

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

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

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

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

Medicaid Section 1115 SUD Demonstrations Monitoring Report – Part B Version 3.0 (customized)  
Maryland HealthChoice

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

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

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

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

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

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

## 2. Executive summary

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

Enter the executive summary text here.

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

A major goal of the HealthChoice program is to expand coverage to residents with low incomes and to improve access to health care services for the Medicaid population. HealthChoice has largely succeeded. On January 1, 2015, Maryland combined mental health and SUD services in an integrated carve-out. Under the carve-out, an administrative services organization (ASO) administers and reimburses all specialty mental health and SUD services for Medicaid participants on an FFS basis, under the oversight of the

Medicaid program and the Behavioral Health Administration (BHA). Between CY 2018 and CY 2019, overall program enrollment increased by 1.0%, from 1,191,110 participants in CY 2018 to 1,202,718 participants in CY 2019.

From the inception of the HealthChoice program in 1997, mental health services were carved out of the benefit package, while services for individuals with SUDs were provided by the MCOs. On January 1, 2015, Maryland combined mental health and SUD services in an integrated carve-out. Under the carve-out, an administrative services organization (ASO) administers and reimburses all specialty mental health and SUD services for Medicaid participants on an FFS basis, under the oversight of the Medicaid program and the Behavioral Health Administration (BHA). The number of participants with an SUD diagnosis decreased by 0.4% from 133,505 in CY 2018 to 132,920 in CY 2019.

In 2016, CMS approved Maryland Medicaid to expand coverage to include SUD treatment in IMDs. Effective July 1, 2017, the approval permitted otherwise-covered services to be provided to Medicaid-eligible individuals aged 21 to 64 who are enrolled in an MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) residential levels 3.1, 3.3, 3.5, 3.7, and 3.7-WM (licensed as 3.7D in Maryland) for up to two non-consecutive 30-day stays annually. In March 2019, the Department received approval to extend coverage for the Residential Treatment for Individuals with a primary SUD and a secondary mental health disorder (MHD) to ASAM level 4.0. Between CY 2018 and CY 2019, the number of participants using an IMD increased by 7.5% from 14,947 in CY 2018 to 16,066 in CY 2019.

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

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

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

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

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| Medicaid covers all FDA-covered pharmaceuticals. Additional medication-assisted treatment covered with clinical criteria: <ul style="list-style-type: none"> <li>· Buprenorphine/Naloxone combination therapies: Bunavail, Suboxone, Suboxone Film, and Zubsolv</li> <li>· Campral</li> <li>· Naltrexone</li> <li>· Subutex – Buprenorphine</li> <li>· Vivitrol</li> </ul> | N/A  |
| ICF-A: Under 21  | Medically monitored intensive inpatient treatment: <ul style="list-style-type: none"> <li>· Level 3.7WM</li> <li>· Level 3.7</li> <li>· Level 3.5</li> </ul> |
| Intensive Inpatient Services   | Level 4 – Inpatient Services and Level 4.0 WM  |
| Certified Peer Recovery Specialists  | N/A  |

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



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

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

| Prompt  | State has no trends/update to report (place an X) | Related metric(s) (if any) | State summary of retrospective reporting period |
|---|---|----------------------------|---|
| <b>1. Assessment of need and qualification for SUD services</b> |   |                            |   |
| <b>1.1 Metric trends</b>  |   |                            |   |



| Prompt   | State has no trends/update to report (place an X) | Related metric(s) (if any)   | State summary of retrospective reporting period |
|--|---|--|---|
| 2.1.1 The state reports the following metric trends related to Milestone 1             | X   | Metric #22:<br>Continuity of Pharmacotherapy for Opioid Use Disorder |   |
| <b>3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)</b> |   |  |   |
| <b>3.1 Metric trends</b>   |   |  |   |

| Prompt   | State has no trends/update to report (place an X) | Related metric(s) (if any)   | State summary of retrospective reporting period   |
|--|---|--|---|
| <p><b>3.1.1 The state reports the following metric trends related to Milestone 2</b></p>   |   | <p><b>Metric #5:<br/>Medicaid Beneficiaries Treated in an IMD for SUD</b></p> <p><b>Metric #36:<br/>Average Length of Stay in IMDs</b></p> | <p><b>The percent difference for Metric #5: "Medicaid Beneficiaries Treated in an IMD for SUD" from DY3Q2 to DY4Q2 was 7.5%. The state estimates that reasons for the difference have been expected variability in metric results and state policy changes expanding access to residential treatment and withdrawal management.</b></p> <p><b>The percent difference for "Metric #36. Average Length of Stay in IMDs" from DY3Q2 to DY4Q2 was 55.4%. The state estimates that reasons for the difference have been expected variability in metric results and state policy changes expanding access to residential treatment and withdrawal management.</b></p> |
| <p><b>4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)</b></p> |   |  |   |
| <p><b>4.1 Metric trends</b></p>  |   |  |   |

