Maryland Department of Health
Fiscal 2021 Budget Overview

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

January 2020

Note: Numbers may not sum to total due to rounding.

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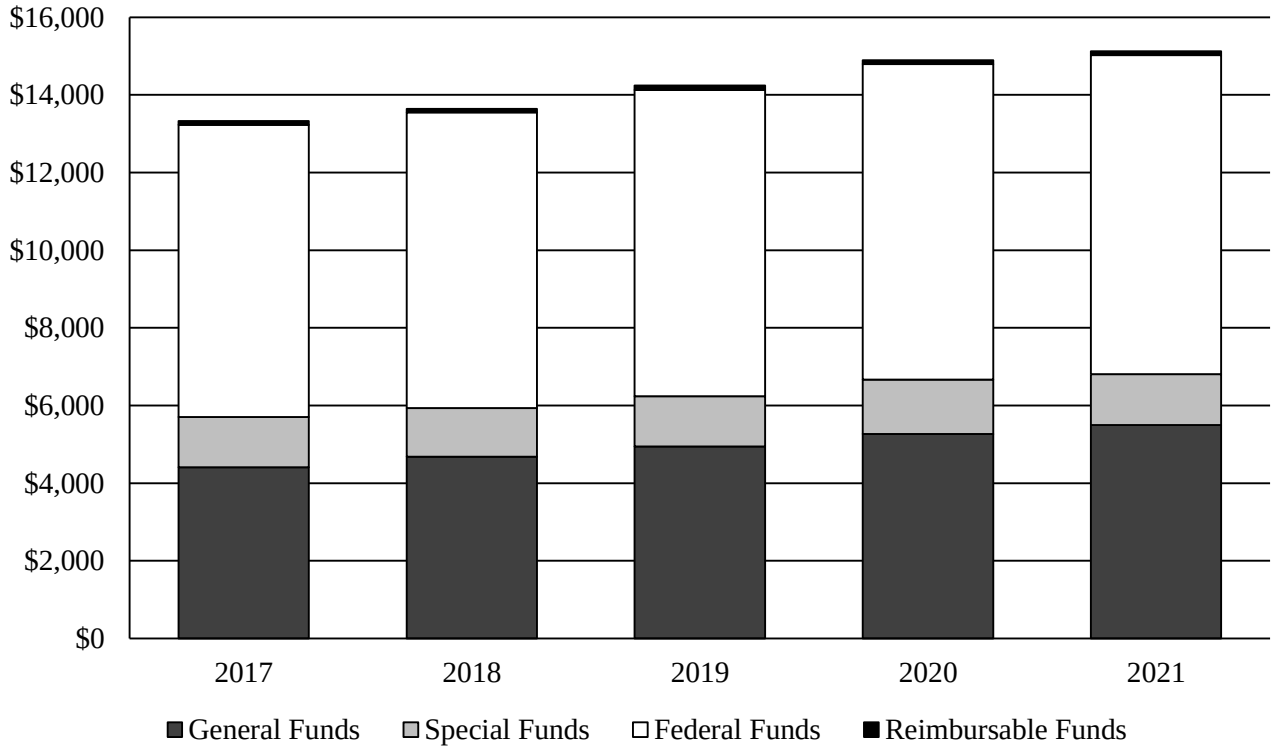
Maryland Department of Health
Fiscal 2021 Budget Overview

Five-year Funding Trends
Fiscal 2017-2021
($ in Millions)

The Fiscal 2021 Budget Increases $230.3 Million, or 1.5%, over Fiscal 2020 to a Total $15.1 Billion in Fiscal 2021. Budget Growth Since Fiscal 2017 Totals $1.8 Billion, 13.5%



Note: Includes fiscal 2020 deficiencies allocated to the appropriate fiscal year. The fiscal 2020 appropriation includes deficiencies, targeted reversions, and general salary increases. The fiscal 2021 allowance includes general salary increases and contingent reductions. A table outlining the department's budget as introduced with total adjustments delineated can be found in **Appendix 1**.

Source: Department of Budget and Management; Department of Legislative Services

Key Observations

- ***Measures of Managed Care Organizations Access and Quality Performance:*** Maryland's managed care program provides care to 1.2 million Marylanders. Overall, Maryland's managed care organizations (MCO) perform well relative to their national peers. However, among the State's MCOs, performance varies.

- ***Establishing Savings Goals for Medicaid:*** Outside of local aid, Medicaid is the largest claimant on Maryland's General Fund. The current tools available to the department to achieve cost savings are limited. However, significant service delivery reforms can take time and be contentious. The legislature has adopted language in recent years for the department to adopt spending targets in order to promote spending constraint, but specific targets have yet to be set.

- ***Recent Studies Find Statewide Health Indicators Show Worsening Disparities Based on Income and Race:*** In the Commonwealth Foundation's *2019 Scorecard on State Health System Performance* and in the Maryland Health Care Commission's *Study on Mortality Rates of African American Infants and Infants in Rural Areas*, Maryland has demonstrated consistent or growing disparities in measures for health care access and outcomes across different income brackets and races.

- ***Uncertain Timing of Cigarette Restitution Fund Litigation Delays Projected Fiscal Impact:*** Maryland is currently involved in multistate litigation with participating manufacturers in the Master Settlement Agreement (MSA) regarding sales year 2004. The Administration projects that Maryland will prevail and receive a $16 million payment in fiscal 2021. However, this is largely uncertain, as the fiscal impact and timing of any increased or reduced payments depends on the arbitration panel's findings and the timing of these findings.

- ***Overtime Expenditures at State Facilities:*** Over 50% of Maryland Department of Health (MDH) employees work at one of 12 State-run facilities. This significant employee footprint has led to growing overtime costs at these facilities, costs that are routinely underfunded by the department. The behavioral health hospitals, with the largest share of facilities and employees, represent the largest component of this problem for MDH.

- ***Maryland's Opioid Crisis:*** Maryland continues to be one of the states hit hardest by the opioid crisis. However, preliminary data for calendar 2019 suggests a leveling off in opioid-related fatalities since 2018's record overdose deaths. The fiscal 2021 budget provides less support for substance use disorder (SUD) treatment than in prior years due to fewer federal grant dollars, anticipated reductions in utilization of SUD treatment in the Medicaid program, and the Budget Reconciliation and Financing Act of 2020 reducing mandated provider rate increases.

Operating Budget Summary

Fiscal 2020 Restricted Funds Not Released by the Administration

Fiscal 2020 Funds Earmarked for Legislative Priorities	**General Funds**	
Prevention and Health Promotion Administration		
Tuberculosis Grants	-$100,000	*
Behavioral Health Administration		
Bed Registry System	-100,000	*
Grants to Nonprofit for Chronic Pain Management	-750,000	*
Tele-education for Childhood Mental Health Disorders	-1,800,000	*
Medical Programs Administration		
Medicaid: Prescription Drug Affordability Board	-750,000	
Medicaid: Expand Medicaid Access to Hepatitis C Treatment	-1,300,000	*
Medicaid: Revise Managed Care Organization Rates	-1,000,000	
Total	**-$5,800,000**	

* The fiscal 2020 budget plan includes proposed deficiencies for these legislative priorities.

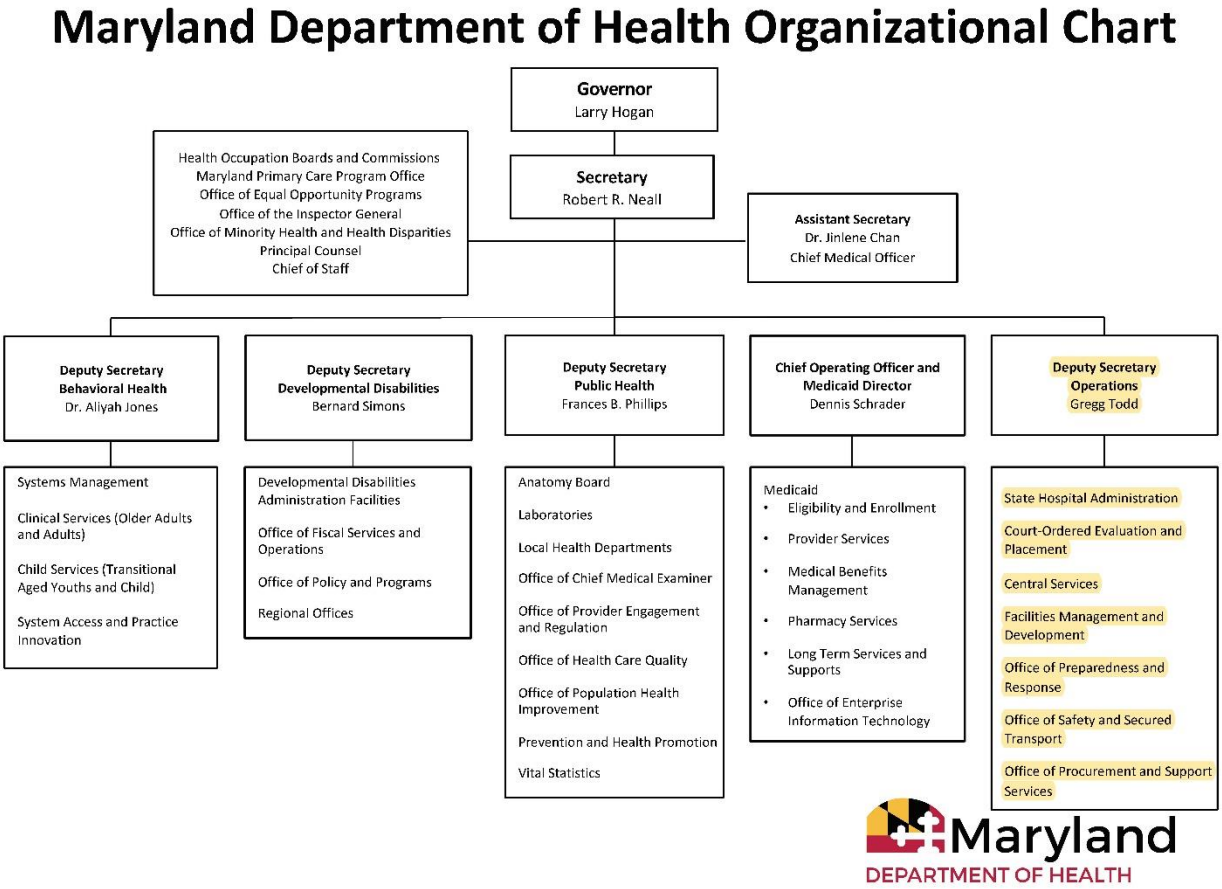
Fiscal 2020 Deficiencies

Program	Item	General Funds	Total Funds
Fiscal 2020 Deficiencies			
Office of the Secretary	Funding for federal indirect cost rate recoveries.	$1,350,967	$0
Health Occupations Boards	Funding for an upgrade to the online platform and content for the State's Residential Child and Youth Care Practitioners training module.	100,000	100,000
Facility Maintenance	Funding for operational costs at Crownsville Hospital Center.	604,110	807,742
Public Health Administration	Funding for the Maryland Primary Care Program Project Management Office.	1,000,000	1,000,000
Prevention and Health Promotion (PHPA)	Funding for additional tuberculosis grants to local health departments.	100,000	100,000
PHPA	Funding for the Family Planning Program.	3,556,247	624,145
PHPA	Additional funding for the Breast and Cervical Cancer Diagnosis and Treatment Program.	812,830	812,830
Behavioral Health Administration (BHA)	Funding to create a statewide bed registry for all inpatient psychiatric beds.	100,000	100,000
BHA	Funding for grants to a nonprofit for nonopioid chronic pain management and tele-education for childhood mental health disorders.	2,550,000	2,550,000
BHA	Funding for community services.	9,083,157	9,083,157
BHA	Funding for service year 2019 Medicaid behavioral health provider reimbursements and contractual services.	11,015,637	28,997,942
BHA	Funding for service year 2020 Medicaid behavioral health provider reimbursements and contractual services.	48,097,926	49,507,080
Developmental Disabilities Administration	General and federal fund availability as a result of the Quality Improvement Organization contracted amount.	-2,563,106	-4,457,577

Program	Item	General Funds	Total Funds
Medical Care Programs Administration (Medicaid)	Funding to replace lower than anticipated Cigarette Restitution Fund revenue attainment.	16,000,000	0
Medicaid	Funding for the Affordable Care Act (ACA) health insurer tax in effect calendar year 2020.	24,000,000	68,000,000
Medicaid	Funding to account for the traditional Medicaid and ACA Expansion populations and additional special fund revenue.	37,295,041	304,417,167
Fiscal 2020 Deficiencies Total		**$153,102,809**	**$461,642,486**
Departmentwide Fiscal 2020 Adjustments			
Maryland Department of Health	Funding for January 1, 2020 1% general salary increase.	$1,784,558	$2,258,414
Departmentwide Fiscal 2020 Deficiencies Total		**$1,784,558**	**$2,258,414**

Source: Governor's Fiscal 2021 Budget Books

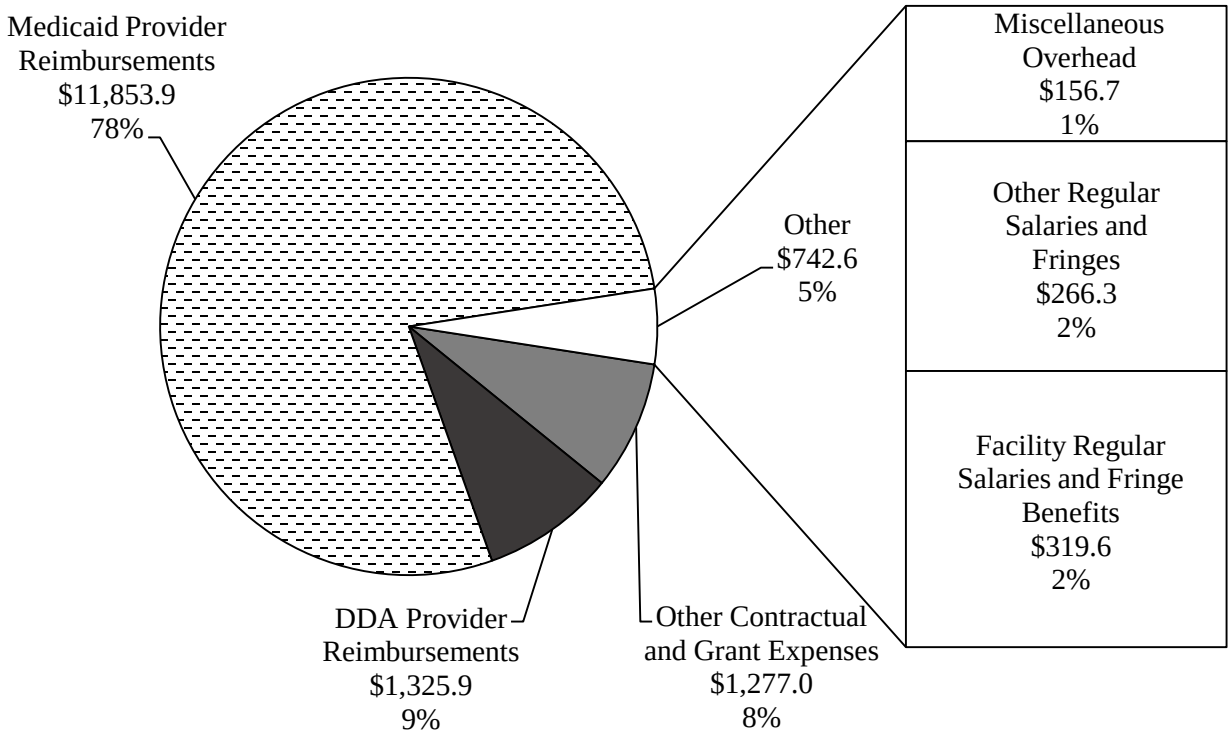
Organizational Chart Following Restructuring



Note: Highlighted text denotes the chronic hospitals and behavioral health facilities that are now administered by a new position, the Deputy Secretary for Operations. The Office of Preparedness and Response was transferred out of the Public Health Administration and will also be overseen by this new role.

Functional Breakdown of Agency Spending
Fiscal 2021 Allowance
($ in Millions)

Total Fiscal 2021 Allowance = $15.2 billion



DDA: Developmental Disabilities Administration

Note: Excludes statewide personnel funding attributable to the Maryland Department of Health.

