Maryland Department of Health
Fiscal 2027 Budget Overview

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

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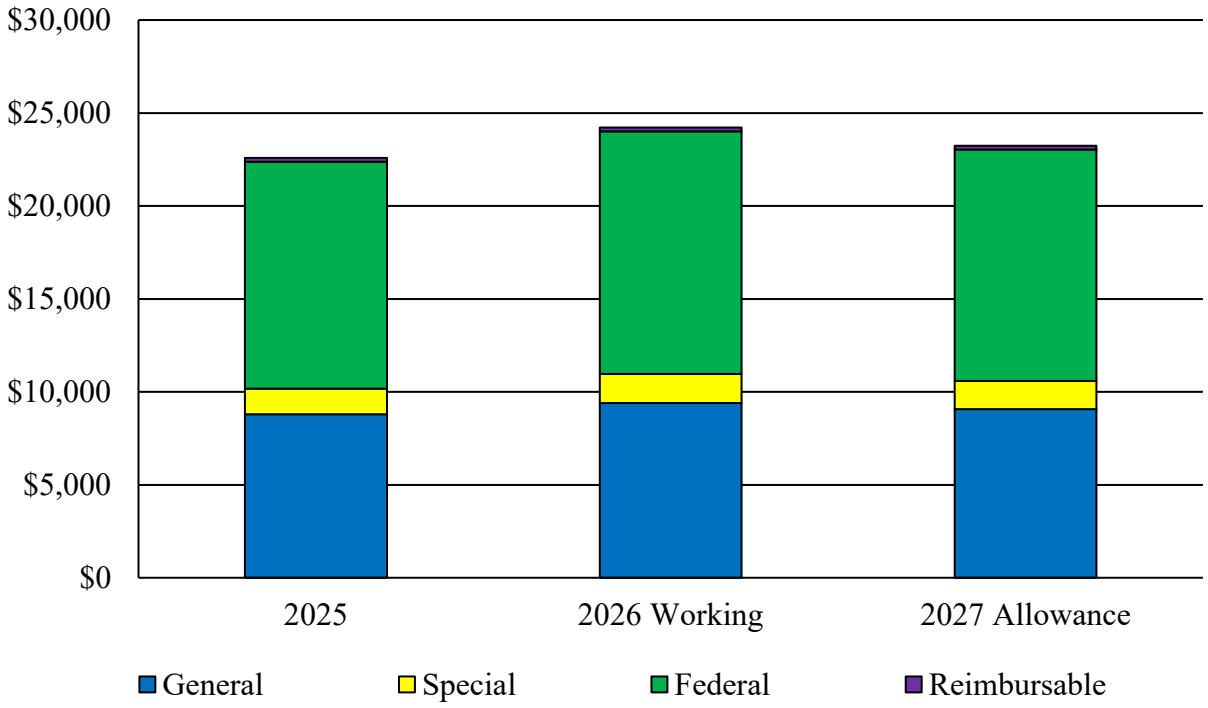
Maryland Department of Health
Fiscal 2027 Budget Overview

Three-year Funding Trends
Fiscal 2025-2027
($ in Billions)

Fiscal 2027 Budget Decreases by $972.8 Million, or 4.0%, to $23.2 Billion



Note: The fiscal 2026 working appropriation accounts for deficiencies and planned reversions. The fiscal 2027 allowance accounts for contingent reductions. The fiscal 2027 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

- The fiscal 2027 allowance for the Maryland Department of Health (MDH) totals $23.2 billion, accounting for $13.6 million in general fund reductions and $21 million in special fund reductions contingent on legislation, the Budget Reconciliation and Financing Act (BRFA) of 2026. The budget plan also includes $4.5 million in contingent special fund appropriations in fiscal 2027.

- The fiscal 2027 budget includes $2.5 billion in proposed deficiency appropriations for fiscal 2026, $718.3 million of which covers fiscal 2025 service costs. The Governor's Budget Plan also assumes $16.7 million in general fund reversions at the close of fiscal 2026 resulting from underspending by local behavioral health administrations (LBHA) in fiscal 2025.

- In October 2025, the Board of Public Works (BPW) approved the elimination of 71.3 positions across MDH and the Office of the Inspector General for Health, resulting in more than $5 million in general fund savings in fiscal 2026.

Key Observations

- ***Fiscal 2025 Closeout Concerns:*** The fiscal 2027 budget includes proposed deficiency appropriations totaling $718.3 million for shortfalls related to fiscal 2025 costs, largely due to higher than anticipated Medicaid spending in the Behavioral Health Administration (BHA), the Developmental Disabilities Administration (DDA), and Medicaid. Because of the various unpredictable factors affecting utilization of health services, MDH should improve the monitoring of spending to expedite identification of shortfalls so that they can be addressed during the budget process. In addition, findings from the Office of Legislative Audits (OLA) *Statewide Review of Budget Closeout Transactions for Fiscal Year 2025*, demonstrated gaps in MDH's federal fund accounting procedures that may have resulted in unrecovered federal funding. This has been an ongoing issue raised by OLA in multiple closeout reports and financial compliance reports. MDH continues to take steps to improve its processes and procedures to ensure that all eligible expenditures receive federal reimbursement.

- ***Maryland Receives $168 Million in First Year of Rural Health Transformation Program:*** The One Big Beautiful Bill Act (OBBBA) enacted on July 4, 2025, established the Rural Health Transformation Program and allocated a total of $50 billion for five-year grants to states. Of this funding, Maryland received $168.2 million in the first year from the Centers for Medicare and Medicaid Services (CMS). MDH described three key initiatives related to the rural healthcare workforce, sustainable access and innovative methods to care, and improving nutrition. The fiscal 2027 budget as introduced does not include federal funds from this program.

- ***Budget Assumes $70 Million in Additional Cigarette Restitution Fund (CRF) Revenue from Litigation:*** As a result of recent activity related to multistate litigation with tobacco manufacturers, Maryland is expected to recover at least $60 million from the Disputed Payments Account. The timing and amount of this payment has not been finalized, although $37 million is expected to be paid in April 2026. The fiscal 2027 budget plan assumes the State will receive $70 million in additional CRF revenue and allocates the first $35 million to supplant general funds for historically Black colleges and universities (HBCU) settlement payments. The BRFA of 2026 proposes to expand the uses of the amount over $35 million in CRF revenue in fiscal 2027 only and reduce two CRF-funded mandates. However, the fiscal 2027 allowance does not specify where the $35 million in additional CRF revenue from litigation is budgeted, making it unclear which programs would be affected if the full $70 million in revenue is not realized.

- ***Home and Community-based Services (HCBS) Waiver Registry Reduction Efforts:*** Chapter 464 of 2022 and Chapter 738 of 2022 require MDH to develop plans to reduce Medicaid HCBS waiver waitlists and registries by 50% and expand outreach to individuals on the registry for the Home- and Community-based Community Options Waiver (Community Options Waiver). From fiscal 2024 to 2025, the registry for the Community Options Waiver increased by 5%, while the waitlist for DDA's Community Pathways Waiver decreased by 13%. Although Community Options outreach activities increased in fiscal 2025, the registry remains high partly due to a steady influx of new registrants. MDH provided updates on waitlist reduction activities with efforts focused on improving provider capacity and staff capacity across waiver programs.

Operating Budget Summary

Federal Recissions

Ten federal grants with funding in the fiscal 2026 MDH budget were determined to be at risk of recission or cancellation, including supplemental grants issued through COVID-19 relief legislation. The grants, shown in **Exhibit 1**, support epidemiology and infectious disease research, address COVID-19-related health disparities, and fund community-based behavioral health programs. However, as of this writing, MDH has not lost any federal funding in fiscal 2025 or 2026 due to the issuance of a preliminary injunction by a federal judge on May 16, 2025, and ongoing litigation related to the Affordable Care Act Personal Responsibility Education Program (PREP). The grants that continued under the preliminary injunction represent $145.4 million in fiscal 2026 federal funding. The federal government initially appealed the preliminary injunction, but subsequently withdrew its appeal, effectively restoring each of these grants. Five grants ended as planned at the end of the grant period.

Exhibit 1
At Risk Federal Grants
Fiscal 2026

Grant Name	Agency / Office	2026 Appropriation	Status
Continued Under Preliminary Injunction			
Epidemiology and Laboratory Capacity for Infectious Diseases (CRRSA)	PHPA	$62,313,690	Ongoing; grant ends July 31, 2026 (no cost extension)
Epidemiology and Laboratory Capacity for Infectious Diseases (ARPA)	Laboratories Administration; PHPA	6,686,886	Ongoing; grant ends July 31, 2026 (no cost extension)
Epidemiology and Laboratory Capacity for Infectious Diseases	Laboratories Administration; PHPA	4,371,664	Ongoing; grant ends July 31, 2026 (no cost extension)
Epidemiology and Laboratory Capacity for Infectious Diseases (CARES)	Laboratories Administration	1,483,987	Ongoing; grant ends July 31, 2026 (no cost extension)

Grant Name	Agency / Office	2026 Appropriation	Status
Block Grants for Prevention and Treatment of Substance Abuse	BHA; Office of Population Health Improvement; PHPA	38,964,431	Grant ended September 30, 2025
Block Grants for Community Mental Health Services	BHA	15,101,992	Grant ended September 30, 2025
Block Grants for Community Mental Health Services (ARPA)	BHA	9,289,821	Grant ended September 30, 2025
Block Grants for Prevention and Treatment of Substance Abuse (ARPA)	BHA; Medicaid; PHPA	7,058,600	Grant ended September 30, 2025
National Initiative to Address COVID-19 Health Disparities (CRRSA)	Medicaid	125,222	Grant ended September 30, 2025
Subtotal		***$145,396,293***	
Continuing Under Ongoing Litigation			
Affordable Care Act Personal Responsibility Education Program	PHPA	921,336	Funded due to ongoing litigation; grant ends September 30, 2026
Grand Total		**$146,317,629**	

ARPA: American Rescue Plan Act
BHA: Behavioral Health Administration
CARES: Coronavirus Aid, Relief, and Economic Security Act
CRRSA: Coronavirus Response and Relief Supplemental Appropriations
PHPA: Prevention and Health Promotion Administration

Note: The Office of Population Health Improvement and the Laboratories Administration are budgeted within the Public Health Administration.

Source: Maryland Department of Health; Department of Legislative Services

Funding for PREP was at risk due to a federal notice directing states to remove gender identity references from sexual education materials paid for with federal dollars. MDH indicated that it has not changed its guidance to grantees nor altered its policy regarding references to gender identity, and that the State is participating in multi-state litigation challenging the directive. While the litigation is ongoing, the grant remains active.

