DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 20, 2022

Steve Schuh
Deputy Secretary and Medicaid Director
Maryland Department of Health
201 West Preston Street, Room 525
Baltimore, Maryland 21201

Dear Mr. Schuh:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Maryland's Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Implementation Plan for the state's approved section 1115(a) demonstration, titled "Maryland HealthChoice" (Project Number: 11-W-00099/3). CMS has determined that the SMI/SED Implementation Plan, which was first submitted on September 28, 2021, and subsequently resubmitted with revisions on July 13, 2022, meets the requirements set forth in the demonstration's Special Terms and Conditions (STCs), and thereby approves Maryland's SMI/SED Implementation Plan. With this approval, the state may begin receiving federal financial participation for the provision of inpatient, residential, and other services provided to otherwise-eligible Medicaid beneficiaries while residing in institutions for mental diseases.

CMS has added the approved SMI/SED Implementation Plan to the demonstration's STCs as Attachment H. A copy of the STCs, which includes the new attachment, is enclosed with this letter. If you have any questions, please contact your project officer, Mr. Felix Milburn. Mr. Milburn can be reached at (410) 786-1315 or Felix.Milburn@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Talbatha Myatt, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Section 1115 SMI/SED Implementation Plan
Attachment H
Approved: July 20, 2022

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Alyssa Brown
Telephone Number:
410.767.9795 (office)
410.662.2727 (cell)
Email Address:
alyssa.brown@maryland.gov

1.   Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Maryland*
Demonstration name	*HealthChoice*
Approval date	*December 14, 2021*
Approval period	*January 1, 2022 through December 31, 2026*
Implementation date	*Proposed: January 1, 2022*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question. This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.	
To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. Psychiatric hospitals: The MDH Office of Health Care Quality (OHCQ) regulates psychiatric hospitals, providing state licensure, and on behalf of CMS, it provides certification and recertification. OHCQ also conducts various types of hospital surveys under federal or state authority to determine compliance with federal and state regulations.

participating in Medicaid	*Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.* N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. The MDH Office of Health Care Quality (OHCQ) regulates psychiatric hospitals, providing state licensure, and on behalf of CMS, it provides certification and recertification. OHCQ also conducts various types of hospital surveys under federal or state authority to determine compliance with federal and state regulations.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. Maryland uses an Administrative Service Organization (ASO) for ensuring beneficiaries access to the appropriate level of care based on their presenting diagnoses and medical necessity criteria (MNC) review. The ASO monitors lengths of stay. based on periodic MNC reviews that are based on Department established authorization periods.

	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. The State confirms that it complies with federal program integrity requirements. All enrolled programs have an initial Medicaid site survey by the Behavioral Health Administration (BHA). Medicaid re-evaluates every enrolled program after five years. BHA license renewal occurs every three years. Every three years, psychiatric hospitals are subject to the requirements of Joint Commission accreditation. Services at these levels of care require authorization and periodic re-authorization for MNC criteria performed by the ASO. Medicaid and BHA in partnership with OIG have established program integrity protocols, including monitoring of licensure, data mining, and other oversight to safeguard against fraud, waste, and abuse.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action.

physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	Psychiatric hospitals are required to perform a medical evaluation upon admission that includes a physical exam, screening for co-occurring SUD, screening for suicidal ideation, and a medical review of systems. Prior to admission medical clearance of someone under consideration for psychiatric admission occurs, as per COMAR definition, when the individual has been evaluated by a physician, a physician's assistant, or a nurse practitioner, and the evaluator has confirmed with the receiving inpatient facility that the receiving facility has the capacity to provide the necessary and appropriate medical management of the individual. The psychiatric hospitals participating in the waiver program are already providing SUD-level of care under the prior waiver. A psychiatric hospital that is not able to appropriately manage a patient's medical needs would transfer the patient to a facility able to manage those needs.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.*
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.

SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs must focus on improving care coordination and transitions to community-based care by taking the following actions.
Improving Care Coordination and Transitions to Community-based Care

2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has these actions in place. Discharge planning is required in state regulations and overseen as a part of the accreditation process for all hospitals in Maryland. Accreditation is overseen by the Maryland Office of Health Care Quality (OHCQ). To facilitate discharge or transfer, the hospital shall: (1) Assess the patient's needs beginning at an early stage of the patient's hospitalization and as the patient's needs change throughout the hospitalization; (2) Develop plans for the patient's discharge or transfer with input, if appropriate, from the patient, the family, or other interested party; (3) Identify appropriately qualified staff, such as registered nurses or licensed social workers, who have the knowledge and experience necessary to determine what services or type of providers can best meet the patient's discharge needs; (4) Arrange or help to arrange for services needed to meet the patient's needs after discharge; and (5) Provide the patient, or the provider who is responsible for providing continuing care to the patient, with written discharge instructions and other necessary medical information in a form the patient or provider can understand. For additional information, please see Maryland's regulations. Additionally, all hospitals in Maryland are accredited by the Joint Commission, which has its own standards around hospital discharges.

In the Child, Adolescent, and Young Adult Services (CAYAS) space, general care coordination is part of the expected role of the Targeted Case Management (TCM) providers. TCM care coordination Child and Adolescent services are provided to assist participants in gaining access to needed medical, mental health, social, educational and other services. This service, established through a 1915(b) waiver, exists with three levels of intensity (Level I-General; Level II-moderate; Level III-Intensive). These programs are intended to provide "wrap around services" to high needs youth to prevent need for higher levels of care. Each level provides increased quantities of care coordination encounters.

All inpatient or partial hospitalization (PHP) discharges would qualify for TCM Level II unless the individual has specific risk factors which might increase qualifications up to TCM Level III. Medical necessity for the higher level (under the level II and III) categories can occur after inpatient and RTC admissions. The highest level of care (level III) requires more than one admission within the prior 12 months, except for youth under the age of 6 These programs are intended to provide "wrap around services" to high needs youth to prevent need for higher levels of care. While the referral to TCM levels of care can be made from an inpatient setting, currently the engagement does not happen until after discharge. Expansion of this process to make it more robust in utilization and implementation design is priority for CAYAS division.

Examples of wraparound services available through C&A TCM, or Care Coordination, include: service coordination (case management), linkage to needed community based services to incl somatic services, behavioral health services, self-help or support groups; assistance w/applying for & maintaining entitlements; assistance addressing housing needs; assistance with assessing & improving ADLs; advocacy & assistance obtaining education/special education services (ex. IEP); crisis care and outreach as needed; family support; transportation assistance (access to local mass transit/ MA-based transport), linkage to legal assistance, etc.

Additional information on TCM criteria can be found here, see p. 35: https://maryland.optum.com/content/dam/ops-maryland/documents/provider/Maryland_State%20Supp%20Clin%20Crit_12.31_Final%20(4).pdf

Psychiatric hospitals are expected to initiate discharge planning at the beginning of service delivery, including early and ongoing communication with an individual's community provider. If an individual is without a community provider a quick referral occurs. A discharge plan is included with the hospital authorization request to the ASO. Community providers can provide information on baseline levels of functioning and medication history, assist with any needs in the area of housing and benefits, and meet with individuals at the hospital.

Individuals admitted to state psychiatric hospitals engage in discharge efforts upon admission. This begins with a multi-disciplinary team assessment including psychiatry, nursing, social work, and rehabilitation staff.

These assessments are used to help determine treatment goals. In addition, treatment teams must address court requirements for those who are court-ordered to state hospitals for evaluation and treatment. As the individual continues to improve, the treatment team then makes recommendations regarding what level of care the individual will need next.

Prior to discharge, a discharge meeting is scheduled and the community-based provider meets with the individual and the treatment team to go over the course of hospitalization and recommendations. Copies of aftercare referrals and discharge summaries are given to community-based providers.

The treatment team at the psychiatric hospital and community providers continue to collaborate post-discharge, as needed.

Additionally, to further support discharges from psychiatric hospitals, the Assertive Community Treatment (ACT) fidelity scale contains the following anchor on which all ACT teams are rated "INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning)." In order to achieve a full rating, the ACT team must be involved in 90% or more of psychiatric hospital admissions and discharges.

The following LBHA requirements are in the Administrative Conditions of Award with the LBHAs and also support discharge planning:
- Develop local strategies and implement specific actions to reduce Emergency Department and inpatient hospitalization. The Vendor (LBHA) shall meet with local hospital to establish an enhanced level of communication and coordination between hospital personnel, and Crisis System providers to enhance the use of community-based alternatives to inpatient admission.
- Meet annually with local hospitals and Emergency Rooms to provide education and training on access to and services within the PBHS.
- Assist with Emergency Department (ED) diversion for child, adolescent, adult, and older adult consumers as funds permit, with clinical staff available for consultation with an ED, day treatment and inpatient staff.

Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.

The State of Maryland has been undergoing a transformation in its healthcare system to achieve better health for Marylanders, including higher quality of healthcare, better integration between systems of care, and decreased costs. The new Total Cost of Care (TCOC) model with CMS builds on the prior All-Payer model that realigned hospital-based care and reimbursement structures to a global budgeting approach.

