

**MARYLAND WORKGROUP
ON CHILDREN IN UNLICENSED
SETTINGS & PEDIATRIC
HOSPITAL OVERSTAYS**

**CHILDREN IN UNLICENSED
SETTINGS & PEDIATRIC
HOSPITAL OVERSTAYS**

FINAL REPORT

2026

Completed pursuant to Chapters 479 and 480, Acts of 2025

TABLE OF CONTENTS

Foreword & Acknowledgements.....	3
Executive Summary & Workgroup Deliverables.....	4
Introduction & Background.....	6
Current Assessment of Resource Gaps.....	8
Inadequate Resources & Barriers to Behavioral Health Services Statewide.....	8
Residential Child Care and Child Placement Agency Bed Capacity & Service Array.....	9
Treatment Foster Care Bed Capacity.....	9
Residential Treatment Centers.....	11
Removing Barriers for Systemic Change.....	12
Table 5: Resources, Services & Beds Needed to Support Children, Youth & Families.....	13
Table 6: Legislative & Regulatory Summary Table.....	15
Successful State Models.....	17
Michigan Children's Therapeutic Family Care (CTFC).....	17
New Jersey Children's System of Care.....	17
Mobile Response and Stabilization Services, Customizing for Children, Youth & Families.....	18
Recommendations & Roadmap for Future Work.....	22
Conclusion.....	23
Appendix.....	24

FOREWORD & ACKNOWLEDGEMENTS

The Executive Leadership Team of the Maryland Workgroup on Children in Unlicensed Settings & Pediatric Hospital Overstays (“Workgroup”) extends its sincerest gratitude to the many individuals who contributed to the development of this report including the members of the work group, members of the public who volunteered their time, State agency representatives and our legislative champions especially Speaker of the House Joseline Peña-Melnyk, Senate Finance Committee Chair Pam Beidle, House Health Committee Chair Heather Bagnall, Delegate Emily Shetty, and Delegate Griffith.

We also owe a heartfelt thanks to the Cornell University students working within Cornell’s State Policy Advocacy Clinic including Katrina Greene, Adrian Gomez, Emily Kolodner and Emily Melcer. This dream team of students researched the New Jersey System of Care model, compiled a legislative analysis and offered invaluable guidance on policy options to address identified issues. We are grateful for the time they spent on this report and presenting it to the work group. We wish them the greatest success in their future endeavors and are confident they will go on to make the world a better place.

We also extend our thanks to Edward “Ted” Gallo, Executive Director of the State Council on Child Abuse and Neglect, who staffed this work group and led the efforts to develop this report.

Finally, to the children, youth and families who have suffered as the result of Maryland’s broken behavioral health and child welfare systems. We lift up and acknowledge your experiences, pain and suffering. It is our greatest hope that your stories and battle scars will serve as a glidepath as we work to reform and create a system of care in our State that truly serves our children, youth and families. We look forward to the day when there are no youth waiting for placements in unlicensed settings, and when the term “pediatric hospital overstay” and “hotelings” are distant memories and no longer practices in our State.

Together we can build the system of care that our children, youth and families deserve.

Sincerely,

Executive Leadership Team,

Laura Edwards (Chair), Robert Basler (Co-Vice Chair), Krystal Williams (Co-Vice Chair), Erica LeMon (Secretary), Ted Gallo and Jane Krienke

EXECUTIVE SUMMARY

The Workgroup on Children in Unlicensed Settings and Pediatric Hospital Overstays in the State (“Workgroup”) was established during the 2025 Maryland General Assembly session (Chapters 479 & 480, Acts of 2025). The law took effect June 1, 2025, and requires the Workgroup to assess the number, type, and cost of the additional beds and supportive services needed to place all children in pediatric overstays and other unlicensed settings in the least restrictive settings. The Workgroup is also tasked with developing a resource development plan designed to increase the number of licensed settings and end the placement of youth in unlicensed settings. In addition, the Workgroup must devise an implementation plan with comprehensive data to inform the plan and create a timeline for when the practice of placing children in unlicensed settings will cease.¹

The law required the Governor to appoint 11 of the 15 members of the Workgroup and to hold the first meeting before August 1, 2025. However, due to delays in the appointment process there were not enough formal appointments received in time to establish a quorum and convene by this deadline. The Workgroup held its first meeting on October 2, 2025. Given the late start, the Workgroup submitted a request for an extension of the mandated report, originally required by October 1, 2025.

In the interim, members of this Workgroup’s Executive Leadership Team met with Senate and House members leading the effort to discuss its preliminary findings, and presented its Interim Brief and Summary Overview along with initial Legislative Proposals to members of the Senate Finance Committee and Joint Briefing of the House Health Committee and Social Services Subcommittee of the House Appropriations Committee on January 28, 2026.² Many of the Workgroup’s initial recommendations were included in several bills that passed during the 2026 session,³ including: House Bill 1559 ([Ch.160](#), 2026)⁴, House Bill 1181 ([Ch.159](#), 2026)⁵ and House Bill 980 ([Ch.158](#), 2026)⁶. A comparison document cross-walking the passed legislation and the initial recommendations of the Workgroup can be found in the Appendix⁷.

This final report provides a brief overview of pediatric hospital overstays and the placement of children in unlicensed settings, a description of relevant legislation passed during the 2026 Maryland General Assembly session and recommendations that will lay the ground work and provide a roadmap for the Advisory Council on Maryland’s System of Care for Children, Youth, and Families established by the passage of House Bill 1559 ([Ch.160](#), 2026).

¹Children in Unlicensed Settings and Pediatric Hospital Overstays, Maryland Workgroup on. Available at: <https://msa.maryland.gov/msa/mdmanual/26excom/html/08childun.html>.

² See Appendix 7 – Workgroup Legislative Briefing Materials: 2026 Interim Report; See also Appendix 8 – DHS/MDH/DJS State Response: Supplemental Workgroup Report.

³ See Appendix 9 – 2026 Legislative Session Summary Highlights and Action Dates.

⁴ H.B. 1559 (Ch.160, 2026) [Children in Unlicensed Settings and Pediatric Hospital Overstay Patients - Placement](#). Available at: <https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb1559/?ys=2026rs>.

⁵ H.B. 1181 (Ch. 159, 2026) [Children in Out-of-Home Placement - Voluntary Placement Agreements](#). Available at: <https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb1181/?ys=2026rs>.

⁶ H.B. 980 (Ch.158, 2026) [Guardianship Assistance Program and State Foster Youth Ombudsman - Establishment \(Kanaiah's Law\)](#). Available at: <https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb0980/?ys=2026rs>.

⁷ See Appendix 10 – Comparative Analysis.

WORKGROUP DELIVERABLES

This Workgroup was tasked with a number of deliverables which were challenging to complete given the composition and limitations of the group. Below is a description of each deliverable and the status. It is the expectation that the Advisory Council will be positioned to finalize these deliverables.

Workgroup Deliverable	Status	Recommendation
Assessment of the number, types, and cost of the additional beds and supportive services needed to place all children in pediatric overstays and other unlicensed settings in the least restrictive settings.	Not completed.	Recommend transfer responsibility to the Advisory Council.
Develop a comprehensive and sustainable resource development plan designed to increase the number of licensed settings and end the use of pediatric overstays and licensed settings.	The workgroup put forward a compilation of the resources that are missing in the State and identified barriers.	Recommend the Advisory Council continue this work to identify how to close the gaps and provide access to these resources.
Develop an implementation plan with comprehensive data to inform the plan.	The work group identified the lack of systemization and coordination of data across State agencies.	Recommend the Advisory Council work to rectify and streamline the collection of data.
Determine the anticipated timeline for when the practice of placing children in unlicensed settings will cease.	H.B. 1559 (Ch.160 , 2026) prohibits the placement of youth in unlicensed settings effective June 1, 2026. H.B. 1559 (Ch.160 , 2026) prohibits the placement of youth in hospitals effective January 1, 2027.	Recommend the Advisory Council continue to monitor implementation efforts and promote the establishment of licensed temporary placements so youth are not waiting in restrictive settings like hospitals.

INTRODUCTION & BACKGROUND

Maryland is experiencing a severe shortage of licensed placement options for children and youth with intensive behavioral health needs, disabilities, trauma histories, and complex clinical profiles. Although the total number of youth in out-of-home care has decreased, the State's ability to meet the needs of high acuity youth has significantly eroded due to shrinking capacity across the entire placement continuum. This includes fewer available foster homes, therapeutic foster care placements, group homes, and residential treatment center (RTC) beds. Staffing shortages—particularly those persisting since the pandemic—further limit placement availability and delay placement for youth requiring specialized care.

Statewide data underscores the magnitude of this gap. Maryland has seen the closure of four RTCs over the last decade, leading to reduced bed capacity. For youth with co-occurring developmental disabilities and behavioral needs, options are especially constrained: only two in-state providers can serve youth with moderate to severe autism and intellectual disabilities below a 55 IQ. Consequently, many children and youth are placed in unlicensed settings such as hospitals, emergency departments, and hotels for extended periods, awaiting placement in licensed settings.

Racial disparities compound these systemic challenges. Multiple analyses from 2023–2025 show Black youth are disproportionately represented in foster care entries, placement disruptions, non-kin placements, and hotel stays. Reports call for developing culturally responsive service models, diversifying the caregiving workforce, and improving the collection and use of disaggregated race-based data to inform equity-focused interventions.

Recent data illustrate the extent of placement instability. Between April 2022 and October 2023, 142 youth experienced 162 hotel stays, with a median stay of 43 days. Most youth were ages 14–17 or over 18, and overwhelmingly Black. Many experienced their first foster care placement in a hotel, and most were recommended for therapeutic foster care or group home placements—settings currently in short supply statewide. Although DHS reported zero hotel placements as of late 2025, the historical pattern reflects profound gaps in age-appropriate and therapeutic placements.

Hospital pediatric overstays represent the most harmful placement failure. As of December 2025, 27 youth known to DHS and MDH were hospitalized beyond medical necessity, with a median overstay of 70 days. Chapin Hall's 2025 analysis shows that youth experiencing overstays typically remain in hospitals 63 days past their expected discharge date, often requiring RTC or step-down placements. Most overstayed youth had psychiatric admissions involving self-harm, significant behavioral dysregulation, or severe mental health crises, and almost half had been in care for over a year prior to hospitalization.

Research strongly demonstrates that prolonged hospitalization harms children across multiple developmental domains. Unnecessary hospital stays disrupt emotional, cognitive, and social development; worsen behavioral and psychiatric symptoms; contribute to institutionalization and loss of autonomy; erode attachments; damage identity; and expose youth to violence and self-harm within inpatient psychiatric units. These harms compound daily and create long-term barriers to stabilization and reintegration into family or community-based placements. For high-acuity youth, prolonged hospital stays often exacerbate underlying conditions and increase future treatment needs.

The Maryland Hospital Association reports that 63% of hospitalized youth awaiting discharge were waiting for RTC, foster home, or group home placements, with an average overstay of 40 days. Nearly 40% had current or prior involvement with DHS. These findings reinforce that insufficient licensed capacity—rather than clinical need—drives many pediatric overstays.

Overall, the decline in licensed placement capacity, the limited availability of specialized providers, persistent staffing shortages, and the disproportionate impact on Black youth have created a statewide placement crisis. This has resulted in harmful hotel stays, dangerous pediatric hospital overstays, and prolonged reliance on unlicensed settings that fail to meet children’s developmental, emotional, and safety needs.

The Workgroup was convened to address Maryland’s ongoing crisis involving pediatric hospital overstays and the placement of children and youth in unlicensed settings. Building on deliberations since October 2025, and the Workgroup’s initial proposed legislative recommendations in January 2026, and informed by urgent child welfare concerns, the Workgroup presents the following assessment, findings and extended recommendations.

CURRENT ASSESSMENT OF RESOURCE GAPS

Inadequate Resources & Barriers to Behavioral Health Services Statewide

Maryland's child welfare system and behavioral health continuum is in crisis. The inability to access appropriate and timely resources has created untenable gaps and barriers in the service array available for children, youth, and families. While certain areas of the state do not have access to specialized in-home and community-based services due to the lack of providers, areas with existing services or providers are unable to effectuate meaningful care due to bureaucratic limitation. Maryland cannot build a functional system of care without investing in and prioritizing the full spectrum of behavioral health services required to meet current demands and to prevent future lapses in crisis and complex care for children and families.

The Workgroup has identified the following root causes leading to significant service gaps in accessing resources to support children with behavioral health needs, disabilities and/or with medical complexities:

- insufficient bed capacity and inadequate reimbursement for care providers;
- lack of coordination across state agencies, counties and local jurisdictions;
- onerous regulatory and systemic barriers to obtaining services;
- delays in implementation of laws and promulgation of regulations; and
- ineffective or inconsistent oversight and accountability of resource utilization.

The Workgroup has also identified a critical gap in the state's ability to proactively identify youth on a trajectory toward crisis. To the best of our knowledge and resources, we have not been able to identify a centralized vetting entity or automated 'Red Flag' system to alert decision-makers when a child experiences rapid placement instability (e.g., multiple moves in a short period). As a result, medical and psychological assessments often occur only *after* a child has been placed in a hospital or hotel, rather than being triggered proactively to prevent the disruption. Critical history is often lost during staff turnover, leaving new care teams without a clear picture of the child's escalating needs.

The reduction in authority and flexible funding for [Local Management Boards](#) (LMBs) is a key barrier to developing community-specific placement resources. Historically, LMBs utilized the Children's [Cabinet Interagency Fund](#) to identify local gaps and fund tailored programs for high-needs youth in their specific jurisdictions. This allowed counties to rapidly develop local solutions for placement and prevention.

However, stakeholders report that this local authority has eroded. Funding has significantly decreased (from \$47 million in 2011 to approximately \$21 million in 2026), and the remaining state focus has shifted almost exclusively to the [ENOUGH Act initiative](#), which prioritizes childhood poverty.⁸ While poverty reduction is important and should not be minimized, this shift has left LMBs without the flexible capital needed to build specialized placement capacity or high-intensity behavioral health services for the specific population of youth currently languishing in hospitals and hotels.

⁸ As stated in the [FY2027 CCIF Notice of Funding Availability \(NOFA\)](#), "CCIF-funded programs and community support initiatives must align with one or more of the ENOUGH pillars. LMBs have flexibility to fund direct services, capacity-building efforts, planning activities, and systems coordination, provided investments demonstrate clear outcomes and alignment with ENOUGH goals."

Funding critical support services for Maryland's children should not be either/or; all critical and basic needs should be prioritized and adequately funded.

Residential Child Care and Child Placement Agency Bed Capacity & Service Array

The Maryland Department of Human Services (DHS) successfully implemented rate reform for residential childcare (RCC) beds in 2025. RCCs are licensed by DHS to provide 24-hour care for children within a structured setting, including food, shelter, clothing, education, and social, health, and recreational services. RCC providers who participated in the Workgroup advised that this rate reform significantly impacted their ability to expand bed capacity and service offerings. DHS is working on rate reform for child placement agencies through the [Quality System Reform Initiative](#). Child placement agencies include providers that offer therapeutic foster care and independent living programs. While a rate model update for Child Placement Agencies (CPAs) was developed with a proposed implementation for FY26, the anticipated rate increase was not funded in the FY27 State budget.

It is imperative that state agencies and eligible stakeholders are responsibly seeking out and applying for all available funding avenues. In particular, SAMHSA's Children's Mental Health Initiative provides federal funding to states to improve mental health outcomes for children and youth at risk for serious emotional disturbances by implementing a system of care approach. This grant funding could help Maryland build a system of care by ensuring RCCs and CPAs have sufficient resources to ensure capacity and availability of services.

Federal funding could also support the expansion of providers offering services available through the [1915\(i\) State Plan Amendment](#). The recent 1915(i) State Plan Amendment is expected to expand patient eligibility, but there was not an accompanying plan to increase Medicaid reimbursement rates for the array of 1915(i) services. This is impacting the availability of these services across the state. For example, one of the 1915(i) services is intensive in-home which provides Medicaid reimbursement for the provision of evidence-based practice (EBP) Family Centered Treatment or for a non-EBP service. Medicaid reimburses at rates significantly lower than the Maryland Department of Juvenile Services (DJS) reimburses providers for those same EBPs. DJS is able to offer higher rates because they use state general funds to pay providers. Consequently, providers relying on Medicaid reimbursement cannot afford to provide those EBPs. Other services in the 1915(i) service array, such as respite and experiential therapies, also have Medicaid reimbursement rates that are too low, resulting in very few providers offering these services across the State.

Across the State there are only three providers that offer Intensive In-Home Services - one provider that offers respite and four providers that offer expressive and experiential behavioral services (therapeutic horsemanship/equine therapy, music therapy and nature-based occupational therapy). The low number of providers contributes to the inability for families in certain regions of the State to access these therapies and service options in their community.

Treatment Foster Care Bed Capacity

Treatment foster care (TFC) is a vital part of the overall capacity need. Currently there is an overall lack of foster bed availability and accessibility, whereby TFC's are operating under a system that is subject to an increasingly defunct and opaque private vs public model of care. While the current [SSA Dashboard](#) does not break down placements by placement type, when previous versions did,

TCF was the second largest number of placements, behind kinship placements. The State has been unable to share the number of licensed and available TFC beds.

Based on reports by TFC providers, it is important to highlight that the number of contracted beds does not typically reflect the number of available beds. For example, a provider may have a contract for 60 beds but may only have 40 certified foster homes. If each of those homes has one available bed, then there is a gap of 20 beds that cannot be used. The extent of this gap is unclear because data regarding availability and capacity of TFC's across Maryland is not readily accessible, and such data has not been provided by DHS when requested.⁹ Providers are required to enter all certified TFC homes into DHS' Child, Juvenile, Adult Management System (CJAMS). However, extracting data from CJAMS that is reliable and consistent is an ongoing challenge, despite efforts to overhaul and improve this system and overall data collection efforts by DHS and additional agencies or entities relying upon this system.

Public TFC vs. Private TFC

Public TFC is characterized as a 24-hour substitute care program run by a Local Department of Social Services (LDSS) intended to provide treatment for children with serious emotional, developmental, behavioral, medical, or psychological conditions in a family setting. The placements are considered restrictive and meant to be temporary. Children placed in these settings must have a step-down plan and must meet certain criteria including having a serious emotional, behavioral condition that limits their ability to perform daily living skills, community living skills, interpersonal relationships and appropriate educational activities.

While certain LDSS' previously operated Public TFC programs, over the past several years DHS has shifted to rely primarily on the use of Private Child Placement Agencies (CPA-TFC) for this level of care, effectively discontinuing the Public TFC model. While there is debate over the use of Public versus Private TFC, what is clear is that there is a lack of transparency and direct feedback mechanisms between licensed providers and State leadership. Stakeholders report that licensed public foster families in some jurisdictions have available beds for high-needs youth but are never contacted, potentially due to administrative gatekeeping or lack of real-time inventory management at the local level. Additional and/or more efficient and effective mechanisms for licensed caregivers to directly alert State headquarters of their availability or to report systemic barriers preventing them from accepting placements should be considered and addressed when assessing and implementing new pathways and systems for urgent and/or higher levels of care needed. For instance, the [Maryland Resource Parent Association](#) (MRPA) maintains a list of open homes.¹⁰ These licensed placements should be considered when social workers are exploring all available placement options for children and youth.

As it stands, public and private TFC differ greatly in their regulatory language. At minimum, licensing reciprocity could be provided between public and private TFC to help remove barriers when placing children, open possible matches, and assist in shortening permanency timelines. This could allow

⁹Although this data has been requested by the work group, to date no data has been shared.

¹⁰This list is kept by the Maryland Resource Parent Association (MRPA) and is not public. MRPA has shared this list with DHS and local DSS.

assessments and care to be provided earlier in a child's journey within foster care, thus reducing hospitalizations and overstays.

Residential Treatment Centers

Residential Treatment Centers (RTCs) serve children and adolescents with the most severe behavioral health needs, but only about two thirds of Maryland's licensed beds are actually staffed, following a decade marked by facility closures, workforce shortages, and inadequate reimbursement rates.¹¹ These constraints have created long waitlists, high denial rates, and significant difficulty placing youth with high-acuity needs. Between 2018–2023, four RTC closures and workforce shortages created a statewide placement crisis. Maryland's RTCs operate near full capacity, leaving limited options for high-acuity youth.¹²

The long-term decline in RTC placements in Maryland reflects a shift towards broader investments in community-based behavioral health services, and a policy preference for treating youth in less restrictive environments whenever possible. Non-community-based placements, including RTCs, now account for a relatively small share of out-of-home placements. However, this decline in utilization does not reflect reduced need. Instead, it presents a paradox: while fewer youth are placed in RTCs, those who are placed tend to have significantly higher acuity, requiring more intensive services and longer stays. Average length of stay has increased substantially over time, often exceeding several hundred days, indicating slower patient turnover and greater system strain. Addressing the system's bottlenecks will require targeted investments in staffing, increased reimbursement, development of specialized high-acuity programs, and expansion of step-down and community-based services.

¹¹ Chapin Hall, *White Paper: Residential Treatment Center Services* (Maryland Health Care Commission, 2025). Available at: https://www.mhcc.maryland.gov/sites/default/files/reports/chcf_rtc_white_paper.pdf.

¹² Data is collected by the Maryland Health Care Commission on behalf of the RTC/RCC Coalition (a group of RTC/RCC providers that meet monthly).

REMOVING BARRIERS FOR SYSTEMIC CHANGE

Within the past five years, several laws have been introduced and passed to address growing concerns with pediatric hospital overstays and placements in unlicensed settings. Unfortunately, some of these laws have not been either fully implemented, or the responsible State agency has not promulgated regulations. See Table 6 for detailed information on legislation that has passed but has not been fully implemented and regulations that have not been updated.

Additional ongoing regulatory barriers and implementation issues that will require further attention and the extended work of the forthcoming Advisory Council include:

- Further review of the procedural and regulatory discrepancies that may require further training, coordination and revision and/or removal of harmful or outdated policies and practices. For instance, continued attention is required for the voluntary placement agreement (VPA) process to address additional regulatory or policy discrepancies not yet realized or recognized in current law or practice.
- Further review of cost structures across all areas of necessary and desired treatment service providers to address payer parity, rate reforms, staffing, licensing, and where funding resources and opportunities may be more effectively obtained and retained.
- Further review of data structures across all entities and agencies to ensure accuracy, consistency, and accountability of vital information that children and their support systems rely upon.
- Racial disparities within the child welfare system must be met with the urgency and critical areas of reform it deserves and demands – including but not limited to the overrepresentation of Black children and youth in foster care and family separation proceedings, emergency and prolonged psychiatric hospitalization, and punitive treatment across educational and court judicial systems.

The weighted work of this Workgroup must continue. The 2026 legislation that recently passed incorporates many of the Workgroup's proposals and represents important progress.¹³ Several additional areas of remaining unmet needs will continue to be addressed in upcoming phases of the Workgroup's efforts. First, a complete and detailed analysis of system capacity and costs will require inter and intra agency cooperation and transparency to put forth a detailed cost projection for the additional licensed beds and supportive services required to meet the needs of children currently in unlicensed settings or pediatric overstays. It will also be necessary to examine how foster care maintenance payments are being utilized in these situations, to conduct a comprehensive review of out-of-state placement contract costs, and to evaluate the adequacy of Medicaid reimbursement rates for residential treatment centers, respite programs, and 1915(i) services. In addition, a financial framework is needed to guide reinvestment of funds currently used for unlicensed or temporary placements, and a system-wide assessment must be conducted to understand provider workforce availability and staffing shortages that directly affect placement capacity.

Second, in order for additional licensed settings to be effectively created and sustained, it is critical to establish and support a statewide registry that captures all licensed placement options and their availability in real time. A coordinated statewide strategy is needed to expand licensed capacity

¹³ See Appendix 9 – 2026 Legislative Session Summary Highlights and Action Dates.

across all levels of care, supported by reforms to Child Placement Agency, Residential Treatment Center, and Qualified Residential Treatment Program rate structures. Strengthening Treatment Foster Care provider support systems is essential, as is developing a broader recruitment and retention plan for the caregiving workforce.

Third, in order to support timely and effective system reform, a statutory or operational deadline for ending all unlicensed placements, without exceptions, must be judiciously implemented and enforced. Successful implementation will require cross-agency coordination to sequence reforms properly, along with critical improvements in data collection and analysis, including tracking instances of placement rejections and monitoring provider staffing capacity, and enforcement mechanisms or triggers to ensure compliance when timelines are missed or when children are not promptly removed from unlicensed placements.

A summary can be found in Table 5 (below) of the identified missing resources, services and bed types, the barriers to expanding bed and service line capacity, the action(s) needed to remove these barriers and the entity responsible for taking action.

