November 17, 2023

Alyssa Lord
Deputy Secretary for Behavioral Health
Maryland Department of Health

Dear Alyssa,

Thank you for the opportunity to review a pre-publication draft of proposed changes to the 10.63 licensing regulations. CBH appreciates the opportunity to share our concerns and recommendations with the Department prior to the implementation of such extensive revisions.

CBH is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

Normally CBH offers detailed comments and suggested amendments when responding to proposed regulations. In this instance, however, there is a wide divergence between our recommendations and the state's proposed regulations. As we suggested in October, we think that a small group dialogue between BHA and several CBH leaders may be useful in better understanding the needs, limitations and solutions as viewed by the state and its providers.

In lieu of a detailed response, our comments below focus on key areas of divergence between the proposed regulatory approach and the alternatives suggested by CBH.

CBH strongly supports regulatory reform that promotes the delivery of high-quality care, offers clear and achievable standards to providers, and ensures that accountability for substandard care is addressed efficiently and effectively. We believe that BHA shares our goals, and we invite further dialogue with the Administration on the concerns outlined below.

A. Clearly define which entity is subject to regulatory standards.

The existing regulations define program as an organization,[1] which was a consensus agreed upon by the leadership of the Behavioral Health Administration, the Attorney General's office, and MDH regulatory experts during the drafting of the 10.63 regulations. The revised definition of program diverges significantly from the current understanding and agreement.

In recent years, BHA has tried to reinterpret the definition of program as a service-line entity (OMHC, ACT, PRP), rather than organization. The proposed regulations are an opportunity for BHA to clarify which obligations apply to organizations, service-line licenses, or sites. As written, BHA has added layers of definitions that introduce confusion rather than clarification. The proposed regulations describe six entities as subject to regulation: agency,[2] behavioral health program,[3] program,[4] provider,[5] and organization.[6] The six layers do not add up to a cohesive picture of which entity is subject to regulation.

Beyond the confusing definitions, the proposed regulations are not internally consistent about what entity is which. For example, an ***organization*** is required to submit contact information for its Board of Directors when applying for a program license,[7] while a ***behavioral health program*** is required to have a Board of Directors.[8] Sites are defined in one place as occurring under organizations[9] but elsewhere as under programs.[10]

We propose keeping the definition of "program" as consistent with new definition of "organization." The new definition as proposed has implications for staffing and notification of closures. It will add significantly to provider bottom lines and create additional challenges for providers that must close service lines due to financial losses or other exigencies.

[1] COMAR 10.63.01.02B (47) "Program" means an organization that provides or seeks a license to provide community-based behavioral health services.
[2] Proposed COMAR 10.63.01.02B(8) "Agency" means provider.
[3] Proposed COMAR 10.63.01.02B(15) "Behavioral health program" means: (a) A substance-related disorders program; (b) a mental health disorders program; (c) An addictive disorders program; or (d) A program that consists of a combination of §B(15)(a) – (c) of this regulation.
[4] Proposed COMAR 10.63.01.02B(78) "Program" means the site and service combination which is recognized through licensure to offer an organized system of activities perform for the benefit of persons served.
[5] Proposed COMAR 10.63.01.02B(80) "Provider" means: (a) An individua, association, partnership, corporation, unincorporated group, or any other person authorized, licensed, or certified to provide services for program recipients; and (b) The Department identifies as program provider by the issuance of a license.
[6] Proposed COMAR 10.63.01.02B(70) "Organization" means a legal entity under which programs and services operate.
[7] Proposed COMAR 10.63.06.02A(2)).
[8] Proposed COMAR 10.63.01.02A(17)).
[9] Proposed COMAR 10.63.01.02B(93)
[10] Proposed COMAR 10.63.01.02B(78)

B. Preserve access to telehealth where desired by client and clinically appropriate.

1. Telehealth should be limited by client choice in all programs, not just OMHCs.

The proposed regulations require patient consent to telehealth only for OMHCs,[11] but nowhere else. CBH believes that client preference for telehealth or in-person services should be a standard incorporated into every program. We believe the client consent to telehealth language in the OMHC regulations should be mirrored in the other service-specific sections so that while telehealth remains a viable option for many programs, the individual served retains the choice to receive in-person services.

