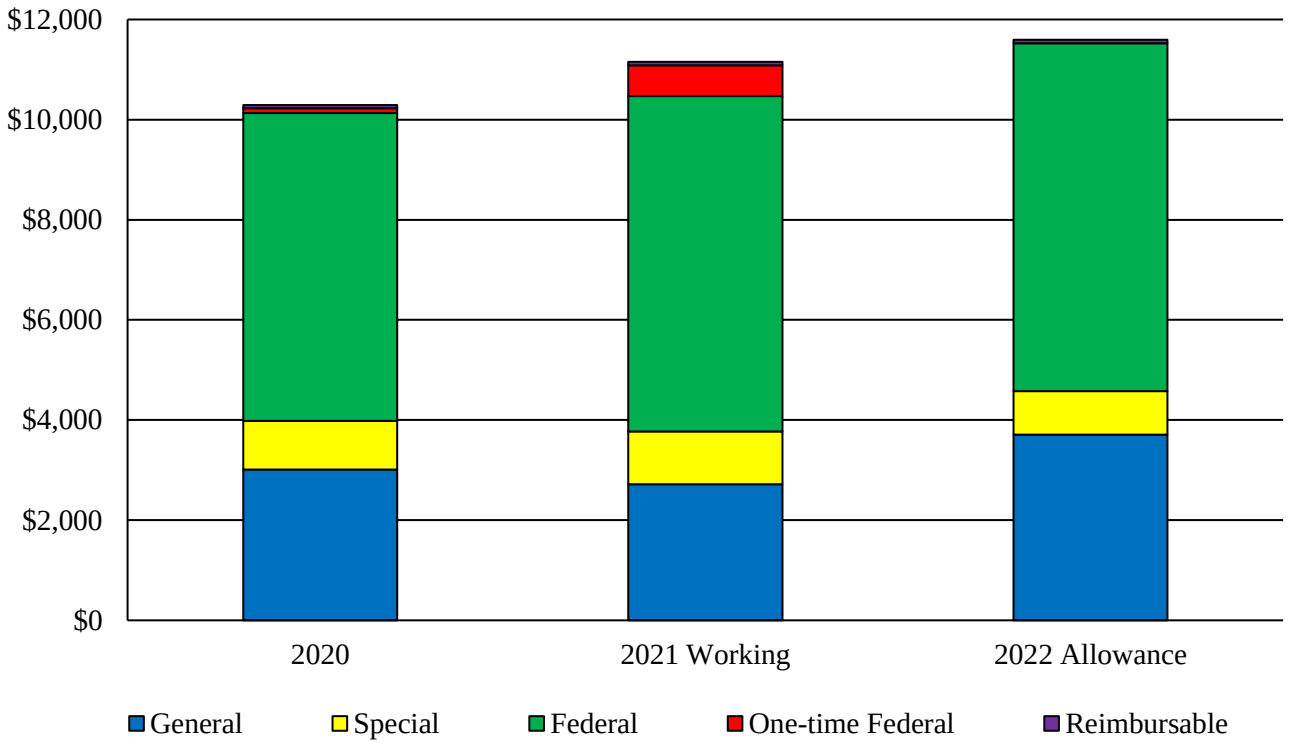
# M00Q01
# Medical Care Programs Administration
## Maryland Department of Health

## *Executive Summary*

The Medical Care Programs Administration (MCPA) is responsible for administering the Medical Assistance Program (Medicaid) and the Maryland Children's Health Program that provide comprehensive health benefits to over 1.5 million Marylanders. MCPA administers various other programs including specialty mental health and substance use disorder services for Medicaid recipients.

## *Operating Budget Summary*

**Fiscal 2022 Budget Increases by $439.2 Million, or 3.9%, to $11.6 Billion**
**General Fund Growth is 36.4%, Primarily due to the**
**Loss of One-Time Fiscal 2021 Federal Funds**
**($ in Millions)**




Note: Fiscal 2021 appropriation is adjusted for deficiencies, contingent reductions, contingent appropriations, and general salary increases. Fiscal 2022 allowance is adjusted for contingent reductions, contingent appropriations, annual salary review adjustments, and the annualization of the fiscal 2021 general salary increase.

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- Both fiscal 2021 and 2022 budgets appear overfunded.

- The declaration of a national public health emergency and with it the associated enhanced federal Medicaid matching rate has afforded Maryland significant general fund relief in fiscal 2020 and 2021. The decision by the Joseph R. Biden, Jr. Administration in January 2020 to extend that emergency through fiscal 2021 is not reflected in the fiscal 2022 budget and provides unanticipated additional relief for six months of fiscal 2022.

# *Key Observations*

- ***Key Managed Care Organization (MCO) Quality Measurements Have Worsened across the Program as a Whole:*** In recent years, more Maryland MCOs, while still outperforming their peers on national performance measures, are not meeting State targets. Concerns about one of the most visible quality programs, the Value-based Purchasing program, has prompted Medicaid to revise it.

- ***Expanding Home- and Community-based (HCBS) Waiver Services:*** In recent years the legislature has considered bills to expand HCBS waiver capacity. These bills have been contentious mainly around the costs of adding waiver slots. Fiscal 2021 Budget Bill language withheld funding pending the development of a cost estimate for expansion by the University of Maryland Baltimore County's Hilltop Institute. The subsequent report (at the time of writing available in draft) indicates that waiver expansion does have a fiscal impact, although less than previously thought. Further, there are benefits to waiver services that cannot be readily quantified.

## Operating Budget Recommended Actions

| | | **Funds** |
|---|---|---|
| 1. | Add language restricting provider reimbursement funding to that purpose. | |
| 2. | Add language to Maryland Children's Health Program restricting program expenditures to that purpose. | |
| 3. | Reduce general funds based on the availability of special funds from the Board of Pharmacy Fund authorized in the Budget Reconciliation and Financing Act of 2020. | $ 750,000 |
| 4. | Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund. | 2,903,849 |

| | | |
|---|---|---|
| 5. | Reduce general funds for the non-emergency transportation program based on the most recent actual federal fund attainment. | 4,500,000 |
| 6. | Reduce general funds based on service utilization trends. | 77,000,000 |
| 7. | Reduce general funds based on the unanticipated availability of enhanced federal matching funds through calendar 2021. | 244,600,000 |
| 8. | Add language authorizing the transfer of special funds from the Cigarette Restitution Fund. | |
| 9. | Adopt narrative on calendar 2020 managed care organization risk corridor settlements. | |
| 10. | Adopt narrative requesting that the Maryland Department of Health investigate shared savings opportunities with Medicare that could result in reducing the costs associated with expansion of home- and community-based waiver services. | |
| 11. | Amend the contingent budget amendment authorization in the Senior Prescription Drug Assistance Program to reflect anticipated need. | |
| 12. | Reduce general fund deficiency appropriations to reflect service utilization trends. | 75,000,000 |
| 13. | Reduce general fund deficiency appropriations to reflect the availability of unrecognized fiscal 2020 enhanced federal match. | 37,300,000 |
| | **Total Reductions to Fiscal 2021 Deficiency Appropriation** | **$ 112,300,000** |
| | **Total Reductions to Allowance** | **$ 329,753,849** |

## Budget Reconciliation and Financing Act Recommended Actions

1. Amend the provision in the Budget Reconciliation and Financing Act of 2021 as introduced to set the minimum appropriation for the Senior Prescription Drug Assistance Program at $11.5 million in fiscal 2022 and not less than $14.0 million beginning in fiscal 2023.

# M00Q01
# Medical Care Programs Administration
## Maryland Department of Health

## *Operating Budget Analysis*

### Program Description

The Medical Care Programs Administration (MCPA), a unit of the Maryland Department of Health (MDH), is responsible for administering the Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Employed Individuals with Disabilities (EID) program, and the Senior Prescription Drug Assistance Program (SPDAP). MCPA also oversees expenditures for fee-for-service (FFS) Medicaid-eligible community behavioral health services for Medicaid-eligible recipients. However, for the purpose of this budget analysis, that funding is excluded from this discussion and is included in the discussion of funding under the Behavioral Health Administration. Until fiscal 2021, the Kidney Disease Program was also part of MCPA but was recently transferred to the Prevention and Health Promotion Administration within MDH.

#### Medicaid

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. In Maryland, the federal government generally covers 50% of Medicaid costs. Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, low-income parents, and childless adults. To qualify for benefits, applicants must pass certain income and asset tests. Income eligibility levels can vary by age and pregnancy status, for example.

Individuals qualifying for cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. The U.S. Congress has extended eligibility to include pregnant women and children who meet certain income eligibility standards through the Pregnant Women and Children Program. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level (FPL) in making their coinsurance and deductible payments. Effective January 1, 2014, Medicaid coverage was expanded to persons below 138% of FPL, as authorized in the Affordable Care Act (ACA). The federal match for this population in fiscal 2022 is 90%. (The most current FPL guidelines are listed in **Appendix 7**.)

Another major group of Medicaid-eligible individuals is the medically needy. The medically needy are individuals whose income exceeds categorical eligibility standards but are below levels set by the state. People with incomes above the medically needy level may reduce their income to the requisite level through spending on medical care.

Medicaid funds a broad range of services. The federal government mandates that the State provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning services; transportation services; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government also allows optional services that Maryland provides that include vision care; podiatric care; pharmacy; medical supplies and equipment; intermediate-care facilities for the developmentally disabled; and institutional care for people over the age of 65 with mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice, which is the name of the statewide mandatory managed care program that began in 1997. Populations excluded from the HealthChoice program are covered on a FFS basis, and the FFS population generally includes the institutionalized and individuals who are dually eligible for Medicaid and Medicare.

## Maryland Children's Health Program

MCHP is Maryland's name for medical assistance for low-income children. The State is normally entitled to receive 65% federal financial participation for children in this program. Those eligible for the higher match are children under the age of 19 living in households with an income below 300% of FPL but above the Medicaid eligibility level. MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% of FPL. It should be noted that during the COVID-19 health emergency, the Governor has suspended premium payments.

## Family Planning

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy. The covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Coverage for family planning services continues until the age of 51 with annual redeterminations unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, no longer lives in Maryland, or is income-ineligible (above 250% of FPL). Chapters 464 and 465 of 2018 required the department to include family planning services in the State Plan (the formal agreement between the federal government and a state on how the state intends to administer the Medicaid program) as opposed to under a waiver that would, among other things, maintain current income eligibility, remove age limitations, and establish a presumptive eligibility process for enrollment in the program.

## Employed Individuals with Disabilities Program

The EID program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program lets disabled individuals return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID program may make more money or have more resources in this program than other Medicaid programs in Maryland. The services

available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of the cost for the EID program.

### Senior Prescription Drug Assistance Program

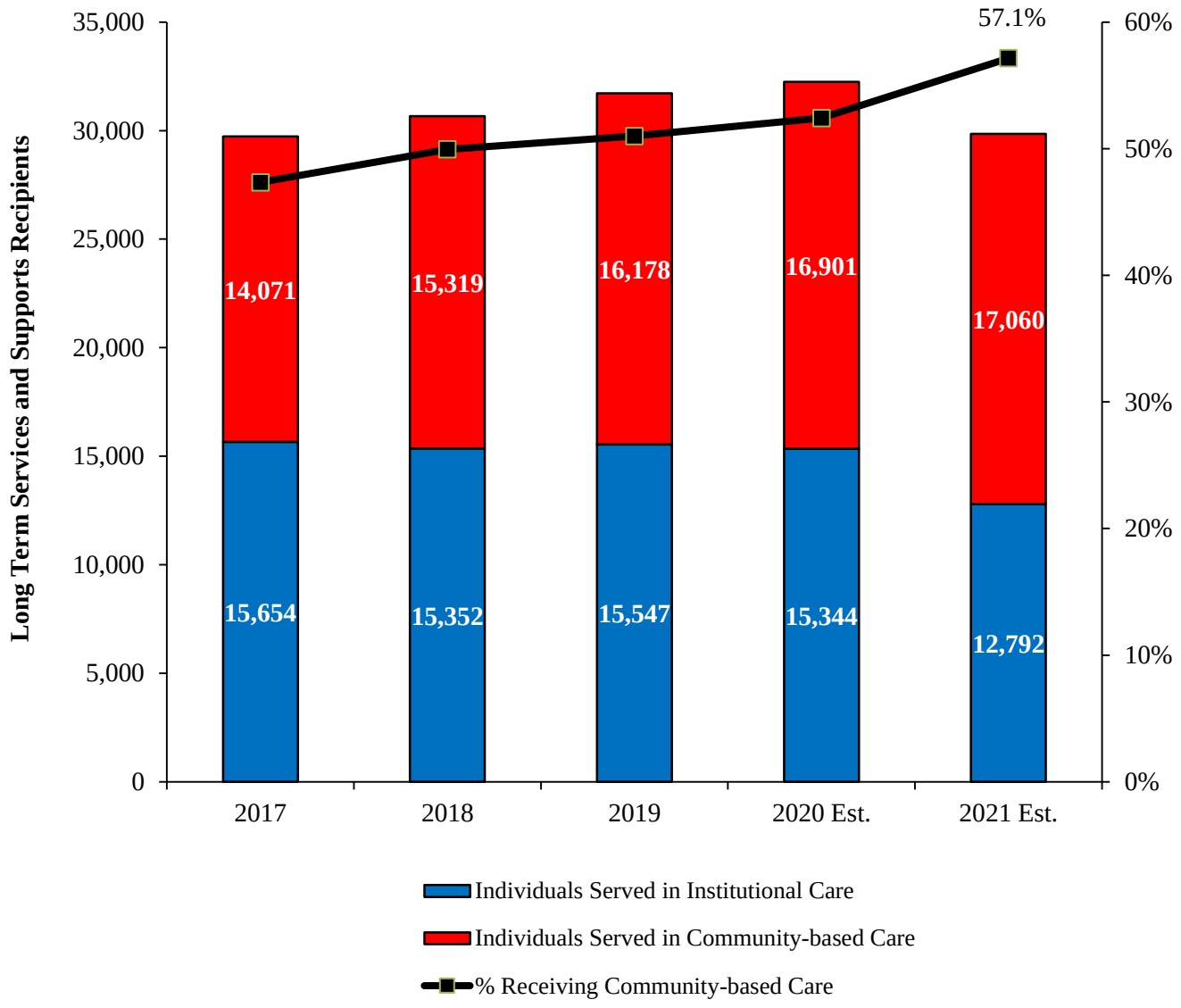
The SPDAP provides Medicare Part D premium and coverage gap assistance for the purchase of outpatient prescription drugs for moderate-income (at or below 300% of FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans. Additional information on the SPDAP is provided in Issue 3 of this analysis.

## *Performance Analysis: Managing for Results*

### 1. Rebalancing and COVID-19

In the past few fiscal years, the Medicaid program has devoted considerable effort to rebalancing long-term care services away from institutional care (nursing homes) to community-based settings. Much of this effort has been underwritten by the availability of enhanced federal funding in the ACA, including the Balancing Incentive Payment Program (enhanced funding that ended in fiscal 2016) and the Community First Choice program, as well as funding through the Money Follows the Person program. As shown in **Exhibit 1**, for the services delivered in the first month of the fiscal year, over the period shown, there has been a steady increase in the number and percentage of individuals receiving long-term care in a community-based setting. While the number of individuals served in community-based settings grew slightly in fiscal 2021 compared to the same period in fiscal 2020, the percentage of individuals served in community-based settings jumped to 57.1%, reflecting a sharp drop in the number of individuals served in nursing homes. This drop reflects the impact of COVID-19 on nursing home censuses (a combination of the disproportionate COVID-19 mortality rates in nursing homes and lower admissions).

**Exhibit 1**
**Medicaid Beneficiaries Receiving Long-term Care**
**By Community-based and Institutional Care**
**Fiscal 2017-2021 Est.**




Note: Data is as reported in the first month of the fiscal year. This chart includes data for the Medical Care Programs Administration only. In this chart, institutional care is defined as being in a nursing facility. Long-term care funded by Medicaid is also provided through the Developmental Disabilities Administration. Data for fiscal 2021 is preliminary.

Source: Maryland Department of Health; Department of Legislative Services

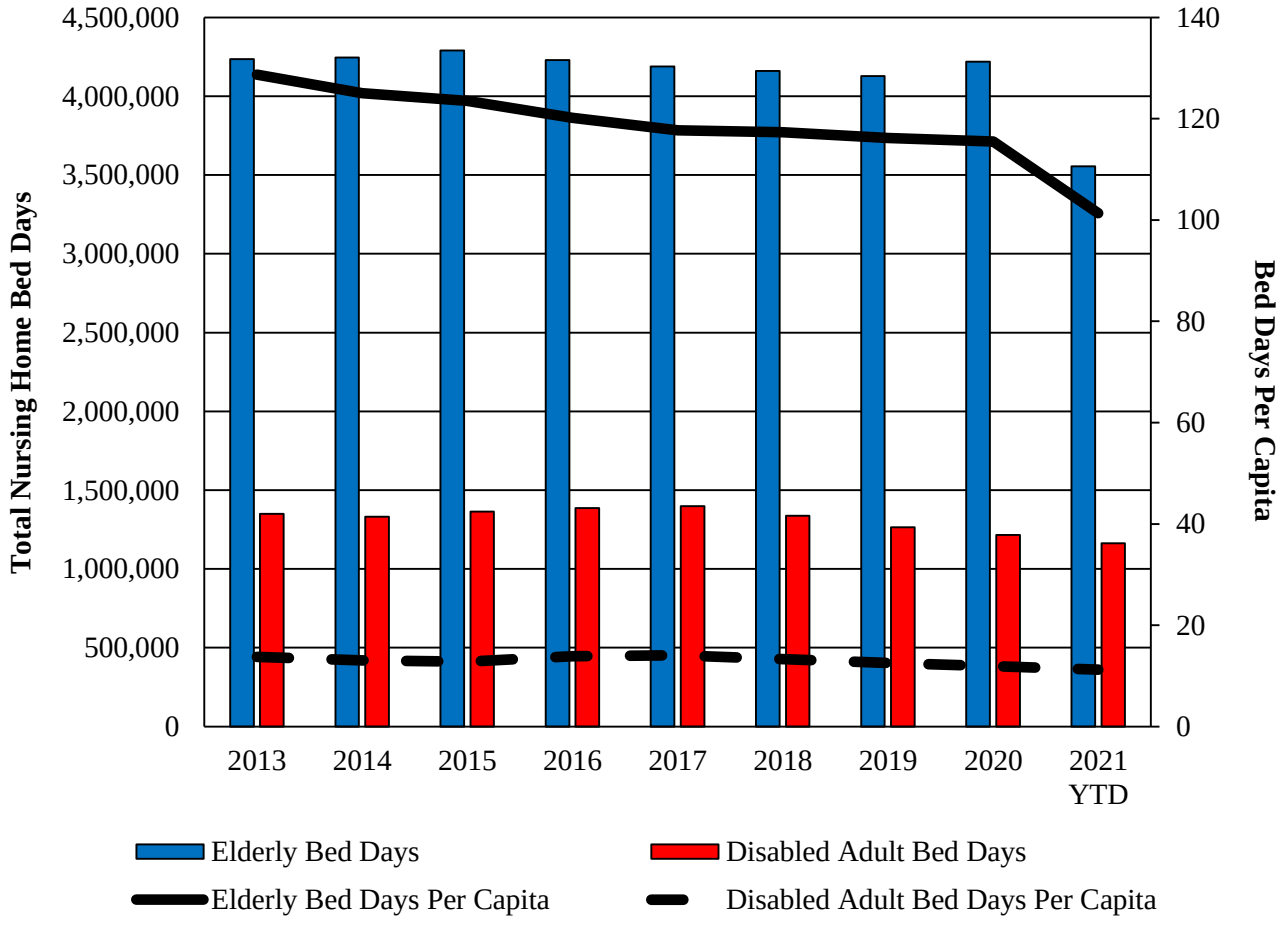
Trends in the actual use of nursing homes by Medicaid recipients prior to fiscal 2021 mirrored this effort to reduce institutional care, showing a gradual decline in both total nursing home bed days

and bed days per capita. However, the fiscal 2021 year to date (YTD) trends reflect the impact of COVID-19 on elderly enrollment and utilization (elderly bed days). Many elderly enrollees access the Medicaid program by spending-down income once they enter nursing home care. The prevalence of COVID-19 deaths in nursing home patients appears to have resulted in declining Medicaid enrollment among the elderly. Monthly elderly enrollment has fallen from just under 36,700 in March 2020 to 34,914 in December 2020, or a 4.8% decline. In the same time period, monthly elderly nursing home bed days fell from just under 339,000 days to just under 292,000 days, or a 13.9% decline. **Exhibit 2** details trends in nursing home bed days among the two largest Medicaid user groups of nursing home care – the elderly and disabled adults (combined, these two groups use 99.7% of Medicaid-funded nursing home bed-days).

**Exhibit 2**

**Nursing Home Utilization, Elderly and Disabled Adults**

**Fiscal 2017-2021 YTD**

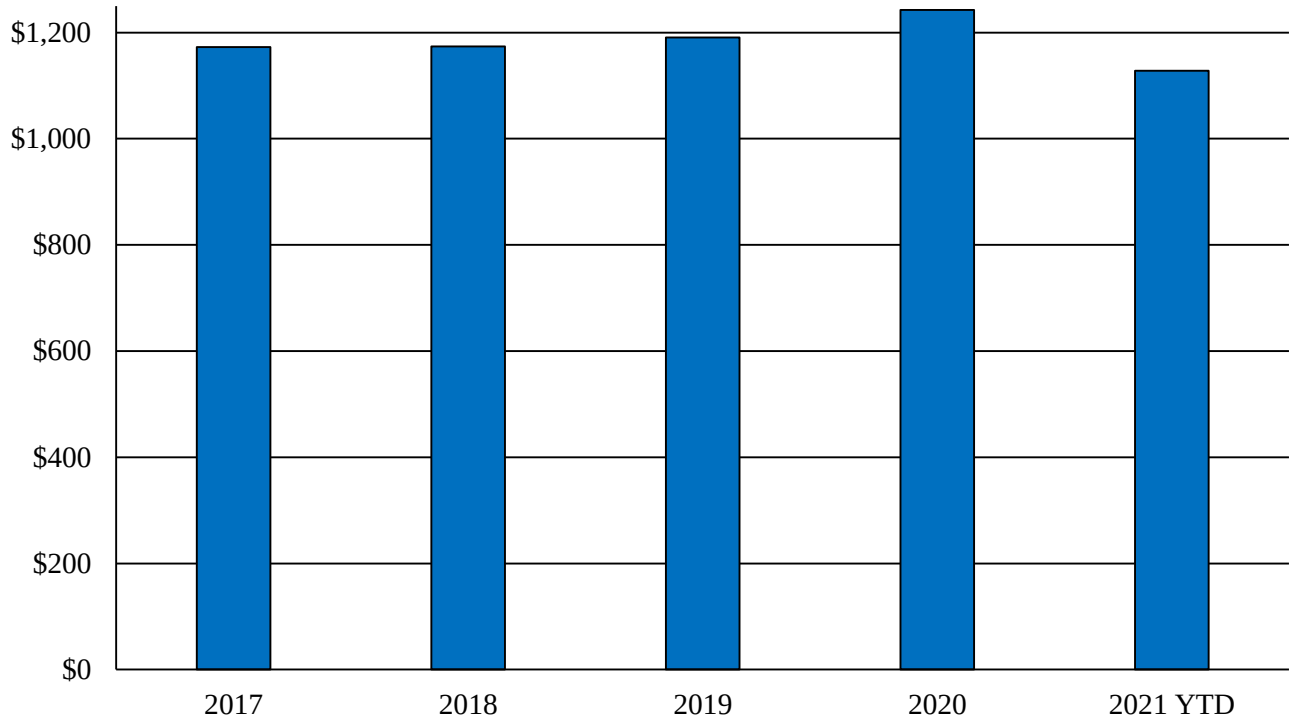



YTD: year to date through December 2020

Source: Maryland Department of Health; Department of Legislative Services

As shown in **Exhibit 3**, prior to fiscal 2021, the trend away from institutional long-term care to community-based alternatives has generally constrained spending on nursing homes: $1.17 billion in fiscal 2017 to $1.24 billion in fiscal 2020, or 6.0%. During these years, rate increases that result in higher daily rates have offset the declining utilization. However, as also shown in the exhibit, based on YTD trends, fiscal 2021 spending is projected to be $115 million lower than fiscal 2020, or 9.2%, in spite of rate increases in July 2020 and the acceleration of the July 2021 4% rate increase to January 1, 2021. As noted in the MDH Overview, nursing homes have been able to access various federal sources of income support as well as State support for personal protective equipment and other supplies. It is unclear the extent to which this additional support, at a time of increased costs related to COVID-19, offsets the loss of Medicaid revenue. The Department of Legislative Services (DLS) does not have the data to track any decline in nursing home revenues from other payers, but a decline can be reasonably expected.

