The Department of Health and Mental Hygiene's Responses to the DLS FY 2018 BHA Budget Analysis February 23, 2017 (House) and February 24, 2017 (Senate)

The department should provide an update on what metrics they are considering and why the HEDIS metrics were included in the initial contract if measurement against these metrics was not going to be feasible. DLS is also recommending the adoption of committee narrative that requests BHA and DHMH to study the issue of combining local addictions authorities and core service agencies into integrated behavioral health authorities, and report back to the General Assembly with their recommendations. (pg. 4, 33)

As noted in the report prepared by the Department in accordance with the FY 2017 Joint Chairmen's Report, the ASO was unable to meet the required HEDIS deliverables but committed to work with DHMH and the Maryland-based MCOs to develop the proper linkages to receive this data in a timely manner. Specifically, Beacon indicated it was not comfortable working with a more limited data set provided directly by the Department. The Department is actively considering possible alternative metrics that can be calculated using only the behavioral health data Beacon has access to in order to assess the ASO's performance. At the time the measures were developed, the Department had not initiated the contract and was unaware of the significant complexities to sharing somatic data and the timing for which this data would be needed to assess performance on the measures.

The Department agrees with the recommendation to study the issue of combining local addictions authorities and core service agencies into integrated behavioral health authorities. The Department remains committed to becoming a fully-integrated system and will continue this collaborative process with the various jurisdictions in addressing systemic and county specific issues. Several of the the local LAAs and CSAs are already exploring the feasibility of combining and some are taking steps to become integrated.

The department should comment on the implementation of the Forensic Services Workgroup recommendations, the number of individuals currently waiting for placement at State hospitals, as well as how the department intends to improve security staffing levels without the addition of more positions for this purpose. (pg. 4, 37)

The Department convened a Forensic Advisory Council to provide advice to the Deputy Secretary of Behavioral Health/BHA Executive Director regarding potential strategies for addressing the six recommendations of the Forensic Services Workgroup. The Council was implemented in early December and meets bi-monthly. The specific tasks for the FAC are to participate in planning activities designed to operationalize specific strategies to address the Workgroup recommendations; identify best practices in service delivery for court-involved individuals and to; track the progress made on each recommendation. Additionally, BHA continues to work with local and state partners to increase bed capacity, including but not limited to enhancing crisis services. Through the improved patient-flow admission and discharge processes, we have seen significant improvement in the expansion of bed capacity. The number of individuals waiting for placement at State hospitals fluctuates daily and can vary based on referral type. BHA monitors this issue closely and receives weekly reports to address any rising

concerns and to track the number of individuals awaiting placement. Overall, through current efforts, we have seen improvement. As of February 20, 2017, statewide, five state hospitals are 11 individuals under census. There are 9 commitment orders on the forensic wait list, 5 of whom are awaiting placement at Perkins, the only secure psychiatric facility. The average wait time for placement in this facility, based on first quarter 2017 data, is 19 days. BHA plans to open a new 20 bed step-down unit at Perkins in April 2017. This will provide additional bed space at this facility. The average wait time for the remaining 4 individuals with commitment orders to be placed in BHA Regional Hospitals, based upon first quarter 2017 data, is 5 days. As of February 13, 2017, there were a total of 25 people awaiting placement in State psychiatric facilities. BHA has also implemented an intensive discharge planning process to place individuals who no longer meet medical necessity criteria for hospital level of care into the community. Of the 98 individuals on the "ready to discharge" list who remained in the hospitals, 72 individuals have been placed in the community.

A security-needs assessment was conducted in 2016 by the Behavioral Health Administration of each State psychiatric facility to identify recommendations regarding security functions at each facility. As a follow-up and in response to a FY 2017 Joint Chairmen's' Report, the findings of that security needs assessment was addressed. A Chief of Police for DHMH was hired to address the identified issues. Chief James Pyles was hired in February 2016 to assure that all security personnel were properly trained, and that Police Officers were credentialed to come into compliance with the Public Safety Article. The Chief of Police continues to work with each hospital CEO to assess ongoing security needs, and assist in recruitment as well as provides ongoing training to security and police personnel. Salary compensation continues to be a barrier in recruitment and retention of security personnel.

The department should comment on the rationale for rolling the funds over as opposed to spending them on other authorized treatment services. (pg. 21)

Since the development of the FY18 budget request, which reflects rolling over funding from FY 2016 to FY 2017 and FY 2017 to FY 2018, the Department has amended its spending plan to use all available revenue from the Problem Gambling Fund in each of the respective years.