As the system evolves, MDH recognizes that there are challenges to identify appropriate community placements for individuals who have more complex medical and behavioral health conditions, creating significant issues for timely patient discharges from both hospitals' emergency departments and inpatient acute care. The challenges center on individual health conditions, and relate to the availability and coordination of resources and services across multiple sectors necessary to support these individuals.

The Department has been developing approaches to address post-acute discharge challenges for patients in acute care settings, including identifying barriers for billing for co-occurring disorders, increasing utilization for Screening, Brief Intervention, and Referral to Treatment (SBIRT) among hospitals and primary care providers, and enhancing resources to identify community-based behavioral health providers. At the same time, strategies for prevention and diversion from acute care settings for complex and high utilizer patients was equally critical to prevent log jams from occurring across the continuum of care especially if the community-based infrastructure was weak. In many instances, strengthening the community-based capacity serves not only to prevent acute inpatient hospitalization, but also to enhance the ability of acute care settings to place individuals in the least restrictive environments.

Expansion of this process to make it more robust in utilization and implementation design is a priority for CAYAS division.

<table>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.

N/A</td>
</tr>
<tr>
<td>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.</td>
<td>Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.

Maryland has completed these actions. While coordinating with housing is not required as a part of the accreditation process, Maryland regulations do require aftercare services, which can include referrals to housing supports when necessary for the patient (Md. HEALTH-GENERAL Code Ann.10-709; <u>Code of Maryland Regulations 10.21.05</u>). Psychiatric hospitals complete a psychosocial assessment at admissions that includes an assessment of housing needs. Hospitals make referrals to appropriate community providers and resources, which include additional case management services that support referrals to housing assistance and services.

Additionally, there is an anchor of the ACT fidelity scale that measures: "INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning)."</td>
</tr>
</table>

	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has completed this action. The ASO contract requires follow up after hospitalization to occur within 72 hours of release for all beneficiaries. The Department measures the ASO on follow up appointments kept after psychiatric hospitalizations within 7 and 30 days as part of the protocol.
	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has these strategies in place. The Local Behavioral Health Authority (LBHAs) work in partnership with the hospitals to ensure patients have access to community-based services. This includes education of hospital employees to ensure they have a comprehensive understanding of the community-based resources available to patients within the hospital's jurisdiction. LBHA's also develop hospital diversion programs that target vulnerable individuals, particularly those engaged with high intensity level of services. When these individuals present at the ED, the Assertive Community Treatment Team (ACT) team is contacted by the hospital. The ACT team assesses whether the person can be safely treated in the community, and where this is possible, the person is diverted from the hospital. There are currently 25 ACT teams. There are providers in the following counties: Anne Arundel, Baltimore City/County, Carroll, Cecil, Charles, Dorchester, Frederick, Harford, Howard, Midshore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties), Montgomery, Prince Georges, Washington and Wicomico. However, there is a need for ACT services in both Southern and Western Maryland. Communities are expected to develop sufficient ACT team capacity to serve approximately .06% of their adult population. BHA has identified two areas of the state where there is not sufficient Mobile Treatment and ACT Team capacity, southern and western Maryland. The Fidelity Team at BHA, Clinical Services Division, submitted a proposal and was awarded funding through Block Grants for Community Mental Health Services/ American Rescue Plan Act ("ARPA Supplemental - MH") to expand ACT in Southern and Western Maryland. The ASO contract requires the ASO to use data exchanges to coordinate care with the MCOs, LBHAs, and hospitals for high utilizers; and to monitor high-risk or at-risk participants and refer them to additional care coordination services.

Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.

The funding awarded through SAMHSA Mental Health Block Grant from the American Rescue Plan Act of 2021, will support two ACT teams, one in southern and one in Western Maryland. Implementation of the team in southern Maryland will begin this fiscal year and continue into next, with the second team in Western Maryland with implementation beginning towards the end of next fiscal year. Both will be fully implemented, and able to be sustained by fee for service system by August of 2025.

In order to be eligible to deliver ACT services, the program must first be accredited by an MDH-approved accreditation organization and licensed by BHA under COMAR 10.63 as a Mobile Treatment Services (MTS) provider. Once in possession of an active, valid BHA-issued accreditation-based license, the program submits a comprehensive training plan for review to the Local Behavioral Health Authority of the jurisdiction in which EBP services are to be provided. Upon LBHA review and comment, the LBHA forwards the proposed training plan to BHA for approval. Individualized training, technical assistance is provided to the program in accordance with the approved training plan by the University of Maryland School of Medicine, Department of Psychiatry, Behavioral Health System Improvement Collaborative, Evidence-Based Practice Center or other BHA-approved entity. Upon completion of the requisite training and with the advice and recommendation of the EBP consultant and trainer, the MTS program submits a request to BHA for an ACT fidelity assessment and evaluation to be conducted of the MTS program to determine the program's adherence to Evidence-Based Practice (EBP) fidelity standards and ACT model practices. Only those licensed MTS programs that have been designated by BHA as an EBP program, at the team level, and which team has been determined by BHA to have met the established ACT EBP fidelity and practice standards are eligible to receive reimbursement for ACT services through the Public Behavioral Health System (PBHS). As a mechanism to prevent model drift and ensure continued, each team submits to an annual or biennial fidelity assessment and evaluation and must continue to meet established EBP ACT

fidelity and practice standards in order to maintain the EBP ACT designation and to receive PBHS reimbursement for ACT services.

As the programs are ramping up to full capacity and receiving targeted training and technical assistance, BHA and the associated LBHAs will continually monitor the program's capacity and capability to meet program standards. Based on this review and analysis, BHA will refine its projections as to when these programs will meet requirements to bill the Fee-for-Service PBHS for ACT services rendered and will ensure that BHA budget projections submitted to DBM reflect these analyses. Services will be available earlier, but will be funded with FBG funds.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.
	FY 2022 - RFP completed and implemented by Anne Arundel Local Authority for interested ACT providers. Provider has been selected and Project Lead located at local authority to be hired in FY 2022.
	FY 2023 - Implement a Team in Southern Maryland.
	FY 2024 - Implement a Team in Western Maryland. By August of 2025, both ACT teams implemented and sustained by the fee for service PBHS.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* The ASO is currently responsible for coordination of Release of Information (ROI) forms. Completed forms allow the ASO to release authorization and claims data to the enrollee's MCO—along with additional providers specified by the patient—and thereby coordinate care across the continuum of care. Behavioral health services are carved out of the MCO package, these forms are used to ensure coordination between somatic and mental health providers.

	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Maryland has a strategy in place. The initial assessment has been completed. The Department's behavioral health ASO is required in its contract to support network adequacy and addressing gaps in services or geographic locations; this includes an annual strategic plan to increase provider enrollment within the PBHS, geo-mapping activities by jurisdiction and provider type to note service availability and gaps in services and ongoing reporting and collaboration with BHA to improve the provider network. Based on the SAMHSA/Crisis Now Model, BHA is continuing to prioritize the development and increase the availability of crisis stabilization services across the state. BHA supports and monitors numerous behavioral health services throughout the state. Behavioral health, including mental health, are assessed annually primarily driven by the Crisis Response Grant program outlined in HB 1092 (2018) which seeks proposals to establish or expand crisis response programs.

stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	*Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.* Maryland will update the assessment annually. HB 108, Behavioral Health Crisis Response Services Modifications (Ch 75 of the Acts of 2021), cross-filed as SB 286, Behavioral Health Crisis Response Services Modifications (Ch 756 of the Acts of 2021) was introduced in the 2021 Maryland General Assembly and was enacted under Article II, Section 17(c) of the Maryland Constitution - Chapters 755 and 756), with an effective date of October 1, 2021. HB 108 adds $5.0 million of annual funding for State Fiscal Years (FY) 2023, 2024, and 2025. Part of the funding for FY23 shall be awarded for competitive grants for Mobile Crisis Teams. The bill also stipulates annual data collection on the number of behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations, hospital diversions, arrests and detentions of individuals with behavioral health diagnoses, and diversion of arrests and detentions of individuals with behavioral health diagnoses. The Department was also awarded a planning grant through the CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. Medicaid will continue to work with BHA on strategies to assess the behavioral health network adequacy.

Prompts	Summary
3.b Financing plan	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Maryland is in compliance; Maryland funds a wide variety of behavioral health services through its 1115 waiver, which spans the continuum of care as outlined in Tables 3 and 5 of Maryland's renewal application. See the discussion regarding crisis services above and discussion regarding bed registry work below. The 1115 demonstration has a budget neutrality requirement for certain services, including the services provided to beneficiaries in an IMD. The Department submits regular quarterly budget neutrality reports to CMS. The State's budget funds other behavioral health services through other authorities, such as the State Plan.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. See Section 5.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* The bed registry is in place and has been operational since February 2022. The Department is in the process of updating its bed registry; please see the Future Status section.

