Maryland Department of Health
Fiscal 2022 Budget Overview

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

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For further information contact: Anne P. Wagner Phone: (410) 946-5530

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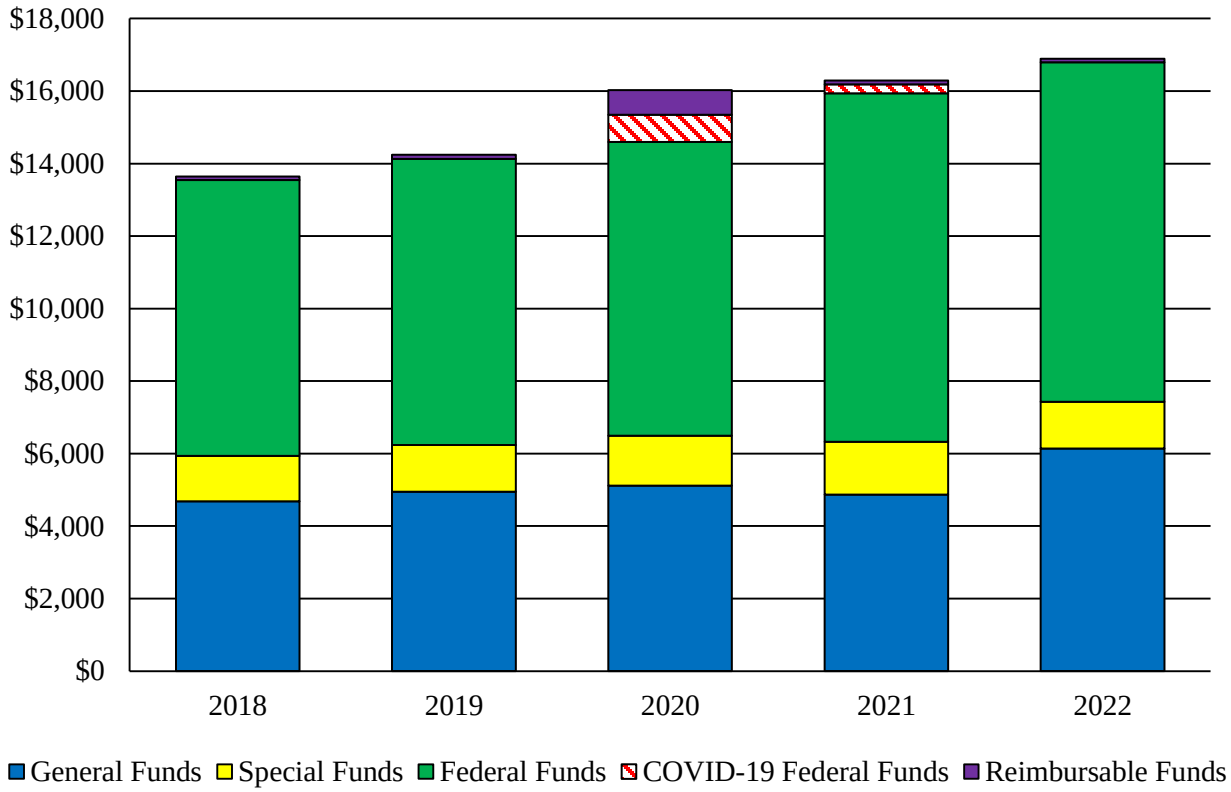
Maryland Department of Health
Fiscal 2022 Budget Overview

Five-year Funding Trends
Fiscal 2018-2022
($ in Millions)

Fiscal 2022 Budget Increases by $604.2 Million, or 3.7%, to $16.9 Billion
Fiscal 2020 Showed Greatest Growth with Increase of $1.8 Billion, or 12.5%, Mainly Due to COVID-19-related Spending



Note: The fiscal 2021 appropriation includes general salary increases, deficiencies, and a back of the bill reduction. The fiscal 2022 allowance includes contingent actions, annualization of general salary increases, annual salary reviews, and State Law Enforcement Officers Labor Alliance salary increases. 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

- ***Federal and State Programs Offer Assistance in Response to COVID-19 Impacts on Providers' Revenue and Service Delivery:*** The COVID-19 pandemic limited in-person services and led to financial losses as patients delayed treatment. Federal and State agencies tried to mitigate pandemic effects on providers by distributing aid from the Provider Relief Fund, expanding telehealth services, and adapting program requirements in the Developmental Disabilities Administration (DDA) Community Services program, among other actions.

- ***COVID-19 Pandemic Highlights Existing Racial and Ethnic Disparities in Health Outcomes and Social Determinants of Health:*** In national and State COVID-19 data, Black and Hispanic individuals have consistently accounted for disproportionate shares of cases and deaths. The pandemic has emphasized other racial and ethnic health disparities, such as rates of chronic conditions that increase the severity of COVID-19. This also causes greater concern because Black and Hispanic individuals have been underrepresented in the State's initial counts of vaccine doses administered.

Updates

- ***Cigarette Restitution Fund (CRF) – Administration Assumes $16 Million Payment in Fiscal 2021 Resulting from Multistate Litigation:*** A three-judge panel is expected to make a decision for Maryland in an ongoing multistate arbitration with tobacco manufacturers participating in the Master Settlement Agreement regarding sales year 2004. The outcome of this litigation and the outcomes in cases for sales year 2005 and beyond have potentially significant budgetary impacts for the State's CRF revenue.

Operating Budget Summary

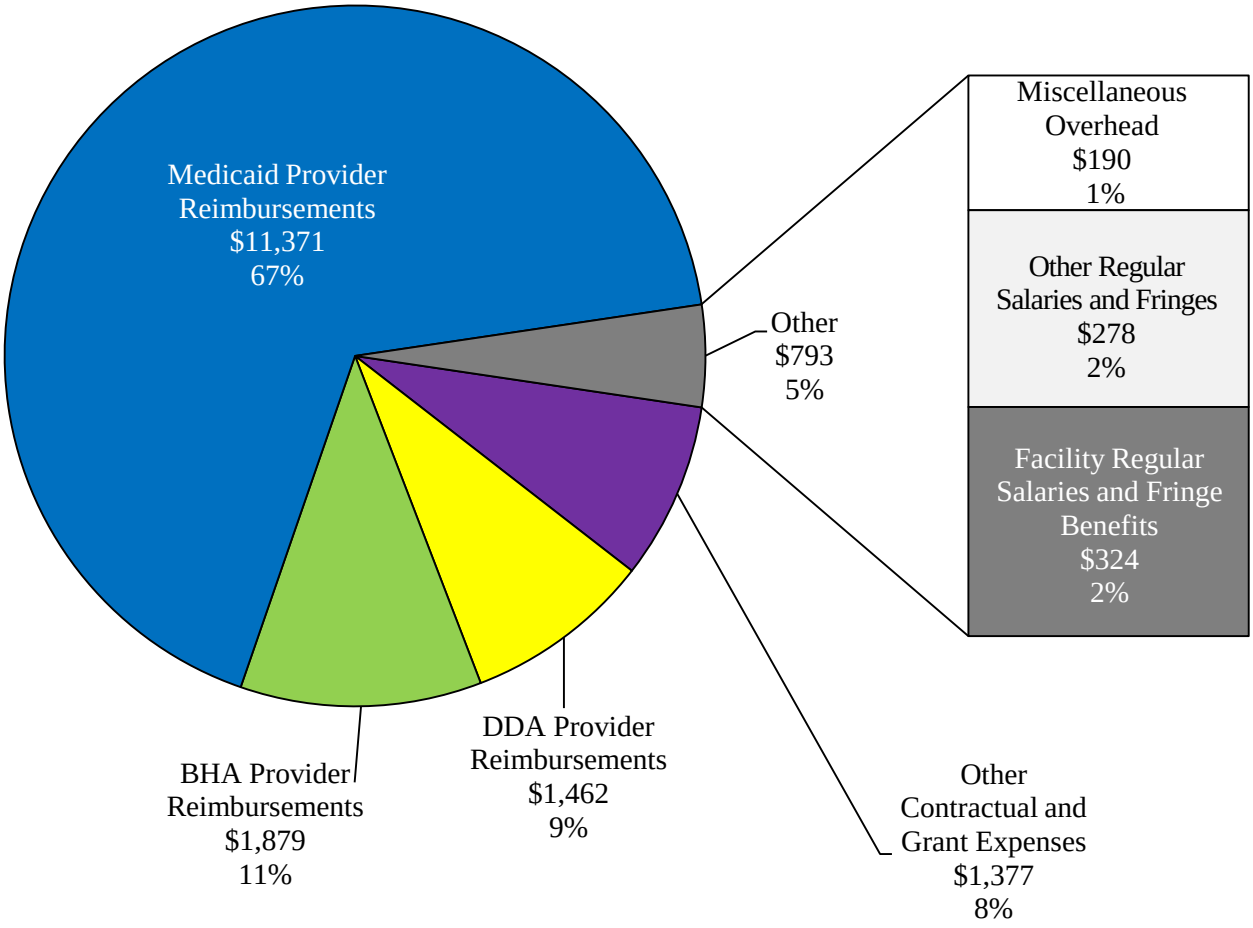
Fiscal 2021

- ***Board of Public Works (BPW) Cost Containment:*** On July 1, 2020, BPW approved a reduction of $52.2 million in total funds ($44.8 million in general funds and $5.9 million in federal funds) from the Maryland Department of Health (MDH) fiscal 2021 appropriation. **Appendix 3** presents details on the reduction by program.

- ***Proposed Deficiencies:*** The Governor's allowance includes deficiency appropriations totaling a net increase of $1.2 billion to the fiscal 2021 appropriation of which $267.7 million is related to the COVID-19 pandemic response and $87.3 million accelerates 4% provider rate increases to January 1, 2021. **Appendix 4** includes an itemized list of the deficiencies.

Functional Breakdown of Agency Spending
Fiscal 2022 Allowance
($ in Millions)

Total Fiscal 2022 Allowance = $16.9 Billion



BHA: Behavioral Health Administration
DDA: Developmental Disabilities Administration

Note: Excludes statewide personnel funding centrally budgeted in the Department of Budget and Management attributable to the Maryland Department of Health totaling $10.7 million.

Source: Governor's Fiscal 2022 Budget Books; Department of Legislative Services

Proposed Budget Change
Maryland Department of Health
Fiscal 2021-2022
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2021 Working Appropriation	$4,871,390	$1,454,821	$9,863,170	$98,849	$16,288,230
2022 Governor's Allowance	6,137,743	1,290,058	9,367,640	97,000	16,892,441
Amount Change	1,266,354	-164,763	-495,530	-1,850	604,211
Percent Change	26.0%	-11.3%	-5.0%	-1.9%	3.7%

Where It Goes:		**Change**
Regular Personnel Expenses		**-$198,878**
Regular earnings, partially due to salary adjustments at State facilities		14,466
Net impact of a 2% general salary increase effective January 1, 2021, including annualization in fiscal 2022		4,162
Employee and retiree health insurance		3,661
Retirement contribution		2,232
Unemployment compensation		1,118
Overtime earnings		1,008
Wage enhancements approved through the annual salary review for fiscal 2022		974
Salary and fringe benefits associated with 9 new positions in the Office of Health Care Quality		693
Other fringe benefit adjustments		236
Workers' compensation premium assessment		-3,166
Turnover adjustments		-4,375
Fiscal 2021 Coronavirus Relief Fund spending for public safety salaries in local health and other agencies		-219,886
Major Programmatic Changes (Excluding Medicaid)		**$371,730**
BHA	**$181,480**	
Service utilization and enrollment		147,898
Annualization of 4% provider rate increase effective January 1, 2021		23,413
Regulated rates		13,889
Funding to core service agencies for behavioral health treatment		5,170
New provider service initiative focused on youth that remain in a hospital environment after their immediate and acute need has been resolved		5,000
Community Mental Health Services Block Grant (MHBG) (federal funds)		1,663
10% set aside in MHBG for individuals with early serious mental illness (federal funds)		1,355
Funding for additional substance use disorder treatment programs		1,132

Where It Goes:		**Change**
Program direction		586
Expiring grant for Screening, Brief Intervention and Referral to Treatment (federal funds)		-1,170
Decrease in other Community Service programs, including reduction in Problem Gambling Fund and other expiring federal grants		-1,888
One-time supplemental appropriations in fiscal 2021		-1,950
Net decrease from State Opioid Response (SOR) I grant expiring, partially offset by SOR II grant (federal funds)		-13,619
Prevention and Health Promotion Administration	**$97,106**	
Supplemental Epidemiology and Laboratory Capacity grant distributed by CDC for COVID-19 related laboratory services, contact tracing, testing, and surveillance		60,543
COVID Link information technology (IT) project for a contact tracing platform		24,003
Ryan White Part B Supplemental Grant (federal funds)		8,382
In-state HIV services (federal funds)		7,975
MADAP rebates supporting HIV health and supportive services (special funds)		5,029
Ending the HIV Epidemic grant passthrough to Montgomery County and Prince George's County Health Departments (federal funds)		2,600
Restoration of Statewide Academic Health Center grant following fiscal 2021 reduction approved by the Board of Public Works		1,500
Net change from SOR I grant expiring, offset by SOR II grant for prevention and harm reduction activities (federal funds)		1,030
Emergency Relief grant authorized in the CARES Act for the Ryan White HIV/AIDS Program (federal funds)		-1,800
Capital Region Medical Center operating grant, in accordance with Chapter 19 of 2017 (general funds)		-3,500
Special Supplemental Nutrition Program for Women, Infants, and Children program (federal funds)		-8,656
Developmental Disabilities Administration (DDA)	**$73,159**	
Additional funding for services based on net traditional growth for new placements and expansion of services		55,294
Annualization of 4% provider rate increase effective January 1, 2021		27,681
Utilization review and Fiscal Management Services contracts		5,400
Other administrative contracts supporting the Community Services program		4,783
Fiscal 2021 spending associated with the Emergency Preparedness and Response Appendix K to the DDA Waiver programs (see Issue 1 of this analysis for more information)		-20,000
Regulatory Commissions	**$18,324**	
Uncompensated Care Fund		17,000
Operating expenses for the Maryland Health Care Commission, including increases to the Trauma Physicians Fund and for database development		1,324

