DEPARTMENT OF HEALTH

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

January 28, 2025

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

RE: Senate Bill (SB) 60 - Maryland Medical Assistance Program and Health Insurance - Required Coverage for Calcium Score Testing - Letter of Support with Amendments

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of support with amendments for SB 60 - Maryland Medical Assistance Program and Health Insurance - Required Coverage for Calcium Score Testing.

SB 60 would require the Medical Assistance Program, including managed care organizations, and commercial insurers to provide coverage for calcium score testing for individuals who have at least three of the following risk factors: diabetes, high blood pressure, high cholesterol, or a family history of premature coronary artery disease.

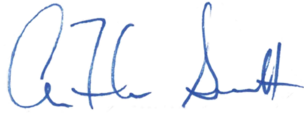
Currently, the Medical Assistance program covers calcium scoring for its participants. Information on family history of premature coronary artery disease is not available in claims and encounter data. However, in CY 2023, 81,924 Medicaid participants had diabetes, high blood pressure, and high cholesterol, while 206,820 participants had two or more of those conditions. As a result, the Department estimates that at least 81,924 to 206,820 participants would qualify for calcium score testing based on the bill as drafted.

However, the Department proposes to amend the language applying the requirement for coverage of calcium score testing so that it is more reflective of current clinical practice. Moderate-quality evidence strongly suggests that coronary artery calcium scoring (CAC) improves predictive value and risk level classification compared with office-based risk assessment in asymptomatic adults. This benefit is particularly marked in asymptomatic adults initially classified as at intermediate risk of a coronary artery disease (CAD) event. Among three studies, 44% to 66% of those initially classified as at intermediate risk of a CAD event were reclassified once CAC scores were considered. However, current evidence is insufficient and does not yet demonstrate that use of CAC scoring translates into improved clinical outcomes (i.e., reduced cardiac events).

CAC scoring may serve as an arbiter of risk and also help to guide clinical-patient risk discussion regarding statin initiation and lipid treatment intensity (e.g., low-density lipoprotein target) and possibly aspirin therapy. If the decision to treat with a statin and lipid treatment target has already been made, the recommendation is against obtaining a CAC scan in such patients.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov

Sincerely,



Laura Herrera Scott, M.D., M.P.H.
Secretary

In the Senate Finance Committee:

AMENDMENTS TO SENATE BILL 60

(First Reading File Bill)

On page 3, in lines 3 and 4, after "**INDIVIDUALS**" strike "**WHO HAVE AT LEAST THREE OF THE FOLLOWING RISK FACTORS:**" and substitute "**BASED ON CURRENT CLINICAL STANDARDS.**"

After line 4, insert:

"**(C)** **THE CURRENT CLINICAL STANDARDS SHALL CONSIDER THE FOLLOWING RISK FACTORS:**"