MDH ATTENDEES: Ryan Moran, Deputy Secretary for Health Care Financing and Medicaid Director
Amalie Brandenburg, Chief Financial Officer

Available For Questions: TBD

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

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
February 21, 2025

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Emily Shetty
February 24, 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 discuss the reasons for Maryland MCOs reporting declines in HEDIS performance compared to the national mean from calendar 2022 to 2023. Additionally, the department should detail its method for determining moderate or major HEDIS performance issues, including the circumstances when an automatic assignment freeze of new Medicaid enrollees, financial penalty, or exclusion from PHIP would apply to MCOs (p. 13).

The purpose of the HEDIS Performance Monitoring Policy is to promote better health outcomes for Marylanders by requiring, at a minimum, 65% or more of a subset of measures to reach or exceed the Medicaid National HEDIS Mean (NHM) for that measurement year.

To determine whether MCOs have moderate or major HEDIS performance issues, the Department selects a subset of reportable Medicaid HEDIS metrics each measurement year and compares those metrics to the national average. If 35% of those metrics or more perform below the Medicaid NHM for one measurement year or two consecutive years, the Department flags it as a minor problem and sends a warning letter to the MCO of potential agency actions if performance fails to improve. Three measurement years within a five-year period, or three consecutive measurement years with 35% or more metrics below the Medicaid NHM results in a moderate HEDIS problem. Four or five measurement years within a five-year period with 35% or more metrics below the Medicaid NHM is equivalent to a major HEDIS problem.

The parameters of the HealthChoice Performance Monitoring Policies are included annually in Appendix D of the HealthChoice MCO Agreement. The policies include proposed enforcement for repeat Systems Performance Review findings (an annual compliance review), EPSDT Medical Record Review findings (an annual review to determine if providers are following the guidelines for the medical care children need at different stages of their development), network adequacy issues (actions taken if MCO provider networks are demonstrating access to care issues), and performance improvement project issues (a focused project to improve quality of care in a specific area). Specifically for HEDIS, moderate HEDIS problems include auto-assignment freezes as a potential penalty; however, during the Covid-19 PHE, financial sanctions were imposed instead of auto-assignment freezes to promote stability in enrollment. After the conclusion of the PHE, auto-assignment suspensions were reintroduced as a penalty option. Major HEDIS problems include both financial sanctions and auto-assignment penalties as enforcement options.

Overall three-year trends indicate incremental improvements for the HealthChoice program after the PHE; however, each MCO has demonstrated room for performance improvement in their individual results. In HEDIS MY 2023 alone, there were fourteen measures for which the majority of MCOs performed at or above the Medicaid NHM, including some for which the majority exceeded the national 75th and 90th percentiles. But under the HEDIS Performance Monitoring Policy, only Jai Medical Systems has successfully met the standard for multiple consecutive years (MY 2021 to MY 2023).

Beginning with measurement year 2025 (which is reported in fall 2026), an MCO may be excluded from PHIP for any HEDIS finding during the same measurement year. This exclusion is outlined in Appendix N of the 2025 HealthChoice MCO Agreement. The Department also is considering increasing financial penalties in calendar year 2026. The goals of revisiting the Performance Monitoring Policies and enhancing their intermediate sanctions structure are to increase accountability of MCOs for delivering quality care in comparison to national benchmarks, implement penalties that motivate and drive focus on improving service delivery and quality of care for HealthChoice populations, and encourage MCOs to invest resources into improving all aspects of health care for which they are responsible.

MDH should provide the current status of NCQA health equity accreditation for each MCO and the timeframe for this new accreditation requirement to be enforced (p. 13).

As of February 2025, five HealthChoice MCOs have NCQA health equity accreditation: Aetna Better Health, CareFirst Community Health Plan, Kaiser Permanente, UnitedHealthcare, and Wellpoint. Wellpoint has also received Health Equity Accreditation Plus under NCQA. MCOs are responsible for achieving health equity accreditation no later than December 31, 2025, and a readiness assessment and updated work plan for the four remaining MCOs will be due to the Department by June 30, 2025.

