COMMUNITY BEHAVIORAL HEALTH ASSOCIATION OF MARYLAND

August 29, 2024

Alyssa Lord
Deputy Secretary for Behavioral Health
Maryland Department of Health

Re: Response to Informal 10.63 Regulatory Changes

Dear Alyssa,

Please accept this letter as the Community Behavioral Health Association of Maryland's response to the informal release of changes to the 10.63 licensing regulations. We appreciate the Department's release of pre-publication regulatory changes and the opportunity to discuss changes with stakeholders.

Given the scale of revisions underway, we request the opportunity to review and respond to a revised copy of the regulatory changes prior to publication.

On July 26, we engaged in a constructive, five-hour dialogue with BHA to address over 120 questions related to the proposed regulations. During that discussion, BHA agreed to more clearly define and harmonize language relating to entity levels (organization, program, site), staffing, supervision, and telehealth. For that reason, we are reserving comments on these critical elements until we have the opportunity to review the revisions. A full list of items discussed is listed in Section B below.

During our discussion with BHA, we agreed to share suggested language for a more recovery-oriented definition of medication monitoring, less stigmatizing language for parental notice, and sample authorizing statutory language for a quality fund. These suggestions can be found in Sections C – E below.

Earlier in 2024, CBH approached you about reviving a never-implemented agreement with BHA from 2019 to modify the Department's approach to Assertive Community Treatment (ACT). That agreement encompassed migrating MTS into the ACT model, differentiating ACT reimbursement based on fidelity scoring, and strengthening providers' ability to deliver high-fidelity ACT through stronger reimbursement at the higher scoring tiers. That proposal is reflected in our proposed rewrite of COMAR 10.63.03.04, enclosed here at Section F.

Finally, our members have expressed significant concerns about eight elements of the proposed regulations. We would welcome the opportunity to engage in dialogue with the Department on these issues to better understand each other's concerns and explore alternatives that may resolve the concerns while advancing our shared interest in effective regulatory reform. Our significant concerns are described in greater detail below.

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SECTION A: SIGNIFICANT CONCERNS

1. **Expanding workforce requirements in the face of a known workforce shortage is not an effective approach to restricting provider proliferation**.

The proposed regulations require a dramatic expansion of staffing, such as requiring a licensed mental health professional or certified rehab specialist at every PRP site, as well as potentially expanding the role of medical directors or clinical/program directors/leads.

Maryland has well-documented shortage areas for licensed mental health professionals. Our most recent member workforce survey identified a 25% average vacancy rate for therapists and 25% vacancy rate for paraprofessionals across our members. Increasing site-based staffing requirements in the face of well-documented, known workforce shortage will result in a reduction in the number of licensed sites. Sites will be most likely to decrease in the largely rural areas already identified as mental health professional shortage areas. It will not reduce PRP proliferation where it is most clustered along the I-95 corridor.

A more effective approach to addressing PRP proliferation would instead tackle the lack of operational infrastructure among sub-standard PRP programs. For example, CBH has suggested that BHA explore instead requiring each PRP program to have an HL-7 certified EMR that is connected to CRISP. CBH invites BHA to engage in alternate approaches to addressing provider proliferation and service quality while recognizing the catastrophic impact that across-the-board workforce requirements will have on access to care.

2. **State approval should not be required before program closure (10.63.06.10B).**

The regulations prohibit a provider from closing a site or program until approved by BHA. Providers close sites because they lack sufficient funding to adequately staff and operate services at the site. In the past, BHA has attempted to withhold permission if alternate capacity cannot be identified. Forcing a site to remain open without adequate funding for staff or operations threatens patient safety. If the state wishes to force a provider to remain open, the state must exercise its receivership authority under Health General §§ 19-333-339 – and dedicate dollars to maintaining the program. In the absence of funding, a provider cannot be forced to remain open. CBH recommends deleting this provision.

3. **The scope and scale of civil monetary penalties is unclear and excessive (10.63.09).**

The proposed regulations apply civil monetary penalties to accreditation standards, not just violations of law or regulation. This is not an appropriate approach to accreditation standards, which represent a ceiling that providers work towards. In addition, the proposed regulations allow BHA to levy civil monetary penalties for recurring, non-material violations. We recommend clarifying that recurring violations must give rise to a material violation.

