MDH ATTENDEES: Meena Seshamani, MD, PhD, Secretary
Perrie Briskin, Deputy Secretary, Health Care Financing and Medicaid Program
Jennifer Maher, CFO, Health Care Financing and Medicaid Program

Available For Questions: TBD

Maryland Department of Health (MDH) Medical Care Programs Administration
Fiscal Year 2027 Operating Budget
Response to Department of Legislative Services Analysis

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Emily Shetty
February 25, 2026

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
March 2, 2026

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 why the [annual PHIP] report was not yet available and brief the committee on MCOs' measurement year 2024 results under the PHIP, including performance and improvement incentive payments shown separately for each MCO (p. 12).

The annual PHIP report for Measurement Year (MY) 2024 was finalized on February 13, 2026, and has been shared with DLS. It is now available on the HealthChoice Quality Assurance website.

For MY 2024 performance in PHIP, the HealthChoice MCOs earned 62% of available Round 1 incentives. Three MCOs earned seven of eight available Round 1 Tier 1 incentives: Kaiser Permanente, Maryland Physicians Care, and Priority Partners. UnitedHealthcare earned the fewest Round 1 Tier 1 incentives (three of eight). For Round 1 Tier 2 improvement incentives, Priority Partners earned five improvement incentives, followed by Maryland Physicians Care and Wellpoint, who were tied at four improvement incentives. CareFirst and Kaiser both earned the fewest improvement incentives (one). To earn Round 2 incentives, MCOs needed to earn at least 80% of Round 1 incentives. No MCO reached that threshold; however, two MCOs earned 79% of available Round 1 incentives: Maryland Physicians Care and Priority Partners. UnitedHealthcare earned the fewest available incentives at 25%.

MDH should discuss the primary reasons for delays in processing non-MAGI cases and comment on the feasibility of reporting monthly application processing measures that show the number of applications processed in more than 45 days by MHBE and 90 days by DHS (p. 14).

For non-MAGI cases in Maryland, eligibility requires coordinated review by multiple state entities, including the operating agency (e.g., OLTSS, DDA, MSDE, or BHA), financial review by the Eligibility Determination Division (EDD) within Maryland Medicaid, and, when disability has not been established by the Social Security Administration (SSA), a disability determination by the DHS State Review Team. All of these steps must occur within the same 90-day federal timeframe. The 90-day federal processing requirement applies to the entire Medicaid eligibility determination period; beginning on the date of application and ending when a final eligibility decision is made. The Maryland Health Benefit Exchange (MHBE) is responsible for processing MAGI eligibility determinations and does not process non-MAGI cases.

The primary reasons for delays in processing non-MAGI HCBS waiver financial eligibility by EDD include the following:

1. **IT system limitations:** Non-MAGI financial eligibility determinations are processed in the Eligibility & Enrollment (E&E) system, while medical and technical eligibility determinations are processed in LTSSMaryland. Limited system functionality leads to interoperability issues and a reliance on manual processing steps that contribute to delays. The E&E system is overseen by Maryland Benefits and supports eligibility processing for SNAP, TANF, and non-MAGI Medicaid populations.

2. **Data and reporting limitations:** At this time, E&E is not configured to routinely produce operational reports that track application processing timelines, including the number of applications exceeding 45 or 90 days. In February, following sustained coordination with Maryland Benefits, MDH obtained access for the Hilltop Institute to E&E data. This will allow Hilltop to view application data from submission, requests for information, time frames, to types of determination. Using this data, Hilltop plans to produce an up-to-date dashboard for MDH which would provide evidence based insight into application processing and delays. While this is a critical step forward, additional

system development and validation will be required before MDH can reliably produce monthly reports on non-MAGI processing timeliness.

3. **Staffing constraints:** Staffing challenges within EDD, the Office of Long-Term Services and Supports (OLTSS), DDA, and other waiver-administering agencies have resulted in application backlogs, limited training capacity for new staff, and delays in completing eligibility actions that are interdependent across agencies.

For non-MAGI cases, as noted above, MDH does not currently have the ability to consistently report monthly counts of applications exceeding 45 or 90 days due to the E&E system's reporting limitations. With recent data access and continued collaboration with Maryland Benefits, MDH is assessing the feasibility of producing these measures on a routine basis in the near-term.

