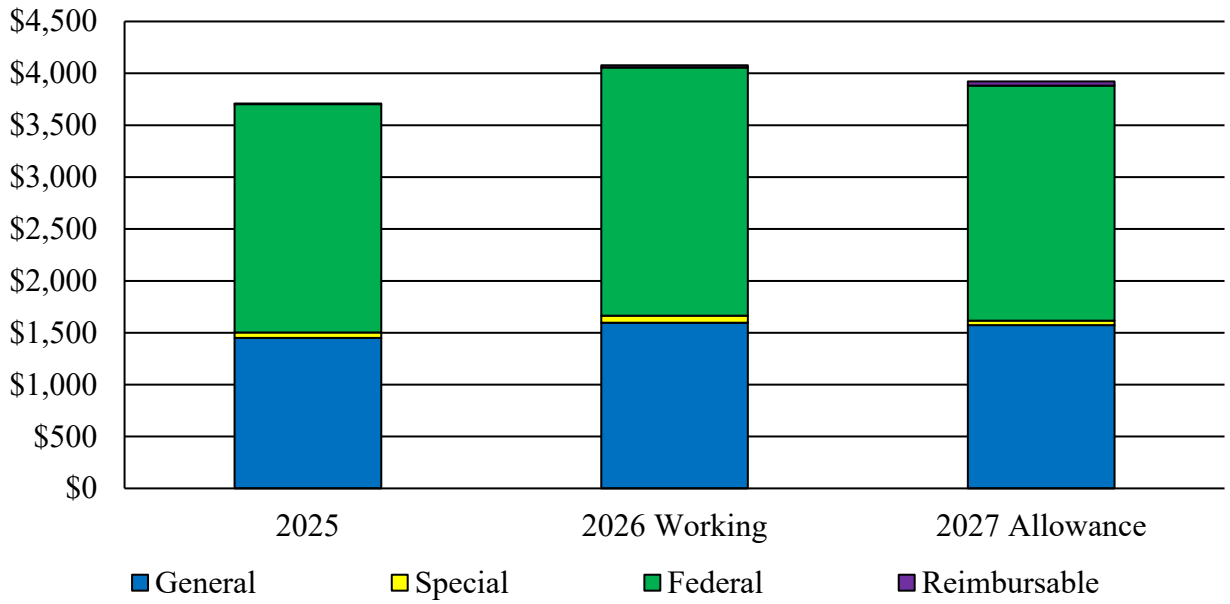
M00L
Behavioral Health Administration
Maryland Department of Health

Executive Summary

The Maryland Department of Health (MDH) Behavioral Health Administration (BHA) is responsible for coordinating State programs to prevent, treat, and support individuals with mental illness, substance use disorders (SUD), problem gambling disorders, and co-occurring conditions. The BHA budget also reflects provider reimbursements for specialty behavioral health services to those in the Medicaid program and the uninsured through the Public Behavioral Health System (PBHS), which is managed through an Administrative Services Organization (ASO). This analysis does not reflect funding the State-run psychiatric facilities, which are included in the analysis for M00A01 – MDH – Administration.

Operating Budget Summary

Fiscal 2027 Budget Decreases $155.8 Million, or 3.8%, to $3.9 Billion
($ in Millions)



Note: Numbers may not sum 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.

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- The fiscal 2027 allowance decreases by $155.8 million compared to the fiscal 2026 working appropriation after accounting for a planned reversion, proposed deficiency appropriations, and a contingent reduction. The fiscal 2027 budget includes five deficiency appropriations that increase the fiscal 2026 working appropriation by a net of $681.1 million. All but one of these deficiency appropriations supports provider reimbursements for behavioral health services, accounting for $698 million, of which $67.1 million is associated with fiscal 2025 costs. The remaining $16.9 million is a general fund withdrawal for behavioral health investments to align with actual spending.

- The fiscal 2027 budget plan assumes a planned reversion of $16.7 million due to underspending among local behavioral health authorities (LBHA) and core service agencies (CSA). Excluding the deficiency appropriation for fiscal 2025 costs and the planned reversion related to prior year costs, the fiscal 2027 allowance would decrease by $105.4 million.

- Reimbursable funds increase by $19.8 million in fiscal 2027 after accounting for proposed deficiency appropriations, driven by increased spending in the Behavioral Health Medicaid program for certain services. These funds are available from funding budgeted for behavioral health investments in the BHA Community Services program.

- Language in the fiscal 2027 Budget Bill would reduce general funds by $500,000 and appropriate special funds of the same amount, contingent on the enactment of legislation that authorizes the use of fund balance from the State Board of Professional Counselors and Therapists for BHA. This authorization is contained in the Budget Reconciliation and Financing Act (BRFA) of 2026.

Key Observations

- ***Assisted Outpatient Treatment Program Begins in Fiscal 2027:*** Chapters 703 and 704 of 2024 authorize local jurisdictions to implement an Assisted Outpatient Treatment (AOT) program by July 1, 2026, and require the State to implement the program for any jurisdiction that did not opt to establish its own. No local governments have opted to implement their own program, and MDH plans to establish three regional programs in fiscal 2027. The BRFA of 2026 includes a provision that would require any jurisdiction in which MDH has established a program to reimburse the State an increasing portion of the State share of program costs beginning in fiscal 2028 through fiscal 2031. The Department of Legislative Services (DLS) notes that despite the cost share continuing into fiscal 2031, under current law the program is no longer required under statute after fiscal 2030.

- ***Certified Community Behavioral Health Clinic (CCBHC) Demonstration in Fiscal 2027:*** The Substance Abuse and Mental Health Servies Administration (SAMHSA) introduced the CCBHC model to expand access to high-quality comprehensive behavioral

health care across the country. Under the model, states certify clinics that meet a set of specific federal standards for staffing, wraparound services, care coordination, and data reporting. After completing a planning grant, states may apply for the demonstration to pilot the model and take advantage of an enhanced federal match. Maryland is completing its planning grant work, which ends December 31, 2026. The fiscal 2027 allowance includes $4.6 million in general funds in the Dedicated Purpose Account (DPA) for the implementation of two CCBHCs beginning January 1, 2027. Current law requires Maryland to apply to SAMHSA for the demonstration grant in fiscal 2027; however, a provision in the BRFA of 2026 would authorize rather than require MDH to apply for the grant in fiscal 2029.

- ***Update on the Transition to the New Administrative Services Organization:*** MDH began transitioning from Optum to the new ASO, Carelon, in March 2024. The new system went live January 1, 2025. MDH has indicated that to date, the transition has gone relatively well, with Carelon and MDH responding quickly to challenges related to provider education and uptake. However, there have been challenges with data transfers, which leads to uncertainty about provider reimbursement costs. In early January 2026, MDH acknowledged data quality issues resulting from misalignment between Optum data categorization and Carelon's, resulting in Medicaid-eligible payments being categorized as non-Medicaid eligible. MDH indicates that it continues to work with Carelon to remedy the issues and anticipates the errors to be resolved within a few months.

- ***Behavioral Health Investments Continue to Underspend:*** Since fiscal 2024, BHA's annual budget as enacted has included at least $50 million for behavioral investments that support a variety of initiatives, focused especially on crisis response and addressing hospital overstays. In fiscal 2024 and 2025, BHA underspent the appropriation, citing program implementation delays. The fiscal 2027 budget includes a $16.9 million general fund withdrawal in fiscal 2026 to align with actual expenditures.

- ***Behavioral Health Workforce Fund Remains Dormant:*** Chapters 286 and 287 of 2023 established the Behavioral Health Workforce Investment Fund to support the education, training, recruiting, and retaining of behavioral health workers in Maryland. Chapters 286 and 287 require the Maryland Health Care Commission (MHCC) to conduct a comprehensive behavioral health workforce needs assessment, which was completed in October 2024. MHCC found significant deficits in the volume of the State's behavioral health workforce and recommended investing $148.5 million over five years, consisting of State and non-State resources, to support recruitment and retainment efforts. Chapters 286 and 287 do not specify a revenue source for the fund. To date, MDH has not added any money into the fund and has indicated that it does not have plans to do so.

Operating Budget Recommended Actions

		Amount
1.	Reduce funding to reflect savings due to an anticipated turnover rate higher than budgeted in fiscal 2027.	-$725,000
2.	Add language restricting the appropriation for M00L01.02 to be expended only in M00L01.02, M00L01.03, M00Q01.03, or M00Q01.10.	
3.	Add language restricting the appropriation for M00L01.03 to be expended only in M00L01.02, M00L01.03, M00Q01.03, or M00Q01.10.	
4.	Add language restricting the appropriation for M00Q01.10 to be expended only in M00L01.02, M00L01.03, M00Q01.03, or M00Q01.10.	
5.	Add language restricting funding pending corrective action from the Maryland Department of Health and a report confirming the status of each repeat audit finding.	
6.	Add language restricting funding pending the submission of the fiscal 2028 budget, which includes a separate program for provider reimbursements for the uninsured and underinsured.	
7.	Add language restricting funding pending the submission of non-Medicaid provider reimbursement data.	
8.	Add language restricting funding pending the submission of a report on the timeliness of grant payments to local nonprofit core service agencies.	
9.	Adopt committee narrative requesting a report on the Administrative Services Organization transition.	
10.	Adopt committee narrative requesting a report on reimbursable fund spending and reporting in the Behavioral Health Medicaid program.	
	Total Net Change to Fiscal 2027 Allowance	**-$725,000**
11.	Add language restricting the fiscal 2026 deficiency appropriation for M00Q01.10 to be expended only in M00L01.02, M00L01.03, M00Q01.03, or M00Q01.10.	

Updates

- ***9-8-8 Trust Fund Update:*** Chapters 145 and 146 of 2022 established the 9-8-8 Trust Fund to support the National Suicide Prevention Lifeline, or the 9-8-8 Crisis Line, which is operated through six call centers throughout the State. Chapters 780 and 781 of 2024 established a telecommunications fee to generate revenue for the fund. Fiscal 2025 revenue ($15.2 million) was lower than expected leading to lower actual expenditures than planned. MDH estimates annual revenue of $21.7 million and $21.9 million in fiscal 2026 and 2027, respectively.

Operating Budget Analysis

Program Description

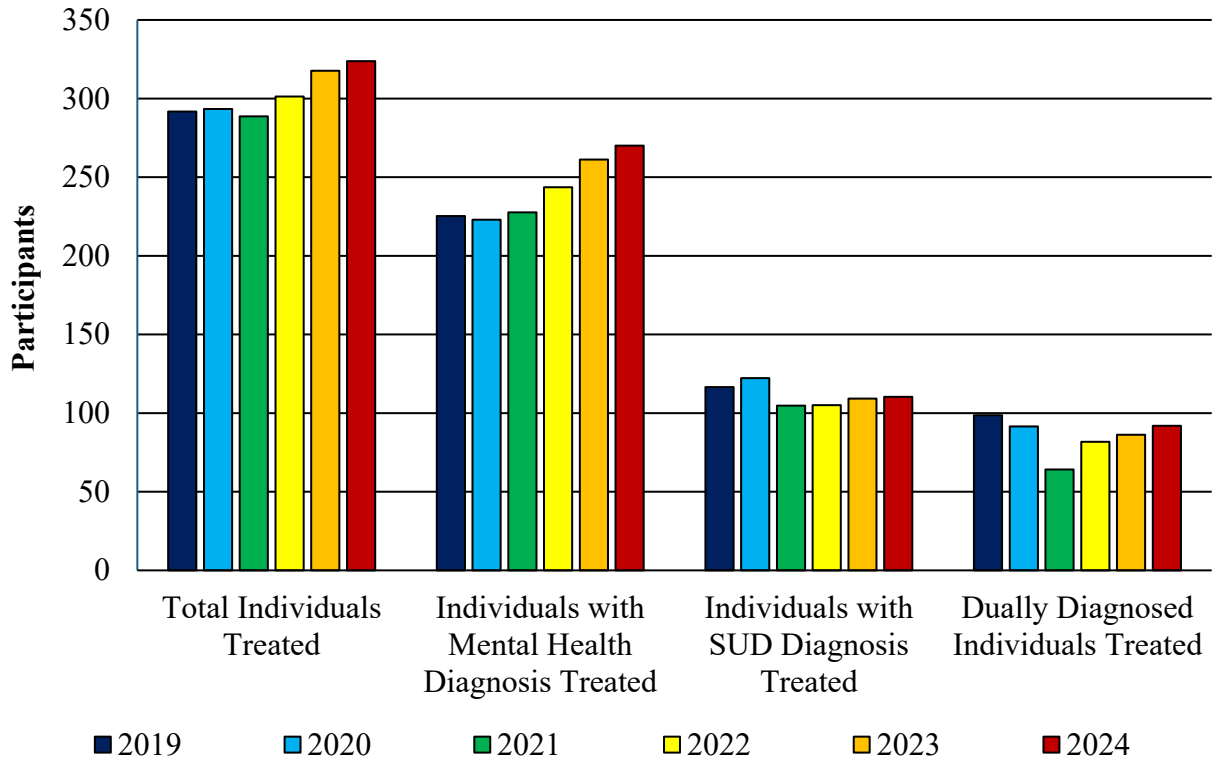
BHA develops and coordinates a comprehensive system of services for people with mental illness, SUD, problem gambling disorders, and those with co-occurring mental illness and SUD. BHA programs and services work across a continuum of care, which includes prevention, care, treatment, and recovery. Local CSAs and LBHAs deliver services in their respective jurisdictions across the State. BHA establishes personnel standards and develops and administers professional development and training to behavioral health professionals. BHA also develops and operates programs for SUD-specific research, education, and prevention efforts, in addition to treatment and recovery programs. BHA oversees three different programs that reimburse providers for behavioral health services under Medicaid and PBHS. The Behavioral Health Medicaid program funds Medicaid-eligible behavioral health services for Medicaid enrollees and receives a federal reimbursement for qualifying expenditures. The State-funded Medicaid program supports non-Medicaid eligible services for Medicaid enrollees. The Community Services program funds services for uninsured or underinsured individuals.

Performance Analysis: Managing for Results

1. Behavioral Health Service Utilization Data Absent for Fiscal 2025

As part of the Managing for Results (MFR) submission, BHA annually reports on utilization of PBHS among individuals with the following diagnoses: mental health condition; SUD; or dually diagnosed. As shown in **Exhibit 1**, overall PBHS utilization decreased slightly in fiscal 2021, from 293,428 to 288,710 individuals receiving services. Between fiscal 2021 and 2024, utilization increased annually in all categories, particularly among individuals who are dually diagnosed, for whom utilization increased by 43.2%. Utilization among all individuals increased by 12.2% during this period.

