

Maryland

UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/10/2020 12.43.54 PM)

Center for Substance Abuse Prevention

Division of State Programs

Center for Substance Abuse Treatment

Division of State and Community Assistance

and

Center for Mental Health Services

Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State SAPT DUNS Number

Number 609980255

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Maryland Department of Health

Organizational Unit Behavioral Health Administration

Mailing Address Spring Grove Hospital Center 55 Wade Avenue, Dix Building

City Catonsville

Zip Code 21228

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Lisa

Last Name Burgess

Agency Name Behavioral Health Administration - Maryland Department of Health

Mailing Address Spring Grove Hospital Center 55 Wade Avenue/Dix Bldg

City Catonsville

Zip Code 21228

Telephone 410-402-8452

Fax 410-402-8441

Email Address lisaa.burgess@maryland.gov

State CMHS DUNS Number

Number 135218621

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Maryland Department of Health

Organizational Unit Behavioral Health Administration

Mailing Address Spring Grove Hospital Center - Dix Building 55 Wade Avenue

City Catonsville

Zip Code 21228

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Lisa

Last Name Burgess

Agency Name Behavioral Health Administration-Maryland Department of Health

Mailing Address Spring Grove Hospital Center 55 Wade Avenue/Dix Bldg

City Catonsville

Zip Code 21228

Telephone 410-402-8452

Fax 410-402-8441

Email Address lisaa.burgess@maryland.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/3/2019 3:30:31 PM

Revision Date 8/10/2020 12:42:16 PM

VI. Contact Person Responsible for Application Submission

First Name Cynthia

Last Name Petion

Telephone 410-402-8468

Fax 410-402-8309

Email Address Cynthia.Petion@maryland.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Lisa A. Burgess, M.D.

Signature of CEO or Designee¹: _____

Title: MDH Deputy Secretary/Executive Director (Acting),
Behavioral Health Administration

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

- to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
 13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
 14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
 15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
 17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
 18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
 19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Maryland

Name of Chief Executive Officer (CEO) or Designee: Lisa A. Burgess, M.D.

Signature of CEO or Designee¹: L.A. Burgess, M.D.

Title: MDH Deputy Secretary/Executive Director (Acting), Behavioral Health Administration

Date Signed: 08/03/2019

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Lisa A. Burgess

Title

MDH Deputy Secretary/Executive Director (Acting), Behavioral Health Administration

Organization

Behavioral Health Administration

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



LARRY HOGAN
GOVERNOR

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

August 26, 2019

Grants Management Officers
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857

Dear Grant Management Officers:

Federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. To expedite the processing of federal grants related to health, I designate the Secretary of Maryland's Department of Health (MDH) or the Secretary's designee to make future assurances, sign applications and agreements, and perform any similar act relevant to the Maryland Department of Health before your agency.

Sincerely,

A handwritten signature in blue ink that reads "Larry Hogan".

Larry Hogan
Governor

Cc: Robert Neall, Secretary, Maryland Department of Health




MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

MEMORANDUM

TO: Lisa A. Burgess, M.D.
Deputy Secretary, Behavioral Health, Maryland Department of Health/
Executive Director, Behavioral Health Administration

FROM: Robert R. Neall 
Secretary
Maryland Department of Health (MDH)

CC: Cynthia Petion
Acting Director, Systems Management
Behavioral Health Administration

DATE: August 29, 2019

SUBJECT: Delegation of Signatory Authority for the Mental Health Block Grant (MHBG) and
Substance Abuse Block Grant (SABG)

Effective August 29, 2019, pursuant to the Public Health Service Act, Title XIX Block Grants, Part B, Subpart I, Block Grants for Community Mental Health Services and Part B, Subpart II, Block Grants for Substance Abuse Prevention and Treatment, I hereby delegate to you as the Deputy Secretary of Behavioral Health/Executive Director of the Behavioral Health Administration the authority to sign funding agreements and certifications, to provide assurances of compliance to the Secretary, Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Mental Health Block Grant (MHBG) and the Substance Abuse Block Grant (SABG). This delegation is subject to an annual renewal so long as the referenced grant remains in effect, or said delegation of authority is otherwise rescinded.

The Community Mental Health Services Block Grant (MHBG) program provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions.

Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses (SMI) and to children with serious emotional disturbances (SED) and to monitor progress implementing a comprehensive, community-based mental health system.

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance;
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health, promotion, treatment, and recovery support services.

Maryland's FY 2018 Final MHBG Allotment was \$11,767,081. Maryland's FY 19 enacted budget was \$13,542,317. For FY 2020, proposed President's budget for Maryland is \$13,546,678. A slight increase of \$4,361. States are required to set-aside 10% for early intervention or first episode psychosis services. The required set-aside amount for FY 20 is \$1,354,668.

The MHBG funding supports the following services throughout Maryland:

- Crisis Response Systems/Services
- Implementation of Evidence Based Practices (Assertive Community Treatment (ACT), Supported Employment (SE), and Family Psycho Education (FPE)
- Early Intervention/First Episode Psychosis (10% Set-Aside) two sites
- Systems Evaluation/Research/Outcome Data
- Data Analysis
- School-Based Mental Health
- Housing Supports
- Public Awareness/Education/Training & Outreach
- Planning Council Technical Assistance

Maryland's FY 2018 Final SABG Allotment was \$34,083,574. In FY19, the enacted budget was \$34,085,216. For FY 2020, the proposed President's budget for Maryland is \$34,075,886 a slight decrease of \$9,330. States are required to set aside 20% for prevention services. The set aside amount is \$6,815,177. SABG funds support substance use treatment, prevention and intervention services. SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) administers the Substance Abuse Block Grant funds (SABG).

The SABG supports the following services in Maryland:

- Substance Use Disorder (SUD) treatment across all ASAM levels of care
- Primary Prevention
- Tobacco Use Prevention – SYNAR Amendment
- Women's Services (Pregnant Women and Women with Dependent Children)
- HIV/AIDS Services – 5% set aside
- Overdose Prevention
- Systems Evaluation/Research/Outcome Data
- Data Analysis
- Recovery Support Services
- Tuberculosis Services



DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Behavioral Health Administration

Lisa A. Burgess, M.D.
(Acting) Deputy Secretary/Executive Director
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

Attention: Anna De Jong, Program Official
Wendy Pang, Grants Specialist

RE: MJ Attestation Letter

Project Title: Substance Abuse Prevention & Treatment Block Grant

Grant Number: 2B08TI010024-19/**FAIN:** B08TI010024-19

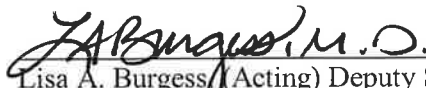
Budget Period: 10/01/2018 – 09/30/2020

Dear Sir/Madam

This is certify that the Maryland Department of Health, State, and all sub-recipients comply with the following Special Condition/Term of Award:

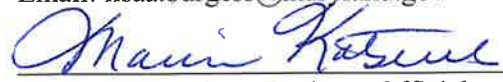
Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to “ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.”); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Sincerely,



Lisa A. Burgess (Acting) Deputy Secretary/Executive Director
Phone: (410) 402-8452
Email: lisaa.burgess@maryland.gov

11/11 2019
Date



Marion Katsereles – Business Official
Phone: (410) 402-8409
Email: marion.katsereles@maryland.gov

10/30/19
Date

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Lisa A. Burgess, M.D.

Signature of CEO or Designee¹: _____

Title: MDH Deputy Secretary/Executive Director (Acting),
Behavioral Health Administration

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

- State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §57401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
 13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
 14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
 15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
 17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
 18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
 19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

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The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
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- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
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1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Lisa A. Burgess, M.D.

Signature of CEO or Designee¹: *L.A. Burgess, M.D.*

Title: MDH Deputy Secretary/Executive Director (Acting),
Behavioral Health Administration

Date Signed: 09/03/2019

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Lisa A. Burgess

Title

MDH Deputy Secretary/Executive Director (Acting), Behavioral Health Administration

Organization

Behavioral Health Administration

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



LARRY HOGAN
GOVERNOR

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

August 26, 2019

Grants Management Officers
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857

Dear Grant Management Officers:

Federal government agencies routinely require that the Chief Executive Officer of a State or his designee sign official grant documents. To expedite the processing of federal grants related to health, I designate the Secretary of Maryland's Department of Health (MDH) or the Secretary's designee to make future assurances, sign applications and agreements, and perform any similar act relevant to the Maryland Department of Health before your agency.

Sincerely,

Larry Hogan
Governor

Cc: Robert Neall, Secretary, Maryland Department of Health




MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

MEMORANDUM

TO: Lisa A. Burgess, M.D.
Deputy Secretary, Behavioral Health, Maryland Department of Health/
Executive Director, Behavioral Health Administration

FROM: Robert R. Neall 
Secretary
Maryland Department of Health (MDH)

CC: Cynthia Petion
Acting Director, Systems Management
Behavioral Health Administration

DATE: August 29, 2019

SUBJECT: Delegation of Signatory Authority for the Mental Health Block Grant (MHBG) and
Substance Abuse Block Grant (SABG)

Effective August 29, 2019, pursuant to the Public Health Service Act, Title XIX Block Grants, Part B, Subpart I, Block Grants for Community Mental Health Services and Part B, Subpart II, Block Grants for Substance Abuse Prevention and Treatment, I hereby delegate to you as the Deputy Secretary of Behavioral Health/Executive Director of the Behavioral Health Administration the authority to sign funding agreements and certifications, to provide assurances of compliance to the Secretary, Substance Abuse and Mental Health Services Administration, and to perform similar acts relevant to the administration of the Mental Health Block Grant (MHBG) and the Substance Abuse Block Grant (SABG). This delegation is subject to an annual renewal so long as the referenced grant remains in effect, or said delegation of authority is otherwise rescinded.

The Community Mental Health Services Block Grant (MHBG) program provides funds and technical assistance to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions.

Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses (SMI) and to children with serious emotional disturbances (SED) and to monitor progress implementing a comprehensive, community-based mental health system.

Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Specifically, block grant recipients use the awards for the following purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance;
- Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health, promotion, treatment, and recovery support services.

Maryland's FY 2018 Final MHBG Allotment was \$11,767,081. Maryland's FY 19 enacted budget was \$13,542,317. For FY 2020, proposed President's budget for Maryland is \$13,546,678. A slight increase of \$4,361. States are required to set-aside 10% for early intervention or first episode psychosis services. The required set-aside amount for FY 20 is \$1,354,668.

The MHBG funding supports the following services throughout Maryland:

- Crisis Response Systems/Services
- Implementation of Evidence Based Practices (Assertive Community Treatment (ACT), Supported Employment (SE), and Family Psycho Education (FPE)
- Early Intervention/First Episode Psychosis (10% Set-Aside) two sites
- Systems Evaluation/Research/Outcome Data
- Data Analysis
- School-Based Mental Health
- Housing Supports
- Public Awareness/Education/Training & Outreach
- Planning Council Technical Assistance

Maryland's FY 2018 Final SABG Allotment was \$34,083,574. In FY19, the enacted budget was \$34,085,216. For FY 2020, the proposed President's budget for Maryland is \$34,075,886 a slight decrease of \$9,330. States are required to set aside 20% for prevention services. The set aside amount is \$6,815,177. SABG funds support substance use treatment, prevention and intervention services. SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) administers the Substance Abuse Block Grant funds (SABG).

The SABG supports the following services in Maryland:

- Substance Use Disorder (SUD) treatment across all ASAM levels of care
- Primary Prevention
- Tobacco Use Prevention – SYNAR Amendment
- Women's Services (Pregnant Women and Women with Dependent Children)
- HIV/AIDS Services – 5% set aside
- Overdose Prevention
- Systems Evaluation/Research/Outcome Data
- Data Analysis
- Recovery Support Services
- Tuberculosis Services



Maryland

DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Behavioral Health Administration

Lisa A. Burgess, M.D.
(Acting) Deputy Secretary/Executive Director
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

Attention: Michelle Gleason, Program Official
Wendy Pang, Grants Specialist

RE: MJ Attestation Letter

Project Title: Block Grants for Community Mental Health Services

Grant Number: 6B09SM010024-19M001/**FAIN:** B09SM010024-19

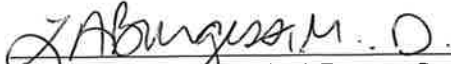
Budget Period: 10/01/2018 – 09/30/2020

Dear Sir/Madam

This is certify that the Maryland Department of Health, State, and all sub-recipients comply with the following Special Condition/Term of Award:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to “ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.”); 21 U.S.C. §§812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Sincerely,



Lisa A. Burgess, (Acting) Deputy Secretary/Executive Director

Phone: (410) 402-8452

Email: lisaa.burgess@maryland.gov

10/28/19
Date



Marion Katsereles – Business Official

Phone: (410) 402-8409

Email: marion.katsereles@maryland.gov

10/28/19
Date

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Lisa A. Burgess

Title

MDH Deputy Secretary/Executive Director (Acting), Behavioral Health Administration

Organization

Behavioral Health Administration

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

B. Planning Steps

For each of the populations and common areas, states should follow the planning steps outlined below:

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Overview of the State's Current Behavioral Health System

The Behavioral Health Administration (BHA) is a Division of the Maryland Department of Health (MDH) that is responsible for overseeing the delivery of public behavioral health services (PBHS). In general, Maryland currently provides or funds public behavioral health services in two ways, directly through its State psychiatric hospital system and by funding its managed fee-for-service system. BHA handles clinical and systemic issues, whereas, Medicaid's Behavioral Health Unit is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan.

BHA and Medicaid worked collaboratively to design integration of mental health and substance use (M/SUD) services. In partnership with BHA, Medicaid Office of Health Services contracts with the Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

The PBHS provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the ASO including inpatient, outpatient, residential treatment (for children and adolescents) and partial hospitalization. Services provided and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. Residential crisis services are also paid through the ASO.

SUD coverage includes a comprehensive assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient detoxification, and residential SUD treatment services at the 3.7WM, 3.7, 3.5, 3.3 and 3.1 levels. The ASO also pays for information and referral, prevention, and recovery support services.

Maryland continue to promote the goal of integration that is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to:

- A. Improve services for individuals with co-occurring conditions;
- B. Create a system of care that ensures a "no wrong door" experience;
- C. Expand access to appropriate and quality behavioral health services;
- D. Enhance cooperation and engagement;

- E. Capture and analyze outcome and other relevant measures for determining behavioral health provider and program effectiveness;
- F. Expand public health initiatives, and
- G. Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services.

Maryland provides inpatient psychiatric services directly to its citizens through a network of five psychiatric hospitals, one of which is a forensic facility, and two regional institutes for children and adolescents, or State operated Psychiatric Residential Treatment Facility (PTRF). This is the only area in which Maryland operates services directly. Upon admission, these may be individuals who were or were not eligible for Medical Assistance (MA). Generally, if an individual has MA eligibility, every effort will be made to provide hospital care in a community based inpatient setting, either in the psychiatric sector of an acute general hospital or in a private psychiatric hospital. Some of these individuals will also participate in the fee-for-service system during the same year in which they have a stay in a State facility; others either remain in the facility for the entire year or elect not to access public care when not in the hospital.

The majority of community PBHS services are funded through a managed fee-for-service system. Both services that are eligible for MA reimbursement and services that are not eligible for MA (e.g., residential rehabilitation services, level III SRD services, and some supported employment services) are funded through this mechanism. Further, services are funded both for individuals who are eligible for MA and individuals who are not eligible for MA. Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS. This system currently provides M/SUD services to 283,000 individuals through a network of over 3,500 individual, group, agency, and institutional service providers. The combined PBHS expenditures were over US\$ 1.4 billion, of which 90% were paid through Medicaid funds. ¹

Local Behavioral Health Entities

The PBHS is managed in collaboration with the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), Local Behavioral Health Authorities (LBHAs) and the Administrative Services Organization (ASO). The CSAs, LAAs and LBHAs are entities at the local level that have the authority and responsibility, in collaboration with BHA, to develop and manage a coordinated network of Maryland's public behavioral health services in a defined service area. These local behavioral health entities are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations.

They vary in size, needs, budgets, and budget sources. They are the administrative, program, and fiscal authority that are responsible for assessing local service needs and planning the implementation of a comprehensive local M/SUD delivery system that meets the needs of eligible individuals of all ages. The CSAs, LAAs and LBHAs are important points of contact for consumers, families, and providers in the PBHS and develop partnerships with other local,

¹ These figures are based on claims paid through 6/30/2019.

state and federal agencies. They provide numerous public education events and trainings. Additionally, local mental health advisory committees, CSA boards and local alcohol and drug abuse councils have the opportunity and responsibility to advise the CSAs/LAAs/LBHAs regarding the PBHS and to participate in the development of local M/SUD plans and budgets.

Recovery Supports

Recovery Residences - Maryland has legislation that requires MDH/BHA to approve a credentialing entity to develop and administer a certification process for recovery residences. This will include the development of guidelines and criteria for the oversight of recovery residences. Since BHA's implementation of Maryland Certification of Recovery Residences (MCORR), Recovery Residences are increasingly viewed as a viable and cost effective alternative to established recovery-oriented systems of care. Certified Recovery Residences reduces the probability of residents in early recovery returning to environments that foster addictive lifestyles, increasing the likelihood of relapse or continued substance use. Increasing the availability of housing ensures that Maryland's systems of care are responsive to the needs of all residents during their recovery process. As of July 2019, there are 222 certified recovery residences and 1836 certified beds in the State of Maryland.

Supported Employment: Supported Employment programs in Maryland provide job development, job coaching, and ongoing employment support services to individuals with serious mental illness for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences and skills. There are 59 provider sites licensed under COMAR 10.63 to provide supported employment services. Of those 59 provider sites, 27 or 46% of these supported employment providers are delivering services at the evidence-based practice fidelity threshold and are receiving an enhanced rate for supported employment.

Assertive Community Treatment: There are 43 provider sites licensed under COMAR 10.63 to provide mobile treatment services. Of those 43 provider sites, 23 or 54% of these providers are providing these services with fidelity or in accordance with empirically-supported standards and approved as assertive community treatment providers and are therefore eligible for an enhanced rate. The goal is to increase the 54% penetration rate of evidence-based practice as research supports that the use of these practices leads to positive treatment outcomes and ultimately improved quality of life for individuals. BHA believes that evidence-based practices should be widely available to individuals seeking services.

Targeted MH Case Management: There are currently 29 targeted case management providers. Targeted MH case management is available in all jurisdictions. Critical time intervention (CTI) is a time-limited evidence-based case management practice that mobilizes support for the most vulnerable individuals (individuals experiencing homelessness, individuals with a diagnosis of serious mental illness, SUD, or co-occurring) during periods of transition. Transitions include homelessness to permanent supportive housing, residential rehabilitation programs to permanent supportive housing, jail or prisons to permanent supportive housing, SUD residential services to

permanent supportive housing, or nursing home to permanent supportive housing. Research supports that the use of these practices leads to positive outcomes and ultimately improved quality of life for individuals. BHA currently funds CTI in two jurisdictions under the auspices of a time-limited federal grant which ends in September 30, 2019. BHA is exploring mechanisms for sustainability of the grant-funded services and, as funding permits, widespread dissemination and replication of CTI statewide.

MAT: MAT is an evidence-based practice that has been shown by research to be an effective approach to treating individuals with an opioid use disorder. To address the opioid epidemic, BHA has established MAT programs across the state. MAT expansion efforts have been strengthened by the award of three SAMHSA grants: Medication Assisted Treatment Prescription Drug Opioid Addiction (MAT PDOA), Maryland Medication Assisted Treatment Recovery Services (MD MATRS), and STR M.O.R.R. These grants were designed to increase access to and enhance services for individuals with an opioid use disorder by addressing unmet treatment need and enhancing prevention efforts, increase the use of MAT among opioid overdose survivors, increase adherence to MAT treatment, decrease illicit drug use by those receiving MAT, increase the length of stay in MAT, and reduce the number of patients leaving MAT against medical advice. As a result, MAT services are available in every jurisdiction in the state.

Despite its statewide availability, this service is underutilized due in part to stigma surrounding the use of pharmacological interventions to individuals who abuse or misuse substances. BHA will continue to work to eradicate the stigma surrounding MAT, exposing those who are in need to this life-saving, life restoring intervention. These awards were implemented to further efforts to promote and expand the use of MAT, BHA was recently awarded two federal grants, the MAT PDOA Pregnant Women and Women with Children grant, and the Maryland State Opioid Response (MD-SOR) grant, both of which took effect on September 30, 2008. Both grants will enhance and expand access to MAT Services, the former for Pregnant Women and Women with Children with an opioid use disorder, and the latter by increasing access to MAT using the three Federal Drug Administration approved medications for the treatment of opioid use disorder. In addition, the SOR grant will address the opioid crisis by fulfilling unmet treatment needs and reducing opioid overdose related deaths through the provisions of prevention, treatment and recovery activities for opioid use disorder (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs).

Peer Recovery Specialist Services: During FY18, BHA worked to expand the peer recovery specialist workforce and its supporting infrastructure. First, BHA integrated the oversight of both adult MH and substance use peer recovery support services.

Second, BHA expanded funding to support peer recovery specialist positions, training and education programs, and leadership and networking conferences. As a result of this additional funding, the peer workforce increased 40% during FY18. Due to the increase in the peer workforce, other state agencies, such as the Maryland Department of Human Services, Maryland Department of Public Safety and Correctional Services, and Maryland Department of Labor, Licensing and Regulation, are better able to serve individuals with behavioral health needs through their increased use of peer specialists.

Revision Request:

Step 1: Assess the strengths and organizational capacity of the service systems to address specific populations:

Overview of Maryland's Child and Adult Behavioral Health System of Care:

1. Child and Young Adult Behavioral Health Services

BHA's Office of Child, Adolescent, and Young Adult Services is charged with developing a system of care for children, adolescents, young adults and their families. This system of care covers those from early childhood up to the age of twenty five. It is designed to meet the needs of individuals within this age range who have mental health, substance-related disorders, and those who have co-occurring conditions. The Division evaluates the network of services that BHA funds for this age group and has the responsibility for statewide planning, development, administration and monitoring of provider performance to assure the highest possible level of quality in the delivery of services. It also manages a number of special projects and is responsible to work with all other child serving agencies at both the State and local levels to assure a highly coordinated and individualized approach to care.

- Development and implementation of an integrated and coordinated system of care;
- Oversight and guidance for all behavioral health services provided to children, adolescents and young adults and their families consistent with BHA's Vision and Mission;
- BHA's liaison to all child serving agencies in the State: Children's Cabinet- DHS, DJJ, MSDE, GOC and others as applicable;
- Oversight and problem resolution for local behavioral health authorities in matters related to the target population;
- Clinical oversight for BHA's facilities serving children and youth;
- Provide leadership for demonstration projects to improve service delivery approaches to population and special needs groups within the child and adolescent population.

The BHA funds and provides oversight for eight Adolescent Clubhouses. This statewide recovery oriented-support is designed for youth ages 12 – 17 receiving treatment for substance use disorders, including opioid use disorders, or following discharge from treatment. Each unique clubhouse uses evidence-based and promising practices to provide screening, intervention, and recovery support to adolescents. Through various approaches to substance use intervention and recovery, the clubhouse's recovery-oriented model supports diminishing triggers and cues that led to past substance abuse and uses youth driven activities to engage adolescents in more enriching and healthy ways.

The Student Assistance Program (SAP) Team provides training and implementation support to schools to better identify and respond to youth who are at-risk or currently using substances in Allegany, Prince George's and Baltimore City. There are three components to the SAP Team's initiative: (1) training school staff in Botvin Life Skills Substance Use Prevention Curriculum who will then deliver this curriculum to middle and high school students; (2) web-based Screening Brief Intervention and Referral to Treatment (SBIRT) Training for school nurses and counselors; and (3) tele-psychiatry consultation to support psychiatrists and training of local health providers on how to provide opioid use disorder tele-psychiatry.

Additionally, BHA provides administrative oversight of the day-to-day operations of residential and community-based programs for Transition-Aged Youth and Young Adult. There are 12 jurisdictions providing TAY RRP and/or PRP services.

- SAMHSA Now Is The Time-Healthy Transitions Grant (5 year- 10/2014-9/2019) known as Maryland Healthy Transitions (MD-HT) is enhancing services and supports for Transition-Aged Youth (TAY), ages 16-25, with or at Risk for Serious Behavioral Health Conditions. There are two Providers serving TAY for this grant: Humanim in Howard County and Pathways serving the Southern MD Tri-County region, St. Mary's, Calvert, and Charles County. The first year of the grant we had a goal to serve a total of 60 unduplicated TAY and then 80 unduplicated TAY in years 2-5. The program goals are to promote awareness of behavioral health challenges among TAY, increase early identification of TAY with behavioral health needs, and to provide coordinated evidence-based practices (EBPs) and supports to assist TAY in a successful transition into adulthood. As a result, the hope for TAY is to be involved in normative activities, including employment, continuing education, and contributing to the community.

Maryland Early Intervention Program/First Episode Psychosis- First Episode Psychosis programs serve youth and young adults, ages 15-30, with a diagnosis of schizophrenia spectrum disorder, diagnosed in accordance with DSM-V criteria, for which the current episode of psychosis is within two years of the first onset of psychiatric symptoms. Services are provided at: Maryland Psychiatric Research Center (MPRC) First Episode Clinic (FEC) in Baltimore County, serving 100 consumers a year; the Recovery After Initial Schizophrenia Episode Connection Program (RAISE CP) in Baltimore City, serving 30 consumers a year; OnTrack Maryland, in Montgomery County, serving 25 consumers a year; and The Johns Hopkins Early Psychosis Intervention Clinic in Baltimore City, serving 25 consumers a year. The 10% set-aside further supports recovery support services, such as person-centered planning, peer involvement, as well as a combined model of evidence-based supported employment and supported education

2. Adult and Older Adult Services

The Office of Clinical Services, Adults and Older Adults is comprised of five Divisions and is responsible for developing and managing an integrated system of care for adults and older adults in alignment with Maryland's Department of Health and BHA's mission and goals. The Office functions include:

- Developing policies and regulations related to clinical services for adults and older adults;
- Developing conditions of awards for local jurisdictions and monitors service deliverables and network adequacy;
- Providing administrative oversight of clinical treatment, recovery supports, evidence-based practices and housing supports;
- Providing technical advice and guidance to the local jurisdictions;
- Designing and implementing state and federally funded services and specialized programs;
- Identifying gaps in services and best practices to enhance access and quality of care;

- Design, develop and implement specialized, culturally sensitive and responsive initiatives to address the needs of individuals who have a mental illness and/or substance-related disorders who are deaf and hard of hearing;
- Directs, administers and oversees the statewide continuum of community-based outpatient behavioral health treatment services, including outpatient mental health centers, outpatient substance use treatment, mental health partial hospitalization programs (PHP), group practices, private licensed practitioners, and residential substance use treatment; and crisis services.
- Designs, plans, directs, implements and evaluates care management services, recovery supports, and community resources; and
- Co-leads the transition of grant funds to fee-for-service to support a fully integrated behavioral health system.

POPULATIONS – CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISORDERS (SED)

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined. This approximate loss in 2017 was 1,700 children. During this same period the total population (both adult and child) has grown slowly by approximately 3%, each year (36,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared

priority for publicly-funded services. BHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

POPULATIONS – ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or

- Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
- Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.
- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
- Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Behavioral Health Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

Overview of efforts to address the needs of diverse, racial, ethnic, and other minority groups

BHA continually strives to address the behavioral health needs of Maryland's diverse population groups and is working towards the elimination of health disparities. To this end, as discussed under the Health Disparities (section 2 of the Environmental Factors and Plan Heading), BHA developed a data-driven Cultural and Linguistic Competency Strategic Plan for FY 2019-2020 to assist its leadership and workforce as well as local behavioral health entities and providers in conducting self-assessment and setting CLC goals, objectives, strategies and measurable outcomes in the formation of policies, programs and provision of services. In addition, with technical assistance (TA) funds received from SAMHSA, BHA has been conducting training seminars and providing TA on cultural and linguistic competence (CLC) and the National Culturally and Linguistically Appropriate Services (CLAS) standards. The goal is to develop and broaden the cultural and linguistic competency of local, regional and state behavioral health entities, providers and those working with individuals with behavioral health needs; and to institute the National CLAS standards in Maryland's Public Behavioral Health System (PBHS). As part of the on-going efforts to ensure equitable access to and delivery of quality behavioral health services to all individuals served by PBHS, BHA will continue to require local behavioral health authorities to conduct CLC self-

assessment basis and institute CLC goals and measurable outcomes in their annual behavioral health plans.

PREVENTION REVISION REQUEST

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

REVISION REQUEST DETAIL:

Please add to this narrative a section that assess the strengths and organizational capacity of the service system to address the prevention population.

Please add the following:

- **Description of substance abuse prevention organization at all levels (i.e. state, regional, and local levels).**

State Level

The Office of Prevention of the Maryland Department of Health provides statewide leadership in the development of policies, programs, and services to prevent the use and/or misuse of substances that adversely impact health and safety.

Effective February 4, 2019, the Prevention programs shifted from being under the Behavioral Health Administration (BHA) to being under Public Health Services (PHS). The BHA will continue to play a central role in supporting public behavioral health treatment services, including treatment-related planning, workforce development, service quality improvement, credentialing and licensing, and treatment grant funding. PHS will assume responsibility for areas of substance use prevention and opioid response aligned with existing public health activities: surveillance, health promotion and prevention, screening, early intervention and referral into treatment. The Administrations will work closely together to fully integrate these services and maximize the effectiveness of operations.

The Maryland Behavioral Health Advisory Council (MBHAC) works to enhance behavioral health services statewide. And addresses a range of health concerns, including mental health, substance use disorders, and addictive behaviors. The Council advocates for a culturally comprehensive approach to publicly funded services for prevention, early intervention, and recovery services to support individuals with behavioral health disorders and their families. It has a membership that consists of 55 members from the recovery community, families, the advocate community, behavioral health organizations, the legislature, local behavioral health authorities, and state agencies.

The Council has established a committee structure which gives greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning, prevention, cultural and linguistic competency, children and adolescents, adults and older adults, criminal justice, crisis services, and community behavioral health services. The Prevention Committee is a standing committee, which provides guidance and advocacy in areas of behavioral health prevention across the lifespan. This may include areas such as substance misuse prevention, mental health promotion, suicide prevention, and preventing addictive

behaviors such as gambling. This committee may examine data and research; identify risk factors and evidence based practices; and make recommendations or suggest strategies to BHA as appropriate and/or as elements for further study. The BHAC Prevention Committee is a broad-based group of state and community representatives with a stake in reducing SUD and other behavioral health disorders in Maryland. It includes stakeholders in the areas of prevention, treatment, public health, mental health, education, juvenile services, etc. The membership advises BHA on matters such as how youth SUD specifically impacts their service population, risk and protective factors specific to these populations, special needs of these populations, and strategies for recruiting and providing services to these populations. This prevention-specific committee strengthens the state's prevention infrastructure by increasing inter-agency communication and planning regarding substance issues common across agencies.

The Prevention Committee will serve as Maryland's SPF Advisory Committee as required by SAMHSA/CSAP to guide and make recommendations to BHA in areas such as needs assessment, inter-agency coordination, strategic planning, program implementation, monitoring, and evaluation.

The Office of Population Health Improvement (OPHI) oversees Maryland's publicly-funded Substance Use Disorder (SUD) prevention system, providing funding annually to local jurisdictions for evidence-based prevention services. It also has contracts with the University of Maryland School of Pharmacy's Behavioral Health Research Team (BHRT) to provide technical assistance and evaluation services to all its prevention grantees. The School of Pharmacy also manages the State Epidemiological Outcomes Workgroup (SEOW). The MBHAC, its Prevention Committee, the BHRT, and the SEOW are specifically structured and intended to strengthen the capacity of Maryland's state and local prevention infrastructure.

Local Level

Maryland's prevention infrastructure is built upon our jurisdictional Prevention Coordinator network. BHA provides each of Maryland's 24 jurisdictions a portion of the state's SABG prevention set-aside based upon a population-based formula. This is the primary source of funding for their jurisdictional Prevention Coordinator, the local prevention activities they provide, the administrative costs related to their prevention services office, and in some instances other prevention program staff. In most instances these funds are provided to the jurisdiction's local health department. For monitoring and technical assistance purposes, Maryland has divided their 24 jurisdictions into four geographic regions (Western, Central, Southern, Eastern Shore).

SABG funds Substance Abuse Prevention Coordinators, other prevention office personnel, prevention office administration and a variety of other primary prevention strategies and programs instituted at the local level. Each jurisdiction develops its own unique SABG Strategic Prevention Plan which lays out the jurisdiction's specific substance abuse issues, resources, contributing factors, objectives and strategies. This plan is submitted to OPHI for review and approval and, upon approval, SABG funds are provided to the jurisdiction to implement its strategic plan. All jurisdictions must allocate at least 50% of their SABG Program

Implementation funds for strategies that are most likely to result in population level change. This includes environmental, community process, and information dissemination strategies.

- **Description of how substance abuse prevention services are delivered, including the role of the Single State Authority (SSA) and other state agencies with respect to the delivery of prevention services. Please indicate if prevention services are delivered directly by the SSA, through another entity or entities, or both.**

The Single State Authority (SSA)

The Behavioral Health Administration (BHA) is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention, treatment and recovery support services. The Single State Authority (SSA) for Maryland resides within the BHA and is responsible for planning, developing and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. The BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes public health and safety of patients, families and communities. The BHA designates, approves, plans and coordinates programming within Maryland that offers prevention, intervention, treatment and recovery support services; establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates “science to service” information relating to services for persons with SUDs, services for the prevention/diagnosis/treatment/rehabilitation of substance use, abuse and dependence, and support services to sustain the recovery beyond the treatment/rehabilitation episode.

The BHA is part of the Maryland Department of Health (MDH) and is responsible for overseeing the delivery of publicly funded addictions prevention and treatment services as well as responsibility for the oversight of public mental health services in Maryland. The BHA remains actively involved in activities to refine, enhance, and improvement management of the service delivery systems. The Deputy Secretary for Behavioral Health, oversees all aspects Behavioral Health integration under the leadership of the Secretary. The BHA, in collaboration with the departments, preserves and strengthens the service system through various efforts and places high priority on access to services and the development of a system in which services meet individual needs across the lifespan and efforts are coordinated that support recovery and resiliency. The BHA continues efforts to support the Department’s mission of fostering an integrated process for planning and collaboration, and of ensuring that a quality system of care is available for individuals with behavioral health disorders.

In February 2019, under the Secretary, the MDH reorganized Prevention services under the Deputy Secretary for Public Health Services (PHS) to further promote the integration. The Office of Prevention is currently located in The Office of Population Health Improvement (OPHI) under PHS. OPHI currently allocates and manages \$ 11,309,716 (State Fiscal Year 2020) in substance use disorder prevention funds annually to Maryland’s 24 local jurisdictions for the provision of locally planned and implemented prevention services. The funds are allocated through three major prevention grant programs: The Substance Abuse Block Grant Prevention Program, the Opioid Misuse Prevention Program (OMPP) and the Maryland Strategic Prevention Framework grant program (MSPF2). These programs are SAMHSA Center for Substance Abuse Prevention (CSAP)-funded prevention grant programs, all of which provide

grants to local jurisdictions for the provision of data-driven, evidence-based prevention activities at the community level.

Substance Abuse Block Grant (SABG) Prevention Program

Maryland's SABG Prevention Program (SABG) adheres to SAMHSA definitions, policies and best practices to plan, fund, implement, and evaluate a comprehensive array of data-driven, evidence based substance abuse prevention practices, strategies, and programs. Only primary prevention activities can be supported through this grant program, i.e., services for those who have not been identified as having a substance use disorder that requires treatment. Through this process, Maryland will support universal, selected and indicated prevention activities designed to reach a broad and diverse group of Maryland youth, at various levels of risk for substance use and abuse, resulting in a reduction of youth substance abuse at the population level. Each jurisdiction will develop its own unique SABG Strategic Prevention Plan which will lay out the jurisdiction's specific substance abuse issues, resources, contributing factors, objectives and strategies. This plan will be submitted to the Office for review and approval and, upon approval, the Office will provide SABG funds to the jurisdiction to implement its strategic plan.

Jurisdictions, based on their plans, can address the particular substances that are supported by their local data and endorsed by their planning body and may provide universal, selected or indicated primary prevention strategies. Since the Office of Prevention emphasizes change at the population-level, all jurisdictions must allocate at least 50% of their SABG Program Implementation funds for strategies that are most likely to result in population level change. This includes environmental, community process, and information dissemination strategies.

Jurisdictions may also provide any of the other SAMHSA strategies, which specifically target individuals and families rather than the entire community, with their remaining prevention block grant funds. However, all funds must be used for programs and strategies that research findings/evidence show to be effective or promising, and that are determined through the SPF planning process.

Opioid Misuse Prevention Program

The Opioid Misuse Prevention Program (OMPP) is a funding initiative to strengthen and enhance local overdose prevention plans and to implement evidence-based misuse prevention strategies contained in those enhanced plans. The purpose is to reduce opioid misuse, overdoses, and overdose fatalities by supporting the implementation of effective and sustainable prevention strategies throughout the State. Each participating jurisdiction works through the five SPF stages in order to plan and implement selected evidence-based strategies.

In year one of the program, jurisdictions conducted the first three steps of the SPF process (data collection/assessment, capacity building, and strategic planning) while implementing local multi-media communication campaigns designed to increase community awareness about opioid misuse. Various forms of media such as PSAs, billboards, information cards, fliers, television/radio ads, banners, posters, social media, and websites have been created to bring attention to this growing epidemic.

In year two of the program, jurisdictions completed their strategic plans and began implementing their data-driven, evidence-based strategies. These include prescriber education; dispenser education; Prescription Drug Monitoring Program (PDMP) awareness and enrollment; media campaigns about sharing, storing and disposal of prescription medications; youth education

regarding the risks and harms opioid misuse; public awareness of naloxone and the Good Samaritan Law; drug take back events and drop boxes; dissemination of locked storage boxes for parents and senior citizens; Screening Brief Intervention and Referral to Treatment (SBIRT); and training for law enforcement and first responders on referring users to treatment. Jurisdictions update their strategic plan activities each year based on updated needs assessment data.

The OMPP is supported by SABG Treatment funds meaning that both primary prevention and intervention strategies can be implemented with grant funds. The funded prevention and intervention strategies can provide primary prevention strategies targeted to the general population, intervention strategies to those who are at increased risk for misusing opioids, and treatment interventions for those who are already misusing opioids.

Maryland Strategic Prevention Framework (MSPF2) Grant Program

The Maryland Strategic Prevention Framework (MSPF2) Project provides CSAP SPF- Partnership for Success (PFS) grant funds to strengthen the efforts of 10 local community coalitions to prevent and reduce underage drinking, non-medical use of prescription drugs/opioids, youth binge drinking, youth marijuana use, and youth heroin use in their communities. These coalitions, with training and technical assistance provided by the Office's SPF Technical Assistance and Evaluation Team, are building upon their past successes and addressing challenges they had faced over the five years of the initial MSPF initiative.

Underage and youth binge drinking are the state's MSPF priorities as determined by a recent statewide youth AOD needs assessment. The primary recipients of the prevention strategies are 367,356 youth living in the ten selected communities. These communities were selected based on a formula that first considered prevalence indicators of youth alcohol use, consequences and contributing factors. This accounted for 70% of their selection score. The remaining 30% of the score was determined based on past coalition performance in bringing resources to bear, and each jurisdiction's contribution to the cultural diversity and geographic balance of the initiative.

The strategic plan outlines each of the programs Maryland supports. The programs are universal, and have selected and indicated prevention activities designed to reach a broad and diverse group of Maryland youth, who are at various levels of risk for substance use and abuse, resulting in a reduction of youth substance abuse at the population level. Each jurisdiction will develop its own unique SABG Strategic Prevention Plan which will lay out the jurisdiction's specific substance abuse issues, resources, contributing factors, objectives and strategies.

Additional Prevention Initiatives Funded with SABG 20% Prevention Set-Aside Funds

- Statewide Prevention System (Prevention Coordinator/Prevention Office in each of our 24 jurisdictions (our state infrastructure);
- A wide variety of Prevention Services in each jurisdiction;
- Four College ATOD Prevention Centers
- The Maryland State Epidemiology Work Group -Contract with UMD School of Pharmacy to provide current and relevant data to policy makers, planners, providers and citizens to help them to determine Maryland's substance use prevention and treatment needs and priorities.
- Maryland Collaborative to Reduce College Drinking and Related Problems (Contract) Co-Led by University of Maryland College Park and Johns Hopkins University.

- **Description of regional, county, tribal, and local entities that provide prevention services or contribute resources that assist in providing the services.**

Local Health Departments

Maryland's prevention infrastructure is built upon our jurisdictional Prevention Coordinator network. BHA provides each of Maryland's 24 jurisdictions a portion of the state's SABG prevention set-aside based upon a population-based formula. This is the primary source of funding for their jurisdictional Prevention Coordinator, the local prevention activities they provide, the administrative costs related to their prevention services office, and in some instances other prevention program staff. In most instances these funds are provided to the jurisdiction's local health department. For monitoring and technical assistance purposes, Maryland has divided their 24 jurisdictions into four geographic regions (Western, Central, Southern, Eastern Shore).

SABG funds Substance Abuse Prevention Coordinators, other prevention office personnel, prevention office administration and a variety of other primary prevention strategies and programs instituted at the local level. Each jurisdiction develops its own unique SABG Strategic Prevention Plan which lays out the jurisdiction's specific substance abuse issues, resources, contributing factors, objectives and strategies. This plan is submitted to OPHI for review and approval and, upon approval, SABG funds are provided to the jurisdiction to implement its strategic plan. All jurisdictions must allocate at least 50% of their SABG Program Implementation funds for strategies that are most likely to result in population level change. This includes environmental, community process, and information dissemination strategies.

- **Description of how the substance abuse prevention system addresses the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.**

Prevention practitioners must understand the cultural context of their target community, and have the willingness and skills to work within this context. Practitioners should draw on community-based values, traditions, and customs, in addition to working with knowledgeable persons of and from the community during planning, implementation, and evaluation of prevention activities.

SAMHSA and OPHI prevention grant programs emphasize the need for prevention grantees to adhere to the following CSAP Principles of Cultural Competence:

- Ensure community involvement in all areas
- Use a population-based definition of community (how the community defines itself)
- Stress the importance of relevant, culturally appropriate prevention approaches
- Employ culturally-competent evaluators
- Promote cultural competence among program staff and hire staff that reflect the community they serve
- Include the target population in all aspects of prevention planning

Other key principles to remember:

- Recognize that each group has unique cultural needs
- Significant diversity exists within cultures
- People have group and personal identities
- The dominant culture serves people from diverse backgrounds in varying degrees

- Culture is ever-present
- Cultural competence is not limited to ethnicity, but includes age, gender, disability, sexual identity and other variables

Grant program guidance documents have emphasized these principles as necessary components of effective comprehensive SPF Strategic Plans and BHA has convened cultural competency training and technical assistance sessions led by the SAMHSA's contractual technical assistance provider, the Center for the Application of Prevention Technologies (CAPT)

- **Description of the current prevention system's attention to Individuals in Need of Primary Substance Abuse Prevention.**

Substance Use Disorder Prevention Initiatives in Maryland

- Strategic Prevention Framework Strategic Plan for the Allocation of SAMHSA Substance Abuse Prevention Funds (July 1, 2017 - June 30, 2019).

The Strategic Prevention Framework Strategic Plan (SEE ATTACHED) describes the SAMSHA Strategic Prevention Framework (SPF) model used to allocate its Substance Abuse Block Grant prevention funding to prevent and reduce underage drinking, non-medical use of prescription drugs/opioids, youth binge drinking, youth marijuana use, and youth heroin use. These substances were identified as state prevention priorities by the State Behavioral Health Advisory Council's (BHAC) Prevention Committee in February 2017, based on the results of its statewide youth substance misuse needs assessment.

The strategic plan outlines each of the programs Maryland supports. The programs are universal, and have selected and indicated prevention activities designed to reach a broad and diverse group of Maryland youth, who are at various levels of risk for substance use and abuse (including those who have never used substances and are in need of primary substance abuse prevention), resulting in a reduction of youth substance abuse at the population level. Each jurisdiction will develop its own unique SABG Strategic Prevention Plan which will lay out the jurisdiction's specific substance abuse issues, resources, contributing factors, objectives and strategies.

Opioid Misuse Prevention Program

The Opioid Misuse Prevention Program (OMPP) is a funding initiative to strengthen and enhance local overdose prevention plans and to implement evidence-based misuse prevention strategies contained in those enhanced plans. The purpose is to reduce opioid misuse, overdoses, and overdose fatalities by supporting the implementation of effective and sustainable prevention strategies throughout the State. Each participating jurisdiction works through the five SPF stages in order to plan and implement selected evidence-based strategies. In year one of the program, jurisdictions conducted the first three steps of the SPF process (data collection/assessment, capacity building, and strategic planning) while implementing local multi-media communication campaigns designed to increase community awareness about opioid misuse. Various forms of media such as PSAs, billboards, information cards, fliers, television/radio ads, banners, posters, social media, and websites have been created to bring attention to this growing epidemic.

In year two of the program, jurisdictions completed their strategic plans and began implementing their data-driven, evidence-based strategies. These include prescriber education; dispenser education; Prescription Drug Monitoring Program (PDMP) awareness and enrollment; media campaigns about sharing, storing and disposal of prescription medications; youth education regarding the risks and harms opioid misuse; public awareness of naloxone and the Good Samaritan Law; drug take back events and drop boxes; dissemination of locked storage boxes for parents and senior citizens; Screening Brief Intervention and Referral to Treatment (SBIRT); and training for law enforcement and first responders on referring users to treatment. Jurisdictions update their strategic plan activities each year based on updated needs assessment data.

The OMPP is supported by SABG Treatment funds meaning that both primary prevention and intervention strategies can be implemented with grant funds. The funded prevention and intervention strategies can provide primary prevention strategies targeted to the general population, intervention strategies to those who are at increased risk for misusing opioids, and treatment interventions for those who are already misusing opioids.

Maryland Strategic Prevention Framework (MSPF2) Grant Program

The Maryland Strategic Prevention Framework (MSPF2) Project provides CSAP SPF-Partnership for Success (PFS) grant funds to strengthen the efforts of 10 local community coalitions to prevent and reduce underage and youth binge drinking in their communities. These coalitions, with training and technical assistance provided by BHA's SPF Technical Assistance and Evaluation Team, are building upon their past successes and addressing challenges they had faced over the five years of the initial MSPF initiative.

Underage and youth binge drinking are the state's MSPF priorities as determined by a recent statewide youth AOD needs assessment. The primary recipients of the prevention strategies are 367,356 youth living in the ten selected communities. These communities were selected based on a formula that first considered prevalence indicators of youth alcohol use, consequences and contributing factors. This accounted for 70% of their selection score. The remaining 30% of the score was determined based on past coalition performance in bringing resources to bear, and each jurisdiction's contribution to the cultural diversity and geographic balance of the initiative.

Goal 1 of the initiative is to reduce underage and youth binge drinking in Maryland. Its measurable objectives are (1) to reduce past 30-day *underage drinking* in the 10 selected jurisdictions and statewide and (2) to reduce past 30-day *binge drinking* by youth, ages 18-25, in the 10 jurisdictions and statewide. The interventions to attain this goal will primarily be evidence-based prevention strategies addressing key intervening variables for underage and youth binge drinking, including retail access to alcohol, social access, youth perception of harm and risk, community and social norms, enforcement of alcohol laws, alcohol pricing, and promotions. While it is expected that most strategies implemented will be environmental and community-process strategies, coalitions may augment these strategies with information dissemination and prevention education to strengthen community awareness of and support for their prevention efforts. Each participating jurisdiction works through the five SPF stages in order to plan and implement selected evidence-based strategies.

Goal 2 of the initiative is to strengthen state and local community prevention capacity and infrastructure. Its measurable objectives are (1) to increase the *capacity* of sub-recipient prevention coalitions through the provision of guidance, training and technical assistance and (2) to strengthen the state and local prevention *infrastructure* by leveraging, redirecting and

realigning the SABG resources administered by BHA to exclusively support evidence-based programs and strategies that are determined through the SPF process.

- **Description of the strengths of the state’s primary substance abuse prevention systems. Here you should describe any long-standing inter-agency relationships, coordinated planning, training systems, and any active network of prevention coalitions.**

BHA contracts with University of Maryland School of Pharmacy’s Behavioral Health Research Team (BHRT) to conduct community- and state-level evaluation activities. BHRT will collect, analyze, and report on all required state level and jurisdiction level performance measures. Grantees are required to contract with a local evaluator who assists them in their evaluation efforts, including but not limited to data identification and data collection to meet their grant goals and objectives. Local evaluators work closely with the State evaluator and report on process and outcomes performance measures at the jurisdiction level. These data collection and evaluation efforts will contribute to a comprehensive assessment of the BHA-funded prevention efforts at the state and jurisdiction levels.

The School of Pharmacy also manages and coordinates the State Epidemiology Outcomes Workgroup (SEOW) which collects, analyzes and disseminates information on state and jurisdictional level alcohol and other drug use, consequences and contributing factors.

The Office also contracts with the University of Maryland, College Park to administer the Maryland Collaborative to Reduce College Drinking and Related Problems, which provides guidance, training and technical assistance to participating colleges and their community partners assisting them to provide evidence-based individual and environmental-level prevention and intervention strategies

FY 2020-2021 Block Grant Application Revisions

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Please amend this narrative to include a specific description of the strengths and organizational capacity of the current services system. What is the role of the SSA? In addition, this narrative does not include any information on the SABG Priority populations, which is required.

STRENGTHS AND ORGANIZATIONAL CAPACITY

The Single State Authority (SSA)

The Behavioral Health Administration (BHA) is the state governmental entity responsible for the establishment and support of a comprehensive service delivery system that provides access to high quality and effective substance abuse prevention, intervention, treatment and recovery support services. The Single State Authority (SSA) for Maryland resides within the BHA and is responsible for planning, developing and funding services to prevent harmful involvement with alcohol and other drugs, and for treating individuals in need of addiction services. The BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes public health and safety of patients, families and communities. The BHA designates, approves, plans and coordinates programming within Maryland that offers prevention, intervention, treatment and recovery support services; establishes and develops standards, regulations and methods of treatment to be employed for the treatment of substance use disorders (SUDs); gathers information and maintains statistical/other records relating to SUDs; disseminates “science to service” information relating to services for persons with SUDs, services for the prevention/diagnosis/treatment/rehabilitation of substance use, abuse and dependence, and support services to sustain the recovery beyond the treatment/rehabilitation episode.

The BHA is part of the Maryland Department of Health (MDH) and is responsible for overseeing the delivery of publicly funded addictions prevention and treatment services as well as responsibility for the oversight of public mental health services in Maryland. The BHA remains actively involved in activities to refine, enhance, and improvement management of the service delivery systems. The Deputy Secretary for Behavioral Health, oversees all aspects Behavioral Health integration under the leadership of the Secretary. The BHA, in collaboration with the departments, preserves and strengthens the service system through various efforts and places high priority on access to services and the development of a system in which services meet individual needs across the lifespan and efforts are coordinated that support recovery and resiliency. The BHA continues efforts to support the Department’s mission of fostering an integrated process for planning and collaboration, and of ensuring that a quality system of care is available for individuals with behavioral health disorders.

BHA is responsible for overseeing the delivery of public behavioral health services (PBHS). In general, Maryland currently provides or funds public behavioral health services in two ways, directly through its State psychiatric hospital system and by funding its managed fee-for-service system. BHA handles clinical and systemic issues, whereas, Medicaid's Behavioral Health Unit is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan.

BHA and Medicaid worked collaboratively to design integration of mental health and substance use (M/SUD) services. In partnership with BHA, Medicaid Office of Health Services contracts with the Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving mental health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback.

Maryland continues to promote the goal of integration that is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to:

- A. Improve services for individuals with co-occurring conditions;
- B. Create a system of care that ensures a "no wrong door" experience;
- C. Expand access to appropriate and quality behavioral health services;
- D. Enhance cooperation and engagement;
- E. Capture and analyze outcome and other relevant measures for determining behavioral health provider and program effectiveness;
- F. Expand public health initiatives, and
- G. Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services.

The PBHS provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the ASO including inpatient, outpatient, residential treatment (for children and adolescents) and partial hospitalization. Services provided and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. Residential crisis services are also paid through the ASO.

SUD coverage includes a comprehensive assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient detoxification, and residential SUD treatment services at the 3.7WM, 3.7, 3.5, 3.3 and 3.1 levels. The ASO also pays for information and referral, prevention, and recovery support services.

Maryland provides inpatient psychiatric services directly to its citizens through a network of five psychiatric hospitals, one of which is a forensic facility, and two regional institutes for children and adolescents, or State operated Psychiatric Residential Treatment Facility (PTRF). This is the only area in which Maryland operates services directly. Upon admission, these may be individuals who were or were not eligible for Medical Assistance (MA). Generally, if an individual has MA eligibility, every effort will be made to provide hospital care in a community based inpatient setting, either in the psychiatric sector of an acute general hospital or in a private psychiatric hospital. Some of these individuals will also participate in the fee-for-service system during the same year in which they have a stay in a State facility; others either remain in the facility for the entire year or elect not to access public care when not in the hospital.

The majority of community PBHS services are funded through a managed fee-for-service system. Both services that are eligible for MA reimbursement and services that are not eligible for MA (e.g., residential rehabilitation services, level III SUD services, and some supported employment services) are funded through this mechanism. Further, services are funded both for individuals who are eligible for MA and individuals who are not eligible for MA. Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS. This system currently provides M/SUD services to 283,000 individuals through a network of over 3,500 individual, group, agency, and institutional service providers. The combined PBHS expenditures were over \$ 1.4 billion, of which 90% were paid through Medicaid funds. ¹

Maryland began the transition from grants to a Fee for Services (FFS) model for its Substance Use Disorder (SUD) ASAM 3.1 Services in 2017. The transition began with ASAM Levels 3.7, 3.5 and 3.3. In January 2018, the Specialty ASAM Levels 3.3 and 3.5 Residential Providers were also moved over to the FFS model and are being reimbursed through Medicaid and State funding. BHA in collaboration with Medicaid completed the final phase of the transition was completed in January 2019 when Medicaid included coverage of ASAM Level 3.1. MDH considered two options for how to move forward with reimbursing ASAM Level 3.1 providers and the decision was made to enroll ASAM level 3.1 providers and develop an all-inclusive daily rate for clinical/therapeutic services associated with ASAM 3.1 level of treatment.

The ASO and BHA provided trainings and technical assistance to providers both prior to full transition, as well after January 2019 through weekly calls with providers to discuss questions and concerns about the transition from grants to FFS.

In conjunction with the transition to a FFS model, in order to become an approved provider for this residential level of care, providers needed to be licensed under COMAR 10.63 as an ASAM level 3.1 provider. In addition, programs were required to be accredited in Order to be licensed to Provide Community-Based Behavioral Health Services. All accreditation-based programs had

¹ These figures are based on claims paid through 6/30/2019.

to 1) have accreditation from a Maryland Department of Health (MDH) approved accreditation organization; and 2) submit an application for licensure by no later than January 1, 2018. All programs were required to have a license under COMAR 10.63 regulations by no later than April 1, 2018.

Under State law, BHA has been selected to serve as the credentialing entity to develop and administer a process for the certification of recovery residences in accordance with nationally recognized certification standards established by the National Alliance for Recovery Residences (NARR). In accordance with statute, certification by the Department is required for recovery residences to operate in Maryland if the residence receives State or federal funds; operates as a certified recovery residence; is advertised or represented by any individual, partnership, corporation, or other entity as being a certified recovery residence; or has been implied to the public to be a certified recovery residence. Maryland currently has 228 certified recovery residences.

Local Behavioral Health Entities

The PBHS is managed in collaboration with the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), Local Behavioral Health Authorities (LBHAs) and the Administrative Services Organization (ASO). The CSAs, LAAs and LBHAs are entities at the local level that have the authority and responsibility, in collaboration with BHA, to develop and manage a coordinated network of Maryland's public behavioral health services in a defined service area. These local behavioral health entities are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations.

They vary in size, needs, budgets, and budget sources. They are the administrative, program, and fiscal authority that are responsible for assessing local service needs and planning the implementation of a comprehensive local M/SUD delivery system that meets the needs of eligible individuals of all ages. The CSAs, LAAs and LBHAs are important points of contact for consumers, families, and providers in the PBHS and develop partnerships with other local, state and federal agencies. They provide numerous public education events and trainings. Additionally, local mental health advisory committees, CSA boards and local alcohol and drug abuse councils have the opportunity and responsibility to advise the CSAs/LAAs/LBHAs regarding the PBHS and to participate in the development of local M/SUD plans and budgets.

In response to Maryland's FY 2018 State Budget Analysis language, a report on the feasibility of merging the Core Service Agencies (CSAs) and the Local Addictions Authorities (LAAs) to become the Local Behavioral Health Authorities (LBHAs) and systems managers at the local level was completed by the Department. BHA in collaboration with MDH secured the services of a nationally known consultant to look at defining integration, principles for integration, and identifying an integrated process for systems management.

The Behavioral Health Administration (BHA) has been working with local jurisdictions and other stakeholders to develop a plan to integrate systems management. The Local Systems Management Integration Project has made good progress with activities that promote development of an integrated approach. This has included the development of standardizing policies and procedures using MDH's Acadia platform, convening a Learning Collaborative for all local authorities led in partnership with Maryland Association of Behavioral Health Authorities (MABHA) and BHA, and completion of a self-assessment of each local authority of their systems management integration status. A training on Change Management was conducted and plans are set to do another one next year. This Integration Plan builds on an analysis of experiences in all 24 local jurisdictions, plus financial data that indicated opportunities to increase value from systems management. While all local jurisdictions have begun the journey toward integration, half have established a Local Behavioral Health Authority (LBHA) in lieu of their CSA and LAA, all have more integration work to do. The Plan lays out a roadmap with pathways and milestones to mark progress toward full management integration.

We have entered a phase where the local behavioral health authorities are addressing their roles and responsibilities in systems management. There is also an Advisory Group that meets quarterly to guide the project activities and input to key materials. We are assisting with working through challenges such as the separate funding streams, blending separate advisory councils for mental health and substance abuse, and limited local staff and budgeting to address integration in addition to their daily job tasks.

STRENGTHS

State Opioid Response (SOR) Grant

The SOR grant is designed to address Maryland's opioid crisis by increasing access to evidence-based treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and other recovery supports; creating links to somatic health care; and designing primary and secondary prevention methods, with an emphasis on peer supports for those with opioid use disorder (OUD). SOR funding will be used to implement new initiatives as well as to support the continuation of activities that were funded in year 1 of the Maryland Opioid Rapid Response (MORR) grant. The MORR grant is also funded through the state targeted response (STR) SAMSHA grant and is strategically aligned with the goals of Maryland's Opioid Operational Command Center (OCCC), established by Executive Order as a part of Governor Hogan's 2017 Heroin and Opioid Prevention, Treatment and Enforcement Initiative.

The goals of the MD SOR initiatives are:

- To prevent overdose fatalities through harm reduction outreach and naloxone distribution;

- Increase early identification of substance use and opioid related disorders,
- Expand access to recovery services through peer supports and increasing recovery housing for young adults, adults, and older adults;
- Enhance public and provider awareness of causes of opioid related disorders and resources available for solutions;
- Expand screening, intervention and referrals for treatment in Emergency Departments (EDs), OB/GYN offices, and colleges and universities;
- Expand access to MAT in local detention centers and other correctional facilities and crisis walk-in or stabilization centers,
- Increase the capacity to handle crises through 24/7 operated crisis walk-in centers, crisis beds and safe stations;
- Provide individualized recovery services across the age spectrum with the assistance of peers and increased housing choices; and
- Establish relationships with sub-acute nursing facilities and opioid treatment providers (OTPs).

Primary prevention is addressed through public awareness campaigns. Campaigns launched in Maryland received national recognition for the “Talk to your Doc” (TTYD) campaign and anti-stigma public service announcements (PSAs). STR funding supported digital media impressions through TV stations, digital media buying with Maryland Public Television (MPT), radio spots, and movie theater advertising. Through the SOR grant initiative, campaigns will be re-released to continue to expand the reach of messages through new media sources.

STR funding provides training and implementation support to middle and high schools to better identify and respond to youth who are at-risk or currently using substances through the Student Assistance Program (SAP). This initiative will advance locally and federally funded substance use prevention efforts by strengthening school’s ability to screen for substance use disorders. The SAP initiative will target school nurses and counselors in schools statewide who will then use the SBIRT framework to better identify, engage, and refer students using or at-risk of using substances.

In meeting the initiative’s goals of increasing access to treatment, SOR funding is used to expand MAT services. Maryland implemented a statewide buprenorphine access expansion plan, created additional residential treatment providers, co-located crisis services within residential treatment facilities, and expanded community recovery supports for individuals with opioid use disorders who are experiencing a substance use or mental health crisis. Access to treatment and recovery services is also expanded with the addition of buprenorphine induction and care coordination by Certified Peer Recovery Specialists (CPRS). Harm reduction initiatives and expansion of other, treatment and recovery activities are also being explored.

Within the SOR grant portfolio there is a major effort to increase crisis services. It is the intent that a full range of crisis services be enhanced. SOR funding will establish seven (7) walk-in centers statewide that will provide screening, monitoring, crisis stabilization (including linkages to crisis beds), care coordination to treatment and peer recovery services, MAT, and transportation assistance to ensure a warm handoff to the appropriate level of care. The centers will operate 24/7/365 and will be staffed by a dedicated crisis response team. The centers will serve adults who have an opioid and/or substance use disorder or were recently revived from an overdose and do not need emergency medical care and can be safely served in a community setting.

Crisis Services

In the 2018 Legislative Session, House Bill 1092/SB703 that established the Behavioral Health Crisis Response Grant Program which provides grants to local jurisdictions to establish and expand community behavioral health crisis response systems and services throughout the State. Three million dollars has been dedicated for FY2020 to create services that provide access or linkages to treatment through mobile crisis teams, crisis walk-in services or residential crisis beds to those in need of immediate, in person crisis intervention and stabilization. This funding opportunity is the product of a strategic plan conducted by the Crisis Subcommittee of the Behavioral Health Advisory Council (BHAC). The subcommittee searched best practices on the delivery of crisis interventions with particular focus on mobile crisis response and voluntary walk-in centers. All services will be implemented through a partnership between BHA, local jurisdictions, and community providers experienced in delivering behavioral health-related disorder services. A workgroup is being formed to work with BHA and other stakeholders to develop a proposal, and to grant the funding to certain jurisdictions. The workgroup will also furnish a report to the Governor and the General Assembly that describes the recipients, details of the programs proposed, identifies the amount of the award, and provides utilization and other outcome data.

Peer Recovery Specialist Services

BHA has been working to expand the peer recovery specialist workforce and its supporting infrastructure. BHA integrated the oversight of both adult MH and substance use peer recovery support services. They also expanded funding to support peer recovery specialist positions, training and education programs, and leadership and networking conferences. As a result of this additional funding, the peer workforce increased 40% during FY18. Due to the increase in the peer workforce, other state agencies, such as the Maryland Department of Human Services, Maryland Department of Public Safety and Correctional Services, and Maryland Department of Labor, Licensing and Regulation, are better able to serve individuals with behavioral health needs through their increased use of peer specialists.

Supported Employment

Supported Employment programs in Maryland provide job development, job coaching, and ongoing employment support services to individuals with serious mental illness for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences and skills. There are 59 provider sites licensed under COMAR 10.63 to provide supported employment services. Of those 59 provider sites, 27 or 46% of these supported employment providers are delivering services at the evidence-based practice fidelity threshold and are receiving an enhanced rate for supported employment.

PRIORITY POPULATIONS

Child and Young Adult

BHA's Office of Child, Adolescent, and Young Adult Services is charged with developing a coordinated system of care for children, adolescents, young adults and their families. This system of care covers those from early childhood up to the age of twenty five. It is designed to meet the needs of individuals within this age range who have mental health, substance-related disorders, and those who have co-occurring conditions. The Division evaluates the network of services that BHA funds for this age group and has the responsibility for statewide planning, development, administration and monitoring of provider performance to assure the highest possible level of quality in the delivery of services. It also manages a number of special projects and is responsible to work with all other child serving agencies at both the State and local levels to assure a highly coordinated and individualized approach to care.

The BHA funds and provides oversight for eight Adolescent Clubhouses. This statewide recovery oriented-support is designed for youth ages 12 – 17 receiving treatment for substance use disorders, including opioid use disorders, or following discharge from treatment. Each unique clubhouse uses evidence-based and promising practices to provide screening, intervention, and recovery support to adolescents. Through various approaches to substance use intervention and recovery, the clubhouse's recovery-oriented model supports diminishing triggers and cues that led to past substance abuse and uses youth driven activities to engage adolescents in more enriching and healthy ways.

The Student Assistance Program (SAP) Team provides training and implementation support to schools to better identify and respond to youth who are at-risk or currently using substances in Allegany, Prince George's and Baltimore City. There are three components to the SAP Team's initiative: (1) training school staff in Botvin Life Skills Substance Use Prevention Curriculum who will then deliver this curriculum to middle and high school students; (2) web-based Screening Brief Intervention and Referral to Treatment (SBIRT) Training for school nurses and counselors; and (3) tele-psychiatry consultation to support psychiatrists and training of local health providers on how to provide opioid use disorder tele-psychiatry.

SAMHSA Now Is The Time-Healthy Transitions Grant (5 year- 10/2014-9/2019) known as Maryland Healthy Transitions (MD-HT) is enhancing services and supports for Transition-Aged Youth (TAY), ages 16-25, with or at Risk for Serious Behavioral Health Conditions. There are two Providers serving TAY for this grant: Humanim in Howard County and Pathways serving the Southern MD Tri-County region, St. Mary's, Calvert, and Charles County. The first year of the grant we had a goal to serve a total of 60 unduplicated TAY and then 80 unduplicated TAY in years 2-5. The program goals are to promote awareness of behavioral health challenges among TAY, increase early identification of TAY with behavioral health needs, and to provide coordinated evidence-based practices (EBPs) and supports to assist TAY in a successful transition into adulthood. As a result, the hope for TAY is to be involved in normative activities, including employment, continuing education, and contributing to the community.

Maryland Early Intervention Program/First Episode Psychosis- First Episode Psychosis programs serve youth and young adults, ages 15-30, with a diagnosis of schizophrenia spectrum disorder, diagnosed in accordance with DSM-V criteria, for which the current episode of psychosis is within two years of the first onset of psychiatric symptoms. Services are provided at: Maryland Psychiatric Research Center (MPRC) First Episode Clinic (FEC) in Baltimore County, serving 100 consumers a year; the Recovery After Initial Schizophrenia Episode Connection Program (RAISE CP) in Baltimore City, serving 30 consumers a year; OnTrack Maryland, in Montgomery County, serving 25 consumers a year; and The Johns Hopkins Early Psychosis Intervention Clinic in Baltimore City, serving 25 consumers a year. The 10% set-aside further supports recovery support services, such as person-centered planning, peer involvement, as well as a combined model of evidence-based supported employment and supported education

Additionally, BHA provides administrative oversight of the day-to-day operations of residential and community-based programs for Transition-Aged Youth and Young Adult. There are 12 jurisdictions providing TAY RRP and/or PRP services.

Maryland's Commitment to Veterans (MCV)

The Department continues to prioritize efforts to address the behavioral health needs of veterans and their families. Maryland's Commitment to Veterans is a program under BHA that collaborates with the VA Maryland Health Care System, Maryland Department of Veterans Affairs as well as other state agencies and community providers. MCV assists veterans and their families with coordinating behavioral health services for the veteran, including mental health and substance abuse services- either with the VA or BHA. MCV also facilitates and covers transportation costs to behavioral health appointments for veterans and provides information and referrals related to employment, education, housing, and VA benefits. All MCV Regional Resource Coordinators are also Mental Health First Aid instructors. Maryland's Commitment to Veterans (MCV) is linking BHA Peer Support to VA Maryland Health Care Peers. Intent is to have peer training and collaboration among BHA peers in the community and VA peers working inside VA medical center.

Gender-Specific Services

The state of Maryland has a long history of providing gender specific, family centered substance use disorder treatment. When Maryland received the Federal Substance Abuse Prevention and Treatment Block Grant (SABG), the state began building a comprehensive system of care that included prevention, intervention, treatment and recovery services for pregnant women and women with dependent children. Maryland's Behavioral Health Administration's Office of Gender Specific Services provides oversight of treatment and recovery services for pregnant women and women with dependent children. These services include residential substance use treatment services, withdrawal management with child care services, legislatively mandated services for child welfare involved families that need substance use disorder treatment, and recovery supports for pregnant women and women with dependent children.

BHA required as a condition of Grant Award that all publicly funded programs develop policies and procedures to address the gender specific needs of this priority population to ensure that all pregnant women gain access to treatment services within 24 hours of request for services. These services can include screening, assessment, interim services, admission or referral for treatment. The Conditions of Grant Award are monitored by the Behavioral Health Administration's Treatment Compliance Unit. Compliance monitors residential treatment programs either quarterly or yearly, depending on the type of funding, to ensure adherence to the 24 hour requirement. If the program is not in compliance with the conditions of award, then they are required to submit a Plan of Correction to the Administration within 30 days of the site visit.

Currently the Behavioral Health Administration has gender specific treatment services at the following Levels of Care: Detoxification services, Level I- outpatient, Level II- Intensive Outpatient Services, Level III.3-Low Intensity Residential Services and Level III.3- Medium Intensive Co-Occurring Capable Residential Services. These services are for pregnant women and women with dependent children. The Level I MAT programs are the medication assisted treatment programs that can induce and maintain pregnant women and women with dependent children on medication assisted therapies and, if needed, provide interim services.

Maryland's Substance Use Disorder Treatment System for Pregnant Women and Women with Dependent Children

The state also adheres to the requirement for interim services for pregnant women and women with dependent children. All medication assisted programs have the ability to induce and maintain pregnant women on medication assisted treatment while attending and participating in a medication assisted program. If the pregnant client needs a higher level of care,

particularly residential treatment, then the program has the ability to refer the client to the appropriate level of care for treatment, while maintaining the patient on medication assisted treatment or referring her to another program for guess dosing. The residential provider may also receive medication assisted treatment for the client that will be supplied by the medication assisted treatment program. The program will transport the medication to the residential provider who will store the medication within a secure location at the residential program. The residential program will also have the ability to transport the client to the medication assisted treatment program for daily dosing if required.

Maryland requires that all treatment programs ensure that if a woman is pregnant, currently in treatment and does not have insurance, then the program will refer the woman to the Department of Social Services for insurance so that the pregnant client can be referred to an OB/GYN Doctor and or community clinic for prenatal care. The program will provide referrals for women that have dependent children for pediatric and child care. If, for some reason, a medication assisted program cannot admit a pregnant client immediately and finds it difficult placing this client into another treatment program, then the program will dose the pregnant patient daily until such time that an opening becomes available. The program will contact the State Opioid Treatment Authority (SOTA) immediately for assistance with placement for this client. Since this is a priority, this client will be first on the list for admission into treatment.

Maryland has two areas of the state that have limited services for pregnant women and women with dependent children. These areas are Western Maryland and Eastern Shore Maryland. Both areas have limited medication assisted treatment programs however the programs that are there are small and have difficulty maintaining the number of pregnant women and women with children in need of services. Typically, several of these women have been sent to Baltimore City for medication assisted therapy due to greater treatment availability for the population. Once the clients have been stabilized then, in most incidences, the clients are placed in residential programs, with ongoing medication assisted therapy. Once residential treatment is completed, the women with infants and/or dependent children are moved to, either outpatient treatment in their area or recovery housing to continue their recovery process.

BHA monitors program compliance related to tuberculosis services made available to individuals receiving SUD treatment through their Grant Monitoring Form. The form reviews whether, to prevent the transmission of TB, the program addresses screening patients and identifying high-risk individuals, meets all state reporting and confidentiality requirements and ensures that individuals receive case management services. In addition, programs are expected to ensure that TB services are made available to each individual receiving treatment for substance abuse. Services could include counseling, testing, or medical treatment. Lastly, the tool reviews the program's compliance with requirements to report all individuals with active TB to the local Health Department as required by State laws.

Persons at Risk of HIV

Statewide Services – HIV/AIDS Prevention/Maryland's Department of Health's Center for HIV Services

The BHA, partners with Prevention and Health Promotion Administration (PHPA), Center for HIV/STI Integration and Capacity to implement and sustain appropriate sexual health best practices for patients with behavioral health disorders.

- Funding goes to Maryland local health departments (LHDs) most impacted by HIV/AIDS;
- The purpose is to incorporate a sexual health framework in SUD treatment;
- HIV testing and linkages is the capstone intervention;
- Core elements of Sexual Health Integration Initiative include screening and referral, training and capacity development for behavioral health staff;
- The Sexual Health and Recovery intervention helps clients avoid relapsing due to patterns of sex/drug-linked behaviors.

Overview of efforts to address the needs of diverse, racial, ethnic, and other minority groups

BHA continually strives to address the behavioral health needs of Maryland's diverse population groups and is working towards the elimination of health disparities. To this end, as discussed under the Health Disparities (section 2 of the Environmental Factors and Plan Heading), BHA developed a data-driven Cultural and Linguistic Competency Strategic Plan for FY 2019-2020 to assist its leadership and workforce as well as local behavioral health entities and providers in conducting self-assessment and setting CLC goals, objectives, strategies and measurable outcomes in the formation of policies, programs and provision of services. In addition, with technical assistance (TA) funds received from SAMHSA, BHA has been conducting training seminars and providing TA on cultural and linguistic competence (CLC) and the National Culturally and Linguistically Appropriate Services (CLAS) standards. The goal is to develop and broaden the cultural and linguistic competency of local, regional and state behavioral health entities, providers and those working with individuals with behavioral health needs; and to institute the National CLAS standards in Maryland's Public Behavioral Health System (PBHS). As part of the on-going efforts to ensure equitable access to and delivery of quality behavioral health services to all individuals served by PBHS, BHA will continue to require local behavioral health authorities to conduct CLC self-assessment basis and institute CLC goals and measurable outcomes in their annual behavioral health plans.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁶ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

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Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Each year, BHA implements an extensive plan development process. As in previous years, BHA sent out Behavioral Health Plan Development guidelines to all the CSAs, LAAs and LBHAs in early November 2018. The guidelines required the local CSAs/LAAs/LBHAs to provide a description of the population they serve including special population groups such as children, pregnant women with dependent children, rural and homeless populations and older adults; highlight the M/SUD services provided during FY 2018-2019; identify priorities, strengths, needs and gaps of their jurisdiction's public behavioral health system (PBHS) for FY2020; provide claims/expenditure data on services provided to individuals with mental illness, including those with co-occurring M/SUD served in the PBHS; set goals and objectives with measurable strategies and performance indicators; and describe the involvement of local stakeholders in the evaluation of existing services and their planning process. All of Maryland's jurisdictions submitted their behavioral health plans and budgets to BHA in January/February 2019, which were then reviewed and approved by a BHA review team composed of staff from the Division of Planning and different offices such as Local Planning and Management; Child, Adolescent and Young Adult Services; Clinical Services, Consumer Affairs, Data Unit; Finance and Fiscal Management; and Workforce Development and Technology Transfer. In FY 2018 and FY 2019, BHA convened regional stakeholder meetings in Central, Eastern Shore, Southern and Western Maryland and facilitated strengths, weaknesses, opportunities, threats (SWOT) analysis. These meetings were well attended and brought together a wide range of stakeholders. There were representatives of consumer advocacy organizations, private/non-profit/public behavioral health providers including outpatient clinics, crisis and recovery services, hospitals, criminal justice services, peer support specialists, local mental health and addiction advisory committees, and local behavioral health authorities. The following are the common recommendations that emanated from the FY 2019 regional stakeholder planning meetings:

WORKFORCE DEVELOPMENT AND TRAINING

- Develop new and innovative approaches to professional recruitment and retention.
- Expand opportunities for training/professional development opportunities.
- Improve pay rates, address licensing and credentialing issues, and create incentives.

DATA COLLECTION/OUTCOMES

- Develop one standard approach to data collection with a set of quality indicators and measures.
- Develop outcomes based on client preference with emphasis on value based social determinants.
- Identify funding to incentivize performance-based outcomes.

RESOURCES AND SERVICES

- Increase services across the lifespan and for special/underserved populations such as older adults, TAY, children/adolescents, individuals with TBI/dementia and other minority groups.
- Expand telehealth, residential MH and SUD, wraparound, housing, mobile treatment and peer support services.

FINANCIAL/SYSTEMIC

- Develop better communication and collaboration between agencies, providers, and consumers to improve systems access and integration.
- Identify efforts to improve the process reimbursement structure/rates setting and the credentialing/licensing process to enhance provider service delivery.

The above described processes inform BHA's FY 2020-2021 Plan which goals and objectives includes priorities identified by Maryland's local CSAs/LAAs/LBHAs, stakeholders' recommendations and the core federal Block Grant goals and aims of the MHBG and SABG programs. BHA also share its bi-annual Plan with the Behavioral Health Advisory Council Planning Committee members for their review and inputs.

In addition, BHA has engaged the University of Maryland Baltimore System Evaluation Center to conduct a needs and gaps assessment of the Maryland PBHS service delivery system. The purpose of this work is to identify needs and gaps in the PBHS through a systematic, data informed review, analysis and summary of documents, and reports of needs assessments/gap analyses performed in Maryland since 2015, including reports at the state, jurisdiction, and community levels.

PREVENTION REVISION REQUESTS

Step 2: Identify the unmet service needs and critical gaps within the current system.

Please identify the unmet service needs and critical gaps within the current system. Please do this by providing the following:

- **A description of data sources used to identify primary prevention needs.**

The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas and populations most impacted by substance misuse and its consequences. Additionally, these data can assist with determining the most salient community contributing factors to target with the grantees' limited prevention resources. Ultimately the use of epidemiological data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements. The current data sources utilized are: Youth Risk Behavior Survey, National Survey on Drug Use and Health, Health Services Cost Review Commission, Maryland Youth Survey on Alcohol, Office of the Chief Medical Examiner data, Maryland Public Opinion Survey on Opioids, Maryland Department of Transportation data, Maryland Poison Control Center data, Maryland State Department of Education data, and Maryland Automated Accident Reporting System data.

- **A description of the state's SEOW, including its membership, and how the SEOW contributes to the process for prevention planning.**

The School of Pharmacy also manages the State Epidemiological Outcomes Workgroup (SEOW).

The SEOW assists in the identification of key AOD related data sources and relevant analyses specific to the SPF-PFS grant program and related to youth and young adult problematic drinking. It reviews available data and conducts analyses of the consumption of alcohol, tobacco and other drugs and the consequences of use in Maryland and then disseminates quarterly data briefs to key state, jurisdiction, and local stakeholders on trends, developments, and findings. One of the briefs focuses on key findings from the biennial Maryland Substance Use and Consequences Epidemiological Profile data. It also provides technical assistance to local health departments on how to generate and understand data.

- **And a discussion of primary prevention needs and gaps within the current system and how the state plans to meet these unmet service needs and gaps.**

During the summer and fall of 2016, the MBHAC Prevention Committee completed a statewide substance misuse prevention needs assessment. The purpose of this needs assessment was to provide data-driven recommendations to The Office of Prevention regarding the state prevention priorities that it should address with its federal substance misuse prevention grant funding.

At the Prevention Committee's July, August and September 2016 meetings, data was reviewed and discussed from:

- The 2015 Maryland State Substance Use and Outcomes Epidemiological Profile, a compendium of state and national substance use and consequences indicators;

- The 2015 National Survey on Drug Use and Health
- The 2014 Maryland Youth Risk Behavior Survey, a statewide survey of Maryland middle school and high school student health-related behaviors; and
- The 2016 Maryland Young Adult Alcohol Survey, a statewide survey of Maryland residents ages 18-25 regarding their perceptions, norms and use of alcohol.

On October 26, 2016, the Prevention Committee held an in-person meeting to review summaries and analyses of the AOD use and consequences indicators that had been presented at its last several committee meetings. Information was presented on underage drinking, binge drinking, nonmedical use of prescription drugs/opioids, marijuana, heroin, cocaine, and “synthetic marijuana” which were the substances most frequently reported being used by adolescents, youth, and young adults on state and national surveys.

Following an extensive discussion, substances were ranked by members as having high, moderate, or low Impact on Maryland’s overall substance abuse problem, looking at factors such as numbers directly impacted, numbers indirectly impacted, consequences of use, and costs of the consequences. The substance misuse issues were then ranked by Changeability. Changeability was defined as the likelihood that each substance under consideration could be reduced over the next 3-5 years based on the level of state resources available for addressing the problem; the experience and capacity of our local prevention providers; the level of evidence based practices that can be brought to bear on each particular substance; and the perceived political will to address each of the problems. A chart based on BHA’s assessment of the changeability of each substance, was developed to help inform this discussion.

Each committee member’s task was then to consider the discussions over the past several meetings and these Impact and Changeability considerations and provide their rankings of these substances from 1-7 (1 = highest; 7 = lowest). These individual substance use rankings would then be combined into a composite ranking and presented to all members prior to the December 2016 committee meeting. At that meeting, the committee would then finalize its recommendations to BHA regarding which substance use issues the BHA Office of Prevention should prioritize as it allocates its substance abuse prevention resources and applies for additional federal prevention resources.

On November 15, 2016 the summary of the October 26th meeting, with its rankings of substance issue Impact and Changeability, was sent to all members who were asked to review this material and provide their personal rankings of which substance use issues they believe should be the state’s prevention priorities.

On December 7, 2016, BHA compiled the rankings of the 9 members who responded and combined them into a composite ranking. At the December 13 Prevention Committee meeting, the participants reviewed the summary of its Substance Misuse Needs Assessment process and agreed to recommend the top five substance misuse issues that emerged from the needs assessment to BHA as the top state prevention priorities. They were #1) underage drinking, #2) nonmedical use of prescription drugs/opioids, #3 tie) youth binge drinking, #3 tie) heroin, #5) marijuana.

These recommendations will be included in the state’s Substance Misuse Prevention Strategic Plan that it submits to SAMHSA/CSAP. That plan will also detail how it will use its prevention resources to address these recommended state priorities.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Each year, BHA implements an extensive plan development process. As in previous years, BHA sent out Behavioral Health Plan Development guidelines to all the CSAs, LAAs and LBHAs in early November 2018. The guidelines required the local CSAs/LAAs/LBHAs to provide a description of the population they serve including special population groups such as children, pregnant women with dependent children, rural and homeless populations and older adults; highlight the M/SUD services provided during FY 2018-2019; identify priorities, strengths, needs and gaps of their jurisdiction's public behavioral health system (PBHS) for FY2020; provide claims/expenditure data on services provided to individuals with mental illness, including those with co-occurring M/SUD served in the PBHS; set goals and objectives with measurable strategies and performance indicators; and describe the involvement of local stakeholders in the evaluation of existing services and their planning process. All of Maryland's jurisdictions submitted their behavioral health plans and budgets to BHA in January/February 2019, which were then reviewed and approved by a BHA review team composed of staff from the Division of Planning and different offices such as Local Planning and Management; Child, Adolescent and Young Adult Services; Clinical Services, Consumer Affairs, Data Unit; Finance and Fiscal Management; and Workforce Development and Technology Transfer. In FY 2018 and FY 2019, BHA convened regional stakeholder meetings in Central, Eastern Shore, Southern and Western Maryland and facilitated strengths, weaknesses, opportunities, threats (SWOT) analysis. These meetings were well attended and brought together a wide range of stakeholders. There were representatives of consumer advocacy organizations, private/non-profit/public behavioral health providers including outpatient clinics, crisis and recovery services, hospitals, criminal justice services, peer support specialists, local mental health and addiction advisory committees, and local behavioral health authorities. The following are the common recommendations that emanated from the FY 2019 regional stakeholder planning meetings:

WORKFORCE DEVELOPMENT AND TRAINING

- Develop new and innovative approaches to professional recruitment and retention.
- Expand opportunities for training/professional development opportunities.
- Improve pay rates, address licensing and credentialing issues, and create incentives.

DATA COLLECTION/OUTCOMES

- Develop one standard approach to data collection with a set of quality indicators and measures.
- Develop outcomes based on client preference with emphasis on value based social determinants.
- Identify funding to incentivize performance-based outcomes.

RESOURCES AND SERVICES

- Increase services across the lifespan and for special/underserved populations such as older adults, TAY, children/adolescents, individuals with TBI/dementia and other minority groups.
- Expand telehealth, residential MH and SUD, wraparound, housing, mobile treatment and peer support services.

FINANCIAL/SYSTEMIC

- Develop better communication and collaboration between agencies, providers, and consumers to improve systems access and integration.
- Identify efforts to improve the process reimbursement structure/rates setting and the credentialing/licensing process to enhance provider service delivery.

The above described processes inform BHA's FY 2020-2021 Plan which goals and objectives includes priorities identified by Maryland's local CSAs/LAAs/LBHAs, stakeholders' recommendations and the core federal Block Grant goals and aims of the MHBG and SABG programs. BHA also share its bi-annual Plan with the Behavioral Health Advisory Council (BHAC) Planning Committee members for their review and inputs.

During the summer and fall of 2016, the BHAC Prevention Committee completed a statewide substance misuse prevention needs assessment. The purpose of this needs assessment was to provide data-driven recommendations to the BHA's Office of Prevention regarding the state prevention priorities that it should address with its federal substance misuse prevention grant funding.

At the Prevention Committee's July, August and September 2016 meetings, data was reviewed and discussed from:

- the 2015 Maryland State Substance Use and Outcomes Epidemiological Profile, a compendium of state and national substance use and consequences indicators;
- the 2015 National Survey on Drug Use and Health
- the 2014 Maryland Youth Risk Behavior Survey, a statewide survey of Maryland middle school and high school student health-related behaviors; and
- the 2016 Maryland Young Adult Alcohol Survey, a statewide survey of Maryland residents ages 18-25 regarding their perceptions, norms and use of alcohol.