**Exhibit 3**
**Medicaid Elderly and Disabled Adult Nursing Home Spending Trends**
**Fiscal 2017-2021 YTD**
**($ in Millions)**




YTD: year to date

Note: Fiscal 2021 projection is based on spending through December 2020 and includes the impact of the proposed accelerated fiscal 2022 mandated 4% rate increase.

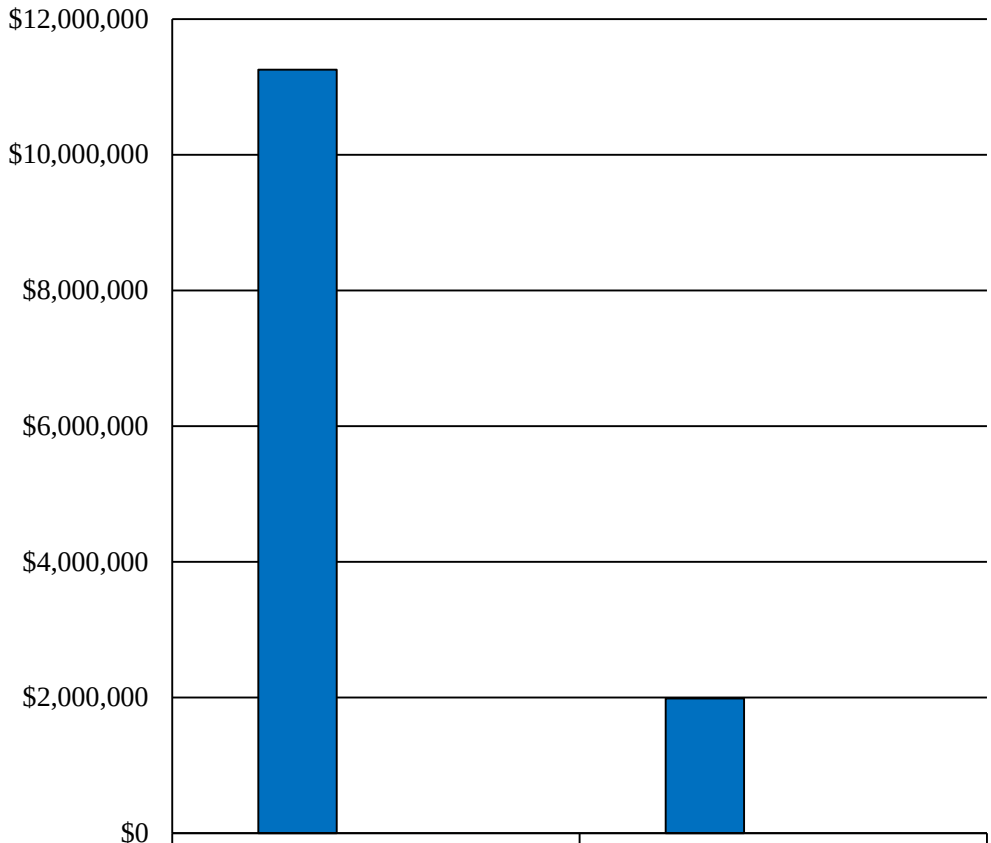
Source: Maryland Department of Health; Department of Legislative Services

## 2. Nursing Home Performance

### Maryland Pay-for-Performance Program

Chapter 503 of 2007 imposed an assessment on all nursing home beds in order to support the Medicaid program. That assessment is now at 6% and is expected to raise just under $160.0 million to support the Medicaid program in fiscal 2022. As part of Chapter 503, a Pay-for-Performance (P4P) program was established for nursing homes. Payments are made for meeting certain benchmarks, while smaller payments are available for facilities that show improvement toward meeting those benchmarks. Pay-outs under the program for fiscal 2020 are shown in **Exhibit 4**. For the P4P component, pay-outs ranged from $4.20 to $8.41 per Medicaid day with an average of $5.66. For the improvement part of the program, pay-outs ranged from $1.27 to $2.53 per Medicaid day with an average of $1.63. In total, 110 facilities got some form of payment, slightly over half of the 207 nursing facilities eligible for the program.

**Exhibit 4**
**Medicaid Nursing Facility P4P Program**
**Fiscal 2020**



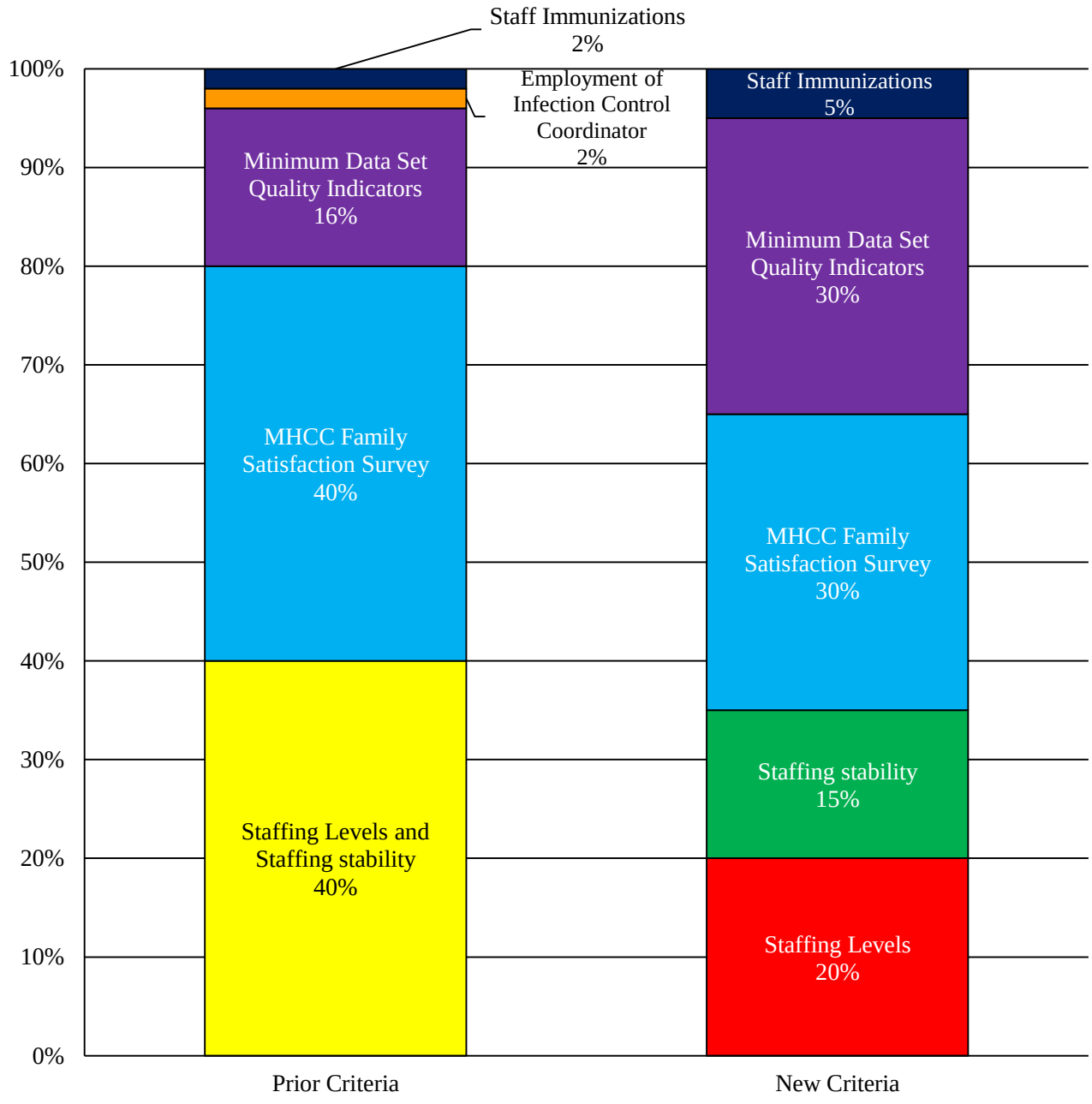

| | P4P | P4I |
|---|---|---|
| Award | $11,255,870 | $1,986,330 |
| Facilities | 67 | 43 |
| New Facilities Receiving Awards | 6 | 9 |

P4P: pay-for-performance
P4I: pay-for-improvement

Source: Maryland Department of Health; Department of Legislative Services

It should be noted that Medicaid has promulgated regulations to revise the scoring components used to develop P4P payments. When reviewing these components during the fiscal 2020 analysis, DLS noted that while some of the components can be considered proxies to good performance, for example, staffing levels, only one measure truly measures outcomes, the nursing home Minimum Data Set, which accounted for 16% of the scoring total. As shown in **Exhibit 5**, the proposed regulations place more of an emphasis on good performance.

**Exhibit 5**
**Nursing Home P4P Scoring Components**




MHCC: Maryland Health Care Commission
P4P: pay-for-performance

Source: Maryland Department of Health; Department of Legislative Services

## Provider Relief Fund Performance Funding

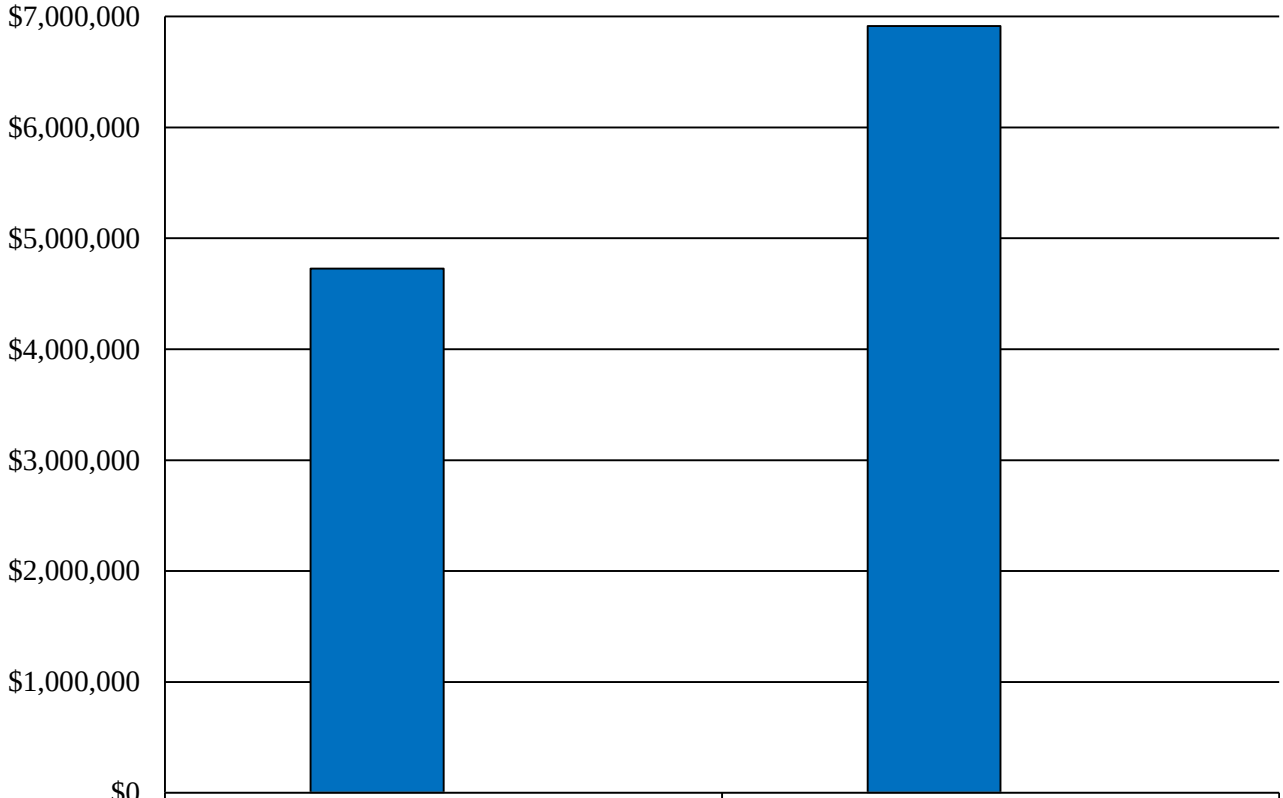
Part of the funding available under the federal Provider Relief Fund to assist health care providers during the national public health emergency is a $2 billion nursing home quality incentive payment. Eligible facilities will have their performance measured on two outcomes:

- ***COVID Infection:*** The infection measure for each facility compared to a baseline rate of COVID infection in the county in which the facility is located; and

- ***Facilities with COVID Infections Will Be Further Judged on Their Performance on COVID Mortality:*** The mortality measure will quantify how facilities with COVID admissions and in-facility infections perform relative to an expected level of mortality, given their total number of infections and the demographic characteristics of their residents. Facilities with mortality rates substantially exceeding expectations will be deemed ineligible from receiving performance payments in a given month.

According to the U.S. Department of Health and Human Services (HHS), payments are based on performance over four one-month periods (September through December 2020) with payments made in the month following the performance period. At the time of this writing, data reported by HHS shows two payments having been made: first payment for September 2020 totaling $331 million; and second payment for October 2020 totaling $523 million. As shown in **Exhibit 6**, 154 facilities in Maryland received payments in the first two rounds awarded.

**Exhibit 6**
**Provider Relief Fund Nursing Home Quality Incentive Payments**
**Maryland Recipients**




| | September | October |
|---|---|---|
| Payments | $4,726,972 | $6,915,732 |
| Recipients | 154 | 154 |

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

## 3. Medicaid Application Times

States have made significant investments in recent years to increase the administrative efficiency of eligibility and enrollment processes. In so doing, states hope to process eligibility determinations in a more accurate, timely, and efficient manner, including real-time determinations. In measuring application efficiency, it is necessary to distinguish between those individuals applying purely on an income basis (so-called Modified Adjusted Gross Income (MAGI) cases) and more complex cases, for example involving disability status and spend down to become Medicaid eligible.

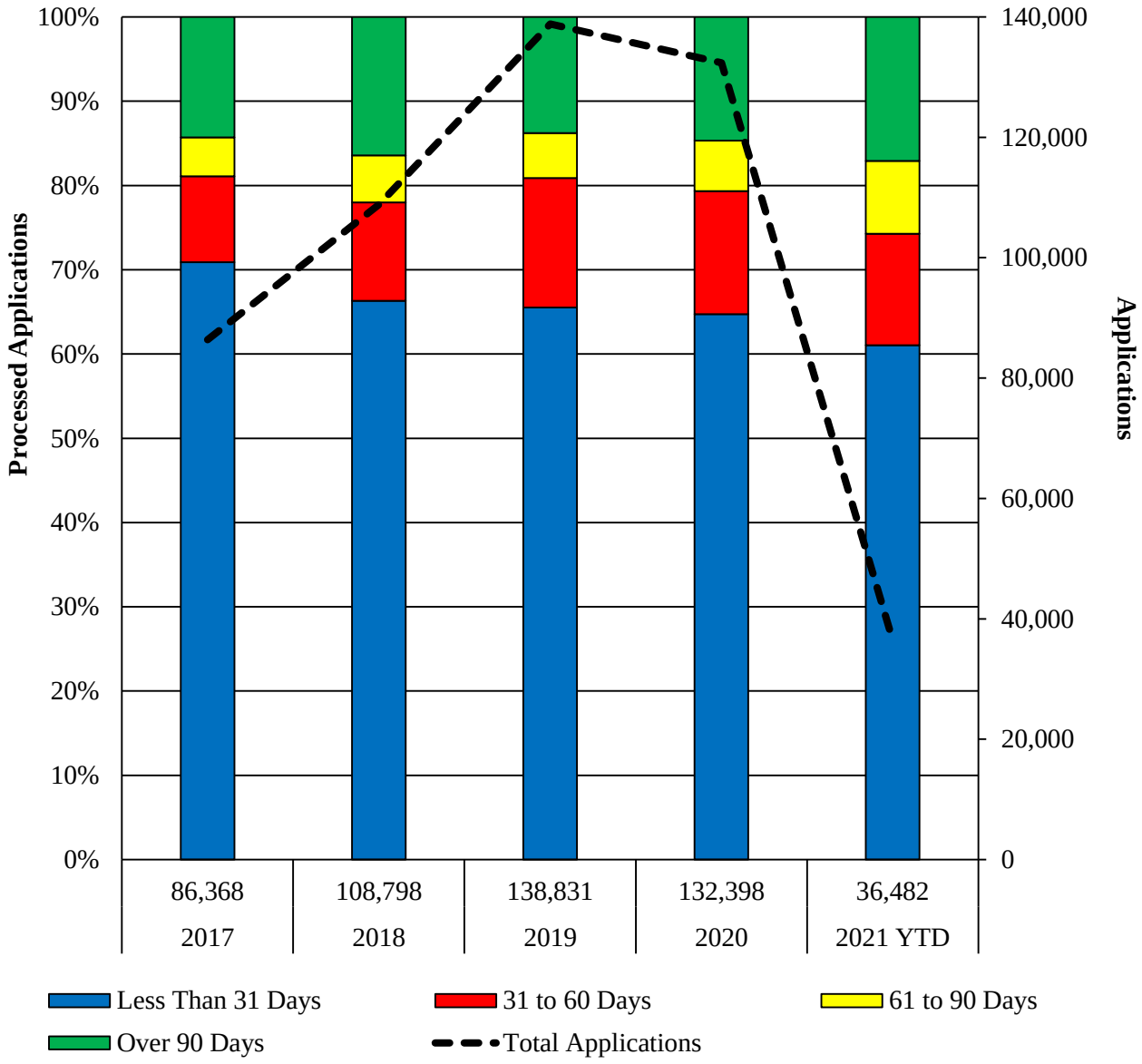
In Maryland, MAGI applications are processed through the Maryland Health Connection administered by the Maryland Health Benefit Exchange (MHBE); non-MAGI cases are still processed by the Department of Human Services (DHS). Since August 2018, some, but not all, of these cases have been processed through the Maryland Total Human-services Integrated Network.

MAGI enrollment rates through the exchange continue to be processed significantly quicker than in most states. In November 2020, the Centers for Medicare and Medicaid Services (CMS) released data on the efficiency of State Medicaid MAGI and Children's Health Insurance Program applications using data from February 2020 to April 2020. Maryland processed 98.2% of applications within 24 hours, up from 97.2% in the same period in 2019.

As shown in **Exhibit 7**, as would be expected, processing of non-MAGI applications tends to take longer than MAGI applications. Based on data for fiscal 2017 through 2020, on average, 67% of applications are completed within 31 days. In fiscal 2018 through 2020, the average was actually lower, 66%. As shown in the exhibit, this slightly worsening performance in application processing came at a time when applications increased significantly, on average 40,000 more applications were processed in fiscal 2018 to 2020 compared to fiscal 2017. DHS (the agency responsible for processing these applications) explained this significant increase as being the result of the number of MAGI-eligible individuals aging out of Medicaid or being eligible for Medicare and having to then apply for non-MAGI eligibility.

However, the impact of COVID-19 on applications and application processing times is also evident in the exhibit. Applications began to drop off beginning in April 2020. Through six months of fiscal 2021, average monthly applications fell to just under 6,100 from just under 11,800 in the same period of fiscal 2020. Similarly, the percentage of applications processed within 31 days fell to 61% in the first six months of fiscal 2021 despite the far fewer number of applications, compared to 69% in the same time period in fiscal 2020.

**Exhibit 7**
**Processing of Maryland Medicaid Non-MAGI Applications**
**Fiscal 2017-2021 YTD**




MAGI: Modified Adjusted Gross Income
YTD: year-to-date

Note: Fiscal 2021 data is YTD through December 2020.

Source: Department of Human Services; Department of Legislative Services

DHS attributes the decline in applications to the extension of Medicaid eligibility during the public health emergency, which means that there are fewer closures per month and, as a result, fewer individuals who have to reapply. This more than offsets new Medicaid applications, which actually grew by 41% between March 2020 and December 2020.

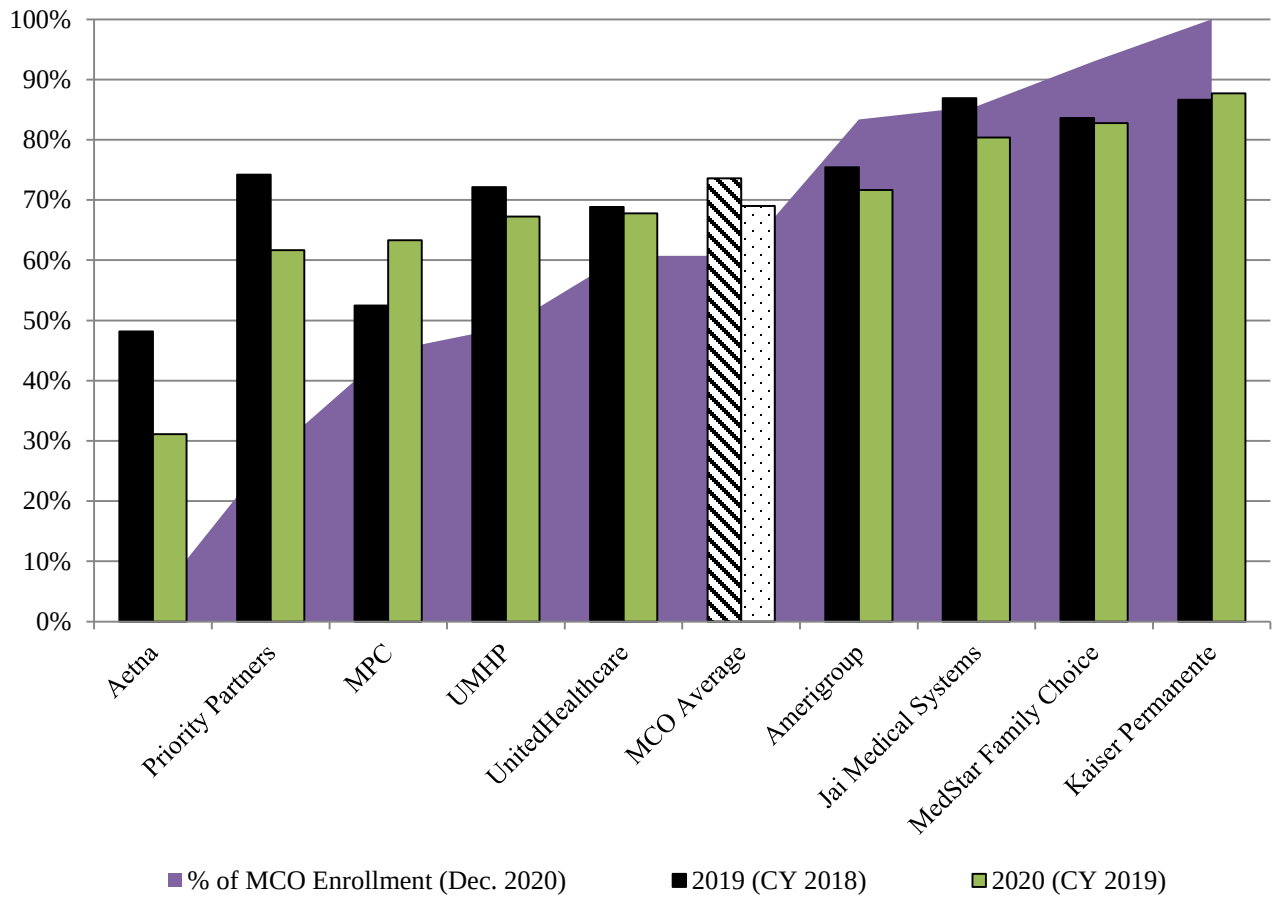
## 4. Measures of Managed Care Organizations Quality Performance

The department conducts numerous activities to review the access to, and quality of, services provided by the managed care organizations (MCO) 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 in calendar 2019 included 51 different measures across multiple quality domains (for example, effectiveness of care and access to care) and consumer assessment scores. Some measures 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 and consists of 60 measures.

