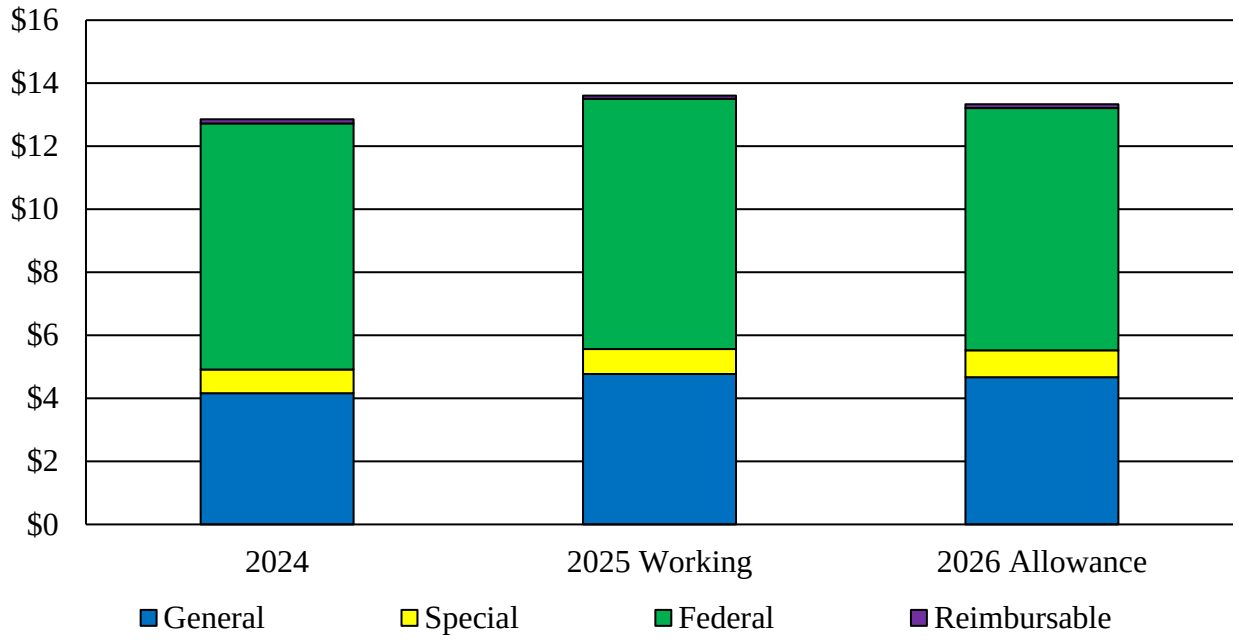
M00Q01
Medical Care Programs Administration
Maryland Department of Health

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 2026 Budget Decreases $269.1 Million, or 2.0%, to $13.3 Billion
($ in Billions)



Note: The fiscal 2025 working appropriation accounts for deficiencies and contingent reductions. The fiscal 2026 allowance accounts for contingent reductions. The fiscal 2025 impacts of statewide salary adjustments are centrally budgeted in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2026 impacts of the fiscal 2025 statewide salary adjustments appear in this agency's budget. The fiscal 2026 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget.

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- MCPA's fiscal 2026 allowance decreases by $269.1 million compared to the fiscal 2025 working appropriation, after adjusting for proposed deficiencies and contingent general fund reductions, including a deficiency to cover a fiscal 2024 shortfall of $509.9 million ($231.7 million in general funds). When excluding the fiscal 2024 expenses from the fiscal 2025 budget, the fiscal 2026 allowance increases by $240.7 million.

- This additional spending is mainly attributed to provider rate increases and hospital costs totaling $315.0 million and expenditures for enrollment growth among MCHP participants and noncitizen pregnant individuals covered through the Healthy Babies initiative totaling $90.8 million. Payments to managed care organizations (MCO) also increase by $159.1 million to adjust for higher health acuity among Medicaid recipients and to annualize costs of certain coverage of anti-obesity medication. Additionally, spending on major information technology development projects (MITDP) within MCPA increases by $67.5 million. A decrease of $471.0 million in Medicaid reimbursements partially offsets the spending growth to account for projected enrollment declines and utilization assumptions.

- Compared to the adjusted fiscal 2025 working appropriation, the adjusted fiscal 2026 allowance decreases by a total of $357.6 million in combined general fund and federal fund spending. In comparison, special fund spending increases by $64.8 million, largely due to the year-over-year increase of $50 million in the Medicaid hospital deficit assessment, contingent on enactment of a provision in the Budget Reconciliation and Financing Act (BRFA) of 2025 increasing the assessment by $50 million in fiscal 2025 and $100 million in fiscal 2026. The fiscal 2026 budget plan includes associated general fund reductions of $46.25 million in fiscal 2025 and $92.5 million in fiscal 2026 contingent on the enactment of this BRFA provision.

Key Observations

- ***Medicaid Is a Key Driver in Overall General Fund Spending Growth and Projected Shortfalls:*** Recent spending growth in Medicaid and MCHP beginning in fiscal 2024 has contributed to out-year structural shortfalls projected in the overall general fund forecast. Despite a large share of pending growth being attributed to Medicaid, the fiscal 2026 budget plan does not include many cost containment actions in Medicaid or MCHP. The only substantial action is a fund swap, under which a provision in the BRFA proposes to increase the Medicaid deficit assessment on an ongoing basis. Other planned cost containment includes a reversion of $500,000 in fiscal 2025 that was added by the Maryland General Assembly (MGA) for medical day care services providers and a reduction of $166,000 in total funds to eliminate oversight of Hepatitis C medications covered by MCOs. Additional cost containment options may be needed to limit Medicaid and MCHP spending, especially considering the uncertainty of federal policies that could increase State fund need to support the Medicaid program and MCHP.

- ***Potential Federal Changes to Medicaid Would Have Significant Budgetary Impacts:*** Maryland currently receives substantial federal fund participation through a matching rate of 50% for most costs to implement Medicaid, with some groups receiving enhanced matching rates of 65% and 90%. Possible changes at the federal level to this reimbursement model, including reducing the enhanced matching rates or transitioning Medicaid to a block grant or per capita cap, would significantly reduce federal support for Medicaid and MCHP, which is assumed to cover approximately $7.6 billion in spending in fiscal 2026.

- ***Medicaid Reimbursement of Behavioral Health Services in Schools:*** Beginning on January 1, 2025, MDH implemented Phase 1 of its school-based services expansion to reimburse behavioral health services provided by school psychologists and school social workers to Medicaid eligible students. Prior to this expansion, Medicaid only reimbursed for school-based services provided through an approved Individualized Education Programs (IEP) or Individualized Family Service Plans (IFSP). Phase 2 of the expansion includes establishing an administrative claiming program, but this expansion is more complex and is not expected to begin until at least fiscal 2027.

Operating Budget Recommended Actions

		Funds	**Positions**
1.	Add language restricting medical care provider reimbursement funding to that purpose.		

		Funds	Positions
2.	Reduce general funds within the Medicaid program and authorize a budget amendment to be processed to replace these funds with special funds in recognition of available Cigarette Restitution Fund support.	-$ 25,000,000	
3.	Reduce funding for the Population Health Incentive Program in fiscal 2026.	-$ 18,000,000	
4.	Reduce funding for Medicaid provider reimbursements to lower rates for managed care organizations to the bottom of the actuarially sound range.	-$ 90,700,000	
5.	Delete funding for the 1% provider rate increase budgeted in fiscal 2026 for Long Term Services and Supports providers.	-$ 21,229,715	
6.	Reduce general funds budgeted to account for hospital assessment revenue collected by the Health Services Cost Review Commission to be transferred to the Medicaid Primary Care Fund and authorize a budget amendment to replace these funds with special funds.	-$ 16,000,000	
7.	Reduce funding for Medicaid provider reimbursements to level fund physician evaluation and management rates at 98% of Medicare rates.	-$ 12,200,000	
8.	Reduce funding for the expansion in the Assistance in Community Integration Services waiver.	-$ 10,800,000	
9.	Reduce funding for Health Home payments as a technical correction due to these expenditures being double budgeted.	-$ 18,225,532	
10.	Reduce provider rates by 2% for home and community-based services providers.	-$ 7,400,000	
11.	Reduce funding for Medicaid reimbursements based on reduced enrollment expectations.	-$ 90,000,000	
12.	Adopt narrative requesting a report on the Community First Choice program and Home and Community-based Options Waiver financial and registry data.		
13.	Adopt narrative requesting quarterly reports with monthly enrollment change, application processing, and call center data.		

		Funds	Positions
14.	Adopt narrative requesting a report on primary care initiatives administered by the Maryland Department of Health and Health Services Cost Review Commission.		
15.	Add language restricting Maryland Children's Health Program funding to that purpose.		
16.	Reduce funding for reimbursements under the Maryland Children's Health Program based on reduced enrollment expectations for participants in the Healthy Babies initiative.	-$ 42,800,000	
17.	Delete funding for 13 long-term vacant positions that have remained unfilled for more than two years, including 11 positions in the Office of Eligibility Services and 2 positions in Benefits Management and Provider Services.	-$ 775,032	-13.0
18.	Reduce funding in the fiscal 2025 proposed deficiency appropriation for Medicaid reimbursements based on unallocated funding under the Population Health Incentive Program.	-$ 9,168,116	
19.	Reduce funding from a fiscal 2025 deficiency appropriation to account for recoveries from the calendar 2021 and 2022 risk corridor and based on lower anticipated healthcare utilization, particularly for inpatient hospital services.	-$ 262,500,000	
	Total Net Change to Fiscal 2025 Deficiency Appropriation	**-$ 271,668,116**	
	Total Net Change to Allowance	**-$ 353,130,279**	13.0

Budget Reconciliation and Financing Act Recommended Actions

1. Amend a provision to establish a Medicaid Primary Card Program Fund as a technical correction to change Card to Care and refer to the Health Services Cost Review Commission, rather than the Health Services Review Commission.
2. Reject the provision in the Budget Reconciliation and Financing Act of 2025 authorizing the Maryland Department of Health to transfer funds among its budgetary programs.
3. Amend a provision to increase the authorized fund balance transfer from the Maternal and Child Health Population Health Improvement Fund to the General Fund from $10.0 million to $14.1 million.

4. Add a provision to expand the allowable uses of funds received from litigation related to the Cigarette Restitution Fund that is placed in a separate account to support Medicaid expenses in fiscal 2026 only.

5. Add a provision to expand the allowable uses of the Senior Prescription Drug Assistance Program Fund in fiscal 2026 and future years to include depositing funds into health reimbursement accounts of certain State retirees transitioning to Medicare Part D to align with the budget.

6. Add a provision to delay the expansion of biomarker testing to conditions other than cancer, required by Chapters 322 and 323 of 2023, from July 1, 2025 to July 1, 2027.

Updates

- ***Medicaid Expenditures on Abortion:*** Annual data on abortion care services are provided. Effective November 2024, MDH expanded coverage of abortion care services to include all pregnant individuals enrolled in Medicaid, including those in the Medicaid Family Planning Program.

- ***Fiscal 2024 Closeout Audit Findings:*** The Office of Legislative Audits (OLA) reported two repeat findings for MDH in the *Statewide Review of Budget Closeout Transactions for Fiscal Year 2024*.

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, 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 individuals, elderly or disabled individuals, low-income parents, and low-income childless adults. To qualify for benefits, applicants must meet certain income and asset limits.

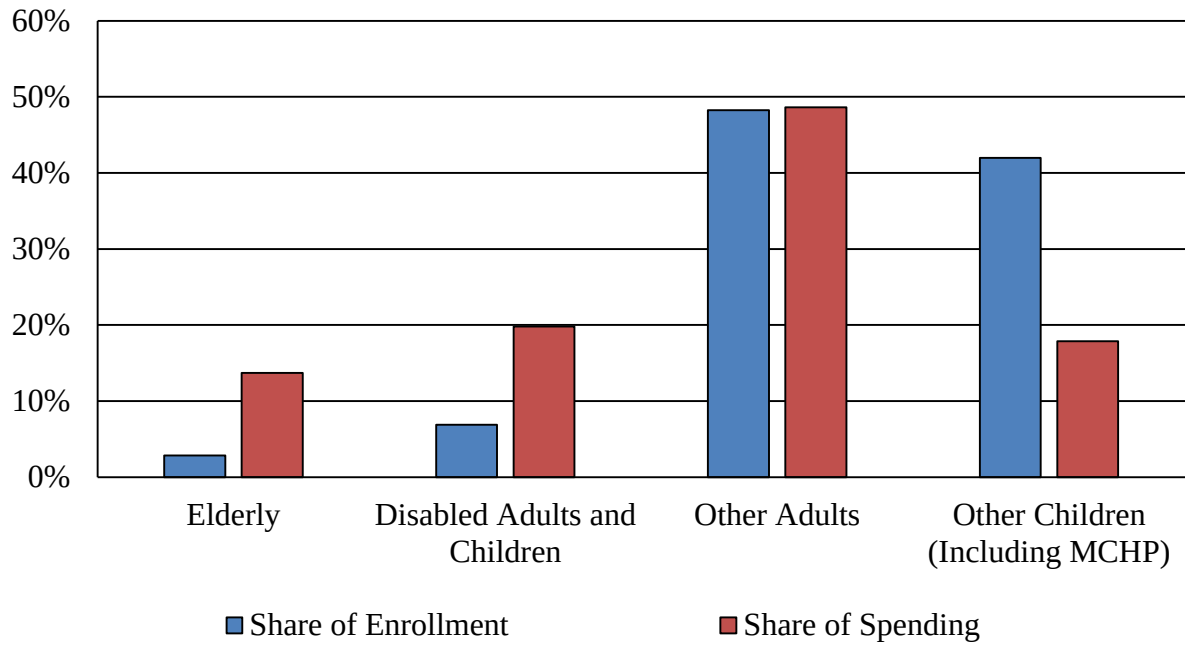
Income eligibility levels vary based on the individual's age and pregnancy status, among other factors. Individuals receiving cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. Pregnant individuals 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 17**.

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 2024 as an example, disabled adults and children represented only 6.9% of average monthly enrollment, while this group accounted for 19.8% of medical care reimbursements. Elderly Marylanders receiving Medicaid

also accounted for a larger share of costs (13.7%) relative to their share of enrollment (2.9%). 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 42.0% of average monthly enrollment but only account for 17.9% of fiscal 2024 Medicaid and MCHP costs.

Exhibit 1
Relative Medicaid and Maryland Children's Health Program Spending and Enrollment by Eligibility Group
Fiscal 2024



MCHP: Maryland Children's Health Program

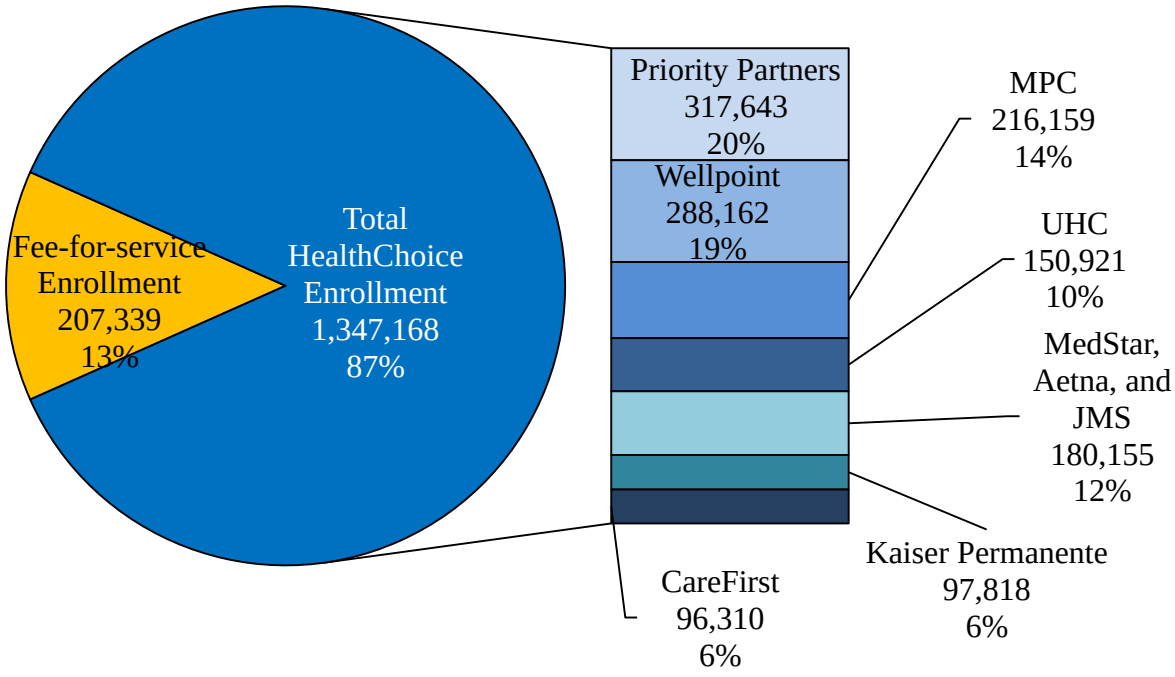
Source: Maryland Department of Health; Department of Legislative Services

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 individuals. 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 2024 were enrolled in HealthChoice under one of nine MCOs 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 a FFS basis.

Exhibit 2
Managed Care and Fee-for-service Medicaid and Maryland Children's Health Program Enrollment
As of December 2024



Total Medicaid and MCHP Enrollment = 1.55 Million

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

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. Beginning in May 2024, MDH eliminated the MCHP premium plan and the requirement that families with income above 212% of FPL pay a family contribution for MCHP coverage in accordance with Chapter 47 of 2024. Participating families in MCHP premium previously paid a monthly premium of about 2% of their income. However, these premiums had been suspended during the national declaration of a COVID-19 public health emergency (PHE) and, due to an MDH extension of the pause, 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, the program no longer has a maximum income level for eligibility. 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:

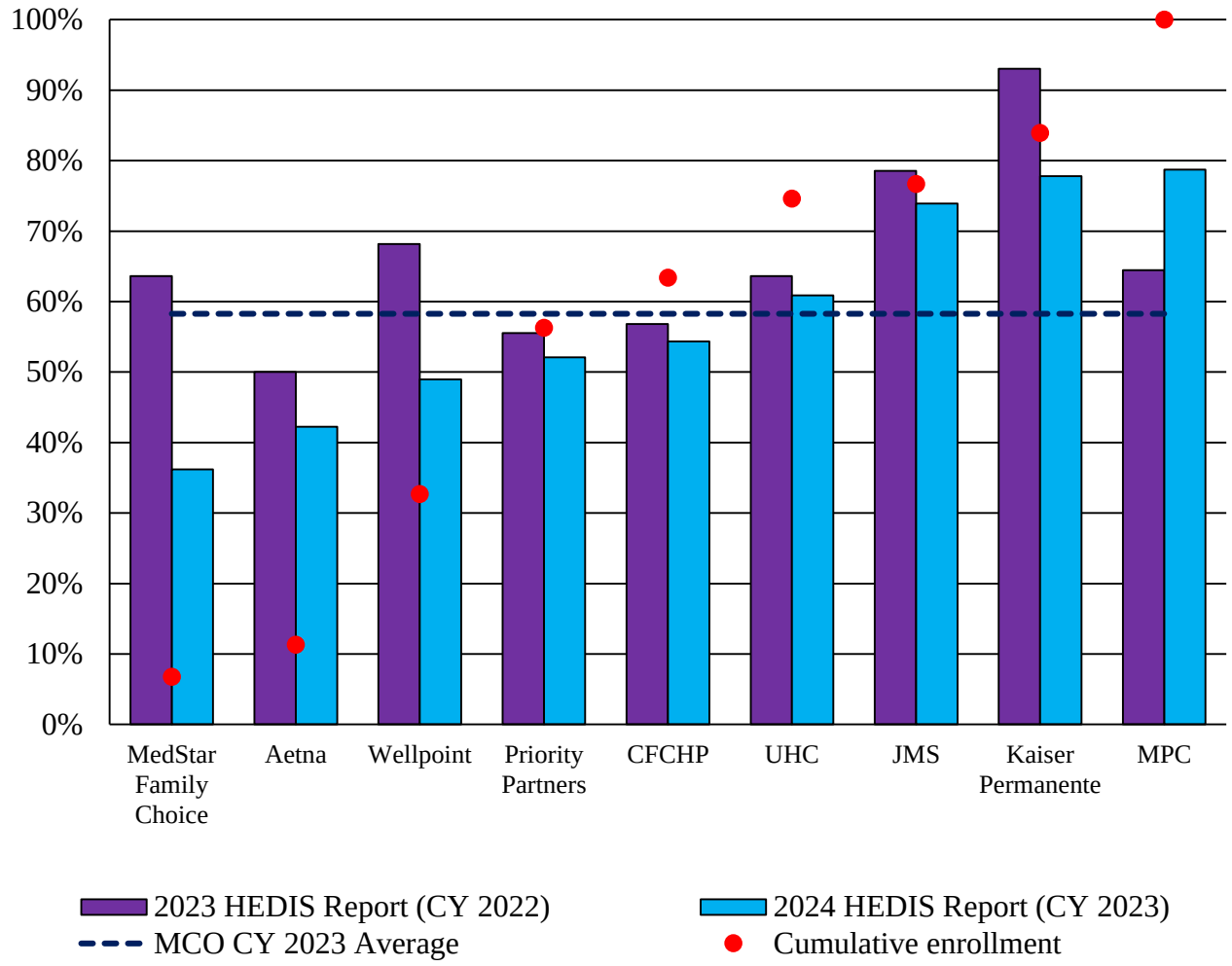
- Healthcare Effectiveness Data and Information Set (HEDIS) data collection;
- record reviews and network adequacy testing to monitor operations;
- survey collections to evaluate enrollee and provider satisfaction;
- an annual technical report for general program management and oversight; and
- the HealthChoice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

HEDIS Performance Monitoring

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 U.S. health plans, including commercial, Medicare, health benefit exchange, and Medicaid plans. MetaStar analyzed calendar 2023 HEDIS data in a report presented to MDH in December 2024 and included 51 measures across multiple quality domains (for example, effectiveness of care and access or availability of care) and consumer assessment scores. Some of the published measures have multiple components. MDH uses a slightly smaller set of measures and components for MCO quality monitoring than the total HEDIS measures collected. This analysis uses the smaller data set provided by MDH, which consisted of 45 measures in calendar 2022 and 38 measures in calendar 2023.

