COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

March 11, 2024

Jourdan Green, Director
Office of Regulation and Policy Coordination
Maryland Department of Health
201 West Preston Street, Room 512
Baltimore, MD 21201

Re: Notices of Proposed Action 23-336-P and 23-339-P

Dear Ms. Green,

Please accept this letter as the formal comments from the Community Behavioral Health Association of Maryland (CBH) on proposed regulations governing the licensing and Medicaid conditions of participation for mobile crisis services and crisis stabilization centers.

CBH is the leading voice for community-based providers serving the mental health and addiction-related needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient, specialty, and residential treatment for mental health and SUD disorders, crisis hotlines, and crisis interventions.

CBH thanks the Department for withdrawing and substantially reworking its approach to crisis services in response to stakeholder feedback.

The proposed regulations and rates achieve a balance that will work in all but the most rural areas for mobile crisis services. Deeper questions remain about both the intensity of the model and sufficiency of the rate for crisis stabilization. Our comments below offer non-material changes to the proposed regulations. In both areas, CBH welcomes continued dialogue with the Department to inform future adjustments to the crisis model.

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

MOBILE CRISIS SERVICES

CBH thanks the Department for substantial changes to the proposed regulations to address many of the concerns raised in earlier versions. Specifically, increasing the reimbursement rate for mobile crisis from $33.95 to $111.80 per 15 minutes addresses our members' concerns about the sustainability of mobile crisis in most areas of the state.

Grant funds will still be required to cover mobile crisis services for uninsured or privately insured individuals, and funding adequacy in rural areas remains a concern. For these reasons, CBH is appreciative of the Department's commitment to ongoing grant funds with year-end reconciliation. Despite the increased flexibility and reimbursement reflected in the proposed regulations, there is concern that the model may not be sustainable in the state's most rural areas. CBH welcomes continued dialogue with the Department to evaluate the implementation of mobile crisis in the coming years to ensure that rural mobile crisis teams remain sustainable under the proposed staffing and rate model.

We have attached a mark-up of the proposed regulations reflecting CBH's recommended changes to the regulations. A rationale for our recommended changes can be found below:

1. **Delete program definition for mobile crisis**.

CBH recommends deleting the program definition for mobile crisis contained in proposed COMAR 10.63.03.20A(2). Earlier in the 10.63 subtitle, COMAR 10.63.01.02A indicates, "**In this subtitle**, the following terms have the meanings indicated" (emphasis added), followed by a definition of "program" as an organization. By contrast, the proposed regulations define a program as a "site and service combination" in COMAR 10.63.03.20A(2).

The Maryland Secretary of State's Style Manual for Regulations indicates, "If definitions are included in your regulations, they should be placed at the beginning of a chapter, that is, under Regulation .01, unless there is a purpose or scope regulation, in which case the definitions are Regulation .02."[1] At odds with the Style Manual's recommendation, the proposed regulations would result in a definition of "program" as organization in Regulation .01, a second definition of "program" as a site in Regulation .03.20A, and a third definition of program in Regulation .03.21A. The purpose of the Style Manual is to "reinforce[] certain rules that are particularly necessary in the drafting of legal text." Adherence to the Style Manual's recommended approach would require a uniform use of the term "program" throughout the subtitle, rather than guesswork to decide which version of the three "program" definitions to apply throughout the regulations. Regulatory guesswork does not translate into effective compliance.

[1] Maryland Office of the Secretary of State, Division of State Documents, "Style Manual for Maryland Regulations," p. 13 (2009).

Critical staffing, notice, liability, compliance, and enforcement activities throughout the 10.63 subtitle all flow from the definition of a "program,"[2] and it is essential to be clear in every instance whether this refers to an organization or a site. For example, subtitle 10.63 requires that a "program" be overseen by a Board,[3] or that a medical director provides oversight of a "program."[4] Whether these requirements attach to organizations or sites has significant impact on cost and infrastructure. Which definition of "program" applies to these requirements if variable definitions exist throughout the subtitle?

Clarity of definition is a prerequisite to successful enforcement, and we are concerned that the proposed regulations reduce effective enforcement by creating conflicting definitions for the same word throughout a single regulatory subtitle. For all of these reasons, CBH recommends deleting a program-specific definition of mobile crisis and, instead, that BHA promulgate regulations in the future to change the definition of program in COMAR 10.63.01.02.

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,[5] or this provision be deleted in its entirety.

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

In our March 23, 2023, comments to the original proposed crisis regulations, 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

[2] *See* COMAR 10.63.06.12 (notice of deficiencies), 10.63.06.17 (initiation of receivership), 10.63.06.18 (civil monetary penalties).
[3] COMAR 10.63.01.02B(11).
[4] COMAR 10.63.01.02B(38).
[5] See MD Code State Government § 10-101(g)(1). See also Office of the Secretary of State, Division of State Documents, "Research Guide for Maryland Regulations," at Section II, pp. 3-4 (1922) ("the broad definition of regulation coupled with the formal publication requirements of the APA make it virtually impossible for an agency policy statement to be enforceable unless it is first promulgated as a regulation under the Administrative Procedure Act").