Exhibit 1
Public Behavioral Health System Utilization
Fiscal 2019-2024
(in Thousands)

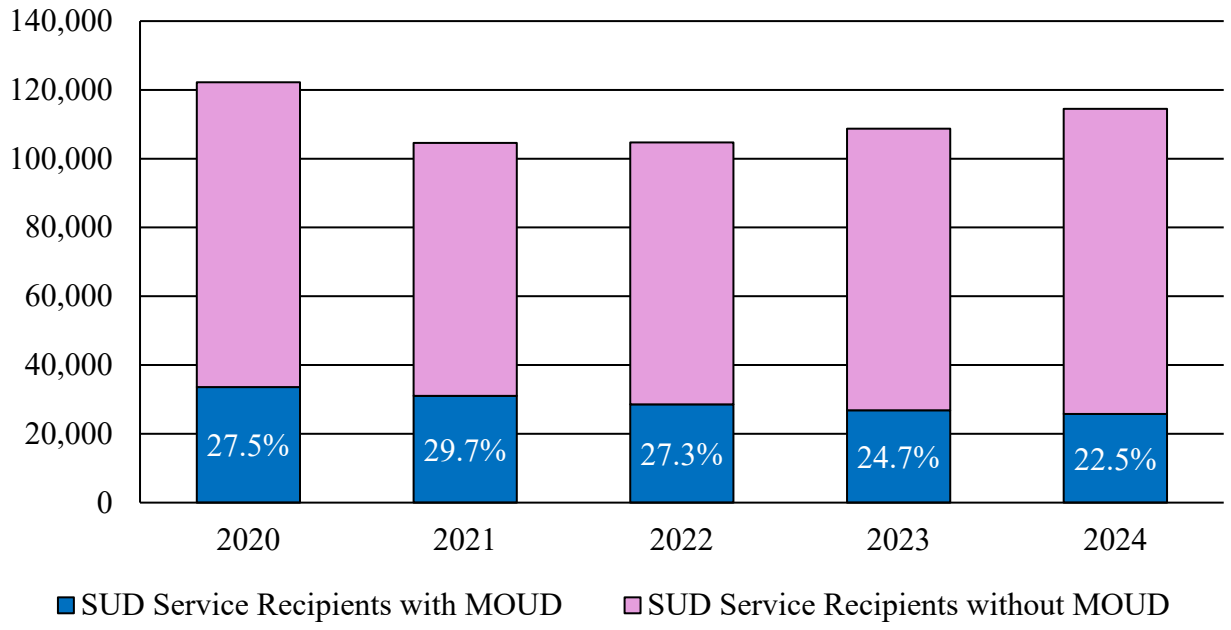


SUD: substance use disorder

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

BHA also submits data on the utilization of medication for the treatment of opioid use disorder (MOUD). MOUD includes treatments such as buprenorphine, naltrexone, and methadone and is offered by qualified providers who are certified by SAMHSA and Maryland. In Maryland, licensed practitioners, except veterinarians, with valid U.S. Drug Enforcement Administration registration with Schedules II through V authority can also prescribe buprenorphine. MOUD services are also available at detention centers, recovery residencies, primary care settings, pharmacies, and SUD residential treatment facilities. As shown in **Exhibit 2**, utilization of MOUD among PBHS participants decreased each year from fiscal 2021, when nearly 30% of PBHS participants used MOUD, through fiscal 2024, when about 22.5% of PBHS participants used MOUD.

Exhibit 2
MOUD Utilization Among PBHS Participants
Fiscal 2020-2024



MOUD: medication for the treatment of opioid use disorder
PBHS: public behavioral health system
SUD: substance use disorder

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

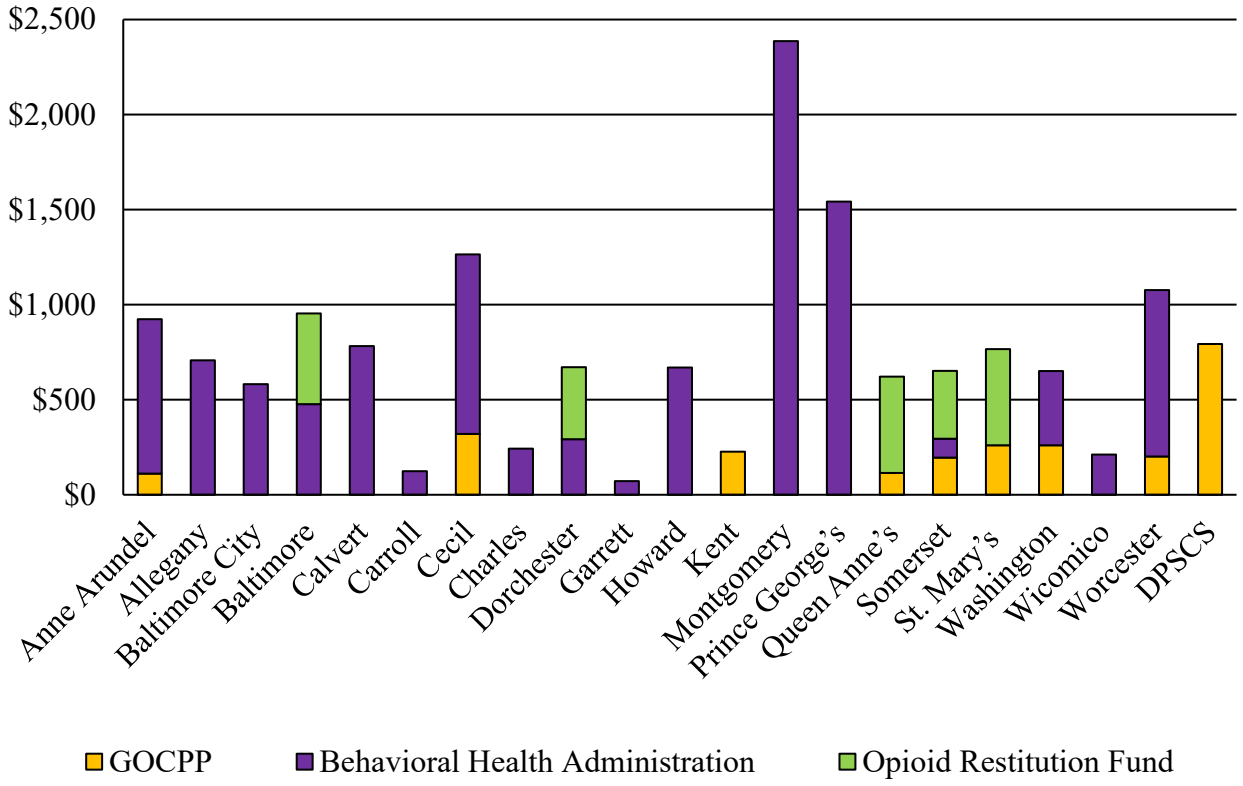
For each of these measures, data is only available through fiscal 2024 because of data quality issues resulting from the transition from the Optum ASO to Carelon. In the transition from Optum to Carelon, there have been challenges properly linking fields of data between the two systems. These issues are discussed in more detail in Issue 3 of this analysis. As a result, BHA was unable to report for fiscal 2025 the MFR data measures that it typically submits annually. **BHA should comment on whether these measures will be reported at a later time in fiscal 2026 or if data for fiscal 2025 will be absent from future MFR submissions.**

2. MOUD Spending in Correctional Facilities

Chapter 532 of 2019 requires local correctional facilities to screen individuals for SUD and administer MOUD as appropriate. The Department of Public Safety and Correctional Services (DPSCS) and the Governor's Office of Crime Prevention and Policy (GOCPP) participate in the Maryland Overdose Response Advisory Council, which provides an opportunity for State agencies

to share their work related to overdose response and find areas of collaboration. Funding for MOUD in correctional facilities is included in MDH and GOCPP budgets and distributed to local governments and DPSCS. **Exhibit 3** shows the actual spending in fiscal 2025 by jurisdiction and fund source. A majority of the funding (70.2%) is from BHA, and about 14% of the funding is from the Opioid Restitution Fund (ORF). Language in the fiscal 2026 Budget Bill included $2.5 million in ORF special funds to support MOUD at correctional facilities in fiscal 2025 and 2026. This use of the ORF was authorized by a provision in the BRFA of 2025 allowing the supplantation of general funds in fiscal 2025 and 2026 only.

Exhibit 3
Spending on MOUD in Correctional Facilities
Fiscal 2025
($ in Thousands)



DPSCS: Department of Public Safety and Correctional Services
GOCPP: Governor's Office of Crime Prevention and Policy
MOUD: medication for the treatment of opioid use disorder

Note: Funding for DPSCS is distributed to facilities statewide.

Source: Maryland Department of Health

Fiscal 2025

Closeout

At fiscal 2025 close, BHA canceled $5.3 million in special funds due to lower than anticipated revenue for the 9-8-8 Trust Fund and $6.1 million in reimbursable funds for school-based behavioral health services. School-based behavioral health services were budgeted with Medicaid under M00Q01.03 but moved into the Behavioral Health Medicaid program (M00Q01.10) in fiscal 2025. This is a billable service under Medicaid; however, as of January 31, 2026, no claims had been submitted through ASO for the service. The fiscal 2027 allowance includes $9.2 million in reimbursable funds budgeted in M00Q01.10. Reimbursable funds are available from the Community Services program. **BHA should clarify the source of available funds in the Community Services program and why these funds are budgeted in this way instead of directly in the Medicaid program. MDH should also discuss its efforts to enroll providers for these services.**

The fiscal 2027 budget includes a proposed deficiency appropriation totaling $67.1 million ($35.1 million in general funds) to cover fiscal 2025 shortfalls in the Behavioral Health Medicaid program. Providers have 12 months to bill for services; therefore, each year MDH accrues funding at closeout to be available for use when it receives claims for that service year's costs. However, in fiscal 2025, MDH did not accrue enough funds to pay for all costs in fiscal 2025. Typically, when an agency does not have sufficient appropriation to cover costs, these are reported to the Comptroller's Office at closeout. While MDH reported other shortfalls in fiscal 2025, it did not report a shortfall in provider reimbursements for behavioral health, and as noted in the MDH Overview analysis, it transferred appropriation from these programs to address shortfalls in Medicaid. Based on a review of monthly reporting by MDH on its spending for fiscal 2025 service year costs, the accrued funds for fiscal 2025 plus the deficiency may resolve the fiscal 2025 shortfall. However, DLS estimates that there may still be some additional need (up to $20 million) for service year 2025 costs. If there are insufficient appropriations, MDH would use fiscal 2026 appropriation to pay for outstanding claims, potentially exacerbating the fiscal 2026 shortfall.

Federal Recissions

BHA receives funding from four federal grants determined to be at risk from federal actions consolidating and canceling U.S. Department of Health and Human Services (HHS) grants, totaling $69.8 million. The grants were the Mental Health Block Grant and the Substance Abuse Block Grant, and an American Rescue Plan Act supplement grant for each. A preliminary injunction was issued by a federal judge on May 16, 2025, and as a result, BHA did not lose any of this funding in fiscal 2025 or 2026. BHA expended the funding as planned, and the grants expired on September 30, 2025. MDH does not anticipate any changes to these grants in future years and continues to monitor federal funding activity and decisions to assess potential impacts on Maryland's budget.

Fiscal 2026

Status of Legislative Additions and Funds Restricted for Particular Purposes

Section 21 of the fiscal 2026 Budget Bill (Chapter 602 of 2025) added $3.1 million in general funds to the BHA budget, including $3 million to address pediatric hospital overstays and $100,000 to support Hygea Healthcare's Middle River residential treatment facility. BHA issued the grant to Hygea Healthcare on July 1, 2025.

On January 14, 2026, MDH submitted a report as required by the 2025 *Joint Chairmen's Report* (JCR) summarizing planned and actual spending on addressing pediatric hospital overstays in fiscal 2026. MDH reported that in fiscal 2026, BHA plans to spend $3.9 million to support the Brook Lane Hospital overstay stabilization program and the 211 Press 4 Program, which helps hospital emergency departments facilitate care coordination services for behavioral health patients. BHA reports the added funds were used to support the Brook Lane Hospital program. **BHA should comment on how much funding is available in fiscal 2027 to support this program.**

In addition, the fiscal 2026 Budget Bill included language restricting $3 million of the appropriation for behavioral health investments to be used only to address pediatric overstays. BHA used these funds to staff and support five additional inpatient beds at the John L. Gildner Regional Institute for Children and Adolescents (JLG-RICA). While fiscal 2026 funding was included in the BHA budget, JLG-RICA is included in the MDH Administration budget. The fiscal 2027 allowance includes the second year of this funding in the JLG-RICA budget, and MDH indicated that it would process a budget amendment to realign the fiscal 2026 funding from BHA. More information on pediatric hospital overstays and funding at the RICA facilities is included in the analyses for N00B – DHS – Social Services Administration and M00A01 – MDH – Administration, respectively.

The fiscal 2026 Budget Bill also included language restricting $500,000 in general funds to provide colleges and universities with funding to procure drug detection products for students. **BHA should clarify if there is ongoing funding for drug detection products included in the fiscal 2027 budget.**

Planned Reversions

The fiscal 2027 budget plan assumes one reversion in fiscal 2026 totaling $16.7 million in general funds due to underspending by LBHAs and CSAs in prior years. 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.

Proposed Deficiency

The fiscal 2027 budget plan includes $614 million of deficiencies related to fiscal 2026 services. These deficiencies include:

- $16.9 million in general fund savings to align with fiscal 2025 spending for behavioral health initiatives, which are discussed in the Updates section of this analysis;

- $11.6 million in general fund savings due to lower than anticipated spending in the State-funded Medicaid program;

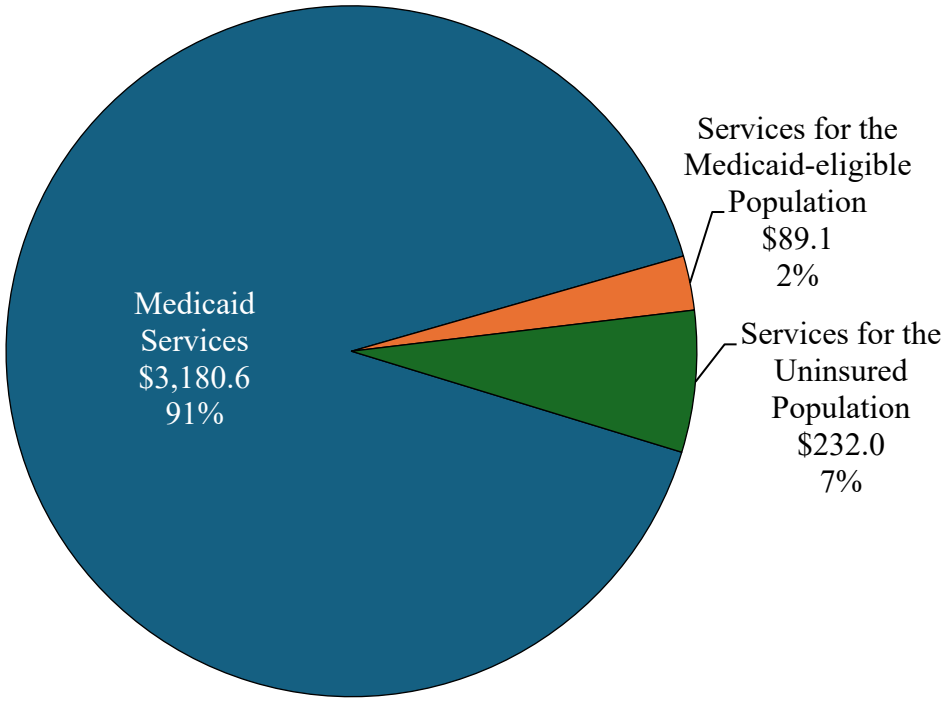
- $87,689 ($4.4 million increase in general funds, $4.3 million reduction in federal funds) to align the budget with projected need for provider reimbursements in the Community Services program. However, MDH reports that the $4.3 million federal fund reduction was an error and that it will work with the Department of Budget and Management (DBM) to restore the federal funds; and

- $642.4 million in total funds ($119.2 million in general funds, $508.9 million in federal funds, and $14.3 million in reimbursable funds) to cover anticipated shortfalls for behavioral health Medicaid services in fiscal 2026.

Fiscal 2027 Overview of Agency Spending

The fiscal 2027 allowance includes $3.9 billion for BHA. Reimbursements to providers for behavioral health services comprise approximately 89% of the total budget. **Exhibit 4** shows the fiscal 2027 budget for provider reimbursements by service type and recipient group. Most of the expenditures for provider reimbursements in BHA are for Medicaid services ($3.2 billion). Provider reimbursement costs for non-Medicaid services total 9.1% of total provider reimbursements, including $89.1 million for the Medicaid-eligible population receiving non-Medicaid-eligible services and $232 million for the uninsured and underinsured population. The fiscal 2027 allowance as introduced does not include funding for provider rate increases.

