



The 449th session of the Maryland General Assembly ended at midnight on April 13. Despite considerable legislative attention directed toward balancing a \$1.5 billion budget deficit, MHAMD and our coalition partners were successful in preserving and expanding mental health and substance use funding, services and protections.

We are proud to present this report outlining the results of our advocacy during the 2026 legislative session, including budgetary and legislative action to:

- ✓ Provide Maryland Medicaid with the resources necessary to **minimize the negative impact of recent federal Medicaid reforms**
- ✓ Preserve **\$100 million annually for school mental health care** across the state
- ✓ Ensure the continued development of Maryland's **Certified Community Behavioral Health Clinic (CCBHC)** program
- ✓ Address **community behavioral health funding** challenges by establishing a process to develop new reimbursement methodologies
- ✓ Expand access to **primary behavioral health care** by requiring insurance companies to provide coverage for the evidence-based Collaborative Care Model
- ✓ Safeguard Marylanders from any potential rollback of federal **behavioral health parity** protections and anti-discrimination requirements
- ✓ Strengthen Maryland's **behavioral health workforce** by improving the timely and effective licensing of behavioral health professionals and paraprofessionals
- ✓ Improve **perinatal behavioral health care** and expand access to resources for pregnant and postpartum women and their families
- ✓ Support **children in need of residential treatment** and their families by reforming Maryland's voluntary placement agreement (VPA) process
- ✓ Enhance **infant and early childhood mental health** data collection requirements
- ✓ Prevent the **extended hospitalization and inappropriate placement** of youth with behavioral health needs

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2026 Legislative Briefing and Reception



As it does each year, MHAMD hosted a Legislative Briefing and Reception in Annapolis to highlight policy priorities and build momentum for coalition advocacy efforts. We were thrilled this year to be joined by Lt. Governor Aruna Miller and Pulitzer Prize-winning author Doris Kearns Goodwin, who reflected on past eras in our history, leaders who led us through periods of turbulent change, and the role we each play in the path forward for Maryland in today's challenging environment. The briefing also included updates from Moore administration officials and members of the General Assembly and an awards ceremony honoring three Maryland behavioral health champions.

Keep the Door Open Maryland



MHAMD and the Maryland Behavioral Health Coalition rallied again this year around a focused agenda to increase access to behavioral health care. In the face of a \$1.5 billion budget shortfall and proposed cuts to essential services, Marylanders from around the state joined in urging the General Assembly to 'Keep the Door Open' for the one in four Marylanders with mental health and substance use needs. In the end, critical funding was preserved and important access-to-

care policies were enacted thanks to a strong grassroots advocacy effort combined with a coordinated press strategy, direct advocacy to legislators and sustained letter-writing campaigns.

Fiscal Year 2027 Budget

Maryland Medicaid

Pursuant to a federal law signed in July 2025, 330,000 Maryland adults who receive Medicaid coverage through the Affordable Care Act will now be subject to new work requirements and more frequent eligibility redeterminations. It is expected that about 130,000 people will lose their coverage because of these new provisions – not because they are ineligible, but because of bureaucratic red tape and overly burdensome reporting and verification processes.

MHAMD and our coalition partners, in coordination with other health and social service advocates from around the state, worked this session to minimize the negative impact of these new Medicaid reforms. As a result, the governor included funding in the budget for IT upgrades and staffing so that Maryland Medicaid can use existing data to verify eligibility and simplify the enrollment and re-enrollment processes, and the General Assembly provided additional funding for navigators at local health departments who can assist people with their applications.

School Mental Health

Over a third of Maryland high school students report feeling persistently sad or hopeless¹ and suicidality among Maryland youth aged 12-17 is 5th highest in the nation.² Despite these grim statistics, the FY27 budget as introduced would have cut annual school mental health funding from \$100 million to \$80 million, impacting students in every jurisdiction across the state.

Last school year this funding supported over 136,000 students across nearly 90% of all public schools and resulted in improved mental health outcomes for 60-80% of those students. The funding also added over 700 new individuals to Maryland's school behavioral health workforce and trained nearly 6,000 school personnel in behavioral health practices to improve student outcomes. Early data from the current school year gives every indication that this program will continue to produce remarkable outcomes and a positive return on investment.³

MHAMD and the behavioral health community mobilized in opposition to this reduction and successfully preserved the full \$100 million for FY27.

