For Public Comment:

FFY27 MHBG Mini Block Grant Application

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Please note: Environmental Factor #14 is still being developed.

Community Mental Health Services Block Grant (MHBG)

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

2. In accordance with the guidelines provided, identify the stages where the existing/proposed system will fit in. Please check the appropriate box for each row to indicate the state's stage of implementation.

3. Briefly explain your stages of implementation.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, explain how the state will develop the crisis system.

5. Other program implementation data that characterizes crisis services system development. Please provide the following data

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

7. Please indicate areas of technical assistance needs related to this section.

14. State Planning/Advisory Council and Input on the Mental Health Block Grant Application

15. Public Comment on the State Plan, Required for MHBG

Please provide responses to all questions ensuring sufficient details are included to fully address all elements of each question. Do not leave any questions unanswered.

Table 2: MHBG Planned State Agency Budget for SFY2027

Table 4: MHBG State Agency Planned Budget

Table 6: MHBG Other Capacity Building/Systems Development Activities

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

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1. **Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds, including the number of programs for each.**

Model(s)/EBP(s) for ESMI	Number of programs[1]
Coordinated Specialty Care (CSC)	3
Supported Employment (SE)	3
Family Psychoeducational (FPE)	3

2. **Please provide the total budget/planned expenditure for ESMI for FY26 and FY27 (only include MHBG funds).**

FY2026	FY2027
$1,787,017	$1,787,017

3. **Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.**

Medicaid is the primary funding source for Supported Employment, Family Psychoeducation, Individual Therapeutic Services, Pharmacotherapy, and Case Management. These services are billed through the Maryland Administrative Service Organization.

Other insurances are used on a case-by-case basis (based on individuals having both Medicaid and private insurance). Staff positions for the Coordinated Specialty Care (CSC) model are currently being funded by Mental Health Block Grant Funding.

[1] This section does not require a narrative. However, to provide context, the programs that use these evidence-based models are: Johns Hopkins, Sante Affiliated, and Interdynamics in Prince George's County. These programs are supported by block grant funds.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

The state's primary initiative for implementing evidence-based practices for individuals with Early Serious Mental Illness (ESMI) is the Maryland Early Intervention Program (MEIP). Designed for young people within the first one to two years of developing psychosis or schizophrenia, MEIP utilizes an evidence-based, collaborative team model to promote treatment adherence, foster recovery, and prevent long-term disability.

As a specialized program, MEIP provides expert early identification, evaluation, and comprehensive psychiatric treatment for adolescents and young adults. The program integrates research throughout its three core components: 1) Outreach and Education Services, 2) Clinical Services, and 3) Training and Implementation Support

Research efforts focus on developing objective methods for early detection, predicting disease progression or recovery, and enhancing intervention effectiveness. MEIP's clinical services include frequent individual therapy, family psychoeducation and support, and specialized skills groups. By fostering trusted relationships and maintaining 24/7 on-call crisis availability, multi-disciplinary teams work alongside clients and families to improve illness management, facilitate recovery, and ensure continuous support.

5. Does the state monitor fidelity of the chosen EBP(s)?

Yes

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI?

Yes

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Funding for the three CSC/FEP programs directly increases access to essential care by eliminating financial, geographical, and navigational barriers. Because these programs are provided at no cost to the participant, financial strain is removed as a barrier to treatment. The programs provide comprehensive care by seamlessly integrating clinical treatment with essential non-clinical support, such as reliable transportation, language interpretation, and dedicated care coordination. Furthermore, specialized support staff help clients and their families navigate the broader Public Behavioral Health System. This hands-on guidance ensures families can access the right resources without the burden of searching through confusing databases or multiple webpages.

To optimize client outcomes and elevate service quality, the Behavioral Health Administration (BHA) developed an integrated data system for state-funded First Episode Psychosis (FEP) efforts. This information network aligns and compares key domains across three distinct reporting streams in Maryland: the FEP Outcomes System, the MEIP Clinical platform, and the MEIP Research System. By tracking and evaluating critical metrics—including employment, education, substance use, somatic health, and legal involvement—this network provides a comprehensive view of client progress.

