

Comprehensive Provider Sub-Group

Purpose: The purpose of the Sub-Group was to determine the criteria to be used in identifying a provider as Comprehensive in the delivery of mental health and/or substance abuse services.

History: The sub-group came about as a result of the September 9th meeting of the Community Support Steering Committee, when a request was made for volunteers to tackle the issue of developing criteria for what constitutes a Comprehensive Provider. Two meetings were held: September 16th and September 23rd. Additional comments were received by the Division from providers who were not in attendance. Participants also joined the meetings by phone.

Following is a summary document that contains the proposed criteria for Comprehensive Providers, the group's reaction to each criterion and the proposed Division of Mental Health/Developmental Disabilities/Substance Abuse Services solutions (DMH/DD/SAS).

Criteria:

Accreditation:

Proposed Criterion:

Comprehensive Providers will have a three year (or longer) accreditation from an accrediting body (e.g., the Council on Accreditation [COA], the Commission on Accreditation and Rehabilitation Facilities [CARF], the Council on Quality and Leadership [CQL], and The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations [TJC]) recognized by the Department of Health and Human Services.

Group's Reaction:

The Group generally agreed with the proposed criterion from DMH/DD/SAS but noted the need for additional time for those providers who have an accreditation for one year.

Proposed Solution:

Comprehensive Providers will have a three year (or longer) accreditation from an accrediting body recognized by DHHS. Providers with accreditations of less than three years will be allowed to continue providing services but shall achieve a three year accreditation within 12 months (01/01/2011). Organizations that do not meet the three year requirement may not act as an affiliate but may provide any service not listed below.

Service Array:

Proposed Criterion:

Each Comprehensive Provider is required to offer the following Core Services:

- Medication management
- Outpatient
- Case Management
- Comprehensive Clinical Assessment

and

Two additional services from the following list:

- Intensive In-Home (IIH)
- Community Support Team (CST)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Child Residential Level II, III, and IV
- Therapeutic Family Services (TFS)
- Day Treatment
- Psychosocial Rehabilitation (PSR)

Group's Reaction:

The Group had a great deal of discussion around the service array and a number of services (Assertive Community Treatment Team (ACTT)/Multi-Systemic Therapy (MST) were removed from the list. This is one criterion that the Group felt needed to be resolved before the system could really move forward with implementation of the Comprehensive Provider concept. The Substance Abuse providers were concerned that this requirement and the staffing component would threaten their ability to remain in business.

Proposed Solution:

In order to meet this requirement, affiliations of two or more providers will be acceptable as a transition during the next two years to allow providers to continue operating. Here is an example of how an affiliation could work: Provider A who is endorsed for CST but no other services may enter into an affiliation with Provider B who is endorsed for IIH and provides the Core Services.

However, only one member of the affiliation will be considered Comprehensive. Providers endorsed for services not identified above are exempt from the Comprehensive Provider requirements. Each two or more parties (Principals) entering into affiliations shall be required to purchase performance bonds, naming the State of North Carolina/DHHS as the obligee.

Staffing:

Medical Director

Proposed Criterion:

A Comprehensive Provider shall have a single named person as Medical Director (licensed physician or psychiatrist). In total, the Comprehensive Provider must have at least 40 hours of professional time from one or both of the above disciplines. The training and experience of the Medical Director must be reflective of the population to be served. The loss of this position for more than 30 days will require a review of the agency's status as a Comprehensive Provider.

Group's Reaction:

The Group did not agree with this proposed criterion as stated. The general consensus was that the requirement of a full time equivalent (or FTE) for this position was too expensive for most providers and lacked sufficient demand in terms of consumers served to sustain the cost of that position.

Proposed Solution:

A Comprehensive Provider shall have one single named Medical Director (licensed physician or psychiatrist) for 20 hours and an additional 20 hours of medical/psychiatric oversight may occur through affiliations. Two or more parties entering into affiliations will both need to purchase performance bonds, naming the State of North Carolina/DHHS as the obligee.

