MDH ATTENDEES: Douglass Jacobs, MD, Executive Director, Maryland Health Care
                          Commission
                          Mark Luckner, Executive Director, Maryland Community Health
                          Resources Commission
                          Jon Kromm, Executive Director, Health Services Cost Review
                          Commission
                          Andrew York, Executive Director, Executive Director,
Prescription

                          Drug Affordability Board

Available For Questions: TBD

Maryland Department of Health (MDH) Health Regulatory Commissions
Fiscal Year 2027 Operating Budget
Response to Department of Legislative Services Analysis

Senate Budget and Taxation Committee
Health and Human Services Subcommittee
Senator Cory McCray
March 6, 2026

House Appropriations Committee
Health and Social Services Subcommittee
Delegate Emily Shetty
March 9, 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.

*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. (pg. 3)*

MHCC Response: MHCC, the Comptroller's office, and MVA have coordinated to fully
recover the $3.7 million transferred in error to the Shock Trauma Center in FY 2025, ensure all

documentation is accurate and reflects this correction, and reconcile all payments to the Shock Trauma Center. As of February 25, 2026 this error is fully addressed.

HSCRC should comment on how its implementation of hospital assessments may change due to the OBBBA provision and uniform and broad-based tax requirements. (pg. 5)

HSCRC Response: CMS issued its final rule on Medicaid provider taxes on January 29, 2026. Per the final rule, hospital taxes–such as Maryland's Medicaid Deficit Assessment–will need to come into compliance by the start of SFY 2029. Maryland's current taxes, including the Medicaid Deficit Assessment, are under CMS review, and MDH has requested direct technical assistance to determine if changes will be needed to maintain compliance once the requirements go into effect. HSCRC staff are working closely with the Medicaid team at MDH to determine what changes might be necessary, if any, to ensure the assessment is broad-based and uniform.

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. (pg. 7)

CHRC Response: The CHRC closed FY 2025 with a fund balance of $2,318,858. The CHRC does not have concerns with the DLS recommendation that the CRF contribution in FY 2027 be reduced by $2 million, provided that the CHRC's total appropriation for FY 2027 remains at $8 million. This amount will enable the CHRC to fulfill its current statutory responsibilities.

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. (pg. 12)

The Maryland Department of Health concurs with this recommendation and thanks DLS for its support.

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. (pg. 14)

In 2024, in partnership with Hilltop and HSCRC, MDH conducted a [full evaluation](#) of the Maryland Primary Care Program (MDPCP) for program years 2019-2022. MDH intends to lead, in collaboration with HSCRC and Hilltop, a full evaluation of MDPCP's performance under the Total Cost of Care (TCOC) Model, evaluating program outcomes for the years 2019-2025. This full evaluation will commence in 2027 to allow time for all 2025 Medicare claims to run out (by December 31, 2026). In the interim, MDH will continue to provide DLS with annual progress reports on the primary care programs under AHEAD.

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. (pg. 18)

CHRC Response: The CHRC considers several factors when making award decisions and funding allocations. These factors include how a proposal is evaluated during the review process (more on this below); priorities determined by local jurisdictions; student population; financial need (as calculated by FRPM enrollment, as pointed out in the DLS analysis); and grantee performance.

In addition, the Blueprint requires the Consortium to ensure that grant funding does not supplant or duplicate efforts that are already under implementation in local jurisdictions. For this reason, the Consortium requires a letter of support from the Local Education Agency attesting that applicant programs are not already funded through another mechanism. Also, the Consortium works closely with local school districts to ensure that Consortium-funded projects reflect local unmet needs and local priorities.

All CHRC grant award decisions are highly competitive and the CHRC utilizes a thorough and rigorous review process. Below is the CHRC and Consortium's review process.

1. All applications are scored on a 100-point scale according to criteria listed in the Request for Applications (RFA) such as local need, organizational capacity, program design, and others. Consortium proposals are scored by the National Center for School Mental Health, the technical assistance provider to the state under the Blueprint, and a second reviewer who is a member of the CHRC or Consortium.

2. The review prioritizes programs that respond to local priorities and gaps in existing services. Consortium grants may not supplant or duplicate existing services, and are required to bill Medicaid for any billable services.

3.   Grantee performance is another consideration. The CHRC prioritizes the continuation of high-performing Consortium grantees to support continuity of care. Poor performance can result in non-renewal.

4.   The CHRC considers financial and social need. Applicants must use quantitative data to demonstrate financial and social need. Reviews also factor in a jurisdiction's total student population and FRPM rate.

The Consortium's overall mandate is to provide comprehensive, nonstigmatized behavioral health and wraparound services to all students, pre-k through grade 12 statewide. The Consortium is responsible for developing a statewide framework for the coordinated delivery of these services through the development of local Community Supports Partnerships.

