September 5, 2023

Marie Grant
Assistant Secretary for Health Policy
Maryland Department of Health

Dear Marie,

Thank you for sharing a pre-publication draft of proposed regulations for crisis services with stakeholders. We appreciate the opportunity to engage in constructive dialogue with the Maryland Department of Health to shape regulations that are effective in defining mobile crisis and crisis stabilization services that are responsive and available to Maryland residents experiencing a behavioral health crisis.

As you know, CBH is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 89 members serve the majority of those accessing care through the public behavioral health system and includes the majority of Maryland existing grant-funded mobile crisis programs, as well as multiple organizations exploring crisis stabilization options.

CBH appreciates the revisions made to the proposed regulations in response to the concerns we raised in our comments dated March 27, 2023. In particular, we note and appreciate the significant increases to the proposed rates for both mobile crisis teams and crisis stabilization centers and elimination of vacancy reporting.

We are grateful for this opportunity to provide an informal response to the Department's revised regulations, and we welcome further dialogue with the Department and impacted providers in discussing remaining regulatory concerns. The Department's commitment to engagement and dialogue with stakeholders strengthens the likelihood of successful launch of crisis programs within the Medicaid framework.

Despite the Department's response, our members report that the revised regulations still raise concerns that crisis programs would not be sustainable, particularly for mobile crisis teams in non-metropolitan areas. We offer below comments on the revised regulations that outline our members' remaining concerns about staffing and financing mobile crisis capacity statewide, as well as concerns with the staffing and sustainability of crisis stabilization centers. These concerns are described in greater detail in our comments below.

Mobile Crisis Teams

Recommendation 1: Offer greater flexibility in the role of the Licensed Mental Health Professional at independent practice level

In our initial comments, we requested that MDH entirely eliminate the requirement of 24/7 availability, either face-to-face or via telehealth, by a licensed mental health professional (LMHP) who is licensed at the independent practice level and who is approved to supervise. We appreciate that MDH eliminated the requirement of the second credential but we remain concerned that mandatory in-person participation by a LMHP at the independent practice level will be expensive and challenging to staff in the face of severe workforce shortage. Rather than reduce the availability of crisis teams across the state, we urge the Department to build in greater telehealth flexibility for this position.

Specifically, we recommend that the Department retain the requirement for 24/7 availability of an LMHP with the independent practice level credential, but clarify:

- in 10.63.03.20(F)(1), that the LMHP at the independent practice level can provide all services via telehealth, including completion of an emergency petition when appropriate; and
- in 10.63.03.20(D), clarify that law enforcement presence is appropriate when the officer is also needed to complete an emergency petition when an LMHP at the independent practice level is not available.

The role of a LMHP at the independent practice level functioning via telehealth is supported by current practice and policy, reflected in federal and state policies:

- While federal law requires a LMHP on a mobile crisis team, it requires neither a professional at the independent practice level nor in-person participation. Moreover, federal law requires only that the LMHP be able to conduct an "assessment," which is less comprehensive than an "evaluation" required for an emergency petition.[1]
- Maryland law does not require the LMHP at the independent practice level who completes an emergency petition to be present in-person. While the statute indicates that a peace officer must "personally" observe "the individual or the individual's behavior," it doesn't similarly require that the examination by a LHMP at the independent practice level to be done "personally."[2]
- Medicaid telehealth regulations allow reimbursable services to be provided via telehealth if permitted by the scope of the provider's practice,[3] and it is within the scope of practice for

[1] P.L. 117–328 (enacted December 29, 2022) amending Title XIX, Section 1947, of Social Security Act
[2] *Compare* Md. Code Ann., Health General, § 10-622(b)(1)(i) and (b)(1)(ii).
[3] COMAR 10.09.49.03(C).

licensed mental health professionals at the independent practice level to conduct assessments or more in-depth evaluations via telehealth.[4]

Nothing in the federal authorizing statute for mobile crisis, Maryland law, and Maryland regulations for health occupations or telehealth requires the mobile crisis assessment to be conducted in person by the LMHP at the independent practice level. For these reasons, we urge MDH to allow the LMHP at the independent practice level to conduct the assessment and an emergency evaluation via telehealth, including allowing and the petition can be signed electronically and printed by a wireless printer.