The department should comment on its future plans for the Crownsville Hospital Center and if it is actually feasible that the State would not have to maintain this property from the beginning of fiscal 2018. (pg. 22)

The Department wants to relinquish ownership of the Crownsville Hospital Center property. It does not know at this time if the property will remain under State ownership at the beginning of FY 2018.

The department should comment on what strategies it is pursuing in order to take advantage of the new federal funding opportunities available due to the passage of this legislation. (pg. 27)

The Department has not received funding through CARA. However, in December 2016 President Obama signed the CURES Act, which provides funding for two years to each state to address the opioid epidemic. Eighty percent of the funding is to be spent on opioid treatment and recovery services with the remainder going toward prevention and infrastructure support.

Maryland's allocation is $10,036,845 per year for two years. The intent is to use the funds to create crisis residential beds throughout Maryland. There will be immediate admission to the beds, induction to buprenorphine or long-acting naltrexone as appropriate, and peers to assist with transferring to the next level of care, including expansion of Level 3.1 residential treatment capacity, creation of crisis services in Level 3.7 residential facilities, enhancing Opioid Treatment Programs and Re-entry Programs with Peer Recovery Specialists, enhancing the existing Naloxone Distribution Programs, expansion of consultation and technical assistance for health care providers, and implementing evidence-based treatment. The Department will also create a bed-tracking system to monitor usage and availability of crisis beds. Funds will also be used to expand local jurisdictions' provision of naloxone to high risk communities as well as to have a prevention messaging campaign aimed at educating the community about prescribed opioids.

The Governor's Office of Crime Control is planning on submitting two applications, one for Technology Assisted Treatment Programs and one for Statewide Planning, Coordination and Implementation Projects.

The department should comment on the extent to which public safety considerations are included in the Health – General Section 8-505 evaluation process. (pg. 28)

The 8-505 assessors evaluate referrals based on ASAM criteria, which are primarily clinically driven. The court is the party that is tasked with balancing clinical versus public safety considerations.

DLS is recommending committee narrative on the adequacy of SUD treatment rates. (pg. 32)

The Department disagrees with this recommendation. As directed by the Lieutenant Governor's Heroin and Opioid Emergency Task Force, the Department is in the final stages of conducting an analysis of Medicaid substance use treatment rates with our neighboring states.

DLS is recommending the adoption of committee narrative that requests BHA and DHMH to study the issue of combining LAAs and CSAs into integrated Behavioral Health Authorities and report back to the General Assembly with their recommendations. (pg. 34)

The Department agrees with the recommendation. The Department remains committed to becoming a fully-integrated system and will continue this collaborative process with the various jurisdictions in addressing systemic and county specific issues. Several of the the local LAAs and CSAs are already exploring the feasibility of combining and some are taking steps to become integrated.

DLS recommends adding the following restriction language to the Behavioral Health Administration's general fund appropriation:

- ***"Further provided that $2,103,478 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for the purpose, but instead may only be transferred to Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to cover shortfalls in base spending for that***

program..." (pg. 38)

- ***"...provided that $365,024 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for that purpose, but instead may only be transferred to Program M00Q01.10 Medicaid Behavioral Health Provider Reimbursements to cover shortfalls in base spending for that program…" (pg. 38-39)***

- ***"...provided that $2,518,010 of this appropriation made for the purpose of providing a community provider rate increase may not be expended for that purpose, but instead may only be expended to cover shortfalls in base spending for this program. Funds not expended for this purpose may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund…" (pg. 39)***

The Department respectfully disagrees with this recommendation, as the Governor's Allowance that provides a rate increase of 2% for all behavioral health providers sustains provider capacity. To reduce the rate to 1% during an opioid epidemic would hamper the Department's ability to respond to this crisis. Moreover, this recommended action limits the ability of the Department to realign funding to cover deficits as needed.

DLS recommends adding the following restriction language to the M00Q01.10 Medicaid Behavioral Health Provider Reimbursements' general fund appropriation: "All appropriations...are to be used for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose." (pg. 39)

The Department respectfully disagrees with this recommendation. Historically, Medicaid provider payments for mental health services have not been restricted, and doing so in conjunction with program M00Q01.03 (Traditional or Somatic Medicaid Provider Payments) will effectively constrain 76% of the Department's overall appropriation.

Moreover, this action would prevent the Department from realigning budgets mid-year should an unexpected cost arise. For example, the Department is still in the process of determining the rates for residential substance abuse services as a result of its HealthChoice Waiver, and the current plan is to realign funding from BHA Community Services to BHA Medicaid via a budget amendment in early FY 2018 following the rate setting study. If an excess of funding is realigned, DLS' recommended action would prohibit the Department from returning funding to BHA Community Services should an unanticipated cost driver occur, such as high utilization for mental health services at an Institution of Mental Disease.

