October 3, 2017

The Honorable Edward J. Kasemeyer   The Honorable Maggie McIntosh
Chair, Senate Budget and Taxation Committee   Chair, House Appropriations Committee
3 West Miller Senate Office Building   121 House Office Building
Annapolis, MD 21401   Annapolis, MD 21401

Re: 2017 Joint Chairman's Report (page 79) – Behavioral Health Accreditation Process

Dear Chair Kasemeyer and Chair McIntosh:

Pursuant to the 2017 Joint Chairmen's Report (JCR), page 79, attached is the report on the Behavioral Health Accreditation Process. The JCR specifically directs:

> *"… submit a report that provides a detailed review of the behavioral health accreditation process. This report should include information on the number and characteristics of the behavioral health provider community, the current status of those providers who are accredited versus those who are not accredited, and an analysis of all small and mid-size providers to determine their progress toward accreditation and any challenges therein."*

If you have any questions or concerns, please contact Mr. Webster Ye, Deputy Chief of Staff, at 410-767-6480 or via email at webster.ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: The Honorable Thomas V. Mike Miller, Jr., President, The Senate of Maryland
     The Honorable Michael E. Busch, Speaker, The Maryland House of Delegates
     Ms. Sarah Albert, Library Associate, Department of Legislative Services

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Executive Summary

In accordance with authorizing legislation, the Maryland Department of Health (MDH) is moving towards accreditation-based licensure for behavioral health providers as of January 1, 2018. Under COMAR 10.63, all behavioral health providers should be scheduled to obtain accreditation by an approved accrediting organization no later than January 1, 2018 to be licensed by April 1, 2018 to provide community-based behavioral health services.

As part of MDH's commitment to improving customer service and patient care, the Substance Use Disorder (SUD) Accreditation Project was initiated in April to ensure SUD providers received the support needed to meet the January 1, 2018 deadline and that quality health care services remain available for all Marylander's seeking addiction treatment services.

The Office of Health Care Quality (OHCQ) is responsible for licensing and certifying community-health programs throughout Maryland. Using their certification list as a baseline dataset, the project team initiated their detailed analysis of Maryland's SUD provider network and their progress in meeting accreditation-based licensure requirements. Specifically, the project team worked to 1) determine the number and characteristics of SUD providers in the state; 2) assess the accreditation status of SUD providers statewide; 3) identify potential obstacles preventing SUD providers from meeting accreditation-based licensure standards; and 4) develop data driven recommendations to address any potential obstacles.