Table 5: Resources, Services & Beds Needed to Support Children, Youth & Families

Missing Resource, Service or Bed Type	Barrier	Action(s) Needed	Responsible Entity
Child Placement Agency Beds (Therapeutic Foster Care and Independent Living Programs)	Funding to support rate reform	Increase Medicaid Reimbursement Apply for federal grants to supplement state dollars Allow for blended state funding that follows the child	Maryland Department of Human Services Maryland Department of Health
Intensive In-Home Services and 1915(i) Eligible Services (Family Centered Treatment, Respite, Experiential Therapies)	Funding to supplement Medicaid reimbursement For children with developmental disabilities and/or medical complexity, there are long wait lists for other HCBS waivers (1915c). For example, the model waiver for medically fragile children caps at 200, which results in a long wait list. The developmental disabilities waivers also have very long wait lists.	Seek additional State or federal funding to fill the gap such as the Families First Act or SAMHSA. Allow for blended state agency funding so the agency a child is associated with isn't a barrier to accessing resources Expand access to waivers that support home and community-based services for non-behavior related services (home nursing, medical/adaptive equipment, home modifications, care assistants, care navigation services etc.).	Maryland Department of Health

Missing Resource, Service or Bed Type	Barrier	Action(s) Needed	Responsible Entity
Mobile Crisis Response System Customized for Kids	Funding to support the pilots and scale statewide.	Leverage Medicaid's EPSDT benefit Seek additional State or federal funding to fill the gap such as the Families First Act or SAMHSA Children's Mental Health Initiative grant Consider requiring or requesting commercial insurers to cover this service.	Maryland Department of Health
Public Treatment Foster Care Beds	Program awareness Engagement of local departments of social services Recruitment of public treatment foster care parents	Research why the public treatment foster care program is not available in all 24 counties Create tool or process for the local departments of social services to identify available homes and match to the needs of youth needing a placement Update, promote, grow, and utilize MRPA list of available licensed homes open to taking 'hard to place' situations (medical, treatment, etc.) in coordination with the local departments of social services	Maryland Department of Human Services Maryland Resource Parent Association (MRPA)
Residential Child Care Providers Allowance for Provisional Emergency Placements	Under COMAR 14.31.06.17, licensed Residential Child Care (RCC) programs face significant barriers to accepting emergency placements because all intake documentation must be completed within 24 hours, exposing providers to licensing and contract risk when records are unavailable. This requirement often	Modify COMAR 14.31.06.17 to allow provisional emergency admissions with essential safety documentation only, while permitting remaining materials to be submitted within 48–72 hours under clear safeguards.	Department of Human Services

Missing Resource, Service or Bed Type	Barrier	Action(s) Needed	Responsible Entity
	prevents timely placement of adolescents boarding in hospitals or crisis settings, leaving licensed beds unused despite available capacity		

Table 6: Legislative & Regulatory Summary Table

Effective Date(s)	Law/Regulation Title	Description	Status	Responsible Agency
Oct. 1, 2023 (effective date) Dec. 1, 2024, MDH to convene stakeholders and submit recommendations on expansion of eligibility and enrollment in 1915(i) services, current eligibility requirements and provider reimbursement rates including value-based purchasing options	H.B. 322 (Ch. 379, 2023) / S.B. 255 (Ch. 378, 2023) : Public Health - Home- and Community-Based Services for Children and Youth	Requiring the Maryland Department of Health to expand access to and provide reimbursement for intensive in-home services, case management, and wraparound services; requiring, beginning in fiscal year 2024. The Behavioral Health Administration to fund 100 slots in the mental health case management program for children or youth at risk of out-of-home placement who are not eligible for program services. Requiring the Governor to include funding in the annual budget bill for customized goods and services for certain youth; etc.	Passed, but not fully implemented (requires transfer of educational funds from DHS to MDH)	Department of Health
Jan. 1, 2024 (effective date)	H.B. 766 (Ch. 500, 2022) : Children – Residential Treatment Centers – Education Funding	Moving responsibility for approving the education funding for a Maryland RTC placement for children on Medicaid from DHS to MDH, making VPAs	Passed, but not fully implemented. Updated regulations proposed in late 2025; awaiting finalization.	Maryland Department of Health Maryland Department of Human Services

Effective Date(s)	Law/Regulation Title	Description	Status	Responsible Agency
		unnecessary in many cases.		
Oct. 1, 2024 (effective date)	H.B. 1134 (Ch. 853, 2024) / S.B. 403 (Ch. 854, 2024) : Hospitals and Related Institutions – Residential Treatment Centers – Accreditation	Expanding the approved accreditation bodies for RTCs to include CARF and COA in addition to Joint Commission. This was in response to a barrier in expanding the Continuum of Care in MD and to expand the number of RTCs in MD. This legislation allows programs to be licensed by the OHCQ, ultimately will not be funded until this change is made. Maryland is currently the only state that does not use this model, and it may even help bring in organizations licensed in other states.	Passed, but the State plan has not been updated.	Maryland Department of Health
Feb. 12, 2021 (Effective date after veto override)	HB 1121 (Ch. 29, 2020) : Maryland Mental Health and Substance Use Disorder Registry and Referral System	This legislation has been enacted, but its efficacy remains limited. This Registry and Referral System should be fully optimized in order to serve its intended purpose: providing a statewide system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients. It should, at minimum, include real-time availability with patient demographics.	Enacted, but not functioning optimally and not inclusive of all stakeholders or bed types.	Maryland Department of Health Maryland Department of Human Services Inpatient and Outpatient Mental Health and Substance Use Disorder Providers

SUCCESSFUL STATE MODELS

Michigan Children's Therapeutic Family Care

Michigan's Children's Therapeutic Family Care (CTFC) program is a specific model that has shown positive results. Operating under a 1915(c) waiver (the 'SED Waiver'), this model treats the placement not as 'foster care' but as an intensive medical service. A child is placed in a therapeutic home for a temporary, defined treatment period (typically 6–9 months) with the explicit goal of stabilizing them to return home, rather than long-term foster care.

Because it is classified as a medical treatment service rather than a custodial placement, Michigan leverages Medicaid funds to pay therapeutic parents a professional wage, allowing them to be stay-at-home caregivers for youth with severe emotional disturbances who would otherwise be in psychiatric hospitals.

One CPA provider in Maryland has launched a pilot Enhanced Treatment Foster Care program, modeled off Texas's Professional Treatment Foster Care program. In addition to meeting all current TFC requirements, the model incorporates an evidence-based intensive in-home intervention model used in addition to the required TFC services. The difficulty of care rate is also higher for the treatment foster parent, accompanied by a requirement that the parent be available to the youth 24 hours a day. The Workgroup recommends conducting a further assessment of this pilot program to determine success metrics and potential for expanding that pilot.

New Jersey Children's System of Care

New Jersey's Children's System of Care (CSOC) is frequently cited as a national model. Central to the issue of improper and harmful placement of children and youth in unlicensed settings and hospital overstays, New Jersey also recognized that children involved in the child welfare system often have complex behavioral health, developmental, and substance use needs that existing structures were unable to adequately address. In response, the state created the Children's System of Care (CSOC) as a division within DCF to operate as New Jersey's public behavioral health system. CSOC follows a wraparound model that uses a team-based, collaborative process to provide children with an individualized set of support services. The idea is to keep children at home and in school, and involved in their usual activities, by "wrapping" services around the family. This could include, but is not limited to, services related to mental health, education, healthcare, social support, and community integration.

In addition to wraparound care coordination, CSOC includes mobile crisis and response services, substance use treatment, developmental disability services, family peer support, care management organization, respite, and residential treatment for youth under age 21. All services are available through PerformCare, a Contracted Systems Administrator that provides a single access point for families. Parents or legal guardians can call PerformCare directly, 24 hours a day, 7 days a week, 365 days a year. **The system also allows children to receive care without ever entering the child welfare or juvenile justice systems, thereby avoiding unnecessary custody relinquishment.** CSOC and PerformCare work together to approve clinical requirements for all services and set rates, which are then billed through the Medicaid Management Information System on a fee-for-service basis. PerformCare also utilizes a secure electronic health record and information system called

CYBER, which enables all service providers to manage treatment, authorizations, and billing in one place.

Mobile Response and Stabilization Services, Customizing for Children, Youth & Families

In the Maryland Department of Health's strategic plan, released in 2021, the State committed to, "designing and implementing a mobile response and stabilization system (MRSS) customized to meet the needs of children, youth, young adults, and families."¹⁴ MDH further reaffirmed this commitment in the 2025 "Behavioral Health Roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth and Families."¹⁵ MRSS is a national best practice model for serving children, youth and families in crisis. The model requires rapid deployment of a specialized team that is available 24/7/365. In contrast to traditional crisis services where a triage and screening protocol is used, once a parent or caregiver requests assistance, a team is deployed. In addition to the immediate on-site support, there is a 72-hour period of initial services and supports, and ongoing stabilization services for up to six to eight weeks.

Implemented within the statewide Children System of Care (CSOC) and accessible by calling PerformCare, New Jersey's Mobile Response and Stabilization Services (MRSS) have reported high success in helping to avoid unnecessary ED visits, out-of-home placements, and placement disruptions, and in reducing overall system costs. Specifically, New Jersey's MRSS was created to support children and families "in crisis as defined by the individual child or family," such as when one's sense of balance is disrupted, coping and problem-solving skills that may have worked in the past are no longer effective, or life functioning is disrupted. The goal of MRSS is to provide intervention and support at the earliest moment families identify that help is needed under a "no-reject/no-eject" philosophy that ensures youth are always provided services.

Through New Jersey's MRSS, a behavioral health worker is available to any family in the state, 24 hours a day, every day. Any child up to age 21 is eligible and services are available to any family in crisis due to a child's escalating emotional or behavioral needs, whether it is the family's first time asking for help or the family is already receiving services from a state agency or private provider.

MRSS in New Jersey follows a four-pronged approach. First, it begins with on-site intervention to immediately de-escalate presenting emotional symptoms and behaviors, including observing, interrupting, and shifting dynamics, providing education, and introducing skills. Next, providers move into assessment, planning, skill-building, psychoeducation, and resource linkage to stabilize presenting needs, including strengths, triggers, communication, and other key contexts (medical, mental health, trauma, development, patterns of behavior, collateral outreach, among others). The third prong is assistance to the child and family in returning to baseline or routine functioning, as well as in preventing further escalation. Finally, MRSS helps children and families develop prevention

¹⁴Available at:

https://health.maryland.gov/bha/Documents/MD%20MRSS%20summary%20two-pager_022422.pdf.

¹⁵Maryland Coalition of Families and Manatt Health, *Roadmap to Strengthen Maryland's Public Behavioral Health System for Children, Youth and Families* (Maryland Department of Health Behavioral Health Administration, June 2025). Available at:

<https://health.maryland.gov/bha/Documents/MDH%20BH%20Roadmap%20for%20Children%202025.pdf>.

strategies and resources to address presenting emotional symptoms, behaviors, and existing circumstances, and to create a plan to avoid future crises.

MRSS is accessible via a toll-free phone number and, during a crisis, an MRSS worker is available *within one hour*. MRSS is initially available for 72 hours following the request for help, but can be extended for up to 8 weeks of stabilization services.

New Jersey's MRSS provides services such as in-home counseling, behavioral assistance, caregiver therapeutic support, intensive in-community services, skill-building, medication management, coordination, and development of informal and natural support systems (such as faith-based organizations, mentors, and peer support), and coordination of specialized services to address the needs of children with co-occurring developmental disabilities and substance use. Each of these areas requires intensive investment of funding, resource identification and coordination, and continuity and accountability in oversight and quality control.¹⁶

New Jersey's MRSS has reported high success rates. Since its creation in 2004, MRSS has consistently maintained 94 percent of children in their living situation at the time of service, including children who are involved with the child welfare system. In fact, this number was 98% in 2017. Additionally, families have reported high satisfaction with services, with a 260% increase in the number of families accessing MRSS since 2011.

Similar to New Jersey, Maryland's system of care must overcome substantial challenges and undertake considerable effort to implement and sustain meaningful child welfare and behavioral health reforms. It is important to critically assess all areas of vulnerability within Maryland's current care systems and to carefully add, expand, and improve services both individually and collectively. One key service that remains inaccessible for most children and families is psychiatric crisis respite—an invaluable resource for stepping children down from hospitals or diverting them from hospitalization altogether. Respite is an essential support for children and families, both within and outside the foster care system, who have complex behavioral health needs.

¹⁶See *Appendix 7, The New Jersey System of Care Model* for a comprehensive overview of costs, resources allocations, measuring tools and additional state model comparative analysis.

RECOMMENDATIONS & ROADMAP FOR FUTURE WORK

Maryland's children are bearing the consequences of a fragmented and under-resourced system of care for children with complex behavioral, medical, and developmental needs. Lacking proper investment, infrastructure, and reliable systems of community access to care and support, Maryland's foster care system has evolved to become the provider of deep end behavioral health care to children and youth. Despite consistent findings and prior reform efforts, too many young people are left without timely access to safe, appropriate, and therapeutic care. Due to the lack of data availability, it is challenging to pinpoint the exact number of children and youth impacted. This status quo is neither sustainable nor acceptable.

Notwithstanding decades of concerns raised by advocates, community providers, legislators and others in the past - including a lawsuit in 1987 and pending litigation against several State agencies over the issue of public hospital overstay - prior work groups, reports, and legislative initiatives have failed to put more than a temporary end to the problem.¹⁷ This is in part because many of the recommendations and initiatives have not been implemented, largely due to systemic gaps and accountability, inefficient resource allocation, and lack of consistent and independent oversight. It is the expectation of this Workgroup that under the guidance of the Advisory Council, this important work will be implemented with the utmost urgency.

The Workgroup urges State agencies, local jurisdictions, and providers to take decisive and coordinated action to truly create a functional continuum of care. This requires sustained investment, modernization of regulatory frameworks, and clear accountability across systems.

Maryland has the expertise, resources, and collective commitment to correct these systemic failures. What is required now is alignment, urgency, and sustained follow-through and oversight. An overarching consensus of the Workgroup is that the following recommended actions are generally and intentionally guiding Maryland toward adopting the New Jersey model – the gold standard for serving children, youth and families. By acting decisively and collaboratively, the State can ensure that every child receives care in the least restrictive, most appropriate setting, when they need it, and without delay.

Building comprehensive and accessible behavioral health systems and support services for all children, meeting them at all levels of care needed for their health and well-being, demands short and long-term actions and continued prioritization of investments and focus on improving the health and safety of Maryland's most vulnerable and underserved children and families.

The Workgroup recommends the Advisory Council created by House Bill 1559 (Ch. 160, 2026) continue to have a sense of urgency to remedy the main broken pieces of Maryland's system of care. In order to hit the ground running, this Workgroup recommends the Advisory Council focus on the following recommendations with the utmost urgency:

Short-Term Interventions (Oversight, Process and Placement)

- Immediate interventions are needed to remove youth currently experiencing a pediatric hospital overstay.

¹⁷ See Appendix 12 – List of Supporting & Supplemental Resources.

-
- To expedite placements for youth with high-acuity needs, the Workgroup recommends the State lay the groundwork to operationalize HB 1559 (Ch. 160, 2026), HB 1181 (Ch. 159, 2026) and HB 980 (Ch. 158, 2026).
 - These actions should take place as soon as possible, ahead of the enactment dates - the majority which occur between June 1, 2026, to October 1, 2026.

Structural Interventions (System of Care)

- Lasting reform requires a transition from a reactive, institution-based system to a proactive, community-based continuum of care. The Workgroup supports the statewide implementation and full funding of Mobile Response and Stabilization Services (MRSS), consistent with successful models in other states, as mandated in HB 1559 (Ch. 160, 2026). However, the Workgroup strongly recommends that the Advisory Council work toward full implementation and funding sooner than 2030.
- Additionally, the Workgroup recommends the State focus on expanding behavioral health bed and service capacity, and child welfare bed and service capacity through leveraging and scaling existing successful pilots.
- Recent Board of Public Works investments to expand intensive group home and treatment foster care capacity must also be strategically deployed, with priority given to youth transitioning from, or at risk of entering, hospital settings.

Post-Session Implementation Roadmap

6 bills enacted

96-10013-10-0000 Children in Unlicensed Settings and Pediatric Hospital Overstay Unlicensed providers, 96-10013-10-0000; Pediatric Nurse, Hospital Management/Practice/Policy (p-p) (p-0)	Effective June 1, 2020 – Continued through June 30, 2021
96-10013-10-0000 HealthySteps Guardianship Assistance Program & State Court Youth Emulation Laidlaw EAP to include: Create an independent Emulation unit (EAP) to address the specific case	Effective January 1, 2020
96-10013-10-0000 Family Services – Voluntary Placement Agreement Refers Family Services, 96-10013-10-0000; Family Services, 96-10013-10-0000; Family Services, 96-10013-10-0000	Effective January 1, 2020
96-10013-10-0000 Residential Child Care – Education & Practitioner Training Standards Child care practitioners, 96-10013-10-0000; Independent Training Standards, 96-10013-10-0000	Effective January 1, 2020
96-10013-10-0000 Children's Cabinet Interpretation Plan – Reformed & Mandated Child care, 96-10013-10-0000; Interpretation Plan, 96-10013-10-0000; Interpretation Plan, 96-10013-10-0000	Effective July 1, 2020
96-10013-10-0000 Healthcare Technology Methodology Modernization – Workgroup Healthcare Technology, 96-10013-10-0000; Workgroup, 96-10013-10-0000; Workgroup, 96-10013-10-0000	Effective July 1, 2020 – Working currently June 30, 2021

[illegible][illegible][illegible]

REPORT DATE July 6, 2027 Annual Review Review Panel: First annual report to General Assembly Covers all product activities and advanced technology activities and the company's overall performance, also reflects the Corporation's Strategy July 6, 2027 NA DASH – Director Panel David C. Johnson, Chairman, President, and Vice President	REPORT DATE July 6, 2027 Annual Review Each Local Department: UPRs data report to DHS Local DHS reports – average time to identification and placement, if and where the child is placed, DHS quality rating, DHS position, report number (includes data published by 6/30) REPORT DATE July 6, 2027 NA DASH – Director Panel David C. Johnson, Chairman, President, and Vice President
Task Force December 1, 2027 Guardianship Assistance Program & Foster Youth Guardianship Assistance Program It is an established and expanding role. This collaborative investigation committee, advises the youth care services coordinator on the best practices for the program, and provides information to the legislature. NA DASH – Director Panel David C. Johnson, Chairman, President, and Vice President	REPORT DATE December 1, 2027 Annual Review Advisory Council: First annual findings & recommendations Annual report to Governor – reviewed by legislature, each agency's meeting report, NA Section of Camp enrollment's, Executive Plan, Single report, and Single report to the legislature. NA DASH – Director Panel David C. Johnson, Chairman, President, and Vice President

July 6, 2027 (January) DHS published statewide aggregated UPRs data published by no later than 6/30/27. NA DASH 700-400 State of Michigan website, report the data.

July 6, 2027 (January) DHS published statewide aggregated UPRs data published by no later than 6/30/27.

[illegible][illegible]

CONCLUSION

Maryland stands at a pivotal moment in its effort to transform the child-serving system and end the longstanding reliance on unlicensed settings and pediatric hospital overstays. The findings of this Workgroup make clear that meaningful progress requires coordinated action, sustained investment, and a commitment to implementing reforms that have too often been delayed. With the passage of key 2026 legislation, the establishment of the new Advisory Council, and a roadmap that prioritizes capacity building, data modernization, mobile crisis expansion, and alignment with national best practices, the State has the structure and momentum needed to achieve lasting change.

The next steps are clear: rapidly operationalize enacted laws, finalize the comprehensive resource development and implementation plans, strengthen cross-agency coordination, and hold all partners accountable to the statutory deadlines ending unlicensed and hospital placements. By following through with urgency and collective resolve, Maryland can finally deliver a functional and equitable system of care in which every child has timely access to safe, appropriate, and least restrictive services, without exception and without delay.

APPENDIX

LIST of APPENDICES

Appendix 1 – Workgroup Roster

Appendix 2 – Standardized Definitions Glossary

Appendix 3 – Classification Framework: Placement Settings

Taxonomy Appendix 4 – Historical Background & Tables 3-4

Appendix 5 – Compilation of Prior Report Recommendations

Appendix 6 – New Jersey System of Care Model and Comparative

Overview Appendix 7 – 2026 Legislative Briefing Materials: Workgroup

Interim Report Appendix 8 – 2026 Supplemental Agency Report Materials

– MDH, DHS, DJS Appendix 9 – 2026 Legislative Highlights & Action Dates

Appendix 10 – 2026 Legislative Comparative Analysis-HB1559,

HB1181 Appendix 11 – 2026-2031 Legislative Implementation

Roadmap Appendix 12 – List of Supporting Resources

Appendix 1

Workgroup Roster

Children in Unlicensed Settings & Pediatric Overstays Workgroup Roster

<u>Agency/Organization</u>	<u>Appointed Member</u>	<u>Designee (if applicable)</u>
Maryland Department of Health	Dr. Meena Seshamani, Secretary	Sonia Chesson, Senior Advisor
Maryland Department of Human Services	Rafael López, Secretary	Stephen Liggett-Creel Creel, Senior Advisor
Maryland Department of Juvenile Services	Betsy Fox Tolentino, Acting Secretary	Maisha Davis, Assistant Secretary of Community Resources
Office of the Public Defender	Natasha Dartigue, Public Defender	Krystal Williams, Assistant Public Defender
Maryland Association of Resources for Families and Youth	Nicole Smith, Executive Director of Domestic Programs, Everstand	
Disability Rights Maryland	Leslie Seid Margolis, Managing Attorney and Policy Counsel	
Community Behavioral Health Association	Sara Hairgrove, Assistant Director of Public Policy	
Maryland Legal Aid	Erica LeMon, Advocacy Director for Children's Rights	
Maryland Court Appointed Special Advocates (CASA)	Laura Edwards, Executive Director	
National Association of Social Workers	Unfilled	
American Academy of Pediatrics-Maryland Chapter	Dr. Rebecca Seltzer, Pediatrician, Child maltreatment/foster care committee member.	
Maryland Hospital Association	Jane Krienke, Assistant Vice President, Government Affairs & Policy	
Specialty Psychiatric Hospital	Carrie Etheridge, Director of Social Worker, Sheppard Pratt	
Residential Treatment Provider	Robert Basler, Associate Vice President, Arrow Child and Family Ministries	
Family of a Child in Foster Care	Unfilled	
Work Group Staff	Edward "Ted" Gallo, Executive Director, Maryland State Council on Child Abuse and Neglect (SCCAN)	

Appendix 2

Standardized Definitions Glossary

Standardized Definitions Glossary

Placement Settings (Licensed)

Foster Care: Continuous 24-hour care and support services provided for a minor child by an individual, or individuals certified by a licensed child placement agency as foster parents. (Sec. 07.05.02.02)

Treatment Foster Care: A 24-hour substitute care program, operated by a licensed child placement agency or local department of social services, for children with a serious emotional, behavioral, medical, or psychological condition (Sec. 07.02.21.03)

Group Homes (Non-therapeutic): A facility owned, leased, or operated by a licensee that provides: (a) Residential services for youths such as care, diagnosis, training, education, and rehabilitation; and (b) A group living experience. (Sec. 14.31.05)

Group Homes (Therapeutic): Therapeutic living services for at least four, but not more than eight, children by providing access to a combination of developmental, diagnostic, and therapeutic mental health services in a home-like environment. (Sec 10.21.07.08)

Residential Treatment Center (RTC): A program of care provided in a residential setting by a provider on a 24-hour basis for longer than 24 hours to a child or children unless otherwise provided by state law. (Sec. 14.31.02.03)

Independent Living Program: A licensed child placement agency that provides services and supervision to prepare youth in out-of-home placement for self-sufficiency after discharge. These programs aim to help youth aged 16-21 develop life skills in areas like housing, employment, financial literacy, and social-emotional well-being, and assist them in building community and professional networks.

Residential Child Care Program (RCC): An entity, licensed by DHS, providing 24-hour care for children within a structured setting, including food, shelter, clothing, education, and social, health, and recreational services.

RCC Program Classes

- Class 0: Pre-QRTP (No Clinical Services)
- Class 99: I/DD Legacy Program (No Clinical Services)
- Class 1: Serve Youth with Significant Behavioral Health Service Needs (6+ Beds)
- Class 1b: Serve Youth with Significant Behavioral Health Service Needs (5 or Fewer Beds)
- Class 2: Serve Youth with Intensive or Specialty Behavioral Health Service Needs (6+ Beds)
- Class 2b: Serve Youth with Intensive or Specialty Behavioral Health Service Needs (5 or Fewer Beds)
- Class 3: Serve Youth with High Intensity I/DD Service Needs (No Behavioral Health Services)
- Class 4: Serve Youth Needing High Intensity Medically Fragile Services

- Class 5: Serve Youth Who Have Experienced/At-Risk for Commercial Sexual Exploitation
- Class 6: Serve Youth with the Highest Intensity Behavioral Health and Intensive I/DD Service Needs

Qualified Residential Treatment Program (QRTP): A specific category of non-family-based placement that provides trauma-informed care for children with serious emotional or behavioral disorders. Must include:

- Registered or licensed nursing staff and licensed clinical staff available 24/7
- Family participation in treatment (when appropriate)
- Documentation of family outreach and integration
- Discharge planning and family-based aftercare supports for at least 6 months post-discharge
- National accreditation by CARE, Joint Commission, COA, EAGLE, or Teaching-Family Association

Support Services

Kin: An individual who is related to the child through blood or marriage, adoption, tribal law or custom, or cultural custom or practice; or an individual who is unrelated to the child, but has a strong familial or significant bond with the child, or is a person identified by the child's parent. (COMAR 07.02.09.02)

Respite Care: Short-term care for a child to temporarily relieve the foster family or treatment foster family or caregiver from the responsibility of providing 24-hour care for a child. (COMAR 07.02.11.03)

Respite Care Services: Services provided for a child or adult with serious emotional disturbance on a short-term basis in a community-based setting or designed to support an individual to remain in the home (COMAR 10.21.27.02)

Problem Placement Categories (To Be Eliminated)

Unlicensed Setting: Any location that houses a child in an out of home placement who is in need of medical or behavioral health care for greater than 24 hours, which is not licensed by the Department of Human Services or Department of Health for the purpose of caring for and housing children in out of home placements. An unlicensed setting does not include stays where a child is receiving medically necessary care in a hospital, placement of a child with an individual who is in the process of applying to be a kinship provider or family-based residential, or a school setting for a specialized population, e.g. School for the Deaf.

Hospital Overstay: Patient remains in the hospital for more than 48 hours after no longer meeting medical necessity criteria.