Exhibit 3 shows the percentage of measures at or above the national HEDIS mean for those components for which a national HEDIS mean was available and an individual MCO had a HEDIS score. Historically, Maryland's MCOs collectively outperform their peers nationally, though MCO performance on HEDIS measures worsened to an average of 50.8% of measures equal to or above the national mean in calendar 2021. MDH indicated that MCO performance worsened during the COVID-19 pandemic due to individuals delaying care and providers lacking capacity. After significantly improving in calendar 2022 the MCO average (65.9%), MCO performance regressed to 58.3% of measures equal to or above the national mean in calendar 2023.

Exhibit 3
Share of Measures Equal to or Above National Healthcare Effectiveness Data and Information Set Mean
Calendar 2022 to 2023, Enrollment as of December 2024



CFCHP: CareFirst Community Health Plan Maryland
CY: calendar year
HEDIS: Healthcare Effectiveness Data and Information Set
JMS: Jai Medical Systems
MCO: managed care organization
MPC: Maryland Physicians Care
UHC: UnitedHealthcare

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

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

All but one MCO reported lower shares of measures equal to or above the national mean in calendar 2023 compared to calendar 2024, ranging from declines of 27.5 percentage points for MedStar Family Choice to 2.5 percentage points for CareFirst Community Health Plan Maryland. Maryland Physicians Care (MPC) was the only MCO to show improvement, increasing from 64.4% to 78.7%. Kaiser Permanente previously reported a high of more than 90% of HEDIS components at or above the national mean in calendar 2022, but no other MCO achieved 80% or more in either year shown. The exhibit also displays the cumulative shares of MCO enrollment as of December 2024, illustrating that the four lowest performing MCOs in calendar 2023 serve more than half (56%) of HealthChoice enrollees.

On January 16, 2025, at a hearing of the Senate Finance committee, MDH outlined changes to MCO accountability expectations that are incorporated in the calendar 2025 HealthChoice agreement and impact the department's HEDIS performance monitoring policy starting with calendar 2025 HEDIS measures. Specifically, for MCOs that report HEDIS measures below the national average over multiple years, MDH restored an automatic freeze of Medicaid enrollee assignment to the affected MCOs. MDH also indicated that it would enforce more substantial financial penalties for moderate and major HEDIS performance issues. Another change prohibits an MCO from receiving any incentive payments through PHIP for measurement years in which the MCO experienced major HEDIS performance issues.

MDH should discuss the reasons for Maryland MCOs reporting declines in HEDIS performance compared to the national mean from calendar 2022 to 2023. Additionally, the department should detail its method for determining moderate or major HEDIS performance issues, including the circumstances when an automatic assignment freeze of new Medicaid enrollees, financial penalty, or exclusion from PHIP would apply to MCOs.

NCQA Accreditation and Star Ratings

Since January 1, 2015, MDH has required that all MCOs receive accreditation from NCQA to participate in the HealthChoice Program. New MCOs must receive accreditation within two years of program entry. 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 2023 results, all MCOs operating in Maryland were granted accreditation. This shows improvement over calendar 2022 when Priority Partners was placed on a provisional status and was under corrective action.

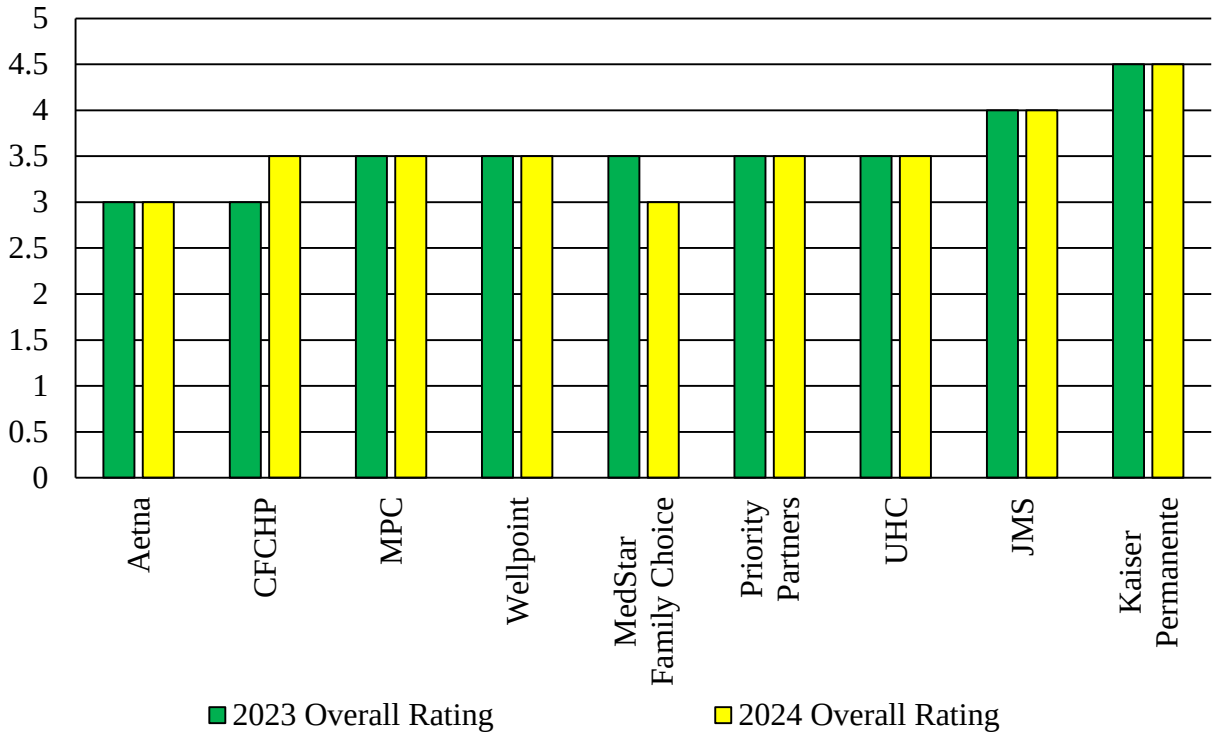
Beginning with the calendar 2025 HealthChoice agreement, MDH added a new requirement that MCOs must attain NCQA Health Equity Accreditation. NCQA determines Health Equity Accreditation based on health plans' activities to (1) support external health equity work; (2) collect data to create and offer language services and provider networks that account for participants' cultural and linguistic needs; and (3) identify opportunities to reduce health inequities. **MDH should provide the current status of NCQA health equity accreditation for each MCO and the timeframe for this new accreditation requirement to be enforced.**

NCQA also implements a star rating system for each MCO, with one star designating the lowest performance and five stars designating the highest performance. 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 equity; and treatment. For example, patient experience assesses the experience of care with doctors, and plan services and prevention and equity 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 4**, in calendar 2024, all Maryland MCOs received at least three stars for their overall ratings, and one MCO (Kaiser Permanente) received 4.5 stars. Seven of nine MCOs received the same rating as in calendar 2023, with only CareFirst gaining a half-point and MedStar Family Choice decreasing by a half-point.

Exhibit 4

National Committee for Quality Assurance Health Plan Overall Star Ratings for Maryland Managed Care Organizations

Published September 2023 and September 2024



CFCHP: CareFirst Community Health Plan Maryland
JMS: Jai Medical Systems
MPC: Maryland Physicians Care
NCQA: National Committee for Quality Assurance
UHC: UnitedHealthcare

Source: Maryland Department of Health; National Committee for Quality Assurance

2. Calendar 2023 Population Health Incentive Program 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 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 selected 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, MDH replaced the VBP program with PHIP. The new program 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. Each MCO can receive a maximum incentive of up to 0.5% of its total capitation payments based on the budgeted amount of $36 million in total funds in each year for fiscal 2025 and 2026. PHIP 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 by benchmark percentiles of national HEDIS performance among Medicaid health maintenance organizations (HMO) or Maryland MCO performance for non-HEDIS measures, from "strong performance" (in which a measure is between the fiftieth and seventy-fifth percentile) to "superlative performance" (in which an MCO is at or above the ninetieth percentile). 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 Medicaid HMO 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 that could redistribute incentives across MCOs so that top performers receive a maximum of 1% of their total capitation between the two rounds. PHIP regulations cap total incentive payments at 1% of each MCO's capitated payments each year, although recent budgets have provided for only up to 0.5% of each MCO's total capitation. 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.

For calendar 2023 performance, MDH defined the following eight measures, of which the first six are HEDIS measures. All six HEDIS measures selected for PHIP incentive consideration were also used to determine incentive, neutral, or disincentive thresholds under the VBP. The subsequent two measures are "homegrown," non-HEDIS measures. PHIP regulations define MCOs' performance and incentive earnings for all eight measures, 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 9.0%);
- 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.

MDH has previously reported that PHIP aims to focus on measures related to the department's population health efforts and priorities. Most recently, these efforts include aligning population health measures with key quality measures outlined in the State's new agreement with the Centers for Medicare and Medicaid (CMS) for the Advancing Health Equity Approaches and Development (AHEAD) model that takes effect in calendar 2026. Although the department indicated during the 2024 session that it would incorporate measures from the AHEAD model in PHIP for the calendar 2025 MCO agreement, the contract does not change any measures from prior years. **MDH should clarify if current PHIP population health measures already align with quality measures prioritized through the AHEAD model, and if not, discuss the new measures that the department would select beginning with the calendar 2026 HealthChoice agreement.**

Although the department had not published an annual report with PHIP calendar 2023 results as of February 1, 2025, MDH provided a draft PHIP report to the Department of Legislative Services (DLS) for inclusion in this analysis, and final benchmark percentiles for the selected HEDIS measures were published in January 2025 with the HEDIS summary report. As shown in **Exhibit 5**, all nine MCOs reported at least one measure that was rated strong or higher (a minimum of the fiftieth percentile of national HEDIS and Maryland MCO benchmarks). Therefore, all MCOs were eligible for at least partial performance incentive payments in the first round for these measures. Four MCOs (Kaiser Permanente, CareFirst Community Health Plan Maryland, Jai Medical Systems, and Priority Partners) earned superlative percentiles in one or more of the selected measures.

Exhibit 5

Population Health Incentive Program Incentive Measures and Benchmark Percentiles

Calendar 2023

	Aetna	CFCHP	JMS	KPMAS	MPC	MedStar Family Choice	Priority Partners	UHC	WPM
Lead Screening in Children	67.92%*	69.59%*	83.2%	86.5%	68.74%*	77.32%*	75.29%*	67.6%	76.16%*
Risk of Continued Opioid Use	2.92%*	3.4%	4.3%	0.8%	4.0%	2.6%	3.6%	4.0%	2.3%
Asthma Medication Ratio	56.0%	79.1%	77.3%	98.7%	74.62%*	58.2%	76.7%	56.6%	52.1%
Postpartum Care	83.33%*	88.3%	86.6%	91.3%	85.4%*	83.8%	78.1%	77.6%	83.21%*
Timeliness of Prenatal Care	89.58%*	93.3%	83.4%	94.4%	91.48%*	85%*	85.6%	86.6%	82.0%
Comprehensive Diabetes Care	34.2%	28.95%*	31.9%	29.14%*	29.2%*	31.4%	35.3%	34.6%	32.6%*
Ambulatory Care Visits (SSI Adults)	56.5%	73.4%	85.1%	69.3%	82.3%	79.0%	81.1%	75.7%	78.1%
Ambulatory Care Visits (SSI Children)	47.9%	69.0%	78.8%	69.7%	80.1%	71.2%	82.2%	75.8%	79.0%
Measures Eligible for Performance Incentive	**4**	**5**	**6**	**6**	**7**	**6**	**4**	**1**	**7**
% of Measures Eligible for Performance Incentive	50%	63%	75%	75%	88%	75%	50%	13%	88%

	Aetna	CFCHP	JMS	KPMAS	MPC	MedStar Family Choice	Priority Partners	UHC	WPM
Measures Eligible for Improvement Incentive	**4**	**2**	**0**	**1**	**5**	**2**	**1**	**0**	**3**
% of Measures Eligible for Improvement Incentive	50%	25%	0%	13%	63%	25%	13%	0%	38%

Benchmark Percentiles
<50th percentile (not eligible for incentives)
<75th percentile (strong)
< 90th (very strong)
≥ 90th percentile (superlative)

CFCHP: CareFirst Community Health Plan Maryland
JMS: Jai Medical Systems
MPC: Maryland Physicians Care
UHC: UnitedHealthcare

HEDIS: Healthcare Effectiveness Data and Information Set
KPMAS: Kaiser Permanente of the Mid-Atlantic States
SSI: Supplemental Security Income
WPM: WellPoint Maryland

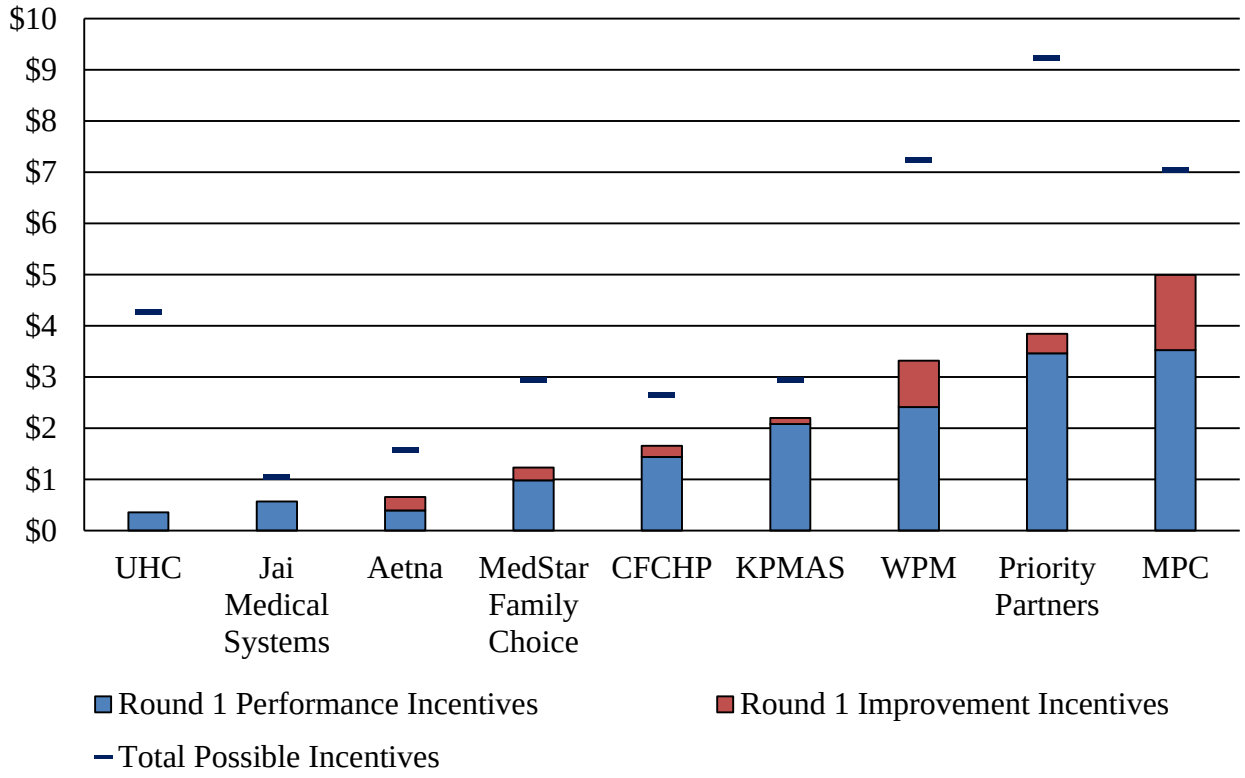
*Indicates measures that improved over the prior calendar year.

Note: This exhibit includes six HEDIS measures and two homegrown measures (ambulatory care visits for SSI adults and children) selected by the Maryland Department of Health for inclusion in the Population Health Incentive Program. Benchmark percentiles vary for each measure. For example, the fiftieth, seventy-fifth, and ninetieth percentiles for lead screening in children are 63.8%, 71.1%, and 79.5%, respectively.

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

Exhibit 6 shows each MCO's total possible incentive payment (up to 0.5% of total capitation per MCO, as budgeted) and performance and improvement incentives for calendar 2023 results. All MCOs received a PHIP first-round payment, with performance incentives ranging from $355,623 for UnitedHealthcare to $5.0 million for MPC. Seven MCOs also earned improvement incentives, ranging from $122,391 for Kaiser Permanente to $1.5 million for MPC. In calendar 2023, the second year implementing PHIP, MCOs generally earned between 0.21% and 0.38% of their capitation. UnitedHealthcare was an outlier as it received 0.04% of its capitation.

Exhibit 6
Population Health Incentive Program Incentives Paid to Managing Care Organizations
Calendar 2023
($ in Millions)



CFCHP: CareFirst Community Health Plan Maryland
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
UHC: UnitedHealthcare
WPM: WellPoint Maryland

Source: Maryland Department of Health

Across MCOs, round-one performance and improvement incentives totaled $18.8 million, and MDH indicated that no MCOs earned incentives through the second round, leaving just under $17.2 million in unallocated funds budgeted in fiscal 2025 for calendar 2023 performance. MDH will credit the unallocated funding to a nonlapsing fund. However, the department reported that it would spend $8 million of this balance for the Health Equity Incentive, another population health initiative. The fiscal 2026 allowance level funds PHIP at $36 million ($13.2 million in general funds), which continues to support incentives of up to 0.5% of anticipated capitated rates.

DLS recommends reducing $9.2 million in total funds from a proposed fiscal 2025 deficiency appropriation for Medicaid reimbursements to account for the balance of unallocated funds for calendar 2023 MCO incentives. Given the fiscal outlook, DLS also recommends reducing $18 million in total funds in fiscal 2026, reducing PHIP incentives to 0.25% of anticipated capitated rates.