2. Telehealth should be limited by clinical appropriateness as evaluated for each patient.

The Preserve Telehealth Act of 2021 requires Medicaid to cover services "appropriately delivered" through telehealth, including services delivered by behavioral health programs.[12] The legislature's codified wishes allow Medicaid to conduct utilization reviews or set preauthorization policies to help determine whether telehealth is appropriately delivered.[13] The proposed regulations eschew the codified approach to telehealth coverage and introduce inflexible licensing limitations on the use telehealth in ten types of licensed programs.

Telehealth is limited in eight of the nine types of licensures for mental health programs (89%),[14] but in only three of thirteen types of SUD program licenses (23%).[15] The proposed regulations treat telehealth differently even at the same level of care. Telehealth is:

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[11] Proposed COMAR 10.63.03.05E states, "Telehealth services shall be provided with the documented informed consent of the individual served, and the individual shall have the choice to receive in-person services" (p. 38).
[12] *See* Md. Code Health General §§ 15-141.2(a)(4)(ii), (b)(1), (c).
[13] *Id*. at (e).
[14] Telehealth is limited in the following eight licensed mental health programs: Proposed COMAR 10.63.03.04B(2)(a)(ii), (6)(c), 6(h)(iii) (mobile treatment services); 10.63.03.05A(3) (outpatient mental health center); 10.63.03.08B (mental health partial hospitalization program); 10.63.03.09P (psychiatric rehabilitation program for adults); 10.63.03.10M (psychiatric rehabilitation program for minors); 10.63.03.14 (respite); 10.63.04.04E(3) (mental health residential crisis service); 10.63.04.05J(a) (residential rehabilitation program). Telehealth is not limited in only a sole level of licensure: 10.63.03.15 (supported employment).
[15] Telehealth is limited in the following three licensed substance use treatment programs: Proposed COMAR 10.63.04.09 (SUD residential Level 3.7); 10.63.04.10 (SUD RCS); 10.63.05.05 (DUI program). Telehealth is not limited in ten levels of licensure: Proposed COMAR 10.63.03.03 (SUD IOP); 10.63.03.06 (Outpt SUD L1); 10.63.03.07 (SUD PHP); 10.63.03.16 (incarcerated SUD); 10.63.03.17 (WMS); 10.63.03.18 (OTP); and 10.63.04.06 (SUD residential Level 3.1); 10.63.04.06 (SUD residential Level 3.1); 10.63.04.07 (SUD residential Level 3.3); and 10.63.04.08 (SUD residential Level 3.5).

- wholly prohibited in mental health partial hospitalization programs, while permissible without limit in substance use disorder partial hospitalization programs;[16]
- limited in outpatient mental health treatment, but available without limit in outpatient substance use treatment.[17]

In particular, we note our strong concerns with limitations on the use of telehealth for medication monitoring[18] and for crisis response or evaluation across multiple programs.[19] We propose adding language that would allow the use of medication adherence technology that incorporates the individual's downloading of medications along with notification to staff and video telehealth capability. Rationale: The workforce crisis demands that we use technological solutions to stretch our workforce. In this instance, the technology not only helps with workforce, but empowers clients to manage their own medications (with staff oversight) and all but eliminates medication errors.

Since the onset of the COVID pandemic, CBH has worked closely with its members to evaluate the impact of telehealth on access to care, patient satisfaction, reliable symptom improvement, and therapeutic alliance.[20] Telehealth is a vital tool that increases access to care. Data developed through CBH's measurement-based care (MBC) initiative demonstrates that clients entering care through telehealth are rated more severe at intake than those entering in-person care, so eliminating telehealth at the front-door will reduce access for the clients who are most in need of support.