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.

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.

CRISIS STABILIZATION CENTERS

Our initial understanding of the rationale behind the creation of crisis stabilization centers was twofold: (1) to relieve congestion in hospital emergency departments; and (2) to provide a less chaotic and more therapeutic approach to crisis stabilization utilizing community-based organizations that could provide a seamless transition to ongoing support services. The "ED-lite" requirements in the proposed regulations will likely preclude the participation of those community-based organizations that had planned on providing crisis stabilization services.

CBH represents three organizations currently offering walk-in crisis programs that are potentially eligible for crisis stabilization, as well as one organization considering expansion to crisis stabilization. All of these organizations indicate that the required services and staffing are not supported by the reimbursement rate. Sustainable crisis stabilization would require MDH to either lower staffing and service requirements, increase the reimbursement rate, or a combination of the two.

CBH recommends, instead, that MDH commit to exploration of a tiered approach to crisis stabilization centers in FY2026. 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.[6] A tiered approach to crisis stabilization that supports less medicalized models of care has been adopted in Virginia.[7] Notably, Virginia's two tiers of crisis stabilization are reimbursed at rates that are 17% and 40% higher than Maryland's.[8] 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.

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[6] M. Balfour, *Psychiatric Times*, "An Imperfect Guide to Crisis Stabilization Units: Matching the Right Level of Care to Individual Needs" (May 5, 2023)
[7] See, e.g., Virginia DMAS, "23-Hour Crisis Stabilization And Residential Crisis Stabilization Unit (RCSU) Services" (October 2021).
[8] Virginia DMAS, Bulletin: https://vamedicaid.dmas.virginia.gov/bulletin/behavioral-health-service-rate-updates-effective-january-1-2024

Our recommended changes to the proposed crisis stabilization centers are reflected in the attached mark-up and explained below:

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.

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.

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.[9]

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).

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 10.63.03.21**F**.

[9] Maryland Office of the Secretary of State, Division of State Documents, "Style Manual for Maryland Regulations," p. 18 at Section 6(h) (2009).

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.[10] 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.

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,[11] 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."[12] CARF accreditation standards likewise require a path to "access appropriate medical personnel."[13] For these reasons, we recommend deleting the provision requiring a physician on call at all times.

[10] Community Behavioral Health Association of Maryland, "Maryland's Missing Workforce: Staff Vacancies Slash Treatment Capacity" (January 22, 2024).
[11] SAMHSA, "National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit" (2020) at p. 22, No. 5(a).
[12] SAMHSA, "National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit" (2020), p. 22 at No. 4.
[13] CARF, Behavioral Health Standards Manual, Section 3E (Crisis Programs) at Standard 26.c.

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.[14] By contrast, Maryland's proposed regulations require prescribers to participate in daily rounds,[15] as well as performing, "staffing," or supervising five assessments or evaluations, of which only the initial evaluation is authorized via telehealth.[16] Consistent with SAMHSA best practices, we recommend deleting the requirement for daily rounds and specifying that prescriber participation via telehealth is authorized.

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.[17] 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.[18]

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[14] SAMHSA, "National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit" (2020) at p. 22, No. 5(a).
[15] COMAR 10.63.03.21D(4)(b).
[16] Nursing assessment and physical exam "in collaboration" with prescriber (F(2)), crisis assessments "staffed with" the prescriber (F(5)), initial evaluations "approved" by the prescriber (F(7)), plus "review and sign off" on all discharge plans (F(6)).
[17] COMAR 10.63.03.21C(6) (medical screening), 10.63.03.21F(2) (nursing assessment and physical examination), 10.63.03.21F(3) (crisis assessment), 10.63.03.21F(6) (discharge plan), 10.63.03.21F(7) (initial evaluation), 10.63.03.21F(7)(a) (medical evaluation), 10.63.03.21F(7)(b) (risk assessment), 10.63.03.21F(7) (care plan).
[18] CARF, Behavioral Health Standards Manual, Section 3E (Crisis Stabilization) at p. 200.

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.[19]

In conclusion, CBH appreciates the Department's work in implementing Medicaid reimbursement to increase capacity for mobile crisis services and crisis stabilization centers. Adoption of the proposed regulations can strengthen mobile crisis in most areas of the state. As implementation of crisis services with Medicaid funding is implemented, we welcome a seat at the table with the Department in evaluation of the programs to ensure that programs are sustainable in coming years.

Please do not hesitate to reach out to me for questions or clarifications about CBH's comments on the proposed regulations. I can be reached at shannon@mdcbh.org.

Sincerely,

Shannon Hall, J.D.
Executive Director

[19] *See, e.g.,* SAMHSA, "National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit" (2020), at pp. 54-56 (reduction in screening and assessment improved crisis center capacity case study).

COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

Subtitle 63 COMMUNITY-BASED BEHAVIORAL HEALTH PROGRAMS AND SERVICES

Notice of Proposed Action
[23-336-P]

10.63.02 Programs Required to Be Accredited in Order to Be Licensed to Provide Community-Based Behavioral Health Services

Authority: Health-General Article, §§7.5-204, 8-402, 8-404, **[**and**]** 10-901, *and 10-1402*, Annotated Code of Maryland

.02 Covered Programs and Services.

A. The following programs shall require an accreditation-based license under this chapter:

(1)—(16) (text unchanged)

(17) Respite Care Services (RPCS) programs; **[**and**]**

(18) Supported Employment Program (SEP) programs**[**.**]**;

(19) Mobile Crisis Team programs; and

(20) Behavioral Health Crisis Stabilization Center (BHCSC) programs.

B.—C. (text unchanged)

10.63.03 Descriptions and Criteria for Programs and Services Required to Have an Accreditation-Based License

Authority: Health-General Article, §§7.5-204, 8-402, 8-404, **[**and**]** 10-901, *and 10-1402*, Annotated Code of Maryland

.20 Mobile Crisis Team Programs.

A. Definition.

(1) In this regulation, the following term has the meaning indicated.

~~*(2) Term Defined. "Program" means the site and service combination which is recognized through licensure to offer an organized system of activities performed for the benefit of persons served.*~~

B. In order to be licensed under this subtitle, a mobile crisis team within a Mobile Crisis Team program shall:

(1) Meet the requirements of COMAR 10.63.01, 10.63.02, and 10.63.06 and this regulation;

(2) Provide, 24 hours per day, 7 days per week, 365 days per year, professional intervention for children or adults whose behaviors are consistent with experiencing:

(a) A mental health crisis;

(b) A substance use disorder crisis; or

(c) Both §B(2)(a) and (b) of this regulation;

(3) Meet the requirements defined in Mental Health Law, Title 10, Subtitle 14, Annotated Code of Maryland;

~~*(4) Be pre-approved by the Department or its designee to participate in the public behavioral health system to receive funding through the Department; and*~~

(5) Respond to urgent, non-threatening emotional symptoms or behaviors that are disrupting an individual's functioning.

C. Mobile crisis team response may also include engaging law-enforcement where the addition of a law enforcement presence provides additional safety measures, when indicated, for all individuals involved in the mobile crisis intervention.

D. Mobile Crisis Team Program Services. A mobile crisis team program shall provide the following services:

(1) In-person, community-based professional and peer intervention services which shall:

(a) Be age and culturally appropriate, and explained in terms understandable to the individual;

(b) Be designed to:

(i) De-escalate an individual's behavioral health crisis;

(ii) Evaluate the nature of the crisis;

(iii) Stabilize the individual to the pre-crisis level of functioning; and

(iv) Maintain continuity of care by coordinating access to various treatment and support services;

(c) Be deployed to the location of an individual in crisis;

(d) Address immediate dynamics that may be contributing to the crisis;

(e) Include response initiated within an average of 60 minutes of determining an individual is in need of crisis intervention;

(f) Use evidence-based tools to screen, assess, stabilize, and refer persons, as clinically indicated;

(g) Be provided by a mobile crisis team that is nearest to the location of the individual in crisis; and

(h) Be provided under the documented ~~***supervision***~~ ***oversight*** *of a licensed mental health professional* ~~***approved by the appropriate board to supervise***~~.

(2) Crisis Intervention Services. A mobile crisis team program shall provide medically necessary crisis intervention services, inclusive of the following:

(a) Triage and screening to determine the level of risk faced by the individual in crisis and assess the most appropriate response;

(b) An immediate assessment conducted by a licensed mental health professional to determine the services necessary to stabilize the crisis for the individual;

(c) A plan for de-escalation and resolution of the crisis, including in-person interventions for immediate de-escalation of presenting emotional or behavioral symptoms;

(d) Brief therapeutic and skill-building interventions and therapeutic counseling techniques specific to the crisis that aims to lower risks and resolve the crisis so that a higher level of care is not needed;

(e) Case management and care coordination services, which may include referrals to other services as well as follow-up contacts;

(f) Engaging peer and natural and family support;

(g) A safety crisis plan, which shall aim to keep an individual in crisis and their environment safe and may include the distribution of opioid overdose reversal drugs, lethal means counseling, and other evidence-based interventions;

(h) Stabilization services to ensure the individual's safety and connection to needed resources which reduce the conditions leading to crisis; and

(i) Follow-up screening and assessment for ongoing risk when indicated by the needs of persons served, in-person, via phone, or via telehealth following the initial crisis intervention.

(3) Follow-up services, which shall include, but are not limited to:

(a) Referral and linkage with other service providers; and

(b) Ongoing coordination to meet identified resource needs.

E. Mobile Crisis Team Program Staffing.

(1) A mobile crisis team program shall include at least one licensed mental health professional available at all times, either via telehealth or face-to-face when indicated, who is:

(a) Licensed at the independent practice level;

(b) Eligible to oversee the staff of the team; and

(c) Eligible to complete an emergency petition.