Appendix 3

Classification Framework: Placement Settings Taxonomy

Classification Framework: Placement Settings Taxonomy

Community-Based Support Services (Support Any Level)

Least Restrictive

- High-Fidelity Wraparound Services (none currently exist)
- Intensive In-Home Services
- Mobile Response and Stabilization Services (MRSS) – not fully implemented
- Intensive Care Coordination
- Crisis Response Teams
- Respite Care
- Outpatient Therapy
- Case Management (Levels I, II, III)

Most Restrictive

- Residential Treatment Center (RTC)
- Qualified Residential Treatment Program (QRTP) - Class 6 (Highest Intensity)
- Qualified Residential Treatment Program (QRTP) - Class 2/2b (Intensive/Specialty)
- Therapeutic Group Home
- Residential Child Care Program (RCC) - Class 1/1b (Significant Needs)
- Treatment Foster Care
- Foster Care
- Kinship Care
- Independent Living (ages 16-21)

Current Problem Placement Categories (TO BE ELIMINATED)

Unacceptable Placements

- Hotel/Motel placements
- Office stays
- Hospital stays beyond medical necessity
- Any unlicensed setting

Appendix 4

Historical Background & Tables 3-4

Historical Background

While there is a decreasing number of youth in an out-of-home placement, the need for additional and a wider array of service options for youth with specialized, more intensive needs urgently remains. At the same time, Maryland has experienced a decline in available placement options for children and youth with disabilities, trauma history, and/or behavioral health challenges who need out-of-home placement. Fewer beds exist along the continuum of placements ranging from foster homes and therapeutic foster care to group homes, therapeutic and residential treatment centers. Staffing shortages further compound bed availability, making it difficult for all children to be placed in a timely manner. For some providers, staffing levels still have not returned from pre-pandemic levels.¹

According to the Maryland Health Care Commission's 2025 White Paper: Residential Treatment Services, there has been a decrease in the overall number of youth placed in residential treatment centers, but that decrease coincides with a decrease in available bed capacity due to the closure of four facilities in the past 10 years.² For youth with complex medical and behavioral health needs, there are also limited options available in Maryland. For example, there are also only two providers in the state capable of caring for youth with moderate to severe autism who have an IQ of less than 55. As a result of the decline in capacity and available service offerings, a significant number of children and youth are placed in unlicensed settings, such as hotels, hospital inpatient units or emergency rooms, for lengthy and harmful periods of time often waiting for an available placement in a licensed setting.

Reports examining racial disparities in Maryland's child welfare system consistently document the overrepresentation of Black youth at multiple points along the placement continuum, including entries into foster care, placement instability, and reliance on non-kin and hotel placements. Stakeholder analyses published between 2023 and 2025 emphasize the need for targeted, equity-focused reforms, including the expansion of culturally responsive services, intentional recruitment and retention of diverse caregivers, and improved collection and use of race- and equity-based data to inform policy and practice.

2025 Data Assessment on Youth Placed in Hotels

According to the Department of Human Services, as of November 24, 2025, there are no youth placed in hotels.

According to the 2025 Chapin Hall report, between April 2022 to October 2023, 142 youth experienced 162 hotel stays.³ Over 75% of these youth were between the ages of 14-17 years (56%) or over 18 (25%). Hotel stays are more prevalent among older youth and those who identify as Black. The majority of children with hotel stays are in their first foster care episode,

¹ RTC representatives have indicated that bed availability is limited by staffing. They attributed the difficulty in hiring staff to low salaries and increased opportunities for teleworking in other settings since the COVID-19 pandemic began in 2020. Staffing has not yet returned to pre-COVID levels. Chapin Hall, *White Paper: Residential Treatment Center Services* (Maryland Health Care Commission, 2025). Available at: https://www.mhcc.maryland.gov/sites/default/files/reports/chcf_rtc_white_paper.pdf.

² *Id.*

³ *Id.* at 60.

The median length of stay was 43 days. The majority of these youth were recommended for placement in a group home (non-therapeutic) or treatment foster care.⁴ For 20 children, their hotel stay started on the day they entered care so the hotel was their first placement, 21 were previously in a non-relative foster care placement, 13 were in a group home and 12 were described as coming from “other settings” meaning they were classified as a runaway, homeless or coming from a secure juvenile detention facility.⁵

2025 Data Assessment on Youth in Pediatric Hospital Overstays

According to the Department of Human Services (DHS) and Department of Health (MDH), as of December 22, 2025,⁶ there were 27 youth known to DHS and MDH who were experiencing a hospital overstay. The median length of stay is 70 days. The majority of these youth are waiting for a residential treatment center placement or a stepdown bed at Brook Lane. At least 11 youth have active plans meaning a placement has been identified and they are awaiting an open bed. This number does not include children in overstay status solely for medical reasons. For example, there is one infant at Georgetown Hospital and one youth at the Brook Lane Step Down Program which considers overstay >120 days.

According to the 2025 Chapin Hall report, 67 foster youth experienced a hospital overstay in FY 2023.⁷ Of these youth, 88% were classified as psychiatric admissions, involving significant behavioral issues, self-harm /suicide attempts, and aggression.⁸ Youth between the ages of 14-17 years comprised the majority for every hospital overstay admission reason except medical.⁹ For 46 of these youth, the most common setting they were in prior to being hospitalized were Treatment Foster Care (Private) (15%), Therapeutic Group Home (13%), and Relative/Fictive Kin Home (11%) and Regular Foster Care (11%).¹⁰ The majority of the children (67%) were in their first foster care episode, while 24% had two prior episodes, and 9% had three prior episodes.¹¹ For 11% of the youth, their time in care was less than eight days. Almost half of the youth had been in care for at least one year prior to the start of their hospitalization.¹² These youth experienced a median hospital length of stay of 47 days. On average, these youth stayed 63 days past their expected discharge date. The most common discharge recommendation for these youth were Residential Treatment Centers (33%) and Group Homes (33%).¹³

Prolonged hospital stays negatively impact children and youth and can worsen social and emotional deficits during critical life stages of growth and development. Despite mandated state and federal education requirements for children and youth, including specific mandates for children who are in need of special education or “individualized education plans”, children and youth in hospitals and other unlicensed settings often do not attend school or engage in

⁴ *Id.* at 63.

⁵ *Id.* at 65.

⁶ See Moore-Miller Administration’s Actions to Address Children in Unlicensed Settings & Pediatric Hospital Overstays, Addendum to Workgroup Interim Report, DHS-MDH, December 2025.

⁷ Chapin Hall report pg. 58.

⁸ *Id.*

⁹ *Id.* at 53.

¹⁰ *Id.* at 54.

¹¹ *Id.* at 55.

¹² *Id.* at 56.

¹³ *Id.* at 53.

educational activities; they do not go outside and do not have access to individualized therapeutic services especially if they are boarding in an emergency department or inpatient psychiatric unit. These levels of care are meant for short-term stays to stabilize the patient so they can transition to the next level of care where their individual needs can be met.

Prolonged Hospitalization is Harmful

Children who are hospitalized beyond medical or psychiatric necessity face severe and escalating harm. These harms are often underestimated, likely due to the notion that a hospital setting is typically a place where people receive care and treatment. However, this notion is misplaced as it pertains to vulnerable children and youth kept in medical and psychiatric emergency departments or hospital wards beyond the period needed for care. Extensive research,¹⁴ has shown that hospital overstay is an active source of harm that causes or worsens aggression, self-harm, trauma, and identity damage in children and youth.

Childhood and adolescence are critical developmental stages requiring safe, supportive environments. Unnecessary hospitalization can have severe, long-term consequences for children's mental health and development. Prolonged hospitalization during sensitive developmental periods embeds maladaptive and harmful behaviors and coping strategies. Chronic exposure to violence and coercive control alters brain regions responsible for impulse control and emotion regulation. These institutional environments are not therapeutic; they are often dangerous environments where aggression and harmful behaviors are routinely on display to young malleable minds. Every unnecessary day in hospital compounds these harms, making recovery and community adjustments more challenging. For high acuity youth, prolonged stays are especially damaging because they are already vulnerable and lack protective factors; keeping them in hospital due to the lack of an appropriate placement exposes them to the highest risk environment for further deterioration.

Because the harms of prolonged hospitalization are cumulative and long lasting, immediate removal to the least restrictive, developmentally appropriate, trauma-informed setting is not just best practice; it is a child protection imperative, and must be treated with urgency, not an optional service decision.

Key harms of hospitalization overstay

- Disrupts Development: Medically unnecessary stays interfere with brain, emotional, social, and identity development, increasing long-term mental health and behavioral problems.
- Worsens Symptoms: Longer admissions correlate with more depression, aggression, internalizing/externalizing issues, and delays in motor and speech development.
- Institutionalization: Children adapt to rigid routines, compliance, and passivity, which hinder functioning in family, school, and community settings.

¹⁴ Maryland OPD Research Paper on “Prolonged Psychiatric Hospitalization for Vulnerable Children” (M. Heuvelmans, 2021).

- Identity Damage: Prolonged labeling as “mentally ill” fosters stigma, shame, low self-esteem, and a dominant “patient” identity that undermines recovery.
- Attachment Erosion: Cold, inconsistent caregiving during long stays weakens trust and secure attachment, increasing anxiety and depression.
- Loss of Autonomy: Strict rules and surveillance reduce independence and problem-solving skills, leaving children dependent and less confident.
- Loss of Normalcy: Lack of access to school, exercise and fresh air, or regular access to friends and family.
- Heightened Stress: Rules, stigma, separation from family, and unsafe environments create cumulative stress, worsening emotional distress.
- Exposure to Harm: Psychiatric units have high rates of violence and self-harm; chronic exposure normalizes aggression and self-injury, increasing risk of harmful behaviors and justice-system involvement.
- Higher Readmission Risk: Longer stays predict future rehospitalization, especially for youth lacking caregiver support.

TABLES 3 & 4

Table 3: Summary Table of Common Characteristics of Youth Placed in Hotels & Experiencing Hospital Overstays (Chapin Hall Report)

Unlicensed Setting	Average Age	Median Length of Stay	Recommended Placement Types
Hotel	14 - 17 years old	43 days	Group Home Treatment Foster Care
Hospital	14 - 17 years old	47 days	Residential Treatment Center Group Home

Table 4: Pediatric Hospital Overstay Common Patient Profiles (Inclusive of Foster Youth and Youth Under the Care and Custody of Parents or Guardians)

The following summary table includes common patient profiles that have been seen repeatedly in patients experiencing a hospital overstay.

Population	Subpopulations
Older teens (14 - 17 years old) with significant behavioral issues and self-harm /suicide attempts	Foster youth often fall into this patient population and/or enter foster care because of these behaviors and family's inability to manage and/or access services without State intervention
Autism/ Pervasive Developmental Disorders /Intellectual Disability	Youth with Moderate/Severe Autism with IQ typically <55
	Youth with mild autism or IQ 55-69
Chronic pattern of severe aggression or history of assaultive behaviors	
Impulse control issues leading to sexualized/predatory behaviors, fire setting, swallowing behaviors	
Chronic untreated or undertreated significant medical issues (especially DM, seizure disorders, or treatments requiring infusion/IV medications)	
Transgender Youth	
Survivors of Sex Trafficking Under 14 years of Age	
Youth With History of Criminal Activity Who May Have Previously Been Charged Prior to Passage of the Juvenile Justice Reform Act (2024)	

Appendix 5

Compilation of Prior Report Recommendations

Compilation of Prior Report Recommendations

<u>Report Source</u>	<u>Recommendation</u>
72nd Compliance Report - Attachment A	Ensure comprehensive health assessments for all new entrants include medical, dental, and mental health components.
72nd Compliance Report - Attachment A	Improve documentation in eClinicalWorks and CJAMS to reflect care plans tied to assessment findings.
72nd Compliance Report - Attachment A	Increase tracking and follow-up to ensure annual EPSDT and dental exams for youth already in placement.
72nd Compliance Report - Attachment A	Use forecasting to match placement types with youth needs and reduce placement disruptions.
72nd Compliance Report - Attachment A	Expand continuous quality improvement processes with case audits and dashboards.
Maryland Out-of-Home Placement Report	Expand family preservation and preventive services to reduce need for placements.
Maryland Out-of-Home Placement Report	Improve coordination across child welfare, behavioral health, and juvenile justice agencies.
Maryland Out-of-Home Placement Report	Enhance statewide data systems to track outcomes for placed youth.
Maryland Out-of-Home Placement Report	Increase support for youth with complex behavioral or developmental needs.
Maryland Behavioral Health Roadmap 2025	Improve cross-agency system coordination and simplify service navigation for families.
Maryland Behavioral Health Roadmap 2025	Strengthen behavioral health workforce capacity and build sustainable funding models.
Maryland Behavioral Health Roadmap 2025	Expand community-based behavioral health services to reduce reliance on institutional care.
Maryland Behavioral Health Roadmap 2025	Elevate youth and family voice in policy design and decision-making.
Maryland Behavioral Health Roadmap 2025	Increase early intervention, screening, and preventative behavioral health services.

MHCC Draft White Paper: Residential Treatment Services	Update and modernize COMAR 10.24.07 (State Health Plan chapter for RTCs) to reflect current service landscape.
MHCC Draft White Paper: Residential Treatment Services	Apply new Certificate of Need review criteria including health equity impact analysis for proposed RTCs.
MHCC Draft White Paper: Residential Treatment Services	Evaluate character and competence of RTC operators based on past performance, compliance history, and quality outcomes.
2025 MHCC Draft White Paper: Residential Treatment Services	Increase availability of community-based alternatives to avoid unnecessary RTC placements.
2025 MHCC Draft White Paper: Residential Treatment Services	Align RTC capacity planning with actual behavioral health system needs and geographic access gaps.
2025 MHCC Draft White Paper: Residential Treatment Services	Develop improved monitoring and reporting data systems for RTC utilization, outcomes, and demographic equity.
2025 MHCC Draft White Paper: Residential Treatment Services	Strengthen partnerships between RTCs and community behavioral health providers to support step-down and reintegration.
2019 Post-Acute Discharge Planning Workgroup	Build out and approve referral protocol
2019 Post-Acute Discharge Planning Workgroup	Implement 24/7 crisis response system including mobile crisis team
2019 Post-Acute Discharge Planning Workgroup	Evaluate effectiveness of available in home and out of home respite
2019 Post-Acute Discharge Planning Workgroup	Build intensive community-based outpatient services for children
2019 Post-Acute Discharge Planning Workgroup	"Evaluate the effectiveness of the Local Care Team and make improvements"
2019 Post-Acute Discharge Planning Workgroup	"All stakeholders need a clear understanding of Voluntary Placement Agreements"
2019 Post-Acute Discharge Planning Workgroup	"Extend Medicaid service preauthorization reviews until close of business (COB) on Friday"

2019 Post-Acute Discharge Planning Workgroup	Ensure comprehensive health assessments for all new entrants include medical, dental, and mental health components.
2019 Post-Acute Discharge Planning Workgroup	"Recreate an improved version of the EBP workgroup in state government"
2019 Post-Acute Discharge Planning Workgroup	"Expand and publicize the Infant and Early Childhood Mental Health Consultation Project"
2019 Post-Acute Discharge Planning Workgroup	Infrastructure to support a real time capacity inventory tool or a bed registry
2019 Post-Acute Discharge Planning Workgroup	"Develop and implement a peer supported respite program for the 18-26-year-old transition age youth"
2019 Post-Acute Discharge Planning Workgroup	"Increase capacity of high quality and responsiveness to current needs RRP beds to serve the TAY population"
2019 Post-Acute Discharge Planning Workgroup	"The state needs more in-state RTC and therapeutic foster care beds including high intensity treatment foster care and therapeutic group home beds"
2019 Post-Acute Discharge Planning Workgroup	"Data sharing is critical across all child serving systems and providers who are coordinating to treat the child and best serve the family –CRISP/MDTHINK/DoIT"
2019 Post-Acute Discharge Planning Workgroup	Address parity between Medicaid and private insurance
2019 Post-Acute Discharge Planning Workgroup	"Evaluate effectiveness of current offerings of Therapeutic Behavioral Services (TBS) and Applied Behavioral Analysis (ABA) for Autism Spectrum Kids"
2019 Post-Acute Discharge Planning Workgroup	"Require training, capacity building and fidelity monitoring for providers to offer a larger menu of reimbursable EBPs"
2019 Post-Acute Discharge Planning Workgroup	Consider use of a single agent as the authorization agent/gatekeeper with access to all fund sources supporting behavioral health services from all state agencies
2019 Post-Acute Discharge Planning Workgroup	Expand medical necessity criteria for 18-26-year-old population within Adult Targeted Case Management for Residential Rehabilitation Program and the Psychiatric Rehabilitation Program services
2019 Post-Acute Discharge Planning Workgroup	Early Childhood Mental Health system of care in Maryland is weak and needs capacity building and adoption of evidence-

	based practices
2019 Post-Acute Discharge Planning Workgroup	Build out centers of excellence around Evidence Informed collaborative clinical practice for autism spectrum youth
2025 Chapin Hall Report	Establish a Placement Review Panel within the Governor's Office of Children - a multidisciplinary team modeled after child fatality review boards, focusing on case level analysis and systemic recommendations to prevent these kinds of stays and improve placement outcomes. This Panel would perform the recommended actions outlined in the Chapin Hall report (pg. 120).
2025 Chapin Hall Report	Require DHS and MDH to create processes to review and avoid the placement of youth in unlicensed settings in the future.
2025 Chapin Hall Report	Expand treatment foster care and emergency shelter options.
2025 Chapin Hall Report	Create pilot programs to establish short-term alternatives to hospitals overstay, hotel and office stays as well as transitional placements for youth leaving intensive care settings to prepare them for family-based or less restrictive environments.
2025 Chapin Hall Report	DHS should track and report on the types of moves children experience (i.e. least restrictive, lateral or more restrictive) and set performance targets using Chapin Hall's recommended methodology outlined in their 2025 report on pg. 122.
2025 Chapin Hall Report	DHS should explore the use of CJAMS alerts that notify workers and supervisors of early warning signs of placement stability in which early intervention may prevent a disruption as outlined in the Chapin Hall 2025 report on pg. 122.

Appendix 6

New Jersey System of Care Model and Comparative Overview

The New Jersey Model

The New Jersey child welfare system is frequently cited as a national model for reform; however, its present structure resulted from a comprehensive overhaul initiated in 2004. Prior to this transformation, the state's system was fragmented and characterized by inconsistent intake practices, overburdened staff, and limited coordination among child protection agencies, behavioral health services, and placement services.¹ These deficiencies culminated in federal litigation, with the class action lawsuit *Charlie and Nadine H. v. Whitman* filed in 2000 alleging that the current system failed to meet the basic needs of the approximately 10,000 children in the state's foster care system.² As part of the litigation, New Jersey entered into a Modified Settlement Agreement that required the state to restructure its child welfare system, including its method of providing placement for foster children with complex needs. The Center for the Study of Social Policy (CSSP) was appointed in 2006 to serve as the federal monitor for this reform and ensure that the State's compliance with the goals of the settlement was being independently assessed.³

In response to the settlement, New Jersey developed and implemented *A New Beginning: The Future of Child Welfare in New Jersey* in 2004, which served as a comprehensive blueprint for restructuring the system. Designed as a plan to initiate a “new beginning” for the children and families of New Jersey, it aimed to fulfill three essential obligations to those children: safety, permanency, and well-being. The state restructured frontline roles by separating investigative and service functions, creating distinct child protection workers responsible for intake and investigations, and permanency workers responsible for supporting each child's long-term stability. This allowed for each position to be trained in skills not universally held by all social workers. This change was also paired with new workload standards, including a cap of eight new investigations per month, and no more than twelve caseloads open at a time per child protection worker. Caseworkers were also assigned neighborhood-based caseloads that allow them to focus on developing long-term working relationships with local service providers, organizations, and families to better meet the needs of every child they work with.⁴

Departmental Restructure and Children's System of Care

One of the most significant structural changes was the decision to move child welfare out of the Department of Human Services (DHS). New Jersey created the Department of Children and Families (DCF) in 2006 as a standalone, cabinet-level agency responsible for overseeing child welfare functions. As such, the DCF is led by a Commissioner who reports directly to the

¹ <https://dspace.njstatelib.org/server/api/core/bitstreams/c10318b7-bf6c-442f-a89d-89d726dcffe5/content>

² <https://law.justia.com/cases/federal/district-courts/FSupp2/83/476/2443588/>

³ <https://www.nj.gov/dcf/about/welfare/modified/>

⁴ <https://dspace.njstatelib.org/server/api/core/bitstreams/c10318b7-bf6c-442f-a89d-89d726dcffe5/content>

Governor of New Jersey. Prior to this change, child welfare responsibilities were handled under the umbrella of the larger DHS (specifically within the Division of Youth and Family Services) and thus lacked the level of accountability, capacity, and focus to actually uphold a system that could ensure the protection of children in its care. The creation of the DCF centralized responsibility within an agency of around 6,600 staff, supported by increased funding, staff training, and federal oversight, which collectively helped shift the department away from its roots as a reactive, crisis-driven system.⁵ Within the DCF, the Division of Child Protection and Permanency (DCP&P) was designated as the welfare agency responsible for investigating allegations of child abuse and neglect. New Jersey's Child Abuse Hotline (State Central Registry) receives reports of child abuse and neglect 24 hours a day, 7 days a week. In response to reports, DCP&P sends a caseworker to the child's home to begin the investigation process.⁶ When placement is necessary, DCP&P caseworkers prioritize kinship placements, sibling togetherness, proximity to the child's school, and the least restrictive environment, with the goal of family reunification.⁷

Central to the issue of youth placement in unlicensed settings and hospital overstay, New Jersey also recognized that children involved in the child welfare system often have complex behavioral health, developmental, and substance use needs that existing structures were not equipped to address. In response, the state created the Children's System of Care (CSOC) as a division within DCF to operate as New Jersey's public behavioral health system.⁸ CSOC follows a wraparound model that uses a team-based, collaborative process to provide children with an individualized set of support services. The idea is to keep children at home and in school, and involved in their usual activities, by "wrapping" services around the family.⁹ This could include, but is not limited to, services related to mental health, education, healthcare, social support, and community integration.¹⁰

In addition to wraparound care coordination, CSOC includes mobile crisis and response services, substance use treatment, developmental disability services, family peer support, care management organization, respite, and residential treatment for youth under age 21. All services are available through PerformCare, a Contracted Systems Administrator that provides a single access point for families.¹¹ Parents or legal guardians can call PerformCare directly, 24 hours a day, 7 days a week, 365 days a year. The system also allows children to receive care without ever entering the child welfare or juvenile justice systems, thereby avoiding unnecessary custody

⁵<https://www.nj.gov/dcf/about/#:~:text=The%20New%20Jersey%20Department%20of,be%20safe%2C%20healthy%20and%20connected.>

⁶ <https://www.nj.gov/dcf/about/divisions/dcpp/>

⁷ https://www.casey.org/media/SF_New-Jersey-reduction-congregate-care.pdf

⁸ <https://www.nj.gov/dcf/about/divisions/dcsc/>

⁹ <https://preventionservices.acf.hhs.gov/programs/830/show>

¹⁰<https://njcmo.org/wraparound-services/the-wraparound-services-for-at-risk-youth/#:~:text=What%20Is%20the%20Wraparound%20Model,of%20the%20child%20and%20family.>

¹¹ <https://www.nj.gov/dcf/about/divisions/dcsc/>

relinquishment.¹² CSOC and PerformCare work together to approve clinical requirements for all services and set rates, which are then billed through the Medicaid Management Information System on a fee-for-service basis.¹³ PerformCare also utilizes a secure electronic health record and information system called CYBER, which enables all service providers to manage treatment, authorizations, and billing in one place.¹⁴

Mobile Response and Stabilization Services

Implemented within the statewide CSOC and accessible by calling PerformCare, New Jersey's Mobile Response and Stabilization Services (MRSS) have reported high success in helping to avoid unnecessary ED visits, out-of-home placements, and placement disruptions, and in reducing overall system costs.¹⁵ Specifically, New Jersey's MRSS was created to support children and families "in crisis as defined by the individual child or family," such as when one's sense of balance is disrupted, coping and problem-solving skills that may have worked in the past are no longer effective, or life functioning is disrupted.¹⁶ The goal of MRSS is to provide intervention and support at the earliest moment families identify that help is needed under a "no-reject/no-eject" philosophy that ensures youth are always provided services.

Through New Jersey's MRSS, a behavioral health worker is available to any family in the state, 24 hours a day, every day. Any child up to age 21 is eligible and services are available to any family in crisis due to a child's escalating emotional or behavioral needs, whether it is the family's first time asking for help or the family is already receiving services from a state agency or private provider.¹⁷ MRSS in New Jersey follows a four-pronged approach. It begins with on-site intervention to immediately de-escalate presenting emotional symptoms and behaviors, including observing, interrupting, and shifting dynamics, providing education, and introducing skills. Next, providers move into assessment, planning, skill-building, psychoeducation, and resource linkage to stabilize presenting needs, including strengths, triggers, communication, and other key contexts (medical, mental health, trauma, development, patterns of behavior, collateral outreach, among others).

The third prong is assistance to the child and family in returning to baseline or routine functioning, as well as in preventing further escalation. Finally, MRSS helps children and families develop prevention strategies and resources to address presenting emotional symptoms, behaviors, and existing circumstances, and to create a plan to avoid future crises. MRSS is accessible via a toll-free phone number and, during a crisis, an MRSS worker is available within

¹² <https://www.casey.org/soc-profile-newjersey/>

¹³ <https://www.casey.org/soc-profile-newjersey/>

¹⁴ <https://www.performcarenj.org/provider/dcpp/dcpp-faq>

¹⁵ https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2025/02/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

¹⁶ <https://www.casey.org/nj-mobile-response-stabilization-services/>

¹⁷ *Ibid*

one hour. MRSS is initially available for 72 hours following the request for help, but can be extended for up to 8 weeks of stabilization services.¹⁸ New Jersey's MRSS provides services such as in-home counseling, behavioral assistance, caregiver therapeutic support, intensive in-community services, skill-building, medication management, coordination, and development of informal and natural support systems (such as faith-based organizations, mentors, and peer support), and coordination of specialized services to address the needs of children with co-occurring developmental disabilities and substance use.¹⁹

New Jersey's MRSS has reported high success rates. Since its creation in 2004, MRSS has consistently maintained 94 percent of children in their living situation at the time of service, including children who are involved with the child welfare system. In fact, this number was 98% in 2017.²⁰ Additionally, families have reported high satisfaction with services, with a 260% increase in the number of families accessing MRSS since 2011.²¹

Care Management and Family Support Organizations

Care Management Organizations are another service available within the CSOC and accessible through PerformCare. New Jersey has 15 Care Management Organizations (CMOs) that operate as independent, nonprofit organizations owned by the communities they serve. They help deliver wraparound services through individualized Child Family Team Meetings that can include the youth, their parents or guardians, DCF personnel, CSOC providers, school staff, and medical providers. The goal of Child Family Team Meetings is to assess and develop individualized service plans for the child, as well as to develop strategies to ensure familial stability.²² Family Support Organizations are another integral service that provides peer-to-peer support, advocacy, educational workshops, and resources for families dealing with behavioral, mental health, or other child welfare challenges.²³ Like Care Management Organizations, they are county-based and accessible through PerformCare. Parents of youth enrolled in Care Management Organizations are automatically paired with a Family Support Organization, at no cost to the family.