On October 26, 2016, the Prevention Committee held an in-person meeting to review summaries and analyses of the AOD use and consequences indicators that had been presented at its last several committee meetings. Information was presented on underage drinking, binge drinking, nonmedical use of prescription drugs/opioids, marijuana, heroin, cocaine, and "synthetic marijuana" which were the substances most frequently reported being used by adolescents, youth, and young adults on state and national surveys.

Following an extensive discussion, substances were ranked by members as having high, moderate, or low Impact on Maryland's overall substance abuse problem, looking at factors such as numbers directly impacted, numbers indirectly impacted, consequences of use, and costs of

the consequences. The substance misuse issues were then ranked by Changeability. Changeability was defined as the likelihood that each substance under consideration could be reduced over the next 3-5 years based on the level of state resources available for addressing the problem; the experience and capacity of our local prevention providers; the level of evidence based practices that can be brought to bear on each particular substance; and the perceived political will to address each of the problems. A chart based on BHA's assessment of the changeability of each substance, was developed to help inform this discussion.

Each committee member's task was then to consider the discussions over the past several meetings and these Impact and Changeability considerations and provide their rankings of these substances from 1-7 (1 = highest; 7 = lowest). These individual substance use rankings would then be combined into a composite ranking and presented to all members prior to the December 2016 committee meeting. At that meeting, the committee would then finalize its recommendations to BHA regarding which substance use issues the BHA Office of Prevention should prioritize as it allocates its substance abuse prevention resources and applies for additional federal prevention resources.

On November 15, 2016 the summary of the October 26th meeting, with its rankings of substance issue Impact and Changeability, was sent to all members who were asked to review this material and provide their personal rankings of which substance use issues they believe should be the state's prevention priorities.

On December 7, 2016, BHA compiled the rankings of the 9 members who responded and combined them into a composite ranking. At the December 13 Prevention Committee meeting, the participants reviewed the summary of its Substance Misuse Needs Assessment process and agreed to recommend the top five substance misuse issues that emerged from the needs assessment to BHA as the top state prevention priorities. They were #1) underage drinking, #2) nonmedical use of prescription drugs/opioids, #3 tie) youth binge drinking, #3 tie) heroin, #5) marijuana.

These recommendations are included in the state's Substance Misuse Prevention Strategic Plan that it submits to SAMHSA/CSAP. The Plan also details how it will use its prevention resources to address these recommended state priorities.

The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas and populations most impacted by substance misuse and its consequences. Additionally, these data can assist with determining the most salient community contributing factors to target with the grantees' limited prevention resources. Ultimately the use of epidemiological data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements. The current data sources utilized are: Youth Risk Behavior Survey, National Survey on Drug Use and Health, Health Services Cost Review Commission, Maryland Youth Survey on Alcohol, Office of the Chief Medical Examiner data, Maryland Public Opinion Survey on Opioids, Maryland Department of Transportation data, Maryland Poison Control Center data, Maryland State Department of Education data, and Maryland Automated Accident Reporting System data.

The University of Maryland, School of Pharmacy, also manages the State Epidemiological Outcomes Workgroup (SEOW). The SEOW assists in the identification of key AOD related data sources and relevant analyses specific to the SPF-PFS grant program and related to youth and young adult problematic drinking. It reviews available data and conducts analyses of the consumption of alcohol, tobacco and other drugs and the consequences of use in Maryland and then disseminates quarterly data briefs to key state, jurisdiction, and local stakeholders on trends, developments, and findings. One of the briefs focuses on key findings from the biennial Maryland Substance Use and Consequences Epidemiological Profile data. It also provides technical assistance to local health departments on how to generate and understand data.

In addition, BHA asked the University of Maryland Baltimore Systems Evaluation Center (SEC) to conduct a meta-synthesis of needs and gaps within the Maryland Public Behavioral Health System and prepare a report identifying the major themes. This was done through a systematic review, summary, and analysis of documents and reports of needs assessments/gap analyses recently performed in Maryland, including reports at the state, jurisdiction, and community level. Ninety-three documents were reviewed; information explicitly identified in the documents as needs, gaps, challenges, or barriers were included. SEC was provided with 82 needs assessments, special reports or systems planning documents BHA had collected from system partners. BHA also provided the most recent Annual Reports/Plans submitted by the LBHA's, CSA's and/or LAA's. Additional needs assessment or gap analysis reports were included from other behavioral health stakeholders for a total of 116 documents.

Overall, the review found that there was a need for more services in all jurisdictions, particularly a need for an array of behavioral health services and supports, and that there is also a need to improve access to these services. Several barriers, including the lack of providers and/or available services available, long wait lists, transportation, lack of insurance coverage and/or high cost were attributed to this need. A lack of public awareness about the services available poses a barrier to some extent, as well as issues related to stigma, rural/geographic location and language barriers.

A prominent theme was the need for a complete array of crisis response services at the local level. Specific concerns included the need for immediate access to care following crisis intervention and the need to train first responders. A lack of funding was seen as the main barrier to addressing this need.

Affordable and accessible transportation and finding secure, affordable housing were identified and it was noted that not getting these needs met impacted individuals in more ways than just meeting their treatment needs, such as employment.

The review highlighted gaps in the availability of Medication Assisted Treatment (MAT) for opioid use disorders. Issues include an insufficient number of prescribers or psychiatrists available to provide MAT, limited capacity of Opioid Treatment Programs (OTPs) and the need for more buprenorphine prescribers.

Case management and/or care coordination were mentioned as a need and included access to this support as well as a need to improve the coordination of services. Challenges to getting this need met include geographic gaps in the availability of these services and high turnover rate.

The need to access inpatient treatment was also identified and it was indicated that inpatient care was inaccessible either due to lack of inpatient treatment units or due to lack of capacity within existing units. This is a need for individuals with mental health and/or substance use disorders. Although, specifically related to residential treatment for substance use disorders, there is a lack of 3.7 residential treatment services and/or long wait lists. The need for more residential treatment centers for children and adolescents was also identified due to the lack of services locally and/or long wait lists. In addition, it was noted that there was a need for more types of psychiatric residential rehabilitation programs and supports such as medium/high intensity services and skilled geriatric nursing facilities. The need for more Recovery Housing was also indicated.

Longer lengths of stays in hospitals due to challenges in finding community placement, as well as the need for individuals to seek a higher level of care due to limited community services and resources contributed to the challenges with meeting this need. Accessing this type of care is particularly difficult for children, older adults and those who live in rural areas. There is also an increasing number of persons who have multiple diagnoses (medical and behavioral health) that require different levels of care.

The need for more beds or for expansion of detoxification capability in emergency rooms and hospitals was also identified. A 2017 needs assessment conducted for BHA estimated that, across the state, only 53% of the need for withdrawal management services (Levels 1, 2, 3.2, and 3.7) could be met. One barrier identified was the lack of reimbursement for residential detoxification through Medicaid is an issue.

Securing employment is difficult for clients with behavioral health challenges; the main barriers include the lack of available jobs, difficulty in connecting clients to employment opportunities, non-livable wages, and barriers for those clients with criminal records. There is a need for Supported Employment programs for such clients, but youth in particular are affected by zero tolerance policies that have disrupted their education, thereby limiting their future education and employment options.

Peer support services was a need identified in the review, specifically the need to increase the peer workforce and the need to expand peer services to the emergency department and the criminal justice system. The lack of funding is a significant challenge to due to peer services not being reimbursable in the fee-for-service system.

Lastly, in regards to needs related to services and supports, needs related to the use of telehealth was indicated. Lower reimbursement rates, as well as issues related to practitioner credentialing, implementation costs and equipment/technology costs were some of the barriers to meeting this need.

Summary of Themes from Meta-Synthesis Analysis

The most frequently mentioned themes in the documents reviewed included needing more services and issues relating to access. Such problems were reported across the system for both mental health and substance use disorder services.

The lack of service programs for children and adolescents was highlighted as a gap within virtually every jurisdiction. While the specific services and challenges varied somewhat across jurisdictions, key issues included the lack of child psychiatrists, psychiatric residential treatment centers, and substance use disorder services for adolescents.

Access appears to be related to a variety of factors, including the lack of programs and workforce shortages. Or, the lack and limitations of insurance coverage (either Medicaid, Medicare, or private insurance) may be a contributing factor due to no-coverage and out-of-pocket costs. Increased telehealth would assist with this need, however there are start-up costs involved in telehealth, and lower reimbursement rates for providers.

Another prevalent theme is the need for more crisis services, with an emphasis on the need for coordinated, multifaceted, integrated crisis response systems. Given the current opioid crisis, in conjunction with the gaps in available services and barriers to access for both substance use disorder and mental health programs, it is not surprising that the need for crisis services has become a central focus across the state. Recently, the BHA has used its federal State Opioid Response (SOR) grant to fund a variety of crisis-related services and supports. While there is optimism that this will help address the issue, it is a short-term solution because the SOR grant will end in a year and, at that time, new resources will be needed to help sustain these services.

The specific services and supports identified across the jurisdictions varied, however, each jurisdiction was described as needing an increase in the availability of Medication Assisted Treatment (MAT). This included both methadone-based Opioid Treatment Programs (OTPs) primarily using as well as Office Based Opioid Treatment (OBOT) providers who prescribe buprenorphine. It does appear as though this evidence-based practice may become more accepted as a treatment for opioid use disorder. The primary challenge appears to be encouraging providers to become a buprenorphine prescriber or, for those already prescribing, to increase their caseload to maximum capacity.

Quality of care needs also emerged. Training needs were related to workforce concerns and special populations, lack of coordination between the mental health and substance use disorder services and systems was related to system integration, and barriers to sharing data and clinical information was a problem both for system integration and care coordination. All of these issues have a direct impact on the ability of service providers to treat clients with the most accurate information and to ensure that resources are coordinated to help individuals in their recovery.

Key issues with system integration including funding streams, different reimbursement levels, different data and data sources, accreditation/certification standards, and policies were identified. These challenges are not only cumbersome and frustrating for administrators and providers but can also have a negative impact on the quality of care because services may be fragmented, duplicative, and/or confusing for clients and their families. Although the jurisdictions have been

encouraged to integrate at the local level, most of these infrastructure-related issues are out of their control and therefore create challenges for local integration.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?
Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Quality and Data Collection Readiness

Maryland's Public Behavioral Health Data Collection/Reporting System

Most of Maryland's major public behavioral health system (PBHS) data is currently collected and managed by an Administrative Services Organization (ASO). In September 2014, Beacon Health Options (BHO), was selected to continue their contract as the ASO for the PBHS through the five (5) year period. A new Request for Proposal (RFP) for the ASO was issued by the Maryland Department of Health (MDH) in November 2018. Upon a bid process, a new ASO vendor was selected for Maryland's PBHS beginning January 2020.

The ASO collects required data for all SRD services, whether or not it manages or reimburses those services. All required mental health Client Level Data (CLD) and substance related disorders Treatment Episode Data Set (TEDS) data elements are built into the ASO. Data will be collected and reported according to federal grant requirements. Maryland's current reporting system is very robust and comprehensive, but we are seeking ways to encourage discharge reporting, especially in light of the system changes and the TEDS requirements. It is noteworthy, however, that most PBHS services are authorized for six months or less, and that Maryland requires updating of CLD and TEDS information at the start of each concurrent authorization period. The movement to view SRD services as chronic disease conditions, as well as the on-going nature of Medication Assisted Treatment, would be better served by a system of reporting that provides regular updates to data as opposed to one reporting data only at admission and discharge.

The data system collects information on those who receive services in the PBHS. As with mental health services, the majority of community SRD PBHS services are funded through a managed fee-for-service system. With the implementation of the IMD waiver for SRD services on July 1, 2017, Maryland began incorporating residential SRD services into the ASO system, a process that was complete as of January 1, 2019. In addition to managing MA services, the ASO manages PBHS funded services to uninsured individuals. Based on income, family size, and severity of need, some individuals not eligible for MA may be eligible for services funded with State only funds by the PBHS. This system serves over 242,000 people (mental health and substance related treatment services) annually through a network of over 3,500 individual, group, agency, and institutional service providers.

The system is driven by a combination of authorizations and claims for behavioral health services. Inherent in the implementation of the PBHS is a series of extremely comprehensive data sets. Data sets on clients' eligibility, service authorization, claims payment, and events, and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the data from the ASO process that providers complete in order to document that an individual meets the criteria to be enrolled as an uninsured individual. Unduplicated counts are facilitated by the ASO assigning a non-changing unique identifier to every individual who enters the system. Authorizations are generally made on-line and required data elements are updated as part of the request process, whether it be an initial or concurrent request. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files. Expenditures for services funded by this managed fee-for-service system will represent nearly

95% of the PBHS community services budget when all of the SRD residential services are included and it is adjusted for administrative costs. Administrative costs include the cost to operate the BHA, the cost of the ASO, and the cost of local administration. Data that is maintained on the consumers using these services are extracted from enrollment, claims, authorization, and Outcomes Measurement System (OMS) data systems.

The Behavioral Health Administration (BHA) appreciates the importance of functional assessment in mental health treatment and started using the Daily Living Activities instrument (DLA-20) as the uniform assessment instrument for adults receiving MH treatment limited to psychiatric and residential rehabilitation and mobile treatment services. In Maryland, the instrument will be used for care planning and identifying support needs, but will not be used in determining eligibility for services. The DLA-20 for the public behavioral health system became operational in February 2017. Work is almost complete in creating a DLA-20 DataMart with secure access to management as well as the jurisdictional authorities and the providers of these specific services. The DLA-20 DataMart will display data by demographic, DLA-20 items and outcome information relative to an episode of care. The DataMart will allow the providers search and display data at the client level which will help the clinician get a snapshot of the progress in treatment. The DataMart with data based on the most recent service request (point in time displays) will be available in August 2017. Change over time analysis will be available later in the year as concurrent authorizations are not yet available to track this.

In addition to support behavioral health services access, utilization review, and care coordination tasks, the ASO is contracted to collect and display Outcomes Measurement System (OMS) data on most outpatient services. The PBHS OMS data are displayed on a publically accessible DataMart by demographic, clinical service, and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PBHS data system, through a series of interrelated databases and software routines, can report over 200 elements for both inpatient and outpatient care, including the National Outcome Measures (NOMS). Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals;
- services utilized by level of care and service;
- treatment service lengths and number of units provided; and
- site visits, including record reviews and second opinion (peer) reviews of authorization.

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal year reports. Currently, over 60 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Currently, access to the PBHS data is monitored by the ASO/BHA. Based on content and appropriateness, these are available to BHA administrators, to administrators of local systems known as Core Service Agencies (CSA) for mental health, Local Addiction Authorities (LAA) for substance use, and Local Behavioral Health Authorities (LBHA) the combined authority for mental health and substance use. Data is also available to licensed providers in the PBHS. Requests for access

must be submitted to the BHA along with signed and approved data user agreements. There are set licenses for administrative executive level staff, Local Addictions Authorities (LAA), as well as for Core Service Agencies (CSA)-county specific behavioral health entities who, in collaboration with BHA, develop and manage a coordinated network of Maryland public behavioral health services. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC) where a parallel data repository is maintained. The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts. SEC staff aid in the reporting capabilities of the BHA. In addition to the processed data, BHA personnel have access to all of the person/claims level data from the ASO data warehouse.

Automated access to the PBHS ASO data reporting platform is disabled after 45 days of inactivity. Password reset protocol is implemented every 90 days. Staff utilizing the PBHS data reporting platform are trained either by the ASO or BHA MIS staff. A user guide is provided, and policies are outlined in the data use agreement. Periodically, information regarding HIPAA policies and Protected Health Information (PHI) are distributed to all licensees.

Mental Health service authorization information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this module has enhanced service quality and provided a rich resource to enhance data analysis efforts.

An unanticipated problem resulting from PBHS implementation contributes to an undercount of persons served. The ASO Management Information System (MIS) does not capture data for individuals who receive services covered by Medicare, unless they receive a service not part of the Medicare benefit but covered by Medicaid. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data.

BHA is currently receiving grants through SAMHSA/Eagle Technologies to help support Behavioral Health Services Information System (BHSIS) related activities. The required Basic and Developmental Tables will be submitted in December 2019 along with a Client Level Data (CLD) file that will contain client specific data for all served in the PBHS and State Psychiatric facilities in FY 2019. The BHA will continue to submit quarterly TEDS required files. A few tables required are NOMs- based data tables. All tables will be submitted this year, including developmental tables. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS), all of which are within the ASO system. Some data, such as employment status and residential status, along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Perception of Care Survey for some of the National Outcome Measures (NOMs).

For individuals who are receiving non-emergency services through other treatment modalities or from private practitioners or groups which are not required to participate in the OMS, authorization of service is also required. As previously indicated, most authorization data are

collected through the web based BHO ProviderConnect© system. Data collected through the authorization process include employment, housing, detailed racial and ethnicity information, as well as information on diagnoses, symptoms, co-occurring substance abuse conditions, and other issues.

Data from state-operated inpatient facilities are obtained from a Hospital Management Information System (HMIS) implemented in 1986. The HMIS system tracks all admissions and discharges in and out of the state facilities. There are various modules that capture basic demographic and diagnosis data, as well as federally mandated National Outcome Measures (NOMs). Access to HMIS is granted at the facility level, as well as limited access by BHA. HMIS is monitored and maintained by DHMH-Office of Information Technology (OIT). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS), NOMs and CLD reporting. While this system does not use the same consumer identifiers as the ASO data system, there are elements common to both which BHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. Data is used at the Executive, facility, and CSA level to track facility usage, forensic population, and length of stay. Data is designed to be used to complete ad hoc requests.

BHA works closely with Softech, Inc., a Maryland based technology solution company that specializes in data architecture, database management, data warehousing and Business Intelligence (BI) solutions. Softech utilizes the breadth and depth of its technology experience and subject matter knowledge in all aspects of healthcare systems management, including eligibility processing, provider enrollment, claims payment, fraud and waste detection and service utilization. Other key data support efforts include provision of data analysis and programming activities with various State and local partners such as Maryland Medicaid, the local system authorities LBHAs, CSAs, LAAs) and the University of Maryland Baltimore's System Evaluation Center, and provide appropriate support and consultation as required. Softech provides support to database design needs and ASO system requirements.

Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC) where a parallel data repository is maintained. This public-academic partnership provides unique value to BHA by providing access to nationally recognized expertise in behavioral health services research and evaluation; training and implementation on evidence-based behavioral health interventions; policy analysis; in-depth knowledge and experience with the Maryland Public Behavioral Health system; and data analysis/technical assistance on program design and implementation to support ongoing system improvements. The University performs a wide range of activities, including:

- Performing Program Evaluations and Data Analyses to support BHA priority programs and initiatives.
- Efforts to evaluate the effectiveness of federal grant programs, collecting and reporting data and responding to inquiries from grant managers related to data and evaluations.
- Conducts targeted data analyses related to emerging issues, such as:
 - Review of substance related disorder (SRD) treatment needs and capacity;

- Data analysis, testing and validation of overdose deaths for individuals in the PBHS;
- Statewide needs assessment used by BHA and local authorities to identify SRD service needs and gaps;
- Opioid Treatment Program Needs Assessment;
- Performs ongoing validation analyses on claims, authorizations, pharmacy and outcome data in conjunction with BHA and the ASO to ensure data accuracy.
- Provides technical support for federal data reporting requirements.
- Designs and conducts required evaluations for Mental Health and Substance Abuse Block Grants.
- Provides technical assistance and data analysis to support behavioral health integration efforts and state reporting requirements, such as conducting research on system capacity and adding substance use programs to the Outcome Measurement System.

The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts. SEC staff aid in the reporting capabilities of the BHA. In addition to the processed data, BHA personnel have access to all of the person/claims level data from the ASO data warehouse.

In addition, BHA contracts with the SEC to assist with policy analysis and literature reviews, consultation, technical assistance, and evaluation. The SEC assists with a variety of tasks including but not limited to preparing reports for the legislature, writing grant applications, developing surveys for the provider community to inform system change planning, researching evidence based practices, and surveying other states for current and innovative practices and technology.

Consumer Quality Team

The Consumer Quality Team of Maryland was established in 2006 to address the urgent need for an oversight mechanism to address quality of care in real time for individuals served by the public mental health system. Prior to the merger, the former Mental Hygiene Administration initiated a stakeholder process that included review of comparable programs in other states. CQT is a consumer run initiative which is housed within the Mental Health Association of Maryland.

Key elements of the model are the following:

- CQT is staffed by trained consumers and family members, and independent of provider organizations and the government entities that fund service delivery. This structure maximizes trust among service recipients and increases their comfort level in sharing information about care they receive.
- While most auditors and regulators focus on the clinical programs, CQT focused on the individual. The consumer-centric model allows for the ability to collect important information about individuals' unique experience for the primary purpose of immediate quality improvement.

- CQT utilizes a structured and confidential qualitative interviewing process, rather than a formal survey, and through this process is able to elicit useful information, both positive and negative, which would not be shared through a survey.
- CQT interviewers are not advocates, they are trained to nonjudgmentally collect data for the purpose of immediate quality improvement in care.
- CQT visits 5 state psychiatric hospitals, 8 youth residential treatment centers, and 63 psychiatric rehabilitation programs and On Our Own Wellness & Recovery Centers, typically 3-6 times a year, and operates a consumer warm line to address service recipient concerns in between visits.
- The CQT feedback loop is central to the success of the program, which ensures that consumer feedback, both positive and negative, is shared at the program, local jurisdiction and state levels. CQT data reports are nonjudgmentally shared through the following processes:
 - o Exit interviews conducted with program or hospital management at the conclusion of each site visit
 - o Written site visit reports shared with program and facility management, local core service agencies and the Behavioral Health Administration
 - o Quarterly review of CQT reports with local behavioral health authorities
 - o Periodic meetings with DHMH Behavioral Health Administration management identifying significant concerns, positive feedback and trending patterns for the reporting period
 - o Responsibility for investigation of complaints lies with the program, local or state government agency, depending on the type of issue raised.
 - o CQT staff are trained to follow state laws and regulations regarding the reporting of safety concerns identified during visits.

Efforts are underway for CQT to address quality issues at substance use programs (SUP). SUP initiative will hire and train three adults with lived experiences to interview service recipients of the public behavioral health system (PBHS). Targeted providers include residential programs addressing substance use disorders including medication assisted treatment to determine their level of satisfaction with the programs/services they receive and help to resolve any issues with the program staff or refer issues to the CSA/LAA/LBHAs or BHA, as appropriate.

Maryland Addiction Consultation Service (MACS)

BHA in collaboration with University of Maryland School of Medicine, Department of Psychiatry expand its existing Maryland Addiction Consultation Service (MACS), which currently offers telephone consultation, training, education, and assistance with referral identification to prescribers across Maryland in the treatment of their patients' substance use disorders and chronic pain management needs. Efforts are underway to plan for an expansion that would offer statewide technology transfer and technical assistance (TT), leverage telemedicine technology to increase access to rural and underserved areas and provide strategies

for educating an emerging workforce. **MACS Technology Transfer (MACS TT)** will work with BHA to study, inform, and disseminate key best practices and policies to optimize the capacity and quality of workforce development related to addiction treatment, and more specifically the use of medication assisted treatment (MAT). One of the goals is to improve quality of primary care and specialty prescribers across Maryland in the identification and treatment of substance use disorders. Evaluation goals will include: (1) document and track activities and determine the effectiveness of the expanded MACS TT efforts, (2) improve the implementation and utilization of MACS TT, and (3) support data-driven decision-making with the goal of continuous quality improvement.

The Administrative Services Organization's Management Information System (ASO MIS) was utilized to produce most of the data. Data for FY 2019 are based on claims paid through June 30, 2019. Since claims can be submitted up to twelve months following the date of service, the data for FY 2019 may be incomplete, although cash flow considerations require most providers to bill within a few days of providing a service. Specific diagnoses were used to define SMI. An individual was categorized as Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted

Maryland's BHA also receives information from the Office of the Chief Medical Examiner (OCME) and the Vital Statistics Administration (VSA) on unintentional deaths in Maryland that involve a drug and/or overdose. Maryland's rich data resources have allowed for the identification of individuals who were in treatment in the PBHS prior to their deaths and data have been analyzed to alert providers to characteristics that may identify individuals at risk of overdose death.

Minimum Data Set (MDS): System Used to Collect Primary Prevention Population Level Measures

The Office of Prevention undertakes an annual assessment to determine how to best utilize its prevention resources to meet the AOD prevention needs of youth in Maryland. This includes reviewing data provided by the Maryland SEOW and other data sources and soliciting and utilizing input from the BHAC.

Requires all funded prevention program providers to collect and report prevention data using the Minimum Data Set (MDS). The MDS is a Web-based client-server data collection system that uses Internet technology to collect information on primary prevention programs, activities and strategies. The MDS is run from a centralized database and web server at the state level. The MDS collects very specific process and group level information and serves as the main repository for prevention program data collection in Maryland.

The Minimum Data Set system was designed to collect basic process data about the services provided. The MDS collects a small set of well-defined data about each prevention service. All information collected about service participants is at the whole-group level. MDS data includes the type of service, target population, group and activity information, dates the service was performed, and applicable CSAP strategy. Other data such as item counts, participant demographics, IOM category and state-defined data are also collected. The MDS data collection

system is uniform across the state and implements extensive validations to ensure it is internally consistent.

The MDS system is designed to run under state control, and does not require continued federal involvement for its ongoing operation. A server at the state level runs the application code and serves as the repository for all data collected.

The MDS is designed to collect basic process data about prevention services provided. The system collects a set of well-defined data about each prevention service. Information collected about service participants is at the whole-group level. MDS data includes, but is not limited to, data on the type of service, service population, group and activity information, dates the service was provided and applicable CSAP strategy. Other data such as item counts, participant demographics and state defined data are also collected.

The MDS was developed to serve as a model for a standardized prevention data collection system. It allows the state and our prevention service providers to quantify and compare the number and type of primary prevention and early intervention services delivered. The MDS also permits county prevention coordinators and prevention service providers to generate onsite reports and analysis relating to services offered, target populations and staff resource deployment.

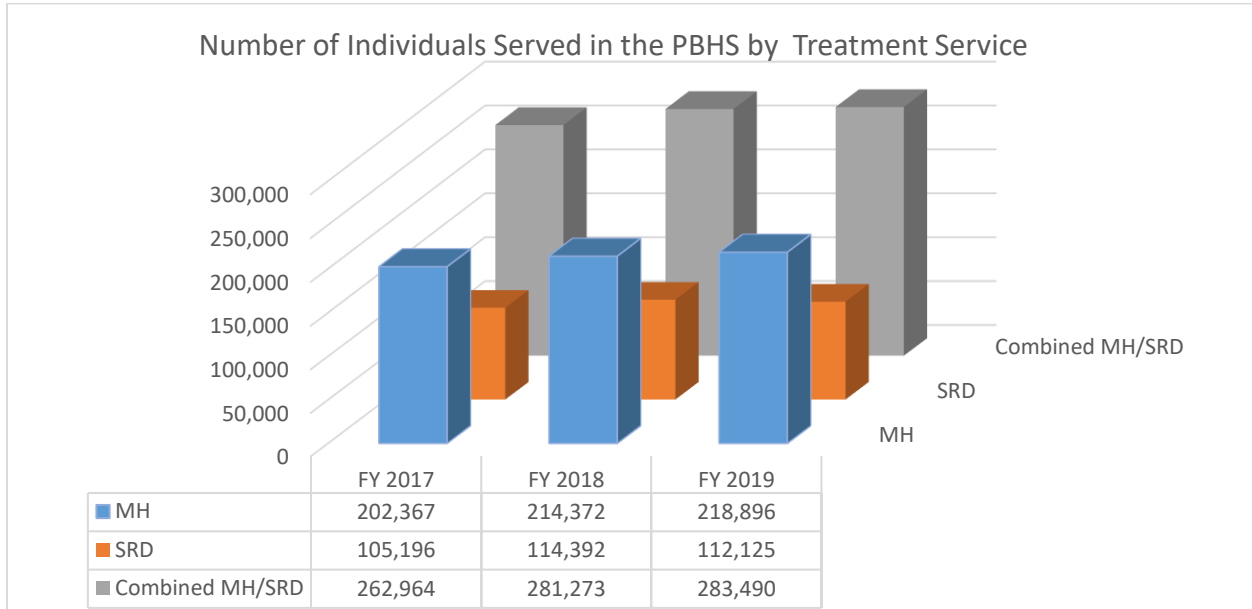
Use of Epidemiological Data to Inform Prevention

The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas and populations most impacted by substance misuse and its consequences. Additionally, these data can assist with determining the most salient community contributing factors to target with the grantees' limited prevention resources. Ultimately the use of epidemiological data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements.

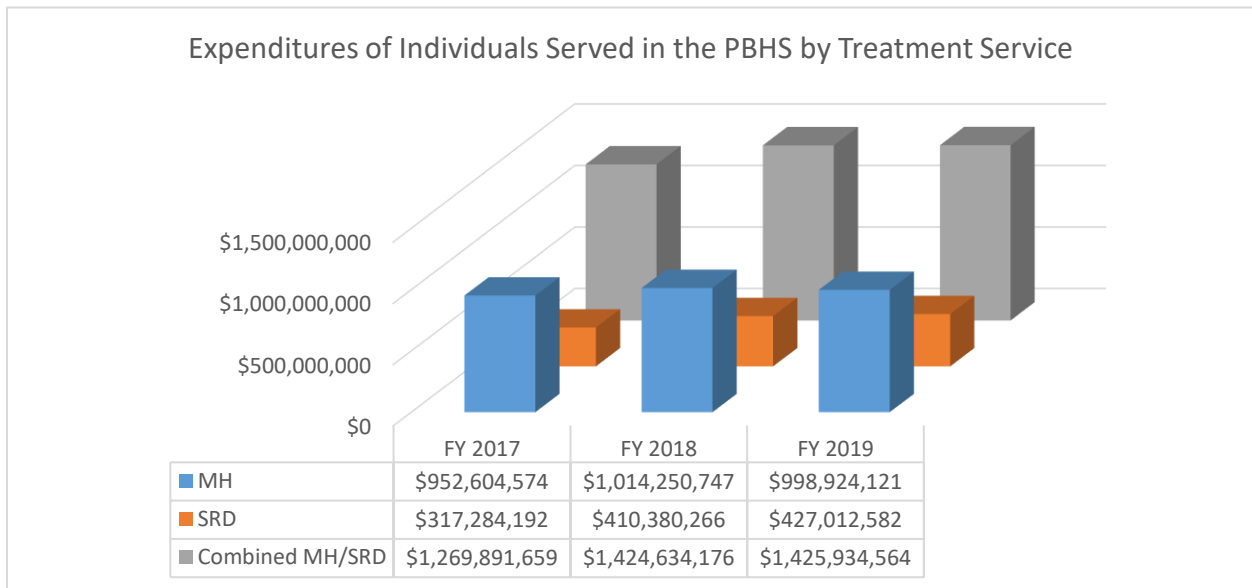
Public Behavioral Health System (PBHS) Service Utilization and Expenditures Coverage

The current Maryland Public Behavioral Health System serves over 283,000 people (mental health and substance related treatment services) annually through a network of over 3,500 individual, group, agency, and institutional service providers. The PBHS services both Medicaid recipients and the uninsured population.

The combined PBHS service expenditures were over \$1.4 billion in FY 2019. 90% of claims were paid through Medicaid funds.



Totals are unduplicated among service categories. Based on Claims Paid through 06/30/2019. FY2019 data may be incomplete as claims may be submitted up to twelve months from date of service.



Access to services is critical for any behavioral health system. In recent years and as an ongoing strategy in the State’s Behavioral Health Plan, BHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PBHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

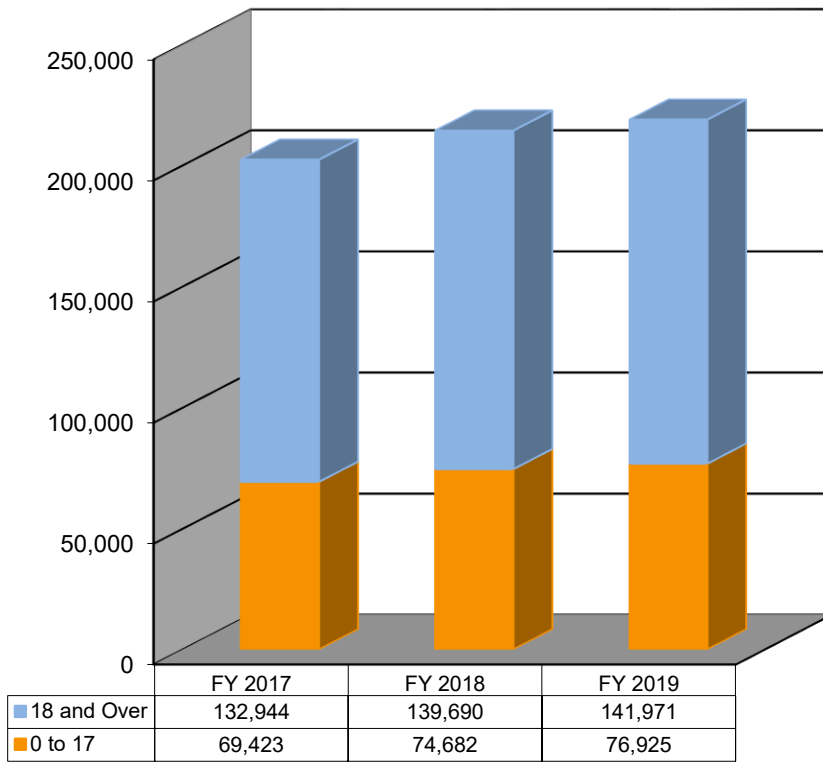
Many of these increases result from the implementation of the Affordable Care Act, which provided funding allowing states to cover more people with Medicaid. The expansion of Medicaid, especially the extension of Medicaid to childless adults and the parents of children in Maryland’s Children’s Health Program (MCHP), improved access to health care and services. It is estimated that an additional 250,000 Marylanders were eligible for Medicaid and 13-15 percent of that population used PBHS services within the coming fiscal years.

	Average Maryland Medicaid Eligible	Total MA Recipients Receiving MH Services	Penetration Rate
FY 2017	1,365,342	193,946	14.2%
FY 2018	1,409,403	205,460	14.6%
FY 2019	1,402,656	209,504	14.9%

Public Behavioral Health System (PBHS) Mental Health Service Utilization and Expenditures

The total number of individuals served in the fee-for-service PBHS for mental health services has increased from 202,367 in FY 2017 to 218,896 in FY 2019, an 8 percent increase. Tables on the following pages provide data on consumers served by age group in FY 2017, 2018 and 2019. FY 2019 data shows 218,896 individuals had claims submitted for mental health services through the fee-for-service system. Of the total, 141,971 are adults, and 76,925 are children. These totals represent an increase of 7% adults and 10% in the child population served during the same time period from FY 2017. In FY19, 9,777 uninsured individuals utilized PBHS services who meet specific eligibility criteria. This is a substantial increase from FY17 (n=6,675), and an almost 20% increase the number of uninsured served from FY18.

**Individuals Receiving Mental Health Services in the PBHS by Age Group
FY2017-19**

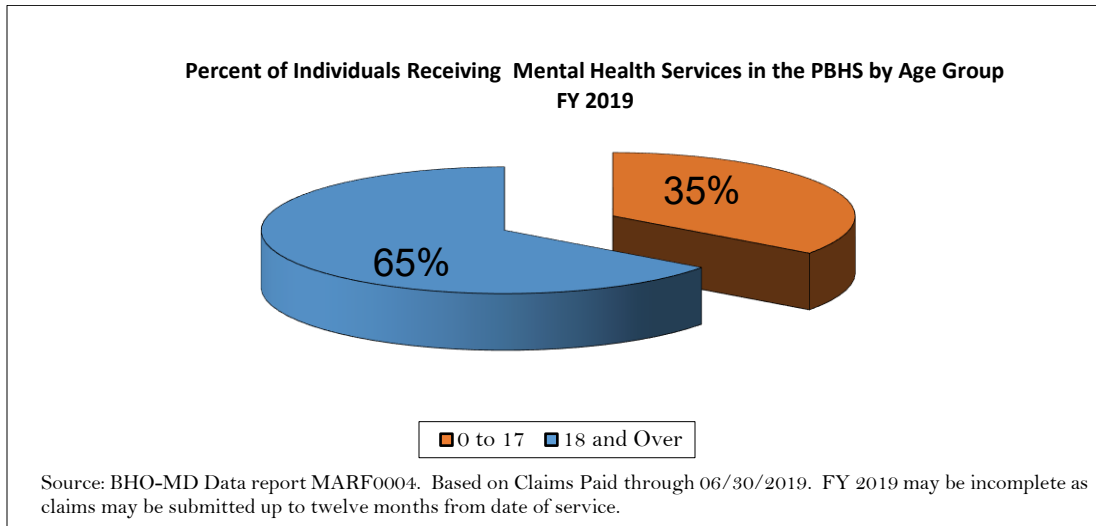


Source: BHO-MD Data report MARF0004 Based on Claims Paid through 06/30/2019. FY2019 data may be incomplete as claims may be submitted up to twelve months from date of service.

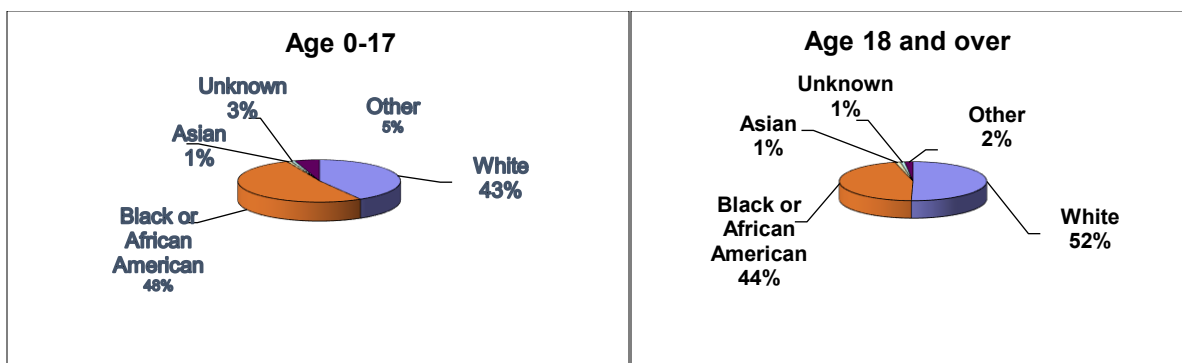
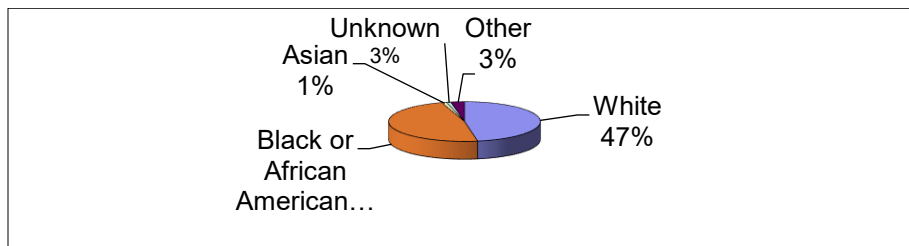
Demographics of Consumers Receiving Mental Health PBHS Services

The number of children and adolescents, aged 0-17, accessing mental health services grew 7% while adults 18 and older experienced a 10% growth, increasing the numbers served by 2 percent over the same time period between FY 2018-2019.

Currently, 65 percent of the individuals served in mental health services are adults and 35 percent are children.



The racial distribution of the PBHS population receiving mental health services is 46% Black/African American, 47 % White, 1% Asian, 3% other and 3 % unknown.



Source: FY 2018 URS Table 2A

Note: Other includes: American Indian, Native Hawaiian, Pacific Islander and those individuals with more than one race. Data includes through also served in state psychiatric facilities.

POPULATIONS – CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISORDERS (SED)

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined. This approximate loss in 2017 was 1,700 children. During this same period the total population (both adult and child) has grown slowly by approximately 3%, each year (36,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

Behavioral Health Administration
Prevalence Estimates for Serious Emotional Disorder (SED) by County
Child and Adolescent
Population

County	Under 18 Population	Low Prevalence	High Prevalence
		6%	12%
Allegany	15,144	909	1,817
Anne Arundel	140,612	8,437	16,873
Baltimore County	202,389	12,143	24,287
Calvert	23,629	1,418	2,835
Caroline	8,561	514	1,027
Carroll	40,897	2,454	4,908
Cecil	25,734	1,544	3,088
Charles	42,585	2,555	5,110
Dorchester	7,359	442	883
Frederick	65,193	3,912	7,823
Garrett	6,097	366	732
Harford	62,329	3,740	7,479
Howard	85,850	5,151	10,302
Kent	3,896	234	468
Montgomery	268,868	16,132	32,264
Prince George's	230,024	13,801	27,603
Queen Anne's	11,791	707	1,415
St. Mary's	30,642	1,839	3,677
Somerset	5,740	344	689
Talbot	7,394	444	887
Washington	36,436	2,186	4,372
Wicomico	27,908	1,674	3,349
Worcester	9,912	595	1,189
Baltimore City	142,782	8,567	17,134
Statewide Total	1,501,772	90,106	180,213

Source: Maryland Vital Statistics Annual Report. July 2017.

POPULATIONS – ADULTS WITH SERIOUS MENTAL ILLNESS (SMI)

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
 - Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.
- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the

American Psychiatric Association as:

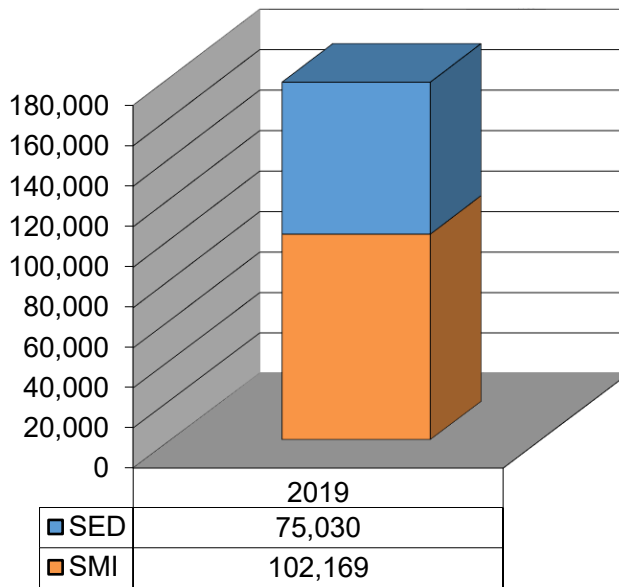
- Schizophrenic disorder,
- Major affective disorder,
- Other psychotic disorder, or
- Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
- Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Behavioral Health Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

Behavioral Health Administration
Prevalence Estimates for Serious Mental Illness (SMI) by County
Adult Population

County	Over 18 Population	Prevalence 5.4%
Allegany	56,471	3,049
Anne Arundel	432,623	23,362
Baltimore County	630,079	34,024
Calvert	67,873	3,665
Caroline	24,632	1,330
Carroll	126,884	6,852
Cecil	77,012	4,159
Charles	117,115	6,324
Dorchester	24,803	1,339
Frederick	186,829	10,089
Garrett	23,136	1,249
Harford	189,831	10,251
Howard	235,263	12,704
Kent	15,488	836
Montgomery	789,942	42,657
Prince George's	682,732	36,868
Queen Anne's	37,979	2,051
St. Mary's	82,025	4,429
Somerset	20,178	1,090
Talbot	29,709	1,604
Washington	114,142	6,164
Wicomico	75,015	4,051
Worcester	41,778	2,256
Baltimore City	468,866	25,319
Statewide Total	4,550,405	245,722

Source: Maryland Vital Statistics Annual Report. July 2017.

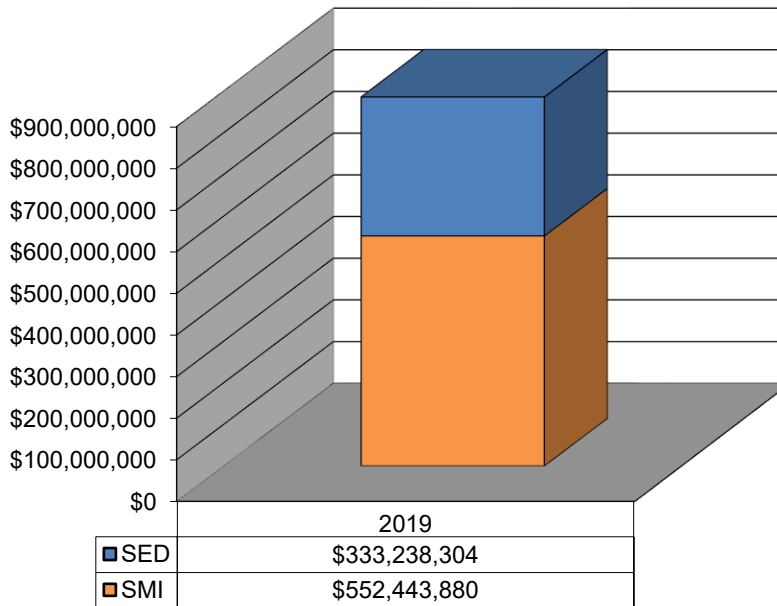
**Total SMI/SED Consumers Served in the PBHS
in FY 2019**



Source: VO-MD Data Report MARS4161 Based on Claims Paid through 06/30/2019. FY 2019 Data may be incomplete as claims may be submitted up to twelve months from date of service.

In FY 2019, 98% of individuals under age 18 served in the PBHS had a SED utilizing 33% of all service expenditures. 72% of all adults served had a SMI and utilized 55% of all service expenditures.

Total PBHS Expenditures for SMI/SED Consumers Served in FY 2019



Source: VO-MD Data Repository Based on Claims Paid through 06/30/2019. FY 2019 Data is incomplete as claims

Specific diagnoses were used to define SED/SMI. An individual was categorized as having a Serious Emotional Disorder (SED) or Serious Mental Illness (SMI) if, at any time during the fiscal year, a diagnosis in the specific categories was submitted.

In FY 2019, 33% of individuals receiving mental health treatment services in the PBHS were dually diagnosed. These individuals have a primary mental health diagnosis, as well as a secondary diagnosis of substance abuse. This population accounted for 45% of all mental health claim expenditures.

	Total Count Receiving MH Services	Number Dually Dx Served	% of Total Served Are Dually Dx
2017	202,367	66,909	33.1%
2018	214,372	71,260	33.2%
2019	218,896	71,301	32.6%

	Total MH Expenditures	Dually Dx Expenditures	Dually Dx % of Total MH Expenditures
2017	\$952,604,574	\$438,408,995	46.0%
2018	\$1,014,250,747	\$476,993,450	47.0%
2019	\$998,924,121	\$453,586,452	45.4%

Maryland's *Commitment to Veterans* initiatives drive the import of tracking those with Veteran status accessing the PBHS.

	Total Veterans Receiving MH Services	MH Expenditures of Veterans	Total Veterans Receiving SRD Services	SRD Expenditures of Veterans
2017	4,526	\$39,262,709	3,683	\$14,840,794.00
2018	4,378	\$37,475,842	3,764	\$19,464,946.00
2019	4,169	\$32,581,643	3,793	\$20,780,581.00

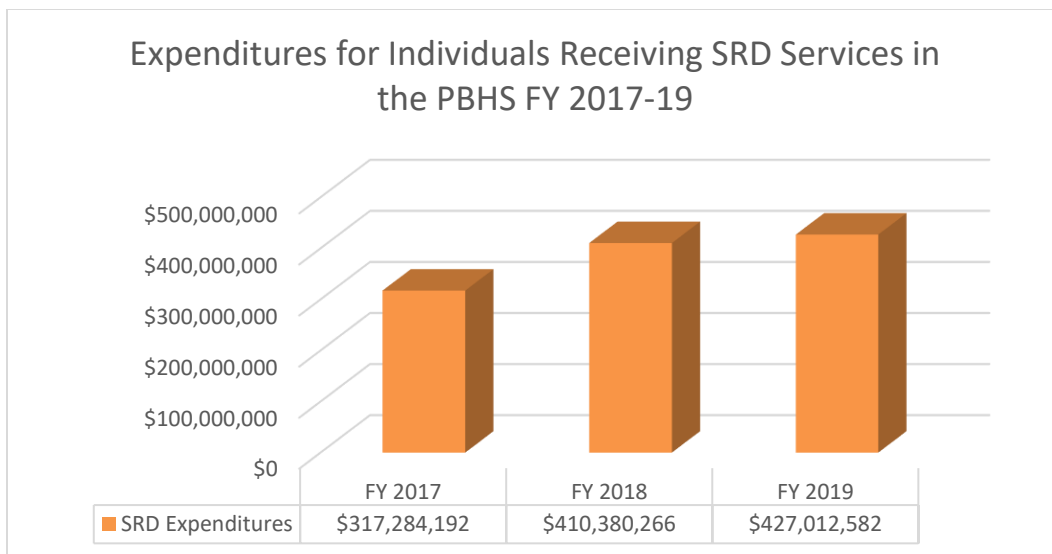
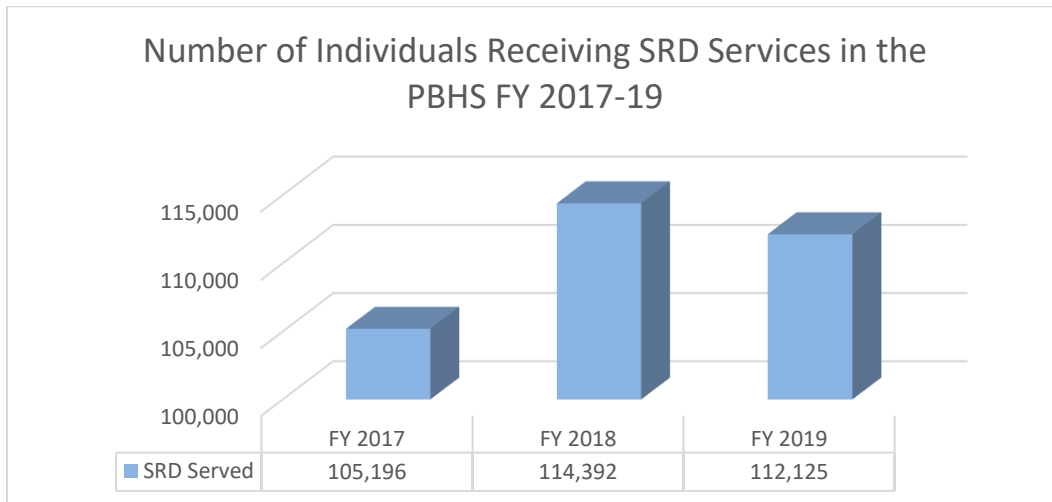
Utilizing the Maryland Outcomes Measurement System (OMS) data, the number of individuals receiving outpatient behavioral health services and response to outcomes and performance measurements.

Fiscal Year 2018

	Outpatient SRD Adolescents		Outpatient MH Adolescents	
	Number Answered Question	Percent Responded "Yes"	Number Answered Question	Percent Responded "Yes"
Have you been homeless in the past 6 months?	444	1.6%	41,228	2.2%
Do you smoke cigarettes?	707	26.3%	28,484	3.2%
Do you attend school when in session?	707	86.4%	46,476	91.9%
In the past 6 months, have you been arrested?	707	30.8%	28,484	2.6%
Are you currently employed, or in the past 6 months?	385	23.1%	12,526	16.4%
	Outpatient SRD Adults		Outpatient MH Adults	
	Number Answered Question	Percent Responded "Yes"	Number Answered Question	Percent Responded "Yes"
Have you been homeless in the past 6 months?	35,093	11.9%	55,656	11.5%
Do you smoke cigarettes?	45,889	71.0%	69,121	36.7%
In the past 6 months, have you been arrested?	45,889	8.8%	69,121	4.9%
Are you currently employed, or in the past 6 months?	45,889	36.6%	69,121	35.5%

Public Behavioral Health System (PBHS) Substance Related Disorder Service Utilization and Expenditures

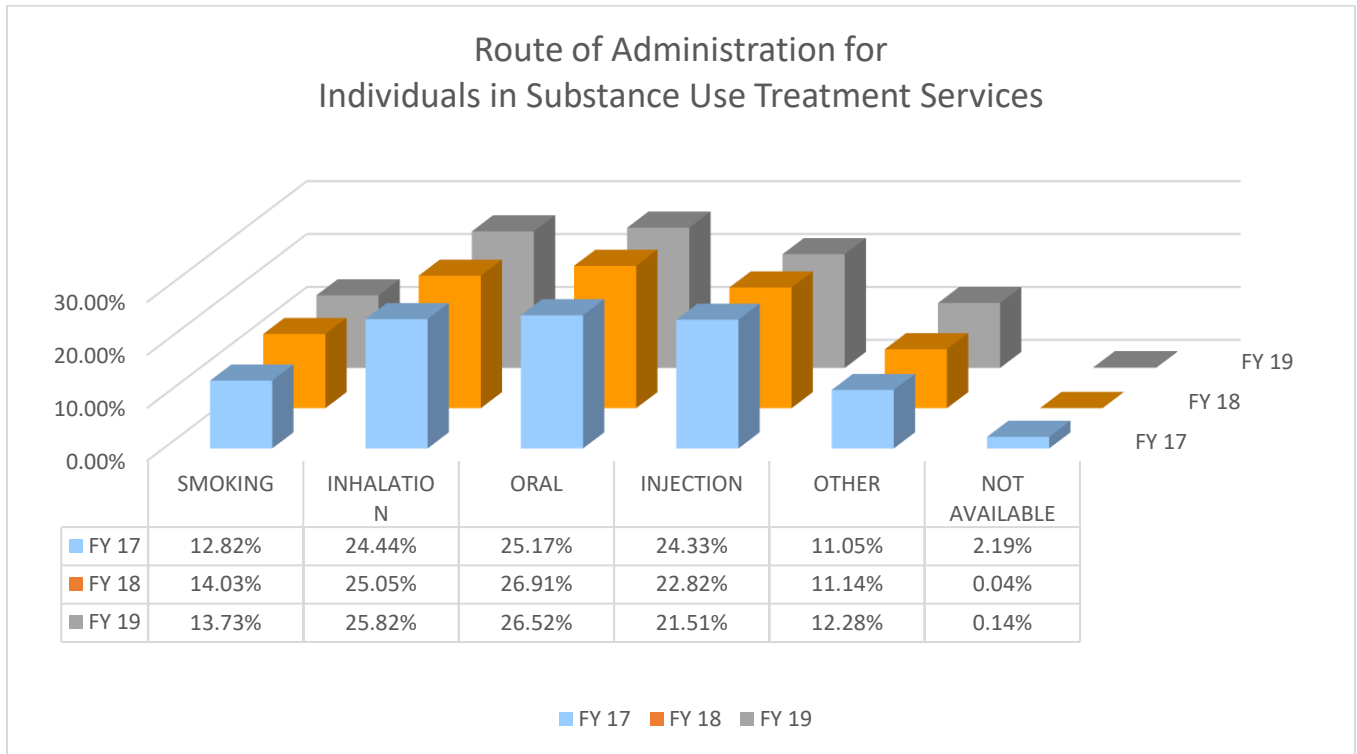
The implementation of a combined MH/SRD data system went live January 1, 2015. The ASO system has the ability to collect required data for all SRD services, whether or not it manages or reimburses those services. FY 2017 represents the second complete fiscal year of substance use data in the merged Public Behavioral Health System. In FY17, over 105,000 individuals received substance related treatment services in the PBHS. To date, FY19 data reports a 7% increase in the number served. This number is expected to grow in FY19 and subsequent years as residential treatment services were transferred from grant funded to fee-for-service. Also, there is a claim lag as providers have twelve months from the time of service in which to submit a claim for payment. For this reason, FY19 data is not considered finalized. 62% of those served in the PBHS for substance use received a Level 1 or Outpatient service and 30% received service from an Opioid Treatment program. 97% of those served through SRD treatment services are adults. In FY 2019, there were 2,079 admissions for 1,538 pregnant women waiting on an average less than one day for service.



In FY19, over 82,900 individuals were admitted to substance-related disorder treatment programs. The primary substance at admission was heroin comprising 49% of all admissions, followed by alcohol 18%, opioids 13%, and marijuana 6%. Final FY 19 is predicted that the number of admissions reporting heroin as the primary substance used at admission will reach 50%-all substance percentages are steady, but marijuana as the primary substance at admission is down 5% from the prior fiscal year.

It is important to note that the difference in the total number served receiving SRD treatment services in FY 2019 (112,125) and the 82,900 referenced above in the same time period were those admitted to treatment services, while the 112,125 includes those that received SRD support services, i.e., labs.

Route of administration for those receiving SRD treatment services has remained stable over the past three fiscal years.



Individuals authorized to receive Substance Related Disorder Treatment through the Maryland PBHS, the number and rate using heroin or other opiates in FY 2017-2019.

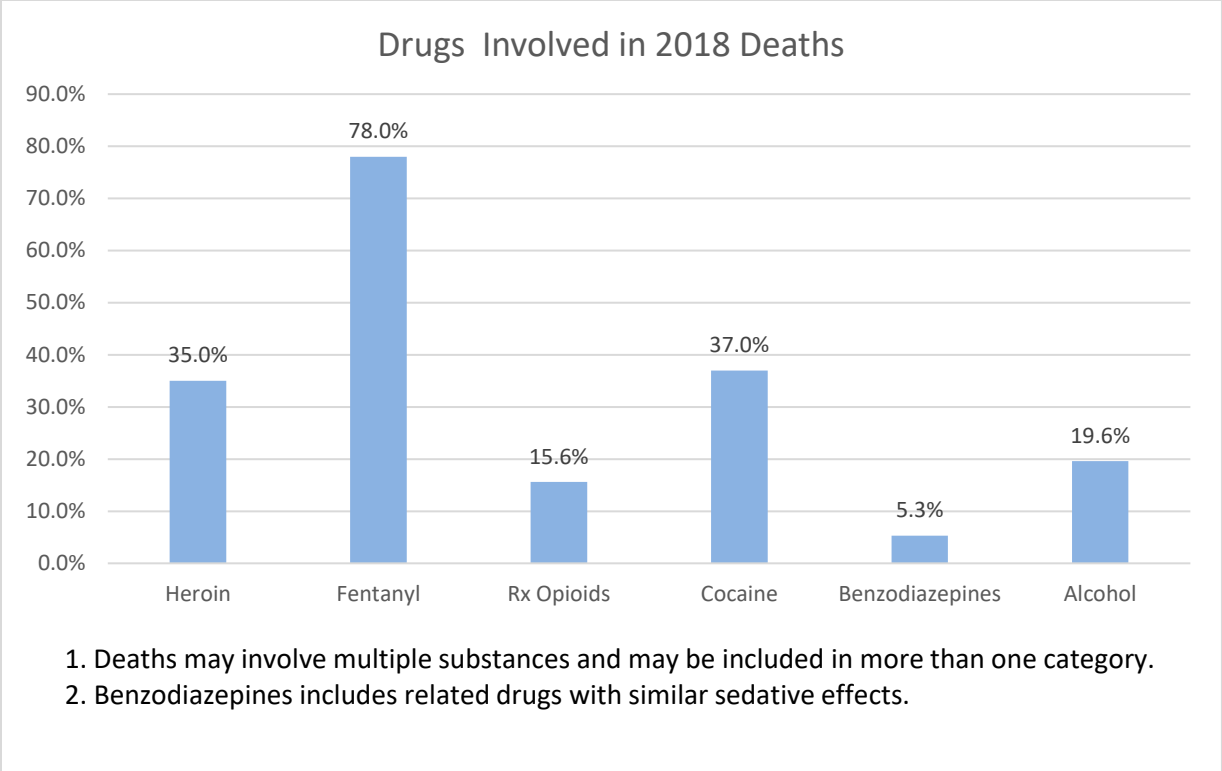
	FY 2017		FY 2018		FY 2019	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Heroin	41,638	68,798.00	44,547	736.05	44,854	741.12
Other opiates	15,678	259.05	17,318	286.14	17,293	285.73
Total Opiates	49,599	819.52	54,495	900.42	55,265	913.14

In recent years, Maryland has experienced a dramatic increase in the number of accidental overdose deaths. In March 2017, Maryland Governor Larry Hogan declared “a state of emergency for opioid crisis.” The signed State of Emergency executive order provided an additional \$50 million in funding to support coordination of care among state agencies in prevention and treatment services.

Total Maryland Deaths with Drug Overdose

- 2012: 799
- 2013: 858 (7.4% increase)
- 2014: 1,041 (21.3% increase)
- 2015: 1,259 (20.9% increase)
- 2016: 2,089 (66.0% increase)
- 2017: 2,282 (9.2% increase)
- 2018 2,406 (5.43% increase)

(Excludes deaths identified as suicides or homicides)



Annual overdose data combined with PBHS utilization and OMS data are being used to identify those individuals most likely to experience a fatal drug overdose. Prior analysis suggests that those whose life experience include homelessness and arrest and who have dual diagnoses of SRD and MH may be at greatest risk of experiencing a fatal overdose, and deserve special clinical attention.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Opioid Crisis Intervention
Priority Type: SAP, SAT
Population(s):
Goal of the priority area:

Reduce rates of opioid misuse, opioid overdoses and related health consequences among Maryland youth and adults

Objective:

1. Increase the percentage of youth and adults who are trained and have access to overdose-reversing drugs by 10% by the end of FY2021.
2. Increase the percentage of youth and adults with OUD participate in opioid treatment services by 2% by the end of FY2021.
3. Increase the percentage of youth and adults who participate in medication assisted treatment (MAT) by 5% by the end of FY2021.
4. Decrease the number of opioid related deaths by 5% by the end of FY2021

Strategies to attain the objective:

Increase the distribution of overdose-reversing drugs
 Work with jurisdiction's, community behavioral health agencies and community based organizations to expand training and access to overdose-reversing drugs and OUD treatment services. Leverage funding to increase the number of MAT providers and programs across the state.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of people trained in opioid overdose response
Baseline Measurement: Number of people trained in opioid overdose response in FY2019 was 44,717
First-year target/outcome measurement: Number of people trained in opioid overdose response in FY2020 will be 45,217
Second-year target/outcome measurement: Number of people trained in opioid overdose response in FY2021 will be 45,717

Data Source:

Overdose Response Program (ORP) Administrative Tracking System

Description of Data:

The ORP Tracking System is maintained by the Maryland Department of Health and contains data on the number of naloxone distribution sites, training conducted, people trained and naloxone doses administered statewide. .

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of Opioid Overdose Deaths
Baseline Measurement: Number of prescribed opioid related deaths occurring statewide in FY2018 was 379
First-year target/outcome measurement: Number of prescribed opioid related deaths occurring statewide in FY2019
Second-year target/outcome measurement: Number of prescribed opioid related deaths occurring statewide in FY2020

Data Source:

Maryland Department of Health (MDH), Vital Statistics Administration (VSA)

Description of Data:

The MDH, VSA produces quarterly and annual reports on unintentional drug and alcohol related intoxication deaths. These reports include the number of opioid overdose deaths occurring throughout the state. In order to better understand the epidemic, Maryland has enhanced surveillance in the state through reports on drug and alcohol intoxication deaths using data from the Office of the Chief Medical Examiner. The more detailed and timely review of data allows the Department and local jurisdictions to identify patterns of overdose activity, which enhances public health responses and planned interventions at the state and local levels.

Data issues/caveats that affect outcome measures::

Priority #: 2
Priority Area: Recovery Supports
Priority Type: SAT, MHS
Population(s): SMI, SED, Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Improve access to and expansion of MH and SUD recovery and support services for individuals with MH/SUD or co-occurring disorders.

Objective:

Increase access to services for individuals with co/occurring MH/SUD across the lifespan.

Strategies to attain the objective:

Support the initiation and expansion of new and existing evidence based community recovery support programs and services by providing funding, training and technical assistance to jurisdiction and community based organizations to increase capacity to provide recovery support services, expand in various health care settings and enhance the person-centered recovery system of care.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of individuals served in the public behavioral health system (PBHS)
Baseline Measurement: The number of children with SED receiving services in 2019: 76,925; number of adults with SMI in 2019:141,971
First-year target/outcome measurement: 78,079 with SED; 143,390 with SMI in 2020
Second-year target/outcome measurement: 79,233 with SED; 144,790 with SMI in 2021

Data Source:

ASO PBHS

Description of Data:

The data system collects information on those who receive services in the PBHS. As with mental health services, the majority of community SRD PBHS services are funded through a managed fee-for-service system. The system is driven by a combination of authorizations and claims for behavioral health services. All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal year reports.

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of individuals served in the PBHS with SUD
Baseline Measurement: In FY 2019 number of individuals with SUD: 112,125
First-year target/outcome measurement: 113325
Second-year target/outcome measurement: 114,525

Data Source:

ASO PBHS

Description of Data:

The data system collects information on those who receive services in the PBHS. As with mental health services, the majority of community SRD PBHS services are funded through a managed fee-for-service system. The system is driven by a combination of authorizations and claims for behavioral health services

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal year reports.

Data issues/caveats that affect outcome measures::**Indicator #:**

3

Indicator:

Evaluate outcome and fidelity data on Supported Employment (SE) EBP

Baseline Measurement:

Number of individuals who received EBP - SE services in 2019-3047

First-year target/outcome measurement:

Number of people receiving supported employment services in FY2020: 3250

Second-year target/outcome measurement:

Number of people receiving supported employment services in FY2021: 3400

Data Source:

Administrative Service Organization/ Maryland Public Behavioral Health System (PBHS) Data

Description of Data:

PBHS claims data/URS TABLES. The data system collects information on those who receive mental health and substance use disorder services in the PBHS. Supported employment data including number served, number of units and expenditures are collected within this system. All stored data can be retrieved and reported using an automated reporting system or ad hoc reports. This data can be formatted to produce monthly, quarterly or annual reports.

Data issues/caveats that affect outcome measures::

n/a

Indicator #:

4

Indicator:

Evaluate outcome and fidelity data on Assertive Community Treatment (ACT) EBP

Baseline Measurement:

Number of individuals who received EBP - ACT services in 2019 3418

First-year target/outcome measurement:

Number of individuals who received EBP - ACT services in 2020: 3600

Second-year target/outcome measurement:

Number of individuals who received EBP - ACT services in 2021: 3800

Data Source:

PBHS: Administrative Service Organization/ Maryland Public Behavioral Health System (PBHS)

Description of Data:

PBHS claims data. The data system collects information on those who receive mental health and substance use disorder services in the PBHS. Assertive Community Treatment data including number served, number of units and expenditures are collected within this system. All stored data can be retrieved and reported using an automated reporting system or ad hoc reports. This data can be formatted to produce monthly, quarterly or annual reports.

Data issues/caveats that affect outcome measures::**Indicator #:**

5

Indicator:

Number of people receiving sBIRT services

Baseline Measurement: Number of of people receiving SBIRT services in FY2019 - 86,878

First-year target/outcome measurement: Number of of people receiving SBIRT services in FY2020- 87,000

Second-year target/outcome measurement: Number of of people receiving SBIRT services in FY2021- 87,500

Data Source:

State Opioid Response (SOR) Grant progress report. BHA has partnered with the University of Maryland, School of Medicine, Department of Psychiatry to support the SOR data collection and evaluation effort. The Maryland SOR data collection and evaluation plan is comprised of two core components that include progress reporting and quality improvement activities, and GPRA (outcome) data collection. Data collection activities to date have focused on the design and development of data collection tools and protocols for monthly progress reporting and GPRA data collection

Description of Data:

State Opioid Response (SOR) Grant progress report

Data issues/caveats that affect outcome measures::

Indicator #: 6

Indicator: Number of Individuals who receive Medication Assisted Treatmen (MAT) services

Baseline Measurement: Number of Individuals who receive Medication Assisted Treatmen (MAT) services in FY2019 was 33,893

First-year target/outcome measurement: Number of Individuals who receive Medication Assisted Treatmen (MAT) services in FY2020 will be 34,393

Second-year target/outcome measurement: Number of Individuals who receive Medication Assisted Treatmen (MAT) services in FY2021 will be 34,893

Data Source:

The data system collects information on those who receive mental health and substance use disorder services in the PBHS. Supported employment data including number served, number of units and expenditures are collected within this system. All stored data can be retrieved and reported using an automated reporting system or ad hoc reports. This data can be formatted to produce monthly, quarterly or annual reports.

Description of Data:

Administrative Service Organization/ Maryland Public Behavioral Health System (PBHS)

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Pregnant Women and Women with Children

Priority Type: SAP, SAT

Population(s): PWWDC

Goal of the priority area:

Reduce rates of SUD among pregnant and parenting women in Maryland

Objective:

1. Increase the number of pregnant women screened for SUD by 2% by the end of FY2021.
2. Increase the number of PWW and families who receive SUD treatment services by the end of FY2021.

Strategies to attain the objective:

Provide access to screening, substance use treatment and recovery support services to pregnant and parenting women and their families

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of pregnant women receiving sBIRT services
Baseline Measurement:	Number of pregnant women participating in sBIRT services in FY2019 - new measure in 2019 1,733
First-year target/outcome measurement:	Number of pregnant women participating in sBIRT services in FY2020 will be 1,768
Second-year target/outcome measurement:	Number of pregnant women participating in sBIRT services FY2021 will be 1,803

Data Source:

State Opioid Response (SOR) Progress Reports

Description of Data:

BHA has partnered with the University of Maryland School of Medicine and the Systems Evaluation Center to support SOR data collection and evaluation efforts. SOR data collection includes progress reporting and quality improvement activities for all SOR implemented programs including sBIRT, crisis, MAT re-entry services, Naloxone distribution, recovery residences, workforce development training in MAT and technical assistance for healthcare professionals (MACS) in the identification and treatment of SUD and management of chronic pain.

collection and evaluation efforts. SOR data collection includes progress reporting and quality improvement activities for all SOR implemented programs including sBIRT, crisis, MAT re-entry services, Naloxone distribution, recovery residences, workforce development training in MAT and technical assistance for healthcare professionals (MACS) in the identification and treatment of SUD and management of chronic pain.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	SUD residential treatment for pregnant and parenting women
Baseline Measurement:	Number of pregnant women & women w/children who recieved SUD Residential treatment services in FY2019: 238 services in FY2019: 210
First-year target/outcome measurement:	Number of pregnant women & women w/children who recieved SUD Residential treatment services in FY 2020: 250 services in FY 2020: 275
Second-year target/outcome measurement:	Number of pregnant women & women w/children who recieved SUD Residential treatment servicesin FY2021: 275 servicesin FY2021: 300

Data Source:

PBHS Data/Administrative Service Organization/ Maryland Public Behavioral Health System (PBHS)

Description of Data:

PBHS Claims Data.The data system collects information on those who receive mental health and substance use disorder services in the PBHS. including number served, number of units and expenditures are collected within this system. All stored data can be retrieved and reported using an automated reporting system or ad hoc reports. This data can be formatted to produce monthly, quarterly or annual reports.

PBHS. including number served, number of units and expenditures are collected within this system. All stored data can be retrieved and reported using an automated reporting system or ad hoc reports. This data can be formatted to produce monthly, quarterly or annual reports.

Data issues/caveats that affect outcome measures::

Priority #:	4
Priority Area:	Individuals with or at Risk of HIV Infection
Priority Type:	SAT
Population(s):	EIS/HIV

Goal of the priority area:

: Increase access to HIV early intervention services; Reduce incidence and transmission of HIV among people with SUD

Objective:

Increase the percentage of people in SUD treatment who are tested for HIV and or receive counseling and education services by 10% by the end of FY2021

Strategies to attain the objective:

Maintain the sexual health integration initiative that provides HIV/EIS funding to local health departments in Maryland jurisdiction's impacted by high rates of HIV; operationalize a sexual health framework within SUD treatment services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of people tested for HIV

Baseline Measurement: Number of people in SUD treatment tested for HIV in FY2019 was 2070

First-year target/outcome measurement: Number of people in SUD treatment tested for HIV in FY2020 will be 2277

Second-year target/outcome measurement: Number of people in SUD treatment tested for HIV in FY2021 will be 2504

Data Source:

Maryland Department of Health, Prevention and Health Promotion Administration (MDH-PHPA)

Description of Data:

HIV data is collected by the MDH-PHPA, Infectious Disease Bureau

Data issues/caveats that affect outcome measures:

Priority #: 5

Priority Area: Behavioral Health Workforce Development

Priority Type: SAT, MHS

Population(s):

Goal of the priority area:

Increase the number of healthcare professionals who are trained and culturally competent to deliver evidence based SUD services to people in need.

Objective:

Conduct and disseminate workforce training, education and technical assistance materials and resources that address prevention, treatment and recovery from SUD to healthcare providers across the state.

Strategies to attain the objective:

Develop and publicize workforce trainings, workshops, conferences, webinars, and other resource materials to prevent and treat mental health and substance use disorders; Utilize innovative technological approaches to boost opportunities for practitioner participation in workforce development offerings.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: MAT Workforce Development Training

Baseline Measurement: Number of healthcare professionals and paraprofessionals completing training in FY2019- new measure data not complete

First-year target/outcome measurement: Number of healthcare professionals and paraprofessionals completing training in FY2020:

Second-year target/outcome measurement: Number of healthcare professionals and paraprofessionals completing training in FY2021:

Data Source:

: State Opioid Response (SOR) Progress Reports

Description of Data:

: BHA has partnered with the University of Maryland School of Medicine and the Systems Evaluation Center to support SOR data collection and evaluation efforts. SOR data collection includes progress reporting and quality improvement activities for all SOR implemented programs including sBIRT, crisis, MAT re-entry services, Naloxone distribution, recovery residences, workforce development training in MAT and technical assistance for healthcare professionals (MACS) in the identification and treatment of SUD and management of chronic pain.

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Behavioral Health Training and Technical Assistance
Baseline Measurement:	Number of healthcare professionals and paraprofessionals completing training in FY2019 - 6691
First-year target/outcome measurement:	Number of healthcare professionals and paraprofessionals completing training in FY2020 - 7000
Second-year target/outcome measurement:	Number of healthcare professionals and paraprofessionals completing training in FY2020 - 7300

Data Source:

University of Maryland Training Center for PBHS

Description of Data:

BHA has partnered with the University of Maryland School of Medicine and the Training Center

Data issues/caveats that affect outcome measures::

Priority #:	6
Priority Area:	Primary Prevention Among Youth
Priority Type:	SAP
Population(s):	PP

Goal of the priority area:

Prevent and reduce underage drinking, non-medical use of prescription drugs/opioids, youth binge drinking, youth marijuana use, and youth heroin use, as measured by the National Survey on Drug Use and Health (NSDUH).

Objective:

1. Reduce rate of past 30-day alcohol use by Maryland youth ages 12-20 as measured by comparison of yearly Community NSDUH data.
2. Reduce rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 by comparison of yearly Community NSDUH data.
3. Reduce rate of past 30-day binge drinking by Maryland youth and young adults ages 18-25 as measured by comparison of yearly Community NSDUH data.
4. Reduce rate of past year use of heroin by Maryland youth and young adults ages 12-25 by comparison of yearly Community NSDUH data.
5. Reduce rate of past 30-day marijuana use by Maryland youth and young adults ages 12-25 by comparison of yearly Community NSDUH data

Strategies to attain the objective:

Ensure that local grantees are implementing evidence-based primary prevention strategies that address underage drinking, non-medical use of prescription drugs/opioids, youth binge drinking, youth marijuana use, youth heroin use, and their contributing factors through the annual review of grant applications, and ongoing monitoring.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce Rate of past 30-day alcohol use by Maryland youth ages 12-20

Baseline Measurement: Rate of past 30-day alcohol use by Maryland youth ages 12-20 in FY19

First-year target/outcome measurement: Rate of past 30-day alcohol use by Maryland youth ages 12-20 in FY20

Second-year target/outcome measurement: Rate of past 30-day alcohol use by Maryland youth ages 12-20 in FY21

Data Source:

National Survey on Drug Use and Health

Description of Data:

"The National Survey on Drug Use and Health (NSDUH) provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States." (taken from <https://nsduhweb.rti.org/respweb/homepage.cfm>)

Data issues/caveats that affect outcome measures::

NA

Indicator #: 2

Indicator: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25

Baseline Measurement: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 in FY19

First-year target/outcome measurement: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 in FY20

Second-year target/outcome measurement: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 in FY21

Data Source:

National Survey on Drug Use and Health

Description of Data:

"The National Survey on Drug Use and Health (NSDUH) provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States." (taken from <https://nsduhweb.rti.org/respweb/homepage.cfm>)

Data issues/caveats that affect outcome measures::

NA

Indicator #: 3

Indicator: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25

Baseline Measurement: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 in FY19

First-year target/outcome measurement: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 in FY20

Second-year target/outcome measurement: Rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 in FY21

Data Source:

National Survey on Drug Use and Health

Description of Data:

"The National Survey on Drug Use and Health (NSDUH) provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States." (taken from <https://nsduhweb.rti.org/respweb/homepage.cfm>)

Data issues/caveats that affect outcome measures::

NA

Indicator #:

4

Indicator:

Rate of past year use of heroin by Maryland youth and young adults ages 12-25

Baseline Measurement:

Rate of past year use of heroin by Maryland youth and young adults ages 12-25 in FY19

First-year target/outcome measurement:

Rate of past year use of heroin by Maryland youth and young adults ages 12-25 in FY20

Second-year target/outcome measurement:

Rate of past year use of heroin by Maryland youth and young adults ages 12-25 in FY21

Data Source:

National Survey on Drug Use and Health

Description of Data:

"The National Survey on Drug Use and Health (NSDUH) provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States." (taken from <https://nsduhweb.rti.org/respweb/homepage.cfm>)

Data issues/caveats that affect outcome measures::

NA

Indicator #:

5

Indicator:

Rate of past 30-day marijuana use by Maryland youth and young adults ages 12-25

Baseline Measurement:

Rate of past 30-day marijuana use by Maryland youth and young adults ages 12-25 in FY19

First-year target/outcome measurement:

Rate of past 30-day marijuana use by Maryland youth and young adults ages 12-25 in FY20

Second-year target/outcome measurement:

Rate of past 30-day marijuana use by Maryland youth and young adults ages 12-25 in FY21

Data Source:

National Survey on Drug Use and Health

Description of Data:

"The National Survey on Drug Use and Health (NSDUH) provides up-to-date information on tobacco, alcohol, and drug use, mental health and other health-related issues in the United States." (taken from <https://nsduhweb.rti.org/respweb/homepage.cfm>)

Data issues/caveats that affect outcome measures::

NA

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Footnotes:

Counts are preliminary and reflect only those programs that were operational as of June 30, 2019. Baselines will be re-established and targets set, once all programs are operational.

BHA has identified the following priorities areas that support our continued efforts to implement behavioral health integration. These include but are not limited to:

Customer Service:

- Combatting the opioid crisis through the expansion of prevention, treatment and recovery support services.
- Addressing serious mental illness and serious emotional disturbances.
- Improving communication and collaboration with/among BHA, local behavioral health authorities, stakeholders and other state and federal

agencies.

Accountability and Compliance:

- Continually improving data collection, analysis, dissemination, and program and policy evaluation.
- Instituting value-based contracting and tracking of financial expenditures.
- Ensuring quality management and adherence to regulations of behavioral health providers/facilities through accountability and compliance.

Learning and Innovation:

- Strengthening behavioral health workforce's training and education.
- Reinforcing recruitment and retention efforts through training and job advancement opportunities.
- Enhancing the use of information technology and organizational resources to improve the accessibility and quality of behavioral health services.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$23,869,866		\$755,288,516	\$37,944,650	\$154,382,114	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$4,013,084		\$1,500,206	\$0	\$0	\$0	\$0
b. All Other	\$19,856,782		\$753,788,310	\$37,944,650	\$154,382,114	\$0	\$0
2. Primary Prevention	\$6,816,365		\$0	\$7,016,580	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$11,000	\$0	\$0
5. Early Intervention Services for HIV	\$1,704,091		\$0	\$0	\$1,300,000	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$1,691,504		\$0	\$0	\$2,524,430	\$0	\$0
10. Total	\$34,081,826	\$0	\$755,288,516	\$44,961,230	\$158,217,544	\$0	\$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention [†]		\$24,387,710	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$2,709,746	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$0	\$0	\$0	\$0	\$0
7. Other 24 Hour Care		\$0	\$0	\$0	\$60,898,882	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$0	\$0	\$0	\$43,509,781	\$0	\$0
9. Administration (Excluding Program and Provider Level)***		\$0	\$0	\$0	\$0	\$0	\$0
10. Total	\$0	\$27,097,456	\$0	\$0	\$104,408,663	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	1547
2. Women with Dependent Children	0	18567
3. Individuals with a co-occurring M/SUD	0	55145
4. Persons who inject drugs	0	24856
5. Persons experiencing homelessness	0	15900

Please provide an explanation for any data cells for which the state does not have a data source.

Numbers for Estimated Need are unavailable at this time. The Behavioral Health Administration currently does not derive and report population estimates and projections on these specific groups. We don't have any clear methodologies, national, or state benchmarks to use to determine these estimates.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$23,869,866	
2 . Primary Substance Abuse Prevention	\$6,816,365	
3 . Early Intervention Services for HIV **	\$1,704,091	
4 . Tuberculosis Services	\$0	
5 . Administration (SSA Level Only)	\$1,691,504	
6. Total	\$34,081,826	

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Strategy	A	B	C
	IOM Target	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
1. Information Dissemination	Universal	\$1,363,035	
	Selective	\$0	
	Indicated	\$0	
	Unspecified	\$0	
	Total	\$1,363,035	\$0
2. Education	Universal	\$408,910	
	Selective	\$238,531	
	Indicated	\$34,077	
	Unspecified	\$0	
	Total	\$681,518	\$0
3. Alternatives	Universal	\$477,063	
	Selective	\$184,010	
	Indicated	\$20,445	
	Unspecified	\$0	
	Total	\$681,518	\$0
4. Problem Identification and Referral	Universal	\$34,075	
	Selective	\$0	
	Indicated	\$0	
	Unspecified	\$0	
	Total	\$34,075	\$0
	Universal	\$615,070	

5. Community-Based Process	Selective	\$32,372	
	Indicated	\$0	
	Unspecified	\$0	
	Total	\$647,442	\$0
6. Environmental	Universal	\$3,408,777	
	Selective	\$0	
	Indicated	\$0	
	Unspecified	\$0	
	Total	\$3,408,777	\$0
7. Section 1926 Tobacco	Universal	\$0	
	Selective	\$0	
	Indicated	\$0	
	Unspecified	\$0	
	Total	\$0	\$0
8. Other	Universal	\$0	
	Selective	\$0	
	Indicated	\$0	
	Unspecified	\$0	
	Total	\$0	\$0
Total Prevention Expenditures		\$6,816,365	
Total SABG Award*		\$34,081,826	
Planned Primary Prevention Percentage		20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award	FFY 2021 SA Block Grant Award
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Column Total	\$0	
Total SABG Award*	\$34,081,826	
Planned Primary Prevention Percentage	0.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input type="checkbox"/>
LGBTQ	<input type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020			FY 2021		
	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	\$267,538	\$1,363,035	\$1,630,573			
2. Infrastructure Support	\$1,691,504	\$4,737,737	\$6,429,241			
3. Partnerships, community outreach, and needs assessment	\$25,107,346	\$34,075	\$25,141,421			
4. Planning Council Activities (MHBG required, SABG optional)						
5. Quality Assurance and Improvement						
6. Research and Evaluation						
7. Training and Education	\$199,073	\$681,518	\$880,591			
8. Total	\$27,265,461	\$6,816,365	\$34,081,826	\$0	\$0	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2020

Activity	FFY 2020 Block Grant	FFY 2021 Block Grant
1. Information Systems		
2. Infrastructure Support		
3. Partnerships, community outreach, and needs assessment		
4. Planning Council Activities (MHBG required, SABG optional)		
5. Quality Assurance and Improvement	\$622,000	
6. Research and Evaluation	\$582,982	
7. Training and Education	\$870,182	
8. Total	\$2,075,164	\$0

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Footnotes:

No updates at this time.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²² Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.²⁷

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³⁰ Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁶ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.³⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²² BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Maryland Department of Health (MDH) – Health Care System

Maryland's Department of Health (MDH) is responsible for administering behavioral health services through the Public Behavioral Health System for Medicaid and eligible uninsured individuals residing in Maryland. Maryland continues to implement ongoing efforts to integrate services for mental health and substance use disorders. MDH serves as the State Mental Health Authority, the Single State Agency (SSA) for Substance Use Services, and the State Medicaid Agency. MDH has four divisions—two of which have significant roles in the administration of Maryland's public behavioral health system: the Behavioral Health Administration (BHA) and the Medicaid Agency.

BHA is responsible for all publicly funded specialty mental health and substance use disorder (SUD) services. BHA maintains a statewide, integrated service delivery system through a continuum of treatment modalities that promotes the public health and safety of patients, participants, families, and communities in all jurisdictions throughout Maryland. MDH's Maryland Medicaid program, in whole or in part, funds the cost of health care services for approximately 1.4 million Marylanders. At present, over 200,000 Marylanders receive specialty mental health services annually through the PBHS, 96% are participants in the Medicaid system. In addition, 100,000 Marylanders receive publicly funded substance use disorder services, 96% are Medicaid participants. Of those receiving services under the PBHS, approximately 33% have dual diagnoses. The services available under the PBHS are those presently covered by Medicaid as well as others offered by Federal, State, and other grants that support the continuum of care.