While the Department can seek a deficiency mid-year through the legislative process, deficiencies are not reflected in accounting ledgers until late April at the earliest, which presents significant cash flow problems for the Department and could potentially lead to delayed payments to providers as well as mistakes to the general ledger.

On July 1, 2017, the Department is implementing a new Medicaid covered service for

residential substance use treatment and is in the process of setting rates. The rate includes two components: one for medical and treatment services that is eligible to receive a federal match under the renewal of the HealthChoice waiver that was received in December 2016. The second component for room and board is not eligible for any federal matching funds. During this period of transition it is critical that the Department have the utmost flexibility to ensure access to care on both the uninsured side (e.g. people not eligible for Medicaid) and through the Medicaid program. This transition is not dissimilar to the transitions that occurred when the department created a SUD benefit for the Primary Adult Care population in 2010 and in 2015 when the Department completed the integration of mental health and substance use services through the single administrative services organization. The Department's ability to effectively implement this new benefit requires us to have the ability to financially manage between M00Q01.10 and the BHA budget and we appreciate the General Assembly's willingness to provide us with this flexibility during this important transition.

Finally, it should be noted that Traditional or Somatic Medicaid has been a locked appropriation for over a decade because of its sheer size and because its consumers do not move from one State-run insurance plan to another. BHA Medicaid, on the other hand, does experience such movement because the State not only provides behavioral health services to those eligible for Medicaid but also to those individuals who are uninsured or ineligible for Medicaid. Because these programs are budgeted separately, DLS' recommended action would prohibit the Department from adjusting its budget to account for this movement and could potentially imperil the care of any individual who moves from BHA Medicaid to BHA Uninsured.

DLS recommends adopting the following narrative: "The Governor's Heroin and Opioid Emergency Task Force recommended that the Department of Health and Mental Hygiene (DHMH) review all of the Medicaid rates for substance use disorder services and then continue to review those rates every three years. The budget committees are concerned about the follow through on this recommendation and request a report from DHMH on the adequacy of the rates for substance use disorder treatment services within the Medicaid program. This report is due on November 1, 2017." (pg. 39-40)

The Department respectfully disagrees with this recommendation. As directed by the Lieutenant Governor's Heroin and Opioid Emergency Task Force, the Department is in the final stages of conducting an analysis of Medicaid substance use treatment rates with our neighboring states.

CHANGING
Maryland
for the Better

BEHAVIORAL HEALTH ADMINISTRATION BUDGET HEARING PRESENTATION

Department of Health and Mental Hygiene
Date: February 23 & 24, 2017

FY 18 - Behavioral Health Administration

Operates:

5
State Psychiatric Hospitals

2
Residential Treatment Facilities

Manages a budget of
$ 664 million

Fund Composition:

General- $ 545 million

Special- $ 37 million

Federal- $ 74 million

Reimbursable- $ 8 million

- Includes Deputy Secretary Budget

Services include:

Children, Adolescents, & Adults Hospital and Community-Based Mental Health and Substance Use Disorder Services Population-Based Health and Forensics

Composed of 3017 positions

2803 PINS,

including **2637** facility PINS,151 BHA HQ PINS, and 15 Deputy Secretary PINS

& **214** Contractual Positions, including **200** facility contractual positions and 14 BHA HQ contractual positions

Services Provided

MENTAL HEALTH

- Inpatient Services
- Health Services
- Targeted Case Management
- Psychiatric Rehabilitation Services
- Residential Rehabilitation Services
- Residential Treatment Services (RTCs)
- Mobile Treatment
- Assertive Community Treatment
- Traumatic Brain Injury
- Respite Services
- Supported Employment
- Crisis Services
- Permanent Supported Housing
- Data Link

SUBSTANCE USE DISORDERS

- Recovery Housing and Supports
- Residential Treatment Facilities
- Withdrawal Management
- Medication Assisted Treatment

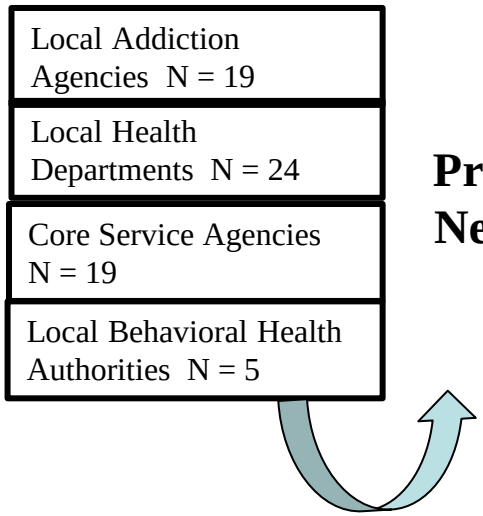
BOTH Mental Health and Substance Use Disorders