MDH should clarify if current PHIP population health measures already align with quality measures prioritized through the AHEAD model, and if not, discuss the new measures that the department would select beginning with the calendar 2026 HealthChoice Agreement (p. 16).

Current PHIP measures overlap with quality measures selected for PC AHEAD, the new federal Medicare model under AHEAD, and the traditional MDPCP program. These include comprehensive diabetes care (PC AHEAD, MDPCP) and controlling high blood pressure (MDPCP). As the state transitions to AHEAD, MDH seeks greater alignment for primary care quality measures, with the goal of focusing population health improvement efforts and decreasing administrative reporting burden for participating primary care providers.

MDH plans to update PHIP measures to better reflect the quality measures selected for the AHEAD program. These updates will be effective for 2026 HealthChoice agreements. MDH aims to finalize the Medicaid quality measures by the end of March 2025, taking into account measure changes announced by NCQA on February 13, 2025. Per federal guidance, MDPCP quality measures may not be changed until CY 2027. It is important to note that PHIP measures are intended to serve the full continuum of services covered by MCOs; in addition to primary care, PHIP measures will be evaluated for alignment with the full range of AHEAD measures.

DLS recommends reducing $9.2 million in total funds from a proposed fiscal 2025 deficiency appropriation for Medicaid reimbursements to account for the balance of unallocated funds for calendar 2023 MCO incentives. Given the fiscal outlook, DLS also recommends reducing $18 million in total funds in fiscal 2026, reducing PHIP incentives to 0.25% of anticipated capitated rates (p. 21).

The Department respectfully disagrees with this recommendation.

In FY 2026, the Department will pay out PHIP incentives for performance year 2024. $34 million is needed to support incentives of 0.5% of the capitation rates. MDH also needs funds to cover the Health Equity Incentive Program in FY 2026. The amount in the CY 2025 contract for Health Equity Incentive Program is $8 million total funds and will be paid out July 2025 and January 2026. This means $25 million will be needed to cover both the Health Equity Incentive Program and PHIP at 0.25% of the capitation rates.

Therefore, for FY 2026, only $11 million total funds would be able to be reduced. For FY 2025, the Department concurs that $9.2 million total funds would be able to be reduced. The Department, in coordination with DBM, plans to reflect this update through the supplemental budget process.

MDH should provide baseline membership data for each MCO across the six jurisdictions included in the calendar 2024 health equity incentive calculation and discuss whether the department has considered calculating health equity incentives based on MCO membership in neighborhoods eligible for the ENOUGH program (p. 23).

HealthChoice MCOs enrollment for the six counties with the greatest levels of socioeconomic disadvantage are included below. The factors selected to compose the index to identify these counties are socioeconomic, structural, and environmental risk factors associated with adverse health outcomes and drivers of health inequities.

Shifting to a methodology aligned with the ENOUGH program would shift allocation of dollars from a county level to a neighborhood or ZIP code basis and is something the Department could consider for future years. Please note, though, the HealthChoice capitation rate structure is based on counties.

Enrollment by MCO, CY24 Health Equity Incentive (cells <10 suppressed)

	2024 HEI MEMBERS										
		AE	CF	JM	KP	MP	MS	PR	UH	WP	TOTAL
1	Baltimore City	8,568	14,383	17,581	10,097	45,850	25,374	66,759	21,090	56,725	**266,427**
2	Dorchester	200	882			983		9,074	305	366	**11,836**
3	Somerset	143	676			515		5,900	206	518	**7,974**
4	Baltimore County	7,621	12,348	7,533	13,864	28,938	21,471	37,571	20,219	43,530	**193,095**
5	Wicomico	951	3,802		14	2,431	31	27,059	767	2,456	**37,517**
6	Allegany	659	309		18	17,186	15	1,190	252	946	**20,582**
	Total	**18,142**	**32,400**	**25,129**	**24,012**	**95,903**	**46,912**	**147,553**	**42,839**	**104,541**	**537,431**
	%	3.4%	6.0%	4.7%	4.5%	17.8%	8.7%	27.4%	8.0%	19.5%	**100.0%**

MDH should provide an update on the MHBE audit finding related to Medicaid application processing, including whether Medicaid applicants that were found to have incomes higher than the eligibility threshold have been disenrolled as appropriate. In addition, MDH should discuss corrective actions taken by the department and MHBE concerning this finding (p. 26).