Currently, about 85% of all Maryland Medicaid participants receive somatic health services through an MCO, which is responsible for providing somatic care and primary behavioral health care through a risk-based, capitated payment system. Currently nine MCOs participate in the HealthChoice program. Providing managed care in Maryland requires ensuring access to services, meeting certain quality measures, collecting and analyzing encounter data, and participating in performance improvement projects as defined by MDH. Any MCO that meets the standards set by MDH can participate in HealthChoice.

The remaining 15% of participants receive their somatic care through a Fee for Service (FFS) system. Populations whose services are paid FFS include individuals who are:

1. Newly eligible for Medicaid and waiting to select an MCO
2. In a spend down category
3. Over the age of 65
4. Dually eligible for Medicare and Medicaid
5. Living in institutions

6. Participating in the Employed Individuals with Disabilities program
7. Participating in the Rare and Expensive Case Management (REM) program, or
8. Participating in the Model Waiver.

In fiscal year (FY) 2015, funding for Medicaid services for mental health was moved from BHA to Medicaid, which created a specialized unit for behavioral health services that works in close partnership with BHA to administer behavioral health services for individuals funded by Medicaid. MDH carved substance use disorder (SUD) treatment out of the MCOs to be jointly administered with MH services under the PBHS. Under this model, MCOs are still responsible for behavioral health services which can be obtained from a Medicaid participant's primary care provider. Medicaid participants needing specialty behavioral health services, both those in managed care and in FFS, receive services through the specialty behavioral health providers.

In February 2019, in an effort to further integrate behavioral health services with public health, the Department moved prevention-related activities to the Public Health Services Division. These activities were previously under BHA's Division of Health Promotion and Prevention (HPP). This also included the prescription drug monitoring program (PDMP), tobacco services, HPP has reorganized and is now the Service Access and Innovation Division. The Division will oversee consumer affairs, veterans, gambling services, and workforce development. Another Departmental reorganization include the state facilities. State facilities are no longer under the BHA. The seven (7) facilities, five (5) psychiatric and two (2) regional institutes for children and adolescents (RICAs) are now overseen by MDH's Deputy Secretary of Operations.

BHA handles clinical and system issues, whereas Medicaid is the lead regarding payment rates, compliance issues, and the development of State regulations and the Medicaid State Plan. BHA and Medicaid worked closely together to design integration of mental health and substance use services. In partnership with BHA, the Department/Medicaid contracts with Maryland's Administrative Services Organization (ASO) that administers integrated behavioral health services. The ASO's responsibilities include: provider management and maintenance; operating a utilization management system; service authorizations; paying all Medicaid claims and uninsured claims for individuals receiving behavioral health services; providing data collection, analysis and management information services (including grant funded SUD services); offering participant and public information; consultation, training, quality management and evaluation services; and managing special projects and stakeholder feedback. The BHA shares responsibility for monitoring performance of all contract deliverables as the ASO administers and manages services for individuals that are Medicaid eligible as well as the eligible uninsured population, and manages services that impact both referenced populations with services that are state only or grant funded. This braided management of resources among Medicaid and non-Medicaid individuals and services creates a seamless system of care that assists individuals receiving services as they move on and off Medicaid, and across various funding streams. The BHA provides key direction and management in the ASO design and building of the system to manage PBHS services. The BHA is also responsible for managing the array of behavioral health services provided across the State and at the local level.

BHA is responsible for planning and monitoring this system of care, and it shares this authority with the local behavioral health authorities referred to as Core Service Agencies (CSAs) for mental health management, Local Addiction Authorities (LAAs) for substance use, and Local Behavioral Health Authorities (LBHAs) for both mental health and substance use. For the purposes of discussion in this document the term "local entities" refers to CSAs, LAAs and LBHAs. These local entities serve Maryland's 23 local jurisdictions and Baltimore City. They provide information and referrals, help build provider networks, handle consumer and provider complaints, and procure and monitor contracts for services not included in the statewide FFS system. The local entities collaborate with criminal justice and other safety net systems, develop innovative services, and assist the ASO with monitoring provider quality and compliance. They authorize certain state and grant funded behavioral health and support services, coordinate care for certain individuals, and assist MDH in reducing the cost of care. For example, each local entity receives regular reports of high cost users of behavioral health services in their jurisdiction and works with the ASO to develop a plan to produce good clinical outcomes while reducing costs of unnecessary health care utilization.

The PBHS provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the ASO including inpatient, outpatient, residential treatment (for children and adolescents) and partial hospitalization. Services provided and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. The ASO also pays for residential crisis services.

SUD coverage includes a comprehensive assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient detoxification, and residential SUD treatment services at the 3.7WM, 3.7, 3.5, 3.3 and 3.1 levels. The ASO also pays for information and referral, prevention, and recovery support services. ASAM Level 4.0 (Medically Managed Intensive Inpatient services) Expansion 1115 Waiver

As part of the \$1115 waiver renewal application submitted on June 30, 2016, the Department sought an amendment to authorize Medicaid funds to be used for co-occurring services with SUD as the primary presenting condition in Institutions for Mental Diseases (IMDs). CMS approved this amendment, permitting the Department to expand coverage to include treatment in IMDs. Specifically, Maryland requested expenditure authority for otherwise-covered services provided to Medicaid-eligible participants 22 through 64 years of age who are residing in a private IMD and have a primary SUD diagnosis and a secondary mental health diagnosis. The Department sought to extend coverage for ASAM Level 4.0 for up to 15 days in a month. The days authorized would be based on medical necessity but would not exceed 15 days per month. For the large cohort of Medicaid adults with co-occurring disorders, private IMDs can deliver specialized services for participants whose active psychiatric symptoms limit their access to many SUD treatment programs.

Effective July 1, 2019, coverage of IMD services at ASAM Level 4.0 for Medicaid adults who have a primary SUD diagnosis and a secondary mental health diagnosis are a covered Medicaid benefit. Participants receiving 4.0 services at an IMD, if subsequently transferred to a hospital or other facility for somatic care, are then readmitted as a second episode of care, or stay.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Behavioral Health Integration Activities

The need for improved coordination and behavioral health integration in Maryland was recognized as early as 2010 and efforts to build on the existing strengths of the PBHS were implemented as a result of the 2011 Joint Chairmen's Report of the Maryland General Assembly. MDH convened multiple workgroups and stakeholder forums resulting in recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance use disorders." In addition, MDH began to move toward using national accreditation standards rather than state-specific regulations for provider qualifications. The goal of integration is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to:

- A. Improve services for individuals with co-occurring conditions;
- B. Create a system of care that ensures a "no wrong door" experience;
- C. Expand access to appropriate and quality behavioral health services;
- D. Enhance cooperation and engagement;
- E. Capture and analyze outcome and other relevant measures for determining behavioral health provider and program effectiveness;
- F. Expand public health initiatives, and
- G. Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services.

BHA works in partnership with the University of Maryland Evidence Based Practice Center (EBPC) to encourage providers to become co-occurring capable. The EBPC supports the Maryland Behavioral Health Administration through various activities, including:

- Provides training/consultation on evidence-based and evidence-supported practices, in order to ensure adherence to fidelity (faithfulness to the EBP model) so expected outcomes are obtained.
- Following BHA's approval of a program to receive EBPC implementation efforts, on-site EBPC training/consultation are provided. When fully trained, a program receives a fidelity assessment by BHA Fidelity Monitors; trainers then develop Fidelity Action Plans (FAPs) in concert with the program which serves as a template for continued training/consultation activities, thus ensuring subsequent consultation addresses areas needing improvement. FAPS are shared with BHA and used during fidelity assessments.
- BHA and the EBPC have been providing EBP support for co-occurring capability for the past 12 years. Training and consultation for the SUD Specialists and Team Leaders on current and future Assertive Community Treatment (ACT) teams to enhance the Dual Diagnosis Capability (DDC) of those teams, in collaboration with the ACT Consultant/Trainer. Additionally, the intensive onsite training and consultation is provided for agencies requesting assistance in implementing practice change which promotes agency-wide Dual Diagnosis Capability (DDC), including provision of training on empirically supported tools to help agencies self-assess their DDC and develop plans for any DDC gaps identified, and to implement and monitor fidelity using empirically supported tools. Behavioral Health providers also have access to training on the use of scientifically validated screening and assessment instruments, in support of state regulations requiring this screening and assessment for COD. In conjunction with this activity, deliver a series of cross-training sessions with mental health and substance abuse professionals, addressing integrated treatment principles and practices.

BHA collaborates with the local behavioral health entities to address the needs of those with co-occurring disorders who have histories of trauma, are homeless, deaf or hard of hearing, or have criminal justice involvement. The Maryland Community Criminal Justice Treatment Program (MCCJTP) behavioral health staff work in partnership with substance abuse staff from the local entities to coordinate services for those with mental illness and substance abuse disorders.

The majority of the women with co-occurring disorders in the criminal justice system have children and a smaller population is pregnant while incarcerated. BHA was instrumental in developing and implementing a program for eligible pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW). The Chrysalis House Healthy Start Program is a collaborative effort with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, BHA, the Archdiocese of Baltimore. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility for pregnant and post-partum women and their babies. Pregnant women are referred by the court, the State's Attorney, or MDH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team. After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment; which includes trauma and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services housing; after-hours residential support; health education; and other support services.

Licensing and Accreditation

In accordance with authorizing legislation, the Maryland Department of Health (MDH) moved towards accreditation-based licensure for behavioral health providers as of January 1, 2018. Under COMAR 10.63, all behavioral health providers should obtain accreditation by an approved accrediting organization no later than January 1, 2018 to be licensed by April 1, 2018 to provide

community-based behavioral health services.

As part of MDH's commitment to improving customer service and patient care, the Substance Use Disorder (SUD) Accreditation Project was initiated in April to ensure SUD providers received the support needed to meet the January 1, 2018 deadline and that quality health care services remain available for all Marylanders seeking addiction treatment services.

The Behavioral Health Administration's Licensing Unit is responsible for licensing and certifying community-health programs throughout Maryland. The Licensing Unit in collaboration with BHAs' Accreditation Unit, which is responsible for accreditation activities for behavioral health providers, initiated detailed analysis of Maryland's SUD and MH provider network and their progress in meeting accreditation-based licensure requirements. The Office of Accreditation works very closely with the Office of Licensing, and Office of Compliance as well as other internal BHA offices and the various Approved Accreditation Organizations responsible for accrediting community-based agencies as a pre-requisite to license application. This office works with Accreditation Organizations to ensure smooth coordination between MDH and the various Approved Accreditation Organizations. Up to date statistics are maintained on Accreditation-based licensing, and technical assistance is provided to the provider community and other stakeholders. The Office is also responsible for handling situations in which organizations have lost accreditation and/or licensing, and for coordinating between the various elements of BHA involved in accreditation-based licensing.

This unit is responsible for the interface between BHA and the Approved Accreditation Organizations (AO).

In the Integrated Behavioral Health System, almost all providers are required to obtain accreditation from an MDH-approved Accreditation Organization as a pre-requisite for licensing under COMAR 10.63, the regulation governing most community-based behavioral health services. Each Accreditation Organization maintains its own standards, which are cross-walked to existing State regulation before approval, in order to sure that they are, at minimum, equivalent to the State regulations which preceded them. The Director of Accreditation maintains ongoing contact with management representatives of the Approved Accreditation Organizations and works closely with them to ensure that problems are resolved quickly, that confusion over standards and procedures is minimized, and that both parties are briefed on developments. Specifically, this team worked to 1) determine the number and characteristics of SUD providers in the state; 2) assess the accreditation status of SUD providers statewide; 3) identify potential obstacles preventing SUD providers from meeting accreditation-based licensure standards; 4) develop data driven recommendations to address any potential obstacles.

The BHA's Office of Licensing is responsible for the licensing of community-based behavioral health programs under COMAR Title 10, Subtitle 63, and COMAR Title 10, Subtitle 21. Community-based behavioral health programs include the following:

Mental Health Program Types:

- Outpatient Mental Health Centers;
- Psychiatric Rehabilitation Programs for Adults/Minors;
- Mobile Treatment Services Programs;
- Psychiatric Day Treatment Programs;
- Respite Care Services Programs;
- Supported Employment Programs;
- Residential Rehabilitation Programs;
- Group Homes for Adults; and
- Therapeutic Group Homes.

Substance Use Disorder Program Types:

- Level 1 Outpatient Treatment Services Programs;
- Level 2.1 Intensive Outpatient Treatment Services Programs;
- Level 2.5 Partial Hospitalization Treatment Services Programs;
- Level 3.1 Residential – Low Intensity Programs;
- Level 3.3 Residential – Medium Intensity Programs;
- Level 3.5 Residential – High Intensity Programs;
- Level 3.7 Residential – Intensive Programs;
- Withdrawal Management Services – may be provided at one or more treatment levels; and
- Opioid Treatment Services (also referred to as Opioid Treatment Programs).

The BHA Office of Licensing reviews each application for a license for compliance with applicable COMAR regulations and determines whether the application meets all conditions required (e.g. appropriate accreditation, staffing, etc.). Once it is determined that an applicant is in compliance, a license is issued.

The BHA Office of Licensing provides technical assistance to community-based behavioral health providers through a variety of methods including:

- Customer Service: Calling providers to remind them of the deadlines and offering resources;
- Provider Assistance: Offering technical assistance to explain the accreditation process and license application process;
- Application Assistance: Assisting providers with filling out the COMAR 10.63 License Application;
- Communication Exchange: Posting FAQs on BHA's website; and
- E-mail Portal: Designating an e-mail address for providers to submit inquiries.

Behavioral Health Integration Project - Local Systems Management Integration Plan

MDH has been moving toward strategic integration of behavioral health, including administrative functions, funding streams, and local systems management. The FY17 Maryland State budget reaffirmed the "policy imperative to fully integrate behavioral health services in the State" and directed the BHA to study the feasibility, costs, and benefits of merging Core Service Agencies (CSAs)

with the Local Addictions Authorities (LAAs) into Local Behavioral Health Authorities (LBHAs). In response to this legislative requirement, the Local Systems Management Integration Plan was developed. This Integration Plan builds on an analysis of experiences in all 24 local jurisdictions, plus financial data that indicated opportunities to increase value from systems management. While all local jurisdictions have begun the journey toward integration, and half have established a Local Behavioral Health Authority (LBHA) in lieu of their CSA and LAA, all have more integration work to do. More than dealing with organizational structure, it must also address differences in approaches to culture, leadership, budgeting, operations, workforce development, relationships and communication.

Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP)

Maryland continues efforts to address the gap between the need for and availability of child behavioral health services. Factors contributing to this gap include a lack of trained specialists, workforce shortages, particularly in rural settings, and/or provider capacity issues. The BHA's Office of Child and Adolescent Services has collaborated with University of Maryland School of Medicine, Johns Hopkins School of Public Health, and Salisbury University to implement the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP). BHIPP is a free service, available to all pediatric primary care providers in Maryland, which aims to expand the capacity of primary care providers (PCPs) to identify, refer, and/or treat child and adolescent mental health problems. There are currently over 375 providers enrolled in BHIPP statewide. The BHIPP program offers the following services:

1. Telephone consultation for PCPs to receive advice from child and adolescent mental health specialists, including psychiatrists, psychologists, and clinical social workers at the University of Maryland and Johns Hopkins. Mental health topics covered include screening, resource and referral, and diagnosis and treatment;
2. Continuing education opportunities for PCPs and their staff to develop and enhance mental health knowledge and skills;
3. Assistance with local referral and resources to link families to mental health services in their community.
4. In partnership with Salisbury University Department of Social Work, Co-location of graduate level social work students in primary care practices to provide on-site mental health consultation.

Maryland will expand this model to include the youth and adults with substance use disorders served in primary care settings.

Warm line consultation would be made available to primary care practitioners on issues related to substance use and abuse, including a focus on supporting buprenorphine prescribers in their primary care practice. This service would be available statewide. The purpose is to strengthen the link between somatic and behavioral health and to increase the number of providers who are willing to prescribe buprenorphine.

Maryland's Medicaid Health Homes Initiative – The health home provision authorized by the Affordable Care Act (ACA) provides an opportunity to build a person-centered system of care that achieves improved outcomes for recipients of state Medicaid programs. Health Homes aim to further integration of behavioral and somatic care through improved coordination. Medical treatment and behavioral health care not only are provided at the same location, but as components of a single treatment plan for the whole person. The program targets populations with behavioral health needs who are at risk for additional chronic conditions, offering them enhanced care management services from providers with whom they regularly receive care.

The BHA continues to collaborate with Maryland Medicaid on the implementation of a Chronic Health Home SPA. Maryland's implementation model enable health homes to act as a locus of coordination for individuals with a serious and persistent mental illness (SPMI) or serious emotional disorder (SED), in combination with meeting medical necessity criteria for Psychiatric Rehabilitation Programs (PRP) or Mobile Treatment (MT) services, or an opioid substance use disorder (SUD) that is being treated with methadone, and at risk for an additional chronic condition due to current alcohol, tobacco, or substance use. Health Home services also include: comprehensive care management, health promotion, comprehensive transitional care, individual and family support and referral to community and social support. Provider training and stakeholder education activities are ongoing. In addition to ongoing training and guidance from the Department, several forms of health information technology aid Health Homes in serving their participants, at zero to minimal cost to the providers. This includes real-time hospital encounter alerts and pharmacy use data from the Chesapeake Regional Information System for our Patients (CRISP), as well as an eMedicaid online portal that acts as an enrollment, reporting, and tracking mechanism. As of September 2016, Maryland has 83 Health Home sites, with 5372 active participants in third quarter reporting of 2016.

Additionally, MDH fosters collaboration with the ASO and MCOs on a regular basis. Behavioral health education materials are made available for somatic care providers that includes information on appropriate screening tools for identifying individuals who need behavioral health services beyond what would be provided by a primary care provider, as well as information necessary to identify individuals who need to be linked with Behavioral Health services e.g., Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Parity

States' Medicaid agencies were required to respond to the Centers for Medicare & Medicaid Services (CMS) final rule on their compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and the Affordable Care Act (ACA). MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical benefits, provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIP). MDH submitted its final report in March 2019.

States were asked to look at their benefit and utilization management practices and policies to ensure compliance with the following requirements:

- Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)—Dollar limits on the total amount of a specified benefit over a lifetime or

on an annual basis are not applied to MH/SUD benefits unless a limit is applied to at least one-third of M/S benefits.

- Financial Requirements (FRs)—Payment by beneficiaries for services received including copayments, coinsurance, and deductibles applied to a classification of MH/SUD benefits may be no more restrictive than the financial requirements applied to M/S benefits in the same classification.
- Quantitative Treatment Limitations (QTLs)—Limits on the scope or duration of a benefit that are expressed numerically such as day or visit limits applied to a classification of MH/SUD benefits may not be more restrictive than the QTLs applied to M/S benefits in the same classification.
- Non-Quantitative Treatment Limitations (NQTLs)—Limits on the scope or duration of benefits that cannot be expressed numerically, such as prior authorization, network admission standards, or data collection requirement, which otherwise limit the scope or duration of benefits applied to MH/SUD benefits such that they are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to M/S benefits.

Based on Maryland’s report, following its initial assessment, MDH determined that AL/ADLs, FRs, and QTLs are not applicable to the State’s parity analysis. Therefore, MDH made the decision to focus its analysis on NQTLs. MDH conducted the parity analysis of NQTLs by surveying benefit information from the State’s nine MCOs, the behavioral health administrative services organization (ASO), and CHIP.

In its preliminary analysis, MDH identified one NQTL of particular concern—Data Collection Requirements. To remedy this potential issue, MDH commenced a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data collection system while minimizing the risk of violating MHPAEA. MDH will use these forums to solicit input from the provider community and the broader public.

MDH intends to align any changes to the data collection process with the implementation of its new ASO contract in January 2020. In its final report to CMS, MDH did not identify any additional NQTLs of concern. However, stakeholders have raised concerns regarding MDH’s process for setting rates for MH/SUD services. MDH is currently engaged in an independent study of the rate setting process. MDH intends to submit the report to the General Assembly in the coming months.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? Yes No

b) and Medicaid? Yes No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

Maryland established a state-based health insurance exchange through inclusive and sustained collaboration with all stakeholders. The Maryland Health Benefit Exchange (MHBE) was established as a public corporation and independent unit of state government in 2011 in accordance with the 2010 Patient Protection and Affordable Care Act (ACA). In collaboration with the Department of Health (MDH), Department of Human Services (DHS) and the Maryland Insurance Administration (MIA), the MHBE created Maryland Health Connection where Maryland residents explore health insurance plans, compare rates, and determine their eligibility for tax credits, cost sharing reductions (CSR) and public assistance programs such as Medicaid and the Maryland Children’s Health Insurance Program (MCHP). Once an individual or family selects one of the many Qualified Health Plans (QHP) or programs available that best meets their needs, they will then enroll in that program directly through Maryland Health Connection.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education Yes No

b) Health risks such as

ii) heart disease Yes No

iii) hypertension Yes No

iv) high cholesterol Yes No

v) diabetes Yes No

c) Recovery supports Yes No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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10. Does the state have any activities related to this section that you would like to highlight?

Maryland Addiction Consultation Service (MACS)

BHA in collaboration with University of Maryland School of Medicine, Department of Psychiatry expand its existing Maryland Addiction Consultation Service (MACS), which currently offers telephone consultation, training, education, and assistance with referral identification to prescribers across Maryland in the treatment of their patients' substance use disorders and chronic pain management needs. Efforts are underway to plan for an expansion that would offer statewide technology transfer and technical assistance (TT), leverage telemedicine technology to increase access to rural and underserved areas and provide strategies for educating an emerging workforce. MACS Technology Transfer (MACS TT) will work with BHA to study, inform, and disseminate key best practices and policies to optimize the capacity and quality of workforce development related to addiction treatment, and more specifically the use of medication assisted treatment (MAT). One of the goals is to improve quality of primary care and specialty prescribers across Maryland in the identification and treatment of substance use disorders. Evaluation goals will include: (1) document and track activities and determine the effectiveness of the expanded MACS TT efforts, (2) improve the implementation and utilization of MACS TT, and (3) support data-driven decision-making with the goal of continuous quality improvement.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for [Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)⁴⁵.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁴⁷. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁴⁸. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
- a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No

7. Does the state have any activities related to this section that you would like to highlight?

BHA developed a data-driven Cultural and Linguistic Competency Strategic Plan for FY 2019-2020 to assist its leadership and workforce as well as local behavioral health entities and providers in conducting self-assessment and setting CLC goals, objectives, strategies and measurable outcomes in the formation of policies, programs and provision of services. The plan was developed in consultation with Maryland's Behavioral Health Advisory Council's Cultural and Linguistic Competence Committee and the Maryland Office of Minority Health and Health Disparities. BHA also reviewed research materials on cultural and linguistic competence, national behavioral health cultural and linguistic competence plans and standards; and adopted the National Culturally and Linguistically Appropriate Services (CLAS) standards. The plan has been widely disseminated to local CSAs/LAAs/LBHAs and other stakeholders, and is posted on BHA's website.

On June 21, 2019, BHA held a Cultural and Linguistic (CLC) Training Seminar. The goal of this event was to develop and broaden the cultural and linguistic competency of local, regional and state behavioral health entities, providers and those working with individuals with behavioral health needs. The training seminar targeted behavioral health professionals and other stakeholders in leadership positions and at the program level.

The Seminar featured two experts in the field of cultural and linguistic competence and skills training. Our keynote speaker was Dr. Karen Francis, Interim Director and Principal Researcher, Diversity and Inclusion, American Institutes for Research. Her presentation focused on what we need to do to achieve cultural and linguistic competence. Our plenary speaker and training facilitator was Ms. Jacqueline Coleman, Visionary Leader and CLAS Trainer/Facilitator and owner of Vision Que! LLC Consulting Firm. She explored with participants the relevance of the national CLAS standards to behavioral health work and provided them with practical tools to do CLAS self-assessment using BHA's CLCSP and develop short and long term goals.

Over a hundred participants from BHA and other state government agencies, local behavioral health entities and the provider community attended the CLC training seminar. Their response to this event was overwhelmingly positive.

To build on the momentum gained through the CLC training seminar, BHA will provide 4 regional in-person consecutive trainings on CLAS self-assessment and implementation of the national CLAS standards to local behavioral authorities and provider communities in September and October 2019. The regional training sessions will be followed by online (e-learning/Webinars). Additional technical assistance will also be provided to local behavioral health authorities on setting their CLC goals, objectives, strategies and performance measures/targets for FY 2021. BHA will also hold a one day CLC Conference in June 2020. The aim is to engage local behavioral health authorities and community based providers in presenting and exploring case studies which implemented the CLAS standards in the provision of BH services.

Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵³ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)⁵⁵ was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁴⁹ United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵⁰ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵¹ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? Yes No

2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) Leadership support, including investment of human and financial resources.
 - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) Use of financial and non-financial incentives for providers or consumers.
 - d) Provider involvement in planning value-based purchasing.
 - e) Use of accurate and reliable measures of quality in payment arrangements.
 - f) Quality measures focus on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (**RAISE**) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? Yes No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? Yes No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The State provides multi-faceted training, consultation and technical assistance on four specific evidence-based practices under the oversight of the BHA Clinical Services Division:

- (a) Supported Employment (SE)
- (b) Family Psychoeducation (FPE)
- (c) Assertive Community Treatment (ACT)

Family Psychoeducation is a therapeutic approach where practitioners' partner with consumers and their family members to treat serious mental illness. Family Psychoeducation includes a lot of working elements and focus on the illness as the purpose of treatment as oppose to family therapy.

Supportive Employment are advocates for their clients in the work field. They help clients in identifying what kind of job interest, conduct mock interviews, and support with on the job training. Supportive Employment Specialist also build relationships with different companies for clients who are interested in working, and they help clients make rational decisions when wanting to terminate or find another job.

Additionally, Supportive Education prepares people with psychiatric disabilities to achieve postsecondary education goals. Its mission is to empower adults with SMI to choose their own higher education goals and acquire the tools necessary for achievement in postsecondary education settings, attain their highest potential, and succeed in their efforts.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

BHA, continues to collaborate with the University of Maryland School of Medicine, the University of Maryland Medical System, Johns Hopkins Bayview Early Psychosis Intervention Clinic (EPIC), and Sheppard Pratt Health Systems Family Services, Inc.- OnTrack to offer specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. The programs use an integrated approach to address the health and mental health needs of young adults, including providing support for co-occurring substance-related disorders with metabolic-related disorders, and other co-occurring medical conditions. These programs are committed to reducing disability by equipping individuals at risk and their families with tools to manage their illness, move successfully through the developmental stages of growth, and establish a life of their choosing.

Maryland Early Intervention Program (MEIP) – University of Maryland School of Medicine service individuals in the early stages of mental illness with psychosis. They provide information for relatives, friends, educators and anyone interested in learning about early stages of mental health with psychosis. Education is provided for health and behavioral health providers interested in early psychosis. MEIP serve ages 15-35. MEIP has served an average of 105 clients. In addition to their services, the program has improved in outreach and education. They also hired 3 Supportive Employment Specialist, 2 Peer Support Specialist, and 1 Recover Coach over the last year. By obtaining additional staff they were able to provide adequate support for clients and render their needs.

RAISE Program-University of Maryland Medical Systems helps individuals cope with experience and improve ability to reach wellness, employment, education, and social skills. RAISE Program serve ages 15-35. RAISE has served an average of 30 clients. They have improved in transitioning clients who have been in their program for more than two years. In addition the team has been a tremendous support to clients who don't have family support and keeping them engaged in services.

Johns Hopkins Bayview EPIC offers comprehensive services to meet the needs of patients with early stages of psychosis. EPIC provides treatment to stabilize and reduce psychotic symptoms, help reduce hospital stays, improve treatment compliance, and maintain daily routine to improve overall day to day functioning. Serve ages 15-30. EPIC has served an average of 28 clients. The team has improved in communicating during treatment team and providing insight in notifying if medication changes has helped or needed improvement with their clients. In addition, the team has improved client's engagement with staff, taking medications, and being discharged to ongoing outpatient mental health clinics.

Family Services OnTrack help with obtaining independence with treatment. They provide outpatient treatment and services individuals and families diagnosis with mental health issues. OnTrack Maryland completes evaluation and treatment for adolescents and young adults. Individuals experiencing auditory or visual hallucinations, obtaining abnormal thoughts or beliefs, abnormal feelings and/or paranoia, serving ages 15-30. OnTrack has served an average of 26 clients. In addition to their services the team had massive improvement with clients obtaining job interviews, job placement, graduating from school and participation in Family Psychoeducation. They are able to maintain enough participants to host the group on a consistent basis.

Lastly, transition planning within our programs emphasize resilience as they assist young people as they prepare for adult life. Transition-Age Youth services and supports are available to youth beginning at age 16. There are twelve jurisdictions in the state of Maryland that provide Transition-Aged Youth services which consist of community and/or residential services. Services and supports are designed to prepare and facilitate achievement of goals related to relevant transition domains, such as: employment, career and educational opportunities, living situations, personal effectiveness, well-being, community contribution and life functioning. Services integrate traditional and nontraditional supports in developmentally appropriate and effective youth-guided local systems of care with the system goal of expansion of the evidence informed service provision throughout the state. The value placed on youth and family member participation continues as a major priority of the child, adolescent, and young adult behavioral health system of care.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Family Psychoeducation is a therapeutic approach where practitioners' partner with consumers and their family members to treat serious mental illness. Family Psychoeducation includes a lot of working elements and focus on the illness as the purpose of treatment as oppose to family therapy.

Supportive Employment are advocates for their clients in the work field. They help clients in identifying what kind of job interest, conduct mock interviews, and support with on the job training. Supportive Employment Specialist also build relationships with different companies for clients who are interested in working, and they help clients make rational decisions when wanting to terminate or find another job.

Additionally, Supportive Education prepares people with psychiatric disabilities to achieve postsecondary education goals. Its mission is to empower adults with SMI to choose their own higher education goals and acquire the tools necessary for achievement in postsecondary education settings, attain their highest potential, and succeed in their efforts.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

We were successful in FFY19 for the implementation of an additional Supported Employment and Education Specialists to each team and also adding a Peer Specialists to each team. The completed efforts have assisted clients to choose, obtain, maintain or advance within a community-integrated work and education environment consistent with their interests and preferences. These efforts have also enhance enrollment in services, expansion of potential referral resources, provide education and awareness to reduce stigma associated with behavioral health diagnoses and treatment. Planned activities for FFY2020 and 2021 include: recruitment of a Peer Specialist Supervisor to assist the Peer Specialists with national certification, specialized trainings, and continued guidance with the maintenance of their own recovery; and we are in the discussion phase of exploring expansion of another team within Maryland and recruitment on another First Episode Psychosis Coordinator to assist with ongoing Supported Employment and Family Psychoeducation Fidelity reviews.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Maryland is working towards an integrated outcome system for state-funded First Episode Psychosis (FEP) efforts. This document compares domains and areas of interest across Maryland's FEP outcome reporting systems. The team identified the domains and areas of interest in this document by evaluating reporting items across several sources. A brief description of each source can be found below.:

BHA/SEC Outcomes System: A system created for the BHA using selected data elements from several existing sources to collect outcomes from clinics receiving funds from the FEP Set Aside portion of the Mental Health Block Grant. This system was constructed but not deployed, therefore, it is not currently in use. The following sources contributed to its design: Conditions of Award (COA); Assertive Community Treatment (ACT); Outcome Measurement System – Adult and Child; Center for Excellence First Episode Psychosis Clinics (REDCap); OnTrackNY – New York implementation of the RAISE Connection Program (RAISE-CP); RAISE-CP Chart Review System used for treatment fidelity during research; Health Transitions / NOMS; IPS Study

Conditions of Award (COA): The conditions of award contract between the BHA and the clinics receiving funds from the FEP Set Aside portion of the Mental Health Block Grant. It outlines clinic-level and client-level information to be included in quarterly reporting from the clinics to the BHA. These reports are used to inform BHA generated reports to SAMHSA.

EIP Clinical System: Created by the Maryland Early Intervention Program (EIP) for Set Aside clinics to collect outcomes data for all individuals receiving FEP clinical services funded by the Set Aside. These data include identifiers and are entered into a HIPAA compliant system. This system may or may not be in use today.

EIP Research System: Created by the Maryland Early Intervention Program (EIP) to collect research data for individuals who have completed informed consent and enrolled in the study. It includes additional assessments, as well as elements collected via chart review. Chart review includes review of clinics' Electronic Health Records (EHRs) and paper medical records, as well as extracting information from the EIP Clinical System for individuals enrolled in the study.

PhenX: The PhenX toolkit provides recommended standard data collection protocols for conducting research. The protocols are selected by Working Groups of domain experts using a consensus process, which includes the scientific community. The Toolkit provides detailed protocols for collecting data and tools to help investigators incorporate these protocols into their studies. Using protocols from the PhenX Toolkit facilitates cross-study analysis, potentially increasing the scientific impact of individual studies.

PhenX toolkits have been developed for clinical and translational research for individuals with early psychosis,

The state of Maryland is currently collecting and reporting on data that reflects various domains which are significant to the clients being served. The domains will assist the state to understand the possible types of additional clinical and medical services that are needed for our clients and it can also help us evaluate appropriate assessments, services, and other miscellaneous items that could give clients the best treatment experience and outcomes. The domains currently collected and reported on are: Demographics, Housing, Monetary Income, Insurance, Primary Care, Course of Illness, Diagnosis, Somatic, Education, Employment, partnership with the Department of Rehabilitation Services (DORS), Safety, Legal System Involvement, Service Use and Utilization, Treatment Status, Identifiers, Substance Use, Cognition, Functioning, Shared Decision Making, Recovery Orientation, CSC Treatment Engagement, Family Outcomes, Client Satisfaction, and CSC Team Structure and Functioning.

10. Please list the diagnostic categories identified for your state's ESMI programs.

All primary psychotic disorders to include schizophrenia, schizophreniform disorder, unspecified psychotic disorder, schizoaffective disorder, brief psychotic disorder.

Please indicate areas of technical assistance needed related to this section.

n/a

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? Yes No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Person centered planning (PCP) is designed to enable individuals to direct their own plan for services and supports. It is aligned with BHA's emphasis on a recovery-oriented system of care. The Plan of care is intended to create a personalized, highly individualized approach oriented toward recovery and resilience. PCP aims to reflect the services and supports important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences.

Participants and family members are the central members of the team responsible for planning and developing a PCP. They are provided the option to direct and manage the planning process. The plan is directed by the individual receiving services. People important to the individual are also included in the process to achieve the desired outcomes. Providers make available the necessary information and support to ensure that the individual directs the process to the maximum extent possible. During the PCP meeting, participants can utilize a variety of PCP methodologies such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent PCP strategy. The family, friends, neighbors, professionals, and others important to the person can be invited to the meeting based on the person's preferences. Community Coordinators work with individuals to organize their meetings and develop their plans. The coordinator either has a relationship with the individual, or establishes a relationship with the individual prior to the meeting. They may be the individual (with support if desired), a family member, the support coordinator or professional affiliated with another organization. They contact the participant to obtain the person's preferences for the best time and location of the meeting. Meetings are held at participants' homes, jobs, community sites, day programs, or wherever he/she feels most comfortable reviewing and discussing his/her plan.

As part of the process of developing a PCP, the Coordinator works with the individual to gather information regarding the participant's goals, needs, preferences, health status, risk factors, etc. Together they review formal health, developmental, communication, and behavioral assessments conducted. This information and choices of available services are then shared with the individual and his/her representatives during initial meetings, quarterly monitoring activities, and annual plan meetings. The individual is encouraged to consider what is important to them to ensure clinical and support services reflect their personal preferences, strengths and needs, so that their desired outcomes are achieved. Providers assist individuals in identifying individual goals related to relationships, community participation, employment, income and savings, healthcare and wellness, education and other activities. This provides the individual with opportunities to seek employment and work in competitive integrated settings, to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid.
4. Describe the person-centered planning process in your state.

Since 2010, the Evidence Based Practice Center (EBPC) Trainers/Consultants have been incorporating Person-Centered Care (PCC) practices and guiding principles in the treatment planning and interventions of all Evidence-Based Practices (EBP) being supported throughout the state (ACT - Assertive Community Treatment, FPE - Family Psycho-education, IPS - Individual Placement and Support Supported Employment, ITCOD – Integrated Treatment for Co-Occurring Disorders, core practices for co-occurring capability and TAY – Transitional Age Youth services and supports including FEP – First Episode Psychosis). In FY 2019, the EBPC added an FTE position for a Trainer-Consultant to collaborate with referenced EBP Trainer-Consultants on reinforcing Person-Centered Care Planning (PCCP) as a complementary practice of these EBPs and to roll out PCCP practices to support interventions by additional programs. These include providers of Mobile Treatment (MT), Psychiatric Rehabilitation Programs (PRP) and

Residential Rehabilitation Programs (RRP) vis-à-vis the required DLA-20 functional assessment tool used by these programs; and the DLA-20's utility in tying person-centered assessment practices to the subsequent plans and interventions. Some products of the first year's efforts include:

The development of a plan for PCCP implementation and maintenance throughout state that sets annual goals and priorities per BHA guidance.

The development and piloting of trainings on using functional assessment data in conjunction with person-centered assessment practices to drive treatment planning and interventions for:

PRP outpatient (Supported Living) programs – developed and piloted trainings for use with agencies identified for technical assistance and for larger audiences with multiple agencies.

RRP -- developed trainings for use with agencies identified for technical assistance and for larger audiences with multiple agencies; and piloted trainings at agencies identified by BHA and by data reviews as needing technical assistance with assessing needs and delivering more effective progress-oriented interventions.

Provider Leadership – developed and piloted trainings for supervisors and leadership at agencies to increase PCCP implementation by supporting leadership's delivery of feedback on PCCP documentation and using person-centered practices to guide clinical or practice-oriented supervision of interventions.

The development of training materials on assessment skills and practices for piloting early this year to address needs identified by feedback from BHA and the Fidelity Monitoring Team (FMT) and colleagues at the EBPC showing system-wide needs for enhancing person-centered assessment skills at a variety of provider types.

The drafting of a Needs Assessment Survey for programs that have completed initial PCCP training offered in years prior to the creation of the PCCP Trainer-Consultant position. The Trainer-Consultant has submitted this plan for feedback to collaborators at the Systems Evaluation Center (SEC) at the University of Maryland, School of Medicine (UMSOM). Then with BHA approval, the Trainer-Consultant plans to roll out the plan and collect data.

The development of an Individual Recovery Plan (IRP) template for PRP programs to support more consistent PCCP treatment planning – in the final stages of revision with anticipated roll out in early FY2020.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes No

3. Does the state have any activities related to this section that you would like to highlight?

The BHA uses two methods to pay for services under contracts with MHBG and SABG subrecipients: cost reimbursement and grant awards with quarterly reconciliation. The funding agreement between BHA and the local behavioral health authorities includes the amount of Federal funds and the Catalog of Federal Domestic Assistance (CFDA) number (93.958). Prohibited MHBG/SABG expenditures are also noted in the federal funding agreement between BHA and the local behavioral health authorities. The allocation of funds to the local behavioral health authorities are exempt from the Maryland procurement statutes and is awarded on a noncompetitive basis.

In a separate administrative agreement between BHA and the local authorities, all applicable State and Federal terms and conditions are included in the document or attachments. This administrative agreement acts as an umbrella agreement for all agreements. In the MOU between BHA and the local behavioral health authorities for MHBG/SABG funds, the A-133 audit requirement and provisions for monitoring the contract are included.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

LOCAL HEALTH DEPARTMENT
FUNDING SYSTEM MANUAL

As of July 1, 2003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LOCAL HEALTH DEPARTMENT FUNDING SYSTEM MANUAL

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SECTION 100 – INTRODUCTION

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Scope

- (a) General coverage - This Manual specifies administrative and fiscal policy for all funding originating in the Local Health Department Funding System (LHDFS) made by the Maryland Department of Health and Mental Hygiene (DHMH) to local health departments (LHD) and which are processed through the Division of Program Cost and Analysis (DPCA) and are reflected on the Unified Funding Document (UFD).

- (b) Exclusions – This Manual does not govern the following:
 - (1) the administrative and fiscal policy of the Developmental Disabilities Administration’s Fee Payment System;

 - (2) grants as defined by COMAR 21.02.02.01B(46), other than Unified Funding Document funding;

 - (3) procurement contracts processed, executed and administered by the Department as provided in COMAR Title 21; or

 - (4) interagency agreements, memoranda of understanding or other similar arrangements with other governmental entities except for local health departments.

- (c) The Manual shall, by reference, become part of each award on the UFD. In the event of a conflict between this Manual and any of the Conditions of Grant Award on the UFD, the specific Condition of Grant Award shall prevail, but only to the extent allowed by applicable law, and only where the specific Condition of Grant Award states intent not to incorporate all or specific parts of this Manual.

- (d) All program administrations are required to have their UFD awards reviewed and processed through the DPCA.

- (e) The Division of Program Cost and Analysis will provide assistance on the UFD to the program administrations relative to sound fiscal management and proper accountability of public funds.

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Background

The DHMH’s LHDFS is performance driven and may involve contributory funding by the LHD in support of health related services. Such contributory funding includes income from user fees, insurance payments, charitable contributions and endowments, other government programs and other third party incomes. DHMH FUNDING GENERALLY DOES NOT COVER THE FULL COST OF THE SERVICE.

This Manual describes the details of the funding system. This revised Manual as

it applies to local health departments, supersedes all previous versions of the DHMH, Human Services Agreements Manual and DHMH, Grants Manual.

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Overview of Funding Process

The LHDFS is a funding system that limits reimbursement of LHD incurred costs to those that the Department agreed to support. It is not a system of full-cost reimbursement. Except for Formula Funding (see Section 1020) and Block Funding (see Section 1005), the funding system generally employed by the Department and which is described in this Manual has the following characteristics:

- a.) it is based on an approved line item budget, which is part of the funding agreement,
- b.) it is a performance driven system incorporating satisfaction of agreement specific performance measures,
- c.) it incorporates limited line item control of the LHD's expenditures,
- d.) it assumes the existence of other incomes to support the program,
- e.) it operates under the condition that departmental monies are spent last and recovered first, unless expressly specified otherwise, and,
- f.) it requires the LHD to attempt to collect fees from clients for certain specific human services.

Payments are made primarily in three ways: (1) as a transfer to an account maintained by DHMH for local health departments, (2) as a reimbursement for net costs of the local health department reflected on the DHMH 990 Report, and (3) per an invoice from local health departments. Local health departments are required to maintain records in accordance with generally accepted accounting principles and as specified by DHMH. At the end of each fiscal year a financial reconciliation is conducted, subject to audit and settlement by DHMH.

Funding reflected on the UFD is subject to audit by the DHMH Audit Division. Post audit resolution is based on these audit findings; this process is known as "Audit Settlement" (See Section 1002).

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Summary of Responsibilities – LHD inquiries should be directed to the Departmental offices indicated below, in the following topical areas.

- a) Annual LHD Budget and Planning Instructions - Division of Program Cost and Analysis
- b) Solicitations - program administration
- c) Status of award - program administration
- d) Request for payment via invoice - Division of Program Cost and Analysis
- e) Request for supplemental funding - program administration
- f) Request for budget modification - program administration
- g) Year-end Report (DHMH 440) - Division of Program Cost and Analysis

- h) Reconciliation - Division of Program Cost and Analysis
- i) Audit - DHMH Audit Division
- j) Post-Audit Settlement - Division of Program Cost and Analysis
- k) DHMH Invoices - DHMH General Accounting Division
- l) General policy clarification and technical or fiscal issues - Division of Program Cost and Analysis or program administration
- m) Corrections to FMIS Reports - DHMH General Accounting Division, except for corrections caused by reconciliation which should be directed to the Division of Program Cost and Analysis
- n) Forms - Division of Program Cost and Analysis or DHMH web page
- o) State procurement issues - the Office of Contracts Policy, Management and Procurement

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Distribution of Manual

One Manual will be issued to each LHD and program administration. The Manual is available on the DHMH web page through the links to the Budget Management Office and then to the Division of Program Cost and Analysis. Please contact a Grants Management Officer in the Division of Program Cost and Analysis for questions concerning the Manual, its distribution and its application. The telephone numbers for the Division of Program Cost and Analysis are: (410) 767-5140 or (410) 767-6062.

SECTION 1000 - DEFINITIONS

- 1000** **Accrual Basis** - a method of accounting whereby revenue is recognized as services are rendered and expenses are recognized as efforts are expended or services utilized to obtain the revenue.
- 1001** **Advance Payment** - a payment made to a LHD by DHMH before the expenditures relevant to that payment have been incurred.
- 1002** **Audit Settlement** - a post audit process in which managerial decisions are made based on reports filed by the DHMH Audit Division.
- 1003** **Award** - refers to that part of the total program budget that is funded by DHMH.
- 1004** **Award Letter** - a document issued by the program administration which summarizes provisions of the funding agreement (See Section 2020.04).
- 1005** **Block Funding** – These funds are awarded to the local health departments for specific program purposes, e.g., some bio-terrorism funding. The local health departments do not need to adhere to a line item budget and funds may be moved between line items without program administration approval unless specified otherwise. Only the total expenditures are considered in the reconciliation process.
- 1006** **Budget** - expenditure plan and income estimate detailed by line item entries.
- 1007** **Budget Modification** - a line item revision of a previously approved budget that neither increases nor decreases the amount of the award and does not increase or decrease the services to be performed.
- 1008** **Conditions of Grant Award** – specific and general conditions relative to each award listed on the UFD, which are accepted by the LHD as binding upon the LHD upon receipt of UFD awards from DHMH.
- 1009** **Construction** - the act of building a new structure from the ground up. This does not relate to repair, maintenance or renovation involving an existing structure.
- 1010** **Consultant** - an individual or organization that the LHD engages to deliver health-related services of a particular type or discipline directly to third party clients. Consultants are non-salaried and receive compensation for professional services by virtue of expertise and/or licensure in a professional discipline. Funding Agreements with Consultants are usually Fixed Price or Unit Price (hourly) and should be shown in the appropriate sub-object 200 series, other than line items 280, 289, 291 and 292 in the DHMH 4542 budget.
- 1011** **Contractor** - an individual or organization that the LHD engages to deliver non-

health related services or goods for the LHD. Examples of such services include: housekeeping, trash removal, bookkeeping, legal, and accounting services. If the funding agreement used by the LHD to acquire these services from the contractor is a Cost Reimbursement Agreement (see definition # 1013, Cost Reimbursement Funding Agreement), these costs should be shown in line item # 899 (Special Projects) on the DHMH 4542 budget packet. If the LHD uses a Fixed Price or Unit Price Funding Agreement for these services (see definition # 1019 , Fixed Price and Unit Price Funding Agreement), the costs should be shown in the appropriate sub-object 800 series, other than line items 881, 896, 898 and 899, in the DHMH 4542 budget.

- 1012** **Core Service Agency (CSA)** - the designated city, county or multi-county authority that is responsible for planning, managing and monitoring publicly funded mental health services.
- 1013** **Cost Reimbursement Funding Agreement** - denotes a funding agreement that relates the award to a detailed line item budget, possible line item control, and detailed reporting requirements such as year-end –reports (DHMH 440), audits, and documentation of the Vendor of Record’s review of the detailed line item budget. The expenditures for these agreements would be found in line item 896 for health related cost reimbursement agreements and line item 899 for non-health related cost reimbursement agreements.
- 1014** **Delinquent Account** - as defined by COMAR 17.01.01.03B or 17.01.01.04B (3)
- 1015** **DHMH** - The Department of Health and Mental Hygiene of the State of Maryland, the Department.
- 1016** **Director** - refers to the chief executive authority in any of the DHMH program administrations.
- 1017** **Encumbrance** - the obligation to expend funds, supported by contract or purchase order. An encumbrance may be recognized as an expenditure under certain conditions.
- 1018** **Fiscal Year** - the State of Maryland's fiscal year, running from July 1 through June 30.
- 1019** **Fixed Price and Unit Price Funding Agreement** - denotes a funding agreement where the award is not related to a budget. These funding agreements include a rate of payment for the services stipulated in the Agreement and payment is made only for services actually delivered. These types of agreements should be used only with documentation of one of the following: 1) the rate to be paid is the market rate for this type of service in the region where the service is being provided; 2) the rate to be paid is a rate set in law or regulation; 3) the rate to be paid is based on at least three years of experience with Cost Reimbursement

Funding Agreements with this vendor; or 4) is competitively procured.

The expenditures for these agreements would be found in line item 881 for health related fixed price and unit price agreements and the appropriate sub-object 800 series other than line items 881, 896 and 899 for non-health related fixed price and unit price agreements. Fixed price or unit price agreements for health related consultant services would be found in the appropriate sub-object 200 series other than line items 280, 289, 291 and 292.

Because of the nature of these agreements, they are exempt from many sections of this Manual, such as Budget Modifications, DHMH 440's, and certain provisions of the Audit section. These exemptions will be noted in the applicable sections.

- 1020** **Formula Funding** – Funds awarded to a local health department based solely on a mathematical formula, e.g., core public health funding. The expenditure of these funds is at the complete discretion of the local health departments unless specified otherwise. Only the total expenditures are considered in the reconciliation process. These funds are typically awarded to provide capacity.
- 1021** **Human Services** - for purposes of this Manual definition, means services acquired by the Department or an LHD by any method for the purpose of providing health related services, support, care or shelter directly to third-party clients under a grant, interagency agreement, contract or any other appropriate mechanism, the primary purpose of which is the arrangement for direct provision of these services to individuals.
- 1022** **Human Service Contracts** - a line item (#896) on the DHMH 4542 budget that is used to budget for health-related, Cost Reimbursement Funding Agreements with organizations. (See definition # 1013, Cost Reimbursement Funding Agreement)
- 1023** **Income** - an inflow of resources, in the form of cash, receivables or other property from customers or clients, which results from: the sale of assets or merchandise, the rendering of services, investments, grants or donations. This includes fee collections, ordinary income and capital gains and/or that which results from grants, gifts or donations.
- 1024** **LHD** - Local Health Department. A local health department is located in Baltimore City and each of the twenty-three Maryland counties.
- 1025** **Local Executive Authority** - a local government official, other than a local health officer/commissioner authorized to enter into and execute LHDFS agreements with the DHMH. Typically, this would be the Mayor, County Executive, the County Council President, County Commission President, etc. or their designees.

- 1026** **Local Funds** - refers to funding supplied by a county or municipal government. The LHD may or may not be the conduit of such funding and the funding may or may not be a statutory requirement or a matching requirement.
- 1027** **Local Health Department Funding System (LHDFS)** - The LHDFS is an administrative process whereby all DHMH awards for a given fiscal year to a LHD are listed in one document. That document is called the Unified Funding Document (UFD). The UFD is updated each month and includes award amounts, changes to existing awards, funding sources, relevant conditions of grant award and contact information for each award. The UFD is produced and distributed by the DPCA based on information received from the program administrations.
- 1028** **Matching Funds** - funding supplied by another source (e.g. state, local or federal) pursuant to a specific agreement to share or match LHDFS expenditures by some ratio, such as 90%/10% match.
- 1029** **Minority Business Enterprise (MBE)** - as defined in COMAR 21.01.02.01.
- 1030** **Modified Accrual Basis** - a basis of accounting whereby expenses are recognized on an accrual basis, i.e., as costs are incurred, while revenue is accrued only if those revenues are both measurable (reasonably estimable) and available to pay current period expenditures. Fee collections from self pay clients are not to be accrued and are recorded only when the income is received.
- 1031** **Performance Measure** - the identified measure of the output of a specific human service agreement. Performance measures are the deliverables identified by the program administration in each UFD award for each service funded by the Department. Performance measures must be specific, objective and measurable. There is an inherent correlation between the satisfaction of the performance expectations, i.e. performance measures, defined in the UFD and Departmental funding. Some examples of performance measures are: number of visits, number of counseling sessions, number of persons trained, number of days of service, funded slot utilization.
- 1032** **Prior Approval** - written permission provided by an authorized official in a DHMH program administration, in advance of an act when such approval is required, particularly when that act might be expected to result in either the obligation or expenditure of funds or performance measures which differ from the approved budget.
- 1033** **Program Administration** - a unit of the Department which funds and administers public health related programs via the LHDFS.
- 1034** **Purchase of Care** - a line item (#0881) on the DHMH 4542 budget that is used to budget for health-related, Fixed Price or Unit Price Funding Agreements with organizations. (See definition # 1019, Fixed Price and Unit Price Funding

Agreement)

- 1035** **Reconciliation** - a year-end process in which the fiscal aspects of an award on the UFD are resolved, subject to audit and settlement.
- 1036** **Renovation** - refers to activities which alter, convert or restore all or part of an existing property and add to the value or prolong the life of a property or adapt the property to new uses. The term also includes the installation or replacement in whole or part, of fixtures or systems such as plumbing, heating/cooling and electrical. Renovation includes activities which would otherwise be considered repair and maintenance such as painting, installation and replacement of minor fixtures if they are part of a renovation project.
- 1037** **Repair and Maintenance** - refers to activities which sustain, prevent damage to or restore existing components of a property or a system and which do **not** add to the value or prolong the life of a property or adapt the property to new uses. A repair keeps a property in good operating condition. The term excludes both activities entailing structural modification and the installation or replacement of systems such as plumbing heating/cooling and electrical.
- 1038** **Subvendor Service Provider** - an organization which delivers health related services to third party clients. The Service Provider can be the Vendor of Record (see # 1042) or an organization that has a funding agreement with the Vendor of Record.
- 1039** **Supplemental Award** - the means by which the Department provides additional funding to a LHD program.
- 1040** **Third Party Clients** - as defined in COMAR 21.01.02.01.
- 1041** **Unified Funding Document (UFD)** – A monthly document listing all the DHMH awards to a LHD. This document contains the following components.
1. Indicates if the original budget was submitted
 2. Indicates that a Fund Certification was submitted
 3. Identifies if a budget was submitted with a supplement /reduction
 4. Identifies the current type of transaction being posted (supplement/reduction/modification)
 5. Identifies the Local Health Department by County
 6. Identifies the program administration’s project code (G5044, T380G)
 7. Identifies the program administration that is providing the funding
 8. Identifies the County’s PCA code (F765N, F696N, F731N) - assigned by Community Health Administration
 9. Identifies the CFDA number for federal funds
 10. Identifies the unique award number (AD394RED, CH357IMM) - assigned by Division of Program Cost and Analysis
 11. Provides a description of the award. (IMMUNIZATION – IAP)

12. Indicates the base award for that fiscal year
13. Indicates any supplements/reductions to the base award
14. Identifies the total amount of the award
15. Identifies the funding source - General, Federal, Special Funds
16. Identifies the federal tracking number for federal funds, e.g., 03-1540, 02-2600
17. Identifies that there are conditions associated with the award
18. Identifies a contact person and phone number
19. Indicates if the signature sheet is signed and received by Program Cost & Analysis

1042

Vendor of Record - the LHD which entered into a LHDFS agreement with the DHMH and to whom Departmental funding is awarded.

2010

ACQUISITION OF SERVICES

2010.01

Selection of a Local Health Department to Provide Services – The local health departments are considered the principal operational arm of the Department. Therefore, except as provided in 2010.03, Directors of program administrations must consider the use of a local health department as the vendor-of-record or service provider for any new human services program within the jurisdiction, before issuing a solicitation for such services under the procurement process. New programs include types of services not previously supported by Department funds and additional or expansion services that are already supported by Department funds.

2010.02

Director Responsibility – The Director of the program administration is responsible for the determination of the content, nature and specifications of the services to be delivered and for the determination of the available level of State funding.

2010.03

Exclusions – The requirement for Directors of program administrations to consider local health departments for funding does not apply to funding: (1) by the Mental Hygiene Administration for Core Service Agencies, (2) by the Developmental Disabilities Administration for provider services under the Provider Consumer Information System (PCIS), or (3) pursuant to specific contrary federal, state or local requirements.

2010.04

New Programs – The Director of the program administration, in consultation with the local health officer, shall make a determination whether to utilize the local health department as the vendor-of-record or provider for any new human services programs within the respective jurisdiction. The Director of the appropriate administration and the local health officer may mutually agree that the services will be provided by a person or entity other than the local health department.

2010.05

Mediation and Appeal Process - If the Director and the local health officer do not agree on the role of the local health department, the issue shall be resolved by the following mediation/appeal steps:

Level 1: An attempt to mediate will be managed by the Director of the
Community Health Administration, or designee.

Level 2: The appropriate Deputy Secretary, or designee.

Level 3: The Secretary, or designee.

2010.06

Notice of Award - When the local health department is not funded as the vendor-of-record or provider for a human services program within its jurisdiction, the local health officer shall be notified in writing by the Director of the program administration of any contract award and supplemental award, reduction and/or termination made by alternative means to organizations located within the jurisdiction.

2020 **LOCAL HEALTH DEPARTMENT FUNDING SYSTEM (LHDFS)**

- 2020.01** **LHDFS** – All funds must be awarded to LHD’s utilizing the LHDFS process. Commencing in Fiscal Year 2004 (July 1, 2003) the Department of Health and Mental Hygiene will be implementing an electronic budget submission process for local health departments. This process is summarized below.
- a) Local health departments will submit their budget for review electronically to the program administration;
 - b) the program administration will review, approve and electronically submit the budget to the Division of Program Cost and Analysis (DPCA);
 - c) the DPCA will review, approve and upload the budget into the FMIS system;
 - d) the program administration will be notified by DPCA that the budget has been uploaded successfully, and
 - e) the program administration will send to the health officer an award letter, pertinent conditions of award and an electronic version of the approved budget file.
- 2020.02** **Term Of Award** – Awards made through the LHDFS are awarded for a period of time not to exceed one year in accordance with State appropriations. This award period must occur within the state fiscal year (July 1 through June 30).
- 2020.03** **Health Officer’s Signature** – A signature sheet must be signed annually by the Health Officer. This sheet is only required for the initial UFD award, and is valid for any subsequent new awards, modifications, reductions, and/or supplements made to the UFD during the award term. The Health Officer’s signature validates the acceptance by the Health Officer of responsibility to provide or secure human services in accordance with the specific conditions delineated by the UFD. If a specific provision(s) on the UFD contradicts the provision(s) of this Manual, said instrument shall prevail over this Manual but only to the extent allowed by applicable law, and only where the UFD specifically states intent not to incorporate all or a specific part of this Manual.
- 2020.04** **Award Letter** – For all awards made through the LHDFS, including new awards, modifications, reductions, and/or supplements, the Health Officer will receive an award letter issued by the program administration. At a minimum the award letter will contain:
- a) Name of the LHD,
 - b) Award number,
 - c) Program Cost Account (PCA) number,
 - d) Amount of award,
 - e) Source(s) of funding, if federal funds are included in the award, the amount of federal funds by CFDA number and the DHMH federal grant tracking number, and
 - f) Term of the award
- 2020.05** **Conditions of Award and Award Specifications** – All initial awards and any

subsequent changes may be accompanied by conditions or specifications placed on the LHD by the program administration that may limit or restrict the expenditure of the awarded funds. The UFD will note if any conditions or specifications are applicable to a particular award. Any full conditions or specifications will be sent to the Health Officer attached to the award letter. These conditions or specifications may include a line item budget, a program plan, performance measures, etc., as determined by the program administration.

2020.06

Unified Funding Document – This document summarizes all DHMH local health department funding awarded annually by each program administration to each local health department. The DPCA will update the UFD monthly and distribute it to each local health department and to each program administration.

2030

FUNDING PRINCIPLES

2030.01 **General** - DHMH FUNDING IS GENERALLY NOT A FULL-COST REIMBURSEMENT SYSTEM. The DHMH LHDFS is generally one of contributory funding to support health related services, which derive income from user fees, insurance payments, charitable contributions and endowments, other government programs and other third-party incomes.

It is a performance driven system. Each award listed on the UFD must identify any specific performance measures required by the program administration. The performance measures are the specific, objective, measurable units of service that are to be provided by the LHD (See Section 1031). Performance measures will be utilized throughout the LHDFS, from application to award, reconciliation and audit. DHMH program administrations and local health departments share responsibility for compliance with the defined performance measures. The LHD is responsible for satisfying all approved performance measures. DHMH program administrations are responsible for approving, monitoring and modifying the LHD's defined performance measures. The LHD's funding will be based upon its compliance with the defined performance measures approved by the funding DHMH program. Failure to comply with approved performance measure standards may result in a reduction in funding.

2030.02 **Maximum Award** - The award figure reflected on the UFD is the maximum amount of funding for which the Department shall be liable.

2030.03 **Supplemental Award** - Funding may be increased via a supplemental award. (See Section 2040)

2030.04 **Modifications** - The UFD award may be modified with respect to allocation of income and expenditures via a budget modification or with respect to performance measures via amended conditions of award. (See Section 2050)

2030.05 **Reduction/Termination** - An award may be reduced and/or altered for the reasons specified in Sections 2060 and 2070.

2030.06 **Funding Period** - Funds are awarded for a specific period as noted in the award letter and the UFD. The LHD must expend those funds during such period. (See Section 2020)

2030.07 **Unspent Funds** – Except for funds awarded to Core Service Agencies, DHMH funds unspent at the close of the funding period will revert to the Department.

2040 **SUPPLEMENTAL AWARDS**

2040.01 **Nature** - A supplemental award is the means by which the Department provides

additional funding to an existing LHD program on the UFD.

- 2040.02** **LHD Request** - A LHD may request supplemental funding at any time. However, the program administration must be contacted prior to written submission of the request to ensure availability of funds and to identify special conditions that may be imposed. If approved, the same processes as that employed for an initial award shall be used.
- 2040.03** **Status** - If approved, the supplemental budget replaces the original budget and any intervening budget action.
- 2040.04** **Notice** - The LHD is notified by the program administration in writing by an award letter and inclusion of the supplemental award on the monthly UFD.

2050 **BUDGET MODIFICATION**

- 2050.01** **Nature** - Budget Modification is a revised budget, which restates the original budget and incorporates line item changes desired by either the LHD or the program administration to achieve a new approved budget. A budget

modification does not affect the total amount of the DHMH award but may affect the amount of other funding sources. A budget modification is to be distinguished from a supplemental award budget. Both are revised budgets. However, a budget modification does not alter the amount of the DHMH award, whereas a budget supplement increases the amount of the DHMH award.

2050.02 **Status** - An approved budget modification supercedes the original budget or any previous budget action.

2050.03 **Implementation** - The LHD may submit budget modifications to the program administration up to April 15th for the current fiscal year. A LHD must submit a budget modification in accordance with the following guidelines.

A) The following guidelines are applicable to LHD's receiving funds from the Alcohol and Drug Abuse Administration, the Community Health Administration, the Family Health Administration, the Mental Hygiene Administration, the Cigarette Restitution Fund Program and non-Ryan White funding received from the AIDS Administration.

The LHD must submit a budget modification when a controlled line item in a previously approved budget is exceeded by the greater of 10% or \$5,000. Controlled line items are:

- 1) the total of salaries, consultants, special payments payroll and fringe costs,
- 2) equipment,
- 3) purchase of service,
- 4) renovation,
- 5) construction,
- 6) real property purchase,
- 7) third party income, including fee collections.

Non-budgeted line items require budget modification at \$5,000 or greater. Also, a budget modification is required if a condition occurs which has been specified by the program administration in the UFD which mandates the submission of a budget modification.

B) The following guidelines are applicable to local health departments receiving funds from the Medical Care Programs Administration and the AIDS Administration that include Ryan White funding. The LHD may

submit budget modifications to the program administration up to April 15th for the current fiscal year.

The LHD must submit a budget modification when a controlled line item in a previously approved budget is exceeded as detailed below. Controlled line items and budget modification thresholds for the

Medical Care Programs Administration and awards from the AIDS Administration that include Ryan White funding are:

- 1) the total of salaries, consultants, special payments payroll and fringe costs - by 4%
- 2) equipment – by \$1,000
- 3) third party income, including fee collections – by 5%

Also, a budget modification is required if a condition occurs which has been specified by the program administration in the UFD which mandates the submission of a budget modification.

C) The following guidelines are applicable to LHD’s receiving funds from the Developmental Disabilities Administration (DDA). The LHD may submit budget modifications to the program administration up to April 15th for the current fiscal year. Controlled line items for funds received from DDA are:

- 1) equipment,
- 2) renovation,
- 3) construction,
- 4) real property purchase.

Budget modifications are required if the budget for the above line items is exceeded by the greater of 10% or \$5,000. All other line items are **not** considered controlled line items for DDA awards on the UFD.

2050.04 **LHD Liability** - Budget modifications subject to approval (per Section 2050.03) that have not been submitted to and approved by the program administration may be considered a breach of the HDFS agreement. Unauthorized changes become the liability of the LHD. Also, it should be noted that annualized costs of personnel changes made without specific approval of the program administration (i.e. changes not requiring a budget modification) might not be funded in subsequent years.

2050.05 **Third-Party Income** - When a modification request is submitted because third-party income is over or under the budget estimate, the LHD may request an increase or decrease of the total program budget to reflect the change. When income from fees or collections exceeds the final approved budget, which may include one or more budget modifications, the DHMH funding must revert to the Department, absent provision to the contrary in the UFD. (See Section 2120.04)

2050.06 **Negotiation and Submittal** - A budget modification typically is negotiated by the LHD and the program administration and then formalized by submission of the budget modification to the program administration.

2050.07 **Form DHMH 4542** – Budget modifications are to be submitted electronically to

the program administration and must be submitted using the Local Health Department Budget Package (DHMH Form 4542). The DPCA is responsible for supplying the LHD Budget Package instructions and the electronic forms.

2050.08 **Addenda** - The program administration may require that the budget package (DHMH 4542) include additional information, for example:
a.) a narrative identification of all changes to the previous budget or
b.) a narrative describing any changes to programmatic operations.

2050.09 **DPCA Processing** - The program administration will forward all approved budget modifications to the DPCA for processing.

2050.10 **Status** – If approved, the modified budget replaces the original budget and any intervening budget actions.

2050.11 **Notice** - The LHD is notified by the program administration whether or not the modification is approved and by inclusion of approved actions on the monthly UFD. If approved, the budget modification is forwarded electronically by DPCA to the program administration who turn is responsible for sending it to the LHD.

2060 **REDUCTION IN FUNDING**

2060.01 **Reasons** - The reasons an award may be reduced are:

- 1) a failure to perform under one or more terms and conditions of the UFD,
- 2) a specified reduction in the scope of services to be delivered, as determined by the program administration,
- 3) a reduction in state appropriations - a cutback in state appropriations or

revision of estimated state income or insufficient appropriations to cover all costs for multi-year contracts,

- 4) a reduction in funding from non-general fund sources,
- 5) a realization of third party income in excess of that estimated in the budget, and/or,
- 6) an actual or projected under spending from that estimated in the budget.

2060.02 **Departmental Liability** -In the event of a reduction in funding, the appropriate program administration will be liable for payment of any valid expenditure, including an encumbrance, made by the LHD prior to receiving notice of the reduction.

2060.03 **Notice** – For a local health department, notification of the reduction is through the UFD. A Change in Grant Status for Local Health Departments (DHMH Form 4542M) will be forwarded to DPCA by the program administration along with the revised budget. The DPCA is responsible for the notification of the local health department.

2070 **TERMINATION**

2070.01 **Unified Funding Document (UFD)** - Termination of funding for a program awarded through the UFD shall follow the guidelines below.

2070.02 **Notice** - The program administration, by ninety (90) day written notice, may terminate funding awarded through the LHDFS in whole or in part when it is deemed by the program administration to be in the best interest of the recipients of service, the program administration and/or the State of Maryland.

- 2070.03** **Termination by the LHD** - Should the LHD wish to terminate a program funded through the UFD, it must make a written request for termination to the Director of the appropriate program administration at least ninety (90) days before the proposed termination date. Approval of the program administration must be secured before services to clients are stopped.
- 2070.04** **Departmental Liability** - In the event of the termination of a UFD program, the appropriate program administration will be liable only for payment of expenditures/encumbrances for authorized activities up to the effective date of termination.
- 2070.05** **Final Report** - Upon termination, by either the program administration or the LHD of a UFD program, the LHD must submit a final report of receipts and expenditures (DHMH 440) and performance measures (DHMH 440A) within sixty (60) days after the effective date of termination. If money is due the Department, a check for the full amount due must follow the final report (DHMH 440) within thirty (30) days of reconciliation.

2080 **ACCOUNTING**

- 2080.01** **Standards** -The vendor must maintain an accounting system and records relating to funds awarded through this Manual which conform to both the Annotated Code of Maryland, State Finance and Procurement Article, Sections 7-401 through 7-405 and Generally Accepted Accounting Principles.
- 2080.02** **Program Specificity** - A separate, distinct accounting record must be maintained for each award on the UFD.

- 2080.03** **Periodicity** - Accounting for each approved budget period must be segregated from every other budget period.
- 2080.04** **Income** - All income must be recorded, either on a cash or accrual basis, showing both source and amount.
- 2080.05** **Expense** - Each expense must be recorded on an accrual basis and charged against its appropriate line item and must be substantiated by documentation sufficient to identify the transaction.
- 2080.06** **Encumbrance** – Obligations for goods and services, which are to be furnished wholly in the subsequent year, are not recognized as expenditures in the current year. The Department recognizes any of the following conditions as a valid encumbrance of funds.
- a) The LHD has signed a contract for capital equipment, the delivery of which is scheduled during the funding period but the delivery is delayed for reasonable cause.
 - b) The LHD has signed a contract for Renovation/Remodeling goods and/or services which contract period begins but may not be completed during the funding period.
 - c) The LHD has signed a contract for services which contract period begins but may not be completed during the funding period.

Note: All of the foregoing encumbrances should be reflected in the final year end (June 30th) financial reports (DHMH 440 Annual Report or FMIS).

- 2080.07** **Salary, Fringe and Consultants – Documentation**
- (a) Salary and fringe costs must be supported by the following:
 - 1) Maintenance of a time-reporting system for personnel funded by the award;

- 2) maintenance of adequate records supporting charges for fringe benefits and,
- 3) maintenance of payroll authorization and vouchers.

- (b) Consultant costs must be supported by the following:
- 1) Maintenance of a time-reporting system for consultants funded by the agreement;
 - 2) maintenance of consultants' invoice and,
 - 3) maintenance of consultants' signed agreement and any professional licenses required by law.

2080.08 **Inspection** - The LHD's and any subvendor's accounting records relating to each award on the UFD must be made available for inspection or audit by the Department during normal business hours. All records must be maintained for five years and until all audit requirements are met, unless a longer retention period is required by federal, state or local requirements and then destroy if no longer needed.

2080.09 **Accounting Methods** - A LHD's accounting method or accounting basis determines when transactions and economic events are reflected in its financial statements. All local health department programs listed on the UFD may be on the accrual or modified accrual basis of accounting.

Generally, a LHD will not be permitted to change its basis of accounting merely to gain short-term advantage. Rather, a change in the basis of accounting would be made to improve accuracy and would remain in effect until it could be demonstrated that another change would result in greater accuracy. (See Section 2120.06)

2080.10 **Client Funds** – Local health departments who act as custodians of client funds or representative payees for clients must maintain appropriate records to account for these monies. The record shall include the client specific detail of source, amount received and nature and amount of any disbursement of clients' funds. Local health departments have a fiduciary responsibility to the clients in the handling of client monies. Local health departments are to establish the controls necessary to safeguard these monies. DHMH will not support or fund the replacement of client funds that are lost or stolen.

2090 **FISCAL REPORTING**

2090.01 **General** - Each LHD receiving funding under the provisions of this Manual generally file one or more of the following reports: DHMH 438 Interim Report of Actual Expenses, Receipts and Performance Measures, DHMH 440 - Annual Report, DHMH 440A Performance Measures Report and/or DHMH 990- Statement of Expenditures and Receipts.

2090.02 **Interim Report of Actual Expenses, Receipts and Performance Measures - DHMH 438** - This report is a required submission for those local health departments paid through invoices (DHMH 437) submitted to the DPCA. Local health departments paid through invoices submitted to DPCA must also submit in accordance with the schedule established by DPCA a separate Interim Report of Actual Expenses, Receipts and Performance Measures (DHMH 438) for each award on the UFD. These reports are required from the LHD on a quarterly or bi-monthly basis. The actual expenses, receipts and performance measures reported will be subject to analysis by the DPCA and/or the program administration prior to making the requested payment (via the DHMH 437).

Detailed instructions relating to the exact methodology and process for local health departments to submit the Interim Report of Actual Expenses, Receipts and Performance Measures (DHMH 438) are issued by and available from DPCA. In conjunction with the instructions on the Interim Report, local health departments should read the detailed instructions for the DHMH 437 Form, Human Service Agreement - Request for Payment – Vendor Invoice that also are available from DPCA.

2090.03 **Annual Report** - A local health department's Annual Report of Expenses, Receipts and Performance Measures (DHMH 440) for the budget period must be submitted to the DPCA by August 31 for the immediately preceding fiscal year or by sixty (60) days after close of funding period, unless the LHD elects to use FMIS. A LHD having its invoices paid by the DHMH, General Accounting Division has the option of submitting a DHMH 440 Report in place of the FMIS report. If the LHD exercises this reporting option, the DHMH 440 Report must be filed by August 31. Failure to submit this report within the specified time may result in funds being withheld until the reports are filed and reconciliation is complete.

2090.03.01 **Letter of Justification** - A Letter of Justification to request approval must accompany the annual report (DHMH 440) if actual expenditures vary from the approved budget for those items listed under Section 2050.03. The DHMH 440 Report will be returned by DPCA to the LHD if the Letter of Justification is missing. Local health departments whose expenditures are included on FMIS reports and who elect not to file a DHMH 440, must, nevertheless, file a Letter of Justification for variances as stated above. The Letter of Justification should state the nature of and rationale for the expenditures(s). The submission of timely

budget modifications is the preferred methodology to address unbudgeted expenditures and controlled line item over expenditures. However, the submission of the aforementioned year end Letter of Justification and its approval, as indicated on the DHMH 440 or FMIS report, is acceptable for reconciliation and audit purposes. It is recognized that the director of the program administration may disapprove any unauthorized expenditure.

- 2090.04** **Computer Facsimile** - A facsimile generated by the LHD may be acceptable in lieu of the departmental forms, DHMH 437, DHMH 438, and DHMH 440. Prior approval of the format by the DPCA is advised. The LHD assumes liability for rejection of their report format if prior approval is not obtained from DPCA.
- 2090.05** **Program Option** - The program administration may require additional fiscal reports at the Director's discretion.

2100 **PAYMENT**

2100.01 **Overview** - There are three primary methods of payment, as follows.

- 1) The DHMH, General Accounting Division through the State Comptroller, pays invoices on behalf of most local health departments.
- 2) The DHMH pays certain local health departments based on their submission of an invoice (DHMH 437) to the DPCA. This payment method is employed for certain costs of some local health departments.
- 3) The DHMH pays local health departments based on submission of monthly DHMH 990 Reports to the DHMH, General Accounting Division.

2100.02 **Payments by Submission of Invoices by a LHD**

Local health departments paid through invoices submitted to DPCA must submit a separate Request for Payment - Vendor Invoice DHMH 437 for each award on the UFD. These invoices are required from the LHD on a quarterly or bi-monthly basis. Detailed instructions relating to the exact methodology and process for local health departments to submit their invoices are issued by and available from DPCA. LHD payments will be subject to departmental cash management practices; funding will be advanced only to the extent warranted by an analysis of the related Interim Report of Actual Expenses, Receipts and Performance Measures (DHMH 438).

2100.02.01 **WIC Program** - The Women, Infants and Children (WIC) Program allows for monthly LHD payments. In such cases, the form DHMH 4330 must be used. Quarterly expenditure reports must be submitted to the State WIC Office.

2110 **COST PRINCIPLES**

2110.01 **Background** - This section establishes the cost principles for Departmental UFD

funding. The Director of the program administration is afforded broad discretionary authority to target Departmental support of LHD program costs to promote maximum effectiveness in the service delivery system consistent with state objectives. Also, this section establishes certain guidelines for the consideration of LHD costs to ensure accountability in the distribution of public funds.

2110.02 **Program Discretion** - The Director of the program administration shall exercise his/her discretion in determining what aspects of a LHD's program are to be supported by departmental human services funding.

2110.03 **Limitations** - The LHD may use funds for expenditures required to carry out an approved project/program limited by:

- a. the budget approved by the Director,
- b. the conditions of grant award and/or award letter (Refer to Section 2030),
- c. the specification of allowable costs in this section, unless specifically modified by the Director of the appropriate administration, and,
- d. the total amount of the award, as enumerated in the approved budget.

2110.04 **Reasonableness** - The Director will subject projected expenditures specified in a proposed budget or budget modification to a reasonableness test in accordance with any applicable DHMH policy and/or his/her own judgment regarding the general public interest and that of the clients to be served. Irrespective of its classification as an allowable cost, a cost is allowable only to the extent it is accepted as reasonable by the Director. Reasonableness requires that the cost be such an amount as would ordinarily be paid for comparable goods or services by a comparable purchaser, depending on the facts and circumstances in each case. Reasonable cost usually is limited by fair market value.

2110.05 **Criteria** - A cost may be considered unreasonable on the basis of either its nature or amount. In determining the reasonableness of a given cost, consideration shall be given to any and all relevant circumstances, including but not necessarily limited to the following:

- a. federal, state, local grant/contract regulations,
- b. requirements imposed by the terms and conditions of the award,
- c. whether the cost is of a type generally recognized as ordinary and necessary for the LHD's performance of the program,
- d. the restraints inherent in and the requirements imposed by sound business practices and arm's length bargaining and,
- e. the action that a prudent business manager would take under the circumstances, including general public policy and considering responsibilities to the employees, customers and the State.

In addition, the Chief, DPCA may review expenditures reported on the annual DHMH 440 for reasonableness and may request specific approval of the Director for all expenditures that the Chief, DPCA does not consider reasonable.

2110.06 **Direct Costs** - Any costs which are or can be specifically identified with a particular cost object (budget line item) and which is allocable to the approved project/program for which the funds are awarded is considered a direct cost. The LHD shall attribute all costs directly unless it is specifically authorized by the program administration to allocate certain costs as indirect costs.

2110.07 **Indirect Costs** - Indirect costs are defined under this policy as those costs which have been incurred for multiple or common objectives (shared costs) or as those costs associated with more than one cost object within that part of the LHD's operation which are both funded by the Department and which are not readily identifiable as direct costs without effort disproportionate to the achievable results. Indirect costs are not administrative or overhead costs per se. Such costs should be identified as direct costs unless they meet the foregoing test.

2110.07.01 **Authorization** - The Director of the program administration may, in accordance with applicable policy, authorize indirect costs to fairly reimburse a LHD for that portion of the program which, while necessary for the performance of the award, cannot readily be identified and funded as separate line items in the direct cost portion of the LHD's budget. The Director shall ensure that the approved budget (DHMH 4542) specifies the indirect cost for each award on the UFD.

2110.08 **Allowable Costs** - The Director may allow any costs which are consistent with the scope and purpose of those aspects of a program, which are or shall be supported by funding approved by the Department. Specific costs decisions not consistent with this Manual must be reflected in the conditions of grant award.

2110.08.01 **Guidelines** - The following expense items, unless specifically rejected or limited by the Director, may be considered allowable costs under the described conditions. Inclusion here does not guarantee acceptability; conversely, omission does not necessarily preclude it. Moreover, specification as an allowable cost does not absolve the LHD from the responsibility to document these costs in accordance with generally accepted accounting principles.

Generally, allowable costs are:

- a. Those costs relating to items included on the DHMH 4542 Program Budget Page, some of which are discussed further below.
- b. Accounting, Audit, and Legal Services as limited by Section 2110.09.o,
- c. Advertising - when it is for the purpose of recruitment of personnel or for outreach to actual or potential recipients of UFD supported services,

- d. Books, Periodicals, and Professional Journals - when these materials are for the general use of the LHD staff and/or the recipients of UFD services,
- e. Communications - including those for printing and copying,
- f. Consultant's Fees - when necessary to provide the level of service established in the UFD and/or award letter (See Section 2160),
- g. Dues and Membership - fees to professional organizations and societies, provided these memberships are organizational rather than personal,
- h. Equipment Lease and/or Purchase - the schedule of equipment prices in the Department of Budget and Management budget instructions for the applicable fiscal year may be used in any reasonableness test for these items (See Personal Property, Section 2150),
- i. Fringe Benefits - such as Life Insurance, Health Insurance, Disability Insurance, Social Security, Workmen's Compensation, Retirement, and Unemployment Insurance. The maximum percentage allotted to fringe benefit elements listed in the Department of Budget and Management budget instructions for the fiscal year for which funds are being requested may serve as a decision-making guide for the Director.
- j. Fund Raising Costs may be allowable. Fund raising costs, which do not generate a net benefit over time, may be disapproved in future budget requests. Income from fund raising in excess of the DHMH supported fund raising costs is not an allocable income source. (See Section 2120.03 Allocation of Income, item g.),
- k. Insurance is an allowable cost. Organizational liability insurance is an allowable cost, as is the cost of vehicle insurance.
- l. Interest costs may be allowable, with the prior approval of the program administration.
- m. Maintenance and Repair, except as provided under COMAR 10.04.01.08
- n. Payments to Advisory Council or Board of Directors as reimbursement for meals and travel only,
- o. Relocation costs for moving an organization; reimbursement for employee relocation costs are limited to the guidelines established by DHMH relating to the reimbursement of interview and moving expenses for new State employees.
- p. Renovation costs, as defined in Section 1036 and to the extent they meet the provisions of Section 2140,
- q. Rent or Mortgage - generally, the State does not pay rent for space occupied in public buildings; the actual costs of operating these buildings, e.g., utilities, janitorial service, grounds keeping, etc., may be allowable. (See Real Property- Section 2140)
- r. Salaries and Wages
- s. Travel - costs for mileage reimbursement by private automobile, van, or truck and daily meal allowances are allowable when related to UFD related programs. Rates published in the Department of Budget and

- Management budget instructions may be used as a reasonableness test.
- t. Vehicle - purchase or leasing costs are allowable if the vehicle is for transportation of recipients of Departmental services to or from service locations or for the transportation of service personnel and/or supplies from one service site to another or to home-bound clients for the purpose of delivering service. Rates published in the Department of Budget and Management budget instructions may be used as a reasonableness test.
 - u. Training costs for staff

2110.09 **Unallowable Costs** - The following items are costs generally considered to be unallowable for purposes of Departmental support. The list is not exhaustive; omission does not constitute acceptance as an allowable cost. The Director may allow cost in any of these categories when it is in the public interest to do so; conversely, he/she may elect not to support funding of a cost not listed here, including those generally considered to be allowable under the previous section (Section 2110.08.01).

Generally, Unallowable Costs are:

- a. Costs or expenses unrelated to the DHMH funded project,
- b. Costs not adequately documented,
- c. Collection costs and credit card processing fees,
- d. Malpractice insurance for a consultant and malpractice insurance for the LHD's professional employees is generally not allowable,
- e. Bonuses, except when awarded in accordance with an established program of state or local government,
- f. Client funeral and/or burial expenses,
- g. Contingency Funds, Reserves or Roll Over Funds, except as noted in CSA Section 2200,
- h. Depreciation - on all real property and on equipment purchased with awarded through the UFD,
- i. Employee/staff relocation costs in excess of limitations included in the DHMH, Personnel Services Administration's guidelines,
- j. Staff entertainment costs,
- k. Fines, claims, judgments, or penalties,
- l. Fundraising cost may be allowable. Fundraising costs, which do not generate a net benefit over time, may be disapproved in future budget requests. Income from fund raising in excess of the DHMH supported fund raising costs is not an allocable income source. (See Section 2120.03 Allocation of Income, item g.),
- m. Gifts, contributions, donations,
- n. Interest on obligations to local, state or federal governments or on obligations arising from item k. above,
- o. Legal fees to defend or pursue claims - A retainer paid to an attorney for normal business expenses such as a real estate transaction is allowable.

- Legal fees for defense of clients are not an allowable cost.
- p. Lobbying and/or advocacy costs (including membership dues in industry associations whose principal activity is lobbying or advocacy),
- q. Sabbatical leave,
- r. Bad debts incurred by private paying clients or third party payers and bad debts resulting from denied costs by the Department.
- s. Chaplain training and other religious training programs for staff members,
- t. Licensure fees for staff members; except for class C driver's license where having the license was a condition of employment at the time of employment,
- u. Losses and/or deficits on other grants and contracts,
- v. Loss of renting out a portion of the facility.

2110.10 **Pre-Payment of Expenses** - The Department prefers that expenses not be incurred until the actual delivery of goods or services. Pre-payment in this context applies only to payment made in the current funding period where the goods or services will not be delivered until the subsequent funding period. However, the Department will recognize the LHD's prepayment of expenses as valid under the following conditions:

- a. the agreement provides for refunding to the Department of unused pre-payment in the event funding is prematurely terminated, and
- b. the prepayment is expressly approved in writing by the program administration.

2120 **INCOME PRINCIPLES**

- 2120.01** **Background** - This section establishes the principles by which LHD income is considered. The section addresses both the DHMH award and all other LHD income and reviews the relationship among income types. The term "Income" is defined in Section 1000.
- 2120.02** **Director Authority** - The Director of the program administration shall have the authority to deviate, on an individual basis, from the principles stated in the following sections so as to exempt or modify the treatment of certain income. The Director of the program administration shall notify the DPCA of his/her decision to exempt or modify the treatment of income.
- 2120.03** **Allocation of Income** - All income resulting from, earmarked for or allocated to the operation or proposed operation of the DHMH supported human services delivery program is considered "allocable income" and must be identified in all budget and fiscal reporting documents and must be used to offset DHMH funded expenditures.