3. Transition from MCO Rural Access Incentive to Health Equity Incentive

Final payments under the MCO Rural Access Incentive were distributed in fiscal 2024 following the program's termination at the end of calendar 2023. This program 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 repurposed funding for the MCO Rural Access Incentive beginning in fiscal 2025 to incentivize MCOs to promote health equity. The fiscal 2025 budget did not include funding for either program, instead MDH covered calendar 2024 health equity incentive payments totaling $8 million with unallocated funds from underutilized PHIP incentives. Similarly, the fiscal 2026 allowance does not include dedicated funding for the health equity incentive.

MDH and the Hilltop Institute at the University of Maryland Baltimore County developed a new methodology in which incentives are based on MCOs' membership in local jurisdictions with high socioeconomic disadvantage. The Hilltop Institute developed the HealthChoice socioeconomic disadvantage index considering socioeconomic, structural, and environmental factors associated with adverse health outcomes and drivers of health inequities to rank jurisdictions 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.

Under the calendar 2024 HealthChoice agreement, MDH allocated available funding across two payments in July and December 2024 based on MCO membership in the six jurisdictions with the highest socioeconomic disadvantage scores. 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. As shown in **Exhibit 7**, all nine MCOs received health equity incentives ranging from $226,674 for Aetna to $2.2 million for Priority Partners.

Exhibit 7
Health Equity Incentive Payments
Calendar 2024

Managed Care Organization	Health Equity Incentive	Share of Incentive	Share of Total HealthChoice Enrollment
Aetna	$226,674	3%	5%
Kaiser Permanente	337,115	4%	7%
CFCHP	349,087	4%	7%
Jai Medical Systems	404,607	5%	2%
UnitedHealthcare	657,918	8%	11%
MedStar Family Choice	754,143	9%	7%
Maryland Physicians Care	1,477,294	18%	16%
Wellpoint Maryland	1,601,652	20%	21%
Priority Partners	2,191,510	27%	24%
All MCOs	**$8,000,000**		

CFCHP: CareFirst Community Health Plan Maryland

Source: Maryland Department of Health; Department of Legislative Services

Exhibit 7 also shows each MCO's share of health equity incentives compared to the share of total statewide managed care enrollment. Only Priority Partners, Jai Medical Systems, MPC, and MedStar Family Choice received a slightly higher share of incentives than their share of statewide enrollment, while five MCOs account for higher shares of enrollment than incentives. This suggests that MCOs tend to enroll more participants in jurisdictions with lower levels of social disadvantage. However, the distribution of health equity payments is not significantly different from the distribution of statewide HealthChoice enrollment, and both measures follow roughly the same order of MCOs from lowest to highest.

Considering calendar 2024 was the first year that MDH distributed health equity incentives, any impact that the program might have on encouraging enrollment in jurisdictions with higher social disadvantage would not have materialized yet. Still, it is not clear from the design of the program, specifically calculating incentives based on jurisdiction-level MCO membership, that the incentives will target MCO enrollment in areas with the highest socioeconomic disadvantage index. In comparison, the Engaging Neighborhoods, Organizations, Unions, Governments, and Households (ENOUGH) program within the Governor's Office for Children targets investment at the census tract level and uses certain poverty indicators to determine if neighborhoods are eligible for grants.

MDH should provide baseline membership data for each MCO across the six jurisdictions included in the calendar 2024 health equity incentive calculation and discuss whether the department has considered calculating health equity incentives based on MCO membership in neighborhoods eligible for the ENOUGH program.

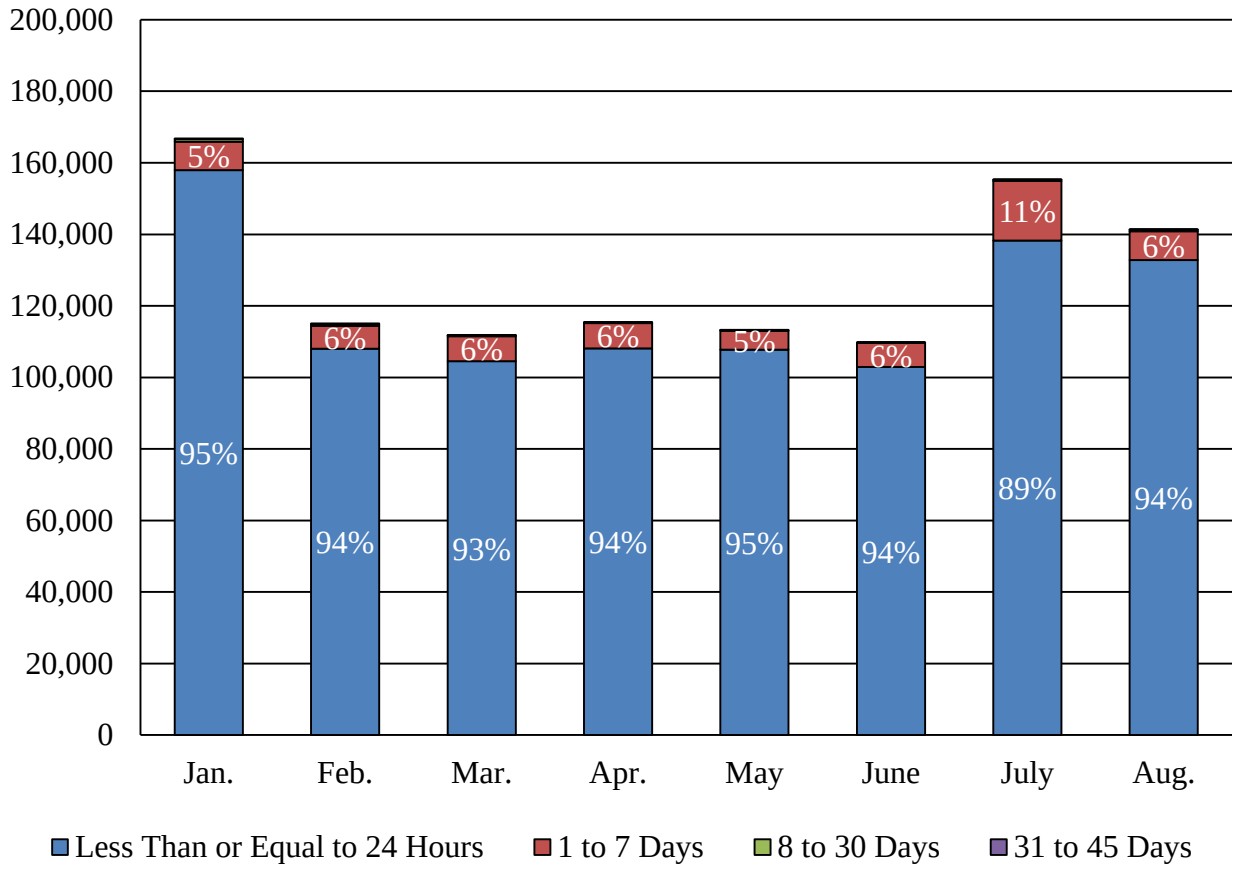
4. Application Processing Times

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 renewed all Medicaid and MCHP participants over 12 cohorts through April 2024.

Application processing through the unwinding period was especially critical as many participants completed eligibility redetermination for the first time since March 2020 or for the first time since enrolling. CMS requires regular reporting of Medicaid application processing times and, during the unwinding period, MDH released monthly reports on a dashboard on the department website. Committee narrative in the 2024 *Joint Chairmen's Report* (JCR) requested that MDH submit quarterly reports with enrollment data as well as monthly application processing measures used in this analysis. As shown in **Exhibit 8**, through the end of the unwinding period, MHBE processed the vast majority (at least 93%) of applications for MAGI cases within 24 hours. This measure fell slightly to 89% in July 2024, corresponding with a surge of applications, before recovering to 94% in August 2024.

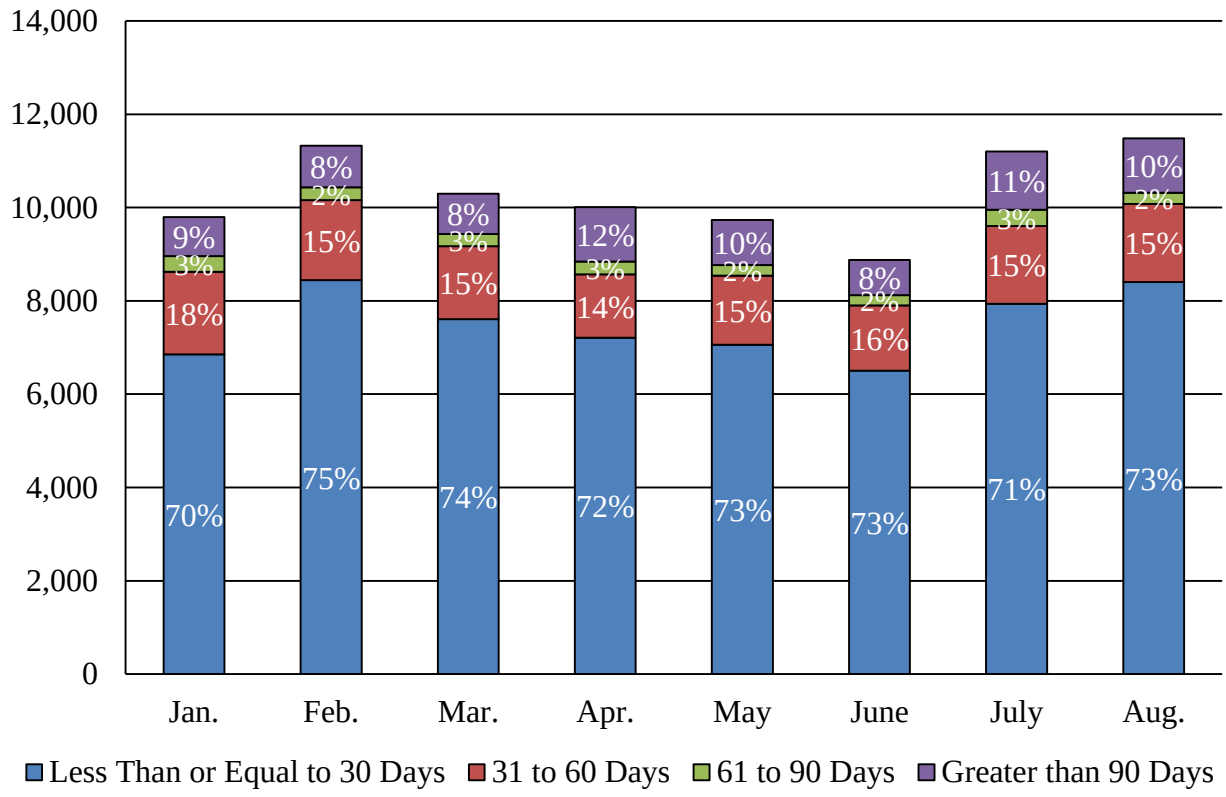
Exhibit 8
Income-based Medicaid Application Processing
January 2024 to August 2024



Source: Maryland Department of Health; Maryland Health Benefit Exchange

As shown in **Exhibit 9**, over the same period, processing of non-MAGI applications tended to take much longer than MAGI applications. On average, from January to August 2024, approximately 73% 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 February 2024 to a high of 30% in January 2024. 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. MDH reported that in April 2024, the last month of the unwinding period, 56% of the 6,055 non-MAGI renewals were automatically renewed compared to 88% of the 69,639 MAGI renewals.

Exhibit 9
Non-modified Adjustment Gross Income Medicaid Application Processing
January 2024 to August 2024



Source: Maryland Department of Health; Department of Human Services

In a fiscal compliance audit of MHBE issued on January 28, 2025, OLA found that MHBE did not request supporting documentation from MAGI applicants who reported no income when State wage records indicated that the applicants had income exceeding the eligibility threshold for Medicaid. During the unwinding period, MDH received federal approval for waiver flexibilities to assist in keeping eligible participants enrolled in Medicaid and MCHP. These flexibilities included automatically renewing individuals with no income or with incomes at or below 100% FPL without requesting additional information or documentation as long as the income was verified in the last twelve months. However, this flexibility applied to eligibility renewals, while OLA's finding concerned new applications in which MHBE only required applicants to sign an affidavit self-certifying that they had no income. Using MHBE reports, OLA identified 4,465 Medicaid applicants in fiscal 2023 who self-certified having no income but had listed income in State wage records around the time of the application.

MDH should provide an update on the MHBE audit finding related to Medicaid application processing, including whether Medicaid applicants that were found to have incomes higher than the eligibility threshold have been disenrolled as appropriate. In addition, MDH should discuss corrective actions taken by the department and MHBE concerning this finding.

Fiscal 2024

Legislative Priorities

Section 19 of the fiscal 2024 Budget Bill (Chapter 101 of 2023) added $3.5 million in general funds to the Medicaid budget to increase provider reimbursement rates for abortion care services. MDH collaborated with Hilltop to determine the following uses:

- rate increases for nonfacility abortion clinics, effective February 1, 2024;
- rate increases for long-acting reversible contraception, effective February 15, 2024; and
- grants for nine Medicaid-enrolled abortion clinics.

Due to the delay in implementing provider rate increases until February 2024, MDH provided one-time grants to expedite the distribution of the remaining funds. At fiscal 2024 closeout, MDH reverted $1.2 million of the $3.5 million legislative addition. However, the department reported that expenditures budgeted separately from the $3.5 million appropriation supported the provider rate increases, and $3.5 million was spent on the outlined uses after accounting for this spending. The provider rate increases are funded on an ongoing basis as MDH annualized the new rates in fiscal 2025.

Accrual Shortfall

Under Medicaid, FFS claims can be submitted up to a year after the service has been delivered. At the end of each fiscal year, Medicaid typically accrues unspent funds to pay for services delivered during the fiscal year but billed in the following fiscal year. Lower than expected disenrollment during the unwinding period and higher health care utilization (primarily among elderly and disabled adults) caused fiscal 2024 Medicaid spending to increase substantially over the budgeted amount. As a result, MDH could not accrue enough funding at the end of fiscal 2024 to cover expected bills that would be received in fiscal 2025, and the department projected a general fund shortfall of $214 million for these costs. The fiscal 2026 budget includes a proposed deficiency including $231.7 million in general funds to backfill the fiscal 2024 shortfall. This amount increased from fiscal 2024 closeout due to an updated estimate of carryover spending in fiscal 2025.

Fiscal 2025

Cost Containment

On July 17, 2024, the Board of Public Works (BPW) approved cost containment measures reducing MCPA's fiscal 2025 budget by a total of $1.3 million in general funds. This includes a reduction of $1.0 million added in Section 21 of the fiscal 2025 Budget Bill (Chapter 716 of 2024) for the Assistance in Community Integration Services (ACIS) program. The entire legislative addition for ACIS was cut, but the fiscal 2025 working appropriation still provides $10.6 million in total funds ($5.4 million in general funds) to expand the program. A total of $347,477 was reduced to delay hiring new positions in the Office of the Deputy Secretary for Health Care Financing ($72,418) and Benefits Management and Provider Services ($275,059).

Implementation of Legislative Priorities

Section 21 of the fiscal 2025 Budget Bill added $500,000 in general funds under Medicaid to provide one-time assistance to medical day care services providers, in addition to the $1.0 million for the ACIS program expansion that was reduced by the July 2024 cost containment actions. MDH reported that it does not plan to expend the $500,000 for medical day care services providers and will instead revert the general funds at the end of fiscal 2025 due to uncertainty of the legislative intent of the addition.

Proposed Deficiency

The fiscal 2026 budget includes five deficiency appropriations providing a net increase of $1.37 billion in total funds ($729.5 million in general funds) in fiscal 2025, including:

- a net increase of $685.3 million ($473.4 million in general funds) due to enrollment, utilization, and rate assumptions in Medicaid reimbursements. This deficiency withdraws $14.7 million in federal funds for an expansion of school-based services that was meant to be realigned to M00Q01.10 Medicaid Behavioral Health Provider Reimbursements included in the BHA analysis. However, due to a technical error, the federal funding was not included in BHA in fiscal 2025 or 2026. Additional information on school-based services can be found in Issue 3;

- $509.9 million ($231.7 million in general funds) to account for anticipated shortfalls in accrued funding for Medicaid services provided in fiscal 2024 that are billed in fiscal 2025;

- a net increase of $172.1 million ($62.3 million in general funds) for enrollment, utilization, and rate assumptions in MCHP reimbursements. This deficiency includes a reduction of $2.0 million in special funds to account for the elimination of required premium payments in accordance with Chapter 47;

- $50 million in special funds added to Medicaid to increase the hospital deficit assessment, allowing for $46.25 million in general fund savings. Both the special fund appropriation and general fund reduction are contingent on the enactment of a provision in BRFA of 2025 that would increase the hospital deficit assessment. Approximately 20% of hospital spending is attributed to Medicaid recipients. Therefore, $3.75 million in general funds would be needed for the State share of the growth in hospital rates for the Health Services Cost Review Commission (HSCRC) to collect the increased deficit assessment; and

- $8.3 million in general funds to backfill an equivalent withdrawal of special funds from the Cigarette Restitution Fund (CRF) to account for lower than anticipated CRF revenue.

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 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 and 2022 are shown in **Exhibit 10**. MCOs took on greater risk in calendar 2022 due to the lowest band requiring MCOs to cover up to 50% of losses compared to up to 10% of losses in calendar 2021. The HealthChoice program reported shared savings in both years, landing in the B+ band in calendar 2021 and the C+ band in calendar 2022. As a result, total government recoveries were $17.5 million and $141.0 million, respectively.