The BHA and University of Maryland Systems Evaluation Center (SEC) FEP Outcomes System was developed in collaboration with funded clinical teams to collect aggregated quarterly data on client demographics, functional outcomes, and services provided. The SEC analyzes this data to provide vital feedback at both the state and team levels, allowing BHA to celebrate successes, address implementation challenges, and fulfill federal SAMHSA reporting requirements. Complementing this system is the Maryland Early Intervention Program (MEIP) Clinical System, a secure, HIPAA-compliant platform designed specifically for Set-Aside clinics to track individualized clinical and outcome data for all participants receiving funded FEP services. Finally, the MEIP Research System collects deep-dive research data for individuals who have consented to participate in ongoing studies, blending specialized clinical assessments with comprehensive chart reviews extracted from Electronic Health Records (EHRs) and the MEIP Clinical System.

Maryland’s data capabilities are further enhanced through its partnership with the National Institute of Mental Health's Early Psychosis Intervention Network (EPINET). This initiative links clinical sites nationwide through common data elements and a unified informatics approach. By participating in EPINET, Maryland has expanded its available data metrics while streamlining submissions to reduce the administrative reporting burden on local teams. Ultimately, this pooled, large-scale data analysis accelerates research into psychosis risk factors and informs best practices for achieving high quality, safety, and long-term value in early psychosis care.

8. Please describe the planned activities in FY2027 for your state's ESMI programs.

In FY2027, we will continue partnering with our three programs to ensure the delivery of high-quality services. To monitor and maintain program integrity, we utilize our CSC Fidelity Tool to review and evaluate CSC programs every two years. Following these evaluations, CSC teams will collaborate directly with the CSC Trainer and Consultant, the Family Psychoeducation Trainer and Consultant, and the Supported Employment Trainer and Consultant. Together, they will implement the specific recommendations in their fidelity action plans, ensuring staff are fully equipped to provide effective, evidence-based services to participants and their families.

Additionally, we have initiated strategic discussions regarding the implementation of the CSC H-codes introduced by CMS in 2023. Incorporating these specific codes will help standardize billing and sustainability pathways for team-based care:

- **H2040:** Coordinated specialty care, team-based, for first episode psychosis, per month
- **H2041:** Coordinated specialty care, team-based, for first episode psychosis, per encounter

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

Schizophrenia: 295.9 (F20.9)
Schizoaffective D/O Bipolar Type: 295.7 (F25.0)
Schizoaffective D/O Depressive Type: 295.7 (F25.1)
Schizoaffective Disorder - Unspecified: 295.70 (F25.9)
Schizophreniform D/O: 295.4 (F20.81)
Delusional D/O: 297.1 (F22)
Brief, Brief Psychotic Disorder: 298.8 (F23)
Other specified schizophrenia spectrum and other psychotic disorder: 298.8 (F28)
Unspecified schizophrenia spectrum and other psychotic disorder: 298.9 (F29)
Major Depressive Disorder with Psychotic Features (single episode or recurrent): 296.34, 296.24 (F32.3, F33.3)
BPD, Bipolar Disorder with Psychotic Features: 296.54, 296.44 (F31.5, F31.2)
Substance-induced psychotic disorder
Other non-affective psychoses

10. What is the estimated incidence of individuals experiencing First Episode Psychosis in the state?

There is an incidence of approximately 130 new cases of first episode psychosis per year (FY25) in Maryland.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

To promote early identification and build robust referral networks, the state requires each First Episode Psychosis (FEP) provider to conduct a minimum of 13 outreach events annually. These initiatives focus on raising awareness and cultivating partnerships with a diverse range of stakeholders, including community behavioral health professionals, mental health partners, state advocacy groups, public schools, hospitals, treatment centers, and state universities, including Historically Black Colleges and Universities (HBCUs).

To further increase access to care, the Maryland Early Intervention Program (MEIP) maintains a centralized phone line dedicated to guiding the public on FEP treatment pathways. Additionally, coordination efforts have expanded to the state's 988 crisis team, providing them with comprehensive overviews of Early Serious Mental Illness (ESMI) and available local resources. The state aims to sustain this collaboration through ongoing, relevant training for crisis counselors.

