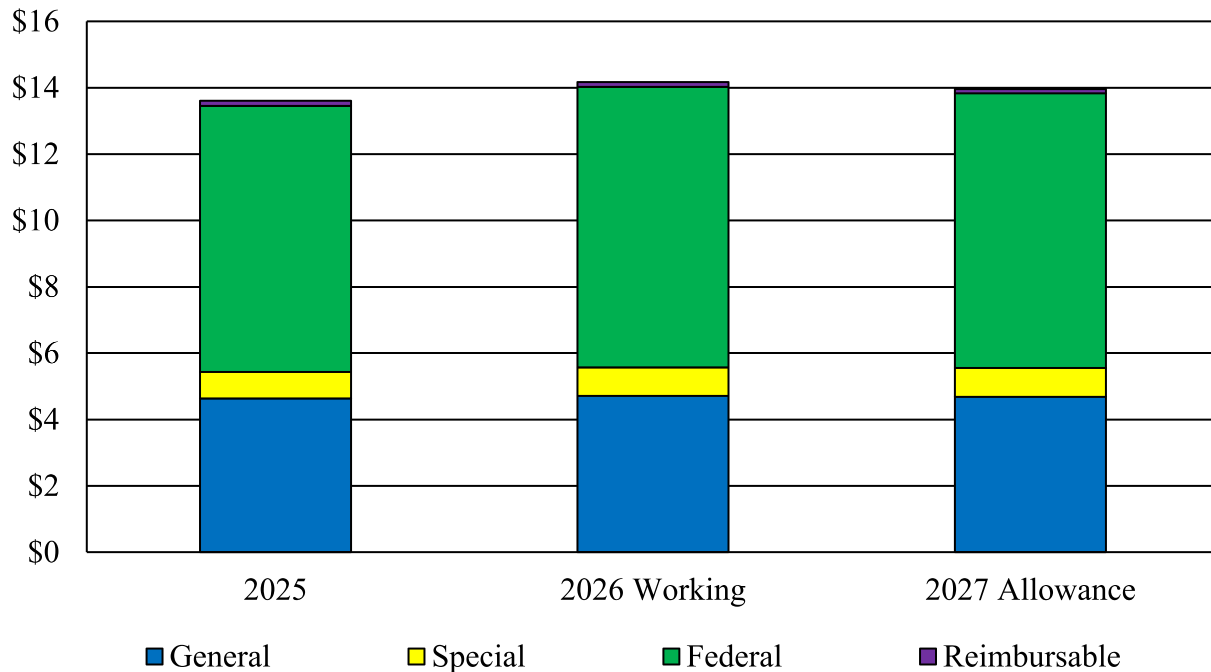
M00Q01
Medical Care Programs Administration
Maryland Department of Health

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. Specialty mental health and substance use disorder (SUD) services for Medicaid recipients are included in the budget analysis for M00L – MDH – Behavioral Health Administration (BHA). MCPA also administers various other programs discussed in this analysis.

Operating Budget Summary

Fiscal 2027 Budget Decreases $215.3 Million, or 1.5%, to $14.0 Billion
($ in Billions)



Note: The fiscal 2026 working appropriation accounts for deficiencies. The fiscal 2027 allowance accounts for contingent reductions. The fiscal 2027 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

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- MCPA's fiscal 2027 allowance decreases by $215.3 million compared to the fiscal 2026 working appropriation, after adjusting for proposed deficiencies and contingent general fund reductions, including a deficiency to cover a fiscal 2025 shortfall of $294.6 million ($62.7 million in general funds). When excluding the fiscal 2025 expenses from the fiscal 2026 budget, the fiscal 2027 allowance increases by $79.3 million.

- The fiscal 2027 allowance accounts for $9.4 million in general fund reductions and a special fund appropriation of $1.0 million, contingent on enactment of provisions in the Budget Reconciliation and Financing Act (BRFA) of 2026 related to the Cigarette Restitution Fund (CRF).

- Increases in the fiscal 2027 allowance are mainly attributed to overall managed care organization (MCO) rate increases and hospital cost increases totaling $453.4 million. This growth is partially offset by $306 million in overall reduced spending due to a projected enrollment decline in fiscal 2027 compared to fiscal 2026. Additionally, funding for major information technology (IT) projects decreases by $71 million in federal funds to defer or suspend some projects as a cost containment measure and due to the Long Term Services and Supports (LTSS) system transitioning from a major information technology development project (MITDP) to ongoing maintenance and operations.

Key Observations

- ***One Big Beautiful Bill Act (OBBBA) Implementation:*** The federal OBBBA was enacted on July 4, 2025, and makes significant policy changes to public benefits programs, including Medicaid. Major provisions impacting Medicaid include establishing work requirements and increasing the frequency of eligibility redetermination for adults eligible due to the Affordable Care Act (ACA) expansion, among other eligibility and Medicaid financing changes. Due to delayed implementation dates for many provisions, most budgetary impacts from resulting disenrollments and other program impacts are not assumed in the allowance until the end of fiscal 2027. However, the fiscal 2027 budget includes new regular positions and contractual full-time equivalents (FTE) and funding for outreach and marketing, though much of the administrative costs for IT system changes are budgeted in the Maryland Health Benefit Exchange (MHBE) in its role as the agency that conducts eligibility determinations for most Medicaid participants.

- ***Medicare Coverage of End-stage Renal Disease (ESRD) Patients:*** Committee narrative in the 2025 *Joint Chairmen's Report* (JCR) requested that MDH submit a report on Medicare and Medicaid coverage of ESRD patients. Both Medicare and Medicaid provide comprehensive health benefits for ESRD patients. For participants who are dually eligible and enroll in both programs, Medicare serves as the primary payer. As part of the response, the Hilltop Institute conducted an analysis that found 1,161 individuals currently enrolled in Medicaid likely qualify for Medicare due to their ESRD diagnosis. MDH reported that

enrolling Medicaid participants with ESRD in Medicare could provide up to $9.9 million in estimated State fund savings. The department outlined a proposal for additional outreach to encourage Medicaid participants with ESRD to enroll in Medicare, and MDH is considering implementing policies to require these participants to apply for Medicare as a condition of continued Medicaid coverage.

Operating Budget Recommended Actions

		Amount
1.	Reduce funding for Medicaid provider reimbursements to account for savings from Medicaid participants with end-stage renal disease enrolling in Medicare as a result of increased outreach efforts.	-$8,000,000
2.	Add language to the special fund appropriation for Medicaid to make funding budgeted from the separate account within the Cigarette Restitution Fund contingent on the enactment of legislation expanding the authorized uses of this funding.	
3.	Add language restricting medical care provider reimbursement funding to that purpose.	
4.	Add language restricting Maryland Children's Health Program funding to that purpose.	
5.	Add language restricting funds until a report is submitted on Community First Choice program and Community-based Options waiver spending.	
6.	Add language restricting funds until a report is submitted on the resolution of repeat audit findings.	
7.	Amend contingent language reducing general funds as a technical correction to more closely align the language with the applicable provision in the Budget Reconciliation and Financing Act.	
8.	Amend contingent language on a special fund appropriation as a technical correction to more closely align the language with the applicable provision in the Budget Reconciliation and Financing Act.	

9. Adopt narrative requesting two reports on the implementation of federal requirements in the One Big Beautiful Bill Act.

Total Net Change to Fiscal 2027 Allowance	**-$8,000,000**

	Amount
10. Reduce funding from a fiscal 2026 deficiency appropriation to account for recoveries from calendar 2023 managed care organization medical loss ratio results.	-$151,430,827
11. Reduce funding from a fiscal 2026 deficiency appropriation due to lower estimated spending on prior year Medicaid expenses, based on recent actual claims paid through January 2026.	-$70,000,000
Total Net Change to Fiscal 2026 Deficiency	**-$221,430,827**

Updates

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

M00Q01

Medical Care Programs Administration

Maryland Department of Health

Operating Budget Analysis

Program Description

MCPA within MDH is responsible for administering Medicaid, MCHP, the Family Planning Program, the Employed Individuals with Disabilities (EID) program, and the Senior Prescription Drug Assistance Program (SPDAP). MCPA also oversees expenditures for fee-for-service (FFS) community behavioral health services, including specialty mental health and SUD services for Medicaid recipients, which 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.

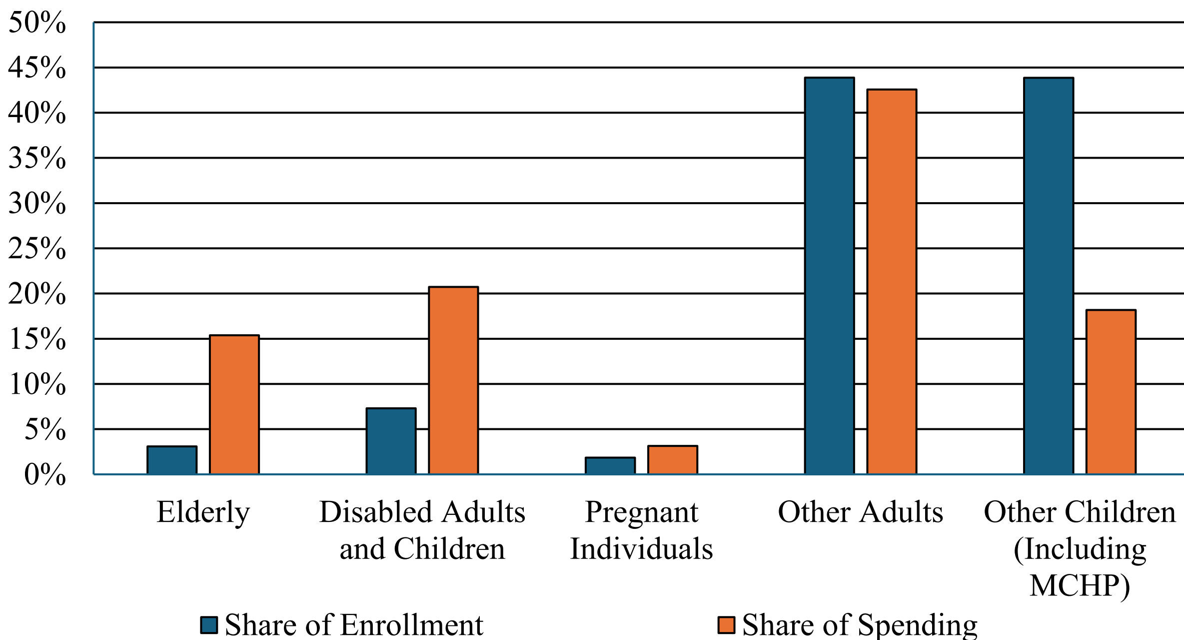
Income eligibility levels vary based on the individual's age and pregnancy status, among other factors. Individuals receiving cash assistance through the Temporary Cash Assistance program or the federal Supplemental Security Income program automatically qualify for Medicaid benefits. Pregnant individuals 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 individuals with incomes below 138% of FPL, as authorized in the federal ACA. The federal match for this population is 90%. The most current FPL guidelines are listed in **Appendix 14**.

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 and MCHP spending does not necessarily align with each eligibility group's share of total enrollment. Using fiscal 2025 as an example, disabled adults and children represented only 7.3% of average monthly enrollment, while this group accounted for 20.7% of medical care reimbursements. Elderly Marylanders receiving Medicaid also accounted for a smaller share of enrollment (3.1%) relative to their share of spending (15.4%). 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 43.9% of average monthly enrollment but only account for 18.2% of fiscal 2025 Medicaid and MCHP costs.

Exhibit 1
Relative Medicaid and MCHP Spending and Enrollment by Eligibility Group
Fiscal 2025



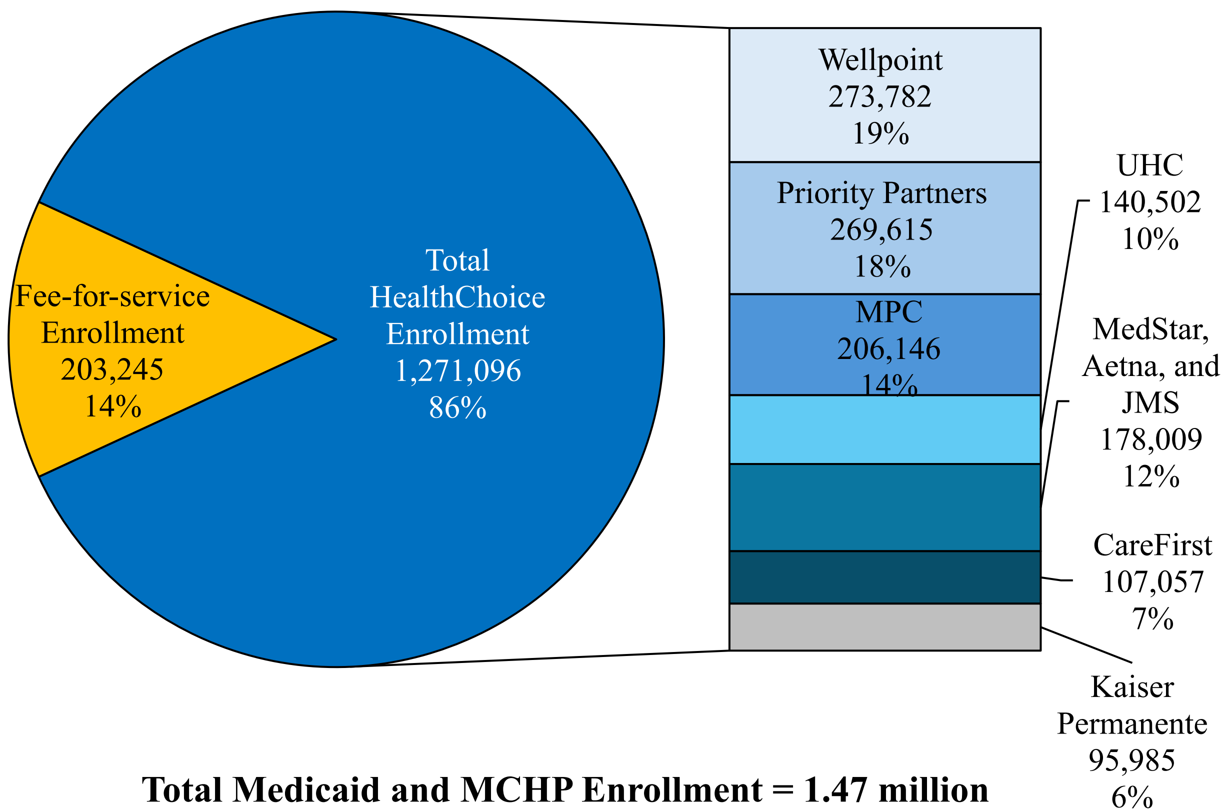
MCHP: Maryland Children's Health Program

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. In accordance with Chapters 302 and 303 of 2022, Medicaid provides dental benefits to adults with household incomes up to 138% of FPL, in addition to children and income-eligible pregnant individuals.

Most Medicaid and MCHP recipients are required to enroll in HealthChoice, the statewide mandatory managed care program that began in calendar 1997. As shown in **Exhibit 2**, approximately 86% of Medicaid and MCHP recipients in January 2026 were enrolled in HealthChoice under one of nine MCOs operating in Maryland. In general, populations excluded from the HealthChoice program are individuals in nursing facilities and other institutional care 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 MCHP Enrollment
As of January 2026



Total Medicaid and MCHP Enrollment = 1.47 million

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

Source: Maryland Department of Health; Hilltop Institute

Maryland Children's Health Program

MCHP provides medical assistance for low-income children with household incomes that exceed income eligibility for Medicaid. The State is normally entitled to receive 65% federal matching funds for MCHP expenditures. To qualify for MCHP, children must be under the age of 19 and live in households with an income between the Medicaid income eligibility threshold (which varies depending on the child's age) and up to 322% of FPL. MCHP covers the same services as Medicaid. Participating families 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 and, due to an MDH extension of the pause, through April 30, 2024. 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.

Family Planning

The Family Planning Program provides certain medical services for individuals 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 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.

Employed Individuals with Disabilities Program

The EID program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program 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.