Providers indicate that telehealth supports participation by clients who may otherwise no-show for care due to barriers created by transportation, childcare, or chaotic thinking. This was echoed in CBH's survey of 1,200 clients in PBHS about their perceptions of telehealth.[21] Telehealth has proven to be a valuable tool for increasing access and providing timely crisis intervention.

We recommend that MDH strike all limits on telehealth from proposed 10.63 regulations and create a workgroup with providers to evaluate data on client choice, therapeutic alliance, reliable symptom improvement and other clinical indicators to better inform the state's thinking on the availability of telehealth.

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[16] *Compare* Proposed COMAR 10.63.03.08B (mental health partial hospitalization program) *to* 10.63.03.07 (SUD partial hospitalization program).
[17] *Compare* 10.63.03.05A(3) (outpatient mental health center) *to* 10.63.03.06 (outpatient SUD L1).
[18] Proposed COMAR 10.63.01.02B(64)(a) and (65) both define "medication monitoring" as an in-person intervention.
[19] Proposed COMAR 10.63.03.04B(2)(a)(ii), (6)(c), 6(h)(iii) (mobile treatment services); 10.63.03.05A(3) (outpatient mental health center).
[20] Community Behavioral Health Association of Maryland, "Measurement-Based Care Implementation Work Group: Year Three Report (April 28, 2023).
[21] Community Behavioral Health Association of Maryland, "Client Response to Telehealth" (survey of 1,200 PBHS clients) (July 10, 2020).

3. Any regulatory limits on telehealth should be built into Medicaid conditions, not licensing requirements.

Limitations, if any, on the use of telehealth should be promulgated through regulations governing Medicaid conditions of participation (COMAR 10.09), not as a condition of licensing. In the face of the rising prevalence of need, many non-Medicaid payers value the increased access to care that telehealth offers. Other payers should have the option to exercise telehealth as an option for their beneficiaries even where Medicaid may wish to restrict utilization and access to levels of care within the Medicaid program. For these reasons, we recommend that any restrictions on telehealth be stricken from proposed 10.63 regulations and promulgated in Medicaid conditions under 10.09 instead.

4. Telehealth for EBPs should be explicitly authorized in conformity with statute

Maryland law specifies that for "the purpose of reimbursement and any fidelity standards established by the Department, a health care service provided through telehealth is equivalent to the same health care service when provided through an in-person consultation."[22] To bring the proposed regulations into conformity with Maryland law, we recommend deleting limitations on telehealth for mobile treatment services.[23] In addition, we recommend adding the statutory protection of telehealth in fidelity standards as an explicit provision for both Assertive Community Treatment and Supported Employment programs.[24]

C. Regulations should define a floor and enable effective oversight

1. Critical incident reporting

In most health care settings, incidents reportable to licensing authorities are only those rising to a high level of seriousness.[25] Accreditation standards require providers to have an internal infrastructure to address and correct less serious incidents.[26] For example, providers should have internal policies and procedures for reporting med errors; the interventions taken may involve remedial training and/or disciplinary action. Rather than hold providers accountable for complying with existing reporting requirements or creating accountability for having an effective internal compliance function in accordance with accreditation, the proposed regulations require providers to turn every non-serious critical incident into a reportable sentinel event. This will overburden both providers and regulatory authorities without appreciable benefit, and it will render existing compliance programs less effective by distorting their capacity to focus on important events.

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[22] Md. Code Health General § 15-141.2(h)(3).
[23] Proposed COMAR 10.63.03.04B(2)(a)(ii), (6)(c), 6(h)(iii) (mobile treatment services).
[24] Proposed COMAR 10.63.03.15 (Supported Employment) and 10.63.03.04C (EBP ACT provider designation).
[25] *See, e.g.,* COMAR 07.02.11.23 (reporting abuse and neglect in out-of-home foster care placements), COMAR 10.07.14.31 (assisted living required reports of death, injury, assault, abuse or medication errors resulting in harm). See also CARF requirements to report sentinel events (death, serious injury or risk thereof).
[26] *See*, *e.g.*, CARF, "2023 Behavioral Health Standards Manual," at Section 1.H.10 at p. 73 (July 1, 2023 – June 30, 2024).

