



## **Behavioral Health Integration Response**

WIN Team, LLC supports Model 2 as the best avenue to improve care, efficiency, and outcomes for the public. However, our strong recommendation is that Model 2 is actualized as a risk-based administrative services organization (ASO).

The following are thoughts and recommendations we would like included in the final large group report on “Integration Model for Medicaid-Financed Behavioral Health Services”.

1. ***Advocacy for Smaller, Community-Based, Minority Providers*** - We encourage the Department of Health and Mental Hygiene (DHMH) to facilitate and report the outcomes of a clear assessment related to how recommended behavioral health integration legislation will effect smaller, community-based, and minority organizations. Many of these organizations are established by indigenous community activists who have a unique insight into the needs of the community. The longevity of these organizations are a by-product of the superior service that community members recognize and appreciate. It appears that the proposed legislative recommendation favors larger, more capitalized organizations who may be equipped to facilitate volume-oriented services. However, our concern is for the smaller, community-based, and minority organizations who are often more user-friendly, individualized, and palatable to the multi-faceted needs of community members with mental health and substance abuse challenges. Statistically, most behavioral health consumers are minorities. We assert the strong value of these consumers identifying the entrepreneurial examples and leadership established via the legacy of small, community-based, minority owned and operated behavioral health service providers.
2. ***Challenges with Evidence-Based Practices (EBP) and Accreditation Requirements*** - We encourage DHMH’s support of evidence-based practices and accreditation requirements for providers. However, we would like to caution the administration of some challenges smaller providers are experiencing as they pursue compliance with evidence-based and accreditation standards. WIN Team, LLC is medium-sized, expanding human service provider who is currently working with Morgan State University and the University of Maryland to validate our grassroots philosophy of care and clinical intervention – Family Strengthening Practice model – as an evidence-based practice. The process has required a significant allocation of funds and investment of human resources and time. We have studied many academic articles, professional studies, and governmental reports that struggle to define what “evidence-based practice” means to the behavioral health and human service industries. By most accounts, “evidence-based practice” is an emerging term. Most nationally recognized “evidence-based practices”, relevant to the behavioral health field, support small, targeted populations. Often they are not transferrable to service continuums and multiple program and service types. Furthermore, these evidence-based practices require a significant amount of financial resources to implement and maintain fidelity. Likewise, accreditation costs are also significant for small, community-based providers.

According to the Commission on Facilities' (CARF) website, steps to or more of preparation before the improvement recommendations Accreditation fees are based on the needed to complete the survey,



Accreditation of Rehabilitation accreditation may involve one year site survey and on-going quality following the survey. number of surveyors and days costs are usually fixed, and there

are additional fees if additional programs are added to the survey. Furthermore, CARF accreditation decisions may be granted as a provisional, one-year, three-year, or five-year accreditation. Consequently, small providers can anticipate to invest significant time and resources into the accreditation process in addition to remaining compliant with COMAR regulations, which should be adequate enough to guide the behavioral health program, service, or practice. Additionally, there are oversight organizations, current ASO, and licensing authorities that have additional auditing requirements that providers must comply with. This redundant process of evaluating the accountability and quality of service providers is redundant. It is feasible for larger organizations that have the financial general fund and multi-faceted human resources to actualize those additional requirements. However, accreditation and evidence-based practice compliance are costly and extremely difficult for smaller, less capitalized service providers to bring to scale. Another concern is related to the emerging electronic health record requirements and the ability of smaller providers to manage the cost to incorporate these requirements in conjunction with these EBP and accreditation standards

3. ***Equitable Service Rates*** - The draft report highlights that an unique benefit of Model 2 implementation would be flexible payment methods. The report notes that “service rates would be based on a provider’s performance, volume, and other factors.” It then attempts to define anticipated provider performance in subjective terms such as “good”, “right”, or “bad.” We strongly encourage DHMH to further explore clear definitions of provider performance criteria so that there is a fair playing field of rules that are not based on the financial liquidity and political connections of providers. We caution against a new Behavioral Health Organization’s (BHO) marginalization of providers that don’t have the volume or “other factors” in place to secure equitable service rates.
4. ***Clear Examples and Implications for Clients & Providers*** – We encourage DHMH to offer the behavioral health provider community examples of how implementation of Model 2 will change the way we are currently providing services, specifically for psychiatric rehabilitation services, substance abuse treatment, and mental health services to youth and adults. We encourage DHMH to clearly delineate the fiscal implications of the changing system, consult with provider communities to further vet the benefit and features of the recommended changes, and offer a clear picture of how the billing requirements will change. We would like the examples to highlight the implications for consumers needing these services and the provider community that offers them. Legislative support for this change in service delivery at the consumer and provider community level is important.