Senior Prescription Drug Assistance Program

The 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:

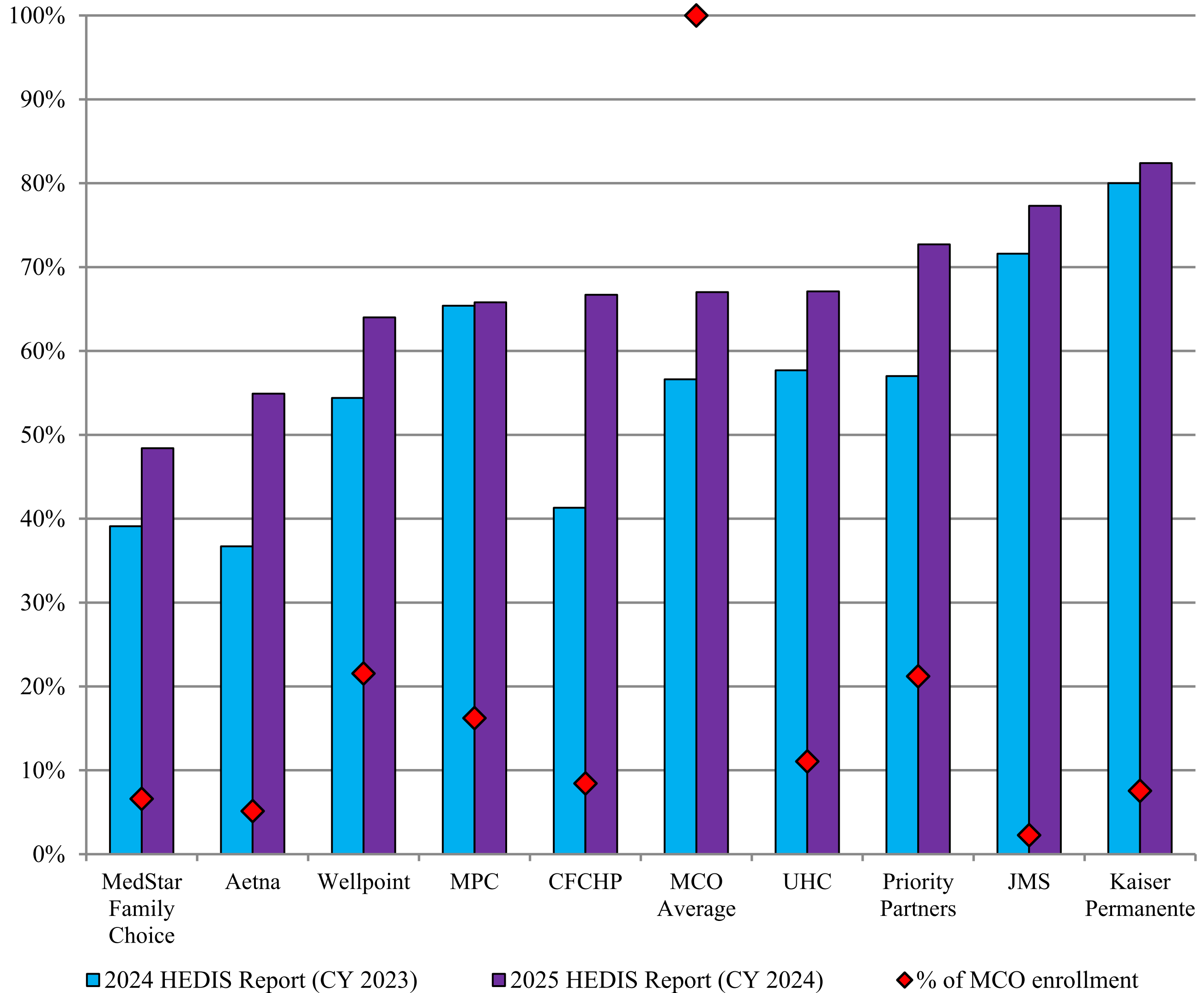
- Healthcare Effectiveness Data and Information Set (HEDIS) data collection;
- record reviews and network adequacy testing to monitor operations;
- survey collections to evaluate enrollee and provider satisfaction;
- an annual technical report for general program management and oversight; and
- the HealthChoice 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 2024 HEDIS data in a report presented to MDH in August 2025 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 larger data set of 51 measures provided to MDH.

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. MCOs' performance against the national HEDIS mean worsened during the COVID-19 public health emergency due to individuals delaying care and providers lacking capacity. MCOs have shown gradual improvement in subsequent years. Maryland MCOs collectively outperformed their peers nationally, reporting more measures above the national mean than below, with an average across Maryland MCOs at 56.62% and 67.02% of measures above the national mean in calendar 2023 and 2024, respectively. Only MedStar Family Choice reported fewer than 50% of measures above the national HEDIS mean, at 48.4% in calendar 2024. All MCOs reported improvement in the share of HEDIS measures above the national mean from calendar 2023 to 2024, with increases ranging from 0.4 (Maryland Physicians Care) to 25.4 (CareFirst Community Health Plan Maryland) percentage points. Annual HEDIS results do not correspond with share of MCO enrollment as the two plans with the highest results, Kaiser Permanente and Jai Medical Systems, serve less than 10% of total MCO enrollees.

Exhibit 3
Share of Measures Equal to or Above National HEDIS Mean
Calendar 2023 to 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

Through annual HealthChoice agreements with MCOs, MDH enforces certain performance monitoring and reporting policies that can involve penalties for MCOs that do not meet minimum standards. Based on calendar 2024 HEDIS results, MDH is enforcing sanctions on two MCOs by freezing auto-enrollment for two or three months, depending on the severity of the HEDIS performance issue. For HEDIS monitoring beginning in calendar 2025, MDH can exclude MCOs from receiving incentives through the PHIP in all rounds if certain minimum percentages of HEDIS measures at or above the national mean are not met in the same year or if MCOs report percentages lower than 65% above the mean for multiple years in a row.

NCQA Accreditation

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. All but one MCO operating in Maryland maintained accreditation in calendar 2025. NCQA suspended Priority Partners' accreditation in February 2025, and as a result MDH froze new enrollment beginning in March 2025 until the MCO restored its accreditation. In December 2025, NCQA granted Priority Partners accreditation after it completed corrective actions and as of February 2, 2026, MDH has allowed Medicaid participants to enroll in Priority Partners again. Medicaid participants already enrolled in Priority Partners at the time accreditation was suspended were unaffected but were given the opportunity to enroll in a different MCO.

2. MCO Population Health Incentive Program

MDH has administered a pay-for-performance quality assurance program for MCOs since the Value-based Purchasing (VBP) program was established in calendar 1999. Penalty payments under the VBP program 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 the PHIP. The 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 a certain percentage of its total capitation payments based on the budgeted amount in each year. 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 less than that percentage of each MCO's total capitation. 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. The PHIP is budgeted at 0.25% of capitated rates for fiscal 2026 and 2027.

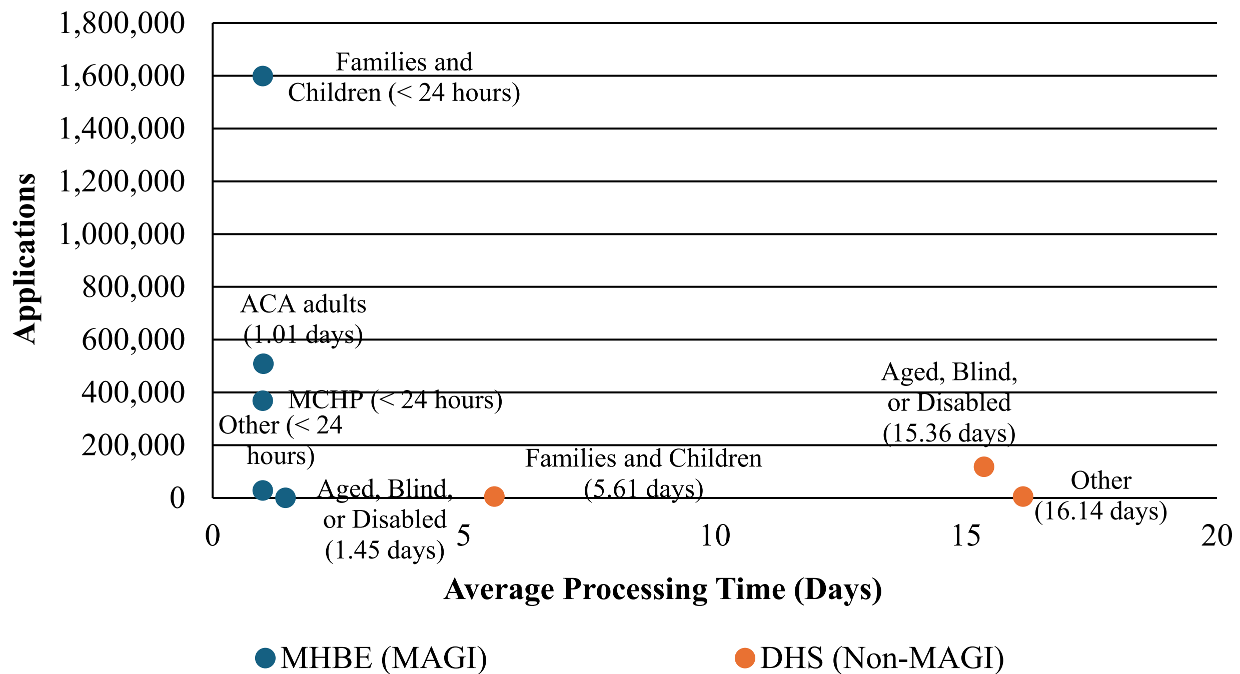
As of February 15, 2026, MDH had not released the annual PHIP report with measurement year 2024 results. **MDH should discuss why the report was not yet available and brief the committee on MCOs' measurement year 2024 results under the PHIP, including performance and improvement incentive payments shown separately for each MCO.**

3. 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 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.

Committee narrative in the 2025 JCR requested that MDH submit quarterly reports with enrollment data and monthly application processing measures used in this analysis. As shown in **Exhibit 4**, for applications received from June 2024 to July 2025, MHBE processed families and children, MCHP participants, and other applicants within 24 hours on average. Families and children accounted for the largest number of applications at just under 1.6 million. MHBE processed applications for ACA adults and aged, blind, or disabled applicants in 1.01 and 1.45 days on average, all well below the federal requirement of 45 days. Larger shares of MAGI cases compared to non-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. MDH reported that of renewals due from June 2024 to July 2025, 49.75% of MHBE cases and 24.04% of DHS cases were automatically renewed. The overall automatic renewal rate was 47.51%, as MHBE processes a much larger volume of applications and renewals.

Exhibit 4
MAGI and Non-MAGI Application Processing
June 2024 to July 2025



ACA: Affordable Care Act
DHS: Department of Human Services
MAGI: Modified Adjusted Gross Income
MCHP: Maryland Children's Health Program
MHBE: Maryland Health Benefit Exchange

Source: Maryland Department of Health; Maryland Health Benefit Exchange; Department of Human Services

For non-MAGI cases, DHS handles relatively few applications but takes longer to process them due to the complexity of non-MAGI eligibility, which can have additional factors like disability verification and asset limits. From June 2024 to July 2025, aged, blind, or disabled individuals made up most applications processed by DHS (118,194, or 91%). DHS processed these applications in 15.36 days on average, also well below the federal requirement of 90 days. This data reflects average processing times; however, previous quarterly reports included monthly application processing times that indicated DHS consistently processed at least 8% of applications in more than 90 days from January 2024 to August 2024. **MDH should discuss the primary reasons for delays in processing non-MAGI cases and comment on the feasibility of reporting monthly application processing measures that show the number of applications processed in more than 45 days by MHBE and 90 days by DHS.**

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. MDH calculated an accrual of $559.9 million ($255.8 million in general funds) at the end of fiscal 2025 for estimated carryover spending based on the assumption that significant decreases in enrollment would drive down carryover claims. This accrual amount is significantly lower than actual fiscal 2024 carryover spending of $682.1 million ($311.1 million in general funds). Year-to-date expenditures for fiscal 2025 carryover claims have tracked more closely and slightly above the fiscal 2024 actual. As a result, the fiscal 2027 budget includes a proposed deficiency of $294.6 million ($62.7 million in general funds) to backfill the estimated shortfall. Based on claims through January 2026; however, carryover spending has slowed and the Department of Legislative Services (DLS) projects an accrual shortfall of up to $112.0 million ($40 million in general funds). **DLS recommends reducing the fiscal 2026 deficiency for prior year service costs by $70 million, including $10 million in general funds, based on year-to-date actual carryover spending. Following this reduction, the deficiency would still provide approximately $12 million in general fund support beyond current estimated need.**

Outstanding Liabilities at Closeout

At fiscal 2025 closeout, MDH reported a shortfall of $27.3 million in general funds within Medicaid to cover anticipated liabilities for disallowed federal reimbursement for nursing facility rate payments and delayed payments to MCOs for very low birthweight (VLBW) deliveries. The disallowance resulted from MDH initiating a nursing facility rate increase before it was approved by the Centers for Medicare and Medicaid Services (CMS) through a State Plan Amendment, which CMS eventually approved but not retroactively. MDH indicated that the VLBW liability resulted from processing and payment backlogs due to staff turnover. To pay for these expenses in fiscal 2026, MDH was able to accrue $159.9 million ($80.0 million in general funds) but expected

the total payments to be $214.4 million ($107.3 million in general funds) and reported the remaining $54.5 million ($27.3 million in general funds) as an unprovided for payable.

As of February 10, 2026, MDH reported that it had paid approximately $26.9 million to MCOs from the accrued funds to cover the VLBW liability and had met with CMS in January 2026 to negotiate a budget neutral method to account for the disallowed nursing facility rate increase without additional penalty to the State. The fiscal 2027 allowance does not include any additional funds to cover the reported unprovided for payable of $27.3 million in general funds. MDH was unable to provide an estimate for the remaining liability for VLBW payments to MCOs. If MDH eventually secures an agreement from CMS to resolve the nursing facility disallowance without additional payment, then up to $66 million in accrued general funds may no longer be needed for liabilities carried forward into fiscal 2026 and could be realigned to identified shortfalls elsewhere in the MDH budget. The final amount of available funds will depend on whether MDH still owes MCOs for VLBW payments. **MDH should provide an update on the negotiation with CMS related to the nursing facility rate disallowance and how this would be resolved without additional payment needed from the State. Additionally, MDH should clarify how much is outstanding in VLBW payments to MCOs.**

Fiscal 2026

Proposed Deficiency

The fiscal 2027 budget includes five deficiency appropriations providing a net increase of $1.09 billion in total funds ($161.2 million in general funds) in fiscal 2026, including:

- a net increase of $799.8 million ($106.4 million in general funds) due to enrollment, utilization, and rate assumptions in Medicaid reimbursements;

- $294.6 million ($62.7 million in general funds) to account for anticipated shortfalls in accrued funding for Medicaid services provided in fiscal 2025 that are billed in fiscal 2026;

- a net reduction of $34.1 million ($11.9 million in general funds) for enrollment, utilization, and rate assumptions in MCHP reimbursements;

- $25.6 million ($3.9 million in general funds) for the LTSS Tracking System as it transitions from a major information technology development project to ongoing system operations and maintenance. Due to enhanced federal matching funds available for some Medicaid information technology costs, the general fund share of this deficiency is approximately 15%; and

- $150,000 in general funds in the Office of Eligibility Services to reclassify vacant positions for implementation of eligibility requirement and frequency changes enacted in the OBBBA, which is discussed further in Issue 1 of this analysis.

Medical Loss Ratio Recovery

MCOs that operate in Maryland under the HealthChoice program are required to meet certain medical loss ratios (MLR), which measure the amount of funding received by MCOs that is used for eligible mandated medical services and quality improvement efforts. Committee narrative in the 2025 JCR requested that MDH submit a report on MCOs' MLR results in calendar 2023 and preliminary results in calendar 2024 and additional information on MCOs' profits and administrative expenses. MDH indicated in its response that federal regulations require capitation rates under managed care to be actuarially sound and must achieve an MLR of at least 85% each rate year, which among other policies establish guardrails for MCO profits. MDH and the Department of Budget and Management (DBM) typically set MCO rates at the bottom of the actuarially sound range, and did so for calendar 2026 rates. If MCOs do not achieve the required MLR, then MDH's HealthChoice agreement with each MCO requires a remittance to be paid.

