Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

January 8, 2025

The Honorable Bill Ferguson
President of the Senate
H-107 State House
100 State Circle
Annapolis, MD 21401-1925

The Honorable Joseline Peña-Melnyk
Speaker of the House of Delegates
H-101 State House
100 State Circle
Annapolis, MD 21401-1925

RE: Chapter 687 of the Acts (2025) – Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access - Plan to Implement Early and Periodic Screening, Diagnostic, and Treatment Requirements (MSAR # 16408)

Dear President Ferguson and Speaker Peña-Melnyk,

Pursuant to the requirements of Chapter 687 of the Acts (2025), the Maryland Department of Health (the Department) respectfully submits this report on the activities of the Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access - Plan to Implement Early and Periodic Screening, Diagnostic, and Treatment Requirements Workgroup.

This report includes information on the workgroup's meetings, discussions, and final recommendations, as well as comments and recommendations from the Department.

If further information is needed please contact Alyssa Brown, Director of Innovation, Research, and Development, at alyssa.brown@maryland.gov.

Sincerely

Meena Seshamani, M.D., Ph.D.

Secretary of Health

cc:

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Early and Periodic Screening, Diagnostic, and Treatment Requirements Workgroup Summary and Recommendations

Chapter 687 of the Acts of 2025

Maryland Department of Health

December 2025

Introduction

Pursuant to Chapter 687 of the Acts (2025), *Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access - Plan to Implement Early and Periodic Screening, Diagnostic, and Treatment Requirements*, the Maryland Department of Health (the Department) must submit a report of the findings and recommendations of the Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access, through its workgroup on Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Health Needs, to implement the recommendations in Center for Medicare and Medicaid Services (CMS) State Health Official (SHO) letter #24-005: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements for children.[1,2] Guidance in SHO #24-005 includes:

1) Screening and assessment of behavioral health conditions
2) The feasibility of implementing the DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood as a diagnostic tool for patients under the age of 5 years
3) Community-based services to correct and ameliorate a wide range of behavioral health conditions
4) Services to:
    a) Ensure children's behavioral health
    b) Address early symptoms of concern, with or without a diagnosis
    c) Address urgent and crisis needs

Background

Purpose of the Workgroup

SB 790/HB 1083 (2025) required the Children, Youth and Families Committee of the Behavioral Health Advisory Council (BHAC) and the Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs workgroup within the Commission on Behavioral Health Care Treatment and Access to serve as the forum for this EPSDT workgroup. The membership of this workgroup can be found in Appendix A.

The Maryland BHAC was established in 2015 through SB 175, *Behavioral Health Administration - Behavioral Health Advisory Council* (Chapter 328 of the Acts of 2015).[3] The BHAC is a forum for disseminating and sharing information concerning the Public Behavioral

[1] HB 1083 - Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access- plan to Implement Early and Periodic Screening, Diagnostic, and Treatment Requirements (Ch. 687 of the 2025 Acts). https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb1083?ys=2025RS

[2] CMS (2024). SHO #24-005, Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

[3] Maryland Department of Health. Maryland Behavioral Health Advisory Council. Maryland.gov. https://health.maryland.gov/bha/pages/maryland-behavioral-health-advisory-council.aspx

Health System (PBHS). The BHAC advocates for a comprehensive, broad-based, person-centered approach to providing social, economic, and medical support for people with behavioral health needs as mandated by Health-General Article § 7.5-305. The BHAC consists of 28 In-Statute Ex-Officio Members (or designees) representing state and local government, the Judiciary, and the Legislature; 13 members, appointed by the Maryland Department of Health Secretary, representing behavioral health provider and consumer advocacy groups; and 14 representatives that include a diverse range of individuals who are consumers, family members, professionals, and involved community members.

The Commission on Behavioral Health Care Treatment and Access[4] (the Commission) was established in the 2023 legislative session by HB 1148/SB 582, *Behavioral Health Care - Treatment and Access (Behavioral Health Model for Maryland)* (Chapters 290 and 291 of the Acts of 2023), to recommend appropriate, accessible, and comprehensive behavioral health services statewide across the behavioral health continuum of care.[5] The Commission is chaired by Dr. Meena Seshamani, Secretary of Health, and the remaining 37 members are selected based upon the criteria in the law. In 2024, HB 1048/SB 212, *Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access - Alterations* (Chapters 41 and 42 of the Acts of 2024), streamlined the BHAC and the Commission by allowing for joint meetings and reporting between the two bodies.[6]

Early and Periodic Screening, Diagnostic, and Treatment

Medicaid is a joint federal-state program that provides health and long-term care coverage to low-income individuals, pregnant women, the elderly, and people living with disabilities. As a federal-state program, Maryland's Medicaid program, the Maryland Medical Assistance Program (Medical Assistance), must cover certain mandatory benefits, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT requirements, established by Sections 1905(a)(4)(B) and (r) of the Social Security Act, entitle Medicaid and Children's Health Insurance Program (CHIP)-eligible children under the age of 21 to coverage of any medically necessary service to correct or ameliorate physical or mental conditions, regardless of if the service is covered in the state plan.[7] The goal of the EPSDT requirements is to ensure children receive the right care, in the right setting, at the right time, to identify and treat health conditions as early as possible.

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[4] Maryland Department of Health. Commission on Behavioral Health Care Treatment and Access. https://health.maryland.gov/commission-bhc/Pages/default.aspx

[5] Senate Bill 582 - Behavioral Health Care- Treatment and Access (Behavioral Health Model for Maryland) (Chapter 290 of the Acts of 2023) https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0582?ys=2023RS

[6] House Bill 1048 - Behavioral Health Advisory Council and Commission on Behavioral Health Care Treatment and Access- Alterations (Chapter 41 of the Acts of 2024) https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB1048?ys=2024RS

[7] Social Security Act Sec. 1905. [42 U.S.C. 1396d]: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

Screening services include comprehensive health and developmental histories, including mental health, comprehensive physical examinations, immunizations, laboratory testing, and health education. Diagnostic services must be provided when a screening examination indicates the need for further evaluation of an individual's health. Medically necessary treatment includes vision, hearing, and dental services.

While EPSDT is a federally-mandated requirement, it is administered through state Medicaid programs. As of October 2026, 714,968 children, youth, and adults ages 0-20 are enrolled in Maryland Medical Assistance. Maryland's EPSDT Program, the Healthy Kids Program, ensures that Maryland youth have access to the required EPSDT services.[8] The Healthy Kids Program provides appropriate practice-based performance improvement assessments and targeted interventions to enhance the quality of health services delivered by Medicaid providers to eligible participants less than 21 years of age. The Program also maintains the Maryland Healthy Kids Preventive Health Schedule, which reflects minimum standards required during well-child visits for Medical Assistance participants.[9] The Maryland Healthy Kids Preventive Health Schedule closely correlates to the American Academy of Pediatrics' (AAP) periodicity schedule.[10]

Background on Maryland's Behavioral Health Financing Model

The majority of children enrolled in Maryland Medical Assistance receive care through HealthChoice, Maryland's statewide mandatory Medicaid managed care program. Under HealthChoice, eligible families and individuals are required to enroll in a managed care organization (MCO). Currently, there are nine Department-approved MCOs serving Marylanders. MCOs are responsible for providing EPSDT services to their members who are under 21 years old.[11] The EPSDT Medical Record Review (MRR), conducted annually by the Department's External Quality Review Organization, measures whether all HealthChoice MCOs achieve minimum levels of performance in delivering EPSDT services. The most recent MRR Report found that all components met or exceeded the MDH minimum threshold of 80% in measurement year (MY) 2023.[12]

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[8] Maryland Department of Health. EPSDT Information & Updates. Maryland.gov. https://health.maryland.gov/mmcp/epsdt/pages/home.aspx

[9] Maryland Department of Health (2022). Maryland Healthy Kids Preventive Health Schedule. Maryland.gov. https://health.maryland.gov/mmcp/epsdt/Documents/20%20Maryland%20EPSDT%20Schedule-01-01-2024%20(1)HealthRiskAssessment2023%20(1).pdf

[10] American Academy of Pediatrics (2025). Preventive Care/Periodicity Schedule. https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/?srsltid=AfmBOop4XsQazVTpFy5D_S1wvNPIuBwd82caRpnI8vg2NvJH0O7p-RoX

[11] COMAR 10.67.06.20. Benefits - EPSDT Services. https://dsd.maryland.gov/regulations/Pages/10.67.06.20.aspx

[12] Maryland Department of Health (2025). Medicaid Managed Care Organization EPSDT Medical Record Review, Statewide Executive Summary Report, Measurement Year 2023. Maryland.gov. https://health.maryland.gov/mmcp/healthchoice/Documents/MY%202023%20EPSDT%20Statewide%20Executive%20Summary%20Report.pdf

Since 2015, specialty behavioral health care has been "carved-out" of the HealthChoice managed care program. Primary behavioral health services, such as assessment and treatment for mild depression or anxiety in the primary care setting, are the responsibility of the MCOs. Specialty behavioral health services, such as treatment for serious mental illness or substance use disorders (SUD), are jointly overseen by the Medical Assistance and the Behavioral Health Administration (BHA) within the Department, and providers are paid for these services on a fee-for-service basis (FFS).[13] The behavioral health administrative services organization (BHASO), Carelon, manages specialty behavioral health services funded by Medicaid and state-only resources to support uninsured and underinsured individuals in need of care and assistance. The BHASO serves as the hub for the provision of both Medical Assistance and state-funded behavioral health services in Maryland.

