COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

Understanding BHA Policy Goals on 10.63 Changes

Underlying Policy Questions | June 4, 2025

The version of 10.63 regulatory changes that was proposed in May 2025 contains new provisions not previously shared with stakeholders, while also reflecting a rejection of some stakeholder feedback offered in response to earlier drafts. It would be helpful to hear BHA's perspective on the underlying policy goals about some of the new provisions or rejected feedback. Questions from CBH include:

1. NEW PROVISION. The proposed regulations describe educational criteria for rehabilitation specialists (COMAR 10.63.02.10) but eliminate the existing regulation's reference to the Psychiatric Rehabilitation Association as a certifying body. This provision did not appear in the draft 2024 regulations. Is the omission of PRA accidental or intentional? If intentional, what policy is BHA trying to achieve? Has BHA projected an expected decline in PRP sites associated with implementation of the regulation? Is BHA aware that 100% of the certified rehabilitation specialists employed by CBH members are certified by PRA?
2. NEW PROVISION. Describe the scope of experimental projects required to get a license (COMAR 10.63.01.02E). What is the goal of this provision?
3. NEW PROVISION. The proposed regulations contain several new provisions relating to telehealth (COMAR 10.63.01.09B), including:
    a. contains a medical necessity definition which belongs in regulations governing Medicaid conditions of participation (COMAR 10.09), rather than in licensing regulations that apply to all payers;
    b. is incomplete, referencing program-specific and practitioner-specific limitations that have not yet been published;
    c. eliminates audio-only back to June 30, 2023 – is this accident or intentional?
    d. Prohibits telehealth without patient present – is this accident or intentional?
    e. How do the proposed regulations align with the Preserve Telehealth Access Act of 2025?
    f. What concerns is BHA trying to address via licensing regulation?
4. NEW PROVISION. The proposed regulations require any program serving food to have a commercial kitchen license (COMAR 10.63.06.03C). 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?
5. NEW PROVISION. CBH and its members are unable to analyze the new staffing requirements in 10.63.02 without the application in program-specific chapters of the proposed regulations. When are the program-specific chapters scheduled to be published?
6. NEW PROVISION. The proposed regulation reference to "dedicated program staff" now includes several staffing positions (such as Medical Director) which were previously "Organizational level staff" (COMAR 10.63.02B). There is an insufficient workforce to support implementation of this requirement, and adoption of the regulation will cause a reduction in treatment sites. How will BHA work to ensure that reductions in

treatment capacity do not disproportionately impact rural areas or vulnerable populations? What projections has BHA made to evaluate projected program closures and increased staffing costs? How does this change impact quality of care and patient outcomes?

7. NEW PROVISION. New staffing position established for "Substance Related Disorder Clinical Supervisor," which is "Dedicated program staff" and does not include CAC-AD with Board-Approved Supervision, which contracts the Board of Professional Counselors and is not a realistic expectation (COMAR 10.63.14). There is an insufficient workforce to support implementation of this requirement, and adoption of the regulation will cause a reduction in treatment sites. How will BHA work to ensure that reductions in treatment capacity do not disproportionately impact rural areas or vulnerable populations? What projections has BHA made to evaluate projected program closures and increased staffing costs? How does this change impact quality of care and patient outcomes?

8. NEW PROVISIONS. The proposed regulations require all line or program supervisors to be Board-approved clinical supervisors (see, e.g., COMAR 10.63.02.09B(2)). Line supervision and clinical supervision, while both forms of mentorship, differ significantly in their focus. Line supervision primarily addresses administrative and organizational tasks, such as ensuring compliance with organizational procedures, managing performance, and assigning tasks. By contrast, clinical supervision concentrates on the professional and clinical development of practitioners such as promoting quality of care, professional development, and ethical practice within a clinical setting. Under Maryland health occupation law, clinical supervisors must generally have the same educational credential category as the staff they are supervising (ie social workers can only supervise social workers). By contrast, an OMHC may have therapists with different licensures (social workers, marriage & family therapists, professional counselors) operating under the line supervision of a single individual, while contracting separately for the clinical supervision of staff. Conflating line supervision functions with clinical supervision duties will conflate 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.

9. UNANSWERED QUESTION. The proposed regulations define "license" as site-specific (COMAR 10.63.01.01B(20)). Currently, RRP licenses are not site-specific. 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. We did not receive a response. Does BHA intend to change RRP licensing to site-specific with these proposed regulations? If so, can BHA please share a written description the site-specific staffing requirements for RRP licenses, which have not yet been published, so that stakeholders have all of the information needed to adequately analyze the proposed regulation?

10. UNANSWERED QUESTION. The proposed regulations define "medically necessary" (COMAR 10.63.01.01B(23)). CBH's feedback on the 2024 draft version of the regulations expressed strong concerns about the bleeding of licensing and payer standards in 10.63 revisions. The continuation of the medical necessity definition in the proposed regulation apparently reflects a rejection of that feedback. It would be helpful to understand why BHA rejected it. Because the medical necessity definition is embedded in licensing regulations, all programs in Maryland are required to adhere to the standard, regardless of broader payer standards. CareFirst and other commercial payers do not currently have cost efficiency as a standard in their definition of medical necessity. Adoption of the proposed medical necessity definition would result in a reduction in access to treatment in the commercial market. What policy goal is BHA trying to achieve with this change?

11. UNANSWERED QUESTION. Organizations offering housing are required to comply with Real Property Code Title 8, which vests tenancy rights in patients residing in housing (COMAR 10.63.01.03C). 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. Can BHA clarify what levels of care fall within the scope of this provision? Does it include RRP, RCS, respite care, and ASAM level 3.0 or higher? What policy is BHA trying to achieve with this provision? If BHA is trying to prevent PHP-with-a-pillow, why was CBH's suggested language referencing the federal standard rejected as an alternate approach? How do tenancy rights interface with medical necessity requirements for continued stay in residential levels of care?

12. UNANSWERED QUESTION. The proposed regulations require providers to seek a variance "upon vacancy" of medical director, program director, clinical director, clinical supervisor or rehab specialist positions, many of which are site-based (COMAR 10.63.02.03B(2)). These positions account for thousands of positions statewide, with an average tenure of 3-5 years. What policy goal is BHA seeking to achieve through reporting of routine turnover? How will bad actors be identified against the overwhelming data submitted? CBH's questions on similar provisions in the draft 2024 regulations went unanswered.

13. UNASWERED QUESTION. The proposed regulations more than triple the type of incidents that trigger a critical incident report to the state (COMAR 10.63.01.06). The expanded list of reportable events includes adverse events (such as interpersonal violence) with sentinel events. There is no nexus between provider action and patient harm in many elements of the revised critical incident list (such as medication error requiring medical intervention), nor is it even clear how providers would conceivably obtain some required reporting elements (suicide attempts after patient discharge). By conflating adverse events with sentinel events, CBH is concerned that overbroad critical incident reporting may obscure providers' ability to identify and respond to sentinel events. It is therefore helpful to understand, item by item, what goals BHA is trying to achieve through its expanded critical incident reporting provisions. It would be helpful to hear how BHA will process the overwhelming volume of data submitted to identify bad actors or reckless programs. This is about patient safety. What we have now doesn't work, and the proposed regulation won't work either. Dialogue and compromise is essential to achieve effective oversight. CBH would welcome an opportunity to host an executive roundtable with BHA about the goals, challenges, and suggested alternative approaches on this provision alone.