

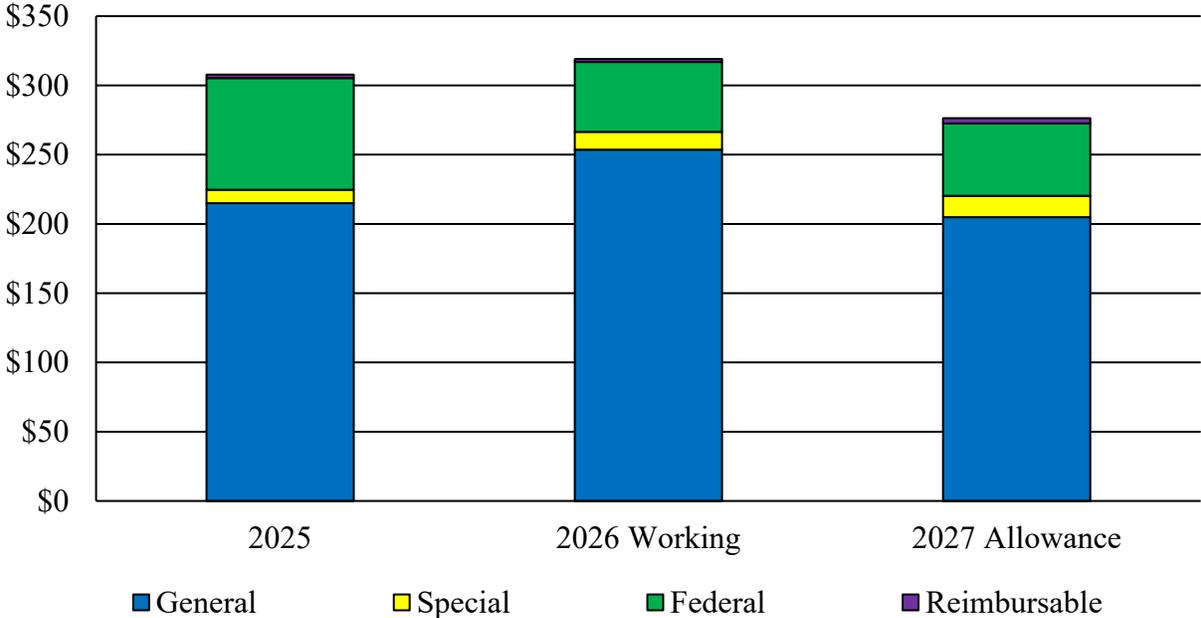
M00F
Public Health Administration
Maryland Department of Health

Program Description

The Maryland Department of Health (MDH) Public Health Administration (PHA) includes the Office of the Deputy Secretary for Public Health Services, the Office of Provider Engagement and Regulation, the Office of Population Health Improvement (OPHI), Core Public Health Services (CPHS) (formula funding for local health departments (LHD)), the Office of the Chief Medical Examiner (OCME), the Office of Preparedness and Response (OPR), and the Laboratories Administration. The key goals of PHA are to complete timely death investigations, strengthen Maryland’s capacity to respond to public health emergencies, minimize irresponsible prescription of controlled dangerous substances, and promote the quality and reliability of public health laboratory practices.

Operating Budget Summary

Fiscal 2027 Budget Decreases \$42.7 Million, or 13.4%, to \$276.3 Million (\$ in Millions)



Note: The fiscal 2026 working appropriation accounts for deficiencies. 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.

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- The fiscal 2027 allowance decreases by \$42.7 million from the fiscal 2026 working appropriation after accounting for deficiency appropriations and a contingent general fund reduction. This overall decrease is due largely to a one-time \$49.4 million general fund backfill in fiscal 2026 for prior year COVID-19 response activities that were not eligible for reimbursement from the Federal Emergency Management Agency (FEMA).

Fiscal 2026

Federal Recissions

Several federal grants with funding in the fiscal 2026 PHA budget were at risk of rescission or cancellation due to federal actions in calendar 2025. These include the Epidemiology and Laboratory Capacity for Infectious Disease (ELC) and the Block Grants for Prevention and Treatment of Substance Abuse (SABG). The ELC grants, including enhancements through COVID-19 relief supplemental funding, represent \$5.9 million in fiscal 2026 funding under the Laboratories Administration. Each of these grants have received a no-cost extension and expire July 31, 2026. The fiscal 2026 appropriation includes \$274,425 for the SABG in OPHI. The grant expired September 30, 2025. PHA did not lose any funding from these sources as both grants continued under a preliminary injunction issued in May 2025. The federal government appealed the injunction but later withdrew its appeal, thereby restoring the grants to their previous status.

