental health services, addiction treatment, dental care and supportive housing for more than 10,000 people during 114,000 patient visits at clinic sites throughout Baltimore. This year, we began a new strategic plan to increase our collaborations with public and private-sector housing providers to do even more to end homelessness and improve health. We are proud to consider HABC an essential partner in the implementation of our strategic goals and in our work to end homelessness. Housing *is* the very foundation for health.

We applaud your leadership at the Housing Authority of Baltimore City and are excited about the opportunities before us to leverage health care resources to support vulnerable people in housing. We look forward to this new partnership and to the chance to continue our work with HABC to end homelessness and improve the quality of life for vulnerable individuals and families in our communities.

Sincerely,

[redacted]

Kevin Lindamood, President & CEO
klindamood@hchmd.org
Cell: 410-916-6364

June 19, 2018

Tricia Roddy
Director of planning
Maryland Medicaid Program
Department of Health
201 west Preston Street, Room 224
Baltimore, MD 21201

Via Email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. Total you Family Dentistry fully support this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

Our organization supports the adult dental pilot because of the obvious need that can be addressed through this process. We fully support the adult dental pilot.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success.

Sincerely,
Alvin B. Williams, DDS

Robert Stephens, MS, Health Officer
1025 Memorial Drive
Oakland, Maryland 21550

Garrett County Health Department

Office of Administration

Public Health
Prevent. Promote. Protect.
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FAX 301-334-7701
Equal Opportunity Employer

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. Garrett County Health Department fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

The Garrett County Health Department supports the adult dental pilot because of our experience with treating uninsured and underinsured adults in our dental clinic. Since 2003 the Garrett County Health Department has treated adults in need of dental care. In some cases, we have worked with Medicaid enrollees in managed care organizations who voluntarily provide some limited dental benefits. The care that we provide these patients has not only improved their oral health but also improved their overall health. This standard of care should be extended to all Medicaid enrollees.

We look forward to working with the Maryland Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success and have demonstrated that commitment to our most vulnerable citizens for over 15 years.

Please do not hesitate to contact me if you have any questions.

Sincerely,

[redacted]

Robert Stephens, MS
Health Officer

Charles County Department of Health

Dianna E. Abney, MD
Health Officer/Director

James C. Bridgers, Jr., PhD
Deputy Health Officer

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. The Charles County Department of Health fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

Our organization supports the adult dental pilot because of the critical need of access to dental care adults with lower income have. Offering and adult dental benefit will improve health outcomes for this vulnerable population. The Charles County Health Department started an emergency walk in clinic in FY2015 to help reduce the emergency department utilization due to dental emergencies and, increase capacity to provide adult and pediatric dental preventive and treatment services especially those not insured and underinsured ; this was funded by a CHRC three year grant. During this period 2,205 adults were seen as emergency in our dental program, 1,021 visited the emergency room at the Charles Regional Medical Center due to dental problems.

Administration
phone: 301-609-6900
fax: 301-934-4632

Core Service Agency
phone: 301-609-5757
fax: 301-609-5749

Disability Services
phone: 301-609-6830
fax: 301-609-6691

Environmental Health Services
phone: 301-609-6751
fax: 301-609-6684

Mental Health Services
phone: 301-609-6700
fax: 301-609-6741

Nursing and Community Health Services
phone: 301-609-6799
fax: 301-934-7048

Public Health Preparedness Services
phone: 301-609-6761
fax: 301-609-6658

Substance Use Services
phone: 301-609-6600
fax: 301-934-1234

Charles County Department of Health

According to data shared from the hospital during this three year grant there was a decrease of 57 percent of emergency room visits for emergency dental health issues. Up to this date the Charles County Health Department is committed to help the population in need. The program has received grant funds from Office of Oral Health for Oral Disease Prevention but funding is not enough to sustain the program since the demand is very high. The health department sees value in this program and will continue to find the funding to sustain current program levels while looking for new funding opportunities.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success.

Sincerely,

[redacted]

Celeste Camerino DDS
Charles County Department of Health
Oral Health Program Coordinator

Phone: 301-645-3556
Fax: 301-645-3932
healthpartnersmd@gmail.com
www.healthpartnersinc.org

Health Partners Inc.
A Non-Profit Primary Healthcare & Dental Provider

Health Partners Charitable Clinic
3070 Crain Highway
P.O. Box 1865
Waldorf, MD 20604

June 16, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. As supporters of SB 284, the legislation that created the pilot, Health Partners, Inc., fully supports this waiver amendment. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

It is a well-established fact that oral health is a fundamental component of good general health. At a time of life (age 21 – 64) considered to be an individual's most productive years, access to reliable, affordable dental care can play a major role in one's overall success and wellbeing. Whether as a student, an employee, a parent, or as a contributing member of society, a person's health stability depends on good dental hygiene and regular dental care. Eliminating financial barriers to such care reduces the possibility that care will be deferred, prevents more costly dental/medical services, enhances self-esteem and contributes to a far better quality of life.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success.

Sincerely,

[redacted]

Christine Mulcahey
Executive Director

Allegany County
HEALTH DEPARTMENT
"Healthy People, Healthy Communities"

Jenelle Mayer, M.P.H., Health Officer
12501-12503 Willowbrook Road, SE
Cumberland, MD 21501-1745

301-759-5000 Phone
1-866-909-9629 Toll Free
www.alleganyhealthdept.com

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to listen to your presentation to understand more fully the proposed waiver amendment for the establishment of an adult dental coverage pilot. The Allegany County Health Department Dental Clinic fully supports this waiver amendment, as we are supporters of SB 284, the legislation that created the pilot. The proposed waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

Our organization supports the adult dental pilot because of the lack of access to needed dental care for adults in Maryland. This pilot program represents a step in the right direction toward a comprehensive adult medical assistance dental benefit.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to doing everything in our control to make the pilot a success.

Sincerely,

[redacted]

Gretchen E. Seibert, DDS, MAGD
Dental Director

Maryland State Dental Association

MSDA CHARITABLE & EDUCATIONAL Foundation

June 18, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: MSDA and MSDA Foundation Support for the Proposed Waiver Amendment

Dear Ms. Roddy:

On behalf of the Maryland State Dental Association (MSDA) and MSDA Foundation, thank you for participating in yesterday's Maryland Dental Action Coalition (MDAC) conference. Representatives from both organizations participated in the conference. We appreciate your participation and support and thank you for your swift action preparing the proposed waiver amendment for the establishment of an adult dental Medicaid benefit pilot.

The MSDA and MSDA Foundation have a longstanding commitment to improving access to oral healthcare for our citizens and were proud leaders in moving forward SB284. Since 2010, we have administered the Mission of Mercy programs throughout Maryland. We have mobilized oral health clinicians to provide over $15 million in free dental care to Maryland adults. These clinics have served to treat thousands of patients each year, while raising the public and legislative awareness needed to drive systemic change.

We wish to share our full support of the waiver amendment, and to offer our input, partnership, and participation by the dental community in the development of the adult dental Medicaid pilot for Maryland. We are committed to making this pilot program a success through continued involvement on the planning team. Together we can engage dental providers to increase access to care and remove barriers for more citizens. We look forward to working with you and all stakeholders to implement the pilot and set ourselves up for the pilot's success.

Sincerely,

[redacted]

Vanessa Benavent, DDS, MSD, FAGD
President, MSDA

[redacted]

Diane Romaine, DMD, MAGD
President, MSDA Foundation

8901 Herrmann Drive | Columbia, MD 21045-4710
Phone: (800) 788-2880 | Other: (410) 964-2880 | Fax: (410) 964-0583
www.msda.com | www.msdaf.org

Disability Rights Maryland

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1500 Union Ave., Suite 2000, Baltimore, MD 21211
www.DisabilityRightsMD.org
Phone: 410.727.6352

June 18, 2018

Tricia Roddy
Director of Planning, Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email to mdh.healthchoicerenewal@maryland.gov

Dear Ms. Roddy:

Disability Rights Maryland (DRM) appreciates the opportunity to provide comments on the 1115 HealthChoice waiver amendment.[1] We focus below on the adult dental pilot program and the expansion of substance use disorder (SUD) residential services.

- *Adult Dental Pilot Program*

We are thrilled to see Maryland provide for expanded dental services to adult Medicaid enrollees. As the Maryland Department of Health (MDH) notes in the draft waiver amendment, untreated dental disease affects dental and physical health and community engagement. The people who will be enrolled in this program—dual eligibles aged 21 through 64—have thus far lacked dental services in a patchwork system of coverage, since they are not enrolled in a Medicaid managed care organization (MCO) or the Rare and Expensive Case Management (REM) program, and we appreciate MDH's work in filling this gap.

Although the waiver amendment acknowledges MDH's statutory flexibility in implementing the pilot program, DRM urges MDH to provide benefits statewide to all eligible duals rather than choosing a subset of counties or limiting the number of enrollees. Further, as MDH considers an overall cap on expenditures per person, we suggest that MDH factor in the actual cost of the most commonly needed procedures so as to ensure practical access to most services. Given the need for this benefit in the first place, Medicaid enrollees are unlikely to be able to supplement this dental benefit with their own funds if dental needs are discovered that exceed a stringent cost cap.

In addition, we appreciate that all Maryland Medicaid MCOs currently provide at least a limited dental benefit, but this does not involve the same level of consistent coverage or guarantee as would a statewide mandate. As MDH evaluates the costs and benefits of this pilot program, we also note this population may have different needs and per capita

[1] Available at https://mmcp.health.maryland.gov/Documents/1115%20Waiver%20Amendment%205.18.2018.pdf

costs than other Medicaid enrollees and strongly urge MDH to implement an adult dental benefit for all Medicaid enrollees. Again, we appreciate Maryland's step forward toward enabling more Medicaid enrollees to access crucial dental services with this pilot program.

- *Expansion of SUD Residential Services*

Given the increase in intoxication deaths and other harms nationwide due to drug and alcohol issues, we acknowledge the need to enable as many people with SUD as possible to receive Medicaid-funded treatment options. Even as this waiver amendment expands the use and availability of residential services—specifically, in institutions for mental diseases traditionally excluded from Medicaid funding—we urge MDH to continue providing and improving the community-based treatment options available under Medicaid. We further encourage MDH to consider the particular needs of people with both intellectual and developmental disabilities and SUD in developing these treatment options.

Please contact Sarah Steege (SarahS@disabilityrightsmd.org or 443-692-2497) with any questions. Again, we appreciate your consideration of these comments.

Sincerely,

[redacted]

Robin C. Murphy
Executive Director

[redacted]

Sarah G. Steege
Attorney

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

Proposed Waiver Amendment for Adult Dental Coverage Pilot

1 message

karla.davis@myactv.net <karla.davis@myactv.net> Tue, Jun 19, 2018 at 9:55 PM
To: mdh.healthchoicerenewal@maryland.gov

Dear Ms. Roddy:

I want to express my support for the establishment of the pilot dental program for dental coverage for dually eligible individuals between 21 and 64 who do not currently have dental insurance. As a chaplain at Meritus Medical Center in Hagerstown, MD, I see so much need in our population. And, I see so many who neglect basic healthcare needs because they do not have the money or the coverage to help provide the care.

I urge you help this waiver pass so that the eligible will find the help they need.

Thank you for your efforts on this project.

Sincerely yours,

Karla K. Davis

MARYLAND RURAL HEALTH ASSOCIATION

June 18, 2018

Tricia Roddy, Director of Planning
Maryland Medicaid Program, Department of Health
201 West Preston Street, Room 224, Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. The Maryland Rural Health Association (MHRA) fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

MRHA recently published the 2018 Maryland Rural Health Plan which included a comprehensive examination of the rural health care needs of Maryland. Not surprisingly, the need for increased access to dental care, was a recurring theme. Specifically, there are several barriers to oral health in rural communities: poverty and the ability to pay; lack of insurance or type of insurance; transportation limitations; lack of understanding the importance of dental health; lack of dental services; and lack of dentist accepting patients on state insurance.[1] The combination of these barriers has resulted in poor dental health outcomes for Maryland's rural communities. The rural jurisdictions of Allegany, Caroline, Charles, Dorchester, Garrett, Queen Anne's, Somerset, Talbot, Washington, Wicomico, and Worcester all contain a Dental Health Professional Shortage Area.

It is for these reasons that MRHA strongly supports the adult dental pilot. We look forward to working with the Maryland Department of Health on the implementation of the adult dental coverage pilot and we are committed to making the pilot a success.

Sincerely,

[redacted]

Lara Wilson, M.S.
Executive Director
Maryland Rural Health Association

1. Oral Health Among Low-Income Rural Families: Implications for Policy and Program https://sph.umd.edu/sites/default/files/files/OralHealthAmongRuralLow-IncomeFamilies2-7-07.pdf

FAMILY HEALTHCARE OF HAGERSTOWN

PRIMARY CARE MENTAL HEALTH DENTAL

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street
Room 224
Baltimore, Maryland 21201

Via Email: mdh.healthchoicerenewal.maryland.gov

Re: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dr. Ms. Roddy:

On behalf of Family Healthcare of Hagerstown (FHH), the only safety net dental provider in the county, it is a pleasure to offer this letter as my comment in support of the proposed waiver amendment to SB 284.

Family Healthcare of Hagerstown (FHH) is a nonprofit healthcare organization whose mission is to promote a healthy community by providing affordable, accessible and compassionate healthcare to individuals and families of all ages, races and economic backgrounds. FHH cares for some of the poorest and most disadvantaged in the county: 69% of patients that report income live at or below poverty level and 91% live at or below 200% poverty level. While FHH does accept patients with private insurance coverage as well as Medicare and Medicaid, we care for patients regardless of ability to pay and without any insurance coverage at all. FHH provides a sliding fee scale for patients based on household income and, last year, FHH provided $1.7 million in charity care; nearly $670,000 of these funds specifically covered dental care.

FHH supports this very creative and efficient approach to dental coverage. Regardless of coverage, or lack thereof, no adult should have to contend with dental pain that interrupts work or study or that interferes with eating and nutrition. Every person should have access to dental care that supports a healthy body, best speech, high self-esteem, and optimal quality of life.

We look forward to working with the Department of Health on the pilot program.

Best regards,

[redacted]

Kim Murdaugh
Executive Director
Family Healthcare of Hagerstown

MACS
Maryland Association of Community Services

ph 410-740-5125
ph 888-838-6227
fax 410-740-5124

June 19, 2018

Tricia Roddy
Director of Planning, Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201
Via email to mdh.healthchoicerenewal@maryland.gov

RE: 1115 HealthChoice waiver amendment- Adult Dental Pilot

Dear Ms. Roddy:

The Maryland Association of Community Services (MACS) is a non-profit association of over 100 agencies across Maryland serving people with developmental disabilities. MACS members provide residential, day and supported employment services to thousands of Marylanders, so that they can live, work and fully participate in their communities. We are pleased to have the opportunity to submit comments regarding the 1115 HealthChoice waiver amendment.

MACS was in strong support of SB 285, the enabling legislation for the Adult Dental Pilot, and is very pleased to see the process moving forward. But for a few narrow exceptions, Marylanders who are part of the adult Medicaid population are without access to oral health services.[1] If approved, the pilot would represent a positive step forward in beginning to meet a long-neglected need of this community. Without access to dental coverage, and without the resources to pay for these services, many of these individuals rely on expensive emergency room care and/or a limited number of safety net dental providers.

As the Maryland Department of Health (MDH) notes in the draft waiver amendment, people with disabilities are more likely to have poor oral health and thus suffer all of the resulting negative consequences that come with it. Access to providers can be further challenging for people with intellectual and developmental disabilities who may need providers trained in meeting their particular needs. If the waiver is approved, MACS encourages the MDH to partner with the disability community in outreach to beneficiaries, recruitment of new dental providers and cultural awareness training for dental providers regarding best practices in meeting the oral health needs of people with disabilities.

We look forward to working with the MDH and hope that a successful pilot will bring expansion to the rest of the Medicaid population in the not too distant future.

Respectfully,

[redacted]

Lauren B. Kallins, Esq.

[1] Maryland Medicaid currently provides dental benefits for children, pregnant woman, Rare and Expensive Case Management adult populations, and former foster care children until the age of 26.

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

Proposed Waiver Amendment for Adult Dental Coverage Pilot

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov> Fri, Jun 15, 2018 at 1:27 PM
To: "Bress, Lisa E." <LBress@umaryland.edu>

Good afternoon Ms. Bress,

This email is to acknowledge receipt of your comments from West Cecil Health Center regarding our proposed 1115 HealthChoice Waiver amendment.

Thank you for your support,

Katie Roulston, MPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
410-767-5677
Katherine.Roulston@maryland.gov

On Fri, Jun 15, 2018 at 8:03 AM, Bress, Lisa E. <LBress@umaryland.edu> wrote:

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. **West Cecil Health Center** fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

I strongly support the dental pilot due to my work with dental and dental hygiene students at the West Cecil Health Center in Perryville located in Cecil County. S**ince 2009 when the clinic opened under the management of the UMD School of Dentistry through our present partnership with West Cecil Health Center we have treated countless patients with the most severe dental disease I have seen in my 34 years of practice. It is not uncommon for patients between the ages of 25- 65 to require multiple or full mouth extractions due to dental caries (cavities) There are also numerous patients with severe periodontal disease often exacerbating diabetic symptoms for patients with diabetes. As you are probably are aware the rate of dental Emergency Department visits in Cecil County has decreased. I am**

confident this improvement is due to the work of the dental providers at the clinic as numerous dental emergencies are treated at the clinic each week with definitive dental care services rather than palliative care as these patients receive in the ED. In addition our dental hygiene students provide preventive dental services that include going out in the community providing education and oral health screenings which help encourage this high risk community to seek dental care. This waiver and the pilot dental program would not only save money by decreasing costs to hospitals and Medicaid as a result of dental ED visits, it will also enhance the professional dental education for dental and dental hygiene students who are eager and able to provide optimal care for this needy patient population.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success.

Sincerely,
Lisa

Lisa Bress, RDH, MS
Division of Dental Hygiene
University of Maryland School of Dentistry

650 W. Baltimore St.,
Baltimore, MD 21201
410-706-7231
Lbress@umaryland.edu

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

Adult Dental Coverage Pilot

2 messages

Widney, Nancy C. <nwidney@bcps.org> Mon, Jun 18, 2018 at 8:25 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>

June 19, 2018

Tricia Roddy
Director of Planning
Mary Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov<mailto:mdh.healthchoicerenewal@maryland.gov>

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for your consideration on the proposed waiver amendment for the establishment of an adult dental coverage pilot. I fully support this waiver amendment, as did I support SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

I support the adult dental pilot. Dental care is essential to overall health and well-being. I have a close friend who, through not fault of her own, has no access to dental care. I believe everyone deserves regular checkups and dental services.

