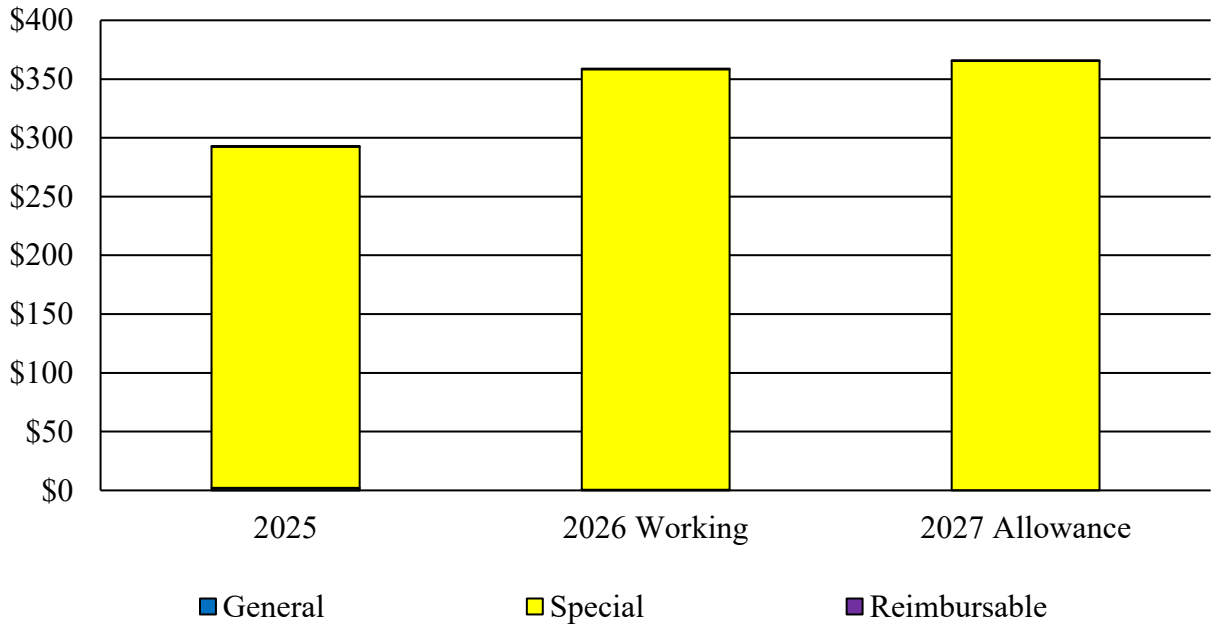
M00R01
Health Regulatory Commissions
Maryland Department of Health

Program Description

Three independent agencies within the Maryland Department of Health (MDH) comprise the Health Regulatory Commissions: (1) the Maryland Health Care Commission (MHCC); (2) the Health Services Cost Review Commission (HSCRC); and (3) the Maryland Community Health Resources Commission (MCHRC). These commissions regulate healthcare delivery, monitor price and affordability of hospital service delivery, and set rates for regulated services and expand access to care for Marylanders, respectively. Each commission has its own separate goals and initiatives. The Health Regulatory Commissions analysis also includes funding for the Prescription Drug Affordability Board (PDAB), which is an independent unit that aims to protect Maryland residents and the State's health care system from the high costs of prescription drug products.

Operating Budget Summary

Fiscal 2027 Budget Increases by $7.1 Million, or 2.0%, to $365.9 Million
($ in Millions)



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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- The fiscal 2027 allowance increases by $7.1 million compared to the fiscal 2026 working appropriation after accounting for a proposed deficiency appropriation and contingent special fund reductions totaling $21 million. Under MCHRC, $20 million from the Blueprint for Maryland's Future (Blueprint) Fund and $1 million from the Cigarette Restitution Fund (CRF) are reduced contingent on enactment of provisions in the Budget Reconciliation and Financing Act (BRFA) of 2026.

Fiscal 2026

Status of Legislative Additions

Section 21 of the fiscal 2026 Budget Bill added a total of $550,000 in general funds in the Health Regulatory Commissions for the following uses:

- $350,000 within HSCRC to distribute funding through the Chesapeake Regional Information System for our Patients (CRISP) for services from DrFirst. According to HSCRC, CRISP provided the grant to DrFirst for a population health information technology tool for Maryland providers, and DrFirst has spent the entire grant. The fiscal 2027 allowance does not include additional funding for this purpose; and

- $200,000 within MHCC to distribute a grant to the Maryland Patient Safety Center. MHCC indicated that the grant has been distributed and was used on various safety programs, including a maternal and child health initiative. Chapters 529 and 530 of 2022 required MHCC to designate a Patient Safety Center for the State by December 31, 2025, established the Patient Safety Center Fund to subsidize a portion of the costs of the center, and established a $1.0 million annual mandated appropriation for the fund beginning in fiscal 2024. A provision in the BRFA of 2025 repealed the funding mandate and instead authorized the Governor to include at least $1.0 million in the annual budget for the fund. The fiscal 2027 allowance does not include an appropriation to the Patient Safety Center Fund or grant funding for the center.

Proposed Deficiency

The fiscal 2027 allowance includes one deficiency appropriation that provides $6.3 million in special funds to MHCC to account for additional projected revenue from the vehicle registration surcharge. Chapters 717, 718, and 719 of 2024 increased the annual vehicle registration surcharge and required increases in the distributions to the R Adams Cowley Shock Trauma Center (Shock Trauma Center) and the Maryland Trauma Physician Services Fund (MTPSF). Of the $6.3 million in special funds, $4.3 million will be distributed to the Shock Trauma Center and $2.0 million will support the MTPSF.

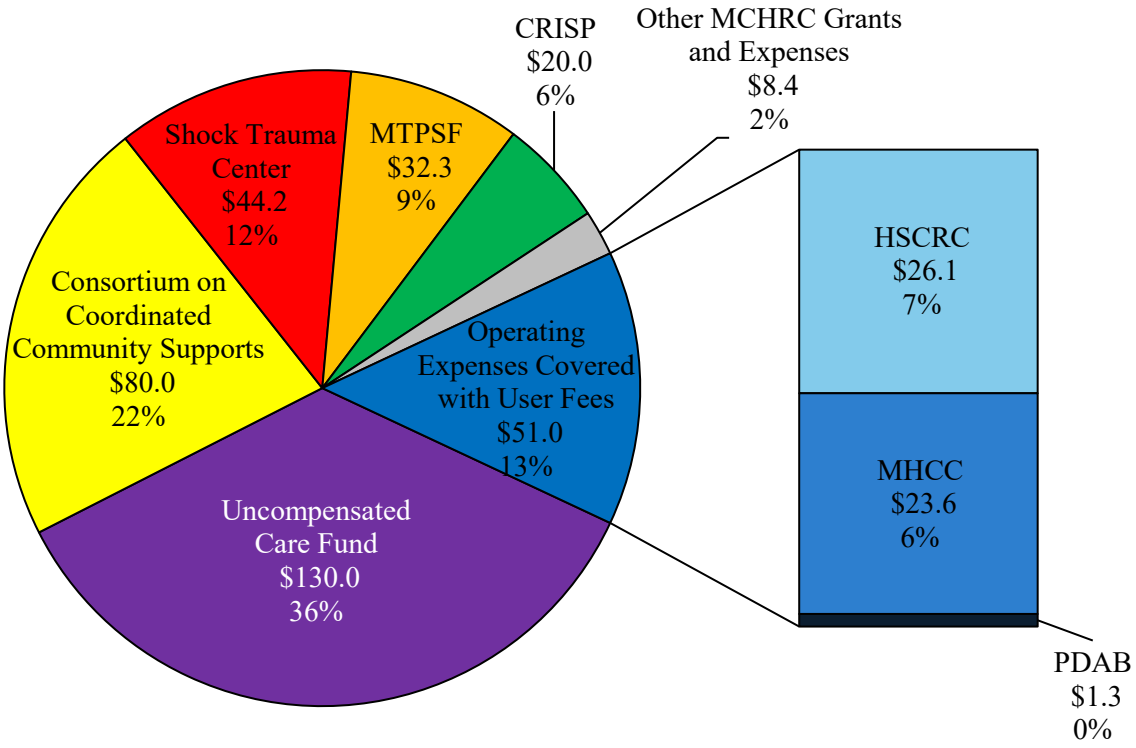
The Governor's fiscal 2027 Budget Books list the Maryland Emergency Medical System Operations Fund (MEMSOF) as the special fund source for the $4.3 million deficiency for the