¹ Maryland Department of Health 2022-2023 Youth Risk Behavioral Survey and Youth Tobacco Survey data.
<https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx>

² Reinert, M, Nguyen, T & Fritze, D. (October 2025). "The State of Mental Health in America 2025." Mental Health America, Alexandria VA. <https://mhanational.org/the-state-of-mental-health-in-america/>

³ <https://health.maryland.gov/mchrc/Pages/Maryland-Consortium-on-Consolidated-Community-Supports.aspx>

Certified Community Behavioral Health Clinics (CCBHC)

In 2023 the General Assembly passed Behavioral Health Coalition priority legislation to establish a statewide network of CCBHCs – community providers that offer a comprehensive range of outpatient mental health and substance use care, coordination with other providers and services, and connection to other systems and supports – and the Behavioral Health Administration (BHA) has done considerable work over the past year engaging stakeholders and preparing for an application to participate in the federal CCBHC demonstration program. Nevertheless, the proposed FY27 budget included a provision that would have made the continuation of this initiative discretionary and left the future of Maryland’s CCBHC program in question. Fortunately, this provision was rejected, the state applied for participation in the federal demonstration program on April 1, and CCBHC development will continue.

Community Behavioral Health Funding

Maryland is experiencing an acute behavioral health workforce shortage, the extent of which was documented in an alarming 2024 assessment by the Maryland Health Care Commission (MHCC).⁴ According to MHCC, low pay is the number one cause of this workforce crisis; a claim supported by data showing that 75% of public behavioral health counselors and social workers do not make a living wage based on the Maryland cost of living when compared to social workers and counselors in comparable roles in schools, hospitals, or private practice.⁵

Given this crisis, MHAMD and our coalition partners urged legislators to heed the MHCC report’s top recommendation and increase funding for public behavioral health providers and services. Unfortunately, given the daunting budget shortfall, the General Assembly did not act on this request, marking the second year in a row public mental health and substance use care will go without an inflationary increase.

But there were some positive developments in this policy area. The General Assembly passed legislation in 2017 requiring the Behavioral Health Administration and Maryland Medicaid to conduct an independent, cost-driven rate-setting study to set reimbursement rates for community behavioral health providers and to implement a payment system based on the findings of this study. For a variety of understandable reasons – including departmental budgetary and staffing challenges, the covid pandemic, uncertainty at the federal level and more – this rate study was never completed. Nevertheless, Maryland behavioral health providers have been asked to continue delivering quality mental health and substance use care for years at rates that do not reflect the cost of doing business.

⁴ *Investing in Maryland’s Behavioral Health Talent*. Maryland Health Care Commission. October 2024.

https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/md_bh_workforce_rpt_SB283.pdf

⁵ Massachusetts Institute for Technology. Living Wage Calculator - Living Wage Calculation for Maryland. Accessed November 14, 2025. https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/md_bh_workforce_rpt_SB283.pdf

[HB 772](#) (passed) was introduced this session as a way of reprioritizing this issue in state government. It establishes a workgroup in MHCC to develop transparent, cost-based reimbursement methodologies for outpatient behavioral health centers and CCBHCs and requires the implementation of rates based on the new methodologies by June 30, 2028.

Reporting Requirements

In addition to the funding allocations and reports referenced above and throughout this summary, the FY27 budget also includes the following notable reporting requirements:

- Department of Aging **report on implementation of the Supporting Older Adults with Resources (SOAR) program** *(due 6/1/26)*
- Department of Health **report on staffing at John L. Gildner Regional Institute for Children and Adolescents (JLG RICA)** *(due 7/15/26)*
- Department of Health **report on plans to improve placement times for patients found not criminally responsible (NCR) or incompetent to stand trial (IST)** *(due 8/31/26)*
- Department of Health **report on staffing at Maryland's five adult state psychiatric hospitals** *(due 9/1/26)*
- Department of Health/Health Services Cost Review Commission **report on financing of long-acting injectable (LAI) medications** used to treat serious and persistent mental illness (SPMI) *(due 9/1/26)*
- Department of Human Services **report on costs associated with children and youth in out-of-home placements placed in hotels** *(due 9/30/26)*
- Behavioral Health Administration **report on planned efforts to address the behavioral health workforce shortage** *(due 11/1/26)*
- Behavioral Health Administration **update about the ongoing Administrative Services Organization (ASO) transition** *(due 11/1/26)*
- Department of Health/Health Services Cost Review Commission **evaluation and update on primary care programs and initiatives** *(due 11/1/26)*
- Department of Human Services **data report on children and youth experiencing stays in hospitals, hotels, and other unlicensed settings** *(due 11/15/26)*
- Department of Health/Health Benefit Exchange **reports on the implementation and impact of federal Medicaid reforms** *(due 12/1/26, 6/1/27)*
- Department of Human Services/Department of Health **report on options and efforts to better serve pediatric hospital overstay patients** *(due 12/1/26)*
- Department of Human Services **report on child fatalities where abuse or neglect are determined to be a contributing factor** *(due 1/11/27)*