Exhibit 10
Risk Corridor Bands, Shares of Gains and Losses, and Recoveries
Calendar 2021-2022
($ in Millions)

2021 MLR Risk Corridor	MCO Share of Gain/Loss	State and Federal Government Share of Gain/Loss	State and Federal Government Recoveries
Corridor C+: Less than 95.29%	10% Gain	90% Gain	
Corridor B+: 95.30% to 96.79%	50% Gain	50% Gain	$17.5 TF; $5.6 GF
Corridor A: 96.80% to 100.00%	100% Gain/Loss	0% Gain/Loss	
Corridor B-: 100.01% to 101.50%	50% Loss	50% Loss	
Corridor C-: Greater than 101.51%	10% Loss	90% Loss	
2022 MLR Risk Corridor			
Corridor C+: Less than 95.29%	50% Gain	50% Gain	$141.0 TF; $46.0 GF
Corridor B+: 95.30% to 96.79%	75% Gain	25% Gain	
Corridor A: 96.80% to 100.00%	100% Gain/Loss	0% Gain/Loss	
Corridor B-: 100.01% to 101.50%	75% Loss	25% Loss	
Corridor C-: Greater than 101.51%	50% Loss	50% Loss	

GF: general funds
MCO: managed care organization
MLR: Medical Loss Ratio
TF: total funds

Source: Maryland Department of Health

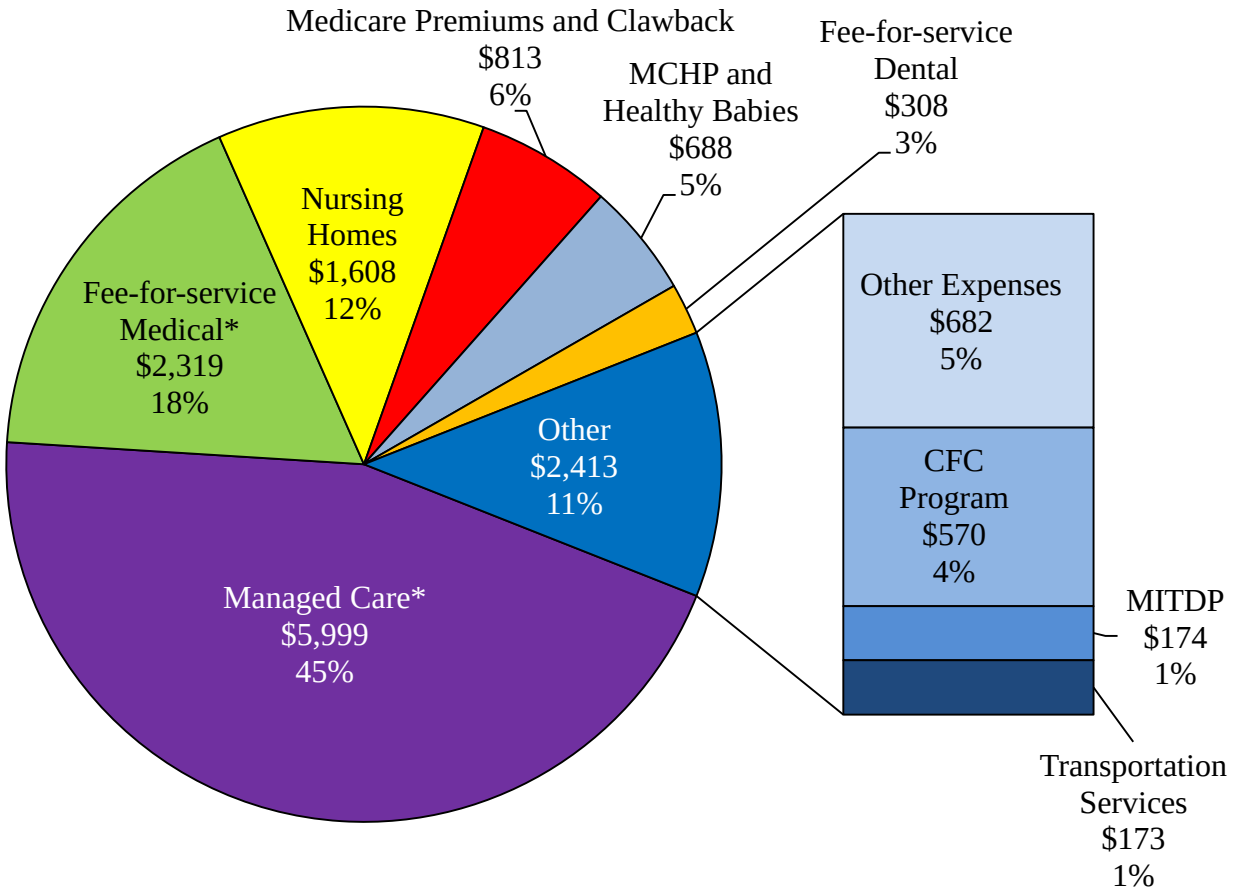
MDH completed the reconciliation process for calendar 2021 in June 2023 and calendar 2022 in June 2024 and collected a combined $51.6 million of State recoveries in October 2024. Due to the timing of the recoveries, the fiscal 2025 budget did not recognize the

savings, and the department indicates that the projections used to calculate the deficiency appropriation for fiscal 2025 Medicaid reimbursements did not apply these general fund savings to the working appropriation either. **DLS recommends reducing the proposed deficiency appropriation by $162.5 million in total funds ($51.6 million in general funds) to account for the calendar 2021 and 2022 risk corridor recoveries.**

Fiscal 2026 Overview of Agency Spending

As shown in **Exhibit 11**, MCPA's fiscal 2026 allowance totals $13.3 billion after accounting for a contingent reduction. The largest share of MCPA's budget (45%, or $6.0 billion) supports reimbursements for health care services paid for by MCOs, referred to as Managed Care in the exhibit. In addition, 32%, or $4.2 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 $829 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 $570 million, and supports home and community-based services (HCBS) through entitlement programs and Medicaid waivers.

Exhibit 11
Overview of Agency Spending
Fiscal 2026 Allowance
($ in Billions)



Total Expenditures = $13.3 Billion

CFC: Community First Choice
MCHP: Maryland Children's Health Program
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 2026 allowance accounts for contingent reductions. The fiscal 2026 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

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

Proposed Budget Change

As shown in **Exhibit 12**, the fiscal 2026 allowance decreases by $269.1 million compared to the fiscal 2025 working appropriation, after adjusting for proposed deficiencies and contingent general fund reductions, including a deficiency to cover a fiscal 2024 shortfall of $509.9 million ($231.7 million in general funds). When excluding the fiscal 2024 expenses from the fiscal 2025 budget, the fiscal 2026 allowance increases by $240.7 million. The largest driver of this change is additional spending for provider rate increases and hospital costs totaling $315.0 million and higher MCHP and Healthy Babies enrollment totaling $90.8 million. Payments to MCOs also increase by $159.1 million to adjust for higher health acuity among Medicaid recipients and to annualize costs of certain coverage of anti-obesity medication. Additionally, spending on MITDPs within MCPA increases by $67.5 million. A decrease of $471.0 million accounts for projected enrollment declines and utilization assumptions, partially offsetting the spending growth.

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 2024 Actual	$4,161,636	$754,420	$7,805,252	$136,577	$12,857,886
Fiscal 2025 Working Appropriation	4,775,877	785,764	7,940,090	101,643	13,603,374
Fiscal 2026 Allowance	4,670,169	850,541	7,688,170	125,346	13,334,226
Fiscal 2025-2026 Amount Change	-$105,708	$64,777	-$251,920	$23,703	-$269,148
Fiscal 2025-2026 Percent Change	-2.2%	8.2%	-3.2%	23.3%	-2.0%

Where It Goes:	Change
Personnel Expenses	
Salary increases and associated fringe benefits including fiscal 2025 COLA and increments	$4,580
Reclassification of positions in the Maryland pharmacy program to hire at salaries above base	$563
One-time general fund reduction in fiscal 2025 due to fund balance transfer from the Health Information Exchange Fund, authorized in the BRFA of 2024 (special funds not yet appropriated in fiscal 2025)	$217
Miscellaneous adjustments, mainly to realign costs for the Maryland Primary Care Program from the Office of the Secretary to Medicaid	$142
Accrued leave payout	-$70

Where It Goes:	**Change**
Personnel Expenses	
Turnover expectancy increases from 6.85% to 6.97%	-84
Employee and retiree health insurance	-825
Other fringe benefit adjustments	-36
Provider Rate Increases and Other Hospital Rate Assumptions	
Other provider rate increases, driven by a 3.5% MCO rate increase and increases for inpatient and outpatient hospital rates	256,578
MCO acuity adjustment	124,000
HSCRC actions increasing hospital rates	25,000
LTSS provider rate increase (1%)	21,230
Physician evaluation and management rate increase (from 98% to over 100% of Medicare) in coordination with the AHEAD model to support primary care initiatives	12,200
Other Changes	
Maryland Children's Health Program, mainly due to projected enrollment growth	61,075
Annualization of federally required coverage for anti-obesity medication for individuals with cardiovascular disease or sleep apnea diagnoses	35,061
Healthy Babies Initiative	29,725
Medicare part D clawback	19,591
Medicaid Advanced Primary Care Program (general funds)	16,000
Medicare part A and B premiums	15,317
Federally Qualified Health Center supplemental payments	13,601
Health Home services, to be transferred to the Behavioral Health Administration but budgeted in Medicaid due to a technical error	10,267
Community First Choice program	7,834
Coverage of fertility preservation services in accordance with Chapter 253 of 2023	6,410
Senior Prescription Drug Assistance program (special funds)	5,017
EID program, due to projected enrollment decline	-2,859
Enrollment and utilization assumptions	-470,959
Fiscal 2025 deficiency to cover fiscal 2024 accrual shortfall	-509,890

Administrative Expenses	
Major IT projects	67,469
Administrative contracts, audits, and IT expenses	14,178
Health information exchange (CRISP)	-30,292
Other expenses	-188
Total	**-$269,148**

AHEAD: Advancing All-payer Health Equity Approaches and Development
BRFA: Budget Reconciliation and Financing Act
COLA: cost-of-living adjustments
CRISP: Chesapeake Regional Information System for Our Patients
EID: Employed Individuals with Disabilities
HSCRC: Health Services Cost Review Commission
IT: information technology
LTSS: Long Term Services and Supports
MCO: managed care organization

Note: Numbers may not sum to total due to rounding. The fiscal 2025 working appropriation accounts for deficiencies and contingent reductions. The fiscal 2026 allowance accounts for contingent reductions. The fiscal 2025 impacts of statewide salary adjustments are centrally budgeted in the Department of Budget and Management (DBM), and adjustments are not reflected in this agency's budget. The fiscal 2026 impacts of the fiscal 2025 statewide salary adjustments appear in this agency's budget. The fiscal 2026 statewide salary adjustments are centrally budgeted in DBM and are not included in this agency's budget.

Budget Reconciliation and Financing Act

Medicaid Hospital Deficit Assessment

Following the Great Recession, a Medicaid deficit assessment was imposed on Maryland hospitals to support the Medicaid program. The assessment consists of (1) an amount included in hospital rates (and paid by hospital users) and (2) a remittance from hospitals. In fiscal 2015 and 2016, the assessment was set at $389.8 million and gradually decreased to $294.8 million beginning in fiscal 2021. A provision in the BRFA of 2023 reduced the assessment by $50 million to $244.8 million in fiscal 2024 only. A proposed fiscal 2025 deficiency appropriation that is contingent on the provision in the BRFA of 2025 increases the assessment from $294.8 million to $344.8 million.

The fiscal 2026 Budget Bill includes language reducing $92.5 million in general funds, contingent on a provision in the BRFA increasing the required Medicaid deficit assessment imposed on hospitals from $294.8 million to $394.8 million in fiscal 2026. A special fund appropriation of $100 million to replace the general funds is also contingent on that provision. The difference of $7.5 million between general fund savings and special fund revenue accounts for the slight increase in Medicaid general fund expenditures to pay for the hospital rate increase administered by HSCRC to collect the assessment. The BRFA provisions increase the assessment to $394.8 million on an ongoing basis and would also authorize HSCRC and MDH to adopt an

alternative method to collect by the end of fiscal 2026 the amount of revenue resulting from the increase in the Medicaid deficit assessment across fiscal 2025 and 2026 (a total of $150 million).

Primary Care Program Fund

The BRFA includes a provision that establishes a Medicaid Primary Card Program Fund within MDH to serve as the foundation for advancing primary care in the State under the AHEAD model. There are two technical errors in the BRFA as introduced: (1) the fund should be referred to as the Medicaid Primary Care Program Fund; and (2) the bill should refer to HSCRC rather than the Health Services Review Commission. **DLS recommends amending the BRFA provision to correct these technical errors.**

Revenue for the new special fund is derived from hospital payments administered by HSCRC and any other source accepted for the fund. MDH indicates that a total of $30.0 million in general funds will be transferred from HSCRC to MDH to establish the fund across fiscal 2026 and 2027. The fiscal 2026 allowance includes $16 million in general funds in MCPA, which is attributed to the first transfer of hospital assessments. The assessment is incorrectly funded with general funds and instead should be supported with special funds collected from hospital payments. **DLS recommends deleting $16 million in general funds for the new Medicaid Primary Care Program Fund and authorizing a budget amendment to allocate special funds for this purpose.**

The AHEAD Model, effective January 1, 2026, is a partnership between CMS and Maryland to continue the State's all-payer hospital rate-setting system, control health care costs, and improve population health, among other initiatives. A component of the AHEAD Model is a new Advanced Primary Care Program under Medicaid that will begin implementation on July 1, 2025, and will be supported by the new Medicaid Primary Card Program Fund established in these BRFA provisions. This program will operate similarly to the existing Maryland Primary Care Program (MDPCP), which is a component of the State's current Total Cost of Care Model. Through the new Advanced Primary Care program, MDH will provide care management fees of $2 per member per month assigned to eligible primary care practices and administer a quality incentive program for the calendar 2026 performance year. In addition to the new Advanced Primary Care Program, MDH budgeted a rate enhancement of $12.2 million in total funds ($4.8 million in general funds) for physician evaluation and management (E&M) fees in fiscal 2026, in coordination with efforts under the AHEAD model to increase funding for primary care services under Medicaid.

DLS recommends adopting committee narrative requesting a report from MDH, in collaboration with HSCRC, evaluating the MDPCP and providing a status update on the new Medicaid Advanced Primary Care Program as well as other primary care initiatives.

Budgetary Transfer

Another provision in the BRFA of 2025 would authorize MDH to transfer funds between budgetary programs within the department through an approved budget amendment in fiscal 2025

and 2026 only. After enactment of the budget bill, appropriations can be changed through the budget amendment process to transfer funds among programs within an agency or department. Budget amendments to transfer funds within an agency or department are submitted to the Secretary of Budget and Management for the Governor's approval. To prevent transfers of funds that might create or increase deficits in entitlement programs, annual language in the budget bill has been placed on certain MDH programs to restrict funds to their budgeted purpose and to prohibit budgetary transfer to other programs or purposes, with some exceptions specified.

Language in the fiscal 2025 Budget Bill restricts funds in the following MDH programs to their budgeted purpose, with certain transfers across programs allowed. For example, language restricting funds in M00L01.02 Community Services within BHA allows budgetary transfers to M00L01.03 Community Services for Medicaid State Fund Recipients, M00Q01.03 Medical Care Provider Reimbursements, or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements. Programs with funding restrictions in fiscal 2025 are:

- ***BHA (General Fund Appropriations O\only):*** M00L01.02 Community Services; M00L01.03 Community Services for Medicaid State Fund Recipients; and M00Q01.10 Medicaid Behavioral Health Provider Reimbursements;

- ***Developmental Disabilities Administration (DDA):*** M00M01.02 Community Services; and

- ***MCPA:*** M00Q01.03 Medical Care Provider Reimbursements and M00Q01.07 Maryland Children's Health Program.

DLS recommends rejecting this BRFA provision so that funding for entitlement programs within MDH continue to be restricted to their budgeted purpose, allowing for certain transfers as specified in budget language. DLS also recommends adding budget bill language for fiscal 2026 restricting funds for Medicaid and MCHP reimbursements to that purpose. Under the recommended language, funding can be transferred between Medicaid and MCHP programs, including M00Q01.10 Medicaid Behavioral Health Reimbursements.

Maternal and Child Health Fund

The BRFA of 2021 (Chapter 150) 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 (PHPA) through calendar 2025. The fund is administered by MDH and HSCRC. Funding is derived from a uniform, broad-based assessment built into hospital rates that supports HSCRC's 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. The hospital assessment for maternal and child health was approved by HSCRC in May 2021 and terminates at the end of calendar 2025.

HSCRC approved $40 million in cumulative funding, and for fiscal 2022 through 2025, appropriations from the fund included $8 million annually under Medicaid to address severe maternal morbidity and $2 million annually under PHPA to support childhood asthma initiatives and additional maternal morbidity interventions. Under Medicaid, these special funds and federal matching funds have supported the Home Visiting Services Pilot, reimbursement for doula services, Centering Pregnancy (which provides group-based prenatal care in a comfortable, community setting), HealthySteps (resources, screenings, support, and services for the first three years of a child's life), and expansion of the Maternal Opioid Misuse model.

Due to underspending, MDH and HSCRC advised that by the end of fiscal 2025, the fund will have a balance of $24.1 million. The fiscal 2026 allowance includes $10 million in spending supported with this fund across MCPA and PHPA. Assuming that amount is spent in calendar 2025, the remaining balance would be $14.1 million when the authority to use the fund expires on December 31, 2025. A provision in the BRFA of 2025 as introduced authorizes the Governor to transfer $10.0 million from the Maternal and Child Health Population Health Improvement Fund to the General Fund on or before June 30, 2026. **DLS recommends amending this BRFA provision to increase the authorized fund balance transfer to $14.1 million to transfer all remaining funds following the expiration of the use of the funds at the end of calendar 2025.**

Departmental bills SB 213 and HB 170 of 2025 would extend, from December 31, 2025, to December 31, 2027, the date through which the Maternal and Child Health Population Health Improvement Fund may be used and would allow MDH to spend through calendar 2027 any monies remaining in the fund at the end of calendar 2025.

Two Programs Realigned within MDH

The fiscal 2026 budget plan transfers several programs across MDH offices, including realignment of the MDPCP Program Management Office from the Office of the Secretary to MCPA. MDH has transferred the MDPCP Program Management Office multiple times between the Office of the Secretary and MCPA. In addition to the administrative costs budgeted in the Program Management Office, HSCRC annually funds MDPCP personnel costs with $600,000 in special funds supported with hospital user fees. Additional information regarding MDPCP can be found in the analysis for M00R01 – MDH Health Regulatory Commissions.

MDH reported that the MDPCP program management office would be renamed the Office of Advanced Primary Care and would coordinate three initiatives under the AHEAD model: (1) the existing MDPCP that has been extended through calendar 2028; (2) the new Medicaid Advanced Primary Care Program; and (3) a new national Medicare program operated in partnership with CMS to work with primary care practices not participating in MDPCP.

Effective January 1, 2025, MDH realigned the Health Home program from Medicaid to M00Q01.10 Medicaid Behavioral Health provider reimbursements, which is included in the analysis for M00L – BHA. A proposed deficiency appropriation withdraws $10.3 million in total funds for this program from traditional Medicaid in fiscal 2025. However, the fiscal 2026 allowance restores the traditional Medicaid budget to provide the full amount of $18.2 million in

total funds ($9.1 million in general funds). **DLS recommends deleting $18.2 million for the Health Home program under traditional Medicaid as a technical correction to reflect the realignment of this program to M00Q01.10 Medicaid Behavioral Health provider reimbursements.**

Medicaid Enterprise Systems Modular Transformation Major Information Technology Project

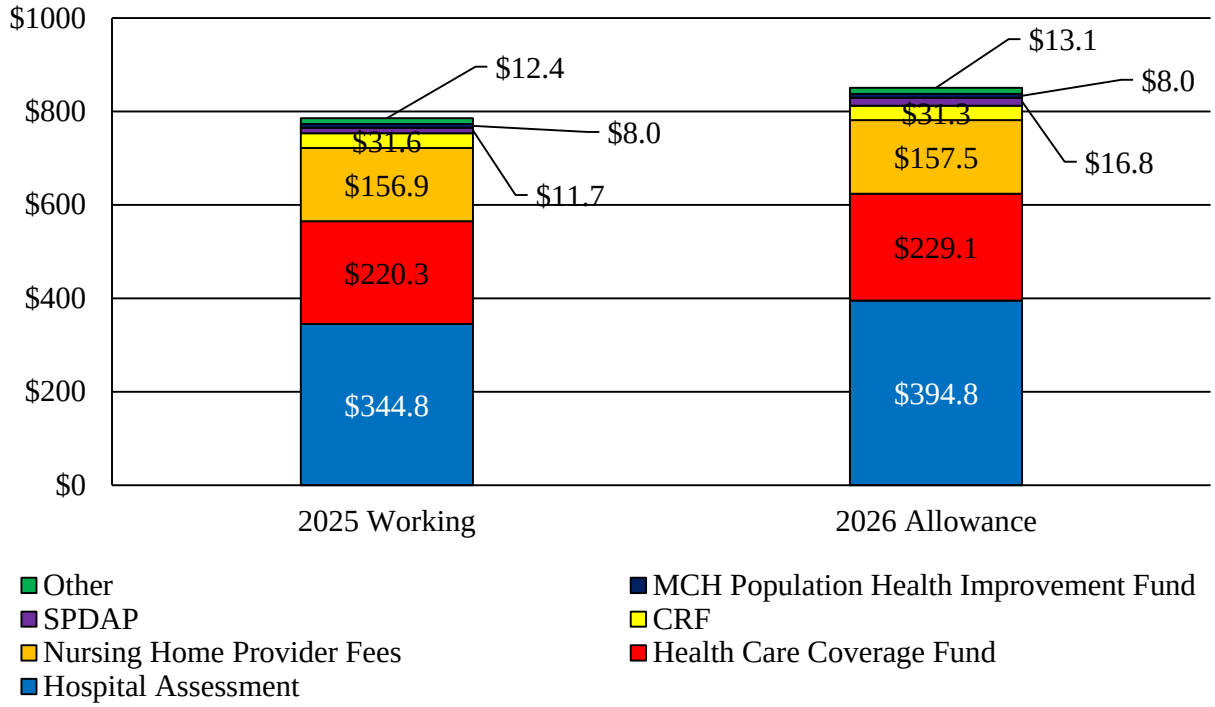
The fiscal 2026 allowance includes a total of $143.4 million for the Medicaid Enterprise Systems Modular Transformation (MMT) project, driving the increase of $67.5 million in development costs for MITDPs over the fiscal 2025 working appropriation. MDH plans to continue development of 14 modular systems and projects that comprise the longstanding MMT MITDP to replace Medicaid's legacy information system with a modern Medicaid Management Information System (MMIS). Of these systems, 13 are summarized in this analysis in **Appendix 4** through **Appendix 16**. The Behavioral Health administrative services organization (ASO) system is discussed in the analysis for M00L – BHA. Across most of the project, MDH received federal approval on an Implementation Advanced Planning Document for an enhanced matching rate of 90% for development. As a result, the fiscal 2026 allowance for this project is made up of $125.2 million in federal funds and $18.2 million in reimbursable funds in MCPA that are supported with general funds in the Department of Information Technology (DoIT).