(2) A mobile crisis team program may also include:

(a) Additional licensed mental health professionals to ensure shift coverage;

(b) Certified peer and family recovery support specialists or individuals who complete the certification process within 2 years of hire; and

(c) Other staff, who shall complete training as set forth in §G of this regulation.

(3) Certified peer and family recovery support specialists may not respond independently without a mental health or licensed professional ***in-person or via telehealth****.*

F. A mobile crisis team responding ~~*in-person*~~*:*

(1) Shall include two staff members ***in person****;*

(2) Shall include a licensed mental health professional ***in person or via telehealth****; and*

(3) May not consider law enforcement, when present, as part of the two-person ***in-person*** *response team.*

G. Mobile Crisis Team Program Staff Training Requirements.

(1) All mobile crisis team program staff shall complete required trainings approved by the Department.

(2) A mobile crisis team program shall have a training and competency plan in place that:

(a) Is reviewed annually;

(b) Is consistent with:

(i) Accreditation requirements; and

(ii) Requirements published by the Department;

(c) Defines the core competencies needed to provide reliable and high-quality care for each clinical discipline, within their scope of practice, as a staff member of a mobile crisis team; and

(d) Ensures that all staff receive competency verification following all initial and ongoing training.

(3) All mobile crisis teams shall be trained in the mobile response and stabilization services (MRSS) model.

H. Mobile Crisis Team Program Reporting Requirements. A mobile crisis team program shall provide data on outcomes and social determinants of care to the State in the format and frequency required by the Department.

~~*I. A mobile crisis team program shall obtain pre-approval from the Department and LBHA or CSA to operate mobile crisis services in the PBHS ensuring that the services meet local community needs for behavioral health crisis services.*~~

.21 Behavioral Health Crisis Stabilization Center (BHCSC) Program.

A. Definition.

(1) In this regulation, the following term has the meaning indicated.

~~*(2) Term Defined. "Program" means the site and service combination which:*~~

~~*(a) Is recognized through licensure to offer an organized system of activities to provide an alternative to emergency departments for behavioral health crisis care, emergency petition assessment, and avoidable inpatient or carceral admissions; and*~~

~~*(b) Serves as a critical access point for individuals experiencing a mental health, substance use disorder, substance use related, or combined crisis.*~~

B. In order to be licensed under this subtitle, a BHCSC program shall:

(1) Meet the requirements of this regulation;

(2) Meet the requirements of Health-General Article, Title 10, Annotated Code of Maryland;

(3) Meet the requirements of COMAR 10.63.01—10.63.06; and

~~*(4) Be pre-approved by the Department or its designee to receive PBHS funding before participating in the PBHS*~~.

C. BHCSC Program Services. The BHCSC program shall:

(1) Provide crisis response services as outlined in Health-General Article, Title 10, Subtitle 14, Annotated Code of Maryland;

*(2) Process involuntary admissions according to Health-General Article, §§ 10-613 **– 10-619**, Annotated Code of Maryland;*

(3) Provide BHCSC services 24 hours a day, 7 days a week, 365 days a year;

(4) Initiate triage upon patient arrival and deliver this service in a manner that aligns with best practice and makes reasonable efforts to minimize time on-site at the BHCSC for law enforcement or other first responders;

(5) Use evidence-based tools to screen, assess, stabilize, and refer persons, as clinically indicated;

(6) Provide medical screening at triage for the presence of any condition of sufficient severity to require transfer to an appropriate facility for immediate medical or surgical care;

(7) Provide active acute mental health and substance use disorder crisis intervention and stabilization services in a BHCSC setting that is not in the Health Services Cost Review Commission regulated space of a hospital, for children, adolescents, and adults whose behaviors are consistent with experiencing:

(a) A mental health crisis;

(b) A substance use disorder crisis; or

(c) Both §C(7)(a) and (b) of this regulation;

(8) Provide assessment, counseling, de-escalation, and safety planning;

~~*(9) Provide withdrawal management services for all substances;*~~

(10) Initiate, maintain, and prescribe psychotropic and somatic medications as appropriate, including:

(a) PRN intramuscular medication;

(b) Long-acting injectable antipsychotic medication;

(c) Medications used for withdrawal management; and

(d) Medications for Opioid Use Disorder;

(11) Provide withdrawal management services for all substances; and

(12) Maintain compliance with the model program structure and facility standards designed by the Department, as required by Health-General Article, §10-621, Annotated Code of Maryland.

D. BHCSC Staffing Requirements.

(1) A BHCSC program shall designate a program director who is a licensed mental health professional operating at the independent level of practice who shall be responsible for the overall management and operation of the BHCSC and whose qualifications and duties are defined in the individual's job description. The job description shall ensure that other job responsibilities will not impede the operation and administration of the BHCSC.

(2) A BHCSC program shall have a nursing manager who is a registered nurse.

(3) A BHCSC program shall continuously employ an adequate number of staff and ensure an appropriate staff composition are on-site to:

(a) Carry out the BHCSC program's services, goals, and objectives; and

(b) Ensure the continuous provision of sufficient supervision and monitoring of individuals receiving crisis stabilization services.