In partnership with MHBE, MDH responded to OLA's audit finding on January 28, 2025 and can be found here. In summary, MHBE and MDH respectfully disagree with the audit finding and need for corrective action that would require these applicants to be disenrolled. The Department, in concert with MHBE, contends that "no income" attestations are acceptable based on attestation from the participant that they do not have income without the requirement for further supporting documentation, as per federal regulations (42 CFR 435.952(c)(2)).

Because no income attestations are acceptable, there may be instances where the state income data would naturally be inconsistent with the applicant's actual income. An example of this would be following an applicant's recent loss of employment, which would not be reflected for some time in state income data base systems, but would be accurately represented in the no income attestation, leading to an understandable inconsistency.

It is also important to note that individuals reviewed by OLA during this time period could also not be disenrolled for any reason due to requirements to retain coverage through at least the end of the public health emergency in May 2023.

DLS recommends reducing the proposed deficiency appropriation by $162.5 million in total funds ($51.6 million in general funds) to account for the calendar 2021 and 2022 risk corridor recoveries (p. 30).

The Department concurs with DLS regarding the budget savings associated with this item. MDH is working with DBM to use the anticipated savings through a supplemental budget request to address projected budget shortfalls within the Developmental Disabilities Administration.

DLS recommends amending the [Maryland Primary Care Program Fund] BRFA provision to correct these technical errors (p. 34).

The Department concurs with the DLS recommendation to address these technical items.

DLS recommends deleting $16 million in general funds for the new Medicaid Primary Care Program Fund and authorizing a budget amendment to allocate special funds for this purpose (p. 35).

The Department, in consultation with DBM, respectfully disagrees with this recommendation. The FY 2026 budget bill mistakenly omitted a contingent reduction to reduce the $16 million general funds contingent upon the receipt of special funds for this purpose. DBM plans to correct this through the supplemental budget process.

DLS recommends adopting a committee narrative requesting a report from MDH, in collaboration with HSCRC, evaluating the MDPCP and providing a status update on the new Medicaid Advanced Primary Care Program as well as other primary care initiatives (p. 35).

The Department concurs with DLS recommendation and looks forward to providing reports on primary care programs in partnership with HSCRC.

DLS recommends rejecting this BRFA provision so that funding for entitlement programs within MDH continue to be restricted to their budgeted purpose, allowing for certain transfers as specified in budget language. DLS also recommends adding budget bill language for fiscal 2026 restricting funds for Medicaid and MCHP reimbursements to that purpose. Under the recommended language, funding can be transferred between Medicaid and MCHP programs, including M00Q01.10 Medicaid Behavioral Health Reimbursements (p. 36).

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.

DLS recommends amending this BRFA provision to increase the authorized fund balance transfer to $14.1 million to transfer all remaining [Maternal and Child Health Population Health Improvement Fund] funds following the expiration of the use of the funds at the end of calendar 2025 (p. 37).

The Department is supportive of *SB213 / HB 170 - Health - Maternal and Child Health Population Health Improvement Fund - Use* which permits use of the fund following its current sunset date of December 31, 2025. The Maternal and Child Health Population Health Improvement Fund supports Medicaid initiatives to address severe maternal morbidity, in alignment with the inclusion of MCH as a population health priority area. These monies are eligible for federal matching dollars. Critical services provided include home visiting services, doula services, and case management interventions to support prenatal and postpartum care, along with pregnant participants who have opioid use disorder.

The proposed increase in the recommended transfer would impede the Department to provide these services in future fiscal years beyond FY 2026. SB 213 and HB 170 of 2025 would allow the Department to spend any unspent funds through CY 2027. The Department supports the additional transfer if this legislation is enacted.