On January 13, 2026, the federal government indicated that it would cut $1.9 billion from the Substance Abuse and Mental Health Administration (SAMHSA), which would affect three mental health and substance use grants that MDH receives. However, the order was rescinded the following day. The three grants are Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis; Strategic Prevention Framework for Prescription Drugs; and the Pilot Program for Treatment for Pregnant and Postpartum Women. MDH confirmed that had the cuts been maintained, the Prevention and Health Promotion Administration (PHPA) and BHA would have lost federal funding in fiscal 2026.

Fiscal 2026

Proposed Deficiency

The fiscal 2027 budget includes deficiency appropriations totaling a net increase of $2.5 billion to the fiscal 2026 appropriation, comprised of $665.0 million in general funds, $28.4 million in special funds, $1.8 billion in federal funds, and $32.9 million in reimbursable funds. These appropriations include $718.3 million ($287.6 million in general funds) to support provider reimbursement costs in fiscal 2025 across BHA, DDA, and Medicaid spending. **Appendix 1** contains an itemized list of deficiency appropriations, including:

- Funding to cover fiscal 2026 shortfalls for provider reimbursements:
  - $799.8 million ($106.4 million in general funds) in Medicaid;
  - $642.4 million ($119.2 million in general funds) in BHA; and
  - $380 million ($190 million in general funds) in DDA.
- Funding to cover fiscal 2025 shortfalls for provider reimbursement payments:
  - $356.6 million ($189.8 million in general funds) in DDA;
  - $294.6 million ($62.7 million in general funds) in Medicaid; and
  - $67.1 million ($35.1 million in general funds) in BHA.
- $14.3 million in general funds to support overtime costs across MDH; and

- $16.9 million in general fund savings to reflect actual spending on behavioral health initiatives.

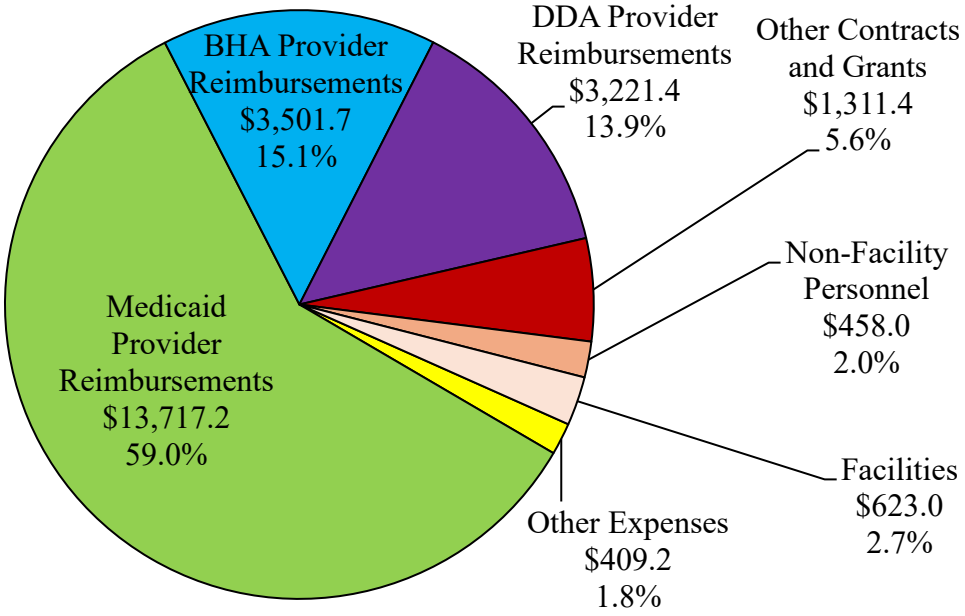
Planned Reversions

The fiscal 2027 budget plan assumes one reversion in fiscal 2026 for MDH totaling $16.7 million in general funds due to underspending by LBHAs and core services agencies (CSA), which oversee behavioral health programs and service delivery in each local jurisdiction and provide financial support to community organizations. The BRFA of 2025 included a provision authorizing, rather than requiring, unexpended grant funds to remain with CSAs and LBHAs at the close of each fiscal year. The Governor's fiscal 2026 budget plan assumed a general fund reversion of $22.7 million from unspent fiscal 2024 funding by CSAs and LBHAs returned to BHA enabled by that provision.

Fiscal 2027 Overview of Agency Spending

Fiscal 2027 Allowance
($ in Millions)

Total Fiscal 2027 Allowance = $23.2 Billion



BHA: Behavioral Health Administration
DDA: Developmental Disabilities Administration

Note: The Other Contracts and Grants category includes $14.9 million for FAMLI Act contributions for health care providers. The fiscal 2027 allowance accounts for contingent reductions. The fiscal 2027 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

Source: Governor's Fiscal 2027 Budget Books; Department of Legislative Services

Proposed Budget
Maryland Department of Health – Overview
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2025 Actual	$8,795,013	$1,383,002	$12,201,497	$205,918	$22,585,430
Fiscal 2026 Working Appropriation	9,400,739	1,567,691	13,037,068	208,374	24,214,872
Fiscal 2027 Allowance	9,068,773	1,517,066	12,453,453	202,731	23,242,023
Fiscal 2026-2027 $ Change	-$330,126	-$47,578	-$584,456	-$5,643	-$972,849
Fiscal 2026-2027 % Change	-3.5%	-3.0%	-4.5%	-2.7%	-4.0%

Where It Goes:	Change
Personnel Expenses	
Employee and retiree health insurance	$37,203
Salary increases and associated fringe benefits	33,397
Overtime, after accounting for a fiscal 2026 deficiency for departmentwide overtime	1,767
Other fringe benefits	1,207
Workers' compensation premium assessment	799
Turnover adjustments	-11,962
Provider Reimbursements	
Medicaid provider reimbursements and Medicaid programs	148,083
Non-Medicaid behavioral health provider reimbursements	20,426
FAMLI Act contributions for health care providers	14,894
Behavioral health Medicaid provider reimbursements	-53,519
Developmental Disabilities Administration provider reimbursements	-148,905
One Time Costs	
One-time payment in fiscal 2026 for disallowance for unallowable Medicaid costs for residential habilitation add-on services	-39,324
COVID-19 response activities that were not eligible for Federal Emergency Management Agency reimbursement	-49,373
Fiscal 2025 shortfall for provider reimbursements	-718,290
COVID-19	
Expiration of ARPA supplement to mental health and substance abuse grants	-15,803
End of CRRSA enhancement for the Epidemiology and Laboratory Capacity for Infectious Disease expansion grant	-51,279
Health Services and Programs	
Increased enrollment in the Women Infants and Children program	16,897
Consortium on Coordinated Community Supports	10,000
Assisted Outpatient Treatment Program implementation	5,000
Family planning and maternal and child health initiatives	2,414
Declining participation in the Immigrant Health Program	-6,948
Opioid manufacturer and distributor settlement revenue	-39,051

Where It Goes:	**Change**
Behavioral health prevention, treatment, and recovery grants and contracts	-55,080
Administration and Operations	
Behavioral Health Administrative Services Organization contract	6,494
Data systems and equipment maintenance	897
Major information technology spending across MDH, largely driven by delayed development schedules of several projects	-80,589
Other	-2,206
Total	**-$972,849**

ARPA: American Rescue Plan Act
CRRSA: Coronavirus Response and Relief Supplemental Appropriations
FAMLI: Family and Medical Leave Insurance
MDH: Maryland Department of Health

Note: Numbers may not sum to total due to rounding. The fiscal 2026 working appropriation accounts for deficiencies and planned reversions. The fiscal 2027 allowance accounts for contingent reductions. The fiscal 2027 statewide salary adjustments are centrally budgeted in the Department of Budget and Management and are not included in this agency's budget.

Budget Reconciliation and Financing Act

The fiscal 2027 Budget Bill includes language reducing general and special funds totaling $34.6 million across MDH, contingent on the enactment of provisions in the BRFA of 2026. Of these reductions, $4.5 million in general funds are replaced by contingent special fund appropriations. The contingent reductions include:

- $730,000 in general funds savings contingent on a provision reducing the funding mandate for tobacco use reduction activities from $18.25 million to $17.52 million; and

- $8.4 million in general funds in Medicaid are reduced contingent on legislation that authorizes distributions beyond the first $35 million in settlement funding from the separate account in the CRF to be used for purposes other than supplanting the general fund appropriation at HBCUs in fiscal 2027 only.

Two provisions in the BRFA would change funding mandates under the Maryland Community Health Resources Commission (MCHRC), resulting in the following budgetary changes:

- $20 million in special funds from the Blueprint for Maryland's Future Fund are reduced from the Consortium on Coordinated Community Supports under the MCHRC, contingent on a provision reducing the funding mandate for the consortium to $80 million beginning in fiscal 2027; and

- $1 million in CRF special funds supporting the MCHRC Fund are reduced, contingent on a provision waiving the requirement for the Governor to include $8 million in CRF support for the MCHRC Fund in fiscal 2027 only. This funding is expected to be backfilled with special fund balance from the MCHRC Fund. CRF savings are reallocated to provide general fund relief as the budget also includes a $1 million CRF special fund appropriation and $1 million general fund reduction in the Medicaid budget contingent on enactment of this provision.

Additional fund swaps resulting in general fund savings include:

- $2 million general fund reduction and $2 million special fund appropriation in the Public Health Administration (PHA), contingent on a provision authorizing the transfer of excess special fund balance from the State Board of Physicians, to support the Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants;

- $1 million reduction in general funds and $1 million appropriation in special funds in PHPA, contingent on a provision expanding the authorized uses of the Advance Directive Program Fund to include supporting maternal and child health initiatives; and

- $500,000 reduction in general funds and $500,000 appropriation in special funds in BHA, contingent on a provision authorizing the transfer of excess special fund balance from the State Board of Professional Counselors and Therapists.