Exhibit 5 shows the final MLR results for calendar 2023 and preliminary results for calendar 2024. The overall MLR for calendar 2023 was 83%, and three MCOs in particular (Aetna, Kaiser Permanente, and Wellpoint) fell below the 85% requirement and owed the State a remittance. MDH received total recoveries of $151.4 million in fall 2025, and the State's share of this payment is $44.2 million, as reported by MDH. Preliminary calendar 2024 results would also result in a remittance of $34.2 million from two MCOs (Aetna and Kaiser Permanente).

Exhibit 5
HealthChoice MLR Results
Calendar 2023-2024
($ in Millions)

	2023				2024			
	Total Payments	**Medical Expenditures**	**MLR**	**Recovery**	**Total Payments**	**Medical Expenditures**	**MLR**	**Recovery**
Aetna	$291.7	$218.2	74.8%	$40.8	$314.8	$245.4	78.0%	$7.7
CFCHP	524.8	441.8	84.2%	0	552.8	508.6	92.0%	0
Jai Medical Systems	207.0	179.7	86.8%	0	195.9	180.3	92.0%	0
Kaiser	583.4	427.2	73.2%	74.9	523.9	429.2	81.9%	26.5
MPC	1,406.2	1,188.7	84.5%	0	1,322.3	1,152.5	87.2%	0
MedStar Family Choice	589.0	534.6	90.8%	0	543.5	501.8	92.3%	0
Priority Partners	1,845.3	1,569.8	85.1%	0	1,779.6	1,632.7	91.7%	0
UHC	857.3	703.8	82.1%	0	823.2	726.3	88.2%	0
Wellpoint	1,419.5	1,145.0	80.7%	35.8	1,407.4	1,198.5	85.2%	0
Statewide	**$7,724.2**	**$6,409.0**	**83.0%**	**$151.4**	**$7,463.4**	**$6,575.2**	**88.1%**	**$34.2**
General Fund Share				**$44.2**				**$12.0**

CFCHP: Care First Community Health Partners
MLR: medical loss ratio
MPC: Maryland Physicians Care
UHC: UnitedHealthcare

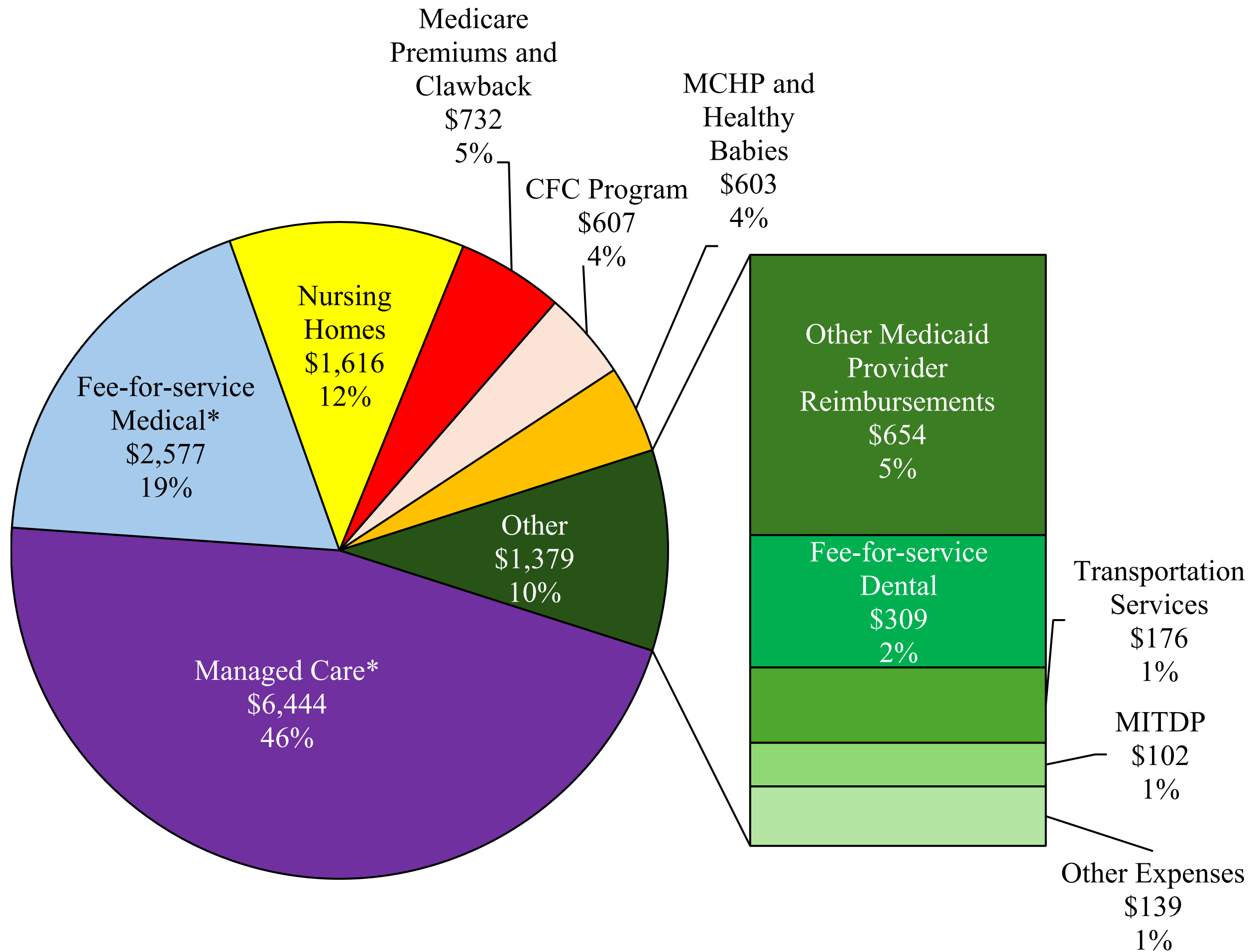
Source: Maryland Department of Health

MDH reported that MLR recoveries tend to fluctuate from year to year and are therefore not assumed in the budget until the final payments are recovered. Nevertheless, the calendar 2023 remittance has been paid, but MDH indicated that the fiscal 2026 working appropriation does not account for the estimated State share of $44.2 million in recoveries. The fiscal 2027 allowance does not assume savings from the preliminary calendar 2024 results. **DLS recommends reducing the fiscal 2026 deficiency appropriation for Medicaid provider reimbursements by $151.4 million ($44.2 million in general funds) to account for the MLR recovery received in fall 2025.**

Fiscal 2027 Overview of Agency Spending

As shown in **Exhibit 6**, MCPA's fiscal 2027 allowance totals $14.0 billion after accounting for contingent reductions. The largest share of MCPA's budget (46%, or $6.4 billion) supports reimbursements for health care services paid for by MCOs, referred to as Managed Care in the exhibit. In addition, 32%, or $4.5 billion, covers FFS costs including dental coverage and nursing home costs. Both managed care and FFS costs are adjusted downward slightly to account for a total of $841 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 $607 million, and supports home and community-based services (HCBS) through entitlement programs and Medicaid waivers.

Exhibit 6
Overview of Agency Spending
Fiscal 2027 Allowance
($ in Millions)



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 2027 allowance accounts for contingent reductions. The fiscal 2027 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 7**, the fiscal 2027 allowance decreases by $215.3 million compared to the fiscal 2026 working appropriation, after adjusting for proposed deficiencies and contingent general fund reductions, including a deficiency to cover a fiscal 2025 shortfall of $294.6 million ($62.7 million in general funds). When excluding fiscal 2025 expenses from the fiscal 2026 budget, the fiscal 2027 allowance increases by $79.3 million. Increased spending in the fiscal 2027 allowance is mainly attributed to overall MCO rate increases and hospital costs totaling $453.4 million. There is also an enhancement of $9.9 million ($3.3 million in general funds) to expand coverage of biomarker testing. This growth is partially offset by $306 million in overall reduced spending due to enrollment decline in fiscal 2027 compared to fiscal 2026. Additionally, funding for MITDPs decreases by $71 million in federal funds to defer or suspend some projects as a cost containment measure and due to the LTSS system transitioning from a MITDP to ongoing maintenance and operations.

Exhibit 7
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 2025 Actual	$4,633,367	$802,567	$8,018,891	$155,164	$13,609,989
Fiscal 2026 Working	4,716,970	851,022	8,460,933	143,900	14,172,824
Fiscal 2027 Allowance	4,685,146	871,990	8,272,260	128,095	13,957,492
Fiscal 2026-2027 $ Change	-$31,823	$20,969	-$188,673	-$15,805	-$215,333
Fiscal 2026-2027 % Change	-0.67%	2.46%	-2.23%	-10.98%	-1.52%

Where It Goes:	Change
Personnel Expenses	
Salary adjustments and associated fringe benefits	$4,883
Employee and retiree health insurance	3,760
Salaries and fringe benefits for 25 new positions and reclassification of existing positions under the Office of Eligibility Services for OBBBA implementation	927
Deferred compensation match due to statewide change in budgeting	210
Turnover rate increases from 6.72% to 13.70%	-5,221
Other fringe benefit adjustments	-366
Other Changes	
Rate increases for MCOs (5.4%) and hospitals (6.4%)	453,404

Where It Goes:	**Change**
Community First Choice Program	21,631
Medicaid Advanced Primary Care Program, mainly due to federal matching funds only reflected in fiscal 2027	20,356
Contract modifications with Telligen for fee-for-service utilization review to include new system requirements and additional staffing	11,619
Biomarker testing expansion to include heart disease, infectious disease, metabolic disease, and perinatal health	9,907
Administrative contracts, audits, and IT expenses	7,206
Participant share of Medicaid covered health services to align with recent actuals (special funds)	4,231
Medicare Part D clawback and pharmacy-related administrative contracts	3,252
Administrative contract for nursing home services to realign with recent actual spending	3,077
Coverage of non-emergency transportation for Medicaid participants	2,109
Employed Individuals with Disabilities program	-2,958
Money Follows the Person initiative for transitions to home and community-based care, largely decreasing due to reduced transitions and new federal limits to administrative spending	-5,815
Senior Prescription Drug Assistance Program	-6,824
Healthy Babies initiative	-8,055
Pharmacy rebates	-9,297
Medicare part A and B premiums	-13,495
Maryland Children's Health Program	-16,283
One-time fiscal 2026 HSCRC hospital rate adjustments paid by Medicaid	-25,000
Major IT projects, driven by the LTSS project transitioning to ongoing maintenance and components of the MMT project delayed due to cost containment efforts	-71,008
Fiscal 2026 deficiency to cover fiscal 2025 accrual shortfall	-294,631
Enrollment and utilization trends	-306,001
Other expenses	3,049
Total	**-$215,333**

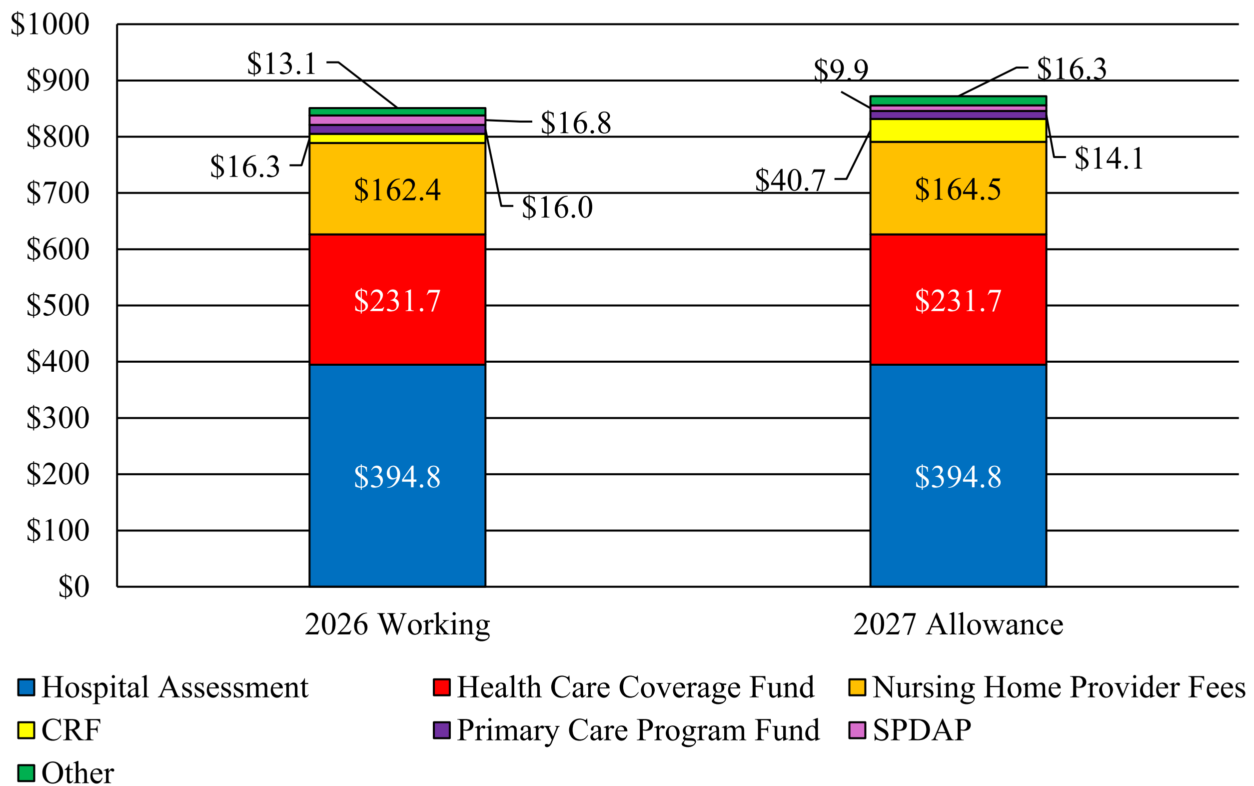
HSCRC: Health Services Cost Review Commission
IT: information technology
LTSS: Long Term Services and Supports
MCO: managed care organization
MMT: Medicaid Enterprise Systems Modular Transformation
OBBBA: One Big Beautiful Bill Act

Note: Numbers may not sum to total due to rounding. The fiscal 2026 working appropriation accounts for deficiencies. The fiscal 2027 allowance accounts for contingent reductions. The fiscal 2027 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

Special Fund Availability

Exhibit 8 shows a variety of special fund sources that support fiscal 2026 and 2027 Medicaid expenditures. Overall, special fund spending under MCPA programs in the fiscal 2027 allowance increases by $21 million compared to the fiscal 2026 working appropriation, after accounting for proposed deficiencies. The net growth is largely due to reduced CRF spending for Medicaid expenses in fiscal 2026 and additional CRF revenue for Medicaid in fiscal 2027.

Exhibit 8
Special Fund Support for the Medical Care Programs Administration
Fiscal 2026-2027
($ in Millions)



CRF: Cigarette Restitution Fund
SPDAP: Senior Prescription Drug Assistance Program

Note: The fiscal 2026 working appropriation includes deficiencies. The fiscal 2027 allowance includes contingent reductions.

Source: Governor's Fiscal 2027 Budget Books

The fiscal 2026 budget plan as introduced proposed reallocating $15 million in CRF support from research grants for Statewide Academic Health Centers to instead support Medicaid. However, this proposal was not approved, resulting in less CRF availability for Medicaid. Section 21 of the fiscal 2026 Budget Bill added $15 million in general funds under Medicaid to backfill the CRF support. The CRF appropriation for Medicaid expenses increases from $16.2 million in fiscal 2026 to $40.7 million in fiscal 2027.

The BRFA of 2026 includes the following two provisions that result in additional CRF availability for Medicaid.