Individual Practitioners
Outpatient Services
Intensive Outpatient Services
Partial Hospitalization
Lab Services (behavioral health related disorders)
Health Homes
Care Coordination

Overview of the Behavioral Service Delivery System

Out-Patient Service System

24 Jurisdictions



Provider Network

In-Patient Behavioral Health Service System

- **5 State Psychiatric Hospitals (adult)**
- **2 State Residential Treatment Centers (children & adolescents)**
- 47 General Acute Care Hospitals
- 3 Psychiatric Institutes for Mental Disease (IMDs) Hospitals:
  - Adventist Behavioral Health
  - Brooklane
  - Sheppard Pratt

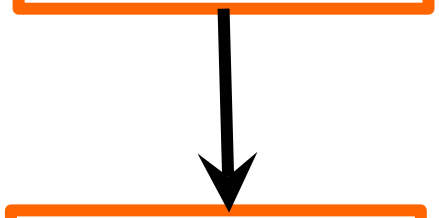
Moving Toward an Integrated System of Care
Accreditation and Licensure

Programs will be required to be accredited by **January 1, 2018** in order to be licensed. Therefore, License applications must be submitted before **January 1, 2018 in order to receive a License before April 1, 2018.**

- Quality of Care

Accreditation

- Joint Commission
- CARF
- ACHC
- COA (in process)



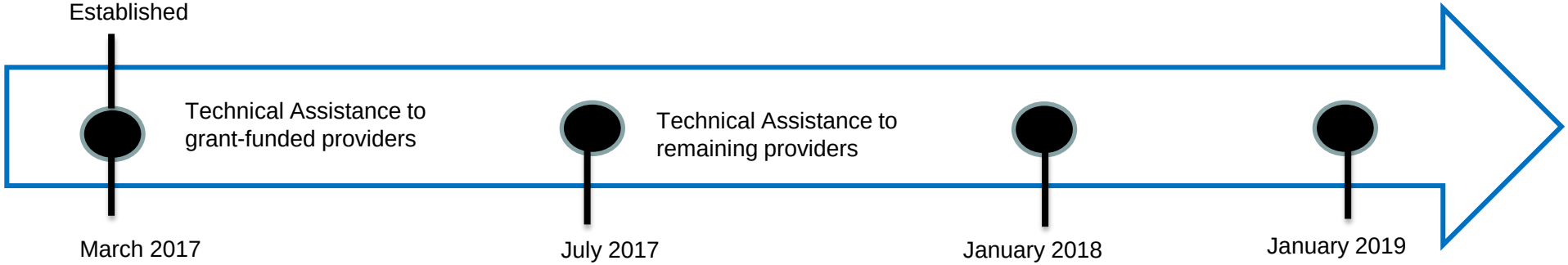
- Fire/building codes
- Policy requirements
- Environment of care

Licensure

- DHMH

Moving Toward an Integrated System of Care…

Transition of Residential Substance Use Disorder Services to Fee-for-Services



March 2017

- Regulations developed and approved
- Reconfiguration of Beacon System
- Build required workflows in Beacon System

July 2017

- Transition of grant-funded residential SUD services.
  - Levels 3.3, 3.5, 3.7/3.7D

January 2018

- Transition of grant-funded residential SUD services for:
  - Pregnant women & children
  - Child welfare
  - Drug exposed newborns
  - 8-507

January 2019

- Transition of grant-funded residential SUD services.
  - Level 3.1

History/Background of 8-505 and 8-507 Services

- **Health-General § 8-505 and Health-General § 8-507 were initially enacted in 1989; revised in 2007** to ensure that DHMH gave notice to the Court that a defendant received appropriate treatment and that he/she could benefit from treatment as a condition of his/her release after conviction or at any other time that the defendant voluntarily agreed to participate.

- **Effective October 1, 2017**, as a part of the 2016 Justice Reinvestment Act, **DHMH is required to place individuals in Court-ordered treatment within 21 days.**

- **H-G § 8-505** was designed as a structured approach for the Court to divert individuals with a substance use disorder from jail/prison to treatment. This was especially important in cases where it appeared the crime committed was a result of the person's addiction.