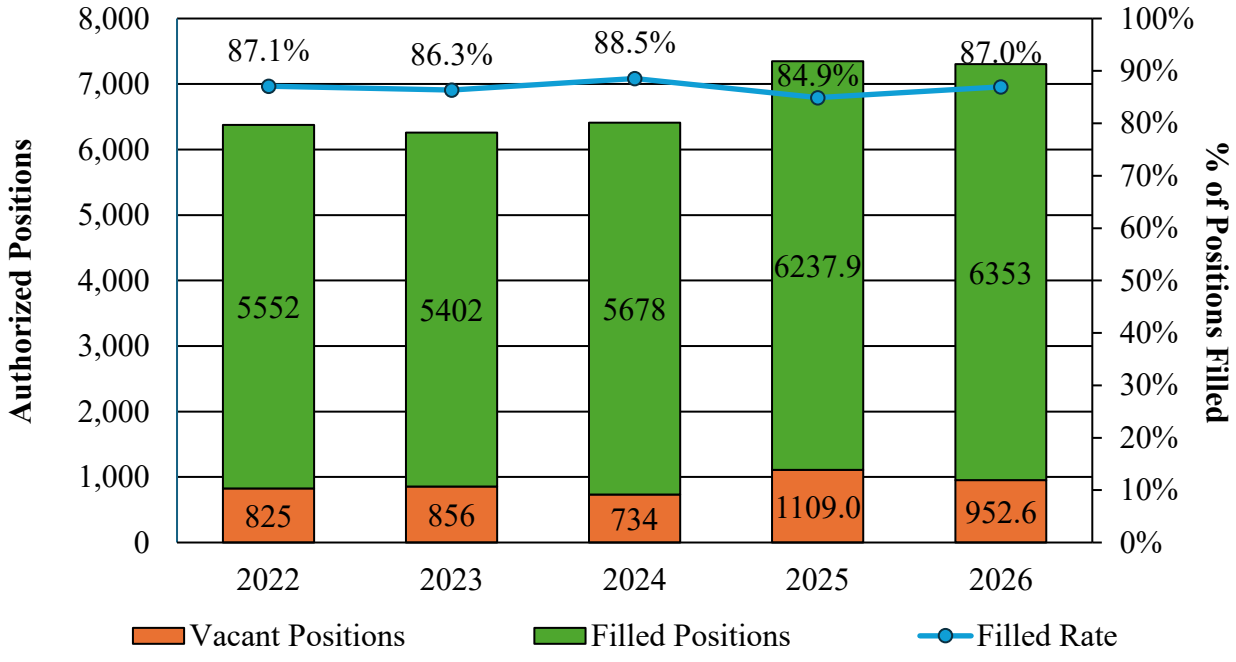
The BRFA also includes two provisions affecting BHA programs. Chapter 703 and 704 of 2024 require local jurisdictions to implement an Assisted Outpatient Treatment program by July 1, 2026, or MDH will need to establish one. Jurisdictions were required to report this decision to MDH in January 2025; no jurisdiction selected to operate this program. The provision establishes a progressive cost-sharing model with the State beginning in fiscal 2028, when jurisdictions will pay 25% of the cost increasing through fiscal 2031 to 100% of program costs.

Current law requires MDH to apply for the Certified Community Behavioral Health Clinic (CCBHC) demonstration grant in fiscal 2027. MDH is currently implementing the CCBHC planning grant, which SAMHSA awarded the department in fiscal 2025. MDH received a no-cost extension from SAMHSA, moving the grant end date from December 1, 2025, to December 1, 2026. Another provision in the BRFA would authorize, rather than require, BHA to apply for the CCBHC demonstration grant from SAMHSA in fiscal 2029.

Personnel Data

MDH staff includes providers in State hospitals and health facilities and local health departments, as well as public health staff who regulate health care providers throughout the State and manage local and State health care policies. The fiscal 2027 allowance includes 7,293.55 regular positions and 454.13 contractual full-time equivalents across MDH. Additional information on regular positions by program and contractual personnel by program from fiscal 2025 to 2027 are shown in **Appendix 3** and **Appendix 4**, respectively. As shown in **Exhibit 2**, MDH filled 87% (6,353) of its 7,305.6 authorized positions as of December 31, 2025, more than 2 percentage points higher than the proportion filled on December 31, 2024 (84.9%, 6,237.9). Compared to this point in fiscal 2025, the department had 115 more positions filled and about 41 fewer authorized positions in fiscal 2026. More than half of the vacant positions are at State hospital facilities. On October 29, 2025, at a briefing with the Joint Committee on Fair Practices and State Personnel Oversight, MDH shared with the General Assembly its recruitment progress at State hospitals, including hiring new leadership and filling 95 vacancies at Clifton T. Perkins Hospital Center.

Exhibit 2
Filled and Vacant Positions
Fiscal 2022-2027



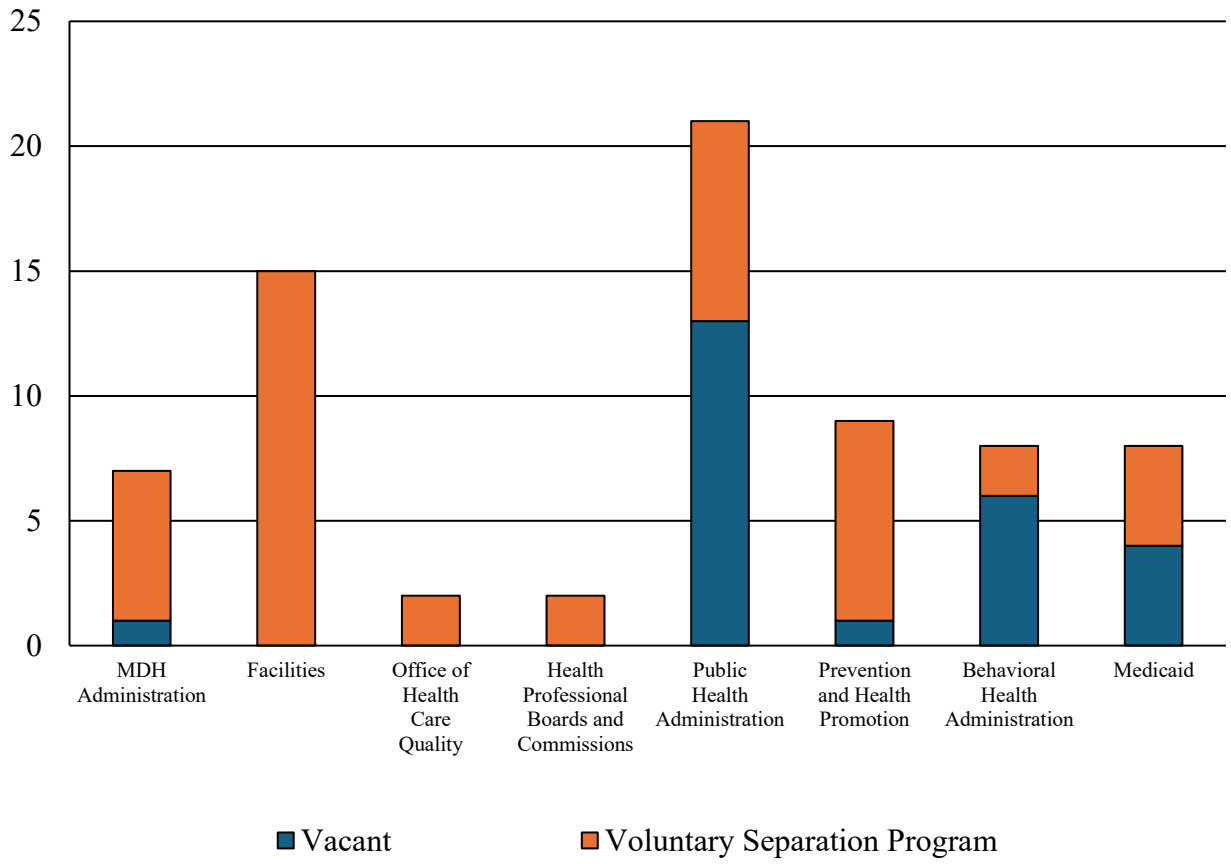
Note: Vacant positions are measured as a point-in-time count as of December 31 of each year. Data includes positions in the Office of the Inspector General for Health and the Prescription Drug Affordability Board.

Source: Department of Budget and Management; Department of Legislative Services

Voluntary Separation Program and Hiring Freeze

In July 2025, the Department of Budget and Management (DBM) established a voluntary separation program (VSP), offering a payout commensurate with time in State service to employees who voluntarily leave their positions in fiscal 2026. In the October 22, 2025, BPW meeting, 47.0 MDH positions were abolished under the VSP along with 24.3 vacant positions. PHA had the largest number of abolished positions (21), 8 of which were vacant administrative roles in the Office of the Deputy Secretary for Public Health Services. **Exhibit 3** shows the abolished positions by program.

Exhibit 3
Board of Public Works Position Abolitions
Fiscal 2026



MDH: Maryland Department of Health

Note: One abolished position in the Behavioral Health Administration was a vacant 0.3 full-time equivalent position.

Source: Board of Public Works

Issues

1. Fiscal 2025 Closeout Concerns

To inform its budget request each year, MDH develops financial forecasts for Medicaid provider reimbursements in BHA, DDA, and Medicaid. Budget forecasts rely on prior and current year spending and service utilization data and apply assumptions about changes in service costs, utilization, and Medicaid enrollment. Factors that affect these components include State and federal policies, changes in population health behaviors, and public health events, such as the COVID-19 pandemic or the opioid crisis. The effects of these factors can be hard to predict.

For example, the COVID-19 pandemic complicated budget projections in multiple ways. As a condition of receiving enhanced federal matching funds during the COVID-19 pandemic, MDH was required to freeze disenrollment with limited exceptions. The freeze on disenrollment ended April 1, 2023, and MDH initiated a 12-month eligibility redetermination schedule, referred to as the unwinding period. Redetermination results during the unwinding period yielded fewer disenrollments than expected, partially due to a system error that caused MDH to temporarily pause procedural disenrollments (*i.e.*, cases in which participants did not complete their renewals or had outstanding verification documents). In addition, as disenrollments resumed during the unwinding period, there was an expectation that relative health acuity would be higher for remaining Medicaid patients, and an estimate for this trend was factored into calendar 2024 rates. However, this trend did not materialize at first due to certain groups, such as childless adults, reporting a significant decrease in health acuity.

While there is a great deal of uncertainty in estimating future spending, consistent and reliable data is critical for projections to be as accurate as possible. Traditional and behavioral health Medicaid service claims data is available to the Department of Legislative Services (DLS) monthly and shows monthly and year-to-date data on cost and utilization rates for each individual service and eligibility group. Beginning in fiscal 2025, DDA is required to submit similar data on its provider reimbursement spending. MDH has not provided data for the two non-Medicaid behavioral health provider reimbursement programs, despite language in recent budget bills requiring BHA to do so. MDH indicates that throughout calendar 2025, it has not been able to provide consistently accurate data for these two programs due to complications with transferring data between the prior Administrative Services Organization (ASO), and the new ASO, which went live in January 2025. In general, provider reimbursement programs with consistent detailed data are better equipped to forecast future spending.