Historically, Maryland's MCOs collectively outperform their peers nationally. In calendar 2019, Maryland MCOs outperformed their peers nationally on 69% of the HEDIS components examined by DLS, a decline from 73.6% in calendar 2018. While the specifics of the HEDIS components being measured are slightly different from year to year, two MCOs (Maryland Physicians Care and Kaiser Permanente) saw relatively higher performance compared to 2018, all the remaining MCOs seeing relatively poorer performance. The newest MCO, Aetna, continues to have relatively poor performance relative to the national HEDIS mean, being above the national average on only 31.1% of measures falling from 48.2% in calendar 2018. In part this reflects Aetna being scored against more measures compared to the prior year when limited enrollment would have excluded them from measurement.

**Exhibit 8** 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. The exhibit also shows the cumulative relative share of MCO enrollment by MCOs of December 2020. The exhibit illustrates that 61% of total enrollees in HealthChoice are enrolled in MCOs that have HEDIS scores below the HealthChoice program average of 69% above the national average. Amerigroup has a slightly higher percentage of HEDIS scores above the national average than the HealthChoice average. Only three MCOs, Jai Medical Systems, MedStar Family Choice, and Kaiser Permanente have more than 80% of HEDIS scores above the national average, but collectively, they only serve 16.4% of enrollees.

**Exhibit 8**
**HealthChoice**
**Percentage of Measurable Components above National HEDIS Mean and MCO Enrollment**
**Calendar 2018 and 2019, Enrollment December 2020**




CY: calendar year
HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care
UMHP: University of Maryland Health Partners

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. UMHP has been acquired by CareFirst, but was still operating as UMHP in calendar 2019.

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

Since 2013, participation in the HealthChoice program requires accreditation by NCQA (accreditation was required within two years for existing MCOs and is required within two years of program entry for new MCOs). In terms of accreditation by NCQA:

- Jai Medical Systems and Kaiser Permanente maintained the highest accreditation status of excellent;

- Amerigroup, MedStar Family Choice, and Priority Partners retained status as commendable; and

- Aetna, Maryland Physicians Care, UnitedHealthcare, and the University of Maryland Heath Partners are accredited. Aetna moved to accredited from interim status in the most recent reporting, and UnitedHealthcare fell from commendable to accredited.

## Fiscal 2020

### Cost Containment

On July 1, 2020, the Board of Public Works took a number of cost containment actions, including a reduction of $46.8 million in total funds to the Medicaid program. General fund reduction totaled just over $41 million, including $44,162 in unemployment insurance savings as part of a statewide reduction in those expenses. **Exhibit 9** summarizes the reductions, excluding the statewide reductions. The largest reduction, $35.0 million, was based on an increase of the Medicaid Deficit Assessment from $294.9 million to $328.8 million to backfill for the general funds. This backfill is proposed in the Budget Reconciliation and Financing Act (BRFA) of 2021, discussed further below.

**Exhibit 9**
**Medicaid Provider Payments**
**July 2020 Board of Public Works General Fund Reductions**
**($ in Millions)**

| Item | Reduction |
|---|---|
| Increase Medicaid Deficit Assessment on hospitals | -$35.0 |
| Reduce Washington, DC hospital reimbursement rate | -1.7 |
| Reduce general funds due to additional special fund availability in the Cigarette Restitution Fund | -1.7 |
| Limit reimbursement on durable medical equipment and disposable medical supplies to 80% of the Medicare rate | -1.5 |
| Reduce funding for the National Diabetes Prevention program to better align with recent spending | -0.8 |
| Delay implementing postpartum dental services by six months | -0.3 |
| **Total** | **-$41.0** |

Source: Department of Budget and Management

## Fiscal 2020 Accrual

At the end of each fiscal year, Medicaid accrues unspent funds to pay for Medicaid bills received in the following fiscal year but that are charged back to the prior year. That accrual can also be used to cover other Medicaid-related expenses. Funding that is not used should be reverted to the General Fund, while deficits usually result in deficiency appropriations. Based on data through January 2020, DLS estimates that the fiscal 2020 accrual will have a surplus of $17.0 million in general funds. The fiscal 2022 budget plan recognizes $19.9 million in surplus as a planned reversion.

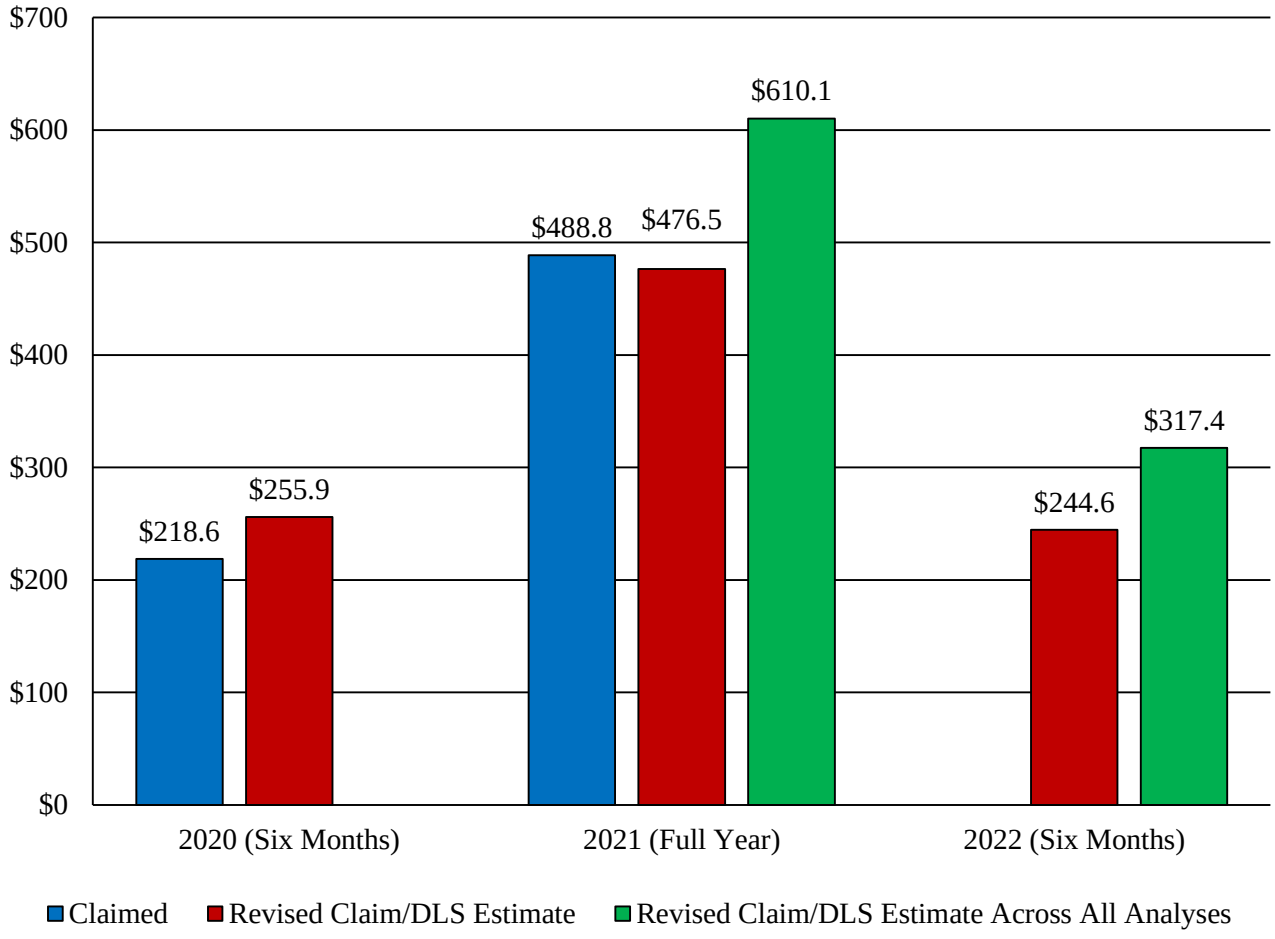
The DLS analysis of the MCHP accrual reveals a small deficit, $0.8 million in general funds. However, DLS projects the MCHP program to have a surplus of over $6.5 million in fiscal 2021.

## Fiscal 2020 Enhanced Federal Medical Assistance Percentage

The Families First Coronavirus Response Act provided an enhanced Federal Medical Assistance Percentage (FMAP) of 6.2 percentage points on qualifying expenses during a national health emergency declared by the U.S. Secretary of Health and Human Services. The enhanced match on MCHP funding is 4.34 percentage points. That declaration was made in March 2020 and applied to certain Medicaid claims made beginning January 1, 2020. The public health emergency declaration has since been extended through December 2021. In order to qualify for the enhanced match, state Medicaid programs are required, among other things, to maintain eligibility requirements; not increase premiums beyond those in place as of January 1, 2020; cover services without cost-sharing for COVID-19 testing and treatment; and (with limited exceptions) not terminate Medicaid coverage for those on the program at the time of the public health emergency declaration, among other program changes during the public health emergency.

At fiscal 2020 close-out, Medicaid reverted $93.6 million in general funds as a result of enhanced FMAP funding. Further analysis of Medicaid claims in fiscal 2020 revealed that an additional amount of enhanced FMAP fund should have been claimed. As shown in **Exhibit 10**, the most recent review estimates that an additional $162.3 million in enhanced FMAP could be claimed in Medicaid (excluding the Developmental Disabilities Administration). The budget currently recognizes $125.0 million in general fund savings in fiscal 2021. **DLS recommends increasing the savings recognized in fiscal 2021 from the fiscal 2020 enhanced FMAP by $37.3 million.**

**Exhibit 10**
**Medicaid Enhanced Federal Medical Assistance Percentage**
**Fiscal 2020-2022**
**($ in Millions)**




DLS: Department of Legislative Services

Note: Estimate for fiscal 2020 includes Medicaid Behavioral Health. Estimates (red bars) for fiscal 2021 and 2022 exclude Medicaid Behavioral Health, which will be considered in the Behavioral Health Administration analysis. Revised claim data is from the Maryland Department of Health. Total across all analyses reflects data from Medicaid including behavioral health and the Developmental Disabilities Administration.

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

## Fiscal 2021

### Fiscal 2021 and 2022 Enhanced FMAP

As also shown in Exhibit 10, the enhanced FMAP is available in fiscal 2021. At the time of the passage of the fiscal 2021 budget, savings from the enhanced FMAP were not included in the budget. As discussed below, deficiency appropriations recognize $488.8 million in fiscal 2021 savings as a result of the enhanced FMAP in this analysis. DLS broadly concurs with the magnitude of the savings but expects savings to be slightly less, $476.5 million, primarily because DLS' analysis of fiscal 2021 spending (discussed further below) is below that anticipated in the revised fiscal 2021 budget. Overall, DLS estimated enhanced FMAP savings of $610.1 million in fiscal 2021.

Also shown in the chart are an expectation of savings from enhanced FMAP for fiscal 2022. As introduced, fiscal 2022 anticipates no savings as the extension of enhanced FMAP was not announced until after the introduction of the Governor's budget. **DLS estimates savings of $244.6 million in this analysis and recommends that the fiscal 2022 budget be reduced accordingly.** In total, DLS is recommending $317.4 million in reductions across various analyses in fiscal 2022 based on the enhanced FMAP.

### Proposed Deficiency

As shown in **Exhibit 11**, the fiscal 2022 budget includes $802.9 million in total fund deficiencies. In addition to the impact of enhanced FMAP, also of note:

- as detailed above, $35 million of the $45 million in special funds from the Medicaid Deficit Assessment is contingent on the BRFA;

- $100 million of general funds savings is contingent on another item in the BRFA to authorize the use of $100 million in special funds from the MHBE Fund designated for its reinsurance program for Medicaid in fiscal 2021. The BRFA further authorizes the use of $100 million in special funds from this source in each of fiscal 2022 through 2026; and

- there is $36.2 million in total funds to accelerate the mandatory 4% increase anticipated on July 1, 2021, related to minimum wage legislation (Chapters 10 and 11 of 2019).

**Exhibit 11**
**Proposed Fiscal 2021 Deficiencies**
**($ in Millions)**

| | General Fund | Special Fund | Federal Fund | Total |
|---|---|---|---|---|
| Increased Enrollment and Utilization | $252.0 | $5.2 | $511.0 | $768.1 |
| Medicaid Deficit Assessment 2020 BRFA and the July 1, 2020 BPW Meeting | 0.0 | 45.0 | 0.0 | 45.0 |
| Medicaid Providers Accelerated 4% Rate Increase | 15.9 | 0.0 | 20.2 | 36.2 |
| Fiscal 2020 and 2021 Enhanced Federal Match | -613.8 | 0.0 | 613.8 | 0.0 |
| Use of Maryland Health Benefit Exchange Fund Reinsurance Program Fund Balance | -100.0 | 100.0 | 0.0 | 0.0 |
| Offset for Fiscal 2020 Medicare Part D Overpayment | -46.4 | 0.0 | 0.0 | -46.4 |
| **Total** | **-$492.2** | **$150.2** | **$1,145.0** | **$802.9** |

BPW: Board of Public Works
BRFA: Budget Reconciliation and Financing Act

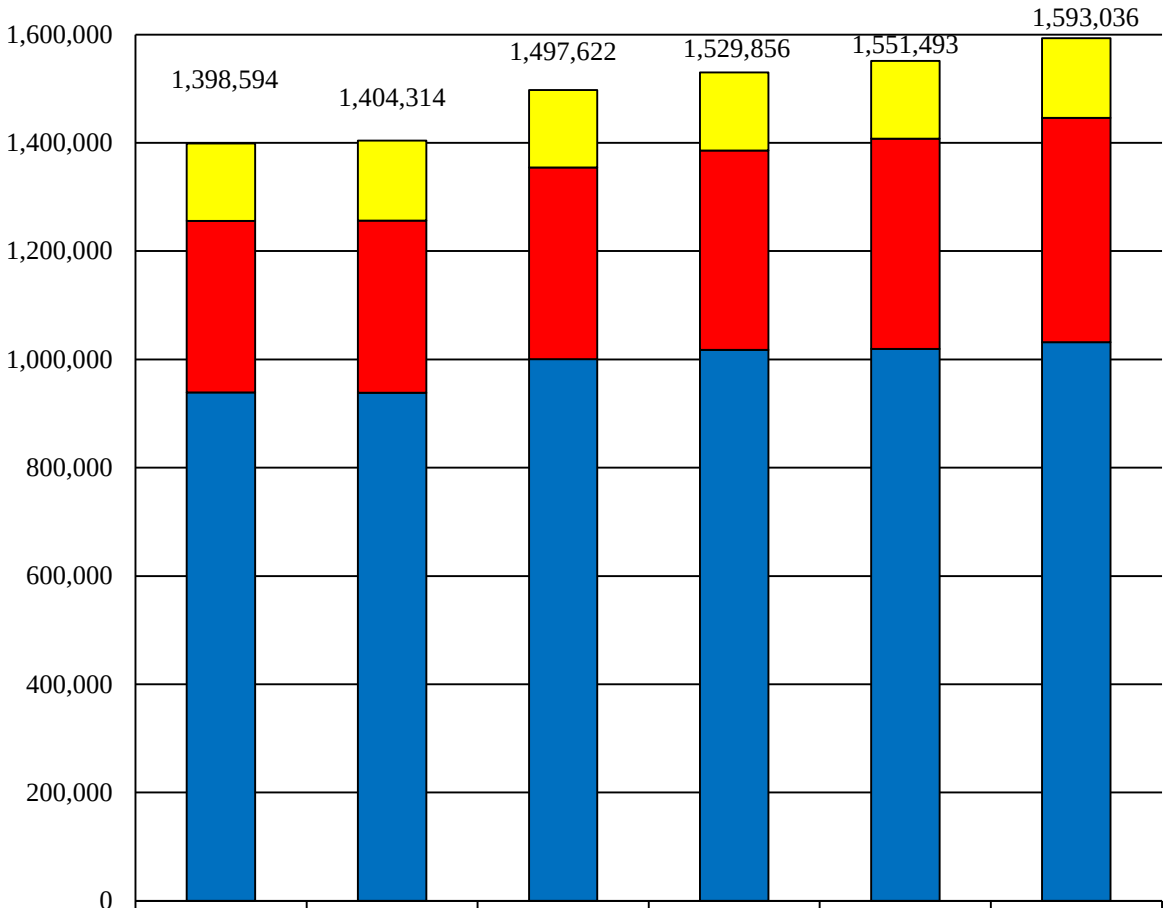
Note: Totals may not sum due to rounding.

Source: Department of Budget and Management

## Fiscal 2021 General Fund Adequacy

The fiscal 2021 budget was based on expectations of a far lower enrollment than actually experienced by the Medicaid program. As shown in **Exhibit 12**, the budget was built on average monthly enrollment of just over 1.4 million. Through January 2021, average monthly enrollment was almost 1.5 million, and DLS estimates fiscal 2021 enrollment will ultimately average almost 1.53 million.

**Exhibit 12**
**Medicaid and MCHP Average Monthly Enrollment**
**Fiscal 2020-2022 Est.**




| | 2020 | 2021 Budget | 2021 YTD | 2021 Est. | 2022 Budget | 2022 Est. |
|---|---|---|---|---|---|---|
| MCHP | 143,030 | 148,109 | 143,147 | 144,259 | 143,900 | 147,239 |
| ACA Expansion | 316,313 | 317,823 | 354,024 | 368,250 | 388,412 | 413,745 |
| Traditional Medicaid | 939,251 | 938,382 | 1,000,451 | 1,017,347 | 1,019,181 | 1,032,052 |

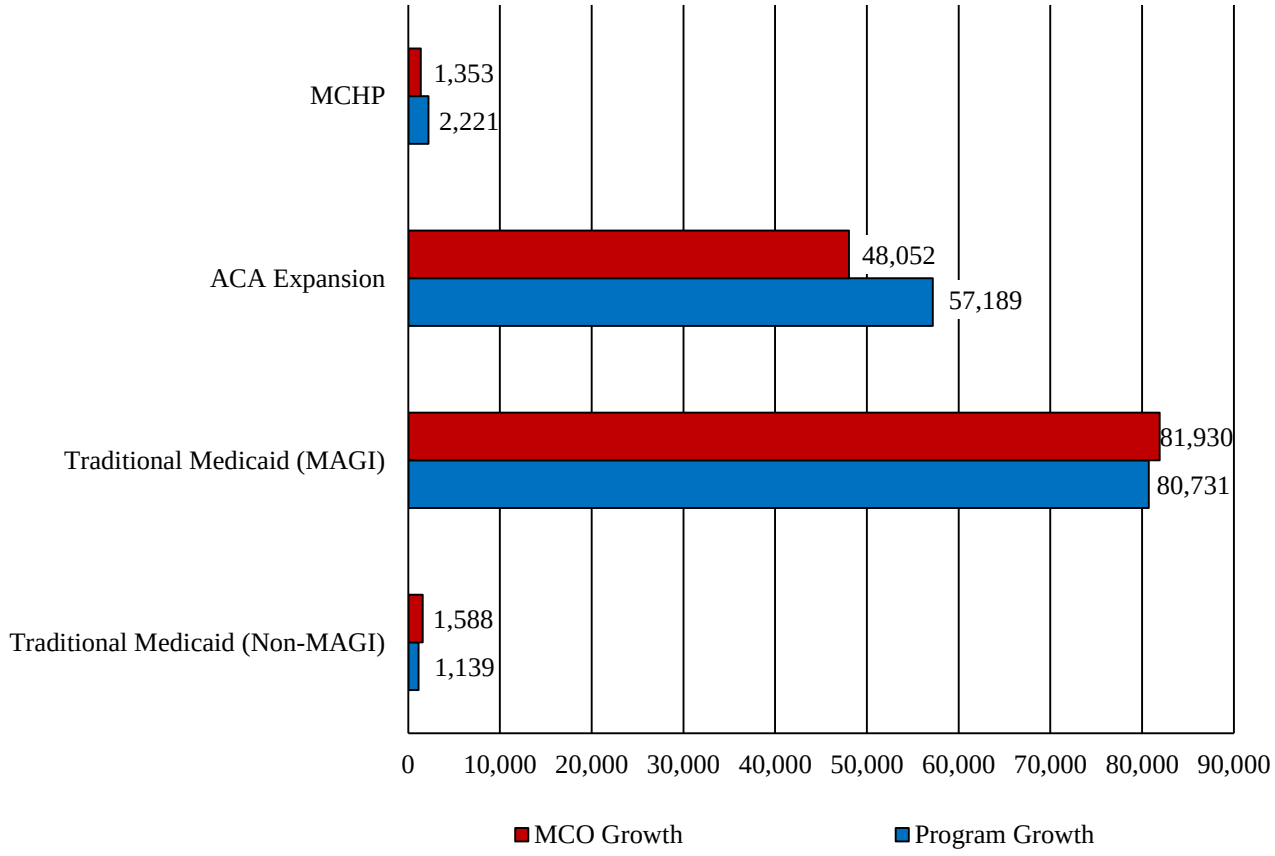
ACA: Affordable Care Act
MCHP: Maryland Children's Health Program
YTD: year-to-date

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

As a result of the increased enrollment, fiscal 2022 includes a deficiency of $768.1 million to offset increased enrollment and utilization noted above.

Virtually all of the recent increase in enrollment has been in HealthChoice, as shown in **Exhibit 13**. A more detailed review of Medicaid spending trends is included in the MDH Overview analysis. However, it is unsurprising that one area of expenditure growth has been in MCO capitated rates. That review also noted areas where spending, while rebounding from the final quarter of fiscal 2020, was still lower than prior year levels, for example in nursing homes (as noted above) and dental services.

