COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

June 16, 2025

Jordan Fisher Blotter
Director, Office of Regulation and Policy Coordination
Maryland Department of Health
201 West Preston Street, Room 534
Baltimore, MD 21201
via email to mdh.regs@maryland.gov

RE: Comments on Notice No. 25-063-P

Dear Ms. Fisher Blotter:

Please accept this letter as the formal comments on the above-referenced proposed regulations impacting the licensure of community-based mental health and addiction treatment programs.

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 95 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.

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 renew our request that the Department withdraw these regulations, engage with stakeholders in more targeted approaches that will help the Department achieve its goals more efficiently, without the radical restrictions on access to care that implementation of the proposed regulations would precipitate.

A. PROCEDURAL CONCERNS ABOUT REGULATORY PROCESS

In November 2023, CBH provided a 12-page letter on draft 10.63 regulatory changes and, in August 2024, CBH submitted an 18-page letter in response to a revised draft. CBH then participated in a five-hour, one-on-one review of our concerns with Department staff and responded to three different drafts over the following months. By October 2024, an almost-complete version of the draft

regulations was shared with CBH which reflected compromises that resolved the overwhelming majority of CBH's concerns. As a next step, Department staff indicated that the revised regulations would be sent to Department leadership for approval prior to publication in the Maryland Register.

CBH was thus dismayed when the Department broke the proposed regulations into three separate phases and began publishing them – with material, substantive changes from the October 2024 version – in the Maryland Register in April 2025.

The Phase 1 publication addressed only civil monetary penalties and was published without prior engagement of stakeholders about the substantive changes made since October 2024. Moreover, the Department's letter in response to CBH's formal comments responded with generalities rather than the substantive response required by the Administrative Procedures Act. The regulations were finalized without addressing the merit or substance of CBH's concerns.

Following the May 16th publication of Phase 2 of the regulatory changes, CBH and trade associations representing behavioral health providers formally requested that the Department withdraw the regulations on May 30, citing the proposed regulations' rejection of stakeholder feedback given earlier in the drafting process, the piecemeal publication strategy, and the material, substantive changes reflected in the proposed regulations. The Department acknowledged receipt of the letter, but did not respond substantively to the request or concerns raised.

On June 4, CBH submitted thirteen questions to the Department to help stakeholders better understand the policy objectives or reasons for rejecting stakeholder feedback. CBH submitted the questions in advance, for these questions to be addressed at stakeholder listening sessions scheduled for June 9 and 10. Again, the Department acknowledged receipt of the questions, but did not respond substantively to them individually, and only one of the thirteen questions was fully addressed in these listening sessions.

The purpose of the regulatory process enshrined in Maryland's Administrative Procedures Act is to give state agencies the mechanisms to act transparently, ensure due process, and establish a record that the state's regulations are not arbitrary and capricious. CBH is concerned that the process reflected in the proposed regulations does not meet the intent of the Administrative Procedures Act. We respectfully request that the Department commit to either withdrawing the proposed regulations or re-publishing of the regulations as proposed, with a new notice and comment period that allows stakeholders to comment on any amendments to the regulations as currently published.

B. OVERALL CONCERNS

Recommendation 1: Cite the appropriate legal authority for regulations.
The draft regulations should be withdrawn because they do not comply with the requirement set forth in the Administrative Procedure Act that "[a] regulation is not effective unless it contains a citation of the statutory authority for the regulation." Md. Code Ann., State Gov't § 10-106. Although the Department has identified purported statutory authority for each of its proposed new chapters of the COMAR 10.63 regulations governing community-based behavioral health programs and services, the statutory provisions the Department has identified do not give it authority to adopt such regulations. Rather, one of the cited provisions does not exist, and the other merely describes the content of regulations without conferring authority to adopt regulations.

Recommendation 2: Do not repeal existing zoning and discrimination protections for halfway houses and group homes.
The proposed regulations repeal existing COMAR 10.63.02.01 - 10.63.02.04 in their entirety. Included in the deleted regulations is COMAR 10.63.02.04, which protects halfway houses and group homes from discriminatory efforts to re-zone or subject such settings to conditional use permits or other restrictions. Almost on an annual basis, CBH members turn to these regulatory provisions to educate community stakeholders and local or state representatives in order to prevent discriminatory housing practices. The protections in COMAR 10.63.02.04 cannot be deleted, even temporarily, pending the Phase 3 promulgation of the 10.63 regulatory rewrite, without jeopardizing hard-fought efforts to increase housing capacity. Even a temporary elimination of this provision risks disrupting the housing pipeline in development to address state hospital capacity issues. CBH asks the Department to amend the proposed regulations to include the protections in existing COMAR 10.63.02.04 without temporary deletion in the process of rewriting 10.63 changes in their entirety.

Recommendation 3: As required by state law, the Department should meaningfully analyze the impact of the proposed regulations on individuals with disabilities and providers.
The proposed regulations failed to conduct the impact analysis required MD Code, State Government, §§ 10-110, 112. The regulations make no effort to evaluate the impact that the proposed regulations will have on access to care (Estimate of Economic Impact, Section II(F), "indirect effects on access to care … unquantifiable"). To evaluate the regulations' impact individuals with disabilities, the Department merely cites its "belief" that the regulations will result in better care.

The Department possesses licensing data, utilization data for the public behavioral health system, and a detailed analysis by the Maryland Health Care Commission of the existing workforce capacity, as well as the additional 32,000 behavioral health staff needed by 2028 (Maryland Health Care Commission, "Investing in Maryland's Behavioral Health Talent," at p. 6 (October 2024) project the impact of expanded staffing requirements on access to care. Conducting an analysis to evaluate

projected impact on provider costs, access to care (particularly in rural areas where workforce shortages are particularly acute), and impact on vulnerable populations, can help the Department evaluate whether any mitigating exceptions or alternative regulatory approaches are needed. Analysis of impact will also help the Department demonstrate that its proposed regulations are not arbitrary and capricious.