I look forward to news of the Department of Health's implementation of the adult dental coverage pilot. I believe the pilot will be a success.

Sincerely,

Nancy Widney

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov> Tue, Jun 19, 2018 at 9:58 AM
To: "Widney, Nancy C." <nwidney@bcps.org>
Cc: Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>, Sandra Kick -DHMH- <sandra.kick@maryland.gov>
Bcc: "Nancy C. Brown -DHMH-" <nancyc.brown@maryland.gov>, "Sian A. Goldson -MDH-" <sian.goldson@maryland.gov>

Good morning Ms. Widney,

This email is to acknowledge receipt of your comments regarding our proposed 1115 HealthChoice Waiver amendment.

Thank you for your support,

Katie Roulston, MPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201
410-767-5677

Katherine.Roulston@maryland.gov
[Quoted text hidden]

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

FW: 1115 Comments - TCC

2 messages

Rachael Faulkner <rfaulkner@policypartners.net> Wed, Jun 6, 2018 at 1:26 PM
To: "mdh.healthchoicerenewal@maryland.gov" <mdh.healthchoicerenewal@maryland.gov>

From: Rachael Faulkner
Sent: Wednesday, June 6, 2018 1:25 PM
To: Tricia Roddy -MDH- <tricia.roddy@maryland.gov>
Cc: mailto:mdh.healthchoicerenewal@maryland.gov
Subject: 1115 Comments - TCC

Tricia,

Please see comments from TCC regarding Medicaid's amendment proposal to the Section 1115 HealthChoice Waiver.

Rachael Faulkner, MSW

Director of Research and Policy Development

Public Policy Partners

48 Maryland Avenue, Suite 304

Annapolis, MD 21401

410-693-4000

rfaulkner@policypartners.net

www.policypartners.net

2018 TCC 1115 Waiver Amendment Ltr.pdf
184K

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov> Fri, Jun 8, 2018 at 8:58 AM
To: Rachael Faulkner <rfaulkner@policypartners.net>
Cc: Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>, Sandra Kick -DHMH- <sandra.kick@maryland.gov>
Bcc: Katherine Roulston -MDH- <katherine.roulston@maryland.gov>, "Sian A. Goldson -MDH-" <sian.goldson@maryland.gov>, "Alexandra M. Loizias -DHMH-" <alexandra.loizias@maryland.gov>, "Danielle C. Lohan -MDH-" <danielle.lohan@maryland.gov>, "Nancy C. Brown -DHMH-" <nancyc.brown@maryland.gov>, "Amy A. Woodrum -MDH-" <amy.woodrum@maryland.gov>

Good morning Ms. Faulkner,

This email is to acknowledge receipt of your comments from TCC regarding our proposed Section 1115 HealthChoice Waiver amendment.

Thank you for your support,

Sandy Kick
Administrative Program Manager 2
[Quoted text hidden]

Maryland Dental Action Coalition

Maryland Dental Action Coalition
10015 Old Columbia Road, Suite B-215
Columbia, MD 20146

Phone: 410-312-5456
http://www.mdac.us/

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. The Maryland Dental Action Coalition (MDAC) fully supports the application for the waiver amendment, and we look forward to working with the Department of Health on implementation.

Adult Dental Coverage

Under the proposed waiver amendment, Maryland will have the opportunity to provide dental coverage to adult Medicaid participants without any dental coverage. These adults are dually-eligible and between 21 and 64 years of age. This coverage is a game-changer for these adults in improving their oral health and overall health care status. It is also critical for improving overall population health.

The Department of Health's proposal is aligned with the provisions of *SB 284 – Maryland Medical Assistance Program – Dental Coverage for Adults – Pilot Program*, which was signed into law by Governor Hogan on May 15th of this year. The legislation received unanimous support from the Maryland General Assembly. This across-the-board support demonstrates that communities across Maryland stand ready to make this dental coverage program a success.

MDAC has outlined several recommendations to support the Department's work in the implementation of the waiver amendment once approved by CMS. MDAC's comments have been shaped by the Maryland Oral Health Plan for 2018 to 2023[i]. MDAC developed this plan in collaboration

with stakeholders in the health care and consumer communities across the state. In addition, MDAC convened stakeholders for an oral health summit on June 18th and gathered feedback from over 100 stakeholders on the proposed waiver amendment.

Cap on Annual Coverage: We fully appreciate that the Department of Health must consider placing an annual cap on reimbursed dental services per Medicaid participant. This is an important tool to ensure the program remains within budget. We recommend that the Department consider allowing for exceptions to the cap if certain medically necessary criteria are met. There will be circumstances in which a delay in dental services will negatively impact health outcomes. For example, there could be a participant who cannot proceed with a needed surgery if their oral health status creates a risk of infection. If the participant had to wait for dental services because they exceeded the cap, this would likely compromise their overall health status.

Consumer Engagement: We are pleased that the proposed waiver amendment provides dental coverage to individuals who lack any dental coverage. This group of consumers currently relies on a patchwork of safety net programs to obtain dental services. For the waiver program to be successful, we recommend working with stakeholders across the state to develop and implement a consumer engagement strategy. Some consumers may have had coverage before and understand how to navigate the system to obtain services. However, other consumers may have little or no experience with utilizing dental coverage. MDAC recommends that the consumer engagement strategy include the following goals:

- Supporting consumers in identifying dental homes.
- Working with consumers to understand their dental coverage. If there is a cap on annual coverage, then it would be helpful to assist consumers in understanding that their treatment plans may have to be structured over 2 years or more for restorative services.
- Facilitating consumers in obtaining preventative services on a routine basis, so they can maintain good oral health and reduce the need for restorative services.

Provider Engagement: Maryland has been successful in increasing provider engagement for the *Healthy Smiles* program under the Maryland Medicaid Program. This success is the result of the collaboration of the Maryland Department of Health, the Maryland Dental Action Coalition, and a large number of stakeholders across the state. Based on this success, we recommend developing and implementing a provider engagement strategy to increase the number of dentists providing services to adults in Medicaid. At MDAC, we are eager to assist the Department in engaging stakeholders to begin the process. We would recommend that goals include:

- Increasing the number of providers in private practice who enroll as Medicaid providers. There should be a specific focus on recruiting providers who work with individuals with disabilities who are the most likely to be dually eligible.
- Expanding the capacity of safety net providers who may already be providing free or reduced cost services to Medicaid participants without dental coverage.
- Supporting all types of providers in creating and maintaining dental homes for their patients.

Covered Services: MDAC supports the Department's plans to include both preventative and restorative services in the program. We understand that financial limitations will preclude the coverage of all types of restorative services. We suggest a stakeholder discussion to provide feedback to the Department on which services to prioritize.

Data Analysis: MDAC recommends that there be further discussion of how data analytics can support improvements and refinements in the program. There may also be opportunities to collaborate on research about the impact of dental coverage on health status, the frequency of emergency department visits for chronic dental conditions, and the cost of treating certain chronic diseases. We also recommend consideration of how a consumer satisfaction survey can provide meaningful feedback about the program.

National Diabetes Prevention Program Pilot

MDAC supports the Department's request for a waiver amendment to continue the National Diabetes Prevention Program Pilot. There may be opportunities to use the results of the National Diabetes Prevention Program Pilot and the adult dental coverage waiver program to develop and implement comprehensive strategies to improve outcomes for individuals with diabetes and other chronic conditions.

Conclusion

Thank you again for the opportunity to submit comments on the Department's proposed amendments to its 1115 waiver. The Department has a long-track record of working with MDAC and other stakeholders across the state to ensure successful implementation of its wavier programs. We look forward to collaborating with the Department as Maryland moves forward with these programs.

Sincerely,

[redacted]

Mary C. Backley
Executive Director

[i] http://mdac.us/2018_01_14/MD_OHP_2018_0102.pdf

THE COORDINATING CENTER
INSPIRED SOLUTIONS

Letter of Support
Section 1115 HealthChoice Waiver Amendment
June 6, 2018

The Coordinating Center (The Center) supports the Maryland Department of Health's (MDH) proposal to amend Maryland's § 1115 HealthChoice Waiver, specifically the inclusion of the National Diabetes Prevention Program Pilot and the Adult Dental Pilot Program.

As a statewide, independent, care coordination organization with over 35 years of experience, The Center coordinates services for more than 10,000 people with disabilities and the most complex medical and social needs across the state. This is accomplished through innovative programs that move people from institutions, nursing facilities, and hospitals to homes in the community of their choice, while reducing costs to the system and the citizens of Maryland.

Through our work, The Center is very familiar with existing gaps in services, including oral health care for Medicaid enrollees. This includes all dental coverage – from complex oral health conditions to simply purchasing dentures. Similar to other health care organizations across the state, we have had to be creative, including raising private dollars, in order to assist our clients when oral health services are needed. Unfortunately, we find that even through this work, we cannot always meet the demand. The importance of piloting a dental benefit in the Maryland Medicaid Program as a first step in addressing this coverage gap cannot be overstated.

In addition, we are very supportive of including the National Diabetes Prevention Program Pilot in the waiver amendment application. The Center currently works in multiple jurisdictions with hospitals and healthcare centers to provide care coordination to individuals with complex medical needs at risk of hospitalization. As such, we know first-hand the devastating health effects from diabetes and resulting health care costs to the system. Therefore, we support Medicaid's efforts to further address this health condition through a prevention strategy.

Thank you for your consideration of our comments. If you need any additional information, please contact Rachael Faulkner at (410) 693-4000 or rfaulkner@policypartners.net.

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www.parkwestmed.org

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. Park West Health System, Inc. fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

Our organization supports the adult dental pilot because of the need to improve the oral health/overall health of the lower income citizens of Maryland.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success.

Sincerely,

Stewart A. Butler, DDS

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4120 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2266
Fax: (410) 358-7413

Park West Medical Center
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The Men and Family Health Center
4151 Park Heights Avenue
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(443) 874-5502
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Maryland Area Health Education Center *West*
39 Baltimore Street, Suite 201
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301-777-9150 | Fax: 301-777-2649
http:www.ahecwest.org

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. The Maryland Area Health Education Center West (AHEC West) fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created the pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

Our organization supports the adult dental pilot because of the negative impact that poor oral health has on the population we serve. Furthermore, we work directly with the low-income population in the Western part of Maryland and see firsthand the suffering that people in poverty deal with when they do not have funds for dental work. As an AHEC, we work to support education and Community Health Worker engagement that lead to positive health behavior changes to improve the health of those in the low-income population.

We look forward to working with the Department of Health on the implementation of the adult dental coverage pilot. We are committed to making the pilot a success.

Sincerely,

[redacted]

Susan K. Stewart
Executive Director

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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June 18, 2018

Tricia Roddy
Planning Administration, Office of Health Care Financing
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

Re: MDH Proposed §1115 Waiver Amendment

Dear Ms. Roddy:

The Mental Health Association of Maryland (MHAMD) is in strong support of the Maryland Department of Health's (MDH) proposed §1115 waiver amendment, particularly as it relates to the expansion of treatment for substance use disorders (SUD) in Institutes of Mental Disease (IMD).

Under Maryland's current §1115 waiver, MDH is authorized to cover certain SUD services delivered in IMDs for up to two nonconsecutive 30-day stays annually. As of July 1, 2017, this has included coverage of American Society of Addiction Medicine (ASAM) levels 3.3, 3.5, 3.7 and 3.7D. Effective January 1, 2019, the waiver will also authorize coverage of ASAM level 3.1 services. The proposed amendment would authorize MDH to expand its coverage of SUD residential services to include ASAM level 4.0 for up to 15 days in a month for certain Medicaid adults.

This expansion of treatment options for individuals with SUDs is a critical step in combatting an opioid crisis that is devastating Maryland families. Eighty-nine percent of the 2,089 intoxication deaths that occurred in Maryland in 2016 were opioid-related. There were 1,501 opioid-related deaths in the state from January through September of 2017, up from 1,344 such deaths during the same period a year earlier. The number of opioid-related deaths increased by 70 percent between 2015 and 2016 and has nearly quadrupled since 2010.

As of March 2018, more than 5,700 individuals have received services under the current waiver. An expansion of the waiver as outlined in the proposed amendment will greatly increase access to needed substance use services and improve Maryland's ability to tackle the ongoing opioid epidemic.

For these reasons, we support the proposed §1115 waiver amendment. Thank you for the opportunity to provide these comments. Should you have any questions or require additional information, please do not hesitate to contact me at (443) 901-1550 x208 or dmartin@mhamd.org.

Sincerely,

[redacted]

Dan Martin
Senior Director of Public Policy

June 13, 2018

Tricia Roddy, Director of Planning, Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Dear Ms. Roddy:

The Maryland Association for the Treatment of Opioid Dependence (MATOD) supports Maryland Medicaid's §1115 Waiver Amendment request submitted May 18, 2018. The two main components MATOD supports are those that further expand coverage for residential substance use disorder (SUD) services and that establish a pilot adult dental benefit.

While the expansion regarding residential treatment for people with co-occurring disorders will impact a relatively small number of people, these intense services should be available to those enrolled in Medicaid and covered accordingly. This is another step in Maryland's progress toward coverage of the full range of SUD treatment services.

MATOD also strongly supports expanding the Medicaid benefit to cover dental services for adults. While this request is limited in scope, it is a positive first step in providing the dental care needed, and typically unaddressed, for people with SUDs. Heroin and other opioids can cause immense cravings for sugars, and the constant intake of candy and sodas leads to the erosion of enamel on teeth. Oral health is also often cited by people in recovery as a barrier to their success. Low self-esteem and a lack of confidence can impact a person's ability to find a job. The pain caused by dental problems can be difficult for people in recovery to address, and for some, can lead to relapse.

Ensuring that people enrolled in Medicaid have access to basic dental services is a wise investment, as is covering a full range of SUD treatment services. We hope you will give approval to Maryland's request.

Sincerely,

Howard Ashkin

Howard Ashkin, MMH, PsA
President

c/o IBR/REACH Health Services
2104 Maryland Avenue
Baltimore, MD 21218

(410) 752-6080

info@matod.org
www.matod.org

MATOD members include community and hospital based Opioid Treatment Programs, Health Departments, Local Addiction Authorities, Local Behavioral Health Authorities and Maryland organizations that support Medication Assisted Treatment. MATOD members include thousands of highly trained and dedicated addiction counselors, clinical social workers, physicians, nurse practitioners, physician assistants, nurses, psychologists, peer recovery specialists and office staff who work every day to save lives.

BALTIMORE CITY
BEHAVIORAL HEALTH DIRECTORATE

June 15, 2018

Tricia Roddy, Director of Planning, Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Dear Ms. Roddy:

The Baltimore City Behavioral Health Directorate (Directorate) supports Maryland Medicaid's §1115 Waiver Amendment request submitted May 18, 2018. The two main components the Directorate supports are those that further expand coverage for residential substance use disorder (SUD) services and that establish a pilot adult dental benefit.

While the expansion regarding residential treatment for people with co-occurring disorders will impact a relatively small number of people, these intense services should be available to those enrolled in Medicaid and covered accordingly. This is another step in Maryland's progress toward coverage of the full range of SUD treatment services.

The Directorate also strongly supports expanding the Medicaid benefit to cover dental services for adults. While this request is limited in scope, it is a positive first step in providing the dental care needed, and typically unaddressed, for people with SUDs. Oral health is also often cited by people in recovery as a barrier to their success. Low self-esteem and a lack of confidence from missing and/or decayed teeth can impact a person's ability to find a job which can have an impact on their recovery process. In additions, the pain caused by dental problems can be difficult for people in recovery to address, and for some, can lead to relapse.

Ensuring that people enrolled in Medicaid have access to basic dental services is a wise investment, as is covering a full range of SUD treatment services. We hope you will give approval to Maryland's request.

Sincerely,

Vickie Walters

Vickie Walters, President
Baltimore City Behavioral Health Directorate

c/o REACH Health Services
2104 Maryland Avenue
Baltimore, Maryland 21218
(410) 752-6080

June 19, 2018

Tricia Roddy, MPH
Director of Planning
Maryland Medicaid Program
Maryland Department of Health
201 W. Preston Street, Room 224
Baltimore, MD 21201

Director Roddy:

Thank you for the opportunity to comment in support of Maryland's 1115 Waiver Amendment. Over the last several years, Maryland's work in the Medicaid system has created a standard for forward-thinking approaches to care delivery and payment. We are strongly supportive of the Centers for Medicare and Medicaid Services (CMS) enabling the state to continue and expanding its innovative approach, and we look forward to continuing to work with Maryland's Medicaid populations to provide high-quality, tech-enabled preventive care. Maryland's work in the sphere of diabetes prevention, creating a delivery system that prioritizes choice and access for Medicaid members and values flexibility, meaningful engagement and patient-centered care, is a shining example of this success.

Omada Health is a digital health company headquartered in San Francisco. We are a fully recognized virtual provider of the National Diabetes Prevention Program (NDPP). To date, we have enrolled more than 160,000 participants, making us the largest CDC-recognized provider, in-person or virtual, in the country.

Aligned with our mission to inspire and enable people everywhere to live free of chronic disease, we began working with the Medicaid population in 2015. The higher risk of chronic disease among low-income populations is well-documented. These populations tend to have less access to healthy food and safe neighborhoods, and are more likely to experience multiple barriers to accessing care. Multiple surveys have also confirmed that more than 2 of every three adults in households with incomes below $30,000 own a smartphone, meaning that virtual delivery of care is a viable option for delivering low-barrier care to populations which need it the most.

In 2015, Omada created an adapted version of our program to meet the needs of underserved populations at risk for diabetes. To date, we have enrolled more than 1,000 Medicaid and low-income uninsured adults across seven states – California, Oregon, Washington, Hawai'i, Nebraska, Minnesota and Maryland.

We've learned that Medicaid members will access, engage and reach clinically meaningful outcomes with an online DPP program. More than 500 of our Medicaid participants are past 6 months; program starters have an average 3.6 percent weight loss and program completers an average of 4 percent weight loss. 3 – 5 percent weight loss is associated with a projected 3 year risk reduction of 38 percent.