- One provision expands, for fiscal 2027 only, the authorized uses of funds distributed to the separate account within the CRF in excess of the first $35 million to include purposes other than supplanting the general fund appropriation for the historically Black colleges and universities settlement. The fiscal 2027 budget as introduced includes an $8.4 million general fund reduction, contingent on the enactment of this provision. However, the corresponding $8.4 million CRF special fund appropriation is not contingent. **To ensure the appropriation is not provided twice, DLS recommends adding budget bill language to make this funding contingent on enactment of this BRFA provision.**

- Another provision eliminates, in fiscal 2027 only, the requirement that the Governor include an $8.0 million appropriation from the CRF for the Maryland Community Health Resources Commission (MCHRC) Fund. The fiscal 2027 budget as introduced includes a $1.0 million CRF special fund reduction under MCHRC, contingent on enactment of legislation eliminating the funding mandate for MCHRC and allowing the commission to use existing fund balance for operations. The CRF savings are reallocated to provide general fund relief under Medicaid through a $1.0 million CRF special fund appropriation and $1.0 million general fund reduction, contingent on enactment of legislation reducing the CRF mandate for the MCHRC Fund and allowing MCHRC fund balance to support its operations. According to the MCHRC, the fiscal 2025 closing balance for the MCHRC Fund was $2.3 million. DLS notes that MCHRC fund balance above $1.0 million could be spent in fiscal 2027 to replace CRF need in MCHRC, which would provide up to $1.3 million in additional general fund relief under Medicaid that could be reallocated to other programs in MDH with an identified shortfall. **DLS also recommends amending the contingent language as a technical correction to more closely align with the applicable provision in the BRFA.**

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.

Provider Assessments

The largest special fund sources continue to be provider assessments on hospitals through the Medicaid deficit assessment and Health Care Coverage Fund and on nursing facilities through the quality assessment. An OBBBA provision that gradually reduces the cap on certain provider

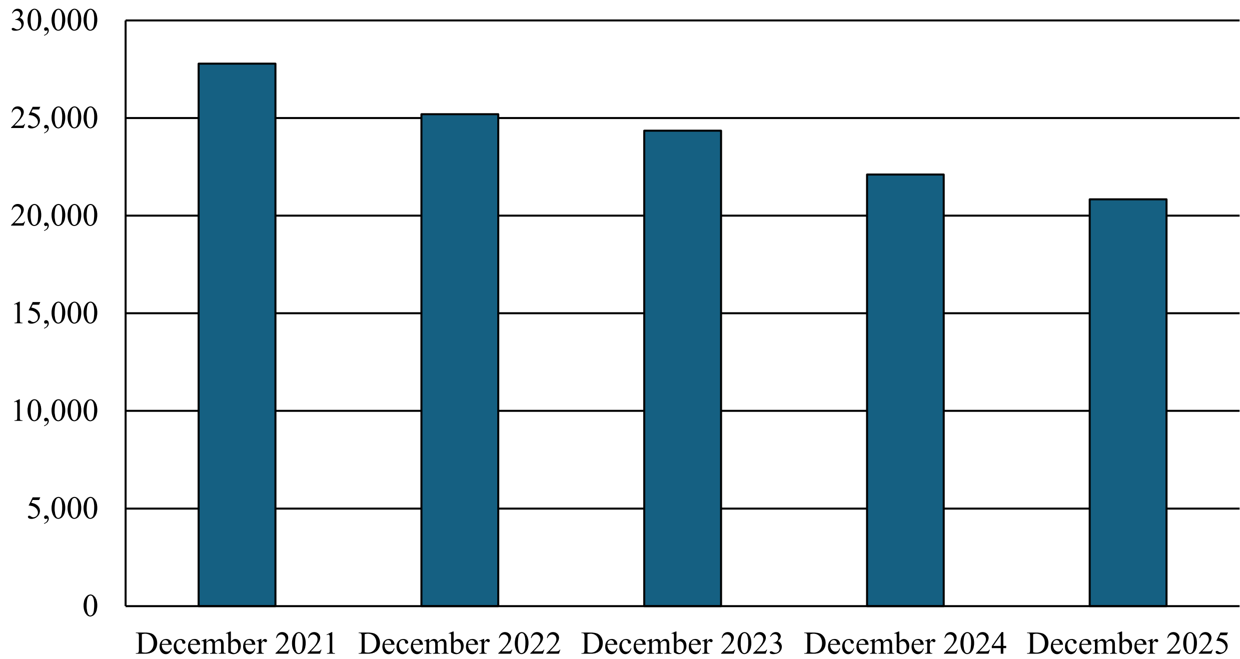
assessments from 6% to 3.5% of net patient revenue is not expected to reduce Maryland's special fund revenue, as current hospital assessments are already near the 3.5% cap and nursing facility assessments are exempt from the reduced cap. The nursing facility quality assessment is currently set at 6% of net patient revenues each year.

There is still some concern that OBBBA implementation and increased scrutiny of provider assessments by CMS could put hospital and nursing facility assessments at risk, which are projected to support $791 million in Medicaid expenses with special funds in fiscal 2027 and generate additional federal matching funds. Maryland collects hospital assessments through the Health Services Cost Review Commission's (HSCRC) rate setting authority, rather than through CMS approval, which creates uncertainty in how OBBBA requirements will be applied. Additionally, current assessments apply only to hospitals regulated by HSCRC and exempt certain nursing facilities. To meet CMS uniform and broad-based tax requirements, MDH may need to expand the provider taxes to other specialty hospitals and all nursing facilities in the State. **MDH should provide an update on any federal guidance or notice that it has received in regard to provider assessment policies, including whether the department is planning to make any changes to gain CMS approval and meet uniform and broad-based tax requirements.**

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. Effective January 1, 2026, the maximum premium subsidy increased from $75 to $100 per member per month. As shown in **Exhibit 9**, program enrollment as of December in each year has steadily decreased, with an average annual decline of 7%. Despite the potential for SPDAP enrollment to grow in calendar 2025 due to State retirees enrolling in Medicare Part D following the termination of prescription drug coverage through the State plan, enrollment continued to decrease to 20,837 participants in December 2025. In an annual SPDAP report, MDH indicated that it conducts outreach by working with the Maryland Department of Aging (MDOA) and sharing SPDAP information with State Health Insurance Assistance Program coordinators and counselors that assist Marylanders navigate Medicare.

Exhibit 9
Senior Prescription Drug Assistance Program Enrollment
December 2021 to December 2025



Source: Maryland Department of Health

The SPDAP is fully supported through its special fund, which is made up of annual payments from CareFirst up to the value of its premium tax exemption. **Exhibit 10** shows anticipated SPDAP revenue and expenditures in fiscal 2026 and 2027. As a result of declining enrollment and lower than anticipated spending, MDH reported a fiscal 2026 opening SPDAP fund balance of $21.6 million. 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 2026 and 2027 budgets transfer $5.0 million in fund balance to be used by BHA for provider reimbursements in the program supporting services for the uninsured, providing equivalent general fund savings. These provisions also expanded the use of the SPDAP fund to include, in fiscal 2025 only, depositing funds into health reimbursement accounts of certain State retirees transitioning to Medicare Part D. A provision in the BRFA of 2025 made this an allowable use on an ongoing basis beyond fiscal 2025. Although the fiscal 2026 budget includes a fund balance transfer of $3.1 million for the health reimbursement accounts budgeted under DBM, the fiscal 2027 budget does not include a SPDAP fund balance transfer for this use.

Exhibit 10
Senior Prescription Drug Assistance Program Fund
Fiscal 2026-2027
($ in Millions)

	2026	2027
Beginning Fund Balance	$21.6	$10.7
Projected Revenue	14.0	14.0
Total Available Revenue	**$35.6**	**$24.7**
Projected SPDAP Expenditures	$16.8	$9.9
Transfer to BHA for Community Mental Health Services	5.0	5.0
Transfer to DBM for Certain State Retirees Transitioning to Medicare Part D	3.1	0.0
Total Expenditures	**$24.9**	**$14.9**
Estimated Closing Fund Balance	**$10.7**	**$9.8**

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

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

For the purpose of this exhibit, estimated SPDAP expenditures in fiscal 2026 are shown as the full $16.8 million working appropriation. However, this estimate is over $6 million more than fiscal 2025 actual SPDAP spending ($10.4 million), and the fiscal 2027 allowance reduces the appropriation for this purpose to just under the fiscal 2025 level. This results in minimum estimated closing fund balances of $10.7 million and $9.8 million in fiscal 2026 and 2027, respectively. Actual closing fund balances are likely to be significantly higher if current spending trends continue. DLS notes that a portion of the SPDAP fund balance can again be transferred to DBM in fiscal 2027, and the remaining balance of at least $6.8 million can be transferred to BHA for community mental health services to the uninsured to support general fund shortfalls identified in MDH programs. **DLS recommends reducing $3.0 million in general funds budgeted in DBM for health reimbursement accounts of certain State retirees transitioning to Medicare Part D in anticipation of an equivalent SPDAP fund balance transfer. This reduction will appear in the analysis for F10A02 – DBM Personnel.**

Maternal and Child Health Fund Balance Transfer Proposed in the Budget Reconciliation and Financing Act

The BRFA of 2021 established the Maternal and Child Health Population Health Improvement Fund under MDH to invest in maternal and child health interventions led by MCPA, MCOs and the MDH Prevention and Health Promotion Administration (PHPA). Funding was derived from a uniform, broad-based assessment built into hospital rates that supports HSCRC Regional Partnership Catalyst program, which distributes funding to support the State's achievement of specific population health goals, including goals related to maternal and child health. The hospital assessment for maternal and child health was approved by HSCRC in May 2021 for $40 million in cumulative funding and terminated at the end of calendar 2025. The fund is administered by MDH and HSCRC and was initially set to terminate at the end of calendar 2025. Chapters 29 and 30 of 2025 extend the date through which the Maternal and Child Health Population Health Improvement Fund may be used to December 31, 2027, and allow MDH to spend through calendar 2027 any monies remaining in the fund at the end of calendar 2025.

For fiscal 2022 through 2027, annual appropriations from the fund totaled $8 million under Medicaid to address severe maternal morbidity and $2 million 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 the fund had a closing balance of $32.8 million in fiscal 2025, of which $13.1 million will be transferred to the General Fund in fiscal 2026 in accordance with a provision in the BRFA of 2025. As shown in **Exhibit 11**, after accounting for this fund balance transfer and total budgeted expenditures of $10 million, the estimated fiscal 2026 closing fund balance is a minimum of $9.7 million. A provision in the BRFA of 2026 as introduced authorizes the Governor to transfer $6.7 million from the Maternal and Child Health Population Health Improvement Fund to the General Fund on or before June 30, 2027, bringing the total amount transferred to the General Fund to $19.8 million, almost half of the approved hospital assessment.

Exhibit 11
Maternal and Child Health Population Health Improvement Fund
Fiscal 2026-2027
($ in Millions)

	Fiscal 2026	Fiscal 2027
Beginning Fund Balance	**$32.8**	**$9.7**
Budgeted Medicaid Expenditures (Reimbursable Funds)	8.0	8.0
Budgeted PHPA Expenditures (Special Funds)	2.0	1.3
Transfer to the General Fund	13.1	6.7*
Total Expenditures	**$23.1**	**$16.0**
Estimated Closing Fund Balance	**$9.7**	**-$6.3**

PHPA: Prevention and Health Promotion Administration

*Transfer to the General Fund proposed in the Budget Reconciliation and Financing Act of 2026.

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

MDH reported that it plans to spend the remaining fund balance on eligible expenses in Medicaid and PHPA before the fund sunsets at the end of calendar 2027. However, the fiscal 2027 allowance includes a total appropriation of $9.3 million from this fund across Medicaid and PHPA, which is $6.3 million more than the minimum available fund balance after the proposed fiscal 2027 transfer. **MDH should provide fiscal 2026 year-to-date spending from the Maternal and Child Health Population Health Improvement fund and describe why eligible programs under Medicaid and PHPA underspent the appropriation, leading to a large fund balance. Additionally, MDH should clarify how it will spend the remaining fund balance and should work with DBM to adjust the fiscal 2026 appropriation and fiscal 2027 allowance through a supplemental budget to accurately reflect planned spending in each year.**

New Major IT Project for Pharmacy Services System

According to the Governor's Fiscal 2027 Budget Books, MDH's current contract for Pharmacy Point of Sale Electronic Claims Management Services expires in July 2029, and a new MITDP is needed to replace the current vendor and system. The Governor's Fiscal 2027 Budget Books describe this project as supporting pharmacy operations for Medicaid, although other MDH programs under PHPA also provide pharmacy services to Marylanders, such as the Kidney Disease Program, Maryland AIDS Drug Assistance Program, and Breast and Cervical Cancer Diagnosis and Treatment Program. The fiscal 2027 allowance includes $1.5 million in general funds budgeted in the Department of Information Technology (DoIT) for this project, and the estimated total cost is up to $10 million. Notably, the budget does not assume any federal matching funds, despite the

information technology project request (ITPR) submitted to DLS on February 20, 2026, indicating that MDH expects to receive enhanced federal fund participation of 90% through an advanced planning document to be approved by CMS. **MDH should brief the committees on the need for this project, including the planned project schedule. Additionally, MDH should clarify whether the MITDP will also support other pharmacy services provided by PHPA. DLS recommends reducing $1.35 million in general funds budgeted in the Information Technology Investment Fund within DoIT and authorizing a budget amendment to replace the funding with federal funds to account for expected federal fund participation of 90% for this project. This reduction will appear in the analysis for F50 – DoIT.**

Expansion of Biomarker Testing

Chapters 322 and 323 of 2023 required Medicaid, beginning in July 1, 2025, to provide coverage of 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 was already in the process of implementing biomarker testing specifically for cancer treatment to be used to determine if a specific medication or therapy would be more effective in treatment, thereby guiding clinical management. The fiscal 2026 working appropriation includes $9.5 million for biomarker testing, and the fiscal 2027 allowance for Medicaid increases by $9.9 million to provide a total of $19.5 million to expand biomarker testing. Additional funding provided in fiscal 2027 will expand biomarker testing to include heart disease, infectious diseases, metabolic diseases, and perinatal health. Under Medicaid behavioral health reimbursements, there is also $2.6 million budgeted for biomarker testing in each year for fiscal 2026 and 2027.

Money Follows the Person Demonstration

MDH administers the Money Follows the Person (MFP) program to provide long-term care services in home and community-based settings to eligible individuals that require a nursing facility or other institutional level of care. The program also provides peer outreach and supports through MDOA and the Maryland Department of Disabilities (MDOD). Medicaid's fiscal 2027 allowance for MFP decreases by $5.8 million ($2.0 million in general funds) due to (1) reduced transition volumes of individuals from institutional care to HCBS funded through MFP and (2) revised federal guidance issued by CMS that took effect January 1, 2026, that limited the cap for administrative spending to 15% of total expenditures. According to MDH, administrative costs in calendar 2025 were 27% of total spending, and the department planned to transfer positions between the Office of Long Term Services and Supports to the Office of Eligibility Services to reduce some of this spending counted as administrative under MFP. Moreover, the federal guidance also reclassified peer outreach and supports services offered by MDOD as administrative, and CMS chose to sunset the program. MDOD has indicated that grantees have been notified of the termination of this program.

MCO Rate Increases and Hospital Rate Assumptions Reflect Significant Growth in Utilization and Health Acuity

Exhibit 12 lists rate increases by service or provider type budgeted under MCPA, reflecting a total increase of $428.4 million in the fiscal 2027 allowance. An overall increase of 5.4% for calendar 2026 MCO rates drives most of the spending growth, accounting for $383.1 million. The fiscal 2027 allowance does not project any additional spending for rate changes that may be determined through the MCO calendar 2027 rate-setting process.