Where It Goes:		**Change**
MDH Administration	**$2,877**	
Supplemental funding for Local Health Departments		4,000
Fiscal Services contract		1,500
Operating expenses across State hospitals, excluding DDA facilities		1,144
Statewide Personnel System allocation		-1,006
Medical support services across chronic care and behavioral health State hospitals, primarily at Clifton T. Perkins Hospital Center		-1,335
IT expenditures		-1,426
Public Health Administration	**$484**	
Rent and utilities expenses budgeted in Office of Preparedness and Response		973
Expenses and grants for medical surge capacity and alternate care sites during the COVID-19 pandemic (federal funds)		845
Grant from the Substance Abuse and Mental Health Services Administration for local coalitions to prevent underage and youth binge drinking (federal funds)		-1,334
Professional Boards and Commissions	**-$1,700**	
One-time costs for MMCC IT project start-up in fiscal 2021		-1,700
Medicaid/Medical Care Programs Administration	**438,253**	
Enrollment and utilization		250,451
Medicare Part D Clawback payments		65,278
Pharmacy rebates		58,441
Major IT Development Projects (federal funds)		30,739
Various systems contracts		29,829
Medicare A and B premium assistance		19,361
Federally Qualified Health Centers supplemental payments		7,342
Utilization reviews		5,374
Senior Prescription Drug Assistance Program		4,055
Prior Year grant activity		3,021
Health Home payments		2,285
Hospital Cost Settlements		1,991
Community First Choice (enrollment excluding rate increase)		1,849
PACE Expansion		1,800
Managed Care Organization Rural Access Initiative		1,650
Graduate Medical Education Payments		1,398
Dental Administrative Services Organization contract		-1,922
Program recoveries		-2,169
Provider rate increases		-2,684
Adult dental services		-3,277

Where It Goes:	**Change**
Health information technology payments	-7,000
School-based services	-8,536
Maryland Children's Health Program	-21,023
Other	**-6,894**
Total	**$604,211**

BHA: Behavior Health Administration
CARES: Coronavirus Aid, Relief, and Economic Security
CDC: U.S. Centers for Disease Control and Prevention
MDH: Maryland Department of Health
MADAP: Maryland AIDS Drug Assistance Program
MMCC: Maryland Medical Cannabis Commission
PACE: Program of All-inclusive Care for the Elderly

Note: Numbers may not sum to total due to rounding. The fiscal 2021 appropriation includes general salary increases, deficiencies, and a back of the bill reduction. The fiscal 2022 appropriation includes contingent actions, annualization of general salary increases, annual salary reviews, and State Law Enforcement Officers Labor Alliance salary increases. Fee-for-service community behavioral health expenditures for Medicaid recipients are shown under BHA as opposed to Medicaid where they are budgeted. **Appendix 5** of this document provides selected caseload measures that partially explain some of the enrollment and utilization changes in the budgets for BHA, DDA, and Medicaid.

Source: Governor's Fiscal 2022 Budget Books; Department of Legislative Services

Fiscal 2022 Contingent Actions
($ in Millions)

Program	Item	General Funds	Special Funds	Total Funds
Public Health Administration	Replace general funds in the Office of Controlled Substances Administration with Board of Pharmacy Fund balance	-$0.5	$0.5	$0.0
Behavioral Health Administration (BHA)	Replace general funds with Maryland Medical Cannabis Commission Fund balance	-6.0	6.0	0.0
BHA	Replace general funds with State Board of Professional Counselors and Therapists Fund balance	-2.0	2.0	0.0
Medicaid	Replace general funds with special funds by reducing the hospital deficit assessment	-35.0	35.0	0.0
Medicaid	Replace general funds with State Reinsurance Fund balance	-100.0	100.0	0.0
Medicaid	Increase the Senior Prescription Drug Assistance Program annual mandated appropriation		4.4	4.4
Community Health Resources Commission (CHRC)	Reduce the CHRC annual mandated appropriation		-4.4	-4.4
Fiscal 2022 Contingent Reductions Total		**-$143.5**	**$143.5**	**$0.0**

Source: Budget Reconciliation and Financing Act of 2021; Governor's Fiscal 2022 Budget Books

Health-related Federal Stimulus Support by Source ($ in Millions)

	FFCRA and CARES Act	Consolidated Appropriations Act	Total
MDH Allocations			
Enhanced Medicaid Federal Match	$935		$935
Pandemic Response Activities			
FEMA funding – MDH Spending*	$818		$818
Coronavirus Relief Fund – MDH Spending*	684		684
Coronavirus Relief Fund – NORI Grants to BHA and DDA providers	10		10
Testing and Contact Tracing	207	$348	555
CDC Crisis Response and Other Grants – Public Health	33		33
Vaccine Distribution	17	55	71
Behavioral Health and Other Health Support			
Mental Health Block Grant		$33	$33
Substance Abuse Prevention and Treatment Block Grant		32	32
Ryan White HIV/AIDS Program Emergency Relief Grant	2		2
Subtotal	***$2,706***	***$467***	***$3,172***
Other Health Funding Directed to Counties, LHDs, and Health Care Providers			
Direct Federal Grants to Medical Care Providers	$2,000	Minimal	$2,000
Direct Coronavirus Relief Fund Grants to Counties	691		691
Community Health Centers	24		24
Nursing Homes Testing Costs	6		6
Subtotal	***$2,721***	***$0***	***$2,721***
Total	**$5,427**	**$467**	**$5,894**

BHA: Behavioral Health Administration
CARES: Coronavirus Aid, Relief, and Economic Security Act
CDC: U.S. Centers for Disease Control and Prevention
DDA: Developmental Disabilities Administration
FEMA: Federal Emergency Management Agency
FFCRA: Families First Coronavirus Response Act
LHD: Local Health Department
MDH: Maryland Department of Health
NORI: Nonprofit Recovery Initiative

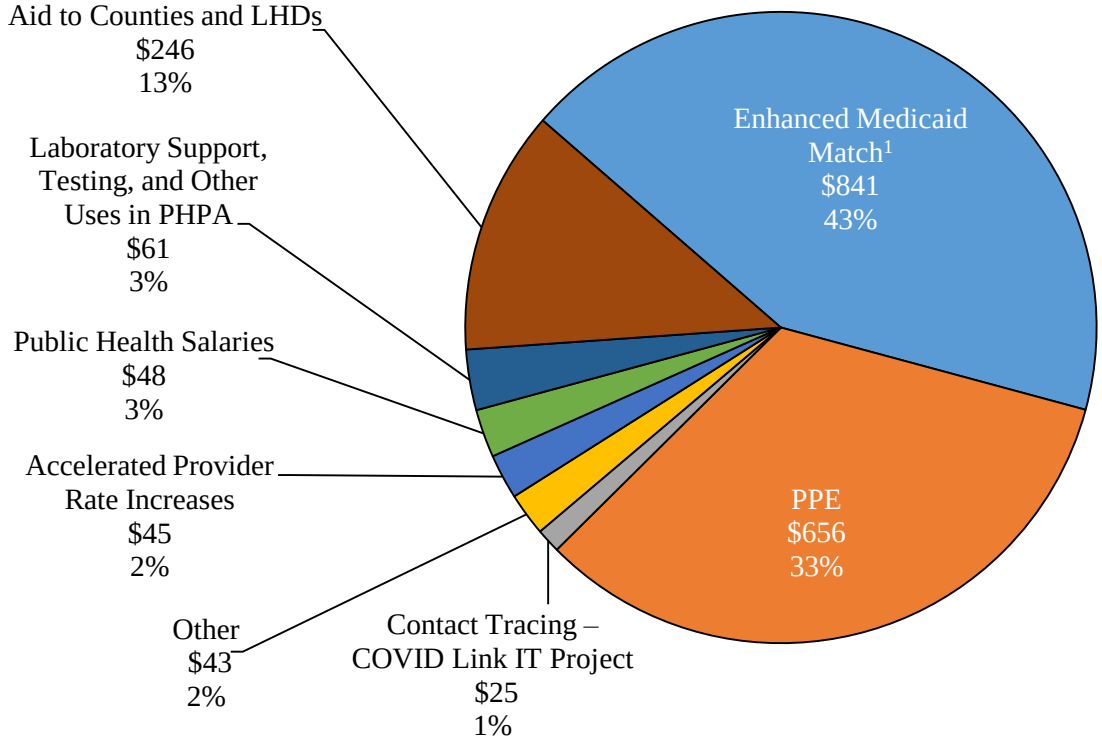
*Only reflects Coronavirus Relief Fund allocation and FEMA reimbursement that MDH retains. The Governor's allowance includes additional federal funding in MDH to reimburse other agencies for pandemic and economic relief efforts.

Source: Governor's Fiscal 2022 Budget Books; Department of Legislative Services

Although there have been funding notices claiming that over $3 billion in federal funds have been allocated to MDH for the State's COVID-19 response, only $2.0 billion is reflected in the budget as introduced from fiscal 2020 to the 2022 allowance. This does not include much of the ongoing spending in fiscal 2021. For example, of $207 million awarded from the Centers for Disease Control and Prevention (CDC) for testing and tracing, $29.3 million had been spent, and $127.4 million had been obligated as of December 31, 2020, leaving approximately $50.3 million remaining to be spent before the supplemental grant expires on November 19, 2022.

Health-related Federal Stimulus Funding Reflected in MDH Fiscal 2020 to 2022 Budget as of Submission of Allowance ($ in Millions)

Total Federal Fund Expenditures = $2.0 Billion



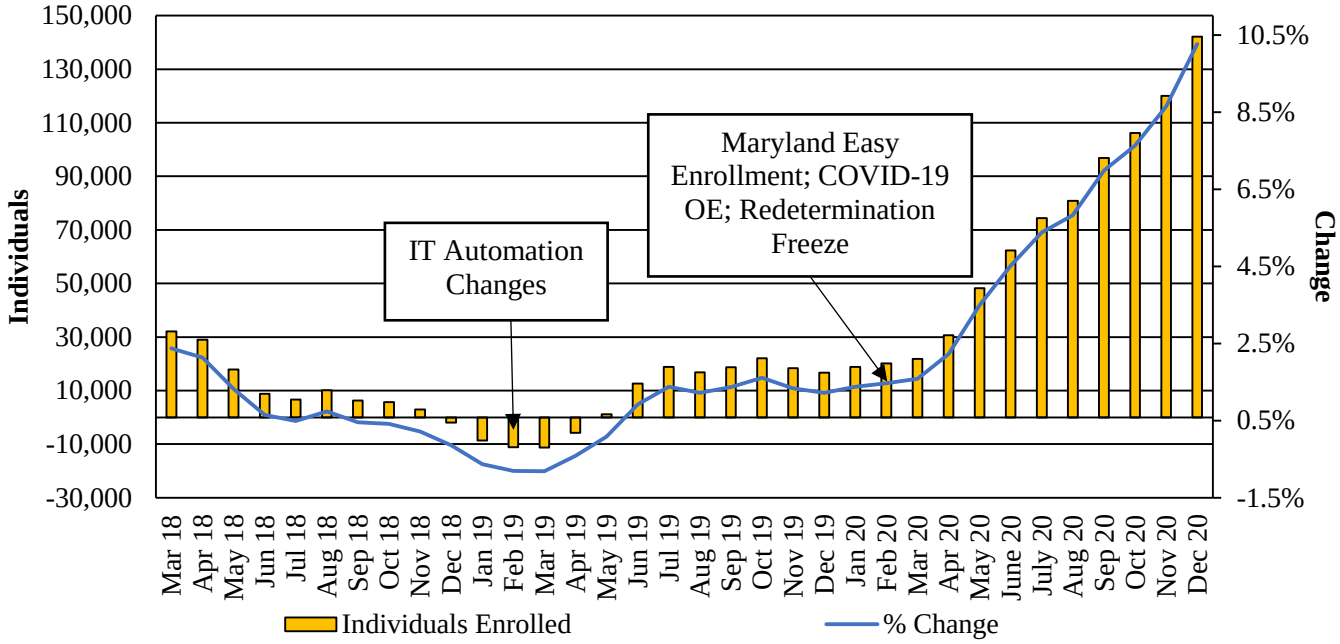
IT: information technology
LHD: Local Health Department
MDH: Maryland Department of Health
PHPA: Prevention and Health Promotion Administration
PPE: personal protective equipment

[1]MDH budget submission does not include all of the federal enhanced match funds in fiscal 2020 that the Department of Legislative Services believes was actually received and is recognized as such in the fund support exhibit.

Note: The Governor's allowance includes expenditures in MDH to reimburse other agencies for pandemic and economic relief efforts that are not pictured. Includes fiscal 2021 expenditures that are estimates and may change.

Source: Governor's Fiscal 2022 Budget Books; Department of Legislative Services

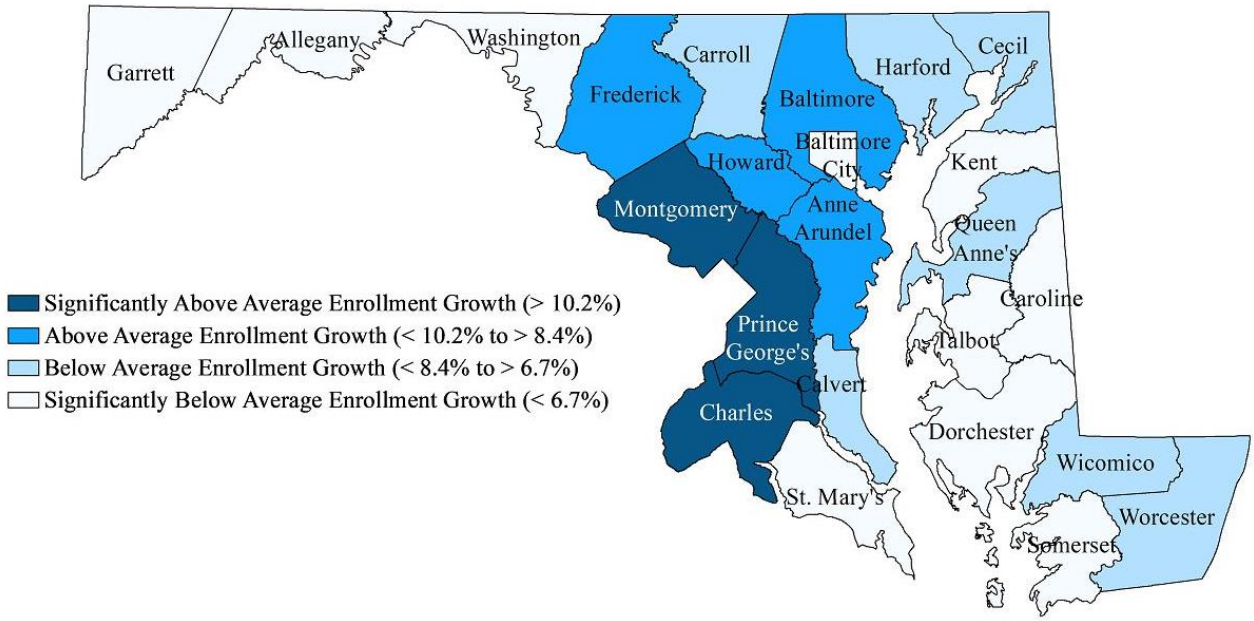
Medicaid Enrollment: Year-over-year Growth
March 2018 to December 2020



IT: information technology OE: open enrollment

Source: Maryland Department of Health; Department of Legislative Services

Medicaid Enrollment Growth by Jurisdiction
February 2020 through December 2020



Source: Maryland Department of Health; Department of Legislative Services

Personnel Data

Appendices 6 and **7** present additional information on regular personnel, including position changes by program from fiscal 2020 to 2022 and historical trends in employee vacancy rates. **Appendix 8** provides contractual personnel by program from fiscal 2020 to 2022.

