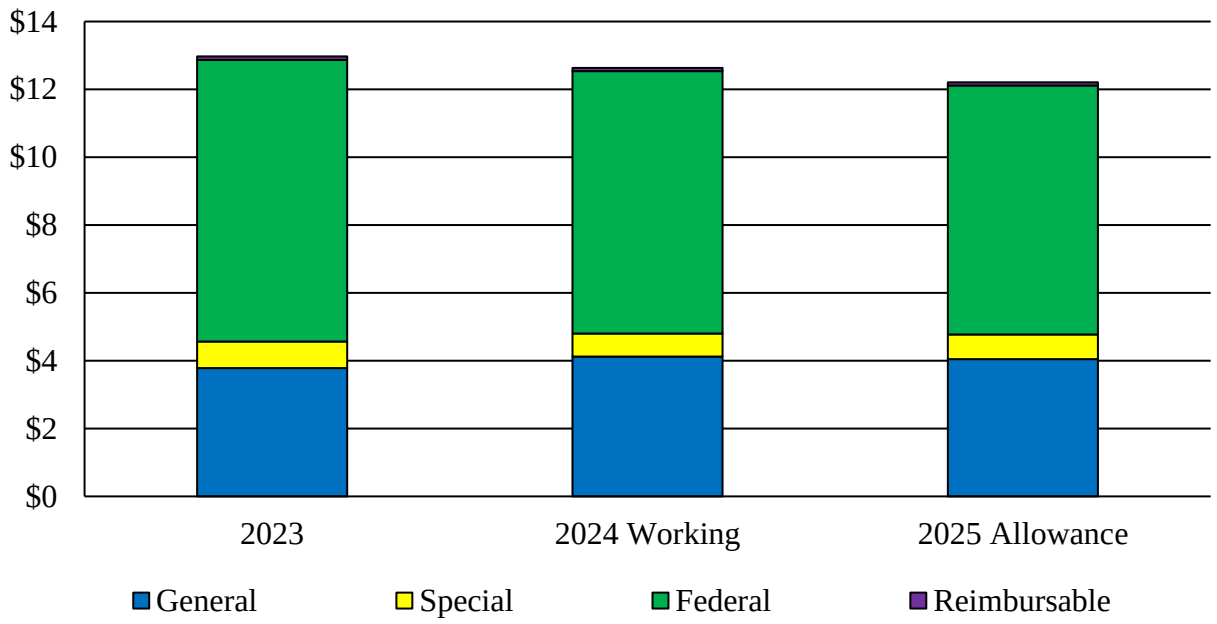
# M00Q01
# Medical Care Programs Administration
### Maryland Department of Health

## *Executive Summary*

The Medical Care Programs Administration (MCPA) within the Maryland Department of Health (MDH) is responsible for administering Medical Assistance (Medicaid) and the Maryland Children's Health Program (MCHP), which provide comprehensive health care coverage to indigent and medically indigent Marylanders. MCPA administers various other programs discussed in this analysis and specialty mental health and substance use disorder (SUD) services for Medicaid recipients included in the budget analysis for M00L – MDH – Behavioral Health Administration (BHA).

## *Operating Budget Summary*

**Fiscal 2025 Budget Decreases $425.6 Million, or 3.4%, to $12.2 Billion**
**($ in Billions)**




Note: The fiscal 2024 working appropriation includes deficiencies. The fiscal 2024 impacts of statewide salary adjustments appear in the Statewide Account in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2025 impacts of the fiscal 2024 statewide salary adjustments appear in this agency's budget. The fiscal 2025 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget. The fiscal 2025 allowance includes contingent reductions.

For further information contact: Anne W. Braun Anne.Wagner@mlis.state.md.us

- MCPA's fiscal 2025 allowance decreases by approximately $425.6 million compared to the fiscal 2024 working appropriation, after accounting for proposed deficiency appropriations and a contingent reduction. The net reduction in fiscal 2025 expenditures is largely attributed to $442.2 million due to decreases in projected Medicaid enrollment and utilization resulting from the continued impact of the unwinding process from the COVID-19 public health emergency (PHE) and general economic improvement. Other significant net decreases include $118.0 million for Major Information Technology Development Project (MITDP) costs and $112.4 million for a one-time proposed deficiency to cover fiscal 2023 services billed in fiscal 2024. Provider rate increases totaling a net $180 million in additional spending partially offsets these reductions.

- Federal fund participation in fiscal 2023 and, to a lesser extent, fiscal 2024 is elevated due to enhanced federal matching funds on qualifying Medicaid and MCHP spending during the COVID-19 PHE. The Consolidated Appropriations Act of 2023 established a phase-out schedule for the enhanced federal match that ended on December 31, 2023. The fiscal 2025 allowance returns to a more typical fund split that is based on Maryland's federal matching rate for Medicaid, which ranges from 50% to 90% depending on the eligibility category, and MCHP, which is set at 65%.

## *Key Observations*

- ***Significant Fiscal 2024 and 2025 General Fund Shortfalls Projected for Medicaid Spending:*** Medicaid and MCHP enrollment projections developed by the Department of Legislative Services (DLS) generally align with estimated caseloads in the fiscal 2024 working appropriation and fiscal 2025 allowance, causing minimal spending differences due to enrollment. However, the DLS spending forecast for Medicaid has identified multiple shortfalls totaling approximately $115 million in the fiscal 2024 working appropriation and $150 million in the fiscal 2025 allowance, mainly due to technical errors and underestimated spending on services for individuals dually eligible for Medicaid and Medicare.

- ***Medicaid Reimbursement of Services in Schools:*** MDH is able to provide Medicaid and MCHP reimbursement of health services in schools for (1) services provided as part of a student's Individualized Education Program (IEP); (2) services provided by a school-based health center (SBHC); and (3) administrative costs that support the provision of Medicaid services to children in schools. The department is undertaking a two-phase plan to expand Medicaid reimbursement of behavioral health services to all students participating in Medicaid and MCHP and develop an administrative claiming program following the release of updated federal guidance. MDH also reported that it is working to limit barriers for SBHCs in claiming Medicaid reimbursement.

- ***2023 Session Legislation Results in Medicaid Coverage Expansion:*** Multiple pieces of legislation enacted in the 2023 session expand Medicaid benefits and otherwise result in programmatic changes. For example, Chapters 252 and 253 of 2023 require Medicaid to provide coverage of gender-affirming treatment beginning January 1, 2024, and Chapters 282 and 283 of 2023 require MDH, by January 1, 2025, to establish an Express Lane Eligibility Program to enroll individuals in Medicaid and MCHP based on findings of eligibility for the Supplemental Nutrition Assistance Program (SNAP).

## Operating Budget Recommended Actions

| | | **Funds** |
|---|---|---|
| 1. | Add language restricting funds until a report is submitted on the resolution of repeat audit findings. | |
| 2. | Amend contingent language reducing general funds to make the reduction contingent on the enactment of legislation authorizing a special fund balance transfer from the Health Information Exchange Fund. | |
| 3. | Strike contingent language on the federal fund appropriation for the Office of Enterprise Technology as a technical correction. | |
| 4. | Add language restricting medical care provider reimbursement funding to that purpose. | |
| 5. | Adopt narrative requesting a report on the Community First Choice program and Home and Community-based Options Waiver financial and registry data. | |
| 6. | Adopt narrative requesting quarterly reports with enrollment change updates following the unwinding process. | |
| 7. | Reduce funding for increased health insurance costs as a technical correction. These expenditures are double budgeted as funding is already budgeted in the Statewide Account within the Department of Budget and Management for this purpose. | -$ 290,757 |
| 8. | Add language restricting Maryland Children's Health Program funding to that purpose. | |
| | **Total Net Change** | **-$ 290,757** |

## Updates

- ***Medicaid Expenditures on Abortion:*** Annual data on abortion services are provided.

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

## *Operating Budget Analysis*

### Program Description

MCPA within MDH is responsible for administering Medicaid, 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) community behavioral health services, including specialty mental health and SUD services, for Medicaid recipients. That funding is discussed in the budget analysis for M00L – MDH – BHA.

#### Medicaid

Medical Assistance (Title XIX of the Social Security Act), more commonly known as Medicaid, is a joint federal and state program that provides health benefits to indigent and medically indigent individuals. Based on Maryland's federal medical assistance percentage (FMAP), which varies depending on a state's per capita income relative to the national average, the federal government generally covers 50% of Medicaid costs. Medicaid eligibility is limited to children, pregnant women, elderly or disabled individuals, low-income parents, and low-income childless adults. To qualify for benefits, applicants must meet certain income and asset limits.

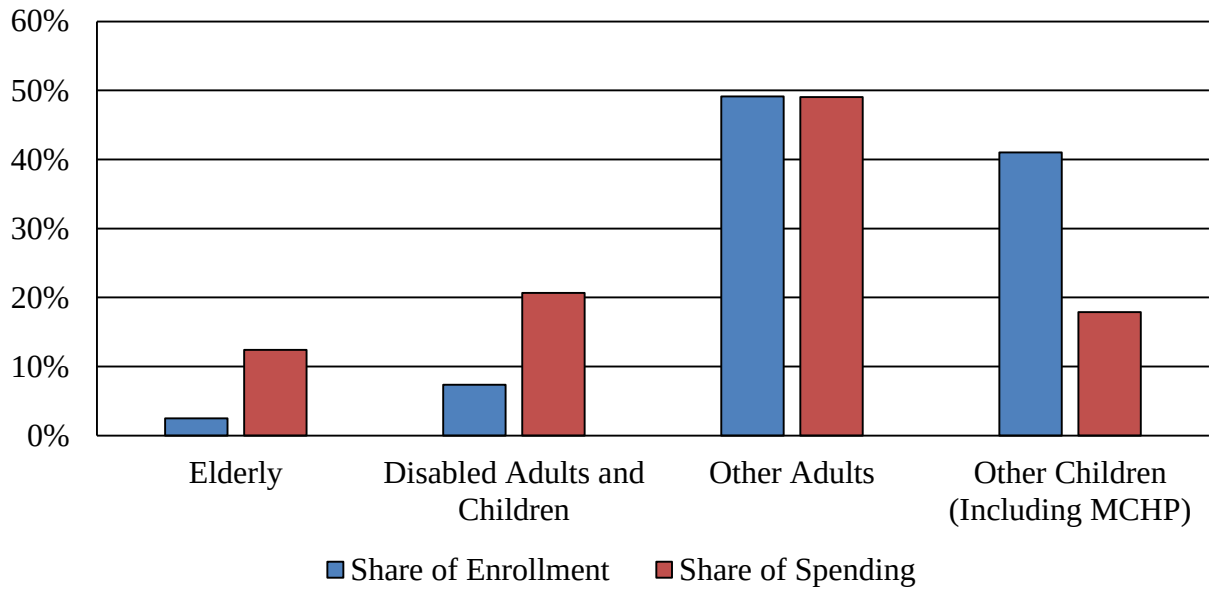
Income eligibility levels vary based on the individual's age and pregnancy status, among other factors. Individuals receiving cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. Pregnant women can have a higher household income than other adults (up to 264% of the federal poverty level (FPL)) and qualify for Medicaid coverage. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below FPL in making their coinsurance and deductible payments. Effective January 1, 2014, Medicaid coverage expanded to persons below 138% of FPL, as authorized in the federal Patient Protection and Affordable Care Act (ACA). The federal match for this population is 90%. The most current FPL guidelines are listed in **Appendix 6**.

Another major group of Medicaid-eligible individuals is the medically needy. This group includes individuals with significant health needs whose income exceeds eligibility thresholds to qualify for Medicaid but are below levels set by the State. People with incomes above the medically needy level may reduce or spend down their income to the requisite level through spending on medical care.

As shown in **Exhibit 1**, Medicaid spending does not necessarily align with each eligibility group's share of total Medicaid and MCHP enrollment. Using fiscal 2023 as an example, disabled

adults and children represented only 7.3% of average monthly enrollment, while this group accounted for 20.7% of medical care reimbursements. Elderly Marylanders receiving Medicaid also accounted for a larger share of costs (12.4%) relative to their share of enrollment (2.5%). The medically needy population has a much more significant impact on Medicaid spending relative to its share of the Medicaid population as this group generally requires both higher cost services and higher health care utilization than other eligibility groups. Conversely, other children represent 41.0% of average monthly enrollment but only account for 17.9% of fiscal 2023 Medicaid and MCHP costs.

**Exhibit 1**
**Relative Total Medicaid and MCHP Spending by Eligibility Category**
**Fiscal 2023**




MCHP: Maryland Children's Health Program

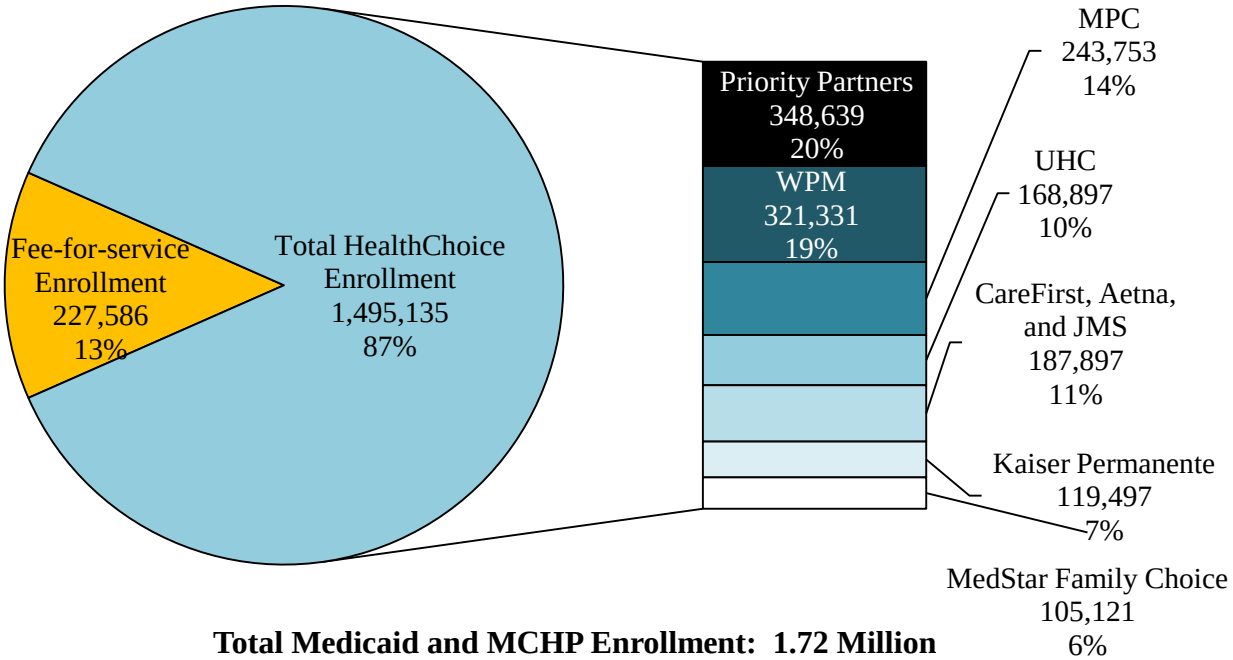
Source: Maryland Department of Health; Department of Legislative Services

Medicaid funds a broad range of services. The federal government mandates that states provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services; family planning services; transportation to medical care; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government allows states to cover optional services, and in Maryland, this includes, but is not limited to, vision care, pharmacy, mental health care, podiatric care, medical supplies and equipment, long-term care services, and hospice care.

Prior to the enactment of Chapters 302 and 303 of 2022, Medicaid only provided comprehensive dental benefits to children and certain adults, including income-eligible pregnant women. Effective January 1, 2023, in accordance with Chapters 302 and 303, Medicaid expanded coverage for dental services, including diagnostic, preventive, restorative, and periodontal services, to adult participants with household incomes up to 133% of FPL.

Most Medicaid recipients are required to enroll in HealthChoice, the statewide mandatory managed care program that began in calendar 1997. As shown in **Exhibit 2**, approximately 87% of Medicaid recipients in December 2023 were enrolled in HealthChoice under one of nine managed care organizations (MCO) operating in Maryland. In general, populations excluded from the HealthChoice program are institutionalized individuals and individuals who are dually eligible for Medicaid and Medicare. Health services for individuals not enrolled in HealthChoice are covered on an FFS basis.

**Exhibit 2**
**Managed Care and Fee-for-service Medicaid and MCHP Enrollment**
**As of December 2023**




**Total Medicaid and MCHP Enrollment: 1.72 Million**

JMS: Jai Medical Systems
MCHP: Maryland Children's Health Program
MPC: Maryland Physicians Care
UHC: UnitedHealthcare
WPM: WellPoint Maryland

Source: Maryland Department of Health; Hilltop Institute

## MCHP

MCHP provides medical assistance for low-income children with household incomes that exceed income eligibility for Medicaid. The State is normally entitled to receive 65% federal matching funds for MCHP expenditures. To qualify for MCHP, children must be under the age of 19 and live in households with an income between the Medicaid income eligibility threshold (which varies depending on the child's age) and up to 322% of FPL. MCHP covers the same services as Medicaid. Participating families with incomes above 212% of FPL pay a premium of about 2% of their income. Monthly premium payments were suspended during the national declaration of a COVID-19 PHE. However, MDH further extended the pause on premiums to extend through April 30, 2024.

## Family Planning

The Family Planning Program provides certain medical services for women who lose Medicaid coverage after being covered for a pregnancy. Covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Family planning services coverage continues until age 51 with annual redetermination, unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, or is income ineligible (above 264% of FPL). Enrollment in the program has declined significantly since the expansion of Medicaid eligibility under the ACA.

## EID Program

The EID program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program allows disabled individuals to 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 than other Medicaid participants in Maryland. Effective January 1, 2024, there is no longer a maximum income level to be eligible for the program. The services available to EID enrollees are the same as the services covered by Medicaid, and the federal government covers 50% of EID program costs. MDH suspended the requirement for EID program participants to pay a premium during the COVID-19 PHE and through the end of calendar 2023.

