



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

August 25, 2026

The Honorable Guy Guzzone, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes, Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

RE: 2026 Joint Chairmen's Report (p. 149-150) – Report on Financing for Long-acting Injectable Medication

Dear Chairs Guzzone and Barnes:

Pursuant to the requirements of the 2026 Joint Chairmen's Report (pages 149-150), the Maryland Department of Health is respectfully submitting this report on financing for long-acting injectables (LAIs). This report includes research and background on LAIs, an overview of Medicaid's existing policy as well as HSCRC's role in regulating hospital rates, and considerations for carving LAIs out of the all-payer facility-based Global Budget Revenue agreement.

If you have any questions or comments concerning the report, please contact Meghan Lynch, Director of Governmental Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary

cc: Perrie Briskin, Deputy Secretary, Health Care Financing and Medicaid
Alyssa Brown, Director, Innovation, Research, and Development
Meghan Lynch, Director, Office of Governmental Affairs
Janice Lepore, Health Services Cost Review Commission
Sarah Albert, Department of Legislative Services (5 copies)



Financing for Long-Acting Injectable Medication

2026 Joint Chairmen's Report p. 149 - 150

September 1, 2026

Introduction

In keeping with the requirements of the 2026 Joint Chairmen’s Report (JCR) pages 149-150, the Maryland Department of Health (the Department) respectfully submits this report on financing for Long Acting Injectables (LAIs). Specifically, this report provides the following information about LAIs:

- Whether the Department and Health Services Cost Review Commission (HSCRC) have evaluated the potential for carving LAIs out of the hospital daily rate, including any impacts on operations, the rate setting processes, and federal considerations;
- The process by which the Department could establish a State Plan Amendment (SPA) for LAI services for Medicaid enrollees in Maryland and how it would interact with the hospital daily rate set by HSCRC;
- The projected impact of carving out LAI services on behavioral health spending through the Medicaid program and hospital finances;
- Research on the impacts of early initiation of LAIs in inpatient settings on reducing readmissions or lengths of stay in emergency departments in Maryland; and
- Utilization of LAIs under current practice in Maryland.

Research and Background

Long Acting Injectables (LAIs) are controlled-release medications that deliver treatment over an extended period of time through an injection. Compared to daily oral medications, LAIs offer a more prolonged drug delivery with one dosage lasting 2-24 weeks, depending on the drug.¹ While there is increasing discussion about the potential of leveraging LAIs for HIV, diabetes, and other conditions, currently LAIs are most often used for providing treatment to individuals living with serious mental illnesses (SMI), especially schizophrenia and bipolar, and substance use disorders (SUD), particularly opioid use disorder (OUD). This report will focus on the use of LAI for individuals with SMI and SUD.

Research on patient outcomes after receiving LAIs in inpatient and ED settings is quite limited; much of the current research focused on the use of LAIs, specifically buprenorphine (LAI-B), for individuals with OUDs. For example, a 2026 study investigated the impact of LAI-B in emergency departments and found that there was no detectable difference in the patients’ engagement with treatment after 7 days when given LAI-B compared to sublingual buprenorphine.²

¹ Source: National Alliance on Mental Illness

<https://www.nami.org/treatments-and-approaches/mental-health-medications/long-acting-injectables-lais/>

² D’Onofrio G, Herring AA, Hawk KF, et al. Emergency Department–Initiated Buprenorphine for Opioid Use Disorder: A Randomized Clinical Trial. JAMA. 2026;335(11):948–960. doi:[10.1001/jama.2025.27019](https://doi.org/10.1001/jama.2025.27019)

Other research suggests that LAIs are effective when short term follow-up is limited, such as when a patient is unable to get to an outpatient clinic easily.³ This includes 30 day LAIs for patients leaving carceral settings, going to skilled nursing facilities for short term rehabilitation, or who experience barriers traveling to an outpatient buprenorphine provider post hospital/emergency department stay.