Exhibit 12
Medicaid and MCHP Provider Rate Changes and Rate Assumptions
Fiscal 2027
($ in Millions)

	Rate Change
Managed Care Organizations Calendar 2026 (5.4%)	$383.1
Inpatient and Outpatient Services (6.4%)	70.4
One-time Fiscal 2026 HSCRC Actions Increasing Hospital Rates	-25.0
Total	**$428.4**

HSCRC: Health Services Cost Review Commission
MCHP: Maryland Children's Health Program

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

MCO Rate and Utilization Trends

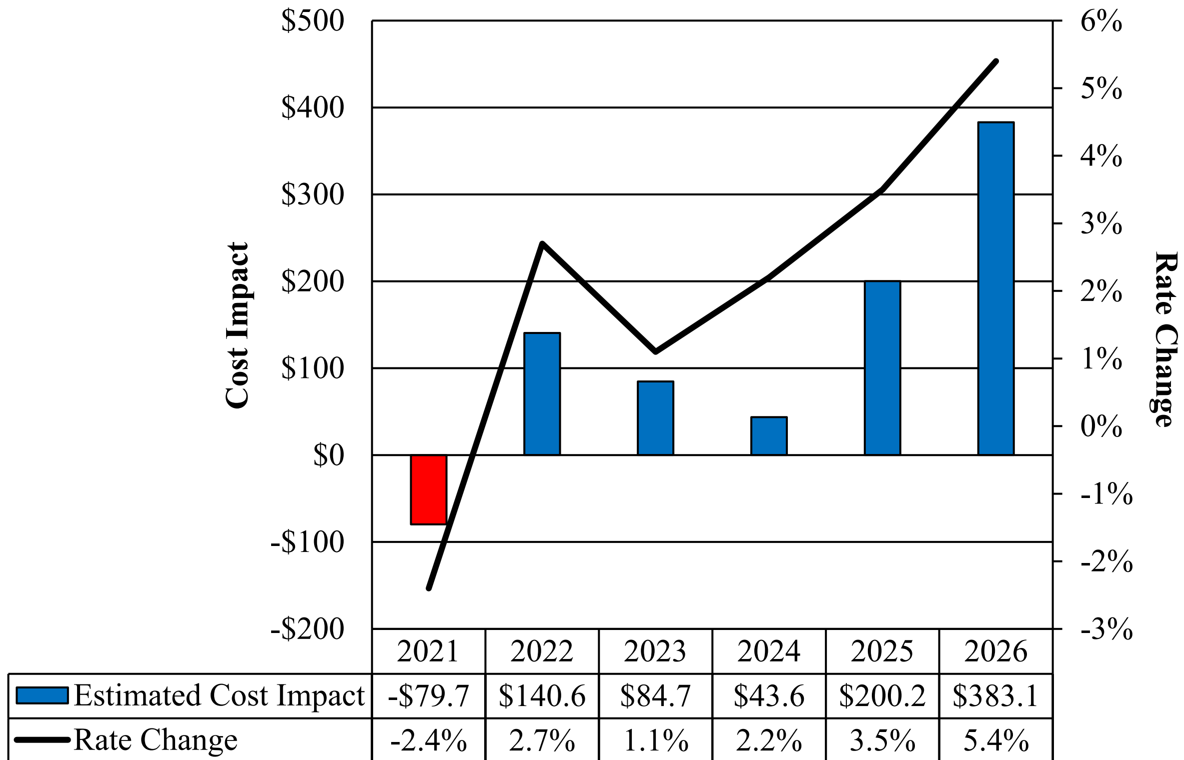
Exhibit 13 shows historical MCO rate adjustments since calendar 2021, reflecting growing rate increases in each year since calendar 2023. Considering that federal regulation requires states to set actuarially sound MCO capitation rates in each year, significant increases in MCO rate adjustments and total fund impacts reflect actual cost increases in the healthcare sector for MCOs covering over 80% of Medicaid participants. Estimated cost impact reflects the budgeted amount for the allowance considered in each calendar year. For example, the estimated cost impact shown for calendar 2026 is the amount assumed in the fiscal 2027 allowance. Recent rate increases of 3.5% in calendar 2025 and 5.4% in calendar 2026 are estimated to cost $200 million and $383 million in total funds, respectively. The estimated cost impact in this exhibit does not reflect midyear adjustments.

Exhibit 13

MCO Rate Changes and Cost Impact

Calendar 2021-2026

($ in Millions)



	2021	2022	2023	2024	2025	2026
Estimated Cost Impact	-$79.7	$140.6	$84.7	$43.6	$200.2	$383.1
Rate Change	-2.4%	2.7%	1.1%	2.2%	3.5%	5.4%

MCO: managed care organization

Note: Estimated cost impact reflects the budgeted amount for the allowance considered in each calendar year. For example, the estimated cost impact shown for calendar 2026 is the amount assumed in the fiscal 2027 allowance.

Source: Maryland Department of Health; Department of Legislative Services

According to the Hilltop Institute and Optumas, MDH's actuary for MCO rate-setting, growing costs within managed care are especially driven by maternal health care as utilization and cost both increase. From calendar 2023 to 2024, Optumas reported that costs for deliveries per member per month grew by over 20% and utilization per 1,000 members grew by over 18%. Pharmacy costs are another notable driver of increasing healthcare costs. Optumas reported that this is driven by medications to treat HIV, which are considered low volume but high-cost drugs, and glucagon-like peptide-1 medications (GLP-1s). Medicaid currently covers GLP-1s for only certain conditions like diabetes and heart disease, but spending on these medications grew by approximately 20% in utilization and cost each from calendar 2023 to 2024.

Hospital Update Factors and Utilization Trends

HSCRC reported an update factor of 6.4% for regulated hospital rates in calendar 2026, which leads to an increase of $70.4 million in estimated Medicaid spending on inpatient and outpatient hospital services in fiscal 2027. However, this spending growth is partially offset by the end of one-time HSCRC actions that increased hospital rates paid by Medicaid by $25 million in fiscal 2026, including:

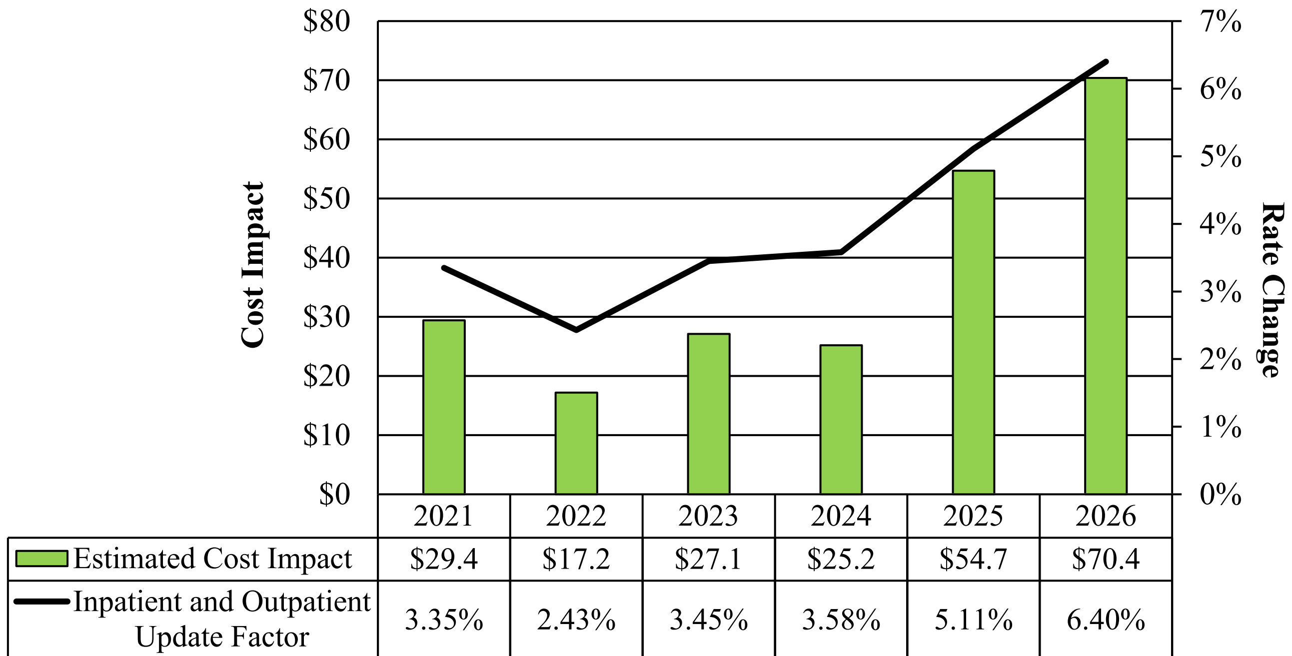
- $10 million in total funds ($4 million in general funds) due to an increased set aside for hospitals facing financial hardship;

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

- $5 million in total funds ($2 million in general funds) for an increase in hospital rates to be paid into the Population Health Improvement Fund, a special fund established by Chapter 615 of 2025 to support population health efforts under the AHEAD model. The fiscal 2027 allowance does not include special fund expenditures from the Population Health Improvement Fund.

As shown in **Exhibit 14**, similar to MCO rates, hospital rates and spending have also increased dramatically in recent years. Annual hospital update factors approved by HSCRC have remained above 2% since calendar 2021 and most recently increased to more than 5% in calendar 2025 and 2026. This translates to overall cost impacts of $54.7 million assumed in the fiscal 2026 appropriation and $70.4 million assumed in the fiscal 2027 allowance. Like the historical cost impact data shown for MCOs, this data also does not reflect adjustments for midyear rate changes. Costs and utilization of inpatient services would also be impacted by reported trends in higher cost deliveries and maternal health. Within Medicaid, however, hospital costs are especially impacted by trends in utilization of inpatient and outpatient services by elderly and disabled participants who receive services on a FFS basis. Annual utilization data reported by MDH indicates a significant shift between average annual reductions in utilization per FFS enrollee from fiscal 2019 to 2023, which was mainly attributable to the COVID-19 pandemic driving down hospital utilization and elective surgeries and notable annual increases in FFS utilization of outpatient and inpatient services per enrollee from fiscal 2023 to 2025 due to pent up demand and higher health acuity.

Exhibit 14
Hospital Rate Changes and Cost Impact
Calendar 2021-2026
($ in Millions)



	2021	2022	2023	2024	2025	2026
Estimated Cost Impact	$29.4	$17.2	$27.1	$25.2	$54.7	$70.4
Inpatient and Outpatient Update Factor	3.35%	2.43%	3.45%	3.58%	5.11%	6.40%

Source: Maryland Department of Health; Health Services Cost Review Commission; Department of Legislative Services

Other Provider Rates

The fiscal 2027 budget provides level rates for long-term services and supports providers and physician evaluation and management (E&M) rates compared to the fiscal 2026 working appropriation. Physician E&M rates are set at 98.8% of Medicare rates in fiscal 2026 and include an enhancement that began in August 2025 as part of the primary care initiatives under the AHEAD model. MDH indicates that Medicare rates for calendar 2027 have not been released yet; therefore, the percentage of physician E&M rates as a share of Medicare rates cannot be calculated for fiscal 2027.

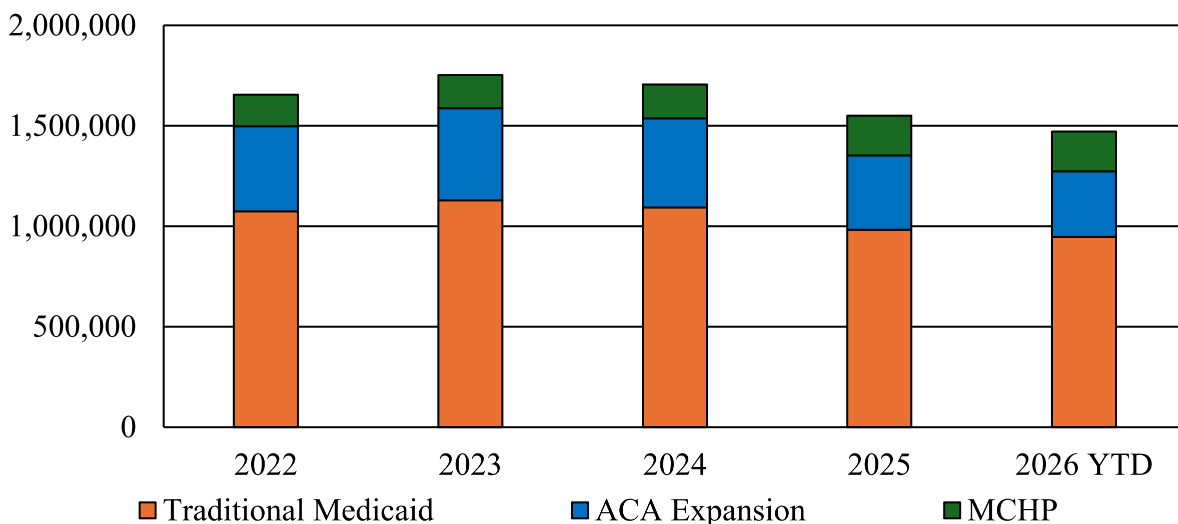
In addition to the standard physician E&M rates, primary care providers can receive additional per member per month payments and quality incentive payments through the new Advanced Primary Care Program, also referred to as the Medicaid Path. Through this program, providers that do not currently participate in the existing Maryland Primary Care Program, such as pediatricians, may become eligible as the Medicaid Path expands in calendar 2026. The BRFA of 2025 established the Medicaid Primary Care Program Fund to support these initiatives using

revenue from hospital payments received by HSCRC via the Medicare savings component for calendar 2023. The fiscal 2026 working appropriation includes $16 million from the Medicaid Primary Care Program Fund but does not reflect federal matching funds. The fiscal 2027 allowance includes a total of $36.4 million ($14.1 million in special funds and $22.2 million in federal funds).

Enrollment Trends

As shown in **Exhibit 15**, between fiscal 2023 and 2025, combined Medicaid and MCHP enrollment gradually decreased from 1.75 million in fiscal 2023 to 1.55 million due to ongoing unwinding processes and system reconciliation following the end of the COVID-19 public health emergency (during which disenrollments were frozen as a condition of states receiving enhanced federal funding). Adults served through the ACA expansion and traditional Medicaid enrollees drove the overall decline, while MCHP participation increased from 164,521 children in fiscal 2023 to 198,384 children in fiscal 2025. MCHP serves low-income children with household incomes that exceed eligibility for Medicaid; therefore, the resumption of eligibility redetermination and rising household incomes likely resulted in children moving from Medicaid into MCHP with the higher income.

Exhibit 15
Average Monthly Medicaid and Maryland Children's Health Program Enrollment
Fiscal 2022-2026 YTD



ACA: Affordable Care Act
MCHP: Maryland Children's Health Program
YTD: year to date (through January 2026)

Source: Maryland Department of Health

Projected Enrollment

Exhibit 16 compares enrollment by eligibility group assumed in the fiscal 2026 legislative appropriation, fiscal 2026 working appropriation, and fiscal 2027 allowance to DLS fiscal 2026 and 2027 enrollment forecasts, showing overall alignment between the budgeted forecast and DLS forecast. Based on decreases in actual caseloads reported in the beginning of fiscal 2026 and annualization of disenrollments from the prior year, both forecasts anticipate that average monthly enrollment in fiscal 2026 will decrease compared to the projection assumed in the fiscal 2026 legislative appropriation for parents and caretakers, other traditional Medicaid enrollees, MCHP, and noncitizen pregnant women enrolled through the Healthy Babies initiative. Both forecasts anticipate enrollment for ACA expansion adults to increase compared to the legislative appropriation projection based on higher than expected actual monthly enrollment. Differences between the two forecasts in fiscal 2026 are largely a function of actual enrollment through January 2026 decreasing further compared to levels reported in fall 2025 that were used for the working appropriation forecast. The only eligibility group that shows diverging trends is children enrolled in Medicaid, as the DBM forecast assumes enrollment will increase from the legislative appropriation based on the average net change in monthly enrollment from May 2024 through August 2025, whereas the DLS estimate assumes recent monthly net declines in enrollment among children will continue.

Exhibit 16
DLS and DBM Medicaid Enrollment Forecasts
Fiscal 2026-2027

	2026			**2027**		**% Change 2026-2027**	
	Legislative Approp.	**Adjusted Working**	**DLS Estimate**	**Allowance**	**DLS Estimate**	**Adjusted Working to Allowance**	**DLS 2026 Estimate to DLS 2027 Estimate**
Parents and Caretakers	232,436	203,109	201,604	201,752	201,100	-0.7%	-0.2%
Children	481,337	490,752	480,975	491,716	480,975	0.2%	0.0%
Other Traditional Medicaid	262,861	259,401	257,658	263,773	259,067	1.7%	0.5%
ACA Expansion	310,127	328,358	326,504	312,964	318,085	-4.7%	-2.6%
MCHP	194,237	191,464	190,288	191,144	190,288	-0.2%	0.0%
Healthy Babies	8,452	7,119	6,738	6,515	3,369	-8.5%	-50.0%
Total	**1,489,449**	**1,480,203**	**1,463,766**	**1,467,864**	**1,452,883**	**-0.8%**	**-0.7%**

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

Major provisions in the OBBBA affecting eligibility and redetermination processes, such as terminating coverage for certain lawfully present individuals (refugees, asylees, and other humanitarian parolees), implementing work requirements, and conducting more frequent eligibility checks for ACA expansion adults, cause uncertainty for the Medicaid enrollment forecast beginning in fiscal 2027. Due to delayed effective dates for these provisions, estimated disenrollments would appear in the second half of fiscal 2027 and later. As a result, fiscal 2027 enrollment in both forecasts is expected to decrease slightly by between 0.7% and 0.8% overall, though there are differing trends expected within some eligibility groups. The largest differences appear in ACA expansion adults and Healthy Babies enrollment. For ACA expansion adults, the fiscal 2027 allowance projects a larger decrease of 4.7% compared to 2.6% in the DLS forecast. The difference between Healthy Babies caseload is due to the DLS forecast assuming enrollment will fall considerably due to a more pronounced chilling effect and reduced levels of immigration, despite no direct impacts of OBBBA provisions on this program.