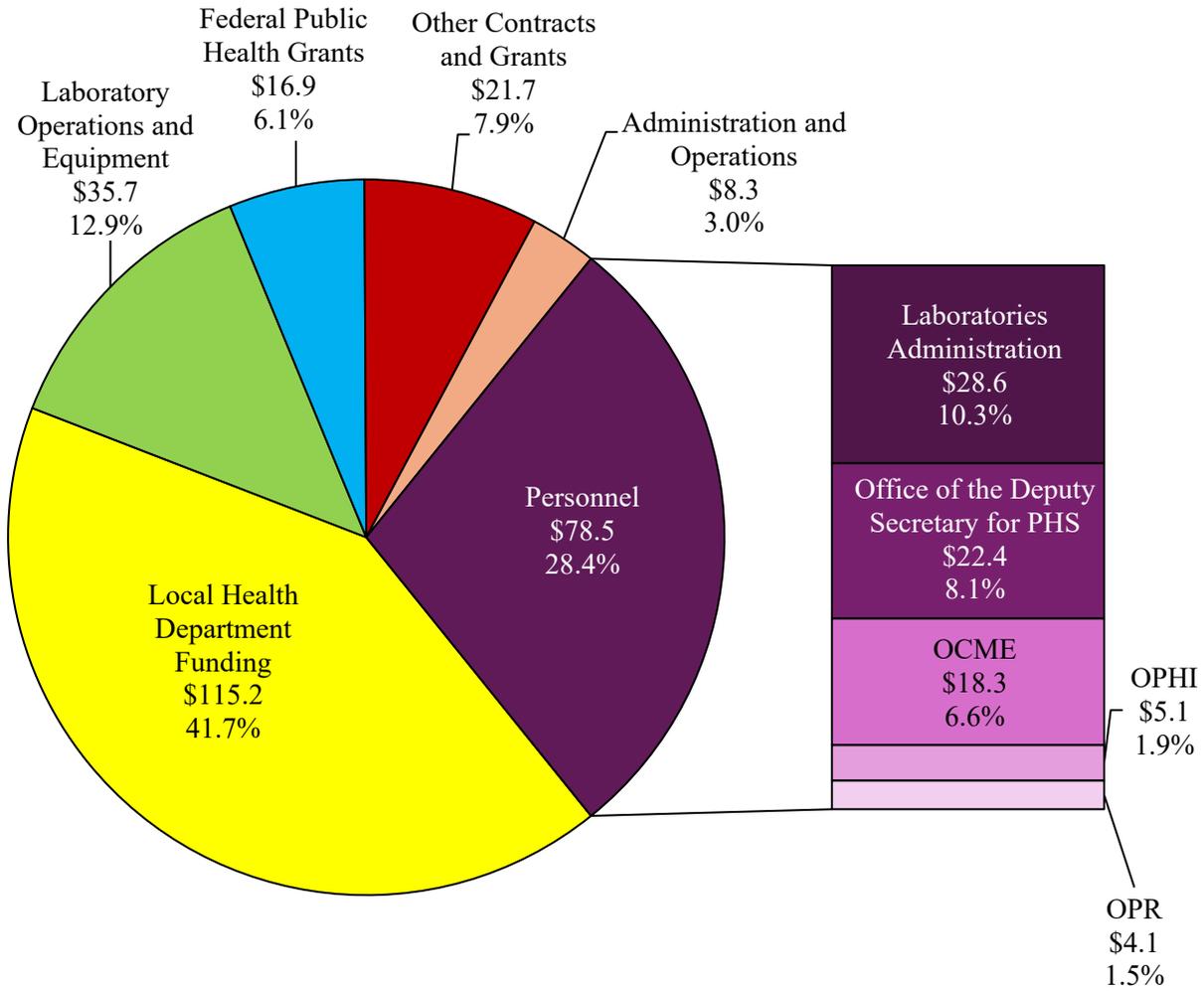
Proposed Deficiency

The fiscal 2027 budget plan includes two deficiency appropriations reducing fiscal 2026 PHA funding by \$1.1 million in federal funds. Both deficiencies reflect actual spending on COVID-19 related expenses in the OPR (\$800,000) and from the Deputy Secretary for Public Health Services (\$340,000). Of these deficiency appropriations, \$908,573 reflect personnel-related savings.

Fiscal 2027 Overview of Agency Spending

The fiscal 2027 allowance includes \$276.3 million in PHA, as shown in **Exhibit 1**. The largest portion of the budget provides the State allocation for LHDs (\$115.2 million), which includes both formula funding and cost-of-living adjustments (COLA) for State employees at LHDs. About 28.4% of the budget supports regular and contractual personnel, more than half of which are in the Laboratories Administration (\$28.6 million) and the Office of the Deputy Secretary for Public Health Services (\$22.4 million). The budget also includes \$35.7 million for various laboratory operations and equipment and \$16.9 million in nonpersonnel costs related to federal public health grants, including preparedness grants for local jurisdictions.