As part of a CDC-funded DPP demonstration project, Omada began working with Maryland in 2016. Partnering with the State Department of Public Health, Medicaid and all four of the HealthChoice MCOs involved in the project. Maryland's well-designed, outcome-based reimbursement model allowing for multiple modalities has set a standard for this type of work across the country. The collaborative efforts within the Maryland Department of Health, and with the HealthChoice MCOs as part of this demonstration project has truly been inspiring.

Of the 639 HealthChoice members in the DPP demonstration project, 85% selected an online DPP provider. Omada is the provider for 361 of the total members, and the outcomes of this subset of our underserved population have been even more impressive than the outcomes for our total national underserved population.

With the current HealthChoice population we have seen an average of 30 points of engagement per week during the first 4 months. This is members engaging with the program – completing lessons, utilizing fitness and meal tracking tools, and engaging both with their coach and their group, all via a smartphone, tablet or computer -- and does not account for proactive outreach from Omada coaches.

Outcomes highlights are even more impressive. There are 172 HealthChoice members in the Omada program who are more than six months into the program. Of that population, program starters (by CDC definition) have lost an average of 3.8 percent weight loss; 132 program completers are averaging 4.4 percent weight loss. At 26 weeks, 41 percent of program completers have lost more than 5 percent. of their weight. Five to seven percent weight loss is associated with a 54 percent projected 3 year risk reduction.

There's extensive well-researched and published evidence of the clinical and economic impact of the DPP. It is the standard of care to help prevent the onset of diabetes, and needs to be available to all members of our population to truly make an impact on our country's health and to help drive down health care spending. Innovation in government programs can spur innovation in the private sector; Maryland's experience proves this fact. Prioritizing flexibility and the needs of Medicaid members has made Maryland's pilot that much more effective.

As Omada continues to engage with CMS around potential coverage of virtual DPP in Medicare, Maryland's experience should be taken as an unequivocal success story. CMS Administrator Verma is already on record as supporting tech-enabled innovation in state Medicaid programs; we are hopeful that the success of the demonstration project in Maryland will add yet another point of evidence on the effectiveness of virtual DPP delivery to a diverse set of populations.

Omada is fully in favor of the Maryland's 1115 waiver amendment, and would encourage CMS to proactively encourage other states to follow the lead of Maryland with this phased-in approach, inclusive of online and in-person delivery. Thank you for being leaders in this work for the most at-risk members of our communities.

If you have any questions regarding our program, or there is any additional information we can provide regarding our work with Maryland Medicaid populations, please don't hesitate to contact me at Adam.Brickman@omadahealth.com.

Sincerely,

Adam Brickman
Senior Director, Public Policy
Omada Health

June 19, 2018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street
Room 224
Baltimore, Maryland 21201

Dear Director Roddy:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) is pleased to provide the following comments regarding the Maryland Department of Health's (Department) Section 1115 Waiver Amendment Submission Draft.

Adults with diabetes are disproportionately covered by Medicaid.[1] For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low-income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions.

According to the Centers for Disease Control and Prevention, over 9.4% of adults in Maryland have diabetes, and additional 36.9% have prediabetes.[2,3] Access to affordable, adequate health coverage is critically important for all people with, and at risk for diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forgo the care they need, potentially leading to costly complications and even death.

The ADA is very encouraged by the Department's continued support and investment in the National Diabetes Prevention Program (National DPP) Pilot. The National DPP is an evidence-based, CDC recognized lifestyle change program designed to reduce the risk of developing type 2 diabetes. Research shows that people with prediabetes who take part in prevention programs can reduce their risk by 58%.[4] Continuing the National DPP Pilot, and potential expansion post pilot, will improve the overall health, reduce the number of diabetes cases by 40% within the first year, therefore significantly reducing the overall cost to the Department.[5]

Thank you for the opportunity to provide these comments on behalf of Maryland residents with diabetes and prediabetes. If you have any questions, please contact Gary Dougherty, Director of State Government Affairs and Advocacy at GDougherty@diabetes.org or 1-800-676-4065 x4832. Or David McShea, Executive Director of Maryland ADA DMcshea@diabetes.org or 410-265-0075 x4675

American Diabetes Association®

[1] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.
[2] Centers for Disease Control and Prevention, Diagnosed Diabetes Atlas. Available at: https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#
[3] Maryland Department of Health, Prediabetes in Maryland Report. January 2015. Available at: https://phpa.health.maryland.gov/ccdpc/Reports/Documents/BRFSS%20Diabetes.pdf
[4] Centers for Disease Control and Prevention, National Diabetes Prevention Program. Available at; https://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html
[5] Center for Disease Control and Prevention, Diabetes Prevention Impact Toolkit. Maryland State Results. Available at: https://nccd.cdc.gov/Toolkit/DiabetesImpact/Dashboard

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June 19, 2018

Tricia Roddy
Director of Planning
Department of Health
201 W. Preston Street, Room 224
Baltimore, MD 21201

Via Email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed § 1115 Waiver Amendment

Dear Ms. Roddy:

On behalf of the Mid-Atlantic Association of Community Health Centers (MACHC), I would like to express our strong support for the above-referenced waiver renewal. MACHC is the federally designated Primary Care Association for Delaware and Maryland Health Centers. Its members consist of community, migrant and homeless health centers, local non-profit and community-owned healthcare programs, including all of Maryland's federally qualified health centers (FQHCs). MACHC's members provide health care services to the medically underserved and uninsured, often Maryland's most vulnerable residents. To that end, MACHC is particularly excited about the proposed expansion of services included in the proposed §1115 Waiver Amendment that clearly target challenging socioeconomic and health care access challenges frequently faced by Medicaid enrollees that directly impact health status and health outcomes.

The three programs included in the proposed Waiver Amendment are of particular relevance to those Medicaid recipients served by MACHC members. Diabetes prevention has long been an objective of FQHCs and MACHC is very supportive of the State's interest in continuing to cover the National Diabetes Prevention Program (National DPP) services through a limited pilot program that builds upon and utilizes the State's current knowledge and experience in developing a delivery system for the National DPP. MACHC is hopeful that the proposed pilot program will yield outcome data that ultimately will result in expansion of the program beyond the proposed pilot.

MACHC also supports the proposed expansion of its Institution for Mental Diseases exclusion (IMD exclusion) waiver for substance use disorder (SUD) residential services to include an additional level of care - enrollees with a dual diagnosis of SUD and mental health disorder. MACHC members have seen a significant growth in the number of patients that are dually diagnosed. The increased incidence of dual diagnosis coupled with the escalating opioid crisis provides strong justification for expanding access to proven treatment services that are designed to provide ongoing treatment and recognize the need to treat SUD's as a chronic condition.

Finally, MACHC has long been a proponent of expanded access for dental services for adults. The proposed dental pilot program that will provide limited adult dental services for dually-eligible participants 21-64 years of age is a modest but good step in the right direction. MACHC believes the pilot project will prove that offering adult dental benefits effectively improves overall health outcomes for vulnerable populations and result in system savings that justify the cost of the benefits.

MDH is to be commended for including in the proposed waiver amendment innovative approaches to addressing three critical health areas of need for expanded access to services that have the potential to dramatically improve the health outcomes of Maryland's most vulnerable populations. MACHC strongly supports the approval of these programs by CMS and looks forward to working with Medicaid leadership on their implementation.

Sincerely,

[redacted]

Karen Williams
Chief Executive Officer

Cc: Robert Neall, Secretary, MDH
Dennis Schrader, COO and Medicaid Director, MDH

MMCOA
MARYLAND MCO ASSOCIATION

June 19, 2018

Ms. Tricia C. Roddy
Director of Planning, Maryland Medicaid Program
Maryland Department of Health
201 Preston Street, Room 224, Baltimore, MD 21201

Sent electronically to mdh.healthchoicerenewal@maryland.gov

Dear Ms. Roddy:

On behalf of the Maryland MCO Association (MMCOA), comprised of HealthChoice's nine MCOs, we would like to provide formal comments in support of the Maryland Department of Health's (the Department) §1115 Waiver Amendment.

The amendment would authorize the Department to: 1) continue the National Diabetes Prevention Program (NDPP) services through a limited pilot program; 2) pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutes of Mental Disease (IMD); 3) cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age; and 4) remove the Family Planning Program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

National Diabetes Prevention Program (NDPP) Pilot. The MMCOA is generally supportive of the continuation of the current pilot. We are however unable to comment on the initial budget allocated for the pilot continuation since data was not provided in the waiver amendment on the total number of Medicaid enrollees that are potentially eligible for the program. At least one MMCOA member is reviewing its current membership to determine whether it could apply for a grant under the new program if approved under the waiver amendment.

Currently four MCOs participate in the pilot. Of those, one MCO highlighted that their members overwhelmingly elected to participate in the virtual program rather than the face to face option. Based on their initial findings the virtual program has been successful. We are encouraged by these results as it indicates that enrollees respond positively to alternative and creative ways to receive services beyond traditional face to face visits.

Residential Treatment for Individuals with Substance Use Disorders: Institutes of Mental Disease (IMD) Expansion. We fully support the Department's tireless efforts to address and resolve the opioid epidemic and support any waiver amendment that makes access to these services more easily and widely available. The MCOs are committed to continuing to work with the state on opioid prescribing and with the Department on future initiatives to better integrate care for individuals with SMI and SUD. Simultaneously, we continue to advocate in support of a

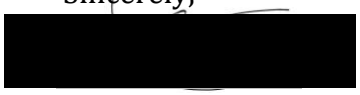
managed care model that fully integrates somatic care with behavioral and substance use disorder treatment to enable better coordination of care for this population.

Adult Dental Pilot. We are supportive of this initiative as dental health is a part of holistic wellbeing and leads to better overall health and wellness. However, we are concerned about the pilot targeting dually eligible individuals ages 21-64 exclusively. This population is small and there are additional Medicaid FFS recipients that do not fall into this category that could also benefit from the pilot.

Family Planning Program. We have no objection to this waiver proposal.

Thank you for allowing us to provide comment. Please contact me should you have any questions at all.

Sincerely,



Delora R. Sanchez
Executive Director
Maryland MCO Association

Maryland
Hospital Association

June 18, 2018

Tricia Roddy
Director of Planning, Maryland Medicaid Program
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, Maryland 21201

Dear Ms. Roddy:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, I write in support of the Maryland Medicaid §1115 demonstration waiver amendments submission.

As noted in the submission, the ever-growing focus on population health management will only increase as the state enters the next phase of the All-Payer Model contract — the Enhanced Total Cost of Care Model. Under this model, hospitals will continue to be responsible for providing care beyond their four walls, investing in and coordinating with community-based health and social services providers. Population health targets under the new model will bolster these efforts.

As population health targets are developed, there will be a need for all stakeholders to participate, and to be held accountable for their role in advancing positive change. This is why there is great value in the Medicaid program's initiative to continue a diabetes prevention program via managed care organizations. Upstream prevention is one of the most effective ways we can reduce potentially avoidable utilization and decrease costs across the care continuum. These are goals the state must continue to support and enhance under the next phase.

We appreciate Medicaid's request to provide coverage of enhanced services in non-public Institutions for Mental Disease (IMDs). With the rise in co-occurring mental health and substance use disorders, the extension of coverage for ASAM Level 4.0 will ensure the sustainability of the specialized, comprehensive care our standing psychiatric hospitals deliver to these vulnerable patients.

We also appreciate the Maryland Department of Health's commitment to fund IMD services for Medicaid enrollees via state funds for the upcoming fiscal year. This waiver amendment submission will help alleviate the pressure on the state budget. We therefore encourage the Department to continue to seek opportunities for permanent IMD funding of both mental health and substance use disorder services. We stand committed to partner with the State on these efforts.

Finally, we support the adult dental pilot included in the submission. During this past legislative session, MHA supported the bill that prompted inclusion of the pilot. Expanding coverage of dental services for Medicaid adults will yield not only important benefits for patients, but also will help mitigate lengthy wait times in hospital emergency departments. Access to dental coverage will help reduce the reliance of Medicaid dual eligible enrollees on hospital emergency departments for dental needs.

As noted in the report from the Maryland Dental Access Coalition, from fiscal 2013 to fiscal 2016, there were an average of more than 49,000 emergency department visits for chronic dental conditions. Over the same time period, the average annual cost to provide these services for Medicaid enrollees was nearly $11.5 million. Many factors contribute to lengthy emergency department wait times, but one of the main causes is the high volume of visits by non-emergent patients.

We thank you for your leadership on this effort and for the opportunity to comment. We look forward to working with you on these important issues.

Please contact me should you need additional information.

Sincerely,

[redacted]

Maansi K. Raswant
Director, Policy and Data Analytics

MARYLAND

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

RE: Proposesd Waiver Amendment for Adult Dental Coverage Pilot

2 messages

Sarah Rose <saraherose97@gmail.com> Tue, Jun 19, 2018 at 11:10 AM
To: mdh.healthchoicerenewal@maryland.gov

June 19t, 1018

Tricia Roddy
Director of Planning
Maryland Medicaid Program
Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

Via email: mdh.healthchoicerenewal@maryland.gov

RE: Proposed Waiver Amendment for Adult Dental Coverage Pilot

Dear Ms. Roddy:

Thank you for the opportunity to comment on the proposed waiver amendment for the establishment of an adult dental coverage pilot. I, Sarah E. Rose, fully supports this waiver amendment, as we were supporters of SB 284, the legislation that created this pilot. The waiver program will provide dental coverage for dually eligible individuals who are between 21 and 64 years of age. These individuals currently do not have dental coverage, forcing them to rely on emergency rooms and a patchwork of safety net providers for services.

I Sarah Rose, support the adult dental pilot because of personal experience where I had to rely on a dentist to fill a cavity for me pro bono when I was 25 years old, and for experiencing years without a dental plan and spotty dental coverage at best.

I look forward to working with the Department of Health on the implementation of the adult dentral coverage pilot. I am committed to making the pilot a success.

Sincerely,
Sarah E. Rose

MDH HealthChoiceRenewal -MDH- <mdh.healthchoicerenewal@maryland.gov> Tue, Jun 19, 2018 at 11:25 AM
To: Sarah Rose <saraherose97@gmail.com>
Cc: Tricia Roddy -DHMH- <tricia.roddy@maryland.gov>, Sandra Kick -DHMH- <sandra.kick@maryland.gov>
Bcc: "Nancy C. Brown -DHMH-" <nancyc.brown@maryland.gov>, "Sian A. Goldson -MDH-" <sian.goldson@maryland.gov>

Good morning Ms. Rose,

This email is to acknowledge receipt of your comments regarding our proposed 1115 HealthChoice Waiver amendment.

Thank you for your support,

Katie Roulston, MPH
Health Policy Analyst
Planning Administration
Office of Health Care Financing
Maryland Department of Health (MDH)
201 W. Preston Street, 2nd Floor
Baltimore, MD 21201

410-767-5677
Katherine.Roulston@maryland.gov
[Quoted text hidden]

June 19, 2018

Tricia Roddy
Director of Planning
Office of Health Care Financing
Maryland Department of Health
201 W. Preston Street
Baltimore, MD 21201
Via Email: mdh.healthchoicerenewal@maryland.gov

RE: § 1115 Waiver Amendment

Dear Ms. Roddy:

On behalf of MedChi, The Maryland State Medical Society, which represents more than 8,000 Maryland physicians and their patients, I would like to express the physician community's strong support for the State's "HealthChoice" §1115 Waiver Amendment. Since its implementation in 1997, HealthChoice has consistently achieved its goals of improved coverage and access to care and is structured to pay careful attention to assuring improved health outcomes and program accountability. The three programs reflected in the proposed Waiver Amendment build on the strength and responsiveness of the HealthChoice program.

MedChi is pleased to see the State's continued efforts to focus on specific health care service access and delivery systems that directly impact overall health outcomes. MedChi is particularly excited by the proposed National Diabetes Prevention Program Pilot (National DPP). The American Medical Association (AMA) has been a key player nationally in this partnership of public and private organizations working to make it easier for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of Type 2 diabetes and improve their overall health outcomes. In conjunction with the AMA nationally, MedChi is committed to the advancement of the DPP and has been an active stakeholder in the development of the program in Maryland.

The proposed expansion of coverage for residential treatment at Institutes of Mental Disease (IMD) for individuals with a primary substance abuse disorder diagnosis and a secondary mental health disorder recognizes the need to address the increasing incidence of co-occurring disorders. Many substance use disorder treatment programs are unable to treat individuals with active psychiatric symptoms. IMDs can deliver specialized services to these individuals. MedChi believes the proposed expansion provides a critical enhancement to the current program and recognizes and the importance of providing a full continuum of substance use disorder services if the State is to be effective in addressing the increasing drug overdose epidemic.

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MedChi also supports the Adult Dental Pilot Program which will provide a limited benefit package of dental services to dually-eligible individuals. The pilot program reflects the commitment of both the General Assembly and the Department to determine the impact that offering adult dental services has on improving the health outcomes of this vulnerable population.

MedChi commends the Department for its commitment to creatively enhance and expand services that focus on addressing particularly challenging health care needs and barriers to access. The implementation of these programs will undoubtedly have a substantial impact on the health outcomes of the recipients. MedChi looks forward to working with the Department to implement these initiatives upon approval and is confident they will not only enhance health outcomes but also the cost-effectiveness of the HealthChoice program.

Sincerely,

Gene M. Ransom, III
Chief Executive Officer

cc: Robert Neall, Secretary, MDH
Dennis Schrader, COO and Medicaid Director, MDH

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JOHNS HOPKINS
UNIVERSITY

THE BRANCATI CENTER
FOR THE ADVANCEMENT OF COMMUNITY CARE

The Brancati Center for the Advancement of Community Care
Nisa Maruthur, MD, MHS
Director of Community Partnership
Department of Medicine, Division of General Internal Medicine
2024 East. Monument Street / Room 2-525
Baltimore, MD 21205 USA
410-502-8896

June 21, 2018

Re: Support for Maryland Section 1115 Waiver Amendment from May 18, 2018

To Whom It May Concern:

I am submitting this letter to indicate my strongest support of the Maryland Section 1115 Waiver Amendment for the National Diabetes Prevention Program pilot. As Director of Community Partnership for the Johns Hopkins Brancati Center for the Advancement of Community Care, I direct several Diabetes Prevention Programs in the Baltimore City area. In our programs, we have enrolled over 100 high-risk individuals who have successfully completed (or are completing) a Diabetes Prevention Program; this includes over 50 participants who are members of a Maryland Medicaid MCO (Priority Partners).

Our experience with over 70% retention, attendance over 80% across the yearlong program, and 5% weight loss demonstrates that we are making a true difference in reducing the risk of diabetes in a high-risk population.

