Region 3

Behavioral Health Services

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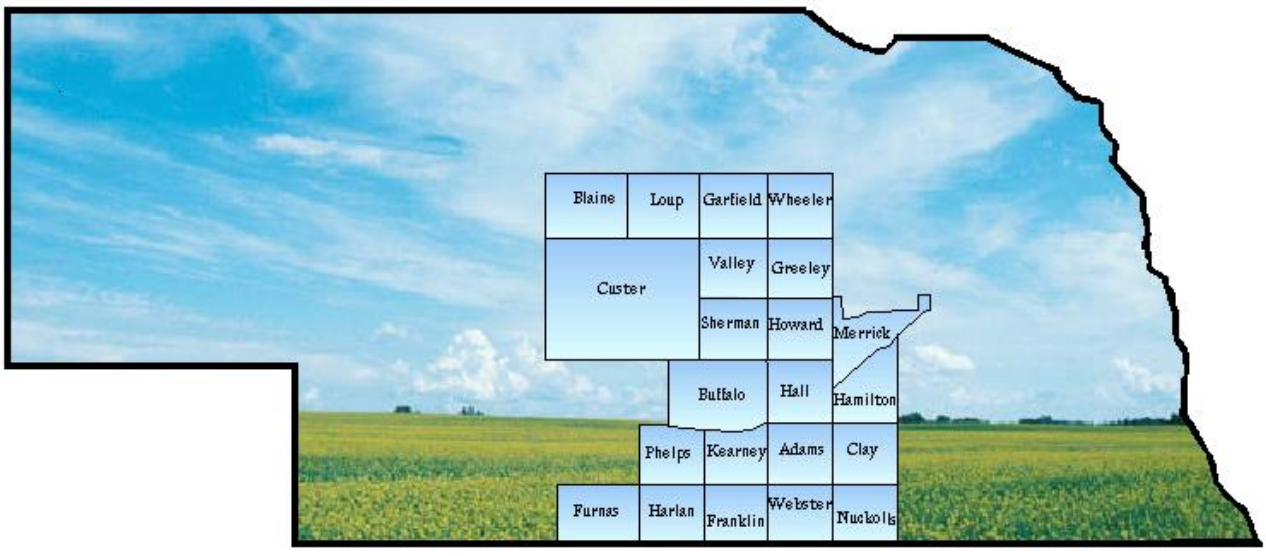
# NETWORK PROVIDER ENROLLMENT MINIMUM STANDARDS

*The mission of Region 3 Behavioral Health Services is to foster recovery and resiliency for individuals and their families who experience a behavioral Health challenge.*



Region 3 Behavioral Health Services (Region 3) shall enroll applicants into its network based on the successful completion of the Network Provider Enrollment Minimum Standards (PEMS) process outlined in this document, the applicant's demonstration of its ability to comply with *Nebraska Administrative Code 206: Behavioral Health Services* (NAC 206) Chapters 5 and 6, including the service definition(s) specific to the service(s) the applicant desires to provide in the network, and the availability of funding Region 3 has to purchase services identified as core and necessary to meet the behavioral health needs of individuals and families who meet Region 3 clinical and financial eligibility criteria. Region 3 seeks additional providers only in the event that new funding is available, a new service is desired, or an existing Network Provider leaves the Region 3 Network.

Region 3 is a component of the Nebraska Behavioral Health System (NBHS) which is overseen by the Department of Health and Human Services (DHHS), Division of Behavioral Health (DBH), and as such, DBH retains the right, based on quality and/or safety issues, to deny approval of new practitioners, providers, and sites in the Region 3 Network, and to terminate or suspend individual practitioners or providers.

Note: NAC 206: Behavioral Health Services including service definitions of all services included in the NBHS service array may be accessed via the internet at: http://dhhs.ne.gov/Pages/reg_bhregs.aspx and click on Title 206 -- Behavioral Health Services

## DESIRED OUTCOMES

The minimum standards for behavioral health network provider enrollment in the Region 3 Network are designed to answer the following questions:

A. Does the applicant have the capability to provide behavioral health services and fulfill its potential role in the Region 3 Network?
B. Are DBH and the Region 3 Network interested in purchasing the services the applicant has to offer?
C. Does the applicant demonstrate adherence to applicable legal requirements, health and safety requirements, and risk management practices?
D. Is the applicant achieving the outcomes DBH and the Region 3 Network are interested in purchasing?
E. Does the applicant demonstrate implementation of person-centered, recovery-oriented philosophy in service delivery?
F. Does the applicant demonstrate ethical practices in business and service delivery?
G. Does the applicant demonstrate fiscal viability and stability?
H. Does the applicant have the capacity and ability to fulfill the mission of the Region 3 network?

