MDH ATTENDEES: Ryan Moran, DrPH, MHSA, Deputy Secretary, Healthcare Financing and Medicaid Director
Alyssa Lord, MA MSc, Deputy Secretary, Behavioral Health Administration
Amalie Brandenburg, Chief Financial Officer

Available For Questions: TBD

Maryland Department of Health (MDH) Behavioral Health Administration
Fiscal Year 2026 Operating Budget
Response to Department of Legislative Services Analysis

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Emily Shetty
February 26, 2025

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
March 3, 2025

The Department thanks the Governor, the Department of Budget and Management (DBM), and the Budget Committees for their support. We thank the Department of Legislative Services for its insightful budget analysis.

MDH should clarify if these special funds (ORF funds) are still needed given the recent waiver approval (page 8).

Waiver approval enables the Department to leverage the federal Medical Assistance match for these services. ORF funding is needed for the state share of services.

DLS recommends modifying the language on the general fund contingent reduction [tied to health occupation board revenue sweeps] to increase the amount that is reduced [from $4,017,728 to $10,077,123] and alter the language on both the general fund reduction and special fund appropriation regarding the boards from which the funds may be transferred (page 17).

Please see attached testimony from the health occupation boards in opposition to this DLS recommendation.

MDH should indicate if any other funding has been awarded for these [Certified Community Behavioral Health Clinic] grants, and if so, the grant totals (page 17).

CH 275 of 2023 requires Maryland to apply to the Substance Abuse and Mental Health Services Administration (SAMHSA) for federal planning, development, and implementation grant funds related to certified community behavioral health clinics (CCBHCs) for FY25 and inclusion in the state CCBHC demonstration program for FY26. Maryland received approval for participation in the planning grant in December 2024.

Participation in the planning and demonstration grant creates a significant budgetary obligation for the state to move forward with implementing benefits. Services must be covered for both Medicaid (federally matched) and uninsured/underinsured (state-only dollars). As per the analysis, the Department estimates that it would cost $227M ($173.3M in general funds and $54.4M in federal funds) to implement and support CCBHCs in fiscal year 2027. Other states, such as Missouri, that have implemented CCBHCs have seen costs of $496M total funds annually.

No other funding, inclusive of grants, have been awarded for Certified Community Behavioral Health Clinics.

Due to the State's fiscal condition, DLS recommends deleting the $19.5 million, representing the 1% provider rate increase in fiscal 2026 (page 18).

The Department acknowledges this recommendation.

DLS recommends adopting committee narrative requesting this [utilization and enrollment] information annually to improve the accuracy of regular forecasting activities (page 19).

The Department proposes we will post the monthly ASO data files in the Virtual Data Unit in lieu of annual utilization and enrollment reports to improve the accuracy of regular forecasting activities. This is a practice that already exists in BH Medicaid, somatic Medicaid, and DDA.

DLS projects a combined surplus across the three programs of $18 million in fiscal 2025 and $2 million in fiscal 2026. DLS recommends reducing the fiscal 2025 general fund appropriation in M00L01.03 by $9 million and leaving the remaining $9 million (which represents about 1% of program spending) as hedge against higher than expected costs over the second half of the fiscal year. No reduction is proposed for fiscal 2026 (page 19).

The Department respectfully disagrees with the DLS recommendation to reduce the FY 2025 general fund appropriation for program M00L0103/State-Funded Medicaid Services by $9 million. BHA's preliminary second quarter projection shows a projected $2.1 million deficit, after factoring in the -$3.1 million deficiency item, reflecting increased costs in Residential Rehab and Psychiatric Rehab services.

MDH should discuss the impact to date of the pause on the number of fraudulent claims submitted (page 21).

Given that providers have up to 12 months to submit claims, the full impact of the pause on fraudulent claims for PRP, PRP Health Home, PHP and IOP may not be fully realized until December 2026 to allow for full claims run out and conclusions of ongoing investigations. There are a total of 127 referrals as outlined below.