We commend Maryland Medicaid for its continuing support of the National Diabetes Prevention Program, the flagship public health prevention program of our time.

Please do not hesitate to contact me about this important program and its implications.

Sincerely,

[redacted]

Nisa Maruthur, MD, MHS
Associate Profess of Medicine & Epidemiology
The Johns Hopkins University


HOPKINS
GIM

Public Comment and Question Log

	Program	Type	Name	Title	Organization	Email	Phone	Date Received	Method	Date Responded	Summary	Response	Respondee	Additional Notes
2	National DPP	Comment	Eliza Gibson	Senior Director Health Plans and Public Innovation	Omada Health	eliza.gibson@omadahealth.com	415-225-5130	5/24/2018	In-person		Eliza is a CSW with experience in public health working with low income populations. Omada delivers online DPP to 150,000 participants nation-wide. Omada is the larrgest recognized DPP provider in the country. Low income populations have barriers accessing care, but may own smartphones. Omada has enrolled 1000 adults nationally to date. They believe people will engage and reach significant outcomes in online DPP. Omada works with all 4 HealthChoice MCOs in MD through the demonstration. They support the inclusion of online and in person DPP in MD. Omada is also supportive of outcomes-based modalities. Inspired by outcomes to date: Most participants in the demonstration (85%) use online DPP. In the current HealthChoice population, Omada sees about 30 points of participation, including online coaching and engagement. Additional highlights include: 172 members passed 26 weeks with 2.8% weight loss. 132 program completes with 4.4% weight loss. Omada is in favor of amendment and encourages others to support as well.			Omada plans to submit a written comment.
4	Dental	Comment	Robyn Elliot	Partner/Consultant	Policy Partners representing Planned Parenthood and the Maryland Dental Action Coalition (MDAC)	N/A	N/A	6/06/2018	In-person	6/6/2018	Thank you for working on this, all the work on children and adult work. MDAC will be submitting comments - it will start with a big thanks. We will have a public meeting on the June 18th and collect public comments. We are really focusing on implementation questions: How do we get providers to participate- particularly with the duals who may have different needs from adults and children? How will we engage consumers? This will be a new opportunity for that - there may be other limitations to access, how can we assist with that? We support a cap. Is there an opportunity for a soft cap- can it be waived in extreme medical circumstances? Other states have done that this will allow the Department financial control. There will be some data in relation to adult coverage - how does it impact chronic disease and the extent to look at that? You will see these items in written comments.			
9	Family Planning	Comment	Robyn Elliot	Partner/Consultant	Policy Partners representing Planned Parenthood and the Maryland Dental Action Coalition (MDAC)	N/A	N/A	6/06/2018	In-person	6/6/2018	Planned Parenthood will be sending a letter support. This is a trend that other states have been doing removing from waiver and putting under SPA.			

Public Comment and Question Log

	Program	Type	Name	Title	Organization	Email	Phone	Date Received	Method	Date Responded	Summary	Response	Respondee	Additional Notes
1	IMD	Question	Ann Ciekot		National Council on Alcohol and Drug Dependence (NCADD)	aciekot@policypartners.net	N/A	5/24/2018	In-person	5/24/2018	Will they put the new levels and payments into the regulations?	Yes they will add the new levels and payments to the regulations.	Alyssa Brown	
3	Dental	Question	Anne Wallerstedt	Associate Director, Social and Economic Justice	Maryland Catholic Conference	anne@mdcathcon.org	N/A	5/30/2018	Email	06/01/18	Do you have a sense of who in MDH will be in charge of deciding participant eligibility and the geographic location(s) of the adult dental pilot program?	Adults who are between 21 and 64 years of age and are dually eligible for Medicare and Medicaid will be eligible for dental services under the proposed pilot. The pilot will be implemented on a statewide basis without geographic restriction. Services delivered through the pilot will be managed by the Department's current dental administrative services organization (ASO).	Danielle Nancy	
5	Dental	Question	Matt Celentaro	Government Relations Specialist	Alliance of MD Dental Plans	mcelentaro@fblaw.com	N/A	6/06/2018	In-person	6/6/2018	Any efforts to engage providers that are reluctant to see Medicaid?	It has not been our focus at this point. We have been focused on figuring out benefit package and responding to CMS questions. It is something to consider. We do provide to REM and they similar to duals. We could look at that to see how we may do this.	Tricia Roddy	
6	Dental	Question	Simon Powell	Manager	Department of Legislative Services	simon.powell@mlis.state.md.us	410-946-5530	6/06/2018	In-person	6/6/2018	DBM gave $5M?	Yes, $5M total funds it is based on fiscal not provided during legislative session. Originally looking at all duals DBM limited the age.	Tricia Roddy	
7	Dental	Question	Simon Powell	Manager	Department of Legislative Services	simon.powell@mlis.state.md.us	410-946-5530	6/06/2018	In-person	6/6/2018	Do you have to include a cap?	We have to ask for waiver to allow for CAP. Will that be in regulation once you set it? Yes we would.	Tricia Roddy	
10	IMD	Question	Simon Powell	Manager	Department of Legislative Services	simon.powell@mlis.state.md.us	410-946-5530	6/06/2018	In-person	6/6/2018	You indicated a 15 days max. Iis there a max number of visits for years?	The benefit is limited to 15 days per month but multiple stays per year.	Amy Woodrum & Tricia Roddy	
11	National DPP	Question	Simon Powell	Manager	Department of Legislative Services	simon.powell@mlis.state.md.us	410-946-5530	6/06/2018	In-person	6/6/2018	Will the National DPP pilot be open to all MCOs?	This will depend on the evaluation of the current demonstration and the budget.	Tricia Roddy	
12	National DPP	Question	Simon Powell	Manager	Department of Legislative Services	simon.powell@mlis.state.md.us	410-946-5530	6/06/2018	In-person	6/6/2018	How many people would this affect?	About 1400 Medicaid beneficiaries, depending on the budget.	Sandy Kick & Tricia Roddy	

Attachment III

Budget Neutrality Worksheet

[Please see “Attachment III - Budget Neutrality Projection to Year 23 January-March '18” (Excel Spreadsheet)]

Projected SFY2012-2014 Extension Total	Eligibility Group	01/01/14 -06/30/14 DY 17: 6 mos	Trend Rate	07/01/14 -06/30/15 DY 18: 12 mos	Trend Rate	07/01/15 -06/30/16 DY 19: 12 mos	Trend Rate	07/01/16 -12/31/16 DY 20: 6 mos	Projected SFY2014-2016 Extension Total
	BN Negotiated PMPM								
	New Adult Group	$790.85	1.0470	$828.02	1.0470	$866.94	1.0470	$907.68	
	TANF Adults 0-123	$809.25	1.0490	$848.90	1.0490	$890.50	1.0490	$934.13	
	Medicaid Child	$445.05	1.0450	$465.08	1.0450	$486.01	1.0450	$507.88	
	Medically Needy Adult	$4,734.49	1.0440	$4,942.81	1.0440	$5,160.29	1.0440	$5,387.34	
	Medically Needy Child	$2,165.30	1.0440	$2,260.57	1.0440	$2,360.04	1.0440	$2,463.88	
	Sobra Adult	3,652.20	1.0510	$3,838.46	1.0000	$3,838.46	1.1046	$4,239.97	
	Pregnant Women PE	892.00	1.0530	$939.28	1.0530	$989.06	0.0000	$0.00	
	SSI ADULT	1,948.31	1.0440	$2,034.04	1.0000	$2,034.04	1.0899	$2,216.97	
	SSI CHILD	$1,765.73	1.0000	$1,765.73	1.0440	$1,843.42	1.0899	$2,009.21	
	Projected With Waiver PMPM Expenditures by EG								
	New Adult Group	$239.44		$660.61		$853.11		$726.40	
	TANF Adults 0-123	$434.98		$493.34		$565.27		$520.78	
	Medicaid Child	$240.29		$272.22		$301.75		$266.07	
	Medically Needy Adult	$1,950.97		$1,767.30		$1,890.98		$1,414.91	
	Medically Needy Child	$535.02		$691.85		$1,731.39		$1,446.41	
	Sobra Adult	$1,874.47		$1,914.39		$1,616.85		$1,422.75	
	Pregnant Women PE	$0.00		$1,130.10		$0.00		$129.86	
	SSI ADULT	$1,562.93		$1,639.15		$1,804.68		$1,606.64	
	SSI CHILD	$1,463.19		$1,553.45		$1,700.14		$1,493.81	
	Family Planning	-$5.86		$0.00		$0.00		$0.00	
	ICS	$0.14		$0.14		$0.00		$0.00	
	WBCCPTA	$30.94		$1,475.49		$914.46		$584.84	
	Projected Member Months	Projected DY 17: 6 mos		Projected DY 18: 12 mos		Projected DY 19: 12 mos		Projected DY 20: 6 mos	
	New Adult Group	1,085,772		2,778,981		2,668,138		1,888,761	
	TANF Adults 0-123	1,474,462		2,872,945		2,255,106		1,345,184	
	Medicaid Child	2,851,037		5,671,322		4,657,991		2,866,391	
	Medically Needy Adult	34,419		75,449		25,124		6,581	
	Medically Needy Child	393		1,211		1,501		1,197	
	Sobra Adult	64,124		116,108		98,917		62,218	
	Pregnant Women PE	0		30		7		18	
	SSI ADULT	348,132		702,885		645,946		387,489	
	SSI CHILD	124,869		250,888		238,311		143,098	
	Family Planning	75,579		173,846		191,231		62,410	
	ICS	83		201		221		165	
	WBCCPTA	2,354		3,313		4,224		999	
	MM w/o FP, & ICS	5,983,208		12,469,819		10,591,041		6,700,937	
	TOTAL Member Months	6,061,224		12,647,179		10,786,717		6,764,510	
	Estimated W/out Waiver Expenditures by EG								
	New Adult Group	$858,682,786		$2,301,051,848		$2,313,115,558		$1,714,390,584	
	TANF Adults 0-123	$1,193,208,374		$2,438,843,011		$2,008,171,893		$1,256,576,730	
	Medicaid Child	$1,268,854,017		$2,637,618,436		$2,263,830,206		$1,455,782,661	
	Medically Needy Adult	$162,956,411		$372,930,072		$129,647,126		$35,454,085	
	Medically Needy Child	$850,963		$2,737,550		$3,542,420		$2,949,264	
	Sobra Adult	$234,193,673		$445,675,914		$379,688,948		$263,802,453	
	Pregnant Women PE	$0		$28,178		$6,923		$0	
	SSI ADULT	$678,269,057		$1,429,696,205		$1,313,880,002		$859,051,488	
	SSI CHILD	$220,484,939		$443,000,468		$439,307,264		$287,513,933	
TOTAL BN limit (without waiver) $16,180,857,033	TOTAL BN limit (without waiver)	$4,617,500,220		$10,071,581,681		$8,851,190,339		$5,875,521,199	$29,415,793,439
	Projected With Waiver Expenditures by EG								
	New Adult Group	$259,974,713		$1,835,822,470		$2,276,211,954		$1,371,991,508	
	TANF Adults 0-123	$641,368,652		$1,417,351,833		$1,274,741,257		$700,542,845	
	Medicaid Child	$685,083,967		$1,543,839,750		$1,405,560,970		$762,662,382	
	Medically Needy Adult	$67,150,407		$133,341,258		$47,509,097		$9,311,517	
	Medically Needy Child	$210,263		$837,831		$2,598,821		$1,731,355	
	Sobra Adult	$120,198,217		$222,275,745		$159,934,337		$88,520,867	
	Pregnant Women PE	$0		$33,903		$0		$2,338	
	SSI ADULT	$544,106,093		$1,152,134,462		$1,165,724,136		$622,554,258	
	SSI CHILD	$182,706,575		$389,742,359		$405,162,292		$213,761,783	
	Family Planning	-$442,700		$0		$0		$0	
	ICS	$12		$29		$0		$0	
	WBCPTTA	$72,838		$4,888,291		$3,862,685		$583,968	
$11,321,344,019	TOTAL With Waiver	$2,500,429,037		$6,700,267,932		$6,741,305,549		$3,771,662,818	$19,713,665,336
$4,859,513,014	(Over)/Under BN Limit	$2,117,071,183		$3,371,313,749		$2,109,884,790		$2,103,858,381	$9,702,128,103

Carryover from 1-14	$ 5,443,824,736
Projected Cushion at end of DY 17	$ 10,303,337,750

	Carryover from 1-17	$ 10,303,337,750
	Sub-Projected Cushion at end of DY 20	$ 20,005,465,853
	Estimated Savings on New Adult Group	$1,443,240,131
	Projected Cushion at end of DY 20	$ 18,562,225,722

******

Note: Included in above cushion is a built in savings of $13,520,400 in expenditures attributable to increased utilization of IMD services for SUD treatment.

Projected SFY2017-2023 Extension Total	Eligibility Group	01/01/17 -06/30/17 DY 20: 6 mos	Trend Rate	07/01/17 -06/30/18 DY 21: 12 mos	Trend Rate	07/01/18 -06/30/19 DY 22: 12 mos	Trend Rate	07/01/19 -06/31/20 DY 23: 12 mos	Projected SFY2017-2023 Extension Total
	BN Negotiated PMPM								
	New Adult Group	$907.68	1.0470	$950.34	1.0470	$995.01	1.0470	$1,041.77	
	TANF Adults 0-123	$934.13	1.0490	$979.90	1.0490	$1,027.92	1.0490	$1,078.29	
	Medicaid Child	$507.88	1.0450	$530.73	1.0450	$554.62	1.0450	$579.58	
	Medically Needy Adult	$5,387.34	1.0440	$5,624.38	1.0440	$5,871.86	1.0440	$6,130.22	
	Medically Needy Child	$2,463.88	1.0440	$2,572.29	1.0440	$2,685.47	1.0440	$2,803.63	
	Sobra Adult	$4,239.97	1.0510	$4,456.21	1.0510	$4,683.48	1.0510	$4,922.33	
	SSI ADULT	$2,216.97	1.0440	$2,314.52	1.0440	$2,416.36	1.0440	$2,522.68	
	SSI CHILD	$2,009.21	1.0440	$2,097.62	1.0440	$2,189.91	1.0440	$2,286.27	
	Projected With Waiver PMPM Expenditures by EG								
	New Adult Group	$726.40		$776.66		$830.41		$887.87	
	TANF Adults 0-123	$520.78		$556.82		$595.35		$636.55	
	Medicaid Child	$266.07		$284.48		$304.17		$325.22	
	Medically Needy Adult	$1,414.91		$1,512.82		#VALUE!		#VALUE!	
	Medically Needy Child	$1,446.41		$1,546.50		$1,653.52		$1,767.94	
	Sobra Adult	$1,430.79		$1,530.50		$1,634.92		$1,746.71	
	Pregnant Women Inpatient Hospital PE	$129.86		$132.50		$135.17		$137.83	
	SSI ADULT	$1,607.91		$1,719.21		$1,837.95		$1,964.94	
	SSI CHILD	$1,506.08		$1,610.69		$1,719.98		$1,837.04	
	Family Planning	$0.00		$0.00		#VALUE!		#VALUE!	
	ICS	$0.00		$0.00		$4,713.03		$4,713.03	
	WBCCPTA	$531.68		$0.00		$2,103.26		$1,912.05	
	Residential Substance Use Disorder	N/A		$5,667.03		$5,562.68		$5,418.23	
	Limited Housing Support Services	N/A		$666.67		$666.67		$666.67	
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		$0.00		$300.00		$150.00	
	Former Foster Dental Care	$0.05		$1.37		$22.01		$22.01	
	National DPP	N/A		N/A		$41.67		$41.67	
	IMD ASAM 4.0--SUD DX	N/A		N/A		$1,195.83		$1,207.53	
	Adult Dental Pilot	N/A		N/A		$10.82		$10.82	
	Projected Member Months	Projected DY 20: 6 mos		Projected DY 21: 12 mos		Projected DY 22: 12 mos		Projected DY 23: 6 mos	
	New Adult Group	1,888,761		3,710,390		4,081,429		4,489,572	
	TANF Adults 0-123	1,345,184		2,514,050		2,765,455		3,042,001	
	Medicaid Child	2,866,391		5,336,286		5,869,915		6,456,907	
	Medically Needy Adult	6,581		13,130		#VALUE!		#VALUE!	
	Medically Needy Child	1,197		4,632		5,095		5,605	
	Sobra Adult	62,218		107,628		118,391		130,230	
	Pregnant Women PE	18		6		6		6	
	SSI ADULT	387,489		712,966		784,263		862,689	
	SSI CHILD	143,098		259,980		285,978		314,576	
	Family Planning	62,410		137,302		N/A		N/A	
	ICS	306		765		1,071		612	
	WBCCPTA	1,098		2,307		2,537		2,791	
	Residential Substance Use Disorder	N/A		4,400		5,711		3,511	
	Assistance in Community Integration Services (ACIS)	N/A		3,600		5,400		7,200	
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		17,920		17,920		17,920	
	Former Foster Dental Care	25,627		31,428		34,356		37,284	
	National DPP	N/A		N/A		16,800		33,600	
	IMD ASAM 4.0--SUD DX	N/A		N/A		7,122		14,532	
	Adult Dental Pilot	N/A		N/A		231,060		466,741	
	MM w/o FP,ICS, WBCCPTA, SUD, LHSS, High Risk PWC, Dental	6,700,937		12,659,068		#VALUE!		#VALUE!	
	TOTAL Member Months	6,790,378		12,856,790		#VALUE!		#VALUE!	
	Estimated W/out Waiver Expenditures by EG								
	New Adult Group	$1,714,390,584		$3,526,135,595		$4,061,050,364		$4,677,111,809	
	TANF Adults 0-123	$1,256,576,730		$2,463,523,553		$2,842,659,828		$3,280,145,715	
	Medicaid Child	$1,455,782,661		$2,832,151,616		$3,255,558,504		$3,742,264,790	
	Medically Needy Adult	$35,454,085		$73,848,148		#VALUE!		#VALUE!	
	Medically Needy Child	$2,949,264		$11,914,851		$13,682,477		$15,714,359	
	Sobra Adult	$263,802,453		$479,612,805		$554,481,301		$641,035,340	
	SSI ADULT	$859,051,488		$1,650,171,699		$1,895,058,146		$2,176,284,018	
	SSI CHILD	$287,513,933		$545,338,010		$626,266,171		$719,204,528	
TOTAL BN limit (without waiver) $16,180,857,033	TOTAL BN limit (without waiver)	$5,875,521,199		$11,582,696,277		#VALUE!		#VALUE!	#VALUE!
	Projected With Waiver Expenditures by EG								
	New Adult Group	$1,371,991,508		$2,881,727,610		$3,389,257,477		$3,986,173,592	
	TANF Adults 0-123	$700,542,845		$1,399,864,079		$1,646,408,141		$1,936,373,861	
	Medicaid Child	$762,662,382		$1,518,080,988		$1,785,445,534		$2,099,898,364	
	Medically Needy Adult	$9,311,517		$19,863,338		#VALUE!		#VALUE!	
	Medically Needy Child	$1,731,355		$7,163,402		$8,424,690		$9,909,331	
	Sobra Adult	$89,020,867		$164,724,560		$193,560,055		$227,473,558	
	Pregnant Women PE	$2,338		$795		$811		$827	
	SSI ADULT	$623,049,258		$1,225,734,785		$1,441,437,571		$1,695,128,609	
	SSI CHILD	$215,516,783		$418,746,372		$491,877,802		$577,889,504	
	Family Planning	$0		$0		N/A		N/A	
	ICS	$0		$0		$5,047,659		$2,884,377	
	WBCPTTA	$583,968		$0		$5,336,365		$5,336,365	
	Residential Substance Use Disorder	N/A		$24,934,918		$31,768,451		$19,023,401	
	Assistance in Community Integration Services (ACIS)	N/A		$2,400,000		$3,600,000		$4,800,000	
	Evidence Based Home Visiting for High Risk PWC up to age 2	N/A		$0		$5,376,000		$2,688,000	
	Former Foster Dental Care	$1,218		$42,912		$756,176		$820,621	
	National DPP	N/A		N/A		$700,000		$1,400,000	
	IMD ASAM 4.0--SUD DX	N/A		N/A		$8,516,725		$17,547,860	
	Adult Dental Pilot	N/A		N/A		$2,500,000		$5,050,140	
$11,321,344,019	TOTAL With Waiver	$3,774,414,036		$7,663,283,759		#VALUE!		#VALUE!	#VALUE!
$4,859,513,014	(Over)/Under BN Limit	$2,101,107,163		$3,919,412,518		#VALUE!		#VALUE!	#VALUE!