Exhibit 4
Overview of Provider Reimbursement Spending
Fiscal 2027 Allowance
($ in Thousands)

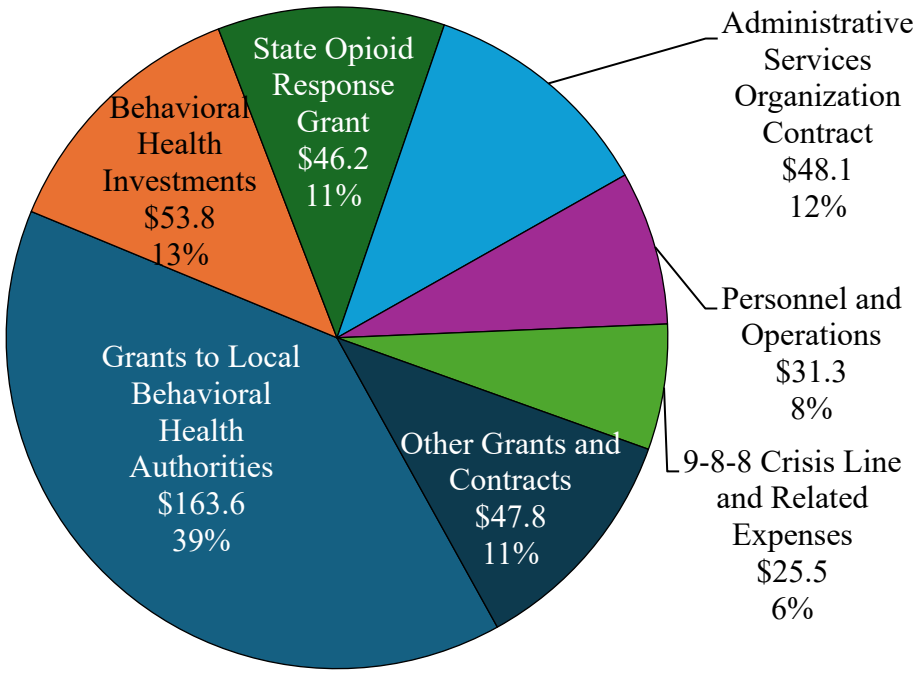


Note: The fiscal 2027 allowance accounts for contingent reductions.

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

Excluding expenditures related to provider reimbursements, the fiscal 2027 allowance totals $421.3 million. As shown in **Exhibit 5**, grants to LBHAs and CSAs comprise the largest share ($163.6 million) of this part of the budget. These grant dollars include federal funding from SAMHSA for the mental health block grant ($9.1 million) and the substance use block grant ($15.9 million). Approximately $46.2 million of the fiscal 2027 allowance is from the federal State Opioid Response grant, which supports opioid abatement services and programs at local government and nonprofit organizations. Behavioral health investments comprise 13% of the nonprovider reimbursements budget ($53.8 million) The fiscal 2027 allowance also includes $25.5 million for 9-8-8 call centers and administrative costs, most of which is supported by special funds from the 9-8-8 Trust Fund.

Exhibit 5
Behavioral Health Spending Excluding Provider Reimbursements
Fiscal 2027 Allowance
$ in Millions



Note: 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 Change

As shown in **Exhibit 6**, the fiscal 2027 allowance for BHA decreases by $155.8 million compared to the fiscal 2026 appropriation. Excluding the proposed deficiency for fiscal 2025 costs and the planned reversion for unspent grant funds, the budget decreases by $105.4 million in fiscal 2027. A significant driver of the change is decreased spending on provider reimbursements in the Behavioral Health Medicaid program in fiscal 2027 compared to fiscal 2026 costs ($53.5 million). Non-Medicaid behavioral health provider reimbursements increase for the Community Services program ($14.7 million) and State-funded Medicaid ($5.7 million). The fiscal 2027 allowance includes $26.3 million in reimbursable funds for behavioral health Medicaid services, $12.1 million more than fiscal 2026 after accounting for the deficiency noted previously. Reimbursable funds have not typically been used in this program; in fiscal 2026 and 2027 funds are available from the behavioral health investments budgeted in the Community Services

program. Another significant contribution is a decrease in the federal fund appropriation for the State Opioid Response grant ($34.1 million) and an expired COVID-19 supplement to the mental health and substance abuse grant ($15.8 million). Other notable changes include:

- an increase of $6.7 million for the AOT program, partially offset by a $3 million reduction for the end of the planning portion of the program (additional discussion of AOT in Issue 2 of this analysis);

- replacement of certain special funds with general funds due to limited-time authorizations or decreased fund availability, including $2.5 million in general funds for the Buprenorphine Initiative, which was funded by special funds in fiscal 2026 ($2.4 million) due to language in the BRFA of 2025 authorizing the use of ORF special funds to supplant general funds in fiscal 2025 and 2026 only; and replacement of $7.3 million in special funds from the Cigarette Restitution Fund to support SUD residential treatment services in the Community Services program;

- end of funding included in § 21 to address pediatric hospital overstays ($3 million), as DLS assumes the funds do not continue in fiscal 2027; and

- a decrease of $12.1 million for the Baltimore City Capitation project, which provides comprehensive mental health services for individuals in Baltimore City. **MDH should clarify if any other funding in the fiscal 2027 budget supports this project.**

Exhibit 6
Proposed Budget
Maryland Department of Health – Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2025 Actual	$1,449,704	$53,106	$2,200,036	$6,581	$3,709,427
Fiscal 2026 Working	1,596,709	67,327	2,392,920	21,337	4,078,293
Fiscal 2027 Allowance	1,573,141	43,278	2,264,957	41,100	3,922,476
Fiscal 2026-2027 $ Change	-$23,568	-$24,049	-$127,963	$19,763	-$155,818
Fiscal 2026-2027 % Change	-2.46%	-35.72%	-5.35%	92.62%	-3.82%

Where It Goes:	Change
Personnel Expenses	
Turnover adjustments (increase from 8.17% to 12.00%)	$932
Employee and retiree health insurance	892
Salary increases and associated fringe benefits	-1,115
Other fringe benefits	-44

Where It Goes:	**Change**
Provider Reimbursements	
Provider reimbursements for the uninsured or underinsured, after accounting for a contingent reduction	14,680
Provider reimbursements for State-funded Medicaid, accounting for withdrawn fiscal 2026 funding	5,746
Provider reimbursements for Medicaid-eligible services	-53,519
One-time proposed deficiency appropriation to cover service year 2025 shortfall in Medicaid-eligible services	-67,087
Grants	
Fiscal 2026 general fund reversion due to underspending of grant dollars among LBHAs and CSAs in prior years	16,700
AOT program costs, including 11.5 contractual FTE for care coordination staff	6,691
End of State AOT program planning costs	-3,000
Grants and contracts for LBHAs and CSAs	-10,734
General and federal funding for intensive wraparound services for youth through the Baltimore City Capitation Project	-12,096
Expiration of ARPA supplement to mental health and substance abuse grants	-15,803
Federal State Opioid Response Grant	-34,125
Other	
Increase of 16.44 contractual FTE	1,280
Administrative Services Organization contract with Carelon	6,494
One time grant in fiscal 2026 to Hygea Healthcare	-100
Funding mandate for the Language Assistance Services Pilot Program ended in fiscal 2026	-120
Funding restricted in the fiscal 2026 budget for drug detection products at colleges and universities	-500
Funding for additional staff for JLG-RICA budgeted in BHA to address pediatric hospital overstays realigned to the MDH Administration budget	-3,000
One time supplement to address pediatric hospital overstays	-3,000
Behavioral health investments, including a $16.9 million general fund withdrawal in fiscal 2026 to align with actual spending	-5,475
Other changes	484
Total	**-$155,818**

AOT: Assisted Outpatient Treatment
ARPA: American Rescue Plan Act
BHA: Behavioral Health Administration
CSA: core service agency
FTE: full-time equivalent
LBHA: local behavioral health authority
MDH: Maryland Department of Health
JLG-RICA: John L. Gildner Regional Institute for Children and Adolescents

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 BRFA of 2026 includes a provision authorizing the transfer of excess special fund balance from the State Board of Professional Counselors and Therapists to BHA. Language in the fiscal 2027 Budget Bill would reduce general funds by $500,000 and appropriate special funds of the same amount contingent on the enactment of this provision. The special funds would replace general fund costs for behavioral health provider reimbursements for the uninsured and underinsured in the Community Services program. The BRFA of 2024 and 2025 also contained provisions authorizing the transfer of balance from various health occupation boards to replace general funds in fiscal 2025 ($2.6 million) and 2026 ($6.9 million) for provider reimbursements.

Two other BRFA provisions affect the AOT Program and requirements for Maryland's participation in the CCBHC model but do not impact the fiscal 2027 budget. Chapters 703 and 704 of 2024 require local jurisdictions to implement an AOT 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 the 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. DLS notes under current law that the AOT program is no longer required after fiscal 2030. The AOT program is discussed further in Issue 2 of this document. **MDH should discuss why a cost share is established for a year after the program terminates in statute.**

Current law requires MDH to apply for the 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. A provision in the BRFA would authorize, rather than require, BHA to apply for the CCBHC demonstration grant from SAMHSA in fiscal 2029 and make the authorization subject to the limitations of the budget. CCBHCs are discussed in more detail in Issue 1 of this document.

Behavioral Health Provider Reimbursements

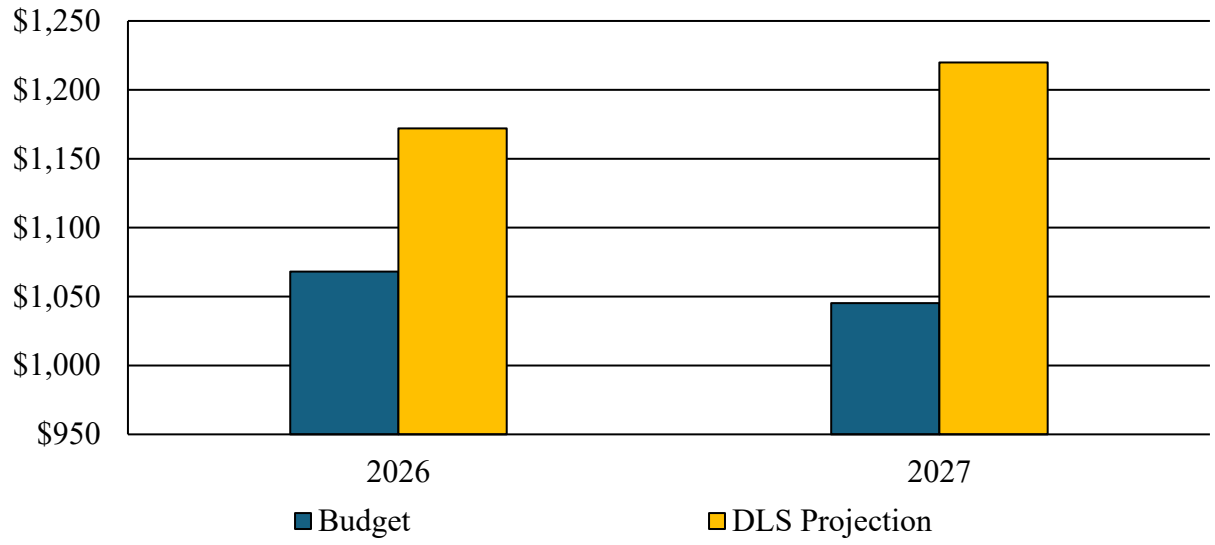
The fiscal 2027 allowance includes $3.5 billion in provider reimbursements for behavioral health services. These payments comprise the largest share of the BHA budget. Reimbursements for Medicaid-eligible services to Medicaid enrollees, included in the Behavioral Health Medicaid program (M00Q01.10), make up 91% of these costs. Reimbursements for services utilized by people who are uninsured or underinsured are included in the Community Services program (M00L01.02), and reimbursements for non-Medicaid services for individuals who are Medicaid-eligible are included in the Community Services for Medicaid State Fund Recipients program (M00L01.03). The fiscal 2027 budget does not include funding for fiscal 2027 provider rate increases in any of these BHA programs.

DLS annually forecasts provider reimbursement costs to assess the adequacy of funding for these purposes. The forecast includes utilization and enrollment data and projections along with known provider rate increases. The forecasts for Medicaid enrollment are incorporated into the

forecasts for Medicaid-eligible services in BHA and for State-funded services for Medicaid-eligible individuals. The DLS forecast reflects the expectation of declining Medicaid enrollment due to major provisions in the federal One Big Beautiful Bill Act, which affect eligibility and redetermination processes for Medicaid enrollees. Due to delayed effective dates for these provisions, estimated disenrollments would appear in the second half of fiscal 2027 and later. Enrollment estimates also reflect recent trends in enrollment. Further discussion of the enrollment forecast for the Medicaid-eligible population is included in the analysis for M00Q01 – MDH – MCPA.

In the Behavioral Health Medicaid program, DLS anticipates a deficit of approximately $125 million in general funds in fiscal 2026 and up to $175 million in general funds in fiscal 2027. As shown in **Exhibit 7**, DLS estimates that the amount needed to cover the State share of fiscal 2026 expenditures is nearly 12% higher ($1.2 billion) than the amount budgeted ($1.0 billion), after accounting for deficiency appropriations included in the fiscal 2027 budget plan. DLS also projects a general fund need of up to 16.7% higher than the amount budgeted in fiscal 2027. However, DLS notes there is considerable uncertainty about ongoing utilization due to data issues during the transition in the ASO discussed later in this analysis.

Exhibit 7
Projected General Fund Deficits in Behavioral Health Medicaid
Fiscal 2026-2027
($ in Millions)

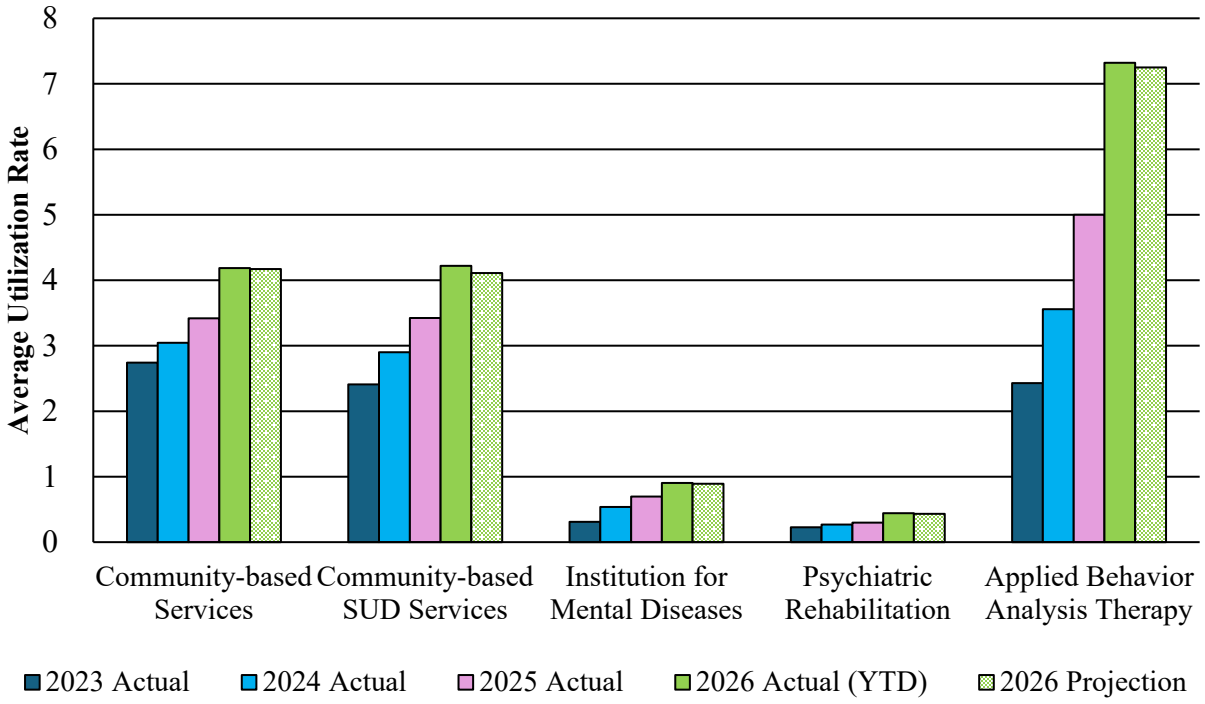


DLS: Department of Legislative Services

Source: Maryland Department of Health; Department of Legislative Services

The large discrepancy between the DLS forecast and the amount budgeted in fiscal 2026 and 2027 for the Behavioral Health Medicaid program appears to be largely attributed to utilization projections. Fiscal 2026 actuals to date suggest significant growth in certain service categories, including inpatient hospital services, residential SUD treatment for minors, psychiatric rehabilitation, community-based SUD treatment, and Institution for Mental Diseases (IMD) residential treatment services. As shown in **Exhibit 8**, several of these service areas have been growing steadily for multiple years. Between fiscal 2023 and the first half of fiscal 2026, there have been large increases in utilization of psychiatric rehabilitation (90.5%), community-based SUD services (70.6%), IMD (188.1%), and applied behavior analysis (ABA) (198.6%). The growth between fiscal 2025 and 2026 may be exaggerated due to data issues in fiscal 2025 related to the transition of the ASO provider (discussed further in Issue 3 of this analysis).