## SPDAP

SPDAP provides Medicare Part D premium assistance to offset costs 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.

# *Performance Analysis: Managing for Results*

## 1. Measures of MCO Quality Performance

Medicaid invests significant effort in a variety of data collection activities related to quality assurance within the HealthChoice program, including:

- Healthcare Effectiveness Data and Information Set (HEDIS) data collection;
- record reviews and network adequacy testing to monitor operations;
- survey collections to evaluate enrollee and provider satisfaction;
- an annual technical report for general program management and oversight; and
- the HealthChoice Population Health Incentive Program (PHIP) for quality measurement and pay-for-performance incentives.

The National Committee for Quality Assurance (NCQA) developed HEDIS to measure health plan performance for comparison among health systems. This tool is used by more than 90% of health plans across the country. Calendar 2022 HEDIS data was analyzed by MetaStar in a report presented to MDH in December 2023 and included 53 measures across multiple quality domains (for example, effectiveness of care and access or availability of care) and consumer assessment scores. This annual report from MetaStar has been presented in August in prior years. Some measures have multiple components. MDH uses a slightly smaller set of measures and components for MCO quality monitoring than the total HEDIS measures collected. The annual report discussed MDH's use of 45 measures to evaluate calendar 2022 results and described the following aggregate findings:

- the prevalence of COVID-19 continued to fluctuate in calendar 2022, but Maryland MCOs' performance normalized somewhat compared to prepandemic performance;
- all nine Maryland MCOs performed better than the national HEDIS mean on eight measures; and
- eight of nine Maryland MCOs performed better than the national HEDIS mean on eight additional measures.

As of February 12, 2024, MDH had not provided supplemental data on its evaluation of the smaller subset of calendar 2022 HEDIS measures detailing MCOs' favorable and unfavorable results in relation to the national HEDIS mean for each selected measure and component. Each MCO's result on this evaluation is typically included in this analysis to summarize MCO performance compared to national health plans and prior year results. Supplemental data previously sent by MDH also clarified the usable measures for MCOs' individual evaluations.

**MDH should discuss the reasons for delayed presentment of the MetaStar annual report on MCOs' calendar 2022 HEDIS performance from August to December. Additionally, MDH should comment on Maryland MCOs' individual calendar 2022 performance compared to the national HEDIS mean on measures selected for analysis by the department, including how each MCO's performance compared to prior years.**

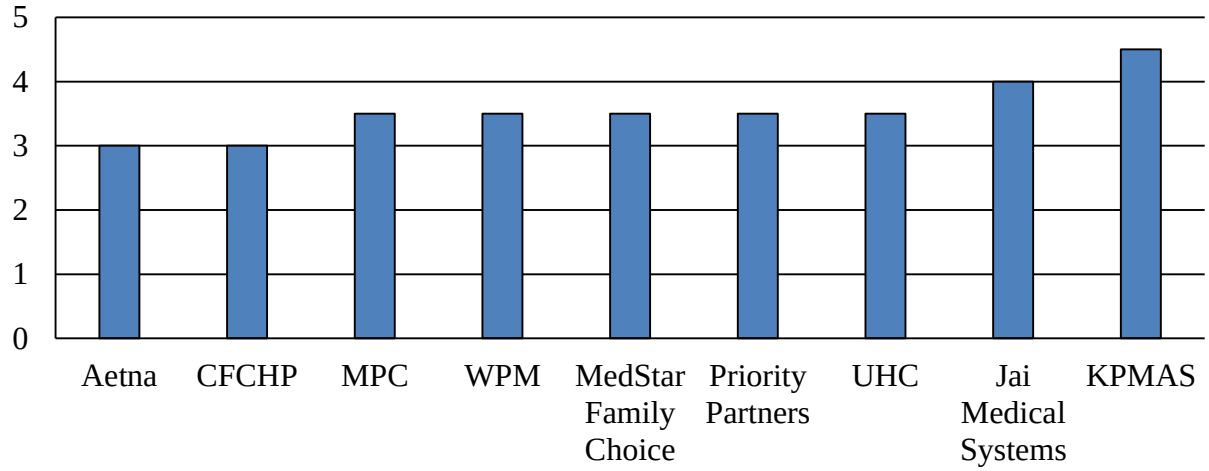
## Accreditation

Since January 1, 2015, all MCOs have been required to be accredited by NCQA to participate in the HealthChoice Program. New MCOs must receive accreditation within two years of program entry. Beginning with the calendar 2020 results, HEDIS and consumer assessment scores for performance are evaluated separately from Health Plan Accreditation standards scoring. Accreditation status is based on MCOs' adherence to accreditation standards and results on an evaluation and analysis of clinical performance and consumer experience. Based on calendar 2022 results, eight out of nine MCOs operating in Maryland were granted accreditation. Priority Partners was placed on a provisional status and is under corrective action. According to MDH, Priority Partners' next accreditation review is scheduled for June 11, 2024. **MDH should discuss what is required under the corrective action for Priority Partners' provisional accreditation, including whether the department is conducting additional monitoring and evaluation.**

## NCQA Rating

NCQA implements a star rating system for each MCO, with one star designating the lowest performance and five stars designating the highest performance. This system replaced the previous numeric rating system. The overall star rating is based on the weighted average of all measures that NCQA tracks for performance scoring across three composites: patient experience; prevention; and treatment. For example, patient experience assesses access to and satisfaction of care with doctors and plan services and prevention measures assess the proportion of eligible members receiving preventive services, such as immunizations, prenatal care, and cancer screenings. Measures and composites are scored from zero to five with the potential for half-point results. As shown in **Exhibit 3**, in calendar 2023, all Maryland MCOs received at least three stars for their overall ratings, and one MCO (Kaiser Permanente) received 4.5 stars.

**Exhibit 3**
**NCQA Health Plan Overall Star Ratings for Maryland MCOs**
**Published September 2023**




CFCHP: CareFirst Community Health Plan Maryland
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MCO: managed care organization
MPC: Maryland Physicians Care
NCQA: National Committee for Quality Assurance
UHC: UnitedHealthcare
WPM: WellPoint Maryland

Source: Maryland Department of Health

## 2. Transition from the Value-based Purchasing Program and Initial PHIP Results

MDH has administered a pay-for-performance quality assurance program for MCOs since the Value-based Purchasing (VBP) program was established in calendar 1999. The goal of the VBP was to improve MCO performance by providing monetary incentives and disincentives up to a certain percentage of each MCO's total capitated payments based on performance in health care measures identified by MDH. Penalty payments were meant to fund the incentive payments, making the program budget neutral if implemented as in statute. However, federal MCO regulations require actuarially sound rates on an individual MCO basis and, to the extent that rates were set at the bottom of the rate range in some years, disincentives in VBP took an individual MCO below this level. Furthermore, the VBP incentive payment structure allowed for the perverse result that MCOs with more disincentives than incentives on targets could still benefit, if they were a top-four performer.

In response to the longstanding concerns with the VBP payment structure, effective January 1, 2022, MCPA replaced the VBP program with PHIP. PHIP uses an incentive-only structure across two rounds of payments, with a level of incentives that is based on the amount provided in the budget for each fiscal year. The new program allows MCOs to receive the following performance incentives or improvement incentives in the first round:

- ***Performance Incentive Payments:*** MCOs can earn payments for achieving incentives ranked from "strong performance" (in which a measure is between the fiftieth and seventy-fourth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures) to "superlative performance" (in which an MCO is at or above the ninetieth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures). Depending on the incentive category achieved, MCOs could earn higher or lower incentive allocations, and MCOs earning a score below the fiftieth percentile are not eligible for a round one performance payment for that measure.

- ***Improvement Incentive Payments:*** If an MCO (1) demonstrates improvement of at least 0.5 percentage points for a measure over the prior year and (2) reports a score at least in the fiftieth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures, then it may also earn a share of the incentive allocation for that measure.

If there are remaining funds unallocated after the initial round, MDH would implement a second round of PHIP payments. However, an MCO would only be eligible for a secondary payment if it (1) earned above 80% of possible round-one incentives and (2) did not have any penalties applied for failure to meet HEDIS monitoring policies included in the MCO contract. If additional funds remain after both rounds of incentives, MDH can make additional payments for performance or improvement to MCOs that earned incentives below 1% of their capitated payments or carry forward a balance in a nonlapsing fund. PHIP regulations cap total incentive payments at 1% of each MCO's capitated payments each year.

MDH defined nine measures, of which the first six are HEDIS measures and the subsequent three are "homegrown," non-HEDIS measures, in PHIP regulations to determine MCOs' performance and incentive earnings, including percentages of:

- members ages 5 to 64 who had persistent asthma and a ratio of controller medications to total asthma medications of 0.5 or greater;

- members with at least 31 days of prescription opioids in a 62-day period;

- members ages 18 to 75 with diabetes (type 1 and 2) whose hemoglobin A1c was at poor control (greater than or equal to 9.0%);

- two-year-old children who had one or more capillary or venous lead blood test for lead poisoning by their second birthday;

- members who delivered live births and received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the MCO;
- members who delivered live births and had a postpartum visit on or between 7 and 84 days after delivery;
- lead screenings for children ages 12 months to 23 months;
- ambulatory care visits for adults receiving SSI; and
- ambulatory care visits for children receiving SSI.

Although MDH had not published an annual report with PHIP calendar 2022 results as of February 12, 2024, final benchmark percentiles for the selected HEDIS measures were published in December 2023 with the HEDIS summary report. As shown in **Exhibit 4**, all nine MCOs reported strong percentiles (between the fiftieth and seventy-fifth percentile compared to nationwide HEDIS Medicaid performance) for at least one of the six HEDIS measures, meaning that the MCOs were eligible for at least partial performance incentive payments in the first round for these measures. Four MCOs (Jai Medical Systems, Kaiser Permanente, MedStar, and Priority Partners) earned superlative percentiles in one or more of the selected HEDIS measures. It should be noted that all six HEDIS measures selected for PHIP incentive consideration were also used to determine incentive, neutral, or disincentive thresholds under the VBP.

**Exhibit 4**
**PHIP Benchmark Percentiles for HEDIS Measures**
**Calendar 2022**

| | Aetna | CFCHP | JMS | KPMAS | MPC | MedStar Family Choice | Priority Partners | UHC | WPM |
|---|---|---|---|---|---|---|---|---|---|
| Lead Screening in Children | 66.2% | 67.2% | 82.2% | 84.8% | 65.0% | 75.4% | 72.0% | 67.3% | 74.0% |
| Risk of Continued Opioid Use | 3.5% | 3.4% | 3.9% | 0.8% | 3.8% | 2.3% | 3.9% | 3.4% | 2.4% |
| Asthma Medication Ratio | 56.2% | 75.8% | 68.6% | 98.1% | 71.4% | 65.4% | 67.3% | 56.8% | 66.9% |
| Prenatal and Postpartum Care | 78.6% | 83.5% | 85.3% | 87.3% | 83.5% | 88.0% | 82.0% | 74.9% | 80.4% |

| | Aetna | CFCHP | JMS | KPMAS | MPC | MedStar Family Choice | Priority Partners | UHC | WPM |
|---|---|---|---|---|---|---|---|---|---|
| Timeliness of Prenatal and Postpartum Care | 84.2% | 88.9% | 87.7% | 88.6% | 89.1% | 83.2% | 92.2% | 87.4% | 90.0% |
| Comprehensive Diabetes Care | 38.0% | 38.0% | 29.2% | 30.7% | 32.9% | 30.7% | 32.4% | 36.3% | 37.2% |
| **Measures Eligible for Incentive** | **3** | **6** | **5** | **6** | **5** | **4** | **5** | **3** | **6** |
| Percentage of Measures Eligible for Incentive | 50% | 100% | 83% | 100% | 83% | 67% | 83% | 50% | 100% |

**Percentile Among Nationwide HEDIS Medicaid Performance**

| |
|---|
| < 50th |
| < 75th (Strong) |
| < 90th (Very Strong) |
| ≥ 90th (Superlative) |

CFCHP: CareFirst Community Health Plan Maryland
HEDIS: Healthcare Effectiveness Data and Information Set
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
PHIP: Population Health Incentive Program
UHC: UnitedHealthcare
WPM: WellPoint Maryland

Note: MDH selected three additional non-HEDIS measures to determine PHIP incentive payments that are not included in this exhibit.

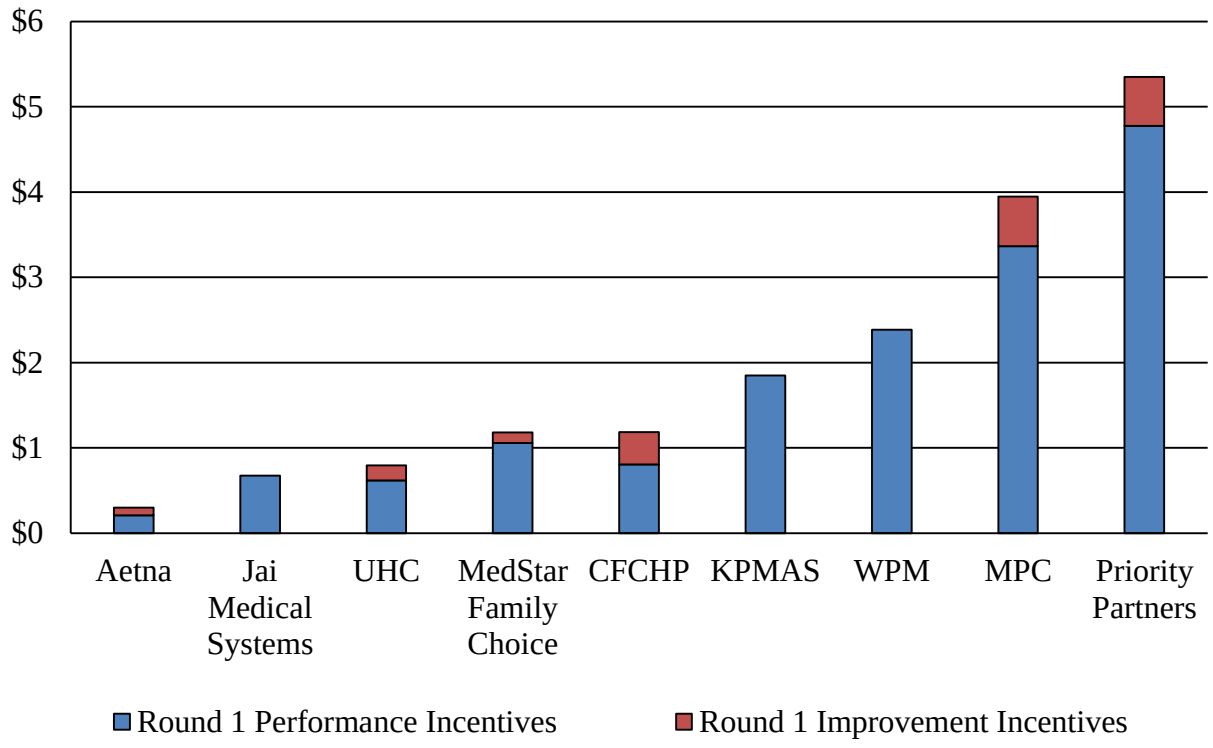
Source: Maryland Department of Health; MetaStar, Inc.; Department of Legislative Services

---

**Exhibit 5** shows how MCOs' calendar 2022 performance and improvement translated to incentives. All MCOs received a PHIP first-round payment, with performance incentives ranging from $208,614 for Aetna to $4.8 million for Priority Partners. Six MCOs also earned improvement incentives, ranging from $89,406 for Aetna to $584,869 for Maryland Physicians Care. Potential maximum incentive payments per MCO depend on each organization's capitated rate as the program is capped at paying 1% of each MCO's capitated rate. In calendar 2022, the first year implementing PHIP, MCOs earned between 0.09% and 0.33% of their capitated rates based on the final performance measures. Priority Partners served the largest share of HealthChoice participants

(23%) as of December 2023 and subsequently received the highest incentive payment. Despite receiving provisional accreditation from NCQA, which requires corrective action, Priority Partners was one of the higher performing MCOs in PHIP as it was one of four MCOs reporting a superlative measure and received partial incentives for five of six HEDIS measures. **MDH should comment on how calendar 2022 PHIP performance measures compare to the factors used in determining NCQA accreditation status and discuss how it will evaluate PHIP measures and overall effectiveness in promoting improved health care outcomes among MCOs.**

**Exhibit 5**
**PHIP Incentives Paid to MCOs in Program's First Year**
**Calendar 2022**
**($ in Millions)**




CFCHP: CareFirst Community Health Plan Maryland
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MCO: managed care organization
MPC: Maryland Physicians Care
PHIP: Population Health Incentive Program
UHC: UnitedHealthcare
WPM: WellPoint Maryland

Source: Maryland Department of Health

Across MCOs, round-one performance and improvement incentives totaled $17.7 million. MDH indicated that no MCOs earned incentives through the second round, leaving just under $20.5 million in unallocated funds budgeted in fiscal 2024 for calendar 2022 performance. The department credited this funding to a nonlapsing fund, rather than distributing it through additional incentive payments to MCOs. The fiscal 2025 allowance level funds PHIP at $36 million ($11.7 million in general funds), which supports incentives of up to 0.5% of anticipated capitated rates. Considering MDH plans to carry forward over $20 million in unallocated funds, which exceeds the $17.7 million in total incentives distributed for calendar 2022, additional funding for the next year of PHIP performance does not seem necessary. DLS notes that the $11.7 million in general funds currently budgeted for PHIP in fiscal 2025 could instead support MCPA general fund shortfalls discussed throughout the analysis.