Generally, income resulting from or associated with the DHMH funded human services program shall be allocated to the human services program. This allocable income includes:

- a.) the DHMH award,
- b.) user or client fee collections,
- c.) Medicare/Medicaid collections,
- d.) other insurance collections,
- e.) federal, state (other than DHMH), county, municipal or private grants, contracts or payments or charitable contributions allocated to the UFD program as specified by the terms of the UFD,
- f.) income from businesses or other ventures operated by the LHD, to the extent that the DHMH award supports the costs of the businesses,
- g.) income from fund raising, to the extent supported by the DHMH award. Excess fund raising over the DHMH support of related cost must be used for program benefit. All fund raising income must be identified separately and explicitly in the budget and all fund raising income must be accounted for and be auditable. Income from fund raising in excess of the state supported fund raising costs will be shown separately on an attachment to the DHMH 440 but will not be used in the calculation of the DHMH liability in the final year end reconciliation.
- h.) interest or dividends earned on DHMH funds or other income allocable to the UFD program,
- i.) donations, charitable contributions, gifts or endowments allocated to the UFD program, as specified by terms of UFD agreement.
- j.) proceeds from the sale of assets (See Personal Property Section 2150),
- k.) awards or judgments derived from civil proceedings, to the extent that any costs associated with the proceedings or the particular case were supported

by DHMH funds or income allocated to the UFD program, except as otherwise provided by applicable State or local law.

- l.) Rent or royalty income to the extent that any costs associated with the activity that generated income were supported with DHMH funds or income allocated to the UFD program.

2120.04 **Order of Utilization** - All allocable income other than DHMH awarded funds shall be utilized before DHMH funds are used unless the UFD specifies an alternative protocol. A LHD is responsible for initiating the negotiations for an alternative protocol.

2120.05 **Recognition** - Accounting for the UFD program may be on the accrual or modified accrual basis. Certain income because of its nature may be recognized on a cash or a modified accrual basis because to do otherwise would distort the relationship between the income and its associated operations. Fee Collections from self-pay clients are recorded only when the income is received; other third party collections may be accrued. The matching of income to the appropriate period is reviewed in the final audit. (See Section 2080.09)

2120.06 **Restricted Funds** - When certain income is designated or restricted by the funding source, its treatment is dependent upon its relationship to the UFD program supported by DHMH funding as follows:

- a) if the designated/restricted funds are in support of the program also supported by the DHMH award, then the funding should be identified as income allocated to the UFD program and displayed in the budget and fiscal reporting documents in accordance with the designation/restriction. Documentation of the designation/restriction must accompany the LHD's budget request, or
- b) if the designated/restricted funds are not in support of the program being supported by the DHMH award, then the income is not allocable to DHMH.

2120.07 **Required Matching Funds** - Required matching funds are governed by this Manual unless statutory provisions provide for alternative treatment. The Director and the health officer must mutually agree to exemptions from the requirements of this Manual and the creation of alternative treatments for required matching funds.

2120.08 **Exclusions** - The Director may exclude from allocation, any income from any source when he/she deems it to be in the public interest. The income exclusions shall be documented in the UFD, and the Director of the program administration shall inform the DPCA of the exclusions. Generally, income exclusions are granted for, but are not necessarily limited to, the following circumstances:

- a) the program administration wishes to bear the full cost of the basic

- service delivery program, or
- b) the program administration concludes that a parallel or auxiliary program funded by such income is in the general public interest or so benefits the clients that it should be indirectly supported via an income exclusion.

2120.09 **Requirement to Generate Interest Income** - The LHD must deposit all DHMH funds and those funds allocated to a DHMH supported program in a federally insured interest bearing account when such funds are not required to meet current expenses. In the event that funds on deposit exceed the federally insured limits, the financial institution must insure the funds. This insurance should take the form of the financial institution pledging collateral equal to or in excess of the deposit's value. Such interest income must be identified in all budget and fiscal reporting documents and allocated in accordance with Section 2120.03.

2120.10 **Allocable Income In Excess of Budget Estimate** - This section is applicable to LHDs receiving funds from all DHMH program administrations except the Developmental Disabilities Administration. All allocable income in excess of the amount budgeted will serve to reduce the amount of DHMH participation unless the Director of the program administration elects to permit the LHD to use such income for program enrichment or to retain the income without prejudice to the Department's support. When this income exceeds or is expected to exceed that which is budgeted, the LHD may request approval to use that excess income in the program by submitting a budget modification request. The program administration will either approve or deny that request, following the procedures for budget modification in Section 2050. When income from fees or collections exceeds what is in the final approved budget, which may include one or more budget modifications, the resulting excess in DHMH funding must revert to the Department, absent provision to the contrary in the UFD.

2120.11 **Income Shortfall** - Any shortfall in income becomes a potential liability for the LHD.

2130 **SETTING OF CHARGES AND FEES**

- 2130.01** **Background** - Local health departments and their subvendors are to set charges, subject to approval and modification by the Secretary, for services funded in whole or in part by state or federal funds administered by the Department of Health and Mental Hygiene. The Secretary may designate services for which no charge is to be set.
- 2130.02** **Context** - Fee collections are an income to the UFD program being funded in whole or in part by the Department. As such, they are governed by Section 2120, Income Principles and by such other provisions of this Manual as may be applicable in the circumstance.
- 2130.03** **Authorities Governing Fee Collections** - The Annotated Code of Maryland, Health General Article, Section 16-101 et. seq. establishes the requirement for fee collections. COMAR 10.02.01 was promulgated pursuant to that statute. DHMH Policy 3416 addresses the DHMH internal administration of this subject.
- 2130.04** **Scope** - The provisions cited above in Section 2130.03 require the collection of fees for services rendered by organizations funded in whole or in part by the DHMH. The intent of this requirement is that charges for health services shall reflect the full costs of rendering those services, that there be a single charge for each service rendered and the charge is based on a uniform methodology approved by the Secretary for determining full costs.
- The regulation provides for:
- (a) an ability to pay schedule which indicates the percentage of a charge that a chargeable person should pay based on the chargeable person's income and possible consideration of family size and related financial condition,
 - (b) the establishment of procedures for billing and collection of fees,
 - (c) the distribution and application of amounts collected, and
 - (d) the maintenance of required reports and records.
- 2130.05** **Administration** - The administration of the fee collection operation to include the application of COMAR 10.02.01, DHMH Policy 3416, and those procedures noted below rests with the DPCA.
- 2130.06** **Procedures For Fee Setting and Cost Reporting** - The procedures for setting of charges and cost reporting are governed by cost report instructions issued by the DPCA. LHDs are bound by its provisions.
- 2130.07** **Client Fee Setting** – All recipients of services and chargeable persons shall be liable for payment of the charges as set forth in the Schedule of Charges. The greater of third party payments or the fee determined by use of an ability to pay schedule may be accepted. The Secretary shall issue and revise an ability to pay

schedule for services rendered adjusted for family size. The difference between the charge for services rendered and the fee derived from this schedule shall be an ability to pay allowance.

2130.08 **Record Keeping** – An individual financial record for each recipient of services or chargeable person shall be maintained which shall contain relevant financial information including:

- a) A record concerning the ability to pay determination including, when available, documents appropriate to the verification of income, expenses, allowances and exemptions. Documentation of reductions to ability to pay determinations must include things like: tax returns, pay stubs, unemployment insurance applications or other reasonable relevant documentation.
- b) A signed authorization to release medical information and assignment of third party benefits.

2130.09 **Collections in Excess of Budget Estimate** - All collected fees must be used for carrying out the purpose of the program up to the amount stated in the most recently approved budget. When fee collections exceed or are expected to exceed that which is budgeted, the LHD may request to use those excess fees in the program by submitting a budget modification request. The Director of the appropriate program administration will either approve or deny that request in accordance with Section 2050, Budget Modification. When fee collections exceed the final approved budget, which may include one or more budget modifications, they may revert to the Department.

2140 **REAL PROPERTY**

2140.01 **Background** - The use of UFD funding may be used for the purchase, construction, renovation or repair and maintenance of real property, as these terms are defined in Section 1036 and Section 1037. These costs are controlled items and these types of costs should be incurred only when necessary to ensure that programmatic concerns are being met. (See 2050.03)

2140.02 **Repair and Maintenance** - Renovation costs are to be differentiated from Repair and Maintenance costs in all proposals, budgets, budget modifications, and other written submissions.

2140.03 **Conditions** - Funds requested for construction or renovation shall be identified in a budget as a separate line item. Requests shall include such documentation as to afford the Director a full and accurate understanding of the nature and scope of the proposed project.

2140.04 **Architectural Study** - Funding for an architectural study or a design project will be subject to the same requirements as a request for construction or renovation.

2140.05 **Review for Technical Merit and Reasonableness** - The Director, prior to approving funding for a project costing \$50,000 or more, may forward the proposal to the Chief of the Division of Engineering and Maintenance. The Director may not approve the project unless the Chief, Division of Engineering and Maintenance approves the project in writing with respect to technical feasibility and reasonableness of cost.

2140.06 **Conformity with Licenses and Other Standards** - The LHD must certify that the project does or will conform to the standards and licensing requirements specified by state law and regulations and must submit such documentation from the licensing/regulatory authority as will verify conformance.

2140.07 **Conditions for Approval** - The Director shall approve or disapprove, in writing, all requests to use UFD funds for purchase, construction, or renovation projects.

2141 **Funding of a Project in a State Facility**

2141.01 A renovation project located at a State facility may be funded directly with UFD funds. However, prior to the budget, encumbrance or expenditure of UFD funds, the LHD must ensure that said project has been reviewed and approved by DHMH under the process described below.

2141.02 **DHMH Review and Approval**
The Deputy Secretary for Public Health Services must approve all projects. The

Deputy Secretary's approval is contingent upon review and recommendation of (1) the Director, program administration funding the project, (2) the Chief, Engineering and Maintenance and (3) the Director, Office of Planning and Capital Financing (OPCF) for the proposed project at a DHMH facility or other State facility.

2141.03 Responsibility for Project Consistency and Compatibility

The LHD, in conjunction with the program administration funding the project and the State agency or DHMH program administration having jurisdiction over the facility, shall be responsible for ensuring that the project is consistent with the stated objectives of the project, and that the project and stated objectives are compatible with the facility.

2141.04 Maryland Department of Planning Clearinghouse Requirements

The LHD, in conjunction with the program administration funding the project and the State agency or DHMH program administration having jurisdiction over the facility, shall ensure that the project meets the Maryland Department of Planning Clearinghouse requirements for use and occupancy of a State facility or property. For any project proposed for a DHMH facility, the OPCF shall notify the Clearinghouse in conformance with Clearinghouse requirements.

2141.05 Responsibility for Conformance with Construction Contract Procedures

The LHD, in conjunction with the DHMH, Division of Engineering and Maintenance, shall conform with standard Maryland Department of General Services and other State procedures applicable to soliciting, awarding, inspecting and expending funds for a project at any State facility. The LHD shall ensure that all proper approvals are received prior to, during, and upon completion of the project.

2141.06 Responsibility for Memorandum of Understanding for the Use and Occupancy of Space at a State Facility

The LHD, in conjunction with the OPCF and Director of the DHMH facility or Director of the State facility, shall enter into a Memorandum of Understanding regarding the use and occupancy of space or property at the State facility.

2142 Real Property Disclosure Requirements

Each annual program narrative related to the renovation or lease of real property may, as required by the program administration, include:

- a.) a listing of every program service site and administrative site that is or will be supported in whole or in part by the funding requested,
- b.) the current rent (annual and monthly cost) for each site and,
- c.) the identification of other (non-DHMH) sources, including amounts of funding for rent costs.

2143

LHD Documentation Requirements

When a LHD leases property, in whole or part with DHMH funds, a copy of the lease agreement must be retained in the LHD's records.

If the lease agreement is not available for review by Departmental representatives then all such costs will be considered undocumented and will be disallowed by DHMH.

2150 **PERSONAL PROPERTY**

2150.01 **Background** - The use of UFD funding for the purchase of personal property is an allowable cost.

2150.02 **Expenditure Categories** -Personal property expenditures fall into two major categories.

1. Consumable expenditures, like supplies, are **not** placed on the LHD’s inventory system and are treated as an expense.
2. Asset expenditures, like furniture, vehicles and computers are placed on the LHD’s inventory system.

For the purposes of recording inventory for other than sensitive items, any single item having a cost of \$500 or greater and a useful life of at least one (1) year is considered an asset. Items costing less than \$500 or having a useful life of less than one (1) year may be treated as a consumable expenditure. An exception to this would be if the purchase is governed by local government procurement. In that case, follow local government inventory recording standards.

Sensitive items must be recorded on the inventory records in accordance with the following guidance. Sensitive items are defined as items costing \$50 to \$499 that are prone to theft and easily concealable, such as in a briefcase, handbag, etc. If the purchase of a sensitive item is governed by local government procurement then the local government standard for classification of an item as a sensitive item can be followed.

2150.03 **Guidelines - Asset Recordkeeping** - Adequate records must be kept for all existing assets and all deleted assets. Inventory control numbers shall be attached to all assets as they are purchased and any previously purchased assets that do not have control numbers. Inventory information shall be maintained for all assets containing the following elements:

- a. date purchased,
- b. description of item, including method of disposal,
- c. vendor from whom purchased,
- d. cost,
- e. location,
- f. inventory control number and
- g. source of funds.

A master file should be prepared for all deleted assets stating:

- a. description of item,
- b. previous location,
- c. original cost and salvage value and
- d. date deleted.

2150.04 **Reclamation of Personal Property Assets - Local Health Departments**

The source of the funds used to purchase the personal property asset determines the manner and process for the reclamation of personal property assets. An asset purchased with funds received from DHMH or any allocable income source, other than local government funds, must be accounted for and disposed of in accordance with State policy. An asset purchased with local government funds should be accounted for and disposed of in accordance with the policies of the local funding agency.

2160 **CONSULTANTS**

- 2160.01** **Background** - The use of consultants is recognized as being necessary and appropriate, however certain considerations are essential; these are outlined below. (See Definition 1010 - Consultant)
- 2160.02** **Consultant Versus Employee** - The bonafide consultant relationship exists only in the absence of an employer-employee relationship. Guidance, such as the Internal Revenue Service’s Publication 15, Circular E, Employer’s Tax Guide can be useful in assisting in defining the employer - employee relationship.
- 2160.03** **LHD Responsibility** - Determination of the appropriate status of an individual is the sole responsibility of the LHD. For compliance with relevant laws, LHDs are advised to seek the advice of legal counsel. Claims and penalties resulting from improper designation of an employee as an independent contractor or consultant are the responsibility of the LHD.
- 2160.04** **Consultant’s Fees** - Fees paid to a consultant are subject to review by the program administration. The Director may be guided by the relevant State Salary Plan when judging the reasonableness of consultant costs.
- 2160.05** **Conflict of Interest** – Retention of consultants must be consistent with the requirements and limitations of the Maryland Public Ethics Law (State Government Article, Title 15), particularly those provisions that limit relationships with their agency (§ 15-503 – employment and interest prohibitions) and those that restrict employees official duties in relationship to private individuals and entities (§§ 15-501 – nonparticipation, 15-506 – misuse of prestige of office, and 15-507 – misuse of official confidential information). In Montgomery County comparable County ethics provisions apply.

2170 **RECONCILIATION**

- 2170.01** **Background** - Reconciliation is a fiscal resolution of the UFD award, pending

audit and settlement, usually conducted at the end of the fiscal year. The reconciliation process encompasses budget review, compliance with Departmental fiscal policies, e.g., on indirect costs, and a determination of net balances and disposition of those balances. Reconciliation is based upon reported expenditures and income, subject to correction by the DPCA.

- 2170.02** **Local Health Departments** – The DHMH 440 Annual Report is the standard means of reporting annual total income, expenditures and performance measures. With some exceptions, local health departments usually are reconciled on the basis of figures provided by the DHMH General Accounting Division via FMIS reports. If a LHD is reconciled using FMIS, the LHD must submit the DHMH 440A Performance Measures Report to DPCA. Any LHD has the option to file a DHMH 440 Annual Report. If this option is exercised, the submitted DHMH 440 takes precedence for fiscal reconciliation.
- 2170.03** **Annual Report Filing Deadline** - The DHMH 440 must be delivered to the DPCA by August 31 or by 60 days after the close of the funding period (See Section 2090.03). Exceptions to the use of departmental forms are listed in Section 2090.04. The DHMH 440 Annual Report must reflect the actual year to date expenses and receipts through the end of the fiscal year. Subsequent annual reports purported to be final or corrected may not be accepted by DPCA and/or the program administration.
- 2170.04** **Failure To File A Year-End Report** - If the Annual Report is not received in accordance with the provisions of Section 2090.03, or if a technically insufficient report is received, future payments may be suspended until compliance with the reporting requirement is achieved.
- 2170.05** **Correction of the Year-End Reports** - The UFD award will be reconciled using the figures supplied on the year-end report (DHMH FMIS reports or DHMH 440). In the case of an error or omission in the report, the DPCA may make corrections. A report may be rejected and returned to the LHD for a technical insufficiency, which cannot or should not be corrected by the DPCA and may result in suspension of future payments.
- 2170.06** **Unbudgeted Expenditures and Overexpenditures** - Unbudgeted expenditures and over expenditures in controlled line items are subject to non-recognition. The LHD may petition for recognition by submitting a Letter of Justification, which states the nature of and a rationale for the expenditure(s) (See Section 2090.03.01). The Letter of Justification shall be submitted with the Annual Report (DHMH 440). The submission of timely budget modifications is the preferred methodology to address unbudgeted expenditures and controlled line item over expenditures. However, the submission of the Letter of Justification and its approval, as indicated on the DHMH 440 or FMIS report, is acceptable for

reconciliation and audit purposes. It is recognized that the director of the program administration may disapprove any unauthorized expenditure.

- 2170.07** **Recognition of Expenditures Subject to Audit and Settlement** - All expenditures recognized for purposes of reconciliation, whether incurred in accordance with an approved budget or not, are subject to audit. (See Section 2180)
- 2170.08** **Disposition** – A reconciliation may result in a net balance due DHMH or the LHD, as set forth below.
- 2170.08.01** **No Balance Due** - No action required beyond notice per Section 2170.09.
- 2170.08.02** **Balance Due LHD** - An account payable will be authorized by the DPCA who will instruct the DHMH General Accounting Division to issue payment. If there is no delinquent (greater than 90 days) receivable for the LHD, a check will be issued. Otherwise, the amount due to the LHD will be applied to a delinquent account receivable.
- 2170.08.03** **Balance Due the Department** - The DPCA shall notify the LHD if it believes that a balance is due to the Department. As a result of that notification, the following will occur:
- a. **Account Receivable** - if the LHD has ceased to be a provider for the program which generated the balance, an account receivable will be established and the LHD billed. If the vendor fails to pay the Department, a referral may be made to the State's Central Collection Unit (CCU).
 - b. **Carryover** - if the LHD continues to deliver services under the program that generated the balance, the amount due will be considered a cash advance (payment) on the following year's award. This operation is referred to as carryover. Carryover is available only to local health departments receiving payments from DHMH.
- 2170.09** **Notice** - The DPCA will communicate reconciliation findings. A copy of the reporting document (FMIS or DHMH 440) showing the details of the reconciliation will accompany the notice.

Distribution of the notice is as follows:

- a. LHD,
- b. program administration,

- c. applicable UFD award file for the reconciled fiscal year,
- d. DHMH, General Accounting Division,
- e. applicable UFD award file for the fiscal year affected by carryover, when appropriate, and
- f. others as requested.

2180 **AUDIT**

2180.01 **Background** - The DHMH Audit Division will periodically audit or cause to be

audited all awards listed on the UFD. The purpose of this audit is to give the State assurance that funds were spent in accordance with the UFD and this Manual. The books, records and all other pertinent data of the LHD will be examined on site by the DHMH auditor. This material must be made available to the auditor upon request during usual business hours. Additional documentation may be requested of the LHD. The audit will address the fiscal aspects of the UFD awards and may also focus on the management/administration aspects of the program. The auditor establishes amounts due either to or from the LHD by comparing funds received with authorized expenditures less allocable revenue. The audit findings are the basis for making a final settlement of the UFD award. A draft audit report is completed and (usually) discussed at an audit exit conference; additional documentation may be taken into account at this time. A final audit report is then issued.

2180.02 **Responsibility** - The Chief, Audit Division, is responsible for auditing or causing to be audited all DHMH awards. The Chief has the discretion to waive the requirement that an award be audited. The Chief reserves the right to audit a LHD, when it is in the best interest of the State to do so. The Chief, Audit Division shall audit or cause to be audited the records of a LHD in accordance with the UFD, this Manual and generally accepted auditing standards.

2180.03 **Availability of Records** - The LHD shall provide full disclosure of all financial statements, books, and records as needed and/or requested by the Chief, Audit Division or his/her designee.

2180.04 **Subvendors** - Each LHD, shall audit or cause to be audited each human service contract sub-vendor (See Definition 1038) in accordance with the DHMH Human Service Agreements Manual or the LHDFS Manual, the DHMH Audit Division's Subvendor Audit Policy and generally accepted auditing standards. The Chief, Audit Division may audit a subvendor, notwithstanding the responsibility of the LHD to audit the subvendor, when it is in the best interest of the State to do so. The Chief, Audit Division, if he/she elects to audit a subvendor shall inform the LHD, in writing, that the LHD is absolved of the responsibility to audit the subvendor.

2180.05 **Draft Audit Report and Exit Conference** - The Chief, Audit Division will issue a draft audit report and distribute it to:

- a.) the vendor and subvendor, if applicable,
- b.) the Chief, Division of Program Cost and Analysis,
- c.) the director of the program administration,
- d.) the Director of the Community Health Administration, and
- e.) other persons as appropriate.

The draft report cover letter will include a date by which the LHD may request or decline an exit conference. The exit conference will not be scheduled less than thirty (30) days from the issuance date of the draft report unless agreed to by the LHD.

2180.06 **LHD Right of Rebuttal** - The LHD must forward documentation intended to refute or mitigate findings in the draft audit report to the Chief, Audit Division, no later than twenty (20) calendar days after the date of the exit conference.

2180.07 **Final Report** - The Chief, Audit Division will issue a final audit report after examining or evaluating any evidence submitted by the LHD in accordance with Section 2180.06 subsequent to the publication of the draft audit report. Distribution will be to the same parties who received the draft report. The Chief, Audit Division in the draft and final audit report shall:

- a.) address and explain each audit exception,
- b.) specify amounts due, and
- c.) comment upon any other issue that warrants attention.

2180.08 **Timing of Audit** - The Chief, Audit Division performs an audit of each UFD award as soon as practicable and in accordance with Audit Division policy.

2190 **POST AUDIT SETTLEMENT**

2190.01 **Background** - The settlement of a UFD award is a process of resolving post-audit issues and of closing the settlement file. The settlement process starts when the audit process terminates. The resolution of the audit is based on the final audit report. The DPCA coordinates the settlement process.

2190.02 **Settlement Process** - The resolution of audit settlement issues will result in one of the following:

- 1.) DHMH and LHD agree on amount owed.
 - a.) Money Due the LHD - The Chief, DPCA shall inform the LHD, in writing, that the Department owes the LHD a specific amount of money and shall authorize payment and forward instructions to the Chief, General Accounting Division, to issue a check.
 - b.) Money Due the Department - The Chief, DPCA shall inform the LHD, in writing, that the LHD owes the Department a specific amount of money. The Chief, General Accounting Division, shall issue an invoice to the LHD for the amount of money owed to the Department. Such invoice is used to establish an account receivable, which is considered delinquent if not paid in thirty (30) days.
- 2.) DHMH and LHD disagree on whether an amount is owed either party or the extent of such amount. The LHD can appeal the amount owed to the program administration and solicit for abatement, in whole or part, of the audit debt. Such appeals are filed with the DPCA, who is responsible for administering the audit appeal process. The time frame for filing audit debt appeals is as follows.
 - a.) The LHD has thirty (30) days from the date of the final audit report to notify the Chief, DPCA of a request for abatement of specific audit exceptions. The DPCA shall forward the abatement request to the program administration. The audit appeal abatement request filed with the DPCA must include the plan of correction for the LHD with copies for the DHMH Audit Division, the Community Health Administration and the relevant program administration.
 - b.) The program administration will have thirty (30) days to review the request and notify DPCA of their decision on the support of the abatement request. If the appeal is denied by the program administration then refer to (1.) above. If the program administration approves the appeal, the following process is used. (See Section 2190.03)

2190.03 **Audit Debt Appeal and Abatement Process -Local Health Department**

As described above in Section 2190.02, a LHD may request the abatement of an amount due to the Department as a result of audit exceptions. The DPCA is responsible for coordinating requests for abatement and is the Department liaison for all dealings with the State's Central Collection Unit (CCU) in these matters. The procedure listed below shall be followed for processing requests for abatement:

- a) A LHD has thirty (30) days from the date of the final audit report to notify the Chief, DPCA of a request for abatement of specific audit exceptions. The audit appeal abatement request filed with the DPCA must include the plan of correction for the LHD with copies for the DHMH Audit Division, the Community Health Administration and the relevant program administration.
- b) The DPCA shall forward the abatement request and the aforementioned plan of correction to the program administration. The program administration will have thirty (30) days to review the request and notify DPCA of their decision on the support of the abatement request.
- c) The DPCA shall forward the audit exceptions and the actions recommended by the program administration to the Deputy Secretary for Operations and/or the Deputy Secretary for Public Health Services or the Deputy Secretary for Health Care Policy, Financing and Regulation. The appropriate Deputy Secretary will review the funding administration's recommendations and render a decision on support of the abatement request and inform the DPCA of that decision within thirty (30) days. If the decision is to abate the LHD debt in whole or part, the Department can not abate such debt but only can recommend abatement to the State's CCU. The CCU is not obligated to follow the Department's recommendations on such referrals.
- d) The DPCA will notify the DHMH Division of General Accounting of the total amount of the audit bill, including items recommended for abatement. General Accounting will bill the LHD every thirty (30) days for the total amount of the audit bill.
- e) After 90 days and the third bill, the amount endorsed for abatement by the Deputy Secretaries, and any unpaid balance, shall be forwarded to the CCU by the Division of General Accounting. The CCU will review the abatement recommendations and advise DHMH of its decision. Any unpaid balance will be subject to any collection fees imposed by the CCU.

2190.04 **Settlement Without Audit** - If the Chief, Audit Division, informs the Chief,

DPCA that a UFD award is not scheduled for audit due to the employment of certain sampling techniques, lack of resources or other reason, the Chief, DPCA will coordinate the settlement of such file in lieu of an audit. The settlement will be based on the final approved reconciliation (See Section 2170).

2190.04.01 **Method** - Coordination of settlement in lieu of audit will contain the following elements.

- 1.) The DPCA will send a confirmation to the Director of the program administration that the UFD award is subject to closure in the absence of being selected for audit.
- 2.) The Director of the program administration must respond in writing to DPCA if:
 - (a) an audit is desired, stating the reason for the request, or
 - (b) a settlement process in lieu of audit should be conducted.
- 3.) If no additional action is required, the Chief, DPCA will close the file.
- 4.) If additional action is required per instructions from #2 above, the Chief, DPCA will take appropriate action to implement the Director's instructions.

2200 **CORE SERVICE AGENCY (CSA)**

2200.01 **Applicability**

The requirements delineated in this section of the Manual represent what is

unique to the operation and funding of core service agencies. Core service agencies are governed by the relevant sections of the DHMH Human Service Agreements Manual for those topics not mentioned specifically in this section.

2200.02 **Roll - Over Fund Policies and Implementation Procedures for Mental Health Core Service Agencies**

The 1991 legislation which formally authorized the establishment of Core Service Agencies (CSA) in Maryland included a provision (10-1203 (C) (3)) that the Secretary shall “develop a mechanism whereby any unexpended funds remaining at the end of the year shall remain with the core service agencies or the community providers”.

The establishment of such a mechanism requires accounting and reporting procedures that will allow CSAs to comply with the legislative requirement while continuing to meet the goals of the Mental Hygiene Administration (MHA). The Department of Health and Mental Hygiene (DHMH) Form 440 has been revised to report these unspent funds once they have been identified at the end of the fiscal year.

2200.02.01 **Policy**

- A. No later than October 15th of each fiscal year, the CSA will report to the MHA, in a format designed by MHA, unspent General funds of the previous fiscal year and a plan for spending these funds in the current fiscal year.
- B. Decisions about the retention of these funds by the CSA will be influenced by the extent to which the prior fiscal year's program goals and objectives were met. Unspent funds, which are allowed to remain with the CSA, rolled-over into the next fiscal year, are to be placed in a separate project. The CSA may:
 - 1) Allow any unspent funds to be retained by the provider of the services,
 - 2) redirect the unspent funds to another provider,
 - 3) utilize the unspent funds for a program conducted directly by the CSA,
 - 4) allow unspent funds to be retained by the CSA; or
 - 5) any combination of the above.
- C. The unspent funds may be utilized in the next fiscal year only for one-time-only expenditures.
- D. The proposed spending plan must be approved by the Director of MHA or designee. Any agreement for the use of these funds by the CSA does not in itself further commit the department to continue that support in subsequent years.

- E. Each year's roll-over funds must be expended or obligated by the end of the fiscal year in which the expenditure of these funds is approved.

2200.02.02 Procedure

- A. No later than October 15th of each fiscal year, the CSA will report unspent funds of the previous fiscal year in the form of a spending plan to the MHA. If the CSA has received an approved 440, the amount of the roll-over plan must equal the amount shown on the approved 440. If after the submission of a spending plan, an approved 440 has been received and the amount of unspent funds on the approved 440 differs from the amount of unspent funds reported in the spending plan, a revised spending plan must be submitted within two weeks of the receipt of the approved 440.
- B. Roll-over funds will be established as a separate project (a separate project number will be assigned by the MHA), which allows for a clear audit trail to verify expenditures of roll-over funds during the fiscal year for which the funds were approved. If roll-over funds are deposited in a bank account that also includes current year funds, all interest credited to that account must be shown in the grant budget for the current fiscal year.
- C. Any fees or receipts generated by the expenditure of these funds must also be shown in the grant budget for the current fiscal year.
- D. The MHA will notify the CSA in writing regarding the approval or disapproval of the CSA's Plan.
- E. All CSAs will use Form DHMH 440 for reporting roll-over funds.
- F. At the end of the year in which the roll-over funds are to be used, the CSA will send two Form 440s to the DPCA; one for the regular budget and one for the roll-over funds.
- G. Requests for revision to the approved plan for spending roll-over funds can be submitted until April 15th of the fiscal year in which the original spending plan was submitted. The MHA will not consider revision requests, which are submitted after that date.
- H. The CSA will be billed by DPCA for the amount of any roll-over funds remaining unexpended at the end of the fiscal year in which they are approved

2200.03 CSA Requirements of Vendors

Core Service Agencies may impose reasonable reporting requirements or

operating standards on sub-vendors that are more demanding or restrictive than those that may be imposed on CSAs by MHA unless the sub-vendor(s) demonstrate to the CSA or MHA the requirements or standards are unreasonable.

2200.04

Close Out Procedures for Mental Health Core Service Agency Providers

- A. Each CSA will collect fiscal year end annual reports from each of their providers. The CSA may redirect unspent funds as of June 30th among providers before submitting the DHMH Form 440 annual report based on the information contained in the providers' annual reports. Unspent funds can be redirected to a provider who has adequately met the fiscal year's program goals and objectives, and has reported a deficit on the annual report. The following are some examples:
- The deficit was unforeseen and reasonable.
 - The CSA was unable to award additional funding to providers before the close of the fiscal year.
- B. The CSA will include information regarding redirected funds with the DHMH Form 440.
- C. The CSA'S submission to DHMH of its year-end DHMH 440 report must include all subvendor year end fiscal reports (expenditure/revenue summary sheet only, not entire package).

2210

MISCELLANEOUS PROVISIONS

2211

Records - Title and Retention

2211.01 **Title** – Records held by the LHD funded by the UFD are considered records of DHMH. The Department has the right to use such records, reports, studies and data as the LHD may compile or have compiled.

2211.02 **Retention** - All records must be maintained for five years and until all audit requirements are met, unless a longer retention period is required by federal, state or local requirements and then destroy if no longer needed.

2212 **AFFIRMATIVE ACTION PLAN**

2212.01 **Development** - The LHD must develop an Affirmative Action Plan to ensure compliance with equal opportunity laws.

2212.02 **Submittal** – As requested, the current Affirmative Action Plan should be sent to:

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Director
Office of Community Relations
O'Conor Building - Room 517
201 West Preston Street
Baltimore, Maryland 21201

A schedule for future plan submittals will be determined by the Office of Community Relations.

2212.03 **Compliance Review** - The office named in Section 2212.02 above, will review the Plan in accordance with relevant state and federal laws and will approve or disapprove the Plan and issue notice of its decision. Requests for assistance in developing a Plan or for clarification of the LHD's obligations under the relevant statutes should be directed to the Executive Director, Office of Community Relations at (410) 767-6600.

HUMAN SERVICE AGREEMENTS MANUAL

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Section 100- INTRODUCTION

101 Scope - This manual specifies administration and fiscal policy for grants/contracts, cost reimbursement contracts, grant-in-aid and purchase of services contracts for human services funding which are made by the Maryland Department of Health and Mental Hygiene (DHMH) and which are processed through the Division of Program Cost and Analysis. This manual does not address programmatic issues. This manual shall, by reference, become part of each DHMH grant/contract agreement and the provisions are extended to any and all subvendors. All Department units are required to have their human services funding instruments reviewed, authorized and processed through the Division of Program Cost and Analysis. The role of the Division of Program Cost and Analysis is to provide assistance to the program administrations in the area of human services agreements within the parameters of sound fiscal management and proper accountability of public funds.

102 Background

DHMH human services funding has grown in both scope and complexity over the years. This manual describes the particulars of the funding system. Sections of the manual have been created with an eye toward easy use with most information arranged by subject and backup materials appended where appropriate. This document is not intended to be static; provision for manual updating has been made. This manual supersedes the DHMH "Grants Manual" issued January, 1978 and revised July, 1980 and supersedes the following Departmental policies: DHMH 3901, DHMH 3536, DHMH 3537, and DHMH 3940.

103 Updates and Inquiries

One manual will be issued to each vendor and program administration.

When a manual is issued, the program administration and the vendor are placed on the mailing list for manual updates. Address all requests for additional manuals to:

Chief, Division of Program Cost and Analysis

Department of Health and Mental Hygiene

201 W. Preston Street Room 546
Baltimore, Maryland 21201

Please contact a Grants Management Officer of the Division of Program Cost and Analysis for questions concerning the manual, its distribution and its application. The telephone number of the Division of Program Cost and Analysis is: (410) 767-6062.

104 Overview of Funding Process

The DHMH human services funding system is generally one of contributory funding to support health related services which may derive income from user fees, insurance payments, charitable contributions and endowments, other government programs and other third party incomes. DHMH FUNDING DOES NOT GENERALLY COVER THE FULL COST OF THE SERVICE.

Several program administrations of the DHMH use grant/contracts as a mechanism for funding human services programs. An administration may issue a Request for Proposal (RFP) and base funding decisions on the State's procurement process or it may fund and operate human service programs

through Local Health Departments or other entities exempt from that process. Any governmental agency or private association, partnership, individual or corporation entitled to do business in the State of Maryland may be eligible to receive DHMH funding and may submit a grant/contract proposal at any time.

Those program administrations funding human services programs via the system described in this manual are listed below:

Addictions Service Administration
Local Health Administration (except Case Formula)

Health Systems Financing Administration

Mental Hygiene Administration
Developmental Disabilities Administration

AIDS Administration
Community Health Surveillance Administration

Family Health Services Administration

The grant/contract application process itself is frequently a lengthy one and will be usually governed by either the Department's budget and planning cycle and/or by the State's procurement process. This time requirement will vary from program to program and from one program administration to another. Start-up money is sometimes available. The appropriate program administration should be contacted by specific requirements.

Payments are made primarily in two ways: 1) as a transfer to an account maintained for Local Health Departments and 2) per invoice from private vendors as an advance against anticipated expenses.

Vendors are required to maintain records in accordance with generally accepted accounting principles and as specified by DHMH. At the end of each

fiscal year a financial reconciliation is conducted subject to audit and settlement.

Grant/contracts are routinely audited by the DHMH Audit Division. Post audit resolution of both fiscal and programmatic aspects of the grant is based on this audit findings; this process is known as "Settlement."

A grant/contract may be re-awarded and continued from year to year. Alternatively, programs may award multi-year contracts, customarily running from one to three years, subject to budgetary approval.

105 Manual Format - For most users, the manual will have five major sections: Definitions, Process and Policy, Appendices, Forms and Index. The most important of these is PROCESS and POLICY (Section 2000) and, accordingly, the discussion of format will focus there. In Section 2000, each major topic is numbered at intervals of ten and identified also by the title being displayed at the top of a right-hand page in all capital letters. Subsection titles are shown in lower case letters except for the first letter. The subsection will contain a suffix of two or more numerals. A sample display is:

2120 FISCAL REPORTING

2120.01 General - (Followed immediately by text)

The DEFINITIONS section (1000) is also numbered. Also, the definitions are alphabetized. The Appendices (3000) have been numbered as well.

However, because the documents in the appendices are administered by units other than the Division of Program Cost and Analysis integral structure of the appendices does not conform to the rest of the manual.

Forms (4000) is next, followed by the INDEX (5000)

106 Summary of Responsibilities - When making inquiries or routing documents to the Department, the vendor should use the following guidelines:

- a) Responding to Annual Budget Instruction: (LHD only) -Division of Program Cost and Analysis
- b) Responding to a Request for Proposal or other solicitation - program administration
- c) Status of award - program administration
- d) Request for payment via invoice (DHMH 437) - Division Program Cost and Analysis
- e) Request of supplemental funding - program administration
- f) Request for budget modification - program administration
- g) Year - end Report (DHMH 440) - Division of Program Cost and Analysis
- h) Reconciliation - Division of Program Cost and Analysis
- i) Audit - Audit Division
- j) Post - audit Settlement - Division of Program Cost and Analysis
- k) Billing (general) - General Accounting Division
- l) Disputes on billing - Division of Program Cost and Analysis or program administration
- m) Policy clarification generally and for technical or, fiscal issues - Division of Program Cost and Analysis
- n) Corrections to form 28-409 (LHD only) - General Accounting Division except as these corrections are occasioned by reconciliation; in this case, inquiry should be directed to Division of Program Cost and Analysis
- o) Forms - Division of Program Cost and Analysis
- p) Procurement issues - the Division of Contracts

Note: Any references to the procurement statutory law, "Article XXI" Annotated Code of Maryland, are currently codified in the State Finance and Procurement Article, Title II et. seq.

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Section 1000

Definitions

SECTION 1000 - DEFINITIONS

- 1000 Accrual basis - A matching process whereby revenue is recognized as services are rendered and expenses are recognized as efforts are expended or services utilized to obtain the revenue.
- 1002 Acquisition of Services - a term for the processes by which the Department obtains vendors to deliver health related human services. It incorporates both "procurement" processes.
- 1003 Advance Payment - a payment made prior to the signing of the funding agreement or the issuance of an award letter.
- 1004 Award - as defined by COMAR 21.01.02.06 and also in the sense of the contract or agreement and/or as it refers to that part of the total program budget which is DHMH funded.
- 1005 Award Letter - a document which summarizes provisions of the funding agreement (contract of MOU) or which acts as the funding instrument.
- 1006 Block Grant - Irrespective of the source of funding, a Block Grant is defined here to be any grant/contract for human service program funding which is directed to a vendor (the primary vendor) for distribution to any number of subvendors (secondary vendors) who provide human services to third party clients under the terms of the grant/contract.
- 1007 BPW - Board of Public Works, consisting of the Governor, the Treasurer and Comptroller.
- 1008 Budget - An expenditure plan and income estimate detailed by line item entries approved by the Department of Health and Mental Hygiene to carry out the purposes of the grant/contract supported project.
- 1009 Budget Modification - A line item revision of the approved budget, as differentiated from a contract modification, which neither increases or

- decreases the amount of the award and/or the services to be performed
- 1010 Contract - as defined in COMR 21.01.02.20
- 1011 Contractor - an individual or organization with whom the vendor engages to deliver goods or services for the operation of the vendor's organization. Such services are not health related and are not delivered directly to their party clients. Examples of such service include bookkeeping, legal, accounting, etc. See "Purchase of Service Contractor."
- 1012 Consultant - an individual who the vendor engages to deliver health-related services of a particular type or discipline directly to third party clients. A consultant is a non-salaried individual receiving compensation for professional discipline. Designation as a consultant is exclusive of trades persons or employees, whether fulll or part time. See section 2181 for a more complete definition of Consultant. See also, "Purchase of Service Contractor."
- 1013 DBM- Department of Budget and Management
- 1014 Delinquent Account - as defined by COMAR 17.01.01.03B or 17.01.01.04B (3)
- 1015 DHMH - The Department of Health and Mental Hygiene of the State of Maryland, synonymous with the Department.
- 1016 Director - Refers to the chief executive authority in any of the DHMH program administrations.
- 1017 Emergency Payment - a payment to a vendor which is marked for expeditious handling.
- 1018 Employee - See Section 2180.
- 1019 Encumbrance - the obligation to expend funds, supported by a contract or purchase order. An encumbrance may be recognized as an expenditure under certain conditions.

- 1021 Fiscal year - the State of Maryland's fiscal year, running from July 1 through June 30.
- 1022 Grant - as defined by COMAR 21.01.02.36 and, for the purposes of this policy, as any finding agreement or award made to an organization which is exempt from procurement.
- 1023 Grant-in-Aid - a funding agreement which specifies neither standards for the recipient's fiscal management of the funds nor programmatic deliverables. When either issue is addressed, only the most general terms are employed. Reporting requirements may be established.
- 1024 Human Health Services - Shelter, support and health or health-related care, including corollary operations necessary to the delivery of that care, to third party clients via independently operated second party vendors, which is funded in whole or part by the Department of Health and Mental Hygiene.
- 1025 Income - an inflow of resources, in the form of cash, receivables or other property from customers or clients, which results from the sale of assets or merchandise or the rendering of services or from investments. This includes fee collections, ordinary income and capital gains and/or that which results from grants, gifts donations, etc.
- 1026 LHD - Local Health Department. A local health department is located in Baltimore City and each of the twenty-three Maryland counties.
- 1027 Local Executive Authority - a local government official authorized to enter into and execute human services grant/agreements with the DHMH. Typically, this would be the Mayor, County Executive, the County Council or County Commission, etc. or their designees.
- 1028 Local Funds - refers to that funding supplied by the local subdivision or municipal government. The Local Health Department may or may not be

- the conduit of such finding and the finding may or may not be a stationary requirement or a matching requirement.
- 1029 Matching funds - refers to funding that is supplied by more than one source (e.g.state and local) pursuant to a specific agreement to share or match expenditures by some ratio, such as a 90%/10% match.
- 1030 Minority Business Enterprise (MBE) - per COMAR 21.11.03.B. (4), any legal entity, other than a joint venture, organized to engage in commercial transactions, that is at least 51% owned and controlled by one or more minority persons, or a non-profit entity organized to promote the interests of the physically or mentally disables.
- 1031 Minority Person - per COMAR 21.11.03.03.B.(4), a member of a socially or economically disadvantaged minority group, and includes Blacks (not of Hispanic origin), Hispanics, American Indians, Alaska natives, Asians, Pacific Islanders, women, and the physically or mentally disabled.
- 1032 MOU - Memorandum of Understanding, the same as "contract" except the parties to the agreement are organizationally related or both are government units. In this context an MOU would be appropriate for any relationship between the program administration and a Local Health Department or other state, county or municipal agency.
- 1033 New Construction - refers to construction which creates a structure or which adds space to an existing structure.
- 1034 Offset - is the netting of outstanding receivables and payables from the same vendor to achieve a new net result. Offset is governed by COMAR 17.01.01.04E. For a more specialized definition see Sections 2220.12, 2220.16 and 2220.17.

- 1035 Prior Approval - written permission provided by an authorized official in advance of an act, particularly when that act might be expected to result in either the obligation of expenditure of funds which differs from the approved budget where such approval is required.
- 1036 Procurement - as defined by COMAR 21.01.02.48 specifically and by the process described generally by the State Finance and Procurement Article and by COMAR Title 21.
- 1037 Program Administration - a unit of the Department which funds and administers health related programs and elects to deliver services to third party clients through vendors.
- 1038 Purchase of Service Contractor - an organization engaged to deliver health related services directly to third party clients. See "Consultants."
- 1039 Reconciliation - a year-end process in which the fiscal aspects of a grant are resolved subject to audit and settlement.
- 1040 Renovation/Remodeling - refers to construction which alters, converts or restores all or part of an existing structure. The term also includes the installation or replacement in whole or part, of fixtures or systems such as plumbing, heating/cooling and electrical. Renovation/remodeling may then include activities which would otherwise be considered Repair and Maintenance such as painting, installation and replacement of minor fixtures, etc.
- 1041 Repair and Maintenance - refers to activities which sustain, prevent damage to or restore existing components of a structure or a system. The term excludes both construction entailing structural modification and the installation or replacement of fixtures or systems such as plumbing, heating/cooling and electrical.

- 1042 RFP - Request for Proposal. One of the methods of securing needed services.
- 1043 Settlement - a post audit process in which managerial decisions regarding both fiscal and programmatic issues are made based on reports filed by the DHMH Audit Division.
- 1044 Supplemental award - is synonymous with the term "supplemental agreement" which is defined by COMAR 21.01.02.66. In the context of this policy a "supplement" increases funding; a "reduction" reduces funding.
- 1045 Third party clients - as defined by COMAR 21.01.02.68-1
- 1046 Vendor - means any organization, public or private, including a local health department, which delivers health related services to third party clients under a funding arrangement governed by this policy.
- 1047 Vendor - of - record- in the context of a Block Grant, the official vendor; the entity which entered into an agreement with the DHMH and to whom the grant/contract award letter is addressed and to whom the grant/contract is officially awarded.

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Section 2000

Process and Policy

Section 2000
PROCESS AND POLICY
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2001 SCOPE

- 2001.01 This manual shall govern all grants/contracts grants-in-aid and purchase of services contracts for human services made by the Department of Health and Mental Hygiene which are processed through the Division of Program Cost and Analysis.
- 2001.02 This manual shall, by reference, become part of each agreement between the Department of Health and Mental Hygiene and its human services vendor.
- 2001.03 In event of conflict between this manual and the aforesaid agreement, the provisions of said agreement shall prevail.
- 2001.04 Each vendor-of-record who subcontracts for the delivery of the human services for which it is responsible shall incorporate, by reference, this manual into any and all subcontracts.
- 2001.05 This manual addresses administrative and fiscal aspects of budget-based human services funding; programmatic manual is established by the respective program administrations.

2002 BACKGROUND

Most DHMH human services programs use a budget-based funding system limited to those costs incurred by the vendor which the department agrees to support; it is not a system of full-cost reimbursement. The funding system generally employed by the Department and that which is described in this manual has the following characteristics:

- a. It is based on an approved budget.
- b. It incorporates limited line item control of the vendor's expenditures.
- c. It assumes the existence of other incomes to support the program.

- d. it operates under the condition that Departmental monies are spent last and recovered first, and
- e. it requires the vendor to collect fees from clients for certain specified human services.

Other funding systems/arrangements may be employed by the Department. Such systems/arrangements may or may not utilize the principles and mechanisms of this policy. Policy for an alternative system will be codified when any such system is implemented.

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2010 ELIGIBILITY FOR VENDOR STATUS

2010.01 General - Any individual, partnership, organization, association, agency, local government, or corporation which is legally entitled to do business in the State of Maryland may submit a proposal for a grant/contract or a grant-in-aid and receive an award. However, eligibility may be limited by statute or by policy of the program administrations.

2010.02 Conflict of Interest - It is the policy of the Department of Health and Mental Hygiene that vendors avoid conflicts of interest or the appearance of same in the direction and operation of a program under a state grant/contract or grant-in-aid. The Department discourages placement of staff of an eligible agency on the agency's board of directors. A financial interest, by any person in a decision-making position on the board of staff of a vendor, in any part of the services of eligible vendors constitutes, on its face, a conflict of interest. Consequently, any costs for which the vendor seeks reimbursements will be questioned where it is determined by the Department or its authorized agents that a conflict of interest exists.

Under the basic concept governing related organizations, an organization related to a vendor as a result of common ownership or control, is treated as if it were part of the vendor. Consequently, costs to the related organization for services, facilities and supplies furnished the vendor may not exceed the lower of actual cost or the price of comparable services, facilities or supplies that could be purchased elsewhere. The purpose of this principle is two-fold:

(1) to avoid payment of a profit factor through the related organization, and (2) to avoid the payment of artificially inflated costs which may be generated from less than arms-length bargaining. The books and records of the related organization shall be made available to the Department's auditors.

The term "related to the vendor" means that the vendor, to a significant extent, is associated or affiliated with, or has control of or is controlled by, the organization furnishing the services, facilities or supplies to the vendor.

Common ownership exists when an individual, individuals or organization possesses significant ownership or equity in the vendor and the institutions or organizations serving the vendor.

The Department may seek a ruling from the State Ethics Commission on questions relating to conflict of interest, related organization and common ownership.

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- 2020 ACQUISITION OF SERVICES
- 2020.01 General - A program administration which has had funding appropriated to it to have services delivered to a target population but either cannot or does not which to deliver those services itself, will be faced with two major technical questions: (1) the nature of the funding mechanism and (2) the acquisition of vendors to deliver services. This section is concerned with the latter issue.
- 2020.02 Choice of Vendor: Options - The acquisition of vendor services is reduced to two major choices: (1) the use of the State's procurement process or (2) the selection of a vendor exempt from that process.
- 2020.03 Use of the State's Procurement Process - The selection of vendors to deliver human services is governed by the State Finance and Procurement Article of the Annotated Code of Maryland and COMAR Title 21 (Procurement). Program administrations which wish to use private agencies, and bound by those statutory and regulatory provisions.
- 2020.04 Selection of an Exempt Vendor - The Director of the program administration must consider the use of a Local Health Department before issuing a solicitation under the procurement process. Although any exempt agency may act as a vendor, the Local Health Departments are considered the principal operational arm of the Department. The process for consideration of a Local Health Department as a vendor for new human services programs is specified in section 2021 and for existing programs in section 2030.
- 2020.05 Exclusions and Exemptions - The State Finance and Procurement Article 21, Subsection 1-202 and COMAR 21.01.03.01 enumerate classes Of agreements which are exempt from the procurement process.

- 2020.06 Director Responsibility - The Director of the program administration is responsible for the determination of the content nature and specifications of the services to be delivered and of the level of State funding available. The Director, Office of Contract Policy, Management and Procurement will act as Procurement Officer in accordance with specific delegation instructions of the Deputy Secretary. Acquisition of services subject to the procurement process will undergo review by the DBFP or the BPW.
- 2021 New Programs - The Director of the program administration shall make a determination whether to utilize the Local Health Department as the vendor for all new human services programs within the respective jurisdiction. New programs include types of services to clients not previously supported by Department funds and additional or expansion services to clients that are already supported by Department funds.
- 2021.01 Initial Offer to Local Health Departments - The Director of the appropriate program administration shall utilize the Local Health Departments as vendors unless the Director believes the services provided by alternate vendors would be preferable. The Director shall simultaneously:
a. Notify Local Health Departments of intent to request funds for new human services contracts for the next fiscal year on or before the first working day of February in the current fiscal year. Such notice must solicit expressions of interest from the Local Health Department regarding such programs. The notice must also specify that the expression of interest must be received on or before the first working day of March in the

current fiscal year in order to be afforded full consideration.

- b. Consider such other vendors who express interest and make a determination based upon them, as well as on other relevant factors, as to whether to utilize the Local Health Department for service, notifying the appropriate local health officer of the decision in writing on or before the working day of April.

2021.02 Expression of interest - in the expression of interest in the local health officer or the vendor shall demonstrate its capacity and cost effectiveness to act as vendor of service in the manner prescribed by the Director of the program administration, appending relevant documentation.

2021.03 Mutual Agreement to Use Alternative Vendor - The Director of the appropriate program administration and the local health officer may mutually agree that the vendor shall be other than the Local Health Department.

2021.04 Mediation and Appeal Process - If the Director and local health officer do not agree on the role of the Local Health Department, the issue shall be resolved by the mediation/appeal steps:

Level 1: An attempt to mediate will be managed by the Director,

Local Health Administration, or designee

Level 2: The appropriate Deputy Secretaries, or designee

Level 3: The Secretary, or designee.

2021.05 Local Health Department as Review Agent - When not serving as the vendor for new human services programs, the Local Health Department shall comment on contract proposals, per Section 2040.04d.

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- 2030 GRANT APPLICATION/CONTRACT PROPOSAL
- 2030.01 Eligibility - Any individual, governmental agency, private association, partnership, or corporation legally entitled to do business in the State of Maryland may apply for and receive a grant/contract from any of the program administrations within the Department of Health and Mental Hygiene. Minority Business Enterprises are encouraged to apply.
- 2030.02 Procurement - If the program administration elects to secure services from the private sector, it will commonly issue a solicitation in the form of a Request for Proposal (RFP). The specifications of the RFP will govern the submission of a contract proposal. The procurement process itself is governed by COMAR Title 21 which is available from the superintendent of State Documents.
- 2030.03 Contact - The program administrations are to be contacted directly for preliminary discussion of grant/contract proposals and to request of them a grant/contract application package.
- 2030.04 Timing - A solicitation, Request For Proposal (RFP) will generally specify a deadline for submitting a proposal. Awards are customarily made for the State fiscal year, which begins July 1 and ends the following June 30. (Note: Local Health Department, See 2030.05 below.)
- 2030.05 Local Health Department - The Local Health Department will receive instructions for grant applications in the document "Annual Budget Instructions" issued each year by the Division of Program Cost and Analysis. Also, the LHD will receive notices of intent to fund new programs per Section 2021.01. Local Health Department applications must conform to these instructions.

- 2030.06 Review - All grant/contract proposals are subject to review and approval by the program administration. Also, the program administration is obliged to secure prospective review of the proposal lby the local health officer in whose jurisdiction the grant/contract will impact. As such, it will direct the applicant to submit a copy of its proposal to the local health officer. See Section 2040.
- 2030.07 Proposal Content - The Request for Proposal (RFP) and any agenda, conferences, instructions, etc. pursuant to the RFP which are provided by the Issuing Office shall collectively be deemed to specify in full the scope, content and format of the proposal.
- 2030.08 Selection and Notice - Proposals will be reviewed and acted upon by the Director of the program administration or his designee. The respondent will be notified of the result of that review per timelines in the RFP or as otherwise specified by the program administration.
- 2030.09 Verification of Legal Status - A new respondent when not a governmental agency, must present acceptable verification of its legal status (corporation, partnership, fictitious name statement, etc.) prior to the advancement of funds.
- 2030.10 Proposal Form - Form DHMH 432 (Human Service Contract Proposal) is the standard proposal form (except for most Local Health Departments, subsection 05 above) provided by the Division of Program Cost and Analysis; however, a program may elect to use an alternative application form.
- 2030.11 Budget - The budget form (DHMH 432B for most vendors and DHMH 1209 by most Local Health Departments) must be completed unless an alternative budget or cost form is specified by the program administration.

The DHMH 432B budget form is the second page of the DHMH 432 application package and contains the most common cost items; any additional items are to be identified in the blank spaces left for this purpose. On form DHMH 1209 (Budget and Personnel Detail-Local Health Department), a Local Health Department must identify line items and code them according to the Department's chart of accounts for Local Health Departments.

2030.12 Routing - Completed proposals and attendant documents are to be sent directly to the program administration or as specified by the RFP.

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- 2040 REVIEW BY AND NOTICE TO THE LOCAL HEALTH OFFICER
- 2040.01 Review - Each grant/contract proposal (Technical proposal only) must be submitted for review to the appropriate local health officer.
- 2040.02 Notice of Award - The local health officer shall be notified in writing by the Director of the program administrations of every contract award (hereinafter understood to include supplemental awards, reductions and terminations) made to organizations located within his/her jurisdiction.
- 2040.03 Notice of New Program Funding - The local health officer shall be notified of all new human service programs to be funded or having a potential to be funded in the local jurisdiction per Section 2021 et sequential so as to afford an opportunity to the Local Health Department to express interest in being the vendor of service.
- 2040.04 Responsibilities of the Director - The Director of the program administration shall:
- a. provide notice of intent to fund new human services programs per section 2021 et sequential.
 - b. instruct every applicant (other than a Local Health department) to submit a copy of its technical proposal to the appropriate local health officer concurrent with submission of the original proposal to the program administration (see 2040.05),
 - c. inform the Director of the Local Health Administration whenever there is an intent to fund or an intent to use a single vendor or consortium of vendors for statewide delivery of service so that the Director, LHA may coordinate local health review of the affected program,
 - d. afford the local health officer an opportunity to review

- f. notified the local officer in writing of every grant award to be made to the Local Health Department, and
- g. issued an annual summary report to the Director of the Local Health Administration of all awards made and of projected grant activity.

2040.05 Applicant's Responsibilities -
An applicant shall submit a copy of its technical proposal to the local health officer in whose jurisdiction the organization's operations site is located. This submission shall be concurrent with submission of the original proposal to the Director of the program administration.

2040.06 Local Health Officer's Responsibilities - The local health officer shall:

- a. review each contract proposal received, make appropriate comments and recommendations, sign the application to signify that review has occurred, forward the application to the Director of the appropriate administration and send a copy to the Director of the Local Health Administration within the time allotted for review,
- b. inform the Director of the appropriate administration when he/she has an interest in or sits on the board of an organization whose proposal is under review. Such disclosure shall be appended to the local health officer's formal review of said proposal,
- c. inform the local executive authority in the matter, frequency and degree of detail as that authority may require, of all human services funding applications which the local health officer has received for review or submitted on behalf of the local health department.

- d. notify the local executive authority of each grant award made to the Local Health Department and of each contract award made to any other organization within its subdivision.
- e. notify the local executive authority of the amount of any required matching funds for which it is obligated as a result of DHMH human services funding operations, and
- f. determine what additional review is required by other local health officers when a proposal identifies services which are to be delivered in one or more contiguous jurisdictions.
- g. Submit proposals, grants or contracts to advisory boards having review authority, as appropriate.

2040.07 Local Health Administration Responsibilities - The Director, LHA, shall:

- a. review funding and vendor selection proposals for statewide delivery of service and monitor local health review of contract proposals to ensure that the appropriate degree of coordination among the local health officers is achieved, and
- b. ensure that forms DHMH 1209 and DHMH 528 contains provisions for the local health officer's signature.

2040.08 Division of Program Cost and Analysis Responsibilities - The Chief, Division of Program Cost and Analysis shall:

- a. not authorize an encumbrance/transfer or a payment of monies (except under the provisions of Section 2140, Advance Payment) for any award unless the local health officer has signed:
 - i. the Local Health Department's own grant application as the official making the application, or

- ii. the contract proposal for local health review, unless the Director of the appropriate administration has furnished a written declaration that the appropriate review period has passed without response from the local health officer and that the Director has either confirmed that the local health officer received the technical proposal and had sufficient time to review and comment or that the local health officer has waived review rights in this instance, and
- b. ensure that the instructions for completing a DHMH application (form DHMH 432) contain explicit directions to the applicant to furnish a review copy of said application to the local health officer.

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2050 FUNDING AGREEMENTS - CONTRACTS AND MEMORANDA OF UNDERSTANDING

2050.01 Contract/MOU - Every award must be perfected by a signed contract (with a private vendor) or by either a Memorandum of Understanding (MOU) or an award letter (with a Local Health Department or other government entity). If provisions of a contract, MOU or award letter contradict the provision(s) of this manual, said instrument shall prevail over this manual.

2050.02 Fiscal Year - Grants/Contracts are usually awarded for one fiscal year in accordance with state appropriations. In case of multi-year agreements, vendor budgets must be approved annually and are subject to annual appropriations.

2050.03 Specifications - When selected, a private vendor will be asked to sign a contract; a government agency will be asked to sign an MOU or will be issued in award letter. The agreement or award letter will include, at a minimum, the following:

- (a) Standard contract clauses, as appropriate, from COMAR Title 21 (contract only). If award is over \$24,000 publication in Maryland Register is required,
- (b) Name of Vendor/Vendor-of-record,
- (c) Award Number and the federal tracking number (when federal funds are used for all or part of the grant/contract),
- (d) Project Number (in the case of grants to Local Health departments),
- (e) Amount of Award,
- (f) Source(s) of Funding,
- (g) Fiscal Years for which the award is made,
- (h) Detail if any, of matching fund requirements of any other contribution.

- (i) The specification of all deliverables (with deadlines as appropriate),
- (j) A line item detail budget (for each year of funding)

2050.04 Award Letter - When a contract is used, an award letter summarizing the agreement will be prepared by the program administration and released by the Division of Contracts. It should contain items b,c,d,e and g in Section 2050.03 noted above. For Local Health Departments a unified grant award letter will summarize all DHMH grants/MOU's. These will be updated monthly as required by the Division of Program Cost and Analysis.

2050.05 Addenda - Addenda to the agreement must be completed as follows:

- a. Those affidavits required by the State Finance and Procurement Article, Title 11 through Title 21.
- b. Those addenda specified in the RFP or may be attached to the contract/MOU or Award Letter by the program administration or Division of Contracts.
- c. A Supplemental Award must be perfected by an addendum to the contract/MOU or Award Letter. See Section 2070.
- d. An Award Reduction must be perfected by an addendum to the contract/MOU or Award Letter. See Section 2090.
- e. Budget Modification when signed by both parties, becomes an addendum to contract/MOU or Award Letter.

See Section 2080.

2050.06 Board of Public Works (BPW) - Proposed contracts with vendors subject to procurement by COMAR 21.01.03.01 are subject to review by the Board of Public Works if the amount of the award exceeds \$100,000 and in certain other situations involving emergency or sole source procurements or certain contract modifications.

2050.06.01 BPW review is governed by COMAR 21.02.01 and by such procedures as that body may issue.

- 2050.06.02 Submittal of proposed human service contracts to the BPW shall be made via the Division of Contracts.
- 2050.07 Department of Budget and Fiscal Planning (DBFP) – Proposed contracts of \$100,000 or less with vendors not exempt from procurement by COMAR 21.01.03.01 are subject to review by the Department of Budget and Fiscal Planning.
- 2050.7.01 DBFP review is governed by COMAR 21.02.03.02 and by such procedures as that agency may issue.
- 2050.07.02 Submittal of proposed human service contracts to the DBFP shall be made via the Division of Contracts.

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2060 FUNDING PRINCIPLES

2060.01 General - The DHMH human service funding system is generally one of contributory funding to support health related services which derive income from user fees, insurance payments, charitable contributions and endowments, other government programs and other third-party incomes. DHMH FUNDING IS GENERALLY NOT A FULL-COST REIMBURSEMENT SYSTEM. Should a program administration wish to support all costs (or all costs less those covered by a specified type of other income) the funding agreement should contain an explicit provision to that effect. In the absence of an explicit disclaimer, the fundamental principle is that Departmental monies are spent last and recovered first.

2060.02 Maximum Award - The award figure stated in the agreement is the maximum amount of funding for which the Department shall be liable.

2060.03 Supplemental Award - Funding may be increased via a budget modification. See Section 2070.

2060.04 Modifications - The funding agreement may be modified with respect to allocation of incomes and expenditures via a budget modification. See Section 2080.

2060.05 Reduction/Termination - An award may be reduced or terminated for cause at the discretion of the Director of the program administration. The Director shall consult with the Division of Contracts to determine the appropriate procedures to be followed. In the event of reduction or termination, the Department will ensure funding for the legitimate obligations of the vendor incurred for the human services program. See Reduction, Section 2090 and Termination, Section 2100.

2060.06 Unauthorized Expenditures - Unauthorized expenditures become the

liability of the vendor. Unauthorized expenditures include but are

not necessarily limited to:

- (a) those which cause total expenditures to exceed the approved budget total,
- (b) unbudgeted expenditures,
- (c) those which differ from the approved budgeted amount (for controlled line items only, see Budget Modification, Section 2080), and
- (d) those which are at variance to an explicit provision of the funding agreement.

2060.07 Excess Income - Excess incomes will serve to reduce the amount of DHMH participation unless the Director of the program administration elects to permit the vendor either to use such incomes for program expansion (formalized via a Budget Modification, Section 2080) or to retain them without prejudice to the Department's support.

2060.08 Income Shortfall – Any shortfall in income (including user fee collections), unless recognized by the Department via an approved budget modification, becomes the liability of the vendor. Such shortfall may be compensated for by either a reduction in expenditures or an increase in other incomes, or both.

2060.09 Funding Period - Funds are awarded for a specific Grant/contract period as noted in the funding agreement or award letter. The vendor must expend those funds during such period. (See Accounting - Encumbrance, Section 2110.)

2060.10 Unspent Funds - Funds unspent at the close of the grant/contract period may be treated in one of the two following methods (See Section 2190.12.03):

- (a) federal funds, may be carried-forward to the subsequent fiscal year, or
- (b) general funds will revert to the state by means of a carry-over or collections.

2060.11 Net Income - A net income, profit or contingency reserve shall

not be allowed to the vendor, unless specifically permitted in the contract. In any case, the net profit shall be limited to 8%.

2061 Federal Block Grant Funds - Grants funded by federal funds under the Alcohol, Drug Abuse, and Mental Health (ADM) Services Block Grant or the Preventive Health Services (PHS) Block Grant are expressly prohibited from the following expenditures unless waived by the Secretary, Department of Health and Human Services:

- (a) Inpatient hospital services
- (b) Cash payment to intended recipients of health services
- (c) Purchasing or improving land, purchasing, constructing or permanently improving (other than minor remodeling) any building or other facility, or purchasing major medical equipment.
- (d) Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.
- (e) Financial assistance to any entity, other than a public or nonprofit private entity.

2060.01 Patient Records - A system must be in effect to protect patients from inappropriate disclosure of records which may be maintained in connection with any activity funded under an ADM or PHS Block Grant allotment.

2061.02 Public Health Services Act - The requirements and restrictions for the Alcohol, Drug Abuse and Mental Health and Preventive Health Services Block Grants are mandated under the Public Health Services Act, Title XIX, as amended by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35.

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2070 SUPPLEMENTAL AWARDS

2070.01 Nature - A supplemental award is the means by which the

Department provides additional funding to a human service program. The decision to provide additional funding is made by the Director of the program administration. Supplemental awards may be subject review by the Board of Public Works and the Department of Budget Fiscal Planning, in accordance with procurement law. (See Section 2050.06 - 2050.07.02.)

The Division of Contracts will coordinate the submission of supplemental awards to the review.

2070.02 Conditions - The vendor may request supplemental funding at

any time. Generally, supplemental funding is requested when one or more of the following conditions is present:

- (a) the cost of human services has increased, in multi-year contracts, and the increase in cost is supported by an increase in specific appropriations.
- (b) an error occurred in the original budget process and additional funds are required to maintain the same quantity and/or quality of service as that originally contemplated,
- (c) an unforeseen event causes a need for administration funds to maintain services,
- (d) program expansion is desired, or
- (e) additional resources are desired to enhance program quality.

2070.03 Vendor Request - A vendor may request supplemental funding

at any time. The request should be submitted using the same type form (DHMH 432 or 1209) as was used in the original application, although it should be labeled "Supplemental Request": The budget document should be accompanied by a narrative explaining the nature of the request. The program administration should be contacted prior to submission to

ensure availability of funds and to discern any special conditions which may be imposed.

2070.04 Status - If approved, the supplemental budget replaces the original budget and any intervening budget modification. See Section 2050.05.

2070.05 Notice - The vendor is notified by the program administration in writing respecting the decision on supplemental funding. If approved, the same processes as the employed for an initial award shall be used. Also, the program administration shall notify the Local Health Department of any supplemental awards made to vendors in the subdivision.

2070.06 Procurement - Supplemental funding is subject to the state's procurement laws and regulations. All requirements or exemptions which apply to human services funding generally, also apply to supplemental funding. Supplemental funding under the procurement process is considered a contract modification. Note: "Contract modification" is not synonymous with "budget modification," the former is defined in COMAR 21: the latter is specified in Section 2080.

2070.07 Approvals - The program administration must obtain the necessary approvals prior to issuance of a supplemental award. For Local Health Departments a "Change in Grant Status in Local Health Departments" (DHMH Form 4291) must be submitted when a supplement has been approved. See Section 2070.01.

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2080 BUDGET MODIFICATION

2080.01 Nature - Budget Modification is a revised budget which restates the original budget and incorporates line item changes desired by either the vendor or the program administration to achieve a new approved budget. A budget modification does not affect the total amount of the DHMH award but may affect the total amount of other funding services. A budget modification is to be distinguished from a supplemental award budget. Both are revised budgets. However, the former does not alter the amount of the DHMH grant/contract award, whereas the latter increased the amount of the DHMH grant/contract award.

2080.02 Status - A budget modification, when signed by both parties, becomes an addendum to the agreement (See Section 2050.05) and supercedes the original budget or any intervening supplemental budget or budget modification.

2080.03 Implementation - A vendor must submit a budget modification to the program administration for proposed changes whenever;

- a. a change would effect any of the following controlled line items to the degree specified:
 - i. Total of salaries, consultants, special payments and fringe costs by ...
 - 4 % for Local Health Departments
 - of 3% for vendors other than Local Health Departments
 - ii. Equipment by \$1,000.
 - iii. Purchase of Service by the greater of 3% or \$2,000 for vendors other than Local Health Departments
 - iv. Renovation/Remodeling by 10% (See Section 2170.07) for vendors other than Local Health Departments.

- b. a new estimate of third-party income (including fee collections) is over or under the previous estimate of incomes by 5% and/or
- c. the program administration has specified in the funding agreement a condition requiring the submission of a budget modification and that condition occurs.

The Vendor may submit budget modifications up to April 15th for the current fiscal year. It is recommended that the vendor discuss the need for a budget modification with the program administration before submission.

2080.04 Approval - The program administration must approve the budget modification to authorize the contemplated change.

2080.05 Vendor Liability - Budget changes subject to approval (per 2080.03) which have not been submitted to and approved by the program administration may be considered a breach of the agreement. Unauthorized changes become the liability of the vendor. Also, it should be noted that annualized costs of personnel changes made without specific approval of the program administration (i.e. changes not requiring a budget modification) may not necessarily be funded in subsequent years.

2080.05 Third- Party Income - When a modification request is submitted because third-party income is over or under the budget estimate, the vendor may request an increase or decrease of the total program budget to reflect the change.

2080.07 Negotiation and Submittal - A budget modification is typically negotiated by the vendor and the program administration and then formalized by submission of two copies of the appropriate budget modification form to the proper administration.

- 2080.08 Form DHMH 436 - Those vendors which used form DHMH 432 for application use form DHMH 436 (Budget Modification Request - Human Services Program) to request modification of the previously approved budget following instructions attached to the form. Program Administration whose vendors do not use DHMH 4432 may develop a form for budget modifications, with the approval of the Division of Program Cost and Analysis.
- 2080.09 Form DHMH 1209 - Those vendors which use form DHMH 1209 (Budget and Personnel Detail - Local Health Departments) for application (Local Health Departments) may use form DHMH 528, following these instructions:
- a. In Column 3 place current approved line item budget.
 - b. Show approved non-state participation, if any in Column 4.
 - c. In Column 5 place requested revise line item non-state participation in Column 6.
- 2080.10 Addenda - The program administration may require that the budget modification form be accompanied by one or more of the following:
- a. a narrative identification of all changes to the previous budget,
 - b. a narrative describing any changes to programmatic operations, or
 - c. revise expenditure schedules for salary, consultants, equipment or renovation/remodeling.
- 2080.11 DPCA Processing - The program administration will forward all budget modifications to the Division of Program Cost and Analysis for processing. All modifications must be accompanied by a narrative; this may be prepared by the program administration or the vendor at the program administration's discretion. If the activities of the vendor have changed substantially the Division of Program Cost and Analysis will inform the program administration within 30 days that a new grant/contract is necessary.

- 2080.12 Fiscal Operations - Once a budget modification is approved by the Director of the program administration, the Division of Program Cost and Analysis will utilize this for all fiscal operations including reconciliation.
- 2080.13 Notification - The vendor is notified by the program administration in writing whether or not the modification is approved within 30 days of receipt of the vendor's request. If approved a copy of the approved modification is sent to the vendor. In the event the vendor is a Local Health Department, notification is through the Unified Grant Award. A change in Grant Status for Local Health Departments (DHMH Form 4291) will be forwarded to the Division of Program Cost and Analysis along with the approved modification. The Division of Program Cost and Analysis is responsible for the notification of the Local Health Department.

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2090 REDUCTION

- 2090.01 General - The Director of the program administration may reduce an award for cause.
- 2090.02 Reasons - Generally, the reasons an award will be reduced include, but are not limited to:
- a. a delay in developing a new program.
 - b. a failure to fully market the target population.
 - c. a reduction in the scope of services to be delivered,
 - d. a cutback in state appropriations (or revision of estimated incomes),
 - e. a failure on the vendor's part to comply with the terms and conditions of the contract/MOU,
 - f. a realization of third-party incomes beyond that estimated in the budget, or
 - g. an actual or projected underspending from that estimated in the budget.
 - h. for multi-year contracts, insufficient appropriations to cover the cost of inflation.
- 2090.03 Hold Harmless - The program administration must ensure that any valid expenditure, including an encumbrance, made by the vendor prior to the notice of the reduction shall be supported by the Department if the expense would have been supported had there not been a reduction. In the event discussions ensue prior to formal notice, a protocol (optional) should be negotiated to establish treatment of expenses incurred prior to formal notice.
- 2090.04 Preliminary Notice - If appropriate and feasible, before a grant/contract

award is reduced, the vendor should be informed in writing at least thirty (30) days in advance that the program administration is considering reduction of the award. The notice should enumerate the reasons for the program administration's intended action, establish the new conditions by which service (s) will be delivered, and provide the vendor an opportunity to respond.

2090.05 Procurement - Reduction of funding is subject to the State's procurement laws and regulations. All requirements or exemptions which apply to human services funding generally, also apply to reduction of funding. A reduction action is considered a contract modification under the procurement process.

2090.06 Notice - A Notice of Reduction must be prepared by the program administration. The notice should address those same areas as displayed in the original award letter (see Section 2050.04). Additionally, the notice must be accompanied by a replacement budget page. Addressees should be the same as the original award letter. The reduction letter package should be forwarded to the Division of Program Cost and Analysis for processing and sign off prior to release to the vendor. If the vendor is a local Health Department notification is through the Unified Grant Award. A change in Grant Status for Local Health Departments (DHMH Form 4291) will be forwarded to the Division of Program Cost and Analysis along with the approved notification. The Division of Program Cost and Analysis is responsible for the notification of the Local Health Department.

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2100 TERMINATION

2100.01 General - Grants/Contracts may be terminated for cause by the Director of the Program Administration.

2100.02 Reasons - Reasons for termination include but are not limited to:

- (a) the vendor does not comply with their terms and condition of the agreement,
- (b) the services delivered by the vendor are of poor quality,
- (c) the administration/management of the vendor is incompetent, irresponsible and/or non-responsive.
- (d) the vendor's accounting procedures are unprofessional and/or inadequate and/or its fiscal records are inaccurate and/or unreliable,
- (e) the vendor fails to comply with applicable federal or state law,
- (f) the services provided by the vendor are no longer required or otherwise are deemed inappropriate or unnecessary as a matter of public policy,
- (g) the legislature fails to appropriate sufficient funds to continue the program, and/or
- (h) the Department changes the priority status of the program as a matter of public policy.

2100.03 Notice - The program administration, by ninety (90) day written notice, may terminate a grant/contract in whole or in part when it is deemed by the program administration to be in the best interest of the recipients of service, Administration and/or the State of Maryland.

2100.04 Preliminary Notice - If appropriate and feasible, before a grant/contract is terminated by the Department, the vendor will be informed in writing that the program administration is considering termination of the

grant/contract. The notice will enumerate the reasons for the program administration's action to terminate, will establish the conditions by which continuity of client service(s) will be maintained and will provide the vendor with an opportunity to respond. The effective date of the scheduled termination will be specified in the letter.

2100.05 Non-Renewal - When the program administration finds it necessary to not renew a grant/contract at the end of a grant/contract year, the administration will make every effort to notify the vendor in writing at least sixty (60) days in advance that the grant/contract is scheduled to be terminated at the end of the current fiscal year. Copies of this notification are also sent to the Divisions of Program Cost and Analysis and the Division of Contracts and to the appropriate local advisory committee, if any.

2100.06 Termination by the Vendor - Should the vendor wish to terminate the contract or MOU, it must make a written request for termination to the Director of the appropriate program administration at least sixty (60) days before the proposed termination date. Approval must be secured before services to clients are stopped.

2100.07 Departmental Liability - In the event of termination, the administration will be liable only for payment for expenditures/encumbrances for authorized activities to the effective date of termination.

2100.08 Final Report - Upon termination by either the administration or the vendor must submit a final report of receipts and expenditures within fifteen (15) days after the effective date of termination. If money is due the Department, a check in the full amount due should accompany the report.

2100.09 Continuity of Service - In the event of termination, the Director will take such action so as to ensure continuity of service to the third party clients. Measures to effect this provision include but are not limited to:

- a. Emergency procurement under the State Finance and Procurement Article of the Annotated Code of Maryland,
- and/or
- b. Concurrent funding/contracts of two or more vendors.

2100.10 Reclamation of Assets - When state funds are used to purchase assets the State has the right to reclaim these assets. The Department retains the right to claim and dispose of any equipment, buildings or property which has been purchased with funds provided by the Department, within three years of the date of the termination or non-renewal or before the asset may be considered fully depreciated, using IRS Guidelines on useful lives of assets, whichever is earlier. In the case of buildings or real property, if the Department has funded, in whole or in part, the down payments, mortgage or payments which include payment of principal or renovation or remodeling costs, the Department has a vested interest in the building or real property. The Department may record this interest in the property with the local jurisdiction to assure that title will not be transferred without satisfaction of the Department's interest. In case of sale of any such real property or equipment, all income shall be due the State. Therefore, provisions for the reversion of title to the Department should be included as an option in the funding agreement. The Department is to act prudently and fairly to claim accordance with the general public interest.

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2110 ACCOUNTING

- 2110.01 Standards - The vendor must maintain an accounting system and records relating to the grant/contract which conform to both Article 19, Section 28A of the Annotated Code of Maryland and Generally Accepted Accounting Principles.
- 2110.02 Program Specificity - A separate, distinct accounting record must be maintained for each grant/contract program.
- 2110.03 Periodicity - Accounting for each approved budget period must be segregated from every other budget period.
- 2110.04 Income - All income must be recorded, showing both source and amount.
- 2110.05 Expense - Each expense must be recorded and charged against its appropriate line item and must be substantiated by documentation sufficient to identify the transaction.
- 2110.06 Full disclosure - all income, expenses and related party transactions must be disclosed.
- 2110.07 Special Conditions -
- (a) Salary and fringe expenses must be supported by the following:
 - i. Maintenance of a time-reporting system for personnel funded by the grant/contract.
 - ii. Maintenance of adequate records supporting charges for fringe benefits.
 - iii. Maintenance of payroll authorization and vouchers.
 - (b) Consultant costs must be supported by the following:
 - i. Maintenance of a time-reporting system for consultants funded by the agreement.
 - ii. Maintenance of consultants' invoice
 - iii. Maintenance of fee-payment authorizations.

2110.08 Inspection - The vendor's accounting records concerning the grant/contract program must be made available for inspection or audit by the Department at any reasonable time. All accounting records must be maintained until a final audit report has been issued by the DHMH Audit Division or until five years have elapsed since the close of the grant/contract period.

2110.09 Accrual Accounting - In order to properly allocate expenses and receipts to the fiscal period cover by the grant/contract, a vendor or Local Health Department may use the accrual basis of accounting, except for fee collections from private pay clients. The accrual basis of accounting provide the expenses incurred and income earned during the funding period must be accounted for in the funding period. Expenses for goods and services received but not paid and income earned but not received should be reported in the funding period. The only exception is fees collected from clients (i.e. those fees not paid by a third party insurer such as Medicaid Assistance or Medicare.) Income from fee collections from private clients may be recorded only when the income is received (i.e. the basis.) See Section 2160.09 for a more detailed discussion of treating income.

A vendor or Local Health Department may request approval to adopt the accrual basis of accounting by submitting a written request (Local Health Departments should submit a request simultaneously to the Director, Local Health Administration) to the Chief, Division of Program Cost and Analysis by May 15th of the fiscal year preceding the year in which the use of the accrual basis is to begin. After consultation with the Director(s) of the program administration(s), the Chief, Division of Program Cost and Analysis will notify the vendor or Local Health Department of the decision by June 15th.

Generally, a vendor or Local Health Department will not be permitted to change its basis of accounting merely to gain the short term advantages. Rather, a change in the basis of accounting would be made to improve accuracy and would remain in effect until it could be demonstrated that another change would result in greater accuracy.

2110.10 Encumbrance - Obligations for goods and services which are to be furnished wholly in the subsequent year are not recognized as expenditures in the current year. The Department recognizes any of the following conditions as a valid encumbrance of funds:

- a) the vendor has signed a contract for capital equipment, the delivery of which is scheduled during the funding period but said delivery is delayed for reasonable cause.
- b) the vendor has signed a contract for Renovation/Remodeling goods and/or services which contract begins but may not be completed during the funding period.
- c) the vendor has signed a contract for services which contract begins but may not be completed during the funding period.

Note: All of the foregoing encumbrances should be reflected as expenditures in the year-end report.

2111 Guidelines - The following material is not applicable to all DHMH grant/contract vendors. However, where it is applicable it must be used.

2111.01 Imprest Petty Cash Fund - This account should be established with not more than \$500 and used, for example, to make emergency food purchases during the month, to pay for postage, to make any travel advance for local travel. This account should not used to cash any personal checks. At least once a month, this fund should be reimbursed by submitting all bills paid to the person in charge of the checking account. (Bills should be charged to the appropriate budget account.) It is

recommended that a limit, usually \$50-\$100, be established for any single disbursement from petty cash.

Note: an operating account used by a residential program for household expenses, such as groceries, is not necessarily subject to the \$500 limit. The limit for this type of account should be in line with typical monthly expenditures.

2111.02 Checking Account - It is strongly preferred that this account should be established with four signatures with a requirement that any two of the four authorized individuals may sign checks. No personal funds should be deposited into this account and no checks should be drawn for personal expenses. There should be no pre-signed checks. The person who prepares the checks should attach, to the check, copies of the bills being paid so that signers can check the amount. The check number and date paid should be noted on the bill. If possible, the person who signs the checks and the person who prepares the checks should not do the bank reconciliation.

In those cases where it is impossible to have two signatures on the check, the vendor must establish other internal control measures that would compensate for this weakness. There other measures may include stratification, (e.g. one authorized signature required on checks up to \$500, two signatures required on checks over \$500), weekly review and sign off on invoices by a person other than the signer of the check, greater separation of duties with respect to handling cash, etc.

2111.03 Record keeping - The most frequent problem the Department's vendors have in audit is with record keeping. It is crucial that proper records be maintained. These records should be established and maintained in accordance with generally accepted accounting principles and should include the following:

- a. For outpatient, clinics or services given on an "event basis" pre-numbered original source document with two copies should be used. Combination "charge" and "receipt" books or an individual "charge" book and an individual "receipt" book should be used to record all necessary data. They should be bound, fastened or glued with the original of the pre-numbered document (combination "charge" and "receipt" or individual "charge" and individual "receipt") given to the client, one copy is retained by the vendor in the receipt book in numerical order and the second copy is used by the accounting office for posting. The document, at a minimum, should have a preprinted number on it, the date, amount of fee charged, amount of fee paid, name of payer and/or person receiving service and the address, the type of service, signature of client and signature of person receiving fee.
- b. Receipts should be summarized daily in a bound Receipts Journal or computerized equivalent. The minimum entry in the Receipts Journal should show the date, the numbers of the appropriate documents and the total amount of money received.
- c. Disbursements should be recorded daily in a bound Disbursement Journal or computerized equivalent. The minimum entry in the Disbursement Journal should show the date, the date of the check, the number of the check, the payee, the amount of the check and the accounts to be

charged and the amount to be charged to each account.

- d. All Disbursement Journal columns starting from the last Journal Ledger entry should be totaled weekly (or more frequently if needed) so that a summary of cash disbursed between Journal Ledger entries is available.
- e. All expenses should be paid by check, except for small purchases paid from the imprest petty cash fund. Paid bills should be marked with the date, check number and the account to be charged, e.g., supplies, food, security, etc. They should be filed by the account charged or by some system that lends itself to review by an auditor.
- f. Entries in the journals should be posted to general ledger accounts periodically. These general ledger accounts are used as the basis for preparing the required financial statements.

2111.04 Furniture and Equipment - Adequate records must be kept of all existing furniture and equipment and all deleted furniture and equipment. Inventory control numbers should be attached to all furniture and equipment as it is purchased (and any previously purchased that does not have control numbers). Inventory control cards should be prepared for all furniture and equipment containing the following information:

- a. Date purchased
- b. Description of item, including method of disposal
- c. Vendor
- d. Cost
- e. Location
- f. Inventory Control Number
- g. Source of funds

A master file should be prepared for all deleted furniture and equipment

stating:

- a. Description of item
- b. Previous location
- c. Original cost and salvage value
- d. Date deleted

In addition, a periodic review of furniture and equipment inventory shall be performed.

For the purposes of recording inventory, any single item having a cost of \$500 or greater and a useful life of at least three years is considered equipment. Items costing less than \$500 or having a useful life or less than three years may be treated as expenses.

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2120 FISCAL REPORTING

2120.01 General - Each vendor receiving human services program funding under

the provisions of this policy must file one or more of the following reports:

DHMH 437 - Report of Receipts and Expenditures/Request for Payment,

DHMH 440 - Annual Report, and DHMH 990 (formerly BM93) - Statement of

Expenditures and Receipts (Local Health Departments only).

2120.02 DHMH 4325 - Semiannual Projection of Expenditures/Income

2120.03 Budget Modification Request - See Section 2080.08

2120.04 Annual Report - A Vendor's Annual Report (DHMH 440) of receipts and

expenditures for the budget period must be submitted to the Division of Program

Cost and Analysis by August 31, covering the preceding fiscal year. Vendors

with multi-year contracts must submit a DHMH 440 for each year of the contract.