4. **Standards for license revocation are vague and overbroad (10.63.06.06).**

It appears that the proposed regulations authorize the Department to revoke a license based on "a history of violation of COMAR 10.63 regulations." A higher standard, more clearly articulated, must be required for license revocation.

5. **Cluttering critical incident reporting workflow with overbroad requirements with no linkage to patient safety or provider operations will decrease efficacy (10.63.01.01B(34).**

The proposed regulations require reporting of suicide attempts, overdoses, sexual assault or abuse beyond mandatory reporting requirements for children or *Demby* vulnerable adults. Critical incident reporting should be limited to a nexus between provider cause and patient harm, patient harms experienced while enrolled with a program, and mandatory reporting categories.

6. **Like nursing homes, any sanctions and penalties should be ~~reinvested~~reinvested in a quality improvement fund for providers, not reverting to the state general fund (10.63.06.15A(6).**

The proposed regulations authorize the Department to have a provider pay sanction penalties in an escrow account to spent at the direction of the state, and are silent on where civil monetary penalties will be directed. The Department must create a dedicated fund, similar to the penalty fund for nursing homes in Health - General, § 19-1811, that prevents penalties from reverting to general fund dollars and are instead ploughed back into quality and compliance capacity-building among behavioral health providers.

7. **Layering application of 10.21 and 10.47 licensing standards layered on top of 10.63 is unnecessary, redundant and, in some cases, conflicting (10.63.06.22C).**

The existing 10.63 regulations sunsetted the application of 10.21 and 10.47 regulations to programs licensed under 10.63. The proposed regulations make both sets of regulations applicable on top 10.63, which is unnecessary given the incorporation, alteration and addition to 10.21 and 10.47 reflected in the proposed changes to 10.63. We recommend deleting this provision.

8. **Strengthening vacancy notices in lieu of applying for a variance creates meaningful enforcement mechanisms (10.63.01.05I).**

The proposed regulations require providers to notify BHA within 30 days of a management vacancy – and apply for a variance at the same time. Instead, the vacancy notice should include a description of how the required duties will be covered during the period of vacancy, creating an auditable trail. There is no value-added from an oversight perspective to the variance process, and this should be deleted. CBH offered edits to the vacancy notice that would, if adopted instead, offer better enforcement tools. See Section B below for details.

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SECTION B: EDITING RECOMMENDATIONS

Note: **Bolded language in red font** reflects additions not shared in previous discussion with Spencer and Angela.

Heading Area	Pages	Key Concerns
Regulatory changes impacting all providers		
Overall Feedback	N/A	• BHA should harmonize language across 10.63 to describe what level of entity is subject to regulation, using terms: organization (for tax-ID level); program (OMHC, RCS, etc); licensed site (for street location). • BHA should harmonize language across 10.63 to describe telehealth terminology consistently, and consistent with the terminology of 10.09.49 and the health occupation boards. • BHA should harmonize staffing terminology across 10.63. • After harmonization, CBH will evaluate vacancy reporting, staffing descriptions, and telehealth requirements for consistency at program level, and location-based staffing requirements.
10.63.01.02 Definitions	pp 1-22	• (4) "Active treatment." BHA to change "psychiatric" to "behavioral health." • (30) "consultant." Should be defined consistent with DLLR. • (34) "critical incident." Limiting reporting to mandatory disclosure categories, harms to current patients, or harms with a nexus to provider action is sought as a significant CBH concern. • (55) Group PRP. Should be defined in program-specific section and consistently, not here. • (77) Medical director definition applies program, site definitions confusingly/differently. Unable to interpret site-level expectations as drafted. • (78) "Medication monitoring." In-person definition in (a) excludes appropriate service, and container/label language in (d) and (e) excludes use of Medherent, strip packaging, and pill planners. BHA trying to address abuse of the 15-minute encounter. BHA solicited specific language suggestions; CBH's proposed edits can be found in Section C. • (115) and (116) SUD disorder definitions are not inclusive of gambling, eating disorders and other addictive-behavior type diagnoses. • (120) Warm hand-off. CBH recommended amending to clarify expectation is subject to client choice and service availability.
10.63.01.05 Requirements for All Licensed Programs	pp. 24-31	• C(4)(a). Changes to Dept of Public Safety policies & procedures for federal background checks do not allow organizations to consistently secure them (p. 25). Further research to resolve barriers is required. • E. Provider must deliver supervision as req'd by Health Occupations (p. 27). CBH recommended specifying that contracting for clinical supervision is permissible. • I. Notice and Variance for Vacancies. CBH recommended that notice following the nursing home requirements for nursing director vacancies, such as including coverage of duties (see COMAR 10.07.02.20), to create auditable trail – and deleting variance request. Policy objectives not advanced through variance process.