Fiscal 2025 Shortfalls

By identifying and monitoring health data trends, including changes in utilization and Medicaid enrollment, MDH estimates overspending or underspending for services and, with some limitations, can make budget adjustments throughout the fiscal year to some extent, though general funds can only be realigned, not added through budget amendment. In addition, annual budget bill language restricts appropriations within provider reimbursements to those purposes, though for some programs, the language authorizes MDH to transfer funding between certain

programs. Other programs not included in that language may have funds transferred between programs through an approved budget amendment. Adjustments may also be made through deficiency appropriations.

If an agency or department has insufficient appropriation to support its expenditures, they are required to report this to the Comptroller at fiscal year close-out. At fiscal 2025 close, MDH reported $411.1 million in shortfalls in DDA and Medicaid. Absent additional appropriation provided through a deficiency appropriation, these shortfalls are paid with current year funds, increasing the likelihood of a shortfall for the current year. As noted previously, the fiscal 2027 budget includes $718.3 million in fiscal 2026 deficiency appropriations to cover fiscal 2025 service costs in BHA ($67.1 million), DDA ($356.6 million), and Medicaid ($294.6 million). The higher level of proposed deficiency appropriations compared to the amount reported to the Comptroller is attributable to additional shortfalls that arise from reserving insufficient funds for fiscal 2025 services for which claims are received in fiscal 2026. These additional shortfalls were in Medicaid and Behavioral Health Medicaid.

In September 2025, MDH shared with DLS its intention to shift funding from agencies with surpluses to cover deficits in other areas. MDH explained that it realigned a $128.0 million surplus from the BHA Community Services program, which pays provider claims for behavioral health services for the uninsured population, and a surplus of $11.0 million from behavioral health services for Medicaid eligible individuals for ineligible services to backfill a $119.2 deficit in the Behavioral Health Medicaid program. MDH reported this left nearly $20 million to be transferred to support a deficit in the traditional Medicaid. MDH shifted a $26.1 million surplus from elsewhere in the department to cover part of the DDA shortfall. Budget amendments effectuating these actions have not been received by DLS as of this writing.

Despite transferring funding out of BHA to cover fiscal 2025 shortfalls in other areas, the Behavioral Health Medicaid program also had a fiscal 2025 shortfall and required a proposed deficiency appropriation of $67.1 million ($35.1 million in general funds) to resolve. The transferred funds would not have been sufficient to cover the full shortfall in BHA, and a larger shortfall would have occurred in Medicaid absent this action. The intent of the annual budget language is to prevent transfers that cause or increase shortfalls in the program from which it is transferred. **MDH should comment on why it transferred funding from BHA that could have been used to cover shortfalls in the Behavioral Health Medicaid program. MDH should also indicate when budget amendments will be submitted reflecting the realignments that occurred at fiscal 2025 closeout**

Myriad factors complicate projecting accurate health spending. However, monitoring ongoing spending against the budget can enable agencies to request deficiency appropriations as rates of service and utilization change in unanticipated ways and avoid significant end-of-year shortfalls. **MDH should comment on its process of monitoring utilization and spending by program to identify potential shortfalls.**

Fiscal 2025 Closeout Audit

Each year OLA conducts a review of the State's budget closeout entries and publishes its findings. In the *Statewide Review of Budget Closeout Transactions for Fiscal Year 2025*, OLA found that several State agencies, including MDH, had not properly supported federal fund accrued revenue transactions. At the close of fiscal 2025, OLA noted that MDH recorded 1,244 accrued federal fund revenue entries totaling $1.55 billion. These entries include $1.15 billion of positive accrual, which would pay fiscal 2025 expenditures in fiscal 2026. However, OLA's review found that MDH lacked documentation demonstrating that it had requested and recovered federal reimbursement for all eligible payments. Of the 20 entries OLA reviewed, MDH could not provide documentation that 10 entries, totaling $425 million, reflected the full amounts collectable from the federal government. OLA also found that MDH recorded 16 entries totaling $466.9 million for which it could not document fully recovering federal fund reimbursement. In cases where federal fund reimbursements were not requested or recovered, funding may no longer be available, and MDH may need to cover spending with general funds. **MDH should comment on the dollar value of the accrued revenues reported in the audit that it has received to date and the timeline for receipt of any remaining receipts.**

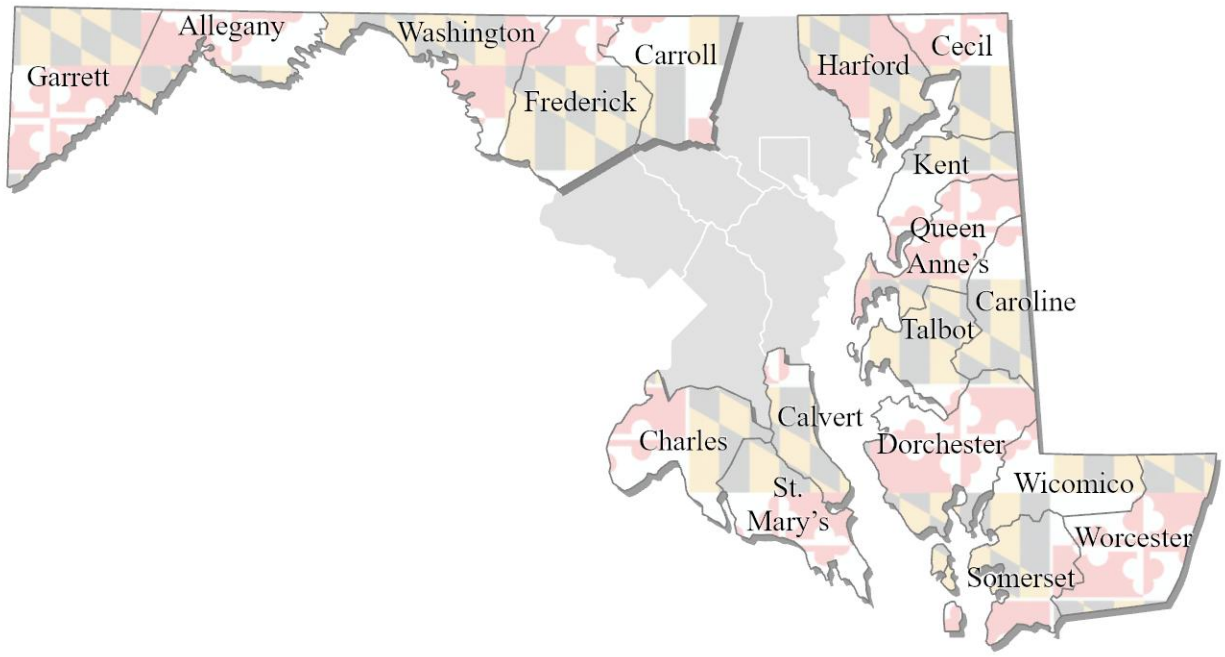
Similar findings were raised by OLA in its *Statewide Review of Budget Closeout Transactions* for fiscal 2022 through 2024 and in the fiscal compliance audit report of MDH Office of the Secretary and Other Units released in calendar 2023. MDH has taken several actions to correct prior year findings and address systemic and procedural issues related to its federal fund accounting process. In the closeout report for fiscal 2025, OLA notes that MDH hired an accounting firm in July 2023 to review accounts for any eligible expenditures and ensure that they are submitted for federal reimbursement and support efforts to improve its accounting procedures. As of October 2025, MDH had paid the firm $10.1 million. **MDH should comment on the status, length, and total cost of this contract, including the amount included in the fiscal 2027 proposed budget. MDH should also discuss planned and implemented improvements to its accounting procedures, particularly related to fiscal year-end closing.**

2. Maryland Receives $168 Million in First Year of Rural Health Transformation Program

On July 4, 2025, the OBBBA was enacted, establishing the Rural Health Transformation Program among other substantial policy changes to health programs in Maryland. OBBBA provisions related to Medicaid will be further discussed in the M00Q01 – MDH Medical Care Programs Administration analysis. The Rural Health Transformation Program administered by CMS will distribute a total of $50 billion in five-year grants to eligible states from federal fiscal 2026 to 2030. In a Notice of Funding Opportunity issued in September 2025, CMS reported that of the available funds, (1) half would be allocated equally across states with approved applications (baseline funding) and (2) half would be allocated at CMS's discretion based on the content of states' applications and rural factors (workload funding). On December 29, 2025, CMS announced that Maryland received $168.2 million for federal fiscal 2026.

Section 2-207 of the State Finance and Procurement Article defines rural areas in Maryland as 18 of the 24 jurisdictions and portions of other counties in close proximity to agricultural activity. **Exhibit 4** labels the 18 counties that qualify under this definition, which is broader than the federal designation of 9 rural counties and multiple rural census tracts within Southern Maryland and Carroll County. In the grant application for the Rural Health Transformation Plan, MDH indicated that it would target resources to residents and healthcare providers in all 18 jurisdictions recognized as rural by State law. Additionally, the OBBBA defined rural health facilities to include hospitals, health clinics, federally qualified health centers, community mental health centers, and CCBHC.

Exhibit 4
Rural Counties as Defined in Maryland Law



Source: Department of Legislative Services

Maryland's grant proposal highlighted two distinct funding types for subgrantees, including (1) immediate impact funding for "shovel-ready" projects that are ready for implementation and (2) transformation funding for initiatives with more planning required. Additionally, the proposal described the following three key initiatives for improving rural health. Following the grant award announcements, states were required to submit revised budget plans to CMS by January 30, 2026. After accounting for approximately $1 million for administrative costs, MDH's proposed uses of funds include, but are not limited to:

- ***$26 Million to Strengthen the Rural Health Workforce****:* Strategies include providing funding to the Maryland Department of Labor to expand the Registered Apprenticeship program and Rural Advancement for Maryland Peers, Workforce Pipeline training program, providing funds to the University of Maryland area health education center and setting up a new center in Southern Maryland, and working with Department of Information Technology and MDH's Office of Population Health Improvement (OPHI) to develop information systems for rural providers;

- ***$126 Million to Promote Sustainable Access and Innovative Care for Rural Marylanders, Including Primary Care, Chronic Disease Management, Specialty Care, and Behavioral Health:*** Strategies include working with the Health Services Cost Review Commission to expand primary care activities, assisting local health departments in establishing the infrastructure to improve billing practices, and supporting school-based health centers;

- ***$15 Million to Address Chronic Disease with Increased Demand for and Supply of Nutritious Food***: Strategies include collaborating with the Maryland Department of Agriculture (MDA) to improve post-harvest infrastructure by increasing cold storage, expanding the Department of Housing and Community Development's Healthy Food Access grant program, and working with the Maryland Department of Emergency Management to establish a rural food coordination program to encourage large-scale buyers to purchase local foods from small and mid-size farms.