## SUMMARY OUTLINE OF NETWORK PROVIDER ENROLLMENT MINIMUM STANDARDS PROCESS

I. Initial Enrollment of Network Providers
   A. Demonstration of Capacity
   B. National Accreditation
   C. Quality Assurance
   D. Consumer Satisfaction
   E. Error-Free Reporting
   F. On-Site Visit
   G. Primary Source Verification
   H. Provisional Enrollment Status

II. Enrollment Process

III. Retention of Network Provider
   A. Demonstration of Capacity
   B. National Accreditation
   C. On-Site Visit
   D. Primary Source Verification

IV. Capacity
   A. Capacity of Network Provider
   B. Capacity Region 3 Network Will Purchase

V. Additional Network Provider Responsibilities

VI. Probation

**BEHAVIORAL HEALTH NETWORK PROVIDER ENROLLMENT MINIMUM STANDARDS, RESPONSIBILITIES, AND SELECTION CRITERIA**

## I. INITIAL ENROLLMENT OF NETWORK PROVIDERS

The decision to enroll a behavioral health provider in the Region 3 Network 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 as listed below:
   a. Workers' compensation,
   b. Motor vehicle liability,
   c. Professional liability (minimum of $1,000,000 per occurrence and $3,000,000 in aggregate per year),
   d. Directors/officers liability,
   e. General liability coverage in an amount not less than $1,000,000.
4. Fiscal Viability – demonstrated as "an ongoing concern" by an audited balance sheet.
5. Applicants must be enrollee as a Medicaid provider (MC 19 and MC 20 form) if the service provider is eligible for Medicaid funding.
6. Organizational documentation:
   a. Board of Directors
   b. Organizational Chart
   c. Staff List to include: Name, Title, Program, and License Number, as applicable
7. A Program Plan for each service provided in the Region 3 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
   f. Administrative and operational overview of applicant
   g. Purpose of program
   h. Need for the program
   i. Target population
   j. Organization of program
   k. Program goals

l. Specific program services
m. Procedures for direct consumer involvement
n. Capacity
o. Facility needs

**B. National Accreditation**

Network providers must comply with state regulations 206 NAC 5-001 to receive funds administered by DBH for service delivery. Providers must furnish documentation to Region 3, demonstrating the following:

1. Provider organizations must be accredited by the national accrediting body that is appropriate to the organization's mission. National accrediting bodies include: Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by Region 3 and DBH. Documentation of accreditation must include:
    a. A complete copy of the most recent official accreditation report;
    b. Documentation of the most recent official award of accreditation; and
    c. A complete copy of the plan of correction submitted in response to the official accreditation report, if applicable.

2) Those organizations that do not have documentation of official award of accreditation by JC, CARF, COA, or other nationally recognized accreditation organization(s) approved by the Director must submit an Accreditation Development Plan for progressively bringing the organization into accreditation status during a two-year period. During the time an organization is working toward accreditation under an Accreditation Development Plan, the organization must meet the standards for behavioral health services in 206 NAC 6. The Accreditation Development Plan must demonstrate a systematic approach toward achieving accreditation and must include:

    a. Policies and procedures to be followed during the accreditation development period including policies and procedures for protecting the life, safety, and rights of consumers served;
    b. A quality improvement program which follows the standards set by the national accreditation body which is being sought by the organization (JC, CARF, COA, or other nationally recognized accreditation organization(s) approved by the Director);
    c. A written plan for accomplishing the accreditation. The plan must include the type of accreditation being sought (JC, CARF, COA, other) that is appropriate to the organization's mission and includes goals, measurable objectives, target dates, person(s) responsible, and deadlines for making application for accreditation and for scheduling accreditation survey; and
    d. A report on the results of a self-administered survey following the standards set by the national accreditation body which is being sought by the organization.

**C. Quality Assurance**

The provider will provide information which demonstrates the operation of behavioral health services, which shall include:

1. Utilization data - process-oriented information, including results of goals and objectives of the program itself.

2. Outcome data - outcome-oriented information which demonstrates results based on actual clinical status (e.g. increased function, increased health status, decreased symptoms,

employment outcomes, improved housing, improved legal status, and other related outcomes).

3. Record of accepting system management referrals - demonstrates that the agency has accepted persons who meet the financial eligibility requirements.

**D. Consumer Satisfaction**

The provider will produce or outline how it will be able to meet the following:

1. Consumer Satisfaction Survey and results
2. Develop and implement a mechanism to track and resolve consumer complaints regarding the provider.
3. Disclose the outcome or status of any malpractice suits (pending or recently adjudicated).

**E. Error-Free Reporting**

The provider will identify its plan for ensuring that accurate information is provided to the Region and DBH on a timely basis. The provider will demonstrate accuracy in billing, consumer service data, and other reporting requirements.