Referrals for Potential Provider Medicaid Fraud, Waste, or Abuse
July 2, 2024 - February, 21, 2025

Referrals to:	**# of Providers**
Office of Inspector General	95
Medicaid Fraud and Vulnerable Victims Unit	5
Total	*100*

Referrals Under Investigation from:	**# of Providers**
Optum	22
Carelon	5
Total	*27*

BHA should discuss the reasons for the delayed reports [on services for children and young adults] and when it will submit the 2024 annual report with fiscal 2023 data (page 23).

MDH apologizes for the delayed submission. As of February 24, 2025, the requested report has been submitted to the Maryland General Assembly.

Therefore, DLS recommends reducing the general fund appropriation by $9.9 million [for crisis services]. BHA should also clarify why staffing expenditures are included in this budget rather than in the BHA budget for personnel (page 25).

The Department respectfully disagrees with the DLS recommendation.

This recommendation concerns two items, Medicaid Crisis and Response Team Expansion and Crisis Stabilization Centers.

There is $8.2 million budgeted within BHA for Medicaid Crisis and Response Teams Expansion and $1.7 million budgeted for Medicaid Crisis Stabilization Centers. These services are eligible for Medical Assistance federal support but a state match is still required. The BHA funding provides support for these state share costs. These costs are budgeted within BHA rather than

within Medicaid because they are supported by the "BHA enhancements" budget, initiated in FY 2022, that is centrally budgeted and tracked by BHA, MDH leadership, DBM, the Governor's Office, and other stakeholders. Expenditures for these services will be charged to Medicaid; the Department will use a reimbursable fund relationship to account for BHA's support of the state share. Taking this reduction would eliminate state budget support for these initiatives, leaving them unfunded.

MDH acknowledges that the current spend plan for these two items does not account for federal reimbursement, conservatively estimated at $4.9 million. The Department respectfully requests to maintain full funding for the spend plan to account for continued investments in programs and initiatives that serve youth and families, such as Behavioral Health in Pediatric Primary Care Program which has been in existence since 2012, Interagency Hospital Overstay to address adolescent emergency department and inpatient overstays (pending FY 2026 legislative session SB696 / HB962), and investments in programs to address the court-ordered waitlist. This reduction would have a detrimental effect on the Department's ability to: 1) maintain critical crisis community-based services; 2) decrease emergency department wait times; 3) build upstream efforts to keep youth out of hospitals; and 4) provide potential alternatives to incarceration and diversion programs to address the court-ordered waitlist.

MDH should clarify which community resources it anticipates coming online to replace spending in this program and explain why the contract for the four new residential treatment center beds was terminated (page 28).

MDH established seven Brook Lane beds with an additional seven slated for March 2025. In August 2025 MDH also established fifteen adolescent inpatient substance-use disorder beds in partnership with Maryland Treatment Centers and Montgomery County. The Department has also invested in additional upstream impacts such as rate increases for providers for Early and Periodic Screening Diagnosis and Treatment (EPSDT), enhancements to the 1915(i) Home and Community-Based Services state plan amendment as well as the billing of school-based mental health services through Medicaid. MDH continues to evaluate the continuum of care for children and adolescents, including residential beds and other levels of care.

MDH should provide an approximate percentage of services included in an AOT program that are billable to Medicaid (page 34).

At this time, we are unable to generate a firm estimate of this percentage because the volume of clinical services received by each AOT patient, and how that volume relates to the volume of time spent on non-clinical non-billable services such as court testimony time, will widely vary depending on the content of the court-ordered treatment plan. Within these constraints, MDH expects that over 50% of AOT services will be billable to Medicaid. Legislation requires that both pre-commitment care coordination services and post-commitment treatment plan services be provided by a psychiatrist, a case manager, and a certified peer recovery specialist; under current Medicaid billing, the services of a psychiatrist, certified peer recovery specialist and case manager are Medicaid-billable. Legislation specifies that pre-commitment care coordination and post-commitment treatment plan services should be provided by an assertive community treatment (ACT) team if clinically appropriate. ACT team services are Medicaid-billable.

MDH should explain its plan to implement the AOT program in each jurisdiction, given no jurisdictions have submitted proposals or spending plans nor indicated their intention to administer the program locally, including the specific steps it will need to take to operate the program in each jurisdiction and the expected cost (page 34).