Children enrolled in Maryland Medical Assistance may receive primary care (including well-child visits) through their MCO, and may be referred to receive specialty behavioral health if medically necessary through the BHASO.

CMS SHO, Brief Description, and Key Behavioral Health Recommendations
On September 26, 2024, CMS released SHO letter #24-005. As required by Section 11004 of title I of division A of the Bipartisan Safer Communities Act, the SHO letter provides guidance on "best practices for ensuring that children have access to comprehensive healthcare services, including children without a mental health or SUD diagnosis." The letter is divided into three sections, which include 1) promoting EPSDT awareness and accessibility, 2) expanding and using the child-focused (EPSDT) workforce, and 3) improving care of EPSDT-eligible children with specialized needs.

Several recommendations from this guidance are specifically referenced in SB 790/HB 1083. Table 1 includes the recommendations included in SB 790/HB 1083, guidance from SHO 24-005, and the Department's current state of compliance.

[13] COMAR 10.67.08.02. Behavioral Health Non-Capitated Covered Services. https://dsd.maryland.gov/regulations/Pages/10.67.08.02.aspx

Table 1. Bill Language, CMS Guidance, and the Department's Current State

SB 790/HB 1083 Language	Guidance from SHO 24-005	Department's Current State of Compliance
Screening and assessment of behavioral health (BH) conditions	All states must cover developmental and BH screening for EPSDT-eligible children. Strategies that states have used to increase BH screening include: ● Requiring primary care providers (PCPs) to use a developmental or BH tool during every well-child visit ● Paying add-on rates to PCPs for using an evidence-based screening tool during well-child and follow-up visits, and ● Using quality incentive payments.	The Department's developmental and BH screening requirements can be found in the Healthy Kids Preventive Health Schedule. The Department reimburses PCPs for using an evidence-based tool for developmental and BH screenings during well-child visits.[14] Effective January 1, 2025, the Department increased rates for multiple developmental and BH screenings required as part of the Healthy Kids Preventive Schedule.[15] The Medicaid Advanced Primary Care Program is seeking to include the Developmental Screening in the First Three Years of Life (DEV-CH) in its quality incentive program.
The feasibility of implementing the DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood as a diagnostic tool for patients under the age of 5 years	States should avoid requiring an EPSDT-eligible child to have a specific BH diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria.	Maryland has not yet adopted the DC:0-5, but has taken steps to prepare for implementation. Maryland has participated in ZERO TO THREE's Infant and Early Childhood Mental Health Financing Policy Project to explore potential implementation of the DC:0-5. BHA has funded the Center of Excellence for Infant and Early Childhood Mental Health to conduct a Train the Trainer program for providers to be trained in and/or use the DC:0-5 for diagnosis and

[14] Maryland Department of Health (2024). Provider Transmittal 50-25. https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT%2050-25%20Billing%20for%20Developmental%20Screenings%20Performed%20During%20Well-Child%20Visits.pdf

[15] Maryland Department of Health (2025). Provider Transmittal 67-25. https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT%2067-25%20Screening%20and%20Assessment%20Professional%20Rate%20Increase.pdf

		assessment and to train state trainers.
Services to: (i) ensure children's BH; (ii) address early symptoms of concerns, with or without a diagnosis; and (iii) address urgent and crisis needs.	States should avoid requiring an EPSDT-eligible child to have a specific BH diagnosis for the provision of services, as screenings may identify symptoms that require attention but do not meet diagnostic criteria. Mobile Crisis Intervention (MCI) services are identified as an important aspect of a state's response to meet children's BH needs in the home or any setting where a crisis may be occurring. States can require mobile crisis providers to receive training specific to working with children and youth.	In Maryland, unspecified diagnosis codes are available without limitation for children within the specialty BH system. MCOs are responsible for covering services for mental or BH when the diagnosis of a participant is not included under the specialty mental health system, as described in COMAR 10.67.08.02. Maryland has a range of crisis services, including mobile response and stabilization services and crisis receiving and stabilization facility services. Eighteen jurisdictions are covered by 24/7 licensed mobile crisis service providers; others are moving toward this licensure. Ten jurisdictions have youth-specific mobile crisis services. BHA has developed and is executing a training program for all crisis providers that aligns with CMS guidance.

Overview of Workgroup Meetings

Beginning July 2025, the Department met with stakeholders during five joint BHAC/Commission meetings to discuss SHO 24-005 and the specific areas of interest. The following provides a summary of these meetings. In addition to formal meetings, the Department also met with workgroup members between meetings to gain further understanding of potential recommendations. The slides from each of these sessions can be found in Appendix B.

Meeting 1- July 10, 2025

- Director of Primary Behavioral Health, Early Intervention Division Laura Torres presented the Roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth, and Families.[16] The Roadmap, developed by BHA, the Maryland Coalition of Families, and Manatt Health, is a consumer-informed strategic plan with recommendations for systematic improvement of the PBHS for children and their families. As part of the Roadmap, Ms. Torres highlighted the strategy "Leverage EPSDT to support early intervention," which includes providing behavioral health services regardless of diagnosis, as screenings may identify problems that warrant treatment but do not meet the criteria of a formal mental health diagnosis
- Alyssa Brown, the director of the Medicaid Office of Innovation, Research, and Development, presented on the behavioral health recommendations in SHO #24-005. Ms. Brown provided context on the Maryland Medical Assistance Program, EPSDT, and SB 790/HB 1083, which mandates the workgroup's consideration of SHO #24-005. Ms. Brown then outlined the process for the workgroup's development of recommendations between July and November of 2025
- Workgroup members and members of the public requested that the Department seek out and share best practices from other states, consider offering behavioral health services without a diagnosis, and look into the possibility of implementing DC:0-5

Meeting 2- September 10, 2025

- Ms. Torres presented on BHA's implementation updates and timelines on the recommendations included in the Roadmap to Strengthen Maryland's PBHS for Children, Youth, and Families. For Roadmap Goal #2, "Leverage EPSDT to support early intervention," It was discussed that the BHA is in the process of working with Medicaid to explore the use of DC:0-5 and will engage with Medicaid in the second half of FY26 to encourage timely follow-up after screenings and assessments
- Ms. Brown presented on the behavioral health recommendations for EPSDT in SHO #24-005 and the Department's current status in meeting this guidance. Key pieces of

[16] Maryland Department of Health (2025). Roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth and Families. Maryland.gov. https://health.maryland.gov/bha/Documents/MDH%20BH%20Roadmap%20for%20Children%202025.pdf

guidance included increasing developmental and behavioral health screening, offering care coordination through community-based management entities, adopting the Collaborative Care Model (CoCM), providing crisis services for children and youth, not requiring children to have a specific behavioral health diagnosis for the provision of services, and adopting the DC:0-5 as a diagnostic tool for patients under 5 years of age. It was noted that the Department has already undertaken efforts to increase developmental and behavioral health screenings. Currently, care coordination is provided through the MCOs, Rare and Expensive Case Management (REM) Program, Maryland AHEAD Primary Care Program, and Targeted Case Management services. The Department has adopted CoCM and provides support to the Behavioral Health Integration in Pediatric Primary Care (BHIPP) program. The provision of behavioral health services without diagnosis was identified as an area of potential area of opportunity by the Department

- Workgroup members and members of the public asked for further information about the Department's data on the provision of developmental and behavioral health screening. Workgroup members also asked about the Departments' plans to share takeaways conversations with other states and leveraging CCBHCs for screening and assessment. Further, workgroup members shared a Maryland DC:0-5 crosswalk that they had developed and recently released AAP guidance, noting that the Maryland Healthy Kids Preventive Health Schedule is not in alignment with the AAP's Bright Futures Periodicity Schedule