**F. On-Site Visit**

Prior to enrollment and service provision, an on-site visit will be conducted by Region 3 at the provider's location.

a. The on-site visit for providers is conducted by Network Management prior to the provider's enrollment in the Network and prior to providing service to person registered or authorized for service.

b. The on-site visit is completed at the provider's location to verify the information provided under Section I.A.

c. 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.

d. The on-site visit will verify that the provider's clinical record keeping practices conform with the program plan submitted and meet the minimum standards as described in 206 NAC 6-007. This is a systematic review of the clinical records for conformity and the type of information included in treatment or rehabilitation plans, but will not make judgment on the appropriateness of treatment.

e. If an individual practitioner does not have National Accreditation, an on-site quality assurance review, using the standards set in NAC 206, will be completed. Organizations and group practices will be required to have National Accreditation.

**G. Primary source Verification**

All information used to meet the criteria under Section I.A. through I.G. (including credentialing and facilities, malpractice insurance coverage, national accreditation, and related documents) is compiled. This is completed by Network Management, which verifies key information such as licenses, insurance coverage, national accreditation, and related documents.

**H. Provisional Enrollment Status**

The decision to enroll a behavioral health Network Providers as "provisional status" is based upon the Enrollment Criteria outlined above. Provisional status is a 12-month trial period where the provider has the opportunity to demonstrate the organizational ability to deliver services within Region 3 Provider Network. Candidates will be considered eligible for a 12-month provisional status in Region 3's Network, according to the Enrollment Criteria, if a

satisfactory Enrollment Plan is submitted, as well as completion of a satisfactory on-site visit by Network Management. (NOTE: Providers already enrolled will go through the Retention Review Process at the end to the Provisional 12-month-time period.)

After the successful completion of the 12-month provisional period, the decision to retain a behavioral health provider is based on actual performance and a retention review. A regular site visit, which includes a services purchased verification, a programmatic review, financial review, and continued compliance with PEMS and contract requirements, will be conducted. Continued status as a member of the Region 3 Network is contingent upon the following:

1. Continued compliance with enrollment requirements, minimum standards, contract requirements and State Regulations;
2. A review of data demonstrating the operation of the service outlined in the current contract;
3. Consumer satisfaction;
4. Compliance with information reporting and data submission to Region 3;
5. Completion of reports specified by Region 3;
6. Inclusion of consumers in development, implementation, and evaluation of services.
7. Successful annual site visits.

## II. ENROLLMENT PROCESS

To receive funds from Region 3 for the delivery of behavioral health services, providers must submit the following:

a. Completed Network Provider Enrollment Minimum Standards Application (Attachment A);
b. Current copy of the required licenses issued by the Department of Health and Human Services or the applicable local licensing authorities of competent jurisdiction which apply to the program;
c. Documentation on the type of organization seeking approval (such as governmental, private non-profit) to operate the program(s); and
d. Accreditation appropriate to the organization's mission by Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director. Documentation of accreditation must include:
    1. A complete copy of the most recent official accreditation report;
    2. Documentation of the most recent official award of accreditation; and
    3. A complete copy of the plan of correction submitted.

    Exceptions to required national accreditation include: (a) Substance abuse prevention organizations, and (b) when a nationally recognized accreditation organization appropriate to the organization's mission cannot be identified.

    Organizations that do not have documentation of official award of accreditation by JC, CARF, COA, or other nationally recognized accreditation organization (s) approved by Region 3 and the DBH must submit an Accreditation Development Plan for progressively bringing the organization into accreditation status during a two-year period. During the time an organization is working towards accreditation under an Accreditation Development Plan, the organization must meet the standards for behavioral health services in NAC 206, Chapter 6. The Accreditation Development Plan must demonstrate a systematic approach toward achieving accreditation and must comply with all requirements contained in NAC 206, Chapter 5.

## III. RETENTION OF PROVIDER

a. Continue to Meet the Requirements for NPEMS in Section 1.A.

b. Performance Review
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 four parts: (1) Contract compliance, (2) Results Produced, (3) Consumer Satisfaction, and (4) Error Free Reporting.

c. Contract Compliance – the provider has complied with all requirements listed in the provider's contract with Region 3. If there were compliance issues, the provider submitted a corrective action plan and fulfilled all requirements in such plan.

d. Results Produced – The behavioral health provider has data demonstrating the operation of the behavioral health service. The data reported includes:
    1. Utilization Data – process orientated information
    2. Outcome Data – demonstrates results based on actual clinical (Increased Functioning, Increased Health Status, Decreased Symptoms, Employment Outcomes, Improved Housing, Improved Legal Status, and/or other related outcomes.
    3. Record of Accepting NBHS referrals.