**Exhibit 13**
**Medicaid and MCHP Total and MCO Enrollment growth**
**March 2020 to January 2021**

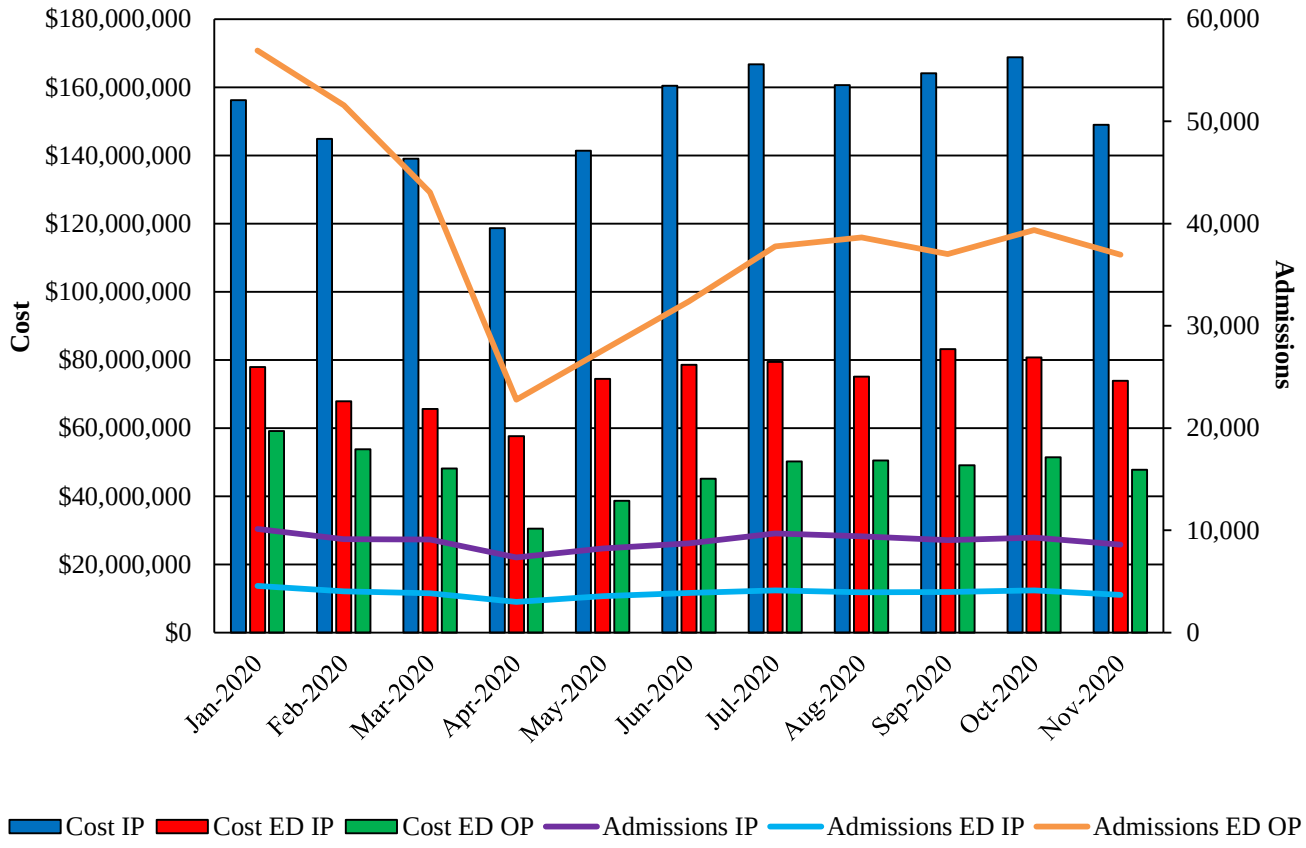



ACA: Affordable Care Act
MAGI: Modified Adjusted Gross Income
MCHP: Maryland Children's Health Program
MCO: managed care organization

Source: Maryland Department of Health; Department of Legislative Services

It should be expected that the same drop in expenditures experienced in FFS claims for services such as inpatient, outpatient, and physician visits would have also been experienced by MCOs. It is interesting to look at Health Service Cost Review Commission (HSCRC) inpatient and emergency department data for Medicaid MCOs through 11 months in calendar 2020. This spending typically represents about 50% of MCO overall expenditures. As shown in **Exhibit 14**, there was clearly a drop in monthly spending and admissions in March and April that coincided with the lockdown and cancellation of elective surgeries. However, since then, admissions and spending have increased, mainly driven by the HSCRC policies that have allowed hospitals to recoup revenues that is reflected in higher costs per admission, as shown in **Exhibit 15**.

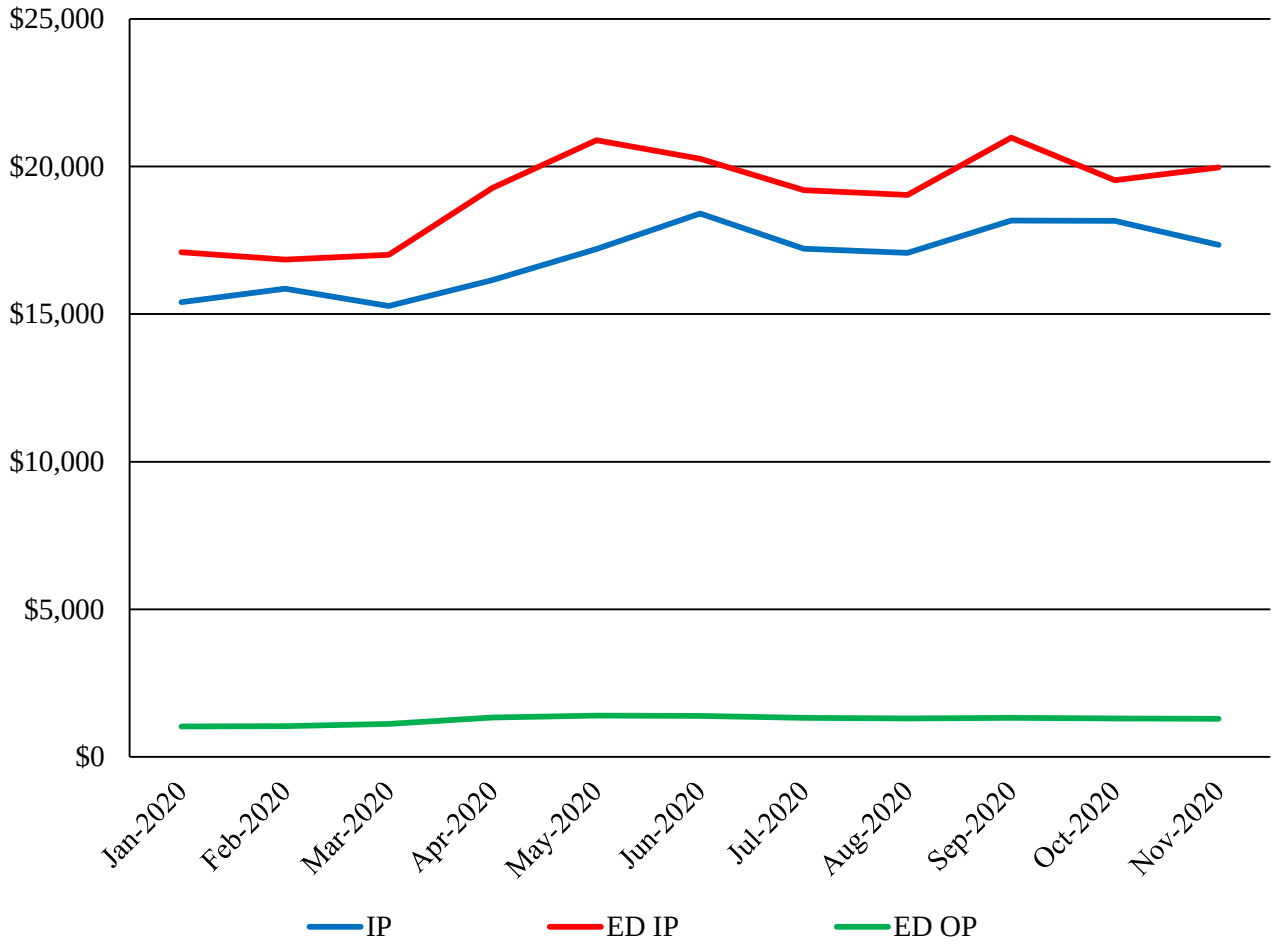
**Exhibit 14**
**MCO Inpatient and ED Costs and Admissions**
**January 2020 through November 2020**




ED: emergency department
IP: inpatient
MCO: managed care organization
OP: outpatient

Source: Health Service Cost Review Commission

**Exhibit 15**
**MCO Inpatient and ED Costs Per Admission**
**January 2020 through November 2020**



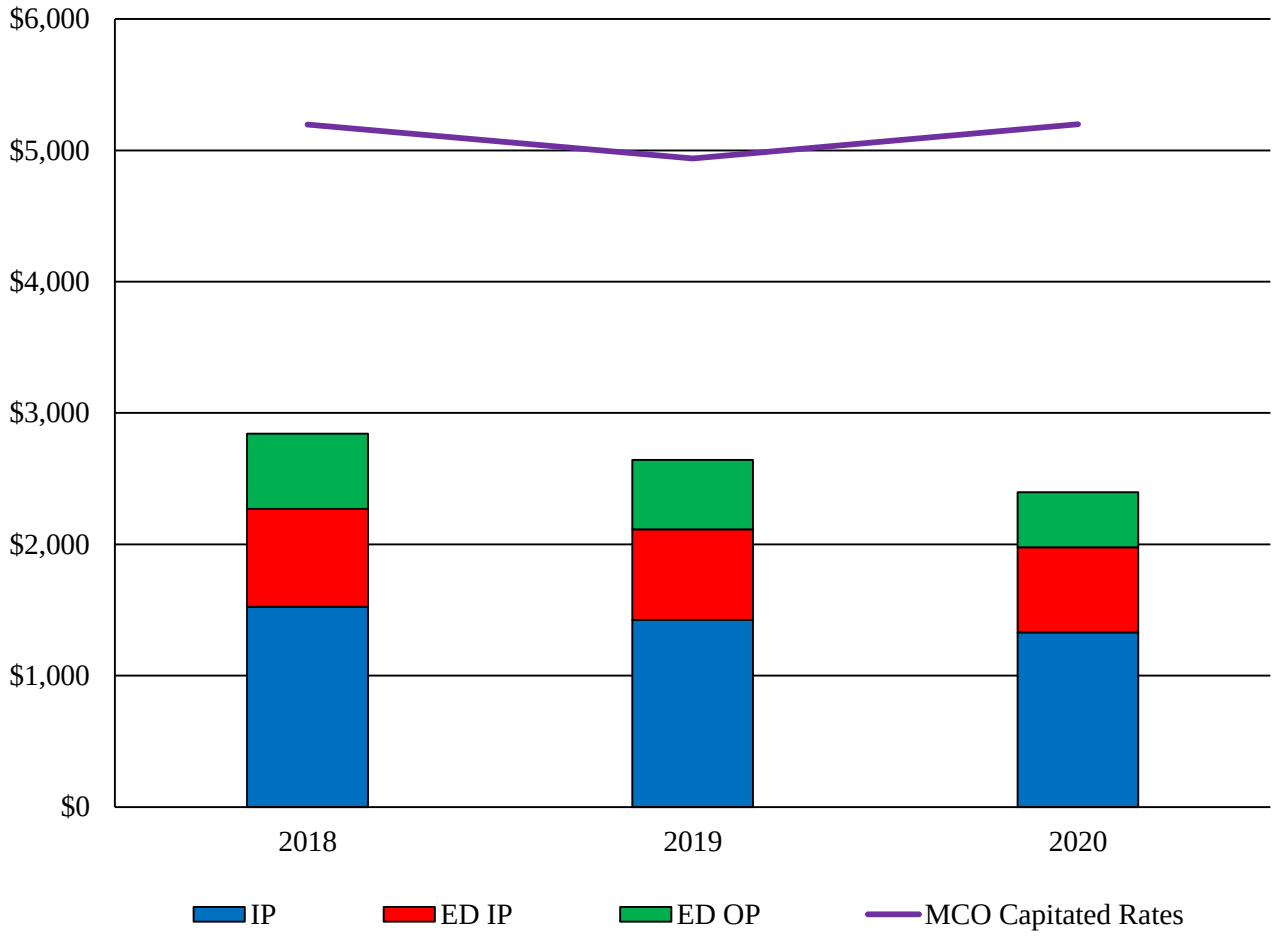

ED: emergency department
IP: inpatient
MCO: managed care organization
OP: outpatient

Source: Health Service Cost Review Commission

However, it is important to note that although costs per admission are increasing, utilization of these services is far lower than in prior years. Overall, total admissions are lower across all hospital settings as are admissions per capita. As shown in **Exhibit 16**, per capita inpatient and emergency department costs are anywhere from 5.9% to 21.1% lower in calendar 2020 compared to calendar 2019. In contrast, average per capita payments received by MCOs increased in calendar 2020 and, as shown

in Exhibit 13, total MCO enrollment has grown significantly. All this would imply that MCO medical spending was likely lower in calendar 2020 relative to capitated payments.

**Exhibit 16**
**MCO Per Capita Inpatient and ED Costs**
**Average Capitation Rates**
**Calendar 2018-2020**




ED: emergency department
IP: inpatient
MCO: managed care organization
OP: outpatient

Source: Health Service Cost Review Commission

Medicaid traditionally relies on the Medical Loss Ratio (MLR) requirement that 85% of capitated payments are spent on qualifying medical expenses to recoup underspending. However, for calendar 2020 and 2021, Medicaid also entered into risk corridor arrangements with MCOs. The specifics of the risk corridor arrangement are different in calendar 2020 and 2021. In calendar 2020, the risk corridor is based on an individual MCOs' experience, whereas in calendar 2021, the risk corridor is based on programwide experience. In both cases, revenues and expenses related to Kaiser Permanente are excluded (as they are in regular rate-setting) because their costs are an outlier. Other specifics also vary by year, but the underlying concept is that if expenses are low relative to revenues, the State will recoup a certain percentage of those revenues. If the opposite is true, and expenses are high relative to costs, the State would bear some of those costs.

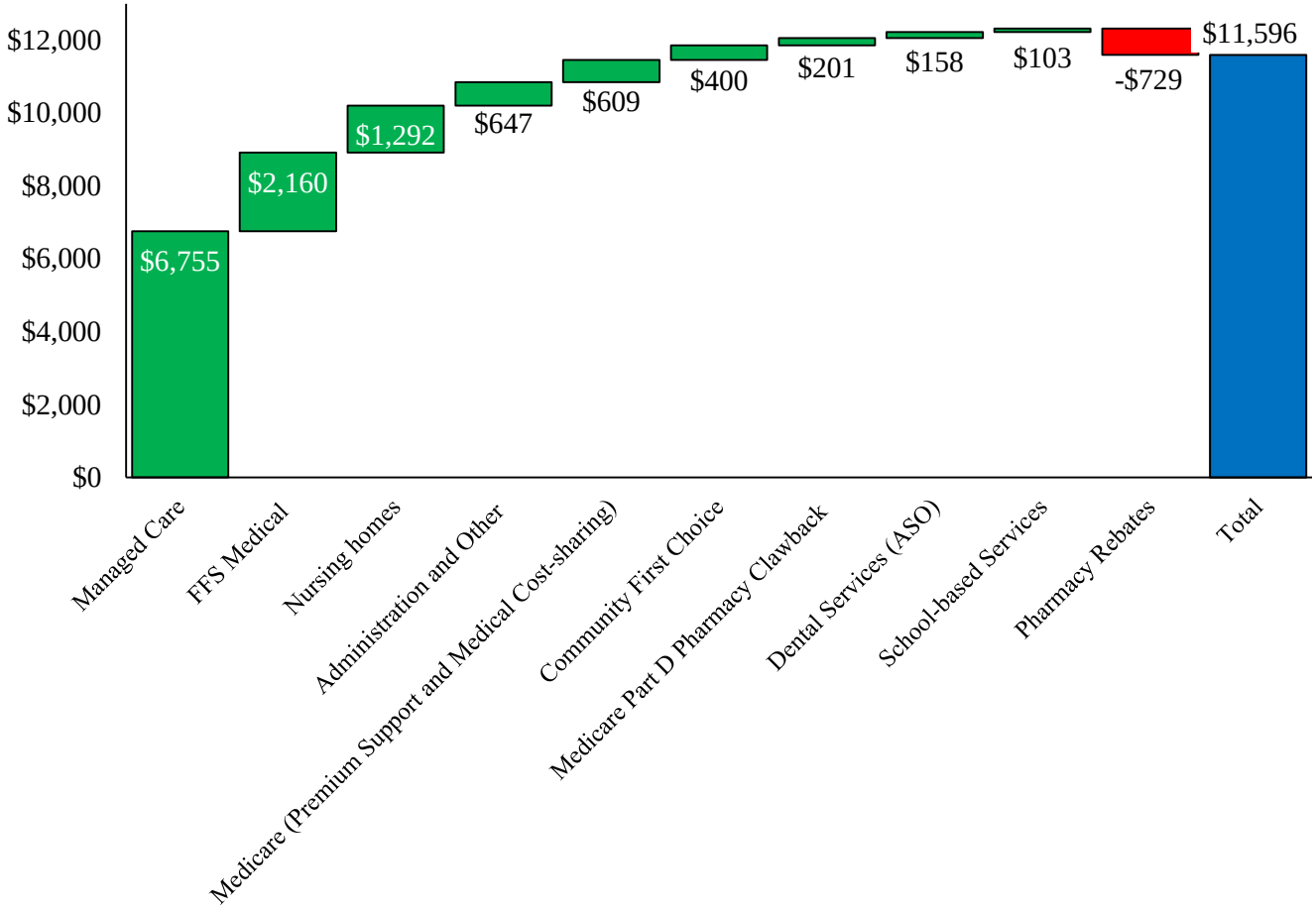
It is too early to know the specific results of the calendar 2020 risk corridor arrangement. DLS would note that projected calendar 2020 financial results as of September 2020 from the Hilltop Institute projected program profits of $306.7 million with a program wide MLR of 82.3%. Every MCO bar Kaiser Permanente has projected profits, and six of nine MCOs have MLRs below 85%. Based on these projections, the State can expect to see savings.

While a reduction based on MCO trends may be premature, trends through December outside of the HealthChoice program indicate that the revised fiscal 2021 budget is overfunded. **DLS recommends reducing the fiscal 2021 deficiency appropriation by $75 million.** This reduction is net of DLS' estimate of lower enhanced FMAP in fiscal 2021 as a result of this lower estimate of expenditures.

## Fiscal 2022 Overview of Agency Spending

The fiscal 2022 allowance for Medicaid is just under $11.6 billion. As shown in **Exhibit 17**, 93% of the agency's budget supports a variety of services including the HealthChoice program, which consumes 58% of the total budget. The remainder includes a payment to the federal government for the Medicare Part D program and a variety of other administrative costs (including major information technology development projects, the SPDAP, personnel, and contracts that underpin program operations).

**Exhibit 17**
**Overview of Agency Spending**
**Fiscal 2022 Allowance**
**($ in Millions)**




ASO: administrative services organization

Note: Fiscal 2022 allowance as adjusted for contingent reductions, contingent appropriations, annual salary review adjustments, and the annualization of the fiscal 2021 general salary increase.

Source: Maryland Department of Health; Department of Legislative Services

## Proposed Budget Change

As shown in **Exhibit 18**, the adjusted fiscal 2022 allowance increases by $439.2 million over the adjusted fiscal 2021 working appropriation, or 3.9%. However, as also shown in the exhibit, there is significant growth in general funds, almost $990 million (36.4%) primarily to backfill for $613.8 million in one-time fiscal 2021 federal funds and lower special fund availability, $188.3 million. The drop in special funds is driven by the action in the BRFA of 2020, which directed the health care premium revenues that had been diverted to the Rate Stabilization Fund to instead go directly to the General Fund. Additional detail on special funds is provided in **Exhibit 19**. In both fiscal 2021 and 2022, $135.0 million in special fund support is contingent on the BRFA of 2021 ($35.0 million from the Medicaid Deficit Assessment, and $100.0 million from the MHBE Fund).

**Exhibit 18**
**Proposed Budget**
**MDH Medical Care Programs Administration**
**($ in Thousands)**

| How Much It Grows: | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| Fiscal 2020 Actual | $3,010,427 | $972,029 | $6,244,566 | $65,734 | $10,292,756 |
| Fiscal 2021 Working Appropriation | 2,720,621 | 1,055,073 | 7,308,143 | 72,518 | 11,156,354 |
| Fiscal 2022 Allowance | 3,710,427 | 866,823 | 6,948,578 | 69,700 | $11,595,528 |
| Fiscal 2021-2022 Amount Change | $989,806 | -$188,250 | -$359,565 | -$2,818 | $439,173 |
| Fiscal 2021-2022 Percent Change | 36.4% | -17.8% | -4.9% | -3.9% | 3.9% |

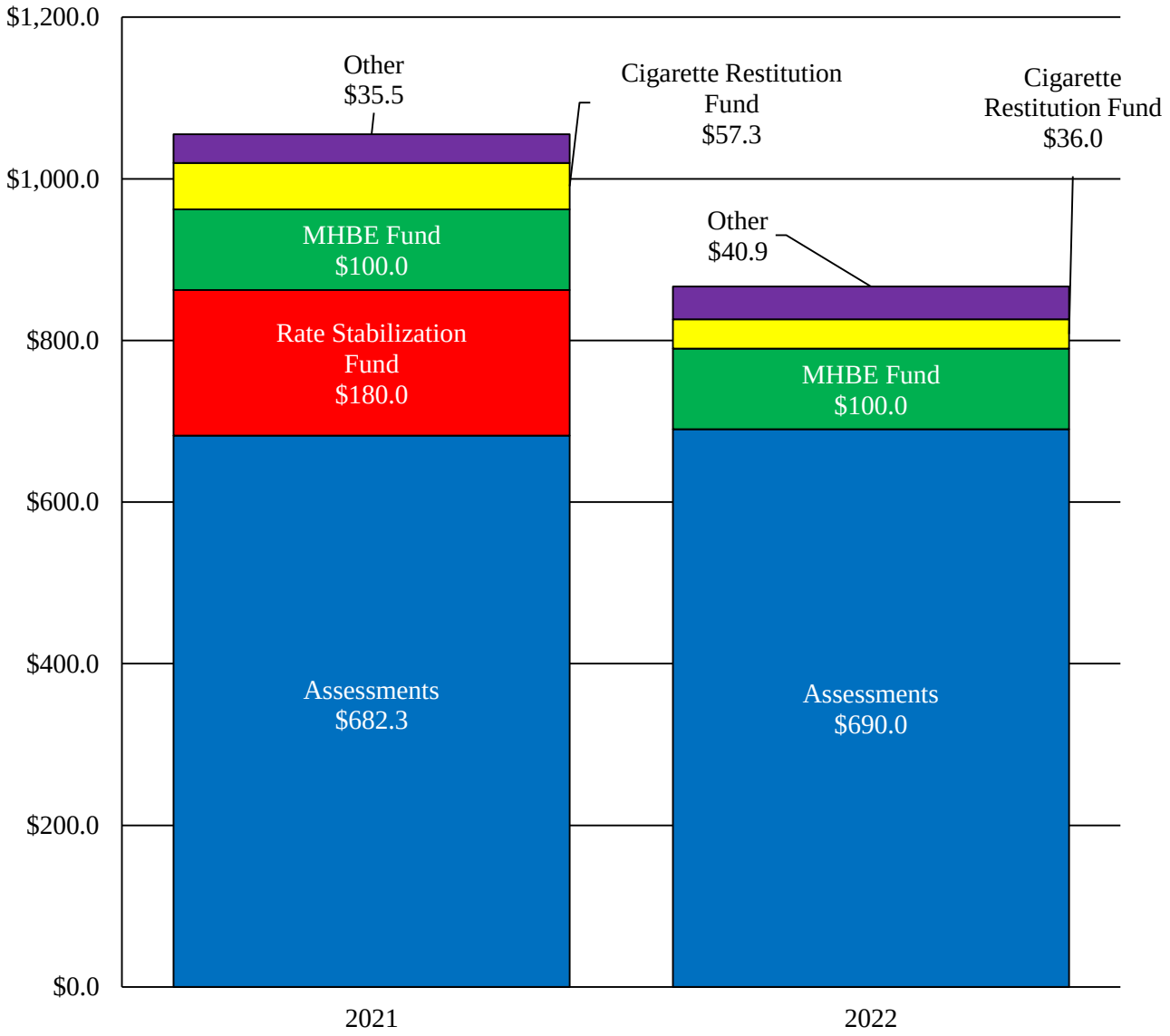
| Where It Goes: | Change |
|---|---|
| **Provider reimbursements and contracts** | **$403,459** |
| Enrollment and utilization | 250,451 |
| Medicare Part D clawback payments | 65,278 |
| Lower pharmacy rebates which results in increased pharmacy expenditures | 58,441 |
| Various systems contracts including significant increases in existing provider enrollment contract ($9.0 million), MMIS support and maintenance contract ($3.5 million), and Electronic Data Interchange contract ($2.5 million) | 29,829 |
| Medicare A and B premium assistance | 19,361 |
| Federally Qualified Health Centers supplemental payments | 7,342 |
| Utilization reviews | 5,374 |
| Prior year grant activity | 3,021 |
| Health Home payments | 2,285 |
| Hospital cost settlements | 1,991 |

| **Where It Goes:** | **Change** |
|---|---|
| Community First Choice (enrollment excluding rate increase) | 1,849 |
| PACE Expansion: Funding for additional 36 individuals for a new PACE program; current program, Hopkins ElderPlus, is approved to serve 200 individuals and has a current enrollment of 91 | 1,800 |
| MCO Rural Access Incentive | 1,650 |
| Graduate Medical Education Payments | 1,398 |
| Dental ASO contract | -1,922 |
| Program recoveries | -2,169 |
| Provider rate increases and assumptions (see **Exhibit 22** for additional detail) | -2,684 |
| Adult dental services | -3,277 |
| Health information technology payments | -7,000 |
| School-based services | -8,536 |
| Maryland Children's Health Program | -21,023 |
| **Other changes** | **34,794** |
| Major information technology development projects (Federal Funds) (see **Appendices 5 and 6** for additional details) | 30,739 |
| Senior Prescription Drug Assistance Program (see Issue 3 for additional discussion) | 4,055 |
| **Personnel Costs** | **741** |
| Annualization of fiscal 2021 general salary increase | 410 |
| Annual salary review adjustments | 126 |
| Employee and retiree health insurance | 318 |
| Other fringe benefit adjustments | -113 |
| Other | 179 |
| **Total** | **$439,173** |

ASO: administrative services organization
MCO: managed care organization
MMIS: Medicaid Management Information System
PACE: Program of All-Inclusive Care for the Elderly

Note: Numbers may not sum to total due to rounding. Fiscal 2021 appropriation is adjusted for deficiencies, contingent reductions, contingent appropriations, and general salary increases. Fiscal 2022 allowance is adjusted for contingent reductions, contingent appropriations, annual salary review adjustments, and the annualization of the fiscal 2021 general salary increase.

