The Centers for Medicare & Medicaid Services (CMS) customized the Monitoring Report Template (Version 3.0) to support Maryland's retrospective reporting of monitoring data for its section 1115 substance use disorder (SUD) demonstration. The state should use this customized template to report on retrospective metric trends as requested in the Monitoring Report Instructions (p. 12 of Version 3.0). This template was customized for retrospective reporting in the following ways:

- Added footnote C to the title page in section 1
- The table in section 3 (Narrative information on implementation, by milestone and reporting topics) has been modified to ask the state to report general trends for each Milestone, rather than changes (+ or -) greater than 2 percent for each metric.
- The prompts in section 3 that requested implementation updates were removed.
- Section 4 (Narrative information on other reporting topics) has been removed entirely.

1. Title page for the state's SUD demonstration or the SUD component of the broader demonstration

CMS has pre-populated the title page for the state (see blue text). The state should review the pre-populated text and confirm that it is accurate. Definitions for certain rows are below the table.

State	Maryland
Demonstration name	Maryland HealthChoice
Approval period for section 1115 demonstration	01/01/2017–12/31/2021
SUD demonstration start date[a]	01/01/2017
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	07/01/2017

SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	The coverage of residential treatment and withdrawal management services expands Maryland's current SUD benefit package to cover the full continuum for care for SUD treatment as described in the national treatment guidelines published by the American Society of Addiction Medicine (ASAM Criteria). SUD services approved through the state plan as well as residential treatment and withdrawal management services approved through this demonstration will be available to all Maryland Medicaid participants aged 21-64 with the exception of dual eligibles. ASAM levels 3.3-3.7WM will be covered beginning July 1, 2017. ASAM level 3.1 will be covered beginning January 1, 2019. Dual eligibles will be covered for SUD residential treatment services for ASAM levels 3.1-3.7WM beginning January 1, 2020. ASAM level 4.0 coverage for all Maryland Medicaid participants aged 21-64 with a primary diagnosis of SUD and a secondary mental health condition will begin July 1, 2019. An independent evaluation will assess whether the SUD program reforms and services delivered through this demonstration are effective in improving health outcomes and decreasing healthcare costs and utilization. The evaluation is designed to demonstrate achievement of Maryland's goals, objectives, and metrics for the demonstration. Thus, the specific aims of the evaluation, which align with the demonstration's goals and objectives, are to capture the impact of the demonstration on increased access to clinically appropriate care; reduced substance use related deaths; and reduced emergency department visits. In addition, researchers will assess the impact of providing the full continuum of SUD services, especially residential treatment, on emergency department utilization, inpatient hospital utilization, and readmission rates to the same level of care or higher.
SUD demonstration year and quarter[c]	SUD DY2Q3–DY5Q4
Reporting period[c]	07/31/2023

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the effective date listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1,

2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions for mental disease.

[c] **SUD demonstration year and quarter, and reporting period.** The demonstration year, quarter, and calendar dates associated with the monitoring reports in which the metric trends would have been reported according to the reporting schedule in the state's approved monitoring protocol. For example, if the state's first monitoring report after monitoring protocol approval is its SUD DY2Q3 monitoring report, the retrospective reporting period is considered SUD DY1Q3 through SUD DY2Q2. The SUD DY1Q1 and DY1Q2 reporting periods are not listed because metrics data are reported with a two-quarter lag.

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information of metrics trends from the retrospective reporting period. The recommended word count is 500 words or less.

Since January 2015, the Department has operated under an ASO model to deliver behavioral health services. Specialty substance use disorder (SUD) and mental health (MH) services are carved out of the HealthChoice MCO benefits package and are administered by an ASO. In 2019, the Department selected Optum as the new ASO, as part of a competitive re-procurement, and transition efforts began in mid-2019.