We propose striking the proposed additions to critical incident reporting and making this section congruent with CARF's requirement that sentinel events be reported to them. The reporting of sentinel events to CARF could also include BHA.

2. Expanding required workforce in face of known shortages will damage access to care

The existing regulations require a program director and medical director per organization, while the proposed regulations require that these professionals expend at least half of their time at each site within the organization.[27] The proposed regulations increase number of prescribers that OMHCs have to recruit and retain by an estimated 52%, and potentially increase the number of licensed mental health professionals serving in a program director role by the same amount.[28]

Table 1 - Estimated Workforce Impact of Key Regulatory Changes

OMHC Required Staff	Current Regulations	Proposed Regulations
Program Director Licensed Mental Health Professional	0.5 FTE x 450 organizations with OMHC license = 225 FTEs	0.5 FTE x 684 OMHC sites = 342 FTEs
Medical Director MD or NP	0.5 FTE x 450 organizations with OMHC license = 225 FTEs	0.5 FTE x 684 OMHC sites = 342 FTEs

Behavioral health providers are in a workforce crisis, unable to recruit and retain sufficient staff to maintain their existing infrastructure. It's unclear how OMHCs would be able to recruit 117 new FTEs to serve as program directors at each OMHC site. There is a finite number of behavioral health professionals in Maryland and a significant number can be assumed to be in practice with non-public payers.[29] To add an additional 117 FTEs to behavioral health settings would require successfully competing with other settings, but social workers employed in school settings earn 20% more than those employed mental health or SUD-related settings pay 20%, while social workers in health care settings earn 6% more than their behavioral health counterparts.[30] With current funding limitations, it is not clear how a significant expansion of the workforce in behavioral health settings could take place.

[27] Proposed COMAR 10.63.05D.
[28] *See* Table 1, estimating current staffing relative to licenses per Public Information Act response of March 2023.
[29] For example, Virginia estimates that roughly 40% of its behavioral health workforce is employed in non-Medicaid or non-governmental settings. *See* Virginia Dept. of Health Professions, "Virginia's Behavioral Health Workforce" Dashboard (launched 2023).
[30] U.S. Dept. of Labor, Bureau of Labor Statistics, "State Occupational Employment and Wage Estimates" at Occupational Group #21-1021 (school social workers, $66,850), #21-1022 (health care social workers, $58,980) and #21-1023 (mental health and SUD social workers, $55,880) (May 2022).

Maryland is facing a rising need for mental health and addiction treatment services during a time of unprecedented workforce shortages that have reduced their treatment capacity. Community providers are at a well-documented disadvantage in terms of their ability to recruit licensed mental health professionals and prescribers. The expanded management staffing required by the proposed regulations will result in a reduction in the number of OMHC sites, which in turn will lead to dramatically lower access to in-person care.

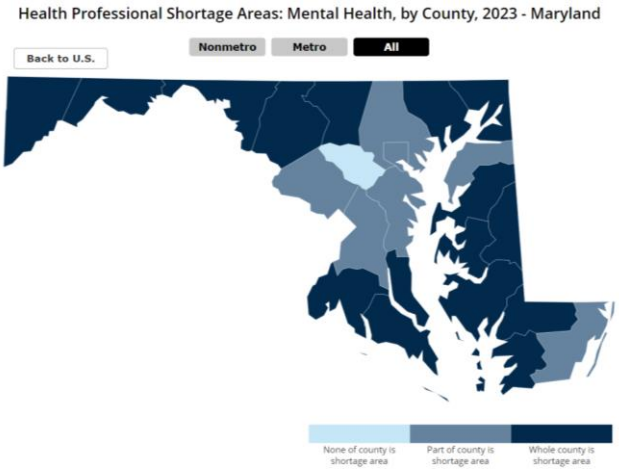
Similarly, the proposed vacancy reporting requirements create another administrative burden in light of the staff turnover all organizations are experiencing. We understand that BHA's rationale for including this new requirement is to catch sub-standard providers. However, we believe that existing civil money penalties allowed under 10.63.03.06.18 can be used effectively against providers who have a documented history of not maintaining staffing required by current regulation – clearly a "material" violation of the regulations – rather than burdening the great majority of providers who operate in accordance with the rules.