**Exhibit 19**
**Medicaid Special Fund Support**
**Fiscal 2021-2022**
**($ in Millions)**



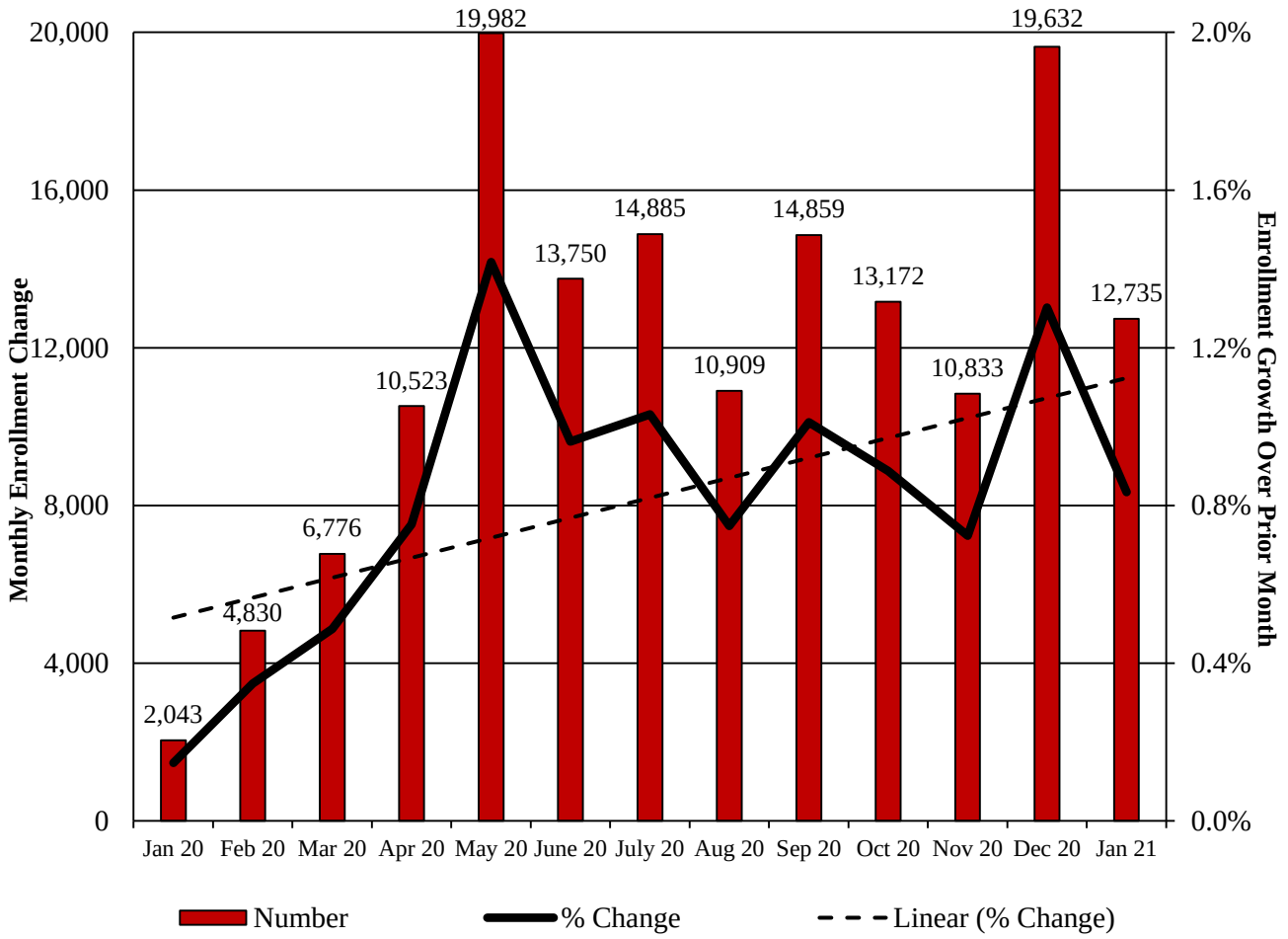

MHBE: Maryland Health Benefit Exchange

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

## Enrollment

As noted in Exhibit 18, the largest driver of Medicaid growth is enrollment and utilization, with enrollment as the primary factor. As shown in Exhibit 12, average monthly Medicaid enrollment through January 2021 is already 1.5 million, with actual enrollment in January of 1.54 million, up over 140,000 since March 2020. Monthly enrollment data and enrollment trend is noted in **Exhibit 20**. DLS anticipates this trend to continue through December 2021, as long as Medicaid continues to delay annual redeterminations and economic conditions continue to be relatively weak.

**Exhibit 20**
**Medicaid and MCHP Enrollment**
**Month over Month Change**
**January 2020 to January 2021**




MCHP: Maryland Children's Health Program

Source: Maryland Department of Health; Department of Legislative Services

**Exhibit 21** contrasts DLS' updated enrollment fiscal 2021 and 2022 forecast with the revised fiscal 2021 budget and fiscal 2022 assumptions developed by the Department of Budget and Management (DBM). As shown in the exhibit, while the details vary slightly by broad population category, DLS' fiscal 2021 estimate is broadly aligned to the revised DBM fiscal 2021 estimate. However, the fiscal 2022 estimates diverge, primarily due to the timing of when the estimates were developed. In developing the budget, DBM assumed that the national public health emergency would end after fiscal 2021. After the budget was submitted, in January 2021, the Biden Administration announced that the public health emergency declaration would last until at least through the second quarter of fiscal 2022. DLS based its estimate on this new information, assuming continued strong enrollment growth through December 2021, at which point Medicaid will recommence redeterminations for both enrollees on the normal annual cycle and those who had their redeterminations frozen beginning in March 2020. The latter group are expected to be processed over a six-month period. DLS anticipates a significant decline in enrollment over that six-month period. Even so, DLS anticipates fiscal 2022 average enrollment growth of 4.1% over its fiscal 2021 estimate.

**Exhibit 21**
**DLS and DBM Enrollment Forecasts**
**Fiscal 2021-2022**

| | 2021 | | 2022 | | % Change 2021-2022 | |
|---|---|---|---|---|---|---|
| | Revised Budget | DLS Estimate | Allowance | DLS Estimate | DLS Estimate to Allowance | DLS Estimate to DLS Estimate |
| Traditional Medicaid | 1,020,806 | 1,017,347 | 1,019,181 | 1,032,052 | 0.18% | 1.45% |
| ACA Expansion | 365,853 | 368,250 | 388,412 | 413,745 | 5.48% | 12.35% |
| MCHP | 144,140 | 144,259 | 143,900 | 147,239 | -0.25% | 2.07% |
| **Total** | **1,530,799** | **1,529,856** | **1,551,493** | **1,593,036** | **1.41%** | **4.13%** |

ACA: Affordable Care Act
DBM: Department of Budget and Management
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

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

## Provider Rates

As shown in **Exhibit 22**, provider rates have little overall impact on the fiscal 2022 budget. There is an estimated additional $39.4 million in total funds to annualize the mandatory 4% increase accelerated to January 1, 2021, related to minimum wage legislation (Chapters 10 and 11 of 2019), $29.4 million based on assumptions of regulated rates, and $8 million for physician evaluation and management (E&M) rates. However, these increases are more than offset by savings from the

MCO calendar 2021 2.4% rate decrease. MCO rates drop primarily to reflect the removal of the calendar 2020 ACA insurer fee, which was intermittently imposed after the passage of the ACA and ultimately repealed beginning in calendar 2021 by the U.S. Congress in December 2019.

**Exhibit 22**
**Medicaid Provider Rates and Rate Assumptions**
**Fiscal 2022**
**($ in Millions)**

| **Item** | |
|---|---|
| Nursing Homes (annualization of 4%) | $25.9 |
| Inpatient and outpatient (3.35%) | 29.4 |
| Community First Choice (annualization of 4%) | 8.0 |
| Physician Evaluation and Management rates | 8.0 |
| Medical Day Care (annualization of 4%) | 2.6 |
| Private Duty Nursing (annualization of 4%) | 2.2 |
| Home- and community-based services (annualization of 4%) | 0.5 |
| Personal Care (annualization of 4%) | 0.2 |
| Rare and Expensive Case Management Services (annualization of 4.0%) | 0.1 |
| Managed Care Organization calendar 2021 net decrease (-2.4%) | -79.7 |
| **Total** | **-$2.7** |

Source: Maryland Department of Health; Department of Legislative Services

It should be noted that the $8 million included in the budget for physician E&M rates would result in Medicaid's E&M rates falling significantly below the 93% of Medicare benchmark that Medicaid has tried to maintain in recent budgets. In December 2020, Medicare announced a 3.75% net increase in the Medicare Physician Rate Schedule as well as a number of policy changes. Based on the E&M rates that resulted from this increase, Medicaid estimated that it would cost a total of $92.0 million to increase physician E&M rates to 93% of Medicare rates for fiscal 2022. Supplemental Budget No. 2 adds $84.0 million in additional funding ($29.9 million in general funds and $54.1 million in federal funds).

## Fiscal 2022 General Fund Adequacy

Currently, DLS projects a higher Medicaid enrollment than the fiscal 2022 budget anticipates. Despite the projected higher enrollment, the impact on the budget is tempered by the fact that a significant number of these new enrollees are either children, who are relatively inexpensive to cover, or ACA adults for whom the State can claim a 90% federal match. Utilization trends, particularly in nursing home care, remain significantly below what is presumed in the budget, as do FFS pharmacy

expenditures. **Taken together, DLS estimates that the fiscal 2022 budget is overfunded and recommends a reduction of $77.0 million in general funds.**

## *Personnel Data*

| | FY 20 Actual | FY 21 Working | FY 22 Allowance | FY 21-22 Change |
|---|---|---|---|---|
| Regular Positions | 625.70 | 608.90 | 609.00 | 0.10 |
| Contractual FTEs | 83.98 | 99.32 | 111.41 | 12.09 |
| **Total Personnel** | **709.68** | **708.22** | **720.41** | **12.19** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 52.43 | 8.61% |
| Positions and Percentage Vacant as of 12/31/20 | 78.00 | 12.81% |
| Vacancies Above Turnover | 25.57 | |

# *Issues*

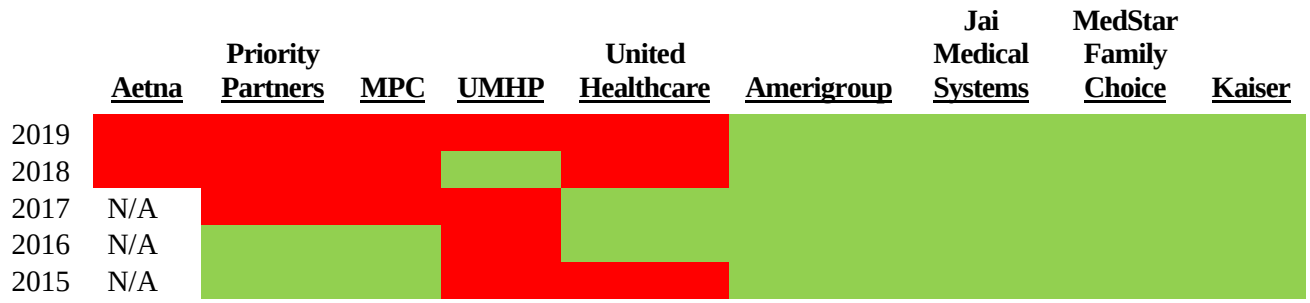
## 1. HealthChoice Program and Performance Quality

Medicaid invests significant effort in a variety of quality assurance efforts around the HealthChoice program:

- operations, for example, record reviews, and network adequacy testing;
- enrollee and provider satisfaction, through survey collections;
- quality measurement, for example through HEDIS data collection, the value-based purchasing (VBP) initiative, and performance improvement projects; and
- program management and oversight, for example through its annual technical report.

In terms of quality, as was noted above using HEDIS data, MCOs operating in the HealthChoice program generally outperform their peers. However, Medicaid chooses a higher bar, namely that MCOs should be above the national HEDIS mean on 70% of the measures used to assess performance. As shown in **Exhibit 23**, in recent years, more MCOs have struggled to achieve this higher bar.

**Exhibit 23**
**MCOs Having 70% or More of Chosen HEDIS Measures Above National HEDIS Mean**
**Calendar 2015-2019**
**(Red is below 70% / Green is above 70%)**




HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care
UMHP: University of Maryland Health Partners

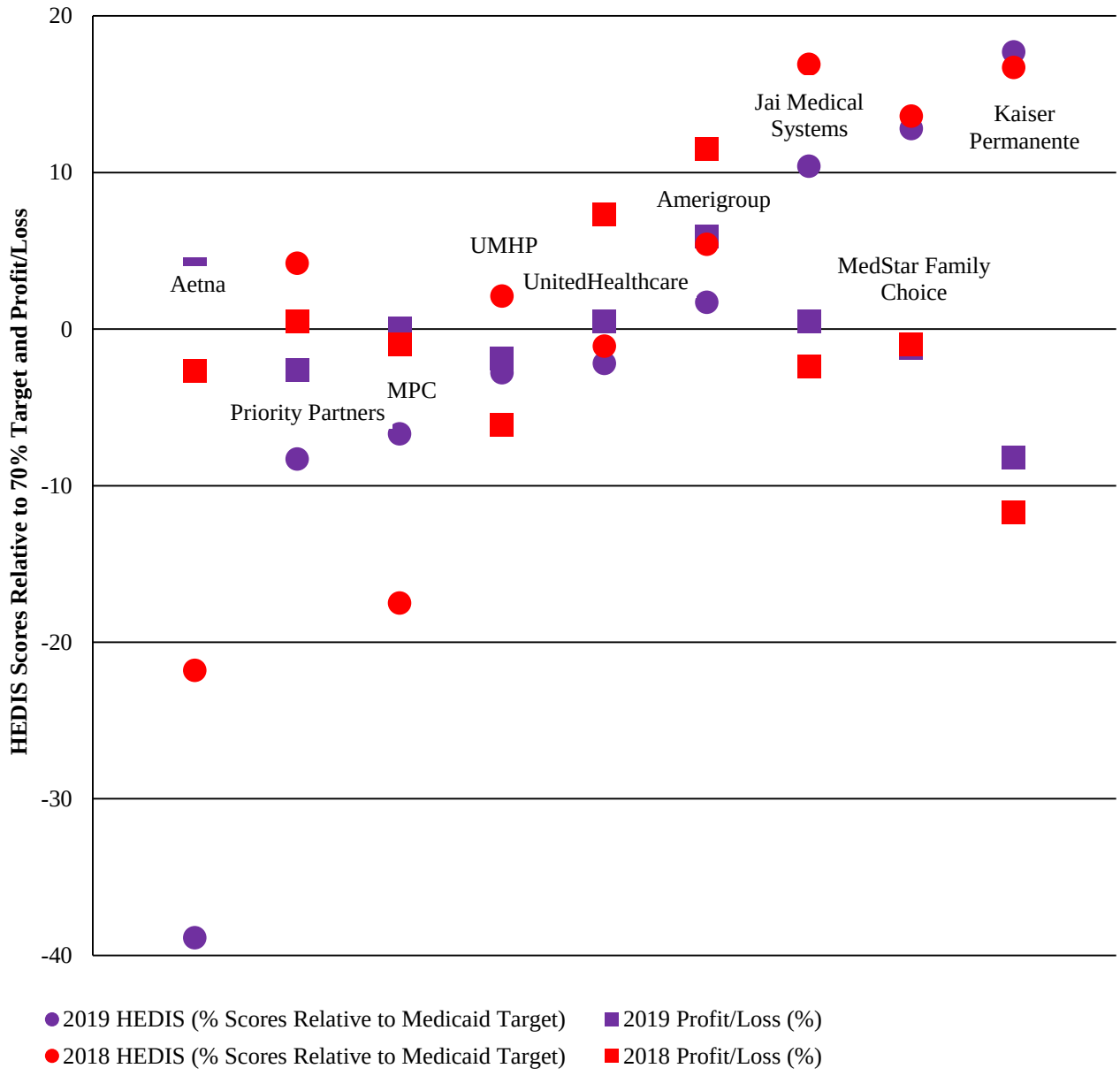
Note: UMHP has been acquired by CareFirst but was still operating as UMHP in calendar 2019.

Source: Maryland Department of Health

**Exhibit 24** tracks the most recent calendar 2018 and 2019 HEDIS performance relative to the Medicaid HEDIS target with MCO financial performance for the same years as reported by the Maryland Insurance Administration. Data is sorted by calendar 2019 HEDIS performance. At the program level, calendar 2018 revealed a 2.1% profit margin with overall profits of $122.9 million. The financial data for calendar 2019 is still preliminary but at best was a break-even year for the program overall. As shown in the exhibit, Amerigroup is the only MCO that was able to meet Medicaid's HEDIS targets and show a profit in both years. Only Jai Medical Systems of the three best-performing MCOs on the HEDIS targets (MedStar Family Choice, Jai Medical Systems, and Kaiser Permanente) showed a profit in either year. On the other hand, UnitedHealthcare shows profits in both years but also fails to meet targets. It may be too early to judge Aetna as a new MCO, but in calendar 2019, it is projected to show a profit, although its relative HEDIS performance is the worst of the nine MCOs in HealthChoice.

**Exhibit 24**

## MCO HEDIS Performance Relative to Medicaid Target and Profit/Loss Margins
**Calendar 2018-2019**




HEDIS: Healthcare Effectiveness Data and Information Set
MCO: managed care organization
MPC: Maryland Physicians Care
UMHP: University of Maryland Health Partners

Note: UMHP has been acquired by CareFirst but was still operating as UMHP in calendar 2018 and 2019.

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

## Value-based Purchasing

The most visible HealthChoice quality assurance program is VBP. VBP is a P4P effort with the goal of improving MCO performance by providing monetary incentives and disincentives up to 1% of each MCOs' total capitated payments based on performance in certain health care measures identified by MDH. For calendar 2019, nine measures were chosen for which MDH sets targets: adolescent well care; two ambulatory care visit measures for certain children and adults; early childhood lead screenings; well-child visits for certain children; breast cancer screening; certain testing as part of comprehensive diabetes care; controlling high blood pressure; and medication management for people with asthma.

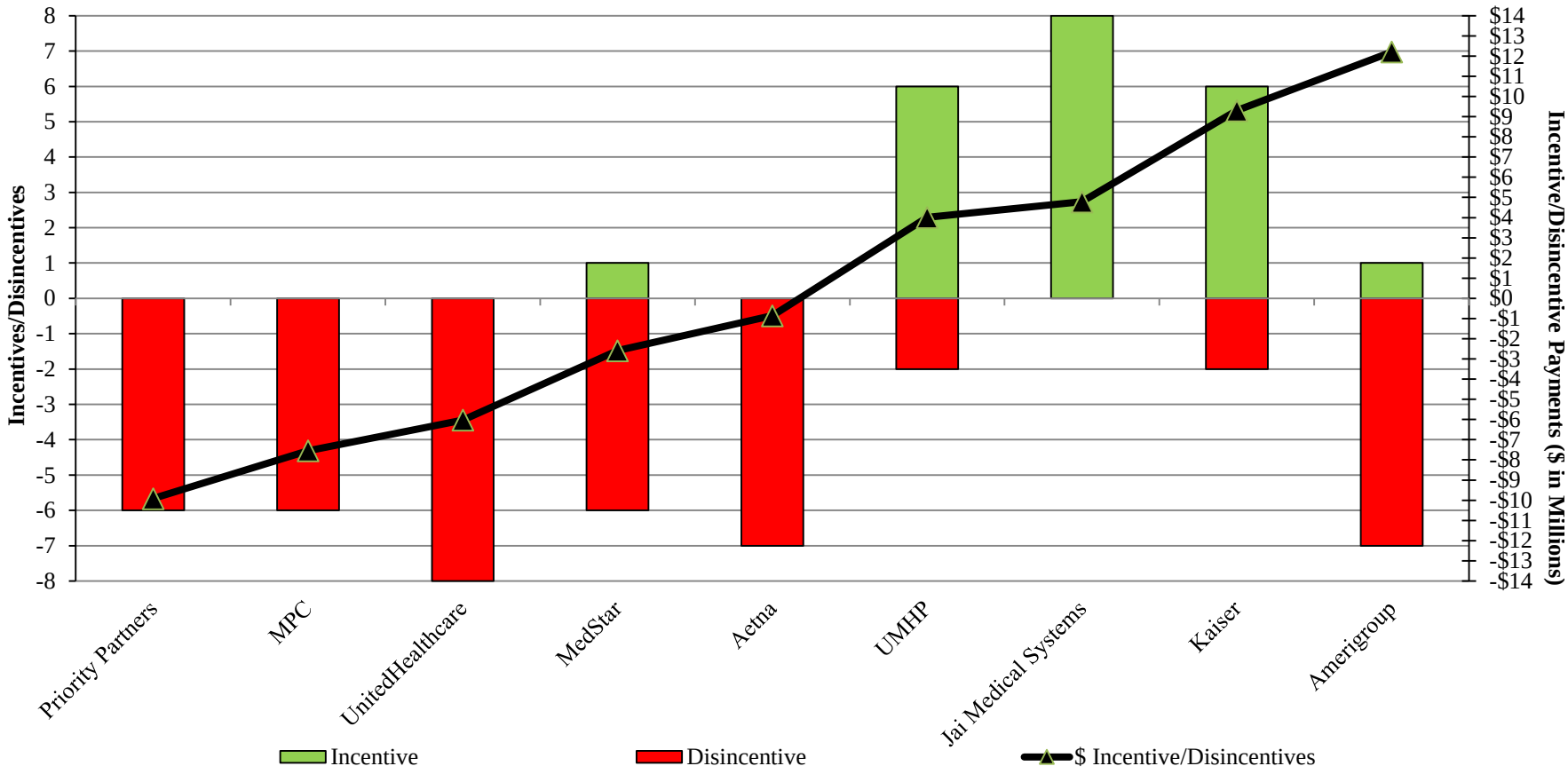
Under VBP, MCOs with scores exceeding the target receive an incentive payment, while MCOs with scores below the target must pay a penalty. There is also a midrange target for which an MCO receives no incentive payment but does not pay a penalty either. Similarly, plans that do not have a sufficient population for any particular measure cannot earn an incentive or be penalized. Incentive and penalty payments equal up to one-ninth of 1% of total capitation paid to an MCO during the measurement year per measure with total penalty payments not to exceed 1% of total capitation paid to a MCO during the measurement year. The penalty payments are used to fund the incentive payments.