| Prompt   | State has no trends/update to report (place an X) | Related metric(s) (if any) | State summary of retrospective reporting period |
|--|---|----------------------------|---|
| <p><b>4.1.1 The state reports the following metric trends related to Milestone 3</b></p> <p><b>Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.</b></p> | X   |                            |   |
| <p><b>5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)</b></p>   |   |                            |   |
| <p><b>5.1 Metric trends</b></p>  |   |                            |   |



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| <p><b>6.1 The state reports the following metric trends related to Milestone 5</b></p>           |  | <p><b>Metric #18:<br/>Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)</b></p> <p><b>Metric #21:<br/>Concurrent Use of Opioids and Benzodiazepines (COB-AD)</b></p> <p><b>Metric #36:<br/>Average Length of Stay in IMDs</b></p> <p><b>Metric #27:<br/>Overdose Deaths (rate)</b></p> | <p><b>The percent difference for Metric #18: "Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)" from DY3Q2 to DY4Q2 was -22.7%. The state estimates that reasons for the difference have been expected variability in metric results. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.</b></p> <p><b>The percent difference for Metric #21: "Concurrent Use of Opioids and Benzodiazepines (COB-AD)" from DY3Q2 to DY4Q2 was -28.7%. The state estimates that reasons for the difference have been expected variability in metric results.</b></p> |
| <p><b>7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)</b></p> |  |   |   |
| <p><b>7.1 Metric trends</b></p>  |  |   |   |

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| <p><b>7.1.1 The state reports the following metric trends related to Milestone 6</b></p> |  | <p><b>Metric #25:<br/>Readmissions<br/>Among<br/>Beneficiaries<br/>with SUD</b></p> <p><b>Metric S2:<br/>Adjusted<br/>Initiation of<br/>AOD Treatment<br/>- Alcohol abuse<br/>or dependence</b></p> <p><b>Metric S3:<br/>Adjusted<br/>Initiation of<br/>AOD Treatment<br/>- Opioid abuse<br/>or dependence</b></p> <p><b>Metric S4:<br/>Adjusted<br/>Initiation of<br/>AOD Treatment<br/>- Other drug<br/>abuse or<br/>dependence</b></p> | <p>The percent difference for "Metric S3. Adjusted Initiation of AOD Treatment - Opioid abuse or dependence" from DY3Q2 to DY4Q2 was -13.8%. The state estimates that reasons for the difference have been expected variability in metric results.</p> <p>The percent difference for "Metric S4. Adjusted Initiation of AOD Treatment - Other drug abuse or dependence" from DY3Q2 to DY4Q2 was -8.4%. The state estimates that reasons for the difference have been expected variability in metric results.</p> |
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|  |  | <p><b>Metric S5:<br/>Adjusted<br/>Initiation of<br/>AOD Treatment<br/>- Total AOD<br/>abuse or<br/>dependence</b></p> | <p><b>The percent difference for "Metric S5. Adjusted Initiation of AOD Treatment - Total AOD abuse or dependence" from DY3Q2 to DY4Q2 was -8.2%. The state estimates that reasons for the difference have been expected variability in metric results.</b></p> |
|  |  | <p><b>Metric S6.<br/>Adjusted<br/>Engagement of<br/>AOD Treatment<br/>- Alcohol abuse<br/>or dependence</b></p>       |   |
|  |  | <p><b>Metric S7:<br/>Adjusted<br/>Engagement of<br/>AOD Treatment<br/>- Opioid abuse<br/>or dependence</b></p>        | <p><b>The percent difference for "Metric S7. Adjusted Engagement of AOD Treatment - Opioid abuse or dependence" from DY3Q2 to DY4Q2 was -10.8%. The state estimates that reasons for the difference have been expected variability in metric results.</b></p>   |