DLS recommends deleting $18.2 million for the Health Home program under traditional Medicaid as a technical correction to reflect the realignment of this program to M00Q01.10 Medicaid Behavioral Health provider Reimbursements (p. 37).

The Department respectfully disagrees with the DLS recommendation to reduce funding. While the accounting for this item has shifted from program M00Q01.03 to M00Q01.10, the Allowance for this item is reflected only in program M00Q01.03 only. The full funding amount therefore should be retained in the Legislative Appropriation.

MDH should provide a status update for the MMT project, including year-to-date fiscal 2025 spending and planned uses of the remaining balance of general funds (p. 38).

MMT consists of fourteen (14) Major IT Development Projects. These projects are in various stages of the project lifecycle.

Project	Status	Status Update
MMT - CMS Interoperability Final Rule	On Track	The planning phase was completed ahead of schedule and MDH is now entering the Design, Development and Implementation (DDI) phase.
MMT - Behavioral Health ASO	On Track	The new ASO launched on January 1, 2025 per schedule.
MMT - Dental Administrative Services (DASO)	On Track	The vendor award was approved by the BPW on February 7, 2025. Once the vendor schedule has been delivered and approved, we will begin the DDI phase.
MMT - Decision Support & Enterprise Data Warehouse	On Track	The planning phase was completed ahead of schedule and MDH is now entering the DDI phase.
MMT - Consolidated Call Center	On Track	This project is on track with the planning phase to be completed by August 30, 2025.
MMT - Enterprise Document Management System	On Track	This project is on track with the planning phase to be completed by June 30, 2025.
MMT - Business Process Reengineering & Consolidated CRM	On Track	This project has three active workstreams this fiscal year. One workstream has been implemented and two are in development.
MMT - Surveillance Utilization Review Subsystem (SURS)	On Track	The project is preparing to enter the procurement phase in 2025.
MMT - MES Claims Module	On Track	This project is in the planning phase. MDH is focusing on documenting system requirements, business rules, and conducting market research to define the project approach and scope.
MMT - Utilization Control Agent (UCA)	On Track	The system went live September 2024. MDH is continuing to monitor the vendor performance.
MMT - Provider Management Module	On Track	Implementation is planned for October 2026. The users are entering into the second phase of User Acceptance Testing which will end March 14, 2025.
MMT - EDI Gateway	On Track	The project is preparing to enter the procurement phase in 2025.
MMT - Non-Emergency Medical Transportation	On Track	The project is preparing to enter the procurement phase in 2025.
MMT - Hospice, Medical Day Care, & 257 Automation	On Track	The MDC module went live on January 13, 2025. The additional modules are on track for delivery later in CY 2025.

To date, the Medicaid MITDP portfolio has spent $3,526,854 in general funds, this includes invoices received through December 2024.

For the remaining months of FY 2025 below is the planned spend for these projects.

MMT Planned Spend Remaining FY 2025							
Project	**Jan**	**Feb**	**March**	**April**	**May**	**June**	
Behavioral Health ASO 2.0 (BHASO)	$558,481	$402,916	$573,857	$402,916	$402,916	$402,916	**$2,744,004**
Business Process Re-Engineering (BPR)	$121,226	$96,068	$106,576	$106,576	$106,576	$158,355	**$695,376**
Consolidated Call Center and IVR	$13,751	$13,751	$38,751	$38,751	$38,751	$38,751	**$182,509**
CMS-Inter-operability Rule (CMS)	$57,976	$57,976	$57,976	$57,976	$57,976	$57,976	**$347,857**
CORE MMIS	$26,052	$26,052	$26,052	$26,052	$26,052	$26,052	**$156,309**
Dental Administrative Services Organization (DASO)	$46,462	$46,462	$46,462	$46,462	$46,462	$46,462	**$278,774**
EDI Gateway	$20,502	$20,502	$20,502	$20,502	$20,502	$20,502	**$123,015**
Electronic Document Management System (EDMS)	$11,551	$11,551	$29,051	$29,051	$29,051	$29,051	**$139,309**
Hospice, MDC, & 257 Automation	$71,477	$71,477	$71,477	$71,477	$71,477	$71,477	**$428,865**
Enterprise Data Warehouse (DSDW)	$87,093	$87,093	$87,093	$87,093	$87,093	$87,093	**$522,557**
Non-Emergency Medical Transportation (NEMT)	$32,751	$32,751	$32,751	$32,751	$32,751	$32,751	**$196,509**
Provider Management Module (PMM)	$283,635	$393,635	$233,635	$233,635	$233,635	$373,635	**$1,751,809**
Surveillance Utilization Review Subsystem (SURS)	$53,019	$53,019	$53,019	$53,019	$53,019	$53,019	**$318,115**
Utilization Control Agent (UCA)	$281,259	$281,259	$281,259	$281,259	$281,259	$281,259	**$1,687,553**
Total General Funds							**$9,572,559**