A major goal of the HealthChoice program is to expand coverage to residents with low incomes and to improve access to health care services for the Medicaid population. HealthChoice has largely succeeded. On January 1, 2015, Maryland combined mental health and SUD services in an integrated carve-out. Under the carve-out, an administrative services organization (ASO) administers and reimburses all specialty mental health and SUD services for Medicaid participants on an FFS basis, under the oversight of the Medicaid program and the Behavioral Health Administration (BHA). Between CY 2019 and CY 2020, overall program enrollment increased by 11.2%, from 1,202,718 to 1,337,378 participants. This dramatic change was likely driven by the COVID epidemic and consequent policy changes.

From the inception of the HealthChoice program in 1997, mental health services were carved out of the benefit package, while services for individuals with SUDs were provided by the MCOs. On January 1, 2015, Maryland combined mental health and SUD services in an integrated carve-out. Under the carve-out, an administrative services organization (ASO) administers and reimburses all specialty mental health and SUD services for Medicaid participants on an FFS basis, under the oversight of the Medicaid program and the Behavioral Health Administration (BHA). The number of participants with an SUD diagnosis decreased by 1.7% from 132,920 in CY 2020 to 130,621 in CY 2021.

A request for amendment to Maryland's 1115 Waiver was approved in April 2020, establishing a Collaborative Care Model (CoCM) pilot program to integrate primary care and behavioral health services to further address behavioral health needs. Coverage for CoCM services for participants from HealthChoice began in July 2020.

In 2016, CMS approved Maryland Medicaid to expand coverage to include SUD treatment in IMDs. Effective July 1, 2017, the approval permitted otherwise-covered services to be provided to Medicaid-eligible individuals aged 21 to 64 who are enrolled in an MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) residential levels 3.1, 3.3, 3.5, 3.7, and 3.7-WM (licensed as 3.7D in Maryland) for up to two non-consecutive 30-day stays annually. In March 2019, the Department received approval to extend coverage for the Residential Treatment for Individuals with a primary SUD and a secondary mental health disorder (MHD) to ASAM level 4.0. Between CY 2019 and CY 2020, the number of participants using an IMD decreased by 16.8% from 16,066 in CY 2019 to 13,364 in CY 2020. A change likely impacted by the COVID epidemic.

As of June 2023, the Department covers the following SUD services:

SUD SERVICES	ASAM Criteria
A major goal of the HealthChoice program is to expand coverage to residents with low incomes and to improve access to health care services for the Medicaid population. HealthChoice has largely succeeded. On January 1, 2015, Maryland combined mental health and SUD services in an	N/A

integrated carve-out. Under the carve-out, an administrative services organization (ASO) administers and reimburses all specialty mental health and SUD services for Medicaid participants on an FFS basis, under the oversight of the Medicaid program and the Behavioral Health Administration (BHA). In 2016, CMS approved Maryland Medicaid to expand coverage to include SUD treatment in IMDs. Effective July 1, 2017, the approval permitted otherwise-covered services to be provided to Medicaid-eligible individuals aged 21 to 64 who are enrolled in an MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) residential levels 3.1, 3.3, 3.5, 3.7, and 3.7-WM (licensed as 3.7D in Maryland) for up to two non-consecutive 30-day stays annually.	
Substance Use Disorder Assessment (CSAA)	N/A
Group Outpatient Therapy	Level 1- Outpatient Service
Individual Outpatient Therapy	Level 1- Outpatient Service
Ambulatory Detoxification	Level 1- Outpatient Service

Intensive outpatient (IOP)	Level 2.1- Intensive Outpatient Service
Partial Hospitalization	Level 2.5- Partial Hospitalization
Clinically Managed Low-Intensity Residential Services	Level 3.1 - Residential/Inpatient Services
Clinically Managed Population-Specific High-Intensity Residential Services	Level 3.3 - Residential/Inpatient Services
Clinically Managed High-Intensity Residential Services	Level 3.5 - Residential/Inpatient Services
Medically Monitored Intensive Inpatient Services	Level 3.7 - Residential/Inpatient Services
Medically Monitored Intensive Inpatient Services	Level 3.7WM (Withdrawal Management) - Residential/Inpatient Services
Medically Managed Intensive Inpatient Services	Level 4.0 - Inpatient Services
Methadone/Buprenorphine: Induction and Maintenance	Level OMT- Opioid Maintenance Therapy