Exhibit 8
Behavioral Health Medicaid Service Utilization Growth
Fiscal 2023-2026



SUD: substance use disorder
YTD: year to date

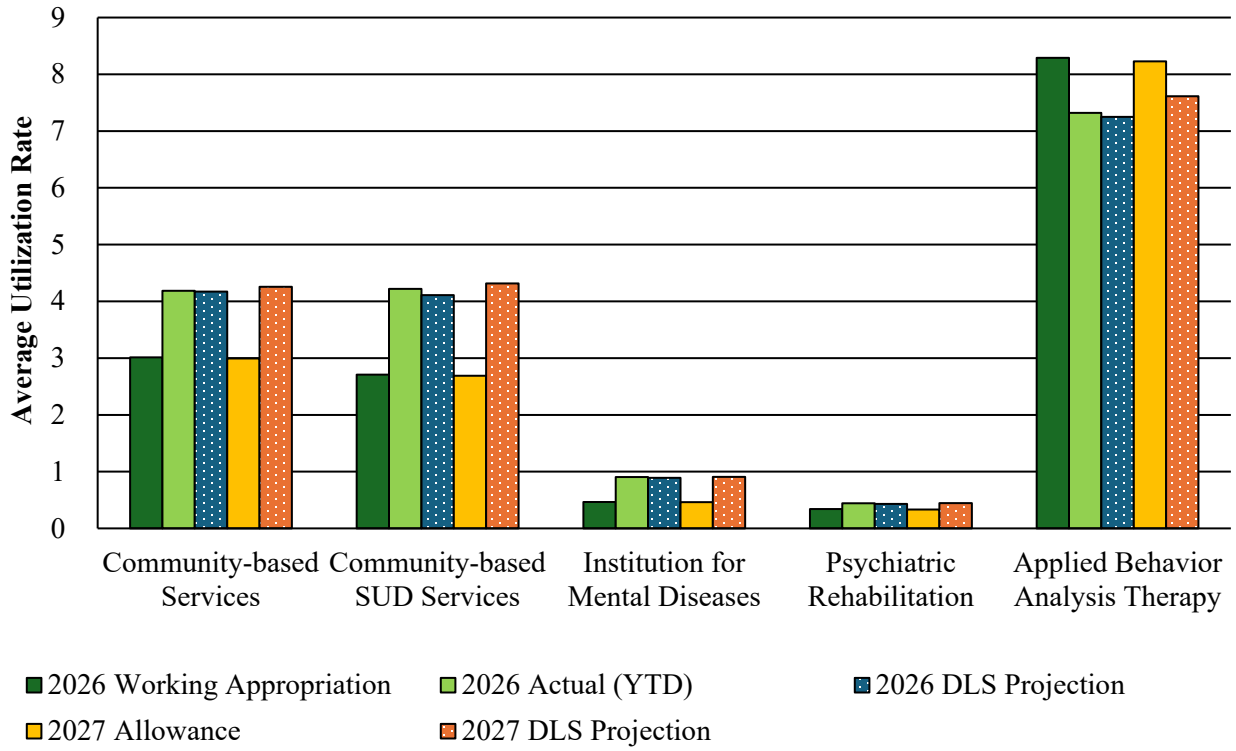
Note: Fiscal 2024 and 2025 utilization is actual data. Fiscal 2026 utilization rates are based on seven months of data from July 2025 through January 2026.

Source: Maryland Department of Health; Department of Legislative Services

ABA services have increased by more than 40% annually from fiscal 2023 through 2026. This service treats individuals under the age of 21 with autism spectrum disorder (ASD) and may include individual or group therapy, social skill development, and training for parents. This service became eligible for Medicaid reimbursement in Maryland beginning January 2017, which accounts for some of the rapid growth. Moreover, MDH indicates that the prevalence of both ASD and ABA providers has expanded exponentially over the last several years. The autism waiver, which supports home and community-based services for children with ASD and is managed by the Maryland State Department of Education, may also be contributing to the growth as the State expands access to services for this population. MDH anticipates growth to begin to level out by calendar 2028, after ABA has been active for about 10 years.

Based on the utilization trends described previously and actual year-to-date utilization data provided for fiscal 2026, DLS projected increased utilization in certain services in fiscal 2026 and 2027. **Exhibit 9** shows the utilization projections among the categories of high growth in fiscal 2026 and 2027, as well as actual utilization rates in fiscal 2026 year to date. The year-to-date rates are based on claims paid between July 1, 2025, and January 31, 2026. Proposed budgets for the fiscal 2026 working appropriation and fiscal 2027 allowance are based in part on utilization actuals through the first couple of months of fiscal 2026. The DLS projections for fiscal 2027 also take into account fiscal 2026 actual data through January 2026. The timing of available data accounts for part of the difference between DLS and DBM estimates. The particularly large discrepancies are driven by reconciliation between providers and the ASO that continued through the first half of fiscal 2026. The extent and timing of the reconciliation was not fully known at the time of budget development.

Exhibit 9
Behavioral Health Medicaid Utilization Assumptions and Estimates
Fiscal 2026-2027



SUD: substance use disorder
YTD: year to date

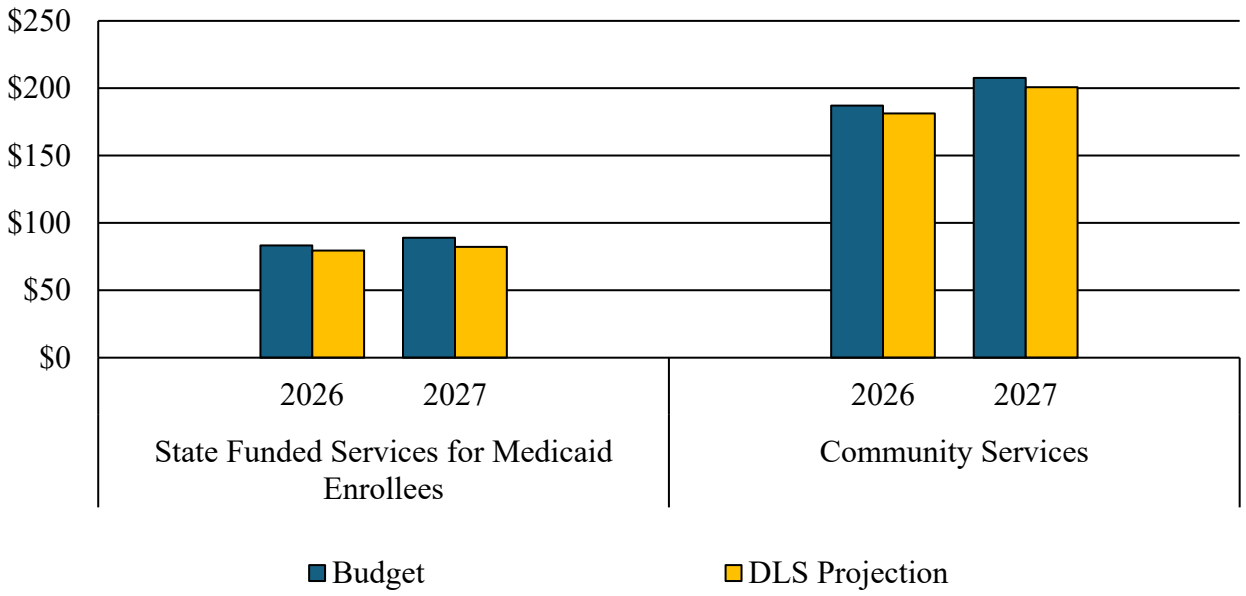
Note: Fiscal 2026 year-to-date rates are based on seven months of data from July 2025 through January 2026.

Source: Maryland Department of Health; Department of Legislative Services

The forecasts for the two non-Medicaid provider reimbursement programs are completed in aggregate, as DLS does not have access to service level utilization or spending data. Language in the fiscal 2025 and 2026 Budget Bills requested that BHA submit this data by program and by service level, but the department has not submitted data as requested, to date. The State-funded Medicaid program forecast factors in Medicaid enrollment trends, and both forecasts use prior year spending and anticipated utilization growth to estimate future costs. As shown in **Exhibit 10**, DLS projects surpluses in both programs in fiscal 2026 and 2027. In the Community Services program (M00L01.02), DLS projects small general fund surpluses of approximately $5.7 million in fiscal 2026 and $6.9 million in fiscal 2027. In State-funded Medicaid (M00L01.03), DLS projects surpluses of $3.9 million in fiscal 2026 and $6.9 million in fiscal 2027. The fiscal 2027 budget contract and grant detail provided to DLS includes a line showing a general fund reduction in the

Community Services program of $45 million in fiscal 2025 labeled "ASO provider forgiveness". Including this reduction, the fiscal 2026 general fund appropriation for Community Services provider reimbursements grows by 39% from fiscal 2025. The DLS forecast assumes this reduction was a one-time offset to provider reimbursement costs actually incurred and that the appropriation for provider reimbursements in this program grows by 4% between fiscal 2025 and 2026. **MDH should clarify if the $45 million reduction in fiscal 2025 is related to provider reimbursements and why the reduction was made.**

Exhibit 10
Projected Surpluses in Non-Medicaid Provider Reimbursement Programs
Fiscal 2026-2027
($ in Millions)



DLS: Department of Legislative Services

Source: Maryland Department of Health; Department of Legislative Services

Provider Oversight

In July 2024, due to substantial growth in certain service areas, BHA instituted a six-month moratorium on new provider enrollments for specific services due to the suspicion of fraudulent claims. The enrollment pause temporarily prevents new providers from enrolling in the following provider types:

- psychiatric rehabilitation programs;

- psychiatric rehabilitation programs (Health Home);
- level 2.5 partial hospital programs; and
- level 2.1 intensive outpatient treatment programs.

BHA extended the moratorium multiple times to continue activities related to preventing, identifying, and addressing cases of fraud and waste. The latest extension took effect January 1, 2026, and expires June 30, 2026. The order prevents new enrollments among the provider types listed previously in Baltimore City and Anne Arundel, Baltimore, Carroll, Frederick, Harford, Howard, Montgomery, Prince George's, and Washington counties. BHA continues to review claims data, and between July 2, 2024, and February 21, 2025, BHA referred claims from 100 providers to the Office of the Inspector General for Health and the Medicaid Fraud and Vulnerable Victims Unit. BHA transitioned to a new ASO, Carelon, on January 1, 2025. The ASO plays a role in preventing erroneous or fraudulent claims by conducting careful reviews of claims prior to adjudication and performing regular audits of service claims and enrollments to ensure propriety of claims. Audit findings published in an October 2024 report found that the prior ASO, Optum, did not have proper procedures and mechanisms in place to ensure the propriety of submitted claims. The audit is discussed in more detail in Issue 3 of this analysis.

In addition to establishing and following appropriate and adequate procedures, oversight of provider enrollment and service delivery is necessary to prevent fraudulent claims and ensure the delivery of high-quality care. Authority over providers is split between BHA and local agencies (LBHAs and CSAs). The Code of Maryland Regulations (COMAR) requires LBHAs/CSAs to issue an "agreement to cooperate" to providers who wish to enroll in their jurisdiction. The agreement is part of the licensing requirement for the provider and requires the provider to meet certain criteria related to their site and service delivery. However, while this agreement authorizes the local agency to conduct site visits and assess provider quality, the LBHAs/CSAs are not authorized to compel the provider to take corrective action. LBHAs/CSAs must report findings to BHA, which may implement a corrective action plan. **BHA should comment on whether or not it has designated staff working with LBHAs/CSAs to investigate complaint findings and take appropriate action.**

Chapter 697 of 2025 requires MDH to submit two annual reports, on December 1, 2025, and December 1, 2026, on revisions to COMAR 10.63, improvements to the oversight of SUD treatment programs, and improvements to procedures for certification, monitoring, and oversight of recovery residences. MDH submitted the first report in December 2025. COMAR 10.63 contains regulations for community-based behavioral health services and includes requirements for licensed programs, standards for accreditation-based and residential programs, guidelines for non-accreditation programs, and processes for licensure. The report notes that COMAR 10.63 regulations have not been updated since calendar 2015. From July 2024 through June 2025, BHA held regional meetings and listening sessions to share proposed changes to the regulations with key stakeholders, including LBHAs/CSAs and advocacy coalitions, and to collect and incorporate feedback. After reviewing the proposed regulations, the Joint Committee on Administrative, Executive, and Legislative Review notified MDH that it wanted to conduct a more detailed review

of the regulations and concerns raised by stakeholders. MDH is holding additional stakeholder meetings and redrafting the regulations. According to its report, MDH anticipated posting the regulations for comment in winter of 2025. **MDH should comment on the status of the regulations.**

In its report, MDH summarizes steps that it has taken to improve provider oversight, specifically of recovery residences as that was the focus of the report. It notes that MDH will increase monitoring of providers through site visits and data review effective January 1, 2026, but does not specify how often audits or visits will occur or what would trigger a review. Moreover, the report does not detail how the regulations may be changed to more clearly define the authority of the department and of LBHAs and CSAs to review, report, and enforce standards of practice among providers working across the State.

Personnel Data

	FY 25 Actual	FY 26 Working	FY 27 Allowance	FY 26-27 Change
Regular Positions	215.80	216.50	209.50	-7.00
Contractual FTEs	46.55	30.44	58.38	27.94
Total Personnel	**262.35**	**246.94**	**267.88**	**20.94**
Vacancy Data: Regular Positions				
Turnover and Necessary Vacancies, Excluding New Positions		25.14	12.00%	
Positions and Percentage Vacant		60.00	27.7%	
Vacancies Above Turnover		34.86		

- The fiscal 2027 allowance reduces the number of regular positions in BHA by 7.0 compared to the fiscal 2026 working appropriation, due to transfers within MDH. MDH transferred positions out of BHA into the Office of the Secretary (7.0) and the Public Health Administration (2.0) and transferred 2.0 positions to BHA from the Prevention and Health Promotion Administration.

- The fiscal 2027 allowance includes 27.94 new contractual full-time equivalents (FTE) compared to the fiscal 2026 working appropriation. These additional contractual FTEs include 11.5 FTEs for members of the AOT care coordination teams, including peer recovery specialists, case managers, social workers, and psychiatrists, at a cost of $1.3 million. **MDH should discuss the functions supported by the remaining 16.44 new contractual FTEs.**

- On October 22, 2025, the Board of Public Works (BPW) approved the abolition of 502.7 positions statewide, including 170.7 vacant positions and 332.0 positions associated with the Voluntary Separation Program (VSP). In BHA, 7.3 positions were abolished, of which 5.3 were vacant and 2.0 were due to the VSP.