Regular Personnel – Vacancy Rates by Program
December 31, 2020

	FTE Vacancies	FTE Positions	Vacancy Rate	Vacancies Above/Below Budgeted Turnover
MDH Administration	331.1	3,497.1	9.5%	18.8
State Psychiatric Hospitals	223.6	2,647.6	8.4%	
Chronic Disease Hospitals	49.5	421.5	11.7%	
Office of Health Care Quality	21.0	221.0	9.5%	0.3
Health Occupations Boards	26.5	280.5	9.4%	7.3
Public Health Administration	38.0	417.0	9.1%	-4.7
Prevention and Health Promotion Administration	56.0	461.4	12.1%	26.8
Behavioral Health Administration	14.5	134.8	10.8%	-0.2
Developmental Disabilities Administration (DDA)	99.0	626.6	15.8%	23.7
DDA Facilities	73.5	452.1	16.3%	
Medical Care Programs Administration	78.0	608.9	12.8%	25.6
Health Regulatory Commissions	5.0	108.9	4.6%	0.2
Total Regular Positions	**669.1**	**6,356.2**	**10.5%**	**97.8**

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

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

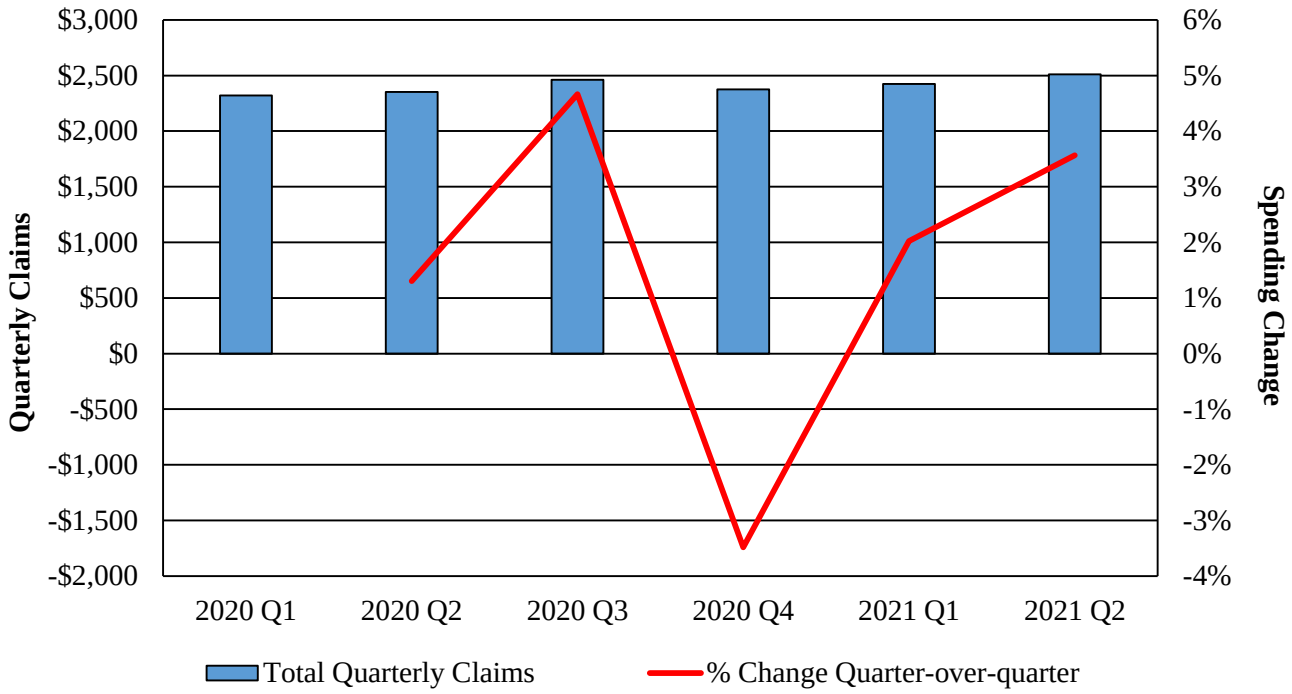
Issues

1. Federal and State Programs Offer Assistance in Response to COVID-19 Impacts on Providers' Revenue and Service Delivery

Impact of COVID-19 on Medicaid Providers

An analysis of claims paid by Medicaid illustrates the impact that COVID-19 had on Medicaid providers. As shown in **Exhibit 1**, which uses data for Medicaid somatic providers only (Medicaid behavioral claims are excluded due to payment issues with the Administrative Services Organization (ASO) transition)), total Medicaid claims dropped by 3.5% in the fourth quarter of fiscal 2020 (April to June).

Exhibit 1
Medicaid: Quarterly Claims and Quarter-over-quarter Spending Change
Fiscal 2020-2021 YTD
($ in Millions)



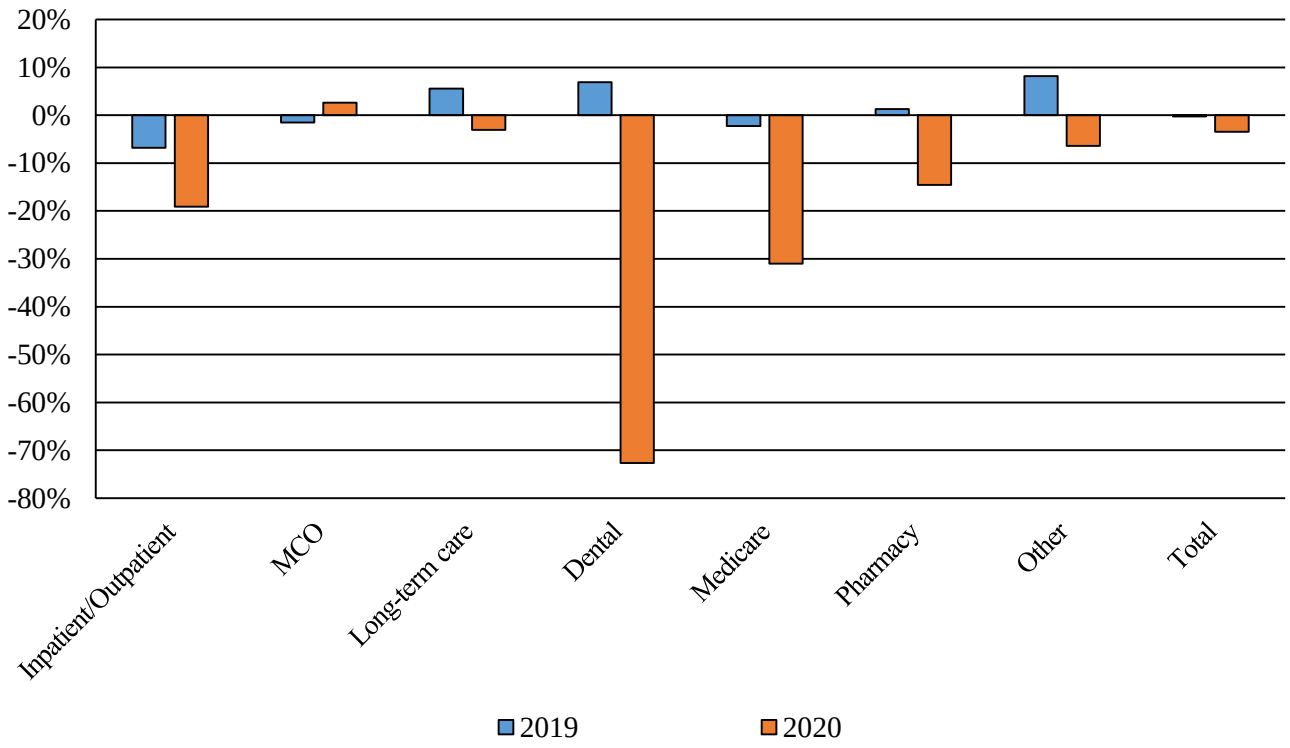
YTD: year to date

Note: YTD spending is through December 2020.

Source: Maryland Department of Health; Department of Legislative Services

While claims clearly declined in the fourth quarter, a closer analysis reveals that this decline was uneven. **Exhibit 2** compares the change in claims paid between the third and fourth quarters of fiscal 2019 and 2020. Fiscal 2019 data is included as a point of comparison and also because there is typically a drop in claims between these periods, the third quarter being the winter months when certain health care services might be expected to be accessed more. As shown in the exhibit, with the exception of managed care organizations (MCO), every category of service claims fell between the third and fourth quarter of fiscal 2020 compared to the same period in fiscal 2019. MCO claims were unsurprisingly higher due to growing enrollment, although a technical change to move certain prescription drugs from fee-to-service into the capitated rates also played a part in the increase (and the corresponding drop in pharmacy claims).

Exhibit 2
Medicaid: Change in Claims from Quarter 3 to Quarter 4
Fiscal 2019-2020



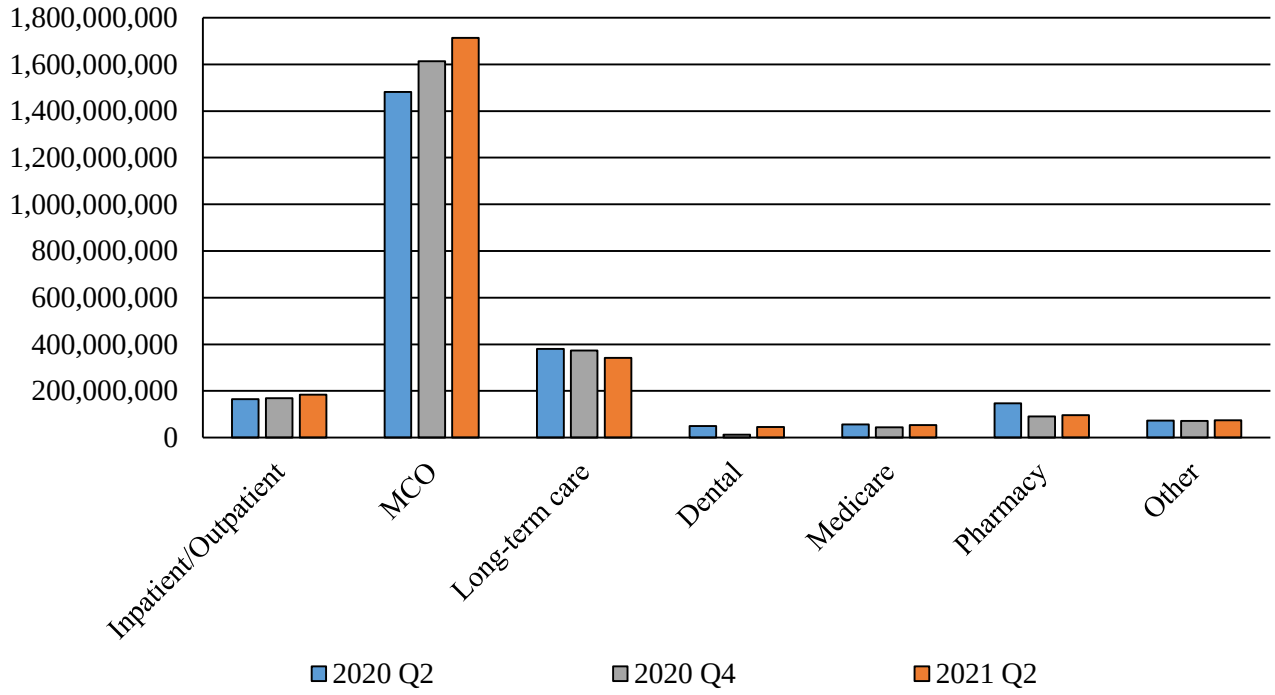
MCO: Managed Care Organization

Source: Maryland Department of Health; Department of Legislative Services

As shown in Exhibit 1, overall Medicaid spending has rebounded since the fourth quarter of fiscal 2020. However, just as the decline was uneven among the various providers, so has been the

rebound. **Exhibit 3** compares quarterly spending in the second quarter of fiscal 2020 to the fourth quarter in fiscal 2020 and second quarter in fiscal 2021. The exhibit illustrates that spending on MCO capitated rates has grown sharply. MCO enrollment in December 2020 was 1.3 million compared to 1.2 million in December 2019 for example, an increase of 10.7%. That, and the realignment of certain pharmacy expenses, results in quarterly MCO spending in the second quarter of fiscal 2021 of over $1.7 billion compared to just under $1.5 billion in the same period in fiscal 2020, a 15.7% increase.

Exhibit 3
Medicaid: Claims by Provider Type over Various Periods



MCO: managed care organization

Source: Maryland Department of Health; Department of Legislative Services

Enrollment growth outside of the HealthChoice program is more modest, 7.3% between December 2019 and December 2020, but claims for that population are mixed: inpatient/outpatient claims being up 11.7% between the second quarter of fiscal 2020 and the same period in fiscal 2021. Long-term care spending, conversely, is down 10% over the same period, and claims have not rebounded. This is virtually all due to lower claims by nursing homes, specifically among the elderly rather than disabled adult population. Dental spending, which is carved out from HealthChoice and delivered fee-for-service, has rebounded from a low of only $12.7 million in claims in the fourth quarter of fiscal 2020 to $45.2 million in the second quarter of fiscal 2021. However, that is still $3.9 million below the same period in fiscal 2020, an 8% drop.

Provider Relief Fund

Perhaps the most significant source of support for health care providers suffering financial losses as a result of the impact of COVID-19 on service delivery is the Provider Relief Fund managed by the U.S. Department of Health and Human Services (HHS). The Provider Relief Fund was established by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which appropriated $100 billion and was subsequently added to in the Paycheck Protection Program and Health Care Enhancement Act ($75 billion) and the Consolidated Appropriations Act of 2021 ($3 billion) for a total of $178 billion.