General Fund Adequacy

Corresponding with the aligned overall enrollment projections, the fiscal 2026 and 2027 Medicaid budget does not reflect notable differences in spending due to caseload assumptions. Any general fund cost differences resulting from enrollment differences in ACA expansion adults and Healthy Babies are less significant due to both eligibility groups receiving enhanced federal matching rates (90% for ACA adults, 65% for Healthy Babies enrollees). As noted earlier, the fiscal 2026 working appropriation does not account for $44.2 million in State savings from MLR recoveries that MDH confirmed it received in fall 2025 and based on year-to-date carryover spending for fiscal 2025 bills paid in fiscal 2026, the general fund deficiency for prior year costs can be reduced by at least $10 million. Combined, these proposed reductions in fiscal 2026 provide $54.2 million in general fund relief. After accounting for these reductions, the budget in both years appears more than adequate to cover projected costs.

Remaining expenditure differences that suggest potential general fund savings in the budget are mainly attributable to differences in anticipated healthcare utilization. However, as discussed earlier in the analysis, healthcare costs and utilization continue to grow at significant rates and that has led to unexpected shortfalls in Medicaid at times and in other programs within MDH more recently. Due to substantial uncertainty related to ongoing healthcare utilization growth and OBBBA implementation, DLS does not recommend reducing the Medicaid budget in fiscal 2027, with exception to a recommended reduction of $3 million to account for projected savings from shifting eligible Medicaid participants to Medicare (discussed in further detail in Issue 2). Rather than reducing the Medicaid budget to account for forecast differences, DLS notes that any general fund savings realized in fiscal 2026 or 2027 could be reallocated within MDH to areas with projected shortfalls.

When considering the fiscal outlook beyond fiscal 2027, Medicaid continues to be the largest driver of State general fund spending, aside from local aid (mainly for K-12 education). As shown in **Exhibit 17**, in the final years of the COVID-19 public health emergency and subsequent years, from fiscal 2022 to 2024, general fund spending on Medicaid and MCHP grew by over

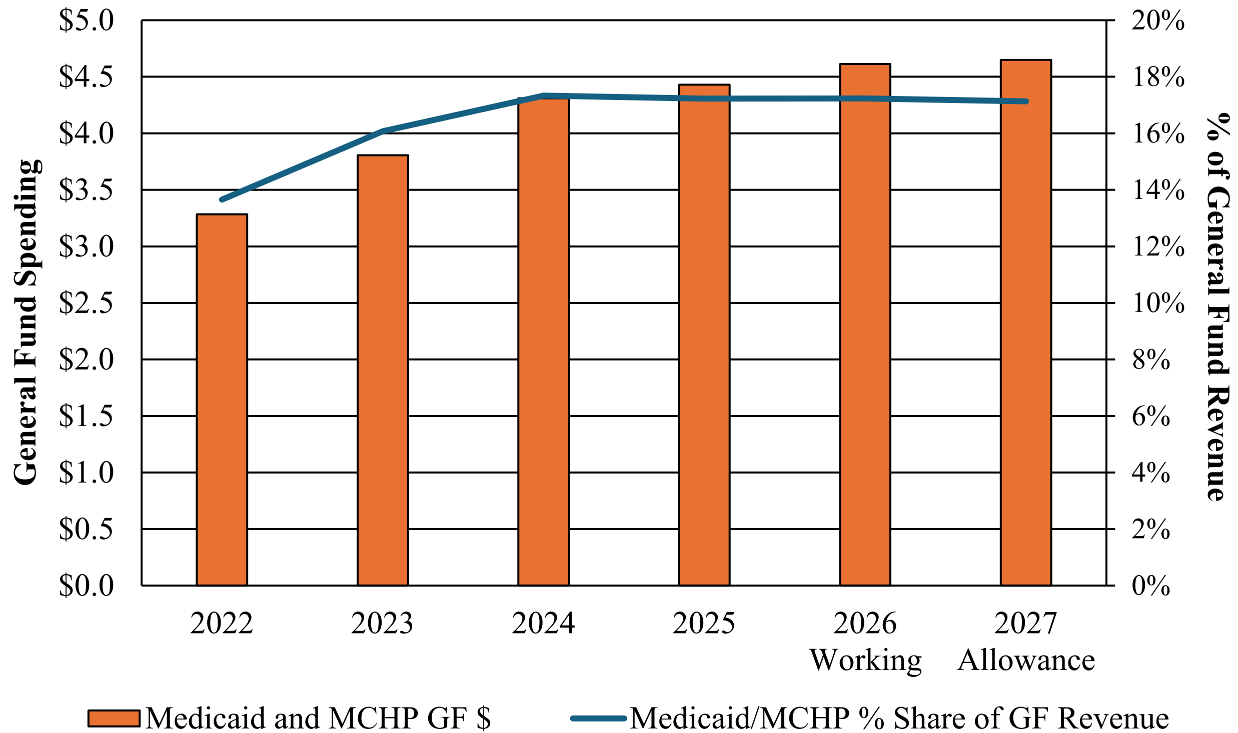
$1 billion overall. Some of this growth was expected as enhanced federal matching funds for Medicaid and MCHP expired. The tremendous growth in healthcare utilization and cost was not anticipated, leading Medicaid and other MDH programs to report shortfalls at fiscal year closeout and significant general fund deficiencies in recent years. This departmentwide trend and further discussion of forecasting challenges can be found in the analysis for M00 – MDH Overview. Although general fund spending on Medicaid and MCHP is projected to level off in fiscal 2026 and 2027, it is still worth examining whether this level of spending is sustainable, as Medicaid and MCHP continue to account for over 17% of statewide general fund revenue each year since fiscal 2024.

Exhibit 17

Medicaid and MCHP Spending as a Share of General Fund Revenue

Fiscal 2022-2027

($ in Billions)



GF: general fund
MCHP: Maryland Children's Health Program

Source: Department of Budget and Management; Bureau of Revenue Estimates; Department of Legislative Services

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Personnel Data

	FY 25 Actual	FY 26 Working	FY 27 Allowance	FY 26-27 Change
Regular Positions	678.10	661.10	681.60	20.50
Contractual FTEs	71.42	87.57	113.25	25.68
Total Personnel	**749.52**	**748.67**	**794.85**	**46.18**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies		93.36	13.70%	
Positions and Percentage Vacant as of 12/31/25		93.90	14.20%	
Vacancies Above Turnover		0.54		

- On October 22, 2025, the Board of Public Works (BPW) approved the abolition of 502.7 positions statewide, including 170.7 vacant positions and 332.0 positions associated with the Voluntary Separation Program (VSP). In MCPA, 8 administrative positions were abolished, of which 4 were vacant and 4 were due to the VSP.

- The fiscal 2027 allowance for MCPA includes a net increase of 20.5 positions due to transfers from other MDH programs. Of these positions, 17.3 are realigned to the Office of Eligibility Services to support eligibility determination and implement changes enacted in the OBBBA, such as work requirements and six-month eligibility redetermination for ACA expansion adults. The Office of Eligibility Services also receives approximately 25 new contractual FTEs. Additionally, 7.2 positions are transferred into the Office of Benefits Management and Provider Services, mainly for long-term care problem resolution and claim services. These positions are partially offset by transfers from MCPA to the Developmental Disabilities Administration (DDA) (3 positions) and Health Professional Boards and Commissions (1 position).

- Of the 93.9 vacancies as of December 31, 2025, 21 positions have been vacant for more than one year. In line with MCPA's persistently high vacancy rate, budgeted turnover increases from 6.7% in fiscal 2026 to 13.7% in the fiscal 2027 allowance. This adjustment brings the number of necessary vacant positions to meet budgeted turnover essentially level with current vacancy trends, which do not yet reflect the fiscal 2027 position transfers. The net 20.5 positions transferred to MCPA in fiscal 2027 will provide capacity to increase staffing.

Issues

1. OBBBA Implementation

The federal OBBBA enacted on July 4, 2025, makes significant programmatic changes to Medicaid that affect eligibility requirements, especially for adults served through the ACA expansion and certain lawfully present individuals, and financing mechanisms such as provider assessments, among other changes. **Exhibit 18** outlines the major OBBBA provisions that affect Medicaid, including the timing of implementation and estimated impacts.

Exhibit 18
Major Medicaid Provisions in the One Big Beautiful Bill Act

Provision	Effective Date	Projected Impact
Work Requirements: Establishes an eligibility requirement for ACA expansion adults (with some exceptions) to work or participate in educational, volunteer, or work programs for 80 hours per month or report income of at least $580 per month.	1/1/27*	An estimated 115,000 ACA adults will lose Medicaid coverage under the provision. As of January 2026, there were 326,510 ACA adults enrolled in Medicaid that would be affected by this provision. MDH and MHBE must update IT systems and hire more staff to implement new eligibility requirements.
Increased Eligibility Redeterminations: Requires Medicaid programs to redetermine eligibility for ACA expansion adults at least once every six months (rather than once a year).	1/1/27	More frequent redeterminations are expected to increase churn (individuals disenrolling and returning to the program). MDH and MHBE must hire more staff to conduct more frequent eligibility checks.
Coverage of Qualified Immigrants: Changes eligibility to exclude certain lawfully present individuals (refugees, asylees, and other humanitarian parolees).	10/1/26	MDH estimates that 15,000 individuals will lose coverage. MDH and MHBE must update IT systems to comply with new eligibility requirements related to residency status.

Provision	Effective Date	Projected Impact
Provider Assessments: Reduces the current cap on provider taxes by 0.5% of net patient revenues each year until the cap decreases from 6% to 3.5%. Prohibits new assessments.	Gradual reduction from federal fiscal 2028 to 2032	Existing Maryland provider assessments on hospitals and managed care organizations are near the 3.5% cap. No increases or new assessments are allowed. Maryland may need to adjust its implementation of provider assessments to ensure they are broad-based and uniform. Maryland collects hospital assessments through HSCRC's rate setting authority, rather than through CMS approval, which creates uncertainty for how the hospital assessments will be affected by this provision.
Prohibition of Reimbursement for Certain Abortion Care Providers: Prohibits federal reimbursement for all services from certain abortion care providers, including Planned Parenthood.	7/4/25 through 7/4/26	Following temporary injunctions that were in place through mid-September 2025 and in December 2025, all services provided by Planned Parenthood are ineligible for federal matching funds. MDH estimated that federal reimbursement for services provided by Planned Parenthood totals $2.5 million.
Cost Sharing: Eliminates certain existing fees and premiums. Requires copays of up to $35 per service, with some services like primary care excluded, for ACA expansion adults with incomes above 100% of the federal poverty limit.	10/1/28	Overall limit in current law for out-of-pocket costs is still in place at 5% of family income. If Maryland is required to increase copays, this could add a barrier to services that might lead to reduced health care utilization and enrollment.

Provision	Effective Date	Projected Impact
Retroactive Coverage: Reduces retroactive coverage of medical expenses incurred prior to enrollment from three months to one month for ACA expansion adults and two months for all other Medicaid eligibility groups.	1/1/27	Upon enrolling in Medicaid, individuals will not receive coverage for health care costs incurred more than one month prior for ACA expansion adults and two months prior for traditional Medicaid enrollees.

ACA: Affordable Care Act
CMS: Centers for Medicare and Medicaid Services
HSCRC: Health Services Cost Review Commission
IT: information technology
MDH: Maryland Department of Health
MHBE: Maryland Health Benefit Exchange

*States may receive an exemption through January 1, 2029, for implementation of work requirements if they demonstrate a good faith effort to comply and receive federal approval.

Source: Maryland Department of Health; Department of Legislative Services

MDH is working with many partner agencies, including MHBE, DHS, and organizations such as providers and MCOs to implement the required OBBBA changes. As mentioned previously, MCPA's fiscal 2027 allowance reflects a net increase of 20.5 regular positions and additional reclassifications of existing vacancies, largely in the Office of Eligibility Services to prepare for the increase in frequency of eligibility redeterminations and new work requirements. Due to the delayed implementation timeline for many of these provisions, the direct impact on Medicaid enrollment is not expected until late in fiscal 2027 and on. The only Medicaid-related provision that took effect immediately prohibited reimbursement of all services provided by certain abortion care providers, namely Planned Parenthood. A preliminary injunction was in place beginning in July 2025, but was lifted in mid-September 2025, at which time MDH stopped paying claims through Medicaid to Planned Parenthood. **MDH should describe any outreach methods that it is using to inform Medicaid participants that services received from Planned Parenthood would not be covered through July 4, 2026.**

Much of the immediate budgetary impact for administrative costs affects MHBE, such as additional funding for call center operations, potential new eligibility determination appeals, and IT system updates. The fiscal 2027 budget includes $2.5 million in the Dedicated Purpose Account to be used across agencies implementing strategies to reduce disenrollment and coverage loss from OBBBA requirements. There is also a total of $2.6 million budgeted in fiscal 2027 across MCPA and MHBE for marketing contracts and outreach efforts to inform Medicaid participants of the upcoming eligibility changes. MDH indicates that the outreach campaign will be similar to efforts undertaken during the unwinding period after the COVID-19 public health emergency, although the communication for OBBBA changes will need to be more specific due to certain policy

changes affecting only ACA expansion adults. The Hilltop Institute has also published a data dashboard specifically related to ACA expansion adults by jurisdiction to track OBBBA impacts on this eligibility group.

Formal guidance from CMS on implementation of work requirements is not expected until June 2026, but MDH has discussed various considerations in how it plans to administer the OBBBA requirements. For example, MDH has reported using broad definitions and opting in to all optional work requirement exemptions to limit disenrollment. These exemptions include, but are not limited to:

- parents or caretakers of children ages 13 and under or disabled individuals;
- medically frail individuals;
- pregnant or postpartum women;
- individuals participating in a substance use disorder program; and
- individuals subject to work requirements under the Supplemental Nutrition Assistance Program (SNAP) or compliant with those imposed by the Temporary Assistance for Needy Families program.

States define medical frailty to include various conditions and levels of health care needs, so this exemption in particular could vary widely depending on how CMS will allow states to apply that exemption. There are also some optional exemptions that could take effect in certain circumstances, such as a national disaster declaration in a county or the Secretary of Health and Human Services approving an exemption for counties with unemployment rates at or above the lesser of 8% or 1.5 times the national rate. Based on April 2025 unemployment data from the Bureau of Labor Statistics, no Maryland counties would be eligible for this exception.

In addition to opting for all available exemptions and defining exemptions as broadly as possible, MDH plans to examine the feasibility of accessing data from the following partnering agencies, programs, and sources to automate and verify work requirement and exemption checks:

- SNAP enrollment and income data from DHS, considering DHS already administers work requirements under SNAP and Medicaid implements express lane eligibility for SNAP recipients;
- wage and workforce development data from the Maryland Department of Labor;
- health records from the Chesapeake Regional Information System for our Patients (commonly referred to as CRISP) to automate medical exemptions for individuals with qualifying diagnoses or conditions;

- education and workforce data from the Maryland State Department of Education (MSDE), considering MDH and MSDE currently have a data sharing agreement for direct certification of students for free and reduced priced lunch eligibility; and

- tax return information from the Comptroller of Maryland.

MDH should comment on the feasibility and timing of using these data sources to automate and verify work requirements and exemptions, including data sharing policies that are already in place and ways to ensure data security of all program participants.