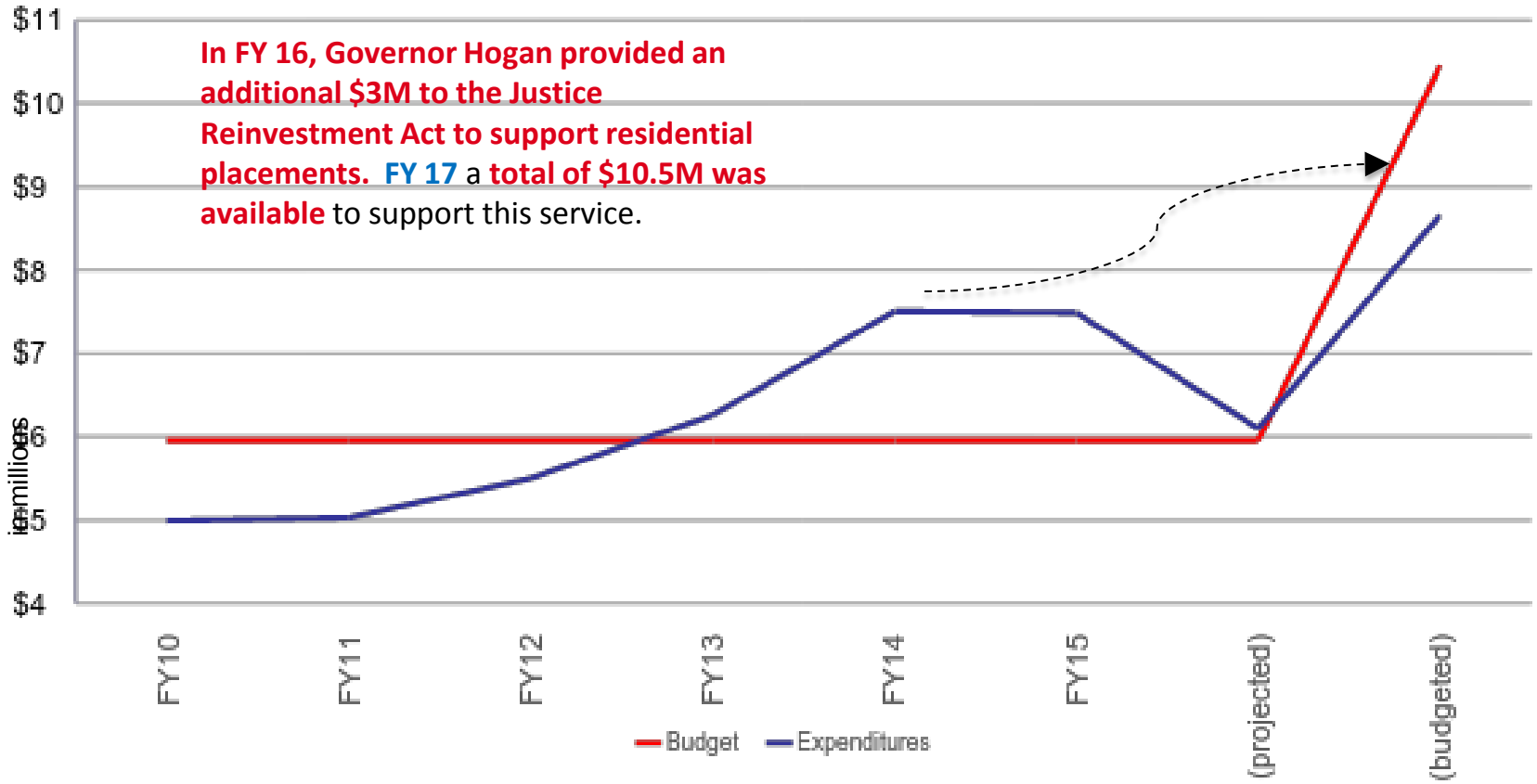
- **H-G § 8-507** requires DHMH to facilitate treatment services for those who have been assessed as needing treatment.

Residential Treatment Program Capacity

- Existing Capacity: BHA Contracts with 3 programs for **245 available residential treatment slots**
  - ❑ Gaudenzia - 135
  - ❑ Jude House - 45
  - ❑ New Horizons -65

Funded Treatment Slots		
FY 2015	**FY 2016**	**FY 2017**
120 ($6M from base budget)	**180** ($3M from JRA – July 2016)	**240** ($1.5M from Governor's Budget – January 2017)

