Substance Use Disorder Treatment Programs: Improvements to Oversight

2025

Pursuant to Ch. 697 (2025)

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Executive summary

In 2025, the General Assembly enacted the Maryland Department of Health — Report on Oversight of Substance Use Disorder Treatment Programs and Recovery Residences (HB 722/Ch. 697, 2025). The law requires the Maryland Department of Health (MDH) to report, on or before December 1, 2025 and December 1, 2026, to the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Health and Government Operations Committee, and the House Appropriations Committee, in accordance with § 2-1257 of the State Government Article, on:

1. the revision of COMAR 10.63;
2. improvements to the oversight of substance use disorder treatment programs; and
3. improvements to procedures for the certification, monitoring, and oversight of recovery residences.

The law further specified that the reports include an analysis of how the revisions to the Code of Maryland Regulations 10.63 et seq. and other changes undertaken by MDH will prevent threats to the health, safety, and welfare of Maryland's residents, including patient relapse and death while enrolled in a substance use disorder program and housed in provider-owned buildings.

Introduction

The Maryland Department of Health (MDH) serves as the state authority for mental health and substance use services. The Behavioral Health Administration (BHA), with its MDH partners agencies and offices, works to maintain a statewide, integrated, person-centered service delivery system through a continuum of treatment modalities that promotes the public health and safety of individuals, participants, families, and communities in all jurisdictions throughout Maryland. BHA is responsible for licensing and overseeing community-based providers to ensure compliance with the Code of Maryland Regulations (COMAR) 10.63 et seq. to assist individuals and families with mental health, substance-related, or co-occurring disorders recover.

Revision of COMAR 10.63

The Code of Maryland Regulations (COMAR) 10.63 establishes the licensing and regulatory framework for community-based behavioral health programs in Maryland. These regulations are overseen by BHA and apply to both mental health and substance use services.

Overview and Legal Authority

The current regulations enumerate licensure and certification requirements for all providers. Key subchapters of COMAR 10.63 include provisions on:

- the general requirements for all licensed programs;
- standards for accreditation-based programs, such as outpatient services, residential programs, integrated behavioral health, and mobile treatment services;
- standards for residential programs;
- guidelines for non-accreditation programs, such as driving under the influence education and early intervention services; and
- processes for licensure and application approval and renewal.

The Legal Authority for COMAR 10.63 is Health-General Article, §§ 7.5–401 through 7.5–405, Annotated Code of Maryland.

Current program and service implementation occurs largely through an accreditation-based licensure model for many provider and service types (COMAR 10.63 et seq.). BHA is the designated credentialing entity, as required by the Health-General Article §19–2501-03, for recovery residences in accordance with the National Alliance for Recovery Residences (NARR) via the Maryland Certification of Recovery Residences (MCORR). MCORR oversees the application, certification, recertification, monitoring, and inspection of recovery residences to improve the quality of services. Additionally, BHA oversees Maryland RecoveryNet (MDRN), which partners with service providers across the state to fund access to recovery support services for individuals seeking treatment for substance use disorder (SUD) and co-occurring mental health and SUD.

BHA oversees the following programs which provide treatment and/or housing to individuals with SUD, including:[1]

[1] Program descriptions, eligibility criteria, provider enrollment and eligibility for each service is outlined in the Maryland Public Behavioral Health System (PBHS) Provider Manual. (2025). https://s18637.pcdn.co/wp-content/uploads/sites/75/carelon-maryland-pbhs-provider-manual.pdf

- The SUD Inpatient Institution for Mental Disease (American Society for Addiction Medicine [ASAM] Level 4.0);
- Low (ASAM 3.1), Medium (ASAM 3.3), High (ASAM 3.5), and Intensive (ASAM 3.7) residential treatment services for adults;
- Adolescents Residential SUD Treatment Non-Specialty Program (ASAM Level 3);
- Adult Residential SUD Treatment Court-Ordered Program (ASAM Level 3);
- Adult Residential SUD Treatment Pregnant Women and Women with Children (PWWC) Program (ASAM Level 3);
- SUD Partial Hospitalization Program (ASAM Level 2.5);
- SUD Intensive Outpatient Program (ASAM Level 2.1);
- SUD Outpatient Program (ASAM Level 1.0);
- Opioid Treatment Program (OTP);
- Gambling SUD Residential (ASAM Level 3.0);
- Maryland RecoveryNet (MDRN) Program;
- Maryland Certified Recovery Residences; and
- Driving Under the Influence education programs.