Following many delays across the various MMT components, this project carries a large balance in the MITDP Fund within DoIT. In July 2024, BPW approved a reduction of $15.6 million in general funds from the MITDP Fund for this project, though the reduction was not characterized as solely for this project. DoIT reported a remaining fund balance of $20.8 million after accounting for the reduction, and this balance will be available to support State fund needs in fiscal 2025 once MDH provides spending estimates reflecting the BPW reduction. **MDH should provide a status update for the MMT project, including year-to-date fiscal 2025 spending and planned uses of the remaining balance of general funds.**

Special Fund Availability

Exhibit 13 details a variety of special fund sources that support fiscal 2025 and 2026 Medicaid and MCHP expenditures. Overall, special fund spending under MCPA programs in the fiscal 2026 allowance increases by $64.8 million compared to the fiscal 2025 working appropriation, after accounting for proposed deficiencies. The net growth in special fund spending is largely due to the increase of $50 million in the Medicaid hospital deficit assessment contingent on BRFA provisions increasing the assessment by $50 million in fiscal 2025 and $100 million in fiscal 2026. Other changes include an increase of just under $8.8 million for the Health Care Coverage Fund, which is also derived from a hospital assessment, and $5.0 million from the SPDAP Fund. Section 31 of the fiscal 2025 Budget Bill authorized a transfer of up to $100 million from the Revenue Stabilization Account (Rainy Day Fund) to cover Medicaid expenditures, but the fiscal 2025 working appropriation does not yet reflect these funds.

Exhibit 13
Special Fund Support for the Medical Care Programs Administration
Fiscal 2025-2026
($ in Millions)



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

Note: The fiscal 2025 working appropriation includes deficiencies and contingent reductions. The fiscal 2026 allowance includes contingent reductions.

Source: Governor's Fiscal 2026 Budget Books

After accounting for a deficiency appropriation that withdraws $8.3 million in the CRF and backfills those funds with general funds in fiscal 2025, CRF spending decreases slightly by $303,666 in fiscal 2026. Further discussion of CRF availability, including settlement recoveries from litigation between states and tobacco manufacturers participating in the Master Settlement Agreement, can be found in the analysis for M00 – MDH Overview.

SPDAP Fund Balance

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. In December 2024, SPDAP

served 22,107 enrollees and had no waiting list. Although year-over-year SPDAP caseloads have declined in recent years, MDH indicated that SPDAP enrollment could grow by approximately 2,500 participants in calendar 2025 due to State retirees enrolling in Medicare Part D following the termination of prescription drug coverage. The program is funded at $11.7 million in fiscal 2025 and $16.8 million in fiscal 2026 through the SPDAP special fund, which is supported by the CareFirst premium tax exemption payment.

As shown in **Exhibit 14**, MDH anticipates the SPDAP Fund will close fiscal 2025 with a balance of $12.8 million, after transferring a total of $8.6 million to other uses. The BRFA of 2024 included provisions that expand allowable uses of the SPDAP Fund to include:

- beginning in fiscal 2025, the Kidney Disease Program and community mental health services to the uninsured. The fiscal 2025 budget transfers $5.0 million in fund balance to be used by BHA, providing equivalent general fund savings; and

- in fiscal 2025 only, depositing funds into health reimbursement accounts of certain State retirees transitioning to Medicare Part D. Section 21 of the fiscal 2025 Budget Bill added $3.6 million in SPDAP special funds to the Statewide Expenses account within the Department of Budget and Management (DBM), contingent on enactment of the BRFA of 2024.

Exhibit 14
Senior Prescription Drug Assistance Program Fund Budget
Fiscal 2025-2026
($ in Millions)

	2025	**2026**
Beginning Fund Balance	$17.6	$12.8
Projected Revenue	14.0	14.0
Total Available Revenue	**$31.6**	**$26.8**
Projected SPDAP Expenditures	$10.2	$16.8
Transfer to BHA for Community Mental Health Services	5.0	5.0
Transfer to DBM for Certain State Retirees Transitioning to Medicare Part D	3.6	3.1
Total Expenditures	**$18.8**	**$24.9**
Estimated Closing Fund Balance	$12.8	$1.9

BHA: Behavioral Health Administration SPDAP: Senior Prescription Drug Assistance Program
DBM: Department of Budget and Management

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

The fiscal 2026 allowance again transfers $5.0 million from the SPDAP Fund to BHA for community mental health services for the uninsured. Additionally, the allowance includes $3.1 million from the SPDAP Fund in the DBM Statewide Expenses Program for the same use as fiscal 2025, but this use of SPDAP funding is only authorized in fiscal 2025. To the extent that the statute remains unchanged in fiscal 2026, DBM will have a $3.1 million general fund deficit due to the inability to use SPDAP fund balance for this purpose. **DLS recommends adding a provision to the BRFA of 2025 to expand the allowable uses of the SPDAP Fund in fiscal 2026 and future years to include depositing funds into health reimbursement accounts of certain State retirees transitioning to Medicare Part D to align with the budget.**

Provider Rate Increases and Hospital Rate Assumptions

Compared to the fiscal 2025 working appropriation, MCPA's fiscal 2026 allowance increases by $315.0 million in total funds to account for various provider rate increases and projected changes to hospital costs. **Exhibit 15** lists rate increases by service or provider type budgeted under MCPA. An overall increase of 3.5% for calendar 2025 MCO rates drives most of the spending growth, accounting for $200.2 million. The fiscal 2026 allowance does not project any additional spending for rate changes that may be determined through the MCO calendar 2026 rate-setting process, with exception to a projected health acuity adjustment discussed below. To prepare for implementation of the AHEAD model, the fiscal 2026 allowance includes $12.2 million to raise physician E&M rates from 98% of Medicare rates in fiscal 2025 to over 100% of Medicare rates in fiscal 2026. Medicare rates were most recently adjusted downward, while MDH is not applying that same reduction, providing for physician E&M rates higher than Medicare rates.

Exhibit 15
Medicaid Provider Rate Changes and Rate Assumptions
Fiscal 2026
($ in Millions)

	Rate Change
Managed Care Organizations Calendar 2025 (3.5%)	$200.2
Inpatient and Outpatient Services (5.11%)	54.7
Other HSCRC Actions Increasing Hospital Rates	25.0
LTSS Providers, Including Nursing Homes (1%)	21.2
Physician E&M Fees (Increase from 98% to over 100% of Medicare Rates)	12.2
Dental (1%)	1.7
Total	**$315.0**

E&M: evaluation and management
HSCRC: Health Services Cost Review Commission
LTSS: Long Term Services and Supports

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

Due to the fiscal outlook, DLS recommends deleting $12.2 million budgeted for enhanced physician E&M rates in fiscal 2026.

MCO Acuity Adjustment

Under HealthChoice, participating MCOs are paid a capitated monthly fee for each Medicaid patient they enroll and are then responsible for meeting all of the individual's medical needs with the exception of services carved out of the managed care program, such as dental care and specialty behavioral health care. Through the rate-setting process, MDH accounts for different health acuity and needs among various patient demographics and eligibility groups. MCO rates must also be set at an actuarially sound level.

As MDH prepared for disenrollments to resume during the unwinding period from the COVID-19 PHE, there was an expectation that relative health acuity would be higher for remaining Medicaid patients, and an estimate for this trend was factored into calendar 2024 rates. However, this trend did not materialize at first due to certain groups, such as childless adults, reporting a significant decrease in health acuity. As a result, in February 2025, MDH plans to adjust MCO payments to recover a portion of the difference in spending due to lower health acuity. Although previous estimates of this recovery were higher, the current estimate is for MDH to collect $28.9 million in total funds (just over $10 million in general funds) from MCOs.

Due to the timing of MCO rate-setting, calendar 2025 rates were determined while the overall health acuity of Medicaid participants appeared to be declining rapidly, and this anticipated lower spending was incorporated into the rates. Considering the more recent increases in overall health acuity, MDH reported that it would need to provide an upward adjustment to MCO payments to cover the higher health acuity levels. Therefore, the fiscal 2026 allowance includes $124.0 million in total funds ($46.0 million in general funds) for an expected MCO acuity adjustment to calendar 2025 rates, though the actual amount will likely change as more data becomes available.

MDH also budgeted calendar 2025 MCO rates at 1.25% above the bottom of the range to be actuarially sound in anticipation of significant downward acuity adjustments. As discussed, the adjustment for calendar 2024 rates decreased since the rate-setting process and is currently estimated to be $28.9 million in total funds, and calendar 2025 rates will be revised upward for higher acuity. **Therefore, DLS recommends reducing $90.7 million in total funds to lower MCO rates for calendar 2025 to the bottom of the actuarially sound range.**

HSCRC Hospital Adjustments

The fiscal 2026 allowance assumes regulated hospital rates for inpatient and outpatient services will each increase by 5.11% based on the growth factor used in HSCRC rate-setting, which would increase Medicaid hospital spending by an estimated total of $50.9 million. In response to the following HSCRC actions, the budget includes a total of $25 million to cover other increases in hospital rates, including:

- $10 million in total funds ($4 million in general funds) due to an increased set aside for hospitals facing financial hardship;

- $10 million in total funds ($4 million in general funds) for a rate increase to support workforce initiatives as part of the AHEAD model; and

- $5 million in total funds ($2 million in general funds) to be paid into the Population Health Improvement Fund, a new special fund that would be established by HB 1104 of 2025. MDH introduced this bill to create a special fund to support population health efforts under the AHEAD model. There are no special funds budgeted in the fiscal 2026 allowance for this purpose.

Long Term Services and Supports Provider Rate Increases

The fiscal 2026 allowance provides a discretionary rate increase of 1% for Medicaid Long Term Services and Supports (LTSS) providers for a total of $21.2 million in additional spending. **Exhibit 16** outlines rate enhancements included in the budget for Medicaid LTSS providers beginning in fiscal 2017. Since fiscal 2021, Medicaid LTSS providers received 4% rate increases on an annual basis, with some rate increases accelerated to an earlier year, as required by Chapters 10 and 11 of 2019. Corresponding with Chapter 2 of 2023 (the Fair Wage Act) accelerating the increase in the minimum wage, the rate increases mandated for fiscal 2025 and 2026 took effect on January 1, 2024.

Exhibit 16
Medicaid Long Term Services and Support Provider Rate Increases
Fiscal 2017-2026

Fiscal Year	Rate Increase	Effective Date
2017	1.1%	July 1, 2016
2018	2%	July 1, 2017
2019	3%	July 1, 2018
2020	3%	July 1, 2019
2021	4%	July 1, 2020
	4%	Jan. 1, 2021
2022	5.2%*	Nov. 1, 2021
2023	4%	July 1, 2022
	Supplemental 4%	July 1, 2022
	Temporary 4%*	July 1, 2022 to June 30, 2023
2024	4%	July 1, 2023
	8%	Jan. 1, 2024

Fiscal Year	Rate Increase	Effective Date
2025 Working	3%	July 1, 2024
2026 Allowance	1%	July 1, 2025

LTSS: Long Term Services and Supports

* Funded with enhanced federal matching funds authorized in the American Rescue Plan Act that were limited to home and community-based services providers.

Note: Italics denote provider rate increases that were required by budget language or legislation, including Chapter 262 of 2014, Chapters 571 and 572 of 2017, and Chapters 10 and 11 of 2019.

Source: Maryland Department of Health; Department of Legislative Services

Due to there being no mandate for an additional rate increase for Medicaid LTSS providers in fiscal 2026 and the significant increases provided over the last decade, DLS recommends reducing $21.2 million for a 1% provider rate increase that would take effect July 1, 2025.

HCBS providers received additional rate increases supported with federal funding authorized in the American Rescue Plan Act (ARPA) through a provision for a 10% enhanced federal match on qualifying HCBS expenses from April 1, 2021, through March 31, 2022. CMS issued guidance in May 2021, requiring that State fund savings resulting from the enhanced federal match be reinvested to enhance, expand, or strengthen HCBS under the Medicaid program by March 31, 2025. All funds reinvested into HCBS also receive the typical federal matching rate, providing additional federal funds through a secondary matching process.

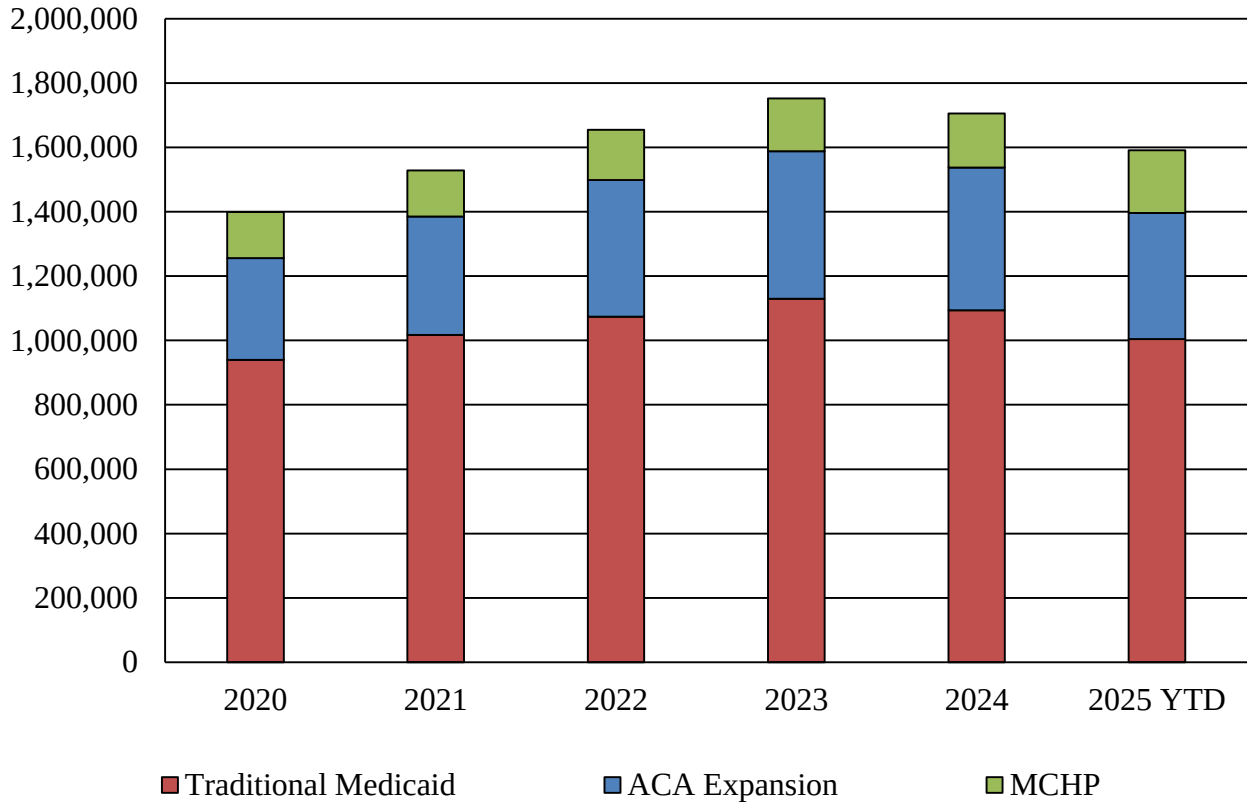
Particularly for DDA and Medicaid, language in the fiscal 2022 Budget Bill further specified the use of ARPA funding for HCBS by requiring that at least 75% of the enhanced federal matching funds be used on a one-time provider rate increase. For HCBS providers under Medicaid, a rate increase of 5.2% took effect November 1, 2021. Rather than eliminating this rate increase when the ARPA funds were fully expended or expired, MDH made these rate increases ongoing and backfilled the federal fund support with State funds. **DLS recommends reducing HCBS provider rates by 2% effective July 1, 2025, due to the end of federal ARPA support for the 5.2% rate increase that was in place since November 1, 2021.**

Enrollment Trends Following the Unwinding Period

As a condition of receiving enhanced federal matching funds during the COVID-19 PHE, MDH was required to freeze disenrollment with limited exceptions. During the continuous enrollment requirement, Medicaid and MCHP caseloads increased significantly, rising to a peak enrollment of over 1.78 million participants in May 2023. The freeze on disenrollment ended April 1, 2023, and MDH initiated a 12-month eligibility redetermination schedule, referred to as the unwinding period.

Redetermination results during the unwinding period yielded fewer disenrollments than expected. As shown in **Exhibit 17**, fiscal 2024 average monthly enrollment decreased by 2.7%, or approximately 47,000 participants, compared to fiscal 2023 but remained higher than the fiscal 2022 level of 1.65 monthly participants. The low rate of disenrollment was partially due to a system error that caused MDH to temporarily pause procedural disenrollments (*i.e.*, cases in which participants did not complete their renewals or had outstanding verification documents). MDH also implemented outreach efforts, federal waiver flexibilities, and other program changes during the unwinding period that kept eligible participants enrolled.

Exhibit 17
Average Monthly Medicaid and Maryland Children's Health Program Enrollment
Fiscal 2020-2025 YTD



ACA: Affordable Care Act
MCHP: Maryland Children's Health Program
YTD: year to date (through January 2025)

Source: Maryland Department of Health

Fiscal 2025 caseloads year to date have decreased to 1.59 million enrollees due in part to expiration of federal waiver flexibilities authorized during the unwinding period. One of the most impactful flexibilities during this period was authorization for MDH to automatically renew individuals with incomes at or below 100% of FPL who did not provide eligibility information. Beginning in October 2024, caseloads also decreased as MDH began to conduct a system reconciliation to ensure that redeterminations in MHBE appeared in the MMIS. According to MDH, both drivers of disenrollments have larger impacts for adults eligible under the ACA expansion; therefore, the ACA expansion group is expected to account for a large share of disenrollments in fiscal 2025.

Through January 2025, the most net disenrollments in fiscal 2025 so far are attributed to children in traditional Medicaid at 57,838 fewer participants compared to fiscal 2024, corresponding with children comprising the largest eligibility category. In contrast, average monthly caseloads have increased for the MCHP eligibility category in fiscal 2025 year to date, beyond even the peak enrollment reported during the COVID-19 PHE. MCHP's year-to-date fiscal 2025 enrollment was 186,456, an increase of just under 25,000 children compared to the fiscal 2024 actual enrollment. This eligibility group has a higher income eligibility threshold at 322% of FPL and likely continues to grow in part due to children in the traditional program reporting higher family incomes that places them in MCHP rather than being fully disenrolled from all coverage. Enrollment declines are also partially offset by an overall increase related to a system error in which Medicaid eligibility was not consistently renewed for individuals receiving SSI.

Fiscal 2025 and 2026 Projected Enrollment

Exhibit 18 compares enrollment figures assumed in the fiscal 2025 legislative appropriation, fiscal 2025 working appropriation, and fiscal 2026 allowance to DLS fiscal 2025 and 2026 enrollment forecasts. Due to the end of waiver flexibilities and system reconciliation between MHBE and MMIS, both forecasts anticipate that average monthly enrollment in fiscal 2025 will decrease below the projection assumed in the fiscal 2025 legislative appropriation. Using actual enrollment through January 2025, DLS estimates that the ACA enrollment and MCHP categories will experience slightly less net disenrollment than projected in the fiscal 2025 working appropriation. However, monthly net disenrollment among children in traditional Medicaid continues to be higher than initially expected, causing the DLS estimate for the traditional Medicaid group to decline compared to the level assumed for the budget development. Another difference appears in the Healthy Babies initiative covering noncitizen pregnant individuals as enrollment trends through January 2025 level off following initial program expansion since the program was first implemented in fiscal 2024.