DLS recommends adding a provision to the BRFA of 2025 to expand the allowable uses of the SPDAP Fund in fiscal 2026 and future years to include depositing funds into health reimbursement accounts of certain State retirees transitioning to Medicare Part D to align with the budget (p. 41).

In consultation with the Department of Budget and Management, the Department respectfully disagrees with this recommendation. The SPDAP fund source was included in error in the

FY 2026 DBM Statewide Account and DBM plans to correct it in the Legislative Appropriation. The fund source should instead be F10310 Various State Agencies.

Due to the fiscal outlook, DLS recommends deleting $12.2 million budgeted for enhanced physician E&M rates in fiscal 2026 (p. 42).

The Department respectfully disagrees. Physicians were the only Medicaid provider in FY 2025 to receive a cut. Long term services and supports, behavioral health and DDA providers all received a 3 percent increase. Additionally, the HSCRC has given hospitals multiple increases in FY 2025.

The $12.2 million is simply restoring the cut taken in FY 2025 and maintaining the physician fee schedule from FY 2024. The care management requirements under the AHEAD Model's Medicaid Advanced Primary Care Program–which aim to improve care of our most vulnerable residents with multiple chronic conditions–will drive referrals to specialty providers. Maintaining a robust and comprehensive physician network is vital to the success of the AHEAD model, including the success of Medicaid primary care providers under the value-based performance schema.

Therefore, DLS recommends reducing $90.7 million in total funds to lower MCO rates for calendar 2025 to the bottom of the actuarially sound range (p. 42).

The Department respectfully disagrees.

The Department has updated the expected CY 2025 mid-year acuity adjustment using data through December 31, 2024. The actuaries are estimating that $165 million is needed rather than $124 million. This assumes that the capitation rates are set at 1% above the bottom of the actuarial sound range. CY 2024 rates were set at 1.25% above the bottom of the actuarial sound range. CY 2025 was set at 1% above the bottom of the actuarial sound range.

If CY 2025 rates are set at the bottom of the actuarial rate range, $98.9 million will be needed for the mid-year acuity adjustment. This means that the most available to cut based on this recommendation should only be $25.1 million total funds; however, this number is also likely to change based on other factors that may increase MCO rates for CY 2025 during a midyear adjustment.

For example, any changes the HSCRC makes to hospital rates for FY 2026 later in the Spring would increase rates needed. Also, our HealthChoice MCOs are managing significant enrollment swings this year, making it difficult to manage a higher acuity population. Lastly, setting the rates at the bottom of the actuarial sound range would mean that some MCOs will lose money if the proposed reduction is implemented. The current CY 2025 rates build in a 1.3% profit margin.

Due to there being no mandate for an additional rate increase for Medicaid LTSS providers in fiscal 2026 and the significant increases provided over the last decade, DLS recommends reducing $21.2 million for a 1% provider rate increase that would take effect July 1, 2025 (p. 44).

The Department acknowledges this recommendation.

DLS recommends reducing HCBS provider rates by 2% effective July 1, 2025, due to the end of federal ARPA support for the 5.2% rate increase that was in place since November 1, 2021 (p. 44).