Funding for Residential Placements Under 8-507



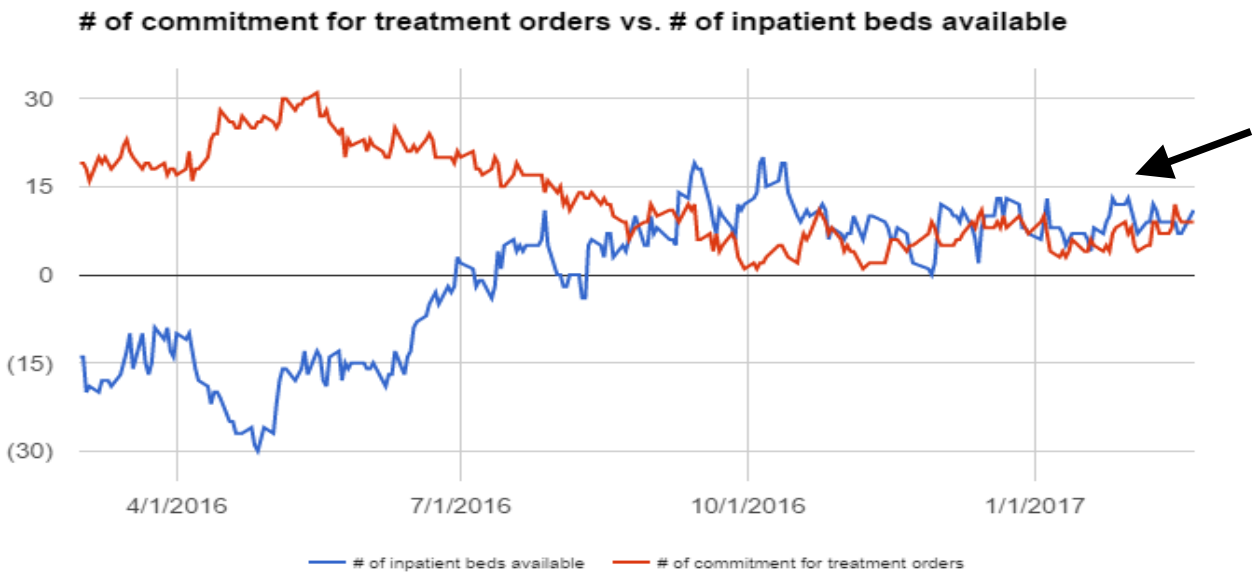
In FY 16, Governor Hogan provided an additional $3M to the Justice Reinvestment Act to support residential placements. FY 17 a total of $10.5M was available to support this service.

State Psychiatric Hospital Bed Capacity Issue

Current Capacity Regional Hospitals = 699

Current Capacity Perkins = 245

Census versus criminal commitments waiting for admission for all five state hospitals:



Data as of February 21, 2017

Census and Wait List Data

		March	May	Jan
	Census	(14)	(30)	(7)
Wait List by Priority level	1	8	12	9
	2	18	31	6
	3	5	11	0
	4	11	13	4
	5	20	27	7
	TOTAL	62	94	26

Note: When the census is negative, that means BHA facilities are over census

Priority levels are based on the BHA Facilities Admission Policy, as follows:

1: patients returning from conditional release in need of acute hospitalization

2: patients committed for treatment by a court

3: patients referred for acute care by a jail or prison

4: patients referred by a court for a forensic evaluation

5: any other referrals

January 2017

Actions Taken by DHMH to Address the Hospital Capacity Issue

Activity	January	February	March	April	May	June	July	August
1. DHMH hires new Behavioral Health Executive Director; CEO at Perkins and Spring Grove Hospital Center	X		X				X	
2. BHA began tracking data weekly to monitor admissions and discharges			X					
3. BHA begins an intensive discharge planning process for 98 patients "ready to discharge." To date, 69 have been discharged.			X					
4. Letter sent from Secretary Mitchell informing the judiciary of the issue related to State hospital bed capacity				X				
5. DHMH staff in court to defend against finding of contempt					X	X	X	X
6. BHA implements a standardized Admissions Policy in all State facilities and identified "intensive discharge process" for those ready to be discharged (ongoing monitoring)					X			
7. Forensic Services Workgroup was convened to develop strategies to address the capacity issue						X		
8. The Segue Program, operated by Way Station, opened on Springfield Hospital campus creating 16 step-down beds							X	
9. Renovations began to relocate the SETT Unit from Perkins to create 16 in-patient beds							X	
10. Forensic Services Work Group report submitted to the Secretary								X

Actions Taken by DHMH to Address the Hospital Capacity Issue (continued)

