ata ACTION
Telehealth Policy to Transform Healthcare

September 18, 2026

Jordan Fisher Blotter
Director, Office of Regulation & Policy Coordination
Maryland Department of Health
201 West Preston Street, Room 534
Baltimore, Maryland 21201

RE: ATA Action Comments on Proposed Action [26-079-P-I] — COMAR 10.63 Community-Based Behavioral Health Programs and Services

Dear Director Fisher Blotter,

On behalf of ATA Action, I am writing to comment on the proposed repeal and adoption of regulations under COMAR 10.63, Community-Based Behavioral Health Programs and Services, published in the August 21, 2026, Maryland Register.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in health, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

ATA Action appreciates the Department's substantial effort to modernize this subtitle and its stated purpose of aligning these regulations with current statutory requirements. We also appreciate that the Behavioral Health Administration has engaged stakeholders across multiple drafting rounds. Much of the proposed telehealth framework is constructive: Regulation .07 of COMAR 10.63.01 appropriately requires consent, sets clear medical record documentation standards, applies the same standard of care to telehealth and in-person services and confirms that telehealth services are subject to the same program restrictions and coverage requirements as in-person services.

Our comments concern a narrower issue. In several places, the proposed regulations restrict telehealth to modalities more limited than those the governing statute provides, in some instances while citing that statute as authority. We respectfully urge the Department to correct these provisions before finalizing the rulemaking.

The Statutory Definition Is Modality-Neutral

The proposed regulations define "Telehealth" by cross-reference to Health-General Article, §15-141.2, Annotated Code of Maryland. That statute expressly provides that telehealth includes synchronous and asynchronous interactions, an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service, and remote patient monitoring

services.[1] The audio-only provision was previously time-limited, but the General Assembly removed that limitation during the 2025 Session through the Preserve Telehealth Access Act, making audio-only a permanent component of the statutory definition.[2] That change applies squarely here: the Act made permanent the behavioral health telehealth protections that govern the services these regulations address.

By incorporating §15-141.2 by reference, the Department has correctly adopted the statutory standard. Our concern is that other provisions of the proposed rule narrow it.

1. The "Face-to-Face" Definition Excludes Audio-Only Across Twelve Chapters

This is our principal concern. Twelve chapters of the proposed subtitle define "face-to-face" as "contact with a program participant that occurs in-person or via audio-visual telehealth in accordance with Health-General Article, §15-141.2, Annotated Code of Maryland."[3]

The definition of "face-to-face" states that it operates in accordance with §15-141.2 while adopting a standard narrower than that section provides. Section 15-141.2 does not limit telehealth to audio-visual modalities; it expressly includes audio-only telephone conversations that result in the delivery of a billable, covered service.

The practical consequence is significant because "face-to-face" is a threshold term throughout the subtitle. Wherever a chapter conditions an assessment, evaluation, required contact or staff availability standard on face-to-face contact, audio-only delivery is foreclosed, across outpatient mental health centers, mobile treatment services, psychiatric rehabilitation programs for minors, partial hospitalization, residential crisis services, opioid treatment programs and therapeutic group homes, among others. This is precisely the population for which audio-only access could matter most. Program participants in rural counties, participants without reliable broadband or video-capable devices and participants for whom video contact presents a barrier to engagement would be unable to access services that the General Assembly has determined are appropriately delivered by audio-only modalities.

We recommend that the definition be revised in each chapter in which it appears to read: "'Face-to-face' means contact with a program participant that occurs in-person or via telehealth in accordance with Health-General Article, §15-141.2, Annotated Code of Maryland." Removing the word "audio-visual" conforms the definition to the statute it already cites and requires no other change.

2. Regulation .07A Excludes Asynchronous Telehealth

Regulation .07A of COMAR 10.63.01 states that the regulation "applies to community-based behavioral health services delivered via synchronous telehealth which are eligible for reimbursement by the Public Behavioral Health System."

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[1] Health-General Article §15-141.2(a)(7)(ii), Annotated Code of Maryland, as amended by Ch. 482 (House Bill 869), 2025 Session.
[2] Ch. 482 (House Bill 869), 2025 Session, striking the bracketed limitation "From July 1, 2021, to June 30, 2025, both inclusive" preceding the audio-only provision at §15-141.2(a)(7)(ii)2.
[3] COMAR 10.62.04.02, 10.63.15.02, 10.63.16.02, 10.63.19.02, 10.63.21.02, 10.63.26.02, 10.63.28.02, 10.63.31.02, 10.63.32.02, 10.63.34.02, and 10.63.35.02, as proposed.

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Because the scope provision reaches only synchronous telehealth, asynchronous care falls outside the regulation entirely, notwithstanding that §15-141.2 expressly includes asynchronous interactions within the definition of telehealth, and notwithstanding that Regulation .07B invokes that same statutory section when setting forth covered service criteria. Asynchronous modalities have well-established clinical applications in behavioral health, including structured assessments, symptom monitoring and between-session therapeutic communication. We recommend that .07A be revised to apply to community-based behavioral health services delivered via telehealth, without the modality qualifier.

3. **The Technical Requirements Address Only Audio-Visual Delivery**

Regulation .07E(2) sets minimum technology requirements for "a service delivered through synchronous audio-visual telehealth," including camera, microphone, bandwidth, and display specifications. No corresponding standard is provided for audio-only delivery. While .07E(1) imposes a general obligation to adopt technology supporting the standard of care, the absence of any audio-only provision alongside a detailed audio-visual specification invites the reading that audio-visual is required. We recommend the Department add a brief provision addressing audio-only delivery, confirming that it is permitted consistent with §15-141.2 and subject to the same privacy, security and standard-of-care obligations.

Conclusion

The Department has stated that the purpose of this action is to align COMAR 10.63 with current statutory requirements. ATA Action supports that objective, and our recommendations are offered to correct identified deficiencies inconsistent with current statute. Conforming the scope provision, the face-to-face definition and the technical requirements to Health-General Article, §15-141.2 would complete the alignment the Department has undertaken and would ensure that community-based behavioral health programs can deliver care through the full range of modalities the General Assembly has authorized

Thank you for your support for telehealth and for the opportunity to comment. Please let us know if there is anything we can do to assist the Department in this rulemaking. If you have any questions or would like to engage in additional discussion regarding the telehealth industry's perspective, please contact me at hyoung@ataaction.org.

Kind regards,

Hunter Young

Hunter Young
Head of State Government Relations
ATA Action