Finally, we note two concerns about the regulatory approach to supervision in the face of documented workforce shortages. The proposed regulations require organizations to "provide supervision by the appropriate staff as required by the Health Occupations Article."[31] There are 11 types of health professionals employed in community behavioral health settings; the health occupation boards require individuals working toward full licensure to have *clinical* supervision by an individual licensed in their same field. In many cases, CBH members may contract with outside consultants to support clinical supervision of those working toward full licensure while day-to-day supervision takes place internally by the supervisors available. This distinction between clinical supervision by the same type of licensee and day-to-day supervision by a higher level of licensure, regardless of type, is important to maintain multidisciplinary team capacity and functioning.

We note that the proposed regulations allow supervision via telehealth,[32] except "all [PRP] staff shall receive regular documented in-person supervision."[33] We recommend deleting the requirement of in-person supervision for direct care staff in PRP. This provision will penalizes all PRP programs by raising costs and workforce challenges, rather than targeting providers where supervison may be demonstrably absent or weak.

[31] Proposed COMAR 10.63.01.05E.
[32] Proposed COMAR 10.63.02.03B(9).
[33] Proposed COMAR 10.63.03.09R(1) and 10.63.03.10I(1).

3. Well-documented shortages in workforce and service capacity limit providers' capability to comply with aspirational regulations.



Behavioral health providers operate in an environment of long-standing, well-documented workforce shortages and chronic underfunding.[34] The overwhelming majority of the state's counties are designated as mental health shortage areas.[35]

An under-resourced system may often lack the capacity to perform as desired.

Licensing regulations should describe a floor of minimum performance, not an ideal world that creates a challenge for even the best of providers to meet. To that end, CBH encourages MDH to define a minimum licensing standard that providers are capable of meeting given the shortages in available workforce and service capacity. Specifically, we urge a modified approach to the following areas:

Cultural and linguistic competence.

As a licensing requirement, all behavioral health programs are required to provide culturally and linguistically appropriate services to all participants.[36] CBH wholeheartedly supports this goal and MDH's focus on ensuring participants in the PBHS have access to culturally linguistic and appropriate services. However, systemic and funding challenges limit providers' ability to consistently achieve the goal of culturally and linguistically competent care.

For example, while nearly one-third of the U.S. population is Black or Hispanic, only about one tenth of practicing psychiatrists come from these communities.[37] Well-documented, systemic barriers created by various health occupations boards decrease the availability of racial and ethnic minorities in behavioral health fields.[38] This mismatch between the population and available workforce fundamentally limits the ability of people to get culturally and linguistically appropriate care.

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[34] In the recent CY2024 Physician Fee Schedule proposed rule, CMS acknowledges that behavioral health provider rates have been systemically undervalued. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 FR 52320 (proposed August 7, 2023).

[35] *See, e.g.,* https://www.ruralhealthinfo.org/charts/7?state=MD

[36] Proposed COMAR 10.63.01.05(S) (p. 25).

[37] Wyse, R., Hwang, WT., Ahmed, A.A. *et al.* Diversity by Race, Ethnicity, and Sex within the US Psychiatry Physician Workforce. *Acad Psychiatry* 44, 523–530 (2020).

[38] *See, e.g.,* WBUR, "Social Work Licensing Exam Report Reveals Large Disparities in Pass Rates Among Age, Racial Groups" (Dec. 7, 2022).