As shown in **Exhibit 4**, as of January 2021, $154 billion of the available funding had been allocated:

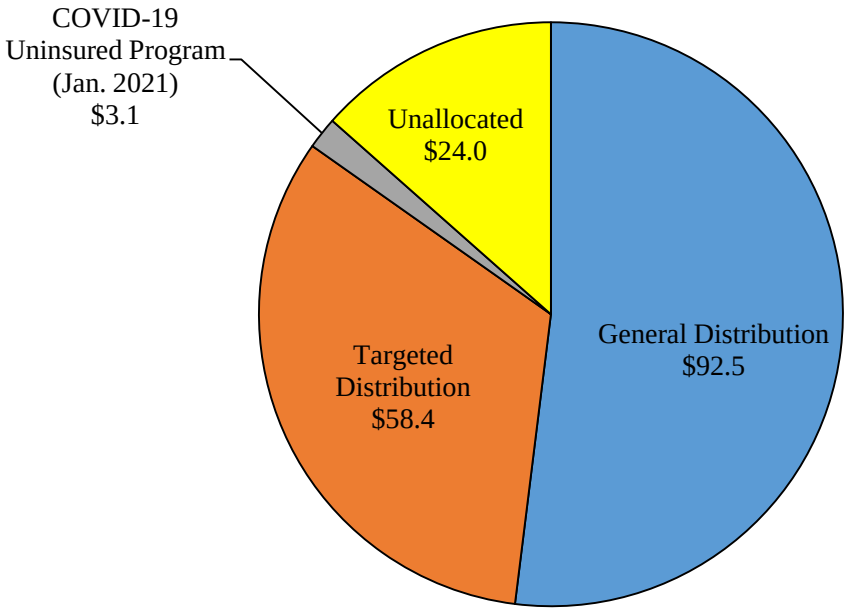
- $92.5 billion based on Medicare fee-for-service billing, Medicaid, Children's Health Insurance Program, dental and assisted living providers that did not receive funding via Medicare billing, and certain behavioral health providers as well as new practitioners that had no billing history prior to 2020. Relief was allowed up to 2% of net patient revenue, plus add-on funding of up to 88% of revenue losses and expenses attributable to COVID-19 initially for the period between January and June 2020;

- $58.4 billion in funding targeted at certain hospitals and health centers, nursing facilities, as well as certain tribal health facilities; and

- $3.1 billion for COVID-19 testing and treatment for the uninsured (this amount is not set but based on actual claims received).

There is $24 billion that remains unallocated.

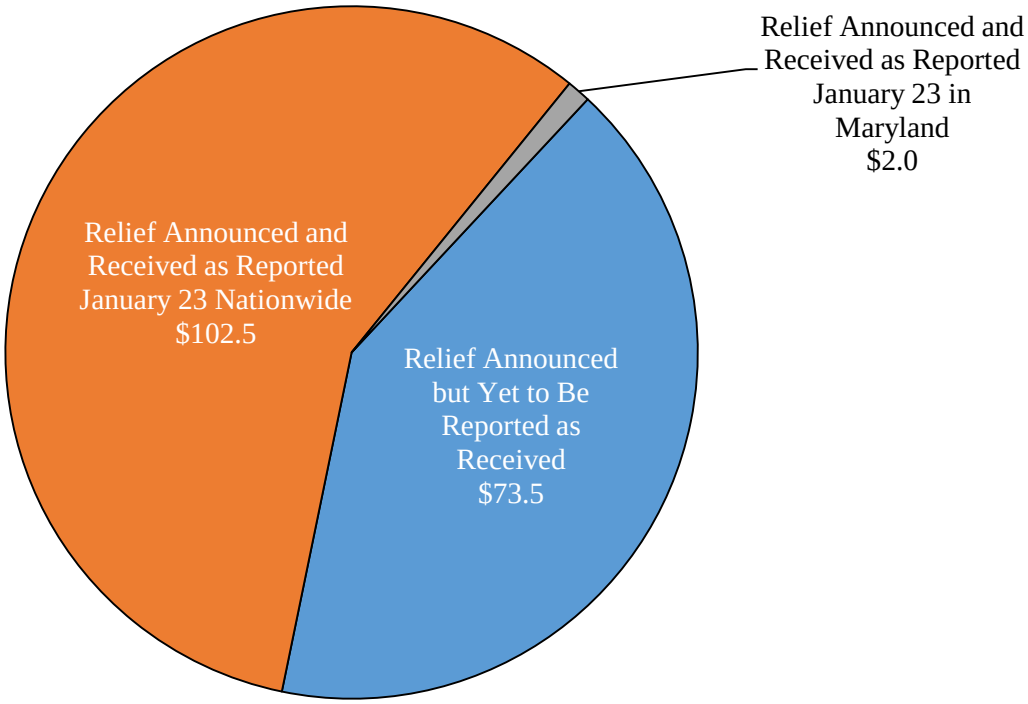
Exhibit 4
How the $178 Billion in Provider Relief Funds Has Been Allocated as of January 2021
($ in Billions)



Source: U.S. Department of Health and Human Services; Manatt Health; Department of Legislative Services

Although $154 billion in funding has been made available, as of January 2021, only $104.5 billion was reported to have been received and the terms and conditions for receipt of those funds attested to by providers. As shown in **Exhibit 5**, that includes just under $2.0 billion for Maryland providers.

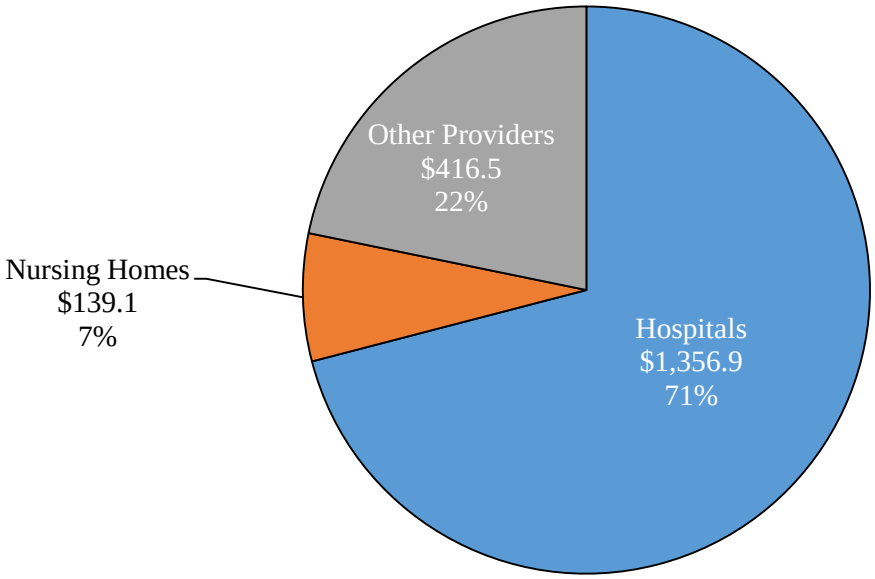
Exhibit 5
Provider Relief Fund: Funds Received and Attested to by Providers as of January 2021
($ in Billions)



Source: U.S. Department of Health and Human Services; Department of Legislative Services

As shown in **Exhibit 6**, of the funding received and attested to in Maryland (as of mid-December 2020), hospitals have received by far the largest amount of funding at almost $1.4 billion, followed by nursing homes. This reflects the extent of billing by these health sectors and the fact that the targeted funding in the Provider Relief Fund was focused on those sectors.

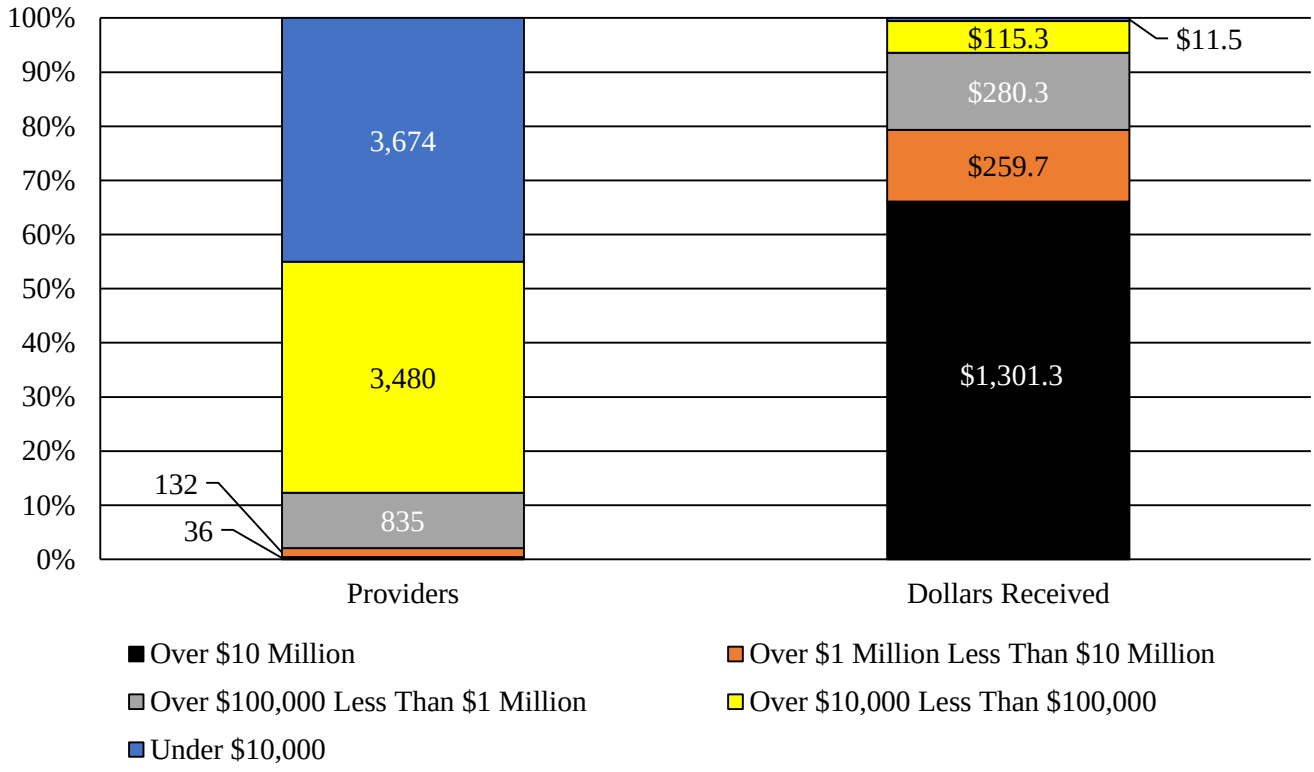
Exhibit 6
Funding Received and Attested to by Maryland Providers as of December 2020
($ in Millions)



Source: U.S. Department of Health and Human Services; Department of Legislative Services

In all, as of January 2021, almost 8,200 Maryland providers were reported to have received and attested to Provider Relief Fund support. **Exhibit 7** underscores that two-thirds of the funding has been received by 36 providers, all hospitals. Conversely, just under 90% of providers received only 6.4% of available funding. Again, given that funding is primarily based on patient revenue plus targeted allotments limited to certain providers, this distribution is to be expected.

Exhibit 7
Distribution of Provider Relief Funds Received and Attested to by Maryland Providers as of January 2021
($ in Millions)



Source: U.S. Department of Health and Human Services; Department of Legislative Services

It should be noted that the receipt of Provider Relief Fund support has not been without problems, with specific rules for receiving support continuing to change, not least how revenue losses attributable to COVID-19 were to be calculated. Indeed, the Consolidated Appropriations Act, for example, further revised the period against which the COVID-19 related losses and expenses may be calculated from January through June 2020 to January 2020 through March 2021 (something HHS had previously announced, although the application process for funding accounted only for the first six months of 2020) and also walked back guidance HHS had issued in October concerning exactly how lost revenues may be calculated. This perhaps explains to some extent why, nine months after the declaration of a national public health emergency, a significant amount of the funding has not been received. Given the change in federal Administration, further changes in the funding guidelines to more quickly allocate funding might be expected.

Provider Rate Increase

Health care providers, including the Behavioral Health Administration (BHA) and DDA providers, received another significant source of financial aid when Governor Lawrence J. Hogan, Jr. accelerated the mandated 4% provider rate increase from July 1, 2021, to January 1, 2021. This effort is estimated to distribute $87.3 million more to providers in fiscal 2021, which is reflected in multiple proposed deficiency appropriations.

Personal Protective Equipment Distribution and Testing Support

In coordinating the State's pandemic response, MDH also ordered large amounts of personal protective equipment (PPE) and distributed some of the PPE supply to providers. For example, DDA reported that, as of November 10, it had distributed five rounds of PPE to providers. Additionally, the State managed strike teams and other mobile medical units to provide COVID-19 testing to nursing homes, in particular. At the start of the pandemic, the State also helped cover some of the testing costs for nursing homes.

Telehealth Services

Health care providers have also been required to rapidly adapt their service delivery models during the COVID-19 pandemic; and an important tool to ensure access to, and continuation of, services has been the use of telehealth services. Prior to the pandemic, Medicaid had to provide mental health services appropriately delivered through telehealth to a patient in the patient's home setting. MDH could also specify other types of health care providers eligible to receive reimbursement for telemedicine health care services provided to Medicaid recipients.

Emergency legislation, Chapters 13 and 14 of 2020, authorized the Governor, for the duration of the COVID-19 catastrophic health emergency, to establish or waive telehealth protocols and order MDH to reimburse certain Medicaid telehealth services for COVID-19 patients. Executive orders from the Governor and waivers from federal requirements have resulted in increased Medicaid coverage for telehealth services (federal actions have also increased Medicare coverage). Expanded coverage includes coverage for telehealth services (1) originating at a participant's home or other secure location; (2) delivered by audio-only technology, including by phone; and (3) delivered by technology that is not compliant with the federal Health Insurance Portability and Accountability Act. These expansions will terminate with the end of COVID-19 emergency orders unless extended through additional executive orders or legislation.

It should be noted that there is considerable interest in making the expansion of telehealth service delivery under the delivery protocols in place ongoing after the current health emergency ends, and numerous bills have been introduced in the 2021 session.

Appendix K

Community services providers that serve individuals with developmental disabilities were also unable to provide some in-person services as the pandemic and stay-at-home order caused day and

employment support programs, among other community activities, to close. The vast majority of individuals receiving community services participate in one of three Home and Community-based Services waiver programs that regulate the service delivery system. DDA administers the waiver programs with approval from the Centers for Medicare and Medicaid Services (CMS) and on April 23, 2020, CMS approved an Emergency Preparedness and Response appendix (referred to as Appendix K) to adapt the program requirements for all three waiver programs in response to the COVID-19 pandemic.

Major provisions of Appendix K and fiscal 2020 expenditures related to the changes are shown in **Exhibit 8**. DDA indicates that 152 of 192 providers billed for retainer days in fiscal 2020, and 100 providers used retainer days in the first quarter of fiscal 2021. Although Appendix K was originally approved for one year to March 12, 2021, CMS has since approved an extension, and the appendix will remain in effect until six months after the end of the federal public health emergency.