Upon enrollment in an FEP program, clients are systematically referred to each program service. This comprehensive framework helps individuals build structure, understand their diagnosis, and engage in their recovery. Key roles within this multidisciplinary team include:

- Supported Employment and Education serve as direct advocates for clients in the work fields. The specialists assist individuals in identifying career interests, conducting mock interviews, and providing ongoing on-the-job or on-campus support to ensure functional retention and success.
- Family Psychoeducation is a therapeutic approach where practitioners partner with consumers and their families to treat serious mental illness. Unlike traditional family therapy, FPE focuses specifically on the clinical realities of the illness itself, equipping families with the collective coping skills and management strategies necessary for long-term stabilization.
- Certified Peer Recovery Specialists (CPRS)**:** Leveraging unique, lived experience, CPRS team members offer emotional support. They share practical knowledge, teach self-advocacy skills, provide hands-on assistance, and bridge connections to community resources, opportunities, and broader networks of support.

12. Please indicate area of technical assistance needs related to this section.

It would be helpful for FEP clinicians to get technical assistance on understanding the differential diagnosis for autism and psychosis. In addition, training on available resources on autism in schools, for effective advocacy for clients across all jurisdictions.

9. Crisis Services - 5 Percent set aside – Required MHBG

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1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Since last reporting, Maryland has continued its transformation efforts to improve and expand the crisis continuum of care available across the state. We want to ensure that regardless of where you live in the state, your age, your race and ethnicity, and your health insurance status, that you have: someone to contact when you need urgent behavioral health care (988); someone to respond to help you in that moment (community-based mobile crisis response and stabilization services); and somewhere safe to get help, stabilize, and get connected to the ongoing support you need (varied levels of crisis receiving & stabilization facility services). There should also be no wrong door – people can enter the system from various entry points, and receive warm handoffs to the services that best align with their needs.

Since 2025, the Maryland Department of Health Behavioral Health Administration's Division of Urgent & Acute Care focused on four core system-level projects:

1) **Crisis Continuum Improvement:** Through review of all crisis programming grants, we identified opportunities to improve and expand the continuum of services in every jurisdiction across the state. BHA meets bimonthly with each jurisdiction to discuss opportunities for improving the availability and quality of crisis services.
2) **Individuals with Developmental Disabilities Crisis Policy Academy:** Maryland was one of six states selected to participate in the The Link Center Policy Academy to enhance crisis services for individuals with I/DD, brain injuries, and cognitive disabilities who also have mental health needs. This included developing and executing a training for crisis

providers on working with individuals with developmental disabilities, brain injury, and other neurodivergent conditions.

3) **Data Reform:** In FY25 reporting on outcomes varied across programs. Maryland is significantly enhancing crisis services data collection for FY26, including record level reporting on mobile crisis response and stabilization services and the standardization of data elements and definitions across all crisis programs. This data reform will be critical in identifying service strengths and opportunities for improvement.
4) **Crisis Services Provider Training:** Established the Maryland Crisis Response and Stabilization Training Center to provide standardized, high-quality training to all crisis services staff at no cost to attendees. This initiative supports workforce development and meets the State's regulated training requirements for licensed programs.

Description of Access to Crisis Call Centers

Maryland launched 988 Lifeline operations in July 2022, which ran concurrently with the State hotline "211*Press 1" for approximately eighteen months, with a full transition in December 2023. Currently, there are nine Lifeline network crisis contact centers in Maryland covering 100% of the geography of the state. In state fiscal year 2025, 137,405 contacts were made to 988/Lifeline Crisis Contact Centers (including calls, texts, chats, and unknown contact methods).

Over the last year, Maryland significantly increased our 988 outreach and engagement efforts. This includes working with other state agencies (including licensing boards), starting a 988 Partnership Committee with community partners, and the development of a quarterly 988 newsletter. In addition, Maryland established a 988 - 911 state Workgroup to enhance partnerships between 988 call centers and Public Safety Answering Points.