- As of December 31, 2025, BHA had 60.0 vacant positions, 34.86 vacant positions above the amount to meet budgeted turnover. The December 2025 vacancy rate (27.7%) is nearly 10 percentage points higher than the vacancy rate at the same point in fiscal 2025. The vacant positions include 36.0 positions authorized in fiscal 2025 that have never been filled. MDH has also indicated the difficulty of recruiting under the statewide hiring freeze; however, some MDH positions are exempt from the freeze. As of this writing, 7.0 of the 60.0 vacant positions have been filled, and 35.0 positions are in various stages of recruitment. If these positions are filled, BHA's vacancy rate would decrease to 8.3%. However, accounting for the 7.0 filled positions, BHA's vacancy rate is more than double (24.5%) the rate needed to meet budgeted turnover. **Therefore, DLS recommends reducing $725,000 to reflect a higher amount of savings from an expected turnover rate of 15%.**

Issues

1. Certified Community Behavioral Health Clinics

As of the end of calendar 2025, more than 500 CCBHCs in 46 states serve approximately 3 million people annually. Since the program's creation in 2014, SAMHSA has awarded planning grants to dozens of states, including Maryland, to begin planning for the model's implementation. Following completion of the planning grant, states may apply to the four-year demonstration grant to certify clinics and pilot the program. CCBHCs must offer services to anyone, regardless of their ability to pay. A majority of CCBHC consumers are insured under Medicaid. States that enroll in the CCBHC demonstration receive an enhanced federal match for Medicaid services, and clinics in those states utilize a Prospective Payment System (PPS) financing model to streamline service delivery and payments and to provide clinics with greater flexibility in budgeting and developing care plans for individuals.

Chapter 275 of 2023 requires Maryland to apply to SAMHSA for the CCBHC planning grant in fiscal 2025 and for the CCBHC demonstration grant in fiscal 2026. Maryland applied and was awarded the planning grant in fiscal 2025 and accepted the award in April 2025. Over the last 10 months, the department has been fulfilling the work of the grant and preparing to apply for the demonstration. MDH is currently planning to apply for the demonstration in April 2026. However, as noted previously, a provision in the BRFA of 2026 as introduced would eliminate the requirement that MDH apply for the demonstration, delay the application year from fiscal 2027 to 2029, and make the authorization subject to the limitations of the budget. The fiscal 2027 allowance includes $4.6 million in general funds for the implementation of two CCBHCs beginning January 1, 2027. This funding is budgeted in the DPA and represents the pro-rated State share for six months of two clinics' participation in the demonstration. Participation is contingent on Maryland applying for and receiving a demonstration grant from SAMHSA. Funds in the DPA remain available for four years after the year in which the funds are appropriated. Therefore, these funds would be available if the State applied for and received the demonstration grant in fiscal 2029.

About the CCBHC Model

SAMHSA awards yearlong planning grants to help states shape the CCBHC model for their state. During the planning period, states must release a community needs assessment for clinics to determine to what extent their services meet the needs of their service area. States must also determine which PPS they will employ, and clinics complete cost reporting to estimate the rates they will receive to operate. States also determine if they want to establish requirements in addition to the federal requirements; for example, some states may opt to require clinics to provide primary care or employ peer support specialists. After completing the planning grant, states can apply for the demonstration grant to begin the four-year demonstration program. Once accepted into the demonstration, states must certify clinics that meet all defined state and federal criteria. After the first demonstration year, states have the option of rebasing the rates that they set at the start of the demonstration. Throughout the demonstration, states can leverage an enhanced federal

match. After the demonstration grant concludes, states may choose to incorporate the CCBHC model through a state plan amendment or waiver.

Clinics operating in alignment with the CCBHC model can apply for expansion grants through SAMHSA regardless of their state's participation in the demonstration. However, if the state is not participating in the demonstration, these clinics must continue to bill as fee-for-service (FFS). **Exhibit 11** shows the various pathways through which states and clinics can leverage federal funding for CCBHC services, and demonstration planning and implementation.

Exhibit 11
Certified Community Behavioral Health Clinic Implementation Process

States	Planning Grants → *18 months; up to $1 million*	Demonstration → *4 years*	State Plan Amendment/Waiver
Clinics	Expansion Grants *4 years; up to $4 million*	Enhanced FMAP PPS Billing	
	SAMHSA	**Medicaid**	

FMAP: Federal Medical Assistance Percentage
PPS: Prospective Payment system
SAMHSA: Substance Abuse and Mental Health Services Administration

Source: Substance Abuse and Mental Health Services Administration

Operational and Service Criteria

To be certified as a CCBHC, a clinic must meet specific levels of service in six different areas. States can add onto these requirements to meet the specific needs of their constituencies. The certification criteria categories are:

- ***Staffing:*** Providers must maintain an adequate number of qualified staff and provide training to ensure staff are trained in cultural competency and trauma-informed care.

- ***Availability and Accessibility of Services:*** Clinics must offer sufficient hours and timely connection to services, and 24/7 crisis management services.

- ***Care Coordination:*** In addition to connecting patients to other relevant services, providers must establish and maintain health information systems to support care coordination across provider networks.

- ***Scope of Services:*** Providers must offer certain services (listed below), either directly or through a formal relationship with an external provider (known as a designated collaborating organization (DCO)).

    - Crisis Services
    - Outpatient Mental Health and Substance Use Services
    - Person- and Family-Centered Treatment Planning
    - Community-Based Mental Health Care for Veterans
    - Peer Family Support and Counselor Services
    - Targeted Care Management
    - Outpatient Primary Care Screening and Monitoring
    - Psychiatric Rehabilitation Services
    - Screening, Diagnosis and Risk Assessment

- ***Quality and Other Reporting:*** Providers must have the capacity to collect and report specific outcome and quality data measures as required by the Centers for Medicare and Medicaid Services (CMS) and maintain a continuous quality improvement plan.

- ***Organizational Authority and Governance:*** CCBHCs must be nonprofit organizations, maintain the proper Medicaid licenses, certifications, and accreditations, and have a governing board representative of the community it serves and involve people with lived experience.

Prospective Payment System

During the demonstration period, or when a State Plan Amendment has made the CCBHC model permanent, CCBHCs utilize a PPS model to support clinic operations. The goal of the PPS model is to encourage providers to offer wraparound care based on patients' needs and disincentivize providing a higher volume of services unnecessarily, which may occur under an FFS payment model. Under the PPS model, Medicaid provides the estimated daily or monthly cost to operate the facility, regardless of the number or types of services provided during that period. CMS defines Special Crisis Services rates for mobile crisis services and crisis stabilization services that may be incorporated into states' PPS rates. In addition, states can use quality-based payments (QBP) as additional incentives for quality improvement. These payments are optional under some models and required under others. To prepare for the demonstration, states choose from four different PPS billing models based on daily or monthly costs, and the inclusion of QBP, and

establish rates by dividing estimated allowable costs by a projected number of visit days or visit months. SAMHSA allows states to rebase their PPS rates after a year of demonstration, and most of the states participating in the demonstration rebased their rates after the first year of the grant to align with actual spending.

Currently Participating States

As shown in **Exhibit 12**, as of January 2025, SAMHSA has awarded dozens of planning grants and selected 10 states to complete the four-year demonstration. According to SAMHSA, this demonstration period was set to end July 2019 but was extended multiple times through September 2025. Of the original states selected for the demonstration, Minnesota, Pennsylvania, and Nevada left the pilot. Minnesota returned after CMS began allowing quality measures for non-FFS services to qualify for a match. Pennsylvania left because it wanted to change the original PPS model chosen and alter its quality reporting (these changes are now permitted without leaving the demonstration). Nevada left because it wanted more flexibility and has since received approval by CMS for a State Plan Amendment to incorporate the CCBHC model in its state Medicaid plan.

Exhibit 12
Timeline of Planning and Demonstration Awards

Date	Planning Grant	Demonstration
October 2015	AK, CA, CO, CT, IA, IL, IN, KY, MA, MD, MI, MN, MO, NC, NJ, NM, NV, NY, OK, OR, PA, RI, TX, VA	
December 2016		MN, MO, NJ, NV, NY, OK, OR, PA
July 2019		
August 2020		KY, MI
June 2024	IA, IL, IN, KS, ME, NH, NM, RI, VT	
January 2025	AK, CO, CT, DC, DE, HI, LA, MD, MT, NC, ND, SD, UT, WA, WV	

Note: Alaska, Colorado, Connecticut, Iowa, Illinois, Maryland, New Mexico, and North Carolina were awarded the planning grant twice but did not necessarily accept the award.

Source: Substance Abuse and Mental Health Services Administration

CCBHC in Maryland

Maryland applied for and was awarded planning grants in fiscal 2016 and 2025, for $982,373 and $926,053, respectively. MDH did not accept the fiscal 2016 planning grant but did accept the fiscal 2025 grant in February 2025. Over the course of calendar 2025, MDH carried out the planning process to prepare for the demonstration. MDH submitted and received a request for a no cost extension of the planning grant to end in December 2026, rather than December 2025, to allow additional time for planning and organization ahead of the demonstration. Absent enactment of the provision in the BRFA, MDH plans to submit the application for the demonstration in April 2026. SAMHSA estimated that the notice of funding opportunity would be posted by March 31, 2026, and anticipates issuing 15 awards.

There are currently five CCBHCs in Maryland, serving four eastern shore counties; Baltimore, Montgomery, and Prince George's counties; and Baltimore City. Each of the five CCBHCs in Maryland have received expansion grant funding from SAMHSA. Four of the five clinics' grants will expire at the end of September 2026. As licensed Medicaid providers, these clinics bill CMS for Medicaid-eligible services. Grant funding from SAMHSA covers additional costs of CCBHC that are not billable to Medicaid, such as specific types of staff, or care coordination for non-Medicaid eligible patients. MDH is determining how to bridge the gap in funding for these clinics should the demonstration begin after September 2026. **MDH should provide an update on its work with the clinics to determine a solution to provide bridge funding if necessary.**

CCBHC Stakeholder Workgroup

MDH established the CCBHC Stakeholder Workgroup in fiscal 2025 to advance the work of the planning grant and decide how the CCBHC demonstration will be structured in Maryland. The group is made up of representatives from Maryland's CCBHCs, behavioral health advocates and providers, and community members and led by MDH staff. The group met seven times during calendar 2025 and will continue to convene at least through April 2026. During the first several meetings, current CCBHCs shared their experiences with serving their populations, utilizing evidence-based practices, data collection and reporting, technical assistance needed, and challenges clinics foresee with implementation. As of December 2025, the group's actions and decisions include:

- ***Community Needs Assessment:*** With input from stakeholders, MDH will develop a statewide community health needs assessment, building on past assessments.

- ***Payment Model:*** Maryland will use the PPS-1 model, which pays clinics based on an estimated daily rate as that is thought to be less risky than using a monthly rate. MDH is contracting with Myers and Stauffer to support the cost reporting process, which will determine rates used in year one of the demonstration. Maryland will also carve out billing for mobile crisis teams (MCT), to ease billing of these services for CCBHCs, many of which will offer MCT through a partner provider.

- ***Certification Criteria:*** Maryland proposes adding more specific criteria to the federal requirements related to staffing and training, service availability, required screenings, utilization of certified and non-certified peer support specialists, and care coordination, including the requirement that CCBHCs use the forthcoming Bed Registry and Referral System. The group also chose not to allow DCOs except in the case of crisis services, due to the added burden on clinics to provide oversight of DCOs to ensure adequate service quality and proper data collection and tracking.

In addition, MDH hired a program manager who started January 28, 2026. Up to that point, other staff in BHA have been managing the CCBHC planning process. While the grant has not been entirely spent or reported on, MDH shared a spending plan with DLS, in **Exhibit 13**.

Exhibit 13
Maryland Fiscal 2025-2026 CCBHC Planning Grant Spending Plan

Purpose	Cost	Description
Actuarial contract for cost reporting (Myers & Stauffer)	$162,990	Collection of cost reports from potential CCBHCs, calculation of the PPS daily rates based on those cost reports; and provider training on cost report completion.
Technical assistance for CCBHCs (Mental Health Association of Maryland)	241,696	Mental Health Association of Maryland will provide technical assistance to potential CCBHCs, via site visits, interviews and reports, focusing on CCBHC governance and implementation, in alignment with national criteria.
Administrative Services Organization functionality	425,818	Updates to Carelon's system to create CCBHCs as a new provider type in their reimbursement systems.
Program Evaluator	95,549	Support for day-to-day operations of the planning grant and CCBHC implementation.
Total	**$926,053**	

CCBHC: Certified Community Behavioral Health Clinic
PPS: Prospective Payment System

Source: Maryland Department of Health

Future Costs

As noted previously, the fiscal 2027 allowance includes $4.6 million in the DPA for the pro-rated State share of the partial year implementation of two CCBHCs under the demonstration. MDH estimates the annual cost for two CCBHCs at $9.3 million in general funds and $5.5 million in federal funds. Although states qualify for an enhanced federal match under the demonstration, MDH indicated that the estimated general fund costs include expenditures not reimbursable by Medicaid and therefore assumed a funding split of 61% general funds and 39% federal funds. **Exhibit 14** compares Maryland's cost estimates with other States that have participated in the demonstration grant. MDH has indicated that it will first establish the CCBHC model at two existing clinics, which will be chosen through a competitive process based on the clinics' ability to meet State and federal certification criteria.

Exhibit 14
Cost Estimates for Demonstration States
($ in Millions)

		Demonstration Year 1			Demonstration Year 2		
State	Total CCBHCs	Total CCBHC Cost	Federal Share	Cost Per Clinic	Total CCBHC Cost	Federal Share	Cost Per Clinic
Maryland	2	$7.54	$2.91	$3.77	$15.08	$5.83	$7.54
Minnesota	6	44.06	30.40	7.34	61.54	42.01	10.26
Missouri	15	289.90	218.63	19.33	360.49	273.56	24.03
Nevada	4	2.06	1.75	0.52	0.69	0.58	0.17
New York	13	57.31	37.25	4.41	155.04	101.94	11.93
Pennsylvania	7	50.45	36.26	7.21	56.73	41.95	8.10
New Jersey	7	21.61	17.26	3.09	32.35	25.58	4.62
Oklahoma	3	34.54	25.43	11.51	54.33	47.90	18.11

CCBHC: Certified Community Behavioral Health Clinic

Note: Maryland federal fund share costs are estimates. Maryland year one demonstration reflects six months of costs for a January 1, 2027 start date.

Source: Office of the Assistant Secretary for Planning and Evaluation; Maryland Department of Health; Department of Legislative Services

Demonstration states operated public behavioral health systems with differing levels of infrastructure. Missouri, for example, started with a disjointed and underfunded behavioral health system prior to the CCBHC model. Then they invested significant resources to establish 15 CCBHCs, covering 78% of the counties. Compared to other states, costs to implement year one

of the demonstration in Missouri were significant; total CCBHC expenditures were five times that of the state with the second highest costs implementing two fewer clinics (New York).

Other states participating in the demonstration reported to HHS that in many cases, clinics seeking certification needed to make significant changes to operations and services to comply with federal and state requirements, such as offering telehealth, increasing the number and types of staff, and implementing better data collection and reporting systems. Because each of the Maryland clinics receives SAMHSA funding, they have been able to establish many elements of the CCBHC model. All of the CCBHCs in Maryland offer the nine required CCBHC services and provide some non-billable services as needed. However, to fully meet the State's criteria, Maryland clinics have indicated that they would need to increase the number of employees and improve data collection and analytic systems, including by hiring designated data managers and working with MDH to ensure interoperability with State data systems like Chesapeake Regional Information Systems for our Patients and the ASO.

CCBHC Outcomes in Other States

The CCBHC model aims to expand access to patient-centered, high-quality wraparound care. In doing so, proponents of the model argue that States may be able to reduce utilization of emergency department visits and more intensive care requiring greater resources. In general, during and following participation in the demonstration, behavioral health-related emergency department visits and hospitalizations decreased or remained stable among adults, and in some cases, increased among children and adolescents. However, results related to cost savings have been mixed across states. Moreover, most of the current demonstration states began the program during the COVID-19 pandemic, when health system usage was abnormal. The demonstration is also relatively new, and it may be difficult to draw definitive conclusions at this point. In addition to data that states are required to report to HHS, many states have commissioned their own evaluations of the model in their state to study the early impacts of the model on the state's health system.

A study in New York, completed by a third party, determined that to offset the additional costs needed to implement CCBHCs in the state, there needed to be a 0.9% reduction in emergency department and inpatient spending. The evaluators estimated that this could be realized if at least 3.8% of those in need of services had access to a CCBHC. From 2018 to 2019, 10.6% of behavioral health care visits took place at a CCBHC facility and thus the evaluation concluded that CCBHCs produced cost savings for New York's state share of Medicaid costs.