Using OHCQ's baseline dataset, a letter was sent by the Secretary on June 7, 2017 to all known SUD provider sites asking them to update MDH on their accreditation progress and what assistance they would need in meeting the January 1 accreditation-based licensure deadline. The letter also contained information related to cash assistance for providers unable to pay their program's accreditation fee and the Department's ability to assist with treatment transition plans for providers who choose to discontinue services subject to COMAR 10.63.
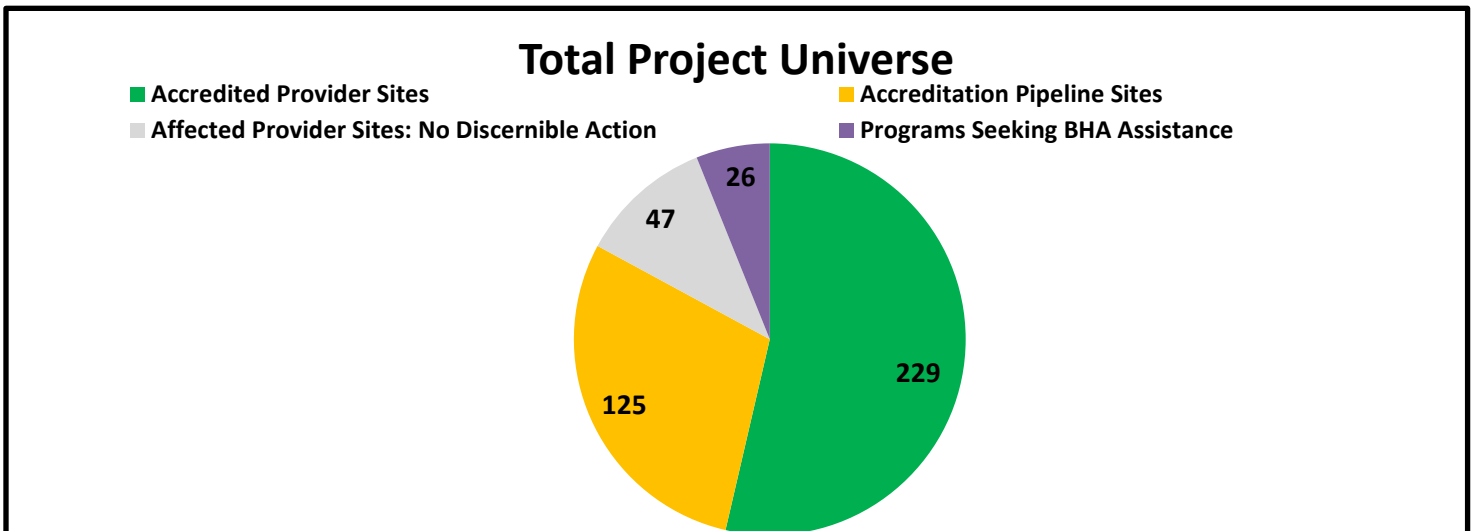
Additionally, the project team conducted nine on-site provider feedback sessions across the state. Participants in these sessions were randomly selected by the project team and represented providers of each size, accreditation level, and geographical region. Feedback sessions were limited to 10 participants per session and lasted about an hour.

Based off data collected and reviewed by the project team, Maryland's affected SUD provider network consists of 427 individual sites, out of which 354 (or 83%) are either accredited or actively engaged in the accreditation process. Of the 427 treatment locations, a majority are considered mid-size or smaller, with 64% offering services in urban jurisdictions. Additionally, the project team found no correlation between a provider's size, geographical location, or levels of care and their ability to seek and obtain accreditation. Likewise, the project team also found that the largest obstacles for achieving accreditation, overall cost and time, were shared by all providers regardless of size or location.

After thoroughly analyzing the SUD provider network and actively engaging with providers, the Department feels Maryland's SUD provider network is fully prepared to meet COMAR 10.63 accreditation-based licensure standards by January 1, and does not believe any regulatory amendments or additional provider exemptions are required to maintain treatment capacity.

Analysis of the Affected SUD Provider Universe

Affected Provider Universe: Based off information collected by the project team, there are 427 individual SUD provider sites subject to accreditation-based licensure. Of those 427 sites, 54% are accredited, 29% are in the accreditation pipeline, 6% are working with BHA on technical or financial assistance, and 11% are assumed to be operational but have taken no discernible action towards accreditation.

Total Project Universe

- ■ Accredited Provider Sites
- ■ Accreditation Pipeline Sites
- ■ Affected Provider Sites: No Discernible Action
- ■ Programs Seeking BHA Assistance

26
47
125
229

Since the project launched in April, the number of accredited provider sites has increased by 108% and the number of no-discernible-action-provider sites has decreased by 82%. BHA is working to confirm the operational status of the 47 providers that have taken no discernible action towards accreditation and is providing additional outreach to ensure that those providers know accreditation assistance is available should they need it.