(Day Care Programs for the Elderly submit the annual report DHMH 2026 by

September 30.) Failure to submit this report within the specified time will result

in funds being withheld until the reports are filed and reconciliation is complete.

This report need not be an audited document. So-called "preliminary" reports will

be processed as final reports; therefore the vendor must not file a report which is

not to be relied upon, merely to comply with the filing deadline.

2120.04.01 Letter of Justification - A letter of justification must accompany the annual

report if actual expenditures vary from the approved budget for those items listed

under Section 2080.03. Local Health Departments whose expenditures are

included in the 28-409 report (Detail Cost Ledger) and who elect not to file form

DHMH 440, must, nevertheless, file a letter of justification for variances as stated

above.

2120.04.02 Local Health Option - A Local Health Department having its invoices

paid by the DHMH General Accounting Division has the option of submitting a

form DHMH 440 to supercede the 28-409. If exercised, the DHMH 440 must be

filed by August 31.

- 2120.04.03 Multi-year Funding - When a multi-year award has been made, the vendor must file a DHMH 440 by August 31 of each year or DHMH 2026 by September 30 (Again, this provision is not applicable to Local Health Departments having their expenses paid directly by the DHMH General Accounting Division except as the Local Health Department may option to file a DHMH 440 in lieu of reliance on the DHMH 28-409.)
- 2120.05 Projection - A semiannual projection to expenditures and income through October 31, and January 31 must be submitted to the Director of the program administration, on December 1 and March 1 in a format to be specified by the Division of Program Cost and Analysis.
- 2120.05.01 The Director will submit a summary report of all vendors' projections to the Chief, Division of Program Cost and Analysis by December 31 and March 31.
- 2120.06 Local Health Departments - Local Health Departments having expenses paid directly by DHMH General Accounting Division and electing not to file a DHMH 440 must file a DHMH 990 - Statement of Expenditures and Receipts - or other memorandum of accounting with DHMH General Accounting Division within 30-days of the close of the budget period. (This provision is not applicable to Local Health Departments exercising the option to file a form DHMH 440.)
- 2120.07 Computer Facsimile - a facsimile generated by the vendor's own computer application may be acceptable in lieu of the departmental form for forms DHMH 432, 436, 437 and 440. Prior approval of the format by the Division of Program Cost and Analysis is advised. The vendor assumes liability for rejection of the report via facsimile if approval is not obtained.
- 2120.08 Program Option - The program administration may require additional fiscal reports of the Director's discretion.

Day Care for the Elderly - The filing deadline has been established as September 30. In addition, this program has its own forms which are acceptable to Health Systems Financing Administration.

2120.09 Baltimore City Health Department - Annual reports from the Baltimore City Health Department (BCHD) for programs funded by Addictions Services and Mental Hygiene Administration shall be due August 31 after the close of the funding period and that the MOU between the Department and the BCHD shall contain additional particulars regarding reporting and reconciliation.

2121 Other Agency Reports - The following provision are not DHMH policy, they are requirements of various other state and federal agencies. The specifications are for informational purposes only. The list is not exhaustive and the Department assumes no responsibility for omissions. For compliance with relevant laws and procedures, vendors are advised to seek direction from the appropriate agency and to seek the advice of legal counsel.

2121.01 Federal Income Tax - While a non-profit corporation is not usually subject to federal income tax, the corporation is required to submit certain forms to the federal government. First, the corporation must complete an Application for Recognition of Exemption (Federal Form 1023). The document should be completed immediately after incorporation. It is advisable to have the attorney who prepares the Articles of Incorporation complete the Form 1023 at the same item.

The form 1023 is to be submitted to the Internal Revenue Service (IRS). If the IRS determines that the applying corporation is exempt from income tax, a letter of exemption determination will be issued. This letter should be kept in a secure place, such as a bank safe deposit box.

A corporation that has been declared exempt from income tax is required to file an annual information tax return (Federal Form 990). Failure to file these returns

in a timely manner could jeopardize the tax exempt status and result in the assessment of penalties and interest against the corporation.

2121.02 Employees Income Tax Withholding - All employers are responsible for withholding amounts for federal and state income tax and FICA (Social Security) from employee's wages. The following actions are required:

- a. The employer obtains an Employer Identification Number by filing Federal Form SS-4 with the IRS.
- b. The employer has each employee complete an Employee's Withholding Allowance Certificate (Federal Form W-4). The employer uses this certificate to determine the amount of withholding for the employee.
- c. The employer pays these withholdings to the government monthly, quarterly or per pay check issuance (check with the the IRS to determine the appropriate frequency for your organization). The employer is also required to match the FICA amount. That is, the employer pays an amount equal to the employee's FICA withholdings. This can be done at most banks, using a special deposit card issued by IRS.
- d. The employer reports the withholdings to the IRS on a Federal Form 941.
- e. The employer completes a Wage and Tax Statement (Federal Form W-2) for each employee annually. These forms must be completed by January 31st of the year following the taxable period.

The importance of complying with these requirements in a timely manner cannot be overemphasized. IRS imposes very serious penalties for failure to complete the proper forms and make all payments due. Moreover, it is a primary responsibility of an employer to properly account for the employee's taxes.

2121.03 Incorporation - A corporation in the state of Maryland must file

Articles of Incorporation with the Maryland Department of Assessments and Taxation (DAT). Different forms are required for stock or non-stock corporations.

A corporation which has been incorporated in another state must register with the State of Maryland as a Foreign corporations in order to transact business in this State. Foreign corporations must file DAT Form AT5-110 and AT5-111 accompanied by a fee of \$50.

2121.04 Reports Required for Corporations - All corporations in Maryland must file a DAT Form 1 or 2 - Schedule of Return of Personal Property of individuals and Firms as of January 1st of each year. This report includes all tangible personal property and is due on or before April 15th of each year. This report must be accompanied by copy of the latest available Balance Sheet & Depreciation Schedule or a copy of Fed. Income Tax Form 1040, 1065, 1040F. All corporations doing business in Maryland must file Maryland Comptroller of the Treasury (COT) Form CRU-1 Combined Registration Application; this form is used to determine whether the corporation is liable for income withholding tax, retail sales tax and unemployment insurance.

- Sections A and I must be completed by all applicants. The remainder of the form depends upon the type of business.
- Section B should be completed only if the corporation will make sales in Maryland, purchases for resale out of state, or seek a non-profit exemption certificate.
- Section D should be completed if the corporation will have employees in the State. If Section D, Parts 1, 2, and 3 are applicable, each employee must complete COT Form MW 507, Employee's Maryland Withholding Exemption Certificate.
- Section H should be completed if the employer has more than one place of business in Maryland.

Other sections of COT Form CRU - 1 should be completed if applicable.

If the corporation is non-profit and has received a 501C3

determination letter from the Internal Revenue Service, the letter should be attached to you Form CRU-1 when it has been completed and then both returned to Central Registration, Comptroller of the Treasury (COT), 301 W. Preston Street, Room 404, Baltimore, Maryland 21201. If the corporation has applied for federal tax exemption but has not yet received the final determination, a letter explaining the status of federal application should be attached to Form CRU-1.

After Form CRU-1 has been completed and returned, it will be reviewed by the Central Registration Office. If Section D, Parts 1, 2 and 3 have been completed, the Comptroller's Office will send Form MW506-Employers Return of Income Tax Withheld-to the corporation. This form is used in making payment of the Maryland income tax which was withheld from employees wages, and is sent to the State of Maryland, Comptroller of the Treasury. The Comptroller will determine the schedule of payments the corporation should follow.

The Department of Human Resources will send Form DHR/ESA 15 and Form DHR/ESA 16 to the corporation. The form DHR/ESA 15 is used in making payments of the Maryland Unemployment Insurance Fund, quarterly. A rate is originally assigned by the DHR; this rate is reviewed annually and is raised or lowered depending on the number of claims paid in the prior year. This rate is then applied to the gross earnings of each employee up to \$7,000 to determine the corporation's contribution for unemployment. Form DHR/ESA 16 is used to report the gross earnings of each employee.

2121.05 Workmen's Compensation - There are three options available to Maryland employer in fulfilling their compensation obligation.

1. The "Self-Insurance Program" is the means whereby it is possible for a Maryland employer after filing an application and meeting the requirements of the Workmen's Compensation Commission to be self-insured for workmen's compensation. The requirements are such that normally only the very largest employers are able to qualify for this type of program. (Note: The Department will generally not support costs for a self-insurance program. Vendors should select either option #2 or #3 to ensure Departmental support.)
2. Employers in Maryland may place the coverage through any number of private insurance companies who write workmen's compensation in the State of Maryland. This is the recommended way of obtaining coverage for workmen's compensation.
3. The Maryland State Accident Fund is a state agency which writes workmen's compensation insurance for Maryland employers. In order to determine what is necessary to place coverage with the State Accident Fund, the employer can contact the State Accident Fund's Underwriting Department at 8722 Loch Raven Boulevard, Towson, Maryland 21204 in writing or by telephone at 321-3993 extensions 18, 20, 21, and 22.

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2130 PAYMENT

- 2130.01 Overview - These are two primary methods of payment: 1) the DHMH General Accounting Division pays invoices on behalf of certain Local Health Departments, or 2) the vendor submits an invoice (and quarterly report) to the Division of Program Cost and Analysis.
- 2130.02 Method #1 (Scope) - Method #1 is employed for all costs by 17 local health departments and for some costs by four other Local Health Departments (Frederick, Anne Arundel, Prince George's and Washington counties).
- 2130.03 Method # 2 (Scope) - Method #2 (Scope) - Method #2 is employed by the three home-rule subdivisions (Baltimore City, Baltimore County, and Montgomery County), all private vendors, by all public entities other than Local Health Departments, and for certain other costs, by those four county health departments mentioned specifically under method #1.
- 2130.04 Payments via Form DHMH 437 Report of Receipts and Expenditures/ Request for Payment - Method 2
- 2130.04.01 Quarterly Payments - Most vendors will request payment via DHMH 437. Payments are generally made four times per year. The first payment request should be submitted before the close of the prior fiscal year or as soon as the contract/MOU is signed. The first amount requested should usually be for an estimated four months' operation of the program. The second, third and fourth invoices (usually for payments for 3 months, 3 months and 2 months, respectively) must be submitted on the same document for reporting first, second, and third quarter operations.
- 2130.04.02 Monthly Payments - The Women, Infants and Children program provides for monthly payments for vendors. In such cases, the

form DHMH 4330 should be used. Fiscal reporting is also done on a monthly basis.

2130.04.03 Signature - The form DHMH 437 must be signed in ink

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2140 ADVANCE PAYMENT

2140.01 Background - Because the application review process can sometimes delay the completion of formal agreement and notification, and because the delivery of essential human services could be disputed or terminated by the interruption of state funding, advance payment of grant/contract monies is sometimes necessary to prevent profound hardship to recipients of services. This section establishes the means for and the limitations upon making advance payments of the operational human service program funds. Additionally, this section further defines the term "advance payment", explains under what circumstances a vendor is considered eligible, and how the vendor should apply for an advance payment.

2140.02 Vendor Request - A vendor who wishes to apply for an advance payment, shall request same from the Chief, Division of Program Cost and Analysis, using form DHMH 437. See Section 2130.

2140.03 Eligibility - Unless a notice to the contrary is issued by the Director of the program administration to the Chief, Division of Program Cost and Analysis, a vendor shall be considered to be eligible for an advance payment if either one of the following has taken place, subject to the approval requirements stated below:

- (a) The vendor has received a grant/contract in the prior fiscal year.
- (b) The vendor received a grant/contract in the prior fiscal year and has not been issued notice that human service funding will be terminated.
- (c) The Director of the program administration has issued a Letter of Intent to fund for the current/next fiscal year.

2140.04 Authorization - Unless notice modifying the amount of requested advance

payment is issued by the Director to the Chief, Division of Program Cost and Analysis, the Chief shall authorize the advance payment in the amount requested by the vendor via form DHMH 437. However, the Chief, Division of Program Cost and Analysis, shall not authorize an amount in excess of 25 percent of the prior year award or amount stated in a Letter-of-Intent without the express written approval of the Director of the program administration or his designee.

2140.05 Approval Requirements: - Director of the Program Administration - The Director of the program administration must approve each advance payment subsequent to the initial one for every vendor.

2140.06 Board of Public Works Review -

2140.06.01 Identification - The Director of the program administration shall identify all those advance payments which require a review by the Board of Public Works and shall convey that information to the Chief, Division of Program Cost Analysis, in the form and manner as the latter shall request.

2140.06.02 Transmittal - The Chief, Division of Program Cost and Analysis, shall toward to the Board of Public Works a request to authorize advance payments to those vendors who have requested same and which are subject to the Board's review.

2140.06.03 Prohibition of Authorization - The Chief, Division of Program Cost and Analysis, shall not authorize an advance payment that is subject to Board of Public Works review and approval to any prospective vendor until the Board has communicated approval of the advance payment.

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2150 COST PRINCIPLES

2150.01 Background - This section establishes the cost principles for

Department human services funding. The Director of the program administration is afforded broad discretionary authority to target Departmental support of vendor program costs to promote maximum effectiveness in the service delivery system consistent with state objectives. Also, the policy establishes certain guidelines for the consideration of vendor costs to ensure accountability in the distribution of public finds.

2150.02 Program Discretion - The Director of the program administration shall

exercise his/her discretion in determining what aspects of a vendor's program are to be supported by Departmental human services funding.

2150.03 Limitations - The vendor may use grant/contract funds for expenditures

required to carry out an approved project-program limited by:

- a. the budget approved by the Director,
- b. the terms of allowable costs in this policy (unless specifically modified by the Director of the appropriate administration),
- c. the specification of allowable costs in this policy (unless specifically modified by the Director of the appropriate administration)
- e. the total amount of the grant/contract award, as enumerated in the approved budget, and
- f. COMAR Title 21, Subtitle 09 - Contract Cost Principles and Procedures, as applicable.

2150.04 Reasonableness - The Director will subject each projected expenditure

specified in a proposed budget or budget modification to a reasonableness test in accordance with DHMH policy and his/her own judgment regarding the general public interest and that of the clients to be served. Irrespective of its classification as an allowable cost, a cost is allowable only to the

extent it is accepted as reasonable by the Director. In addition, the Chief, Division of Program Cost and Analysis shall review expenditures reported on the annual DHMH 440 for reasonableness and shall request special approval of the Director for all expenditures that are not considered reasonable.

2150.05 Criteria - A cost may be considered unreasonable on the basis of either its nature or amount. In determining the reasonableness of a given cost, consideration shall be given to any and all relevant circumstances including but not necessarily limited to the following:

- a. federal grant/contract regulations.
- b. requirements imposed by the term and conditions of the grant/contract,
- c. whether or not the cost is of a type generally recognized as ordinary and/or necessary to the provision of contracted goods or services.
- d. sound business practice, and/or
- g. the general public interest.

Reasonableness requires that the cost be such an amount as would ordinarily be paid for comparable goods or services by a comparable purchaser, depending on the facts and circumstances in each case. Reasonable cost is usually limited by fair market value.

2150.06 Direct Costs - Any costs which are or can be specifically identified with a particular cost object (budget line item) and which is allocable to the approved project/program for which the grant/contract is awarded is considered project/program for which the grant/contract is awarded is considered a direct cost. The vendor shall attribute all costs directly unless it is specifically authorized by the Department of the program administration to allocate certain costs as indirect costs.

2150.07 Indirect Costs - Indirect costs are defined under this policy as those costs

which have been incurred for multiple or common objectives (shared costs) or as those costs associated with more than one cost object within that part of the vendor's operation which is both funded by the Department and which are not readily identifiable as direct costs without effort disproportionate to the results achievable. Indirect costs are not administrative or overhead costs per se. Such costs should be identified as direct costs unless they meet the foregoing test.

2150.07.01 Authorization - The Director of the program administration may authorize indirect costs to fairly reimburse a vendor for that portion of the program which, while necessary for the performance of the grant or contract, cannot readily be identified and funded as separate line items in the direct cost portion of the vendor's budget.

2150.07.02 Funding Agreement - The Director shall ensure that the grant/contract agreement specifies:

- a. whether the vendor is eligible or ineligible to earn indirect costs.
- b. whether the indirect costs are to be calculated on the aggregate of that part of direct costs supported by Departmental funding or on another basis as specified, and
- c. the mathematical formula, percentage limitation on which the indirect cost is to be earned or the amount of indirect cost approval.

2150.07.03 Prohibition - The Director shall ensure that the approved budget of a vendor or freestanding subsidiary thereof whose operations are exclusively devoted to one program of which the Departmental funding is an income source, identifies all costs as direct costs and, therefore, does not allocate any costs as indirect costs.

2150.07.04 Local Health Departments

Note: The Secretary DHMH shall establish and issue instructions, at the beginning of each FY's budgetary process, the percentage which may be charged against grants and contracts at the discretion of Local Health Departments for indirect costs.

2150.08 Allowable Costs - The Director may allow any costs in whole or in part which are consistent with the scope and purpose of those aspects of a program which are or shall be supported by departmental finding.

2150.08.01 Guidelines - The following expense items, unless specifically rejected or limited by the Director, may be considered allowable costs under the conditions described. Inclusion here does not guarantee acceptability, conversely, omission does not necessarily preclude it. Moreover, specification in this policy as an allowable costs does not absolve the vendor from the responsibility to document these costs in accordance with generally accepted accounting principles.

Generally, allowable costs are:

- a. Those costs relating to items preprinted on form DHMH 432, some of which are discussed further below.
- b. Accounting, Audit, and Legal Services costs are allowable.
- c. Administrative Costs - including, but not limited to, those associated with a Block Grant. However, such amount of administrative costs which include unallowable elements as listed in 2150.09 is not allowable.
- d. Advertising may be allowable cost when it is for the purpose of recruitment or for outreach to actual or potential recipients of grant/contract supported services.

- e. Books, Periodicals, and Professional Journals may be allowable costs providing these materials are for the general use of the vendor staff and/or the recipients of grant/contract services.
- f. Communications costs, including those for printing and copying, are allowable.
- g. Consultant's Fees are allowable when necessary to provide the level of service established in the grant/contract and/or award letter. (See Section 2180.)
- h. Credit Card and Collection Costs
- i. Depreciation may be an allowable cost in certain instances when applied to assets when used for the purpose of creating and maintaining a reserve fund for replacement of capital equipment. The guidelines for estimating useful life will be issued by the Division of Program Cost and Analysis. Such costs may be allowed at the discretion of the Director, who may require special handling and/or disclosure of the reserve fund at his/her discretion as a quid pro quo for allowing this cost. (See Section 2150.09g, for Depreciation, not allowed)
- j. Dues and Membership fees to professional organizations and societies may be considered an allowable cost provided these memberships are organizational rather than personal.
- k. Equipment Lease and/or Purchase is an allowable cost. The schedule of equipment prices in the DBFP Budget Instructions for the applicable fiscal year may be used in any reasonableness test. Only assets counting at least \$500 and having a useful life of at least three years are considered equipment. Assets costing less than \$500 or having a useful life of less than three years need not be itemized and may be

reported as "small equipment."

- l. Fringe Benefits are generally limited to Life Insurance.

Health Insurance, Disability Insurance, Social Security, and certain benefits are available to employees with at least three years of service.

The maximum percentage allotted to fringe benefit elements listed in the DBM Budget Instructions for the fiscal year for which grant/contract funds are being requested may serve as a decision-making guide

for the Director.

- m. Fund Raising Costs up to \$1000 or 2% of the DHMH

award whichever is less. Fund raising costs which do

not generate a net benefit over time should be

disapproved in future proposals. A three year trial period

should be sufficient. If fund raising proves successful in

generating excess incomes and does not interfere

with the quality or quantity of services, the Director may

increase the previously stated limits for these costs for the purpose of

increasing the scope of services while reducing the percentage of the

DHMH grant to the total budget or for the purpose of enabling the vendor

to become more self sufficient. Generally, fund raising costs would be

inappropriate for a one-time-only agreement unless the

incomes to be derived would be received and utilized within

the grant period. It should be noted that the Department

will participate in the income generated to the same

extent the Department participates in the cost of the

fund raising. For example, if the Department supports 10%

of the fund raising costs, then 10% of the income generated

will be treated as income to the contract and used to

reduce the Department's expenditures.

Funeral or burial expenses for clients are allowable, subject to the approval of the Director of the program administration, up the limit permitted by State policy for clients in the DHMH institutions.

- n. Insurance is allowable cost. Both organizational liability insurance and malpractice insurance for the vendor's professional employees is an allowable cost; the cost of individual professional malpractice insurance for consultants is not allowable. The cost of vehicle insurance may be an allowable cost.
- o. Interest costs may be allowable:
 - i. when part of a mortgage payment or part of an installment payment for an approval equipment purchase and
 - ii. when borrowing working capital. Note: The Alcohol and Drug Abuse Administration (ADAA) requires that approval be secured to ensure support for this cost.
- p. Maintenance and Repair is an allowable cost.
- q. Payment to Advisory Council or Board of Directors are allowable as reimbursement for meals and travel only.
- r. Relocation costs for moving and organization are allowable; however, reimbursement for relocation of an employee is limited to the maximum rates provided in Department of Budget and Management, Office of Personnel Services and Benefits policy.
- s. Renovation and Remodeling costs allowable to the extent that they are meet the provisions of Section 2170.
- t. Rent or Mortgage costs are allowable to the extent that they are reasonable. A cost which is in excess of normal market rates may

be allowable in full if the location is essential to the vendor's performance of the terms of the grant contract. Generally, the State does not pay rent for space occupied in publicly building; the actual costs of operating these buildings (i.e. utilities, janitorial service, grounds keeping, etc.) may be allowable.

- u. Salaries and Wages are allowable to the extent they are reasonable. A general guideline of reasonableness of salaries/wages is the fair market value of wages paid in the area for comparable positions. Accrued leave may be identified under this item or under Fringe. Bonuses that are paid in accordance with vendor's salary plan, which has been submitted to and approved by the Director are allowable.
- v. Staff Entertainment Costs for holiday parties or employee recognition are allowable up to a limit of \$800 per year if approved by the Director of the program administration.
- w. Travel costs are allowable when related to the grant/contract. Travel costs by automobile, van or truck will be allowed at the State of Maryland mileage reimbursement rate are specified in The DBM Budget instructions for the applicable fiscal year. Other travel costs may be governed by DHMH Policy 3232. See The Appendices, Section 3020.
- x. Vehicle purchase or leasing costs are allowable if the vehicle is for transportation of recipients of grant/contract services to or from service locations or for the transportation of service personnel and/or supplies from on service site to another or to home-bound clients for the purpose of delivering service. Rates published in the DBM Budget Instructions should be used as a reasonableness test.

y. Training costs for staff are allowable to the extent that they are reasonable.

2150.09 Unallowable Costs - The following items are costs generally considered to be unallowable for purposes of Departmental grant/contract support.

The list is not exhaustive; omission does not constitute acceptance as an allowable cost. The Director may allow cost in any of these categories when it is in the public interest to do so; conversely, he/she may elect not to support funding of a cost not listed here, including those generally considered to be allowable under the previous section.

The Unallowable Costs are:

- a. Administrative costs which relate to unallowable elements,
- b. Bonuses, except when awarded in accordance with a vendor's salary plan, approved by the Director
- c. Client Funeral and/or Burial Expenses in excess of \$500
- d. Contingency Funds for Reserves,
- e. Costs in Excess of the Grant/Contract Award,
- f. Cost of Response to RFP except as provided by the RFP,
- g. Depreciation - on all real property and on equipment purchased with DHMH grant funds. (See Section 2150.08.01i, for Depreciation allowed),
- h. Employee/Staff Relocation, in excess of \$500
- i. Entertainment, except for holiday parties for staff, or employee recognition, as approved by the Director of the program administration.
- j. Fines, Claim, Awards, Judgments, or Penalties.
- k. Fund-Raising (beyond the limits specified in 2150.08),
- l. Gifts, Contributions, Donations,
- m. Interest on obligations to local, state or federal

governments or on obligations arising from "j" above.

- n. Lobbying and/or Advocacy Costs (including membership dues in industry associations whose principal activity is lobbying or advocacy)
- o. Malpractice insurance for a consultant.
- p. Sabbatical Leave.
- q. Bad debts incurred by private paying clients or third party payers and bad debts resulting from denied costs by the Department.
- r. Chaplainry training and other religious training programs for staff members
- s. Conferences, conventions, meetings. Usually, the business meetings are allowed subject to the Director's determination that the costs are reasonable. Registration fees and overnight expenses for conference or conventions are allowed only with the program director's approval.
- t. Costs not Adequately documented.
- u. Housing of non-clients unless it is a prerequisite of staff employment.
- v. Income Taxes
- w. Licensure fees for staff members except for class C drivers license where having the license was not a condition of employment at the time of employment.
- x. Losses on other grants and contracts.
- y. Expense of business activities operated by the vendor are allowed only to the extent of income generated.
- z. Expense of renting out a portion of the facility is allowable only to the extent of income generated.

- aa. Expenses resulting from transactions with related parties and/or parent organization which are greater than the expense to the related party.
- bb. costs or expenses incurred for the benefit of or on behalf an individual or organization other than the vendor.

2150.10 Pre-Payment of Expenses - The Department prefers that expenses not be incurred until the actual delivery of goods or services. However, it may recognize the vendor's pre-payment of certain expenses as valid under the following conditions:

- a. The agreement provides for recoupment to the state of unused pre-payment in the event funding is prematurely terminated, and
- b. a budget not documents the pre-payment.

2150.10.01 "Pre-Payment" in this context applies only to payment made in the current funding period where the goods or services will not be delivered until a subsequent funding period. It does not refer to payment prior to delivery when both actions occur in the same funding period or where delivery is timed to meet the test for encumbrance in the current period per Section 2110.09.

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2160 INCOME PRINCIPLES

2160.01 Background - The section establishes the principles by which program income is considered. The policy addresses both the DHMH award and all over vendor income and reviews the relationship among income types. The term "Income" is defined in Section 1000.

2160.02 Program Director Authority - The Director of the program administration shall have the authority to deviate, on an individual basis, from the principles stated in the following subsections so as to exempt or modify the treatment of certain income. The Director of the Program Administration shall notify the Division of Program Cost Analysis of its decisions to exempt or modify the treatment of income individual cases.

2160.03 Full Disclosure - Vendors whose DHMH award (s) plus income allocable to the DHMH supported human service delivery program accounts for at least 50% of the vendors income for that year, shall disclose all income in an addendum to the budget and fiscal reporting documents, in a form prescribed by the Director of the Program Administration.

2160.04 Allocation of Income - All income resulting from, earmarked for or allocated to the operation or proposed operation of the DHMH supported human services-delivery program must be identified in all budget and fiscal reporting documents and must be used to offset DHMH-funded expenditures. Generally, income resulting from or associated with the DHMH funded human services program shall be allocated to the human services program.

This allocable income includes:

- a.) the DHMH award
- b.) user of client fee collections
- c.) Medicare/Medicaid collections
- d.) other insurance collections
- e.) federal, state (other than DHMH), county or municipal

- grants/contracts derived from matching agreement in
- f.) which the Department participates
income from businesses or other ventures operated by
the vendor, to the extent that the DHMH award supports
the costs of the businesses
- g.) federal, state, county, municipal or private grants/contracts
or payments that are used to supplement DHMH funding
- h.) income from fund raising or charitable contributions
allocated to the human services program specified by
terms of the human services agreement
- i.) county or municipal funding, not part of a matching
agreement, allocated to the human services program as
specified by terms of the human services agreement.
- j.) interest or dividends earned on DHMH funds or other
income allocable to the human services program
- k.) donations, gifts or endowments allocated to the human services program
as specified by terms of the human service agreement
- l.) proceeds from the sale of assets to the extent supported, in whole or in
part, with DHMH funds or income allocated to the human services
program
- m.) awards or judgments derived from civil proceedings, to the extent that any
costs associated with the proceedings, or the instant case were supported
by DHMH funds or income allocated to the human services program
- n.) rent or royalty income to the extent that any costs associated with the
activity that generated income were supported with DHMH funds or
income allocated to the human services program.

Other income which shall be disclosed in accordance with Section 2160.03, but which will not be used to offset DHMH- funded expenditures includes:

- a.) income from businesses or other ventures operated by the vendor in excess of the business costs supported by DHMH award
- b.) federal, state, county, municipal or private grants/contracts or payments not associated with the human services programs
- c.) fund raising or charitable contributions in excess of the amount allocated to the human services program as specified by terms of the human services agreement
- d.) donations, gifts or endorsements in excess of the amount allocated to the human services program as specified by terms of the human services agreements
- e.) proceeds from the sale of assets which were purchased with funds that did not include DHMH funds or income allocated to the DHMH funded human services program
- f.) proceeds from the sale of stock or other forms of ownership
- g.) awards or judgments derived from derived from civil proceeding in excess of costs supported by the DHMH award and income allocated to the human services program
- h.) rental or royalty income in excess of costs supported by the DHMH award and income allocated to the human service program
- i.) interest or dividends earned on non-DHMH funds.

2160.05 Order of Utilization - All income other than DHMH awarded funds shall be utilized before DHMH funds are used unless the agreement specifies an alternative protocol.

2160.06 Special Treatment of Federal Funds - Federal funds which are part of the DHMH award are spent before State funds which are part of the same award. However, if there is under spending by the vendor, then the amount unspent shall be allocated to the federal funds first so as to ensure their use in the following period.

2160.07 Recognition - Accounting for the grant/contract may be on an accrual basis. Certain income because of its nature may be recognized on a cash or a modified accrual basis because to do otherwise would distort the relationship between the income and its associated operations. Fee Collections from private pay clients is recorded only when the income is received. (See Section 2110.08.) The matching of income to the appropriate period is reviewed in the final audit.

2160.08 Restricted Funds - When certain vendor income is designated or restricted by the funding source, its treatment is dependent upon its relationship to the human services program supported by DHMH as follows:

- a) if the designated/restricted funds are in support of the program also supported by the DHMH award, then the funding should be identified as income allocated to the human services program and displayed in the budget and fiscal reporting documents in accordance with the designation/restriction. (Documentation of the designation/restriction must accompany the vendor's grant application/contract proposal), or
- b) if the designated/restricted funds are not in support of the program being supported by the DHMH award, then the income is not shared by DHMH. However, the vendor should disclose the nature of the program and amount of the income and provide documentation of the designation/restriction as an addendum to the vendor's grant application/contract proposed and fiscal reporting documents, In accordance with Section 2160.03.

2160.09 Local Matching Funds - Local Matching Funds are governed by this

policy unless statutory provisions provide for alternative treatment.

Exemptions to this policy and the creation of alternative treatments for local matching funds may be agreed upon mutually by the Director and the local health officer. Such agreement must be recorded in the funding agreement.

2160.10 Exclusions - The Director may exclude from allocation any income from any source when he/she deems it to be in the public interest. Exclusions should be documented in the funding agreement. Also, the Director of the program administration shall notify the Division of Program Cost and Analysis.

Generally, income exclusions are granted for, but are not necessarily limited to, the following circumstances:

- a) the program administration wished to bear the full cost of the basic services delivery program, or
- b) the program concludes that a parallel or auxiliary program funded by such income is in the general public interest or so benefits the clients that it should be indirectly supported via an income exclusion, or
- c) the vendor has established an income schedule from sources independent of and for purposes distinct from the human services program to which the department contributes, or
- d) the vendor has established an income schedule which predates its association with the Department, or
- e) the vendor has established an income schedule which both predates its association with the Department, and is targeted for goods or services independent of the health program.

2160.11 Requirement to Generate Interest Income - The vendor must deposit all DHMH funds and those funds allocated to the DHMH supported program in a federally insured interest bearing account when such funds are not required to meet current expenses. Such interest income must be identified in all

budget and fiscal reporting documents and allocated in accordance with

Section 2160.04.

2160.12 Fees or Collections Excess of Budget Estimate - User or client fees, Medicare/Medicaid collections and other insurance collections in excess of the amount budgeted will serve to reduce the amount of DHMH participation unless the Director of the program administration elects to permit the vendor to use such income for program enrichment or to retain the income without prejudice to the Department's support. When this income exceeds or is expected to exceed that which is budgeted, the vendor may request approval to use that excess income in the program by submitting a budget modification request. The program administration will either approve or deny that request, following the procedures for budget modification in Section 2080. When income from fees or collections exceeds the final approved budget (which may include one or more budget modifications), the DHMH funding must revert to the Department in accordance with subsections 2160.06, 2160.07 and 2160.10, absent provision to the contrary in the human services agreement.

2160.13 The vendor shall retain income, derived from sources other than user or clients fees, Medicare/Medicaid collections or other insurance collections, in excess of the amount identified in the human services agreement as an offset of DHMH-funded expenditures. The vendor may use such excess income at any time for program enrichment or any other purpose without prejudice to the Department's support.

2160.14 Exception to Disposition of Excess Income - An exception may be made to Section 2160.12 if the vendor is required to produce matching funds. In such case the program administration may elect to permit the vendor to share excess income, in accordance with provisions of the human services agreement.

2160.15 Income Shortfall - Any shortfall in income becomes the liability of the vendor unless recognized by the Department via an approved budget modification. Such shortfall may be compensated for by either a reduction in expenditures or an increase in other income, or both.

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2170 CONSTRUCTION RENOVATION OR REMODELING

- 2170.01 Background - It is the intent of the Department that human services funds be used for the delivery of health and health-related services to third party clients. This funding should not customarily be utilized to fund construction or renovation/remodeling projects. However, the Department does recognize that circumstances may exist when, without the expenditure of human services funds on construction or renovation/remodeling, delivery of services would be substantially prevented, impaired or delayed. The Department, in order to ensure that human services funds are used primarily for the delivery of services to third party clients, has developed a policy which establishes parameters within which such funds may be used for renovation/remodeling projects. The purpose of the policy is to ensure accountability for Departmental expenditures and to ensure that human services funds will be used only for construction or renovation/remodeling projects that facilitate program operations.
- 2170.02 Definitions - See Section 1000 for "New Construction" "Renovation/Remodeling, and Repair and Maintenance."
- 2170.03 Prohibition on Transferring Costs -Grant/Contract funds approved for construction or renovation/remodeling may not be used for any other costs and visa versa except via an approval budget modification per Section 2080.03.
- 2170.04 Repair and Maintenance - Renovation/Remodeling costs are to be differentiated from Repair and Maintenance costs in all proposals, budgets, budget modification, etc.
- 2170.05 Limitations - Grant/Contract funds may be used for the construction or

renovation/remodeling of a vendor's or subvendor's owned physical plant or when, except for the expenditure of grant/ contract funds on construction or renovation/remodeling, the delivery of services would be substantially prevented, impaired or delayed. However, limitations imposed by federal block grant statute or other categorical language may preclude the use of certain human services funds, in whole or in part, for construction or renovation/remodeling projects.

2170.06 Conditions – Grant/Contract funds for construction or renovation/remodeling projects shall be subject to the same requirements and restraints as are other line items in an RFP, grant/contract application and/or budget. Funds requested for construction or renovation/remodeling shall be identified in a budget as a separate line item or shall be requested via a separate application. The proposed budget or modification shall be appended by such schedules, notes, estimates, architectural drawings and quotations as to afford the Director a full and accurate understanding of the nature and scope of the proposed project.

2170.07 Prohibited Projects – A request for an architectural study or design project Which does not include a construction or renovation/remodeling component or which is associated with a project to be funded by Community Bond or ADC Bond monies shall not be funded with operational grant/contract funds. Renovation/remodeling will not be allowed on leased property, unless the term of the lease is fifteen years or longer, per Section 2170.11.

2170.08 Exemption – The Director may, at his discretion, exempt from any or all Provisions of this policy, (except provisions in Section 2171) a construction, remodeling or renovation project costing less than \$20,000 during the period of the contract. A project costing \$20,000 or may or not be divided for the purpose

of exempting one or more aspects of the project.

2170.09 Indemnification - The vendor and program administration shall negotiate the terms for indemnification to the State of Maryland if, because of early termination of the grant/contract, failure of the project to conform to local regulations, or for any other reason, the grant/contract funds awarded for renovation/remodeling were not fully amortized. The terms agreed upon shall become part of the agreement and shall include, at a minimum, the following:

- a. an agreement of indemnity,
- b. an amortization schedule,
- c. a repayment schedule, and
- d. a performance bond (optional).

2170.10 Renovation/Remodeling Projects in Leased Facilities - If the vendor is a lessee, renovation/remodeling to the lease physical plant should be made by the owner (lessor) of the property. If the remaining term of the lease is 10 years or greater, however, the Director may give written approval for specific renovation/remodeling project subject to funding limits, with the approval of the Chief, Division of Engineering and Maintenance. In the case of fire safety or projects required for licensure, the Director and the Chief, Division of Engineering and Maintenance may approve the projects for a leased facility with a remaining term of less than 10 years subject to funding limits.

2170.10.01 Reasonableness Test - The Chief, Division of the Program Cost and Analysis shall subject every site cost, either rental or mortgage, including cost resulting in part from or in contemplation of a capital improvement, to a reasonableness test, and may disallow (or not support) site costs in whole or in part which exceed local market rates. If the vendor establishes a reasonable and sufficient basis for

otherwise excessive site costs, the Chief, Division of Program Cost and Analysis may allow (or support) such costs to the extent he deems reasonable.

2170.11 Review for Technical Merit and Cost Reasonableness - The Director, prior to approving a project, shall forward the proposal to the Chief, Division of Engineering and Maintenance, DHMH, for review. The Chief, Division of Engineering and Maintenance, shall review the project for technical merit (meeting all applicable codes, etc.) and cost reasonableness and notify the Director and the Chief, Division of Program Cost and Analysis of his/her findings.

2170.11.01 Deficiencies - The Chief, Division of Engineering and Maintenance, prior to notifying the Director, may advise the vendor of deficiencies in its proposal and require that modifications be made or additional documentation be submitted before approving the project on technical grounds.

2170.11.02 Applicability - The Director shall be bound by the Chief's disapproval on technical grounds and be advised by the Chief's comment regarding cost reasonableness.

2170.11.03 Documentation Required - The Chief, Division of Engineering and Maintenance, shall provide to each Director governed by this policy and the Chief, Division of Program Cost and Analysis a schedule of items, categorized by type of project if appropriate, which a vendor may be required to submit with a proposed construction or renovation/remodeling project. The Chief, Division of Engineering and Maintenance, may require more or less documentation as the circumstances warrant.

2170.12 Impact on Licensed Program - The vendor must submit a written certification which states whether the construction or renovation/remodeling project will impact a licensed program. If the program will impact upon a licensed program, the vendor must certify that the project does or will

conform to the applicable review standard and/or licensed requirements as specified by state law and regulations and must submit such documentation from the licensing/regulatory authority as will verify conformance.

2170.13 Conditions for Approval - The Director shall approve or disapprove, in writing, all requests to use grant/contract funds for renovation/remodeling projects. The director may not approve a project unless:

- a. the Chief, Division of Engineering and Maintenance, approves of a project respecting its technical merits.
- b. the documentation specified in 2170.11 is submitted, and
- c. the project conforms to all other provisions of this policy as applicable.

2171 Grant/Contract Funding of a Project in a State Facility

2171.01 Approval - A renovation/remodeling project in a state facility leased by a vendor may be funded directly by operational human services funds only with the approval of the Deputy Secretary for Public Health Services, subject to the review and approval of the Chief, Division of Engineering and Maintenance and the Director, Office of Planning and Policy Management.

2171.02 Responsibility For Project - The administrative unit having jurisdiction over the state facility shall be responsible for ensuring that the project conforms with state objectives for utilization of the facility and that the project is processed in accordance with standard departmental and state procedures for construction contracts.

2171.03 DHMH Review - The Directors of the General Services Administration and of the office of Planning shall review all projects proposed to be completed in a DHMH facility on behalf of a vendor.

2171.04 Non-DHMH State Facilities - For a project in a non-DHMH state facility, the Director shall ensure that the project conforms with the requirements of the agency having jurisdiction over the facility, of the Department of General Services and of the Department of State Planning as appropriate.

2171.05 Optional Criteria - The Director may, at his discretion, require that a project in a state facility on behalf of the vendor meet any or all of the specifications contained in sections 2170 et seq.

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2180 CONSULTANTS

- 2180.01 Background - The use of consultants is recognized as being both necessary and appropriate. However, certain considerations are essential; these are outlined below.
- 2180.02 Consultant Versus Employee - The bonafide contractor-consultant relationship exists only in absence of an employer-employee relationship.
- 2180.03 Vendor Responsibility - Determination of the appropriate status of individual is the sole responsibility of the vendor. Claims and penalties resulting from improper designation of an employee as an independent contractor or consultant are the responsibility of the vendor.
- 2180.04 Fees - Fees paid to a consultant are subject to review by the Department. The Director of the program administration may elect to limit support for consultant costs when fees paid or proposed to be paid are deemed excessive. The Director may be guided by the State Salary Plan when judging cost reasonableness. Note: DHMH Policy 3.1 on Consultant Costs no longer applies.
- 2180.05 Prohibition of Dual Status - Generally officers, employees, and members of the Board of Directors of vendor organizations should not also be paid consultants to that organization. Exceptions may be granted by the Director if the circumstances are disclosed in the budget application, if the compensation does not exceed reasonable cost and if it is demonstrated that no conflict of interest exists.
- 2181 Guidelines To Determine Appropriate Status - The following subsections offer guidelines to assist in the determination of the appropriate status of an individual as a consultant or employee. The guidelines are for informational purposes only. For compliance with relevant

laws, vendors are advised to seek the advice of legal counsel.

2181.01 Employee Defined - "Employee" is defined in Section 4401 (C-1) of the Federal Employee Tax Regulations to include every individual performing services under the terms of an employee-employer relationship. In general, this relationship exists if the person for whom services are performed has control or direction of the individual performing the services. This applies not only to the result of the service but may extend to the means by which that result is attained.

2181.02 Consultant Reviewed - Examples of persons customarily accepted as independent consultants or contractors are: physicians, psychologists, lawyers and dentists providing these persons are engaged in the presentation of independent work, business or trade in which they offer services to the public. If an employer-employee relationship exists, the person, regardless of title used, or existence of a written agreement, may not be considered as a independent contractor or consultant. Where no employer-employee relationship exists, and the person renders bonafide contractual services, he/she will submit an invoice specifying the service rendered and the amount due him/her. The consultant is paid on the basis of that invoice and no withholding or social security deductions are made.

2181.03 Factors to Consider - Guidelines which may be used to distinguish between an employer-employee relationship versus a contractor-consultant one

are:

- a. If the vendor have a right to control and direct the performance of services not only as to the results, but also as to the details and means,
- b. If the vendor have the right to discharge,
- c. If the vendor furnishes the tools and a place for work,
- d. If the persons involved render their services exclusively to one vendor,
- e. If the degree to which the individual has become integrated into

the vendor's operation for which services are performed is

significant

- f. If authority is vested in or reserved by such persons to require compliance with vendor's general policy, or
- g. If the degree to which the individual been accorded rights and privileges which the vendor has created or established for its employees generally is significant, then the relationship is usually employer-employee.

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2190 RECONCILIATION

2190.01 Background - Reconciliation is a fiscal resolution of the grant/contract pending audit and settlement, usually conducted at the termination of the grant/contract period or at the end of each fiscal year in the case of a multi-year agreement. The reconciliation operation is an arithmetic check of expenditures and incomes, a determination of net balances and disposition of those balances. Reconciliation is based upon reported expenditures and incomes, subject to correction by the Division of Program Cost and Analysis.

2190.02 Local Health Departments - With some exceptions, (See Section 2130.02 and 03) Local Health Departments are usually reconciled on the basis of figures provided by the General Accounting Division via the DHMH 28-409 printout. Any Local Health Department has the option to file an Annual Report on a DHMH 440. If exercised, this latter provision takes precedence. (See 2120.06)

2190.03 All Other Vendors - all other vendors shall use form DHMH 440 as the means of reporting their annual totals of incomes and expenditures.

2190.04 Filing Deadline - Form DHMH 440 must be delivered to the Division of Program Cost and Analysis by August 31 or by 60 days after the close of the funding period, (See 2120.04.) Exceptions are listed in 2120.07. This report need not be an audited document. So-called "preliminary" reports will be processed as final reports; therefore, the vendor must not file a report which is not to be relied upon merely to comply with the filing deadline. Subsequent reports purported to be final or corrected will not be honored.

2190.05 Failure to File A Year-End Report - If the Annual Report is not received in accordance with the provisions of Section 2120.04 or if a technically

insufficient report is received, payment may be suspended until compliance with the reporting requirement is achieved. If an organization is no longer a human services vendor, the grant/contract will be reconciled using the last available fiscal report and account receivable will be established accordingly.

2190.06 Correction of the Year-End Reports - The grant/contract will be reconciled using the figures supplied on the year-end report (DHMH 28-409 or 440). In the case of an error or omission in the report, corrections will be made (if possible, practical and desirable) by the Division of Program Cost and Analysis. A report may be rejected and returned to the vendor for a technical insufficiency which cannot or should not be corrected by the Division of Program Cost and Analysis.

2190.07 Reliance on the Funding Agreement - Reconciliation will be conducted in accordance with the terms of the funding agreement.

2190.08 Unbudgeted Expenditures and Overexpenditures - Unbudgeted expenditures and overexpenditures in controlled line items (see 2080.03) which have not been previously approved by the program administration are subject to non-recognition. The vendor may petition for recognition by submitting a "Letter of Justification" which states the nature of and a rationale for the expenditure(s). If submitting form DHMH 440, the letter should accompany it. The Director of the program administration may disapprove any unauthorized expenditure.

2190.09 Delegation of Recognition Authority - The program administration may delegate authority to the Division of Program Cost and Analysis to recognize unbudgeted line items and/or overexpenditures of controlled line items in accordance with conditions and limitations which have been agreed upon mutually.

2109.10 Recognition of Expenditures Subject to Audit and Settlement - All

expenditures recognized for purposes of reconciliation, whether incurred in accordance with an approved budget or not, are subject to audit (See Section 2210). Subsequent to identification as a audit exception, an expenditure may or may not be allowed in whole or in part by the program administration as part of final settlement. (See Section 2220).

2190.11 Findings - The results of reconciliation can be effectuated in several ways. The process discussed below relates net recognized expenditures to the total of the Department's payments to date.

2190.11.01 Expenditures Exceed Payments - When the vendor's expenditures exceed the Department's payments, the appropriate result is dependent on the relationship of the total of payments to the award total as follows:

- a. When payments are less than the award, the difference between the expenditures and payments, limited by the award, is due the vendor,
- b. when payments are equal to the award, no money is due either party,
- c. when payments are greater than the award, the difference between the payments and the award is due the Department.

2190.11.02 Expenditures Are Less Than Payments - When the vendor's expenditures are less than the Department's payments, the appropriate result is dependent on the relationship of the expenditures to the award as follows:

- a. when expenditures are less than or equal to the award, the difference between the total payments and the expenditures is due the Department,
- b. when expenditures are greater than the award, the difference between total payments and the award is due the Department.

2190.11.03 Expenditures Equal Payments - when expenditures equal payments, the

appropriate result is dependent on the relationship of the payments of

the award as follows:

- a. when payments are less than or equal to the award, no money is due either party,
- b. when payments exceed the award, the difference between the total of payments and the award is due the Department.

2190.12 Disposition - Net balances due the parties will be disposed of as follows:

2190.12.01 No Balance Due - No action required beyond notice per 2190.13.

Division of Program Cost and Analysis which will instruct the General Accounting Division to issue payment. If there is no outstanding receivable for the vendor, a check will be issued.

2190.12.02 Balance Due the Department - A balance due the Department will

be acted upon in one or more of the following ways:

- a. Account Receivable - If the organization has ceased to be a vendor for the program which generated the balance, an account receivable will be established and the organization billed,
- b. Carryover - if the vendor continues to deliver services under the program which generated the balance, the amount due will be considered a cash advance (payment) on the following year's award. This operation is referred to as carryover,
- c. Carry-Forward - For federal funding only, the program administration may elect to permit the vendor to utilize the balance due from one year in the following year's operations. This is accomplished by re-awarding the balance due and is referred to as carry-forward. The program administration must

invoke carry-forward concurrent with the reconciliation operation.

- i. The amount carried-forward is re-encumbered on the Division of Program Cost and Analysis ledger but not re-encumbered on the General Accounting Division's ledger.
- ii. Carry-forward is not available to Local Health-Departments reporting on the 28-409 system.

2190.13 Notice - Reconciliation findings will be communicated by the Division of Program Cost and Analysis. A copy of the reporting document (28-409 or DHMH 440) showing the details of the reconciliation will accompany the notice. Distribution of Notice is as follows:

- a. Vendor,
- b. Program Administration,
- c. Grant/Contract file for FY being reconciled,
- d. General Accounting Division (when appropriate),
- e. Grant/Contract file for FY affected by carryover (when appropriate) and
- f. as requested.

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2200 FEE COLLECTIONS

2200.01 Background - In 1975, the state legislature instructed the Secretary of Health and Mental Hygiene to set charges for state funded inpatient, community residential, and outpatient services. Local Health Departments and other vendors are to set charges, subject to approval and modification by the Secretary, for services funded in whole or in part by state or federal funds administered by the Department of Health and Mental Hygiene. The Secretary may designate services for which no charge is to be set.

2200.02 Context - User fee collections are an income to the human services program being funded in whole or in part by the Department. As such, they are governed by section 2160, Income Principles and by such other provisions of this policy as may be applicable in the circumstance.

2200.03 Authorities Governing Fee Collections - The Health General Article, Title 16 (and especially Sections 16-201 through 16-205) establishes the requirement for fee collections. COMAR 10.02.01 was promulgated pursuant to the statute. DHMH Policy 3416 addresses the internal administration of this subject.

2200.04 Scope - The provisions cited above require the collection of fees for services rendered by organizations funded in whole or in part by the DHMH. The intent of this requirement is that charges for health services shall reflect the full costs of rendering those services, that there be a single charge for each service rendered in each unit and that the methods for determining full costs be uniform for all units. The regulation provides for:

- (a) a sliding fee schedule which indicates the fee a client should pay based on the client's income, and family size with special consideration for financial condition,
- (b) the establishment of procedures for billing and collection of charges and fees,

- (c) the distribution and application of amounts collected, and
- (d) the maintenance of required reports and records.

2200.05 Administration - The administration of the fee collection operation to include the application of COMAR 10.02.01, DHMH Policy 3416 (see Section 3010 and 3011), and those procedures and forms noted below rests with the Division of Program Cost and Analysis.

2200.06 Procedures for Fee Setting and Cost Reporting - The procedures for fee setting and cost reporting are governed by cost instructions issued annually by the Division of Program Cost and Analysis.

Vendors are bound by its Provisions.

2200.07 Collection in Excess of Budget Estimate - All collected fees must be used for carrying out the purpose of the program up to the amount stated in the most recently approved budget. When fee collections exceed or are expected to exceed that which is budgeted, the vendor may request to use those excess fees in the program by submitting a budget modification request. The Director of the appropriate program administration will either approve or deny that request. When fee collections exceed the final approved budget (which may include one or more budget modifications), they must revert to the Department.

2200.07.01 Exception to Disposition of Excess Fee Collections - An exception may be made to the requirement to revert fee collections if a vendor is required to produce matching funds. In such case the program administration may elect to permit the vendor to share excess fees as an unallocated income, or use them to pay a greater share of the full cost of the program. If this option is employed, it should have the following features:

- a. apportionment will be available only to the vendor: no other income sources may share in the excess fees, and
- b. the apportionment of excess fees should be in the same ratio as the respective funding of the sharing parties,
- c. the option should be specified in the funding agreement.

2200.08 Client Funds - Vendors who act as custodians of client funds or representatives payees for clients must appropriate records to account for these monies. The account shall include the client specific detail of source and amount received and of nature and amount of disbursement. Vendors have a fiduciary responsibility to the clients in the handling of client monies. Vendors are to establish the controls necessary to safeguard these monies, such as the procedures described in Section 2111. DHMH will not support or fund the replacement of client funds that are lost or stolen.

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2210 AUDIT

2210.01 Background - The DHMH Audit Division will periodically audit all human services grants and contracts issued by DHMH. The books, records, and all other pertinent data of the vendor are examined by the DHMH auditor on site. This material must be made available to the auditor upon request during usual business hours. Additional documentation may be requested of the vendor. The audit will address the fiscal aspects of the grant and may also focus on the management/administration aspects of the program. A draft audit report is completed and (usually) discussed at an audit exit conference; additional documentation may be taken into account at this time. A final audit report is then issued.

2210.02 Responsibility - The Chief, Audit Division, is responsible for auditing all DHMH human services agreements. He may, at this discretion, waive the requirement that a grant/contract be audited. The Chief reserves the right to audit a sub-contractor, when it is the best interest of the state to do so. The Chief, Audit Division shall audit the financial records of a vendor in accordance with the grant/contract agreements and generally accepted auditing standards.

2210.03 Availability of Records - The vendor shall provide full disclosure of all financial statements, books, and records as needed and/or requested to the Chief, Audit Division or his designee.

2210.04 Sub-contracts - Each primary vendor, or vendor of record, shall audit each secondary vendor in accordance with those provisions and the directives of the Chief, Audit Division. The Chief, Audit Division may audit a secondary vendor, notwithstanding the responsibility of the primary vendor to audit the secondary vendor, when it is in the best interest of the State to do so. The Chief, Audit Division, if he elects

to audit a secondary vendor shall inform the primary vendor, in writing that the primary vendor is absolved of the responsibility to audit the secondary vendor.

2210.05 Methods - The purpose of the grant/contract audit is to give the State assurance that funds were spent in accordance with the grant/contract agreement. The audit review expenditures and revenues to determine if they are consistent with the approved budget and supported by adequate documentation, in accordance with generally accepted accounting principles, and/or the grant/contract agreement. Other objectives of the audit are to ascertain whether there has been compliance with regulations, to identify the causes of significant errors and suggest improvements, and to follow up on areas of concern from prior audits. The auditor establishes amounts due either to or from the vendor by comparing funds received with authorized expenditures less allocable revenues. The audit findings are the basis for making a final settlement of the grant.

2210.06 Exit Conference - The Chief, Audit Division shall conduct an audit exit conference. Prior to the exit conference, he shall distribute a copy of the draft audit report to:

- a. The vendor,
- b. The Chief, Division of Program Cost and Analysis,
- c. The Director of the program administration, and
- d. Other persons as appropriate.

2210.07 Vendor Right of Rebuttal - The vendor has the right to explain his/her position on any audit issue and to present further evidence to the Chief, Audit Division.

2210.08 Final Report - The Chief, Audit Division after examining or evaluating any evidence presented by the vendor subsequent to the issuance of the draft audit report, shall issue a final audit report or confirmation of the draft audit report based on the information that is in the possession of the Audit Division. Distribution will be to the same parties who received the draft report.

The Chief, Audit Division in the draft and final audit report shall:

- a. address and explain each audit exception,
- b. specify amounts due and when they are due and,
- c. comment upon any other issue that warrants attention.

2210.09 Timing of Audit - The Chief, Audit Division performs an audit of each grant/contract as soon as practicable after its termination. If the grant/contract is a multi-year agreement, the audit may address a distinct period which is less than the full term of the agreement.

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2220 POST AUDIT SETTLEMENT

2220.01 Background - The settlement of a grant/contract is a process of resolving post-audit issues, both fiscal and programmatic, and of closing the settlement file. The settlement process starts when the audit process terminates. The resolution of the audit is based on the Final Audit Report and may include consideration of additional factors. The Division of Program Cost and Analysis coordinates the settlement process.

2220.02 Vendor Responsibility - It is the vendor's responsibility to appraise the Chief, Division of Program Cost and Analysis, of any disagreement with the intended to refute or mitigate those findings within thirty (30) days of receipt of the final audit report.

2220.03 Guidelines - The Chief, Division of Program Cost and Analysis may be guided by the following sources to resolve settlement issues:

- a. recommendation of the Director of the program administration
- b. the grant/contract agreement and the approved budget (with approved modifications),
- c. the findings of the Audit Division as specified in the final audit report,
- d. the operation/programmatic performance of the vendor as established by ongoing monitoring of the program by the Director of the program administration and/or his designee,
- e. the replies of the vendor to the audit findings,
- f. the information transmitted from the Division of Program Cost and Analysis and
- g. the financial condition of the vendor (as verified by the Audit Division's review of the vendor's financial statement).

2220.04 Division of Program Cost and Analysis - The Chief, Division of Program

Cost and Analysis, or his designee shall:

- a. make a determination of the amount due to or from the vendor
after considering the above information
- b. develop procedures to ensure the orderly resolution of
settlement issues,
- c. advise the Director of the decision permissible under law,
regulation, and policy, and allow the Director 60 days to
provide input,
- d. act as the liaison between the units of the Department and the
vendor,
- e. be responsible for communicating to the vendor the Department's
official grant settlement decision, and
- f. be the custodian of the files that pertain to the Department's
settlement decision.

2220.05 Primary Decision-Making Authority - The Chief, Division of Program

Cost and Analysis, is the primary decision-making authority on post audit settlement.

However, the input and recommendations of the Director of the program are to be given fair consideration.

2220.06 Operational/Programmatic Issues - The Director of the appropriate

program administration shall make such decisions as he deems necessary to require that the vendor performs certain operational/programmatic actions to fulfill the terms and/or intent of the grant/contract funding. He/she shall be responsible for monitoring the actions of the vendor and taking such steps as are necessary to ensure compliance by the vendor with the terms of the settlement decision.

2220.07 Fiscal Issues - The Division of Program Cost and Analysis shall make one of the three following decisions regarding the fiscal part of the grant agreement:

- a. no money is due to either party,
- b. the Department owes the vendor a specific amount of money, but that amount shall not exceed the Department's grant/contract award for the period being audited, less any payments made to date, or
- c. the vendor owes the Department a specific amount of money.

2220.08 Administrative Allowance - The Chief, Division of Program Cost and Analysis may make an administrative decision that allows an increase or a decrease in the amount of money which is represented by the audit exceptions. The administrative allowance must be for cause, be based on good and bona fide reasons and be in the general public interest. The decision to make the administrative allowance may be based on evidence available to the Chief, Division of Program Cost and Analysis or on recommendation of the Director of the program administration.

2220.09 Determination to Collect a Lesser amount for the Purposes of Ensuring Continuity of Service - The Chief, Division of Program Cost and Analysis may authorize the collection of a lesser amount of money than that which has been established to be due to the Department after the Chief's initial review of the auditor's report, other reports and opinions and the pertinent papers and after all Administrative Allowances have been made. The Decision to collect a lesser amount of money may only be made if the Chief has documentation or is supplied with documentation which demonstrates that "collection of the full amount would seriously impair the financial condition of the vendor and a written statement containing the basis for finding is filed by the Department," i.e., Department of Health and Mental Hygiene (see Article 15A, Section 28 of the Annotated Code of Maryland). Further, this provision may

be utilized only upon a determination that continuity of client services would be jeopardized were the claim against the vendor to be pressed in full.

2220.10 Recording the Settlement Decisions - The Chief, Division of Program

Cost and Analysis shall put his settlement decision in writing and send the decision with full explanation and documentation to the Director of the Program Administration within 30 days of the receipt of the audit report. The Director of the program administration may, within 60 days of the date of the notice from the Division of Program Cost Analysis,

- accept the decision (no further action required by the Director of the program administration)
- submit comments and recommendations on the matter to the Division of Program Cost and Analysis.

After due consideration to the comments and recommendations of the Director of the program administration, the Division of Program Cost and Analysis will take action and notify the Director of the Program Administration.

2220.11 Money Due the Vendor - The Chief, Division of Program Cost and

Analysis, shall inform the vendor, in writing, that the Department owes the vendor a specific amount of money and shall authorize payment and forward instructions to the Chief, General Accounting Division, to issue a check.

2220.12 Money Due the Department - The Chief, Division of Program Cost and

Analysis, shall inform the vendor, in writing, that the vendor owes the Department a specific amount of money and shall request that the Chief, General Accounting Division, issue an invoice to the vendor for the amount of money owed to the Department specifying either one lump sum repayment or a repayment schedule (see "Installment Payment" Section 2220.16).

The Chief, General Accounting Division, shall carry out the collection request of the Chief, Division of Program Cost and Analysis less "Offset Of Accounts Resulting From Settlement and Reconciliation Operations" if feasible (see 2220.15).

2220.13 Offset of Accounts Resulting From Settlement and Reconciliation Operations (COMAR 17.01.01.04) (to be differentiated from "Offset of A Delinquent Account Receivable Against a Current Grant/Contract" -see 2220.18") - Collection by Offset of an account receivable against an account payable shall be undertaken when the offset operation conforms to both of the following provisions:

- a. the vendor has both an account payable and account receivable which were generated as a result of settlement or reconciliation operations, and
- b. the operation shall cause an amount due the vendor to be used to reduce an amount due the Department emanating from a prior or concurrent settlement or reconciliation decision.

2220.13.01 Scope - The operation shall be applied irrespective of the nature of the original funding source of the subject grants/contracts (except for federal, categorical funds which may only be offset against like funding).

2220.13.02 Notice - The Chief, General Accounting Division, shall issue notice of the offset operation and shall specify all grants/contract affected thereby and the net result to the settlement or reconciliation decision of each grant/contract and to each account. The notice shall be issued to:

- a. the vendor
- b. each Director of the program administration as warranted, and
- c. the Chief, Division of Program Cost and Analysis.

- 2220.14 Installment Payment - The Chief, Division of Program Cost and Analysis may establish an installment payment schedule in lieu of a lump sum repayment.
- 2220.14.01 Regulatory Limitation - The installment payment schedule shall not exceed thirty-six months duration (see COMAR TITLE 17.01.01). Also, this provision (installment payment) does not apply to any government agency. A vendor which is a government or government agency is required to pay in full, in a lump sum, that amount of money owed to the Department per COMAR 17.01.01.
- 2220.14.02 Vendor's Financial Condition - The Division of Program Cost and Analysis may require that the vendor make a formal request in writing, stating that collection of the full amount in one lump sum repayment would seriously impair the financial condition of the vendor and providing an explanation of the nature and scope of the potential impairment. The Chief may also require that the vendor submit its most recent audited financial statements (balance sheet and income statement) and any other statements, documents or financial papers which he deems appropriate for review.
- 2220.15 Delinquent Accounts - The Chief, General Accounting Division, shall monitor the accounts receivable of all vendors.
- 2220.15.01 Status Report - The Chief, General Accounting Division, shall notify the Chief, Division of Program Cost and Analysis, of the status of accounts receivable of vendors on a monthly basis, identifying those accounts to which offset of accounts resulting from settlement and reconciliation operations has been applied.
- 2220.15.02 Resolution - The Chief, Division of Program Cost and Analysis, shall identify those delinquent accounts receivable which cannot be collected

by offset against monies owed to the vendor because such money was not generated from the result of a grant/contract settlement or reconciliation and shall coordinate the decision to collect those delinquent accounts receivable either by applying offset against a current grant/contract (COMAR 17.01.01) or by referring those delinquent accounts receivable to the Central Collection Unit. Department of Budget and Management, or shall initiate other administrative action as appropriate. The Chief, General Accounting Division, upon notice from the Chief, Division of Program Cost and Analysis, shall be responsible for carrying out the decision.

2220.16 Offset of Delinquent Account Receivable Against A Current

Grant/Contract- Collection of a delinquent account receivable by offset against a current grant/contract shall be taken administratively to the extent permitted by law when:

- a. offset would not weaken the financial condition of the vendor to an extent that services to clients would be impaired,
- b. the programmatic Deputy Secretary approved of the collection by offset when the amount to be offset exceeds \$100,000.

2220.16.01 Notice - Chief, General Accounting Division, shall issue notice of the

offset operation to:

- a. the vendor,
- b. the Director of the program administration, and
- c. the Chief, Division of Program Cost and Analysis.

2220.16 Referral of Delinquent Accounts to the Central Collection Unit,

Department of Budget and Management - Referral to the Central Collection Unit shall be done in accordance with COMAR 17.01.01.

2220.17 Abatement - Upon petition by the vendor for a whole or partial abatement

of a debt owed to the Department, the Chief, Division of Program Cost and Analysis of the appropriate administration may recommend to the Central Collection Unit, that the vendor's indebtedness be fully or partially abated.

2220.18.01 Criteria - A recommendation to partially or wholly abate a vendor's

indebtedness may be sent to the Central collection Unit when the

following minimum criteria are met:

- a. the vendor petitions the Department, in writing, to abate all or part of debt resulting from settlement. The petition must be accompanied by the vendor's most recent audited financial statements, if available, (to include balance sheet and income statement) and any other statements, financial papers or documents that the Chief, Division of Program Cost and Analysis may require,
- b. the Chief, Audit division, has reviewed the financial statements and other documents as required and expressed an opinion, in writing, to the Chief, Division of Program Cost and Analysis respecting the vendor's financial condition,
- c. the Deputy Secretary has certified in writing that he approves of the recommendation for abatement for all amounts of \$100,000 and over.

2220.18.02 Less Than \$10 - The Chief, Division of Program Cost and Analysis, pursuant to COMAR 17.01.01.05C, may unilaterally determine that an applicable account (less than \$10) shall be abated.

2220.18.03 Coordinating by General Accounting Division - The Chief, Division, of Program Cost and Analysis, shall forward all abatement recommendations to the Chief, General Accounting Division, for referral to the Central Collections Unit, Department of Budget Management.

2220.19 Settlement Without Audit - If the Chief, Audit Division, informs the Chief, Division of Program Cost and Analysis, that a contract is not scheduled for audit due to the employment of certain sampling techniques, lack of resources or other reason, the Chief, Division of Program Cost and Analysis

will coordinate the settlement of such file in lieu of an audit.

2220.19.01 Method - Coordination of settlement in lieu of audit will contain the following elements:

- a. confirmation to the program administration that the grant is subject to closure in the absence of being selected for audit.
- b. feedback from the Director of the program administration if:
 - i. an audit is desired (stating the reason for that course), or
 - ii. a settlement process in lieu of audit should be conducted because of one or more outstanding issues.
- c. If no additional action is required, the Chief, Division of Program Cost and Analysis, will close the file, and
- d. if additional action is required per instructions from "b" above, the Chief will take appropriate action to implement the Director's instructions.

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2230 UNIFIED GRANT AWARDS BACKGROUND - In order to simplify the award process for the Local Health Departments the Unified Grant Award was begun in FY1988 to combine all grant awards, supplements, reductions, and payments into a single documents for each health department. The Division of Program Cost and Analysis is responsible for coordination and dissemination of the Unified Grant Award.

2230.01 Responsibility of Program Administration - The Director of each program administration must provide the Division of Program Cost and Analysis with the following information annually by June 15th:

- a. Amount of each award to the Local Health Departments
- b. Grant number
- c. Funding
- d. Conditions
- e. Contact person
- f. Copy of all grant award documents

As a change occurs in each Local Health Department's grant such as a supplement, reduction or budget modification, a Change in Grant Status for Local Health Departments (DHMH Form 4291) must be completed and sent along with appropriate documentation/attachments to the Division of Program Cost and Analysis.

2230.02 Responsibility of Program Cost and Analysis - The Division of Program Cost and Analysis will be responsible for coordinating the information from the program administrations and providing the Unified Grant Award and the supporting material to each Local Health Department on or before July 1. As additional material and Change in Grant Status for Local Health Departments

forms are received from the program administrations, the Unified Grant Awards will be updated. Monthly, the Unified Grant Award documents will be issued along the appropriate supporting documentation if there were changes from the previous month. That is, each Local Health Department will receive a monthly update only in those months in which there is change in the grant status.

2230.03 Responsibility of Local Health Departments - The Unified Grant Award

does not in any way alter the manner in which the Local Health Departments administer grants in accordance with Department policy. There are some special procedures applicable to Local Health Departments only, for the Unified Grant Award. These are:

Letters of Intent - Whenever possible, the Department will issue letters of intent to signify anticipated funding levels for grant programs operated by home rule counties. The purpose of these letters is to assist the Local Health Department in documenting its requests for appropriations from the local authorities.

Budget Instructions - The Department will issue consolidated instructions to Local Health Departments that require the submission of the same forms used for the General Local Health Services budgets. These budget instructions may include other detail as required by the program administrations such as detail of site costs for certain rehabilitation programs, training costs, etc.

The Division of Program Cost and Analysis, after appropriate consultation with the program administrations, shall issue these budget instructions by October 31st for the coming fiscal year.

The Local Health Departments shall submit their budgets

in accordance with these instructions by January 31st.

It should be noted that the program administrations may have to

request the Local Health Departments to submit revisions to

the budget detail to reflect changes made by the legislative

in the Department's appropriations.

2240 PROCUREMENT - All DHMH Human Services Funding Agreements not otherwise exempt, are subject to procurement regulations, rules, guidelines, and status as delineated in COMAR XXI, the Health General Article, this document (including appendices) and all future related publications and memoranda regarding human services procurement which may be forthcoming. The Office of Contract Policy, Management and Procurement may issue instructions or guidelines relating to the processing of human services procurements. The Division of Program Cost and Analysis is responsible for reviewing all human services procurements, especially RFP's and contracts, for compliance with the policies and requirements, set forth in this manual. Local Health Department procurement actions are governed by the individual Local Health Department procurement policy. This Local Health Department procurement action authority may either be to:

1. Conduct procurement actions through the local jurisdiction procurement process or
2. Conduct procurement in house via specific written delegated purchasing authority from appropriate county government or
3. Conduct all procurement following the State of Maryland procurement rules as delineated in COMAR XXI.

- 2240.01 General - The intent of Procurement Legislation which brought human services funding agreements under the provisions of COMAR21 was to promote competition in the human services market place and to encourage sound fiscal management, theoretically assuring the State of optimal services for given funding level.
- 2240.02 Types of Procurement - Competitive Sealed Proposals is the preferred method of procurement for human services. However, other types of procurement may sometimes be used as warranted by certain anomalous circumstances. These include, but are not necessarily limited to: Emergency Procurement, Sole Source Procurement, Small Procurement, and Contract Modification. Final decision as to appropriateness of a given type of procurement rests with DBM; program administrations are advised to secure approval of the Office of Contract Policy, Management & Procurement before selecting a procurement method.
- 2240.03 Data Processing Procurement – All procurements having to do with electronic data processing in excess of \$7,500 are to be routed through the Information Resources Management Administration, with the exception of purchases controlled by local jurisdictions.
- 2240.03 Contractual Agreements - All human service procurements will be finalized by a contract. The primary contractual document is the DHMH 4133. This form has been approved for both form and legal sufficiency. The program administrations may substitute other contractual documents but, when this option is exercised, the document in question must contain (at a minimum) all mandatory provisions and clauses of the DHMH 4133, all necessary identifying information, and sufficient specificity to afford no ambiguity as to the terms of the contract, including but not necessarily limited to: start/end date, units of measure,

deliverables, method and amount of payment (s), restrictions prohibitions, penalties and provisions for continuity of care. Additionally, any contract must incorporate both the RFP and the Human Service Procedures Manual with the contract.

2240.05 Exemptions - There are various exemptions to the procurement process.

Before an exempt human service funding agreement can be finalized and awarded to the vendor, sign-off must be secured from the Director, Office of Contract Policy, Management & Procurement (or designee) that the agreement is exempt.

2240.06 Procedure -

1. Prior to its submission to the budget office for approval, the funding agreement must be submitted, along with a statement signed by the Director of Program Administration and summarizing the case for exemption to the Director, Office of Contract Policy, Management & Procurement.
2. If the Director, Office of Contract Policy, Management & Procurement is in agreement as to the exempt status, the funding agreement will be signed-off and returned to the originating administration for processing.
3. If the Director, Office of Contract Policy, Management & Procurement is in disagreement as to the exempt status, the funding agreement will be so noted and returned to the originating administration for processing as a agreement subject to procurement.
4. If the case for exemption is insufficient, ambiguous, or otherwise not compelling, the Director, Office of Contract Policy, Management & Procurement may, at his discretion, return the finding agreement to the originating program administration for clarification and/or referral to the Assistant Attorney General for legal opinion.

Exemptions for the following reasons are further exempted from the procedures listed directly above:

- 1.) Exempted by virtue of having funding specified in the administration's annual budget bill.
- 2.) Exempted by virtue of having funding controlled by an approved alternate DHMH funding system, such as the Prospective Payment System for the services funded by the Developmental Disabilities Administration.
- 3.) Exempted by virtue of being a State or Local Government.

- a. Local Health Departments, which are exempt from the requirement to procure under COMAR XXI are still required to use some approved system of procurement.

- b. A Local Health Department must follow any one of three procurement options. These options are as follows:

1. County Government Option

The Local Health Department follows the county procurement policy and virtually all procurements are accomplished within the county procurement regulations. Exceptions might include small petty cash purchases and the purchase of biologicals through the master State contract. Pass through monies from DHMH which are predicted upon and intended for award to a specific entity or group of entities which, in turn, will provide direct, hands-on human services to the public are excluded from any local procurement restrictions. In such instances, both the Local Health Department

and the recipient(s) of the award must agree that the Local Health Department becomes the vendor of record and will administer the award and ensure compliance, adhering to all terms and conditions imposed by DHMH. The State Attorney General's Office will represent the Local Health Department regarding DHMH pass through grant matters.

2. Compliance with Article 21

The second option available to a Local Health Department is to accomplish all procurements in accordance with Article 21.

Following this option the Local Health Department would conduct procurement in much the same manner as a state facility. The capacity of a local health department to accept pass through grants may be impacted if this option is selected.

3. Specific Written County Government Delegated Purchasing Authority

The third option is that the Local Health Department prepare a detailed Specific written purchasing policy and that the local governing authority delegate in writing specific authority to the Local Health Department and health officer to conduct procurement in accordance with this written delegation of authority.

This is the commitment on the part of local government to support the Local Health Department procurements by providing legal support should the Local Health Department or health officer be sued by a vendor. The following is a procurement outline may be followed for this option. This option may be most appropriate for medium to small size counties where there is little formal county purchasing policy or procedure. At a minimum, such policy would include the following notices and provisions.

- a. Any request to proposal or other solicitation for bids or offers must bear the legend, "Minority business enterprises are encouraged to respond to this solicitation notice." No other language may be substituted.
- b. Human Service contracts will be let, whenever possible by means of competitive sealed proposals.
- c. Standard contracts are let, whenever possible, by means of competitive sealed bidding.
- d. Exceptions to "b" and "c", above, may be made, when necessary, by means of: 1) Sole Source Procurement and 2) Emergency Procurement.
- e. Solicitation of Bids, Proposals, offers must be posted prominently in a public place, during normal

working hours for a minimum of three working days, additional notice(s) may be placed in other areas and in publications. Notice may also be sent directly to known vendors.

- f. The local health officer (or his designee) and the Local Health Department's procurement Coordinator will be signatories for the Local Health Department in such procurements.

2241 RFP's

Each program administration will develop human services RFP's and contracts with technical assistance from the Office of Contract Policy, Management & Procurement and submit them to the Division of Program Cost and Analysis for review for conformance to the policies and requirements set forth in this manual. After its review, the Division of Program Cost and Analysis forwards them to the Office of Contract Policy, Management & Procurement for processing.

- a.) If the RFP and/or the contract is for less than \$7,500.00 the Office of Contract Policy, Management & Procurement will approve/disapprove the submission.
- b.) If the solicitation is for more than \$7,500.00, a formal set of specifications must be submitted to the Office of Contract Policy, Management & Procurement which will obtain DBFP approval prior to solicitation.
- c.) The Office of Contract Policy, Management & Procurement will be responsible for all other stages of procurement processing including, but not necessarily limited to: securing appropriate sign-off (s) for emergency or sole source procurements, forwarding to DBFP, notification (s) for Maryland Register, quarterly affirmative action reports, and arranging for the attendance of appropriate

administrative and/or fiscal personnel from the Administration at BPW meetings and notifications on final action on contracts.

Pre-bid/Pre-proposal Conference - Pre-bid/Pre-proposal Conferences are encouraged and will be held at the discretion of the Director, Office of Contract Policy, Management & Procurement. The Director, Office of Contract Policy, Management & Procurement, or his designee, will lead the Pre-bid/Pre-proposal conference.

Debriefing - unsuccessful offerors are entitled to a debriefing at their request.

- a.) this debriefing must be requested in writing to the Director, Office of Contract Policy, Management & Procurement within 30 calendar days of the offeror's having been informed of the unsuccessful offer.
- b.) the debriefing will be conducted by the Director, Office of Contract Policy, Management & Procurement within (or his designee) within 30 working days of receipt of written request for debriefing.
- c.) the Director, Office of Contract Policy, Management & Procurement will assemble appropriate staff, as needed, for the debriefing, including, but not necessarily limited to, the program administration representative and/or member (s) of the selection committee.
- d.) debriefing will be limited to an examination of the requestor's offer from the perspective of the goals of the awarding administration and the Department.
- e.) debriefings may be group debriefings or individual debriefings, or individual debriefings, at the discretion of the Director, Office of Contract Policy, Management & Procurement.

Public Information - interested parties may see copies of any proposal which is accepted by the department.

- a.) Requests must be in writing to the Director, Office of Contract Policy, Management & Procurement.
- b.) The Director, Office of Contract Policy, Management & Procurement will make pertinent materials available for examination within 60 working days of receipt of written request.
- c.) Examination will take place during normal DHMH working hours and will take place in the DHMH Headquarters building, 201 West Preston Street, Baltimore, Maryland 21201.
- d.) Offerors who believe parts of their offers to be confidential or proprietary, must clearly designate them as such at the time the offer is submitted and provide an explanation of each instances which is satisfactory to the Director, Office of Contract Policy, Management & Procurement.
 - 1.) If the explanation is sufficiently compelling the Director, Office of Contract Policy, Management & Procurement will withhold the designated sections from materials to be examined.
 - 2.) If not, the Director, Office of Contract Policy, Management & Procurement will so inform the offeror who will have 10 working days to either provide compelling documentation or revise his position.
 - 3.) If #2 above is still not sufficient to warrant withholding, the Director, Office of Contract Policy, Management & Procurement will make a decision on an as-needed basis, as to the confidential or propriety nature of a given proposal.

2250 MISCELLANEOUS PROVISIONS

2251 GRANT/CONTRACT AGREEMENTS - BLOCK GRANT STANDARDS -

2251.01 Defined - For purposes of Department funding, a Block Grant/Contract is one in which the vendor-of-record's (or "pass-through" agency's) grant/contract

specifically names subvendors as deliverers of human services to third party clients.

Under this concept, the vendor need not necessarily be the recipient of any Federal Block Grant monies.

2251.02 Approval of Subvendors - Any grant/contract or award of funds will be contingent upon the Director's approval of each subvendor and each subvendor contract.

2251.03 Responsibility - The vendor-of-record is responsible to the Division of Program Administration for compliance with the full terms and conditions specified in the grant/contract and the award letter. The vendor-of-record is responsible for the accuracy and timeliness of all reports as well as for the performance of any and all subvendors.

2251.05 Administrative Costs - Administrative costs are allowable to the vendor-of-record subject to the discretion of the Director. In so far as feasible, all such costs should be identified as direct costs although indirect costs may be available. (See Section 2150).

2252 State Travel Policy - All vendors are bound by State Travel Policy, specifically DHMH Policy 02.02.10 entitled "Policy on Travel and Reimbursement of Travel Expenses" as amended from time to time. See Section 3020.

2253 PURCHASE OF SERVICE -

2253.01 Defined - 1) For the purposes of this policy "Purchase of Service" denotes a type of funding agreement where the award is not related to a budget, where line item control of and detail on the vendor's expenditure management plan is absent.

A Purchase of Service agreement should specify and quantify deliverables but does not generally govern the vendor's financial management. 2) The term "Purchase of Service" may also be employed with respect to a vendor's subcontract for services related to the delivery of third-party health care. In this secondary context, it is a controlled line item. See Section 2080.03.

2253.02 Use - A Purchase of Service agreement may be used at any time, for any type of service or vendor at the Director's discretion. It is often employed in association with a Block Grant (Section 2251).

2253.03 Applicability of DHMH Policy – The Chief, Division of Program Cost and Analysis may exempt a Purchase of Service agreement from the provisions of these policies to the extent that such exemption would not contravene any state law, regulation or other DHMH policy.

2253.04 Review of Purchase of Service Subcontracts (Secondary Definition) - Review of Purchase of Service subcontracts of the type which are for services related to the delivery of third-party health care are subject to review by the Director of Program Administration and Office of Contract Policy, Management & Procurement. (OCPMP)

2254 GRANT-IN-AID - A Grant-in Aid is similar to a Purchase of Service in that the agreement does not govern the financial management of the grantee. In addition, a Grant-in-Aid does not specify programmatic deliverable in anything but the most general terms. Also, only the most modest reporting requirements are employed. A Grant-In-Aid generally does not require an audit. The Director may employ the Grant-in-Aid with the approval of the Chief, Division of Program Cost and Analysis. Note: If feasible, Grant-in-Aid funding should be budgeted in Object 12.

However, Object 8 funds may be used if the Grant-in-Aid mechanism is appropriate in the circumstances. A Grant-in-Aid awarded to a Local Health Department must be included the Unified Grant Award.

2255 CONFLICT OF INTEREST FOR DHMH EMPLOYEES – This governed by Administrative Memorandum #3 date August 30, 1977 and by Secretary's memorandum on that subject of the same date.

2256 APPEAL - The vendor has the right to appeal any action, procedure or policy emanating from this manual of the funding agreement.

2256.01 Process - An appeal should be initiated at the same level where a dispute arises or where a policy decision originated. The appeal must be in writing, within thirty days. The hierarchy of the appeal process is as follows:

- a. Chief, Division of Program Cost and Analysis,
- b. Director of the program administration,
- c. Deputy Secretary overseeing the program administration,
- d. Secretary or designee,
- e. Maryland State Board of Contract Appeals,
- f. Judicial review.

2256.02 Local Health Department - The Local Health Department appeal process terminates with the decision by the Secretary of designee.

2256.03 Agreements Exempt From Procurement - Agreements exempt from the State Finance and Procurement Article are not subject to review by the Maryland State Board of Contract Appeals. A vendor wishing to sustain an appeal beyond the Department's review process should seek judicial review.

2256.04 Appeals Before the Secretary - Appeals before the secretary shall

be governed by the Administrative Procedure Act, Article 41, Subsection 244-256A.

2256.05 Maryland State Board of Contract Appeals - Appeals before the Maryland State Board of Contract Appeals are governed by the State Finance and Procurement Sections 17-202 and 203 Article, of the Annotated Code of Maryland and by COMAR Title 21, Subtitle 10, Administrative and Civil Remedies.

2256.06 Judicial Review - The right of judicial review is provided by Article 41, Subsection 255 of the Annotated Code of Maryland.

2257 RECORDS, TITLE AND RETENTION –

2257.01 Title - The vendor may hold title to all organizational records including patient/client records. However, the Department is considered to have a lien on patient/client records which may be exercised in the event of reduction or termination when quality or continuity of services may be jeopardized.

2257.02 Retention - All Records must be maintained for five years or until an audit per Section 2210 is completed. The Department grants to the vendor the right to dispose of patient/client records at such time unless another retention standard of an appropriate oversight organization applies or unless other instructions are issued by the Director for their continued retention or physical delivery to the Department.

2257.03 Other Retention Schedules - Local Health Departments and other government agencies should adhere to state, local or municipal directives concerning record retention as directed.

2257.01 License to Use -The Department reserves full rights as a licensee of the vendor to use such reports, studies and data as the vendor may compile or

have compiled whether or not such material is copyrighted and shall retain such rights without cost or fee.

2258 AFFIRMATIVE ACTION PLAN -

2258.01 Development - The vendor must develop and Affirmative Action Plan to ensure compliance with equal opportunity laws.

2258.02 Submittal - An organization which is a new human services vendor must submit its Affirmative Action Plan to the department within ninety (90) days of signing the agreement or date of award letter whichever is earlier. An existing vendor should submit its current plan within ninety (90) days of receipt of this manual. Plans should be sent to:

Director
Equal Access Compliance Office
O'Conor Building
201 West Preston Street
Baltimore, Maryland 21201

A schedule for future plan submittals for vendors who maintain a long-term status as a human services vendor will be determine by the Equal Access Compliance Office.

2258.03 Compliance Review - The office named in 2258.02 above will review the plan in accordance with relevant state and federal laws and will approve or disapprove the plan and issue notice of its decision. Requests for assistance in developing a plan or for clarification of the vendor's obligations under the relevant statues should be directed to the Director.

I. BACKGROUND

1. The Secretary of the Maryland Department of Health (MDH) recognizes and authorizes the xxxxxxxx as the Local Behavioral Health Authority (LBHA)/Local Addictions Authority (LAA)/ Core Service Agency (CSA) for xxxxx County.
2. This attachment details the administrative duties and responsibilities of the CSA/LAA/LBHA. This agreement may also include funding for the provision of, or subcontracting for, behavioral health services, and specific conditions for those services are detailed in separate attachments as noted in Section VII of the agreement. Additionally the Vendor shall fulfill all the duties, powers, and responsibilities as set forth in Maryland Code Ann. Health General §10-1202 et. seq.
3. It is the policy of MDH to empower the Vendor to deliver, where applicable, plan, develop, manage, monitor, and report on the implementation of a full range of publicly funded local behavioral health services, for persons who have, or are at risk of developing, behavioral health disorders.
4. The Vendor develops and implements public health approaches to prevent and mitigate behavioral health related trauma affecting their communities, and collaborates with other human service agencies to promote comprehensive services for recipients who have multiple needs These services include those paid under contract with state general funds and or federal funds, as well as those funded under the Fee for Service System (FFS) of the Public Behavioral Health System (PBHS).
5. The MDH, the County, and the Vendor are committed to developing strategies that result in a comprehensive and well-integrated community behavioral health system that provides high quality, medically necessary services for the residents of the County and increases the involvement of the private sector.