Meeting 3- October 1, 2025

- Ms. Brown presented the Department's deeper dive on the SHO #24-005 recommendations of interest to the workgroup. Ms. Brown began by providing an update on the provision of behavioral health screens for CY2024 and CY2025 YTD, which suggested that billing for behavioral health screenings is on track to increase. The Department provided snapshots of other states' efforts, including: the implementation of DC:0-5 in Washington state and Washington, D.C.; and the offering of behavioral health services without diagnosis in California, Massachusetts, and Colorado. Finally, Ms. Brown presented on the most recent AAP Clinical Report on Screenings for Mental Health, Emotional, and Behavioral Problems
- Workgroup participants commented that California, which has a similar behavioral healthcare financing model as Maryland, Massachusetts, and Colorado are promising examples of implementing the EPSDT guidance. Members of the workgroup, who are clinicians, shed more light on how the DC:0-5 would allow for more appropriate diagnoses for children under 5, and how allowing for the use of additional short-term, integrative behavioral health services could benefit children without a formal diagnosis. Workgroup participants also raised that the AAP Bright Futures Periodicity Schedule recommends that mental/behavioral assessments begin earlier than required in the Maryland Healthy Kids Preventive Schedule

Meeting 4- October 22, 2025

- Ms. Brown presented a brief summary of the workgroup's discussions thus far and potential recommendations, including implementation of the DC:0-5; changes to Maryland's requirements for behavioral, social, and emotional screenings; and different solutions to help children receive appropriate behavioral health services "without diagnosis"
- During the second half of the meeting, Joyce Harrison, MD(Johns Hopkins/Kennedy Krieger), Kristi Machemer, MD (Maryland AAP), Ms. Kay Connors, LCSW-C (University of Maryland School of Medicine) and Antonia Girard, PsyD (University of Maryland School of Medicine) presented potential recommendations for consideration (see Figure 1 below). Their recommendations were divided into Primary Behavioral Care and Specialty Behavioral Care. The Department committed to reviewing the information provided and preparing a departmental response

Figure 1. Final Recommendations Proposed at 10/22 Meeting

DC:0-5

1. Formally recognize the DC:0-5 as the recommended diagnostic classification for children under 6
2. For children 0-5 allow for up to 5 appointments before rendering a diagnosis

Screenings

1. Remove unit limits on developmental BH screens
2. Increase allowable screening units per visit from 2 to 3 or 4
3. Align the Healthy Kids periodic screening schedule with the AAP recommend periodicity schedule
4. 96161 is used for SDOH and Maternal Depression screenings: No recommendation, the Department clarified current guidance

Primary Behavioral Health Care

1. Expand use of CoCM in pediatrics: The Department clarified current guidance.
2. Expand HealthySteps for infants and toddlers, allow use of the enhanced code to include children ages 4-5
3. Work with research institutions to learn about how CoCM and HealthySteps can increase practices' ability to deliver EPSDT services
4. Allow 96112 and 96113 without a diagnosis and remove PA*
5. Allow LMSW and LGPC providers to bill for integrated care services

Specialty Behavioral Health Care

1. Allow billing for Autism Spectrum Disorder, Global Developmental Delay and Intellectual Development Disorder ICD-10 codes in Specialty BH Care: The Department will issue clarifying guidance
2. Allow for parent group therapy to be billed via telehealth

3. Investigate the barriers and limitations set by the BH carve out 4. Consider enhanced billing codes for evidence-based intervention and parent groups
Additional Recommendations 1. Review the benefits of HCPCS Level II codes in primary and specialty BH EPSDT Advisory Group to BHA/Medicaid 2. Maximize BHIPP consultation and training services, increase opportunities to expand BHIPP's Extension for Community Healthcare Outcomes (ECHO) model 3. Work with researchers to understand Maryland's Medicaid data and use it for quality improvements 4. Review data collected under current and federal grants on Healthy Steps, CoCM, and training of interns and integrated care specialists

Meeting 5- November 12, 2025

- Ms. Brown began the final workgroup meeting by discussing the process by which the Department would solicit written feedback from the workgroup members. A survey sent out via email where recipients would have the opportunity to prioritize which recommendations they thought were most important, and provide any final thoughts. Ms. Brown reviewed the proposed recommendations that had been gathered in the previous meetings, and provided Departmental comments on the feasibility and potential costs associated with each recommendation (see the Recommendations section beginning on page 11)
- The meeting concluded with a series of final questions from the workgroup members and a reminder that workgroup feedback would be solicited via survey

Department Preparations for Workgroup Meetings

In preparation for meeting with the full workgroup, the Department held additional meetings to better understand the guidance, best practices in other states, and the context and current practices among providers in Maryland. The Department also frequently corresponded with engaged workgroup participants via email to gather further information.

- December 19, 2024- Colorado Department of Health Care Policy & Financing to discuss their coverage of behavioral health services for members under 21 without a covered diagnosis[17]
- September 9, 2025- Georgetown McCourt School of Public Policy Center for Children and Families to discuss best practices and implementation of SHO guidance in other states
- September 15, 2025- National Center for Children in Poverty to discuss their survey of state Medicaid programs on infant and early childhood mental health services and best practices

[17] Senate Bill 23-174 - Coverage Policy. https://hcpf.colorado.gov/sb23-174-coverage-policy

- September 24, 2025- Medicaid and BHA met with several workgroup participants who had previously worked on DC:0-5 (Dr. Joyce Harrison, Dr. Antonia Girard, and Melissa Rock), to learn more about the need for more appropriate diagnoses for infants and children ages 0-5
- October 21, 2025- Medicaid and BHA met with Ms. Kay Connors, Dr. Joyce Harrison, Dr. Antonia Girard presented their recommendations for the Department in advance of their presentation to the workgroup on 10/22
- December 17, 2025- The California Department of Health Care Services to learn more about their approach to providing EPSDT behavioral health services without a clinical diagnosis

Recommendations

Detailed Description of the Workgroup's Recommendations and Department Comments

As presented by the Department at the final EPSDT workgroup meeting on November 11, 2025, the table below addresses each of the recommendations raised in the October 22nd meeting, with additional context and the Department's comments and recommendations. Recommendations that the Department plans to prioritize have been identified as near term priorities (within the next 12 months), intermediate priorities (within the next 18 months), and long-term priorities (within the next 36 months). The following icons are used to provide a high level summary of the Department's recommendations:

Figure 2. Department Response Key

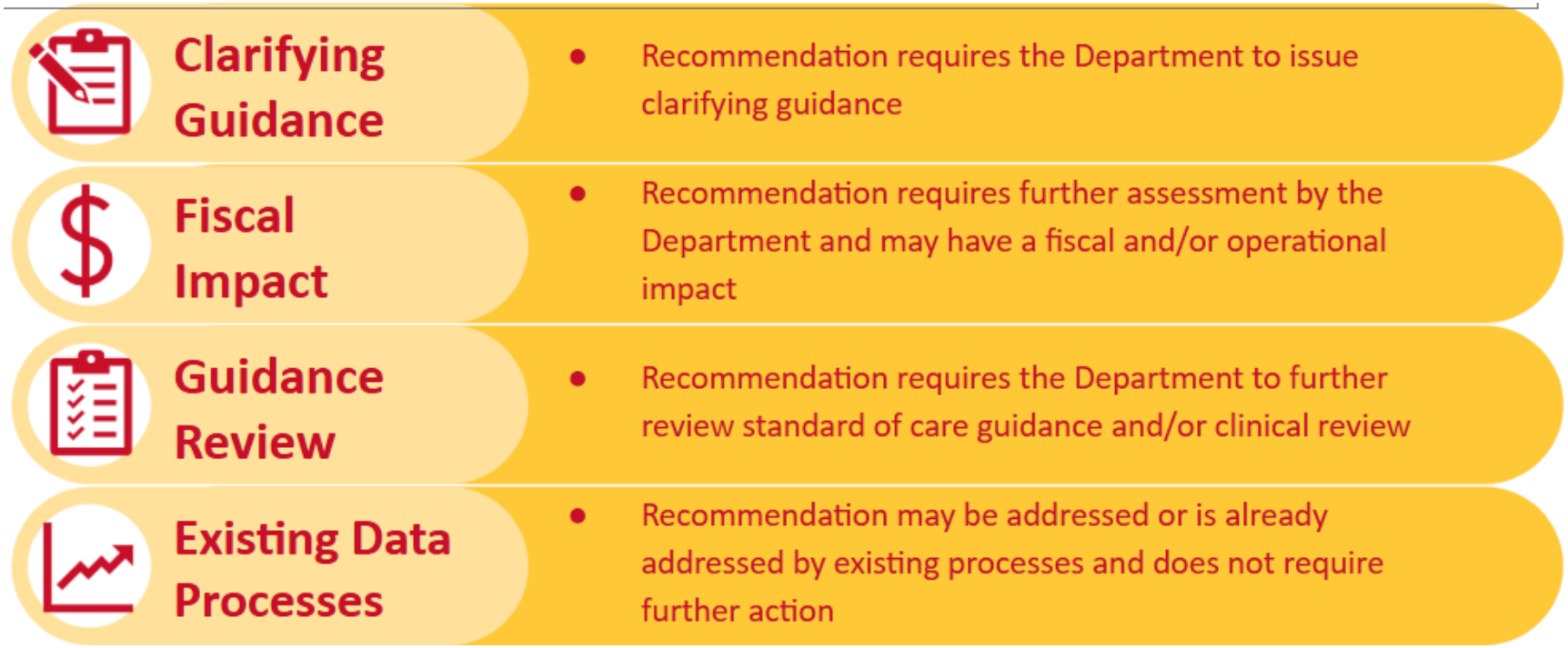

Table 2a. DC:0-5

Recommendation	Description	Department Comments and Recommendations
Formally recognize the DC:0-5 as the recommended diagnostic classification system for children under 6	The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) is designed to provide information about mental health and developmental disorders in infants/young children, including developmentally appropriate diagnostic criteria. The DC:0-5 is comparable to the DSM-V for older children, adolescents, and adults. Due to federal rules, as with the DSM-V, diagnoses made using the DC:0-5 must be crosswalked to ICD-10 codes.[18] Workgroup members have crosswalked the DC:0-5 to Maryland's PBHS. Maryland has participated in Zero to Three's Infant and Early Childhood Mental Health Financing Policy Project to explore potential implementation of the DC:0-5. BHA has funded the Center of Excellence for Infant and	 **The Department will recommend use of DC:0-5 and issue new guidance in the near term.** The Department agrees with the recommendation to adopt the use of the DC:0-5. The Department will issue clarifying guidance on which diagnoses are covered by the MCOs versus specialty BH (Carelon). This recommendation aligns closely with the Roadmap's Goal 2 strategy "Leverage EPSDT to support early intervention."

[18] Code of Federal Regulations Title 45, Subtitle A, Subchapter C, Part 162 - Administrative Requirements. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-162

	Early Childhood Mental Health to conduct a Train the Trainer program for providers to be trained in and/or use the DC:0-5 for diagnosis and assessment and to train state trainers.	
For children 0-5 allow for up to 5 appointments before rendering a diagnosis (as recommended in DC:0-5)	Every claim must have a valid ICD-10 diagnosis code. In Maryland's carve-out context, in order to bill Carelon, providers must use a specialty BHcarved-out code. Currently, providers can bill F99 (mental disorder, not otherwise specified) for the first two sessions, and then must use a carved-out diagnosis for subsequent sessions (in order to bill Carelon). Workgroup members have recommended that providers be able to bill for up to 5 appointments before rendering a specified carved-out diagnosis. The workgroup recommended that the Department allow use of service codes 96156 (Health and Behavior Assessment/Intervention) or H0031 (Mental Health Assessment for non-physician) to be used over the 1-5 sessions needed to complete a comprehensive child/adolescent diagnostic evaluation to render a specific, carved-out diagnosis.	 **The Department is reviewing this recommendation and recognizes further conversations are needed to understand current practices and the gap that needs to be filled. The Department is meeting with California in the near-term and plans to review and clarify use of unspecified codes in the intermediate term.** ● F98.9 (Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence) is an available carved-out code for the purpose of billing for services before a specific diagnosis is made. Unlike F99, F98.9 is specific to children and **not** subject to any limitations. ● Using Z-codes as the primary diagnosis for the provision of BH services without a clinical diagnosis presents challenges, given that Maryland's model of behavioral healthcare financing is diagnosis based ● Currently, the Department has assigned six Z-codes for use in the Assistance in Community Integration Services (ACIS) program (Z59.00, Z59.02, Z59.811, Z59.812, Z59812). The remaining Z codes have not

		been assigned a specific purpose. In CY 2024 and CY 2025 year to date, each of the Z codes have been utilized as a primary or secondary diagnosis in MCO and FFS billed services. Carving out a Z code will limit its use as a primary diagnosis to only BH and eliminate its use for other services. The Department must consider these effects on somatic care and any future benefits that may be implemented. ● California has a specialty BH carve-out with guidance that recommends the use of "other specified" and "unspecified" diagnosis codes when services are provided due to a suspected mental health disorder that has not yet been diagnosed or may be due to trauma (see Behavioral Health Notice 21-073).[19] ● The Department notes that based on initial conversation with the Medi-Cal Behavioral Health - Policy Division at the California Department of Health Care Services, there are fundamental differences between Maryland and California's Medicaid programs that make their approach to use of Z codes not directly translatable. ● In California, psychotherapy and psychological testing are carved **into** managed care plans (Section 14189 of the California Welfare and Institutions Code). These services, which have been highlighted by the workgroup for potential use of Z codes, are carved out in Maryland. ● California's carve out does not hinge on diagnosis, but rather is based on the service provided. California has distinct billing systems

[19] State of California Department of Health Care Services (2021). Behavioral health Information Notice 21-073. ca.gov https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf

		for primary care/managed care plans, specialty mental health services, and SUD services. ● Therefore, the utilization of a Z code for a specialty mental health service in California does not have the same implications as in Maryland, where carving out a Z code would restrict its use as a primary diagnosis to specialty behavioral health only. ● A behavioral health (MH or SUD) diagnosis is not required in California to access medically necessary specialty mental health or SUD services. The medical necessity is determined through clinical assessment. The Department is planning to continue this conversation with California in the new year and will update the Joint BHAC/Commission on its findings. ● Use of 96158 and H0031: These codes are currently in use for other Medicaid programs.The Department will require further time to evaluate the potential use of these codes or identify alternative procedure codes. Adding coverage of new services would require analysis for fiscal impact and potentially a budget initiative

Table 2b. Screenings

Recommendation	Description	Department Comments/Recommendations
Remove unit limits on developmental and BH screens	Currently, the following unit limits are described in the Healthy Kids Provider Manual (p. 147)[20]: • 96161 (maternal depression screening) will be reimbursed up to 4 units total per child through 12 months. 0 units will be reimbursed age 13 months and older • 96110 (developmental screening/autism screening) will be reimbursed up to 8 units total per child through age 5 year • A max of 1 unit of W7000 (alcohol and/or SUD screening) will be reimbursed annually for recipients age 11 and up	  **Requires additional review and fiscal impact analysis in the near term.** The Department is reviewing the unit limits on developmental and behavioral screens in the Healthy Kids Preventive Health Schedule and plans to review with the Office of Medical Benefits of Management. Further, the Department is reviewing current utilization of these codes. Based on the Department's review of utilization data and consultation with physician advisors, the Department will review this recommendation for fiscal impact of increasing unit limits.

[20] Maryland Department of Health (2025). Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Maryland Healthy Kids Medical Program, Clinical and Administrative Manual. Maryland.gov. https://health.maryland.gov/mmcp/epsdt/ABA/Documents/2025%20Healthy%20Kids%20Provider%20Manual_web.pdf

Recommendation	Description	Department Comments/Recommendations
Increase allowable screening units per visit from 2 to 3 or 4	Currently, a max of 2 units of 96110 (developmental screening) or 96127 (brief emotional/behavioral assessment) will be reimbursed per visit; or a combination of 2 total units of a combination of 96110, 96127, or W7000 will be reimbursed per session.	
Align the Healthy Kids periodic screening schedule with the AAP recommended periodicity schedule	There are several differences between the Maryland Healthy Kids and AAP Bright Futures periodicity schedules, such as the recommended age intervals for Behavioral, Social, and Emotional Screening	 **The Department will review the Healthy Kids Preventive Health Schedule with physician advisors in the near term.** The Healthy Kids Preventive Health Schedule was most recently brought into alignment with the AAP Recommendations in 2018. The COVID-19 pandemic introduced significant constraints to program and clinical staff time. The Department commits to conducting a review of the AAP's updates with the EPSDT Team within the Office of Medical Benefits Management (OMBM) and Chief Medical Officer, with the goal of reviewing these updates annually. The Department will also review billing guidance in the Healthy Kids Provider Manual. The Department anticipates issuing updated recommendations in Summer 2026.
Using the same	During the 10/22 meeting, workgroup	**Clarification:** In Maryland, code 96161 is used for maternal