(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;

~~*(b) Make daily rounds*~~*; and*

(c) Be approved by the Department if the qualified prescriber is not a psychiatrist or a psychiatric nurse practitioner.

~~*(5) A physician shall be on call at all times for the provision of those BHCSC services that may only be provided by a physician.*~~

(6) There shall be a minimum of one registered nurse on site at all times.

(7) There shall be additional staff, including mental health professionals, on-site at all times to provide active crisis intervention to ensure BHCSC services are provided by personnel within their scope of practice and with expertise appropriate to the service recipient's needs.

E. BHCSC Staffing Plan.

(1) A BHCSC program shall develop and maintain a written staffing plan designed to ensure sufficient coverage, discipline mix, service quality, and safety and which shall:

(a) Outline the qualifications and duties of each staff position; and

(b) Be approved by the Department at the time of licensure.

(~~2) A BHCSC program shall notify the Department of any changes in staffing composition, or an addition or reduction in staffing numbers that varies from the approved staffing plan by greater than 10 percent~~.

F. BHCSC Program Quality Assurance and Reporting.

(1) A BHCSC program shall begin assessment and active treatment immediately upon a patient's admission.

*(2) A BHCSC program shall ensure that, within 60 minutes or less of the individual's arrival, a registered nurse initiates an in-person nursing assessment and physical exam in collaboration with the approved physician or psychiatric nurse practitioner, **who may function via telehealth**, and develops and implements an initial treatment plan for services in the BHCSC.*

(3) A BHCSC mental health professional shall provide a crisis assessment at the earliest opportunity.

(4) For individuals with stays beyond 23 hours, BHCSC mental health professional staff shall perform, at a minimum, daily in-person reassessment.

*(5) Crisis assessments shall be staffed with the approved physician or psychiatric nurse practitioner, **who may function via telehealth;***

(6) An approved physician or psychiatric nurse practitioner shall review and sign off on every discharge plan for individuals receiving services in the BHCSC.

(7) 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, and include the following:

(a) A medical evaluation;

(b) Assessment of suicide, homicide, violence, and other risk factors; and

(c) Review and authorization of the BHCSC initial crisis intervention care plans.

*(8) A psychiatrist or psychiatric nurse practitioner, **who may function via telehealth**, shall conduct at least daily follow-up examinations for individuals that have not been discharged.*

(9) A BHCSC program shall maintain relationships with existing community behavioral health service providers who may receive referrals from the BHCSC, which shall include written referral agreements with the following:

(a) Outpatient community behavioral health providers;

(b) Hospital psychiatric units;

(c) Residential crisis programs;

(d) Respite programs;

(e) Residential substance use treatment programs; and

(f) Providers of medications for opioid use disorders.

(10) A BHCSC program shall make documented attempts to contact and follow up with all individuals discharged to a community setting and, for individuals who received outpatient services and who initially presented or were later evaluated as a danger to self or others, follow up within 72 hours after discharge from the BHCSC.

(11) A BHCSC program shall have protocols, which may include referral agreements with other programs, that provide for admission and treatment of individuals with:

(a) Limited English proficiency;

(b) Hearing and speaking disabilities; and

(c) Physical and intellectual disabilities.

(12) A BHCSC program shall develop and maintain written triage policies and procedures approved by the Department, including ability to accept and provide services to individuals under an emergency petition.

(13) A BHCSC program shall notify the Department and LBHA, in a form and manner determined by the Department, of the following:

(a) Initiation of diversion status for the BHCSC program; and

(b) Diversion of any individual on an emergency petition.

(14) A BHCSC program shall maintain a referral log that includes documentation and rationale for individuals not accepted for admission or transfer to the BHCSC, and make this available to the Department upon request.

(15) A BHCSC program shall develop, implement, and maintain written policies and procedures in place to ensure the safety of all individuals, regardless of age.

(16) A BHCSC program shall provide data to support quality assurance and improvement initiatives to the State in the format and frequency requested by the Department.

G. BHCSC Program Staff Training Requirements.

(1) BHCSC program staff shall complete required trainings published by the Department.

(2) A BHCSC program shall have a training and competency plan in place that:

(a) Is reviewed annually;

(b) Is consistent with:

(i) Accreditation requirements; and

(ii) Requirements published by the Department;

(c) Defines the core competencies needed to provide reliable and high-quality care for each clinical discipline within their scope of practice as a part of the BHCSC program; and

(d) Ensures that all staff receive needed training and competency verification.

H. Clinical Record Documentation. A BHCSC program shall maintain, either manually or electronically, adequate documentation of each contact with a participant as part of the medical record, which, at a minimum, includes:

(1) The date or dates of service within the BHCSC, including triage and discharge times;

(2) The individual's presenting problems or reason for the BHCSC admission;

(3) A brief description of services provided, including progress notes;

(4) An official e-Signature, or a legible signature, along with the printed or typed name, and appropriate title of each individual providing services;

(5) Documentation of risk assessments;

(6) Documentation of medication evaluation and management throughout the stabilization period;

(7) Crisis assessment or assessments by the mental health professional staff; and

(8) A crisis discharge plan for each individual, which shall indicate the referrals and other activities intended to maintain stabilization.