The Department respectfully disagrees with this recommendation to reduce HCBS provider rates by 2%. According to the Ensuring Access to Medicaid Services Final Rule (CMS-2442-F), effective July 9, 2024, at a reduction level of 2%, CMS requires an analysis and a public comment period for any rate reductions or rate restructuring to ensure that reductions or restructuring do not result in diminished access to care. The analysis must include a summary of the proposed change, comparison of payment rates before and after the proposed change along with a comparison to comparable Medicare rates, metrics related to provider capacity and participant population, information related to the services impacted by the change, and a summary of responses to complaints received regarding the proposed change. CMS must provide approval for any rate reductions or restructuring ahead of the proposed change after review of the analysis provided by the State. Reducing rates without prior approval from CMS could put Maryland Medicaid's federal match at risk.

Furthermore, this proposed reduction does not support the End the Wait initiative to reduce registries or waitlists by 50% for HCBS programs. Rate sufficiency is paramount to ensuring an adequate provider network to serve additional participants enrolled to achieve the goals of the End the Wait Act.

Due to the budget overstating healthcare utilization, DLS recommends reducing the fiscal 2025 proposed deficiency appropriation by $100 million in general funds (p. 48).

The Department respectfully disagrees with the recommendation. The Department also wishes to work with DLS to understand more detail and analysis behind this recommendation as the Administration continues to see strong utilization trends related to increased clinical acuity for physical and behavioral health that follow national trends.

The DLS analysis specifically notes forecasts differed significantly particularly for inpatient utilization. The chart below compares fee-for-service inpatient utilization used to formulate the FY 2025 deficiency with the actual utilization through January 2025 stat pack. Utilization for inpatient services has actually increased through January, or effectively held neutral, for all major coverage groups except Pregnant Women and HPE-All Other.

	FY25 Deficiency Submission (actuals through Sept)	January Stat Pack		Deficiency vs	Deficiency vs
	FY25 Projection	FY25 YTD avg	FY25 Projection	Jan YTD	Jan Projection
T309 Elderly	0.217	0.219	0.219	0.002	0.001
T318 Disabled Children	4.260	4.703	4.676	0.443	0.417
T319 Disabled Adults	0.547	0.573	0.568	0.026	0.021
T331 Children	5.207	5.497	5.064	0.290	-0.144
T336 Other Eligibles	0.021	0.020	0.019	-0.001	-0.001
T337 Pregnant Women	1.253	1.016	1.080	-0.237	-0.173
T343 Parents & Caretakers	0.315	0.333	0.330	0.018	0.016
T369 Former Foster Care	0.623	1.849	1.609	1.226	0.987
T372 ACA New Adults	1.581	2.069	1.967	0.488	0.385
T382 Undocumented Immigrants	41.820	53.470	50.201	11.650	8.381
T384 HPE - All Other	9.290	4.357	5.940	-4.933	-3.350

As a result of lower projected enrollment in fiscal 2026, DLS recommends reducing the fiscal 2026 allowance for Medicaid by $90 million in total funds ($35 million in general funds) and for MCHP by $42.8 million in total funds ($15 million in general funds) (p. 48).

The Department respectfully disagrees that enrollment projections should be reduced. Through the Consensus Budgeting Process with DLS, the Administration has provided detailed and refined assumptions for enrollment as it moves to establish a new baseline of enrollment by the end of FY 2025. The Department strongly affirms these enrollment estimates and is committed to its continued transparency around enrollment data reporting for DLS to monitor enrollment trends throughout FY 2026.

The chart below illustrates FY 2025 year-to-date enrollment through January by category and compares those figures to the FY 2025 deficiency and Governor's Allowance projections. As illustrated below, the FY 2025 deficiency projection for traditional enrollment is actually slightly lower than the FY 2025 year-to-date average, and the ACA population is trending 10% higher than what is assumed in the FY 2025 deficiency projection. The FY 2026 Governor's Allowance assumes a moderate enrollment increase of 1% for traditional enrollment, a 3% increase for MCHP, and an overall decline of 2% inclusive of the ACA population based on pre-COVID enrollment trends.