Exhibit 1
Overview of Agency Spending
Fiscal 2027 Allowance
(\$ in Millions)



OCME: Office of the Chief Medical Examiner
 OPHI: Office of Population Health Improvement
 OPR: Office of Preparedness and Response
 PHS: Public Health Services

Note: 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

Proposed Budget Change

The fiscal 2027 allowance for PHA decreases by \$42.7 million compared to the fiscal 2026 working appropriation after accounting for deficiency appropriations and a contingent general fund reduction. This overall decrease is driven mainly by the end of fiscal 2026 funding for COVID-19 response efforts (\$49.4 million). These expenditures were not eligible for FEMA reimbursement and were covered with general funds in fiscal 2026. As seen in **Exhibit 2**, the \$49.4 million decrease is partially offset by an increase in personnel expenditures associated with salary increases and fringe benefits and 14.0 additional employees transferred to PHA from other areas of MDH. There is also a \$1.4 million net increase in special funds for the Maryland Loan Assistance Repayment Program (MLARP) for Physicians and Physicians Assistants. In addition, PHA’s budget includes an increase in federal funding (\$2.1 million) from the State Opioid Response grant to support public health workforce development for training, which is almost entirely offset by a decrease in federal funding (\$2.0 million) for Public Health Infrastructure grants to LHD.

**Exhibit 2
Proposed Budget
Maryland Department of Health – Public Health Administration
(\$ in Thousands)**

How Much It Grows:	General <u>Fund</u>	Special <u>Fund</u>	Federal <u>Fund</u>	Reimb. <u>Fund</u>	<u>Total</u>
Fiscal 2025 Actual	\$214,995	\$9,611	\$80,713	\$2,493	\$307,812
Fiscal 2026 Working	253,619	12,841	50,468	2,079	319,008
Fiscal 2027 Allowance	<u>204,933</u>	<u>15,384</u>	<u>52,214</u>	<u>3,762</u>	<u>276,294</u>
Fiscal 2026-2027 \$ Change	-48,687	2,544	1,746	1,683	-42,714
Fiscal 2026-2027 % Change	-19.20%	19.81%	3.46%	80.96%	-13.39%

Where It Goes: **Change**

Personnel Expenses

Salary increases and associated fringe benefits including 14 positions transferred from other units of MDH.....	\$5,556
Employee and retiree health insurance	2,813
Turnover adjustments	-426
Deferred compensation match	141
Overtime	-61
Other	-30

Federal Grants

State Opioid Response Grant for workforce development	2,123
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Where It Goes:	<u>Change</u>
Expiration of three ELC grants in fiscal 2026	-1,400
Public Health Infrastructure grants to local health departments.....	-1,991
Other Changes	
Net increase of 12.78 contractual full-time equivalents	222
Maryland Loan Assistance Repayment Program for Physicians and Physician Assistants.....	1,364
CRISP expenditures related to delay of Public Health Services Data Modernization Program IT project.....	-1,149
Reduced rent expenditures driven by the end of a facility lease (\$746,086).....	-1,344
Prior year COVID-19 related expenses that were not eligible for Federal Emergency Management Agency reimbursement	-49,373
Other	841
Total	-\$42,714

CRISP: Chesapeake Regional Information System for our Patients

ELC: Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases

IT: information technology

MDH: Maryland Department of Health

Note: The fiscal 2026 working appropriation accounts for deficiencies. 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 \$2.0 million in general funds, contingent on a provision in the Budget Reconciliation and Financing Act (BRFA) of 2026 that would authorize the transfer of excess special fund balance from the State Board of Physicians. The budget also includes a contingent special fund appropriation of \$2.0 million, available from this transfer and which would supplement the appropriation for MLARP for Physicians and Physician Assistants. MLARP programs provide student loan repayment assistance in exchange for a two-year service commitment to help ensure that underserved areas of the State have sufficient clinicians. Program participants are eligible for an award of up to \$50,000 per year of service and must work in a health professional shortage area or medically underserved area in primary or behavioral health care. The BRFA provision results in a total budget of \$4.4 million (\$1.0 million in general funds) for the program in fiscal 2027, an increase of \$1.4 million compared to the fiscal 2026 working appropriation. The fiscal 2027 budget returns the program to the fiscal 2025 funding level. During the latest application cycle, the program awarded first-year funding to 61 new applicants and second-year funding to 92 returning participants. Spending on all awards for loan repayment in fiscal 2026 totaled \$3.3 million, and PHA has obligated \$1.5 million for second year awards in fiscal 2027.

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Another provision in the BRFA of 2026 authorizes the transfer of \$10 million in special funds from the MLARP for Nurses and Nursing Support Staff Fund to the General Fund in fiscal 2026. However, the Department of Budget and Management (DBM) indicates that the provision as written incorrectly names MLARP for Nurses and Nursing Support Staff Fund as the fund source, rather than the Nurse Support Program (NSP II) Assistance Fund. DBM will submit a BRFA amendment to correct the language. NSP II focuses on expanding the capacity to educate nurses through nursing education programs at Maryland institutions. The NSP Assistance Fund generates revenue through a hospital fee as defined by the Health Services Cost Review Commission. The Maryland Higher Education Commission administers NSP II.