If collected penalties exceed incentive payments, the surplus is distributed in the form of a bonus to the four highest performing MCOs using normalized scores and relative enrollment. In recent years, this secondary distribution has resulted in the perverse result that an MCO with more disincentives than incentives on VBP targets can still benefit as one of the "top four" performers. Calendar 2019 results were no exception to this skewed distribution, as shown in **Exhibit 25**. In total, $34.5 million in disincentive payments were collected, $4.2 million in incentive payments were awarded in the first round of distribution to Jai Medical Systems, Kaiser Permanente, and the University of Maryland Health Partners (UMHP), with the remaining $30.3 million awarded to the same three MCOs plus Amerigroup even though Amerigroup had seven of nine measures on which they had to pay disincentives.

**Exhibit 25**

## Results of Value-based Purchasing

**Calendar 2019**




Kaiser: Kaiser Permanente
Medstar: MedStar Family Choice
MPC: Maryland Physicians Care
UMHP: University of Maryland Health Partners

Note: Aetna was only included in seven measures as fewer than 30 members could be included in two measures. UMHP has been acquired by CareFirst but was still operating as UMHP in calendar 2019.

Source: Maryland Department of Health

## The Future of VBP

Two issues have sharpened focus on the VBP program:

- MCO regulations adopted at the federal level require actuarial soundness not on a programwide basis but on an individual MCO basis. While this interpretation has been disputed, MDH reports that CMS has indeed confirmed that this is the intent of the rule. To the extent that rates are set at the bottom of the rate range, any net loss would take an individual MCO below an actuarially sound level, and the VBP cannot operate as currently constituted. In calendar 2018 with rates at the bottom of the range, Medicaid announced the program would be incentive only. However, because regulations were not changed, this ruling was contested, and ultimately, Medicaid settled with three MCOs on a percentage of the secondary distribution that would have been owed. In the current calendar year, 2021, with rates again at the bottom of the range, Medicaid has indicated it will not be collecting disincentives nor has it committed to an incentive program.

- Second, the structure of the secondary distribution can, if significant disincentive payments are collected, result in significant secondary payouts to smaller MCOs. For example, calendar 2019 secondary distributions to Kaiser Permanente, Jai Medical Systems, and UMHP are equal to 3.1%, 2.4%, and 1.6% of net premiums, respectively. Similarly, the secondary distribution, since it is based on enrollment, among other factors, can mean the largest dollar payout goes to an MCO that did not do well on the VBP measures, for example, the $12.2 million to Amerigroup in calendar 2019. The extent of these secondary distributions has nettled some MCOs, although it should be countered that if those MCOs improved performance, this would be less of an issue.

In response to longstanding concerns about the secondary distribution, the BRFA of 2020 restructured the VBP program so that the secondary distribution be allocated:

- 40% to the four highest performing MCOs, except that MCOs with net disincentives could not collect funding;

- 25% to MCOs based on improvement to be used to further target performance improvement;

- 25% for health improvement programs in HealthChoice; and

- 10% to establish a reserve in the HealthChoice Performance Incentive Fund, although once the fund balance exceeds $5 million, then the funding would be distributed between the other funding priorities.

However, Medicaid recently announced the intent to go in a different direction for VBP. Initially, for calendar 2022, Medicaid intends to reevaluate existing VBP measures, shift to an incentive-only program, and potentially modify performance thresholds. The level of incentives available will be based on what is provided in the budget by the Governor plus penalties collected under quality improvement programs. Medicaid proposes changing payments so MCOs earn a targeted

amount based on performance and also enrollment, eliminating the secondary allocation to the four highest performers but using the BRFA guidelines concerning improved performance and funding health improvement projects, if available incentive funding provided is not allocated in the initial round based on performance. This process is described as Phase One of a more wide-ranging change.

It remains to be seen what the level of incentives will be provided in the budget (there is no funding included in the fiscal 2022 budget for the calendar 2022 program as payouts would not occur until fiscal 2023). The commitment to this kind of program will be judged by the level of incentives provided. Certainly, recent history in terms of supporting the program is mixed, based on the continued budgeting of rates at the bottom of the rate range. In the short term, the change is causing angst among some of those MCOs that have performed well under the current VBP structure and reaped the sometimes sizeable financial rewards that come with that performance.

**Medicaid should comment on the change to the incentive-only program and also outline potential changes beyond Phase One.**

## 2. Expansion of Home- and Community-based Waiver Services

In recent sessions, legislation has been introduced to increase the utilization of home- and community-based (HCBS) waiver services, specifically the Community Options waiver, in the Medicaid program. Through this waiver, individuals who would not otherwise qualify for Medicaid can access services such as assisted living, case management, medical day care and other Medicaid services in order for them to live at home or an assisted living facility rather than in a nursing facility. In addition to financial eligibility requirements (individuals must have monthly incomes of no more than 300% of the monthly SSI benefit, or approximately 220% of the FPL, plus meet certain asset guidelines), individuals must need the level of care required to qualify for nursing facility services.

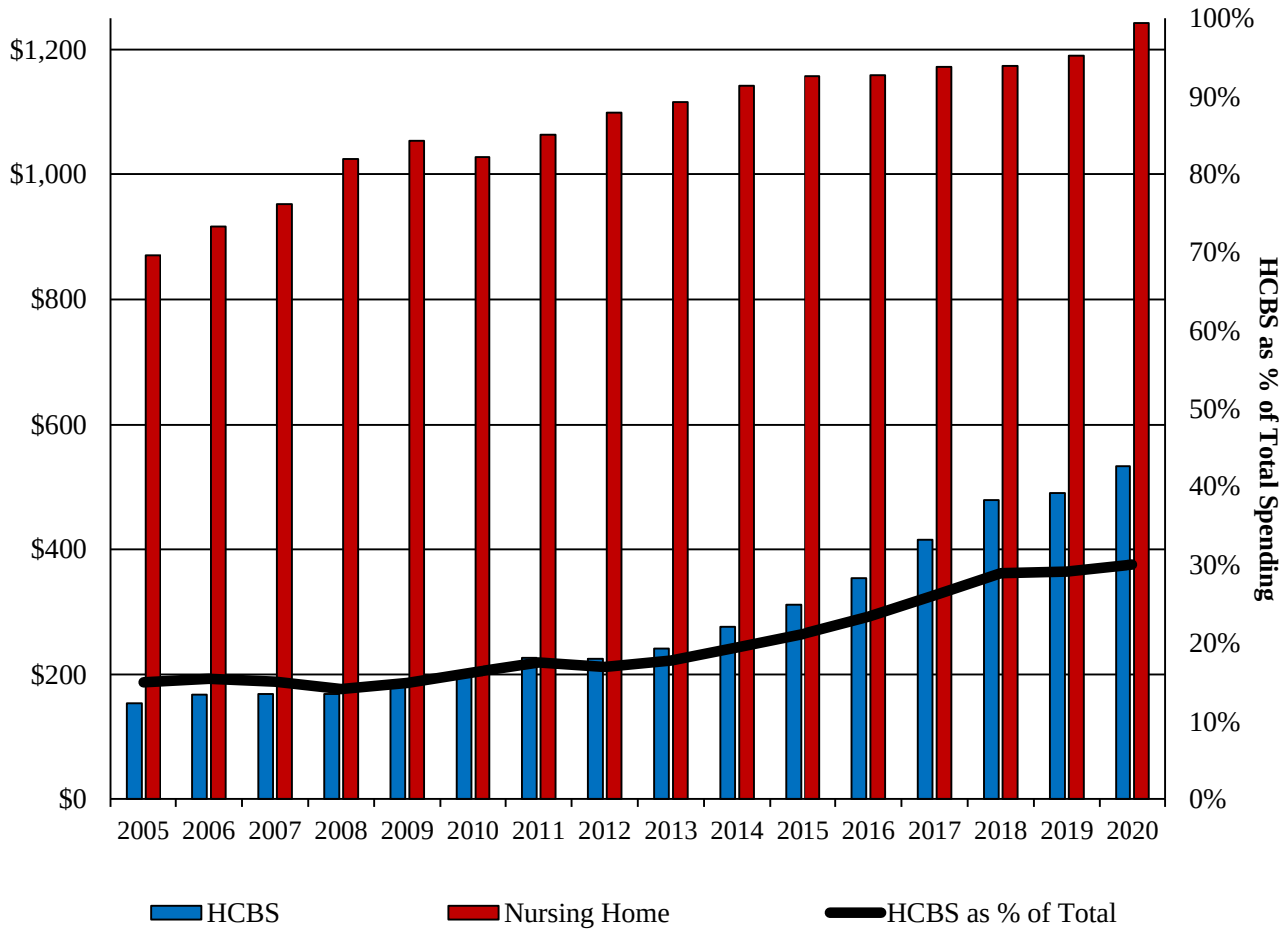
In the 2020 session, language was added to the fiscal 2021 Budget Bill requiring MDH and the Hilltop Institute at the University of Maryland Baltimore County, in consultation with other stakeholders, to provide a cost-benefit analysis of expanding access to long-term care services through HCBS waivers over a five-year period. Also, since much of the savings from the provision of waiver services through Medicaid accrues to Medicare, the language asked for the report to investigate how to capture those savings for the benefit of the Medicaid program.

### Background

Research has shown that individuals generally prefer living in community-based rather than institutional (nursing facility) settings. Further, there is evidence that use of HCBS care reduces the risk of institutional care, reduces levels of family stress, and improves the quality of life for individuals served in those community settings. While it is clear that serving an individual in HCBS as a direct alternative to institutional care is cheaper, studies evaluating the cost to states of expanding access to HCBS have produced only mixed results. Further, evidence points to savings from such initiatives accruing to Medicare (a federally funded only program) rather than to Medicaid.

There have been consistent efforts in recent years to "re-balance" care away from institutional to community-based care. Maryland Medicaid has taken advantage of various federal initiatives including Money Follows the Person, the Balancing Incentive Program, and Community First Choice all of which offer/offered an enhanced federal match, to help accomplish this rebalancing. As shown in **Exhibit 26**, Medicaid spending (exclusive of spending on the developmentally disabled) on long-term care delivered through HCBS has slowly expanded both in terms of the absolute funding level and share of total long-term care services.

**Exhibit 26**
**Maryland Medicaid: Delivery of Long-term Care Services**
**Fiscal 2005-2020**
**($ in Millions)**



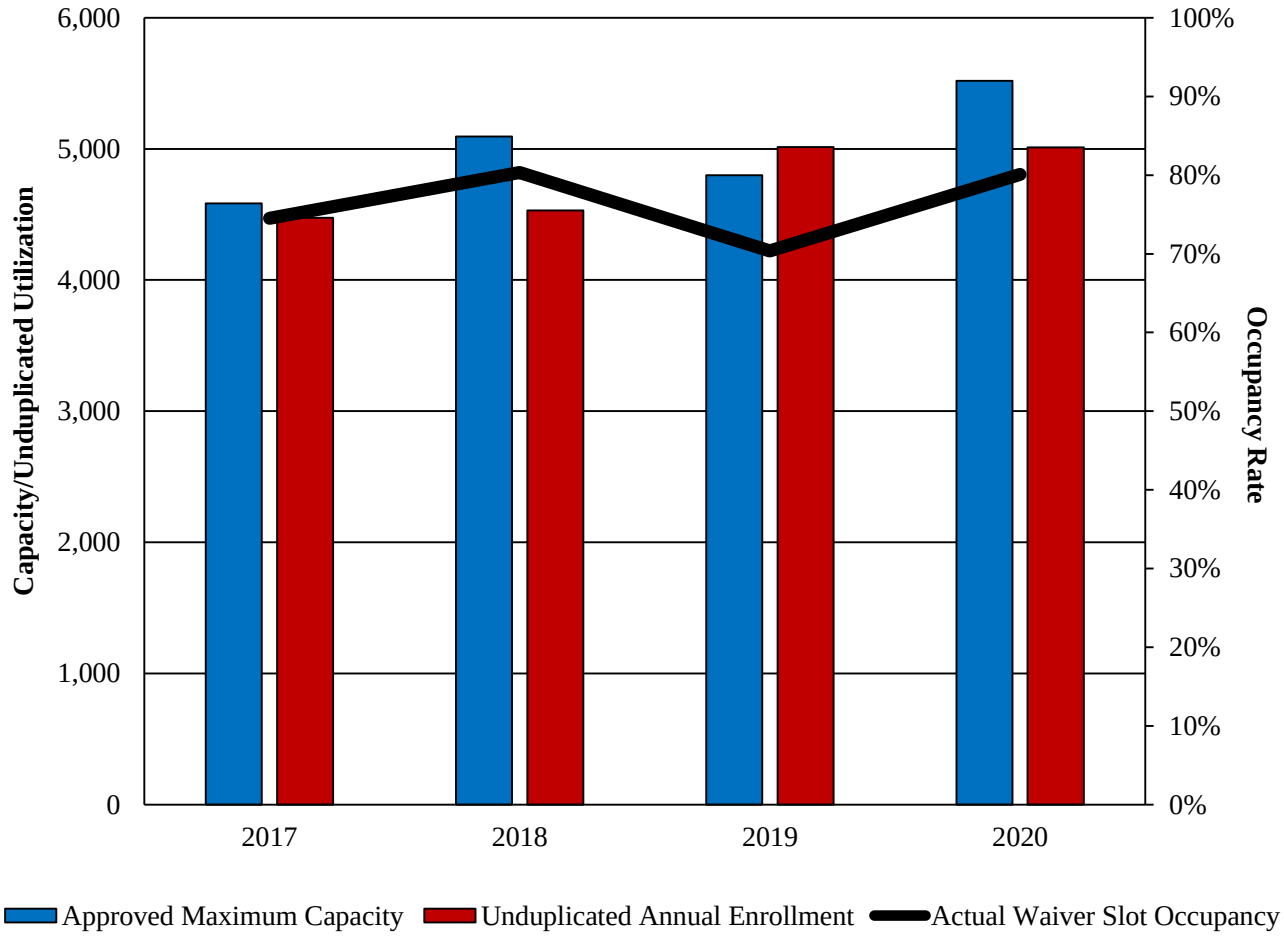

HCBS: home- and community-based

Source: Maryland Department of Health; Department of Legislative Services

## Community Options Waiver

Despite the trends noted in Exhibit 25, concern has been raised about the extent to which HCBS waiver slots are utilized. As shown in **Exhibit 27**, in recent years, the number of unduplicated individuals using waiver services has been close to, or even exceeded, the approved maximum capacity. However, the occupancy rate (defined as the percentage of approved person-month waiver slots that are actually filled) has been lower, ranging between 705 to 80%.

**Exhibit 27**
**Community Options Waiver Approved Capacity**
**Unduplicated Utilization Occupancy Rate**
**Fiscal 2017-2020**

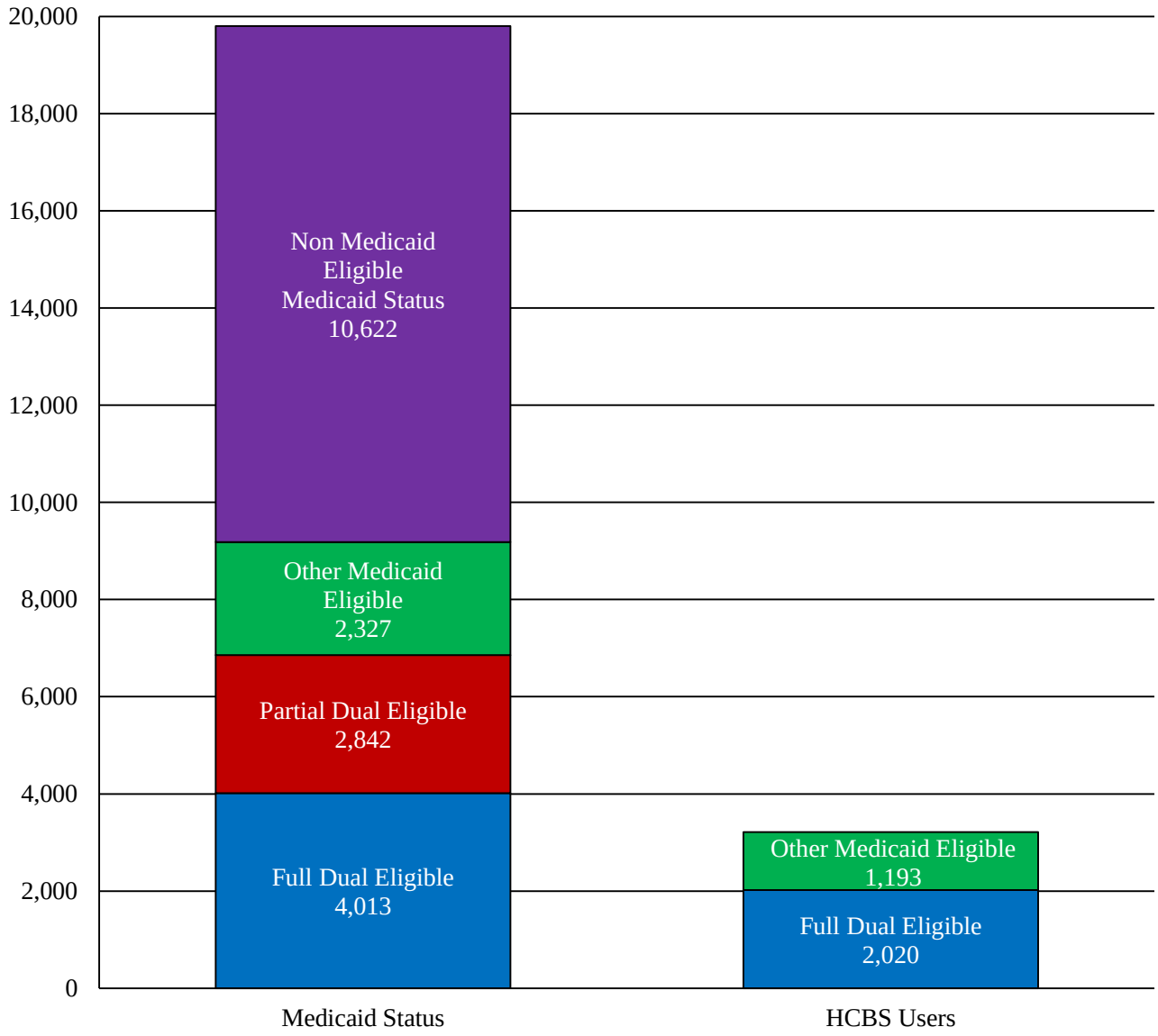



Source: Hilltop Institute

MDH has offered a number of reasons for the inability to better utilize slots, including (1) having a high number of slots; (2) providing flexibility to avoid having to submit a waiver application to increase slots; (3) program expansion on the entitlement side; (4) the provider network utilized by the entitlement and waiver population is the same, and the capacity of that network (personal assistance agency providers, case management, *etc*.) is limited with available capacity taken up by the entitlement programs; and (5) methods for pulling people off of the waiver registry are outdated and ineffective. MDH has looked to improve the operation of the registry including prioritization of people most in need: nursing home residents and individuals in the community based on risk of institutionalization (moving away from a first-come first-served methodology).

These changes notwithstanding, there remains a significant waiting list (registry) for the Community Options waiver. As of September 30, 2020, there were 19,804 individuals on the registry. As shown in **Exhibit 28**, of these individuals, 9,182, or 46.4%, are Medicaid-eligible including individuals who are full dual Medicare and Medicaid eligible and part duals (eligible for premium assistance). Of these individuals, 3,213, or 35%, already receive Medicaid HCBS. However, they remain on the waiver registry in order to access HCBS services not available in the regular Medicaid program.

**Exhibit 28**
**Medicaid Eligibility Status of Individuals on the Community Options Registry**
**September 30, 2020**



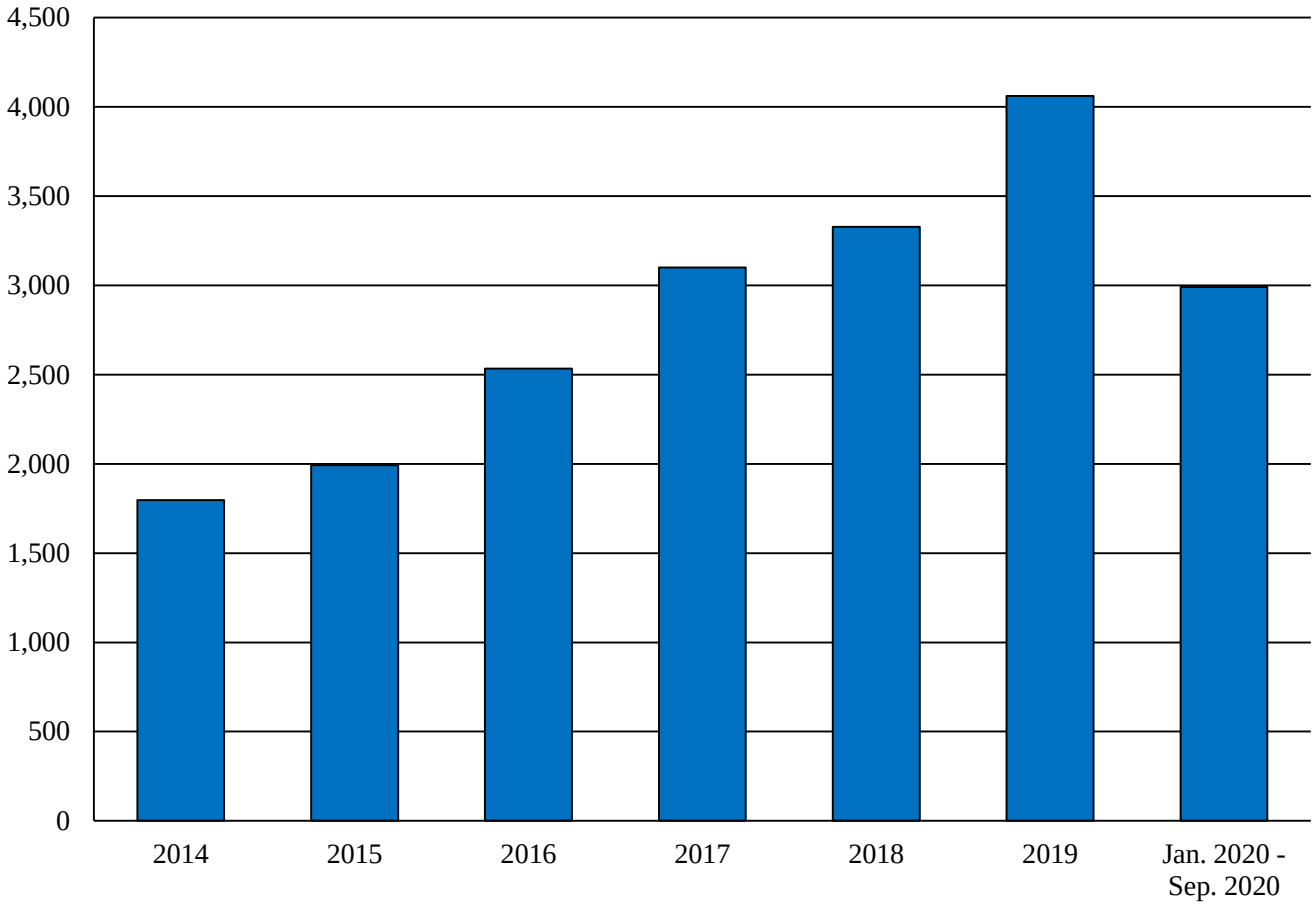

HCBS: home- and community-based

Source: Hilltop Institute; Department of Legislative Services

It is important to note that many individuals on the registry have been on it for some considerable time, as shown in **Exhibit 29**. While this would, on its face, point to the need for additional waiver slots, it is unclear how many individuals on the registry actually meet financial and nursing

facility level of requirements to participate in the program. Eligibility is not generally determined until an individual is formally offered a waiver slot (although those assessed for, and potentially already enrolled in, other HCBS programs, are known to be eligible). Hilltop estimated how many individuals would meet nursing facility level of care eligibility requirements for a waiver slot based on available screening data (including data submitted when a person asks to be added to the registry, information generally available since calendar 2016) and then used historical enrollment data for those meeting nursing facility level of care who also met financial eligibility requirements. Taken together, Hilltop estimated that 3,088 of those on the waiver registry, or 15.6%, would qualify for a waiver slot if offered.