DLS recommends reducing the fiscal 2026 deficiency for prior year service costs by $70 million, including $10 million in general funds, based on year-to-date actual carryover spending. Following this reduction, the deficiency would still provide approximately $12 million in general fund support beyond current estimated need (p. 14).

MDH respectfully disagrees with the DLS recommendation to reduce the FY 2026 deficiency supporting service year 2025 carryover claims. Provider behavior with respect to claims submission is difficult to project. While it is possible that $12 million GF would be enough to address remaining carryover claims, this is far from certain. Last year, the Medicaid program paid $22.7 million GF in carryover claims from February through June for service year 2024, and the year before that, the program paid $31.8 million GF for service year 2023 carryover claims during that period. If the program were to exhaust the carryover claims budget before all prior year claims are paid, those costs would be applied against appropriation budgeted for service year 2026 program costs. Stretching the current year appropriation to the point where it cannot cover all current year expenditures would expose our Department to a repeat audit finding. We therefore ask that rather than impose a negative deficiency, the General Assembly allow us to work with DBM to make this item a targeted reversion.

MDH should provide an update on the negotiation with CMS related to the nursing facility rate disallowance and how this would be resolved without additional payment needed from the State. Additionally, MDH should clarify how much is outstanding in VLBW payments to MCOs (p. 15).

<u>Nursing Facility Rate Disallowance</u>
Maryland Medicaid is currently in discussion with CMS about a budget neutral path forward by the end of FY26 that can account for the rate increase without additional penalty to Maryland. CMS mentioned increasing the rates prospectively to the Medicare upper payment limit to address the federal match that would otherwise need to be paid back. Medicaid will work closely with CMS in upcoming meeting and follow the instruction provided.

Very Low Birth Weight Payments

The amount of outstanding VLBW payments due to MCOs is estimated to be $1.2 million TF for claims prior to FY26.

DLS recommends reducing the fiscal 2026 deficiency appropriation for Medicaid provider reimbursements by $151.4 million ($44.2 million in general funds) to account for the MLR recovery received in fall 2025 (p. 18).

MDH respectfully disagrees with the DLS recommendation to reduce the current year budget to account for MLR recoveries received in fall 2025. The MLR recoveries are one item among dozens that push the Medicaid somatic services budget in the direction of deficit or surplus. Rather than make such a large reduction to the budget based on this one item, and in light of potential budget drivers that could push this particular budget into deficit, and to provide budget flexibility should other areas of Medicaid require budget support post-session, we ask that this reduction not be taken.

To ensure the [Cigarette Restitution Fund] appropriation is not provided twice, DLS recommends adding budget bill language to make this funding contingent on enactment of this BRFA provision (p. 23).

MDH concurs with this recommendation.

DLS also recommends amending the contingent language [regarding the CHRC funding mandate] as a technical correction to more closely align with the applicable provision in the BRFA (p. 23).

MDH concurs with this recommendation.

MDH should provide an update on any federal guidance or notice that it has received in regard to provider assessment policies, including whether the department is planning to make any changes to gain CMS approval and meet uniform and broad-based tax requirements (p. 24).

CMS issued a final rule on provider taxes on January 29, 2026, effective April 3, 2026, implementing the provider tax provisions enacted under H.R. 1. Under the final rule, CMS prohibits provider taxes that impose higher effective tax rates on Medicaid services or enrollment than on non-Medicaid activity, that tax providers with higher Medicaid volumes at higher rates than those with lower Medicaid volumes, or that have the same practical effect even if structured differently. CMS also revises its waiver framework, clarifying that non-uniform provider taxes are no longer automatically approvable based on statistical tests alone; instead, CMS retains discretion to deny waivers that conflict with the statute's intent.

The rule establishes transition periods for states to bring existing taxes into compliance. Managed care organization (MCO) taxes face the earliest deadlines, generally by January 1, 2027, or by the start of state fiscal year 2028 depending on when the waiver was approved, while

the other two provider taxes (hospitals and nursing facilities) must comply by the start of state fiscal year 2029.

MDH is continuing to review its current provider taxes with CMS. Based on additional, direct CMS technical assistance informed by the recent final rule, the Department will consider whether adjustments can or need to be made to its existing provider assessments to maintain funding.

DLS recommends reducing $3.0 million in general funds budgeted in DBM for health reimbursement accounts of certain State retirees transitioning to Medicare Part D in anticipation of an equivalent SPDAP fund balance transfer. This reduction will appear in the analysis for F10A02 – DBM Personnel (p. 26).