Personnel Data

	FY 25	FY 26	FY 27	FY 26-27
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>
Regular Positions	564.75	537.75	551.75	14.00
Contractual FTEs	<u>54.27</u>	<u>34.70</u>	<u>47.48</u>	<u>12.78</u>
Total Personnel	619.02	572.45	599.23	26.78

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	51.69	9.37%
Positions and Percentage Vacant as of 12/31/2025	82.50	15.34%
 Vacancies Above Turnover	 30.81	

- On October 22, 2025, the Board of Public Works approved the abolition of 502.7 positions statewide, including 170.7 vacant positions and 332.0 positions associated with the Voluntary Separation Program (VSP). MDH eliminated 21.0 positions in PHA, of which 12 positions were vacant and 9 positions were abolished through the VSP, resulting in \$2.4 million in fiscal 2026 general fund savings across the agency. These positions were budgeted in the Office of the Deputy Secretary for Public Services (10.0), OPHI (1.0), OPR (5.0), and the Laboratories Administration (5.0).
- The fiscal 2027 allowance includes a net increase of 14.0 regular positions in PHA due to transfers from other areas of MDH. The majority of these positions (13.0) are transferred from the Prevention and Health Promotion Administration (PHPA) to the Office of the Deputy Secretary for Public Health Services for the MDH Internship Program, which is supported by the federal Public Health Infrastructure Grant. Other transfers include 2.0 positions to the Behavioral Health Administration (BHA) from OPHI and 2.0 positions to the Laboratories Administration from BHA; 3.0 positions to OPHI from PHPA; and 2.0 positions from OPR to Spring Grove Hospital Center.

- There is a net increase of 12.78 contractual full-time equivalents in the fiscal 2027 allowance, made up mainly of interns from the MDH Internship Program, which is funded by the federal Public Health Infrastructure Grant.
- As of December 31, 2025, PHA had 82.50 vacant positions, 30.81 above the number of vacancies needed to meet budgeted turnover in fiscal 2027. More than half of the vacant positions (47.5) are in the Office of the Deputy Secretary for Public Health.

Key Observations

1. Commission on Public Health Sunsets in Fiscal 2026

Following the COVID-19 public health emergency, the Maryland General Assembly passed Chapter 385 of 2023, which established the Commission on Public Health to study Maryland’s public health system and make recommendations to improve State and local “foundational public health services”. Funded mainly through philanthropic organizations via the National Foundation for the Centers for Disease Control and Prevention, the commission carried out its analysis and assessment over two years, releasing a final report in October 2025. The commission will terminate in June 2026. Per the legislation, the commission’s 16-person membership included State health officials, local health officers, State legislators, and public health scholars and advocates. The legislation also required the commission to organize its work into five workgroups: (1) governance and organizational capabilities; (2) funding; (3) workforce; (4) data and information technology (IT); and (5) communication and public engagement. Workgroup participants included commission members and 102 additional individuals from academia, LHDs, health associations, and private health organizations. The commission met regularly as a whole and in workgroups throughout its tenure.

The commission’s work consisted of:

- assessing the State’s current public health system, including through a community assessment utilizing focus groups and listening sessions in each jurisdiction;
- identifying gaps in the public health system and health delivery, and areas for improvement;
- studying, developing, and prioritizing policy solutions;
- creating and publicizing draft recommendations and soliciting public feedback; and
- refining and releasing final recommendations.

Now that the commission’s report is complete, the group will work with LHDs, MDH, and coalitions such as the Maryland Association of County Health Officers (MACHO) and Maryland Association of Counties (MACo), to advance the recommendations.

Identifying the Issues

To complete a comprehensive assessment of the State’s public health system, the commission met 26 times between December 2023 and November 2025, in addition to monthly workgroup meetings. To guide its work, the group developed and followed a framework which involved:

- completing a community assessment;
- quantifying the issue;
- developing a concise statement of the issue;
- identifying evidence based practices;
- developing and prioritizing program and policy options;
- creating an action plan and implementing interventions; and
- evaluating proposed programs or policies.

Through these components, the commission engaged the community in decision-making, leveraged available data and assessment tools, and evaluated MDH and LHD capacity for health program oversight and service delivery, all of which relied on evidence based public health approaches and interventions. Throughout the assessment process, the commission engaged many different stakeholders, including academic partners who helped develop assessment tools, including materials for surveys, interviews, and focus groups with State public health leaders and advocates. In addition, the commission gathered input on individuals’ experience with the public health system through online public surveys, and visits to six LHDs in Baltimore City and Howard, Montgomery, St. Mary’s, Talbot, and Washington counties.

Through this research and collaboration, the commission evaluated to what degree LHDs and MDH fulfilled foundational public health services. Chapter 385 defines foundational public health services as the Public Health Accreditation Board (PHAB)’s foundational public health capabilities and foundational public health areas. The commission altered the foundational public health areas to include behavioral health, which was not a part of PHAB’s original model. The components of these services are listed in **Exhibit 3**.