Recommendation 4: Correction of already identified errors will result in substantive changes requiring republication of the proposed regulations.

During a public listening session on June 9, the Department indicated that it accidentally omitted the Psychiatric Rehabilitation Association (PRA) as a certifying body for rehabilitation specialists in COMAR 10.63.02.10, and that it intended to amend the proposed regulations to add PRA back in. However, the Department staff did not respond to questions about whether it plans to increase educational requirements for rehabilitation specialists. The certification *and education* of rehabilitation specialists is a substantive issue as defined by Maryland law. Thus, any addition of PRA certification and any change to the rehabilitation specialist educational requirements would require republication of the proposed regulations (MD Code, State Government, § 10-113(b)).

Similarly, during the same listening session, Departmental staff said that group homes and certain programs were exempt from requirements to obtain a commercial kitchen license in COMAR 10.63.06.03C. In fact, such an exemption was written into the October 2024 draft regulations shared with stakeholders but has been removed from the current proposal. If the Department intends to restore the exemption and describe which programs are eligible for the exemption, that too would be a substantive change requiring republication of the proposed regulations.

During listening sessions on June 9 and 10, the Department also indicated that references to telehealth would be updated to reflect passage of the Preserve Telehealth Access Act of 2025 (SB372). Amending the proposed regulations to comply with the bill's extension of audio-only and other telehealth provisions will also require substantive changes to the proposed regulations.

Finally, the restoration of zoning and permitting protections in existing COMAR 10.63.02.04 are a critical protection against discriminatory housing practices that must be restored to these proposed regulations.

Any changes to proposed regulations that will substantially affect the rights and duties of the regulated profession are substantive changes that will require re-publication of the proposed regulations with a new notice-and-comment period (MD Code, State Government, § 10-101(i). Because each of the four changes described above meets the definition of a substantive change, CBH requests that the Department re-publish the regulations as proposed, allowing stakeholder an opportunity to comment on the substantive amendments indicated above.

C. COMMENTS ON COMAR 10.63.01.01-.05

Recommendation 1: Amend the definition of "license" to be inclusive of RRP licensing process.
The proposed regulations define a license as tied to "a specific site" in COMAR 10.63.01.01B(20). Currently, a provider offering a Residential Rehabilitation Program (RRP) obtains one license per county, with an average of 8 group homes incorporated under a single, county-wide RRP license. In the 2024 draft version of the regulatory changes, CBH asked whether the conversion to site-specific licenses was intended to apply to RRPs or was an accidental oversight, and posed this question again to the Department after publication of the proposed regulations. Converting the RRP license from a county-wide application to a site-based application increases all regulatory and staffing requirements by a factor of eight. CBH's previous feedback recommending retention of the current standard is no longer reflected in the current proposal, and our request to clarify the Department's underlying policy goal in the proposed changes has gone unaddressed to date.

Recommendation 2: Amend the definition of "medically necessary" to specify its limitation to the publicly funded behavioral health services.
The proposed regulations define "medically necessary" in COMAR 10.63.01.01B(23) with a cost efficiency limitation. Cost efficiency is not necessarily a medical necessity standard for commercial payers, self-funded services, or contracts and grants that may be subject to 10.63 licensing regulations. The licensing regulations should not unnecessarily limit providers to delivering care with a "cost efficiency" standard if a payer does not. CBH recommends amending the definition of medically necessary to state, "(23) 'Medically necessary' means***, for a publicly-funded service,*** a service or benefit that is…" If the Department intends to regulate medical necessity for commercially-funded payers, self-funded care, and contracts or grants that originate outside the Department of Health, it would be helpful to understand the goals and rationale for doing so.

Recommendation 3: Amend the definition of "public behavioral health system" to be inclusive of all insurance statuses served.
In COMAR 10.63.01.01B(3), the proposed regulations define participants in the public behavioral health system as serving those with Medical Assistance and some uninsured. CBH recommends amending the definition to be inclusive of all those served by Maryland's public behavioral health system, including those with Medicare and commercial insurance.

Recommendation 4: Amend the definition of "telehealth" to specify its limitations to the publicly funded behavioral health services.
CBH is similarly concerned that the definition of telehealth proposed in COMAR 10.63.01.01B(35) builds in PBHS limitations that would extend to all payers and experimental programs. As written, the current proposal defines telehealth with reference to a medical necessity standard that incorporate cost efficiency limitations, and limits all telehealth for all payers to adhering to the Medicaid conditions of participation in COMAR 10.09.49. We recommend amending the definition of telehealth to state, "(35) 'Telehealth means***, for a publicly-funded service,*** the synchronous

delivery of medically necessary services…" If the Department intends to regulate telehealth for commercially-funded programs and contracts or grants that originate outside the Department of Health, it would be important to understand the goals and rationale for doing so.

Recommendation 5: Clarify the scope of experimental programs required for licensure.
The scope of experimental projects expected to apply for licensure is unclear **in** COMAR 10.63.01.02E. To the extent that the regulation may give the Department authority to deny a provider a license for services funded by a grant or contract, CBH is concerned that providers may be restricted from pursuing federal or philanthropy projects that can bring innovation and needed research opportunities to the field.

