Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

April 22, 2024

Shannon Hall, J.D.
Executive Director
Community Behavioral Health Association of Maryland
18 Egges Lane
Catonsville, MD 21228

Re: COMAR 10.63.03 Community-Based Behavioral Health Programs and Services and 10.19.16 Behavioral Health Crisis Services - Response to February 9, 2024 Proposed Regulation Comments

Dear Shannon Hall:

Thank you for submitting your comments to the Maryland Department of Health's Office of Regulation and Policy Coordination regarding the COMAR 10.63.03 Community-Based Behavioral Health Programs and Services and 10.19.16 Behavioral Health Crisis Services regulations published in the Maryland Register on February 9, 2024. These regulations aim to improve access to behavioral health services for Maryland residents who have urgent and acute mental health and/or substance use disorder needs.

The Department's goal is to ensure Marylanders experiencing a crisis have someone to call, someone to respond, and somewhere safe to go 24 hours a day, 7 days a week. Mobile Crisis Team (MCT) and Behavioral Health Crisis Stabilization Center (BHCSC) services will increase access to high-quality and effective care across the state. These regulations seek to build off existing programs and establish standardized clinical care, intervention practices, and sustainable funding. The Department is committed to partnering with all jurisdictions and providers to support the implementation of these services.

The Department appreciates your input and looks forward to continuing our partnership. The attached Appendix provides responses to your specific comments. If you have any further questions, please contact the BHA Office of Government Affairs at bha.ogac@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

APPENDIX

MOBILE CRISIS SERVICES

Comment

1. Delete program definition for Mobile Crisis.

CBH recommends deleting a program definition specific for Mobile Crisis as proposed in COMAR 10.63.03.21B.

Response

The current definition of "program" in COMAR 10.63.01.02 does not contain language used to define crisis programs. The definition of "program" in COMAR 10.63.01.02 is being amended to include such language. The program definition in COMAR 10.63.03.21 will be removed when the current program definition is amended.

Comment

2. Delete pre-approval requirement for mobile crisis in (B)(4) and (I).

CBH is pleased that the proposed regulations have removed a service pre-authorization requirement as originally proposed. However, we are concerned with new language requiring "pre-approval." The regulations already describe requirements for accreditation, licensing, and Medicaid conditions of participation, but are silent on what additional "pre-approval" steps are required. If providers are to face additional requirements prior to delivering mobile crisis services, we request that those steps be promulgated through regulation, or this provision be deleted in its entirety.

Response

Thank you for this comment. We have not made changes to the regulation because we are requiring these MCTs to be approved by Medicaid and the BHA.

Comment

3. Conform oversight responsibilities of licensed mental health professional in D(1)(h) with E(1)(b)

CBH recommended amending the supervisory language to the term "oversight," because health occupation regulations require supervisors to have the same degree as supervisees. The proposed regulations adopted CBH's recommendation in one section – under E(1)(b) – but failed to make the change under D(1)(h). That provision requires mobile crisis services to be "provided under the documented supervision of a licensed mental health professional approved by the appropriate board to supervise." We recommend amending the language in this provision to require documented oversight, rather than supervision. This change ensures that a supervisory licensed

professional can offer oversight of lower licensed staff, regardless of the specific type of licensure.

Response
Thank you for your comment. LCSW-Cs can be approved by the board of professional counselors to supervise licensed and certified clinicians licensed by their board. CRNPs and Psychologists and Physicians can also become approved by BOPC to supervise individuals licensed or certified by that board. The BSWE is the board which requires their licensees to only be supervised by individuals licensed under their board. Individuals who are licensed at the graduate/master level and certified clinicians are required to practice under the supervision of a board approved supervisor. If there is not a board-approved supervisor then non-independently licensed clinicians and certified staff would not be eligible to provide the service (supervisors have to sign off on documentation such as assessments).

Comment
4. Conform 10.63 telehealth requirements to 10.09.
CBH's attached mark-up recommends changes to bring proposed mobile crisis licensing regulations into conformity with the proposed regulations for conditions of participation in 10.09.16.05(B)(3), which allow the licensed mental health professional to function as a third team member via telehealth.

Response
Thank you for bringing this to our attention. The revised 10.63 regulation now aligns with 10.09.