New Jersey's Fiscal Implications

This plan included an investment in fiscal year (FY) 2005 of \$125,352,000 in new funding (in addition to the Division of Youth and Family Services's existing budget) devoted to

¹⁸ *Ibid*

¹⁹ *Ibid*

²⁰ https://www.casey.org/media/SF_New-Jersey-MRSS.pdf?utm_

²¹ <https://www.casey.org/nj-mobile-response-stabilization-services/>

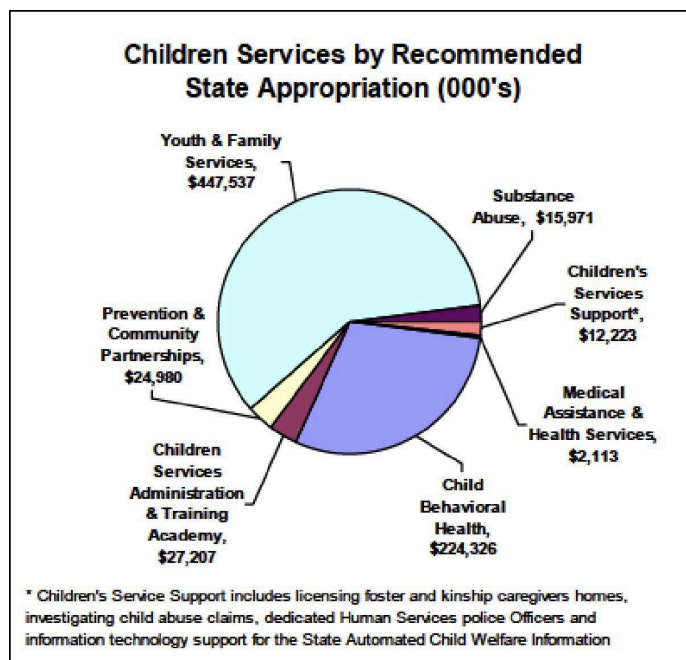
²² <https://www.performcarenj.org/educators>

²³ [https://www.nj.gov/dcf/families/support/support/#:~:text=Family%20Support%20Organizations%20\(FSOs\)%20are%20family%20Drun%20organizations,County**%200%2D108%2029th%20Street%2C%20Fairlawn%2C%20NJ%2007410](https://www.nj.gov/dcf/families/support/support/#:~:text=Family%20Support%20Organizations%20(FSOs)%20are%20family%20Drun%20organizations,County**%200%2D108%2029th%20Street%2C%20Fairlawn%2C%20NJ%2007410)

its implementation. It also stipulated that \$180,228,000 was projected for year two. The plan outlined five core services at the center of the system's new preventative service model. First, it called for \$10 million for the remainder of FY 2004 and approximately \$10 million per year thereafter to support a range of substance abuse services for parents with children at risk. It included \$1 million in FY 2005 (to purchase and renovate a facility) and \$2.3 million annually for five years to add, each year, 25 short-term residential treatment beds and 125 intensive outpatient treatment slots around the state for substance-abusing adolescents – adding a total of 125 residential beds and 625 outpatient treatment slots by FY 2009.

Next, it included approximately \$10 million over five years to expand statewide a program of specialized services for children from homes with domestic violence. It hoped to address the needs of hundreds of families at risk of initial or ongoing family dissolution due to tenuous housing situations through a variety of means, including a Section 8 voucher bridge fund, expanding Emergency Assistance housing grants, and \$1 million per year to rehabilitate the homes of birth or resource families. Finally, the plan included \$4.5 million for the remainder of FY 2004 and approximately \$12 million per year thereafter, for a range of child behavioral health services, including Mobile Response, Youth Case Management, Treatment Homes, Behavioral Assistance, and Intensive In-Community supports. The plan also called for 416 new child protection and permanency workers, 48 new casework supervisors, 136 new adolescent specialists, 191 new resource family support workers, 12 new community collaboratives, and a 25% increase in foster care board rates over the next 2 years.²⁴

The New Jersey FY 2005-2006 budget included an additional \$55 million in state funds to sustain and expand Child Welfare Reform efforts, increasing state appropriations from \$149.8 million in FY 2005 to \$204.8 million in FY 2006.²⁵ These reform efforts included moving all child welfare services within the Department of Human Services to the Department of Children and Families (DCF); funding for additional employees including additional case-carrying staff that would allow the department to move toward its goal of achieving caseload-to-staff ratios of 12-to-one for protective staff and 15-to-one for permanency staff; rate increases for resource families (ie. foster care/subsidized adoption) to increase the board rates to meet the USDA's



²⁴<https://dspace.njstatelib.org/server/api/core/bitstreams/c10318b7-bf6c-442f-a89d-89d726dcffe5/contet>

²⁵ <https://nj.gov/treasury/omb/publications/06budget/pdf/front.pdf>

estimated cost of raising a child in a two-parent, middle income family in the urban northeast; funding to reduce the inappropriate reliance on institutional settings by expanding child behavior health services, including intensive in-home services, mobile response and stabilization services, care management organizations, family support organizations, and community-based treatment homes; additional funding to create and support more substance slots for women who are involved or at-risk of involvement with the child welfare system and their children; funding to support expanded community-based planning services including school-based youth programs to preserve and support healthy families; funding to allow the continued development of the Child Welfare Training Academy, which provides training for resource families, community-based provider employees, and all Office of Children Services staff; operational support for the Statewide Automated Child Welfare Information System (SACWIS); and an additional \$3.5 million in State capital to modify a component of an existing SACWIS system from another state so it could be used in New Jersey.²⁶

Beyond the growth associated with Child Welfare Reform efforts, the New Jersey FY 2006 budget provided an additional \$24.5 million for Child Behavioral Health services and \$4.3 million for various DYFS out-of-home placement categories. The combined value of state and federal funds dedicated to protecting children in FY 2006 was nearly \$1.2 billion.²⁷ Finally, the appropriation to New Jersey's DCF in FY 2024 totaled \$2,242,666; this included \$1,435,990 in state funds.²⁸ Comparatively, Maryland's DHS budget (excluding federal SNAP and P-EBT) in FY 2024 was \$1,864,087.²⁹

Oversight Process

To end federal court oversight by the Center for the Study of Social Policy, parties to the lawsuit developed a comprehensive Exit Plan which would ensure that welfare reform outcomes continued to be successful.³⁰ Notably, New Jersey implemented a new Collaborative Quality Improvement (CoQI) process that replaced the prior Qualitative Review system and uses data from several sources to identify strengths as well as improvement areas within DCF. CoQI evaluates data from local offices including case record reviews, interviews with youth and families who have received services from DCF, and performance metrics.³¹ Using this information, local office CoQI teams develop and implement an annual improvement plan.

The Staffing and Oversight Review Subcommittee (SORS) of the New Jersey Task Force on Abuse and Neglect (NJTFCAN), codified in legislation, also evaluates DCF performance.

²⁶ <https://nj.gov/treasury/omb/publications/06budget/pdf/front.pdf>

²⁷ *Ibid*

²⁸ https://pub.njleg.state.nj.us/publications/budget/governors-budget/2025/dcf_analysis_2025.pdf.

²⁹ <https://mgaleg.maryland.gov/pubs/budgetfiscal/2024fy-budget-docs-operating-N00-DHS-Overview.pdf>.

³⁰ <https://cssp.org/new-jersey-child-welfare-system-ends-federal-court-oversight/>

³¹ <https://cssp.org/wp-content/uploads/2025/03/10-30-2023-Final-Charlie-and-Nadine-H-Addendum-Report-for-the-Transition-Period.pdf>

Specifically, SORS is responsible for reviewing, analyzing, and making recommendations to a number of functions in DCP&P including case management and information systems, case practice models, the State Central Registry, providing the most appropriate and least restrictive placements, and maintaining successful training programs among other performance areas. SORS is made up of independent representatives who regularly review DCF data based on the priorities the Subcommittee established, and publish annual reports with their findings and recommendations. Specifically, SORS is required to have at least 15 members, and typically include parents, advocates, attorneys, the DCP&P Commissioner, and other professionals involved in service provision.³²

The Office of Monitoring (OOM) is the most recently implemented quality assurance tool in the system. The OOM assesses the quality of contracted services, ensures consistency in all services, and evaluates families' experience with providers. The ultimate goal of the OOM is to develop a standard monitoring process for all service networks within DCF.³³ Together, these systems establish ongoing performance monitoring, public transparency, and oversight bodies that enable DCF to continue improving beyond the period of federal court supervision.

Ohio

The Children's System of Care Model (CSOC) has proven successful in multiple states. In Ohio, system-wide reforms were implemented to address gaps in care for children with complex behavioral health needs. In 2022, Ohio launched the Ohio Resilience through Integrated Systems and Excellence (OhioRISE) reform, a Medicaid-funded program designed to serve children with behavioral health needs through coordinated and community-based care.³⁴ Children under 21 who are eligible for Ohio Medicaid can determine their eligibility by completing a Child and Adolescent Needs and Strengths (CANS) assessment.³⁵ OhioRISE also uses a centralized platform, Aetna Better Health of Ohio, to connect all service providers, determine eligibility, and coordinate care across agencies. Services within the program include Intensive and Moderate Care Coordination, Mobile Response and Stabilization Services, Intensive Home-based Treatment, Residential Treatment Facilities, and Respite care.³⁶

OhioRISE is overseen by the Ohio Department of Medicaid, Ohio's Family and Children First Cabinet Council, the Governor's Children's Initiative, and a partnership of state and local government offices, community, and families called Ohio Family and Children First. Like all Medicaid managed care plans in the state, OhioRISE reports data annually on its quality and access to care, and member satisfaction. In particular, the focus is on improving outcomes related

³² *Ibid*

³³ *Ibid*

³⁴ <https://www.casey.org/soc-profile-ohio/>

³⁵ <https://managedcare.medicaid.ohio.gov/managed-care/ohiorise>

³⁶ <https://www.caresource.com/oh/plans/medicaid/benefits-services/ohio-rise/>

to custody relinquishment, keeping families together, reducing unnecessary hospitalization, decreasing juvenile system involvement, reducing out of home or state placement, and increasing school attendance.³⁷

Using a wraparound care model similar to New Jersey's, OhioRISE has been associated with a 41% reduction in emergency department visits, 28% reduction in psychiatric hospitalizations, and a 40% decrease in the average length of a hospital stay for participating youth.³⁸ Additionally, the average length of stay in psychiatric residential treatment facilities decreased by 60% between 2022 and 2025, indicating a shift away from prolonged institutional care.³⁹ OhioRISE has also invested \$7 million dollars in flexible funds to address non clinical needs, including transportation and equipment that help support treatment plans and reduce barriers to care across families.⁴⁰

New Hampshire

New Hampshire's efforts to address hospital overstay and gaps in the child behavioral health system were driven in part by litigation. Most notably, the class action lawsuit, *Amanda D. v Sununu*, challenged the state's practice of holding individuals, including youth, in hospital emergency departments for prolonged periods without appropriate placement. The case resulted in a settlement agreement and court ruling that found extended emergency department boarding unconstitutional and required the state to significantly improve timely access to mental health services and reduce delays in placement.⁴¹

The outcomes of this litigation led to measurable improvements in hospital overstay conditions. For example, New Hampshire reduced average emergency department wait times for psychiatric placement from 6.2 days in 2017 to 3.8 days in 2019, and cut total monthly boarding days nearly in half, from 1,500 days to 755 days over that same period.⁴² More recently, state-led initiatives following continued legal and regulatory pressure resulted in even sharper improvements, with the number of patients boarding in emergency departments dropping from 32 individuals to 0 on a single day in December 2024, reflecting the state's progress toward eliminating prolonged hospital stays.⁴³

³⁷ <https://www.casey.org/soc-profile-ohio/>

³⁸ https://dam.assets.ohio.gov/image/upload/managedcare.medicare.ohio.gov/OhioRISE/OhioRISE_Working_Board_20250513.pdf

³⁹ *Ibid*

⁴⁰ *Ibid*

⁴¹

https://www.govinfo.gov/content/pkg/USCOURTS-nhd-1_20-cv-00517/pdf/USCOURTS-nhd-1_20-cv-00517-0.pdf

⁴² <https://www.nhpr.org/health/2020-01-29/gov-sununu-says-progress-being-made-in-states-er-boarding-crisis>

⁴³ <https://emworkforce.substack.com/p/new-hampshire-had-zero-involuntary>

Unlike New Jersey, New Hampshire did not respond to litigation by building a fully centralized, wraparound system of care. Instead, it relied more heavily on regulatory enforcement and oversight, with the New Hampshire Department of Health and Human Services monitoring hospital compliance and issuing citations when facilities failed to meet discharge or care coordination expectations.⁴⁴ The state also implemented targeted interventions including expanding inpatient beds, mobile crisis services, and rapid response systems. However, these operate within a still-fragmented structure rather than a single, unified entry point.⁴⁵

As a result, while New Hampshire demonstrates that litigation and citation-based accountability can produce measurable reductions in hospital overstay, its approach remains reactive and enforcement-driven compared to New Jersey's proactive investment in system integration, real-time data infrastructure, and wraparound care coordination.

Oklahoma

Like New Jersey, the state of Oklahoma also settled a class action lawsuit (*DG vs. Yarbrough*) against its foster care system and agreed to make improvements to its child welfare system.⁴⁶ Its major reform efforts came from its Pinnacle Plan.⁴⁷ In March, 2025, a federal court declared that Oklahoma Human Services had fulfilled its obligations under the settlement agreement.⁴⁸ Oklahoma's foster care system was able to reduce the number of children in state custody from 11,000 in 2014 to just under 5,800 in March 2025.⁴⁹ Their areas of focus included maltreatment of children in the state's legal custody; development of foster homes and therapeutic foster homes regular and consistent visitation of caseworkers with children in the state's legal custody; reduction in the number of children in shelters; placement stability; child permanency through reunification, adoption, or guardianship; and enforcing manageable caseloads for child welfare staff.⁵⁰

Unlike New Jersey, Oklahoma kept its child welfare system housed under the broad Department of Human Services, with regional and district staff providing Child Protective Services (CPS), Family-Centered Services (FCS), and Permanency Planning (PP) services.⁵¹ However, Oklahoma adopted several of the same substantive strategies that made New Jersey's

⁴⁴ <https://www.dhhs.nh.gov/doing-business-dhhs/licensing-certification/health-facilities-administration>

⁴⁵ <https://www.nhpr.org/health/2024-05-17/nh-missed-a-court-deadline-to-end-er-boarding-but-its-making-some-progress>

⁴⁶ <https://oklahoma.gov/okdhs/services/child-welfare-services/pinnacle-plan-home.html>

⁴⁷ <https://oklahoma.gov/content/dam/ok/en/okdhs/documents/okdhs-pdf-library/pinnacle-plan/oklahomapinnacleplanfinal-cfsd-07252012.pdf>

⁴⁸ <https://oklahoma.gov/okdhs/newsroom/2025/march/comm03132025.html>

⁴⁹ *Ibid*

⁵⁰ *Ibid*

⁵¹ https://oklahoma.gov/content/dam/ok/en/okdhs/documents/okdhs-pdf-library/child-welfare-services/Oklahoma2025-2029ChildandFamilyServicesPlanCFSP_cws_07012024.pdf, p. 3

model successful. Like New Jersey's wraparound-oriented CSOC, Oklahoma's Department of Mental Health and Substance Abuse Services (ODMHSAS) runs a statewide "Systems of Care" framework that uses wraparound and coordinated services to stabilize families in crisis through individualized, strength-based planning.⁵² ODMHSAS also utilizes mobile crisis teams⁵³ and a statewide 988 mental health crisis connection point.⁵⁴

Oklahoma also mirrors New Jersey's emphasis on family preservation. New Jersey's system is built to prevent unnecessary custody relinquishment and connect families to crisis response, care management, and supports before formal child welfare involvement becomes deeper. Oklahoma similarly uses its Family Centered Services (FCS) as a prevention program to provide services for families who come to the attention of the child welfare system without the child needing to be removed from the home.⁵⁵ Its explicit goal is to support children and families while maintaining the child safely in their own home.

Oklahoma also utilizes a legally mandated, centralized, and statewide record-keeping system called the Child Abuse and Neglect Information System (CANIS) that "requires the maintenance of all reports of child abuse, sexual abuse, and neglect made," and which only authorized Oklahoma Human Services staff can access.⁵⁶ The Division of Children and Family Services of the Department of Human Services is responsible for maintaining an organized system for all of the reports.⁵⁷

Recommendations

The recommendations in this section pertain to the development and implementation of a "System of Care" in Maryland. System of care in this section will utilize the definition employed by Sheila Pires in *Building Systems of Care: A Primer*, which she describes as "a roadmap for stakeholders interested in building systems of care for children, youth, and families who are involved, or at risk for involvement, in multiple systems."⁵⁸ The concepts in the *Primer* were central to the system of care reform efforts in New Jersey when they began and still continue to be embedded in the current system. System of Care in this case is defined as:

"a broad flexible array of effective services and supports for a defined multisystem involved population, which is organized into a coordinated network, integrates care planning and care

⁵²<https://oklahoma.gov/odmhsas/treatment/children-youth-treatment-services/systems-of-care/wraparound-and-coordinated-services.html>

⁵³ <https://oklahoma.gov/odmhsas/treatment/comprehensive-crisis-response/mobile-crisis-teams.html>

⁵⁴<https://oklahoma.gov/odmhsas/about/public-information/press-releases-and-other-news/2025/oklahoma-s-988-mental-health-lifeline-marks-three-years--thousan.html>

⁵⁵ https://oklahoma.gov/okdhs/services/fcs/family-centered-services.html?utm_

⁵⁶ <https://www.law.cornell.edu/regulations/oklahoma/OAC-340-75-3-140>

⁵⁷ <https://law.justia.com/codes/oklahoma/title-10a/section-10a-1-2-108/>

management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management and policy levels, has supportive management and policy infrastructure, and is data-driven.”⁵⁹

In order to build an integrated system that can serve the complex and varied needs of children and families in Maryland, a number of important steps must be taken. These recommendations are informed by research as well as interviews with subject matter experts involved in the implementation of system of care reforms in New Jersey and Maryland and are focused on feasible and sustainable solutions essential to the implementation of an effective system of care. When analyzing the system of care in New Jersey, the following areas emerged as critical components that contributed to successful systemic reforms that we recommend be explored and implemented within Maryland.

State and Local Leadership Support:

Executive level support to bring agency leaders and community partners together is a critical component for large scale systemic reforms. Systems of care require buy-in from the top down to ensure there is a shared goal among all agencies. Bringing together leaders at the state and local level ensures that the varied strength and needs of all stakeholders can be taken into account. Of course, local leadership also includes community organizations that serve children and families across the state. In order to ensure all stakeholders are represented, surveys should be conducted to determine which agencies and organizations play critical roles within each county. Once leaders are brought together, their inputs can be utilized to design a system of care tailored to their needs and strengths.

A Centralized System for Children and Families:

Reformers should prioritize building a centralized system that serves the needs of all children and families, regardless of circumstance. This includes the creation of a new division similar to New Jersey’s CSOC and a service administrator similar to PerformCare. This system would primarily be a behavioral health system focused on facilitating and coordinating services to serve the emotional and mental health care needs of individuals under the age of 21 and have an agency lead with a title equivalent to their counterparts. A system of care would ensure that children and families are not barred from accessing services due to a lack of DCSS involvement – this is a critical component of the current issues impacting pediatric overstay in Maryland. Through the implementation of a centralized system, New Jersey has no need for a VPA process since services are all accessible through CSOC so long as the individual is eligible for and enrolled in Medicaid.

Improvement of Medicaid Enrollment and Title IV-E Reimbursement Efforts:

Medicaid and Title IV-E are essential sources of funding for children and family services. In FY 2022 these two funding sources accounted for 76.9% (\$323,703,866) of federal spending in New Jersey and represent 29.4% of their total spending for children and family services.⁶⁰ In order to maximize available federal funding in Maryland, the verification of and support for enrollment in Medicaid should be a top priority. To accomplish this, all children and family services organizations should be required to verify Medicaid enrollment and support families in enrollment if eligible. In order to ensure that Medicaid reimbursement is maximized and enrollment is not a barrier to services for families, a centralized system of care would ensure that all agencies and organizations follow the same verification and enrollment procedures. In New Jersey, all agencies are required to verify Medicaid or private insurance enrollment before they are reimbursed for services. This is an intentional bottleneck designed to ensure that the system is fiscally sustainable and families receive support in accessing vital services and resources. In the long term, it would be important for Maryland to run a state administered healthcare system for families not covered by Medicaid similar to NJ FamilyCare to ensure they have coverage and access to needed services.

Centralized Data Management System:

Ensuring data is up to date, easily accessible, and transparent is vital to a collaborative system that provides timely and relevant services to children and families. A centralized system similar to New Jersey's CYBER, which provides a one stop solution for families, agencies, service providers, and even commercial insurers by connecting directly to the PerformCare system, should be implemented in Maryland. In New Jersey, a record is started as soon as a call is made for assistance, providing real time Medicaid data, demographic, and other important information. The first task of this system should be to ensure all children eligible for healthcare receive coverage. Another benefit of this system is that all agencies and partners have access to relevant data so that they can provide more targeted services and resources. This would lower the burden on youth and families to navigate multiple systems by themselves. However, it is also important that this data is not readily accessible by CPS in Maryland, so as to protect the privacy of children and families and ensure that the fear of CPS involvement is not a barrier to those wishing to access services. Parent and family advocates in New Jersey consulted in the creation of this report were adamant about this digital separation to ensure the system can be trusted by the community.

Collaboration Across Agencies and Within Communities:

Building connections between agencies and community service providers allows for a more holistic support system. The creation of a centralized system of care for children and families would ensure that relevant agencies within the department operate under a central structure improving collaboration and with the title equivalency of the agency lead they would be more readily available to collaborate with other state agencies. Through the centralized data management system, not only would information on children and families be available, but also information on service providers. New Jersey's CMO system is the most comprehensive in the country, with a lead organization in each jurisdiction responsible for coordinating community-based services. This process should be tailored to local conditions in Maryland and community service organizations should be included in the design of any system of care in the state.

Utilization of Mobile Response and Stabilization Services (MRSS):

MRSS's ability to provide rapid response services for individuals and families within 1-24 hours is crucial to maintaining children in their homes. MRSS provides intervention services and plays a key role in preventing children from entering DCSS custody or being admitted to the ER. It allows for youth and families to receive services by making a phone call to a toll free number that is monitored 24/7 by trained staff. MRSS is also able to tailor services to the individual needs of children and families across the state. Mobile response should possess the ability to recommend and connect families with longer term stabilization management services when required. Additionally, law enforcement and other relevant partners should be trained as to when they should refer individuals to MRSS.

Comparison: New Jersey CSOC vs. Maryland Children's Behavioral Health System

System Structure & Scope

New Jersey – CSOC

- **Comprehensive statewide system of care** focused on coordinated, community-based services for children and youth with behavioral, emotional, substance use, and developmental needs.
- **Fully operational statewide continuum** including entry, crisis response, care management, family support, and specialized programs.
- Serves children from birth through age 21 through a unified framework with centralized entry and data/outcome tracking.

Maryland

- Behavioral health services for children and youth are administered through the **Behavioral Health Administration (BHA)** and multiple county-level **Core Service Agencies** under the Department of Health.
- Maryland uses **multiple programs and funding streams** (e.g., Medicaid waivers like the 1915(i) amendment to expand community-based services) rather than one single, integrated “system of care.”
- Programs like **Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP)** provide **consultation and referral support** to primary care and emergency clinicians; helps pediatricians and family practice providers **identify, manage, and coordinate care for children with behavioral health needs**

Access & Care Coordination

New Jersey – CSOC

- Centralized access through a **24/7 Systems Administrator** with service authorization and continuity across settings.
- Integrated care teams provide rapid crisis response, wraparound care management, and family support.
- Uses standardized assessment tools (e.g., CANS) across the system.

Maryland

- Behavioral health services include **county core service agencies** coordinating publicly funded care plus statewide programs expanding home and community-based services through Medicaid policy changes.
- Primary care providers have access to consultation, training, referrals, and tele-mental health support through BHIPP.
- No single statewide entry point for all services; families often navigate **multiple agencies and provider networks**.

Crisis Response & Community Supports

New Jersey – CSOC

- **Mobile Response & Stabilization Services (MRSS)** ensure rapid, in-home crisis intervention and short-term stabilization.
- Specialized out-of-home programs added to address complex trauma and developmental needs.

Maryland

- Crisis response and acute care are managed through BHA networks including mobile crisis and outpatient options; local agencies may provide crisis services.
- Recent Medicaid 1915(i) expansion broadens eligibility for home and community-based services and peer support.
- School-based mental health and community grants (e.g., Consortium on Coordinated Community Supports) fund counseling and local services, with funding levels subject to legislative appropriations.