The fiscal 2027 budget as introduced does not include federal funds from the Rural Health Transformation Plan, and MDH has not yet published more information on how the $168.2 million allocation for the first year of the grant will be used. MDH designated its State Office of Rural Health within OPHI as the coordinator of overall implementation, management, and assessment of Rural Health Transformation Plan initiatives. OPHI has created a website for updates and competitive funding announcements related to this program and released a call for applications for a Rural Health Transformation Committee to provide stakeholder feedback, with applications due January 30, 2026. **MDH should discuss its preliminary spending plan for Rural Health Transformation Program funding for strategies within the three main initiatives and provide a timeline for budgeting the funds and developing competitive grant programs.**

3. Budget Assumes $70 Million in Additional Cigarette Restitution Fund Revenue from Litigation

The CRF, established by Chapters 172 and 173 of 1999, is a special fund supported by payments made by tobacco manufacturers under the Master Settlement Agreement (MSA). Through the MSA, the settling manufacturers pay substantial annual payments in perpetuity to the litigating parties and conform to restrictions on marketing to youth and the public. Litigating parties include 46 states (excluding Florida, Minnesota, Mississippi, and Texas due to previously settling litigation), 5 territories, and the District of Columbia. The distribution of MSA funds

among the states is determined by formula, with Maryland receiving 2.26% of MSA payments, which are adjusted upward for inflation and downward for volume and prior settlements.

The Nonparticipating Manufacturer Adjustment

One of the conditions of the MSA was that the states take steps toward creating a more "level playing field" between participating manufacturers to the MSA (and thus subject to annual payments and other restrictions) and nonparticipating manufacturers (NPM) to the agreement. This condition is enforced through an additional adjustment to the states' annual payments, the NPM adjustment. Participating manufacturers have long contended that NPMs have avoided or exploited loopholes in state laws that give them a competitive advantage in the pricing of their products. If certain conditions are met, the MSA provides a downward adjustment to participating manufacturers' contribution.

Under the MSA, participating manufacturers may pursue the NPM adjustment on an annual basis. To prevail and reduce their MSA payments, participating manufacturers must show that they experienced a demonstrable market share loss of over approximately 2%, that the MSA was a significant factor in that loss and that a state was not diligently enforcing its qualifying statute (Chapter 169 of 1999 in Maryland, with subsequent revisions in the 2001 and 2004 sessions). Participating manufacturers have consistently pursued the NPM adjustment, and litigation regarding the adjustment started in calendar 2005, beginning with the NPM adjustment for sales year 2003.

Arbitration Findings and Budgetary Impacts

Sales Year 2003 and 2004

Arbitration regarding the "diligent enforcement" issue for sales year 2003 commenced in July 2010. Maryland was one of six states that were found to not have diligently enforced their qualifying statute. Based on the arbitration ruling, Maryland not only forfeited approximately $16 million that the participating manufacturers placed in escrow for the 2003 sales year, but under the MSA arbitration framework, also saw its fiscal 2014 payment reduced by $67 million based on the panel's assessment that those states that settled before arbitration could not be found as nondiligent. Subsequent litigation reduced Maryland's fiscal 2014 payment loss to $13 million.

The participating manufacturers sought a multistate arbitration related to sales year 2004 for Maryland and the other states that did not settle the sales year 2003 litigation. Arbitration on sales year 2004 began in fall 2018. On September 1, 2021, the Office of the Attorney General (OAG) announced that a panel of three arbitrators decided in favor of Maryland, finding that it diligently enforced the qualifying statute. As a result, Maryland recovered $18.4 million in withheld funds in April 2023.

Sales Year 2005 through 2007 and Future Litigation

An arbitration hearing to determine Maryland's settlements and diligent enforcement of qualifying statute in sales year 2005 through 2007 occurred in March 2023. On

November 20, 2023, OAG announced that the panel of three arbitrators unanimously decided in favor of Maryland, and as a result, the State was expected to recover at least $25 million in withheld funds. However, on September 30, 2025, Maryland settled with a subset of smaller participating manufacturers that account for approximately 10% of MSA payments. This settlement applies to sales year 2005 through 2025 and results in an anticipated recovery of $37 million in April 2026. Because the settlement includes sales year 2005 to 2007, the payments overlap, and the initial estimated recovery of $25 million is revised down by approximately 10% to $22.5 million. In combination, the projected funding to be paid back to Maryland will range from $60 million to $67 million, though the final amount and timing of the payments are still to be determined.

As of January 2026, the timing of arbitration hearings for sales year 2008 and on for the remaining participating manufacturers is uncertain. OAG indicates that it continues to aim to arbitrate multiple sales years at once and will begin work on the next round of arbitration in calendar 2026. For each disputed year since sales year 2000 with some exceptions, an amount of Maryland's payments has been withheld and deposited into a disputed payments account. According to OAG, based on account documentation from April 2024, there was an estimated $350 million in principal and interest held on behalf of Maryland in this account, including the payments that will be made for sales year 2005 to 2007 arbitration and settlements. If the State (1) were found to have diligently enforced the statute beginning in sales year 2008 and in the following years or (2) settles with additional participating manufacturers, some share of this funding could be realized in CRF revenue to the separate account. Alternatively, Maryland could forfeit the remaining funds and see its payment adjusted downward in certain fiscal years if the State were found to be nondiligent, as occurred for sales year 2003.

Projected CRF Revenue and Spending

Chapters 41 and 42 of 2021 require payments received by the State as a result of litigation related to Maryland's enforcement of State law regarding the MSA to go into a separate account that may only be used to supplant the general fund appropriation for settlement payments to HBCU. The BRFA of 2025 authorizes the use of these funds to support Medicaid expenses in fiscal 2026 only. Due to delays in recovering the funds that Maryland won through litigation, the fiscal 2026 working appropriation does not include revenue from this separate account for either purpose, and the HBCU settlement is entirely supported with general funds.

As shown in **Exhibit 5**, the fiscal 2027 allowance estimates a total of $154.9 million in CRF revenue and includes an equivalent amount of special fund expenditures. Of this funding, $70 million is from the separate account. The BRFA of 2026 as introduced includes a provision that would expand the use of CRF funds distributed to the separate account in excess of the first $35 million to include purposes other than supplanting the general fund appropriation for the HBCU settlement in fiscal 2027 only. A total of $60.7 million is budgeted for the HBCU settlement payment in fiscal 2027, and of that funding, $35 million is supported with the first payment of CRF revenue to the separate account, and the remaining $25.7 million is supported with general funds.

Exhibit 5
Cigarette Restitution Fund Budget
Fiscal 2025-2027
($ in Millions)

	2025 Actual	2026 Working	2027 Allowance		2026-2027 Change
Beginning Fund Balance	$4.4	$9.8	-$1.0		-$10.8
Settlement Payments	115.8	107.7	98.4		-$9.3
Nonparticipating Manufacturer Adjustment and Other Shortfalls in Payments[1]	-15.2	-17.0	-15.0		$2.0
Other Adjustments	3.9	0	0		$0.0
Tobacco Laws Enforcement Arbitration	0	0	70.0		$70.0
Prior year Recoveries	8.7	2.5	2.5		$0.0
Total Available Revenue	**$117.7**	**$103.0**	**$154.9**		**$51.9**
Health					
Tobacco Enforcement, Prevention and Cessation	$10.4	$11.3	$11.3		$0
Cancer Prevention	27.2	27.2	27.2		0
Substance Abuse Services	0	7.3	0		-7.3
Breast and Cervical Cancer Services	8.7	13.2	13.2		0
Maryland Community Health Resources Commission Fund	8.0	8.0	7.0	[2]	-1.0
Medicaid	31.6	16.3	40.7	[2]	24.4
Subtotal	**$85.9**	**$83.4**	**$99.5**		**$16.1**
Other					
Aid to Nonpublic Schools, including the Nonpublic School Health and Security Program	$8.4	$8.9	$8.9		$0
BOOST	9.0	9.0	9.0		0
HBCU Settlement	2.4	0	35.0		35
Crop Conversion	0.9	1.0	0.7	[2]	0
Attorney General	1.4	1.7	1.8		0
Subtotal	**$22.0**	**$20.6**	**$55.4**		**$34.8**
Total Expenditures	**$107.9**	**$104.0**	**$154.9**		**$50.9**
Ending Fund Balance	**$9.8**	**-$1.0**	**$0**		

BOOST: Broadening Options and Opportunities for Students Today Program
HBCU: historically Black colleges and universities

[1] The nonparticipating manufacturers adjustment represents the bulk of this total adjustment.
[2] Denotes budget items with Cigarette Restitution Fund appropriations or reductions that are contingent on provisions in the Budget Reconciliation and Financing Act of 2026.

Note: Numbers may not sum to total due to rounding.

Source: Governor's Fiscal 2027 Budget Books; Department of Legislative Services

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The budget notably does not differentiate between expenditures using traditional CRF revenue and the $35 million that is assumed in the separate account above the first $35 million paid to HBCUs, with the exception of a general fund reduction of $8.4 million from Medicaid that is contingent on enactment of the provision discussed previously, indicating that at least that portion of the anticipated CRF in Medicaid must be from this source. However, none of the additional special funds budgeted from the separate account are contingent on enactment of the BRFA provision, and no general funds beyond the $8.4 million would be reduced contingent on enactment of the provision. As a result, there is no record of how the additional $35 million is dispersed across CRF uses. If the legislature does not enact the BRFA provision, then only $8.4 million under Medicaid would be automatically backfilled with general funds, and CRF-supported programs would be underfunded by $26.6 million. **DLS recommends adding budget bill language to make $8.4 million of the CRF special fund appropriation under Medicaid contingent on enactment of the BRFA provision expanding the use of certain funding from the separate account. This recommendation will appear in the M00Q01 – Medical Care Programs Administration analysis.**

Considering the timing and amount of the recovery are uncertain, funds budgeted above the first $35 million payment to the separate account are at risk of not being realized in fiscal 2027. Furthermore, the budget assumes $70 million will be paid into the separate account, while a recent projection of the State's total recovery is a range of $60 million to $67 million. As introduced, the budget does not outline which CRF-supported programs receive this funding and would therefore be reduced if the State does not receive the estimated revenue. **MDH should discuss (1) how it will allocate the reduction of CRF spending from the separate account if Maryland does not receive the $35 million in additional payment assumed in the allowance and (2) the projected impact of this reduction on CRF-supported programs.**

CRF uses are restricted by statute. Some uses of the fund are allowed in statute but do not have a mandated funding level, such as nonpublic school support. The fiscal 2027 allowance provides level CRF support of $17.9 million for education, including $9 million budgeted for the Broadening Options and Opportunities for Students Today Program. The BRFA of 2026 as introduced includes two provisions that would reduce the following mandated CRF appropriations.