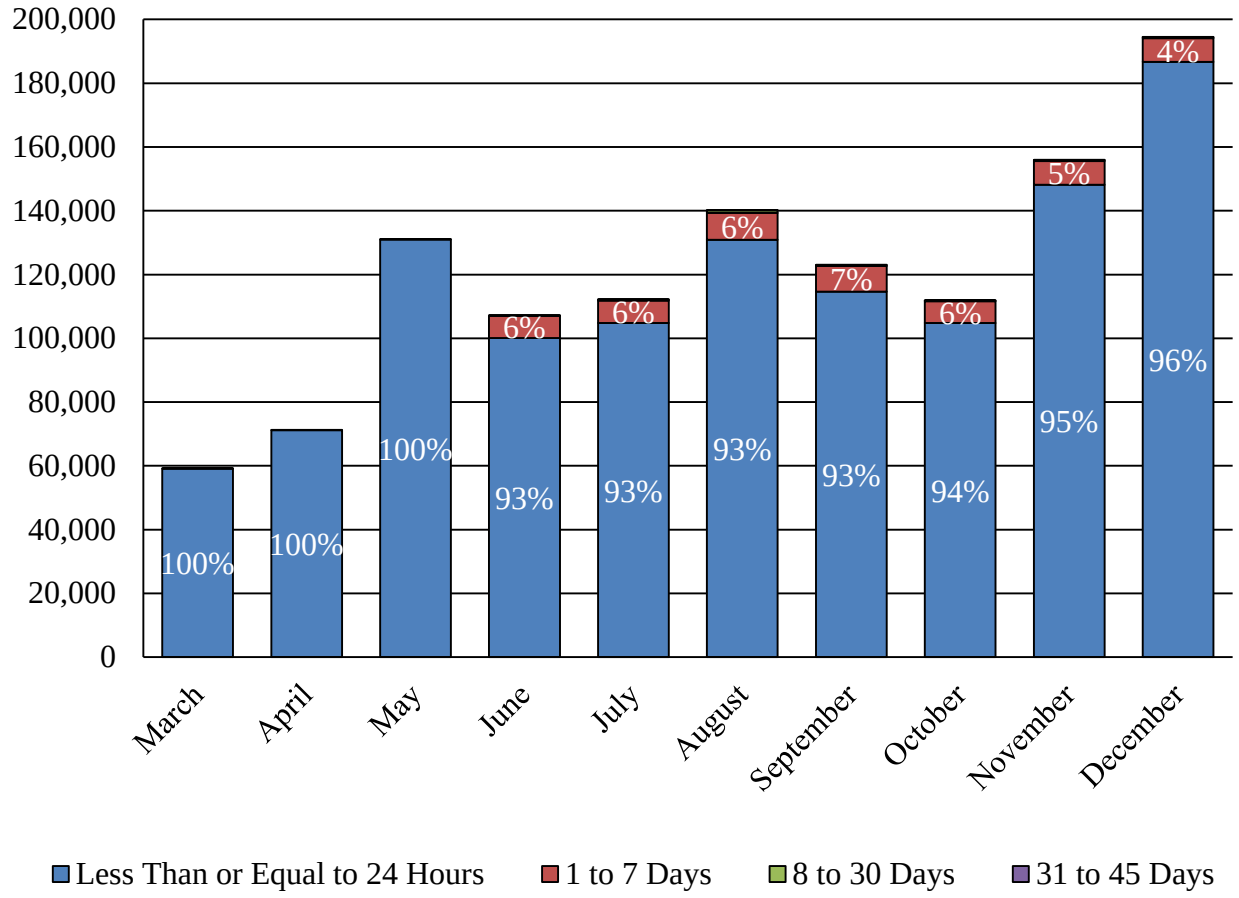
## 3. Application Processing Times and Call Center Activity

Maryland aims to process Medicaid eligibility determinations in an accurate, timely, and efficient manner, including real-time determinations. In measuring application efficiency, it is necessary to distinguish between individuals qualifying based on income (Modified Adjusted Gross Income (MAGI) cases) and more complex non-MAGI cases, such as involving disability status or the inability to pay extraordinary medical bills resulting from an extended nursing home or hospital stay to become Medicaid eligible. Federal regulations require states to process MAGI applications within 45 days and non-MAGI applications within 90 days. In Maryland, MAGI applications are processed through the Maryland Health Connection administered by the Maryland Health Benefit Exchange (MHBE), and non-MAGI cases are processed by the Department of Human Services (DHS). Cases determined by DHS are processed through the Eligibility and Enrollment System.

As a condition of receiving an enhanced federal match on qualifying Medicaid and MCHP spending during the COVID-19 PHE, Maryland was required to freeze disenrollment (with limited exceptions). However, Maryland continued processing eligibility renewals during this time but overrode cases that would have resulted in a termination so that individuals remained enrolled. The Consolidated Appropriations Act of 2023 ended the continuous enrollment requirement on April 1, 2023. On that date, MDH initiated a 12-month eligibility redetermination schedule (referred to as the unwinding period) in which Maryland is renewing all Medicaid and MCHP participants over 12 cohorts.

Application processing through the unwinding period is especially critical as many participants complete eligibility redetermination for the first time since March 2020 or for the first time since enrolling. The Centers for Medicare and Medicaid Services (CMS) requires regular reporting of Medicaid application processing times and, during the unwinding period, MDH has made monthly reports public on a dashboard on the department website. As shown in **Exhibit 6**, throughout the unwinding period, of processed applications each month, MHBE processed the vast majority (at least 93%) for MAGI cases within 24 hours.

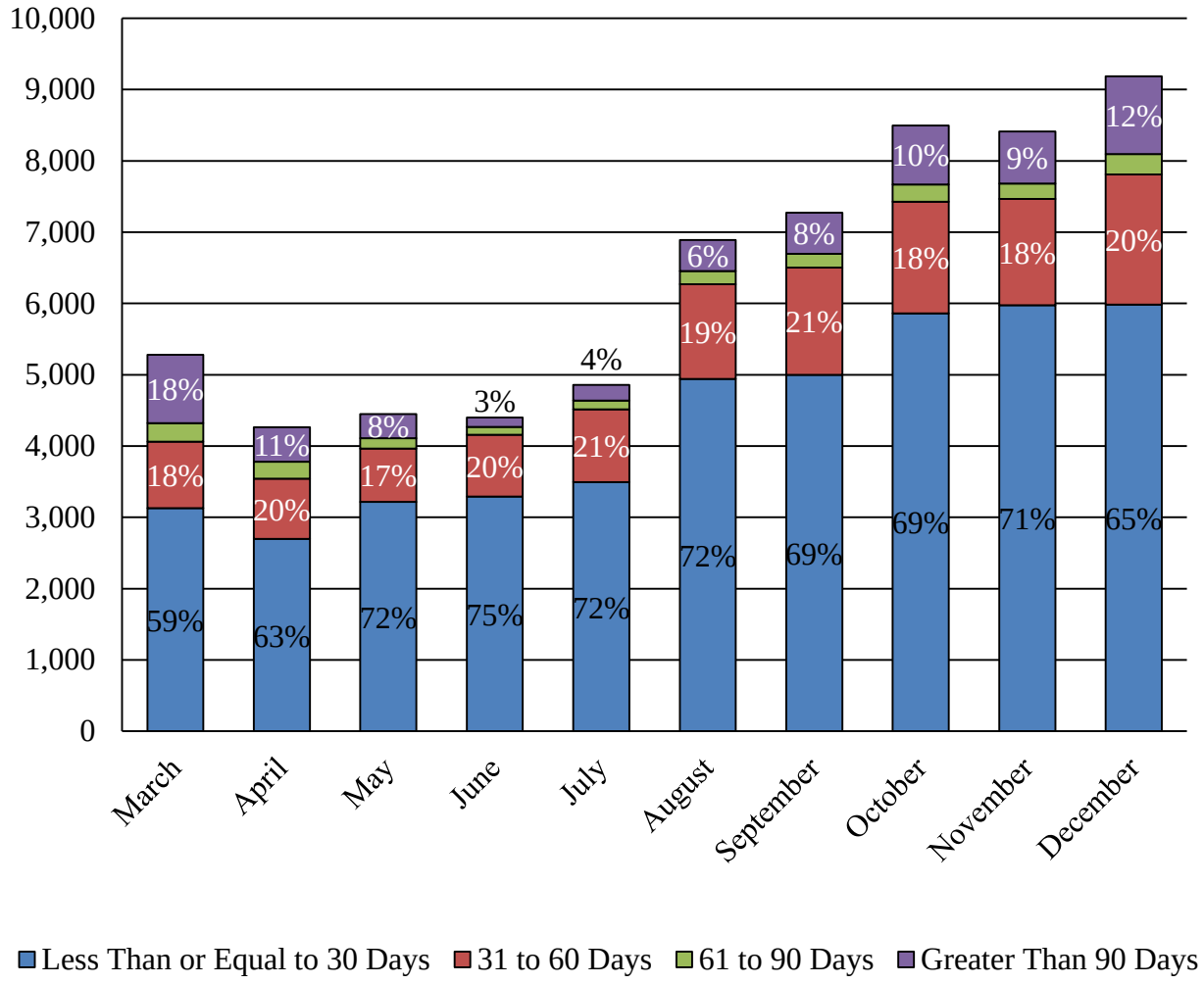
**Exhibit 6**
**Income-based Medicaid Application Processing**
**March 2023 to December 2023**




Source: Maryland Department of Health; Maryland Health Benefit Exchange

As shown in **Exhibit 7**, over the same period, processing of non-MAGI applications tended to take much longer than MAGI applications. On average, from March 2023 to December 2023, approximately 69% of applications were completed within 31 days. The shares of non-MAGI applications processed in over 31 days ranged from a low of 25% in June 2023 to a high of 41% in March 2023. Smaller shares of non-MAGI cases compared to MAGI cases are able to automatically renew their Medicaid and MCHP coverage (referred to as ex parte renewals) in which MHBE and DHS are able to approve coverage based on information that is already on file. This is due to the relative complexity of determining non-MAGI eligibility, which can have additional factors like asset limits. In December 2023, MDH reported that just 25% of the 4,872 non-MAGI renewals were automatically renewed compared to 81,224 of 91,791 MAGI renewals (or 88%).

**Exhibit 7**
**Non-MAGI Medicaid Application Processing**
**March 2023-December 2023**

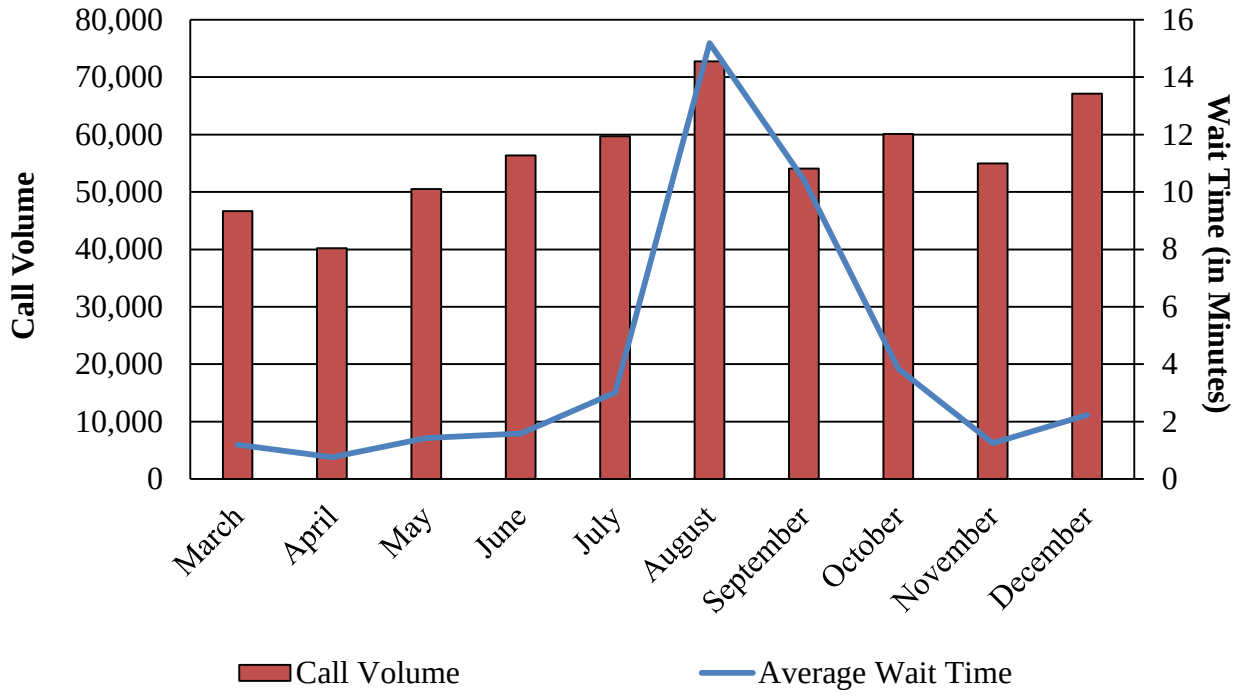



MAGI: modified adjusted gross income

Source: Maryland Department of Health; Department of Human Services

In addition to application processing times, CMS requires states to report monthly administrative data related to Medicaid call centers during the unwinding process. As shown in **Exhibit 8**, call center volume fluctuated from a low of 40,210 calls in April 2023 to a high of 72,748 calls in August 2023. Average wait times also increased with the higher call volume in August 2023, rising to over 15 minutes. By December 2023, average wait times decreased to approximately two minutes, closer to the reported wait times from March to June 2023.

**Exhibit 8**
**Monthly Medicaid Call Center Activity**
**March 2023 to December 2023**




Source: Maryland Department of Health

## Fiscal 2024

### Implementation of Legislative Priorities

#### Abortion Care Services Rate Increase

Section 19 of the fiscal 2024 Budget Bill (Chapter 101 of 2023) added $3.5 million in general funds to the MCPA budget to increase Medicaid provider reimbursement rates for abortion care services. MDH reported that the funding would support average rate increases of 88% for medical and surgical abortion performed in clinics and 19% for long-acting reversible contraceptives. The department expects the rate increases to take effect in February 2024 and continue in fiscal 2025. If any portion of the $3.5 million is not spent on the rate increases due to the delayed effective date, MDH plans to distribute one-time grants to abortion clinic providers serving Medicaid participants.

## Proposed Deficiency

The fiscal 2025 budget includes a net increase of $197.0 million in proposed deficiencies for fiscal 2024 Medicaid and MCHP expenditures. That amount includes a reduction of $79.9 million in general funds offset by increases of $254.8 million in federal funds, $12.3 million in reimbursable funds, and $9.75 million in special funds for the following uses:

- $112.4 million ($52.1 million in general funds) to account for anticipated shortfalls in accrued funding for Medicaid services provided in fiscal 2023 that are billed in fiscal 2024. Under the Medicaid program, FFS claims can be submitted up to a year after the service has been delivered. At the end of each fiscal year, Medicaid accrues unspent funds to pay for anticipated Medicaid bills received in the following fiscal year but are charged back to the prior year;

- a net increase of $84.5 million due to enrollment, utilization, and rate assumptions in Medicaid and MCHP reimbursements, including a reduction of $132.0 million in general funds more than offset by increases of $9.8 million in special funds, $194.4 million in federal funds, and $12.3 million in reimbursable funds;

- $207,674 to transfer 2 positions and operating costs for the Hospital Audit Unit from the Office of the Inspector General for Health (OIGH) to MCPA; and

- a reduction of $125,000 for a pharmacy audit contract that is transferred from MCPA to OIGH.

## MCO Risk Corridor Agreements and State Recoveries

The COVID-19 PHE led to lower health care service utilization beginning in calendar 2020, causing MCOs to spend less relative to their capitated payments. Medicaid traditionally relies on the Medical Loss Ratio (MLR) requirement that 85% of capitated payments are spent on qualifying medical expenses to recoup underspending. Given the uncertainty around service utilization trends throughout the pandemic, CMS allowed states to retroactively enter risk-sharing arrangements, and MDH established two-sided risk corridor arrangements with MCOs to share in both savings and losses. MDH incorporated risk corridor arrangements into MCOs' annual contracts in calendar 2020, 2021, and 2022. One exception is that Kaiser Permanente was excluded from the risk corridor arrangement across all years (as it is in regular rate-setting) due to its significantly higher operating costs and disproportionate risk of losses relative to other MCOs.

Risk corridors in calendar 2021 and 2022 were based on MCOs' programwide experience, in which all MCOs' MLR results (with exception to Kaiser Permanente) are aggregated to determine the corridor band that applies. Risk corridor bands set for calendar 2021 are shown in **Exhibit 9**. MDH completed the calendar 2021 reconciliation process in June 2023 and received $17.5 million in recoveries due to MCOs overall falling in a band providing shared savings. Due

to the timing of this determination, the proposed budget does not recognize savings from these recovered costs. DLS notes that the $17.5 million in savings not currently accounted for in the proposed budget can also partially offset general fund shortfalls identified in this analysis. MDH estimates the calendar 2022 recoveries to be $15.1 million, though this amount will not be audited or finalized until June 2024 and is not recognized in the fiscal 2025 allowance.