Related to our request for greater flexibility in the role of the LMHP at the independent practice level, we urge MDH to amend 10.63.03.20(F)(3), which prohibits peer and family support specialists from responding without a "mental health or licensed professional." As described above, we believe that the crisis regulations can allow the LMHP at the independent practice level to function via telehealth. In addition, however, we urge the Department to clarify that this limitation applies *only* to the initial crisis response. Follow-up services, including referral, linkage, and ongoing coordination can be done by peer specialist without an accompanying mental health professional.

A final element of flexibility that can ensure stronger statewide capacity for mobile crisis teams relates to the two-member requirement for mobile crisis response reflected in 10.63.0.20(G). In our initial response, we encouraged the Department to consider one-member response during overnight shifts. The revised regulations retain the two-member crisis response, and we now propose the following compromise: retain the requirement that two-member teams are required for all shifts, but allow: i) the LMHP to do the assessment via telehealth for all shifts if that is necessary due to workforce shortage; and ii) allow the LMHP to be the second team member (via telehealth) during the overnight shift if that is necessary due to workforce shortage.

CBH's position that assessments and evaluations can be performed via telehealth is well-supported. As noted earlier, federal law governing mobile crisis does not require that the LMHP be at the independent practice level and requires only that the LMHP be able to conduct an "assessment."[5] Similarly, the Board of Social Work Examiners permits Master's Social Workers and Licensed Certified Social Workers to perform "assessments" via telehealth, and even permits those professionals to conduce "evaluations" via telehealth if done so under the supervision of an LCSW-C.[6]

Recommendation 2: Clarify billing increments and same-day limitations

The proposed regulations at 10.09.16.08(C) describe hourly and 15-minute increments for mobile crisis. It is unclear how the hourly increment will be applied, and additional detail will help providers better evaluate the sustainability of the Medicaid rate. If a mobile crisis team has a 3.5 hour initial response to a crisis call, will the provider round down to a 3 hour increment, round up to a 4 hour increment, or bill 14 units of the 15-minute increment? Are the 15-minute increments

[4] *See* COMAR 10.27.17.04 (nursing); 10.36.10.05 (psychology); 10.42.10.05 (social work); 10.58.06.05 (professional counseling).
[5] *See* note 1 *supra*.
[6] *See* COMAR 10.42.10.03 and 10.42.10.05.

only available after the day of the initial response, or also available for referral and follow-up care performed on the same day as the initial crisis response? We believe that a 15-minute increment in lieu of an hourly increment may offer more benefit and flexibility.

It would also be helpful if billing rules addressed mobile crisis dispatches that do not result in a client contact. It is not unusual for a dispatched team to be unable to locate a client who has departed, to encounter police or EMS interventions prevent the mobile crisis team from engaging the client, or if a call in progress gets cancelled.

Recommendation 3: For statewide capacity, mobile crisis reimbursement rate must be sustainable in rural areas

The revised rate of $55.90 per 15-minute increment is a substantial and welcome increase from the initial rate of $33.95. However, CBH members in non-metropolitan areas of the state continue to express concern that the revised rate is not sufficient to maintain crisis teams in low-volume areas of the state. One rural provider notes that their financial model indicates that their program would break even if they used Virginia's mobile crisis rate, which is more than double the $55.90 rate.

The dynamics of staffing licensed clinicians overnight, in the midst of a workforce crisis, and ensuring 24/7 coverage in rural areas causes CBH members to continue to express concerns about the sufficiency of the proposed rate.

Recommendation 4: Extend two-year commitment of grant funds with end-of-year reconciliation

As Maryland transitions its existing grant-funded crisis programs to Medicaid funding, we applaud the Department's commitment to providers that it plans to maintain grant funding. Continued availability of grant funding for non-billable services, subject to an end-of-year reconciliation, will help ensure that program viability during the transition period.

Crisis Stabilization Centers

Recommendation 1: Align definitions to the Crisis Stabilization Center's scope of services

In the proposed regulations, 10.63.01(B)(3) defines "active treatment" as "inpatient psychiatric services." This definition is subsequently applied in 10.63.03.21(G)(1), requiring a crisis stabilization center to begin assessment and "active treatment" immediately. The SAMHSA toolkit indicates that crisis stabilization services should be provided in a "home-like, non-hospital environment."[7] We recommend deleting "inpatient" from the definition of active treatment because crisis stabilization centers do not provide an inpatient level of care and it is at odds with the SAMHSA-defined best practice.

[7] SAMHSA, "National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit," p. 12 (2020).