Outcomes & Evaluation

New Jersey – CSOC

- Reported measurable reductions in institutional placements, high rates of youth maintained at home post-crisis, and reinvested savings into community care.
- Strong outcomes tracking and quality monitoring infrastructure.

Maryland

- State policy reports highlight expansion of community services and improved access - for example, broader eligibility and reduced administrative burdens through Medicaid changes.
- Independent indicators suggest strong state performance on some youth mental health access metrics (e.g., above national average according to external reports).
- Outcome tracking across the full continuum is **less centralized** and may vary by jurisdiction and program.

Key Takeaways

- **New Jersey's CSOC** is a mature, integrated System of Care with centralized entry, coordinated services, and measurable statewide outcomes.
- **Maryland** offers a **diverse set of behavioral health services** delivered through statutory agencies, local core service agencies, and targeted programs, with recent reforms expanding eligibility and community-based supports.
- **Access to therapeutic placement in Maryland is driven not by clinical need but by government custody**

Appendix 7

2026 Legislative Briefing Materials: Workgroup Interim Report

Workgroup on Children Unlicensed Settings & Pediatric Hospital Overstays: Interim Brief

January 28, 2026



Overview

Workgroup: Initially, the workgroup was to set to convene in June 2025 with a report due in October 2025. Due to delays in obtaining the member appointments, the workgroup convened in October 2025 with a commitment to provide an interim brief in January, with a final report deliverable in April 2026. Due to the death of a child in foster care in an unlicensed setting, and legislative desire to impact Children in Unlicensed Settings & Pediatric Hospital Overstays, the Workgroup provided legislative recommendations ahead of the interim report.

Legislative Charge (Section 2(c)(1)): The Workgroup on Children in Unlicensed Settings and Pediatric Hospital Overstays must:

- (i) Complete an assessment of the number, type, and cost of additional beds and supportive services needed to place all children in pediatric overstays and other unlicensed settings in the least restrictive settings
- (ii) Develop a comprehensive and sustainable resource development plan designed to increase licensed settings and end unlicensed settings and overstays
- (iii) Develop an implementation plan with comprehensive data
- (iv) Determine the anticipated timeline for ending unlicensed placements

Executive Summary

The Workgroup met (October 2025 – present) and established the executive committee, which includes the Chair, (2) Vice Chairs and a Secretary. Sub-groups were established to ensure the top priorities would be met, in a timely manner.

The sub-workgroups include:

- a. Resources and Barriers
- b. Definition, History and Other States
- c. Data and Assessment of Needs
- d. Legislation and Policy

Each sub-workgroup was tasked with providing a preliminary report that provides necessary content to be included in the summary brief and ultimately the final report.

Leveraging the sub-workgroup preliminary reports, the executive committee prepared an interim brief of proposed recommendations, that was distributed the week of January 19, 2026, to Senate Finance Committee Chair Beidle, House Health Committee Chair Bagnall, House Health Committee Vice Chair Cullison and House Appropriations Health and Social Service Subcommittee Chair Shetty. The final report of findings and recommendations will be distributed to the Governor and the General Assembly - April 2026.

Pediatric Hospital Overstay Data

As of Jan. 8, 2026, there were 32 youth experiencing a hospital overstay (excluding infants and youth at the Brook Lane Step Down Program which counts an overstay as greater than 120 days.) These data were compiled by MDH, DHS and DJS as of Jan. 8.

Twenty five of these youth were in inpatient units and seven were in Emergency Departments.

Demographic breakdown of the 32 youth:

- 12 girls
- 20 boys
- Age range from 7 to 20 years, average age 14

Department of Human Services

- 7 youth were in the care and custody of DHS (3 in the Emergency Department, 4 in inpatient units)
- 9 of the youth were pending a Voluntary Placement Agreement
- 5 of the youth and their families were working with DHS
- Total of 21 youth out of the 32 youth were known to DHS

Priorities

1. Expand Behavioral Health & Child Welfare Capacity
2. Ensure State Agency Accountability & Collaboration
3. Improve Data Tracking & Sharing
4. Implement Previously Passed Legislation



Priority 1

Expand Behavioral Health & Child Welfare Capacity

- Fund Quality Service Reform Initiative rate reform
- Implement START or similar model for 24/7 crisis intervention for youth with intellectual disabilities and behavioral health needs
- Fund and expand Mobile Response and Stabilization Services (MRSS)
- Create a state centralized registry of foster homes and group homes
- Increase Medicaid reimbursement for RTC providers, respite and 1915i
- Mandate OPEGA audits of local management board funding priorities
- Ensure annual funding and PINS for state regional institutes for children and adolescents (RICAs) to fully staff these facilities
- Redirect state dollars to fund these recommendations
- Require the State to apply for federal grants to supplement state funds



Priority 2

Ensure State Agency Accountability & Collaboration

- Establish a permanent cross-agency oversight body within Governor's Office of Children (GOC)
- Create Children & Youth State Placement Manager position
- Require monthly Placement Review Panel meetings, while maintaining weekly meetings with care team and legal representation
- Convene Rapid Response Placement Team for overstays > 72 hours
- Create stakeholder oversight body to reviews policies, make recommendations, hold State agencies accountable
- Identify and remove policy loopholes allowing unlicensed placements
- Implement stringent timeline and alert system; Mandate State agency reporting when youth not timely removed from unlicensed settings



Priorities 3 & 4

Priority 3: Improve Data Tracking & Sharing

- Designate central repository within GOC for data collection
- Develop state-mandated standardized data metrics across agencies
- Require daily reporting on youth in unlicensed settings
- Publish quarterly aggregate data reports on youth in unlicensed settings

Priority 4: Implement Previously Passed Legislation

- [HB 1121, Ch. 29](#) (2020) - Mental Health Registry and Referral System
- [HB 766, Ch. 500](#) / [SB 656](#) (2022) - Residential Treatment Centers Education Funding
- [HB 322, Ch. 379](#) / [SB 255, Ch. 378](#) (2023) - Home & Community-Based Services for Children
- [HB 1134, Ch. 853](#) / [SB 403, Ch. 854](#) (2024) - RTC Accreditation Requirements
- [HB 962, Ch. 479](#) / [SB 696, Ch. 480](#) (2025) - Pediatric Hospital Overstay Patients Workgroup



Call to Action

These comprehensive reforms address the root causes of unlicensed placements and pediatric hospital overstay.

Immediate action on these priorities will protect Maryland's most vulnerable children and youth.

APPENDIX

Children in Unlicensed Settings & Pediatric Hospital Overstays Workgroup Members

Dr. Meena Seshamani, Department of Health (Sonia Chessen, Designee)
Rafael López, Department of Human Services (Stephen Liggett-Creel, Designee) Betsy Fox
Tolentino, Department of Juvenile Services (Maisha Davis, Designee) Natasha Dartigue, Office
of the Public Defender (Krystal Williams, Designee) Laura Edwards, Maryland CASA
Association
Rob Basler, Arrow Child & Families Ministries Erica LeMon,
Maryland Legal Aid
Jane Krienke, Maryland Hospital Association
Sara Hairgrove, Community Behavioral Health Association
Nicole Smith, Maryland Association of Resources for Families and Youth
Leslie Seid Margolis, Disability Rights Maryland Carrie
Etheridge, Sheppard Pratt
Rebecca Seltzer, Maryland Chapter, American Academy of Pediatrics Jocelyn Route,
Representative of a Family of a Child in Foster Care
Work Group Staff: Edward “Ted” Gallo, Executive Director, Maryland State
Council on Child Abuse and Neglect (SCCAN)

Work Group and subcommittee meetings were open to the public and media.

Preventing Pediatric Hospital Overstays and the Placement of Youth in Unlicensed Settings: Legislative Proposals

Factors Leading to Pediatric Hospital Overstays & Placement in Unlicensed Settings

Problem Statement: (CAPACITY) - There are children and youth waiting in hospitals for placement in non-acute care settings. - Approximately 60% of youth 14-17 years old are custody relinquishments because they are in need behavioral health care. This leads to an overpopulation of youth in the foster care system and utilization of the voluntary placement agreement (VPA) policies that mandate relinquishment of custody in order to receive such services. These waits can stretch for days, weeks, months and years. There is a racial disparity. - Providers who could take these youth are not adequately reimbursed so that they can operate with the higher staffing ratios needed to care for these youth safely. - The mobile crisis system is insufficient and not customized for kids and families, therefore, referrals to the nearest emergency department are common. - There is not enough accessible respite for foster families in crisis. - There are gaps in the care continuum from acute care hospitals to lower levels of care.	What are the contributing factors? ● Lack of appropriate behavioral health beds to meet unique and complex needs (developmental disabilities, low IQ, Autism) ● Lack of intermediate levels of care, stepdown and respite beds where youth can wait outside of a hospital if they need a long-term placement in a residential setting or if respite is needed. ● Lack of appropriate foster family matching and monitoring for youth to minimize placement disruptions. ● Low reimbursement for child placement agencies – rate reform needs to be funded. ● There are not enough beds in the State for youth with low IQ and Autism. ● Mobile crisis is not available across the state and not customized for kids and families. ● There is not a dedicated response customized for youth with dual intellectual disabilities and behavioral health needs.	What are the solutions? ● Increase bed capacity and service offerings across the continuum that can care for youth with high needs and offer care in the community and respite. - Residential Treatment Center (RTC) - Qualified Residential Treatment Program (QRTP) - Class 6 (Highest Intensity) - Qualified Residential Treatment Program (QRTP) - Class 2/2b (Intensive/Specialty) - Therapeutic Group Home - Residential Child Care Program (RCC) - Class 1/1b (Significant Needs) - Treatment Foster Care - High-Fidelity Wraparound Services (none currently exist) - Intensive In-Home Services - Mobile Response and Stabilization Services (MRSS) - Intensive Care Coordination - Crisis Response Teams - Respite Care - Short-term stabilization placements (shelter beds and crisis stabilization)
--	---	--

Problem Statement: (ACCOUNTABILITY/COLLABORATION) • The State does not have a singular process or system to track the number of youth experiencing	What are the contributing factors? • There is no oversight or accountability for the State to take responsibility for all youth	What are the solutions? • Reform interagency placement coordination by establishing a permanent, cross agency oversight body within the Governor's
---	---	--

Preventing Pediatric Hospital Overstays and the Placement of Youth in Unlicensed Settings: Legislative Proposals

a hospital overstay or placement in an unlicensed setting. • There is a lack of coordination across state agencies and with appropriate stakeholders (hospital, providers, families, resource parents, youth, etc.) • Hospitals can be viewed as “safe places” so there can be a lack of urgency to transition youth out of an acute care hospital setting urgently. These settings have been described as “worse than jail” and are considered restrictive settings for youth. Often youth do not have access to their personal belongings, cannot go outside or even leave their room or the unit, they might not be able to participate in educational activities/attend school or have contact with family and friends. • There is no external oversight body that can hold the State accountable for tracking these youth and ensuring placements in licensed settings are identified as soon as possible and youth are transferred accordingly.	who experience a hospital overstay or placement in an unlicensed setting. • There is not an official placement team to take responsibility and efficiently locate an appropriate placement with urgency. • There is no public reporting requirement to hold the State responsible for ensuring youth are not placed and/or living in unlicensed settings.	Office of Children (GOC), led by the Special Secretary, to address hospital overstays and monitor outcomes. • Identify a single point of contact within the GOC with proper authority to oversee the MDH and DHS liaisons and take responsibility for these youth. • Establish a Placement Review Panel within the Governor’s Office of Children - a multidisciplinary team modeled after child fatality review boards, focusing on case level analysis and systemic recommendations to prevent these kinds of stays and improve placement outcomes including research into diminishing resource homes due to significant attrition and recruitment barriers. This Panel would perform the recommended actions outlined in the Chapin Hall report (pg. 120). • A Rapid Response Placement Team which can convene and create a plan for any youth who has been in an unlicensed setting for more than 72 hours and for pediatric hospital overstay patients.
--	---	--

Problem Statement: (DATA TRACKING/SHARING) • There is not a standardized process for the State to maintain data on each pediatric hospital overstay patient as required by HB 926 (2025 session). • Youth in the process of obtaining a voluntary placement agreement are not usually counted by DHS as being in their care and custody, therefore,	What are the contributing factors? • Data is not easily shared across agencies – this is currently a manual process. • Certain data are not publicly available to ensure accountability for preventing the placement of youth in unlicensed settings.	What are the solutions? • Establish a central repository within the Governor's Office of Children to maintain data elements identified as important to track at a State level by this work group. Ensure this data is reviewed on a regular cadence. • Require DHS to provide publicly accessible reports of all children in unlicensed settings under their care.
--	--	---

Preventing Pediatric Hospital Overstays and the Placement of Youth in Unlicensed Settings: Legislative Proposals

these youth are often not counted by the State. This practice has started to change recently.	• There is not a centralized IT platform currently being utilized to share information across agencies and with external stakeholders as appropriate (i.e. hospitals, potential resource homes, etc.)	• DHS should also report the type of placement or service transitioned to for all kids under their care and custody in unlicensed settings from 1/25 to date. • In 2003, Cleverex built the Subcabinet for Children, Youth & Families Information System (SCYFIS). SCYFIS was a secure, web-based case management information system, developed to replace an old DOS-based program. The system addressed information needs for several interagency activities supported by the Maryland Subcabinet. SCYFIS captured business processes relating to the LCC/SCC tracking of children and youth at risk of or entering into residential level care. It was developed quickly and within budget: in less than a year. A similar system could be built again.
---	---	--

A summary can be found of legislation that has been passed but has either not been implemented at all or not fully implemented, meaning regulations have not been promulgated along with other supporting actions to fully implement the law.

Legislative & Regulatory Summary Table

Effective Date(s)	Law/Regulation Title	Description	Status	Responsible Agency
Oct. 1, 2023 (effective date) Dec. 1, 2024 MDH to convene stakeholders and submit recommendations on expansion of eligibility and enrollment in 1915(i) services, current eligibility requirements and provider reimbursement rates including value-based purchasing options.	<u>SB 255, Ch. 378 / HB 322, Ch. 379 (2023)</u> ; Public Health - Home -and Community-Based Services for Children and Youth	Requiring the Maryland Department of Health to expand access to and provide reimbursement for intensive in- home services, case management, and wraparound services; requiring, beginning in fiscal year 2024. The Behavioral Health Administration to fund 100 slots in the mental health case management program for children or youth at risk of out-of-home placement who are not eligible for program services. Requiring the Governor to include funding in the annual budget bill for customized goods and services for certain youth; etc.	Passed, but not fully implemented	Department of Health

Preventing Pediatric Hospital Overstays and the Placement of Youth in Unlicensed Settings: Legislative Proposals

Jan. 1, 2024 (effective date)	HB 766, Ch. 500 / SB 656 (2022) : Children – Residential Treatment Centers – Education Funding	Moving responsibility for approving the education funding for a Maryland RTC placement for children on Medicaid from DHS to MDH, making VPAs unnecessary in many cases.	Passed, but not fully implemented	Maryland Department of Health Maryland Department of Human Services
Oct. 1, 2024 (effective date)	SB 403, Ch. 854 / HB 1134, Ch. 853 (2024) : Hospitals and Related Institutions – Residential Treatment Centers – Accreditation	Expanding the approved accreditation bodies for RTCs to include CARF and COA in addition to Joint Commission. This was in response to a barrier in expanding the Continuum of Care in MD and to expand the number of RTCs in MD. This legislation allows programs to be licensed by the OHCQ, ultimately will not be funded until this change is made. Maryland is currently the only state that does not use this model, and it may even help bring in organizations licensed in other states.	Passed. Updated regulations proposed in late 2025; awaiting finalization	Maryland Department of Health
Feb. 12, 2021 (Effective date after veto override)	HB 1121, Ch. 29 (2020) : Maryland Mental Health and Substance Use Disorder Registry and Referral System	This legislation has been enacted but its efficacy remains limited. This Registry and Referral System should be fully optimized in order to serve its intended purpose: providing a statewide system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients. It should, at minimum, include real-time availability with patient demographics.	Enacted, but not functioning optimally and not inclusive of all stakeholders or bed types	Maryland Department of Health Maryland Department of Human Services Inpatient and Outpatient Mental Health and Substance Use Disorder Providers

		State entities providing mental health and substance use disorder services, including inpatient, crisis and outpatient services are not yet included in the bed registry.		
--	--	---	--	--

Preventing Pediatric Hospital Overstays and the Placement of Youth in Unlicensed Settings: Legislative Proposals

June 1, 2025, July 1, 2025 (Effective dates)	SB 696, Ch. 480 / HB 962, Ch. 479 (2025): Public Health – Pediatric Hospital Overstay Patients and Workgroup on Children in Unlicensed Settings and Pediatric Overstays	The bill authorized funding for a new 5 bed unit at the Rockville RICA. This unit has not officially opened yet. Two permanent coordinators have not been identified yet. Previous coordinators transitioned. There is not a plan yet to collect the data outlined in the law.	Passed, but not fully implemented.	Maryland Department of Health Maryland Department of Human Services
---	--	---	------------------------------------	--

Appendix 8

2026 Supplemental Agency Report Materials

Moore-Miller Administration's Actions to Address Children in Unlicensed Settings & Pediatric Hospital Overstays

Addendum to Workgroup Interim Report

- I. Administration Actions by Department
- II. Implementation of [SB696 \(2025\)](#)
- III. Other Future and Related Activities

I. ADMINISTRATION'S ACTIONS BY DEPARTMENT DEPARTMENT OF HUMAN SERVICES (DHS)

The safety and well-being of Maryland's children are our highest priorities. We envision a Maryland where all children are safe from abuse and neglect, thriving in permanent homes, and surrounded by loving families. We have moved with urgency since we took office in 2023 to end the use of unlicensed settings¹ and worked with the Maryland Department of Health (MDH), the hospitals, providers, and the General Assembly to sharply reduce pediatric hospital overstays for youth in DHS care and custody.

We have lowered the number of youth experiencing hospital overstays by increasing communication and closing systemic gaps in our system. We initiated a new protocol of weekly staff meetings between the Social Services Administration (SSA) and the local departments of social services (LDSS) to review individual cases, address placement and treatment needs, and identify potential placements before discharge.

We hired a hospital liaison whose sole purpose is coordinating efforts and communicating with all of the hospitals serving our youth. There are weekly staffings between the DHS case team and the hospital to ensure effective communication and to enhance responsiveness.

We closed systemic gaps in our continuum of care by implementing rate reform, hiring a hospital liaison, increasing communication, and intensifying oversight. We are using our new category based rate structure to incentivize our residential care providers to develop innovative programming when a youth has idiosyncratic needs not well met by our current system of care.

DHS commissioned Chapin Hall to complete the SSA placement needs assessment to better assess the current state of this long-standing issue using both quantitative and qualitative actions.

¹ DHS has also worked to remove structural barriers to end the practice of youth in our care staying in hotels, including issuing a Directive on the Use of Unlicensed Settings that clarified we will not facilitate the use of hotels or other unlicensed settings for youth in our care. As of November 19, 2025, no DHS youth are in a hotel. *See [October 22, 2025 DHS Directive on the Use of Unlicensed Settings](#).*

Chapin Hall used existing data to evaluate current placement needs, identify trends to help ensure youth in DHS custody are placed in the appropriate level of care, and end the reliance on unlicensed settings. The workgroup's report and recommendations rely heavily on Chapin Hall's report. We are currently acting on the following recommendations included in the final report submitted by Chapin Hall, and evaluating the resources needed to implement other recommendations:

1. Reduce or eliminate the use of external tracking forms (e.g., spreadsheets outside of Child, Juvenile, and Adult Management System (CJAMS)) by updating CJAMS to accommodate this information.
2. Establish a Placement Review Panel to address the complex challenges for children experiencing placement disruption, hospital overstay, hotel stays, and office stays.
3. Support placement efforts that collaborate with caseworkers, providers, and other stakeholders to expedite placement finding and ensure alignment with the child's needs and preferences.
4. Establish recommendations to address recurring issues, such as provider accountability, resource gaps, and systemic barriers and expand specialized placement options.
5. Increase caseworker training to contextualize youth behaviors as communication of unmet needs rather than pathologizing such actions
6. Prioritize placement settings for youth aged 14–17 and those with complex behavioral or psychological needs.
7. Conduct regular needs assessments to adapt strategies on emerging trends and challenges.

We highlight the following actions:

1. Implemented a Statewide Tracking Tool

DHS implemented a coordinated statewide tracking tool for all youth placed in unlicensed settings and pediatric overstay, followed by issuing formal guidance in early 2025. This guidance clarified reporting and documentation requirements for any youth in care; required all hotel stays to be reported to SSA and Office of the Secretary immediately, and that a Rapid Response Meeting to be convened within 48 hours. The SSA Placement and LDSS team members are required to conduct ongoing weekly meetings for each case. In addition, CJAMS was enhanced effective July 2025 to ensure that youths' living arrangements are accurately captured in the system.

2. Supported Provider Capacity to accept youth with complex needs

With DHS’s improved tracking and insight into the use of unlicensed settings and pediatric overstay, we took action to develop and implement a plan to build out a placement continuum that is aligned with the needs of the youth in out of home care and is positioned to be innovative and respond to placement referrals with a 'yes' versus just saying 'no'.

With support of Governor Moore and the General Assembly, DHS was able to deliver on Phase 1 of Rate Reform beginning in October 2024 with a \$27 million investment in increased residential provider rates. This investment has been continued in state fiscal year 2026. The first part of rate reform has already allowed us to engage the existing provider network to increase placement capacity and deliver services targeted to youth with complex needs.

Class	Description	Total Per Diem Rate
0	Pre-QRTP (No Clinical Services)	\$446.46
99	I/DD Legacy Program (No Clinical Services)	\$624.85
1	Serve Youth with Significant Behavioral Health Service Needs (6+ Beds)	\$762.08
1b	Serve Youth with Significant Behavioral Health Service Needs (5 or Fewer Beds)	\$832.43
2	Serve Youth with Intensive or Specialty Behavioral Health Service Needs (6+ Beds)	\$919.41
2b	Serve Youth with Intensive or Specialty Behavioral Health Service Needs (5 or Fewer Beds)	\$1,016.14
3	Serve Youth with High Intensity I/DD Service Needs (No Behavioral Health Services)	\$1,353.16
4	Serve Youth Needing High Intensity Medically Fragile Services	\$1,629.00
5	Serve Youth Who Have Experienced/At-Risk for Commercial Sexual Exploitation	\$2,056.56
6	Serve Youth with the Highest Intensity Behavioral Health and Intensive I/DD Service Needs	\$2,162.79

With the support of the increased Residential Child Care (RCC) rates, As part of the provider relationship reset, we have made clear [our written expectations](#) in Fall 2024 and again in Summer 2025. We followed up with several 2025 town halls enabling providers to engage directly with the leadership of the agency.

The practice of programs “interviewing” youth or conducting “meet and greets” prior to acceptance was ended with the policy goal to hold contracted providers accountable to place youth identified as having needs listed in their provider profile. The new contract expectation is to support a reduction of youth being rejected for reasons outside of the provider profile.

DHS issued a [Statement of Need in June 2025 to expand the provider continuum](#), for new providers to obtain licensure and to allow current providers to expand their programming. We anticipate completing this work by summer 2026 as part of a broader strategy to strengthen the continuum of care and reduce reliance on temporary and non-traditional placements. In addition, DHS issued an [expression of interest](#), allowing existing providers to expand capacity within their current license.

3. Instituted Placement Case Coordination

All levels of DHS have been engaged in specific case coordination and helping to reduce hospital overstay, and we have empowered a key team member - the DHS Hospital Coordinator. The DHS Hospital Coordinator actively serves as a liaison between SSA, the LDSS, and hospitals on youth in overstay status. DHS also created and hired a Director of Well-Being and Clinical Services to have direct oversight of youth's clinical needs and develop a routine clinical staffing cadence to ensure that youth are being re-evaluated for a lower level of care when safe and appropriate.

To assist with the items above, the SSA placement team and the LDSS implemented a weekly waitlist call with providers to create a way for providers to proactively learn about youth needing placement, partnering with our Placement Specialists to secure appropriate placement quickly.

SSA held a Placement Learning Lab in spring 2025 with representation from all 24 LDSS, hospital social workers, providers, and SSA to discuss current barriers and trends with placement. There was a cross participant hands-on, practical application of completing placement referrals to communicate youth needs without unnecessarily pathologizing prior behaviors.

4. Participated in Weekly Interagency Case Consultation Meetings

DHS, Maryland Department of Health (MDH) (Behavioral Health Administration and Developmental Disabilities Administration) and Department of Juvenile Services (DJS) have conducted team meetings to review overstay data, conduct case reviews, and problem placement barriers. The DHS and MDH Coordinators will be initiating a new series of meetings at the individual and policy level beginning in the new year. This is further explained in Part II of this report.

MARYLAND DEPARTMENT OF HEALTH

As part of its ongoing commitment to improving behavioral health outcomes for Maryland youth and families, MDH has been working, through the expansion of home and community-based services and other supports, to reduce the number of children who are boarding in emergency departments or overstay in hospital inpatient units. The Department has undertaken the following activities:

1. Establishing an Online Bed Registry, Referral and Care Traffic Control Platform (BRRS)

Under House Bill 1121 (2021), MDH is implementing a statewide, real-time platform that will track the availability of inpatient and outpatient care for mental health and SUD treatment. The

BRRS will facilitate and expedite transitions of care and ensure children will access care in the appropriate setting. The BRRS is also governed under [COMAR 10.21.31](#), which reinforces the utilization of the platform.