**Exhibit 9**
**Risk Corridor Bands and Shares of Gains and Losses**
**Calendar 2021**
**($ in Millions)**

| MLR Risk Corridor | State/Federal Government Share of Gain/Loss | MCO Share of Gain/Loss |
|---|---|---|
| Corridor C+: Less Than 95.29% | 90% Gain | 10% Gain |
| Corridor B+: 95.30% to 96.79% | 50% Gain | 50% Gain |
| Corridor A: 96.80% to 100.00% | 0% | 0% |
| Corridor B-: 100.01% to 101.50% | 50% Loss | 50% Loss |
| Corridor C-: Greater Than 101.51% | 90% Loss | 10% Loss |

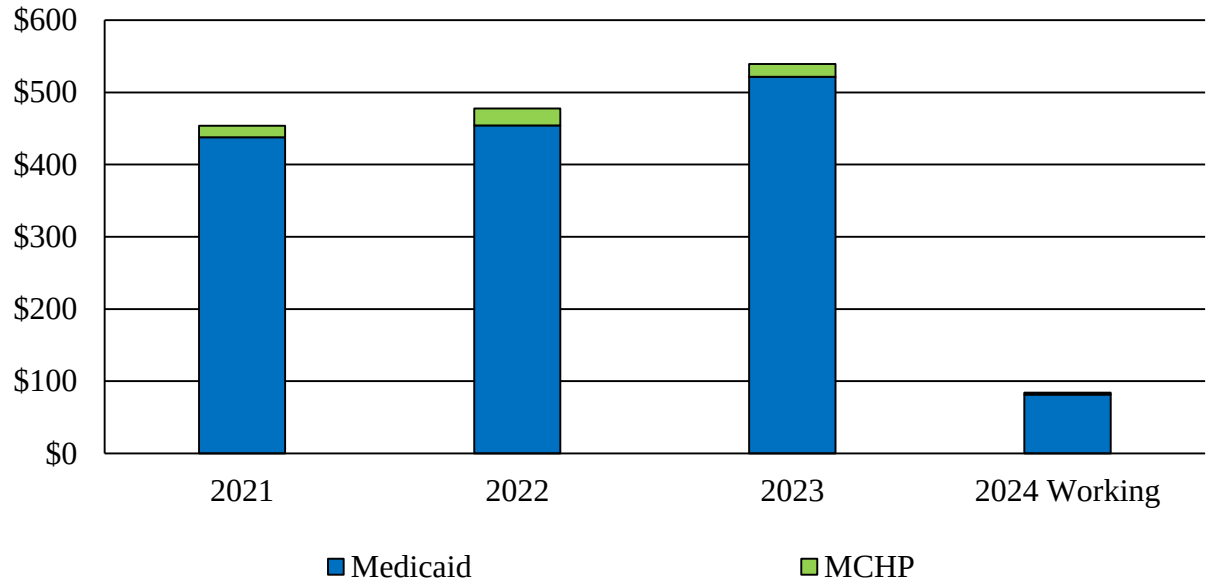
MCO: managed care organization
MLR: Medical Loss Ratio

Source: Maryland Department of Health

## End of COVID-19 Enhanced Federal Match on Medicaid Spending

The Families First Coronavirus Response Act of 2020 authorized a 6.2% enhanced federal match on qualifying Medicaid expenses (4.34% for MCHP) during the national COVID-19 PHE. As shown in **Exhibit 10**, this provision led to over $450 million in annual federal assistance and equivalent general fund savings across Medicaid and MCHP in fiscal 2021 through 2023, excluding federal funds claimed for specialty behavioral health services and services for individuals with developmental disabilities covered by Medicaid.

**Exhibit 10**
**COVID-19 Enhanced Federal Match on Medicaid and MCHP Expenses**
**Fiscal 2021-2024 Working**
**($ in Millions)**




MCHP: Maryland Children's Health Program

Note: Enhanced federal funds claimed on specialty behavioral health services and services for individuals with developmental disabilities covered by Medicaid are included in the budget analyses for M00L – Maryland Department of Health (MDH) – Behavioral Health Administration and M00M – MDH – Developmental Disabilities Administration, respectively.

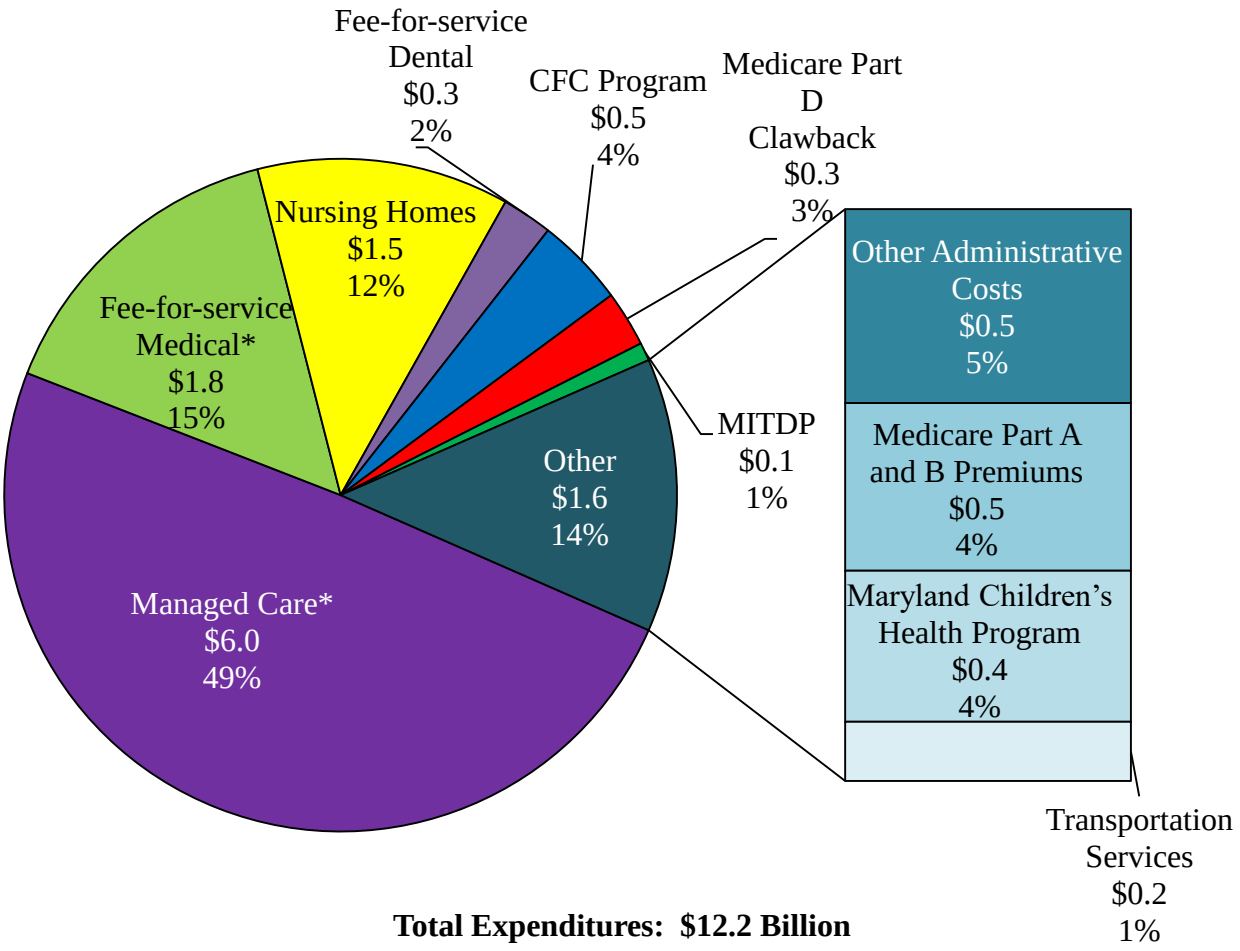
Source: Department of Budget and Management; Maryland Department of Health

Initially, the enhanced FMAP was set to end in the last quarter in which the national COVID-19 PHE ends. However, the Consolidated Appropriations Act of 2023 established a phase-out schedule that reduced the 6.2% and 4.34% enhanced matching rates each quarter, beginning April 1, 2023, until the match fully expired on December 31, 2023. The fiscal 2024 working appropriation includes $84.4 million in federal funds and equivalent general fund savings across Medicaid and MCHP, as the enhanced FMAP phased out in the first two quarters. The fiscal 2025 allowance includes general funds to backfill the elevated federal fund claiming, but overall reductions in spending related to enrollment and utilization offset the increased general fund need.

## Fiscal 2025 Overview of Agency Spending

As shown in **Exhibit 11**, MCPA's fiscal 2025 allowance totals $12.2 billion after accounting for a contingent reduction. About half of the MCPA budget (49%, or $6.0 billion) supports reimbursements for health care services provided to Medicaid enrollees participating in the Medicaid HealthChoice program, referred to as Managed Care in the exhibit. In addition, 30%, or $3.6 billion, covers FFS medical costs including dental coverage and nursing home costs. Both managed care and FFS costs are adjusted downward slightly to account for a total of $823 million in pharmacy rebates that the State receives on prescription drugs purchased above a certain federally set price. Long-term care spending under the Community First Choice (CFC) program makes up 4% of the budget, at $525 million, and supports home and community-based services (HCBS) through entitlement programs and Medicaid waivers.

**Exhibit 11**
**Overview of Agency Spending**
**Fiscal 2025 Allowance**
**($ in Billions)**




**Total Expenditures: $12.2 Billion**

CFC: Community First Choice
MITDP: Major Information Technology Development Projects

*Managed care and fee-for-service medical care reimbursements are adjusted downward to account for pharmacy rebates that Maryland receives on prescription drug purchases above a certain federally set price.

Note: The fiscal 2025 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget. The fiscal 2025 allowance includes contingent reductions.

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

## Proposed Budget Change

As shown in **Exhibit 12**, the fiscal 2025 allowance decreases by approximately $425.6 million compared to the fiscal 2024 working appropriation, after accounting for proposed deficiency appropriations and a contingent general fund reduction. The net reduction in fiscal 2025 expenditures is largely attributed to $442.5 million in decreases due to projected Medicaid enrollment and utilization. Other significant net decreases include $118.0 million for MITDP costs and $112.4 million for a one-time proposed deficiency to cover fiscal 2023 services billed in fiscal 2024. Provider rate increases totaling a net $180 million in additional spending partially offsets these reductions.

**Exhibit 12**
**Proposed Budget**
**Maryland Department of Health – Medical Care Programs Administration**
**($ in Thousands)**

| How Much It Grows: | General Fund | Special Fund | Federal Fund | Reimb. Fund | Total |
|---|---|---|---|---|---|
| Fiscal 2023 Actual | $3,782,829 | $783,862 | $8,301,400 | $106,634 | $12,974,724 |
| Fiscal 2024 Working Appropriation | 4,123,958 | 681,613 | 7,729,275 | 100,557 | 12,635,403 |
| Fiscal 2025 Allowance | 4,046,320 | 729,460 | 7,337,922 | 96,127 | 12,209,830 |
| Fiscal 2024-2025 Amount Change | -$77,638 | $47,847 | -$391,353 | -$4,430 | -$425,573 |
| Fiscal 2024-2025 Percent Change | -1.9% | 7.0% | -5.1% | -4.4% | -3.4% |

| Where It Goes: | Change |
|---|---|
| **Personnel Expenses** | |
| Expenses related to 63.1 new positions | $5,024 |
| Salary increases and associated fringe benefits including fiscal 2024 COLA and increments | 4,450 |
| Turnover adjustments (decrease from 6.72% to 6.44%) | 171 |
| Additional assistance | 111 |
| Overtime | 56 |
| Other fringe benefit adjustments | -38 |
| **Provider Reimbursements and Contracts** | |
| Medicaid LTSS provider 3% rate increase effective July 1, 2024 | 68,860 |
| Other provider rate increases (driven by a 2.2% MCO calendar 2024 rate increase that incorporates costs of legislative changes outlined in Issue 2 of this analysis) | 77,790 |
| Partial annualization costs for 8% Medicaid LTSS provider rate increase effective January 1, 2024, covering only nursing home providers | 59,246 |
| Medicare Part A and B premium assistance | 28,251 |

| **Where It Goes:** | **Change** |
|---|---|
| Medicare Part D clawback | 22,352 |
| Administrative contracts | 17,297 |
| Money Follows the Person rebalancing initiative | 12,712 |
| Assistance in Community Integration Services pilot program expansion ($5.4 million in general funds) | 7,000 |
| EID program | 5,318 |
| Federal share of Medicaid reimbursements for emergency transportation services | 5,000 |
| Maryland Children's Health Program | 2,551 |
| Healthy Babies Equity Initiative | 1,037 |
| Estimated increase in pharmacy rebates, causing lower pharmacy costs | -2,559 |
| End of MCO incentive payments for Rural Access Initiative | -8,000 |
| Community First Choice Program due to reduced projected enrollment | -17,839 |
| Reduced physician evaluation and management rates to 100% of Medicare | -25,920 |
| Fiscal 2024 deficiency to cover fiscal 2023 accrual shortfall | -112,426 |
| Enrollment and utilization | -442,216 |
| **Other Changes** | |
| Staffing for hospital transition program to divert individuals from nursing facilities at hospital discharge | 1,607 |
| LTSS Tracking System project (federal funds) | 1,144 |
| Senior Prescription Drug Assistance Program | 727 |
| Contractual personnel savings from a net decrease of 50.21 FTE positions, most of which are contractual conversions | -1,110 |
| End of one-time CDC grant for MDPCP | -1,670 |
| Maternal and Child Health Population Health Improvement fund | -14,750 |
| Medicaid Management Information System project (federal funds) | -119,156 |
| Other operating expenses | -594 |
| **Total** | **-$425,573** |

CDC: U.S. Centers for Disease Control and Prevention
COLA: cost-of-living adjustment
EID: Employed Individuals with Disabilities
FTE: full-time equivalent
LTSS: Long Term Services and Supports
MCO: managed care organization
MDPCP: Maryland Primary Care Program

Note: Numbers may not sum to total due to rounding. The fiscal 2024 working appropriation includes deficiencies. The fiscal 2024 impacts of statewide salary adjustments appear in the Statewide Account in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2025 impacts of the fiscal 2024 statewide salary adjustments appear in this agency's budget. The fiscal 2025 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget. The fiscal 2025 allowance includes contingent reductions.

## Health Information Exchange Fund Balance Transfer

The Budget Reconciliation and Financing Act (BRFA) of 2024 includes a provision that authorizes the Governor to transfer $216,845 from the Health Information Exchange Fund in fiscal 2025 to MCPA to support information technology (IT) activities. Following the repeal of the Maryland Health Insurance Plan, fund balance from that program was transferred to MCPA to be used for integrated care networks. MCPA's statutory authority to spend this fund balance expired in fiscal 2020. The fiscal 2025 allowance includes a general fund reduction of $216,845, contingent on the enactment of legislation extending the spending authority of the Integrated Care Network Fund into fiscal 2025. Rather than extending the spending authority for the fund, the BRFA authorizes the transfer of special fund balance to MCPA.

Additionally, the Governor's proposed fiscal 2025 budget for MCPA's Office of Enterprise Technology includes a federal fund appropriation of $216,845, contingent on the enactment of legislation extending the spending authority of the Integrated Care Network Fund. That is a technical error as transferred funding from the Integrated Care Network Fund would be budgeted as special funds in MCPA. **DLS recommends two technical corrections:**

- **to strike the language making $216,845 in federal funds under the Office of Enterprise Technology contingent on enactment of the BRFA; and**

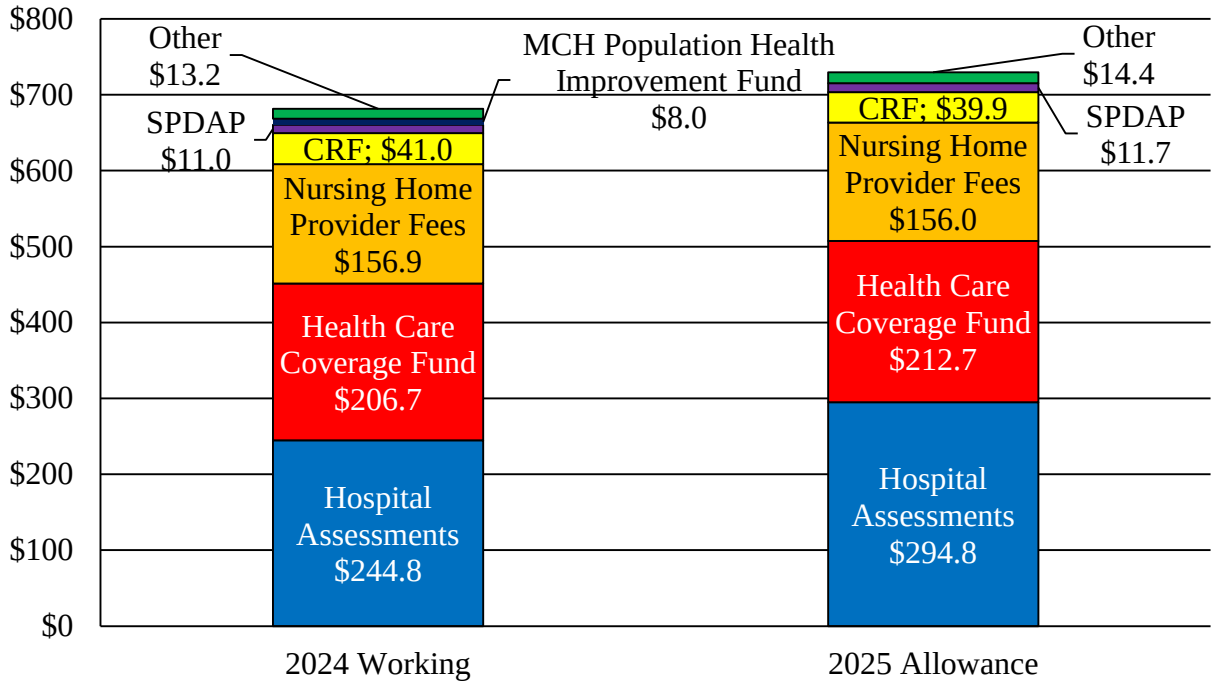
- **to amend contingent language reducing $216,845 in general funds under the Office of Enterprise Technology to refer to the Health Information Exchange Fund and to make the reduction contingent on legislation authorizing the transfer of special fund balance.**

**MDH should comment on the timing and method for adding $216,845 in special funds to the Office of Enterprise Technology to recognize the fund balance transfer.**

## Special Fund Availability

**Exhibit 13** details a variety of special fund sources that support fiscal 2024 and 2025 Medicaid and MCHP expenditures. Overall, special fund spending under MCPA programs in the fiscal 2025 allowance increases by $47.8 million compared to the fiscal 2024 working appropriation, largely due to a one-time fiscal 2024 reduction of $50 million in the Medicaid Deficit Assessment authorized in the BRFA of 2023.

**Exhibit 13**
**Special Fund Support for the Medical Care Programs Administration**
**Fiscal 2024-2025**
**($ in Millions)**




CRF: Cigarette Restitution Fund
MCH: Maternal and Child Health
SPDAP: Senior Prescription Drug Assistance Program

Note: The fiscal 2024 working appropriation includes deficiency appropriations. The fiscal 2025 allowance includes a contingent reduction.