DLS recommends adopting narrative requesting two reports on OBBBA implementation, including the effects on eligibility redetermination and disenrollment.

2. Medicare Coverage of End-stage Renal Disease Patients

Committee narrative in the 2025 JCR requested that MDH submit a report on coverage of ESRD patients who are dually eligible for Medicare and Medicaid, including a review of other states' policies for enrollment of ESRD patients under 65 years old in Medicare and Medicaid and potential gaps in coverage for ESRD patients enrolled in Medicaid. ESRD patients eligible for Medicare qualify for Part A hospital coverage and Part B medical coverage or can enroll in a Medicare Advantage plan to receive additional coverage. Medicare benefits include dialysis and kidney transplantation, among other services. For patients under 65 years old enrolled in Medicare due to an ESRD diagnosis, coverage ends one year after dialysis services end or three years after a kidney transplant, with exception to immunosuppressive drugs, which are covered beyond the three-year coverage period for kidney transplant recipients.

Medicaid provides services for eligible individuals with ESRD while their Medicare application is processed and during the waiting period of up to 90 days between a diagnosis of ESRD and approval of coverage. ESRD patients enrolled in Medicaid receive comprehensive coverage, including hospital and physician services, dialysis, medications, and lab testing. MDH also provides services to eligible participants with ESRD who are under 20 years old through the Rare and Expensive Case Management program, which is administered through a Medicaid waiver. The Public Health Administration within MDH administers the Kidney Disease Program, which offers financial assistance to Maryland residents with ESRD for certain services, such as dialysis, kidney transplantation, and other approved hospital and medical care, as a payer of last resort.

Medicare is the primary payer and Medicaid is the payer of last resort for individuals who are dually enrolled. Considering Medicare is 100% federally funded and Medicaid has varying federal fund participation rates of 50% to 90%, enrolling more eligible Medicaid participants in Medicare leads to potentially significant State fund savings. It should be noted that individuals eligible for Medicaid through the ACA adult expansion cannot be dually enrolled in Medicaid and

Medicare. As part of the report, the Hilltop Institute analyzed claims and encounter data associated with ESRD and found that as of May 2025, 1,161 Medicaid participants were likely to qualify for Medicare due to an ESRD diagnosis. The department projected that enrolling more dually eligible Medicaid participants with ESRD in Medicare could result in annual savings of $9.9 million in general funds.

MDH noted that ESRD patients might not be aware that they could be eligible for Medicare or there could be barriers due to the complexity of the Medicare application process. Through a review of enrollment policies for ESRD patients under 65 years old in six states (California, Massachusetts, New York, North Carolina, Texas, and Washington), the department found that the other states encouraged, or in some cases required, Medicaid participants with ESRD to apply for Medicare. Common outreach strategies were letters and calls to Medicaid participants strongly encouraging them to apply, sharing information on the Medicare application process and services on the Medicaid program's website, and working with the State Health Insurance Assistance Program to offer Medicare counseling. Half of the reviewed states (Massachusetts, New York, and Washington) require participants with ESRD to apply for and/or enroll in Medicare as a condition of Medicaid eligibility.

The report outlined a new process for MDH to provide outreach and instructions to Medicaid participants with ESRD to apply for Medicare and to consider termination of coverage for nonresponsive participants. Outreach methods would be conducted on a monthly basis and would include:

- preliminary notices by mail;
- detailed letters with information on Medicare enrollment and a request for return documentation showing an attempt to apply for Medicare; and
- follow-up letters distributed to nonresponsive participants 30 days after the detailed letter.

Medicaid coverage would continue for all participants that provide documentation or evidence that they applied to Medicare until their application is approved. Once approved for Medicare coverage, dually eligible participants would maintain Medicaid coverage, and individuals in the ACA expansion group would be disenrolled from Medicaid. If participants are denied Medicare coverage, their Medicaid participation would continue. MDH did not provide a definite outcome for nonresponsive participants but indicated that it would consider terminating Medicaid coverage if participants do not provide timely responses. Other outreach efforts to encourage and assist ESRD patients to enroll in Medicare would involve MDOA, MDOD, and dialysis providers. MDH reported that it would implement strategies beginning in fall 2025 to encourage ESRD patients to enroll in Medicare. **MDH should provide a status update and timeline for implementation of new outreach strategies and requirements for Medicaid participants with ESRD diagnoses to apply for Medicare. Additionally, the department should discuss whether there are other conditions or diagnoses that would qualify Medicaid participants for Medicare and should be included in these outreach efforts.**

DLS recommends reducing $8.0 million, including $3.0 million in general funds, in fiscal 2027 to account for savings from Medicaid participants with ESRD enrolling in Medicare as a result of MDH's outreach efforts.

Operating Recommended Actions

		Amount Change
1.	Reduce funding for Medicaid provider reimbursements to account for savings from Medicaid participants with end-stage renal disease enrolling in Medicare as a result of increased outreach efforts.	-$3,000,000 GF -$5,000,000 FF

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

Further provided that $8,390,332 of this appropriation is contingent upon the enactment of legislation authorizing distributions beyond the first $35,000,000 in settlement funding from the separate account in the Cigarette Restitution Fund to be used for purposes other than supplanting the General Fund appropriation at historically Black colleges and universities in fiscal 2027 only.

Explanation: This action adds language to make a special fund appropriation of $8,390,332 from the separate account within the Cigarette Restitution Fund contingent on the enactment of legislation expanding the authorized uses of funds distributed to the separate account in excess of the first $35 million to include purposes other than supplanting the General Fund appropriation for the historically Black colleges and universities settlement in fiscal 2027 only.

3. 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.

4. 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.

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

, provided that $100,000 of this appropriation made for the purpose of administrative expenses may not be expended until the Maryland Department of Health (MDH) submits a report on Community First Choice (CFC) program and Community-based Options (Community Options) waiver spending. The report shall include monthly enrollment, utilization, and cost data that aligns with actual fiscal 2026 budget expenditures under the CFC program. Additionally, the report shall provide:

(1) the number of budgeted Community Options waiver slots in fiscal 2026 and 2027;

(2) the number of Community Options waiver slots filled in fiscal 2026;

(3) 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);

(4) 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;

(5) an update on MDH staffing that supports the Community Options waiver and eligibility determination services for all home and community-based services waivers, including the number of vacant regular and contractual positions and the status of procuring additional staffing assistance;

(6) the number of individuals on the Community Options waiver registry as of June 30, 2026; and

(7) 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.

The report shall be submitted by August 1, 2026, and the budget committees shall have 45 days from the date of the receipt of the report to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted.

Explanation: 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. This language restricts funds in the Office of the Deputy Secretary for Health Care Financing pending the submission of a report on CFC program and Community Options waiver spending and registry information.

Information Request	**Author**	**Due Date**
Report on CFC program and Community Options waiver spending and registry data	MDH	August 1, 2026

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

Further provided that since the Maryland Department of Health has had four or more repeat audit findings in the most recent Medical Care Programs Administration (MCPA) fiscal compliance audit issued by the Office of Legislative Audits (OLA), $250,000 of this agency's administrative appropriation may not be expended unless:

(1) MCPA has taken corrective action with respect to all repeat audit findings on or before November 1, 2026; and

(2) a report is submitted to the budget committees by OLA listing each repeat audit finding along with a determination that each repeat finding was corrected. The budget committees shall have 45 days from the date of the receipt of the report to review and comment to allow for funds to be released prior to the end of fiscal 2027. General funds restricted

pending the receipt of a report may not be transferred by budget amendment or otherwise and shall revert to the General Fund if the report is not submitted.

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

If OLA reports that an agency failed to completely resolve or make adequate progress toward resolving those repeat audit findings, JAEC requests that $250,000 in general funds is withheld from each agency's appropriation in the fiscal year following the OLA report until more satisfactory progress has been made toward resolution of those repeat findings.

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

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

Further provided that this appropriation shall be reduced by $1,000,000 contingent upon the enactment of legislation reducing the Cigarette Restitution Fund funding mandate for the Maryland Community Health Resources Commission Fund~~ and using the Cigarette Restitution Fund balance to offset Medicaid general fund expenditures, and allowing the Commission to use its special fund balance to support operations~~.

Explanation: This action makes a technical correction to contingent language on a general fund reduction to more closely align with the applicable provision in the Budget Reconciliation and Financing Act.

8. Amend the following language on the special fund appropriation:

, provided that $1,000,000 of this appropriation is contingent upon the enactment of legislation reducing the Cigarette Restitution Fund funding

mandate for the Maryland Community Health Resources Commission Fund~~ and using the Cigarette Restitution Fund balance to offset Medicaid general fund expenditures, and allowing the Commission to use its special fund balance to support operations~~.

Explanation: This action makes a technical correction to contingent language on a special fund appropriation to more closely align with the applicable provision in the Budget Reconciliation and Financing Act.

9. Adopt the following narrative:

One Big Beautiful Bill Act (OBBBA) Implementation: The OBBBA was enacted on July 4, 2025, and makes substantial changes to the Medicaid program, including establishing new work requirements and requiring more frequent eligibility redeterminations for adults enrolled through the Affordable Care Act (ACA) expansion, among other provisions. The committees request that the Maryland Department of Health (MDH), in collaboration with the Maryland Health Benefit Exchange (MHBE), submit two reports on OBBBA implementation activities and enrollment and case closure trends before and after implementation of new work requirements and six-month eligibility redeterminations. The reports should include:

- descriptions of information technology system updates, including year to date spending and estimated total costs, outreach activities to limit disenrollments, and partnerships and data sharing agreements with other agencies and organizations to check individuals for exemptions;

- a discussion of approved exemptions for work requirements and definitions of those exemptions; and

- a status update on the number of positions added and reclassified within MDH for OBBBA implementation, including the total cost of the positions by fund type and hiring status.

Additionally, the reports should include the following fiscal 2027 year-to-date enrollment data on a monthly basis and divided by eligibility category and administrative data on a monthly basis:

- 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 month over month;

- measures of churn that reflect the number of individuals who previously received Medicaid or Maryland Children's Health Program coverage and the timeframe of when they were last enrolled;

- the number of individuals disenrolled month over month, shown by reason for disenrollment, identifying procedural disenrollments and disenrollments due to overscale income, aging out, noncompliance with work requirements, and other common reasons for disenrollment.

- 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**
Report on OBBBA implementation and impacts within Medicaid	MDH MHBE	December 1, 2026 June 1, 2027

Total Net Change to Fiscal 2027 Allowance -$8,000,000

		Amount Change
10.	Reduce funding from a fiscal 2026 deficiency appropriation to account for recoveries from calendar 2023 managed care organization medical loss ratio results.	-$44,200,000 GF -$107,230,827 FF
11.	Reduce funding from a fiscal 2026 deficiency appropriation due to lower estimated spending on prior year Medicaid expenses, based on recent actual claims paid through January 2026.	-$10,000,000 GF -$60,000,000 FF

Total Net Change to Fiscal 2026 Deficiency -$221,430,827

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. The General Assembly amended the language regarding abortion services funded under Medicaid and MCHP in the fiscal 2023 Budget Bill to refer to any qualified provider of abortion services, as defined in Section 20-103 of the Health – General Article, and for the restrictive language to remain in effect for the first six months of fiscal 2023, contingent on enactment of Chapter 56 of 2022 (the Abortion Care Access Act). 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 19** provides a summary of the number and cost of abortions by service provider in fiscal 2023 through 2025.

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.

Exhibit 19
Abortion Funding under Medicaid
Fiscal 2023-2025

	Performed under 2023 State and Federal Budget Language	**Performed under 2024 Federal Budget Language and State Law**	**Performed under 2025 Federal Budget Language and State Law**
Abortions	12,808	12,540	12,858
Total Cost ($ in Millions)	**$8.0**	**$9.2**	**$11.3**
Average Payment Per Abortion	$623	$731	$876
Abortions in Clinics	10,938	10,692	11,128
Average Payment	$456	$546	$697
Abortions in Physicians' Offices	1,302	1,222	1,276
Average Payment	$1,055	$1,264	$1,483
Hospital Abortions – Outpatient	*	*	*
Average Payment	$2,703	$2,815	$3,472
Hospital Abortions – Inpatient	*	*	*
Average Payment	$44,486	$24,190	$23,676
Abortions Eligible for Joint Federal/State Funding	0	0	0

*Indicates a dataset of less than 11 cases. The number of outpatient abortions was suppressed to prevent the calculation of inpatient abortions by subtracting from the total.

Note: A provider's classification was changed from physicians' office to clinic and all years were updated. Data for fiscal 2023 and 2024 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2025 includes all abortions for which a Medicaid claim was filed through November 2025. 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 2025. For example, for fiscal 2024, 22 additional claims were paid after November 2024, which explains differences in the fiscal 2024 data reported in this analysis compared to prior Medicaid budget analyses.

Source: Maryland Department of Health

Appendix 1
2025 Joint Chairmen's Report Responses from Agency

The 2025 JCR requested that MCPA prepare seven reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***End the Wait Initiatives for HCBS Waivers:*** On January 15, 2026, MDH submitted a report on efforts to reduce HCBS waiver registries and wait lists. The report included updates on implementation of the department's registry reduction plans required by Chapter 464 of 2022 (the End the Wait Act). Additional information about the status of Medicaid HCBS waiver registries and wait lists can be found in the analysis for M00 – MDH Overview.

- ***Maryland Health Insurance Coverage Protection Commission Activities:*** Committee narrative in the 2025 JCR requested that MDH, in collaboration with HSCRC and the Maryland Insurance Administration, submit a report by September 15, 2025, on the reestablishment and planned activities of the Maryland Health Insurance Coverage Protection Commission. The first iteration of the commission was established through Chapter 17 of 2017 to monitor potential and actual federal changes to the ACA, Medicaid, MCHP, Medicare, and the Maryland All-Payer Model, among other responsibilities. As of February 15, 2026, the agencies had not submitted a report.

- ***CFC Program and Community Options Waiver Financial and Registry Data:*** On November 11, 2025, 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.

- ***Quarterly Medicaid Enrollment Change and Application Processing:*** Committee narrative in the 2025 JCR requested that MDH submit quarterly reports with monthly eligibility redetermination data and administrative measures, such as call center volume and application processing times. Similar narrative was included in the 2024 JCR, and on August 20, 2025, MDH submitted the final quarterly report requested in the previous year. MDH did not submit the first quarterly report in response to the 2025 JCR. On December 8, 2025, MDH submitted a quarterly report with data through July 2025. As of February 15, 2026, the third quarterly report has not been submitted, and the fourth quarterly report is due on April 15, 2026.

- ***Evaluation of Primary Care Programs and Initiatives:*** MDH and HSCRC are implementing primary care and population health initiatives in coordination with the State's AHEAD Model, which took effect at the start of calendar 2026. On December 11, 2025, the agencies submitted a report on the launch of the Medicaid

Advanced Primary Care Program, referred to as the Medicaid Path. The report also provides continued reporting and evaluation of the Maryland Primary Care Program that was first implemented under the Total Cost of Care Model. Additional information on the primary care initiatives under the AHEAD Model will be included in the analysis for M00R01 – MDH Health Regulatory Commissions.

- ***Medicare and Medicaid Coverage of ESRD Patients:*** On November 11, 2025, MDH submitted a report on Medicare and Medicaid coverage for dually eligible ESRD patients. Further discussion of this report can be found in Issue 2 of this analysis.

- ***MCO MLR Results:*** MCOs that operate in Maryland under the HealthChoice program are required to meet certain MLRs, which account for the amount of capitation payments used for eligible mandated medical services and quality improvement activities. Federal regulations require that states' capitation payments have an MLR of at least 85% programwide, and MDH's HealthChoice contract with each MCO requires payment of a remittance if the MCO's MLR is below 85%. For the calendar 2023 rate year, three MCOs fell below this standard. As a result, Maryland recovered approximately $151 million from those MCOs in fall 2025. Further discussion of this data can be found in the fiscal 2026 section of this analysis.