The Bed Registry will provide:

- **Searchable Provider Inventory:** Comprehensive directory of public and private behavioral health and substance use disorder (MH/SUD) providers, including inpatient, crisis, and outpatient services.
- **Real-Time Updates:** Functionality for MH/SUD providers to manage and update registry information, ideally reflecting real-time service availability.
- **Electronic Referral System:** Secure, statewide system enabling health care providers to make streamlined referrals to MH/SUD services.
- **Crisis Lines:** Accept all calls and dispatch support based on caller needs
- **Mobile Crisis Teams:** Deploy teams to provide support directly in the community
- **Collaboration with CRISP:** Integrate with the Chesapeake Regional Information System for our Patients

Milestones are outlined below; however, they may be subject to change after vendor onboarding and detailed planning

Milestone	Forecasted Due Date
Board of Public Works Approval of Internal Resource Team	March 19, 2025
Complete onboarding of internal resources team	May 27, 2025
Board of Public Works Approval of selected BRRS vendor	November 5, 2025
Vendor Contract Finalized & Project Kickoff	*December 2025
Requirements Validation	*February 2025
Design & Configuration: Go Live 1	*July 2026
Training & Testing: Go Live 1	*September 2026
Phased Go Live Start	*October 2026

2. Amending 1915(i) Waivers to Increase Utilization

The 1915(i) program provides intensive in-home/community-based Medicaid services to eligible youth. Having seen a limited utilization of these services in FY 26, MDH proposed regulatory changes to the 1915(i) Intensive Behavioral Health Services for Children, Youth and Families

State Plan Amendment. These changes facilitate access to intensive home- and community-based services for youth with a history of inpatient hospitalization, use of emergency departments or crisis services due to a serious mental health diagnosis or at risk of out-of-home placement or placement disruption. The amendments also create a low barrier to access services and increase the number of youth to be served.

3. Improving Residential Treatment Centers' (RTC) Provider Rates

To retain existing RTCs and identify opportunities to attract new RTC providers, MDH rebased RTC provider rates in FY22 (effective April 2022) to better support RTCs and address population differences, increasing rebasing frequency and allowing for exceptions. MDH amended COMAR 10.09.29 to raise the daily rate cap from \$750 to \$850 and require rebasing every two to four years, or more frequently if errors or significant cost/behavior changes cause payment inequity. Amended regulations were promulgated in August 2023.

4. Established the Brook Lane Step Down Pilot Program

Since February 2024, MDH has piloted the first hospital overstay stabilization program in Maryland at Brook Lane. This program provides seven beds for high-intensity complex youth between the ages of 8-17. It is intended for youth who are overstaying in inpatient hospital units or emergency departments and have been accepted into a placement. As such, it serves as a bridge care program for youth to step-down from the hospital environment while waiting for their placement. The program offers daily schooling, therapy three times per week, nightly group activities with a recreational therapist, bi-weekly psychiatric nurse practitioner visits, and weekly individual therapy.

5. Launched 211Press 4

BHA has contracted with Maryland Information Network / 211 Maryland, Inc. to provide a single access point for behavioral health care coordination for hospital emergency departments (EDs). It receives referrals from hospital staff for any individuals in Maryland who have been in an emergency department for over 48 hours and are in need of behavioral health care coordination services. 211 assesses incoming referrals, collects clinical and administrative data, facilitates coordination with local and state agencies, contacts the Behavioral Health Administration when additional assistance is needed regarding appropriate discharge dispositions for hospital discharge planners, and contacts the receiving facility to ensure a successful placement. The goal of this program is to improve patient flow and reduce the length of stay in EDs due to behavioral health care needs.

6. Expanded Project ECHO

Through a partnership with the Kennedy Krieger Institute, BHA has supported the expansion of Project ECHO to Eastern and Western Maryland. Project ECHO is an evidence-based model that creates a “hub and spoke” approach utilizing telehealth to connect providers to consult on

complex behavioral health youth.

II. IMPLEMENTATION OF SB696

SB 696 was passed during the FY25 Legislative Session.

Implementation Plan by Section

SECTION 1 - Establish Pediatric Hospital Overstay Coordinators (MDH and DHS)

While the Departments already had designated individuals working with the other relevant agencies to address challenging overstay cases, since the passage of the bill, the Pediatric Hospital Overstay Coordinator position was officially established and given the specific duties outlined per the statute.

Recently, DHS and MDH both lost their Coordinators due to a retirement and a move out of state and are actively recruiting new Coordinators. Departmental staff are currently serving in this capacity and are continuing to meet weekly to work on the cases on the overstay tracking list. The Coordinators use data from 211p4, DHS's CJAMS and their regular conversations with Sheppard Pratt and Brooklane hospitals to create the list. This data will be provided to the Secretaries of MDH and DHS quarterly in an aggregated format to protect patient confidentiality.

MDH and DHS Coordinators meet regularly with Sheppard Pratt, Brook Lane as well as the other treating facilities to determine the appropriate stepdown setting for the youths, be it kinship care, placement in an in-state or out-of-state residential treatment center, or return home to parents care with wraparound, community-based supports.

Finally, DHS and MDH-BHA convened sister agencies including DJS, MDH-DDA, Maryland State Department of Education (MSDE) and the Governor's Office for Children to begin revamping the current Interagency policy level meeting to ensure more effective processes are in place to address the complex behavioral health needs of youth who are served by multiple agencies.

SECTION 2 - Workgroup on Children in Unlicensed Settings and Pediatric Hospital Overstays in the State.

Per the legislation, the Secretaries of MDH, DHS and DJS have designated senior staff to participate in the Workgroup and its subcommittees. These representatives have been providing data as requested by the workgroup and have worked to develop this report as the Administration's contribution to the interim report being developed by the Workgroup.

SECTION 3 - Establish a new 5-bed unit at John L. Gildner Regional Institute for Children and Adolescents (JLG-RICA)

SB696 authorized funding for a new 5-bed unit at JLG-RICA to accommodate pediatric overstays. The budget did not originally provide the PINs needed to staff the unit, so the MDH Hospital System reassigned the necessary PINs.

One of the primary impediments to accepting children in overstay status at JLG-RICA is that the majority of the children referred require placement in a secure setting to assure their safety. Many of them are at high risk of acting impulsively and harming themselves, assaulting others and eloping. The only building on the JLG-RICA campus that can safely accommodate these children is Cottage 2. However, Cottage 2 also currently houses a 5-bed unit designated for the Facilities for Children (FFC). The FFC provides attainment services for Department of Juvenile Services (DJS) youth in detention. While these children theoretically do not take up the whole Cottage, they, too, are often highly emotionally dysregulated and need to be separated from each other and from other potentially vulnerable children.

In addition to the children already in the FFC, DJS and MDH have been threatened with contempt charges because there is a waiting list of children in detention needing attainment services and the magistrates would like to see an increase in capacity to admit off that waitlist.

MDH and DJS staff work together weekly on the FFC waitlist issues. In recent conversations, the agencies have begun discussing the feasibility of a solution that could address several of these challenges simultaneously. In the last fiscal year, DJS received \$3 million to re-open part of the Noyes Children's Center as a small, in-state residential substance use treatment program serving justice-involved youth. MDH and DJS are exploring whether Noyes could also effectively be used to house the FFC thus opening up the beds in Cottage 2 for use for children in overstay status. This move would also allow an expansion of the FFC beyond 5 beds if funding were available.

In addition, DJS has offered to work with MDH and DHS to develop a plan to support educational programming for the FFC, which would ensure that education of youth in detention was not interrupted when they were sent for attainment services. DJS already has three educational trailers on the Noyes site in which, with additional staffing, they could house the year-round, accredited education program provided by the Juvenile Services Education Program (JSEP).

In return, MDH is working with DJS to help establish the new residential substance use treatment unit on the Rockville campus.

III. RELATED AND FUTURE ACTIVITIES

In addition to the activities described above MDH and DHS are exploring other ways of facilitating transitions for the children currently in overstay status, as well as ensuring this does not occur in the future.

1. Improved Data Collection

BHA is in the process of working with other state agency partners, such as HSCRC, to understand and track data related to pediatric overstay. There is currently no standardized data definition or mechanism to track youth who are deemed to be in overstay status. BHA is also working with Maryland Information Network / 211 Maryland to enhance their data collection efforts through referrals made for referral coordination of care. Once the Bed Registry and Referral System is operational, this will serve as another tool to track bed availability, referrals, and linkages to services.

2. Commercial Insurance Payment for RTCs

Through a partnership with the Maryland Insurance Agency (MIA), BHA is currently undertaking efforts to understand the barriers that youth and families may face with accessing RTC care if they have commercial insurance. The Department is going to conduct an analysis of which commercial payers RTCs have contracted to understand what gaps may exist. This information could potentially mitigate the utilization of a VPA or Medicaid to access service delivery.

3. Implementation of HB766

The behavioral health needs of some of the students in overstay status may require their placement in an RTC. However, Local Education Agencies (LEAs) are prohibited from approving or funding the special education services within an RTC unless the student possesses an Individualized Education Program (IEP) that specifically designates a nonpublic school with a residential level of care as the appropriate educational placement (a "nonpublic IEP").

Without an IEP to cover special educational costs, the only other state funding mechanism identified is a Voluntary Placement Agreement (VPA). VPAs require children to enter the child welfare system to access funding for education in addition to treatment. Some families view this as being required to “give up” custody to their child. The process also requires that families pay child support while their child is in care. Many children remain in overstay because their families do not want to consider a VPA.

Effective January 1, 2024, MD Code, Health - General, § 10-1202(7) authorized the Local Behavioral Health Authority to approve funding for a youth’s educational costs incurred during an RTC admission made for medical or psychiatric purposes if the costs are not covered by the LEA.

This bill was seen as an alternative to requiring families to pursue VPAs but there was no funding appropriated for the bill and the mechanism for funding and delivering services is somewhat complex. MDH is in conversation with MSDE to see whether there may be a means of implementing the bill through an interagency agreement if funding can be identified.

4. BHA Roadmap

The BHA Roadmap is designed to be a living document that provides a 3-5 year strategic vision. It was informed by data, family voice, and community insights. The Roadmap offers system-level improvements and serves as a strategic guide for strengthening Maryland's behavioral health landscape.

The Roadmap outlines core goals and strategies including:

- Coordinated and Accessible services and supports: Support youth and families in navigating the Behavioral Health System
- Upstream focus: Leverage Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to support early intervention
- Efficient and sustainable: Develop a diverse workforce, an accountability structure, and appropriate financing to ensure the behavioral health system can function effectively on the ground in a sustainable way
- Comprehensive and equitable: A full continuum of services available to address the needs of Maryland's children, youth, and families that reflect the unique circumstances and specialized needs of children and youth at heightened risk for behavioral health challenges
- Youth and Family-Centered: Maintain and enhance a dedicated focus on what children, youth, and their families need in terms of support and services and respect their lived experience, diversity, and values in individual treatment decisions and policy making
- Support the Roadmap: the BHA is partnering with the Commission on Behavioral Health Care Access and Treatment and the Behavioral Health Advisory Council to develop an actionable workplan that will map programs, services, identify gaps, and develop short and long term strategies for addressing identified needs.

5. Behavioral Health Rate Setting Study

In accordance with the HOPE Act, MDH is required to undertake a behavioral health rate setting study. This study will allow MDH to review current community-based behavioral health provider rates in comparison to national and commercial rates. This will also allow MDH to assess whether adjustments need to be made or whether new services should be added to the continuum and array within Medicaid.

Maryland Mobile Crisis Team Services (MCT) and Mobile Response and Stabilization Services (MRSS)

Over the last several years, the Maryland Department of Health Behavioral Health Administration (MDH-BHA) has invested in expanding the availability and quality of mobile crisis response and stabilization services. On May 27, 2024, [COMAR 10.63.03.20](#) became effective establishing Mobile Crisis Team (MCT) services as a licensed service which qualify for fee-for-service reimbursement. Licensed MCT providers are required to serve the entire lifespan, including children and adolescents.

MCT Status and Funding

Currently, MCT providers operate in 18 jurisdictions. One of these licensed providers is dedicated to serving children, adolescents, and their support network in Baltimore City. Providers in two jurisdictions have submitted licensing applications and BHA is working with them and the other four jurisdictions to move toward licensure.

In FY2025, \$13 million was awarded to jurisdictions to establish the infrastructure to become a licensed provider and improve access to and the quality of services - this funding was in addition to annual grants. In FY2026, approximately \$20 million was invested in mobile crisis response and stabilization services, including \$17 million in state funding and \$3 million in federal funding.

Fee-for-Service Reimbursement

Licensed MCT services are reimbursable for the initial mobile crisis response and for up to two weeks of follow-up services by Medicaid (leveraging federal Medicaid matching funds) and the public behavioral health system. Since commercial insurance does not currently cover MCT services, the public behavioral health system covers services provided to the uninsured and to those with commercial insurance.

MRSS

Mobile Response and Stabilization Services (MRSS) is an evidence-based model outlined in SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care. MRSS provides rapid, in-person interventions that help de-escalate situations, provide immediate support, and stabilize acute and chronic crises for up to eight weeks. Ten jurisdictions have mobile crisis response and stabilization services dedicated to children and adolescents including stabilization after an initial crisis response, in alignment with the MRSS model (Anne Arundel, Baltimore City, Cecil County, Dorchester County, Frederick County, Harford County, Kent County, Montgomery County, Queen Anne's County, St. Mary's County).

Funding

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 (Allegany, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, and Washington

County) and \$413,000 in state legislated Crisis Response Grant grants for stabilization services for five jurisdictions (Caroline, Dorchester, Somerset, Talbot, and Wicomico).

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 (Dorchester, Frederick, Harford, Kent, and Queen Anne's County) - in addition to the \$413,000 Crisis Response Grant funding. These counties and the other three counties that previously received federal COVID funding 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.

Training

[COMAR 10.63.03.20](#) requires all MCT providers to be trained in the MRSS model. In FY25, MDH-BHA established a statewide training program. MDH-BHA 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.

1915(i) Changes

A comparison to three states with similar models to Maryland's identified additional covered services that could be beneficial to Maryland youth and families/guardians. These models had a lower threshold for eligibility, a less complex and shorter evaluation and access process, and a more streamlined delegation of responsibilities across Medicaid, the ASO and behavioral health lead.

SPA Changes

Distribution of state plan HCPS operational and administrative functions	Revise to streamline and clarify roles of the state entities performing each HCBS Operational and Administrative Function.
	Updated the "specifications of agencies/entities" language under the "HCBS Function Chart" to clearly outline the state's eligibility process from initial application to receipt of 1915(i) services, by identifying the role and specific activities of the state agencies/entities involved in each step for the determination of one's eligibility. Also include reporting responsibilities that are completed by each agency/entity
	ASO, instead of the LBHA, confirms the youth's home address and completes the needs-based assessment
Evaluation/Reevaluation of Eligibility	Modify the state's needs-based HCBS eligibility criteria, including reconsideration of the instrument(s) used, loosen certain eligibility requirements that present barriers to access to services - Lower the CASII of 3 to 5 and/or CSA score of 3 to 6 - Lower the # of ER visits, specifically children 5 and under (currently 2 ER visits within the past 12 months to 1)
	Extend timeframe that is considered recent or updated psychosocial assessment from the current 30-day to 60-day standard with a language change from "serious" to "potential harm" to self or others

	Plan of Care (POC) created by Care Coordination Organization increased from 45 days to 60 days
Additional Service	Added Youth Peer Support Services modeled from the Family Peer Support requirements and aligned with the MD state peer certification requirements
	Added meeting via audio-visual and audio-only telehealth vs exclusively in-person to align with the Telehealth Act

Appendix 9

2026 Legislative Highlights & Action Dates

**2026 Legislative Session - Summary Highlights with Action Dates
(Pertinent to Workgroup Proposals & Next Steps)**

**HB 1559 (Ch. 160) - Children in Unlicensed Settings and Pediatric Hospital Overstay Patients
- Placement**

Section 1

- Effective June 1, 2026

- Amends the Family Law Article to define an “unlicensed setting” as a setting for an out-of-home placement that is not licensed by a State licensing entity for custody, placement, welfare, and housing of children.
 - Includes: a hotel, motel, or short-term rental; a shelter designated to meet the needs of a child who has run away or is homeless; and an office building or other non-residential environment.
 - Excludes: the voluntary placement of a former CINA; a semi-independent living arrangement; or the placement of a child with a kinship caregiver or foster parent who is in the process of applying to be a kinship caregiver or foster parent; or a parent (including in a family-based residential treatment setting).
- Prohibits DHS’ out-of-home placement program established by the Administration from using an “unlicensed setting” for a child.

Section 2

- Effective January 1, 2027 (per Section 8)

- The definition of “unlicensed setting” is expanded to include an inpatient unit or emergency department of a hospital in which the child is a patient younger than age 22 who remains for more than 48 hours after being medically cleared for discharge or transfer.

Section 3

- Effective October 1, 2026; for 3 yrs, until September 30, 2029 (per Section 7)

- Amends the Human Services Article to define “child in an unlicensed setting” as an individual younger than age 22 (1) in an out-of-home placement who is residing in a hotel, an office building for more than 12 consecutive hours, a shelter, or any other unlicensed setting or (2) who is a pediatric overstay patient.
- Establishes a Child and Youth Placement **Review Panel** (Review Panel); a Rapid Response **Placement Team** (Placement Team); and a **Senior Advisor** for Children and Families (Senior Advisor) in the Governor’s Office for Children.
 - The Senior Advisor:
 - Shall oversee the work of the Review Panel
 - to ensure the provision of adequate medical and behavioral health care for children in unlicensed settings in the State; keep the official records of the Review Panel; and document information for cases using standard forms and data; and
 - Serve as a point of contact for the Pediatric Overstay Coordinators (Coordinators).
 - The Review Panel:
 - Shall consist of the Senior Advisor (to serve as Chair of the Review Panel), the Secretary or designee of MDH, the Secretary or designee of

- Shall analyze any instance involving a child in a pediatric overstay or unlicensed setting and propose systemic improvements based upon the analysis conducted; and may consult with individuals who have knowledge of the child for such analysis.
- Shall meet at least every 2 months.
- **Shall report on the analysis conducted to the General Assembly on or before July 1, 2027, and each July 1 thereafter.**

- Shall consist of the Senior Advisor (in an advisory capacity); the Coordinators; and if applicable, the following members who have knowledge of the child, designated by the Coordinators: a representative of LDSS and a representative of the hospital where the child is located.
- Shall develop a plan for the appropriate placement of the pediatric overstay patient; and
- Shall arrange for a temporary placement in a licensed setting when a placement has been identified, but a bed is not immediately available.
- May conduct immediate clinical placement assessments; override local department decisions if necessary to place the child in a clinically appropriate, least restrictive environment; secure immediate placement in appropriate and least restrictive available licensed settings; and authorize DHS to execute emergency procurement with an in state or out of state provider by providing justification for use of emergency procurement:
 - Require out of state placements only when no in-state provider offers the required care needed by the child; and
 - Require any out-of-state provider to maintain communication with the parent or guardian regarding treatment and care of the child.
- Shall hold an initial in person or virtual meeting immediately with all members of the Placement Team and have daily communication with all members of the Placement Team until a placement is secured; and once convened shall hold at least one in person or virtual meeting per week.

- Shall convene a rapid response Placement Team within 48hrs of being notified of a pediatric overstay patient; or within 72hrs if notified on a Friday.
- Are not prevented taking steps to secure placement before holding the initial rapid response Placement Team meeting.
- Shall in addition to current data collection mandates, maintain data on information regarding whether the admission was based on an emergency petition and, if so, whether the emergency petition was executed in a school.
- Report monthly on all data collected, not only to MDH and DHS, but also to the Review Panel.

Page 100

- DHS shall be deemed to be compliant with the prohibition on the use of an inpatient unit or emergency room department for a pediatric overstay patient established under Sec. 5-525(c)(2) of the Family Law Article, if actively searching for a placement for the child.

Section 4

- Effective June 1, 2026

- Establishes an **Advisory Council** (Advisory Council) on Maryland's System of Care for Children, Youth, and Families, and a **Subgroup** (Subgroup) of the Advisory Council.

- The Advisory Council:

- Shall consist of the following members -

- *Special Secretary, or designee*
 - *Secretary of MDH, or designee*
 - *Secretary of DJS, or designee*
 - *Secretary of DDA, or designee*
 - *Secretary of DHS, or designee*
 - *MD Insurance Commissioner, or designee*
 - *State Superintendent of Schools, or designee*
 - *Executive Director of the MD Health Care Commission, or designee*
 - *Executive Director of CRISP, or designee*
 - *211 Services Representative, appointed by the Governor*
 - *The Coordinators*
 - *The Public Defender, or designee*
 - The State Foster Youth Ombudsman; and
 - The following members who have experience and knowledge working with children in behavioral health challenges, adverse childhood experiences, and developmental disabilities, appointed by the Governor
 - The Senior Advisor
 - One representative of LDSS
 - One representative of MD Association of Resources for Families and Youth
 - One representative of DRM
 - One representative of the Community Behavioral Health Association of MD
 - One representative of MD Legal Aid
 - One representative of CASA
 - One representative of the National Association of Social Workers - MD, who is a hospital-based clinical social worker
 - One representative of the MD Chapter of the American Academy of Pediatrics
 - One representative of the MD Hospital Association
 - One representative of a specialty psychiatric hospital
 - One representative of an acute care hospital emergency department
 - One representative of the MD Resource Parent Association

- One representative of the MD Mental Health Association
- One representative of a Residential Treatment Provider in MD
- One representative with lived experience in the State foster care system
- The Special Secretary or Senior Advisor shall serve as Chair of the Advisory Council.
- Shall meet quarterly.
- Shall review and recommend any additions or changes to existing laws and regulations to ensure that they facilitate the provision of adequate medical and behavioral health care in the state, including youth in out-of-home placements.
- Shall identify any grant money from the federal government, private foundations, or other sources that may be available for programs related to children in out-of-home placements.
- Shall recommend improvements for education, outreach, and support to foster care parents in the State to prevent disruption in placement.
- Shall examine the New Jersey Children's System of Care model and provide recommendations on how the model can be replicated in Maryland, in consultation with an institution of higher education or a private research entity with expertise in the model.
- Shall review existing laws and regulations, and provide recommendations if gaps are identified, and make recommendations to ensure, if a parent or guardian is not available to make medical decisions or while in the process of obtaining a voluntary placement agreement, all pediatric overstay patients have access to legal representation and education.
- Shall review any recommendations of the Workgroup.
- Shall review barriers to capacity expansion, including rate reform and insurance parity, and make recommendations.
- Shall form a Subgroup consisting of members listed under subsection (c)(1)-(12). (*Italicized above*).
 - The Subgroup may consult with experts as necessary, including insurers, payors, and the Maryland Medical Assistance Program.
 - The Subgroup of the Advisory Council:
 - Shall complete an assessment of the current numbers of licensed beds, staffed beds, and physical beds intended to serve the needs of children and youth by agency, categorized by type of bed inclusive of age, gender, severity, and specialty accepted for the following bed types:
 - Traditional foster homes; private and public treatment foster homes; group homes; residential treatment centers; private and public inpatient psychiatric beds; and respite beds.
 - Shall develop an electronic process for tracking the real-time location, length of stay, and discharge plans for

Section 5
- *Effective June 1, 2026*

- pediatric hospital overstay patients (as defined in Sec. 19-388 of the Health-General Article), including youth under or in the process of a voluntary placement agreement.
 - Shall develop a model for standardized data collection with mandatory uniform metrics, including age, gender identity, race, ethnicity, county of origin, payor type, and length of stay for pediatric hospital overstay patients (as defined in Sec. 19-388 of the Health-General Article), including youth under or in the process of a voluntary placement agreement.
 - Shall designate an entity to serve as a central repository for data collected.
 - Shall develop a plan and identify resources needed to expand mobile response and stabilization services across the State to ensure statewide access and full implementation **by 2030.**
 - Shall report its findings and recommendations to the Governor and General Assembly **on or before October 1 of each year, beginning in 2027.**
- **On or before January 1, 2027**, DHS and MDH shall report to the General Assembly on its progress of capacity building and preventative services to end pediatric overstay, including:
 - residential treatment beds
 - therapeutic foster care homes
 - specialized placements for high-needs youth
 - licensure of facilities and foster youth homes
 - mobile crisis response
 - 1915(i) waiver services
 - in-home services and wraparound supports; and
 - necessary staffing.

Section 6
- *Effective June 1, 2026*

- Nothing in the Act authorizes a hospital to discharge a pediatric patient in a

manner that is inconsistent with Sec. 19-308.8 of the Health-General Article, State regulations governing hospital discharge, or Centers for Medicare and Medicaid Services conditions of participation.

Section 7

- Establishes *effective date for Section 3: October 1, 2026 (for 3 years)*.

Section 8

- Establishes *effective date for Section 2: January 1, 2027*.

Section 9

- Establishes *effective date for the Act: June 1, 2026 (except for Sections 7 and 8)*.

[HB 980 \(Ch. 158\)](#) - Family Law and Human Services - Guardianship Assistance Program and State Foster Youth Ombudsman - Establishment (Kanaiyah's Law)

Section 1

- Codifies provisions of the guardianship assistance program regulations by requiring DHS to establish and maintain a Guardianship Assistance Program for the placement and maintenance of children in permanent guardianship homes by providing guardianship assistance to guardians of minor children.
- Establishes the State Foster Youth Ombudsman within DHS to:
 - (1) provide legal expertise in the areas of child welfare, custody and guardianship matters, and appeals and due process issues;
 - (2) provide a neutral voice to address differences between youth experiencing out of home care, caregivers, guardians, and resource and adoptive parents interacting with DHS and local departments of social services;
 - (3) investigate complaints from youth experiencing out of home care;
 - (4) address concerns, problems, areas of improvement in service delivery, or needs associated with the rights and responsibilities of youth experiencing out of home care; and
 - (5) advocate for youth experiencing out of home care.