Source: Governor's Fiscal 2025 Budget Books

### Maternal and Child Health Population Health Improvement Fund

The BRFA of 2021 established the Maternal and Child Health Population Health Improvement Fund under MDH to invest in maternal and child health interventions led by MCPA, MCOs, and the MDH Prevention and Health Promotion Administration. Funding support for the special fund is derived from an assessment built into hospital rates that supports the Health Services Cost Review Commission's (HSCRC) Regional Partnership Catalyst program, which distributes funding to support the State's achievement of specific population health goals, including goals related to maternal and child health. HSCRC reported that from fiscal 2022 to

2025, $8 million annually will be directed to the Maternal and Child Health Population Health Improvement Fund for initiatives led by MCPA.

Despite the catalyst funding continuing through fiscal 2025, the proposed budget does not include $8 million in special funds for this use or the corresponding federal matching funds claimed on Medicaid and MCHP spending. MDH indicated that it was working with the Department of Budget and Management (DBM) to allocate the special funds and corresponding federal funds in fiscal 2025. **MDH should provide an update on the timing and method for adding $8 million in special funds from the Maternal and Child Health Population Health Improvement Fund and corresponding federal matching funds to the fiscal 2025 allowance.**

### SPDAP Fund Balance Transfer to BHA

MCPA administers the SPDAP to provide Medicare Part D premium assistance to offset costs for Maryland residents with incomes at or below 300% of FPL who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans. As of February 1, 2024, MDH reported that SPDAP served 24,354 enrollees and had no waiting list. The program is funded at $11.7 million in fiscal 2025 through the SPDAP special fund, which is supported by the CareFirst premium tax exemption payment. According to MDH, SPDAP closing fund balances have grown in recent years from $6.4 million in fiscal 2021 to $11.1 million in fiscal 2023. The department attributed reduced spending to declining enrollment causing a lower need for premium subsidy payouts and third-party administrator fees.

The fiscal 2025 allowance transfers $5.0 million in SPDAP fund balance to be used by BHA for the provision of mental health services to the uninsured, resulting in equivalent general fund savings. As specified in Section 15-1004 of the Health – General Article, this was an allowable use of the SPDAP special fund in fiscal 2018 only. To the extent this statute remains unchanged in fiscal 2025, BHA will have a $5 million general fund deficit due to the inability to use SPDAP fund balance for this purpose. MDH indicated that it was working with DBM to address this issue, which will be discussed further in the M00L – MDH – BHA analysis.

## Provider Rate Increases

Compared to the fiscal 2024 working appropriation, MCPA's fiscal 2025 allowance increases by $180 million to account for various provider rate increases. **Exhibit 14** lists rate increases by service or provider type budgeted under MCPA. Rate increases for Long Term Services and Supports (LTSS) providers drive the overall increase. MCOs also receive a calendar 2024 rate increase of 2.2% that incorporates additional costs for legislative changes outlined in Issue 2 of this analysis. The fiscal 2025 allowance does not project any additional spending for rate changes that may be determined through the MCO calendar 2025 rate-setting process. Increased spending on rates is partially offset by a reduction of $25.9 million ($9.3 million in general funds) for evaluation and management fees paid to physicians to rebase the fiscal 2025 rates at 100% of calendar 2024 Medicare rates from 103% of calendar 2023 Medicare rates.

**Exhibit 14**
## Medicaid Provider Rate Changes and Rate Assumptions
**Fiscal 2025**
**($ in Millions)**

| | Rate Change |
|---|---|
| ***LTSS Providers, Including Nursing Homes*** | |
| 3% Increase, Effective July 1, 2024 | $68.9 |
| Annualization of 8% for Nursing Homes, Effective January 1, 2024 | 59.2 |
| ***Subtotal*** | ***$128.1*** |
| Managed Care Organizations Calendar 2024 (2.2%) | $43.6 |
| Inpatient and Outpatient Services (3.58%) | 25.2 |
| Pharmacy (2.15%) | 9.0 |
| Physician Evaluation and Management Fees (Reduction from 103% to 100% of Medicare rates) | -25.9 |
| **Total** | **$180.0** |

LTSS: Long Term Services and Supports

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

### Rate Increases for LTSS Providers

On January 1, 2024, Medicaid LTSS providers received accelerated rate increases totaling 8% that were enacted in the fiscal 2024 Budget Bill and Chapter 2 of 2023 (the Fair Wage Act) to align mandated provider rate increases for fiscal 2025 and 2026 with the State's minimum wage rate increase to $15 per hour. The fiscal 2024 Budget Bill initially allocated the funding for the 8% accelerated rate increase in the MDH Office of the Secretary, and a fiscal 2024 budget amendment processed in November 2023 transferred the portion for LTSS providers to MCPA. The fiscal 2025 allowance includes $59.2 million to annualize these rates, which appears to cover annualization costs for nursing home providers only. This technical error leaves a shortfall of $29.8 million ($13.5 million in general funds) that is needed to annualize the rate increase for the remaining LTSS providers.

Due to the acceleration of mandated provider rate increases, there is no required rate increase in fiscal 2025. However, the proposed budget includes discretionary funding of $68.9 million for a 3% rate increase for Medicaid LTSS providers. Further discussion of provider rate increases, including behavioral health and Developmental Disabilities Administration (DDA) service providers can be found in the M00 – MDH Overview budget analysis.

## Transition from MCO Rural Incentive Program to Health Equity Focus

The fiscal 2025 allowance decreases by $8.0 million ($2.8 million in general funds) due to the end of the MCO Rural Access Incentive, which provided semi-annual supplemental payments to MCOs accepting new members in rural counties defined in regulation. If there were unallocated funds after this first incentive calculation, additional funds would be distributed to all MCOs in accordance with each MCO's statewide enrollment. MDH indicated that this program ended December 31, 2023, with final payments to be distributed in fiscal 2024.

MDH and the Hilltop Institute at the University of Maryland Baltimore County developed a proposed methodology to repurpose funding for the MCO Rural Access Incentive to instead incentivize MCOs to promote health equity beginning in fiscal 2025. Under this new methodology, incentives would be based on MCOs' membership in Maryland counties with high socioeconomic disadvantage. The Hilltop Institute developed an index considering socioeconomic, structural, and environmental factors associated with adverse health outcomes and drivers of health inequities to rank counties for directing incentives to MCOs. For example, Hilltop used component measures such as the violent crime rate per 100,000 residents to measure community safety and the proportion of children living in food-insecure households to measure food security.

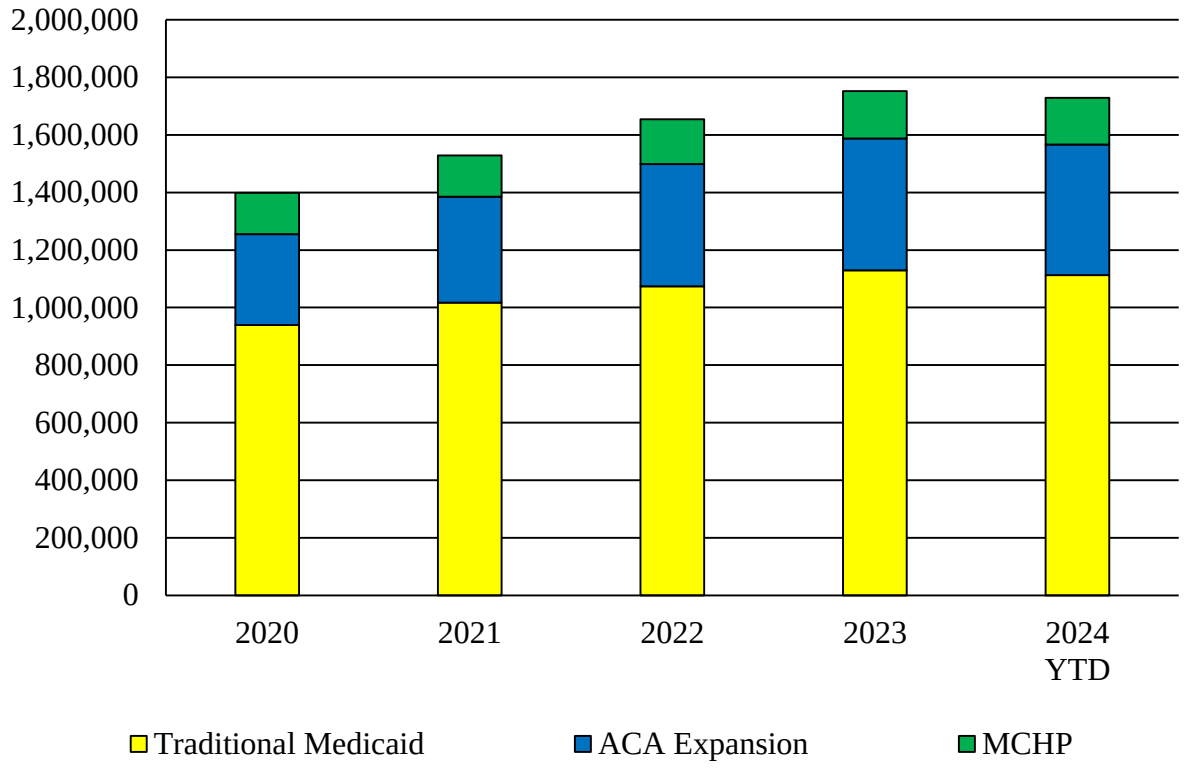
After calculating an equal-weighted average for each county's proposed socioeconomic disadvantage index, Hilltop identified the following six local jurisdictions as those with the highest rankings: (1) Dorchester County; (2) Baltimore City; (3) Somerset County; (4) Wicomico County; (5) Allegany County; and (6) Baltimore County. Hilltop's proposal was to prioritize MCOs serving members in Maryland counties with the highest relative levels of socioeconomic disadvantage and allocate available funding proportional to MCO membership in those areas. Although the fiscal 2025 allowance does not include funding for incentives to promote health equity, MDH reported that $8 million ($2.8 million in general funds) was left out of the proposed budget for this purpose in error and that it would work with DBM to address this issue. These unallocated funds further contribute to the overall MCPA shortfall.

**MDH should discuss the timing and method for allocating $8 million in the proposed fiscal 2025 budget to cover health equity incentives. In addition, MDH should provide an update on the methodology selected for determining MCO incentive payments to promote health equity, including the timing of implementation and when regulations will be finalized establishing the payment structure for the program. The department should also clarify whether calendar 2024 contract agreements with MCOs include a health equity incentive structure.**

## Enrollment Trends throughout the COVID-19 PHE Unwinding Process

As a condition of receiving an enhanced federal match on qualifying Medicaid and MCHP spending during the COVID-19 PHE, Maryland was required to freeze Medicaid disenrollment with limited exceptions. **Exhibit 15** shows that average monthly Medicaid and MCHP enrollment increased by 25% during this period, from 1.40 million participants in fiscal 2020 to an all-time high of 1.75 million participants in fiscal 2023.

**Exhibit 15**
**Average Monthly Medicaid and MCHP Enrollment**
**Fiscal 2020-2024 YTD**




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

Note: Beginning in fiscal 2024, MCHP includes individuals covered under the Healthy Babies initiative, which covers noncitizen pregnant and postpartum individuals who would otherwise qualify for Medicaid but for their immigration status. Through January 2024, the average monthly enrollment for this group was 5,173.

Source: Maryland Department of Health

Following the end of the continuous enrollment requirement on April 1, 2023, MDH initiated a 12-month unwinding process to complete renewals for all Medicaid and MCHP participants over 12 cohorts. The department's schedule follows guidance from CMS discouraging states from initiating renewals for more than one-ninth of the total caseload each month. Additionally, MDH prioritized participants who appeared to be ineligible for Medicaid or MCHP coverage mainly due to reporting increases in income or aging out. These individuals' eligibility was redetermined in cohorts 2 through 7, or May through November 2023. Based on monthly enrollment through January 2024, the fiscal 2024 year-to-date average caseload decreased by 1.4%, or 23,714 overall enrollees.

**System Error Related to Ex Parte Renewal**

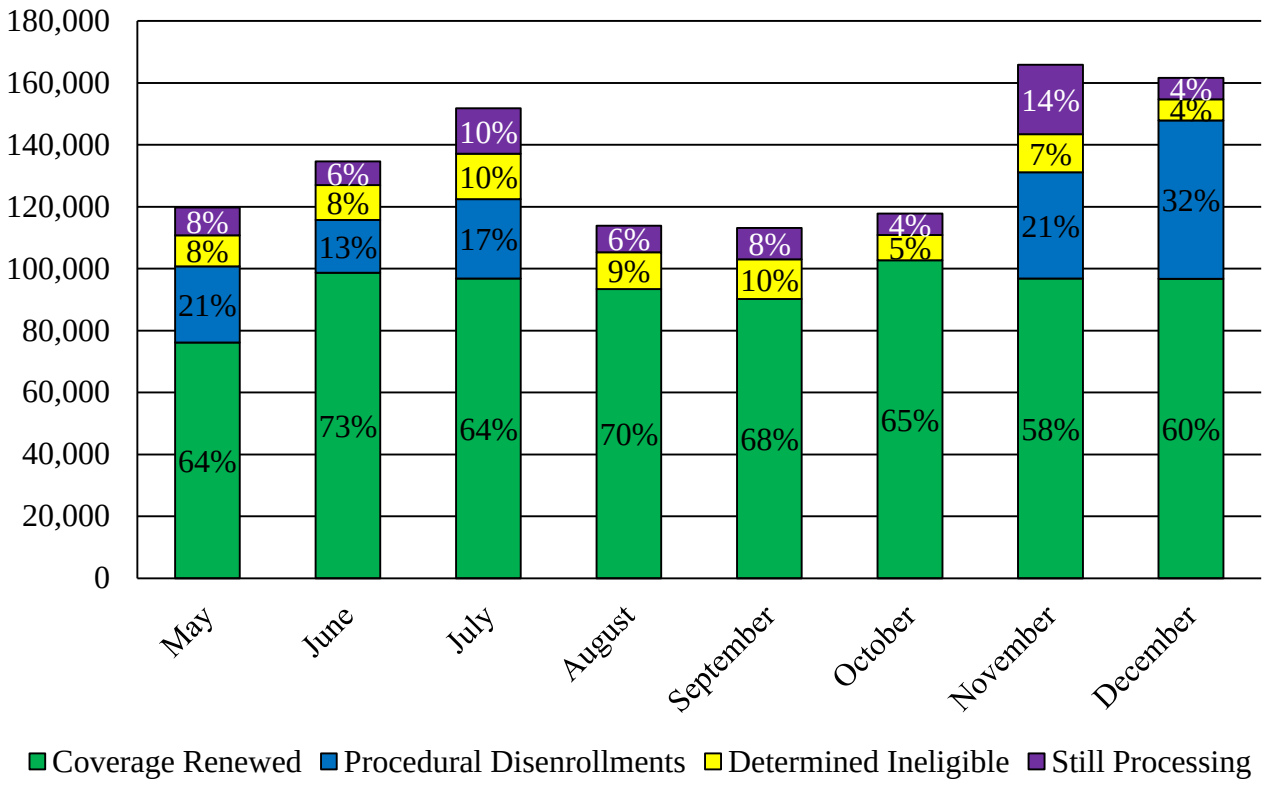
As part of the eligibility redetermination process, Maryland's Medicaid program administers an ex parte renewal process to redetermine participants' eligibility based on available data, rather than requiring additional data submissions. In August 2023, CMS noted that approximately 30 state Medicaid systems, including Maryland, were processing ex parte renewals at the household level rather than the individual level. Using a household level for this process can lead to unnecessary procedural terminations (cases in which individuals lost coverage due to a renewal not being completed, outstanding verification documents for a submitted renewal, and returned mail), especially among children, because of the higher income thresholds to be considered eligible for Medicaid or MCHP. In response, MDH unexpectedly changed its unwinding process by:

- pausing all procedural disenrollments from August through October 2023;
- reinstating coverage for approximately 5,000 children;
- submitting a comprehensive mitigation plan to CMS; and
- making system changes to the ex parte process to come into compliance with CMS guidance.

**Medicaid and MCHP Eligibility Redetermination Results**

As shown in **Exhibit 16**, of total renewals completed each month from May to December 2023, at least 58% of participants were renewed for continued health care coverage through Medicaid or MCHP. Procedural disenrollments made up the next largest share of monthly renewal outcomes, except between August and October 2023 when those terminations were paused. Instead of coverage being terminated, individuals who would have been procedurally disenrolled from August to October 2023 had their redetermination dates extended to November 30, 2023, or later (when MDH completed ex parte renewal systems changes). Overall procedural disenrollments ranged from a low of 17,075, or 13%, in June 2023 to a high of 51,249, or 32%, in December 2023, when MHBE and DHS had both completed the systems changes and initiated procedural disenrollments that had been paused.