Recommendation 6: Amend tenancy requirements with exemptions consistent with residential programs subject to medical necessity standards.
The proposed regulations require organizations offering or referring to housing to comply with Real Property Code Title 8, which vests tenancy rights in patients residing in housing (COMAR 10.63.01.03C). The May 2025 version removes October 2024 edits that created an exemption to tenancy requirements for licensed and certified housing required to follow discharge standards and medical necessity requirements. Although the proposed regulation is not yet final, CBH has two member organizations subject to corrective action plans for moving patients out of RRPs without an eviction process. There are many programs licensed in 10.63 that provide housing (e.g. RCS and RRP), and yet Maryland property statutory and caselaw views the legal relationship between the provider and the client as one of licensor-licensee and not as landlord-tenant. This regulation could be misinterpreted as trying to change Maryland property law. CBH recommends amending this provision by adding, "*This requirement is not to be construed as determining that the legal relationship between the organization and the program participant is one of tenancy if Real Property Code, Title 8 and Maryland caselaw indicates the relationship is not one of tenancy or duration in the program is otherwise managed by medical necessity criteria."*

D. COMMENTS ON COMAR 10.63.01.06 (REPORTING REQUIREMENTS)

CBH has significant concerns with the proposed regulations governing reporting, particularly around the expansion of critical incident reporting from 7 to 22 categories. CBH's recommended edits to earlier drafts have been rejected, our questions to understand the Department's goals unanswered, and our invitation to discuss with our member CEOs was acknowledged but unaccepted.

Recommendation 1: Withdraw proposed regulations pending rewrite to eliminate duplicative reporting requirements and resolve conflicts with state law.
The Department lacks authority to adopt the expanded "critical incident" reporting requirements that would be set forth at COMAR 10.63.01.06, because, in many cases, the reports required by those draft provisions would be, for purposes of the Confidentiality of Medical Records Act ("the Confidentiality Act"), prohibited "disclosures" of "medical records developed in connection with the

provision of mental health services." *See* Md. Code Ann., Health-Gen. § 4-307(b). The Department cannot compel providers by regulation to engage in conduct that would be prohibited by statute, and the proposed reporting requirements should therefore be withdrawn. *See* State Gov't § 10-125(d) (providing that a court on judicial review "shall declare a provision of a regulation invalid if the court finds that . . . the provision exceeds the statutory authority" of the unit adopting the regulation).

By way of background, the Confidentiality Act represents a deep legislative commitment to protecting the privacy interests of patients in their medical information, imposing severe restrictions on the "disclosure" of "medical records." A provider may only "disclose" a "medical record" in accordance with the terms of the Confidentiality Act or as otherwise provided by law. *See* Health-Gen. § 4-302(a)(2). As further discussed below, the Confidentiality Act imposes additional and particularly severe restrictions on the disclosure of "medical records developed in connection with the provision of mental health services," *see id*. § 4-307, reflecting both the profound privacy interests of patients in their mental health information and the fact that, in the context of mental health treatment, confidentiality and trust are often essential to the rendering of effective treatment. *Cf. McCormack v. Board of Educ. of Baltimore County*, 158 Md. App. 292, 305 (2004) (recognizing "imperative need for confidence and trust" between patients and providers of mental health services as the principal basis for recognition of the patient-therapist privilege).

As an initial matter, the Confidentiality Act broadly defines the term "medical record" to include "any oral, written, or other transmission in any form or medium of information that: (i) Is entered in the record of a patient or recipient; (ii) Identifies or can readily be associated with the identity of a patient or recipient; and (iii) Relates to the health care of the patient or recipient." Health-Gen. § 4-301(k). The Confidentiality Act's coverage is further expanded by its broad definition of the terms "disclose" or "disclosure," which refer to "the transmission or communication of information in a medical record, including an acknowledgement that a medical record on a particular patient or recipient exists." *Id*. § 4-301(d). Thus, the Confidentiality Act regulates not only the "transmission" of "medical records" themselves, but also any "communication of information" contained in a "medical record," and even a mere "acknowledgement that a medical record . . . exists." *Id*. The Appellate Court of Maryland recognized the breadth of the Confidentiality Act's coverage in *Shady Grove Psychiatric Group v. State*, 128 Md. App. 163, 168-69 (1999), holding that, in responding to a subpoena from a State's Attorney, a provider's production of a bare list of patients seen during a particular time period would be a "disclosure" for purposes of the Confidentiality Act, because such a list, although not disclosing anything about the treatment provided to any of the listed patients, would "acknowledge the existence of a medical record" for those patients.

The Confidentiality Act imposes severe consequences on providers who violate the Act's requirements. A provider who knowingly violates the Act is liable for actual damages. *See* Health-Gen. § 4-309(f). A provider who knowingly and willfully violates the Act is guilty of a criminal misdemeanor. *See id*. § 4-309(d).

As noted above, the Confidentiality Act, at HG § 4-307, confers particularly strong protections on, and imposes particularly severe restrictions on the "disclosure" of, "medical records develop in connection with the provision of mental health services." A provider may only disclose mental health records pursuant to authorization in HG § 4-307, which "govern[s]" such disclosures. *See* Health-Gen. § 4-307(b). Thus, even where the Confidentiality Act generally recognizes the permissibility of "disclosures" of "medical records" to "government agenc[ies]" and "health professional licensing and disciplinary boards," the statute qualifies that recognition, in the context of mental health records, by referring to and imposing the "additional limitations for a medical record developed primarily in connection with the provision of mental health services in § 4-307 of this subtitle." *See* Health-Gen. §§ 4-305(b)(3), 4-306(b)(2).

Most importantly for present purposes, HG § 4-307 does not confer general authority on the Health Department or any other government agency to adopt regulations identifying general circumstances when providers must disclose patients' or recipients' mental health records. To the contrary, HG § 4-307(k)(1)(v) provides that, even in the context of health professional licensing and discipline, such "disclosures" are permitted only "*[i]n accordance with a subpoena*," and only where that subpoena seeks the disclosure with respect to "*specific recipients*." (Emphasis added.). Moreover, even in the context of a provider's response to such a subpoena from a licensing board, each employee of the licensing board who will have access to those mental health records must "sign[] an acknowledgement of the duty under this Act not to redisclose personal identifying information about a recipient." *Id*. § 4-307(i).