Shock Trauma Center. However, MHCC provides the Shock Trauma Center's share of the vehicle registration surcharge as a direct distribution, and this funding is not counted as MEMSOF expenditures. The Shock Trauma Center previously received an annual operating grant through MHCC that was supported by MEMSOF. Although a fiscal 2025 deficiency appropriation withdrew the $3.7 million operating grant, fiscal 2025 actual MEMSOF spending reflects the $3.7 million grant to the Shock Trauma Center. The Department of Budget and Management and MHCC acknowledged the overpayment and plan to recover the funding. **MHCC should discuss the timeline for recovering $3.7 million that was distributed to the Shock Trauma Center from MEMSOF in error in fiscal 2025.**

Fiscal 2027 Overview of Agency Spending

The fiscal 2027 allowance for the Health Regulatory Commissions totals $365.9 million, almost entirely in special funds. As shown in **Exhibit 1**, the largest component of the budget is the Uncompensated Care Fund (UCF) at $130 million, accounting for 36% of total expenditures. HSCRC distributes the UCF to acute general hospitals that provide a disproportionate amount of uncompensated care through charity care or financial assistance and bad debt for regulated services that are not anticipated to be paid for out of pocket by the patient. The next largest share of the budget (22%) is for the Consortium on Coordinated Community Supports (Consortium) within MCHRC, which receives $80 million in special funds from the Blueprint Fund after accounting for a contingent reduction. Within MHCC, a combined $76.5 million (21%) supports trauma centers through the MTPSF and funding distributed to the Shock Trauma Center.

Exhibit 1
Overview of Agency Spending
Fiscal 2027 Allowance
($ in Millions)



CRISP: Chesapeake Regional Information System for our Patients
HSCRC: Health Services Cost Review Commission
MCHRC: Maryland Community Health Resources Commission
MHCC: Maryland Health Care Commission
MTPSF: Maryland Trauma Physician Services Fund
PDAB: Prescription Drug Affordability Board
Shock Trauma Center: R Adams Cowley Shock Trauma Center

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

Other special fund sources that support the fiscal 2027 allowance mainly consist of user fees assessed on healthcare payors, hospitals, nursing homes, and prescription drug product manufacturers, among other related health

care practitioners and providers. Of the $50.5 million in operating expenses supported with user fees, HSCRC accounts for approximately half at $26.1 million. Chapters 25 and 26 of 2025 repealed the termination date for the current formula used to calculate HSCRC's maximum user fees, which authorizes fees up to the greater of (1) 0.1% of budgeted hospital revenue or (2) the largest cap amount determined during the immediately preceding five fiscal years.

HSCRC also collects the Medicaid deficit assessment to support Medicaid expenses, among other hospital assessments. The One Big Beautiful Bill Act (OBBBA) includes a provision that gradually reduces the overall cap on hospital assessments from 6% to 3.5% of net patient revenue, but this is not expected to reduce revenue in Maryland as current hospital assessments are already near the 3.5% cap. There is still some concern that OBBBA implementation and increased federal scrutiny could put hospital assessments at risk. For example, through HSCRC's rate setting authority, hospital assessments apply only to regulated hospitals. To meet uniform and broad-based tax requirements, MDH and HSCRC may need to expand the provider taxes to other specialty hospitals. **HSCRC should comment on how its implementation of hospital assessments may change due to the OBBBA provision and uniform and broad-based tax requirements.**

Proposed Budget Change

As shown in **Exhibit 2**, the fiscal 2027 allowance increases by $7.1 million compared to the fiscal 2026 working appropriation after accounting for a deficiency appropriation within MHCC and contingent special fund reductions within MCHRC. Increases of $9.9 million for Consortium grants (including a $20 million contingent reduction) and $2.5 million for personnel expenses drive the overall budget growth. Decreases of $5 million in the UCF and $1.5 million for a contract with Mathematica to support planning for the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model partially offset the spending increase.

Exhibit 2
Proposed Budget
Maryland Department of Health – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Reimb. Fund	Total
Fiscal 2025 Actual	$2,125	$290,233	$560	$292,918
Fiscal 2026 Working	550	357,713	560	358,823
Fiscal 2027 Allowance	0	365,326	560	365,886
Fiscal 2026-2027 $ Change	-$550	$7,613	$0	$7,063
Fiscal 2026-2027 % Change	-100.00%	2.13%	0.00%	1.97%

Where It Goes:	**Change**
Personnel Expenses	
Salary adjustments and associated fringe benefits, partially attributed to a net increase of 4.1 transferred positions	$1,161
Employee and retiree health insurance	720
Turnover decreases from 6.23% to 4.27%	439
Accrued leave payments	127
Other fringe benefit adjustments	33
Maryland Health Care Commission	
Consulting, project management, and data retrieval services for the All-payer Claims Database	603
Maryland Trauma Physician Services Fund, including third party administrator costs	389
Contracts for assistance with annual reports, mandated reports, and actuary studies	384
Direct distribution of vehicle surcharge revenue to the R Adams Cowley Shock Trauma Center after accounting for a fiscal 2026 deficiency	220
One-time legislative addition for the Patient Safety Center (general funds)	-200
One-time costs for privacy and security audits of CRISP and financial audits	-387
Database development costs to align with recent actual spending	-674
Fiscal 2026 special fund appropriation for the Patient Safety Center that was overbudgeted following the repeal of the mandate through the BRFA of 2025	-1,000
Health Services Cost Review Commission	
CRISP funding for State Health Information Exchange functions and reporting, including additional funds to backfill potential losses in federal support	2,000
New contracts to assist with rate application processing and review of methodologies for determining global budget revenues	1,400
Contractual personnel costs driven by a net increase for administrative support	340
One-time legislative addition for services provided by DrFirst to CRISP (general funds)	-350
Contract costs to align with recent actual spending, including financial analysis services required as part of full hospital rate review	-1,353
Contract with Mathematica to assist in developing the AHEAD model, including support with data analytics and monitoring	-1,537
Uncompensated Care Fund based on recent actual experience	-5,000

Where It Goes:	**Change**
Other Changes	
Consortium on Coordinated Community Supports grants, after accounting for a contingent special fund reduction	9,852
Other operating costs	-105
Total	**$7,063**

AHEAD: Achieving Healthcare Efficiency through Accountable Design
BRFA: Budget Reconciliation and Financing Act
CRISP: Chesapeake Regional Information System for our Patients

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.

