March 5, 2025

House Health & Government Operations Committee

House Bill 1289 – Mandated Regulations for Discharge Procedures and Referral Services in Drug and Alcohol Treatment Programs

POSITION: UNFAVORABLE

The Recovery Housing & Treatment Center Coalition of Maryland (RHTC) appreciates the opportunity to provide testimony in opposition to House Bill 1289. RHTC represents a diverse network of recovery residences, group homes, treatment centers, and essential services that support Maryland's comprehensive continuum of care for individuals with substance use disorders (SUDs). Our coalition is dedicated to educating the public, policymakers, and stakeholders on the critical role of recovery facilities in improving individual and community health outcomes.

While we acknowledge the importance of ensuring safe and appropriate discharge practices for individuals in drug and alcohol treatment programs, we believe that HB1289 is unnecessary and misaligned with national standards in addiction medicine. The bill introduces redundant and overly prescriptive requirements that would hinder the flexibility and clinical discretion of treatment providers, ultimately undermining the effectiveness of patient-centered care.

Maryland's current regulations, particularly COMAR 10.47.01.04, already mandate individualized treatment planning, including criteria for discharge, comprehensive assessment of physical and mental health needs, and required referrals to ancillary services. Treatment programs are already required to develop written discharge summaries that document the reason for discharge, services provided, and recommendations for continuing care. HB1289 does not introduce new substantive protections beyond what is already required by state regulations.

Additionally, the Maryland Department of Health (MDH) has been working to update its regulations in accordance with American Society of Addition Medicine (ASAM[i])'s national standards and best practices. While RHTC does have concerns that the proposed regulations are not as to date as the most recent ASAM recommendations, we do appreciate the efforts of MDH and stakeholders to update COMAR regulations to better align with national standards. These updated standards, expected to be finalized in the spring/summer of 2025, will provide a more comprehensive, evidence-based framework for patient care and discharge planning.[ii]

HB1289 proposes standards that are not in alignment with ASAM, potentially causing confusion, inconsistency, and operational challenges for treatment programs that are striving to meet national best practices. It is critical that Maryland adheres to the most recent recommendations in ASAM, rather than implementing state-level regulations that conflict with national standards.

The bill's rigid discharge mandates could limit the ability of clinical professionals to exercise judgment in determining the most appropriate and timely discharge plans for patients. Requiring treatment programs to actively facilitate entry into external services, such as employment support and legal assistance, places an undue administrative burden on providers who are already operating under strict compliance requirements. Unintended consequences may include delays in discharge, unnecessary administrative obstacles, and increased costs—all of which could hinder access to treatment rather than improve it.

Lastly, HB1289 fails to consider the complexity of housing and recovery services. The bill attempts to prevent discharges that would result in homelessness but does not account for the reality that some individuals may refuse housing or other services despite best efforts by providers. Maryland already has a network of recovery residences, group homes, and transitional housing options available, and treatment programs currently work to ensure appropriate referrals whenever possible. Instead of imposing additional barriers to treatment, Maryland should focus on enhancing partnerships and best practices to better serve the needs of Marylanders.

In conclusion, RHTC firmly believes that House Bill 1289 is unnecessary, duplicative, and misaligned with national best practices in addiction treatment.

For these reasons, we respectfully urge the General Assembly to oppose HB1289 and to instead allow further work around the updating of regulations in COMAR to take full effect before introducing additional legislation.

Thank you for your time and consideration. We welcome further discussion on how to best support recovery and treatment programs in Maryland.

For more information call or email:
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[i] The American Society of Addiction Medicine (ASAM) 4.0 Standards establish a framework for delivering the highest level of care for individuals with substance use disorders. These standards focus on medically managed intensive inpatient services, providing 24-hour medical care, crisis stabilization, and comprehensive treatment for patients with severe addiction and co-occurring conditions. ASAM 4.0 emphasizes an individualized, multidisciplinary approach that integrates medical, psychiatric, and therapeutic interventions to address complex withdrawal symptoms, stabilization needs, and ongoing recovery planning. The goal is to ensure patient safety,

continuity of care, and long-term recovery success by providing structured, evidence-based treatment in a highly supportive environment.

[ii] Please see the following document regarding our concerns on the proposed regulations as they pertain to ASAM.

August 26, 2024

Maryland Department of Health
Behavioral Health Administration

Dear Members of the Behavioral Health Administration,

The Recovery Housing and Treatment Centers Coalition of Maryland (RHTC) represents a coalition of recovery residences, group homes, and treatment centers throughout Maryland. We are committed to maintaining and expanding recovery facilities and services in our state to benefit individuals in recovery, the community, and the State at large.