Future Status:

In 2021, by the introduction of new requirements under state law, enacted under Ch. 29 (2021 Laws of Maryland), all prior Maryland Bed Availability Registry (MD-BAR) work was halted as a new expansive design approach was explored for implementation across the state. Current functional requirements, as outlined in House Bill 1121, are more extensive in scope, utility, capacity, and implementation. The Maryland Mental Health and Substance Use Disorder Registry and Referral System will establish a regularly updated searchable inventory or "bed registry" of treatment options of varying intensity and duration that are used to stabilize the behavioral health related emergency. The system will have the capability to allow a provider of mental health and substance use disorder services to update registry information including real-time availability of services. The services inventory will include not only all crisis, residential, and acute care general hospital inpatient beds, but also the addition of outpatient behavioral health providers and available appointments. Crisis counselors, hospital emergency room staff, in addition to any healthcare provider across the state, will use the system. It is the intent of the system for all end users to have access to the system in order to identify and access available inpatient, outpatient mental health and substance use services. Expanded functionality over prior system configurations gives providers the ability to make referrals to care on behalf of their patient.
The future system enables the quick search for available settings, identifying the most appropriate and proximate settings and ease the transition and admission to a facility for care. It will not only improve timely access to available beds; but also expand the range of treatment options to include the less restrictive and lower cost options to inpatient care like community crisis respite, stabilization units and outpatient services. Currently, MDH contracted with a vendor to conduct a feasibility study for any future system.

The Department sanctioned a feasibility study designed to give a brief overview of high-level requirements, potential partner vendors, and assistance available from the state-designated health information exchange, CRISP, recommendations for vendor selection and policy/programmatic implications of the behavioral health bed registry and referral system. Information was gathered from a review of research, discussions with other states' experiences with bed registries, and review of three potential vendors. The recently received feasibility study will guide the state steering committee through any design, vendor selection implementation decisions, and funding considerations. The legislatively mandated steering committee meets quarterly and includes representatives from various behavioral health

stakeholders at the state and local level. The advisory committee is led under the direction of the Deputy Secretary of Behavioral Health. The committee was formed and began meeting in October 2021 and continues to meet quarterly. A Behavioral Health Provider Directory/Resource Directory is being developed in coordination with Maryland's 211 Press 1 Hotline. The online resource directory is scheduled to launch 3/1/22. The resource directory will provide users an opportunity to search for a specific behavioral health need in a specific geographic area (by zip code). The search generates providers of those services in that geographic area. The study is complete and the advisory council meetings are ongoing.

As part of any future bed registry and behavioral health crisis system it is the task of BHA to develop a standardized data collection, reporting and performance measurement system to capture, summarize and highlight pertinent, client-level and actionable crisis services information including service utilization, effectiveness, performance and outcome measures. Providers and local behavioral health authorities will receive this information to improve quality of care.

The Maryland Department of Health Office of Enterprise Technology will lead any efforts to secure state funding of the major IT project. It is anticipated that funding will begin in state fiscal year 2023 (July 1, 2022-June 30, 2023). Through the first half of 2022, provider engagement activities will begin, including hosting Advisory Committee meetings, listening sessions, and targeted outreach to hospitals and community providers. This process will allow the Department to orient all of the various stakeholders to the goals of the system and what they should expect to be delivered initially and in the future. Additionally, the Department is developing a provider directory and planning a pilot project to study referral challenges and opportunities for reducing hospital stay time for individuals needing community based behavioral health services.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. Provider engagement activities, including hosting Advisory Committee meetings, listening sessions, and targeted outreach to hospitals and community providers – Targeted to be completed in 2022
3.d State requirement that	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.*

providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	There is no current requirement that providers use a patient assessment tool to determine appropriate level of care for adults. CAYAS is rolling out early components of comprehensive crisis stabilization model that will be utilizing CAT as initial data collection screening tool (along with others of provider/county selection). The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment will be used as a more robust longer term tool and incorporates existing TCM III / 1915i waiver opportunity for Evidence Based Practices (EBP) intensive in home stabilization services for highest needs youth. The Daily Living Activities- 20 (DLA-20) is required for Psychiatric Rehabilitation Programs for Adults (PRP-A), Residential Rehabilitation Programs (RRP), Mobile Treatment Services (MTS) programs, and Assertive Community Treatment (ACT) programs. This is used as part of the overall medical necessity determination to ensure that individuals are properly placed in the appropriate program, and to judge the necessity for ongoing stay. Accreditation standards encourage the use of standardized instruments for evaluation. Similar to the use of the DLA-20 in these above levels of care, for other levels, the Adult Needs and Strengths Assessment (ANSA) will be incorporated into the overall medical necessity determinations for proper program placement, and judging the necessity for ongoing stays.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. CAYAS is rolling out early components of comprehensive crisis stabilization model that will be utilizing CAT as initial data collection screening tool (along with others of provider/county selection). The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment will be used as a more robust longer term tool and incorporates existing TCM III / 1915i State Plan Amendment (SPA) opportunity for Evidence Based Practices (EBP) intensive in home stabilization services for highest needs youth.

	The Daily Living Activities- 20 (DLA-20) is required for Psychiatric Rehabilitation Programs for Adults (PRP-A), Residential Rehabilitation Programs (RRP), Mobile Treatment Services (MTS) programs, and Assertive Community Treatment (ACT) programs. This is used as part of the overall medical necessity determination to ensure that individuals are properly placed in the appropriate program, and to judge the necessity for ongoing stay. Accreditation standards encourage the use of standardized instruments for evaluation. Similar to the use of the DLA-20 in these above levels of care, for other levels, the Adult Needs and Strengths Assessment (ANSA) will be incorporated into the overall medical necessity determinations for proper program placement, and judging the necessity for ongoing stays.
	Summary of Actions Needed: Specify list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The milestone will be completed by the end of Calendar Year 2022.

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Currently BHA has funded several projects that have supported crisis stabilization centers within the state. Current stabilization centers are not operated under any formalized policy. The Department, which is establishing national best practices, monitors current stabilization centers based on the conditions of awards to ensure quality services are provided.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. In February 2021, The Behavioral Health Administration launched the Maryland Crisis System Workgroup (MCSW). This workgroup is composed of over 95 diverse stakeholders from around Maryland including representatives from state government, local government, providers, advocates, and people with lived experience. The workgroup has conducted an environmental scan of what services are being funded in the crisis space. Through this work, BHA is working to standardize best practices and policy, funding sustainability and data evaluation, and developing child/adolescent/young adult crisis services. Through this workgroup BHA will formalize the Maryland hybrid crisis system that will address the continuum of crisis care. MCSW has proposed the development of a comprehensive, public/private, integrated behavioral health crisis care system. Specifically, Maryland residents will have 24/7 behavioral health (mental health and addiction) access to hotline, crisis walk-in/urgent care, community response (mobile crisis) teams and stabilization services that provide care in the most effective, least restrictive, person and family focused. Meetings are held every other month. The meeting schedule for 2022 is: 2/15/22; 4/19/22; 6/21/22; 8/16/22; 10/18/22; 12/20/22.

The Department is working to develop Regional Crisis Centers across Maryland as identified in the 2021 Facilities Master Plan. This is being developed in partnership with Western (Garrett, Allegany, Washington) and Southern Maryland (St. Mary's, Charles, Calvert) Counties to develop urgent care centers which will serve as regional comprehensive crisis center hubs. Ideally a regional comprehensive crisis center will include a 24/7 urgent care walk-in center, 23 hour stabilization beds, have the capacity to accept emergency petitions, initiate pharmacologic medications, withdrawal management capabilities for all substances along with initiation of medications for treatment of opioid use disorder, integrate peers and have the capacity for warm handoff to short term stabilization services or traditional community outpatient resources when necessary.

Additionally, the Department was also awarded a planning grant through the CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying- community-based-mobile-crisis-intervention-services/index.html.

The planning grant provides funding to develop, prepare for, and implement qualifying community-based mobile crisis intervention services under the Medicaid program. The grant will help Maryland integrate community-based mobile crisis intervention services into the Medicaid programs which is a critical component of establishing a sustainable and public health-focused crisis system. The intended start date for these services in Medicaid is July 1, 2023.

The Department is working with the Crisis Services Subcommittee of the Commission to Study Mental Behavioral Health in Maryland. This subcommittee is devoted to enhancing crisis services throughout the State. The Opioid Operational Command Center (OOCC) awarded a grant to the Department to increase the availability of comprehensive crisis stabilization services for mental health (MH) by leveraging the outpatient mental health center (OMHC) provider network. The Department formed a stakeholder workgroup to inform the process and collaborated with Hilltop to produce data analysis and an environmental scan. The Maryland Health Services Cost Review Commission (HSCRC) has also awarded three Regional Partnership Catalyst Grants totaling approximately 79 million dollars for the expansion of behavioral health (BH) crisis services rooted in the Crisis Now model over a period of five years.