**Exhibit 29**
**Community Options Waiver Registry Enlistment by Year**
**Calendar 2014-2020**




Source: Hilltop Institute; Department of Legislative Services

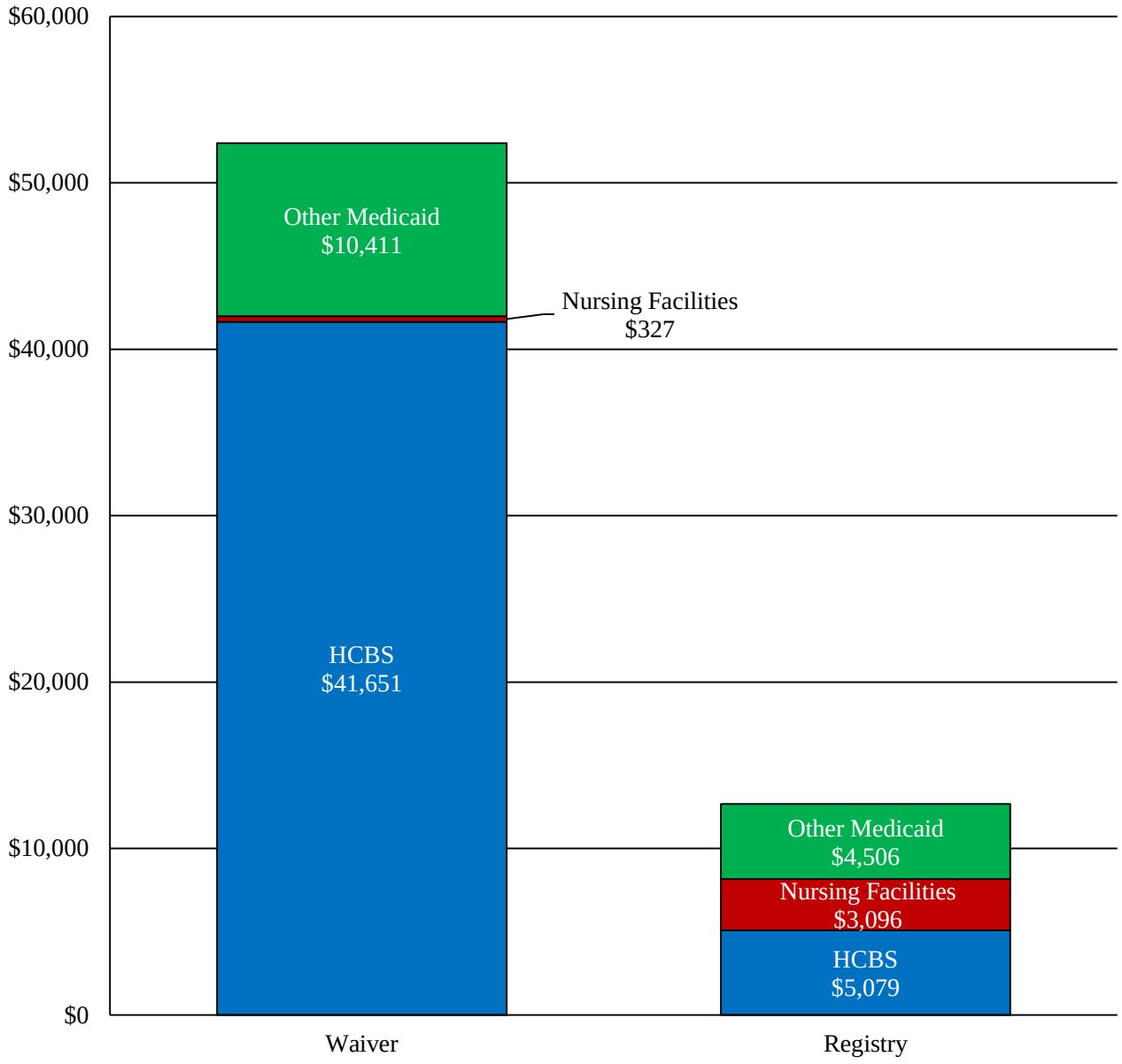
## Community Options Waiver Expansion Cost Analysis

The thornier issue that the Hilltop study was asked to grapple with was the question of cost associated with waiver slot expansion. Specifically, trying to estimate additional costs associated with accessing services (HCBS and regular Medicaid services) through additional waiver slots while recognizing cost avoidance from individuals on the registry who use Medicaid services because they are already qualified for Medicaid or subsequently become Medicaid-eligible (for example, through spend-down).

Hilltop's methodology for developing such an estimate was first to estimate individual Medicaid spending for those enrolled in an HCBS and then to compare those costs to Medicaid costs incurred by an individual on the registry who is Medicaid-eligible. After making certain exclusions, Hilltop developed a data set for individuals on the waiver (or a predecessor waiver) for at least a calendar year between 2010 and 2019 (6,778 unique individuals) and somebody on the registry for at least a year in the same time period (24,716 individuals) and limited the analysis to data when a person was actively in the waiver, was actively on the register, or left the registry. Cohorts were developed in order to compare costs on an annual basis for up to 10 years. There are limitations to the methodology chosen by Hilltop, including the inability to account for the total health costs of those on the registry that are ineligible for Medicaid that would have provided a fuller picture of the health status of individual on the registry, the assumption that costs for a waiver enrollee would have been that of a similar registry enrollee had they not been on the waiver, that all costs attributable to an individual once on the registry would have been avoided if they had been in the waiver, and registry data issues.

**Exhibit 30** provides an example of the different costs associated with people serving on the registry versus those on the registry for the Year One cohort (while specific costs vary by cohort, there is reasonable consistency between different cohorts). Individuals participating in the waiver tend to have a much higher total spend than those on the registry. Unsurprisingly, expenditures for HCBS and other Medicaid services are higher for those on the waiver, reflecting an access to services that would otherwise not be covered, while spending on nursing home care is negligible (short-term residence in a nursing home can expedite the application process, but nursing home residents are not eligible to receive Community Options waiver services). Conversely, nursing home costs are a major component of costs for those on the registry, especially for those on the registry for a longer period of time.

**Exhibit 30**
**Medicaid Costs**
**Individuals in HCBS Waiver and on HCBS Registry**
**Year One Cohort**




HCBS: home- and community-based

Source: Hilltop Institute; Department of Legislative Services

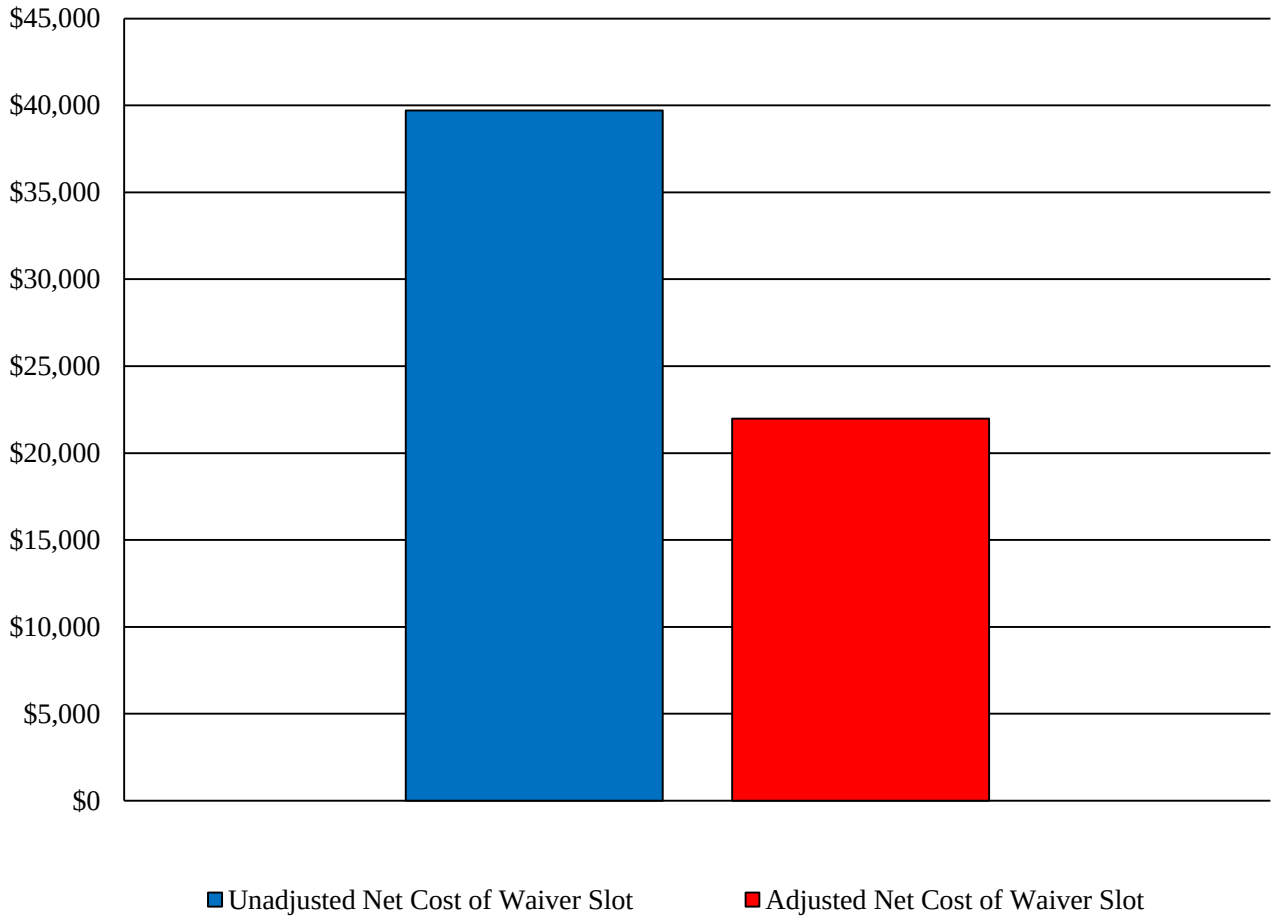
Having established that individuals on the waiver incur more Medicaid costs than those on the waiver registry, the final part of the analysis was to calculate the cost to Medicaid of adding a waiver slot, taking into account additional waiver costs that will be incurred by adding a slot net of Medicaid costs that would be incurred if the slot was not added. To do this, Hilltop applied two adjustments:

- An adjustment to reflect that waiver slots are not continuously occupied, not least because of the length of time that it can take to fulfill the requirements to fill a vacant waiver slot. As noted earlier, occupancy rates vary, but Hilltop assumes an overall occupancy rate of 76.13%. In comparison, a registry spot is filled continuously. As a result, waiver costs are reduced by the occupancy rate.

- An adjustment to reflect that individuals on waiver slots must, by definition, meet a nursing facility level of care, whereas individuals on the registry do not need to meet that level of care to simply be on the registry. As a proxy for health status, this would imply individuals on the registry might be healthier that those on the waiver. To correct for this, Medicaid costs for registry participants were adjusted upward to mimic the Medicaid costs for individuals on the registry expected to have a nursing facility level of care. This increases Medicaid costs for those on the registry by 1.412.

Taken together, these adjustments provide an estimate for the cost of an additional waiver slot, which is significantly lower than the cost difference between an individual's costs on the waiver versus registry shown above. Depending on the cohort, the average cost of an additional waiver slot is $20,000 to $25,000 per year (the relative cost for the Year One cohort, $22,000, is shown in **Exhibit 31**). The State cost will be slightly under 50% given the enhanced match available for any Community First Choice services provided to individuals under the waiver but can be expected to be close to $10,000 to $12,500 annually.

**Exhibit 31**
**Net Cost to Medicaid of a Waiver Slot: Before and After Adjustments for Slot Occupancy Rate and Relative Health Costs**
**Year One Cohort**




Source: Hilltop Institute; Department of Legislative Services

## Conclusion

The Hilltop analysis confirms that expanding waiver slots will increase total Medicaid spending. However, the extent of spending increase is generally lower than had been previously thought. It is also important to note, and the analysis underscores this, that there are nonquantifiable benefits from expanding waiver capacity, not least improved quality of life for waiver enrollees and reduced family stress.

The major unanswered question contained in the analysis is the extent to which waiver expansion that includes dual-eligibles will reduce Medicare costs. Certainly, there is an understanding that the provision of high-quality HCBS through Medicaid can generate Medicare savings from avoided hospitalizations and emergency department visits. Then the issue remains on how to capture some of those savings to help defray the State cost of providing the additional waiver services. There are examples of states developing service delivery models which capture Medicare savings under CMS' Financial Alignment Initiative, for example, Washington State's health homes for dual-eligibles, which resulted in Medicare making performance payments to the State after it demonstrated Medicare savings as well as meeting quality benchmarks. This kind of shared savings in a waiver expansion proposal could offset the State cost of expanding waiver participation. **DLS recommends narrative to ask Medicaid to pursue a model that can expand waiver participation and at the same time capture the Medicare savings from such an expansion.**

## 3. Senior Prescription Drug Assistance Program

The SPDAP provides Medicare Part D premium assistance to moderate-income Maryland residents (income levels below 300% of FPL) who are eligible for Medicare and are enrolled in a Medicare Part D prescription drug plan. The program is funded by the CareFirst premium tax exemption payment. In fiscal 2022, that payment is expected to be just over $17.6 million and is split between the SPDAP and the Maryland Community Health Resource Commission (CHRC). Through calendar 2019, the SPDAP also provided a subsidy for the Medicaid Part D coverage gap or "donut hole." The Bipartisan Budget Act of 2018 ended this gap, the subsidy is no longer provided, and CareFirst also no longer makes a payment to provide the funding for the coverage gap subsidy.

In fiscal 2020, the SPDAP had a monthly average enrollment of 28,635, slightly down from the prior year. Enrollment in the first six months of fiscal 2021 was 27,520. Importantly, after many years of providing a premium subsidy of up to $40 per month, the SPDAP increased the subsidy to a maximum of $50 per month effective January 2021. This move was in recognition of an increase in the Standard Medicare Part D maximum deductible from $435 in 2020 to $445 in 2021.

Based on the increased subsidy and current enrollment, the latest SPDAP fund forecast is shown in **Exhibit 32**. Expenditures under the program dropped in fiscal 2020 as coverage gap expenditures diminish. Expenditures in fiscal 2021 are broadly in line with budgeted expenditures even with the proposed subsidy increase. However, expenditures are likely to increase further in fiscal 2022 as the full impact of the increased subsidy is felt, expenditures which are not fully reflected in the allowance as introduced.

As was the case in the 2020 session, the BRFA of 2021 proposes to reprioritize the use of CareFirst premium tax exemption revenue so that the SPDAP will be funded at a minimum of $14.0 million (instead of that being the ceiling) at the same time as changing the funding for CHRC, establishing the maximum funding level for that commission at $8.0 million (instead of being the floor). The budget bill assumes a contingent increase of almost $4.4 million in the SPDAP funding and a concomitant reduction in CHRC funding. The impact of that change is also shown in Exhibit 32.

**Exhibit 32**

## Senior Prescription Drug Assistance Program Various Financial Data

**Fiscal 2019-2022**

| | Actual 2019 | Actual 2020 | Working 2021 | Allowance 2022 | Allowance with 2021 BRFA | DLS Proposal |
|---|---|---|---|---|---|---|
| **Opening Balance** | **$7,226,911** | **$7,007,051** | **$7,696,391** | **$5,157,627** | **$5,157,627** | **$5,157,627** |
| Income | $13,756,949 | $12,878,198 | $9,636,280 | $9,636,280 | $14,000,000 | $11,500,000 |
| Expenditures/Projected Expenditures | -13,976,809 | -12,188,858 | -12,175,044 | -16,230,193 | -16,230,193 | -16,230,193 |
| Transfers to Other Programs | | | | | | |
| **Fund Balance (After Transfers)** | **$7,007,051** | **$7,696,391** | **$5,157,627** | **-$1,436,286** | **$2,927,434** | **$427,434** |
| | | | | | | |
| **DLS Estimate of Projected Expenditures** | | | | | **-$12,625,790** | **-$14,276,990** |
| Fund Balance Using DLS Estimate | | | | $516,917 | $4,880,637 | $2,380,637 |

BRFA: Budget Reconciliation and Financing Act
DLS: Department of Legislative Services

Note: Fiscal 2022 allowance expenditure figure includes proposed additional funding contingent on the BRFA of 2021. DLS estimates based on recent enrollment data and the increase in the premium subsidy from $40 to $50 per month effective January 2021.

Source: Maryland Department of Health; Department of Legislative Services

In the 2020 session, DLS' analysis of the SPDAP program trends indicated that, at that time, the change was unwarranted. However, DLS noted that this needed to be reevaluated going forward. As shown in Exhibit 32, without the increase in funding proposed in the BRFA, using the adjusted fiscal 2022 anticipated spending level, the SPDAP would have a negative end of fiscal 2022 fund balance of $1.4 million. With the anticipated BRFA changes, the fund balance would be almost $3.0 million. DLS' projections of expenditures in fiscal 2022 reflect an increase over fiscal 2021, annualizing the impact of the increased subsidy. However, DLS' projections are still lower than the adjusted expenditure levels assumed in the budget.

As noted above, last year, DLS concluded that the SPDAP would ultimately need increased revenues to support the program at the prior level of subsidies. The increase in premium subsidies has made this question more urgent. Without the increase in funding proposed in the BRFA, the SPDAP might be able to use fund balance to cover additional costs in fiscal 2022. However, if the SPDAP maintains the premium subsidy at the $50 per month level in calendar 2022 (a decision that would take place in fall 2021), the program would need to know that the out-year funding level would support such a subsidy level.

**For fiscal 2022, DLS recommends that the funding change proposed in the BRFA be amended to set the floor for the SPDAP in fiscal 2022 at $11.5 million but increase that floor to $14 million in fiscal 2023. A corresponding change would be made in the budget to allow a budget amendment to add $1,863,720 to the SPDAP and reduce the contingent reduction to CHRC by the same amount. No change would be required to the BRFA language for CHRC.**

Whatever the decision of the legislature, DLS would note that in the near future, it seems unlikely that that the CareFirst premium exemption can support the SPDAP at the higher subsidy level while maintaining CHRC funding at the traditional $8 million annual level. The original legislation that claimed the CareFirst premium tax exemption was designed specifically to support SPDAP without general fund support. When expenditures on SPDAP fell far short of revenue, the CHRC program was created to take advantage of those revenues. However, the revenue stream cannot fully support both programs moving forward.

# *Operating Budget Recommended Actions*

1. Add the following language:

   All appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

   **Explanation:** This annual budget bill language restricts Medicaid provider reimbursements to the purpose.

2. Add the following language:

   All appropriations provided for program M00Q01.07 Maryland Children's Health Program are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose.

   **Explanation:** The language restricts funding in the Maryland Children's Health Program to that purpose.

| | | **Amount Reduction** | |
|---|---|---|---|
| 3. | Reduce general funds based on the availability of special funds from the Board of Pharmacy Fund authorized in the Budget Reconciliation and Financing Act of 2020. The special funds were not included in the fiscal 2022 budget. | $ 750,000 | GF |
| 4. | Reduce general funds based on the availability of special funds from the Cigarette Restitution Fund. | 2,903,849 | GF |
| 5. | Reduce general funds for the non-emergency transportation program based on the most recent actual federal fund attainment. | 4,500,000 | GF |
| 6. | Reduce general funds based on service utilization trends. | 77,000,000 | GF |
| 7. | Reduce general funds based on the unanticipated availability of enhanced federal matching funds through calendar 2021. | 244,600,000 | GF |

8. Add the following language to the special fund appropriation:

, provided that authorization is hereby provided to process a special fund budget amendment of up to $2,903,849 from the Cigarette Restitution Fund to support Medicaid provider reimbursements.

**Explanation:** The language authorizes the transfer of up to just over $2.9 million from the Cigarette Restitution Fund to support Medicaid reimbursements. This transfer is related to a reduction of a like amount of special funds for nonpublic schools.

9. Adopt the following narrative:

**Calendar 2020 Managed Care Organization (MCO) Risk Corridor Settlements:** Given the uncertainty around service utilization trends during the COVID-19 pandemic, the Maryland Department of Health (MDH) entered into risk corridor arrangements with MCOs for both calendar 2020 and 2021. Under these arrangements, the MCOs and State will share in any underspending when revenues exceed certain expenditure levels and also share risk when revenues fall short of expenditures. The specific details of the risk corridor arrangements vary between the two calendar years. It is anticipated that fiscal 2020 MCO spending will be below capitated revenue. However, settlements from the calendar 2020 risk corridor arrangement will not be known until after session. The committees are interested in the results of the calendar 2020 risk corridor process and request MDH to submit a report detailing results by individual MCO.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Calendar 2020 MCO risk corridor settlements | MDH | July 1, 2021, or earlier if the results are known |

10. Adopt the following narrative:

**Home- and Community-based Waiver Services Expansion:** A draft report completed by the Hilltop Institute for the Maryland Department of Health (MDH) concluded that, on balance, there are costs to Medicaid associated with the expansion of home- and community-based waiver services although these costs were lower than cited in the past. However, the report noted opportunities that may exist for programming that allows the State to share in the savings that can accrue to Medicare from Medicaid-funded waiver services to the dual-eligibles and using those savings to defray the costs of waiver expansion. The committees are interested in pursuing such opportunities and request MDH submit a report with specific programmatic recommendations on ways to claim Medicare savings to apply to costs for waiver expansion.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Home- and community-based waiver services expansion | MDH | December 1, 2021 |

11. Amend the following language to the special fund appropriation:

    Authorization is granted to process a special fund budget amendment of ~~$4,363,720~~ $1,863,720 contingent upon the enactment of legislation to increase the Senior Prescription Drug Assistance Program annual mandated appropriation.

    **Explanation:** The language amends the contingent budget amendment authorization in the Senior Prescription Drug Assistance Program to reflect anticipated need.

| | | Amount Reduction | |
|---|---|---|---|
| 12. | Reduce general fund deficiency appropriations to reflect service utilization trends. | 75,000,000 | GF |
| 13. | Reduce general fund deficiency appropriations to reflect the availability of unrecognized fiscal 2020 enhanced federal match. | 37,300,000 | GF |
| | **Total Reductions to Fiscal 2021 Deficiency** | **$ 112,300,000** | |
| | **Total General Fund Reductions to Allowance** | **$ 329,753,849** | |

## *Budget Reconciliation and Financing Act Recommended Actions*

1. Amend the provision in the Budget Reconciliation and Financing Act of 2021 as introduced to set the minimum appropriation for the Senior Prescription Drug Assistance Program at $11.5 million in fiscal 2022 and not less than $14.0 million beginning in fiscal 2023.

# *Updates*

## 1. Medical Assistance Expenditures on Abortion

Language attached to the Medicaid budget since 1979 authorizes the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must certify that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999. Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion.

**Exhibit 33** provides a summary of the number and cost of abortions by service provider in fiscal 2018 through 2020. **Exhibit 34** indicates the reasons abortions were performed in fiscal 2020 according to the restrictions in the State budget bill.