The difficulty with the expanded "critical incident" reporting requirements set forth in the draft COMAR 10.63 regulations is that, in many cases, the report that the regulations require providers to make would be, for purposes of HG § 4-307, a "disclosure" of a "medical record developed in connection with the provision of mental health services." For example, the draft regulations would treat as a "critical incident," and require community-based behavioral health programs to report unilaterally, "[a]ny unexplained loss of medications." DRAFT COMAR 10.63.01.06(k)(ii). A report required by this broad requirement would be, in all or almost all cases, a "disclosure" of the affected patient's mental health records for purposes of the Confidentiality Act, because the required report would "communicat[e] information in [the patient's] medical record" or, at a minimum, "acknowledge[] that a medical record . . . exists" for that patient. Health-Gen. § 4-301(d). Similar concerns would be raised by the broad requirement that community-based behavioral health programs disclose any "injur[y]"—not matter how minor—that is "[t]he result of interpersonal violence." DRAFT COMAR 10.63.01.06(b)(ii).

Again, the Confidentiality Act prohibits providers from making "disclosures" of "medical records developed in connection with the provision of mental health services" other than in accordance with HG § 4-307, and there is no provision in HG § 4-307 that authorizes providers to make such "disclosures" in accordance with general reporting requirements like those that would be imposed

in the Department's draft regulations. Rather, as discussed above, even in the context of licensure, HG § 4-307(k)(1)(v) authorizes a provider to make "disclosures" of mental health records only in response to a subpoena and only where that subpoena seeks information with respect to "specific recipients." Thus, the "critical incident" reporting requirements in the Department's draft 10.63 regulations conflict with the Confidentiality Act, and the Department lacks authority to adopt them.

To be clear, these legal concerns are separate and apart from any analysis from a public policy perspective of the benefits and burdens of the Department's proposed expansion of its "critical incident" reporting requirements. Regardless of whether it would be good policy for the Department to require community-based behavioral health programs to report to it whenever a program participants sustains *any* "injury" (no matter how minor) that is "the result of interpersonal violence," or to make a report whenever there is "*any* unexplained loss of medications," *see* DRAFT COMAR 10.63.01.06(b)(ii)&(k)(ii) (emphasis added), the Department nonetheless may do so only if such a requirement would be consistent with the statutory law of the state. Plainly, the Department cannot compel providers to make "disclosures" of mental health records that the General Assembly, through the Confidentiality Act, has prohibited them from making. The "critical reporting" provisions of the draft regulations therefore "exceed the statutory authority" of the Department, *see* State Gov't § 10-125(d)(2), and they should be withdrawn.

Recommendation 2: Delete "any other serious incident" provision as too vague in COMAR 10.63.01.06A(1)(m).

CBH also recommends deleting the provision in 1(m) allowing the Department to levy civil monetary penalties for providers who fail to meet the vague language of "any other serious incident" that the Department deems warranting a critical incident report. Currently, CBH members report being sanctioned by the Department for failing to file critical incident reports for client injuries that the provider deemed not serious or for patients at risk of hospitalization but safely stabilized in community programs. Because providers are currently subject to sanction by the Department for conduct that they were unaware was required reporting, CBH is concerned that the existing language gives the Department latitude to revoke licenses and issue civil monetary penalties without adequate notice to providers of what is expected reporting.

Recommendation 3: Limit civil monetary penalty in COMAR 10.63.01.06A(3) to intentional failure to file report of material patient harm.

To align risk for incurring civil monetary penalties to parity with regulation of other health care industries, CBH recommends limiting liability for civil monetary penalties to intentional failures to file report and only to incidents of patient harm.

Recommendation 4: Delete "at a minimum" in COMAR 10.63.01.06B and add clarifying language to establish nexus with regulated services.

CBH recommends amending the financial status reporting to more clearly delineate financial reporting requirements by, adding:

- To (e)(ii): *Breach of lease* ***by a landlord regarding property on which services are provided and licensed pursuant to this subtitle*** *;*
- To (f): *Any utility shut-off due to non-payment* ***regarding property at which services are provided and licensed pursuant to this subtitle****;*
- To (g): *Any legal actions brought against the organization or the organization's owner seeking to recover greater than* ***10% of the organization's annual budget****; and*

Recommendation 5: Specify outcome reporting in COMAR 10.63.01.06C.
Outcome reporting requirements identified in COMAR 10.63.01.06C can potentially create duplication, technology costs, and administrative burdens to providers. Because of the potential costs and impact on providers to effectively fulfill important outcome reporting, the Administrative Procedures Act supports more substantive detail on the scale and substance of anticipated reporting requirements for providers.

E. COMMENTS ON COMAR 10.63.01.07 - .09 (SITE, DOCUMENTATION & TELEHEALTH REQUIREMENTS)

Recommendation 1: Amend prohibition on co-located services in COMAR 10.63.01.07A(2) to more narrowly target Department's policy goal without disrupting existing residential service delivery.
CBH recommends editing the provision to specify that licensed sites (as opposed to services) can't be located in the same unit, as opposed to the same property. This language change will allow the continued delivery of certain off-site group services in an RRP, as well as continuation of RRP where existing in the same commercial unit as other behavioral health services.

Recommendation 2: The regulations should define a compliance standard compatible with the investments that the state is willing to make in accessible low-income housing and diversifying the behavioral health workforce, rather than holding providers accountable for resolving systemic shortages.
In COMAR 10.63.01.07A(3), the proposed regulations require providers to ensure that all locations are ADA compliant and translation services are available as needed. Neither the affordable housing nor the workforce with translation skills required to allow providers to fully comply with this regulation exists in Maryland. Where solutions exist – such as the capacity of the Certified Community Behavioral Health Clinics (CCBHCs) to support investments in immediately accessible translation services – MDH has indicated it lacks the financial resources to sustain funding. Thus, while the state eschews sustainable funding solutions, providers are subject to an array of penalties, including sanctions and license revocation, for violations – no matter how immaterial (see COMAR 10.63.09). Behavioral health providers should not be penalized for the structural inequities in housing and health care policy that drive these shortages. CBH recommends that, instead, the regulations adopt a more nuanced approach that works toward building capacity and operations with the existing resources available to providers.