Enrollment Category	FY 2025 YTD Average	FY 2025 Deficiency Projection	*% Difference YTD v. Deficiency*	FY 2026 Governor's Allowance	*% Change FY 2025 Deficiency to FY 2026 Governor's Allowance*
Parents/Caretakers	249,187	235,695	*5%*	239,080	*1%*
Elderly	47,435	47,399	*0%*	47,356	*0%*
Disabled Adults	92,097	99,043	*-8%*	99,745	*1%*
Disabled Children	19,224	19,243	*0%*	19,610	*2%*
Other	71,060	72,078	*-1%*	75,186	*4%*
Pregnant Women	20,986	20,285	*3%*	21,525	*6%*
Children	496,164	501,679	*-1%*	505,330	*1%*
Former Fost Care	816	803	*2%*	790	*-2%*
EMS Undocumented	1,339	1,326	*1%*	1,257	*-5%*
HPE Pregnant Women	-	-	*0%*	-	
HPE All Other	6	8	*-33%*	8	*0%*
ACA New Adults	391,945	353,870	*10%*	309,479	*-14%*
MCHP	142,945	143,502	*0%*	148,404	*3%*
MCHP Plus*	43,511	41,798	*4%*	43,226	*3%*
Healthy Babies	8,452	9,628	*-14%*	9,628	*0%*
Traditional Only	**998,314**	**997,559**	***0%***	**1,009,887**	***1%***
MCHP Only	**194,908**	**194,928**	***0%***	**201,258**	***3%***
Traditional, ACA, and MCHP	**1,585,166**	**1,546,357**	***2%***	**1,520,624**	***-2%***

Further, it is important to note that these projections were solidified without an appreciation for how changes at the federal level may impact Medicaid enrollment. As Maryland has a disproportionately higher share of federal workers and government contractors, impacts to Maryland's workforce by current and future decisions at the federal level will potentially increase Medicaid enrollment; therefore, it is our opinion that this moment is too full of risk to endorse adjusting enrollment to achieve savings.

The only enrollment projection that can reasonably be lowered, although modestly, relates to the Healthy Babies Initiative. The actual average enrollment for July 2024 through October 2024 is 8,800. The Department does not recommend lowering the FY 2026 estimate to 8,452 individuals per DLS recommendation, but rather to 8,900 individuals, resulting in savings of $5,175,960 GF (xxx TF). DBM is working on a related supplemental budget item to recognize these savings.

DLS recommends deleting funding for the 13 long-term vacant positions that have remained unfilled for more than two years (p. 48).

The Department respectfully disagrees with the recommendation to delete funding for these vacant positions. While we recognize DLS concern of the long-term vacancy of these positions, the Department has transitioned to new leadership within the Office of Eligibility Services (OES) and Office of Long Term Services and Supports (OLTSS), and it is the highest priority to fill these vacant positions to support the eligibility team in determining timely review of Medicaid enrollment applications, which aids in the shared goals of the legislature to ensure efficient and accessible pathways to enroll in Medicaid and reduce waitlists within home and community-based service waiver programs.

All identified positions are moving forward to being filled to support important efforts across the Medicaid program.

- Five (5) of these identified positions are currently pending a commitment letter to be sent to the desired incumbent. These roles are expected to be filled in the next two weeks. These positions are crucial to the processing of home and community-based services (HCBS) applications in support of the Developmental Disabilities Administration (DDA) and OLTSS "End the Wait" initiative.
- Three (3) of these identified positions are currently posted on the JobsAps site for active recruitment after a process of reclassifying roles to better meet the needs of the OES and OLTSS. These positions are crucial to complete contract monitoring functions related to supporting activities to support medical reviews for Medicaid eligibility purposes.
- Five (5) of these positions are being transferred to the Department of Corrections and Public Safety to support efforts in collaboration with the Department to expand Medicaid services to people leaving incarceration prior to release. These roles are envisioned to navigate participants in this program to enroll in Medicaid coverage and connect to necessary community supports. This transfer will be reflected in the Administration's supplemental budget request.

Therefore, DLS recommends adding a provision to the BRFA of 2025 delaying the expansion of biomarker testing from July 1, 2025, to July 1, 2027 (p. 50).