Medicaid covers all FDA-covered pharmaceuticals. Additional medication-assisted treatment covered with clinical criteria: · Buprenorphine/Naloxone combination therapies: Bunavail, Suboxone, Suboxone Film, and Zubsolv · Campral · Naltrexone · Subutex – Buprenorphine · Vivitrol	N/A
ICF-A: Under 21	Medically monitored intensive inpatient treatment: · Level 3.7WM · Level 3.7 · Level 3.5
Intensive Inpatient Services	Level 4 – Inpatient Services and Level 4.0 WM
Certified Peer Recovery Specialists	N/A

Consistent with CMS guidance, coverage in the future waiver period will be available for up to two non-consecutive 30-day stays every 12 months.

3. Narrative information on implementation, by milestone and reporting topic

The state should provide a general summary of metric trends by milestone and reporting topic for the entire retrospective reporting period. In these general summaries, the state should discuss any relevant trends that the data shows related to each milestone or reporting topic, including trends in state-specific metrics.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
1. Assessment of need and qualification for SUD services			
1.1 Metric trends			
1.1.1. The state reports the following metric trends related to assessment of need and qualification for SUD services	**X**	**Metric #3: Medicaid Beneficiaries with SUD Diagnosis** **Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually)**	
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.1 Metric trends			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
2.1.1 The state reports the following metric trends related to Milestone 1	**X**	**Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder**	
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.1 Metric trends			
3.1.1 The state reports the following metric trends related to Milestone 2		**Metric #5. Medicaid Beneficiaries Treated in an IMD for SUD** **Metric #36: Average Length of Stay in IMDs**	**The percent difference for Metric #5: "Medicaid Beneficiaries Treated in an IMD for SUD" from DY4Q2 to DY5Q2 was -16.8%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment, and state policy changes expanding access to residential treatment and withdrawal management.**

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.1 Metric trends			
4.1.1 The state reports the following metric trends related to Milestone 3 **Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.**	**X**		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.1 Metric trends			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
5.1.1 The state reports the following metric trends related to Milestone 4		**Metric #13: SUD Provider Availability** **Metric #14: SUD Provider Availability - MAT**	**The percent difference for "Metric #13. SUD Provider Availability" from DY4Q2 to DY5Q2 was 65.3%. The state estimates that reasons for the difference have been expected variability in metric results, the COVID pandemic's impact on service utilization and Medicaid enrollment, and state policy changes expanding access to residential treatment and withdrawal management.** **The percent difference for "Metric #14. SUD Provider Availability - MAT" from DY4Q2 to DY5Q2 was 66.2%. The state estimates that reasons for the difference have been expected variability in metric results, the COVID pandemic's impact on service utilization and Medicaid enrollment, and state policy changes expanding access to residential treatment and withdrawal management.**
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.1 Metric trends			

6.1 The state reports the following metric trends related to Milestone 5		**Metric #18. Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)**	**The percent difference for Metric #18: "Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)" from DY4Q2 to DY5Q2 was -25.6%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.**
		Metric #21. Concurrent Use of Opioids and Benzodiazepines (COB-AD)	**The percent difference for Metric #21: "Concurrent Use of Opioids and Benzodiazepines (COB-AD)" from DY4Q2 to DY5Q2 was -20%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric #27. Overdose Deaths (rate)	**The percent difference for Metric #27: " Overdose Deaths (rate)" from DY4Q2 to DY5Q2 was 23.1%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric #36. Average Length of Stay in IMDs	

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
			The percent difference for "Metric #36. Average Length of Stay in IMDs" from DY4Q2 to DY5Q2 was 12.2%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment, and state policy changes expanding access to residential treatment and withdrawal management.
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.1 Metric trends			