Contingent Reduction of CRF Support within MCHRC

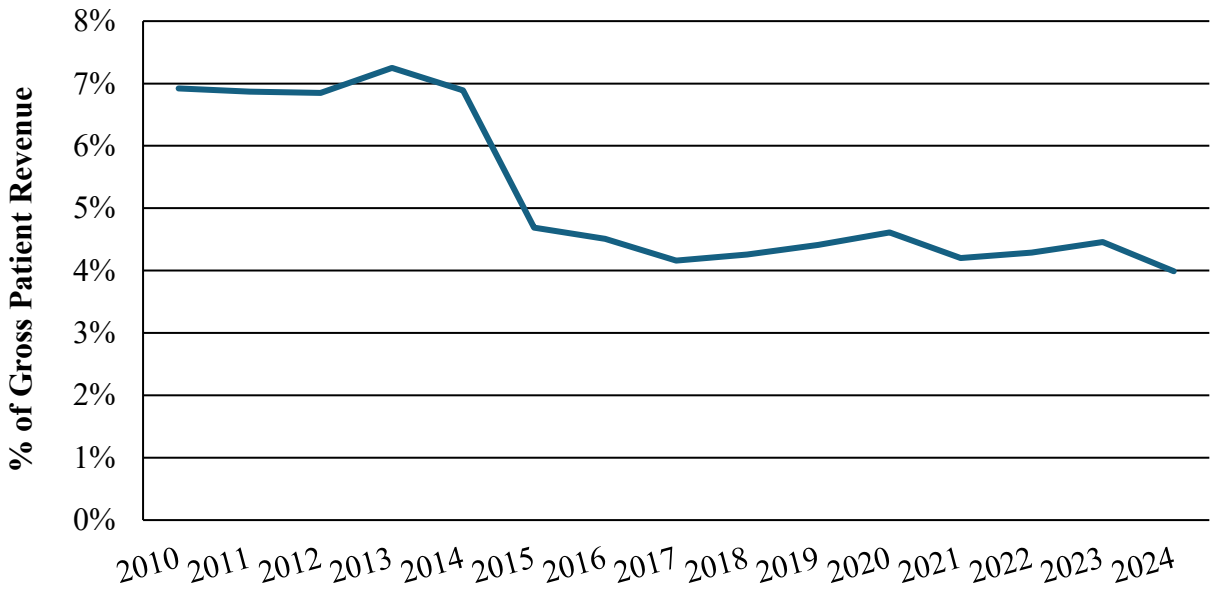
Language in the fiscal 2027 budget would reduce $1.0 million of special funds from the CRF in the MCHRC budget, contingent on a provision waiving the requirement for the Governor to include $8 million in CRF support for the MCHRC fund in fiscal 2027 only. This funding is expected to be backfilled with special fund balance from the MCHRC fund. CRF savings are reallocated to provide general fund relief as the budget also includes a $1 million CRF special fund appropriation and $1 million general fund reduction in the Medicaid budget contingent on enactment of this provision. According to MCHRC, the fiscal 2025 closing balance for the MCHRC fund was $2.3 million. **The Department of Legislative Services (DLS) recommends reducing CRF support by a total of $2.0 million (rather than the $1.0 million proposed by the Administration) in fiscal 2027 and allowing MCHRC to replace the reduction with $2.0 million from its fund balance, which provides a corresponding $2.0 million in general fund relief under Medicaid. The contingent language under MCHRC is unaffected by this recommendation, but the contingent general fund reduction under Medicaid would increase from $1.0 million to $2.0 million. DLS recommends amending the contingent language under MCHRC as a technical correction to more closely align with the applicable provision in the BRFA.**

Federal Action Causes Uncertainty in Uncompensated Care Trends

HSCRC administers the UCF, which is funded by hospital rate increases collected through payments from all acute care hospitals, which are then redistributed to hospitals that serve a disproportionate share of the uninsured and underinsured population. These payments are expected to generate $130 million in special funds in fiscal 2027, a decrease of $5 million compared to the fiscal 2026 working appropriation. Hospital rates and UCF appropriations are adjusted each year based on recent actual trends in hospitals' uncompensated care. In calendar 2026, HSCRC reported that 3.99% of gross patient revenue is built into the rates based on uncompensated care trends.

Exhibit 3 shows actual statewide uncompensated care in rates as a percentage of gross patient revenue from rate year 2010 to 2024. Medicaid expansion and low- or no-cost health coverage offered on the Maryland Health Benefit Exchange (MHBE) implemented as part of the federal Patient Protection and Affordable Care Act (ACA) led to a substantial reduction in uncompensated care from approximately 7% to less than 5% annually. Recent federal changes in the OBBBA, such as work requirements and increased frequency of eligibility redetermination for adults served through the ACA expansion, which will begin in fiscal 2027, among other programmatic changes, are expected to result in significant disenrollments from Medicaid. In addition, changes in eligibility and the value of the premium tax credit available to participants in MHBE are also expected to reduce enrollments. These changes that reduce individuals covered by health insurance are expected to cause an increase in uncompensated care in hospitals. HSCRC also reported that uncompensated care would likely increase due to various changes in accordance with Chapters 693 and 694 of 2025, which require hospitals to reduce a patient's out-of-pocket expenses for medically necessary care by specified percentages of the patient's family income on a sliding scale and prohibit hospitals from filing civil action against a patient to collect debt under specified circumstances, among other changes.

Exhibit 3
Actual Statewide Uncompensated Care in Rates as a Share of Patient Revenue
Rate Year 2010-2024



Source: Health Services Cost Review Commission

Personnel Data

	FY 25 Actual	FY 26 Working	FY 27 Allowance	FY 26-27 Change
Regular Positions	121.90	121.90	126.00	4.10
Contractual FTEs	9.29	9.63	10.93	1.30
Total Personnel	**131.19**	**131.53**	**136.93**	**5.40**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		5.21	4.27%	
Positions and Percentage Vacant as of 12/31/25		10.00	8.20%	
Vacancies Above Turnover		4.79		

- The fiscal 2027 allowance includes 4.1 additional management positions transferred to the Health Regulatory Commissions from other MDH programs. HSCRC receives 3.0 positions from the Prevention and Health Promotion Administration, MCHRC receives 1.0 position from the Thomas B. Finan Hospital Center, and MHCC reflects a 0.1 position transfer from the Western Maryland Hospital Center to make a position full-time.

- The Health Regulatory Commissions also receive a net increase of 1.30 contractual full-time equivalents, driven by additional administrative support within HSCRC for special projects and audits.

- As of December 31, 2025, the Health Regulatory Commissions reported a total of 10 vacancies, including 1 position in PDAB, 2 positions in MHCC, 6 positions in HSCRC, and 1 position in MCHRC. HSCRC reported 1 long-term vacant position that has been unfilled for more than a year.

Key Observations

1. Maryland Renegotiates the AHEAD Model

From January 1, 2019, through December 31, 2025, Maryland implemented the Total Cost of Care (TCOC) model, which built on the All-Payer Model contract and was designed to (1) improve population health; (2) improve care outcomes for individuals; and (3) control growth in the TCOC for Medicare beneficiaries. The TCOC model was an agreement with the federal Center for Medicare and Medicaid Innovation (CMMI) that continued to provide HSCRC with rate setting authority for regulated hospital rates. This authority includes establishing global budget

revenues (GBR), which are annual revenue targets for each Maryland hospital that consider inflation, changes in population, the hospital's performance on quality and efficiency metrics, and other factors. Under the TCOC model, Maryland committed to reaching annual Medicare expenditure savings targets in Medicare Part A (*e.g.*, hospital services) and Part B (*e.g.*, doctor office visits, preventive services, and other nonhospital services). The State far exceeded the target of $336 million through the end of calendar 2024 (program year six), reporting $795 million in savings. Maryland met or exceeded all of the goals evaluated by CMMI for TCOC in calendar 2024. **Appendix 2** shows the State's performance on each of the goals in calendar 2022 through 2024.

On November 1, 2024, Maryland and CMMI signed an agreement for the successor to the TCOC model, the All-Payer Health Equity Approaches and Development model. However, under a new federal administration, CMMI signaled its interest in altering the agreement, specifically with respect to the State's ability to set rates for Medicare services. Negotiations between Maryland and CMMI took place throughout calendar 2025, and on November 12, 2025, Maryland and CMMI entered an amended and restated 10-year agreement under a new program name, the Achieving Healthcare Efficiency through Accountable Design model. Although the new model agreement keeps some of the same overarching goals as initially negotiated, such as controlling growth in health care costs, improving health care quality, improving population health, and investing in primary care initiatives, there are substantial changes in the new agreement.

The new AHEAD model agreement took effect January 1, 2026, and will continue through the end of calendar 2035. The renegotiated model authorizes HSCRC to continue to set all-payer GBRs for calendar 2026 and 2027. Beginning in calendar 2028, Maryland will enter a three-year transition period for the federal government to take over GBR and rate setting authority for fee-for-service (FFS) Medicare beneficiaries, while HSCRC will still set GBRs for commercial payers, Medicare Advantage (MA), and Medicaid. Over the next seven years, the new agreement requires the State to deliver approximately $460 million in Medicare FFS savings, which is significantly higher than the amount of savings required under the previous AHEAD agreement. The AHEAD model also requires all-payer targets to manage cost growth in Medicaid and MA on the same trajectory. Including Medicaid and MA, HSCRC indicated the cumulative cost savings target would be $870 million by plan year seven (calendar 2032). Other statewide accountability targets outlined in the model include Medicare FFS and all-payer primary care investment targets, and statewide health care quality and population health targets.