Regardless of patient setting, LAIs appear to be advantageous in reducing relapse of individuals with low adherence rates, according to a 2025 meta-analysis of 25 observational studies. For example, in cases of individuals with schizophrenia, whose average oral antipsychotic adherence rate is estimated to be less than 60%, LAIs appear to be associated with higher adherence rates, lower rehospitalization rates, longer time to treatment failure, and lower nonsuicidal mortality rates.⁴ Overall, this research suggests that LAIs have the potential to be helpful in patient care, but more research is needed.

LAI Coverage and Utilization

Under existing Maryland policy, LAIs are included in the rates set by HSCRC (explained in more detail in the following section) and reimbursed by Medicaid in inpatient and outpatient settings. Coverage is approved regardless of whether the medication is Tier 1 or Tier 2 on the Department's Preferred Drug List (PDL). In addition, prior authorization and step therapy are not applied for any of these medications.

The Medicaid program does not impose additional oversight or utilization management on LAIs prescribed to patients in inpatient or emergency department settings. The LAI medications may be prescribed at the time of discharge or pre-discharge.

Maryland has experienced steady growth in LAI use in both hospital outpatient (overall) and emergency department (ED) settings (a subset of outpatient) over the last three years. From FY23 to FY25, behavioral health (BH) LAI utilization for Medicaid participants increased from 609 to 1,215 visits⁵ in hospital outpatient settings (Table 1), and from 117 to 607 visits in the subset of outpatient ED settings (Table 2). This is a growth in charges from \$1.5 to \$3.3 million in overall outpatient settings, and from \$400k to \$1.9 million in ED settings. While the number of high utilizer patients (those with four or more outpatient visits during the fiscal year) who received LAIs has remained steady during the past three years (Table 3), ED utilization of patients receiving LAIs has increased. Notably, the number of unique patients with three or more ED visits increased from 11 to 29 between FY24 and FY25 (Table 4).

³ 2021 PubMed Central [Long-Acting Injectable Antipsychotic Use in Patients with Schizophrenia and Criminal Justice System Encounters](#)

⁴ [Schizophrenia in adults: Pharmacotherapy with long-acting injectable antipsychotic medication](#)

⁵ These counts reflect the number of visits, not the number of unique beneficiaries.

Table 1: Overall Outpatient BH LAI Utilization by Payer

Payer	FY23 Visits	FY23 Total Charges	FY24 Visits	FY24 Total Charges	FY25 Visits	FY25 Total Charges
CHARITY/SELF PAY	20	\$58,851.32	51	\$103,433.90	75	\$198,200.79
COMMERCIAL	293	\$907,796.30	292	\$1,187,312.24	371	\$1,385,274.19
MEDICAID	609	\$1,568,425.89	930	\$2,433,316.54	1,215	\$3,296,342.70
MEDICARE	883	\$2,490,024.77	1,199	\$4,295,750.24	1,616	\$6,041,328.58
OTHER	*	\$42,265.88	53	\$187,415.49	64	\$296,686.34

*Values less than 11 are suppressed; Source: HSCRC Outpatient Discharge Data

Table 2: ED (Subset of Outpatient) BH LAI Utilization by Payer

Payer	FY23 Visits	FY23 Total Charges	FY24 Visits	FY24 Total Charges	FY25 Visits	FY25 Total Charges
CHARITY/SELF PAY	11	\$27,763.27	48	\$100,448.79	73	\$188,671.55
COMMERCIAL	94	\$327,480.61	203	\$800,814.12	300	\$1,155,503.16
MEDICAID	117	\$439,545.13	326	\$909,753.91	607	\$1,954,686.60
MEDICARE	150	\$767,267.82	538	\$2,601,118.01	1,005	\$4,868,938.85
OTHER	*	\$42,265.88	52	\$184,752.95	63	\$292,864.01

*Values less than 11 are suppressed; Source: HSCRC Outpatient Discharge Data

Table 3: Overall Outpatient BH LAI Utilization by Unique Beneficiary

Total LAI Visits by Unique Beneficiary	FY23	FY24	FY25
1	344	1,077	1,774
2	44	72	130
3	18	28	33
4+	116	112	110