Carryover from 1-14	$ 5,443,824,736	Carryover from 1-20	$ 18,562,225,722
Carryover from 15-17	$ 10,303,337,750	Sub-Projected Cushion at end of DY 23	#VALUE!

Projected Cushion at end of DY 20	18,562,225,722

Estimated Savings on New Adult Group	$2,349,538,165

Projected Cushion at end of DY 23	#VALUE!

Projected SFY2021-2022 Extension Total	Eligibility Group	07/01/20 -06/30/21 DY 24: 12 mos	Trend Rate	07/01/21 -1230/21 DY 25: 6mos	Trend Rate				Projected SFY2021-2022 Extension Total
	BN Negotiated PMPM								
	New Adult Group	$1,090.74	1.0470	$1,142.00					
	TANF Adults 0-123	$1,131.12	1.0490	$1,186.55					
	Medicaid Child	$605.66	1.0450	$632.91					
	Medically Needy Adult	$6,399.95	1.0440	$6,681.54					
	Medically Needy Child	$2,926.99	1.0440	$3,055.78					
	Sobra Adult	$5,173.37	1.0510	$5,437.21					
	SSI ADULT	$2,633.67	1.0440	$2,749.55					
	SSI CHILD	$2,386.86	1.0440	$2,491.88					
	Projected With Waiver PMPM Expenditures by EG								
	New Adult Group	$949.31		$1,015.01					
	TANF Adults 0-123	$680.60		$727.69					
	Medicaid Child	$347.72		$371.78					
	Medically Needy Adult	#VALUE!		#VALUE!					
	Medically Needy Child	$1,890.29		$2,021.09					
	Sobra Adult	$1,866.35		$2,002.00					
	Pregnant Women Inpatient Hospital PE	$147.33		$157.67					
	SSI ADULT	$2,100.73		$2,247.07					
	SSI CHILD	$1,962.38		$2,107.62					
	Family Planning	N/A		N/A					
	ICS	$4,713.03		$4,713.03					
	WBCCPTA	$1,738.23		$3,476.46					
	Residential Substance Use Disorder	$5,418.23		$10,836.46					
	Limited Housing Support Services	$666.67		$666.67					
	Evidence Based Home Visiting for High Risk PWC up to age 2	$150.00		$300.00					
	Former Foster Dental Care	$22.01		$22.01					
	National DPP	$41.67		$41.67					
	IMD ASAM 4.0--SUD DX	$1,219.82		$1,231.73					
	Adult Dental Pilot	$10.82		$10.82					
	Projected Member Months	Projected DY 20: 6 mos		Projected DY 21: 12 mos					
	New Adult Group	4,938,529		2,469,265					
	TANF Adults 0-123	3,346,201		1,673,101					
	Medicaid Child	7,102,598		3,551,299					
	Medically Needy Adult	#VALUE!		#VALUE!					
	Medically Needy Child	6,166		3,083					
	Sobra Adult	143,253		71,627					
	Pregnant Women PE	6		3					
	SSI ADULT	948,958		474,479					
	SSI CHILD	346,034		173,017					
	Family Planning	0		0					
	ICS	612		306					
	WBCCPTA	3,070		1,535					
	Residential Substance Use Disorder	3,511		1,756					
	Assistance in Community Integration Services (ACIS)	7,200		3,600					
	Evidence Based Home Visiting for High Risk PWC up to age 2	17,920		8,960					
	Former Foster Dental Care	37,284		18,642					
	National DPP	33,600		16,800					
	IMD ASAM 4.0--SUD DX	14,820		7,560					
	Adult Dental Pilot	471,409		238,061					
	MM w/o FP,ICS, WBCCPTA, SUD, LHSS, High Risk PWC, Dental	#VALUE!		#VALUE!					
	TOTAL Member Months	#VALUE!		#VALUE!					
	Estimated W/out Waiver Expenditures by EG								
	New Adult Group	$5,386,629,452		$2,819,901,089					
	TANF Adults 0-123	$3,784,960,027		$1,985,212,128					
	Medicaid Child	$4,301,733,558		$2,247,655,784					
	Medically Needy Adult	#VALUE!		#VALUE!					
	Medically Needy Child	$18,047,833		$9,420,969					
	Sobra Adult	$741,100,956		$389,451,271					
	SSI ADULT	$2,499,244,830		$1,304,605,801					
	SSI CHILD	$825,935,434		$431,138,297					
TOTAL BN limit (without waiver) $16,180,857,033	TOTAL BN limit (without waiver)	#VALUE!		#VALUE!					#VALUE!
	Projected With Waiver Expenditures by EG								
	New Adult Group	$4,688,218,296		$2,506,322,008					
	TANF Adults 0-123	$2,277,407,957		$1,217,502,658					
	Medicaid Child	$2,469,732,568		$1,320,319,031					
	Medically Needy Adult	#VALUE!		#VALUE!					
	Medically Needy Child	$11,655,507		$6,231,034					
	Sobra Adult	$267,360,081		$143,397,093					
	Pregnant Women PE	$884		$473					
	SSI ADULT	$1,993,500,510		$1,066,186,119					
	SSI CHILD	$679,050,003		$364,653,686					
	Family Planning	N/A		N/A					
	ICS	$2,884,377		$1,442,188					
	WBCPTTA	$5,336,365		$5,336,365					
	Residential Substance Use Disorder	$19,023,401		$19,023,401					
	Assistance in Community Integration Services (ACIS)	$4,800,000		$2,400,000					
	Evidence Based Home Visiting for High Risk PWC up to age 2	$2,688,000		$2,688,000					
	Former Foster Dental Care	$820,621		$410,310					
	National DPP	$1,400,000		$700,000					
	IMD ASAM 4.0--SUD DX	$18,077,806		$9,311,878					
	Adult Dental Pilot	$5,100,641		$2,575,824					
$11,321,344,019	TOTAL With Waiver	#VALUE!		#VALUE!					#VALUE!
$4,859,513,014	(Over)/Under BN Limit	#VALUE!		#VALUE!					#VALUE!

Carryover from 1-14	$ 5,443,824,736		Carryover from 1-23 #VALUE!
Carryover from 15-17	$ 10,303,337,750		Sub-Projected Cushion at end of DY 25 #VALUE!

Projected Cushion at end of DY 20	18,562,225,722
Projected Cushion at end of DY 23	#VALUE!

Estimated Savings on New Adult Group	$1,011,990,237

Projected Cushion at end of DY 25	#VALUE!

HealthChoice

Budget Neutrality Calculations
Waiver Extension to DY 11

Revised 03/25/13, 7.1% CAP trend yrs 9 thru 11
Revised member months and Expenditures
Actuals Based on 09/30/17 MMIS Data

Budget Cap Trend

-

0

Demonstration Year 1

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	2,392,785	660,720	179,849	795,103	35,418	4,063,875
Year 1 PMPM Cap	164.49	679.66	617.12	276.89	298.65	
Budget Cap	$393,589,205	$449,064,955	$110,988,415	$220,156,070	$10,577,586	$1,184,376,231

$1,212,086,573	Actual Spending Year 1 through MMIS
$0	Projected Prog. 03 Future Year 1 Spending
$0	Projected MHA Future Year 1 Spending
$0	Additional Capitation per All Services
$0	GME: N/A, included in rates in FY 1998
$1,212,086,573	Total Projected Year 1 Spending
Less:	
$9,170,286	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$1,202,916,287	Year 1 Charged Against Cap
($18,540,056)	Year 1 Balance
101.57%	Percentage of Cap

Demonstration Year 2

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	1,916,687	668,114	152,540	1,096,714	34,175	3,868,230
Change from prior yr	-19.90%	1.12%	-15.18%	37.93%	-3.51%	-4.81%
Year 2 PMPM Cap	173.53	717.04	651.06	292.11	315.08	
Budget Cap	$332,602,695	$479,064,463	$99,312,692	$320,361,127	$10,767,859	$1,242,108,836

$1,294,374,685	Actual Spending Year 2 Through MMIS
$0	Projected Prog. 03 Future Year 2 Spending
$0	Projected MHA Future Year 2 Spending
$0	Additional Capitation per All Services
$24,252,573	GME Payments
$1,318,627,258	Total Projected Year 2 Spending
Less:	
$8,942,016	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$11,100,000	DSH in MCO in " Actual Spending Year 2 thru MMIS"
$1,298,585,242	Year 2 Charged Against Cap
($56,476,406)	Year 2 Balance
104.55%	Percentage of Cap

Demonstration Year 3

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	1,611,269	662,328	315,557	1,404,680	31,853	4,025,687
Change from prior yr	-15.93%	-0.87%	106.87%	28.08%	-6.79%	4.07%
Year 3 PMPM Cap	183.08	756.47	686.87	308.18	332.41	
Budget Cap	$294,991,129	$501,031,262	$216,746,637	$432,894,282	$10,588,256	$1,456,251,566

$1,330,954,311	Actual Spending Year 3 Through MMIS
$0	Projected Prog. 03 Future Year 3 Spending
$0	Projected MHA Future Year 3 Spending
$0	Adjustment, Capitation per All Services,collections
$24,185,831	GME Payments
$1,355,140,142	Total Projected Year 3 Spending
Less:	
$10,608,823	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$11,500,000	DSH in MCO in " Actual Spending Year 3 thru MMIS"
$1,333,031,319	Year 3 Charged Against Cap
$123,220,247	Year 3 Balance
91.54%	Percentage of Cap

Demonstration Year 4

	AFDC	SSI/BD	MA Only	Sobra	SSI Aged	Total
Member Months	1,503,611	642,403	384,173	1,621,965	13,964	4,166,116
Change from prior yr	-6.68%	-3.01%	21.74%	15.47%	-56.16%	3.49%
Year 4 PMPM Cap	193.15	798.08	724.65	325.13	350.69	
Budget Cap	$290,422,465	$512,688,986	$278,390,964	$527,349,480	$4,897,035	$1,613,748,930

$1,435,800,580	Actual Spending Year 4 Through MMIS
$0	Projected Prog. 03 Remaining Year 4 Spending
$0	Projected MHA Remaining Year 4 Spending
$25,713,820	GME Payments
$0	MCO Supplemental Payments in actual MMIS
$1,461,514,400	Total Projected Year 4 Spending
Less:	
$11,436,899	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$14,020,964	DSH in MCO in " Actual Spending Year 4 thru MMIS"
$1,436,056,537	Year 4 Charged Against Cap
$177,692,393	Year 4 Balance
88.99%	Percentage of Cap

Demonstration Year 5

	AFDC	SSI/BD	MA Only	Sobra	Total
Member Months	1,509,152	653,745	434,506	1,782,269	4,379,672
Change from prior yr	0.37%	1.77%	13.10%	9.88%	5.13%
Year 5 PMPM Cap	203.77	841.97	764.51	343.01	
Budget Cap	$307,519,903	$550,433,678	$332,184,182	$611,336,090	$1,801,473,853

$1,557,941,967	Actual Spending Year 5 Through MMIS
$0	Projected Prog. 03 Remaining Year 5 Spending
$0	MCO Supplemental Payments in actual MMIS
$6,461,407	FQHC Adjustment 2002
$29,076,794	GME Payments
$1,593,480,168	Total Projected Year 5 Spending
Less:	
$18,376,107	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$20,392,424	DSH in MCO in " Actual Spending Year 5 thru MMIS"
$1,554,711,637	Year 5 Charged Against Cap
$246,762,216	Year 5 Balance
86.30%	Percentage of Cap

Demonstration Year 6

	AFDC	SSI/BD	MA Only	Sobra	Total
Member Months	1,498,629	661,227	473,100	1,939,668	4,572,624
Change from prior yr	-0.70%	1.14%	8.88%	8.83%	4.41%
Year 6 PMPM Cap	220.07	909.33	825.67	370.45	
Budget Cap	$329,805,682	$601,271,961	$390,624,855	$718,551,562	$2,040,254,060

$1,884,682,404	Actual Spending Year 6 Through MMIS
$0	Projected Prog. 03 Remaining Year 6 Spending
$0	Projected MHA Remaining Year 6 Spending
$11,357,976	FQHC Adjustment 2003
$0	MCO Supplemental Payments in actual MMIS
$31,666,200	GME Payments
$1,927,706,580	Total Projected Year 6 Spending
Less:	
$30,721,415	Pharmacy Rebate Offset
$0	CHIP Provider Reimbursement
$17,305,398	DSH in MCO in " Actual Spending Year 6 thru MMIS"
$1,879,679,767	Year 6 Charged Against Cap
$160,574,293	Year 6 Balance
92.13%	Percentage of Cap

Demonstration Year 7

	AFDC	SSI/BD	MA Only	Sobra	Total
Member Months	1,402,428	673,202	497,663	2,251,067	4,824,360
Change from prior yr	-6.42%	1.81%	5.19%	16.05%	5.51%
Year 7 PMPM Cap	237.68	982.07	891.72	400.09	
Budget Cap	$333,325,340	$661,134,052	$443,778,272	$900,622,337	$2,338,860,001

	Actual Spending Year 7	
$2,106,613,459	Through MMIS	
0	MSDE projection	
$33,468,056	GME Payments	
	Projected Prog. 03 Remaining Year 7	
0	Spending	
	MCO Supplemental	
$0	Payments in actual MMIS	
27,245,547	FQHC Adjustment 2004	
$2,167,327,062	Total Actual & Projected	
Less:		
$42,188,140	Pharmacy Rebate Offset	
	CHIP Provider	
0	Reimbursement	
	DSH in MCO in " Actual Spending Year 7 thru	
16,306,326	MMIS"	
	Year 7 Charged Against	
2,108,832,596	Cap	
$230,027,405	Year 7 Balance	
90.16%	Percentage of Cap	

Demonstration Year 8

	AFDC	SSI/BD	MA Only	Sobra	Total	
Member Months (11 months, Jul-May)	**1,258,181**	**640,276**	**461,631**	**2,203,916**	4,564,004	11 month year: Jul 1, 2004 thru May 31, 2005
June, Mo 12, (in year 9)	109,681	58,119	42,425	204,117		
12 Month Total for prior year comparison	1,367,862	698,395	504,056	2,408,033		
Change from prior yr based on 12 mos	-2.46%	3.74%	1.28%	6.97%		
Year 8 PMPM Cap	256.69	1,060.64	963.06	432.09		
Budget Cap (based on 11 Months)	$322,964,386	$679,102,153	$444,579,469	$952,298,468	$2,398,944,476	11 month year

	Actual costs thru MMIS DY 8 to-date less Malpractcie Adj & Therapeutic Rehab in
2,082,248,927	MMIS: (11 months)
14,781,238	FQHC Actual Payments
	MCO Supplemental
$0	Payments in actual MMIS
31,639,201	GME Actual Payments
	6 month eligibiltiy pro-
($1,833,333)	rated 1/2 year
($24,136,831)	DSH in MCO Payments
($50,640,104)	Pharmacy Rebates
6,416,667	Malpractice Adjustment
16,651,360	Therapeutic Rehab
2,075,127,125	Year 8 Total Charged Against Cap
$323,817,351	Year 8 Balance
86.50%	Percentage of Cap
$454.67	Year 8 Cost PMPM