MDH is in the preliminary stages of determining its implementation plan for a state-wide, MDH-run AOT program, which will be implemented as a regional approach. This strategy has been devised, in part, as a result of no jurisdiction electing to implement AOT. Preliminary plans are as follows:

Regulations
MDH is currently in the process of drafting regulations for the AOT program, with a goal of finalizing regulations by summer 2025. MDH is utilizing its current staffing resources for the regulations process and does not anticipate additional costs associated with this.

Program Staffing
MDH anticipates that program staffing required to implement AOT statewide will include (1) A central MDH AOT team overseeing the development and implementation of the program; (2) regional AOT Care Coordination team staff; and (3) targeted expansion of Assertive Community Treatment (ACT) Capacity in the state:

(1) MDH AOT team: MDH is in the early stages of determining appropriate staffing. Roles that are being considered for the MDH AOT team include 3-5 AOT Regional Coordinators, 1 Data Analyst, and 1 Clinical Program Manager. AOT Regional Coordinators will be responsible for several components of AOT implementation work, including Stakeholder Engagement, development of Program Materials, development and implementation of training and technical assistance resources; once AOT is operational, AOT Regional Coordinators will be responsible for oversight of core AOT program functions across multiple jurisdictions, including the AOT petition referral and investigation process, coordination with the judiciary, tracking of outcomes, etc. The AOT Data Analyst will be responsible for developing and implementing an AOT data outcomes reporting system, implementing continuous quality improvement initiatives to refine the program process, and providing data-driven justifications for funding proposals such as federal grant applications. The AOT Clinical Program Manager's responsibilities will include the development of standardized clinical treatment protocols, the implementation of evidence-based practices in AOT, review of complex and high-risk AOT cases, etc. MDH is in the early stages of estimating costs for this staffing, as cost will depend on determination of the required credentials and experience of this staff.
(2) AOT Care Coordination Team staffing: MDH is in the process of reviewing several potential for providing AOT Care Coordination Team staff as well as AOT Program Leads across the state. As per legislation, the AOT Care Coordination Team consists of a psychiatrist, a case manager, and a certified peer recovery specialist. Staffing models that

MDH is reviewing incorporate a regional approach based on projected Year 1 AOT respondent capacity by jurisdiction. MDH plans to obtain these staff either through a competitive procurement targeting provider organizations, or through direct state hires. MDH estimates that the cost for this staffing will be in the range of $3,000,000 - $6,000,000

(3) Targeted Expansion of Assertive Community Treatment (ACT) Capacity: MDH has surveyed all ACT teams across the state to assess current capacity to accept new participants. Based on this data, MDH anticipates that funding will be needed to support the expansion of ACT capacity in at least 3 jurisdictions in FY26, with additional jurisdictions potentially requiring such expansion in FY27 and beyond. MDH intends to support expansion of ACT capacity via state-awarded grant funding to support the conversion of existing Mobile Treatment Services (MTS) teams to ACT teams. MDH cannot precisely estimate the cost of ACT expansion as the exact staffing needs of the ACT teams in the 3 jurisdictions requiring additional capacity for FY26 needs to be further assessed.

Stakeholder Engagement

MDH plans to continue its current stakeholder engagement efforts, and expand these efforts to connect with stakeholders in local jurisdictions. Current stakeholder engagement consists of (1) monthly engagement meetings with local behavioral health authorities and local health departments to provide updates on MDH AOT implementation and share draft operational guidance for feedback; and (2) monthly meetings with an AOT Clinical Advisory Group to receive feedback on draft clinical program guidance. MDH plans to launch a monthly consumer advisory group within the next 1-2 months, consisting of individuals with lived experience with mental illness and family members of individuals with lived experience that will also focus on obtaining feedback on draft program operational/clinical guidance. MDH anticipates that these current stakeholder engagement activities can be performed without additional cost to the department.