Exhibit 3
Foundational Public Health Services

Foundational Public Health Areas

Communicable Disease Control	Chronic Disease and Injury Prevention
Environmental Public Health	Maternal, Child, and Family Health
Access to and Linkage with Clinical Care	Behavioral Health

Foundational Public Health Capabilities

Assessment and Surveillance	Community Partnership Development
Equity	Organizational Competencies
Policy Development and Support	Accountability and Performance Management
Emergency Preparedness and Response	Communications

Source: Public Health Accreditation Board; Commission on Public Health; Department of Legislative Services

Each of the commission’s five workgroups identified specific challenges within their areas. Funding availability was cited as one of the main challenges in several areas, including in the context of improving outdated data systems, expanding and maintaining the workforce, and updating CPHS funding for LHDs. In the report, the commission noted the wide variation of funding levels and structures at different LHDs and estimated that core funding represents about 13% of all LHD budgets. The report points out that the CPHS funding model is outdated, does not adjust commensurate with changes to State salaries, and does not equitably account for public health needs. The commission also identified challenges in identifying alternative sources of funding for LHDs and investing fully in the Achieving Healthcare Efficiency through Accountable Design model, a federal value-based care system modeled on Maryland’s Total Cost of Care model.

The commission identified several strengths in Maryland’s system, including an extensive network of governmental and nongovernmental partnerships; a prioritization of preventive and primary care; and the integration of health equity in policies and services. The commission’s report points out that each of these elements could be strengthened by addressing the challenges noted earlier, such as improved communication systems to support partner cultivation and stewardship, and increased investments in preventive and primary care.

Chapter 385 also requires the commission to evaluate the State’s ability to respond to emergent public health events, overdoses, and maternal and child mortality. The group identified multiple issues in the State’s preparedness and response systems, including challenges with logistic and communication protocols between State and local governments, workforce shortages, and fiscal investments in preparedness. The report noted the reliance of OPR on federal funds which could be at risk if the priorities of the federal government change. Regarding overdoses and

maternal and infant mortality, the report noted several actions taken by the State and local governments to improve outcomes for those impacted. However, the report also emphasizes the need to strengthen and diversify the behavioral health workforce to expand and sustain efforts to prevent overdoses, and increase funding for maternal and infant care, an area that those interviewed and surveyed argue is perennially underfunded.

Final Recommendations

Finally, the commission drafted recommendations and released them for public comment on June 9, 2025. After reviewing, evaluating, and incorporating edits and suggestions from commission members and members of the public, the commission released its final recommendations in the report published in November 2025. The commission organized its final recommendations into five categories:

1. **Strengthen public health infrastructure** through leadership and governance, human resources, and funding. Recommendations under this category include creating statewide healthcare outcome metrics and goals, establishing laws that protect public health employees, and assessing the CPHS funding formula.
2. **Modernize and maximize communication, data, and IT tools** by streamlining IT operations and enhancing public engagement and communication. In addition to increasing channels for the public to provide feedback and expanding the visibility of public health initiatives, the commission recommends implementing significant changes to IT systems and data collection, management, and analysis tools.
3. **Leverage and formalize partnerships** with State agencies, academic institutions, nonprofit organizations, health care organizations, and the private sector. These recommendations define specific ways in which MDH and LHDs can partner with existing and potential partners to improve structural gaps in the public health system.
4. **Bridge public health and health care service delivery** by increasing public health education and improving primary care access. These recommendations are means by which the State can connect the various stakeholders involved in the community's health, including individuals, primary care providers, LHDs, MDH, and policymakers, in service of normalizing and promoting primary health care throughout communities.
5. **Pave the way for current and future public health leaders** with investments in public health workforce policy, planning, and innovative educational and professional development opportunities. The commission suggests workforce initiatives such as a statewide public health workforce training strategy and expansion of the existing Maryland Corps to include public health professions.

The feasibility of implementing these recommendations varies widely. Some recommendations will require legislative action, while others will be up to State or local health officials to establish and implement. Many of the recommendations are related to structural and

system challenges experienced by the State and LHDs, which will require significant human and financial resources to alleviate. MDH indicates that it is working closely with the commission, LHDs, and other stakeholders to determine which recommendations can be implemented given MDH’s authority and funding availability. One area in which MDH has made progress relates to public information sharing and communication, with one example being the several public interactive dashboards the department maintains, which share data on public health issues such as overdose fatalities, firearm violence, and women’s health.

MDH is also in the process of replacing or developing 24 major IT systems across its department, including a Public Health Services (PHS) data modernization project to support surveillance, maternal health, newborn screening, vital statistics and other data. The PHS data modernization project has been delayed, and there is no funding in the proposed fiscal 2027 budget for the project. This system aligns with commission recommendations related to modernization of clinical documentation, standardization of workflows, and integration with the Chesapeake Regional Information System for our Patients.

The commission’s recommendations were released during a period in which health departments are operating under immense uncertainty with regard to State and federal funding and federal policies. However, MDH notes that there is potential to leverage new and existing federal grants, such as the Public Health Infrastructure Grant and the Rural Health Transformation Grant, to implement some of the commission’s recommendations in the short term. The extent to which this work and these recommendations result in policy and procedural changes will depend largely on health departments’ capacities to implement them sustainably with available funding.