Exhibit 18
DLS and DBM Management Enrollment Forecasts
Fiscal 2025-2026

	2025			2026		% Change 2025-2026	
	Leg. Approp.	Adjusted Working	DLS Estimate	Allowance	DLS Estimate	Adjusted Working to Allowance	DLS 2025 Estimate to DLS 2026 Estimate
Parents and Caretakers	252,067	235,695	237,179	239,080	232,436	1.4%	-2.0%
Children	523,920	501,679	490,653	505,330	481,337	0.7%	-1.9%
Other Traditional Medicaid	257,425	260,177	260,472	265,469	262,861	2.0%	0.9%
ACA Expansion	406,278	353,870	365,650	309,479	310,127	-12.5%	-15.2%
MCHP	139,654	185,300	190,429	191,630	194,237	3.4%	2.0%
Healthy Babies Initiative	5,785	9,628	8,452	9,628	8,452	0.0%	0.0%
Total	**1,585,129**	**1,546,349**	**1,552,834**	**1,520,616**	**1,489,449**	**-1.7%**	**-4.1%**

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

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

Both forecasts anticipate that annualization of disenrollments in fiscal 2025 will lead to an overall decrease in enrollment in fiscal 2026 compared to the prior year, driven by the ACA expansion group. The forecasts diverge in the traditional Medicaid group as the allowance assumes that family eligibility groups (parents/caretakers and children) will marginally increase compared to fiscal 2025 assuming growth rates experienced before the COVID-19 PHE will resume. In comparison, the DLS forecast projects that the decline in enrollment since the unwinding period began will carry forward into fiscal 2026, with caseloads for each family group declining by about 2% from fiscal 2025 to 2026.

General Fund Adequacy

In assessing the adequacy of the Medicaid budget for fiscal 2025, DLS finds that there are not significant cost differences due to enrollment assumptions. Despite the forecasts having variations in disenrollment assumptions across the eligibility groups, the fiscal 2025 working appropriation would meet the expected need calculated in the DLS forecast. However, the forecasts differed significantly in anticipated healthcare utilization, particularly for inpatient hospital services. **Due to the budget overstating healthcare utilization, DLS recommends reducing the fiscal 2025 proposed deficiency appropriation by $100 million in general funds.**

Based on the diverging fiscal 2026 enrollment projections among the family categories in traditional Medicaid, DLS estimates that the fiscal 2026 allowance is slightly overbudgeted. The reduction in expected enrollment in the Healthy Babies initiative in fiscal 2026 after accounting for recent experience also offsets any expenses needed to cover more children enrolled in MCHP. **As a result of lower projected enrollment in fiscal 2026, DLS recommends reducing the fiscal 2026 allowance for Medicaid by $90 million in total funds ($35 million in general funds) and for MCHP by $42.8 million in total funds ($15 million in general funds).**

Personnel Data

	FY 24 Actual	FY 25 Working	FY 26 Allowance	FY 25-26 Change
Regular Positions	638.00	682.10	682.10	0.00
Contractual FTEs	68.72	97.75	87.57	-10.18
Total Personnel	**706.72**	**779.85**	**769.67**	**-10.18**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	47.54	6.97%
Positions and Percentage Vacant as of 12/31/24	111.00	16.27%
Vacancies Above Turnover	63.46	

- As of December 31, 2024, MCPA reported 111 vacant positions, which is 63.46 more vacancies than necessary to meet budgeted turnover in fiscal 2026. Of these vacant positions, 28 are new positions or contractual conversions added in fiscal 2025. In addition, 27 positions have been vacant for more than one year, including 13 positions that have been vacant for more than two years. **DLS recommends deleting funding for the 13 long-term vacant positions that have remained unfilled for more than two years.**

Issues

1. Medicaid is a Key Driver of State Fund Spending Growth

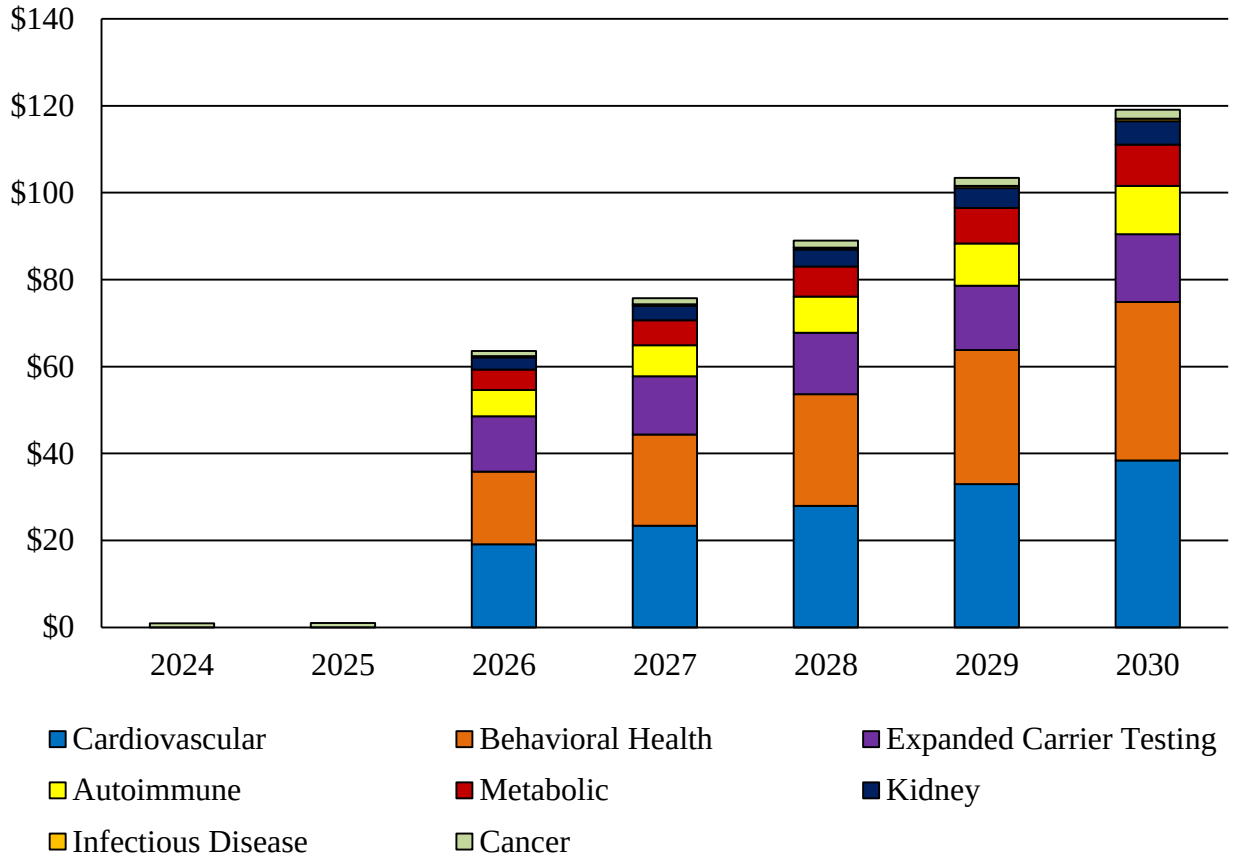
Aside from local aid (mainly for K-12 education), Medicaid is the largest driver of State general fund spending. The combined impact of the COVID-19 PHE freezing disenrollments, program expansions of eligibility and coverage, and higher healthcare utilization has led Medicaid spending to increase drastically. Medicaid costs in fiscal 2024 and 2025 greatly surpassed budgeted amounts, as proposed deficiency appropriations add a net total of $767.4 million in general funds to cover Medicaid and MCHP cost overruns. This immediate spending growth was unexpected as MDH reported higher than anticipated enrollment following the unwinding period and rapid growth in healthcare utilization and inflation.

Despite the fact that a large share of the State's structural deficit projected in fiscal 2026 and beyond is attributed to rising Medicaid costs, the fiscal 2026 allowance does not include many cost saving measures in Medicaid and MCHP in the short term or on an ongoing basis. The most significant cost containment action proposed in the BRFA of 2025 and fiscal 2026 budget plan is an ongoing increase in the Medicaid deficit assessment to $394 million beginning in fiscal 2026, providing $92.5 million in general fund savings each year. Another cost containment measure in the allowance reduces $166,000 in total funds to eliminate oversight of Hepatitis C medications covered by MCOs.

Due to the out-year forecast projecting significant structural shortfalls, partially driven by Medicaid spending growth, cost containment actions within Medicaid should be considered. At the federal level, there is also significant uncertainty related to federal fund availability and policy changes to reduce Medicaid spending and enrollment that exacerbate potential State costs for Medicaid in the future and underscore the importance of proactively reducing Medicaid spending.

A potential area for Medicaid spending reductions could be recent program expansions established through newly approved waivers or legislation. For example, 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. MDH submitted a mandated report on this coverage expansion in December 2024 that projected significant costs related to this policy. **Exhibit 19** shows MDH's estimates for costs of providing biomarker testing for various conditions.

Exhibit 19
Estimated Costs of Biomarker Testing Expansion by Condition
Fiscal 2024-2030
($ in Millions)



Source: Maryland Department of Health

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. Costs shown in fiscal 2024 and 2025 reflect actual and expected spending for only the expansion of biomarker testing for cancer. The fiscal 2026 allowance provides $8 million in general funds in the Dedicated Purpose Account (DPA) to cover the costs for expanding biomarker testing to all other conditions shown in the exhibit, although MDH estimated total costs to increase by $62.4 million in total funds ($23.7 million in general funds) in fiscal 2026. **Therefore, DLS recommends adding a provision to the BRFA of 2025 delaying the expansion of biomarker testing from July 1, 2025, to July 1, 2027.**

MDH has implemented other recent program expansions by applying for waivers from CMS and receiving federal approval to expand services. Most recently, MDH received CMS approval to implement a reentry demonstration program to provide Medicaid coverage to individuals transitioning out of State prisons. The fiscal 2026 budget does not currently include funding for this purpose.

MDH also received federal approval to expand a pilot program for ACIS for housing support services. Under the pilot program, the department collected local government contributions as special funds to claim federal reimbursement for ACIS spending. Effective January 1, 2025, MDH expanded this program and replaced the local contributions with State spending, budgeting a total of $10.8 million ($5.4 million in general funds) in each year in fiscal 2025 and 2026. **DLS recommends reducing $10.8 million in fiscal 2026 for the ACIS expansion and returning to the pilot program's funding mechanism of using local spending to draw down federal reimbursement.**

The following list details Medicaid and MCHP program expansion implemented through legislation in the 2022, 2023, and 2024 sessions.

- ***EID Program:*** EID extends Medicaid to Marylanders with disabilities to encourage them to seek or maintain employment. Chapters 845 and 846 of 2024 repeal existing EID provisions and establish new requirements for the program that generally align or are consistent with existing program policies such as not limiting eligibility based on the earned or unearned income of the applicant or applicant's spouse. The fiscal 2026 allowance includes $12.2 million in total funds ($6.1 million in general funds) for the program overall.

- ***Coverage for Prostheses:*** Beginning January 1, 2025, Chapters 822 and 823 of 2024 require Medicaid to provide coverage for prostheses and replacement for prostheses. Among other requirements, the coverage must include prostheses determined to be medically necessary to perform activities of daily living, essential job-related activities, or physical activities. The budget plan includes $1.7 million in total funds ($843,750 in general funds) in fiscal 2025 and $3.4 million in total funds ($1.7 million in general funds) in fiscal 2026 for this expansion.

- ***Gender-affirming Treatment:*** Chapters 252 and 253 of 2023 express the intent of MGA 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. These services were estimated to cost just under $8.5 million in total funds ($3.0 million in general funds) in calendar 2024.

- ***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.

- ***Adult Dental Coverage Expansion:*** Prior to the enactment of Chapters 302 and 303 of 2022, Medicaid and MCHP only provided comprehensive dental benefits to children and certain adults, including income-eligible pregnant individuals, certain former foster care adolescents, and adults enrolled in the Rare and Expensive Case Management program. All nine MCOs operating in Maryland voluntarily covered limited adult dental services for their members as an add-on benefit but did not receive reimbursement from MDH for these services. Individuals ages 21 to 64 who were dually eligible for Medicaid and Medicare could also receive dental benefits through a statewide pilot program that took effect June 1, 2019. Since January 1, 2023, Chapters 302 and 303 have required Medicaid to cover diagnostic, preventive, restorative, and periodontal dental services for adults with household incomes up to 133% of FPL. The fiscal 2026 allowance includes $138.4 million in total funds ($42.5 million in general funds) for the dental coverage expansion.

- ***Healthy Babies Equity Act:*** Chapter 28 of 2022 requires Medicaid to provide comprehensive medical care and other health care services to noncitizen pregnant individuals who would be eligible for Medicaid, but for their immigration status, and codifies the requirement that Medicaid cover their children up to the age of one. This eligibility group receives an enhanced federal match of 65%. The fiscal 2026 allowance includes $202.1 million in total funds ($70.7 million in general funds) for this program.

Given the State's budget challenges and expected federal reductions in Medicaid funding for states, the General Assembly should carefully consider whether the most recent enhancements to Medicaid are affordable.

2. Possible Federal Changes to Medicaid Have Significant Budgetary Impacts

Potential changes to Medicaid funding mechanisms at the federal level pose additional budgetary challenges as federal support could be reduced. The fiscal 2026 allowance projects federal fund support totaling $7.69 billion (57.7%) within MCPA, excluding Medicaid behavioral health reimbursements. This estimate is based on the current federal reimbursement model with most qualifying costs receiving 50% federal matching funds and some groups receiving enhanced matching rates, including adults covered under the ACA expansion (90%) and MCHP and Healthy Babies initiative participants (65%). If the enhanced federal match for the ACA expansion group was reduced from 90% to 50%, federal support in the fiscal 2026 allowance would decrease by approximately $992 million. For MCHP and Healthy Babies initiative spending, an adjustment to a 50% federal match would reduce fiscal 2026 federal support by $103 million. Certain spending

also receives enhanced federal reimbursement that could be reduced, such as development costs for approved major information technology projects.

Federal legislation or restrictions on the federal budget could prohibit support for certain eligibility groups or services covered under Medicaid and MCHP. For example, language included in the federal budget since 1977, commonly referred to as the Hyde amendment, forbids the use of federal funds for abortions except in certain cases. If federal fund participation was prohibited for coverage of noncitizens and undocumented immigrants, in fiscal 2026, this would reduce $142 million in federal funds that Maryland expects to claim for emergency medical services for undocumented immigrants and $131 million in federal funds expected to support the Healthy Babies initiative to cover noncitizen pregnant individuals. Other services currently covered by Medicaid that could be affected include gender-affirming treatment and family planning services, including the expansion of these services under the Medicaid Family Planning program.

One federal policy change considered in the past was transitioning Medicaid to a block grant or per capita cap. The impact of this change on the State budget would vary drastically based on how the block grant or cap is designed. Therefore, DLS has not yet estimated potential budget impacts from this change without more information. Based on past analyses at the national level, moving from a reimbursement model would be expected to reduce federal funding in the long term, potentially by a significant amount. Other considerations would be that limiting federal funds to a certain cost per person could make the program less reactive to inflation and increasing medical costs depending on how growth factors are applied. Another consideration specifically for a block grant is that depending on how the formula is calculated, federal funding levels might not respond as quickly to economic downturns that would drive Medicaid enrollment higher.

Other changes in federal requirements could lead to lower Medicaid and MCHP costs overall by limiting enrollment. However, if the State chose to continue coverage for disenrolled individuals using only State funds, this would lead to higher State costs. Work requirements for Medicaid participants have been discussed at the federal level before, and for illustrative purposes, the Congressional Budget Office previously estimated that there could be a 3.5% reduction in enrollment among adults as a result. Procedural changes, such as requiring Medicaid programs to redetermine eligibility more than once per year, could also reduce enrollment. Any reduction in spending due to work requirements or changes to eligibility redetermination requirements would be partially offset by additional administrative costs to implement the changes.

Exhibit 20 presents the fiscal impact for fiscal 2026 of various possible changes in federal policy.

Exhibit 20
Impact of Potential Changes to Federal Medicaid Policies
Fiscal 2026 Allowance
($ in Millions)

Policy	$ Impact
Reduce Federal Match on ACA Expansion Costs from 90% to 50%	$992
Reduce Federal Match on MCHP and Healthy Babies Costs from 65% to 50%	103
Deny Federal Match for Services for Undocumented Immigrants	142
Deny Federal Match for Healthy Babies Program	130
Deny Federal Match for Gender Affirming Treatment	6
Apply Work Requirements to Adults Enrolled in Medicaid	Indeterminate State Savings

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

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

3. Expansion of Medicaid Reimbursement for School-based Behavioral Health Services

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/IFSPs and (2) administrative costs as permitted under federal guidance. CMS issued a notice of funding opportunity for a cooperative agreement that would provide federal support for costs associated with school-based service expansion. MDH applied for this funding and received an award of $2.5 million over three years, from fiscal 2025 to 2027.

Behavioral Health Services Reimbursement

To implement phase one, MDH received federal approval for a waiver to expand school-based behavioral health services coverage and beginning on January 1, 2025, can reimburse services provided by licensed school psychologists and school social workers for children with or without IEPs/IFSPs enrolled in Medicaid or MCHP. Previously, Medicaid only covered school-based services provided through an approved IEP or IFSP. As part of this change, Medicaid established requirements for school psychologists to enroll as Medicaid providers that differ slightly from requirements for licensed community-based psychologists. For example, school psychologists are licensed by MSDE, while community-based psychologists are licensed by the

State Board of Examiners for Psychologists, and the two entities have different licensure requirements.

In response to committee narrative in the 2024 JCR requesting a report on school-based services expansion, MDH indicated that behavioral health reimbursement rates for services provided in a school setting and community-based setting would be set at the same level. Additionally, like most specialty behavioral health services provided by Medicaid, behavioral health services for children will continue to be processed on a FFS basis by the behavioral health ASO, regardless of setting or provider type. The department reported that it planned to spend some of its federal cooperative agreement funding to assist the ASO in developing a process for facilitating referrals from school psychologists and social workers to community-based behavioral health providers in cases when a student needs additional services.

The BRFA of 2024 contained 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 in fiscal 2025 only. Language in the fiscal 2025 Budget Bill further specified that no more than $12 million from the consortium could be spent for this purpose. However, the fiscal 2025 working appropriation does not yet reflect reimbursable funds in Medicaid to account for this support for the school-based services expansion.

The fiscal 2026 allowance includes the State share of funding as general funds within BHA for the expansion in school-based behavioral health services. MDH indicates that it will add reimbursable funds in the Medicaid budget to account for this spending and to claim federal matching funds. **MDH should provide an estimate for the annualized cost to continue the phase one expansion of school-based behavioral health services in fiscal 2026.**

Administrative Claiming in Schools

State Medicaid programs are also able to cover school-based administrative services that support the provision of Medicaid services to children in schools and activities related to outreach and enrollment. MDH reported in past status reports on Medicaid coverage of administrative costs in schools 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 indicated that it would not consider the steps needed to implement an administrative claiming program until new guidance was issued.

In May 2023, CMS released *Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming* that provides guidance for Maryland to develop an administrative claiming program. MDH plans to implement coverage of administrative costs in schools as part of the second phase of school-based services expansion. Early planning for an administrative claiming program entails MDH developing cost report

templates and methodology to receive federal fund participation and for local education agencies to receive Medicaid reimbursement of administrative costs for their school-based health services. Currently, the department is using a portion of the federal cooperative agreement funding for a vendor to develop a request for proposals (RFP) for an Administrative Planning Contractor. MDH expects to issue the RFP in summer 2025.

The department has noted previously that development of an administrative claiming program is complex and requires extensive planning and technical assistance. As a result, MDH does not expect to begin reimbursing for these services until at least calendar 2026 or fiscal 2027. Additionally, the fiscal 2026 budget plan does not include funding to launch administrative claiming.

