



The Hospital + Healthsystem
Association of Pennsylvania

November 17, 2025

Tara Pride
Director of Regulatory Implementation
Office of Mental Health and Substance Abuse Services
303 Walnut Street, 11th Floor
Harrisburg, PA 17105
RAPWCRISISRVSREGS@pa.gov
RE: Reference Regulation #14-557

Dear Director Pride:

The Hospital and Healthsystem Association of Pennsylvania (HAP) welcomes the opportunity to comment on the draft crisis intervention services regulations at 55 Pa. Code Chapter 5250. Crisis intervention services—crisis call centers, mobile crisis team services, medical mobile crisis team services, emergency behavioral health crisis walk-in center services, and crisis stabilization unit services—save lives and support recovery. And while crisis intervention is just one part of a robust behavioral health care delivery system, a strong crisis response network is essential for a healthier Pennsylvania. Crisis services are a safety net for individuals during behavioral health emergencies. They improve outcomes for individuals; they reduce emergency department (ED) overcrowding and boarding; they decrease overdependence on restrictive longer-term inpatient services; and they reduce overuse of law enforcement and incarceration.

HAP advocates for more than 235 hospitals and health systems across the commonwealth, as well as for the patients and communities they serve. HAP member hospitals know intimately that Pennsylvanians are not receiving the right mental health care, at the right time, or in the right setting—in some counties, hospital EDs are often a main point of entry for individuals in crisis who need time-sensitive behavioral health care. Every individual in every Pennsylvania community deserves access to high-quality crisis intervention services when needed. The current crisis intervention services delivery system lacks uniform standards and consistency resulting in variable access to the different crisis intervention service modalities across all 67 counties. The current landscape is challenging for individuals seeking crisis care and for stakeholders (caregivers, families, behavioral health professionals) who often need to coordinate services across county borders.

We applaud the Department of Human Services' (DHS) efforts to strengthen and standardize practice across the commonwealth and align with national best practices. We believe that robust licensure requirements shape stakeholder expectations and hopefully foster stronger federal, state, and county government investment in crisis services.



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HAP supports the following proposed regulations put forth:

- Establish that all modalities of crisis intervention services be available 24 hours a day, 7 days a week, 365 days a year.
- Define mobile crisis team services as community-based interventions delivered by a two-person team and allow for team participation via tele-behavioral health.
- Allow mobile medication administration that meets individuals where they are through the establishment of medical mobile crisis teams.
- Require that emergency behavioral health crisis walk-in centers have continuous access—at the center or via tele-behavioral health access—to a physician for the purpose of completing the required process outlined in Section 302 of the Mental Health Procedures Act.
- Establish a waiver process at § 5250.13 allowing the department to grant waivers to specific provisions under certain conditions provided the benefit of waiving the provision outweighs any risk to the health, safety, and well-being of an individual receiving crisis intervention services.

We are moving toward a more comprehensive crisis intervention system in a commonwealth of unique counties and unique communities. We're building on an existing infrastructure that has been shaped by local needs and as well as local constraints. The diversity within the HAP memberships reflects highly local dynamics with some member EDs maintaining strong intervention services capacity and successfully connecting individuals to less restrictive, community-based care settings, while other EDs lack the crisis intervention staffing and expertise. Some EDs share campuses with hospital-adjacent crisis response centers, while other systems have developed cost-effective, lower-acuity behavioral health walk-in services to meet community needs. In many cases, services have evolved in hyper-local ecosystems to meet specific community needs. We caution the department to be mindful of the following concerns as we move forward:

1. **Speed of implementation**—Success of the system will be determined by our ability to build on existing infrastructure. At best, providers need time to formalize practice and develop policies and procedures for their current practice that already meet proposed standards. Even formalization will take administrative effort in environments that are already under-resourced and over-stretched. Other providers will need time to attract and recruit workforce needed to meet staffing requirements. Providers may also need time to evolve their physical space and program design. We hope that implementation can be staged in a manner that doesn't jeopardize access to current services while providers build up to proposed standards.
2. **Continuity of care beyond 23 hours crisis center limitation**—§ 5250.91 establishes that an emergency behavioral health crisis walk-in center shall provide stabilization services within 23 hours and referral to appropriate level of care. In the event that an individual needs inpatient services and a placement is unavailable, providers should be able to



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authorize a longer flexible stay at the walk-in center to avoid disruption of services and support care continuity.

3. **Flexibility for local innovation**—While we need consistent standards, in some communities, local solutions have demonstrated capacity to meet unique local needs. We encourage the Office of Mental Health and Substance Abuse Services (OMHSAS) to allow for flexibility for local innovation through the waiver process. Additionally, OMHSAS may consider the role of other licensure categories (including Moderate-Intensity Behavioral Health Crisis Center and Behavioral Health Urgent Care) in expanding access to on-demand behavioral health services.
4. **Workforce constraints**—Pennsylvania must attract and retain the workforce necessary to meet the proposed standards. HAP applauds the department’s allowance of the use of telehealth resources to expand access. We also encourage the department to consider allowing current staffing to remain in place as they obtain required educational credentials and/or while organizations work to recruit additional master’s-level staff.
5. **Funding and long-term sustainability**—As DHS acknowledges in its regulatory analysis, sustaining crisis intervention services at the proposed standards will require increases in both county base and Medical Assistance funding. We encourage the department to, if at all possible, explore options to tie implementation to an increase in available funds as to not exclude providers who cannot meet requirements at the current reimbursement levels.

Additionally, HAP puts forward the following questions from members for clarification:

- **Seclusion Rooms**—The proposed language in 5250.96 implies that crisis centers must have a seclusion room and be prepared to perform this resource-intensive clinical intervention. Are seclusion rooms required for all licensed centers or are waivers available for those who do not perform that clinical intervention?
- **Age of Patients**—The proposed regulation indicates that crisis intervention services should be available to all, but current licensure and programming documentation for some providers are age-specific. Can the regulatory language be amended to acknowledge this type of situation?
- **Fire Drills**—Does the department intend for individuals who are utilizing crisis services to participate in fire drills? This is not common practice in health care facilities (for patient safety reasons). If individuals are not required to participate, can the department clarify in 5250.48 that fire drills are intended for only facility staff?
- **Patient Complaints**—Can the proposed language regarding patient complaints be harmonized with similar Centers for Medicare & Medicaid Services (CMS) regulations (see 42 CFR 482.13(a)(2)), to provide necessary clarity to providers?

HAP welcomes the opportunity to share comments related to the proposed regulations and to affirm our ongoing support for a robust crisis intervention system. We stand ready to partner



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with the department and the stakeholder community to build up the existing infrastructure to ensure that Pennsylvanians can get the care they need, when and where they need it. We appreciate your consideration of these comments. Please contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jennifer Jordan', is written over a light gray rectangular background.

Jennifer Jordan
Vice President, Care Continuum & Behavioral Health Strategy