In addition, BHA funds opioid treatment programs in correctional facilities, including those under Maryland Health-Gen. § 8-507, and detention centers. However, such programs are overseen by the Maryland Department of Public Safety and Correctional Services' Office of Clinical Services[2] and Inmate Health, or the Governor's Office of Crime Control and Prevention Justice Reinvestment Division, in collaboration with the Maryland Office of Overdose Response, which offers Medication-Assisted Treatment in local correctional facilities.[3]

Recovery residences provide alcohol-free and illicit-drug free housing to individuals with substance-related disorders, addictive disorders, or co-occurring mental health, substance-related, or addictive disorders. The purpose of a recovery residence is to provide a safe and healthy living environment complemented by mutual, peer, or other recovery support for individuals with substance-related, addictive, or co-occurring disorders to initiate and sustain recovery. Recovery residences range from self-monitored resident-run residences to staff-managed residences in which clinical services are provided. BHA oversees *only* certified recovery residences.

Historical Context

As part of the FY2012 budget, the General Assembly asked the then-Maryland Department of Health and Mental Hygiene to convene a workgroup "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues" and to provide recommendations for developing such a system. The results of the workgroup and associated recommendations were included in a December 2011 Joint Chairman's Report (p. 68). The report also was written in anticipation of the *Patient Protection and Affordable Care Act*'s forthcoming changes, many of which would take effect in 2014.

The report included a proposal to consolidate the Mental Hygiene and Alcohol and Drug Abuse Administrations to create a single Behavioral Health Administration and to "carve out"

[2] Maryland Department of Public Safety and Correctional Services. (2024). Office of Clinical Services. https://www.dpscs.state.md.us/agencies/ots.shtml

[3] Governor's Office of Crime Control and Prevention. (undated). Criminal Justice Programs. https://gocpp.maryland.gov/criminal-justice-programs/

SUD services alongside mental health services to be managed by an Behavioral Health Administrative Services Organization (BH ASO). With this reorganization came the need to revise and consolidate regulations in COMAR 10.21 et seq. (Mental Hygiene) and 10.47 et seq. (Alcohol and Drug Abuse).

COMAR 10.63 et seq. was developed and became effective July 1, 2016. For most providers that were previously regulated under COMAR 10.21 and 10.47, 10.63 now required accreditation by one of the approved, national accrediting organizations such as The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

COMAR 10.63 has not been updated since 2015. Since that time, MDH received a vast amount of feedback that the regulations are vague or confusing, with broad interpretations of their application and oversight. As such, BHA prepared a regulatory package to provide a clear, comprehensive regulatory scheme for organizations operating community-based behavioral health programs in the State.

MDH proposed changes to 10.63 to protect the health, safety, and welfare of Maryland's residents, as, following the move to accreditation standards alone, the State witnessed a dramatic growth in provider enrollment and alarming concerns of potential Medicaid and other fraud, waste, and abuse.