II. GENERAL CONDITIONS:

1. The Vendor's administrative duties described herein are to be provided by the Vendor to all funding agreements between the Vendor and the BHA.
2. Unless specifically excluded, all funding included in this agreement is subject to the provisions of the MDH Local Health Department Funding System Manual (LHDFSM), or the Human Service Agreements Manual (HSAM), whichever is applicable, which are incorporated by reference, portions of which are included below. The inclusion of these provisions does not remove the responsibility of the Vendor for knowing the provisions of the manual in its entirety. The Vendor shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
3. Diversity and Cultural Sensitivity:

The Vendor's Policy and Procedure Manual shall include protocols that will assure that:

- a. The diversity of the citizenry which the Vendor serves is represented by the County's appointments to the Vendor's advisory and/or governing board, and by the Vendor's hiring and subcontracting decisions.
- b. The Vendor shall have a system to provide for the behavioral health needs of non-English speaking individuals, individuals who are deaf or hard of hearing, and/or individuals with other disabilities to maximize their access to services and information.
- c. Americans with Disabilities Act: The Vendor shall comply with the Americans with Disabilities Act, Public Law 101-336, all requirements imposed by the applicable Code of Federal Regulations, and all guidelines and interpretations issued pursuant thereto. The Vendor shall assure, to the extent practicable, that its, and its Vendors, facilities, services, and programs are accessible to individuals with disabilities as required by the Americans with Disabilities Act. The Vendor and its Vendors shall not discriminate against individuals with disabilities in the provision of its services and programs unless to do so would be an undue burden or result in a fundamental alteration in the program as those terms are used in Title II of the Act.

4. Procurement:

- a. As an agent of local government, the Vendor shall follow state Procurement Policy, local procurement policy, or if the local government has designated a 501 (c) (3) as its' Vendor, a procurement policy approved by its Board of Directors.
- b. If no modifications have been made from the previously submitted policy, an annual attestation, to include the type of procurement policy that is being followed, is required to be submitted with the Vendor's Annual Plan and/or Plan Update. Any revision or modification to the Vendor's procurement policy must be provided to the BHA within 30 days of adoption by the appropriate governing authority. Electronic copies of the policy are acceptable, with the provision of the website address and documentation of approval.
- c. At a minimum the Vendor's procurement policy shall:
 1. Assure that any conflict of interest is avoided in hiring of staff or consultants for the Vendor, and in selecting providers of community behavioral health services for members of the PBHS.
 2. Foster competition and minority business enterprise, and provide for conflict resolution and debriefing protocol in contested award of funds

5. Designated Liaison:

- a. The Vendor's Director or designee will act as liaison between the BHA, the Vendor, and the MDH Administrative Services Organization (ASO).
- b. The Vendor shall designate employee(s) who shall be on-call 24 hours a day seven days a week who can respond to emergency situations and act in the place of the Director as necessary. The Vendor's Director will forward to the BHA Director, Local Planning and Management and the ASO, its On-Call list, which designates these individual(s) at least five days prior to the implementation of the list.

6. Termination/Suspension/Reallocation:

Non-availability of Funding:

If the General Assembly fails to appropriate funds or if funds are not otherwise made available for continued performance for any fiscal year of this agreement succeeding the first fiscal year, this agreement shall be cancelled automatically as

of the beginning of the fiscal year for which funds were not appropriated or otherwise made available; provided, however, that this will not affect the State's rights or the Vendor's rights under any termination clause in this agreement. The effect of termination of the agreement hereunder will be to discharge both the Vendor and the State from future performance of the agreement, but not from their rights and obligations existing at the time of termination. The Vendor shall be reimbursed for the reasonable value of any non-recurring cost incurred but not amortized in the price of the agreement. The State shall notify the Vendor as soon as it has knowledge that funds may not be available for the continuation of this agreement for each succeeding fiscal year beyond the first.

7. Default:

- a. A default shall consist of (i) any use of the funds for any purpose other than authorized by this agreement, or (ii) any breach of substantive covenant, agreement, provision, presentation or warranty of the Vendor made in this agreement.
- b. Upon the occurrence of a default, the BHA shall notify the Vendor in writing of the default. The BHA may suspend both administrative and services funding payments to the Vendor if the Vendor fails to cure within 10 working days of the receipt of the BHA's written notice.
- c. If a default occurs, the Vendor shall have thirty (30) calendar days from its receipt of the BHA's written notice to cure the default. After the conclusion of this thirty (30) day period, or such longer period to which the parties may agree, if the Vendor has not cured the default to the satisfaction of the BHA, the BHA may, after written notice to the Vendor, terminate this agreement. All funds in the Vendor's accounts previously transferred to the Vendor pursuant to this agreement will then become the property of the State. The State shall pay the Vendor fair and equitable compensation for satisfactory Vendor performance prior to receipt of notice of termination, less the amount of damages caused by the Vendor's breach. If the damages are more than the compensation payable to the Vendor, the State can affirmatively collect damages.
- d. If the BHA fails to fulfill its obligations under this agreement properly and on time, or otherwise substantially violates any provision of this agreement, the Vendor shall notify the BHA in writing of the default. The BHA shall have 30 calendar days from receipt of Vendor's written notice, to cure the default. If the BHA fails to cure the default, the Vendor may terminate this agreement with written notice.

8. Terminate For Convenience:

The performance of work under this agreement may be terminated with ninety (90) day written notice, by the State or the Vendor, in accordance with this clause in whole or, from time to time, in part whenever the State or the Vendor shall determine that such termination is in the best interest of the State or the Vendor. Should the State elect to terminate this agreement, the State will pay all reasonable costs associated with termination of the agreement. The Vendor shall return to the State any funds previously paid by the State for services to be rendered that have not been provided.

9. Pre-Existing Regulations:

The regulations set forth in Title 10, Subtitles 9 and 21 of the Code of Maryland Regulations in effect on the date of execution of this agreement are applicable to this agreement and continue in effect unless otherwise revised.

10. Subcontracting or Assignment: Management of Behavioral Health Services

The Vendor shall not subcontract or assign any portion of the services related to managing the Behavioral Health services in its jurisdiction without the express written permission of the BHA.

11. Defense of Suits:

- a. To the extent permitted by statute, the State of Maryland will provide legal counsel or defense to the Vendor in the event that a suit, claim or action of any character is brought by any person not a party to this agreement against the Vendor as a result of, or relating to, the Vendor's obligations under this agreement.
- b. To the extent permitted by statute, the State will be responsible for the payment of any judgement or the settlement of any claims of the Vendor or its contractors as a result of, or relating to, the Vendor or its contractor's negligence or malfeasance in performing their obligations under this agreement.
- c. The Vendor shall immediately notify the BHA if any claim or suit is made or filed against the Vendor or its contractors regarding any matter resulting from or relating to the Vendor's obligations under this agreement.
- d. The Vendor will cooperate, assist, and consult with the State in the defense or investigation of any claim, suit or action made or filed against the State by a

third party as a result of, or relating to, the Vendor's/BHA's performance under this agreement.

- e. The State will cooperate, assist, and consult with the Vendor in the defense or investigation of any claim, suit, or action made or filed against the Vendor by a third party as a result of or relating to the Vendor's/BHA's performance under this agreement.
- f. Vendors that are organized as non-profit entities shall maintain insurance against negligence and be bonded against loss of funds for the appropriate amounts.

12. Retention of Records:

- a. The Vendor shall include in its Policy and Procedure Manual, protocols to ensure that records are maintained as required, and all consumer information is kept confidential. The Vendor must ensure that its employees are informed of this policy.
- b. The Vendor shall retain and maintain all financial records and documents including agreements and Conditions of Award relating to this agreement for five (5) years, or until all audit requirements are met unless a longer retention period is required by federal, state, or local governments, and then destroy if no longer needed.
- c. The Vendor shall maintain all patient information in accordance with Maryland Law Health General § 4-301 et. seq., Ann. Code of Maryland and Federal HIPAA regulations, including 45(FR 164 et. seq.).

III SCOPE OF WORK

1. Planning

The CSA/LAA/LBHA shall:

- a. Assess and plan for behavioral health related disorder service needs for its jurisdiction. The plan shall be the basis for Vendor budgetary requests to the BHA. The plan shall be data-driven, identify plans to address gaps in the service delivery continuum, and reflect stakeholder input into both planning and evaluating services, including, but not limited to, representatives of the local recovery community. Annually, the BHA will issue instructions for the completion and submission of the Behavioral Health Plan.
 - 1) The plan must be informed by the BHA needs assessment and geo-mapping.
 - 2) When addressing gaps in service delivery, be aware of input from community leaders regarding perception of areas in need of treatment versus areas with sufficient treatment resources. Develop measurable outcomes for strategies and activities pertaining to the PBHS system.
 - 3) Develop and maintain an All Hazards Plan, including coordination of responses to emergencies to insure service availability. Plans must be reviewed annually by the vendor and sent to BHA's Coordinator of Crisis and Criminal Justice Services with updates and changes to the Plan.

2. Cooperation and Interfacing

The CSA/LAA/LBHA shall:

- a. Develop and maintain an integrated system of publicly funded behavioral health services, which is responsive to the needs of consumers and providers in its jurisdiction. The Vendor shall make all reasonable efforts to coordinate the activities of publicly funded FFS Vendors providing behavioral health services.
- b. Meet with providers registered in the PBHS network that provide services to the citizens in the Vendor's jurisdiction, to collaborate with, develop, plan, and implement behavioral health services.
- c. Coordinate the position of the BHA, the ASO, the Vendor, and/or the Attorney General's Office, when a treatment plan or recommendation for a minor in Juvenile Court proceedings is required. When requested, prepare a written report for the court and send a representative to assist in the proceeding regarding available services and treatment options as well as to monitor cases committed to the BHA.
- d. Assist the BHA's Office of Behavioral Health Licensing in monitoring the BHA's therapeutic group homes licensed under COMAR 10.63. Review as needed, annual budgets for the intensity of staffing and programming, to determine the appropriateness

- of a rate increase request from an existing program, or to establish a rate for a new program.
- e. Collaborate with behavioral health providers to enable service recipients to access appropriate treatment and recovery services in a timely fashion.
 - f. Participate in state and /or local activities to implement health reform.
 - g. Assure that its Director, or designee, attends the Maryland Association of Behavioral Health Authorities (MABHA) meetings, and participates in the BHA committees and on various local boards and committees.
 - h. Cooperate and collaborate with ASO by:
 - 1) Designating a representative(s) to meet with the ASO;
 - 2) Facilitating communication with local agencies;
 - 3) Responding to ASO requests within a reasonable time;
 - 4) Working with the ASO and Vendors to participate in the development of a transition plan, following determination by ASO that service to an individual is no longer medically necessary.
 - i. Serve on local planning and advisory boards and committees to include local community boards as needed, in order to help prevent miscommunication between providers and local community leaders.
 - j. Attend the County Behavioral Health Advisory Committee Meetings, the Vendor's Board of Director Meetings, and meet with County and State Delegations and other governmental agencies.
 - k. Participate in Consumer Quality Team monthly and quarterly feedback meetings for designated services.
 - l. Serve on local planning boards and committees, including but not limited to, Local Management Boards (LMB), and the Local Care Team (LCT), and promote, arrange and implement working relationships.
 - m. Meet with providers, registered in the PBHS, which provide services for the citizens of the LBHA/LAA/CSA
 - n. Meet annually with local Emergency Rooms to provide education and training on access to and services within the PBHS.
 - o. Attend BHA Policy Forums, the BHA Annual Conference, and the BHA in-service trainings, as time, staffing, and funding permit.

- p. Upon request from ASO:
 - 1) Determine if an individual meets criteria for the public PBHS, using criteria established by BHA.
 - 2) Assist in developing a multi-agency or provider-specific treatment plan
- q. Be aware of, and have access to, Federal and Maryland Statutes and regulations and the BHA Policies and Procedures, governing the delivery of behavioral health services to children, adults, and elderly, and the Medicaid program.

3. Public and Consumer Education and Information

The Vendor shall:

- a. Inform individuals in their jurisdiction of the availability of public behavioral health services and benefits to include stigma reduction and educational information on providers and treatment in general.
- b. Establish and maintain a resource directory to assist clients in their jurisdiction to obtain services ancillary to behavioral health services that are necessary to meet the basic human needs for food, clothing, shelter, medical care, personal safety, and income.
- c. Have available a current list and description of behavioral health services and providers for its jurisdiction identifying those providers which have special capacity to provide for the behavioral health needs of non-English speaking individuals, individuals who are deaf or hard of hearing, and/or individuals with other disabilities.
- d. Provide information and training to local health providers on access to local community based behavioral health services.

4. Provider Network Development

The Vendor shall:

- a. Encourage providers, as necessary, to enroll in the public PBHS to ensure choice and access to appropriate levels of care. This includes encouraging providers to locate in areas of identified treatment gaps, based on needs assessment and geo-mapping information.
- b. Help new providers connect with community leaders and associations.
- c. Assist with ER diversion for Child & Adolescent consumers as funds permit, with clinical staff available for consultation with an Emergency Department, day treatment and inpatient staff.

- d. As funds permit, develop Urgent Care Capacity (UCC) within the Outpatient Mental Health Clinic (OMHC), Outpatient substance use treatment providers, and other provider networks concerning rapid availability of appointments for consumers using an Emergency Department or receiving Mobile Crisis team services.

5. Management of Public Behavioral Health System

The Vendor shall:

- a. Assist BHA to safeguard against unnecessary utilization of publicly funded services in its jurisdiction and assure that these services are medically appropriate and necessary.
- b. Develop local strategies and implement specific actions to reduce Emergency Department and inpatient hospitalization. The Vendor shall meet with local hospital Emergency Departments to establish an enhanced level of communication and coordination between Emergency Department personnel, and Crisis System providers to enhance the use of community based alternatives to inpatient admission.
- c. Participate in appropriate demonstration projects with the ASO and the BHA for FFS Vendors providing Assertive Community Treatment (ACT) services to allow the ACT Team to provide ongoing authorizations in 3-day increments after initial authorization by the ASO.
- d. Review and authorize, disapprove, or return for additional information requests, within 72 hours of receipt, excluding weekends and holidays, for the following services funded under the Fee for Service System.
 - 1) Residential Rehabilitation Program (RRP) transition visits,
 - 2) Supported Employment (SE). and associated PRP,
 - 3) Enhanced client supports for Mobile Treatment Services, Assertive Community Treatment, PRP, and RRP.
 - 4) Residential Crisis Services (concurrent review only)
- e. Transmit by secure fax or Health Insurance Portability and Accountability Act (HIPAA) compliant, password protected email the decision made to the ASO, and to the provider for request made in section 5.d (1-4)
- f. Follow the BHA's current policies, protocols, and guidelines for approval of the services.
- g. Assure that staff who perform the authorizations for services in section d are appropriately credentialed and/or supervised.
- h. Utilize the forms developed and updated by the BHA for the purpose of review and approval of services.

- i. Review information on high cost users of services and providers of service, along with readmission data, on a regular basis, and take steps to assist service recipients to receive any medically appropriate levels of care that are less costly.
- j. Assess hospitalization data at least monthly to include average length of stay (ALOS) Cost, and number of readmissions.
- k. Review Utilization of all services with the Public Behavioral Health System to identify changes in service deliver trends for the BHA based upon a monthly review of the data. The CSA/LAA/LBHA shall report its findings to the BHA director or designee, noting the CSA/LAA/LBHA's planned interventions with the provider to assure appropriate delivery of services.
- l. Upon review of the High Utilization Cost Report and High Inpatient user data, notify provider and refer individual consumer to appropriate level of care for ACT, Case Management, Mobile Treatment, or other community supports.
- m. Explore and develop local strategies to improve integration of care between the PBHS and local primary care providers.
- n. Serve as the BHA's designee regarding Health General Article 8-505, Health General Article 8-506 and Health General 8-507 legislative requirements, providing clinical staff to conduct Health General Article 8-505 substance-related disorder evaluations, and facilitating patient placement into the appropriate level of care.
- o. Serve as BHA's designee regarding referral for residential placements of pregnant women and women with children, providing technical assistance for coordination of care as needed.
- j. Provide a list of authorized persons and their signature to the ASO for the review and approval of services. The list should be categorized by service type, any modifications to the list needs to be promptly communicated to the ASO noting the effective date of the change.
- k. Clinically deny service only based upon review by a Psychiatrist currently licensed in State of Maryland.
- l. Retain and transmit all patient information in a confidential manner consistent with State and Federal Statutes and Regulations.
- m. Review PRP services encounter data to determine outliers of PRP service provision.
- n. Evaluate the encounter data and conduct an on-site visit in order to validate that the service provision meets the consumer's needs for PRP services. For the purposes of

- the review, only programs with encounter data outliers should be reviewed on-site by the CSA/LAA/LBHA. Additionally, an on-site review by the CSA/LAA/LBHA should be conducted on programs that have submitted encounter data for which the LBHA has reason to believe an investigation is required. The CSA/LAA/LBHA's review shall verify a Vendor's provision of both on-site and off-site services in order to receive the "blended rate" under the PRP case rate.
- o. Participate in the process of review of Residential Treatment Center (RTC) admission requests in order to identify any available appropriate services, which could divert the admission, and provide services in the community.
 - p. Monitor the relative distribution of general-level RRP beds, intensive-level RRP beds, specialty beds, and non-specialty beds for its jurisdiction. Any change in level of intensity or the nature of specialty designation of existing RRP beds shall be approved by BHA in writing in advance of the change.
 - q. Assure that the number of RRP beds remains constant, unless changes are approved in writing by the BHA.
 - r. Continue partnership with the local community hospital that is participating in the Total Patient Revenue Project.
 - s. Promote best practices in service delivery.

6. Manage Public Behavioral Health System Quality Assurance

The Vendor shall:

- a. Participate in BHA's evaluation of the PBHS system, including but not limited to: collaboration in BHA's *Outcomes Measurement System* and partner with BHA to develop outcome measures for services
- b. Collaborate with the BHA by:
 - 1) completing *Agreements to Cooperate* for new programs;
 - 2) Prior to a community behavioral health provider applying for licensure within a jurisdiction the CSA/LAA/LBHA shall enter into an agreement to cooperate with the community provider. The agreement to cooperate shall provide for coordination and cooperation between the parties in carrying out behavioral health activities in the jurisdiction, including but not limited to facilitating:
 - A complaint investigation; and
 - The transition of services if the program closes.

- 3) The agreement to cooperate may not include a provision that authorizes the CSA/LAA/LBHA to prohibit a program from offering services at any location.
 - 4) Participating in site visits with BHA to programs.
 - 5) reviewing, evaluating, and providing feedback on Program Improvement Plans
- c. Designate one or more staff members to perform the role and functions of the Residential Specialist position, as delineated in the *Residential Specialist Duties and Responsibilities* document, developed and updated by BHA, including, but not limited to:
- 1) Submit reports as required by the BHA guidelines on waiting lists, admissions, discharges, and an inventory of RRP sites,
 - 2) Perform on-site annual reviews of Group Homes for Adults with Mental Illness, RRP's and Residential Crisis Services to determine compliance with site requirements set forth in COMAR 10.63.04.07.

7. Manage Public Behavioral Health System Compliance

The Vendor shall:

- a) For grant-funded services, review *Conditions of Award*; develop and monitor criteria for contract performance standards; procure services; develop budgets and monitor expenses; monitor service provision; repurpose unspent grant funds to ensure best utilization of funding; conduct reviews for continued need of services performed
- b) Participate as requested by BHA , or the ASO as an agent of BHA, in on-site Regulatory Compliance reviews
- c) Monitor the implementation of Program Improvement Plans and notify BHA of its findings using the protocol developed by the BHA.
- d) Identify appropriate LBHA staff to be available when requested by BHA to participate in sanction proceedings.
- e) Perform Risk Assessments on sub-vendors of Federal grants in conformance with the most current Federal guidance that is available.
- f) Identify appropriate Vendor staff to be available when requested by the BHA to participate in the Office of Administrative Hearing's procedures or a case resolution conference.

8. Manage Public Behavioral Health System Grievances

The Vendor shall:

- a) Comply with the formal grievance and appeals protocols, as identified in COMAR 10.09.80 and in the ASO's policy manual for the public behavioral health system.
- b) Provide that a psychiatrist, licensed to practice in Maryland, review any clinical denial of care made by the Vendor under section K.

9. Manage Public Behavioral Health System Complaints

The Vendor shall:

- a) Ensure that the Vendor's sub-vendors have a protocol for a complaint to be filed by a service recipient. The Vendor shall require the sub-vendor to report to the Vendor any complaints received and their resolution on a periodic basis.
 - 1) Ensure that Outpatient Treatment Programs (OTP's) also have a formal process for addressing community /program complaints and documents meetings to attempt to resolve complaints.
 - 2) Should existing process not be sufficient to resolve community/complaints, consider using a mediator to assist in resolution of issues.
 - 3) Provide peer assistance to programs experiencing complaints related to large volume of patients waiting for or post treatment "loitering" to recommend solutions.
- b) Respond appropriately to all complaints made or referred to the Vendor within five (5) business days, documenting the complaint and the type of response, and submit a report to the BHA as required.
- c) Proactively determine that service recipients are able to freely access services without being subject to discriminatory admission and treatment policies. This includes individuals on substance use disorder medications requesting admission to residential treatment and recovery housing services.
- d) Vendor shall require the sub-vendor to report to the Vendor any complaints received and their resolution on a periodic basis.

C. PAYMENT AND FINANCIAL REPORTING

1. The CSA/LAA/LBHA shall deposit all MDH funds in an interest bearing account that is properly insured or collateralized and that maintains security of the funds. This account may be a federally insured interest bearing account or guaranteed by other financial instruments used by the local government or State of Maryland Treasury for State funds.
2. The CSA/LAA/LBHA shall maintain an accounting system which separates the funding for the different agreements being financed by the State, i.e. CSA/LAA/LBHA Administrative services, federal grant agreements and other State or Special funded agreements.
3. The BHA will transfer funds to the CSA/LAA/LBHA for administrative and behavioral health contract services at the frequency set forth by MDH policy. The LBHA's proposed use of these funds shall be detailed using the MDH 4542, as detailed in the MDH Local Health Department Funding System Manual (LHDFSM). These budgets may be modified during the term of this agreement, as agreed to by both parties. Further, both parties may agree to submit a modification near the end of the fiscal year, which will incorporate all modifications agreed to by the parties during the fiscal year.
4. Subcontracting or Assignment: Provision of Behavioral Health Services
 - a. The CSA/LAA/LBHA may subcontract for the provision of behavioral health services funded in this agreement as detailed in the attached budget.
 - b. Any such subcontractor assignment shall be subject to any terms and conditions that the BHA deems necessary to protect the interest of the State. The BHA shall not be responsible for the fulfillment of the LBHA's obligations to its contractors.
 - c. If the BHA approves a subcontract, the BHA may require the subcontractor to indemnify the CSA/LAA/LBHA and/or the State.
 - d. If the BHA approves a subcontract, the State of Maryland will have no obligation to provide legal counsel or defense to the subcontractors in the event that a suit, claim or action of any character is brought by any person not a party to this agreement against the subcontractor.
 - e. The CSA/LAA/LBHA shall execute agreements with all its contractors who receive funds from the CSA/LAALBHA for the provision of behavioral health services. At a minimum, the CSA/LAA/LBHA shall include the requirements of the BHA's Condition of Awards (COA) in their funding agreements with their providers of services. All of these agreements must be executed prior to the inception of their covered period and shall incorporate requirements of the BHA specific program COAs and all relevant Federal, State, and local laws, regulations, and policies. Cost reimbursement agreements must also

incorporate the requirements of the MDH Local Health Department Funding System Manual.

- f. The CSA/LAA/LBHA shall include in its Policy and Procedure Manual procedures to monitor all contractors to determine if the services or goods to be provided under the contract have been delivered and the actions to be taken if said services or goods have not been delivered. These procedures shall, at a minimum, require the CSA/LAA/LBHA to verify that the terms and conditions of the contract have been met and that the actual number of services reported by the contractors have been provided.
- g. The CSA/LAA/LBHA shall include in its Policy and Procedure Manual, the protocols and eligibility requirements for the distribution of Client Support funds.

5. Audits

a. General

There are three areas that need to be examined: financial statements, compliance with the terms and conditions of the agreement or contract, and compliance with the terms and conditions of the MDH Department Funding System Manual. Depending on the contract type, the first and last may not be necessary. The BHA will be reviewing CSA/LAA/LBHA records to determine if audits have been obtained and reviewed to evaluate compliance with the terms of the CSA agreement.

b. Guidelines for Audits of CSA/LAA/LBHAs

Private non-profit CSA/LAA/LBHAs should contract with an independent accounting firm to perform an annual audit of their financial statements. The MDH auditors will audit all private CSA/LAA/LBHAs who receive over \$250,000 and all Health Department CSA/LAA/LBHAs to determine the compliance with the terms and conditions of the MDH Department Funding System Manual Guidelines for Audits of CSA/LAA/LBHA Vendors

CSA/LAA/LBHA contracts with vendors shall contain a requirement that the vendor will be audited by an independent accounting firm or local government auditors based on the guidelines presented below. The CSA/LAA/LBHA shall obtain a copy of the audit and review the audit findings and address those that affect the delivery of behavioral health services to our consumers and/or jeopardize a provider's ability to fulfill the terms and conditions of their contract with the CSA/LAA/LBHA

1) Unit Priced and/or Fixed Price Contracts

These types of contractual agreements do not require an audit of the financial statements or an audit to determine the sub-vendor's compliance with the terms and conditions with the MDH Department Funding System Manual. If a vendor has a financial audit performed, the CSA/LAA/LBHA shall obtain a copy and review the findings to determine if conditions exist that may prevent the vendor from delivering services or fulfilling the terms and conditions of their contract with the CSA/LAA/LBHA.

2.) Cost Reimbursement Contract

Under the terms and conditions of the MDH Department Funding System Manual vendors using the cost based reimbursement methodology to contract with a CSA/LAA/LBHA must have an audit to determine their compliance with the Manual. The BHA has established the following guidelines for auditing vendors:

a) Up to \$100,000

Vendors and private practitioners, both individuals and groups, with contracts for less than \$100,000 do not need to be audited. This does not exempt the vendor from submitting the reporting forms required by the MDH Department Funding System Manual and certifying that the reported expenditures and revenues are true and correct. The CSA/LAA/LBHA should carefully review the reports to determine the vendor's compliance with the terms and conditions of the contract. In addition, if the vendor has a financial audit performed, the CSA/LAA/LBHA shall request a copy of the audit and review the findings to determine if conditions exist that may prevent the vendor from delivering services and/or fulfilling the terms and conditions of their contract with the CSA/LAA/LBHA

Please note that should a CSA/LAA/LBHA, through review of the expenditure reports and/or sampling of services delivered, suspect that a vendor has fiscal problems, the CSA/LAA/LBHA shall request an audit of the vendor. The vendor's independent auditor may perform these audits or the CSA/LAA/LBHA may request that local government auditors perform the audit.

b.) \$100,000 or Greater

Vendors with contracts for \$100,000 or greater must be audited once every two years to determine their compliance with the MDH Department Funding System Manual. Each report issued for a vendor audit should provide sufficient schedules, forms, analysis, etc., to allow the reader to evaluate the results of the subcontracted service during each of the contract fiscal years (ending June 30) separately and isolated from the sub-vendor's total operations. In addition, the CSA/LAA/LBHA shall obtain a copy of the annual financial audit and review the findings to determine if conditions exist that may prevent the vendor from delivering services and/or fulfilling the terms and conditions of their contract with the CSA/LAA/LBHA. The vendor's independent auditor may perform these audits or the CSA/LAA/LBHA may request that local government auditors perform the audit.

3.) Guidelines for Vendor Compliance Audits (contract deliverables)

All contracts, regardless of the type of contract, require a review by the CSA/LAA/LBHA to determine the sub-vendors compliance with the terms and conditions of their contract. Of particular importance is the validation of the number and type of services provided for the purpose of evaluating whether services are appropriate and cost beneficial. Vendor compliance audits may be done on a sample basis to reduce CSA/LAA/LBHA workloads.

In addition to any other available remedies, if in the opinion of the BHA, the CSA/LAA/LBHA fails to perform in a satisfactory and timely manner, the BHA may refuse to pay or limit the approved amount of any invoice for payment and may cause payments to the CSA/LAA/LBHA to be reduced or withheld until such time as the CSA/LAA/LBHA meets the requirements of these agreements. Any such decision by the BHA to withhold payments to the CSA/LAA/LBHA may be appealed by the CSA/LAA/LBHA to the Deputy Secretary for Behavioral Health, MDH.

6. The BHA will notify the CSA/LAA/LBHA in writing, of any alleged unsatisfactory performance.
7. The BHA and the State retain the authority to reduce funds because of budgetary reductions in the MDH/BHA budget.
8. Reconciliation and Rollover Funds:
 - a. Funds awarded under this agreement are subject to the reconciliation and rollover provisions of the MDH LHDFSM.
 - b. The CSA/LAA/LBHA shall use the balance shown on the MDH 440/DAFR 7410 as the amount for which the Rollover request is made. All interest earned on Administrative or services funding is to be reported on the MDH 440\DAFR 7410. Written BHA approval must be received before any Rollover funds can be spent.

Duties of the Maryland Department of Health (MDH)/Behavioral Health Administration

Behavioral Health Administration will provide technical assistance, quality assurance and fiscal oversight.

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁶ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - a) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) Intervening variables (including risk and protective factors)
 - d) Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

Archival indicators (Please list)

Hospital data (HSCRC); Impaired driving data (MAARS); and Vital Statistics data (NVSS)

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

State developed surveys are the Maryland Public Opinion Survey on Opioids (MPOS) and Maryland Young Adult Survey on Alcohol (MYSA)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

Our SEOW and State Advisory Council conducted a statewide substance misuse prevention needs assessment. The purpose of the needs assessment was to provide data-driven recommendations to the (at that time) BHA Prevention Office regarding the state prevention priorities that it should address with its federal substance misuse prevention grant funding. Then, in order to receive funding, local jurisdictions were required to conduct local needs assessment activities to determine the substances/substance misuse issues they would be addressing with SABG funds, the target populations for their efforts, the intervening variables and contributing factors they would be addressing, their goals, objectives, and evidence-based strategies.

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

The Maryland Association of Prevention Professionals and Advocates oversees Maryland's prevention certification process in collaboration with the International Certification and Reciprocity Consortium.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

The Office of Population Health Improvement (OPHI) contracts with the University of Maryland, School of Pharmacy to provide intensive, on-going technical assistance and training to Maryland's prevention workforce. Training is provided year round and is organized by specific components related to needs assessment, capacity building, strategic planning, program implementation, and evaluation. OPHI also contracts with the University of Maryland, College Park and the Johns Hopkins School of Public Health to provide training and technical assistance in preventing alcohol misuse and high-risk drinking on college campuses and in college communities.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

Our efforts to provide capacity building training and technical assistance activities to our prevention workforce have been ongoing, intensive, and cumulative. We started this capacity building process with our initial SPF-SIG grant, continued with our Opioid Misuse Prevention Program, then our SPF-PFS grant program, and now our SABG grant program. As our technical assistance team has provided capacity building training and technical assistance to our statewide prevention workforce, it has also continually strengthened its capacity to assist local communities in implementing the SPF process.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

This plan is currently being updated to reflect the reorganization of the SABG primary prevention funding from the Maryland Department of Health's (MDH) Behavioral Health Administration to MDH's Office of Population Health Improvement. The State will forward the updated plan upon completion.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- b) Timelines
- c) Roles and responsibilities
- d) Process indicators
- e) Outcome indicators
- f) Cultural competence component
- g) Sustainability component
- h) Other (please list):
- i) Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Currently, all recipients of SABG primary prevention funds are in the process of implementing the strategies they selected based on a thorough Needs Assessment and Strategic Planning process. Implementation of these strategies began on July 1, 2018. Currently there is no need for the selection of new evidence-based strategies. Once recipients have been implementing their evidence-based strategies for another full year, they will examine the outcome measures they selected during Strategic Planning to assess whether changes to strategies are necessary. At that time, an ad-hoc Evidence Based Workgroup will be convened to

review and approve any proposed changes to the previously selected evidence-based strategies. During the Strategic Planning phase, the BHA Office of Prevention provided a roster of evidence-based prevention programs, strategies, and practices that local jurisdictions were required to adhere to in selecting and implementing their SABG funded prevention activities. At the time, the program roster was developed by our technical assistance team based on its on-going review of prevention literature on evidence-based practices, including CAPT Decision Support Tools, the CDC Community Guide, the SAMHSA NREPP, and other program registries. With the loss of the CAPT and NREPP resources, OPHI will continue to utilize the CDC Community Guide and other program registries for guidance on evidence-based prevention programming. OPHI will also utilize the newly created Prevention Technology Transfer Center (PTTC) as a resource.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
Public Awareness Campaigns (TV, radio, print, billboard, etc.); distribution of awareness literature at a wide variety of community events; drug education presentations in schools, and community events
 - b) Education:
All Stars; Dare to be You; Guiding Good Choices; Life Skills Training; Parenting Wisely
 - c) Alternatives:
Alcohol-free Post Prom Activities; peer leadership training and events
 - d) Problem Identification and Referral:
Student Assistance Programs; staff referrals to direct services programs such as those listed above (such as Life Skills Training, Parenting Wisely, etc.)
 - e) Community-Based Processes:
Establishment and coordination of community substance misuse coalitions (MSPF Coalitions, OMPP Coalitions, Drug-Free Communities Coalitions); multi-agency coordination and collaboration; town hall meetings; and Communities That Care
 - f) Environmental:

Multimedia Social marketing campaigns designed to change substance use behaviors and reduce community contributing factors; supporting local community coalitions' advocacy for alcohol and other drug policy enhancements (i.e. social host ordinances, school alcohol policies, alcohol advertising restrictions, alcohol policies at public events) through the provision of data and information about the benefits of policy change; responsible alcohol server training; administrative compliance checks; and TIPS lines. Administrative compliance checks are compliance checks conducted by local civilian liquor licensing boards that may result in administrative penalties, but not criminal charges. TIPS lines are telephone hotlines routed to local law enforcement agencies that community members can use to report underage drinking parties that are either planned or underway. All primary prevention activities funded by the SABG are consistent with 18 U.S.C. § 1913, which prohibits the use of appropriated federal moneys, including SABG funds, for lobbying.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

- a) All jurisdictions must submit a strategic plan when applying for SABG funding, which describes in detail the substances whose use they will be preventing/reducing, the community contributing factors that their prevention activities will be addressing; the target populations they will be impacting, and the evidence based strategies and programs they will be implementing with their SABG funds.
- b) OPHI and its technical assistance contractor review these plans, provide feedback as needed and only approve the plans when they meet all of the SABG program requirements. These SABG requirements clearly state that funds can only be used for primary prevention activities and cannot supplant other funding.
- c) Jurisdictions provide monthly activity reports to the Maryland MDS prevention data management system and quarterly expenditure reports.
- d) OPHI staff monitor these program and fiscal reports to make sure that they are aligned with the approved prevention activities they have been funded to provide.
- e) Technical assistance is provided when these activities are not aligned, to assist the jurisdiction to get back on track with providing only approved evidence-based primary prevention SABG activities.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

This is included as part of the overall State Strategic Plan, cited above in the Planning section, the State Strategic Plan will be uploaded as an attachment.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use

- Perception of harm
- c)** Disapproval of use
- d)** Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)** Other (please describe):

Footnotes:

Maryland Behavioral Health Administration

**Strategic Prevention Framework Strategic Plan for the Allocation of SAMHSA
Substance Abuse Prevention Funds
July 1, 2017 - June 30, 2019**



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OVERVIEW

This plan details how the Maryland Behavioral Health Administration (BHA) will use the SAMSHA Strategic Prevention Framework (SPF) model to allocate its Substance Abuse Block Grant prevention funding to prevent and reduce underage drinking, non-medical use of prescription drugs/opioids, youth binge drinking, youth marijuana use, and youth heroin use. These substances were identified as state prevention priorities by the State Behavioral Health Advisory Council's (BHAC) Prevention Committee in February 2017, based on the results of its statewide youth substance misuse needs assessment.

I. NEEDS ASSESSMENT

During the summer and fall of 2016, the BHAC Prevention Committee completed a statewide substance misuse prevention needs assessment. The purpose of this needs assessment was to provide data-driven recommendations to BHA's Office of Prevention regarding the state prevention priorities that it should address with its federal substance misuse prevention grant funding.

The BHAC membership consists of 55 members from the recovery community, families, the advocate community, behavioral health organizations, the legislature, local behavioral health authorities, and state agencies. The Council has met bi-monthly since November 2015 and has elected officers, developed by-laws, and established a committee structure which gives greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning, prevention, cultural and linguistic competency, children and adolescents, adults and older adults, criminal justice, crisis services, and community behavioral health services.

The duties of the BHAC Prevention Committee include providing guidance and advocacy in the areas of behavioral health prevention across the lifespan. This may include areas such as substance misuse prevention, mental health promotion, suicide prevention, and preventing addictive behaviors such as gambling. This committee may examine data and research; identify risk factors and evidence based practices; and make recommendations or suggest strategies to BHA as appropriate and/or as elements for further study. The Prevention Committee will serve as Maryland's SPF Advisory Committee as required by SAMHSA/CSAP to guide and make recommendations to BHA in areas such as needs assessment, inter-agency coordination, strategic planning, program implementation, monitoring, and evaluation.

ASSESSMENT ACTIVITIES

At the Prevention Committee's July, August and September 2016 meetings, data was reviewed and discussed from:

- the 2015 Maryland State Substance Use and Outcomes Epidemiological Profile, a compendium of state and national substance use and consequences indicators;
- the 2015 National Survey on Drug Use and Health
- the 2014 Maryland Youth Risk Behavior Survey, a statewide survey of Maryland middle school and high school student health-related behaviors; and
- the 2016 Maryland Young Adult Alcohol Survey, a statewide survey of Maryland residents ages 18-25 regarding their perceptions, norms and use of alcohol.

On October 26, 2016, the Prevention Committee held an in-person meeting to review summaries and analyses of the AOD use and consequences indicators that had been presented at its last several committee meetings. Information was presented on underage drinking, binge drinking, nonmedical use of prescription drugs/opioids, marijuana, heroin, cocaine, and "synthetic marijuana" which were the substances most frequently reported being used by adolescents, youth, and young adults on state and national surveys.

Ten committee members (out of 14 active members) were at the October 26, 2016 meeting and participated in a discussion and analysis of the data presented by the University of Maryland's (UMD) Behavioral Health Research Team (BHRT), BHA's Technical Assistance and Evaluation Team. The ten participating committee members comprised 71 % of the committee's active membership and represented community members, county health officers, health and wellness agencies, crisis services, substance abuse treatment programs, gambling prevention, mental health promotion, health insurance providers, and academia.

Following an extensive discussion, substances were ranked by members as having high, moderate, or low *Impact* on Maryland's overall substance abuse problem, looking at factors such as numbers directly impacted, numbers indirectly impacted, consequences of use, and costs of the consequences. Rankings were:

Highest Impact:

Underage Drinking
Nonmedical Use of Prescription Drugs
Youth Binge Drinking
Heroin

Moderate Impact:

Marijuana

Lowest Impact:

Cocaine
"Synthetic Marijuana"

The substance misuse issues were then ranked by *Changeability*. Changeability was defined as the likelihood that each substance under consideration could be reduced over the next 3-5 years based on the level of state resources available for addressing the problem; the experience and capacity of our local prevention providers; the level of evidence based practices that can be brought to bear on each particular substance; and the perceived political will to address each of the problems. A chart based on BHA's assessment of the changeability of each substance, was developed to help inform this discussion.

Assessment of Changeability Summary Chart

	Level of Resources	Level of Experience and Capacity	Level of Evidence-Based Strategies	Level of Political Will	Total Changeability
Underage Drinking	High (3 pts.)	High (3)	High (3)	Moderate (2)	11
Nonmedical Use of Prescription Drugs/Opioids (12-25)	High (3)	Medium/High (2.5)	Medium/High (2.5)	High (3)	11
Youth Binge Drinking (18-25)	High (3)	Medium (2)	Low/Medium (1.5)	Moderate (2)	8.5
Marijuana (12-25)	Medium (2)	Medium (2)	Low/Medium (1.5)	Moderate (2)	7.5
Heroin (18-25)	Low (1)	Low (1)	Low (1)	High (3)	6
Cocaine (18-25)	Low (1)	Low (1)	Low (1)	Low (1)	4
“Synthetic Marijuana”	Low (1)	Low (1)	Low (1)	Low (1)	4

In keeping with a prioritization process followed in previous substance misuse needs assessments, we then plotted these levels of Impact and Changeability onto a 3X3 table to give members a visual picture of where each substance ranks based on Impact and Changeability.

Change-Impact → ability	High	Moderate	Low
High	Underage Drinking Nonmedical Use of Prescription Drugs/Opioids		
Moderate	Binge Drinking	Marijuana	
Low	Heroin		Cocaine Synthetic Marijuana

Each committee member's task was then to consider the discussions over the past several meetings and these Impact and Changeability considerations and provide their rankings of these substances from 1-7 (1 = highest; 7 = lowest). These individual substance use rankings would then be combined into a composite ranking and presented to all members prior to the December 2016 committee meeting. At that meeting, the committee would then finalize its recommendations to BHA regarding which substance use issues the BHA Office of Prevention should prioritize as it allocates its substance abuse prevention resources and applies for additional federal prevention resources.

On November 15, 2016 the summary of the October 26th meeting, with its rankings of substance issue Impact and Changeability, was sent to all members who were asked to review this material and provide their personal rankings of which substance use issues they believe should be the state's prevention priorities.

On December 7, 2016, BHA compiled the rankings of the 9 members who responded and combined them into a composite ranking as follows:

#1 substance misuse issue: Underage Drinking (average ranking 1.6)

#2 substance misuse issue: Non-Medical Use of Prescription Drugs/Opioids (average ranking 2.3)

#3 (tie) substance misuse issue: Youth Binge Drinking (average ranking 3.4)

#4 (tie) substance misuse issue: Heroin (average ranking 3.4)

#5 substance misuse issue: Marijuana (average ranking 4.0)

#6 substance misuse issue: "Synthetic Marijuana" (average ranking 6.0)

#7 substance misuse issue: Cocaine (average ranking 6.1)

SUBSTANCE MISUSE PREVENTION PRIORITY RECOMMENDATIONS TO BHA

At the December 13 Prevention Committee meeting, the participants reviewed the summary of its Substance Misuse Needs Assessment process and agreed to recommend the top five substance misuse issues that emerged from the needs assessment to BHA as the top state prevention priorities. They are #1) underage drinking, #2) nonmedical use of prescription drugs/opioids, #3 tie) youth binge drinking, #3 tie) heroin, #5) marijuana.

BHA will include these recommendations in the state's Substance Misuse Prevention Strategic Plan that it submits to SAMHSA/CSAP. That plan will also detail how it will use its prevention resources to address these recommended state priorities.

This final report was reviewed and approved by the Prevention Committee at its February 14, 2017 meeting.

II. CAPACITY AND RESOURCES

The BHA Office of Prevention currently allocates and manages \$9,081,770 in substance use disorder prevention funds annually to Maryland's 24 local jurisdictions for the provision of locally planned and implemented prevention services. The funds are allocated through three major prevention grant programs: The Substance Abuse Block Grant Prevention Program (SABG, \$6,208,310 annual funding), the Opioid Misuse Prevention Program (OMPP, \$1,600,000 annual funding), and the Maryland Strategic Prevention Framework grant program (MSPF2, \$1,273,460 annual funding).

A. Aligning Prevention Needs and Resources

The BHA Office of Prevention has determined in its assessment of needs and resources that it is important to provide its prevention resources to local communities to address, based on their local needs assessments, each of the five-priority youth AOD issues through its grant program initiatives, as follows.

- Priority #1 - Underage drinking
 - MSPF2 Initiative
 - SABG Prevention Set-Aside funds
- Priority #2 - Prescription drug misuse, ages 12-25
 - Opioid Misuse Prevention Program
 - SABG Prevention Set-Aside funds
- Priority #3(tie) - Binge drinking, ages 18-25
 - MSPF2 Initiative
 - SABG Prevention Set-Aside funds
- Priority #3 (tie) - Heroin Use
 - Opioid Misuse Prevention Program (OMPP)
- Priority #5 - Marijuana use, ages 12 -25
 - SABG Prevention Set-Aside funds

B. Maryland's State Substance Use Disorder (SUD) Prevention Infrastructure

State Advisory Council

In October 2015, the Behavioral Health Advisory Council (BHAC) was created within the Governor's Office. The Council replaces both the Maryland State Drug and Alcohol Abuse Council and the Maryland Advisory Council on Mental Hygiene. Behavior health concerns a range of health matters, including mental health, substance use disorders, and addictive behaviors.

The BHAC works to enhance behavioral health services statewide. It promotes policy, workforce development, and services that will ensure a system of care that is coordinated and integrates prevention, recovery, and cost-effective strategies. Further, the Council advocates for a culturally comprehensive approach to publicly funded services for prevention, early intervention, and recovery services to support individuals with behavioral health disorders and their families. The BHAC convened its first meeting in January 2016.

The BHAC includes a standing Prevention Committee which provides guidance to the council in the areas of prevention across the lifespan. This may include areas such as substance-related prevention, suicide prevention, gambling prevention and mental health/wellness promotion. This committee may examine data, research, risk factors, and evidence-based practices, and may make recommendations or suggest strategies to BHA as appropriate.

The BHAC Prevention Committee is a broad-based group of state and community representatives with a stake in reducing SUD and other behavioral health disorders in Maryland. It includes stakeholders in the areas of prevention, treatment, public health, mental health, education, juvenile services, etc. The membership advises BHA on matters such as how youth SUD specifically impacts their service population, risk and protective factors specific to these populations, special needs of these populations, and strategies for recruiting and providing services to these populations. This prevention-specific committee strengthens the state's prevention infrastructure by increasing inter-agency communication and planning regarding substance issues common across agencies.

BHA Office of Prevention

The BHA Office of Prevention oversees Maryland's publicly-funded SUD prevention system, providing funding annually to local jurisdictions for evidence-based prevention services. BHA also has contracts with the University of Maryland School of Pharmacy's Behavioral Health Research Team (BHRT) to provide technical assistance and evaluation services to all its prevention grantees. The School of Pharmacy also manages the State Epidemiological Outcomes Workgroup (SEOW). The new BHAC, its Prevention Committee, the BHRT, and the SEOW are specifically structured and intended to strengthen the capacity of Maryland's state and local prevention infrastructure.

The Office of Prevention oversees the following SAMHSA Center for Substance Abuse Prevention (CSAP)-funded prevention grant programs, all of which provide grants to local jurisdictions for the provision of data-driven, evidence-based prevention activities at the community level.

Substance Abuse Block Grant (SABG) Prevention Program

Maryland's SABG Prevention Program adheres to SAMHSA definitions, policies and best practices to plan, fund, implement, and evaluate a comprehensive array of data-driven, evidence based substance abuse prevention practices, strategies, and programs. Only primary prevention activities can be supported through this grant program, i.e., services for those who

have not been identified as having a substance use disorder that requires treatment. Through this process, Maryland will support universal, selected and indicated prevention activities designed to reach a broad and diverse group of Maryland youth, at various levels of risk for substance use and abuse, resulting in a reduction of youth substance abuse at the population level. Each jurisdiction will develop its own unique SABG Strategic Prevention Plan which will lay out the jurisdiction's specific substance abuse issues, resources, contributing factors, objectives and strategies. This plan will be submitted to the BHA for review and approval and, upon approval, BHA will provide SABG funds to the jurisdiction to implement its strategic plan.

Jurisdictions, based on their plans, can address the particular substances that are supported by their local data and endorsed by their planning body and may provide universal, selected or indicated primary prevention strategies. Since the Office of Prevention emphasizes change at the population-level, all jurisdictions must allocate at least 50% of their SABG Program Implementation funds for strategies that are most likely to result in population level change. This includes environmental, community process, and information dissemination strategies.

Jurisdictions may also provide any of the other SAMHSA strategies, which specifically target individuals and families rather than the entire community, with their remaining prevention block grant funds. However, all funds must be used for programs and strategies that research findings/evidence show to be effective or promising, and that are determined through the SPF planning process.

Opioid Misuse Prevention Program

The Opioid Misuse Prevention Program (OMPP) is a funding initiative to strengthen and enhance local overdose prevention plans and to implement evidence-based misuse prevention strategies contained in those enhanced plans. The purpose is to reduce opioid misuse, overdoses, and overdose fatalities by supporting the implementation of effective and sustainable prevention strategies throughout the State. Each participating jurisdiction works through the five SPF stages in order to plan and implement selected evidence-based strategies.

In year one of the program, jurisdictions conducted the first three steps of the SPF process (data collection/assessment, capacity building, and strategic planning) while implementing local multi-media communication campaigns designed to increase community awareness about opioid misuse. Various forms of media such as PSAs, billboards, information cards, fliers, television/radio ads, banners, posters, social media, and websites have been created to bring attention to this growing epidemic.

In year two of the program, jurisdictions completed their strategic plans and began implementing their data-driven, evidence-based strategies. These include prescriber education; dispenser education; Prescription Drug Monitoring Program (PDMP) awareness and enrollment; media campaigns about sharing, storing and disposal of prescription medications; youth education regarding the risks and harms opioid misuse; public awareness

of naloxone and the Good Samaritan Law; drug take back events and drop boxes; dissemination of locked storage boxes for parents and senior citizens; Screening Brief Intervention and Referral to Treatment (SBIRT); and training for law enforcement and first responders on referring users to treatment. Jurisdictions update their strategic plan activities each year based on updated needs assessment data.

The OMPP is supported by SABG Treatment funds meaning that both primary prevention and intervention strategies can be implemented with grant funds. The funded prevention and intervention strategies can provide primary prevention strategies targeted to the general population, intervention strategies to those who are at increased risk for misusing opioids, and treatment interventions for those who are already misusing opioids.

Maryland Strategic Prevention Framework (MSPF2) Grant Program

The Maryland Strategic Prevention Framework (MSPF2) Project provides CSAP SPF-Partnership for Success (PFS) grant funds to strengthen the efforts of 10 local community coalitions to prevent and reduce underage and youth binge drinking in their communities. These coalitions, with training and technical assistance provided by BHA's SPF Technical Assistance and Evaluation Team, are building upon their past successes and addressing challenges they had faced over the five years of the initial MSPF initiative.

Underage and youth binge drinking are the state's MSPF priorities as determined by a recent statewide youth AOD needs assessment. The primary recipients of the prevention strategies are 367,356 youth living in the ten selected communities. These communities were selected based on a formula that first considered prevalence indicators of youth alcohol use, consequences and contributing factors. This accounted for 70% of their selection score. The remaining 30% of the score was determined based on past coalition performance in bringing resources to bear, and each jurisdiction's contribution to the cultural diversity and geographic balance of the initiative.

Goal 1 of the initiative is to reduce underage and youth binge drinking in Maryland. Its measurable objectives are (1) to reduce past 30-day *underage drinking* in the 10 selected jurisdictions and statewide and (2) to reduce past 30-day *binge drinking* by youth, ages 18-25, in the 10 jurisdictions and statewide. The interventions to attain this goal will primarily be evidence-based prevention strategies addressing key intervening variables for underage and youth binge drinking, including retail access to alcohol, social access, youth perception of harm and risk, community and social norms, enforcement of alcohol laws, alcohol pricing, and promotions. While it is expected that most strategies implemented will be environmental and community-process strategies, coalitions may augment these strategies with information dissemination and prevention education to strengthen community awareness of and support for their prevention efforts. Each participating jurisdiction works through the five SPF stages in order to plan and implement selected evidence-based strategies.

Goal 2 of the initiative is to strengthen state and local community prevention capacity and infrastructure. Its measurable objectives are (1) to increase the *capacity* of sub-recipient prevention coalitions through the provision of guidance, training and technical assistance and

(2) to strengthen the state and local prevention *infrastructure* by leveraging, redirecting and realigning the SABG resources administered by BHA to exclusively support evidence-based programs and strategies that are determined through the SPF process.

C. Maryland's Local SUD Prevention System

Maryland's prevention infrastructure is built upon our jurisdictional Prevention Coordinator network. BHA provides each of Maryland's 24 jurisdictions a portion of the state's SABG prevention set-aside based upon a population-based formula. This is the primary source of funding for their jurisdictional Prevention Coordinator, the local prevention activities they provide, the administrative costs related to their prevention services office, and in some instances other prevention program staff. In most instances these funds are provided to the jurisdiction's local health department. For monitoring and technical assistance purposes, Maryland has divided their 24 jurisdictions into four geographic regions (Western, Central, Southern, Eastern Shore).

On-Going Local-Level Capacity Building Activities

From FY10 through FY15, BHA administered the SPF-State Incentives Grant (SIG)-funded MSPF initiative which significantly enhanced our state and local prevention infrastructure through the provision of intensive training, technical assistance, and additional grant funding to local jurisdiction prevention offices. These resources assisted local community coalitions in preventing and reducing youth problem drinking in their communities. The MSPF initiative resulted in many concrete enhancements to the state and local prevention infrastructure that we are continually building upon.

For example, at the state level, we added a prevention planning body (MSPF Advisory Council) and conducted a formal youth AOD needs assessment that had been needed in Maryland for some time. At the jurisdictional level, the initiative resulted in 24 new jurisdictional youth alcohol needs assessments that were initially used to identify MSPF communities, but have since also been used for local planning efforts and securing additional funding for prevention services. At the community level, 24 prevention coalitions have been created and/or enhanced with hundreds of community members participating. Prevention office staff has been augmented by the addition of MSPF Coordinators and Evaluators. Twenty-one comprehensive MSPF Strategic Plans were completed utilizing SPF-SIG funds and hundreds of evidence-based prevention activities have been implemented across the state.

The MSPF initiative resulted in many concrete enhancements to the state and local prevention infrastructure that we are currently building upon through:

- the implementation of a new SPF model grant program, OMPP,
- securing additional federal funding to implement the MSPF2 initiative, and
- continued strengthening of the SABG grant program by applying lessons learned from the implementation of the SPF process during the MSPF, MSPF2 and OMPP grant programs.

Finally, as reported in the Maryland Strategic Prevention Framework Project Final Report (<http://www.pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/programs/bhrt/pdf/mspf/mspf-annual-report-publication.pdf>) during the course of the initiative, underage drinking, binge drinking and alcohol-related crashes involving youth in Maryland decreased as follows:

- Underage Drinking (ages 12-20): Data from the Maryland Youth Risk Behavior Survey (YRBS) and the National Survey on Drug Use and Health (NSDUH) suggest that Maryland underage drinking rates are decreasing and lower than the national average.
- Youth Binge Drinking (ages 18-25): According to NSDUH, the rates of binge drinking in Maryland have fluctuated over the years, and are currently slightly down. Most recent data show that binge drinking in Maryland was close to the national rate (39.4% vs. 38.7% in 2013).
- Alcohol Crashes Involving Youth (ages 16-25): The Maryland Automated Accident Reporting System (MAARS) data shows a 28% decline in the number of impaired crashes from 2008 to 2013.

While these statewide reductions cannot be directly attributed to the MSPF program, we believe the added awareness of and programs targeted to reducing youth problem drinking certainly contributed to these reductions – as did the persistent overall alcohol prevention efforts of Maryland’s local prevention providers,

BHA will continue its efforts to increase the capacity of local prevention system through:

- the continued provision of grant awards to the jurisdictions for evidence based prevention services that adhere to the SAMHSA SPF planning process and other accepted prevention best practices;
- the continued and expanded provision of on-going expert guidance, training and technical assistance in implementing best prevention practices to the local jurisdictions by the BHRT team from the University of Maryland School of Pharmacy;
- the provision of (1) enhanced youth AOD consumption, consequences and contributing factor data and trend analysis and (2) data on underserved and high-risk service populations by the SEOW for local communities to use in their strategic planning; and
- the provision of research and guidance on evidence-based practices to local communities regarding implementing the most effective evidence-based programs to the youth, including high-needs and underserved population

III. STRATEGIC PLANNING

A. BHA Planning Processes

The Office of Prevention undertakes an annual assessment to determine how to best utilize its prevention resources to meet the AOD prevention needs of youth in Maryland. This includes reviewing data provided by the Maryland SEOW and other data sources and soliciting and utilizing input from the BHAC. It determined through its most recent annual assessment to provide prevention resources to Maryland's 24 local prevention offices that would enable them to address any of the five-state priority youth AOD issues identified in the February 14, 2017 statewide needs assessment. The office will continue to monitor youth AOD data from the SEOW and other appropriate data sources to make sure it is aware of changing trends and needs and can adjust its resources to local communities accordingly.

B. BHA Prevention Approach

Principles Grounding BHA Substance Use Disorder Prevention Efforts

The BHA approach to prevention for the state, advocated by the SAMHSA's CSAP, maintains that prevention should:

- be outcomes based;
- be public health-oriented; and
- use epidemiological data.

Outcomes-Based Prevention



BHA uses a data-driven, outcomes-based approach to identifying priority substance-related problems and recommending strategies that address those priorities. Starting with a solid understanding of the substance misuse and behavioral outcomes, it then uses data to identify the risk and protective factors related to those outcomes, and to align strategies to impact those factors.

Public Health Approach to Prevention

The public health approach encourages a focus on population-level change. Under this approach, preventionists should be sure to implement strategies that will target and measure change at the population level (i.e., among the state population as a whole, a local jurisdiction, or among certain sub-populations sharing similar characteristics), rather than solely at an individual/programmatic level (i.e., among prevention direct services program recipients). To this end, BHA has required local jurisdictions over the past several years to increase in their mix

of prevention services the percentage of strategies that are more likely to result in population-level change. This includes environmental, community process, and information dissemination strategies. We require that 50% of grantees' implementation funds be spent on activities in these three CSAP Primary Prevention categories.

Use of Epidemiological Data to Inform Prevention

The use of epidemiological data to discern measurable, population-level outcomes provides a solid foundation upon which to build substance use/abuse prevention efforts. Use of data facilitates informed decision making by helping to identify areas and populations most impacted by substance misuse and its consequences. Additionally, these data can assist with determining the most salient community contributing factors to target with the grantees' limited prevention resources. Ultimately the use of epidemiological data permits monitoring and evaluation of prevention efforts in order to track successes and highlight needed improvements.

BHA's SUD Prevention Theory of Action

The BHA SUD Prevention Theory of Action proposes that by providing culturally competent, evidence based prevention strategies and programs at the community level, Maryland will impact a number of key contributing factors for substance use problems and disorders, and as a result, will prevent and reduce the incidence of those problems.

The Maryland Strategic Prevention Framework (MSPF) Process

Based on its experiences and lessons learned to date in implementing the SPF process to allocate its prevention resources, BHA has developed a very specific process and set of requirements for its prevention grantees. BHA requires all of its SABG, OMPP and MSPF2 sub-grantees to very rigorously adhere to the SAMHSA Strategic Prevention Framework process. This includes:

- establishing and maintaining a multi-organizational coalition to guide its efforts;
- completing and submitting for approval a structured comprehensive community needs assessment report as the basis for all of its prevention efforts;
- completing and submitting for approval a comprehensive SPF Strategic Plan that details the substances, intervening variables and contributing factors to be addressed with grant funding, the evidence-based strategies to be implemented, and the grant programs measurable short-term, intermediate and long-term objectives
- completing and submitting a detailed logic model for each strategy to be implemented, establishing a thread between the needs assessment data used to select the substances to be addressed, the community variables and factors being targeted for change, the strategies selected for implementation, and the measures and objectives that will be used to track program effectiveness
- completing and submitting a detailed implementation plan that describes tasks, timelines, responsibilities and resources needed for each strategy to be implemented
- implementing the evidence-based programs identified in the strategic plan, following the action steps, procedures and timeline detailed in the

implementation plan

- collecting, organizing and submitting data to BHA on attainment of grant program performance/process measures, short-term, intermediate-term, and long-term outcome objectives to help inform the evaluation of both the individual grant programs and the grant program as a whole.

In order to assist our grantees to successfully complete this rigorous process, BHA's SPF Technical Assistance and Evaluation Team, provides on-going, intensive technical assistance, training, guidance and instructional materials (tool kits, work books, manuals, research summaries) to all prevention grantees.

IV. IMPLEMENTATION PLAN

GOAL 1: Prevent and reduce underage drinking, non-medical use of prescription drugs/opioids, youth binge drinking, youth marijuana use, and youth heroin use, as measured by the National Survey on Drug Use and Health (NSDUH) and the Maryland Youth Risk Behavioral Survey (YRBS)

Outcome Objectives

1. Reduce rate of past 30-day alcohol use by Maryland youth ages 12-20 as measured by comparison of 2017, 2018 and 2019 Community NSDUH data.
2. Reduce rate of past 30-day nonmedical use of prescription drugs by Maryland youth and young adults ages 12-25 by comparison of 2017, 2018 and 2019 Community NSDUH data.
3. Reduce rate of past 30-day binge drinking by Maryland youth and young adults ages 18-25 as measured by comparison of 2017, 2018 and 2019 Community NSDUH data.
4. Reduce rate of past year use of heroin by Maryland youth and young adults ages 12-25 by comparison of 2017, 2018 and 2019 Community NSDUH data.
5. Reduce rate of past 30-day marijuana use by Maryland youth and young adults ages 12-25 by comparison of 2017, 2018 and 2019 Community NSDUH data

Process Objectives and Activities

Objective 1: Secure federal grant funding

Activity: Apply for new/continuation funding

Grant	Action Step	Person(s) responsible	Time Frame
SABG –Prevention	Write/submit the prevention section of the Maryland’s SABG application to SAMHSA/CSAP	Prevention Data Administrator (Erik Gonder, incumbent); Prevention Program Manager (Larry Dawson, incumbent)	Annually
SPF-PFS (MSPF2)	Write/submit continuation grant applications to SAMHSA/CSAP	Prevention Program Manager	Annually
OMPP (SABG Treatment)	Internal discussions to continue use of SABG Treatment funds to support this initiative	Prevention Program Manager	Annually

Objective 2: Administer the federal funds received and the grant programs that allocate funds to local jurisdictions for provision of prevention services

Activity	Person responsible	Time Frame
Administer funds received per federal conditions of grant award	Prevention Program Manager	On-going
Address the specific SAMHSA/CSAP recommendations/mandates from its 2015 Site Review regarding state needs assessment and strategic prevention plan, state advisory council, and revitalized SEOW and EBP Workgroups	Prevention Program Manager	On-going
Allocate prevention services grants to local jurisdictions for services that meet all SAMHSA and BHA requirements and conditions of award	Prevention Program Manager	On-going
Manage the contracts with technical assistance partners: (1) TA and Evaluation contract with UMB; (2) SEOW contract with UMB; (3) Maryland Collaborative contract with UMCP	Prevention Program Manager	On-going

Objective 3: Monitor the implementation and effectiveness of funded prevention programs by grantees

Activity	Person(s) Responsible	Time Frame
Monitor the implementation of grant-funded activities in the 24 jurisdictions through review of SPF strategic plan process measures, monthly reports, Minimum Data Set (MDS) reports, fiscal reports, etc.	Regional Coordinator/Program Managers (Shayna Dee, MSPF; Brooke Holmes, OMPP; Laura Bartolomei-Hill (OFR) incumbents)	On-going
Monitor grantee compliance with program requirements and conditions of award through site visits, review of monthly reports, regular phone and e-mail correspondence, etc.	Regional Coordinator/Program Managers	On-going
Monitor monthly grantee activity reports (MDS) to compare what is done with what was proposed to be done in grantee proposals	Prevention Data Administrator; Regional Coordinator/Program Managers	On-going
Monitor grantee progress toward meeting SPF strategic plan short and intermediate objectives through review of strategic plan objectives, monthly reports, CLI reporting, site visits, face-to-face TA, regular phone and e-mail correspondence, etc.	State Technical Assistance and Evaluation Team (Contractor, University of Maryland School of Pharmacy)	On-going

Objective 4: Provide technical assistance and training to grantees to assist them to provide high quality, evidence based programs that are most likely to meet grant requirements and prevent and reduce substance use and misuse.

Activity	Person(s) Responsible	Time Frame
Based on the monitoring activities described above, provide technical assistance to grantees related to meeting grant conditions of award, implementing evidence-based strategies, helping resolve administrative, fiscal, personnel issues, etc.	Regional Coordinator/Program Managers	On-going
Based on the monitoring activities described above, provide ongoing training and technical assistance to grantees on implementing the SPF process to collect and utilize data, assess community needs, develop strategic plans, implement and evaluate evidence-based programs.	State Technical Assistance and Evaluation Team	On-going
Based on the monitoring activities described above, provide training and technical assistance to grantees regarding reporting their grant-funded prevention activities	Prevention Data Administrator	On-going
Work with the SAMHSA Center for the Application of Prevention Technology (CAPT) to develop and provide technical assistance or training that can't be best met by BHA and/or the State Evaluation Team	Regional Coordinator/Program Managers	On-going
Facilitate bi-monthly peer-to-peer phone conferences to OMPP, MSPF2 and OFR grantees.	Regional Coordinator/Program Managers	Bi-Monthly

Objective 5: Review grantee performance annually to make informed decisions about continuation of funding and level of funding.

Activity	Person(s) Responsible	Time Frame
Review the attainment of performance measures from grantee strategic plans to assess what activities were provided compared to what activities were supposed to be provided by the grantee	Regional Coordinator/Program Managers	March of each year
Review the attainment of short and intermediate objectives from grantee strategic plans to assess the extent to which the strategic plan activities are successfully addressing the grantees' contributing factors	Regional Coordinator/Program Managers	March of each year
Review the monitoring activities described above to assess the level of grantee compliance with program requirements and conditions of grant award.	Regional Coordinator/Program Managers	March of each year
Convene meetings to discuss the attainment of grantees' performance measures, strategic plan objectives and program compliance and develop subsequent year funding recommendations	Prevention Program Manager; Regional Coordinator/Program Managers	April of each year

Objective 6: Report grant program progress to BHA, the BHAC Advisory Council, funding sources and others as required for insure accountability and facilitate planning

Activity	Person(s) Responsible	Time Frame
Analyze MDS data and fiscal data to ensure that Maryland meets its 20% set-aside requirements program	Prevention Data Administrator	On-going
Submit Quarterly SPF-PFS Progress Reports to SAMHSA/CSAP	Prevention Program Manager	Quarterly
Submit Quarterly SPF-Rx Progress Reports to SAMHSA/CSAP	Prevention Program Manager	Quarterly
Submit Quarterly Community Level Instrument (CLI) reports to the National Cross Site Evaluation contractor	State Technical Assistance and Evaluation Team	Quarterly
Submit annual year end evaluation reports to BHA for the SABG-SPF, MSPF2, OMPP, and SPF-Rx grant programs	State Technical Assistance and Evaluation Team	2nd quarter of the subsequent year
Develop and disseminate Prevention Office Annual Report	Prevention Data Administrator	2nd quarter of the subsequent year

Objective 7: Provide state and local AOD use and consequences data to BHA and grantees to inform their prevention planning and evaluation activities

Activity	Person(s) Responsible	Time Frame
Coordinate a multi-agency work group of data administrators who possess and/or need AOD consumption, consequences and contributing factors data in order to provide effective services to their identified service population.	State Epidemiology Outcomes Work Group (Contractor, University of Maryland School of Pharmacy)	On-going

Activity	Person(s) Responsible	Time Frame
Assist in the identification of key AOD related data sources and relevant analyses specific to the SPF-PFS grant program and related to youth and young adult problematic drinking	State Epidemiology Outcomes Work Group	On-going
Review available data and conduct analyses of the consumption of alcohol, tobacco and other drugs and the consequences of use in Maryland	State Epidemiology Outcomes Work Group	On-going
Disseminate quarterly data briefs to key state, jurisdiction, and local stakeholders on trends, developments, and findings identified by the SEOW, with one of the briefs focusing on key findings from the biennial Maryland Substance Use and Consequences Epidemiological Profile data.	State Epidemiology Outcomes Work Group	Quarterly
Publish biennial Substance Use and Outcomes State Epidemiological Profile and Jurisdiction Profiles	State Epidemiology Outcomes Work Group	Bi-Annual
Create and administer a young adult (18-25) statewide survey on underage and youth binge drinking norms, perceptions and use	State Technical Assistance and Evaluation Team	Bi-Annual
Create and administer an adult statewide survey on perceptions, attitudes, beliefs, and practices regarding prescription opioids and heroin	State Technical Assistance and Evaluation Team	Bi-Annual
Provide technical assistance to local health departments on how to generate and understand data.	State Technical Assistance and Evaluation Team and State Epidemiology Outcomes Work Group	On-going

GOAL2: Promote prevention and early intervention of behavioral health disorders across the lifespan by providing statewide leadership in the development of policies, programs, and services to prevent youth substance use, misuse, and consequences.

Process Objectives

Objective 1: BHA will provide funding to 24 local prevention offices to implement data-driven, evidence-based prevention and early intervention services for youth, including:

- \$6,208,310 in SABG prevention funds will be awarded to 24 jurisdictions and 4 college prevention centers for provision of primary prevention services for youth in both FY18 and FY19
- \$1,600,000 in general SABG funds will be awarded to 22 jurisdictions for OMPP prevention and intervention strategies and programs in both FY18 and FY19
- \$1,273,460 in PFS funds will be awarded to 10 communities for the prevention of underage drinking and youth binge drinking in both FY18 and FY19

Objective 2: BHA will provide on-going training and technical assistance to 24 local prevention offices and coalitions in the provision of the SAMHSA SPF process

- The UMD Behavioral Health Research Team, through its contract with BHA, will continue to provide intensive, on-going training and technical assistance to SABG, OMPP and PFS grantees in 24 local jurisdictions in how to most effectively implement the SPF process through:
 - grantee training events,
 - individual-and multi-jurisdictional technical assistance sessions,
 - daily phone and online consultation, and
 - the development/dissemination of guidance documents and grant instructional materials (i.e., templates, workbooks, toolkits).

Objective 3: BHA will evaluate all funded prevention programs for their effectiveness in addressing community-specific contributing factors for substance abuse

- The UMD Behavioral Health Research Team, through its contract with BHA, will conduct annual evaluations of the SABG, OMPP and PFS grant programs to track jurisdictional and state-level effectiveness in addressing community-specific contributing factors for substance abuse
- The UMD School of Pharmacy, through its contract with BHA, will review and analyze annual National Survey on Drug Use and Health (NSDUH) and biennial Maryland Youth Risk Behavior Survey (YRBS) use and consequences data to inform the jurisdiction- and state-level outcome evaluations of the SABG, OMPP and PFS grant programs.

- The UMD Behavioral Health Research Team will submit end of grant year evaluation reports for the SABG, OMPP and PFS grant programs for FY18 and FY19.

Objective 4: BHA will compile, maintain and disseminate current research on best practices for preventing and reducing alcohol and other drug use, misuse and consequences and utilize it to:

- guide its evidence-based prevention grant programs and policies
- develop guidance documents and resources for prevention and early intervention providers statewide

V. EVALUATION

BHA is committed to evaluating the reach and effectiveness of all the grant programs that it funds. One of the advantages of the SPF planning model is that it focuses on the collection and use of data from the onset of the planning process so that all prevention strategies implemented are based on local needs assessment data and can be evaluated on an on-going basis. All grant recipients are required to complete comprehensive SPF Strategic Plans that include measurable short-term, intermediate, and long-term objectives. Local and state evaluators track, document, and report on progress toward these objectives for program evaluation purposes. BHA and program staff also utilize the objectives data as an administrative tool to determine if strategies are being implemented as planned, if progress is being made toward desired outcomes, and if revisions to the strategies are needed to attain the desired strategy outcomes.

BHA contracts with BHRT at UMD's School of Pharmacy to conduct community- and state-level evaluation activities. BHRT will collect, analyze, and report on all required state level and jurisdiction level performance measures. Grantees are required to contract with a local evaluator who assists them in their evaluation efforts, including but not limited to data identification and data collection to meet their grant goals and objectives. Local evaluators work closely with the State evaluator and report on process and outcomes performance measures at the jurisdiction level. These data collection and evaluation efforts will contribute to a comprehensive assessment of the BHA-funded prevention efforts at the state and jurisdiction levels.

Evaluation Process:

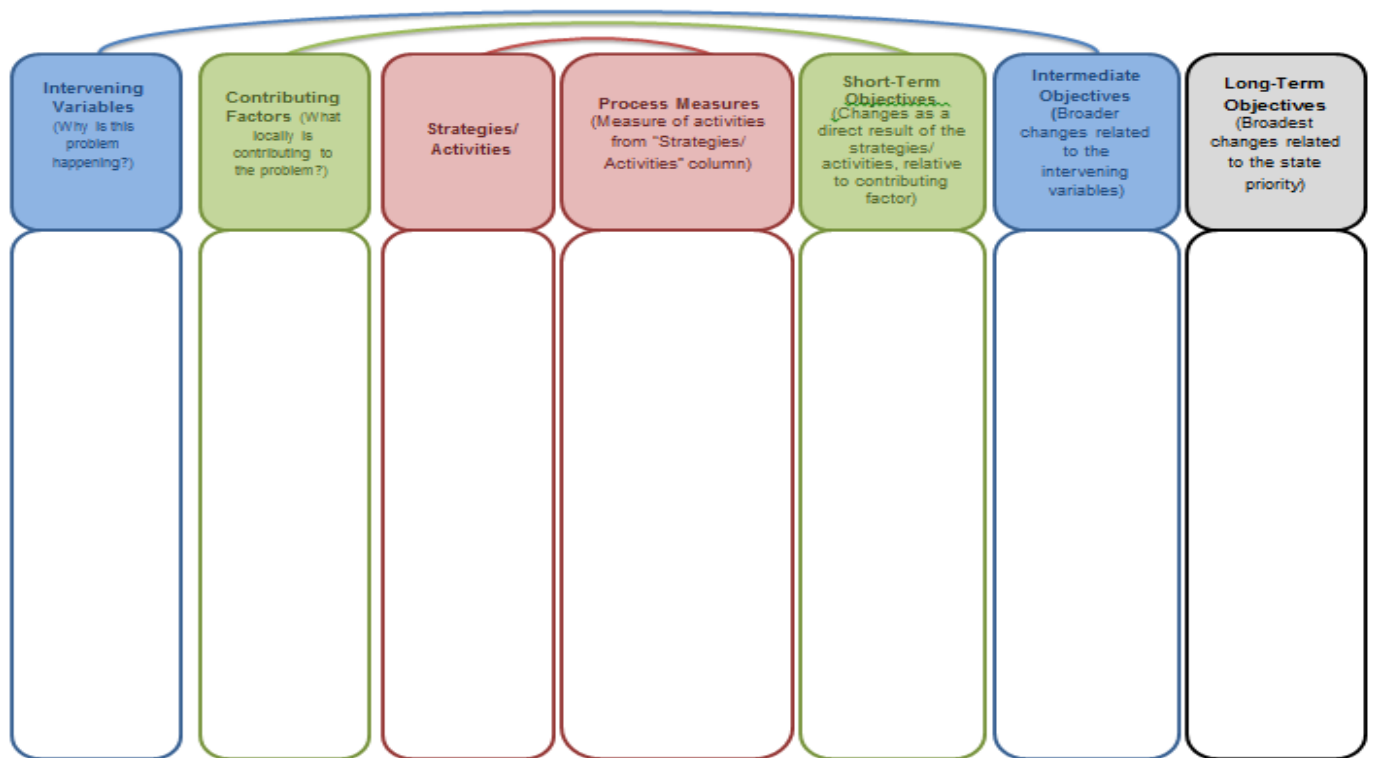
BHA requires all prevention grantees to strictly follow the SPF planning process (described above) to determine how they will allocate their SAMHSA prevention funding. This process, with its emphasis on data collection and needs assessment, greatly facilitates program evaluation.

Each grantee must submit a detailed community needs assessment report that describes in detail:

- the quantitative and qualitative data that it analyzed to identify the substances it will be addressing with its prevention funds;
- the high needs populations that will be targeted for prevention services;
- the prioritized community-specific intervening variables and contributing factors that it will need to address in order to reduce its selected substance misuse issues; and
- the data that it used to identify these variables and contributing factors, which serves as the baseline data for its efforts and will be tracked to measure its progress over time.

Upon review and approval of their community needs assessment reports, each community will then develop its SPF Strategic Plan for addressing the prioritized community contributing factors and by doing so, reducing the incidence and consequences of their selected substance misuse issues. To start this process, each grantee must review a menu of evidence based programs and strategies, provided by BHA and the Technical Assistance and Evaluation Team at BHRT. Then, using a structured decision-making process each grantee must determine which programs and strategies are the best fit for addressing its community-specific contributing factors and reducing their identified substance misuse issues.

Once the evidence based programs and strategies are determined, the planning group will develop a logic model for each strategy to be implemented, specifying the substance misuse issue, intervening variables and contributing factors being addressed by the strategy/program, and the short-, intermediate-, and long-term objectives to be attained through the implementation of the program/strategy. The logic model:



As depicted, this logic model enables the grantee, the local program evaluator, the state program evaluator and BHA to track attainment of projected process measures (measure of activities implemented), short-term objectives (changes related to targeted community contributing factors), intermediate objectives (changes related to identified intervening variables), and long-term objectives (changes related to the reduction of the identified substance misuse issue).

The logic model’s long-term consumption objectives for each jurisdiction are tracked by review of results from the biennial Maryland Youth Risk Behavioral Survey. This survey of 27,401 Maryland public middle- and high school students provides local and state level measures of past 30-day alcohol use, past 30-day binge drinking, past 30-day prescription drug misuse, past 30-day marijuana use, and if students have ever used heroin. These are the five consumption indicators we use to track the trends in use among youth ages 12-17 in our grantee jurisdictions. YBRS data are used in this instance instead of NSDUH data, because unlike NSDUH data which in many instances must combine individual jurisdictional data into regional data, YBRS data is uniformly available at the jurisdictional level.

These consumption trends are not used to assess the overall effectiveness of the grantees' prevention efforts since there are too many other variables involved in rates of use that cannot be controlled for, but it does provide context for future prevention planning and programming. Grantee success is more appropriately determined by tracking changes in the contributing factors and intervening variables targeted by the strategic plan strategies. The local SPF Evaluator measures these changes on a regular basis by collecting process and outcome evaluation measures. Process measures are collected with a variety of administrative reports and tracking tools. Outcome measures, changes in contributing factors, intervening variables and rates of use, are collected using local surveys (pre/post), the Maryland Youth Survey on Alcohol (MYSA), the Maryland Public Opinion Survey on Opioids (MPOS), the Maryland Youth Risk Behaviors Survey (YRBS), as well as secondary sources such as Health Services Cost Review Commission (HSCRC) data, Maryland Automated Accident Reporting System (MAARS) data, and Office of the Chief Medical Examiner (OCME) data.

The SPF Strategic Plan also includes for each selected strategy, an implementation plan which details the action steps needed to implement the strategy with fidelity, the person(s) responsible for carrying out the action steps, and the timeline for carrying out each action step. The plan also includes an implementation budget for each strategy implemented, detailing the costs for implementing the strategy

During the strategy implementation phase, each grantee must submit a monthly progress report detailing progress in attaining its process measures and its short- and intermediate-term outcome objectives. The state Technical Assistance and Evaluation Team collects, analyzes, and documents the reported grantee data and uses it to develop its annual evaluation reports to BHA for each state grant program (MSPF2, OMPP and SABG). These annual grant program evaluation reports document the process and outcome evaluations at both the jurisdictional and the state levels. Process measures document the progress of the jurisdiction through the SPF process and summarize the status of each jurisdiction's strategy implementation. Jurisdictional outcome measures are collected by the local program evaluators and reported to the state evaluation team in their biannual evaluation reports and are then included in the evaluation team's annual evaluation reports to BHA.

BHA then utilizes data from the annual evaluation reports for each state grant program to inform its planning regarding the technical assistance, training, and staff development needs of local grantee staff and coalition members, as well as to determine changes it may need to make in each grant program's policies, practices, and procedures. BHA and the state Technical Assistance and Evaluation Team utilize evaluation report data on individual grantee performance to assist grantees with the revision and/or updating of their SPF strategic plans and budgets as needed to increase attainment of their performance measure and objectives.

The discretionary MSPF2 grant program also participates in SAMHSA's national cross-site SPF-PFS evaluation. This requires each MSPF2 jurisdiction to complete and submit a Community Level Instrument (CLI) biannually. This report details the prevention activities that it is providing with SPF-PFS funding, using structured definitions of the types and numbers of activities they are providing. The state Technical Assistance and Evaluation Team reviews each

jurisdiction's CLI submission, and either asks for revisions or accepts the report and submits it to SAMHSA.

Additionally, the state evaluation team has developed and conducts two statewide on-line surveys biennially to collect information on (1) opioid misuse perceptions, attitudes and practices and (2) drinking behaviors and attitudes of young adults between ages 18-25 in Maryland. The survey results are utilized by state and local jurisdictions to inform their community needs assessment processes; to determine the most effective strategies to implement in their communities to reduce opioid misuse and youth binge drinking; and will serve as baseline data for their on-going program evaluation efforts. Surveys are conducted on a biennial basis to help track changes in behaviors, perceptions, attitudes and practices that are targeted by BHA-funded prevention efforts.

VI. CULTURAL COMPETENCE

Cultural competence refers to the ability of an individual or organization to interact effectively with people of different cultures. Prevention practitioners must understand the cultural context of their target community, and have the willingness and skills to work within this context. Practitioners should draw on community-based values, traditions, and customs, in addition to working with knowledgeable persons of and from the community during planning, implementation, and evaluation of prevention activities.

SAMHSA and BHA prevention grant programs emphasize the need for prevention grantees to adhere to the following CSAP Principles of Cultural Competence:

- Ensure community involvement in all areas
- Use a population-based definition of community (how the community defines itself)
- Stress the importance of relevant, culturally appropriate prevention approaches
- Employ culturally-competent evaluators
- Promote cultural competence among program staff and hire staff that reflect the community they serve
- Include the target population in all aspects of prevention planning

Other key principles to remember:

- Recognize that each group has unique cultural needs
- Significant diversity exists within cultures
- People have group and personal identities
- The dominant culture serves people from diverse backgrounds in varying degrees
- Culture is ever-present
- Cultural competence is not limited to ethnicity, but includes age, gender, disability, sexual identity and other variables

Grant program guidance documents have emphasized these principles as necessary components of effective comprehensive SPF Strategic Plans and BHA has convened cultural competency training and technical assistance sessions led by the SAMHSA's contractual technical assistance provider, the Center for the Application of Prevention Technologies (CAPT).

VII. SUSTAINABILITY

The SPF model emphasizes sustainability from the very beginning of the five-step process. In the Capacity Building step, BHA requires all grantees to have a community-based SPF Coalition to help it plan, advocate for, implement, and evaluate its prevention efforts. This step builds the community ownership and stakeholder support that are shown to increase the likelihood of sustaining community prevention efforts. Additionally, community coalitions often produce “community champions” that step to the forefront of advocating for the coalition’s prevention efforts with the media, elected officials and potential funding sources.

During the Needs Assessment step, the community coalition is required to do a thorough review of quantitative and qualitative data to determine the specific substances and contributing factors that are most problematic in the community. This process not only results in being able to identify, based on data, the key issues to be addressed by the coalition, but also gives the coalition members an active role in the development of the community’s plan, and therefore more ownership of that plan. Such stakeholder ownership is another key to being more likely to sustain community efforts.

As in needs assessment, BHA requires that there be active community coalition participation in the Strategic Planning step of the SPF process. Having community stakeholder involvement in the key task of identifying what strategies should be implemented in the community in order to address their specific problem substances and contributing factors again builds stakeholder ownership and advocacy for the community prevention efforts. The strategic plan is also a document that can be used by the coalition to help it apply for other sources of prevention funding such as Drug Free Communities (DFC) funding, Sober Truth on Preventing Underage Drinking (STOP Act) funding, and local jurisdiction funding opportunities.

BHA emphasizes, during the Program Implementation step, that grantees focus a portion of their efforts on low-cost/no-cost strategies that can result in sustaining their funded prevention efforts. These strategies include media advocacy which strategizes getting the media to promote awareness of the community’s substance misuse issues; community contributing factors that exacerbate these issues; the coalition’s efforts to address those issues; and how the community can be a part of those coalition efforts. BHA also encourages coalitions to implement policy change strategies that change organizational and institutional standards, regulations, rules, and operating procedures in a manner that will help reduce substance misuse and its consequences in the community. *Policy changes* are frequently more effective, longer lasting and more sustainable than grant funded prevention *programs*, which tend to be unsustainable when their source of funding runs out.

As part of the SPF Evaluation step, BHA emphasizes to community coalitions that evaluating and documenting their program outcomes can be important steps in sustaining their program efforts. It is important for the coalitions to tout their successes and outcomes to funders, elected officials, policy makers, and other stakeholders. Sharing their results often results in additional or new funding. Sharing their outcomes within the community, especially by involving members in spreading the word about the program, may increase

public interest, community participation, and local funding support. Including positive program outcomes in state and/or federal prevention grant proposals demonstrates the capacity of the community coalition to utilize grant funding effectively, and as a result increases the likelihood that the funding agency will look favorably on its grant proposal.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Behavioral Health Administration, as part of the Department of Health, has oversight responsibility for publicly-funded inpatient and outpatient (community) behavioral health services, which include a comprehensive array of services and supports to help individuals with substance-related disorders, mental health disorders, co-occurring disorders, and problem-gambling disorders recover.

VISION

Improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care.

MISSION

The BHA will, through publicly-funded services and support, promote recovery, resiliency, health and wellness for individuals who have or are at risk of emotional, substance related, addictive and/or psychiatric disorders to improve their ability to function effectively in their communities.