During its first year, the Consortium provided grants directly to service providers. The program served more than 136,945 students across the state in 86% of schools. 87% of students and families reported satisfaction with services. 73% of students demonstrated a desired behavioral health outcome or improvement as a result of the services. The Consortium also expanded local capacity to provide services: 705 new behavioral health workforce members were hired, and 1,620 providers were trained in evidence-based practices to support student behavioral health. An additional 5,946 school staff also received training in behavioral health practices.

Now in its second year, the Consortium has established seven full-scale Community Support Partnerships across the state, and these CSPs collectively serve 12 jurisdictions. The grants in year two have already served more than 109,000 students this school year across all jurisdictions. The satisfaction rate is 90% and more than 86% of students have demonstrated improvement or stability. After award decisions are made later this spring, 20 of 24 jurisdictions will be served through full Community Supports Partnerships, and there are plans in place to achieve statewide coverage of CSPs in the following year. The CHRC continues to manage service implementation in jurisdictions not represented by a full CSP until the model is adopted statewide.

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. (pg. 22)

PDAB Response: The Prescription Drug Affordability Board (PDAB) has discussed that it would like to complete the Cost Review Study Process for the first 6 drugs by mid-to-late this year. For each drug, this would include publishing the final Cost Review Study Report documenting their findings, approval of any non-upper payment limit (UPL) policies and recommendations, and approving the proposed rules establishing a UPL if the Board decides to

set one. Farxiga and Jardiance are furthest along in the process, and are on track to be completed this spring. Ozempic and Trulicity on track to be completed this summer, and Skyrizi and Dupixent to be completed this fall.

The implementation timelines for UPLs and non-UPL policies may vary depending on the specific recommendations or policies. Regulations that establish UPLs will have an implementation date, as well as any additional details that may affect the implementation and timeline. Non-UPL policies can vary from taking action to propose legislation to conducting additional research and studies, and each of these policies can have their own timeline.

PDAB is supporting the multi-agency regulatory working group related to the AHEAD model. The PDAB believes that there is significant opportunity in advancing prescription drug price transparency under the model to encourage consumer choice, and the PDAB will continue to support the working group wherever possible.

Maryland Health Care Commission

FISCAL YEAR 2027

BUDGET PRESENTATION

TO THE LEGISLATURE

M00R0101

The Maryland Health Care Commission

The Maryland Health Care Commission is a 15-member independent regulatory commission organized around the health care systems we evaluate, regulate, or influence, utilizing a wide range of tools (data gathering, public reporting, planning and regulation) to improve quality, address costs, and increase access.

Our Mission:

Is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

Our Roles

► Plan for health facility development;

► Measure and make transparent aggregate cost and quality data;

► Enable information technology innovation;

► Convene and engage stakeholders; and

► Assess health policy options

MHCC 2026 Vision Priorities

The Maryland Health Care Commission's overarching goal in the next four years is to reduce health care disparities while improving health care access, quality, outcomes, and cost in Maryland; MHCC will achieve this by focusing on four strategic priority areas.

Access

Focus on primary care, workforce, utilization management, and coverage.

Action Items address:

- Primary care targets and investments
- Incorporating primary care investments into Certificate of Need
- Workforce strategy that addresses Gradual Medical Education
- Telehealth funding
- Prior authorization
- Data integration to ensure eligible individuals continue to receive social service and support benefits

Reducing Disparities

Focus on quality and safety, competition, primary care, and data.

Action Items address:

- Identifying plans/providers delivering high quality care to underserved populations
- Connecting medical and social service providers
- Health equity focused mapping tool
- Encouraging entrants in underserved areas, strengthen health equity criteria in CON
- Prioritizing investments in care for underserved communities in Trauma Grants

Value

Focus on quality and safety and competition.

Action Items address:

- Improving quality in long term care facilities
- Increasing consumer, discharge planner use of MHCC quality data
- Increasing authority and data transparency for mergers, acquisitions, ownership changes, and corporate transactions
- Improving surveys and leveraging AI to share additional information with consumers
- Introducing competition in monopolistic markets

Operations

Focus on infrastructure, data, communication, and workforce.