10.63.02.02 Covered Programs		• **A(4) lists mobile treatment services as a program required to have an accreditation-based license. MTS is not an accreditation-recognized service. CARF, ACHC accredit ACT while COA and TJC accredits a psych rehab-type service. As discussed further below, CBH recommends deleting MTS and replacing with references to ACT.** Section F for more detailed CBH comments. • **A new section for PSH is created in 10.63.03 but it isn't listed here as an accredited service. Accrediting bodies do not accredit for PSH.**
10.63.02.03 Requirements for All Accredited Programs	pp. 3-4	• B(7). Prohibition on below market-rate housing. CBH recommended that BHA follow a more nuanced definition. CBH recommended modifying to allow provision of below market-rate housing at enrollment as long as patient protected by lease/tenancy that is not contingent on continued participation. • B(8) Documentation of supervision; doesn't specify whether clinical supervision for licensing or simple staff supervision or both.
10.63.06 Application and Licensure Process	pp. 1-25	• B(5)(c). In lieu of providing documentation that a site is allowed to provide BH services, CBH recommends amending to state the lease cannot prohibit the use of the site for health care services. • .06 Denial or Revocation of License. There is another license revocation standard in .06.14 with different standards. Have a single section describing a unitary standard for license revocation. • (10)(a). "history of 10.63 violations" is not appropriate standard for license revocation. A higher standard, more clearly articulated, is needed. • (11) considerations for license application. Organizations apply for licenses and the factors considered apply to individuals. Rewrite for consistency and clarity. • B. Notice of revocation. Regulations should specify notice period. • .10. Notice of Program Closure. Half of the notice period is devoted to BHA review of closure plan; CBH recommended limiting BHA time to respond to 5 business days. • Temporary Discontinuation. CBH recommended that the regulations differentiate temporary, unplanned discontinuations from fire alarms, critical incident reports for evacuations that threaten safety of participants, and what is desired under this regulation. • Penalties paid to account in control of Dept. Instead, should have quality fund following MD Code, Health - General, § 19-1811. • Delete civil monetary penalty sections in COMAR 10.63.06.18. There is now a separate, standalone section with different standards.
10.63.09 Civil Monetary Penalties	pp. 1-4	• Modifies current standard of "material and egregious" deficiencies to material or recurring, and does not consistently define. CBH recommends recurring violations must add up to material violation. • CBH opposes levying penalties on violations of accreditation standards.
Program-specific changes		
10.63.03.03 SUD IOP	pp. 1-3	• **B(8). Family services should be limited by client choice. Family involvement may be contra-indicated & possibly damaging to client. Client should have right to choose family involvement. Defined program services require a scope and frequency that commercial payers may not cover; these expectations should be moved to 10.09 Medicaid conditions of payment.** • C(1)(c). Regulations should clearly spell out that LCSWs have scope of practice for SUD. Social workers are not among the health occupations permitted to supervise addiction counselors in COMAR 10.58.07.14A(2), but that social workers,