Section 2

- Establishes *effective date for the Act: October 1, 2027.*

[HB 1181 \(Ch.159\)](#) - Family Services - Children in Out-of-Home Placement - Voluntary Placement Agreements

Section 1

- Amends provisions of Family Law Article Sec. 5-525 related to children placed in out-of-home placements under a voluntary placement agreement (VPA) with a local department of social services (LDSS).
 - An LDSS may not seek legal guardianship or custody of a child under a VPA if the child has a developmental disability or a mental illness and the purpose of the VPA is to obtain treatment or care that the parent is unable to provide.
 - A child may remain in an out of home placement, including a residential placement, under a VPA for more than 180 days if the child's disability necessitates care or treatment in the out of home placement, and a juvenile court makes a finding that continuation of the placement is in the best interests of the child.
- Establishes the following new provisions under Family Law Article 5-525:
 - If an LDSS receives a request for a VPA, it must (1) within five business days after receiving the request, schedule an assessment meeting with the child's family and treating provider and (2) within five business days after the assessment meeting, issue a written eligibility determination to the child's family and referring provider.
 - LDSS must report any delay in assessing the child and providing an eligibility determination, including reasons for the delay and corrective actions taken by the LDSS.
 - Requires annual VPA training to be in consultation with MDH and also include training on timeline and procedural compliance; trauma-informed family engagement; and interagency coordination.

Section 2

- Specifies that a child's parent or legal guardian need not exhaust all home and community-based services in determining reasonable efforts to preserve and reunify families.
- Specifies that a parent or guardian who enters into a VPA retains all legal and educational decision-making rights, unless otherwise agreed.
- Specifies that a local department may not require a parent or legal guardian to relinquish custody or guardianship of a child to access services.
- Specifies that a local department shall notify the parent or legal guardian of a child subject to a VPA of the right to petition the court for a modification of an existing child support obligation.
- The Administration may not refer a child's case to the Child Support Administration when the family enters a VPA, unless doing so will not adversely affect the child or impede the completion of the child's permanency plan.
- The Court may not order the payment of child support by the parent or guardian of a child placed in out of home placement by a local department in accordance with a VPA if it will adversely affect the child or impede the completion of the child's permanency plan.
- The State may not accept an assignment of the right to child support for a child placed in an out-of-home placement by a local department in accordance with a VPA if the Administration determines that the assignment of an existing support obligation to the State will adversely affect the child or impede the completion of the child's permanency plan.

- The local behavioral health authority shall be notified of a child with special needs who is the subject of a VPA request for psychiatric residential treatment and who is eligible to receive medical assistance.
- The new provisions may not be interpreted to prevent a local care team from providing the child and family with alternative or interim services.
- **On or before July 1, 2027, and each July 1 thereafter**, each local department shall report to the Department:
 - the number of VPA requests in the preceding year;
 - the average time it took for the local department to make a determination and placement;
 - the number of requests that were denied and the reasons for the denials; and the average length of a hospital stay for a child awaiting placement.
- **On or before December 1, 2027**, and each December 1 thereafter, the Department shall publish on its website aggregated statewide data compiled from the local department reports (July 1 reports).
- **On or before October 1, 2029**, DHS and MDH shall submit a joint report to the Governor, the Joint Committee on Children, Youth, and Families, and to the General Assembly that contains the following information concerning children who are placed in an out-of-home placement under a voluntary placement agreement:
 - the impact on hospital discharge delays;
 - family outcomes and reunification rates;
 - the implementation status of voluntary placement agreement reform; and
 - recommendations for changes in the law.

Section 3

- The balance of any child support owed to the State before the effective date of this Act for a child whose parent or guardian has entered into a voluntary placement agreement with a local department shall be unenforceable and uncollectable on the taking effect of this Act.

Section 4

- Establishes *effective date for the Act: October 1, 2026.*

SB 402 (Ch. 641) / HB 396 (Ch. 640) - Residential Child Care Programs - Education of Children and Training of Child and Youth Care Practitioners

Section 1

- Alters Family Law Article 5-526 to ensure that a child remains enrolled in the school in which the child was previously enrolled, unless a determination is made by a local department of social services that remaining enrolled is not in the child's best interest, then:
 - the child shall be enrolled in the local school system where the residential child care program is located; or
 - if the residential child care program operates an approved educational program in accordance with the licensing regulations that govern residential child care programs, the child shall be enrolled in that program.
- Requires a licensed operator of a residential child care program that receives State funding and has legal custody or care and control of a child who is at least age five to ensure the child is provided:
 - regularly scheduled time to study to support academic work;
 - assistance with homework, projects, skills practice and test preparation;
 - encouragement and support for participation in extracurricular activities;
 - applicable IEP or 504 Plans goals to be completed within the residential care program that are consistent with the child's program or plan;
 - applicable BIPs support and goals that reinforce the child's plan in the school setting; and
 - access to a computer for required assignments if in high school or institution of higher education.
- Requires that training programs for residential child and youth care practitioners approved by the State Board for the Certification of Residential Child Care Program Professionals to include training on specified areas of child development, disabilities and socio-environmental factors that may impact processing and/or ability to learn - including but not limited to child abuse and neglect identification reporting, suicide risk assessment and prevention, approved forms of discipline and behavioral management techniques, communication skills, parenting issues, impact of family separation, medication management, etc.

Section 2

- An individual who holds a certificate as a residential child and youth care practitioner on July 1, 2026, must complete any new training program required only once the individual's certificate is due for renewal.

Section 3

- Establishes *effective date for the Act: January 1, 2027.*

[SB 668 \(Ch. 764\)](#) / [HB 680 \(Ch. 765\)](#) - Children's Cabinet Fund - Renaming and Funding for Grants to Local Management Boards

Section 1

- Renames the Children's Cabinet Fund to be the Children's Cabinet Interagency Fund (CCIF).
- Requires the Governor to include in the annual budget bill an appropriation to CCIF (1) **for fiscal 2028 through 2030**, an appropriation at least equal to the appropriation to CCIF **in fiscal 2027**; and (2) **for fiscal 2031**, \$500,000 above the appropriation for to the fund **in fiscal 2030**.
- The mandated funds must be used for grants to eligible LMBs and are supplemental to funding that otherwise would be expended for such grants.

Section 2

- Establishes *effective date for the Act: July 1, 2026*.

[SB 39 \(Ch. 218\)](#) / [HB 772 \(Ch. 219\)](#) - Behavioral Health Rate Methodology Modernization - Workgroup Establishment and Study

Section 1

- Requires MDH, rather than the BHA and MCPA, to conduct the study required under Chapters 571 and 572, **by June 30, 2028**. MDH is required to administer cost-reporting tools and oversee cost-report submissions required to support the rate-setting study required by Chapters 571 and 527. MHCC must assist MDH with the facilitation of the rate-setting study, and BHA and the Medical Care Programs Administration are required develop and implement a payment system incorporation the findings of the rate-setting study.

Section 2

- Establishes a Workgroup on Behavioral Health Rate Methodology Modernization in the Maryland Health Care Commission to develop transparent, cost-based reimbursement methodologies for certified community behavioral health clinics, outpatient mental health centers, and independent outpatient providers using federally required and existing cost-study data as the foundation for future rate reform.
- The workgroup must submit an interim report **by June 1, 2027**, and a final report by December 1, 2027, to the Governor and the General Assembly. MDH is required to implement the recommendations of the workgroup.

Section 3

- Establishes *effective date for the Act: July 1, 2026*.
- Further establishes that Section 2 shall remain in effect for a period of 2 years, and at the end of June 30, 2028, Section 2 of the Act shall be abrogated by the General Assembly with no further action required.

Appendix 10

2026 Legislative Comparative Analysis- HB1559, HB1181

2026 Legislative Comparative Analysis – HB1559, HB1181
(Workgroup Recommendations Review by Cornell)

Main Findings:

- A large number of recommendations are under the responsibility of the Interagency Council on Children, Youth, and Families with their work mainly focused on assessment, identification, and tracking.
 - Developing a model for a centralized and standardized data collection system, no mention of CJAMS and how to better leverage existing data systems.
 - Monthly meetings to complete a number of tasks including an assessment of the current number of licensed beds, staffed beds, and physical beds.
 - Identification of available grant money.
 - No discussion of how this is connected to data tracking (i.e. Title IV-E)
 - Identify resources needed to expand Mobile Response and Stabilization Services
 - Examine New Jersey Children's System of Care Model
- HB 1181 attempts to address some of the issues identified by the workgroup, but it focuses mostly on legal reforms rather than expanding services.
- No expansion of agency capacity, services, or placements in either HB 1559 or HB 1181 and no increase in funding towards these efforts.
 - Focuses on plans to identify funding opportunities
- HB 1559 and HB 1181 acknowledge specific areas of coordination, but do not address this at the systems level (i.e. agency coordination at large)
- DHS policies are at times inconsistent with the objectives of proposed legislation or suggested recommendations.
 - Licensing requirements for private versus public TFC
- Mobile crisis centers and rapid response needs are an area of overlapping priority.
- Impacts of private insurers as a barrier to accessing services is not addressed in either bill.
- Reforms and recommendations mainly focus on operational capacity rather than system level alignment at the leadership level.
- No mention of workforce capacity or development needs in the workgroup report.

Workgroup recommendations/concerns	HB 1559	HB 1181
Maryland is missing resources, across the child welfare and behavioral health continuum, including: • Residential treatment beds • Therapeutic foster care homes • Specialized placements for high-needs youth The report describes how the root causes leading to these gaps include, “inadequate reimbursement, lack of coordination across state agencies, counties and local jurisdictions, onerous regulatory barriers and delays in implementation of laws and proclamation of regulations.”	• HB 1559 does not create new beds, increase reimbursement rates, or directly expand providers in areas of the state. • However, it does tackle coordination across state agencies by requiring the Interagency Council on Children, Youth, and Families meet monthly to complete a number of tasks including an assessment of the current number of licensed beds, staffed beds, and physical beds intended to serve the needs of children and youth by agency...” ○ This is useful to map capacity but is still an assessment rather than direct fix of underlying shortages across the state.	N/A
The state lacks a centralized mechanism to proactively identify youth headed toward crisis. “Workers report that critical history is often lost during staff turnover, leaving new care teams without a clear picture of the child’s escalating needs.”	• HB 1559 also requires the Interagency Council on Children, Youth, and Families to “develop an electronic process for tracking the real-time location, length of stay, and discharge plans for pediatric hospital overstay patients,” “develop a model for standardized data collection” and “designate an entity to serve as a central repository for data collected.” • This is a meaningful overlap because it creates a more centralized data infrastructure system. ○ However the bill does not explicitly create the ‘red flag’ system the report	N/A

	describes that alerts decision-makers	
--	--	--

	when a child experiences rapid placement instability. Instead, these systems appear to be most useful once a child is already in overstay status rather than identify potential overstays and prevent the crisis itself.	
State Plan Amendment 1915(i) expanded patient eligibility but did not subsequently increase Medicaid reimbursement rates. This limited providers and impacts the availability of 1915 (i) services such as intensive in-home, respite, and experiential therapies because providers cannot afford to offer them.	Not addressed in HB 1559. The bill does not mention Medicaid reimbursement rates. The closest it comes to this issue is through authorizing the Advisory Council to "identify any grant or money from the federal government, private foundations, or other sources" and "assistance organizations in applying for such grants." These actions could help supplement funding but are not a substitute for rate reform.	N/A
Maryland has far too few providers for key services, due to the lack of eligible youth. The report states that across the state there are only, "three providers offering Intensive In-Home Services, one provider that offers respite, and four providers that offer expressive and experiential behavioral services."	HB 1559 does not directly expand the provider base for these services. What it does do is direct the Interagency Council to develop a plan and identify resources needed to expand mobile response and stabilization services across the state, with full implementation by 2030. However, the bill is limited to expanding MRSS and does not address the wider shortage of intensive in-home, respite, and experiential service providers.	N/A
The workgroup identified Public Treatment Foster Care (TFC) programs as a significant underused resource in the State. DHS has shifted	HB 1559 does not expand/mention public TFC, or create any incentives for counties to use such a model.	N/A

from public		
-------------	--	--

TFC over the last three years and these homes historically served youth with complex needs.		
Lack of transparency and direct feedback mechanisms between licensed providers and state leadership, leaving willing license homes unused. No standardized channel for caregivers to alert the state about bed availability despite some licensed public foster families having beds available. Creation of a centralized placement coordination system that would: • Track open beds in real time statewide • Match youth to appropriate placements and services faster • Identify service gaps • Improve coordination across agencies		
Child-specific MRSS system that Maryland already committed to in prior plans.	Strong overlap. HB 1559 directs the Interagency Council to “develop a plan and identify resources needed to expand mobile response and stabilization services across the State to ensure statewide access and full implementation by 2030.” However, the bill itself does not mandate any implementation milestones between now and 2030 or appropriate funding.	N/A

The report points to New Jersey's Children's System of Care (CSOC) model that uses a single contracted system administrator (PerformCare) and an MRSS that mandates a 1 hour in person response time.	Direct overlap with HB 1559 which specifically requires the Advisory Council to "examine the New Jersey Children's System of Care model and provide recommendations on how the model can be replicated in the State." The bill also directs the Interagency Council to create a method to standardize data collection, which is exactly what NJ's PerformCare does.	N/A
--	--	------------

Funding is a barrier to expanding MRSS across Maryland.	HB 1559 requires the Interagency Council to identify resources needed for statewide MRSS expansion. The bill also requires the Advisory Council to identify federal/private grant opportunities, but does not appropriate any funding towards expansion.	N/A
According to DHS's policy, LDSSs must find that reasonable efforts have been made to avoid out-of-home placement - for some reason, this has been treated as "all options must be exhausted," rather than "reasonable efforts must be made."	N/A	Under the criteria for "a child who is committed to its custody or guardianship in an out-of-home placement on a short-term basis or placed in accordance with a voluntary placement agreement," HB 1181 adds a line that explicitly states "a child's parent or legal guardian need not exhaust all home-and community-based services" .
Policy requires that a VPA is not signed until a placement is identified, meaning that DHS can't take custody of a child until the LDSS has a placement for them. This leads to a delay of services. DHS also postpones signing CINA petitions if they can't find an appropriate placement. When there are delays like this, children end up in unlicensed settings.	N/A	HB 1181 targets delays in VPA processing by imposing concrete deadlines for response. Specifically, it adds that: • "If a local department receives a request for a voluntary placement agreement, the local department shall: within 5 business days after receiving the request, schedule an assessment meeting with the child's family and treating provider; and within 5 business days after the assessment

		meeting, issue a written eligibility determination to the child’s family and referring provider.” ● It also has built in accountability mechanisms, adding that “each local department shall report any delay in assessing the child and providing an eligibility determination as required... to the Administration, including reasons for the delay and corrective actions taken by the local department.” ● However, The bill does not eliminate the requirement that a placement must be identified before signing the VPA.
DHS policy essentially states that VPAs should only be entered into “when a child is assessed to have a high level of clinical needs that require residential interventions which cannot be provided in the home...” ie. when RTC care is necessary. The workgroup emphasizes that the least intensive placement necessary is best, and not all kids need an RTC. Further, the law does not require that kids under a VPA	N/A	HB 1181 seems to clarify that RTCs are just one of many placement options for children by adding that a child under a VPA “may remain in an out-of-home placement, including a residential placement... if the child’s disability necessitates care or treatment in the out-of-home placement and a juvenile court makes a finding that continuation of the placement is in the best

need to go to an RTC, but this policy does.		interests of the child.” However, the bill does not explicitly prohibit DHS policies that limit VPAs to RTC-level care.
Private insurers make RTC reimbursement really hard - there are frequent reauthorizations, long delays in payments, and they often wrongly deny claims. This drives families toward VPAs so they can access intensive behavioral health services they otherwise couldn’t afford.	N/A	N/A
Public and private treatment foster care (TFC) have very different regulatory standards. Licensing reciprocity is needed between public and private TFC to make the system work better. Only 6 out of 24 jurisdictions operate public treatment foster care programs – more public treatment foster care beds are needed.	HB 1559 does not explicitly address licensing reciprocity or expanded public TFC. However, it does create and direct the Interagency Council on Children, Youth, and Families to “complete an assessment of the current number of licensed beds, staffed beds, and physical beds intended to serve the needs of children and youth by agency, categorized by type of bed, inclusive of age, gender, diagnosis, severity, and specialty accepted” for bed types including RTCs and public and private inpatient psychiatric beds.	HB 1181 does not address licensing reciprocity or expanded public TFC; it focuses mostly on legal reforms rather than expanding services.
Funding to support rate reform is an issue.	Rate reform is not explicitly addressed in HB 1559. However, it creates the Advisory Council on Maryland’s System of Care for Children, Youth, and Families. Part of the Advisory Council’s mandate is to “identify any grant or money from the federal government, private foundations, or other sources that may be available for programs related to children in out-of-home placements” . This could help with	Rate reform is not addressed in HB 1181

	identifying funding to support rate reform.	
Supportive of a widespread mobile crisis response system customized for kids. Request funding to support pilots and scale statewide.	HB 1559 directs the Interagency Council to “ develop a plan and identify resources needed to expand mobile response and stabilization services across the state to ensure statewide access and full implementation by 2030. ”	N/A
Create a tool or process for LDSSs to identify available foster homes and match them to the needs of youth needing a placement; update/promote/grow a list of available licensed homes open to take “hard to place” kids.	HB 1559 directs the Interagency Council to “ develop a model for standardized data collection with mandated uniform metrics, including age, gender identity, race, ethnicity, county of origin, payer type, and length of stay for pediatric hospital overstay patients... including youth under or in the process of a voluntary placement agreement; and designate an entity to serve as a central repository for data collected. ” However, the bill does not explicitly require a statewide foster-home availability matching tool.	N/A
Under COMAR 14.31.06.17, licensed Residential Child Care (RCC) programs face significant barriers to accepting emergency placements because all intake documentation must be completed within 24 hours, exposing providers to licensing and contract risk when records are unavailable. This requirement often prevents timely	HB 1159 does not explicitly modify this part of COMAR. However, the bill does implement the requirement that once a pediatric hospital overstay patient has remained in the hospital for more than 72 hours, the Placement Manager shall convene a Rapid Response Placement Team which may “conduct immediate clinical and placement assessments; override local department placement decisions, if necessary; and secure immediate placement in available licensed settings. ” This could make it easier, in practice, to move emergency cases into licensed placements faster and to bypass local bottlenecks.	HB 1181 does not explicitly modify this part of COMAR. However, its quicker VPA timeline will help children get access to care faster by eliminating some of the procedural delays.

Appendix 11

2026-2031 Legislative Implementation Roadmap

Post-Session Implementation Roadmap

A chronological guide to effective dates, reporting deadlines,
and strategic next steps — 2026 through 2031



6 bills enacted

Six Bills Enacted

Each reflects our recommendations — all carry implementation obligations running through 2028

HB 1559 / CH 0160

Effective June 1, 2026 (phased through Jan 1, 2027)

Children in Unlicensed Settings & Pediatric Hospital Overstay

Unlicensed placement ban · Advisory Council · Review Panel · Rapid Response Placement Team (3-yr pilot)

HB 980 / CH 0158 · Kanaiyah's Law

Effective October 1, 2027

Guardianship Assistance Program & State Foster Youth Ombudsman

Codifies GAP in statute · Creates independent Ombudsman within DHS to advocate for youth in care

HB 1181 / CH 0159

Effective October 1, 2026

Family Services — Voluntary Placement Agreement Reforms

5-day LDSS timeline · Parent rights retained · Child support assignment barred · Pre-existing balances unenforceable

SB 402 / HB 396

Effective January 1, 2027

Residential Child Care — Education & Practitioner Training Standards

School stability protections · Mandatory academic supports · Expanded training (trauma, suicide risk, IEP, medication)

SB 668 / HB 680

Effective July 1, 2026

Children's Cabinet Interagency Fund — Renamed & Mandated

CCIF renamed · Mandated LMB grant appropriations FY 2028–2030 at FY 2027 baseline · \$500K step-up in FY 2031

SB 39 / HB 772

Effective July 1, 2026 · Workgroup sunsets June 30, 2028

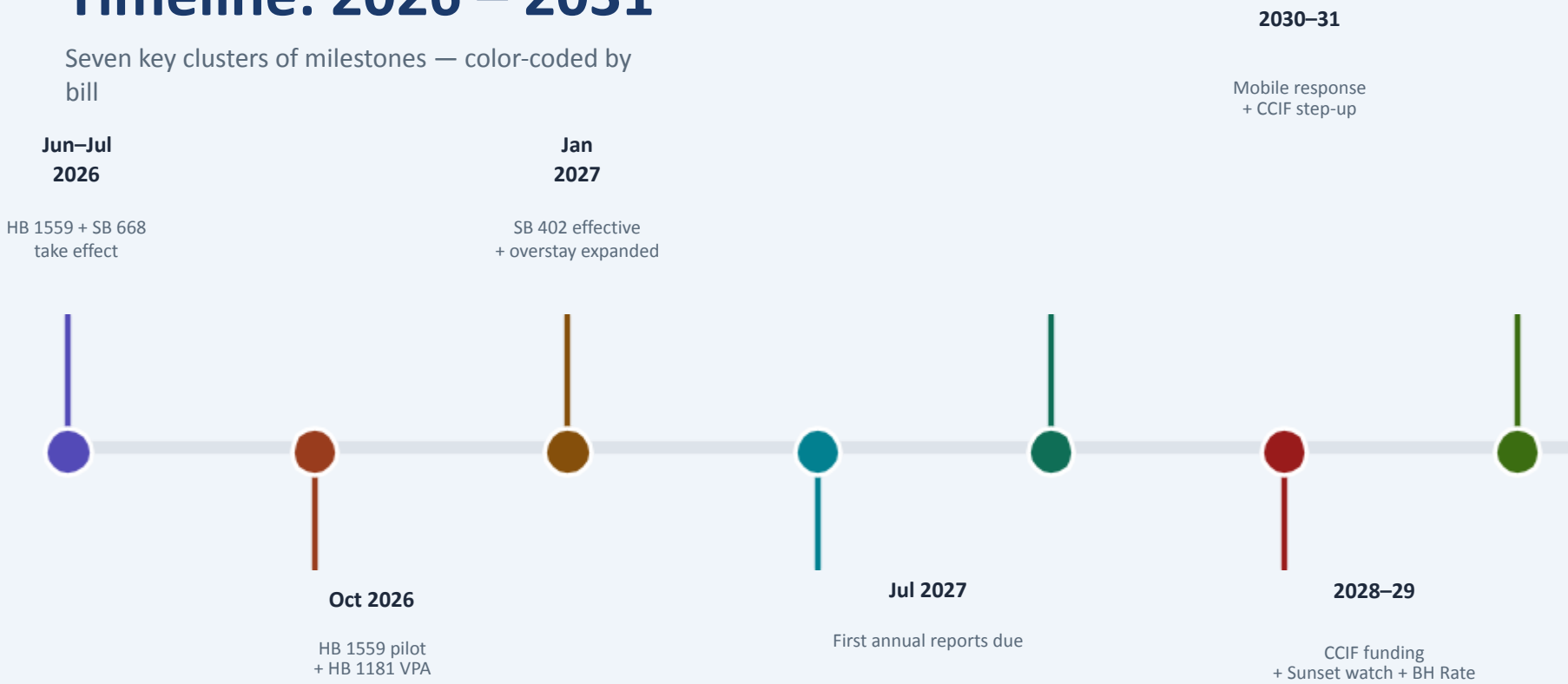
Behavioral Health Rate Methodology Modernization — Workgroup

Establishes MHCC Workgroup on BH Rate Methodology · MDH cost-reporting study by June 30, 2028 · Reports: June 1, 2027 (interim) & Dec 1, 2027 (final)

Implementation

Timeline: 2026 – 2031

Seven key clusters of milestones — color-coded by bill



2026 — Immediate Implementation

All provisions below are in effect now — confirm agency protocols, Advisory Council appointments, and LDSS compliance · SB 39 / HB 772 (BH Rate Workgroup) also takes effect July 1, 2026

TAKES EFFECT

June 1, 2026

Unlicensed placement ban takes effect

DHS prohibited from placing children in hotels, shelters, offices, or non-residential environments. Advisory Council on MD System of Care established

— must meet quarterly.

HB 1559 Lead: DHS · Governor's Office for Children

FUNDING

July 1, 2026

Children's Cabinet Interagency Fund (CCIF) formally established

Fund renamed. Mandated LMB grant appropriations begin in FY 2028. All funding is supplemental to existing LMB allocations — track annual budget bills.

SB 668 / HB 680

Lead: Governor's Office · Children's Cabinet · Local Management Boards

TAKES EFFECT

October 1, 2026 · 3-yr pilot

Review Panel, Rapid Response Placement Team & Senior Advisor established

Hospitals notify Coordinators within 48 hrs. Placement Team can override local decisions and authorize emergency procurement. Pilot runs through Sept 30, 2029.

HB 1559 — Sec. 3

Lead: Governor's Office for Children · DHS · MDH · DJS

TAKES EFFECT

October 1, 2026

Voluntary Placement Agreement (VPA) reforms take effect

5-day LDSS assessment & eligibility timelines begin. Parents retain legal and educational rights. Pre-existing child support obligations under VPAs become immediately unenforceable.

HB 1181

Lead: LDSS · DHS · Child Support Administration

January 2027 — New Provisions Take Effect

Three provisions effective January 1st — including the first hard reporting deadline of the next session period

TAKES EFFECT

January 1, 2027

Residential child care education & training standards effective

School stability: children remain in prior school unless LDSS determines otherwise. Programs must provide academic supports, IEP/BIP reinforcement, extracurricular access, and computer access. Practitioner training expanded to include suicide risk, trauma, medication management, and child abuse reporting.

SB 402 / HB 396

Lead: Licensed Residential Child Care Operators · State Board for Certification of RCCP

TAKES EFFECT

January 1, 2027

"Unlicensed setting" definition expanded to include pediatric hospital overstay

An inpatient unit or ED where a child under 22 remains 48+ hours after medical clearance is now formally an "unlicensed setting." Full HB 1559 protections apply. DHS is deemed compliant only if actively searching for placement.

HB 1559 — Sec. 2

Lead: DHS · MDH · Pediatric Overstay Coordinators

REPORT DUE

DEADLINE: January 1, 2027

DHS & MDH: joint capacity building progress report to General Assembly

Must cover: residential treatment beds · therapeutic foster homes · specialized placements · facility and foster home licensure · mobile crisis response · 1915(i) waiver services · in-home/wraparound supports · staffing needs.