Source: Governor's Fiscal 2021 Budget Books; Department of Legislative Services

Budget Overview: All Funding Sources
Fiscal 2019-2021 Allowance
($ in Thousands)

	Actual 2019	Working 2020	Allowance 2021	$ Change 2020-2021	% Change 2020-2021
Medical Programs/ Medicaid	**$9,945,931**	**$10,277,932**	**$10,407,073**	**$129,141**	**1.3%**
Provider Reimbursements	9,542,258	9,870,897	9,966,020	95,123	1.0%
Maryland Children's Health Program	279,130	266,351	258,919	-7,432	-2.8%
Other	124,543	140,684	182,134	41,450	29.5%
Behavioral Health	**$1,926,474**	**$2,007,067**	**$2,061,626**	**$54,559**	**2.7%**
Program Direction	41,601	16,210	15,275	-934	-5.8%
Community Services	1,884,873	1,990,857	2,046,351	55,493	2.8%
Developmental Disabilities	**$1,231,707**	**$1,348,573**	**$1,401,561**	**$52,987**	**3.9%**
Program Direction	9,906	9,990	9,563	-427	-4.3%
Community Services	1,176,112	1,295,135	1,347,857	52,722	4.1%
Facilities	45,689	43,449	44,141	692	1.6%
MDH Administration	**$417,402**	**$423,262**	**$423,338**	**$77**	**0.0%**
Behavioral Health Facilities	314,585	315,385	312,899	-2,486	-0.8%
Chronic Disease Hospitals	46,581	47,490	47,264	-226	-0.5%
Other	56,236	60,387	63,176	2,789	4.6%
Public Health Administration	**$141,196**	**$168,190**	**$173,788**	**$5,598**	**3.3%**
Targeted Local Health	51,865	59,119	60,044	925	1.6%
Other	89,331	109,071	113,745	4,674	4.3%
Prevention and Health Promotion Administration	**$375,762**	**$443,412**	**$410,846**	**-$32,566**	**-7.3%**
WIC Program	36,003	109,269	123,391	14,122	12.9%
CRF Tobacco and Cancer Programs	33,302	35,737	35,754	17	0.0%
Maryland AIDS Drug Assistance Program (Including MOE)	63,603	59,332	60,130	797	1.3%
Other	242,854	239,073	191,571	-47,502	-19.9%

	Actual 2019	Working 2020	Allowance 2021	$ Change 2020-2021	% Change 2020-2021
Other Budget Areas	**$204,079**	**$226,485**	**$237,586**	**$11,101**	**4.9%**
Office of Health Care Quality	20,820	24,743	24,218	-526	-2.1%
Health Occupations Boards	38,240	42,177	47,968	5,791	13.7%
Health Regulatory Commissions	145,019	159,465	165,400	5,935	3.7%
Departmentwide Actions		**$2,258**	**$11,643**	**$9,385**	
Total Funding	**$14,242,551**	**$14,897,180**	**$15,127,462**	**$230,283**	**1.5%**

CRF: Cigarette Restitution Fund
MDH: Maryland Department of Health
MOE: Maintenance of Effort
WIC Program: Special Supplemental Nutrition Program for Women, Infants, and Children

Note: Includes fiscal 2020 deficiencies allocated to the appropriate fiscal year. The fiscal 2020 appropriation includes targeted reversions and general salary increases. The fiscal 2021 appropriation includes general salary increases and contingent reductions. For the purpose of this chart, fee-for-service community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration as opposed to Medicaid where they are budgeted. Numbers may not sum to total due to rounding.

Source: Governor's Fiscal 2021 Budget Books; Department of Legislative Services

Proposed Budget Change
Maryland Department of Health
Fiscal 2020-2021
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2020 Working Appropriation	$5,265,279	$1,402,997	$8,129,982	$98,922	$14,897,180
2021 Governor's Allowance	5,494,740	1,314,830	8,219,164	98,727	15,127,462
Amount Change	229,462	-88,166	89,182	-195	230,283
Percent Change	4.4%	-6.3%	1.1%	-0.2%	1.5%

Where It Goes:		**Change**
Regular and Contractual Personnel		**$13,602**
Contractual salaries and fringe benefits associated with a net increase of 130 positions		$9,989
Regular earnings, including a 2% general salary increase effective January 1, 2021, and a net reduction of 68 regular positions departmentwide		6,658
Retirement contribution		3,486
Turnover adjustments		3,364
Net impact of 2% cost-of-living adjustment effective January 1, 2020, including annualization in fiscal 2021		2,258
Fiscal 2021 State Law Enforcement Officers Labor Alliance increments and 4% salary increase effective July 1, 2020		219
Other regular fringe benefit adjustments		78
Overtime and additional assistance		-453
Reclassifications and miscellaneous adjustments		-5,054
Employee and retiree health insurance		-6,945
Major Programmatic Changes (Excluding Medicaid)		**$91,625**
Behavioral Health Administration	**$54,476**	
Provider rate increases (2%)		24,552
Substance use disorder pharmacy expenditures		11,608
Increase in applied behavioral health analysis		11,456
Increase in regulated rates for hospitals and residential providers of behavioral health.		11,224
Increased support for other community service grants for behavioral health needs		5,392
Administrative Services Organization contract expenditure		4,868
Increase in utilization across FFS programs for Medicaid and community services, partially offset by fiscal 2020 deficiency for Medicaid provider reimbursements		4,133
Deficiency appropriation to backfill funds reverted by the department for funds restricted for grants in the fiscal 2020 budget.		-2,650
Federal SOR grant – treatment		-16,108

Where It Goes:		**Change**
Developmental Disabilities Administration	**$51,149**	
Additional funding for services based on net traditional growth for new placements and expansion of services		26,000
Provider rate increases (2%)		25,149
Prevention and Health Promotion Administration	**-$27,456**	
Special Supplemental Nutrition Program for Women, Infants, and Children Program (federal funds)		14,158
Maryland AIDS Drug Assistance Program (special funds and federal funds)		447
Fiscal 2020 deficiency appropriation for the Breast and Cervical Cancer Diagnosis and Treatment Program		-813
Federal SOR grant – prevention		-5,517
HIV services (primarily special funds)		-35,731
Public Health Administration	**$4,367**	
Nonpersonnel spending of federal funds from the U.S. Centers for Disease Control and Prevention National Center for Injury Prevention and Control		5,542
Grant to the Maryland Hospital Association to improve medical surge capabilities of 46 acute care hospitals (federal funds)		3,200
Targeted Local Health Grant, excluding contractual health insurance and enhancement funding found under MDH Administration		925
Maryland Primary Care Program Project Management Office contracts, including reduction for fiscal 2020 deficiency		-923
Federal grant for Ebola preparedness and response activities ending in fiscal 2020		-1,877
Fiscal 2020 Regional Healthcare Coalition Emergency Preparedness Support concluding (federal funds)		-2,500
Professional Boards and Commissions	**$2,974**	
Maryland Medical Cannabis Commission expenditures, including increases for contractual employees, additional contracts, and $2.2 million for an enterprise licensing system		2,974
Regulatory Commissions	**$3,189**	
Increased support for CRISP from HSCRC, offset by loss of Maryland Health Insurance Plan funding for CRISP and other Integrated Care Network projects		4,200
Reduction in HSCRC database expenditures		-1,011
MDH Administration	**$2,926**	
Executive direction, driven by a new $500,000 grant under the Office of the Secretary for the Amyotrophic Lateral Sclerosis Association		1,189
Procurement expenditures due to anticipated cost savings achieved through contract negotiations in fiscal 2020 not yet available in fiscal 2021		886
Statewide personnel system allocation assessed to the department		852
Medicaid/Medical Care Programs Administration		**$125,654**
Provider rate increases		98,134
Major Information Technology Development Projects (federal funds)		39,642

Where It Goes:	**Change**
Enrollment and Utilization	18,437
Money Follows the Person	18,362
Community First Choice (enrollment, utilization, and administration excluding rate increase)	17,361
Medicare Part D Clawback payments	4,658
Assistance to rural pharmacies	3,000
Federally Qualified Health Centers supplemental payments	2,419
Health Home payments	1,943
Graduate Medical Education Payments	1,774
Systems Software	1,495
Initiatives: Integration of health homes into the Primary Care model and support in collaborative care	1,089
Kidney Disease Program	755
Pharmacy administrative contracts (primarily lower costs with Point of Service system)	-1,272
Costs associated with Long-term Support Services system	-1,729
Senior Prescription Drug Assistance Program (special funds)	-2,752
Health information technology payments	-3,700
Program recoveries	-6,970
Maryland Children's Health Program (lower enrollment)	-7,432
Medicare A and B premium assistance	-11,203
Pharmacy rebates	-48,357
Other	**-$599**
Total	**$230,283**

CRISP: Chesapeake Regional Information System for Our Patients
FFS: fee-for-service
HSCRC: Health Services Cost Review Commission
MDH: Maryland Department of Health
SOR: State Opioid Response

Note: Includes fiscal 2020 deficiencies and statewide personnel funding with exception to salary increases for certain class codes that were adjusted upward as part of the annual salary review (ASR). The ASR adjustment applies to State employees under the developmental disabilities associate, direct care, licensed practical nurse, social worker, and other series. For the purpose of this chart, FFS community behavioral health expenditures for Medicaid recipients are shown under the Behavioral Health Administration (BHA) as opposed to Medicaid where they are budgeted. Numbers may not sum to total due to rounding. **Appendix 2** of this document provides selected caseload measures that partially explain some of the enrollment and utilization changes in the budgets for BHA, the Developmental Disabilities Administration, and the Medical Care Programs Administration.

Source: Governor's Fiscal 2021 Budget Books; Department of Legislative Services

Fiscal 2021 Contingent Actions
($ in Millions)

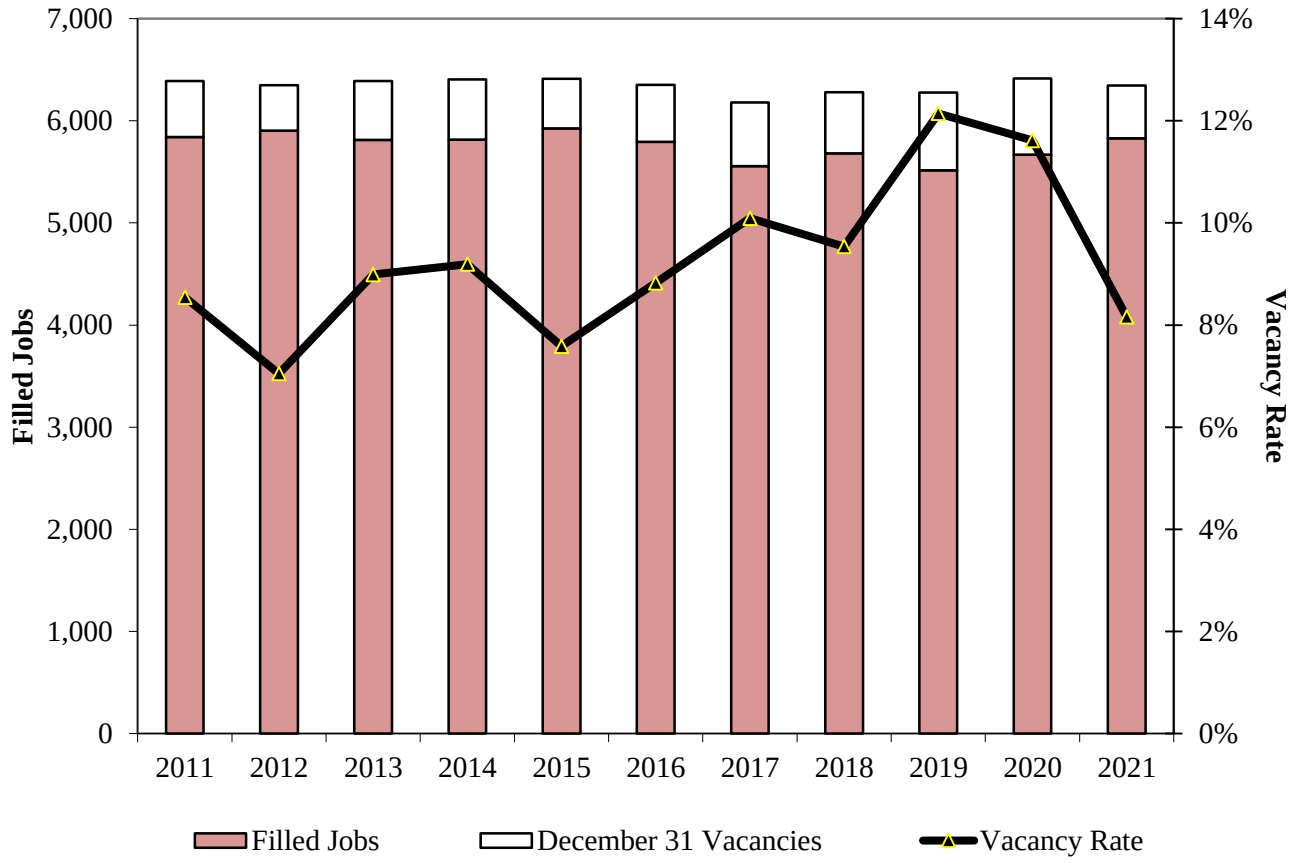
Program	Item	General Funds	Federal Funds	Total Funds
Behavioral Health Administration	Reduce the mandated provider rate increase from 4% to 2%.	-11.1	-13.0	-24.1
Developmental Disabilities Administration	Reduce the mandated provider rate increase from 4% to 2%.	-13.3	-11.8	-25.1
Medical Care Programs Administration	Reduce the mandated provider rate increase from 4% to 2%.	-15.1	-19.2	-34.3
Medical Care Programs Administration	Replace general funds with special funds by limiting the statutory reduction in the hospital deficit assessment.	-10.0		0.0
Fiscal 2021 Contingent Reductions Total		**-49.5**	**-44.1**	**-83.6**

Source: Budget Reconciliation and Financing Act of 2020; Governor's Fiscal 2021 Budget Books

Personnel Data

The following two charts present departmentwide regular employee vacancy rates compared to authorized and filled positions. **Appendices 3** and **4** provide further detail into the changes in regular and contractual personnel by program from the fiscal 2019 actual to fiscal 2021 allowance.

Regular Employee Filled Jobs and Vacancy Rates
Fiscal 2011-2021



Note: Fiscal 2021 vacancy rate is based on budgeted turnover.

Source: Maryland Department of Health; Department of Legislative Services

Regular Employees – Vacancy Rates
December 31, 2019

	FTE Vacancies	FTE Positions	Vacancy Rate
MDH Administration	346.90	3530.90	9.8%
Office of Health Care Quality	20.00	211.00	9.5%
Health Occupations Boards	40.50	272.60	14.9%
Public Health Administration	53.00	422.00	12.6%
Prevention and Health Promotion Administration	73.50	468.60	15.7%
Behavioral Health Administration	18.50	131.90	14.0%
Developmental Disabilities Administration	118.05	650.75	18.1%
Medical Care Programs Administration	64.60	623.50	10.4%
Health Regulatory Commissions	10.00	103.90	9.6%
Total Regular Positions	745.05	6,415.15	11.6%

FTE: full-time equivalent
MDH: Maryland Department of Health

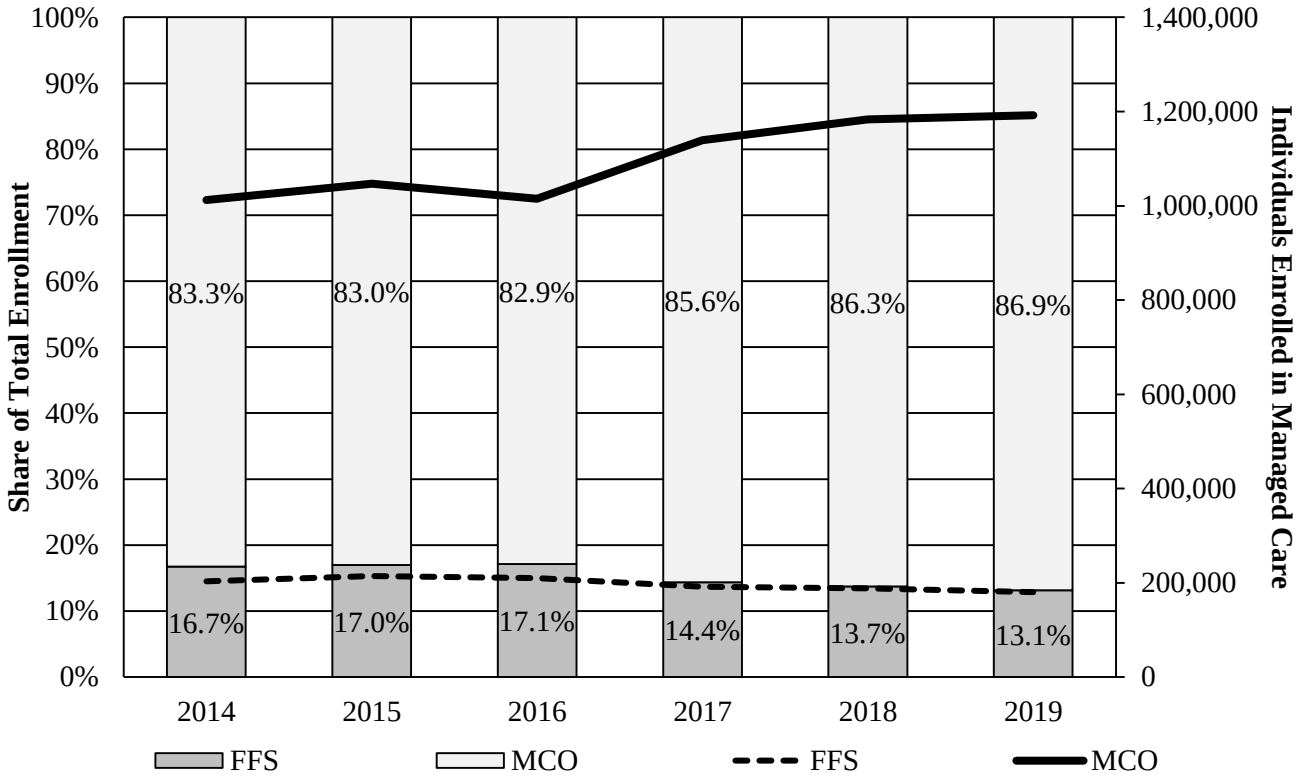
Source: Department of Budget and Management

Issues

1. Measures of Managed Care Organizations Access and Quality Performance

As shown in **Exhibit 1**, most of Maryland's Medicaid enrollees receive services through MCOs in the HealthChoice program. In exchange for capitated payments that are adjusted annually, MCOs deliver care to a significant portion of Maryland's total population. Given the number of Marylanders receiving care in HealthChoice, ongoing monitoring of access to and the quality of services received by Medicaid recipients is important.