Demonstration Year 9

	(TANF) AFDC	SSI/BD	(Medically Needy) MA Only	Sobra	EID	PAC	FAMILY PLAN	Total	
Member Months (13 June '05-July '06)	1,388,805	777,397	546,448	2,678,817	Member Months:	Eld, PAC & FP	Not counted in CAP	5,391,467	
June, Mo 12, (in year 9)	109,681	58,119	42,425	204,117					
12 Month Total for prior year comparison	1,279,124	719,278	504,023	2,474,700					
13 Month base times avg % change	**1,388,805**	**777,397**	**546,448**	**2,678,817**				5,391,467	13 month year
Year 9 PMPM Cap	274.91	1,135.95	1,031.44	462.77	BN Negotiated PMPM				
Budget Cap	$381,796,383	$883,084,122	$563,628,325	$1,239,676,143	Estimated without Waiver Expenditures			$3,068,184,973	
	483,909,276	998,254,384	427,238,407	764,759,255				2,674,161,322	Actual costs thru MMIS, DY 9 to-date
Percent of Actual Costs	18.10%	37.33%	15.98%	28.59%					
					100.00%				
	483,909,276	998,254,384	427,228,987	758,830,755				2,668,223,402	Actual costs thru MMIS DY 9 to-date less "expansion population" costs in MMIS:
									Expansion population costs EID and PAC are included in Medically Needy
									Expansion population costs Family Planning are in Sobra
	3,341,601	6,891,822	2,950,209	5,278,253				18,461,885	FQHC Cost Settlements (manual, not thru MMIS)
	0	0	0					0	MCO Supplemental Payments (in MMIS)
	6,964,558	14,363,920	6,148,820	11,000,923				38,478,221	GME Payments (manual, not thru MMIS)
	21,069,418	21,621,594	11,569,060	41,453,462					
	(15,636,352)	(32,248,896)	(13,804,912)	(24,698,525)				(86,388,686)	Pharmacy Rebates
	(5,082,761)	(10,482,843)	(4,487,432)	(8,028,515)				(28,081,550)	DSH in MCO Payments
	(784,333)	(1,617,633)	(692,467)	(1,238,900)				($4,333,333)	6 month eligibility, full year
	493,781,407	996,782,348	428,912,265	782,597,453				2,606,359,939	Net Actual & Projected Year 9 Spending Before expansion population below
	355.54	1,282.21	784.91	292.14				$483.42	PMPM Cost before Expansion Population costs
								expansion population:	
					9,420			9,420	EID
						0		0	PAC
							5,928,500	5,928,500	Family Planning
With Waiver Actual	493,781,407	996,782,348	428,912,265	782,597,453	9,420	0	5,928,500	2,612,297,859	Year 9 Total Charged Against Cap, Includes expansion population costs
	$355.54	$1,282.21	$784.91	$292.14				$484.52	PMPM after expansion population costs
								$455,887,114	Year 9 Balance
								85.14%	Percentage of Cap
	$355.54	$1,282.21	$784.91	$292.14				$484.52	Year 9 Cost PMPM includes expansion population cost

Demonstration Year 10 Actual

	(TANF) AFDC	SSI/BD	(Medically Needy) MA Only	Sobra	EID	PAC	FAMILY PLAN	Total	
Year 10 Actual (12 months)	1,195,688	722,756	484,326	2,495,605	Member Months:	Eld, PAC & FP	Not counted in CAP	**4,898,375**	
Year 10 PMPM Cap	294.43	1,216.60	1,104.67	495.62	BN Negotiated PMPM				
Budget Cap	$352,046,418	$879,304,950	$535,020,402	$1,236,871,750	Estimated without Waiver Expenditures			$3,003,243,520	
	454,587,877	987,098,527	377,217,275	787,277,674				2,606,181,353	Actual costs thru MMIS, DY 10 to-date
	17.44%	37.88%	14.47%	30.21%					Percent of costs:
	454,587,877	987,098,527	318,737,803	782,202,586				2,542,626,793	Actual costs thru MMIS DY 10 to-date less expansion population costs in MMIS &
									Expansion population costs EID and PAC are included in Medically Needy
									Expansion population costs Family Planning are in Sobra
	3,811,964	8,279,655	3,162,793	6,603,178				$21,857,590	FQHC Cost Settlements (manual, not thru MMIS)
	6,560,513	14,249,554	5,443,270	11,364,283				37,617,620	GME Payments (manual, not thru MMIS)
	(8,809,714)	(19,134,860)	(7,309,436)	(15,260,404)				(50,514,414)	Pharmacy Rebates
	(3,564,708)	(7,742,612)	(2,957,645)	(6,174,876)				(20,439,841)	DSH in MCO Payments
	(38,187)	(171,087)	(29,027)	(151,039)					
	452,547,745	982,579,177	317,047,758	778,583,728				2,531,147,748	Net Projected Year 10 Spending before DY 10 expansion population increases and other additons
	$378.48	$1,359.49	$654.62	$311.98				$516.73	DY 10 cost PMPM before DY 10 increases to expansion population
								Other Additions:	
								2,531,147,748	Net Projected Year 10 Spending before DY 10 expansion population increases with other additons
								Expansion Population Costs	
					383,845			383,845	EID
						58,095,627		58,095,627	PAC, start 7/1/06
							5,075,088	5,075,088	Family Planning
	452,547,745	**982,579,177**	**317,047,758**	**778,583,728**	**383,845**	**58,095,627**	**5,075,088**	**$2,594,702,308**	Total charged against CAP
	0	0	0	0				$0	Total Funds, SCHIP Shortfall (Fully Funded in DY 10)
With Waiver Actual	**452,547,745**	**982,579,177**	**317,047,758**	**778,583,728**	**383,845**	**58,095,627**	**5,075,088**	**2,594,702,308**	**Year 10 Charged Against Cap**
								$529.71	Year 10 PMPM
								$408,541,212	Year 10 Balance
								86.40%	Percentage of Cap
	$378.48	$1,359.49	$654.62	$311.98				$529.71	Year 10 Cost

Demonstration Year 11 Projection

	(TANF) AFDC	SSI/BD	(Medically Needy) MA Only	Sobra	EID	PAC	FAMILY PLAN	Total			
Year 11 Actual (12 months)	**1,249,798**	**735,426**	**427,219**	**2,525,029**				**4,937,472**			
	1,249,798	735,426	427,219	2,525,029							
Projected % of Change in Member Months	0.00%	0.00%	0.00%	0.00%							
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000							
12 Month base times avg % change	1,249,798	735,426	427,219	2,525,029	Member Months:	Eld, PAC & FP	Not counted in CAP	4,937,472			
Year 11 PMPM Cap	315.34	1,302.98	1,183.10	530.81	BN Negotiated PMPM						
Budget Cap	$394,111,301	$958,245,369	$505,442,799	$1,340,310,643	Estimated without Waiver Expenditures			$3,198,110,112	$647.72	Average CAP PMPM	
	466,735,107	1,036,962,382	364,992,986	831,426,711				$2,700,117,186.00		Actual costs thru MMIS, DY 11 to-date	
	17.29%	38.40%	13.52%	30.79%						Percent of costs:	
	466,735,107	1,036,962,382	285,002,934	826,657,359				$2,615,357,782.46		Actual costs thru MMIS DY 11 to-date less EID, PAC & FP	Check
	$10,722,510.00	$24,625,829.00	$8,488,812.00	$19,573,392.00							
	(7,194,063)	(15,977,561)	(5,625,433)	(12,811,174)				(41,608,231)		Pharmacy Rebates	**(41,608,231)**
	(5,026,722)	(11,164,034)	(3,930,670)	(8,951,578)				(29,073,004)		DSH in MCO Payments	
	6,039,996	13,414,451	4,723,004	10,756,014				34,933,465		FQHC Cost Settlements (Manual, not thru MMIS)	
	6,773,903	15,044,412	5,296,887	12,062,954				39,178,156		GME Payments (manual, not thru MMIS)	
	478,050,731	1,062,905,479	293,955,535	847,286,967				2,618,788,168		Net Actual & Projected Year 11 Spending before DY 11 increases to add-on's	
	382.50	1,445.29	688.07	335.56				530.39		DY 11 Cost PMPM before DY 11 increases to population expansion	
	$478,050,731	**$1,062,905,479**	**$293,955,535**	**$847,286,967**				**$2,618,788,168**		**Net Actual & ProjectedYear 11 Spending before DY 11 expansion population increases**	
								Expansion Population:			
					$716,244			$716,244		EID	
						$79,273,808		$79,273,808		PAC	
							4,769,352	4,769,352		Family Planning	
	0	0	0	0				0		Total Funds, SCHIP Shortfall (Fully Funded in DY 11)	
With Waiver Actual	**478,050,731**	**1,062,905,479**	**293,955,535**	**847,286,967**	**716,244**	**79,273,808**	**4,769,352**	**2,703,547,572**		**Year 11 Charged Against Cap**	2,766,958,115
								$547.56		Year 11 PMPM	
								$494,562,540		Year 11 Balance	

	$382.50	$1,445.29	$688.07	$335.56							84.54% Percentage of Cap $547.56 PMPM						
Demonstration Year 12 Actual & Projected	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		EID	PAC	FAMILY PLAN		Total	
Year 12 Actual (12 months)	609,776	1,213,796	341,952	433,711	142,675	75,071	149,938	1,997,286	538,428	222,969		973	352,878	331,592			
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000			
12 Month base times avg % change	**609,776**	**1,213,796**	**341,952**	**433,711**	**142,675**	**75,071**	**149,938**	**1,997,286**	**538,428**	**222,969**	Member Months:	Eld, PAC & FP	Not counted in CAP			**5,725,602**	Member Months excluding EID, PAC & FP
												973	**352,878**	**331,592**		**685,443**	Member Months for add-on population Items: PAC, EID, FAMILY PLANNING
Year 12 PMPM Cap	593.35	316.90	593.35	316.90	2,574.01	393.99	2,734.69	394.98	1,432.55	1,298.31	BN Negotiated PMPM			0.00	0.00		
Budget Cap	$361,810,590	$384,651,952	$202,897,219	$137,443,016	$367,246,877	$29,577,223	$410,033,949	$788,888,024	$771,325,031	$289,482,882	Estimated without Waiver Expenditures			$0	$0	$3,743,356,763	
	319,112,080	373,710,528	133,642,402	83,074,844	220,557,185	16,137,042	257,815,626	492,343,207	825,668,365	305,687,841						3,027,749,120	Total Actual Year 12 Spending before adjustments below
	(2,501,894)	(4,503,409)	(1,000,758)	(4,503,409)	(2,501,894)	(2,301,743)	(200,152)	(2,501,894)	(24,518,562)	(5,504,167)						(50,037,881)	Pharmacy Rebates
	(2,976,852)	(3,484,751)	(1,244,352)	(773,135)	(2,054,169)	(149,548)	(2,404,055)	(4,588,021)	(7,694,669)	(2,847,056)						(28,216,609)	DSH in MCO Payments
	2,978,302	3,486,448	1,244,958	773,512	2,055,169	149,621	2,405,226	4,590,255	7,698,416	2,848,442						28,230,349	FQHC Cost Settlements (Manual, not thru MMIS)
	3,466,494	7,142,190	1,542,640	1,863,044	3,379,558	843,089	1,041,168	16,283,273	3,487,215	1,443,015						40,491,686	GME Payments (manual, not thru MMIS)
	22,276	26,076	9,311	5,785	15,371	1,119	17,989	34,332	57,579	21,304						211,143	UNIDENTIFIED
	2,459,997	4,388,794	976,360	4,459,249	197,356	2,314,546	180,026	2,453,908	24,103,328	5,415,815							211,143
	322,560,402	380,765,876	135,170,562	84,899,890	221,648,576	16,994,126	258,855,828	508,615,060	828,801,671	307,065,195						3,018,427,808	Total Projected Year 12 Spending with other additions & before , PAC & FP
	$528.98	$313.70	$395.29	$195.75	$1,553.52	$226.37	$1,726.42	$254.65	$1,539.30	$1,377.17						527.18	DY 12 cost PMPM after other additions & before EID, PAC & FP
	$565.59	$335.41	$422.64	$209.30	$2,117.12	$1,061.26	$1,845.89	$272.27	$1,645.82	$1,472.47						$563.66	Year 12 cost PMPM trended forward to DY 13
												1,793.06	165.03	1.09			
												$1,917.14	$176.45	$1.17			
												1,744,647	58,234,769	362,697		60,342,113	Total Costs of add-on Population: EID, PAC, FAMILY PLAN
Percent of costs before expansion population:	10.55%	12.35%	4.41%	2.74%	7.28%	0.53%	8.52%	16.26%	27.27%	10.09%	100.00%						
	$322,560,402	**$380,765,876**	**$135,170,562**	**$84,899,890**	**$221,648,576**	**$16,994,126**	**$258,855,828**	**$508,615,060**	**$828,801,671**	**$307,065,195**		**$1,744,647**	**$58,234,769**	**$362,697**		**$3,078,769,921**	Total charged against CAP
	0	0	0	0	0	0	0	0	0							0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**322,560,402**	**380,765,876**	**135,170,562**	**84,899,890**	**221,648,576**	**16,994,126**	**258,855,828**	**508,615,060**	**828,801,671**	**307,065,195**		**1,744,647**	**58,234,769**	**362,697**		**3,078,769,921**	**Year 12 Charged Against Cap**
																$537.72	Year 12 PMPM including add-on population Costs, excluding add on member months
																$664,586,842	Year 12 Balance
																82.25%	Percentage of Cap
	$528.98	$313.70	$395.29	$195.75	$1,553.52	$226.37	$1,726.42	$254.65	$1,539.30	$1,377.17		$1,793.06	$165.03	$1.09		$537.72	Year 12 PMPM including add-on population Costs, excluding add on member months
																$574.93	Year 12 PMPM including add-on population Costs, trending forward to YEAR 13
Demonstration Year 13 Projection	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Total	
Year 13 Actual (12 months)	892,767	1,629,402	737,700	1,041,810	114,385	2,889	134,225	1,542,440	565,796	229,716		11	476,415	193,850	0		
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000	1.0000		
12 Month base times avg % change	**892,767**	**1,629,402**	**737,700**	**1,041,810**	**114,385**	**2,889**	**134,225**	**1,542,440**	**565,796**	**229,716**	Member Months:	PAC & FP	Not counted in CAP			**6,891,130**	Member Months excluding add-on population
												11	**476,415**	**193,850**	**0**	**670,276**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
	6.95%	6.95%	6.95%	6.95%	6.86%	6.86%	6.95%	6.95%	6.86%	6.86%							
Year 13 PMPM Cap	648.07	348.82	648.07	348.82	3,794.66	1,755.40	2,924.75	422.43	1,530.82	1,387.37	BN Negotiated PMPM	0.00	0.00	0.00	0.00		
Budget Cap	$578,575,510	$568,368,006	$478,081,239	$363,404,164	$434,052,184	$5,071,351	$392,574,569	$651,572,929	$866,131,833	$318,701,087	Estimated without Waiver Expenditures	$0	$0	$0	$0	$4,656,532,872	
	458,778,817	479,610,109	332,991,522	213,077,888	243,464,641	519,536	217,815,528	426,501,806	861,538,285	313,020,335						3,547,318,467	Total Actual Year 13 Spending: excluding PAC, EID & adjustments below
	(5,547,628)	(8,717,701)	(3,170,073)	(8,717,701)	(6,102,392)	0	(237,755)	(3,170,073)	(35,663,324)	(7,925,183)						(79,251,830)	Pharmacy Rebates
	5,440,132	5,683,971	3,947,669	2,526,676	2,884,026	4,204	2,581,330	5,053,352	10,211,808	3,708,034						42,041,202	GME Payments (manual, not thru MMIS)
	(86,520)	(90,398)	(62,784)	(40,184)	(45,868)	(67)	(41,054)	(80,369)	(162,410)	(58,973)						(668,627)	Unidentified
	1,264,787	4,024,474	131,271	6,478,064	3,549,806	(51,908)	(1,714,779)	(915,010)	27,095,555	3,567,626							
	(4,216,419)	(4,405,408)	(3,059,673)	(1,958,321)	(2,235,289)	(3,258)	(2,000,681)	(3,916,643)	(7,914,746)	(2,873,942)						(32,584,381)	DSH in MCO Payments
	2,927,490	3,058,707	2,124,353	1,359,677	1,551,977	2,262	1,389,087	2,719,353	5,495,266	1,995,399						22,623,572	FQHC Cost Settlements (Manual, not thru MMIS)
	458,560,658	479,163,753	332,902,285	212,726,098	243,066,902	470,769	217,791,676	426,192,417	860,600,434	311,433,296						3,499,478,403	Total Projected Year 13 Spending with other additions & before add-on population costs
	$513.64	$294.07	$451.27	$204.19	$2,124.99	$162.95	$1,622.59	$276.31	$1,521.04	$1,355.73						$507.82	DY 13 cost PMPM after other additions & before add-on Population Costs
	$549.18	$314.42	$482.50	$218.32	$2,272.04	$174.23	$1,734.87	$295.43	$1,626.30	$1,449.55						$542.96	Year 13 cost PMPM trended forward to DY 14
Percent of costs before expansion population:	12.94%	13.52%	9.39%	6.01%	6.86%	0.01%	6.14%	12.02%	24.29%	8.82%	100.00%						
												$32,483.82	$238.83	$1.17			
												$34,731.70	$255.35	$1.25			
												357,322	113,780,268	(825,401)	0	113,312,189	Total Costs of add-on population: 300% SSI, PAC, FAMILY PLAN
	$458,560,658	**$479,163,753**	**$332,902,285**	**$212,726,098**	**$243,066,902**	**$470,769**	**$217,791,676**	**$426,192,417**	**$860,600,434**	**$311,433,296**		**$357,322**	**$113,780,268**	**($825,401)**	**$0**	**$3,612,790,592**	Total charged against CAP
	0	0	0	0	0	0	0	0	0							0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**458,560,658**	**479,163,753**	**332,902,285**	**212,726,098**	**243,066,902**	**470,769**	**217,791,676**	**426,192,417**	**860,600,434**	**311,433,296**		**357,322**	**113,780,268**	**(825,401)**	**0**	**3,612,790,592**	**Year 13 Charged Against Cap**
																$1,043,742,280	Year 13 Balance
																77.59%	Percentage of Cap
	$513.64	$294.07	$451.27	$204.19	$2,124.99	$162.95	$1,622.59	$276.31	$1,521.04	$1,355.73						$524.27	Year 13 PMPM including add-on population Costs, excluding expansion population member months
																$560.55	Year 13 PMPM including add-on population Costs, trended forward DY 14
Demonstration Year 14 Projection	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Pharmacy Discount Prog	Total
Year 14 Actual; base for trending to DY15	1,067,548	1,867,981	989,040	1,429,548	114,664	2,777	139,620	1,310,016	602,293	240,257		10	624,225	124,254	0	0	
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	
DY 14 Projection, member months	**1,067,548**	**1,867,981**	**989,040**	**1,429,548**	**114,664**	**2,777**	**139,620**	**1,310,016**	**602,293**	**240,257**	Member Months:	Eld, PAC & FP	Not counted in CAP				**7,763,744**	Member Months excluding add-on population
												10	**624,225**	**124,254**	**0**	**0**	**748,489**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
	6.95%	6.95%	6.95%	6.95%	6.86%	6.86%	6.95%	6.95%	6.86%	6.86%							
Year 14 PMPM Cap	693.11	373.06	693.11	373.06	4,054.98	1,875.82	3,128.02	451.79	1,635.84	1,482.54	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00	
Budget Cap	$739,928,194	$696,868,992	$685,513,514	$533,307,177	$464,960,227	$5,209,152	$436,734,152	$591,852,129	$985,254,981	$356,190,613	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$5,495,819,131	
	594,068,414	527,994,309	477,120,468	297,666,811	241,583,232	1,091,982	256,046,813	373,133,268	957,924,418	338,454,104							4,065,083,819	Total Actual Year 14 Spending: excluding PAC, EID & adjustments below
	(14,865,522)	(13,217,189)	(11,945,327)	(7,448,024)	(6,043,888)	(40,701)	(6,410,184)	(9,340,554)	(23,961,879)	(8,475,688)							(101,748,956)	Pharmacy Rebates
	6,329,548	5,627,709	5,086,166	3,171,272	2,573,410	17,329	2,729,374	3,977,087	10,202,659	3,608,839							43,323,393	GME Payments (manual, not thru MMIS)
	(7,360,313)	(6,544,180)	(5,914,447)	(3,687,713)	(2,992,489)	(20,152)	(3,173,852)	(4,624,755)	(11,864,160)	(4,196,537)							(50,378,598)	DSH in MCO Payments
	5,482,936	4,874,972	4,405,864	2,747,098	2,229,202	15,012	2,364,305	3,445,131	8,837,998	3,126,137							37,528,655	FQHC Cost Settlements (Manual, not thru MMIS)
	18,853	16,762	15,149	9,446	7,665	39	8,130	11,846	30,389	10,749							129,041	Unidentified
	11,070,971	14,762,850	7,949,429	3,978,949	1,524,228	(38,867)	7,260,316	4,784,887	13,400,292	210,251								
	594,744,887	533,515,233	476,717,302	296,437,839	238,881,360	1,024,642	258,824,902	371,386,910	954,569,717	332,737,855							4,058,840,647	Total Projected Year 14 Spending: excluding add-on population
Percent of costs before expansion population:	14.61%	12.99%	11.74%	7.32%	5.94%	0.03%	6.30%	9.18%	23.55%	8.33%	99.99%							
	0	0	0	0	0	0	0	0	0	0								
																	0	Pharmacy Waiver Program
	594,744,887	533,515,233	476,717,302	296,437,839	238,881,360	1,024,642	258,824,902	371,386,910	954,569,717	332,737,855							4,058,840,647	Total Projected Year 14 Spending with other additions & before add-on population costs
	$557.11	$285.61	$482.00	$207.36	$2,083.32	$368.97	$1,853.78	$283.50	$1,584.89	$1,384.92							522.79	DY 14 cost PMPM after other additions & before add-on Population Costs
	$595.66	$305.37	$515.35	$221.71	$2,227.49	$394.50	$1,982.06	$303.12	$1,694.56	$1,480.76							$558.97	Year 14 cost PMPM trended forward to DY 15
												$34,731.70	$257.22	$1.25	0.00	$0.00		
												$37,135.13	$275.02	$1.34	$0.00	$0.00		
												0	160,564,819	(3,392,903)	0	0	157,171,916	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$594,744,887	**$533,515,233**	**$476,717,302**	**$296,437,839**	**$238,881,360**	**$1,024,642**	**$258,824,902**	**$371,386,910**	**$954,569,717**	**$332,737,855**		**$0**	**$160,564,819**	**($3,392,903)**	**$0**	**$0**	**$4,216,012,563**	Total charged against CAP
	0	0	0	0	0	0	0	0	0								0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**594,744,887**	**533,515,233**	**476,717,302**	**296,437,839**	**238,881,360**	**1,024,642**	**258,824,902**	**371,386,910**	**954,569,717**	**332,737,855**		**0**	**160,564,819**	**(3,392,903)**	**0**	**0**	**4,216,012,563**	**Year 14 Charged Against Cap**
																	$1,279,806,568	Year 14 Balance
																	76.71%	Percentage of Cap
	$557.11	$285.61	$482.00	$207.36	$2,083.32	$368.97	$1,853.78	$283.50	$1,584.89	$1,384.92		$0.00	$257.22	($27.31)	$0.00	$0.00	$543.04	Year 14 PMPM including add-on population Costs, excluding add on member months
																	$580.62	Year 14 PMPM including add-on population Costs, trended forward DY 15
Demonstration Year 15 Projection	(TANF) LT 30 Adult	(TANF) LT 30 CHILD	TANF 30-116 ADULT	TANF 30-116 CHILD	Medically Needy Adult	Medically Needy Child	Sobra Adult	Sobra Child	SSI Adult	SSI Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Pharmacy Discount Prog	Total
Year 15 Actual; base for trending to DY16	1,118,853	1,928,723	1,673,971	1,673,971	84,910	2,380	137,666	1,200,232	616,108	239,280		30	745,683	133,298	0	0	
Projection Adjustment factor:	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000	1.0000	1.0000	
DY 15 Projection, member months	**1,118,853**	**1,928,723**	**1,186,502**	**1,673,971**	**84,910**	**2,380**	**137,666**	**1,200,232**	**616,108**	**239,280**	Member Months:	Eld, PAC & FP	Not counted in CAP				**8,188,625**	Member Months excluding add-on population
												30	**745,683**	**133,295**	**0**	**0**	**879,008**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%								
Year 15 PMPM Cap	729.84	391.34	729.84	391.34	4,269.89	1,967.74	3,293.81	473.93	1,733.99	1,571.49	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$816,583,674	$754,786,459	$865,956,620	$655,091,811	$362,556,360	$4,683,221	$453,445,647	$568,825,952	$1,068,325,111	$376,026,127	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$5,926,280,982	
	653,343,351	552,260,949	553,056,829	343,852,492	167,995,702	4,963,757	243,473,131	339,872,943	1,015,871,374	343,622,735							4,218,313,263	Total Projected Year 15 Spending: excluding add-on population
Percent of costs before expansion population:	15.49%	13.09%	13.11%	8.15%	3.98%	0.12%	5.77%	8.06%	24.08%	8.15%								
	7,072,475	5,978,253	5,986,868	3,722,221	1,818,562	53,733	2,635,609	3,679,142	10,996,859	3,719,733							45,663,454	GME Payments (manual, not thru MMIS)
	(18,624,927)	(15,743,360)	(15,766,049)	(9,802,239)	(4,789,071)	(141,502)	(6,940,714)	(9,688,793)	(28,959,551)	(9,795,689)							(120,251,896)	Pharmacy Rebates

