COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

January 27, 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 of Proposed Action 24-213-P

Dear Ms. Fisher Blotter:

Please accept this letter as the formal comment from the Community Behavioral Health Association of Maryland (CBH) on Notice 24-213-P, proposed amendments to 10.09.59 governing specialty mental health services operating within the Medicaid program. Please note that we will be addressing the school-related portion of the proposed regulations in a separate communication.

Recommendation: Ensure regulations reflect current statutory protections for telehealth in fidelity-reviewed behavioral health programs like Assertive Community Treatment (ACT) and Supported Employment (SE).

Under COMAR 10.09.59.04B(4), the proposed regulations delete the allowance of telehealth in mobile treatment services (MTS) or Assertive Community Treatment (ACT). The regulatory language is derived from the Preserve Telehealth Act of 2021. Currently, Health General § 15-141.2(h)(3) states, "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." For this reason, we recommend retaining COMAR 10.09.59.04B(4) but updating its telehealth reference to conform with Health General § 15-141.2(h)(3) by stating, "(4) ~~**For dates of service between October 1, 2018 and September 30, 2021, a**~~ **[A]** health care service provided through telehealth is equivalent to the same health care service provided through an in-person visit if the service provided **by a Supported Employment Program or** ~~**through telemedicine is provided**~~ by a fully integrated psychiatrist or psychiatric nurse practitioner (CRNP-PMH) attached to an ACT or mobile treatment program."

We believe that the regulatory change recommended above ensures that the proposed regulations fully adopt the General Assembly's repeated legislative initiatives requiring the allowance of telehealth in fidelity-rated programs licensed by the Department.

Recommendation: Disallow subregulatory guidance for telehealth until the Department has single, clear, and durable channel for providing notice to behavioral health providers of subregulatory guidance.

Under COMAR 10.09.59.09F(3), the proposed regulations allow the Department to define telehealth limitations through subregulatory guidance. CBH has strong concerns with the Department's poor history of communicating and maintaining subregulatory guidance for behavioral health services. There is currently no single channel to communicate subregulatory guidance to behavioral health providers; information is delivered via Provider Alerts, Provider Bulletins, manuals, and various training programs. Communications are not numbered, given future effective dates, nor identified when superceded. Links and publication histories to all provider communications disappear every five years when the ASO contract turns over. These problems are illustrated, for example, by an Optum alert in 2021 that "reminded" providers to comply with a transmittal published 19 years earlier, a copy of which is no longer publicly available.[1] This is an absurd approach to distributing subregulatory guidance, and it must change.

The absence of a clear subregulatory publication channel is a categorical barrier to effective enforcement of the rules by the ASO vendor, auditors and other agencies performing oversight.[2] Notice is the core principle of an effective compliance program, and until such practices are in place across the Department, CBH strongly opposes the use of subregulatory guidance to communicate telehealth limits to behavioral health providers. For these reasons, we recommend that COMAR 10.09.59.09F(3) be amended as follows: "Professional services rendered by mail or telehealth, unless the services are provided in compliance with COMAR 10.09.49 ~~**and any subregulatory guidance issued by the Department**~~."

Recommendation: The Department should offer a rational basis for proposing telehealth limits at odds with the Maryland Health Care Commission's recommendations and Preserve Telehealth Act.

The proposed regulations limit telehealth in psychiatric rehabilitation programs for group services or where telehealth exceeds 50% of a client's PRP services. No clinical support, client choice, or other rational basis for the limitation is offered in the statement of purpose for the proposed regulations, nor has it been articulated to stakeholders.

The Maryland Health Care Commission (MHCC) recently published an analysis of telehealth, including behavioral health services, recommends that telehealth remain available in behavioral health services despite utilization growth.[3] In 2021, the Department published a report identifying a 17% increase in expenditures for PRP with a 3% decline in per-person spend, as well as a range of

[1] Optum, "Provider Alert: TAY PRP and School Systems" (April 28, 2021) ("This is a reminder of the original MDH transmittal sent Wednesday, November 13, **2002 [emphasis added**] to Child and Adolescent PRP providers detailing revised PRP guidelines").
[2] *See* CBH, "10.63 Regulatory Confusion" (March 28, 2023); CBH, "Managing the Utilization and Quality of PRP" at p. 7 (June 2023).
[3] Maryland Health Care Commission, "Preserve Telehealth Access Act of 2023 / Behavioral Health Care – Treatment and Access Act" (October 2024).

intended policy and operational changes to strengthen the quality of the program.[4] To date, few of the identified actions have been fully implemented.

To the extent that utilization growth is a concern, it will simply shift to other programs unless the Department takes meaningful action to implement a quality improvement approach to services and strengthen its oversight. If utilization growth in an underlying concern, it would be helpful for the Department to publish the analysis describing the rational basis for its proposed regulation. Understanding patterns in utilization by age, eligibility category, geography, and program can provide assurance to the stakeholder community that the Department's actions have a rational basis. For example, in Baltimore City, the average cost of SUD partial hospitalization program services grew from $5,709 to $12,163 in a three-year period. Despite substantial growth in certain other program services, no limitations on telehealth proposed in COMAR 10.09.80 for community-based substance use services.

CBH supports the Department's efforts to ensure that clients receive appropriate, effective care – and decisions about the appropriate use of telehealth must be informed by utilization data in the Department's possession, as well as the outcome data generated through CBH's measurement-based care project and research such as MHCC's analysis. We look forward to engaging with the Department in future conversations about telehealth that bring all of these informative resources to bear.

We welcome any questions or further discussion about the recommendations described here. Thank you for the opportunity to share our concerns with the Department, and please contact me at shannon@mdcbh.org if you need more information. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director

[4] MDH, "Report on the Causes for the Increase in Psychiatric Rehabilitation Program Expenditures" (January 2021).