Exhibit 1
Medicaid and Maryland Children's Health Program
Enrollment in Managed Care
Fiscal 2014-2019



FFS: fee-for-service
MCO: managed care organization

Source: Maryland Department of Health; Department of Legislative Services

Access to Care

Under federal rules, the HealthChoice program requires a choice of at least two MCOs in any jurisdiction, unless a region has been officially defined as a rural area. As shown in **Exhibit 2**, every jurisdiction has at least four MCOs open for enrollment for calendar 2020. As of January 1, 2020, there were also four MCOs operating statewide (Aetna, Amerigroup, Maryland Physicians Care, and Priority Partners). Detailed MCO coverage is included in **Appendix 5**.

Compared to calendar 2019, four jurisdictions have more MCOs open for enrollment in calendar 2020: Baltimore City and Calvert, Caroline, and Charles counties. It is interesting to compare calendar 2020 to calendar 2013 for example. There are now nine MCOs in the marketplace compared to only seven, and enrollees in all jurisdictions have more choice in which MCO to enroll. For example, in calendar 2013, nine jurisdictions had only two MCOs open for coverage, and six jurisdictions had only three. As noted, the minimum is now four in every jurisdiction.

The HealthChoice program has certain network adequacy requirements for primary and specialty care. For primary care, the program requires every participant to have a primary care physician (PCP), and each MCO must have enough PCPs to serve its enrollees. Regulations require a ratio of one PCP for every 200 participants within each of the 40 local access areas in the State. Ratios for certain high-volume providers can be higher. The latest HealthChoice evaluation was published in July 2019 and covers the period of calendar 2013 through 2017. The evaluation includes two measures of PCP network adequacy: 200 and 500 participants per PCP office. The data aggregates across all MCOs and does not allow a single provider that contracts with multiple MCOs to be counted twice. In this regard, it is a higher standard than that in regulation.

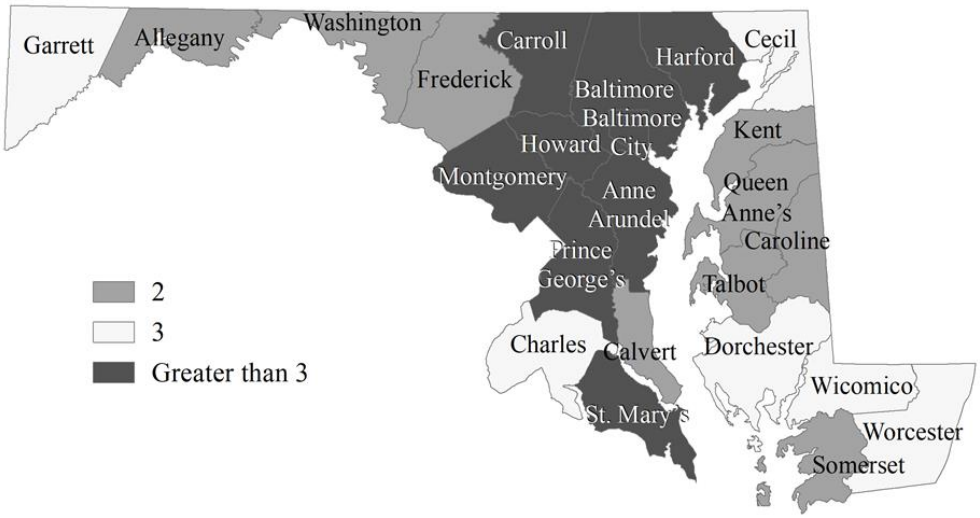
In calendar 2017, only one jurisdiction was unable to meet the more stringent 1:200 provider to participant ratio: Prince George's County. However, the ratio for Prince George's County can be misleading as participants can receive care from PCPs in neighboring Washington, DC that are not captured in the physician data. Nevertheless, as discussed below, other measures reported by MCOs do indicate some access issues.

Medicaid has increased its network adequacy validation efforts since 2015 because of the focus on network adequacy in the recently revised MCO regulations. Efforts include provider phone surveys and matching up provider responses against online provider directories. As a result, all MCOs have had to submit corrective action plans to correct PCP details in online directories.

In a survey of 1,319 PCPs listed in MCO directories that were contacted as part of a validation test in calendar 2017, 66% were successfully reached with the other 34% having an incorrect phone number, incorrect address, or were no longer with the facility listed. Most, 94%, confirmed that they accepted the MCO listed, and 84% were accepting new patients. MCOs also met compliance with routine and urgent care appointment requirements 89% and 67% of the time, respectively.

Exhibit 2
Managed Care Organizations Open for Enrollment by Jurisdiction
Calendar 2013 and 2020

Calendar 2013



Calendar 2020

Note: As reported January 1, 2013, and January 1, 2020.

Source: Maryland Department of Health; Department of Legislative Services

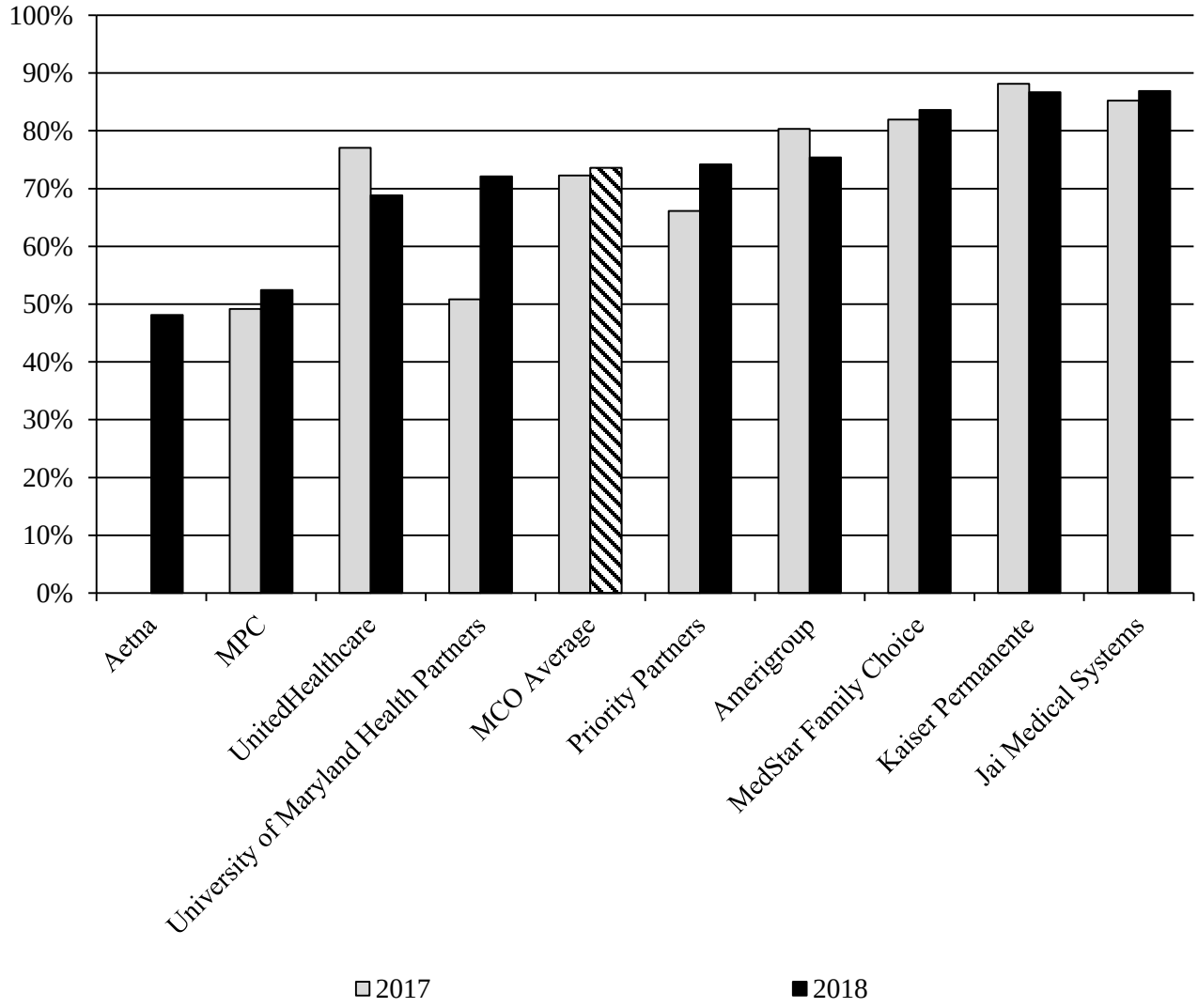
MCO Quality Performance

The department conducts numerous activities to review the access to, and quality of, services provided by MCOs participating in HealthChoice. One such activity is the review of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is developed by the National Committee for Quality Assurance (NCQA) to measure health plan performance for comparison among health systems. This tool is used by more than 90% of health plans across the country. The HEDIS data collected by the department includes 45 different measures, some of which have multiple components. A slightly smaller set of measures/components than those actually collected are used by the department for MCO quality monitoring. The data presented below is generally drawn from the smaller data set used by the department.

Historically, Maryland's MCOs collectively outperform their peers nationally. In calendar 2018, Maryland MCOs outperformed their peers nationally on 73.6% of the HEDIS components examined by the Department of Legislative Services (DLS), a slight improvement from calendar 2017 (72.3%). While the specifics of the HEDIS components being measured are slightly different from year to year, three MCOs (Kaiser Permanente, Amerigroup, and UnitedHealthcare) saw relatively lower performance compared to the national HEDIS mean. The most significant improvement was shown by University of Maryland Health Partners. The newest MCO, Aetna, has data only in calendar 2018, and as is often the case as a new MCO, has relatively poor performance relative to the national HEDIS mean.

Exhibit 3 shows the percentage of measures above the national HEDIS mean for those components for which a national HEDIS mean was available and for which an individual MCO had a HEDIS score.

Exhibit 3
Percent of Measurable Components Above National HEDIS Mean
Calendar 2017 and 2018



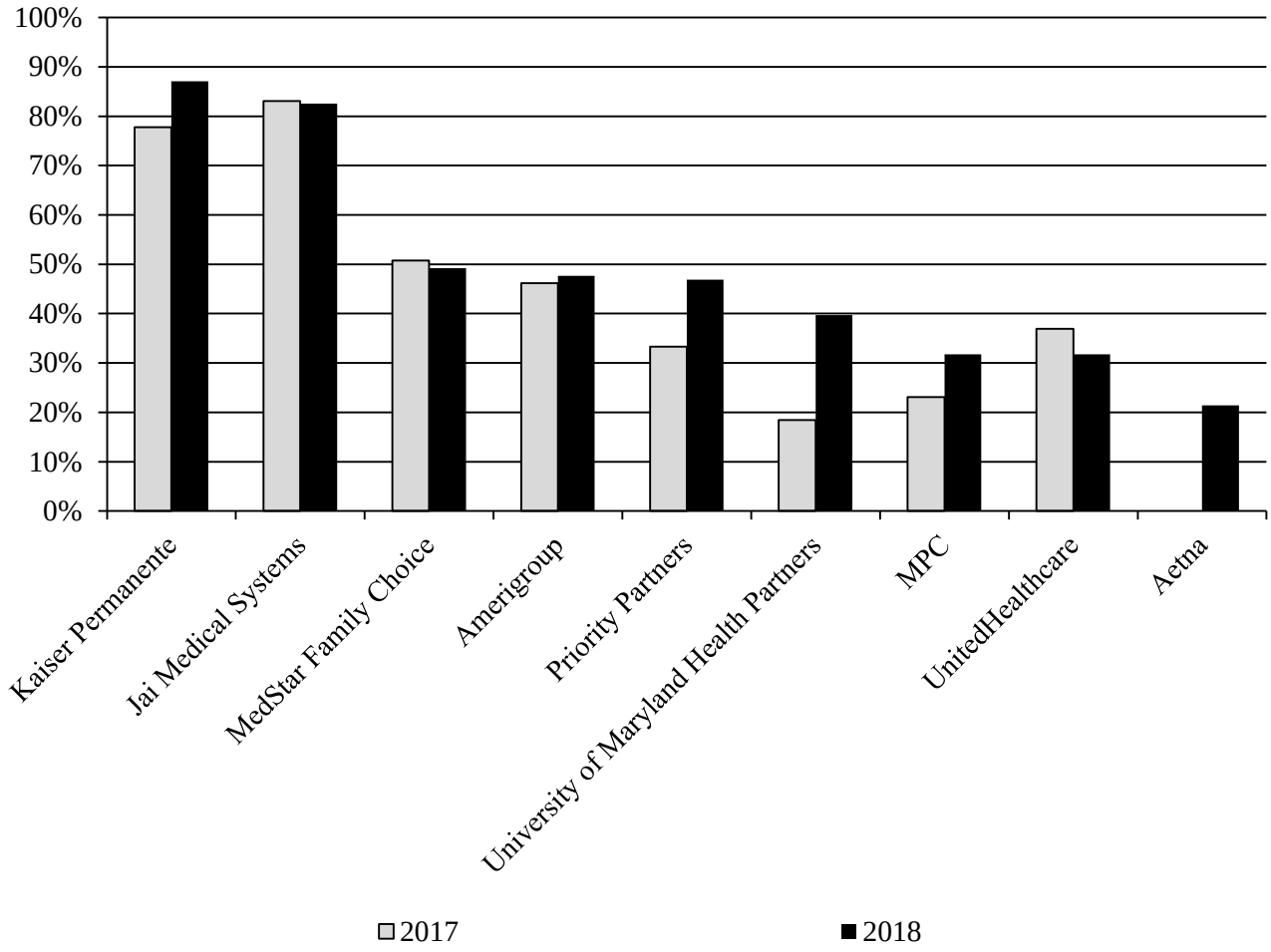
HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care

Note: A number of the HEDIS measures/components used in the analysis were not applicable to certain MCOs based on the small number of patients included in the measure/component. For the purpose of calculating relative performance, those measures are excluded for that MCO.

Source: Maryland Department of Health; MetaStar, Inc.; Hilltop Institute; Department of Legislative Services

Exhibit 4 shows the percent of components for which each MCO scored above the average score for all of the HealthChoice MCOs.

Exhibit 4
Percentage of Each MCO HEDIS Components Above the Maryland MCO Average
Calendar 2017 and 2018



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Source: Maryland Department of Health; MetaStar, Inc.; Department of Legislative Services

Comparisons between calendar years are imperfect because of the variance in the data set. Nevertheless, the following general observations can be made.

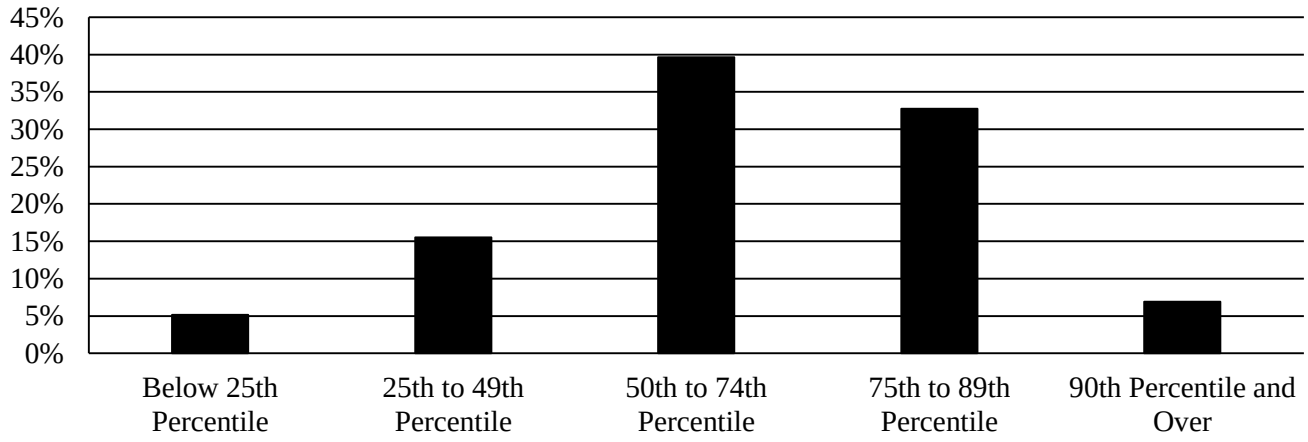
- Jai Medical Systems and Kaiser Permanente continue to perform at superior levels and are recognized by NCQA as such, both receiving the highest accreditation level possible.