The PBHS provides a wide array of mental health services, most of which are covered by Medicaid and reimbursed through the ASO including inpatient, outpatient, residential treatment (for children and adolescents) and partial hospitalization. Services provided and reimbursed through the ASO include a range of recovery and support services, including mental health case management, mobile treatment/assertive community treatment, psychiatric rehabilitation, residential rehabilitation, supported employment, and respite care services. The ASO also pays for residential crisis services.

SUD coverage includes a comprehensive assessment, outpatient counseling, intensive outpatient treatment, opioid maintenance treatment, partial hospitalization, medically managed inpatient detoxification, and residential SUD treatment services at the 3.7WM, 3.7, 3.5, 3.3 and 3.1 levels. The ASO also pays for information and referral, prevention, and recovery support services.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

- | | |
|---|---|
| a) Physical Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) Mental Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) Housing services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| g) Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| h) Medical and dental services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| i) Support services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| k) Services for persons with co-occurring M/SUDs | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

The need for improved coordination and behavioral health integration in Maryland was recognized as early as 2010 and efforts to build on the existing strengths of the PBHS were implemented as a result of the 2011 Joint Chairmen's Report of the Maryland General Assembly. MDH convened multiple workgroups and stakeholder forums resulting in recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance use disorders." In addition, MDH began to move toward using national accreditation standards rather than state-specific regulations for provider qualifications.

The goal of integration is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to:

- A. Improve services for individuals with co-occurring conditions;
- B. Create a system of care that ensures a "no wrong door" experience;
- C. Expand access to appropriate and quality behavioral health services;
- D. Enhance cooperation and engagement;
- E. Capture and analyze outcome and other relevant measures for determining behavioral health provider and program effectiveness;
- F. Expand public health initiatives, and
- G. Reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on prevention of unnecessary or duplicative services.

BHA works in partnership with the University of Maryland Evidence Based Practice Center (EBPC) to encourage providers to become co-occurring capable. The EBPC supports the Maryland Behavioral Health Administration through various activities, including:

- Provides training/consultation on evidence-based and evidence-supported practices, in order to ensure adherence to fidelity (faithfulness to the EBP model) so expected outcomes are obtained.
- Following BHA's approval of a program to receive EBPC implementation efforts, on-site EBPC training/consultation are provided. When fully trained, a program receives a fidelity assessment by BHA Fidelity Monitors; trainers then develop Fidelity Action Plans (FAPs) in concert with the program which serves as a template for continued training/consultation activities, thus ensuring subsequent consultation addresses areas needing improvement. FAPS are shared with BHA and used during fidelity assessments.
- BHA and the EBPC have been providing EBP support for co-occurring capability for the past 12 years.

3. Describe your state's case management services

Targeted Case Management (TCM) in Maryland serves individuals with severe mental illness, both with Medical Assistance (MA) and those who lack insurance. In Maryland there are nearly 30 programs serving over 2500 adults annually. Separate TCM programs exist for children under the age of 18. The Behavioral Health Administration (BHA) facilitates the Request for Proposal (RFP) process that is required every 5 years for the Core Service Agency/Local Behavioral Health Authority (CSA/LBHA) to procure TCM programs. For consumers with Federal Medicaid, requests for service are submitted directly to the Administrative Service Organization (ASO). Requests for consumers who are uninsured (Medicare, State MA, etc.) are submitted to the CSA/LBHA for review, and then forwarded to BHA for approval.

Efforts are underway for the availability of peer-to-peer/family support and customized goods and services for up to 250 youth enrolled in any of the three levels of Targeted Case Management (TCM). This new program is called "TCM Plus." In addition, these same services, as well as care coordination, will be made available to 50 youth with private insurance or who otherwise do not have access to Medical Assistance. This program is called "Care Coordination Plus." These "Plus" services will both be offered through the existing Care Coordination Organization (CCO) structure. The goal is to ensure that CCOs have access to resources to meet the needs of families that are enrolled in TCM as well as youth with private insurance.

The Clinical Services Division is responsible for developing and managing an integrated system of care for adults and older adults in alignment with the Department and Behavioral Health Administration's (BHA) mission and goals. Functions include:

- Providing technical advice and guidance to the local jurisdictions;
- Designing and implementing state and federally funded services and specialized programs;
- Development of conditions of awards and monitoring deliverables;
- Administrative oversight of clinical treatment, recovery supports, evidenced-based practices, and housing supports
- Identifying gaps in service and best practices to enhance the quality of care

Maryland State Care Coordination utilizes state funding to expand access to a comprehensive array of community-based recovery support services for Maryland residents in varying stages of recovery. In order to be enrolled in the program individuals must meet eligibility requirements, must have chosen to enroll and participate in the program, and must be referred through a designated portal/access point. The Behavioral Health Administration (BHA) provides funding for State Care Coordination (SCC) to each Local Addiction Authority (LAA) and Local Behavioral Health Authority (LBHA) jurisdiction in the State of Maryland to enroll individuals into SCC services for individuals participating in residential treatment (Levels 3.7, 3.5, and 3.3) and other populations identified by each jurisdiction or agency. All services are designed to assist recipients in remaining engaged in their recovery while promoting independence, self-sufficiency, and stability.

Maryland RecoveryNet (MDRN) develops partnerships with service providers statewide and funds access to clinical and recovery support services for individuals with substance use/co-occurring disorders treatment and recovery support needs. All Maryland RecoveryNet service recipients receive Care Coordination through which they can access a menu of services which includes funding for Halfway House and Recovery Housing, Transportation, Employment services, Vital Records, Peer/Recovery Coaching, Medical and Dental services, and other unmet needs as expressed by the individual and/or identified by the Care Coordinator.

All services are designed to assist recipients in remaining engaged in their recovery while promoting independence, self-

sufficiency, and stability.

Maryland SOAR - SSI/SSDI Outreach, Access, and Recovery (SOAR) is a federal initiative that assists individuals experiencing homelessness or at risk of homelessness and diagnosed with a mental illness and/or co-occurring disorder apply for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Maryland's SOAR Initiative is led by Maryland's Department of Health's Behavioral Health Administration. It has the third highest SOAR approval rate in the country. Maryland's average approval rate for initial SOAR SSI/SSDI cases is 85% and many of the communities that use SOAR are seeing approval rates above 90%. Furthermore, SOAR also expedites the application process and the average processing time for initial SOAR claims within Maryland is about 80 days. Through training and technical assistance, the SOAR process hopes to increase the rate of approvals and decrease the time taken to decide claims. SOAR works within the existing SSA application process but uses specific tools and strategies to facilitate successful applications. SOAR focuses on helping those who are either filing initial claims or who are requesting that DDS reconsider their claim.

The purpose of SOAR, however, is not just to help individuals obtain benefits. Rather, these benefits are regarded as a means to aid recovery and help individuals lead more productive and fulfilling lives. After obtaining benefits, many individuals gain housing, greater access to healthcare, and make significant improvements in their mental and physical health and in some cases obtain employment.

The State Hospital Benefits project is to assist individuals who are transitioning out of the State Psychiatric Hospitals into the community. The State Hospital Benefits Project has hired two SOAR case managers to work with individuals transitioning from Spring Grove Hospital Center and Springfield Hospital. A Benefits Case Manager has also been hired to assist at both hospitals for complex entitlement cases.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Crisis response systems collaborate and partner with local law enforcement agencies to ensure those with behavioral health needs receive appropriate levels of treatment rather than incarceration in local jails and/or prevent other negative and traumatic outcomes. Maryland's Crisis Response Continuum includes 24/7 clinical crisis phone line/hotline, walk-in crisis services, mobile crisis teams, police-based crisis intervention teams, urgent care clinics, emergency department psychiatric services, 23 hour holding bed, and crisis residential beds.

Residential crisis beds are programs designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments. There are both residential crisis beds funded by BHA, attached to an annual Condition of Award, as well as beds available to the PBHS, which are Fee-for-Service and managed by the ASO.

The Recovery Support Specialist in Pregnancy/ Postpartum and Women with Children Project- (RSPPW) is an initiative for women who have an opioid or other substance use disorder. This program combines service delivery navigation processes, wraparound services and recovery supports for opioid dependent pregnant/postpartum women. Recovery Support Specialist focus on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. This project is operational in 5 jurisdictions in MD. The jurisdictions are Washington, Worcester, Baltimore, Prince George's Counties and Baltimore City. These jurisdictions were targeted because they have the highest rates of substance exposed newborns.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	245722	102169
2. Children with SED	90106	75030

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 6% up to 12% of the population under 18. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined. This approximate loss in 2017 was 1,700 children. During this same period the total population (both adult and child) has grown slowly by approximately 3%, each year (36,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau). Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services Yes No
- b) Educational services, including services provided under IDE Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse prevention and SUD treatment services Yes No
- e) Health and mental health services Yes No
- f) Establishes defined geographic area for the provision of services of such system Yes No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4**a.** Describe your state's targeted services to rural population.

The State of Maryland recognizes 18 out of the 24 counties/jurisdictions as rural. Maryland's rural counties include; Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester. 25% of Maryland's residents live in rural Maryland. Maryland's rural communities face unique health care concerns that include lack of health care providers and difficulty accessing those providers due to transportation and technology barriers. Rural hospitals and health care providers, which frequently are the economic backbone of the communities they serve, deserve special consideration so that they can continue to provide high-quality services and meet the needs of rural residents.

MDH's State Office of Rural Health (SORH) and MDH's Healthcare Workforce Programs address the rural health care needs in Maryland through local and federal partnership to develop policy and programs. The State Office of Rural Health (SORH) is federally funded by the Health Resources and Services Administration's Office of Rural Health Policy (ORHP) to provide technical assistance to rural entities throughout Maryland; coordinate rural health resources and activities in the State; encourage recruitment and retention in the State; collect and disseminate information; and participate in local, state, and federal partnerships. Maryland SORH's mission is to improve the quality of health care for all rural Marylanders by developing strong partnerships; building local resources; promoting relevant state and national rural health policies; and supporting efforts to recruit and retain health care providers in rural area.

With a collaboration between Maryland Rural Health Association (MRHA), the Maryland Department of Health (MDH), the Rural Maryland Council (RMC), and the Robert Wood Johnson Foundation (RWJF) the 2018 Maryland Rural Health Plan was created. The health plan is a collaborative document that synthesizes data from multiple sources, such as county health plans, the State Health Improvement Process (SHIP), and feedback from citizens in rural counties, among others. The 2018 Maryland Rural Health Plan highlighted six areas of need including: access to care, sustainable funding mechanisms for health care services, care coordination, chronic disease prevention and management, health literacy and health insurance literacy, and, outreach and education. The full plan can be read at: <https://pophealth.health.maryland.gov/Documents/Rural%20Health/MDRH-Plan-2018.pdf>. The Maryland Rural Health Plan has also a new interactive website which provides up-to-date information, addresses questions and provides count data at: <https://mdruralhealthplan.org/>.

M/SUD services in rural areas are similar to those that are available in other urban/suburban areas of Maryland. Maryland's rural local behavioral health entities (CSAs/LAAs/LBHAs) are responsible for planning, and fiscal management at the local level to address the behavioral needs of individuals with mental illness, SUD and other addictions. Review of their annual behavioral health plans reveals two main challenges that rural areas face in addressing the behavioral health needs of their populations: workforce shortage/adequate level of M/SUD services and lack of transportation. In most cases, the local behavioral health entities and providers have come up with creative solutions to address these challenges. One such approach is organizing contiguous counties into M/SUD regional service provision system. Behavioral health providers in rural areas have a history of collaboration and coordination. They share resources with each other and with other service related agencies, to address the behavioral health needs of the populations they serve. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas.

As stated above, one of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The problem of behavioral health workforce shortage spans throughout the State of Maryland. It is not only common in small, rural and remote areas of jurisdictions but also in the bigger counties and metropolitan areas. However, it is more pronounced in rural areas. Most of the CSA/LBHA/LAA annual behavioral health plans emphasize the workforce shortage issue as a major challenge. Jurisdictions have tried to take various measures to address the issue of workforce shortage. Some of these include:

- telemedicine as one solution to the psychiatric workforce shortage;
- collaboration with public and private providers in neighboring counties;
- workforce development training (this appears in most of the rural behavioral health plans as one of the major strategies to address workforce shortage, especially in the area of co-occurring disorders);
- assisting providers with the accreditation process and providing funds to cover the accreditation costs;
- hiring of nurse practitioners (NP) and other physicians licensed to prescribe medication to alleviate the problem in medication assisted treatment (MAT) services;
- efforts to integrate providers serving MH and SUD clients;
- using Peer Recovery Specialists (PRS).

To address the lack of transportation to and from behavioral health services, rural M/SUD programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local

health departments and community action agencies also provide some publicly-supported transportation. They also collaborate with the Mobility Management Program in rural counties as well as local community/support groups such as veterans and volunteers including peers in providing access to transportation and behavioral health services. Additionally, CSAs and LAAs have some funding in their budgets for transportation services for eligible individuals.

b. Describe your state's targeted services to the homeless population.

This year's, 2019, point in time (PIT) count in Maryland counted 6,561 individuals experiencing homelessness with 1,337 diagnosed with a serious mental illness (SMI). The PIT count also identified 5,213 as being sheltered. Persons identified with substance use disorder totaled 1,210 or 18% of the total homeless population. Chronically homeless persons totaled 1,295 or 20% of the total homeless population. Veterans totaled 490 (7%).

BHA contracts directly with Maryland's CSAs/LBHAs, which then contract with providers, to support those programs that provide specialized services outside of the Medicaid fee for service system. BHA's Mental Health Block Grant (MHBG) provides federal funds to support efforts to promote prevention and early intervention, crisis response systems for children with serious emotional disorders and adults with serious mental illness, implementation of evidence-based practices, evaluation, data analysis and quality improvement efforts, emergency shelter and transitional housing for individuals who experience homelessness, services for young adults and first episode psychosis programs to address early onset of mental illness.

BHA will provide \$5.0 million in Continuum of Care Program funding for SFY 2020 to local mental health authorities through sixteen grants from the Department of Housing and Urban Development. The Continuum of Care Program provides tenant and leasing assistance to individuals experiencing homelessness who have a serious mental illness and or co-occurring substance-related disorders and their families. Priority for BHA's Continuum of Care Program are individuals experiencing homelessness who have criminal justice involvement and have a serious mental illness and or co-occurring mental illness and substance-related disorders.

BHA also provides \$500,000 in state general funds for a Homeless Identification Project which originally was funded in 2011 through the Maryland's Alcohol Tax Appropriation. This award provides funding to individuals who are experiencing homelessness or at imminent risk of homelessness to access state identification cards and birth certificates. Also, these funds allow BHA to provide funding to the CSAs and LBHAs to contract with community providers to assist individuals with applying for SSI and SSDI using SOAR components. The CSAs and LBHAs have hired five (5) SOAR trained outreach specialists who work closely with the local PATH providers.

c. Describe your state's targeted services to the older adult population.

The Behavioral Health Administration continues to implement the Older Adult Behavioral Health Pre-admission Screening and Resident Review (PASRR) project. This project is a partnership of BHA and Maryland's Money Follows the Person (MFP) Project. Key partners include the Mental Health Association of Maryland and Maryland Core Service Agencies (CSAs) and Local Behavioral Health Authorities (LBHAs). PASRR is designed to bridge the gap between systems of care which are designed for individuals with behavioral health needs but may lack the expertise and skills to support older adults and those that serve older adults but may lack knowledge of and expertise in behavioral health.

There are currently 6 regional specialists who serve as resources to community-based organizations whose clients are aging and experiencing behavioral health issues. These include:

- Aging and Disability Resource Centers
- Health Departments
- Local Maryland Access Point (MAP) sites
- Behavioral health providers
- Support planners

Other entities involved with diversion from nursing homes and transitions from nursing home back to the community They also provide behavioral health resources and consultation for older adults with behavioral health conditions for the purpose of diverting them from or reducing the duration of nursing facility admission.

The Older Adult Behavioral Health PASRR Specialists primary role in PASRR involves follow up visits, training, and coordination of mental health services. The specialists conduct follow up visits with individuals with mental illness, admitted to Maryland nursing facilities through the PASRR process. They meet with both the individual and the staff at the facility to determine training needs, specialized service needs, and whether community options such as counseling is desired. In addition to PASRR training, they can also offer behavioral health training for nursing facility staff. The specialists have been trained as trainers on a new curriculum created by the Mental Health Association of Maryland called ENGAGE with Older Adults. This curriculum is geared toward direct care level staff in long term care settings and meet the new federal nursing facility regulatory requirements around behavioral health training. Additionally, the specialists assist nursing facilities with coordinating mental health services for nursing facility residents admitted through PASRR by identifying local mental health providers that are qualified and willing to provide services within this setting.

In June 2019, BHA, with support from the University of Maryland Training and Evaluation Center, held an Older Adult Behavioral Health Policy Summit. This Policy Summit brought together State Government decision makers and stakeholders to better understand the unique challenges that older adults with behavioral health conditions face; and identify gaps and possible solutions for improving access to appropriate care. 125 people attended the Summit in person and 25 more participated via Zoom teleconference. Attendees represented virtually every service sector in the State of Maryland including representatives from State Departments of Health, Aging, Housing, and Disabilities; home and community-based service providers; local agencies on aging; local health departments and behavioral health authorities; hospitals; nursing facilities; behavioral health providers; advocates;

homeless and elder abuse services. The Zoom video conference option was added due to the high demand to attend after conference registration closed at 125--two weeks prior to the event.

The Keynote Speaker was Nirmala Dhar, the Older Adult Behavioral Health Project Director for Oregon Health Authority's Health Systems Division. She has over 30 years of experience in behavioral health in the public sector in Missouri, New Jersey and Oregon. The keynote focused on older adult behavioral health challenges and opportunities. It highlighted evidenced-based practices, Oregon's needs assessment and response system, and overall opportunities for policy makers that would apply to states nationally.

Following the keynote, three panels were held. The first included senior leadership from BHA, Maryland Medicaid's Long Term Services and Supports Division, the Department of Aging, and the Department of Housing and Community Development. Available data, services, and service gaps were presented. The second panel included residential rehabilitation program directors from across the State discussing innovative practices as well as challenges serving aging individuals. The third panel was titled, the "Continuum of Crisis Care" and included representatives from the Maryland Hospital Association, the Department of Health, and Health Care for the Homeless, a community-based organization working to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy and community engagement. This panel discussed lengthy hospital stays and discharge challenges as well as the rising rate of homelessness among seniors. The fourth and final panel of the day was an interactive discussion between the stakeholders in attendance and policy makers. The representatives from the four state agencies on the first panel, the Maryland of Disabilities, and Senator Adelaide Eckart, a member of the Behavioral Health Advisory Council and Planning Committee, fielded ideas and questions from the audience to address the needs of older adults with behavioral health conditions.

Planned activities for FY 2020:

The Office of Older Adults and Long Term Services and Supports is planning two training activities in FY 2020. The first is a two day conference. This event will reflect the focus of the work of the Traumatic Brain Injuries Partner Grant and will include presentations and interactive sessions on Mental Health and Addictions, specifically opioid related use disorders. The second is technical assistance and consulting related to PASRR.

Planned activities for FY 2020-2021:

The Office of Older Adults and Long Term Services and Supports is planning two training activities in FY20. The first is a two day conference. This event will reflect the focus of the work of the Traumatic Brain Injuries Partner Grant and will include presentations and interactive sessions on Mental Health and Addictions, specifically opioid related use disorders. The second is technical assistance and consulting related to PASRR.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Behavioral Health Administration's (BHA's) budget currently contains state general, special, reimbursable, and federal funds for specialty behavioral health services.

The overall budget is \$732 million and does not include behavioral health services billed to Medicaid. The budget is mostly State General funds. Of the \$732 million, \$425 million is for Administration (includes Community Services) and \$307 million is for State Psychiatric Hospital Centers. About \$103 million of this is federal dollars. BHA continues to contract directly with the core service agencies, local behavioral health authorities and the local addiction authorities to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. Federal grants include: block grants for mental health and substance use, housing, prevention, crisis services, and transitional aged youth services.

Maryland's PBHS is comprised of 5 State Psychiatric Hospitals and 2 Residential Treatment Facilities. Of the budget for the State Psychiatric Hospital Centers and RICAs, approximately \$244 million is for salaries for the individuals who provide the care in these hospitals. The State of Maryland has over 3000 employees with about 2,894 of these being permanent employees and 190 contractual employees.

Behavioral Health Disaster Services have the responsibility for coordinating the delivery of community behavioral health services in response to natural and man-made disasters in partnership with the local behavioral health authorities (CSAs, LAAs and LBHAs). The goal is to establish a synchronized, comprehensive, integrated, inclusive and coordinated plan to respond to environmental and man-made disasters in Maryland. The purpose of planning is to minimize the adverse effects of traumatic events affecting all individuals in Maryland communities.

The Plan identifies necessary administrative and clinical activities, supports, and resources that can be mobilized quickly when a disaster occurs. It is well recognized that disaster services require rapid, integrated, flexible, collegial and collaborative responses. To that end, the Plan concentrates on four areas of activities: (1) Mitigation; (2) Preparedness; (3) Response; and (4) Recovery. For each activity the responsibilities of the BHA Executive Director, BHA Facilities Directors, CSAs, and local health departments are addressed. Where appropriate, other partner responsibilities are delineated. The Office of Workforce Development & Training (OWDT) continues to collaborate with our stakeholders as well as federal and state agencies including but not limited to SAMHSA, On Our Own of Maryland, Department of Veterans Affairs, Maryland Coalition of Families and the Mental Health Association of Maryland. These collaborations lead to many opportunities to disseminate and promote core competencies for our professional workforces. These professional workforces include behavioral health clinicians, primary care providers, social workers, drug and alcohol counselors, prevention specialists and peer recovery support providers. Core competencies have been identified for each of these workforces and the OWDT adheres to the training needs, recommendations, and exam requirements, as outlined by the various credentialing and licensing boards. The OWDT collaborates with the licensing boards to ensure that continuing education opportunities are ample, accessible, and meet the various criteria required for each level of certification and/or license. The OWDT provides guidance to various boards to assist in the expansion of trained and skilled professionals in the behavioral health field. OWDT also collaborates with the University of Maryland Evidence-Based Practice Center and the University of Maryland Training Center on the development and execution of BHA conferences, evidence-based trainings and SAMHSA's Region 3 Workforce Development Committee. The OWDT is currently involved in a long-term project with SAMHSA in increasing field placements and internship opportunities and improving employment pathways of our Social Workers. With the University of Maryland School of Social Work partnering on this as well as other stakeholders, we are demonstrating the benefits of infusing current curriculum with Substance Use Disorder topics in the Master of Social Work programs, and strive to demonstrate the benefits of working within the behavioral health field to students enrolled in MSW programs.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening Yes No
- ii) Education Yes No
- iii) Brief Intervention Yes No
- iv) Assessment Yes No
- v) Detox (inpatient/social) Yes No
- vi) Outpatient Yes No
- vii) Intensive Outpatient Yes No
- viii) Inpatient/Residential Yes No
- ix) Aftercare; Recovery support Yes No

b) Services for special populations:

- Targeted services for veterans? Yes No
- Adolescents? Yes No
- Other Adults? Yes No
- Medication-Assisted Treatment (MAT)? Yes No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, and custody issues? Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The compliance unit provides system oversight, and evaluates service system compliance of Opioid Treatment Programs and other behavioral health treatment programs (substance related) with regulatory requirements and guidelines. The unit is responsible for regularly scheduled clinical compliance reviews, provides technical support, and interpretation of COMAR/CFR 42 regulations. The compliance unit works closely with Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHA) to investigate complaints received directly from the community or from local authorities.

In addition, we accompany Beacon Health Options on behavioral health program audits and work cooperatively with the Drug Enforcement Agency (DEA), Maryland Office of Controlled Substances (OCS), Office of Substance Abuse and Mental Health Services Administration (SAMHSA) and, Maryland State clinical licensing boards.

Treatment Compliance Evaluators use the Code of Maryland Regulations (COMAR) Title 10 Subtitle 47, COMAR Title 10 Subtitle 63, Code of Federal Regulations (CFR) Title 42 Part 2 and Part 8, Health General Articles, other related COMAR regulations (as applicable), and internal BHA policy as guidance documents to determine program compliance.

At the beginning of each fiscal year, compliance unit staff meets with the Director of Gender Specific Services to review our monitoring tool to ensure it is inclusive of all provider requirements and conditions of award for pregnant women and women with children.

Prior to the compliance review, service providers receive a letter of introduction that confirms the date and time of the review along with a list of documents that will be requested during the review. Upon arrival, evaluators meet with key program staff to review the purpose of the visit. After the review is complete, an exit conference is facilitated that includes discussion of the preliminary results of the review.

The provider will receive notification of the compliance review results that summarizes the full findings, specifies areas that require a Corrective Action Plan (CAP) and identifies the date for submission of the CAP. The summary of findings may also include recommended areas of improvement that will be reviewed at the next scheduled compliance review.

Service providers are monitored on a semi-annual or quarterly basis. Providers may be eligible for participation in a graduated monitoring (annual) schedule if no corrective action plan is required for two (2) consecutive fiscal years.

The compliance review process consists of two areas of review; Administrative and Patient records.

The administrative review includes but is not limited to an examination of a programs' compliance with requirements for:

- Program accreditation and license
- Clinical and medical staff license and certification
- Background checks
- Continuing education and professional development activities

- Service delivery and performance measures

The Patient record review includes but is not limited to an examination of a programs' compliance with requirements for:

- ASAM admission criteria
- Establishment of an individualized treatment plan that is based on a comprehensive assessment of the mothers (and child) needs, and includes appropriate goals and interventions.
- Therapeutic services between 20-36 hours depending on the level of care
- Medical services including physical exams, toxicology screens and lab tests
- Privacy
- Patient education (i.e. Fetal Alcohol Syndrome, Safe Sleeping, Domestic Violence.)
- Children's services
- Discharge and Continuing Care Planning

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
- a) 90 percent capacity reporting requirement Yes No
- b) 14-120 day performance requirement with provision of interim services Yes No
- c) Outreach activities Yes No
- d) Syringe services programs Yes No
- e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Has your state identified a need for any of the following:
- a) Electronic system with alert when 90 percent capacity is reached Yes No
- b) Automatic reminder system associated with 14-120 day performance requirement Yes No
- c) Use of peer recovery supports to maintain contact and support Yes No
- d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? Yes No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The compliance unit provides system oversight, and evaluates service system compliance of Opioid Treatment Programs and other behavioral health treatment programs (substance related) with regulatory requirements and guidelines. The unit is responsible for regularly scheduled clinical compliance reviews, provides technical support, and interpretation of COMAR/CFR 42 regulations. The compliance unit works closely with Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHA) to investigate complaints received directly from the community or from local authorities.

In addition, we accompany Beacon Health Options on behavioral health program audits and work cooperatively with the Drug Enforcement Agency (DEA), Maryland Office of Controlled Substances (OCS), Office of Substance Abuse and Mental Health Services Administration (SAMHSA) and, Maryland State clinical licensing boards.

Treatment Compliance Evaluators use the Code of Maryland Regulations (COMAR) Title 10 Subtitle 47, COMAR Title 10 Subtitle 63, Code of Federal Regulations (CFR) Title 42 Part 2 and Part 8, Health General Articles, other related COMAR regulations (as applicable), and internal BHA policy as guidance documents to determine program compliance.

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Prior to the compliance review, service providers receive a letter of introduction that confirms the date and time of the review along with a list of documents that will be requested during the review. Upon arrival, evaluators meet with key program staff to review the purpose of the visit. After the review is complete, an exit conference is facilitated that includes discussion of the preliminary results of the review.

The provider will receive notification of the compliance review results that summarizes the full findings, specifies areas that require a Corrective Action Plan (CAP) and identifies the date for submission of the CAP. The summary of findings may also include recommended areas of improvement that will be reviewed at the next scheduled compliance review.

Service providers are monitored on a semi-annual or quarterly basis. Providers may be eligible for participation in a graduated monitoring (annual) schedule if no corrective action plan is required for two (2) consecutive fiscal years.

The compliance review process consists of two areas of review; Administrative and Patient records.

The administrative review includes but is not limited to an examination of a programs' compliance with requirements for:

- Program accreditation and license
- Clinical and medical staff license and certification
- Background checks
- Continuing education and professional development activities
- Service delivery and performance measures

The Patient record review includes but is not limited to an examination of a programs' compliance with requirements for:

- ASAM admission criteria

- Establishment of an individualized treatment plan that is based on a comprehensive assessment of the mothers (and child) needs, and includes appropriate goals and interventions.
- Therapeutic services between 20-36 hours depending on the level of care
- Medical services including physical exams, toxicology screens and lab tests
- Privacy
- Patient education (i.e. Fetal Alcohol Syndrome, Safe Sleeping, Domestic Violence.)
- Children's services
- Discharge and Continuing Care Planning

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 Compliance is monitored with the accreditation standards and federal regulations to screen/assess individuals for high risk behaviors that are associated with infectious disease and to ensure they receive education.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas Yes No
 - b) Establishment or expansion of tele-health and social media support services Yes No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C. 300x-31(a)(1)F)? Yes No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No
 If yes, please provide a brief description of the elements and the arrangement
 NA

Criterion 8,9&10**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement Yes No
2. Has your state identified a need for any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of services for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? Yes No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) An organized referral system to identify alternative providers? Yes No
 - c) A system to maintain a list of referrals made by religious organizations? Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No
 - c) Identify workforce needs to expand service capabilities Yes No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? Yes No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements Yes No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
 - c) Updating written procedures which regulate and control access to records Yes No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure Yes No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

The number of block grant sub-recipient identified to undergo an independent peer review is estimated to be 5, which is a percentage of all the programs/providers.

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan Yes No
 - b) Establishment of policies and procedures related to independent peer review Yes No
 - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations Yes No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If Yes, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

The Accreditation Commission for Health Care
The Council on Accreditation

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Has your state identified a need for any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? Yes No
 - b) Mental Health TTC? Yes No
 - c) Addiction TTC? Yes No
 - d) State Targeted Response TTC? Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No

c) Coordination of Various Activities and Services

Yes No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

<https://health.maryland.gov/regs/Pages/10-63-01-10-63-06-Behavioral-Health-Regulations-.aspx>

Footnotes:

Maryland's COMAR 10.63 regulations have brought about significant changes in the way that mental health (MH) and substance-related disorder (SRD) treatment programs are permitted to operate in the State.

Previously, all SRD treatment programs in the public system were required to be "certified" by the Office of Health Care Quality (OHCQ) in order to operate. In contrast, MH programs in the Public Mental Health System were "approved" to operate by OHCQ in order to be eligible to receive public funds (e.g., Medicaid reimbursement).

Effective in October 2016, however, the newly integrated behavioral health system began to transition to a new arrangement, in which both SRD programs and MH programs are required to be licensed in order to operate. This licensing requirement is no longer limited to those agencies using public funds, it applies to all programs that meet the criteria specified in the regulations.

By April 1, 2018 all eligible programs must be licensed in order to continue operation, but, in order to achieve this, license applications must be submitted before January 1, 2018 to the Behavioral Health Administration (BHA), which has taken over the function previously performed by OHCQ.

In Reference to Criterion 7 & 11: BHA in collaboration with the MDH's Office of Capital Planning, Budgeting and Engineering Services administers the Capital Bond Bill Program, also known as Community Bond Grant Program. The program leverages non-state capital funds such as HUD and other federal funding, Community Development Block Grants, Maryland Affordable Housing Trust Fund, and/or local public/private funding to counties, municipalities, and nonprofit agencies for community-based services for the acquisition, construction, or renovation of facilities to provide mental health, developmental disability and drug and alcohol abuse treatment services. The primary focus is to develop and expand housing for eligible populations. This year the Governor provided an additional \$1 million in grant funds for Certified Recovery Residences. This funding is available for agencies and providers that offer services to individuals with substance-related disorders. The funds are to be used for the acquisition, construction, or renovation of these facilities.

Other potential efforts are underway to support Pregnant Women with Children. The Maryland Department of Housing & Community Development (DHCD) is seeking to select Eligible Respondents to participate in the Opioid Addiction Recovery Pilot Program for Pregnant Women and Women With Newborns which involves the acquisition and/or rehabilitation of a building that will be used as a residential treatment facility that will assist pregnant women and women with newborns by providing substance abuse and addiction treatment in Maryland.

The Maternal Opioid Misuse (MOM) Model, through CMS, is another effort that is being explored by the States' Medicaid Administration to support clinical care coordination and integration of other services for pregnant and postpartum Medicaid beneficiaries with opioid use disorder.

SABG Application – Prevention Narrative

Assessment:

5. Does your state use Needs Assessment data to make decisions about the allocation of SABG primary prevention funds? **YES**

If yes, please explain: Our SEOW and State Advisory Council conducted a statewide substance misuse prevention needs assessment. The purpose of the needs assessment was to provide data-driven recommendations to the (at that time) BHA Prevention Office regarding the state prevention priorities that it should address with its federal substance misuse prevention grant funding. Then, in order to receive funding, local jurisdictions were required to conduct local needs assessment activities to determine the substances/substance misuse issues they would be addressing with SABG funds, the target populations for their efforts, the intervening variables and contributing factors they would be addressing, their goals, objectives, and evidence-based strategies.

Capacity Building:

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? **YES**

If yes, please describe: The Maryland Association of Prevention Professionals and Advocates oversees Maryland's prevention certification process in collaboration with the International Certification and Reciprocity Consortium.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? **YES**

If yes, please describe mechanism used: The Office of Population Health Improvement (OPHI) contracts with the University of Maryland, School of Pharmacy to provide intensive, on-going technical assistance and training to Maryland's prevention workforce. Training is provided year round and is organized by specific components related to needs assessment, capacity building, strategic planning, program implementation, and evaluation. OPHI also contracts with the University of Maryland, College Park and the Johns Hopkins School of Public Health to provide training and technical assistance in preventing alcohol misuse and high-risk drinking on college campuses and in college communities.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? **YES**

If yes, please describe mechanism used: Our efforts to provide capacity building training and technical assistance activities to our prevention workforce have been ongoing, intensive, and cumulative. We started this capacity building process with our initial SPF-SIG grant, continued with our Opioid Misuse Prevention Program, then our SPF-PFS grant program, and now our SABG grant program. As our technical assistance team has provided capacity building training

and technical assistance to our statewide prevention workforce, it has also continually strengthened its capacity to assist local communities in implementing the SPF process.

Planning:

1. Does your state have a Strategic Plan that addresses substance use disorder prevention that was developed within the past 5 years? **YES – additional explanation below.**

If possible, please add the following text: This plan is currently being updated to reflect the reorganization of the SABG primary prevention funding from the Maryland Department of Health's (MDH) Behavioral Health Administration to MDH's Office of Population Health Improvement. The State will forward the updated plan upon completion.

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? **YES**

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based: Currently, all recipients of SABG primary prevention funds are in the process of implementing the strategies they selected based on a thorough Needs Assessment and Strategic Planning process. Implementation of these strategies began on July 1, 2018. Currently there is no need for the selection of new evidence-based strategies. Once recipients have been implementing their evidence-based strategies for another full year, they will examine the outcome measures they selected during Strategic Planning to assess whether changes to strategies are necessary. At that time, an ad-hoc Evidence Based Workgroup will be convened to review and approve any proposed changes to the previously selected evidence-based strategies. During the Strategic Planning phase, the BHA Office of Prevention provided a roster of evidence-based prevention programs, strategies, and practices that local jurisdictions were required to adhere to in selecting and implementing their SABG funded prevention activities. At the time, the program roster was developed by our technical assistance team based on its on-going review of prevention literature on evidence-based practices, including CAPT Decision Support Tools, the CDC Community Guide, the SAMHSA NREPP, and other program registries. With the loss of the CAPT and NREPP resources, OPHI will continue to utilize the CDC Community Guide and other program registries for guidance on evidence-based prevention programming. OPHI will also utilize the newly created Prevention Technology Transfer Center (PTTC) as a resource.

Implementation:

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies.
 - a) Information Dissemination: Public Awareness Campaigns (TV, radio, print, billboard, etc.); distribution of awareness literature at a wide variety of community events; drug education presentations in schools, and community events
 - b) Education: All Stars; Dare to be You; Guiding Good Choices; Life Skills Training; Parenting Wisely
 - c) Alternatives: Alcohol-free Post Prom Activities; peer leadership training and events

- d) Problem Identification and Referral: Student Assistance Programs; staff referrals to direct services programs such as those listed above (such as Life Skills Training, Parenting Wisely, etc.)
 - e) Community Based Process: Establishment and coordination of community substance misuse coalitions (MSPF Coalitions, OMPP Coalitions, Drug-Free Communities Coalitions); multi-agency coordination and collaboration; town hall meetings; and Communities That Care
 - f) Environmental: Multimedia Social marketing campaigns designed to change substance use behaviors and reduce community contributing factors; supporting local community coalitions' advocacy for alcohol and other drug policy enhancements (i.e. social host ordinances, school alcohol policies, alcohol advertising restrictions, alcohol policies at public events) through the provision of data and information about the benefits of policy change; responsible alcohol server training; administrative compliance checks; and TIPS lines. Administrative compliance checks are compliance checks conducted by local civilian liquor licensing boards that may result in administrative penalties, but not criminal charges. TIPS lines are telephone hotlines routed to local law enforcement agencies that community members can use to report underage drinking parties that are either planned or underway. All primary prevention activities funded by the SABG are consistent with 18 U.S.C. § 1913, which prohibits the use of appropriated federal moneys, including SABG funds, for lobbying.
3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? **YES**

If yes, please describe:

- a) All jurisdictions must submit a strategic plan when applying for SABG funding, which describes in detail the substances whose use they will be preventing/reducing, the community contributing factors that their prevention activities will be addressing; the target populations they will be impacting, and the evidence based strategies and programs they will be implementing with their SABG funds.
- b) OPHI and its technical assistance contractor review these plans, provide feedback as needed and only approve the plans when they meet all of the SABG program requirements. These SABG requirements clearly state that funds can only be used for primary prevention activities and cannot supplant other funding.
- c) Jurisdictions provide monthly activity reports to the Maryland MDS prevention data management system and quarterly expenditure reports.
- d) OPHI staff monitor these program and fiscal reports to make sure that they are aligned with the approved prevention activities they have been funded to provide.
- e) Technical assistance is provided when these activities are not aligned, to assist the jurisdiction to get back on track with providing only approved evidence-based primary prevention SABG activities.

Evaluation:

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last 5 years? **YES - additional explanation below.**

If possible, please add the following text: This is included as part of the overall State Strategic Plan, cited above in the Planning section, the State Strategic Plan will be uploaded as an attachment.

BHA FY 20
Compliance Review Monitoring Summary Form
Grant Funded Programs

Program Name:	
Program Type: <input type="checkbox"/> Detention Center <input type="checkbox"/> Health Department <input type="checkbox"/> OTP	
<input type="checkbox"/> IFB/WWC <input type="checkbox"/> IFB/8-507 <input type="checkbox"/> IFB	
Program Services: <input type="checkbox"/> 0.5 <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2.1 <input type="checkbox"/> Level 2.5 <input type="checkbox"/> 3.1 <input type="checkbox"/> 3.3	
<input type="checkbox"/> 3.5 <input type="checkbox"/> 3.7 <input type="checkbox"/> OTS <input type="checkbox"/> WM	
Certification <input type="checkbox"/> 10.47/10-226 Letter <input type="checkbox"/> Licensed	Expires:
Accreditation Org <input type="checkbox"/> CARF <input type="checkbox"/> TJC <input type="checkbox"/> COA <input type="checkbox"/> ACHC	Expires: _____
Reviewer Name:	Date of Compliance Review:

Instructions: If the program is in partial or noncompliance, indicate whether or not a CAP is required. If a Corrective Action Plan **will not be developed**, use the Comment section to explain why. Areas of deficiencies that don't meet requirements for a CAP or other identified areas of concern should be addressed as a **Recommended Areas of Improvement (RAI)**.

Key

- Yes: Program meets all the conditions of the requirement.
- No: Program does not meet any of the conditions of the requirement.
- Partial: Program is in partial compliance but does not meet all conditions of the requirement.
- N/A: Requirement is "Not Applicable" to the program.

Administrative Review

SECTION I

Certification Comment: Compliance CAP

Licensure Comment: Compliance CAP

Accreditation Comment: Compliance CAP

Section 2 Policies, Procedures and Provider Requirements

Policies, Procedures and Provider Requirements	Compliance	CAP	Recommended Area of Improvement
Admission policy with preference for admissions within 24 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Program has policies and procedures that mirror the co-occurring capable standard delivery of services as identified in the ASAM Criteria for co-occurring conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Program has policies and procedures that ensure <ul style="list-style-type: none"> • An individual is not denied admission or continued stay for an individual solely due to the individual being on full or partial opiate agonist therapy or methadone for pain management medication regardless of dose • admission is not contingent upon eventual detoxification from full or partial opiate agonist or methadone for pain management • it does not limit the number of individuals on full or partial opiate maintenance or detoxification that are admitted 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a policy regarding staff member requirements for driving vehicles that transport patients.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program assesses individuals upon admission for Medical Assistance (MA) eligibility determination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Policies, Procedures and Provider Requirements	Compliance	CAP	Recommended Area of Improvement
The program completes fee assessments that fully explains to patients the amount of their financial obligation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a policy that is compliant with Federal Block Grant Award: § 96.127 Requirements Regarding Tuberculosis (screening, testing, reporting, case management, counseling, providing or referring for services)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a policy that is compliant with Federal Block Grant Award: § 96.128 Requirements Regarding HIV (directly or through referral for screening, assessment, pre/post-test counseling, service delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a policy that is compliant with Federal Block Grant Award Drug Free Workplace Requirements (Notification of prohibition/ actions for violation of, Implementation of a drug-free awareness program, agreement to abide by policy signed by employee with copy in record	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a Grievance/Complaint Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The program has a Critical Incident policy; incidents are reported in the time frame required and on the form provided by BHA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Policies, Procedures and Provider Requirements	Compliance	CAP	Recommended Area of Improvement
The program has a Criminal Background Check Policy that is compliant with 10.63 BH regulations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program completes toxicology screening upon admission, and during the course of the patient's treatment with unannounced random and incidence-related retesting.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a Wait List policy that includes the provision of interim and referral services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
The program has a Medical Diversion policy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Section 3 Documentation

Documentation	Compliance	CAP	Recommended Area of Improvement
Contract/agreement for Multi Lingual Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contract/agreement for laboratory services (includes off-site access to laboratory services including drug screening, lab test and monitoring of necessary medication blood levels)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contract/agreement for interpreter services for individuals who are Deaf/Hard of Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Continuous Quality Improvement meeting minutes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Critical Incident reports	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Patient Complaint/Grievance Log	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Program includes therapeutic services 3.3 > 20-35 hours/week 3.5 > 36 hours/week	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Section 4 Staffing and Program Census			
Staffing and Program Census	Compliance	CAP	Recommended Area of Improvement
Organizational Chart provided	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Program meets all staffing requirements required by regulation.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> No	<input type="checkbox"/> No
Comment:			
Census: Program meets Counselor to Patient/Program average Caseload requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total Pt Census: _____ #of Counselors _____			
Comment:			

Section 5 Employee Records			
Employee Records (Documented in staff personnel file)	Compliance	CAP	Recommended Area of Improvement
Copy of valid licensure/certification/authorization by the appropriate Maryland State Professional Licensing Board(s) for the services performed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Training on Safe Sleep Practices	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Employee Records (Documented in staff personnel file)	Compliance	CAP	Recommended Area of Improvement
Annual Cultural Competency training	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Annual (8) hours of training on the Assessment and Treatment of Problem and/or Pathological Gambling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Records (Documented in staff personnel file)	Compliance	CAP	Recommended Area of Improvement
Annual Fetal Alcohol Spectrum Disorder training	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Annual Domestic Violence/Intimate Partner Violence education	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Signed statement of compliance with Drug Free Workplace Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signed statement of compliance with Confidentiality Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Background Check conducted prior to date of hire	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Documentation of Clinical Supervision	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Other: Best Practices			
Best Practices	Compliance	CAP	Recommended Area of Improvement
Program utilizes/provides access to best practices based on individual need.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Practices	Relapse Prevention (Cognitive Behavioral)		
	Motivational Enhancement Therapy / Motivational Interviewing		
	The Matrix Model		
	Medication Assisted Treatment <input type="checkbox"/> On-site <input type="checkbox"/> Referral		
Other:	Pharmacological Therapy		
Other:			
Comment:			

Other: Performance Measures * Interview Program Director.				
Performance Measure calculated for the previous three month period, from _____ to _____.	Program Data	Compliance	CAP	Recommended Area of Improvement
90% of individuals who enter treatment will remain in treatment for 90 days based on medical necessity criteria.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial
90% of patient discharges shall be referred to a lower level of treatment		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial
100% of those who enter the program will receive care coordination/case management, transportation to court and medical appointments.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial
100% of the children will be provided childcare, recreational, and ancillary services.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial
Comment:				

Other: Reporting			
Reporting	Compliance	CAP	Recommended Area of Improvement
Program submits to BHA Women & Children's and HG 8-507 monthly progress report by the 5 th of each month.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
The program submits weekly census reports for Pregnant Women/Women & Children's and HG 8-507 to the BHA treatment placement coordinator	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
BHA is notified of the patient's discharge by the next working day; report is sent within 5 days of discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge summaries & Judicial Continuing Care plans submitted to BHA for HG 8-507	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Summary of Administrative Compliance Review

9/2018

Instructions: For the each area of the Patient Record Review, state the program's Compliance Review Result: Compliance, Corrective Action Plan (CAP) or Recommended Area(s) of Improvement (RAI), or N/A. Use the comment section to document percentage/area of non-compliance. File the completed form in the electronic and/or program folder along with the Patient Record Review form, and any ancillary documents obtained during the Compliance Review.

Administrative Review Results

Section 1: Certification/Licensure/Accreditation

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Section 2: Policies and Procedures:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Section 3: Documentation:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Section 4: Census/Counselor to Patient Caseload:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Section 5: Employee Records:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Reviewer Signature: _____ Date _____

Patient Record Review

Infectious Disease Assessment and Education (Documented in the patient record)	Compliance	CAP	Recommended Area of Improvement
Completed Risk assessments for HIV, Hepatitis, STI, and TB; referrals for counseling/testing as needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Treatment Services (Documented in the patient record)	Compliance	CAP	Recommended Area of Improvement
Fee assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Assisted with MA application(copy in record); assess every patient upon admission for eligibility for Medical Assistance (MA); <ul style="list-style-type: none"> • help eligible patients apply for these entitlements; • check MA enrollment status via the EVS system, if providing an MA reimbursable service; for eligible recipients, bill MA for services covered by those entitlements 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family needs assessment; counseling made available if applicable/requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Initial treatment plan established within required time frame of admission	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Treatment Services (Documented in the patient record)	Compliance	CAP	Recommended Area of Improvement
Treatment plan updated within required frequency	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Treatment plan is individualized and contains interventions to address needs and/or in response to positive urinalysis results	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Group notes are individualized	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Individuals sessions are weekly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Random urinalysis performed; results in record	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Treatment Services (Documented in the patient record)	Compliance	CAP	Recommended Area of Improvement
Pharmacological therapies based on treatment needs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Gender specific BH problems addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Minimum of weekly therapeutic services 3.3 > 20-35 hours 3.5 > 20-36 hours	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Tobacco assessment/cessation offered documented on treatment plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Gambling assessment/provides treatment and prevention services documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Medical Requirements	Compliance	CAP	Recommended Area of Improvement
Program completes a medical examination on individuals within five (5) working days following admission unless the individual was directly transferred from an ambulatory or hospital withdrawal management program, an intermediate care facility or residential setting in which a physical was performed within the last thirty (30) days	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Completes toxicology screens	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Completes lab tests in patient record	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Patient Records	Compliance	CAP	Recommended Area of Improvement
Patient has a paper/electronic record	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Contains documentation the patient meets admission criteria	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Acknowledgement of state and federal confidentiality or privacy laws or regulations signed by patient	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Informed consent to share information signed by patient	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Contains documentation of the coordination of somatic services and medication with the individual's insurance, local health department or FQHC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Integrated Care for Co-Occurring Disorders (Documented in the patient record)	Compliance	CAP	Recommended Area of Improvement
Dual Diagnosis assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Co-occurring disorders addressed in the treatment plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Record reflects participation in Psycho-educational mental health and substance-related disorders treatment services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Record reflects medication management is integrated into the treatment plan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Co-occurring disorders addressed in discharge plans	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Record reflects the patients counselor monitors and promote compliance with pharmacotherapies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Pregnant Women & Women/Children Services (Documented in the patient record)	Compliance	CAP	Recommended Area of

			Improvement
Assessment for domestic violence and sexual abuse history; Domestic Violence education and information provided	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Domestic violence and sexual abuse clinical interventions in the patient's file when indicated on assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
FASD education and information provided	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Prenatal and postpartum medical services, medical evaluation, medication monitoring, psychiatric evaluation, other services as needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Receives trauma informed services as needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Education on Safe Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Accommodations for Women with Children with Medical or Psychiatric	Compliance	CAP	Recommended Area of
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9/2018

Problems :			Improvement
The program obtains a letter from the physician who last examined the female patient and found that the patient no longer requires intensive or hospital care and is determined to be at lower risk for medical problems.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Program provides accommodations or persons with non-acute but chronic and/or persistent but stabilized medical or psychiatric problems.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accommodations include but is not limited to the following: <ul style="list-style-type: none"> a) Double occupancy bedroom b) Restricted exposure to other patients c) Separate meals in patient's room d) Restricted group attendance if others are sick e) Space to have medical equipment/medications f) Parent, visiting nurse, or medical technician responsible for medical equipment 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Children Services (Documented in the child's record)	Compliance	CAP	Recommended Area of
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9/2018

			Improvement
Needs of the child/children identified by an evidence-based assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Care plan for the child/children that are developed based on the evidence-based assessment.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Prevention programming for the child/children.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Provision of/Referral for primary medical care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Child care services provided to the child/children.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Access to education for school age children.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Children Services (Documented in the child's record)	Compliance	CAP	Recommended Area of Improvement
Participation in recreational activities that support the developmental needs of the child/children.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Provision of or referral to appropriate services for children that have been exposed to sexual, physical and neglect issues to.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

Discharge and Continuing Care Planning:	Compliance	CAP	Recommended Area of Improvement
The program ensures that a Continuing Care Plan is completed with the Discharge Plan and provided to all patients	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
For each admitted patient, who does not complete treatment within 120 days of their admission, the program shall submit to BHA a completed Statewide Residential Service Continued Stay Review form. This form is submitted at the 90 day treatment date and every 30 days thereafter	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Patient's record reflects justification & reason for Discharge and documentation of notification to BHA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			

HG 8-507 Requirements (Documented in the patient's record)	Compliance	CAP	Recommended Area of Improvement
Program provides medication to patients	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Utilization of Criminal conduct educational module	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Continued stay review form completed for all Pts who do not complete tx within 120 days; form submitted at 90 day treatment date and 30 days thereafter	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Comment:			
Documentation that Discharge summaries & Judicial Continuing Care plans were submitted to BHA.			
Comment:			

Summary of Patient Record Compliance Review

9/2018

Instructions: For the each area of the Patient Record Review, state the program's Compliance Review Result: Compliance, Corrective Action Plan (CAP) or Recommended Area(s) of Improvement (RAI), or N/A. Use comment section to document percentages of non-compliance. File the completed form in the electronic and/or program folder along with the Administrative Review form, and any ancillary documents obtained during the Compliance Review.

Patient Record Review Results

Infectious Disease/Disease Education:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Treatment Services:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Medical Requirements

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Patient Records:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Admission Criteria:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Integrated Care for Co-Occurring Disorders

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Pregnant Women, Women with Children, Children:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

Accommodations/Services: Women, Pregnant Women, Women with Children, Children:

Corrective Action Plan Recommended Area(s) of Improvement N/A

9/2018

Comment:

Children's Services

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

HG 8-807 Requirements:

Corrective Action Plan Recommended Area(s) of Improvement N/A

Comment:

of Active Records Reviewed_____ **# of Discharge Records Reviewed**_____

Reviewer Signature: _____ Date_____

Revised 9/2018

9/2018

Program Name:

Date of Review:

IFB Patient Record Review

Record Number												
Admission Date												
Level of Care												
Assessment Date												
Discharge Date												
Infectious Diseases												
Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Completed Risk assessments for HIV, Hepatitis, STI, and TB; referrals for counseling/testing as needed.												
Treatment Services												
Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Fee assessment												
MA application												
Assessment of Family tx needs/ counseling available as requested												
Gambling assessment												
Gambling treatment/prevention services documented												
Tobacco assessment												
Tobacco cessation goal included on Tx plan												
Initial Tx plan within required time frame Date>												
Treatment plan is individualized												
Tx plan/ updated with clinical interventions within required frequency												
Group notes individualized												
Individual sessions weekly												
Random urinalysis performed/ interventions to address positive results are documented on the tx plan												
Pharmacological therapies based on treatment needs												
Gender specific BH problems addressed												
Minimum of weekly therapeutic services 3.3 > 20-35 hours 3.5 > 20-36 hours												
Medical Requirements												
Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Medical exam within 5 days of admission Date>												
Complete toxicology screen												
Complete lab tests												

Patient Records 42 CFR Part 2												
Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Pt has paper/electronic record												
Contains documentation the patient meets admission criteria												
Acknowledgement of state and federal confidentiality or privacy laws or regulations signed by patient												
Informed consent to share information signed by patient												
Documentation of the coordination of somatic services and medication with the individual's insurance, local health department or FQHC												
Integrated Care for Co-Occurring Disorders												
Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Dual Diagnosis(DD) assessment												
Co-occurring disorders addressed in the treatment plan.												
Record reflects participation in Psycho-educational mental health and substance-related disorders treatment services												
Record reflects medication management is integrated into the treatment plan												
Record reflects the patients counselor monitors and promote compliance with pharmacotherapies												
Co-occurring disorders addressed in discharge plan												
Pregnant Women & Women & Children Services												
Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Assessment for domestic violence and sexual abuse history; Domestic Violence education/information provided/ interventions documented												
FASD education and information provided												
Prenatal and postpartum medical services, medical evaluation, medication monitoring, psychiatric evaluation, other services as needed.												
Receives trauma informed services as needed.												
Access to Trauma informed services												
Education on Safe Sleeping												

Accommodations for pregnant women and WWC with non-acute, chronic &/or persistent but stabilized medical or psychiatric problems

Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Documentation from physician that Pt no longer requires intensive hospital care & is at low risk for medical problems												

Accommodations include:

Double occupancy bedroom												
Restricted exposure to other pts												
Separate meals in pts room												
Restricted group attendance if others are sick												
Space to have medical equipment/medications												
Parent, visiting nurse, or medical tech. responsible for medical equipment												

Children's Services

Child's Record Number

Parent's Record Number

Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Evidenced-based needs assessment												
Care plan based on assessment												
Provision of/Referral for primary medical care												
Prevention programming for the child/children												
Child care services provided to the child/children.												
Access to education if school aged												
Recreational activities												

HG 8-507 Requirements

Documented in the patient record	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Program provides medication to patients												
Utilization of Criminal conduct educational module												
Continued stay review form completed for all Pts who do not complete tx within 120 days; form submitted at 90 day treatment date and 30 days thereafter												
Documentation that Discharge summaries & Judicial Continuing Care plans were submitted to BHA.												

BHA

Provider (IFB) Administrative Review Form

Program:

Level of Care:

Contact Person:

Telephone Number:

Reviewer:

Date of Review:

Section 1: 10.63 License # _____ Expires _____ **Certification under 10-226 Expires** _____
Accreditation CARF TJC COA ACHC Expires _____

Comments: _____

Section 2:

Policies, Procedures and Provider Requirements	Program has policy or documented procedure	Comments
Admission Policy addresses Preference for pregnant women MAT (non-discrimination)	Yes No Yes No	
Program meets ASAM Criteria for Co-occurring <input type="checkbox"/> Capable <input type="checkbox"/> Enhanced	Yes No	
Staff Driving Policy	Yes No	
Assessment of individuals upon admission for Medical Assistance (MA)	Yes No	
Fee Assessment	Yes No	
TB Policy & Procedure Employee/Patient	Yes No	
HIV Policy & Procedure Patient	Yes No	
Grievance Policy	Yes No	

Policies, Procedures and Provider Requirements	Program has policy or documented procedure	Comments
Wait List/Interim Services Policy	Yes No	
Toxicology Screening	Yes No	
Medication Diversion (if applicable)	Yes No	
Critical Incident (Reported within 24 hours on BHA form)	Yes No	
Drug-free Workplace Policy & Procedures	Yes No	
Patient Transportation	Yes No	
Policy/Program content that addresses Dual Diagnosis	Yes No	

Section 3 Documentation

Policies, Procedures and Provider Requirements	Document Provided	Comments
Contract/agreement for Multi Lingual Services	Yes No	
Contract/agreement for laboratory services	Yes No	
Contract/agreement for interpreter services for individuals who are Deaf/Hard of Hearing	Yes No	
CQI meeting minutes	Yes No	
Most recent Critical Incident reports	Yes No	
Patient Grievance/ Complaint Log	Yes No	
Program Schedule 3.3 > 20-35 hrs/wk/ 3.5 > 36 hrs/wk	Yes No	
Education Module Core Elements of Criminal Conduct for 8-507 Patients	Yes No	
Criminal Background Check compliant with 10.63	Yes No	

Section 4: Staffing and Program Census

Program Director

Name	Emergency (Home/Personal Cell) Phone Number

Org Chart Yes No Number of Employees: Administrative _____ Counselors _____ Other _____

Required Staff 3.3	Hours worked	Requirement 3.5 On-site On call	Hours worked
Physician/NP/PA On-site 4/wk On call 1hr		Physician/NP/PA On-site 1/wk	
Psychiatrist or Psych Nurse Available 3/wk		Psychiatrist or Psych Nurse Available 1/wk	
RN or LPN On site 40/wk		RN or LPN	
Program Director On-site 20/wk		Program Director On-site 20/wk	
Certified CPR Crisis Intervention Trng Y N		Certified CPR Crisis Intervention Trng Y N	

		Comments
Census By Payment Type		
Medicaid		
Private/Self Pay		
Private Insurance		
Other		
Total Census		
Counselor to Patient Ratio		

Section 5: Employee Records:

Employee	Doc of Clinical Supervision	Training					
		Safe Sleeping	Fetal Alcohol Spectrum Disorder	Domestic Violence/Intimate partner (Annual)	Co-Occurring Disorders (Annual)	Cultural Competency (Annual)	Ass/Tx Problem Gambling (8hrs Annually)
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A

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		Safe Sleeping	Fetal Alcohol Spectrum Disorder	Domestic Violence/Intimate partner (Annual)	Co-Occurring Disorders (Annual)	Cultural Competency (Annual)	Ass/Tx Problem Gambling (8hrs Annually)
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A

Section 5: Employee Records:

Employee	Doc of Clinical Supervision	Training					
		Safe Sleeping	Fetal Alcohol Spectrum Disorder	Domestic Violence/Intimate partner (Annual)	Co-Occurring Disorders (Annual)	Cultural Competency (Annual)	Ass/Tx Problem Gambling (8hrs Annually)
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A

Section 5: Employee Records:

Employee	Doc of Clinical Supervision	Training					
		Safe Sleeping	Fetal Alcohol Spectrum Disorder	Domestic Violence/Intimate partner (Annual)	Co-Occurring Disorders (Annual)	Cultural Competency (Annual)	Ass/Tx Problem Gambling (8hrs Annually)
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A
Position: Lic/Cert/Auth # _____ Expires: _____ BC date _____/Yrly Affirm _____ Hire date _____ Annual PPD _____ Confidentiality: Y N Drug Free Workplace Y N	Y N N/A Most Recent Dates _____ _____ _____ Caseload: _____	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A	Y N N/A

Number of Employee Records Reviewed:

Section 6: Records Requested

#Active Records Reviewed () # _____ # _____ # _____ # _____ # _____ # _____ # _____
 # _____ # _____ # _____ # _____ # _____ # _____ # _____ # _____

#Discharge Records Reviewed (): # _____ # _____ # _____ # _____ # _____ # _____ # _____

Other:

Best Practices Utilized	Relapse Prevention (Cognitive Behavioral)
	Motivational Enhancement Therapy / Motivational Interviewing
	The Matrix Model
	Medication Assisted Treatment <input type="checkbox"/> On-site <input type="checkbox"/> Referral
	Pharmacological Therapy
	Other:
	Other:

Performance Measure calculated for the previous three month period, from _____ to _____.	Program Data
90% of individuals who enter treatment will remain in treatment for 90 days based on medical necessity criteria.	
90% of patient discharges shall be referred to a lower level of treatment	
100% of those who enter the program will receive care coordination/case management, transportation to court and medical appointments.	
100% of the children will be provided childcare, recreational, and ancillary services.	

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? Yes No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁵⁸ paper.

⁵⁷ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

⁵⁸ Ibid

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁵⁹

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶⁰

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁵⁹ Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No
5. Does the state have any activities related to this section that you would like to highlight?
Maryland Community Criminal Justice Treatment Program (MCCJTP)
? MCCJTP assists local detention centers in meeting the comprehensive behavioral health needs of justice-involved individuals. In collaboration with the CSAs, the program delivers both clinical treatment and case management services.

Trauma, Addiction, Mental Health, and Recovery (TAMAR)

? TAMAR is a detention-based education program for individuals with a history of abuse, a recent treatment history for a mental health concern or treatment for an alcohol or drug disorder. In addition to education, participants identify resources in the community that aid in the success of reentry.

Detention Center Medication Assisted Treatment (MAT) Reentry Program

? Inmates with a substance use disorder (opioid or alcohol) identified as appropriate at intake, would receive the first injection of Naltrexone prior to their date of release. Inmates enter an education group explaining the aspects of Vivitrol as a Medication Assisted Treatment (MAT) tool. The inmate begins counseling services at least a number of weeks prior to release. The first injection takes place approximately 8 to 10 days prior to release. Once released from the detention center, they are maintained on

Naltrexone (Brand Name Vivitrol) through their participation in treatment at the health department. The program will maintain a peer support specialist or case manager to identify needed resources for successful reentry, such as insurance, housing, employment, health care, recovery supports, and transportation.

Drug Court

? Drug Court is a program co-funded by BHA and the Office of Problem Solving Courts. The primary function of the program is to cover the costs of non-reimbursable services including transportation, SUD case management, time spent in court on behalf of the client, and correspondence with court officials.

DataLink

? The purpose of DataLink is to promote the continuity of treatment for individuals with serious mental illness who are detained in the detention center. The data is compared against Medicaid eligibility data, utilizing agreed upon data points to identify a detainee as a "match". Detention center medical staff utilizes this data to address the detainees medical and mental health needs.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No

5. Does the state have any activities related to this section that you would like to highlight?

In 2015, SAMHSA awarded the Behavioral Health Administration a three-year MAT PDOA grant consisting of \$2.4 million. The project was entitled MD MATRS. BHA chose the two state jurisdictions that had the highest risk for overdose deaths in the state- Baltimore City and Anne Arundel County. MD MATRS provides targeted care coordination, treatment expansion and peer enhancement services with the intent of reducing the number of overdoses and overdose related deaths. The primary goals of the project are:

- Increase enrollment in medication assisted treatment (MAT) through peer outreach to overdose survivors in emergency rooms
- Conduct buprenorphine induction prior to discharge from a level 3.7 facility and facilitate admission into MAT programs
- Provide specialized training to peers
- Enhance existing MAT services using innovative peer and social supports.
- Addressed stigma, misinformation, and myths regarding MAT by producing a video entitled Better Options- Better Outcomes with MAT.

• Provided specialized Peer training for the project through MARS, Inc. (Medication-Assisted Recovery Services)

the State has also received the State Opioid Response Grant (SOR). The State will receive \$33 million a year for a two year period beginning September 30, 2019 through September 30, 2021. The purpose of the grant is to increase access to Medication Assisted Treatment (MAT), reduce unmet treatment need, and, ultimately, to decrease opioid deaths. The funds will support numerous projects including:

- Crisis Walk-In Centers

- Crisis Bed Expansion
- Safe Stations
- SBIRT
- MAT with Criminal Justice/Detention Centers
- Public Awareness
- Harm Reduction- Naloxone
- Expansion of Buprenorphine
- Medical Patient Engagement
- Recovery Residences for Adults and Children
- Young Adult Recovery Housing

Maryland's State Opioid Response (MD-SOR) Year one treatment activities consist of a continuation of the State Targeted Response (STR) grant activities and implementing Medication Assisted Treatment (MAT) within nine local detention centers. This includes providing Buprenorphine Inductions to individuals being served through SOR funded residential crisis beds and stabilization centers.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

- f) Recovery community coaches/peer recovery coaches
- g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

The MHBG supports several crisis response systems in Baltimore City, and Anne Arundel and Prince George's counties. Baltimore City has two crisis response and intervention systems, one for children and adolescents and another for adults.

There is considerable variability of the services offered from jurisdiction to jurisdiction. As an example, currently there are 19 Mobile Crisis Team (MCT) programs operating in Maryland. The current continuum of crisis response services is:

24/7 hotline and/or clinical crisis phone response

Crisis Intervention Team (CIT) programs

Mobile Crisis Team (MCT) programs

Walk-in Crisis Services

Crisis Residential Beds

Hospital Diversion

Criminal Justice Diversion

23 Hour Holding Beds

Emergency Psychiatric Services

Urgent Care

Crisis Intervention Training (CIT): In FY 2019, each Maryland jurisdiction received funding to train law enforcement officers (LEOs) on crisis intervention. In FY 2019, an estimated 600 LEOs have participated in a 40 hour training. An additional combination of 500 officers, supervisors, and dispatchers have attended a one-day academy training.

Mobile Crisis Teams (MCT) is defined as community-based mobile crisis services that provide 24/7 availability of face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, whether at home or wherever the crisis may be occurring, to begin the process of assessment and definitive treatment outside of a hospital or health care facility. A multi-disciplinary team, including peer support workers, works to de-escalate the person's behavioral health crisis, engages the person in other therapeutic interventions, and assists with continuity of care by providing support that continues past the crisis period. Maryland has expanded its mobile crisis services from 13 jurisdictions to 19 jurisdictions. This is a 46% increase of MCT programs from the previous year. Only 20% are available 24/7, but as funding increases in response to the opioid crisis, many of the programs are expanding services to 24/7. Additionally, MCT has expanded to reach many of our rural areas. 11 of the 19 MCT programs are located in the Eastern and Western regions of the state.

Residential Crisis beds are short-term, intensive mental health and support services provided in a community-based, non-hospital, residential setting which are designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay. 12 jurisdictions provide 161 residential crisis services for mental health disorders and 5 jurisdictions with 79 beds provide services for substance use disorders.

Crisis Stabilization Centers/Crisis Walk-in Services: 24/7 walk-in services are defined as a direct service that assists with the de-escalation of a person's clinical behavioral health crisis and, if applicable, his or her possible diversion from emergency department admission, police/incarceration, or out of home treatment intervention by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability delivered in a timely manner and leading to stabilization. Anyone experiencing a behavioral health and/or substance-related crisis is eligible for acceptance regardless of age, insurance status, ethnic, cultural or linguistic (such as, use of language interpreting or certified ASL interpreter) preference. The service setting, whether free-standing or attached to a hospital, will serve, as needed, as an entry point to long-term, ongoing service delivery and care. The primary functions of walk-in crisis services are: screening and assessment, crisis stabilization (including medication), brief treatment, and linkage to social services and other behavioral health services. A walk-in crisis service can function as a central point from which to organize the jurisdiction's array of crisis services and deploy services such as MCT as needed.

With the passage of the HOPE Act, Maryland has partnered with two jurisdictions to establish a comprehensive crisis stabilization center. Baltimore City and Harford County have facilities that provide walk-in services, assessment bays, and crisis beds.

Additionally, Anne Arundel, Calvert, Carroll, Cecil, Frederick, Howard, Montgomery, and Washington Counties provide walk-in crisis services.

Safe Stations utilize fire and police stations as access hubs for entry into the treatment system 24 hours a day, 7 days a week.

Serving as a point of access, individuals with substance-related disorders and a motivation for change may voluntarily seek assistance. Safe station programs include care coordination, peer recovery support, and legal assistance such as warrant resolution. State and local dollars support Safe Stations in Anne Arundel, Queen Anne, Wicomico, and Worcester Counties.

In response to legislation that was signed into law in FY 2019, a workgroup of sixteen internal and external partners were formed to develop a program that addresses the need for increased crisis services. Competitive grants are awarded to local behavioral health authorities to develop and expand behavioral health crisis response programs and services. 12 jurisdictions submitted a total of 19 proposals. With a total of three million dollars in State funding, the workgroup recommended seven jurisdictions to provide an array of services including walk-in, urgent care, and mobile crisis to youth, family, and adults with services to begin in FY 2020.

The main challenges the Crisis Services face is staffing shortage. Rural jurisdictions repeatedly report difficulty in finding psychiatrists and, lately peer support specialists. Another challenge for rural areas is transportation. Calvert County has created a Rapid Response Program that includes a treatment van so they may bring the service to the individual.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
- b) Required peer accreditation or certification? Yes No
- c) Block grant funding of recovery support services. Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Maryland's commitment to the principles of recovery and recovery support is long standing. This commitment to further define a recovery-oriented system has been carried out by the Behavioral Health Administration (BHA). BHA's mission and vision speak to promoting recovery, resiliency, health and wellness for individuals who have or are at risk for emotional, substance related, addictive, and/or psychiatric disorders through coordinated, quality systems of care that are supportive of individual rights and preferences, to improve their ability to function effectively in their communities. BHA is committed to remaining a system that focuses on the wellbeing of those they serve; both while in care and after they have successfully integrated back into their community, as defined by the individual.

BHA has developed an integrated process for planning, policy and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions. Although we offer services that can be specific, we support an integrated behavioral health model which offers recovery and recovery support services that serve both individuals with severe mental illness (SMI) and individuals with substance use disorders (SUD). A continuum of care is offered that includes prevention, intervention, treatment, and recovery services in all jurisdictions across the state. The system incorporates recovery approaches such as person centered planning, self-directed care, peer recovery support, and consumer/participant/family education, as well as the promotion and expansion of access to employment, education wellness, and affordable housing. Over the years, the system has also promoted and/or provided access to training for behavioral health providers in step with these concepts. The most significant strengths are the existing recovery systems for both mental health and substance-related disorders. The system utilizes State Care Coordination, which is an activity designed to improve recovery outcomes for individuals identified as at high risk for relapse. Individuals in the program are assisted with gaining access to community/faith-based medical, behavioral, social and other recovery support services appropriate to their needs and includes recovery assessment, care planning, referral/linkage, on-going monitoring, and follow-up.

The Office of Clinical Services, Adults and Older Adults is responsible for developing and managing an integrated system of behavioral health treatment and recovery services for adults and older adults in alignment with the Maryland Department of Health and BHA's mission and goals. The Office directs, administers and oversees the statewide continuum of community-based outpatient behavioral health treatment services, including outpatient mental health centers, outpatient substance use treatment, mental health partial hospitalization programs (PHP), group practices, private licensed practitioners, and residential substance use treatment. It also designs, plans, directs, implements and evaluates care management services, recovery supports, and community resources.

The Office of Clinical Services is comprised of five divisions, which are:

- System Integration/Community Liaison
- Gender-Specific Services
- Crisis and Criminal Justice Services
- Older Adults/Long-term Care Services and Supports
- Evidence-Based Practices, Housing and Recovery Supports

The Crisis and Criminal Justice Services Division provides oversight of crisis services, which include crisis intervention teams (CIT), mobile and crisis response, residential crisis, crisis stabilization, disaster preparedness and response as well as jail-based and and/or trauma-based services: Maryland Community Criminal Justice Treatment Program (MCCJTP); and Trauma, Addiction, Mental Health and Recovery (TAMAR).

The Evidence-Based Practice Center (EBPC) is a collaboration between BHA and the University of Maryland School of Medicine. A few of the evidence-based, empirically supported and promising practices currently being implemented through the EBPC include: Supported Employment (SE); Assertive Community Treatment (ACT), Family Psychoeducation, (FPE), Co-Occurring Disorders, Transition to Independence Process (TIP); and Person-Centered Care Planning (PCCP).

Supported employment (SE) services provide job development and placement, job coaching, and ongoing employment support to individuals with serious mental illness (SMI) or emotional disturbance for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences, and skills. This level of service is available for individuals ages 16 and above.

Assertive Community Treatment/Mobile Treatment (ACT) is an intensive, community-based service which provides assertive outreach, treatment, rehabilitation, and support to individuals with severe and persistent mental illness (SPMI) who may be

without a home or for whom more traditional forms of outpatient treatment have been ineffective. Services are provided by a mobile, multidisciplinary team in the individual's natural environment.

Maryland's Public Behavioral Health System (PBHS) prides itself on its consumer-driven, consumer-focused service system. BHA's Office of Consumer Affairs has a leadership role in both policy and program development. The Office coordinates with local peer support chapters, individual consumers, and consumer advocacy groups in an effort to improve services, and empower consumers throughout their recovery. In addition, the Office, in conjunction with local behavioral health entities, can assist consumers with their complaints and/or concerns regarding services received or treatment options.

Activities that support recovery and recovery supports for individuals with SMI and SUD are monitored and implemented through BHA's Office of Consumer Affairs. One particular service specific to individuals with SMI are the Wellness Recovery Centers (WRC). WRC are peer-operated programs normally outside of clinical settings that offer recovery support services to individuals seeking recovery from mental health conditions. These recovery supports are non-clinical in nature and are focused on reducing the isolation experienced by individuals with mental health conditions. Additionally, some centers provide individuals access to transportation, housing, health, vocational/educational and other types of supports vital to a person's success in recovery.

The Evidence-Based Practices, Housing and Recovery Supports Division provides oversight of evidenced-based practices, housing and homeless initiatives, and recovery supports. This includes the Maryland Collaboration for homeless enhancement services (CHES); the continuum of care housing programs; residential rehabilitation programs (RRP); psychiatric rehabilitation programs (PRP); the balancing incentive program (BIP); housing first pilot program; Maryland's SSI/SSDI; outreach, access and recovery (SOAR) initiative; state hospital benefits project; homeless identification project; Maryland partnership for affordable housing (MPAH); as well as ACT, SE, and PCCP.

Maryland's Certified Peer Recovery Specialist program, in conjunction with the Maryland Addiction and Behavioral Health Professional Certification Board (MABPCB), provides State certification for individuals who provide direct peer-to-peer support services to others who have mental health, substance use, or co-occurring disorders. Due to their lived experience, CPRS can, with specialized training and guidance, draw from their own journey of recovery to inspire hope and provide support to others who are facing similar situations. The State of Maryland utilizes both non-certified and certified peer recovery specialist within the Public Behavioral Health System (PBHS). Peer Recovery Specialists (PRS) support individuals who are in the process of initiating or maintaining their recovery from serious mental illness, substance use, or co-occurring disorders. The PRS workforce is expanding with almost 338 PRS positions in the PBHS, 116 of which are certified. Some of the services provided by Peer Recovery Specialist include:

- accompanying individuals to appointments/12-step meetings and leisure activities;
- providing assistance with completing paperwork for social services and other support services;
- providing assistance/preparation for employment such as shopping for work related clothing and coaching to prepare for an interview.

Wellness and Recovery Action Plan (WRAP) is a project provided to consumers in partnership with On Our Own of Maryland, a statewide mental health consumer education and advocacy organization. These trainings are being conducted by the Copeland Center, the national program developer of WRAP. The training includes the core concepts of recovery, daily maintenance, early warning signs and action plans, breakdown and crisis plans, and post crisis plans that provides training in consumer-operated programs. This program is part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.

Community Bond and Recovery Residences Grants

BHA has had a long-standing goal of supporting affordable, "independent" and accessible housing for individuals with mental health, substance-related, or co-occurring disorders. BHA co-sponsors the "Capital Improvement Grants and Loans for Behavioral Health, Addictions Recovery, Developmental Disabilities and Federally Qualified Health Centers Facilities" (also known as community bond) Award Program. Priority areas are for individuals with M/SUD. The grant supports projects that effectively expand, support, or enhance capital resources (buildings, houses, projects involving bricks and mortar) for the following priority populations:

- Applicants Providing Substance-Related Disorder (SRD) Services
- Applicants Providing Mental Health Services

Additionally, the Governor's budget provided an additional \$1 million grant for FY2020 specifically for certified recovery residences.

The Children's Services Division of BHA is charged with developing a system of care for young people and their families ranging from early childhood all the way through to the time when young people reach the age of majority and legally become adults. The system of care is designed to meet the needs of individuals within this age range who have mental health conditions, substance-related disorders, and those who have both. The Division evaluates the network of services that BHA funds for this age group and has the responsibility for statewide planning, development, administration and monitoring of provider performance to assure the highest possible level of quality in the delivery of services. It also manages a number of special projects and is responsible to work

with all other child serving agencies at both the State and local levels to assure a highly coordinated and individualized approach to care.

BHA and the University of Maryland School of Medicine have collaborated to offer specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. The programs use an integrated approach to address the health and mental health needs of young adults, including providing support for co-occurring substance-related disorders with metabolic-related disorders, and other co-occurring medical conditions. These programs are committed to reducing disability by equipping individuals at risk and their families with tools to manage their illness, move successfully through the developmental stages of growth, and establish a life of their choosing.

Transition planning services emphasize resilience as they assist young people (emerging adults) with mental illnesses and emotional disabilities as they prepare for adult life. Transition-age services and supports are available to youth beginning at age 16. Services and supports are designed to prepare and facilitate achievement of goals related to relevant transition domains, such as employment, career, and educational opportunities, living situations, personal effectiveness, well-being, community contribution and life functioning. Services integrate traditional and nontraditional supports in developmentally appropriate and effective youth-guided local systems of care with the system goal of expansion of the evidence informed service provision throughout the state. The value placed on youth and family member participation continues as a major priority of the child and adolescent behavioral health system of care.

The Healthy Transitions Initiative (HTI) is a five year systems change state/community partnership to create developmentally appropriate and effective youth guided/family supported local systems of care that will improve outcomes for Transition Age Youth (TAY) with mental health and co-occurring disorders in the areas of:

- employment
- education
- housing
- decreased contacts with juvenile and criminal justice systems

The goals of HTI are to provide individualized services to TAY that lead to seamless transitions, including post-school employment and/or postsecondary education; to enhance collaboration among Public Mental Health System and other TAY serving systems (e.g.- school systems, foster care, rehabilitation services, criminal/juvenile justice system); to facilitate collaboration with families and other community partners to improve service delivery and inform policy issues that affect the transition process; to create a statewide infrastructure that supports TAY/young adults; and to improve community capacity to effectively serve TAY.

HTI collaborates with existing community resources including DSS, DJJ, NAMI, On Our Own Maryland, and the Maryland Coalition of Families to support and encourage self-efficacy, self-advocacy, and community attachment. TAY/young adults and families provide input to all aspects of project developments.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Maryland's Public Behavioral Health System (PBHS) prides itself on its consumer-driven, consumer-focused service system. BHA's Office of Consumer Affairs has a leadership role in both policy and program development. The office coordinates with local peer support chapters, individual consumers, and consumer advocacy groups in efforts to improve services, and empower consumers throughout their recovery. In addition, the Office, in conjunction with local behavioral health entities, can assist consumers with their complaints and/or concerns regarding services received or treatment options. Activities that support recovery and recovery supports for individuals with SMI and SUD are monitored and implemented through BHA's Office of Consumer Affairs. Some of these that are specific to individuals with SUD include:

Recovery Community Centers: Community based programs offering recovery support services to individuals seeking recovery from substance use disorders. These recovery supports are non-clinical in nature and provide individuals access to transportation, housing, health, vocational/educational and other types of supports vital to a person's success in recovery.

Peer to Peer Services: Peer to Peer support services are unique in that the delivery of these services is facilitated exclusively by individuals who identify as having lived experience in behavioral health recovery. Peer-to-Peer services can be facilitated within a formal setting such as a community-based treatment program but are not exclusive to that setting. Peer-to-peer services are frequently effective in non-traditional settings such as no-barrier community support agencies, areas in the community where high rates of overdose, homelessness, and other health disparities exist, and other diverse settings such as hospitals, courthouses, and jails. Peer-to-peer services must be voluntary. Peer-to-peer services are guided by a recovery plan which is created and maintained by the individual receiving the support. The peer's main function is to help the individual receiving services navigate community-based supports and resources while providing support to the individual and their recovery process.

Maryland's Certified Peer Recovery Specialist program, in conjunction with the Maryland Addiction and Behavioral health Professional Certification Board (MABPCB), provides State certification for individuals who provide direct peer-to-peer support services to others who have mental health, substance use, or co-occurring disorders. Due to their lived experience, CPRS's can, with specialized training and guidance, draw from their own journey of recovery to inspire hope and provide support to others who are facing similar situations. The State of Maryland utilizes both non-certified and certified peer recovery specialist (CPRS)

within our public behavioral health system (PBHS). Peer Recovery Specialists (PRS) support individuals who are in the process of initiating or maintaining their recovery from serious mental illness, substance use, or co-occurring disorders. The Peer Recovery Specialist (PRS) workforce is expanding with almost 338 PRS positions in the PBHS, 116 of which are certified. Some of the services provided by Peer Recovery Specialist include:

- accompanying individuals to appointments/12-step meetings and leisure activities
- providing assistance with completing paperwork for social services and other support services
- providing assistance/preparation for employment such as shopping for work related clothing coaching to prepare for an interview

The Treatment and Recovery Services Unit ensures an integrated system of behavioral health treatment and recovery services are available and accessible to individuals experiencing substance-related disorders. In collaboration with the Office of Adult and Specialized Behavioral Health Services, the Unit is responsible for the development and monitoring of effective behavioral health treatment and substance-related recovery services and the implementation of evidence-based practices and standards statewide. The Unit aims to increase access to appropriate clinical and recovery support services, improve treatment outcomes; and to provide education on, and increase the public's awareness of the risks associated with substance use. The Unit also allocates and monitors the use of federal and state fiscal resources, provides training and technical assistance to jurisdictions and service providers, and monitors the achievement of outcome and performance measures. The following programs/services are offered:

Peer Support/Recovery Coaching: services involve the development of a supportive peer relationship with individuals that will assist in developing healthy living skills, and the acquisition and enhancement of recovery self-management skills. Peer services are facilitated by Certified Peer Recovery Specialists (CPRS) in consideration of the four domains: Advocacy, Recovery and Wellness, Mentoring and Education, and Ethical Responsibility. CPRS are certified by the Maryland Addictions Professional Certification Board. Peer activities may include but are not limited to accompanying individuals to appointments/meetings and leisure activities, providing assistance with completing paperwork for social services and other support services, providing assistance/preparation for employment such as shopping for work related clothing, coaching to prepare for an interview.

Maryland RecoveryNet: develops partnerships with service providers statewide and funds access to clinical and recovery support services for individuals with substance-related disorders and substance-related disorders co-occurring with mental health conditions who have treatment and recovery support needs. All Maryland RecoveryNet service recipients receive Care Coordination through which they can access a menu of services which includes Halfway House, recovery housing, transportation, employment services, vital records reports, medical and dental services, and other unmet needs as expressed by the individual and/or identified by the Care Coordinator.

Recovery Community Centers (RCC): BHA now has twenty funded Recovery Community Centers. These centers are designed to be a safe haven for those in recovery to convene. They are also a place where interested persons in recovery can obtain a multitude of services to support a healthy and recovering lifestyle. Services include: 12-step support meetings, meditation sessions, care coordination/enrollment into MD RecoveryNet, peer support group, recovery coaching, computer access, and discussions on HIV, mental health, and tobacco use. Some RCC serve as an access point linking individuals needing somatic care, behavioral health care, and/or insurance.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based comprehensive, integrated public health approach to the delivery of providing early intervention and treatment services to patients who have risky alcohol or drug use. The SBIRT grant was awarded to Maryland for five years. Within this time, BHA's plan is to implement and expand SBIRT into 53 Community Primary Care Centers and two hospitals in 15 jurisdictions across Maryland with the expectation of screening at least 90,000 individuals.

The problem of alcohol and drug misuse is widespread in Maryland. By initiating a conversation and providing information, health care providers can normalize the conversation and help patients identify risky use early and make choices that lead to better health. The Maryland SBIRT trains health care providers in community health centers and hospitals throughout Maryland to initiate conversations with patients about alcohol and drug use, and if necessary, refer patients for further assessment or treatment.

SBIRT can reduce:

- Healthcare costs: Studies show cost savings of \$3.81 to \$5.60 for every \$1.00 invested in SBIRT services.
- Emergency department visits, Non-fatal injuries, Hospitalizations, Arrests, and Motor vehicle crashes.
- Severity of drug and alcohol use: Studies show that substance use screening and intervention help people recognize and change unhealthy patterns of use.
- Risk of physical trauma and percentage of patients who go without specialized substance use treatment.

Maryland SBIRT aims to reduce:

- Drug overdose deaths,
- Health disparity outcomes among minorities,
- Health care costs in Maryland.

The Gender-Specific Services Division of the Clinical Services Division provides oversight of gender-specific services and provides technical advice and guidance. This includes oversight of residential treatment and transitional services for pregnant women and women with children, childcare during withdrawal management initiative, recovery support specialist in pregnancy/postpartum

project, recovery housing for women and women with children, and several legislatively mandated initiatives including SB 512-Substance Exposed Newborns.

The Evidence-Based Practices, Housing and Recovery Supports Division provides oversight of Maryland RecoveryNet (MDRN), Maryland Certification of Recovery Residences (MCORR),

Certified Recovery Residences

Recovery residences are therapeutic, sober living housing for people who are not in treatment. However, in many instances, they are still receiving treatment. Under State law, BHA has been selected to serve as the credentialing entity to develop and administer a process for the certification of recovery residences in accordance with nationally recognized certification standards established by the National Alliance for Recovery Residences (NARR). In accordance with statute, certification by the Department is required for recovery residences to operate in Maryland if the residence receives state or federal funds; operates as a certified recovery residence; is advertised or represented by any individual, partnership, corporation, or other entity as being a certified recovery residence; or has been implied to the public to be a certified recovery residence. Maryland currently has 228 certified recovery residences.