- Chapter 644 of 2023 requires the Governor to include $8.0 million in CRF support each year from fiscal 2025 through 2029 for the MCHRC Fund. A provision in the BRFA of 2026 waives this requirement in fiscal 2027 only. The fiscal 2027 allowance includes a special fund reduction of $1 million in CRF support from MCHRC that is contingent on enactment of this provision and is expected to be backfilled with an equivalent amount of MCHRC special fund balance. These CRF savings are reallocated to provide general fund relief as the budget includes a $1 million special fund appropriation and $1 million general fund reduction in the Medicaid budget contingent on the enactment of this BRFA provision.

- Chapters 575 and 576 of 2024 increased the annual mandated CRF appropriation from $900,000 to $1 million for the Tri-County Council for Southern Maryland to be used for activities of the Southern Maryland Agricultural Development Commission. A provision in the BRFA of 2026 reduces the mandated appropriation to $700,000 each year beginning in fiscal 2027. The fiscal 2027 budget includes a CRF special fund reduction of $300,000 within the MDA contingent on the enactment of this BRFA provision.

In addition, at least 30% of the annual CRF appropriation must be used for Medicaid, with an exception for fiscal 2026 due to a provision in the BRFA of 2025 temporarily waiving this requirement. Section 7-317 of the State Finance and Procurement Article requires that at least 50% of the CRF appropriation must support the following activities:

- the Tobacco Use Prevention and Cessation Program;

- the Cancer Prevention, Education, Screening, and Treatment Program;

- tobacco enforcement activities;

- the Breast and Cervical Cancer Program;

- alcohol and substance abuse treatment and prevention programs; and

- tobacco production alternatives.

The fiscal 2027 allowance includes CRF appropriations of $40.7 million for Medicaid and $52.5 million for the other enumerated uses. Expenditures from the separate account of recoveries from litigation are not typically included in the calculation of required CRF distributions. However, because the fiscal 2027 budget does not identify specific CRF expenditures from the separate account, it is not possible to confirm that the budget meets annual required CRF distributions. **To align with CRF spending from the separate account across several statutorily required CRF uses, MDH and DBM should propose an amendment to the BRFA to waive, in fiscal 2027 only, the requirement that 50% of the CRF appropriation support specified programs.**

4. HCBS Waiver Registry Reduction Efforts

The Medicaid program covers HCBS through the Community First Choice program and Community Personal Assistance Services program, among other programs. In partnership with CMS, MDH also implements HCBS waivers that allow older adults, people with disabilities, and children with chronic illnesses who might not otherwise qualify for Medicaid to access HCBS. Waiver participants must meet financial eligibility based on income and asset levels and medical eligibility requiring a need for institutional or facility levels of care. HCBS programs fund a variety of service types, such as case management, residential services, nursing, and personal care, that help individuals live at home, in a community setting, or in an assisted-living facility, rather than in a nursing facility or State health facility.

The Office of Long Term Services and Supports (OLTSS) within the Medical Care Programs Administration administers the following HCBS waiver programs:

- the Community Options Waiver;
- the Medical Day Care Services Waiver; and
- the Model Waiver for Medically Fragile Children (Model Waiver).

As of October 2025, DDA consolidated its three HCBS waiver programs into one waiver program – the Community Pathways Waiver. Other HCBS waivers include the Autism Waiver administered by the Maryland State Department of Education (MSDE) in partnership with MDH and the Waiver for Individuals with Brain Injury (Brain Injury Waiver) administered by BHA.

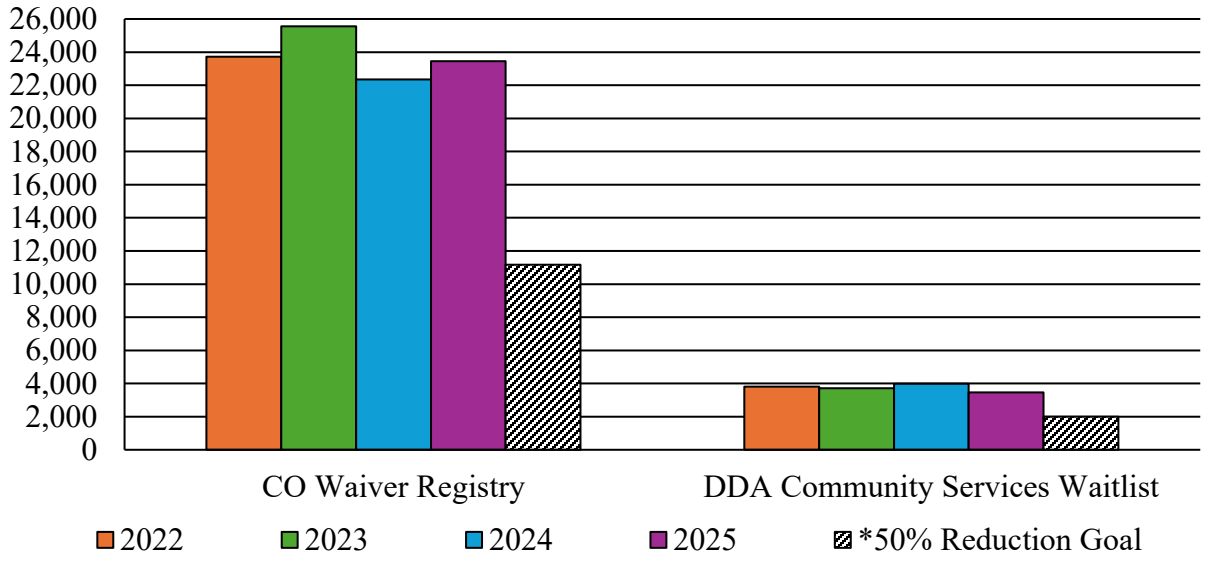
Current Status of HCBS Waiver Registries

MDH maintains registries for individuals who have requested HCBS through Medicaid waiver programs but have not completed the eligibility determination or application process. As of July 2025, all HCBS waivers had a registry except for the Medical Day Care Services Waiver and Brain Injury Waiver. The registry for individuals requesting HCBS through waiver programs administered by DDA is referred to as the Community Services waitlist. As required in Chapter 464 of 2022 (End the Wait Act), the Autism Waiver transitioned to maintaining a registry that includes individuals interested in applying for services and a waitlist that includes individuals from the registry that have been screened and meet preliminary eligibility criteria for the waiver program. The following discussion of HCBS waiver registries and capacity focuses on MDH-administered programs, more information on the Autism Waiver will be available in the R00A02 – MSDE Aid to Education analysis.

The End the Wait Act required MDH to develop plans to reduce the waitlists for Medicaid HCBS waiver programs by 50% by fiscal 2028, beginning in fiscal 2024. Based on the status of the waitlists as of fiscal 2024, the Community Options Waiver and Community Pathways Waiver would need to reduce their waitlists to 11,175 and 1,988, respectively, to meet the waitlist reduction goal.

Exhibit 6 shows that the number of individuals on HCBS registries and progress toward achieving the End the Wait Act goal varies significantly by waiver. For example, at the end of fiscal 2025, the registries ranged from 3,465 for the Community Services waitlist to 23,461 for the Community Options Waiver registry. Although MDH reported that the Model Waiver's registry census was 169 individuals as of July 2025, this registry is not included in the exhibit due to its relative size and the nature of the waiver program being at capacity with 200 participants enrolled. From fiscal 2024 to 2025, the Community Options Waiver registry grew by 5%, with a net increase of 1,112 individuals added to the registry. The Community Services waitlist decreased in fiscal 2025, reducing by almost 13% by removing a net total of 511 registrants compared to fiscal 2024. To meet the waitlist reduction goals, the Community Options Waiver would need to decrease its registry by over 12,000 registrants, while the Community Services waitlist would need to remove an additional 1,477 individuals.

Exhibit 6
MDH-administered Home and Community-based Services Waiver Program Registries
Fiscal 2022-2025



* End the Wait Act goals include reducing the Community Options registry and Community Services waitlist by 50% by fiscal 2028.

CO Waiver: Home and Community-based Options Waiver MDH: Maryland Department of Health
DDA: Developmental Disabilities Administration

Note: Registries and waitlists are reported as point-in-time counts on June 30. For fiscal 2023, the Community-based Options Waiver registry shows the count as of July 1, 2023.

Source: Maryland Department of Health

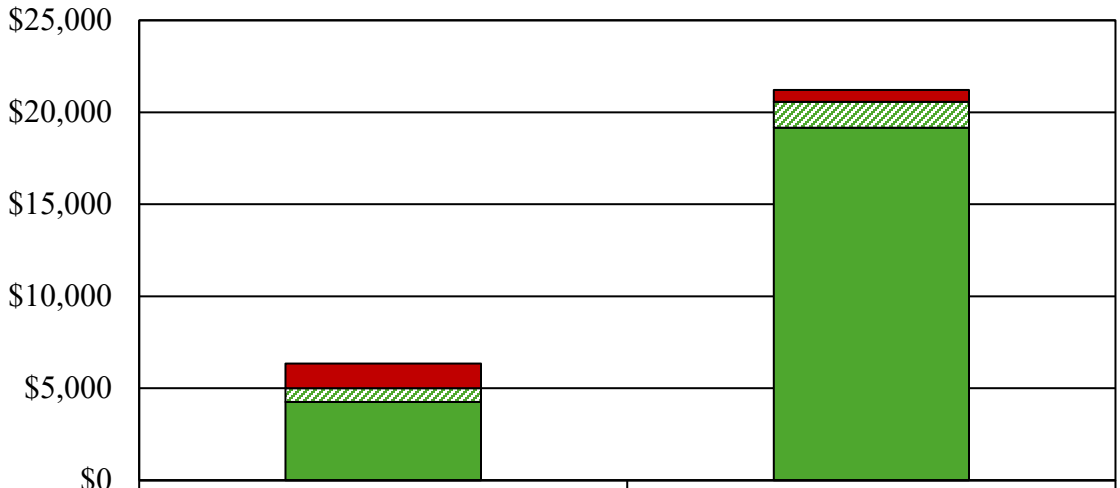
Reserve Categories Allow Priority Populations to be Served Quicker

A portion of available slots are intentionally left available to more quickly fill priority populations – these are known as reserved categories. DDA had 17 reserved categories and a total of 1,424 reserved slots in fiscal 2025 across its waiver programs. In fiscal 2025, most reserved slots (62%) in DDA's waiver programs fell into one of three reserved categories: (1) End the Wait Act to support legislative efforts to reduce the wait list (400 reserved slots); (2) State Funded Conversions for individuals receiving services funded with 100% general funds (256 reserved slots); and (3) Crisis Resolution for individuals at risk of harm or homelessness without services (225 reserved slots). MDH reported that although a reserved category for End the Wait initiatives was created to reduce the waitlist, DDA did not utilize the reserved slot category because funding was not allocated to support the plan for designated slots. Nonetheless, DDA surpassed its goal of enrolling 400 individuals by inviting 1,644 individuals from the waitlist to apply in fiscal 2025. The Community Options Waiver has 750 reserved slots in fiscal 2025 for their Spend-Down and Affordable Care Act (ACA) Expansion category, pursuant to Chapter 414 of 2019, which prohibited the denial of HCBS services for individuals who lost their Medicaid eligibility when they became eligible for Medicare under the ACA expansion.