Clinical Director**Proposed Criterion:**

A Comprehensive Provider shall have a full time licensed clinical director (40 hours per week) with education and experience sufficient to provide clinical direction to the staff employed by the provider agency (provisional licenses are not acceptable). The following licensed disciplines are acceptable:

- Social Work
- Psychology
- Nursing
- Counselor
- Clinical Addiction Specialist
- Certified Clinical Supervisor

Group's Reaction:

Generally, the Group did agree with this proposed criterion as stated. The consensus was that the requirement of a full time equivalent or FTE for this position, while expensive for most providers, was appropriate for a Comprehensive Provider organization.

Proposed Solution:

Two providers who are unable to meet staffing requirements may affiliate to share a single clinical director as 1 FTE. Parties entering into affiliation relationships will both need to purchase performance bonds, naming the State of North Carolina/DHHS as the obligee.

Quality Improvement Director**Proposed Criterion:**

A Comprehensive Provider shall have 1 FTE Quality Improvement Director (required to provide evidence of quality improvement activities as required in the standard agreement/contract). This position requires a Bachelors Degree and three years experience or a Masters Degree and one year of experience utilizing data to support the development of quality services.

Group's Reaction:

The Group did not agree with this proposed criterion as stated. The general consensus was that the requirement of a full time equivalent or FTE for this position was expensive for most providers.

Proposed Solution:

Two providers who are unable to meet staffing requirements may affiliate. Parties entering into affiliations will both need to purchase performance bonds, naming the State of North Carolina/DHHS as the obligee.

Training Director**Proposed Criterion:**

A Comprehensive Provider shall have 1 FTE Training Director.

Group's Reaction:

The Group did not agree with this proposed criterion as stated. The general consensus was that the requirement of a full time equivalent or FTE for this position was expensive and unnecessary as the system has developed a reliance upon more Qualified Professionals (QPs) and licensed personnel.

Proposed Solution:

Two or more providers who are unable to meet staffing requirements may affiliate. Parties entering into affiliations will both need to purchase performance bonds, naming the State of North Carolina/DHHS as the obligee.

State Funds/Medicaid Funds:**Proposed Criterion:**

A Comprehensive Provider shall serve consumers who are eligible for Medicaid as well as indigent consumers supported by State funds (when requested by the LME).

Group's Reaction:

The majority of the Group did not object strongly to this proposed criterion, however, several members felt that this criterion may not be enforceable.

Standard Contract/Agreement:**Proposed Criterion:**

A Comprehensive Provider shall demonstrate the ability to meet the terms of the standard agreement or contract. The standard agreement is designed to be signed as a statewide document referenced in the Medicaid Enrollment Agreement.

Group's Reaction:

The Group agreed with this criterion and had no objection to it.

Performance Bond:**Proposed Criterion:**

When deemed necessary "to be in the best interests of the Department," the Comprehensive Provider and Affiliate Provider purchasing the Performance Bond must meet the requirements set forth within such bond.

Group's Reaction:

The Group generally did not oppose this criterion, but did have questions regarding how it would work in actuality.

Please note for Performance Bond Criterion:

The following legislative excerpt is taken from the Medicaid Provider Performance Bonds Section {Section 10.36 (e) (1and 1a)}. DHHS may require that Medicaid-enrolled providers purchase a performance bond of no more than \$100,000 or ask for a letter of credit honoring demand for an equivalent amount as a requirement of enrollment, re-enrollment, or reinstatement. DHHS may also waive this requirement based on specific standards such as a provider's amount of monthly billings, length of time providing

services in the State, quality of performance, and a need to ensure adequate access to care. [Although the changes here apply to all Medicaid-enrolled providers, the drive behind requiring some providers to have performance bonds is the result of Community Support cost overrides and suspected fraud and waste associated with the service.]

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