The State is also expected to implement reforms broadly related to patient choice and health care market competition by calendar 2029. By January 1, 2027, Maryland must select one of the following options related to choice:

- implementing Medicaid site neutrality;
- improving access to new or additional modes of care delivery via telehealth;
- advancing prescription drug price transparency; or

- prohibiting the use of noncompete clauses to increase provider mobility.

The State must also select one of the following initiatives to promote competition:

- modifying scope of practice restrictions, including physician assistants and nurse practitioners;

- repealing certificate of need requirements for all non-hospital settings;

- expanding access to care by revising network adequacy provisions in compliance with federal requirements; or

- expanding contracting flexibilities by repealing any willing provider laws.

On September 23, 2025, the Governor created a multi-agency regulatory working group led by the Secretary of Health to assist in meeting the goals under the AHEAD model and address issues that arise from implementation of the model and the OBBBA, particularly cost-shifting, stabilization of the MA market, and other multi-agency priorities. The working group includes representatives from MDH, HSCRC, the Maryland Insurance Administration, MHCC, and MHBE. In October 2025, the regulatory working group issued a workplan that discussed its priorities and plan for stakeholder engagement, including monthly updates for designated members of the General Assembly in an AHEAD Legislative Group. One of the key decision points for the State will be which choice and competition efforts to select, and the workplan noted planned listening sessions in calendar 2026 and public comment period for April to June 2026 before the regulatory working group will issue a final proposal later in calendar 2026.

Cost Shifting Proposal and MA Market Stabilization

To spread the required cost savings across multiple payers, the regulatory working group issued a policy proposal that was approved by the Governor and authorizes HSCRC to increase commercial hospital rates by $87 million annually from calendar 2028 through 2032 (a cumulative increase of $435 million). After calendar 2032, annual rates would maintain the $435 million, which is approximately half of the required Medicare and Medicaid savings in 2032. HSCRC reported that it is still in the process of deciding how these rate increases would be applied to hospitals in Maryland through the update factor process.

Language in the fiscal 2026 Budget Bill restricts $250,000 in special funds within HSCRC pending the submission of a report on the alignment of incentives between MA plans and hospitals under the AHEAD model and efforts to support MA plans operating in underserved communities. HSCRC submitted the report on December 16, 2025, including a recommendation for MA market stabilization from the regulatory working group. Under MA plans, Medicare beneficiaries receive coverage of Part A and B services, often in addition to prescription drug, vision, dental, hearing, and other services, from private health insurers that receive a per member per month capitation payment from the Centers for Medicare and Medicaid Services (CMS) to cover the beneficiary.

MA plans and FFS Medicare have several different policies related to premiums, copays, and out-of-pocket expense limits, among other differences.

HSCRC acknowledged that although MA plans have become more popular among Medicare beneficiaries nationally and in Maryland over time, MA plans in the State have struggled to be profitable because the market has included many small private insurance plans with limited ability to reach efficiencies through scale or achieve high scores on quality measures. From July 2020 to July 2025, HSCRC found that MA enrollment grew by 120% in Maryland, which would increase the plans' scale. HSCRC initiated the MA Partnership (MAP) Funding Program to facilitate access to MA plans in Maryland by linking hospitals with specific MA plans to improve care quality and support plan stability. Across two funding rounds in fiscal 2021 and 2022, HSCRC distributed:

- $27.8 million to four partnerships, including Johns Hopkins, University of Maryland Medical System (UMMS), Holy Cross Health and Kaiser Permanente, and Luminis Health and Kaiser Permanente; and

- $35.7 million to seven partnerships, including the round one partnerships and three new partnerships with CareFirst, including UMMS, Luminis Health, and various hospitals in Advanced Healthcare Collaborative III.

The report found that long-term funding stability and quality improvements after the end of the MAP Program were inconsistent, and some MA plans like Johns Hopkins Health Advantage ended coverage in Baltimore City.

In calendar 2025, HSCRC and multiple partnering agencies considered an MA Alignment Program that would have tied population health improvement and strategic intervention plans with financial assistance through a differential hospital rate for members of MA plans. However, this proposal is not moving forward. Instead, the regulatory working group was charged with recommending policy changes under the AHEAD model to sustainably support MA plans in Maryland. This proposal involves identifying qualified MA plans annually that (1) have at least 50% of beneficiaries in Maryland; (2) serve at least 5,000 beneficiaries or 20% of Maryland beneficiaries in eight counties with the lowest incomes; and (3) have a quality star rating of 3.5 or higher by the calendar 2028 reporting period. For these qualified MA plans, HSCRC would reduce hospital costs through its rate-setting authority, provide 11.55% in additional rate relief beginning in calendar 2027, and be offset by cost shifting to Medicaid and commercial rates in calendar 2027 and to commercial rates in calendar 2028 and on.

DLS determined the report on incentives for MA plans under the AHEAD model to be in compliance with the language and recommends the release of $250,000 in withheld special funds. DLS will process a letter to this effect if no objections are raised by the committee at the hearing.

Maryland Primary Care Program Evaluation

A component of the TCOC model that continues under the AHEAD model is the Maryland Primary Care Program (MDPCP), a voluntary program that offers incentives for primary care providers to deliver advanced primary care services with the goal of improving individual and population health outcomes prioritized under the model. MDPCP incentives are fully supported with federal funds and are provided through care management fees offering additional per Medicare beneficiary per month payment for care management and team-based care, performance-based incentive payments, and comprehensive primary care payments for certain eligible providers that transition to a more stable funding stream. Payments made through the MDPCP count toward TCOC Medicare spending. Beginning in calendar 2022, CMMI added Health Equity Advancement Resource and Transformation Payment as a new component to care management fees, though within the existing fees, to address beneficiaries' social needs. Under the AHEAD model, the MDPCP is extended through at least calendar 2028, when the program will be evaluated to determine if it will continue or transition to a consolidation with Primary Care AHEAD (PC AHEAD), a new initiative.

As of January 2025, 481 primary care practices located across all 24 Maryland jurisdictions participated in the MDPCP. Among participating practices, the program attributes Medicare beneficiaries to practices that provide a plurality of the beneficiaries' health services. Practices assigned to a panel of beneficiaries are tasked with providing advanced primary care, which uses a model similar to a patient-centered medical home. At the start of calendar 2025, approximately 50% of eligible Medicare beneficiaries in Maryland (345,488) were attributed to a provider under the MDPCP.

Given the role of the MDPCP in TCOC, the budget committees have annually requested program evaluations in the *Joint Chairmen's Report* (JCR), with particular focus on whether the cost of incentive payments have been offset by savings elsewhere in the State's health care system. The Hilltop Institute conducted the MDPCP cost effectiveness evaluation requested in the 2024 JCR and used a different methodology than in previous years. Specifically, the Hilltop Institute used a difference-in-differences approach for FFS Medicare beneficiaries attributed to MDPCP participating practices compared to FFS Medicare beneficiaries in Maryland. From this study, Hilltop found that MDPCP attributed beneficiaries experienced an average reduction in total Medicare FFS spending of $119.60 per person per quarter prior to accounting for program costs. The Hilltop Institute found that the aggregate impact from calendar 2019 to 2022 was budget neutral or suggested cost savings of $161.9 million that could rise to $342.2 million for the lower bound of the 95% confidence interval, though the upper bound would still result in slight net cost of $18.3 million.

The response to the 2025 JCR, submitted by MDH on December 11, 2025, noted improvements in inpatient utilization, emergency department (ED) visits, and quality measures among participating Medicare beneficiaries. Despite reporting that MDPCP practices maintained lower costs per beneficiary per month, MDH did not conduct a new analysis of the overall cost effectiveness of the program in calendar 2025 to evaluate whether incentive payments are fully offset by health care savings. MDH indicated that the Hilltop Institute would conduct another

independent evaluation for calendar 2026 to assess MDPCP data throughout the entire TCOC model term.