MDH will defer to DBM's response to the F10A02- DBM Personnel budget analysis. MDH acknowledges that the current SPDAP revenue balance can support the proposed $3 million realignment to DBM. However, given recent and upcoming SPDAP revenue transfers to the Behavioral Health Administration for Community Mental Health Services ($10 million across FY 2025 and FY 2026) and to DBM for Health Reimbursement Accounts for certain State retirees ($3.1 million in FY 2025 and FY 2026), the SPDAP's ability to implement new Program benefits or benefit levels in the future, i.e. increasing the current premium subsidy benefit in future years or providing a subsidy to help SPDAP enrollees partially offset their Medicare Part D Prescription Drug Plan (PDP) deductible costs, becomes problematic. Uncertainty regarding potential future changes in SPDAP enrollment, unknown future fluctuations in monthly Medicare Part D premium costs, and SPDAP Fund transfers, could leave the SPDAP underfunded in the future. Continued realignment of revenue might force the SPDAP to implement a "Waiting List" for new applicants and/or decrease current benefit levels for the SPDAP enrollment.

MDH should provide fiscal 2026 year-to-date spending from the Maternal and Child Health Population Health Improvement fund and describe why eligible programs under Medicaid and PHPA underspent the appropriation, leading to a large fund balance. Additionally, MDH should clarify how it will spend the remaining fund balance and should work with DBM to adjust the fiscal 2026 appropriation and fiscal 2027 allowance through a supplemental budget to accurately reflect planned spending in each year (p. 28).

This MCH Population Health Improvement Fund is budgeted across Medicaid and Prevention and Health Promotion Administration (PHPA). We anticipate that the full $40 million will be obligated by the 12/31/27 sunset date, inclusive of BRFA actions to realign fund revenue to the State General Fund. MDH will review the current year and request year special fund budgets for these activities and work with DBM to address any needed appropriation adjustments.

See chart below showing YTD and projected expenditures for fund expenditures in PHPA and Medicaid programs.

Subprogram/Service (YTD Expenditures Date)	FY 2026 YTD Expenditures	FY 2026 Total Proj. Expend.
M00F0301N357/Asthma Home Visiting (1/31/26)	$84,280.19	$633,601.09
M00F0301N358/Asthma Community-Based Interventions (1/31/26	$7,740.45	$7,740.45
M00F0304N448/Maternal and Child Health SIHIS (1/31/26)	$170,017.27	$261,266.65
M00Q0103/Medicaid Provider Reimbursements (2/3/26)	~$500,000.00	$1,100,000.00
Total	*$762,037.91*	*$2,002,608.19*

Current year PHPA projects supported by the fund include work by the Maternal and Child Health Bureau to expand the number of accredited home visiting and CenteringPregnancy providers, as well as work by Environmental Health for asthma prevention. PHPA is on track to fully spend its overall share of the fund revenue.

Within Medicaid, the fund supports Medicaid doula, home visiting, CenteringPregnancy, HealthySteps, and Maternal Opioid Misuse (MOM) services. Payments are made through MCO capitation and are subject to a risk corridor on a calendar year basis. For CY 2025, $7.7M was built into the risk corridor, and so far $2.1M TF has been spent, with $1M of state share costs supported by the special fund. However, due to claims run-out over a 12-month period, this amount will grow. Looking specifically at state FY 2026, the total spend is 1.1M as of 2/3/26, with $500k of that amount tied to the state share supported by the fund.

Slow uptake of new services among the Medicaid population is not unexpected, but Medicaid has seen strong growth in utilization of these MCH services since FY23. Medicaid continues to enroll providers and work with our MCOs to inform eligible members of benefit availability. Current performance improvement projects focus on perinatal health and include interventions to increase benefit participation. Interventions include:

- Coordinate and collaborate with the local county health departments (LHDs) to cultivate improved provider completion and timely submission of Maryland Prenatal Risk Assessments (MPRAs) to the LHD/MCOs. Standardize an electronic workflow for MPRA.
- Contract Medicaid-enrolled Doulas, implement a referral workflow, and increase enrollee engagement.
- Expand doula and home visiting services (HVS) network, implement a referral workflow, and increase enrollee engagement.
- Increase the number of identified pregnant enrollees with substance use disorder (SUD) and integrate workflows to increase the number of identified pregnant SUD enrollees into enhanced case management.