Specifically, in 2022, $1.1 million worth of claims were audited with Psychiatric Rehabilitation Programs (PRP), Health Home, Level 2.5 Partial Hospital Program (PHP), and Level 2.1 Intensive Outpatient Treatment Programs (IOP) provider types accounting for over $600,000 in retractable Medicaid payments for many reasons, including but not limited to poor service documentation, providers enrolling patients in services for which they did not meet medical necessity criteria, and providers not meeting regulatory requirements for services provided. Additional concerns were identified and included:

- a trend of the same individuals identified to fulfill the duties for positions mandated by Maryland regulations are documented to be employed simultaneously by multiple organizations, effectively making quality patient care impossible.
- complaints from constituents, family members, community advocacy groups, and other provider types alleging potential fraudulent practices. Most often, complainants note that the provider is unknown to the participant, resulting in the allegation that the participant never received services.
- IOP and PHP programs have allegedly engaged in the illegal practice of offering free housing in exchange for required participation in their treatment program in order to bill Medicaid; however this is difficult to manage under the current statutory and regulatory schemes.

Given these concerns, the Centers for Medicare and Medicaid Services (CMS) permitted Maryland to place a six-month moratorium on new provider enrollment into Medicaid PRP, PHP, and IOP beginning July 1, 2024. The initial pause was extended to July 1, 2025. On June 30, 2025, MDH announced it would lift the moratorium on newly enrolled PRP, PHP, and IOP providers in Allegany; Calvert; Caroline; Cecil; Charles; Dorchester; Garrett; Kent; Queen Anne's; St. Mary's; Somerset; Talbot; Worcester; and Wicomico counties on July 1, 2025. The pause remains in effect in Anne Arundel, Baltimore, Carroll, Frederick, Harford, Howard,

Montgomery, Prince George's, and Washington counties and Baltimore City.[4] The agreement also required that MDH complete and promulgate a comprehensive revision of licensure regulations (COMAR 10.63 and 10.21) and corresponding Medicaid regulations (COMAR 10.09) to include stronger State oversight for service delivery.

The moratorium was necessary as Maryland is an "any willing provider" state for behavioral health. This means that any provider or program who meets statutory and regulatory requirements must be issued a license or certification and may enroll as a Medicaid provider. (By contrast, managed care entities have the ability to selectively contract with providers subject to federal regulations that require network adequacy and standards of access to timely care.[5])

Status of Current Regulatory Revisions

In July 2024, BHA hosted six regional meetings detailing proposed changes to COMAR. A draft version of regulations for providers to submit informal written comments was posted from July through October 2024. These regional meetings garnered over 900 provider attendees and nearly 350 comments. Groups providing comments included: Community Behavioral Health Association of Maryland, Maryland Association for the Treatment of Opioid Dependence, Maryland Addiction Directors Council, Optum Maryland, National Alliance on Mental Illness, Baltimore City Substance Use Treatment Directorate, and Local Behavioral Health Authorities (LBHAs) (Carroll, Cecil, Garrett, and Wicomico).

In response to significant public comments, additional edits were undertaken in order to address concerns raised by the regulated community related to clarity within the regulatory scheme. After incorporating feedback, MDH began a three-phase approach to revising 10.63:

- Phase 1, Civil Money Penalties (10.63.08). Finalized April 14, 2025, this subchapter created, for the first time, civil money penalties for community-based behavioral health organizations with material and egregious violations of state or federal laws or regulations;
- Phase 2, Chapters 1, 2, 6, and 9. The second phase proposed changes to address long-standing issues regarding vagueness and inconsistent interpretations of regulations for community-based behavioral health programs:
    - Chapter 1: Compliance and Reporting Requirements (10.63.01) to reduce misinterpretation and enhance the MDH's ability to ensure consistent provider accountability.
    - Chapter 2: Staffing Requirements (10.63.02) establishes the staffing requirements for all community-based behavioral health organizations licensed under this subtitle.
    - Chapter 6: Application and Licensure Process (10.63.06) provides clear

[4] Maryland Department of Health. (2025). Maryland Department of Health Lifts Pause for Certain Behavioral Health Providers in Specific Jurisdictions. https://health.maryland.gov/newsroom/Pages/MDH-lifts-pause-for-certain-behavioral-health-providers-in-specific-jurisdictions.aspx

[5] See, e.g., Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 Federal Register 41002. https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

application requirements and licensing procedures for community-based behavioral health organizations to streamline submission, review, and decision-making, and enhance the ability to ensure that all licensed organizations fully comply with relevant regulations.
    - Chapter 9: Corrective Actions and Sanctions for Non-Compliance (10.63.09) strengthens the potential actions MDH might take when provider organizations fail to meet the regulatory requirements, as well as creating more transparency with provider organizations regarding the disciplinary measures that may be implemented for non-compliance.
- Phase 3, Programmatic Chapters. The third and final phase, initially slated to occur during the Summer of 2025, was to create more detailed requirements for each licensed program type.