Availability of Mobile Crisis Teams and Behavioral Health Responder Services

Maryland has four primary models for Mobile Crisis Response and Stabilization Services: Mobile Crisis Teams, Mobile Response Teams, child-specific teams, and co-responder teams. All are described in detail below. In State Fiscal Year 2025, the Governor invested $8 million to expand mobile crisis responder availability to 24/7 in 19 of the 24 Maryland jurisdictions.

1. **Mobile Crisis Teams (MCT)** are a specific regulated licensed service type with requirements outlined in Code of Maryland Regulations 10.63.03.20 for key program elements including staffing, training, dispatch protocols, assessment, services, and follow-up. Select program requirements include: Available 24/7/365; Two-person, in-person response; Licensed Mental Health Professional required to complete assessment and must be involved with the response either in-person or via audio-video telehealth; Serve all ages and priority populations. Program regulations went into effect in May of 2024. Notably as of January 2025, licensed MCTs became eligible for fee-for-service revenue for all response and follow-up services for all insurance types (all non-Medicaid-

covered service claims are reimbursed by state dollars). As of April 2026, 19 of 24 jurisdictions have providers that are licensed and enrolled in Medicaid. These services are provided by 8 different provider organizations.

2. **Mobile Response Teams (MRT)** are similar to MCTs, but do not meet all of the regulatory requirements, such as hours of operation or required staffing. An MRT is composed of one or two responders, such as licensed mental health professionals, medical professionals, individuals with lived experience (peers), and may include other trained non-licensed staff and paraprofessionals (but not law enforcement). These services are not reimbursable through the Maryland BHASO, including Medicaid. We are working with the five jurisdictions operating MRTs to become accredited and licensed to meet the MCT model requirements.

3. Maryland is committed to working with jurisdictions and providers to ensure youth and their support system can access high quality mobile crisis response and stabilization services when they are experiencing an urgent behavioral health need. Ten of 24 jurisdictions are funded by the state to operate mobile crisis programs and/or staff **dedicated to serving children and adolescents and their support networks**, including stabilization after an initial crisis response, in alignment with the Mobile Response and Stabilization Services (MRSS) model. **These specialized teams responded to 2,412 children/families** in state fiscal year 2025.
4. Maryland **Co-Response Teams (CRT)** are staffed by behavioral health and first responder team members. They work in tandem based out of the same vehicle, responding primarily to active 911 calls designated with a behavioral health issue, but a high level of acuity or safety risk beyond what an MCT can provide. On CRT teams with law enforcement (LE), behavioral health staff are typically a master's level clinician licensed at the independent practice level. On CRT teams with EMS, support staff are typically a substance use peer, focused on overdose response efforts. There are five co-responder teams in Maryland that use the following models: (1) Clinician/LE/EMS, (3) Clinician/LE, and (1) Peer/EMS.

Utilization of Crisis Receiving and Stabilization Centers

There are three primary service types in Maryland, as described below: Crisis Stabilization Centers, Urgent Care, and Safe Stations. Funding to operate these programs varies by jurisdiction and depends on the type of organization operating the program. In state fiscal year 2025, 8,060 individuals were served across programs funded all or in part by awards through the State.

1. **Behavioral Health Crisis Stabilization Center** (consistent with SAMHSA's high-intensity behavioral health emergency center definition) is a specific regulated service service type with requirements outlined in Code of Maryland Regulations 10.63.03.21 for key program elements including staffing, training, facility protocols, services, and follow-up. This service operates 24/7 and accepts both voluntary and involuntary status individuals on a walk-in basis without restrictions or exclusionary criteria. In 2025, there was one Behavioral Health Crisis Stabilization Center that subsequently closed due to the provider discontinuing services. There is currently one Behavioral Health Crisis Stabilization Center. This center's facility is being remodeled to meet regulatory requirements to serve individuals under age 18 and to meet facility requirements to serve individuals on involuntary status.
2. There are two models of **Behavioral Health Urgent Care** centers in Maryland– some services are offered on an immediate "walk-in" basis, while others are by appointment within 48 hours of referral. At least 15of these programs are available across the state, 11 of which are funded by BHA. Of those programs that receive funding through State grants, there were 1,291 individuals served (274 children/adolescents and 1,010 adults). Many providers operating these services receive funding from unique sources; therefore, BHA does not have access to further information about the total number of programs operating statewide or their service volume.
3. The **Safe Station** model utilizes existing emergency services facilities (i.e. fire and police stations) to provide individuals struggling with opioid addiction with immediate, community-based access to support, treatment, and resources. Safe Station services are available 24 hours a day, seven days a week and provide various levels of intervention. Five programs are funded statewide by the federal State Opioid Response (SOR) program to operate these services.