- Establish community-based substance use provider partnerships to identify pregnant persons with Opioid Use Disorder (OUD) and refer them to the Maternal Opioid Misuse (MOM) Case Management Program.
- Implement a second CenteringPregnancy location.

MDH should brief the committees on the need for this [Pharmacy Services System] project, including the planned project schedule. Additionally, MDH should clarify whether the MITDP will also support other pharmacy services provided by PHPA. DLS recommends reducing $1.35 million in general funds budgeted in the Information Technology Investment Fund within DoIT and authorizing a budget amendment to replace the funding with federal funds to account for expected federal fund participation of 90% for this project. This reduction will appear in the analysis for F50 – DoIT (p. 29).

MDH is pursuing the Pharmacy Services System project to replace the current Conduent Pharmacy Benefits Management system contract, or Pharmacy Point-of-Sale Electronic Claims Management Services (POSECMS). The Conduent Pharmacy contract expires June 2029 and starting this project now provides MDH adequate time to complete the procurement process and implement the new system.

MDH is currently drafting the Request For Proposal (RFP) to solicit the new claims and benefits management system. Pharmacy services provided by the Prevention and Health Promotion Administration (PHPA) are intended to be included in the RFP, including the Kidney Disease Program, Breast and Cervical Cancer Diagnosis and Treatment, and the Maryland AIDS Drug Assistance Program.

The FY 2027 MITDP should reflect 90% project support through the Medicaid federal participation match. More recent cost estimates, however, lead MDH to believe that overall project costs in FY 2027 will run closer to $2.5 million, rather than $1.5 million, which would require $250,000 of state share support. We therefore request that the Information Technology Investment Fund budget associated with this project be reduced by $1.25 million rather than the $1.35 million recommended by DLS. We also request that this $1.25 million be realigned to support the state share of FY 2027 project costs associated with another MDH Medicaid MITDP, the Provider Management Module (PMM), to better align with projected expenditures.

MDH should describe any outreach methods that it is using to inform Medicaid participants that services received from Planned Parenthood would not be covered through July 4, 2026 (p. 42).

Maryland Medicaid notified all nine HealthChoice managed care organizations (MCOs) that services provided by Planned Parenthood would not be covered under the HealthChoice program through July 4, 2026. Consistent with established HealthChoice requirements, MCOs are responsible for communicating coverage changes to their enrolled members, including provider network changes and non-covered services.

MDH conducts oversight of MCO member communications to ensure compliance with contractual requirements and federal access standards. In addition, MDH has communicated with providers and stakeholders regarding the coverage limitation to support appropriate referral and continuity-of-care planning.

Separately, MDH notes that Planned Parenthood affiliates in the Metro DC region have received replacement funding support and may continue to provide certain services outside of Medicaid coverage.

MDH should comment on the feasibility and timing of using these data sources to automate and verify work requirements and exemptions, including data sharing policies that are already in place and ways to ensure data security of all program participants (p. 44).

MDH is in conversations with other state agencies, federal agencies, and other data sources to identify and create new data streams to further automate and verify work requirements and exemptions.

- SNAP enrollment and income data from DHS, considering DHS already administers work requirements under SNAP and Medicaid implements express lane eligibility for SNAP recipients
    - Status: MDH, through MHBE, already uses data from the SNAP program to renew MAGI individuals through the Express Lane Eligibility (ELE) program. MDH and DHS are working to augment that data feed to include whether an individual is subject to SNAP work requirements. These conversations are underway and systems staff are discussing.
- Wage and workforce development data from the Maryland Department of Labor (DoL)
    - Status: MDH, through MHBE, uses wage data from DoL. Further conversations are underway to determine how workforce development data may be shared and used to verify work requirements. MDH, DoL, and MHBE meet bi-weekly to continue work on this topic.
- Health records from the Chesapeake Regional Information System for our Patients (commonly referred to as CRISP) to automate medical exemptions for individuals with qualifying diagnoses or conditions
    - Status: Through existing data sharing agreements, CRISP has access to all Medicaid claims. Conversations are underway to create an API to enable MHBE to receive a medical frailty flag for applicable individuals, based on a predetermined definition of medical frailty. In addition, a flag may be returned to indicate if an individual meets the inpatient exemption. MDH notes that only an indicator will be returned to MHBE when processing an application or renewal. PHI will not be stored in MHBE's system.
- Education and workforce data from the Maryland State Department of Education (MSDE), considering MDH and MSDE currently have a data sharing agreement for direct certification of students for free and reduced priced lunch eligibility