BEHAVIORAL HEALTH CRISIS STABILIZATION CENTERS

Comment
The proposed crisis stabilization center regulations describe a model of care that is staffing and facility intensive, one that is identified as "Hospital/ED affiliated" in crisis literature. A tiered approach to crisis stabilization that supports less medicalized models of care has been adopted in Virginia. Notably, Virginia's two tiers of crisis stabilization are reimbursed at rates that are 17% and 40% higher than Maryland's.

For these reasons, we urge MDH to explore a modified approach to crisis stabilization services in FY2026, after evaluating the initial roll-out of crisis stabilization centers under the proposed regulations.

Response

The Department acknowledges your organization's concerns regarding the staffing model and reimbursement rate for BHCSC services. We have been studying models in other states and determining the best strategy given the service needs in Maryland. We will work closely with jurisdictions to monitor implementation of BHCSCs and will provide peer-to-peer learning opportunities to support continuous quality improvement.

The Department - through a well-established rate-setting contractor - completed a robust rate-setting process to identify a sustainable rate sufficient to cover providers' reported costs. In addition to the per diem reimbursement rate, the Department will separately reimburse providers for the applicable evaluation and management (E/M) procedure code corresponding to each admission.

Comment

1. Delete program definition for crisis stabilization centers.
CBH recommends deleting a program definition specific for crisis stabilization as proposed in COMAR 10.63.03.21B for the same reasons as offered above for mobile crisis.

Response

The current definition of "program" in COMAR 10.63.01.02 does not contain language used to define crisis programs. The definition of "program" in COMAR 10.63.01.02 is being amended to include such language. The program definition in COMAR 10.63.03.21 will be removed when the current program definition is amended.
or your comment.

Comment

2. Delete pre-approval requirement for crisis stabilization centers.
CBH recommends deleting a program definition specific for crisis stabilization as proposed in COMAR 10.63.03.21B(4) for the same reasons as offered above for mobile crisis.

Response

Thank you for this comment. We have not made changes to the regulation because BHCSs are required to submit an application for licensure and be approved by BHA and they must enroll as a Medicaid provider.

The current definition of "program" in COMAR 10.63.01.02 does not contain language used to define crisis programs. The definition of "program" in COMAR 10.63.01.02 is being amended to include such language. The program definition in COMAR 10.63.03.21 will be removed when the current program definition is amended.
or your comment.

Comment

3. Clarity or amend reference for involuntary admissions.

In COMAR 10.63.03.21C(2), the proposed regulations reference a specific statutory citation – Health General § 10-613 – to describe how crisis stabilization centers should handle involuntary admissions. The referenced citation refers only to the inclusion of minors in involuntary admission procedures, creating confusion about whether crisis stabilization centers are expected to handle involuntary admissions of children only. If the proposed regulations intend to refer to the involuntary admission sections in their entirety, we recommend amending the reference in accordance with the regulatory style manual.

Response

Thank you for your comment. The department can designate CSCs as emergency facilities. CSCs designated by the department will have to follow involuntary procedures under Health General §§10-613 through 10-621.

Comment

4. Delete duplicative provision.

CBH recommends deleting COMAR 10.63.03.21C(9). The same language is duplicated two provisions later in COMAR 10.63.03.21C(11).

Response

Thank you for bringing this to our attention. We have made the suggested revision to the revised regulation.

Comment

5. Align cross-referenced provision between 10.09 and 10.63.

COMAR 10.09.16.05C(3) cross-references an initial evaluation requirement in COMAR 10.63.03.21G. The reference is no longer contained in that provision of the 10.63 regulations. We recommend updating this provision to COMAR 10.63.03.21F.

Response

The Department has corrected the reference in 10.09.16.05C(3).

Comment

6. Delete notice of staffing changes.

CBH recommends deleting COMAR 10.63.03.21E(2) and .21N. Both provisions require the program to notify the Department of staff turnover. In COMAR 10.63.03.21N, the proposed regulation requires reporting of vacancies in accordance with COMAR 10.63.01.05; however, the cited regulatory provision does not require vacancy reporting. We understand that the

Behavioral Health Administration intends to amend COMAR 10.63.01.05 in the future, but the proposed regulations should reference existing regulations, not imaginary ones.

Meanwhile, COMAR 10.63.03.21E(2) requires a provider to report "any changes in staffing composition." It is unclear how reporting staff turnover reasonably relates to any policy objective. CBH's annual workforce surveys indicate that staff turnover in community-based behavioral health programs averages roughly 30% per year, while the time to fill vacancies is at a record high. While we appreciate the Department's interest in ensuring that minimum safe staffing standards are met, reporting staff turnover is overbroad and not an effective means to achieve this goal. CBH recommends that the Department create an enforcement mechanism relying on civil monetary penalties for providers with a demonstrated history and pattern of noncompliance with the staffing requirements of the Medicaid conditions of participation regulations.