The Greater Baltimore Region Integrated Crisis System (GBRICS) received nearly 45 million dollars to implement a care-traffic control system, increase same day access to services, and expand mobile crisis teams in Baltimore City and Baltimore, Carroll, and Howard counties. Totally Linking Care in Prince George's County and Southern Maryland received over 22 million dollars to implement care traffic control, crisis bed expansion, mobile crisis team expansion, and crisis receiving and stabilization services. Tri-County Behavioral Health Engagement (TRIBE) received over 11 million dollars to build a hub-and-spoke like model for crisis stabilization in Somerset, Wicomico, and Worcester counties. The Department has engaged all of the HSCRC awardees in order to align efforts to enhance the crisis response system.

See additional discussion on bed registry and related activities above.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.
	The workgroup needs to establish the best practices, sustainability, and data collection requirements. The key milestone will be the ability to find funding that is not tied to grant awards, potentially through Medicaid and other commercial payors.
	The Department will engage in the planning process described in its grant awarded by CMS.
	Proposed revisions to the State Plan Amendment are anticipated to be completed 12/31/22.

SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.
Earlier Identification and Engagement in Treatment

| 4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs | *Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.*

Maryland has adopted these strategies. To increase engagement in transitional support services and allow for care coordination, TCM III enrollment is permitted prior to age 18 and eligible youth can continue to receive 1915i waiver services until age 21.

A memorandum of agreement (MOA) is currently under draft with Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), and Department of Disability (DOD) to align efforts in vocational/rehabilitative space. These include:
● Maryland Early Intervention Program (MEIP) and Healthy Transitions (HT) programs designed to identify and engage SMI youth and young adults (YA) and their families.
● Building collaborative relationships with MSDE through Center for School Based Mental Health to promote EBP screening and evaluation tools across all BH issues, as well as parent engagement tools / strategies (adding to efforts currently funded under SOR grant and AWARE grant).

Maryland BHA has been a pioneer in implementation of high fidelity individualized placement and support (IPS) model of supported employment services, disseminating these in its Transitional Age Youth (TAY) Maryland Model programs for both youth and young adults with or at are at risk for an SMI or SED and adults with an SMI. Employment is a powerful incentive for youth and young adults and is often a mechanism to facilitate engagement and retention in treatment services, particularly when the symptoms or functional limitations related to mental illness interferes with the individual's ability to acquire or retain competitive employment.

The TAY Maryland Model is specifically developed for working with youth and young adults with emotional/behavioral difficulties and serious mental health conditions (SMHC) to provide youth led family supported age appropriate services. Core services, provided to all youth include intensive case management to include |

individualized multi-systems service coordination (to assist the youth in the process of learning to understand and lead their own interdisciplinary team); guidance in the development of an individualized person centered care plan and skills development in goal setting progress measurement, and maintenance; community based services and relevant skills development delivered in environments of the youth's choosing and comfort level; assistance and guidance in understanding their mental health needs and taking charge/responsibility for treatment choices; providing access to appropriate mental health treatment and services; and guidance in the process of community resource mapping and recognition/understanding of available natural supports. It is a training that is provided to all TAY Providers with annual or two year training/refresher. At this time BHA is working on an assessment to test the model and this is still ongoing.

In order to coordinate and to integrate supported employment efforts with mental health treatment, Maryland has adopted an EBP approach to require that the that the employment specialist regularly collaborates with members of a multidisciplinary treatment team, as applicable. The treatment team is broadly defined, and includes the case manager, the psychiatric rehabilitation counselor, the residential or housing specialist, the therapist, the psychiatrist, family member, peer advocate, and any other individuals who may be involved in the treatment and rehabilitation of the individual. The following goals have been identified for the Clinical Coordination service:

- in pursuit of the consumer's goals for competitive employment, to establish a working alliance with the clinician and to enlist his or her support for the consumer's interests and desires;
- to enhance the program's ability to engage and to retain consumers in supported employment through assertive engagement and follow-up;
- to facilitate effective, efficient communication between the consumer and clinical, rehabilitation, and treatment providers as a means to coordinate care;
- when desired by the consumer, to encourage timely, fully integrated interventions which collectively support the individual in identifying and selecting employment options, resolving employment-related crises, and in preserving employment placements; and
- to incorporate employment-related issues in treatment and rehabilitation plans and to ensure congruence of rehabilitation and treatment goals, interventions, activities, and plans.

Future Status:

The COVID-19 MH Federal Block Grants (FBG) and American Rescue Plan Act (ARPA) MH FBG funding expansions have both provided significant allocations towards early interventions for youth with first (early) episodes of psychosis. The aforementioned programs, including treatment, integrated rehabilitation and vocational training will be expanding to several additional locations as a result of these awards. These new locations will increase both the geographic coverage and capacity of these valuable evidence-based programs.

The COVID 19 Mental Health FBG Supplemental Grant has a Project Period & Budget Period of 03/15/2021 - 03/14/2023. Funding will expand several current programs including:
1. Behavioral Health Assisted Living Programs- There is a Pilot project currently in Eastern Shore- will fund behavioral health assisted living programs in up to four regions.
2. Mental Health Family Peer Support Expansion-project would expand existing Family Peer Support and Navigation (intervention and mental health wellness and recovery support) services to families (expand the age range and jurisdictional reach of services).
3. Expansion of Child Crisis Services - Central and Western Region- to build upon the very limited crisis services available in Washington County and potentially incorporating additional providers, Affiliated Sante (Carroll Co) and Frederick Co Health Department, to provide child focused crisis and stabilization services to the county and/or region.
4. 211 Press 1 Statewide Crisis Hotline- funding in order to optimize the current 211 Press 1 statewide crisis hotline system. The State of Maryland is coordinating with SAMHSA and Vibrant Emotional Health to integrate 988 with the currently operational Maryland 211 press 1 hotline. The national 988 call center is scheduled to go-live July 16,2022. The 211 press 1/988 call centers will coordinate with other crisis system components such as the Maryland bed registry, mobile crisis teams and walk-in/urgent care centers.

The ARPA Mental Health FBG Supplemental Grant has a Project Period & Budget Period of: 09/01/2021 - 09/30/2025. Funding will expand several current programs including:
1. Operation Rollcall Expansion- purpose of this project is to expand the current capacity of MCV's Operation Roll Call program. Operation Roll Call provides SMVF with a weekly or bi-weekly call providing support and connection to those that are socially isolated and/or suffering from SMI or SED in silence.
2. Maryland Assertive Community Treatment Team Expansion ("ACT Team Expansion")- development of two Assertive Community Treatment (ACT)teams in two underserved areas of Maryland
3. Crisis Walk-in/BH Urgent Care Peer Expansion Project- This proposal looks to expand positions for peer recovery

specialists specifically within funded Crisis Walk-In Centers and Behavioral Health Urgent Care Centers.

4. Training Crisis Peer Expansion Project-This proposal supports the Crisis Walk-in and BH Urgent Care Peer Expansion proposal and will fund the required training the peer workforce needs in order to obtain the credential in Maryland and provide effective services to individuals in crisis.

5. Mental Health Family Peer Support- will allow for the continuation of the provision of Family Peer Support and Navigation (intervention and recovery support) services.

Additional interagency collaboration between MSDE and MDH/BHA continues to be defined, both through the Center for School Based Mental Health and the establishment of regional school based consultation teams and shared partnership to support the efforts of Project Bounce Back and the expansion of adolescent and transitional aged youth centered resources through the efforts of the Boys and Girls Clubs, LinkedIn Learning, Microsoft, KPMG, Discourse Analytics and eCare Vault. In regards to the MOA, there will be continued conversation with DORS and BHA to work to operationalize the agreement. These efforts are still ongoing

All contracts have been executed for COVID-19 and ARPA to its respective vendor to fund expansion and enhancement of services through 3/14/2023 (COVID-19) and 9/30/25 (ARPA). COVID-19 funding went to our Maryland Early Intervention Program (EIP) to focus on three things: staffing- hotline, peer specialists, and supported employment specialist; create a manual with evidence-based approaches to crisis reduction and management among those with emerging psychosis symptoms; and further embed a culturally responsive and equitable perspective into Maryland EIP pre-service training resources. ARPA funding went to two of our First Episode Psychosis (FEP) programs: Johns Hopkins Bayview and Family Services Montgomery County to provide Crisis Support services to individuals with first episode psychosis (FEP) who are not able to receive adequate care due to lack of resources available to meet the needs of their acuity, lack of step-down care from inpatient units, wait lists into FEP outpatient programs, insurance barriers, location barriers and lack of crisis services for immediate assistance.