New Primary Care Initiatives under the AHEAD Model

The Office of Advanced Primary Care under MDH coordinates four initiatives under the AHEAD model: (1) the existing MDPCP; (2) a new national Medicare program, referred to as PC AHEAD, operated in partnership with CMS to work with primary care practices not participating in the MDPCP; (3) the new Medicaid Advanced Primary Care Program (also known as the Medicaid Path); and (4) the new Episode Quality Improvement Program – Primary Care (or the Infrastructure Path), which focuses on expanding primary care availability in underserved areas of the State. Administrative costs for the Office of Advanced Primary Care are budgeted in MDH, but HSCRC and MHCC each annually fund MDPCP personnel costs with $600,000 in special funds supported with user fees.

The Medicaid Path began a phased implementation on August 1, 2025, and is supported by the Medicaid Primary Care Program Fund that was established through the BRFA of 2025. The special fund is supported with $30 million ($16 million budgeted in fiscal 2026 and $14 million budgeted in fiscal 2027) from hospital payments received by HSCRC via the Medicare savings component for calendar 2023. The Medicaid Path provides enhanced physician evaluation and management rates but otherwise operates similarly to the MDPCP. Through the new program, MDH provides care management fees of $2 per member per month for Medicaid managed care program participants assigned to eligible primary care practices. This funding is distributed through managed care organizations. MDH and HSCRC reported 94 practices are in the first cohort that began on August 1, 2025, and the program will gradually expand eligibility to practices that are not currently enrolled in the MDPCP, such as pediatricians, in calendar 2026 and 2027. The department will also administer a quality incentive program for the calendar 2026 performance year.

Population Health Improvement Fund

MDH and HSCRC's response to the 2025 JCR on primary care initiatives also provided an update on the Population Health Improvement Fund established in Chapter 615 of 2025. The fund is meant to support statewide population health targets under the AHEAD Model with funding from an approved hospital rate assessment. In December 2024, HSCRC approved a one-time broad-based uniform hospital assessment that will yield approximately $25 million in revenue for the fund that became available beginning January 1, 2026, according to MDH and HSCRC. Maryland is partnering with the National Governors Association Rx for a Healthier America Policy Academy to plan how to administer the funding with a focus on reducing the incidence of chronic disease. The fiscal 2027 allowance does not include any funding from the Population Health Improvement Fund.

DLS recommends adopting committee narrative requesting a report from MDH, in collaboration with HSCRC, evaluating the MDPCP for the entire performance period under

the TCOC model and providing status updates on the new primary care and population health initiatives under the AHEAD Model.

2. BRFA Provision Proposes Ongoing Reduction to Consortium Grants

Chapter 36 of 2021 (Blueprint – Implementation) established the Consortium within MCHRC to:

- develop coordinated community support partnerships to meet student behavioral health needs and other related challenges in a holistic, nonstigmatized, and coordinated manner;
- provide expertise in developing best practices in the delivery of behavioral health services, supports, and wraparound services; and
- provide technical assistance to local school systems to support positive classroom environments and close achievement gaps.

The Consortium is also tasked with implementing a grant program for coordinated community supports partnerships and developing a model for expanding available behavioral health services and support to all students through the maximization of public funding through Medicaid, among other financing efforts. Special funds from the Blueprint Fund support the Coordinated Community Supports Partnership Fund. Chapter 36 required the Governor to budget increasing minimum funding levels for the Consortium's grant program beginning in fiscal 2022. Due to the timing of the Governor's veto and legislature's veto override for Chapter 36, the fiscal 2022 budget did not provide funding for the Consortium.

Exhibit 4 shows the annual mandated appropriation for Consortium grants as enacted in Chapter 36 and amended through Chapter 713 of 2022 and Chapter 237 of 2025. The BRFA of 2026 includes a provision to reduce the amount that the Governor must provide annually for the Coordinated Community Supports Partnership Fund from $100 million to $80 million beginning in fiscal 2027. The fiscal 2027 budget as introduced includes a $20.0 million special fund reduction of Blueprint Funds, contingent on the enactment of legislation that reduces the mandate for the Consortium. Considering that current projections indicate general funds will be needed to support Blueprint costs beginning in fiscal 2028, the cumulative Blueprint Fund savings from the Consortium grants will result in general fund savings totaling $40 million in fiscal 2028 and $20 million annually in fiscal 2029 and subsequent years.

Exhibit 4
Consortium on Coordinated Community Supports Mandates and Funding
Fiscal 2023-2027
($ in Millions)

	2023	2024	2025	2026 Working Approp.	2027 Allowance
Original Mandate (Chapter 36 of 2021)	$50.0	$75.0	$100.0	$125.0	$125.0
Updated Mandate (Chapter 713 of 2022)		85.0	110.0	130.0	130.0
Current Mandate (Chapter 237 of 2025)			40.0	70.0	100.0
Opening Balance		50.0	119.7	42.9	0
Actual Reported Spending/Appropriation	50.0	69.7	39.0	70.0	80.0*
Total Available Blueprint Funds		**$119.7**	**$158.7**	**$112.9**	**$80.0**
Consortium Grants Awarded			$115.8	$96.0	
Consortium Grants Budgeted					$80.0
Accrued Balance	$50.0	$119.7	42.9	0	
Special Funds Reverted to the Blueprint Fund				16.9	

Blueprint: Blueprint for Maryland's Future

*Includes a special fund reduction of $20 million, contingent on enactment of a provision in the Budget Reconciliation and Financing Act of 2026 that reduces the mandate for the Coordinated Community Supports Partnership Fund beginning in fiscal 2027.

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

Fiscal 2025 Consortium Grants and Medicaid Spending

The Consortium experienced start up delays that led to a growing balance of special funds from the Blueprint Fund that were accrued at the end of fiscal 2023 and 2024 for use in future years. In August 2023, the Consortium issued its first request for proposals (RFP) focused on grants to service providers statewide to expand access to high quality behavioral health or wraparound services. The RFP described the grants as being able to support each tier of the multi-tiered system of supports: (1) universal promotion or prevention; (2) early intervention; and (3) treatment. On February 8, 2024, the Consortium announced 129 grant awards totaling $111.1 million with a grant term from March 2024 to June 2025.

In October 2023, the Consortium released a second RFP for grants to hub pilot programs that would coordinate service providers and schools. On March 19, 2024, the Consortium awarded 10 hub pilot grants totaling $4.7 million, with a grant term of April 2024 to June 2025. The Consortium is in the process of establishing community supports partnerships with statewide hubs that (1) coordinate service providers; (2) act as a fiduciary by managing MCHRC grants and awarding grants to service providers as subgrantees; and (3) collect and report data. Local behavioral health authorities, local health departments, and local management boards are eligible to apply for hub pilot program funding that serves as a planning grant to become a community supports partnership in the following year.

The BRFA of 2024 expanded the authorized uses of Blueprint funds for the Consortium in fiscal 2025 to include not only providing grants for school based behavioral health services but also reimbursing MDH for school-based behavioral health services provided on a FFS basis through a Medicaid waiver. Language in the fiscal 2025 Budget Bill specified that no more than $12 million in special funds budgeted for the Consortium may be used to reimburse MDH for this purpose. By using Consortium funds to reimburse MDH for general funds spent on eligible Medicaid-covered services, this State spending would receive matching federal fund rates of 50% under Medicaid and 65% under the Maryland Children's Health Program (MCHP).