**SUD Programs subject to COMAR 10.63 Accreditation-Licensure:**

| Program Type	Total number of individual programs	Number of individual accredited programs	Accreditation Percentage by program
Outpatient Level I	338	277	82%
IOP Level II.1	303	220	73%
PHP II.5 Partial Hospitalization	62	54	87%
Residential Level III.1 (HH)	59	44	75%
Residential Level III.3	35	31	86%
Residential Level III.5	23	22	96%
Residential Level III.7	17	16	95%
Ambulatory Detoxification Level I-D	40	35	88%
Extended On-Site Detox Level II-D	42	37	88%
Residential Detoxification Level III.2-D	8	7	88%
Inpatient Detoxification Level III.7-D	17	16	94%
OTP	75	75	100%

Provider Demographics:

To assess the full impact of accreditation-based licensure on Maryland's SUD provider network, the project team collected and reviewed information relating to the overall number of SUD programs, their geographical location, and the number of patients treated per year.

The project team used the State's definition of a "rural area" when assessing a site's geographical location. § 2-207 of the State Finance and Procurement Article defines 18 of Maryland's 24 jurisdictions as rural areas. Therefore, programs located in Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester counties are considered rural.

Where are Maryland's SUD providers located?

■ Rural: 154 sites   ■ Urban: 271 sites
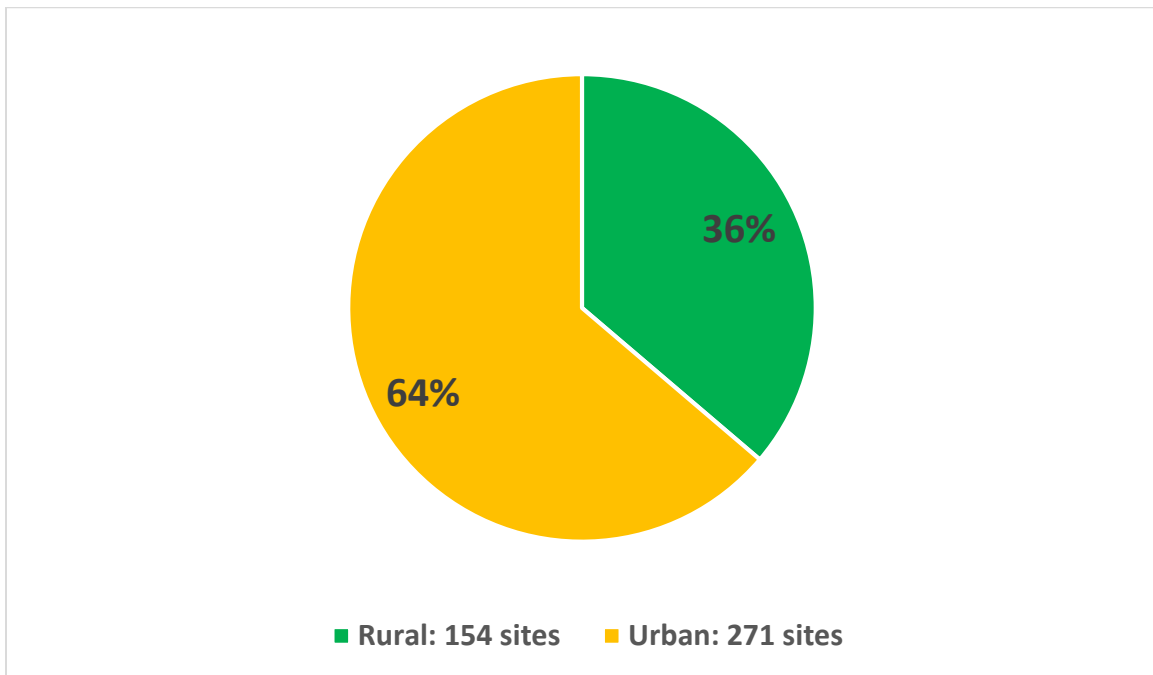
Accreditation: Maryland's rural and urban SUD provider network