		nurses and other licensed health occupations with three years of experience in alcohol & drug counseling pursuant to COMAR 10.58.07.02B(3) may apply to serve as supervisors. CBH's position is that SWs scope of practice includes SUD (see Health Occupations 19-101(n)(2)(i)) and having to demonstrate experience – while art therapists and LMFTs do not – must be addressed. • Concerns about staffing, staff supervision, telehealth and site requirements held pending ASAM rewrite and clarifications.
10.63.03.04 MTS	pp. 3 – 9	• See Section F.
10.63.03.05 OMHC	pp. 9 – 12	• Concerns about medical director, program director/lead, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.06 Outpatient SUD	pp. 12 – 14	• Concerns about staffing, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.07 SUD PHP	pp. 14-15	• Concerns about staffing, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.08 MH PHP	pp. 15	• Concerns about staffing, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.09 PRP-A	pp. 16 - 22	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications
10.63.03.10 PRP-M	pp. 23 – 27	• CBH expressed concern that language required in parental notice in PRP-M requirements is stigmatizing; see Section D; • BHA agreed to delete PRP-M requirements for additional 0.5 FTE rehab specialist for every additional 30 clients; • Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.11 Respite	pp. 31 - 33	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.12 Supported Employment	pp. 35 - 38	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.13 PSH	pp. 38 - 40	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.17 Incarcerated SUD	pp. 41	
10.63.03.18 WMS	pp. 41	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications.
10.63.03.19 OTP	pp. 42 - 47	• **Requiring 50:1 patient to counselor ratio "regardless of whether a patient has refused counseling or services" is cost-prohibitive for providers.** • Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications
10.63.04.04 RCS	pp. 2 - 10	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications.

10.63.04.05 RRP	pp. 11-14	• **J(a) requires daily, on-site services in the RRP residence for a minimum of 40 hours per week. Compared to existing requirements in COMAR 10.63.04.05I, the new requirements add requirements for daily services in the residential site for 40 hours per week. Currently, many RRPs have residents participate in onsite services that do not occur in the residential site, ie day program. We believe the regulation should be clarified to be consistent with current practice**. • Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications. Unclear if rehab specialist requirement in M is per program or per site.
10.63.04.06 Level 3.1	pp. 14-17	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications
10.63.04.07 Level 3.3	pp. 17 - 20	• Concerns about staffing, staff supervision, telehealth and site requirements held pending rewrite and clarifications
10.63.04.08 Level 3.5	pp. 20 – 23	• Concerns about staffing, staff supervision, telehealth and site requirements held pending ASAM rewrite and clarifications
10.63.04.09 Level 3.7	pp. 23 - 26	• Concerns about staffing, staff supervision, telehealth and site requirements held pending ASAM rewrite and clarifications
10.63.04.10 SUD RCS	pp. 26 - 30	• Concerns about staffing, staff supervision, telehealth and site requirements held pending ASAM rewrite and clarifications
10.63.04.11 Application Requirements for Residence	pp. 30 - 32	
10.63.04.12 Environmental Reqmts for Residential Programs	pp. 32-37	• **B(6) requires heat & ventilation but not cooling. CBH recommends adding cooling.** • E(5) CBH recommends eliminating itemization of self-harm items as promotion of community living philosophy at odds with approach outlined.
10.63.05.05 DUI Education Program	pp. 1-12	

SECTION C: SUGGESTED LANGUAGE FOR RECOVERY-ORIENTED MEDICATION MONITORING DEFINITION (COMAR 10.63.03.04)

Suggested Edits	Rationale
(78) "Medication monitoring" means: (a) Providing ~~**in-person**~~ assistance to an individual to achieve compliance with treatment with all prescribed psychiatric or somatic medications;	Provisions (a) through (h) are linked by an "and" preposition, indicating that all eight provisions must apply to medication monitoring activity. However, not every component of medication monitoring requires in-person assistance; some can be accomplished virtually or through assistive technology. Deleting the mandatory "in person" provision creates the flexibility required to allow the use of proven technologies and strategies to strengthen medication adherence.
(b) Review**ing** an individual's existing medication regimen with the prescribing authority; (c) Supporting the individual's self-administration of prescribed medication;	Harmonizing verb tense
(d) ~~Reading the medication label to~~ ~~ensure~~ **In residential programs, ensuring** that each **dose-time specific** container of medication**, if used,** is ~~**clearly**~~ **correctly** labeled with the individual's name, ~~**the contents**~~ **medication name**, ~~**directions for use**~~ **strength**, and ~~**expiration date**~~ **time to be self-administered**;	Edits move provision from label reading toward more assessment of accuracy, while ensuring that pill planners, strip packaging and technologies like Medherent are compatible with regulatory provision. Incorporating standards of COMAR 10.34.36.08B in (d) and (e) for ALF- and group home-specific regulation
(e) ~~Monitoring compliance with instructions appearing on the medication label~~ **In residential programs, supporting the individual's review of per-dispense medication information (available on paper or electronically) including name, contents, directions for use, and expiration date to ensure compliance**;	Edits emphasize the recovery orientation and skills-building aspects of medication monitoring, while incorporating standards of COMAR 10.34.36.08B in (d) and (e) for ALF- and group home-specific regulation.
(f) Ensuring that each individual has secure, appropriate, and accessible space in which to store medications; (g) Observing and documenting any apparent reactions to medication and, either verbally or in writing, and, in a timely fashion, communicating to the prescribing authority any problems that possibly may be related to the medication; and	No change
(h) ~~**Reinforcing, with the individual, education on the role and effects of medication in symptom management**~~ Supporting the individual in building knowledge and skills around medication use; reinforcing, with the individual, education on the role and effects of medication in symptom management.	Edits emphasize the recovery orientation and skills-building aspects of medication monitoring.