	294,029	248,538	248,896	154,747	75,604	2,234	109,572	152,956	457,180	154,643							1,898,400	Pharmacy Waiver Program
	(7,802,769)	(6,595,559)	(6,605,064)	(4,106,572)	(2,006,344)	(59,281)	(2,907,758)	(4,059,045)	(12,132,379)	(4,103,828)							(50,378,598)	DSH in MCO Payments
	4,446,514	3,758,569	3,763,985	2,340,186	1,143,342	33,782	1,657,026	2,313,102	6,913,801	2,338,622							28,708,929	FQHC Cost Settlements (Manual, not thru MMIS)
	(1,739,298)	(1,470,201)	(1,472,320)	(915,387)	(447,230)	(13,214)	(648,162)	(904,793)	(2,704,401)	(914,775)							(11,229,780)	Unidentified
	9,246,512	9,054,936	9,328,321	5,812,357	1,150,666	(4,063,351)	12,035,236	6,160,146	19,858,701	7,116,273								
	646,235,887	547,492,124	548,541,468	341,057,805	164,941,232	776,157	249,413,940	337,525,657	1,010,301,584	342,137,715							4,112,723,772	Total Projected Year 15 Spending with other additions & before add-on population costs
	$577.59	$283.86	$462.32	$203.74	$1,942.54	$326.12	$1,811.73	$281.22	$1,639.81	$1,429.86							502.25	DY 15 cost PMPM after other additions & before add-on Population Costs
	$617.56	$303.50	$494.31	$217.84	$2,076.96	$348.69	$1,937.10	$300.68	$1,753.28	$1,528.81							$537.01	Year 15 cost PMPM trended forward to DY 16
												$37,135.13	$275.02	$1.34	$0.00	$0.00		
												$39,704.88	$294.05	$1.43	$0.00	$0.00		
												0	199,021,986	(2,950,077)	0	0	196,071,909	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$646,235,887	**$547,492,124**	**$548,541,468**	**$341,057,805**	**$164,941,232**	**$776,157**	**$249,413,940**	**$337,525,657**	**$1,010,301,584**	**$342,137,715**		**$0**	**$199,021,986**	**($2,950,077)**	**$0**	**$0**	**$4,308,795,681**	Total charged against CAP
	0	0	0	0	0	0	0	0	0		4,188,423,569						0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**646,235,887**	**547,492,124**	**548,541,468**	**341,057,805**	**164,941,232**	**776,157**	**249,413,940**	**337,525,657**	**1,010,301,584**	**342,137,715**		**0**	**199,021,986**	**(2,950,077)**	**0**	**0**	**4,308,795,681**	**Year 15 Charged Against Cap**
																	$1,617,485,301	Year 15 Balance
															4,384,495,478		72.71%	Percentage of Cap
	$577.59	$283.86	$462.32	$203.74	$1,942.54	$326.12	$1,811.73	$281.22	$1,639.81	$1,429.86		$0.00	$266.90	($22.13)	#DIV/0!	$0.00	$526.19	Year 15 PMPM including add-on population Costs, excluding add on member months
																	$562.60	Year 15 PMPM including add-on population Costs, trended forward DY 16

Demonstration Year 16 Projection	(TANF) LT 30	(TANF) LT 30	TANF 30-116	TANF 30-116	Medically Needy	Medically Needy	Sobra	Sobra	SSI	SSI								
	Adult	CHILD	ADULT	CHILD	Adult	Child	Adult	Child	Adult	Child		ICS	PAC	FAMILY PLAN	Premium Subsidy MHIP	Pharmacy Discount Prog	Total	
Year 16 actual; base for trending to DY17	1,200,409	2,034,891	1,299,133	1,770,496	72,837	2,584	138,427	1,187,661	643,912	241,375		30	882,818	171,778	0	0		
Projection Adjustment factor:	1.1100	1.0900	1.1100	1.0900	1.0500	1.0300	0.8200	0.8200	1.0300	1.0300		1.0000	1.0000	1.0400	1.0000	1.0000		
DY 16 Projection, member months	**1,332,454**	**2,218,031**	**1,442,038**	**1,929,841**	**76,479**	**2,662**	**113,510**	**973,882**	**663,229**	**248,616**	Member Months:	Eld, PAC & FP	Not counted in CAP				**9,000,742**	Member Months excluding add-on population
												30	**882,818**	**178,649**	**0**	**0**	**1,061,497**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%								
Year 16 PMPM Cap	768.52	410.52	768.52	410.52	4,496.19	2,064.16	3,468.38	497.15	1,838.03	1,665.78	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$1,024,017,548	$910,546,086	$1,108,235,044	$792,238,327	$343,864,115	$5,494,794	$393,695,814	$484,165,436	$1,219,034,799	$414,139,560	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$6,695,431,523	
	623,332,808	557,020,775	589,423,808	376,388,077	123,441,559	1,244,714	224,392,654	343,478,163	988,421,032	339,609,752							4,166,753,342	Total Projected Year 16 Spending: excluding add-on population
Percent of costs before expansion population:	14.96%	13.37%	14.15%	9.03%	2.96%	0.03%	5.39%	8.24%	23.72%	8.15%								
	7,060,387	6,309,281	6,676,305	4,263,285	1,398,202	14,099	2,541,658	3,890,520	11,195,680	3,846,703							$47,196,119	GME Payments (manual, not thru MMIS)
	(13,791,922)	(12,324,696)	(13,041,648)	(8,327,999)	(2,731,280)	(27,541)	(4,964,934)	(7,599,831)	(21,869,899)	(7,514,238)							(92,193,988)	Pharmacy Rebates
	283,994	253,782	268,545	171,485	56,241	567	102,235	156,491	450,331	154,728							1,898,400	Pharmacy Waiver Program
	(12,790,370)	(11,429,692)	(12,094,580)	(7,723,230)	(2,532,938)	(25,541)	(4,604,386)	(7,047,941)	(20,281,735)	(6,968,564)							(85,498,976)	DSH in MCO Payments
	4,345,758	3,883,443	4,109,351	2,624,106	860,611	8,678	1,564,423	2,394,665	6,891,084	2,367,695							29,049,814	FQHC Cost Settlements (Manual, not thru MMIS)
	18,465	16,501	17,461	11,150	3,657	37	6,647	10,175	29,281	10,061							123,435	Unidentified
	15,253,802	13,531,959	14,149,203	9,191,947	4,016,123	(259,110)	5,654,090	8,175,601	29,452,823	8,220,294								
	623,712,923	557,261,355	589,508,445	376,598,821	124,512,175	955,903	224,692,387	343,457,842	994,288,596	339,726,431							4,067,328,146	Total Projected Year 16 Spending with other additions & before add-on population costs
	$468.09	$251.24	$408.80	$195.14	$1,628.06	$359.09	$1,979.49	$352.67	$1,499.16	$1,366.47							451.89	DY 15 cost PMPM after other additions & before add-on Population Costs
	$500.48	$268.63	$437.09	$208.64	$1,740.72	$383.94	$2,116.47	$377.07	$1,602.90	$1,461.03							$483.16	Year 16 cost PMPM trended forward to DY 17
												$39,704.88	$294.05	$1.43	$0.00	$0.00		
												$42,452.46	$314.40	$1.53	$0.00	$0.00		
												0	236,621,511	(2,171,112)	0	0	234,450,399	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$623,712,923	**$557,261,355**	**$589,508,445**	**$376,598,821**	**$124,512,175**	**$955,903**	**$224,692,387**	**$343,457,842**	**$994,288,596**	**$339,726,431**		**$0**	**$236,621,511**	**($2,171,112)**	**$0**	**$0**	**$4,301,778,545**	Total charged against CAP
	0	0	0	0	0	0	0	0	0								0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**623,712,923**	**557,261,355**	**589,508,445**	**376,598,821**	**124,512,175**	**955,903**	**224,692,387**	**343,457,842**	**994,288,596**	**339,726,431**		**0**	**236,621,511**	**(2,171,112)**	**0**	**0**	**4,301,778,545**	**Year 16 Charged Against Cap**
	623,712,001	557,260,510	589,507,551	376,598,250	124,521,178	955,903	224,692,386	343,457,842	994,288,596	339,726,431							$2,393,652,978	Year 16 Balance
																	64.25%	Percentage of Cap
	$468.09	$251.24	$408.80	$195.14	$1,628.06	$359.09	$1,979.49	$352.67	$1,499.16	$1,366.47		$0.00	$268.03	($12.15)	#DIV/0!	$0.00	$477.94	Year 16 PMPM including add-on population Costs, excluding add on member months
																	$511.01	Year 16 PMPM including add-on population Costs, trended forward DY 17

Demonstration Year 17 Projection (6 Months)	(TANF) LT 30	(TANF) LT 30	TANF 30-116	TANF 30-116	Medically Needy	Medically Needy	Sobra	Sobra	SSI	SSI								
	Adult	CHILD	ADULT	CHILD	Adult	Child	Adult	Child	Adult	Child		ICS	PAC	FAMILY PLAN	Childless Adults	Pharmacy Discount Prog	Total	
.	703,265	1,129,191	612,801	861,754	36,606	680	70,833	599,553	344,319	124,450		30	515,637	84,736	0	0		
	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000	1.0000	1.0000		
DY 17 Projection, member months	**703,265**	**1,129,191**	**612,801**	**861,754**	**36,606**	**680**	**70,833**	**599,553**	**344,319**	**124,450**	Member Months:	Eld, PAC & FP	Not counted in CAP				**4,483,452**	Member Months excluding add-on population
												30	**515,637**	**84,736**	**0**	**0**	**600,403**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%								
Year 17 PMPM Cap	809.25	430.64	809.25	430.64	4,734.49	2,165.30	3,652.20	521.51	1,948.31	1,765.73	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00	0.00	0.00		
Budget Cap	$569,117,201	$486,274,812	$495,909,209	$371,105,743	$173,310,741	$1,472,404	$258,696,283	$312,672,885	$670,840,151	$219,745,099	Estimated without Waiver Expenditures	$0	$0	$0	$0	$0	$3,559,144,528	
	$362,912,193	$322,121,512	$354,288,298	$233,677,399	$132,816,489	$827,171	$240,446,275	$193,770,549	$1,050,156,859	$277,606,007							$3,168,622,752.00	Total Projected Year 17 Spending: excluding add-on population
Percent of costs before expansion population:	11.45%	10.17%	11.18%	7.37%	4.19%	0.03%	7.59%	6.12%	33.14%	8.76%								
																		GME Payments (manual, not thru MMIS)
																		Pharmacy Rebates
	217,430	192,991	212,263	140,002	79,574	496	144,057	116,093	629,175	166,321							1,898,400	Pharmacy Waiver Program
	1,334,012	1,943,673	700,404	644,638	1,404,750	(407,140)	(193,898)	(99,605)	37,426,153	87,640,822								DSH in MCO Payments
																		FQHC Cost Settlements (Manual, not thru MMIS)
	$364,463,635	$324,258,176	$355,200,965	$234,462,039	$134,300,813	$420,527	$240,396,434	$193,787,037	$1,088,212,187	$365,413,150							3,170,521,152	Total Projected Year 17 Spending with other additions & before add-on population costs
	$518.25	$287.16	$579.64	$272.08	$3,668.82	$618.42	$3,393.85	$323.22	$3,160.48	$2,936.22							707.16	DY 16 cost PMPM after other additions & before add-on Population Costs
												12	142,097,984	(442,700)	0	0	141,655,296	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$364,463,635	**$324,258,176**	**$355,200,965**	**$234,462,039**	**$67,150,406.32**	**$210,263.29**	**$120,198,217.15**	**$193,787,037**	**$544,106,093.43**	**$182,706,574.80**		**$12**	**$141,582,546**	**($442,700)**	**$0**	**$0**	**$3,312,176,448**	Total charged against CAP
	0	0	0	0	0	0	0	0	0									Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**364,463,635**	**324,258,176**	**355,200,965**	**234,462,039**	**67,150,406**	**210,263**	**120,198,217**	**193,787,037**	**544,106,093**	**182,706,575**		**12**	**141,582,546**	**(442,700)**	**0**	**0**	**3,312,176,448**	**Year 17 Charged Against Cap**
	364,463,635	324,258,176	355,200,965	234,462,039	134,300,813			193,787,037	1,088,212,187	365,413,150							$246,968,080	Year 17 Balance
																	93.06%	Percentage of Cap
	$518.25	$287.16	$579.64	$272.08	$1,834.41	$309.21	$1,696.92	$323.22	$1,580.24	$1,468.11		$0.40	$274.58	($5.22)	#DIV/0!	$0.00	$738.76	Year 17 PMPM including add-on population Costs, excluding add on member months
																	$789.88	Year 17 PMPM including add-on population Costs, trended forward DY 18