- All but three MCOs saw an improvement in the percentage of measures with scores above the Maryland MCO average between calendar 2017 and 2018. In part, this is due to calendar 2018 including Aetna in the data, which, as noted above, struggled with its relative HEDIS performance.

- The most significant improvement over the prior year was shown by University of Maryland Health Partners, with 40% of its measures above the statewide average. This represents a continuance of the improvement shown over prior years, improvement that was closely monitored by Medicaid. It would be expected that similar oversight will be shown to Aetna moving forward.

A final measure of quality is shown in **Exhibit 5**. This exhibit charts overall HealthChoice performance on 58 HEDIS components against NCQA's benchmark rates (measurement of percentile performance for all Medicaid reporting organizations rather than just the national HEDIS mean). As would be expected, given that Maryland's MCOs generally outperform other MCOs, in most of the measures, HealthChoice's performance is generally skewed to the higher benchmarks.

Exhibit 5
Performance of HealthChoice Measured Against NCQA Benchmarks
Calendar 2018



NCQA: National Committee for Quality Assurance

Source: Maryland Department of Health; MetaStar, Inc.; Department of Legislative Services

However, it is interesting to note that in some areas, HealthChoice's scores are relatively poor. Three fall below the twenty-fifth percentile benchmark: adults' aged 20 to 44 access to preventive/ambulatory health services; persistence of beta-blocker treatment after a heart attack; and statin therapy for patients with diabetes who stay on therapy for at least 80% of the treatment period. Other measures that fall below the fiftieth percentile benchmark include those related to medication management for people with asthma, access to primary care practitioners both for children ages 12 to 24 months and 25 months to six years, and eye exams performed as part of comprehensive diabetes care.

Importantly, some of these areas of relative weakness are targeted in Medicaid's value-based purchasing (VBP) program that traditionally has placed up to 1% of an MCO's capitated program at risk depending on meeting certain performance targets. In calendar 2018, for example, access to care for children and certain adult groups as well as asthma management was part of the VBP program.

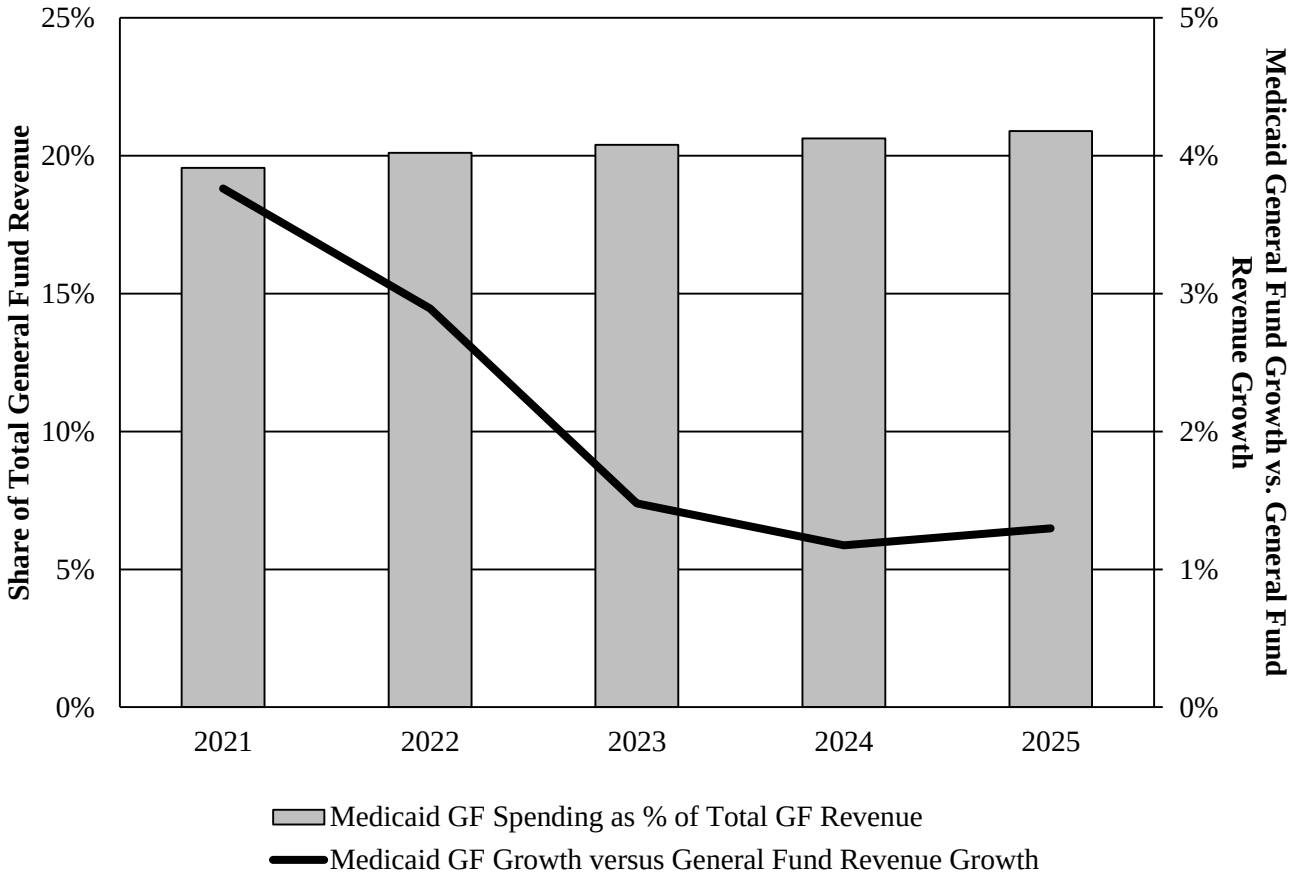
2. Establishing Savings Goals for Medicaid

Outside of local aid, Medicaid is the largest driver of State general fund spending. In recent years, Medicaid has usually been the largest dollar contributor to general fund spending. As a result, Medicaid general fund spending as a share of total general fund spending has gradually increased over the last 10 years, from just over 13% to just under 20% in fiscal 2021. That increase reflects the significant growth in the program over that time with enrollment almost doubling due to the impact of the last recession and the State's decision to expand Medicaid as authorized by the Affordable Care Act (ACA). This despite a substantial number of those new enrollees being supported by an enhanced federal matching rate.

As shown in **Exhibit 6**, Medicaid spending as a percentage of total general fund spending is expected to increase but only slightly between fiscal 2021 and 2025. Over the forecast period, general fund growth in Medicaid is significantly above general fund revenue growth, although the gap narrows toward the end of the forecast period. This forecast of Medicaid growth is based on flat or marginally declining enrollment, relatively flat utilization, and cost growth of below 4%, arguably the most favorable Medicaid forecast that could be anticipated in the next five years.

Despite this, DLS is still forecasting significant out-year general fund deficits, rising to $1.3 billion in fiscal 2025. Given the interest in expanding local aid, in particular Aid to Education, absent significant new revenues, Medicaid will be looked to as a source of general fund savings. In Maryland, holding down general fund expenditure growth in Medicaid has generally involved limiting provider rate increases, such as contained in the fiscal 2021 budget, as well as seeking additional sources of special fund revenues, or at the very least, slowing down planned reductions in special fund revenues such as the proposed scaling back of the Medicaid Deficit Assessment in the Budget Reconciliation and Financing Act (BRFA) of 2020. There has been little appetite to scale back the benefit package (in fact, small benefits have been added such as adult hearing aids and a pilot adult dental benefit) or reduce eligibility.

Exhibit 6
Medicaid General Fund Need and General Fund Revenues
Fiscal 2021-2025



GF: general fund

Source: Department of Budget and Management; Department of Legislative Services

If policymakers want to avoid resorting entirely to those traditional cost containment strategies, efforts must be undertaken to change the way Medicaid services are delivered. As a tool to promote service delivery change, in each of the past two sessions, language has been adopted requiring the department and the Health Services Cost Review Commission (HSCRC) to develop 5- and 10-year Medicaid-specific cost-savings targets, including a reduction in total hospital costs and total cost-of-care costs as well as quality measures (Chapter 10 of 2018 and Chapter 565 of 2019). To date, while MDH has been responsive in submitting reports analyzing trends in Medicaid HealthChoice (managed care) and fee-for-service (FFS) expenditures as well as noting various strategies that the agency has implemented, is in the process of implementing, or has begun preliminary conversations about that could generate savings in Medicaid, it has not established specific targets.

In choosing not to set specific targets in the HealthChoice program, MDH argued that, while it can implement changes to the rate-setting process and quality outcomes that increase efficiency, it cannot set arbitrary savings targets because of the need to pay actuarially sound rates. MDH also notes efforts made within the HealthChoice program to limit costs (for example, the calendar 2020 outlier adjustment methodology) and the impact on HealthChoice costs of enrollment trends that are outside of its control as well as the impact of key investments on costs (for example, coverage of new Hepatitis C treatments).

It should be noted that the intent of the language in both Chapter 10 and Chapter 565 was not to set arbitrary targets but rather targets based upon expectations of health care trends as well as expectations of general fund availability. The Administration already makes decisions annually on the precise level of managed care rates, and it has chosen rates at, or near the bottom of, the rate range with regularity; a decision driven by the need to constrain general fund spending. While acknowledging the efforts made to improve efficiency in the HealthChoice program, DLS would note that MDH itself commissioned a report on ways to further improve efficiency and the many recommendations of that report indicate further improvement is possible.

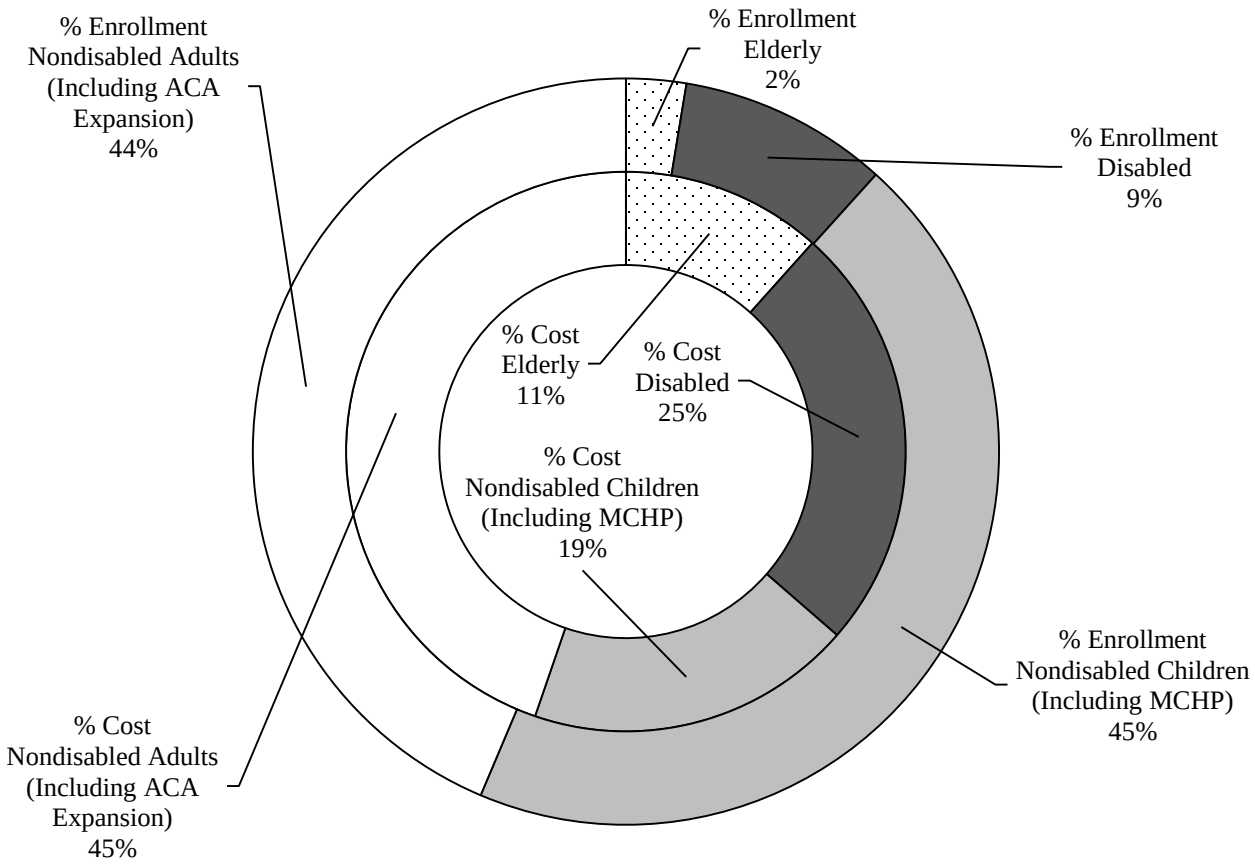
Further, one of the reasons to establish long-term spending targets is so that the savings from the large investments that MDH is making in Hepatitis C treatment for example, or even the more modest investment in diabetes treatment contained in the fiscal 2020 budget, can be seen to bear fruit. Tracking those benefits provides key support for appropriate future investments. Finally, the need to discount the impact of enrollment on cost is self-evident.

Similarly, no targets are included for FFS programs. The department acknowledges that targeting expenditures in these areas has broader potential. Indeed, this can be demonstrated in **Exhibit 7**. In this exhibit, services to the elderly and disabled adults that are almost all delivered FFS consume over one-third of total Medicaid expenditures even though these individuals only account for around one-tenth of total enrollment.

MDH offers the example of working with HSCRC to monitor the impact of HSCRC programs within the dually eligible population (enrollees eligible for Medicaid and Medicare). However, it also notes that increases in spending often relate to investments in services; residential SUD treatment and community-based long-term care are specifically mentioned. In addition, rates for FFS providers have been impacted by legislation such as Chapters 10 and 11 of 2019 (the minimum wage bill), adding costs to the program, although, as noted above, these are costs that the Administration is attempting to control in fiscal 2021.

DLS would again note that investments in residential SUD and community-based long-term care can yield long-term savings. Indeed, trends in nursing home per capita utilization have been declining at the same time that Maryland's investment in community-based alternatives has increased, moderating overall spending growth. DLS concurs that the impact of legislation, such as Chapters 10 and 11, and other factors outside of the control of MDH, can drive costs. That is why forecasts can change and why targets that are established can also change or the failure to meet those targets are explained.

Exhibit 7
Medicaid – Relative Cost by Enrollment Category
Fiscal 2019



ACA: Affordable Care Act
MCHP: Maryland Children's Health Program

Note: Includes Medicaid Behavioral Health Expenditures.

Source: Maryland Department of Health; Department of Legislative Services

Moving forward, the legislature needs to decide if it wants to pursue the idea of establishing broad-based spending targets for Medicaid and requiring MDH to do so. As currently envisaged, the idea of targets was simply to heighten awareness of the increasing stress that Medicaid will place on the General Fund. There is no mechanism in place to require that those targets be met, but it puts in place a general framework in which decisions about Medicaid can be discussed and made by both the Executive Branch and the legislature. The concern is that, without some kind of growth target, efforts to change the delivery of services to achieve cost savings could stall, especially toward the end of the second term of the Administration.

Given the time and effort involved in making structural programmatic changes in Medicaid, the hope is that establishing spending targets can be a lever to reinforce efforts to make these changes. In that way, the State can better respond to changes in economic conditions or the need to support other funding priorities rather than to continue to rely on the limited tools currently available to it.

3. Two Recent Studies Highlight Worsening Health Disparities Based on Income, Race, and Geography in Maryland

In addition to directly impacting health outcomes for Medicaid enrollees in the HealthChoice Program, MDH strives to improve population health indicators statewide as the central entity regulating the health care delivery and public health systems in Maryland. There are undoubtedly social determinants of health, population-level trends, and systemic obstacles to healthcare outside of MDH's control that affect trends in statewide health outcomes. Still, it is important to consider whether the department's existing programs and strategies effectively mitigate adverse systemwide trends, such as the stark disparities in health care access and outcomes based on income, race, or geography.