COMAR 10.63.04.04C(5)	Definition of medication monitoring in RCS needs to be harmonized with definition in 10.63.01.

SECTION D: SUGGESTED NON-STIGMATIZING LANGUAGE FOR PARENTAL CONSENT TO PRP-M (COMAR 10.63.03.10M)

Suggested Edits	Rationale
A. Minors referred to PRP-M shall have written informed consent from an authorized parent or guardian documenting that they have been informed that: *(1)* ~~PRP is not a treatment, social or mentoring program~~ Psychiatric Rehabilitation Program services are for children, adolescents and young adults with serious mental illness or emotional disturbance who are at-risk for requiring a higher level of care; *(2)*	Lay audience may be unaware of differences between treatment, social and mentoring programs. Used more concrete language of MNC to describe.
(3) PRP services are ~~only~~ available to individuals ~~who have a mental health **diagnoses** and are at risk of needing higher levels of care~~ who have been referred by a licensed mental health professional and remain in active treatment while receiving Psychiatric Rehabilitation Program services; and	Familiarize parents with referral and active treatment requirements for securing and maintaining PRP.
(4) The ~~**program**~~ **organization** will bill Medical Assistance ~~**to cover the cost of**~~ **for** services provided.	Subject to BHA's revised entity-level definitions, clarifies level of entity handling billing matters, and clarifies that PRP is not a cost-based reimbursable service.

SECTION E: SAMPLE AUTHORIZING STATUTE FOR HEALTH CARE QUALITY FUND

MD Code, Health - General, § 7.5-405

§ 7.5-405. Health Care Quality Account for Community-Based Behavioral Health Programs

In general
(a)(1) There is a Health Care Quality Account for Community-Based Behavioral Health Programs established in the Department.
(2) The Account shall be funded by civil money penalties paid by behavioral health providers and other penalties that the Office of Health Care Quality may assess.
(3) The Department shall pay all penalties collected under this title to the Comptroller.
(4) The Comptroller shall distribute funds collected under this title to the Health Care Quality Account for Community-Based Behavioral Health Programs.
(5) The Account is a continuing, nonlapsing fund, not subject to § 7-302 of the State Finance and Procurement Article.
(6) Any unspent portions of the Account may not be transferred or reverted to the General Fund of the State, but shall remain in the Account to be used for the purposes specified in this section.

Purpose
(b) The Health Care Quality Account for Assisted Living Programs shall be used for training, grant awards, demonstration projects, or other purposes designed to improve the quality of care.

Regulations
(c) The Department shall adopt regulations for the distribution of funds from the Health Care Quality Account for Community-Based Behavioral Health Programs.