Summary of Actions Needed:

As this has evolved, funding will be awarded to Garrett County for the development of a new Mobile Crisis team (all ages) to serve Garrett and Allegany Counties. Start-up funding for Southern Maryland (St Mary's, Calvert and Charles) will also be awarded to develop mobile crisis/mobile response stabilization services. Finally, additional funding is being awarded to expand child services in Washington, Frederick, greater Eastern Shore region, and potentially other counties served by Affiliated Sante (Carroll, Baltimore Counties). The Department expects statewide services to begin on July 1,

	2023. All funding should be released prior to that date. Crisis Walk-in/Urgent Care Center funding is being awarded to Calvert County. This is new funding which will allow the jurisdiction to expand their currently operating walk-in/urgent care center. Four counties were selected to develop Peers in Walk-in/Urgent Care centers. The counties include: Frederick, Harford, Howard and St. Mary's. Contracts/scopes of work are currently being developed.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status: Provide information on current strategies to increase earlier identification/engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* The Maryland Early Intervention Program (MEIP) is a specialized program for young people with SMI of early psychosis and currently providing additional staffing support to their MEIP hotline, supported employment and education specialists, and peer support specialists; exploring and developing evidence-based approaches to crisis reduction and management among those with emerging psychosis symptoms; and improving outreach and education (O&E) working with one of our Historically Black Colleges and Universities (HBCUs) as the pandemic has highlighted and exacerbated pre-existing disparities and equity gaps in mental health care outcomes, particularly those among marginalized racial groups, indicating the need for both intensified and novel outreach and education efforts to address these needs. It is the idea that all of these areas will assist with earlier identification/engagement in treatment. Also, BHA has increased our capacity to serve 25 more individuals who are experiencing their first episode of psychosis by implementing a new program in Prince George's County. BHA is currently able to serve 245 individuals throughout our six providers who provide treatment to this population. The Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) and related tele-psychiatry efforts again offer consultation regarding diagnosis and treatment to pediatric and other PCPs to improve identification and early intervention of SMI. Specifically BHIPP provides real time consultation resources for child/adolescent and early developmental concerns. These resources are available via telephonic or telehealth, as well as expanding co-location of social workers or physician assistants trainees into pediatric practices in our underserved communities. PCPs and other healthcare providers also received a suicide prevention kit. It contains information on suicide prevention trainings, screening and assessment tools, decision tree, safety planning, and referrals to specialty care. The Collaborative Care Model (CoCM) pilot program will also be leveraged to increase integration of behavioral health services in non-specialty care settings, along with continued promotion of SBIRT. The CoCM pilot program began

providing services in July 2020 in three pilot sites across Maryland.

CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. A collaborative care team is responsible for delivery and management of patient-centered care. Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders for the patient. This in turn encourages patients to seek access to the evidence-based behavioral health services available in their regular primary care clinics resulting in improved patient outcomes. Patients are screened through a standardized questionnaire, such as the PHQ-9 for depression or the GAD-7 for anxiety.

The CoCM incorporates a team of three providers: (1) a primary care provider (PCP), (2) a behavioral health (BH) care manager, and (3) a psychiatric consultant. In Maryland's Medicaid program, a physician, nurse practitioner, nurse midwife, or physician assistant may serve as a PCP. The BH care manager possesses formal education or specialized training in behavioral health. The role is typically filled by a nurse, clinical social worker, or psychologist who is trained to provide coordination and intervention who works under the oversight and direction of the PCP. Together, the BH care manager and the PCP form the primary care team. The psychiatric consultant is typically either a licensed psychiatrist or psychiatric nurse practitioner. For purposes of the CoCM Pilot Program, an addiction medicine specialist or any other behavioral health medicine specialist as allowed under federal regulations governing the model may also serve as a consultant.

The CoCM is still ongoing; MDH will conduct a full evaluation after the end of the pilot in June 2023.

Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.

For FY23 under MEIP BHA plans to put out a survey to collect information on providers serving transitional aged youth with psychosis so that the Hotline can refer across the state and to identify providers interested in receiving

education and training resources related to this target population and provide it to them. The benefits to implementing this project could include: increasing access to services among this vulnerable population, especially in rural regions, improving the quality of care for these individuals by providing informational resources and consultation to the service providers, and promoting the expansion of first episode psychosis programs across the state.

CAYAS is expanding collaboration with MSDE to support screening and early intervention tools across many diagnostic categories.

BHA has, in collaboration with University of Maryland, Baltimore (UMB) Center for School Based Mental Health, repeatedly provided MSDE with an extensive list of recommendations, resources and training opportunities across a wide array of MH and SUD screening and early intervention topics. These also include recommendations regarding how to implement a regional approach to providing consultative services to the schools and how to begin to integrate these proposed services into the developing BH crisis and stabilization system.

Finally, the Behavioral Health System of Care Integration and Optimization Workgroup formed in 2019, paused during CY 2020 due to COVID-19, and reconvened in fall 2021, aims to better serve Medicaid participants by developing a System of Care that addresses the needs to individuals by aligning the roles of Medicaid, the Behavioral Health Administration (BHA), the nine MCOs, the administrative services organization (ASO) that administers behavioral health benefits in Medicaid, and local systems management.

The key themes for potential initiatives under discussion by the workgroup are:
• Value-based payment, measure-based care, quality measurement, and provider management;
• Case management, care coordination, and clearly defining roles within the system;
• Integration of care; and
• Data sharing

The workgroup is considering and vetting a variety of programs and projects with the potential to forward progress on the themes outlined above. Expansion of CoCM is one proposal under consideration. Other initiatives under discussion include but are not limited to establishing standards for behavioral health provider networks and quality; development of a formal structure for addressing high utilizers of services; identification of barriers to billing for co-occurring disorders; review of supports needed by MCOs to further increase uptake of SBIRT by providers; and enhancements to

	CRISP to improve data sharing, Discussion by the workgroup regarding selection of an initiative to move forward are ongoing.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. BHA CAYAS and Maryland's partners at UMB Systems Evaluation Center (SEC) met with MABHA on 3/16/22 to share this initiative and gather information from each LBHA/CSA Representative. MDH will have ongoing meetings with the partner at UMB SEC as MDH starts working with the LBHA/CSA to send an email out to their BH Providers to participate in the survey. The timeline: get surveys out by May 2022, review surveys June/July 2022, compile responses Aug/Sept 2022 and resend surveys out Oct/Nov 2022 in case MDH missed any BH Providers. Based on responses BHA will be able to update our Provider Directory housed at our Hotline, provide trainings/consultations to BH Providers who request training/consultation, and the goal to help BH Providers increase their referrals. MDH will conduct an evaluation in 2023 of its CoCM Pilot Program after the pilot ends on June 30, 2023. MDH will submit the finished evaluation report to the Maryland legislature on or before November 1, 2023. MDH will continue to work with the pilot sites and the evaluator to collect pilot data and will implement findings from the pilot programs.

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* Expanding crisis stabilization services for youth is one of the primary goals and objectives of CAYAS, an ongoing $7M multi-grant funded effort to expand upon existing crisis resources and lay out a framework for a statewide-specialized child/adolescent crisis and stabilization system. As noted above, TCM III/ 1915i bundle provides a platform for highest intensity youth to access longer term, EBP based in-home stabilization services. The Maryland Early Intervention Program (MEIP) supports individuals, families, and professionals who may encounter early psychosis. MEIP increases earlier identification through: Outreach and Education Services- to behavioral health providers, schools, and primary care settings: Clinical Services- for 12-30 year olds who present with clinical high risk symptoms that may be predictive of future psychosis, who have early signs of psychosis or are in the initial stages of psychoses; Consultation Services- servicing providers regarding identification and treatment for individuals who may be experiencing symptoms that may be predictive of future psychosis; and Training and Implementation Support Services- support established Early Intervention Teams (EIT) throughout the state and provide trainings, resources, coordination of service delivery. MEIP also provides a 24/7 hotline to all MD residents and providers for assessments, consultation, training requests, and referrals. This initiative also provides training of early identification of psychosis assessments/screenings to students in the UMB Social Work program. The Healthy Transitions (HT) program is also designed to identify youth with or in prodromal stages of SMI, in addition to SED. HT also provides outreach and education, clinical services, and consultation to those within the program and to those not in the program seeking information and resources. Both MEIP and HT provided extensive EBP programming including family engagement support to help maintain these adolescents and young adults with SMI in treatment. Additional information and plan framework are available if more details are required.
	Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI. The state will continue to work on CAYAS.