*Values less than 11 are suppressed; Source: HSCRC Outpatient Discharge Data

Table 4: ED (Subset of Outpatient) BH LAI Utilization by Unique Beneficiary

Total LAI Visits by Unique Beneficiary	FY23	FY24	FY25
1	319	1,027	1,725
2	24	52	107
3+	*	11	29

*Values less than 11 are suppressed; Source: HSCRC Outpatient Discharge Data

Maryland Policy and Financing

HSCRC and Hospitals

In Maryland, hospitals' financing of medications, including LAIs, are overseen by the Maryland Health Services Cost Review Commission (HSCRC), an independent state agency that works alongside the Department to ensure affordable access to high-quality health care for all Marylanders. HSCRC is charged with setting and regulating hospital rates, advancing health system transformation, and supporting the innovative Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model to improve care quality, health outcomes, and cost-efficiency.

All regulated acute-care Maryland hospitals operate under all-payer facility-based Global Budget Revenue (GBR) agreements. Regulated services are defined in statute, and include all inpatient services, emergency department services, and outpatient services delivered on a hospital's campus for each of Maryland's 43 acute-care hospitals and 8 Freestanding Medical Facilities. In addition, HSCRC sets commercial rates only for four psychiatric hospitals and one pediatric specialty hospital, none of which operate under GBRs. Other services a hospital may provide, such as care within off-campus outpatient clinics, do not fall under HSCRC regulations. HSCRC is required by statute to ensure that hospital costs are reasonable, rates are set equitably across all purchasers, and that revenues for regulated services are broadly aligned with aggregate costs.⁶

The all-payer component of the Maryland approach means that all payers, including Medicare, Medicaid, commercial payers, and self-pay patients are charged generally the same rates for the same services at a given hospital. Maryland's GBR approach operates on a prospective, population-based model where the HSCRC sets a predictable annual revenue target for each facility based on a number of factors, including inflation, population growth and demographics, quality performance, capital investments, specific hospital needs, and grant programs. The GBR methodology is developed, adjusted, and adapted through collaborative work led by the HSCRC and including stakeholders from across the health care sector. The annual rate setting process, known as the Update Factor, also includes significant collaboration with industry stakeholders, and is directly informed by detailed data provided by hospitals themselves. This approach differs markedly from payment structures that reimburse using daily or diagnostic rates, sometimes termed 'bundled' payments.

⁶ Maryland Health-General Article §19-219

Global Budget Incentives and Long Acting Injectables

Among other goals, the GBR approach seeks to mitigate incentives that may exist under fee for service systems, such as increasing service delivery in order to increase revenue, and instead incentivizes a focus on preventative care and improved long-term outcomes.

Quality and performance incentives are deeply integrated into the GBR methodology in order to ensure high-value care and patient safety. The HSCRC operates several hospital quality programs that link a percentage of hospital revenue with outcomes related to potentially avoidable hospital utilization, such as increased patient safety, reductions in readmissions, and fewer treatment complications. These initiatives align financial incentives with outcomes such that improved hospital performance in these areas benefit both the financial health of the hospital and the overall health of its population. Further, given the all-payer nature of Maryland's hospital quality models, including the Readmissions Reduction Incentive program, Maryland hospitals have a greater incentive to reduce readmissions for all patients, including patients with Medicaid coverage. Finally, opportunities exist within the methodology for hospitals to make use of innovative or new treatments that may improve care outcomes and reduce costs long-term, such as the Cost of Drugs Sold - Audit (CDS-A) and the Service Carve-Out Policy. Services prioritized for carve-out under the GBR⁷ include highly acute and specialized services that are not ideal for a population-based methodology due to their variable nature (*e.g.*, unpredictable or inconsistent cost, volume, length of stay, or care pathway).

Considerations on Carving LAIs out of the GBR

As referenced above, the GBRs for each hospital are developed based on case mix and cost reporting provided to the HSCRC by each facility.⁸ In this reporting, hospitals provide detailed operational and financial information, including inpatient and outpatient volumes, hospital revenues, care-related expenses and overhead expenses. The use and administration of medications during the course of care, including LAIs, are included in case mix and cost report data provided by hospitals, and as such are embedded within the rates set by the HSCRC for relevant services.