Recommendation 2: Clarify what services can be only performed by a physician or remove requirement for on-call physician.

10.63.03.21(E)(5) adds a new requirement that physician must be on-call at all times for the provision of services that can only be delivered by a physician. The proposed regulations do not describe what services can only be delivered by a physician. Our review suggests that the scope of practice for nurse practitioners fully encompasses all services delivered in a crisis stabilization unit.[8] Nurse practitioners are unable to perform surgery independently from physicians, but crisis stabilization centers will not perform operations. As a result, we recommend that this provision be deleted in its entirety or clarified to specifically delineate which crisis stabilization services can only be performed by a physician.

Recommendation 3: Clarify staffing and timing of assessments and evaluations in crisis stabilization center.

The timing of assessments and evaluations required by 10.63.03.21(G) is conflicting, and the staffing of the required activities is more limited than a licensed mental health professional's scope of practice, while the supervision requirements are at odds with health occupation requirements.

Section 10.63.03.21(G)(3) requires the completion of a "crisis assessment" by a licensed mental health professional "at the earliest opportunity," while 10.63.03.21(G)(7) requires an "initial evaluation" by a physician or nurse practitioner at the "earliest reasonable opportunity." Presumably, the crisis assessment should be completed before the more in-depth evaluation, and the regulations may benefit from a more clear ordering of the expected activities.

We also note that crisis stabilization may be used as a stepdown from a higher level of care or by mobile crisis teams. We recommend modifying 10.63.03.21(G) throughout to allow assessments completed in the preceding 72 hours to qualify, as Virginia does.[9]

Also of concern, the crisis assessment in 10.63.03.21(G)(3) can be completed by a licensed mental health professional who must be "staffed" by a physician or nurse practitioner, 10.63.03.21(G)(5). As stated earlier, licensed mental health professionals who are not at an independent practice level can conduct assessments and evaluations under the supervision of a health professional at the independent practice level within the same health occupation.[10] Licensed mental health professionals at less than an independent practice level could not conduct assessments and evaluations under the supervision of physicians or nurses. However, a licensed mental health professional at an independent practice level is capable of conducting assessments and evaluations fully independently, and thus no "staffing" by physicians or nurses is needed. We thus recommend deleting 10.63.03.21(G)(5) in its entirety, and amending 10.63.03.21(G)(3) accordingly.

[8] *Compare* Md. Code Ann., Health Occupations, at § 8-101(m) with § 14-101(o).
[9] Va. DMAS, "23-Hour Crisis Stabilization and Residential Crisis Stabilization Unit (RCSU) Services," at p. 15 (Oct. 29, 2021).
[10] *See, e.g.,* COMAR 10.42.10.03 and 10.42.10.05.

Recommendation 4: Clarify referral agreements to area hospitals

Section 10.63.03.21(G)(9)(b) requires a crisis stabilization center to maintain written referral agreement to hospital psychiatric units. Crisis centers cannot make referrals directly to hospital inpatient levels of care and would need to send any patient to the hospital emergency department in order to secure an psychiatric inpatient admission. We recommend deleting this provision or modifying it to describe referral procedures for emergency departments.

Recommendation 5: Align seclusion room size with existing community facility requirements

The proposed regulations at 10.63.03.21(K)(1)(f)(i) require a seclusion room to be 80 square feet, which we recommend modifying to 70 square feet. Rooms in behavioral health group homes, such as residential crisis or residential rehabilitation settings, are required to be 70 square feet.[11] Standardizing room size requirements across community-based licenses will improve providers' ability to adapt existing facilities to become crisis stabilization centers.

Section 10.63.03.21(K)(2) gives the Department authority to require a provider to offer additional seclusion rooms. We recommend deleting this provision. Providers seeking or having a crisis stabilization license need certainty in the facility design and cost. Modifying a facility to add seclusion rooms would introduce significant additional cost to providers.

Recommendation 6: Retain grant funding with end-of-year reconciliation pending sustainability evaluation

CBH members continue to express concern about the sustainability of the model and rate for crisis stabilization centers. Retention of grant funding with an end-of-year reconciliation will help providers and the Department evaluate costs, unbillable services, and patient volume assumptions, while offering providers viability throughout the transition period.

Overall 10.63 Definitions

Recommendation 1: Delete definitions that are not applied.