Given the shortages of diverse professionals, providers who successfully recruit, hire and retain staff who are fluent in languages other than English are required to pay a premium to these staff -- with no funding mechanism to offset the higher costs.

Meanwhile, the language access line is beset by its own workforce crisis, resulting in unavailability or long delays when providers attempt to use it, particularly in situations - such as psychiatric crises - where there is short or no advance notice. There is no funding to defray provider costs associated with language line or translation services, resulting in a loss of services requiring language line support.

Immediate and longer-term policy solutions must be deployed to increase the culturally and linguistic competence of behavioral health services. Stakeholders have recommended improvements to the language access line.[39] We note that one of the SAMHSA grant-funded Certified Community Behavioral Health Clinics has used its award to purchase translation software that is employed to address the needs of those who communicate in languages other than English.

In the face of these systemic barriers to the consistent delivery of culturally competent care, we urge MDH to create a forum for dialogue with the provider community to understand the workforce and funding limitations that can reduce the availability of culturally and linguistically appropriate services, create a plan to identify and reduce those barriers, and work to establish clear and realistic expectations for a regulatory floor that is achievable for providers statewide, even those operating in shortage areas. For these reasons, we recommend that COMAR 10.63.01.05S be stricken from the proposed regulations pending further evaluation and discussion with the provider community.

Warm hand-off.

The proposed regulations require a warm hand-off prior to an unplanned program closure,[40] as well as warm hand-offs by mobile and residential crisis programs.[41] The definition of warm hand-off requires the participant to engage in and access the resource.[42] This fails to recognize that a needed service may not be available, that a participant may choose not to access the resource, or that the participant simply stopped engaging with a provider. We recommend that regulations encourage warm hand-offs, subject to client choice, service capacity, and other reasonable limits. Conversely, the definition of “warm hand-off" should be amended to read, “Warm hand-off” means ongoing communication between the referring provider, receiving provider, and participant to attempt to ensure that the participant has engaged in the services or accessed the resources to which an individual has been referred prior to the referring provider discharging the participant or ceasing communication with the individual and the receiving provider.

[39] Public Justice Center, https://publicjustice.org/wp-content/uploads/2022/12/Speaking-the-Language-Report.pdf
[40] Proposed COMAR 10.63.06C(6).
[41] Proposed COMAR 10.63.03.11, 10.63.04.04 10.63.04.10.
[42] Proposed COMAR 10.63.01.02B(101).

Prior approval in advance of site closure.

The proposed regulations require an organization to receive "prior approval" before closing a site.[43] CBH supports requiring organizations to provide notice of a site closure and to work to find alternative placements for those impacted, but Maryland's under-resourced behavioral health system cannot achieve these outcomes in all cases. Thus, CBH has strong concerns with requiring "prior approval" of a closure by the Department or an LBHA. Organizations usually close sites or programs due to financial challenges, and delays in closing a money-losing site could risk jeopardizing the financial stability of the broader organization. In some site closures, participants may not be referred to an alternative placement because the needed service does not exist or has long waitlists. CBH is concerned that this language places the onus squarely on providers and fails to recognize the autonomy needed to successfully run organizations that struggle to operate in the black.

Although our organizations partner with the government, they are private entities that must retain the right to make decisions based on clinical or financial considerations. We therefore also object to the proposed language in 10.63.04.05Q and 10.63.04.05 R that restricts a provider's autonomy in making decisions for admission to RRP. Our goal is to fill empty RRP beds, both from a mission perspective and also from a financial perspective. However, our organizations hold the liability for any mishaps that occur while individuals are residing in RRP. We must therefore have control over both admissions and discharges and propose that sections (Q) and (R) be struck.

D. Civil monetary penalties

Behavioral health organizations are one of the few health care providers already subject to civil monetary penalties (CMP) – over and above those created by the False Claims Act of 2015 – with the other entities tending to be facilities, such as hospitals and nursing homes.[44] The proposed regulations contain a new section for CMP, without integrating or amending the current section.