Additional listening sessions occurred on June 9 and June 10, 2025 during which the MDH announced that the regulations would be altered to:

- Align with the *Preserve Telehealth Access Act of 2025* to ensure that participants receive quality and medically necessary behavioral health care in-person and through the utilization of telehealth audio-only behavioral services given the complex nature of behavioral health;
- Correct an unintentional error in which BHA inadvertently failed to include the Psychiatric Rehabilitation Association (PRA) as a recognized certification in the proposal for rehabilitation specialists; and
- Permit Certified Associate Counselor – Alcohol and Drug (CAC-AD) to be clinical supervisors, but, based on the Board of Professional Counselors and Therapists regulations (COMAR 10.58.07.07A and COMAR 10.58.07.13), require that CAC-ADs have appropriate clinical supervision.

MDH acknowledged concerns raised by stakeholders during the meeting, including:

- Only a partial proposal of regulations was available for review and that it was difficult to offer complete feedback on general regulations without also reviewing program-specific regulations;
- Anticipated difficulty recruiting and retaining dedicated program and organization-level staff despite similar requirements set by the Office of Health Care Quality for their licensees or requirements set by sister states or jurisdictions such as Virginia, Delaware, and the District of Columbia. MDH explained that for any provider having difficulties meeting the new staffing standards, the Department's existing variance process could be used to provide conditional approvals to allow organizations to remain licensed and operational while the organization works to obtain the required staffing to meet regulatory standards;
- Coming into compliance with federal requirements pertaining to the Medicaid Clinic Benefit that physicians provide oversight of outpatient mental health clinics to comport with federal requirements. MDH explained that as we noted in the June 18 Carelon provider transmittal, Federal law at Title XIX, Section 1905(a)(9) of the Social Security Act and federal regulations at 42 Code of Federal Regulations (CFR) § 440.90 require that clinic services billed to Medicaid under the Clinic Option be rendered by or under the direction of a physician. CMS released a final rule in November 2024 that reiterated this requirement and has informed states that there is no waiver for this requirement; and
- Critical incident reporting. MDH explained that this was not an expansion of critical

> incident reporting but an enumeration of all incidents already required to be reported by providers and that such reporting is aligned with other federal initiatives to expand critical incident reporting. For example, the July 2024 *Ensuring Access to Medicaid Services Final Rule* establishes a standard definition of a critical incident to include, at a minimum, verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.[6]

On June 16, 2025, the Joint Committee on Administrative, Executive, and Legislative Review (AELR) issued a memo (see Appendix I) to MDH notifying the Department of "its intent to conduct a more detailed study of these regulations and to ask that the [D]epartment delay final adoption of the regulations. The committee expects to engage the department in a constructive review of issues relating to these regulations….The committee wishes to ensure that concerns raised by stakeholders about the regulations are addressed. To this end, the committee encourages the department to work together with the stakeholders to resolve the issues raised by stakeholders concerning these regulations."

In response to AELR's memo, MDH held seven additional, virtual stakeholder meetings in July and August 2025 to receive additional feedback on each of the outstanding issues raised by stakeholders. Despite these meetings, MDH was unable to satisfy each of the concerns raised by stakeholders. On August 15, 2025, MDH announced the Department's intent to withdraw the proposed COMAR 10.63 regulations which were published on May 16, 2025 in the Maryland Register. A formal notice of withdrawal published in the Maryland Register on August 22, 2025.