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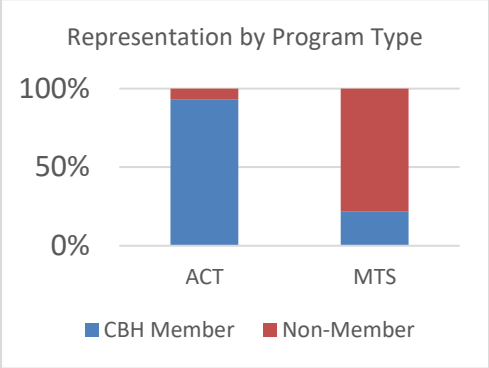
SECTION F: MOBILE TREATMENT SERVICES (COMAR 10.63.03.04)

CBH offers this proposal to migrate existing MTS providers into the ACT model and strengthen incentives to deliver high-fidelity ACT by June 30, 2028, under the regulatory and rate reforms outlined below. Our proposal aligns with the efforts of other states to standardize the delivery of services under the ACT designation, increase payer confidence in the quality of care delivered, reduce hospital utilization by individual with serious mental illness, and ensure that providers receive resources needed to be successful.

1. CBH's Representation of MTS/ACT Providers

CBH represents roughly 42% of all ACT/MTS licensed sites across the state. CBH represents the overwhelming majority of sites receiving ACT fidelity status and nearly a quarter of sites with an MTS license but without ACT status.



This proposal reflects the consensus of CBH members, including ACT and MTS-only provider organizations.

2. Background

In Maryland, providers who receive a license to deliver Mobile Treatment Services (MTS) are accredited under Assertive Community Treatment (ACT) standards,[1] and are reimbursed by billing the nationally standardized description of "assertive community treatment" for their services.[2] Patients for both MTS and ACT must meet the same medical necessity criteria.[3] Only 28 of the 80 licensed MTS sites are evaluated by BHA using ACT fidelity standards, and providers meeting minimum fidelity scores are reimbursed at a rate 41% higher than the MTS rate.

Against this backdrop, several factors warrant a fresh look at Maryland's use of mobile treatment and ACT. Specifically, Maryland must:

- **Increase community capacity to alleviate ED strain**. In order "to alleviate strain in EDs," the Maryland General Assembly Hospital Throughput Work Group's report indicated that the "highest priority policies" should "create a sustainable funding pathway for specialized behavioral health services for individuals with serious mental illness."[4]

[1] See BHA, CARF Reference Grid (MTS accredited under Assertive Community Treatment standard); ACHC reference grid (MTS accredited under Assertive Community Treatment Team standard); TJC Reference Grid (MTS accredited under Outpatient; Mental Health; Adult; Assertive Community Treatment/Community Support Services; Recovery/Resilience (Community Integration Services) standards). Only COA sets a lower standard (allowing MTS to be accredited as Psychiatric Rehabilitation Services (PSR) – Assertive Community Outreach standards), but no MTS licensed providers are currently accredited by COA.
[2] H0040 effective January 1, 2003.
[3] Optum, MNC.
[4] Maryland General Assembly, "Hospital Through-Put final report" at p. 29 (March 2024).

- **Restrict licensing growth in MTS**. Between 2020 and 2024, there was 78% growth in the number of MTS licensed sites associated with an influx of new providers, making MTS one of the top five fastest-growing licenses in the behavioral health continuum.

- **Strengthening fidelity focus**. This proposal is aligned with SAMHSA's increased its focus on ACT fidelity supervision by states.[5]

To address these needs, CBH proposes to bring Maryland's accreditation standards, MTS regulations, and payment policies within the ACT fidelity framework, essentially eliminating MTS as a service distinct from ACT. At this same time, this proposal creates a tiered reimbursement structure based on ACT scores in order to ensure that high-fidelity ACT providers have sufficient capacity to retain full treatment teams.

3. CBH Proposal

To address the changing climate and concerns facing MTS/ACT programs, CBH offers a three-prong proposal:

a. Full migration of MTS to ACT model by June 30, 2028

All providers with an MTS license will be subject to ACT fidelity reviews using the TMACT tool to understand their baseline score. Beginning on July 1, 2025, each MTS program will develop a two-year plan to transition to an ACT model within a two-year timeframe. By June 30, 2028, all MTS licensed programs must meet a minimum ACT fidelity score of 2.5 or higher in order to continue to qualify for Medicaid reimbursement.

b. Regulatory and Policy Reform

Under this proposal, BHA would adopt changes to licensing requirements under COMAR 10.63.03.04 (Mobile Treatment Services) to migrate MTS to the ACT model and promulgate standards for ACT fidelity reviews. Core elements of regulatory reform would incorporate the regulatory reforms outlined in Section 4 below.

c. Enhancement of ACT rates for high fidelity programs

CBH proposes to tier ACT reimbursement based on the TMACT fidelity score.