Appendix 2

Audit Findings
Managed Care Program

Audit Period for Last Audit	April 1, 2022 – May 15, 2025
Issue Date	January 2026
Number of Findings	4
Number of Repeat Findings:	3
% of Repeat Findings:	75%
Rating (if applicable)	n/a

Finding 1: **MCPA did not have comprehensive procedures to ensure that ineligible costs reported by MCOs were excluded from the capitation rate calculation.**

Finding 2: **MCPA did not have an effective process to identify capitation payments to MCOs for incarcerated individuals, resulting in improper payments totaling $7.8 million.**

Finding 3: **MCPA did not investigate and recover $13.8 million in potentially improper supplemental payments to MCOs for newborn deliveries.**

Finding 4: MCPA did not ensure that payments made to a State university were adequately supported, were reasonable in relation to the tasks performed, and in accordance with the terms of the agreement.

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

Appendix 3

Medicaid Pharmacy Benefits Electronic Claims System

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: New					
Start Date: Unknown				**Est. Completion Date:** Fiscal 2030	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.000	$0.000	$1.500	Up to $8.500	$0.000-$10.000
Total	**$0.000**	**$0.000**	**$1.500**	**Up to $8.500**	**$0.000-$10.000**

- ***Project Summary:*** Medicaid uses Pharmacy Point of Sale Electronic Claims Management Services across multiple programs that provide pharmacy services to Marylanders, including programs administered by the MDH Public Health Administration (the Kidney Disease Program, the Maryland AIDS Drug Assistance Program, and the Breast and Cervical Cancer Diagnosis and Treatment Program). This IT project will replace the current system due to the contract expiring in July 2029.

- ***Concerns:*** Section 3.5-308 of the State Finance and Procurement Article requires that all MITDPs for Executive Branch agencies, except higher education institutions have an ITPR, which is a comprehensive document about the project. An ITPR for this new MITDP was not submitted with the fiscal 2027 budget. Therefore, the need, risks, scope and complexity, and development and support costs are unknown.

Appendix 4
Medicaid Enterprise Systems Modular Transformation – Business Process Reengineering and Consolidated Customer Relationship Management
Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: July 1, 2018				**Est. Completion Date:** 2030	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$1.715	$0.762	$1.557	$1.446-$2.816	$5.480-$6.850
SF					
FF	5.687	6.857	12.868	9.108-17.738	34.520-43.150
Total	**$7.402**	**$7.619**	**$14.425**	**$10.554-$20.554**	**$40.000-$50.000**

This is the first of ten modular systems in the Medicaid Enterprise Systems Modular Transformation (MMT) MITDP to replace Medicaid's antiquated and inflexible legacy information system with a modern Medicaid Management Information System (MMIS). These systems are summarized in this analysis in Appendix 4 through Appendix 13.

- ***Project Summary***: The Business Process Reengineering and Consolidated Customer Relationship Management (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. In fiscal 2026, two work streams have been completed through this component for recovery and financial services and the Healthy Kids program. MDH and DoIT reported that future work streams are decided based on business prioritization.

- ***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:** 2031	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.643	$0.860	$1.182	-$0.367-$0.791	$2.317-$3.476
FF	2.290	7.742	10.453	-2.803-6.038	17.683-26.524
Total	**$2.933**	**$8.603**	**$11.635**	**-$3.171-$6.829**	**$20.000-$30.000**

- ***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:*** As of July 2025, MDH reported that this project was still in the procurement phase, though MDH's operations team is meeting to define the operational and reporting metrics needed through this project, including monthly CMS reporting.

- ***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. Additionally, MDH notes the procurement offices' capacity is limited.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 6

Dental Administrative Services Organization

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: July 1, 2018				**Est. Completion Date:** 2028	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.313	$8.670	$0.000	$0.866-$4.149	$9.849-$13.132
FF	2.127	8.670	7.583	1.772-8.489	20.151-26.868
Total	**$2.440**	**$17.340**	**$7.583**	**$2.637-$12.637**	**$30.000-$40.000**

- ***Project Summary***: This component of the MMT project contracts a Dental Administrative Services Organization (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:*** This project is in the implementation stage, though MDH reported operational challenges such as vacant positions and the vendor not testing data transfers with the current DASO vendor.

- ***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. MDH also indicated that a project director has not been hired, causing high risks for progress and decision making.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 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: October 14, 2024				**Est. Completion Date:** 2033	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.323	$1.670	$0.995	$1.247-$2.094	$4.236-$5.083
FF	1.621	15.029	15.640	13.474-22.627	45.764-54.917
Total	**$1.944**	**$16.699**	**$16.635**	**$14.721-$24.721**	**$50.000-$60.000**

- ***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 Administrative Services Organization (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:*** MDH held project kick off and planning activities. In line with CMS Interoperability rules, MDH also established a project timeline and plan, including staffing and preparing for procurement of Amazon Web Services infrastructure.

- ***Concerns***: MDH acknowledged that this project is delayed due to limited staffing and length of time to set up consulting and other contracts. The infrastructure set up for the project was expected July 1, 2025, which was not met.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 8

MMT – Electronic Data Interchange Gateway

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: July 1, 2024				**Est. Completion Date:** 2030	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.241	$0.000	$0.256	-$0.050-$0.397	$0.447-$0.895
FF	3.276	4.616	2.727	-1.066-8.487	9.553-19.105
Total	**$3.517**	**$4.616**	**$2.983**	**-$1.116-$8.884**	**$10.000-$20.000**

- ***Project Summary***: This component of the MMT project relates to automated data transfers with Medicare, health providers, and health plans. MDH transitioned its Electronic Data Interchange Gateway (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 and DoIT completed an analysis of functional and nonfunctional requirements and finalized a request for proposals (RFP) to be issued. MDH plans to engage vendors to solicit bids and responses to the RFP.

- ***Concerns*:** MDH and DoIT identified capturing all project requirements in the RFP as high risk.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 9

MMT – Hospice and Maryland Daycare Enrollment

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: December 20, 2023				**Est. Completion Date:** 2028	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$1.403	$0.000	$0.572	-$0.271-$1.433	$1.705-$3.409
FF	1.399	5.670	2.547	-1.321-6.974	8.295-16.591
Total	**$2.803**	**$5.670**	**$3.119**	**-$1.592-$8.408**	**$10.000-$20.000**

- ***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:*** Development, user acceptance testing, and provider training had been completed as of July 2025. The system had a planned roll out in phases starting in August 2025, with additional hospice providers added as they entered data sharing agreements.

- ***Concerns*:** MDH and DoIT identified finalizing the remaining data share agreements as the highest risk as this is required for providers to use the system.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 10

MMT – Medicaid Enterprise System Claims Module

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: July 1, 2024				**Est. Completion Date:** 2035	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$2.965	$0.000	$0.000	$12.689-$14.925	$15.654-$17.890
FF	3.004	3.021	4.268	44.053-51.817	54.346-62.110
Total	**$5.969**	**$3.021**	**$4.268**	**$56.742-$66.742**	**$70.000-$80.000**

- ***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. CMS requires that states implement a modular approach to MMIS.

- ***Observations and Milestones:*** MDH continues to be in the planning stages of this project and extended this stage by a year. Current project activities include documenting system functionality and business rules to develop project requirements and develop a road map for the project.

- ***Concerns***: The scope of this project is large as it affects many Medicaid service types and programs across multiple MDH administrations. MDH and DoIT identified data migration as potentially high risk as incompatible data migration could lead to data loss or financial loss across programs.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 11

MMT – Non Emergency Medical Transportation

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: July 1, 2018				**Est. Completion Date:** 2030	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.228	$0.000	$0.518	$0.433-$1.023	$1.179-$1.768
FF	2.127	5.033	$4.743	6.918-16.328	18.821-28.232
Total	**$2.354**	**$5.033**	**$5.261**	**$7.351-$17.351**	**$20.000-$30.000**

- ***Project Summary***: This component of the MMT project involves procuring a system for dispatching and claims processing for Medicaid Non Emergency Medical Transportation (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:*** The RFP has been reviewed internally by MDH's legal team, DoIT, and the Department of General Services. CMS will review the RFP next before it is published.

- ***Concerns***: MDH and DoIT identified three medium risks: (1) the NEMT business team potentially not having resources to manage ASO implementation; (2) enforcing a new requirement for providers to be enrolled in ePrep within Medicaid systems could reduce the number of providers; and (3) if transportation providers are not adequately trained, they may not update their business systems properly and project implementation could be delayed.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 12
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**	**2026**	**2027**	**Remainder**	**Total**
GF	$3.199	$3.920	$3.889	$4.063-$6.574	$15.069-$17.581
FF	25.206	37.778	35.570	36.376-58.865	134.931-157.419
Total	**$28.405**	**$41.697**	**$39.459**	**$40.439-$65.439**	**$150.000-$175.000**

- ***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, interactive voice response system 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 reported that it completed development for the provider self service module and has completed 80% of requirements for the module. Business user acceptance testing is planned for May 2026.

- ***Concerns***: MDH and DoIT identified a high risk with interdependencies with Maryland Benefits and potential delays from shared systems not having necessary upgrades.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 13

MMT – Surveillance Utilization Review Subsystem

Major Information Technology Development Project
Maryland Department of Health

New/Ongoing: Ongoing					
Start Date: July 1, 2018				**Est. Completion Date:** 2029	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$0.314	$0.000	$0.693	-$0.253-$0.501	$0.754-$1.508
FF	1.703	5.249	5.400	-3.106-6.140	9.246-18.492
Total	**$2.017**	**$5.249**	**$6.092**	**-$3.359-$6.641**	**$10.000-$20.000**

- ***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, the Office of Legislative Audits 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 continued efforts to use the National Association of State Procurement Officials (NASPO) to procure application development services. As of July 2025, MDH and DoIT reported sending all required documentation to NASPO.

- ***Concerns***: MDH and DoIT identified uncertain cost estimates as medium risk because the project does not yet have a vendor, which will determine a more accurate estimate.

- ***Other Comments:*** This is 1 of 10 modular systems or components of the MMT project summarized in Appendix 4 through Appendix 13 of this analysis.

Appendix 14
Federal Poverty Guidelines as of January 2026
(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	$3,990	$7,980	$11,970	$15,960	$19,950	$21,227	$21,546	$22,025	$31,920	$33,835	$39,900	$42,134	$51,391
2	5,410	10,820	16,230	21,640	27,050	28,781	29,214	29,863	43,280	45,877	54,100	57,130	69,681
3	6,830	13,660	20,490	27,320	34,150	36,336	36,882	37,702	54,640	57,918	68,300	72,125	87,970
4	8,250	16,500	24,750	33,000	41,250	43,890	44,550	45,540	66,000	69,960	82,500	87,120	106,260
5	9,670	19,340	29,010	38,680	48,350	51,444	52,218	53,378	77,360	82,002	96,700	102,115	124,550
6	11,090	22,180	33,270	44,360	55,450	58,999	59,886	61,217	88,720	94,043	110,900	117,110	142,839
7	12,510	25,020	37,530	50,040	62,550	66,553	67,554	69,055	100,080	106,085	125,100	132,106	161,129
8	13,930	27,860	41,790	55,720	69,650	74,108	75,222	76,894	111,440	118,126	139,300	147,101	179,418
9	15,350	30,700	46,050	61,400	76,750	81,662	82,890	84,732	122,800	130,168	153,500	162,096	197,708
10	16,770	33,540	50,310	67,080	83,850	89,216	90,558	92,570	134,160	142,210	167,700	177,091	215,998
11	18,190	36,380	54,570	72,760	90,950	96,771	98,226	100,409	145,520	154,251	181,900	192,086	234,287
12	19,610	39,220	58,830	78,440	98,050	104,325	105,894	108,247	156,880	166,293	196,100	207,082	252,577
13	21,030	42,060	63,090	84,120	105,150	111,880	113,562	116,086	168,240	178,334	210,300	222,077	270,866
14	22,450	44,900	67,350	89,800	112,250	119,434	121,230	123,924	179,600	190,376	224,500	237,072	289,156

[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 15
Object/Fund Difference Report
Maryland Department of Health – Medical Care Programs Administration

Object/Fund	FY 25 Actual	FY 26 Work Approp.	FY 27 Allowance	FY 26 - 27 $ Change	FY 26 - 27 % Change
Positions					
01 Regular	678.10	661.10	681.60	20.50	3.1%
02 Contractual	71.42	87.57	123.43	35.86	41.0%
Total Positions	**749.52**	**748.67**	**805.03**	**56.36**	**7.5%**
Objects					
01 Salaries, Wages, and Fringe Benefits	$78,445,266	$75,609,475	$79,803,007	$4,193,532	5.5%
02 Technical and Special Fees	4,976,563	8,223,669	9,255,125	1,031,456	12.5%
03 Communications	899,077	950,390	920,674	-29,716	-3.1%
04 Travel	85,346	344,258	345,947	1,689	0.5%
06 Fuel and Utilities	10,513	7,216	1,142	-6,074	-84.2%
08 Contractual Services	13,525,123,647	14,086,895,953	13,876,056,643	-210,839,310	-1.5%
09 Supplies and Materials	136,979	182,752	232,413	49,661	27.2%
10 Equipment – Replacement	9,068	219,110	16,274	-202,836	-92.6%
13 Fixed Charges	302,909	391,427	250,703	-140,724	-36.0%
Total Objects	**$13,609,989,368**	**$14,172,824,250**	**$13,966,881,928**	**-$205,942,322**	**-1.5%**
Funds					
01 General Funds	$4,633,367,041	$4,716,969,667	$4,694,536,576	$-22,433,091	-0.5%
03 Special Funds	802,567,290	851,021,802	871,990,391	20,968,589	2.5%
05 Federal Funds	8,018,890,567	8,460,932,686	8,272,259,964	-188,672,722	-2.2%
09 Reimbursable Funds	155,164,470	143,900,095	128,094,997	-15,805,098	-11.0%
Total Funds	**$13,609,989,368**	**$14,172,824,250**	**$13,966,881,928**	**-$205,942,322**	**-1.5%**

Note: The fiscal 2026 appropriation includes proposed deficiency appropriations. The fiscal 2027 allowance does not include contingent reductions or statewide salary adjustments budgeted within the Department of Budget and Management.

Appendix 16
Fiscal Summary
Maryland Department of Health – Medical Care Programs Administration

Program/Unit	FY 25 Actual	FY 26 Work Approp.	FY 27 Allowance	FY 26 - 27 $ Change	FY 26 - 27 % Change
01 Deputy Secretary for Health Care Financing	$6,477,235	$11,463,982	$13,115,227	$1,651,245	14.4%
02 Office of Enterprise Technology – Medicaid	17,653,982	42,567,275	41,302,324	-1,264,951	-3.0%
03 Medical Care Provider Reimbursements	12,761,898,723	13,241,288,660	13,114,406,194	-126,882,466	-1.0%
04 Benefits Management and Provider Services	46,973,925	50,302,219	51,652,451	1,350,232	2.7%
05 Office of Finance	10,010,216	10,402,272	10,692,349	290,077	2.8%
07 Maryland Children's Health Program	610,182,171	610,768,282	602,691,458	-8,076,824	-1.3%
08 Major Information Technology Development Projects	130,871,991	173,485,190	101,798,690	-71,686,500	-41.3%
09 Office of Eligibility Services	15,559,595	15,784,478	21,285,712	5,501,234	34.9%
11 Senior Prescription Drug Assistance Program	10,361,530	16,761,892	9,937,523	-6,824,369	-40.7%
Total Expenditures	**$13,609,989,368**	**$14,172,824,250**	**$13,966,881,928**	**-$205,942,322**	**-1.5%**
General Funds	$4,633,367,041	$4,716,969,667	$4,694,536,576	-$22,433,091	-0.5%
Special Funds	802,567,290	851,021,802	871,990,391	20,968,589	2.5%
Federal Funds	8,018,890,567	8,460,932,686	8,272,259,964	-188,672,722	-2.2%
Total Appropriations	**$13,454,824,898**	**$14,028,924,155**	**$13,838,786,931**	**-$190,137,224**	**-1.4%**
Reimbursable Funds	$155,164,470	$143,900,095	$128,094,997	-$15,805,098	-11.0%
Total Funds	**$13,609,989,368**	**$14,172,824,250**	**$13,966,881,928**	**-$205,942,322**	**-1.5%**

Note: The fiscal 2026 appropriation includes proposed deficiency appropriations. The fiscal 2027 allowance does not include contingent reductions or statewide salary adjustments budgeted within the Department of Budget and Management.