e. Consumer Satisfaction
This is based on the attention paid to customer service and includes:
    1. Consumer Satisfaction Survey
    2. Tracking consumer complaints regarding the provider
    3. Malpractice suits (is anything pending in the area, or recently adjudicated?)
    4. Does the provider or service create unnecessary dependence (service demonstrates promotion of growth and independence and does not foster dependence)?

f. Error Free Reporting
    1. Information reported is "without mistakes" in the billing, utilization of the Centralized Data System, consumer service data, and other reporting.
    2. When there are errors, it is costly to correct the problem. The measure here is the "error rate" in reporting – the lower the error rate the better.

g. On-Site Visit
    1. The on-site visit reconfirms the information in Section I. A-F and is conducted before the Retention Review is completed.
    2. The site visit report must include information on how well the record keeping system conforms to the standards sets. There will be specific requirements for corrective actions with deadlines when standards are not met.

h. Primary Source Verification
Information used to meet the criteria in Section I.A. and I.G. must be verified and documented by Network Management to complete the Retention Review.

## IV. CAPACITY

The capacity will indicate the behavioral health services the provider desires to deliver in the Region 3 Network and how much service the provider is capable of offering.

## V. ADDITIONAL PROVIDER RESPONSIBILITIES

In addition to the above stated requirements, each provider must meet the following criteria to be an approved behavioral health provider to be included in the Region 3 Network.

If services of a provider are eligible for Medicaid funding, the provider must be enrolled as a Medicaid provider.

Providers will continue to be enrolled only as long as licensure is maintained. Providers will be immediately terminated as an approved provider upon written notification by Region 3 whenever licensure is denied or revoked, or in the event of the imminent jeopardy of the health and safety of the consumers.

Failure to maintain compliance with the criteria set forth in the Provider Responsibilities and Provider Selection Criteria stated throughout this document will jeopardize the provider's inclusion in the Region 3 Network. Region 3 will notify the provider in writing of the failure to maintain compliance, at which time, the provider shall be allowed thirty (30) days to meet requirements or file a "Plan of Compliance" within twenty (20) days with Region 3. If the provider fails to meet compliance within thirty (30) days or file a "Plan of Compliance" within twenty (20) days with the Region, the provider shall be dis-enrolled from the Region 3 Network.

Providers of Federal Block Grant set-aside services (substance abuse prevention services and services for pregnant women and women with dependent children and/or mental children's services and services for persons disabled by serious mental illness) must have the demonstrated ability to provide these services per federal block requirements.

Providers must have the capacity to provide an evaluation and assessment of the behavioral health needs of any person seeking authorization and payment for the service(s) they provide.

To be enrolled as a network provider, all providers must agree to comply with all reporting and billing requirements of Region 3.

Providers must agree to routine verification of the services delivered. Verification will be completed by Region 3 Network Management and/or DBH.

To be enrolled as a Region 3 Network Provider, all providers must agree to comply with the clinical eligibility, levels of care entry and exit criteria, and assessment and service definition guidelines as contained in NAC Title 206, Service Definitions. A provider, that does not comply, will not be eligible for continued membership in the Region 3 Network.

Providers must agree to serve all clinically and financially appropriate referrals registered and authorized through the NBHS Centralized Data System.

Providers must agree to register all persons in the NBHS Centralized Data System for Non Fee for Service (NFFS), which do not require prior authorization, within 48 hours of admission to a service.

Providers shall comply with all reporting requirements for person placed in their services pursuant to the Mental Health Commitment Act.

To be enrolled as a Network Provider, all providers must agree to comply with the financial eligibility criteria, the fee schedule, and to accept the rate schedules established by Region 3 and/or DBH. A provider that does not comply will not be eligible for continued membership in the Region 3 Network.

Providers must agree to ensure continuity of care to link the consumer to other services and providers so behavioral health care is not interrupted. This shall include coordinating consumer care through other providers and Region 3.

Providers shall comply with federal and state required standards of confidentiality and shall collaborate as a member of the Region 3 Behavioral Health Network and comply with confidentiality protocols to ensure continuity of care within the Network. Such protocols include at a minimum, a release of information for each consumer to sign, which allows Region 3 and DBH to receive confidential information and make a determination if care shall be authorized. Providers must agree to attend at least 80% of Region 3 Network meetings on an annual basis.

## VI. PROBATION

Region 3 can make recommendation to the Regional Governing Board to place a provider on probationary status at any time for failure to comply with the minimum standards for enrollment.

- If a provider is placed on probation status, a Corrective Action Plan is mutually developed with Region 3 to address the identified problems and submitted to Region 3 within 30 days.
- Region 3 will review the Plan of Correction.
- Region 3 will conduct an on-site visit to determine compliance with the Plan of Correction.
- Region 3 will make recommendation to the Regional Governing Board regarding continued provider status.