Response
Thank you for your comment. The Department is interested in ensuring there is sufficient staffing to safely care for individuals in a BHCSCs. This will be further clarified in policy and regulatory guidance.

Comment
7. Delete requirement for physician on-call at all times.
The proposed regulations require a higher level of medical staffing than is required by SAMHSA's national guidelines or CARF accreditation standards for crisis stabilization. The proposed regulations require a "physician on call at all times for the provision of those BHCSC services that may only be provided by a physician" (10.63.02.21D(5)). By contrast, SAMHSA allows participation of either physicians or nurse practitioners, not both. It is our understanding that the only key difference in the scope of practice between physicians and nurse practitioners relates to surgical interventions, which would not be performed in a crisis stabilization center. The regulations already ensure adequate coverage by either physicians or nurse practitioners. SAMHSA national guidelines encourage crisis stabilization to have the "capacity to assess physical health needs and deliver care for most minor physical health challenges with identified pathways in order to transfer the individual to more medically staffed services if needed." CARF accreditation standards likewise require a path to "access appropriate medical personnel." For these reasons, we recommend deleting the provision requiring a physician on call at all times.

Response
Thank you for your comment. A physician is required to be on-call because there are certain elements of emergency petitions and seclusion and restraint that are required to be checked by a physician within a certain period of time. Staffing and physician requirements will be clarified in policy and regulatory guidance.

Comment

8. In accordance with SAMHSA best practices, allow prescriber to function via telehealth. SAMHSA's best practices indicate that the physician or nurse practitioner may participate via Telehealth. By contrast, Maryland's proposed regulations require prescribers to participate in daily rounds, as well as performing, "staffing," or supervising five assessments or evaluations, of which only the initial evaluation is authorized via telehealth. Consistent with SAMHSA best practices, we recommend deleting the requirement for daily rounds and specifying that prescriber participation via telehealth is authorized.

Response

Thank you for your comment. The regulation at 10.63.03.21E(7) permits a prescriber to participate via telehealth - "An initial evaluation by an approved physician or psychiatric nurse practitioner shall be completed at the earliest reasonable opportunity, which shall be no later than 4 hours after admission, either in-person or via telehealth." Additionally, 10.63.03.21 D(4)(a) notes that a qualified prescriber must be available 24 hours a day. Additional information will be provided in policy and regulatory guidance. The revised regulation maintains daily rounds, but specifies it may need to occur for individuals under an emergency petition if they remain in a BHCSC for more than 24 hours.

(4) A BHCSC program shall employ a qualified prescriber or prescribers who are authorized to prescribe medications by the Maryland Board of Physicians or the Maryland Board of Nursing to provide general medical services and prescription of medications and treatment, and who shall:

(a) Be available 24 hours per day;

Comment

9. Modify regulations to describe minimum information to be gathered, as opposed to series of assessments and evaluations.

The proposed regulations describe ten different activities that must be performed in a crisis stabilization center, including medical screening, nursing assessment, physical exam, crisis assessment, initial treatment plan, initial evaluation, medical evaluation, risk assessment, crisis care plan, and discharge plan. It is unclear whether a crisis stabilization center would be eligible for reimbursement if all these required activities were incomplete, even though a patient's condition upon admission or discharge against medical advice may make the regulatory timeframes or requirements impossible to meet. For these reasons, we recommend a more flexible approach to defining a minimum regulatory floor for the scope of work performed in crisis stabilization centers. CARF, for example, takes a more flexible approach that accounts for

the challenges encountered in crisis stabilization centers. Specifically, CARF's intent statement notes:

Persons served in a crisis stabilization program are frequently transferred or discharged in a matter of hours or very few days. As the completion of a thorough and comprehensive assessment as specified in Section 2.B is impractical in these cases, this standard defines the minimum assessment data that should be collected for persons served. There may be times when completing this is challenging for some persons served if they are unable to participate in the assessment due to their condition at admission. We recommend that the proposed regulations define a minimum floor of information to be collected from individuals presenting in crisis stabilization centers, following CARF's approach, rather than the formulaic series of interventions described in the proposed regulations.

Response
Thank you for your comment. This will be further explored in policy and regulatory guidance.