**Exhibit 16**
**Eligibility Redetermination Results by Month**
**May 2023 to December 2023**



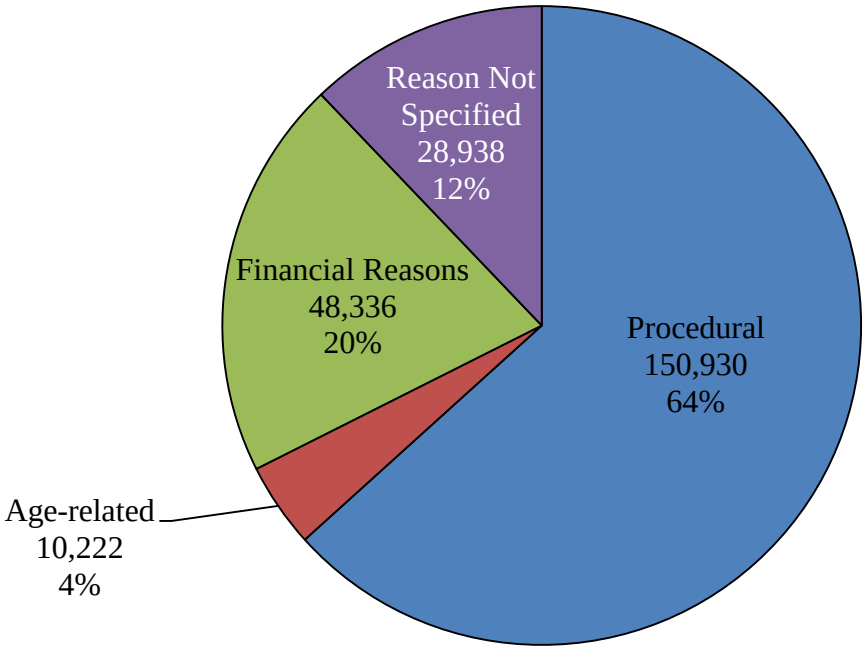

Note: Procedural disenrollments were temporarily paused due to a system error from August to October 2023. Percentages may not sum to 100% due to rounding. Percentages show the share of individuals receiving each redetermination result out of total renewals completed that month. Renewal processing times vary between the Maryland Health Benefit Exchange (up to 60 days) and the Department of Human Services (up to 95 days).

Source: Maryland Department of Health; Department of Legislative Services

### Reasons for Coverage Termination and Churn Analysis

As shown in **Exhibit 17**, Maryland disenrolled a total of 238,426 participants from Medicaid and MCHP from May to December 2023, more than half of the 12-month unwinding process. Approximately 64% of all disenrollments during this period were due to procedural reasons, rather than MDH finding the participants ineligible for the programs. DLS notes that some individuals determined ineligible for procedural reasons, such as not reapplying, may have chosen not to reapply due to anticipated ineligibility. The leading reasons for disenrollment among ineligible participants were financial reasons (20%), such as income over scale.

**Exhibit 17**
**Medicaid Coverage Terminations by Reason**
**May 2023 to December 2023**




**Total Disenrollments: 238,426**

Note: Renewal periods vary as participants are given 60 days to renew through the Maryland Health Benefit Exchange or 95 days to renew through the Department of Human Services.

Source: Maryland Department of Health

From May to December 2023, MDH reported a net decrease of just under 74,000 monthly Medicaid and MCHP participants, or 4.1%. Although over 235,000 participants were disenrolled throughout the first eight months of the unwinding process, new and returning enrollment partially offset the caseload declines. The Hilltop Institute reported that 106,129 individuals were newly enrolled, and 51,575 disenrolled individuals reenrolled in Medicaid or MCHP between May and December 2023. Prior to the continuous enrollment requirement, individuals temporarily losing Medicaid coverage and later reenrolling, referred to as churn, was common. For the first two cohorts of Medicaid and MCHP participants disenrolled in May and June 2023, the Hilltop Institute found that between 28.7% and 33.2% had reenrolled within six months. This analysis did not follow disenrolled individuals churning from Medicaid to other health care coverage (particularly qualified health plans), though MDH indicated that it would monitor individuals disenrolled from Medicaid for their health care coverage outcomes.

Language in the fiscal 2024 Budget Bill restricted $500,000 in general funds until MDH submitted quarterly reports regarding the Medicaid eligibility redetermination process following the end of the continuous enrollment requirement. The language allowed for withheld funds to be released in $125,000 increments following the submission of each quarterly report, and $250,000 has been released following the submission of the first two reports. MDH submitted the third quarterly report on January 26, 2024, and provided supplemental enrollment information that is discussed throughout this analysis. **DLS determined the report and additional enrollment information to be in compliance with the language and recommends the release of the third increment of $125,000 in general funds and will process a letter to this effect if no objections are raised by the subcommittees.**

Throughout the unwinding process, MDH has also published eligibility redetermination data through monthly summaries and trackers on the department's website. These summaries have included the number of renewals completed (specifying the share of ex parte renewals) and terminations by reason, among other data. **MDH should discuss whether it will continue updating the enrollment change summaries and administrative data required by CMS on its website following the end of the unwinding process and comment on the ability to add monthly new enrollment and returning enrollment or churn data to the published summaries. DLS recommends adopting committee narrative requesting the continued submission of quarterly reports with Medicaid and MCHP enrollment data, as MDH transitions from the unwinding process.**

**Unwinding Strategies and Express Lane Eligibility**

In the first three quarterly reports on the unwinding process, MDH stated its goal of ensuring eligible individuals keep Medicaid coverage and that ineligible individuals are referred to other sources of low- or no-cost health coverage. The department has implemented many strategies to avoid inappropriate disenrollments and connect individuals who are ineligible for Medicaid coverage with other programs during the unwinding period. MDH received federal approval for these strategies through waiver authorities and flexibilities. For example, for individuals who previously reported zero income that was verified within the prior year and did not submit updated income information, MDH received CMS approval to conduct ex parte renewals for these cases.

CMS approved Maryland to temporarily renew Medicaid eligibility based on SNAP participation through April 30, 2024. Chapters 282 and 283 require MDH, by January 1, 2025, to establish an Express Lane Eligibility Program to enroll individuals in Medicaid and MCHP based on eligibility findings by SNAP. MDH is pursuing separate authorities that would extend this policy so that express lane eligibility is continuously in place between the end of the unwinding process on April 1, 2024, and January 1, 2025.

Other unwinding strategies were initiated at the State-level and do not require federal approval, such as extending the reconsideration period to 120 days. This allows participants disenrolled for procedural reasons to resume their renewal process without filling out a new application within 120 days of the initial coverage termination. MDH detailed other statewide

efforts and partnerships in effect throughout the unwinding period, including a multimedia communications campaign (known as Medicaid Check-In) and outreach activities with MCOs, health care providers, and community organizations, among other stakeholders.

**MDH should provide an update on the termination dates for these federally approved and State-level flexibilities and policy changes implemented during the unwinding period. In addition, MDH should discuss whether it is pursuing extensions or incorporating any flexibilities into ongoing Medicaid and MCHP redetermination procedures.**

## Fiscal 2024 and 2025 Projected Enrollment

**Exhibit 18** compares enrollment figures assumed in the fiscal 2024 legislative appropriation, fiscal 2024 working appropriation, and fiscal 2025 allowance to DLS' fiscal 2024 and 2025 enrollment forecasts. Both forecasts revise overall fiscal 2024 enrollment upward from the estimated 1.54 million participants assumed on average per month in the fiscal 2024 budget as enacted. From July 2023 to January 2024, redetermination results during the unwinding process have yielded lower disenrollments than anticipated, partially due to the pause on procedural terminations from August 2023 to October 2023, while Maryland corrected its ex parte renewal system error described previously. MDH also received federal approval for a variety of flexibilities and implemented State-level redetermination policy changes that have reduced disenrollments to some extent. DLS estimates a slightly higher fiscal 2024 enrollment than DBM's assumptions in the fiscal 2024 working appropriation due to additional months of actual enrollment data during the unwinding period continuing to show fewer disenrollments than expected, driving the increase in average monthly enrollment.

**Exhibit 18**
**DLS and DBM Enrollment Forecasts**
**Fiscal 2024-2025**

| | 2024 | | | 2025 | | % Change 2024-2025 | |
|---|---|---|---|---|---|---|---|
| | Leg. Approp. | Adjusted Working | DLS Estimate | Allowance | DLS Estimate | Adjusted Working to Allowance | DLS 2024 Estimate to DLS 2025 Estimate |
| Traditional Medicaid | 1,026,078 | 1,081,207 | 1,096,084 | 1,033,422 | 1,039,855 | -4.4% | -5.1% |
| ACA Expansion | 358,349 | 427,922 | 443,864 | 406,278 | 399,477 | -5.1% | -10.0% |
| MCHP | 154,056 | 144,992 | 155,947 | 139,654 | 143,471 | -3.7% | -8.0% |
| **Total** | **1,538,483** | **1,654,121** | **1,695,895** | **1,579,354** | **1,582,804** | **-4.5%** | **-6.7%** |

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

Note: Enrollment estimates shown do not include individuals covered under the Healthy Babies initiative, which covers noncitizen pregnant and postpartum individuals who would otherwise qualify for Medicaid but for their immigration status. Both forecasts project average monthly enrollment under this program to be 5,785 in fiscal 2024 and 2025.

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

Although the fiscal 2024 working appropriation and fiscal 2024 DLS estimate assume higher average monthly enrollment than budgeted in the fiscal 2024 legislative appropriation, the assumed enrollment mix lessens the estimated general fund need to cover these individuals. Compared to the fiscal 2024 legislative appropriation, estimated fiscal 2024 Medicaid and MCHP caseloads include 115,638 more participants in the working appropriation and 157,412 more participants in the DLS estimate. ACA adults account for 60% and 54% of the enrollment increases in the fiscal 2024 working appropriation and DLS forecast, respectively. This eligibility group receives an enhanced federal matching rate of 90%, which lessens the general fund need in fiscal 2024 to cover the higher enrollment.

In fiscal 2025, both the enrollment forecast that supports the proposed budget and the DLS estimate continue to decrease from fiscal 2024 caseload levels due to the annualization of the unwinding (caseloads by end of fiscal 2024 are lower than the average monthly caseload for the fiscal year) and favorable economic trends. Projected enrollment and utilization decline, accounting for a decrease of $442.2 million in Medicaid spending, is the largest driver of the net decrease in the fiscal 2025 allowance compared to the fiscal 2024 working appropriation, after

accounting for proposed deficiencies and a contingent reduction. Though the DLS estimate has a higher rate of decline in fiscal 2025 at 6.7%, this is due to a slightly higher enrollment in fiscal 2024. Both forecasts have similar total enrollment projections for fiscal 2025 of 1.58 million participants. Despite the enrollment mix varying slightly, the general fund cost differences due to caseload assumptions appear to be minimal with DLS projecting approximately $4.3 million more in fiscal 2025 general fund need.

## General Fund Adequacy

In assessing the adequacy of the Medicaid budget for fiscal 2024 and 2025, DLS finds that there are significant cost differences between the proposed budget and the DLS spending forecast that are not related to enrollment assumptions and cause significant general fund shortfalls of approximately $115 million in fiscal 2024 and $150 million in fiscal 2025. Specifically, under FFS spending, the budget appears to underestimate costs for MCPA to assist individuals who are dually eligible for Medicaid and Medicare in paying for Medicare cost sharing by approximately $105 million in general funds in each year for fiscal 2024 and 2025. The proposed budget estimates approximately $30 million in total spending for these services compared to recent actual fiscal 2023 spending that was closer to $250 million.

DLS also identified that $13.5 million in general funds is needed in fiscal 2025 to cover part of the annualization costs of the 8% accelerated provider rate increase. The remaining differences of $10 million and $30 million in fiscal 2024 and 2025 general fund costs, respectively, are largely attributed to differences in utilization assumptions. For example, DLS forecasts that fiscal 2025 nursing home utilization will increase as utilization approaches prepandemic levels. However, the fiscal 2025 allowance projects declining utilization, accounting for a difference of approximately $14 million in cost savings.

**DLS identified potential cost savings, as noted earlier, totaling $29.2 million in general funds across fiscal 2024 and 2025; however, even with these potential savings, there would be remaining general fund deficits of $97.5 million in fiscal 2024 and $138.3 million in fiscal 2025. MDH should comment on how it plans to backfill projected general fund shortfalls in fiscal 2024 and 2025.**

## *Personnel Data*

| | FY 23 Actual | FY 24 Working | FY 25 Allowance | FY 24-25 Change |
|---|---|---|---|---|
| Regular Positions | 608.00 | 614.00 | 680.10 | 66.10 |
| Contractual FTEs | 76.22 | 150.46 | 100.25 | -50.21 |
| **Total Personnel** | **684.22** | **764.46** | **780.35** | **15.89** |

***Vacancy Data: Regular Positions***

| | | |
|---|---|---|
| Turnover and Necessary Vacancies, Excluding New Positions | 39.73 | 6.44% |
| Positions and Percentage Vacant as of 12/31/23 | 85.60 | 13.94% |
| Vacancies Above Turnover | 45.87 | |

- The fiscal 2025 allowance includes 66.1 new positions for MCPA, which include 22 contractual conversions approved by the Board of Public Works (BPW) in October 2023 that are not yet reflected in the fiscal 2024 working appropriation and 12 additional contractual conversions. Two contractual conversions approved by BPW in January 2024 and other contractual conversions allowed through language in the fiscal 2025 Budget Bill authorizing 540 contractual conversions departmentwide are not shown in the fiscal 2025 proposed budget.

- Remaining new and transferred regular personnel totaling 32.1 positions include:

  - 8.1 positions within the Office of Long Term Services and Supports for HCBS;

  - 5 positions providing accounting support to the Office of Finance;

  - 4 positions supporting the expansion of the Program of All-inclusive Care for the Elderly (commonly referred to as PACE);

  - 4 health policy analyst positions for the Office of Innovation, Research, and Development;

  - 3 skilled professional positions to support the Office of Pharmacy Services;

  - 1 medical billing and coding specialist position in the Office of Medical Benefits Management;

  - 1 fiscal services administrator in the Office of Finance;

- 1 assistant Attorney General position;
- 3 existing positions transferred from other MDH offices to MCPA; and
- 2 positions transferred from OIGH for oversight of the hospital audit contract.

- It should be noted that vacancy data as of December 31, 2024, submitted by DBM was slightly elevated due to the inclusion of 20 new positions for contractual conversions approved by BPW in October 2023. MDH indicated that most of the contractual full-time equivalent positions were filled at the time they were converted to regular positions. Therefore, the vacancy data shown above has been adjusted to remove these 20 new positions and instead show 85.6 vacancies, which is a vacancy rate of 13.94%. Of the 85.6 vacancies, 27.6 positions (32%) had been vacant for more than one year. Even after the downward adjustment, MCPA reported over 45 vacancies more than needed to meet fiscal 2025 budgeted turnover. **The department should discuss how it will spend salary and fringe benefit savings resulting from having more vacancies than necessary to meet budgeted turnover.**

# *Issues*

## 1. Expansion of Medicaid Reimbursement for School-based Services, Administrative Claiming, and SBHC Services

Medicaid and MCHP can reimburse health care services provided in schools in three ways, through:

- services provided as part of a student's IEP, such as speech therapy and counseling;
- SBHCs that act as providers; and
- school-based administrative services that support the provision of Medicaid services to children in schools and activities related to outreach and enrollment.

MCPA is in the process of a two-phase plan that involves expanding Medicaid reimbursement to cover (1) behavioral health services provided by school psychologists and social workers to students without IEPs and (2) administrative costs as permitted under federal guidance.

### Behavioral Health Services Reimbursement

The BRFA of 2024 contains a provision to expand the authorized uses of funding under the Consortium on Coordinated Community Supports within the Maryland Community Health Resources Commission to reimburse MCPA for school-based behavioral health services provided on an FFS basis through a Medicaid waiver. MDH indicated that phase one of its plan includes amending regulations and seeking federal approval for a State Plan Amendment to the Medicaid program that would allow for reimbursement for services delivered by school psychologists and social workers for students with or without IEPs. As part of this change, MCPA would be applying for a waiver to reimburse school psychologists and social workers who meet different requirements than are currently required for other Medicaid behavioral health providers.

MDH expects to implement expanded reimbursement for school-based behavioral health services beginning in the first quarter of calendar 2025. The department estimates that $27.4 million in total funds ($12.7 million in general funds and $14.7 million in federal funds) will be spent in fiscal 2025 to provide school-based services to just under 530,000 students enrolled in Medicaid or MCHP and to support MDH technical assistance. The BRFA provision would allow the consortium to reimburse MCPA for the $12.7 million of general fund expenditures. **It should be noted that the fiscal 2025 allowance does not include general funds for this purpose within MCPA, and failure to adopt the BRFA provision would result in a general fund shortfall if MDH pursues federal approval to reimburse behavioral health services in schools as currently planned.**

## Administrative Claiming in Schools

In a September 2022 status report on Medicaid coverage of administrative costs in schools submitted in response to language in the fiscal 2023 Budget Bill, MDH indicated that Medicaid did not employ an administrative claiming program for school-based services at that time. The response highlighted that the U.S. Department of Health and Human Services Office of the Inspector General found vulnerabilities in school-based administrative claiming methodologies and deficiencies in time-study methodologies at both the State and federal levels, leading to a significant volume of improper payments. Federal guidance for states on school-based administrative claiming had not been updated since calendar 2003, and MDH reported that it would not consider the steps needed to implement an administrative claiming program until new guidance was issued.

CMS released *Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming* in May 2023 that provides guidance for Maryland to develop an administrative claiming program. Although the federal guidance was updated, MDH noted that implementation will still be complex and require extensive planning and technical assistance. Early planning for an administrative claiming program will entail MDH developing cost report templates and methodology to receive federal fund participation and for local education agencies (LEA) to receive Medicaid reimbursement of administrative costs for their school-based health services. MDH did not provide a timeframe for implementing phase two and a new administrative claiming program but estimated that $3 million across both fiscal 2025 and 2026 would be needed for technical assistance. The fiscal 2025 allowance does not include funding in MCPA for this purpose.

**MDH should clarify the following related to development of a new administrative claiming program:**

- **the process for implementing the program, including tasks to be completed by MDH, the Maryland State Department of Education, and LEAs;**
- **required federal approvals and State regulatory or legislative changes;**
- **the estimated total cost to the State and projected federal fund claiming; and**
- **the anticipated timeline for each step of the development process and implementation.**

## Medicaid Claiming in SBHCs

In response to committee narrative in the 2023 *Joint Chairmen's Report* (JCR), MDH submitted a report on Medicaid claims for SBHCs and efforts to expand Medicaid claiming. Key findings from the report included that in calendar 2023 year to date (reported as of June 2023), SBHCs billing Medicaid for visits increased to 50 from 32 in calendar 2021, and the number of billed visits increased to 4,455 from 1,532 in calendar 2022. MDH found that the majority of

Medicaid billing in SBHCs is conducted by Federally Qualified Health Centers (FQHC) serving as sponsoring organizations. However, MDH also noted that 72% of billed visits were provided by SBHCs under just two sponsoring organizations. Despite the improvement in Medicaid billing in SBHCs, MDH reported continued barriers for Medicaid reimbursement, including the following findings from a survey of SBHCs:

- 63% of SBHCs did not bill for services they consider confidential;
- 44% of SBHCs reported a lack of accurate patient insurance information;
- 38% of SBHCs reported that MCOs did not recognize them as a self-referred provider; and
- 25% of SBHCs reported coding errors.