2. In accordance with the guidelines provided, identify the stages where the existing/proposed system will fit in. Please check the appropriate box for each row to indicate the state's stage of implementation.

Entire System: "Initial Implementation", nearing "Full Implementation"

- Someone to Call = Program Sustainment/100%
- Someone to Respond = Program Sustainment/100%
- Safe Place to Be = Partial Implementation/50%

3. Briefly explain your stages of implementation.

"Initial Implementation stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published Guidelines."

Maryland's crisis system is in the **Initial Implementation** stage because we have implemented the three core crisis services and providers have been putting the MCT and BHCSC regulations into practice, as well putting into practice the revamped statewide standards for crisis services provision, as laid out in statements of work for all crisis services awards starting in FY2025. Primary barriers to Maryland achieving the "fulfilling implementation stage" at this time are chronic workforce and funding shortages, which are endemic in the national crisis services field. Below is a summary of the status for each segment of the continuum.

Someone to talk to: Crisis Call Capacity

- 100% of the state of Maryland has access to the 988 Suicide & Crisis Lifeline via phone, text, and chat.
- Additional local hotlines provide supplemental support, often for specific service needs or populations.

Someone to respond: Number of jurisdictions that have mobile behavioral health crisis capacity:

- 100% of the state of Maryland is covered by a mobile crisis response and stabilization (MCRS) program
    - 80% of Maryland jurisdictions (19 of 24) have coverage by licensed Mobile Crisis Teams
    - 20% of jurisdictions (5 of 24) are working to align their existing program with the regulated requirements
- 42% of jurisdictions in Maryland (10 of 24) operate programs specialized to serve children, youth, and caregivers
- At least two thirds of all MCRS programs employ peer supports

Safe place to go or to be:

- 58% of Maryland jurisdictions have at least one place for individuals to go for same-day crisis services (14 of 24). This includes walk-in centers, Safe Stations, and urgent care capabilities.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the National Guidelines for Child and Youth Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Our vision for the Maryland Behavioral Health System is a statewide continuum of integrated and comprehensive behavioral health services made easily accessible to Marylanders across the lifespan. All of Maryland's efforts align with the Substance Abuse Mental Health Services Administration best practices for a comprehensive crisis system. We believe a robust crisis system includes prevention of serious behavioral health challenges to begin with; in-person assistance in the moment of crisis, where 'crisis' is defined by the person seeking support; and provision of stabilization care to help individuals heal and thrive. We believe care must be person-centered, compassionate, trauma-responsive, and address the needs of the whole person, including social drivers of health. Care must build on the person's strengths and incorporate their self-defined support system. We must also ensure that caregivers have the support they need to care for loved ones. We believe that ensuring the availability of high quality services across the state is critical in achieving health for everyone.

All 24 jurisdictions in Maryland have mobile crisis programs that serve the lifespan through a range of models. Nineteen of 24 jurisdictions have a licensed Mobile Crisis Team provider that is required to serve the lifespan. Ten of 24 jurisdictions have additional, mobile crisis programs and/or staff dedicated to serving children and adolescents, including stabilization after an initial crisis response, in alignment with the MRSS model.