	During FY22 and FY23 the CAYAS unit will explore the creation of a fidelity assessment to assess the current providers who serve those experiencing their first episode of psychosis to ensure a few things: the model being used to serve this population is effective, to assess the screenings/assessments being used, assess the EBPs being used, assess outreach and education, and assess the effectiveness of ongoing trainings.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The state will continue to implement CAYAS. The IA with UMB Evidence Based Practice (EBP) Center was executed in December 2021, BHA had a first meeting 3/31/22 to discuss timeline: year 1 (June 2022) with the UMB EBP Center BHA will work on the draft fidelity assessment created back in 2016 to understand if its components are still relevant while comparing it to other FEP fidelity scales ex.: PA and MA's FEP assessment and year 2 (July 2022-June 2023) after finalizing the assessment, a pilot fidelity assessment will be conducted by BHA to all FEP providers in the state, and BHA will review the information with UMB EBP Center to determine the effectiveness of the assessment. If acceptable, the assessment will be used to assess all FEP providers in the future.
4.d Other state strategies to increase earlier identification/engagement,	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* N/A

integration, and specialized programs for young people	*Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.*
	The COVID 19 Mental Health FBG Supplemental Grant has a Project Period & Budget Period of 03/15/2021 - 03/14/2023. Funding will expand several current programs including:
	1. Behavioral Health Assisted Living Programs- There is a Pilot project currently in Eastern Shore- will fund behavioral health assisted living programs in up to four regions.
	2. Mental Health Family Peer Support Expansion-project would expand existing Family Peer Support and Navigation (intervention and mental health wellness and recovery support) services to families (expand the age range and jurisdictional reach of services).
	3. Expansion of Child Crisis Services - Central and Western Region- to build upon the very limited crisis services available in Washington County and potentially incorporating additional providers, Affiliated Sante (Carroll Co) and Frederick Co Health Department, to provide child focused crisis and stabilization services to the county and/or region.
	4. 211 Press 1 Statewide Crisis Hotline- funding in order to optimize the current 211 Press 1 statewide crisis hotline system. The State of Maryland is coordinating with SAMHSA and Vibrant Emotional Health to integrate 988 with the currently operational Maryland 211 press 1 hotline. The national 988 call center is scheduled to go-live July 16,2022. The 211 press 1/988 call centers will coordinate with other crisis system components such as the Maryland bed registry, mobile crisis teams and walk-in/urgent care centers.
	The ARPA Mental Health FBG Supplemental Grant has a Project Period & Budget Period of: 09/01/2021 - 09/30/2025. Funding will expand several current programs including:
	6. Operation Rollcall Expansion- purpose of this project is to expand the current capacity of MCV's Operation Roll Call program. Operation Roll Call provides SMVF with a weekly or bi-weekly call providing support and connection to those that are socially isolated and/or suffering from SMI or SED in silence.
	7. Maryland Assertive Community Treatment Team Expansion ("ACT Team Expansion")- development of two Assertive Community Treatment (ACT)teams in two underserved areas of Maryland
	8. Crisis Walk-in/BH Urgent Care Peer Expansion Project- This proposal looks to expand positions for peer recovery specialists specifically within funded Crisis Walk-In Centers and Behavioral Health Urgent Care Centers.
	9. Training Crisis Peer Expansion Project-This proposal supports the Crisis Walk-in and BH Urgent Care Peer Expansion proposal and will fund the required training the peer workforce needs in order to obtain the credential in

	Maryland and provide effective services to individuals in crisis.
	10. Mental Health Family Peer Support- will allow for the continuation of the provision of Family Peer Support and Navigation (intervention and recovery support) services.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of nonhospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status* Currently BHA has funded several projects that have supported crisis stabilization centers within the state. Current crisis services are monitored by the state based on the conditions of awards to ensure quality services are provided. BHA established and publicized a 3-digit crisis call-center number to access acute and non-acute services and resources. The crisis call centers link to those and other services to address the needs of the caller wherever mobile crisis exist.
	Future Status BHA in collaboration with the Opioid Operational Command Center (OOCC), Medicaid and other external stakeholders have formulated the Maryland Crisis System Workgroup. The workgroup has conducted an environmental scan of what services are being funded in the crisis space. Through this work, BHA is working to standardize best practices and

policy, funding sustainability and data evaluation. Through this workgroup BHA will formalize the Maryland hybrid crisis system that will address the continuum of crisis care, including the integration of 988 crisis calls into the existing crisis call system.

In February, 2021, The Behavioral Health Administration launched the Maryland Crisis System Workgroup (MCSW). This workgroup is composed of over 95 diverse stakeholders from around Maryland including representatives from state government, local government, providers, advocates, and people with lived experience. A statewide Behavioral Health Crisis System vision was identified: A comprehensive, public/private, integrated behavioral health crisis care system will be developed. Specifically, Maryland residents will have 24/7 behavioral health (mental health and addiction) access to hotline, crisis walk-in/urgent care, community response (mobile crisis) teams and stabilization services that provide care in the most effective, least restrictive, person and family focused. Meetings are held every other month. The meeting schedule for 2022 is: 2/15/22; 4/19/22; 6/21/22; 8/16/22; 10/18/22; 12/20/22.

The Department is working to develop Regional Crisis Centers across Maryland as identified in the 2021 Facilities Master Plan. This is being developed in partnership with Western (Garrett, Allegany, Washington) and Southern Maryland (St. Mary's, Charles, Calvert) Counties to develop urgent care centers which will serve as regional comprehensive crisis center hubs. Ideally a regional comprehensive crisis center will include a 24/7 urgent care walk in center, 23 hour stabilization beds, have the capacity to accept emergency petitions, initiate pharmacologic medications, withdrawal management capabilities for all substances along with initiation of medications for treatment of opioid use disorder, integrate peers and have the capacity for warm handoff to short term stabilization services or traditional community outpatient resources when necessary.

There are currently 9 walk-in/urgent care centers in Maryland. There are 2 currently being developed. They are scheduled to open: Eastern Shore -Summer, 2022 (June), and Southern Maryland - Fall, 2022 (September-November).

A Request for Expression of Interest (REOI) is scheduled for release in April, 2022 targeting the Western Maryland Region. The REOI is seeking proposals to develop/expand crisis services in the region. The Southern Maryland urgent care is currently being developed. It is scheduled to open late 2022 (September-November).

Additionally, the Department was also awarded a planning grant through the CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services:
https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-

community-based-mobile-crisis-intervention-services/index.html.

The planning grant provides funding to develop, prepare for, and implement qualifying community-based mobile crisis intervention services under the Medicaid program. The grant will help Maryland integrate community-based mobile crisis intervention services into the Medicaid programs which is a critical component of establishing a sustainable and public health-focused crisis system. The intended start date for these services in Medicaid is July 1, 2023.

The Department will engage in the planning process described in its grant awarded by CMS. Based on SAMHSA Best Practices, BHA has developed the Maryland Crisis System Model and the 4 components which will be minimum for each location (ie regional hubs as per Facilities Master Plan.) These components are a Call Center (integrate to statewide,) Mobile Response Teams (often called mobile crisis teams), Urgent Care (walk-in centers), and Short-term Stabilization Services. There are additional requirements of the "urgent/walk in centers." BHA intends for those to be regionally operationalized, and for the mobile response teams to be more local in scope. BHA is defining and describing consistent expectations (staffing and service provision) for all of these components statewide, as well as consistent evaluation, assessment and data collection elements. This work is very much in progress, and expected to be completed late spring. The expansion of these services into all regions is dependent, but expected to be statewide by FY 2023. Full array may take a few more years.

Currently underway, the Maryland Medicaid Administration and BHA are working closely (meeting bi-weekly) to develop the funding structure for mobile crisis teams and walk-in/urgent care/stabilization center. The structure includes developing the definitions of the services, defining the provider type/services, qualifications of the provider, eligibility, and reimbursement rate. Proposed revisions to the State Plan Amendment are anticipated to be completed 12/31/22.

See Milestone 3.e. for additional information on investments is the crisis continuum of care.

	Summary of Actions Needed The workgroup needs to establish the best practices, sustainability, and data collection. The key milestone will be the ability to find funding that is not tied to grant awards, potentially through Medicaid and other commercial payors. Maryland Crisis System and the 4 components will be statewide by July 1, 2023; however it may take longer. BHA already has a number of these services funded under a wide variety of sources. The purpose of the grant is to help the state utilize Medicaid funding mechanisms. BHAS has a contracted agency who is assisting in this by the end of grant (expected 8/30/2022).
F.b Increase availability of ongoing community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status* A statewide assessment was completed to ascertain locations of current ACT teams and current Mobile Treatment Services providers to establish where services were most needed. This was done by population count based on the 2019 census data and then converted into a formula for adults over 18, needing ACT services, in each jurisdiction in Maryland. These jurisdictions were then shown using geo mapping software to display highlighted areas needing services.
	Future Status: In response to SAMHSA Mental Health Block Grant funding from the American Rescue Plan Act of 2021, a plan for the expansion of ACT in Maryland was submitted and approved. The Assertive Community Treatment Expansion program will be implemented through LBHAs and Core Service Agencies (CSAs). CSA will be selected using a statewide assessment to ascertain locations of current ACT teams and current Mobile Treatment Services providers. This also established where significant gaps in the service continuum and lack of ACT services exist, thus providing comprehensive community mental health services and a strong continuum of care for persons with serious mental illness. The funding awarded will support two teams, one in southern and one in Western Maryland. Implementation of the team in southern Maryland will begin this fiscal year and continue into next, with the second team in Western Maryland with implementation beginning towards the end of next fiscal year. Both will be fully implemented, able to be

	sustained by fee for service system by August of 2025. BHA will partner with the local behavioral health authorities to implement the Assertive Community Treatment Expansion program. Discussions with the identified local behavioral health authority for year 1, began in the Fall of 2021. The Conditions of Award /Statement of Work for State Fiscal Year 22 has been developed and signed by both BHA and the local health authority. The local authority will begin the work of hiring a Project Director and begin the Request for Proposal (RFP) for interested providers in southern Maryland in January 2022. The BHA, evidence-based Practice Manager, the Project Director at the local authority and the provider selected will collaborate and begin the process of hiring and training required staffing with the goal of being able to offer these services in Southern Maryland prior to the end of the state fiscal year (June 30, 2022) and continuing into State fiscal year 2023. The implementation process will be followed in State fiscal year 2024, to implement a team in Western Maryland.