Recommendation 3: Delete language limiting telehealth to licensed mental health professionals in contravention of state law.

In COMAR 10.63.01.08A(5), (7), telehealth documentation standards define the healthcare provider as a "licensed mental health professional." This is an inappropriate limitation from state law. In Health-General § 15-141.2(a)(4), both certified health care professionals (as opposed to licensed) and mental health and substance use disorder programs licensed in accordance with § 7.5-401 are specifically included in the list of programs and providers covered by telehealth. We recommend amending the documentation standards to note that certified professionals may also engage in telehealth with program participants.

Recommendation 4: Delete language limiting covered telehealth services in the public system to licensed mental health professionals in contravention of state law.

In COMAR 10.63.01.09B(3) and COMAR 10.63.01.09C, the proposed regulations limits telehealth in the public behavioral health system to only a "licensed mental health professional." This is an inappropriate limitation from existing state law. In Health-General § 15-141.2(a)(4), both certified health care professionals (as opposed to licensed) and mental health and substance use disorder program licensed in accordance with § 7.5-401 are specifically included in the list of programs and providers covered by telehealth. We recommend amending the covered service standards to note that certified professionals may also engage in telehealth with program participants.

Recommendation 5: Delete limitations on scope of audio-only telehealth and professionals, in contravention of state law.

In COMAR 10.63.01.09G(2)(a), the proposed regulations limit coverage of audio-only telehealth in the public system to a two-year period that ended three years ago, and further restricts coverage to only licensed mental health professionals. Health-General § 15-141.2(a)(7)(ii)(2) requires coverage of audio-only telehealth, and provisions referenced in recommendations above do not limit participation in telehealth to only licensed professionals. CBH urges the Department to amend the proposed regulations in accordance with the existing statutory requirements.

Recommendation 6: Restore telehealth coverage of collateral contacts for effective family therapy in safety-net settings like schools and clinics.

CBH urges the Department to amend restriction on telehealth collateral contacts in COMAR 10.63.01.09G(2)(d). As written, the proposed regulation would prevent schools and outpatient clinics from talking with parents about a child's progress. This core component to effective family therapy would be taken offline for critical, publicly-funded safety net providers – but left intact for Medicaid group practices and commercial providers. CBH believes that utilization management by the ASO vendor can alleviate cost concerns underlying this provision without disrupting the treatment model. For these reasons, CBH urges the Department to amend the proposed regulations in accordance with the existing statutory requirements.

F. COMMENTS ON COMAR 10.63.01.13 (PROGRAM DISCONTINUATION)

Recommendation 1: Plans to transition clients from a closing program should recognize that alternate services may not always be available.
The proposed regulations in COMAR 10.63.01.13A(2) describe the content of a notice of program discontinuation. CBH recommends adding, "(d) Transitioning program participants to other behavioral health services***, if available*.**" In the past, BHA or local authorities have attempted to withhold permission to close if alternate capacity cannot be identified. It is important for program discontinuation planning to recognize that workforce shortages and limited residential capacity exist across the state.

Recommendation 2: Regulations should reference that an acceptable discontinuation plan is one meeting the regulatory requirements.
The proposed regulations in COMAR 10.63.01.13A(3)(a)and B(4)(a) describe the state's determination that a provider's closure plan is "acceptable." Providers who fail to comply with §A may be unable to obtain future licenses by the organization or leadership under § C. Given the severity of the penalty for noncompliance, it is critical that the regulation clearly define what an acceptable plan is, and CBH recommends amending COMAR 10.63.01.13A(3)(a) and B(4)(a) as follows: "(a) Notify the organization in writing whether the organization's written discontinuation plan ***is*** ~~***acceptable***~~ ***materially meets the requirements described in COMAR 10.63.01.13A(2)***."

Recommendation 3: Delete prohibition on closure without state approval.
In COMAR 10.63.01.13A(4) and B(5), the regulations prohibit a provider from closing a site or program until approved by BHA. Providers close sites because they lack sufficient funding to adequately staff and operate services at the site. In the past, BHA has attempted to withhold permission if alternate capacity cannot be identified. Forcing a site to remain open without adequate funding for staff or operations threatens patient safety. If the state wishes to force a provider to remain open, the state must exercise its receivership authority under Health General §§ 19-333-339 – and dedicate dollars to maintaining the program. In the absence of funding, a provider cannot be forced to remain open. Absent the exercise of receivership, it is unclear what legal authority the Department has to prevent provider closure. CBH recommends deleting this provision.

G. COMMENTS ON COMAR 10.63.02 (GENERAL STAFFING)

Recommendation 1: Amend regulations to reflect administrative and clinical duties taking place across multiple sites simultaneously.
COMAR 10.63.02.02B(3), (4). It is unclear how to timekeep for program staff working multiple sites if the work – such as developing policies and reviewing performance data – applies across multiple sites. The proposed regulation appears to disallow performance of program-wide administrative and programmatic duties by not allowing simultaneous work across sites.

Recommendation 2: Site-based requirements eliminate staff supervision via telehealth at odds with health occupation board, Medicare and other payer practices.
Proposed regulations in COMAR 10.63.02.02B(4), (5)(b) prohibit a supervisor from conducting supervision of staff at another location via telehealth and thus requires supervision to take place with the supervisor on site. Compliance with this provision would prevent Maryland's behavioral health providers from complying with Medicare's supervision standards. In recent years, Medicare specifically relaxed supervision requirements in behavioral health settings in order to improve access to care in the face of workforce shortages. Similarly, Maryland's health occupation boards have allowed supervision via telehealth.