Low fidelity ACT programs will be paid from July 1, 2025, thru June 30, 2028, at the MTS rate, while programs scoring moderate fidelity will continue to receive the ACT rate. However, programs achieving a higher score will receive a higher rate in order to ensure that funding is sufficient to achieve fully staffed treatment teams.

[5] SAMHSA, "Maryland 2022 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System," at p. 17.

TMACT Score	HCPCS Code & Modifier	FY25 Rate	FY26	FY27	FY28
3.7+ (high fidelity)	H0040-21 (Medicaid)	$1,876.22	$2,176.42 (+16%)	$2,285.24 (+5%)	$2,422.35 (+6%)
	H0040-U9 (Medicare)	$1,663.00	$1,929.08 (+16%)	$2,025.53 (+5%)	$2,147.07 (+6%)
3.2 to 3.6 (moderate fidelity)	H0040-21(Medicaid)	$1,876.22	$1,876.22	$1,876.22	$1,876.22
	H0040-U9 (Medicare)	$1,663.00	$1,663.00	$1,663.00	$1,663.00
2.5 to 3.1 (low fidelity)	H0040 (Medicaid)	$1,330.41	$1,330.41	$1,330.41	$1,330.41
	H0040-52 (Medicare)	$1,019.98	$1,019.98	$1,019.98	$1,019.98
1.0 to 2.4 (no fidelity)	H0040 (Medicaid)	$1,330.41	$1,330.41	$1,330.41	N/A
	H0040-52 (Medicare)	$1,019.98	$1,019.98	$1,019.98	N/A

4. Proposed Regulatory Changes for 10.09.59.04

10.09.59.04

.04 Provider Requirements for Participation.

B. Community Mental Health Program Providers. To participate in the Program as a community-based mental health program provider, the provider shall be approved under COMAR 10.63.01, 10.63.02, and 10.63.06 and possess licensure by the Behavioral Health Administration as: ...

(3) A**n** ~~**mobile treatment**~~ **Assertive Community Treatment** program, which shall:

(a) Comply with COMAR 10.63.03.04;

(b) Consist of a multidisciplinary team including, at a minimum:

(i) A program director that is a mental health professional;

(ii) A psychiatrist **or nurse practitioner**;

(iii) A licensed registered nurse;

(iv) At least one licensed social worker or licensed graduate social worker;

(v) At least one mental health professional who may include the staff identified in §B(3)(b)(iii) and (iv) of this regulation; and

(c) Maintain sufficient staffing to fulfill the following service requirements including:

(i) Initial and continuing psychiatric evaluation, diagnosis, and individual treatment planning;

(ii) Medication services;

(iii) Independent living skills assessment and training;

(iv) Health promotion and training;

(v) Interactive therapies;

(vi) Crisis intervention services; and

(vii) Support, linkage, and advocacy; or

(5) ~~**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 through telemedicine is provided by a ~~**fully integrated**~~ psychiatrist or psychiatric nurse practitioner (CRNP-PMH) attached to an ACT ~~**or mobile treatment**~~ program.

5. **Proposed Regulatory Changes for 10.63.03.04**

Mark-Up	**Rationale**
.04 ~~Mobile Treatment Services (~~Assertive Community Treatment~~)~~	Consistent with CBH's proposal and ACT accreditation standards, this edit removes MTS as a licensed program type pending migration of existing licenses as described further below.
A. In order to be licensed under this subtitle, a mobile treatment services program shall: (1) Meet the requirements of this regulation, COMAR 10.63.01, COMAR 10.63.02; and COMAR 10.63.06;	No change.
(2) Provide intensive, assertive outpatient mental health treatment and support services *delivered* by a multidisciplinary *treatment* team to an *adult or a minor whose mental health treatment needs have not been met through* traditional outpatient *mental health programs.*	Harmonize to definition in 10.63.01.02B(80)?
(3) – (5)	No change.
B (1)	No change
B(2) *Individual Assessment.* *(a) The program shall complete the following individual assessments:* *(i) In-person, comprehensive, clinical assessment by the program mobile treatment services mental health professional shall be conducted with the individual on the day of the initial referral assessment; admission; or within 48 hours of the admission date and updated prior to or in conjunction with the development of an individualized treatment plan and, at a minimum, every 6 months thereafter; and* *(ii) In-person psychiatric evaluation by the program psychiatrist or licensed psychiatric nurse practitioner*	Incorporate Dimitri feedback