Primary Behavioral Health Care

At the urging of MHAMD and the Behavioral Health Coalition, Maryland has adopted the proven Collaborative Care Model (CoCM) as a way of integrating and improving the quality of behavioral health care delivered in primary and pediatric care settings. However, practices are finding that patients are reluctant to return after the initial CoCM visit for important follow-up appointments because of additional co-pays and other out-of-pocket costs.

Accordingly, the Coalition introduced [SB 428/HB 746](#) (passed) to begin addressing this issue. The bill prohibits Maryland Medicaid from imposing cost-sharing requirements for CoCM services and requires the Maryland Health Care Commission (MHCC) to examine the impact of eliminating cost-sharing in the commercial health insurance market. It also requires that health insurance companies provide coverage for CoCM, expanding access to the evidence-based model and ensuring MHCC has consistent data when completing its cost impact report.

Insurance Parity

The current federal administration has suspended enforcement of new rules implementing the Mental Health Parity and Addiction Equity Act (MHPAEA). These rules were issued in 2024 to ensure consumers can access meaningful, non-discriminatory coverage for behavioral health care. Given uncertainty around the future of these protections, [SB 205/HB 280](#) (passed) was introduced to safeguard Marylanders from any potential federal rollback of MHPAEA's anti-discrimination requirements. Among other provisions, the bill requires health plans to collect, evaluate, and explain data to assess access to behavioral health care; prohibits the use of discriminatory information, evidence, sources, and standards in the design and application of treatment limitations; and clarifies the Maryland Insurance Administration's (MIA) authority to enforce parity protections based on state regulations, in addition to the federal law.

According to an [independent national report](#)⁶ from 2024, Maryland consumers are nearly nine times more likely to go out-of-network for behavioral health care versus primary care. This can make care unaffordable, even for people with insurance. [SB 774/HB 1157](#) (failed) would have required insurance companies to publicly report data on mental health and substance use coverage, empowering consumers and employers with information they could use to compare and identify companies offering strong coverage, value, and in-network access to care. The bill passed the Senate unanimously, however, it was met with strong opposition from insurance companies and never received a vote in the House.

⁶ Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International.

Behavioral Health Workforce

According to the Maryland Health Care Commission (MHCC), the state will need to double its current behavioral health workforce over the next two years just to keep pace with the need.⁷ MHCC has recommended a variety of funding strategies to address this crisis, but Maryland's budget challenges made it unlikely any major funding initiative would find success this year. Accordingly, MHAMD and our coalition partners prioritized support this session for efforts to improve the timely and effective licensing of behavioral health professionals and paraprofessionals.

[SB 18/HB 769](#) (passed) establishes a new provisional license that will allow social work graduates to practice under supervision for up to two years prior to completing the exam required for full licensure, [SB 88/HB 7](#) (passed) allows an eligible individual to practice music therapy under a limited license while completing the requirements for full licensure, and [SB 238/HB 340](#) (passed) enters Maryland into a compact with other states allowing licensed school psychologists to operate across state lines.

Children, Youth and Families

The Children's Behavioral Health Coalition (CBHC) spearheaded and supported critical initiatives this session to expand resources and support for new moms and their families, enhance data collection to inform the state's infant and early childhood mental health efforts, and address an over-reliance on hospitals and other inappropriate placements for youth.