Recommendation	Description	Department Comments/Recommendations
billing code for SDOH/Maternal Depression Screening- 96161	members shared that the Maternal Depression Screening and SDOH screening use the same billing code- 96161 (caregiver risk assessment), which can only be billed 4 units total per child through age 12 months.	depression screening. The Department does not reimburse providers for SDOH screening as separate billable service; instead MCOs are implementing SDOH screenings at the organizational level. Note also, 96161 is not an appropriate code for this purpose. The psycho-social/environmental assessment/update is included in the comprehensive preventive medicine visit and is not billed separately. Note, Medicaid's MCOs are currently implementing SDOH screenings at the organizational-level as part of initial health screenings for new members. **Providers should not bill separately for SDOH screenings.** **The Department also advises that 96161 does not count towards the two screening units/visit limit.**

Table 2c. Primary Behavioral Health Care

Recommendation	Description	Department Comments and Recommendations
Expand use of CoCM in pediatrics (0-12)	The CoCM is an established evidence-based, patient-centered care model used to treat BH in primary care settings. Maryland has implemented Medicaid coverage of CoCM.[21]	 **The Department will issue clarifying guidance.**

[21] Maryland Department of Health. Collaborative Care Provider Information. Maryland.gov. https://health.maryland.gov/mmcp/Pages/Collaborative-Care-Providers.aspx

Recommendation	Description	Department Comments and Recommendations
		Currently, pediatricians can participate in CoCM. Effective Oct.1, 2023, Maryland Medicaid expanded coverage for CoCM services to *all* Medicaid participants, including children.[22] However, utilization among children ages 0-12 is very limited. The Department can issue clarifying guidance on pediatricians' eligibility to participate in CoCM.
Expand Healthy Steps for infants and toddlers Allow use of the enhanced code to include children ages 4-5	HealthySteps, a ZERO TO THREE program, is a pediatric primary care model for children ages 0-3 that promotes positive parenting and healthy development for babies and toddlers by providing a tiered model of risk-stratified supports. Since 2023, the Department has provided additional reimbursement to HealthySteps providers, who can add the code H0025 '*BH prevention education service*' to each pediatric E&M or well-child visit encounter that includes HealthySteps services and was provided in the clinic or outpatient setting.[23]	 **The Department encourages providers to enroll as HealthySteps providers. The Department does not recommend use of the enhanced HealthySteps code for children ages 4-5.** Currently, provider uptake and billing for HealthySteps are limited; only two sites have enrolled as HealthySteps providers, and these sites are located in the Baltimore area. Strategies to improve provider enrollment in geographic areas across the state may improve utilization of HealthySteps for

[22]Maryland Department of Health (2024). Provider Transmittal 71-24. https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT71-24_SG_Medicaid_Coverage_Collaborative_Care_Model_Services_HealthChoice_FFS.pdf

[23] Maryland Department of Health (2022). Provider Transmittal 30-23. https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Documents/CenteringPregnancy/PT%2030-23%20Coverage%20of%20CenteringPregnancy%20and%20HealthySteps%20Services.pdf

Recommendation	Description	Department Comments and Recommendations
		the 0-3 population. HealthySteps is funded by the Health Services Cost Review Commission (HSCRC) Maternal and Child Health Fund through December 31, 2027. At this time, the Department has not identified evidence that supports the use of HealthySteps in children ages 4-5 and does not recommend its expansion for that age group. The Department is interested in reviewing any research on HealthySteps that supports use in the 4-5 age group.
Allow 96112 (developmental test-first hour) and 96113 (second hour) without a diagnosis and remove prior authorization clause (Treatment Authorization Request) 96111 has been deleted since Jan 1, 2019, yet is still listed in the Healthy Kids Provider Manual- 2025 as an active code	During the 10/22 meeting, workgroup members recommended removing prior authorizations from 96112 and 96113 to increase the rate of proper diagnoses and decrease over-referral for early childhood intervention and Autism Spectrum Disorder Centers. Workgroup members also highlighted that 96111, a retired code, is included in the 2025 EPSDT Healthy Kids manual.	 **The Department will update the Healthy Kids Provider Manual. Further review is required to assess 96112 (developmental-test first hour) and 96113 (not covered at this time) in the intermediate term.** The Department will remove 96111 from the Healthy Kids Provider Manual. 96112 can be billed to the MCOs depending upon diagnosis code. The Department covers 96112 (developmental test-first hour) and Medicaid FFS does not require prior authorization. Among the MCOs, seven of the nine do not require prior authorization for 96112.

Recommendation	Description	Department Comments and Recommendations
		96113 is not covered at this time. The Department will review 96112 and 96113 with the Clinical Coverage Committee.
Work with research institutions to learn about how the CoCM and HealthySteps can increase practices' ability to deliver EPSDT services	HealthySteps is evaluated in the Health Services Cost Review Commission's annual Maternal and Child Health Population Health Improvement Fund (PHIF) Report.[24] CoCM has been evaluated in prior Joint Chairmen's Reports (most recently, in 2021)[25] and the Annual Healthchoice Evaluation from 2022 through 2024.[26]	 **The Department does not recommend further action at this time. The Department will continue to analyze these programs in collaboration with the Hilltop Institute at UMBC.** The Department will provide quarterly check-ins on EPSDT to the BHAC/Commission subgroup on children and can provide further information on the evaluation of CoCM and HealthySteps. The Department affirms that CoCM and HealthySteps can increase practices' ability to deliver EPSDT services; at this time, efforts to improve provider uptake may be more impactful than further research.

[24] Maryland Department of Health. Health Services Cost Review Commission, Statewide Integrated Health Improvement Strategy. Maryland.gov. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx
[25] Maryland Department of Health (2022). Joint Chairmen's Report (p. 113-114) - Collaborative Care Pilot Updates. Maryland.gov. https://health.maryland.gov/mmcp/Documents/JCRs/2021/collaborativecarepilotJCRfinal11-21.pdf
[26] Maryland Department of Health. HealthChoice Monitoring and Evaluation. Maryland.gov. https://health.maryland.gov/mmcp/healthchoice/Pages/HealthChoice-Monitoring-and-Evaluation.aspx

Recommendation	Description	Department Comments and Recommendations
Allow LMSW and LGPC providers to bill for integrated care services, including screening, brief interventions, follow-up, referral, and care coordination CPT code H2014 (family skills training) and H2015 (community support).	Integrated care services are delivered in primary care settings and are billed by the primary care provider. Currently, LMSWs and LGPCs are not eligible to enroll as primary care providers.	  **Requires further review and assessment of fiscal impact and implementation considerations, including scope of practice. This recommendation requires review in the long-term.** H2015 is already in use for mobile crisis team follow-up services and will not be realigned. H2014 is not currently covered. Supervision and licensure requirements, as well as a provider type's scope of practice, are determined by the respective Board, further consultation may be required. This recommendation will require further assessment by the Department for potential fiscal impact and implementation considerations.

Table 2d. Specialty Behavioral Health Care

Recommendation	Description	Department Comments and Recommendations
Allow billing for Autism Spectrum Disorder (ASD) and Global Developmental Delay and Intellectual Developmental Disorder diagnostic codes in Specialty BH Care	ASD (F84.0) is carved into managed care. Because Maryland's specialty BH carve out logic relies on diagnosis, if a diagnosis code can be billed to the MCOs, it cannot be billed to the specialty BHASO (Carelon). Members of the workgroup shared that providers (i.e. psychologists) who evaluate children who screen positive on an ASD screen may seek authorization from and bill Carelon for the evaluation with ICD-10 code F98.9 unspecified emotional and behavioral diagnosis.	 **The Department will issue clarifying guidance in the intermediate term.** The Department reviewed the utilization of the F84.0, and found that there are many participants receiving somatic (carved-in) and waiver services for ASD. As such, the Department cannot carve out ASD into specialty BH care. While the diagnosis code is carved in, the provider types and billing codes that provide services to young children with ASD are not carved out. **Psychologists, physicians (i.e. psychiatrists), and nurse practitioners can bill both the MCOs and Carelon. Therefore, these providers can bill the MCOs for services delivered to children with an ASD diagnosis.** The Department will release a transmittal which clarifies payer responsibilities for ASD services and the ability of providers to bill the MCOs for ASD therapies.
Allow for parent group therapy to be billed via telehealth	90849 (multi-family group psychotherapy) has not historically been covered via telehealth. The 2026 Medicare Physician Fee Schedule (PFS) Final Rule included telehealth coverage	