Oregon reported increases in behavioral health-related emergency department visits between calendar 2021 and 2023 among the overall CCBHC population but decreases among those with significant behavioral health needs (24%). In addition, during this period, Oregon observed a 24.5% reduction in SUD-related emergency department visits, and a 38.4% reduction in acute detox inpatient hospitalization. Oregon calculated cost savings at the clinic level by service and estimated that CCBHCs in the state saved the system about $7 million annually, not enough to fully offset the costs of CCBHC implementation in the state, but demonstrative of CCBHCs' ability to divert patients from higher-cost care.

The latest Office of the Assistant Secretary for Planning and Evaluation report from 2024 to Congress included impact measures for Minnesota, Nevada, and Oklahoma covering the first four demonstration years (federal fiscal 2017-2021), which includes the first two years of the COVID-19 pandemic. These figures compare the rates of hospitalization and emergency department visits among CCBHC consumers of all ages with that of non-CCBHC consumers. Nevada saw a 23% decrease in hospitalizations among people who receive care at CCBHCs, driven mainly by a reduction in behavioral health-related hospitalizations, and Oklahoma saw a 6.3% decrease in hospitalizations among adults and 11.2% decrease in hospitalizations among people with SUD. Minnesota and Oklahoma both saw increases in emergency department visits among CCBHC consumers, but mainly for physical health-related concerns. Among individuals with SUD, there was a 12% decrease in emergency department visits in Oklahoma. In Nevada, CCBHC consumers had 18% fewer behavioral health-related emergency department visits. The report does not connect this data to specific fiscal savings.

Prior to implementing the demonstration, Kansas compared its current behavioral health system, which utilizes community mental health clinics (CMHC), with potential CCBHC utilization and costs. It estimated costs and utilization for CMHCs if they increased access to care to the extent that CCBHCs do. With the same level of expanded access, the state estimated that CCBHCs would cost more overall than expanding CMHCs but would cost less in state general dollars due to the enhanced Federal Medical Assistance Percentage. However, Kansas estimated that the state fund savings would end in fiscal 2029 due to the expiration of the demonstration and the expanded federal match.

One study from an Oklahoma CCBHC estimated that the expansion of crisis response services would yield $427 million in health care savings annually. An evaluation of an Oklahoma CCBHC, GRAND Mental Health, estimated $62.5 million in savings from reductions in behavioral health-related hospitalizations among GRAND patients. In addition, the evaluation estimated that the state saved $718,681 in law enforcement expenses due to reduced mileage and officer time, as under the new model officers transported clients to nearby crisis stabilization centers, rather than the hospital.

Other Benefits

Based on data reported to HHS and data from states' evaluations, there do not seem to be significant cost savings thus far from implementing CCBHCs. The original demonstration states have recently completed their four-year demonstration, and much of it took place during COVID-19, when the healthcare system faced myriad challenges. As more states complete the demonstration and transition to a sustainable CCBHC model, it will be more clear what ongoing costs and savings will be. It is possible that continued investment in wraparound care results in reduced costs for hospitalization and law enforcement. There are also harder-to-quantify benefits to consider, such as increased chance of individuals retaining employment or having an easier time getting through school when receiving adequate behavioral health care.

The purpose of implementing the CCBHC model is to expand access to behavioral health care by working around common barriers, such as insurance status, disjointed service coordination, and clinic and service availability. All demonstration states reported increases in utilization of

services and increased number of users of the behavioral health system. States differed on which services saw increases and among which populations, but across the board, states reported increases in access to behavioral health services. It seems as though under the CCBHC model, while costs may be higher, care is provided much more efficiently because clinics can address patient needs with sufficient resources.

Other Considerations

Unlike Maryland, most other states in the demonstration employ third party organizations (often managed care organizations (MCO) or coordinated care organizations (CCO)) to oversee payment of individual clinics and manage the Medicaid billing. In these settings, the MCO or CCO receives payment from Medicaid and pays the CCBHC the required PPS rate. Oregon and Colorado both said that using MCOs or CCOs makes the billing process more complicated. In Oregon, the CCOs pay providers a normal rate, and the Oregon Health Authority carries out a reconciliation process to ensure that the CCBHCs received the proper PPS rate. This makes it hard to track the budget. Because in their system clinics are paid through both PPS and FFS payments, it is not always straightforward to monitor when the correct payments are issued. Having one ASO to centrally receive and pay out behavioral health provider claims could alleviate the difficulty states have overseeing payment processes with multiple MCOs and CCOs.

Lastly, the demographics of different states affect service availability and access, and service needs. Oregon is a geographically large state, with much of the population living in remote or rural communities, whereas New Jersey has only one CCBHC serving rural communities and CCBHCs serve 29% of counties in the state. Across six demonstration states, 64% of CCBHC consumers were enrolled in Medicaid in year four of the demonstration. The percentage ranged from 55% in Oklahoma to 79% in Oregon. People's ability to access a clinic near their home and the share of Medicaid-eligible clients contribute to the state's cost of this program and how states shape it to best serve their constituencies.

2. Assisted Outpatient Treatment Program

Chapters 703 and 704 require the establishment of AOT programs in each local jurisdiction by July 1, 2026 (fiscal 2027). Specifically, the chapters require local jurisdictions to convene a care coordination team to develop treatment plans for individuals court-ordered to adhere to mental health treatment and who have not adhered to mental health treatment in the past and are determined unlikely to voluntarily adhere to treatment plans in the future. The care coordination team must include a psychiatrist, case manager, certified peer recovery specialist, and other providers as clinically appropriate such as an assertive community treatment (ACT) team. The treatment plans may consist of several types of services, dependent on the individuals' needs, and the service recipient must have an opportunity to participate in the creation of their treatment plan. The legislation also requires that local jurisdictions notify MDH if they intend to oversee the program independently or in partnership with other counties or opt for MDH to oversee the program in their jurisdiction by January 1, 2025. MDH extended the deadline to January 31, 2025, and no jurisdictions opted to oversee the program independently; therefore, MDH is required to

implement the program statewide by July 1, 2026. The department indicated that it would do so by the end of fiscal 2027.

About AOT

AOT programs offer a treatment regimen for individuals with serious and persistent mental illness who have been court-ordered to seek treatment, have a demonstrable lack of adherence to treatment in the past, and are determined unlikely to voluntarily adhere to treatment in the future. AOT programs require a care coordination team consisting of a psychiatrist, case manager, certified peer recovery specialist, and other providers as clinically appropriate, such as an ACT team. This team develops outpatient treatment plans for eligible adults. The treatment plans may consist of several types of services, dependent on the individuals' needs, and the service recipient must have an opportunity to participate in the creation of their treatment plan. Research from Arizona, New York, and North Carolina have demonstrated a correlation between AOT programs and reduced rates of incarceration and hospitalization among individuals with serious and persistent mental illness, and in New York, AOT programs were associated with cost savings due to reduced need for more intensive mental health services.

AOT Planning and Implementation Funding

The fiscal 2027 allowance includes $6.7 million for the administration and implementation of AOT programs across the State, beginning in three regions: Baltimore City, Anne Arundel County, and the Eastern Shore. These regions cover 11 jurisdictions. MDH has indicated that it will phase in the program to other regions of the State over the course of fiscal 2027, as shown in **Exhibit 15**. **MDH should discuss why it has chosen a phased-in implementation given the statutory requirement to implement in all jurisdictions on or before July 1, 2026.**

Exhibit 15
Assisted Outpatient Treatment Program Implementation Phases
Fiscal 2027

Phase 1 – July 1, 2026	**Anne Arundel**	**Baltimore City**	**Eastern Shore** Caroline County Cecil County Dorchester County Kent County Queen Anne's County Somerset County Talbot County Wicomico County Worcester County

Phase 2 – January 1, 2027	**Montgomery**	**Prince George's**	**Western** Allegany County Garrett County Washington County Frederick County
Phase 3 – April 1, 2027	Baltimore County Howard County	**North Central** Carroll County Harford County	**Southern** Calvert County Charles County St. Mary's County

Source: Maryland Department of Health

The fiscal 2025 and 2026 budgets included $3 million annually for AOT program startup costs. To date, MDH has utilized its fiscal 2025 and 2026 appropriation to hire an AOT program director and carry out preliminary work to support program implementation, including establishing administrative policies and procedures and cultivating relationships with governmental and community partners such as law enforcement, hospitals, and peer support organizations. Between February and August 2025, MDH convened an advisory group of LBHAs, local health departments, providers, and advocates to discuss statewide AOT implementation and solicit feedback. MDH also posted and shared draft AOT regulations in October 2025, held public listening sessions in November and December 2025, and accepted written comments through December 31, 2025. Finalized regulations have not yet been released. MDH has advised that $1 million of the fiscal 2026 appropriation will be used to establish care coordination teams for the first group of regions, who will begin on July 1, 2026, and to support the hiring of 2 new program coordinators. MDH indicated that the other $2 million of the fiscal 2026 appropriation will be used to address program deficits but did not specify how these deficits arose or to which program funding moved. **MDH should clarify the deficits that it is projecting, in which program, and why funds for the AOT program are being used in this way.**

The fiscal 2027 allowance includes $4.2 million for AOT care coordination team services. **Exhibit 16** shows how this funding will be distributed to the three groups of regions between fiscal 2027 and 2029. The fiscal 2027 allowance also includes funding for ACT teams ($1.4 million), uninsured participants ($600,000), MDH staff ($413,077), and training and technical assistance ($100,000). **MDH should specify how the care coordination team services will be divided across the regions noted in each group.**

Exhibit 16
Assisted Outpatient Treatment Care Coordination Team Funding
Fiscal 2027-2029

	2027	2028	2029
Phase 1: Anne Arundel, Baltimore City, Eastern Shore	$2,731,250	$2,296,550	$1,694,180
Phase 2: Western, Montgomery, Prince George's	1,005,158	1,908,540	1,548,360
Phase 3: Baltimore County, North Central, Southern	491,798	2,053,440	1,763,640
Total	**$4,228,206**	**$6,258,530**	**$5,006,180**

Source: Maryland Department of Health

Many of the AOT program services are reimbursable through Medicaid. Services that are not Medicaid-eligible or for individuals who are not enrolled in Medicaid will be supported with general funds. MDH advises that care coordination team funding will support some non-treatment costs, such as staff time spent on court testimony. MDH cautioned that the proportion of Medicaid-billable costs is difficult to estimate due to the variance in the number of services each participant uses and the balance of clinical and nonclinical service. Considering these limitations, MDH estimates that about half of all AOT program costs will be billable to Medicaid.

SAMHSA awards AOT program grants to states. MDH did not receive funding that it applied for in fiscal 2025 but was awarded two grants in fiscal 2026. MDH noted that these funds cannot be used for direct services. SAMHSA anticipates releasing an additional funding opportunity shortly, pending approval of federal fiscal 2026 appropriations. **MDH should comment on the total amount of the fiscal 2026 awards and if they are included in the fiscal 2026 working appropriation. In addition, MDH should indicate if it intends to apply for the forthcoming SAMHSA grant opportunity.**

Local Implementation

MDH has indicated that it has involved many stakeholders, including LBHAs and CSAs, in developing its approach to implementing the statewide AOT program regionally, and in phases. MDH notes some of the benefits of implementing the program in phases include identifying and addressing barriers in a smaller area before expanding statewide. MDH chose the three regions in Phase 1 (Baltimore City, Anne Arundel County, and Eastern Shore) based on expected AOT participation and a geographic balance of rural, suburban, and urban areas. Using estimates from fiscal 2024, MDH projects that about 477 individuals are eligible to receive AOT services. Of these, 183 reside in one of the three regions included in Phase 1 of the program's implementation.

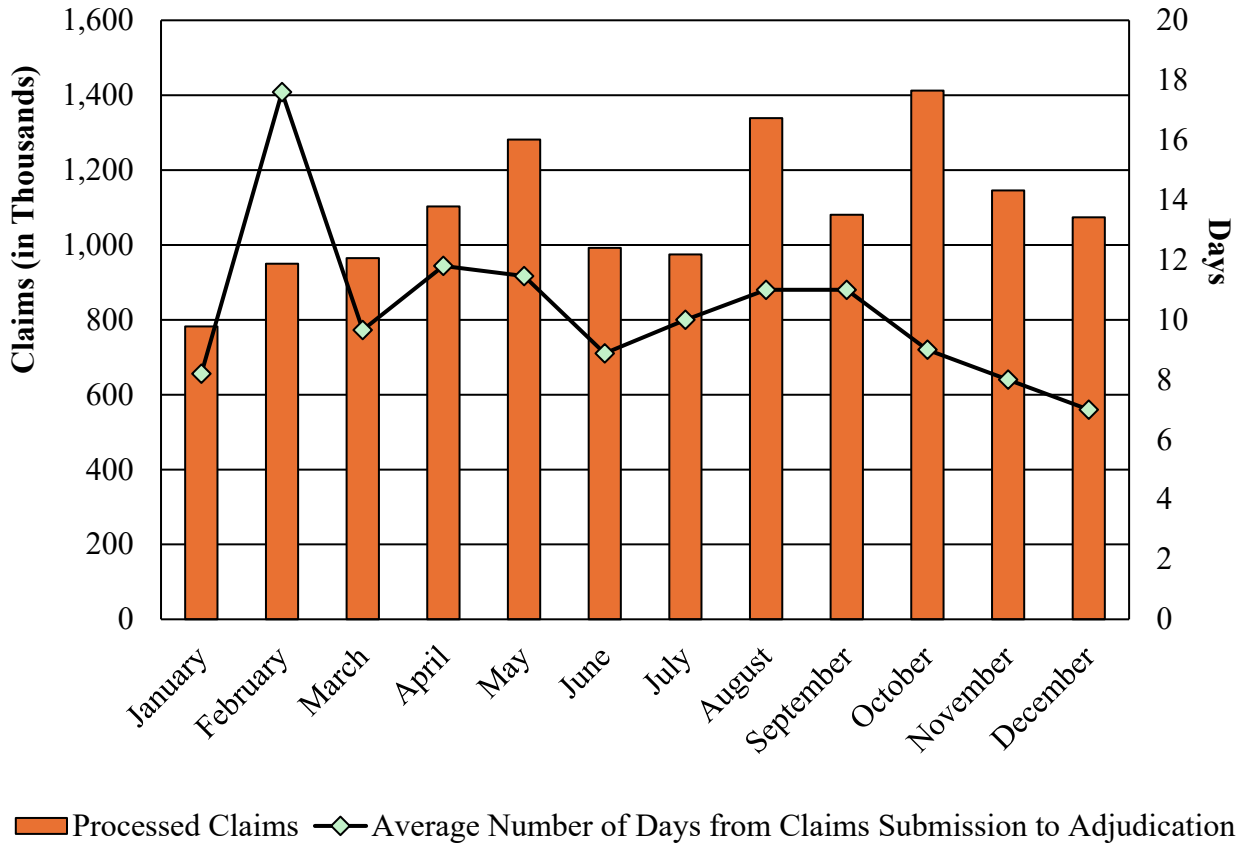
As discussed previously, the BRFA of 2026 includes a provision that would require local jurisdictions in which MDH has established an AOT to reimburse the department for a progressively greater share of the costs beginning in fiscal 2028 through fiscal 2031, at which point local entities would reimburse 100% of the costs. However, it is unclear which local entities will be responsible for the reimbursement (the county government or the LBHA/CSA). Information provided by DBM estimates that when fully phased in, the total statewide program costs would be $6.3 million. If this cost estimate is accurate, each 25% phase-in would require a combined local reimbursement of $1.58 million. However, it is unclear how this total cost was estimated or how the amount would be allocated by jurisdiction.