Under the proposed regulations, all behavioral health programs in the state – whether operating under Medicare or commercial funding – would have to radically redesign workforce supervision to comply with the proposed regulations' elimination of telehealth supervision. Implementation will have a significant, negative impact on access to care.

To the extent that the prohibition on telehealth supervision applies to medical directors, the proposed regulation is not in conformity with MD Code, Health - General, § 7.5-402(a)(4)(ii), which allows OMHCs "to satisfy any regulatory requirement that the medical director be on site through the use of telehealth by the director."

Recommendation 3: Standardize timeframe for reporting a vacancy, and extend the reporting requirement beyond the average time to fill a vacancy.
COMAR 10.63.02.03A requires an organization to take action "upon vacancy," which conflicts with .03B(3), requiring a vacancy report within 40 days, which conflicts with COMAR 10.63.02.03C, requiring a vacancy report within 48 hours under vaguely-defined circumstances. Turnover in the behavioral health field is high and time to fill vacancies exceed those of healthcare generally. The Department should identify the vacancy reporting and variance request standards applied to other health care providers in Maryland and explain how these provisions align with the state's parity obligations.

Recommendation 4: Add timeframe to respond to variance request.
Providers have not always received timely responses to their applications for variance. CBH recommends amending COMAR 10.63.02.03 to add a provision requiring the Department to reach a decision on a variance application with 10 days of submission. Ensuring a timely response to provider variance requests ensures that the state is adequately staffed to meet this requirement and promotes smooth operational workflows required to support the licensing and personal requirements affiliated with variance requests.

Recommendation 5: Add standard for decision on variance request.
Nothing in the proposed regulations describe what standards the Department will use in approving or denying a provider's application for a variance. CBH recommends that the Department describe

the increased level of Department staff allocated to evaluate variance requests, and the standards that the Department will use to reach its decisions.

Recommendation 6: Delete duplicative training requirements.
We propose that the staff training and competency plans be removed from COMAR 10.63.02.04. While we support the compliance goals of building a framework for enforcement, duplication of accreditation's extensive training requirement is not a reasonable burden for behavioral health providers.

Recommendation 7: Eliminate CJIS background check requirement until the Department undertakes changes required to allow providers to access CJIS under new policy.
CBH recommends amending proposed COMAR 10.63.02.05A to replace (5) with alternative language reflecting the need for the Department to update statutory and regulatory authorities to conform to new policies about the availability of the Criminal Justice Information System (CJIS) policy. In a conversation with CBH in July 2024, after an earlier draft of the regulations was shared, the Maryland Department of Public Safety & Correctional Services indicated that it had changed CJIS access in response to a change in federal interpretation. At that time, the Department of Public Safety had a list of changes to MDH professionals and practices that needed to be addressed in statutory and/or regulatory changes, but no BHA-regulated programs were on the list to be added. In its feedback to the July 2024 draft, CBH advised BHA to ensure that community behavioral health programs were among those that MDH flagged for update in accordance with the Department of Public Safety's new policy. That does not appear to have occurred. Until it does, CBH recommends deleting (5) in its entirety and replacing it as follows: "(5) *An organization which either participates in or demonstrates in writing its willingness and ability to participate in the Criminal Justice Information System if and when that becomes allowed is exempt from the requirements of Section A(1)(b) of this regulation*."

Recommendation 8: Remove clinical supervision duties from the clinical director, and differentiate between program and clinical supervision.
In COMAR 10.63.02.06D(2), the proposed regulations require the clinical director to provide clinical supervision to staff. This provision is an example of the proposed regulations' confusion of programmatic supervision with clinical supervision. Under Maryland health occupation law, clinical supervisors must generally have the same educational credential category as the staff they are clinical supervising (ie social workers can only supervise social workers). By contrast, many behavioral health programs \ employ licensed health professionals from six or more health occupations. Thus, a clinical director will almost certainly be unable to provide clinical supervision to all staff and thus unable to comply with COMAR 10.63.02.06D(2) as written. Conflating program supervision functions with clinical supervision duties will reduce the available workforce to only those individuals with the same type of licensure as the supervisor. This would result in a reduction in capacity without meaningfully advancing quality.

Because the Department has not promulgated the proposed regulations in full, stakeholders are unable to see which types of programs are required to have a clinical director. Currently, not all program types in the public behavioral health system are administered by an individual meeting the educational requirements of the clinical director. However, without access the program-specific regulatory changes, CBH is unable to comment substantively on the educational and experiential requirements for this position, nor evaluate the extent to which this proposed position may change existing regulatory requirements for our member programs. The absence of this information prevents us from meaningfully exercising our opportunity to comment on the proposed regulation.

Recommendation 9: Reduce supervisory experience requirement from five to three years.
In COMAR 10.63.02.06B(2) and .07(B)(2), the proposed regulations limit clinical directors and program directors to individuals with five years of experience. According to a CBH member survey conducted in May 2025, 74% of members report that their directors meet this standard. Organizations whose directors do not meet this standard are overwhelmingly located in rural areas of the state. Given the workforce shortages, it is unclear how existing programs in rural areas of the state will be able to come into compliance with the higher experience requirements, and this provision may result in program closures and reduced access to care in rural areas of the state. CBH invites the Department to consider more flexible standards that will support statewide capacity of access to critical behavioral health services.