Perinatal Behavioral Health

Perinatal depression is the most underdiagnosed and untreated obstetric complication in the United States. This and other perinatal behavioral health (PBH) disorders can have serious adverse effects on the health and functioning of the mother, her infant and her family. And though they are treatable once recognized, 75% of all mothers who experience PBH disorders are never identified.⁸

[HB 1118/SB 891](#) (passed) will improve the identification and treatment of mental health and substance use conditions in pregnant and postpartum women. The bill expands coverage for PBH screenings, requires that insurance companies provide a standing referral to a behavioral health provider during pregnancy and for one year postpartum, requires treating providers to

⁷ Investing in Maryland's Behavioral Health Talent. Maryland Health Care Commission. October 2024.
https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/md_bh_workforce_rpt_SB283.pdf

⁸ Maternal Mental Health Overview. Maternal Mental Health Leadership Alliance (2025).
<https://static1.squarespace.com/static/637b72cb2e3c555fa412eaf0/t/68a45ac0be50d4791f30a5bd/1755601600598/Maternal+Mental+Health+Overview+Fact+Sheet+-+August+2025.pdf>

offer culturally and linguistically appropriate PBH information to patients at various times during and after pregnancy, and incentivizes the completion of continuing education on PBH among clinicians delivering perinatal care.

Voluntary Placement Agreements

The Children’s Behavioral Health Coalition has long sought to simplify and streamline the Voluntary Placement Agreement (VPA) process, which was established to assist families seeking out-of-home treatment for a child with serious mental health needs. Maryland’s existing process is complicated and burdensome and can prevent children from accessing needed care, cause hospital overstays, and force families to relinquish full custody of their child to the state to access medically necessary residential treatment.

[HB 1181](#) (passed) includes several measures designed to better support children in need of residential treatment and their families. The bill sets clear deadlines for VPA actions, removes the requirement that a Local Care Team meeting must be held before the Local Department of Social Services (LDSS) can approve a VPA request, clarifies that a family must make “reasonable efforts” to prevent an out-of-home placement rather than “exhaust” all possible community-based resources, prohibits the LDSS from referring a child’s VPA case to the Child Support Enforcement Administration if it would adversely impact the child, and requires that the Child Support Enforcement Administration remove all existing child support orders under a VPA. In addition, the bill requires extensive data collection and reporting on VPAs by the Department of Human Services.

Infant and Early Childhood Mental Health Care

Prior to FY25, the Maryland State Department of Education (MSDE) contracted with University of Maryland School of Social Work to collect statewide data on the Infant and Early Childhood Mental Health Support Services (IECMHSS) program, which pairs behavioral consultants with early childcare providers to help reduce challenging behaviors, preschool suspensions and expulsions, and racial disparities in teacher-child conflict. The data included information on the demographics of children served, consultations with childcare staff and parents or caregivers, program locations, behavioral health outcomes, and consultant demographics and salaries. These data were compiled into reports for MSDE and shared with the General Assembly and stakeholders to support program monitoring and quality improvement.

MSDE did not renew this contract in FY25. Although some data are currently collected by the nine IECMHSS programs, it is not collected consistently across the state and it is not reported publicly. Per MHAMD’s request, the FY27 budget includes a requirement that MSDE submit a report that describes how the department is currently collecting this data, including statewide information on the program data previously collected under the contract with the University of Maryland School of Social Work.

Pediatric Hospital Overstays and Inappropriate Placements

A lack of treatment options for youth with behavioral health needs contributes to an over-reliance on emergency departments, extended hospitalizations, and the placement of youth in inappropriate and unlicensed settings. There is particular concern about youth in the custody of the Department of Human Services (DHS) being placed in hotels, offices and other unlicensed settings for lack of other out-of-home placements.

[HB 1559](#) (passed) is omnibus legislation that will implement a variety of strategies designed to address this crisis. It creates a Children and Youth Placement Review Panel and a Rapid Response Placement Team in the Governor's Office for Children to respond when a child remains in a hospital for more than 48 hours after being medically cleared for discharge. It also authorizes DHS to execute an emergency procurement when necessary to secure placement for a child and establishes an Advisory Council on Maryland's System of Care for Children, Youth and Families, which must work to expand mobile response and stabilization services (MRSS) across the state by 2030. MRSS is an evidence-based model of crisis services tailored to meet the unique needs of children and families. Finally, the bill prohibits the placement of children in unlicensed settings, including hospital overstays.

Older Marylanders

MHAMD and our partners on the Mental Health and Aging Coalition (MHAC) advocated this session in support of successful initiatives to expand protections for residents in long-term care facilities and to ensure a continuation of multi-sector coordination in support of Maryland's growing older adult population.

Long-Term Care Ombudsman

The Maryland Long-Term Care Ombudsman Program (LTCOP) advocates for the health, safety, well-being, and rights of residents in assisted living and nursing homes. In FY25, LTCOP made 7,250 visits to long-term care settings and investigated 4,000 resident complaints, resolving 86% of those complaints to the satisfaction of the resident. [SB 340/ HB 671](#) (passed) increases the LTCOP annual budget to \$2 million, expanding resources for a program charged with serving an estimated 54,000 Marylanders who reside in long-term care facilities.