In FY2025, MDH-BHA provided more than $4.1 million in funding to jurisdictions to establish MRSS programming. This included $3.7 million of federal COVID funding to eight jurisdictions and $413,000 in state legislated Crisis Response Grant grants for stabilization services for five jurisdictions. When the federal COVID funding expired at the end of state fiscal year 2025, MDH-BHA worked with Local Authorities to review the services, volume, and expenditures, which informed FY26 funding needs. As a result of this analysis, MDH-BHA identified more than $2 million in FY26 state general funds to support MRSS in five jurisdictions. These counties continue to leverage their MCT infrastructure and funding noted above to support the full lifespan and provide follow-up and stabilization for up to eight weeks.

In May 2024, Maryland MCT regulation became effective which requires licensed MCTs to be trained in the MRSS model. Up to 2 weeks of stabilization services will be funded through the BHASO (Medicaid and state general funds fee for service) and up to 8 weeks funded by other grant awards. Maryland applied for and was awarded $250,000 in National Association of State Mental Health Program Directors (NASMHPD) to support the continuation of training with a focus on the MRSS model in FY27. Additional state funding is provided to support statewide crisis workforce training.

5. Other program implementation data that characterizes crisis services system development. Please provide the following data

Someone to contact: Crisis Contact Capacity

a. **Number of locally based crisis call Centers in state**
   i. In the 988 Suicide and Crisis lifeline network: 9
   ii. Not in the suicide lifeline network: 40 other hotline/warmline numbers that we are aware of at this time. We do not know how many non-lifeline "call centers" this represents.
b. **Number of Crisis Call Centers with follow up protocols in place**
   i. In the 988 Suicide and Crisis lifeline network: 9 (100%)
   ii. Not in the suicide lifeline network: Since the state does not fund almost all of these non-988 call centers, we do not have an in-depth understanding of their follow-up policies and procedures. However, for the non-988 call center that we do provide funding to, the follow-up requirements are the same as our 988 centers.
c. **Estimated percent of 911 calls that are coded out as behavioral health related**: 15%

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 24 of 24
b. Integrated with public safety first responder structures (police, paramedic, fire): 5 of 24 (supplemental co-response team services). Many mobile crisis response programs partner closely with first responder structures for diversion, rather than full integration of response.
c. Number that utilizes peer recovery services as a core component of the model: 16

Safe place to be

a. **Number of Emergency Departments:** 48 total; 44 emergency units with psychiatric emergency facility designation
b. **Number of Emergency Departments that operate a specialized behavioral health component:** 11
c. **Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis):** 3 centers matching this description receive grants through the State (Baltimore City, Calvert, Frederick). Many other similar programs exist across the state but are not wholly known to BHA as they receive full funding from other sources.

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Maryland plans to utilize the 5% Crisis Set-Aside to strengthen the full continuum of behavioral health crisis services, with a primary focus on increasing access to timely, high-quality direct care. Building on the recent statewide solicitation conducted by the Behavioral Health Administration (BHA), the State is identifying geographic and service delivery gaps and directing resources to areas with the greatest unmet need. Funding will support the enhancement of core crisis services, including mobile crisis response teams and short-term crisis stabilization services, ensuring individuals in behavioral health crises receive rapid, community-based interventions as an alternative to emergency department utilization or law enforcement involvement where appropriate.

Maryland is intentionally leveraging the Certified Community Behavioral Health Clinic (CCBHC) model as a critical component of its crisis response system. CCBHCs are expected to play a key role in coordinating mobile crisis team services and providing timely crisis follow-up care, including next-day or rapid access appointments to ensure continuity of care after a crisis episode. Through this model, the State aims to improve care transitions, reduce repeat crises, and promote stabilization in the least restrictive setting.

In alignment with national best practices, Maryland is strengthening coordination between the 988 Suicide & Crisis Lifeline system and CCBHC providers. This includes developing formal protocols for warm handoffs between 988 centers and mobile crisis teams, as required by their grant contracts. In some cases, the 988 Center and crisis response provider are the same, improving system efficiency and responsiveness.