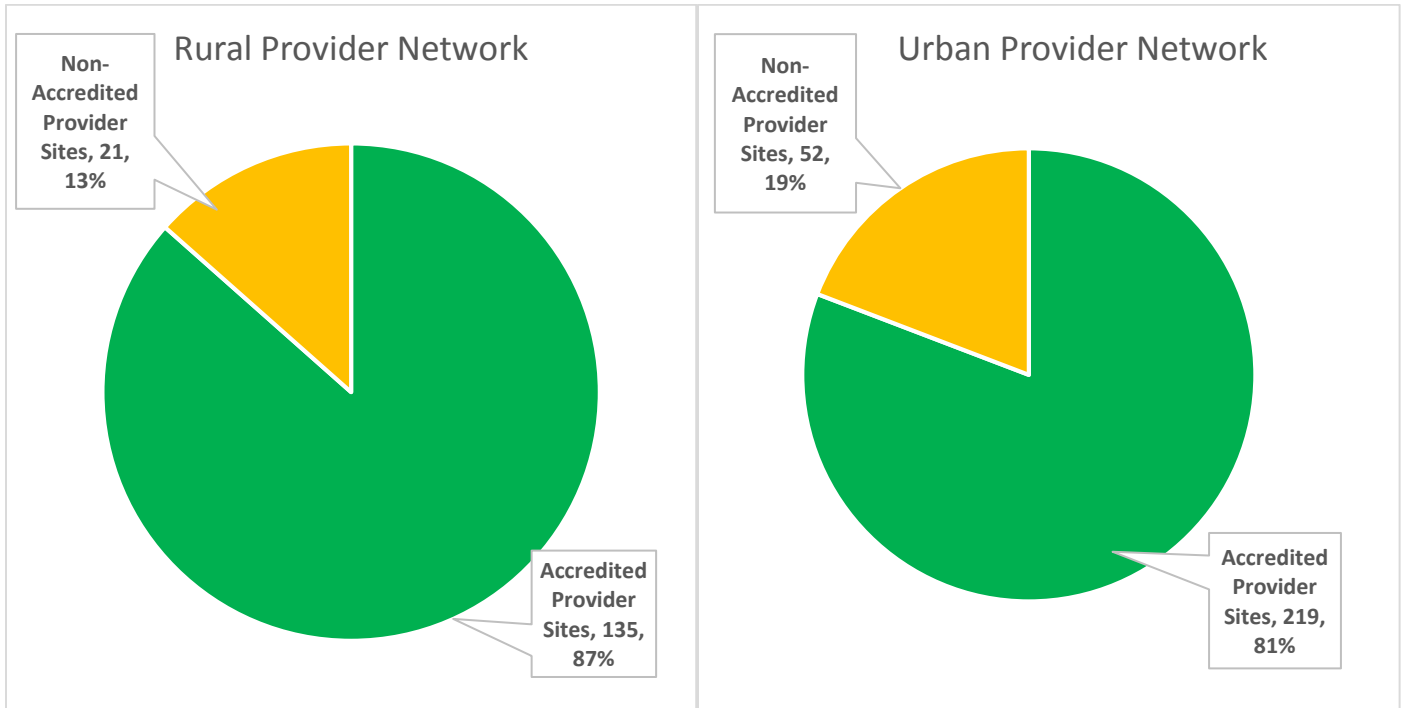
Given the above information, as well as additional supporting data collected by the project team, a provider's geographical location does not appear to impact their ability to become accredited. That being said, Maryland's rural providers do appear to be seeking and obtaining accreditation at a slightly higher rate than urban providers.
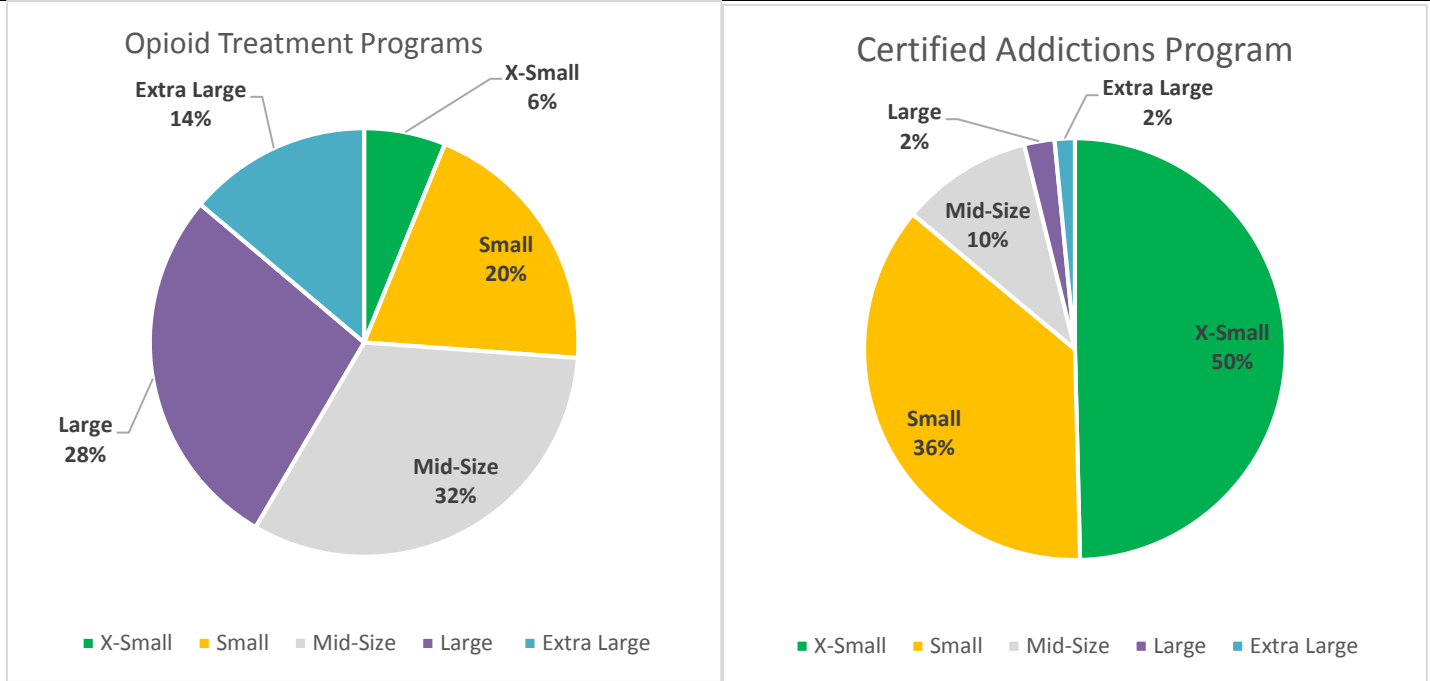
In order to understand this slight discrepancy, the project team sought feedback from various stakeholders. Based on the information collected, the 6% difference between rural and urban accreditation rates has less to do with geography and more to do with the introduction of integrated behavioral health regulation by the State.