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|  | <p><b>Metric S8:<br/>Adjusted<br/>Engagement of<br/>AOD Treatment<br/>- Other drug<br/>abuse or<br/>dependence</b></p> <p><b>Metric S9:<br/>Adjusted<br/>Engagement of<br/>AOD Treatment<br/>- Total AOD<br/>abuse or<br/>dependence</b></p> <p><b>Metric S10:<br/>Adjusted 31-<br/>Day Follow-up<br/>After<br/>Emergency<br/>Department<br/>Visit for Alcohol<br/>or Other Drug<br/>Dependence<br/>(FUA-AD)</b></p> | <p><b>The percent difference for "Metric S9. Adjusted Engagement of AOD Treatment - Total AOD abuse or dependence" from DY3Q2 to DY4Q2 was -6.4%. The state estimates that reasons for the difference have been expected variability in metric results.</b></p> <p><b>The percent difference for "Metric S10. Adjusted 31-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)" from DY3Q2 to DY4Q2 was 7.6%. The state estimates that reasons for the difference have been expected variability in metric results.</b></p> <p><b>The percent difference for "Metric S11. Adjusted 8-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)" from DY3Q2 to DY4Q2 was 12.0%. The state estimates that</b></p> |
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|  | <p><b>Metric S11:<br/>                 Adjusted 8-Day<br/>                 Follow-up After<br/>                 Emergency<br/>                 Department<br/>                 Visit for Alcohol<br/>                 or Other Drug<br/>                 Dependence<br/>                 (FUA-AD)</b></p> <p><b>Metric S12:<br/>                 Adjusted 31-<br/>                 Day Follow-Up<br/>                 After<br/>                 Emergency<br/>                 Department<br/>                 Visit for Mental<br/>                 Illness (FUM-<br/>                 AD)</b></p> <p><b>Metric S13:<br/>                 Adjusted 8 Day<br/>                 Follow-Up After<br/>                 Emergency<br/>                 Department<br/>                 Visit for Mental<br/>                 Illness (FUM-<br/>                 AD)</b></p> | <p>reasons for the difference have been expected variability in metric results.</p> <p>The percent difference for "Metric S12. Adjusted 31-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)" from DY3Q2 to DY4Q2 was -7.6%. The state estimates that reasons for the difference have been expected variability in metric results.</p> <p>The percent difference for "Metric S13. Adjusted 8 Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)" from DY3Q2 to DY4Q2 was -6.7%. The state estimates that reasons for the difference have been expected variability in metric results.</p> |
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| Prompt  | State has no trends/update to report (place an X) | Related metric(s) (if any) | State summary of retrospective reporting period |
|---|---|----------------------------|---|
| <b>8. SUD health information technology (health IT)</b> |   |                            |   |
| <b>8.1 Metric trends</b>                                |   |                            |   |

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| <p><b>8.1.1 The state reports the following metric trends related to its health IT metrics</b></p> |  | <p><b>Metric S1:<br/>                 Number of HealthChoice participants enrolled in corrective managed care program</b></p> | <p><b>The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY3Q3 to DY3Q4 was -11.3%. The state estimates that reasons for the difference have been expected variability in metric results. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.</b></p> <p><b>The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY3Q4 to DY4Q1 was -3.9%. The state estimates that reasons for the difference have been expected variability in metric results. Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number.</b></p> <p><b>The percent difference for Metric S1: "Number of HealthChoice participants enrolled in corrective managed care program" from DY4Q1 to DY4Q2 was -8.6%. The state estimates that reasons for the difference have been expected variability in metric results.</b></p> |
|--|--|---|---|

| Prompt  | State has no trends/update to report (place an X) | Related metric(s) (if any)  | State summary of retrospective reporting period   |
|---|---|---|---|
|   |   |   | Additionally, due to the small number of beneficiaries in this metric the percentage of change can vary greatly as a result of small changes of the total number. |
| <b>9. Other SUD-related metrics</b>   |   |   |   |
| <b>9.1 Metric trends</b>  |   |   |   |
| <b>9.1.1 The state reports the following metric trends related to other SUD-related metrics</b> | <b>X</b>  | <b>Metric #26.<br/>Overdose Deaths (count)</b><br><br><b>Metric S14.<br/>Access to Preventive/<br/>Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD</b> |   |

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

Measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics #15, 17(1), 17(2), and 32] are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided “as is” without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

The measure specification methodology used by CMS is different from NCQA’s methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a “rate”) from a HEDIS measure that has not been certified via NCQA’s Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a “HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as “Adjusted, Uncertified, Unaudited HEDIS rates.”