Additionally, a portion of the set-aside funds will be used to support workforce development and system capacity building. This includes training, participation in crisis learning collaboratives, and attendance at conferences to ensure state efforts continue to align with evolving evidence-based practices in crisis care. Collectively, these investments are designed to create a more coordinated, responsive, and person-centered crisis system that fully integrates CCBHCs and aligns with the broader goals of the 988 and crisis framework.

7. Please indicate areas of technical assistance needs related to this section.

As indicated in last year's plan, we would appreciate technical assistance on billing Medicare for Mobile Crisis Team and Behavioral Health Crisis Stabilization Services. We are also interested in other payment models for these services other than fee-for-service.

14. State Planning/Advisory Council and Input on the Mental Health Block Grant Application

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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.

Please provide responses to all questions ensuring sufficient details are included to fully address all elements of each question. **Do not leave any questions unanswered.**

1. How was the Council involved in the development and review of the state plan and report. Utilizing the textbox provided, please clearly describe the Council's involvement. Please **upload supporting documentation** such as meeting minutes, letters of support, letter from the council chair, etc. In addition, **please upload comments received from the Council after reviewing the Application/State Plan and Report, if any.**
2. Has your state received any recommendations on the State Plan or comments on the previous year's State Report? Please select the appropriate "yes" or "no" checkbox. In addition, if the state response is 'yes', **please upload the recommendations and/or comments received from the Council without regard to whether the state has made the recommended modifications.**

   Yes

   No
3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services? Utilizing the textbox provided, please clearly articulate the mechanism used.
4. Has your Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? **Please select the appropriate "yes" or "no" checkbox.**

   Yes

   No
5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children)? **Please select the appropriate "yes" or "no" checkbox.**

   Yes

No

6. Utilizing the textbox provided, 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 advocated for individuals with SMI or SED.
7. Please indicate areas of technical assistance needs related to this section.

Name	Type of Membership*	Agency or Organization Represented
[redacted]	Advocates/representatives who are not state employees or providers	
	State Employees	
	State Employees	
	Advocates/representatives who are not state employees or providers	
	State Employees	
	State Employees	
	State Employees	
	Advocates/representatives who are not state employees or providers	
	Advocates/representatives who are not state employees or providers	
	State Employees	
	Advocates/representatives who are not state employees or providers	
	Advocates/representatives who are not state employees or providers	

	Advocates/representatives who are not state employees or providers	
	Parents of children with SED	
	State Employees	
	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	
	State Employees	
	Advocates/representatives who are not state employees or providers	
	Advocates/representatives who are not state employees or providers	
	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	
	Family Member of an Adult in Recovery (Family members of adults with SMI and family members who are not parents of children with SED)	
	Family Member of an Adult in Recovery (Family members of adults with SMI and family members who are not parents of children with SED)	
	Family Member of an Adult in Recovery (Family members of adults with SMI and family members who are not parents of children with SED)	
	Family Member of an Adult in Recovery (Family members of adults with SMI and family	

	members who are not parents of children with SED)	
	Family Member of an Adult in Recovery (Family members of adults with SMI and family members who are not parents of children with SED) Parent of a Child with SED: A parent or legal guardian of a child or youth with Serious Emotional Disturbance.	

Advisory Council Composition by Member Type

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery (to include family members of adults with SMI)		
Parents of children with SED		
Vacancies (individual & family members)		
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others[2]		
Total individuals in recovery, family members, and parents of children with SED[3]		
State Employees		

[2] There are three (3) consumers, one (1) of whom is a Youth/Young Adult. There is currently one (1) vacancy for a Youth/Young Adult Consumer. There are four (4) family members, two (2) of whom are Family Members of a Child.

[3] Data are not collected regarding the following categories of individuals:

1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)
2.Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)
3.Parents of children with SED
4.Persons in Recovery from or providing treatment for or advocating for SUD services
5.Representatives from Federally Recognized Tribes

Providers		
Vacancies		
TOTAL State Employees & Providers		
Persons in Recovery from or providing treatment for or advocating for SUD services		
Representatives from Federally Recognized Tribes		
Youth/adolescent representative (or member from an organization serving young people).		
Advocates/representatives who are not state employees or providers		
Other vacancies (who are not individuals in recovery/family members or state employees/providers)		
Total non-required but encouraged members		
Total Membership (Should count all members of the council)		

15. Public Comment on the State Plan, Required for MHBG

Title XIX, Subpart III, section 1941 of the PHS Act (42 USC §300x-51) requires, as a condition of the funding agreement for the grant, that 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 the federal government.