The proposed regulations contain multiple new definitions of terms that are not applied elsewhere in the 10.63 regulations. We encourage the Department to delete definitions that are not applied, including:

- "culturally and linguistically appropriate services" (10.63.01(B)(25));
- "cultural and linguistic competency" (10.63.01(B)(26));
- "medication administration" (10.63.01(B)(51));
- "medication monitoring" (10.63.01(B)(52));
- "social skills" (10.63.01(B)(77)); and
- "warm hand off" (10.63.01(B)(81)).

[11] *See* COMAR 10.63.04.07(E)(1).

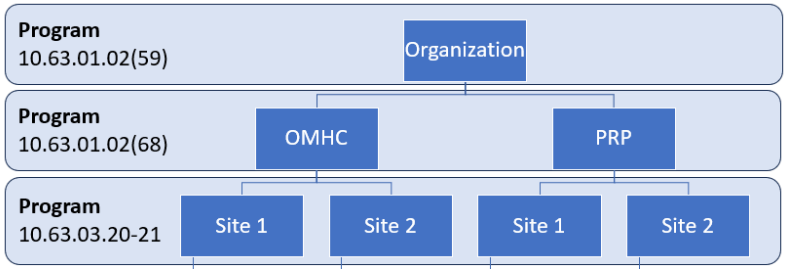
In particular, CBH remains concerned that the proposed regulations define "medication monitoring" as an "in-person assistance to an individual to achieve compliance with treatment" (10.63.01(B)(52)(a)(i)). Medication monitoring is conducted by paraprofessionals and clinicians in clinic, psychiatric rehabilitation, residential rehabilitation, and other settings. In community-based care settings, medication monitoring prompts participants to take their medication; it does not police participants to verify that medication has been taken. Staff do not have participants open their mouths to verify that medication hasn't been cheeked or held under the tongue to spit out later. Because medication monitoring in community settings is around support, prompting and observation of medication, it can be safely and adequately performed via audio-visual telehealth. Moreover, the term "medication monitoring" does not appear in the 10.63 regulations, so it is unclear why the definition has been introduced.

For all of these reasons, we recommend that the Department delete the definition of medication monitoring or, at a minimum, eliminate the in-person requirement and other definitions not applied in the proposed regulations.

Recommendation 2: Delete definitions of "organization" and program-specific definitions of program

CBH remains concerned that the revised regulations fundamentally fail to clarify what entity is subject to regulation. Expensive staffing obligations are tied to the definition of program,[12] and providers have faced licensing confusion and audit risk from BHA's efforts to shift the definition of program through unpromulgated interpretation changes.[13] The proposed regulations retain the existing definition of program,[14] add a definition of organization,[15] and add new definitions of program in the regulations for crisis services.[16]

Rather than clarify the Department's intent, the triplicate layers of program definitions introduce further confusion. As proposed, the 10.63 regulations now define a program as both an organization and a site, and everything in between.



[12] See COMAR 10.63.03.05 (each OMHC shall employ a medical director); COMAR 10.63.03.09 (each adult PRP shall employ a rehabilitation specialist); COMARD 10.63.03.10 (each child PRP shall employ a rehabilitation specialist).
[13] CBH, "10.63 Regulatory Confusion" (March 28, 2023) (citing AAG written guidance from 2015 that a program, not a site, is required to meet regulatory staffing standards, BHA's intent in 2021 to "chang[e] how we interpret" the definition of program, and audit standards in 2023 applying staffing standards at the site level).
[14] "~~(47)~~ (66) 'program' means an organization that provides or seeks a license to provider community-based behavioral health services."
[15] "(59) 'Organization' means a legal entity under which programs and services operate."
[16] 10.63.03.20(B) and 10.63.03.21(B) 'Program' means the site and service combination which is recognized through licensure to offer an organized system of activities.

We recommend simply deleting the proposed definition of organization (10.63.01.02(B)(59) and proposed program definitions within the crisis regulations (10.63.03.20(B) and 10.63.03.21(B). This retains the existing 10.63 definition of program – 'program' means an organization that provides or seeks a license.

Thank you for the opportunity to respond to the revised comments informally. We believe that the dialogue created by stronger engagement of stakeholders in the regulatory and policy-making process will help the Department ensure that its goals are achieved more efficiently and effectively. We would be more than happy to engage in further dialogue with the Department around our comments in these regulations. Please do not hesitate to reach out to me at shannon@mdcbh.org if you have any questions or need clarification of any remarks.

Sincerely,

Shannon Hall
Executive Director