Recommendation	Description	Department Comments and Recommendations
	for 90849 effective 1/1/2026.[27] 90849 is only reimbursed to clinics (Outpatient Mental Health Clinics and Federally Qualified Health Centers).	**Requires additional review and fiscal impact analysis in the near-term.** Expanding telehealth coverage of 90849 may have a fiscal impact. The Department will review this recommendation with clinical staff to assess clinical appropriateness of adding coverage for telehealth multi-family group psychotherapy. Currently, the Department covers the following telehealth services: ● 90846 GT/UB- Family psychotherapy without patient present ● 90847 GT/UB- Family psychotherapy with patient present
Investigate the barriers and limitations set by the BH financing model / carve out	Maryland implemented the integrated BH service delivery and finance system for Medicaid beneficiaries and uninsured individuals in 2015 as a result of a multi-year stakeholder process intended to align services for individuals with mental health and SUD needs.	**The Department does not recommend further action at this time.** SB 212/HB 1048 (Ch. 42 and 41 of the Acts of 2024) required the Commission on BH Care Treatment and Access to submit recommendations on the continuation of the State's BH carve-out to the Governor and the General Assembly by July 1, 2025. The bills also required a report that was due July 1, 2025. However, due to the extensive shifts in the federal policy and budgetary landscapes the Department anticipates that an additional year will be needed to complete this report and anticipates submission on July 1, 2026. Under the current federal administration there are proposed

[27] Centers for Medicare & Medicaid Services (2025). Physician Fee Schedule. CMS.gov. https://www.cms.gov/medicare/payment/fee-schedules/physician

Recommendation	Description	Department Comments and Recommendations
		Medicaid cuts that will have a significant impact on the decisions we as a Commission, Council and State make regarding the financial model.
Consider enhanced billing codes for evidence-based interventions and parent groups	Evidence-based practices (EBPs) are systematic approaches to delivering services that have been demonstrated to improve outcomes for participants. EBPs require rigorous training and must be implemented with fidelity. In Maryland, assertive community treatment and supported employment are examples of EBPs with enhanced billing codes.[28]	**The Department proposes that through the existing convening of the BHAC and Commission youth workgroups discussions occur related to the potential development of an EBP model, including the selection of EBPs, rate setting, and fidelity monitoring and oversight.** This recommendation requires further consideration.

Table 2e. Additional Recommendations

Recommendation	Description	Department Comments and Recommendations
EPSDT Advisory Group to BHA/Medicaid	Workgroup members suggested the creation of a new EPSDT workgroup to engage BHA and Medicaid.	**The Department does not recommend the creation of a new advisory group. The Department recommends that the Joint BHAC/Commission continue to serve as a forum to gather stakeholder feedback on the EPSDT program.** The Department will provide quarterly updates on the implementation of EPSDT initiatives and to solicit input. The Healthy Kids/EPSDT Program is staffed by one Division Chief and five Nurse Consultants, whose primary role is to offer training and support services to EPSDT providers throughout the state. The

[28] Maryland Department of Health (2019). Joint Chairmen's Report, p. 83- Report on Fidelity Audits of SE and ACT Programs. Maryland.gov. https://dlslibrary.state.md.us/publications/JCR/2018/2018_82-83.pdf

Recommendation	Description	Department Comments and Recommendations
		creation of an EPSDT Task Force would require the hiring of a Health Policy Analyst, with an annual cost of $96,043 ($48,021 state general funds, $48,021 federal funds). Additional staff may be required to implement the workgroup's recommendations.
Maximize BHIPP consultation and training services Increase opportunities to expand ECHOs to better support children with Developmental disabilities and BH conditions	BHA provides funding for Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP). BHIPP supports the efforts of primary care and emergency medicine professionals to assess and manage the mental health needs of their patients from infancy through the transition to young-adulthood through a consultation warmline, training and education, telemental health services, and co-location internships. BHIPP's Project ECHO is a web-based learning collaborative that provides education and consultative services to providers around developmental, social, and emotional issues affecting children ages 0-8.	**BHA will continue to promote BHIPP and ECHO through its networks, as well as assist and support recruitment to the various programs.** BHA will continue to pursue new avenues to strengthen promotion of these programs and ensure stakeholders are aware of opportunities. The Department is interested in learning about specific ideas stakeholders may have on how to maximize BHIPP and ECHOs.
Work with researchers to understand Maryland's Medicaid data and use it for quality improvements	During the 10/22 meeting, workgroup participants recommended that the Department work with researchers to analyze Maryland's Medicaid data and use it to improve quality.	 **The Department does not recommend further action at this time. The Department will continue to analyze the program**

Recommendation	Description	Department Comments and Recommendations
		following current procedures and processes. Maryland Medicaid has robust quality standards and assessment. Data and metrics are continuously being reviewed. Annually, the Department's External Quality Review Organization (EQRO) conducts a review of EPSDT.[29] The review assesses MCO performance in delivering services to children under the age of 21. The EPSDT review measures whether all HealthChoice MCOs achieve minimum levels of performance in delivering EPSDT services. In addition, EPSDT is included in the Annual HealthChoice Evaluation.[30] The Annual HealthChoice Evaluation includes nationally-recognized Healthcare Effectiveness Data and Information Set® (HEDIS®) quality and performance measures. Further, the Department has a longstanding contract with the Hilltop Institute at UMBC to evaluate Maryland's Medical Assistance Program.

[29] Maryland Department of Health (2025). Medicaid Managed Care Organization, EPSDT Medical Record Review https://health.maryland.gov/mmcp/healthchoice/Documents/MY%202023%20EPSDT%20Statewide%20Executive%20Summary%20Report.pdf

[30] Maryland Department of Health (2025). Medicaid Managed Care Organization EPSDT Medical Record Review, Statewide Executive Summary Report, Measurement Year 2023. Maryland.gov. https://health.maryland.gov/mmcp/healthchoice/Documents/MY%202023%20EPSDT%20Statewide%20Executive%20Summary%20Report.pdf

Recommendation	Description	Department Comments and Recommendations
Review data collected under current and federal grants on HealthySteps implementation, CoCM coding, and training of social work and counseling interns in the roles of integrated care specialists	During the 10/22 meeting, workgroup participants recommended that the Department review data on HealthySteps, the CoCM, and the training of interns in integrated care.	 **The implementation of Healthy Steps and PHIF have been evaluated in previous reports.** HealthySteps is evaluated in the annual Population Health Improvement Fund (PHIF) report. CoCM has been evaluated in prior Joint Chairmen's Reports and the Annual Healthchoice Evaluation from 2022 through 2024. **BHA will review data from BHIPP on the training of social work and counseling interns in integrated care.**
Review HCPCS Level II codes to support screening, follow-up, parent skills training, and care coordination.	Healthcare Common Procedure Coding System (HCPCS) Level II codes are standardized billing codes maintained by CMS. Multiple HCPCS Level II H codes are in use by the Department for BH services.	 **Requires additional review and fiscal impact analysis.** This recommendation would require a budget initiative to cover new service codes. This recommendation requires further analysis by the Department to understand current coverage and the specific services the workgroup is interested in expanding.

Recommendations Survey and Results

The Department sent a survey to the workgroup attendees requesting their final prioritization of the recommendations presented on October 22, 2025 as well as any additional written feedback they would like to include. The survey was sent via email to the listservs for members and non-members of the Joint BHAC/Commission. Recipients were also provided with a link to the meeting materials, which included the Department's final presentation to the workgroup responding to the proposed recommendations. Stakeholders had one week to submit survey responses (November 13, 2025–November 19, 2025). The survey can be found in Appendix C.

Thirteen participants responded to the survey. Three responses were provided by official workgroup members. Two additional responses were submitted to the Department via email. Respondents to the survey also identified the following 10 recommendations for potential prioritization by the Department:[31]

First Priority

1. *Allow billing for Autism Spectrum Disorder and Global Developmental Delay and Intellectual Developmental Disorder diagnostic codes in Specialty Behavioral Health Care* **(3 votes)**
2. *Expand use of Collaborative Care Model (CoCM) in pediatrics* **(3 votes)**
3. *Align the Healthy Kids periodic screening schedule with the AAP recommended periodicity schedule* **(2 votes)**
4. *Remove limits on developmental and behavioral health screens* **(2 votes)**

Second Priority

1. *For children 0-5 allow for up to 5 appointments before rendering a diagnosis (as recommended in DC:0-5)* **(2 votes)**
2. *Formally recognize the DC:0-5 as the recommended diagnostic classification system for children under 6* **(2 votes)**
3. *Allow LMSW and LGPC providers to bill for integrated care services, including screening, brief interventions, follow-up, referral, and care coordination CPT code H2014. For example, H2015 Community Support (help finding resources) and H2014 Family skills training* **(2 votes)**
4. *Expand HealthySteps for infants and toddlers. Allow use of the enhanced code to include children ages 4-5* **(2 votes)**

Third Priority

[31] The counts of votes in this section refer to the number of votes each recommendation received as the first, second, and third priorities, not across all priorities.