Exhibit 8
Major Appendix K Provisions and Fiscal 2020 and 2021 Spending
($ in Millions)

Appendix K Provisions	**Fiscal 2020 Actual**	**Fiscal 2021 YTD[1]**
Retainer payments for certain providers of residential services, day/employment services, and personal supports services when providers were unable to offer services due to the pandemic	$18.4	$2.6
Residential, day, and supports services providers were authorized to provide services in alternative locations (*i.e.*, acute care hospitals, in the individual's home, *etc.*) and were authorized to provide services remotely or through telehealth		
Increased rate payments for direct support services provided to individuals who were exposed to or tested positive for COVID-19	3.5	2.2
Payments were available to residential service providers for shared day time service hours while day/employment services could not be provided or remote day services were provided		
Modifications to staffing qualifications and onboarding requirements to maintain and support the workforce		
Exceptions to preauthorization requirements to provide flexibility and allow for additional services		
Total Cost	**$21.9**	**$4.8**

YTD: year to date

[1]Fiscal 2021 spending through September 30, 2020. The Governor's allowance includes a proposed deficiency of $20 million ($10 million in general funds and $10 million in federal funds) in fiscal 2021 to cover Appendix K costs.

Source: Maryland Department of Health; Department of Legislative Services

Administrative Services Organization Status

During the COVID-19 pandemic, behavioral health providers were also faced with financial hardships; however, the extent of these challenges is largely unknown due to the inability of the new ASO, Optum, to process claims in an accurate and timely manner. This inability has caused significant lapses in data for the Department of Legislative Services (DLS) when determining the downturn in utilization experienced by the providers during the pandemic. After a failed initial go-live date of January 1, 2020, the department began processing estimated payments to providers based on average weekly payments made in calendar 2019. These estimated payments continued through August 3, 2020, when the Optum system was finally able to address the challenges faced in the initial launch. During the nearly 30 weeks that it took the department and Optum to prepare the new ASO to accurately and timely process claims, the department reported it made $1.06 billion in estimated payments to providers. DLS estimates that nearly 80% of the total estimated payments were distributed during the pandemic.

While at the time, the estimated payments did provide some stability in revenues for providers, the estimated payments ultimately need to be matched with actual services provided to be able to claim the appropriate federal fund match. Throughout the estimated payments period, providers were still submitting claims for services provided. The *2020 Joint Chairmen's Report* requested a report on the ASO transition, the estimated payments processed, and the future reconciliation of these payments. In this report submitted on November 16, 2020, the department reported that $894 million of claims submitted throughout the entire estimated claims period had been authorized, meaning that on net, MDH has overpaid providers by $163 million during the nearly 30-week estimated payments window. The department notes that it will ultimately enter a reconciliation and recoupment process with providers to finalize the amount of overpayment and provide avenues for the providers to pay back the funds distributed in excess of the approved claims over the period.

The reconciliation and recoupment presents several challenges to providers, the full extent of which is not known by DLS, due to the significant data shortfalls:

- One area of concern is the disparate impact of the pandemic on service utilization, ultimately creating inequitable amounts of overpayments by provider type. For instance, it is DLS' understanding that residential providers had more challenges in maintaining prepandemic service levels due to health and safety concerns around congregate living facilities. These providers are then likely to owe the State more than providers who were more easily able to transition to telehealth provision of care to maintain service utilization.

- Another concern is the cost incurred throughout the Public Behavioral Health System (PBHS) in adjusting care settings to meet health and safety considerations to limit the spread of COVID-19, such as PPE for employees. While these additional costs are being incurred by providers, many providers were unwilling or unable to use surplus funding through the estimated payment period, knowing that they would be required to return any overpayments made.

- Providers have also reported that the act of reconciliation with ASO in and of itself presents an additional administrative burden in reviewing all individual claims denied over this period.

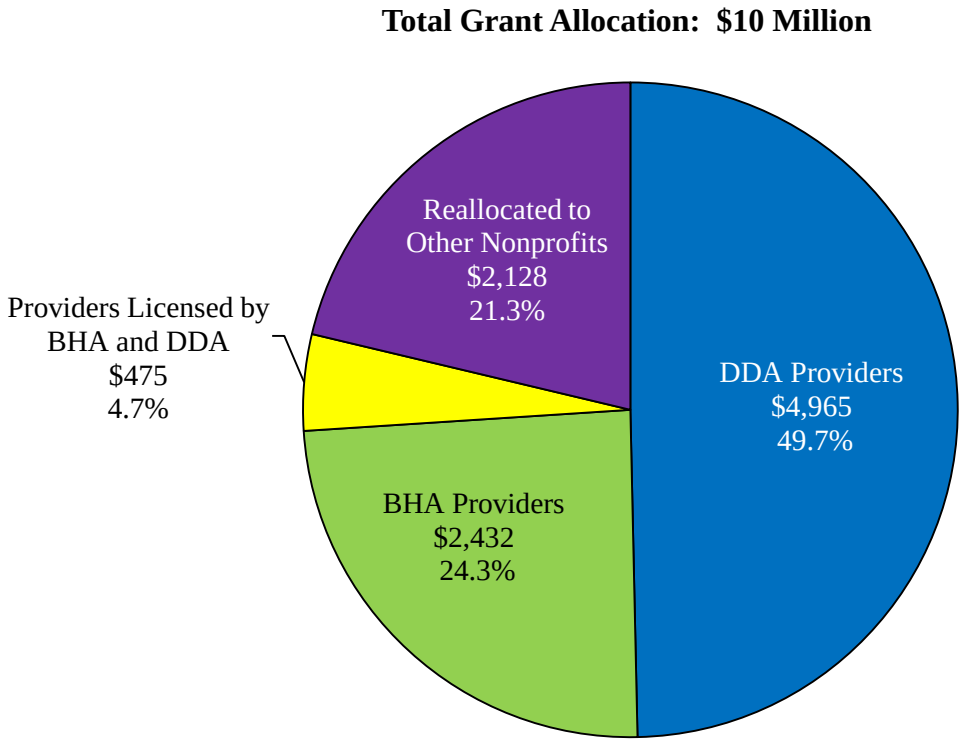
- Once the amount owed is agreed upon for recoupment, the providers may still be facing utilization below previous levels, only increasing financial hardships faced by PBHS.

Nonprofit Recovery Initiative for BHA and DDA Providers

On June 30, 2020, the Governor announced that $10 million of the State's Coronavirus Relief Fund allocation would support a grant program for licensed BHA and DDA providers as part of the Maryland Nonprofit Recovery Initiative administered by the Department of Housing and Community Development (DHCD). The Notice of Funding Availability, published on July 10, specified that grants ranging from $5,000 to $75,000 would be provided for staffing, rent, utilities, PPE, or cleaning supplies. Similar to the Provider Relief Fund, grantees were required to show that they had decreased revenue or increased expenses as a result of the COVID-19 pandemic between March 1 and December 30, 2020, to qualify for aid.

Despite extending the due date for grant applications and increasing the maximum grant award from $50,000 to $75,000, DHCD indicates that it received less than $10 million in funding requests from BHA and DDA providers. As shown in **Exhibit 9**, only $7.9 million was disbursed, with 49.7% going to DDA providers. Of the 144 providers that received grants, 83 were DDA providers, 53 were BHA providers, and 8 providers were licensed with both administrations. The remaining $2.1 million was reallocated to other nonprofits applying for financial aid through the Nonprofit Recovery Initiative.

Exhibit 9
Nonprofit Recovery Initiative Grants Awarded to BHA and DDA Providers
($ in Thousands)



BHA: Behavioral Health Administration
DDA: Developmental Disabilities Administration

Source: Department of Housing and Community Development

2. COVID-19 Pandemic Highlights Existing Racial and Ethnic Disparities in Health Outcomes and Social Determinants of Health

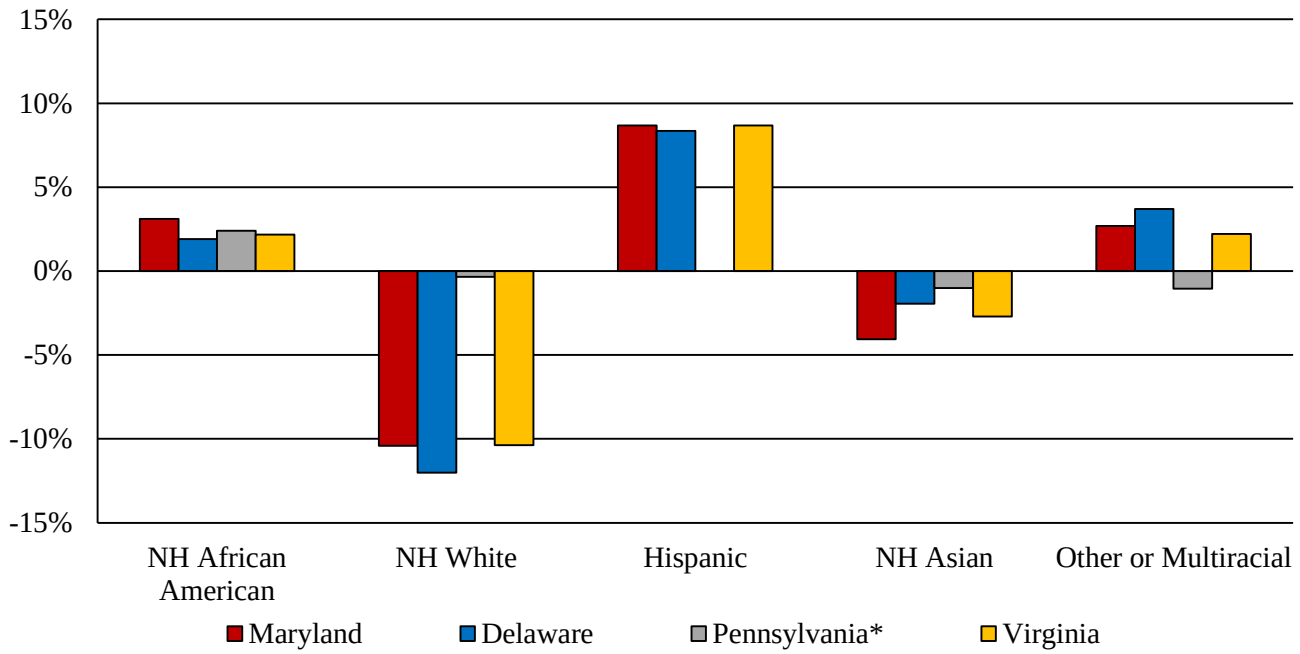
Annual reports published by the Vital Statistics Administration under MDH show persistent racial and ethnic disparities in population health indicators, including infant mortality, life expectancy, and the rates of death due to chronic conditions such as diabetes and heart disease. In reports spanning decades, Black individuals especially have been found to experience significantly worse health outcomes than White individuals, although other minority races also show worse health outcomes than White individuals for some indicators. The COVID-19 pandemic and resulting economic crisis has emphasized the racial and ethnic health disparities and inequitable social determinants of health that persist nationally and in Maryland.

Disparities in COVID-19 Cases and Deaths

Early in the pandemic as some states published COVID-19 data by race and ethnicity, a national trend emerged among those states showing that minority communities made up a disproportionate share of COVID-19 cases and deaths. CDC reported, as of November 30, 2020, that the rate of COVID-19 cases among Hispanic and non-Hispanic (NH) African American individuals was 1.7 times higher and 1.4 times higher, respectively, compared to the rate of COVID-19 cases among NH White individuals. CDC reported an even greater disparity in COVID-19 deaths, as the rate of deaths was 2.8 times higher for both African American and Hispanic individuals. It should be noted that this data is limited to the number of states that chose to publicly track COVID-19 measures by racial demographic, posing a challenge for measuring the extent of racial and ethnic disparities nationwide.

COVID-19 racial demographic data in Maryland and in nearby states also indicates that COVID-19 has disproportionately impacted Hispanic and NH Black communities. **Exhibits 10** and **11** show the difference between the shares of cumulative COVID-19 cases and deaths and the share of a State's population by race and ethnicity. A 0% difference means that the racial or ethnic group is equally represented in COVID-19 case and death counts as they are in the general population, whereas any difference above 0% means that a racial or ethnic group is overrepresented in the State's case and death count. For example, in Maryland, Hispanic individuals make up 10.6% of the State population but account for 19.3% of COVID-19 cases as of January 21, 2021. This is reflected in the exhibit as an 8.7% difference. It should be noted that Exhibits 10 and 11 show the percent of cases and deaths by race and ethnicity among the cases where race is known. All States pictured also report an often significant share of cases and deaths in which the race or ethnicity is not known. For example, Maryland reported approximately 14.4% of its cases on January 22, 2021, as having an unknown race.

Exhibit 10
Racial and Ethnic Disparities in COVID-19 Cumulative Cases
Share of Cases Minus Share of State Population



NH: non-Hispanic

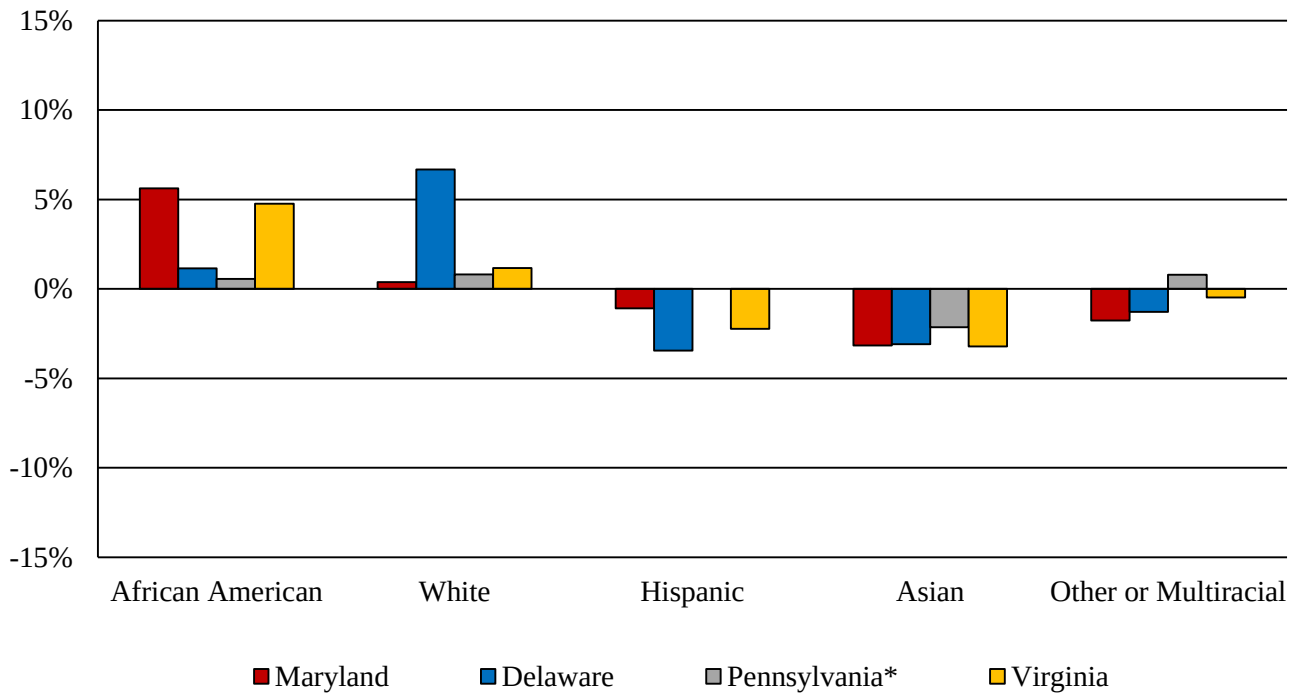
*Data for Pennsylvania's Hispanic population is not pictured, as the Pennsylvania Department of Health reports cases by race and ethnicity separately.