Please provide responses to all questions ensuring sufficient details are included to fully address all elements of each question. Do not leave any questions unanswered.

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: https://health.maryland.gov/bha/Pages/SAMHSA-Block-Grant.aspx

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Review the final version of the MHBG here.

Review the final version of the SUPTRS here.

c. Other (e.g. public service announcements, print media)

Yes
No

d. Please indicate areas of technical assistance needs related to this section.

Table 2: MHBG Planned State Agency Budget for SFY2027[4]

States are asked to present their projected one-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Activity	**A. SUPTRS BG**[5]	**B. Mental Health Block Grant**	C. Medicaid (Federal, State, and Local)	Source of Funds 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 Use Disorder Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children (PWWDC)							
b. All Other							
2. Recovery Support Services							
3. Primary Prevention							

[4] Please note that the areas that are in gray are not reported for the FFY27 MHBG Mini Block Grant Application.

[5] Please note that these fields are grayed out for the FFY27 MHBG Mini Block Grant Application.

4. Early Intervention Services for HIV							
5. Tuberculosis Services							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)a		1,787,017	0	119,408	0	0	0
7. State Hospital			0	0	5,761,433	0	0
8. Other Psychiatric Inpatient Care			0	0	284,176	0	5,000,000
9. Other 24-Hour Care (Residential Care)		0	0	0	45,626,348	0	0
10. Ambulatory/Community Non-24 Hour Care		4,311,446	0	26,046,677	205,041,143	0	9,133,083
11. Crisis Services (at least 5 percent set-aside) Set Aside		4,869,815	0	3,195,546	20,082,239	0	23,919,071
12. Other Capacity Building/Systems Development		6,008,384					
13. Administration (5% Cap)		893,509	0	4,532,903	15,610,082	0	781,728
14. Total		**17,870,171**	**0**	**33,894,534**	**292,405,421**	**0**	**38,833,882**

Table 4: MHBG State Agency Planned Budget

Planning Tables

Table 4 addresses the planned SFY 2027 budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 12-month period (for most states, it is July 1, 2026 - June 30, 2027).

Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	0
1b. Crisis Services for Adults	4,006,430
1c. CSC/ESMI program for Adults	1,589,844
1d. Other outpatient/ambulatory services for Adults	0
1e. *Other Direct Services for Adults	3,185,090
2. Subtotal of Services for Adults	**8,781,364**
3. Services for Children	

3a. EBPs for Children	212,505	
3b. Crisis Services for Children	863,385	
3c. CSC/ESMI program for Children	197,173	
3d. Other outpatient/ambulatory services for Children	0	
3e. *Other Direct Services for Children	913,851	
4. Subtotal of Services for Children	**2,186,914**	
5. Other Capacity Building/Systems Development	6,008,384	
6. Administrative Costs	893,509	
7. *Any Other Cost	0	
8. Total MHBG Allocation	**17,870,171**	

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Planning Period Start Date: 07/01/2026 MHBG Planning Period End Date: 06/30/2027

MHBG Plan Table 6 address MHBG funds to be expended on other capacity building /systems development activities during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027). Please use these columns to capture how much the state plans to expend over a 12-month period.

Activity	FFY 2026 MHBG	FFY 2026 BSCA Funds	FFY 2027 MHBG
1. Information Systems	402,868	0	292,350
2. Infrastructure Support	0	0	0
3. Partnerships, Community Outreach, and Needs Assessment	4,000	0	260,435
4. Planning Council Activities	0	0	0
5. Quality Assurance and Improvement	2,089,236	0	1,044,618
6. Research and Evaluation	3,310,390	0	3,391,118
7. Training and Education	3,426,532	0	1,019,863
8. Total	**9,233,026**	**0**	**6,008,384**