The Department respectfully disagrees with this recommendation. CH 322 / CH 323 of 2023 requires the Maryland Medicaid program to provide broad coverage for biomarker testing beginning July 1, 2025. This was a priority for the Legislative Black Caucus in 2023 that passed both chambers with near unanimous votes. The State's current fiscal challenges have prevented the Administration from being able to fully implement the vision for this initiative in FY 2026, which was projected to cost $24 million in State funds in FY 2026 increasing to $45 million by FY 2030. The $8 million proposed in the budget focuses additional testing to have the greatest impact on eliminating health disparities and improving health outcomes.

DLS recommends reducing $10.8 million in fiscal 2026 for the ACIS expansion and returning to the pilot program's funding mechanism of using local spending to draw down federal reimbursement (p. 51).

The Department respectfully disagrees. The local spending to support ACIS in Baltimore City was largely funded by the hospitals. The hospitals have stopped providing this support. Additionally, the local health departments have likely not budgeted for these funds and are

facing other budget cuts that would make reallocating the dollars necessary for ACIS challenging. Cutting this program would result in the loss of critical services needed to support individuals experiencing housing insecurity.

CMS approved expansion of ACIS to 2,140 spaces in December 2024. $2,184,541.00 in GF would be sufficient to sustain the program at its pre-expansion allocation of 620 spaces for both FY 2025 and FY 2026.

Under the ACIS Pilot Program, the Department works with local government agencies, known as Lead Entities (LE), to provide a set of home and community-based services (HBCS) to eligible participants. The ACIS pilot has been in effect since July 1, 2017 through present. Under this pilot, tenancy-based case management services/tenancy support services and housing case management services, are provided to eligible Medicaid participants to assist them in obtaining the services of state and local housing programs. In addition, ACIS locates and supports the individual's medical needs in the home, and/or housing case management services. Four jurisdictions currently participate in ACIS. The four counties/cities are

- Baltimore City Mayor's Office of Homeless Services
- Cecil County Health Department
- Montgomery County Department of Health and Human Services
- Prince George's County Health Department

In the fall of 2023, the Hilltop Institute published the Assistance in Community Integration Services Program Assessment (Calendar Year (CY) 2018 to CY 2021). This evaluation indicated positive health and housing outcomes for ACIS participants. Overall, 77 percent of pilot participants received stable housing, including more than 90 percent of participants in Baltimore City and Prince George's County. There was also a statistically significant reduction in the mean number of ED visits and inpatient admissions. Additionally, ACIS participants with four or more ED visits in the pre- versus post-ACIS year declined 37 percent.

For more information on the evaluation, see https://health.maryland.gov/mmcp/Documents/HealthChoice%20Community%20Pilots/ACIS/SummaryReportACISProgramAssessment-September2023-For%20Dept%20%281%29.pdf.

Given the State's budget challenges and expected federal reductions in Medicaid funding for states, the General Assembly should carefully consider whether the most recent [EID Program, Prosthetics Coverage, Gender-Affirming Treatment, Collaborative Care, Adult Dental Expansion, Healthy Babies Equity Act] enhancements to Medicaid are affordable (p. 52).

The Department advises that action at the state and federal levels would be required to terminate these programs and for cost savings to occur. At the federal level, the Department would need to develop and submit amendments to the Medicaid and CHIP State Plans to remove these programs from the entitlement. Within the state, statutory and regulatory changes would be needed, followed by systems changes within the Department, MHBE, and the Department's contractors, including DentaQuest and the HealthChoice MCOs. The Department anticipates a minimum of six to 12 months for implementation and the onset of cost savings.

The Department respectfully requests the opportunity to work with the General Assembly as it assesses potential programmatic changes or cuts.

MDH should provide an estimate for the annualized cost to continue the phase one expansion of school-based behavioral health services in fiscal 2026 (p. 55).

In FY 2026, Medicaid will leverage $25,774,186 TF ($12,034,259 GF, $13,739,927 FF) in funding from BHA's budget.