MDH is currently redrafting 10.63 and anticipates releasing all subchapters for informal comment in the late fall or early winter of 2025 with a goal of promulgation in the late spring or early summer of 2026.

Improvement to the Oversight of SUD Treatment Programs

This section first describes the actions MDH/BHA has taken to improve the oversight of SUD treatment programs. Those improvements are followed by an overview of the current review process for SUD providers.

During the moratorium (see *Historical Context*, above), MDH strengthened its collaborative relationship with the Office of Inspector General for Health's (OIGH) investigations unit. The Department has successfully implemented a regular schedule for meetings and has established a Standard Operating Procedure for referrals with the OIGH investigations unit. These initiatives were specifically designed to facilitate an increase in the referral acceptance rate from the Department. Furthermore, the MDH's BH ASO investigated 79 fraud tips received from Maryland constituents regarding potential fraud, waste, and abuse within community-based behavioral health programs. Significantly, each of these tips was determined to contain credible allegations and has been subsequently referred to the OIGH. Since the implementation of the

[6] See 42 CFR § 441.302(a)(6)(i)(A).

moratoria, the Department has submitted a total of 103 referrals to OIGH, of which five investigations have been transitioned to the Medicaid Vulnerable Victim Unit.

In addition, MDH/BHA has:

- Enhanced licensing and auditing by implementing a monitoring system that prioritizes programs with higher patient acuity or a history of compliance issues. The number of unannounced site inspections has increased, as has the use of standardized audit tools;
- Used data to identify outliers in prescribing practices, relapse rates, and readmission trends using the Crisis Data Warehouse and Medicaid claims data;
- Fostered cross-agency collaboration between BHA and the Office of Controlled Substances to detect irregularities in prescribing;
- Increased oversight when there are findings of non-compliance by requiring corrective action plans, initiating license suspension, and referring to the Office of the Attorney General, as applicable; and
- Strengthen requirements for collecting patient feedback and establishing grievance reporting systems.
- BHA conducted multiple training and technical assistance sessions with the Local Behavioral Health Authorities, Local Addiction Authorities, and Core Service Agencies on investigation of complaints and critical incidents reports.

<u>Compliance Review Process for SUD Treatment Programs</u>

BHA's Office of Licensing & Compliance, Managed Care & Quality Improvement conducts statewide monitoring and investigative activities to:

- Ensure publicly funded and private treatment programs comply with State and federal statutes, regulations, accreditation standards, and conditions of grant award;
- Monitor and ensure the provision of quality, comprehensive person-centered services; and
- Investigate and detect fraud, waste, and abuse.

The Compliance Unit maintains a list of licensed programs. After a program is licensed, the program information is added to the master list and assigned a review cycle (annual, twice yearly, or quarterly) based on the service or program type. The master program list is updated upon notification of a change in key staff, program location, type of service provided, frequency of monitoring, and discontinuance of services.

The Compliance Unit maintains a spreadsheet with each program's name, date of review, type of review, and assigned evaluator. Evaluators receive a google calendar invite for each review they are assigned to complete. Compliance review schedules are established based on the program's review cycle:.

- Initial reviews are conducted approximately six months after the initiation of services.
- Newly established providers are monitored quarterly with eligibility for a reduction in the frequency of monitoring after four consecutive findings of compliance.
    - New providers must complete virtual training, *Overview of the Compliance Review Process* prior to the initial review.
    - Increased monitoring of new and established providers may be implemented as a result of complaints or critical incidents.

- Announced and unannounced investigations follow complaints and reports of critical incidents.

Notification of Compliance Review

The Compliance Unit sends a Notification of Compliance Review to the provider with a Provider Document Request list (identifies records and documents that will be reviewed) and a request to complete and return the Key Staff and Program Information form (used to update the master list). Each LBHA is notified, as are other entities when applicable (e.g., justice services for Maryland Health-Gen. § 8-507 programs).