Prior to the creation of Local Addiction Authorities (LAAs) in 2015, interactions between MDH and SUD providers mainly centered around site certification and facility compliance, not program regulation and management. Today, LAAs are responsible for the planning, managing, and monitoring of publicly funded SUD providers. While this integrated system of service delivery has proven successful for mental health, SUD providers have been slower to adapt, resulting in delayed relationship building, and ultimately slower communication of critical information, between LAAs and urban providers.

What does Maryland's SUD provider network look like?

To determine a program's size, the project team worked with Maryland Medicaid to review the unduplicated number of Medicaid members served during a calendar year. While this analysis did not provide information on every provider within Maryland's SUD provider network, it did provide information on 65 Opioid Treatment Programs (OTPs) and 181 Certified Addictions Programs. It should be noted that neither OHCQ nor BHA capture annual treatment demographics that could have been used by the project team.

Number of Medicaid Patients Served in a Calendar Year	Defined Program Size
1-99	Extra Small
100-250	Small
251-500	Mid-Size
501-750	Large
751 or more	Extra Large

Opioid Treatment Programs

Extra Large 14%
X-Small 6%
Small 20%
Mid-Size 32%
Large 28%

■ X-Small ■ Small ■ Mid-Size ■ Large ■ Extra Large

Certified Addictions Program

Extra Large 2%
Large 2%
Mid-Size 10%
X-Small 50%
Small 36%

■ X-Small ■ Small ■ Mid-Size ■ Large ■ Extra Large

Maryland's SUD provider network is primarily composed of programs serving less than 500 patients per calendar year. As part of its analysis of the accreditation process, the project team evaluated whether a program's size affected its ability to make progress towards meeting accreditation-based licensure standards. While the overall cost and dedicated staff time needed to become accredited did present a greater challenge to smaller providers, the project team did not find any notable discrepancy between the number of accredited x-small, small, mid-size, large, and extra-large providers that would suggest a program's size determines their ability to meet accreditation standards.

Overview of SUD Provider Feedback Sessions:

As part of the project team's analysis, two types of provider surveys were conducted. One was an online survey sent hardcopy by MDH to all SUD providers currently certified by OHCQ as well as electronically by each jurisdiction's LAA or Local Behavioral Health Authority (LBHA). The second was a series of on-site regional feedback sessions in which providers representing programs of various sizes, accreditation levels, and geographical regions, provided direct feedback to the project team.

The first provider survey conducted by the project team took place in early June. In the letter sent to all currently certified SUD provider sites, the Secretary asked providers to 1) update the Department on their accreditation status and what steps their program(s) had undertaken to achieve accreditation; 2) what (if any) assistance their program required; and 3) if they decided to discontinue services subject to accreditation-based licensure, what went into making that decision and what assistance they required from the Department in ensuring patient treatment was successfully transferred to other area SUD providers.

In all, 157 providers responded to the June survey, providing information on 251 individual treatment sites. Out of those who responded, 92% were either accredited or undergoing the accreditation process and did not require any additional assistance, eight providers (.5%) had yet to formally start the accreditation process and were seeking both financial and technical assistance, two providers (.1%) were exempt from accreditation as they treat patients under their own professional license, and two providers (.1%) were choosing to discontinue services subject to COMAR 10.63.

Following the June survey, the project team conducted nine regional provider feedback sessions. Feedback session participants were randomly selected by the project team and consisted of mental health and SUD providers from each of Maryland's 24 jurisdictions, as well as various program sizes and accreditation levels. During each feedback session, participants were asked a series of seven informative questions:

> 1) What were your biggest obstacles in preparing for accreditation?
> 2) What specific quality improvements/benefits has your organization experienced in seeking/receiving accreditation?
> 3) What has been/what was the most helpful to you during the accreditation process?
> 4) How could the Department improve upon the accreditation and application process within 10.63?
> 5) What forms of communication are most helpful to you?
> 6) As a provider, do you feel supported and informed by the Department?
> 7) What general feedback do you have for the Department?

When comparing the results from both surveys, the project team found that regardless of a program's size, geographical location, or progress with accreditation, providers agreed that seeking/obtaining accreditation had improved their quality of service and program operations. Additionally, all providers surveyed cited overall cost and staff time as the biggest obstacles faced during the accrediting process.

Conclusion of Project Findings

Based off data collected and reviewed by the project team, Maryland's affected provider network consists of 427 individual sites, out of which 354 (or 83%) are either accredited or actively engaged in the accreditation process. Of the 427 treatment locations, a majority are considered mid-size or smaller, with 64% offering services in urban jurisdictions. Additionally, the project team found no correlation between a provider's size, geographical location, or levels of care and their ability to seek and obtain accreditation. Likewise, the project team also found that the largest obstacles for achieving accreditation, overall cost and time, were shared by all providers regardless of size or location.

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