3. Year One of the New ASO

On February 14, 2024, BPW approved MDH's award of a new ASO contract with Carelon. The current contract began March 1, 2024, and ends December 31, 2029, with one two-year renewal option. Following a 10-month period for design, development, and implementation, the ASO systems went live on January 1, 2025. The 2025 JCR required MDH to submit an update of the transition, and in August 2025, MDH submitted the report including data related to provider enrollment, service usage, and claims. Between January 1, 2025, and June 30, 2025, MDH processed 6.6 million service claims for 6,651 providers, representing $1.5 billion in payments. MDH reported that each of these numbers is consistent with data from prior years, suggesting Carelon's proactive training sessions leading up to and during the system's launch have been effective to facilitate provider registration and billing.

MDH also reported on the average time it took for Carelon to process claims, which involves reviewing submitted information, verifying propriety of the service, service recipient, and provider, and ultimately approving or denying the claim. Per the State's contract with Carelon, the ASO is required to pay approved claims within 14 days of submission and adjudicate all claims within 30 days of submission. Among adjudicated claims, the average number of days between submission and adjudication peaked in February 2025 at 17.6 days. As of June 30, 2025, MDH reported 216,466 unadjudicated claims, which remained outstanding for an average of 51 days and represented $274.1 million in potential payments. In January 2026, MDH noted improvements in the new system's processes and provided DLS with additional provider registration and claims reimbursement data since June 30, 2025. As of December 31, 2025, 22,077 providers were registered in the ASO and Carelon processed 13.1 million provider claims for 7,466 providers. As shown in **Exhibit 17**, the average number of days to process claims decreased to seven in December 2025.

Exhibit 17
Behavioral Health Service Claim Processing in Carelon
January through December 2025



Source: Maryland Department of Health; Department of Legislative Services

Beginning in January 2025, Carelon opened a call center to support providers through the transition and assist with claims submission. In March 2025, Carelon added 36 additional staff to address the unanticipated volume of provider calls. The additional staff significantly reduced the wait time of calls from 5.6% of calls waiting fewer than 30 seconds to speak to a call representative in January 2025, to 85.1% of calls waiting fewer than 30 seconds in June 2025.

Data Transfer Issues

In January 2026, MDH reported ongoing challenges related to data importation from Optum into Carelon. Claims submitted during the first half of fiscal 2025 were submitted through Optum, while claims submitted during the second half of the fiscal year were processed through Carelon. After Carelon started processing claims, MDH continued transferring data from Optum

into the new system to properly align service categories and prior claim information. MDH indicated that the data transfers from Optum to Carelon were completed in April 2025; however, there have been issues with the way the data has been imported, and as of January 2026, the department continues to correct the transferred data. MDH anticipates that the errors will be resolved within the next few months. This process resulted in a significant amount of spending in fiscal 2026 on fiscal 2025 services compared to the expected amount of carryover as reported by the department (exceeding $200 million).

The lack of data makes it difficult to analyze utilization trends and determine ongoing funding needs for behavioral health Medicaid and non-Medicaid services. Language in the fiscal 2025 and 2026 budget bills require BHA to submit data on non-Medicaid provider reimbursement spending to facilitate DLS's forecast and increase transparency of service utilization and cost in those programs. To date, MDH has not submitted data from either year and advised in January 2026 that the data would not be able to be furnished until the last half of fiscal 2026 due to ongoing data quality improvement efforts. **DLS recommends restricting $500,000 in general funds pending the submission of monthly non-Medicaid provider reimbursement data.**

While some delays and data errors are expected with any new system, it is important that ASO follows proper procedure in reviewing claims and eligibility to ensure accuracy and improved data quality moving forward. MDH indicates that Carelon is continuing to reach out to providers regularly and proactively address issues and questions as they arise. **To continue monitoring the progress of the ASO transition, DLS recommends adopting committee narrative requesting a report updating the budget committees on the transition and identifying any challenges or issues that may develop.**

Audit

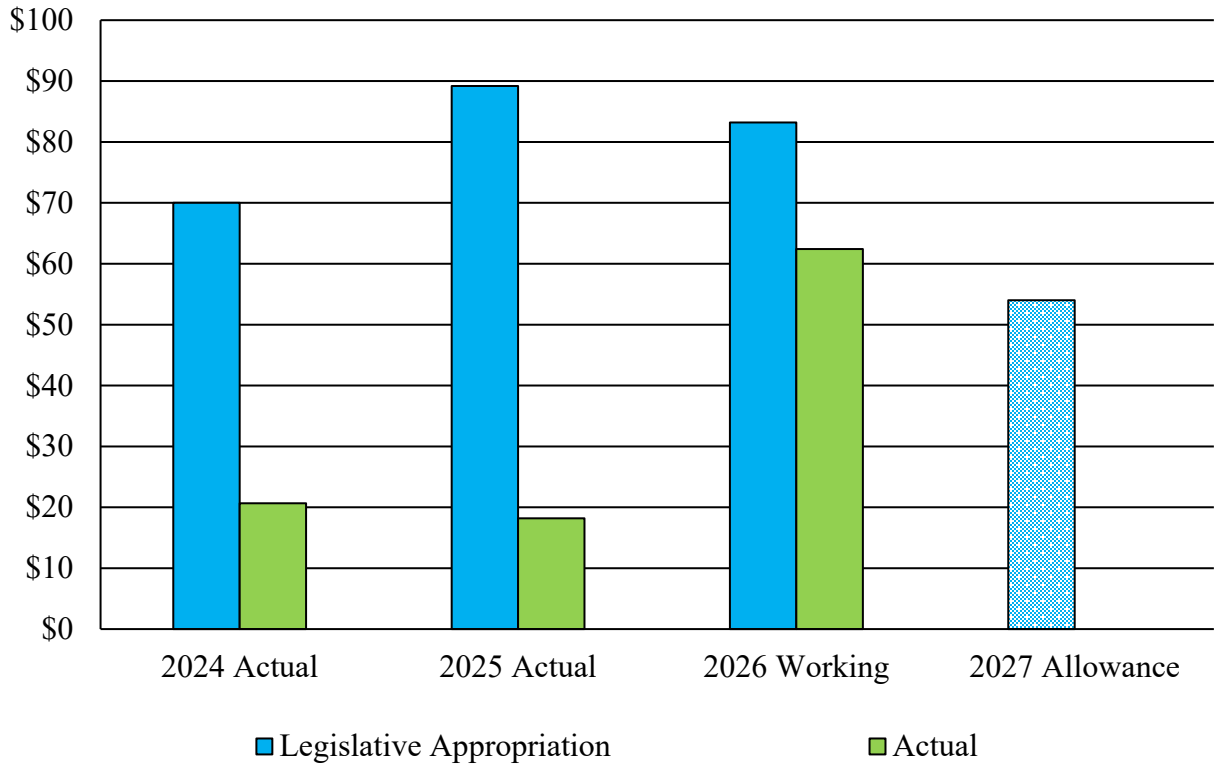
In October 2025, the Office of Legislative Audits (OLA) released a fiscal compliance audit of BHA and Medical Care Program Administration (MCPA)'s oversight and management of the ASO for the period July 1, 2021, through October 31, 2024. Specific audit findings are included in **Appendix 2** of this document. As discussed previously in this analysis, OLA found that MDH did not ensure that the claims paid out by Optum were properly supported. Optum did not consistently audit its claims data to ensure that the individuals receiving services were eligible for that service. In addition, the audit notes the lack of oversight over Optum's overpayments to providers. The audit highlights the role the ASO plays to regularly carefully evaluate claims, review decisions, investigate questionable claims, and take corrective action.

4. Behavioral Health Investments

The fiscal 2027 allowance includes $53.1 million for behavioral health investments, about $8.4 million less than the fiscal 2026 working appropriation after accounting for a deficiency appropriation. The proposed deficiency appropriation withdraws $16.9 million out of the $83.2 million initially appropriated in fiscal 2026 to better reflect fiscal 2025 actual expenditures.

Exhibit 18 shows spending from this program from fiscal 2025 through 2027. The goal of this budget is to support efforts that cannot be funded through other sources. In fiscal 2025 and 2026, MDH primarily supported crisis response and hospital overstay initiatives with the funding. As discussed previously, the fiscal 2026 Budget Bill restricted $3.5 million from this program to be used to address pediatric hospital overstays ($3 million) and to procure drug detection products for students at colleges and universities ($500,000). In fiscal 2027, $17.1 million from this program supports provider reimbursements for mobile crisis services, crisis stabilization centers, school-based behavioral health services, and the Medicaid re-entry waiver. **MDH should clarify the purpose of the remaining $36 million of investment funding in fiscal 2027. In addition, MDH should indicate if the fiscal 2027 budget will continue to fund the purposes for which funds were restricted in fiscal 2026.**

Exhibit 18
Behavioral Health Investment Spending
Fiscal 2025-2027
($ in Millions)



Note: Actuals are shown for fiscal 2024 and 2025 only. The fiscal 2026 legislative and working appropriation include funds restricted to be used for particular purposes per language in the fiscal 2026 budget bill.

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

5. Behavioral Health Workforce Investment Fund

Chapters 286 and 287 of 2023 established the Behavioral Health Workforce Investment Fund to support the education, training, recruiting, and retaining of behavioral professionals and paraprofessionals in Maryland. The legislation does not identify a revenue source for the fund. Per the legislation, MHCC released a behavioral health workforce needs assessment in October 2024. The report estimated that Maryland required 18,200 more behavioral health workers to meet the behavioral health needs of the State as of calendar 2024 and that 14,600 additional staff will be required to meet the need by calendar 2028 due to workers leaving the workforce. MHCC put forward several recommendations to strengthen the workforce, including investing $148.5 million over five years from public and private sources, including nearly $60 million from the Behavioral Health Workforce Investment Fund. MDH advised that there is no money in the fund and no plans to deposit money into the fund.

In September 2025, MDH shared at the Joint Meeting of the Behavioral Health Advisory council and the Behavioral Health Committee on Treatment and Access, that it was developing a four-year plan to make improvements to the behavioral health workforce. MDH indicated that it had plans to build a Center for Excellence for children, youth, and families to offer workforce development and training programs. It is unclear if this center would be funded through the Workforce Investment Fund or other means. **MDH should provide an updated timeline for the Center and indicate if there are plans to invest any money in the fund in the future.**

Operating Budget Recommended Actions

		Amount Change	
1.	Reduce funding to reflect savings due to an anticipated turnover rate 3% higher than budgeted in fiscal 2027.	-$725,000	GF

2. Add the following language:

   Further provided that these funds are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.03 Community Services for Medicaid State Fund Recipients, M00Q01.03 Medical Care Provider Reimbursements, or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements. Funds not expended or transferred shall be reverted.

   Explanation: This language restricts the entire general fund appropriation for M00L01.02 Community Services for that purpose or for transfer for provider reimbursements in M00L01.03 Community Services for Medicaid State Fund Recipients, M00Q01.03 Medical Care Provider Reimbursements, or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

3. Add the following language:

   , provided that these funds are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.02 Community Services, M00Q01.03 Medical Care Provider Reimbursements, or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements. Funds not expended or transferred shall be reverted.

   Explanation: This language restricts the entire general fund appropriation for provider reimbursements in M00L01.03 Community Services for Medicaid State Fund Recipients for that purpose or for transfer to M00L01.02 Community Services, M00Q01.03 Medical Care Provider Reimbursements, or M00Q01.10 Medicaid Behavioral Health Provider Reimbursements.

4. Add the following language:

   , provided that these funds are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.02 Community Services, M00L01.03 Community Services for Medicaid

State Fund Recipients, or M00Q01.03 Medical Care Provider Reimbursements. Funds not expended or transferred shall be reverted.

Explanation: This language restricts the entire general fund appropriation for provider reimbursements in M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to that purpose or for transfer to M00L01.02 Community Services, M00L01.03 Community Services for Medicaid State Fund Recipients, or M00Q01.03 Medical Care Provider Reimbursements.

5. Add the following language:

, provided that since the Maryland Department of Health (MDH) has had four or more repeat audit findings in the most recent fiscal compliance audit issued by the Office of Legislative Audits (OLA), $100,000 of this agency's administrative appropriation may not be expended unless:

(1) MDH has taken corrective action with respect to all repeat audit findings on or before November 1, 2026; and

(2) a report is submitted to the budget committees by OLA listing each repeat audit finding along with a determination that each repeat finding was corrected. The budget committees shall have 45 days from the receipt of the report to review and comment to allow for funds to be released prior to the end of fiscal 2027.

Explanation: The Joint Audit and Evaluation Committee has requested that budget bill language be added for each unit of State government that has four or more repeat audit findings in its most recent fiscal compliance audit. Each agency is to have a portion of its administrative budget withheld pending the adoption of corrective action by the agency and a determination by OLA that each finding was corrected. OLA shall submit a report to the budget committees on the status of repeat findings.

Information Request	**Author**	**Due Date**
Status of corrective actions related to the most recent fiscal compliance audit	OLA	45 days before the release of funds

6. Add the following language:

Further provided that $100,000 of this appropriation is contingent on the fiscal 2028 budget submission including provider reimbursements for the uninsured and underinsured population in a separate program from the nonprovider reimbursement expenditures in the Community Services program. It is the intent of the General Assembly that beginning in

fiscal 2028, provider reimbursement expenditures be budgeted in a separate program from grants, contracts, and other administrative expenses in program M00L01.02.

Explanation: Provider reimbursements for services utilized by the uninsured and underinsured are budgeted within the M00L01.02 Community Services program. This budget also includes funding for various behavioral health programs, services, and initiatives. This language states the intent of the General Assembly for Community Services program provider reimbursements to be budgeted separately from other Community Services program spending beginning in fiscal 2028. The separation will facilitate simpler tracking and analysis of provider reimbursement spending and service utilization.

Information Request	Author	Due Date
Separate program for Community Services program provider reimbursements	Maryland Department of Health	With the submission of the fiscal 2028 allowance

7. Add the following language:

Further provided that $500,000 of this appropriation made for the purpose of administration may not be expended until the Maryland Department of Health submits quarterly letters confirming that it has uploaded data on reimbursements to non-Medicaid providers through the Virtual Data Unit each month through March 31, 2027. The data shall include provider reimbursement spending in M00L01.02 and M00L01.03, separated by budget program and by service type within each program. The data shall be provided beginning with data from January 1, 2026, through June 30, 2026, submitted July 31, 2026, and every three months thereafter. Funds shall be available to be released in $125,000 increments pending receipt of each letter confirming the submission of data. The first letter shall confirm uploading of data through June 30, 2026, and be submitted by July 31, 2026. The second letter shall confirm the uploading of data for the period from July 1 through September 30, 2026, and be submitted by October 31, 2026. The third letter shall confirm the uploading of data from October 1 through December 31, 2026, and be submitted by January 31, 2027. The fourth letter shall confirm the uploading of data covering the period January 1 through March 31, 2027, and be submitted by April 30, 2027. The budget committees shall have 45 days from the date of the receipt of each confirmatory letter to review and comment. Funds restricted pending the receipt of data may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if each letter is not submitted to the budget committees.

Explanation: The committees are interested in better understanding the spending on provider reimbursements by service type for spending outside of the Medicaid Behavioral Health Provider Reimbursements program. This language restricts funds pending submission of four letters confirming data submission of non-Medicaid provider reimbursements.

Information Request	Author	Due Date
Submission of data on provider reimbursements	Maryland Department of Health	July 31, 2026 October 31, 2026 January 31, 2027 April 30, 2027

8. Add the following language:

Further provided that $100,000 of this appropriation made for the purpose of Community Services may not be expended until the Maryland Department of Health submits a report on the timeliness of payments to local nonprofit core service agencies (CSA). The report shall include the following information:

(1) the total number of nonprofit CSAs with which Behavioral Health Administration (BHA) held a grant agreement in each fiscal 2024, 2025, and 2026;

(2) the number and share of nonprofit CSAs with a grant agreement in fiscal 2024, 2025, and 2026 for which BHA did not meet the required timeframe for distribution of payments;

(3) the number of fourth quarter invoices submitted by nonprofit CSAs in each fiscal 2024, 2025, and 2026 that did not meet the required timeframe for distribution of payments;

(4) the number of annual 440 reconciliations submitted by nonprofit CSAs in fiscal 2024, 2025, and 2026 that did not meet the required timeframe for distribution of payments;

(5) a description of the current process to track and monitor the timeliness of payments to grantees; and

(6) the steps that BHA has taken and plans to take to ensure timely payment distribution moving forward.