Conducting Compliance Reviews

Evaluators are assigned to work in teams or individually depending on the size of the program. Upon arrival, the evaluator facilitates an entrance interview (meet with key staff to explain the purpose of the review and receive requested documents). Compliance reviews consist of two components:

(1) Administrative Review Form, which includes but is not limited to, license and accreditation, policies, personnel records, staff credentials, supervision and training, quality improvement activities, complaints and critical incidents, group/program schedules, review of active patient census from which records are selected for review; and
(2) Patient Record Review Form, which includes, but is not limited to ensuring patients meet ASAM criteria for admission, clinical concerns identified in the comprehensive assessment are addressed in the initial treatment plan, treatment plans are revised to reflect the current needs of the patient, positive drug screen results are addressed with the patient/referral to a higher level of care as warranted, informed consent and releases of information are compliant with confidentiality and HIPAA requirements, individual and group session notes include the required and clinically appropriate documentation of services provided, and the type and frequency of clinical services received is consistent with the needs of the patient.

At the conclusion of the compliance review, the evaluator facilitates an exit interview with key staff to discuss preliminary findings.

Post Compliance Review

After a compliance review, the evaluator(s) completes verification of credentials and other tasks necessary to finalize the review and prepares the Review Summary which consolidates the administrative and patient record review findings. Next, the evaluator prepares a finding(s) letter and submits it for supervisory review, if required.

Within 30 days of the compliance review, a Letter of Finding or a Notice of Deficiency is sent to the provider and the Compliance Unit requests a plan of correction. Upon receipt, the plan of correction is reviewed to determine if the stated corrective action sufficiently addresses the deficiency. Providers receive notification that the plan has been approved, or the plan requires revision; the LBHA is copied, as are other relevant parties (e.g., justice services for Maryland Health-Gen. § 8-507 programs). Established providers may request virtual training and technical

assistance, or may receive such assistance following concerns identified by an evaluator during a compliance review.

All compliance review related documents are filed in a shared program folder with limited user permissions (i.e., only appropriate staff may access all or portions of the folder). Compliance review data (review findings, date of notification of findings (compliance or deficiency), date the plan of correction is received, date plan of correction letter (approved/requires revision is sent) is entered into a tracking sheet for ongoing data analysis.

Improvements to the Procedures for Certification, Monitoring, and Oversight of Recovery Residences

This section first describes the actions MDH/BHA has taken to improve the certification, monitoring, and oversight of recovery residences followed by an overview of the current review process for certified entities.

Certified recovery residences provide safe and structured environments that support individuals recovering from SUD. MCORR recognizes all certified recovery residences. As of September 2025, the state has 285 recovery residences and 2,704 certified beds. Anne Arundel County and Baltimore City have the highest numbers of recovery residences and beds. Anne Arundel County leads with 92 recovery residences and 1014 beds, while Baltimore City has 81 residences and 602 beds. MCORR does not recognize non-certified recovery residences. While these residences can still offer a supportive environment, they operate without formal oversight or verified quality and safety standards.

MDRN collaborates with State Care Coordination (SCC) entities and MCORR to ensure access to certified recovery residences for individuals in early recovery who have been diagnosed with SUDs or co-occurring conditions. These services help cover the costs of an individual's stay in a recovery residence when other resources—such as those from the individual, their family, the community, or various private and public sources—have been used up or are unavailable. MDRN funding is intended to supplement existing services and funding streams and is not meant to replace them. Individuals eligible for MDRN can access SUD Client Support Services funding through their LBHA or Local Addiction Authority. This funding can be used to purchase emergency goods and other services to address needs that may hinder their recovery.

The administration oversees the work of certified recovery residences by collecting data and information from all certified and MCORR approved facilities. This includes information on applicant demographics, staffing, and property details.