2. LHD Funding and Match Requirement Regulations

Each year, the Governor includes CPHS funding for LHDs in the budget, as required by §2-302 of the Health – General Article. The statute stipulates that through fiscal 2024, funding must be adjusted annually based on population growth and inflation factors and sets minimum funding levels of \$70 million and \$80 million in fiscal 2025 and 2026, respectively. Beginning with the fiscal 2027 allowance, the annual appropriation must be determined by applying the annual change in population and Consumer Price Index to the prior year appropriation. The statute also requires that each jurisdiction’s allocation of State funding in fiscal 2027 and subsequent fiscal years must be no lower than its fiscal 2026 allocation. As noted in Key Observation 1, the commission recommended assessing and updating the CPHS formula and LHD match requirement.

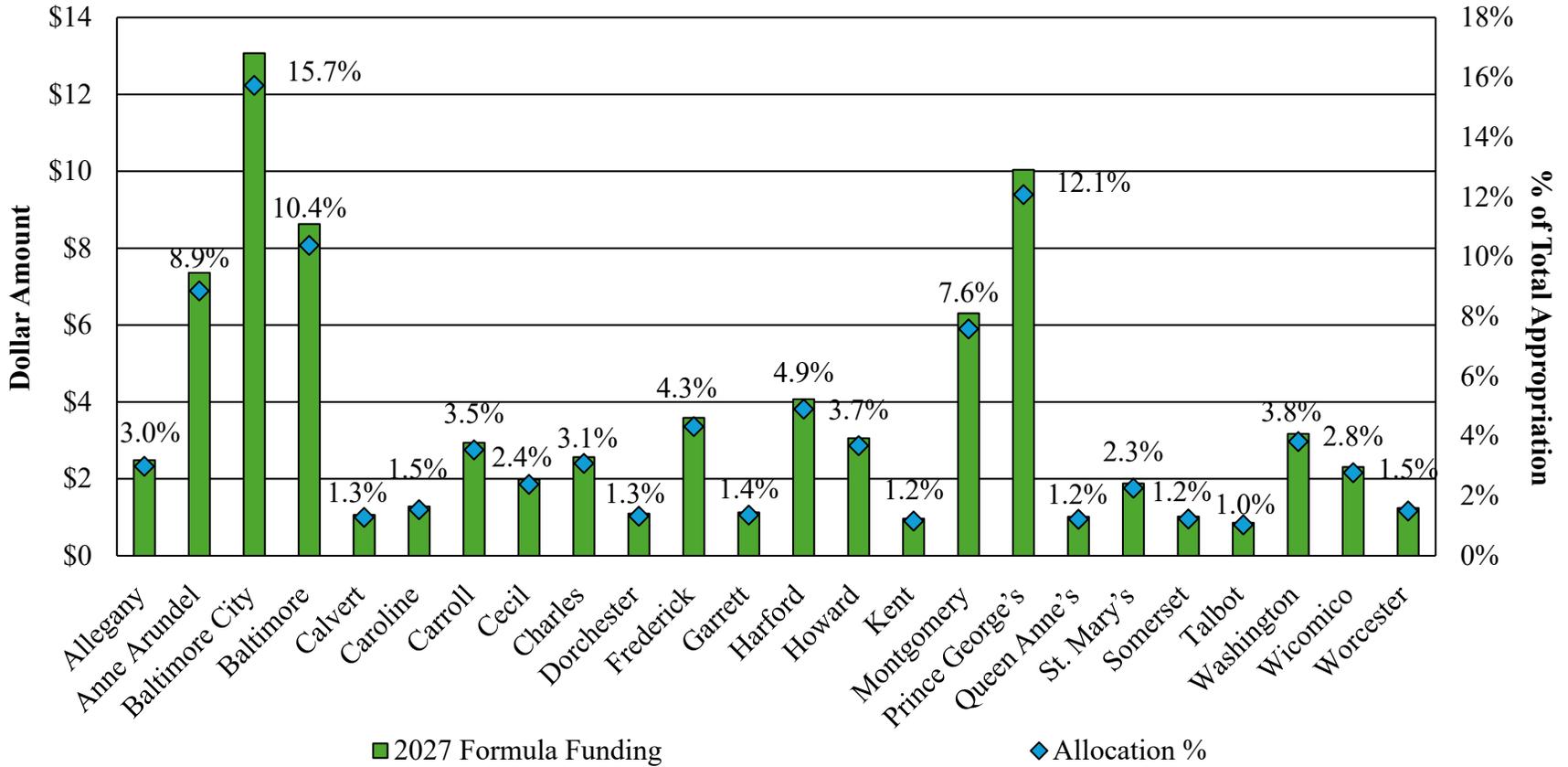
CPHS funding has previously been budgeted in one program that included both core formula funding and funding for COLAs for State staff employed at LHDs. However, language in the fiscal 2026 Budget Bill requires DBM to budget formula funding and LHD salary funds in separate programs beginning in fiscal 2027. LHDs are staffed by a combination of local and State employees, and the makeup of each LHD’s workforce differs between jurisdictions; therefore, the amount of funding allocated for salaries is dependent on the number of State staff each LHD employs. The bill language restricts funds pending the fiscal 2027 budget submission with the two

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components budgeted separately. DBM submitted the budget with separate programs as required, and MDH confirmed the separation of the two budgets in a report submitted January 16, 2026. **The Department of Legislative Services (DLS) determined that the budget submission complies with the language and recommends the release of \$250,000 in general funds. DLS will process a letter to this effect if no objections are raised by the subcommittees.**

The fiscal 2027 allowance includes \$83.1 million for the core formula funding. To calculate the fiscal 2027 formula funding appropriation, DBM applied the formula growth factors to a base of \$80 million. DBM and MDH allocated the \$3.1 million formula increment to local jurisdictions in the same proportion as the base. The fiscal 2027 allocation of the core formula funding by subdivision is shown in **Exhibit 4**.