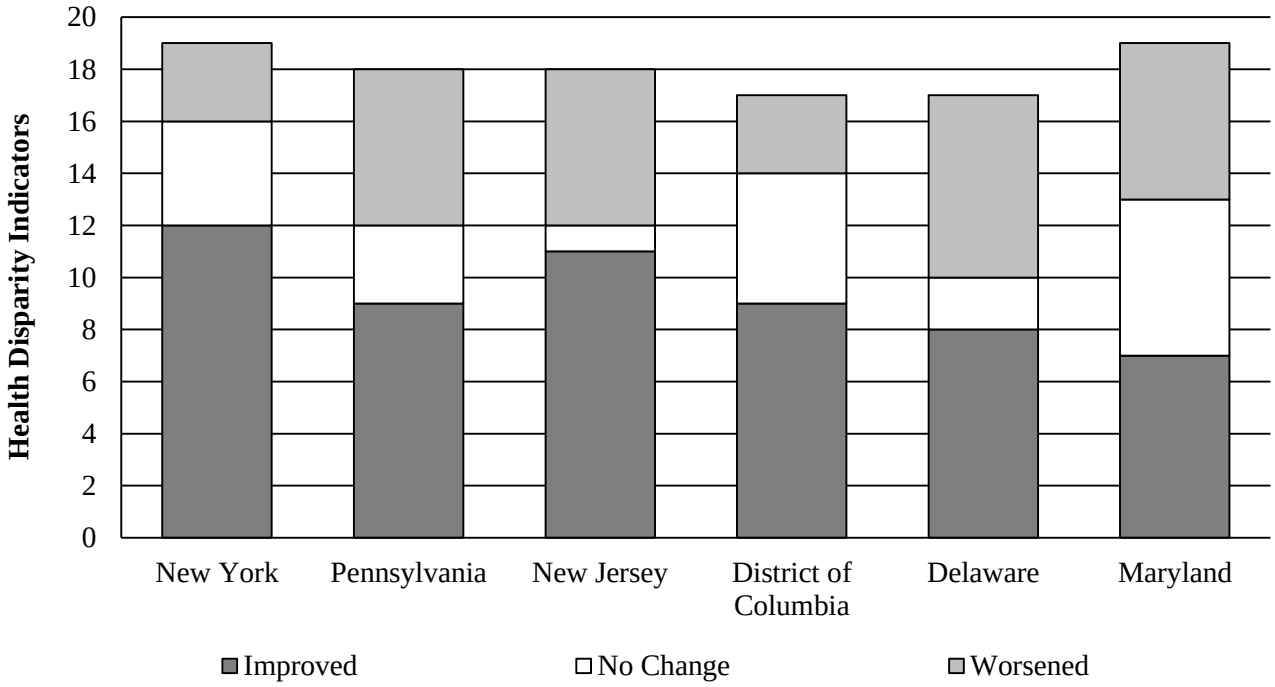
Consistent with national trends, many statewide health measures persistently show that non-Hispanic African Americans and individuals with lower household income have worse health outcomes relative to non-Hispanic whites and individuals with higher household income. According to two 2019 studies that examined statewide health indicators, Maryland appears to either show no change or worsening disparities in a range of measures related to insurance status, age-appropriate cancer screenings and vaccines, and infant mortality, among others.

Commonwealth Fund 2019 Scorecard on State Health System Performance

In June 2019, the Commonwealth Fund published its annual Scorecard on State Health System Performance that compares and ranks States on measures related to access to care, quality of care, health outcomes, and health disparities based on income at the State level. To evaluate states' health disparities among different income brackets, the Commonwealth Fund calculated the difference in 19 health indicators between individuals with household income under 200% of the federal poverty guidelines (FPG) and those with incomes 400% of FPG or more. The report then assessed the change over time using mostly calendar 2017 actual data and comparing the measures to a baseline year ranging from 2012 to 2016. Maryland's state disparity indicator data can be found in **Appendix 6**.

While the Commonwealth Fund found that Maryland received an overall ranking of 18 out of 51 states (including the District of Columbia) and 2 out of 6 Mid-Atlantic States, Maryland received a ranking of 35 and 6, respectively, for disparities based on income. As shown in **Exhibit 8**, Maryland was ranked last out of Mid-Atlantic States and had the lowest number of improved indicators. This is a sharp contrast to the other dimensions that the Commonwealth Fund studied as Maryland was ranked equal to or better than the U.S. average for overall rank, access and affordability, prevention and treatment, avoidable hospital use and cost, and healthy lives.

Exhibit 8
Changes in Income Disparity Measures Over the Baseline Year among Mid-Atlantic States
Calendar 2017 Compared to a Baseline Year[1]



[1] For the majority of State disparity indicator data, 2017 actual measures were compared to a 2013 baseline. However, due to data availability, some indicators use a range between 2014 to 2016 data and compare it to 2012 data as the baseline.

Note: The Commonwealth Fund measures improvement as the disparity between higher-income and low-income populations narrowing. An indicator was considered to have no change if it showed a change of less than one-half standard deviation. The chart depicts states' rankings from left to right, with New York receiving the best disparity ranking.

Source: Commonwealth Fund 2019 Scorecard on State Health System Performance

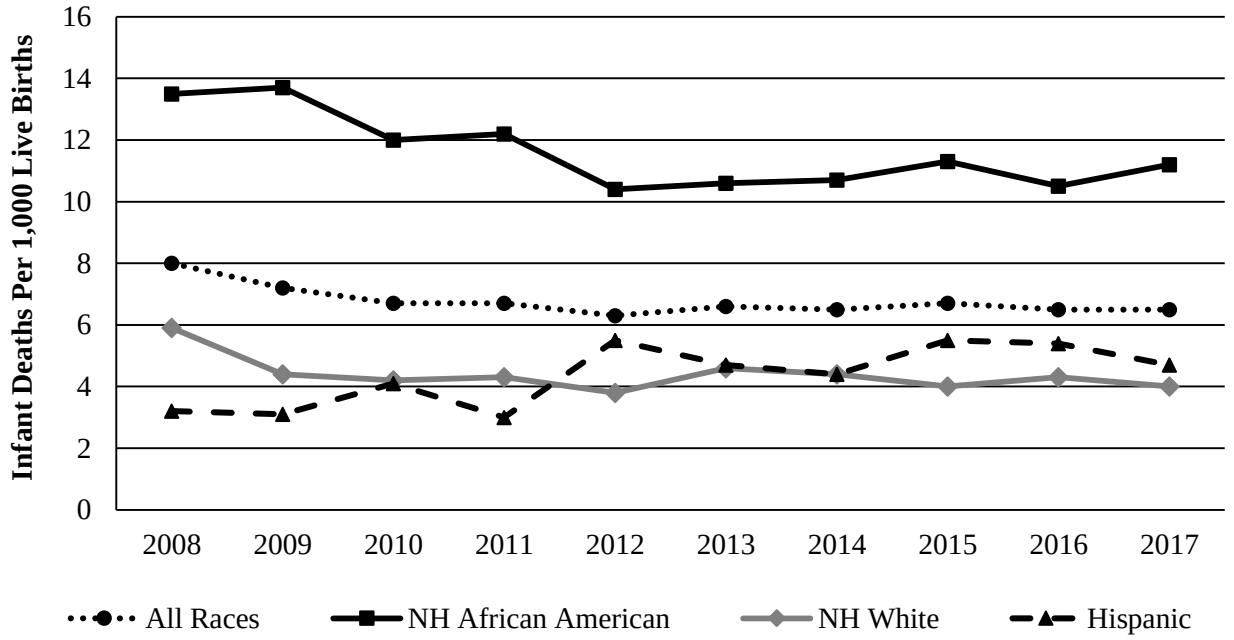
Study of Mortality Rates of African American Infants and Infants in Rural Areas

In November 2019, the Maryland Health Care Commission (MHCC), in consultation with multiple MDH divisions, including the Office of Minority Health and Health Disparities, the Maternal and Child Health Bureau, and the Vital Statistics Administration, submitted the findings of a study related to mortality rates of African American infants and infants in rural areas, as required by Chapters 82 and 83 of 2018. Infant mortality rates refer to the number of deaths under age one per 1,000 live births and are used to indicate the total health of populations.

To conduct the study, MHCC convened a workgroup of stakeholders and entered an agreement with the University of Maryland, College Park Campus School of Public Health to perform a literature review regarding factors beyond the known factors of low birth weight, teen pregnancy, poor nutrition, and lack of prenatal care that affect the mortality of African American infants and infants in rural areas in the United States and in the State.

MHCC found in its research that the overall infant mortality rate and racial disparities in the rate have not narrowed substantially since a 2011 epidemiological study focused on infant mortality in Maryland. As shown in **Exhibit 9**, since 2008, the infant mortality rate among non-Hispanic African Americans has remained above 10.0 infant deaths per 1,000 live births, and the difference from non-Hispanic whites has been 6.0 or higher. Between calendar 2008 and 2017, there was also a disparity among African Americans and Hispanics as the African American infant mortality rate remained at least 4.0 higher than that for Hispanics. Most recently, the 2017 disparity between non-Hispanic African Americans and other races worsened compared to 2016 as the Hispanic infant mortality rate decreased by 0.7, or 13.0%, the white infant mortality rate decreased by 0.3, or 7.0%, and the African Americans infant mortality rate increased by 0.7, or 6.7%.

Exhibit 9
Maryland: Infant Mortality Rates by Race
Calendar 2008-2017

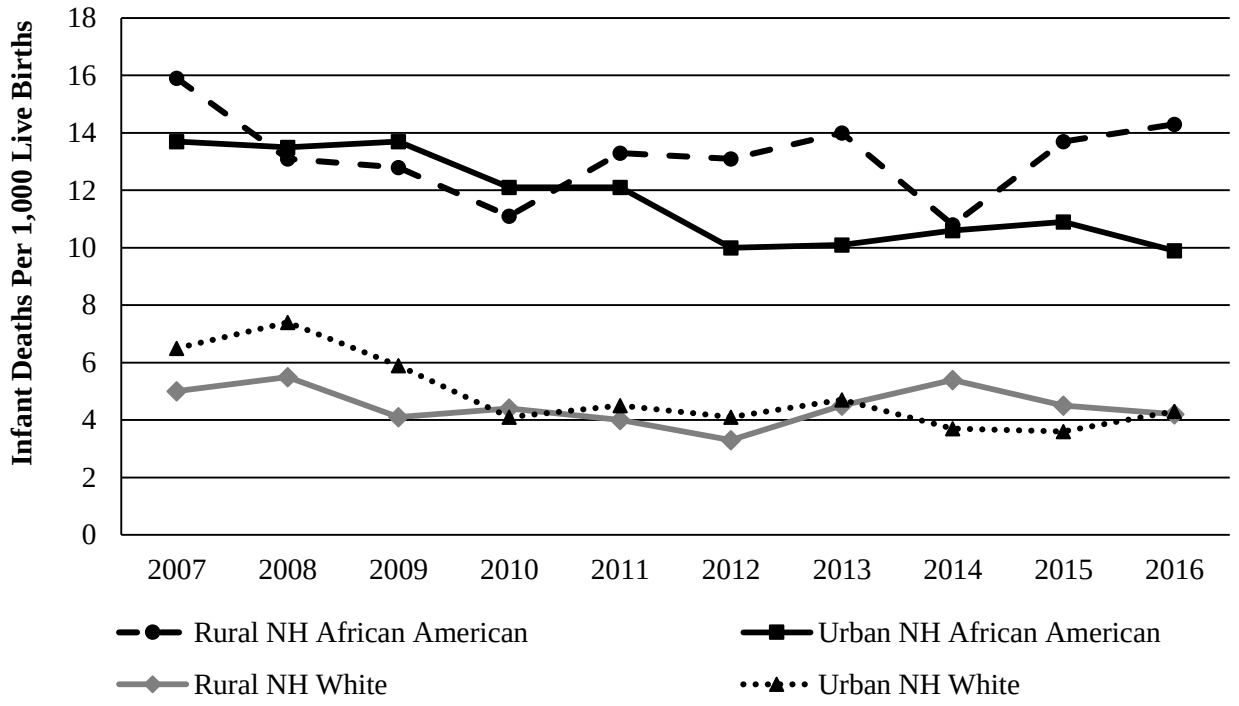


NH: non-Hispanic

Source: Maryland Health Care Commission; Vital Statistics Administration

When analyzing the difference in the infant mortality rate across geography, the study generally found that the overall infant mortality rate in urban areas was higher than that for rural areas. However, when stratifying the infant mortality rate by race and geography, rural non-Hispanic African Americans showed higher infant mortality rates than urban non-Hispanic African Americans in 7 of 10 years studied, as shown in **Exhibit 10**.

Exhibit 10
Maryland: Infant Mortality Rates by Race and Geography
Calendar 2007-2016



NH: non-Hispanic

Source: Maryland Health Care Commission; Vital Statistics Administration

To reduce the infant mortality rate among African American infants and rural infants, the stakeholder workgroup made the following 13 recommendations regarding care coordination, expanding and enhancing access and utilization of services, and the need for a sustained centralized focus on infant mortality.

Care Coordination

- Improving existing care coordination processes and tools;
- including programs in care coordination to address social determinants of health outcomes, including the impact of racism and bias;
- implementing rigorous implicit racial bias training in relevant health care providers' education and clinical practices;
- strengthening coordination of care by assessment and referral to necessary mental health and SUD treatment programs;
- improving continuity of care;
- increasing adoption of breastfeeding prior to hospital discharge and support continuation through the first year of life; and
- encouraging health care providers, community health workers, and other organizations to enhance patient education on pregnancy spacing.

Expanding and Enhancing Access and Utilization of Services

- Expanding and improving home visiting programs throughout the State to improve maternal and infant health and reduce infant mortality and disparities;
- increasing adoption of evidence-based group prenatal care programs;
- enhancing the use of telehealth to provide care in rural communities;
- encouraging State and local health agencies to invest in an infant mortality prevention health literacy initiative across sectors to create an informed and activated community of residents, health and social service providers, and facilities; and
- continuing investment in safe sleep education and increasing investment in safe sleep resources.

Need for a Sustained and Centralized Focus on Infant Mortality

- Establishing a permanent council focused on disparities in infant mortality and maternal mortality.

The department should discuss its current plan and timeline to implement any of the above recommendations. Considering the department's efforts to define statewide priorities, such as diabetes and substance abuse, and targets for the Total Cost of Care Model, MDH should also comment on how it will incorporate measures of health disparities by income and race to evaluate the progress toward narrowing the disparities across a variety of population health indicators.

4. Cigarette Restitution Fund: Delayed Ruling on Multistate Litigation Pushes Projected Budgetary Impact into Fiscal 2021

Background

The Cigarette Restitution Fund (CRF) was established by Chapters 172 and 173 of 1999 and is supported by payments made under the MSA. Through the MSA, the settling manufacturers pay the litigating parties substantial annual payments in perpetuity and conform to a number of restrictions on marketing to youth and the general public. Litigating parties include 46 states (Florida, Minnesota, Mississippi, and Texas had previously settled litigation), five territories, and the District of Columbia. The distribution of MSA funds among the states is determined by formula, with Maryland receiving 2.26% of MSA payments, which are adjusted upward for inflation and downward for volume and prior settlements.

The use of the CRF is restricted by statute. For example, at least 30% of the annual CRF appropriation must be used for Medicaid. Activities funded through the CRF in fiscal 2021 include the Tobacco Use Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment Program; substance abuse treatment and prevention; the Breast and Cervical Cancer Program; Medicaid; tobacco production alternatives; legal activities; and nonpublic school support.

The Nonparticipating Manufacturer Adjustment

One of the conditions of the MSA was that the states take steps toward creating a more "level-playing field" between participating manufacturers (PM) to the MSA (and thus subject to annual payments and other restrictions) and nonparticipating manufacturers (NPM) to the agreement. This condition is enforced through an additional adjustment to the states' annual payments, the NPM adjustment. PMs have long contended that NPMs have avoided or exploited loopholes in state laws that give them a competitive advantage in the pricing of their products. If certain conditions are met, the MSA provides a downward adjustment to the contribution made by PMs based on their MSA-defined market share loss multiplied by three. For the NPM adjustment to be applied, PMs must show that they experienced a demonstrable market share loss of over approximately 2%, that the MSA was a significant factor in that loss, and that a state was not diligently enforcing its qualifying statute (Chapter 169 of 1999 with subsequent revisions in the 2001 and 2004 sessions). The agreement allows PMs to pursue this adjustment on an annual basis.

Sales Year 2003 Arbitration Findings and Budgetary Impact

Litigation regarding the NPM adjustment started in 2005, beginning with the NPM adjustment for sales year 2003. Arbitration regarding the "diligent enforcement" issue for 2003 commenced in July 2010. Maryland was 1 of 15 states that did not settle with PMs during the arbitration process and was 1 of 6 states that were found to not have diligently enforced their qualifying statute. The arbitration panel found that Maryland lacked dedicated and trained personnel to conduct enforcement efforts and that the Comptroller's office, in particular, failed to meaningfully participate in enforcement efforts.

Based on the arbitration panel's finding, Maryland not only forfeited approximately $16 million that PMs placed in escrow for the 2003 sales year but, under the MSA arbitration framework, also saw its fiscal 2014 payment reduced by $67 million based on the panel's assessment that those states that settled before arbitration could not be found as nondiligent. Subsequent litigation reduced Maryland's fiscal 2014 payment loss to $13 million.

Those states that did settle with PMs realized a one-time cash windfall with the release of funds from disputed payment escrow accounts for sales years 2003 through 2012. However, under the terms of the settlement, PMs were given credit for future payments from those states (*i.e.*, reducing the payments to those states). Those states also had to enact new legislation and will be held to an enhanced standard in NPM adjustment disputes beginning in 2015.