Note: Measured as the difference between each race or ethnicity's share of cumulative COVID-19 cases reported on January 22, 2021, and the share of State population estimated by the U.S. Census Bureau as of July 1, 2019. Racial groups are labeled based on the Maryland Department of Health COVID-19 dashboard, but demographic groups reported by other states vary.

Source: U.S. Census Bureau; Maryland Department of Health; Delaware Department of Health and Social Services; Pennsylvania Department of Health; Virginia Department of Health; Department of Legislative Services

All States shown in Exhibit 10 reported that Hispanic and NH Black individuals were overrepresented in COVID-19 case counts on January 21, 2021, with Virginia and Maryland both showing the highest disparities for Hispanic individuals at 8.7%, and Maryland showing the largest disparity for NH Black individuals at 3.1%. CDC attributes housing, occupation, discrimination, health care access and utilization, and other social determinants of health as the main factors driving disparities in COVID-19 prevalence among racial and ethnic minority groups. The Office of Minority Health and Health Disparities (MHHD) under MDH also stressed the role of housing and occupation in a July 2020 presentation. MHHD described how minority groups having more employment in essential occupations, less ability to telework, and higher density or multigenerational households all contribute to increased cases of COVID-19.

Exhibit 11
Racial and Ethnic Disparities in COVID-19 Cumulative Deaths
Share of Cases Minus Share of State Population



*Data for Pennsylvania's Hispanic population is not pictured as the Pennsylvania Department of Health reports cases by race and ethnicity separately.

Note: Measured as the difference between each race or ethnicity's share of cumulative COVID-19 cases reported on January 22, 2021, and the share of State population estimated by the U.S. Census Bureau as of July 1, 2019.

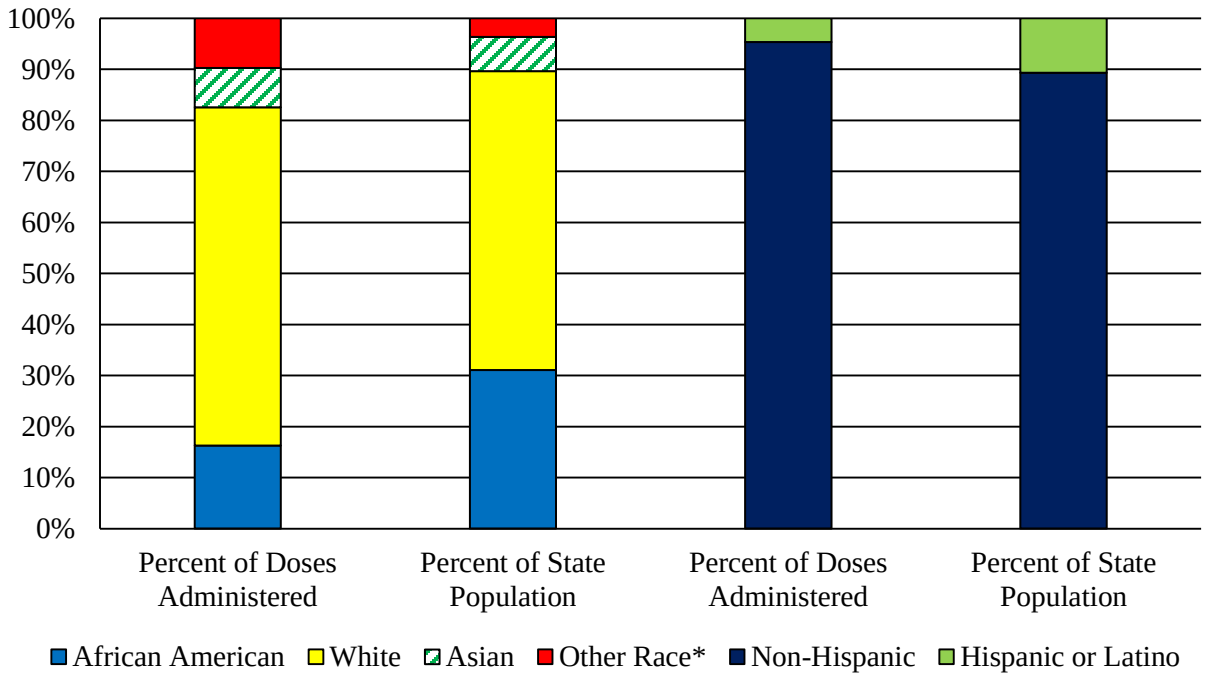
Source: U.S. Census Bureau; Maryland Department of Health; Delaware Department of Health and Social Services; Pennsylvania Department of Health; Virginia Department of Health; Department of Legislative Services

While CDC indicated that both NH Black and Hispanic populations nationally showed 2.8 times higher rates of COVID-19 deaths compared to NH White individuals; in Maryland, NH Black individuals are substantially overrepresented in the number of cumulative COVID-19 deaths compared to all other races. As shown in Exhibit 11, Maryland again showed the largest overrepresentation of NH Black individuals, accounting for 35.6% of the cumulative COVID-19 deaths versus 29.9% of the State population. Only Virginia showed a similar disparity among NH Black individuals, making up 23.9% of deaths versus 19.1% of the State population. MHHD reported in a document titled *Coronavirus Disease 2019 (COVID-19) and Minority Communities* that higher rates of chronic conditions, such as diabetes, obesity, hypertension, and asthma, among Black communities were linked with higher fatality from the virus.

Initial Disparities in COVID-19 Vaccine Administration

As of January 22, 2021, Maryland is in Vaccination Phase 1B and is reporting 314,861 total doses of COVID-19 vaccinations administered (first and second doses). Despite ongoing racial and ethnic disparities in COVID-19 cases and deaths, the early stages of the vaccination effort have shown smaller shares of doses going to Black and Hispanic individuals than would be expected based on the State population. **Exhibit 12** demonstrates that while Black Marylanders account for 31.1% of the State population, they have received 16.3%, or 47,372, of the total doses administered. Hispanic populations are also underrepresented, making up 10.7% of the State population but receiving 4.7%, or 12,757 doses. Due to the department reporting vaccination rates by race and ethnicity separately, slightly different U.S. Census population estimates were used for Exhibit 12 compared to Exhibits 10 and 11.

Exhibit 12
Maryland Shares of COVID-19 Vaccine Doses Administered by Race and Ethnicity



*Other race includes American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander individuals.

Note: Depicts total doses administered in Maryland (including first and second doses) reported on January 22, 2021, and U.S. Census Bureau estimates of Maryland population by race and ethnicity as of July 1, 2019.

Source: Maryland Department of Health; U.S. Census Bureau; Department of Legislative Services

It is concerning that the State reports uneven vaccine administration across race and ethnicity due to the more severe impacts of COVID-19 on Black and Hispanic communities discussed above, and because these communities are more likely to show greater distrust of vaccines and health care providers and may struggle with health care access. MDH has seen early racial disparities in vaccine administration as priority groups are largely distinguished by occupation and nursing home residency and age. On January 25, 2021, Maryland is set to advance to Phase 1C in which certain essential workers will become eligible to receive the vaccine, but the State does not prioritize doses based on certain comorbidities that are known to disproportionately affect Black and Hispanic communities until Phase 2. During a January 16, 2021 presentation to the Joint COVID-19 Response Legislative Workgroup, MDH described its plan for a public outreach campaign that would offer multilingual education regarding safety, efficacy, and availability of vaccines and would leverage trusted leaders and voices.

Approaches to Lessening Disparities Related to COVID-19

At the federal level, an executive order signed on January 21, 2021, by President Joseph R. Biden established a COVID-19 Health Equity Task Force under HHS. The executive order acknowledged a lack of complete data on COVID-19 infection, hospitalization, mortality rates, and underlying health and social vulnerabilities that posed challenges in conducting an equitable pandemic response. The task force is charged with preparing recommendations for mitigating health inequities caused or exacerbated by the COVID-19 pandemic and collaborating with heads of relevant federal agencies to make recommendations for expediting data collection and addressing data shortfalls for communities of color and other underserved populations, among other tasks.

In *Coronavirus Disease 2019 (COVID-19) and Minority Communities*, MHHD listed the following strategies that the department was using to respond to COVID-19-related racial and ethnic disparities, including:

- increasing testing and testing sites in minority communities;
- providing accurate information through a variety of platforms;
- funding community partners to conduct community conversations;
- partnering with other agencies to increase access to hospital beds and ventilators; and
- utilizing partnerships with faith-based organizations, community-based organizations, Historically Black Colleges and Universities, and local community organizing groups to coordinate the delivery of available resources and messaging to minority communities.

MHHD also noted that the department has administered longstanding programs, such as prevention and control for cancer, asthma, and diabetes, that aim to tackle health disparities through early intervention, prevention strategies, and community partnerships.

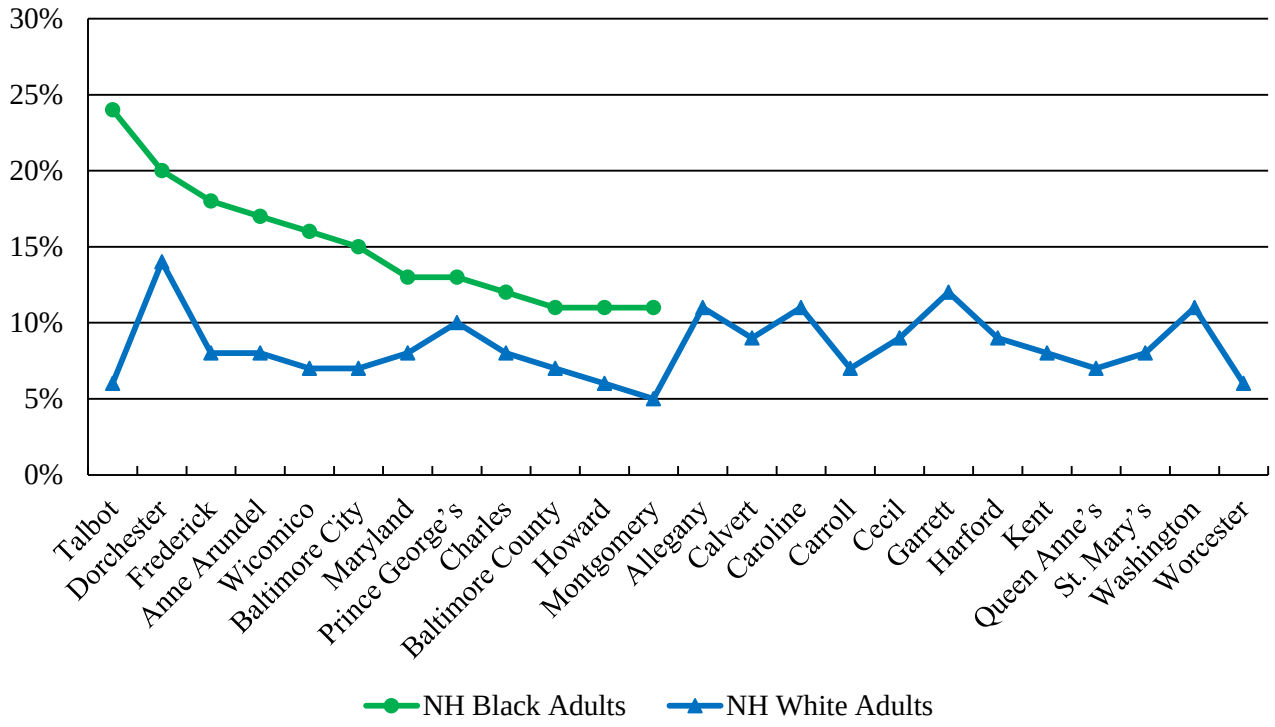
A January 2021 report of the Senate President's Advisory Workgroup on Equity and Inclusion also outlines recommendations that focus in part on the State's longstanding health disparities, not limited to COVID-19 related outcomes. These recommendations, such as improving data analysis around health care disparities, expanding maternal and child health services, and increasing the number of minority health care providers, along with multiple bills introduced in the 2021 session, relate to narrowing health care disparities based on race and improving outcomes for underserved communities.

Disparities in Prevalence of Diabetes

The department's diabetes prevention and management efforts are just one example of programs targeting the State's racial and ethnic health disparities. CDC has determined that there is sufficient evidence that people with type 2 diabetes are at increased risk of severe illness from the virus that causes COVID-19.

Maryland has recently prioritized diabetes prevention and management programs and metrics as part of the State's population health component required in the Total Cost of Care (TCOC) Model Contract that went into effect January 1, 2019. Related to this effort, the Health Services Cost Review Commission has invested $86.3 million of its $165.4 million Regional Partnership Catalyst Grant Program specifically in diabetes prevention and management activities over a five-year term. Many Vital Statistics Administration annual reports and the State *Diabetes Action Plan*, published in June 2020, repeatedly demonstrate that NH Black adults in Maryland experience higher diabetes prevalence and mortality than all other races. As shown in **Exhibit 13**, all jurisdictions with reportable age-adjusted prevalence rates of diagnosed diabetes have higher rates for NH Black adults than NH White adults in the jurisdiction.