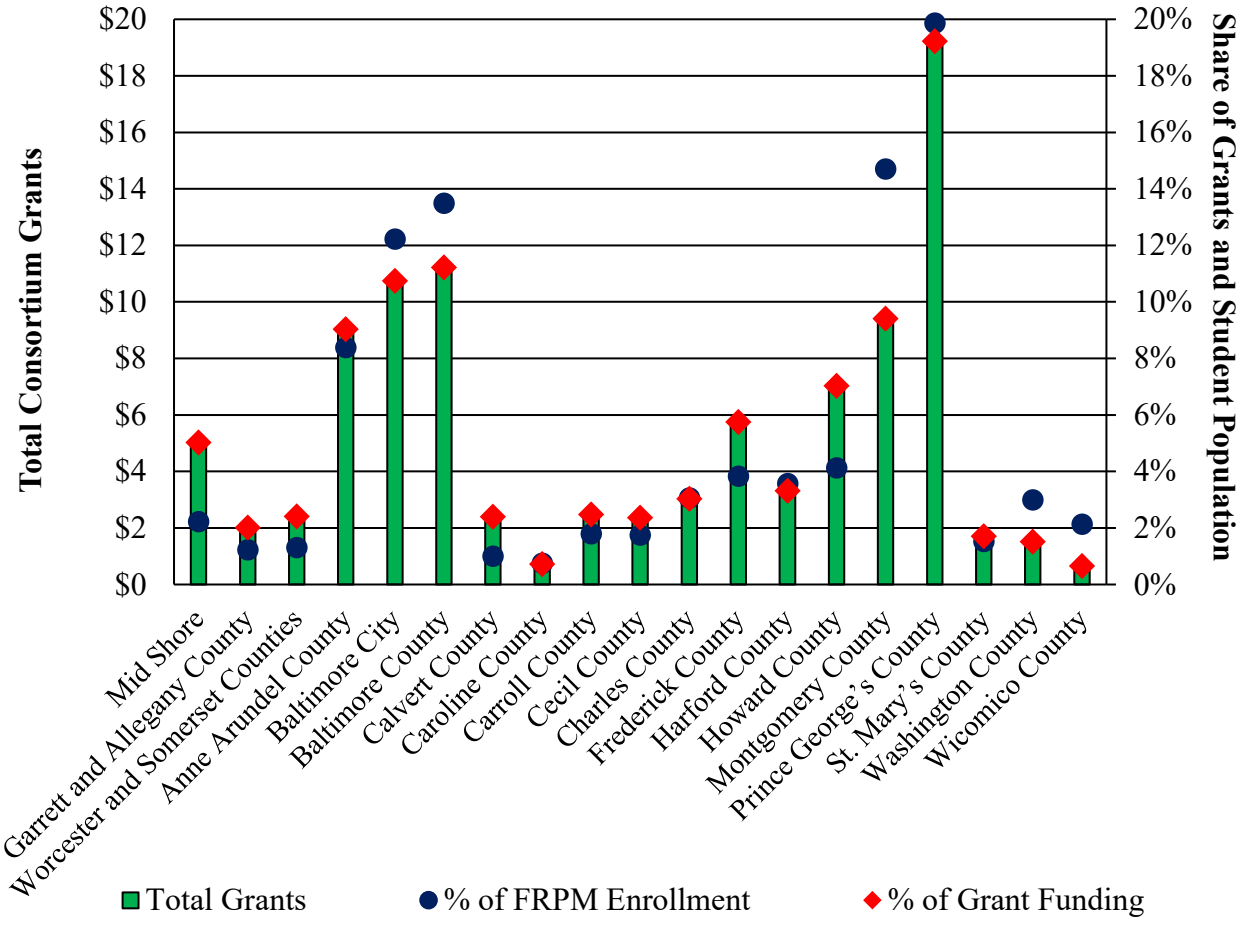
Medicaid reimbursement for school-based services was previously limited to only services required by a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) and services provided by community-based providers that directly bill Medicaid. Beginning on January 1, 2025, Medicaid reimbursement expanded to school-based services provided by school psychologists and social workers to students without IEPs and IFSPs who are eligible for Medicaid or MCHP. Supplemental Budget No. 1 in the fiscal 2026 Budget Bill provided a supplemental deficiency appropriation of $6.1 million in reimbursable funds within MDH to account for Consortium funding to cover the State share for six months of expanded school-based services provided in fiscal 2025. According to MDH, this amount from the Coordinated Community Supports Partnership Fund was not spent due to start up delays, specifically school psychologists and social workers not enrolling as Medicaid providers until after fiscal 2025.

Fiscal 2026 Consortium Grants

The Consortium published an RFP in December 2024, for a second round of grants with a grant period from July 1, 2025, through June 30, 2026. The RFP described three funding tracks to support (1) community supports partnerships; (2) future partnership hub capacity; and (3) grants to service providers. **Appendix 3** provides detailed regional/county allocations by funding track for this round of grants, which was initially published as a total of $99.6 million overall. Subsequent descriptions of the grants published by the Consortium revised the total grant awards to $97.3 million, including $30.4 million across seven community supports partnerships, $2.6 million for nine pilot hubs, and $64.3 million for direct service provision. In the fiscal 2026 grant period, three jurisdictions (Caroline, Charles, and Wicomico counties) received only service grants awarded directly to providers.

Exhibit 5 shows total Consortium grant awards by jurisdiction, with Prince George's County receiving the largest allocation at $19.1 million in fiscal 2026. Some counties receive Consortium funding as a region, such as Mid Shore Behavioral Health, which serves Dorchester, Kent, Queen Anne's, and Talbot Counties. It is not clear that Consortium funding is prioritized across regions and counties based on financial need. Although the shares of fiscal 2026 awards tend to align with each jurisdiction's share of student enrollment that is eligible for free and reduced-price meals (FRPM) as reported by the Maryland State Department of Education in December 2025, there are some discrepancies. For example, Baltimore City and Baltimore and Montgomery counties each make up more than 12% of statewide FRPM enrollment but receive between 9.4% to 11.2% of Consortium grants. In budget hearing testimony provided during the 2025 session, MCHRC indicated that county allocations differ mainly due to the cost of providing behavioral health services in each jurisdiction and due to the various levels of services and interventions requested based on local needs and priorities. **MCHRC should discuss how the Consortium grant-making process considers financial need and other factors such as social determinants of health and access to care when determining county allocations.**

Exhibit 5
Consortium on Coordinated Community Supports Grants by Jurisdiction
Fiscal 2026
($ in Millions)



FRPM: free and reduced-price meals

Note: Mid Shore includes Dorchester, Kent, Queen Anne's, and Talbot Counties. Reflects preliminary grant awards ($66.6 million for service providers grants and $99.6 million for total grants). The Consortium on Coordinated Community Supports subsequently published service provider grant awards totaling $64.3 million and total grant awards of $97.3 million for fiscal 2026. The FRPM counts use the data as counted under current law for fiscal 2027, which changed how counts were conducted for schools participating in the Community Eligibility Provision program.

Source: Maryland Community Health Resources Commission; Maryland State Department of Education; Department of Legislative Services

Fiscal 2027 Consortium Grants

On December 10, 2025, the Consortium published a new RFP for Consortium grants for the fiscal 2027 grant period. The grants would again be awarded through three tracks for community supports partnerships, pilot hubs, and direct service grants. Grant proposals were due February 11, 2026, and the Consortium expects to make award decisions in spring 2026. MCHRC reported that any remaining special funds for Consortium grants that are not spent in fiscal 2026 will revert to the Blueprint Fund at closeout and there would be no balance to draw additional grant funding. Therefore, the fiscal 2027 allowance provides up to $80 million for Consortium grants and administration, a decrease of $16 million from the fiscal 2026 grant period, after accounting for the contingent reduction.

3. PDAB Cost Review Process and Upper Payment Limit Policies

Chapter 692 of 2019 established PDAB and required the board to make specified determinations, collect data, and identify specified prescription drug products that may cause affordability issues. Under Chapter 692 as amended by Chapters 610 and 611 of 2025, PDAB is authorized to conduct a cost review of each identified drug product, and if PDAB determines it is in the State's best interest to establish a process for setting upper payment limits (UPL) for prescription drugs purchased by or on behalf of a unit of State or local government, PDAB must establish a process for setting UPLs in consultation with the stakeholder council. This authority allows for the establishment of UPLs through regulations for prescription drug products purchased by or on behalf of a unit of State or local government, through a health benefit plan on behalf of a unit of State or local government, or by the Medicaid program. To the extent appropriate, the process must use the *Upper Payment Limit Action Plan*, approved by the Legislative Policy Committee in October 2024. PDAB issued new regulations and amended existing regulations related to the cost and policy review and UPL processes, which took effect April 2025.