Available Slots Remain Underutilized

Reducing the registry involves both increasing the number of authorized and funded slots and fully utilizing available slots. **Exhibit 7** shows filled and unfilled slots, compared to the registry in fiscal 2025 for the Community Options Waiver and DDA waiver programs. In fiscal 2025, the Community Options Waiver was authorized to provide services to a total of 6,348 participants, but 33% (2,095) of all available slots were unfilled. DDA waiver programs had a lower percentage of unfilled slots, with only 3% (627) of all slots being unfilled in fiscal 2025.

Exhibit 7
MDH-administered HCBS Waiver Slot Utilization
Fiscal 2025



	CO Waiver	DDA Community Services
Unfilled Slots	1,345	627
Reserved Slots	750	1,424
Filled Slots	4,253	19,155

CO Waiver: Home and Community-based Options Waiver
DDA: Developmental Disabilities Administration
HCBS: Home and Community-based Services
MDH: Maryland Department of Health

Source: Maryland Department of Health

Community Options Registry Remains High as Outreach Increases

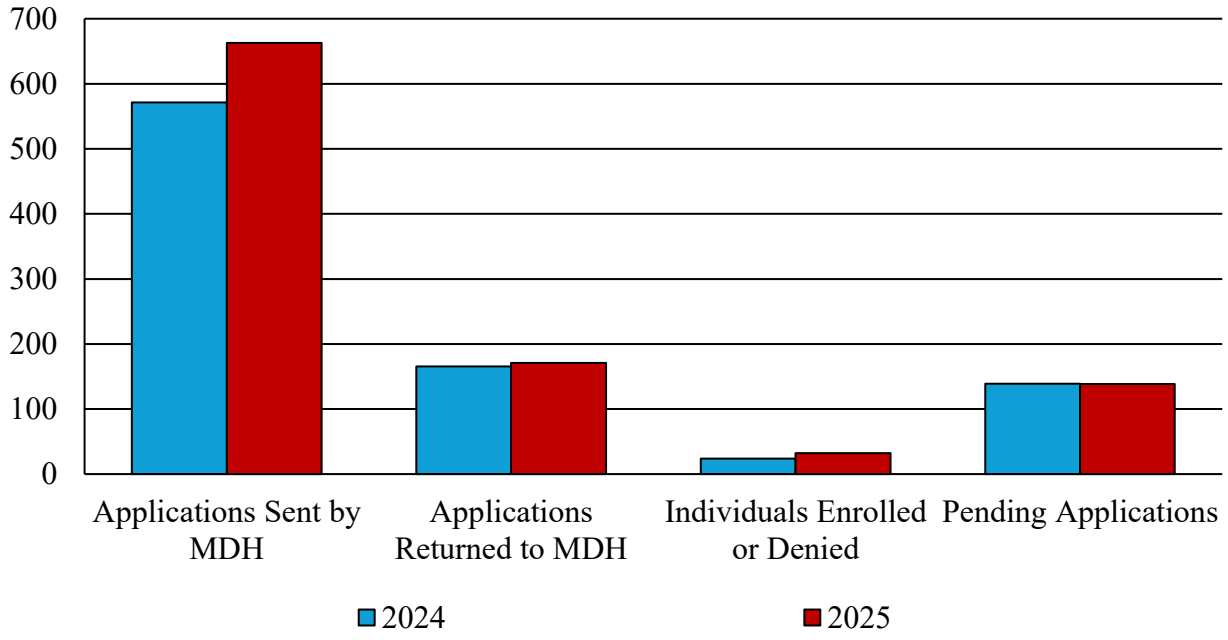
Although there have been improvements in conducting outreach activities in the Community Options Waiver, a low response rate to invitations, high rate of ineligible applicants, and a steady increase of new registrants create challenges in reducing the registry. MDH has made substantial progress in meeting outreach goals including surpassing monthly outreach goals. Additional outreach activities include:

- partnering with the Maryland Department of Aging beginning April 2025 to conduct targeted outreach to individuals in nursing facilities who are invited to bypass the registry and apply to the Community Options waiver directly; and

- improving data sharing with the Vital Statistics Administration within MDH to create monthly reports that identify deceased individuals on the registry with 2,457 individuals identified to be removed from the registry from the first report in June 2025.

As shown in **Exhibit 8**, OLTSS conducted substantial outreach in fiscal 2025 by distributing over 663 Community Options Waiver applications on average each month – an improvement from the average monthly distributions of 571 in fiscal 2024. In accordance with Chapter 738 of 2022, effective October 1, 2022, OLTSS must send a waiver application to at least 600 individuals on the registry each month. MDH exceeded this minimum distribution in every month in fiscal 2025 with monthly distributions ranging from 601 distributions in July 2024 to a high of 710 distributions in February 2025. Chapter 738 also limits applicants' response time from eight weeks to six weeks before being removed from the registry.

Exhibit 8
Average Monthly Community Options Waiver Registry Outreach Results
Fiscal 2024-2025



MDH: Maryland Department of Health

Note: Fiscal 2024 data was provided in a report submitted on August 15, 2024, and could have changed as applications were received and processed. Individuals enrolled or denied is understated as monthly outcomes with fewer than 10 cases were suppressed.

Source: Maryland Department of Health; Department of Legislative Services

Following the expansion of outreach activities, MDH reported that only 26% of applications were returned after invitations to apply were sent in fiscal 2025. Of the applications returned to MDH that were processed in fiscal 2025, only 23% of applicants were enrolled with most processed applications resulting in a determination that the individual was ineligible. Additionally, a steady increase of new registrants is continuously added to the registry with an average of 650 new registrants per month in fiscal 2025. Thus, even though MDH has made progress in conducting outreach activities, enrollment remains low, and it has been challenging to reduce the registry.

Delays in enrollment are exacerbated by MDH not having enough staff to process all applications. Of the total 2,050 applications received in fiscal 2025, 81% remained pending as of July 2025 (a slight improvement over fiscal 2024 when 84% pending applications). MDH reported that filling 3 vacant positions in fiscal 2025 provided the support needed to increase the number of applications distributed to over 700 per month. Across the divisions involved in the operation and administration of the Community Options Waiver, there are a total of 50 merit and contractual positions, 8 of which are vacant positions.

HCBS Waiver Provider and Staff Capacity

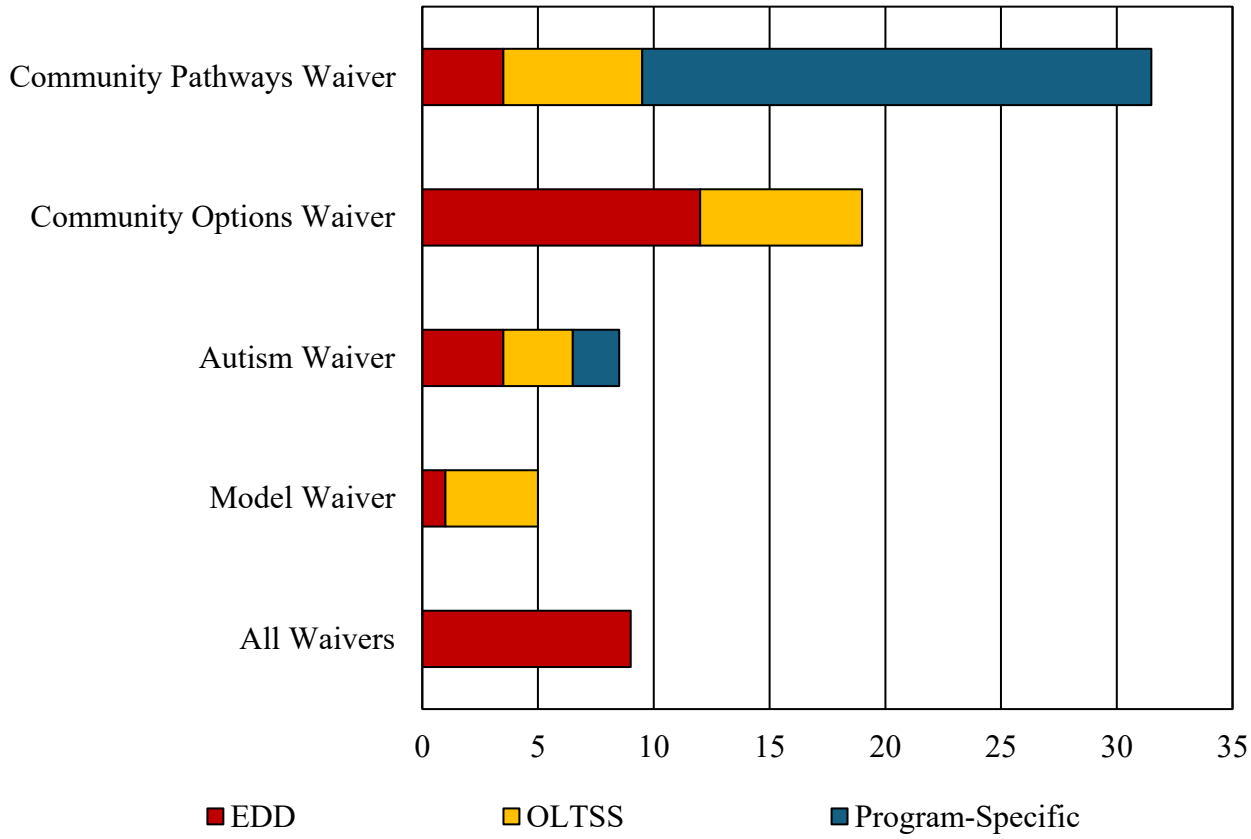
In January 2026, MDH submitted a report required by language in the fiscal 2026 Budget Bill (Chapter 602 of 2025) providing updates on the End the Wait initiatives, including efforts focused on improving provider capacity and staff capacity across waiver programs. Activities to improve provider capacity across MDH include convening the first Interested Parties Advisory Group in late calendar 2025 to advise on Medicaid rate sufficiency. MDH is also assessing the feasibility of establishing an online provider directory to allow individuals to identify home health care providers based on criteria such as language proficiency, certifications, experience, and skills, as required by Chapter 748 of 2025.