I. Seclusion and Restraint.

(1) A BHCSC program shall have the capacity for both seclusion and restraint. For purposes of this regulation:

(a) Seclusion has the meaning set forth in 42 CFR §482.13(e)(1)(ii); and

(b) Restraint has the meaning set forth in 42 CFR §482.13(e)(1)(i).

(2) A BHCSC program shall be compliant with State and federal seclusion and restraint regulations and laws, including 42 CFR §482.13 and Health-General Article, §10-701, Annotated Code of Maryland, and any successor laws and regulations.

(3) Application of seclusion or restraint within a BHCSC program requires:

(a) Use as a last resort, only after less restrictive interventions have been considered or tried, unless the emergency nature of the situation precludes the latter, and

(b) An order from an approved physician or other clinician permitted by law, with exceptions noted for an emergency as outlined in §I(4) of this regulation.

(4) Seclusion and restraint may be initiated by a registered nurse, if a physician or other clinician permitted by law is not present and an emergency situation warrants immediate seclusion or restraint, in which case:

(a) BHCSC staff shall obtain an order as soon as possible, but no later than within 1 hour; and

(b) A clinical assessment by a psychiatrist or psychiatric nurse practitioner shall occur within 1 hour of initiation or renewal by a registered nurse.

(5) An order for seclusion or restraint may not exceed 4 hours for adults, 2 hours for youth 9 years old or older, and 1 hour for children younger than 9 years old. Such an order does not require continuation of the seclusion or restraint for the entire time specified by the order. The seclusion or restraint shall be discontinued as soon as clinically indicated.

(6) An individual in seclusion or restraint shall be maintained on 1:1 observation the entire time the individual is secluded or restrained to protect them from harm.

(7) Restraint and seclusion shall never occur simultaneously for an individual.

J. Environmental/Life Safety Requirements.

(1) A BHCSC program shall:

(a) Provide a comfortable, furnished admission pre-triage waiting area for individuals who voluntarily present;

(b) Provide a locked and secure dedicated drop-off admission space, designed to accommodate those individuals who have been emergency petitioned;

(c) Provide a comfortable, furnished waiting area for individuals accompanying participants in the BHCSC program;

(d) Allow for continual visual observation and monitoring of individuals being served;

(e) Ensure a safe environment of care for a participant younger than 18 years old by having a separation from adults, with appropriate staff maintaining an adequate level of supervision;

(f) Ensure that the 23-hour crisis BHCSC shall have at least one locked door seclusion room, which:

(i) Shall be a minimum of 80 square feet;

(ii) Allows for continual visual observation and monitoring that allows for immediate emergency response; and

(iii) Uses a locking mechanism consistent with National Fire Protection Association (NFPA) standards for the facility; and

(g) Ensure that there is at least one quiet room that is separate from the seclusion room and remains unlocked whenever in use.

(2) The Department may require the BHCSC program to add additional seclusion or quiet rooms, based on the intended capacity of the BHCSC Program.

(3) The BHCSC program facility shall be free from fire hazards and have:

(a) Adequate smoke detectors;

(b) Working and updated fire extinguishers;

(c) Fire sprinklers as required by law;

(d) A written fire evacuation plan; and
(e) A current fire inspection certification.

(4) The BHCSC program shall conduct and document an annual environmental safety review and take actions to replace items that create an unnecessary risk of self-harm with safer items designed for behavioral health settings, including, but not limited to:

(a) Anchor points;
(b) Door handles;
(c) Curtains;
(d) Hooks; and
(e) Shower rods and curtains.

(5) The BHCSC program shall comply with applicable federal, State, and local sanitation, building, fire codes, and zoning requirements.

(6) The BHCSC program shall maintain documentation of legally and accreditation required periodic evacuation drills.

(7) The BHCSC program shall have:

(a) Bathrooms;
(b) Telephones;
(c) An automated external defibrillator; and
(d) Confidential office space for treatment.

K. BHCSC Dietary Services. BHCSC program dietary services shall be as follows:

(1) At least three meals plus an evening snack provided daily with no more than 14 hours between any two meals;
(2) Dietary services shall comply with applicable local, State, and federal laws;
(3) A BHCSC program shall have a written plan describing the organization and delivery of dietary services; and
(4) A dietitian licensed under Health Occupations Article, §5-101, Annotated Code of Maryland, shall develop and implement the dietary service plan.

L. Infection Control—Universal Precautions. A BHCSC program shall observe universal precautions as required under COMAR 10.52.11 as applicable to health care facilities.