If PDAB sets UPLs through regulations on two prescription drugs for purchases by or on behalf of State or local government, and each UPL is in effect for one year, PDAB must notify DLS within five days of these conditions being met. If DLS receives this notice by September 30, 2030, a provision in Chapters 610 and 611 takes effect, which specifies that PDAB, in consultation with the stakeholder council, must determine whether it is in the State's best interest for the board to establish a process for setting UPLs more broadly for purchases and payor reimbursements of prescription drug products in the State, including the commercial market. PDAB is prohibited from enforcing a UPL against provider or pharmacy reimbursement requirements for Medicare Part C or Part D plans and counting a pharmacy dispensing fee toward or subjecting a dispensing fee to an UPL.

Under the cost review study process, PDAB can identify prescription drugs to refer to the prescription drug affordability stakeholder council for cost review. Eligible prescription drugs for review must be selected at an open meeting and meet the following regulatory requirements:

- brand name drugs or biologics that, as adjusted for inflation, have a launch wholesale acquisition cost (WAC) of $30,000 or more per year or course of treatment;

- brand name drugs that have a WAC increase of over $3,000 or more in any 12-month period or course of treatment;

- biosimilar drugs that have a launch WAC that is not at least 15% lower than the brand biologic;

- generic drugs that, as adjusted for inflation, have a WAC of $100 more and a WAC increase of 200% or more over a specified period; and

- other prescription drug products that may create affordability challenges, in consultation with the Prescription Drug Affordability stakeholder council.

After identifying such drugs, PDAB must determine whether to conduct a cost review by seeking Stakeholder Council input and considering the average cost share of the drug. If PDAB conducts a cost review, it must determine whether use of a prescription drug has led or will lead to affordability challenges for the State health care system or high out-of-pocket costs for patients by considering specified factors.

In March 2024, PDAB identified eight prescription drugs to consider for cost review and referred them to the Stakeholder Council. PDAB narrowed the list to six drugs for cost review in May 2024 and chose not to study two (Biktarvy and Vyvanse). The six selected drugs are for the treatment of diabetes (Farxiga, Jardiance, Ozempic, and Trulicity) and auto-immune diseases (Dupixent and Skyrizi). PDAB reported the following preliminary findings related to cost reviews for four of the drugs, with the cost review reports for Dupixent and Skyrizi expected in early calendar 2026.

- At the PDAB meeting on July 28, 2025, board staff presented the findings and policy recommendations from the cost review studies for Farxiga and Jardiance, and the board made preliminary determinations that the drugs created affordability challenges in Maryland due to the WAC growing at a significantly faster rate than inflation, out-of-pocket costs being disproportionate to the costs paid by payors for certain markets, and both drugs accounting for over 1% of gross prescription drug spending for State and local governments.

- At the PDAB meeting on November 17, 2025, board staff presented the findings and policy recommendations from the cost review studies for Ozempic and Trulicity. The board's preliminary determination was that Ozempic and Trulicity created an affordability challenge due to the drugs accounting for over 4.87% and 2.27% of gross prescription drug spending for State and local governments, respectively. The WAC for Trulicity also grew at a significantly faster rate than inflation.

Following the preliminary determinations for Farxiga and Jardiance, next steps included receiving public input through hearings in September 2025 and engaging the stakeholder council. In November 2025, PDAB recommended implementing the process to set UPLs for State and local government pharmacy plans for Farxiga and Jardiance. The board also recommended examining non-UPL options, such as WAC inflation penalties, delinking pharmacy benefit manager compensation from rebates, and administering a navigator program to assist patients in finding resources to reduce the out-of-pocket cost.

PDAB is now in the process of creating a methodology framework for UPL proposals for Farxiga and Jardiance, which will eventually be released for public comment. This UPL-setting process will continue throughout calendar 2026, as well as cost and policy review studies for the final two selected drugs. PDAB indicated that it aims to streamline the cost and policy review and UPL-setting process moving forward. In its 2025 Annual Report, PDAB also made general recommendations to (1) improve transparency related to the cost of prescription drugs; (2) establish navigator programs and services to assist patients in finding resources for lowering their out-of-pocket costs; and (3) promote a more competitive biosimilar market in Maryland, similar to the market competition for generic drugs. **PDAB should comment on the projected timeline for setting UPLs and implementing non-UPL recommendations for Farxiga and Jardiance and how it would streamline the current UPL-setting process. Additionally, PDAB should discuss whether it is working with the multi-agency regulatory working group related to the AHEAD model, considering advancing prescription drug price transparency is one of the potential efforts the State can choose under the model to encourage consumer choice.**

Operating Budget Recommended Actions

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

   Further provided that this appropriation shall be reduced by $1,000,000 contingent upon the enactment of legislation eliminating the funding mandate for the Maryland Community Health Resources Commission ~~and allowing the Commission to use existing fund balance for operations~~.

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

2. Adopt the following narrative:

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

Information Request	**Author**	**Due Date**
Evaluation and update on primary care programs and initiatives	MDH HSCRC	November 1, 2026

Updates

- ***Maryland ED Wait Time Reduction Commission Interim Report:*** In calendar 2021, according to ED wait time data released by CMS, Maryland had the highest ED wait times among all states. In July 2023, the Maryland Hospital Association convened the Maryland General Assembly Hospital Throughput Work Group to address ED wait times. The workgroup identified several root causes of throughput delays occurring at different points in a patient's care continuum and offered policies aimed at addressing those delays for consideration by the General Assembly. Chapter 844 of 2024 subsequently established the Maryland ED Wait Time Reduction Commission, staffed by HSCRC, to further review and address factors in the health care system that contribute to increased ED wait times. The commission met six times in calendar 2024 and 2025. The final report is due November 1, 2026. However, in November 2025, the commission issued an interim report with the following preliminary recommendations:

  - strengthen data infrastructure by creating a validated capacity reporting system spanning acute and post-acute care;

  - leverage statistical modeling and simulation to test the impact of hospital interventions and performance measures, and guide future HSCRC pay-for-performance programs; and

  - develop a formal post-acute care proposal with regional capacity targets and infrastructure recommendations for complex patient populations.

Appendix 1
2025 *Joint Chairmen's Report* Responses from Agency

The 2025 JCR requested that the Health Regulatory Commissions prepare three reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Access to Electronic Health Data for Skilled Nursing Facilities:*** On July 28, 2025, MHCC submitted a report on the implementation of Chapter 333 of 2023, including activities to authorize nursing homes that use electronic health networks (EHN) or electronic health record (EHR) vendors to share clinical data and electronic health care transactions with CRISP. The Nursing Facility Connectivity Program was created in September 2022 to support these data sharing efforts. As part of the program, CRISP contracted Real Time Medical Systems, LLC for data integration and technical support. MHCC published regulations related to EHN data sharing with CRISP in the Maryland Register on August 8, 2025. MHCC described implementation challenges, including litigation between Real Time Medical Systems and one of the commonly used EHR vendors related to potential information blocking, and EHNs expressing concerns with the regulations and data sharing requirements. The report detailed four recommendations: (1) require EHR vendors to use interoperability standards and amend regulations to require compliance; (2) strengthen data governance requirements for EHR vendors; (3) promote participation in the Nursing Facility Connectivity Program; and (4) update the legislature on CRISP and EHN implementation of regulations related to required data sharing.

- ***Incentives for Medicare Advantage Plans under the AHEAD Model:*** Language in the fiscal 2026 Budget Bill restricts $250,000 in special funds within HSCRC pending the submission of a report on incentives for Medicare Advantage Plans under the AHEAD model. The report was submitted to the budget committees on December 16, 2025. Further discussion can be found in Key Observation 1.