DDA efforts to support provider capacity building include participating in the National Core Indicators Intellectual and Developmental Disabilities State of the Workforce survey that assesses the Direct Support Professional (DSP) workforce, as well as participating in the Maryland Developmental Disabilities Council's Provider Think Tank Workgroup established to provide recommendations on strengthening DSP capacity. DDA also reported supporting providers through orientations, webinars, and training sessions, in addition to supporting the development of a DSP career development and training curriculum delivered through an online training platform.

MDH also provided updates on staffing needs to implement the waitlist reduction plan. **Exhibit 9** shows the additional staff identified in the reduction plan with a total of 73 positions needed across waiver programs. The area with the most needed support is the Eligibility Determination Division (EDD), which processes participant eligibility and would require an additional 29 staff to support all waiver programs. MDH also reported a need of 20 additional staff in OLTSS across all waiver programs. In addition to supplementary support within EDD and OLTSS offices, MDH identified staffing needs specific to certain waiver programs including 22 additional staff in DDA for the Community Pathways Waiver and 2 additional staff in MSDE to support the Autism Waiver. Overall, the highest reported staffing needs were within DDA to support the Community Pathways Waiver. Although there was a total additional need of

31.5 positions within DDA to support their waiver program, DDA currently has a vacancy rate of 30 positions as of December 31, 2025. Thus, staffing efforts should focus first on filling already-available vacant positions.

Exhibit 9
Staff Needed for Waitlist Reduction Plans
As of January 2026



EDD: Eligibility Determination Division
OLTSS: Office of Long Term Services and Supports

Source: Maryland Department of Health; Department of Legislative Services

Appendix 1
Proposed Fiscal 2026 Deficiencies
($ in Millions)

Program	General Funds	Special Funds	Federal Funds	Reimb. Funds	Total Funds
Office of the Secretary					
Savings due to network security expenditures aligned with prior year actuals	-$6.92				-$6.92
Updates and survey work at Rosewood per the Facilities Master Plan	0.60				0.60
Grievance settlement with hospital system	0.60				0.60
Fines related to noncompliance admitting forensic patients within statutorily required time frames	1.50				1.50
Departmentwide overtime expenditures	14.25				14.25
Office of Health Care Quality					
Salary and fringe benefit shortfalls	1.30		0.14		1.44
Public Health Administration					
Reduction to reflect actual ARPA spending in the Office of Preparedness and Response			-0.80		-0.80
Reduction to reflect actual COVID-19 response spending under the Deputy Secretary of Public Health Services			-0.34		-0.34
Public Health Promotion Administration					
Supplemental funding due to available revenue from MADAP rebates		4.99			4.99
Behavioral Health Administration					
Savings to reflect prior year spending on behavioral health initiatives	-16.87				-16.87
Savings due to less than anticipated spending in State-funded Medicaid	-11.60				-11.60
Align funding for Community Services with projected expenditures	4.38		-4.30		0.09
Funding to cover a fiscal 2025 shortfall for behavioral health Medicaid services	35.05		32.04		67.09
Funding to cover a fiscal 2026 shortfall for behavioral health Medicaid services	119.19		508.92	14.29	642.41
Developmental Disabilities Administration					
Replace general funds with special funds available through the Community Services Trust Fund	-17.60	17.60			0.00
Funds to cover a fiscal 2026 shortfall in the Community Services program	190.00		190.00		380.00

Program	General Funds	Special Funds	Federal Funds	Reimb. Funds	Total Funds
Funds to address a fiscal 2025 shortfall for the Community Services program	189.84		166.73		356.57
Medicaid					
Adjustments for MCHP due to spending and enrollment trends	-11.93		-22.21		-34.14
Reclassification of existing vacancies in the Office of Eligibility Services to implement revised federal Medicaid eligibility requirements	0.15				0.15
Funding for ongoing program operations for the LTSS Maryland system	3.92		21.71		25.63
Funding to cover a fiscal 2025 shortfall for traditional Medicaid services	62.68		231.95		294.63
Adjustments to reflect enrollment, utilization, and rate projections for the traditional Medicaid and ACA Expansion populations	106.42	-0.51	675.31	18.55	799.77
Maryland Health Care Commission					
Funding for the R Adams Cowley Shock Trauma Center and Maryland Trauma Physician Services Fund resulting from higher than anticipated vehicle surcharge revenue		6.30			6.30
Total Proposed Fiscal 2026 Deficiencies	**$664.96**	**$28.38**	**$1,799.16**	**$32.85**	**$2,525.35**
Proposed Deficiencies to Cover Fiscal 2025 Costs	**$287.57**		**$430.72**		**$718.29**

ACA: Affordable Care Act
ARPA: American Rescue Plan Act
LTSS: Long Term Services and Supports
MADAP: Maryland AIDS Drug Assistance Program
MCHP: Maryland Children's Health Program

Appendix 2
Selected Caseload Estimates Used in Fiscal 2027 Budget Plan
Fiscal 2023-2027 Estimated

	2023	2024	2025	Est. 2026	Est. 2027	Amt. Change 2026-2027	% Change 2026-2027
Medical Care Programs/Medicaid							
Traditional Medicaid Enrollees	1,129,433	1,093,570	982,319	953,262	957,241	3,979	0.4%
Maryland Children's Health Program[1]	164,521	168,394	198,384	198,583	197,659	-924	-0.5%
Affordable Care Act Medicaid Expansion	458,587	443,516	369,807	328,358	312,964	-15,394	-4.7%
Total	**1,752,541**	**1,705,480**	**1,550,511**	**1,480,203**	**1,467,864**	**-12,339**	**-0.8%**
Developmental Disabilities Administration[2]							
Residential Services	6,963	7,141	7,037	7,213	7,282	176	2.5%
Day Services	13,213	12,664	10,670	11,328	11,881	658	6.2%
Support Services	3,645	4,462	6,169	6,243	6,345	74	1.2%
Self-directed Services	2,679	3,746	3,968	4,433	4,635	465	11.7%
Total Services	**26,500**	**28,013**	**27,844**	**29,217**	**30,143**	**1,373**	**4.9%**
Targeted Case Management	25,138	24,620	25,282	24,097	24,595	-1,185	2.7%
Unduplicated count of individuals receiving community-based services	19,748	20,501	20,748	20,901	21,301	153	1.2%

[1] Beginning in fiscal 2024, the Maryland Children's Health Program includes individuals covered under the Healthy Babies initiative, which covers noncitizen pregnant and postpartum individuals.
[2] The service components show a duplicated count as individuals can be counted in multiple service types. Targeted case management is provided to individuals on the waiting list as well as individuals receiving community services. Residential services include individual family care. Day services include supported employment and summer programs. Support services include individual, family, and personal support services.

Source: Department of Budget and Management; Department of Legislative Services; Maryland Department of Health

Appendix 3
Regular Personnel – Authorized Positions by Program
Fiscal 2025-2027

	Actual 2025	Working 2026	Allowance 2027	Amt. Change 2026-2027
MDH Administration	4,473.80	4,465.80	4,453.60	-12.20
State Psychiatric Hospitals	3,129.10	3,125.30	3,083.20	-42.10
Chronic Disease Hospitals	401.20	390.20	393.10	2.90
DDA Facilities	467.50	467.30	468.30	1.00
Office of the Inspector General for Health	41.00	39.00	42.00	3.00
Administration	435.00	444.00	467.00	23.00
Regulatory Services	552.50	551.50	553.10	1.60
Public Health Administration	526.75	537.75	551.75	14.00
PHPA	604.00	541.00	508.00	-33.00
Behavioral Health Administration	215.80	216.50	209.50	-7.00
DDA	211.00	210.00	210.00	0.00
Medical Care Programs Administration	678.10	661.10	681.60	20.50
Health Regulatory Commissions	116.90	121.90	126.00	4.10
Total Regular Positions	**7,378.85**	**7,305.55**	**7,293.55**	**-12.00**

DDA: Developmental Disabilities Administration
MDH: Maryland Department of Health
PHPA: Prevention and Health Promotion Administration

Note: Health Regulatory Commission figures include the Prescription Drug Affordability Board.

Source: Governor's Fiscal 2027 Budget Books

Appendix 4
Contractual Personnel – Authorized FTE Positions by Program
Fiscal 2025-2027

	Actual 2025	Working 2026	Allowance 2027	Amt. Change 2026-2027
MDH Administration	299.99	131.87	151.77	19.90
State Psychiatric Hospitals	191.47	78.80	92.87	14.07
Chronic Disease Hospitals	18.96	12.68	10.13	-2.55
DDA Facilities	24.76	7.30	7.13	-0.17
Office of the Inspector General for Health	4.11	6.51	3.50	0.00
Administration	60.69	26.58	38.14	11.56
Regulatory Services	46.17	21.91	24.24	2.33
Public Health Administration	54.27	34.70	47.48	12.78
PHPA	50.46	19.34	25.75	6.41
Behavioral Health Administration	46.55	30.44	58.38	27.94
DDA	7.41	16.68	22.33	5.65
Medical Care Programs Administration	71.42	87.57	113.25	25.68
Health Regulatory Commissions	7.79	8.13	9.43	1.30
Total Contractual Positions	**584.06**	**350.64**	**452.63**	**101.99**

DDA: Developmental Disabilities Administration
FTE: full-time equivalent
MDH: Maryland Department of Health
PHPA: Prevention and Health Promotion Administration

Note: Health Regulatory Commission figures include the Prescription Drug Affordability Board.

Source: Governor's Fiscal 2027 Budget Books