    - Status: MDH has determined that the National Student Clearinghouse has more comprehensive data that may be used to determine an individual's education enrollment status. MDH and MHBE have been regularly meeting with the National Student Clearinghouse to determine next steps related to this data stream.
- Tax return information from the Comptroller of Maryland
    - Status: MHBE uses tax return data from the Comptroller for the Easy Enrollment Program. MDH, MHBE, and the Comptroller's Office have met to discuss if there is further utility for this information.

DLS recommends adopting narrative requesting two reports on OBBBA implementation, including the effects on eligibility redetermination and disenrollment (p. 44).

MDH concurs with this recommendation. We will note that MDH, on a quarterly basis through JCRs, already reports the following measures, and will use the existing report content to inform two new reports on OBBBA:

- the number of eligibility renewals completed, including the number and share that were automatically renewed, with modified adjusted gross income (MAGI) cases and non-MAGI cases shown separately;
- the number of new individuals enrolled;
- measures of churn;
- the number of individuals disenrolled by reason for disenrollment, identifying procedural disenrollments and disenrollments due to overscale income, aging out, and other common reasons for disenrollment.
- call center volume, average wait times, and average call center abandonment rate as submitted to the Centers for Medicare and Medicaid Services; and
- measures of application processing times and the total number of applications processed for MAGI cases and non-MAGI cases shown separately.

MDH should provide a status update and timeline for implementation of new outreach strategies and requirements for Medicaid participants with ESRD diagnoses to apply for Medicare. Additionally, the department should discuss whether there are other conditions or diagnoses that would qualify Medicaid participants for Medicare and should be included in these outreach efforts (p. 45).

In Fall 2025, Maryland Medicaid launched an initiative to connect participants with ESRD who appear to be categorically eligible for Medicare to the application for Medicare coverage. MDH has contacted each Medicare-eligible ESRD participant by mail with information to help guide them through the process of applying for Medicare benefits. Contact information for the nearest SSA offices, the local State Health Insurance Program (SHIP) office, as well as with a counselor at the local Maryland Access Point (MAP) Office are included. MDH also sends a follow-up letter 30 days after the initial letter is mailed and if no response is received from the participant.

MDH is dedicated to building partnerships with providers and state agencies to further encourage Medicare enrollment of ESRD patients. MDH plans to issue a transmittal in March to encourage providers delivering services to ESRD patients that have the infrastructure and services to help coordinate SSA applications, to partner with MDH in the outreach effort. Providers can support MDH in reinforcing the state communications by following-up directly with patients and providing them with assistance in applying for Medicare coverage.

DLS recommends reducing $8.0 million, including $3.0 million in general funds, in fiscal 2027 to account for savings from Medicaid participants with ESRD enrolling in Medicare as a result of MDH's outreach efforts (p. 46).

MDH respectfully disagrees with this recommendation. MDH acknowledges Medicaid's role as the payor of last resort for ESRD services, and is working to implement this initiative to leverage Medicare eligibility, but at the same time we must balance the need to maintain coverage for those with ESRD through the implementation period.

Full implementation will require additional operational build out within Medicaid eligibility systems. System enhancements are necessary to capture Medicare application status, track compliance, generate appropriate notices, and ensure proper coordination with the MMIS-II claims management system. These system changes require design, development, and testing before any savings could be reliably projected. As a result, MDH cannot project fiscal savings in FY 2027 absent completed system modifications. Eligibility system resources are strained with ensuring compliance with H.R. 1 implementation timelines.

MDH is working with the Hilltop Institute to perform an analysis of the take up rate from the ESRD outreach letter. Early estimates indicate about 20% of approximately 1,300 consumers contacted have applied for Medicare but no attributable savings have been reported. MDH will continue to monitor application rates to Medicare and successful transition to Medicare coverage for individuals contacted. Additionally, MDH is releasing a provider transmittal offering an opportunity to ESRD providers/ dialysis facilities to partner with MDH in its outreach efforts to encourage Medicaid participants with ESRD to apply for Medicare coverage.