

REGION II HUMAN SERVICES BEHAVIORAL HEALTH PROVIDER ENROLLMENT GUIDELINES

Department of Health and Human Services

Division of Behavioral Health

DESIRED OUTCOMES

The minimum standards for behavioral health provider enrollment in the regional networks are designed to answer the following questions:

- A. Does the provider have the capability to provide behavioral health services?
- B. Are the Division and the Network interested in purchasing the services the provider has to offer?
- C. Are there any health and safety issues?
- D. Is the provider achieving the outcomes the Division and the Network are interested in purchasing?

NETWORK MANAGEMENT RESPONSIBILITIES

- A. Network Management will enroll providers to participate in the Nebraska Behavioral Health regional networks.
- B. Additional requirements beyond these minimum standards may be added consistent with local needs for providers.
- C. Network Management will complete the initial enrollment process outlined in the four parts (Demonstration of Capacity, National Accreditation, On-Site Visit, Primary Source Verification) under Enrollment of Providers for each provider enrolled and submit a provider enrollment form for each provider to the Division.
- D. Network Management will complete the review process after the first year, outlined in the four parts (Demonstration of Capacity, National Accreditation, On-Site Visit, Primary Source Verification) under Retention of Providers for each provider enrolled and submit a provider enrollment form for each provider to the Department.
- E. Network Management will have a system in place to keep the enrollment information current and accurate.
- F. Network Management will conduct Services Purchased Verifications at least annually and Program Fidelity Reviews at least every three years for each provider enrolled.

DIVISION RESPONSIBILITIES

- A. The Division shall provide training to Network Management to ensure the Enrollment Process, Data Maintenance, On-Site Visit, and Primary Source Verification are conducted in a manner consistent with the standards set by the National Committee for Quality Assurance, "Standards for the Accreditation of Managed Behavioral Healthcare Organizations".
- B. The Division's Administrative Service Organization (ASO) assigns a provider number upon receipt of the provider enrollment form from the Network Manager.
- C. The ASO shall provide outcome data reports to the Networks.
- D. The Division will designate the Network Manager as the authority to enroll and certify providers and will evaluate and oversee the Network Management performance.
- E. The Division retains the right, based on quality issues, to approve new practitioners, providers, and sites in each network, and to terminate or suspend individual practitioners or providers.

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SUMMARY OUTLINE OF ENROLLMENT PROCESS

- I. Initial Enrollment of Providers
 - A. Demonstration of Capacity
 - B. National Accreditation
 - C. On-Site Visit
 - D. Primary Source Verification

- II. Retention of Providers
 - A. Demonstration of Capacity
 - B. National Accreditation
 - C. On-Site Visit
 - D. Primary Source Verification

- III. Categories of Enrollment
 - A. Provisional
 - B. Ongoing
 - C. Probation

- IV. Capacity
 - A. Provider's Service Capacity
 - B. Capacity Network Will Purchase

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I. INITIAL ENROLLMENT OF PROVIDERS

The decision to enroll a behavioral health provider is based on the collection of the following information: (A) Demonstration of Capacity, (B) National Accreditation, (C) On-Site Visit, and (D) Primary Source Verification.

A. Demonstration of Capacity

1. Facility Licenses, Fire Inspections, and Food Permits, as required.
2. Professional Licenses, as required.
3. Insurance (workers' compensation; motor vehicle liability, professional liability, directors/officer's liability, and general liability coverage)
4. Fiscal Viability - demonstrated as "a going concern" by an audited balance sheet.
5. Providers must be enrolled as a Medicaid provider (MC 19 or MC 20 form) if the service provided is eligible for Medicaid funding.
6. A Program Plan for each service provided in the Network.
 - a. Entry (admission) and exit (discharge) criteria
 - b. Description of the assessment procedures
 - c. Description of how consumer input into the program is completed
 - d. Staffing
 - e. Quality improvement

B. National Accreditation

1. OPTION 1: National Accreditation for large mental health service providers (total DHHS Behavioral Health revenue is greater than or equal to \$75,000 annually or \$6,250 per month).
2. OPTION 2: Accreditation Development Plan for mental health service providers which are in the process of attaining National Accreditation (total DHHS Behavioral Health revenue is greater than or equal to \$75,000 annually or \$6,250 per month)
3. OPTION 3: Waiver????