The report shall be submitted by October 31, 2026, and the budget committees shall have 45 days from the date of the receipt of the report to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

Explanation: Chapter 155 of 2023 established a State policy requiring State agencies to make payments under specific grant agreements with nonprofit CSAs within 37 days of the later of either (1) the payment becoming due under the grant agreement or (2) the date of receipt of a proper invoice. Interest accrues at the rate of 9% per year on any amount for

which a grant-making entity has received and failed to submit a proper invoice to the Comptroller within 30 days of its receipt. This language restricts funds pending submission by BHA of a report detailing its plan to improve the timeliness of grant distribution to comply with the State policy. This information was requested in the 2025 *Joint Chairmen's Report* but has not been submitted.

Information Request	Author	Due Date
Report on timeliness of payments to local nonprofit CSAs	BHA	October 31, 2026

9. Adopt the following narrative:

Report on the Administrative Services Organization (ASO) Transition: The Behavioral Health Administration (BHA) transitioned to a new ASO on January 1, 2025. The Maryland Department of Health (MDH) and the new contractor, Carelon have provided two reports with information about the transition, challenges that have arisen, and how issues have been addressed. The reports also include data on provider registration, claim submission, and claims payments. During the first year of the transition, issues with data transfer between the previous ASO and Carelon have occurred, leading to the incorrect categorization of some claims and minor delays in paying out claims. To ensure that Carelon and MDH are continuing to quickly address issues related to data quality and provider payments, the committees request that BHA submit a report by October 1, 2026, with the following data as of June 30, 2026:

- the number of providers registered with Carelon;
- the number of claims processed by Carelon during fiscal 2026;
- the dollar value of the claims approved by Carelon during fiscal 2026;
- a description of issues, challenges, or barriers faced by BHA, Carelon, or providers since January 1, 2026;
- a description of how Carelon or BHA have addressed any identified challenges; and
- a description of remaining data transfer needs between Optum and Carelon.

Information Request	Author	Due Date
Report on ASO transition	BHA	October 1, 2026

10. Adopt the following narrative:

Report on Reimbursable Fund Spending in Behavioral Health Medicaid: Fiscal 2026 and 2027 are the first in recent years in which reimbursable funds have been budgeted in the Behavioral Health Medicaid program (M00Q01.10). In both years these funds are available from the Community Services program budget for behavioral health investments. These funds support the following Medicaid-eligible services: mobile crisis; crisis stabilization; and school-based behavioral health services, as well as spending for the Centers for Medicare and Medicaid re-entry waiver. While the monthly data submitted on service utilization and spending includes most of these services as of fiscal 2026, it is unclear how the department will report utilization and spending for the reentry waiver. The committees are interested in understanding how reimbursable funding in this program will be reported and tracked to facilitate analysis of utilization trends and estimations of funding needs. BHA should submit by July 31, 2026, a report which includes:

- description of how spending on the reentry waiver is recorded and tracked;
- anticipated spending for these four services in fiscal 2027; and
- explanation for using reimbursable funds rather than general funds for these service areas.

Information Request	Author	Due Date
Report on reimbursable fund spending in behavioral health Medicaid	Behavioral Health Administration	July 31, 2026

Total Net Change to Fiscal 2027 Allowance **-$725,000**

11. Add the following language:

Provided that all fiscal 2026 deficiency appropriations are to be used only for the purposes herein appropriated, and there shall be no transfer to any other program or purpose except that funds may be transferred to programs M00L01.02 Community Services, M00L01.03 Community Services for Medicaid State Fund Recipients, or M00Q01.03 Medical Care Provider Reimbursements. Funds not expended or transferred shall be reverted or canceled.

Explanation: This language restricts the entire general and federal fund deficiency appropriation for provider reimbursements in M00Q01.10 Medical Care Provider Reimbursements to that purpose or for transfer to M00L01.02 Community Services, M00L01.03 Community Services for Medicaid State Fund Recipients, or M00Q01.03 Medical Care Provider Reimbursements.

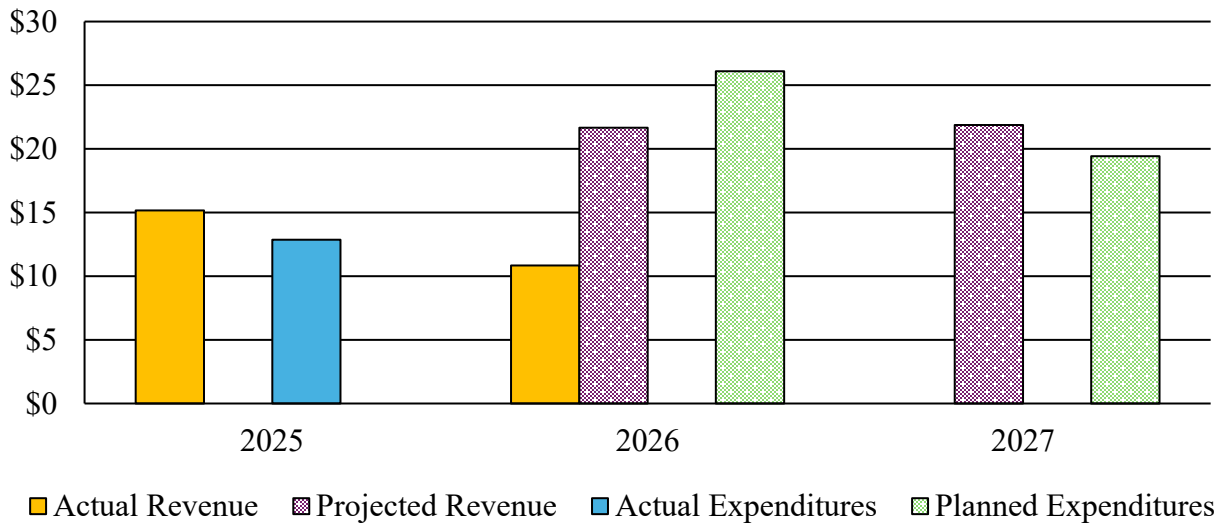
Updates

1. 9-8-8 Crisis Line and Trust Fund

The National Suicide Help Line is 9-8-8 in Maryland. Maryland's 9-8-8 line operates 24/7 and is supported by six call centers across the State, many of which offer text and chat services in addition to call capabilities. The call centers receive State funding to launch, operate, and increase public awareness about the crisis line. Maryland also received federal funding from fiscal 2024 through 2026 for market research, marketing, and a security audit. Chapters 780 and 781 of 2024 established a fee on 9-8-8 accessible services, providing an ongoing revenue source for the 9-8-8 Trust Fund. The fiscal 2026 working appropriation includes $26.1 million in special funds, and the fiscal 2027 allowance includes $19.4 million in special funds for the crisis line.

Exhibit 19 shows the actual and projected revenue and expenditures of 9-8-8 Trust Fund special funds. In fiscal 2025 BHA canceled $5.3 million of $20.8 million special funds appropriated for 9-8-8 expenditures. The cancellation was due to lower than projected revenue in fiscal 2025. MDH indicated that fiscal 2025 expenditures from the 9-8-8 Trust Fund totaled $15.2 million; however, actual grant awards totaled $13.1 million. Of that total, $274,859 went unspent by two grantees, representing 5.9% and 12.1% of their total award, respectively. As of February 16, 2026, fiscal 2026 revenue totaled $10.8 million, and MDH projects total fiscal 2026 revenue of $21.7 million.

Exhibit 19
9-8-8 Trust Fund Revenue and Expenditures
Fiscal 2025-2027
($ in Millions)



Source: Maryland Department of Health; Department of Legislative Services

Appendix 1
2025 *Joint Chairmen's Report* Responses from Agency

The 2025 JCR requested that BHA prepare five reports and submit three letters confirming uploading of data. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Update on ASO Transition:*** BHA submitted a report in August 2025, detailing the progress of the transition to the new ASO, Carelon. Details about the transition, provider uptake, and claims are included in Issue 3 of this analysis.

- ***Report on Behavioral Health Crisis Response Grant:*** In October 2025, BHA submitted a report summarizing the uses of funding awarded through the Behavioral Health Crisis Response Grant program, including mobile crisis response and stabilization, school-based mobile crisis services, urgent care, and behavioral health crisis beds. BHA issued grants to 10 LBHAs and CSAs in fiscal 2026.

- ***Report on Spending to Address Pediatric Hospital Overstays:*** MDH submitted a report outlining its programs that enable the department to better place children and adolescents ready for discharge from an inpatient facility. Discussion of pediatric hospital overstays and information from the report is included in the analysis for M00A – MDH Administration.

- ***Report on Timeliness of Payments to Nonprofit CSAs:*** Due to delays in grant distribution in fiscal 2025, the committees requested that MDH submit a report by January 1, 2026, on its processes for distributing grants to CSAs and LBHAs. As of this writing, MDH had not yet submitted this report.

- ***Non-Medicaid Provider Reimbursement Data in Virtual Data Unit:*** MDH was required to submit three letters, on a quarterly basis, confirming submission of non-Medicaid provider reimbursement data in the virtual data unit. As of this writing, MDH has not submitted any letters and has not uploaded the requested data. MDH indicated that data issues with the transfer between the prior and current ASO have hindered its ability to produce reliable data. Discussion about the ASO is included in Issue 3 of this analysis.

- ***Report on Cost Savings Associated with CCBHCs:*** This study is due May 2026 and therefore has not been submitted at the time of this writing.

Appendix 2
Audit Findings
MDH – BHA and MCPA
Administrative Services Organization for Behavioral Health Services

Audit Period for Last Audit	July 1, 2021 – October 31, 2024
Issue Date	October 2025
Number of Findings	4
Number of Repeat Findings:	4
% of Repeat Findings:	100% (4/4)
Rating (if applicable)	n/a

Finding 1: **MDH did not ensure that claims paid by the ASO were proper and supported, that overpayments identified were recovered, and that necessary corrective or disciplinary actions were taken.**

Finding 2: **BHA did not conduct required audits to ensure that ASO properly authorized behavioral health services.**

Finding 3: **MCPA did not timely investigate and resolve claims paid by ASO that were denied for federal reimbursement or approved for an amount that was different than the amount paid.**

Finding 4: **MDH circumvented State procurement regulations to obtain information technology consulting services from a vendor totaling $18 million and could not support that the costs were reasonable.**

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

Appendix 3
Bed Registry and Referral System
Major Information Technology Development Project
MDH – BHA

New/ Ongoing: Ongoing					
Start Date: September 1, 2021				**Est. Completion Date:** June 2027	
Implementation Strategy: Agile					
($ in Millions)	**Prior Year**	**2026**	**2027**	**Remainder**	**Total**
GF	$5.857	$0.000	$1.885	$2.258-$12.258	$10.000-$20.000
Total	**$5.857**	**$0.000**	**$1.885**	**$2.258-$12.258**	**$10.000-$20.000**

- ***Project Summary:*** The project will enable healthcare providers to quickly identify available and appropriate spots for patients that need to be connected to behavioral health care services. The system will include an inventory of public and private behavioral health providers in the State offering inpatient, outpatient, and crisis services and a referral system accessible by any health care provider in the State. The system will also integrate with the Care Traffic Control System and be enabled for crisis response reporting and deploying mobile crisis response teams.

- ***Need:*** Chapter 29 of 2021 mandates MDH to manage a bed registry and referral system to monitor bed capacity and availability at healthcare providers across the State. MDH currently lacks a technological system to manage and track bed availability to streamline the movement of individuals into and out of inpatient facilities as their care plan necessitates.

- ***Observations and Milestones:*** MDH published a request for proposals in November 2024 for a vendor to implement the system. Carahsoft was the only vendor to submit a proposal and offered a cost estimate nearly 15% below MDH's pre-bid estimate. At its November 5, 2025 meeting, BPW approved a contract with Carahsoft Technology for $6.1 million. The contract began December 1, 2025, and terminates September 15, 2026. MDH anticipates that it will extend the contract beyond September 2026 to fully enable and equip the system. MDH held a project kickoff event with the vendor on January 13 and 14, 2025.

- ***Changes:*** The fiscal 2026 Major Information Technology Development Program plan listed an estimated completion date of May 3, 2027, and in February 2026, MDH had indicated that it anticipates the project to be complete by the end of fiscal 2027.

- ***Concerns:*** BHA initially identified potential delays with the vendor procurement as a high-risk factor; however, since that information was provided, the procurement award has been approved, and the contract has begun.

Appendix 4
Object/Fund Difference Report
Maryland Department of Health – Behavioral Health Administration

Object/Fund	FY 25 Actual	FY 26 Wrk Approp	FY 27 Allowance	FY 26 - 27 $ Change	FY 26 - 27 % Change
Positions					
01 Regular	215.80	216.50	209.50	-7.00	-3.2%
02 Contractual	46.55	30.44	58.38	27.94	91.8%
Total Positions	**262.35**	**246.94**	**267.88**	**20.94**	**8.5%**
Objects					
01 Salaries, Wages, and Fringe Benefits	$20,776,500	$25,315,184	$25,980,411	$665,227	2.6%
02 Technical and Special Fees	3,815,269	2,419,059	5,019,367	2,600,308	107.5%
03 Communications	102,805	106,263	96,089	-10,174	-9.6%
04 Travel	57,700	49,730	36,630	-13,100	-26.3%
07 Motor Vehicle Operation and Maintenance	1,169	530	539	9	1.7%
08 Contractual Services	3,666,126,936	4,027,333,286	3,872,841,905	-154,491,381	-3.8%
09 Supplies and Materials	5,129	11,764,021	7,324	-11,756,697	-99.9%
10 Equipment – Replacement	364	5,288	5,288	0	0.0%
11 Equipment – Additional	0	63,455	63,455	0	0.0%
12 Grants, Subsidies, and Contributions	18,451,091	27,810,871	18,834,772	-8,976,099	-32.3%
13 Fixed Charges	89,840	125,710	89,962	-35,748	-28.4%
Total Objects	**$3,709,426,803**	**$4,094,993,397**	**$3,922,975,742**	**-$172,017,655**	**-4.2%**
Funds					
01 General Funds	$1,449,704,377	$1,613,409,008	$1,573,640,713	-$39,768,295	-2.5%
03 Special Funds	53,105,766	67,326,676	43,277,692	-24,048,984	-35.7%
05 Federal Funds	2,200,036,112	2,392,920,267	2,264,956,880	-127,963,387	-5.3%
09 Reimbursable Funds	6,580,548	21,337,446	41,100,457	19,763,011	92.6%
Total Funds	**$3,709,426,803**	**$4,094,993,397**	**$3,922,975,742**	**-$172,017,655**	**-4.2%**

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

Appendix 5
Fiscal Summary
Maryland Department of Health – Behavioral Health Administration

Program/Unit	FY 25 Actual	FY 26 Wrk Approp	FY 27 Allowance	FY 26 - 27 $ Change	FY 26 - 27 % Change
L01 Behavioral Health Administration	$594,712,702	$752,147,495	$694,241,533	-$57,905,962	-7.7%
Q01 Medical Care Programs Administration	3,114,714,101	3,342,845,902	3,228,734,209	-114,111,693	-3.4%
Total Expenditures	**$3,709,426,803**	**$4,094,993,397**	**$3,922,975,742**	**-$172,017,655**	**-4.2%**
General Funds	$1,449,704,377	$1,613,409,008	$1,573,640,713	-$39,768,295	-2.5%
Special Funds	53,105,766	67,326,676	43,277,692	-24,048,984	-35.7%
Federal Funds	2,200,036,112	2,392,920,267	2,264,956,880	-127,963,387	-5.3%
Total Appropriations	**$3,702,846,255**	**$4,073,655,951**	**$3,881,875,285**	**-$191,780,666**	**-4.7%**
Reimbursable Funds	$6,580,548	$21,337,446	$41,100,457	$19,763,011	92.6%
Total Funds	**$3,709,426,803**	**$4,094,993,397**	**$3,922,975,742**	**-$172,017,655**	**-4.2%**

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