Considering these results, MDH described the following efforts to minimize barriers for SBHCs to bill Medicaid:

- ensuring all SBHCs implement an electronic medical record;
- facilitating connection of each SBHC to the health information exchange (Chesapeake Regional Information System for our Patients (CRISP));
- investigating MCO claim denials to understand what actions by the SBHC or MCO commonly lead to denials;
- assigning National Provider Identifiers to individual sites of care under local health departments and FQHCs that sponsor SBHCs; and
- integrating Early and Periodic Screening, Diagnosis, and Treatment Program enrollment with SBHC program approval procedures for new SBHCs.

## 2. State Legislation Impacting Medicaid Coverage and Requirements

Legislation from the 2023 session altered Medicaid program coverage and requirements, with select changes described as follows. MDH indicated that the fiscal 2025 budget incorporates projected costs for each piece of legislation as needed through the calendar 2024 MCO rate-setting process.

- ***Biomarker Testing:*** Chapters 322 and 323 of 2023 require Medicaid, beginning July 1, 2025, to provide coverage for biomarker testing for the diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence. When Chapters 322 and 323 were enacted, MDH was

already in the process of implementing biomarker testing specifically for cancer treatment when used to determine if a specific medication or therapy will be more effective in treatment, thereby guiding clinical management. Based on a 1% uptake of biomarker testing for cancer treatment, MDH included a total cost impact of approximately $2.6 million in calendar 2024 MCO rates.

Due to the effective date of July 1, 2025, for expanding biomarker testing under Medicaid, the proposed budget does not reflect an impact from the legislation. However, MDH anticipated a significant fiscal impact as many of the diseases and conditions covered under the legislation are prevalent in the Medicaid population, and an individual may require more than one biomarker test for certain diseases or multiple tests for more than one disease in a year. Chapters 322 and 323 require that, by December 1, 2024, MDH submit a report to the Governor and General Assembly on the fiscal impact of the expansion of biomarker testing coverage established in the legislation and recommendations for any legislative changes to the biomarker testing requirements relating to Medicaid and MCOs, among other information.

- ***Gender-affirming Treatment:*** Chapters 252 and 253 express the intent of the General Assembly that Medicaid provide gender-affirming treatment to all Medicaid recipients for whom gender-affirming treatment is medically necessary, including transgender, nonbinary, intersex, two-spirit, and other gender-diverse individuals. Beginning January 1, 2024, Medicaid is required to provide coverage for gender-affirming treatment, meaning any medically necessary treatment consistent with current clinical standards of care prescribed by a licensed health care provider for the treatment of a condition related to the individual's gender identity. MDH projected the total cost impact of Chapters 252 and 253 to be $8.4 million in calendar 2024 MCO rates.

- ***Collaborative Care:*** Chapters 284 and 285 of 2023 repeal the Collaborative Care Pilot Program and instead require MDH to implement and provide reimbursement for services rendered in accordance with the Collaborative Care Model statewide in primary care settings that provide health care services to Medicaid recipients. MDH added $15.7 million in calendar 2024 MCO rates to account for this reimbursement.

- ***Reimbursement for Prescription Drugs:*** Chapter 217 of 2023 requires MDH and the Prescription Drug Affordability Board to jointly study, by October 31, 2023, the total amount that MCOs paid pharmacies for prescription drug claims in calendar 2021 and 2022; what the total amount paid to pharmacies would have been if claims had been reimbursed at FFS rates; and how to best address the inconsistency between these amounts by considering the total cost to the State and recommending a methodology for determining the most accurate ingredient cost of a drug and an appropriate dispensing fee.

# *Operating Budget Recommended Actions*

1. Add the following language to the general fund appropriation:

, provided that since the Maryland Department of Health Medical Care Programs Administration (MCPA) has had four or more repeat audit findings in the most recent fiscal compliance audit issued by the Office of Legislative Audits (OLA), $100,000 of this agency's administrative appropriation may not be expended unless:

(1) MCPA has taken corrective action with respect to all repeat audit findings on or before November 1, 2024; and

(2) a report is submitted to the budget committees by OLA listing each repeat audit finding along with a determination that each repeat finding was corrected. The budget committees shall have 45 days from the receipt of the report to review and comment to allow for funds to be released prior to the end of fiscal 2025.

**Explanation:** The Joint Audit and Evaluation Committee has requested that budget bill language be added for each unit of State government that has four or more repeat audit findings in its most recent fiscal compliance audit. Each agency is to have a portion of its administrative budget withheld pending the adoption of corrective action by the agency and a determination by OLA that each finding was corrected. OLA shall submit a report to the budget committees on the status of repeat findings.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Status of corrective actions related to the most recent fiscal compliance audit | MCPA | 45 days before the release of funds |

2. Amend the following language on the general fund appropriation:

, provided that this appropriation shall be reduced by $216,845 contingent upon the enactment of legislation ~~extending the spending authority of the Integrated Care Network Fund into fiscal 2025~~ authorizing the transfer of excess special fund balance from the Health Information Exchange Fund in fiscal 2025.

**Explanation:** This action is a technical correction to amend contingent language reducing general funds to refer to the Health Information Exchange Fund and to make the reduction contingent on legislation authorizing the transfer of special fund balance in fiscal 2025.

3. Strike the following language on the federal fund appropriation:

~~, provided that $216,845 of this appropriation is contingent upon the enactment of legislation extending the spending authority of the Integrated Care Network Fund into fiscal 2025.~~

**Explanation:** This action strikes contingent language on the federal fund appropriation for the Office of Enterprise Technology as a technical correction. The language specifies that $216,845 in federal funds are contingent on legislation extending the spending authority of the Integrated Care Network Fund, which is a special fund.

4. Add the following language:

Provided that all appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funds may be transferred to program M00Q01.07 Maryland Children's Health Program. Funds not expended or transferred shall be reverted or canceled.

**Explanation:** This language restricts funding for Medical Care Provider Reimbursements to that purpose only and prevents budgetary transfers to any program except M00Q01.07 Maryland Children's Health Program.

5. Adopt the following narrative:

**Community First Choice (CFC) Program and Home and Community-based Options (Community Options) Waiver Financial and Registry Data:** Recent efforts to expand home and community-based services have led to significant increases in CFC program expenditures, including spending under the Community Options waiver. The committees request that the Maryland Department of Health (MDH) submit a report on CFC program spending. The report should include monthly enrollment, utilization, and cost data that aligns with actual fiscal 2024 and year-to-date fiscal 2025 budget expenditures under the CFC program. Additionally, the report should provide:

- the number of Community Options waiver slots filled and funded in fiscal 2024 and 2025 year to date;

- the number of Community Options waiver applications sent to individuals on the registry each month and the results of that outreach (including the number of applications returned and processed);

- an update on changes to registry operations to improve efficiency in taking individuals off of the registry and efforts to determine financial and medical eligibility for individuals while they remain on the registry;

- an update on MDH staffing supporting the Community Options waiver, including the number of vacant regular and contractual positions and the status of procuring additional staffing assistance;

- the number of individuals on the Community Options waiver registry as of June 30, 2024;

- an update on activities or efforts to implement the plan to reduce the Community Options waiver registry by 50% submitted to the General Assembly in February 2023; and

- details regarding the timing and amount of funds transferred from the Dedicated Purpose Account for End the Wait initiatives and to improve provider capacity.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Report on CFC program and Community Options waiver financial and registry data | MDH | August 1, 2024 |

6. Adopt the following narrative:

**Quarterly Medicaid Enrollment Change and Application Processing:** The Maryland Department of Health (MDH) will complete its 12-month unwinding process following the COVID-19 public health emergency on April 1, 2024, in which the department redetermined all Medicaid and Maryland Children's Health Program (MCHP) participants' eligibility. To continue to monitor the redetermination process after the unwinding period, the committees request that MDH submit quarterly reports with the following enrollment data on a monthly basis and divided by eligibility category:

- the number of eligibility renewals completed, including the number and share that were automatically renewed;

- the number of new individuals enrolled;

- measures of churn that reflect the number of individuals enrolled who previously received Medicaid or MCHP coverage and the timeframe of when they were last enrolled; and

- the number of individuals disenrolled, shown by reason for disenrollment, identifying procedural disenrollments and disenrollments due to overscaled income, aging out, and other common reasons for disenrollment.

Additionally, the committees request that the quarterly reports include the following administrative data on a monthly basis:

- call center volume, average wait times, and any other data related to call center activities that are required to be submitted to the Centers for Medicare and Medicaid Services; and

- measures of application processing times and the total number of applications processed for Modified Adjusted Gross Income (MAGI) cases and non-MAGI cases shown separately.

| **Information Request** | **Author** | **Due Date** |
|---|---|---|
| Quarterly reports on Medicaid and MCHP enrollment and applications | MDH | July 15, 2024<br>October 15, 2024<br>January 15, 2025<br>April 15, 2025 |

| | | **Amount Change** | |
|---|---|---|---|
| 7. | Reduce funding for increased health insurance costs as a technical correction. These expenditures are double budgeted as funding is already budgeted in the Statewide Account within the Department of Budget and Management for this purpose. | -$ 77,392<br>-$ 213,365 | GF<br>FF |

8. Add the following language:

Provided that all appropriations provided for program M00Q01.07 Maryland Children's Health Program are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funds may be transferred to program M00Q01.03 Medical Care Provider Reimbursements. Funds not expended or transferred shall be reverted or canceled.

**Explanation:** This language restricts funding for the Maryland Children's Health Program to that purpose only and prevents budgetary transfers to any program except M00Q01.03 Medical Care Provider Reimbursements.

| | |
|---|---|
| **Total Net Change** | **-$ 290,757** |
| **Total General Fund Net Change** | **-$ 77,392** |
| **Total Federal Fund Net Change** | **-$ 213,365** |

# *Updates*

## 1. Medicaid Expenditures on Abortion

Language attached to the Medicaid budget from fiscal 1979 to 2022 authorized the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must have certified 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 through 2022. The General Assembly amended the language regarding abortion services funded under Medicaid and MCHP in the fiscal 2023 Budget Bill to refer to any qualified provider of abortion services, as defined in Section 20-103 of the Health – General Article, and for the restrictive language to remain in effect for the first six months of fiscal 2023, contingent on enactment of Chapter 56 of 2022 (the Abortion Care Access Act). Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion. **Exhibit 19** provides a summary of the number and cost of abortions by service provider in fiscal 2021 through 2023.

**Exhibit 19**
**Abortion Funding under Medicaid**
**Fiscal 2021-2023**

| | Performed under 2021 State and Federal Budget Language | Performed under 2022 State and Federal Budget Language | Performed under 2023 State and Federal Budget Language |
|---|---|---|---|
| Abortions | 10,997 | 11,596 | 12,727 |
| **Total Cost ($ in Millions)** | **$7.2** | **$7.7** | **$7.9** |
| Average Payment Per Abortion | $652 | $661 | $617 |
| Abortions in Clinics | 8,831 | 9,459 | 10,865 |
| Average Payment | $464 | $459 | $456 |
| Abortions in Physicians' Offices | 1,811 | 1,647 | 1,303 |
| Average Payment | $1,088 | $1,094 | $1,053 |
| Hospital Abortions – Outpatient | 355 | * | * |
| Average Payment | $3,107 | $3,054 | $2,635 |
| Hospital Abortions – Inpatient | 0 | * | * |
| Average Payment | $0 | $19,968 | $60,211 |
| Abortions Eligible for Joint Federal/State | 0 | 0 | 0 |

*Indicates a dataset of less than 11 cases.

Note: Data for fiscal 2021 and 2022 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2023 includes all abortions for which a Medicaid claim was filed through November 2023. Providers have up to 12 months after the date of service to submit fee-for-service claims; therefore, Medicaid may receive additional claims for abortions performed during fiscal 2023. For example, for fiscal 2022, 29 additional claims were paid after November 2022, which explains differences in the fiscal 2022 data reported in this analysis compared to prior Medicaid budget analyses.

Source: Maryland Department of Health

**Exhibit 20** indicates the reasons that abortions were performed in fiscal 2023, according to the restrictions in the federal budget and State budget bill. Beginning on January 1, 2023, the amended budget language regarding abortion services authorized Medicaid and MCHP funds to cover abortion care services with restrictions that are consistent with Title 20, Subtitle 2 of the Health – General Article, also contingent on Chapter 56. The fiscal 2025 Budget Bill as introduced included language attached to the Medicaid and MCHP budgets that returned to the phrasing included in fiscal 1979 to 2022 budget bills, authorizing the use of State funds to pay for abortions

under specific circumstances. However, Supplemental Budget No. 1 to the fiscal 2025 Budget Bill includes a provision that would strike that language and would instead allow Medicaid-funded abortions as defined in statute.

**Exhibit 20**
## Abortion Services by Reason
**Fiscal 2023**

**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 2021 State budget.)

| | | |
|---|---|---|
| 1. | Likely to result in the death of the woman. | * |
| 2. | Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health. | 422 |
| 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. | 12,287 |
| 4. | Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality. | 17 |
| 5. | Victim of rape, sexual offense, or incest. | * |
| **Total Fiscal 2023 Claims Received Through November 2023** | | **12,726** |

*Indicates a dataset of less than 11 cases.

Source: Maryland Department of Health

## Appendix 1
## 2023 *Joint Chairmen's Report* Responses from Agency

The 2023 JCR requested that MCPA prepare nine reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Quarterly Reports on Medicaid and MCHP Eligibility Redetermination:*** Language in the fiscal 2024 Budget Bill required MDH to submit quarterly reports with monthly eligibility redetermination data and administrative measures, such as call center volume and application processing times. Three of four quarterly reports have been submitted, and $250,000 of the $500,000 in restricted general funds have been released as of February 12, 2024. Additional information regarding the administrative measures can be found in the performance analysis section and information regarding the Medicaid redetermination process can be found in the budget analysis section of this document.

- ***Medicaid Rates and Rate-setting Studies:*** MDH submitted a report in January 2024 outlining rate increases for providers of Medicaid LTSS, behavioral health, and DDA services. The report also provided updates on how rate structures were determined and the current status of rate-setting studies. Further discussion of provider rates and rate-setting studies can be found in the M00 – MDH Overview analysis.

- ***Corrective Actions for Closeout Audit Finding:*** The Office of Legislative Audits' (OLA) *Statewide Review of Budget Closeout Transactions for Fiscal Year 2022* included a finding that MDH could not support the propriety of $3.5 billion in accrued federal fund revenue as of June 30, 2022, among other findings. Considering this finding, the committees requested that MDH provide a report on corrective actions taken in response to this audit, and the department submitted this report on July 21, 2023. Additional information on this report, on OLA's fiscal 2022 closeout audit findings, and other audit findings concerning MDH can be found in the M00 – MDH Overview analysis.

- ***Referral Platform for Medicaid and MCHP Participants' Health-related Social Needs:*** MDH submitted a report in November 2023 regarding referral services for health-related social needs within existing platforms and the feasibility of developing a new closed-loop referral platform to connect Medicaid and MCHP participants with community-based organizations. MDH defined health-related social needs as unmet, adverse social conditions that contribute to poor health. Current referral services included those provided through CRISP and Maryland Primary Care Program and referral processes and strategies implemented by each Maryland MCO to address members' health-related social needs. According to the report, MCOs indicated to MDH that they would support required screening for a set of health-related social need domains and see potential benefits to a statewide referral platform. On December 21, 2023, $100,000 in general funds restricted pending receipt of this report was released.

- ***CFC Program and HCBS Waiver Financial and Registry Data:*** In September 2023, MDH submitted the first of two requested reports on HCBS provided through the CFC program and Community Options Waiver program. The report provided enrollment, utilization, and spending data for both programs. MDH also reported registry, outreach, and application outcome information for the Community Options Waiver program. Additional information about the Community Options Waiver program and other Medicaid HCBS waivers can be found in the M00 – MDH Overview analysis. As of February 10, 2024, the second requested report had not been submitted.

- ***Rate Adjustments for Dental Services under Medicaid:*** MDH submitted a report detailing reimbursement rate increases for dental services provided under the Maryland Medicaid Healthy Smiles dental program in fiscal 2015, 2023, and 2024. The report specified that dental reimbursement rates are the same across all coverage groups, including adults ages 21 and older who received dental benefits, effective January 1, 2023. Additionally, the report provided dental payment rates effective August 1, 2023, which reflect fiscal 2024 increases for all 66 preventive and restorative services. MDH compared Medicaid dental rates with median fees charged by dentists to commercial payers (noting that rates paid would typically be lower than fees charged via contract) and found that Medicaid rates were significantly lower. Compared to neighboring states' weighted average Medicaid dental rates for high-volume procedures, Maryland had the third highest rates out of six states.

- ***EID Program Eligibility Requirements:*** The committees requested that MDH submit a report on the EID program, also known as the Medicaid Buy-in. Specifically, the committees requested enrollment and expenditure data following changes to the program's eligibility requirements. As of February 10, 2024, MDH had not submitted a report.

- ***Community Options Waiver Care Plan Backlog:*** The committees requested that MDH submit monthly reports on the progress in addressing the outstanding care plan backlog under the Community Options Waiver program. As of February 10, 2024, no monthly reports had been submitted.

- ***Remote Services Model for Adult Medical Day Care:*** MDH submitted a report in October 2023 providing the purpose and goals of medical day care services, such as providing health support services and maximizing optimal health functioning and independence in program participants. The report detailed the impacts of the COVID-19 PHE on medical day care centers, including closures and implementation of a temporary remote service model delivered through telephonic service. To provide financial assistance during extended closures, MDH also distributed a percentage of the in-person per diem rate for administrative costs of remote services. Following the COVID-19 PHE, the Medical Adult Day Care Advisory Committee recommended the adoption of a permanent remote service delivery model and offered two models. As of the submission of the report, Maryland was still determining if a remote service delivery model is feasible and in the best interest of program participants.