**Exhibit 33**
**Abortion Funding under Medical Assistance Program***
**Three-year Summary**
**Fiscal 2018-2020**

| | Performed under 2018 State and Federal Budget Language | Performed under 2019 State and Federal Budget Language | Performed under 2020 State and Federal Budget Language |
|---|---|---|---|
| Abortions | 9,875 | 9,676 | 9,864 |
| **Total Cost ($ in Millions)** | **$6.3** | **$6.1** | **$6.5** |
| Average Payment Per Abortion | $636 | $626 | $660 |
| Abortions in Clinics | 7,644 | 7,490 | 7,545 |
| Average Payment | $434 | $433 | $466 |
| Abortions in Physicians' Offices | 1,720 | 1,773 | 1,903 |
| Average Payment | $982 | $972 | $986 |
| Hospital Abortions – Outpatient | 506 | 409 | 416 |
| Average Payment | $2,417 | $2,592 | $2,677 |
| Hospital Abortions – Inpatient | ** | ** | 0 |
| Average Payment | $13,228 | $6,443 | $0 |
| Abortions Eligible for Joint Federal/State | 0 | 0 | 0 |

* Data for fiscal 2018 and 2019 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2020 includes all abortions performed during fiscal 2020, for which a Medicaid claim was filed through November 2020. Since providers have 12 months to bill Medicaid for a service, Medicaid may receive additional claims for abortions performed during fiscal 2020. For example, during fiscal 2020, an additional 16 claims from fiscal 2019 were paid after November 2019, the date of the report used in the fiscal 2021 Medicaid analysis and explains differences in the data reported in that analysis to that provided here.
** Indicates a dataset of less than 10 cases.

Source: Maryland Department of Health

**Exhibit 34**
## Abortion Services
**Fiscal 2020**

**I. Abortion Services Eligible for Federal Financial Participation**
(Based on restrictions contained in the federal budget.)

| Reason | | Number |
|---|---|---|
| 1. | Life of the woman endangered. | 0 |
| | **Total Received** | **0** |

**II. Abortion Services Eligible for State-only Funding**
(Based on restrictions contained in the fiscal 2020 State budget.)

| | | |
|---|---|---|
| 1. | Likely to result in the death of the woman. | 0 |
| 2. | Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health. | 181 |
| 3. | Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health and, if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health. | 9,642 |
| 4. | Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality. | 39 |
| 5. | Victim of rape, sexual offense, or incest. | * |
| **Total Fiscal 2020 Claims Received Through November 2020** | | **9,864** |

* Indicates a dataset of less than 10 cases.

Source: Maryland Department of Health

## Appendix 1
## 2020 *Joint Chairmen's Report* Responses from Agency

The 2020 *Joint Chairmen's Report* (JCR) requested that Medicaid prepare eight reports. Electronic copies of the full JCR responses can be found on the Department of Legislative Services (DLS) Library website.

- ***Cost-benefit Analysis of Expanding Home- and Community-based Waiver Services:*** At the time of writing, the formal JCR response had not been submitted. However, a draft report was available to DLS, and the findings are discussed in Key Observation 2 of this analysis.

- ***Baltimore City Capitation Project:*** In the 2019 interim, a review of the Baltimore City Capitation Project was undertaken. Among the conclusions was that additional research was required prior to any decision to expand the program. At the time of writing, the additional report requested had not been submitted

- ***Hepatitis C in the HealthChoice Program:*** In January 2020, the Maryland Department of Health (MDH) removed fibrosis restrictions for accessing new Hepatitis C therapies. The committees were interested in understanding the impact of that decision. At the time of writing, the requested report had not been submitted.

- ***Community First Choice (CFC) Financial Data:*** Medicaid has consolidated a lot of long-term care spending under the CFC umbrella. As a result, the program has grown to almost $400 million. Medicaid was requested to submit monthly data that aligned with expenditure data included in the budget. That data was submitted, although spending identified in the reports as "actuals" still do not correspond to "actuals" as included in submitted budget data.

- ***Medicaid Business Processes and Organization Structure:*** In July 2018, Medicaid hired a consulting firm to review its existing business processes and organizational structure and to make recommendations for improvement. Numerous recommendations were made, and the committees were interested in an updated timeline for improvements being pursued by Medicaid. In a requested follow-up report, MDH indicates that it is pursuing just one option at this point concerning the administration of non-emergency medical transportation services. Specifically, it is pursuing a statewide broker option moving away from the current grant model in two phases. MDH anticipates releasing a request for proposal for the first phase in fiscal 2022.

- ***Impact of Health Services Cost Review Commission (HSCRC)-led Programs on Medicaid Dual Eligibles:*** The committees were interested in what programs developed HSCRC are being utilized by the duals and the benefits accruing to Medicaid. The report noted that 86 % of total Medicaid spending for dual-eligibles occurs outside of the rate-setting system, reducing the potential impact of HSCRC programs. However, the report noted that Medicaid did share in savings from programs to prevent hospitalization and readmissions.

- ***Delivery of Medicaid Dental Services:*** Maryland currently uses an administrative services organization for the delivery of dental services. The committees were interested in the different service delivery models being utilized in other states and the advantages and disadvantages of each. At the time of writing, the report had not been received.

- ***Enteral Nutrition:*** The committees were concerned about reimbursement rates for enteral nutrition and asked Medicaid to develop a reimbursement methodology to cover costs. At the time of writing, the report had not been received.

## Appendix 2
## Audit Findings
### Improper Medicaid Payments

| | |
|---|---|
| Audit Period for Last Audit: | July 1, 2015 – June 30, 2018 |
| Issue Date: | June 23, 2020 |
| Number of Findings: | 9 |
| Number of Repeat Findings: | 0 |
| % of Repeat Findings: | 0% |
| Rating: (if applicable) | n/a |

***Finding 1:*** Maryland Department of Health's (MDH) process to identify and analyze improper Medicaid payments through its Division of Program Integrity (DPI) was not comprehensive and did not incorporate certain best practices. The audit recommended improving data analytics to identify irregularities in payment activity, improving analytics of managed care organization (MCO) encounter data, taking advantage of federal data matching tools, and performing periodic documented risk assessment.

***Finding 2:*** MDH did not ensure that prescribing physicians and referring providers were enrolled in Medicaid. The audit recommended ensuring that providers are enrolled before paying claims and ensure that enrollment information is available to DPI.

***Finding 3:*** MDH did not ensure that rendering providers for certain group practices were enrolled in Medicaid. The audit recommended ensuring that providers are enrolled and denying claims if the rendering provider information is not submitted.

***Finding 4:*** MDH accepted encounter data from MCOs that did not include data that allowed for effective oversight. The audit recommended requiring MCOs to submit required federal encounter data and updating Medicaid Management Information System II (MMIS) to all DPI to use this data for integrity efforts.

***Finding 5:*** MDH did not perform data matching or use an alternative methodology for ensuring that MCOs were paying claims for services carved out of HealthChoice. The audit recommended that such data matching or alternative tools be adopted.

***Finding 6:*** MDH did not ensure that MCO providers were enrolled as Medicaid providers. The audit recommended that MDH comply with federal regulations and require such enrollment.

***Finding 7:*** MDH did not ensure that MCO conduct required investigations of encounter data. The audit recommended that such investigations be undertaken and that MCO contracts be amended to state what investigations should be undertaken and the frequency of those investigations.

***Finding 8:*** MDH's data matching to ensure that payments to MCOs for individuals who were improperly enrolled was inadequate. The audit recommended that MDH work with the Department of Public Safety and Correctional Services to ensure accurate data is available to perform appropriate data matching.

***Finding 9:*** Claims processing edits were not properly implemented in MMIS to prevent payments after a credible allegation of fraud against a provider was determined. The audit recommended that such edits be established and enhanced edits be implemented to trigger a denial/suspension if duplicate or overpayments appear likely.

## Appendix 3
## Audit Findings
### Maryland Department of Health – Pharmacy Services*

| | |
|---|---|
| Audit Period for Last Audit: | July 1, 2015 – June 30, 2019 |
| Issue Date: | August 31, 2020 |
| Number of Findings: | 7 |
| Number of Repeat Findings: | 1 |
| % of Repeat Findings: | 14% |
| Rating: (if applicable) | n/a |

***Finding 1:*** Maryland Department of Health (MDH) did not establish financial and reporting requirements and did not monitor pharmacy services provided through managed care organization (MCO). The audit recommended including appropriate financial and reporting requirements in MCO contracts and obtaining and reviewing agreements between MCOs and their pharmacy benefit managers.

***Finding 2:*** MDH did not perform audits of certain pharmacy claims and did not use available data to identify improper claims. The audit recommended periodic audits of pharmacy claims and utilization of all available data to identify improper claims.

***Finding 3:*** MDH did not ensure that the pharmacy vendor obtain required documentation and properly authorize high risk and high cost pharmacy claims for certain programs. The audit recommended that MDH independently review prior authorizations.

***Finding 4:*** MDH did not have procedures to ensure that prescribing providers were licensed prior to approving pharmacy claims for payment. The audit recommended that such procedures be adopted.

***Finding 7:*** MDH did not obtain adequate assurance that the pharmacy vendor had sufficient security over its information system. The audit recommended that appropriate security reviews are conducted.

* This audit included a review of pharmacy services in Medicaid, the Maryland AIDS Drug Assistance Program, and the Breast and Cervical Cancer Diagnosis and Treatment Program. Of the seven findings, five pertained to the Medicaid program, and this summary is limited to those five findings but references the finding number in the OLA audit.

## Appendix 4
## Audit Findings
### Medicaid – Managed Care Program

| | |
|---|---|
| Audit Period for Last Audit: | July 1, 2015 – June 30, 2019 |
| Issue Date: | April 22, 2020 |
| Number of Findings: | 5 |
| Number of Repeat Findings: | 1 |
| % of Repeat Findings: | 20% |
| Rating: (if applicable) | n/a |

***Finding 1:*** Medicaid did not take follow-up action when its independent accounting firm was unable to validate certain managed care organizations (MCO) reported expenditures used to calculate capitation rates. The audit recommended that Medicaid take appropriate steps when MCO expenditure data cannot be verified.

***Finding 2:*** Medicaid did not verify that MCO expenditure data used in the capitation rate calculations were accurate or ensure that the rates calculated were accurate. The audit recommended establishing processes to ensure accuracy of data and rate calculations.

***Finding 3:*** Medicaid did not ensure that its independent accounting firm verified that MCOs were maximizing their third-party cost recovery and cost avoidance efforts. The audit recommended that Medicaid verify the sufficiency of those efforts and take actions if they are found to be insufficient.

***Finding 4:*** Medicaid did not have procedures to verify that supplemental payments for newborn deliveries and Hepatitis C treatments were appropriate. The audit recommended that such procedures be adopted.

***Finding 5:*** **MDH did not consistently ensure that labor and overhead charges invoiced by University of Maryland Baltimore County under its interagency agreement were appropriate. The audit recommended that procedures be adopted to verify the appropriateness of those charges.**

*Bold denotes item repeated in full or part from preceding audit report.

## Appendix 5
## Major Information Technology Project
## Medical Care Programs Administration
# Medicaid Management Information System (MMIS) II
# (Medicaid Enterprise Systems Modular Transformation)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **New/Ongoing:** Ongoing | | | | | | | |
| **Start Date:** 7/1/2016 | | | | **Est. Completion Date:** 6/30/2025 | | | |
| **Implementation Strategy:** Agile | | | | | | | |
| **($ in Millions)** | **Prior Year** | **2021** | **2022** | **2023** | **2024** | **2025** | **Total** |
| **GF** | $9.651 | $5.543 | $12.351 | $12.598 | $12.294 | $11.441 | **$63.878** |
| **FF** | 71.105 | 43.695 | 82.938 | 79.965 | 110.649 | 102.966 | **490.318** |
| **Total** | **$79.756** | **$49.238** | **$95.289** | **$92.563** | **$122.944** | **$114.407** | **$554.196** |

- ***Project Summary:*** Procurement of a modern MMIS system to replace the current system that is antiquated and inflexible. The Maryland Department of Health (MDH) has completed the required assessment and documentation to receive enhanced federal fund participation for federal fiscal 2020 through 2022. According to the major information technology mid-year report, MDH is writing the winter Implementation Advanced Planning Document Update. The project will involve the rollout of modules over the next three to six years covering all aspects of the Medicaid program such as pharmacy, provider management, claims processing, decision support as well as migration to the Maryland Total Human-services Integrated Network cloud solution.

- ***Key Goals:*** Three key goals are real-time adjudication of claims; a new financial management system to automate the federal fund claims process; and improved reporting capability.

- ***Observations and Milestones:*** The behavioral health administrative services organization (ASO) component went live January 2020 with limited functionality and resulted in significant provider payment issues that may take several years to resolve. Pharmacy point-of-sale module go-live date was missed, which required an emergency contract extension for the current system. A new release schedule is under negotiation. Non-emergency medical transportation, electronic health records, and Centers for Medicare and Medicaid Services interoperability rules are being added to the scope of the project. Final extension of project management contract to May 2021.

- ***Concerns:*** The behavioral health ASO module go-live was a complete failure. Defects continue to be resolved, and the module is only now approaching expected functionality. The pharmacy point-of-sale module was delayed. Additional initiatives are being added that will require updates to the project roadmap. A State hiring freeze has resulted in delays in hiring special payments personnel that has created gaps in the program management staff. Lack of choice in the Medicaid information technology field also remains a significant risk.

## Appendix 6
## Major Information Technology Project
## Medical Care Programs Administration
# Long Term Supports and Services Tracking System (LTSS)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **New/Ongoing:** Ongoing | | | | | | | |
| **Start Date:** 3/18/2013 | | | | **Est. Completion Date:** Final development anticipated during fiscal 2025 | | | |
| **Implementation Strategy:** Waterfall and Agile Mix | | | | | | | |
| **($ in Millions)** | **Prior Year** | **2021** | **2022** | **2023** | **2024** | **2025** | **Total** |
| **GF** | $32.004 | $0.500 | $2.277 | $6.832 | $4.555 | $13.664 | **$59.831** |
| **FF** | 99.456 | 29.606 | 20.084 | 20.084 | 20.084 | 60.252 | **249.566** |
| **Total** | **$131.460** | **$30.106** | **$22.361** | **$26.916** | **$24.639** | **$73.916** | **$309.397** |

- ***Project Summary:*** LTSS is an integrated care management system for long-term care services that includes a standardized assessment instrument, in-home services verification, and real-time medical and service information. Initially developed to respond to various long-term care program opportunities under the Affordable Care Act, LTSS has been incorporating other modules to cover all home and community services under Medicaid, including services to the developmentally disabled.

- ***Observations and Milestones:*** LTSS recently added new features for the Rare and Expensive Case Management system and improved functionality for multiple long-term support business units. The project recently began long-term implementation of Model Waiver functionality. In August 2020, a new implementation vendor contract was awarded, and the project is in the third and final phase of database re-platforming.

- ***Concerns:*** The highest risk for the project remains engagement with, and adoption by, stakeholder groups.

## Appendix 7
# Calendar 2021 Federal Poverty Guidelines
### (48 Contiguous States Excluding Alaska and Hawaii)

| Household/ Family Size | 25% | 50% | 75% | 100% | 125% | 133% | 135% | 138% | 185% | 200% | 225% | 250% | 275% | 300% |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | $3,220 | $6,440 | $9,660 | $12,880 | $16,100 | $17,130 | $17,388 | $17,774 | $23,828 | $25,760 | $28,980 | $32,200 | $35,420 | $38,640 |
| **2** | 4,355 | 8,710 | 13,065 | 17,420 | 21,775 | 23,169 | 23,517 | 24,040 | 32,227 | 34,840 | 39,195 | 43,550 | 47,905 | 52,260 |
| **3** | 5,490 | 10,980 | 16,470 | 21,960 | 27,450 | 29,207 | 29,646 | 30,305 | 40,626 | 43,920 | 49,410 | 54,900 | 60,390 | 65,880 |
| **4** | 6,625 | 13,250 | 19,875 | 26,500 | 33,125 | 35,245 | 35,775 | 36,570 | 49,025 | 53,000 | 59,625 | 66,250 | 72,875 | 79,500 |
| **5** | 7,760 | 15,520 | 23,280 | 31,040 | 38,800 | 41,283 | 41,904 | 42,835 | 57,424 | 62,080 | 69,840 | 77,600 | 85,360 | 93,120 |
| **6** | 8,895 | 17,790 | 26,685 | 35,580 | 44,475 | 47,321 | 48,033 | 49,100 | 65,823 | 71,160 | 80,055 | 88,950 | 97,845 | 106,740 |
| **7** | 10,030 | 20,060 | 30,090 | 40,120 | 50,150 | 53,360 | 54,162 | 55,366 | 74,222 | 80,240 | 90,270 | 100,300 | 110,330 | 120,360 |
| **8** | 11,165 | 22,330 | 33,495 | 44,660 | 55,825 | 59,398 | 60,291 | 61,631 | 82,621 | 89,320 | 100,485 | 111,650 | 122,815 | 133,980 |
| **9** | 12,300 | 24,600 | 36,900 | 49,200 | 61,500 | 65,436 | 66,420 | 67,896 | 91,020 | 98,400 | 110,700 | 123,000 | 135,300 | 147,600 |
| **10** | 13,435 | 26,870 | 40,305 | 53,740 | 67,175 | 71,474 | 72,549 | 74,161 | 99,419 | 107,480 | 120,915 | 134,350 | 147,785 | 161,220 |
| **11** | 14,570 | 29,140 | 43,710 | 58,280 | 72,850 | 77,512 | 78,678 | 80,426 | 107,818 | 116,560 | 131,130 | 145,700 | 160,270 | 174,840 |
| **12** | 15,705 | 31,410 | 47,115 | 62,820 | 78,525 | 83,551 | 84,807 | 86,692 | 116,217 | 125,640 | 141,345 | 157,050 | 172,755 | 188,460 |
| **13** | 16,840 | 33,680 | 50,520 | 67,360 | 84,200 | 89,589 | 90,936 | 92,957 | 124,616 | 134,720 | 151,560 | 168,400 | 185,240 | 202,080 |
| **14** | 17,975 | 35,950 | 53,925 | 71,900 | 89,875 | 95,627 | 97,065 | 99,222 | 133,015 | 143,800 | 161,775 | 179,750 | 197,725 | 215,700 |

**Appendix 8**
**Object/Fund Difference Report**
**Maryland Department of Health – Medical Care Programs Administration**

| Object/Fund | FY 20 Actual | FY 21 Working Appropriation | FY 22 Allowance | FY 21 - FY 22 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 625.70 | 608.90 | 609.00 | 0.10 | 0% |
| 02 Contractual | 185.24 | 99.32 | 111.41 | 12.09 | 12.2% |
| **Total Positions** | **810.94** | **708.22** | **720.41** | **12.19** | **1.7%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 53,495,856 | $ 53,289,370 | $ 53,494,377 | $ 205,007 | 0.4% |
| 02 Technical and Spec. Fees | 4,172,078 | 4,241,590 | 5,305,492 | 1,063,902 | 25.1% |
| 03 Communication | 1,067,083 | 995,749 | 996,069 | 320 | 0% |
| 04 Travel | 63,245 | 1,017,069 | 155,524 | -861,545 | -84.7% |
| 06 Fuel and Utilities | 7,049 | 6,734 | 7,683 | 949 | 14.1% |
| 07 Motor Vehicles | 938 | 5,889 | 5,564 | -325 | -5.5% |
| 08 Contractual Services | 10,233,505,397 | 10,292,485,315 | 11,529,560,901 | 1,237,075,586 | 12.0% |
| 09 Supplies and Materials | 185,455 | 362,725 | 293,222 | -69,503 | -19.2% |
| 10 Equipment – Replacement | 70,869 | 299,706 | 93,149 | -206,557 | -68.9% |
| 11 Equipment – Additional | 488 | 23,242 | 0 | -23,242 | -100.0% |
| 13 Fixed Charges | 187,267 | 225,749 | 216,141 | -9,608 | -4.3% |
| **Total Objects** | **$ 10,292,755,725** | **$ 10,352,953,138** | **$ 11,590,128,122** | **$ 1,237,174,984** | **11.9%** |
| **Funds** | | | | | |
| 01 General Fund | $ 3,010,426,717 | $ 3,212,630,568 | $ 3,845,025,316 | $ 632,394,748 | 19.7% |
| 03 Special Fund | 972,029,108 | 904,900,410 | 727,456,958 | -177,443,452 | -19.6% |
| 05 Federal Fund | 6,244,565,648 | 6,162,904,043 | 6,947,945,819 | 785,041,776 | 12.7% |
| 09 Reimbursable Fund | 65,734,252 | 72,518,117 | 69,700,029 | -2,818,088 | -3.9% |
| **Total Funds** | **$ 10,292,755,725** | **$ 10,352,953,138** | **$ 11,590,128,122** | **$ 1,237,174,984** | **11.9%** |

Note: Fiscal 2021 appropriation does not include deficiencies, contingent reductions, contingent appropriations, and general salary increases. Fiscal 2022 allowance does not include contingent reductions, contingent appropriations, annual salary review adjustments, and the annualization of the fiscal 2021 general salary increase.

**Appendix 9**
**Fiscal Summary**
**Maryland Department of Health – Medical Care Programs Administration**

| Program/Unit | FY 20 Actual | FY 21 Wrk Approp | FY 22 Allowance | Change | FY 21 - FY 22 % Change |
|---|---|---|---|---|---|
| 01 Deputy Secretary for Health Care Financing | $ 5,820,700 | $ 10,954,765 | $ 11,535,239 | $ 580,474 | 5.3% |
| 02 Enterprise Technology - Medicaid | 15,341,062 | 16,905,795 | 15,984,931 | -920,864 | -5.4% |
| 03 Medical Care Provider Reimbursements | 9,858,650,009 | 9,905,065,247 | 11,091,489,465 | 1,186,424,218 | 12.0% |
| 04 Office of Health Services | 53,385,792 | 54,192,012 | 54,401,449 | 209,437 | 0.4% |
| 05 Office of Finance | 7,100,854 | 7,198,528 | 6,927,269 | -271,259 | -3.8% |
| 06 Kidney Disease Treatment Services | 7,363,268 | 0 | 0 | 0 | 0% |
| 07 Maryland Children's Health Program | 265,970,215 | 259,029,425 | 279,730,907 | 20,701,482 | 8.0% |
| 08 Major Information Technology Development Projects | 52,535,392 | 73,301,291 | 104,040,427 | 30,739,136 | 41.9% |
| 09 Office of Eligibility Services | 14,399,575 | 14,131,031 | 14,151,962 | 20,931 | 0.1% |
| 11 Senior Prescription Drug Assistance Program | 12,188,858 | 12,175,044 | 11,866,473 | -308,571 | -2.5% |
| **Total Expenditures** | **$ 10,292,755,725** | **$ 10,352,953,138** | **$ 11,590,128,122** | **$ 1,237,174,984** | **11.9%** |
| General Fund | $ 3,010,426,717 | $ 3,212,630,568 | $ 3,845,025,316 | $ 632,394,748 | 19.7% |
| Special Fund | 972,029,108 | 904,900,410 | 727,456,958 | -177,443,452 | -19.6% |
| Federal Fund | 6,244,565,648 | 6,162,904,043 | 6,947,945,819 | 785,041,776 | 12.7% |
| **Total Appropriations** | **$ 10,227,021,473** | **$ 10,280,435,021** | **$ 11,520,428,093** | **$ 1,239,993,072** | **12.1%** |
| Reimbursable Fund | $ 65,734,252 | $ 72,518,117 | $ 69,700,029 | -$ 2,818,088 | -3.9% |
| **Total Funds** | **$ 10,292,755,725** | **$ 10,352,953,138** | **$ 11,590,128,122** | **$ 1,237,174,984** | **11.9%** |

Note: Fiscal 2021 appropriation does not include deficiencies, contingent reductions, contingent appropriations, and general salary increases. Fiscal 2022 allowance does not include contingent reductions, contingent appropriations, annual salary review adjustments, and the annualization of the fiscal 2021 general salary increase.