1. *EPSDT Advisory Group to BHA/Medicaid* **(3 votes)**
2. *Remove unit limits on developmental and behavioral health screens* **(2 votes)**
3. *Expand HealthySteps for infants and toddlers. Allow use of the enhanced code to include children ages 4-5.* **(2 votes)**

Further Recommendations Detailed in the Survey of Workgroup Participants

In the survey, some respondents took the opportunity to raise additional recommendations that had not been included in the October 22nd recommendations or discussed during one of the workgroup meetings. The following table lists those recommendations and includes comments from the Department on the necessity and feasibility of implementing them.

Table 3. Survey Responses and Department Comments

Recommendation	Department Comments and Recommendations
Use of Z-codes for the delivery of BH services without a diagnosis through the following strategies: 1. Assigning Z-codes to coverage by either MCOs or Carelon 2. If differentiation is needed, using modifiers to route claims appropriately 3. Expanding allowable provider types to ensure adequate provider capacity for services related to Z-code encounters	The Department has reviewed utilization of Z codes (Z550-Z659) among Medicaid MCOs, FFS, and BH for CY2024 and CY2025. Currently, the Department has assigned six Z-codes for use in ACIS. The remaining Z codes have not been assigned a specific purpose. In CY 2024 and CY 2025 year to date, each of the Z codes have been utilized as a primary or secondary diagnosis in MCO, non-BH FFS, and BH FFS. As carving out a Z code will limit its use as a primary diagnosis to only BH, the Department must consider the effects on somatic care and any future benefits that may be implemented. At this time, carved-out code F98.9 (Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence), is available for the provision of medically necessary EPSDT BH services without a diagnosis. The recommendations to carve out Z codes, use modifiers, and expand allowable provider types for services related to Z-codes require further analysis. The Department is continuing to meet with the California Department of Health Care Services to better understand their approach and will update the workgroup on its

	findings in the New Year.
Recommendation of the addition of HCPCS code G0136 to the Maryland Medicaid Fee Schedule to bill for "a validated assessment of social needs that interfere with a patient's diagnosis or treatment, such as the assessment of known or suspected SDOH risks."	At this time the Department does not reimburse providers for SDOH screenings. The MCOs are currently implementing SDOH screenings at the organizational-level as part of initial health screenings for new members.
Recommendation to re-evaluate reimbursement rates to pediatricians for maternal depression screening, given that when pediatricians screen for maternal depression using 96161 (caregiver risk screening), they are paid a fraction of what the caregiver's primary care provider is paid to complete the same screening (using Medicare code G0444). This leads to pediatricians performing medically necessary follow-up for the caregiver without reimbursement.	The Department requires additional time to analyze reimbursement rates for maternal depression screening. The Department recently increased the rate for 96161 (caregiver risk screening), effective January 1, 2025.[32]
Multiple participants recommended that pediatricians, pediatric nurse practitioners, child psychologists, and child psychiatrists be included in the formation of an EPSDT advisory group.	Joint BHAC/Commission meetings are open to the public. The Department has included non-member meeting participants in discussions and will continue to do so in the future.
CoCM codes are not able to be reimbursed for a child who is also receiving mental health care for the same diagnosis, "which limits children from accessing therapy if they are in the CoCM model."	PT 71-24 provides guidance on billing for CoCM and coordination with the ASO.[33] CoCM services, provided by a team of a primary care provider, BH care manager, and psychiatric consultant, include care coordination and management; regular, systematic monitoring and treatment using a validated clinical rating scale; and regular, systematic

[32] Maryland Department of Health (2025). Provider Transmittal 67-25. https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT%2067-25%20Screening%20and%20Assessment%20Professional%20Rate%20Increase.pdf

[33] Maryland Department of Health (2024). Provider Transmittal 71-24. https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT71-24_SG_Medicaid_Coverage_Collaborative_Care_Model_Services_HealthChoice_FFS.pdf

	psychiatric caseload reviews and consultation for patients who do not show clinical improvement. CoCM services are provided in primary care settings and billed by primary care providers. One of the main goals of CoCM services is to decrease stigma by enabling primary care providers to provide BH services instead of sending them to specialty care. Because of this, the MCOs and not the BHASO are responsible for reimbursing for CoCM. Specialty BH reimbursed by the BHASO for the same condition would be considered duplicative of the care already being provided by the MCO.
Recommendation that the Department to pair clarifying guidance on CoCM with "technical assistance for pediatric and family medicine settings."	The Department requires further time to explore potential options for technical assistance depending on the state budget and in conjunction with the AHEAD Model/Maryland Primary Care Program.
Recommendation that in addition to investigating barriers of the carve out, the Department should also "investigate the barriers and limitations set by a BH carve-in."	As described above, the Commission and the Department are drafting recommendations on the continuation of the BH carve out as required by SB 212/HB 1048 (Ch. 42 and 41 of the Acts of 2024), which the Department anticipates submitting on July 1, 2026.
Guidance to be issued to providers regarding the use of enhanced codes during the first six months while an infant can still be covered by the mother's Medicaid.	The Department requires further clarification to understand this recommendation.

Conclusion/Next Steps

Among the workgroup's recommendations, the Department has identified near-term, intermediate, and long-term priorities. The Department will focus on near-term priorities within the next 12 months; intermediate priorities within the next 18 months, and long-term priorities within the next 36 months. Milestones are contingent upon the availability of limited Department resources as the Department navigates the implementation of the HR1 and other significant federal changes in the near future.

Near-term priorities include:

- Implementing the optional use of DC:0-5 diagnosis codes
- Reviewing developmental and behavioral screening unit limits
- Aligning the Healthy Kids Schedule with the AAP Bright Futures Periodicity Schedule and reviewing Medicaid coverage of telehealth parent group therapy (90849)
- The Department is meeting with the California Department of Health Care Services to learn more about their approach to providing EPSDT behavioral health services without a clinical diagnosis

Intermediate priorities include:

- Reviewing and clarifying use of unspecified codes prior to determination of a specified mental health diagnosis
- Clarifying provider guidance and billing for ASD
- Reviewing developmental testing CPT codes with the Clinical Coverage committee

Long-term priorities that will require additional time for the Department to review include:

- Assessing the fiscal and operational impacts of allowing licensed master social workers (LMSW) and licensed graduate professional counselors (LGPC) to bill for integrated care services
- Exploring the creation of an EBP model, and reviewing HCPCS Level II behavioral health services and assessing current practices, service gaps, and the fiscal impact of implementing new services

The Department plans to provide quarterly updates on this work during Joint BHAC/Commission meetings.

Appendix

Appendix A - Workgroup Membership

Behavioral Health Care Treatment and Access, Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Workgroup

Workgroup Chair

- Alyssa Lord, Deputy Secretary for the Behavioral Health Administration
- Karen Duffy, Representative of the Maryland Coalition of Families

Workgroup Members

- Carol Beatty, Secretary of the Maryland Department of Disabilities
- Clara Baker, an Individual with an Intellectual Disability who uses Self-Directed Behavioral Health Services
- Dr. Arlene Tyler, Representative of a School-Based Health Center
- Leslie Sied Margolis, Representative of Disability Rights Maryland
- Linda Dietsch, Representative of a Managed Care Organization
- Mercia Cummings, Representative of a Providers of Substance Use Treatment Services
- Rachel London, Representative of the Developmental Disability Coalition
- Senator Malcolm Augustine, Member of the Senate, appointed by the President of the Senate
- Stacey Garnett, Representative of an Inpatient Psychiatric Hospital
- Stephen Ligett-Creel, Secretary of Human Services Designee
- Tamar Rodney, an Individual with Expertise in Social Determinants of Health

Workgroup Staff

- Alexandra Baldi, Chief of Staff, Behavioral Health Administration

By Invitation from the Workgroup Chair

- Ashley Tauler, Representative of the Maryland Coalition of Families
- Gina Rogari, Representative of Manatt Health
- Jocelyn Guyer, Representative of Manatt Health
- Karen Duffy, Representative of the Maryland Coalition of Families
- Michaiah Parker, Representative of Manatt Health

Behavioral Health Advisory Council, Children Youth and Families Workgroup

Workgroup Chairs

- Karen Duffy, Executive Director, Maryland Coalition of Families
- Alyssa Lord , Deputy Secretary, Behavioral Health Administration

Workgroup Formal Members

- Candace Harris, Representative of the Maryland Governor's Office of Crime Prevention and Policy
- Dr. Joseline Castanos, Academic and Research Professional
- Dr. Joyce Harrison, Academic and Research Professional
- Kim Hall, Representative of the Maryland Department of Juvenile Service
- Laura Kimmel, Caregiver/Parent of a Child, Appointed by Governor Moore