Exhibit 13
Age-adjusted Prevalence of Diagnosed Diabetes by Race and Jurisdiction
Maryland 2015-2017 BRFSS



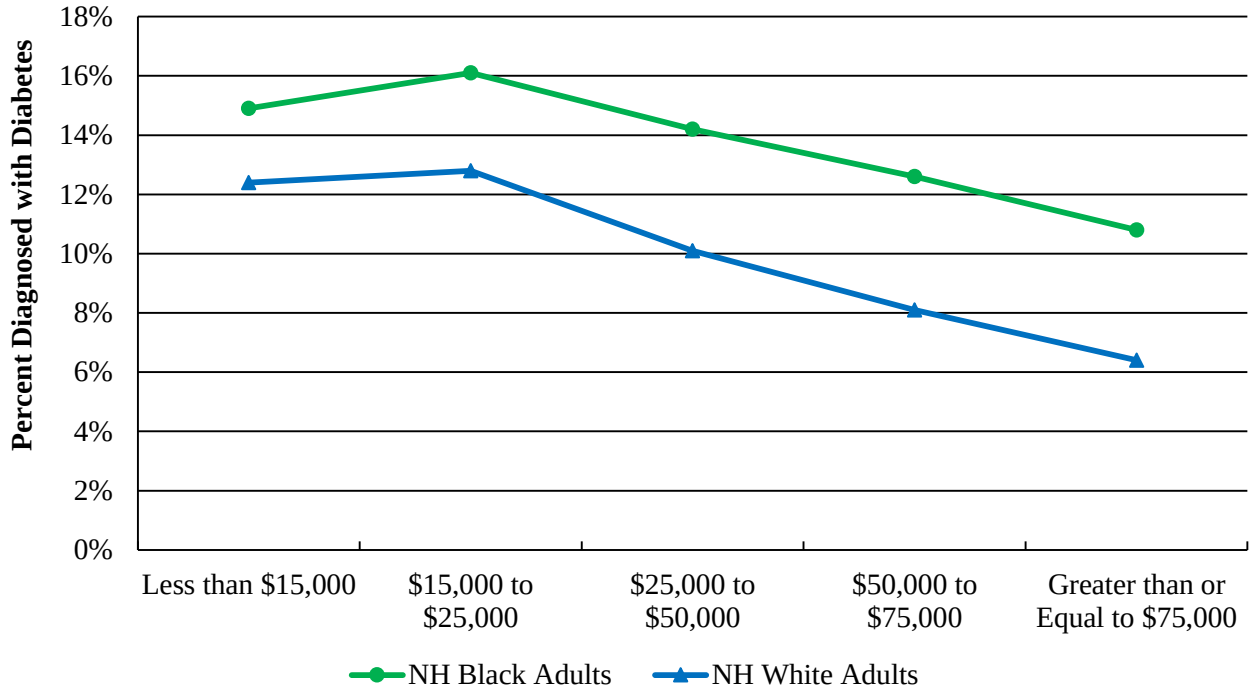
BRFSS: Behavioral Risk Factor Surveillance System
NH: Non-Hispanic

Note: Rates of diagnosed diabetes for NH Black adults are only shown in jurisdictions where the rate was reportable.

Source: Maryland *Diabetes Action Plan* 2020

Further, **Exhibit 14** reflects that NH Black adults experience a higher prevalence of doctor-diagnosed diabetes even when social determinants of health, like income, are controlled. NH Black adults in Maryland, regardless of income, had higher rates of diabetes. MDH reported that while differences in income contributed to the disparity in diabetes prevalence between NH Black and NH White adults, income does not fully explain the difference. The State *Diabetes Action Plan* also measured diabetes prevalence rates by race while controlling for weight status and education level, and NH Black adults continued to show higher rates in all categories compared to NH White adults. MDH discusses other social determinants of health such as food security or stress related to poverty and racism as other factors that exacerbate disparities.

Exhibit 14
Age-adjusted Adult Prevalence of Doctor Diagnosed Diabetes
By Income and Race
Maryland BRFSS 2015-2017



BRFSS: Behavioral Risk Factor Surveillance System
NH: Non-Hispanic

Source: Maryland *Diabetes Action Plan* 2020

Implementing the State *Diabetes Action Plan* was designated as one of the State's three targeted initiatives in the TCOC Model Contract for setting improvement goals and population health goals statewide. The June 2020 *Diabetes Action Plan* established objectives and action steps that support the following four health indicator goals, to be completed by 2024.

- ***Keeping People at a Healthy Weight Goal:*** 32%t of Maryland adults will be of healthy weight;

- ***People Who are Overweight and Obese Goal:*** Maryland will maintain the percent of adults with a Body Mass Index (BMI) greater than 25 at 66.5% and reduce by 10%t the BMI greater than the eighty-fifth percentile in high school students;

- ***People with Prediabetes and Gestational Diabetes Goal:*** Increase the prevalence of Maryland adults who know their prediabetes status by 30%; and

- ***People with Diabetes Goal:*** Reduce the age-adjusted diabetes mortality by 5%.

Although Maryland established 2024 statewide population health goals, they did not specify any targets for improving diabetes-related racial disparities. This is especially notable as the *Diabetes Action Plan* presents consistent racial disparities in diabetes prevalence and mortality across years and jurisdictions. The *Diabetes Action Plan* suggests many systemwide strategies for partners, such as health care providers, community groups, schools, among others, that may identify or serve at-risk individuals. Still, the department does not distinguish lessening racial and ethnic health disparities as one of the quantifiable targets of the plan.

Updates

1. Cigarette Restitution Fund – Administration Assumes $16 Million Payment in Fiscal 2021 Resulting from Multistate Litigation

Background

The CRF was established by Chapters 172 and 173 of 1999 and is supported by payments made under the Master Settlement Agreement (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 appropriation must be used for Medicaid. Activities funded through the CRF in fiscal 2022 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 are now held to an enhanced standard in NPM adjustment disputes.

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. A decision from the three-judge arbitration panel on Maryland's case is expected in early calendar 2021. Although New Mexico recently joined the arbitration proceedings as a ninth state, this is not expected to delay the decision for Maryland. The fiscal 2022 allowance reflects $16 million being released from escrow in fiscal 2021, which assumes that the arbitration panel will find that Maryland diligently enforced its qualifying statute and that the timing of this decision will allow for an April 2021 payment to the State. If the arbitration panel instead finds that Maryland was nondiligent, any reduction to the CRF payment would likely impact fiscal 2022 revenue due to the time that it would take to resolve payment amounts.

Sales Year 2005 through 2007

The next round of arbitration recently began for Maryland and nine other states and will determine settlements for sales year 2005 through 2007 at once. 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 2021, there was approximately $245.3 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.

Fiscal 2020 to 2022 CRF Programmatic Support

Exhibit 15 provides CRF revenue and expenditure detail for fiscal 2020 to 2022. Settlement payments have declined by 7.5% 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.

Exhibit 15
Cigarette Restitution Fund Budget Allowance
Fiscal 2020-2022
($ in Millions)

	2020 Actual	2021 Working	2022 Allowance
Beginning Fund Balance	$4.5	$0.1	$2.0
Settlement Payments	151.6	147.2	140.2
NPM and other shortfalls in payments [1]	-23.1	-22.4	-22.4
Awards from disputed account	0.0	0.0	0.0
National Arbitration Panel award	5.3	5.3	5.3
Tobacco Laws Enforcement Arbitration	0.0	16.0	0.0
Subtotal	***$138.3***	***$146.2***	***$125.0***
Prior Year Recoveries	$1.8	$2.5	$2.5
Total Available Revenue	**$140.1**	**$148.7**	**$127.5**
Health			
Tobacco enforcement, prevention and cessation	$9.5	$9.7	$10.9
Cancer	27.1	25.6	27.2
Substance Abuse	21.5	25.1	14.9
Breast and Cervical Cancer	13.3	13.2	13.2
Medicaid	54.7	57.3	36.0
Subtotal	***$126.0***	***$130.9***	***$102.1***
Other			
Aid to Nonpublic Schools	$12.3	$13.7	$16.3
Crop Conversion	1.0	0.7	0.5
Attorney General	0.8	1.5	1.5
Subtotal	***$14.0***	***$15.8***	***$18.2***
Total Expenses	**$140.0**	**$146.7**	**$120.3**
Ending Fund Balance	**$0.1**	**$2.0**	**$7.2**

NPM: nonparticipating manufacturer

[1] The NPM adjustment represents the bulk of this total adjustment.

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

Source: Governor's Fiscal 2022 Budget Books; Department of Legislative Services

Due to the Administration's assumption that the State will prevail in the 2004 sales year arbitration proceedings, fiscal 2021 CRF revenues include a payment of $16 million. This, along with the declining settlement payments cause fiscal 2022 revenues to decrease by $23.1 million. 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.

As a result of the anticipated decline in CRF revenue in fiscal 2022 and later years, CRF spending shows a net decrease, primarily in Medicaid and alcohol and substance abuse treatment and prevention programs, which is slightly offset by increased spending in cancer prevention programs and nonpublic school support. Changes of note include:

- Medicaid funding decreases by $21.3 million. Due to the uncertain timing of the 2004 sales year arbitration results, any beneficial or detrimental budgetary impact could occur in fiscal 2021 or beyond. Historically, any shortfalls in anticipated revenue are accounted for in Medicaid support.

- The appropriation for alcohol and substance abuse treatment and prevention programs decreases by $10.2 million.

- CRF support for cancer research at two Statewide Academic Health Centers increases by $1.5 million in fiscal 2022 following a BPW cost containment action that reduced the fiscal 2021 grant by the same amount.

- The Administration has increased funding for nonpublic schools to a total of $16.3 million. Specifically, funding for the Broadening Options and Opportunities for Students Today Program increases from $2.6 million to $10.0 million.

Appendix 1
Budget Overview
Fiscal 2018-2022
($ in Millions)

	2018 Actual	2019 Actual	2020 Actual	2021 Working	2022 Allowance	2021-2022 Change
General Funds	**$4,684**	**$4,947**	**$5,118**	**$5,489**	**$6,269**	
Fiscal 2021 Deficiencies and Back of the bill salary adjustment				-$622		
Contingent Actions					-$139	
Departmentwide Adjustments				5	8	
Adjusted General Funds	**$4,684**	**$4,947**	**$5,118**	**$4,871**	**$6,138**	**$1,266**
Special Funds	**$1,252**	**$1,292**	**$1,371**	**$1,304**	**$1,150**	
Fiscal 2021 Deficiencies				$151		
Contingent Actions					$139	
Departmentwide Adjustments				0	1	
Adjusted Special Funds	**$1,252**	**$1,292**	**$1,371**	**$1,455**	**$1,290**	**-$165**
Federal Funds	**$7,613**	**$7,891**	**$8,861**	**$8,242**	**$9,366**	
Fiscal 2021 Deficiencies				$1,621		
Contingent Actions						
Departmentwide Adjustments				1	$2	
Adjusted Federal Funds	**$7,613**	**$7,891**	**$8,861**	**$9,863**	**$9,368**	**-$496**
Reimbursable Funds	**$95**	**$112**	**$681**	**$99**	**$97**	**-$2**
Adjusted Total	**$13,643**	**$14,243**	**$16,031**	**$16,288**	**$16,892**	**$604**
Annual Percent Change From Prior Year	**2.4%**	**4.4%**	**12.6%**	**1.6%**	**3.7%**	

Note: Numbers may not sum to total due to rounding. The fiscal 2021 appropriation includes general salary increases, deficiencies, and a back of the bill reduction. The fiscal 2022 appropriation includes contingent actions, annualization of general salary increases, annual salary reviews, and State Law Enforcement Officers Labor Alliance salary increases.

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

Appendix 2
Budget Overview: All Funding Sources
Fiscal 2020-2022 Allowance
($ in Millions)

	2020 Actual	2021 Working	2022 Allowance	2021-2022 $ Change	2021-2022 % Change
Medical Programs/Medicaid	**$10,293**	**$11,156**	**$11,590**	**$434**	**3.9%**
Provider Reimbursements	9,866	10,666	11,091	425	4.0%
Maryland Children's Health Program	212	301	280	-21	-7.0%
Other	215	189	219	30	15.9%
Behavioral Health	**$1,940**	**$2,174**	**$2,355**	**$181**	**8.3%**
Program Direction	18	17	16	-1	-8.3%
Community Services	1,922	2,157	2,339	183	8.5%
Developmental Disabilities	**$1,329**	**$1,466**	**$1,541**	**$75**	**5.1%**
Program Direction	10	10	10	1	7.7%
Community Services	1,273	1,415	1,488	73	5.2%
Facilities	46	42	43	1	1.8%
MDH Administration	**$455**	**$437**	**$450**	**$13**	**2.9%**
Behavioral Health Facilities	341	311	319	8	2.7%
Chronic Disease Hospitals	47	47	46	-1	-2.5%
Other	67	79	85	6	6.9%
Public Health Administration	**$1,411**	**$396**	**$178**	**-$218**	**-55.1%**
Coronavirus Relief Fund	657	220	0	-220	-100.0%
Targeted Local Health	59	61	62	0	0.7%
Other	695	114	116	2	1.7%
Prevention and Health Promotion Administration	**$390**	**$416**	**$513**	**$97**	**23.4%**
WIC Program	87	114	105	-9	-7.7%
CRF Tobacco and Cancer Programs	35	33	36	2	6.8%
Maryland AIDS Drug Assistance Program (including MOE)	69	60	69	9	14.6%
ELC Grant for Infectious Diseases	4	2	87	85	3785.9%
Other	195	209	303	95	45.5%
Other Budget Areas	**$213**	**$238**	**$254**	**$16**	**6.9%**
Office of Health Care Quality	24	24	25	1	2.7%
Health Occupations Boards	41	48	45	-3	-5.7%

	2020 Actual	2021 Working	2022 Allowance	2021-2022 $ Change	2021-2022 % Change
Health Regulatory Commissions	148	165	184	18	11.1%
Departmentwide Actions		**$5**	**$11**	**$6**	
Total Funding	**$16,031**	**$16,288**	**$16,892**	**$604**	**3.7%**

CRF: Cigarette Restitution Fund
ELC: Epidemiology and Laboratory Capacity
MDH: Maryland Department of Health
MOE: maintenance of effort
WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

Note: The fiscal 2021 appropriation includes general salary increases, deficiencies, and a back of the bill reduction. The fiscal 2022 appropriation includes contingent actions, annualization of general salary increases, annual salary reviews, and State Law Enforcement Officers Labor Alliance salary increases. 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 2022 Budget Books; Department of Legislative Services

Appendix 3
Fiscal 2021 Cost Containment Actions Approved by the Board of Public Works
July 1, 2020
($ in Millions)

	General Funds	Special Funds	Federal Funds	Total Funds
Executive Direction				
Delay implementation of the new Employed Individuals with Disabilities Pilot Program by six months.	-$0.3			-$0.3
Public Health Administration				
Adjust Medicaid transportation grant to Garrett County to align with updated expenditure projections.	-$0.3			-$0.3
Increase the overhead rate from Newborn Screening for Administrative services from 15% to 20%.	-0.1			-0.1
Prevention and Health Promotion Administration				
Reduce grant to the Capital Region Medical Center by 10%.	-$1.5			-$1.5
Reduce grant to Statewide Academic Health Centers for cancer research by 10%.		-$1.5		-1.5
Reduce funding to the Advance Directives Fund to reflect actual spending.	-0.5			-0.5
Medicaid				
Increase Medicaid Deficit Assessment on hospitals.	-$35.0			-$35.0
Limit reimbursement on durable medical equipment and disposable medical supplies to 80%percent of the Medicare rate.	-1.5			-1.5
Reduce funding for the National Diabetes Prevention program to better align with recent spending.	-0.8			-0.8
Delay implementing postpartum dental services by six months.	-0.3			-0.3
Reduce Washington, DC hospital reimbursement rate.	-1.7			-1.7
Reduce general funds due to additional special fund availability in the Cigarette Restitution Fund.	-1.7			-1.7
Medicaid federal matching funds based on reductions noted above.			-$5.7	
Administrative and Across-the-board Reductions				
Reduce operating costs, including supplies, contractual services for information technology, travel, *etc.*	-$0.3			-$0.3
Transfer excess fund balance from the State's self-insured unemployment insurance to the General Fund.	-0.9	-$0.1	-0.2	-1.2
Total	**-$44.8**	**-$1.6**	**-$5.9**	**-$52.2**