M. Site Inspection. At a minimum, an annual site inspection of each BHCSC shall be conducted by the assigned LBHA.

~~*N. Required Management Staff. The required staff in a BHCSC program, as defined in subsection §D of this regulation and COMAR 10.63.01, and subject to the requirements for reporting of vacancies under COMAR 10.63.01.05, includes:*~~

~~*(1) Program director;*~~
~~*(2) Medical director;*~~
~~*(3) Nurse manager; and*~~
~~*(4) Mental health professionals in the event that the vacancy leads to an inability to meet the staffing requirements of the regulation*~~.

LAURA HERRERA SCOTT

10.09.16 Behavioral Health Crisis Services

Authority: Health-General Article, §§2-104(b), 2-105(b), 15-103, and 15-105, Annotated Code of Maryland

Notice of Proposed Action

[23-339-P]

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Administrative Services Organization (ASO)" means the contractor procured by the State to provide the Department with administrative support services to operate the Maryland Public Behavioral Health System.

(2) "Behavioral Health Administration (BHA)" means the administration within the Department that establishes regulatory requirements for behavioral health programs are to maintain in order to become licensed by the Department.

(3) "Core Service Agency" means the local mental health authority responsible for planning, managing, and monitoring public mental health services at the local level.

(4) "Crisis" means the experience of stress, emotional or behavioral symptoms, difficulties with substance use, or a traumatic event that compromises an individual's ability to function within their current family and living situation, school, workplace, or community, as defined by the individual experiencing the crisis.

(5) "Crisis intervention" means the ability to perform or provide crisis assessment, crisis de-escalation, psychoeducation, brief behavioral support, and referral and linkage to appropriate services and supports.

(6) "Department" means the Maryland Department of Health, as defined in COMAR 10.09.36.01, or its authorized agents acting on behalf of the Department.

(7) "Licensed mental health professional" means a:

(a) Psychiatrist;

(b) Licensed psychologist;

(c) Psychiatric nurse practitioner (CRNP-PMH);

(d) Clinical nurse specialist in psychiatric and mental health nursing (APRN-PMH);

(e) Licensed certified social worker-clinical (LCSW-C);

(f) Licensed clinical alcohol and drug counselor (LCADC);

(g) Licensed clinical marriage and family therapist (LCMFT);

(h) Licensed clinical professional art therapist (LCPAT);

(i) Licensed clinical professional counselor (LCPC); or

(j) Properly supervised:

(i) Licensed master social worker (LMSW);

(ii) Licensed graduate alcohol and drug counselor (LGADC);

(iii) Licensed graduate marriage and family therapist (LGMFT);

(iv) Licensed graduate professional art therapist (LGPAT);

(v) Licensed graduate professional counselor (LGPC);

(vi) Licensed certified social worker (LCSW); or

(vii) Psychology associate.

(8) "Medical Assistance" has the meaning stated in COMAR 10.09.24.02.

(9) "Medically necessary" has the meaning stated in COMAR 10.09.36.01.

(10) "Participant" means an individual who is certified as eligible for, and is receiving, medical assistance benefits.

(11) "Program" has the meaning stated in COMAR 10.09.36.01.

(12) "Provider" means an organization or an individual practitioner furnishing the services covered under this chapter which, through appropriate agreement with the Department, has been identified as a Program provider by the issuance of a provider account number.

.02 License Requirements.

To participate in the Program, a provider shall meet the license requirements stated in COMAR 10.09.36.02, 10.63.01.05, and 10.63.02.03.

.03 Provider Requirements for Participation.

A. A provider shall meet all conditions for participation as set forth in COMAR 10.09.36.03.

B. To participate in the Program, a provider of behavioral health crisis services shall:

(1) Meet the conditions for licensure and practice as set forth in COMAR 10.63.01, 10.63.02, and 10.63.06;

(2) Have clearly defined and written patient care policies;

(3) Maintain, either manually or electronically, adequate documentation of each contact with a participant as part of the medical record, which, at a minimum, meets the following requirements:

(a) Includes the date of service with service start and end times;

(b) Includes the participant's primary behavioral health complaint or reason for the visit;

*(c) Includes a brief description of the service provided, including progress notes**, which can indicate no progress if none has been achieved**;*

(d) Includes an official e-Signature, or a legible signature, along with the printed or typed name, and appropriate title of each individual providing services, including each separate member of the mobile crisis team;

(e) Is made available to the Department or its designee as requested; and

(f) Complies with all federal statutes and regulations, including the Health Insurance Portability and Accountability Act, 42 U.S.C. §1320D et seq., and implementing regulations at 45 CFR Parts 160 and 164.04.

C. To participate in the Program, a mobile crisis team provider shall:

(1) Comply with COMAR 10.63.03.20;

(2) Be available to provide services outlined in Regulation .05 of this chapter 24 hours a day, 7 days a week;

(3) Provide a timely response with a two-person team as described in COMAR 10.63.03.20;

(4) Comply with staffing and supervision requirements as described in COMAR 10.63.03.20F; and

(5) Ensure all crisis team staff members receive training as required and approved by the Department.