Sales Year 2004 Ongoing Litigation and Potential Budgetary Impact

PMs sought a multistate arbitration related to sales year 2004 for Maryland and the other states that did not settle the 2003 sales year litigation. Arbitration on sales year 2004 began in fall 2018 with eight states involved. New Mexico could still be involved in the arbitration proceedings as a ninth state, but it has not joined due to litigation regarding its involvement in the current arbitration proceedings. Depending on the involvement of New Mexico in those proceedings, a decision may be forthcoming in fiscal 2020 but could be delayed further if, and when, New Mexico joins the arbitration.

While it is possible that the arbitration panel for Maryland could make its decision before New Mexico has concluded arbitration, Maryland's proceedings have recently been delayed due to the unexpected passing of one of the members of the panel in fall 2019. Maryland has selected a new judge to complete a review of the case and serve as the third panel member. The selected judge has not been formally approved yet and, at this point, the timing of a final ruling is largely uncertain, making any resulting budgetary impact unpredictable as well. Further, if there are winners and losers at arbitration, resolving payment amounts could also delay any beneficial or detrimental effect on Maryland's payments.

Sales Year 2005 and Beyond

It should be noted that for each disputed year since 2004, with some exceptions, an amount of Maryland's payments has been withheld and deposited into a disputed payments account. As of January 2020, there was approximately $223 million attributed to principal held on behalf of Maryland in this account. If the State were found to have diligently enforced the statute beginning in sales

year 2005 and in the following years, at least this amount could be realized in revenue. Alternatively, Maryland could forfeit these funds and see its payment adjusted downward in certain fiscal years if the State were found to be nondiligent, as was seen in fiscal 2014 for sales year 2003.

The timing of any additional or reduced funding will depend on whether PMs continue to pursue annual sales year litigation or whether they try and bring all states back into realignment by pursuing multi-year settlements with the states that are currently in arbitration. Individual states could also affect funding availability depending on the strategies they decide to pursue. Both sides will more easily determine future arbitration strategies once the current round of arbitration for sales year 2004 is resolved.

Fiscal 2019 to 2021 CRF Programmatic Support

Exhibit 11 provides CRF revenue and expenditure detail for fiscal 2019 to 2021. Settlement payments have declined by 3.9% over the period shown, primarily as a result of the downward adjustment for volume reduction being greater than the upward adjustment for inflation. The volume of cigarettes sold is projected to continue declining in Maryland in line with national trends of declining cigarette consumption overall in recent years. Chapter 396 of 2019 likely reduces the volume of cigarettes sold further, beginning in fiscal 2020, as it raises the minimum age from 18 to 21 for an individual to purchase or be sold tobacco products among other actions relating to tobacco products effective October 1, 2019.

Despite reduced settlement payments, total revenues in fiscal 2021 increase compared to fiscal 2020 due to the Administration's assumption that the State will prevail in the 2004 sales year arbitration proceedings, yielding approximately $16.0 million. This was an assumption made in each of the last three fiscal years (fiscal 2018 to 2020). As described above, the current status of the arbitration is uncertain, both in what the final ruling will be and when any payment amounts would be resolved. In projecting that the fiscal 2020 payment will now not occur until fiscal 2021, there is a fiscal 2020 deficiency appropriation reducing CRF support for Medicaid and replacing it with general funds.

Programs supported from the CRF have been relatively unchanged for a number of years with certain exceptions, and the proposed 2021 budget is little different. Changes of note include:

- The CRF appropriation for alcohol and substance abuse treatment and prevention programs has increased for the first time since fiscal 2017, by $3.6 million.

- The Administration has increased funding for nonpublic schools by $3.4 million to a total of $16.3 million. Specifically, funding for the Broadening Options and Opportunities for Students Today Program increases from $6.6 million to $10.0 million.

- Medicaid funding increases by $2.6 million after taking into consideration the withdrawal of $16.0 million from fiscal 2020 included as a deficiency in the fiscal 2021 budget. Due to the uncertain timing and the result of the 2004 sales year arbitration, any beneficial or detrimental

budgetary impact could occur in fiscal 2020, 2021, or beyond. Historically, any shortfalls in anticipated CRF revenue are accounted for in Medicaid support.

- Estimates for legal expenses increase by $527,685 in fiscal 2021 as a result of the delays in the arbitration proceedings related to sales year 2004.

Exhibit 11
Cigarette Restitution Fund Budget Allowance
Fiscal 2019-2021
($ in Millions)

	2019 Actual	2020 Allowance	2021 Allowance
Beginning Fund Balance	$7.2	$4.5	$1.0
Settlement Payments	154.0	151.1	149.1
NPM and Other Shortfalls in Payments[1]	-22.1	-21.5	-21.5
Awards from Disputed Account	0.0	0.0	0.0
Other Adjustments[2]	5.3	5.3	5.3
Tobacco Laws Enforcement Arbitration	0.0	0.0	16.0
Subtotal	***$144.5***	***$139.4***	***$149.9***
Prior Year Recoveries	$2.5	$2.5	$2.5
Total Available Revenue	**$147.0**	**$141.9**	**$152.4**
Health			
Tobacco Enforcement, Prevention, and Cessation	$9.4	$9.7	$9.7
Cancer	24.9	27.1	27.1
Substance Abuse	21.5	21.5	25.1
Breast and Cervical Cancer	13.2	13.2	13.2
Medicaid[3]	62.4	54.7	57.3
Subtotal	***$131.5***	***$126.1***	***$132.4***
Other			
Aid to Nonpublic Schools	$7.4	$12.9	$16.3
Crop Conversion	1.9	1.0	0.9
Attorney General	1.6	0.9	1.5
Subtotal	***$11.0***	***$14.8***	***$18.7***
Total Expenses	**$142.5**	**$140.9**	**$151.0**
Ending Fund Balance	**$4.5**	**$1.0**	**$1.3**

NPM: nonparticipating manufacturer

[1] The NPM adjustment represents the bulk of this total adjustment.
[2] National Arbitration Panel Award.
[3] Medicaid funding for fiscal 2020 includes a reduction of $16.0 million proposed in the fiscal 2021 budget.

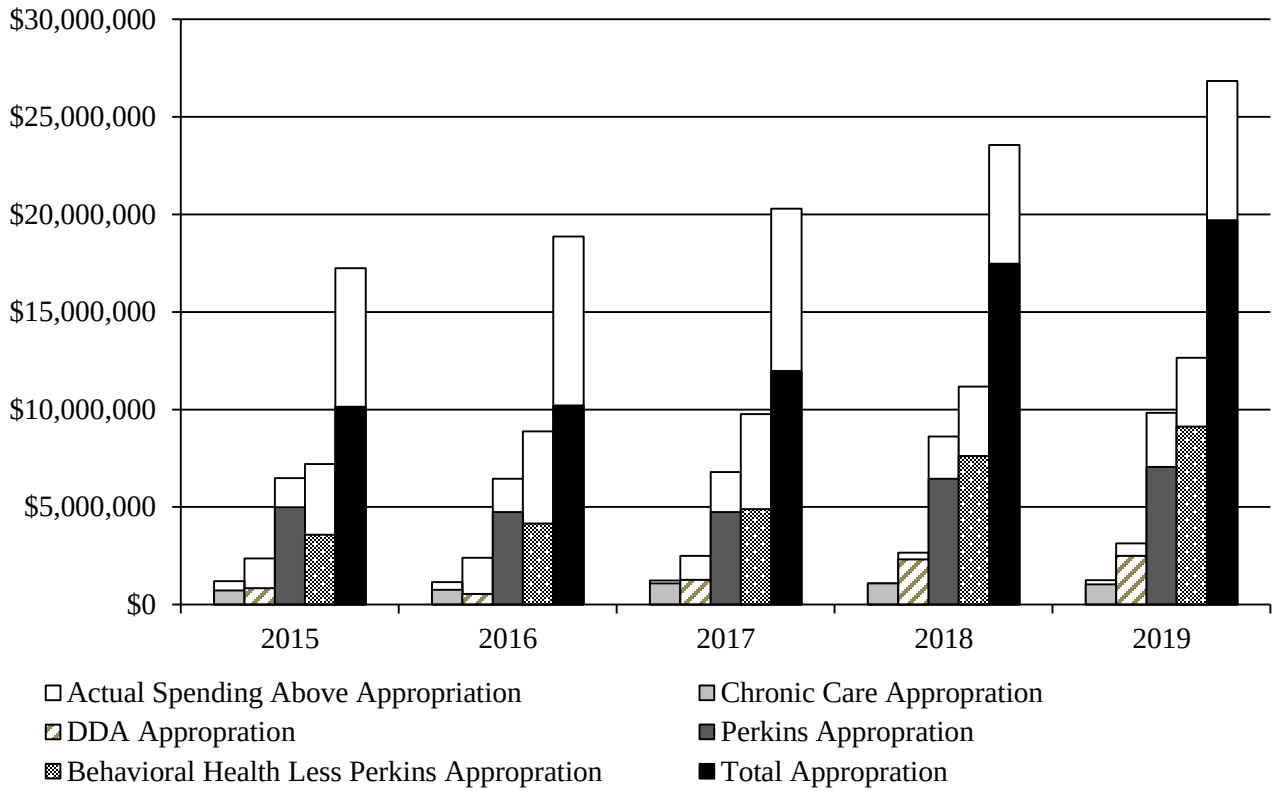
Note: Numbers may not sum to total due to rounding.

Source: Governor's Fiscal 2021 Budget Books; Department of Legislative Services

5. Overtime Expenditures at State Facilities

A significant share of MDH's employee footprint is at the 12 State-run facilities focused on treating individuals with mental health, developmental disability, and chronic care needs. Together, these facilities employ over 3,500 State employees (2,679 in behavioral health hospitals, 472 in Developmental Disabilities Administration (DDA) facilities, and 421 in chronic care hospitals), which is 56% of the department's total regular personnel. With the high volume of staff at these facilities, the State hospitals also account for a significant amount of the department's annual overtime expenditures. Overtime is traditionally underfunded in certain facilities. **Exhibit 12** shows the amount appropriated to each facility type as well as the total for all facilities compared to the actual overtime amount paid in that fiscal year.

Exhibit 12
State Health Facilities Actual Overtime Spending versus Appropriations
Fiscal 2015-2019



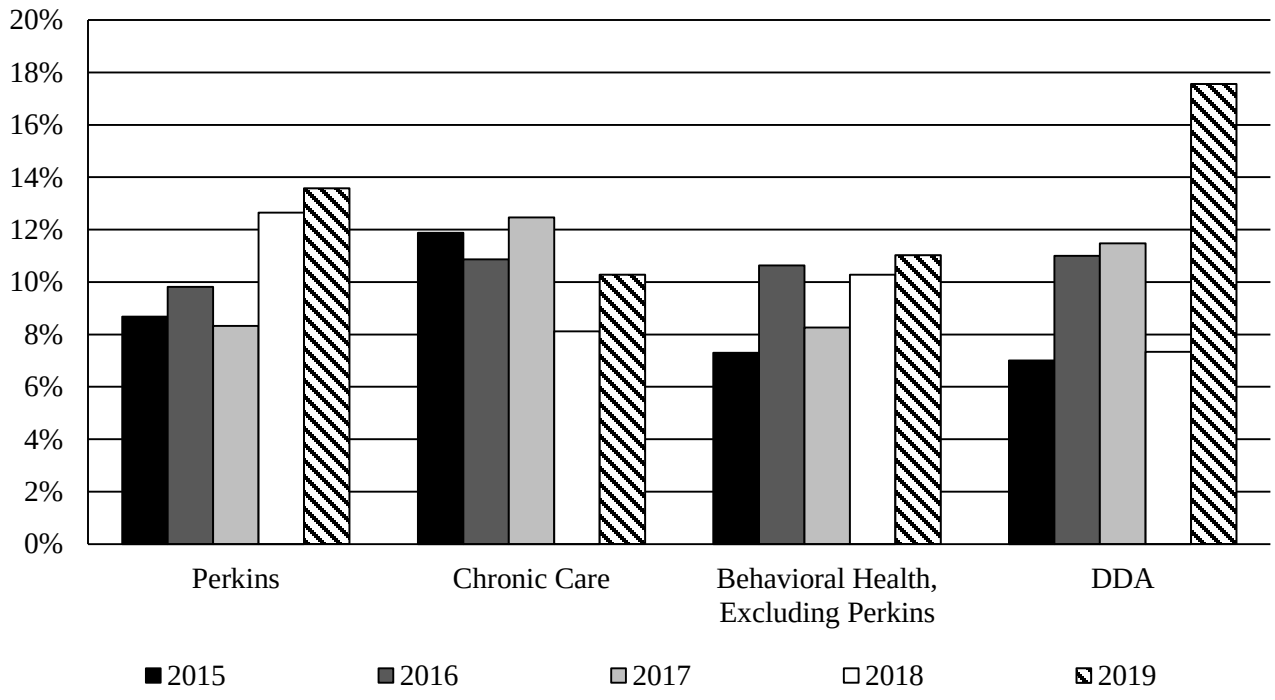
DDA: Developmental Disabilities Administration
Perkins: Clifton T. Perkins Hospital Center

Source: Department of Budget and Management

In fiscal 2019, overtime expenditures were underbudgeted by over $7 million with the behavioral health facilities contributing most, both in terms of absolute overtime dollars and underbudgeted amount. The Clifton T. Perkins Hospital Center (Perkins) alone contributes over a third of the total overtime amount throughout State facilities. Exhibit 12 also highlights that, while overtime expenditures have continued to increase, since fiscal 2015, the department has been more accurately accounting for overtime in the budget process, and that the chronic care and development disabilities facilities overtime spending is close to their budgeted level. However, even with more accurate accounting across all facilities, overtime expenditures have been underfunded by at least $6 million in each of the five most recent fiscal years with the majority of the shortfalls occurring in behavioral health facilities.

The major reason for the increasing level of overtime expenditures is vacancy rates at the respective facilities. **Exhibit 13** shows the historical vacancy rates for the groups of facilities discussed above over the same period.

Exhibit 13
Historical Vacancy Rates for State Health Facilities
Fiscal 2015-2019



DDA: Developmental Disabilities Administration
Perkins: Clifton T. Perkins Hospital Center

Source: Department of Budget and Management

With the exception of Western Maryland Hospital Center and the Regional Institute for Children and Adolescents in Baltimore, every State-run hospital experienced a higher vacancy rate in fiscal 2019 than in fiscal 2015. However, this trend did not perfectly correlate to overtime expenditures at the MDH facilities.

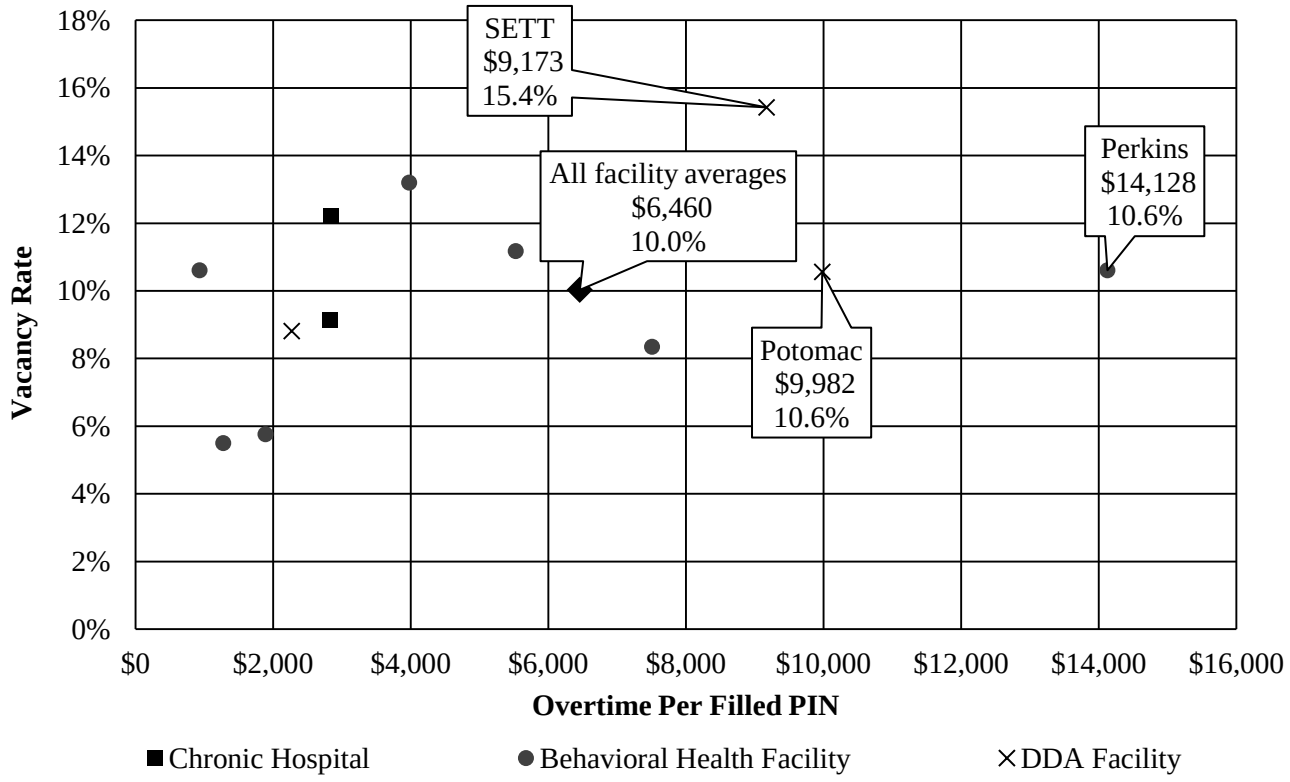
For example, DDA facilities saw the most drastic increase in the vacancy rate from 7.0% in fiscal 2015 to 17.6% in fiscal 2019, an increase of 151%. Actual overtime expenditures shown in Exhibit 12 also increased, albeit at a much slower rate, from $2.3 million in fiscal 2015 to $3.1 million in fiscal 2019, 35%. Overtime appropriations for DDA facilities have generally increased and narrowed the underfunded amount. In fiscal 2019, actual expenditures outpaced the appropriation by only $639,377 compared to fiscal 2015 when actual spending was $1.5 million higher than the appropriation.