Community Bond and Recovery Residences Grants

BHA has had a long-standing goal of supporting affordable, "independent" and accessible housing for individuals with mental health, substance-related, or co-occurring disorders. BHA co-sponsors the "Capital Improvement Grants and Loans for Behavioral Health, Addictions Recovery, Developmental Disabilities and Federally Qualified Health Centers Facilities" (also known as community bond) Award Program. Priority areas are for individuals with mental health and substance use disorders. The grant supports projects that effectively expand, support, or enhance capital resources (buildings, houses, projects involving bricks and mortar) for the following priority populations:

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The Children's Services Division of BHA is charged with developing a system of care for young people and their families ranging from early childhood all the way through to the time when young people reach the age of majority and legally become adults. The system of care is designed to meet the needs of individuals within this age range who have mental health conditions, substance-related disorders, and those who have both. The Division evaluates the network of services that the BHA funds for this age group and has the responsibility for statewide planning, development, administration and monitoring of provider performance to assure the highest possible level of quality in the delivery of services. The Division also manages a number of special projects and is responsible to work with all other child serving agencies at both the State and local levels to assure a highly coordinated and individualized approach to care.

Adolescent Recovery Clubhouses

The Behavioral Health Administration funds and provides oversight for eight Adolescent Recovery Clubhouses that are located in DC Metro Area, Central, and Southern Maryland. This statewide recovery-oriented support is designed for youth ages 12–17 receiving treatment for substance use disorders, including opioid use disorders, co-occurring (mental health and substance-related) disorders, or following discharge from treatment. Each unique clubhouse uses evidence-based and promising practices to provide screening, intervention, and recovery support to adolescents. Through various approaches to substance use intervention and recovery, the clubhouse's recovery-oriented model supports diminishing the triggers and cues that led to past substance use and engages youth-driven peer activities such as educational/vocational, family events, life skills, recovery planning, and social/recreational opportunities to engage adolescents in more enriching and healthy ways.

5. Does the state have any activities that it would like to highlight?

A Crisis Stabilization Center opened in Baltimore City in April 2018. The center is a 24/7 site that serves persons intoxicated with alcohol or drugs and diverts them from emergency rooms to the facility by EMS or Baltimore Crisis Response, Inc. Services provided at the Center include:

- Biopsychosocial medical assessment and vital signs are monitored
- Individuals are provision of a place to get sober and a shower
- Engagement with nurses and peer recovery specialists and connections to treatment resources
- Formulations of discharge plans

Peer Support Services

BHA's Office of Consumer Affairs organizes yearly events to commemorate National Recovery Month. This year's Recovery Month Kickoff Event will be held at BHA's Rice Auditorium on Sept. 6, 2019. To celebrate this year's theme "Together We Are Stronger," the first half day of the event will focus on personal wellness. There will be a presentation by a certified yoga instructor, who will show participants wellness skills including yoga, meditation, and journaling as possible methods of self-care. The second part of the day will focus on resources gathering. Peer Recovery Specialists will have the opportunity to network with one another as well as share information regarding "hidden resource gems" they use when assisting the individuals they work with. BHA will also

introduce the Carroll Conquest Outstanding Leadership Nomination form for 2019. The Carroll Conquest Outstanding Leadership Award is in remembrance of Carroll Conquest, who was a great advocate for the recovery community. This year will be the 3rd time that BHA has been presenting this award.

The Recovery Month Kickoff Event will provide Peer Recovery Specialists with 6 CEUs toward certification and/or re-certification. We are expecting 100-125 attendees. Various resource materials will be available at this event. Maryland Addiction and Behavioral-health Professionals Certification Board (MABPCB), Maryland's Commitment to Veterans (MCV), Maryland Coalition of Families (MCF), National Alliance of Mental Illness (NAMI), On Our Own Maryland (OOOMD), and BHA's Suicide Prevention Office and 211 Maryland will have resource tables.

Last year's Recovery Month Kickoff Event was also held at Rice Auditorium, on Sept. 7, 2018. Gayle Danley, an award winning slam poet was BHA's guest speaker for the first half of the day. She shared her work with the event participants and led a workshop on how to express one's feelings through slam poetry. She also had attendees share their work with the group. We had 2 workshops in the afternoon on Harm Reduction. The 2018 Recovery Month Kickoff Event provided 6 CEUs toward certification and recertification. 125 individuals attended this event. We had resource tables that included MABPCB, NAMI, MCF, OOOMD, and 211 Maryland.

Consumer Directed Organizations

On Our Own of Maryland (OOOMD) is a statewide peer-operated behavioral health advocacy and education organization which focuses on changing attitudes and supporting recovery. It represents 23 affiliated non-profit and peer-operated organizations which provide peer services in their local jurisdictions. OOOMD works with service providers, peers, and professional and community organizations to ensure that services and systems are trauma-informed, culturally responsive, and recovery-oriented by reducing stigmatizing practices and expanding consumer involvement in M/SUD policy formation and planning at local, state, and national levels. OOOMD organizes annual conferences where different topics of interest to the recovery community are discussed. This year, OOOMD held its 27th annual conference in June 2019 which was entitled Mindfulness in Recovery Communities: The Science and the Magic. The conference attracted over 430 individuals, making it the largest conference to date. Discussions on how the professional role of peer support specialists, career options and integration into various behavioral health systems and settings also took place at this event.

Also this year, OOOMD held its 7th Annual Young Adult Peer Support and Leadership Retreat in May. This event was organized in collaboration with Maryland Coalition of Families' Taking Flight. The event brought together 30 young adult peers from across the state to connect with one another, develop their leadership and advocacy skills, learn about navigating the behavioral health system of care, and participated in a number of creative art activities.

Housing First/Permanent Supportive Housing

The Behavioral Health Administration (BHA) has adopted the Housing First principles when housing individuals diagnosed with M/SUD seeking permanent supportive housing. BHA oversees the Housing First pilot program in 3 jurisdictions (Baltimore City, and Montgomery and Prince George's counties). The Housing First pilot prioritizes individuals being discharged from the State's psychiatric hospitals, individuals transitioning from residential rehabilitation programs and individuals experiencing homelessness or at risk of homelessness. 81 individuals have served been served by this program.

In addition to the Housing First Pilot Program, BHA has awarded funding for 12 Continuum of Care (CoC) program in the State of Maryland. BHA's CoC program provides permanent housing and supportive services to individuals with disabilities and to families with children in which one adult member has a disability. Participation in the CoC program must meet the requirements of the US Department of Housing and Urban Development's (HUD) definition of homelessness. Individuals who participate in the program are linked to the services of their choosing to ensure the success of the program. 410 households have been served by this program.

BHA has also piloted EBP, Permanent Supportive Housing (PSH) with a SAMHSA grant which ends on September 30, 2019. PSH follows the Housing First principles, which allows an individual a choice in housing and services. BHA has been introducing the concepts of PSH by drawing on the similarities of Housing First and PSH. The EBP, Housing and Recovery Supports Division at BHA has been partnering with the Planning Division on introducing PSH in the work being done to expand permanent supportive housing through MDH's Office of Capital Planning, Budgeting and Engineering Services' Community Bond grant.

Recovery Housing

Since BHA's implementation of Maryland Certification of Recovery Residences (MCORR), Recovery Residences are increasingly viewed as a viable and cost effective alternative to established recovery-oriented systems of care. Certified Recovery Residences reduces the probability of residents in early recovery returning to environments that foster addictive lifestyles, increasing the likelihood of relapse or continued substance use. Increasing the availability of housing ensures that Maryland's systems of care are responsive to the needs of all residents during their recovery process.

Recovery residences offer a unique alternative to harm reduction for residents whose main goal is to obtain a sober living environment. Recovery Residences are now monitored to ensure residents are receiving services that promote a safe and healthy living environment, assist them in their recovery with substance and/or opioid use, and improve their physical, mental, spiritual, and social well-being. Individuals are developing a mutual and peer support network while living in a recovery residence that will continue to support their recovery as they transition to living independently and productively in the community. In addition, individuals are offered an opportunity to continually surround themselves with other individuals who are pursuing the same goal of recovery and wellness within a residence that operates according to the National Alliance of Recovery Residences (NARR) standards.

MCORR is housed in the Office of Clinical Services, Adults and Older Adults under the EBP, Housing and Recovery Supports Division. The team is overseen by a Director and Program Manager and is comprised of one FTE administrative support staff and four (4) Field Assessors. The team has daily interactions with the recovery residences based on the process of certification and where a provider is in their certification process. In FY 2019, MCORR has hosted trainings and meetings throughout the year to inform providers of the certification process. MCORR will also provide emails and memos to inform the providers of changes in the

system and other important information.

MDH has promulgated regulations to set forth the requirements and processes for certification that govern recovery residences. BHA has been meeting with the Maryland Attorney General's (AG) office to review the comments to the regulations posted on its website in November 2017. Recently during the course of conversations with the AG, the AG concluded that recovery residences are subject to landlord tenant law, which results in substantial changes to proposed regulations. The Assistant Attorney General (AAG) has recommended the 2017 regulations be withdrawn and new regulations were developed in February 2019 following meetings with stakeholders. The regulations have been submitted to the Maryland's Secretary of Health for approval. Currently, BHA is waiting for a determination from the State Fire Marshal on the classification of recovery residences in order to determine which fire codes, if any, may be applicable to recovery residences. BHA has been working actively and closely with the AAG assigned to BHA. The current interpretation from the State Fire Marshal has been that fire suppression devices or sprinkler systems are required for recovery residences with more than five residents; however, this is not consistently enforced at the local level, and is further complicated by varying local fire codes which may be more restrictive than the State fire codes. The result is that recovery residences that are seeking certification from BHA may be subject to more extensive and rigorous fire inspections that those required under the National Alliance for Recovery Residence (NARR) standards on which recovery residence certification is based. This barrier has caused a number of recovery residences to reduce the number of beds. Currently there are 228 certified recovery residences and 1836 certified beds in the State of Maryland.

Recovery residences are self-funded through resident contributions. As part of their recovery, residents are expected to work, pay rent, and otherwise support the house. In some cases, residents may not be able to fully afford the cost of their stay. In such cases, residents may be eligible to apply, under certain circumstances, for short-term scholarship beds or time-limited subsidies for assistance available through Maryland RecoveryNet or the LAA/LBHA. In FY 2019, BHA--through its federal State Targeted Response (STR) and State Opioid Response (SOR) programs—provided funding for training and expansion of recovery housing which will result in increased number of certified recovery residences and beds. This award is in support of the ongoing statewide efforts to combat the opioid epidemic. The SOR grant is designed to address Maryland's opioid crisis by increasing access to evidence-based treatment, reducing unmet treatment needs and opioid related deaths through the provision of prevention, treatment, and recovery support services. Naloxone training and kits were provided to individuals residing in a recovery residence using funds from overdose response federal grants. In addition, BHA has solicited proposals from LAAs' and/or LBHAs' and corresponding providers who are interested in expanding recovery residence capacity for young adults with an OUD within their respective jurisdictions. The funding sources mentioned are allocated to the resident in need of the recovery support services and not the program.

State Opioid Response (SOR) Grant

The State will receive \$33 million a year for a two year period beginning September 30, 2019 through September 30, 2021. The purpose of the grant is to increase access to Medication Assisted Treatment (MAT), reduce unmet treatment need, and, ultimately, to decrease opioid deaths. The money provides funding for numerous projects such as Crisis Walk-In Centers, Safe Stations, Harm Reduction, and Young Adult Recovery Housing to name a few.

Money will also be used for projects that weren't funded in the past or that had limited funding such as Sign language services, services for pregnant women and women with children and workforce development.

The grant will also fund activities that will promote efforts to increase and improve services for transition aged youth (TAY). Other efforts will include expansion of:

- Screening Brief Intervention and Referral to Treatment (SBIRT)
- Hospital based intervention that includes Peer Recovery Specialists going into Emergency Departments and working with people who have had near fatal overdoses and connecting them to care
- Naloxone distribution, the saturation rate and need in our communities. Every behavioral health provider should have access to Naloxone and know how to use it
- Medication Assisted Treatment (MAT). This will give people with substance use disorders access and choices of treatment.

BHA is also exploring specialized recovery housing for adolescents, as providing a drug free environment for 16 and 17 year olds is very different than the needs of 20, 30 or 40 year olds. We are also expanding the use of Adolescent Community Recovery Approach (ACRA) an evidence-based practice (EBP) that address issues of youth who have substance use disorders.

SAMHSA has reached out to states to offer up to \$17 million supplemental funding for year two of the SOR grant. BHA is excited about this funding opportunity and will be working with the Opioid Command Center, the Secretary's and the Governor's Offices and PHA to develop a strategic plan and budget, and apply for the additional funding.

In addition to the SOR Grant money, a supplement of \$17 million dollars has just been approved by the Lieutenant Governor's Office to go towards some new initiatives. Some initiatives that will be covered with this money include:

- Minority Outreach TA
- Grants for non-profits and faith based organizations
- Workforce Development for persons in recovery
- Care Coordination Grants (something new to the SUD world)
- Department of Public Safety and Correction Services and Detention Centers

SAMHSA awarded a two year "State Targeted Response to the Opioid Crisis Grant" (Opioid STR) to BHA. The grant award will be used to address Maryland's opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) including prescription opioids as well as illicit drugs such as heroin.

The MORR initiative will take a strategic and comprehensive approach to increasing access to and enhancing services for individuals with OUD by reducing gaps throughout Maryland's PBHS. Our goal is--through utilizing a public health framework of prevention, treatment and recovery services--to reduce unmet treatment needs and opioid related deaths. Our priorities are to:

- Prevent opioid misuse and abuse through enhanced prescriber practices and public awareness
- Treat opioid dependence by expanding treatment and increasing quality
- Prevent overdose fatalities through naloxone expansion; and
- Expand recovery supports in the community.

The targeted population for this effort are adults (age 18 and older) who are experiencing an active substance (Opioid) or co-occurring (Opioid and Mental Health) disorder related crisis or emergency.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

- Does the state's Olmstead plan include :
 - Housing services provided. Yes No
 - Home and community based services. Yes No
 - Peer support services. Yes No
 - Employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶³ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁶⁴ For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.⁶⁵

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁶⁶ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁵Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult M/SUD system? Yes No
 - for youth in foster care? Yes No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

As reported in our FY 2018 – FY2019 MHBG/SABG application, Maryland’s interagency system of care is guided and operationalized by the Children’s Cabinet. The Children’s Cabinet was originally created in 1987 by the Governor as the Subcabinet for Children and Youth. It was renamed the Subcabinet for Children, Youth, and Families in 1990. Established by statute in 1993, the Subcabinet worked to improve the structure and organization of State services to children, youth, and families (Chapter 556, Acts of 1993). Authorization for the Subcabinet expired June 30, 2005, and in its place, the Governor authorized the Children’s Cabinet in June 2005 (Executive Order 01.01.2005.34).

The Children’s Cabinet coordinates the child and family-focused service delivery system by emphasizing prevention, early intervention, and community-based services for all children and families. The Children’s Cabinet includes the Secretaries from the Departments of Budget and Management; Disabilities; Health; Human Services; Juvenile Services; Labor, Licensing, and Regulation; and Public Safety and Correctional Services, as well as the State Superintendent of Schools for the Maryland State Department of Education and the Executive Director of the Governor’s Office of Crime Control and Prevention (see: <https://goc.maryland.gov/cc/>)

More recently, an Interagency Placement Team was created at the State level to oversee a network of locally driven interagency care management entities. Local Care Teams (LCTs) have been created in each of Maryland’s 24 jurisdictions under the head of Local Management Boards funded by the Governor’s Office for Children. The LCTs are tasked with the coordination of complex interagency cases at the local level. The Governor’s Office for Children was subsumed under the Governor’s Office for Crime

Description of the Major State Level Agency Partners in the System of Care

Department of Human Services – (social services including child welfare) – The social service sector in Maryland is primarily housed in the Department of Human Services (DHS). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, and formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the State's child welfare system. Other DHS social services, outside of child welfare, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers).

Of special note is a program entitled Mental Health Supportive Services (MHSS) that is funded through the DHS to local jurisdictions for Mental Health Mobile Crisis and Stabilization Services. DHS and BHA monitor these services that are designed to support foster care youth in their placements, and to avoid hospitalizations. Improved outcomes have been documented in the areas of a reduction in acute admissions, and disrupted placements. Due to these successes, some of the funding through MHSS has now been able to be used for family support services, prevention of foster care placements, and education. This has also allowed mental health to provide early intervention services for identified youth, while still being able to respond to mobilize services during times of crisis.

Maryland State Department of Education (MSDE)

MSDE and the BHA have worked on integrating School Based Mental Health (SBMH) services since the 1990's. The Center for School Mental Health (CSMH – located at the University of Maryland -Baltimore, is a nationally funded center for TA for school-based behavioral health services. These efforts also include a focus on early childhood mental health and school readiness. Through these partnerships the CSMH, MSDE, and BHA have been supported in successfully applying for a number of grants that serve to improve SBMH services across Maryland. There has also been the development of a number of Children's MH online modules that are geared to school personnel. As systems become more integrated, there is the recognition that substance use services, along with mental health services, need to be available through local school districts.

School-Based Behavioral Health Interventions - To address the need for multi-system involvement due to the high number of children and youth who are frequently involved in more than one specialized system, the state is working to strengthen the connection between available behavioral health services, and recovery support services and educational services in the Maryland public school system. BHA continues its extensive work with the Maryland State Department of Education (MSDE), both with regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). BHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services. Additionally, the MHBG supports school-based mental health initiatives that foster diversion to hospitals and RTCs, as well as funding that address school expulsion and bullying.

Also, school-based behavioral health interventions are available in Maryland along with more comprehensive School Wellness Centers that provide somatic and behavioral health services to students. These services will be expanded and made available in school settings across the State. The University of Maryland, School of Medicine (UMSOM) will partner with the BHA and provide technical assistance for the development of school mental health services. In addition, Maryland has made a significant investment in early childhood mental health by focusing on mental health programs placed in Head Start Centers that will provide mental health consultation to day care center staff around the State. The day care mental health services efforts were developed to prevent the unnecessary expulsion of young children from child care settings because of perceived behavioral problems.

Department of Juvenile Services

BHA and the Department of Juvenile Services (DJS) have a history of cooperation at the State and local levels to support behavioral health services to DJS youth in need of these services. These behavioral health services focus on the needs of youth in the care of DJS both before and after adjudication and disposition by the juvenile court.

BHA promotes behavioral health services by supporting substance use counseling within the juvenile detention centers. BHA Child and Adolescent (C&A) staff provide training for DJS direct care staff on as needed basis.

Given the prevalence of behavioral health problems in youth with DJS contact, as well as concerns youth with behavioral health problems may be at higher risk for DJS contact, BHA has extended the partnership with DJS to include substance use disorder services. DJS and BHA will develop and implement additional treatment and related recovery supports for individuals with DJS involvement, including early diversion from juvenile justice and criminal justice systems as appropriate. These developments will be planned, monitored and evaluated collaboratively by DJS and BHA in phases over the next three years.

7. Does the state have any activities related to this section that you would like to highlight?

Early Childhood Intervention: Maryland supports programs and activities for children with SED by applying available funding for prevention and treatment for SED's in early childhood, as most mental health disorders have their roots in childhood. The main strategy is to incorporate mental health services into existing early childhood programs and other community settings for infants and children up to 8 years of age. BHA recently created a Center of Excellence for Early Childhood at the University of Maryland, Division of Child Psychiatry in order to provide training and technical assistance on early childhood issues.

Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis (CHR-P) funded with SAMHSA Grant (project duration: 09/30/18-09/29/22): This project intends to fundamentally improve the lives and

functional trajectories of adolescents and young adults at clinical high-risk (CHR) for mental illness with psychosis, including schizophrenia. BHA will expand our already existing early intervention collaboration between UMSOM and University of Maryland Baltimore County (UMBC) to create a comprehensive, evidence-based, stepped model of care. Our goal also involves a commitment to community outreach, specialized training, and culturally competent service delivery that aspires towards sustainability. CHR-P program will serve individuals in Central Maryland, a demographically diverse area including Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's counties and Baltimore City. Additionally, through telehealth services, this program will provide services to rural, underserved communities. Over half of the State's population resides in Central Maryland, including approximately 770,000 between the ages of 12-24, the peak age for CHR symptoms. Services will help youth at CHR improve symptomatic and behavioral functioning; engage in developmentally appropriate activities (school, work); delay, reduce, or prevent onset of psychosis; and minimize the duration of untreated psychosis (DUP).

FY2019 Healthy Transitions (HT): Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program funded with SAMHSA grant (project duration: 03/31/19-03/3024): This project intends to create specialized services for Transition-Aged Youth (TAY) ages 16 to 25 to support them as they move from adolescence into productive adulthood. Also, this project will help support BHA's ability to provide comprehensive services across the lifespan for Maryland residents. It is highly consistent with BHA's mission to support coordinated quality care for those experiencing behavioral health disorders. The goals of the HT project are to:

Provide coordinated, high-fidelity evidence-based services and supports that are youth-driven and culturally and linguistically competent to TAY with serious mental health conditions (SMHC) in the two jurisdictions;

Expand and improve on local and statewide infrastructure and cross-agency collaboration to support seamless transition from child to adult systems for TAY with mental health challenges;

Increase early identification of TAY with mental health concerns, especially those who may otherwise fall through the cracks; and

Promote public awareness of mental health challenges faced by TAY among the general populations in the target counties, including outreach to TAY with or at-risk for developing a serious mental health condition.

Lastly, HT will provide a variety of necessary services to include clinical treatment and an array of evidence-based practices such as Supported Employment and Assertive Community Treatment. In addition, HT will have the ability to refer TAY who may be showing symptoms of psychosis to Maryland's Early Identification Program.

Behavioral Health Integration in Pediatric Primary Care (BHIPP): The BHIPP program provides a number of services to pediatric practices around the state including telephone consultation with a child psychiatrist, access to an up-to-date resource and referral data based and telemedicine intervention in selected communities. In addition, BHIPP provides for the placement of social work interns in rural and inner city pediatric practices in order to address behavioral health issues that arise on site. A recent grant from HRSA has expanded the telemedicine component.

Transitional Age Youth (TAY): For youth and young adults, individuals between the ages of 16 and 25 years, transitioning into adult responsibilities, negotiating between the child and adult serving systems requires additional coordination. Maryland had developed many partnerships between community agencies and mental services to make the process of transitioning between child and adult services more manageable. Transitional care and services provided by Maryland for children with SED in the following settings are available for those moving between institutions and the community, from one educational setting to another, in-home to out-of-home placements, as well as from out-of-state to in-state placements. Special efforts are underway with in-state residential providers to reduce the utilization of out-of-state placements, which has been showing a downward trend over recent years. As stated earlier, Maryland's 1915(i) program is designed to help address transitions that youth, young adults and their families may encounter through an array of services developed to address the unique challenges for individuals who are not fully participants in adult programs. The specific needs of this population transitioning into adulthood can include co-occurring disorders, developmental disabilities, traumatic brain injury, somatic conditions, and also involves needs for LGBTQ youth and young adults; justice-involved youth and young adults; homeless youth and young adults; and youth and young adults in the deaf and hard of hearing community. The following programs and grant-funded efforts address issues related to supported services important for youth transitioning into the community:

Consumer and Family Collaborative Initiatives: A partnership with On Our Own (OOOMD) and the Maryland Coalition of Families (MCF) around young adult leadership development has been very successful in developing increased availability of peer support for young adults and opening channels for young adult voices to be heard. OOOMD's Director of Network and Peer Services provides oversight to the activities of the Statewide Consumer Network Grant Project, technical assistance to local Wellness & Recovery Centers, TAY outreach, and liaisons with local and state agencies.

OOOMD and MCF sponsor an annual young adult leadership retreat, giving young adults the skills and peer support needed to explore working and advocating in the field. The retreat provides a number of team-building activities including ropes courses, games, zip-lines, rock-climbing, yoga, and many other activities. Workshops and activities supporting topics such as Leadership Skills, Social Justice through Art, Becoming an LGBTQ Youth Ally, and Storytelling in Peer Support & Advocacy will be led and facilitated by peers in all of the participating programs.

Other collaborative efforts that support youth involvement and activities include:

Taking Flight: Maryland Coalition of Families for Children's Mental Health Young Adult Council (grant funded). This grant is intended to cultivate a group of young adult leaders who work to empower and support young adult transition; to facilitate system collaboration in an effort to promote acceptance and education; and reduce stigma. Housed within the Maryland Coalition for Families, it works closely with other young adult peer efforts in the statewide consumer organization.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

BHA was awarded a five-year grant by the SAMHSA for youth suicide prevention. The grant provides \$735,000 per year to address specific goals and objectives. The funding and grant period ends in September 2019. Maryland's Suicide Prevention and Early Intervention Network (MD-SPIN) provides a continuum of suicide prevention training, resources, and technical assistance to advance the development of a comprehensive suicide prevention and early intervention service system for youth and young adults. MD-SPIN will increase the number of youth, ages 10–24, identified, referred and receiving quality behavioral health services, with a focus on serving high risk youth populations (LGBTQ, transition age, veterans and military families, youth with emotional and behavioral concerns) and in target settings (schools, colleges/universities, juvenile services facilities, primary care, emergency departments).

Led by BHA, key partners include the University of Maryland Department of Psychiatry, the Johns Hopkins University Bloomberg School of Public Health, the Maryland Coalition of Families, the Community Behavioral Health Association of Maryland, and the public education system (1,424 public kindergarten to 12th grade schools; 30 public universities, colleges, and community colleges; and 12 juvenile facilities programs).

Goals of MD-SPIN are to:

Enhance culturally competent, effective, and accessible community-based services and programs by developing a network that includes technical assistance and support;

Broaden public awareness of suicide by utilizing MD-SPIN to support marketing and dissemination and diffusion efforts related to suicide prevention for youth/young adults;

Increase evidence-based training opportunities for professionals and others who work with high risk groups by training a diverse, multidisciplinary group of youth and adults across the State using online suicide prevention programs (i.e., Kognito) and evidence-based resources to promote continuity of care; and

Ensure effective services to those who have attempted suicide or others affected by suicide attempt or death by developing a state training and technical assistance model to promote referral and access to and follow through with high quality care.

Maryland Crisis Connect

The Maryland Crisis Hotline began in 1990 as a youth suicide prevention line. In 2014, the line expanded to serve adults with mental health needs. In 2015, the line expanded again to take substance use calls.

The Maryland Crisis Hotline is available 24/7 to callers in need of crisis intervention, risk assessment for suicide, homicide or overdose prevention, support, guidance, and information or linkage to community behavioral health providers. The Maryland Crisis Hotline also provides assistance to accessing resources such as naloxone education, recovery support, veteran's services, and family services as available and appropriate for the individual.

Trained crisis counselors are available to assist individuals struggling with issues such as substance use, depression, anxiety, suicidal/homicidal ideation or intent, physical and sexual abuse, eating disorders, sexual identity concerns, running away, relationship problems, divorce, sexually transmitted disease, school issues or any other identified concern.

In April 2018, the Maryland Crisis Hotline partnered with 211 Maryland to establish Maryland Crisis Connect. Marylanders can now access the state crisis hotline by calling 2–1–1 and pressing option 1 to speak with a counselor about a mental health or substance use crisis. Marylanders can also access resources by visiting MDCrisisConnect.org and using the statewide resource database or crisis chat or by texting their zip code to 898–211.

New System Goals for Maryland Crisis Connect:

Create unified consistent management structure for call centers

Have one "storefront" for all regardless of which call centers is reached

Solve problems with call routing via cell towers, not number on phone

Have shared universal database for all call centers

Have consistent data reporting to BHA for system management

Align with law that identifies 211 as statewide line

TRAINING

Executive Order 01.01.2018.26D(1) requires that the Commission address training in suicide prevention, intervention, and post-suicide services. Training is an integral component of suicide prevention including current initiatives and recommendations.

Below, various training initiatives led by BHA are outlined.

A. Annual Suicide Prevention Conference

The Annual Suicide Prevention Conference is held to provide information and education on the latest topics related to suicide prevention. The conference takes place each year on the first Wednesday in October. The planning committee acquires speakers to present workshops on engaging topics related to suicide prevention including survivors of suicide, risk assessment, evidence-based practices, etc. The conference target audience is behavioral health professionals, peers, students, survivors of suicide, and interested community members.

B. Lunch and Learn Series

BHA recently launched a "lunch and learn" series on the third Thursday of every month from 12 to 1 p.m. The "lunch and learn" presentations focus on topics related to mental health and suicide prevention and are offered in person or via webinar.

C. Applied Suicide Intervention Skills Training, safeTALK, and Kognito

BHA offers Applied Suicide Intervention Skills Training (ASIST) and safeTALK workshops to the community and at the request of agencies. In May 2018, BHA hosted its first "train the trainer" for safeTALK and has trained 26 safeTALK trainers as of November 2018. Through the MD- SPIN grant, Kognito modules are available online at no cost to Marylanders. There are modules for K-12 educators, peers, military, and higher education faculty and students.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? Yes No

If so, please describe the population targeted.

Suicide attempt survivors

- Suicide loss survivors
- LGBTQ
- Individuals with disabilities and behavioral health conditions
- Native Americans
- Older adult males
- Individuals in the justice and child welfare systems
- Those who engage in non-suicidal self-injury
- Military members, veterans, and their families

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

Maryland moved to an accreditation-based licensing system for most community-based services. The Office of Accreditation works very closely with the Office of Licensing, and Office of Compliance as well as other internal BHA offices and the various Approved Accreditation Organizations responsible for accrediting community-based agencies as a pre-requisite to license application. This office works with Accreditation Organizations to ensure smooth coordination between MDH and the various Approved Accreditation Organizations. The Director of Accreditation maintains ongoing contact with management representatives of the Approved Accreditation Organizations and works closely with them to ensure that problems are resolved quickly, that confusion over standards and procedures is minimized, and that both parties are briefed on developments.

Specifics of this role include:

- Working with the AO's to ensure that new standards continue to meet the State's requirements, and that changes in State requirements are communicated to the AO's.
- Negotiating procedures to be used to ensure that accreditation and licensing is properly coordinated.
- Working with the AO's concerning problems that arise with the accreditation process, ensuring that communication is consistent.
- Working with the AO's on problem situations in which there are complaints about agencies, accreditation is endangered, or licensing/medical assistance eligibility is endangered to ensure that there is a properly coordinated response.
- Working with the AAG and Medicaid on interpretation of the regulations concerning accreditation-based licensing.
- Leading the internal workgroup which makes recommendations on decisions concerning accreditation/licensing policy.
- Providing technical assistance and training to providers, local behavioral health authorities and other stakeholders concerning accreditation and licensing. This includes monitoring and responding to the bha.regulations@maryland.gov email which providers and others may use to ask questions about the accreditation-licensing process. It also includes developing and

delivering webinars and updating the relevant web resources.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Behavioral Health Administration (BHA) continues to interface with other agencies and administrations to support a comprehensive system of mental health, somatic health, substance use, and other services and community supports. On a local level the Core Service Agencies (CSAs), Local Addiction Authorities (LAAs), and the Local Behavioral Health Authorities (LBHAs) do an excellent job of collaborating with local resources, as evidenced in their annual reports. The development of the State Behavioral Health Plan is a result of the existing collaborative/interagency efforts and cooperation, and public and private partnerships. Overall, alliances have been strengthened and new partnerships have been formed to further build upon the infrastructure, to coordinate care, and improve service systems. BHA is confident these successful partnerships will continue to support implementation of the priorities identified in our plan as exemplified in the specific interagency activities described.

State Medicaid Agency

BHA has worked with Maryland's Medical Assistance (MA) program on State Plan Amendments (SPA) and Waiver Programs such as the 1915 (i) SPA for Children, Youth and Families and Telehealth Program. The Section 1915(i) SPA amendment entitled "Intensive Behavioral Health Services for Children, Youth and Families" is designed to provide intensive care coordination utilizing the wraparound practice model with a set of highly specialized services not otherwise available to Medicaid recipients. The 1915 (i) SPA provides home and community-based services for children and youth with emotional disturbances and their families, as well as a full range of Medicaid somatic and behavioral health benefits. Participants also have access to a number of additional specialized services. These include respite care, family peer support, intensive in-home services, crisis and stabilization services, expressive and experiential therapies, for example, art, music, and equine assisted therapy, with a unique program of participant-directed customized goods and services. The Targeted Case Management program and 1915(i) service package are specifically designed to both divert and to transition youth from Residential Treatment Centers (RTC's) that are currently the primary institutional setting used for children and adolescents with SED in Maryland.

Services for behavioral health are carved out of the HealthChoice system, the mandatory managed care program for Maryland Medicaid enrollees. These services are delivered according to the 1115 waiver under the Public Behavioral Health System's (PBHS) fee- for -service (FFS) System. Under a renewed Institution for Mental Diseases (IMD) Waiver, community residential clinical services for individuals with substance use disorders (SUD) are being transferred to FFS on a rolling basis. By January 2018, specialty community residential clinical services for women and children with substance use disorders and individuals certified under Health General Article 8-507 will be available. In January 2019, providers of community residential services to level 3.1 and halfway houses were added to the FFS system. BHA continues to review provider billings and refers providers of concern to the Maryland Medicaid Fraud Control Unit.

Maryland Medicaid is the source of finance for BHA's FFS system and works in concert with Maryland's Administrative Services Organization (ASO) to provide oversight of the expanded Medicaid population. BHA participated in the Maryland Medicaid (MA) Advisory Committee and in the Medical Care Organization's (MCOs) monthly medical directors meetings. BHA also works with Maryland's MA program on issues and state plan amendments such as: Money Follows the Person, the 1915 (i) Waiver for psychiatric rehabilitation service, telemental health services, and the Medicaid Emergency Psychiatric Demonstration.

BHA has partnerships with other state agencies assisting individuals with mental and/or substance use disorders who have contact with the criminal justice or juvenile justice systems. The Office of Forensic Services cooperates with the Department of Public Safety and Correctional Services (DPSCS), in regards to individuals who require civil certification to BHA facilities, who hold the status of mandatory release, and/or who present with complex cases. The Administration collaborated with DPSCS for the expansion of DataLink, a data sharing initiative to promote the continuity of treatment for individuals with serious mental illness who are detained in the detention center. BHA also partnered with DPSCS to start the Chrysalis House Healthy Start Program, which provides services and supports to women in the correctional system who are dually diagnosed, have trauma issues, and who are pregnant or have infants.

BHA works with the Department of Juvenile Justice (DJS) to plan mental health services and oversee behavioral health programs for youth within their juvenile detention centers. They also consult with the DJS on initiatives involving children's mental health issues and participate in protocol reviews, joint meetings and symposiums, and provide trainings to DJS and judges. The mental health programs focus on the needs of youth in the care of DJS prior to adjudication and disposition by the juvenile court. The BHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis.

Partnerships in Education

The Maryland State Department of Education (MSDE) and the BHA have worked on integrating School Based Mental Health (SBMH) services since the 1990's. The partnership with MSDE includes collaborating on mutual concerns involving the mental health needs of children in school and in early childhood settings.

BHA and MSDE collaborate to provide services to children and youth and to strengthening student support services for students

in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services. BHA and MSDE also collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. The mental health block grant supports school-based mental health initiatives that foster diversion to hospitals and RTC's, as well as funding that address school expulsion and bullying. School Wellness Centers that provide somatic and behavioral health services to students will be expanded and made available in school settings across the State.

Joint efforts with the Division of Rehabilitative Services (DORS), a division of MSDE, continue regarding the Maryland Mental Health Workforce Initiative, including the continued implementation of the evidence-based practice model of Supported Employment (SE) and the dissemination of shared data and outcomes.

Child Welfare/Department of Human Services

BHA works with DHS/SSA to address the needs of children and adolescents in the foster care, child welfare and out of home placement systems. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state's child welfare system. BHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PBHS as a performance indicator.

The Student Assistance Program (SAP) Team provides training and implementation support to schools to better identify and respond to youth who are at-risk or currently using substances in Allegany, Prince George's and Baltimore City. There are three components to the SAP Team's initiative: (1) training school staff in Botvin Life Skills Substance Use Prevention Curriculum who will then deliver this curriculum to middle and high school students; (2) web-based Screening Brief Intervention and Referral to Treatment (SBIRT) Training for school nurses and counselors; and (3) telepsychiatry consultation to support psychiatrists and training of local health providers on how to provide opioid use disorder telepsychiatry.

In collaboration with the Office of Problem Solving Courts, BHA provides funding and oversight to establish drug treatment courts or Drug Courts. These courts are specialized court dockets that target criminal defendants and offenders, juvenile offenders, and parents with pending child welfare cases who have alcohol and other drug dependency problems who may be better served outside of incarceration. Justice involved individuals agree to participate in structured, intensive treatment programs. Participating health authorities agree to participate in team meetings, attend court status hearings, collect data (i.e., case notes, drug tests), and work with case managers and coordinators for consultation on participants progress, issues.

DHS provides a spectrum of effective community-based services and supports including services for children in homeless families and homeless youth. BHA has funded and provided technical assistance to a project for young children who are homeless, children living with their mothers and other family members in family shelters throughout Baltimore City. This outreach focuses on family shelters across the entire city. The unmet needs of youth that are homeless are extensive, however the exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. BHA has been participating in the efforts of DHS and local communities to implement the Homeless Management Information System statewide.

In collaboration with the State's Opioid Operations Command Center (OOCC), BHA provided consultation and technical assistance to Opioid Intervention Teams (OITs) on performance measurement and performs ongoing (quarterly) monitoring of OIT performance.

- o Two quarterly performance summary reports have been produced to date.
- o Prepared and conducted two webinars for OIT representatives pertaining to performance measurement.
- Technical assistance to the OOCC on development of a set of core performance metrics for use in monitoring progress in addressing the opioid crisis.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁶⁹

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁶⁹<https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Commission to Study Mental and Behavioral Health in Maryland

In January 2019, Lt. Governor Rutherford announced Executive Order 01.01.2019.06, signed by Governor Hogan, establishing the Commission to Study Mental and Behavioral Health in Maryland. The commission, which is chaired by Lt. Governor Rutherford, has been tasked with studying mental health in Maryland, including access to mental health services and the link between mental health issues and substance use disorders. The commission includes representatives from each branch of State government, representatives from the State departments of Health, Public Safety and Correctional Services, and Human Services, as well as the Maryland State Police, the Maryland Insurance Administration, the Opioid Operational Command Center (OCC), and six members of the public with experience related to mental health including representation from BHA and the BHAC.

The Commission is conducting regional meetings across the State to elicit stakeholder input. From these meetings, the Commission will formulate recommendations to advise and assist the Governor to improve access to a continuum of mental health services, including: (1) improving the statewide, comprehensive crisis response system; and (2) ensuring parity of resources to meet mental health needs. The Commission has held three regional meetings throughout the State with at least two more meetings scheduled before the end of 2019.

Systems Management Integration Plan

BHA, through the work of a consultant, has been working with the 24 local jurisdictions to implement the Local Systems Management Integration Plan. The goal of integrated systems management is to support the delivery of high-quality, culturally and linguistically appropriate, person-centered behavioral health experiences in a timely manner, regardless of which "door" a person enters the system. The plan was developed to provide clarity, support, and a consistent framework to guide progress toward integrated systems management, while affirming the importance of local control and flexibility in design.

The Plan lays out a Roadmap with pathways and milestones to mark progress toward full systems management integration. It also includes a Systems Management Integration Toolkit with several elements to support local jurisdictions in their own processes to increase integration. Working with key partners, local jurisdictions can adapt and use the tools that are most relevant to their situation and needs, tailored to reflect their specific approach

to managing the change process. The Integration Plan was developed in collaboration with local and statewide stakeholders.

BHA will oversee implementation of the Integration Plan between FY2019 and FY2022. This will include outreach and engagement with interested stakeholders, as well as Learning Communities so that local jurisdictions can learn from peers and other experts.

Local Planning Level

BHA continues to move toward strategic integration of behavioral health and the vision is to provide "improved health, wellness, and quality of life for individuals across the life span through a seamless and integrated behavioral health system of care. Core Service Agencies (CSAs) and Local Addiction Authorities/Local Behavioral Health Authorities (LAAs/LBHAs) have the authority and responsibility, in collaboration with BHA, to plan, develop, and manage a coordinated network of Maryland's public behavioral health services in a defined service area.

CSA's, LAAs and LBHAs develop plans to describe how the local behavioral health entities plan, develop and manage a full range of prevention, intervention, treatment and recovery services. These plans include discussions that identify any issues or initiatives within the jurisdiction that are important in understanding the local plan in the context of the broader system. They also describe what activities are planned or implemented that support BHA priorities of moving toward an integrated system of care and improving access and quality of services throughout the continuum of care.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? Yes No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Behavioral Health Advisory Council, established through legislation effective October 1, 2015, was established to promote advocacy for planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and that integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the State. The Council is also responsible for promoting and advocating for a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment, and recovery services that supports and fosters wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The Council has established by-laws, elected officers and implemented a committee structure which integrates mental health and substance use disorders across the lifespan. This integration is evident by membership composition- co-chairs (one from each area) and the committees' membership.

The council is composed of consumers/participants, family members of persons with behavioral health disorders, behavioral health professionals, representatives of other State agencies, and other interested citizens who serve as important sources of advice and advocacy in Maryland. Members provide important input into the planning and policy development of the Public Behavioral Health System (PBHS). The Council has implemented a solid committee structure to further enhance full participation of members and other stakeholders to monitor the system of care, to facilitate and inform the planning process and policy making decisions of BHA, and to maintain the connection with Local Behavioral Health entities. These committee structures provide work that have impacted or influenced advocacy and give greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning, prevention, cultural and linguistic competency, children and adolescents (including SED issues), adults and older adults, criminal justice, and crisis services.

Committees report out at each Council meeting, which affords members the opportunity to comment, question, or share concerns on committees they may not be able to attend regularly. This offers a more collaborative effort and helps committee members stay informed on planning, goals, and policy efforts of other subcommittees. Council meetings are open to the public and non-committee members are encouraged to participate. Non-committee members often include individuals with lived experience, community stakeholders, and experts in the behavioral health field, which provides the subcommittees with valuable input from many aspects of the system. Each subcommittee is charged with developing recommendations for input and advocacy for the PBHS in Maryland as it relates to the Council's overarching mission and duties.

Standing Committees - As listed currently in the Behavioral Health Advisory Council By-Laws

There are three standing committees:

A. Executive Committee:

The Executive Committee shall be composed of the Council Co-Chairs, together with any standing committee and ad hoc committee chairs and co-chairs. The Executive Committee shall meet as needed. The Executive Committee responsibilities include, but are not limited to: preparing, reviewing or approving testimonies, other public presentations, documents, or reports submitted on behalf of the Council especially when review and approval of the entire Council is not possible for timely submittal

of items of critical importance, etc. Another duty of the Executive Committee is to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

B. Planning Committee:

The Planning Committee addresses efforts that comply with the Federal Mental Health Block Grant (MHBG) requirement. The duties of this committee include participation in a yearlong planning process comprised of development, review, and final recommendation of the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application which may be used to inform special projects. The committee also identifies focus areas/issues to be monitored and makes recommendations to the Council. As mentioned, the Planning Committee provided initial and final reviews of BHA's Behavioral Health Plans, including the strategies linked to the federal block grant applications. As mentioned, the Planning Committee provided initial and final review of BHA's Behavioral Health Plans, including the strategies linked to the federal block grant applications.

C. Prevention Committee:

The Prevention committee addresses efforts that comply with the Federal Substance Abuse Block Grant (SABG)/Strategic Prevention Framework Grant (SPFG) which began in September 2015 and ends September 2020 at \$1.6 million per year. The Prevention Committee serves as Maryland's required Strategic Prevention Framework Advisory Committee (SPFAC). This is a requirement for recipients of Strategic Prevention Framework grants from SAMHSA for monitoring progress and strengthening the initiative. The focus during the second phase of the initiative is to prevent and reduce under-age drinking and youth binge-drinking. To prepare for this initiative, the Committee reviewed youth substance use and consequences data, such as the Maryland Youth Risk Behavioral Survey (YRBS) and the Substance Use and Outcomes 2015 Epidemiological State Profile. The Committee identifies system gaps through a needs assessment and facilitates a process for analyzing and ranking the substance use and consequences data, using the rankings to support priorities and make recommendations.

BHA continues to play a central role in supporting PBH treatment services, however, the Public Health Services (PHS) division of the Maryland Department of Health (MDH) will assume responsibility for areas of opioid response aligned with existing public health activities, which includes health promotion and prevention. As of February 4, 2019 the Prevention unit shifted from BHA to PHS.

The membership and committee structure of the new Behavioral Health Advisory Council meets the federal requirements for the behavioral health planning (in statute - section, Title XIX, subpart 3 of the Planning Law 99-660), as well as the requirements for Strategic Prevention Framework grants from SAMHSA (focusing on substance abuse prevention and treatment or co-occurring disorder issues, concerns).

Ad Hoc Committees

These committees have been formed, as needed, to address specific duties, needs, or issues as deemed appropriate by the Executive Committee or Council:

A. Children, Young Adults, and Families Committee:

The duties of this committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, as it relates to children, young adults and families, including individuals with SED. which are important for a system of care for behavioral health services and supports. The committee has been reviewing crisis services for children and adolescents in other states as well as Maryland and assessing them for how they handle integration related issues. As a result, the committee identified recommendations that they shared with the Crisis Services Committee. Committee members also identified priorities in the areas of stigma reduction, including expanding awareness and use of tools such as Youth Mental Health First Aid and increasing communication and education about the opioid epidemic. The Committee is also looking into the amount of MHBG funding for Children and Adolescent services.

B. Recovery Services and Supports Committee:

The duties of this committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, as it relates to adults and older adults including individuals with SMI, other mental health and/or substance-related disorders, which are important for a comprehensive system of behavioral health services and supports. The Committee welcomed the challenge to identify recommendations to further improve the PBHS. Key focal points of the Recovery Services and Supports Committee included but were not limited to: Overdose prevention – saving lives through naloxone access and stabilizing the expanding opioid epidemic; promotion of anti-stigma efforts – addressing the stigma of mental health and substance use disorders; and timely access to a full range of continuum of care – Crisis intervention, housing (recovery housing, supported housing), wrap around services, supported employment, and effective standards of care.

C. The Cultural and Linguistic Competence Committee:

The primary objective of the Cultural and Linguistic Competence Committee is to assist the Council in its role of gathering and disseminating information about the role culture plays in the delivery of behavioral health services and generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services. The Committee actively participated in the drafting of BHA's FY2019-2020 Cultural and Linguistic Competency

Strategic Plan. Currently, it is working on identifying and recommending strategies for the delivery of culturally and linguistically appropriate behavioral health services as part of the implementation of BHA's Cultural and Linguistic Competence Strategic Plan and future planning activities.

D. Criminal Justice/Forensics Committee:

The purpose of this committee is to advise the Council regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems. Committee members have been focusing on: the clarification of the Maryland's Health General 8-505 and 8-507, which describe orders for commitment of individuals to a behavioral health facility or residential treatment by the court; efforts to ensure that a statewide diversion system provides access, sufficient capacity, and high-quality care to individuals requiring substance use treatment; the impact of barriers faced by individuals eligible for discharge from State facilities, and the reduction of the waiting list for State hospital beds; implementation of the Justice Reinvestment Act, Senate Bill 1005, that manages and allocates criminal justice populations in a more cost effective manner, and reinvests savings in strategies that decrease crime; and examining gaps in Maryland's current substance use treatment system. The Committee has been looking into the impact on the transfer of grants to fee for service structure, and issues related to staffing requirements for substance use disorder (SUD) Residential services. The Committee will continue to evaluate issues around quality of care delivered throughout the State and develop a set of recommendations to submit to the Governor.

Final Thoughts

Throughout the year Council members continued to gather and share pertinent information from people in recovery, families, and other involved stakeholders through full Council presentations on a variety of topics such as those that focused on the progress of the Crisis Services Committee, overview of the Federal Block Grants (SUD and MH), progress reports from all Council committees, update on Maryland Medicaid and support for maintaining benefits of the Medicaid expansion despite challenges to the ACA, and monitoring of the activities of the Maryland OOC through regular reports. The work from the Council and subcommittees as a whole will continue to drive positive change within Maryland's Behavioral Health System.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.⁷⁰

⁷⁰There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

21. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

Behavioral Health Advisory Council (BHAC)/Planning Committee Plan Review

The Behavioral Health Advisory Council's (BHAC) Planning Committee and other stakeholders have participated in several processes related to the development and review of State and Local behavioral health plans. The Planning Committee of the BHAC is involved in the development, review and final recommendations of Maryland's State Behavioral Health Plan, the Federal Combined Block Grant and the Implementation Reports of these documents. The Planning Committee provides the overall recommendations to strategies on behalf of the full BHAC. Also, the Committee is involved in BHA's State Behavioral Health Planning process through discussions of local jurisdiction plans which are developed by Maryland's local behavioral health entities (Core Service Agencies, Local Addiction Authorities and Local Behavioral Health Authorities); and participation in the Stakeholder regional meetings and in review of the recommendations from these meetings.

On August 20, 2019 the Planning Committee met to review the recommendations derived from the Regional Stakeholder meetings, as well as identify recommendations or concepts/strategies for the goals and objectives for the FY 2020-2021 State Behavioral Health Plan. Sections of the FY 2020-2021 Combined Block Grant Application were also reviewed.

The Committee approved the recommendations that emanated from the regional stakeholder meetings and emphasized the importance of underpinning them with:

CULTURAL COMPETENCE AND ELIMINATION OF DISPARITIES

- Promote respect and responsiveness to the health beliefs, practices, and cultural and linguistic needs of diverse population groups.
- Institute the use of culturally and linguistically appropriate services (CLAS) standards in the Maryland's Public Behavioral Health System (PBHS) to eliminate health disparities among various ethnic, racial, and other minority groups.

INTEGRATED RESOURCES MANAGEMENT SYSTEM

- Develop a streamlined and effective system for planning and budgeting that track expenditures and fund balances.
- Develop and implement strategies for value-based contracting.

Stakeholder Involvement

BHA hosted four (4) regional stakeholder information meetings between April and May of 2019 to solicit input from stakeholders across the State on Maryland's PBHS to inform local, state and federal planning activities, including the FY2020-2021 State Behavioral Health Plan (henceforth called The Plan). These series of brainstorming sessions generated ideas and recommendations that will help in the development and implementation of strategies to further support BHA's major goals and priority areas.

The meetings represented Maryland's Southern, Western, and Central and the Eastern Shore regions and included representatives from consumer, family and provider organizations, behavioral health advisory committees, local behavioral health authorities (Core Service Agencies, Local Addiction Authorities and Local Behavioral Health Authorities), and other State Agencies. These broader stakeholder meetings afforded participants the opportunity to engage in open dialogue on systems integration, identify gaps in service delivery, and provide policy recommendations. Participants performed a SWOT Analysis (Strengths, Weaknesses, Opportunities, and Threats) as a way to provide

their perspectives of the strength, weaknesses and needs of the State behavioral health system. The meetings concluded with stakeholders' recommendations to BHA. Recommendations noted from each meeting share common themes that include workforce development, data collection and outcomes, financial and systemic challenges, and resource development.

The following recommendations were themes that evolved across the four regional stakeholder meetings:

WORKFORCE DEVELOPMENT AND TRAINING

- Develop new and innovative approaches to professional recruitment and retention
- Expand opportunities for training/professional development
- Improve pay rates, address licensing and credentialing issues, and create incentives

DATA COLLECTION/OUTCOMES

- Develop one standard approach to data collection with a set of quality indicators and measures
- Develop outcomes based on client preference with emphasis on value based social determinants
- Identify funding to incentivize performance based- outcomes

RESOURCES AND SERVICES

- Increase services across the lifespan and for special/underserved populations e.g. (geriatric/older adults, TAY, children/adolescents, TBI/dementia and other minority groups)
- Expand telehealth, residential MH and SUD, wraparound, housing, mobile treatment and peer support services

FINANCIAL/SYSTEMIC

- Develop better communication and collaboration between agencies, providers, and consumers to improve systems access and integration.
- Identify efforts to improve the process reimbursement structure/rates setting and the credentialing/licensing process to enhance provider service delivery.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Opioid Response

In January 2019, the Secretary of the Maryland Department of Health (MDH) issued directives to address the State's opioid epidemic as a successful response to Maryland's opioid crisis is a top priority for MDH and requires action across all units. Firstly, he established a Departmental Opioid Steering Committee (DOSC) comprised of leadership from all Administrations. The DOSC serves as an internal forum through which Department Heads will make recommendations to the Secretary on their goals and outcome measures to reduce fatal and nonfatal overdoses; and increase the number of Marylanders who successfully complete M/SUD treatments. Secondly, the DOSC will develop and integrate a surveillance network that provides coherent and timely data to inform decision-making and action. Thirdly, it will guide unified MDH communication and action with the public and our various partners.

As stated below in paragraph 2 under Prevention Committee, some opioid-response programs aligned with public health activities have been moved from BHA to MDH's Public Health Services (PHS) Division to improve coordination of programs. These include surveillance, health promotion, prevention, screening, early intervention and referral into treatment.

Local Planning Level

BHA continues to move toward strategic integration of behavioral health and the vision is to provide “improved health, wellness, and quality of life for individuals across the lifespan through a seamless and integrated behavioral health system of care. Core Service Agencies (CSAs) and Local Addiction Authorities (LAAs) and Local Behavioral Health Authorities (LBHAs) have the authority and responsibility--in collaboration with BHA--to plan, develop, and manage a coordinated network of Maryland’s public behavioral health services in a defined service area.

CSAs, LAAs and LBHAs develop plans to describe how the local behavioral health entities plan, develop and manage a full range of prevention, intervention, treatment and recovery services. These plans include discussions that identify any issues or initiatives within the jurisdiction that are important in understanding the local plan in the context of the broader system. They also describe what activities are planned or implemented that support BHA priorities of moving toward an integrated system of care and improving access and quality of services throughout the continuum of care.

Systems Management Integration Plan

BHA, through the work of a consultant, has been working with the 24 local jurisdictions to implement the Local Systems Management Integration Plan. The goal of integrated systems management is to support the delivery of high-quality, culturally and linguistically appropriate, person-centered behavioral health experiences in a timely manner, regardless of which “door” a person enters the system. The plan was developed to provide clarity, support, and a consistent framework to guide progress toward integrated systems management, while affirming the importance of local control and flexibility in design.

The Plan lays out a Roadmap with pathways and milestones to mark progress toward full systems management integration. It also includes a Systems Management Integration Toolkit with several elements to support local jurisdictions in their own processes to increase integration. Working with key partners, local jurisdictions can adapt and use the tools that are most relevant to their situation and needs, tailored to reflect their specific approach to managing the change process. The Integration Plan was developed in collaboration with local and statewide stakeholders.

BHA will oversee implementation of the Integration Plan between FY2019 and FY2022. This will include outreach and engagement with interested stakeholders, as well as Learning Communities so that local jurisdictions can learn from peers and other experts.

Commission to Study Mental and Behavioral Health in Maryland

Also in January 2019, Lt. Governor Rutherford announced Executive Order 01.01.2019.06, signed by Governor Hogan, establishing the Commission to Study Mental and Behavioral Health in Maryland. The Commission, which is chaired by Lt. Governor Rutherford, has been tasked with studying mental health in Maryland, including access to mental health services and the link between mental health issues and substance use disorders. The Commission includes representatives from each branch of State government, representatives from the State departments of Health, Public Safety and Correctional Services, and Human Services as well as the Maryland State Police, the Maryland Insurance Administration, the Opioid Operational Command Center (OCCC), and six members of the public with experience related to mental health. Representatives from BHA and BHAC also members of the Commission.

The Commission is conducting regional meetings across the State to elicit stakeholder inputs. It will then formulate recommendations to advise and assist the Governor to improve access to a continuum of mental health services based on the stakeholders’ inputs, including: (1) improving the statewide, comprehensive crisis response system; and (2) ensuring parity of resources to meet mental health needs. The Commission has held three regional meetings throughout the State with at least two more meetings scheduled before the end of 2019.

SUD Residential IMD Waiver

During 2017-2019, MDH, under the SUD Residential IMD Waiver, phased in the transition of the transfer of grant funded SUD residential services to fee for service model. BHA in collaboration with Medicaid and the ASO managed the implementation of the residential SUD waiver starting. The ASAM residential levels initially impacted were 3.3, 3.5, 3.7 and 3.7 WM.

Phase 1 - encompassed opening these services only to existing providers who were providing the grant funded services.

Phase 2 - was rolled out on 01/01/2018 and it included the management of special populations such as 8-507 and Pregnant Women and Children program (PWC); and

Phase 3 - included the management of 3.1 level of care services (recovery/halfway residences) that was implemented on 1/1/2019.

One of the essential elements of the treatment continuum within the state of Maryland is the role of care coordination. Each of the local jurisdictions have various teams of care coordinators that assist recipients with obtaining a variety of supports to assist members in their recovery process.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities?

The Council was created to integrate the activities of two separate Councils: The Maryland Advisory Council on Mental Hygiene and The Maryland State Drug and Alcohol Abuse Council. The two councils were repealed through SB 174 (2015) effective October 1, 2015 to create the new Behavioral Health Advisory Council, which was intended to combine the strengths of the two existing councils. From this time on, the Council's mission has been advocating for continued and increased access to services, and promoting adequate and appropriate wellness and prevention activities for individuals with mental illness and substance-related disorders.

Behavioral Health Crisis Response Grant Program

Through the passage of legislation HB682/SB551, the Council was charged with developing a strategic plan for ensuring that clinical walk-in services and mobile crisis teams were available statewide. The Council established a Steering Committee to guide the process for the development of the Maryland Crisis Services Strategic Plan. The subcommittee researched best practices on the delivery of crisis interventions with particular focus on mobile crisis response and voluntary walk-in centers. The Council shared the draft plan with the CSAs, LAAs and LBHAs for their recommendations and inputs. The Crisis Services Strategic Plan was presented to the 2018 Legislative Session and HB 1092/SB 703 was passed establishing an opportunity for local health Departments (LDHs), CSAs, LAAs, LBHAs and community providers statewide to apply for funding to develop and /or expand behavioral health crisis services.

The funding is to be used to create services that provide access or linkages to treatment through mobile crisis teams, crisis walk-in services or residential crisis beds to those in immediate, in-person crisis intervention and stabilization. Individuals will also be offered the opportunity to connect with ongoing behavioral health treatment, peer and recovery support services, case management assistance and transportation as a warm handoff to additional care as needed. Crisis services should be responsive to local needs and integrated into the behavioral health crisis care system. The goal is to divert people in crisis away from emergency departments and provide stronger links to community-based behavioral health care for individuals who have not been engaged by the behavioral health system.

Data collection, monthly reporting requirements, and site visits will be in place in order to monitor and evaluate the quality of the services. Local behavioral health entities will be responsible for tracking outcomes that demonstrate the reach, benefits and impact of these services.

BHAC Meetings

BHAC meetings allow the sharing of projects, initiatives, conferences and community events on both mental health and substance use, including other addictive disorders, such as gambling and tobacco cessation. Some examples of information that has been shared over the past year are: youth organization Active Minds-Changing the Conversation about Mental Health; HB1522 Needs Assessment for Student School-Based Behavioral Health Services; Sobriety Treatment and Recovery Team (START) initiative through Department of Human Services; new commissions and committees; conferences of advocacy organizations such as On Our Own of Maryland and National Alliance on Mental Illness (NAMI); available grants and funding; Cultural and Linguistic Competency seminar; and legislative updates.

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, etc.)?

BHAC consists of 54 members - 28 in statute Ex-Officio members (or designees) representing state and local governments, the Judiciary, and the Legislature; 12 members appointed by the Secretary of the MDH, representing behavioral health provider and consumer advocacy groups; and 14 representatives that include individuals who are consumers, family members, professionals, and involved community members. According to the legislation, membership is to be appointed/selected composed of balanced representation from areas of mental health and substance use disorders and a range of geographical areas of the State. Membership is also representative of different ethnicities/races, genders, cultures, age groups and languages, including American Sign Language.

Of the 53 current members, there are 2 Hispanic individuals, 1 Asian and 9 African Americans. The Deaf and Hard of Hearing communities are represented by a member of the Governor's Office of Deaf and Hard of Hearing. Sign language interpreters are available at meetings. There are two members representing youth who are under the age of 27, one family member, two individuals formerly or currently receiving services and two parents of a young child. There are 35 female members and 14 male members. In addition to the four representatives from the local County Behavioral Health Advisory Councils (one from each region of the State), members represent rural, suburban, and urban areas of the State. There are also non-Council members who participate in the Council committees to add to the diversity. Additional information can be found in the Behavioral Health Council Composition by Member Type chart elsewhere in this Block Grant section. The membership and committee structure of the BHAC also meets the federal requirements for the behavioral health planning section, Title XIX, subpart 3 of the Planning Law 99-660.

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders; how as it advocated for individuals with SMI or SED?

BHAC, established through legislation effective October 1, 2015, promotes advocacy for planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the State. The Council is also responsible for promoting and advocating for a culturally competent and comprehensive approach to publicly-funded prevention, early intervention, treatment, and recovery services that supports and fosters wellness,

recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

The Council has established by-laws, elected officers and implemented a committee structure which integrates mental health and substance use disorders across the lifespan. This integration is evident by membership composition: co-chairs (one from each area) and the committees' membership.

The council is composed of consumers/participants, family members of persons with behavioral health disorders, behavioral health professionals, representatives of other State agencies, and other interested citizens who serve as important sources of advice and advocacy in Maryland. Members provide important input into the planning and policy development of the PBHS. The Council has implemented a solid committee structure to further enhance full participation of members and other stakeholders to monitor the system of care, to facilitate and inform the planning process and policy making decisions of BHA, and to maintain the connection with local behavioral health entities. These committee structures provide work that have impacted or influenced advocacy and give greater focus to specific areas of interest within the behavioral health arena and across the lifespan. These areas include planning, prevention, cultural and linguistic competency, children and adolescents (including SED issues), adults and older adults, criminal justice, and crisis services.

Committees report out at each Council meeting, which affords members the opportunity to comment, question, or share concerns on committees they may not be able to attend regularly. This offers a more collaborative effort and helps committee members stay informed on planning, goals, and policy efforts of other subcommittees. Council meetings are open to the public and non-committee members are encouraged to participate. Non-committee members often include individuals with lived experience, community stakeholders, and experts in the behavioral health field, which provides the subcommittees with valuable inputs from many aspects of the system. Each subcommittee is charged with developing recommendations for input and advocacy for the PBHS in Maryland as it relates to the Council's overarching mission and duties.

Standing Committees - As listed currently in the Behavioral Health Advisory Council By-Laws

There are three standing committees:

A. Executive Committee:

The Executive Committee shall be composed of the Council Co-Chairs, together with any standing committee and ad hoc committee chairs and co-chairs. The Executive Committee shall meet as needed. The Executive Committee's responsibilities include, but are not limited to: preparing, reviewing or approving testimonies, other public presentations, documents, or reports submitted on behalf of the Council especially when review and approval of the entire Council is not possible for timely submission of items of critical importance, etc. Another duty of the Executive Committee is to develop and identify directives and initiatives for the work of standing and ad hoc committees, as well as provide oversight, when needed, to ensure that each committee of the Council completes assigned special projects.

B. Planning Committee:

The Planning Committee addresses efforts that comply with the Federal Mental Health Block Grant (MHBG) requirements. The duties of this Committee include participation in a yearlong planning process comprised of development, review, and final recommendations of the Maryland Behavioral Health Plan and Federal Mental Health Block Grant Application which may be used to inform special projects. The Committee also identifies focus areas/issues to be monitored and makes recommendations to the Council. As mentioned, the Planning Committee provided initial and final reviews of BHA's Behavioral Health Plans, including the strategies linked to the Federal Block Grant applications.

C. Prevention Committee:

The Prevention Committee addresses efforts that comply with the Federal Substance Abuse Block Grant (SABG)/Strategic Prevention Framework Grant (SPFG) which began in September 2015 and ends September 2020 at \$1.6 million per year. The Prevention Committee serves as Maryland's required Strategic Prevention Framework Advisory Committee (SPFAC). This is a requirement for recipients of Strategic Prevention Framework grants from SAMHSA for monitoring progress and strengthening the initiative. The focus during the second phase of the initiative is to prevent and reduce under-age drinking and youth binge-drinking. To prepare for this initiative, the Committee reviewed youth substance use and consequences data, such as the Maryland Youth Risk Behavioral Survey (YRBS) and the Substance Use and Outcomes 2015 Epidemiological State Profile. The Committee identifies system gaps through a needs assessment and facilitates a process for analyzing and ranking the substance use and consequences data, using the rankings to support priorities and make recommendations.

BHA continues to play a central role in supporting PBH treatment services. However, the PHS Division of MDH will assume responsibility for areas of opioid response aligned with existing public health activities, which includes health promotion and prevention. As of February 4, 2019, the Prevention Unit shifted from BHA to PHS.

The membership and committee structure of the new Behavioral Health Advisory Council meets the federal requirements for the behavioral health planning (in statute - section, Title XIX, subpart 3 of the Planning Law 99-660), as well as the requirements for Strategic Prevention Framework grants from SAMHSA (focusing on substance abuse prevention and treatment or co-occurring disorder issues, concerns).

Ad Hoc Committees

These committees have been formed, as needed, to address specific duties, needs, or issues as deemed appropriate by the Executive Committee or Council:

A. Children, Young Adults, and Families Committee:

The duties of this Committee are to identify recommendations for the development of strategies and initiatives, including evidence-based practices, as it relates to children, young adults and families, including individuals with SED which are important for a system of care for behavioral health services and supports. The Committee has been reviewing crisis services for children and adolescents in other states as well as Maryland and assessing them for how they handle integration related issues. As a result, the Committee identified recommendations that they shared with the Crisis Services Committee. Committee members also identified priorities in the areas of stigma reduction, including expanding awareness and use of tools such as Youth Mental Health First Aid and increasing communication and education about the opioid epidemic. The Committee is also looking into the amount of MHBG funding for Children and Adolescent services.

B. Recovery Services and Supports Committee:

The duties of this Committee are to identify recommendations for the development of strategies and initiatives such as evidence-based practices, as it relates to adults and older adults including individuals with SMI, other mental health and/or substance-related disorders, which are important for a comprehensive system of behavioral health services and supports. The Committee welcomed the challenge to identify recommendations to further improve the PBHS. Key focal points of the Recovery Services and Supports Committee included but were not limited to: Overdose prevention – saving lives

through naloxone access and stabilizing the expanding opioid epidemic; promotion of anti-stigma efforts – addressing the stigma of mental health and substance use disorders; and timely access to a full range of continuum of care – crisis intervention, housing (recovery housing, supported housing), wrap around services, supported employment, and effective standards of care.

C. The Cultural and Linguistic Competence Committee:

The primary objective of the Cultural and Linguistic Competence Committee is to assist the Council in its role of gathering and disseminating information about the role culture plays in the delivery of behavioral health services and generate recommendations and concepts that will facilitate the development of cultural and linguistic competence and culturally responsive services. The Committee actively participated in the drafting of BHA's FY2019-2020 Cultural and Linguistic Competency Strategic Plan. Currently, it is working on identifying and recommending strategies for the delivery of culturally and linguistically appropriate behavioral health services as part of the implementation of BHA's Cultural and Linguistic Competency Strategic Plan and future planning activities.

D. Criminal Justice/Forensics Committee:

The purpose of this Committee is to advise the Council regarding the delivery of behavioral health services to individuals who are involved with the criminal and juvenile justice systems. Committee members have been focusing on: the clarification of the Maryland's Health General 8-505 and 8-507, which describe orders for commitment of individuals to a behavioral health facility or residential treatment by the court; efforts to ensure that a statewide diversion system provides access, sufficient capacity, and high-quality care to individuals requiring substance use treatment; the impact of barriers faced by individuals eligible for discharge from State facilities and the reduction of the waiting list for State hospital beds; implementation of the Justice Reinvestment Act, Senate Bill 1005, that manages and allocates criminal justice populations in a more cost effective manner, and reinvests savings in strategies that decrease crime; and examining gaps in Maryland's current substance use treatment system. The Committee has been looking into the impact on the transfer of grants to fee for service structure, and issues related to staffing requirements for substance use disorder (SUD) residential services. The Committee will continue to evaluate issues around quality of care delivered throughout the State and develop a set of recommendations to submit to the Governor.

Member Involvement

The BHAC held a Strategic Planning Retreat in July 2019. The purpose of the retreat was to clarify the strategic focus and expected activities to ensure that BHAC has a positive impact on improving the Behavioral Health System in Maryland; and to develop a shared understanding and strengthened commitment to BHAC activities for FY2020. In preparation for the retreat, all BHAC members were asked to complete a short survey. The results were used to refine the retreat agenda and meeting materials. The BHAC Committees provided FY2019 reports that addressed the purpose and lessons learned, impact or outcomes achieved, obstacles and challenges, and recommendations going forward. The retreat also looked at future BHAC activities, using the survey results to create a baseline understanding of perspectives shared by the BHAC members. Small group discussions allowed members to brainstorm. Several suggestions for improvements and potential BHAC activities for FY2020 came out of these discussions. The five common/main areas of interest were:

- **BHAC Impact**
 - What happens with BHAC recommendations? (create feedback loops and ensure follow-up)
 - Given BHAC focus on the behavioral health system, why is the Prevention Committee on hold?

- **Role Clarity**
 - What are the expectations of BHAC members? (take information back to your organization; bring information to BHAC; do more than just attend a meeting)
 - What do State agencies want from the BHAC? (sounding board for updates about program activities and for policy ideas and proposals)
- **Communication and Outreach about BHAC**
 - Do people know what the BHAC is and what it does? (agency staff and leaders; BHAC member organizations; others)
 - How is the BHAC information being shared? (conduct an information campaign)
 - How to inform and engage community members? (individuals, families, consumers; providers)
 - How to have broader community engagement? (“Nothing about us without us”)
- **Improve Understanding of the System**
 - How to raise awareness of opportunities in behavioral health: funding, engagement, etc.?
 - Is there a central repository of what is happening to shape the future of the behavioral health system, such as task forces, councils, etc.?
- **BHAC Support (Getting and Giving)**
 - How to involve State agencies beyond the BHA in supporting the BHAC? (BHAC needs to be adequately staffed to have an impact)
 - What does BHA need? How can the BHAC help? (BHAC member organizations can help with outreach and engaging communities)

At the conclusion of the retreat, members were able to identify next steps. These steps involve convening a meeting with BHA staff and the BHAC chairs to review the summary from the retreat; reaching out to key MDH and Governor’s Office staff to discuss the retreat summary and to get their advice; providing a copy of the summary to those members who were not able to attend the retreat; and working on a draft BHAC Work Plan for FY2020. From the summary, four goals were also outlined as possible content for a draft FY2020 BHAC Work Plan. The goals will help to strengthen BHAC’s foundation for having a greater impact in achieving its purpose. The four goals identified were:

- Clarify BHAC purpose, value and roles
- Increase awareness of the value of BHAC and promote it as a vital resource
- Increase the impact of the BHAC
- Improve collaboration among BHAC members

Throughout the year, Council members continued to gather and share pertinent information from people in recovery, families, and other involved stakeholders through full Council presentations on a variety of topics. Discussions were held on the progress of the Crisis Services, implementation of M/SUD programs funded by the Federal Block Grants, reports from all Council committees. BHAC also received periodic updates on Maryland Medicaid and support for maintaining benefits of the Medicaid expansion despite challenges to the ACA; and monitoring the Maryland OOC’s activities. The work from the Council and subcommittees as a whole will continue to drive positive change within the Maryland’s Behavioral Health System.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Makeitha Abdulbarr	Others (Advocates who are not State employees or providers)	MD County Behavioral Health Advisory Councils	11604 Capstan Drive Upper Marlboro MD, 20772 PH: 301-343-7765	ABDULBARR@COMCAST.NET
Barbara Allen	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Community Advocate	8325 Fall Chill Court Ellicott City MD, 21043 PH: 410-491-4149	BARBARA@JAMESPLACEINC.ORG
Robert Anderson	State Employees	Maryland Department of Juvenile Services	120 W. Fayette Street Baltimore MD, 21201 PH: 410-230-3147	ROBERT.ANDERSON1@MARYLAND.GOV
Dori Bishop	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Advocate	4204 Greenway Baltimore MD, 21218-1134 PH: 410-913-8614	DORIBISHOP@AOL.COM
Karyn Black	Others (Advocates who are not State employees or providers)	MD Assoc of Behavioral Health Authorities	Po Box 1050, 10480 Theodore Green Blvd. White Plains MD, 20695 PH: 301-609-5757	KARYNM.BLACK@MARYLAND.GOV
T-Kea Blackman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		13903 Shannock Lane Upper Marlboro MD, 20774 PH: 908-414-1468	KEA@FIREFLIESUNITE.COM
Lori Brewster	Others (Advocates who are not State employees or providers)	Maryland Association of County Health Officers	108 E Main Street Salisbury MD, 21801 PH: 410-543-6930	LORI.BREWSTER@MARYLAND.GOV
Mary Bunch	Parents of children with SED/SUD	Advocate	224 Doncaster Road Joppa MD, 21085-4414 PH: 443-617-5016	MARYBUNCH1@VERIZON.NET
			55 Wade	

Lisa A. Burgess	State Employees	Maryland Department of Health	Avenue/Dix Building Baltimore MD, 21228 PH: 410-402-8452	LISAA.BURGESS@MARYLAND.GOV
John-Pierre Cardenas	State Employees	Maryland Health Benefit Exchange	750 East Pratt Street Baltimore MD, 21202 PH: 410-547-1832	JCARDENAS@MARYLAND.GOV
Kenneth Collins	Others (Advocates who are not State employees or providers)	MD County Behavioral Health Advisory Councils	401 Bow Street Elkton MD, 21921 PH: 443-245-3772	KEN.COLLINS@MARYLAND.GOV
Shayna Dee	State Employees	Maryland Department of Health	201 W. Preston St. Baltimore MD, 21201 PH: 410-767-0802	shayna.dee@maryland.gov
Jan A. Desper Peters	Others (Advocates who are not State employees or providers)	Black Mental Health Alliance, Inc.	900 East Fayette Street Baltimore MD, 21203 PH: 410-338-2642	JANDESPER@BLACKMENTALHEALTH.COM
Kathryn Dilley	Others (Advocates who are not State employees or providers)		28578 Mary's Court Baltimore MD, 21601 PH: 410-770-4801	KDILLEY@MIDSHOREBEHAVIORALHEALTH.ORG
Lillian Donnard	Providers	MD Assoc for the Treatment of Opioid Dependence	6205 Pinehurst Road Baltimore MD, 21212 PH: 410-323-9811	LDDONNARD@GLENWOODLIFE.ORG
Catherine Drake	State Employees	Maryland Division of Rehabilitation Services	2301 Argonne Drive Baltimore MD, 21218 PH: 410-554-9440	CATHERINE.DRAKE@MARYLAND.GOV
Adelaide Eckardt	State Employees	Maryland State Senate	James Senate Office Building, Room 322 Annapolis MD, 21401 PH: 410-841-3590	ADELAIDE.ECKARDT@SENATE.STATE.MD.US
Kate Farinholt	Family Members of Individuals in Recovery (to include family members of adults with SMI)	National Alliance for Mental Illness - Maryland	10630 Little Patuxent Pkwy Columbia MD, 21044 PH: 410-884-8691	ed@namimd.org
Ann Geddes	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy Columbia MD, 21044 PH: 410-730-8267	AGEDDES@MDCOALITION.ORG
Frances Glendening	Others (Advocates who are not State employees or providers)	Maryland Association of Boards of Education	621 Ridgely Avenue Annapolis MD, 21401 PH: 410-841-5414 FX: 410-841-5424	fglendening@mabe.org

Lauren Grimes	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	On Our Own of Maryland, Inc.	7310 Esquire Court Elkridge MD, 21075 PH: 410-746-7924	LAUREN@ONOUROWNMD.ORG
Shannon Hall	Providers	Community Behavioral Health Association of Maryland	18 Egges Lane Catonsville MD, 21228-4511 PH: 202-302-8397	SHANNON@MDCBH.ORG
Christina Halpin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3607 Willow Birch Drive Glenwood MD, 21738-9650 PH: 240-778-8176	CHALPIN@MDCOALITION.ORG
Rosanne Hanratty	State Employees	Maryland Department of Aging	301 West Preston Street Baltimore MD, 21201 PH: 410-767-0708	ROSANNE.HANRATTY@MARYLAND.GOV
Carlos Hardy	Persons in recovery from or providing treatment for or advocating for SUD services	MD Recovery Organization Connecting Communities	5236 Fredcrest Road Baltimore MD, 21229 PH: 410-456-2228	CARLOS5236@COMCAST.NET
Dayna Harris	State Employees	Maryland Department of Housing and Community Development	7800 Harkins Road Lanham MD, 20706 PH: 301-429-7845	DAYNA.HARRIS@MARYLAND.GOV
Joyce Harrison	Others (Advocates who are not State employees or providers)	Academic/Research Professional	302 Wyndhurst Avenue Baltimore MD, 21210 PH: 443-923-7000	JHARRI47@JHMI.EDU
Jim Hedrick	State Employees	Maryland - Governor's Office of Crime Control and Prevention	100 Community Place Crownsville MD, 21032 PH: 410-697-9311	JIM.HEDRICK@MARYLAND.GOV
Mariana Izraelson	Providers	Maryland Addictions Directors Council	2800 Kirk Ave Baltimore MD, 21218 PH: 443-691-0954	maizraelson@gmail.com
Sylvia Lawson	State Employees	Maryland State Department of Education	200 W Baltimore Street Baltimore MD, 21201-2595 PH: 410-767-0463	SYLVIA.LAWSON@MARYLAND.GOV
Sharon Lipford	Others (Advocates who are not State employees or providers)		1009 Longstream Court Bel Air MD, 21014-2580 PH: 443-619-3659	SLIPFORD@MHAMD.ORG
George Lipman	State Employees	Maryland District Court	John R. Hargrove, Sr. Building Baltimore MD, 21225 PH: 410-878-8107	GEORGE.LIPMAN@MDCOURTS.GOV
Dan Martin	Others (Advocates who are not State employees or providers)	Mental Health Association of Maryland, Inc.	1301 York Road Lutherville MD, 21093 PH: 410-235-1178	DMARTIN@MHAMD.ORG
			45 Calvert Street	

Jonathan Martin	State Employees	Maryland Department of Budget and Management	Annapolis MD, 21401 PH: 410-260-7280	JONATHAN.MARTIN1@MARYLAND.GOV
Dana Moylan Wright	State Employees	Maryland Courts	24 Summit Avenue Hagerstown MD, 21740 PH: 240-313-2560	DANA.WRIGHT@MDCOURTS.GOV
Luciene Parsley	Others (Advocates who are not State employees or providers)	Disability Rights Maryland	1500 Union Avenue Baltimore MD, 21211 PH: 410-727-6352	LUCIENEP@DISABILITYRIGHTSMD.ORG
William Patten	Others (Advocates who are not State employees or providers)	MD County Behavioral Health Advisory Councils	701 N Adams Street Havre de Grace MD, 21078 PH: 410-273-0400	WPATTEN123@GMAIL.COM
Keisha Peterson	State Employees	Maryland Department of Human Resources	311 W Saratoga Street Baltimore MD, 21201 PH: 410-767-7144	KEISHA.PETERSON1@MARYLAND.GOV
Mary Pizzo	State Employees	Maryland Office of the Public Defender	6 St. Paul Street Baltimore MD, 21202 PH: 410-767-1839	MPIZZO@OPD.STATE.MD.US
Keith Richardson	Persons in recovery from or providing treatment for or advocating for SUD services	Natl Counc on Alcoholism and Drug Dependence of MD	11354 School House Road Mardela Springs MD, 21837 PH: 410-430-2997	XLR8ME@COMCAST.NET
Kirsten Robb-McGrath	State Employees	Maryland Department of Disabilities	217 East Redwood Street Baltimore MD, 21202 PH: 410-767-3656	KIRSTEN.ROBB-MCGRATH@MARYLAND.GOV
Jacob Salem	State Employees	Governor's Office of Deaf and Hard of Hearing	100 Community Place Crownsville MD, 21032 PH: 443-453-5797	JACOB.SALEM@MARYLAND.GOV
Dana Sauro	Youth/adolescent representative (or member from an organization serving young people)		17308 Pink Dogwood Court Mount Airy MD, 21771 PH: 240-205-5996	DANA.SAURO@GMAIL.COM
Sabrina Sepulveda	Others (Advocates who are not State employees or providers)	Medical Professional	PO Box 452 Valley Lee MD, 20692 PH: 410-394-0681	SABRINACRNP@GMAIL.COM
Jeffrey Sternlicht	Others (Advocates who are not State employees or providers)	Medical Professional	7906 Terrapin Court Baltimore MD, 21208 PH: 443-849-2528	JHSTERNY@GMAIL.COM
Deneice Valentine	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1222 Kitmore Road Baltimore MD, 21239 PH: 410-884-8691	PROGRAMSPECIALIST@NAMIMD.ORG
			12634 Spickler	

Mary Vaughan	Parents of children with SED/SUD		Road Clear Spring MD, 21722 PH: 443-741-8255 FX: 410-730-8331	cvaughan@mdcoalition.org
Ambrosia Watts	State Employees	Maryland Medicaid	201 W Preston Street Baltimore MD, 21201 PH: 410-767-9732	AMROSIA.WATTS@MARYLAND.GOV
Tracey Webb	State Employees	Maryland Governor's Office for Children	100 Community Place Crownsville MD, 21032 PH: 410-697-9252	TRACEY.WEBB@MARYLAND.GOV
Anita Wells	Others (Advocates who are not State employees or providers)	Academic/Research Professional	382 Homeland Southway Baltimore MD, 21212 PH: 443-885-3495	AMWELLS991@GMAIL.COM

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Keisha Peterson is the representative from The Department of Human Services which is the State Social Services Agency

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	51	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED/SUD*	2	
Vacancies (Individuals and Family Members)	1	
Others (Advocates who are not State employees or providers)	15	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	28	54.90%
State Employees	19	
Providers	3	
Vacancies	1	
Total State Employees & Providers	23	45.10%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

The Council had two vacancies, Family Member of Individual in Recovery and a Youth member. We had two applicants just recently for Family Member of Individual in Recover and both applicants were vetted. One was chosen and will be sent an acceptance/welcome letter this month and will be expected to begin attending meetings starting January 2020. This leaves us with one vacancy, our second youth seat. We continue to try to recruit for this seat by making announcements at each meeting. We have asked our current youth member for referrals since she works for an organization that targets college students. One of our academic/research professional members is an instructor at

Morgan State University and has inquired as to how the Council can utilize the students as a resource and we expressed our need for a youth members, so we are hoping we can recruit from this avenue.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
- a) Public meetings or hearings? Yes No
- b) Posting of the plan on the web for public comment? Yes No
- If yes, provide URL:
- c) Other (e.g. public service announcements, print media) Yes No

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Footnotes:

In order to inform the FY 2020-2021 Behavioral Health Plan, the Behavioral Health Administration's (BHA) Office of Planning facilitated four (4) regional stakeholder meetings in April and May of 2019. The meetings were held on:

- 04/24/2019 in Charles County for the Southern Maryland region;
- 05/08/2019 in Washington County for the Western Maryland region;
- 05/14/2019 at the BHA Headquarters in Baltimore County for the Central region;
- 05/29/2019 in Talbot County for the Eastern Shore region.

Each meeting commenced with a presentation from the Office of Planning reporting on some of the BHA's FY2018-2019 initiatives and accomplishments and updates from other BHA offices such as Workforce Development and Clinical Services in relation to recommendations from previous stakeholder meetings.

Attendees also received a status update and overview on the Local Behavioral Health Systems Management Integration Plan. The Planning Committee of the Behavioral Health Advisory Council hosted a half day meeting in August for review of the Plan, the Block Grant Application and to provide recommendations.

Additionally, information on the development of the Behavioral Health Plan and Block Grant application is posted in the Maryland Register. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BEHAVIORAL HEALTH ADMINISTRATION

Subject: Availability of Behavioral Health Plan for Citizen Review

Date/time: July through August 1, 2019, Monday through Friday, 8:30 a.m. – 4:30 p.m.

Place: Spring Grove Hospital Center, Mitchell Bldg., 55 Wade Avenue, Catonsville, MD, 21228

Additional Information: The Behavioral Health Administration (BHA) is in the process of developing the FY 2020 Behavioral Health Plan as part of its application for the FY 2020 – 2021 Federal Mental Health (MHBG) and Substance Abuse (SABG) Block Grant funds. Final submission of the FY 2020-2021 MHBG and SABG application to the federal Substance Abuse and Mental Health Services Administration, Centers for Mental Health Services, Substance Abuse Prevention and Treatment will occur by September 3, 2019. Recommendations from public regional planning meetings held April through May will inform the strategies for the planning documents. Drafts of the 2019-2020 Behavioral Health Plan can be reviewed in late July 2019 at the above address. Any general comments regarding the Behavioral Health Plan or specific comments regarding drafts to the finalization of the Combined Application for MHBG/SABG will be considered and incorporated as appropriate. The documents will be available after their due dates, and will be posted on the BHA website: <https://bha.health.maryland.gov>. Comments on the plan may also be made after submission of the plan to the Federal Government.

THE 2019 Behavioral Health Plan was available for review. Additionally, as a result of recommendations from the Strategic Crisis Plan developed by BHAC and other stakeholders, funding was appropriated to further support crisis services for SUD and MH across the lifespan.