D. To participate in the Program, a behavioral health crisis stabilization center provider shall:

(1) Comply with COMAR 10.63.03.21;

(2) Be open and accessible to walk-ins 24 hours a day, 7 days a week;

(3) Comply with the staffing requirements described in COMAR 10.63.03.21E;

(4) Maintain the ability to initiate withdrawal management capabilities for all substances as well as initiate medication assisted treatment for opioid use disorder; and

(5) Equally accept individuals presenting due to an emergency petition and individuals presenting voluntarily.

.04 Participant Eligibility.

A. A participant is eligible for mobile crisis team services and behavioral health crisis stabilization center services if they are experiencing a crisis as defined in Regulation .01 of this chapter.

B. A participant is eligible for behavioral health crisis services if the service is appropriate to the specific provider type listed in Regulation .05 of this chapter.

.05 Covered Services.

A. The Department shall reimburse for the services in §§B—C of this regulation when these services have been documented, pursuant to the requirements in this chapter, as necessary.

B. Mobile crisis team services shall:

(1) Comply with COMAR 10.63.03.20;

(2) Consist of an in-person response by at minimum a two-person team;

*(3) Include an initial assessment by a licensed mental health professional, which may be rendered via telehealth only when the licensed mental health professional functions as a third team member; [**conform 10.63 to this provision**]*

(4) Involve the following interventions and objectives:

(a) Crisis intervention and stabilization of the individual's behavioral health crisis;

(b) Safety planning; and

(c) Referrals to community supports, including behavioral health providers, health providers, or social and other services; and

(5) Include mobile crisis follow-up outreach by means of telephone, telehealth, or in-person contact with the individual served or family member and referred providers, if applicable.

C. Behavioral health crisis stabilization center services shall:

(1) Comply with COMAR 10.63.03.21;

(2) Consist of an initial nursing assessment and physical exam by a registered nurse in collaboration with a physician or psychiatric nurse practitioner;

*(3) Include an initial evaluation by an approved physician or psychiatric nurse practitioner in accordance with COMAR ~~10.63.03.21G~~ **10.63.03.21F***

(4) Include a crisis assessment completed by a licensed mental health professional; and

(5) Involve the following interventions and objectives:

(a) Crisis intervention and stabilization of the individual's behavioral health crisis;

(b) Safety planning;

(c) Pharmacological interventions, including the ability to initiate withdrawal management capabilities for all substances, and initiate medications for medication assisted treatment for opioid use disorder; and

(d) Referrals to community-based services or to higher levels of care as clinically indicated.

.06 Limitations.

A. The Program does not cover the following:

(1) Services not delivered in compliance with Regulation .05 of this chapter;

(2) Services not medically necessary;

(3) Investigational or experimental drugs and procedures;

(4) Services solely for the purpose of:

(a) Prescribing medication;
(b) Administering medication;
(c) Drug or supply pick-up;
(d) Collecting laboratory specimens;
(e) Interpreting laboratory tests or panels; or
(f) Administering injections;

(5) Separate reimbursement to an employee of a program for services that have been provided by and reimbursed directly to a program;

(6) Services provided to or for the primary benefit of individuals other than the participant;

(7) Mobile crisis team services rendered by telehealth with the exception of those specified as permissible via telehealth in Regulation .05 of this chapter;

(8) Behavioral health crisis stabilization center services rendered by telehealth with the exception of those specified in COMAR 10.63.03.21;

(9) Non-emergency services not authorized by the ASO;
(10) Services provided to participants in a hospital inpatient setting; and
(11) Services rendered but not appropriately documented.

B. Providers may not be reimbursed by the Program for:
(1) Behavioral health crisis stabilization center services exceeding 23 hours 59 minutes;
(2) Presumptive and definitive drug testing when billed by a behavioral health crisis stabilization center; or
(3) Transportation costs.

.07 Payment Procedures.

A. General policies governing payment procedures that are applicable to all providers are set forth in COMAR 10.09.36.04.

B. Billing time limitations for claims submitted under this chapter are set forth in COMAR 10.09.36.06.

C. Rates for the services outlined in this chapter shall be as follows:
(1) For services outlined in this regulation as delivered through a mobile crisis team:
(a) Mobile crisis team services – $111.80 per 15-minute unit increment; and
(b) Mobile crisis follow-up outreach – $111.80 per 15-minute unit increment.
(2) For services outlined in this regulation as delivered through a behavioral health crisis stabilization center:
(a) Behavioral health crisis stabilization services – $721.21 per diem; and
(b) Office-based evaluation and management services, according to COMAR 10.09.02.07D.

.08 Recovery and Reimbursement.

Recovery and reimbursement are as set forth in COMAR 10.09.36.07.

.09 Cause for Suspension or Removal and Imposition of Sanctions.

Cause for suspension or removal and imposition of sanctions are as set forth in COMAR 10.09.36.08.

.10 Appeal Procedures for Providers.

Appeal procedures for providers are as set forth in COMAR 10.09.36.09.

.11 Appeal Rights — Denial of Services.

Appeal procedures for applicants and participants are as set forth in COMAR 10.01.04.

.12 Interpretive Regulation.

State regulations are interpreted as set forth in COMAR 10.09.36.10.