- ***Registered Apprenticeship Opportunities in Hospitals:*** On December 2, 2025, HSCRC submitted a report on registered apprenticeships in hospitals and goals to increase and scale these programs. For the purpose of this report, HSCRC defined registered apprenticeships as structured, work-based learning programs recognized by the U.S. Department of Labor or a State apprenticeship agency. The Maryland Department of Labor reported a total of 50 registered apprenticeships as of June 2025 for patient care technicians, licensed practical nurses, and surgical technologists. Howard Community College was the largest sponsor for active apprentices, specifically providing opportunities for surgical technologists. HSCRC held roundtable discussions with hospitals and found there was strong interest in increasing apprenticeships but also some concerns such as long durations of apprenticeships, alternative and comparatively shorter training programs, limited interest for hard to fill positions, and delays in receiving licensure and certification after apprenticeships. The report included recommendations to scale apprenticeship programs for high-vacancy occupations, elevate community colleges as regional assets, and scale youth apprenticeship models, among other recommendations.

Appendix 2

Total Cost of Care Model Performance Results

Calendar 2022-2024

	Calendar 2022/Program Year 4		Calendar 2023/Program Year 5		Calendar 2024/Program Year 6	
	Goal	**Performance**	**Goal**	**Performance**	**Goal**	**Performance**
Annual Medicare Savings*	$267 million	$269 million	$300 million	$509 million	$336 million	$795 million
TCOC Guardrail	**Not to exceed national Medicare growth in TCOC by more than 1%**	**0.9% above national Medicare growth (second consecutive year above)**	Not to exceed national Medicare growth in TCOC by more than 1%	1.9% below national Medicare growth	Not to exceed national Medicare growth in TCOC by more than 1%	2.5% below national Medicare growth
All-payer Revenue Limit	Average growth ≤ 3.58% per capita annually	2.72%	Average growth ≤ 3.58% per capita annually	2.68%	Average growth ≤ 3.58% per capita annually	2.73%
Reductions in Hospital-acquired Conditions	Not to exceed calendar 2018 rates for potentially preventable conditions	0.2% average reduction below calendar 2018	Not to exceed calendar 2018 rates for potentially preventable conditions	0.36% average reduction below calendar 2018	Not to exceed calendar 2018 rates for potentially preventable conditions	0.5% average reduction below calendar 2018
Reduction in Readmissions*	**≤ national rate for FFS Medicare beneficiaries (15.40% for calendar 2022)**	**15.56%**	≤ risk-adjusted national ratio of 1.0 for FFS Medicare beneficiaries	Standardized readmission risk ratio of 0.9671	≤ risk-adjusted national ratio of 1.0 for FFS Medicare beneficiaries	Standardized readmission risk ratio of 0.9519

	Calendar 2022/Program Year 4		Calendar 2023/Program Year 5		Calendar 2024/Program Year 6	
	Goal	Performance	Goal	Performance	Goal	Performance
Hospital Revenue Population-based Payment	At least 95% of regulated revenue paid according to population-based methodology	98%	At least 95% of regulated revenue paid according to population-based methodology	98%	At least 95% of regulated revenue paid according to population-based methodology	98%

FFS: fee-for-service
TCOC: Total Cost of Care

*In calendar 2023 and beyond, a risk-adjusted measure is used for the annual Medicare readmissions reduction test. This measure is reported as the standardized risk ratio, with a ratio under 1.0 meaning Maryland had statistically significant lower readmission rates than national readmission rates.

Note: Bold denotes performance results that did not meet targets.

Source: Center for Medicare and Medicaid Innovation; Health Services Cost Review Commission

Appendix 3
Consortium on Coordinated Community Supports Grants
Fiscal 2026

	Track 1 – Community Supports	Track 2 – Hub Capacity– Building	Track 3 – Direct Service Grants	Total Grants	% of Grant Funding	Grantees	Funding per Grantee	Coordinating Supports/ Hub Type
Mid Shore (Dorchester, Kent, Queen Anne's, and Talbot Counties)	$5,000,000			$5,000,000	5.0%	16	$312,500	LBHA
Garrett and Allegany County	2,000,000			2,000,000	2.0%	6	333,333	LHD
Worcester and Somerset Counties	2,400,000			2,400,000	2.4%	7	342,857	LMB
Anne Arundel County	9,000,000			9,000,000	9.0%	13	692,308	LBHA
Baltimore City		$375,000	$10,329,388	10,704,388	10.7%	15	713,626	LBHA
Baltimore County		360,684	10,816,262	11,176,946	11.2%	10	1,117,695	LBHA
Calvert County		195,000	2,195,706	2,390,706	2.4%	8	298,838	LBHA
Caroline County			715,269	715,269	0.7%	3	238,423	
Carroll County		195,000	2,264,615	2,459,615	2.5%	4	614,904	LMB
Cecil County		200,000	2,149,523	2,349,523	2.4%	5	469,905	LHD
Charles County			3,022,349	3,022,349	3.0%	4	755,587	
Frederick County		200,000	5,522,934	5,722,934	5.7%	13	440,226	LBHA
Harford County	3,300,000			3,300,000	3.3%	10	330,000	LBHA
Howard County	7,000,000			7,000,000	7.0%	6	1,166,667	LMB
Montgomery County		500,000	8,864,762	9,364,762	9.4%	7	1,337,823	LHD
Prince George's County		350,000	18,792,718	19,142,718	19.2%	15	1,276,181	LBHA
St. Mary's County	1,700,000			1,700,000	1.7%	4	425,000	LBHA
Washington County		200,000	1,304,579	1,504,579	1.5%	6	250,763	LBHA
Wicomico County			653,921	653,921	0.7%	2	326,961	
Total	**$30,400,000**	**$2,575,684**	**$66,632,026***	**$99,607,710***		**154**	**$646,803**	

LBHA: local behavioral health authority
LHD: local health department
LMB: local management board

*Reflects preliminary grant awards. The Consortium on Coordinated Community Supports subsequently published service provider grant awards totaling $64.3 million and total grant awards of $97.3 million for fiscal 2026.

Source: Maryland Community Health Resources Commission; Department of Legislative Services

Appendix 4
Object/Fund Difference Report
Maryland Department of Health – Health Regulatory Commissions

Object/Fund	FY 25 Actual	FY 26 Work Approp.	FY 27 Allowance	FY 26 - 27 $ Change	FY 26 - 27 % Change
Positions					
01 Regular	121.90	121.90	126.00	4.10	3.36%
02 Contractual	9.29	9.63	10.93	1.30	13.5%
Total Positions	**131.19**	**131.53**	**136.93**	**5.40**	**4.11%**
Objects					
01 Salaries, Wages, and Fringe Benefits	$22,198,010	$22,090,595	$24,570,234	$2,479,639	11.2%
02 Technical and Special Fees	840,683	737,220	1,071,239	334,019	45.3%
03 Communications	125,824	115,457	120,444	4,987	4.3%
04 Travel	92,424	343,168	309,401	-33,767	-9.8%
06 Fuel and Utilities	3,372	3,607	50,600	46,993	1,302.8%
08 Contractual Services	165,693,522	208,731,450	205,807,209	-2,924,241	-1.4%
09 Supplies and Materials	74,369	75,973	79,221	3,248	4.3%
10 Equipment – Replacement	80,120	55,500	121,518	66,018	119.0%
11 Equipment – Additional	51,921	955,475	1,108,737	153,262	16.0%
12 Grants, Subsidies, and Contributions	103,149,561	124,840,463	152,786,695	27,946,232	22.4%
13 Fixed Charges	607,948	874,326	860,524	-13,802	-1.6%
Total Objects	**$292,917,754**	**$358,823,234**	**$386,885,822**	**$28,062,588**	**7.8%**
Funds					
01 General Funds	$2,125,000	$550,141	$0	-$550,141	-100.0%
03 Special Funds	290,232,754	357,713,093	386,325,822	28,612,729	8.0%
09 Reimbursable Funds	560,000	560,000	560,000	0	0.0%
Total Funds	**$292,917,754**	**$358,823,234**	**$386,885,822**	**$28,062,588**	**7.8%**

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.