Alternatively, the behavioral health hospitals, without considering Perkins, had a more modest vacancy increase, 7.3% in fiscal 2015 to 11.02% in fiscal 2019. However, over this period, overtime expenditures far outpaced DDA hospitals, increasing by 76% from $7.2 million to $12.6 million in fiscal 2019. Perkins also saw an increase in vacancy rates during the last five fiscal year actuals, increasing nearly 5 percentage points. During this period, the growth in overtime expenditures at this facility increased by 52%, representing a $3.35 million change.

Although Deer's Head Hospital Center experienced a slightly higher vacancy rate in 2019 than in 2015, this increase was more than offset by Western Maryland Hospital Center's decrease in vacancies, making the chronic care hospitals the only subset of state facilities that reduced vacancy rates. The overtime expenditure growth was nearly nonexistent at these facilities, increasing by only 4%, or $52,214.

To account for variations in employee complement at the facilities, **Exhibit 14** shows the average vacancy rate and average overtime per filled PIN at each individual facility from fiscal 2015 to 2019.

Exhibit 14
Vacancy Rates and Actual Overtime Spending
Per Filled Regular Position for State Health Facilities
Average, Fiscal 2015-2019



DDA: Developmental Disabilities Administration
SETT: Secure Evaluation and Therapeutic Treatment
Perkins: Clifton T. Perkins Hospital Center
Potomac: Potomac Center

Source: Department of Budget and Management

As shown above, broadly, the behavioral health facilities, represented by dots, have a lower overtime expenditure per filled PIN than two of the three DDA facilities (represented by Xs in Exhibit 14). The one exception to this is Perkins, which spends over twice the facility average on overtime per filled position.

Over the period analyzed by DLS, total facility overtime expenditures have grown by an average of over 10% year over year with the fiscal 2019 overtime amount representing a 55.6% increase, nearly $10 million higher than fiscal 2015. While MDH and certain facilities have achieved overtime actuals that more accurately reflect the budgeted values, the rising overtime costs, paired with the underfunding

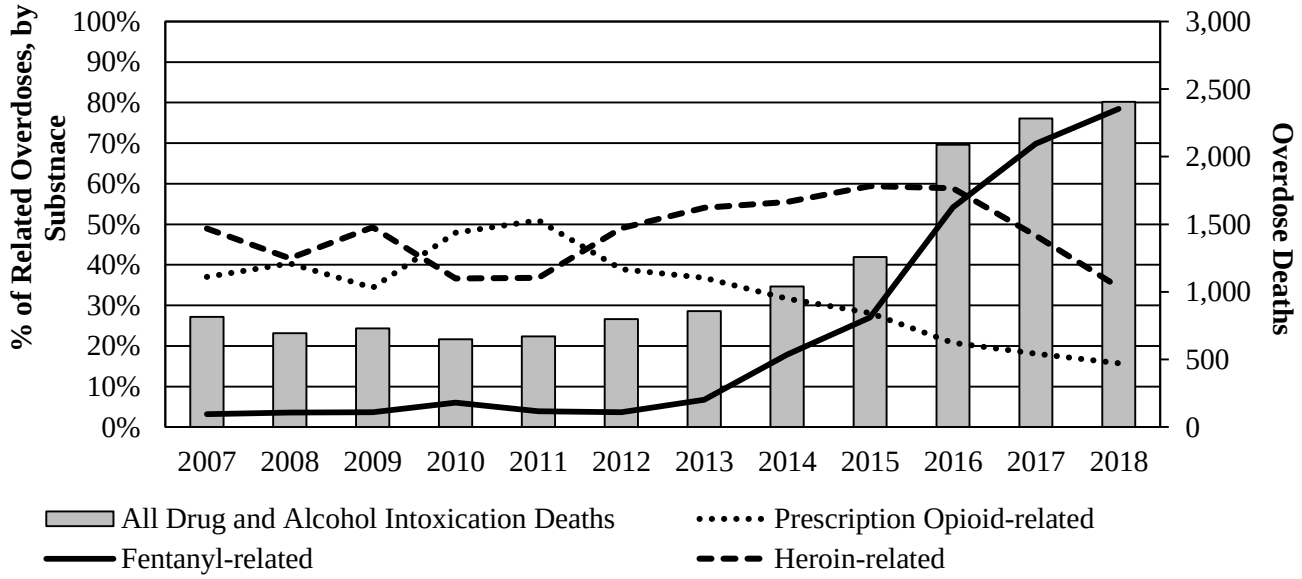
at the behavioral health facilities, still cause concern. The fiscal 2021 allowance has flat funded the overtime expenditures at $18 million, or $8.5 million below the most recent actuals.

The fiscal 2021 allowance also contains funding for salary increases for social workers, direct care workers (including licensed practical nurses; geriatric nurses; and developmental disabilities associates who provide direct care assistance at chronic care, behavioral health, and DDA facilities) and psychologists. These salary enhancements will likely assist with recruitment and retention, subsequently reducing vacancy rates and reducing overtime hours in the long term. However, these positive outcomes may not immediately materialize in fiscal 2021, and increased salaries will cause overtime expenditures to increase until MDH can increase the number of filled positions. Further, as discussed above, vacancy rates are not the exclusive drivers of overtime expenditures. **MDH should comment on efforts, aside from salary enhancements, being taken to reduce overtime expenditures throughout State facilities and how the reorganization of the department to move most facilities under the Deputy Secretary for Operations will be beneficial. MDH should also explain why DDA facilities remain under DDA.**

6. Maryland's Opioid Crisis

Maryland continues to be one of the states hit hardest by the opioid crisis with opioid-related fatalities continuing to rise. The last complete year of data (2018) saw further increases in opioid-related fatalities, driven by the prevalence of fentanyl in the drug supply, as shown in **Exhibit 15**.

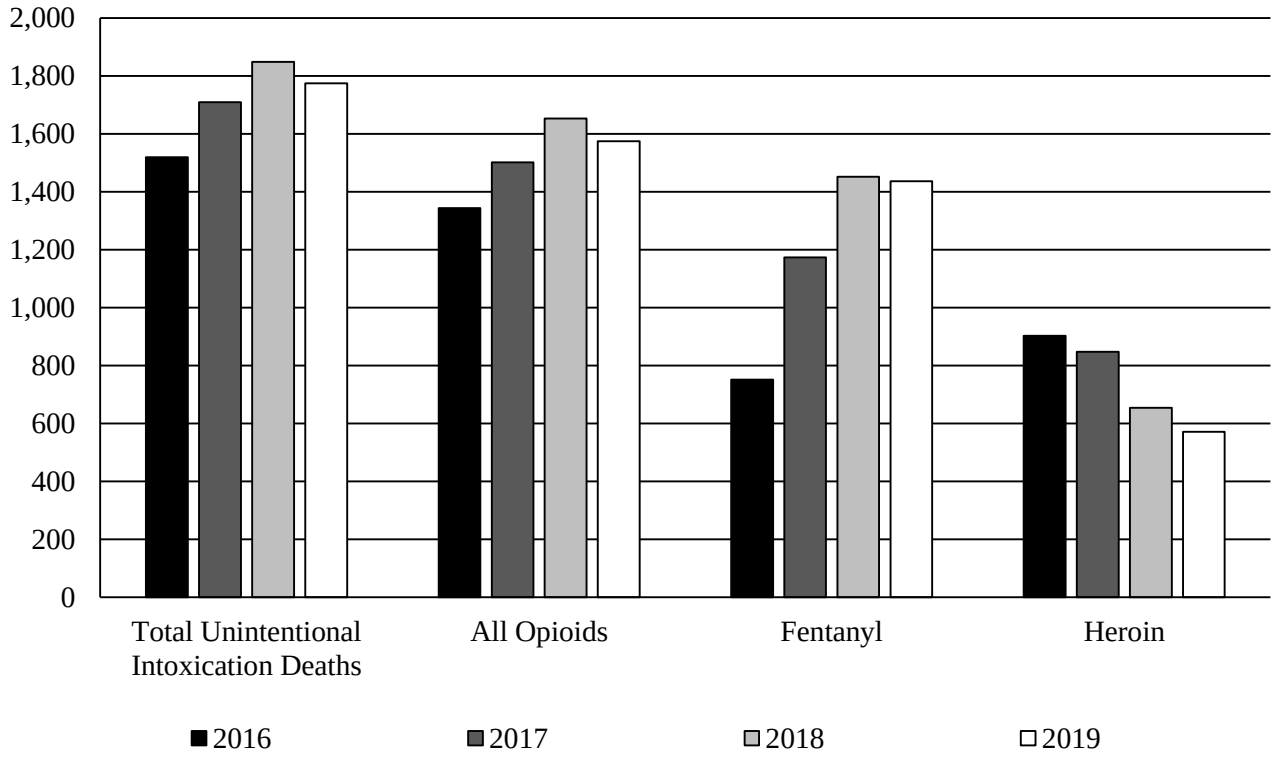
Exhibit 15
Overdose Deaths and Substance Prevalence
Calendar 2007-2018



Source: Maryland Department of Health

Preliminary data for 2019 published by the Opioid Operation Command Center (OOCC) indicates that the total number of overdose deaths in Maryland for the first nine months of 2019 was lower than the number of deaths at the same point in 2018. **Exhibit 16** shows the total overdose deaths, overdoses involving opioids, and deaths involving heroin and fentanyl for the first nine months of the last four years.

Exhibit 16
Statewide Overdose Deaths, January through September
Calendar 2016-2019



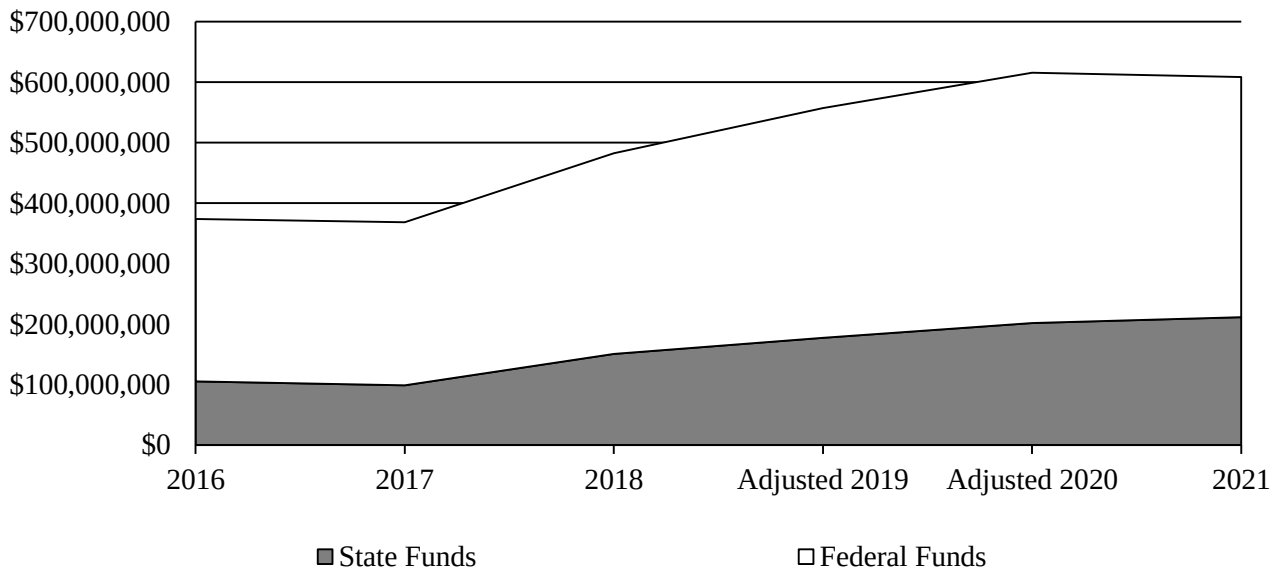
Source: Maryland Department of Health

While the preliminary data suggests a slight decline in calendar 2019, all opioid fatalities for 2019 are still above the 2017 mark. The preliminary fentanyl-related fatalities show little change in 2019 and are well above the number of fatalities in 2017. Heroin-related fatalities continue to steadily decline over this period. It is also important to note that the overdose deaths for heroin and fentanyl are not mutually exclusive, as law enforcement often finds fentanyl mixed into the heroin supply. Research conducted by DLS analyzing data from the Office of the Chief Medical Examiner used to populate the OOCC reports found that nearly 30% of all overdose deaths in the State in 2018 involved both heroin and fentanyl.

Funding

Maryland's largest share of funding to combat the opioid crisis comes from SUD treatment services provided through the Medicaid program: $512 million in total funds in fiscal 2021. An additional $96.5 million is provided to Medicaid-eligible and uninsured populations through FFS for non-Medicaid benefits. These totals include the 2% contingent rate reduction in the BRFA. When this is taken into consideration, fiscal 2021 is the first year FFS SUD treatment expenditures have declined after substantial growth. The Medicaid population using SUD treatment services is disproportionately in the ACA expansion, which provides a greater share of federal funds to provider reimbursements. **Exhibit 17** shows the trends in FFS provider reimbursements since fiscal 2016 for SUD treatment**.**

Exhibit 17
Substance Use Disorder Fee-for-service Expenditures
Fiscal 2016-2021

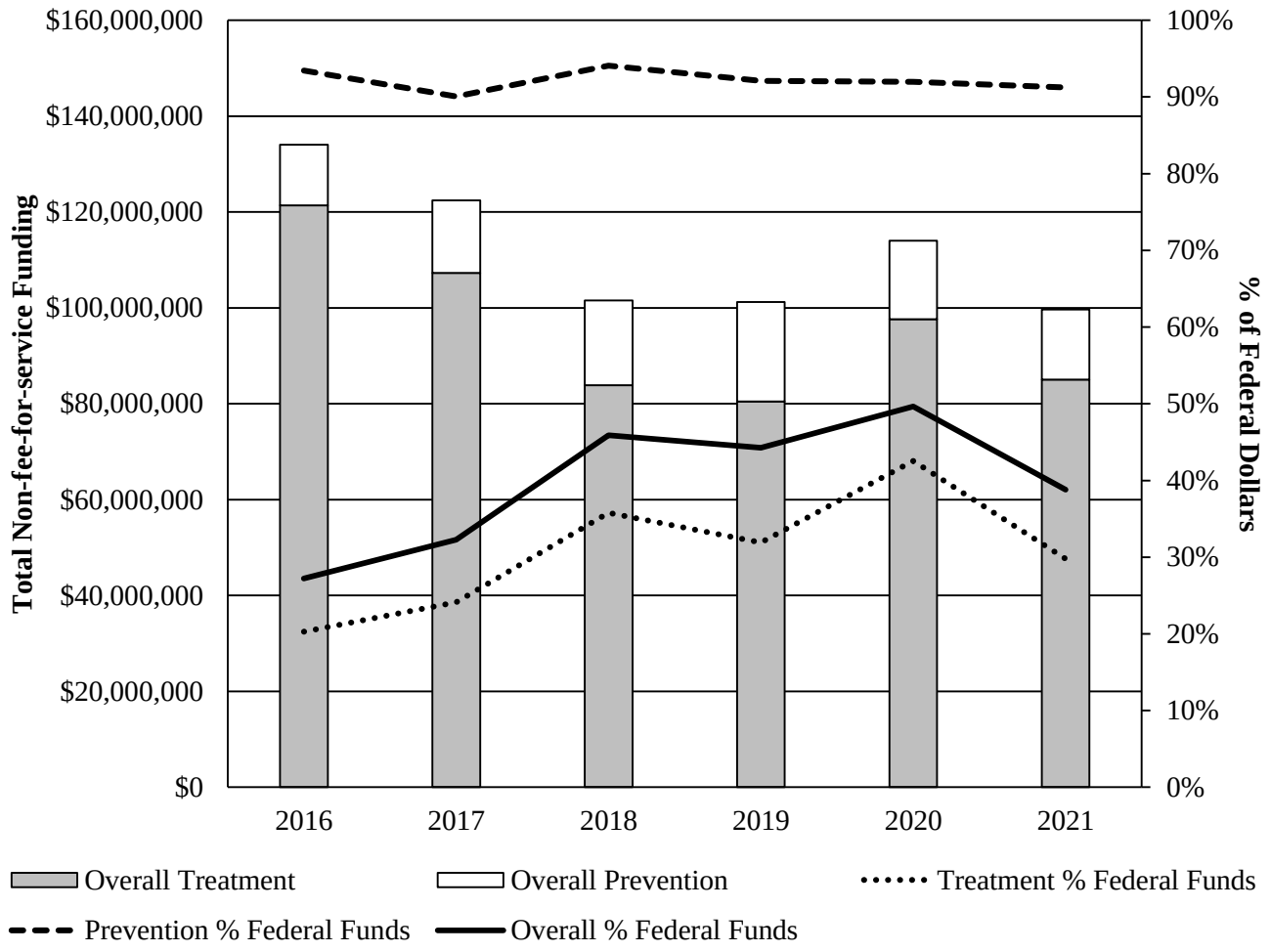


Note: Fiscal 2019 and 2020 are updated to include relevant deficiencies in the fiscal 2021 budget allocated to the appropriate year.

