For Public Comment:

FFY27 SUPTRS Mini Block Grant Application

To leave a comment, please visit:
https://app.smartsheet.com/b/form/019ddaac4a877efa8520fad3c7af806f

---

Substance Use Prevention, Treatment and Recovery Services (SUPTRS)

9. Crisis Services - 5 Percent set aside – Requested for SUPTRS

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.

15. Public Comment on the State Plan, Requested for SUPTRS

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 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

Table 5a SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

9. Crisis Services - 5 Percent set aside – Requested for SUPTRS

---

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.

In 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.

15. Public Comment on the State Plan, Requested for SUPTRS

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

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

        Yes
        No

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

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned expenditures by State Fiscal Year (Table 2), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4 must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each Fiscal Year should match the SUPTRS BG Final Allotments for the state.
Planning Period Start Date: 10/1/2026 Planning Period End Date: 9/30/2027

Expenditure Category	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1 . Substance Use Disorder Prevention and Treatment	$20,938,061.00	$14,997,259.00
2 . Recovery Support Services	$1,945,810.00	$7,886,510.00
3 . Substance Use Primary Prevention	$6,979,447.00	$7,115,477.00
4 . Early Intervention Services for HIV		$0.00
5 . Tuberculosis Services		$0.00
6 . Other Capacity Building/Systems Development	$3,289,057.00	$3,177,015.00
7. Administration	$1,744,862.00	$1,746,119.00
8. Total	$34,897,237.00	$34922380.00

Table 5a SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Tables

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

Strategy IOM Classification		FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
1. Information Dissemination	Universal	$1,500,892	$1,574,477.00
	Selective		
	Indicated		
	Unspecified		
	Total	**$1,500,892**	**$1574477**
2. Education	Universal	$213,615	$216,000.00
	Selective	$367,893	$380,000.00
	Indicated	$11,868	$15,000.00
	Unspecified		
	Total	**$593,376**	**$611000**
3. Alternatives	Universal	$563,707	$570,000.00
	Selective	$99,478	$100,000.00
	Indicated		

	Unspecified		
	Total	**$663,185**	**$670000**
4. Problem Identification and Referral	Universal	$34,904	$40,000.00
	Selective		
	Indicated		
	Unspecified		
	Total	**$34,904**	**$40000**
	Universal	$656,204	$670,000.00
	Selective	$41,885	$50,000.00
5. Community-Based Processes	Indicated		
	Unspecified		
	Total	**$698,089**	**$720000**
6. Environmental	Universal	$3,489,001	$3,500,000.00
	Selective		
	Indicated		
	Unspecified		
	Total	**$3,489,001**	**$3500000**
7. Section 1926 (Synar)-Tobacco	Universal		
	Selective		
	Indicated		

	Unspecified		
	Total	**$0**	**$0**
8. Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	**$0**	**$0**
Total Prevention Budget		**$6,979,447**	**$7115477**
Total Award a		**$34,897,237**	**$34922380**
Planned Primary Prevention Percentage		**20.00%**	20.38%

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

Planning Tables
States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026		
Strategy	FFY 2026 SUPTRS BG Award	FFY2026 SUPTRS BG Award
1. Universal Direct	$6,458,323	$6,570,477.00
2. Universal Indirect		
3. Selective	$509,256	$530,000.00
4. Indicated	$11,868	$15,000.00
5. Column Total	**$6,979,447**	$7,115,477.00
6. Total SUPTRS Award	**$34,897,237**	$34,922,380.00
7. Primary Prevention Percentage	**20.00%**	20.38%

Environmental Factors and Plan

15. Public Comment on the State Plan - Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, 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 respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? Yes **X** No

b) Posting of the plan on the web for public comment? **X** Yes No

If yes, provide URL:

MDH-BHA Office of Planning https://health.maryland.gov/bha/Pages/-Planning.aspx

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

MDH-BHA Office of Planning, SAMHSA Block Grant Apps https://health.maryland.gov/bha/Pages/SAMHSA-Block-Grant.aspx

c) Other (e.g. public service announcements, print media) **X** Yes No

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

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

None at this time.