NOTE: The following are approved accreditation bodies for the Behavioral Health delivery system.

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
2. Commission on Accreditation of Rehabilitation Facilities (CARF)
3. Council on Accreditation of Services for Families and Children, Inc. (COA)
4. American Osteopathic Association (AOA) for hospital psychiatric services only

C. On-Site Visit

1. The on-site visit for all providers is conducted by Network Management prior to the provider's enrollment in the Network and prior to providing service to persons authorized by the ASO. The on-site visit is completed at the provider's location to verify the information provided under Section I. A.
2. The on-site visit will evaluate the site where services are provided. When the service is not a "facility based program", the building or location visited is the site where the provider's organized program, clinical, financial record keeping function is established.
3. The on-site visit will verify that the provider's clinical record keeping practices conform with

- the program plan submitted and minimum standards. This is a systematic review of the clinical records for conformity and content but will not make judgment on the appropriateness of treatment.
4. The on-site visit will include a data audit to verify the information reported to DHHS.
 5. In addition, practitioners and facilities without documentation of National Accreditation and practitioners and facilities using an "Accreditation Development Plan" to meet the requirements for national accreditation will need to have an on-site visit.
 6. If a practitioner or facility does not have National Accreditation and the Division has waived the need for such Accreditation, an on-site quality assurance review using the standards set in Title 206 must be completed.

D. Primary Source Verification

All information used to meet the criteria under Sections A and B (credentialing and facilities, malpractice insurance coverage, national accreditation, and related documents) is completed. This will be completed by Network Management which verifies key information such as licenses, insurance coverage, national accreditation, and related documents.

II. RETENTION OF PROVIDERS

The decision to retain a behavioral health provider is based on actual performance and a retention review. The Retention Review is completed by Network Management and consists of the following parts.

A. Continue to meet the requirements for initial enrollment.

B. An Actual Performance Review is completed to determine if the provider has demonstrated a commitment to providing quality services. The Actual Performance Review consists of three parts: (1) Results Produced, (2) Consumer Satisfaction, and (3) Error Free Reporting.

1. Results Produced

The behavioral health provider has data demonstrating the operation of the behavioral health service. The data reported includes:

- a. Utilization Data - process oriented information
- b. Outcome Data - demonstrates results based on actual clinical status (Increased Functioning, Increased Health status, Decreased Symptoms, Employment Outcomes, Improved Housing, Improved Legal Status and/or other related outcomes).

2. Consumer Satisfaction

This is based on *customer service* and includes the following:

- a. Consumer Satisfaction Survey
- b. Tracking consumer complaints regarding the provider
- c. Malpractice suits (is anything pending in this area, or recently adjudicated)
- d. Does the provider or service create unnecessary dependence (service demonstrates promotion of growth and independence and does not foster dependence)

3. Error Free Reporting

Error free reporting means the "approved provider" has administrative processes which make it easy to work with because information reported is "without mistakes" in the billing, consumer service data, and other reporting. When the information is transferred, it is accurate and correct, resulting in a given job being performed only one time. When there are errors, it is costly to correct the problem. The measure here is the "error rate" in reporting--the lower the better.

C. On-Site Visit

1. The on-site visit is conducted before the Retention Review is completed.
2. The site visit report must include a information on how well the record keeping system

conforms to the standards set. There will be specific requirements for corrective actions with deadlines when standards are not met.

D. Primary Source Verification

Information used to meet the criteria in Section I. A. and I. B. must be documented by Network Management to complete the Retention Review.

III. CATEGORIES OF ENROLLMENT

A. Provisional

This is a twelve (12) month trial period where the provider has the opportunity to demonstrate their capacity to deliver services within the Nebraska Behavioral Health System (NBHS).

B. Ongoing

1. After the initial Retention Review is completed, the provider enters this category. The initial Retention Review is completed after the first 12 months of Enrollment in the Network.
2. After the initial Retention Review is completed, it is repeated as needed, but no later than:
 - a. annually for Services Purchased Verifications
 - b. every three years for Program Fidelity Reviews

C. Probation

1. Providers with documented significant problems.
2. A Corrective Action Plan is mutually developed with Network Management to address the identified problems.

IV. CAPACITY

The capacity will indicate both (1) how much service the provider is capable of offering, and (2) how much service the Network wants to purchase.