Involuntary Discharge from Long-Term Care Facilities

Unplanned or inappropriate discharges or transfers can have serious negative consequences for nursing facility residents, particularly those with complex medical, behavioral health, or housing needs. [SB 493/ HB 1002](#) (passed) strengthens protections for nursing facility residents facing involuntary discharge. It requires that a resident must be discharged to a safe, secure, and

sustainable placement and that the receiving facility has confirmed they are able to accept and care for the resident prior to transfer. It also expands discharge notice requirements to include residents who have been in a facility for fewer than 30 days and requires that notices include information about a resident's right to appeal and information on how they can contact the Long-Term Care Ombudsman Program and other advocacy resources.

Longevity Ready Maryland

Throughout much of 2024 and 2025, MHAMD participated in a stakeholder process led by the Maryland Department of Aging (MDoA) to develop a multi-sector plan for addressing the needs of Maryland's growing older adult population. The resulting Longevity Ready Maryland (LRM) plan is designed to promote independence and maintain quality of life for older Marylanders, and it includes a variety of behavioral health-related goals, including the expansion of community behavioral health care, improved hospital discharge policies, and enhanced social connections. [SB 113/](#)[HB 278](#) (passed) codifies the LRM plan, ensuring a continuation of this work, and it requires that MDoA provide the legislature with annual progress reports.

Other Behavioral Health Bills

Involuntary Treatment

States use involuntary treatment as a last resort when an individual, due to a mental illness, presents a danger to themselves or others. In Maryland, however, the law does not define "danger to self or others," leaving the standard open to interpretation and inconsistent application across the state. [SB 707/](#)[HB 1014](#) (passed) was introduced to define this standard and provide clarity for the legal process, clinicians, first responders, and families seeking emergency treatment.

MHAMD opposed the bill as introduced, concerned that the initial definition would subject an overly broad portion of Maryland's population to involuntary commitment based on a non-imminent risk of potential future psychiatric/substantial deterioration. However, all concerns raised by MHAMD were considered and addressed and every amendment we offered was adopted. In the end, the General Assembly enacted the following standard, which is similar to the definition recommended following a lengthy state-led stakeholder process in 2021:

"Danger to the life or safety of the individual or of others" means there is, as a result of a mental disorder, a substantial risk, based on conduct that is recent and relevant to the danger that the individual may present and in consideration of the individual's current condition and, if available, recent personal, medical, and psychiatric history, that the individual will:

(1) cause serious bodily harm to the individual or another, or

(2) be unable, except for reasons of indigence, to provide for the individual's basic needs or safety to such a degree as to create a substantial risk of serious bodily harm, serious illness, or death in the near future.

Suicide Fatality Review Teams

[HB 1012](#) (passed) will strengthen suicide prevention efforts by allowing local jurisdictions to establish multidisciplinary suicide fatality review teams. These teams will examine individual suicide deaths to identify contributing factors, system gaps, and opportunities for prevention. The bill builds on the work of Maryland's Suicide Fatality Review Committee. While that committee reviews aggregated data to inform statewide prevention efforts, these local teams will be able to perform a deeper, individualized analysis to provide a better understanding of root causes and a strengthening of prevention strategies at the local level.

Certified Recovery Residences

Medications for opioid use disorder (MOUD), including methadone and buprenorphine, are the most effective treatment for those experiencing opioid use disorder (OUD). Recovery residences can also play a critical role in a person's recovery from OUD, offering a supportive environment, peer support, accountability and structure. Unfortunately, for reasons that include stigma and misinformation, many recovery residences limit or prohibit access to MOUD. [HB 1249](#) (passed) will prevent further discrimination by prohibiting certified recovery residences from refusing services to individuals on MOUD.

Community Forensic Aftercare

[SB 412/](#)[HB 658](#) (passed) requires that the Department of Health establish a community forensic aftercare program (CFAP) to monitor individuals on conditional release from state mental health facilities and support them in complying with their treatment plan and other conditions of their release. CFAP is an existing program within MDH, but there are no statutory guidelines, and standards vary greatly across CFAP monitors. This bill will clarify and standardize existing best practices and increase transparency and accountability in the CFAP program.