7.1.1 The state reports the following metric trends related to Milestone 6		**Metric #25. Readmissions Among Beneficiaries with SUD**	**The percent difference for Metric #25: "Readmissions Among Beneficiaries with SUD" from DY4Q2 to DY5Q2 was 6.7%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S2. Adjusted Initiation of AOD Treatment - Alcohol abuse or dependence	**The percent difference for "Metric S2. Adjusted Initiation of AOD Treatment - Alcohol abuse or dependence" from DY4Q2 to DY5Q2 was 2.7%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S3. Adjusted Initiation of AOD Treatment - Opioid abuse or dependence	**The percent difference for "Metric S3. Adjusted Initiation of AOD Treatment - Opioid abuse or dependence" from DY4Q2 to DY5Q2 was -6.7%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S4. Adjusted Initiation of AOD Treatment - Other drug abuse or dependence	**The percent difference for "Metric S4. Adjusted Initiation of AOD Treatment - Other drug abuse or dependence" from DY4Q2 to**

		Metric S5. Adjusted Initiation of AOD Treatment - Total AOD abuse or dependence **Metric S6. Adjusted Engagement of AOD Treatment - Alcohol abuse or dependence** **Metric S7. Adjusted Engagement of AOD Treatment - Opioid abuse or dependence** **Metric S8. Adjusted Engagement of AOD Treatment - Other drug**	**DY5Q2 was 12.0%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.** **The percent difference for "Metric S5. Adjusted Initiation of AOD Treatment - Total AOD abuse or dependence" from DY4Q2 to DY5Q2 was -4.9%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.** **The percent difference for "Metric S6. Adjusted Engagement of AOD Treatment - Alcohol abuse or dependence" from DY4Q2 to DY5Q2 was -7.6%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.** **The percent difference for "Metric S7. Adjusted Engagement of AOD Treatment - Opioid abuse or dependence" from DY4Q2 to DY5Q2 was -15.1%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID**

		abuse or dependence	**pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S9. Adjusted Engagement of AOD Treatment - Total AOD abuse or dependence	**The percent difference for "Metric S9. Adjusted Engagement of AOD Treatment - Other drug abuse or dependence" from DY4Q2 to DY5Q2 was 4.0%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S10. Adjusted 31-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	**The percent difference for "Metric S9. Adjusted Engagement of AOD Treatment - Total AOD abuse or dependence" from DY4Q2 to DY5Q2 was -16.3%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S11. Adjusted 8-Day	**The percent difference for "Metric S10. Adjusted 31-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)" from DY4Q2 to DY5Q2 was -20.7%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID**

		Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	**pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S12. Adjusted 31-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	**The percent difference for "Metric S11. Adjusted 8-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)" from DY4Q2 to DY5Q2 was -22.3%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**
		Metric S13. Adjusted 8 Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	**The percent difference for "Metric S12. Adjusted 31-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)" from DY4Q2 to DY5Q2 was -19.3%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**

			The percent difference for "Metric S13. Adjusted 8 Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)" from DY4Q2 to DY5Q2 was -27.9%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.
8. SUD health information technology (health IT)			
8.1 Metric trends			

8.1.1 The state reports the following metric trends related to its health IT metrics		**Metric S1. Number of HealthChoice participants enrolled in corrective managed care program**	**The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY4Q2 to DY4Q3 was -9.7%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.** **The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY4Q3 to DY4Q4 was 3.4%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.** **The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY4Q4 to DY5Q1 was -14.1%. The state estimates that reasons for the difference have**

			been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number. **The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY5Q1 to DY5Q2 was -10.5%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.**
9. Other SUD-related metrics			
9.1 Metric trends			

9.1.1 The state reports the following metric trends related to other SUD-related metrics		**Metric #26. Overdose Deaths (count)**	**The percent difference for Metric #26: "Overdose Deaths (count)" from DY4Q2 to DY5Q2 was 24.5%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.**
		Metric S14. Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	**The percent difference for "Metric S14. Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD" from DY4Q2 to DY5Q2 was 5.9%. The state estimates that reasons for the difference have been expected variability in metric results and the COVID pandemic's impact on service utilization and Medicaid enrollment.**

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

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