Demonstration Year 17 Projection (6 Months) January1-June 30th	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 17 projection; base for trending to DY18	1,085,772	1,474,462	2,851,037	34,419	393	64,124	0	348,132	124,869		83	2,354	75,579		
Projection Adjustment factor x 50% to account for half year (thru Dec 31 ony)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.0000		
DY 17 Projection, member months	**1,085,772**	**1,474,462**	**2,851,037**	**34,419**	**393**	**64,124**	**0**	**348,132**	**124,869**	Member Months:	ICS & Family Planning	Not counted in CAP		**5,983,208**	Member Months excluding add-on population
											83	**2,354**	**75,579**	**78,016**	Member Months for add-on population Items: FAMILY PLANNING & ICS
Year 17 PMPM Cap	790.85	809.25	445.05	4,734.49	2,165.30	3,652.20	892.00	1,948.31	1,765.73	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00		
Budget Cap	$858,682,786	$1,193,208,374	$1,268,854,017	$162,956,411	$850,963	$234,193,673	$0	$678,269,057	$220,484,939	Estimated without Waiver Expenditures	$0	$0	$0	$4,617,500,220	
	$788,728,673	$611,150,478	$684,926,910.00	$132,816,489.00	$827,171.00	$240,446,275	$0.00	$1,050,156,859	$277,606,007					$3,786,658,862.00	Total Actual Year 17 Spending: excluding add-on population
	$726.42	$414.49	$240.24	$3,858.81	$2,104.76	$3,749.71	$0.00	$3,016.55	$2,223.18					$632.88	Actual DY 17 PMPM costs before DY 17 increases to add-onpopulation:
	$776.69	$443.17	$256.86	$4,125.84	$2,250.41	$4,009.19	$0.00	$3,225.29	$2,377.02					$676.68	Year 17 cost PMPM trended forward to DY 18
	20.83%	16.14%	18.09%	3.51%	0.02%	6.35%	0.00%	27.73%	7.33%						Percent of costs before expansion population:
	9,888,670	7,662,287	8,587,258	1,665,184	10,371	3,014,591	0	13,166,321	3,480,480					$47,475,162	GME Payments (manual, not thru MMIS)
	(16,544,597)	(12,819,666)	(14,367,221)	(2,785,996)	(17,351)	(5,043,669)	0	(22,028,388)	(5,823,142)					(79,430,031)	Pharmacy Rebates
	(11,183,667)	(8,665,722)	(9,711,825)	(1,883,253)	(11,729)	(3,409,374)	0	(14,890,551)	(3,936,275)					(53,692,396)	DSH in MCO Payments
	5,604,415.2	4,342,610.0	4,866,838.1	943,745.0	5,877.6	1,708,522.6	0.0	7,462,027.5	1,972,566.0					26,906,602	FQHC Cost Settlements (Manual, not thru MMIS)
	(526,083,620)	32,287,301	2,475,963	1,933,991	(403,844)	764,220	0	40,620,766	85,237,013					1,000,000	Presumptive Eligibility
	0	0	0	0	0	0	0	990,000	3,510,000					4,500,000	REM Case Management
	9,564,838	7,411,364	8,306,044	1,610,653	10,031	2,915,869	0	12,735,153	3,366,502					45,920,453	Unidentified
	259,974,713	641,368,652	685,083,967	134,300,813	420,527	240,396,434	0	1,088,212,187	365,413,150					3,779,338,652	Total Projected Year 17 Spending with other additions & before add-on population costs
	$239.44	$434.98	$240.29	$3,901.94	$1,070.04	$3,748.93		$3,125.86	$2,926.37					631.66	DY 16 cost PMPM after other additions & before add-on Population Costs
										$	0.14	$ 30.94	($5.22)		
											$0.15	$33.08	($5.58)		
											12	72,838	(442,700)	(369,850)	Total Costs of Expansion Population Items: FAMILY PLAN, & ICS

	$ 259,974,713	**$ 641,368,652**	**$ 685,083,967**	**$ 67,150,407**	**$ 210,263**	**$ 120,198,217**	**$ -**	**$ 544,106,093**	**$ 182,706,575**		**$12**	**$72,838**	**($442,700)**	**$3,778,968,802**	Total charged against CAP
	0	0	0	0	0	0	0	0	0						Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**259,974,713**	**641,368,652**	**685,083,967**	**67,150,407**	**210,263**	**120,198,217**	**0**	**544,106,093**	**182,706,575**		**12**	**72,838**	**(442,700)**	**3,778,968,802**	**Year 17 Charged Against Cap**
														$838,531,418	Year 17 Balance
	259,974,713	641,368,652	685,083,967	134,300,813		240,396,434								81.84%	Percentage of Cap
	$239.44	$434.98	$240.29	$1,950.97	$535.02	$1,874.47	$0.00	$1,562.93	$1,463.19		$0.14	$30.94	($5.86)	$631.60	Year 17 PMPM including add-on population Costs, excluding add on member months
									365,413,150					$675.31	Year 17 PMPM including add-on population Costs, trended forward DY 18
Demonstration Year 18 Actuals (12 months)	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 18 Actual base for trending to DY19	2,778,981	2,872,945	5,671,322	75,449	1,211	116,108	30	702,885	250,888		201	3,313	158,042		
Projection Adjustment factor	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.0000	1.0000	1.1000		
DY 18 Actual, member months	**2,778,981**	**2,872,945**	**5,671,322**	**75,449**	**1,211**	**116,108**	**30**	**702,885**	**250,888**	Member Months: Eld, PAC & FP				**12,469,819**	Member Months excluding add-on population
											201	**3,313**	**173,846**	**177,360**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
Year 18 PMPM Cap	828.02	848.90	465.08	4,942.81	2,260.57	3,838.46	939.28	2,034.04	1,765.73		0.00	0.00	0.00		
Budget Cap	$2,301,051,848	$2,438,843,011	$2,637,618,436	$372,930,072	$2,737,550	$445,675,914	$28,178	$1,429,696,205	$443,000,468	Estimated without Waiver Expenditures	$0	$0	$0	$10,071,581,682	
	$660.61	$493.34	$272.22	$1,767.30	$691.85	$1,903.66	$1,130.10	$1,636.33	$1,525.47					$482.56	Actual DY 18 PMPM costs before DY 18 increases to add-onpopulation:
	$706.32	$527.48	$291.06	$1,889.60	$739.73	$2,035.39	$1,208.31	$1,749.57	$1,631.03					$515.95	Year 18 cost PMPM trended forward to DY 19
	1,823,463,822	1,071,451,683	1,540,170,694	132,816,489	827,171	240,446,275	33,893	891,017,471	317,175,223					6,017,402,721	Total Projected Year 18 Spending: excluding add-on population
Percent of costs before expansion population:	30.30%	17.81%	25.60%	2.21%	0.01%	4.00%	0.00%	14.81%	5.27%						
	0	0	0	0	0	1,245,971	0	0	0					1,245,971	Presumptive Eligibility
	0	0	0	0	0	0	0	1,980,000	7,020,000					9,000,000	REM Case Management
	27,441,340	16,124,296	23,178,057	1,998,758	12,448	3,618,480	510	13,408,938	4,773,176					90,556,003	Unidentified
	14,676,760	8,623,938	12,396,580	1,069,018	6,658	1,935,312	273	7,171,653	2,552,891					$48,433,082	GME Payments (manual, not thru MMIS)
	(33,587,867)	(19,735,942)	(28,369,660)	(2,446,455)	(15,236)	(4,428,976)	(624)	(16,412,377)	(5,842,309)					(110,839,446)	Pharmacy Rebates
	(15,116,562)	(8,882,362)	(12,768,055)	(1,101,052)	(6,857)	(1,993,306)	(281)	(7,386,558)	(2,629,391)					(49,884,423)	DSH in MCO Payments
	7,130,497	4,189,819	6,022,704	519,367	3,235	940,244	133	3,484,246	1,240,286					23,530,531	FQHC Cost Settlements (Manual, not thru MMIS)
	11,814,480	345,580,401	3,209,430	485,133	10,413	(19,488,256)	0	258,871,089	65,452,483						Voucher Carryover
	0	0	0	0	0	0	0	0	0						MA Carryover
	1,835,822,470	1,417,351,833	1,543,839,750	133,341,258	837,831	222,275,745	33,903	1,152,134,462	389,742,359					6,029,444,439	Total Actual Year 18 Spending with other additions & before add-on population costs
	$660.61	$493.34	$272.22	$1,767.30	$691.85	$1,914.39	$1,130.10	$1,639.15	$1,553.45					483.52	DY 18 cost PMPM after other additions & before add-on Population Costs
					837,831	222,275,745		1,152,134,462	389,742,359						
											$0.14	$1,475.49	($5.22)		
											$0.15	$1,577.59	($5.58)		
											29	4,888,291	(907,476)	3,980,844	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$1,835,822,470	**$1,417,351,833**	**$1,543,839,750**	**$133,341,258**	**$837,831**	**$222,275,745**	**$33,903**	**$1,152,134,462**	**$389,742,359**		**$29**	**$4,888,291**	**$0**	**$6,033,425,283**	Total charged against CAP
	0	0	0	0	0	0	0	0	0					0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**1,835,822,470**	**1,417,351,833**	**1,543,839,750**	**133,341,258**	**837,831**	**222,275,745**	**33,903**	**1,152,134,462**	**389,742,359**		**29**	**4,888,291**	**0**	**6,033,425,283**	**Year 18 Charged Against Cap**
	1,835,822,470	1,417,351,833	1,543,839,750	133,341,258										$4,038,156,399	Year 18 Balance
														59.91%	Percentage of Cap
	$660.61	$493.34	$272.22	$1,767.30	$691.85	$1,914.39	$1,130.10	$1,639.15	$1,553.45		$0.14	$1,475.49	$0.00	$483.84	Year 18 PMPM including add-on population Costs, excluding add on member months
														$517.32	Year 18 PMPM including add-on population Costs, trended forward DY 19
Demonstration Year 19 Actual (12 months)	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 19 actual; base for trending to DY20	2,668,138	2,255,106	4,657,991	25,124	1,501	98,917	7	645,946	238,311		201	3,840	173,846		
Projection Adjustment factor)	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000		1.1000	1.1000	1.1000		
DY 19 Actual member months	**2,668,138**	**2,255,106**	**4,657,991**	**25,124**	**1,501**	**98,917**	**7**	**645,946**	**238,311**	Member Months:				**10,591,041**	Member Months excluding add-on population
											221	**4,224**	**191,231**	**195,676**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
Year 19 PMPM Cap	866.94	890.50	486.01	5,160.29	2,360.04	3,838.46	989.06	2,034.04	1,843.42	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00		
Budget Cap	$2,313,115,558	$2,008,171,893	$2,263,830,206	$129,647,126	$3,542,420	$379,688,948	$6,923	$1,313,880,002	$439,307,264	Estimated without Waiver Expenditures	$0	$0	$0	$8,851,190,340	
	$853.11	$565.27	$301.75	$1,890.98	$1,731.39	$1,616.85	$852.20	$1,804.68	$1,700.14					$636.15	Projected DY 19 PMPM costs before DY 19 increases to add-onpopulation:
	$912.14	$604.39	$322.63	$2,021.84	$1,851.21	$1,728.74	$911.17	$1,929.56	$1,817.79					$680.17	Year 19 cost PMPM trended forward to DY 20
	2,276,211,954	1,274,741,257	1,405,560,970	47,509,097	2,598,821	159,934,337	0	1,165,724,136	405,162,292					6,737,442,864	Total Projected Year 19 Spending: excluding add-on population
Percent of costs before expansion population:	33.78%	18.92%	20.86%	0.71%	0.04%	2.37%	0.00%	17.30%	6.01%						
	0	0	0	0	0	0	0	0	0						Presumptive Eligibility
		0	0	0	0	0	0	0	0						REM Case Management
	0	0	0	0	0	0	0	0	0						
	0	0	0	0	0	0	0	0	0						
	2,276,211,954	1,274,741,257	1,405,560,970	47,509,097	2,598,821	159,934,337	0	1,165,724,136	405,162,292					6,737,442,864	Total Projected Year 19 Spending with other additions & before add-on population costs
	$853.11	$565.27	$301.75	$1,890.98	$1,731.39	$1,616.85	$0.00	$1,804.68	$1,700.14					636.15	DY 19 cost PMPM after other additions & before add-on Population Costs
											$0.14	$914.46	($5.22)		
											$0.15	$977.74	($5.58)		
											0	3,862,685	0	3,862,685	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$2,276,211,954	**$1,274,741,257**	**$1,405,560,970**	**$47,509,097**	**$2,598,821**	**$159,934,337**	**$0**	**$1,165,724,136**	**$405,162,292**		**$0**	**$3,862,685**	**$0**	**$6,741,305,549**	Total charged against CAP
	0	0	0	0	0	0	0	0	0					0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**2,276,211,954**	**1,274,741,257**	**1,405,560,970**	**47,509,097**	**2,598,821**	**159,934,337**	**0**	**1,165,724,136**	**405,162,292**		**0**	**3,862,685**	**0**	**6,741,305,549**	**Year 19 Charged Against Cap**
	2,276,211,954													$2,109,884,791	Year 19 Balance
														76.16%	Percentage of Cap
	$853.11	$565.27	$301.75	$1,890.98	$1,731.39	$1,616.85	$0.00	$1,804.68	$1,700.14		$0.00		$0.00	$636.51	Year 19 PMPM including add-on population Costs, excluding add on member months
														$680.56	Year 19 PMPM including add-on population Costs, trended forward DY 20
Demonstration Year 20 Actual (6 Months)	New Adult Group	TANF Adults 0-123	Medicaid Child	Medically Needy Adult	Medically Needy Child	Sobra Adult	Presumptive Eligibility	SSI Adult	SSI Child		ICS	WBCCPTA	FAMILY PLAN	Total	
Year 20 projection; base for trending to DY21	3,777,522	2,690,367	5,732,782	13,161	2,394	124,435	35	774,977	286,196		329	1,997	124,820		
Projection Adjustment factor)(6 months)	0.5000	0.5000	0.5000	0.5000	0.5000	0.5000	0.5000	0.5000	0.5000		0.5000	0.5000	0.5000		
DY 20 Actual member months	**1,888,761**	**1,345,184**	**2,866,391**	**6,581**	**1,197**	**62,218**	**18**	**387,489**	**143,098**	Member Months:				**6,700,937**	Member Months excluding add-on population
	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%		**165**	**999**	**62,410**	**63,573**	Member Months for add-on population Items: PAC, FAMILY PLANNING, & 300% SSI, Premium Subsidy MHIP
Year 20 PMPM Cap	907.68	934.13	507.88	5,387.34	2,463.88	4,239.97	0.00	2,216.97	2,009.21	BN Negotiated PMPM (Proposed)	0.00	0.00	0.00		
Budget Cap	$1,714,390,584	$1,256,576,730	$1,455,782,661	$35,454,085	$2,949,264	$263,802,453	$0	$859,051,488	$287,513,933	Estimated without Waiver Expenditures	$0	$0	$0	$5,875,521,198	
	$726.40	$520.78	$266.07	$1,414.91	$1,446.41	$1,422.75	$129.86	$1,606.64	$1,493.81					$1,125.54	Projected DY 20 PMPM costs before DY 20 increases to add-onpopulation:
	$776.66	$556.82	$284.48	$1,512.82	$1,546.50	$1,521.21	$138.85	$1,717.82	$1,597.19					$1,203.43	Year 20 cost PMPM trended forward to DY 21
	2,743,983,016	1,401,085,690	1,525,324,763	18,623,034	3,462,709	177,041,734	4,675	1,245,108,515	427,523,565					7,542,157,701	Total Projected Year 20 Spending: excluding add-on population
Percent of costs before expansion population:	36.38%	18.58%	20.22%	0.25%	0.05%	2.35%	0.00%	16.51%	5.67%						
	0	0	0	0	0	0	0	0	0					0	
	0	0	0	0	0	0	0	0	0					0	
	0	0	0	0	0	0	0	0	0					0	
	0	0	0	0	0	0	0	0	0					0	
	2,743,983,016	1,401,085,690	1,525,324,763	18,623,034	3,462,709	177,041,734	4,675	1,245,108,515	427,523,565					7,542,157,701	Total Projected Year 20 Spending with other additions & before add-on population costs
	$1,452.80	$1,041.56	$532.14	$2,829.82	$2,892.82	$2,845.51	$259.72	$3,213.27	$2,987.63					1,125.54	DY 20 cost PMPM after other additions & before add-on Population Costs
															1
											$0.14	$584.84	($5.22)		
											$0.15	$625.32	($5.58)		
											0	583,968	0	583,968	Total Costs of Expansion Population Items: MHIP, PAC, FAMILY PLAN, etc
	$1,371,991,508	**$700,542,845**	**$762,662,382**	**$9,311,517**	**$1,731,355**	**$88,520,867**	**$2,338**	**$622,554,258**	**$213,761,783**		**$0**	**$583,968**	**$0**	**$7,542,741,669**	Total charged against CAP
	0	0	0	0	0	0	0	0	0					0	Total Funds, SCHIP Shortfall (Fully Funded in DY 12)
With Waiver Actual	**1,371,991,508**	**700,542,845**	**762,662,382**	**9,311,517**	**1,731,355**	**88,520,867**	**2,338**	**622,554,258**	**213,761,783**		**0**	**583,968**	**0**	**7,542,741,669**	**Year 20 Charged Against Cap**
														($1,667,220,471)	Year 20 Balance
														128.38%	Percentage of Cap
	$726.40	$520.78	$266.07	$1,414.91	$1,446.41	$1,422.75	$129.86	$1,606.64	$1,493.81		$0.00	$584.84	$0.00	$1,125.62	Year 20 PMPM including add-on population Costs, excluding add on member months
														$1,203.51	Year 20 PMPM including add-on population Costs, trended forward DY 20