## Appendix 2
## Audit Findings
## MDH – Medical Care Programs Administration

| | |
|---|---|
| Audit Period for Last Audit: | August 1, 2018 – March 31, 2022 |
| Issue Date: | November 2023 |
| Number of Findings: | 10 |
| Number of Repeat Findings: | 6 |
| % of Repeat Findings: | 60% |
| Rating: (if applicable) | Unsatisfactory |

***Finding 1:*** **MCPA did not ensure that all referrals of potential third-party health insurance information were investigated and recorded in the Medicaid Management Information System (MMIS), which could result in MCPA improperly paying claims that should have been paid by a third party.**

***Finding 2:*** **MCPA did not have effective processes to identify, prevent, and recover questionable Medicaid payments, including $7.1 million in payments on behalf of incarcerated and deceased recipients.**

***Finding 3:*** MCPA did not ensure that changes to recipient Medicaid eligibility information were processed timely and accurately.

***Finding 4:*** **MCPA had not established adequate oversight to ensure that all CFC program recipients received personal assistance services in accordance with their plans of service.**

***Finding 5:*** **MCPA did not monitor the utilization control agent contractor to ensure continued stay reviews of Medicaid recipients receiving services from nursing facilities were performed timely.**

***Finding 6:*** **MCPA did not have an established process to ensure costly recipient ventilator care claims submitted by nursing facilities were valid, as required by State regulations.**

***Finding 7:*** **MCPA did not conduct the required audits of Medical Day Care and Supports Planning providers, and the related audit policy and procedures were not sufficiently comprehensive.**

***Finding 8:*** MCPA did not adequately monitor the hospital claims audit contractor and had not collected or recovered improper claims identified by the contractor totaling $6.9 million.

***Finding 9:*** Redacted cybersecurity-related finding.

***Finding 10:*** Redacted cybersecurity-related finding.

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

## Appendix 3
## Audit Findings
## MDH – MCPA Managed Care Program

| | |
|---|---|
| Audit Period for Last Audit: | April 1, 2019 – March 31, 2022 |
| Issue Date: | December 2023 |
| Number of Findings: | 4 |
| Number of Repeat Findings: | 2 |
| % of Repeat Findings: | 50% |
| Rating: (if applicable) | N/A |

***Finding 1:*** MCPA procedures were not sufficiently comprehensive to ensure the validity of MCO reported expenditure data used in the capitation rate calculation.

***Finding 2:*** **MCPA did not have comprehensive procedures to ensure that ineligible costs reported by MCOs were excluded from the capitation rate calculation.**

***Finding 3:*** **MCPA did not have an effective process to identify capitation payments to MCOs for incarcerated individuals, resulting in approximately $14 million in improper payments during fiscal 2019 to 2022.**

***Finding 4:*** MCPA did not investigate and recover potentially improper supplemental payments to MCOs for newborn deliveries totaling $10.4 million.

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

## Appendix 4
# MMIS II, Also Known as the Medicaid Enterprise Systems Modular Transformation
### Major Information Technology Development Project
### Maryland Department of Health

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **New/Ongoing:** Ongoing | | | | | | | | |
| **Start Date:** July 1, 2016 | | | | **Est. Completion Date:** March 1, 2029 | | | | |
| **Implementation Strategy:** Agile | | | | | | | | |
| **($ in Millions)** | **Prior Year** | **2024** | **2025** | **2026** | **2027** | **2028** | **Remainder** | **Total** |
| **GF** | $45.562 | $17.500 | $9.810 | $3.056 | $0.000 | $0.000 | $0.000 | $75.929 |
| **FF** | 314.932 | 198.769 | 63.710 | 66.422 | 55.847 | 46.762 | 0.000 | 746.442 |
| **Total** | **$360.494** | **$216.269** | **$73.520** | **$69.479** | **$55.847** | **$46.762** | **$0.000** | **$822.370** |

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

- ***Project Summary*:** This longstanding MITDP replaces Medicaid's antiquated and inflexible legacy information system with a modern MMIS. MDH has completed a Medicaid IT Architecture self-assessment of its business operations and subsequently developed a roadmap for procurement, replacement, and implementation of various modular systems, including:

  - Business Process Reengineering (formerly referred to as Customer Relationship Management);
  - Decision Support System/Data Warehouse;
  - Pharmacy Point-of-sale Electronic Claims Management System;
  - Behavioral Health Administrative Service Organization (BHASO);
  - TierPoint Migration of the Electronic Data Interchange Transaction Processing System;
  - eMedicaid migration to the Maryland Total Human-services Information Network (MD THINK);
  - No Wrong Door project integrating application transfers between Maryland Health Connection and eligibility and enrollment;
  - Nonemergency Medical Transportation
  - CMS Interoperability; and

- other business processes, such as provider and financial management, enterprise security, surveillance and utilization reviews, and core MMIS services.

- ***Need:*** The legacy MMIS was installed in 1995 and is unable to meet the needs of Maryland's increasingly complex Medicaid program. Three key goals of the new modular systems are (1) real-time and automated adjudication of claims (part of core MMIS implementation); (2) a new financial management system to automate the federal fund claims process; and (3) improved reporting capability. MDH will also integrate services through the MD THINK cloud-based platform as applicable.

- ***Changes:*** The timeline for this project has been pushed out considerably from an estimated completion date of September 30, 2017, to project components being completed in March 2029. Despite this delay, estimated total project costs presented in the 2024 session have decreased by $134.9 million, or 14%, compared to estimated costs in the 2023 session. IT project requests for this project were also sent separately for each component in January 2024, rather than all components described in one report as was done in the past.

- ***Concerns:*** The BHASO module go-live was a complete failure, with defects continuing to be resolved. A new roadmap and timeline have been necessary after the COVID-19 pandemic further delayed procurements and work on some modules.

- ***Other Comments:*** CMS may approve 90% federal financial participation for design, development, or installation of MMIS costs. MDH completed the required assessment and documentation to receive enhanced federal fund participation for eligible expenses under the MMIS II project. The current budget reflects a federal fund participation rate of 90%.

## Appendix 5
## Long Term Services and Supports Tracking System
### Major Information Technology Development Project
### Maryland Department of Health

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **New/Ongoing:** Ongoing | | | | | | | | |
| **Start Date:** July 1, 2020 | | | | **Est. Completion Date:** June 30, 2029 | | | | |
| **Implementation Strategy:** Waterfall and Agile mix | | | | | | | | |
| **($ in Millions)** | **Prior Year** | **2024** | **2025** | **2026** | **2027** | **2028** | **Remainder** | **Total** |
| **GF** | $33.540 | $0.167 | $3.834 | $3.834 | $3.834 | $11.503 | $0.000 | $56.713 |
| **FF** | 184.493 | 29.516 | 26.077 | 26.077 | 26.077 | 78.231 | 0.000 | 370.470 |
| **Total** | **$218.032** | **$29.683** | **$29.911** | **$29.911** | **$29.911** | **$89.734** | **$0.000** | **$427.183** |

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

- ***Project Summary:*** The LTSS tracking system 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 ACA, LTSS has been incorporating other modules to cover all HCBS under Medicaid, including services to the developmentally disabled.

- ***Need:*** This MITDP integrates many common functions across HCBS programs and allows the State to meet federal requirements for electronic visit verification (EVV) of personal care services.

- ***Observations and Milestones:*** In federal fiscal 2023, CMS certified LTSS EVV functions for Medicaid participants through a mobile application. This certification and further expansion of EVV to all HCBS waivers brings Maryland into compliance with the federal Twenty First Century Cures Act. LTSS expansion to DDA modules and functions is expected to be completed by the end of calendar 2025.

- ***Changes:*** The project's scope has been expanded beyond DDA modules to include case management and billing modules for other HCBS waivers, such as the Autism Waiver and Model Waiver, that extend the estimated project completion date from calendar 2025 to 2029. Estimated total project costs presented in the 2024 session also rose substantially due to this change, increasing by $93.7 million compared to estimates provided during the 2023 session.

- ***Concerns:*** One identified risk for the LTSS project is sponsorship, concerning both the lack of an authority to serve as sponsor of the project and engagement with stakeholder groups. MDH identified other factors as medium risk, such as interdependencies among State agencies, funding availability through federal matching, and supportability through ongoing upgrades for maintaining a custom application.

- ***Other Comments:*** MDH received approval for enhanced federal financial participation for certain costs associated with this project. The department anticipates that this higher federal share of costs will continue through the life of this project, as fiscal 2028 projected costs are budgeted with an 87.2% federal matching rate.

## Appendix 6
## Federal Poverty Guidelines as of January 17, 2024
## (48 Contiguous States and the District of Columbia, Excluding Alaska and Hawaii)

| Household/ Family Size | 25% | 50% | 75% | 100% | 125% | 133% | 135% | 138% | 200% | 212% | 250% | 264% | 322% |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | $3,765 | $7,530 | $11,295 | $15,060 | $18,825 | $20,030 | $20,331 | $20,783 | $30,120 | $31,927 | $37,650 | $39,758 | $48,493 |
| **2** | 5,110 | 10,220 | 15,330 | 20,440 | 25,550 | 27,185 | 27,594 | 28,207 | 40,880 | 43,333 | 51,100 | 53,962 | 65,817 |
| **3** | 6,455 | 12,910 | 19,365 | 25,820 | 32,275 | 34,341 | 34,857 | 35,632 | 51,640 | 54,738 | 64,550 | 68,165 | 83,140 |
| **4** | 7,800 | 15,600 | 23,400 | 31,200 | 39,000 | 41,496 | 42,120 | 43,056 | 62,400 | 66,144 | 78,000 | 82,368 | 100,464 |
| **5** | 9,145 | 18,290 | 27,435 | 36,580 | 45,725 | 48,651 | 49,383 | 50,480 | 73,160 | 77,550 | 91,450 | 96,571 | 117,788 |
| **6** | 10,490 | 20,980 | 31,470 | 41,960 | 52,450 | 55,807 | 56,646 | 57,905 | 83,920 | 88,955 | 104,900 | 110,774 | 135,111 |
| **7** | 11,835 | 23,670 | 35,505 | 47,340 | 59,175 | 62,962 | 63,909 | 65,329 | 94,680 | 100,361 | 118,350 | 124,978 | 152,435 |
| **8** | 13,180 | 26,360 | 39,540 | 52,720 | 65,900 | 70,118 | 71,172 | 72,754 | 105,440 | 111,766 | 131,800 | 139,181 | 169,758 |
| **9** | 14,525 | 29,050 | 43,575 | 58,100 | 72,625 | 77,273 | 78,435 | 80,178 | 116,200 | 123,172 | 145,250 | 153,384 | 187,082 |
| **10** | 15,870 | 31,740 | 47,610 | 63,480 | 79,350 | 84,428 | 85,698 | 87,602 | 126,960 | 134,578 | 158,700 | 167,587 | 204,406 |
| **11** | 17,215 | 34,430 | 51,645 | 68,860 | 86,075 | 91,584 | 92,961 | 95,027 | 137,720 | 145,983 | 172,150 | 181,790 | 221,729 |
| **12** | 18,560 | 37,120 | 55,680 | 74,240 | 92,800 | 98,739 | 100,224 | 102,451 | 148,480 | 157,389 | 185,600 | 195,994 | 239,053 |
| **13** | 19,905 | 39,810 | 59,715 | 79,620 | 99,525 | 105,895 | 107,487 | 109,876 | 159,240 | 168,794 | 199,050 | 210,197 | 256,376 |
| **14** | 21,250 | 42,500 | 63,750 | 85,000 | 106,250 | 113,050 | 114,750 | 117,300 | 170,000 | 180,200 | 212,500 | 224,400 | 273,700 |

[1] The ACA expanded Medicaid coverage to individuals with household incomes below 138% of the FPL.
[2] Pregnant women can have higher household incomes and still qualify for Medicaid. The income eligibility threshold for pregnant women is 264% of FPL.
[3] The income eligibility threshold for children enrolled in MCHP is 322% of FPL. MCHP participants with household incomes above 212% pay monthly premiums, though premiums have been suspended through March 31, 2024.

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

**Appendix 7**
**Object/Fund Difference Report**
**MDH – Medical Care Programs Administration**

| Object/Fund | FY 23 Actual | FY 24 Working Appropriation | FY 25 Allowance | FY 24 - FY 25 Amount Change | Percent Change |
|---|---|---|---|---|---|
| **Positions** | | | | | |
| 01 Regular | 608.00 | 614.00 | 680.10 | 66.10 | 10.8% |
| 02 Contractual | 76.22 | 150.46 | 100.25 | -50.21 | -33.4% |
| **Total Positions** | **684.22** | **764.46** | **780.35** | **15.89** | **2.1%** |
| **Objects** | | | | | |
| 01 Salaries and Wages | $ 60,089,826 | $ 64,220,640 | $ 74,202,840 | $ 9,982,200 | 15.5% |
| 02 Technical and Special Fees | 5,447,065 | 8,731,647 | 7,621,825 | -1,109,822 | -12.7% |
| 03 Communication | 780,303 | 930,870 | 972,827 | 41,957 | 4.5% |
| 04 Travel | 60,782 | 293,930 | 336,838 | 42,908 | 14.6% |
| 06 Fuel and Utilities | 6,033 | 6,049 | 6,033 | -16 | -0.3% |
| 07 Motor Vehicles | 180 | 0 | 0 | 0 | 0.0% |
| 08 Contractual Services | 12,887,914,500 | 12,363,541,003 | 12,126,255,170 | -237,285,833 | -1.9% |
| 09 Supplies and Materials | 115,396 | 186,344 | 155,633 | -30,711 | -16.5% |
| 10 Equipment – Replacement | 68,046 | 188,526 | 163,496 | -25,030 | -13.3% |
| 12 Grants, Subsidies, and Contributions | 20,000,000 | 0 | 0 | 0 | 0.0% |
| 13 Fixed Charges | 242,075 | 329,192 | 332,129 | 2,937 | 0.9% |
| **Total Objects** | **$ 12,974,724,206** | **$ 12,438,428,201** | **$ 12,210,046,791** | **-$ 228,381,410** | **-1.8%** |
| **Funds** | | | | | |
| 01 General Fund | $ 3,782,828,825 | $ 4,203,871,002 | $ 4,046,536,824 | -$ 157,334,178 | -3.7% |
| 03 Special Fund | 783,861,830 | 671,862,302 | 729,460,255 | 57,597,953 | 8.6% |
| 05 Federal Fund | 8,301,399,708 | 7,474,451,746 | 7,337,922,245 | -136,529,501 | -1.8% |
| 09 Reimbursable Fund | 106,633,843 | 88,243,151 | 96,127,467 | 7,884,316 | 8.9% |
| **Total Funds** | **$ 12,974,724,206** | **$ 12,438,428,201** | **$ 12,210,046,791** | **-$ 228,381,410** | **-1.8%** |

Note: The fiscal 2024 appropriation does not include deficiencies. The fiscal 2025 allowance does not include contingent reductions or statewide salary adjustments budgeted within DBM.

**Appendix 8**
**Fiscal Summary**
**MDH – Medical Care Programs Administration**

| Program/Unit | FY 23 Actual | FY 24 Wrk Approp | FY 25 Allowance | Change | FY 24 - FY % Change |
|---|---|---|---|---|---|
| 01 Deputy Secretary for Health Care Financing | $ 63,773,470 | $ 29,880,582 | $ 13,094,644 | -$ 16,785,938 | -56.2% |
| 02 Enterprise Technology - Medicaid | 15,929,602 | 19,571,757 | 16,748,119 | -2,823,638 | -14.4% |
| 03 Medical Care Provider Reimbursements | 12,389,699,157 | 11,755,880,616 | 11,527,614,586 | -228,266,030 | -1.9% |
| 04 Office of Health Services | 39,685,503 | 71,855,072 | 81,899,182 | 10,044,110 | 14.0% |
| 05 Office of Finance | 7,988,531 | 8,612,803 | 10,211,439 | 1,598,636 | 18.6% |
| 07 Maryland Children's Health Program | 357,563,650 | 301,152,633 | 424,856,661 | 123,704,028 | 41.1% |
| 08 Major Information Technology Development Projects | 75,436,680 | 223,702,411 | 105,942,314 | -117,760,097 | -52.6% |
| 09 Office of Eligibility Services | 13,734,541 | 16,759,779 | 17,935,767 | 1,175,988 | 7.0% |
| 11 Senior Prescription Drug Assistance Program | 10,913,072 | 11,012,548 | 11,744,079 | 731,531 | 6.6% |
| **Total Expenditures** | **$ 12,974,724,206** | **$ 12,438,428,201** | **$ 12,210,046,791** | **-$ 228,381,410** | **-1.8%** |
| General Fund | $ 3,782,828,825 | $ 4,203,871,002 | $ 4,046,536,824 | -$ 157,334,178 | -3.7% |
| Special Fund | 783,861,830 | 671,862,302 | 729,460,255 | 57,597,953 | 8.6% |
| Federal Fund | 8,301,399,708 | 7,474,451,746 | 7,337,922,245 | -136,529,501 | -1.8% |
| **Total Appropriations** | **$ 12,868,090,363** | **$ 12,350,185,050** | **$ 12,113,919,324** | **-$ 236,265,726** | **-1.9%** |
| Reimbursable Fund | $ 106,633,843 | $ 88,243,151 | $ 96,127,467 | $ 7,884,316 | 8.9% |
| **Total Funds** | **$ 12,974,724,206** | **$ 12,438,428,201** | **$ 12,210,046,791** | **-$ 228,381,410** | **-1.8%** |

Note: The fiscal 2024 appropriation does not include deficiencies. The fiscal 2025 allowance does not include contingent reductions or statewide salary adjustments budgeted within DBM.