Source: Department of Budget and Management

Appendix 4
Fiscal 2021 Deficiencies
($ in Millions)

Program	Item	General Funds	Special Funds	Federal Funds	Total Funds
Deficiencies Related to the COVID-19 Pandemic Response					
Office of Preparedness and Response					
	Coronavirus Relief Funding added to reimburse State agencies for public safety salaries.			$178.4	$178.4
	Coronavirus Relief Funding added to reimburse State agencies for State agency response and quarantine pay.			42.1	42.1
	Coronavirus Relief Funding added to reimburse higher education institutions for public safety salaries.			26.7	26.7
	Funding for costs of the new Candlewood office and warehouse to store COVID-19 supplies.	$0.5			0.5
Behavioral Health Administration (BHA)					
	Funding to account for savings resulting from an enhanced federal match for community services.	-61.6		61.6	0.0
Developmental Disabilities Administration (DDA)					
	Funding to reflect Emergency Preparedness and Response Appendix K waiver costs.	10.0		10.0	20.0
	Funding to account for savings resulting from an enhanced federal match for community services.	-72.0		72.0	0.0
Medicaid					
	Funding to account for savings resulting from an enhanced federal match for Medicaid services.	-600.7		600.7	0.0
	Funding to account for savings resulting from an enhanced federal match for the Maryland Children's Healthcare Program (MCHP) services.	-13.0		13.0	0.0
Subtotal		***-$736.9***	***$0.0***	***$1,004.5***	***$267.7***
Provider Rate Deficiencies					
BHA					
	Funding to accelerate the mandated provider rate increase from July 1, 2021, to January 1, 2021.	$11.0	$0.4	$11.9	$23.4
DDA					
	Funding to accelerate the mandated provider rate increase from July 1, 2021, to January 1, 2021.	14.6	0.1	13.0	27.7

Program	Item	General Funds	Special Funds	Federal Funds	Total Funds
Medicaid					
	Funding to accelerate the mandated provider rate increase from July 1, 2021, to January 1, 2021.	15.9		20.2	36.2
Subtotal		***$41.5***	***$0.5***	***$45.2***	***$87.3***
Other Deficiencies					
Prevention and Health Promotion					
	Funding to reflect additional funds awarded for the State Opioid Response federal grant.			$11.3	$11.3
	Funding to fund contracts related to the Kidney Disease Program.	$0.5			0.5
	Funding to reflect an additional federal grant from the Title X Family Planning program.	-3.0		3.0	0.0
BHA					
	Funding to reflect additional funds awarded for the State Opioid Response federal grant.			48.3	48.3
BHA Facility Maintenance					
	Funding for operational costs at Crownsville Hospital Center.	0.6	$0.1		0.7
DDA					
	General and federal fund availability as a result of the actual costs of medical, financial, and utilization review contracts.	-3.4		-2.5	-5.9
Medicaid					
	Funding to account for the traditional Medicaid and the Affordable Care Act Expansion populations and additional special fund revenue.	233.7	10.0	482.7	726.4
	Special fund allocation to account for increases to the Medicaid Deficit Assessment.		45.0		45.0
	Funding to adjust enrollment, utilization, and rate projections for MCHP enrollees and to account for a freeze on premium collections.	18.2	-4.8	28.3	41.7
	Special fund balance available from the State Reinsurance program creating general fund savings in Medicaid provider reimbursements.	-100.0	100.0		0.0
	General fund availability due to Part D clawback overpayment in fiscal 2020.	-46.4			-46.4
Subtotal		***$100.3***	***$150.3***	***$571.0***	***$821.5***

Program	Item	General Funds	Special Funds	Federal Funds	Total Funds
Fiscal 2021 Deficiencies Total		**-$595.1**	**$150.8**	**$1,620.7**	**$1,176.5**
Other Fiscal 2021 Adjustments					
Public Health Administration					
	Back of the bill reduction for public safety salaries in Local Health Departments that are reimbursed with federal funds in Office of Preparedness and Response.	-$27.0			-$27.0
Departmentwide					
	Funding for January 1, 2021 2% general salary increase.	4.5	$0.2	$0.7	5.4

Source: Governor's Fiscal 2022 Budget Books

Appendix 5
Selected Caseload Estimates Used in Budget
Fiscal 2018-2022

	2018	2019	2020	Estimated 2021	Estimated 2022	Change 2021-2022	% Change 2021-2022
Medical Care Programs/Medicaid							
Medicaid Enrollees	914,578	908,849	939,251	1,010,379	1,019,194	8,815	0.9%
MCHP	147,837	154,321	143,030	144,140	143,900	-240	-0.2%
ACA Medicaid Expansion	309,504	309,330	316,313	359,388	388,412	29,024	8.1%
Total	**1,371,919**	**1,372,500**	**1,398,594**	**1,513,907**	**1,551,506**	**37,599**	**2.5%**
Behavioral Health Administration							
Individuals Treated in PBHS	275,667	291,740	289,027	327,799	327,799	0	0.0%
Individuals Treated by PBHS for Mental Health Condition	211,325	225,278	222,966	238,795	238,795	0	0.0%
Individuals Treated by PBHS for Substance-related Disorders	110,398	116,536	122,219	130,940	130,940	0	0.0%
Individuals in PBHS Dually Diagnosed	91,914	98,624	91,526	98,700	102,000	3,300	3.3%
Developmental Disabilities Administration (DDA)[1]							
Residential Services	6,510	6,560	6,604	6,732	6,862	130	1.9%
Day Services	13,754	13,732	13,617	13,862	14,112	250	1.8%
Support Services	8,222	4,787	4,697	4,856	4,943	87	1.8%
Self-directed Services	688	983	1,121	1,143	1,166	23	2.0%
Total Services	**29,174**	**26,062**	**26,039**	**26,593**	**27,083**	**490**	**1.8%**
Targeted Case Management	22,646	23,012	23,445	23,914	24,392	478	2.0%
Unduplicated Count of Individuals Receiving Community-based Services	16,700	16,868	17,296	17,642	17,995	353	2.0%
Average Daily Population at State-run DDA Facilities[2]	124	117	120	120	120	0	0.0%
MDH Administration							
Hospitals Excluding RICAs and Assisted Living	997	1,015	964	1,013	1,024	11	1.1%
RICAs	70	87	81	80	90	10	12.5%
Assisted Living	54	38	40	36	40	4	11.1%

	2018	2019	2020	Estimated 2021	Estimated 2022	Change 2021-2022	% Change 2021-2022
Subtotal – Average Daily Populations at State-run Psychiatric Hospitals	***1,121***	***1,140***	***1,085***	***1,129***	***1,154***	***25***	***2.2%***
Chronic Hospitals	92	87	83	97	98	1	1.0%
Total – Average Daily Population at State Hospitals, Excluding DDA Facilities	**1,213**	**1,227**	**1,168**	**1,226**	**1,252**	**26**	**2.1%**

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

[1] The service components show a duplicated count as individuals can be counted in multiple service types. Targeted case management is provided to individuals on the waiting list as well as individuals receiving community services. Residential services include individual family care. Day services include supported employment and summer programs. Support services include individual, family, and personal support services.
[2] DDA institutional data includes the secure evaluation and therapeutic treatment center unit relocated to the Potomac Center in 2019.

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

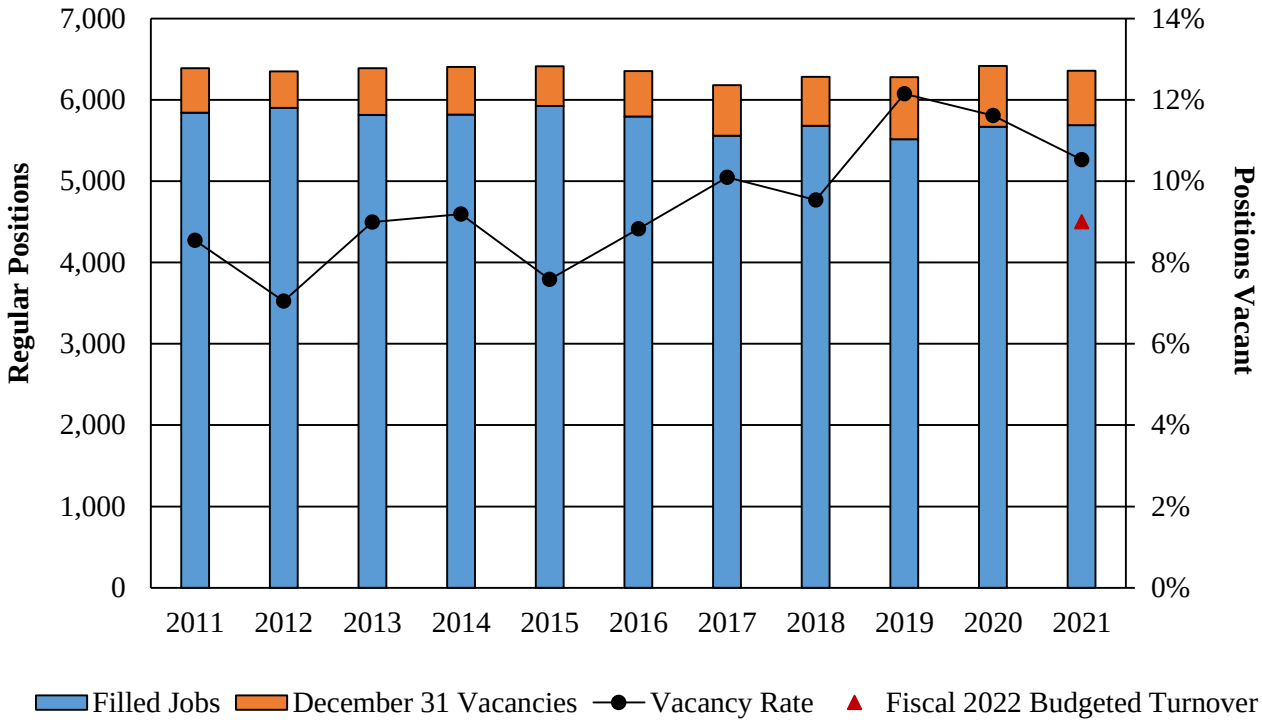
Appendix 6
Regular Personnel – Authorized Positions by Program
Fiscal 2020-2022

	Actual 2020	Working 2021	Allowance 2022	Change 2021-2022	% Change 2021-2022
MDH Administration	**3,505.9**	**3,497.1**	**3,474.3**	**-22.8**	**-0.7%**
Behavioral Health Facilities	2,646.3	2,647.6	2,620.2	-27.4	-1.0%
Chronic Disease Hospitals	426.6	421.5	414.1	-7.4	-1.8%
Administration	433.0	428.0	440.0	12.0	2.8%
Office of Health Care Quality	**210.0**	**221.0**	**230.0**	**9.0**	**4.1%**
Health Occupations Boards	**286.6**	**280.5**	**282.5**	**2.0**	**0.7%**
Public Health Administration	**431.8**	**417.0**	**420.8**	**3.7**	**0.9%**
Prevention and Health Promotion Administration	**466.5**	**461.4**	**460.4**	**-1.0**	**-0.2%**
Behavioral Health Administration	**136.8**	**134.8**	**134.8**	**0.0**	**0.0%**
Developmental Disabilities Administration	**642.0**	**626.6**	**640.5**	**14.0**	**2.2%**
Administration	170.5	174.5	176.5	2.0	1.1%
Facilities	471.5	452.1	464.0	12.0	2.6%
Medical Care Programs Administration	**625.7**	**608.9**	**609.0**	**0.1**	**0.0%**
Health Regulatory Commissions	**109.9**	**108.9**	**112.9**	**4.0**	**3.7%**
Total Regular Positions	**6,415.2**	**6,356.2**	**6,365.2**	**9.0**	**0.1%**

MDH: Maryland Department of Health

Source: Governor's Fiscal 2022 Budget Books

Appendix 7
Regular Personnel – Departmentwide Filled Jobs and Vacancy Rates
Fiscal 2011-2021



Note: Fiscal 2022 budgeted turnover is based on authorized positions in the Governor's fiscal 2022 allowance, which would authorize a net increase of 9 regular positions compared to the fiscal 2021 working appropriation.

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

Appendix 8
Contractual Personnel – Authorized FTE Positions by Program
Fiscal 2020-2022

	Actual 2020	Working 2021	Allowance 2022	Change 2020-2021	% Change 2020-2021	Change 2021-2022	% Change 2021-2022
MDH Administration	**188.9**	**206.8**	**209.9**	**17.9**	**9.5%**	**3.1**	**1.5%**
Behavioral Health Facilities	155.2	166.3	164.8	11.2	7.2%	-1.6	-0.9%
Chronic Disease Hospitals	18.3	24.8	25.8	6.4	35.1%	1.0	4.0%
Administration	15.4	15.7	19.4	0.3	2.1%	3.7	23.4%
Office of Health Care Quality	**8.2**	**12.5**	**12.5**	**4.3**	**52.3%**	**0.0**	**0.0%**
Health Occupations Boards	**61.3**	**85.2**	**84.8**	**23.9**	**39.0%**	**-0.4**	**-0.5%**
Public Health Administration	**64.5**	**86.9**	**84.9**	**22.5**	**34.8%**	**-2.0**	**-2.3%**
Prevention and Health Promotion Administration	**43.0**	**72.2**	**75.3**	**29.2**	**67.7%**	**3.1**	**4.2%**
Behavioral Health Administration	**34.5**	**45.6**	**56.1**	**11.2**	**32.3%**	**10.4**	**22.8%**
Developmental Disabilities Administration	**42.9**	**44.9**	**47.9**	**2.0**	**4.6%**	**3.0**	**6.7%**
Administration	22.8	33.0	33.3	10.2	44.6%	0.3	0.9%
Facilities	20.1	11.9	14.6	-8.2	-40.8%	2.7	22.8%
Medical Care Programs Administration	**84.0**	**99.3**	**111.4**	**15.3**	**18.3%**	**12.1**	**12.2%**
Health Regulatory Commissions	**7.2**	**7.9**	**9.6**	**0.7**	**9.3%**	**1.7**	**21.9%**
Total Contractual Positions	**534.5**	**661.3**	**692.3**	**126.8**	**23.7%**	**31.0**	**4.7%**

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

Source: Governor's Fiscal 2022 Budget Books