Exhibit 4
Local Health Department Core Funding Allocation
Fiscal 2027
(\$ in Millions)



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

The fiscal 2027 CPHS appropriation, including salary costs and formula funding, totals \$115.2 million, which is level-funded from the fiscal 2026 working appropriation. The fiscal 2026 working appropriation includes fiscal 2026 COLAs totaling \$3.7 million. No COLAs for fiscal 2027 have been applied to the allowance under the CPHS program, as these adjustments are budgeted centrally in DBM and will be transferred to the CPHS budget via budget amendment. DBM indicated that to calculate the fiscal 2027 formula amount, it applied a formula increment of \$3.1 million to a base of \$80 million. However, as the overall CPHS appropriation is level-funded in fiscal 2027, that growth is fully offset by reducing prior year salary support for State employees in LHDs by a corresponding \$3.1 million.

The decision to fund the formula increase by reducing the COLA funding has significant distributional impacts across counties. Jurisdictions that receive little to no COLA funding such as Baltimore City (\$2.7 million increase), Baltimore County (\$1.8 million increase), Montgomery County (\$1.2 million increase), and Prince George’s County (\$1.7 million increase) receive increases in formula funds, while many of the smaller counties that receive substantial COLA support see a net reduction in State support for their health department. However, the LHD share of funding for fiscal 2027 COLAs for State employees is not yet reflected in the CPHS budget, and once applied, these smaller LHDs will likely see a net increase in their total CPHS allocation. **MDH should update the committees on the amounts that will be allocated to LHDs to fund COLAs in fiscal 2027, how the funds will be allocated by county, and when LHDs will be notified of their allocation. In addition, DBM should clarify when fiscal 2027 COLAs will be realigned into the CPHS budget.**

The five largest counties, which typically employ few or no State staff and thus receive little to zero funding for salaries, do not have any funding budgeted for State salary expenses in fiscal 2027. With the exception of Baltimore City, the other four jurisdictions (Anne Arundel, Baltimore, Montgomery, and Prince George’s counties) are overseen by a health officer who is a State employee. The remaining staff are a mix of local and State employees; but in Baltimore and Montgomery counties, only the health officer is employed by the State. **MDH and DBM should comment on why there is no salary funding budgeted for these four jurisdictions in fiscal 2027, despite employing at least one State staff member.**

Local Match Requirement

Chapter 504 of 1995, which mandated the minimum appropriation for each LHD to be no less than the amount received in the prior year, also requires LHDs to provide a partial match of State CPHS funding and established the match percentages for each jurisdiction using the Case formula, which was adopted in the Code of Maryland Regulations in fiscal 1956. Because the match percentage is applied to the CPHS appropriation, large increases in formula funding result in a significant match burden for some local governments. In its report summarizing changes to the match requirement regulations, MDH noted that CPHS growth between fiscal 2014 and 2025 averaged 10%, but between fiscal 2023 and 2024, the CPHS budget increased by 55%. To lessen the burden on LHDs, MDH indicated that it would amend the match requirement regulations to cap the match percentages.

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Language in the fiscal 2026 Budget Bill restricted funds pending MDH submitting amended regulations to the Joint Committee on Administrative, Executive, and Legislative Review (AELR) and a report summarizing the updated regulations to the budget committees following submission of the new regulations. MDH included the requested information in the report submitted January 16, 2026. MDH reported that it had drafted regulations which:

- clarified that the match applies only to base formula funding and, when applicable, any discretionary funding, excluding funding for salary adjustments;
- capped the annual match requirement increase at 10% of the prior year’s local match; and
- formalized the Secretary of Health’s authority to approve waiver reduction requests for local governments that demonstrate financial hardship.

The department indicated that it refined these regulations based on feedback from stakeholders, including MACo and MACHO. MDH submitted the regulations to AELR in January 2026, and the department indicated that the regulations would be published in the Maryland Register by March 2026, at which point they would be available for public comment. MDH anticipates the regulations to be enacted July 1, 2027. **DLS determined the report and submission to AELR to be in compliance with the restrictive language and recommends the release of \$100,000 in general funds. DLS will process a letter to this effect if no objections are raised by the subcommittees.**

Operating Budget Recommended Actions

1. Concur with Governor's allowance.

Updates

- ***OCME Maintains Accreditation and Caseload Ratio:*** Following an inspection on February 9, 2024 which found two Phase II violations, the National Association of Medical Examiners (NAME) issued OCME provisional accreditation status through May 14, 2025. OCME addressed the findings and in May 2025, self-reported to NAME the status of the corrections. OCME currently maintains provisional accreditation through May 2026. In fiscal 2025, the average death investigation caseload ratio was 229 examinations per medical examiner (ME) per year, down from 261 per ME per year in fiscal 2024, and far below the NAME maximum standard of 325 cases per year.