Operating Budget Recommended Actions

1. 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 programs M00Q01.07 Maryland Children's Health Program or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements. 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 or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

		Amount Change	
2.	Reduce general funds within the Medicaid program and authorize a budget amendment to be processed to replace these funds with special funds in recognition of available Cigarette Restitution Fund support.	-$ 25,000,000	GF
3.	Reduce funding for the Population Health Incentive Program in fiscal 2026 to provide performance incentive payments of up to 0.25% of anticipated capitated rates for managed care organizations.	-$ 6,583,517 -$ 11,416,483	GF FF
4.	Reduce funding for Medicaid provider reimbursements to lower rates for managed care organizations in calendar 2025 to the bottom of the actuarially sound level.	-$ 32,700,000 -$ 58,000,000	GF FF
5.	Delete funding for the 1% provider rate increase budgeted in fiscal 2026 for Long Term Services and Supports providers.	-$ 10,544,663 -$ 10,685,052	GF FF
6.	Reduce general funds budgeted to account for hospital assessment revenue collected by the Health Services Cost Review Commission to be transferred to the Medicaid Primary Care Fund and	-$ 16,000,000	GF

authorize a budget amendment to replace these funds with special funds.

7.	Reduce funding for Medicaid provider reimbursements to level fund physician evaluation and management rates at 98% of Medicare rates.	-$ 4,800,000 -$ 7,400,000	GF FF
8.	Reduce funding for the expansion in the Assistance in Community Integration Services (ACIS) housing support waiver. Prior to fiscal 2025, the ACIS pilot program was supported with local contributions that would be used as the matching amount for federal reimbursement.	-$ 5,400,000 -$ 5,400,000	GF FF
9.	Reduce funding for Health Home payments as a technical correction. These expenditures are double budgeted as funding is also budgeted in M00Q01.10 Medicaid Behavioral Health Provider Reimbursements as part of a program realignment.	-$ 9,112,766 -$ 9,112,766	GF FF
10.	Reduce provider rates by 2% for home and community-based services (HCBS) providers. Federal funding authorized through the American Rescue Plan Act (ARPA) temporarily supported a 5.2% HCBS provider rate increase, but the rate increase was made ongoing with State support despite the ARPA funds expiring in fiscal 2025.	-$ 3,600,000 -$ 3,800,000	GF FF
11.	Reduce funding for Medicaid reimbursements based on reduced enrollment expectations in fiscal 2026.	-$ 35,000,000 -$ 55,000,000	GF FF

12. 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 2025 budget expenditures under the CFC program. Additionally, the report should provide:

- the number of budgeted Community Options waiver slots in fiscal 2025 and 2026;

- the number of Community Options waiver slots filled in fiscal 2025;

- 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 that supports 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, 2025; and

- 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.

Information Request	**Author**	**Due Date**
Report on CFC program and Community Options waiver financial and registry data	MDH	August 1, 2025

13. Adopt the following narrative:

Quarterly Medicaid Enrollment Change and Application Processing: The Maryland Department of Health (MDH) completed 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 monitor Medicaid and MCHP enrollment trends 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, with modified adjusted gross income (MAGI) cases and non-MAGI cases shown separately;

- 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 overscale 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 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, 2025 October 15, 2025 January 15, 2026 April 15, 2026

14. Adopt the following narrative:

Evaluation of Primary Care Programs and Initiatives: The Maryland Department of Health (MDH) and the Health Services Cost Review Commission (HSCRC) are implementing primary care and population health initiatives in coordination with the State's Advancing All-payer Health Equity Approaches and Development (AHEAD) model. These efforts include launching the Medicaid Advanced Primary Care Program in fiscal 2026, establishing the Population Health Improvement Fund, and continuing to administer the Maryland Primary Care Program (MDPCP) that was first implemented under the Total Cost of Care model (the federal agreement before the AHEAD model). The committees request that MDH, in consultation with HSCRC, submit a report on implementation of the new initiatives, including design and initial activities of the programs, uses of any funding allocated to these initiatives, descriptions of fund sources supporting the initiatives, and estimated cost savings and provider incentives under the Medicaid Advanced Primary Care Program. The report should also include an evaluation of the effectiveness of the existing MDPCP. In particular, this evaluation should outline cost savings from the MDPCP reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives.

Information Request	Author	Due Date
Evaluation of primary care programs and initiatives	MDH HSCRC	November 1, 2025

15. 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 programs M00Q01.03 Medical Care Provider Reimbursements or M00Q01.10 Medicaid Behavioral Health 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 or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

		Amount Change		Position Change
16.	Reduce funding for reimbursements under the Maryland Children's Health Program based on reduced enrollment expectations for participants in the Healthy Babies initiative.	-$ 15,000,000 -$ 27,800,000	GF FF	
17.	Delete funding for 13 long-term vacant positions that have been unfilled for more than two years, including 11 positions in the Office of Eligibility Services and 2 positions in Benefits Management and Provider Services. The Maryland Department of Health is authorized to allocate this reduction across programs within the Medical Care Programs Administration.	-$ 271,262 -$ 503,770	GF FF	-13.0
18.	Reduce funding in the fiscal 2025 proposed deficiency appropriation for Medicaid reimbursements based on unallocated funding under the Population Health Incentive Program for managed care organization performance in calendar 2023.	-$ 2,971,910 -$ 6,196,206	GF FF	

19.	Reduce funding from a fiscal 2025 deficiency appropriation to account for recoveries from the calendar 2021 and 2022 risk corridor and based on lower anticipated healthcare utilization, particularly for inpatient hospital services.	-$ 151,600,000 -$ 110,900,000	GF FF	
	Total Net Change to Fiscal 2025 Deficiency	**-$ 271,668,116**		
	Total Net Change to Allowance	**-$ 353,130,279**		**13.0**
	Total General Fund Net Change to Allowance	**-$ 164,012,208**		
	Total Federal Fund Net Change to Allowance	**-$ 189,118,071**		

Budget Reconciliation and Financing Act Recommended Actions

1. Amend a provision to establish a Medicaid Primary Card Program Fund as a technical correction to change Card to Care and refer to the Health Services Cost Review Commission, rather than the Health Services Review Commission.
2. Reject the provision in the Budget Reconciliation and Financing Act of 2025 authorizing the Maryland Department of Health to transfer funds among its budgetary programs.
3. Amend a provision to increase the authorized fund balance transfer from the Maternal and Child Health Population Health Improvement Fund to the General Fund from $10.0 million to $14.1 million.
4. Add a provision to expand the allowable uses of funds received from litigation related to the Cigarette Restitution Fund that is placed in a separate account to support Medicaid expenses in fiscal 2026 only.
5. Add a provision to expand the allowable uses of the Senior Prescription Drug Assistance Program Fund in fiscal 2026 and future years to include depositing funds into health reimbursement accounts of certain State retirees transitioning to Medicare Part D to align with the budget.
6. Add a provision to delay the expansion of biomarker testing to conditions other than cancer, required by Chapters 322 and 323 of 2023, from July 1, 2025 to July 1, 2027.

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 certain circumstances. Specifically, a physician or surgeon must have certified that, based on his or her professional opinion, the procedure was necessary. Similar language had been attached to the appropriation for MCHP since its advent in fiscal 1999 through 2022. MGA 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). Beginning on January 1, 2023, Medicaid and MCHP funds are authorized to cover abortion care services with restrictions that are consistent with Title 20, Subtitle 2 of the Health – General Article. **Exhibit 21** provides a summary of the number and cost of abortions by service provider in fiscal 2022 through 2024.

Exhibit 21
Abortion Funding under Medicaid
Fiscal 2022-2024

	Performed under 2022 State and Federal Budget Language	Performed under 2023 State and Federal Budget Language	Performed under 2024 Federal Budget Language and State Law
Abortions	11,596	12,807	12,518
Total Cost ($ in Millions)	**$7.7**	**$8.0**	**$9.1**
Average Payment Per Abortion	$661	$623	$726
Abortions in Clinics	9,459	10,938	10,684
Average Payment	$459	$456	$545
Abortions in Physicians' Offices	1,647	1,302	1,216
Average Payment	$1,094	$1,055	$1,257
Hospital Abortions – Outpatient	*	*	*
Average Payment	$3,054	$2,699	$2,777
Hospital Abortions – Inpatient	*	*	*
Average Payment	$19,968	$44,486	$24,190
Abortions Eligible for Joint Federal/State	0	0	0

*Indicates a dataset of less than 11 cases.

Note: Data for fiscal 2022 and 2023 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2024 includes all abortions for which a Medicaid claim was filed through November 2024. 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 2024. For example, for fiscal 2023, 80 additional claims were paid after November 2023, which explains differences in the fiscal 2023 data reported in this analysis compared to prior Medicaid budget analyses.

Source: Maryland Department of Health

Effective November 18, 2024, MDH updated regulations for the Medicaid program to expand coverage of abortion care services and post-abortion services to all pregnant individuals, including those under the Medicaid Family Planning Program and participants eligible for Medicaid solely due to a pregnancy. The income threshold to be eligible for Medicaid is higher based on pregnancy status (up to 264% of FPL) and prior to November 18, 2024, individuals eligible for Medicaid due to pregnancy status alone did not qualify for coverage of abortion care services. The Medicaid Family Planning Program is a limited benefit program for low-income people (up to 264% of FPL) who are not already enrolled in Medicaid. Benefits are limited to services related to contraceptive management. To implement this coverage expansion, the fiscal 2025 working appropriation and the fiscal 2026 allowance each includes $11.9 million in total funds ($5.2 million in general funds). In each year, $398,000 in general funds is budgeted to cover the State-only costs for the expansion in abortion care services.

2. Statewide Review of Budget Closeout Transactions for Fiscal 2024

Each year, OLA conducts a review of the State's preceding fiscal year budget closeout transactions. OLA's *Statewide Review of Budget Closeout Transactions for Fiscal Year 2024* included two repeat findings for MDH. Specifically, OLA found that MDH (1) could not provide documentation to support the propriety of accrued federal fund revenue totaling approximately $1.7 billion or the subsequent recovery of the funds and (2) reported $273.6 million in unprovided for general fund payables and other general fund liabilities as of June 30, 2024. As discussed in the Budget Analysis section of this document, the fiscal 2026 budget includes a proposed deficiency appropriation to cover reported fiscal 2024 shortfalls.

Appendix 1
2024 *Joint Chairmen's Report* Responses from Agency

The 2024 JCR requested that MDH prepare 12 reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Quarterly Reports on Medicaid Enrollment Change and Application Processing:*** Committee narrative in the 2024 JCR requested that MDH submit quarterly reports with monthly eligibility redetermination data and administrative measures, such as call center volume and application processing times. MDH submitted the first three quarterly reports on October 11, 2024, October 17, 2024, and February 3, 2025, respectively. The final report is due on April 15, 2025. Additional information regarding the administrative measures can be found in the Performance Analysis section and further discussion of Medicaid enrollment data can be found in the Budget Analysis section of this document.

- ***CFC Program and HCBS Waiver Financial and Registry Data:*** On August 15, 2024, MDH submitted a report 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 analysis for M00 – MDH Overview.

- ***End the Wait Initiatives to Increase Provider Capacity:*** On December 17, 2024, MDH submitted a report on plans to reduce HCBS waiver registries and wait lists by 50%. MDH developed the registry reduction plans as required by Chapter 464 of 2022 (the End the Wait Act). A total of $16 million in general funds was budgeted in the DPA in fiscal 2024 and 2025 for End the Wait initiatives and efforts to increase HCBS provider capacity. However, cost containment measures approved by BPW in July 2024 and proposed in the fiscal 2026 budget plan transfer the funds to the General Fund. Additional information about efforts to reduce Medicaid HCBS waiver registries and build HCBS provider capacity can be found in the analysis for M00 – MDH Overview.

- ***Proposed Federal Rule on Medicaid Long-term Care Data Reporting:*** CMS published the *Ensuring Access to Medicaid Services Final Rule* in May 2024, and the rule took effect July 9, 2024. The committees requested that MDH submit a report within 180 days of the release of the final rule detailing the provisions and plans to operationalize the rule in Maryland. On December 17, 2024, MDH submitted a report indicating that the Office of Long Term Services and Supports within MCPA would implement the rule and as a result, the office would need 15 additional positions. MDH outlined new federal requirements such as written notice to CMS and certain limitations for HCBS provider rate reductions; the establishment of a beneficiary advisory council and an advisory committee for interested parties affected by service rates; publication of a comparative rate analysis between Medicare and Medicaid FFS rates for HCBS; a grievance system for participants

to file complaints or dissatisfaction with the State's or providers' performance; and changes to improve HCBS rate transparency and adequacy by ensuring providers spend 80% of total payments on total compensation for direct care workers, among other efforts.

- ***Nursing Home Participation in Medicaid and Reported Revenues:*** MDH submitted a report on January 14, 2025, with data on nursing facility participation in Medicaid and reimbursement by local jurisdiction and ownership type in fiscal 2024. A total of 206 nursing facilities actively participated in Medicaid in fiscal 2024 and received $1.7 billion in reimbursements, with most reimbursements (82%) supporting for-profit facilities. Nursing facilities in Baltimore City received the highest amount of reimbursement at $315.6 million, while those in Queen Anne's County had the lowest amount at $8.8 million. The number of nursing facilities participating in Medicaid ranged from 1 in Queen Anne's County to 38 in Baltimore County.

- ***Reimbursement for Maternal Fetal Medicine:*** On February 3, 2025, MDH submitted a study of Medicaid reimbursement rates for services provided by maternal fetal medicine (MFM) specialists (physicians who specialize in high-risk pregnancies). The department reported that 3,583 Medicaid participants received services from MFM specialists in fiscal 2023, accounting for approximately 11% of annual births. However, physicians must self-report their status as an MFM specialist and submit certification when enrolling as a Medicaid provider, leading to underestimated data on MFM specialists and service volume in Medicaid. The report outlined Medicaid reimbursement rates for MFM services and found that Maryland's reimbursement rates were similar to nearby states but fell below Medicare and commercial rates. MDH estimated that Maryland's annual State share of reimbursements would increase by $3.2 million to $18.2 million if rates were set to the Medicare level. The range in cost estimates depends on how many MFM codes are adjusted.

- ***Medicaid Reimbursement of School-based Behavioral Health Services:*** Effective January 1, 2025, Maryland Medicaid expanded coverage of school-based behavioral health services provided by certified school psychologists and school social workers to include services for students without an IEP or IFSP. Maryland Medicaid previously reimbursed school-based psychological services for children with IEPs or IFSPs only. The committees requested a report on the implementation of this coverage expansion, and MDH submitted a report on February 5, 2025. Further discussion of school-based services can be found in Issue 3.

- ***Status of Corrective Actions Related to the Most Recent Fiscal Compliance Audit:*** Language in the fiscal 2025 Budget Bill restricted $100,000 in general funds from MCPA pending the submission of a letter from the OLA on the status of corrective actions related to a fiscal compliance audit issued in November 2023. As of February 1, 2025, OLA has not submitted a letter, and the withheld funding has not been released.

- ***Recruitment and Retention of Anesthesiologists in Maryland:*** The committees requested that MDH, the Maryland Health Care Commission, and HSCRC, in coordination with the Maryland Society of Anesthesiologists, study barriers in the recruitment and retention of anesthesiologists. Additionally, the committees requested that the agencies submit a joint report by December 15, 2024, that outlines the findings and recommendations resulting from the study. As of February 8, 2025, the joint report had not been submitted.

Appendix 2
Audit Findings
MDH – Pharmacy Services

Audit Period for Last Audit:	July 1, 2019 – December 31, 2022
Issue Date:	August 2024
Number of Findings:	4
Number of Repeat Findings:	2
% of Repeat Findings:	50%
Rating: (if applicable)	N/A

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

Finding 1: MCPA did not ensure manually processed pharmacy claims were proper, resulting in overpayments of approximately $397,000 related to 11 of the 15 claims tested by the Office of Legislative Audits.

Finding 2: **MDH did not have procedures to ensure that prescribing providers were licensed prior to approving pharmacy claims for payment.**

Finding 3: **MDH did not audit three of the four FFS programs' pharmacy claims, did not analyze claim reversals, and did not use available drug utilization claims data to identify improper claims.**

Finding 5: Redacted cybersecurity-related finding.

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

Appendix 3
Long Term Services and Supports Tracking System
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2012				**Est. Completion Date:** June 30, 2029				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$35.792	$3.834	$0.200	$0.000	$0.000	$0.000	$0.000	$39.827
FF	193.017	26.077	29.865	0.000	0.000	0.000	0.000	248.959
Total	**$228.809**	**$29.911**	**$30.065**	**0.000**	**0.000**	**0.000**	**0.000**	**$288.786**

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, real-time medical and service information, service authorization, and claims submission. Initially developed in calendar 2012 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 was completed in calendar 2024. MDH is now implementing modules for the Autism Waiver and a reportable incident module.

- ***Changes:*** MDH extended the contracts with its software development vendor through October 31, 2026, and operations and management vendor through December 31, 2025. Following the completion of DDA modules in calendar 2024, estimated total project costs presented in the 2025 session have decreased by $138.4 million, or 32%, from the estimate of $427.2 million provided during the 2024 session. In addition, MDH has shortened the timeframe for funding need for this project from fiscal 2028 to 2026.

- ***Concerns:*** MDH identified four factors as medium risk, including resource availability as contracts were extended but still terminate in fiscal 2026 and 2027; organizational culture due to changes in program leadership; supportability through ongoing upgrades for

maintaining a custom application; and implementation to ensure new code and functionalities are properly tested before release.

- ***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 2026 projected costs are budgeted with a 99.3% federal matching rate.

Appendix 4
MMT – Business Process Reengineering (BPR) and Consolidated Customer Relationship Management (CRM)
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: April 1, 2024				**Est. Completion Date:** January 1, 2030				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.833	$1.442	$2.902	$2.509	$1.507	$9.193
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	5.878	7.049	6.606	4.176	1.815	1.489	27.014
Total	**$0.000**	**$5.950**	**$7.882**	**$7.079**	**$7.079**	**$7.319**	**$2.995**	**$36.278**

This is the first of 14 modular systems in MMT MITDP to replace Medicaid's antiquated and inflexible legacy information system with a modern MMIS. Of these systems, 13 are summarized in this analysis in Appendix 4 through Appendix 16. The Behavioral Health ASO system is discussed in the analysis for M00L – BHA.

- ***Project Summary***: The BPR and Consolidated CRM component of the MMT project aims to modernize manual paper processes through electronic document management capabilities, automation, enhanced operational and financial controls, and strategic use of dashboards and financial reports. MDH plans to procure a Software as a Service (SaaS) solution for Medicaid participant and provider CRM.

- ***Observations and Milestones:*** MDH initially contracted with multiple vendors that could not complete the project due to various issues, such as filing for bankruptcy or not meeting development needs. MDH reported completing procurement in October 2024 and is using the statewide Salesforce master contract for development services.

- ***Changes:*** MDH and DoIT previously reported updates on the MMT project as one MITDP with a roadmap describing each of the various components and modules. Beginning in the 2025 session, these projects are now presented separately.

- ***Concerns*:** MDH and DoIT identified medium risks with (1) resource availability, specifically strains on business team members due to multiple IT projects being developed simultaneously, (2) funding due to the 10% State match requirement, and (3) technical needs due to the need for MMIS technical expertise for complex Medicaid data.

Appendix 5
MMT – CMS Interoperability Rule
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2024				**Est. Completion Date:** December 20, 2027				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.932	$1.322	$1.639	$0.000	$0.000	$3.893
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	2.482	7.934	7.934	4.098	0.000	0.000	22.447
Total	**$0.000**	**$2.553**	**$8.866**	**$9.256**	**$5.737**	**$0.000**	**$0.000**	**$26.411**

- ***Project Summary***: This component involves designing a data warehouse for MDH to store certain data required by CMS to be accessible for multiple stakeholders and processes, including providers, Medicaid recipients, claims, authorization, etc.

- ***Need:*** CMS issued the Interoperability and Patient Access final rule that mandates Fast Healthcare Interoperability Resources application programming interfaces (API) to improve data exchange and improve prior authorization processes. MDH must comply with several APIs by January 1, 2027, as part of the CMS requirement.

- ***Changes:*** MDH initially planned to use the State health information exchange for interoperability capabilities but is designing a different approach due to a high level of data requirements. This component is still in the planning stage, but MDH expects to complete the procurement stage at the end of calendar 2025.