Recommendation 10: Clarify limitation on serving multiple sites for licensed mental health professionals and clinical supervisors in order to allow telehealth in accordance with state law, health occupation boards, and other payer practices.
In COMAR 10.63.02.09A(1), the proposed regulations limit licensed mental health professionals and clinical supervisors from performing duties at multiple program sites simultaneously. We note that these positions are subject to COMAR 10.63.02.02B(5)(b), which prohibits a supervisor from conducting supervision of staff at another location via telehealth and thus requires supervision to take place with the supervisor on site. Compliance with this provision would prevent Maryland's behavioral health providers from complying with Medicare's supervision standards. In recent years, Medicare specifically relaxed supervision requirements in behavioral health settings in order to improve access to care in the face of workforce shortages. Similarly, Maryland's health occupation boards have allowed supervision via telehealth. In the face of Maryland's well-documented behavioral health workforce shortage, increasing site-based supervision requirements combined with the prohibition on telehealth supervision at odds with health care licensing and other payer practices will result in a dramatic reduction in provider capacity and accompanied reduction in access to treatment services.

As previously noted, the Department has not provided an analysis of the potential impact these changes would have on service availability across regions or populations. Given the extent of behavioral health needs facing Maryland residents, CBH recommends that the Department delete

prohibitions on telehealth supervision and allow behavioral health providers to continue supervision as regulated by the health occupation boards, Medicare and other payers.

Recommendation 11: Classify clinical supervisors and SUD clinical supervisors as organizational staff.

We note the licensed mental health professionals can function as organizational level staff under 10.63.02.06A, and CBH recommends that the proposed regulations align requirements for clinical supervisors in COMAR 10.63.02.09B(1) and SUD clinical supervisors in COMAR 10.63.02.14A(1) as organizational staff. Allowing supervisors to function at the organizational level – in combination with telehealth supervision, as allowed within the scope of practice – preserves access to care and aligns with other payer standards.

Recommendation 12: Restore the Psychiatric Rehabilitation Association as certifying body for rehabilitation specialists.

In COMAR 10.63.02.10, the proposed regulations eliminate the existing regulation's reference to the Psychiatric Rehabilitation Association (PRA) as a certifying body. While BHA staff orally agreed to restore PRA as a certification body during listening sessions on June 9 and 10, 2025, staff would not address whether educational criteria for certified rehabilitation specialists would change. Because the overwhelming majority of certified rehabilitation specialists in Maryland are certified with PRA, any future edits to the educational requirements for this credential would have significant impacts on provider costs and workforce availability. For these reasons, CBH believes any change to the rehabilitation specialist educational requirements would require republication of the proposed regulations as a substantive change (MD Code, State Government, § 10-113(b)).

Recommendation 13: Amend rehabilitation specialist's duties to allow oversight.

CBH recommends amending COMAR 10.63.02.13D to indicate that a rehabilitation specialist's duties include oversight of the enumerated activities, in order to align with the current practice and job duties associated with the position of the rehabilitation specialist. The existing language appears to assume that the rehabilitation specialist is a direct service position, not a director position, which would radically restructure the existing service model.

Recommendation 14: Allow continued employment of peers without certification.

CBH recommends amending COMAR 10.63.02.11 to allow providers to continue their existing practice of employing uncertified peer recovery specialists in some programs. Although certification is required for peers within certain, Medicaid-funded programs, peers serve far broader rules in other behavioral health programs and payers. To require certification upon hiring would rule out so many highly qualified candidates who because of their illness or poverty will be able to obtain certification only if they are provided the resources and support from a behavioral health provider with experience hiring peer recovery specialists. We propose requiring certification within 18 months of hire.

Recommendation 15: In accordance with state law, remove the requirement that a medical director be a physician.
In COMAR 10.63.02.13B(1), the proposed regulations require medical directors to be physicians. Health - General, § 7.5-402(a)(4)(iii) allows nurse practitioners to serve as medical directors of outpatient mental health clinics.

Recommendation 16: Remove the requirement that a medical director be an employee of the organization.
In COMAR 10.63.02.13B(2), the proposed regulations require medical directors to be employees of the organization. CBH has not been able to identify a single other state with this standard. Maryland, like the rest of the country, has a severe shortage of psychiatrists and other physician specialties necessary for behavioral health services.

Recommendation 17: Remove prohibition on medical director's ability to complete duties via telehealth, as allowed by health occupation boards and other payers.
In COMAR 10.63.02.13, the proposed regulations require medical directors of OMHCs and an unknown number of other program types in the behavioral health system to be psychiatrists. Although this requirement alone will radically restrict the number of qualifying programs, the Department also seeks to add two additional catastrophic limitations on the role of the medical director – and leaves the actual supervision standards of the director undefined, waiting on future promulgations. The absence of an articulated supervision standard in these proposed regulations deprives CBH of the ability to meaningfully evaluate the impact of these provisions.

In .13A, the regulations restate prohibitions from performing duties at multiple sites, including the prohibition on telehealth supervision. This is a substantially higher standard than Medicare or any other payer. It is at odds with MD Code, Health - General, § 7.5-402(a)(4)(ii), which allows a behavioral health program licensed as an outpatient mental health center to satisfy any regulatory requirement that the medical director be on site through the use of telehealth by the director. Telehealth supervision is allow by health occupations boards. To our knowledge, no other state imposes such broad restrictions on a medical director's ability to provide supervision via telehealth, regardless of payer source.

We also note that the regulations define the medical director position as program-specific rather than organizational. Medical director creates policies and procedures across .02.02C(1) and should be organization-level staff, not program-specific.

We note that other state Medicaid programs allow non-physicians to administer Medicaid clinics, and we have not identified any other example of a state applying such broad restrictions on clinics' medical director credentials across the entire state, regardless of payers.

Recommendation 18: Align SUD clinical supervisor requirements with all Board-approved supervisors.
COMAR 10.63.02.14A(2)(b) establishes a new Substance Related Disorder Clinical Supervisor staffing role as dedicated program staff. However, it explicitly excludes CAC-ADs with Board-approved supervision despite the fact that these professionals are approved by the Board of Professional Counselors. This exclusion is not aligned with the realities of Maryland's workforce, and there is no evidence that a sufficient pool of eligible supervisors exists to meet this new requirement. If adopted, this regulation will significantly reduce provider capacity and limit access to care.