Operationally, hospitals charge assigned unit rates for each service provided, and are responsible for tracking revenue, services and charges in order to and make adjustments as needed and to remain within given allowances for their GBR. Hospitals submit data to HSCRC on a monthly basis, which HSCRC reviews to ensure that budgeted rates and total global budget revenues

⁷ For a comprehensive discussion of the 2026 Global Budget Carve Out policy, please see the HSCRC July Commission meeting materials, pp521 - 548;

<https://hscrc.maryland.gov/Documents/July%202026%20POST%20MEETING%20-FINAL.pdf>.

⁸ For comprehensive information on hospital case mix and cost reporting, please refer to the HSCRC Accounting and Budget Manual; https://hscrc.maryland.gov/Documents/WayneN%20Files/SECTION%20500_10.1.24.pdf.

remain in compliance. Penalties are assessed on an annual basis if hospitals are not in compliance; however, under certain conditions hospitals may present special circumstances and request exceptions. In addition, hospitals may request and present data for consideration by HSCRC staff as part of the service carve-out policy.

Within payment models that rely on daily or diagnostic rates, sometimes referred to as ‘bundled’ payments, hospitals are reimbursed a set price for service delivery, with no additional incentive tied to outcomes or future utilization. Within such a payment model, ‘carving out’ the cost of high-cost therapies, such as LAIs, and reimbursing these costs separately, may incentivize their use. In contrast, the design of Maryland’s global budget structure provides strong financial incentives to use therapies and treatments that contribute to improved outcomes and reduce overall treatment costs, such as reductions in readmissions and subsequent lengths of stay, as these benefit the financial health of the hospital as well as the patient.

Medicaid Considerations

To carve LAIs out of hospital inpatient and emergency department Medicaid rates, the Department would need to update its Medicaid State Plan, in consultation with the HSCRC. A Medicaid State Plan is the agreement between Maryland and the federal government (overseen by the Centers for Medicare and Medicaid Services) that outlines how Maryland administers its Program.⁹ To amend the State Plan, Maryland would need to provide one public notice period (30 days) announcing its intent to amend the Maryland State Medical Assistance State Plan under Title XIX of the Social Security Act.¹⁰

Then, the Department can draft and submit the amendment to CMS for review. The amendment would include:

- Cover letter
- Copies of the public notice documents
- The amended pages of the State Plan
- A description of the change proposed including fiscal impact
- Standardized forms to ensure successful processing

Customarily, CMS asks questions about the State Plan Amendment prior to approval. Approval timelines can vary; the median number of days between submission and approval of a SPA in CY 2024 was 69 days. If CMS issues a request for additional information (RAI), the median number of days increases by 155.¹¹ Upon CMS approval, the amendment is added to the State Plan and the State can begin drawing down federal match for the new service.

⁹ Source: Medicaid State Plan Amendments. <https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments>.

¹⁰ A copy of Maryland’s State Plan is found on the MDH website:: <https://health.maryland.gov/mmcp/Pages/Maryland-Medicaid-State-Plan-.aspx>.

¹¹ Source: 2025 Medicaid Scorecard, [State Plan Amendment and 1915 Waiver Processing](#).

Conclusion and Next Steps

The unique elements of the Maryland hospital payment model include strong incentives to reduce unnecessary hospital utilization and promote preventative care, such as the use of LAIs, when clinically appropriate. The recent data indicating steady growth in the use of these medications in the hospital setting suggests that these incentives are effective, and that Maryland's hospital payment model is not creating barriers to the use of LAIs. Consultation with the hospital industry regarding access to and use of LAIs did not surface any concerns or known barriers to their use. Finally, given that there is no 'daily rate' within the GBR structure, the mechanism of focus for this report (*i.e.*, 'carving out' from a daily or bundled rate) could not be easily enacted in Maryland. Maryland Medicaid and HSCRC will continue to monitor this benefit moving forward, and collaborate to ensure timely access to behavioral health care in Maryland.