	Summary of Actions Needed:
	FY 2023 - Implement a Team in Southern Maryland. FY 2024 - Implement a Team in Western Maryland. By August of 2025 - Both teams implemented and sustained by the fee for service PBHS.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT *interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the:* • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education. Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	Over the last seven years, Maryland has placed considerable emphasis on advancing HIT and engaging stakeholders in planning and implementation activities. The State has a long tradition of hospital-to-hospital and hospital-to government collaboration on projects, including the award-winning Maryland Patient Safety Center. The Department is working in partnership with the State HIE, CRISP, to enable both the ASO and MCOs to receive alerts for the patient panels, which include emergency department visits and inpatient admissions. The state's HIE has a mature data network and data integration capabilities to inform care and service providers on patient's medical history, care plans, and risk assessments. Maryland Medicaid (Medicaid) providers can leverage CRISP's technical capabilities through routed data, portal, and integrated data reports. CRISP's network provides MDH and providers access to both data and tools; thereby improving an individual's health, quality of care, and Maryland's population health. The primary care coordination technology used by CRISP is Encounter Notification Service (ENS) which enables healthcare providers to receive real-time alerts when that provider's active patient has an encounter with one of the organizations sharing encounter information to CRISP (such as hospitals, skilled nursing facilities, and ambulatory providers). ENS allows for improved care coordination between settings. Care coordinators and nurses can choose to call the hospital to relay important patient information or can call the patient to schedule a post-discharge encounter to reduce the risk of a readmission. CRISP also displays the organizations that are part of a patient's care team, thereby enabling

	proactive coordination and reducing duplication of services.

---

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	*Enter text here* Maryland has a Medicaid Health IT Plan. Maryland does not have a standalone Behavioral Health IT Plan.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	The Department intends to assess the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B and will include them, as appropriate in Maryland's Medicaid Managed Care contracts. MDH's Medicaid Enterprise Systems Modular Transformation Program (MMT) has submitted Advanced Planning Documents to CMS for funding in support of Enterprise Integration Solutions, Electronic Documents Management Systems, and the CMS Interoperability Rule. These efforts are part of MMT's overall process to move up the MITA maturity scale. The Department made significant investments to enhance privacy and security capabilities and maturity, including but not limited to, recruiting subject matter experts to build out a security team to conduct routine monitoring as well as system and infrastructure assessments. This team will also be instrumental in developing the overall enterprise security model for continued protection of Maryland's Medicaid data. Much of the state's health IT infrastructure is reused across these purposes. For example, CRISP receives Medicaid claims and encounter data to share them with providers at the point of care. The same database and application programming interfaces (APIs) are being reused to supply data to third party applications on behalf of patients as required by the CMS Interoperability Rule. By consolidating these services, investments to align with industry standards and security protocols are more impactful.

---

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
	To assist states in their health IT efforts, CMS released [SMDL #16-003](#) which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3]
	Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."[4]

Closed Loop Referrals and e-Referrals (Section 1)

Prompts	Summary

1.1 Closed loop referrals and referrals from physician/mental health provider to physician/mental health provider	*Current State: # and/or % of Behavioral Health Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) and utilize it for e-referrals and or closed loop referrals.*
	   1) # and/or % of Behavioral Health Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals
	   2) # and/or % of Primary Care Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) that are utilizing it for e-referrals and or closed loop referrals with mental health providers
	   3) # or % of Primary Care Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals with Mental Health Providers
	
	Maryland is developing specific critical supportive infrastructure. CRISP does have an MPI-based matching process, which allows the patient data from different sources to link together such that when a user makes a data request; clinical content from across the state is presented in a single view for a particular patient, within CRISP itself or within an EHR through standard APIs.
	
	The Social Determinants of Health (SDOH) eReferral Tool is available through the CRISP web-based portal designed

---

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/nowrong-door/index.html.

to allow providers and select members of their staff to refer patients to various health programs, such as diabetes prevention programs, and Community Based Organizations (CBO), and mental health providers across the region. The eReferral Tool allows somatic providers to send referrals directly to participating providers, along with important notes and medical results for the patient. Receiving providers respond within the tool and provide updates on patient status, which are shared with the referring provider and the patient's care team. Specific counts of primary care providers utilizing e-referrals and or closed loop referrals with mental health providers is indeterminate at this time.

Future State: Describe the future state of the health IT functionalities outlined below:

Maryland plans to expand the use of the eReferral Tool to new providers in the coming years. In addition, some providers already use external systems to generate e-referrals. CRISP plans to support a vendor-agnostic approach that enables display of external referrals in CRISP to provide providers with a more holistic view of patient care across organizations.

Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:

Technical support to onboard mental health providers in particular will be included. General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. General troubleshooting and resolution of participant-specific questions will also be addressed by technical support personnel.

Prompts	Summary
1.2 Closed loop referrals and ereferrals from institution/hospital/clinic to physician/mental health provider	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The Social Determinants of Health (SDOH) eReferral Tool is available through the CRISP web-based portal designed to allow providers and select members of their staff to refer patients to various health programs, such as diabetes prevention programs, Community Based Organizations (CBO), and mental health providers across the region. Specific counts of primary care providers utilizing e-referrals and or closed loop referrals with mental health providers is indeterminate at this time.
	Future State: Describe the future state of the health IT functionalities outlined below: In its recent MITA State self-assessment, the Department identified care management as a high priority for capability improvements. Many of the targeted improvements related to care management could be further enhanced by integrating with CRISP's care coordination, point of care, and population health reporting services. The use of the SDOH eReferral Tool will expand the overall use of closed-loop referral tools by Medicaid programs.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. Technical support personnel also address general troubleshooting and resolution of participant-specific questions.

1.3 Closed loop referrals and ereferrals from physician/mental health provider to community based supports	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The SDOH eReferral Tool is available through the CRISP web-based portal designed to allow providers and select members of their staff to refer patients to various health programs, such as diabetes prevention programs, and Community Based Organizations (CBO) across the region.
	Future State: Describe the future state of the health IT functionalities outlined below: The SDOH eReferral Tool could expand the overall use of closed-loop referral tools by Medicaid programs. The tool will also allow physicians/mental health providers to link patients with community-based supports. By encouraging referrals to be shared through the state-designated HIE – either directly in the CRISP tools or via integrations with existing platforms – providers will have access to a complete set of resources utilized by their patients.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. Technical support personnel also address general troubleshooting and resolution of participant-specific questions.

Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* CRISP's mature data network and data integration capabilities inform Medicaid care and service providers on patient's medical history, care plans, and risk assessments. Medicaid providers can leverage CRISP's technical capabilities through routed data, portal, and integrated data reports. CRISP's network provides Medicaid and providers access to data and tools improving individual's health, quality of care, and Maryland's population health. Health care providers and MCOs are sharing clinical documents with CRISP, including care plans in most cases. Although the care plans are not edited within a central source, they are available to all members of the care team and therefore influence the design and updates of local care plans. CRISP has also developed a separate module for Maryland's Maternal Opioid Misuse Model (MOM Model) called the MOM Care Coordination Module (MOM CCM) that houses a care plan and care plan update. This is shared with patient's providers who have access to CRISP. Care alerts also are sent that are MOM specific when a patient enrolls into MOM and upon discharge that other providers can see within CRISP.
	Future State: CRISP will continue to build connectivity across the state, with a particular focus on mental health providers. The consent utility within CRISP allows patients to register consents compliant with 42 CFR Part 2, allowing these sensitive documents to be shared with care teams according to patient preferences.
	Summary of Actions Needed: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. Technical support personnel also

| | address general troubleshooting and resolution of participant-specific questions |
| | |