Source: Department of Budget and Management

Aside from the SUD treatment available through Medicaid and non-Medicaid FFS payments, MDH's budget contains funding for additional targeted programs to address the opioid crisis such as expanding medication assisted treatment, increasing distribution of naloxone, the Prescription Drug Monitoring Program, and operating drug treatment courts. These additional programs total $99.7 million in the fiscal 2021 budget. **Exhibit 18** shows how this funding has evolved and how it has been directed since fiscal 2016.

Exhibit 18
Non-fee-for-service Funding for the Opioid Crisis
Fiscal 2016-2021



Note: Fiscal 2019 and 2020 updated to include relevant deficiencies in the fiscal 2021 budget allocated to the appropriate year.

Source: Department of Budget and Management

As shown above, a significant portion is supported through federal grants targeted at the opioid crisis. Federal grants have played an outsized role in the funding for prevention services in MDH's response to the opioid crisis. Exhibit 18 also highlights the federal fund share of the treatment and prevention initiatives. Notably, federal grants have provided over 90% of the prevention funding since fiscal 2016. Overall, these various federal grants have combined to make up 40% of the non-FFS funding MDH has used when targeting the opioid epidemic.

The most recent major federal grant was the State Opioid Response (SOR) grant that totaled $83.6 million over the two-year term of the grant. However, federal fiscal 2019 is slated to be the last year of the SOR funding. In fiscal 2021, $11.7 million is budgeted for the SOR grant. Further, fiscal 2020 was the last year of another large federal grant, the State Targeted Response (STR) grant, that supported the Maryland Opioid Rapid Response. Several of the projects that lost STR funding have continued with support from the SOR grants, but with the SOR grant nearing the end of the terms, MDH will have to find additional funding or sustainable models to support the ongoing efforts to combat the opioid crisis. The SOR grant supported crisis services in local jurisdictions, improved naloxone distribution, and expanded medication assisted treatment and drug screening throughout the State. In fiscal 2021, the amount of federal funds to these programs decreases by $18 million, $16 million of which is the decline in SOR funding. On January 6, 2020, MDH announced that it was awarded a $3.6 million grant from the Centers for Medicare and Medicaid Services over five years to address the opioid crisis' impact on expectant and postpartum women, which will only slightly offset the funding gaps left by the SOR grant expiring.

MDH should comment on the availability of additional federal funds to support programs targeted at the opioid crisis and opportunities for sustainable funding.

Appendix 1
Budget Overview
Fiscal 2017-2021
($ in Millions)

	Actual 2017	Actual 2018	Actual 2019	Working 2020	Allowance 2021	Change 2020-2021
General Funds	**$4,408**	**$4,684**	**$4,936**	**$5,127**	**$5,535**	
Fiscal 2020 Deficiencies			$11	$142		
Targeted Reversions and Contingent Actions				-6	-$49	
Departmentwide Adjustments				2	10	
Adjusted General Funds	**$4,408**	**$4,684**	**$4,947**	**$5,265**	**$5,495**	**$229**
Special Funds	**$1,298**	**$1,252**	**$1,292**	**$1,312**	**$1,304**	
Fiscal 2020 Deficiencies				$90		
Targeted Reversions and Contingent Actions					$10	
Departmentwide Adjustments				0	1	
Adjusted Special Funds	**$1,298**	**$1,252**	**$1,292**	**$1,403**	**$1,315**	**-$88**
Federal Funds	**$7,526**	**$7,613**	**$7,873**	**$7,930**	**$8,262**	
Fiscal 2020 Deficiencies			$18	$200		
Targeted Reversions and Contingent Actions					-$44	
Departmentwide Adjustments				0	1	
Adjusted Federal Funds	**$7,526**	**$7,613**	**$7,891**	**$8,130**	**$8,219**	**$89**
Reimbursable Funds	**$95**	**$95**	**$112**	**$99**	**$99**	**$0**
Adjusted Total	**$13,327**	**$13,643**	**$14,243**	**$14,897**	**$15,127**	**$230.283**
Annual % Change From Prior Year	**9.5%**	**2.4%**	**4.4%**	**4.6%**	**1.5%**	

Note: Includes fiscal 2020 deficiencies allocated to the appropriate fiscal year. The fiscal 2020 appropriation includes deficiencies, targeted reversions, and general salary increases. The fiscal 2021 allowance includes general salary increases and contingent reductions.

Source: Department of Budget and Management; Department of Legislative Services

Appendix 2
Selected Caseload Estimates Used in Budget
Fiscal 2017-2021

	2017	2018	2019	Estimated 2020	Estimated 2021	Change 2020-2021	% Change 2020-2021
Medical Programs/ Medicaid							
Medicaid Enrollees	895,546	914,578	908,849	926,978	938,393	11,415	1.2%
Maryland Children's Healthcare Program	144,293	147,837	154,321	148,109	148,109	0	0%
ACA Medicaid Expansion	290,714	309,504	309,330	313,196	317,823	4,627	1.5%
Total	**1,330,553**	**1,371,919**	**1,372,500**	**1,388,283**	**1,404,325**	**16,042**	**1.2%**
Behavioral Health Administration							
Individuals Treated in PBHS	260,213	275,667	291,740	309,244	327,799	18,555	6.0%
Individuals Treated by PBHS for Mental Health Condition	200,959	211,325	225,278	238,795	253,123	14,328	6.0%
Individuals Treated by PBHS for Substance-related Disorders	103,115	110,398	116,536	123,528	130,940	7,412	6.0%
Individuals that the PBHS Dually Diagnosed	85,657	91,914	98,624	104,541	110,813	6,272	6.0%
Developmental Disabilities Administration[1]							
Unduplicated Count of Individuals Receiving Community-based Services	16,309	16,700	16,868	17,304	17,646	342	2.0%
Resource Coordination	22,421	22,646	23,012	23,357	23,708	351	1.5%
Average Daily Census at Institutions[2]	129	124	114	126	126	0	0%

	2017	2018	2019	Estimated 2020	Estimated 2021	Change 2020-2021	% Change 2020-2021
MDH Administration							
Average Daily Populations at State-run Psychiatric Hospitals							
Hospitals, Excluding RICAs and Assisted Living	1,001	997	1,015	1,028	1,039	11	1.1%
RICAs	60	70	87	90	90	0	0%
Assisted Living	45	54	38	42	42	0	0%
Total	**1,106**	**1,121**	**1,140**	**1,160**	**1,171**	**11**	**0.9%**

ACA: Affordable Care Act
MDH: Maryland Department of Health
PBHS: Public Behavioral Health System
RICA: Regional Institutions for Children and Adolescents

[1] Residential services include community residential services and individual family care. Day services include activities during normal working hours such as day habilitation services, supported employment, and summer programs. Support services include individual and family support and Community Supported Living Arrangements. Resource coordination is shown separately from the support services category as all individuals in the system receive resource coordination.
[2] The Developmental Disabilities Administration institutional data includes the secure evaluation and therapeutic treatment center unit. The average daily census measures for fiscal 2017 and 2018 have changed from the fiscal 2020 Managing for Results submission to reflect actual counts.

Source: Maryland Department of Health; Department of Legislative Services

Appendix 3
Regular Employees
Fiscal 2019-2021

	Actual 2019	Working 2020	Allowance 2021	Change 2020-2021	% Change 2020-2021
MDH Administration	**3,454.7**	**3,530.9**	**3,472.1**	**-58.8**	**-1.7%**
Behavioral Health Facilities	2,685.5	2,722.7	2,680.6	-42.1	-1.5%
Chronic Disease Hospitals	432.7	435.7	421.5	-14.2	-3.3%
Administration	336.5	372.5	370.0	-2.5	-0.7%
Office of Health Care Quality	**201.0**	**211.0**	**221.0**	**10.0**	**4.7%**
Health Occupations Boards	**283.6**	**272.6**	**280.5**	**7.9**	**2.9%**
Public Health Administration	**393.0**	**422.0**	**417.0**	**-5.0**	**-1.2%**
Prevention and Health Promotion Administration	**401.8**	**468.6**	**453.4**	**-15.2**	**-3.2%**
Behavioral Health Administration	**180.9**	**131.9**	**132.8**	**0.9**	**0.7%**
Developmental Disabilities Administration	**646.0**	**650.8**	**644.6**	**-6.2**	**-1.0%**
Administration	164.5	155.5	172.5	17.0	10.9%
Facilities	481.5	495.3	472.1	-23.2	-4.7%
Medical Care Programs Administration	**606.0**	**623.5**	**616.9**	**-6.6**	**-1.1%**
Health Regulatory Commissions	**110.9**	**103.9**	**108.9**	**5.0**	**4.8%**
Total Regular Positions	**6,277.9**	**6,415.2**	**6,347.2**	**-68.0**	**-1.1%**

MDH: Maryland Department of Health

Source: Governor's Fiscal 2021 Budget Books

Appendix 4
Contractual Employees
Fiscal 2019-2021

	Actual 2019	Working 2020	Allowance 2021	Change 2019-2020	% Change 2019-2020	Change 2020-2021	% Change 2020-2021
MDH Administration	**193.3**	**192.5**	**206.8**	**-0.8**	**-0.4%**	**14.3**	**7.4%**
Behavioral Health Facilities	162.6	166.2	166.3	3.6	2.2%	0.1	0.1%
Chronic Disease Hospitals	19.0	18.2	24.8	-0.8	-4.2%	6.5	35.9%
Administration[1]	11.7	8.9	16.0	-2.8	-24.1%	7.1	79.4%
Office of Health Care Quality	**6.6**	**12.5**	**12.5**	**5.9**	**90.3%**	**0.0**	**0.0%**
Health Occupations Boards	**42.0**	**64.9**	**85.2**	**22.9**	**54.6%**	**20.3**	**31.3%**
Public Health Administration	**35.7**	**36.9**	**86.9**	**1.2**	**3.3%**	**50.1**	**135.9%**
Prevention and Health Promotion Administration	**28.7**	**52.6**	**72.2**	**23.9**	**83.2%**	**19.6**	**37.1%**
Behavioral Health Administration	**26.8**	**18.5**	**45.6**	**-8.3**	**-30.9%**	**27.1**	**146.6%**
Developmental Disabilities Administration	**31.5**	**44.6**	**44.9**	**13.2**	**41.9%**	**0.3**	**0.6%**
Administration	17.5	34.0	33.0	16.5	94.5%	-1.0	-2.9%
Facilities	14.0	10.6	11.9	-3.3	-23.9%	1.3	11.8%
Medical Care Programs Administration	**92.5**	**101.3**	**99.3**	**8.8**	**9.5%**	**-1.9**	**-1.9%**
Health Regulatory Commissions	**13.8**	**7.6**	**7.9**	**-6.3**	**-45.3%**	**0.3**	**4.0%**
Total Contractual Positions	**470.8**	**531.4**	**661.3**	**60.6**	**12.9%**	**130.0**	**24.5%**

MDH: Maryland Department of Health

[1] Includes Office of Preparedness and Response in fiscal 2020 and 2021. This office appears in Public Health Administration in fiscal 2019.

Source: Governor's Fiscal 2021 Budget Books

Appendix 5
HealthChoice Managed Care Organization Open Service Area by County
January 2020

County	Aetna	Amerigroup	Jai Medical Systems	Kaiser Permanente	Maryland Physicians Care	MedStar Family Choice	Priority Partners	University of Maryland Health Partners	UnitedHealthcare
Allegany	X	X			X		X		
Anne Arundel	X	X	X	X	X	X	X	X	X
Baltimore City	X	X	X	X	X	X	X	X	X
Baltimore County	X	X	X	X	X	X	X	X	X
Calvert	X	X		X	X	X	X	X	
Caroline	X	X			X		X	X	
Carroll	X	X			X		X	X	X
Cecil	X	X			X		X	X	X
Charles	X	X		X	X	X	X	X	X
Dorchester	X	X			X		X	X	
Frederick	X	X			X		X	X	
Garrett	X	X			X		X		
Harford	X	X		X	X	X	X	X	X
Howard	X	X		X	X		X	X	X
Kent	X	X			X		X		
Montgomery	X	X		X	X	X	X	X	X
Prince George's	X	X		X	X	X	X	X	X
Queen Anne's	X	X			X		X	X	
Somerset	X	X			X		X	X	
St. Mary's	X	X			X	X	X	X	X
Talbot	X	X			X		X		
Washington	X	X			X		X		
Wicomico	X	X			X		X	X	
Worcester	X	X			X		X	X	

X = Managed care organization participation effective January 1, 2020.

Source: Maryland Department of Health

Appendix 6
Maryland Health System – Disparity Indicator Data

Table 2. State Disparity Indicator Data

Dimension and indicator	Data year	Low-income rate[d]	Disparity[e]	State ranking	Data year	Low-income rate[d]	Disparity[e]	Change over time[f]
Disparity	**2019 Scorecard**				**Baseline**			
Adults ages 19–64 uninsured	2017	18	-15	25	2013	30	-24	Improved
Children ages 0–18 uninsured	2017	6	-4	15	2013	7	-4	No Change
Adults age 18 and older without a usual source of care	2017	27	-17	48	2013	27	-16	Worsened
Adults age 18 and older who went without care because of cost in past year	2017	22	-18	36	2013	26	-21	Improved
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2016-17	26	-25	24	2013-14	26	-25	No Change
Adults age 18 and older without a dental visit in past year	2016	26	-16	45	2012	20	-10	Worsened
Adults without all age- and gender-appropriate cancer screenings	2016	33	-8	15	2012	31	-10	No Change
Adults without age-appropriate flu and pneumonia vaccines	2017	60	-10	37	2013	62	-10	No Change
Children without a medical home	2017	61	-26	33	2016	55	-20	Worsened
Children without age-appropriate medical and dental preventive care visits in the past year	2017	32	-12	19	2016	33	-12	No Change
Children ages 19–35 months who did not receive all recommended vaccines	2016	33	-14	33	2012	43	-18	Improved
Hospital admissions for pediatric asthma, per 100,000 children ages 2–17	2015	363.5	-309	29	2012	499.1	-427.9	Improved
Potentially avoidable emergency department visits, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2014	358	-184.2	23	2012	352.8	-177.6	Worsened
Hospital admissions for ambulatory care–sensitive conditions, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2015	99.4	-54.1	25	2012	93.1	-41.5	Worsened
30-day hospital readmissions among, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2015	66.5	-30.3	28	2012	98.4	-48.9	Improved
Adults who report fair or poor health	2017	32	-25	38	2013	22	-15	Worsened
Adults who smoke	2017	23	-14	20	2013	25	-15	Improved
Adults who are obese	2017	38	-5	2	2013	36	-8	No Change
Adults who have lost six or more teeth	2016	14	-10	13	2012	17	-11	Improved

Notes

(a) The 2019 Scorecard rankings generally reflect 2017 data. The 2019 Scorecard added or revised several performance measures since the May 2018 Scorecard report; rankings are not comparable between reports. Rank change from the baseline period represents states' rank difference from the baseline data year (generally 2012 or 2013). Positive values represent an improvement in rank; negative values are a worsening in rank.

(b) Trend data available for 45 of 47 total Scorecard indicators. Improved/worsened denotes a change of at least one half (0.5) standard deviation larger than the indicator's distribution among all states over the two time points. No change denotes no change in rate or a change of less than one-half standard deviation.

(c) Estimated impact if this state's performance improved to the rate of two benchmark levels — a national benchmark set at the level of the best-performing state and a regional benchmark set at the level of the top-performing state in region (www.bea.gov: Great Lakes, Mid-Atlantic, New England, Plains, Rocky Mountains, Southeast, Southwest, West). Benchmark states have an estimated impact of zero (0). Equivalent estimated impact based on national and regional benchmarks indicate that the best observed rate in the region was equal to the best observed rate nationally.

(d) Rates are for states' low income population, generally those whose household income is under 200% FPL.

(e) Disparity is the difference between the states' low-income and higher-income (400%+ FPL) populations.

(f) Improvement indicates that the low-income rate improved and the disparity between low- and higher-income populations narrowed; worsening indicates the low-income rate worsened and the disparity between low- and higher-income populations widened.

Source: Commonwealth Fund 2019 Scorecard on State Health System Performance