1. Recommendations by Forensic Workgroup Report reviewed & implementation strategies identified	X				
2. Continued to communicate with Court Officials and respond to Court Orders	X	X	X	X	X
3. A Forensic Advisory Board Convened to monitor progress and advise Executive Director				X	
4. Moved SETT unit from Perkins to Springfield Hospital campus			X		
5. Completed renovations at Perkins for a 'step-down unit' (opening April 2018)					X
6. Closely monitoring admissions-discharge process	X	X	X	X	X

Forensic Services Advisory Council

The Forensic Services Advisory Council was convened in December 2016 to:

- Participate in planning activities to operationalize specific strategies to address the Forensic Workgroup recommendations
- Track progress made on each recommendation
- Provide advice/guidance to the Deputy Secretary of Behavioral Health

Workgroup Recommendations:

1. Increase bed capacity within the Department of Health and Mental Hygiene
2. Increase availability of community crisis services
3. Expand the capacity of the Office of Forensic Services
4. Increase outpatient provider capacity to meet the needs of forensic patients
5. Centralize DHMH forensic processes
6. Increase education to reduce stigma in both the general public and the mental health treatment community

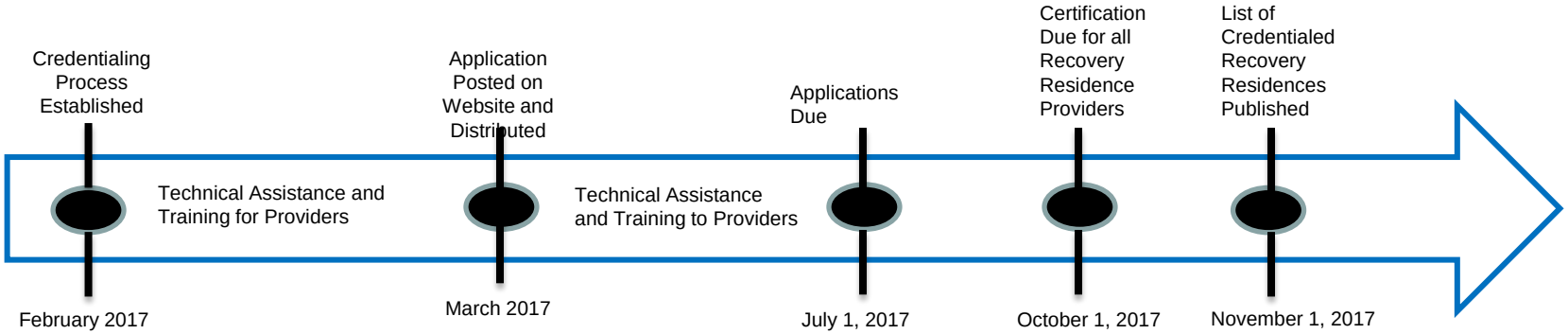
Addressing Hospital Safety

In response to a FY 17 Joint Chairmen's Report, findings of a Security Needs Assessment were addressed.

- Needs Assessment completed in 2016
- Chief of Police was hired February 2016
    - Assures that all security personnel are trained and credentialed to ensure compliance with policy and with Public Safety Article.
    - Works with each hospital CEO to assess security needs, assists with recruitment and provides ongoing trainings.
- Salaries of security personnel continues to be a barrier in recruitment and retention.

Expanding Recovery Supports - Provision of Recovery Residences in Compliance with HB1411

Establishing credentialing, monitoring and inspection process for Recovery Residences (N=136 houses with a capacity of 1,271 beds)



February 2017

- Service and environmental standards established based upon the National Association of Recovery Residence (NARR) Standards

March 2017

July 1, 2017

- Providers Currently Holding Certificates/MSARR Membership will be "grandfathered"

October 1, 2017

November 1, 2017

Gambling Fund

	FY 17	FY 18
Anticipated Revenue	$5,248,725*	$5,444,625
Center of Excellence:		
• Substance Use Support Services • (Helpline, training, referral support, policy development & best practices, outreach)	$1,646,180	$1,646,180
• Non-Reimbursement Treatment Services	$1,331,045	$1,526,945
• Research (prevalence study, Epidemiological studies)	$2,271,500	$2,271,500

*Includes rollover funds from FY 16. Funds adjust based on increase/decrease of casino video lottery terminals & table games.