- ***Concerns*:** MDH and DoIT identified two high risks related to staffing: (1) resource availability due to MDH lacking in house technical staff and needing to use statewide master contracts for development activities that have delayed the project; and (2) supportability due to the concern that MDH will not have the technical capabilities to support the new technology after the deadline to go live on January 1, 2027.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 6
MMT – Consolidated Call Center and Integrated Voice Response (IVR)
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: September 2, 2024				**Est. Completion Date:** April 1, 2029				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.071	$0.648	$0.479	$0.345	$0.000	$1.544
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	1.869	3.917	3.886	2.876	2.072	0.000	14.622
Total	**$0.000**	**$1.940**	**$3.988**	**$4.534**	**$3.356**	**$2.418**	**$0.000**	**$16.237**

- ***Project Summary***: This component of the MMT project aims to concentrate all existing direct dial call centers within MDH to use one central single point of entry. MDH plans to use a competitive bid procurement process to select a vendor.

- ***Need:*** MDH operates many call centers for system support to Medicaid participants and providers, and this project will upgrade the call center and IVR technology to meet strategic direction from CMS to install a single point of entry.

- ***Observations and Milestones:*** Due to planning delays, the project kickoff occurred in September 2024 rather than in calendar 2023. MDH expects the planning stage to end at the end of August 2025 before transitioning to the procurement stage.

- ***Concerns*****:** MDH and DoIT identified four medium risks, including sponsorship (one main business sponsor is needed to ensure efficiency), resource availability (currently low risk but overlapping IT projects could strain employees), interdependencies (this component involves multiple call centers and systems that will require coordination), and technical needs (requiring voice over internet protocols to avoid systems lagging).

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 7
MMT – Decision Support and Enterprise Data Warehouse
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2024				**Est. Completion Date:** January 2, 2030				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$1.741	$2.441	$1.339	$1.182	$1.182	$7.945
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	1.812	15.221	13.421	8.091	2.386	2.386	43.318
Total	**$0.000**	**$1.884**	**$16.962**	**$15.862**	**$9.490**	**$3.568**	**$3.568**	**$51.334**

- ***Project Summary***: This component of the MMT project implements a data store/lake and analytics platform to house various MDH data sources and systems that will be linked to support the CMS Interoperability requirement. Data will come from MMIS, the behavioral health ASO, and other sources.

- ***Need:*** By housing data in one place, MDH will be able to support informed decision making and share core data functions like tracking claims.

- ***Observations and Milestones:*** This project is in a planning stage for Phase 1, which will focus on consolidating data that will be used for the CMS Interoperability mandate.

- ***Concerns*:** MDH and DoIT identified six high risks for this project, such as defining the objectives of the project to clearly determine which data should be incorporated and technical needs to find a capable partner to develop a data lake for MDH's large number of data sets.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 8
MMT – Dental Administrative Services Organization (DASO)
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: January 1, 2022				**Est. Completion Date:** December 2, 2026				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$8.741	$6.672	$0.000	$0.000	$0.000	$15.413
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	2.318	8.861	7.872	0.000	0.000	0.000	19.052
Total	**$0.000**	**$2.390**	**$17.603**	**$14.544**	**$0.000**	**$0.000**	**$0.000**	**$34.536**

- ***Project Summary***: This component of the MMT project contracts DASO to procure a dental claims processing system with validation functions. It should be noted that the federal share for this project is closer to the typical 50% match, rather than the 90% match for development costs.

- ***Need:*** MDH reported a CMS requirement to procure a modular system to support coverage and claims processing of dental care.

- ***Observations and Milestones:*** MDH has selected DentaQuest of Maryland, LLC as its new vendor and approval for the contract from BPW on January 29, 2025. However, MDH was required to extend its legacy contract with the incumbent vendor (SKYGEN) due to project delays.

- ***Concerns*:** MDH and DoIT identified supportability as a high risk because the legacy system contract was set to expire in December 2024, while BPW had still not approved the new contract and vendor when risk was determined.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 9
MMT – Electronic Data Interchange (EDI) Gateway
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2024				**Est. Completion Date:** January 3, 2028				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.070	$1.533	$0.738	$0.000	$0.000	**$2.341**
SF	0.000	0.050	0.000	0.000	0.000	0.000	0.000	0.050
FF	0.000	3.276	4.797	3.854	1.871	0.000	0.000	13.797
Total	**$0.000**	**$3.326**	**$4.867**	**$5.387**	**$2.609**	**$0.000**	**$0.000**	**$16.189**

- ***Project Summary***: This component of the MMT project relates to automated data transfers with Medicare, health providers, and health plans. MDH transitioned its EDI transaction processing system (TPS) to a cloud platform but is further modernizing the legacy EDITPS.

- ***Need:*** The current EDITPS does not comply with 80% of security requirements, and implementation of this project will improve the security of MDH's EDI application.

- ***Observations and Milestones:*** MDH has developed an RFP for the project that is currently under internal review. The current schedule is to publish the RFP in calendar 2025 and complete procurement by the end of the calendar year.

- ***Concerns*:** MDH and DoIT identified all risk factors as no known risk or low risk.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 10
MMT – Enterprise Document Management System
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: New								
Start Date: November 2, 2024				**Est. Completion Date:** July 1, 2028				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.071	$1.197	$1.989	$0.636	$0.000	$3.894
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	1.385	3.805	3.805	1.846	1.083	0.000	11.924
Total	**$0.000**	**$1.456**	**$3.877**	**$5.002**	**$3.835**	**$1.719**	**$0.000**	**$15.889**

- ***Project Summary***: This component of the MMT project establishes a document management system across Medicaid business systems to make documents easier to access, edit, and share.

- ***Need:*** MCPA personnel must work with paper documents and electronic files that are not well organized. By implementing a new management system, employees will be more productive in finding files while maintaining more secure document management through less need for emailing files or storing files in unsecure places.

- ***Observations and Milestones:*** This project is in the planning stage as MCPA leadership defines a roadmap.

- ***Concerns*****:** MDH and DoIT identified funding as a high risk because the fiscal 2025 budget did not include an appropriation for this project. However, MDH carried forward some underutilized funds from fiscal 2024 to begin project design.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 11
MMT – Hospice and Maryland Daycare Enrollment
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: December 12, 2022				**Est. Completion Date:** July 1, 2026				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$1.474	$0.071	$0.393	$0.000	$0.000	$0.000	$1.937
FF	0.000	1.580	5.851	1.583	0.000	0.000	0.000	9.014
Total	**$0.000**	**$3.054**	**$5.921**	**$1.976**	**$0.000**	**$0.000**	**$0.000**	**$10.951**

- ***Project Summary***: This component of the MMT project connects the DHS Eligibility and Enrollment application for long-term care services with MMIS to fix conflicts when applicants transition between long-term care, medical adult day care, and hospice services.

- ***Need:*** By connecting MMIS with the long-term care Eligibility and Enrollment system, MDH will limit issues such as claims payment delays that can result from short-term stays in care facilities.

- ***Observations and Milestones:*** This project is in the implementation phase and user acceptance testing was completed for the long-term care activity reporting component of this project in June 2024.

- ***Concerns*:** MDH and DoIT identified objectives and interdependencies as high risks due to implementing this project with DHS and the Maryland Total Human services Information Network (MD THINK) platform, which involve multiple development teams and data sharing across service types.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 12
MMT – Medicaid Enterprise System Claims Module
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: September 25, 2023				**Est. Completion Date:** August 1, 2031				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.071	$1.145	$0.653	$1.821	$5.528	$9.187
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	3.196	3.212	3.916	3.916	11.888	40.749	66.876
Total	**$0.000**	**$3.267**	**$3.284**	**$5.030**	**$4.568**	**$13.709**	**$46.277**	**$76.135**

- ***Project Summary***: This component of the MMT project is far reaching as it replaces the legacy claims processing system with a new MMIS system with new technologies and business rules to process all Medicaid claims and eliminate duplication across Medicaid, BHA, and DDA.

- ***Need:*** Modules in the legacy MMIS are built with old technology, resulting in delayed maintenance and limited resources that still know the language used in these systems. The MMIS mainframe and legacy language has been in operation since calendar 1985.

- ***Observations and Milestones:*** MDH is still planning this project and expects to complete design by the end of calendar 2025. Current project activities include documenting system functionality and business rules to develop project requirements.

- ***Concerns*:** MDH and DoIT identified technical needs and implementation as high risks due to MMIS expertise needed to work with the complex network of programs and systems. Additionally, the scope of this project is large as it affects many Medicaid service types and programs across multiple MDH administrations.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 13
MMT – Nonemergency Medical Transportation (NEMT)
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: September 25, 2023				**Est. Completion Date:** July 1, 2028				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.071	$0.871	$2.042	$0.168	$0.000	$3.151
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	2.318	5.225	5.225	5.104	1.006	0.000	18.879
Total	**$0.000**	**$2.390**	**$5.296**	**$6.096**	**$7.146**	**$1.174**	**$0.000**	**$22.101**

- ***Project Summary***: This component of the MMT project involves procuring a system for dispatching and claims processing for Medicaid NEMT services that will conform with federal regulations and requirements.

- ***Need:*** Local jurisdictions currently manage individual contracts for NEMT systems, and this causes a range of costs, compliance with federal regulations, and accountability and enforcement of vendors. This module will better standardize and monitor NEMT system delivery and management.

- ***Observations and Milestones:*** An RFP for this project has been developed and is currently in internal review. MDH reported that it expects to complete the procurement process by the end of calendar 2025.

- ***Concerns*:** MDH and DoIT identified three medium risks: (1) user interface as Medicaid participants will use the system directly; (2) organizational culture due to local jurisdictions having a variety of business processes for their current NEMT systems, and (3) supportability as the system will be standardized across local jurisdictions.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 14
MMT – Provider Management Module
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: April 1, 2023				**Est. Completion Date:** October 9, 2029				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$4.269	$3.813	$3.583	$8.207	$0.000	$19.871
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	25.398	37.969	29.815	27.745	23.121	0.000	144.049
Total	**$0.000**	**$25.469**	**$42.238**	**$33.628**	**$31.328**	**$31.328**	**$0.000**	**$163.992**

- ***Project Summary***: This component of the MMT project develops a system for all MDH programs interacting with providers to support provider enrollment, updates and revalidations, help desk and application processing, IVR implementation, and other provider services.

- ***Need:*** MCPA must administer a system for provider services as required by CMS. Provider enrollment and help desk services are currently managed through a SaaS vendor, and this project develops a custom system.

- ***Observations and Milestones:*** MDH plans to extend its current contract with the SaaS vendor through fiscal 2027 while a new provider management module is developed. This project is in the design stage as MCPA staff determines system requirements and go live dates are scheduled for October 2026 following delays.

- ***Concerns*:** MDH and DoIT identified interdependencies, technical needs, supportability, and implementation as high risks, mainly due to the use of the MD THINK platform to support provider services in the provider management module. For example, MDH reported concerns with data masking and security needs.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 15
MMT – Surveillance Utilization Review Subsystem
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: February 1, 2023				**Est. Completion Date:** April 1, 2027				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$0.071	$1.046	$0.000	$0.000	$0.000	$1.117
SF	0.000	0.071	0.000	0.000	0.000	0.000	0.000	0.071
FF	0.000	1.895	5.441	2.615	0.000	0.000	0.000	9.951
Total	**$0.000**	**$1.966**	**$5.512**	**$3.661**	**$0.000**	**$0.000**	**$0.000**	**$11.139**

- ***Project Summary***: This component of the MMT project replaces the current surveillance and utilization review system referred to as PIRAMID.

- ***Need:*** CMS requires that states operate a fraud, waste, and abuse prevention and detection system to receive federal reimbursement. Additionally, OLA found in a fiscal compliance audit that MCPA was unable to administer the data analytics necessary to detect fraud, waste, and abuse through its current operations. This project will allow the Medicaid Program Integrity Unit to run claim reports data to monitor utilization of services by Medicaid providers and recipients.

- ***Observations and Milestones:*** MDH is in the procurement stage of this project and rather than issuing an RFP, the department plans to use the National Association of State Procurement Officials to procure application development services.

- ***Concerns*:** MDH and DoIT identified funding and organizational culture as medium risks due to the requirement for a 10% State match and the MCPA business team needing training to use a new system after using the legacy system for many years.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 16
MMT – Utilization Control Agent (UCA)
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: February 1, 2023				**Est. Completion Date:** April 1, 2027				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2025**	**2026**	**2027**	**2028**	**2029**	**Remainder**	**Total**
GF	$0.000	$0.000	$1.113	$0.000	$0.000	$0.000	$0.000	$1.113
SF	0.000	0.070	0.000	0.000	0.000	0.000	0.000	0.070
FF	0.000	6.113	3.309	0.000	0.000	0.000	0.000	9.423
Total	**$0.000**	**$6.183**	**$4.422**	**$0.000**	**$0.000**	**$0.000**	**$0.000**	**$10.606**

- ***Project Summary***: This component of the MMT project will secure a federally designated quality improvement organization (QIO) or QIO-like entity to ensure utilization control of hospital, nursing facility, and HCBS receiving Medicaid reimbursement to ensure that services are medically necessary and are provided in an appropriate setting based on the participants' eligibility for services.

- ***Need:*** The UCA contract aims to procure services from a vendor with experience making level of care determinations for long-term care services and conducting utilization control for acute care services and long-term care services.

- ***Observations and Milestones:*** The go-live date for this project was delayed from July to September 2024 due to the need to extend the training schedule.

- ***Concerns*:** MDH and DoIT identified all risk factors as no known risk or low risk.

- ***Other Comments:*** This is 1 of 13 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 16 of this analysis.

Appendix 17
Federal Poverty Guidelines as of January 2025
(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	$3,913	$7,825	$11,738	$15,650	$19,563	$20,815	$21,128	$21,597	$31,300	$33,178	$39,125	$41,316	$50,393
2	5,288	10,575	15,863	21,150	26,438	28,130	28,553	29,187	42,300	44,838	52,875	55,836	68,103
3	6,663	13,325	19,988	26,650	33,313	35,445	35,978	36,777	53,300	56,498	66,625	70,356	85,813
4	8,038	16,075	24,113	32,150	40,188	42,760	43,403	44,367	64,300	68,158	80,375	84,876	103,523
5	9,413	18,825	28,238	37,650	47,063	50,075	50,828	51,957	75,300	79,818	94,125	99,396	121,233
6	10,788	21,575	32,363	43,150	53,938	57,390	58,253	59,547	86,300	91,478	107,875	113,916	138,943
7	12,163	24,325	36,488	48,650	60,813	64,705	65,678	67,137	97,300	103,138	121,625	128,436	156,653
8	13,538	27,075	40,613	54,150	67,688	72,020	73,103	74,727	108,300	114,798	135,375	142,956	174,363
9	14,913	29,825	44,738	59,650	74,563	79,335	80,528	82,317	119,300	126,458	149,125	157,476	192,073
10	16,288	32,575	48,863	65,150	81,438	86,650	87,953	89,907	130,300	138,118	162,875	171,996	209,783
11	17,663	35,325	52,988	70,650	88,313	93,965	95,378	97,497	141,300	149,778	176,625	186,516	227,493
12	19,038	38,075	57,113	76,150	95,188	101,280	102,803	105,087	152,300	161,438	190,375	201,036	245,203
13	20,413	40,825	61,238	81,650	102,063	108,595	110,228	112,677	163,300	173,098	204,125	215,556	262,913
14	21,788	43,575	65,363	87,150	108,938	115,910	117,653	120,267	174,300	184,758	217,875	230,076	280,623

[1] The Affordable Care Act expanded Medicaid coverage to individuals with household incomes below 138% of the federal poverty level (FPL).
[2] Pregnant individuals can have higher household incomes and still qualify for Medicaid. The income eligibility threshold for pregnant individuals is 264% of FPL.
[3] The income eligibility threshold for children enrolled in the Maryland Children's Health Plan is 322% of FPL.

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

Appendix 18
Object/Fund Difference Report
Maryland Department of Health – Medical Care Programs Administration

Object/Fund	FY 24 Actual	FY 25 Working Appropriation	FY 26 Allowance	FY 25 - FY 26 Amount Change	Percent Change
Positions					
01 Regular	638.00	682.10	682.10	0.00	0%
02 Contractual	68.72	97.75	87.57	-10.18	-10.4%
Total Positions	**706.72**	**779.85**	**769.67**	**-10.18**	**-1.3%**
Objects					
01 Salaries and Wages	$ 66,421,893	$ 73,520,502	$ 78,008,162	$ 4,487,660	6.1%
02 Technical and Special Fees	5,438,025	7,449,084	7,959,557	510,473	6.9%
03 Communication	919,274	972,827	950,390	-22,437	-2.3%
04 Travel	72,455	336,838	384,818	47,980	14.2%
06 Fuel and Utilities	7,216	6,033	7,216	1,183	19.6%
08 Contractual Services	12,784,560,805	12,149,454,182	13,338,622,792	1,189,168,610	9.8%
09 Supplies and Materials	126,986	155,633	182,752	27,119	17.4%
10 Equipment – Replacement	56,635	163,496	219,110	55,614	34.0%
11 Equipment – Additional	655	0	0	0	0.0%
13 Fixed Charges	281,958	332,129	391,427	59,298	17.9%
Total Objects	**$ 12,857,885,902**	**$ 12,232,390,724**	**$ 13,426,726,224**	**$ 1,194,335,500**	**9.8%**
Funds					
01 General Fund	$ 4,161,636,469	$ 4,046,395,110	$ 4,762,669,320	$ 716,274,210	17.7%
03 Special Fund	754,420,269	737,460,255	850,540,755	113,080,500	15.3%
05 Federal Fund	7,805,252,345	7,352,407,892	7,688,170,126	335,762,234	4.6%
09 Reimbursable Fund	136,576,819	96,127,467	125,346,023	29,218,556	30.4%
Total Funds	**$ 12,857,885,902**	**$ 12,232,390,724**	**$ 13,426,726,224**	**$ 1,194,335,500**	**9.8%**

Note: The fiscal 2025 appropriation does not include deficiencies or contingent reductions. The fiscal 2026 allowance does not include contingent reductions or statewide salary adjustments budgeted within the Department of Budget and Management.

Appendix 19
Fiscal Summary
Maryland Department of Health – Medical Care Programs Administration

Program/Unit	FY 24 Actual	FY 25 Wrk Approp	FY 26 Allowance	Change	FY 25 - FY 26 % Change
01 Deputy Secretary for Health Care Financing	$ 10,037,659	$ 13,022,226	$ 11,714,932	-$ 1,307,294	-10.0%
02 Enterprise Technology - Medicaid	15,143,265	16,531,274	17,086,272	554,998	3.4%
03 Medical Care Provider Reimbursements	12,187,497,595	11,550,813,598	12,441,352,117	890,538,519	7.7%
04 Office of Health Services	39,554,418	81,333,366	51,155,995	-30,177,371	-37.1%
05 Office of Finance	9,000,823	10,211,439	10,627,568	416,129	4.1%
07 Maryland Children's Health Program	473,381,150	424,856,661	687,794,240	262,937,579	61.9%
08 Major Information Technology Development	96,947,967	105,942,314	173,508,370	67,566,056	63.8%
09 Office of Eligibility Services	14,936,406	17,935,767	16,718,891	-1,216,876	-6.8%
11 Senior Prescription Drug Assistance Program	11,386,619	11,744,079	16,767,839	5,023,760	42.8%
Total Expenditures	**$ 12,857,885,902**	**$ 12,232,390,724**	**$ 13,426,726,224**	**$ 1,194,335,500**	**9.8%**
General Fund	$ 4,161,636,469	$ 4,046,395,110	$ 4,762,669,320	$ 716,274,210	17.7%
Special Fund	754,420,269	737,460,255	850,540,755	113,080,500	15.3%
Federal Fund	7,805,252,345	7,352,407,892	7,688,170,126	335,762,234	4.6%
Total Appropriations	**$ 12,721,309,083**	**$ 12,136,263,257**	**$ 13,301,380,201**	**$ 1,165,116,944**	**9.6%**
Reimbursable Fund	$ 136,576,819	$ 96,127,467	$ 125,346,023	$ 29,218,556	30.4%
Total Funds	**$ 12,857,885,902**	**$ 12,232,390,724**	**$ 13,426,726,224**	**$ 1,194,335,500**	**9.8%**

Note: The fiscal 2025 appropriation does not include deficiencies or contingent reductions. The fiscal 2026 allowance does not include contingent reductions or statewide salary adjustments budgeted within the Department of Budget and Management.