within 14 days of admission and at a minimum of every 3 months thereafter for treatment and medication management	
(b) Assessments shall be completed on a validated instrument approved by the Administration that provides ratings, scores, and other information required by the Administration and is submitted to the Administration in the time and manner prescribed by the Administration.	
B(3) – (7). No change.	
B(8) *The program shall designate the program director, **and** psychiatrist~~, and~~ **or** licensed psychiatric nurse practitioner as required management staff and shall report management vacancies as required under COMAR 10.63.01.05.*	Prepositions rewritten for clarity
C, Rewrite Delete 5(f) *C, Evidence-Based Program Assertive Community Treatment (EBP ACT) Provider Designation.* Programs designated by the Administration as an EBP ACT provider at the team level shall: *(1) Meet the established EBP ACT fidelity standards adopted by the Administration;* *(2) Execute a cooperative agreement with the Maryland State Department of Education Division of Rehabilitation Services (DORS) to provide employment services that are inclusive of the ACT team* *(3) Maintain an executed cooperative agreement with DORS to be eligible to receive ACT authorization and reimbursement;* *(4) Serve less than 120 participants, per team, on its active monthly census;* *(5) Provide and maintain sufficient staffing to fulfill the following service requirements:* *(a) Supported employment;* *(b) Supported education;* *(c) Peer support services;* *(d) Integrated co-occurring disorder treatment;* *(e) Family psychoeducation and* *(f) Permanent supportive housing; and* (6) *Notify the Administration within 14 days of identifying the issue that the program is no longer able to meet the established EBP ACT fidelity standards*	
D. *Eligibility. An individual is eligible for MTS if:* *(1) Based on a screening assessment conducted according to the provisions of §B of this regulation, the individual would benefit from services that are:* *(a) Directed at providing mental health treatment;*	

and *(b) Available, by being delivered at a site that is accessible to an individual who:* *(i) Is homeless;* *(ii) For reasons related to mental illness, has been unable or unwilling to use, on a continuing basis, community-based mental health services that are prescribed for the individual;* *(iii) Is in an institution or inpatient facility and would be able to reside in a community setting if the individual received MTS and other appropriate support services; and* *(2) The individual is presenting an emerging risk to self, property, or others, as evidenced by:* *(a) Frequent use of emergency rooms or crisis services for psychiatric reasons within the prior 12 months;* *(b) A pattern of repeated psychiatric inpatient facility admissions or long-standing psychiatric hospitalizations within the prior twelve months; or* *(c) A recent history of arrests for reasons associated with the individual's mental illness*	
E. Required Staff. Credentialed RN? *(7) Required Staff.* *i. The program shall ensure that the required staff consists of a multidisciplinary team that includes:* *1. A full-time equivalent program director who is a licensed mental health professional operating at the independent level of practice and is dedicated exclusively to the team;* *2. A psychiatrist or licensed psychiatric nurse practitioner;* *3. A licensed registered nurse certified as RN-PMH-BC by the American Nurses Credentialing Organization;* *4. At least one licensed certified social worker-clinical or licensed clinical professional counselor, who may be the program director;* *5. At least one additional licensed mental health professional;* *6. At least one full-time equivalent staff member for every twelve individuals served on its active monthly census; and* *(g) At the discretion of the program, a licensed occupational therapist.* *ii. The program shall ensure that any health care service provided through telehealth is provided*	

by an individual who is a fully integrated member of the mobile treatment services team. *iii. The program shall designate the program director and psychiatrist or licensed psychiatric nurse practitioner as required management staff that are subject to the reporting of vacancies requirements under COMAR 10.63.01.05.*	

August 29, 2024

CBH appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please contact Shannon Hall at shannon@mdcbh.org. Thank you for your time and consideration.

Sincerely,

Shannon Hall
Executive Director