The existing regulation authorizes a penalty for any "material and egregious violation" of the licensing regulations.[45] By contrast, the proposed regulations authorize a penalty for any violation – no matter how minimal – of law and accreditation standards, not violations of regulations.[46] It includes violation of a State or federal law or accreditation standard governing a program and allows monetary penalties to be imposed regardless of whether any other civil, criminal, or administrative action is taken against the program by any State, federal, or Departmental agency for the same covered period or violation.

This proposed new section is overly broad. There are hundreds of accreditation standards providers must meet, most of which do not inherently involve the health or safety of individuals served and should not be the basis for imposition of money penalties. In fact, most if not all providers must

[43] Proposed COMAR 10.63.06.07A.
[44] COMAR 10.10.63.06.18. COMAR 10.07.01.32-2 (hospitals subject to civil monetary penalties for failure to comply with discharge planning requirements); COMAR 10.07.02.71 (nursing homes for deficiencies causing more than minimal harm).
[45] COMAR 10.63.06.18A(2).
[46] Proposed COMAR 10.63.XX.02A.

submit a Program Improvement Plan outlining how they will meet those accreditation standards they did not meet. This language would allow imposition of monetary penalties on virtually all providers. Additionally, the False Claims Act differentiates between knowingly engaging in fraudulent behavior versus mistakes or unwitting errors, recognizing that a violation of state or federal law may occur without the provider's awareness.

Existing regulation allows for civil monetary penalties – notwithstanding any penalties imposed under False Claims – for operating without a license or engaging in any "material and egregious violation" of the subtitle. This language strikes a balance between the need to reign in sub-par providers and reasonable protections for rule abiding providers against the arbitrary imposition of civil monetary penalties. For these reasons we propose that this new section be struck in favor of retaining the language in 10.63.06.18 (the existing Civil Monetary Penalties section).

E. Regulations should raise bar to getting a license

Regulations present an opportunity to raise the bar of licensing threshold to apply. For example, consider adding threshold for new license entrant into 10.63.06 such as:

a. Have an established referral system with community resources required to serve this population;
b. Have a minimum of one year's experience in providing all core elements of service;
c. Have the capacity to ensure the provision of quality service in accordance with State and federal requirements;
d. Have a financial management capability that provides documentation and cost in conformity with generally accepted accounting principles;
e. Have the capacity to document and maintain case records in compliance with state and federal requirements; and
f. Meet all state and federal requirements for provider participation in the Maryland Medicaid Assistance Program.

F. Amend regulations governing EBP fidelity assessments to offer procedural protections to providers.

CBH welcomes the promulgation of regulations for the fidelity assessment process. Developing an EBP program is an expensive and labor-intensive process for providers. EBP regulations should protect providers from recurring procedural problems experienced with fidelity assessment process in recent years by adopting the following language:

- Fidelity review will take place by an employee or contractor who has been trained in conducting assessments based on fidelity tool used for review;
- Providers will receive preliminary assessment results within 30 days of completion of the fidelity review;
- Providers will have an exit conference with the reviewer(s) and have the opportunity to dispute or correct preliminary findings;
- The final fidelity determination and rate decision will be issued within 14 days of the exit conference;

- The provider's EBP reimbursement at the time of the latest review will be effective until the final determination occurs. Should the final determination result in a higher reimbursement rate, that new rate shall be retroactive to the time of the fidelity review.
- Should the final determination result in a lower reimbursement rate or loss of EBP status, the provider shall have 30 days to appeal that decision to the Deputy Secretary of Behavioral Health, who shall make the final determination.

As stated above, we also recommend amending both EBP provisions to incorporate statutory protection of telehealth against decrease in fidelity standards or payment, in accordance with the Preserve Telehealth Act of 2021 (Chapter 71).

Thank you once again for eliciting CBH's input regarding the proposed 10.63 regulatory changes. We look forward to an ongoing dialogue with MDH to work through our differences and reach consensus on the final product.

Sincerely,

Shannon Hall
Executive Director