Action Items address:

- Calibrating MHCC budget to reflect priorities and vision
- New website and comms
- Database improvements (APCD, CRISP) and data hub for internal and external use
- Building staff capacity to use data to answer policy questions
- Streamlining processes, modernizing systems to improve monitoring, reporting, revenue collection
- HIT strategy to guide planning, innovation, and responsible use of AI

Organizational Structure

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                    │     Executive Direction     │
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Center for Analysis & Information Systems	Center for Quality Measurement & Reporting	Center for Health Planning	Center for Health Information Technology & Innovative Care Delivery

Center for Analysis and Information Services

▶ **Monitor Costs and Quality**

- Produces annual reports and issues briefs on spending and health care coverage
- Collaborates with MDH on expanding the health care work force and reducing health care disparities

▶ **Enhance Maryland Care Data Base (the state's all-payer claims database)**

- Analyzes the database to better inform valuation of services
- Using the database to set and monitor all-payer spending targets in AHEAD
- Collecting information on claims subject to prior authorization
- Collaborates with MIA in enhanced rate review

▶ **Develop Data and Software**

- Develops information dissemination systems
- Manages data acquisition, data release and data use agreement compliance
- Conducts data analysis for sister MHCC centers

Center for Quality Measurement and Reporting

▶ **Health Plan Quality and Performance**

  • Publishes HMO/PPO Consumer Guide and collaborates with Maryland Health Benefit Exchange to provide quality reporting on QHPs

▶ **Long Term Care Quality and Performance**

  • Publishes Nursing Home and Assisted Living Guides

  • Monitors flu vaccine rates among health care facility workers

▶ **Hospital Quality and Performance**

  • Publishes Hospital Guide, reports on hospital efforts in surgical infection prevention, and supports HSCRC quality improvement efforts

  • Maintains quality outcome measures

▶ **Maintains Maryland Health Care Quality Reports Website**

  • https://www.marylandqmdc.org/

Center for Health Planning

▶ **Acute Care Planning**

- Planning & policy development for regulation of hospital, ambulatory surgical, and other acute care services

▶ **Long Term Care Planning**

- Planning and policy development for regulation of nursing home, home health agency, hospice services

- Oversees and reviews nursing facility transactions to protect Marylanders

▶ **Certificate of Need**

- Management of the Certificate of Need (CON) program, regulating the supply & distribution of hospitals & hospital bed capacity, nursing homes & nursing home bed capacity, surgical facilities & services, specialized hospital services, home health agency services, hospice services, residential treatment centers, & intermediate care facilities

Center for Health Information Technology and Innovative Care Delivery

▶ **Innovative Care Delivery**

- Partners with MDH, local health departments, and providers on advanced primary care initiatives including AHEAD and primary care targets

- Supports practice transformation (e.g., team-based care, data-sharing and infrastructure)

▶ **Health Information Exchange**

- Advances health IT diffusion statewide to balance information sharing and privacy and security

- Designates the state HIE; manages, oversees, and audits CRISP

- Oversight of HIE-related Rural Health Transformation work, in collaboration with MDH

- Working with CRISP, DHS, and MDH to link information that would qualify individuals for exemptions related to HR1 implementation for Medicaid and SNAP

▶ **Health Information Technology**

- Collaborates with payers and providers to promote use of health IT

- Establishing standards for electronic exchange of prior authorization processes between plans and providers

- Working with Electronic Health Networks to protect Legally Protected Health Information and expand data collection for the Maryland Patient Care Database (MCDB)

MHCC'S IMPACT IN FISCAL YEAR 2025

Access

- Published the primary care investment report, worked with primary care investment workgroup to set targets.
- Worked with payors to meet prior authorization benchmarks for electronic prior authorization.

Reducing Disparities

- Displaying health equity accreditation on consumer-facing quality website.
- Worked with MDH to establish maternal health score card.
- New trauma grant funding that supports care delivered to underserved populations.

Value

- Implemented program to oversee nursing home acquisitions to ensure that future ownership changes prioritize quality, patient safety, and affordability.
- Published report on provider and plan consolidation and its effect on the health care marketplace.

Operations

- Improved program integrity for the Maryland Trauma Physician Services Fund with more accurate and timely claims processing, reporting, and independent auditing.
- Improvements for user fee assessment process to improve accuracy, timeliness, and completeness.

MHCC Fiscal Year 2027 Budget Allowance

FY 2027 Allowance - $99,522,071

1. Operating Budget - $23.6 million

    •   Industries Assessed – Payers, Hospitals, Nursing Homes, and Health Occupation Boards

    •   FY 2025 Closing Fund Balance - $5,358,273

    •   Total Permanent Staff : 56.0 FTE

    •   Total Contractual Staff: 1.0 FTE

2. Managing Critical Funds – Trauma and Maryland Patient Safety Center

    •   Maryland Trauma Physicians Services Fund - $22,000,000 (*estimated*)

    •   Maryland Trauma Grants – $5,000,000 *(estimated)*

    •   Shock Trauma - $38,000,000 (*estimated*)

3. Serving where we can help in FY 2027

    •   Sustaining the MDPCP - $600,000