Overdose Prevention Initiatives

- Improve epidemiology & strategic planning at state & local levels
  - Overdose surveillance & data dissemination
  - Local Overdose Fatality Review Teams
  - Opioid Misuse Prevention Program
- Naloxone training & distribution (Overdose Response Program)
- Reduce Rx opioid misuse & inappropriate prescribing
  - Prescription Drug Monitoring Program
  - Medicaid “lock-in” standardization across MCOs
  - Prescriber education
- Targeted outreach to high-risk individuals for treatment & recovery support services
  - Overdose Survivors Outreach Program
  - Medication-assisted treatment and recovery support grant
  - Overdose Awareness Campaign

Prescription Drug Monitoring Program

- Goal: reduce Rx drug misuse & diversion
- Integrated with CRISP, the state-designated health information exchange
- Secure, electronic database with information on the prescribing and dispensing of Rx controlled substances
- Data is reported by drug dispensers, including pharmacies and dispensing practitioners
- Access granted to healthcare practitioners, licensing boards, law enforcement & specific DHMH agencies

***12,427** total registered clinical users, including:*

8,482 prescribers (physicians, PAs, NPs, dentists)
1,568 prescriber delegates (nurses, social workers, counselors, etc.)
2,482 dispensers & dispenser delegates (pharmacists & pharmacy techs)
Averaging 21,000 patient queries per week
*Data from CRISP, current as of 7/28/2015

Prevent Opioid Misuse - Public Awareness Activities

- Collaboration with MPT on documentary on recovery from opioid addiction. (Aired February 11, 2017)
- Public Service Announcements for TV and movie theaters on:
  - –Naloxone
  - –Good Samaritan
  - –Anti-stigma
- Billboards and bus ads on naloxone
- Fentanyl alert cards for high risk population
- PDMP awareness outreach
- Digital Stories covering treatment and recovery, fentanyl, use of naloxone, peers, medication assisted treatment

INTERAGENCY COORDINATION – BHA & Medicaid

- Oversight of the Public Behavioral Health System
  - Medicaid oversees Medicaid funding and is contract monitor of ASO contract.
  - DHMH's Behavioral Health Administration continues to provide clinical oversight of the system, and oversees funding for the uninsured.
- Workgroup participation
  - Medicaid is represented on the Behavioral Health Advisory Council and the Forensics Workgroup
  - Behavioral health providers sit on the Medicaid Advisory Committee
- Provider Rate Setting
  - Residential Substance Use Treatment will become a Medicaid covered service effective July 1, 2017.
  - Medicaid and BHA staff are working to establish rates for these services.
- Accreditation and Improve Quality
  - Effective July 1, 2016 new regulations require behavioral health programs to become accredited by an approved national accrediting organization
  - All accreditation-based programs must have accreditation from a DHMH-approved accrediting body and must submit an application for licensure by January 1, 2018

EXPANDING MEDICAID OVERDOSE ACTIVITIES

- **Lock-In Program:** MCOs are required to participate in a ***Corrective Managed Care (CMC) Program***; it monitors for members receiving duplicate opioid prescriptions from multiple providers and locks them into a single pharmacy to prevent abuse
- **Medication-Assisted Treatment (MAT) Access:** Medicaid beneficiaries have access to medication like methadone, buprenorphine, and naloxone to assist with opioid addiction
- **Rebundling Methadone Payment:** After significant consultation with stakeholders, DHMH is rebundling the weekly reimbursement rate for methadone services to ensure OTP providers provide counseling with MAT as required; effective March 1, 2017.
- **Minimum Prescribing Standards:** The Drug Utilization Review Workgroup, consisting of representatives from DHMH and all 8 MCOs, reached consensus in establishing minimum opioid prescribing standards as well as its full implementation date of July 1, 2017.
- **SUD Waiver:** Through the recently-approved HealthChoice waiver, Medicaid will pay for substance use treatment services in Institute for Mental Disease (IMD) settings enhancing its already robust continuum of SUD care; effective July 1, 2017.
- **Pharmacy & Therapeutics Committee:** Medicaid has used the P&T Committee as a forum for overdose education and drug access/contraction.
- **Opioid Drug Utilization Review (DUR) Workgroup:** As one of the largest payers in the state, in June of 2016, Medicaid convened a DUR workgroup consisting of DHMH and the 8 HealthChoice MCOs representatives met to deliberate on and build consensus around minimum opioid prescribing rules and an implementation timeline.

1115 WAIVER RENEWAL INITIATIVES

- **Residential Treatment for Substance Use Disorders**
  - Presently, CMS will not provide matching funds for state dollars that fund SUD treatment for individuals receiving care in a residential facility without a waiver.
  - Under the waiver, the State may use Medicaid funds to cover a continuum of SUD services.
- **Transitions for Criminal Justice Involved Individuals**
  - Connecting individuals to Medicaid coverage upon release is a key component of Gov. Hogan's *Justice Reinvestment Act*
  - CMS advised the State to provide presumptive eligibility for Medicaid-eligible individuals leaving jails and prisons in the state through a State Plan Amendment (SPA)

For More Information

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