Joint EPSDT Workgroup Meeting Attendees

- Abigail Baines, Health Policy Analyst, Medicaid Behavioral health Division
- Adrienne Mickler, Executive Director, Anne Arundel County Mental Health Agency, Inc.
- Alana Aronin, Senior Policy Associate, Children's National Hospital
- Alyssa Brown, Director, Medicaid Office of Innovation, Research, and Development
- Ann Ciekot, Partner and Director of Strategic Partnerships, Public Policy Partners
- Ann Geddes, Director of Child and Older Adult Policy, Mental Health Association of Maryland
- Antonia Girard, Assistant Professor, Licensed Psychologist, University of Maryland School of Medicine
- Audra Cherbonnier, Program Manager, Mid Shore Behavioral Health
- Austin Morris, Government Affairs Manager, Children's National Hospital
- Barbara Allen, Program Manager, Cornerstone Montgomery
- Candice Adams, Administrative Officer, Office of School Aged-Programming, Behavioral Health Administration
- Celia Serkin, Executive Director, Montgomery County Federation of Families for Children's Mental Health, Inc.
- D'Lisa Worthy, Director, Early Childhood Mental Health, Primary Behavioral Health/Early Intervention, Behavioral Health Administration
- Dan Martin, Senior Director of Public Policy, Mental Health Association of Maryland
- Daniel Shattuck, Partner, Brocato & Shattuck
- Darian Elliot, affiliation unknown
- Diamond Cassidy, Child And Adolescent Specialist, Anne Arundel County Mental Health Agency

- Diamond Washington, affiliation unknown
- Diane Stollenwerk, President, StollenWerks Consulting
- Dr. Renee Neely, Comprehensive Planning Specialist, Maryland State Department of Education
- Elizabeth Vaidya, Director, Office of Primary Care, Maryland Department of Health
- Emma Schreier, Health Policy Analyst, Medicaid Office of Innovation, Research, and Development
- Erin Smith, School- Aged Program Manager, Primary Behavioral Health, Early Intervention Division, Behavioral Health Administration
- Gregory Gibson, affiliation unknown
- Heather Dewey, Child, Adolescent and Young Adult and Family Services, Baltimore County Department of Health
- Henry Gillespie-Hill, Health Policy Analyst, Medicaid Office of Innovation, Research, and Development
- Jeffrey Grossi, Chief of Government Relations, Sheppard Pratt
- Jennifer Navabi, Director of Operations, Intergovernmental Relations, and Community Affairs, Public Policy Partners
- Joana Joasil, Deputy Division Director, Primary Behavioral Health and Early Intervention, Behavioral Health Administration
- Jocelyn Erby, Cecil County Local Behavioral Health Authority
- Joy Binion, Founder, Mental Elevation
- Karen Powell, affiliation unknown
- Kathryn Dilley Chief Executive Officer, Mid Shore Behavioral Health, Inc.
- Kay Connors, Executive Director, Taghi Modarressi Center for Infant Study, University of Maryland School of Medicine
- Kirsten Bosak, Representative of Maryland Department of Disabilities
- Dr. Kristi Machemer, Pediatric Mental Health Co-chair, Maryland Chapter, American Academy of Pediatrics
- Krystal Williams, Attorney, Office of the Public Defender Maryland
- Laura Torres, Director, Primary Behavioral Health/Early Intervention, Behavioral Health Administration
- Lead Mandley, affiliation unknown
- Lillie Rosen, Senior Health Policy Expert, ZERO TO THREE
- Linda Raines, Chief Executive Officer, Mental Health Association of Maryland
- Lorianne Moss, Program Manager, Maryland Community Health Resources Commission
- Mary Jo Harris, Division Chief, Healthy Kids/EPSDT Program, Maryland Department of Health
- Megan Brown, Consortium Director, Maryland Community Health Resources Commission
- Megan O'Donnell, affiliation unknown

- Melissa Rock, Birth to Three Program Director, Maryland Family Network
- Melissa Schober, Senior Director, Office of Governmental Affairs, Behavioral Health Administration
- Meredith Lawler, Special Assistant to the Director, Medicaid Office of Innovation, Research, and Development
- Moboluwape Adeoti, Executive Assistant to Deputy Secretary Lord, Behavioral Health Administration
- Natalee Solomon, Program Manager Transition-Aged Youth (Tay) & Young Adult Services, Behavioral Health Administration
- Natasha Mehu, Vice President, Government Affairs and Policy, Maryland Hospital Association
- Olivia Suite, Youth Engagement Coordinator, Maryland Coalition of Families
- Rachel Stoyanov, Family Support Coordinator, Talbot County Public Schools
- Rebecca Lakew - Program Manager of Intensive Services, Primary Behavioral Health/Early Intervention, Behavioral Health Administration
- Rebecca Raggio, Chief, Medicaid Behavioral Health Division · Maryland Department of Health
- Sarah Barclay Hoffman, Program Manager, Children's National Hospital
- Sarah Fegan, Behavioral Health Coordinator, Child, Adolescent & Young Adult Population, Mid Shore Behavioral Health, Inc.
- Sarah Reiman, Program Manager, Behavioral Health Administration
- Stephanie Trice, Anne Arundel County Mental Health Agency, Inc.
- Tammy Loewe, Director, Behavioral health Division, St. Mary's County Health Department
- Tim Santoni, The Maryland County Behavioral Health Advisory Councils
- Triss Todd, Data and Quality Manager, Mid Shore Behavioral Health, Inc.
- Dr. Vandana Sajankila, Western Maryland Regional Representative, American Academy of Pediatrics

Additional Respondents to Recommendations Survey

- Christina Trenton Nee, Wells House
- Dr. Gwendolyn Harter, Pathways to Housing DC
- Catherine Meyers, Center for Children
- Paul Berman, Maryland Psychological Association
- Rachel Dodge, Maryland AAP
- Angela Kimball, Inseparable

Appendix B - Workgroup Meeting Slides

Meeting materials are posted on the Commission on Behavioral Health Care Treatment and Access webpage.

1. July 10, 2025 Presentation
2. September 10, 2025 Presentation
3. October 1, 2025 Presentation
4. October 22, 2025 Presentation
    a. October 22, 2025 Workgroup Member Presentation: EPSDT Recommendations
5. November 12, 2025 Presentation

Appendix C - Survey to Solicit Written Feedback from Workgroup Participants

Insert PDF- HB 1083 Workgroup - Request for Feedback - Google Forms.pdf

Appendix D - Support of Recommendations in Survey

Recommendation	"Yes" Votes	"No" Votes
1. Formally recognize the DC:0-5 as the recommended diagnostic classification system for children under 6	13	0
2. For children 0-5 allow for up to 5 appointments before rendering a diagnosis (as recommended in DC:0-5)	13	0
3. Remove unit limits on developmental and BH screens	13	0
4. Increase allowable screening units per visit from 2 to 3/4	13	0
5. Align the Healthy Kids periodic screening schedule with the AAP recommended periodicity schedule	13	0
6. Clarifying billings code for SDOH/Maternal Depression Screening - 96161	13	0
7. Expand use of Collaborative Care Model (CoCM) in pediatrics (0-12)	13	0
8. Expand Healthy Steps for infants and toddlers. Allow use of the enhanced code to include children ages 4-5	11	2
9. Work with research institutions to learn about how the CoCM and HealthySteps can increase practices' ability to deliver EPSDT services	13	0
10. Allow 96112 (developmental test- first hour) and 96113 (second hour) without a diagnosis and remove prior authorization clause (Treatment Authorization Request) 96111 has been deleted since Jan 1, 2019, yet is still listed in the Healthy Kids Provider Manual- 2025 as an active code	13	0
11. Allow LMSW and LGPC providers to bill for integrated care services, including screening, brief interventions, follow-up, referral, and care coordination CPT code H2014 For example, H2015 Community Support (help finding resources) and H2014 Family skills training	13	0
12. Allow billing for Autism Spectrum Disorder and Global Developmental Delay and Intellectual Developmental Disorder diagnostic codes in Specialty Behavioral Health Care	12	1

13. Allow for parent group therapy to be billed via telehealth	12	1
14. Investigate the barriers and limitations set by the BH carve out	10	3
15. Consider enhanced billing codes for evidence-based interventions and parent groups	12	1
16. Review the benefits of HCPS Level II codes in primary and specialty BH	12	1
17. EPSDT Advisory Group to BHA/Medicaid	13	0
18. Maximize BHIPP consultation and training services, increase opportunities to expand ECHOs	12	1
19. Work with researchers to understand Maryland's Medicaid data and use it for quality improvements	13	0
20. Review data collected under current and federal grants on HealthySteps implementation, CoCM coding, and training of social work and counseling interns in the roles of integrated care specialists	13	0