In a memo, BHA described changes to the MDRN program, effective October 1, 2025 that include but are not limited to:

- Participant enrollment and eligibility criteria. Individuals screened by SCC State Care Coordination (SCC) must meet the eligibility criteria for both SCC and MDRN (which requires additional screening) for client support funds/or recovery housing. These include being 18 or older; Maryland residency for the duration of their relationship with an assigned SCC; have a documented primary SUD diagnosis or co-occurring SUD and mental health disorders; have signed, written documentation from the treating clinician stating that the individual is actively engaged in SUD related treatment services for the full duration of the individual's eligibility for MDRN services; be transitioning out of an

ASAM Level of Care 3.1, 3.3, 3.5, or 3.7 withdrawal management program, be transitioning from from a controlled environment (jail/detention center), or be referred by another authorized access point (e.g., homeless shelter, recovery residence, ASAM Level of Care 1, 2.1, 2.5); have an income at or below 250 percent of the Federal Poverty Level; and be actively seeking community-based recovery support services. The SCC must confirm that the participant meets eligibility criteria for both the SCC program and MDRN upon admission, and throughout the duration of participation.

- Bed days. MDH will maintain MDRN as an annual benefit with the ability to access services for 60 days. In addition, MDH will grant exemptions for a one time additional 30-day extension for extenuating circumstances, including but not limited to, judiciary requirements, documented ongoing or emergent health conditions and conditions of release. The 30-day extension is contingent on BHA receiving an updated Individual Recovery Plan demonstrating the need for an additional 30 days of services; updated, signed, written documentation from the treating clinician stating that the individual was recently engaged or currently engaged in SUD related treatment services for the full duration of the individual's eligibility for MDRN services; and supporting documentation disdemonstrating conditional release mandates and judicial directives.
- Maintaining the pause on new MDRN provider locations. Continuing the pause will allow MDH to assess the level of service needed and the provision of MDRN across the State, and to align the location of services with existing or emerging needs, with the goal of targeted outreach and engagement to the most affected communities.
- Data collection. Effective January 1, 2026, BHA will implement a data collection and performance-based outcome measurement system to track MDRN provider metrics and quality. The metrics to be tracked include the total number of beds, by location; the total number of individuals served, by location, a count of stays, by individual; discharges to due relapse; the average length of stay prior to relapse; and the number of individuals transitioning to independent living.
- Oversight and monitoring. Effective January 1, 2026, MDH will increase the monitoring of MDRN providers through chart and case audits, in-person site visits, and data review and reconciliation. MDRN Providers will be required to provide recovery outcome data to include total number of individuals referred, served, assessments completed, recovery plans completed, discharges due to relapses, discharges to other locations, transitions to independent living, client bed days prior to client relapse and individuals employed.

Application and Compliance Review Process for Recovery Residences

Entities wishing to become certified recovery residences must first submit an electronic application to BHA. Complete applications are reviewed by BHA in order of priority: relocations, changes, renewals, and initial applications.

A first reviewer logs and verifies all required documentation (e.g., MCORR application, proof of ownership, insurance, policy manual, fire and safety report). If complete, documents are attached to a shared drive with appropriate user permissions.. If incomplete, the MCORR Manager notifies the provider. Once complete, the MCORR Manager logs the application and assigns it to a Field Assessor for a Level 2 review. The Level 2 Reviewer verifies documentation and may contact the provider for clarification. A Final Review Checklist is submitted to the MCORR Manager. The MCORR Manager reviews the application and documentation for validity and, once validated, issues the Certificate of Compliance if it has been determined that the provider

has met the NARR standards and Department's requirements for certification. If the MCORR Manager determines that certification should not be granted due to errors, the application is returned for correction. If a certification is denied, the organization receives a denial notice with appeal rights outlined in accordance with the Administrative Procedures Act.

Complaints and Critical Incidents

Complaints and Critical Incidents are submitted via the online Complaint or Critical Incident form. Once BHA receives the form, BHA reviews the critical incident/complaint. If the complaint or critical incident concerns a certified recovery residence, BHA investigates the complaint or critical incident and takes any appropriate action within the confines of the authority of the MDH. In FY25, BHA received 53 complaints and incident reports related to SUD programs (35 involved SUD Residential programs and 18 reports involved certified recovery residences).