HB 1559 — Sec. 5

Lead: DHS · MDH

Mid–Late 2027 — First Full Reporting Cycle

Annual reports begin · Kanaiyah's Law takes effect · VPA data goes public for the first time

REPORT DUE July 1, 2027 · Annual thereafter Review Panel: first annual analysis report to General Assembly Covers all pediatric overstay and unlicensed placement instances analyzed; systemic improvements proposed; data collected by Coordinators. Recurring every July 1. HB 1559 — Review Panel Lead: Governor's Office for Children · Review Panel · Pediatric Overstay Coordinators	REPORT DUE July 1, 2027 · Annual thereafter Each local department: VPA data report to DHS # of VPA requests · average time to determination and placement · # and reasons for denials · average hospital LOS awaiting placement. DHS publishes aggregated statewide data publicly Dec 1, 2027. HB 1181 Lead: LDSS (report to DHS) · DHS (publishes Dec 1)
TAKES EFFECT October 1, 2027 Guardianship Assistance Program & Foster Youth Ombudsman established DHS must establish and maintain the GAP. The Ombudsman investigates complaints, advocates for youth in care, provides a neutral voice between youth/caregivers and LDSS, and offers legal expertise in custody, guardianship, and appeals. HB 980 — Kanaiyah's Law Lead: DHS · State Foster Youth Ombudsman	REPORT DUE October 1, 2027 · Annual thereafter Advisory Council: first annual findings & recommendations Annual report to Governor + General Assembly: bed capacity · overstay tracking system · NJ System of Care model replication · insurance parity · legal representation gaps · mobile response expansion. Recurring Oct 1. HB 1559 — Advisory Council Lead: Advisory Council · Governor's Office for Children

Also Dec 1, 2027 (annual): DHS publishes statewide aggregated VPA data publicly on website (HB 1181) · SB 39 / HB 772: BH Rate Workgroup interim report due June 1, 2027; final report due Dec 1, 2027

2028–2031 — Sustained Compliance, Sunset & Final Targets

Critical: the 2029 sunset requires proactive advocacy — use annual reports as your evidence base starting now · SB 39 / HB 772 BH Rate Workgroup abrogated June 30, 2028

FUNDING

FY 2028, 2029, 2030

CCIF appropriations held at or above FY 2027 baseline

Governor's annual budget must include CCIF LMB grants at least equal to the FY 2027 appropriation each year. These are supplemental to existing funding. Monitor budget bills and flag any shortfalls.

SB 668 / HB 680

Lead: Governor's Office · Children's Cabinet · General Assembly

REPORT DUE

DEADLINE: October 1, 2029

DHS & MDH: joint report to Governor on VPA reform outcomes

Comprehensive impact analysis due: hospital discharge delay improvements · family outcomes and reunification rates · VPA reform implementation status · recommendations for further changes in law.

HB 1181 — Sec. 2 Lead: DHS · MDH

SUNSET

SUNSET: September 30, 2029

Review Panel, Placement Team & Senior Advisor provisions expire

3-year pilot sunsets unless reauthorized. Begin building the case for permanent codification by 2028 — leverage the July 1 annual reports starting 2027 as your evidence base for the 2029 legislative session.

HB 1559 — Sec. 3

Lead: General Assembly (reauthorization) · Governor's Office for Children

TARGET

FY 2031 · By 2030

CCIF \$500K step-up · Mobile response statewide

FY 2031: \$500,000 above FY 2030 CCIF appropriation for LMB grants. By 2030: Advisory Council Subgroup must achieve full statewide implementation of mobile response and stabilization services.

SB 668 / HB 680 + HB 1559

Lead: Governor's Office · Advisory Council Subgroup · MDH

Strategic Next Steps & Watchpoints

Confirm HB 1559 protocols are live now

Verify DHS has stopped all unlicensed placements · Advisory Council membership appointed · Hospital notification system to Coordinators operational

Build the case for HB 1559 pilot renewal — now

Pilot sunsets Sept 30, 2029 · Use July 1 annual reports (starting 2027) as evidence · Launch renewal advocacy ahead of the 2029 session

Track residential program compliance with SB 402

School enrollment policies updated by Jan 1, 2027 · Monitor training curriculum updates · Track renewal cycles for existing certificate holders

Monitor LDSS VPA compliance

Track 5-day assessment & eligibility timelines · Flag any child support assignment violations · Confirm pre-existing VPA support balances zeroed

Engage the Foster Youth Ombudsman (Oct 2027)

Track DHS implementation · Establish intake/referral pathways for youth in care · Ensure the Ombudsman has independence and adequate resources

Monitor CCIF appropriations every budget cycle

FY 2028–2030: must match FY 2027 level · FY 2031: must exceed FY 2030 by \$500K · Flag any budget proposals that fall below mandate · SB 39 / HB 772: Track BH Rate Workgroup progress; interim report June 1, 2027; final Dec 1, 2027; MDH implements findings; Workgroup sunsets June 30, 2028

Looking Ahead

6 bills. Multiple agencies. Dozens of deadlines.

One shared goal: better outcomes for Maryland's children, youth, and families.

4

Leads effective
in 2026

8+

Report deadlines
in 2027

2029

Pilot sunset
to review

2031

Final COIF
step-up

Appendix 12

List of Supporting Resources

Supporting & Supplemental Resource List

REPORTS

Maryland General Assembly (MGA) – [Department of Legislative Services \(DLS\)](#) - Joint Chairmen’s Reports (JCR) – By the Chairmen of the Senate Budget and Taxation Committee and House Appropriations Committee

- [Joint Chairmen’s Report – 2025](#)

Maryland Department of Health (MDH)

Office of the Secretary	M00A01	138
Health Professional Boards and Commissions.....	M00B0104	139
Public Health Administration (PHA).....	M00F	140
Prevention and Health Promotion Administration.....	M00F03	143
Behavioral Health Administration (BHA).....	M00L	144
Developmental Disabilities Administration (DDA).....	M00M	153
Medical Care Programs Administration	M00Q01	162
Health Regulatory Commissions (HRC/MHCC)	M00R01	174

Department of Human Services (DHS)

Office of the Secretary	N00A	178
Social Services Administration (SSA).....	N00B	180
Office of Technology for Human Services.....	N00F00	185
Local Department Operations (LDSS).....	N00G00	186
Child Support Administration (CSA).....	N00H00	192
Family Investment Administration	N00I00	193

<u>Department of Juvenile Services</u>	V00A	279
--	------	-----

- [Joint Chairman’s Report – 2024](#)

- [Joint Chairman’s Report – 2023](#)

Out-of-Home Placement Reports in Response to JCR’s

(Note: a significant amount of mandated information is consistently either missing or not provided with necessary specificity.)

- DHS - Hospital, Hotel Stays and Unlicensed Settings - Completed pursuant to the 2025 Joint Chairmen’s Report, pages 180 – 181, November 1, 2025
- [DHS – Report on Hospital Stays, Average Length of Stay, and Placement after Discharge - Completed pursuant to the 2024 Joint Chairmen’s Report, pages 144 – 145, February 6, 2025](#)
- [DHS – Report on Hospital Stays, Average Length of Stay, and Placement after Discharge - Completed pursuant to the 2023 Joint Chairmen’s Report, page 136 – 181, January 2, 2024](#)
- [MDH - Annual Report on Behavioral Health Services for Children - Required By Section 7.5-209 of the Health-General Article \(MSAR # 13361\) and the 2023 Joint Chairmen’s Report \(Pages 112-113\), September 2023](#)
- [Governor’s Office of Crime Prevention, Youth, and Victim Services – DHS, DJS, MDH, and MSDE Joint Agency Report required by 2023 Joint Chairmen’s Report \(Pages 267-268\); Human Services Article § 8-703\(e\) \(MSAR#6523\)- FY 2023 State of Maryland Out-of-Home Placement and Family Preservation Resource Plan, January 9, 2024](#)

Scoping Evaluation Reports – Office of Program Evaluation and Government Accountability (OPEGA)

- [Scoping Evaluation of the Social Services Administration, Jan. 2026](#) (This evaluation examines foster care, including foster children who had been staying in hotels.)

Audit Reports – Office of Legislative Audits (OLA)

- [MDH-Behavioral Health Administration and Medical Care Programs Administration-Administrative Services Organization for Behavioral Health Services, Oct. 2025](#)
- [DHS–Social Services Administration, Sept. 2025](#)
- [MDH-Regional Institutes for Children and Adolescents, Aug. 2025](#)
- [MDH-Developmental Disabilities Administration, Jun. 2025](#)
- [DJS, May 2025](#)
- [Review of Actions Taken by DHS-SSA to Resolve Repeat Audit Findings in Response to the April 2024 Joint Chairman’s Report, Apr. 2025](#)
- [DHS-Local Department Operations, Apr. 2025](#)
- [Maryland Department of Health-Office of the Secretary and Other Units-Follow-up Review, Mar. 2025](#)
- [DHS-Office of the Secretary and Related Units, Feb. 2025](#)

Related Reporting Materials

DHS (Data & Reports)

- [Report on Programs for Children in Out-of-Home Placement Standards for Staff and System for Outcomes Evaluation, Completed pursuant to the Human Services Article§ 8-7004\(g\), January 2, 2025](#)
- [FY 2026 Annual Progress and Services Report, June 27, 2025](#)
- [Statement of Need-Residential Child Care Services, November 5, 2025](#)
- [Child and Family Services Plan \(CFSP\) 2025-2029, June 28, 2024](#)

DHS – Out-of-Home Care

- [Child Welfare Policy Directives](#) (current policies listed on DHS webpage)
 - These policies are subject to change frequently and vary over the years, *see e.g.*:
 - [SSA-CW #20-03](#), Children with Disabilities – Voluntary Placement Agreements (VPAs) – Effective Date: February 01, 2022
 - [SSA # 10-12](#), Children with Disabilities – Voluntary Placement Agreement, September 30, 2009 (UPDATED 6/22/10)

DHS – Place Matters

- [Place Matters Initiative](#)
- [Families Blossom Place Matters](#) (Title IV-E)

MDH (Reports & Publications)

- [FY23 Report on Behavioral Health Services for Children, Health-General Article § 7.5-209, February 2025](#)
- [FY 25-27 State Strategic Plan, updated 8.18.25](#)
- [Roadmap to Strengthen Maryland’s Public Behavioral Health System for Children, Youth and Families, June 2025](#) (Prepared by the Maryland Coalition of Families and Manatt Health for the Maryland Department of Health Behavioral Health Administration.)

MHCC ([Reports & Policy Papers](#))

The Maryland Health Care Commission reports on a variety of health care data to inform decision making by policy makers, payors, providers, and consumers.

CRBC ([Reports and Publications](#), 2013-2025)

The Citizen Review Board for Children reviews cases of children in out-of-home placement and monitors child welfare programs, making recommendations for system improvements.

- [FIRST QUARTER FY2026 REPORT Jul 1 2025 – Sept. 30 2025](#)
- [Annual Report, FY2024 Jul 31 2023-Jun 30 2024](#)

SCAAN

- [Maryland State Council on Child Abuse & Neglect Annual Report, Jan. 1, 2022- Dec. 31, 2023](#)
- [Maryland State Council on Child Abuse & Neglect Annual Report, Jan. 1, 2024- Dec. 31, 2024](#)

Chapin Hall

Chapin Hall is an independent policy research center focused on providing public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of children, families and communities.

- [White Paper: Residential Treatment Center Services, March 2025](#), Published February 2025 (available on [MHCC webpage](#) – Reports/Briefing Papers)
 - DRAFT White Paper: Residential Treatment Center Services, January 2024
- [Final Report, Maryland Social Services Administration Placement Needs Assessment, January 2025 \(72nd Compliance Report - Attachment A\)](#)

Miscellaneous

- Department of General Services, Office of State Procurement, DHS-SSA Child Placement Agency Services Contract, September 10, 2025 (Board of Public Works TFC Beds)
- Chronology of Board of Public Works Decisions Regarding Out-of-State Placements, 2016-2025, (including contract costs).
- CRISP_Data Sharing Policy for DHS-DSS-MATCH Program_2024
- CRISP_Cross-Facility-Patient-Level-Data-Sharing-Policy_2023
- Maryland OPD Research Paper on “Prolonged Psychiatric Hospitalization for Vulnerable Children” (M. Heuvelmans, 2021).

DATA RESOURCE HUBS

- [211 Care Coordination](#)
- [Behavioral Health Hospital Coordination Dashboard](#)
- [DHS PROVIDER DIRECTORIES](#)
- DHS-CJAMS
 - *Child, Juvenile, and Adult Management System (CJAMS) is an integrated, statewide software platform used by DHS to manage child welfare, foster care, adoption, and various protective services.*
- MD THINK (Maryland Total Human-services Integrated Network) initiative.
 - Provides frontline caseworkers, administrators, and providers to efficiently coordinate care, track investigations, and evaluate system outcomes in real-time.
- [CRISP](#) (Chesapeake Regional Information System for Patients)
 - *CRISP is the State Designated Health Information Exchange (HIE) and Health Data Utility (HDU) for Maryland*
- [Maryland Resource Parent Association](#)

MARYLAND STATE LAW

Maryland's child welfare system is primarily governed by:

Maryland Statutes ([Md. Code](#))

- Family Law Title 5. Children (§ 5–101 to § 5–1405)
- Health—General (§ 1–101 to § 24–2702)

Maryland Regulations ([COMAR](#))

- **Title 07- Department of Human Services**
 - 07.02.09.02 - Kinship Care Program
 - 07.02.11 - Out-of-Home Placement Program
 - 07.02.11.03 - Maryland Safe Haven Program
 - 07.02.11.06 - Voluntary Placement
 - 07.02.11.12 Education for the Child in Out-of-Home Placement.
 - 07.02.21.03 – Treatment Foster Care
 - 07.05.02.02 - Private Foster Care
- **Title 10 Maryland Department of Health**
 - 10.07.04 – Residential Treatment Centers
 - 10.21.27.02 - Community Mental Health Programs — Respite Care Services
 - 10.21.07.08 - TGH Program Model
- **Title 16 Department of Juvenile Services**
- **Title 14 Independent Agencies – Office for Children**
 - 14.31.01 – Local Care Teams and State Coordinating Council
 - 14.31.02 - Interagency Coordination
 - 14.31.03 - Interagency Discharge Planning for Hospitalized Children and Adolescents
 - 14.31.04 – Rate Setting for Child Care Providers
 - 14.31.05 - Licensing and Monitoring of Residential Child Care Programs
 - 14.31.06 – Standards for Residential Child Care Programs
 - 14.31.06.17 - Admission, Individual Plan of Care, Behavior Intervention Plan, and Discharge
 - 14.31.07 – Specialized Licensing Standards
 - 14.31.08 - Eligibility and Prioritization for Services for Interagency Funds [Repealed]
 - 14.31.09 – Statement of Need

See also: [DHS – Proposed Regulations](#)

PRIOR LEGISLATION IN MARYLAND

- [HB 1134](#) / [SB 403](#) (2024): *Hospitals and Related Institutions – Residential Treatment Centers – Accreditation*

- This bill expands the definition of “accredited residential treatment center” to include a center accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA), in addition to the Joint Commission on Accreditation of Healthcare Organizations under current law. The bill also makes conforming changes.

- [*HB 322 / SB 255 \(2023\) Public Health - Home- and Community-Based Services for Children and Youth*](#)
 - This bill requires the Maryland Department of Health (MDH) to expand access to and provide reimbursement for specified wraparound, intensive in-home, and case management services relating to the 1915(i) Intensive Behavioral Health Services for Children, Youth, and Families Program. Beginning in fiscal 2024, the Behavioral Health Administration must fund 100 slots in the “mental health case management program” for children or youth who are not eligible for Medicaid services and are at risk of out-of-home placement. The Governor must include in the annual operating budget bill the following amounts to fund customized goods and services for youth receiving services under the 1915(i) model or mental health case management program: \$150,000 in fiscal 2025; \$250,000 in fiscal 2026; and \$350,000 in fiscal 2027 and each fiscal year thereafter. The bill also establishes specified consultation and reporting requirements for MDH.
- [*HB 766 \(2022\) \[SB 656\]: Children – Residential Treatment Centers – Education Funding*](#)
 - This bill authorizes a core service agency, local addictions authority, or local behavioral health authority, subject to the availability of funding in the State budget, to approve funding for a youth’s educational costs during a residential treatment center (RTC) admission for medical or psychiatric purposes.
- [*HB 1121 \(2020\): Maryland Mental Health and Substance Use Disorder Registry and Referral System*](#)
 - This bill establishes a Maryland Mental Health and Substance Use Disorder Registry and Referral System (and a related advisory committee) to provide a statewide system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients in a seamless manner.

FEDERAL LAW, POLICIES & FUNDING/DATA GUIDANCE

The Children's Bureau Laws & Policies

- Office of the Administration for Children & Families [Website](#) provides guidance to states, tribes, child welfare agencies, and more on the complex and varied federal laws as they relate to child welfare.

What's New in Laws & Policies?

- This page provides resources and information about new federal legislation, regulations, and Children's Bureau policies.

Child Welfare Policy Manual

- This Child Welfare Policy Manual contains policy questions and answers applicable to child welfare programs operated by the Children's Bureau.

1. AFCARS

2. CAPTA

- Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.)

3. INDEPENDENT LIVING

- The law requires each State/Tribe to coordinate its Independent Living Program and services with other agencies and providers that serve youth. Programs listed in the legislation (transitional living programs, abstinence education programs, local housing programs, programs for disabled youth and school-to-work programs) must be included

in the State's/Tribe's coordination effort; however, we encourage States/Tribes to coordinate with an even broader range of youth-oriented agencies and programs such as health-related programs, local job training and employment programs, community colleges and youth shelters. Regulations at 45 CFR 1357 offer guidance on how to consult and coordinate with other public/private entities for the title IV-B program that might be useful in implementing the Chafee Program.

- Social Security Act - section 477(b)(3)(F) and (j); 45 CFR 1357

4. MEPA/IEAP

- Social Security Act - Section 471(a)(18); The Multiethnic Placement Act (MEPA) of 1994 (PL 103-382); Title VI of the Civil Rights Act of 1964

5. MONITORING

- The State remains responsible for complying with all State plan requirements for titles IV-B and IV-E, even if each requirement is not subject to review in the child and family services review. The regulations at 45 CFR Section 1355.32 (d) clarify that we will use a partial review to determine conformity with State plan requirements outside the scope of the child and family services reviews. Because defining the variety of State plan compliance issues in advance is not possible, we will approach each circumstance on a case-by-case basis. Consistent with section 1123A, the necessary elements of the program improvement plan and, if necessary, the amount of the withholding, will be commensurate with the extent of the State's non-conformity.
 - Social Security Act - section 1123A; 45 CFR 1355.32(d)

6. CCWIS

- Comprehensive Child Welfare Information System
- 1355.52(b)(1)(iv) requires the title IV-E agency's CCWIS to maintain "Case management data to support federal audits, reviews, and other monitoring activities."
- The title IV-E agency should collect such data in a CCWIS using methods that support the efficient, economical, and effective administration of the program, pursuant to paragraph 1355.52(a).
 - Section 474 of title IV-E of the Social Security Act; Section 106 CAPTA; 45 CFR 1355.52(b)(1)(iv); 80 FR 48200 at 48213 (August 11, 2015); 58 FR 67939 at 67946 (December 22, 1993); ACYF-CB-PI-13-06

Federal Guidance for Child Welfare IT Systems

- Strengthening Technology Support for Recruitment, Approval, and Retention of Foster Homes - [ACYF-CB-IM-20-03](#)
 - Information on how to use information systems, websites, and applications to support the recruitment, approval, and retention of foster homes.
- Program Instructions (PI)
 - [CCWIS Pilots - ACYF-CB-PI-24-01](#)
 - Issuance Date: February 2, 2024
 - Guidelines for conducting time-limited information technology demonstration projects (pilots) in a Comprehensive Child Welfare Information System (CCWIS) environment.
- **Policy Manual**
 - [Child Welfare Policy Manual](#) - This link navigates to questions and answers regarding Comprehensive Child Welfare Information System (CCWIS) regulation in the Child Welfare Policy Manual.

- **Regulations**

- **[CCWIS Final Rule](#) (PDF)**

- The Comprehensive Child Welfare Information System

(CCWIS) Final Rule published in the Federal Register.

- [CCWIS Notice of Proposed Rule Making \(PDF\)](#)
 - The CCWIS Notice of Proposed Rule Making (NPRM) for the CCWIS regulation.

7. TITLE IV-B

- In accordance with 45 CFR 1355.30 (p)(3) records maintained under title IV-B of the Act are subject to the confidentiality provisions in 45 CFR 205.50.
 - Social Security Act - section 471 (a)(8); 45 CFR 205.50 Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) - sections 106 (b)(2)(B) (viii), (ix), and (x) and 106(c)(4)(B)
- Section 422 of the Social Security Act requires that all of the protections set forth therein be provided to all children in foster care.
 - Social Security Act - section 422 (22); 45 CFR 1355.20

8. TITLE IV-E

- Maryland must comply with federal [Title IV-E](#) foster care requirements, which mandate that children must be placed in licensed foster family homes or child care institutions to be eligible for federal reimbursement.
- Federal matching funds are provided for children placed in family foster homes or childcare institutions that meet applicable licensure and safety-related requirements.

- Title IV-E Foster Care Eligibility Reviews

The Children's Bureau conducts title IV-E foster care eligibility reviews (IV-E reviews) in accordance with 45 CFR §1356.71 to monitor the title IV-E agency's substantial compliance with certain requirements of title IV-E at §472(a) of the Act and implementing federal regulations at 45 CFR Parts 1355 and 1356 pertaining to:

- Judicial determinations regarding "reasonable efforts" and "contrary to the welfare"
- Voluntary placement agreements
- Responsibility for placement and care vested with the title IV-E agency
- Child's eligibility for Aid to Families with Dependent Children (AFDC) under the state plan in effect July 16, 1996
- Child's placement in a licensed foster family home or childcare institution
- Safety requirements are met by the child's foster care provider

9. TRIBES/INDIAN TRIBAL ORGANIZATIONS AND CONSORTIA (policies related to the tribal IV-B/E procedural requirements, tribal IVE agencies and title IV-E agreements)

Title II of the Americans with Disabilities Act ("ADA")

- People with disabilities must have an equal opportunity to participate in and benefit from state and local governments' programs, services, and activities.

Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794)

- Prohibits discrimination against qualified individuals with disabilities in programs receiving federal funds or conducted by federal agencies, ensuring equal access to education, healthcare, transportation, and more, requiring reasonable accommodations and accessibility, and setting standards for disability inclusion in federally supported activities.

EPSDT provisions of the Medicaid Act, 42 U.S.C. 1396d, et seq. (through 42 U.S.C. § 1983)

- Medicaid eligible children must receive all medically necessary diagnostic and treatment services "to correct or ameliorate" their physical and mental illnesses and conditions.

MARYLAND LITIGATION

- [DHS – Consent Decree](#) (64th – 73rd Compliance Reports & Independent Verification Agency (IVA) Reports/Responses)
 - *L.J. v. Lopez* (formerly Massinga) [Consent Decree](#) contains requirements for the Maryland Department of Human Services (DHS) and Baltimore City Department of Social Services (BCDSS) in five areas of care for children in the custody of BCDSS.
 - [L.J. v. Massinga, Independent Verification Agent \(IVA\), Certification Report for Defendants' 72nd Compliance Report \(January 1 - June 30, 2024\)](#)
 - The *L.J. v. Massinga* Modified Consent Decree (MCD) approved in October 2009 requires the Maryland Department of Human Services (DHS) and the Baltimore City Department of Social Services (BCDSS, the Department, or the Agency) to submit semi-annual Court Reports. This 72nd report covers the period from January 1, 2024, through June 30, 2024.
 - ~~72nd Compliance Report – Attachments (A-F)~~
 - [Att. A.pdf](#), July 17 2025
 - [Att. B.pdf](#), July 17 2025
 - [Att. C.pdf](#), July 17 2025
 - [Att. D.pdf](#), July 17 2025
 - [Att. E.pdf](#), July 17 2025
- *T.G., et. al. v. Maryland Department of Human Services, et. al*, 8:23-cv-01433 (U.S. District Court for the District of Maryland, Filed Date: May 30, 2023), [Case Ongoing](#)
 - [Case Summary](#): This case concerns the integration mandate of Title II of the Americans with Disabilities Act. Plaintiffs, children with mental health disabilities in Maryland's foster care system who are institutionalized despite being medically cleared for discharge, filed suit against the Maryland Department of Human Services in the U.S. District Court for the District of Maryland. Plaintiffs were represented by Disability Rights Maryland. On March 4, 2024, the U.S. Department of Justice's Civil Rights Division filed a statement of interest explaining the applicability of Title II of the ADA to children in plaintiffs' circumstances.
 - [Docket Entries](#)
 - [Initial Complaint](#) (May 30, 2023)
 - [Amended Complaint](#) (Aug 25, 2025)
 - [Reply to Motion to Dismiss Amended Complaint](#) (Mar 5, 2024)
 - [MOTION to Certify Class Motion to Reopen and Supplement Plaintiffs' Motion for Class Certification and Appointment of Class Counsel](#) (Jan 12, 2026)
 - [Memorandum in Support](#) (Att 1)

Maryland General Assembly Workgroup Briefings

- [Senate Finance Committee \(January 28, 2026\).](#)
- [House Health Committee and Social Services Subcommittee of House Appropriations Committee \(January 28, 2026\).](#)

Workgroup Note: *This is not an exhaustive list of all relevant resources and authority but rather a selection of key materials and information to highlight and*

to also demonstrate the breadth of scope, complexity and need for continued efforts and work to ensure accountability and absolute finality for children in unlicensed settings and pediatric overstay in Maryland.