Appendix 1
2025 Joint Chairmen’s Report Responses from Agency

The *2025 Joint Chairmen’s Report* (JCR) requested that PHA prepare one report. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Report on LHDs Funding Match Requirement Regulations:*** MDH submitted a report summarizing the proposed changes to local match requirement regulations. MDH finalized the new regulations with input from relevant stakeholders and anticipates that the changes will be effective beginning in fiscal 2027. Further discussion on CPHS funding and the local match requirement is included in Key Observation 2 of this report.

**Appendix 2
Audit Findings
Vital Statistics Administration**

Audit Period for Last Audit	January 16, 2020 – January 15, 2024
Issue Date	March 2025
Number of Findings	7
Number of Repeat Findings	1
% of Repeat Findings	14.3%
Rating: (if applicable)	n/a

Finding 1: The Vital Statistics Administration (VSA) did not adequately monitor the Integrated Electronic Vital Records Registration Systems (IEVRRS) project management vendor to ensure that the project was completed on budget and on time. As of June 30, 2023, the projected IEVRRS budget costs have increased by \$16 million, and the projected completion date has been delayed by four years.

Finding 2: VSA did not obtain support for amounts invoiced and paid to IEVRRS vendors. In addition, VSA made payments totaling \$53,000 that were not in accordance with the related contract, including overpayments totaling \$28,000.

Finding 3: Redacted cybersecurity-related finding.

Finding 4: Redacted cybersecurity-related finding.

Finding 5: VSA did not review manual changes to birth records on the Electronic Birth Registration System.

Finding 6: VSA did not ensure that LHDs remitted fees collected on behalf of VSA for certified copies of birth and death certificates resulting in the failure to identify and recover at least \$376,000.

Finding 7: **VSA had not established adequate procedures and controls over certificate fee collections received at its headquarters.**

*Bold denotes item repeated in full or part from preceding audit report.

Appendix 3
Object/Fund Difference Report
Maryland Department of Health – Public Health Administration

<u>Object/Fund</u>	<u>FY 25</u> <u>Actual</u>	<u>FY 26</u> <u>Working</u> <u>Appropriation</u>	<u>FY 27</u> <u>Allowance</u>	<u>FY 26 - 27</u> <u>\$ Change</u>	<u>% Change</u>
Positions					
01 Regular	564.75	537.75	551.75	14.00	2.6%
02 Contractual	54.27	34.70	47.48	12.78	36.8%
Total Positions	619.02	572.45	599.23	26.78	4.7%
Objects					
01 Salaries, Wages, and Fringe Benefits	\$62,390,298	\$66,436,463	\$74,429,747	\$7,993,284	12.0%
02 Technical and Special Fees	7,134,538	3,825,861	4,048,064	222,203	5.8%
03 Communications	755,778	498,061	575,523	77,462	15.6%
04 Travel	170,845	332,882	179,017	-153,865	-46.2%
06 Fuel and Utilities	3,905,482	3,154,476	3,882,771	728,295	23.1%
07 Motor Vehicle Operation and Maintenance	113,688	23,935	28,518	4,583	19.1%
08 Contractual Services	81,260,677	86,818,756	40,902,420	-45,916,336	-52.9%
09 Supplies and Materials	11,563,016	12,834,961	11,452,716	-1,382,245	-10.8%
10 Equipment – Replacement	961,029	1,098,093	1,200,091	101,998	9.3%
11 Equipment – Additional	271,973	2,121,546	1,148,260	-973,286	-45.9%
12 Grants, Subsidies, and Contributions	117,379,772	119,113,648	119,439,919	326,271	0.3%
13 Fixed Charges	21,905,281	22,748,922	21,006,566	-1,742,356	-7.7%
Total Objects	\$307,812,377	\$319,007,604	\$278,293,612	-\$40,713,992	-12.8%
Funds					
01 General Funds	\$214,995,468	\$253,619,320	\$206,932,663	\$-46,686,657	-18.4%
03 Special Funds	9,611,235	12,840,795	15,384,296	2,543,501	19.8%
05 Federal Funds	80,712,550	50,468,398	52,214,324	1,745,926	3.5%
09 Reimbursable Funds	2,493,124	2,079,091	3,762,329	1,683,238	81.0%
Total Funds	\$307,812,377	\$319,007,604	\$278,293,612	-\$40,713,992	-12.8%

Note: The fiscal 2026 appropriation includes proposed deficiency appropriations. The fiscal 2027 allowance does not include contingent reductions or statewide salary adjustments budgeted within the Department of Budget and Management.