Initial and Ongoing Monitoring

Certified Recovery Residences are subject to announced and unannounced site visits. MCORR conducts on-site inspections of a recovery residence before issuing a certificate of compliance and at least once during each renewal period. When MCORR has a complaint and/or critical incident submitted pertaining to a certified recovery residence, MCORR may conduct an unannounced site visit in order to compile information for the investigation. MCORR may also conduct unannounced site visits at any time to ensure that the MCORR-certified house is meeting all standards and the Department's requirements for certification.

Conclusion

The Department remains committed to quality improvement in the public behavioral health system, including through the use of data analyses, continuous performance improvement processes and improvements to regulatory and procedural monitoring and oversight of treatment and "support outside of clinical treatment" such as housing to ensure "people in recovery feel supported and empowered to continue on their recovery journey."[7]

[7] Maryland's Office of Overdose Response. (2025). Maryland's Overdose Response Strategy Priorities for Reducing Overdoses and Increasing Equitable Access to Care. https://stopoverdose.maryland.gov/wp-content/uploads/sites/34/2025/02/Maryland-Overdose-Response-Strategy.pdf

Appendix I.

MARY L. WASHINGTON, PH.D
SENATE CHAIR

SAMUEL I. "SANDY" ROSENBERG
HOUSE CHAIR

MARYLAND GENERAL ASSEMBLY
JOINT COMMITTEE ON ADMINISTRATIVE, EXECUTIVE, AND LEGISLATIVE REVIEW

June 16, 2025

Dr. Meena Seshamani, Secretary
Maryland Department of Health
201 West Preston Street
Baltimore, Maryland 21201

Re: DLS Control No. 25-061
Maryland Department of Health:
Community-Based Behavioral Health Programs and Services:
Requirements for All Licensed Programs: COMAR 10.63.01.01 – .13
Programs Required to be Accredited in Order to be Licensed to Provide Community-Based Behavioral Health: COMAR 10.63.02.01 – .14
Application and Licensure Process: COMAR 10.63.06.01 – .21
Corrective Actions and Sanctions: COMAR 10.63.09.01 – .10

Dear Secretary Seshamani:

The Joint Committee on Administrative, Executive, and Legislative Review (AELR) is currently reviewing the above-referenced proposed regulations, which were published in the May 16, 2025 issue of the *Maryland Register*.

According to the Maryland Department of Health, these regulations update Chapters 1, 2, 6, and 9 under COMAR 10.63, which governs community based behavioral health programs. The regulations address licensure requirements, application procedures, program operations, and sanctions and corrective actions for violations.

For the reasons outlined below, and in accordance with the committee's authority under § 10-111 of the State Government Article, the committee hereby notifies you of its intent to conduct a more detailed study of these regulations and to ask that the department delay final adoption of the regulations. The committee expects to engage the department in a constructive review of issues relating to these regulations.

The purpose of the requested delay is to provide the committee with an opportunity to examine more closely a number of issues relating to whether the statutes under which the

regulations were adopted authorize the adoption and whether the regulations conform to the legislative intent of the statutes. The committee wishes to ensure that concerns raised by stakeholders about the regulations are addressed. To this end, the committee encourages the department to work together with the stakeholders to resolve the issues raised by stakeholders concerning these regulations.

To facilitate its review, the committee would be grateful if the department would submit to the committee copies of any correspondence that the department received concerning the regulations during the public comment period.

The committee appreciates your cooperation in this matter.

Sincerely,

Senator Mary L. Washington
Senate Chair

Delegate Samuel I. Rosenberg
House Chair

MLW:SIR/TNB:KPK/bal

cc: President Bill Ferguson
Speaker Adrienne A. Jones
AELR Committee Members
Sally Robb, Senate Chief of Staff
Matthew Jackson, House Chief of Staff
Jordan Fisher Blotter, Regulations Coordinator, Maryland Department of Health
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