To implement AOT statewide, MDH anticipates that similar stakeholder engagement opportunities will need to be created for the following stakeholder groups over the next 6-9 months: (1) the circuit court judiciary; (2) the Office of the Public Defender; (3) the County Attorney; (4) Law enforcement. MDH anticipates that representation from each jurisdiction will need to be included in these engagement opportunities, and that engagement will consist of monthly contact to provide updates on AOT planning including receipt of feedback from stakeholders on the planning process and orientation to the role of each stakeholder group in the AOT process. MDH anticipates that these tasks will be completed by the MDH AOT Director and MDH AOT Regional Coordinators, and that the primary expected cost will be for the hiring of MDH AOT Regional Coordinators (see *Program Staffing* above).

Program Materials

MDH plans to create model program materials, including forms and guidance documents. Initial draft versions of several of these documents, including the AOT Treatment Plan and an AOT Housing Resource Document, are currently under review by MDH's stakeholder advisory

groups. MDH anticipates the primary cost associated with development of these materials will be staffing (see ***Program Staff)*** above.

Communications/Marketing
MDH has implemented several communications and marketing mechanisms, including the MDH AOT webpage and the MDH AOT email inbox. MDH will continue to use these platforms to obtain feedback from the public and provide public-facing updates on program implementation. MDH is leveraging internal staffing resources for communications and marketing and does not anticipate additional costs beyond current resources.

Data and Outcomes Analysis
MDH has developed a data dictionary for all required reporting elements mandated in AOT legislation. MDH intends to build an electronic reporting platform for outcome data reporting. MDH does not have a current cost estimate for data and outcome analysis as it is in the early planning stages, but anticipates that needed components will include the above-referenced MDH AOT data analyst, expansion of licensure for an existing electronic data reporting platform such as Qualtrics, and the cost of engaging the developers of an evidence-based clinical assessment tool (the Adult Needs and Strengths Assessment) to provide a modified version of this tool as well as accompanying training.

MDH should share a timeline for completing this [Behavioral Health Workforce Assessment] workplan and plans to share the workplan publicly (page 37).

The Maryland Health Care Commission (MHCC) in collaboration with the Maryland Department of Health and Department of Labor are engaged in the development of a request for proposal (RFP) for a vendor to work with the state on the next steps in implementation of the Behavioral Health Workforce Assessment. A vendor will be procured to assist with establishing the systems, interagency collaborations, program model, and determining the infrastructure required for a successful investment into the Behavioral Health Workforce Investment Fund. It is anticipated that the State will work with the vendor throughout the remainder of calendar year 2025.

DLS determined the report to be in compliance with the language and recommends the release of $250,000 in general funds restricted in fiscal 2025 pending the submission of a report on the recoupment of provider payments and an update on the ASO transition and will process a letter to this effect if no objections are released by the subcommittees (page 40).

The Department thanks DLS for its review and for the recommendation to release funds.

MDH should clarify why the final six months of the Optum contract cost nearly the same amount as a full contract year in fiscal 2024 actuals (page 40).

The Department respectfully disagrees and seeks clarification from DLS on their analysis related to contractual payments. MDH paid Optum $24,479,880.57 total funds in FY24. In the final six months of the Optum contract MDH has paid $12,123,322 for January - June 2024 and $7,820,265.10 from July through October and has received final invoices for the last two months

of the year. The ASO invoices are based on a PMPM rate for Medicaid enrollment and a flat fee for the BHA state-funded population.

DLS Budget Lock Recommendations

The Department respectfully disagrees with the DLS recommendations to restrict budget realignments. The restrictions proposed by DLS place undue stress on the budgeting process and impede MDH's ability to internally address budget shortfalls.

At minimum, MDH urges the General Assembly to allow for budget realignments within Medicaid programs to include Developmental Disabilities Administration (DDA) Community Service. If projections turn, and Medicaid or DDA Waiver program costs run higher than budgeted, realignment limitations could lead to situations where provider payments are halted if general fund appropriation is fully expended before closeout and we are not able to realign available appropriation from elsewhere in the Department.

This flexibility is important to maintain moving forward, and is especially needed now, when budget pressures disallow inclusion of any cushion that would allow for changes in enrollment, utilization, and other drivers.