We are writing to submit our comments and concerns regarding the recently proposed regulatory changes to the Code of Maryland Regulations (COMAR) under 10.63. These proposed changes, as currently drafted, do not align with the most recent national standards of treatment and care, specifically the American Society of Addiction Medicine (ASAM) Criteria. We respectfully request that the proposed regulations be updated to reflect the 4th edition of the ASAM Criteria, which was released in December 2023.

General Concerns
Our primary concern is that the proposed COMAR 10.63 changes do not reflect the most current version of the ASAM Criteria. We have been informed during various trainings and meetings that the Behavioral Health Administration (BHA) has yet to adopt and implement the changes in the 4th edition of ASAM. We believe that any regulatory updates to COMAR should align with the most current ASAM Criteria.

Specific Concerns by COMAR Section
10.63.01 Definitions

- **Clinical Director Definition**: The definition of "Clinical Director" in 10.63.01 differs from the definition provided in 10.63.03. Specifically, 10.63.01 assigns clinical oversight responsibility, while 10.63.03 assigns operational responsibility. This inconsistency needs clarification.
- **Recovery House Staff Member Definitions**: The definitions provided are overly broad, and the reference to MSARR, which has not existed for years, is outdated. Clarification on whether MSARR is MCORR's successor and the associated membership dues is requested in writing to confirm the unclarity expressed in Stakeholder meetings.
- **Group Home Definitions**: The definitions lack clarity regarding whether they pertain to public or private entities.

10.63.02 Program Requirements

- **Section 10.63.02.03 B7**: The language "Not provide housing that offers below-market-rate housing..." is vague. We request clarification on how "below-market-rate" is determined and whether this regulation applies to services reimbursed by private insurance payers. We believe it should apply to all licensed programs, regardless of the funding source.

10.63.03 Services

- **Group Counseling Sessions**: The requirement for group counseling sessions to consist of 15 persons or less in level 2.1 programs needs further detail, particularly regarding the consistency of caseload requirements across different levels of care.
- **Participant to Counselor Ratios**: The proposed regulations inconsistently define participant-to-counselor ratios across various levels of care (e.g., 2.5 level care vs. Outpatient level 1 LOC). More detail and clarity are needed to eliminate confusion.
- **Compliance with ASAM Criteria**: Multiple sections of 10.63.03 reference the need to meet "current ASAM criteria," which is contradictory given that the regulations are not based on the 4th edition of ASAM. This makes compliance challenging for providers.
- **PHP Program Clinical Director**: It is proposed that a PHP program must have a full-time Clinical Director. Further clarification is needed around this change in staffing. I.e., would this mean they would be fulfilling the role at the same time as being engaged with residential services?

10.63.04 Residential Services

- **Non-existent ASAM Level**: The 3.3 LOC does not exist in the current ASAM (4th edition). We propose aligning 3.5 clinical hours with ASAM 4.
- **Environmental/Life Safety Requirements**: The requirement for 1 full bathroom for every 4 residents should be consistent across all programs. Additionally, there needs to be clarity on whether the same requirements apply to recovery residences.
- **PRP Services**: Clients will be ineligible for PRP services at the same time.

10.63.05 Licensing

- **Non-Accreditation Based License**: The regulation requires clarification on what constitutes a valid non-accreditation-based license or certificate for operating in Maryland.

10.63.06 Complaint Investigations

- No major concerns, but we request clarity on certain ambiguous statements.

10.63.09 Enforcement

- **Civil Money Penalties**: The regulation states that the Department can impose a civil money penalty of up to $1,000 per day or per incident. The use of "or" suggests that the $1,000 per day cap does not apply to per incident penalties, which needs clarification.

Additional Concerns Based on Stakeholder Feedback

1. **ASAM 4 Adoption**: Despite the intention to use ASAM 4, it was disclosed that the regulations are not being fully promulgated based on ASAM 4, with the exception of increasing the 3.1 clinical hours. This partial adoption causes confusion.

2. **Bedroom Occupancy**: There was a comment indicating a move towards allowing only 2 persons per bedroom, regardless of square footage, aligning with hospital settings. If passed as currently drafted, this could cause may treatment centers to lose beds, therefore lowering the amount of available care for the residents of Maryland when they need it the most. This requires further discussion and clarification.

Conclusion

In conclusion, we urge the Behavioral Health Administration to consider these concerns and make the necessary revisions to the proposed regulations to ensure they reflect the most current standards of care, as outlined in the ASAM 4th edition. We appreciate your attention to these matters and look forward to continuing our collaborative relationship.

Thank you for your time and consideration.
The Recovery Housing and Treatment Centers Coalition of Maryland (RHTC)

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