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* Primary Care Coordination technology used by CRISP is ENS which enables healthcare providers to receive real-time alerts when that provider's active patient has an encounter with one of the organizations sharing encounter information to CRISP (such as hospitals, skilled nursing facilities, and ambulatory providers). ENS allows for improved care coordination between settings. As providers receive real-time alerts, they can access clinical records within CRISP. These records often include discharge summaries and care plans. Mental health providers utilize CRISP for both real-time alerts and clinical records. Behavioral Health Care Coordination technology (DataLink): MDH/ASO are working with LBHAs linked with local detention centers. If a behavioral health client is incarcerated, a DataLink alerts LBHAs. This is an effort to ensure coordination of care between jails and providers. The current focus is on the 16 counties that have a signed Memorandum of Understanding (MOU) in place. ECG accounts have been set up for 16 county LBHAs and detention centers.
	Future State: MDH is working in partnership with the State HIE, CRISP, to enable both the ASO and MCOs to receive alerts for the patient panels, which include emergency department visits and inpatient admissions. These alerts are configurable so the ASO and MCOs can focus on specific types of encounters or patients with specific health concerns. For example, MCOs receive alerts as new patients transfer into their MCO, and the alerts include information such as high-risk patient flags. CRISP will continue to integrate with providers, parse clinical data, and present alert options for the ASO

	and MCOs. Behavioral Health Care Coordination technology (DataLink): BHA, in collaboration with ASO, will be working with the remaining 7 counties to review the process and reason for the DataLink project and to establish the necessary MOUs to begin sharing data.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: MDH will continue to collaborate with CRISP and BHA to integrate new providers, develop new alerts, and execute the DataLink project.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Maryland has not yet reached this milestone. However, the Long Terms Services and Supports Maryland (LTSS Maryland) portal is being updated to integrate existing programs and waivers. 1915(c) Community Pathways, Family Supports, and Community Supports waivers require continuation and expansion of functionality to improve oversight of the Developmental Disabilities Administration (DDA) program by providing tracking and reporting of billing, case management, and assessments. Implementation will support waiver assurances by allowing accurate tracking and reporting on service utilization, billing activities, assessments, and other case management data to ensure that the necessary services are provided appropriately within policy and regulatory guidelines The DDA State-only program supplements the 1915(c) Community Pathways, Family Supports and Community

	Supports Waivers. This project will develop a system that solely handles processing of non-Medicaid, state-only services and integration with LTSSMaryland to improve care coordination and service tracking for participants who receive services via both State-only and Medicaid reimbursable payment streams. The current system integration will assist with over medical record transitions from youth-oriented systems of care to the adult behavioral health system through electronic communications.
	Future State: Describe the future state of the health IT functionalities outlined below: Enhancements to improve reporting and workflow may be required during the further rollout of the DDA modules in FFY22.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Continue integration of DDA into LTSS Maryland
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries who are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Home and Community Based Options Waivers mentioned above utilize LTSS Maryland to enter medical information, plans of service, and facilitate detailed assessments, service authorizations, and claims submissions. Providers enter specific plans of care for youth-oriented waivers into LTSS.
	Future State: Describe the future state of the health IT functionalities outlined below: Continue to maintain and monitor current LTSS system.

	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Continue to maintain and monitor current LTSS system.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Home and Community Based Options Waivers mentioned above utilize LTSS to enter medical information, plans of service, and facilitate detailed assessments, service authorizations, and claims submissions. Providers enter specific plans of care for youth-oriented waivers into LTSS.
	Future State: Describe the future state of the health IT functionalities outlined below: N/A
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: N/A
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42	*Current State: Describe the current state of the health IT functionalities outlined below:* Maryland's HIE, CRISP, launched a consent tool in Spring 2021 which enables SUD providers to share data protected by 42 CFR Part 2 through the HIE. This project will improve care coordination between SUD providers and other health care providers, strengthen continuity of care for patients throughout SUD treatment levels, and ease SUD workflow burden when obtaining consent and disclosing information. SUD providers who have executed a qualified service organization agreement (QSOA) with CRISP will share SUD data with the HIE. CRISP will only share SUD information once a patient has registered consent via the CRISP tool. CRISP

CFR part 2 and state laws)	is focusing on sharing relationship information based on patient panels submitted by SUD providers. CRISP is exploring sharing additional data elements with the pilot sites. SUD data will have a notice that states SUD information cannot be re-disclosed due to Part 2 requirements.
	SUD providers will access the consent tool though the CRISP Unified Landing Page (ULP) or EMR single sign-on (SSO) and will have the option to register a new consent or search for an existing consent on file. There are two forms to document patient consent for Part 2 data sharing (provider or payer) and a consent history log. Patients will indicate their consent preferences and will electronically sign the consent form. Providers must attest to providing patient education and verifying patient identity before registering consent.
	In addition, the Department is working in partnership with the State HIE, CRISP, to enable both the ASO and MCOs to receive alerts for the patient panels, which include emergency department visits and inpatient admissions.
	Future State: Describe the future state of the health IT functionalities outlined below:
	Maryland is continuing development on a consent manager and data router to facilitate the exchange of substance use data across the health care system and the integration of data with rules-based exchange provided at the point of care (in-context ENS reporting).
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state:
	CRISP will continue to develop consent manager for providers with a long-term goal of integration at the payer level.

Interoperability in Assessment Data (Section 4)

4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:*
	Providers can share screening information on patients' social determinants of health with CRISP in a number of different formats, including through inputting a structured questionnaire accessible via CRISP, sending SDOH diagnosis codes, or exporting screening questions and answers directly from EMRs. Providers are able to view the information on each patient's available SDOH information within CRISP, eliminating repetitive questions and enhancing coordination of care.

	Future State: The screening capture and display module will be enhanced to include additional types of data and data sources.
	Summary of Actions Needed: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to screening participants will also be included. Technical support activities include ensuring participants are properly configured, and utilizing the service, and remain compliant with privacy and security protocols. Technical support personnel will address general troubleshooting and participant-specific questions.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Maryland currently allows telehealth and audio-only visits for nearly behavioral health services. Services delivered via telehealth may be provided in the participant's home, a provider's office, or another secure setting. Certain services are where delivery of services via telehealth is not clinically appropriate must be offered in person. For example, OMHCs must maintain the capability to offer services on site. Rules for delivery of group services/activities by psychiatric rehabilitation programs and child and adolescent respite services have reverted back to pre-pandemic requirements and these services must be delivery in-person. In addition, use of telehealth to deliver residential treatment services is limited. At a maximum, only 50% of therapeutic services can be performed via telehealth.

	Future State: Describe the future state of the health IT functionalities outlined below: N/A
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: N/A
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The state has developed HIT tools to identify persons at risk for hospitalization if they are infected with COVID-19. These algorithms use multiple sources of data to predict risk and are leveraged by Medicaid and MCOs to direct participant outreach.
	Future State: Describe the future state of the health IT functionalities outlined below: Future work could focus on adapting this technology or other models to identify patients that are at risk for discontinuing engagement in their treatment, and notify their care teams in order to ensure treatment continues or resumes.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Scope and plan the work, evaluate risk tool expansion, design, pilot and test, implement statewide.

---

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from
https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Much of the provider community, both somatic and mental health, connects to CRISP and share patient rosters. These connections create a robust Master Person Index, which can link records across settings. CRISP links and shares somatic episodes of care and their corresponding clinical documents. Care alerts are currently available to providers and MCOs following hospitalization or ED utilization, which can help flag events such as experience of a first episode of psychosis. CRISP's mature data network and data integration capabilities inform Medicaid care and service providers on patient's medical history, care plans, and risk assessments. Medicaid providers can leverage CRISP's technical capabilities through routed data, portal, and integrated data reports. CRISP's network provides Medicaid and providers access to data and tools improving individual's health, quality of care, and Maryland's population health. Health care providers and MCOs are sharing clinical documents with CRISP, including care plans in most cases. Care plans are not edited within a central source, but they are available to all members of the care team and therefore influence the design and updates of local care plans and coordination efforts.
	Future State: Describe the future state of the health IT functionalities outlined below: CRISP has developed a separate module for Maryland's Maternal Opioid Misuse Model (MOM Model) called the MOM Care Coordination Module (MOM CCM) that houses a care plan and care plan update. Patient providers have access to CRISP and can view the MOM CCM. Care alerts also sent that are MOM specific when a patient enrolls into MOM and upon discharge that other providers can see within CRISP. In the future, this type of model could be replicated in combination with other care coordination components and analytic tools to identify persons during their first episode of psychosis and improve the care coordination as well as the workflow.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Maryland will continue to work with the HIE to develop care alerts and leverage data available in the HIE to better

9/28/21 Submitted on 9/28/21	coordinate care for individuals with SMI. CRISP is working to establish more connectivity with mental health providers. CRISP will link patient consents and records across settings and make them available based on consent preferences.

Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Parents and caretakers have access to their children's records; however, at this time the care team does not have the ability to link a child's electronic medical records with their respective parent/caretaker medical records.
	Future State: Describe the future state of the health IT functionalities outlined below: The future state of this health IT functionality is unknown at this time.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Specific action items are unknown at this time.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* Much of the provider community, both somatic and mental health, connects to CRISP and share patient rosters. These connections create a robust Master Person Index, which can link records across settings. CRISP links and shares somatic episodes of care and their corresponding clinical documents.
	Future State: CRISP is working to establish more connectivity with mental health providers. CRISP will link patient consents and records across settings and make them available based on consent preferences.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Establish connectivity with mental health providers, assure EMR update among providers

- **Section 3: Relevant documents**

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.