H. COMMENTS ON COMAR 10.63.06 (LICENSURE PROCESS)

Recommendation 1: Delete "accreditation" from deficiency definition.
COMAR 10.63.06B(13) defines a failure to meet an accreditation standards as a deficiency. CBH members are subject to 1,400 or more accreditation standards; no provider is ever found to meet all standards because accreditation is designed to be a quality improvement process, not a penalizing process. By including accreditation standards as grounds for deficiencies, the Department subverts the quality improvement purpose of accreditation – and puts behavioral health providers at high risk for civil monetary penalties for failing to meet aspirational standards. No other health care provider in the state is subject to such penalties, raising concerns about how these provisions comply with the state's parity obligations.

Recommendation 2: Add a "material" standard to deficiency definition.
COMAR 10.63.06B(13) does not contain a "materiality" or patient harm standard in the definition of deficiency. CBH recommends that such a limitation be added. If the Department declines to adopt this change, we urge them to explain the underlying parity analysis and policy rationale for subjecting behavioral health providers to a stricter standard than other health care providers in Maryland.

Recommendation 3: Add clear exemption to commercial kitchen licensing requirement.
The proposed regulations require any program serving food to have a commercial kitchen license (COMAR 10.63.06.03C). While BHA staff described an exemption to the regulation during listening sessions, no such exemption is contained in the proposed regulations. This is a material change from the 2024 draft version, which contained a group home/RRP exception. The new provision is at odds with the model of care in RRP and group home settings. Is this accidental or intentional? If intentional, what policy is BHA trying to achieve? Has BHA evaluated the cost of remodeling and coming into compliance for RRP and group home settings, evaluating any potential impact on capacity or access?

Recommendation 4: Add language notifying provider of incomplete application.
In COMAR 10.63.06.04A, we recommend adding language that requires the Department to notify a provider if an application is incomplete and reason that it is incomplete. In the absence of notice of incompleteness, a provider risks having its application withdrawn.

Recommendation 5: Add language requiring the Department to complete license renewals within 30 days of submission.
CBH recommends adding language to COMAR 10.63.06.06B that adds a 30-day timeframe for the Department to communicate its licensing decision to a provider. In 2025, providers report that some licensing renewal applications remain pending for months, leading to challenges maintaining other core operational requirements.

Recommendation 6: Delete standard for denying a license due to unspecified "program deficiencies."
COMAR 10.63.06.06D(4)(a) allows the Department to deny a license renewal application due to unaddressed "program deficiencies." Because deficiency includes accreditation standards and because there is no materiality standard in the deficiency definition, this provision gives the Department the authority to deny a license to virtually every provider under its jurisdiction. A higher bar – and one that is more clearly articulated – is warranted so that providers have the opportunity to try to become compliant. CBH urges the Department to delete 4(a) in its entirety and allow the Department to deny a license only for the reasons articulated in 4(b), including failure to comply with a plan of correction. At a minimum, 4(a) should align with the standard for license denial in COMAR 10.63.06.08C, where the acceptable standard of material non-compliance with statutes and regulations and other material violations are described.

Recommendation 7: Provide a 30-day timeframe for responding to a variance request.
CBH recommends adding a 30-day timeframe for the Department to respond to variance requests in COMAR 10.63.06.10C. A timely response – or the inability to meet it – will help the state evaluate whether it has sufficient staff capacity to meet its obligations under 10.63.

Recommendation 8: Amend regulations to permit appeal from variance decision.
CBH recommends amending COMAR 10.63.06.10I to allow providers to appeal variance decisions.

I. COMMENTS ON COMAR 10.63.09 (CORRECTIVE ACTIONS AND SANCTIONS)

Recommendation 1: Delete "accreditation standard" from deficiency definition.
COMAR 10.63.09B(9) defines a failure to meet an accreditation standard as a deficiency that may form the grounds for issuing a notice of deficiencies (.02A). CBH members are subject to 1,400 or more accreditation standards; no provider is ever found to meet all standards because accreditation is designed to be a quality improvement process, not a penalizing process. By including accreditation standards as grounds for deficiencies, the Department subverts the quality

improvement purpose of accreditation – and puts behavioral health providers at high risk for civil monetary penalties for failing to meet aspirational standards. No other health care provider in the state is subject to such penalties, raising concerns about how these provisions comply with the state's parity obligations.

Recommendation 2: Add materiality or patient harm threshold to deficiency definition, notice of deficiencies, directed plan of correction, intermediate sanctions, summary suspension, and license revocation.

COMAR 10.63.09 does not contain a materiality or patient harm standard in any of the enforcement actions available to the Department. CBH worked extensively with Department staff in earlier iterations of the draft regulations to achieve a compromise approach to provider sanctions. The complete departure from that consensus in the proposed regulations is deeply concerning.

CBH recommends that a materiality or patient harm limitation be added throughout COMAR 10.63.09. If the Department declines to adopt this recommendation, the Department should explain the parity analysis and policy purpose of holding behavioral health providers to a higher standard than any other health provider in the state. We also request a description of the enforcement actions projected under the proposed regulations, and the staffing changes made at the Department to effectuate them.

Recommendation 3: Clarify appeal rights for plans of correction and variance denials.

In COMAR 10.63.05.09, no right of appeal or hearing is described for COMAR 10.63.06.03 (directed plan of correction). For consistency and clarity, CBH recommends adding a right to a hearing for directed plans of action in COMARD 10.63.05.09. We recommend adding an appeal right for variances to the list in COMAR 10.63.05.09 as well.

We welcome any questions or further discussion about the recommendations described here. Please contact me at shannon@mdcbh.org. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director